COLORADO

Department of Regulatory Agencies

2014 Sunset Review:

Colorado Medical Marijuana Code

Office of Policy, Research and Regulatory Reform

October 15, 2014

COLORADO
Department of Regulatory Agencies
Executive Director's Office

October 15, 2014

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the Colorado Medical Marijuana Code. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2015 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination….

The report discusses the question of whether there is a need for the regulation provided under Article 43.3 of Title 12, C.R.S. The report also discusses the effectiveness of the Executive Director of the Colorado Department of Revenue and the staff of the Marijuana Enforcement Division in carrying out the intent of the statutes and makes recommendations for statutory changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Barbara J. Kelley
Executive Director

1560 Broadway, Room 1550, Denver, CO 80202 P 303.894.7855 F 303.894.7885 www.colorado.gov/dora

COLORADO
Department of Regulatory Agencies

2014 Sunset Review
Colorado Medical Marijuana Code

SUMMARY

What Is Regulated?
The Colorado Medical Marijuana Code (Medical Code) creates the framework for the regulation of the medical marijuana industry. It provides for the licensing of medical marijuana centers, optional premises cultivation (OPC) operations and medical marijuana-infused products (MMIPs) manufacturers, as well as the individuals who own and work for such enterprises. The Medical Code also provides for the regulation of other aspects of the industry, such as labeling and packaging requirements and diversion prevention. The Medical Code does not regulate medical marijuana patients or their primary caregivers, nor does it address the recreational use of marijuana.

Why Is It Regulated?
Although Amendment 20 to the state's constitution essentially decriminalized medical marijuana for patients with certain debilitating medical conditions, marijuana remains illegal under federal law. The Medical Code helps to ensure that the state does not run afoul of the federal government's stated enforcement priorities of preventing diversion to children, other states and criminal organizations.

Who Is Regulated?
In fiscal year 13-14, the Executive Director of the Colorado Department of Revenue (Executive Director) licensed 493 medical marijuana centers, 729 OPC operations, 149 MMIPs manufacturers and 11,289 marijuana industry employees. That same fiscal year, 99 vendors and 147 primary caregiver cultivations were registered with the Executive Director.

How Is It Regulated?
All individuals who own or work for a licensed medical marijuana enterprise must pass a fingerprint-based criminal history background check, demonstrate Colorado residency and demonstrate financial responsibility. Medical marijuana enterprises must also document their funding sources, ownership structure and right to possess the premises where they operate.

What Does It Cost?
In fiscal year 13-14, the Executive Director employed 35 full-time equivalent employees and spent approximately $9.5 million to administer and enforce both the Medical Code and the Retail Marijuana Code.

What Disciplinary Activity Is There?
Between fiscal years 11-12 and 13-14, the Executive Director denied 119 individual and 252 business license applications, entered into 85 stipulated agreements, summarily suspended 3 licenses and issued 36 fines totaling $182,000.

KEY RECOMMENDATIONS

Continue the Medical Code for four years, until 2019.
Amendment 20 to the state's constitution decriminalized medical marijuana in 2000, though it remains illegal under federal law. Though not perfect, the Medical Code represents Colorado's effort to implement a strong and effective regulatory and enforcement system that addresses the federal government's enforcement priorities.

Make it unlawful for primary caregivers to fail to register their cultivation operations with the Executive Director and make proof of registration available to law enforcement on a verification only basis.
Primary caregivers who grow medical marijuana for their patients are required to register their cultivations with the Executive Director. However, only approximately five percent of primary caregivers have so registered, creating difficulties for law enforcement when trying to confirm whether someone is a primary caregiver.

Schedule the medical marijuana program administered by the Colorado Department of Public Health and Environment for a sunset review, with a sunset date of September 1, 2019.
The program administered by the Colorado Department of Public Health and Environment, among other things, creates the medical marijuana registry of medical marijuana patients and delineates the process by which the list of debilitating medical conditions can be expanded. This program lacks a sunset clause. Scheduling it to sunset in conjunction with the Medical Code in 2019 ensures that the entire medical marijuana industry is reviewed at that time.

MAJOR CONTACTS MADE DURING THIS REVIEW

Building Owners and Managers Association of Metro Denver
Cannabis Business Alliance
Cannabis Patients Alliance
Colorado Association of Chiefs of Police
Colorado Chapter of the National Organization to Reform Marijuana Laws
Colorado Department of Agriculture
Colorado Department of Law
Colorado Department of Public Health and Environment
Colorado District Attorneys' Council
Colorado Marijuana Enforcement Division
Hydroponic Society of America
Marijuana Industry Group
Patient and Caregiver Rights Litigation Project
Rocky Mountain High Intensity Drug Trafficking Area
SMART Colorado
United States Department of Justice

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are prepared by:
Colorado Department of Regulatory Agencies
Office of Policy, Research and Regulatory Reform
1560 Broadway, Suite 1550, Denver, CO 80202
www.dora.state.co.us/opr

Table of Contents

Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

[1] Criteria may be found at § 24-34-104, C.R.S.

- Whether the agency through its licensing or certification process imposes any disqualifications on applicants based on past criminal history and, if so, whether the disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subparagraph (i) of paragraph (a) of subsection (8) of this section shall include data on the number of licenses or certifications that were denied, revoked, or suspended based on a disqualification and the basis for the disqualification; and
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Types of Regulation

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review via DORA's website at: www.dora.colorado.gov/opr.

The regulatory functions of the Executive Director of the Colorado Department of Revenue (Executive Director) as enumerated in Article 43.3 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2015, unless continued by the General Assembly. During the year prior to this date, it is the duty of DORA to conduct an analysis and evaluation of the administration of the Colorado Medical Marijuana Code by the Executive Director pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation of medical marijuana should be continued for the protection of the public and to evaluate the performance of the Executive Director and staff of the Department of Revenue's Marijuana Enforcement Division (MED). During this review, the Executive Director must demonstrate that the regulation serves to protect the public health, safety or welfare, and that the regulation is the least restrictive regulation consistent with protecting the public. This review does not include an analysis of the Medical Marijuana Program at the Colorado Department of Public Health and Environment,[2] the Colorado Medical Board,[3] or the Colorado Retail Marijuana Code.[4]

[2] The Medical Marijuana Program is tasked with maintaining the Medical Marijuana Registry and issuing Registry Identification Cards to medical marijuana patients. It is not subject to sunset review.
[3] The Colorado Medical Board regulates physicians, who recommend medical marijuana to their patients, and in so doing, certify the number of plants to which such patients are entitled. It is scheduled to sunset in 2019.
[4] The Colorado Retail Marijuana Code was enacted following the passage of Amendment 64. It is scheduled to sunset in 2016.

DORA's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

Methodology

As part of this review, DORA staff performed a literature review; interviewed MED staff, officials with state and national industry associations, medical marijuana patients, medical marijuana licensees, and representatives of professional associations, law enforcement agencies and local governments; reviewed Colorado statutes and the Executive Director's rules; and reviewed the laws of other states.

Additionally, in August 2014, DORA conducted surveys of medical marijuana patients, primary caregivers and municipal and county governments. Due to the confidential nature of their registry information, medical marijuana patients and primary caregivers were notified of the surveys by the Colorado Department of Public Health and Environment (CDPHE) by way of email,[5] a link on the CDPHE website and various social media outlets frequently utilized by CDPHE to communicate with these populations. As a result, it is not possible to determine an overall response rate because it is not possible to determine the number of individuals who viewed the links to the surveys. However, 101 responses to the patient survey were submitted and 23 responses to the primary caregiver survey were submitted. Given that over 110,000 patients have registered with CDPHE and approximately 2,900 primary caregivers have been identified as such to CDPHE,[6] these "response rates" are extremely low.

Surveys of municipal and county governments were sent by way of email to addresses that DORA obtained through independent research of those entities. DORA sent the survey links to 403 municipal governments and 64 county governments. The response rate for municipalities was 17.6 percent and 18.8 percent for counties.

Survey responses can be found in Appendices A through D.

Profile of the Medical Marijuana Industry

The term "marijuana" refers to the plant species *Cannabis sativa L.*, and typically refers to the dried leaves, flowers, stems and seeds of that plant.[7] *Cannabis sativa L.*, has two main subspecies, *Cannabis sativa* and *Cannabis indica*. Hybrids of these main subspecies produce what are often referred to as "strains" of marijuana.[8]

[5] Only those who had previously provided their email addresses to CDPHE were notified of the survey by email.
[6] Primary caregivers do not directly register with CDPHE. Rather, when a patient registers with CDPHE, the patient identifies his or her primary caregiver, if the patient has one.
[7] *See* National Institute on Drug Abuse. *DrugFacts: Marijuana*. Retrieved April 21, 2014, from www.drugabuse.gov/publications/drugfacts/marijuana and ProCon.org. *Medical Marijuana: What Are the Differences between Cannabis Indica and Cannabis Sativa, and How Do They Vary in Their Potential Medical Utility?* Retrieved on May 1, 2014, from www.medicalmarijuana.procon.org/view.answers.php?questionID=000638
[8] ProCon.org. *Medical Marijuana: What Are the Differences between Cannabis Indica and Cannabis Sativa, and How Do They Vary in Their Potential Medical Utility?* Retrieved on May 1, 2014, from www.medicalmarijuana.procon.org/view.answers.php?questionID=000638

The marijuana plant contains over 100 chemicals called cannabinoids, which are similar to endocannabinoids. Endocannabinoids are produced by the human body and play a role in regulating pleasure, memory, thinking, concentration, movement, coordination, sensory and time perception, appetite and pain.[9] When cannabinoids are ingested, they act on specific molecular targets on brain cells, called cannabinoid receptors, which can overactivate the endocannabinoid system, resulting in the "high" and other effects users often experience.[10]

Of the over 100 cannabinoids known to exist, only two are of therapeutic interest—cannabidiol (CBD) and delta-9-tetrahydrocannabinol (THC). These two cannabinoids are found in varying ratios in the marijuana plant. THC, the more widely known of the two because of its mind-altering effects, not only stimulates appetite and reduces nausea, but it may also decrease pain, inflammation and spasticity. CBD is non-psychoactive and may be useful in reducing pain and inflammation, controlling epileptic seizures and possibly even treating psychosis and addictions.[11]

Cannabis sativa strains tend to have higher levels of THC, and *Cannabis indica* strains tend to have higher levels of CBD.[12]

As a result of these characteristics, medical marijuana is most typically used to provide relief from muscle spasms and chronic pain, reduce interlobular pressure inside the eye, suppress nausea and stimulate appetite. Patients suffering from Acquired Immune Deficiency Syndrome (AIDS), glaucoma, cancer, Multiple Sclerosis (MS), epilepsy, chronic pain, anxiety, depression and obsession are most frequently associated with medical marijuana use.[13]

The earliest written reference to cannabis being used for healing purposes can be found in a Chinese pharmacopeia dating to the 15th century B.C.[14] Various references to the plant being used for healing purposes can be found in writings from ancient Rome, Greece, India, North Africa and the Middle East.[15] Marijuana was even listed in the *United States Pharmacopeia* from 1850 until 1942 for various conditions, including labor pains, nausea and rheumatism.[16]

---

[9] National Institute on Drug Abuse. *DrugFacts: Is Marijuana Medicine?* Retrieved on April 21, 2014, from www.drugabuse.gov/publications/drugfacts/marijuana-medicine

[10] National Institute on Drug Abuse. *DrugFacts: Marijuana*. Retrieved on April 21, 2014, from www.drugabuse.gov/publications/drugfacts/marijuana

[11] National Institute on Drug Abuse. *DrugFacts: Is Marijuana Medicine?* Retrieved on April 21, 2014, from www.drugabuse.gov/publications/drugfacts/marijuana-medicine

[12] ProCon.org. *Medical Marijuana: What Are the Differences between Cannabis Indica and Cannabis Sativa, and How Do They Vary in Their Potential Medical Utility?* Retrieved on May 1, 2014, from www.medicalmarijuana.procon.org/view.answers.php?questionID+000638

[13] Disabled World. *Medical Marijuana for Pain and Depression*. Retrieved on April 21, 2014, from www.disabled-world.com/medical/pharmaceutical/marijuana

[14] ProCon.org. *Medical Marijuana Historical Timeline*. Retrieved on April 21, 2014, from medicalmarijuana.procon.org/view.timeline.php?timelineID=000026

[15] Infoplease.com. *Marijuana: History of Marijuana Use.* Retrieved on April 21, 2014, from www.infoplease.com/encyclopedia/science/marijuana-history-marijuana.use.html

[16] Infoplease.com. *Marijuana: History of Marijuana Use.* Retrieved on April 21, 2014, from www.infoplease.com/encyclopedia/science/marijuana-history-marijuana.use.html

The therapeutic value of THC has been recognized by the federal Food and Drug Administration (FDA) in its approval of Dronabinol and Nabilone, two synthetic THC-containing drugs used to treat nausea caused by chemotherapy and wasting disease caused by AIDS. A third drug, Sativex, containing synthetic variations of both THC and CBD, has been approved in the United Kingdom and other countries to treat spasticity caused by MS, and is currently in Phase III clinical trials in the United States to treat cancer pain. A fourth drug, Epidiolex, is CBD-based, and is intended to treat certain forms of childhood epilepsy. Epidiolex has yet to receive FDA approval for clinical trials.[17]

Thus, the medicinal use of marijuana is not a new phenomenon. Indeed, it is thousands of years old. Yet, Colorado's experience with medical marijuana began in earnest on December 28, 2000, when Amendment 20 took effect.

In short, Amendment 20 authorized those with certain debilitating medical conditions to grow, possess and use limited amounts of marijuana.[18] Amendment 20 envisioned patients either growing their own marijuana (up to six plants, or more if medically necessary)[19] or forming relationships with primary caregivers who grow the plants for their patients and who bear "significant responsibility for managing the well-being of" their patients.[20]

Colorado's medical marijuana environment has evolved dramatically in the 14 years since Amendment 20's passage. Although the intimate, one-on-one relationship of the primary caregiver and patient continues, it has been subsumed by the commercialization of marijuana in the state.

Patients can now obtain medical marijuana from medical marijuana centers (historically known as dispensaries). Many medical marijuana centers will provide discounts or special pricing to those patients who designate a particular medical marijuana center as their "primary center." These medical marijuana centers, in turn, may legally grow marijuana for their registered patients, but they must grow 70 percent of what they sell, and they must sell 70 percent of what they grow. The remaining 30 percent may be sold to other medical marijuana centers or medical marijuana-infused products manufacturers. This "70/30" rule helps the medical marijuana centers account for fluctuations in patient counts (which may result in having too much or too little product on hand) and crop failures.

[17] National Institute on Drug Abuse. *DrugFacts: Is Marijuana Medicine?* Retrieved on April 21, 2014, from www.drugabuse.gov/publications/drugfacts/marijuana-medicine
[18] Colo. Const. Art. XVIII, § 14.
[19] Colo. Const. Art. XVIII, § 14(4).
[20] Colo. Const. Art. XVIII, § 14(1)(f).

Regardless of whether a patient grows his or her own medical marijuana or obtains it from a primary caregiver or a medical marijuana center, the patient must first obtain, from a Colorado-licensed physician, a diagnosis of suffering from one of the enumerated debilitating medical conditions. The physician must also find that the patient "might benefit from the medical use of marijuana."[21]

Medical marijuana is now available in a variety of forms. The dried buds and leaves of the cannabis plant may be smoked through a variety of paraphernalia, including joints, pipes or bongs. The cannabinoid crystals may also be harvested and dried to form hash, which can also be smoked. Cannabinoid oils can be extracted from the cannabis plant and used to create tinctures, ointments and concentrates, which can, in turn be infused into an infinite number of edible products.

The method of consumption, in part, dictates the speed at which the patient experiences the desired effects of medical marijuana. When marijuana is smoked, the cannabinoids quickly pass into the bloodstream from the lungs, and are then carried to the brain and other organs. When cannabis is ingested in food or drink, the cannabinoids are absorbed more slowly.[22] Importantly, the cannabinoids must be activated by heat, which can be achieved when smoked, processed for consumption or consumed using pipes, vaporizers or vaporizer pens.

The overall annual demand for marijuana by adults in Colorado is estimated at between 104.2 and 157.9 metric tons. This is a combined total for both medical and retail marijuana, and, for retail marijuana, includes demand by out-of-state visitors.[23]

Although medical marijuana, and now retail marijuana, is widely available in Colorado, all forms of marijuana remain illegal under federal law.

[21] Colo. Const. Art. XVIII, § 14(2)(a)(II).
[22] National Institute on Drug Abuse. *DrugFacts: How Does Marijuana Affect the Brain?* Retrieved on April 21, 2014, from www.drugabuse.gov/publications/drugfacts/marijuana
[23] Miles Light, et al, "Market Size and Demand for Marijuana in Colorado." Prepared for the Colorado Department of Revenue by the Marijuana Policy Group, July 2014, p. 2.

Legal Framework

History of Regulation

The history of cannabis in the United States is long and storied, and it even predates the founding of the nation. As early as 1619, the Virginia Assembly required every farmer in that colony to grow hemp, to be used primarily in the production of rope, sails and clothing. Domestic production flourished until after the Civil War, when other materials began to replace hemp for many purposes.[24]

In the late 19th century, cannabis became a popular ingredient in many medicinal products and was sold openly in public pharmacies. The federal Pure Food and Drug Act of 1906 required the labeling of any cannabis contained in over-the-counter remedies.[25]

The Mexican Revolution of 1910 forever altered public perception of cannabis. Mexican immigrants to the United States brought with them their recreational use of cannabis, which became known as marijuana. This instigated a flurry of research that linked the use of marijuana with violence, crime and other "socially deviant" behavior. By 1931, 29 states had outlawed marijuana.[26]

In 1937, Congress passed the Marijuana Tax Act, which effectively criminalized marijuana by restricting possession to individuals who paid an excise tax for certain, authorized medical and industrial uses.[27]

Despite a resurgence of hemp production during World War II (for the production of marine cordage, parachutes and other military necessities),[28] Congress placed marijuana and tetrahydrocannabinol in Schedule I of the Controlled Substances Act of 1970, where they remain today.[29]

Schedule I substances have a high potential for abuse and no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of the substance under medical supervision.[30]

[24] PBS Frontline. *Marijuana Timeline: Busted – America's War on Marijuana.* Retrieved on April 21, 2014, from www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.htm
[25] PBS Frontline. *Marijuana Timeline: Busted – America's War on Marijuana.* Retrieved on April 21, 2014, from www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.htm
[26] PBS Frontline. *Marijuana Timeline: Busted – America's War on Marijuana.* Retrieved on April 21, 2014, from www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.htm
[27] PBS Frontline. *Marijuana Timeline: Busted – America's War on Marijuana.* Retrieved on April 21, 2014, from www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.htm
[28] PBS Frontline. *Marijuana Timeline: Busted – America's War on Marijuana.* Retrieved on April 21, 2014, from www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.htm
[29] 21 U.S.C. § 812(c)(c)(10) and (17).
[30] 21 U.S.C. § 812(b)(1).

Notwithstanding the status of marijuana at the federal level, on November 7, 2000, the voters of Colorado passed Amendment 20 to the state's constitution, effectively decriminalizing the medical use of the drug. Amendment 20 became effective on December 28, 2000.

The provisions of Amendment 20 create an affirmative defense for any patient, or the patient's primary caregiver, whose physician has diagnosed the patient as having a debilitating medical condition, and whose physician has advised the patient that the patient might benefit from the use of medical marijuana.[31]

Amendment 20 also provides for the creation of a registry of medical marijuana patients, including requirements for inclusion on the registry and the issuance of registry identification cards.[32]

Amendment 20 generally limits possession of medical marijuana to no more than two ounces of marijuana in a useable form and no more than six plants. However, the patient or the patient's primary caregiver may raise as an affirmative defense that more than these general limitations are medically necessary to address the patient's condition.[33]

Patients must be at least 18 years old. Those under 18 may use medical marijuana only when two physicians recommend its use and the patients' parents consent.[34]

No health insurance carrier, neither public nor private, is required to provide reimbursements for medical marijuana,[35] and no employer is required to accommodate the use of medical marijuana in the workplace.[36]

House Bill 01-1371 designated the Colorado Department of Public Health and Environment (CDPHE) as the agency responsible for establishing and maintaining the medical marijuana registry envisioned by Amendment 20. The General Assembly granted CDPHE broad rule-making authority to promulgate the registry application forms, the processes for issuing medical marijuana registry cards and the manner in which CDPHE could consider adding to the list of debilitating medical conditions outlined in Amendment 20.

In the years that followed, local governments began licensing medical marijuana dispensaries.

[31] Colo. Const. Art. XVIII, § 14(2)(a).
[32] Colo. Const. Art. XVIII, § 14(2)(b).
[33] Colo. Const. Art. XVIII, § 14(4).
[34] Colo. Const. Art. XVIII, § 14(6).
[35] Colo. Const. Art. XVIII, § 14(10)(a).
[36] Colo. Const. Art. XVIII, § 14(10)(b).

On October 19, 2009, the United States Department of Justice issued what has come to be known as the "Ogden Memo," which, while recognizing the plenary authority of the various United States Attorneys, directed they,

> should not focus federal resources in [their] states on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana.[37]

Thus, the 2010 legislative session began within the context of Colorado's local governments having created a patchwork of regulations and the federal government having indicated that it might not enforce federal law with fervor.

The two major marijuana-related pieces of legislation passed in 2010 were Senate Bill 109 and House Bill 1284 (HB 1284). The first defined a "bona fide physician-patient relationship," more clearly delineating the process physicians must follow when recommending medical marijuana and prohibiting physicians from holding an economic interest in an enterprise that provides or distributes medical marijuana.

House Bill 1284 created the Colorado Medical Marijuana Code (Medical Code), the subject of this sunset report. Among other things, HB 1284 created the framework for the licensing of medical marijuana centers, their cultivation operations, medical marijuana-infused products (MMIPs) manufacturers and the individuals who work in such facilities. The bill named the Executive Director of the Colorado Department of Revenue (Executive Director) as the state licensing authority to administer the Medical Code.

The bill also provided that those who were operating established, locally approved businesses as of July 1, 2010, could continue to do so, so long as they applied for a state license by August 1, 2010.

House Bill 1284 had statewide applicability, unless a local government "opts out" and bans medical marijuana centers, cultivation operations and MMIPs manufacturers. The bill further refined the role the primary caregivers play, by, among other things, providing that primary caregivers may, in general, care for no more than five patients at any time. It also banned primary caregivers from having employees and from joining together to cultivate marijuana.

House Bill 11-1043, among other things, essentially placed a moratorium on new medical marijuana licenses by providing that those who had applied for a license by August 1, 2010, could continue to operate, but that no new applications could be submitted until July 1, 2012. The bill also limited manufacturers of marijuana-infused products to no more than 500 marijuana plants and created procedures for the destruction of any unauthorized medical marijuana or MMIPs.

---

[37] U.S. Department of Justice. *Memorandum for Selected United States Attorneys, from David W. Ogden, Deputy Attorney General, regarding Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana*, October 19, 2009. Retrieved October 23, 2013, from http://blogs.justice.gov/main/archives/192

House Bill 11-1250 required that MMIPs be sold in packaging that is designed to be significantly difficult for children under five years of age to open.

In November 2012, the voters of Colorado legalized the recreational use of marijuana. The ballot initiative, known as Amendment 64, took effect on December 10, 2012, requiring the Executive Director to begin accepting license applications for retail marijuana stores, cultivation operations and marijuana products manufacturers on October 1, 2013. Though some of the terminology in this amendment differed from that used in HB 1284, such as "stores" rather than "centers," the basic licensing structure mirrored the Medical Code.

House Bill 13-1317 implemented Amendment 64 by creating the Colorado Retail Marijuana Code (Retail Code). In so doing, the General Assembly also amended the Medical Code with respect to the way in which the two codes would work to fund the Executive Director's regulatory obligations.

Although the Retail Code imported many of the concepts contained in the Medical Code, the two codes differed in significant ways, particularly with respect to matters such as mandatory testing, labeling and packaging requirements.

House Bill 13-1061 created the parameters for the approval of responsible medical marijuana vendor training programs.

House Bill 13-1238 required the Executive Director to issue medical marijuana licenses upon the successful completion of the state application process, thus obviating the previous practice of withholding state approval until local approvals had been obtained. Under the provisions of this bill, a local licensing authority's refusal to issue a license became grounds for the Executive Director to revoke the state license, thereby ensuring that both state and local licenses are obtained prior to commencing operations.

House Bill 14-1122 removed from statute the packaging requirements for medical marijuana, and directed the Executive Director to promulgate rules that are consistent with the federal Poison Prevention Packaging Act of 1970.

Federal Laws and Guidance

The federal Controlled Substances Act classifies marijuana and the cannabinoid tetrahydrocannabinol (THC) in Schedule I, [38] which means that they have a high potential for abuse, they have no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of them under medical supervision.[39] As such, both substances are illegal under federal law.

[38] 21 U.S.C. §§ 812(c)(c)(10) and (17).
[39] 21 U.S.C. § 812(b)(1).

Their illegal status means that possession of any amount of marijuana is punishable by up to a year in prison and a fine of $1,000 for a first offense, and a second offense carries a mandatory penalty of between 15 days and two years in prison. Subsequent offenses can carry a prison term of between 90 days and three years, plus a $5,000 fine.[40]

The penalties for selling or cultivating marijuana depend on the amount at issue:[41]

- Less than 50 kilograms (kg) = up to five years in prison and a fine of $250,000;
- 50-100 kg = up to 20 years in prison and a fine of $1 million;
- 100-1,000 kg = between 5 and 40 years in prison and a fine of $2 million; and
- More than 1,000 kg = between 10 years and life in prison and a fine of $4 million.

In addition to the relatively simple issues of possession, cultivation and sale of marijuana, the plant's status under federal law raises other, more complicated legal matters. These include, but are not limited to, banking and the utilization of the Federal Reserve System, money laundering, air emissions, water emissions, the use of pesticides and the payment of taxes (including deductible and allowable expenses).

The United States Department of Justice (DOJ), recognizing the fact that nearly half the states had either decriminalized or legalized medical marijuana, issued a memorandum in 2013 to all United States Attorneys providing guidance regarding marijuana enforcement. That memorandum, often referred to as the "Cole Memo," delineated the DOJ's enforcement priorities as preventing:[42]

- The distribution of marijuana to minors;
- Revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- The diversion of marijuana from states where it is legal under state law in some form to other states;
- State-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
- Violence and the use of firearms in the cultivation and distribution of marijuana;
- Drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Growing marijuana on public land and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Marijuana possession or use on federal property.

[40] LegalMatch Law Library. *Federal Marijuana Laws.* Retrieved June 25, 2014, from www.legalmatch.com/law-library/article/federal-marijuana-laws.html
[41] LegalMatch Law Library. *Federal Marijuana Laws.* Retrieved June 25, 2014, from www.legalmatch.com/law-library/article/federal-marijuana-laws.html
[42] U.S. Department of Justice. *Memorandum for all United States Attorneys, from James M. Cole, Deputy Attorney General, regarding Guidance Regarding Marijuana Enforcement,* August 29, 2013, pp. 1-2. Retrieved on October 22, 2013, from www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf

While the Cole Memo's guidance reinforces the DOJ's position that United States Attorneys and federal law enforcement should continue to focus on the enumerated priorities, it also clarified the DOJ's expectation,

> that states and local governments that have enacted laws authorizing marijuana-related conduct will implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests.[43]

In such circumstances,

> enforcement of state law by state and local law enforcement and regulatory bodies should remain the primary means of addressing marijuana-related activity.[44]

Taken together, these provisions are generally interpreted as meaning that so long as state law creates a robust regulatory environment that is strongly enforced, the federal government will not interfere except in those individual cases where the DOJ's enforcement priorities are at risk.

Medical Marijuana under Colorado law

Medical marijuana is marijuana that is grown and sold pursuant to the provisions of the Medical Code and for a purpose authorized by Colorado's constitution.[45]

The state's constitution defines medical use as:

> the acquisition, possession, production, use, or transportation of marijuana or paraphernalia related to the administration of such marijuana to address the symptoms or effects of a patient's debilitating medical condition . . .[46]

Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, cachexia, severe pain, severe nausea, seizures and persistent muscle spasms constitute debilitating medical conditions. Additionally, CDPHE may deem other conditions to be debilitating medical conditions,[47] but it has not, as of this writing, done so.

---

[43] U.S. Department of Justice. *Memorandum for all United States Attorneys, from James M. Cole, Deputy Attorney General, regarding Guidance Regarding Marijuana Enforcement,* August 29, 2013, p. 2. Retrieved on October 22, 2013, from www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf

[44] U.S. Department of Justice. *Memorandum for all United States Attorneys, from James M. Cole, Deputy Attorney General, regarding Guidance Regarding Marijuana Enforcement,* August 29, 2013, p. 3. Retrieved on October 22, 2013, from www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf

[45] § 12-43.3-104(7), C.R.S.

[46] Colo. Const. Art. XVIII, § 14(1)(b).

[47] Colo. Const. Art. XVIII, § 14 (1)(a) and § 25-1.5-106(2)(f), C.R.S.

In short, the state's constitution creates an affirmative defense to the state's criminal laws relating to the use of marijuana where the patient:[48]

- Was diagnosed by a physician as having a debilitating medical condition;
- Was advised by his or her physician that the patient might benefit from the medical use of marijuana; and
- Was in possession of amounts of marijuana only as permitted by the state's constitution.

A medical marijuana patient may possess no more than two ounces of a useable form of marijuana and no more than six marijuana plants, with three or fewer being mature, flowering plants that are producing a useable form of marijuana. A patient may possess more than this, if he or she can demonstrate that a greater amount is medically necessary to treat the patient's debilitating medical condition.[49]

Medical marijuana patients must register with CDPHE to be considered in compliance with the state's constitution.[50]

A medical marijuana patient may grow his or her own medical marijuana plants, obtain medical marijuana from a primary caregiver, or obtain medical marijuana from a medical marijuana center.

A primary caregiver is a person, other than the patient or the patient's physician, who is at least 18 years old and has "significant responsibility for managing the well-being" of the patient.[51]

Any primary caregiver who cultivates medical marijuana for his or her patients is required to register that cultivation with the Executive Director.[52]

The Executive Director, in turn, is required to, among other things: [53]

- Grant or refuse state licenses for the cultivation, manufacture, distribution and sale of medical marijuana;
- Suspend, fine, restrict or revoke such licenses upon a violation of the Medical Code or the rules promulgated thereunder; and
- Promulgate such rules as are necessary for the proper regulation and control of the cultivation, manufacture, distribution and sale of medical marijuana and for the enforcement of the Medical Code.

[48] Colo. Const. Art. XVIII, § 14(2)(a).
[49] Colo. Const. Art. XVIII, § 14(4).
[50] § 25-1.5-106(9)(a), C.R.S.
[51] Colo. Const. Art. XVIII, § 14(1)(f).
[52] §§ 25-1.5-106(7)(e) and 12-43.3-201(1), C.R.S.
[53] § 12-43.3-202(1), C.R.S.

In furtherance of this assignment, the Executive Director is authorized to promulgate rules, and has done so, on a variety of subjects, including:[54]

- Compliance with, enforcement of or violation of any provision of the Medical Code or any rule promulgated thereunder, including procedures and grounds for denying, suspending, fining, restricting or revoking a state license;[55]
- Requirements for inspections, investigations, searches, seizures, forfeitures and such additional activities as may become necessary from time to time;
- Creation of a range of penalties;[56]
- Prohibition of misrepresentation and unfair practices;
- Control of informational and product displays on licensed premises;
- Development of individual identification cards for owners, officers, managers, contractors, employees and other support staff or entities licensed pursuant to the Medical Code, including a fingerprint-based criminal history record check as may be required prior to issuing a card;
- Security requirements for any premises licensed pursuant to the Medical Code, including, at a minimum, lighting, physical security, video, alarm requirements and other minimum procedures for internal control;[57]
- Regulation of the storage of, warehouses for and transportation of medical marijuana;[58]
- Sanitary requirements for medical marijuana centers, including, but not limited to, sanitary requirements for the preparation of MMIPs;[59]
- The specification of acceptable forms of picture identification that a medical marijuana center may accept when verifying a sale;[60]
- Labeling standards;[61]
- Prohibition of the sale of MMIPs unless the product is packaged in packaging meeting requirements that are similar to the federal Poison Prevention Packaging Act of 1970;[62]
- Records to be kept by licensees and the required availability of records;[63]
- State licensing procedures, including procedures for renewals, reinstatements, initial licenses and the payment of license fees; and
- Such other matters as are necessary for the fair, impartial, stringent and comprehensive administration of the Medical Code.

No one may operate a medical marijuana center, optional premises cultivation (OPC) operation or a MMIPs manufacturing facility unless he or she first obtains a license from both the Executive Director and the appropriate local licensing authority.[64]

[54] § 12-43.3-202(2)(a), C.R.S.
[55] *See* 1 CCR 212-1, §§ M 1200 and 1300, *et seq.*
[56] *See* 1 CCR 212-1, § M 1307.
[57] *See* 1 CCR 212-1, § M 305.
[58] *See* 1 CCR 212-1, §§ M 801 and 802.
[59] *See* 1 CCR 212-1, §§ M 407, 504 and 604.
[60] *See* 1 CCR 212-1, § M 405.
[61] *See* 1 CCR 212-1, § M 1001, *et seq.*
[62] *See* 1 CCR 212-1, § M 1001.
[63] *See* 1 CCR 212-1, §§ M 309 and 901.
[64] § 12-43.3-310(2), C.R.S., and 1 CCR 212-1, § M 101.

In order to better prevent unlicensed parties from controlling medical marijuana licensees, the Executive Director must require a complete disclosure of all people having a direct or indirect financial interest in each licensee.[65]

The Executive Director is authorized to issue four classes of licenses:[66]

- Medical marijuana center license;
- OPC operation license;
- MMIPs manufacturing license; and
- Occupational licenses.

A medical marijuana center is a business that sells medical marijuana to patients or primary caregivers, but is not, itself, a primary caregiver.[67]

An OPC operation refers to where a medical marijuana center or a MMIPs manufacturer grows and cultivates the medical marijuana that it sells.[68]

A MMIPs manufacturer is a person or business that manufactures products infused with medical marijuana that are intended for use or consumption other than by smoking, including edible products, ointments and tinctures.[69]

In general, occupational licenses are issued to owners, managers, operators, employees, contractors and other support staff employed by, working in or having access to restricted areas of a licensed premises.[70] There are three basic types of occupational licenses:

- Associated key licenses are issued to individuals who are owners of a medical marijuana business.[71]
- Key licenses are issued to individuals who perform duties that are key to the medical marijuana business' operation and have the highest level of responsibility.[72]
- Support licenses are issued to individuals who perform duties that support the medical marijuana business' operations, such as sales clerks and cooks.[73]

[65] § 12-43.3-313, C.R.S.
[66] § 12-43.3-401(1), C.R.S.
[67] § 12-43.3-104(8), C.R.S.
[68] §§ 12-43.3-104(11) and (12), C.R.S.
[69] §§ 12-43.3-104(9) and (10), C.R.S.
[70] § 12-43.3-401(1)(d), C.R.S.
[71] 1 CCR 212-1, § M 103.
[72] 1 CCR 212-1, § M 103.
[73] 1 CCR 212-1, § M 103.

No license may be issued,[74]

- If an application pertains to a premises that is the same or within 1,000 feet of a location for which a license was denied within the previous two years due to the nature of the use or other concern related to the location;
- Until the applicant is in possession of the premises;
- If such use is not permitted under the applicable zoning laws; or
- If the premises are within 1,000 feet of a school; an alcohol treatment facility; the principal campus of a college, university or seminary; or a residential childcare facility.

All medical marijuana licenses are valid for a period not to exceed two years from the date of issuance.[75]

The Executive Director is specifically prohibited from issuing any license to:[76]

- A person whose criminal history indicates that he or she is not of good moral character;
- A corporation, if the criminal history of any of its officers, directors or stockholders indicates that such an individual is not of good moral character;
- A licensed physician who makes patient recommendations for medical marijuana usage;
- A person employing, assisted by, or financed in whole or in part by any other person whose criminal history indicates that he or she is not of good moral character and reputation;
- A person under 21 years old;
- A person who has failed to provide a surety bond or file any tax return with a taxing agency;
- A person who has failed to pay any taxes, interest or penalties due;
- A person who has failed to pay any judgments due to a governmental agency;
- A person who has failed to stay out of default on a government-issued student loan;
- A person who has failed to pay child support;
- A person who has failed to remedy an outstanding delinquency for taxes owed, judgments owed to a government agency or child support;
- A person who has discharged a sentence in the five years immediately preceding the application date for a conviction of a felony;
- A person who at any time has been convicted of a felony regarding the possession, distribution, manufacturing, cultivation or use of a controlled substance;
- A person who employs another person at a medical marijuana facility who has not passed a criminal history background check;

[74] § 12-43.3-308, C.R.S.
[75] § 12-43.3-310(6), C.R.S.
[76] § 12-43.3-307(1), C.R.S.

- A sheriff, deputy sheriff, police officer or prosecuting officer, or an officer or employee of the Executive Director or any local licensing authority;
- A person whose authority as a primary caregiver has been revoked by CDPHE;
- A person for a location that is currently licensed as a retail food establishment or wholesale food registrant; and
- An owner who has not been a resident of Colorado for at least two years prior to the date of the owner's application.

Since an individual's criminal history is grounds to deny a license application, all license applicants are required to submit to fingerprint-based criminal history background checks.[77]

A licensed OPC operation, commonly referred to as a "grow," must be associated with a licensed medical marijuana center or a licensed MMIPs manufacturer.[78] This is commonly referred to as "vertical integration." This is further codified by limiting licensed medical marijuana centers' ability to sell to other licensed medical marijuana centers no more than 30 percent of a given licensee's total on-hand inventory of medical marijuana.[79]

This is commonly referred to as the "70/30 rule," which essentially dictates that a medical marijuana center licensee must sell 70 percent of what it grows and grow 70 percent of what it sells. The remaining 30 percent may be wholesaled to other medical marijuana licensees and, likewise, it may purchase up to 30 percent of what it sells from other medical marijuana centers. This also requires any wholesale transactions to be based on the medical marijuana center, not the associated OPC operation. If a licensee desires to wholesale any medical marijuana, the medical marijuana must be transferred from the OPC operation to its associated medical marijuana center. From there, the medical marijuana may be transferred to the purchasing medical marijuana center or MMIPs manufacturer.

In general, then, most of the medical marijuana sold at a medical marijuana center must be grown at its own licensed OPC operation. Additionally, a licensed medical marijuana center may sell immature plants to patients, primary caregivers, MMIPs manufacturers and other licensed medical marijuana centers.[80]

Finally, a licensed medical marijuana center may sell prepackaged and labeled MMIPs that are manufactured by a licensed MMIPs manufacturer.[81] However, MMIPs may not be consumed on any premises licensed pursuant to the Medical Code.[82]

[77] § 12-43.3-307(2)(c), C.R.S.
[78] § 12-43.3-403(1), C.R.S.
[79] § 12-43.3-402(4), C.R.S.
[80] § 12-43.3-402(3), C.R.S.
[81] § 12-43.3-402(2), C.R.S.
[82] § 12-43.3-404(6), C.R.S.

All medical marijuana products must be labeled with a list of all chemical additives that were used in the cultivation and the production of the medical marijuana product.[83]

Prior to making any sale of medical marijuana or MMIPs to a patient, the licensed medical marijuana center must verify that the purchaser has a valid medical marijuana registry card[84] and valid photo identification.[85] Unless authorized by a physician, a patient may purchase no more than two ounces of medical marijuana, or its equivalent in MMIPs, during a single sales transaction.[86]

A licensed MMIPs manufacturer may obtain medical marijuana from licensed medical marijuana centers, or it may have its own OPC operation.[87] If it has its own OPC operation, it may not sell that medical marijuana unless it is contained in the MMIPs it manufactures itself.[88] In general, a MMIPs manufacturer may grow no more than 500 plants at any one time.[89]

The Executive Director may suspend or revoke a license, or impose a fine on any licensee for a violation of the Medical Code by the licensee or any of its agents or employees.[90] Any such actions can only be taken after an investigation and an opportunity for a public hearing.[91]

No suspension, except a summary suspension, may last more than six months[92] and in those instances when a suspension is for 14 days or less, the licensee may petition the Executive Director to pay a fine in lieu of suspension.[93] Such a fine may be no less than $500 and no more than $100,000.[94]

[83] § 12-43.3-402(7), C.R.S.
[84] § 12-43.3-402(5), C.R.S., and 1 CCR 212-1, § M 405(A)(1).
[85] 1 CCR 212-1, § M 405(A)(1).
[86] 1 CCR 212-1, § M 403(E).
[87] §§ 12-43.3-404(3) and (8), C.R.S.
[88] § 12-43.3-404(8), C.R.S.
[89] § 12-43.3-404(9), C.R.S.
[90] §§ 12-43.3-601(1) and (2), C.R.S.
[91] § 12-43.3-601(1), C.R.S.
[92] § 12-43.3-601(2), C.R.S.
[93] § 12-43.3-601(3)(a), C.R.S.
[94] § 12-43.3-601(3)(b), C.R.S.

If the Executive Director or a local licensing authority issues a final agency order imposing a disciplinary action against a licensee, that final agency order may specify that some or all of the licensee's marijuana, including any MMIPs, is not medical marijuana and is therefore an illegal controlled substance. As such, the final agency order may direct the destruction of any such marijuana and MMIPs.[95] In such a case, the licensee has 15 days within which to petition the District Court in the City and County of Denver for a stay of the agency's action.[96] At the conclusion of this period, the Executive Director must notify the relevant district attorney of the Executive Director's intent to destroy the marijuana or MMIPs to ensure that it is not evidence in a criminal proceeding. The Executive Director must then wait 15 days from the date of notice before the actual destruction can commence.[97]

Licensees are required to keep and maintain books and records necessary to fully document the business transactions of the licensee.[98] The Executive Director may inspect such records as well as any licensed premises during business hours.[99]

It is unlawful for any person to consume medical marijuana in a licensed medical marijuana center, to knowingly permit the use of his or her registry identification card by another person for the unlawful purchasing of medical marijuana,[100] or to buy, sell, transfer, give away or acquire medical marijuana except as allowed under the Medical Code.[101]

It is unlawful for any licensee to:[102]

- Be within a limited access area[103] unless the person's license badge is displayed;
- Fail to designate areas of ingress and egress for limited access areas;
- Fail to report a transfer of medical marijuana;
- Fail to report the name of or a change in managers;
- Display any signs that are inconsistent with local laws or regulations;
- Use advertising material that is misleading, deceptive or false, or that is designed to appeal to minors;
- Provide public premises for the purpose of consumption of medical marijuana in any form;

[95] § 12-43.3-602(4), C.R.S.
[96] § 12-43.3-602(5), C.R.S.
[97] § 12-43.3-602(6), C.R.S.
[98] § 12-43.3-701(1), C.R.S.
[99] § 12-43.3-701(2), C.R.S.
[100] § 12-43.3-901(1), C.R.S.
[101] § 12-43.3-901(2), C.R.S.
[102] §§ 12-43.3-901(3) and (4), C.R.S.
[103] Section 12-43.3-105, C.R.S., defines limited access area as "a building, room or other contiguous area upon the licensed premises where medical marijuana is grown, cultivated, stored, weighed, displayed, packaged, sold, or possessed for sale, under control of the licensee, with limited access to only those persons licensed by" the Executive Director. A limited access area can be differentiated from a restricted access area, which 1 CCR 212-1, § M 103, defines as a designated and secure area within a licensed medical marijuana center where medical marijuana and MMIPs are sold, possessed for sale, and displayed for sale, and where no one without a valid medical marijuana registry card is permitted.

- Sell medical marijuana to a person who is not licensed or who is not able to produce a valid patient registry identification card;
- Possess more than six medical marijuana plants and two ounces of medical marijuana for each patient who has registered the medical marijuana center as his or her primary center, unless such patients are authorized to have more than such amounts;
- Offer for sale medical marijuana in person except within licensed premises;
- Buy medical marijuana from a person not licensed to sell medical marijuana;
- Sell medical marijuana except in the permanent location specifically designated in the license;
- Sell, serve or distribute medical marijuana at any time other than between the hours of 8:00 a.m. and 7:00 p.m.;
- Burn or otherwise destroy medical marijuana for the purpose of evading an investigation or preventing seizure; or
- Abandon a licensed premises without notifying the Executive Director and local licensing authority at least 48 hours in advance and without accounting for and forfeiting to the Executive Director for destruction all medical marijuana.

A medical marijuana center may sell medical marijuana to any patient with a valid registry identification card,[104] but it may only grow for those patients who designate it as their primary center.[105] Once a patient designates a primary care center, he or she cannot change that designation for at least 30 days.[106]

All money collected pursuant to the Medical Code is deposited into the Marijuana Cash Fund, which is also funded by money collected pursuant to the Retail Code.[107]

Finally, the Executive Director, in consultation with CDPHE, is directed to approve responsible medical marijuana vendor server and seller training programs.[108] Such programs must last at least two hours and must cover a core curriculum addressing:[109]

- Information on required licenses, age requirements, patient registry identification cards, maintenance of records, privacy issues and unlawful acts;
- Administrative and criminal liability and license and court sanctions;
- Statutory and regulatory requirements for employees and owners;
- Acceptable forms of identification, including medical marijuana registry identification cards and associated documents and procedures; and
- Local and state licensing and enforcement statutes and rules.

[104] § 12-43.3-402(5), C.R.S.
[105] 1 CCR 212-1, § M 402(A).
[106] 1 CCR 212-1, § M 402(B).
[107] § 12-43.3-501(1), C.R.S.
[108] § 12-43.3-1101(1), C.R.S.
[109] § 12-43.3.-1101(2)(b), C.R.S.

A medical marijuana business may be designated as a responsible vendor after successfully completing a responsible vendor training program.[110] Such designation is valid for two years[111] and may be considered as a mitigating factor if the licensee is subsequently found to violate the Medical Code.[112]

Any municipality, county, city or city and county (local government) may opt out of the Medical Code, thereby banning the commercial cultivation and sale of medical marijuana in that jurisdiction.[113]

Local Regulation of Medical Marijuana

A local government that opts to allow the commercial cultivation or sale of medical marijuana within its jurisdiction must adopt an ordinance or resolution, as applicable, containing specific licensing standards, or it may consider the provisions of the Medical Code to be the minimum licensing standards.[114] Local governments are expressly authorized to promulgate licensing standards pertaining to:[115]

- Distance restrictions between premises for which local licenses are issued;
- Reasonable restrictions on the size of an applicant's licensed premises; and
- Any other requirements necessary to ensure the control of the premises and the ease of enforcement of the terms and conditions of the license.

Local governments are limited to issuing licenses to medical marijuana centers, OPC operations and MMIPs manufacturers.[116] Any application for a local license must be submitted to the Executive Director along with the application for a state license.[117] No medical marijuana center, OPC operation or MMIPs manufacturer may operate until it has been issued the appropriate licenses from both the Executive Director and the local government.[118]

Data as to the counties and municipalities that specifically allow or ban medical marijuana is surprisingly difficult to come by. As a result, staff of the Department of Regulatory Agencies (DORA) utilized several sources to compile the data in the following paragraphs.

[110] § 12-43.3-1102(1)(a), C.R.S.
[111] § 12-43.3-1102(1)(a), C.R.S.
[112] § 12-43.3-1102(3), C.R.S.
[113] § 12-43.3-106, C.R.S.
[114] § 12-43.3-301(2)(a), C.R.S.
[115] § 12-43.3-301(2)(b), C.R.S.
[116] § 12-43.3-301(1), C.R.S.
[117] § 12-43.3-301(3), C.R.S.
[118] § 12-43.3-310(2), C.R.S., and 1 CCR 212-1, § M 101.

As of July 2014, at least 23 of Colorado's 64 counties, mostly along the Front Range, allowed medical marijuana, with an additional three having enacted partial bans. The remaining counties had banned medical marijuana, either through a vote of the people or through their respective boards of county commissioners. Two of the counties that allow medical marijuana businesses were not allowing any new businesses to open.[119]

As of January 2014, at least 45 Colorado municipalities specifically allowed medical marijuana within their jurisdictions, with another 158 specifically banning it.[120]

However, as of September 22, 2014, the Executive Director had issued licenses to medical marijuana centers in 54 municipalities, within 20 counties, including the City and County of Denver.

According to the responses received related to the survey DORA conducted in August 2014, 33 percent of municipal government respondents and 20 percent of county government respondents reported having implemented standards that are more stringent than those provided in the Medical Code. The vast majority of these are related to zoning and land use restrictions.

[119] Map: *Medical Marijuana Regulatory Status.* Created by Trent Pingenot for CCI. July 21, 2011.
[120] Colorado Municipal League. *Election Results Medical Marijuana: Appendix B: Municipal Actions & Elections: Table 5: Medical Marijuana Prohibition and Taxation: 2009 January 2014*. Retrieved on July 10, 2014, from www.cml.org/search.aspx?q=medical%20marijuana

Program Description and Administration

The Colorado Medical Marijuana Code (Medical Code) designates the Executive Director of the Department of Revenue (Executive Director) as the state licensing authority. As such, the Executive Director has all rulemaking, licensing and enforcement authority. As a practical matter, the Director of the Marijuana Enforcement Division (Director and MED, respectively) is responsible for the day-to-day implementation of the Medical Code and the rules promulgated thereunder.

The MED is also tasked with the day-to-day implementation of the Colorado Retail Marijuana Code (Retail Code). With the exception of Table 1, all tables and data in this sunset report, unless otherwise specified, pertain to the MED's enforcement of the Medical Code only.

Table 1 illustrates, for the fiscal years indicated, the MED's total program expenditures and full-time equivalent (FTE) employees.

Table 1
Agency Fiscal Information

Fiscal Year	Total Program Expenditure	FTE
10-11	$1,127,118	22
11-12	$5,262,020	13
12-13	$2,103,341	17
13-14	$9,555,599	35

The MED commenced operations in fiscal year 10-11, so no data are available for the period before this time. Both the level of expenditures and the number of FTE have fluctuated considerably over the MED's short lifespan.

Throughout this period, the MED's funding fluctuated as the medical marijuana market came under regulation. As a result, expenditures, too, fluctuated.

Expenditures and staffing increased appreciably in fiscal year 13-14. This can be attributed to the Executive Director's, and thus the MED's, assumption of regulatory responsibility for retail marijuana that year.

With respect to FTE, it should be noted that the figures in Table 1 represent the staff employed as of the end of each fiscal year. Fiscal year 12-13 is particularly noteworthy since, at one point during that year, the MED employed 35 FTE. Due to significant budget shortfalls, much of that staff had been reassigned by the end of the fiscal year.

The 35 FTE employed by the MED as of the end of fiscal year 13-14 comprised:

- 1.0 FTE Management—The Director is responsible for management of the MED, budget, rulemaking, public speaking and outreach, responding to executive management and legislative requests/mandates and strategic planning and implementation.
- 1.0 FTE Criminal Investigator IV—The Chief of Investigations is responsible for the day-to-day operation of the MED, facilitates Director requests and mandates, and develops and implements policies and processes.
- 2.0 FTE Criminal Investigator III—The Agents-in-Charge are responsible for the operation of the MED's licensing operations, including background investigations, as well as for field enforcement operations.
- 5.0 FTE Criminal Investigator II—These investigators supervise field enforcement operations and investigations, supervise business license application processing and background investigations.
- 11.0 FTE Criminal Investigator I—These investigators conduct in-depth background, compliance and criminal investigations, perform site compliance inspections and engage in enforcement actions.
- 3.0 FTE Compliance Investigator I—These investigators assist and support background investigations and field enforcement actions.
- 1.0 FTE General Professional IV—The Communications Specialist manages the MED's website, develops and maintains data reports, facilitates special projects and is responsible for processing all Colorado Open Records Act and subpoena requests.
- 1.0 FTE Office Manager—The office manager manages administrative business and occupational licensing activities.
- 2.0 FTE Program Assistant I—These positions provide administrative support to the Director, the Chief of Investigations and other staff.
- 2.0 FTE Administrative Assistant III—These positions are line staff engaged in business and occupational licensing activities.
- 6.0 FTE Administrative Assistant II—These positions provide administrative support to business and occupational licensing activities.

As of the end of fiscal year 13-14, the MED had been appropriated 55.2 FTE. Most of these positions are on track to be filled by the end of calendar year 2014. These FTE are divided into three primary program areas: the Director's office, licensing and enforcement. While most of this staff works out of the MED's headquarters in Denver, the MED also has field offices in Colorado Springs, Grand Junction and Longmont.

The MED is a cash-funded agency, receiving revenue through the fees it imposes on licensees.

In addition to licensing fees, medical marijuana centers also remit to the state, sales taxes collected on medical marijuana transactions. The state sales tax rate on medical marijuana is 2.9 percent. Table 2 illustrates, for the fiscal years indicated, the revenue generated by this tax.

Table 2
Medical Marijuana Sales Tax Receipts

Fiscal Year	Receipts
10-11	$4,367
11-12	$5,982,950
12-13	$9,112,237
13-14	$10,562,577

The data for fiscal year 10-11 are approximates, since the medical marijuana taxes were tracked manually prior to fiscal year 11-12. Though the regulation of medical marijuana is relatively new, the tax revenue it generates continues to increase from year to year.

Licensing

The Executive Director issues four basic types of licenses: medical marijuana center, optional premises cultivation (OPC) operation, medical marijuana-infused products (MMIPs) manufacturer and occupational. The first three types are issued to businesses and the last is issued to individuals. The Executive Director also registers vendors who work with licensed medical marijuana businesses, as well as the cultivations of primary caregivers.

All license applications must be submitted in person at a MED office. In general, occupational licenses can be submitted at any MED office, but business licenses must be submitted at the MED's headquarters in Denver.

All medical marijuana licenses issued by the MED are valid for two years from the date of issue.

Occupational Licensing

The Executive Director issues four types of occupational licenses:

- **Support** licenses are issued to individuals who perform duties that support the medical marijuana business' operations, such as sales clerks, cultivation staff, trimmers and cooks;
- **Key** licenses are issued to individuals who perform duties that are key to the medical marijuana business' operation and have the highest level of responsibility;
- **Associated Key** licenses are issued to individuals who are owners of a medical marijuana business and who also act as a key executive, employee or agent while physically working in a licensed medical marijuana business; and
- **Associated Person** licenses are issued to individuals who are owners of a medical marijuana business and who do not act as a key executive, employee or agent.[121]

Table 3 illustrates, for the four fiscal years indicated, the number of active support and key licenses. Table 3 does not include data pertaining to associated key or associated person licenses. Such data may be found in Table 4.

Table 3
Occupational Licensing

Fiscal Year	Key	Support	Total
10-11	157	503	660
11-12	1,083	3,628	4,711
12-13	1,372	4,529	5,901
13-14	2,397	8,892	11,289

As the medical marijuana industry has grown, so too has the overall number of licensed individuals working within it.

To obtain a support license, the applicant must complete the appropriate application and appear in person at a MED office. Walk-ins are accepted at the MED headquarters in Denver, but appointments must be made at the MED's offices in Colorado Springs, Grand Junction and Longmont. In general, an applicant utilizing one of the field offices can obtain an appointment the same day he or she calls to schedule one.

[121] This license type was discontinued in fiscal year 12-13. However, anyone holding such a license prior to such time may continue to renew that license.

The license application requires the applicant to attest that none of seven disqualifiers (i.e., conviction of drug-related crimes, age, status as a physician or primary caregiver and status as a law enforcement officer or employee) are applicable. The application further requires the applicant to disclose several matters related to financial history (i.e., delinquency with respect to taxes, student loans and child support) as well as criminal history (i.e., arrests or convictions for non-drug related charges).

When the applicant arrives at the MED office, the application and the applicable fees are collected, along with any supporting documentation (i.e., documents indicating final dispositions of any arrests or criminal convictions, evidence of Colorado residency and photographic identification). Applicants can pay the license fee of $150 with cash, check or money order. If any element of the application, including court documents evidencing disposition, is missing, the application is not accepted until the missing documents can be supplied.

MED staff runs a preliminary criminal history background check based on the applicant's name and social security number through the National Crime Information Center database to determine if there are any outstanding warrants for the applicant's arrest. If an arrest warrant is outstanding, law enforcement is summoned. Staff reports that this occurs several times each month.

If the initial criminal history background check reveals no warrants, the applicant is fingerprinted for a more comprehensive criminal history background check and has his or her photograph taken for a photographic license badge.

Next, a member of the MED's staff checks several databases to ensure that the applicant is not delinquent on child support or any Colorado taxes. If such delinquencies exist, the application is held until the applicant can demonstrate that he or she has satisfied the debt or is on a payment plan. Staff also runs a state-based criminal history record check using the applicant's name and social security number in the Colorado Bureau of Investigation database, and checks the applicant's credit record.

If there are problems, the applicant is immediately notified and given an opportunity to take appropriate steps. If there are no problems, the applicant is informed of such and is also informed that his or her photographic license badge will be mailed to him or her as soon as the fingerprint-based criminal history background check is completed by the Federal Bureau of Investigation (usually within 7 to 10 days). The applicant cannot begin working in the medical marijuana industry until he or she receives the badge.

The process for obtaining a key license is essentially the same as that for a support license, except that the applicant must surrender his or her support license. Additionally, key license applicants must disclose more of their financial history, particularly with regard to any other professional licenses, bankruptcies and judgments. The fee for a key license is $300.

The process for renewing either license type is the same as for obtaining the initial license. The fee to renew a support license is $75 and the fee to renew a key license is $200.

The process for obtaining an associated key or an associated person license is substantially similar to that of obtaining a support or key license. The individuals are photographed and fingerprinted at the time they appear at the MED to submit the underlying business license application, and their license badges are not sent to them until the underlying business license is issued.

The application for an associated key and associated person license, which are issued to the owners of a business license applicant, delves deeper into the applicant's financial history and relationship to the business license applicant. It also requires the applicant to disclose his or her employment history, income and character references.

The initial fee for either of these license types is $1,300, and the fee to renew is $200.

Table 4 illustrates, for the fiscal years indicated, the number of associated key and associated person licenses that have been approved, denied and withdrawn, but not the total number of active licenses at any given point in time because the MED has not historically archived such data.

Importantly, new associated person licenses are no longer issued. This license type was discontinued in fiscal year 12-13. Any such licenses approved after that time have been, in practice, renewals of previously issued associated person licenses.

Table 4
Associated Key and Associated Person Licensing Activity

Type	Pending	Approved	Denied	Withdrawn	Totals
Associated Key	46	520	97	860	1,523
Associated Person	8	76	8	119	211
FY 10-11					**1,734**
Associated Key	1	31	3	6	41
Associated Person	0	11	0	2	13
FY 11-12					**54**
Associated Key	0	42	2	1	45
Associated Person	0	2	0	0	2
FY 12-13					**47**
Associated Key	58	151	1	8	218
Associated Person	8	89	8	121	226
FY 13-14					**444**

The relatively higher totals in fiscal year 10-11 can be attributed to the initial wave of license applications as the MED was created and Medical Code-implementation began.

Figures in the "Approved" column indicate the number of license applications approved, but not necessarily issued. Associated key and associated person licenses are not issued until and unless the underlying business license is ultimately issued. Thus, in fiscal year 10-11, for example, 596 associated key and associated person licenses were approved, but none were issued because none of the underlying business license applications were approved until fiscal year 11-12.

Figures in the "Pending" column reflect applications that were still pending as of the last day of the indicated fiscal year.

Staff at the MED attributed the increases in fiscal year 13-14 to an increase in the number of changes in ownership of currently licensed medical marijuana business licensees. These could include the addition of new owners or the sale of the entire business to a new group of owners, thus necessitating new associated key licenses.

MED staff further attributes the high number of withdrawals in fiscal year 10-11 to the fact that many people initially misunderstood the qualifications for licensure. For example, they may not have been Colorado residents for two years, they had criminal convictions, or they had issues with a taxing authority. The MED allowed these individuals to withdraw their applications, rather than deny them, so as to preserve the applicants' ability to reapply later and so as to conserve the Executive Director's own resources by avoiding the need for administrative hearings.

Business Licensing

Just as each owner of a medical marijuana business needs to be licensed, so too does the business itself.

As with occupational licenses, business license applications must be submitted to the MED in person. Applications are not accepted by mail and all of the owners of the business must be physically present so that they can be fingerprinted and photographed as part of the processing of their associated key or associated person license applications. Appointments are generally available within one to two weeks of requesting one.

The MED accepts medical marijuana business license applications at its Denver headquarters only, and only by appointment. The MED staff strongly encourages all owners to come in at the same time because MED staff will not begin to process an application until such time as all owners have physically presented themselves.

During this appointment, an investigator from the MED's licensing section reviews the application package to ensure that it is complete. Each application package must include, at a minimum:

- An application form for each license being sought (i.e., each medical marijuana center, OPC operation and MMIPs manufacturing facility must be individually licensed);
- An associated person or associated key license application form for each owner;
- Evidence of having applied for a medical marijuana license from the appropriate local licensing authority;
- Payment of all application and licensing fees;
- Verification that the proposed licensed premises is not within 1,000 feet of a school, and if it is, verification that the local licensing authority has issued a waiver from this restriction;
- A copy of the operating agreement if the applicant is a limited liability company;
- A copy of the articles of incorporation and any bylaws if the applicant is a corporation;
- Copies of any financing documents, such as promissory notes, security interests or other loan documents;
- A copy of a current certificate of good standing issued by the Colorado Secretary of State if the applicant is a business entity;
- A copy of the lease for the property where the business is to be located or other documentation evidencing a right to possess that property;
- A copy of the floor plans for each facility to be licensed;
- Evidence of having a medical marijuana sales tax bond; and
- A copy of a current state sales tax license.

The fees that must be paid vary depending on the type of license sought. The application fee for an OPC, as well as that for a MMIPs manufacturer, is $1,000, and the initial license fee for each is $2,200.

The Executive Director has divided medical marijuana centers into tiers, based on the number of patients that designate a particular facility as their primary center. Tier 1 centers have up to 300 such patients, Tier 2 centers have between 301 and 500 such patients, and Tier 3 centers have more than 500 such patients. Accordingly, the application and license fees vary according to the tier in which a particular medical marijuana center is located. Table 5 illustrates the application and license fees for the three tiers of medical marijuana centers.

Table 5
Application and License Fees for Medical Marijuana Centers

Tier	Application Fee	Initial License Fee	Total Amount Due at Time of Application
1	$6,000	$3,000	$9,000
2	$10,000	$7,000	$17,000
3	$14,000	$11,000	$25,000

Each medical marijuana facility and location must be individually licensed. This means that, since each medical marijuana center, regardless of tier, must also have an associated OPC operation, due to vertical integration, the applicant must pay the application and license fees for the OPC operation and the medical marijuana center at the time of application. For example, a Tier 1 medical marijuana center applicant with one OPC operation must pay $12,200 (Tier 1 application fee ($6,000) + Tier 1 license fee ($3,000) + OPC operation application fee ($1,000) + OPC operation license fee ($2,200) = $12,200) in application and license fees.

Licenses are valid for two years, and as with the occupational licenses, must be renewed in person at the MED's offices. To renew a license, the licensee must pay the license fee for each license held, plus a single $300-renewal fee. So, in the example above, the Tier 1 medical marijuana center with a single OPC operation must pay $5,500 to renew both licenses (Tier 1 license fee ($3,000) + OPC operation license fee ($2,200) + renewal fee ($300) = $5,500).

Table 6 illustrates, for the fiscal years indicated, the number of active medical marijuana business licenses.

Table 6
Business Licensing Activity

License Type	FY 10-11	FY 11-12	FY 12-13	FY 13-14
Medical Marijuana Center	0	118	388	493
OPC Operation	0	48	467	729
MMIPs Manufacturer	0	14	77	149

Although medical marijuana businesses were operating prior to fiscal year 10-11, the MED did not begin accepting medical marijuana business license applications until August 1, 2010. Only those medical marijuana businesses that were operating as of July 1, 2010, could apply on August 1. Anyone desiring to start a new medical marijuana business had to wait until July 1, 2012, to apply for a license.

No licenses were approved or denied in fiscal year 10-11 because the MED lacked the employees to process the influx of initial applications that were filed that year. Indeed, the MED came into existence barely a month before the August 1, 2010, deadline. Additionally, the Medical Code at the time required the Executive Director to refrain from issuing any business licenses until the local licensing authority had first acted on an application. According to MED staff, the local licensing authorities did not begin consistently approving license applications until the August-September 2011 timeframe. This, among other things, such as staffing shortages and challenges associated with coordinating with local licensing authorities, contributed to a delay in processing business license applications. Importantly, no license applications that were submitted by the initial August 1, 2010, deadline remain pending. All have been withdrawn by the applicant or granted or denied by the Executive Director, though some that were denied are currently being appealed within the administrative process.

The Executive Director issued the first business licenses on October 24, 2011.

MED staff reports that on average, business licenses are now issued within 45-50 days.

Table 7 illustrates, for the fiscal years indicated, the number of medical marijuana centers in each licensing tier.

Table 7
Medical Marijuana Center Licenses by Tier

Tier	FY 10-11	FY 11-12	FY 12-13	FY 13-14
1	0	92	326	423
2	0	12	34	39
3	0	14	28	31
Total	**0**	**118**	**388**	**493**

Although the number of licenses issued in each tier has increased each year, it is clear that the vast majority (approximately 86 percent in fiscal year 13-14) of medical marijuana centers are relatively small, Tier 1 centers.

In addition to the background checks performed on the owners of a medical marijuana business, in connection with their individual applications for associated key and associated person licenses, MED staff conducts a more comprehensive investigation of the business itself.

For example, MED staff looks to ensure that all owners are identified and have submitted the appropriate occupational license applications. Staff also seeks to ensure that all owners have been Colorado residents for at least two years, and staff investigates any financing that might be in place. While standard promissory notes are acceptable, convertible promissory notes (those that can be converted into equity interests) are not. MED staff seeks to ensure that anyone who shares in the profits of a licensee has been properly disclosed and vetted.

MED investigators also conduct other types of routine investigations that are not the result of a complaint or an indication that anything is amiss. For example, a pre-license inspection is routine, as are investigations resulting from a change in ownership or change in location.

Table 8 illustrates for the fiscal years indicated, the number and types of investigations performed by MED staff.

Table 8
Investigations Summary

Type	FY11-12	FY12-13	FY13-14
Corporate Background Investigation	2,378	72	612
Licensing Field Inspection	148	696	1,669
Change of Ownership	30	166	379
Assist Other Agency	5	39	85
Investigator Initiated Field Visit	486	132	240
Individual Background Investigation	1,734	64	240
Mandatory Reporting	2	17	76
Voluntary Withdrawal	57	248	391
Voluntary Surrender of Product	8	30	44
Voluntary Surrender of License	0	41	180
Change of Location	8	117	259
Modification of Premises	2	89	245
Change of Trade Name	1	16	61
Renewal Investigation	0	0	299
Total	**4,859**	**1,727**	**4,780**

Figures in fiscal year 11-12 for "Corporate Background Investigations" and "Individual Background Investigations" were derived by manually tracking license applications. Since these types of investigation were not tracked in the MED's licensing system during this fiscal year, figures pertaining to them can be considered approximations.

Overall fluctuations in numbers can be attributed to the initial round of license applications in fiscal year 11-12 and the increase in staffing in fiscal year 13-14.

While many of the investigations identified in Table 8 are self-explanatory, several are not:

- "Mandatory Reporting" includes investigations resulting from a licensee's failure to report to the MED any felony criminal charges or convictions that occurred after the person was licensed.
- "Voluntary Withdrawal" includes those individuals who voluntarily withdrew their applications for licensure.
- "Voluntary Surrender of Product" includes those instances in which a licensee relinquishes custody of medical marijuana without being ordered to do so by the Executive Director. Most often this occurs because the applicant is withdrawing an application, closing the business or the OPC operation has overproduced medical marijuana.
- "Voluntary Surrender of License" includes those instances in which a licensee relinquishes an occupational or business license.

Several of these categories are not investigations, within the ordinary meaning of that word, yet this is the manner in which the MED tracks such activity within its licensing database.

Vendor Registrations

All businesses that work within the medical marijuana industry providing services to industry members and the employees of which commonly work within restricted areas of the medical marijuana business or take custody of medical marijuana product must register with the MED as medical marijuana vendors.

These types of businesses include those that employ trim crews that travel from facility to facility to harvest medical marijuana crops and couriers that transport medical marijuana from facility to facility.

To register as a vendor, the business must complete the vendor registration application, which solicits much of the same information as is solicited from a medical marijuana business license application. However, rather than licensing each owner of a vendor, the Executive Director issues a key occupational license to the individual who takes responsibility for the registered business. Additionally, each of the vendor's employees who will be working in the medical marijuana industry must obtain an occupational support license.

The fee for a vendor registration is $300, which includes the fee for the key license as well. Vendor registrations are valid for two years.

Table 9 illustrates, for the fiscal years indicated, the number of total active vendor registrations as of the end of the indicated fiscal year.

Table 9
Vendor Registration Activity

Fiscal Year	Total Active
10-11	4
11-12	45
12-13	63
13-14	99

The number of registered vendors has grown steadily from one year to the next.

The MED does not track the nature of the services provided by each registered vendor, so it is not possible to provide any breakdown of this nature.

Primary Caregivers

Under the statutory provisions of the medical marijuana program (Medical Program) administered by the Colorado Department of Public Health and Environment (CDPHE), but not pursuant to any provision of the Medical Code, primary caregivers are required to register the location of their cultivation operations with the Executive Director.

There are no fees associated with this registration and the registrations do not expire. Applicants can submit the application form by mail or in person. Registrants are given no proof of having registered.

Table 10 illustrates, for the calendar years indicated, the number of primary caregivers who complied with this directive each year. Figures provided for 2014 are year-to-date, as of September 12.

Table 10
Primary Caregiver Cultivation Registrations

Calendar Year	Number of Registered Cultivations
2012	9
2013	64
2014	74
Total	147

Although CDPHE was unable to provide historical data for this sunset review, CDPHE staff was able to report that as of September 12, 2014, 2,961 individuals had been identified to CDPHE as primary caregivers.[122] This means that only approximately five percent of primary caregivers have registered the location of their cultivations with the Executive Director.

To be sure, not all primary caregivers necessarily grow medical marijuana. Some may be parents of children who are patients. Thus, it is not reasonable to expect all primary caregivers identified to CDPHE to register cultivations with the Executive Director. Regardless, five percent is shockingly low.

According to the survey the Department of Regulatory Agencies conducted of primary caregivers in August 2014, 58.8 percent of respondents conceded to having not registered their cultivations with the MED. Of these, 13 percent[123] indicated that they were not aware of the registration requirement and 39.1 percent indicated that they had not registered because they do not want the government to know of their cultivation.

Regardless, the purpose of this registration process is to provide local law enforcement agencies with a resource to verify whether someone is truly a primary caregiver. As such, the Executive Director is limited to confirming whether a particular address, as provided by the inquiring law enforcement agency, is a registered primary caregiver cultivation operation.

Although the Executive Director does not track the number of such queries, MED staff estimates that it has received over 200 queries in the last three years.

Complaints/Disciplinary Actions

The Executive Director receives complaints from a variety of sources, including members of the public, licensees and the MED staff. Staff may initiate a complaint when a routine investigation, for example a background investigation or a field investigation, reveals possible violations of the Medical Code.

[122] Primary caregivers do not directly register with CDPHE. Rather, when a patient registers with CDPHE, the patient identifies his or her primary caregiver, if the patient has one.
[123] Due to technical difficulties, only those taking the survey after 8:00 a.m. on August 21, which was approximately half of all respondents, were given the option of indicating that they were unaware of the registration requirement.

Table 11 illustrates, for the fiscal years indicated, the sources of complaints.

Table 11
Complaint Information

Type	FY 11-12	FY 12-13	FY 13-14
Background Investigation	2	19	39
Field Inspection	0	9	47
Citizen Complaint	2	10	53
Report of Violations	0	3	32
Tip Line	2	24	34
Regulatory Violation	0	26	237
Criminal Violation	0	2	21
Totals	**6**	**93**	**463**

While many of the types of complaints described in Table 11 are self-explanatory, some are not. A "Report of Violations" is essentially a licensee self-reporting that it has committed a violation. This could include items as innocuous as an erroneous entry in the MED's Marijuana Enforcement, Tracking, Reporting and Compliance (METRC) computerized inventory tracking system.[124]

"Regulatory Violations" refer to allegations that a licensee has violated a provision of the Medical Code or of the rules promulgated thereunder. The MED does not track such allegations in any greater detail. So, for example, the MED cannot report on how many "Regulatory Violations" pertained to incorrect labeling or employees working without their license badges.

"Criminal Violations" are similar to "Regulatory Violations" in that they refer to allegations that a licensee has engaged in conduct that is criminal in nature. Again, the MED does not track such allegations in any greater detail.

Regardless, as the medical marijuana industry has continued to grow, so too have the number of complaints, from all sources.

When a complaint is received, it is assigned to the investigator in whose geographic region[125] the complained of activity occurred. If the complaint appears to be non-jurisdictional (i.e., those involving primary caregivers or home grows), the investigator may forward the information to local law enforcement and/or dismiss.

[124] METRC is the computer program through which the MED tracks medical marijuana inventory. Medical marijuana plants are tagged with radio frequency identification tags (RFID tags) when they are planted in growing media. The plants are then tracked throughout their growth cycles, through harvesting and ultimately sale to a patient. This is often referred to as "seed-to-sale tracking."

[125] Although the MED has offices in Denver, Colorado Springs, Grand Junction and Longmont, the MED has actually divided the state into four geographic regions: Denver, South, North and Western Slope. The investigators assigned to the South region work out of the Colorado Springs office and those assigned to the Western Slope work out of the Grand Junction office. Those assigned to Denver and the North region work out of the Denver and Longmont offices.

If the case is jurisdictional, the investigator begins his or her investigation by examining the license file, any background information the MED may have and even social media. Depending on the issue, the investigator may conduct a site visit and he or she may contact local law enforcement to determine if that agency has any interest in joining the investigation.

If the complaint is unfounded, it is dismissed. However, if a violation is found, the MED's progressive disciplinary process is implemented.

The level of discipline taken is determined, in part, by the severity and type of violation, and whether there are any mitigating or aggravating circumstances. In short, the Executive Director classifies all violations as license infractions, license violations or license violations affecting public safety.

License infractions tend to be the least severe and may include failure to display required badges, unauthorized modifications of the premises of a minor nature, or failure to notify the Executive Director of a minor change in ownership. Possible penalties include a verbal or written warning, license suspension, license restriction, a fine per individual violation or a fine in lieu of suspension of up to $10,000.[126]

License violations tend to be more severe, but generally do not have an immediate impact on the health, safety and welfare of the public. These may include advertising or marketing violations, packaging or labeling violations that do not directly impact patient safety, failure to maintain minimum security requirements, failure to keep and maintain adequate business books and records and minor clerical errors in METRC. Possible penalties include written warnings, license suspension, a fine per individual violation, a fine in lieu of suspension of up to $50,000, license restrictions and license revocation.[127]

License violations affecting public safety are the most severe types of violation and include sales of medical marijuana to non-patients, consuming medical marijuana on a licensed premises, medical marijuana sales in excess of the relevant transaction limit, permitting the diversion of medical marijuana outside the regulated distribution system, possessing medical marijuana from outside the regulated distribution system, misstatements or omissions in METRC, and packaging and labeling violations that directly impact patient safety. Possible penalties include license suspension, a fine per individual violation, a fine in lieu of suspension of up to $100,000 and license revocation.[128]

[126] 1 CCR 212-1, § M 1307(A)(3).
[127] 1 CCR 212-1, § M 1307(A)(2).
[128] 1 CCR 212-1, § M 1307(A)(1).

Mitigating and aggravating factors may include:[129]

- Whether the licensee took any actions to prevent the violation;
- The licensee's past history of success or failure with compliance inspections;
- Whether the licensee has taken any actions to correct the violation;
- Whether the licensee has previously committed any violation;
- The willfulness and deliberateness of the violation;
- The circumstances surrounding the violation;
- Whether an owner or manager committed the violation, or directed an employee to commit the violation; and
- Whether the licensee has participated in a medical marijuana responsible vendor training program.

The Executive Director began using this type of hierarchy of violations in mid-fiscal year 13-14. As a result, there are no data to report for the period prior to this, and the Executive Director is not currently tracking violations in a way that lends itself to reporting such data even for half of that fiscal year. However, the MED is closely monitoring what data collection is possible with this new method, and it is making adjustments to more thoroughly collect this data.

However, the MED has tracked those violations that result in disciplinary action. Table 12 illustrates, for the fiscal years indicated, the number and types of final agency actions taken.

Table 12
Final Agency Actions

Final Agency Action	FY11-12	FY12-13	FY13-14
Stipulated Agreements	54	0	31
Summary Suspensions	0	1	2
Disciplinary Actions that Led to the Resolution of Regulatory Concern	0	0	75
Disciplinary Actions that Led to the Withdrawal of an Application	0	0	85
Disciplinary Actions that Led to the Surrender of a License	0	0	61
Denials	143	1	108
Fines	10	17	9

[129] *iComply Training Manual: Responsible Vendor Training*, iComply (2014), p. 14.

Some of the terms in Table 12 are self-explanatory, but some are not. The term "Disciplinary Actions" refers to actions such as administrative holds, orders to show cause and notices of denial. The Executive Director will place an administrative hold on a portion or all of a licensee's medical marijuana inventory, meaning that inventory cannot be sold or transferred, when there is a concern with a facility's operation. The hold remains in place until the concern is resolved, inventory is destroyed, or action is taken to end operation of the facility.

A notice of denial differs from an actual denial in that it serves as a notice to an applicant that the Executive Director is considering denying the application, provides the regulatory concerns at issue and provides the timeframe within which the applicant must request a hearing if the applicant wishes to challenge the denial. A notice of denial is to a license applicant what an order to show cause is to a licensee.

A "Regulatory Concern" refers to any number of issues that place a licensee in the disciplinary process, such as failure to pay taxes due or selling medical marijuana after hours. The term "Resolution of Regulatory Concern" indicates that the licensee addressed the regulatory concern to the satisfaction of the Executive Director. For example, the licensee paid the taxes or paid a fine and agreed to provide training to staff to prevent future after hour sales.

Table 13 illustrates, for the fiscal years indicated, the number and value of fines imposed.

Table 13
Fines

Fiscal Year	Number of Fines Imposed	Total Value of Fines Imposed
11-12	10 Sept. 1, 2010 Certification Failure	**Total: $23,000**
12-13	12 Sept. 1, 2010 Certification Failure 4 After Hours Sales 1 Inspection Failure	$26,000 $8,000 $1,000 **Total: $35,000**
13-14	1 Sept. 1, 2010 Certification Failure 3 After Hours Sales 2 Multiple Inspection Failures 2 Failure to File or Pay Taxes 1 Falsified Certification Documents Multiple Compliance Violations	$2,500 $6,500 $5,000 $7,500 $5,000 $97,500 **Total: $124,000**

Fines characterized as "Sept. 1, 2010 Certification Failure" refer to licensees' failure to certify that as of September 1, 2010, they were growing 70 percent of what they sold. This category of fine has declined significantly since fiscal year 11-12.

The fine in fiscal year 13-14 for $97,500 was imposed on a single ownership group that held 13 medical marijuana licenses. Each facility had multiple violations and each facility was fined $7,500 for a total of $97,500.

Analysis and Recommendations

Recommendation 1 – Continue the Colorado Medical Marijuana Code for four years, until 2019.

On November 7, 2000, the voters of Colorado passed Amendment 20 to the state's constitution, effectively decriminalizing the medical use of marijuana. Amendment 20 became effective on December 28, 2000.

In short, this constitutional provision:

- Creates an affirmative defense for any patient, and the patient's primary caregiver, whose physician has diagnosed the patient as having a debilitating medical condition, and whose physician has advised the patient that the patient might benefit from the use of medical marijuana;[130]

- Provides for the creation of a medical marijuana registry, including requirements for inclusion on the medical marijuana patient registry and the issuance of registry identification cards;[131]

- Generally limits possession of medical marijuana to no more than two ounces of marijuana in a useable form and no more than six plants;[132] and

- Generally applies only to patients who are at least 18 years old.[133]

In the years that followed, local governments began licensing medical marijuana dispensaries.

This era was characterized by what some refer to as "the backpack brigades." Dispensaries could sell medical marijuana; primary caregivers could grow medical marijuana; and patients could grow, possess and use medical marijuana. The dispensaries, however, had no way to legally obtain the medical marijuana they sold. As a result, each morning, individuals would appear at the dispensaries offering to sell them medical marijuana out of backpacks.

In short, there was little to no regulation, a considerable amount of illegally grown medical marijuana, and a tremendous amount of cash trading hands.

[130] Colo. Const. Art. XVIII, § 14(2)(a).
[131] Colo. Const. Art. XVIII, § 14(3).
[132] Colo. Const. Art. XVIII, § 14(4).
[133] Colo. Const. Art. XVIII, § 14(6).

On October 19, 2009, the United States Department of Justice issued what has come to be known as the "Ogden Memo", which, while recognizing the plenary authority of the various United States Attorneys, directed they,

> should not focus federal resources in [their] states on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana.[134]

Thus, the 2010 legislative session began within the context of Colorado's local governments having created a patchwork of regulations and the federal government having indicated that it might not enforce federal law with fervor.

The two major marijuana-related pieces of legislation passed in 2010 were Senate Bill 109 and House Bill 1284 (HB 1284). The first, among other things, defined a "bona fide physician-patient relationship," more clearly delineating the process physicians must follow when recommending medical marijuana and prohibiting physicians from holding an economic interest in an enterprise that provides or distributes medical marijuana.

House Bill 1284 created the Colorado Medical Marijuana Code (Medical Code), the subject of this sunset report. Among other things, HB 1284 created the framework for the licensing of medical marijuana centers, their cultivation facilities, medical marijuana-infused products (MMIPs) manufacturers and the individuals who work in such facilities. The legislation named the Executive Director of the Department of Revenue (Executive Director) as the state licensing authority to administer the Medical Code.

This is the first sunset review of the Medical Code, and it is relatively unprecedented in its scope. On the one hand, the Medical Code represents the General Assembly's attempt to regulate an entire industry. It encompasses the production processes (cultivation, extraction, and the manufacture of concentrates and edible products), the sales and distribution networks (how medical marijuana is transferred from one facility to another, how medical marijuana is accounted for and how medical marijuana is ultimately sold to patients), how it is packaged and labeled, and who may participate in the industry (including owners and their employees).

[134] U.S. Department of Justice. *Memorandum for Selected United States Attorneys, from David W. Ogden, Deputy Attorney General, regarding Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana*, October 19, 2009. Retrieved October 23, 2013, from http://blogs.justice.gov/main/archives/192

On the other hand, the Medical Code represents only one facet of Colorado's burgeoning marijuana industry. The Medical Code does not address primary caregivers or the registration of patients (such matters lie within the purview of the Colorado Department of Public Health and Environment (CDPHE)), the physicians who write the recommendations entitling patients to medical marijuana (such matters lie within the purview of the Colorado Medical Board), or the Colorado Retail Marijuana Code (Retail Code).

Complicating matters further, the Medical Code itself is relatively new, having been enacted less than five years ago. Because of the fluid nature of marijuana regulation in general, it has been amended several times since then.

Thus, it is important to remember that, although the Medical Code is broad in what it does cover, its scope is nonetheless limited. This sunset review does not, nor can it, provide a comprehensive overview of marijuana regulation in Colorado.

At the outset, it must be noted that this review is confined to the Medical Code, not the constitutional provision that the Medical Code implements. If the Medical Code were to sunset, medical marijuana would still be legal under the state constitution. The primary impact of the Medical Code sunsetting would be a reversion to the environment that existed prior to 2010, when the Medical Code was enacted.

Regardless of any scope or timing issues, the first sunset criterion asks:

> Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;[135]

All three of these questions are highly relevant in this particular sunset review and will be addressed in order.

Regardless of marijuana's status under state law, federal law continues to ban its use. The federal Controlled Substances Act (CSA) classifies marijuana and the cannabinoid tetrahydrocannabinol (THC) in Schedule I,[136] meaning they have a high potential for abuse, they have no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of them under medical supervision.[137]

Although many contend that the CSA misclassifies marijuana, the fact remains that it is a Schedule I substance. This means that the federal government, particularly the federal Food and Drug Administration (FDA), lacks the same regulatory oversight over its production and distribution as it does for drugs in the other CSA schedules.

[135] § 24-34-104(9)(b)(I), C.R.S.
[136] 21 U.S.C. §§ 812(c)(c)(10) and (17).
[137] 21 U.S.C. § 812(b)(1).

Without the Medical Code, medical marijuana, a Schedule I substance under federal law, would be completely unregulated but legal, given its status in the state's constitution.

Even if the conclusion that marijuana itself is a dangerous substance is rejected, it is now being grown on a commercial scale in Colorado. These commercial cultivations use various pesticides, herbicides, fungicides and fertilizers to protect their crops and to encourage more profitable growth. Many of these substances are themselves hazardous.

Therefore, regulation of medical marijuana is necessary to protect the public health, welfare and safety because without the Medical Code, there would be no governmental oversight of any aspect of medical marijuana.

Additionally, conditions that led to the initial enactment of the Medical Code have changed. Since the General Assembly enacted the Medical Code, the voters of the state passed Amendment 64, which legalized retail marijuana, the General Assembly enacted the Retail Code, and the United States Department of Justice (DOJ) issued a memorandum delineating that department's enforcement priorities. In short, the legal status of marijuana has been a predominant policy issue since the Medical Code was enacted.

Of the three conditions that have changed, perhaps the most relevant to medical marijuana has been the DOJ memorandum, which was issued in August 2013. It was addressed to all United States Attorneys and provides guidance regarding marijuana enforcement. Often referred to as the "Cole Memo," after the Deputy Attorney General who drafted it, it delineates the DOJ's enforcement priorities as preventing:[138]

- The distribution of marijuana to minors;
- Revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- The diversion of marijuana from states where it is legal under state law in some form to other states;
- State-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
- Violence and the use of firearms in the cultivation and distribution of marijuana;
- Drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Growing of marijuana on public land and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Marijuana possession or use on federal property.

[138] U.S. Department of Justice. *Memorandum for all United States Attorneys, from James M. Cole, Deputy Attorney General, regarding Guidance Regarding Marijuana Enforcement,* August 29, 2013, pp. 1-2. Retrieved on October 22, 2013, from www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf

While the Cole Memo's guidance reinforces the DOJ's position that United States Attorneys and federal law enforcement should continue to focus on the enumerated priorities, it also clarified the DOJ's expectation,

> that states and local governments that have enacted laws authorizing marijuana-related conduct will implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests.[139]

In such circumstances,

> enforcement of state law by state and local law enforcement and regulatory bodies should remain the primary means of addressing marijuana-related activity.[140]

Taken together, these provisions are generally interpreted as meaning that so long as state law creates a robust regulatory environment that is strongly enforced, the federal government will not interfere except in those individual cases where the DOJ's enforcement priorities are at risk.

Though not perfect, the Medical Code represents Colorado's effort to implement a strong and effective regulatory and enforcement system that addresses the Cole Memo's enforcement priorities. Without the Medical Code, it is reasonable to conclude that the federal government would increase its enforcement actions in the state.

Finally, the passage of Amendment 64 and the Retail Code represent conditions that have arisen that warrant if not more, at least the same degree of regulation of medical marijuana. If the Medical Code were to sunset, medical marijuana would remain legal, given its constitutional status, but would be unregulated and it would exist alongside the highly regulated retail marijuana industry. This would create an absurd environment where a single product is regulated when used recreationally but is unregulated when used medicinally.

Yet another sunset criterion asks whether the agency performs its statutory duties efficiently and effectively.

---

[139] U.S. Department of Justice. *Memorandum for all United States Attorneys, from James M. Cole, Deputy Attorney General, regarding Guidance Regarding Marijuana Enforcement,* August 29, 2013, p. 2. Retrieved on October 22, 2013, from www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf

[140] U.S. Department of Justice. *Memorandum for all United States Attorneys, from James M. Cole, Deputy Attorney General, regarding Guidance Regarding Marijuana Enforcement,* August 29, 2013, p. 3. Retrieved on October 22, 2013, from www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf

As part of this sunset review, the Department of Regulatory Agencies (DORA) surveyed municipal and county governments. Although overall response rates were low, 36.4 percent of county respondents and 37.5 percent of municipal respondents rated the Marijuana Enforcement Division (MED) as effective. Importantly, 45.5 percent of county and 46.9 percent of municipal respondents reporting having had no meaningful interaction with the MED, so were unable to offer an opinion regarding effectiveness.

For all of these reasons, the General Assembly should continue the Medical Code. The length of that continuation, however, is another matter.

The marijuana industry, as a whole, continues to evolve at an alarming pace. Nary a legislative session passes without the General Assembly amending either the Retail Code or the Medical Code. The Executive Director appears to be in an unending rulemaking cycle. New concerns continue to arise as the industry matures and the focus of regulators and stakeholders shifts from a near obsession with preventing diversion, to other issues involved in regulating an entire industry (i.e., packaging, labeling and testing).

Complicating matters is the fact that this sunset review focused exclusively on the Medical Code, merely one facet of Colorado's marijuana industry. This sunset review did not address issues related to the Retail Code or to CDPHE's medical marijuana program (Medical Program), or the relative lack of regulation surrounding primary caregivers.

As a result, Recommendation 3 of this sunset review advocates that the General Assembly schedule CDPHE's Medical Program for its own sunset review. That review should coincide with the next review of the Medical Code and, ideally, the Retail Code. This will enable DORA to review the state's marijuana industry in a more comprehensive manner.

Thus, a short continuation period for the review of the Medical Code is amply justified.

To ensure that the entire marijuana industry is reviewed on a coordinated basis sooner rather than later, the General Assembly should continue the Medical Code for four years, until 2019.

Recommendation 2 – Make it unlawful for primary caregivers to fail to register their cultivation operations with the Executive Director and make proof of registration available to law enforcement on a verification only basis.

There are two ways in which the State and law enforcement agencies can determine whether someone is a primary caregiver—one involves CDPHE and one involves the Executive Director.

When medical marijuana patients register as such with CDPHE, they are required to identify their primary caregiver, if they have one. This process includes providing CDPHE with the primary caregiver's name, address, date of birth and other identifying information. As part of this process, the primary caregiver acknowledges that he or she will be serving as such for the particular patient. The primary caregiver does not directly register with CDPHE.

The state's constitution renders this data confidential and limits access to law enforcement on a verification only basis. Thus, law enforcement can confirm whether someone is a primary caregiver by obtaining the names and patient identification numbers of those patients for whom the person claims to provide care. Law enforcement can then query the Colorado Crime Information Center (CCIC) with that data, or submit the information to CDPHE in writing. The identity of a patient's declared primary caregiver is then provided, allowing confirmation of such person's status.

Additionally, section 25-1.5-106(7)(e), Colorado Revised Statutes (C.R.S.), requires every primary caregiver who cultivates medical marijuana for his or her patients, to register the location of such cultivation operation with the Executive Director. Registration also requires that the primary caregiver provide the patient identification numbers and recommended plant counts for each patient. Local licensing authorities and law enforcement agencies can then submit address-specific inquiries to the Executive Director for the purposes of verifying a cultivation operation. In all other respects, this data is confidential.

Since CDPHE considers MED staff to be law enforcement, by virtue of the fact that many are peace officers, CDPHE will only respond to constitutionally valid requests by MED staff.

Thus, two departments of state government maintain lists of primary caregivers and neither is able to communicate with the other. As a result, the Executive Director is unable to access the CDPHE patient registry to ascertain which primary caregivers have not registered their cultivations with the Executive Director.

Additionally, since this provision lies within the organic statute that creates CDPHE's Medical Program, the Executive Director has no ability to enforce it.

This is problematic given that, as of September 12, 2014, 4,374 patients had identified to CDPHE 2,961 individuals as primary caregivers. By contrast, the Executive Director had registered a total of only 147 primary caregiver cultivation operations. Thus, 2,814 primary caregivers who have been identified and confirmed to CDPHE have not registered their cultivations with the Executive Director.

This is not to imply that all primary caregivers who have not registered with the Executive Director are necessarily breaking the law. Only those who cultivate medical marijuana are required to register their cultivation operations. However, it is reasonable to conclude that a good portion of the 2,814 primary caregivers not registered with the Executive Director maintain cultivation operations.

To better understand this registration gap, DORA's survey of primary caregivers asked whether respondents had registered their cultivations with the Executive Director and if not, why not. Fully 58.8 percent reported that they had not complied with the registration requirement. While 9.1 percent reported that they do not grow marijuana, 13 percent reported not knowing about the registration requirement.[141] Regardless, 39.1 percent of respondents indicated that they had not registered because they did not want the government to know of their cultivation.

This registration gap creates two problems. First, when local law enforcement agencies encounter questionable cultivation operations, they must query CCIC or contact CDPHE to determine, indirectly, whether that the person is a primary caregiver or contact the MED to verify that the cultivation is legitimate.

CDPHE data can be accessed through CCIC at any time, so it is more accessible. However, its utility is somewhat limited by the fact that in order for law enforcement to determine whether the person claiming to be a primary caregiver is as he or she claims, the law enforcement officer must enter all of the caregivers' patients into CCIC and then confirm the caregiver's status. Further, this data does not include the recommended plant counts for the patients, making it difficult for the law enforcement officer on the scene to determine the number of plants the primary caregiver should be growing.

The MED, on the other hand, will also conduct only address-specific verifications for law enforcement or local licensing authorities, but will do so over the phone. The limitation is that MED staff is generally only available between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.[142] MED staff reports receiving several hundred such requests over the last three years.

[141] Due to technical difficulties, only those taking the survey after 8:00 a.m. on August 21, which was approximately half of all respondents, were given the option of indicating that they were unaware of the registration requirement.

[142] While MED investigators also work weekends, law enforcement personnel would need to know how to contact the staff that may be working on a particular weekend in order to verify a specific cultivation.

Additionally, primary caregivers are not required to renew the registrations of their cultivations or to keep the reported data current. So, it is likely that such information also has limited utility to law enforcement. Further, given that such a small percentage (approximately five percent) of primary caregivers identified as such to CDPHE have also registered with the Executive Director, this exercise is even more futile. More importantly, if law enforcement inappropriately seizes plants, thinking that someone is not a primary caregiver and that person is a primary caregiver, law enforcement is obligated to compensate the primary caregiver for the loss of the plants. This occurs because law enforcement agencies are not equipped to care for marijuana plants. Once a plant is seized, it is as good as dead. As a result, law enforcement seizes few such plants.

Further, many speculate that primary caregivers are a major source of diversion. Since so few register their cultivations with the Executive Director, it is impossible to verify or discredit this speculation. However, DORA's survey of primary caregivers asked them what they do when they grow more medical marijuana than their patients need. While 65.2 percent reported fairly legitimate actions, such as destroying it, saving it, or using it to make oils or salves, 30.4 percent, nearly a third, reported selling or giving it away to other primary caregivers, medical marijuana centers or people who are not their patients. Thus, the theory of primary caregiver-grown marijuana being diverted has some legitimacy, though the low number of overall survey respondents tempers this conclusion somewhat.

Regardless, this apparent loophole in the regulation of medical marijuana may cause the state to run afoul of the enforcement priorities laid out in the Cole Memo, particularly with respect to diversion to other states and to children.

Enabling the enforcement of the statutory mandate already articulated in Title 25 is reasonable and can be expected to help mitigate the risk of the state running afoul of the Cole Memo's constraints.

This will enable the Executive Director to provide meaningful and reliable information to law enforcement so that action can be taken against primary caregivers who are required to register their cultivations under current statutory mandate, but fail to do so. In doing so, the General Assembly would not be creating any new obligations for primary caregivers. Rather, the legislature would be providing an effective mechanism to enforce an obligation it has already deemed necessary.

Additionally, law enforcement needs to be able to verify the legitimacy of a cultivation operation and primary caregivers who comply with the law should be able to prove that they have done so. The Executive Director should be directed to make proof of registration available, on a verification only basis. This could take the form of an on-line database that is accessible at all hours, or a simple proof of registration document.

For all these reasons, the General Assembly should declare it an unlawful act for a primary caregiver to fail to register his or her cultivation operation with the Executive Director and direct the Executive Director to make this information more readily available to law enforcement, on a verification only basis.

Recommendation 3 – Schedule the Medical Program administered by CDPHE for a sunset review, with a sunset date of September 1, 2019.

Section 25-1.5-106, C.R.S., creates the Medical Program at CDPHE. Among other things, this statute:

- Creates the medical marijuana registry (Registry) of medical marijuana patients;
- Provides for the issuance of medical marijuana registry cards to medical marijuana patients;
- Delineates the process by which physicians recommend medical marijuana to patients;
- Delineates the process by which the Executive Director of CDPHE can add to the constitutionally defined list of debilitating medical conditions that qualify patients to possess and use medical marijuana; and
- Provides the framework within which primary caregivers cultivate and supply medical marijuana to patients.

The Medical Program is an integral component of the medical marijuana industry, yet it is outside the scope of this sunset review and is not scheduled for a sunset review at any time. This is unfortunate for several reasons.

Some of the more prominent themes that consistently arose during interviews with stakeholders for this review focused on:

- Primary caregivers and the general lack of regulation under which they work, thereby creating the perception that they are a major source of diversion in the state;
- Distrust of government in general, and CDPHE in particular, within the patient and primary caregiver communities;
- The status of patients on the Registry and whether they are legitimate patients with legitimate debilitating medical conditions, or whether they, in fact, use marijuana recreationally rather than medicinally;[143] and
- The debilitating medical conditions that qualify patients to use medical marijuana and how to add other conditions to that list.

[143] Nearly half (47.3 percent) of patients who responded to DORA's survey acknowledged using marijuana recreationally, although 99 percent responded that they also use it medicinally. This indicates that many patients use marijuana both medicinally and recreationally.

All of these issues are addressed in the Medical Program's organic statute, but the Medical Code is silent on them. As a result, these issues are not addressed in this sunset review, and will not be addressed in any future sunset reviews because the Medical Program is not presently subject to sunset.

The lack of a sunset review means that any future sunset reviews of the Medical Code will lack the same comprehensive nature as this one. In order to review and assess the effectiveness of the state's medical marijuana regulatory program in its entirety, both components must be reviewed.

Therefore, the General Assembly should schedule section 25-1.5-106, C.R.S., to repeal on September 1, 2019, and direct that it be the subject of a sunset review prior to such date.

Recommendation 4 – Require medical marijuana to be tested in the same manner as retail marijuana and authorize the Executive Director to license medical marijuana testing facilities.

The Medical Code represents Colorado's first attempt to regulate the commercial marijuana industry. Between the time it was enacted in 2010 and the time when the Retail Code was enacted in 2013, regulators gained valuable experience, thinking on certain subjects had evolved and the industry had begun to mature. As a result, the Retail Code does not mirror the Medical Code. In many respects, they are similar. In many other respects, they are dissimilar. While some of these differences are warranted, many are not. These unwarranted differences cause confusion on the part of licensees trying to comply with two sets of standards, and this confusion can lead to lapses in compliance. Similarly, it is burdensome to the Executive Director and MED staff in that they must enforce two sets of standards on what amounts to a single industry.

As a result, this sunset report attempts to begin the process of harmonizing the two codes. One area in which the two codes differ is in the area of testing marijuana.

The Retail Code contains robust requirements mandating the testing of retail marijuana. It requires the Executive Director to promulgate rules to require testing for residual solvents, poisons, toxins, harmful chemicals, dangerous molds and mildew, pesticides, filth, harmful microbials such as E. Coli or salmonella, and THC potency.[144] The Executive Director has promulgated these rules, and has further complied with the statutory directives to develop testing protocols and to license testing facilities.

[144] § 12-43.4-202(3)(a)(IV), C.R.S.

Ironically, under the Medical Code, testing of medical marijuana products is purely voluntary on the part of licensees.[145] The irony lies in the fact that the Retail Code mandates testing for what amounts to a recreational product, but the Medical Code does not mandate testing for what amounts to a medicinal product.

Medical marijuana users are patients. Depending upon the debilitating medical condition that qualifies them to use marijuana medicinally, they may have compromised immune systems. Medical marijuana that contains pesticides, molds or solvents could actually exacerbate such patients' conditions.

Testing for such contaminants will help to ensure patients that the medical marijuana they purchase at a medical marijuana center is safe.

Additionally, testing for potency and homogeneity[146] will assist patients, their primary caregivers and their physicians in determining how to best achieve their target dose. For example, a package of medical marijuana-infused cookies may claim to have 100 milligrams (mg) of THC per cookie, but without testing, the patient has no way of knowing if this claim is accurate or whether there is, in fact, only 80 mg of THC in each cookie. Testing will help to ensure that labeling claims are accurate and not misleading.

Patients also seem to want to have medical marijuana tested. When asked why they purchase their medical marijuana from a medical marijuana center, 14.3 percent of respondents to DORA's patient survey reported doing so because the marijuana is tested, and therefore safer. This response also indicates a possible misunderstanding on the part of patients, in that they believe that such marijuana is tested, which may or may not be accurate.

Testing of medical marijuana, therefore, is necessary to protect the health, safety and welfare of the public. Some argue, however, that the testing regime created under the Retail Code is overly burdensome and unreliable.

Arguments surrounding reliability focus on the proposition that, as of this writing, the Executive Director has certified four testing facilities to conduct the testing mandated by the Retail Code. Some claim that different testing facilities produce different test results, rendering those results unreliable.

However, some variability is to be expected. Whether that variability is acceptable remains to be determined.

[145] §§ 12-43.3-402(6) and 12-43.3-404(10), C.R.S.
[146] Homogeneity refers to the even distribution of cannabinoids in edible products.

Additionally, to ensure consistency amongst the testing facilities, and to develop a robust testing program, the Executive Director is actively seeking to designate a reference laboratory. Such a facility would be independent of the testing facilities that test products. Rather, the reference laboratory would, among other things, prepare a sample and blindly send it to the licensed testing facilities to ensure consistent results. If results vary outside of acceptable parameters, appropriate steps can then be taken.

Arguments surrounding the burden that testing places on the industry typically focus on the samples that must be tested. The Executive Director's requirements are extensive, but this is a new industry and Colorado is leading the way. It is reasonable to conclude that as the marijuana industry matures, and as the testing protocols are implemented and refined, testing requirements will be reduced, if doing so will not jeopardize public safety.

For all these reasons, the General Assembly should replicate in the Medical Code, the marijuana testing requirements of the Retail Code, along with the Executive Director's authority to license marijuana testing facilities.

Recommendation 5 – Prohibit the infusion of trademarked items with medical marijuana.

Another area in which substantive differences between the Medical Code and Retail Code are unjustified pertains to the infusion of trademarked items with marijuana.

The Retail Code specifically prohibits this practice.[147] In short, this prohibits well recognized brand named products, such as cookies and candies, from becoming marijuana-infused edibles. The intent is to reduce the likelihood of an individual, but particularly children, from mistaking a marijuana-infused cookie for a non-infused cookie. In short, one would not expect a well-recognized sandwich cookie to be infused with marijuana.

However, the Medical Code lacks this prohibition. Since the same logic applies to MMIPs as to any other marijuana-infused product, the General Assembly should prohibit the infusion of trademarked items with medical marijuana.

Recommendation 6 – Declare it to be an unlawful activity to have an undisclosed financial interest in a medical marijuana licensee.

Another area in which substantive differences between the Medical Code and Retail Code are unjustified pertains to the matter of undisclosed financial interests in business licensees.

[147] § 12-43.4-404(1)(e), C.R.S.

Both codes require a complete disclosure of all persons having a financial interest in a business licensee.[148]

However, having an undisclosed financial interest in a retail marijuana licensee is an unlawful act,[149] whereas such is not the case in the medical marijuana setting.

Under both codes, a person who engages in an unlawful act commits a class 2 misdemeanor.[150] Thus, a person who has an undisclosed financial interest in a retail marijuana licensee commits a criminal act, but the same conduct with respect to a medical marijuana licensee is not a criminal act.

This issue is particularly salient in the marijuana industry where licensees are required to disclose such financial interests, in part, to ensure that criminal enterprises do not enter the market.

Therefore, the General Assembly should declare it to be an unlawful act to have an undisclosed financial interest in a medical marijuana business licensee.

Recommendation 7 – Allow Optional Premises Cultivation licensees to sell medical marijuana directly to other medical marijuana licensees within the context of vertical integration.

When the General Assembly enacted the Medical Code, considerable consideration was placed on preventing diversion. This is evidenced by the principal of vertical integration, where 70 percent of what a medical marijuana center sells has been grown at its affiliated (commonly owned) optional premises cultivation (OPC) operation. Production is then tied to the number of patients registered at a particular medical marijuana center. Since each patient is entitled to a specific number of plants, the OPC operation can then calculate the amount of marijuana to grow for each of the medical marijuana centers with which it is affiliated.[151]

Since the patients, and thus their medical marijuana, are tied to the medical marijuana center, any transfers of medical marijuana to other licensees must go through the appropriate medical marijuana center.[152] This is true for transfers to licensees inside, as well as outside, of the same ownership group.

[148] §§ 12-43.3-313 and 12-43.4-312, C.R.S.
[149] § 12-43.4-901(2)(b), C.R.S.
[150] §§ 12-43.3-901(7) and 12-43.4-901(6), C.R.S.
[151] So long as the ownership structure is the same, a single OPC can grow medical marijuana for multiple medical marijuana centers.
[152] *See* §§ 12-43.3-402(4), 12-43.3-403(2) and 12-43.3-404(3), C.R.S.

For example, an OPC operation grows medical marijuana for medical marijuana centers A and B (they are all part of the same ownership structure). Each plant at the OPC operation is designated as belonging to either Center A or Center B. The medical marijuana produced from a plant designated for Center B cannot be transported directly to Center A. Rather, it must first be transported to Center B and then transported to Center A.

This scenario becomes somewhat comical if the OPC operation is located in Denver, Center A is in Denver and Center B is in Steamboat. In order for the OPC operation to transfer Center B marijuana to Center A, the medical marijuana must be physically transported from Denver to Steamboat and then back to Denver. This is not only inefficient in terms of time, money and fuel, but it also increases the risk of diversion and theft.

This same scenario plays out for wholesale activities between separately owned medical marijuana centers as well as for marijuana sold to MMIPs manufacturers.

This made a modicum of sense prior to the introduction of the Marijuana Enforcement, Tracking, Reporting and Compliance computer system (METRC). METRC is utilized to prevent diversion of marijuana and ensure compliance with various aspects of the Medical Code by establishing an electronic seed-to-sale tracking system. Within METRC, inventory can be virtually separated and tracked such that accountability is retained even when, as in the example above, plants for Center A grow alongside plants for Center B.

Given METRC's ability to track marijuana electronically, it is no longer necessary for medical marijuana to physically be transported multiple times. Requiring such is not only overly burdensome, but it potentially increases the chances of diversion and theft, the very eventualities the current system is intended to prevent.

In order to improve efficiency and reduce the risk of theft and diversion, the General Assembly should allow the direct transfer of medical marijuana from an OPC operation to other medical marijuana licensees, both within and outside of the same ownership group, within the context of vertical integration. Since programing changes to METRC may be necessary to implement this change, it should be effective no later than January 1, 2016.

Recommendation 8 – Harmonize the license disqualifiers in the Medical Code to those in the Retail Code.

Another area in which substantive differences between the Medical Code and Retail Code are unjustified pertains to who may not be issued a license, thereby disqualifying them from participating in the industry. Table 14 illustrates the differences and similarities in this regard.

Table 14
License Disqualifiers[153]

Grounds for License Denial	Retail Code	Medical Code
Failing to pay the annual fee	X	X
Having a criminal history that indicates lack of good moral character	X	X
Being financed by a person whose criminal history indicates a lack of good moral character	X	X
Being under 21	X	X
Failing to provide a surety bond	X	X
Failing to file any tax return related to a marijuana establishment	X	
Failing to pay any taxes, interest, or penalties related to a marijuana establishment	X	
Having discharged the sentence for a felony conviction within the previous five years	X	X
Having discharged the sentence for a felony conviction related to a controlled substance within the previous 10 years, or within five years of May 28, 2013	X	
Having been convicted of a felony related to a controlled substance		X
Employing a person at a marijuana establishment who has not passed a criminal history background check	X	X
Being a sheriff, deputy sheriff, police officer, prosecuting officer, or an officer or employee of the Executive Director or a local licensing authority	X	X
Applying for a license for a location that is currently licensed as a retail food establishment or wholesale food registrant	X	X
Being an owner who has not been a Colorado resident for at least two years	X	X
Being a licensed physician who makes patient recommendations for medical marijuana		X
Failing to file any tax return with a taxing agency		X
Failing to pay any taxes, interest or penalties due		X
Failing to pay any judgments due to a government agency		X
Defaulting on a government-issued student loan		X
Failing to pay child support		X
Failing to remedy an outstanding delinquency for taxes, child support or a judgment owed a government agency		X
Having had the authority to be a primary caregiver revoked by CDPHE		X

[153] *See* §§ 12-43.4-306 and 12-43.3-307, C.R.S.

Some of these differences are understandable, such as the Medical Code's prohibition on licensing physicians who recommend medical marijuana to patients and its prohibition on primary caregivers who have their status as such revoked. Many of these differences, though, are overly restrictive. Of particular note is the prohibition relating to a previous conviction for a felony related to a controlled substance. Such an individual could never be licensed under the Medical Code, but could be licensed under the Retail Code after just 10 years.

Similarly, the restrictions in the Medical Code relating to child support, student loans and taxes are unnecessarily restrictive. Presumably, they were enacted to ensure that those who work in such a cash-intensive industry possess a modicum of financial responsibility. However, these same limitations were omitted from the Retail Code, indicating that they are no longer thought to be necessary.

Therefore, with the exception of the Medical Code's prohibitions relating to physicians and primary caregivers, the General Assembly should harmonize the Medical Code's restrictions on licensure to match those of the Retail Code.

Recommendation 9 – Authorize the Executive Director to implement a system of seed-to-sale tracking with respect to medical marijuana.

Another area in which substantive differences between the Medical Code and Retail Code are unjustified pertains to seed-to-sale tracking.

The Retail Code requires the Executive Director to:

> develop and maintain a seed-to-sale tracking system that tracks retail marijuana from either seed or immature plant stage until the marijuana or retail marijuana product is sold to a customer at a retail marijuana store to ensure that no marijuana grown or processed by a retail marijuana establishment is sold or otherwise transferred except by a retail marijuana store.[154]

To implement this directive, the Executive Director developed and implemented the METRC system.

While the Medical Code lacks any specific directive to develop and maintain a seed-to-sale tracking system for medical marijuana, the METRC system is utilized in the medical marijuana industry as well as the retail marijuana industry.

To clarify that medical marijuana under the jurisdiction of the Executive Director is subject to the same seed-to-sale tracking requirements as is retail marijuana, the General Assembly should replicate in the Medical Code, the Retail Code's mandate to develop and maintain such a system.

[154] § 12-43.4-202(1), C.R.S.

Recommendation 10 – Harmonize the Medical Code to the Retail Code with respect to the destruction of marijuana.

Another area in which substantive differences between the Medical Code and Retail Code are unjustified pertains to the destruction of marijuana.

Both codes authorize the Executive Director to order the destruction of marijuana, in addition to any other discipline imposed.[155] In such a case, the licensee has 15 days within which to file a petition with the district court for a stay.[156]

However, the codes diverge with respect to the involvement of the relevant district attorney. The Retail Code requires any district attorney that begins investigating any licensee to notify the Executive Director. The Executive Director is then obligated to refrain from destroying any marijuana until the district attorney approves of the destruction,[157] indicating that the marijuana is not needed as evidence. Thus, if the district attorney is not investigating the licensee and no petition is filed, or a judge denies the petition to stay the destruction, the marijuana can be destroyed 15 days after the Executive Director issues the order.

The Medical Code, on the other hand, requires the Executive Director to notify the appropriate district attorney after the initial 15 day petition clock has run, or if the court simply denies the petition. The district attorney then has 15 days to determine whether the marijuana is needed as evidence in any criminal proceeding.[158]

Thus, under the Medical Code, 30 days could potentially lapse between the time the Executive Director orders the marijuana destroyed until that order is actually carried out. In the interim, the marijuana, or some of it, could be diverted. This is particularly salient given that the licensee in possession of the marijuana has already demonstrated a propensity to violate the law—thus the order to destroy.

To be sure, a licensee should be afforded the opportunity to appeal an order to destroy, and the district attorney should be given an opportunity to intervene if the marijuana is needed as evidence, but the Retail Code addresses both concerns more efficiently.

Therefore, the General Assembly should amend the Medical Code to replicate the Retail Code with respect to the destruction of marijuana.

[155] §§ 12-43.3-602(4) and 12-43.4-602(4), C.R.S.
[156] §§ 12-43.3-602(5) and 12-43.4-602(5), C.R.S.
[157] § 12-43.4-602(6), C.R.S.
[158] § 12-43.3-602(6), C.R.S.

Recommendation 11 – Repeal the hours during which medical marijuana centers can sell medical marijuana to patients and authorize the Executive Director to establish such hours in rule.

Another area in which substantive differences between the Medical Code and Retail Code are unjustified pertains to hours of operation.

It is unlawful for a medical marijuana center to sell, serve or distribute medical marijuana at any time other than between 8:00 a.m. and 7:00 p.m.[159] This restriction is placed in statute.

Retail marijuana, on the other hand, can be sold, served, distributed or transported between the hours of 8:00 a.m. and midnight.[160] This restriction is placed in rule, and by statute, local licensing authorities may establish different hours of operation.[161]

Since many medical marijuana centers are co-located with retail marijuana stores, this distinction makes little sense and causes confusion. The store may be open, but medical marijuana cannot be sold after 7:00 p.m.

Thus, a medical marijuana patient must time his or her visit to the medical marijuana center so as to avoid getting there too late, but the retail marijuana user is not subject to the same constraints.

Therefore, the General Assembly should repeal the statutory provisions regarding hours of operation from the Medical Code, and replicate in the Medical Code, the same authority the Executive Director has to address this issue as in the Retail Code, ensuring local licensing authorities' ability to establish different hours of operation.

Recommendation 12 – Require that MMIPs be properly refrigerated.

Another area in which substantive differences between the Medical Code and Retail Code are unjustified pertains to the proper refrigeration of MMIPs.

The Retail Code specifically requires that marijuana products that require refrigeration to prevent spoilage, be stored and transported in a refrigerated environment.[162] While this is an odd requirement for a regulator that is not a health regulator to enforce, as the sole regulator of the marijuana industry, the Executive Director is called upon to perform a number of unexpected tasks.

[159] § 12-43.3-901(4)(l), C.R.S.
[160] 1 CCR 212-2, § R 308(A).
[161] § 12-43.4-301(2), C.R.S.
[162] § 12-43.4-404(9), C.R.S.

Regardless, the obvious point of such a requirement is to ensure that such products, primarily edibles, are stored and transported properly so as to avoid spoilage and illness. As such, this is a fairly straightforward public protection measure.

However, the Medical Code lacks this specific requirement with respect to MMIPs. This means there is no affirmative obligation for licensees to store their products in this manner.

Therefore, the General Assembly should require that MMIPs be properly refrigerated.

Recommendation 13 – Clarify that certain proprietary and personal information in the possession of the Executive Director is confidential.

Section 12-43.3-202(1)(d), C.R.S., provides that the Executive Director shall:

> Maintain the confidentiality of reports or other information obtained from a licensee showing the sales volume or quantity of medical marijuana sold, or revealing any patient information, or any other records that are exempt from public inspection pursuant to state law.

Of particular concern in this provision is its focus on sales information. While this information should be protected and not disclosed to a licensee's competitors, the Executive Director collects and possesses a great deal more information that should be similarly protected.

METRC collects a considerable amount of information that could be used for nefarious purposes and that is not sales-related. For example, METRC captures data related to the number of plants in various stages of growth, when and how much medical marijuana is transferred from OPC operations to medical marijuana centers and MMIPs manufacturers, MMIPs manufacturers' inventory, and so on.

Since this data is not specifically protected as confidential, it could be subject to disclosure under the Colorado Open Records Act. This would allow, for example, criminals to request data relating to medical marijuana transfers so that they could properly time a theft of marijuana. Additionally, if a licensee could request data relating to the growth cycles of competitors, it could time price hikes and discounts accordingly, thereby providing a competitive advantage.

Additionally, as part of the licensing process, the Executive Director comes to possess a considerable amount of personal information, such as individual applicants' tax records and credit reports. The Executive Director also requires business license applicants to submit information related to security systems. All of this is necessary from a regulatory prospective, but should not be readily accessible by the public.

Therefore, the General Assembly should amend the Medical Code to protect as confidential all individualized data and records contained in METRC or in the possession of the Executive Director.

Recommendation 14 – Clarify that the Executive Director may administratively continue a license renewal application.

Another area in which substantive differences between the Medical Code and Retail Code are unjustified pertains to license renewals.

With respect to license renewals, the Retail Code authorizes the Executive Director to "administratively continue the license and accept a later application for renewal of a license at the discretion of the [Executive Director]."[163] This enables the Executive Director to allow a licensee to continue to operate after the expiration of the previous license, but before the renewal application is fully processed.

The Medical Code expresses this in principal, but is less explicit, by providing that, with respect to license renewals, "[t]he [Executive Director], in its discretion . . . based upon reasonable grounds, may waive the forty-five-day or thirty-day time requirements . . .."[164] These time requirements refer to how far in advance of license expiration a licensee must apply to renew.

Both provisions have substantially similar results, but the Retail Code is more explicit.

Therefore, the General Assembly should grant the Executive Director the authority to administratively continue license renewals.

Recommendation 15 – Make technical changes to the Medical Code.

The Medical Code contains several instances of obsolete, duplicative and confusing language, and it should be revised to reflect current terminology and administrative practices. These changes are technical in nature, meaning that they have no substantive impact.

The General Assembly should make the following technical changes:

- **Section 12-43.3-104(16), C.R.S.** To the definition of State Licensing Authority, add "and retail" after "sale of medical" to clarify that the State Licensing Authority has regulatory authority over both types of marijuana and to harmonize the definition with the Retail Code.

[163] § 12-43.4-310(2)(b), C.R.S.
[164] § 12-43.3-311(1), C.R.S.

- **Section 12-43.3-105, C.R.S.** To correct a grammatical error, after "under control of the licensee, with limited" strike the word "access" and place it in front of the word "limited."
- **Section 12-43.3-202(3), C.R.S.** Since the required report has been posted and since the backlog of license applications that spurred this reporting requirement has been erased, repeal this section.
- **Section 12-43.3-303(4), C.R.S.** Since the State Licensing Authority does not issue local licenses, strike "local" after "issue a" and before "license".
- **Section 12-43.3-601(4), C.R.S.** Since the Marijuana Cash Fund replaced the Medical Marijuana License Cash Fund, correct the reference to the Medical Marijuana License Cash Fund.

Appendix A – Results of the Survey of Patients

As part of this sunset review, the Department of Regulatory Agencies conducted an on-line survey of medical marijuana patients. The Colorado Department of Public Health and Environment (CDPHE) assisted in this endeavor by informing patients of the survey by email,[165] on the CDPHE website and by way of various social media platforms. The survey closed at 4:00 p.m. (MDT) on Monday, August 25, 2014. One hundred one responses were received. The results of the survey follow.

Do you use marijuana medicinally?

Response	Chart	Frequency	Count
Yes		**99.0%**	**98**
No		1.0%	1
Not Answered			2
	Valid Responses		**99**
	Total Responses		**101**

Have you registered as a medical marijuana patient with CDPHE?

Response	Chart	Frequency	Count
Yes		**91.9%**	**91**
No		8.1%	8
Not Answered			2
	Valid Responses		**99**
	Total Responses		**101**

[165] Only those who had previously provided their email addresses to CDPHE were notified of the survey by email.

If no, why not?

Response	Chart	Frequency	Count
I am not a patient		1.0%	1
I do not want CDPHE to know that I am a medical marijuana patient, even though CDPHE must keep this fact confidential.		3.0%	3
I do not want my local law enforcement agency to know that I am a medical marijuana patient.		3.0%	3
I do not want the federal government to know that I am a medical marijuana patient.		3.0%	3
Other:		**5.9%**	**6**
	Valid Responses		**101**
	Total Responses		**101**

If you are not a patient, are you completing this survey on behalf of a patient?

Response	Chart	Frequency	Count
Yes		8.0%	2
No		**92.0%**	**23**
Not Answered			76
	Valid Responses		**25**
	Total Responses		**101**

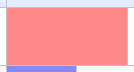
If yes, which of the following best describes your relationship to the patient?

Response	Chart	Frequency	Count
The patient is my child		0.0%	0
The patient is my spouse/life partner/significant other		1.0%	1
The patient is my parent		0.0%	0
The patient is my sibling		0.0%	0
The patient is my friend		**2.0%**	**2**
The patient is under my professional care.		0.0%	0
		Valid Responses	**101**
		Total Responses	**101**

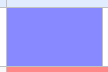
From which source do you obtain your medical marijuana?

Response	Chart	Frequency	Count
I grow my own plants		41.6%	42
Caregiver		20.8%	21
Medical Marijuana Center		**73.3%**	**74**
		Valid Responses	**101**
		Total Responses	**101**

What is the primary reason you obtain most of your medical marijuana from this source?

Response	Chart	Frequency	Count
Higher quality		**27.6%**	**27**
I know the marijuana has been tested, so it is safer		14.3%	14
I grow the marijuana myself, so I know that it is safe		12.2%	12
To obtain a particular strain		4.1%	4
To obtain a particular product		5.1%	5
Convenience		11.2%	11
Other:		25.5%	25
Not Answered			3
		Valid Responses	**98**
		Total Responses	**101**

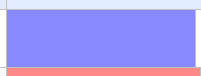
Do you have a caregiver registered with CDPHE?

Response	Chart	Frequency	Count
Yes		25.3%	24
No		**74.7%**	**71**
Not Answered			6
		Valid Responses	**95**
		Total Responses	**101**

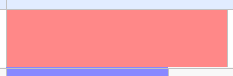
If you obtain medical marijuana from a caregiver, approximately what percentage of your medical marijuana do you obtain from your caregiver?

The average of 18 responses was 71.7%

Should caregivers be regulated?

Response	Chart	Frequency	Count
Yes		49.5%	47
No		**50.5%**	**48**
Not Answered			6
		Valid Responses	**95**
		Total Responses	**101**

Have you registered as a patient with a Medical Marijuana Center?

Response	Chart	Frequency	Count
Yes		**57.7%**	**56**
No		42.3%	41
Not Answered			4
		Valid Responses	**97**
		Total Responses	**101**

If you obtain medical marijuana from a medical marijuana center, approximately what percentage of your marijuana do you obtain from your center?

The average of 64 responses was 71%.

How many plants are you authorized to grow/own?

The average of 75 responses was 16.6 plants.

If you grow your own medical marijuana, approximately what percentage of the medical marijuana that you use do you grow?

The average of 37 responses was 69.2%.

Do you obtain marijuana from illegal sources?

Response	Chart	Frequency	Count
Yes		8.6%	8
No		**91.4%**	**85**
Not Answered			8
		Valid Responses	**93**
		Total Responses	**101**

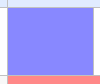
Do you use marijuana recreationally?

Response	Chart	Frequency	Count
Yes		47.3%	44
No		**52.7%**	**49**
Not Answered			8
		Valid Responses	**93**
		Total Responses	**101**

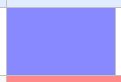
For approximately how many years have you been registered as a patient at CDPHE?

Response	Chart	Frequency	Count
1-2 years		**34.8%**	**31**
3-4 years		24.7%	22
4-5 years		18.0%	16
5-6 years		14.6%	13
6-10 years		7.9%	7
More than 10 years		0.0%	0
Not Answered			12
		Valid Responses	**89**
		Total Responses	**101**

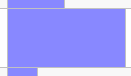
Prior to when MED began licensing retail marijuana testing facilities, approximately what percentage of your medical marijuana did you have tested yourself?

Response	Chart	Frequency	Count
I was not a patient at that time		18.1%	17
I never had my medical marijuana tested		**68.1%**	**64**
Less than 25%		6.4%	6
Between 25 and 50%		2.1%	2
Between 50 and 75%		2.1%	2
Between 75 and 100%		3.2%	3
Not Answered			7
		Valid Responses	**94**
		Total Responses	**101**

What effect did testing have on your consumption?

Response	Chart	Frequency	Count
I no longer consume untested marijuana		28.6%	20
It had no effect; I still obtain marijuana from my caregiver		**35.7%**	**25**
It had no effect; I still grow my own marijuana		**35.7%**	**25**
Not Answered			31
		Valid Responses	**70**
		Total Responses	**101**

In what form do you prefer to take your medical marijuana?

Response	Chart	Frequency	Count
Smoke		**50.0%**	**47**
Vape pen		10.6%	10
Edibles		26.6%	25
Tinctures		3.2%	3
Ointments/lotions		1.1%	1
Liquid concentrates		8.5%	8
Not Answered			7
		Valid Responses	**94**
		Total Responses	**101**

Understanding that the constitutional provisions regarding medical marijuana would remain in place, should the Medical Code be continued?

Response	Chart	Frequency	Count
Yes		**78.7%**	**74**
No		21.3%	20
Not Answered			7
		Valid Responses	**94**
		Total Responses	**101**

Appendix B – Results of the Survey of Primary Caregivers

As part of this sunset review, the Department of Regulatory Agencies conducted an on-line survey of primary caregivers. The Colorado Department of Public Health and Environment (CDPHE) assisted in this endeavor by informing primary caregivers of the survey by email,[166] on the CDPHE website and by way of various social media platforms. The survey closed at 4:00 p.m. (MDT) on Monday, August 25, 2014. Twenty-three responses were received. The results of the survey follow.

Do you provide caregiving services to patients?

Response	Chart	Frequency	Count
Yes		**85.0%**	**17**
No		15.0%	3
Not Answered			3
	Valid Responses		**20**
	Total Responses		**23**

Have you registered as a caregiver with CDPHE?

Response	Chart	Frequency	Count
Yes		40.0%	8
No		**60.0%**	**12**
Not Answered			3
	Valid Responses		**20**
	Total Responses		**23**

[166] Only those who had previously provided their email addresses to CDPHE were notified of the survey by email.

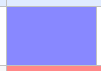
If not, why not?

Response	Chart	Frequency	Count
I do not want CDPHE to know that I am a caregiver, even though CDPHE must keep this fact confidential.		17.4%	4
I do not want CDPHE to inform MED that I am a caregiver.		17.4%	4
I do not want my local law enforcement agency to know that I'm a caregiver.		17.4%	4
I do not want the federal government to find out that I am a caregiver.		21.7%	5
Other:		**26.1%**	**6**
	Valid Responses		**23**
	Total Responses		**23**

What is the primary reason you became a caregiver?

Response	Chart	Frequency	Count
I believe in the medicinal value of marijuana and want to help others.		**60.0%**	**12**
I want to cultivate marijuana, but have no interest in operating a medical marijuana center or retail marijuana store.		5.0%	1
I am not able to obtain a medical marijuana license due to my criminal history.		15.0%	3
Other:		20.0%	4
Not Answered			3
	Valid Responses		**20**
	Total Responses		**23**

Do you have plans to obtain a Retail Marijuana Cultivation license when they become available in October 2014?

Response	Chart	Frequency	Count
Yes		23.5%	4
No		**76.5%**	**13**
Not Answered			6
		Valid Responses	**17**
		Total Responses	**23**

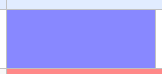
For how many patients do you currently provide care?

The average of 15 responses was 6.1 patients.

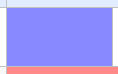
Approximately what percentage of those patients have registered with CDPHE?

The average of 14 responses was 71.6%.

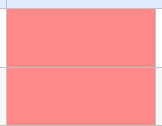
Do you live in a jurisdiction that bans medical marijuana centers?

Response	Chart	Frequency	Count
Yes		38.9%	7
No		**61.1%**	**11**
Don't know		0.0%	0
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

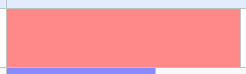
Do you live in a jurisdiction that bans optional premises cultivation facilities?

Response	Chart	Frequency	Count
Yes		27.8%	5
No		**50.0%**	**9**
Don't know		22.2%	4
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

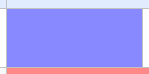
Do you live in a jurisdiction that bans medical marijuana-infused product manufacturers?

Response	Chart	Frequency	Count
Yes		**38.9%**	**7**
No		**38.9%**	**7**
Don't know		22.2%	4
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

Do you grow your plants inside your residence?

Response	Chart	Frequency	Count
Yes		**61.1%**	**11**
No		38.9%	7
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

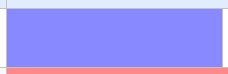
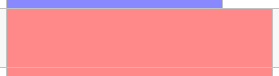
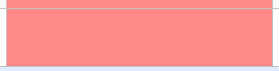
Do you grow your plants at an indoor facility other than your residence?

Response	Chart	Frequency	Count
Yes		35.3%	6
No		**64.7%**	**11**
Not Answered			6
		Valid Responses	**17**
		Total Responses	**23**

Do you grow plants with other caregivers, in a cooperative-type setting?

Response	Chart	Frequency	Count
Yes		16.7%	3
No		**83.3%**	**15**
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

How many plants are you growing right now?

Response	Chart	Frequency	Count
Clones		56.5%	13
Vegging		**69.6%**	**16**
Flowering		**69.6%**	**16**
		Valid Responses	**23**
		Total Responses	**23**

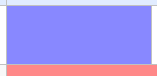
Are you growing more plants that you should be?

Response	Chart	Frequency	Count
Yes		0.0%	0
No		**100.0%**	**18**
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

What do you do when you grow more medical marijuana than your patients need or can use?

Response	Chart	Frequency	Count
I use it myself		21.7%	5
I sell it to other caregivers		8.7%	2
I sell it to medical marijuana centers		4.3%	1
I sell it people who are not my patients		8.7%	2
I destroy it		8.7%	2
I save it until my patients need it.		**47.8%**	**11**
Other:		17.4%	4
		Valid Responses	**23**
		Total Responses	**23**

Have you registered your cultivation with MED?

Response	Chart	Frequency	Count
Yes		35.3%	6
No		**58.8%**	**10**
I do not grow marijuana		5.9%	1
Not Answered			6
		Valid Responses	**17**
		Total Responses	**23**

If not, why not? [167]

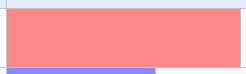
Response	Chart	Frequency	Count
I do not want CDPHE to know that I am a caregiver, even though CDPHE must keep this fact confidential.		**18.2%**	**2**
I do not want CDPHE to inform MED that I am a caregiver.		9.1%	1
I do not want my local law enforcement agency to know that I'm a caregiver.		9.1%	1
I do not want the federal government to find out that I am a caregiver.		**18.2%**	**2**
I do not grow marijuana		9.1%	1
Other:		**18.2%**	**2**
	Valid Responses		**11**
	Total Responses		**11**

If no, why not?[168]

Response	Chart	Frequency	Count
I was not aware that I am required to register with MED.		**25.0%**	**3**
I do not want MED to know that I am a caregiver.		8.3%	1
I do not want my local law enforcement agency to know that I'm a caregiver.		8.3%	1
I do not want the federal government to know that I am a caregiver.		8.3%	1
I do not grow marijuana.		0.0%	0
Other:		**25.0%**	**3**
	Valid Responses		**12**
	Total Responses		**12**

[167] Due to technical difficulties, only these selections were available to respondents until approximately 8:00 a.m. on Thursday, August 21, 2014.
[168] Due to technical difficulties, only these selections were available to respondents after approximately 8:00 a.m. on Thursday, August 21, 2014.

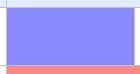
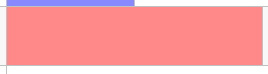
Do you produce extracts?

Response	Chart	Frequency	Count
Yes		**61.1%**	**11**
No		38.9%	7
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

If yes, do which extraction method do you utilize?

Response	Chart	Frequency	Count
Heat		20.0%	2
Cold		**80.0%**	**8**
Not Answered			13
		Valid Responses	**10**
		Total Responses	**23**

Have you ever been visited by your local law enforcement agency regarding your cultivation of medical marijuana or your status as a caregiver?

Response	Chart	Frequency	Count
Yes		33.3%	6
No		**66.7%**	**12**
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

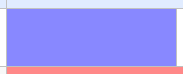
If yes, what was the nature of this visit?

Response	Chart	Frequency	Count
Polite and professional		**83.3%**	**5**
Rude and accusatory		16.7%	1
Hostile		0.0%	0
Other:		0.0%	0
Not Answered			17
		Valid Responses	**6**
		Total Responses	**23**

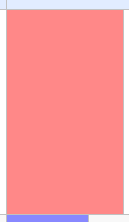
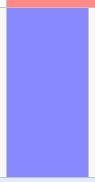
Did the law enforcement agency seize any of your plants as a result of this visit?

Response	Chart	Frequency	Count
Yes		0.0%	0
No		**100.0%**	**9**
Not Answered			14
		Valid Responses	**9**
		Total Responses	**23**

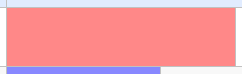
Do you think caregivers should be regulated?

Response	Chart	Frequency	Count
Yes		44.4%	8
No		**55.6%**	**10**
Not Answered			5
		Valid Responses	**18**
		Total Responses	**23**

If yes, what criteria should be used to determine which caregivers should be regulated and which that should be exempt? (Check all that apply)

Response	Chart	Frequency	Count
The number of plants a person grows. What number should be the line of demarcation between regulation and exemption?		**30.4%**	**7**
The number of patients a caregiver cares for. What number should be the line of demarcation between regulation and exemption?		21.7%	5
		Valid Responses	**23**
		Total Responses	**23**

Understanding that the constitutional provisions regarding medical marijuana would remain in place, should the Medical Code be continued?

Response	Chart	Frequency	Count
Yes		**60.0%**	**12**
No		40.0%	8
Not Answered			3
		Valid Responses	**20**
		Total Responses	**23**

Appendix C – Results of the Survey of Municipal Governments

As part of this sunset review, the Department of Regulatory Agencies (DORA) conducted an on-line survey of municipal governments. The link to the survey was sent to 403 email addresses that DORA staff obtained through original research of those governmental entities. The survey closed at 4:00 p.m. (MDT) on Monday, August 25, 2014. Seventy-one responses were received. The results of the survey follow.

Does your jurisdiction currently allow medical marijuana optional premises cultivation facilities?

Response	Chart	Frequency	Count
Yes		23.9%	17
No		**76.1%**	**54**
	Valid Responses		**71**
	Total Responses		**71**

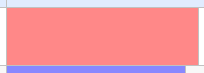
Does your jurisdiction currently allow medical marijuana centers?

Response	Chart	Frequency	Count
Yes		34.3%	24
No		**65.7%**	**46**
Not Answered			1
	Valid Responses		**70**
	Total Responses		**71**

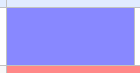
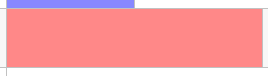
Does you jurisdiction currently allow medical marijuana-infused products manufacturers?

Response	Chart	Frequency	Count
Yes		15.5%	11
No		**84.5%**	**60**
	Valid Responses		**71**
	Total Responses		**71**

If your jurisdiction allows the medical marijuana establishments listed above, do you actively inspect them?

Response	Chart	Frequency	Count
Yes		**48.4%**	**15**
No		45.2%	14
Not All (Please explain)		6.5%	2
Not Answered			40
		Valid Responses	**31**
		Total Responses	**71**

If your jurisdiction allows the medical marijuana establishments listed above, are your licensing requirements any more stringent than the state's?

Response	Chart	Frequency	Count
Yes		33.3%	10
No		**66.7%**	**20**
Not Answered			41
		Valid Responses	**30**
		Total Responses	**71**

If yes, in what ways?

Response
land use limitations
Zoning requirements, hours of operation, residency requirement for owners
we regulate the number of centers by the land use code
safety requirements
None
Does not apply
NA
The business must have a local agent - someone who lives in or very near our town
Limitations on what zone districts they can locate within
hours of operation, signage

Has the Medical Marijuana Code in any way hindered you from enacting any standards?

Response	Chart	Frequency	Count
Yes		3.6%	2
No		**62.5%**	**35**
Not Applicable		33.9%	19
Not Answered			15
		Valid Responses	**56**
		Total Responses	**71**

If yes, in what ways

Response
refusal of District Attorney to prosecute MMJ related cases no matter how egregious
Caregivers are difficult to regulate due to provisions under Amendment 20

Which of the following best characterizes your interactions, in general, with the Marijuana Enforcement Division?

Response	Chart	Frequency	Count
Very Cooperative		28.6%	18
Somewhat cooperative		19.0%	12
Not particularly cooperative nor uncooperative		6.3%	4
Somewhat uncooperative		3.2%	2
Very uncooperative		0.0%	0
We have had no meaningful interaction.		**42.9%**	**27**
Not Answered			8
		Valid Responses	**63**
		Total Responses	**71**

Which of the following best characterizes the way in which Marijuana Enforcement Division administers the Medical Marijuana Code?

Response	Chart	Frequency	Count
Very effective		12.5%	8
Somewhat effective		25.0%	16
Neither effective nor ineffective		10.9%	7
Somewhat ineffective		3.1%	2
Very ineffective		1.6%	1
We have had no meaningful interaction.		**46.9%**	**30**
Not Answered			7
		Valid Responses	**64**
		Total Responses	**71**

Understanding that the constitutional provisions regarding medical marijuana would remain in place, should the Medical Marijuana Code be continued?

Response	Chart	Frequency	Count
Yes		**77.4%**	**48**
No		22.6%	14
Not Answered			9
		Valid Responses	**62**
		Total Responses	**71**

Appendix D – Results of the Survey of County Governments

As part of this sunset review, the Department of Regulatory Agencies (DORA) conducted an on-line survey of county governments. The link to the survey was sent to 64 email addresses that DORA staff obtained through original research of those governmental entities. Two emails were returned as undeliverable. The survey closed at 4:00 p.m. (MDT) on Monday, August 25, 2014. Twelve responses were received. The results of the survey follow.

Does your jurisdiction currently allow medical marijuana optional premises cultivation facilities?

Response	Chart	Frequency	Count
Yes		33.3%	4
No		**66.7%**	**8**
		Valid Responses	**12**
		Total Responses	**12**

Does your jurisdiction currently allow medical marijuana centers?

Response	Chart	Frequency	Count
Yes		25.0%	3
No		**75.0%**	**9**
		Valid Responses	**12**
		Total Responses	**12**

Does you jurisdiction currently allow medical marijuana-infused products manufacturers?

Response	Chart	Frequency	Count
Yes		25.0%	3
No		**75.0%**	**9**
		Valid Responses	**12**
		Total Responses	**12**

If your jurisdiction allows the medical marijuana establishments listed above, do you actively inspect them?

Response	Chart	Frequency	Count
Yes		20.0%	1
No		**60.0%**	**3**
Not All (Please explain)		20.0%	1
Not Answered			7
	Valid Responses		**5**
	Total Responses		**12**

If yes, in what ways?

Response
We allow them but do not have any in place yet. Once in place, we will inspect them.

If your jurisdiction allows the medical marijuana establishments listed above, are your licensing requirements any more stringent than the state's?

Response	Chart	Frequency	Count
Yes		20.0%	1
No		**80.0%**	**4**
Not Answered			7
	Valid Responses		**5**
	Total Responses		**12**

If yes, in what ways?

Response
specific building and/or fire life safety code requirements; air handling/odor mitigation control requirements; location/zoning requirements; signage/public display restrictions; hours of operation restrictions.

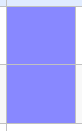
Has the Medical Marijuana Code in any way hindered you from enacting any standards?

Response	Chart	Frequency	Count
Yes		0.0%	0
No		**87.5%**	**7**
Not Applicable		12.5%	1
Not Answered			4
	Valid Responses		**8**
	Total Responses		**12**

Which of the following best characterizes your interactions, in general, with the Marijuana Enforcement Division?

Response	Chart	Frequency	Count
Very Cooperative		18.2%	2
Somewhat cooperative		18.2%	2
Not particularly cooperative nor uncooperative		9.1%	1
Somewhat uncooperative		0.0%	0
Very uncooperative		9.1%	1
We have had no meaningful interaction.		**45.5%**	**5**
Not Answered			1
	Valid Responses		**11**
	Total Responses		**12**

Which of the following best characterizes the way in which Marijuana Enforcement Division administers the Medical Marijuana Code?

Response	Chart	Frequency	Count
Very effective		18.2%	2
Somewhat effective		18.2%	2
Neither effective nor ineffective		0.0%	0
Somewhat ineffective		9.1%	1
Very ineffective		9.1%	1
We have had no meaningful interaction.		**45.5%**	**5**
Not Answered			1
		Valid Responses	**11**
		Total Responses	**12**

Understanding that the constitutional provisions regarding medical marijuana would remain in place, should the Medical Marijuana Code be continued?

Response	Chart	Frequency	Count
Yes		**90.0%**	**9**
No		10.0%	1
Not Answered			2
		Valid Responses	**10**
		Total Responses	**12**