Top Marijuana and THC Policy Recommendations for State Legislatures

A policy brief for state legislators and legislative staff

Legislators keep asking SAM for concrete ideas they can carry into the next session. What follows are priority recommendations for each type of state, a short explanation of why each one matters, and draft model language in the appendix that legislative counsel can adapt to any state code.

How to use this brief. Find your state's track. **Track 1** is for states with no medical or recreational marijuana program, including states with only a narrow low-THC oil or CBD law. **Track 2** is for states with legal marijuana, whether medical, recreational, or both. Each Track 2 recommendation is labeled to show whether it applies to medical programs, recreational programs, or both.

The Big Three: For States With Legal Marijuana (Track 2)

Every Track 2 package should include these three reforms, for both medical and recreational programs.

Product-form limits. Medical programs should allow measured-dose pills and capsules only. Recreational markets should ban vapes, dabbable concentrates, candy-like edibles, and THC beverages.

Potency caps. Set maximum THC levels in statute, measured as total THC: 10 to 15 percent for flower, no concentrates or vapes, and strict milligram limits on pills and edibles.

Warning labels. Require large health warnings and plain, child-resistant packaging on every product, including a statement that the FDA has not approved marijuana for any medical purpose.

And in every state, including Track 1: ban intoxicating hemp-derived THC under state law at or below the federal limit of 0.4 milligrams of total THC per container. The lower the limit, the better.

The Recommendations at a Glance

Track 1: No Legal Marijuana	Track 2: Legal Marijuana States
1. Ban intoxicating hemp THC at or below the federal limit 2. Firewall state law from federal rescheduling 3. Stop THC from being shipped or sold into the state 4. Keep medicine in the FDA lane 5. Measure harm, fund prevention, and strengthen drugged-driving laws	***Medical and recreational programs*** 1. Limit product forms 2. Cap potency in statute 3. Require strong warning labels and plain packaging 4. Crack down on drugged driving 5. Rein in marketing, guarantee local opt-out, and close the revolving door 6. Tax heavily, dedicate the revenue, and deny write-offs 7. Mandate public health reporting and independent review ***Medical programs only*** 8. Restore real medical standards 9. Stop medical creep toward recreational sales

Why States Should Act Now

The hemp fight is moving to the states. Section 781 of Public Law 119-37, enacted in November 2025, redefines hemp using a total-THC standard and limits consumable hemp products to 0.4 milligrams of total THC per container. A stopgap funding law signed September 2, 2026 (H.R. 6500) delayed most of those restrictions from November 12 to December 11, 2026. Only a narrow category, cannabinoids the plant cannot produce naturally, still loses hemp status on November 12. That early date does not reach most products on the market, including semi-synthetics such as delta-8 THC made from CBD, which can stay on shelves until December 11.

Federal rescheduling makes state law the front line. An April 2026 Justice Department order moved marijuana produced and sold under state medical licenses, along with FDA-approved marijuana drugs, from Schedule I to Schedule III. The order created a DEA registration pathway for state licensees and relies heavily on state rules for certifications, labeling, and packaging. The order is being challenged in federal court, and a decision on rescheduling all marijuana is still pending. In practice, the guardrails states write now are the guardrails that will apply.

Today's marijuana is a different drug. THC levels in marijuana flower have climbed from low single digits a generation ago to roughly 20 percent or more in legal markets, and concentrates can exceed 90 percent. In a major 2019 study published in The Lancet Psychiatry, daily use of high-potency marijuana (10 percent THC or more) was associated with nearly five times the odds of a psychotic disorder compared with never using.

Track 1: States Without Legal Marijuana

For states with no medical or recreational program, including states with only a narrow low-THC oil or CBD law. The goal is to keep commercial marijuana out and close the hemp back door before an industry builds a customer base.

1. Ban intoxicating hemp THC at or below the federal limit

The ask. Write a total-THC standard (including THCA) into state code and cap hemp-derived products at no more than 0.4 milligrams of total THC per container, the federal limit. States should set the lowest limit they can pass; the strongest version allows no THC above what a state-accredited laboratory can reliably measure. Prohibit any cannabinoid that is synthesized or chemically converted from another cannabinoid, such as delta-8 THC made from CBD. Require businesses that sell hemp products that remain legal, such as non-intoxicating CBD, to register with the state, and back the law with civil penalties, product seizure, and the ability to suspend a store's tobacco and alcohol retail licenses. Give the attorney general and the state agriculture or alcohol agency clear enforcement authority.

Why it matters. Congress has already delayed the federal date once, and the industry is lobbying for more. A state statute makes the ban permanent in your state no matter what happens in Washington, and it gives state and local officials the tools to act against products sold in gas stations and convenience stores, often in candy and snack packaging.

2. Firewall state law from federal rescheduling

The ask. Amend the state controlled substances act so that marijuana and THC remain in state Schedule I unless the legislature itself votes to move them. State plainly that no federal scheduling change, DEA registration, or federal order authorizes marijuana activity under state law. Exempt FDA-approved drug products.

Why it matters. Many state drug laws follow the Uniform Controlled Substances Act model, which directs the state to adopt federal scheduling changes unless a state official objects within a short window. With state medical marijuana already in Schedule III and a broader federal decision pending, an old provision could hand the industry a change no legislator voted for. Legislators should ask their legislative counsel to check the state code now.

3. Stop THC from being shipped or sold into the state

The ask. Prohibit the shipment, mail delivery, and home delivery into the state of any marijuana or THC product that is unlawful to sell in the state, including products ordered online from sellers in legal states. Require common carriers and delivery platforms to refuse such shipments, and give the attorney general civil enforcement authority against out-of-state sellers, online marketplaces, and payment processors that knowingly facilitate those sales. Prohibit in-state advertising of products that cannot lawfully be sold in the state.

Why it matters. A state without a legal market can still end up with one through the mailbox and the internet. Online THC sellers, and marijuana storefronts in neighboring legal states, market directly to residents regardless of state law. Federal rescheduling of medical marijuana has already prompted

proposals to expand delivery, so states should make clear now that delivery into the state is not allowed.

4. Keep medicine in the FDA lane

The ask. Answer calls for “medical marijuana” by supporting FDA-approved cannabinoid medicines, such as prescription cannabidiol for certain seizure disorders and dronabinol and nabilone for nausea and appetite loss, along with research at state universities. Reject bills that allow smokable marijuana, open-ended lists of qualifying conditions, or unlimited licenses.

Why it matters. FDA approval means a tested dose, verified purity, and proven effectiveness. By contrast, Oklahoma’s 2018 ballot measure included no list of qualifying conditions and set low barriers to licensing; it produced thousands of licensed grow operations and a well-documented illicit market problem.

5. Measure harm, fund prevention, and strengthen drugged-driving laws

The ask. Require the state health department to report every year on THC-related poison control calls, emergency visits, hospitalizations, psychosis, drugged-driving crashes, and youth use. Fund school-based prevention. Make it illegal to drive with any detectable active THC in the blood or oral fluid, authorize roadside oral fluid testing, and fund drug recognition expert training for officers.

Why it matters. Baseline data is the strongest tool legislators have when the industry claims legalization caused no harm. On the roads, the problem is already here: in a 2022 federal study of seriously and fatally injured road users at trauma centers, active THC was the most common substance detected, found in 25 percent, slightly ahead of alcohol.

Track 2: States With Legal Marijuana

For states with a medical program, a recreational market, or both. SAM's long-term goal remains ending commercialization, but these reforms reduce harm now and are winnable in a single session. Each recommendation is labeled to show where it applies. Because the April 2026 federal order defers to state rules for medical marijuana, the details a legislature writes are now the main line of defense. Doctors cannot prescribe marijuana; they can only recommend or certify it.

Reforms for All Legal Marijuana States

1. Limit product forms

APPLIES TO: MEDICAL AND RECREATIONAL PROGRAMS

Medical programs. Allow measured-dose pills and capsules only. Prohibit smokable flower, vapes and vape cartridges, dabbable concentrates, edibles such as gummies, chocolates, and baked goods, and beverages.

Recreational programs. Prohibit vapes and vape cartridges, dabbable concentrates (wax, shatter, budder, live resin, rosin), infused pre-rolls, flavored inhalable products, and THC beverages. Prohibit edibles that are gummies, candy, chocolate, or baked goods, or that imitate food brands marketed to children. The strongest version limits all ingestible products to plain, measured-dose pills and capsules.

Why it matters. Medicine is not smoked or vaped, and it does not come as candy. Pills and capsules deliver a known dose and are easy to count and track. Candy-like products are also driving poisonings of young children: reported edible marijuana exposures among children under 6 rose more than 1,300 percent from 2017 to 2021, according to a 2023 study in Pediatrics.

2. Cap potency in statute

APPLIES TO: MEDICAL AND RECREATIONAL PROGRAMS

Medical programs. Limit each package of pills or capsules to no more than 5 milligrams of total THC. If other forms remain during a transition, cap flower at 10 to 15 percent and prohibit concentrates and vapes. Require each certification to state the maximum potency recommended.

Recreational programs. Cap flower and any other smokable product at 10 to 15 percent total THC, limit edibles and other ingestible products to no more than 5 milligrams of total THC per package, and prohibit concentrates and vapes, or at a minimum cap them with no exemption for prefilled cartridges.

Both. Measure total THC, including THCA. Let regulators lower the caps but never raise them, and set strict daily purchase limits.

Why it matters. Only Vermont and Connecticut cap both flower and concentrates, at 30 and 60 percent, and both exempt prefilled vape cartridges, where some of the highest potencies are found. Purchase limits matter too. Even after its 2021 reforms, Colorado's limits for medical marijuana users remain very high: up to 2 ounces of flower in a single day, about 56 grams, or 8 grams of

concentrate. A standard joint contains roughly 0.3 to 0.5 grams of marijuana, so 2 ounces equals well over 100 joints. Caps can also be defended: when a 2026 Vermont Senate bill tried to eliminate the flower cap and raise the concentrate cap, a House committee removed those provisions after testimony from public health officials and prevention leaders.

3. Require strong warning labels and plain packaging

APPLIES TO: MEDICAL AND RECREATIONAL PROGRAMS

The ask. Require large health warnings on the front of every package, covering at least 30 percent of the panel, that state at a minimum: marijuana is known to cause psychosis and addiction and can worsen PTSD, anxiety, and depression; it is not safe for pregnant women and is linked to low birth weight and infant death; the FDA has not approved it for any medical purpose; and marijuana use has been linked to several types of cancer, and smoking marijuana is no safer than smoking tobacco. Require plain, opaque, child-resistant packaging without cartoons or lifestyle imagery, THC per serving and per package printed prominently, and warning signs at every point of sale.

Why it matters. The federal order largely defers to state labeling and packaging rules for medical marijuana, so the warnings users see will depend on what the state requires. Canada already requires health warnings and plain packaging on legal marijuana products, which shows the approach works in a commercial market. Users deserve the same honesty about risk that tobacco labels have required for decades.

4. Crack down on drugged driving

APPLIES TO: MEDICAL AND RECREATIONAL PROGRAMS

The ask. Make it illegal to drive with any detectable active THC (delta-9 THC) in the blood or oral fluid. Authorize roadside oral fluid testing and include it in the state's implied consent law, fund drug recognition expert training, and require toxicology testing, by consent or warrant, of drivers involved in fatal and serious-injury crashes. Prohibit using marijuana or carrying an open package of it in a vehicle, set tougher penalties for driving with both alcohol and THC, and make clear that a medical marijuana card is never a defense.

Why it matters. Unlike alcohol, THC levels in the blood do not track impairment well, and they fall quickly after use, so numeric limits such as 5 nanograms let impaired drivers go free. Active THC was the most common substance found in a 2022 federal study of seriously and fatally injured road users, present in 25 percent, slightly ahead of alcohol. The National Transportation Safety Board has also found that national data on drugs in crashes is unreliable, which is why mandatory crash testing and reporting matter.

5. Rein in marketing, guarantee local opt-out, and close the revolving door

APPLIES TO: MEDICAL AND RECREATIONAL PROGRAMS

The ask. Ban marijuana advertising on billboards, social media, and podcasts, along with influencer marketing and event sponsorships. Ban sales gimmicks such as buy-one-get-one deals, free samples, loyalty rewards, and happy hours. Guarantee that cities and counties can opt out of storefronts and consumption lounges at any time. Permanently bar legislators and regulators from ever working for the marijuana industry, and prohibit lawmakers from owning any interest in a marijuana business while in office.

Why it matters. A commercial market grows by recruiting new and heavier users. These limits restrain that business model, keep decisions about storefronts in the hands of local communities, and make sure the officials who write and enforce the rules are never working for, or profiting from, the industry they oversee.

6. Tax heavily and dedicate the revenue to prevention, treatment, and enforcement

APPLIES TO: MEDICAL AND RECREATIONAL PROGRAMS

Taxes. Impose a high excise tax on every retail sale, on top of the sales tax, and structure it by THC content so the most potent products carry the highest tax. Do not exempt medical sales, which invites recreational buyers to move into the medical program to avoid the tax.

Revenue. Require by statute that marijuana tax revenue go into a dedicated fund used only for addiction prevention, addiction treatment and recovery, and enforcement and oversight of the industry, including inspections, laboratory testing audits, intoxicating hemp enforcement, drugged-driving enforcement, and public health data collection. Bar transfers to the general fund and any use of the revenue to promote or subsidize marijuana businesses.

No write-offs. Enact a state version of Section 280E of the federal tax code so that marijuana businesses cannot deduct ordinary business expenses, such as advertising and expansion costs, on state income or franchise taxes. Repeal any existing state law that exempts marijuana businesses from 280E for state tax purposes, and pass a resolution urging Congress to enact the No Deductions for Marijuana Businesses Act (H.R. 1447 / S. 471).

Why it matters. Higher prices reduce use, especially among young people, as decades of tobacco tax policy have shown. Washington already levies a 37 percent excise tax at retail, and Illinois, New York, and Connecticut tax marijuana by potency. SAM's Local Control Toolkit explains why the public costs of commercialization outpace tax revenue and why the industry fights the very taxes it promised once sales begin, so every dollar collected should go to the harms the industry creates. On deductions, states cannot override federal tax law, but they control their own tax codes. The April 2026 order moved state medical licensees to Schedule III, ending the federal 280E penalty for them, and many legal states have already carved marijuana businesses out of 280E for state taxes. A state version keeps the penalty in place no matter what happens federally, though it has little effect in states without a corporate income or franchise tax.

7. Mandate public health reporting and independent review

APPLIES TO: MEDICAL AND RECREATIONAL PROGRAMS

The ask. Require annual public reporting on THC-related poison control calls, emergency visits, hospitalizations, psychosis, drugged-driving crashes, workplace testing, youth use, and potency trends. For medical programs, add participant counts by qualifying condition, adverse events, and diversion. Commission an independent review of the program's costs and benefits every four years.

Why it matters. Voters were promised strict regulation and new revenue. Independent data shows whether either promise is being kept, and it gives legislators the record they need to tighten the rules.

Reforms for Medical Programs Only

8. Restore real medical standards

APPLIES TO: MEDICAL PROGRAMS ONLY

The ask. Require an in-person exam and a genuine, ongoing relationship between the physician and the medical marijuana user. Require each certification to state the product form, maximum potency, daily quantity, and follow-up schedule. Screen for mental health history and pregnancy. Bar anyone with a financial interest in a marijuana business from certifying users, and require the state to publish how many certifications each practitioner issues each year.

Under 21. No one under 21 should be certified for medical marijuana. If a state cannot enact a full bar, the floor should be certification by two physicians from different practices after in-person exams, follow-up visits every six months, and parental consent for minors. Colorado requires two physicians for users 18 to 20.

Why it matters. The federal order accepts a state certification as sufficient for dispensing, so the quality of that certification is now entirely a state responsibility. Certification mills that approve nearly every applicant are a common way medical programs drift toward de facto recreational markets.

9. Stop medical creep toward recreational sales

APPLIES TO: MEDICAL PROGRAMS ONLY

The ask. Keep a closed list of qualifying conditions set by the legislature, not by regulators or individual practitioners. Cap the number of licenses. State in law that a medical license confers no right, preference, or priority for any future recreational license. State that federal Schedule III status or DEA registration does not expand what the state program allows, including home delivery, shipping by mail or common carrier, advertising, and new product forms.

Why it matters. The industry has long used "medical" to open the door to full commercialization, and operators who expect to convert their medical licenses become a well-funded lobby for legalization. SAM does not agree that Schedule III status allows marijuana to be delivered through the U.S. Postal Service, but Georgia's medical cannabis commission has proposed exactly that, pointing to the federal change. Georgia also enacted a 2026 law removing its 5 percent THC cap and allowing vaping, a reminder of how quickly a narrow program can expand.

Appendix: Draft Model Provisions

These provisions are starting points for legislative counsel, not finished bills. Definitions and cross-references should be adapted to each state's code, and items in brackets identify state-specific references to fill in. SAM can provide drafting assistance.

A. Product-Form Limits (Track 2)

(a) As used in Sections A through D, "total THC" means the sum of all tetrahydrocannabinols, including delta-8, delta-9, and delta-10 tetrahydrocannabinol and any other isomer, analog, or derivative of tetrahydrocannabinol, plus 0.877 multiplied by the concentration of tetrahydrocannabinolic acid (THCA).

A-1. Medical programs

Marijuana may be dispensed under [medical program act] only in the form of a pill or capsule, and each package shall contain no more than 5 milligrams of total THC. No person shall dispense, sell, or transfer under [medical program act] any product intended to be smoked, vaporized, or otherwise inhaled; any edible, candy, confection, baked good, or beverage; or any concentrate.

A-2. Recreational programs

No person shall manufacture, sell, transfer, or offer for sale any marijuana or THC product that:

(1) is a vaporizer, vaporizer cartridge, or other product intended to be vaporized;

(2) is a concentrate intended for inhalation, including wax, shatter, budder, crumble, live resin, or rosin;

(3) is flower or a pre-roll infused with or coated in concentrate;

(4) is a beverage;

(5) is a gummy, candy, lollipop, chocolate, cookie, brownie, or other confection or baked good;

(6) is shaped like, or bears the image of, an animal, fruit, person, cartoon character, or toy; or

(7) uses packaging, a name, or trade dress that imitates a food, beverage, or candy product or is attractive to minors.

Drafting note: *For the strongest version, add "(8) is intended to be smoked" and replace (5) with a requirement that all ingestible products be plain, measured-dose pills or capsules.*

B. THC Potency Limits (Track 2)

(a) "Total THC" has the meaning given in [Section A(a)].

(b) Medical programs. No product dispensed under [medical program act] shall contain more than 5 milligrams of total THC per package.

(c) Recreational programs. No person shall cultivate, manufacture, sell, transfer, or offer for sale:

(1) marijuana flower, or any product intended to be smoked, containing more than 10 percent total THC by weight;

(2) any product intended for oral consumption containing more than 5 milligrams of total THC per package; or

(3) any concentrate, extract, or product intended to be vaporized or inhaled, including a prefilled vaporizer cartridge or disposable vaporizer.

(d) A product that exceeds a limit in this section is adulterated and shall be destroyed. Potency shall be verified by an independent, state-accredited laboratory.

(e) The [agency] may adopt lower limits by rule. No rule, waiver, or exemption may raise a limit in this section.

Drafting note: *A state that cannot pass a 10 percent flower cap should set it no higher than 15 percent. If concentrates and vapes cannot be prohibited outright, cap them by percentage and apply the cap to prefilled cartridges without exception.*

C. Mandatory Health Warnings (Track 2)

(a) Every package of a marijuana or THC product shall display, on the front panel and covering at least 30 percent of that panel, the following statements in bold black text on a yellow background:

(1) “WARNING: Marijuana is known to cause psychosis and addiction, and can worsen PTSD, anxiety, and depression.”

(2) “WARNING: Not safe for pregnant women. Marijuana use during pregnancy is linked to low birth weight and infant death.”

(3) “WARNING: The FDA has not approved this product for any medical purpose.”

(4) “WARNING: Marijuana use has been linked to several types of cancer. Smoking marijuana is no safer than smoking tobacco.”

(b) Each package shall also display the following statements: “THC impairs driving. Do not drive or operate machinery after use.” “Keep out of reach of children. Accidental ingestion can require emergency medical care.” “Marijuana use by teens and young adults can harm the developing brain.” “Frequent use can cause cannabinoid hyperemesis syndrome, a condition involving severe, repeated vomiting.”

(c) The label shall state total THC in milligrams per serving and per package, and as a percentage.

(d) Packaging shall be opaque, child-resistant, and plain, with no cartoons, images of people, or imagery other than the licensee’s name, a standard THC symbol, and required text.

(e) Every retail location shall post the statements in subsection (a) at each point of sale.

Drafting note: *Government-mandated warnings are more likely to survive a First Amendment challenge when they are factual and supported by the record. Build a legislative record with citations for each statement, especially those on cancer, tobacco, and PTSD.*

D. Intoxicating Hemp Prohibition (Tracks 1 and 2)

(a) No person shall manufacture, distribute, sell, or offer for sale in this state any hemp-derived cannabinoid product intended for human consumption or inhalation that contains:

(1) more than 0.4 milligrams of total THC per container; or

(2) any cannabinoid that was synthesized, or that was converted from another cannabinoid by chemical process, including delta-8 THC produced from CBD.

(b) "Total THC" has the meaning given in [Section A(a)].

(c) Any person selling hemp-derived cannabinoid products that remain lawful under this section, such as non-intoxicating CBD products, shall register with the [agency]. A violation of this section is subject to a civil penalty for each violation for each day, seizure of products, and suspension or revocation of the registration and of any state tobacco or alcohol retail license held by the violator. The attorney general and the [agency] may enforce this section.

(d) This section applies regardless of any change to the federal definition of hemp or the effective date of any federal law.

Drafting note: *The 0.4 milligram figure mirrors federal law and should be treated as a ceiling. States should set the lowest limit they can pass; the strongest version prohibits any total THC above the limit of quantitation of a state-accredited laboratory. Insert a daily civil penalty amount appropriate to the state.*

E. Federal Rescheduling Firewall (Tracks 1 and 2)

(a) Notwithstanding [section authorizing the state to conform its schedules to federal action], marijuana, tetrahydrocannabinols, and products containing them shall remain in Schedule I of this chapter unless the General Assembly enacts a law expressly moving them to another schedule.

(b) No federal scheduling action, federal registration, or federal order authorizes the cultivation, manufacture, distribution, dispensing, delivery (including by mail or common carrier), advertising, or possession of marijuana or THC under the laws of this state.

(c) This section does not apply to a drug product approved by the U.S. Food and Drug Administration and dispensed by a licensed pharmacist under a valid prescription.

Drafting note: *In medical states, add "except as expressly authorized under [medical program act]" to subsections (a) and (b), so the firewall preserves the existing program without letting federal changes expand it.*

F. Impaired Driving (Tracks 1 and 2)

(a) A person commits the offense of driving under the influence if the person drives or is in actual physical control of a motor vehicle while any detectable amount of delta-9 tetrahydrocannabinol is present in the person's blood or oral fluid.

(b) A person who drives in this state is deemed to have consented to a roadside oral fluid test for THC, and, upon lawful arrest for impaired driving, to a chemical test for THC.

(c) Law enforcement shall seek toxicology testing for alcohol and THC, by consent or warrant, of every surviving driver involved in a crash resulting in death or serious bodily injury, and the [medical examiner] shall test every deceased driver. Results shall be reported to the [department] in a standard format.

(d) No person shall use marijuana, or possess an open package of marijuana or a THC product, in the passenger area of a motor vehicle on a public road.

(e) Authorization to use marijuana under [medical program act] is not a defense to a charge under this section.

(f) A person convicted under this section who also had a blood alcohol concentration at or above [the state's per se level] is subject to [enhanced penalties].

Drafting note: *Limiting the per se offense to active THC, rather than inactive metabolites, targets recent use and is more defensible in court. Blood testing must comply with Birchfield v. North Dakota and Missouri v. McNeely; electronic warrants speed the process.*

G. Marijuana Taxes, Dedicated Revenue, and Deduction Disallowance (Track 2)

G-1. Excise tax

(a) There is imposed on each retail sale of marijuana or a THC product in this state an excise tax of 37 percent of the retail price, in addition to any sales tax.

(b) The tax applies to sales under [medical program act] and [recreational program act] alike. No exemption, credit, or reduced rate shall apply to medical sales.

Drafting note: *States may instead, or in addition, tax per milligram of total THC, as New York and Connecticut do, or by potency tier, as Illinois does, so that higher-potency products carry higher taxes.*

G-2. Dedicated revenue

(a) All revenue from the tax imposed by G-1 shall be deposited in the Marijuana Harm Prevention Fund, which is created in the state treasury.

(b) Money in the fund may be appropriated only for: (1) addiction prevention, including school-based prevention; (2) addiction treatment and recovery services; and (3) enforcement and oversight of the marijuana industry, including licensing inspections, laboratory testing audits, intoxicating hemp enforcement, drugged-driving enforcement and drug recognition expert training, and public health data collection and reporting.

(c) Money in the fund shall not be transferred to the general fund or used to promote, subsidize, or provide loans or grants to any marijuana business.

G-3. Deduction disallowance

(a) In computing taxable income under [state income or franchise tax chapter], no deduction or credit shall be allowed for any amount paid or incurred in carrying on a trade or business that consists of cultivating, manufacturing, distributing, dispensing, or selling marijuana or THC products, regardless of how marijuana is classified under federal law.

(b) This section does not disallow the cost of goods sold.

(c) [Section exempting marijuana businesses from 26 U.S.C. § 280E for state tax purposes] is repealed.

Drafting note: *G-3(b) tracks the federal approach under Section 280E, which denies deductions and credits but not the cost of goods sold.*

H. Ethics and Conflicts of Interest (Track 2)

(a) No person who has served as a member of the General Assembly, or as a member or employee of [marijuana regulatory agency], shall at any time thereafter be employed by, contract with, lobby on behalf of, or hold any financial interest in a marijuana business.

(b) No member of the General Assembly shall hold any direct or indirect ownership or other financial interest in a marijuana business while in office.

(c) No member or employee of [marijuana regulatory agency] shall hold any direct or indirect ownership or other financial interest in a marijuana business while serving.

(d) As used in this section, "marijuana business" means any person licensed or registered under [medical program act] or [recreational program act], and any parent, subsidiary, or affiliate of that person.

I. Medical License No-Conversion Clause (Track 2, medical programs)

A license, registration, or certification issued under [medical program act] does not confer any right, preference, or priority to a license, permit, or registration under any law authorizing the sale of marijuana for non-medical use.

Key Sources

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Questions or drafting help

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