State-By-State Medical Marijuana Laws

How to Remove the Threat of Arrest

2015

with a December 2016 supplement

"For now, federal law is blind to the wisdom of a future day when the right to use medical marijuana to alleviate excruciating pain may be deemed fundamental. Although that day has not yet dawned, considering that during the last ten years eleven states have legalized the use of medical marijuana, that day may be upon us sooner than expected."

— Ninth Circuit Court of Appeals, *Raich v. Gonzales*, March 2007

Since the March 2007 decision, 16 additional states have passed effective medical marijuana laws, bringing the total number to 28, plus Washington, D.C.

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December 2016 Supplement

The last comprehensive update to MPP's *State-By-State Medical Marijuana Laws* was in late 2015. This supplement highlights key developments in state medical marijuana policies since then. It is divided into three sections — states that enacted new medical marijuana laws, updates from states with existing medical marijuana laws, and updates from states with unworkable medical marijuana laws or low-THC laws. States without significant developments since late 2015 are not included.

The biggest development is that five additional states have enacted effective medical marijuana laws — Arkansas, Florida, North Dakota, Ohio, and Pennsylvania — bringing the total number to 28 plus D.C., Guam, and Puerto Rico. In addition, Louisiana improved its flawed medical marijuana law, but further revisions to both its law and rules are likely needed before the program is truly workable. Therefore, MPP still does not count Louisiana as having an effective medical marijuana law.

Additionally, programs in New York and New Hampshire are now operational, and several states have made improvements to existing medical marijuana or low-THC medical cannabis laws. Most importantly, two states — Montana and Michigan — added regulated medical marijuana dispensing systems to their medical marijuana programs.

States That Enacted New Medical Marijuana Laws In 2016

Arkansas — After narrowly rejecting medical marijuana at the ballot box in 2012, 53% of Arkansas voters approved Issue 6 — the Arkansas Medical Marijuana Amendment — in November 2016. Two competing initiatives had fought for placement on the ballot, Issue 6 and Issue 7. In a ruling issued after early voting began, the Arkansas Supreme Court struck Issue 7 from the ballot after finding errors in signature collection procedures.

The Alcoholic Beverage Control Division (ABCD) will operate the Arkansas Medical Marijuana Amendment, and patients will enroll through the Department of Health (DOH). The ABCD has 120 days to issue guidelines for the approval of between four and eight cultivation facility licenses and up to 40 dispensaries. DOH also has 120 days to issue guidelines for the issuance of ID cards for patient enrollment in the program. It should be noted that legislators are considering delaying these timelines by up to 60 days so that the program will be fixed to the state's fiscal year. MPP estimates that it could be a year before patients can start consuming medical cannabis under the program.

Once guidelines for implementation are finalized, patients will be able to apply for enrollment with the DOH. In order to qualify, they must submit a written certification from an Arkansas-licensed physician certifying that they suffer from an applicable disease, and pay a yet-to-be-established "reasonable" application fee. Designated caregivers can enroll in the program to assist the physically disabled and minors under 18. Qualifying conditions include cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Tourette's syndrome, Crohn's disease, ulcerative colitis, PTSD, severe arthritis, fibromyalgia, Alzheimer's disease, or the treatment of any of these conditions. In addition, patients with doctors' certifications qualify if they have a chronic or debilitating medical condition (or its treatment) that produces cachexia or wasting syndrome, peripheral neuropathy, intractable pain that has not responded to other treatment for at least six months, severe nausea, seizures, and severe or persistent muscle spasms. DOH has the power to approve new qualifying conditions.

Patients visiting Arkansas from out-of-state can qualify for the program if the Arkansas law covers their condition and they have their medical marijuana ID card with them.

Registered patients and caregivers who have their registry ID cards on hand are not subject to arrest, prosecution, or penalty for the use and possession of up to two and one-half ounces of marijuana. Such penalties include "disciplinary action by a business, occupational, or professional licensing board or bureau." Further, employers cannot discriminate or penalize patients or caregivers based on their past or present status of enrollment with the program. The law allows landlords to prohibit on-site cannabis smoking.

The amendment permits local control and cities, towns, and counties may pass reasonable zoning restrictions on dispensaries and cultivation facilities. Localities can only outright prohibit the operation of any facilities through a popular election pursuant to Arkansas' initiative process.

Florida — On November 8, 2016, 71% of voters approved constitutional Amendment 2, which mandates the creation of an effective medical marijuana program. Florida already had a program that was both a low-THC law and an unworkable medical marijuana program for terminally ill patients; the latter was passed by the Legislature earlier in 2016. Unlike most other low-THC laws, Florida's provided for in-state access, although there are currently only seven businesses permitted to cultivate and dispense medical cannabis in the entire state.

Amendment 2, which takes effect January 3, 2017, requires the Department of Health to promulgate regulations within six months. Many of the specifics of how the law will be implemented are left up to the agency, and the Legislature may also pass laws to implement the program as long as they are not inconsistent with the amendment. The health department is also required to begin issuing ID cards to patients and licensing dispensaries, called "medical marijuana treatment centers," within nine months. If the department fails to meet these deadlines, Amendment 2 explicitly creates a private right of action, allowing any Florida citizen to sue to compel it to act.

To qualify for the program, a patient must have a debilitating medical condition, a certification from a physician licensed to practice medicine in Florida, and an ID card from the Department of Health. The physician must conduct a physical exam and assess the patient's medical history, in addition to certifying that the patient suffers from a debilitating medical condition, that the medical use of marijuana would likely outweigh the potential health risks for the patient, and for how long the physician recommends the medical use of marijuana. Written parental consent is required for minors. Debilitating medical conditions are: cancer, epilepsy, glaucoma, HIV/AIDS, post-traumatic stress disorder, amyotrophic lateral sclerosis, Crohn's disease, Parkinson's disease, multiple sclerosis, or "other debilitating medical conditions of the same kind or class as or comparable to those enumerated."

Amendment 2 contemplates a variety of medical marijuana products, including food, tinctures, aerosols, oils, and ointments. The health department will determine how much medical cannabis will be "presumed to be an adequate supply," but this presumption can be overcome if a patient can show that they need more. Patients may designate caregivers, who must be at least 21 years old and have an ID card. The number of caregivers per patient, and patients per caregiver, as well as background checks and any other requirements, will be set by regulation.

Once the program is operating, registered patients and their designated caregivers will be protected from arrest, prosecution, and civil sanctions for actions in compliance with the program. Educational institutions and employers need not accommodate medical marijuana use. The number and location of dispensaries, the rules governing their licensing and operation, and applicable taxes and fees will all be determined by regulation.

North Dakota — On November 8, 2016, 64% of voters approved Measure 5, a compassionate medical marijuana initiative spearheaded by an all-volunteer North Dakota-based group. The Department of Health is charged with drafting regulations for the implementation of the program, which went into effect on December 8, 2016.

To qualify for the program and access medical cannabis, a patient must have a written certification from a physician with whom the patient has a bona fide relationship.

The qualifying conditions are cancer, HIV/AIDS, hepatitis C, ALS, PTSD under certain circumstances, agitation of Alzheimer's disease, dementia, Crohn's disease, fibromyalgia, spinal stenosis, chronic back pain (including neuropathy or damage to the nervous tissues of the spinal cord with objective neurological indication of intractable spasticity), glaucoma, epilepsy, a medical condition that produces cachexia or wasting syndrome, severe and debilitating pain that has not responded to previously prescribed medication or surgical measures for more than three months or for which other treatment options produced serious side effects, intractable nausea, seizures, or severe and persistent muscle spasms.

Patients are prohibited from using marijuana in a public place or a workplace.

Patients may designate a caregiver to assist with their medical use of marijuana, such as by picking it up from a dispensary for them. To serve as a caregiver, an individual must be 21 years of age or older, have no felony convictions, and must register with the state. They may assist no more than five patients.

Patients and caregivers are allowed to possess no more than three ounces of usable marijuana per 14-day period. Registered patients and caregivers will be able to obtain medical cannabis from a licensed nonprofit compassion center.

The department will license an undetermined number of nonprofit compassionate care centers that are required to maintain appropriate security, including well-lit entrances, an alarm system that contacts law enforcement, and video surveillance. They may not be located within 1,000 feet of a school, and they will be subject to inspections and other rules.

If a qualified patient lives more than 40 miles from the nearest compassionate care center, the patient or caregiver can cultivate up to eight marijuana plants in an enclosed, locked facility as long as it is not within 1,000 feet of a public school.

Ohio — While Ohio decriminalized marijuana possession in 1973, it took until 2016 for state lawmakers to adopt a workable medical marijuana law. That year, the Marijuana Policy Project and Ohioans for Medical Marijuana led a voter initiative campaign to adopt a medical marijuana constitutional amendment. However, the state Legislature intervened and passed its own measure, HB 523, before voters could weigh in. As a result, the initiative campaign did not complete its signature drive. Gov. John Kasich signed the bill on June 8, 2016.

The result was a more limited medical marijuana law, which technically went into effect on September 8, 2016. However, it will be at least a year before patients receive the full benefit of the law as the program is established and rolled out. Also beginning on September 8, patients were to receive a limited affirmative defense, which was intended to allow them to avoid a criminal conviction for possession of marijuana under certain circumstances. Unfortunately, language contained in the law was not clear on the requirements for physicians who might want to help patients obtain the affirmative defense, and it is uncertain if the affirmative defense is possible without additional regulatory assistance from the state medical board, or an amendment to the law by lawmakers.

Also starting on September 8, three different agencies — each charged with overseeing different parts of the program — were to begin the process of developing and adopting rules for the state program. The Department of Commerce, which will oversee cultivators, processors, and testing labs, will have nine months to adopt rules. The Board of Pharmacy will have 12 months to establish rules related to patients and dispensaries, and the state's previously mentioned medical board will likewise have 12 months to consider and adopt rules related to recommending physicians. Much of the 2016 law leaves the specifics up to the agencies overseeing the program, so the rule-making process will be particularly important to ensure the program is fair and workable for patients.

The costs and exact qualifications for patients to participate have not yet been officially adopted, nor the specific amount patients will be allowed to possess, which the current law defines as a "90-day supply." The state's sales tax would apply to the sale of medical marijuana. Currently, the state's sales tax rate is 5.75%, and depending on additional rates set by local municipalities, the total sales tax could be as high as 8% at the register.

Once the program is fully in effect, registered patients and their designated caregivers will be protected from arrest, prosecution, and discrimination in child custody matters. Registration status alone cannot be used as the basis for a DUI investigation, nor can patients be discriminated against when seeking organ transplants or housing. Employers do not have to accommodate employees' on-site use, but prospective employers cannot refuse to hire due to a person's registry status. Importantly, full legal protections under the law do not take effect until the patient has been issued a medical cannabis registration card.

Ohio's law does include a fairly broad list of qualifying medical conditions. These include AIDS, Alzheimer's disease, amyotrophic lateral sclerosis, cancer, chronic traumatic encephalopathy, Crohn's disease, epilepsy or another seizure disorder, fibromyalgia, glaucoma, hepatitis C, inflammatory bowel disease, multiple sclerosis, chronic or intractable pain, Parkinson's disease, positive status for HIV, post-traumatic stress disorder, sickle cell anemia, spinal cord disease or injury, Tourette's syndrome, traumatic brain injury, and ulcerative colitis. The state medical board may add other diseases or medical conditions.

It is possible that out-of-state patients will be allowed to access medical marijuana in Ohio-licensed dispensaries. The law allows the state to enter into agreements with particular states if regulators wish to do so, although reciprocity is not automatic under the law.

Whole plant cannabis is allowed for vaporization, but smoking is not permitted.

The burden on recommending physicians is significant, which may seriously limit patients' ability to enroll in the program. Doctors who plan to recommend medical use of marijuana to patients must be preapproved by the state in order to do so, and he or she will be required to take a class. To certify a patient, physicians must expect to provide ongoing care for the patient, apply on behalf of each patient seeking to be included in the state registry, and provide further information to the state on how effective the treatment is.

The number of dispensaries, cultivation centers, and testing labs that will be allowed to operate is left to regulatory authorities to determine, along with the fees the various agencies expect to charge for licenses. In fact, the vast majority of the regulatory system for businesses will be up to the regulatory authorities to adopt. By the end of 2016, some regulations had been proposed, but are not likely to be adopted until early 2017.

Pennsylvania — The Pennsylvania Senate first approved SB 3, a comprehensive medical marijuana bill, on May 12, 2015. After a sustained campaign by patients and families with Campaign for Compassion, with significant help from MPP's lobbying and communications team, the House followed suit and approved an amended bill on March 16, 2016. The Senate made final tweaks, and on April 17, Gov. Tom Wolf signed Pennsylvania's medical marijuana legislation into law, making it Act 16. Pennsylvania's medical marijuana law went into effect on May 17, 2016.

To qualify for the program and access medical cannabis, patients must have a qualifying condition and must submit a doctor's recommendation to the health department. Physicians wishing to recommend medical cannabis must first register with the department and take a four-hour course. They must also have an ongoing relationship with the patient and complete an in-person exam prior to issuing the recommendation.

The qualifying conditions are terminal illness, cancer, HIV/AIDS, amyotrophic lateral sclerosis, Parkinson's disease, multiple sclerosis, epilepsy, inflammatory bowel disease, neuropathies, Huntington's disease, Crohn's disease, post-traumatic stress disorder, intractable seizures, glaucoma, autism, sickle cell anemia, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, and severe chronic or intractable pain of neuropathic origin, or if conventional therapeutic intervention and opiate therapy is contraindicated or ineffective. Pennsylvania is the first state to specifically list autism as a qualifying condition without limiting the condition to autism with self-injurious or aggressive behavior.

The program allows patients to use pills, oils, gels, creams, ointments, tinctures, liquid, and non-whole plant forms that may be administered through vaporization, but not smoking. Dispensaries will not be allowed to sell edibles, but medical marijuana products can be mixed into food or drinks for patients in a facility or residence.

Registered patients and caregivers will be protected from arrest, prosecution, and discrimination in child custody and employment. However, out-of-state patients will not have legal protections for use or possession in Pennsylvania, nor access to Pennsylvania dispensaries. Parents and guardians of minors with qualifying conditions can apply for a safe harbor letter that provides legal protections for the administration of medical marijuana.

The Department of Health has released many of the temporary regulations that will guide the implementation process, including the rules for grower/processor, dispensary, and laboratory permits. The applications for medical marijuana businesses will be released on January 17 and are due on March 20. The department

announced that they will be distributing permits in at least two phases. For the first phase, there will be a maximum of 12 grower/processor licenses and 27 dispensary licenses issued. The department plans to announce the recipients 90 days after the deadline. Grower/processor applicants will pay $10,000 for applications and $20,000 for registration. They will also pay a 5% tax on the sale of medical marijuana to the dispensary. Dispensary applicants will pay $5,000 per application and $30,000 for each location.

The department has divided the state into six regions with a maximum of two grower/processor permits issued per region. Meanwhile, up to 27 dispensary permits will be issued in specific counties. Each dispensary permit is allowed three locations. The first location must be in the assigned county, but additional locations must be located elsewhere in the region.

Portions of the law related to dispensaries will expire three years after the federal government completes rescheduling of marijuana.

Patient and doctor regulations are expected to be released prior to April 2017.

Updates From States With Existing Medical Marijuana Laws

Colorado — Colorado passed several bills in 2016 related to medical marijuana. SB 40 allows out-of-state ownership of state marijuana businesses, while HB 1371 establishes important protections for medical marijuana patients in school. Under the new law, students who are patients may not be punished for possessing and consuming medical marijuana products while on campus — subject to school rules — and patients cannot be denied admission simply due to their patient status.

Connecticut — In February, several new conditions were added to Connecticut's medical marijuana program through the administrative process — sickle cell disease, post-laminectomy syndrome with chronic radiculopathy, severe psoriasis and psoriatic arthritis, amyotrophic lateral sclerosis, ulcerative colitis, and complex regional pain syndrome. However, Connecticut remains one of a handful of states that does not have a general qualifying condition for severe or intractable pain.

Later in 2016, the Connecticut Legislature passed legislation to expand its existing program to allow minor patients to qualify for the program. Connecticut had been the last remaining state to completely exclude minors from its medical cannabis program. Minors' registrations require certification from two doctors, and minor patients are prohibited from smoking, inhaling, or vaporizing medical marijuana.

Delaware — The Legislature adjourned after adding terminal illness as a qualifying condition under the state's medical marijuana program, as well as allowing CBD oil use by minors in schools and on school buses. Both measures were signed by Gov. Jack Markell. Meanwhile, a second compassion center was approved in 2016, and a third is expected to be licensed shortly, which will bring the total number to three.

Hawaii — The Hawaii Legislature passed legislation to clarify and strengthen the state's medical marijuana dispensary law, which was enacted in 2015. HB 2707 creates a legislative oversight commission to recommend legislation to improve the dispensary program. In addition, the law decriminalizes possession and use of paraphernalia for authorized individuals and allows, in some cases, for the interisland transport of marijuana to certified laboratories. It also allows advance practice-registered nurses to issue recommendations to qualifying patients and adds patches, inhalers, and nebulizers to the approved list of modes of administration.

Illinois — Lawmakers in Illinois passed and Gov. Bruce Rauner signed SB 10, a much-needed bill that made significant changes to the state's medical marijuana program. First, it changed the recommendation process for physicians, making it easier for patients to get through the registration process. The bill also added post-traumatic stress disorder to the state's list of qualifying medical conditions, and extended the program — which was set to sunset on January 1, 2018 — to July 1, 2020.

Massachusetts — Under Gov. Charlie Baker's administration, the Department of Public Health began accepting dispensary applications on a rolling basis. As of December 2016, six dispensaries were open and serving patients.

Maryland — Maryland announced another delay in the implementation of its medical marijuana program. The Maryland Medical Cannabis Commission announced which cultivators and processors received preliminary license approval in the summer and which dispensaries received approval in December 2016. Medical marijuana is now expected to be available to patients in mid to late 2017. Maryland has been one of the slowest states to implement its program, and its selection process for growers was subject to a controversy. During the 2016 session, the Legislature enacted HB 104, which will also allow nurse practitioners, dentists, podiatrists, and nurse midwives to recommend medical marijuana beginning June 1, 2017.

Michigan — On September 20, 2016, Gov. Rick Snyder signed into law significant improvements to the state's medical marijuana program. The state will now allow licensed provisioning centers to dispense marijuana. Also, medical marijuana extracts and products made from them are now allowed.

Minnesota — In 2016, the Legislature approved Rep. Nick Zerwas's HF 3142, which permits a single dispensary employee to transport medical cannabis to a laboratory for testing or to a facility for disposal. If the medical cannabis is being transported for any other purpose, two employees must staff the transport vehicle. The bill also allows pharmacists to videoconference with patients, allowing them to provide expertise to many more seriously ill patients. Also in 2016, the state health commissioner approved adding PTSD as a qualifying condition. Under Minnesota law, patients with PTSD will be allowed to register beginning in August 2017.

Montana — 2016 was a year of significant change for the state medical marijuana program. Montana's original medical marijuana law, passed through a 2004 voter initiative backed by MPP, was overturned by lawmakers in 2011 and replaced with a program that was largely unworkable.

Among many burdensome requirements, cultivators could not assist more than three patients, and the state medical board was required to audit any doctor who recommended medical marijuana for more than 25 patients a year. Testing medical marijuana for safety and potency was illegal, and law enforcement officers could enter any provider's location — even private homes — to conduct a warrantless search. Most troubling, the law contained many serious defects, leaving medical marijuana providers vulnerable to criminal prosecution under even the best of circumstances.

The law was challenged in state court and some of the worst provisions were temporarily blocked, which enabled the program to continue while the matter was under consideration by the courts. The proceeding lasted nearly five years, and in April 2016, the Montana Supreme Court issued its final order, upholding most of the bad 2011 law. The result was that by August, over 11,000 patients — 94% of the state program — were without access to medical marijuana except through illicit sources.

A voter initiative designed to change or remove many of the harmful provisions that were upheld by the Montana Supreme Court, I-182, appeared on the November 2016 ballot, and it passed with 54% of the vote. The election result was a welcome relief to the thousands of patients waiting to restore access, but an error in the initiative language meant possible delay before access was to be fully restored in July 2017. Local patients, activists, and medical marijuana businesses again took the matter to court, and on December 7, 2016, the state court ordered the state health department to allow patients to reunite with their providers immediately.

New Hampshire — In November 2015, the Department of Health and Human Services began allowing patients to preregister for medical marijuana ID cards. Despite the fact that patients were still being arrested in the state, the Attorney General's office argued that patients should not be able to obtain ID cards (which would protect them from arrest) until the first dispensary was ready to open. A terminally ill lung cancer patient, Linda Horan, became the first patient to receive an ID card in December after she sued the state and won, and she was able to visit a dispensary in Maine to obtain cannabis legally.

The first dispensary began serving patients on April 30, 2016, and the other three all opened by late 2016.

New York — The first medical marijuana dispensary opened January 7, 2016, and all but one of the 20 dispensaries were operational as of December 2016. Registered organizations were also permitted to implement home delivery programs beginning in August 2016. Access to the program has been difficult due to few doctors participating, high costs, and a restrictive list of qualifying conditions, which does not include severe or chronic pain. After extensive criticism of the program as being unduly restrictive, the Department of Health issued a report in August 2016 announcing numerous planned expansions of the program, some of which are in the process of being implemented. For example, nurse practitioners can now recommend medical marijuana to their patients.

The department also announced in December 2016 that it would no longer limit each registered organization to five "brands" of medical marijuana and would allow registered organizations to sell to one another, which will greatly increase the variety of products available to patients. Also in December 2016, the department announced plans to allow marijuana for chronic plan.

Oregon — One of two sweeping omnibus marijuana bills, SB 1511, furthers efforts to enable medical marijuana businesses to pivot to the nonmedical marijuana industry in several significant ways, including provisions that allow medical marijuana dispensaries to temporarily sell marijuana products to the adult consumption market. The other omnibus marijuana bill, HB 1404, allows out-of-state investment and ownership in Oregon's marijuana businesses — including medical marijuana. Finally, SB 1524 makes it easier for veterans getting assistance through the VA to apply or renew registration in the state medical marijuana program by reducing paperwork requirements that might be difficult to get from VA facilities.

Rhode Island — Article 14 of the state budget, which was approved by the Legislature on June 17, 2016, makes several changes to the medical marijuana program, including the creation of new cultivator licenses and a requirement that all marijuana plants grown by patients and caregivers be accompanied by tags sold by the Department of Business Regulation for $25. Patients with financial hardship or physical disability will not be charged a fee for their plant tags. Most of the changes took effect on January 1, 2017. The General Assembly also passed H 7142, which adds post-traumatic stress disorder to the list of qualifying conditions for medical marijuana. Gov. Gina Raimondo has not yet acted on the bill.

Vermont — In 2016, the Legislature passed and Gov. Peter Shumlin signed S. 14, which expands the existing medical marijuana program by enabling patients with glaucoma or chronic pain (previously "severe pain," a much higher standard) to qualify for the program. The bill also reduced the required minimum provider-patient relationship period from six months to three months and created exceptions to the three-month period for patients who are in hospice care and for patients who move to Vermont after being a qualified patient in another state.

Updates From States With Unworkable Medical Marijuana Programs or With Low-THC Laws

Alabama — The 2016 session saw the passage Rep. Mike Ball's HB 61. This low-THC law builds on the passage of Carly's Law in 2014, which offers an affirmative defense to patients and caregivers who suffer from intractable epilepsy. HB 61 — or "Leni's Law" — expands the previous law by creating an affirmative defense for the use of the oil by patients and caregivers who suffer from specified debilitating conditions that produce seizures that are resistant to conventional medicine, provided the patient's doctor recommends this course of treatment. Carly's Law permitted only health care practitioners at the University of Alabama to recommend a patient for use of the oil.

Louisiana — Since 1978, the Louisiana Legislature has sought to establish a medical marijuana program, but due to problems with the drafting, a workable system has yet to be implemented. The Legislature took two important steps to-

wards rectifying this issue during the 2016 session, but the law still remains just shy of workable. Specifically, Sen. Fred Mills introduced two bills, both of which have been signed by Gov. John Bel Edwards. The first, SB 271, replaces the word "prescribe" in existing law with "recommend." Doctors cannot prescribe medical marijuana, as it is a violation of their federal DEA license. However, physicians do have the First Amendment right to recommend the treatment option to patients.

SB 180 amended criminal statutes to offer protections specifically to patients and their caregivers for possession and consumption of medical marijuana. However, the law does not explicitly exempt growers, pharmacies, and their staff from state felonies for growing and distributing marijuana. While it is possible the law will eventually prove workable, it should be improved to explicitly offer protections to the entire supply chain.

To qualify for the medical marijuana program, a patient will need a doctor's recommendation and must have cancer, HIV/AIDS, cachexia or wasting disorder, seizure disorders, spasticity, Crohn's disease, muscular dystrophy, or multiple sclerosis. Inhaled or "raw or crude" marijuana is not allowed.

The law provides for 10 specially licensed pharmacies that may dispense marijuana and one or two production facilities — two are only allowed if Louisiana State and Southern University agricultural centers decide to exercise a right of first refusal. Medical cannabis is unlikely to be available before late 2017 or 2018. Unless the law is re-enacted by the Legislature, the act will expire on January 1, 2020. Also, upon federal rescheduling to Schedule II, each reference to a "recommendation" would change to "prescription."

In June 2016, both Louisiana State and Southern University announced that their boards approved plans to operate medical marijuana cultivation facilities. If they follow through, they would be the first universities to cultivate marijuana in contravention of federal law. Some universities and hospitals in other states have expressed interest in similar involvement, but have ultimately not participated due to concerns about federal law and funding.

Missouri — The Department of Agriculture has issued two grower licenses, the maximum allowed by law. Two dispensaries are open and serving patients in the St. Louis area, making it the first state to provide access pursuant to a low THC medical cannabis program. However, the patient base is extremely small, which could jeopardize the viability of the program.

Oklahoma — HB 2835, which allows adults to possess low-THC oil, was enacted on November 1, 2016. (Minors were already allowed to do so.) The law also adds several qualifying conditions: Spasticity due to multiple sclerosis or paraplegia, intractable nausea and vomiting, and chronic wasting diseases, in addition to severe epilepsy. However, the law still fails to provide for an in-state source of medical marijuana. In addition, the U.S. Supreme Court declined to hear Oklahoma's challenge to Colorado's marijuana laws.

Tennessee — Tennessee tweaked its ineffective low-THC law by enacting HB 2144 on May 20, 2016. The law now provides that patients may possess CBD oils with no more than 0.9% THC if they have "a legal order or recommendation" for the oil and they or an immediate family member have been diagnosed with

epilepsy by a Tennessee doctor. In addition, universities could cultivate marijuana with no more than 0.6% THC, process it into oil, and dispense it to qualified patients as part of a research study, but they are unlikely to do so, as it would violate federal law.

Utah — The Legislature and governor approved Rep. Gage Froerer's HB 58, which builds on an existing low-THC program by requiring the Department of Health to establish a procedure for neurologists to transmit records of their evaluation of a patient's use of low-THC oil. The law also required the department to accept requests for proposals to conduct a study of the oil, which were to be completed by November 2016. Also passed was SCR 11, a resolution urging Congress to reschedule marijuana to Schedule II. Utah law still does not provide for include in-state production of low-THC oils.

Executive Summary

- Favorable medical marijuana laws have been enacted in 43 states and the District of Columbia since 1978. (Three of those states' laws have since expired or been repealed.) However, many of the laws that remain on the books are ineffectual, due to their reliance on the federal government to directly provide or authorize a legal supply of medical marijuana.
- Currently, 40 states, the District of Columbia, and Guam have laws on the books that recognize marijuana's medical value — or the value of certain strains:
  - Since 1996, 23 states, the District of Columbia, and Guam have enacted laws that effectively allow patients to use and access medical marijuana despite federal law. To be effective, a state law must remove criminal penalties for patients who use and possess medical marijuana with their doctors' approval or certification. Effective laws must also have a realistic means for patients to access marijuana, such as by growing it at home or buying it at a dispensary. Finally, the laws must allow patients to either smoke or vaporize marijuana or marijuana oils and must allow for a variety of strains of marijuana, including both strains with higher and lower amounts of THC.
  - One state, Louisiana, has an ineffective law that recognizes marijuana's medical value but relies on doctors and pharmacies breaking federal law.
  - An additional 16 states allow only low-THC marijuana or cannabis oils. Most of those laws — much like dozens of ineffective medical marijuana laws enacted before 1996 — are unlikely to provide patients with relief until federal law changes. Several depend on risk-averse individuals and institutions, such as universities, to break federal law by distributing cannabis. Others have no means of in-state access to cannabis preparations at all.
- Eleven of the 23 effective state medical marijuana laws were enacted through the ballot initiative process — in Alaska, Arizona, California, Colorado, Maine, Massachusetts, Michigan, Montana, Nevada, Oregon, and Washington state. The other 12 effective state laws were passed by the state legislatures of Connecticut, Delaware, Hawaii, Illinois, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, and Vermont. Washington, D.C.'s law was approved by voter initiative but was substantially revised before the D.C. Council prior to taking effect. Several of the states' laws that were enacted by voters were later revised or added to by the state's legislature.
- The federal government cannot force states to criminalize conduct that is illegal under federal law, nor can the federal government force state and local police to enforce federal laws.
- Because 99% of all marijuana arrests in the nation are made by state and local (not federal) officials, properly worded state laws effectively protect at least 99 out of every 100 medical marijuana users who would otherwise be prosecuted. Indeed, there aren't any known cases in which the federal government has prosecuted patients for small amounts of marijuana in the 23 states that have enacted medical marijuana laws since 1996.

- Since 2001, federal courts have handed down decisions on three significant medical marijuana cases: *U.S. v. Oakland Cannabis Buyers' Cooperative (OCBC)*, *Gonzales v. Raich*, and *Conant v. Walters.* The U.S. Supreme Court issued opinions on the first two of these cases and declined to hear the third.
  - In *OCBC*, the court determined that the medical necessity defense cannot be used to avoid a federal conviction for marijuana distribution; in *Raich*, the court held that the federal government can arrest and prosecute patients in states where medical marijuana is legal under state law. Despite issuing unfavorable decisions in both cases, the U.S. Supreme Court did not in any way nullify effective state medical marijuana laws, nor did it prevent additional states from enacting similar laws.
  - The U.S. Supreme Court also sent the *Raich* case back to the Ninth U.S. Circuit Court of Appeals to consider additional legal issues. The Ninth Circuit ruled that there is not yet a constitutional right to use marijuana to preserve one's life. It also held that the "medical necessity" criminal defense cannot be used in a civil suit to prevent a federal prosecution.
  - In deciding *Conant*, the Ninth U.S. Circuit Court of Appeals held that doctors cannot be prosecuted for recommending that their patients use medical marijuana. By choosing not to hear *Conant*, the U.S. Supreme Court let this protection stand.
- A handful of courts have considered whether specific medical marijuana laws — or specific provisions of those laws — are preempted (or nullified) by federal law. In 2008 and 2009, the U.S. Supreme Court refused to hear appeals of two California court decisions finding that federal law does not preempt the challenged parts or applications of California's medical marijuana laws. In May 2011, Arizona Gov. Jan Brewer asked a federal court to rule whether federal law preempts the state's medical marijuana law. Her case was thrown out. Subsequently, a state-level trial court in Arizona ruled against another claim that the state's law was preempted.
- Ultimately, the federal government should reschedule or de-schedule marijuana so it can be sold as other medicines are sold. Because the federal government has only taken the very limited step of directing the Department of Justice not to interfere with well-regulated state marijuana programs, the only way to provide patients with legal protections and safe access to medical cannabis is through legislation in the states.
- This report describes all favorable medical marijuana laws ever enacted in the United States, details the differences between effective and ineffective state laws, and explains what must be done to give patients immediate legal access to medical marijuana. Accordingly, a model bill and a compilation of resources for effective advocacy are provided.

Overview

Despite marijuana's widely recognized therapeutic value, the medical use of marijuana remains a criminal offense under federal law. Nevertheless, favorable medical marijuana laws have been enacted in 43 states since 1978.[1] Many of the favorable state laws are ineffectual often due to their reliance on the federal government to directly provide or authorize a legal supply of medical marijuana. Fortunately, since 1996, 23 states and the District of Columbia have found ways to allow seriously ill people to use and safely access medical marijuana with virtual impunity, despite federal law.[2]

Sixteen additional states currently have laws on the books that extend only to cannabis preparations that have low amounts of tetrahydrocannabinol or "THC" (a compound that can cause euphoria, which also has medical benefits). Almost all of those laws are limited to patients with seizure disorders and most — like laws enacted before 1996 — are unlikely to actually result in patients receiving in-state access because they fail to take federal law into account. The 40th state with some sort of medical cannabis law currently on its books, Louisiana, has a law that is not explicitly limited in the THC content, but its law will almost certainly be ineffective until federal law changes.

While the U.S. Supreme Court ruled in *U.S. v. Oakland Cannabis Buyers' Cooperative* (OCBC) (532 U.S. 483) that the medical necessity defense cannot be used to avoid a federal conviction for marijuana distribution, a state may remove its own criminal penalties from citizens who possess, grow, or distribute medical marijuana. Moreover, both the Obama administration and Congress have signaled that federal authorities should not target those complying with well-regulated state marijuana laws, although those activities are still prohibited by federal law.[3]

Even before federal policy relaxed, carefully crafted state laws provided near complete protection because the overwhelming majority of marijuana arrests are made at the state and local levels, not the federal level. The relatively few medical marijuana arrests made at the federal level almost always involve larger-scale distribution.

The recent federal policy of non-intervention in state laws has allowed for better medical marijuana programs that include well-regulated distribution systems and laboratory testing, rather than relying solely on small-scale or underground systems of access that were less vulnerable to federal law enforcement. However, many complications remain because of outdated federal laws, including difficulties getting banking services.

This report analyzes the existing federal and state laws and describes what can be done to give patients legal access to medical marijuana. The most effective way to allow patients to use medical marijuana is for state legislatures to pass bills similar to the laws in Nevada, Rhode Island, and Maine.

A model state medical marijuana law, which is influenced by the aforementioned laws, can be found in Appendix Q.

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[1] See Appendix A.

[2] See Table 1 for details on these laws.

[3] James M. Cole, Guidance Regarding Marijuana Enforcement, United States Department of Justice, Office of the Deputy Attorney General, Aug. 29, 2013; Josh Harkinson, "The Federal War on Medical Marijuana Is Over," *Mother Jones,* Dec. 16, 2014.

Marijuana's Medical Uses

Marijuana has a wide range of therapeutic applications, including:

- relieving nausea and increasing appetite;
- reducing muscle spasms and spasticity;
- relieving chronic pain; and
- reducing intraocular ("within the eye") pressure.

Hundreds of thousands of patients and their doctors have found marijuana to be beneficial in treating the symptoms of HIV/AIDS, cancer, multiple sclerosis, glaucoma, seizure disorders, and other serious conditions.[4] For many people, marijuana is the only medicine with a suitable degree of safety and efficacy.

These patients' experiences are also backed up by research. In March 1999, the National Academy of Sciences' Institute of Medicine (IOM) released its landmark study, "Marijuana and Medicine: Assessing the Science Base." The scientists who wrote the report concluded that "there are some limited circumstances in which we recommend smoking marijuana for medical uses."[5]

Although obstacles created by federal policy have made it difficult to conduct research into marijuana's medical value, studies continue to demonstrate marijuana's medical benefits. In 2010, the Center for Medicinal Cannabis Research, which was created and funded by the California State Legislature to "coordinate rigorous scientific studies to assess the safety and efficacy of cannabis," presented its findings. They included clinical research showing that marijuana is effective at relieving muscle spasticity associated with multiple sclerosis and at alleviating neuropathic pain, which is notoriously unresponsive to traditional medications.[6]

Marijuana is comprised of over 85 cannabinoids, or components. These cannabinoids act synergistically in whole plant medical cannabis for an "entourage effect." Researchers discovered that the body has receptor proteins for THC and other cannabinoids, and that it makes its own similar substances, called endocannabinoids.[7]

The most well known cannabinoid, which is responsible for the "high," is THC. Although other cannabinoids also have therapeutic value, THC (currently in synthetic form), is the only cannabinoid that can be obtained by prescription in the U.S., under the brand name Marinol. Another cannabinoid, cannabidiol (CBD), is being administered under the brand name Epidiolex to a limited number of patients in the U.S. in trials. While these medications are important options, they include only a single cannabinoid each and are no substitute for medical marijuana laws. In addition, Marinol is also much slower acting than inhaled marijuana, and nauseated patients are often unable to keep pills down.

Given the life experiences of millions of Americans and the large and growing body of evidence showing marijuana's relative safety and medical value, it should

[4] See Appendix B for a more detailed briefing paper about marijuana's medical uses.

[5] See Appendix C for excerpts from the IOM report.

[6] Grant, Igor M.D., et al. *Report to the Legislature and Governor of the State of California presenting findings pursuant to SB847 which created the CMCR and provided state funding.* UC San Diego Health Sciences, University of California, February 11, 2010.

[7] Seppa, Nathan. "Not just a high," *Science News*, Vol. 177 #13 (p.16), June 19, 2010. http://www.sciencenews.org/view/feature/id/59872/title/Not_just_a_high

come as no surprise that public opinion polls find that most Americans support legal access to medical marijuana.[8]

Criminalizing Patients

Federal marijuana penalties assign up to a year in prison for as little as one marijuana cigarette — and up to five years for growing even one plant. There is no exception for medical use, and many states mirror federal law.

There were more than 693,000 marijuana arrests in the United States in 2013, 87% of which were for possession (not sale or manufacture).[9] Even if 1% of those arrested were using marijuana for medical purposes, then there are more than 7,000 medical marijuana arrests every year!

In addition, untold thousands of patients are choosing to suffer by not utilizing a treatment that could very well cause them to be convicted in 27 states.

Changing Federal Law

The federal Controlled Substances Act of 1970 established a series of five "schedules" (categories) into which all illicit and prescription substances are placed. Marijuana is currently in Schedule I, defining the substance as having a high potential for abuse and no currently accepted medical use in treatment in the United States.[10] The federal government does not allow Schedule I substances to be prescribed by doctors or sold in pharmacies. Schedule II substances, on the other hand, are defined as having accepted medical use "with severe restrictions." Schedules III, IV, and V are progressively less restrictive.

The Attorney General has the authority to move marijuana into a less restrictive schedule, and has delegated that authority to the DEA. Despite multiple petitions and years of litigation, the DEA has refused to move cannabis into a less restrictive schedule.[11] The DEA most recently rejected a petition to reschedule marijuana on July 8, 2011. Its decision was upheld in federal court, and the U.S. Supreme Court rejected a request that it review the decision.[12]

Unfortunately, current federal research guidelines make it nearly impossible to do sufficient research to meet the DEA and FDA's exceedingly high standard of medical efficacy for marijuana.[13] Since 1995, MPP has been helping scientists attempt to navigate federal research obstacles, and there is no clear end in sight. Gaining FDA approval would likely take at least a decade, a major change in federal policy, and assumes that a privately funded company is willing to spend the tens of millions of dollars necessary to do the research.

[8] A November 2012 CBS News poll found 83% of Americans believe doctors should "be allowed to prescribe marijuana for medical use." (Backus, Fred and Condon, Stephanie. "Poll: Nearly half support legalization of marijuana," *CBS News*, November 29, 2012.)

[9] Federal Bureau of Investigation, Uniform Crime Reports, Crime in the United States 2013.

[10] See Appendix E for more details on the federal Controlled Substances Act.

[11] Appendix B provides more information about this litigation.

[12] *Americans for Safe Access v. DEA,* 706 F.3d 438 (D.C. Cir., Jan. 2013).

[13] See Appendices B and K for details on the difficulties involved with marijuana research.

Nonetheless, there are several other ways to change federal law to give patients legal access to medical marijuana[14]:

- The U.S. Secretary of Health and Human Services (HHS) can declare that marijuana meets sufficient standards of safety and efficacy to warrant rescheduling. However, rescheduling alone will not provide patients prescription access to marijuana.
- Because Congress created the Controlled Substances Act (CSA), Congress can change it. Some possibilities include: passing a bill to move marijuana into a less restrictive schedule, moving marijuana out of the CSA entirely, or even replacing the entire CSA with something completely different. In addition, Congress can remove criminal penalties for the medical use of marijuana regardless of what schedule it is in.
- HHS can allow patients to apply for special permission to use marijuana on a case-by-case basis. In 1978, the Investigational New Drug (IND) compassionate access program was established, enabling dozens of patients to apply for and receive marijuana from the federal government. Unfortunately, the program was closed to all new applicants in 1992, and only four are still receiving medical marijuana through the program.

While none of the federal reforms listed above have happened yet, nearly 20 years after the first modern medical marijuana law passed, state medical cannabis laws have created sufficient pressure that Congress is finally beginning to reconsider its stance. In 2014, Congress approved an appropriations bill that prevents the Department of Justice from spending any resources interfering with the implementation of state medical marijuana laws through the 2015 fiscal year.

Meanwhile, both the House of Representatives and the Senate are considering the C.A.R.E.R.S. Act, which would amend the Controlled Substances Act to allow states to set their own policies in regard to medical marijuana. The act — S.683/H.R.1538 — would also reschedule marijuana, facilitate research, and make other positive changes. Unfortunately, it is currently stalled in committee. Carefully crafted state medical marijuana programs remain the only mechanism to provide relief to patients who benefit from medical cannabis.

Changing State Laws: From 1978 to 1995[15]

States have been trying to give patients legal access to marijuana since 1978. By 1991, favorable laws had been passed in 34 states and the District of Columbia. (The other nine states that have had favorable laws are Hawaii, enacted in 2000; Maryland, initially in 2003; Delaware in 2011; Kentucky, Missouri, Mississippi, and Utah in 2014, and Oklahoma and Wyoming in 2015. The latter six laws are restricted to low-THC, CBD-rich cannabis preparations.)

Unfortunately, because of numerous federal restrictions, most of these laws have been largely symbolic, with little or no practical effect. For example, Louisiana, Texas, and several other states have passed laws stating that doctors may "prescribe" marijuana or certain marijuana preparations. However, federal law prohibits doc-

[14] Appendix B details some of these other routes.

[15] See "Overview of Kinds of State Laws," beginning on page 15.

tors from writing "prescriptions" for marijuana, so doctors are unwilling to risk federal sanctions for doing so. Other states rely on universities or pharmacies to grow or dispense marijuana, institutions which have been unwilling to openly break federal law.

Changing State Laws: Since 1996

The tide began to turn in 1996 with the passage of a California ballot initiative. California became the first state to effectively remove criminal penalties for qualifying patients who possess and use medical marijuana.

California's law, like the initial wave of effective state laws, provided access by allowing patients to cultivate their own medicine or to designate a caregiver to do so. It also encouraged "federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana."

California's law specifies that qualifying patients need a doctor to "recommend" marijuana. By avoiding issuing a prescription, doctors are not violating federal law in order to certify their patients. (Of note, Arizona voters also passed a medical marijuana initiative in 1996, but it turned out to be only symbolic because it required a prescription — an order to dispense a medication — rather than a recommendation — a statement of a doctor's professional opinion.)

Over the next four years, seven states and the District of Columbia followed in California's footsteps. Alaska, Oregon, Washington, and the District of Columbia passed similar initiatives in 1998. (Until 2010, Congress prevented the D.C. initiative from taking effect. D.C. is a district, not a state, and is therefore subject to strict federal oversight.) Maine passed an initiative in 1999, and Colorado and Nevada followed suit in 2000. Also in 2000, Hawaii broke new ground when it became the first state to enact a law to remove criminal penalties for medical marijuana users via a state legislature.

In 2003, Gov. Robert Ehrlich of Maryland became the first Republican governor to sign workable medical marijuana legislation into law. This law was a very limited sentencing mitigation, which was later expanded several times and finally included a realistic means of accessing cannabis in 2014.

Later in 2003, California's legislature and Gov. Gray Davis (D) expanded the state's existing law to allow patients and caregivers to collectively or cooperatively cultivate marijuana as long as it was not done for "profit." The improved law provided a legal basis for dispensaries operating in the state, but did not explicitly allow them. It also did not include any state regulation or registration.

Vermont, Montana, and Rhode Island joined the ranks of medical marijuana states next, in 2004 and 2006. All three laws followed the pattern of the prior laws — allowing patients and caregivers to possess and grow a limited amount of marijuana, without providing for any regulated distribution.

Beginning in 2007, some states began to include state-regulated dispensaries in their laws. In 2007, Gov. Bill Richardson (D) signed SB 523, making New Mexico the 12th state to protect medical marijuana patients from arrest. New Mexico's law was the first to allow state-regulated and state-licensed larger-scale providers. It did not explicitly include home cultivation, but the health department has issued patients personal cultivation licenses.

In 2008, Michigan voters approved a medical marijuana initiative, making Michigan the first Midwestern state with an effective medical marijuana law. Michigan's was the last effective state medical marijuana law enacted that relied only on home cultivation and caregivers without providing for state-regulated dispensaries.

In 2009, Rhode Island became the first state to add regulated nonprofit dispensaries to its existing law. Maine's voters followed suit in November 2009, approving an initiative that added nonprofit dispensaries, a patient and caregiver registry, and additional qualifying conditions to the state's medical marijuana law.

On January 18, 2010, New Jersey became the 14th medical marijuana state and the first to enact a medical marijuana law that relied solely on dispensaries, without providing for home cultivation.

In late 2009, Congress finally allowed an initiative Washington, D.C. voters had enacted in 1998 to go into effect. The D.C. Council put the initiative on hold in 2010 and then significantly restricted the law. The council removed home cultivation — but included regulated dispensaries and cultivation facilities — and eliminated most of the qualifying conditions. (The qualifying conditions were restored in 2014.)

Also in spring 2010, Colorado's legislature expanded the state's existing medical marijuana law by explicitly allowing, regulating, and licensing dispensaries (called "medical marijuana centers"), growers, infused product manufacturers, and labs. Unlike most states, Colorado's dispensaries are allowed to be for-profit, and there are no caps on the numbers of each type of business.

Arizona voters approved an initiative that made their state the 15th with an effective medical marijuana law in November 2010. Unlike the state's 1996 measure, this law used "certification" instead of "prescription" to ensure it would be effective. The law allows about 125 nonprofit dispensaries and for patients or their caregivers to cultivate if they do not live near dispensaries.

Since 2011, eight more states — Connecticut, Delaware, Illinois, Maryland, New Hampshire, Massachusetts, Minnesota, and New York — and the U.S. territory Guam have enacted effective medical marijuana laws. Massachusetts' measure was a ballot initiative; Guam's law was approved by voters after being referred to the ballot by the legislature; and the other programs were approved by the states' legislatures and governors. Of those laws, only Massachusetts allows home cultivation, and the provision is limited to patients who obtain a waiver due to hardship.

All of the medical marijuana laws enacted since 2009 have allowed regulated dispensaries, although the regulatory and licensing process have sometimes taken two years or longer. In the cases of Connecticut, Maryland, and Illinois, the laws provide for separate commercial cultivation licenses as well.

Following the relaxation of federal enforcement policies, several states with existing medical marijuana laws have improved their laws to include licensed and regulated dispensaries. Vermont followed Rhode Island and Maine's lead in 2011, and Nevada and Oregon did so in 2013. In 2015, Hawaii's legislature added a licensed dispensary system and California's legislature enacted a licensing and regulatory system for all types of medical marijuana businesses.

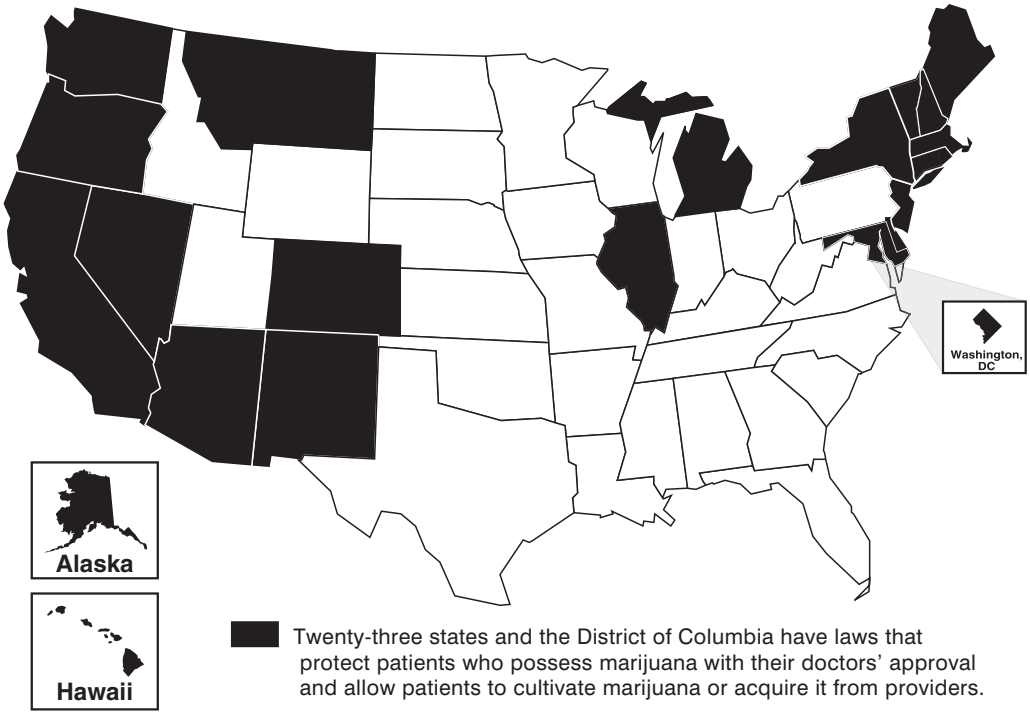
Washington and Alaska voters made marijuana legal for adults who are 21 or older in 2012 and 2014. Neither state had a licensed dispensary system (numerous dispensaries operate in Washington, but are not legal under state law), but those laws allow for regulated distribution to individuals who are 21 or older. Washington's legislature also provided for a medical endorsement for adult-use stores in 2015.

In 2014, a new wave of medical marijuana-related laws was enacted after a growing number of parents of children with devastating seizure disorders became aware of cannabis's potential to bring relief to their children. Since then, three states approved effective comprehensive medical marijuana laws and 16 states enacted laws intended to allow patients with seizures — and sometimes other conditions — to use strains of cannabis that are low in THC. As was mentioned, many of those 16 laws do not reflect the lessons learned about how to craft workable laws, and almost all fail to provide in-state access that will work in light of federal law.

In addition, in 2015, Louisiana amended and expanded an existing ineffective medical marijuana law, but it failed to fix the law's fatal flaws. The law still requires a "prescription" and relies on pharmacies to break federal law by distributing cannabis.

Many of the effective state medical marijuana laws continue to evolve including by adding anti-discrimination protections, improving options for access, and expanding qualifying conditions. In addition, new states — including Nebraska and Utah — are seriously considering comprehensive medical cannabis laws.

23 States and D.C. Have Effective Medical Marijuana Laws



In addition to state laws, some state courts — including the Idaho Supreme Court and a Florida Court of Appeals — have found that patients can avoid a conviction for either possession or cultivation by proving a medical necessity defense. Other states have ruled against a necessity defense. Details are available in Appendix K. Also, Maryland will allow teaching hospitals to propose medical marijuana programs.

In all, more than 148 million Americans — about 47% of the U.S. population — now live in the 23 states, or the federal district, with effective medical marijuana laws. Eighty-five percent live in a state that has some form of medical cannabis legislation on the books. See Tables 1 to 5 and Appendix F for more details about each law.

What Effective Medical Marijuana Laws Do

The 14 laws (including Washington, D.C. and Guam) that were originally enacted by initiative and the 12 laws created by state legislatures are similar in what they accomplish.[16] Each of these jurisdictions allow patients to possess and use medical marijuana if approved by a medical doctor.[17] Depending on the state, patients may cultivate their own marijuana, designate a caregiver to do so, and/or obtain marijuana from a dispensary.

Fifteen of the laws allow at least some patients to cultivate a modest amount of marijuana in their homes. Nineteen states, Guam, and the District of Columbia allow for regulated dispensing, though in some of the states with newer laws, the dispensaries are not yet up and running. In addition, while Washington and Alaska have no state-licensed dispensaries, voters in both states approved state-licensed adult-use stores.

23 States, Guam, and D.C. Have Effective Medical Marijuana Laws

Twenty-three states, Guam, and the District of Columbia have laws that protect patients who possess marijuana with their doctors' approval and allow patients to cultivate marijuana or acquire it from providers.

In addition to these statutes, some state courts — including the Idaho Supreme Court and a Florida Court of Appeals — have found that patients can avoid a conviction for either possession or cultivation by proving a medical necessity defense. Other states have ruled against a necessity defense. Details are available in Appendix L.

In addition, under each of the state laws, physicians are immune from liability for discussing or recommending medical marijuana in accordance with the law.

To qualify for protection under the law, patients typically must have documentation verifying they have been diagnosed with a serious illness. Most laws include a list of qualifying conditions, but in California and Washington, D.C., doctors may recommend cannabis for any condition they believe it will alleviate.

States typically require a statement of approval signed by a physician. To help law enforcement verify that patients qualify for legal protections, all of the states have provisions for state registry programs that issue identification cards to registered patients and their caregivers, though the ID cards are voluntary in California, Maine, and Washington.

Patients' marijuana possession and cultivation limits are generally restricted to a concrete number: One to 24 ounces of usable marijuana and six to 24 plants, sometimes limiting the number that can be mature.

[16] See Table 1 for specifics on each state law. Also see Appendix F for how these laws are working in the real world.

[17] The text of New Mexico's law does not specify that patients can cultivate marijuana; it provides for state-regulated distribution and allows the department to determine how much marijuana patients and their caregivers can possess. The New Mexico Department of Health enacted rules allowing the amount of marijuana patients can possess to include plants.

In many states, regardless of what the source of the marijuana is — including if it was purchased on the criminal market — a patient in possession of an allowable quantity of marijuana and otherwise in compliance with the law is protected from arrest and/or conviction. However, some states, such as New Jersey and Washington, D.C. only allow patients to possess marijuana that was obtained from dispensaries.

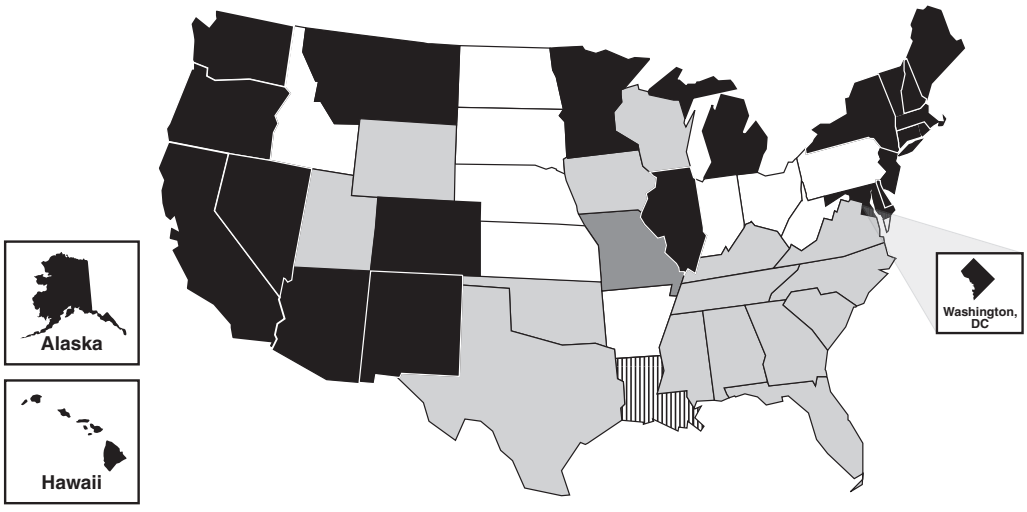
To illustrate how the laws work, consider the following prototypical vignette:

"Joe" has AIDS. His doctor advised him that marijuana could boost his appetite, so he has three marijuana plants growing in a locked closet in his apartment, and he uses a smoke-free vaporizer to consume four puffs of marijuana every evening before dinner. While he waits for his plants to produce harvestable cannabis and whenever they fail to produce a sufficient supply, he purchases cannabis from a licensed dispensary. One day, Joe's neighbor smells marijuana and calls the police. The officer knocks on Joe's door, and when Joe opens it, the officer sees the vaporizer on the table.

Luckily, Joe lives in one of the 23 states with an effective medical marijuana law. Joe acknowledges using marijuana, but then shows the officer his state-issued ID card. The officer calls the state health department to verify the ID card, gives Joe his best wishes, and goes on his way.

If Joe lived in one of the 27 other states, he would be arrested, prosecuted, and possibly sent to prison.

40 States With Medical Marijuana Laws, 2015



Twenty-three states and the District of Columbia have laws that protect patients who possess marijuana with their doctors' approval and allow patients to cultivate marijuana or acquire it from providers.

Louisiana has a law that is intended to protect patients and provide access to medical cannabis, but which unrealistically relies on doctors "prescribing" cannabis.

Missouri enacted a law to protect certain patients who possess low-THC marijuana with their doctors' approval and to allow patients to acquire it from providers.

Sixteen states have laws that are intended to protect certain patients who possess low-THC marijuana with their doctors' approval, but which have serious flaws such as failing to provide in-state access.

Most of the state laws protect patients who are complying with the state's law and have an ID card from being arrested. The other states have a defense that can be raised in court to prevent a conviction.[18]

Is There Conflict Between Modern State Laws and Federal Law?

In the 19 years since California and other states began protecting medical marijuana patients from arrest, many questions have surfaced regarding the status of those laws in relation to federal law. Some believe that the federal government can nullify state laws, or that state laws have no real value in the face of conflicting federal law. That is not the case.

Even though federal authorities can penalize patients for violating federal marijuana laws, and a state cannot require its employees to violate federal law, a state government is not required to have laws identical to those of the federal government. A state may remove its criminal penalties for possessing, growing, or distributing marijuana for medical (or even non-medical) purposes.

This crucial distinction is often misunderstood: It is true that the federal government can enforce federal laws anywhere in the United States, even within the boundaries of a state that rejects those laws. Nevertheless, the federal government cannot force states to criminalize conduct that is illegal under federal law, nor can the federal government force state and local police to enforce federal laws.

While it is quite clear that states can remove their own criminal penalties for marijuana, some have claimed that the federal government could preempt (trump and nullify) state programs that seek to regulate a limited number of dispensaries. However, the federal government itself has never made this argument in court, and the federal Controlled Substances Act includes strong anti-preemption language.[19]

In testimony before Congress, Deputy U.S. Attorney General James Cole recognized that it would be against the federal government's interest to challenge regimes regulating marijuana sales and cultivation. Discussing the federal government's decision not to challenge laws regulating the legal sales of marijuana to adults in Colorado and Washington, Mr. Cole explained, "It would be a very challenging lawsuit to bring to preempt the state's decriminalization law. We might have an easier time with their regulatory scheme and preemption, but then what you'd have is legalized marijuana and no enforcement mechanism within the state to try and regulate it and that's probably not a good situation to have."[20]

A handful of state courts have ruled on arguments that federal law preempts some or all of a state's medical marijuana law. All appellate-level decisions on the issue have found that removing a state's criminal penalties is not preempted by federal law, and two decisions finding against preemption were denied review by the U.S. Supreme Court.[21] In addition, the Oregon Supreme Court found that the state's medical marijuana law was preempted in its application to employment law

[18] See Appendix G for more detailed definitions of these defenses.

[19] 21 U.S.C. 903.

[20] Flatow, Nicole. "Deputy Attorney General Explains Why State Pot Regulation Is His Least Worst Option," *ThinkProgess.org*, September 11, 2013.

[21] See: *County of San Diego v. San Diego NORML*, 165 Cal.App.4th 798 (2008) *cert. denied*, 129 S. Ct. 2380 (2009) ("Congress does not have the authority to compel the states to direct their law enforcement personnel to enforce federal laws.") and *City of Garden Grove v. Superior Court*, 68 157 Cal.App.4th 355 (Cal.App. 4th Dist. 2007), *review denied* (Cal. 2008), *cert denied* 129 S.Ct 623 (2008).

protections, but the case strongly indicated that the act's criminal law protections were not preempted.[22]

Claims arguing that federal law preempts the licensing or regulation of dispensaries have also generally failed.[23] In one of the more recent rulings, a state superior court judge in Arizona ruled against a city's claim that providing a certificate to a dispensary was preempted by state law. Judge Michael Gordon reasoned,[24]

> It is of considerable consequence that it is Arizona's attempt at partial decriminalization with strict regulation that makes the AMMA vulnerable ... This view, if successful, highjacks Arizona drug laws and obligates Arizonans to enforce federal prescriptions that categorically prohibit the use of all marijuana. The Tenth Amendment's "anti-commandeering rule" prohibits Congress from charting that course.

At least three other cases in California raised the issue of federal preemption. In *City of Garden Grove v. Superior Court*, the Fourth District of the California Court of Appeals held that the police must return medical marijuana to a patient and that returning the medicine is not precluded by principles of federal preemption.

In *Qualified Patients Association v. Anaheim*, the same court ruled against a claim of federal preemption in the context of a city refusing to allow a dispensing collective to operate. However, in *Ryan Pack v. Long Beach*, a different California appellate court ruled that the city could not issue permits on a lottery basis that do more than confirm that the entity is exempt from state criminal penalties, but that the state could decriminalize collectives and cooperatives and the city could issue regulations. The *Pack* case is not binding outside of Long Beach and it was dismissed before an appeal to the California Supreme Court was heard.

In May 2011, Arizona Gov. Jan Brewer and Attorney General Tom Horne filed a lawsuit in federal court questioning the validity of the medical marijuana program established in Arizona by the passage of Proposition 203 in November of 2010. The lawsuit was dismissed after a federal court found there was no realistic threat to state workers. Arizona did not appeal and it now licenses and regulates more than 90 dispensaries.[25]

In December 2014, the attorneys general of Nebraska and Oklahoma asked the U.S. Supreme Court to consider whether federal law preempts Colorado's adult use marijuana legalization and regulation law.[26] As of fall 2015, the Supreme Court has not decided whether it will consider the case, which claims the Supreme Court has original jurisdiction (meaning the case was filed directly with the Supreme Court, rather than being heard by lower courts first and then appealed).

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[22] *Emerald Steel Fabricators v. Bureau of Labor & Indus*, 348 Or 159, 176; 230 P3d 518 (2010).

[23] See, i.e.: *Arizona v. United States*, No. CV 11-1072-PHX-SRB, slip op. at 2 (D. Ariz. Jan. 1, 2012) and *Qualified Patients Ass'n v. Anaheim*, 187 Cal. App. 4th 734, 759–60 (Cal. Ct. App. 2010).

[24] *White Mountain Health Center Inc. v. County of Maricopa*, CV-2012-053585, (December 3, 2012).

[25] *Arizona v. United States*, Case No. CV 11-1072-PHX-SRB (D.C. Ariz. January 4, 2012) at 7.

[26] U.S. Supreme Court docket number No. 22O144

Federal Law Enforcement and State Medical Marijuana Programs

The federal-state division of power is advantageous to patients who need to use marijuana: Because 99% of all marijuana arrests in the nation are made by state and local — not federal — officials, favorable state laws effectively protect 99 out of every 100 medical marijuana users who otherwise would have been prosecuted. Federal drug enforcement agents simply do not have the resources or the mandate to patrol the streets of a state to look for cancer patients growing a few marijuana plants.[27]

Not only that, but the federal government has declared its intention not to pursue patients and their caregivers who possess or use small amounts of marijuana for medical use.[28] In 2013, the U.S. Department of Justice directed federal law enforcement not to target distributors who act in compliance with a strong state regulatory framework unless one of eight federal priorities is implicated.[29]

In practice, during the entire Obama administration, the federal government has not targeted providers in states where they were licensed by the state and regulated unless there was a credible allegation that the provider was not in clear and unambiguous compliance with state laws. It has, however, prosecuted and raided providers in states like Montana and California, where the laws were less clear and did not include state licensing and state regulations.

In December 2014, Congress showed its support for the Obama administration's stated policy of non-intervention in medical marijuana programs. It attached a rider to a FY 2015 federal appropriations bill providing that none of the funds could be used to "prevent [medical marijuana states] from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana."

(See Appendix S for a more thorough examination of federal enforcement policy as it relates to state medical marijuana programs.)

Federal Court Rulings

Although most medical marijuana cases are resolved in state courts, some cases have been heard in the federal courts.

To date, there have been only two medical marijuana cases heard by the U.S. Supreme Court: *U.S. v. Oakland Cannabis Buyers' Cooperative* (OCBC) and *Gonzales v. Raich*.[30] These cases do not challenge the legitimacy of state medical marijuana laws and therefore do not affect the ability of states to protect medical marijuana patients under state law. Instead, they focus solely on federal issues. (Three more cases, *Conant v. Walters* and two cases where state courts ruled against preemption challenges, were appealed to the U.S. Supreme Court, but the court chose not to hear the cases.)

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[27] In 2010, there were 7,607 federal arrests for marijuana related offenses. U.S. Marshals Service, Justice Detainee Information System (JDIS), as analyzed and reported by the Bureau of Justice Statistics, (http://www.bjs.gov/fjsrc/). State and local marijuana arrests in 2010 totaled 853,839. FBI Uniform Crime Report, Crime in the United States, 2010.

[28] Cole, James M. *Memorandum for United States Attorneys: Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use.* U.S. Department of Justice, Office of the Deputy Attorney General, June 29, 2011.

[29] Cole, James M. *Memorandum for United States Attorneys: Guidance Regarding Marijuana Enforcement.* U.S. Department of Justice, Office of the Deputy Attorney General, August 29, 2013.

[30] See Appendix I.

In the OCBC case, the U.S. Supreme Court unanimously ruled (8–0) that medical marijuana distributors cannot assert a "medical necessity" defense against federal marijuana distribution charges. The ruling, issued on May 14, 2001, did not overturn state laws allowing seriously ill people to possess and grow their own medical marijuana.

OCBC dealt exclusively with federal law and was essentially limited to distribution issues. The case did not question a state's ability to allow patients to grow, possess, and use medical marijuana under state law, and it presents no foreseeable barriers to additional state-level protections.

At issue in *Gonzales v. Raich* was whether the federal government has the constitutional authority to arrest and prosecute patients who are using medical marijuana in compliance with state laws. On June 6, 2005, the U.S. Supreme Court ruled 6-3 that the federal government can continue arresting patients who use medical marijuana legally under their state laws. However, the decision did not affect the states' ability to pass medical marijuana laws — and it did not overturn the laws now protecting the rights of Americans to use medical marijuana legally under state laws.

Meanwhile, *Conant* considered whether the federal government can punish physicians for discussing or recommending medical marijuana. The U.S. District Court for the Northern District of California ruled in 2000 that the federal government cannot gag doctors in this fashion; the ruling was upheld in a 2002 opinion from the U.S. Court of Appeals for the Ninth Circuit. The federal government filed an appeal with the U.S. Supreme Court, which chose not to hear the case on October 14, 2003. This is the only appellate court decision on the issue of physicians recommending medical marijuana, and it is controlling law in the eight medical marijuana states in the Ninth Circuit. This unanimous decision in the Ninth Circuit is solidly grounded in the First Amendment, and physicians who evaluate the risks and benefits of the medical uses of marijuana outside the Ninth Circuit should also have nothing to fear.

There are other important federal cases that have not made it up to the U.S. Supreme Court; these are reviewed in Appendix J.

At the state level, the vast majority of cases that have emerged have questioned whether individuals or organizations are in compliance with state law and the extent of protections they are entitled to — such as regarding employment rights and the right to use medical marijuana while on probation.

Overview of Kinds of State Laws

At various times since 1978, 43 states and the District of Columbia have had favorable medical marijuana laws.

Laws in three states have either expired or been repealed, but 40 states and D.C. currently have laws on the books. Although well-intentioned, many of these laws do not provide effective protection for patients who need to use medical marijuana.

Because some states have enacted more than one type of law, the totals for the following subsections add up to more than 43.

Effective laws

The only laws that currently provide meaningful protection for patients are ones that remove state-level criminal penalties for possession and use of medical marijuana and provide a means of access. Twenty-three states — Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Montana, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington state — and the District of Columbia and Guam have effective laws of this nature, all of which have been enacted since 1996.

Therapeutic research programs[31]

The four states listed under this title in Appendix A, plus California, Illinois, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Rhode Island, and Washington, currently have laws that allow patients to legally use medical marijuana through state-run therapeutic research programs. During the late 1970s and early 1980s, at least seven states obtained all of the necessary federal permissions, received marijuana from the federal government, and distributed the marijuana to approved patients through pharmacies.

The federal approval process for medical marijuana research is excessively cumbersome. As a result, state health departments are generally unwilling to devote their limited resources to the long and probably fruitless application process, nor are they willing to spend taxpayer money administering the program. Additionally, many patient advocates oppose research programs as the primary mode of access to medical marijuana because enrollment in such programs is highly restrictive and trials tend to be very short-term.

Since 2014, some states have passed laws intended to allow therapeutic research programs solely for low-THC, CBD-rich marijuana. They have encountered the same problems. A modest number of patients has been admitted to clinical trials for Epidiolex — a CBD-based pharmaceutical produced in the United Kingdom — but state legislation is not necessary for those federally approved trials.

In sum, because of federal obstructionism, therapeutic research program laws are not effective as a means of providing patients with access to medical cannabis.

Symbolic measures/Pseudo-prescriptive access

Eight states have laws that allow patients to possess marijuana if obtained directly through a valid prescription. The problem is that there is no legal supply of marijuana to fill such a prescription. Federal law prohibits the distribution of marijuana and other Schedule I substances for any reason other than research. Doctors cannot "prescribe" marijuana, and pharmacies cannot dispense it.

Prescriptive-access laws demonstrate a state's recognition of marijuana's therapeutic value, but they are not effective as written without a change in federal policy.

[31] See Appendix J for details on therapeutic research programs.

Establishing provisions for the state government to distribute confiscated marijuana

Before it was repealed in 1987, an Oregon law allowed physicians to prescribe confiscated marijuana. Several other states have considered similar legislation, although it does not appear that confiscated marijuana has ever been distributed in any state.

It is one thing for state governments to remove their penalties for patients or private entities that grow medical marijuana, but it's another thing for the state government itself to distribute a Schedule I substance for anything other than federally approved research. State officials could be subject to federal prosecution for marijuana distribution if they provide marijuana to patients. Another concern is that confiscated marijuana may contain adulterants and would require screening, which could be prohibitively expensive.

Programs intended to allow low-THC cannabis

Since 2014, 16 states have enacted laws that are intended to allow certain patients — typically only those with seizure disorders — to use cannabis oils that are low in THC and rich in cannabidiol. All but one of those laws includes flaws that will likely make the programs unworkable. Of the 16, only Missouri appears poised to have an operational system of in-state access.

Seven of the low-THC state laws — Alabama, Georgia, Iowa, Utah, Virginia, Wisconsin, and Wyoming — include no means of in-state access to medical cannabis. Mississippi and Tennessee rely on universities breaking federal law by growing marijuana, while Kentucky, Oklahoma, North Carolina, and South Carolina unrealistically only provide for access to the medicine through studies.

Both Texas and Alabama's laws rely on doctors being willing to break federal law by "prescribing" cannabis, while Florida and Kentucky require a doctor's "order" to obtain cannabis, which also puts physicians in jeopardy under federal law.

Rescheduling marijuana

States have their own controlled substance schedules, which typically mirror the federal government's. However, states are free to schedule substances as they see fit.

At least seven states — Alaska, Connecticut, Iowa, Montana, North Carolina, Oregon, and Tennessee — and the District of Columbia currently place marijuana in schedules that recognize its therapeutic value.

However, there is little or no practical significance to rescheduling marijuana on the state level because the federal schedule supersedes state schedules, and the federal government does not permit marijuana prescriptions. As with "pseudo-prescriptive access" laws, it is unclear whether courts would interpret these laws as permitting a "medical necessity" defense.

Non-binding resolutions

At least seven state legislatures — California, Michigan, Missouri, New Hampshire, New Mexico, Rhode Island, and Washington — have passed non-binding resolutions urging the federal government to allow doctors to prescribe marijuana. Non-binding resolutions are passed by one or both chambers of a state's legislature and do not require the governor's signature.

In addition, the National Conference of State Legislatures passed a resolution in 2015 urging that "federal laws, including the Controlled Substances Act ... be amended to explicitly allow states to set their own marijuana policies without federal interference."

The resolutions send a message, officially proclaiming the legislatures' positions, but do not have the force of law.

Laws that have expired or been repealed

In addition to the 40 states with current laws, Arkansas and West Virginia have repealed their medical marijuana laws. In Ohio, one law expired and a second law was repealed. A few other states have had laws that have expired or been repealed, but subsequently enacted other medical marijuana laws that are still on the books.

And, finally, seven states have never had favorable medical marijuana laws.

Where Things Are Going From Here

The earliest effective medical marijuana laws were enacted by initiative, creating the first wave of activity to protect medical marijuana patients nationwide. Now, a total of 11 state medical marijuana initiatives have been enacted, providing legal protection for patients in states that collectively contain almost 27% of the population and embodying the strong support for medical marijuana found in poll after poll.

In turn, the successes of Hawaii and the 11 subsequent legislatures embody the growing recognition by lawmakers of the medical efficacy of marijuana and the need to exempt the seriously ill from laws that prevent them from realizing its benefits.

While an ever-growing list of states moves toward enacting new medical marijuana legislation, those with existing programs continue to expand upon them. Now, all but three of the medical marijuana states allow for larger-scale access through medical marijuana businesses.

The role of state legislatures in the movement to protect medical marijuana patients cannot be overstated. Only 23 states and the District of Columbia have the initiative process, which means that the citizens in 27 states cannot directly enact their own laws. They must rely on their state legislatures to enact favorable medical marijuana laws, and the number of future legislative victories will depend on how many people effectively lobby their state officials. Moreover, legislation is much more cost-effective than ballot initiatives, which can be very expensive endeavors.

The passage of additional state medical marijuana laws has the added benefit of pressuring the federal government to change its laws.

The final wave of activity to protect medical marijuana patients has started on the federal level. Throughout the Obama administration, federal law enforcement officials have not targeted medical marijuana providers complying with clear, well-regulated state medical marijuana laws.

In December 2014, Congress passed a historic medical marijuana amendment as part of the federal spending bill, marking the first time in history that Congress approved legislation rolling back the federal government's war on medical marijuana patients and providers in states with medical marijuana laws.

Also in 2015, for the first time, a bipartisan bill was introduced in both the U.S. Senate and U.S. Congress to improve federal medical marijuana policies. In addition to other positive changes, the C.AR.E.R.S Act — S. 683 and H.R. 1538 — would modify the Controlled Substances Act so it did not penalize patients, providers, and businesses that are acting in compliance with state laws.

The recent loosening of federal policies toward medical marijuana does not diminish the need for state-level reforms. Federal policy changes are happening slowly, having finally begun more than a decade after the first modern medical marijuana law passed. In addition, proposals in Congress have been gaining support due to an increasing number of states' efforts to protect their seriously ill patients. They also have been tailored to respect those state laws.

TABLE 1: Effective Medical Marijuana Laws in 16 States and Washington, D.C.

State; Measure/% of vote; Date enacted	How law protects patients (defenses provided)[a]	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Dispensaries	Recognizes out-of-state ID cards
Alaska Measure 8 (ballot initiative/58%) November 3, 1998 (modified by S.B. 94, effective June 2, 1999)	Affirmative defense provided only for those registered with the state[b]	With state Department of Health and Social Services	One ounce of marijuana in usable form and six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time; also, anyone 21 or older can possess an ounce of marijuana, grow up to six plants (three mature), and possess the marijuana from those plants	One primary and one alternate caregiver who may serve only one patient at a time, with limited exceptions	While dispensaries are not authorized under the medical marijuana program, adult use retailers will be licensed in 2016 and may provide to adults 21 and over	No; however, anyone 21 or over can possess marijuana in the state and buy it from marijuana stores once they are open in 2016
Arizona Proposition 203 (ballot initiative/50.1%) November 2, 2010	Exemption from arrest and prosecution if in lawful possession of a registry card; also an affirmative defense that sunset once cards became available	With state Department of Health Services	2.5 ounces of usable marijuana; patients located more than 25 miles from a medical marijuana dispensary may cultivate 12 plants in an enclosed, locked facility	One caregiver per patient; a caregiver may assist up to five patients at a time	Yes, the Arizona Department of Health Services may register one nonprofit dispensary for every ten pharmacies; 85 have opened as of fall 2014	Yes, for patients with conditions that qualify under Arizona law, but not for obtaining marijuana from dispensaries
California Proposition 215 (ballot initiative/56%) November 5, 1996 (modified by S.B. 420, effective January 1, 2004)	Exemption from arrest for those with voluntary ID cards; affirmative defense or dismissal for those with only written recommendations	Voluntary patient registry system; caregivers and patients with IDs are verified through the California Medical Marijuana Program website	The state initiative, which cannot be amended by legislation, did not include limits; the legislature later enacted safe harbor amounts, which are not caps; see Appendix F for details	The individual designated by the patient who has consistently assumed responsibility for the housing, health, or safety of that person; this may include a person who was designated by more than one patient if they all reside in the same city or county	Currently, collectives and cooperatives are allowed; there is no state licensing or registration. In late 2015, the state adopted a new regulatory system, which will be phased in over the next several years. Expected to go into effect in 2018, the new system will replace the collective/ cooperative model with a licensing system, including dispensaries and several other business categories.	No

TABLE 1: Effective Medical Marijuana Laws in 16 States and Washington, D.C.

TABLE 1: Effective Medical Marijuana Laws in 23 States and Washington, D.C.						
State; Measure/% of vote; Date enacted	How law protects patients (defenses provided)[a]	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Dispensaries	Recognizes out-of-state ID cards
Colorado Amendment 20 (ballot initiative/54%) November 7, 2000 (modified by HB 1284, effective July 1, 2010)	Exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law	With state Department of Public Health and Environment	Also, anyone 21 or older in Colorado can possess an ounce of marijuana, grow up to six plants (three mature), and possess the marijuana from those plants	An individual who has significant responsibility for managing the well-being of the patient; generally, a caregiver cannot assist more than five patients	Yes, hundreds of dispensaries — called "medical marijuana centers" — are regulated and registered both locally and by the state Department of Revenue; medical marijuana is subject to sales tax, though there is an exemption for indigent patients	No, however, pursuant to Amendment 64, anyone over 21 can possess marijuana in the state and buy it from marijuana stores
Connecticut HB 5389 (enacted by legislature) June 1, 2012	Exemption from arrest and prosecution if in lawful possession of a registry card	With state Department of Consumer Protection	Up to 2.5 ounces every month, which may be changed based on advice from the Board of Physicians; home cultivation is not allowed	Caregivers may not cultivate, they obtain marijuana from dispensaries for patients; patients may have one caregiver, and caregivers may assist one patient unless a parent, guardian, or sibling relationship exists	Yes, dispensaries must be run by licensed pharmacists and they are regulated by the Department of Consumer Protection; six are open, with three more expected in 2016. Up to 10 separate cultivation licenses are allowed and four have been issued	No
Delaware SB 17 (enacted by legislature) May 13, 2011	Exemption from arrest and prosecution if in lawful possession of a registry card; affirmative defense under certain conditions, such as while waiting for the department to process a patient application	With state Department of Health and Social Services	Six ounces of usable marijuana; three ounces can be obtained from a dispensary every 14 days; home cultivation is not allowed	One caregiver per patient; a caregiver may assist up to five patients at a time; caregivers may not cultivate marijuana	The law called for at least three Department of Health and Social Services-regulated compassion centers (dispensaries); however, after initially refusing to register any compassion centers, Gov. Markell directed DHSS to only register one pilot dispensary, which opened in June 2015	Yes, for patients with conditions that qualify under Delaware law, but a Delaware registry card is needed to obtain marijuana from dispensaries

TABLE 1: Effective Medical Marijuana Laws in 23 States and Washington, D.C.						
State; Measure/% of vote; Date enacted	How law protects patients (defenses provided)[a]	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Dispensaries	Recognizes out-of-state ID cards
District of Columbia Initiative 59 (ballot initiative/69%) November 3, 1998 (effective date delayed by Congressional action, amended by B-18-622 — enacted by legislature — July 27, 2010)	Exemption from arrest and prosecution if in lawful possession of a registry card	With Department of Health	Two ounces of dried marijuana, though the law allows the mayor to increase the limit to four ounces by rulemaking; home cultivation is not allowed	Caregivers may not cultivate marijuana, but may obtain it from a dispensary on the patient's behalf and assist with administration; patients may have one caregiver, and caregivers may assist only one patient	Yes, regulated by the Department of Health; as of fall 2015, five dispensaries and seven cultivation centers have opened; the mayor may authorize three more dispensaries and as many cultivation centers as are needed	No
Hawaii S.B. 862 HD1 (enacted by legislature) June 14, 2000 (modified by H.B. 668, CD1 and S.B. 642, CD1 in June 2013)	Exemption from prosecution if in lawful possession of a registry card; "choice of evils" defense also on the books, independent of this statute	With the Department of Health	Seven plants and four ounces of usable marijuana	One caregiver per patient, and a caregiver may serve only one patient at any given time	Yes, eight vertical licenses will be issued with two dispensary locations and two cultivation locations allowed for each license. The cultivation facilities must be separate from the dispensary locations and can have a maximum of 3,000 plants. In 2017, the state health department will be allowed to issue more licenses as needed.	No
Illinois HB 1 (enacted by legislature) August 1, 2013	Exemption from arrest and prosecution if in lawful possession of a registry card	With state Department of Public Health	2.5 ounces in a 14-day period; home cultivation is not allowed	Caregivers may not cultivate marijuana, but may obtain it on behalf of a patient and assist in medical use	Yes, 60 dispensaries are allowed and regulated by the Department of Financial and Professional Regulation; up to 22 cultivators are also allowed.	No
Maine Question 2 (ballot initiative/61%) November 2, 1999 (modified by L.D. 611 in 2002; by Question 5 in 2009, a ballot initiative/ 59%; by LD 1811 in 2010; and by LD 1296 in 2011)	Exemption from arrest and prosecution if in lawful possession of a registry card or a written certification from a physician	Yes, with the Department of Health and Human Services, though registering is optional for patients and caregivers of patients who are family or household members	2.5 ounces of usable marijuana and six mature plants; patients charged with possession of excess marijuana may plead, as a defense, that such excess marijuana was necessary to ensure uninterrupted availability	Patients who do not obtain marijuana from a dispensary may appoint one caregiver to cultivate up to six mature plants on their behalf; caregivers may assist up to five patients	Yes, the Department of Health and Human Services regulates eight non-profit dispensaries; patients may only obtain marijuana from their designated dispensary	Yes, but visiting patients may not obtain marijuana from a Maine dispensary

TABLE 1: Effective Medical Marijuana Laws in 23 States and Washington, D.C.						
State; Measure/% of vote; Date enacted	How law protects patients (defenses provided)[a]	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Dispensaries	Recognizes out-of-state ID cards
Maryland HB 881/SB 923 (enacted by the legislature) April 14, 2014 (modified by HB 490, effective May 12, 2015)	Exemption from arrest and prosecution if registered with the Maryland Medical Cannabis Commission and certified to use medical marijuana by a physician	Yes, once certified by a physician, patients and their caregivers will be entered into a registry database to be used to verify patient or caregiver status	A 30-day supply, defined as 120 grams of usable marijuana or 36 grams of THC via an infused product; a physician may determine on a case-by-case basis that a patient needs a greater amount	Patients may have up to two caregivers; caregivers may assist up to five patients; patients under 18 must have a caregiver who must be a parent or legal guardian	Yes, the Maryland Medical Cannabis Commission may issue up to two dispensary licenses in each of the 47 state senate districts; the commission expects to begin giving initial approval to licensees by January 2016	No
Massachusetts Question 3 (ballot initiative/63%) November 6, 2012	Exemption from arrest and prosecution if in lawful possession of a registry ID card	With state Department of Public Health	A 60-day supply, presumptively defined as 10 ounces; a special "hardship cultivation registration" is required in order to cultivate plants	Up to two caregivers per patient; a caregiver typically may only assist one patient; caregivers may only cultivate if the patient has a "hardship cultivation registration"	Yes, regulated by the Department of Public Health, which registered 15 dispensaries in 2015 and may approve more as needed	No
Michigan Proposal 1 (ballot initiative/63%) November 4, 2008	Exemption from arrest and prosecution if in lawful possession of a registry card	With the state Department of Licensing and Regulatory Affairs	2.5 usable ounces and 12 plants	One caregiver per patient, five patients per caregiver	Not provided for in state law (see *People v. Compassionate Apothecary*, Isabella County Court of Appeals (Aug. 23, 2011)), though some municipalities license and regulate dispensaries	Yes, protections apply for possession. But until dispensaries are formally recognized under state law, many out-of-state visitors will have significant problems finding ways to access medical marijuana while in Michigan
Minnesota SF 2470 (enacted by the legislature) May 29, 2014	Exemption from arrest and prosecution if in lawful possession of registry ID card	Yes, with the Minnesota Department of Health Office of Medical Cannabis	A patient may possess a 30-day supply worth of medical cannabis products, which will vary per patient based on a determination by a pharmacist working at the patient's dispensary	Patients are allowed to have one caregiver who may assist them with administering their medicine or picking it up for them if the patient's medical provider certifies the patient is so physically or developmentally disabled that the patient cannot administer his or her own medication	Yes, two medical marijuana manufacturers — which are both operational as of fall 2015 — are each allowed to have four dispensing locations spread throughout the state	No

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State; Measure/% of vote; Date enacted	How law protects patients (defenses provided)[a]	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Dispensaries	Recognizes out-of-state ID cards
Montana Initiative 148 (ballot initiative/62%) November 2, 2004 (modified by S.B. 423, effective July 1, 2011)[c]	Exemption from arrest and prosecution if in lawful possession of a registry card	With state Department of Public Health and Human Services	One ounce of usable marijuana; either patients, or providers on behalf of patients (but not both), may possess four mature plants and 12 seedlings	One provider per patient; if S.B. 423 is held to be constitutional, providers will only be able to assist three patients at a time and will not be able to receive compensation	Not allowed under S.B. 423; however, due to a court case challenging S.B. 423, as of fall 2013, providers can assist an unlimited number of patients	No
Nevada A.B. 453 (enacted by the legislature; implements ballot initiative Question 9, which passed with 59% of the vote in 1998 and again with 65% in 2000) June 14, 2001 (modified by A.B. 519, effective 2005 and S.B. 374	Exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law	With state Department of Health and Human Services	2.5 ounces every 14 days and 12 plants (for those allowed to grow); patients may use affirmative defense to argue that greater amounts are medically necessary	One caregiver per patient, although caregivers can serve multiple patients simultaneously; caregivers may not receive compensation	The state licenses dispensaries and other businesses, which began operating in the latter half of 2015	Yes, as long as the other state programs are substantially similar to the requirements of Nevada law; as of 2015, patients must fill out paperwork and be served at a licensed dispensary
New Hampshire HB 573 (enacted by legislature) July 23, 2013	Exemption from arrest and prosecution if in lawful possession of a registry ID card	With state Department of Health and Human Services	Two ounces of usable marijuana; home cultivation is not allowed	One caregiver per patient; caregivers typically may assist no more than five patients; caregivers may not cultivate	Yes, regulated by the Department of Health and Human Services; four nonprofit alternative treatment centers were provisionally approved in 2015	Yes, for patients with conditions qualifying in New Hampshire; visiting patients must bring their own marijuana
New Jersey S. 119 (enacted by legislature) January 11, 2010	Exemption from prosecution if in lawful possession of a registry card	With state Department of Health	No more than two ounces can be dispensed to a patient in 30 days; home cultivation is not allowed	One caregiver per patient; a caregiver may assist only one patient	Yes, Department of Health-regulated "alternative treatment centers" (ATCs) are allowed; in March 2011, the department registered six ATCs, four of which were open as of fall 2015	No
New Mexico SB 523 (enacted by legislature) April 2, 2007	Exemption from arrest and prosecution if in lawful possession of a registry card	With state Department of Health	An "adequate supply" not to exceed six ounces of usable marijuana, four mature plants, and 12 seedlings, or a three-month supply of topical treatment	A caregiver may have up to four patients and possess up to eight ounces of usable cannabis collectively with any one patient; caregivers may not independently cultivate, but they may assist their patients	Yes, the New Mexico Department of Health regulates nonprofit producers; as of fall 2015, there were 23 with 24 dispensaries, while another 12 producers had been issued licenses; each producer may cultivate up to 150 plants	No

TABLE 1: Effective Medical Marijuana Laws in 23 States and Washington, D.C.						
State; Measure/% of vote; Date enacted	How law protects patients (defenses provided)[a]	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Dispensaries	Recognizes out-of-state ID cards
New York S 7923 (enacted by legislature) July 5, 2014	Exemption from arrest and prosecution if in lawful possession of a valid registry identification card	With state Department of Health	A 30-day supply of a physician-determined dosage; smoking is not allowed	A caregiver may assist up to five patients at a time and may possess up to the 30-day supply for each patient	Each of five organizations registered with the Department of Health may operate up to four dispensaries for a maximum of 20 sites; as of fall 2015 the first are expected to open in early 2016	No
Oregon Measure 67 (ballot initiative/55%) November 3, 1998 (modified by H.B. 3052, effective July 21, 1999; S.B. 1085, effective January 1, 2006; and H.B. 3460, effective August 14, 2013)	Exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law; "choice of evils" defense also authorized by statute	With state Department of Human Services	24 ounces of usable marijuana, six mature marijuana plants, and 18 seedlings per patient jointly with his or her caregiver; patients no longer have an affirmative defense to argue that greater amounts are medically necessary	One caregiver per patient who has "significant responsibility for managing the well-being of the patient;" caregivers can serve multiple patients simultaneously, but cannot grow for more than four patients at a time	Yes, the Oregon Health Authority registers medical marijuana facilities, which may transfer usable marijuana and immature plants to patients and their caregivers; the program took effect August 14, 2013, and as of September 21, 2015, 345 dispensary applications had been approved	No
Rhode Island H 6052 and S 710 (enacted by legislature) January 3, 2006 (made permanent in 2007; modified by H 5359/S 185 in 2009 and S 2555 in 2012)	Exemption from arrest and prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law	With state Department of Health	2.5 usable ounces and 12 plants	Patients are allowed up to two caregivers, with a dispensary considered a caregiver; non-dispensary caregivers can assist up to five patients	Yes, the Health Department approved three nonprofit compassion centers (dispensaries); all three of which are serving patients as of fall 2015	Yes
Vermont S. 76 (enacted by legislature) May 26, 2004 (modified by S.7 in 2007, S. 17 in 2011, and S. 247 in 2014)	Exemption from arrest and prosecution if in lawful possession of registry card	With state Department of Public Safety	Two usable ounces and nine plants, two of which may be mature	One caregiver per patient, and a caregiver may serve only one patient at a time; a caregiver cannot have a drug-related conviction and must be registered with the state	Yes, the Department of Public Safety has approved three dispensaries, pursuant to a 2011 law, and conditionally approved a fourth and final dispensary in fall 2013	No

TABLE 1: Effective Medical Marijuana Laws in 23 States and Washington, D.C.						
State; Measure/% of vote; Date enacted	How law protects patients (defenses provided)[a]	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Dispensaries	Recognizes out-of-state ID cards
Washington Measure 692 (ballot initiative/59%) November 3, 1998 (modified by SB 5073, effective April 29, 2011; by SB 5052, most of which effective July 1, 2016)	Exemption from arrest and prosecution if in lawful possession of a registry card; affirmative defense available to those who chose not to register if in compliance with law	Voluntary registry with a marijuana retail store holding a medical marijuana endorsement working in conjunction with the Department of Health	Patients who have registered may possess eight ounces and six plants; those who have not registered may possess six ounces and four plants; with an ID, a health care professional may authorize possession of up to 16 ounces and 15 plants	An individual who has significant responsibility for managing the well-being of the patient; generally, a caregiver cannot assist more than one patient	Marijuana retail stores licensed pursuant to Initiative 502 may seek a "medical marijuana endorsement" allowing them to discuss medical benefits, to dispense to registered patients who are 18-20 years old, and to dispense amounts greater than one ounce to registered patients	No; however, pursuant to Initiative 502, anyone over 21 may possess marijuana in the state and buy it from marijuana stores.

a See Appendix G for definitions of "affirmative defense," "exemption from prosecution," and "choice of evils."

b In addition to Alaska's medical marijuana law, a 2014 voter initiative — Measure 2 — legalized marijuana for adults 21 and over. The state's constitutional right to privacy has been interpreted as including protections for possession of a modest amount of marijuana for personal use in one's home.

c The constitutionality of several provisions of S.B. 423 are being decided in a state court case, Montana Cannabis Industry Association, et al. v. Montana, and these provisions have not yet gone into effect. See Appendix F for more details.

TABLE 2: Tally of State Medical Marijuana Laws

TABLE 2: Tally of State Medical Marijuana Laws								
State	Effective		Therapeutic Research Program		Symbolic		Workable Low-THC	Flawed Low-THC
	Previously had	Currently has	Previously had	Currently has	Previously had	Currently has	Currently has	Currently has
Alabama				√				√
Alaska		√	√					
Arizona		√	√			√		
Arkansas					√			
California		√		√				
Colorado		√	√					
Connecticut		√				√		
Delaware		√						
District of Columbia		√			√			
Florida			√					√
Georgia				√				√
Hawaii		√						
Idaho								
Illinois		√		√				
Indiana								
Iowa			√			√		√
Kansas								
Kentucky								√
Louisiana			√			√		
Maine		√	√					
Maryland		√						
Massachusetts		√		√				
Michigan		√	√					
Minnesota		√		√				
Mississippi								√
Missouri							√	
Montana		√						
Nebraska								
Nevada		√	√					
New Hampshire		√				√		
New Jersey		√		√				
New Mexico		√		√				

TABLE 2: Tally of State Medical Marijuana Laws								
State	Effective		Therapeutic Research Program		Symbolic		Workable Low-THC	Flawed Low-THC
	Previously had	Currently has	Previously had	Currently has	Previously had	Currently has	Currently has	Currently has
New York		√		√				
North Carolina					√			√
North Dakota								
Ohio			√					
Oklahoma								√
Oregon		√	√					
Pennsylvania								
Rhode Island		√		√				
South Carolina				√				√
South Dakota								
Tennessee			√			√		√
Texas				√				√
Utah								√
Vermont		√						
Virginia						√		√
Washington		√		√				
West Virginia			√					
Wisconsin						√		√
Wyoming								√
Totals	**0**	**23 plus D.C. and Guam**	**13**	**13**	**2 plus D.C.**	**8**	**1**	**15**
Grand Totals	**23 plus D.C.**		**26**		**10 plus D.C.**		**1**	**15**

Forty-three states have had favorable medical marijuana laws at one point or another. Thirty-one of those states have had more than one type of medical marijuana law. California, for example, has both an effective law and a research law, while the District of Columbia's law was symbolic until Congress allowed it to go into effect. In addition to state laws, decisions in the Idaho Supreme Court and a Florida appellate court allow patients using marijuana for medical purposes to assert a necessity defense to marijuana charges in court. See Appendix L for more information.

TABLE 3:
Medical Conditions Approved for Treatment with Marijuana in the 23 States and One District with Medical Marijuana Laws

Specific Diseases

	Alaska	Ariz.	Calif.	Colo.	Conn.	Del.	D.C.	Hawaii	Ill.	Maine	M.D.	Mass.	Mich.	Minn.	Mont.	Nev.	N.H.	N.J.	N.M.	N.Y.	Oreg.	R.I.	Vt.	Wash.
Agitation of Alzheimer's disease		√	2			√	2		√	√	4	2	√				√ 6					√		
AIDS or HIV	√	√	√	√	√	√	√	√	√	√	4	√	√	√	√	√	√ 6	√ 5	√	√ 5	√	√	√ 5	√
ALS		√	2			√	2		√	√	4	√	√		√		√ 6	√	√ 1	√				
Cancer	√	√	√	√	√	√	√	√	√	√	4	√	√	√ 5	√	√	√ 6	√ 5	√	√ 5	√	√	√ 5	√
Crohn's disease		√	2		√		2		√	√	4	√	√	√	√		√ 6	√	√ 1	√				√ 5
Glaucoma	√	√	√	√	√		√	√	√	√	4	√	√	√	√	√	√ 6	√ 5	√		√	√		√ 5
Hepatitis C		√	2			3	2		√	√	4	√	√				√ 6		√ 1, 6			√		√ 5
Huntington's disease			2				2				4	2							√	√ 5				
Lupus			2				2		√		4	2					√ 6							
Muscular dystrophy			2				2		√		4	2					√ 6	√						
Multiple sclerosis			2		√		2		√		4	√			√		√ 6	√	√	√			√ 5	√
Nail Patella			2				2		√	√	4	2	√											
Parkinson's disease			2		√		2				4	√					√ 6		√	√ 5				
PTSD		√ 1	2		√	√	2	√		√	4	2	√ 1			√ 1			√ 1		√			√

Debilitating medical conditions or symptoms produced by those conditions

	Alaska	Ariz.	Calif.	Colo.	Conn.	Del.	D.C.	Hawaii	Ill.	Maine	M.D.	Mass.	Mich.	Minn.	Mont.	Nev.	N.H.	N.J.	N.M.	N.Y.	Oreg.	R.I.	Vt.	Wash.
Cachexia, anorexia, or wasting syndrome	√	√	√	√	√	√	2	√	√	√	√ [4]	2	√		√	√	√ [6]	√ [5]	√ 1, 5		√	√	√ [5]	√ [5]
Severe or chronic pain	√	√	√	√		√ [5]	2	√	8	√ [5]	√ [4]	2	√		√ [5]	√	√ 5, 6		√ 1, 5	12, 13	√	√ [5]	√ [5]	√ [5]
Severe or chronic nausea	√	√	√	√		√ [5]	2	√		√	√ [4]	2	√		√	√	√ [6]		√ 1, 5		√	√	√ [5]	√ [5]
Seizure disorders (e.g., epilepsy)	√	√	√	√	√	√ [5]	2	√		√	√ [4]	2	√	√	√	√	√ [6]	√ [5]	√	√	√	√	√ [5]	√ [5]
Muscle spasticity disorders (e.g., multiple sclerosis)	√	√	√	√	√ [5]	√	√	√	√	√	√ [4]	2	√	√	√ [5]	√	√ [6]	√ [5]	√	√	√	√		√ [5]
Allows addition of diseases or conditions by state health agency	√	√		√	√	√ [7]	√	√	√	√			√	√ [9]		√	√ [10]	√ [9]	√ 11, 12	√ 11	√ 14	√		√ [15]

[1] Condition added by state agency.

[2] In addition to the specific diseases and conditions listed, the law covers any condition for which treatment with medical marijuana would be beneficial, as determined by the patient's physician. In Massachusetts, the condition must also be debilitating.

[3] The law does not cover Hepatitis C itself, but instead covers decompensated cirrhosis, a condition that occurs at the end stage of the disease.

[4] The law covers any severe condition for which other medical treatments have been ineffective if the symptoms reasonably can be expected to be relieved by the medical use of marijuana.

[5] There are additional restrictions on this condition in this state, or the term used for the symptom or condition is more restrictive.

[6] This law requires providers to certify that the patient has both a qualifying disease and a qualifying symptom.

[7] In addition, the health department added autism with aggressive or self-injurious behaviors as a qualifying condition in November 2015.

[8] In addition, Illinois' law includes severe fibromyalgia, spinal cord disease, Tarlov cysts, hydromyelia, syringomyelia, rheumatoid arthritis, fibrous dysplasia, spinal cord injury, traumatic brain injury and post-concussion syndrome, Arnold-Chiari malformation and syringomyelia, spinocerebellar ataxia, myoclonus, dystonia, reflex sympathetic dystrophy, causalgia, complex regional pain syndromes type II, neurofibromatosis, chronic inflammatory demyelinating polyneuropathy, Sjögren's syndrome, interstitial cystitis, myasthenia, and residual limb syndrome.

[9] In addition, the law includes terminal illnesses. In Minnesota, the terminal illness must also cause a listed symptom. Minnesota's program also includes Tourette Syndrome, and, beginning on August 1, 2016, it will include intractable pain, which was approved by the health department in December 2015.

[10] The state health department may include a medical condition on a case-by-case basis if a provider certifies it is "severely debilitating or terminal."

[11] In addition to the specific diseases and conditions listed, the law covers certain patients admitted to hospice care.

[12] In addition to the specific diseases and conditions listed, the program covers inclusion body myositis, inflammatory autoimmune-mediated arthritis, damage to the nervous tissue of the spinal cord, painful peripheral neuropathy, Spasmodic Torticollis (Cervical Dystonia), Ulcerative Colitis, and certain patients admitted to hospice care.

[13] In addition, this program includes neuropathy.

[14] In addition, Oregon's law includes any "degenerative or pervasive neurological condition."

[15] In addition, a state agency added chronic renal failure/requiring hemodialysis as a qualifying condition.

TABLE 4: An Overview of State Medical Marijuana Dispensary Programs

State	How Dispensaries Are Selected	Number of Dispensaries	Separate Cultivators?	For-Profit or Not-for-Profit?	Taxes?
Alaska	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries
Ariz.	By lottery, if the applicant qualified, with one allowed per Community Health Analysis Area	Up to 126 allowed (one for every 10 pharmacies); about 90 dispensaries open as of fall 2015	No	Not-for-profit	Yes, subject to 5.6% sales tax plus local taxes
Calif.	The Department of Consumer Affairs will grant licenses beginning in 2018 when the formal state licensing process is expected to begin	Unknown, in the hundreds, possibly over 1,000	Yes, to be regulated by the Department of Food and Agriculture	They may be for-profit or not-for-profit	Medical marijuana is subject to 7.6 to 8.5% state and local sales taxes; some localities enacted additional business taxes
Colo.	Qualified applicants are granted state registrations; localities also may have their own licensing processes	515 "medical marijuana centers" as of fall 2015	There are separate grow licenses but they must have a partnership with a dispensary; there are currently 763 growers and 194 infused product makers	They may be for-profit	Medical marijuana is subject to 2.9% state tax and local sales taxes, but there is an exception for indigent patients
Conn.	The Department of Consumer Protection decides which applicants to approve	Six dispensaries open, three more expected in 2016	Yes, there are four producers and up to 10 are allowed	They may be for-profit	No, medical marijuana is exempt from state sales tax
Del.	The health department decides based on a merit-based application process	The law calls for three compassion centers but only one is currently open	No	Not-for-profit	Revenues above $1.2 million per year are subject to gross receipts taxes
D.C.	The health department selected applicants	Up to eight are allowed; five are open as of fall 2015	Yes, three are open as of fall 2015; more may be approved	They may be for-profit	Yes, 6% sales tax applies
Hawaii	The health department will issue licenses to eight entities (three on Oahu, two each on Big Island and Maui, and one on Kauai) with two locations each	Up to 16 are permitted	No; each dispensary license allows the license holder to have two cultivation sites	They may be for-profit or not-for-profit	General excise tax of 4.5% on Oahu and 4% on the other islands
Ill.	The state has issued licenses based on a merit-based application process	60 are allowed; eight have been approved so far, five of which opened in fall 2015	Yes, up to 22 are allowed	They may be for-profit	Yes, 7% excise tax at cultivator level and 1% sales tax
Maine	The health department selected applicants based on a merit-based application process	At least eight are allowed; eight are open as of fall 2015	Caregivers may sell two pounds per year of excess marijuana to dispensaries	Not-for-profit	Yes, subject to 5% sales tax; edibles subject to 7% meals and rooms tax

State	How Dispensaries Are Selected	Number of Dispensaries	Separate Cultivators?	For-Profit or Not-for-Profit?	Taxes?
Md.	The Maryland Medical Cannabis Coalition selects applicants	There will be two dispensaries for each of the 47 state Senate districts. In addition, each of the 15 cultivators may operate a dispensary.	Yes, 15 statewide	They may be for-profit or not-for-profit	Likely won't be taxed; Maryland's 6% sales tax does not apply to the sale of medicine
Mass.	The health department selects licensees based on a merit-based application process	Up to 35 are allowed; a few have opened as of fall 2015	No	Not-for-profit	No, medical marijuana is not subject to sales taxes
Mich.	State law does not provide for dispensaries, though some cities license them	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries
Minn.	The commissioner of health selected two manufacturers who may open up to four dispensaries	Two are open as of fall 2015; eight are allowed	No	They may be for-profit or not-for-profit	No
Mont.	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries	N/A – State law does not provide for dispensaries
Nev.	The state selected applicants based on a merit-based application process	The first dispensaries opened in summer 2015; 66 are allowed	Yes, there will be separate growers, infused product makers, and labs	They may be for-profit	Yes, 6.85 to 8.1% state and local sales taxes likely apply, along with two 2% excise taxes
N.H.	The health department selected applicants based on a merit-based application process	Four alternative treatment centers are allowed; they received preliminary approval as of fall 2015	No	Not-for-profit	No, N.H. does not have a sales tax
N.J.	The health department selected applicants	At least six alternative treatment centers are allowed; five are open as of fall 2015	No	The first six must be not-for-profit	Yes, subject to 7% sales tax
N.M.	The health department selected applicants	23 are open as of fall 2015; more are expected to be approved	No	Not-for-profit	Yes, subject to a gross receipts tax (5.125% to 8.8675% depending on location)
N.Y.	The health department selects applicants	None are open as of fall 2015; a total of 20 are allowed	No; five manufacturers are allowed with four dispensaries each	They may be for-profit or not-for-profit	7% excise tax
Ore.	The Oregon Health Authority approves qualified applicants	The law does not include a limit; 310 are open as of fall 2015	Yes, the dispensaries will distribute marijuana grown by patients and caregivers	The law does not specify	No, Oregon does not have a sales tax

State	How Dispensaries Are Selected	Number of Dispensaries	Separate Cultivators?	For-Profit or Not-for-Profit?	Taxes?
R.I.	The health department selected applicants based on a merit-based application process	Three compassion centers are allowed and all three are open	No; but compassion centers may dispense marijuana grown by patients or caregivers or by themselves	Not-for-profit	Yes, 7% sales tax applies, along with a 4% surcharge
Vt.	The health department selected applicants based on a merit-based application process	Four dispensaries are allowed; all four are open	No	Not-for-profit	No, it is not expected that marijuana will be subject to sales taxes
Wash.	There are no state-regulated dispensaries, but in 2016 adult use stores will be able to get medical marijuana endorsements	Dispensaries are not allowed, but adult use stores are and can get medical endorsements	Yes, for adult use, which can have a medical endorsement	I-502 businesses may be for-profit	Marijuana and marijuana products purchased by registered patients or caregivers are not subject to sales tax, but are subject to the 37% excise tax at the point of sale

TABLE 5: Numbers of Patients, Caregivers, and Dispensaries In Each Medical Marijuana State[1]

State	Patients enrolled in the program	Caregivers registered with the program	Dispensaries and other medical marijuana businesses
Alaska	745 cardholders (patients and caregivers)	106 cardholders (patients and caregivers)	N/A; dispensaries not included in law
Arizona	80,745	735	About 90 dispensaries are open
California	75,118 registered, many more not registered	7,240	Unknown, but in the hundreds or thousands; state licensing of dispensaries will begin by 2017
Colorado	113,862	3,083	515 medical marijuana centers, 194 infused product manufacturers, 763 growers
Connecticut	5,357	No data	6 dispensaries, 4 producers
D.C.	4,362	49	5
Delaware	340	No data	1
Hawaii	13,833	1,673	None; 16 permitted as of 7/2015
Illinois	2,800	No data	None open; 60 dispensaries and 22 growers allowed
Maine	24,377	2,073	Eight dispensaries are open
Maryland	N/A; not yet open	N/A; not yet open	None open
Massachusetts	13,607	554	At least three open; up to 35 dispensaries allowed
Michigan	173,495	33,004	N/A; dispensaries not included in law
Minnesota	567	49	Two open; two manufacturers with four dispensing locations each are allowed
Montana	12,672	459 providers	N/A; dispensaries not included in law
New Hampshire	N/A; not yet open	N/A; not yet open	None open; four dispensaries have preliminary approval
New Jersey	5,236	338	Five dispensaries are open
New Mexico	16,700	215	23 licensed producers; 12 more anticipated in 2016
New York	N/A; not yet open	N/A; not yet open	None open; five manufacturers with four dispensing locations each allowed
Nevada	10,019	714	At least three open in fall 2015; 66 allowed, plus growers, labs, and product makers
Oregon	76,723	36,754	310 dispensaries open in fall 2015
Rhode Island	12,099	3,232	Three dispensaries open
Vermont	2,056	230	Four dispensaries open
Washington	N/A; Optional registry is not yet open	N/A; Optional registry is not yet open	N/A; medical dispensaries not included specifically in law, but adult use stores will soon be able to apply for medical licensing

[1] Most of the numbers are current as of September 2015.

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Alaska	Nov. 3, 1998	March 4, 1999	Ballot Measure 8 (modified by S.B. 94, effective June 2, 1999)	S.B. 94 — Chapter 37, SLA 1999	§ 17.37	VIA	§ 11.71.160
Current Law:	Ballot Measure 8 removed state-level criminal penalties for medical marijuana use, possession, and cultivation. However, S.B. 94, which took effect June 2, 1999, made the state's medical marijuana registry program mandatory and removed the affirmative defense for patients (or their caregivers) who possess more marijuana than is permitted by the law.						
History:	A therapeutic research program — which was never operational — for cancer chemotherapy and radiology and glaucoma (statute § 17.35) was enacted in 1982 (session law § 5 Ch. 45). The law was repealed by Ch. 146 (1986). Details of the program included administration by the Board of Pharmacy and patient certification by a Patient Qualification Review Committee; the Board of Pharmacy was also permitted to include other disease groups if a physician presented pertinent medical data. As a Schedule VIA drug, marijuana has the "lowest degree of danger or probable danger to a person or the public."						
Ariz.	Nov. 2, 2010	Dec. 10, 2010	Proposition 203 (modified by H.B. 2585 and H.B. 2541 in 2011, H.B. 2349 in 2012, S.B. 1443 in 2013, and H.B. 2346 in 2015)	N/A	Ariz. Rev. Stat §§ 36-2801 to -2819	I	Ariz. Rev. Stat. § 36-2512
Current Law:	Proposition 203 removed state-level criminal penalties for medical marijuana use and possession, and in certain circumstances, for cultivation. It created a mandatory ID card program for patients and caregivers and also provided for a state-regulated and licensed nonprofit dispensary system.						
History:	On Nov. 5, 1996, 65% of Arizona voters passed Prop. 200 (Ariz. Rev. Stat. § 13-3412.01), a ballot initiative that made several drug policy changes including an inoperable provision that could have allowed medical marijuana if it was worded properly. The provision relied on a physician "prescribing" medical marijuana (a federal crime), as opposed to "recommending" it. Prop. 200 would have allowed physicians to prescribe any Schedule I drug to seriously ill patients, including heroin and LSD. In 1997, the legislature passed H.B. 2518, which repealed Prop. 200's provision on prescribing Schedule I drugs, by adding a condition prohibiting Arizona physicians from prescribing such drugs until the FDA approved their medical use. On Nov. 3, 1998, 64% of Arizona voters rejected H.B. 2518 in a referendum, thus preserving Prop. 200's symbolic medical marijuana provision. In addition, a law creating a medical marijuana (and THC) therapeutic cancer and glaucoma research program (§ 36-2601) — which was never operational — was enacted on April 22, 1980 (H.B. 2020: Ch. 122) and expired on June 30, 1985. Under the law, the director of the Department of Health Services was authorized to appoint a Patient Qualification Review Board, which was supposed to review patients and doctors for participation in the program. The University of Arizona was to obtain marijuana or THC from NIDA (National Institute on Drug Abuse). In 1981, S.B. 1023 (Ch. 264) moved the therapeutic research program provisions from § 36-1031 to § 36-2601. Arizona originally scheduled marijuana dually in Schedules I and II (provisionally). Ultimately, marijuana was solely scheduled in Schedule I and synthetic THC in Schedule III.						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)							
State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Calif.	Nov. 5, 1996	Nov. 6, 1996	Ballot Initiative, Proposition 215 (added to by S.B. 420, effective January 1, 2004) A.B. 266, A.B. 243, and S.B. 243, effective January 1, 2016	S.B. 420 — Chapter 875, Statutes of 2003	Cal. Health & Safety Code § 11362.5, et seq.	I	Cal. Health & Safety Code § 11054
Current Law:	Proposition 215 removed the state-level criminal penalties for medical marijuana use, possession, and cultivation. In 2003, S.B. 420 was passed, which provided some clarifications to the law and allowed nonprofit cooperative and collective patient gardens. While the 2003 law allowed limited exchanges of money for expenses and services performed by caregivers, it stopped short of providing substantive regulations and clear legal protections for businesses involved in medical marijuana-related activity. In 2015, three bills were passed by the California Legislature and signed by Gov. Jerry Brown. They will provide a regulatory framework including licensing for cultivators, processors, transporters, dispensaries, and other types of businesses. The regulatory authority has until 2018 to adopt new regulations and implement them. At that point, the collective/cooperatives system will be phased out. In addition, S.B. 847, which took effect in 1999, established the California Center for Medicinal Cannabis Research to research marijuana's safety and efficacy using federal marijuana.						
History:	From July 25, 1979, until June 30, 1989, a therapeutic research program — which was operational — for cancer and glaucoma existed (H & S § 11260 and H & S § 11480); enacted via S.B. 184, session law Ch. 300 (1979). The Research Advisory Panel coordinated research with marijuana and its derivatives; $100,000 was appropriated for the first year. Minor amendments by Ch. 374 (1980) and Ch. 101 (1983). H & S § 11260 would have expired on June 30, 1985, but the program was extended and modified slightly by Ch. 417 (1984); the program finally expired on June 30, 1989; § 11480 remains on the books.						
Colo.	Nov. 7, 2000	June 30, 2001	Ballot Initiative, Amendment 20 (modified by HB 1284, effective July 1, 2010)	HB 1284 – Chapter 355, Session Laws of Colorado, 2010	Constitutional Amendment 20, Article XVIII, Section 14; C.R.S § 12-43.3-101, 18-918-406.3, and 25-1.5-106 et seq.	N/A	§ 18-18-203
Current Law:	Amendment 20 removed state-level criminal penalties for medical marijuana use, possession, and cultivation. HB 1284, passed in 2010, set up clear licensing procedures and standards for for-profit retail dispensaries, cultivation centers, and marijuana-infused product manufacturers.						
History:	A therapeutic research program — which was never operational — for cancer and glaucoma (§ 25-5-901 to -907) was enacted and took effect on June 21, 1979 (H.B. 1042, Ch. 265). The program was administered by the Chancellor for Health Affairs at the University of Colorado Medical Center. The Pharmacy and Therapeutics Committee (PTC) of the medical board of Colorado General Hospital was charged with reviewing applicants and their practitioners and certifying their participation in the program. Additionally, the PTC could include other disease groups after reviewing pertinent data presented by a "practitioner," who was authorized to prescribe and administer drugs, and the chancellor would apply to receive marijuana from the National Institute on Drug Abuse (NIDA). If unable to obtain marijuana from NIDA, the chancellor would investigate the feasibility of using marijuana acquired from other sources, including seized marijuana that had been tested for impurities; $15,000 was appropriated for the program. In 1981, the program was amended by H.B. 1224 (Ch. 322), which stipulated that other disease groups could be included after pertinent data was presented by a "clinical researcher" who was licensed to experiment with, study, or test any dangerous drug within the state and who had an IND (Investigational New Drug) number issued by the FDA. The amendment also provided that the chancellor would apply to receive marijuana from the "federal government" rather than NIDA. The law was repealed by H.B. 95-1020 in 1995 (Ch. 71).						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Conn.	May 31, 2012	October 1, 2012	H.B. 5389	Public Act 12-55	Conn. Gen. Stat. Ann. § 21a-408 et seq.	II	Conn. Gen. Stat. Ann. § 21a-243-7 through 21a-243-11
Current Law:	H.B. 5389 removed state-level criminal penalties for medical marijuana use and possession for medical marijuana patients and possession for caregivers on behalf of patients. It also established a regulatory framework for dispensary facilities and cultivators.						
History:	Connecticut has had a symbolic medical marijuana law since July 1, 1981, which is still on the books at § 21a-246 and 21a-253. This law allows physicians licensed by the Commissioner of Consumer Protection to prescribe marijuana for glaucoma or to treat the effects of chemotherapy. The law makes no provision for the source of the marijuana supply and is separate and distinct from the more functional Act Concerning the Palliative Use of Marijuana.						
D.C.	November 3, 1998	July 27, 2010	Initiative 59 (modified by B18-622, effective July 27, 2010)	L18-0210	D.C. Code § 7-1671	III	D.C. Code § 48-902.08
Current Law:	B18-622 removed district-level criminal penalties for the use and possession of marijuana for medical purposes by qualifying patients and allowed regulated cultivation centers and dispensaries.						
History:	After it was passed in 1998, Congressional opponents immediately stepped in to prevent implementation of Initiative 59. Initially, Congressional opponents moved to prevent the counting of the votes, but after advocates sought and won a court victory allowing the ballots to be counted, the so-called "Barr Amendment," a provision in the District's annual Congressional appropriations bill named after sponsor and then-Congressman Bob Barr, prevented the District from using any funds to implement the act (Congress has control over all D.C. budget matters, including the use of local funds, not just federal funds as with the 50 states). That provision was removed in late 2009, and the D.C. Council soon after passed B18-622 which narrowed the law by, among other things, shortening the list of qualifying conditions (to just cancer, HIV/AIDS, glaucoma, and multiple sclerosis), preventing home cultivation, and mandating that patients may only use marijuana obtained from a D.C. dispensary. In 2014, the D.C. Council passed legislation to allow physicians to recommend medical marijuana for "any condition for which treatment with medical marijuana would be beneficial, as determined by the patient's physician."						
Del.	May 13, 2011	July 1, 2011	SB 17	78 Del. Law c. 23 (2011)	Del. Code Ann. tit. 16, § 4901A et seq.	I	Del. Code Ann. tit. 16, § 4714
Current Law:	SB 17 removed state-level criminal penalties for medical marijuana use and possession and provided extensive civil protections against discrimination based on patient status. It created a mandatory ID card program for patients and caregivers and also provided for a state-regulated and licensed nonprofit dispensary system. This is Delaware's first medical marijuana law of any kind.						
Hawaii	June 14, 2000	June 14, 2000	S.B. 862 added to by H.B. 321 and S.B. 1291 (both effective July 14, 2015)	Act 228 (2000), Act 242 (2015)	§ 329-121	I	§ 329-14
Current Law:	In 2000, S.B. 862 removed state criminal penalties for patient use of medical marijuana. The law was revised in 2015, including to allow civil protections and a system for regulated access. Patients are now allowed to possess from three to four ounces and seven plants at any stage. Eight licenses will be awarded, with two dispensaries allowed per license.						
History:	S.B. 862 was the first law of this nature to be enacted by a state legislature, rather than by a ballot initiative. (Other legislatures had enacted research laws and symbolic laws relating to marijuana scheduling or prescriptive access.) This was Hawaii's first medical marijuana law of any kind.						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Ill.	August 1, 2013	January 1, 2014	H.B. 1	98-2716	410 ILCS 130/1 et seq., 720 ILCS 550/11, 550/15 and 77 IAC Ch. X, Sec. 2085	N/A	720 ILCS 570/206 and 77 IAC Ch. X,Sec. 2070
Current Law:	H.B. 1 removed state-level criminal penalties for medical marijuana possession and use by qualified, registered patients. The law, which creates a four-year pilot program, establishes a regulatory framework for dispensaries and cultivation facilities.						
History:	Illinois established a Therapeutic Research Program on September 9, 1978 that was never operational but still exists in state statute at 720 ILCS 550/11. The program was established for glaucoma and cancer chemotherapy and radiology or other procedures. It allows persons "engaged in research" to use marijuana when authorized by a physician; must be approved by the Department of Mental Health and Developmental Disabilities. The law also encourages research on cannabis to "establish methods to assess accurately the effect of cannabis" and to create related research programs.						
Maine	Nov. 2, 1999	Dec. 22, 1999	Referendum Election Ballot Question 2 (Modified by LD 611, effective April 1, 2002; Question 5, Nov. 3, 2009; LD 1811, effective April 9, 2010; LD 1296, effective Sept. 27, 2011; and LD 480, LD 1062, LD 1404, LD 1423, LD 1462, and LD 1531 effective Sept. 17, 2013)	Laws of Maine 1999, Initiated Bill Ch. 1 L.D. 611 — Laws of Maine 2001, Chapter 580 Question 5 – Laws of Maine 2009, Initiated Bills, Chapter 1 LD 1811 – Laws of Maine 2009, Chapter 631 LD 1296 – Public Law, Chapter 407	22 MRSA § 2383-B	Z	17-A MRSA § 1102
Current Law:	Question 2 removed state-level criminal penalties for medical marijuana use, possession, and cultivation. L.D. 611, effective April 1, 2002, clarified protections for patients and caregivers and increased the amount of usable marijuana a patient may possess. Question 5 added qualifying conditions, allowed for the establishment of eight medical marijuana dispensaries in the state, and established a registry system for patients and caregivers. LD 1296, among other things, made registration optional for patients, as well as caregivers whose patients are family or household members.						
History:	A therapeutic research program — which was never operational — for glaucoma and cancer chemotherapy (22 § 2401-2410) was enacted on Sept. 14, 1979 (H.B. 665, Ch. 457). The program expired in 1981, but an almost identical law reinstated the program on Sept. 23, 1983 (H.B. 1025, Ch. 423, 22 § 2411-2420). That law, which expired on Dec. 31, 1987, had authorized a research program within the Department of Human Services to use federal marijuana or, if necessary, marijuana confiscated by state law enforcement agencies; a Participation Review Board would approve physicians. Controlled substances are in Schedules W, X, Y, and Z, which determine the severity of penalties for possession, manufacture, and distribution of these substances. The schedules make no statement as to the medical value of the controlled substances.						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Md.	April 4, 2014	June 1, 2014	HB 881/SB 923 (2014); HB 490 (2015)	Chapter 240 (2014); Chapter 251 (2015)	Md. Code Ann., § 13-3301 — §13-3316	I	Md. Code Ann., Criminal Law § 5-402(c)
Current Law:	HB 881/SB 923, as amended by HB 490, removed state-level criminal penalties for the use and possession of marijuana for medical purposes by certified patients. It also establishes a regulatory framework for medical marijuana producers and dispensaries.						
History:	Prior to passage of legislation establishing an effective medical marijuana program, Maryland was considered to have a "workable" law. Beginning in 2003, individuals could present evidence of a medical necessity during sentencing for possession and, if accepted, have their sentences reduced to a $100 fine with no possibility of jail. This law was modified in 2011 to allow certain patients to assert the medical use of marijuana as a defense, meaning they would be found not guilty. In 2013, the legislature enacted HB 1101, which sought to allow teaching hospitals to create programs to distribute medical marijuana to patients. This law was similar to the ineffective "therapeutic research law" and was amended the following year to create a workable medical marijuana law.						
Mass.	Nov. 6, 2012	Jan. 1, 2013	Question 3		Mass. Gen. Laws ch. 94C § 1-2 to 1-17	D	Mass. Gen. Laws ch. 94C § 31
Current Law:	The Department of Public Health is tasked with approving and regulating dispensaries. Fifteen provisional certificates were issued to dispensary applicants in 2014, and the Department may approve as many additional applicants as it deems appropriate.						
History:	On Dec. 31, 1991, Massachusetts passed a therapeutic research law for cancer chemotherapy, radiation, glaucoma, and asthma. It was never operational, but remains on the books beginning at 94D § 1. On August 8, 1996, the Massachusetts Legislature passed a medical marijuana bill (H. 2170), which mandated that within 180 days the state's public health department must establish the rules and regulations necessary to get its therapeutic research program running and to allow a defense of medical necessity for enrolled patients. Rules were established, but federal permission for research was never obtained.						
Mich.	Nov. 4, 2008	December 4, 2008	Ballot initiative, Proposal 1	N/A	MCL § 333.26421-26430	I	333.7212; MAC 338.3114 and 338.3119a (1986 Annual Supplement); MAC 338.3113 (1988 Annual Supplement)
Current Law:	The Michigan Medical Marihuana Act removed state-level criminal penalties for medical marijuana use, possession, and cultivation.						
History:	On Oct. 22, 1979, a law was enacted to allow patients with glaucoma and cancer chemotherapy to use medical marijuana. It also allowed patients with other diseases to use THC or marijuana if they had an IND (Investigational New Drug) permit from the FDA. It also authorized patients to use marijuana confiscated by state law enforcement agencies (which almost certainly never happened). The program was operational and used federal marijuana and was administered by the Department of Public Health. The law expired on November 1, 1982. A month later, a nearly identical law was enacted, which expired on November 1, 1987.						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)							
State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Minn.	May 29, 2014	May 30, 2014	SF 2470 (2014)	Chapter 311 (2014)	Minn. Stat Ann. §§ 152.21-152.37	I	Minn. Stat. Ann. § 152.02
Current Law:	SF 2470 removed state-level criminal penalties for the use and possession of marijuana products for medical purposes by certified patients and established a regulatory framework for medical marijuana manufacturers who will also dispense medical marijuana products. Minnesota law does not allow patients to use marijuana flowers; they are only allowed to use liquids, oils, and pills made of marijuana, including whole plant extracts and resins.						
History:	Prior to enactment of SF 2470 in 2014, Minnesota had enacted a therapeutic research act. The program was initially appropriated $100,000, but this appropriation was line-item vetoed by the governor. The program was never operational.						
Mont.	Nov. 2, 2004	Nov. 2, 2004	Initiative 148 (modified by S.B. 423, effective July 1, 2011)	2011 Mont. Laws 419 (S.B. 423)	M.C.A. §50-45-301 et seq.	I	MCA § 50-32-222
Current Law:	Initiative 148 removed state-level criminal penalties for medical marijuana use, possession, and cultivation and created a mandatory ID card program for patients and caregivers. S.B. 423 significantly restricted Montana's medical marijuana law. It made it much more difficult for pain patients to get recommendations and invalidated out-of-state ID cards, allowed caregivers only to serve three patients and prohibited them from receiving compensation, banned all advertising, and required physicians that make more than 25 medical marijuana recommendations per year to pay for an automatic Board of Medical Examiners investigation into their practice. The constitutionality of several provisions of S.B. 423 is still being decided in a state court case, *Montana Cannabis Industry Association, et al. v. Montana*, and, as a result, some provisions have not gone into effect.						
History:	Montana's symbolic law — §50-32-222(7) — was enacted on March 26, 1979. It would automatically reschedule THC and marijuana to Schedule II if the federal government authorizes the prescription or administration of these substances.						
N.H.	July 23, 2013	July 23, 2013	HB 573	Chapter 242	RSA Chapter 126-W	I	RSA 318-B:1-a
Current Law:	HB 573, which is one of the most restrictive medical marijuana laws in the country, removed state-level penalties for medical marijuana use and possession for patients and caregivers who are registered with the state. It created a mandatory ID card program for patients and caregivers and also provided for a state-regulated and licensed system of up to four dispensaries, called alternative treatment centers.						
History:	In 1981, the legislature enacted a symbolic law allowing medical marijuana for cancer chemotherapy and radiology. It was amended by HB 1563 (enacted June 8, 1998; took effect Jan. 1, 1999), which says doctors may prescribe marijuana only if it is approved by the FDA; previously doctors could prescribe it without FDA approval, but the absence of a legal supply made the law ineffective. This symbolic law remains on the books at RSA 318-B:9 (VI).						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
N.J.	January 18, 2010	October 10, 2010	S. 119 (modified by S. 2842, effective Sept. 10, 2013)	2009 N.J. Laws c. 307	N.J. Stat. Ann. § 24:6I and § 45:1-45.1	I	N.J. Stat. Ann. § 24:21-5 and N.J. Admin. Code § 8:65-10
Current Law:	S. 119, which is one of the most restrictive medical marijuana laws in the country, removed state-level criminal penalties for medical marijuana use and possession. It created a mandatory ID card program for patients and caregivers and also provided for a state-regulated and licensed system with six or more dispensaries, called alternative treatment centers. The law was amended by A. 3104 in 2012 and S. 2842 in 2013.						
History:	On March 23, 1981, the New Jersey Legislature enacted A.B. 819 (Ch. 72 1981), a law creating a medical marijuana therapeutic research program (§ 26:2L) — which was never operational. Under the law, patients with life- or sense-threatening diseases participating in research programs conducted by the FDA were eligible to join a state therapeutic research program to receive any Schedule I substance (not specific to marijuana). The Department of Health was to administer the program, and a Therapeutic Research Qualification Board was to certify patients and physicians. The Schedule I substances were to come from NIDA (National Institute on Drug Abuse).						
N.M.	April 2, 2007	July 1, 2007	SB 523	Ch. 210 (2007)	NMSA § 26-2B-1-7	I (II for purposes of the Lynn and Erin Compassionate Use Act)	§ 30-31-6, 7 NMSA
Current Law:	SB 523 removed state-level criminal penalties for the use, possession, or cultivation of marijuana for medical purposes. It also allowed non-profit producers to register to cultivate marijuana for patients.						
N.Y.	July 5, 2014	July 5, 2014	A 6357/S 7923	N.Y. Sess. Laws Ch. 90 (2014).	N.Y. Pub. Health Law § 3360-69, 3371	I	N.Y. Pub. Health Law § 3306(d)(13), (21)
Current Law:	New York's Compassionate Care Act was signed by Gov. Andrew Cuomo on July 5, 2014. The law will protect certain seriously ill patients who use marijuana pursuant to their doctors' advice from civil and criminal penalties. Patients will not be allowed to smoke medical cannabis, the law will sunset after seven years, and there will be no more than five manufacturers — with a total of up to 20 locations — in the entire state.						
History:	In 1980, the legislature enacted the Controlled Substances Therapeutic Research Act. The program was operational and covered cancer, glaucoma, and other life- and sense-threatening diseases approved by the commissioner. In 1981, the name of the "controlled substances therapeutic research program" was changed to the "Antonio G. Olivieri controlled substances therapeutic research program" by Ch. 208 (1981).						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)							
State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Nev.	June 14, 2001	Oct. 1, 2001	Question 9 passed in 1998 and 2000; A.B. 453 passed the legislature in 2001 (modified by A.B. 519, effective July 1, 2005 and modified by S.B. 374, most of which became effective April 1, 2014)	Statutes of Nevada 2001, Ch. 592	Title 40-Ch. 453A of NRS, and Art. 4, Sec. 38 of the Nevada Constitution	I	453.510 NAC
Current Law:	Question 9, an initiative on the ballot in 1998 and 2000, amended the state constitution to require the legislature to implement a medical marijuana law. It was mostly implemented by A.B. 453, which removed state-level criminal penalties for medical marijuana use, possession, and cultivation. S.B. 374, which passed in 2013, allows medical marijuana dispensaries, cultivators, infused product manufacturers, and laboratories.						
History:	A therapeutic research program — which was never operational — for glaucoma, cancer chemotherapy, and other approved conditions (453.740 - 453.810 and 453.740 NAC) was enacted on June 2, 1979 (S.B. 470, Ch. 610). It was administered by the Health Division of Department of Human Services and a Board of Review for Patients. The law was repealed by A.B. 695 in 1987 (Ch. 417).						
Ore.	Nov. 3, 1998	Dec. 3, 1998	Ballot Measure 67 (modified by H.B. 3052, effective July 21, 1999; S.B. 1085, effective Jan. 1, 2006; and H.B. 3460, effective Aug. 14, 2013)	Oregon Laws 1999, Ch. 4 H.B. 3052 — Oregon Laws 1999, Ch. 825	475.300	II	475.035 and OAR 855-080-0022
Current Law:	Measure 67 removed state-level criminal penalties for medical marijuana use, possession, and cultivation. Minor amendments were made via H.B. 3052, which took effect July 21, 1999. It mandates that patients may not use medical marijuana in a correctional facility; limits patients and caregivers to growing marijuana at one location each; requires that a patient be diagnosed within 12 months prior to arrest to assert an affirmative defense; and relieves police from the responsibility to maintain live marijuana plants while a case is pending. S.B. 1085, passed by the legislature in 2005, increases the limits to 24 plants — six of which may be mature — and 24 ounces of dried marijuana per patient or caregiver. However, the bill eliminates the affirmative defense for going over these limits. The law was once again modified in 2013 by H.B. 3460, which establishes a registration system for medical marijuana facilities that can transfer both usable marijuana and immature marijuana plants to registered patients and caregivers.						
History:	A law to allow physicians to prescribe marijuana for cancer chemotherapy and glaucoma (§ 475.505) was enacted on June 18, 1979 (H.B. 2267, Ch. 253). Oregon State Police could make confiscated marijuana available to the Health Division to test it for contaminants; if marijuana were found to be free of contaminants, the Health Division could make marijuana available to physicians upon written request; patients who are prescribed such marijuana could possess less than an ounce. In 1980, the Health Division received federal permission to distribute marijuana, pursuant to the statute, and a federal supply of marijuana; however, it is unlikely that distribution ever occurred. The law was repealed by S.B. 160 in 1987 (Ch. 75).						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
R.I.	Jan. 3, 2006 and June 21, 2007	Jan. 3, 2006 and June 21, 2007	H 6052 and S 710 (2006); H 6005 and S 791 (2007); H 5359 and S 185 (2009); modified by S 2555, effective May 23, 2012	Ch. 72 & 475, Laws of 2007; Ch. 16, Laws of 2009	RISA § 21-28.6-1 et seq.	I	RISA § 21-28-2.08
Current Law:	The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act removed state-level penalties for medical marijuana use, possession, and cultivation for patients and their caregivers who are registered with the state. Amendments made to the law in 2009 created three, state-registered and licensed medical marijuana dispensaries, called compassion centers. Amendments were again made in 2012 to assuage fears Gov. Lincoln Chafee had that federal government would interfere if the existing compassion center program was implemented. The law was amended to allow compassion centers to possess no more than 150 marijuana plants (only 99 of which may be mature) and 1,500 ounces of usable marijuana. To ensure supply, the law also allows patients and caregivers to sell excess medicine that they grow to the compassion centers. The law was amended again to remove the compassion center cultivation and possession caps. Qualified patients are still allowed to sell excess medicine to compassion centers.						
History:	A therapeutic research program — which was never operational — for patients with life- or sense-threatening conditions was enacted in 1980 by H.B. 79.6072 (Ch. 375) and amended in 1986 (by 86-H 7817, Ch. 236) to expand the law from patients with specified disease groups to patients with "life- or sense-threatening conditions" and to delete references to Patient Qualification Review Board. The program would have been administered by the director of the Department of Health.						
Vt.	May 26, 2004	July 1, 2004	S.76 (modified by S.7, effective July 1, 2007, by S.17, effective June 2, 2011, and again by S.247, effective July 1, 2014)	Act No. 135 (2004)	18 VSA § 4471 et seq.	N/A	N/A
Current Law:	S.76 removed state-level penalties for medical marijuana use, possession, and cultivation for patients and their caregivers who are registered with the state. Initially, registration was permitted only for people diagnosed with AIDS, cancer, multiple sclerosis, or HIV. S.7, effective July 1, 2007, expanded the definition of "debilitating medical condition" by adding conditions and treatments that cause cachexia or wasting, severe pain, severe nausea, or seizures. S.7 also increased the number of plants a patient or caregiver can possess and allowed doctors licensed to practice in New Hampshire, Massachusetts, and New York to recommend marijuana to their Vermont patients. S.17, passed in 2011, allowed for the establishment of four non-profit medical marijuana dispensaries. Patients may only purchase medical marijuana at their designated dispensaries, and the number of plants dispensaries can cultivate is dependent on the number of patients who have designated that dispensary. S.17 also allowed physician assistants and advanced practice registered nurses to certify patients for the program. S.247, passed in 2014, allowed naturopaths to certify patients and allowed dispensaries to deliver to qualifying patients.						
History:	On April 27, 1981, the Vermont Legislature passed H. 130 (Act No. 49, session law 18 VSA § 4471), which allowed physicians to prescribe marijuana for cancer and other medical uses as determined by the commissioner of health. The program was administered by the Department of Health. Called a "research program," H. 130 allowed physicians to prescribe marijuana and provided that "[the] commissioner of health shall have the authority to obtain … cannabis administered under this program."						

Appendix A, States With Effective Medical Marijuana Laws (Removal of Criminal Penalties and Access)							
State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Wash.	Nov. 3, 1998	Nov. 3, 1998	Initiative Measure No. 692; SB 6032 (2007); SB 5798 (2010); SB 5073 (2011); SB 5052 (2015)	1999 c 2 §1; Chapter 181, Laws of 2011; Chapter 70, Laws of 2015	RCW 69.51A	I	69.50.204 and WAC 246-887-100

Current Laws: Measure 692 created an affirmative defense at trial against charges of marijuana use, possession, and cultivation by patients and caregivers. SB 5073, passed by the legislature in 2011 and partially vetoed by Gov. Gregoire, explicitly allowed patients and caregivers to collectively grow their medicine, but made caregivers wait for 15 days between assisting two different patients. Passage of SB 5798 in 2010 allowed physician's assistants, osteopathic physician's assistants, naturopaths, and advanced registered nurse practitioners to legally recommend marijuana to their patients. SB 5052 (2015) creates a voluntary patient registry and exempts patients and caregivers who register from arrest and prosecution if in possession of a registry card. Those who do not register still have an affirmative defense available. SB 5052 also deceased possession limits for patients and caregivers, but gave retail marijuana shops the ability to apply for a medical marijuana endorsement, which will allow them to sell greater quantities of marijuana to registered patients as well as discuss the medical benefits of marijuana.

History: A therapeutic research program – which was operational – for cancer chemotherapy and radiology, glaucoma, and other disease groups (RCW 69.51) was enacted on March 27, 1979 (H.B. 259, Ch. 136) and remains on the books. Program administered by Board of Pharmacy and Patient Qualification Review Committee; "Board shall obtain marijuana through whatever means it deems most appropriate and consistent with regulations promulgated by federal government;" "board may use marijuana which has been confiscated by local or state law enforcement agencies and has been determined to be free from contamination."

There was dual scheduling for marijuana and every compound (including THC – tetrahydrocannabinol, the primary active ingredient) in the marijuana plant; an amendment in 1986 (Ch. 124) removed the dual scheduling of marijuana and THC.

On March 30, 1996, Washington enacted a 1996 supplemental operating budget allocating $130,000 for two medical marijuana-related projects: $70,000 to research a tamper-free means of cultivating marijuana for medical purposes and $60,000 to research the therapeutic potential of marijuana. Research, however, was never conducted, and the $60,000 appropriation expired.

States with Workable Low-THC Laws

State	Low-THC Law Approved	Took Effect	Bill/Initiative #	Citation for Low-THC Law	Marijuana Schedule	Citation for Schedules
Mo.	July 14, 2014	July 14, 2014	HB 2238	Mo. Rev. Stat. §§ 192.945, 195.207, 261.265	I	Mo. Rev. Stat. § 195.017
Current Law:	Directs the Department of Agriculture to regulate nonprofit producers of low-THC "hemp oil," which must contain no more than 0.3% THC and at least 5% cannabidiol (CBD). The Department of Health and Senior Services issues cards authorizing qualified patients with intractable epilepsy to obtain, possess, and use the oil. Patients may not grow their own medicine.					

States with Flawed Low-THC Laws

State	Low-THC Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Low-THC Law	Marijuana Schedule	Citation for Schedules
Ala.	April 2, 2014	July 1, 2014	SB 174		Act No. 2014-277 Ala. Code § 13A-12-214.2; Ala. Code § 20-2-110 to -120	I	Ala. Code § 20-2-23(3) and Ala. Admin. Code r. 420-7-2
Carly's Law provides an affirmative defense for possession of CBD oil to patients with debilitating epileptic conditions who have a prescription from the University of Alabama at Birmingham (UAB). It defines CBD extracts as having less than 3% THC. The law also includes $1 million for a CBD oil study at UAB, through which patients receive CBD oil. As of late 2015, Carly's Law is set to expire July 1, 2019. Carly's Law includes a research program and is listed above under "States with Medical Marijuana Research Laws" along with an older research law.							
Fla.	June 16, 2014	June 16, 2014	SB 1030		Fla. Stat. §§ 381.986, 385.211, 385.212, 893.02, 1004.441	I	Fla. Stat. § 893.03
Current Law:	The "Compassionate Medical Cannabis Act of 2014" allows specified physicians to issue orders for certain patients, allowing them to use low-THC cannabis, which is defined as having no more than 0.8% THC and more than 10% CBD. It requires the Department of Health to create a registry of patients and to authorize five organizations to grow and dispense the cannabis. Requiring doctors to issue "written orders" rather than recommendations or certifications could put them at risk under federal law.						
History:	In 1978, the Florida Legislature enacted the Therapeutic Research Program, which was never operational. The program would have required federal permission and would have involved pharmacies dispensing marijuana to cancer and glaucoma patients. It was repealed in 1984.						
Ga.	March 25, 2015	April 16, 2015	H.B. 1	No. 20 (2015)	Ga. Code § 16-12-190; § 16-12-191	I	Ga. Code § 16-25-25
Current Law:	Haleigh's Hope Act protects certain individuals who possess up to 20 ounces of "low THC oil" — cannabis oil which contains less than 5% THC. Individuals must be registered in the state registry and have one of these conditions: Seizure disorders, cancer, ALS, multiple sclerosis, Crohn's disease, mitochondrial disease, Parkinson's disease, and sickle cell disease. The law is considered flawed because it does not establish any lawful means for low-THC oil to be produced or distributed. Georgia also has a therapeutic research law, which is listed later in this appendix.						

States with Flawed Low-THC Laws

State	Low-THC Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Low-THC Law	Marijuana Schedule	Citation for Schedules
Iowa	May 30, 2014	July 1, 2014	SF 2360		Iowa Code § 124.401	I*	Iowa Code §§ 124.204, 124.206
Current Law:	*Iowa has a dual scheduling scheme for marijuana and THC, which are in Schedule I but are considered to be in Schedule II when used for medical purposes. Iowa's law provides a complete defense to criminal charges for card-carrying patients with intractable epilepsy, including minors. It covers use or possession of marijuana products with no more than 3% THC and essentially no plant material. The law does not provide for in-state production of cannabis or cannabis extracts.						
History:	A June 1, 2017 law appropriated $247,000 to the Board of Pharmacy Examiners, contingent upon the Board of Pharmacy Examiners establishing a therapeutic research program within 90 days of the effective date of the act (July 1, 1979). The board was mandated to organize a Physicians Advisory Group to advise the board on the structure of the program — which was never operational. Scheduling information was originally located at § 204.204 but was moved to § 124.204 in 1993 by the Iowa Code Editor. No disease groups were specified in the bill. The dual scheduling scheme still exists in the statutes, but the language for the therapeutic research program — Administrative Code 620-12 — was active from October 1, 1979, to June 30, 1981, and was removed on January 20, 1987. On February 17, 2010, following an activist lawsuit and hearings, the Iowa Board of Pharmacy decided that marijuana has medical value and recommended that the legislature end the dual scheduling and reschedule marijuana solely to Schedule II. It recommended that it form a task force to study how to administer a medical marijuana program. As of this printing, the legislature has not taken action.						
Ky.	April 10, 2014	April 10, 2014	S.B. 124		Ky. Rev. St. 218A.010	I	Ky. Rev. St. Chapter 218A and 902 KAR 55:020
Current Law:	Exempts from the definition of "marijuana" drugs used in FDA-approved studies or compassionate use programs and the substance cannabidiol when recommended by a physician practicing at a state research hospital. The law fails to provide a source for CBD and relies on a "written order" which would violate federal law absent federal approval.						
Miss.	April 17, 2014	April 17, 2014	HB 1231		Miss. Code Ann. §41-29-113, 119, 176	I	Miss. Code Ann. § 41-29-113
Current Law:	"Harper Grace's Law" provides an affirmative defense to patients who suffer from a debilitating epileptic condition (and their parents, guardians, or custodians) for the use and possession of marijuana extracts that contain more than 15% of cannabidiol (CBD) and no more than 0.5% THC. It also removes such extracts from the state's Controlled Substances Act. Patients' use of the oil must be pursuant to a physician's order. The law provides no realistic source for obtaining the extracts. CBD oil must be dispensed by the University of Mississippi's Department of Pharmacy Service, which would violate federal law. Only three entities, all affiliated with universities, could possess or produce cannabis oil.						

States with Flawed Low-THC Laws

State	Low-THC Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Low-THC Law	Marijuana Schedule	Citation for Schedules
N.C.	July 3, 2014, July 17, 2015	July 3, 2014, August 1, 2015	H.B. 1220 (2014), H.B. 766 (2015)	2014-53, 2015-154	N.C. Gen Stat. Article 5G § 90-113.100	VI	N.C. Gen Stat. § 90-94
Current law:	The North Carolina Epilepsy Alternative Treatment Act exempts certain individuals with intractable epilepsy from criminal penalties for using and possessing hemp extracts, which must have less than 1% THC content and at least 5% CBD. An earlier version of the law, enacted in 2014, required neurologists to be affiliated with a university study in order to recommend the treatment, and it was limited to 0.3% THC. The law does not allow in-state production of hemp extracts.						
History:	H.B. 1120 (SL 2014-53) proposed a pilot study program and registry to investigate the safety and efficacy of hemp extract in the treatment of intractable epilepsy. Meanwhile, a 1979 law allowed physicians to dispense or administer tetrahydrocannabinols pursuant to rules adopted by the state drug commission. It was de facto repealed by a 1987 law that allowed physicians only to administer dronabinol (synthetic THC).						
Okla.	April 30, 2015	April 30, 2015	HB 2154		Okla. Stat. tit. 63, § 2-101, 2-801 to 805	I	Okla. Stat. tit. 63, § 2-204
Current Law:	"Katie's Law" provides limited legal protections for seriously ill patients who possess and use CBD oil with no more than 0.3% THC and who have a physician's written recommendation. It covers only severe forms of epilepsy and does not protect those under 18 years old. There is no provision for in-state access to the oil.						
S.C.	June 2, 2014	June 2, 2014	S. 1035	Act No. 221 (2014)	S.C. Code Ann. §§ 44-53-110, 44-53-1810 to 1840.	I	S.C. Code Ann. § 44-53-160, -190
Current Law:	The law exempts a limited class of individuals with severe forms of epilepsy from criminal penalties for using and possessing marijuana products with no more than 0.9% THC. There is no in-state producer, although it's possible that patients and caretakers may be allowed to cultivate. Federally approved clinical trials (which do not require state approval) are also allowed. South Carolina also has a research law listed under "States with Medical Marijuana Research Laws."						
Tenn.	May 4, 2015	May 4, 2015	SB 280		Tenn. Code Ann. §§ 39-17-402	VI	Tenn. Code Ann. §§ 39-17-415
Current Law:	There is no in-state access or production. Patients may possess CBD oils with no more than 0.9% THC if they have "a legal order or recommendation" for the oil. In addition, Tennessee Tech could cultivate marijuana, process it into oil, and dispense it to qualified patients, but it is unlikely to break federal law.						
History:	In 1981, HB 314 created a therapeutic research program — which was operational — for cancer chemotherapy or radiology or glaucoma (marijuana or THC). The program was administered by a Patient Qualification Review Board within the Board of Pharmacy, which was authorized to contract with the federal government for marijuana. The program was repealed by SB 1818 in 1992.						
Texas	May 20, 2015	June 1, 2015	S.B. 339	Chapter 301 (2015)	Tex. Health & Safety Code § 487.001 - § 487.201	I	Tex. Health & Safety Code §481.032 and §481.038 and 37 TAC §13.1
Current Law:	The Texas Compassionate Use Act is intended to allow some qualifying patients to access "low-THC cannabis" with 10% or more cannabidiol (CBD) and not more than 0.5% tetrahydrocannabinol (THC). Regulated "dispensing organizations" are authorized to cultivate, process, and distribute low-THC cannabis to certain patients. The law is considered flawed because physicians must "prescribe" low-THC cannabis, which places prescribing doctors at risk. Texas also has a therapeutic research law.						
History:	Texas also has a research law listed under "States with Medical Marijuana Research Laws."						

States with Flawed Low-THC Laws

State	Low-THC Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Low-THC Law	Marijuana Schedule	Citation for Schedules
Utah	March 20, 2014	July 1, 2014	H.B. 105	2014 Chapter 25	Utah Code Ann. §26-55-102	1	Utah Code Ann. §58-37-4
Current law:	H.B. 105 allows individuals suffering from intractable epileptic disorders to legally possess and use CBD oils if certified to do so by their neurologists. Cannabis extracts must have a certificate of analysis from a testing lab in the state where they originated, and the lab must transmit the certificate to the Utah Department of Health.						
Va.	Feb. 26, 2015	Feb. 26, 2015	HB 1445	HB1445ER	Va. Code Ann. § 18.2-250.1	1	§ 18.2-250.1
Current law:	HB 1445 provides an affirmative defense to patients who suffer from intractable epilepsy (and, for minors, their parents or legal guardians) for the possession of marijuana extracts that contain at least 15% of either cannabidiol (CBD) or THC-A and no more than 5% THC. The law provides no in-state source for obtaining extracts.						
History:	On March 27, 1979, a law was approved allowing physicians to prescribe and pharmacists to dispense marijuana and THC to cancer and glaucoma patients. The symbolic law — which depends on doctors and pharmacies breaking federal law or on federal law changing — remains on the books.						
Wisc.	April 16, 2014	April 16, 2014	AB 726		Wis. Stat. §§ 961.14, 961.34, 961.38	I	Wis. Stat. §§ 961.14
Current Law:	Individuals with seizure disorders are exempt from criminal penalties for using and possessing CBD if the medicine has no psychoactive effect. It is unclear whether non-psychoactive extracts with trace amounts of THC would be covered. The law authorizes physicians who have FDA approval and pharmacies with an FDA-issued investigational drug permit to dispense CBD, meaning it would not help patients until federal policies change. Patients could also obtain CBD oil from another state that allows out-of-state patients, but no bordering states allow dispensing to visiting patients.						
History:	On April 20, 1988, the Wisconsin Legislature approved a law allowing medical marijuana prescriptions in accordance with federal investigational new drug permits. The symbolic law, which is still on the books, gives the Controlled Substances Board the authority to set up regulations.						
Wyo.	July 1, 2015	July 1, 2015	HB 32		Wyo. Stat. Ann. §§ 35-7-1063, 1801 to 1803	I	Wyo. Stat. Ann. §§ 35-7-1023
Current Law:	Registered individuals with intractable epilepsy or seizure disorders are exempted from certain criminal penalties for the use and possession of "hemp extracts" with less than 0.3% THC and at least 5% CBD. Registration cards are issued to qualified applicants. Does not provide for in-state cultivation of marijuana or production of hemp oil.						

States with Medical Marijuana Research Laws (Therapeutic Research Programs)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Ala.	July 30, 1979 and April 2, 2014	July 30, 1979 and July 1, 2014	S. 559 (1979) and SB 174 (2014)	Acts No. 79-472 and 2014-277	Ala. Code § 13A-12-214.2 and § 20-2-110 to -120	I	§ 20-2-23(3) and AAC Ch. 420-7-2
Current Law:	The 1979 law authorized the State Board of Medical Examiners to create a review committee to administer the therapeutic research program, which has never been operational. The qualifying conditions are cancer chemotherapy and glaucoma. The 2014 law, Carly's Law, includes $1 million for a CBD oil study at the University of Alabama at Birmingham (UAB). Carly's Law is also listed in more detail under "States with Flawed Low-THC Laws."						
Ga.	Feb. 22, 1980	Feb. 22, 1980	H.B. 1077	No. 710 (1980)	§ 43-34-120 et seq. and Rules and Regulations Chapter 360-12	N/A	O.C.G.A. § 16-13-25
Current Law:	The Composite State Board of Medical Examiners has the authority to appoint a Patient Qualification Review Board, which can approve patients with cancer or glaucoma, physicians, and pharmacies for participation in the program. The program — which was for cancer and glaucoma — was once operational. Georgia is also listed under "States with Flawed Low-THC Laws."						
S.C.	Feb. 28, 1980	Feb. 28, 1980	S. 350	Act No. 323 (1980)	S.C. Code Ann. § 44-53-610 to -660	I	S.C. Code Ann. § 44-53-160, -190
CCurrent Law:	The law covers glaucoma, cancer chemotherapy and radiology, and other disease groups. The program has never been operational. Administered by the commissioner of the Department of Health and Environmental Control and Patient Qualification Review Advisory Board, "[t]he director shall obtain marijuana through whatever means he deems most appropriate consistent with federal law." South Carolina is also listed under "States with Flawed Low-THC Laws."						
Texas	June 14, 1979	January 1, 1980	S.B. 877	Ch. 826 (1979)	H & S § 481.111 and § 481.201-205	I	H & S § 481.032 and § 481.038 and 37 TAC § 13.1
Current Law:	The program — which envisioned administering THC or its derivatives to cancer and glaucoma patients — has never been operational. It is administered by the Board of Health and the Research Program Review Board (RPRB), which, after approval by Board of Health, may seek authorization to expand the research program to include other diseases. It would get THC from the federal government. H.B. 2213, signed into law by Texas Gov. George W. Bush in 1997, prohibits local governments in Texas from adopting policies to not fully enforce existing state drug laws. The bill was in response to a voter initiative in San Marcos — rejected by voters on May 3, 1997 — which would have allowed police to overlook the medical use of marijuana. It does not affect the state therapeutic research program law. Texas is also included under "States with Flawed Low-THC Laws."						

States with Symbolic Medical Marijuana Laws								
State	Medical Marijuana Law Approved	Took Effect	Measure	Session Law	Citation for Medical Marijuana Law	Description of Law	Marijuana Schedule	Citation for Schedules
La.	July 17, 1978; July 23, 1991, June 29, 2015	Aug. 14, 1978; Aug. 21, 1991, June 29, 2015	SB 245 (1978); HB 1187 (1991); SB 143 (2015)	Act No. 725 (1978); Act No. 874 (1991); Act No. 261 (2015)	La. Rev. Stat. Ann. §§ 40:1021, 1046	physicians may prescribe	I	§ 40:964
Current Law:	The Alison Neustrom Act, enacted in 1991, was intended to allow Louisiana physicians to prescribe medical marijuana in certain circumstances. Unfortunately, under federal law, no physician can prescribe marijuana without risking losing their license to prescribe other medications. The law was amended and re-enacted in 2015, but without fixing its flaws. It is very unlikely to be workable without changes to state or federal law. The law covers spastic quadriplegia, chemotherapy symptoms, and glaucoma, but allows for the addition of conditions. Up to 10 pharmacies would be allowed to dispense marijuana, but are not expected to do so due to federal law. "Raw or crude" marijuana is not allowed.							
History:	An earlier law, 40:1021 - 40:1026, was repealed by H.B. 1224 in 1989 (Act No. 662). The earlier law was a therapeutic research program that addressed only glaucoma and cancer.							

States in Which Medical Marijuana Laws Have Expired or Been Repealed

State	Medical Marijuana Law Approved	Took Effect	Bill #	Session Law	Citation for Medical Marijuana Law	Description of Law	Law Expired / Repealed	Marijuana Schedule	Citation for Schedules
Ark.	Jan. 30, 1981	Jan. 30, 1981	H.B. 171	Act No. 8 (1981)	§ 82-1007 (numbering system has changed since law was repealed)	physicians may prescribe	repealed by Act No. 52 (1987)	VI	§ 5-64-215
Current Law:	Marijuana and THC are listed in Schedule VI, but Schedule VI substances are defined similarly to — yet even more restrictively than — Schedule I substances.								
History:	For cancer (lawfully obtained THC).								
Ohio	March 21, 1980; 1996	June 20, 1980; July 1, 1996	S.B. 184; S.B. 2	Act No. 230 (1980); not available	§ 2925.11(I)	therapeutic research program; medical necessity defense	first law expired in 1984; medical necessity defense repealed by S.B. 2 in 1997	I	§ 3719.41
History:	The 1980 law, which expired on June 20, 1984, was a therapeutic research program — which was never operational — to be administered by the Director of Health; marijuana and THC; Patient Review Board; glaucoma, cancer chemotherapy or radiology, or other medical conditions; law appeared at § 3719.85. The 1996 law reads as follows: "It is an affirmative defense … to a charge of possessing marijuana under this section that the offender, pursuant to the prior written recommendation of a licensed physician, possessed the marijuana solely for medicinal purposes." Coincidentally, the enacting (1996) and repealing laws (1997) had the same number: S.B. 2.								
W.V.	March 10, 1979	June 8, 1979	S.B. 366	Ch. 56 (1979)	§ 16-5A-7	therapeutic research program	repealed by H.B. 2161, Ch. 61 (1997)	I	§ 60A-2-204
History:	This 1979 law established a therapeutic research program for cancer chemotherapy and glaucoma. It was to be administered by the director of the Department of Health and Patient Qualification Review Board (PQRB), which was authorized to certify patients, physicians, and pharmacies for participation in the program; it may have included other disease groups if approved; the director would contract with the federal government for a supply of marijuana. This program was never operational, and it was repealed in 1997.								

States That Have Never Had Medical Marijuana Laws

State	Schedule	Citation for Schedule
Idaho	I	37-2705
Ind.	I	35-48-2
Kan.	I	65-4105
N.D.	I	19-03.1-04
Neb.	I	§ 28-405
Pa.	I	35 § 780-104 and *28 § 25.72 Penn. Code*
S.D.	n/a	§ 34-20B-11

NOTES:

1. States with effective medical marijuana laws are not also included in other categories, even if they have additional types of ineffective laws on the books. Their symbolic or research laws are noted in Table 2 and in the History section. States that are listed as having low-THC laws are not also listed as having symbolic or repealed medical marijuana laws. Instead, those laws are noted in Table 2 and in the History section. States are included in both the low-THC and therapeutic research sections if they have both types of law.
2. Some states use the spelling "marihuana" in their statutes — "marijuana" is used in this report.
3. Italics for a citation indicate that it is in the state's administrative code (developed by state agencies in the executive branch), not the state's statutes (laws passed by the state legislature).
4. The definitions of Schedule I and Schedule II in state controlled substances acts are always similar to the federal definitions — which can be found in Appendix E of this report — unless noted otherwise. When marijuana is not in Schedule I or Schedule II, a clarifying description is noted.
5. THC is an abbreviation for tetrahydrocannabinol, the only active ingredient in dronabinol and the primary active ingredient in marijuana.
6. Dronabinol is an FDA-approved prescription drug (its trade name is Marinol) and is defined as THC "in sesame oil and encapsulated in a soft gelatin capsule in a U.S. Food and Drug Administration approved drug product." 21 CFR Sec. 1308.13(g)(1)
7. Trivial amendments are not listed; bills that make minor, non-trivial amendments are listed.
8. Column with drug schedule: "N/A" simply means substance is not scheduled in state statutes or administrative code.
9. Statute citations for medical marijuana laws: The administrative code provisions for the therapeutic research programs are cited when possible but are not necessarily cited for all such states.
10. Many states have used a dual scheduling scheme for marijuana and/or THC. In these states, marijuana and THC are in Schedule I but are considered to be in Schedule II when used for medical purposes.

Appendix B: Medical Marijuana Briefing Paper

Medical Marijuana Briefing Paper
The Need to Change State and Federal Law

MARIJUANA POLICY PROJECT • P.O. BOX 77492 • CAPITOL HILL • WASHINGTON, D.C. 20013 • WWW.MPP.ORG

For thousands of years, marijuana has been used to treat a wide variety of ailments. Until 1937, marijuana (Cannabis sativa L.) was legal in the United States for all purposes. Presently, federal law allows only four Americans to use marijuana as a medicine.

On March 17, 1999, the National Academy of Sciences' Institute of Medicine (IOM) concluded, "[T]here are some limited circumstances in which we recommend smoking marijuana for medical uses. "The IOM report, the result of two years of research that was funded by the White House drug policy office, analyzed all existing data on marijuana's therapeutic uses. Please see http://www.mpp.org/science.

MEDICAL VALUE

Marijuana is one of the safest therapeutically active substances known. No one has ever died from an overdose, and it has a wide variety of therapeutic applications, including:

- Relief from nausea and appetite loss;
- Reduction of intraocular (within the eye) pressure;
- Reduction of muscle spasms; and
- Relief from chronic pain.

Marijuana is frequently beneficial in the treatment of the following conditions:

AIDS. Marijuana can reduce the nausea, vomiting, and loss of appetite caused by the ailment itself and by various AIDS medications. Observational research has found that by relieving these side effects, medical marijuana increases the ability of patients to stay on life-extending treatment. (See also CHRONIC PAIN below.)

HEPATITIS C. As with AIDS, marijuana can relieve the nausea and vomiting caused by treatments for hepatitis C. In a study published in the September 2006 European Journal of Gastroenterology & Hepatology, patients using marijuana were better able to complete their medication regimens, leading to a 300% improvement in treatment success.

GLAUCOMA. Marijuana can reduce intraocular pressure, alleviating the pain and slowing—and sometimes stopping — damage to the eyes. (Glaucoma is the leading cause of blindness in the United States. It damages vision by increasing eye pressure over time.)

CANCER. Marijuana can stimulate the appetite and alleviate nausea and vomiting, which are common side effects of chemotherapy treatment.

CROHN'S DISEASE. A placebo-controlled clinical trial that was published in 2013 found that complete remission was achieved in five out of 11 subjects who were administered cannabis, compared to one of the 10 who received a placebo.

MULTIPLE SCLEROSIS. Marijuana can limit the muscle pain and spasticity caused by the disease, as well as relieving tremor and unsteadiness of gait. (Multiple sclerosis is the leading cause of neurological disability among young and middle-aged adults in the United States.)

EPILEPSY. Marijuana can prevent epileptic seizures in some patients.

CHRONIC PAIN. Marijuana can alleviate chronic, often debilitating pain caused by myriad disorders and injuries. Since 2015, seven published clinical trials have found that marijuana effectively relieves neuropathic pain (pain cause by nerve injury), a particularly hard to treat type of pain that afflicts millions suffering from diabetes, HIV/AIDS, multiple sclerosis, and other illnesses. In addition, a yearlong trial in Canada that was published in 2015 found that marijuana reduced chronic pain and had a reasonable safety profile.

Each of these applications has been deemed legitimate by at least one court, legislature, and/or government agency in the United States.

Many patients also report that marijuana is useful for treating arthritis, migraine, menstrual cramps, alcohol and opiate addiction, post-traumatic stress disorder, and depression and other debilitating mood disorders.

Marijuana could be helpful for millions of patients in the United States. Nevertheless, other than for the four people with special permission from the federal government, medical marijuana remains illegal under federal law!

People currently suffering from any of the conditions mentioned above, for whom the legal medical options have proven unsafe or ineffective, have two options:

1. Continue to suffer without effective treatment; or
2. Illegally obtain marijuana — and risk suffering consequences directly related to its illegality, such as:

- An insufficient supply due to the prohibition-inflated price or scarcity; impure, contaminated, or chemically adulterated marijuana; and
- Arrests, fines, court costs, property forfeiture, incarceration, probation, and criminal records.

BACKGROUND

Prior to 1937, at least 27 medicines containing marijuana were legally available in the United States. Many were made by well-known pharmaceutical firms that still exist today, such as Squibb (now Bristol-Myers Squibb) and Eli Lilly. The Marijuana Tax Act of 1937 federally prohibited marijuana. Dr. William C. Woodward of the American Medical Association opposed the Act, testifying that prohibition would ultimately prevent the medical uses of marijuana.

The Controlled Substances Act of 1970 placed all illicit and prescription drugs into five "schedules" (categories). Marijuana was placed in Schedule I, defining it as having a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

This definition simply does not apply to marijuana. Of course, at the time of the Controlled Substances Act, marijuana had been prohibited for more than three decades. Its medical uses forgotten, marijuana was considered a dangerous and addictive narcotic.

A substantial increase in the number of recreational users in the 1970s contributed to the rediscovery of marijuana's medical uses:

- Many scientists studied the health effects of marijuana and inadvertently discovered marijuana's medical uses in the process.
- Many who used marijuana recreationally also suffered from diseases for which marijuana is beneficial. By accident, they discovered its therapeutic value.

As the word spread, more and more patients started self-medicating with marijuana. However, marijuana's Schedule I status bars doctors from prescribing it and severely curtails research.

THE STRUGGLE IN COURT

In 1972, a petition was submitted to the Bureau of Narcotics and Dangerous Drugs — now the Drug Enforcement Administration (DEA) — to reschedule marijuana to make it available by prescription.

After 16 years of court battles, the DEA's chief administrative law judge, Francis L. Young, ruled on September 6, 1988:

"Marijuana, in its natural form, is one of the safest therapeutically active substances known. ..."

"... [T]he provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II."

"It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance. ..."

Marijuana's placement in Schedule II would enable doctors to prescribe it to their patients. But top DEA bureaucrats rejected Judge Young's ruling and refused to reschedule marijuana. Two appeals later, petitioners experienced their first defeat in the 22-year-old lawsuit. On February 18, 1994, the U.S. Court of Appeals (D.C. Circuit) ruled that the DEA is allowed to reject its judge's ruling and set its own criteria — enabling the DEA to keep marijuana in Schedule I.

However, Congress has the power to reschedule marijuana via legislation, regardless of the DEA's wishes.

TEMPORARY COMPASSION

In 1975, Robert Randall, who suffered from glaucoma, was arrested for cultivating his own marijuana. He won his case by using the "medical necessity defense," forcing the government to find a way to provide him with his medicine. As a result, the Investigational New Drug (IND) compassionate access program was established, enabling some patients to receive marijuana from the government.

The program was grossly inadequate at helping the potentially millions of people who need medical marijuana. Many patients would never consider the idea that an illegal drug might be their best medicine, and most who were fortunate enough to discover marijuana's medical value did not discover the IND program. Those who did often could not find doctors willing to take on the program's arduous, bureaucratic requirements.

In 1992, in response to a flood of new applications from AIDS patients, the George H.W. Bush administration closed the program to new applicants, and pleas to reopen it were ignored by subsequent administrations. The IND program remains in operation only for the four surviving, previously approved patients.

PUBLIC AND PROFESSIONAL OPINION

There is wide support for ending the prohibition of medical marijuana among both the public and the medical community:

- Since 1996, a majority of voters in Alaska, Arizona, California, Colorado, the District of Columbia, Guam, Maine, Massachusetts, Michigan, Montana, Nevada, Oregon, and Washington state have voted in favor of ballot initiatives to remove criminal penalties for seriously ill people who grow or possess medical marijuana.
- A May 2013 Fox News poll found that 85% of Americans think "adults should be allowed to use marijuana for medical purposes if a physician prescribes it."

- Organizations supporting some form of physician-supervised access to medical marijuana include the American Academy of Family Physicians, American Nurses Association, American Public Health Association, American Academy of HIV Medicine, Epilepsy Foundation, and many others.
- A 2013 scientific survey of physicians conducted by the New England Journal of Medicine found that 76% of doctors supported use of marijuana for medical purposes. [J. Adler & J. Colbert, "Medicinal Use of Marijuana — Polling Results," New England Journal of Medicine 368 (2013): 30.]

CHANGING STATE LAWS

The federal government has no legal authority to prevent state governments from changing their laws to remove state-level penalties for medical marijuana use. Twenty-three states, Guam, and the District of Columbia have already done so: Connecticut, Delaware, Hawaii, Illinois, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, and Vermont through their legislatures, and the others by ballot initiatives. State legislatures have the authority and moral responsibility to change state law to:

- exempt seriously ill patients from state-level prosecution for medical marijuana possession and cultivation; and
- exempt doctors who recommend medical marijuana from prosecution or the denial of any right or privilege.

Even within the confines of federal law, states can enact reforms that have the practical effect of removing the fear of patients being arrested and prosecuted under state law — as well as the symbolic effect of pushing the federal government to allow doctors to prescribe marijuana.

U.S. CONGRESS: THE FINAL BATTLEGROUND

State governments that want to allow marijuana to be sold in pharmacies have been stymied by the federal government's overriding prohibition of marijuana.

The U.S. Supreme Court's June 2005 decision in *Gonzales v. Raich* preserved state medical marijuana laws but allowed continued federal attacks on patients, even in states with such laws. While the Justice Department indicated in 2009 that it would refrain from raids where activity is clearly legal under state law, that policy change could be reversed anytime. While the Justice department indicated in 2009 that it would refrain from raids where activity is clearly legal under state law, that policy change could be reversed anytime.

Efforts to obtain FDA approval of marijuana also remain stalled. Though some small studies of marijuana have been published or are underway, the National Institute on Drug Abuse — the only legal source of marijuana for clinical research in the U.S. — has consistently made it difficult (and often nearly impossible) for researchers to obtain marijuana for their studies. At present, it is effectively impossible to do the sort of large- scale, extremely costly trials required for FDA approval. Recent calls to expand federal marijuana production in order to facilitate further research have had positive results, but obtaining permission for studies remains difficult.

An amendment introduced by Reps. Dana Rohrabacher and Sam Farr to the government funding bill passed in December 2014 prevents the Department of Justice from using funds to interfere with state medical marijuana laws. However, this amendment may be revisited when the current budget expires, and medical marijuana remains illegal under federal law.

In the meantime, patients continue to suffer. Congress has the power and the responsibility to change federal law so that seriously ill people nationwide can use medical marijuana without fear of arrest and imprisonment.

Appendix C: Excerpts from the Institute of Medicine 1999 Report

> *"[W]e concluded that there are some limited circumstances in which we recommend smoking marijuana for medical uses."*
>
> — from principal investigator Dr. John Benson's opening remarks at IOM's 3/17/99 news conference

Questions about medical marijuana answered by the Institute of Medicine's report

Marijuana and Medicine: Assessing the Science Base*

Excerpts compiled by the Marijuana Policy Project

What conditions can marijuana treat?

"The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation." [p. 3]

"[B]asic biology indicates a role for cannabinoids in pain and control of movement, which is consistent with a possible therapeutic role in these areas. The evidence is relatively strong for the treatment of pain and, intriguing although less well established, for movement disorders." [p. 70]

"For patients such as those with AIDS or who are undergoing chemotherapy and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad-spectrum relief not found in any other single medication. The data are weaker for muscle spasticity but moderately promising." [p. 177]

"The most encouraging clinical data on the effects of cannabinoids on chronic pain are from three studies of cancer pain." [p. 142]

Why can't patients use medicines that are already legal?

"[T]here will likely always be a subpopulation of patients who do not respond well to other medications." [Pp. 3, 4]

"The critical issue is not whether marijuana or cannabinoid drugs might be superior to the new drugs, but whether some group of patients might obtain added or better relief from marijuana or cannabinoid drugs." [p. 153]

"The profile of cannabinoid drug effects suggests that they are promising for treating wasting syndrome in AIDS patients. Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana. Although some medications are more effective than marijuana for these problems, they are not equally effective in all patients." [p. 159]

What about Marinol®, the major active ingredient in marijuana in pill form?

"It is well recognized that Marinol's oral route of administration hampers its effectiveness because of slow absorption and patients' desire for more control over dosing." [Pp. 205, 206]

Why not wait for more research before making marijuana legally available as a medicine?

"[R]esearch funds are limited, and there is a daunting thicket of regulations to be negotiated at the federal level (those of the Food and Drug Administration, FDA, and the Drug Enforcement Administration, DEA) and state levels." [p. 137]

"Some drugs, such as marijuana, are labeled Schedule I in the Controlled Substance Act, and this adds considerable complexity and expense to their clinical evaluation." [p. 194]

"[O]nly about one in five drugs initially tested in humans successfully secures FDA approval for marketing through a new drug application." [p. 195]

"From a scientific point of view, research is difficult because of the rigors of obtaining an adequate supply of legal, standardized marijuana for study." [p. 217]

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"In short, development of the marijuana plant is beset by substantial scientific, regulatory, and commercial obstacles and uncertainties." [p. 218]

"[D]espite the legal, social, and health problems associated with smoking marijuana, it is widely used by certain patient groups." [p. 7]

Do the existing laws really hurt patients?

"G.S. spoke at the IOM workshop in Louisiana about his use of marijuana first to combat AIDS wasting syndrome and later for relief from the side effects of AIDS medications. … [He said,] 'Every day I risk arrest, property forfeiture, fines, and imprisonment.' " [Pp. 27, 28]

Why shouldn't we wait for new drugs based on marijuana's components to be developed, rather than allowing patients to eat or smoke natural marijuana right now?

"Although most scientists who study cannabinoids agree that the pathways to cannabinoid drug development are clearly marked, there is no guarantee that the fruits of scientific research will be made available to the public for medical use." [p. 4]

"[I]t will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, is available for patients. In the meantime there are patients with debilitating symptoms for whom smoked marijuana might provide relief." [p. 7]

"[W]hat seems to be clear from the dearth of products in development and the small size of the companies sponsoring them is that cannabinoid development is seen as especially risky." [Pp. 211, 212] *[IOM later notes that it could take more than five years and cost $200-300 million to get new cannabinoid drugs approved—if ever.]*

"Cannabinoids in the plant are automatically placed in the most restrictive schedule of the Controlled Substances Act, and this is a substantial deterrent to development." [p. 219]

Isn't marijuana too dangerous to be used as a medicine?

"[E]xcept for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications." [p. 5]

"Until the development of rapid onset antiemetic drug delivery systems, there will likely remain a subpopulation of patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. It is possible that the harmful effects of smoking marijuana for a limited period of time might be outweighed by the antiemetic benefits of marijuana, at least for patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. Such patients should be evaluated on a case-by-case basis and treated under close medical supervision." [p. 154]

"Terminal cancer patients pose different issues. For those patients the medical harm associated with smoking is of little consequence. For terminal patients suffering debilitating pain or nausea and for whom all indicated medications have failed to provide relief, the medical benefits of smoked marijuana might outweigh the harm." [p. 159]

What should be done to help the patients who already benefit from medical marijuana, prior to the development of new drugs and delivery devices?

"Patients who are currently suffering from debilitating conditions unrelieved by legally available drugs, and who might find relief with smoked marijuana, will find little comfort in a promise of a better drug 10 years from now. In terms of good medicine, marijuana should rarely be recommended unless all reasonable options have been eliminated. But then what? It is conceivable that the medical and scientific opinion might find itself in conflict with drug regulations. This presents a policy issue that must weigh—at least temporarily—the needs of individual patients against broader social issues. Our assessment of the scientific data on the medical value of marijuana and its constituent cannabinoids is but one component of attaining that balance." [p. 178]

"Also, although a drug is normally approved for medical use only on proof of its 'safety and efficacy,' patients with life-threatening conditions are sometimes (under protocols for 'compassionate use') allowed access to unapproved drugs whose benefits and risks are uncertain." [p. 14]

"Until a nonsmoked rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting. One possible approach is to treat patients as *n*-of-1 clinical trials (single-patient trials), in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system and in which their condition is closely monitored and documented under medical supervision. …" [p. 8] *[The federal government's "compassionate use" program, which currently provides marijuana to four patients nationwide, is an example of an n-of-1 study.]*

The IOM report doesn't explicitly endorse state bills and initiatives to simply remove criminal penalties for bona fide medical marijuana users. Does that mean that we should keep the laws exactly as they are and keep arresting patients?

"This report analyzes science, not the law. As in any policy debate, the value of scientific analysis is that it can provide a foundation for further discussion. Distilling scientific evidence does not in itself solve a policy problem." [p. 14]

If patients were allowed to use medical marijuana, wouldn't overall use increase?

"Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential. … [T]his question is beyond the issues normally considered for medical uses of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids." [Pp. 6, 7]

"No evidence suggests that the use of opiates or cocaine for medical purposes has increased the perception that their illicit use is safe or acceptable." [p. 102]

"Thus, there is little evidence that decriminalization of marijuana use necessarily leads to a substantial increase in marijuana use." [p. 104]
[Decriminalization is defined as the removal of criminal penalties for all uses, even recreational.]

Doesn't the medical marijuana debate send children the wrong message about marijuana?

"[T]he perceived risk of marijuana use did not change among California youth between 1996 and 1997. In summary, there is no evidence that the medical marijuana debate has altered adolescents' perceptions of the risks associated with marijuana use." [p. 104]

"Even if there were evidence that the medical use of marijuana would decrease the perception that it can be a harmful substance, this is beyond the scope of laws regulating the approval of therapeutic drugs. Those laws concern scientific data related to the safety and efficacy of drugs for individual use; they do not address perceptions or beliefs of the general population." [p. 126]

Isn't marijuana too addictive to be used as a medicine?

"Some controlled substances that are approved medications produce dependence after long-term use; this, however, is a normal part of patient management and does not generally present undue risk to the patient." [p. 98]

"Animal research has shown that the potential for cannabinoid dependence exists, and cannabinoid withdrawal symptoms can be observed. However, both appear to be mild compared to dependence and withdrawal seen with other drugs." [p. 35]

"A distinctive marijuana and THC withdrawal syndrome has been identified, but it is mild and subtle compared with the profound physical syndrome of alcohol or heroin withdrawal." [Pp. 89, 90]

Drug Category	Proportion Of Users That Ever Became Dependent (%)	
Alcohol	15	
Marijuana (including hashish)	9	[p. 95]

"Compared to most other drugs … dependence among marijuana users is relatively rare." [p. 94]

"In summary, although few marijuana users develop dependence, some do. But they appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence on other drugs." [p. 98]

Doesn't the use of marijuana cause people to use more dangerous drugs?

"[I]t does not appear to be a gateway drug to the extent that it is the *cause* or even that it is the most significant predictor of serious drug abuse; that is, care must be taken not to attribute cause to association." [p. 101]

"There is no evidence that marijuana serves as a stepping stone on the basis of its particular physiological effect." [p. 99]

"Instead, the legal status of marijuana makes it a gateway drug." [p. 99]

Shouldn't medical marijuana remain illegal because it is bad for the immune system?

"The short-term immunosuppressive effects are not well established; if they exist at all, they are probably not great enough to preclude a legitimate medical use. The acute side effects of marijuana use are within the risks tolerated for many medications." [p. 126]

Doesn't marijuana cause brain damage?

"Earlier studies purporting to show structural changes in the brains of heavy marijuana users have not been replicated with more sophisticated techniques." [p. 106]

Doesn't marijuana cause amotivational syndrome?

"When heavy marijuana use accompanies these symptoms, the drug is often cited as the cause, but no convincing data demonstrate a causal relationship between marijuana smoking and these behavioral characteristics." [Pp. 107, 108]

Doesn't marijuana cause health problems that shorten the life span?

"[E]pidemiological data indicate that in the general population marijuana use is not associated with increased mortality." [p. 109]

Isn't marijuana too dangerous for the respiratory system?

"Given a cigarette of comparable weight, as much as four times the amount of tar can be deposited in the lungs of marijuana smokers as in the lungs of tobacco smokers." [p. 111]

"However, a marijuana cigarette smoked recreationally typically is not packed as tightly as a tobacco cigarette, and the smokable substance is about half that in a tobacco cigarette. In addition, tobacco smokers generally smoke considerably more cigarettes per day than do marijuana smokers." [Pp. 111, 112]

"There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use. … More definitive evidence that habitual marijuana smoking leads or does not lead to respiratory cancer awaits the results of well-designed case control epidemiological studies." [p. 119]

Don't the euphoric side effects diminish marijuana's value as a medicine?

"The high associated with marijuana is not generally claimed to be integral to its therapeutic value. But mood enhancement, anxiety reduction, and mild sedation can be desirable qualities in medications—particularly for patients suffering pain and anxiety. Thus, although the psychological effects of marijuana are merely side effects in the treatment of some symptoms, they might contribute directly to relief of other symptoms." [p. 84]

What other therapeutic potential does marijuana have?

"One of the most prominent new applications of cannabinoids is for 'neuroprotection,' the rescue of neurons from cell death associated with trauma, ischemia, and neurological diseases." [p. 211]

"There are numerous anecdotal reports that marijuana can relieve the spasticity associated with multiple sclerosis or spinal cord injury, and animal studies have shown that cannabinoids affect motor areas in the brain—areas that might influence spasticity." [p. 160]

"High intraocular pressure (IOP) is a known risk factor for glaucoma and can, indeed, be reduced by cannabinoids and marijuana. However, the effect is too and [sic] short lived and requires too high doses, and there are too many side effects to recommend lifelong use in the treatment of glaucoma. The potential harmful effects of chronic marijuana smoking outweigh its modest benefits in the treatment of glaucoma. Clinical studies on the effects of smoked marijuana are unlikely to result in improved treatment for glaucoma." [p. 177] *[Note that IOM found that marijuana does work for glaucoma, but was uncomfortable with the amount that a person needs to smoke. Presumably, it would be an acceptable treatment for glaucoma patients to eat marijuana. Additionally, MPP believes that IOM would not support arresting patients who choose to smoke marijuana to treat glaucoma.]*

Do the American people really support legal access to medical marijuana, or were voters simply tricked into passing medical marijuana ballot initiatives?

"Public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally report 60-70 percent of respondents in favor of allowing medical uses of marijuana." [p. 18]

But shouldn't we keep medical marijuana illegal because some advocates want to "legalize" marijuana for all uses?

"[I]t is not relevant to scientific validity whether an argument is put forth by someone who believes that all marijuana use should be legal or by someone who believes that any marijuana use is highly damaging to individual users and to society as a whole." [p. 14]

The full report by the National Academy of Sciences can be viewed online at www.nap.edu/openbook.php?record_id=6376

Appendix D: Surveys of Public Support for Medical Marijuana

Scientifically conducted public opinion polls have consistently found a majority of support for making marijuana medically available to seriously ill patients.

In addition to the following tables, which break down nationwide and state-specific public opinion poll results, there have been two reports that have analyzed nationwide polls on medical marijuana over time.

Nationwide Medical Marijuana Public Opinion Polling Results

Date	Percent in favor	Margin of error/ respondents	Wording	Polling firm/where reported
April 2015	84	± 3.0% 1,012 adults	Should doctors "be allowed to prescribe marijuana for medical use?"	CBS News
Oct. 2014	78	856 registered voters	Do you support "allowing individuals to use marijuana for medical purposes if a doctor recommends it?"	Third Way
May 2013	85	±3.0/ 1,010 registered voters	"Do you think adults should be allowed to use marijuana for medical purposes if a physician prescribes it?"	Fox News Poll, conducted under the joint direction of Anderson Robbins Research and Shaw & Company Research
November 2012	83	±3.0/ 1,100 adults	"Should doctors be allowed to prescribe marijuana for medical use?"	CBS News
Jan. 2011	77	N/A/ 1,137 adults	"If a loved one had an illness for which medical marijuana might be prescribed, would you support or oppose that use?"	CBS News interviewing facility (60 Minutes/Vanity Fair poll)
Oct. 2010	70	± 5.0%/514 adults	"Would you favor or oppose making marijuana legally available for doctors to prescribe in order to reduce pain and suffering?"	Gallup
March 2010	73	± 3.0%/1,500 adults	"Favor their state allowing the sale and use of marijuana for medical purposes if it is prescribed by a doctor?"	Pew Research Center
Jan. 2010	81	± 3.5%/1,083 adults	"Do you think doctors should or should not be allowed to prescribe marijuana for medical purposes to treat their patients?"	ABC News/*Washington Post*
Jan. 2009	72	± 3.1%/1,053 adults	"During the presidential campaign, Barack Obama said he would stop federal raids against medical marijuana providers in the 13 states where medical marijuana has become legal. Should President Obama keep his word to end such raids?"	Zogby America

Nationwide Medical Marijuana Public Opinion Polling Results				
Date	**Percent in favor**	**Margin of error/ respondents**	**Wording**	**Polling firm/where reported**
Nov. 2005	78	± 2%/ 2,034 adults	"Do you support making marijuana legally available for doctors to prescribe in order to reduce pain and suffering?"	Gallup
Nov. 2004	72	± 2.37%/ 1,706 adults aged 45 and older	"I think that adults should be allowed to legally use marijuana for medical purposes if a physician recommends it."	International Communications Research, on behalf of *AARP The Magazine*
Nov. 2002	80	± 3.1%/ 1,007 adults	"Do you think adults should be allowed to legally use marijuana for medical purposes if their doctor prescribes it?"	Harris Interactive for *Time* magazine
Jan. 2002	70	N/A	"Should medical marijuana be allowed?"	Center for Substance Abuse Research, Univ. of Maryland
March 2001	73	± 3%/ 1,513 adults	"Regardless of what you think about the personal non-medical use of marijuana, do you think doctors should or should not be allowed to prescribe marijuana for medical purposes to treat their patients?"	Pew Research Center
March 1999	73	± 5%/ 1,018 adults	Support "making marijuana legally available for doctors to prescribe in order to reduce pain and suffering?"	Gallup
June 1997	74	± 2.8 %/ 1,000 registered voters	"People who find that marijuana is effective for their medical condition should be able to use it legally."	Commissioned by the Family Research Council
1995	79	± 3.1%/ 1,001 registered voters	"It would be a good idea … to legalize marijuana to relieve pain and for other medical uses if prescribed by a doctor."	Belden & Russonello on behalf of the American Civil Liberties Union

State-Specific Medical Marijuana Public Opinion Polling Results

State	Date	% in favor	Margin of error/ respondents	Wording	Polling firm/ where reported
Alabama	July 2004	75	312 respondents	"Would you approve or disapprove of allowing doctors to prescribe marijuana for medical purposes?"	University of South Alabama, commissioned by the *Mobile Register*
Alaska	Feb. 2014	74	± 3.4% 850 registered AK voters	"Do you think marijuana should be legally allowed for medical purposes with the approval of a doctor, or not?"	Public Policy Polling
Arizona	March 2014	67	±3.4% 870 AZ voters	"Do you think marijuana should be legally allowed for medical purposes with the approval of a doctor, or not?"	Public Policy Polling
Arkansas	Oct. 2015	68	± 3.5% 800 AR residents	"Do you favor allowing patients to use marijuana for medical purposes if supported by their doctor?"	University of Arkansas
California	Feb. 2013	72	± 3.5/ 845 registered CA voters	"In 1996, California voters approved Proposition 215, the medical marijuana initiative, which exempted from state criminal laws patients or caregivers who possessed or cultivated marijuana for medical use when prescribed by a doctor. Do you favor or oppose this law?"	Field Poll
Colorado	April 2015	89	± 3.3% 894 CO voters	"Do you support or oppose allowing adults in CO to legally use marijuana for medical purposes if their doctor prescribes it?"	Quinnipiac University Poll
Connecticut	May 2014	90	± 2.4% 1,668 registered voters	"Do you support or oppose allowing adults in Connecticut to legally use marijuana for medical purposes if their doctor prescribes it?"	Quinnipiac University Poll
Delaware	March 2014	64	± 3.2% 951 DE voters	"Under current Delaware law, it is legal for people who have certain serious illnesses to register to use marijuana for medical purposes, as long as their physicians approve. Overall, do you support or oppose this law?"	Public Policy Polling
District of Columbia	April 2013	78	1,621 registered voters	"Under the District of Columbia's current medical marijuana law, only patients with cancer, AIDS, glaucoma, and multiple sclerosis qualify to use marijuana legally. Would you support or oppose a change in the law that would allow any patient to use medical marijuana legally as long as their physician believes it would be beneficial to them?"	Public Policy Polling

State-Specific Medical Marijuana Public Opinion Polling Results					
State	**Date**	**% in favor**	**Margin of error/ respondents**	**Wording**	**Polling firm/ where reported**
Florida	Oct. 2015	87	± 2.9% 1,173 FL voters	"Do you support or oppose allowing adults in Florida to legally use marijuana for medical purposes if their doctor prescribes it?"	Quinnipiac University Poll
Georgia	Jan. 2015	83% yes	905 GA residents	"Should the general assembly in Georgia legalize the use of a marijuana-based medication to treat certain medical conditions, or not?"	Atlanta Journal-Constitution
Hawaii	Jan. 2014	85	± 4.9% 400 registered HI voters	"As you may be aware, the Hawaii State Legislature passed a law in the year 2000 allowing patients with terminal or debilitating conditions to possess and consume marijuana if their doctors recommend it. Do you favor or oppose that law?"	QMark Research
Idaho	Oct. 2010	61	± 3.9%/400 respondents	"Do you support or oppose state laws that allow marijuana use for medical purposes with a doctor's prescription?"	Northwest OpinionScape
Illinois	Feb. 2013	63	±4.0/600 registered IL voters	"Some in Springfield have proposed that the state should make it legal for people with certain health issues to be prescribed small amounts of marijuana. Generally speaking, do you favor or oppose legalized medical marijuana in Illinois?"	Southern Illinois University, Paul Simon Public Policy Institute
Iowa	Feb. 2015	87	± 3.2% 948 IA voters	"Do you support or oppose allowing adults in IA to legally use marijuana for medical purposes if their doctor prescribes it?"	Quinnipiac University Poll
Kansas	Feb. 2014	64	± 3.7% 693 KS voters	"Do you think marijuana should be legally allowed for medical purposes with the approval of a doctor, or not?"	SurveyUSA News Poll, sponsored by KWCH-TV Wichita
Kentucky	Feb. 2013	60	±4.0/616 registered KY voters	"Do you support or oppose legalizing marijuana for prescribed medical use in Kentucky?"	SurveyUSA News Poll, sponsored by *The Courier-Journal* Bluegrass Poll
Louisiana	Feb. 2015	60	± 3.1% 980 adult residents	"Would you favor or oppose legalizing the possession of small amounts of marijuana for medical use?"	Louisiana State University

State-Specific Medical Marijuana Public Opinion Polling Results					
State	**Date**	**% in favor**	**Margin of error/ respondents**	**Wording**	**Polling firm/ where reported**
Maine	Nov. 2009	60	401 ME residents	"Do you want to change the medical marijuana laws to allow treatment of more medical conditions and to create a regulated system of distribution?"	Pan Atlantic SMS Group Omnibus Poll
Maryland	Sept. 2013	72	678 MD voters	"Do you support or oppose allowing seriously and terminally ill patients to safely obtain and use medical marijuana if their doctors recommend it?"	Public Policy Polling
Massachusetts	Nov. 2013	74	± 4.3% 517 adults	"Do you support or oppose legalizing the use of marijuana for medical purposes?"	Western New England University Polling Institute
Michigan	Jan. 2011	61	±4.0/600 voters	"If you were voting on this issue again today, would you vote YES, to approve the medical use of marijuana in Michigan, or NO, to reject it?"	Marketing Resource Group, Inc.
Minnesota	March 2013	65	600 MN voters	"Do you support or oppose changing the law in Minnesota to allow people with serious and terminal illnesses to use medical marijuana if their doctors recommend it?"	Public Policy Polling
Missouri	Nov. 2010	49	604 likely MO voters	Would you support "allow[ing] Missouri residents with . . . serious illnesses to grow and use marijuana for medical purposes, as long as their physician approves?"	Public Policy Polling
Montana	Feb. 2011	63	2,212 Montana voters	"Do you support allowing patients with multiple sclerosis, cancer, and other serious illnesses to have the freedom to use marijuana for medical purposes with their doctors' approval?"	Public Policy Polling
Nebraska	Feb. 2002	64	± 2.6% to 3.1%/ between 1,004 and 1,464 adults	Support an initiative that "would remove the threat of arrest and all other penalties for seriously ill patients who use and grow their own medical marijuana with the approval of their physicians?"	Lucas Organization and Arlington Research Group, on behalf of MPP

State-Specific Medical Marijuana Public Opinion Polling Results

State	Date	% in favor	Margin of error/ respondents	Wording	Polling firm/ where reported
Nevada	Aug. 2006	78	±4.3/500 likely voters	"Under present Nevada state law, it is legal for people who have cancer, AIDS, or other serious illnesses to use and grow marijuana for medical purposes, as long as their physician approves. Overall, do you strongly favor, somewhat favor, somewhat oppose, or strongly oppose this law?"	Goodwin Simon Victoria Research
New Hampshire	April 2013	79	±4.4/507 NH adults	"Do you support or oppose allowing doctors in New Hampshire to prescribe small amounts of marijuana for patients suffering from serious illnesses?"	WMUR Granite State Poll/The University of New Hampshire Survey Center
New Jersey	Nov. 2011	86	±3.6/753 registered NJ voters	"Recently New Jersey legalized the use of marijuana for medical purposes. Do you support or oppose making marijuana available for medical use by prescription?"	Rutgers-Eagleton poll
New Mexico	March 2014	70	674 NM voters	"Do you think marijuana should be legally allowed for medical purposes with the approval of a doctor, or not?"	Public Policy Polling
New York	May 2013	82	±3.9/623 registered NY voters	"Do you support or oppose allowing seriously and terminally ill people to legally use marijuana for medical purposes if recommended by their doctor?"	Siena Research Institute
North Carolina	Feb. 2013	76	±3.28/891 respondents	"Should North Carolina allow doctors to prescribe medical marijuana for reasons such as cancer?"	Elon University Poll
North Dakota	Oct. 2014	47	± 5.0% 505 ND residents	Would you support the legalization of medical marijuana in North Dakota?	University of North Dakota College of Business and Public Administration
Ohio	Oct. 2015	90	± 2.9% 1,180 OH voters	"Do you support or oppose allowing adults in OH to legally use marijuana for medical purposes if their doctor prescribes it?"	Quinnipiac University Poll
Oklahoma	Sept. 2013	71.2	± 4.9% 400 likely voters	"Twenty states now have laws allowing seriously ill patients to possess marijuana for medical purposes with a physician's recommendation. Do you support or oppose Oklahoma joining these other twenty states?"	Sooner Poll

State-Specific Medical Marijuana Public Opinion Polling Results					
State	**Date**	**% in favor**	**Margin of error/ respondents**	**Wording**	**Polling firm/ where reported**
Oregon	Sept.-Oct. 2010	64	± 3.9%/400 respondents	"Do you support or oppose state laws that allow marijuana use for medical purposes with a doctor's prescription?"	Northwest OpinionScape
Pennsylvania	Oct. 2015	90	± 3.0% 1,049 PA voters	"Do you support or oppose allowing adults in PA to legally use marijuana for medical purposes if their doctor prescribes it?"	Quinnipiac University Poll
Rhode Island	Jan. 2012	72	714 RI voters	"Under current Rhode Island state law, it is legal for people who have cancer, AIDS, and other serious illnesses to use and grow marijuana for medical purposes, as long as their physicians approve. Overall, do you support or oppose this law?"	Public Policy Polling
South Carolina	July 2014	60	1650 registered SC voters	Would you support the legalization of medical marijuana in North Dakota?	Susquehanna Polling and Research
South Dakota	March 2006	52	N/A/500 respondents	Would you support an initiative that would "allow people with cancer, multiple sclerosis, and other serious illnesses to use and grow their own marijuana for medical purposes, as long as their physician approves?"	Goodwin Simon Strategic Research
Texas	Sept. 2013	58	860 Texas voters	"Do you support or oppose changing the law in Texas to allow seriously and terminally ill patients to use medical marijuana for a limited number of conditions if their doctors recommend it?"	Public Policy Polling
Utah	Feb. 2015	72	± 4.9% 400 likely voters	"Should doctors who specialize in treating serious illnesses like cancer, epilepsy, and Alzheimer's be allowed to recommend cannabis, sometimes referred to as marijuana, as treatment for their patients with serious medical conditions, or not?"	Y2 Analytics

State-Specific Medical Marijuana Public Opinion Polling Results					
State	**Date**	**% in favor**	**Margin of error/ respondents**	**Wording**	**Polling firm/ where reported**
Vermont	Feb. 2012	75	1,086 VT voters	"Under current Vermont state law, it is legal for people who have cancer, AIDS, and other serious illnesses to use and grow marijuana for medical purposes, as long as their physicians approve. Within a year, qualified patients will also be able to obtain marijuana from one of four regulated not-for-profit dispensaries. Overall, do you support or oppose this law?"	Public Policy Polling
Virginia	April 2015	86	± 3.2% 961 VA voters	"Do you support or oppose allowing adults in Virginia to legally use marijuana for medical purposes if their doctor prescribes it?"	Quinnipiac University Poll
Washington	Sept.-Oct. 2010	78	± 3.9%/400 respondents	"Do you support or oppose state laws that allow marijuana use for medical purposes with a doctor's prescription?"	Northwest OpinionScape
West Virginia	Jan. 2013	53	1,232 WV voters	"Do you support or oppose changing the law in West Virginia to allow seriously and terminally ill patients to use medical marijuana if their doctors recommend it?"	Public Policy Polling
Wisconsin	July 2005	76	±4%/ 600 residents	Support a bill that would "allow people with cancer, multiple sclerosis, or other serious illnesses to use marijuana for medical purposes, as long as their physician approves?"	Chamberlain Research Consultants, on behalf of MPP
Wyoming	Dec. 2014	72	± 4.0% 768 WY voters	"Do you support adult use of marijuana if prescribed by a physician?"	University of Wyoming

Appendix E: The Federal Controlled Substances Act (and Drug Schedules)

The federal Controlled Substances Act of 1970 created a series of five schedules establishing varying degrees of control over certain substances. Marijuana and two of its active ingredients — tetrahydrocannabinol (THC), and cannabidiol (CBD) — are presently in Schedule I. As such, doctors may not prescribe marijuana under any circumstances.

Although the DEA has not rescheduled marijuana, it has made the drug "dronabinol" available by prescription. Dronabinol — marketed as "Marinol" — is synthetic THC in sesame oil in a gelatin capsule. Dronabinol is currently in Schedule III. The DEA has proposed a rule to also make natural THC, including in forms other than gelatin capsules, Schedule III. This proposal would allow for generic versions of dronabinol. Unfortunately, evidence indicates that dronabinol is less effective than marijuana for many patients.

Most states mirror the scheduling criteria established by the federal government. However, marijuana has been assigned to Schedule II or lower in a few states that have recognized its medicinal value and/or relative safety.[1] Rescheduling on the state level is largely symbolic at this time — doctors in those states may not prescribe marijuana nor either THC or CBD derived from marijuana because the federal schedules supersede state law.

The criteria for each of the schedules, listed in Title 21 of the U.S. Code, Section 812(b) (21 U.S.C. 812(b)), and a few example substances from Title 21 of the Code of Federal Regulations, Section 1308, are:

Schedule I (includes heroin, LSD, and marijuana)

- A. The drug or other substance has a high potential for abuse.
- B. The drug or other substance has no currently accepted medical use in treatment in the United States.
- C. There is a lack of accepted safety for use of the drug or other substance under medical supervision.

Schedule II (includes morphine, used as a painkiller, and cocaine, used as a topical anesthetic)

- A. The drug or other substance has a high potential for abuse.
- B. The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- C. Abuse of the drug or other substance may lead to severe psychological or physical dependence.

[1] See Appendix A.

Schedule III (includes anabolic steroids and Marinol)

- A. The drug or other substance has a potential for abuse less than the drugs or other substances in Schedules I and II.
- B. The drug or other substance has a currently accepted medical use in treatment in the United States.
- C. Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

Schedule IV (includes Valium and other tranquilizers)

- A. The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
- B. The drug or other substance has a currently accepted medical use in treatment in the United States.
- C. Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.

Schedule V (includes codeine-containing analgesics)

- A. The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule IV.
- B. The drug or other substance has a currently accepted medical use in treatment in the United States.
- C. Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.

Appendix F: How the Effective State Laws Are Working

New York

Gov. Andrew Cuomo signed New York's Compassionate Care Act into law on July 5, 2014, making the state the 23rd with a comprehensive medical marijuana law. Assembly Health Committee Chair Richard Gottfried championed the issue in the Assembly for many years, with Sen. Diane Savino sponsoring the Senate bill since 2012. MPP led the advocacy effort for several years, with Compassionate Care New York (led by the Drug Policy Alliance) taking the lead beginning in spring 2012. Once the Compassionate Care Act is fully implemented, it will protect certain seriously ill patients who use marijuana pursuant to their doctors' advice and will allow them to access medical cannabis from regulated entities.

Several modifications were made at Gov. Cuomo's insistence before the bill was enacted and as a result it is extremely restrictive. New York is one of only two states where patients will not be allowed to smoke medical cannabis, and it is not clear if whole plant cannabis will be allowed. In addition, New York's qualifying conditions are quite limited, and do not include severe pain. Furthermore, patients still lack any legal protections nearly a year and a half after the law's passage. In addition, the law will sunset after seven years if it is not renewed, and there will be no more than five manufacturers — with a total of up to 20 locations — in the entire state.

Implementation of the dispensary piece of the law, however, has been quicker than in some states. Five entities were granted preliminary approval in July 2015 and the first dispensaries are expected to open in early 2016.

The health department will eventually issue ID cards for patients who submit valid applications, a written certification from the patient's physician, and fees of up to $50. Patients have no legal protection until they receive an ID card. Registry identification cards will generally expire after a year, unless the patient has a terminal illness or the physician specified an earlier date.

To qualify for an ID card, a patient must have a written certification from his or her physician that specifies that the patient is in the physician's continuing care for the condition, is likely to receive therapeutic or palliative benefits from marijuana, and has a qualifying condition. The doctor must consider what form of medical marijuana the patient should use and state any recommendations or limitations on the certification. In another feature that is sure to depress participation, physicians can only write certifications if they take a four-hour continuing medical education course on medical cannabis, something that is not required for far more dangerous medications.

Patients will be allowed to designate up to two caregivers, who may pick up their medical marijuana for them. Caregivers generally must be at least 21 years old and they may not serve more than five patients. Minors can qualify if an appropriate person who is 21 or older fills out their application. A minor's caregiver must be his or her parent, guardian, or — if neither is available — another appropriate person who is approved by the department.

Patients will be allowed to possess a 30-day supply of medical marijuana, an amount that will be determined either by the health commissioner during rule-making or by the physician. They may refill their 30-day supply seven days before it runs out. Medical marijuana may not be consumed in a public place and any form of medical marijuana not expressly approved by the health commissioner is prohibited. The law does not include protections for out-of-state patients. Health insurance will not be required to cover medical marijuana.

Patients, caregivers, physicians, and staffers of state-legal medical marijuana organizations will not be subject to arrest or prosecution, or subject to any civil penalty, for the actions allowed under the act. In addition, in one of the more compassionate features of New York's law, being a medi-

cal marijuana patient is be considered a disability for purposes of the state's anti-discrimination laws, meaning that state anti-discrimination protections apply. The law also includes language to protect patients from discrimination in family law or domestic relations cases.

In a feature that is unique to New York's law, the health commissioner will determine the price of marijuana, which will also be subject to a 7% excise taxes. 22.5% of the tax revenue will go to the county where the marijuana was sold and 22.5% to the county where the marijuana was manufactured. Five percent will be directed to drug abuse prevention, counseling, and treatment, and five percent will be directed to criminal justice services.

On November 11, 2015, Gov. Cuomo signed a bill into law to provide emergency access to patients with progressive and degenerative conditions, and in cases where a delay could pose a serious risk to the patient's health. The law requires approval of additional entities that are already providing cannabis to patients in other states.

Minnesota

On May 29, 2014, Minnesota became the 22nd state to enact an effective medical marijuana law when S.B. 2470, sponsored by Sen. Scott Dibble (D), was signed into law by Gov. Mark Dayton. The bill's passage and subsequent signing culminated a nearly eight-year lobbying and grassroots effort by MPP, Minnesotans for Compassionate Care, patients, their loved ones, and advocates.

At the beginning of the 2007 session, MPP's model bill was introduced in both chambers with bipartisan sponsorship. After two years of patient advocacy in the face of fierce resistance by law enforcement, both chambers of the legislature approved a very restrictive medical marijuana bill in 2009, but then-governor Tim Pawlenty (R) vetoed the bill, citing law enforcement concerns. Republicans took control of both chambers in the 2010 election and chose to steer clear of debating social issues like medical marijuana during the 2011-2012 legislative session.

In November 2012, legislative control switched back to the DFL party, greatly increasing the level of support medical marijuana had in the legislature. Unfortunately, Gov. Mark Dayton (D) had stated he would not sign a medical marijuana bill that law enforcement opposed. Despite his position, MPP and our allies moved forward with introducing legislation in the 2013-2014 legislative session and launching a robust advocacy campaign. Finally, at the end of the 2013-2014 session, and after a very public campaign imploring Gov. Dayton to sign a medical marijuana law despite law enforcement's continued opposition, a compromise bill passed both chambers and was signed by Gov. Dayton.

The law took effect the following day, May 30, 2014, at which point the Minnesota Department of Health began the process of drafting regulations, creating applications and registries, selecting medical marijuana manufacturers, and conducting outreach to health care practitioners across the state. The department successfully adhered to the legislatively prescribed timeline and the first dispensary opened its doors to registered patients on July 1, 2015, just over a year after the bill was signed.

The law protects registered patients and their caregivers from arrest and prosecution for using, possessing, or transporting medical marijuana products if they are registered with the Department of Health. It also protects registered parties from discrimination in employment, child custody disputes, organ transplants, and other medical care.

In order to register with the department, a health care practitioner who has registered with the department to participate in the medical marijuana program must certify that the patient suffers from one of the enumerated qualifying conditions. The patient then enrolls in the medical marijuana program via the Department of Health. The certifying health care practitioner must then submit follow-up reports to the department on patient outcomes.

Once enrolled, the patient may obtain medical marijuana products from a dispensary. The law severely limits the number of dispensaries that may be sited. The law restricts the Department of Health to licensing just two medical marijuana manufacturers, each of which can have up to four dispensing locations.

The law also limits the types of medical marijuana administration methods available to patients. Unlike a vast majority of effective medical marijuana laws, Minnesota's law prevents patients from obtaining marijuana in its natural form. Patients may only use products — like liquids, pills, and oils — that are made of marijuana. Patients may use a vaporizer, but only to consume medical marijuana oils, not whole plant marijuana. While the commissioner of health is authorized to allow additional administration methods, such as by allowing patients to vaporize marijuana flowers, the law prevents patients from smoking marijuana. Patients are unable to cultivate their own medicine.

The limitations of the law laid out above — which MPP and Minnesotans for Compassionate Care opposed — have restricted the number of patients who are able to legally participate in the medical marijuana program. A patient's health care practitioner must be willing to both certify that the patient has a qualifying condition and then participate in the program as well. In addition, there are many individuals who simply do not have access to legal medical marijuana products because they live too far from one of the distribution points. Furthermore, the initial law failed to include intractable pain in the list of qualifying conditions.

On December 2, 2015, Health Department Commissioner Ed Ehlinger approved adding intractable pain as a qualifying condition. Even former vehement opponents — such as the head of the Minnesota chiefs of police and Gov. Dayton — did not object to the move. Unless Ehlinger is overruled by the legislature, which is unlikely, intractable pain patients will be allowed to sign up beginning on July 1, 2016.

Currently, the following conditions qualify for the medical marijuana program: Cancer (if the patient has severe pain, nausea, or wasting), HIV/AIDS, Tourette's, seizures, severe and persistent spasms, Crohn's disease, and a terminal illness (if the patient has severe pain, nausea, or wasting). Legislation enacted in 2015 requires the commissioner of health to make a recommendation on whether intractable pain should be added to the list by January 2016. The health commissioner may add other conditions as well.

Passage and enactment of the medical marijuana program, while at times challenging due to intransigence in the administration, was widely supported by Minnesotans at large. A March 2013 Public Policy Polling poll found 65% support for "changing the law in Minnesota to allow people with serious and terminal illnesses to use medical marijuana if their doctors recommend it."

Maryland

On April 14, 2014, Maryland became the 21st state to enact an effective medical marijuana law when H.B. 881, sponsored by Dels. Dan Morhaim, MD, and Cheryl Glenn, was signed into law by then-Gov. Martin O'Malley. Sens. Jamie Raskin and David Brinkley sponsored the Senate companion bill. The bill's passage and subsequent signing culminated more than a decade-long lobbying and grassroots effort by MPP, patients, their loved ones, and fellow advocates.

The road to an effective medical marijuana law included several partial victories before the state enacted a comprehensive law that provided protection from arrest and safe access to medical marijuana. In 2003, Republican Gov. Bob Ehrlich signed a bill into law that provided for a sentencing mitigation. It allowed a patient to claim "medical necessity" in court if she had been arrested for a marijuana crime. If successful, the patient would receive a criminal conviction and a $100 fine, but would not face jail time. While this law was better than nothing, it still treated patients like

criminals because they were still arrested and had to face the legal system. There were widely divergent applications of the law, and some patients had been unsuccessful in asserting the defense.

In 2011, MPP helped pass legislation to improve the medical necessity law by granting patients a full affirmative defense — meaning that they would be acquitted of the charges. In 2013, these protections were extended to caregivers. In order to raise the defense, a patient or caregiver had to show that they, or someone they care for, had been diagnosed with a debilitating medical condition by a doctor with whom they had a bona fide, ongoing relationship. In addition, only individuals in possession of an ounce or less of marijuana could raise the defense.

Also in 2011, the legislature approved creating a medical marijuana working group focused on crafting a comprehensive medical marijuana law. Karen O'Keefe, MPP's director of state policies, served on the work group and drafted legislation supported by half of the working group that would allow the licensing of medical marijuana dispensaries. Unfortunately, the other model — which was put forth by Health & Mental Hygiene Secretary Joshua Sharfstein — was the version that was ultimately enacted. That model allowed only teaching hospitals to dispense marijuana. MPP explained that no hospital would participate due to federal law, but given the Health Department's position, the legislature adopted that proposal instead. The ineffective law was approved in 2013.

Once teaching hospitals had predictably failed to sign up to openly commit federal felonies — albeit ones that were not prioritized for federal enforcement — the legislature was ready to consider the approach that was working in other states. In 2014, Dels. Dan Morhaim and Cheryl Glenn introduced legislation to create a workable medical marijuana program that relied on private, licensed, and regulated medical marijuana dispensaries to provide access to qualified patients.

The commission accepted applications for medical marijuana producers and dispensaries in the fall of 2015. Also that fall, physicians were allowed to sign up to make recommendations. Qualified patients are expected to be allowed to register with the program by January 2016. The commission expects medical marijuana to become available to patients in the second half of 2016.

In order to qualify for the medical marijuana program, an interested patient must first register with the medical marijuana commission. Once registered, a potential patient will visit a doctor who has also registered with the commission to obtain a written recommendation. This visit must be in person.

A physician may issue a patient a medical marijuana recommendation if the patient has a severe condition for which other medical treatments have been ineffective or if the patient has been diagnosed as having a chronic or debilitating condition resulting in severe lose of appetite, wasting, severe or chronic pain, severe nausea, seizures or severe muscle spasms, glaucoma, or PTSD. After receiving the written recommendation, a patient may visit one of the state-regulated medical marijuana dispensaries to obtain his or her medicine. The commission will register two medical marijuana dispensaries per state Senate district, of which there are 47 across the state.

Compared to other medical marijuana laws that have been enacted by legislatures in recent years, Maryland's allows more seriously ill patients to qualify and allows more points of access to medical cannabis throughout the state. Several of the other recent laws have excluded patients with chronic pain.

Illinois

Illinois became the 20th state to enact an effective medical marijuana bill when H.B. 1, sponsored by Rep. Lou Lang (D), was signed into law by Gov. Patrick Quinn (D) on August 1, 2013. The formal title of the law is the Compassionate Use of Medical Cannabis Pilot Program Act. As its name indicates, the law is a pilot program, and the program will expire four years after the law goes into effect, unless there is further legislation passed to either extend the program or replace it. The bill's passage followed a nearly 10-year lobbying and grassroots effort by MPP, patients, and other advocates.

In the Senate, the lead champion was former state's attorney, Sen. Bill Haine (D). A previous version of the bill sponsored by Sen. Haine, S.B. 1381, passed the Senate in 2010, but fell just short of passing in the House in January 2011. Several changes were made to the bill to secure passage. As a result, the law established by H.B. 1 is one of the more restrictive in the nation — it does not allow patients to grow their own medicine, and there is no qualifying medical condition for pain, though several types of medical conditions causing pain are included. The original law did not include seizures as a qualifying medical condition, nor did it allow minors to be included in the registry, but a subsequent amendment, S.B. 2636, which passed in 2014, added both features to the pilot program.

The law went into effect on January 1, 2014, and three state agencies were given oversight responsibilities and rule-making authority. The Department of Public Health oversees the patient registry, the Department of Agriculture oversees cultivators, and the Department of Financial and Professional Regulation oversees dispensaries and physicians. Each department had four months from the effective date of the act to adopt rules. Despite this rapid timeline for rule-making, the licensing process was slow. The first medical marijuana dispensaries opened in November 2015, two years and three months after the law's enactment.

Under the pilot program, patients may obtain up to 2.5 ounces of medical marijuana every 14 days. Caregivers registered with the state may obtain and transport medical marijuana on behalf of designated patients. Patients may obtain marijuana from one of 60 state-registered dispensaries, whose locations were determined in the rule-making process based on population. The dispensaries may, in turn, obtain marijuana from one of 22 cultivation facilities (one per state police district). Cultivation facilities must abide by rules on labeling and marijuana-testing requirements, 24-hour video surveillance, photo IDs for staff, cannabis-tracking systems, and inventory control measures.

Registered patients are protected from arrest under state law. There are also protections in relation to patients being discriminated against in medical care — such as organ transplants — and in reference to child custody. In addition, landlords may not refuse to rent to a person solely due to his or her status as a registered patient or caregiver, unless housing the applicant violates federal law on the part of the landlord. Landlords may, however, prohibit smoking medical marijuana on their premises.

While Illinois has the fifth largest population in the U.S. and is currently the second largest medical marijuana state by population, the total number of participants is expected to be relatively modest due to several significant limitations on patients who wish to participate in the program. Patients may only receive a medical marijuana recommendation from a physician who treats the underlying condition – as opposed to a physician or clinic dedicated exclusively to the purpose of making recommendations. Further, Illinois currently has a unique requirement in that individuals with convictions of certain enumerated criminal offenses are prohibited from participating in the program regardless of their medical qualifications. In addition, people who work in certain professions, including law enforcement personnel, firefighters, and commercial drivers, are not allowed to participate in the program.

Whereas most states allow patients with severe pain or spasms to qualify, patients must have one of the following specifically listed conditions to qualify in Illinois. The qualifying medical conditions are: Cancer; glaucoma; HIV/AIDS; hepatitis C; amyotrophic lateral sclerosis (ALS); Crohn's disease; agitation of Alzheimer's disease; cachexia/wasting syndrome; muscular dystrophy; severe fibromyalgia; rheumatoid arthritis; spinal cord disease; Tarlov cysts; hydromyelia; syringomyelia; spinal cord injury; traumatic brain injury and post-concussion syndrome; multiple sclerosis; Arnold Chiari malformation; spinocerebellar ataxia (SCA); Parkinson's disease; Tourette's syndrome; myoclonus; dystonia; reflex sympathetic dystrophy (RSD); causalgia; CRPS; neurofibromatosis; chronic inflammatory demyelinating polyneuropathy; Sjogren's syndrome; lupus; interstitial cystitis; myasthenia gravis; hydrocephalus; nail patella syndrome; residual limb pain; seizures, including those characteristic of epilepsy; and the treatment of these conditions.

The Department of Public Health has the authority to add additional medical conditions, and advocates will be encouraging it to do so. As is the case nationwide, Illinois voters are very sympathetic to patients who could benefit from medical marijuana. A Paul Simon Public Policy Institute poll in February 2013 indicated that 62% of voters in the state support giving access to a small amount of medical marijuana to seriously ill patients. Despite strong support by voters, the program rollout has been plagued with delays, and recent efforts to expand the program to include additional qualifying medical conditions or the duration of the pilot program have fallen short following vetoes by Gov. Bruce Rauner in 2015. In addition, the Department of Health rejected a recommendation from its medical marijuana advisory board that 11 conditions — including chronic post-operative pain, Ehlers-Danlos Syndrome, eripheral and diabetic neuropathy, and PTSD — be added in 2015.

New Hampshire

Gov. Maggie Hassan (D) signed HB 573 into law on July 23, 2013, creating one of the most restrictive medical marijuana laws in the country. The legislature had previously passed medical marijuana legislation in both 2009 and 2012, but those bills were vetoed by former Gov. John Lynch (D). MPP led a multi-year lobbying and grassroots campaign in support of patient protections. New Hampshire's law became the first effective state medical marijuana law to pass with majority support from both major parties in both chambers of the legislature.

The law went into effect immediately, but as a result of changes demanded by Gov. Hassan prior to the bill's passage, patients will not receive legal protection until rules are adopted by the Department of Health and Human Services (DHHS) and registry ID cards are issued. DHHS was expected to begin issuing cards by July 2014, but an unfavorable advisory opinion issued by the state attorney general's office delayed the registration process, and the DHHS is thus refusing to issue cards until the first dispensary is ready to open in 2016. (A stage 4 cancer patient, Linda Horan, filed suit in November 2015 to challenge that decision.) Gov. Hassan also insisted on removing home cultivation from the bill, gutting the affirmative defense provisions, removing post-traumatic stress disorder (PTSD) as a qualifying medical condition, and adding a provision requiring patients to receive written permission before using marijuana on someone else's property.

To qualify for an ID card, a patient must obtain a written certification from a physician or an advanced practice registered nurse and submit it to DHHS. The provider must be primarily responsible for treating the patient's qualifying condition. Minors with qualifying serious medical conditions may register if the parent or guardian responsible for their health care decisions submits written certifications from two providers, one of which must be a pediatrician. The parent must also serve as the patient's caregiver and control the frequency of the patient's use. Out-of-state patients with valid medical marijuana cards from other states are allowed to bring their marijuana into New Hampshire and use it in the state. They must also have documentation from their physicians that they have a condition that qualifies under New Hampshire law.

The law allows patients to qualify if they have both one of the listed medical conditions and one of the listed qualifying symptoms. The qualifying conditions are: Cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, Alzheimer's, multiple sclerosis, lupus, epilepsy, Parkinson's disease, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, and injuries that significantly interfere with daily activities. The qualifying symptoms are: Severely debilitating or terminal medical conditions or their treatments that have produced elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, severe pain if it has not responded to other treatments or if treatments produced serious side effects, severe nausea, vomiting, seizures, or severe, persistent muscle spasms. In addition, the law provides that, on a case-by-case basis, the department may allow patients to register who do not have a listed medical condition if their providers certify that they have a debilitating medical condition. However, the Attorney General's office has reinterpreted this provision to only allow providers to petition the department to add new conditions rather than allowing for decisions on a case-by-case basis.

Patients may have a single caregiver who may pick up medical marijuana for them. Caregivers must be 21 or older and cannot have a felony conviction. Caregivers typically may assist no more than five patients.

Registered patients may not be arrested or prosecuted or face criminal or other penalties for engaging in the medical use of marijuana in compliance with the law. The law also offers protections against discrimination in child custody cases and in medical care — such as organ transplants.

New Hampshire's law allows a patient with a registry ID card to obtain up to two ounces of processed marijuana every 10 days. Caregivers may possess that amount for each patient they assist. Patients and caregivers may not grow marijuana. Instead, they will be allowed to obtain medical marijuana from one of up to four state-regulated alternative treatment centers (ATCs).

AATCs will be nonprofit and may not be located within 1,000 feet of the property of a drug-free zone or school. They must provide patients with educational information on strains and dosage and must collect information that patients voluntarily provide on strains' effectiveness and side effects. Staff must be at least 21 years old, wear ATC-issued badges, and cannot have any felony convictions. The law includes numerous additional requirements, including for periodic inventories, staff training, incident reporting, prohibiting non-organic pesticides, and record keeping. ATCs cannot possess more than either 80 mature plants and 80 ounces total or three mature plants and six ounces per patient. The health department — with input from an advisory council — adopted additional rules, including for electrical safety, security, sanitary requirements, advertising, hours of operations, personnel, liability insurance, and labeling. Rules on security include standards for lighting, physical security, video security, alarms, measures to prevent loitering, and on-site parking.

New Hampshire's law does not allow marijuana to be smoked on leased premises if doing so would violate rental policies. Marijuana also cannot be smoked or vaporized in a public place, including a public bus, any other public vehicle, a public park, a public beach, or a public field.

Massachusetts

Question 3, a ballot initiative, passed with 63% of the vote in November 2012. It went into effect January 1, 2013, and patients were immediately able to qualify for legal protections if they carried a physician's written certification in lieu of a registry ID card. The Department of Public Health (DPH) began issuing ID cards to patients and caregivers in 2014.

Massachusetts' law allows a patient or caregiver to possess a 60-day supply of marijuana. The Department of Public Health's rules define a presumptive 60-day supply as 10 ounces, but physicians can certify that a greater amount is needed if they document the rationale.

Under the law passed by voters, doctors may recommend medical marijuana for the following medical conditions: "Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis and other conditions as determined in writing by a qualifying patient's physician." In its rules, the health department has also required that other conditions be debilitating, which it has also defined.

The law required DPH to certify at least 14 registered marijuana dispensaries by January 1, 2014. DPH did not meet this deadline, but it did issue 15 provisional certificates to dispensaries in 2014, and the first dispensaries opened in the summer of 2015. In 2015, DPH opened up the application process significantly and received over 150 applications. The law stipulates that at least one dispensary must be located in each county, and no more than five may locate in a single county.

Massachusetts' law also allowed qualifying patients to begin growing marijuana immediately. Question 3 generally only allows home cultivation if the patient does not have access through a dispensary, but since no dispensaries were open, initially all qualifying patients were eligible to begin cultivating marijuana. DPH now issues hardship cultivation registrations only to patients whose access to dispensaries is limited by financial hardship, the physical incapacity to access reasonable transportation, or the lack of dispensaries reasonably close to — or that will deliver to — the patient.

Massachusetts' law provides that "Any person meeting the requirements under this law shall not be penalized under Massachusetts law in any manner, or denied any right or privilege, for such actions." Patients, caregivers, and dispensary agents who present their ID cards to law enforcement and possess a permissible amount of marijuana may not be subject to arrest, prosecution, or civil penalty. Massachusetts' law does not provide recognition for out-of-state ID cards.

Connecticut

Connecticut became the 17th state to approve an effective medical marijuana law when Gov. Dannel Malloy (D) signed H.B. 5389 on June 1, 2012. The law went into effect on October 1 of that year, and the state Department of Consumer Protection, charged with administrative oversight for program participants, began accepting patient applications under what the state referred to as a "temporary registration" process. Once formal rules were adopted by the department on September 6, 2013, the program was no longer considered "temporary."

While Connecticut's list of qualifying conditions is otherwise similar to those in other medical marijuana states (see Table 2), severe or chronic pain is not recognized as qualifying for patients in Connecticut. In 2015, the Department of Consumer Protections agreed with the Board of Physicians that four new conditions should be added to the list of qualifying medical conditions: Sickle cell disease, post-laminectomy syndrome ("failed back syndrome"), severe psoriasis, and psoriatic arthritis. The conditions will not be part of the program until the legislature considers them.

The Department of Consumer Protection adopted rules for the regulation of cultivation centers and dispensary facilities on September 6, 2013 and began accepting applications for businesses shortly thereafter. Unfortunately, the department's rules have made it very costly to operate in the Constitution State, particularly for small, family-run businesses. The department requires a $25,000 application fee from producers, plus an additional $75,000 if they are accepted as licensees. Operators must also have a $2 million bond or insurance policy payable to the state if the producer falls behind on state requirements. In addition, producers must have all marijuana tested, even if there is no testing facility available in the state.

Connecticut's law allows for up to ten producer licenses — which allow both growing and processing cannabis — but only four producers were operating in Connecticut at the end of 2015.

In the fall of 2015, there were only six licensed dispensaries operating in the state. However, the Department of Consumer Protections decided to add up to three additional dispensaries, which will likely be located in New Haven and Fairfield counties, where roughly 50% of the state's patients live. The state Department of Consumer Protection said it expects to make selections in early 2016, and the dispensaries could be open by June. It received 19 applications for the three dispensary licenses.

Delaware

On May 13, 2011, Gov. Jack Markell (D) signed comprehensive medical marijuana legislation (SB 17) into law. The passage of SB 17 followed a two-and-half year campaign led by MPP, which involved working closely with patient advocates and legislative champions. Sixty-six percent of the House and 81% of the Senate (17 senators) voted for the final bill, clearing the required three-fifths vote threshold mandated because of the bill's revenue provisions. SB 17 also had strong bipartisan support, with bipartisan sponsors in both chambers. It received eight Republican votes, including a majority of Senate Republicans.

The Delaware Medical Marijuana Act contains many elements of MPP's model bill. Patients whose doctor, in the course of a bona fide physician-patient relationship, certifies that "the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition" qualify for the program. The listed conditions initially were: Cancer; HIV/AIDS; decompensated cirrhosis; multiple sclerosis; amyotrophic lateral sclerosis (ALS); agitation of Alzheimer's disease; post-traumatic stress disorder (PTSD); or a medical condition that produces wasting syndrome, intractable nausea, seizures, persistent muscle spasms, or severe debilitating pain that has not responded to other treatments for more than three moths or for which other treatments produced serious side effects.

Patients may have one caregiver to possess and pick up marijuana on their behalf. The law also created the structure for a state-regulated, nonprofit, compassion center program to distribute medical marijuana to registered patients. The law does not include home cultivation because there was not enough support for such a provision in the legislature. Delaware's law recognizes medical marijuana cards issued by other states for conditions that qualify under Delaware Law. It also includes extensive civil discrimination protections for medical marijuana patients in the areas of employment, housing, education, organ transplants, and child custody, visitation, and parental rights.

One way in which Delaware's initial law departed from MPP's model bill was that it excluded minors. This was remedied in 2015. Legislation sponsored by Sen. Ernesto Lopez (R) was enacted with overwhelming support allowing doctors to recommend medical marijuana oils to certain patients under the age of 18. To qualify, the young patients must suffer from intractable epilepsy or a medical condition that has not responded to other treatments and that involves wasting, intractable nausea, or severe, painful, and persistent muscle spasms. Also in 2015, the state health department approved a new qualifying condition — autism with aggressive or self-injurious behavior.

SB 17 took effect on July 1, 2011, but on February 12, 2012, Gov. Markell halted implementation of the compassion center portion of the law, citing concerns about possible federal enforcement activity against those complying with the law. He did not stop the patient registry portion of the law from going into effect. The Department of Health and Social Services issued draft regulations on April 1, 2012 and started accepting patient applications on July 2, 2012. However, implementa-

tion of the compassion center program was still on hold, meaning patients had no access to the medicine they were legally allowed to possess and use if recommended to by their doctors. Since they could not cultivate their own supply, they had very little incentive to register.

On August 15, 2013, after seeing that similar, well-regulated programs in other states were not facing federal interference, Gov. Markell directed the Department of Health and Social Services to move forward with drafting regulations for the compassion center program. However, the governor ordered the department to issue only one pilot compassion center license (as opposed to the three, one in each county, as called for in law). Additionally, the governor ordered the department to issue regulations capping the number of marijuana plants that a center may possess at 150 and the amount of usable marijuana it may possess at 1,500 ounces. The department finalized the regulations, including the possession caps, in early February 2014, and issued a request for proposal for the one pilot compassion center.

The state's first compassion center, First State Compassion Center located in Wilmington, opened its doors to patients on June 24, 2015. On August 1, 2015, the Department of Health and Social Services issued emergency regulations that removed the plant possession cap altogether and increased the amount of usable marijuana a compassion center may be in possession of to 2,000 ounces. As of this publication, there has been no action taken by the department, or the governor, to issue compassion center registrations to individuals or entities wishing to provide safe access to patients in Delaware's other two counties, Kent and Sussex.

Arizona

On November 2, 2010, Arizona voters enacted a medical marijuana initiative — Proposition 203 — with 50.13% of the vote. Prop. 203 was the only statewide marijuana-related initiative to pass in any state in 2010. The law passed even as that same Arizona electorate flipped control of its Congressional delegation to Republicans and expanded the conservative majority in both chambers of the state legislature, further demonstrating that compassionate medical marijuana laws are supported by voters of both parties.

The law, which MPP drafted and backed the campaign for, went into effect on December 10, 2010. As was the case with Delaware's law, Arizona's included a provision allowing patients to raise their medical need for marijuana in court as an affirmative defense until the state's registry ID card program was up and running.

The Arizona Department of Health Services (DHS) finalized dispensary and registry identification card regulations on March 28, 2011. On April 14, 2011, it began accepting applications for registry cards that provide patients and their caregivers with protection from arrest. DHS was preparing to accept dispensary applications starting in June and to register one nonprofit dispensary for every 10 pharmacies in the state, totaling 125. However, on May 27, 2011, Gov. Jan Brewer (R) filed a federal lawsuit seeking a declaratory judgment on whether Arizona's new medical marijuana program conflicts with federal law.

This lawsuit gave Brewer an excuse to delay implementation, and she ordered DHS to cease moving forward with licensing any dispensaries, although DHS continued to issue patient and caregiver ID cards. A safety valve in the law provides that a doctor's certification and notarized statement would function as an ID card if DHS ever stopped issuing ID cards. That provision was apparently the reason Gov. Brewer did not seek to halt the ID card portion of Prop. 203.

Arizona's law also provides that any patient living 25 miles or more away from a dispensary can cultivate marijuana. As a result, prior to dispensaries opening, patients and their caregivers were permitted to cultivate statewide.

When Gov. Brewer's lawsuit was rejected by a federal judge in 2012, she relented and DHS drew up rules for dispensaries. Over 500 applications were submitted; the regulations allowed one for each of 126 Community Health Analysis Areas (CHAAs). DHS held a lottery-style drawing in August 2012 to determine which qualified applicants could move forward with the licensing process, and 98 applicants were selected to move forward. As of fall 2015, about 90 dispensaries were open and serving patients.

To qualify under Arizona's program, patients must have one of the listed debilitating medical conditions: Cancer; HIV/AIDS; hepatitis C; glaucoma; multiple sclerosis; amyotrophic lateral sclerosis (ALS); Crohn's disease; agitation of Alzheimer's disease; PTSD; or a medical condition that produces wasting syndrome, severe and chronic pain, severe nausea, seizures, or severe and persistent muscle spasms. The patient's doctor must certify in the course of a physician-patient relationship that "the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition."

Registered patients may possess up to 2.5 ounces of marijuana and may designate one caregiver to possess it on their behalf. Those allowed to cultivate can grow up to 12 plants. The law also includes extensive civil discrimination protections for medical marijuana patients in the areas of employment, housing, education, organ transplants, and child custody, visitation, and parental rights.

Sadly, in 2011, the Arizona Legislature rolled back some of Prop. 203's protections with legislation, despite the state's Voter Protection Act, which was designed to prevent legislative meddling. The legislature passed H.B. 2541, which possibly allows an employer to fire a medical marijuana patient based on a report alleging workplace impairment from a colleague who is "believed to be reliable." It also seemingly allows termination based on a positive drug test, which contradicts Prop. 203's explicit language protecting patients from termination without proof of workplace impairment or possession.

The legislature also passed H.B. 2585, which contradicts Prop. 203 by adding confidential medical marijuana patient data to the prescription drug monitoring program, where it could be subject to "fishing expeditions" by law enforcement and others. Legal challenges to these laws are possible.

In 2012, the legislature passed another law to undermine Prop. 203 — H.B. 2349 — which prohibited medical marijuana at all schools, including college campuses and vocational schools. In 2013, the legislature passed S.B. 1443 to clarify that federally approved medical marijuana research could still be conducted at universities.

The legislature undermined patient protections again in 2015 with the passage of H.B. 2346, which specifies that nothing requires a provider of workers' compensation benefits to reimburse a person for costs associated with the medical use of marijuana.

Arizona honors visiting patients' out-of-state registry identification cards for up to 30 days, but they are not valid for obtaining marijuana. The law has an affirmative defense for unregistered patients with doctors' recommendations and their caregivers, but it sunset once the Department of Health Services began issuing ID cards.

New Jersey

On January 18, 2010, Gov. Jon Corzine (D) signed the New Jersey Compassionate Use Medical Marijuana Act into law on his last day in office. The Assembly voted 48-14 (77% of the chamber), and the Senate 25-13 (66%), to pass S. 119, which removed criminal penalties for registered qualified patients possessing marijuana for medical purposes.

Patients with registry identification cards that possess up to two ounces of marijuana dispensed by an alternative treatment center are protected from arrest, prosecution, and other statewide

criminal penalties. The law allows a patient to have a primary caregiver possess medical marijuana on his or her behalf and includes an organized system of at least six state-licensed alternative treatment centers. It does not include home cultivation.

To qualify, the patient's doctor must certify that he or she authorizes the patient to apply for registration for the medical use of marijuana. The patient must also have one of the listed debilitating medical conditions: cancer and HIV/AIDS (only if the condition or its treatment results in severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome); terminal cancer; terminal illness where the physician has determined a prognosis of less than 12 months of life; multiple sclerosis; muscular dystrophy; amyotrophic lateral sclerosis (ALS); inflammatory bowel disease, including Crohn's disease; and, if they are resistant to conventional medical therapy, glaucoma, seizure disorders, and intractable skeletal muscular spasticity. New Jersey's program does not include a general category for severe, chronic, or debilitating pain. However, the health department can add additional conditions.

After Gov. Corzine's signing of the bill, newly-elected Gov. Chris Christie (R) immediately began delaying implementation and asked the legislature to pass S. 2105 to postpone the law's effective date by three months. New Jersey's law went into effect on October 1, 2010, but patients still lacked protections because ID cards were mandatory and were not being issued. The bill lacked an affirmative defense for unregistered patients. Christie's Department of Health and Senior Services (DHSS) — currently the Department of Health — drafted needlessly harsh rules that overstepped DHSS's authority and did not track the already strict legislation. The legislature pushed back, passing ACR 151, a resolution to repeal the draft rules, forcing DHSS to start over. In January 2011, DHSS re-proposed draft rules and held public comment on them. During this process, on March 21, 2011, DHSS approved six nonprofit alternative treatment centers (ATCs), two in each part of the state.

On June 15, 2011, after U.S. attorneys had written letters to legislators in other states, reiterating that marijuana is Schedule I and indicating they may target dispensaries, Gov. Christie decided to halt implementation of the medical marijuana program. However, upon further consideration, he reversed himself, and on July 19, 2011, he announced that he was moving forward with program implementation "as expeditiously as possible." In his press conference, Christie also recognized medical marijuana as compassionate pain relief, and stated, as a former U.S. attorney, that he does not believe federal law enforcement will expend "significantly lessening resources" raiding New Jersey's dispensaries.

In December 2012, the first ATC opened and began serving patients. Unfortunately, it was not able to meet the needs of patients and was forced to close for several months in 2013, leaving patients without legal access. As of fall 2015, four ATCs have opened, while a fifth has been issued a permit by the Department of Health.

The slow implementation of this law has negatively impacted New Jersey patients. While waiting for the state to implement dispensaries, multiple sclerosis patient John Ray Wilson was convicted for growing 17 marijuana plants for his personal medical use. Wilson was sentenced to five years in prison and began serving his sentence in January 2011.

Michigan

On Tuesday, November 4, 2008, 63% of Michigan voters approved Proposal 1, the Michigan Medical Marihuana Act, making their state the first in the Midwest to approve an effective medical marijuana law. MPP drafted the measure and its campaign committee led the successful initiative campaign, which received a majority of votes in each of Michigan's 83 counties.

Michigan's law allows patients with debilitating medical conditions to register with the state to use marijuana according to their doctors' recommendations. Patients may possess up to 2.5 ounces of marijuana and may cultivate up to 12 plants in an enclosed, locked facility, or appoint a caregiver to cultivate marijuana on their behalf. Caregivers may assist no more than five patients.

The law provides for increased penalties of up to two years and a $2,000 fine in the event that a patient or caregiver sells marijuana to someone who is not a registered patient. It also provides an affirmative defense intended to protect patients and caregivers who may or may not be registered, but who can establish (1) that a doctor has diagnosed the patient with a serious medical condition for which marijuana is likely to provide relief, (2) the patient was in possession of an amount only reasonably necessary to ensure an uninterrupted supply, and (3) the patient was using marijuana for medical purposes. Finally, Michigan's law is one of only a handful that provides protections for out-of-state patients; the provision applies only if the patient visits for no more than 30 days.

The Department of Community Health began accepting applications on April 4, 2009. The Department of Heath was initially in charge of administering the program; however, oversight was shifted to the Department of Licensing and Regulatory Affairs (LARA) in 2011. The department is required to process applications within 15 days; however, it quickly fell behind this schedule, and the backlog continued with LARA for a period of time.[1] Fortunately, a separate provision of the law provides that if the department fails to act on a completed application within 20 days, it is deemed granted until a decision is made.

Michigan's law was drafted during the George W. Bush administration, when no state law included regulated dispensaries. It does not provide for the establishment of dispensaries, though some have made the case that it allows patient-to-patient transfers, and this essentially allows a means for some form of dispensaries to operate.

Many businesses – more than 100 by some estimates – began operating as dispensaries in 2010, and many cities, including Lansing, Ann Arbor, and Ypsilanti, passed ordinances regulating and recognizing such businesses. However, in 2012, the Michigan Supreme Court ruled that patient-to-patient transfers are not legal under the law.[2] Many dispensaries closed their doors in the wake of the ruling and a similar ruling by the state's appellate court, and it is not clear how many remain open now. Rep. Mike Callton (R) and a bipartisan group of co-sponsors have introduced a bill that would allow dispensaries in those cities that regulate and register them.

New Mexico

In 2007, Gov. Bill Richardson (D) became the first governor in history to sign a medical marijuana law while running for the presidency by signing SB 523, making New Mexico the 12th state to protect medical marijuana patients from arrest. According to Department of Health regulations, patients may possess up to six ounces of usable marijuana and, after obtaining a separate permit, cultivate up to four mature plants and 12 seedlings.

New Mexico's law was the first in the country to direct the state to implement a system for the distribution of medical marijuana to qualifying patients. The state issued its first license to a dispensary — or "licensed producer" as they are known locally — in March 2009. Four more were issued that November and 20 more in 2010. Since then, two have closed, bringing the total to 23. Twelve additional producers were approved by the department in 2015, but were not yet open as of fall 2015.

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[1] Report on the Amount Collected and Cost of Administering the Medical Marihuana Program, April 1, 2011. The report showed $9.7 million in revenue through March 31, 2011, with a surplus of $8.1 million.

[2] *Michigan v. McQueen*, 820 N.W.2d 914 (Mich. 2012).

There have been periodic reports of shortages and patients who were unable to obtain an adequate supply, which are caused by New Mexico limiting both the number of producers and the number of plants. In late 2010, the department increased the maximum number of plants each could produce from 95 to 150. That number was again increased in 2015 to 450.

Although the law's initial list of conditions was quite limited and did not include a general category for severe pain, the Department of Health has taken a proactive approach toward adding to the list of conditions for which patients can qualify for the program. The law calls for the establishment of a "Medical Advisory Board" to review petitions to add conditions to the list, and the department has added conditions to the list in some cases and declined to in others. New Mexico was the first state to explicitly recognize post-traumatic stress disorder, which affects many veterans returning from Iraq and Afghanistan, as a qualifying condition. In fact, PTSD is the most oft-cited condition for patients applying for registry ID cards. New Mexico's program was also expanded to include severe chronic pain.

Rhode Island

In January 2006, the Rhode Island General Assembly became the first state legislature to override a medical marijuana veto. Eighty-two percent of voting members in each chamber voted to override the veto of MPP's medical marijuana bill, while only 60% of their votes were needed to enact it.

The law included a sunset clause, which would have caused it to expire on June 30, 2007. However, the state legislature enacted a bill to make the law permanent and slightly modify it. Gov. Don Carcieri (R) vetoed that bill too, and an even higher percentage of the state legislature overrode his veto on June 21 and June 22, 2007.

The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act — named in honor of Senate sponsor Rhoda Perry's nephew, who succumbed to AIDS, and House sponsor Thomas Slater, whose life was subsequently taken by cancer — went into effect upon its passage on January 3, 2006. The Department of Health issued the first medical marijuana ID cards in May 2006. Patients with medical marijuana ID cards are protected from arrest, prosecution, and other statewide civil and criminal penalties if they possess no more than 2.5 ounces of marijuana and 12 plants. They are also allowed to have one or two caregivers cultivate marijuana for their medical use.

In 2008, Rep. Thomas Slater and Sen. Rhoda Perry proposed a bill to improve access for patients, many of whom were unable to grow their own medicine or find reliable caregivers, by allowing up to three state-regulated, nonprofit compassion centers to distribute medical marijuana to patients. The Senate passed Sen. Perry's bill, 29-5. The House modified its bill to create a study commission on the issue, which easily passed both chambers. Gov. Carcieri vetoed the study commission resolution.

In 2009, the full Rhode Island General Assembly passed legislation to create compassion centers. H 5359 and S 0185 mirrored the legislation passed by the Senate in 2008. This proposal passed both chambers, but was vetoed by Gov. Carcieri. However, the Rhode Island General Assembly overwhelmingly overrode the veto with only three of 113 legislators siding with the governor.

The Rhode Island Department of Health set rules and regulations for compassion centers and accepted applications, though it ran behind the statutory schedule. In September 2010, the department rejected all 15 applicants, in some cases saying the applications were longer than the rules allowed them to be. After another round of application submissions, the department approved three compassion centers in March 2011. Unfortunately, after receiving a letter from United States Attorney Peter Neronha suggesting that the federal government could prosecute individuals op-

erating compassion centers, Gov. Lincoln Chafee (I) placed a hold on issuing the certificates of operation to the entities chosen to operate the compassion centers.

In late September 2011, Gov. Chafee announced that he would not lift the hold and called on lawmakers to work with him to create a system of safe and regulated access to medical marijuana that would not draw the ire of the federal government. MPP worked with then-Sen.Rhoda Perry and Rep. Scott Slater (son of the late Rep. Tom Slater) on legislation that would appease Gov. Chafee's concerns about federal interference while allowing a viable compassion center program to operate.

In May 2012, Gov. Chafee signed legislation that rewrote the compassion center law. It capped the amount of usable marijuana the compassion centers could possess at no more than 1,500 ounces at any given time, while restricting the centers to growing no more than 150 plants, 99 of which can be mature. In order to ensure supply, the legislation also allowed registered patients and their caregivers to sell excess medical marijuana that they grew directly to the compassion centers.

In 2014, following a change in federal policy, the General Assembly passed and Gov. Chafee signed a bill removing the possession caps previously placed on the compassion centers. The centers may now possess an amount of plants and usable marijuana to meet their patient demand. Patients and caregivers may still sell excess medical marijuana to compassion centers.

In April 2013, the Thomas C. Slater Compassion Center in Providence opened its doors, becoming the first compassion center in Rhode Island. Since then, the other two centers have opened — Greenleaf Compassion Center in Portsmouth and Summit Medical Compassion Center in Warwick.

Montana

In November 2004, Montana voters enacted a medical marijuana initiative – Initiative 148 – by what was at the time the largest margin for an initial vote on any effective statewide medical marijuana ballot measure, 62% to 38%. The law, which MPP drafted and campaigned for, went into effect upon its passage. Patients could immediately raise their medical need for marijuana in court, if they were arrested on marijuana charges.

Protection from arrest quickly followed. The Department of Public Health and Human Services (DPHHS) began accepting applications for registry ID cards on December 21, 2004. Registered patients and their caregivers were each able to possess up to an ounce of marijuana and six plants for the patient's medical use.

Under I-148, caregivers could serve an unlimited number of patients. Responding to patients' need for safe access to their medicine, by 2009, several had begun to operate as storefront dispensaries. While some localities, such as Bozeman, established sensible regulations, there was also some backlash related to unregulated dispensaries. In addition, "cannabis caravans" began to operate where doctors provided large numbers of recommendations after very short consultations. The Montana Board of Medical Examiners has the authority to regulate doctors to ensure they abide by a standard of care, and it set professional standards for medical marijuana recommendations in May 2010.

According to a February 20, 2011 Public Policy Polling poll, 76% of Montanans wanted to either leave the law as it was enacted by voters or they wanted new regulations, such as licensing and regulating providers. Despite this sentiment, the newly elected, socially conservative Montana Legislature approved H.B. 161, which would have completely repealed the voter-enacted law. On April 13, 2011, Gov. Brian Schweitzer (D) vetoed the repeal bill.

Then, the Montana Legislature passed S.B. 423, restrictive legislation designed to massively reduce participation in the medical marijuana program. Gov. Schweitzer issued an amendatory veto of an earlier version of S.B. 423 on April 28, 2011. After his amendatory veto, the legislature moved swiftly the same day, rejecting most of his proposed changes, and passing "repeal in disguise", as it was also known to medical marijuana advocates, 88-12 in the House and 33-16 in the Senate. S.B. 423 was sent to Gov. Schweitzer on May 3. With no time left in the legislative session, he reluctantly let it become law without his signature on May 13.

Most of S.B. 423 went into effect on July 1, 2011, but a state court judge has blocked several provisions from going into effect until their validity under the state constitution is decided in court. The Montana Cannabis Industry Association (whose name was later changed to the Montana Cannabis Information Association) filed a lawsuit to prevent implementation of S.B. 423. Separately, an unsuccessful referendum campaign was launched in 2012 to repeal the new law. The results of the repeal effort were mixed. Members of the legislature claimed the vote validated the new law in its entirety, even though it had never been fully in effect. Both sides agreed that the ballot language was confusing. According to the ballot language, voting against S.B. 423 appeared to be a vote against medical marijuana in the state, and it is likely that voters on both sides of the issue were confused by the effect a vote either in favor or in opposition would have on the law. Regardless, the voters did not overturn S.B. 423 in 2012, and the lawsuit challenging the law continues.

As of this printing, the Montana medical marijuana program has been changed significantly. To qualify, patients must have one of the listed debilitating medical conditions: cancer; glaucoma; HIV/AIDS; wasting syndrome; intractable nausea or vomiting; epilepsy or an intractable seizure disorder; multiple sclerosis; Crohn's disease; painful peripheral neuropathy; a central nervous system disorder resulting in chronic, painful spasticity or muscle spasms; or admittance into hospice care in accordance with rules adopted by the department.

Patients with severe chronic pain will also continue to qualify under the new rules, but only if it is "persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician and by (i) objective proof of the etiology of the pain, including relevant and necessary diagnostic tests that may include but are not limited to the results of an x-ray, computerized tomography scan, or magnetic resonance imaging; or (ii) confirmation of that diagnosis from a second physician who is independent of the treating physician and who conducts a physical examination." Regardless of the patient's condition, the doctor must now also create extensive documentation of the condition on the written certification, and it must state that the doctor has a reasonable degree of certainty that the person's debilitating medical condition would be alleviated by the use of marijuana and thus the person would benefit from its use.

Montana used to give out-of-state medical marijuana cards the same force and effect as Montana registry identification cards, but that ended with S.B. 423. S.B. 423 also changed possession limits to four mature plants, 12 seedlings, and one ounce of marijuana, and cardholders must now always carry their registry ID cards.

There is still no organized system of state-licensed dispensaries, and caregivers had to re-register as providers under many new restrictions. Gardens may not be shared, except for by close relations, and doctors must adhere to much more onerous regulations.

As of fall 2015, the following provisions of S.B. 423 have been permanently enjoined: A requirement that caregivers only serve three patients, a prohibition on caregivers receiving any compensation for their efforts, an advertising ban, and a requirement that physicians that make more than 25 medical marijuana recommendations a year must pay for an automatic Board of Medical Examiners investigation into their practice, regardless of whether any evidence of wrong-

doing is present. The injunction has been appealed and as of the time of this writing, the matter is pending before the Montana Supreme Court.

Vermont

Vermont's medical marijuana law — S. 76 — was the first effective medical marijuana law to be passed by a state legislature in spite of the public objections of a governor. After MPP organized a robust campaign, Gov. James Douglas (R) allowed S. 76 to become law without his signature on May 26, 2004. The law went into effect on July 1, 2004, and the Vermont Department of Public Safety (DPS) began accepting applications for registry ID cards on October 28, 2004.

Vermont's law is one of only three in which physicians are not required to recommend the medical use of marijuana. A medical provider must only "certify" that his or her patient has a qualifying condition in order for that patient to register with the Department of Public Safety.

In May 2005, a 54-year-old former construction worker who had been impaled by a metal rod 30 years earlier was convicted of cultivating 49 plants for his medical use. Although he did not qualify under Vermont's medical marijuana law, the jury acquitted him of possession of marijuana, finding that his marijuana use was medically necessary.

During the 2007 legislative session, the Vermont Legislature passed S. 7, which improved the medical marijuana law by expanding the qualifying conditions for the program. As he did in 2004, Gov. Douglas allowed the bill to become law without his signature. The new medical marijuana law took effect on July 1, 2007. It allows seriously ill patients suffering from conditions that cause nausea, wasting, chronic pain, or seizures to apply for the program. It also increased the number of plants patients and caregivers are allowed to grow to two mature and seven immature plants. Additionally, the law reduced the nonrefundable annual application fee from $100 to $50. Finally, it allowed licensed physicians in New York, Massachusetts, and New Hampshire to certify that Vermont patients have a qualifying condition.

In response to concerns from many patients who were unable to procure medical marijuana despite holding an ID card, the legislature again acted to improve the law in 2011 when it passed S.17, which allows for the establishment of four nonprofit medical marijuana dispensaries. Under the law, which was championed and signed by Gov. Peter Shumlin (D), patients designate one dispensary and can only obtain marijuana from their designated dispensary. The dispensaries, which are regulated by the Department of Public Safety, can cultivate a number of marijuana plants that is dependent on the number of patients that have designated that dispensary. In addition, S.17 also allows physician's assistants and advance practice registered nurses, in addition to physicians, to certify patients as having qualifying medical conditions.

Pursuant to a law enacted on June 2, 2011, the Department of Public Safety was directed to approve four nonprofit dispensaries. In the first round of applications, only two applicants met the standards, and they both opened in late Spring 2013. A third dispensary was approved in Spring 2013 and opened in Fall 2013, and a fourth dispensary was approved in Fall 2013.

Under the law, dispensaries were chosen based on a competitive process, including factors like convenience to patients, the applicants' experience, and their ability to provide for patients. Each dispensary employee must register with the state, and they generally cannot have drug convictions or convictions for violent felonies. Dispensaries must be located at least 1,000 feet from schools. Municipalities can regulate their locations and operations and may also ban them within the locality. The state's Department of Public Safety developed rules for dispensaries' oversight, record keeping, and security. Fees include a $2,500 application fee, a $20,000 registry fee for the first year, and a $30,000 annual fee in subsequent years.

A patient must designate the dispensary he or she wishes to utilize, though the patient can change the designation. Dispensaries may only dispense by appointment. Dispensaries must cultivate their own marijuana, either at the retail site or at a second enclosed, locked cultivation location that must be registered with the department. They may dispense no more than two ounces of marijuana every 30 days to a given patient. The 2011 law also included a survey of patients and an oversight committee that will assess the effectiveness of the dispensaries and security measures.

In 2014, the Legislature passed S. 247, which allowed dispensaries to deliver to patients and allowed naturopathic physicians to certify patients for the program.

Vermont's law does not include any protections for unregistered patients or out-of-state patients.

Hawaii

Hawaii's initial medical marijuana statute was signed into law on June 14, 2000 — making Hawaii the first state to enact such a law through the state legislature — and took effect on December 28, 2000, when the Department of Public Safety issued administrative regulations and finalized forms allowing patients to register with the state.

Unlike some of the newer medical marijuana laws, patients with a fairly broad range of conditions qualify — including severe pain and nausea. Patients are also allowed to cultivate a modest amount of marijuana.

In addition to the registry, patients have a "choice of evils" defense to charges of marijuana possession if they have qualifying medical records or signed statements from their physicians attesting that they have debilitating conditions and that the medical benefits of marijuana likely outweigh the risks.

Patient interest in the Hawaii law has been strong since its enactment. The biggest problem facing Hawaiian patients was accessing medicine because dispensaries were initially not allowed. That will soon be remedied: On July 14, 2015, Gov. David Ige signed two important medical marijuana bills into law. HB 321 will allow medical marijuana dispensaries to operate in Hawaii, and SB 1291 strengthens civil protections for patients.

HB 321 initially allows eight entities (three on Oahu, two each on Big Island and Maui, and one on Kauai) to operate two dispensing locations each. Starting in 2017, the state health department will be allowed to issue more licenses as needed. Each dispensary license will allow the license holder to have two cultivation sites with up to 3,000 plants, as well as the two dispensing locations that must be separate from the cultivation locations.

Meanwhile, SB 1291 strengthens existing civil protections for medical marijuana patients and adds new protections that prevent landlords, schools, and courts from discriminating against medical marijuana patients.

The other major flaw with the initial medical marijuana law — tasking the Department of Public Safety's Narcotics Enforcement Division with being the regulatory agency — was remedied after the legislature approved moving the program to the Department of Health in 2013.

Also in 2013, a second bill (S.B. 642, C.D. 1) made both positive and negative changes to the state's medical marijuana law. The amount of usable marijuana a patient may possess increased from three to four ounces and the mature/immature definitions for cultivation were removed, allowing patients to have seven plants at any stage of growth. However, the bill allows only a patient's primary care physician to recommend medical marijuana. Because many doctors — including Veterans Administration physicians — will not recommend medical marijuana, this could make it impossible for some patients to participate.

Colorado

Colorado voters passed a ballot initiative on November 7, 2000 to remove state-level criminal penalties for medical marijuana use, possession, and cultivation. On June 1, 2001, less than three weeks after the U.S. Supreme Court's negative ruling on medical marijuana distribution in *U.S. v. Oakland Cannabis Buyers' Cooperative*, the Colorado Department of Public Health and Environment (CDPHE) implemented the Medical Marijuana Registry program and began issuing identification cards to patients and caregivers who qualify for legal protection under state law. After scrutiny from then-Gov. Bill Owen (R) and Attorney General Ken Salazar — both of whom opposed medical marijuana — no reason could be found to scrap the Medical Marijuana Registry program.[3]

Colorado's program received a boost in legitimacy when, in July 2001, Kaiser Permanente gave its Colorado doctors permission to recommend medical marijuana.[4] Kaiser, one of the nation's largest health maintenance organizations, has over 400,000 patients in Colorado.

In November 2007, Senior Denver District Judge Larry Naves overturned a Colorado Department of Health and Environment policy limiting the number of patients a caregiver can assist. The department had adopted a limit of five patients per caregiver during a closed meeting, during which no health care professionals, patients, caregivers, or horticulturists were consulted.

Although the Colorado medical marijuana program did not create a legal and regulated medical marijuana dispensing program, some individuals chose to open storefront dispensaries to meet the need for immediate access for patients. With the five-patient cap gone, they did so under the theory that they would be protected as caregivers. Under Amendment 20, caregivers are required to be a person over 18 and to have "significant responsibility for managing the well-being of a patient who has a debilitating medical condition."

In October 2009, the U.S. Department of Justice issued a memo by then-Deputy Attorney General David Ogden. This memo recommended that United States attorneys in states with medical marijuana laws not waste federal resources investigating and prosecuting individuals acting in clear compliance with a state program. Sensing a more hands-off approach, the number of dispensaries increased substantially.

On October 29, 2009, the Colorado Court of Appeals issued a ruling that signaled that dispensaries and cultivators were potentially vulnerable under existing state law (*People v. Clendenin*, 232 P.3d 210). The court ruled against Stacy Clendenin, a woman who cultivated marijuana in her home for distribution through dispensaries. It found a caregiver "must do more than merely supply a patient who has a debilitating medical condition with marijuana." In a specially concurring decision, Judge Loeb said the state's law "cries out for legislative action" because the law does not protect patients' and caregivers' suppliers.

In response to the new, unregulated dispensary industry with its murky legal status, the Colorado Legislature became the first governing body to implement a regulatory scheme and clear legal recognition for pre-existing medical marijuana dispensaries. Signed into law on June 7, 2010 by then-Gov. Bill Ritter (D), HB 1284 created a clear licensing scheme for the rapidly growing industry. It would not be the last time Colorado led the nation in implementing effective regulations for marijuana-related businesses.

Under Colorado law, dispensary owners and operators are subject to licensing fees and criminal background checks. Dispensaries may operate as for-profit businesses, but are required to grow at least 70% of their inventory themselves. Moreover, they may not operate within 1,000 feet of

[3] "Owens' and Salazar's joint statement on medical marijuana," *Denver Rocky Mountain News*, May 31, 2001.

[4] "Kaiser to allow medical marijuana," *Daily Times-Call*, July 7, 2001.

a school. HB 1284 also contains provisions licensing growing operations and infused product manufacturers connected to dispensaries, establishes standards for allowing some on-site consumption of medicine for patients who cannot safely use their medicine elsewhere, and makes medical marijuana purchases for indigent patients exempt from sales tax. In the 2012 fiscal year, medical marijuana sales taxes brought in more than $5.4 million to state coffers.[5, 6]

The Colorado Legislature took up medical marijuana legislation again in 2011, creating further registration requirements. Signed into law on June 2, 2011 by Gov. John Hickenlooper (D), HB 1043 sought to clarify a number of provisions in the "Colorado Medical Marijuana Code."

In 2013, partially in response to the successful campaign in November 2012 to remove all criminal penalties for limited possession, use, and cultivation of marijuana for adults 21 and older, the legislature amended their laws as they related to driving while under the influence of marijuana. The legislature passed a law creating a rebuttable presumption of intoxication for drivers who are found to have five or more nanograms of THC per milliliter of blood. The rebuttable presumption allows patients who are unfortunately charged with driving under the influence of marijuana to refute the charges by submitting evidence of sobriety, such as the results of a successful field sobriety test. Past versions of the DUID bill would have made driving with five nanograms of THC/ml of blood a *per se* conviction, meaning patients would not be allowed the chance to prove sobriety. Passage of the initiative to legalize marijuana for adults and regulate it like alcohol had no other effect on the medical marijuana program.

Nevada

Nevada voters twice approved a constitutional amendment allowing the use of medical marijuana, most recently in November 2000 (with 65% of the vote). The amendment required the legislature to provide for "appropriate methods" of supply. The legislature passed an implementing law, A.B. 453, in 2001, which established the state's medical marijuana registry program. A.B. 453 originally intended for the state to grow and distribute medical marijuana to patients who are either unable or unwilling to grow their own. That provision was dropped, however, and the bill was amended to simply allow patients and caregivers to cultivate.

Enacted after the U.S. Supreme Court's May 2001 ruling on medical marijuana in *U.S. v. Oakland Cannabis Buyers' Cooperative*, the preamble of A.B. 453 says that "the State of Nevada as a sovereign state has the duty to carry out the will of the people of this state and to regulate the health, medical practices and well-being of those people in a manner that respects their personal decisions concerning the relief of suffering through the medical use of marijuana."

Nevada's law is one of only two in the nation that includes a requirement that patients undergo a background check to ensure that they have no prior convictions for distributing drugs. The program requires that patients provide a fingerprint card to aid in the background check.

Once patients are approved, they are issued a 30-day temporary certificate, which affords them legal protection and allows them to obtain a one-year photo identification card from a Department of Motor Vehicles office. Patients who fail to register with the program — but are otherwise in compliance with the law — are allowed to argue at trial that they had a medical need to use marijuana.

A.B. 453 also required the state Department of Agriculture to work aggressively to obtain federal approval for a distribution program for marijuana and marijuana seeds and required the University of Nevada School of Medicine to seek, in conjunction with the state Agriculture Department,

[5] "Colorado Medical Marijuana Dispensary Retail Sales and State Sales Tax by County FY2012," Colorado Department of Revenue.

[6] For more details on the revenue in Colorado and other states from medical marijuana taxes, see Appendix U.

federal approval for a research project into the medical uses of marijuana. Apparently, no work has been done to carry out either of these directives.

In 2003, the legislature passed a bill that slightly amended the medical marijuana law. A.B. 130, introduced on behalf of the Nevada Department of Agriculture, allows osteopathic physicians to qualify as "attending physicians" for the medical marijuana program. This is good for patients in Nevada because it expands the scope of those who may receive legal protection for using medical marijuana. In 2005, the legislature passed a bill that would allow the Department of Agriculture to revoke the registry identification card of a participant in the state's medical marijuana program who has been convicted of drug trafficking or who has provided false information on his or her application.

Nevada's registry program was once the only one in the nation that did not charge patients an application or registry fee. It became the most expensive, with the Nevada State Health Division charging patients as much as $242 for the application and its processing, the ID card, and fingerprinting.

Nevada's medical marijuana program has had few, if any, reports of abuse. However, as one of the older laws, its lack of recognized, regulated dispensaries left many patients without access. Nevada caregivers cannot receive compensation for their work. Some sought to fill the void by providing marijuana at storefronts for donations. Local police raided and closed most of those entities, claiming they were impermissibly receiving donations. More than a dozen people were indicted as a result.

On September 12, 2011, Clark County Judge Donald Mosley dismissed charges against one of them, Leonard Schwingdorf, because the grand jury was not told that the co-op accepted but did not require, donations, so marijuana was not sold. Judge Mosley called the law "mind-boggling" and called on the legislature to act, saying, "I'm looking at it thinking I can't make any sense out of this law. ... Are people supposed to give it away? I mean it just makes no sense."[7]

Judge Mosley's decision appeared to be a tipping point, and in 2013, during the following legislative session, the Nevada Legislature passed a regulatory framework allowing and regulating cultivators, infused product manufacturers, testing labs, and dispensaries. The law allowed up to 66 dispensaries in the state, licensed through the Health Division. The rollout was not without its challenges (including a dispute between state and local government authorities), but by the fall of 2015, the dispensaries had opened and the law was functioning on behalf of patients.

S.B. 374 also made other changes to the law, including reducing the exorbitant patient registry card fees to no more than $100 and increasing possession limits. The bill also restricts home cultivation, providing that patients can only cultivate if they do not live near a dispensary, cannot travel to one, or there is no nearby dispensary with the strain they need. It grandfathers in those patients who were growing before the law passed until March 31, 2016.

Maine

Maine, which in 1999 became the fifth state to enact a modern medical marijuana law, broke new ground in 2002, when its legislature made it the first state to expand an existing medical marijuana law. Signed into law on April 1, 2002, LD 611 doubled the amount of usable marijuana a patient may possess, from 1.25 ounces to 2.5 ounces. The bill also clarified protections for patients and caregivers, explicitly providing them with an "affirmative defense" against charges of unlawfully growing, possessing, or using marijuana.

[7] "Nonsensical Law," *Las Vegas Review Journal*, September 18, 2011.

In November 2009, 59% of Maine voters approved a measure to expand the law — Question 5, which was drafted by MPP. The measure provided for a registry ID card system, which gave patients and caregivers protection from arrest, and it maintained an affirmative defense that could be raised by unregistered patients in court. It also increased qualifying conditions, including by adding intractable pain, and dramatically improved patients' access to medical marijuana.

Question 5 required the Department of Health to register eight dispensaries to provide medical marijuana to patients. The department issued six registrations in July 2010 and the final two the following month. All eight dispensaries were operational by the end of 2011.

In 2010, the legislature made several changes to Question 5. Most of the changes were relatively minor, but they also eliminated the law's affirmative defense.

In 2011, a new legislature restored some of the affirmative defense, by passing LD 1296. Gov. Paul LePage (R) signed the bill on June 24, 2011. The revised law makes registration optional for patients, who can be protected either by having a registry ID card or a "written certification," a document signed in the last year by a physician with whom the patient has a bona fide doctor-patient relationship saying the patient has a debilitating medical condition for which marijuana is likely to provide relief. Patients must also have a valid state-issued photo ID.

Notably, the legislative improvements took place with little fanfare or controversy. In 2002, LD 611 passed the Senate by a simple voice vote, as did LD 1296, which was sponsored by a Republican, Sen. Deborah Sanderson, in 2011. In fact, Republicans have been relatively supportive of efforts to expand Maine's medical marijuana law for years. When asked whether federal law served as a hindrance to expanding the law in 2002, Republican Rep. Robert Nutting said the law was "workable under federal law ... It's kind of like driving five miles an hour over the speed limit – no one's going to [enforce that]."[8]

Several amendments to the law passed in 2013. Most significantly, post-traumatic stress disorder (PTSD), inflammatory bowel disease, and dyskinetic and spastic movement were added to the list of qualifying conditions.

Oregon

The Oregon Medical Marijuana Program (OMMP) was enacted by a 1998 ballot initiative. Like other effective medical marijuana laws, Oregon's protects patients from state-level criminal penalties for the use, possession, and cultivation of medical marijuana. The OMMP, run through the Oregon Department of Human Services, issues registry ID cards to qualified patients and caregivers. Like other early medical marijuana laws, Oregon's allows patients or caregivers to cultivate marijuana. Patients may possess 24 ounces of usable marijuana and may cultivate six mature marijuana plants and 18 seedlings. A bill to create a dispensary program was enacted in 2013.

In addition to administering the registry program, the Department of Human Services considers petitions to add new medical conditions to the list of qualifying conditions, diseases, and symptoms covered by the law. In the first year of the program, an expert panel considered eight conditions — agitation of Alzheimer's disease, anxiety, attention deficit disorder, bipolar disorder, insomnia, post-traumatic stress disorder, schizophrenia, and schizo-affective disorder — and recommended three of them — agitation of Alzheimer's disease, anxiety, and bipolar disorder — for final approval. The department approved agitation of Alzheimer's disease, while rejecting the other two. The unapproved conditions may be reconsidered if additional supporting evidence can be offered, but no new medical conditions have since been approved.

[8] "Bill clarifies medical marijuana guidelines," *Bangor Daily News*, March 6, 2002.

In July 1999, less than nine months after the law was passed, the state amended the Medical Marijuana Act when Gov. John Kitzhaber (D) signed H.B. 3052 into law. The changes included:

- Mandating that patients may not use marijuana for medical purposes in correctional facilities;
- Limiting a given patient and primary caregiver to growing marijuana at one location each;
- Requiring that people arrested for marijuana who want to raise the medical necessity defense in court must have been diagnosed with a debilitating medical condition within 12 months prior to the arrest; and
- Specifying that a law enforcement agency that seizes marijuana plants from a person who claims to be a medical user has no responsibility to maintain the live marijuana plants while the case is pending.

To address remaining ambiguities in the medical marijuana law, the state attorney general's office convened a working group to develop recommendations on how state and local authorities should enforce the law. Issued on December 15, 1999, the recommendations elaborate on the range of defenses provided by the law and when they are applicable and offer cautious policies for seizing and destroying marijuana plants for jurisdictions to consider.

In 2001, with the volume of patients overwhelming the understaffed program, an internal audit revealed numerous problems: The program had a backlog of almost 800 applications, often failed to verify doctor signatures on applications, regularly missed deadlines for processing applications, and had no clear procedure for rejecting incomplete applications. Three registry cards (out of more than 2,000) had been issued to patients who had forged doctors' signatures. In response, the OMMP dramatically increased its staffing, which allowed it to clear the application backlog and greatly improve oversight.

The program has also adopted stricter rules for physicians, requiring that doctors who sign patients' applications maintain an up-to-date medical file for each patient, perform a physical, and develop a treatment plan. The state program may also examine a copy of the patient's file. Despite these more stringent standards, physician participation in Oregon has remained strong, with close to 1,700 physicians currently treating medical marijuana patients.

In 2010, the Oregon Supreme Court decided that employers can terminate an employee for testing positive for marijuana metabolites, which can linger in a person's system for weeks after their last use of marijuana (*Emerald Steel v. Bureau of Labor and Industries,* 348 Or. 159, 2010). Not even a year later, the same court found that county sheriffs are required to issue conceal and carry permits to applicants who qualify under state law, even if they are medical marijuana patients (*Willis v. Winters*, 350 Or. 299, 2011). The court reasoned that although federal government has decided that the illegal use of drugs prohibits an individual from purchasing a firearm, there is nothing in the state's conceal and carry law that would prohibit a medical marijuana patient being granted that permit. The sheriff in question appealed to the United States Supreme Court for a *writ of certiorari*. On September 1, 2012, the United States Supreme Court denied cert.

Like many early medical marijuana laws, Oregon's law originally did not allow for medical marijuana dispensaries. The lack of safe and immediate access was recognized early on leading to prolonged efforts to change the law. In 2004, activists gathered the signatures necessary to bring the question of whether to add medical marijuana dispensaries to the ballot. Measure 33, as it came to be known, lost 58% to 42%. Activists again tried to enact a dispensary program via the ballot in 2010. Like Measure 33, Measure 74 was defeated 56% to 44%.

After unsuccessful efforts via the ballot, activists approached the legislature seeking a legislative amendment to create a medical marijuana dispensary program. Prolonged efforts paid off when, in 2013, the legislature passed HB 3460, a law that created medical marijuana facilities that can transfer usable marijuana and immature plants to medical marijuana patients and their caregivers. Activists were also successful in adding post-traumatic stress disorder (PTSD) to the list of qualifying conditions in 2013.

In November 2014, Oregon voters passed Measure 91, which removed all penalties for adults 21 and older who possess and cultivate limited amounts of marijuana. The initiative also requires the Oregon Liquor Control Commission to license and regulate marijuana growers, producers, wholesalers, and retailers.

Legislation enacted in 2015 allowed medical marijuana dispensaries to sell a limited amount of marijuana to all adults 21 and older beginning on October 1, 2015. Unfortunately, the state also enacted legislation that will require future medical marijuana patients and renewals to be able to prove residency. Before then, Oregon's medical marijuana program lacked a residency requirement, allowing patients from states without medical marijuana programs to use marijuana medically if they were able to travel to, and stay in, Oregon for a period of time.

Alaska

Alaska voters passed a ballot initiative in 1998 to protect seriously ill state residents from arrest for possessing, using, and cultivating medical marijuana. In 1999, S.B. 94 made it mandatory for patients to participate in a state registration program. It also significantly reduced patients' protections by making the law an affirmative defense that must be proven in court, rather than protection from prosecution.

The legislature also limited the amount of marijuana that a patient may legally possess to one ounce and six plants, with no exceptions. Previously, patients who exceeded the numerical limit could argue at trial that a greater amount was medically necessary. Patients now often complain that the plant limit is too low.

Additionally, local advocates believe some patients are unable to maintain a consistent supply of medical marijuana. With the nation's shortest growing season, Alaskans generally have no choice but to grow indoors, which often presents a financial hardship. Not only does the state not permit medical marijuana distribution, but the Department of Health and Social Services rejected an idea to allow the registry program to provide patients with a list of independent groups that could provide them with the assistance necessary to grow marijuana on their own.

Because of these factors, there are only 745 registered medical marijuana patients and caregivers in the state, making it one of the nation's smallest medical marijuana programs. However, in addition to the problems mentioned above, low registration rates may also be due to the fact that in November 2014, voters voted to legalize marijuana possession and cultivation for all adults 21 and over. (Adult use stores are expected to open in 2016.) In addition, courts previously established basic constitutional privacy rights for adults who possess marijuana in the home, irrespective of a person's registry with the state medical marijuana system.

District of Columbia

Although 69% of District of Columbia voters approved an initiative removing district-level criminal penalties for the medical use of marijuana back in 1998, the District's medical marijuana program is just now taking root. That's because a long-standing provision, or "rider," in Congress' appropriations to the District prevented the District from using any federal or local funds to implement the act. The author of the "Barr Amendment" rider, Georgia Congressman Bob Barr

(R), had a change of heart, and MPP hired him to lobby to have the provision removed in 2007. The effort succeeded in late 2009.

Immediately after the Barr Amendment was removed and the initiative was transmitted to Congress for review (all legislation passed in the District must be sent to Congress which then has 30 days to nullify the law), the D.C. Council passed amending the legislation drastically narrowing the law.

Originally, the initiative would have allowed doctors to recommend marijuana for any condition that the doctor thought could be alleviated by marijuana. However, the Council's amending legislation restricted the conditions for which marijuana could be recommended to HIV/AIDS, glaucoma, cancer, multiple sclerosis, and conditions treated by chemotherapy, AZT, protease inhibitors, or radiotherapy. Additionally, the council removed wording that would have allowed patients to grow their own marijuana or have caregivers grow it for them.

The Council reversed course in the fall of 2014, passing legislation that partially restores the intent of the voters by allowing physicians to recommend medical marijuana for any debilitating condition they think would favorably respond to its use. While the medical marijuana law itself still prevents qualified patients and their caregivers from cultivating their own medicine, passage of Initiative 71 in November of 2014 has allowed anyone, including patients, 21 and over to cultivate up to six marijuana plants in their residence and to possess up to two ounces of marijuana.

The District's medical marijuana law allows patients to obtain marijuana from a dispensary licensed by the District's Health Department. The first dispensary began serving patients in July 2013. As of fall 2015, five dispensaries and seven cultivation facilities are operational. The mayor may approve up to five more dispensaries and additional cultivation facilities.

Caregivers may be appointed to pick up marijuana on patients' behalf from their designated dispensary and to assist in the administration of marijuana. There is also an affirmative defense in the law for individuals who are not registered caregivers but can establish they were only assisting a patient with the administration of medical marijuana because the patient's caregiver was unavailable.

Washington

Although Washington state was one of first states to adopt a medical marijuana law, until 2015 Washington had one of the country's weakest medical marijuana laws. Although it was considered effective, it failed to provide patients with protections against arrest and prosecution and instead made patients rely solely on an affirmative defense at trial. Washington was also the only medical marijuana state without some sort of patient registry system in place and one of a handful that lacked a state-regulated medical marijuana dispensary program, although some cities regulated medical marijuana dispensaries within their jurisdictions. Additionally, some individuals took advantage of a grey area of the law in order to operate quasi-legal dispensaries.

In 2011, the legislature approved SB 5073 in order to bring much needed legal protections to patients and providers. The bill would have created a state-registered and regulated dispensary system and a voluntary patient registry. Patients who registered would have been granted immunity from arrest and prosecution so long as they were within possession limits. In addition, the bill allowed for small-scale patient collectives, where no more than 10 patients could collectively cultivate no more than 15 plants per patient or 45 total (whichever number was smaller).

Unfortunately, then-Gov. Christine Gregoire (D) used her power of the sectional veto to reject the sections creating regulated medical marijuana dispensaries and the voluntary patient registry. The governor issued another blow to the program by leaving intact a provision that clarified the law regarding how many patients a caregiver could take on, closing the loophole that arguably al-

lowed pre-existing dispensaries to operate. To her credit, Gov. Gregoire did sign off on provisions that protect patients' parental rights.

While much debate and uncertainty swirled around Washington's medical marijuana program, the voters of the state legalized marijuana for adults in November 2012, approving a measure to regulate marijuana like alcohol. While this ballot initiative did not change the medical marijuana law, it arguably enhanced and eased access to needed medicine for patients who are over 21.

The initiative removed all penalties for the limited possession and use of marijuana for people over 21, meaning patients over 21 no longer face arrest and prosecution. In addition, the initiative required the Washington State Liquor and Cannabis Board to license and regulate marijuana retail shops, easing access to marijuana for patients 21 and over. Unfortunately, patients under 21 are still left without protections from arrest and prosecution, and they also lack access to regulated medical marijuana.

In 2015, after years of debating how to adequately regulate medical marijuana, the Washington Legislature passed, and Gov. Jay Inslee signed, legislation that folded the medical marijuana program into the existing system implemented in response to passage of the legalization initiative. The legislation contains provisions similar to the ones that Gov. Gregoire vetoed out in 2011. For instance, the state will create a voluntary patient registry. Patients who choose to register will not face arrest and prosecution so long as they are within possession limits. Patients who register with the state are allowed to possess eight ounces of usable marijuana and can cultivate up to six plants. Those who do not are allowed to possess six ounces of medical marijuana and four plants. A doctor may increase these limits on a case-by-case basis.

The 2015 legislation also requires any entity that sells marijuana, medical or otherwise, have a state license to do so. This means that the existing medical marijuana dispensaries — which were seemingly already illegal — will be closed if they do not obtain one of these licenses. In an effort to ensure that retail stores stock products that are intended to be medicinal in nature, the legislation created a medical marijuana "endorsement" that retail shops can apply for. This endorsement allows the retail shop to discuss medical use with patients and registered patients to purchase up to three ounces of marijuana at a time, rather than the one-ounce limit for adults who are not patients.

California

California's law — which voters approved in November 1996 — was the first effective medical marijuana law to be enacted. As with all initial efforts, Proposition 215 did not address every aspect of medical marijuana policy. Most notably, the law — called the Compassionate Use Act (CUA) — did not specify the amount of marijuana that may be possessed or grown by a patient, or the means of supply of marijuana, and it did not permit any state agency to establish guidelines for the law.

Unlike most of the later state medical marijuana laws, the CUA has not been interpreted as providing protection from arrest. Law enforcement officials sometimes erred on the side of prosecuting — or at least hassling — patients if the quantity seemed too large, as the amount was not defined in the law. On July 18, 2002, in a unanimous ruling, the California Supreme Court interpreted the CUA as allowing CUA patients to move to dismiss attempts to prosecute them in a pretrial motion.[9] In essence, the CUA allows patients to avoid a jury trial if they are valid medical marijuana users.

In the years that followed its passage, there were numerous attempts to address questions left unanswered by the CUA. A 1999 task force provided recommendations for the establishment of

[9] *People v. Mower*, (Cal. 2002) 49 P.3d 1067.

a registry program, oversight by the Department of Health Services, and regulated cooperative cultivation projects, among other suggestions. Those recommendations were initially included in proposed but unsuccessful legislation, S.B. 848, some features of which were later modified and incorporated into S.B. 420 in 2003.

S.B. 420, now referred to as the Medical Marijuana Program (MMP), passed and was signed by Gov. Gray Davis (D). This legislation included more specific protections for patients and caregivers, including provisions for possession of at least eight ounces of marijuana and six mature or 12 immature plants per patient. Counties and localities may raise those amounts, but are not permitted to lower them. In addition, a patient can possess a greater amount with a doctor's recommendation stating that the limit would be insufficient.

The MMP also mandated the creation of a voluntary statewide ID card and registry system, which provides patients and caregivers who choose to participate in the system with protection from arrest. County health departments are required to verify information in the applications, approve or deny the applications, and issue cards. The California Department of Health Services maintains a website for law enforcement to verify the ID cards' validity. However, even a decade after its passage, two counties — Colusa and Sutter — are still not offering ID cards.

The most important provision of the MMP is that it made California the first state to expressly allow cooperatives. It also provides that caregivers cannot be prosecuted solely for being compensated for their actual expenses and services. However, the MMP does not authorize for-profit marijuana distribution, and provisions allowing dispensing collectives are vague. Following its passage, some local governments allowed businesses to operate, while others claimed they were prohibited under the state law and implemented moratoriums on business licenses or simply banned the businesses outright.

In 2008, then-California Attorney General Jerry Brown issued long-awaited medical marijuana guidelines in August of that year. The "Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use" sought to clarify the state's medical marijuana law for patients, caregivers, dispensing collectives, and law enforcement personnel. Among other things, the guidelines included recordkeeping requirements and established that marijuana may not be obtained from sources other than patients and caregivers who are part of the collective. The document also provided guidance that state and local law enforcement officers should not arrest individuals or seize marijuana under federal law if they determine that the activity is protected under state law.

Unfortunately, the guidelines do not carry the weight of law and therefore are limited in their ability to provide legal protections for individuals and businesses that operate in compliance with them. Both before and after publication of these guidelines, various local governments interpreted the protections and rights under the CUA and the MMP differently.

In a May 2013 ruling in *Riverside v. Inland Empire Patients Health Wellness Center, Inc.*,[10] the California Supreme Court implicitly acknowledged that dispensaries are not prohibited under either the CUA or the MMP, but did make clear that local governments have the authority to ban such businesses. The court noted that "nothing in the CUA or the MMP expressly or impliedly limits the inherent authority of a local jurisdiction, by its own ordinances, to regulate the use of its land, including the authority to provide that facilities for the distribution of medical marijuana will not be permitted to operate within its borders."[11]

As of the time of the court decision, approximately 200 local governments in California had either banned or temporarily blocked businesses through moratoriums. But while some prevented businesses from operating, others, including San Francisco, Los Angeles, and Sacramento, passed ordinances specifically allowing and regulating medical marijuana dispensaries.

[10] *City of Riverside v. Inland Empire Patients Health Wellness Ctr., Inc.,* 56 Cal. 4th 729, 300 P.3d 494, (2013).
[11] Id at 738.

This patchwork of local ordinances has created havoc in the state's medical marijuana program, in which regulations and protections vary from local government to local government. Shortly after the California Supreme Court's ruling in *City of Riverside*, the U.S. Attorney for the Eastern District of California, Benjamin Wagner, commented that California continues to experience a "weed free for all." He also noted that Colorado and other states experience less interference from federal law enforcement authorities because they have more robust and consistent sets of regulations. Indeed, California has seen far more interference from federal law enforcement activities than any other medical marijuana state in the country, including hundreds of raids on businesses and hundreds more letters sent by U.S. attorneys to property owners threatening forfeiture of property used for marijuana-related activity.

In a Department of Justice memorandum issued to federal prosecutors on August 29, 2013, Deputy Attorney General James Cole outlined federal law enforcement policy with respect to state laws that allow citizens access to marijuana, as well as businesses and individuals complying with those laws. The cornerstone of this policy is its emphasis on state regulation. Deputy Attorney General Cole made clear that to ensure the U.S. government's concerns are addressed, the department expects states to implement a strong regulatory framework. The memo states, "The Department's guidance in this memorandum rests on its expectation that state 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." Unfortunately for many, California has become the prime example of a state with protections for marijuana patients but little regulatory oversight for cultivators and dispensaries.

Assemblymember Tom Ammiano presented a bill designed to clearly establish a regulatory framework that would provide those protections and end the "free for all" which places so many at risk. The bill was originally introduced early in the 2013 – 2014 session as A.B. 473, but the bill fell short during voting in the Assembly due to a technicality. Asm. Ammiano re-introduced a similar bill, A.B. 604, following the August Department of Justice memo. It will carry over to 2014 and is currently pending in committee. Among other things, this bill would create a Division of Cannabis Regulation and Enforcement to establish rules and carry out law enforcement responsibilities. The program is self-funding through fees paid by those who participate. The law would limit physicians from having financial ties to other types of businesses in the industry, protect specific types of patient and caregiver information from public disclosure, and respect zoning ordinances adopted by local governments.

In 2015, 19 years after the passage of the CUA, the California Legislature passed a trio of bills that together provide a framework similar to those in states that already regulate the industry. The bills included what was by then a familiar range of license types, including cultivators, processors, testing labs, and dispensaries. The legislation also included a new type of license in medical marijuana regulatory systems — that of distributors. The effort received unprecedented support, including from a bipartisan group of legislators, local governments, community and cannabis activists, law enforcement, and the governor's office. The governor signed the three bills, AB 266, AB 243, and SB 643, into law on October 9, 2015.

Many of the more controversial details were left to the rule-making process, which must be adopted in January 2017, with the program going into effect the following January. Under the new law, California will gradually phase out collectives and cooperatives, establish a new bureau within the Department of Consumer Affairs, and share oversight for the program among several agencies, including the State Department of Public Health and the Department of Food and Drugs.

Appendix G: Low-THC Medical Cannabis Laws

In 2012 and 2013, the *LA Times*, CNN, and other outlets ran stories about young patients whose treatment-resistant seizure disorders were showing dramatic improvement with treatment by certain medical marijuana oils.[1] Following the coverage, parents of children with intractable seizures began advocating for legal protections in states across the country. State legislatures responded swiftly but incompletely. By late 2015, 16 states had enacted a new, very limited kind of medical cannabis law. Unfortunately, almost all of these laws were crafted in a way that is unlikely to provide much — if any — relief to the patients they were meant to help.

Unlike the 23 states that have effective medical marijuana laws, these 16 laws allow only strains that are low in THC (which has medical value, including relieving nausea, and which can cause euphoria) and rich in another beneficial compound of marijuana, cannabidiol (CBD).

Most of these very limited laws protect only patients with seizure disorders, although a few include other medical conditions. None of the CBD-focused laws extend to patients who have intractable pain or AIDS, and almost all of them exclude patients with cancer wasting, muscle spasms, or any condition other than seizure disorders.

In addition, all but one or two of the laws — Missouri's and possibly Florida's — fail to allow for realistic, in-state access. The 23 effective state medical marijuana laws allow in-state access to marijuana by allowing private entities or individuals to grow and distribute it to patients. In contrast, the new CBD-focused laws typically either have no provisions for in-state access, rely on federal permission, or rely on risk-averse actors — such as universities, pharmacies, or doctors — openly breaking federal law. Until federal law changes, which could take years, most these laws will be of little or no help to patients.

State	Condition(s)	Type of Cannabis	Means of Access	Workability Issues
Alabama	Epilepsy or another neurological disorder that produces serious, debilitating, or life-threatening seizures.	Extracts that are "essentially free from plant material" with no more than 3% THC.	The law does not appear to include any way to access cannabis. Certain doctors could break federal law by prescribing it, but it's not clear where the cannabis would come even from if they did so.	The law is limited to an affirmative defense; it does not prevent an arrest or trial. There is also no reasonable means of access and only practitioners from the University of Alabama's Department of Neurology would be allowed to prescribe CBD. Prescribing CBD violates federal law.
Florida	Cancer and physical medical conditions that chronically produce seizures or "severe and persistent muscle spasms" if no other satisfactory alternative treatment options exist.	Cannabis with more than 10% CBD and no more than 0.8% THC.	The health department may approve up to five in-state cannabis producers. Only registered nurseries that have operated in Florida for at least 30 years may apply.	The physician must "order" the low-THC marijuana from one of the five registered manufacturers, although doing so would break federal law. Doctors must also take an eight-hour class and an exam to certify patients for the program.

[1] Marc Martin, "To treat son's epilepsy, a father turns to medical marijuana," *LA Times*, September 13, 2012; Saundra Young, "Marijuana stops child's severe seizures," CNN, August 7, 2013.

State	Condition(s)	Type of Cannabis	Means of Access	Workability Issues
Georgia	Seizure disorders, cancer, ALS, multiple sclerosis, Crohn's disease, mitochondrial disease, Parkinson's disease, and sickle cell disease.	Cannabis oils with no more than 5% THC and with at least an equal amount of CBD.	None. There is no in-state means of accessing cannabis other than allowing the University System of Georgia to develop a low THC oil clinical research program in compliance with federal regulations.	No in-state access.
Iowa	An epileptic seizure disorder where standard treatments do not significantly ameliorate uncontrolled seizures or where standard treatments cause harmful side effects.	"Cannabidiol," "a nonpsychoactive cannabinoid" of cannabis or any other preparation of it "that is essentially free from plant material" with under 3% THC.	None. There is no in-state means of accessing cannabis.	There is no in-state source of cannabis and no state that borders Iowa allows non-resident patients to obtain cannabis from the state.
Kentucky	Intractable seizure disorders.	"Cannabidiol."	None. The law fails to include a source for CBD. It does not make it legal for anyone to produce the marijuana that CBD would be extracted from in the state.	"Cannabidiol" must be transferred pursuant to a written order of a physician practicing at a hospital or clinic affiliated with a public Kentucky university with a medical school. However, issuing such an order would break federal law. Those participating in an FDA trial would also be protected.
Mississippi	Debilitating epileptic conditions.	"CBD oil" with more than 15% CBD and no more than 0.5% THC.	CBD oil must be dispensed by the University of Mississippi's Department of Pharmacy Service. Only three entities, all affiliated with universities, could possess or produce cannabis oil.	The law would only work if universities were willing to openly break federal law, or if federal law changes. It is also not clear that patients would be protected from arrest, or if they would merely have an affirmative defense that prevents a conviction.
Missouri	Epilepsy that has been untreatable with three or more other treatment options.	"Hemp extracts," cannabis extract oils with at least 5% CBD and under 0.3% THC.	The state would license private "cannabidiol oil care centers" to cultivate marijuana and process it into cannabis oil. The oils would be extracted at a laboratory.	As long as regulators do not impose any unworkable restrictions, this may result in a workable system of access for patients with seizures who can benefit from low-THC cannabis. However, it leaves behind patients who benefit from more THC and those with other conditions.
North Carolina	Intractable epilepsy.	Hemp extracts with at least 10% CBD and less than 0.3% THC.	None. Cannabis would have to be obtained from another jurisdiction.	Patients would have to work with a neurologist at one of four universities and would have to enroll in a pilot study. This is very unlikely to result in a workable program due to federal law and the lack of in-state access to cannabis oils.

State	Condition(s)	Type of Cannabis	Means of Access	Workability Issues
Oklahoma	Minors with Lennox-Gastaut Syndrome, Dravet Syndrome, or other severe epilepsy that is not adequately treated by traditional medical therapies.	A preparation of cannabis with no more than 0.3% THC and that is delivered in liquid form.	No in-state production allowed (it would have to be brought in). Also, the only formal distribution system would require federal approval, which is unlikely.	There will be no in-state source of cannabis. The law also allows for federally approved clinical trials, which are notoriously difficult to undertake for cannabis and which do not rely on state permission.
South Carolina	Lennox Gastaut Syndrome, Dravet Syndrome, or "any other severe form of epilepsy that is not adequately treated by traditional medical therapies."	Cannabidiol or any "manufacture, salt, derivative, mixture, or preparation" of marijuana that contains 0.9% or less THC and over 15% CBD. Extracts provided at trials must have at least 98% CBD and no more than 0.9% THC.	Federally approved sources for clinical trials (which are not dependent on state approval). Also, patients and their caretakers could arguably produce their own supplies.	There will be no in-state producer, other than the possibility that patients and their caretakers could produce their own supplies. The law also allows for federally approved clinical trials, which are notoriously difficult to undertake for cannabis and which do not rely on state permission.
Tennessee	Intractable seizures.	Cannabis oil with less than 0.9% of THC.	Tennessee Tech may cultivate marijuana, process it into oil, and dispense it to qualified patients. Patients may also possess low-THC cannabis oils that are obtained "legally in the United States" outside of Tennessee (such as in medical cannabis states).	Tennessee Tech would have to commit a federal crime to distribute cannabis without federal permission. In addition, cannabis oils would be dispensed by physicians conducting a study, so they, too, would probably have to break federal law. Regarding out-of-state access, patients would have to travel through states where cannabis is illegal.
Texas	Intractable epilepsy	"Low THC cannabis" with at least 10% CBD and no more than 0.5% THC.	Dispensing organizations — regulated by the Department of Public Safety — would cultivate marijuana plants, process them, and distribute low-THC directly to patients or their parents.	Physicians would have to "prescribe" low-THC cannabis for patients to qualify, and doing so would break federal law.
Utah	Epilepsy "that, as determined by a neurologist, does not respond to three or more treatment options overseen by the neurologist."	"Hemp extracts," with less than 0.3% THC and at least 15% CBD.	It's not entirely clear. Probably out-of-state providers, but they would have to jump through many hoops. It's not clear if the health department or research institutions could also produce extracts (though that is unrealistic because it would rely on them breaking federal law).	There is no in-state access. Patients could possibly obtain extracts from Nevada or Colorado. This will only work if those states' providers comply with Utah's requirements: Extracts must have a certificate of analysis from a testing lab in the state where they originated, and the lab must transmit the certificate to the Utah health department.

State	Condition(s)	Type of Cannabis	Means of Access	Workability Issues
Virginia	Intractable epilepsy.	Cannabis oils with at least 15% CBD or THC-A and no more than 5% THC.	None. There is no in-state means of accessing cannabis.	No in-state access. Also, patients are not protected from arrest; they merely have an affirmative defense that prevents a conviction.
Wisconsin	Seizure disorders.	This new law creates an exception to the definition of THC (which is what is illegal under state law) for certain patients who possess "cannabidiol in a form without a psychoactive effect."	Physicians and pharmacies with an investigational drug permit from the FDA could dispense cannabidiol. Absent federal cooperation, which is unlikely, patients could only access CBD from a dispensary in a medical marijuana state that allows out-of-state patients to use its dispensaries.	The law provides for no realistic, in-state access. No state that borders Wisconsin allows nonresident patients to obtain cannabis from any of the states' dispensaries.
Wyoming	Intractable epilepsy that does not respond to other treatments and other seizure disorders.	"Hemp extracts" with less than 0.3% THC and at least 5% CBD.	No in-state means of accessing cannabis. It would have to be brought in from another jurisdiction.	There will be no in-state source of cannabis.

Appendix H: Types of Legal Defenses Afforded by Effective State Medical Marijuana Laws

1. Exemption from Arrest and Prosecution

A state may establish that it is no longer a state-level crime for patients to possess, purchase, or cultivate marijuana for medicinal purposes in accordance with state law. Federal laws would be broken by individual patients, but an "exemption from arrest and prosecution" prevents the state from arresting and prosecuting qualified patients. Most exemptions are tied to a state registry program, which allows patients' credentials to be easily verified. Most states also provide similar protections for licensed medical marijuana businesses or nonprofits that provide patients with medical cannabis.

2. Affirmative Defense

Several state medical marijuana laws allow individuals to assert an affirmative defense to charges of unlawful marijuana cultivation and/or possession. To establish the affirmative defense, individuals must prove at trial — often by a preponderance of the evidence — that they are in compliance with the medical marijuana statute or the affirmative defense portion of the law.

The affirmative defense is the only defense afforded to individuals by Alaska's medical marijuana law, but all adults 21 and older in the state may possess up to an ounce of marijuana.

Colorado, Maine, Michigan, Nevada, and Washington state's laws allow individuals to use an affirmative defense to argue that an amount of marijuana in excess of the specified legal limit is medically necessary. California, Colorado, Maryland, Michigan, Nevada, Oregon, and Rhode Island allow unregistered patients to raise an affirmative defense.[1] Delaware's law includes an affirmative defense that protects qualified patients from conviction if they possessed marijuana before the registry program was up and running. It also protects them from conviction while they wait for the health department to process their applications.

3. "Choice of Evils" Defense

In addition to being exempt from prosecution or providing an affirmative defense, medical marijuana patients may raise a medical necessity defense,[2] often referred to as a "choice of evils" defense. This is brought up to show that violation of the law (such as using marijuana) was necessary to prevent a greater evil (such as exacerbation of an illness).

[1] The language in some of these cases has not been litigated completely, so there are some states where the law seems to allow unregistered patients to raise a defense or a defense to be raised for additional amounts, but where courts may ultimately interpret the language more narrowly.

[2] See Appendix L for details.

Appendix I: Physicians' Roles Under State Medical Marijuana Laws

California and Arizona, the first two states to pass medical marijuana initiatives in 1996, used slightly different wording in their enacting statutes:

- California law allows patients to use medical marijuana if they possess a recommendation from a physician.
- Arizona's 1996 law allowed patients to use medical marijuana if they possessed a prescription from a physician.

The difference seems slight, but its effect is great. Patients in California are protected under state law if they possess valid recommendations for medical marijuana. In Arizona, however, patients did not enjoy state-level legal protection until voters approved a new initiative in 2010 because it is impossible to obtain a prescription for medical marijuana.

Definitions of "prescription" and "recommendation," as they apply to medical marijuana, explain the difference in legal protections for California and a handful of states that solely have laws that allow physicians to "prescribe" marijuana.

Vermont, New Hampshire, and Minnesota's medical marijuana laws are unusual in that they do not require physicians to prescribe or recommend medical marijuana; rather, a physician must simply certify that a patient has a qualifying illness.

- Vermont, New Hampshire, and Minnesota's laws allow a person to register with the state as a medical marijuana patient if that patient possesses a certification from his or her physician.

Prescription

A prescription is a legal document from a licensed physician, ordering a pharmacy to release a controlled substance to a patient. Prescription licenses are granted by the federal government, and it is a violation of federal law to "prescribe" marijuana, regardless of state law. Furthermore, it is illegal for pharmacies to dispense marijuana (unless as part of a federally sanctioned research program).

In addition to Arizona's 1996 law, the medical marijuana laws in Louisiana, Virginia, and Wisconsin use the word "prescribe" and are therefore ineffective. Alabama and Texas' low-THC laws are also ineffective due to this flaw.

Specifying Dosage and Requiring Doctor's Orders

Under federal law, it is a criminal offense for a doctor to aid or abet the purchase, cultivation, or possession of marijuana or to engage in a conspiracy to cultivate, distribute, or possess marijuana. Issuing an order to consume marijuana or directing a patient how much to consume also likely crosses the line into aiding and abetting a federal crime, and thereby puts physicians at risk.

Two of the flawed low-THC laws — Florida and Kentucky's — require doctors to issue orders for cannabis to patients. These laws are likely to prove ineffective as a result. Even if doctors would not actually be prosecuted by federal authorities,

few are willing to openly engage in federally illegal conduct. Requiring a doctor to specify the amount of marijuana a patient should consume may also render a law ineffective, since doctors may be unwilling to risk possible federal sanctions.

Recommendation

A recommendation is not a legal document, but a professional opinion provided by a qualified physician in the context of a bona fide physician-patient relationship. The term "recommendation" skillfully circumvents the federal prohibition on marijuana prescriptions, and federal court rulings have affirmed a physician's right to discuss medical marijuana with patients, as well as to recommend it. A "recommendation" is constitutionally protected speech.[1]

Whereas patients do not receive meaningful legal protection via marijuana "prescriptions" because they cannot be lawfully obtained, patients who have physicians' "recommendations" can meet their state's legal requirements for medical marijuana use.

Certification

The states that have enacted medical marijuana laws since 1996 have generally avoided using the words "prescription" and "recommendation." Instead, they generally protect patients who submit written certifications to a health department. Like a "recommendation," a "certification" is not a legal document. In issuing a "certification," a physician simply signs a written statement. In most states, the statement must affirm that the physician discussed, in the context of a bona fide physician-patient relationship, the risks and benefits of medical marijuana use and advised the patient that the medical benefits of marijuana would likely outweigh the health risks. The certifications must also verify that the patient has a qualifying condition.

Certifications and recommendations merely state a physician's First Amendment-protected opinion without directing the patient to engage in any conduct or directing anyone to provide the patient with marijuana. Therefore, they also avoid putting physicians at risk of an aiding and abetting charge.

In two states, Vermont and New Hampshire, the physician needs only to certify that the patient has a medical condition that the state has approved as a qualifying condition for the medical use of marijuana.[2] Some medical societies have preferred this language to fully eliminate concerns that they might face liability related to medical marijuana.

[1] See *Dr. Marcus Conant v. John L. Walters* in Appendix J for details.

[2] Minnesota's law also only requires that physicians — or nurse practitioners or physicians assistants — certify that the patient has a qualifying condition, but the law requires other potentially onerous reporting that exceeds the requirements of other states.

Appendix J: Federal Litigation Related to Effective State Medical Marijuana Laws

The federal government's position on medical marijuana

The federal government has not tried to overturn any state medical marijuana law, nor is it planning to do so.

In fact, high-ranking members of the U.S. Department of Justice evaluated the legal prospects of a court challenge to the medical marijuana initiatives and concluded that such a challenge would fail.

This was stated on the record by David Anderson of the U.S. Department of Justice during a hearing in *Wayne Turner v. D.C. Board of Elections and Ethics, et al.* (Civil Action No. 98-2634 RWR, September 17, 1999).[1]

Anderson's comments are supported by Footnote 5 in the federal court's *Turner* opinion: "In addition, whatever else Initiative 59 purports to do, it proposes making local penalties for drug possession narrower than the comparable federal ones. Nothing in the Constitution prohibits such an action."

Testifying at a June 16, 1999 hearing of the U.S. House Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, then-drug czar Barry McCaffrey also admitted that "these [medical marijuana] statutes were deemed to not be in conflict with federal law."

In May 2011, Arizona Gov. Jan Brewer filed a federal lawsuit questioning whether federal law preempts state law and named the U.S. Department of Justice (DOJ) as a defendant. The DOJ filed a motion to dismiss the case, which did not take a position on preemption, but asked the court to dismiss the suit for failing to be a case or controversy. The case was subsequently dismissed.

In 2013, Deputy U.S. Attorney General James Cole testified before Congress, "It would be a very challenging lawsuit to bring to preempt the state's decriminalization law. We might have an easier time with their regulatory scheme and preemption, but then what you'd have is legalized marijuana and no enforcement mechanism within the state to try and regulate it and that's probably not a good situation to have."

The federal government cannot force states to have criminal laws that are identical to federal law, nor can the federal government force state and local police to enforce federal laws. Courts have typically also found that licensing systems for medical marijuana are not preempted.[2] While the federal government is not arguing in court that state medical marijuana laws or regulations are preempted, it may take legal action against individuals and organizations for violations of federal law. See Appendix S for a discussion of the federal government's statements and practices on enforcing its laws in medical marijuana states.

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[1] Turner challenged the constitutionality of U.S. Rep. Bob Barr's (R-GA) amendment to the fiscal year 1999 budget, which prohibited the District from spending any funds to conduct any initiative that would reduce the penalties for possession, use, or distribution of marijuana. This amendment had the effect of preventing the local Washington, D.C. government from tallying the votes on the local medical marijuana ballot initiative in November 1998. The U.S. District Court for the District of Columbia ruled in Turner's favor—albeit not on constitutional grounds. The votes were counted, and the medical marijuana initiative was found to have passed; however, Congress subsequently prevented it from taking effect. This occurred only because D.C. is a district, not a state, and therefore is legally subject to greater federal oversight and control.

[2] See, i.e., *White Mountain Health Center Inc. v. County of Maricopa*, CV-2012-053585 (December 3, 2012) and *Qualified Patients Ass'n v. Anaheim*, 187 Cal. App. 4th 734, 759–60 (Cal. Ct. App. 2010).

Medical marijuana litigation in federal court

Since 1996, there have been five key federal cases relating to medical marijuana: *Conant v. Walters, U.S. v. Oakland Cannabis Buyers' Cooperative, County of Santa Cruz v. Ashcroft, Gonzales v. Raich*, and *Arizona v. Department of Justice*.

In addition, Nebraska and Oklahoma's attorneys general are asking the U.S. Supreme Court to decide whether federal law preempts (or trumps) Colorado's adult-use marijuana regulatory law. It is not yet known if the court will hear the case, which has not been heard in any lower courts.

Dr. Marcus Conant v. John L. Walters (309 F.3d 629)

Ruling: A federal district court ruled that the federal government cannot punish physicians for discussing or recommending medical marijuana. After this ruling was upheld by the Ninth U.S. Circuit Court of Appeals, it was appealed to the U.S. Supreme Court, which declined to take the case, letting the ruling stand.

Background: Shortly after California voters approved Proposition 215 in 1996, the federal government threatened to punish — even criminally prosecute — physicians who recommend medical marijuana. Specifically, the federal government wanted to take away physician authority to write prescriptions for any controlled substances. In response to those threats, a group of California physicians and patients filed suit in federal court on January 14, 1997, claiming that the federal government had violated their constitutional rights.

The lawsuit asserted that physicians and patients have the right — protected by the First Amendment to the U.S. Constitution — to communicate in the context of a bona fide physician-patient relationship, without government interference or threats of punishment, about the potential benefits and risks of the medical use of marijuana.

On April 30, 1997, U.S. District Court Judge Fern Smith issued a preliminary injunction prohibiting federal officials from threatening or punishing physicians for recommending medical marijuana to patients suffering from HIV/AIDS, cancer, glaucoma, and/or seizures or muscle spasms associated with chronic, debilitating conditions. According to Judge Smith, "[t]he First Amendment allows physicians to discuss and advocate medical marijuana, even though use of marijuana itself is illegal."

The case was finally heard in the U.S. District Court for the Northern District of California in August 2000. Plaintiffs argued that the threats amounted to censorship. The federal government countered that there is a national standard for determining which medicines are accepted and that the use of marijuana should not be decided by individual physicians. In response to that argument, Judge William Alsup stated, "Who better to decide the health of a patient than a doctor?"

Alsup ruled on September 7, 2000 that the federal government cannot penalize California doctors who recommend medical marijuana under state law. Specifically, he said the U.S. Department of Justice is permanently barred from revoking licenses to dispense medication "merely because the doctor recommends medical marijuana to a patient based on a sincere medical judgment and from initiating any investigations solely on that ground."

The U.S. Department of Justice sought to overturn Alsup's ruling. In a hearing before the Ninth Circuit on April 8, 2002, judges questioned Justice Department attorneys who were appealing an injunction against sanctioning these doctors.

"Why on earth does an administration that's committed to the concept of federalism . . . want to go to this length to put doctors in jail for doing something that's perfectly legal under state law?" asked Judge Alex Kozinski at the hearing.

U.S. Attorney Mark Stern argued that the government should be allowed to investigate doctors whose advice "will make it easier to obtain marijuana." But he had difficulty convincing judges that there was a distinction between discussing marijuana and recommending it.

On October 29, 2002, the Ninth Circuit upheld the *Conant v. McCaffrey* ruling, which affirms that doctors may recommend marijuana to their patients, regardless of federal laws prohibiting medical marijuana. The government's attempt to bar doctors from recommending medical marijuana "does … strike at core First Amendment interests of doctors and patients. … Physicians must be able to speak frankly and openly to patients," Chief Judge Mary Schroeder wrote in the 3–0 opinion.

The court also noted, "A doctor would aid and abet by acting with the specific intent to provide a patient with the means to acquire marijuana."[3]

On October 14, 2003, medical marijuana patients and doctors achieved a historic victory when the U.S. Supreme Court refused to hear the Justice Department's appeal of *Conant*, letting stand the Ninth Circuit ruling from October 2002. This powerful ruling has put a stop to the federal government's campaign to punish physicians who recommend medical marijuana to patients.

United States of America v. Oakland Cannabis Buyers' Cooperative (532 U.S. 483)

Ruling: The U.S. Supreme Court ruled that people who are arrested on federal marijuana distribution charges may not raise a "medical necessity" defense in federal court to avoid conviction.

Background: In California, dozens of medical marijuana distribution centers received considerable media attention following the passage of Proposition 215. Yet many of them had been quietly operating for years before the law was enacted. State and local responses ranged from prosecution to uneasy tolerance to hearty endorsement.

In January 1998, the U.S. Department of Justice filed a civil suit to stop the operation of six distribution centers in Northern California, including the Oakland Cannabis Buyers' Cooperative (OCBC).

The U.S. District Court issued an injunction in May 1998 to stop the distributors' actions and rejected, in October 1998, OCBC's motion to modify the injunction to allow medically necessary distributions of marijuana. In September 1999, the Ninth Circuit ruled 3–0 that "medical necessity" is a valid defense against federal marijuana distribution charges, provided that a distributor can prove in a trial

[3] To avoid crossing the line into aiding and abetting, effective state medical marijuana laws limit doctors' roles to stating their opinion. They avoid requiring conduct that indicates a specific intent to give a patient the means to obtain marijuana such as specifying the dose for marijuana.

court that the patients it serves are seriously ill, face imminent harm without marijuana, and have no effective legal alternatives.

The case then went back to U.S. District Court, where the 1998 injunction was modified, allowing OCBC to distribute marijuana to seriously ill people who meet the Ninth Circuit's medical necessity criteria. The Justice Department then filed an appeal, asking the U.S. Supreme Court to overturn the Ninth Circuit's decision establishing a federal "medical necessity defense" for marijuana distribution.

Writing for a unanimous court (8–0), Justice Clarence Thomas affirmed what medical marijuana patients, providers, and advocates have long known: The U.S. Congress has not recognized marijuana's medical benefits, as evidenced by the drug's placement in the most restrictive schedule of the federal Controlled Substances Act.

Specifically, Thomas wrote: "In the case of the Controlled Substances Act, the statute reflects a determination that marijuana has no medical benefits worthy of an exception (outside the confines of a Government-approved research project)."

"Unable … to override a legislative determination manifest in statute" that there is no exception at all for any medical use of marijuana, the court held that the "medical necessity defense" is unavailable to medical marijuana distributors like OCBC.

The ruling does not affect the ability of states to remove criminal penalties for medical marijuana. It merely asserts that similar protections do not currently exist at the federal level. Of note, the case did not challenge the viability of Proposition 215, the California law that allows patients to legally use medical marijuana.

This ruling left large-scale medical marijuana distributors vulnerable to federal prosecution. Until federal enforcement policies relaxed under the Obama administration, it resulted in many states having programs that only allowed small-scale cultivation by patients and caregivers.

Unclear, however, is whether individual patients can assert a "medical necessity defense" to federal marijuana charges.

Footnote 7 of the opinion says nothing in the court's analysis "suggests that a distinction should be made between prohibitions on manufacturing and distributing and other prohibitions in the Controlled Substances Act."

In a concurring opinion, Justice John Paul Stevens criticized Footnote 7, writing that "the Court reaches beyond its holding, and beyond the facts of the case, by suggesting that the defense of necessity is unavailable for anyone under the Controlled Substances Act."

Given the U.S. Supreme Court's narrow ruling, OCBC appealed the case again in U.S. District Court, raising constitutional and other issues.

OCBC argued that the federal injunction against it exceeds federal authority over interstate commerce. The organization also argued that barring marijuana distribution would violate its members' fundamental rights to relieve pain and the life-threatening side effects of some treatments for conditions like AIDS and cancer.

Ruling for the U.S. District Court on May 3, 2002, Judge Charles Breyer said OCBC has no constitutional right to distribute medical marijuana to sick patients.

Breyer also said the federal government has the constitutional authority to regulate drug activity, even if it takes place entirely within a state's boundaries. OCBC appealed the ruling to the Ninth Circuit.

On June 12, 2003, Judge Breyer issued a permanent injunction prohibiting OCBC and two other organizations from distributing medical marijuana. The order, requested by the U.S. Department of Justice, affects OCBC, the Marin Alliance for Medical Marijuana in Fairfax, and a dispensary in Ukiah.

Gonzales v. Raich (545 U.S. 1), on remand *Raich v. Gonzales* (500 F.3d 850)

Ruling: On June 6, 2005, the U.S. Supreme Court ruled 6-3 that the federal government has the power under the Commerce Clause of the U.S. Constitution to prohibit purely intrastate cultivation and possession of marijuana authorized by state medical marijuana laws.

The Supreme Court also sent *Raich* back to the Ninth Circuit to consider legal issues that had not been argued. On March 14, 2007, the Ninth Circuit ruled that there is not yet a constitutional due process right to use marijuana to preserve one's life. It also held that the criminal defense "medical necessity" cannot be used in a civil suit to prevent a federal prosecution.

Background: On October 9, 2002, two seriously ill medical marijuana patients sued the federal government for violating the Fifth, Ninth, and Tenth Amendments to the U.S. Constitution in its raids on patients and providers.

Angel Raich, who suffers from life-threatening wasting syndrome, nausea, a brain tumor, endometriosis, scoliosis, and other disorders that cause her chronic pain and seizures, uses marijuana because of her adverse reaction to most pharmaceutical drugs.

Diane Monson, a medical marijuana patient suffering from severe chronic back pain and spasms, was raided by the Drug Enforcement Administration (DEA) on August 15, 2002. Ms. Monson has tried several pharmaceutical drugs, but none of them allowed her to function normally.

The lawsuit sought to prevent the federal government from arresting or prosecuting the plaintiffs for their medical use of marijuana. According to the complaint, then-U.S. Attorney General John Ashcroft and DEA Administrator Asa Hutchinson were overstepping their authority by seizing marijuana plants that were grown under the state's medical marijuana law. The plaintiffs argued that the federal government has no constitutional jurisdiction over their activities, which were entirely noncommercial and did not cross state lines.

On March 5, 2003, the U.S. District Court denied the preliminary injunction, despite finding that "the equitable factors tip in plaintiff 's favor."

A week later, on March 12, 2003, Angel Raich and Diane Monson filed an appeal with the U.S. Court of Appeals for the Ninth Circuit.

The appeals court heard oral arguments on October 7, 2003. On December 16, 2003, the court issued an opinion reversing the U.S. District Court decision, sending it back to the district court with instructions to enter a preliminary injunction, as sought by the patients and caregivers. The Ninth Circuit found that "the appellants have demonstrated a strong likelihood of success on their claim that, as

applied to them, the CSA [Controlled Substances Act of 1970] is an unconstitutional exercise of Congress' Commerce Clause authority."

This decision stated that federal interference in state medical marijuana laws was unconstitutional. This was a huge victory for medical marijuana patients — and for the states that have these laws. A federal court had ruled that the federal Controlled Substances Act does not apply to noncommercial medical marijuana activities that do not cross state lines.

On February 26, 2004, the Ninth Circuit unanimously rejected the U.S. Department of Justice's petition for an en banc review of the ruling. The Justice Department appealed to the U.S. Supreme Court, which on June 28, 2004 agreed to hear the case.

On June 6, 2005, the U.S. Supreme Court reversed the Ninth Circuit's ruling that federal raids on medical marijuana patients exceeded the federal government's authority. The court ruled 6-3 that the federal government has the power under the Commerce Clause of the U.S. Constitution to prohibit purely intrastate cultivation and possession of marijuana authorized by state medical marijuana laws. Justices Sandra Day O'Connor and Clarence Thomas and Chief Justice William Rehnquist argued in dissent that prohibiting this activity is beyond the scope of the Commerce Clause.

This ruling in no way invalidated existing state medical marijuana laws, nor does it prevent states from enacting medical marijuana laws. It merely found that federal authorities have the legal authority under the Constitution to continue to criminalize medical marijuana users and providers.

The Supreme Court remanded the case to the Ninth Circuit for further proceedings to determine whether an injunction blocking on federal raids on state-legal medical marijuana patients was warranted based on due process, medical necessity, or Tenth Amendment claims. The Ninth Circuit had not addressed these claims in earlier proceedings since the Court of Appeals held that an injunction was warranted based on the Commerce Clause argument. On March 27, 2006, the Ninth Circuit heard oral arguments on these issues, with Diane Monson no longer a party to the case.

On March 14, 2007, the three-judge panel unanimously ruled against Raich's remaining arguments for an injunction to prevent federal prosecution.

The court found that there is not a due process right "to use marijuana to preserve bodily integrity, avoid pain, and preserve [one's] life." The majority decision, authored by Judge Harry Pregerson and signed by Judge Richard Paez, suggested that there is a possibility that under emerging standards of fundamental rights the medical use of marijuana could eventually be recognized as a fundamental right. The opinion said, "For now, federal law is blind to the wisdom of a future day when the right to use medical marijuana to alleviate excruciating pain may be deemed fundamental. Although that day has not yet dawned, considering that during the last ten years eleven states have legalized the use of medical marijuana, that day may be upon us sooner than expected."

The Ninth Circuit also unanimously ruled that Raich could not use a medical necessity defense to obtain a civil injunction barring a federal prosecution. The ruling noted that it did not decide whether Raich could successfully raise the de-

fense if she were criminally prosecuted. The majority evaluated the three prongs that must be proven in a necessity defense and said, "Raich appears to satisfy the threshold requirements for asserting a necessity defense under our case law." The opinion also said that the issue of whether the Supreme Court's OCBC ruling and the Controlled Substances Act foreclose the possibility of patients like Raich asserting marijuana necessity defenses is an unanswered question.

The third judge, C. Arlen Beam, issued an opinion that concurred with the decision to uphold the district court's denial of an injunction. However, he dissented "from the court's expansive consideration" of whether Raich met the prongs of a necessity defense. He argued that because Gonzales v. Raich was a civil case that followed civil rules of evidence and procedure, the court could not make a determination about whether Raich could meet the requirements for a necessity defense to a criminal prosecution. He did, however, "acknowledge that [Raich] certainly may be eligible to advance such a defense to criminal liability in the context of an actual prosecution."

Although the Ninth Circuit's ruling on remand did not provide any immediate protection to Raich, it was not entirely negative. It left open the possibility that the seriously ill might eventually have a due process right to use medical marijuana if states continue enacting effective medical marijuana laws. It also left open the possibility that the seriously ill could avoid criminal liability under federal law by raising the medical necessity defense.

County of Santa Cruz, et al. v. Mukasey, et al. (C-03-1802 JF)

Ruling: On April 21, 2004, U.S. District Court Judge Jeremy Fogel issued a historic preliminary injunction barring the U.S. Department of Justice from raiding or prosecuting Wo/Men's Alliance for Medical Marijuana (WAMM) in Santa Cruz, California. The Ninth Circuit reversed the injunction following the U.S. Supreme Court decision *Gonzales v. Raich*, but the case is still alive. The plaintiffs raised additional claims for declaratory relief and an injunction, and Judge Fogel ruled against the defendants' motion to dismiss the claims based on medical necessity and the Tenth Amendment.

In 2009, after Deputy Attorney General David Ogden issued a memo stating that federal prosecutors should not target those in clear and unambiguous compliance with state medical marijuana laws, the city and county of Santa Cruz agreed to voluntarily dismiss their lawsuit. On May 9, 2011, following letters from several U.S. attorneys that were not consistent with the DOJ policy, the ACLU — which represents plaintiffs in the Santa Cruz case — wrote the DOJ requesting that it stand by the policy articulated in the Ogden memo. The ACLU's letter cited the stipulation in the Santa Cruz case that if the DOJ withdrew, modified, or failed to follow the Odgen memo, the case could be reinstated at the same posture, which was immediately preceding discovery (such as subpoenas and depositions of the department).

Background: This suit was prompted by a DEA raid that received national attention in September 2002, when heavily armed federal agents stormed the Wo/Men's Alliance for Medical Marijuana cooperative. During this raid, they handcuffed several medical marijuana patients while cutting down the plants that Valerie and Michael Corral had been dispensing free of charge.

The lawsuit — which aimed to end the Bush administration's active interference with state medical marijuana laws — was filed by eight plaintiffs who were patients of the cooperative. Several of them have passed away. The defendants in the case are the U.S. attorney general, the DEA administrator, the director of the White House Office of National Drug Control Policy, and the DEA agents who conducted the raid. This is a historic lawsuit because it was the first time that a public entity sued the federal government on behalf of medical marijuana patients.

On September 24, 2002, 20 to 30 DEA agents raided WAMM, a collective of medical marijuana patients and their caregivers. While holding the founders of the collective, Valerie and Mike Corral, at gunpoint, they confiscated 160 plants. The Corrals were taken into custody but have not been charged with a crime. Following the raid, WAMM and the City and County of Santa Cruz jointly sued the federal government, challenging the authority of the federal government to conduct medical marijuana raids. *County of Santa Cruz, et al. v. Mukasey* initially focused on constitutional issues related to the Commerce Clause; because no interstate trade or commercial activity was involved, plaintiffs argued that the federal raid was unconstitutional in that it went beyond the scope of the Commerce Clause.

On August 28, 2003, Judge Fogel of the U.S. District Court for Northern California denied the plaintiffs' motion for a preliminary injunction that would have barred the federal government from conducting raids while the case was tried. Later that year, in light of the Ninth Circuit's landmark decision in *Raich* — which specifically criticized Judge Fogel's decision in this case — the plaintiffs asked the judge to reconsider his decision. On April 21, 2004, Judge Fogel issued a historic preliminary injunction barring the U.S. Department of Justice from raiding or prosecuting WAMM in Santa Cruz, California.

On September 20, 2005, after the U.S. Supreme Court decision overturning and remanding the Ninth Circuit's *Raich* decision, the Ninth Circuit reversed the order for a preliminary injunction. The County of Santa Cruz, et al. raised additional legal theories requesting declaratory relief and an injunction. Those included claims based on the Tenth Amendment, medical necessity, and due process. On June 23, 2006, the court heard a motion to dismiss, filed by the defendants. The court waited to decide until after the Ninth Circuit ruled on *Raich v. Gonzales* on remand (*Raich II*). In the wake of *Raich II*, both parties filed supplemental briefings, and Judge Fogel heard oral arguments on July 13, 2007. The defendants argued that *Raich II* controlled and that the claims should be dismissed.

The *County of Santa Cruz, et al.* argued that the medical necessity claims are distinguishable from those raised in *Raich II* because they are in the context of part of a criminal prosecution, since charges could still be filed against the members of WAMM. They also maintained that the due process claims are valid because the court in *Raich II* did not consider the right to control the circumstances of one's death. The plaintiffs also claimed that the Tenth Amendment claims are distinguishable from those raised in *Raich II* because they are raised by local governments. They argued that the federal government cannot interfere in the state's affairs.

On August 20, 2007, Judge Fogel granted a federal motion to dismiss all of the claims except medical necessity. He also allowed *County of Santa Cruz, et al.* to submit an amended complaint on the Tenth Amendment issue. In their amended complaint,

County of Santa Cruz, et al. argued that the federal government engaged in a plan to try to force California and other states to repeal their medical marijuana laws. This conduct included threatening to punish doctors who recommend medical marijuana, threatening officials who issue medical marijuana cards, interfering with zoning plans, and raiding and arresting providers who work closely with municipalities.

On August 19, 2008, Fogel ruled against the federal government's motion to dismiss the Tenth Amendment claims. The court found, "If Plaintiffs can prove that Defendants are enforcing the CSA in the manner alleged … they may be able to show that Defendants deliberately are seeking to frustrate the state's ability to determine whether an individual's use of marijuana is permissible under California law. A working system of recommendations, identification cards and medicinal providers is essential to the administration of California's medical marijuana law. The effect of a concerted effort to disrupt that system at least arguably would be to require state officials to enforce the terms of the CSA."

Santa Cruz and the other plaintiffs voluntarily dismissed their case against the federal government and DEA agents following the issuance of the Ogden memo in 2009, which detailed a shift in federal enforcement policy to not prioritize those in clear and unambiguous compliance with state laws. However, it is possible the suit could be reinstated at the same status at any point, based on a changed position from the Justice Department. The suit was dismissed immediately prior to depositions of the Justice Department.

Arizona, et al. v. United States, et al. (No. CV-11-01072-PHX-SRB)

Ruling: On January 4, 2012, U.S. District Judge Susan Bolton dismissed a lawsuit filed by Arizona Attorney General Tom Horne and Arizona Gov. Jan Brewer questioning whether the state's medical marijuana law was preempted (nullified) by federal law. Judge Bolton did not decide the merits of whether the state law was preempted, but instead found that the case was not ripe for judicial review because the state did not establish that state employees faced "genuine threat of imminent prosecution" by federal officials. Judge Bolton gave Arizona 30 days to decide whether to re-file. The governor and state attorney general did not re-file or appeal.

Background: On May 27, 2011, Arizona Attorney General Tom Horne filed a suit for a declaratory judgment against the United States, the U.S. Department of Justice, Arizona's U.S. attorney, and U.S. Attorney General Eric Holder asking whether state employees and others had safe harbor against federal prosecution or whether Arizona's state medical marijuana law is preempted by federal law. Arizona also invented hypothetical defendants, DOES I-XX, that it claimed were on either side of the issue and invited interested parties to volunteer as defendants. Only supporters of the law, such as patients, voters, and prospective dispensary operators, volunteered to be defendants.

The Department of Justice and the other defendants filed motions to dismiss. On January 4, 2012, U.S. District Judge Susan Bolton dismissed the lawsuit. Judge Bolton did not decide whether the state law was preempted, but instead found that the case was not ripe for judicial review because state employees did not face a "genuine threat of imminent prosecution." Arizona had the option of re-filing an amended complaint, but did not do so.

While Judge Bolton did not need to decide the preemption issue on its merits, a state trial court heard a similar case and found that state law was not preempted by federal law. In *White Mountain Health Center, Inc. v. County of Maricopa*, Judge Michael Gordon found that a county issuing certificates to dispensaries would not be preempted by federal law. On December 3, 2012, Gordon explained that the argument in favor of preemption "highjacks Arizona drug laws and obligates Arizonans to enforce federal prescriptions that categorically prohibit the use of all marijuana. The Tenth Amendment's anti-commandeering rule prohibits Congress from charting that course." Maricopa County is appealing the decision.

Appendix K: Therapeutic Research Programs

The federal government allows one exception to its prohibition of the cultivation, distribution, and use of Schedule I controlled substances: research. Doctors who wish to conduct research on Schedule I substances such as marijuana must obtain a special license from the DEA to handle the substance, FDA approval of the research protocol (if experimenting with human subjects), and a legal supply of the substance from the only federally approved source — the National Institute on Drug Abuse (NIDA).

An individual doctor may conduct research if all of the necessary permissions have been granted. In addition, a state may run a program involving multiple doctor-patient teams if the state secures the necessary permission for the researchers from the federal government.

Beginning in the late 1970s, a number of state governments sought to give large numbers of patients legal access to medical marijuana through federally approved research programs.

While 26 states passed laws creating therapeutic research programs, only seven obtained all of the necessary federal permissions, received marijuana and/or THC (tetrahydrocannabinol, the primary active ingredient in marijuana) from the federal government, and distributed the substances to approved patients through approved pharmacies. Those seven states were California, Georgia, Michigan, New Mexico, New York, Tennessee, and Washington.

Typically, patients were referred to the program by their personal physicians. These patients, who often had not responded well to conventional treatments, underwent medical and psychological screening processes. Then, the patients applied to their state patient qualification review board, which resided within the state health department. If granted permission, they would receive marijuana from approved pharmacies. Patients were required to monitor their usage and marijuana's effects, which the state used to prepare reports for the FDA.

(Interestingly, former Vice President Al Gore's sister received medical marijuana through the Tennessee program while undergoing chemotherapy for cancer in the early 1980s.)

These programs were designed to enable patients to use marijuana. The research was not intended to generate data that could lead to FDA approval of marijuana as a prescription medicine. For example, the protocols did not involve double-blind assignment to research and control groups, nor did they involve the use of placebos.

Such programs were discontinued by the mid-1980s, and the federal government has since made it more difficult for researchers to obtain marijuana for study, preferring to approve only those studies that are well-controlled clinical trials designed to yield essential scientific data.

Outlining its position on medical marijuana research, the U.S. Department of Health and Human Services — in which NIDA resides — issued new research guidelines, which became effective on December 1, 1999. The guidelines were widely criticized as being too cumbersome to enable research to move forward as expeditiously as possible.

These new obstacles are not surprising, given NIDA's institutional mission: to sponsor research into the understanding and treatment of the harmful consequences of the use of illegal drugs and to conduct educational activities to reduce the demand for and use of these illegal drugs. This mission makes NIDA singularly inappropriate for expediting scientific research into the potential medical uses of marijuana.

In addition, NIDA obfuscates its own part in preventing marijuana from being medically approved. It explains on its website that the FDA will not approve medication that has not undergone sufficient clinical trials – omitting mention of its own significant role in complicating the process for applying to those trials.

Three cases further demonstrate the federal barricade to medical marijuana research:

- Lyle Craker, Ph.D., a researcher at the University of Massachusetts at Amherst, was denied permission to cultivate research-grade medical marijuana to be used in government-approved medical studies by himself and other scientists. Prof. Craker was given elusive and contradictory information several times by the DEA, which finally denied the permission to conduct research. He argued that researchers were not adequately served by NIDA's marijuana. NIDA produces marijuana at only one location, the University of Mississippi. The DEA has not prohibited other Schedule I drugs — even cocaine — from being produced by DEA-licensed private labs for research. Six years into Craker's efforts, Drug Enforcement Administration Administrative Law Judge Mary Ellen Bittner issued a ruling in his favor, concluding "that there is currently an inadequate supply of marijuana available for research purposes." Scientists testified in his favor that NIDA denied their requests for marijuana to be used in FDA-approved research protocol. However, the decision is non-binding, and the DEA rejected the recommendation on January 14, 2009. Craker appealed the decision in court, but the U.S. First District Court of Appeals rejected his appeal.
- Donald Abrams, M.D., a researcher at the University of California at San Francisco (UCSF), tried for five years to gain approval to conduct a study on marijuana's benefits for AIDS patients with wasting syndrome. Despite approval by the FDA and UCSF's Institutional Review Board, Abrams' proposal was turned down twice by NIDA, in an experience he described as "an endless labyrinth of closed doors." He was able to gain approval only after redesigning the study so that it focused on the potential risks of marijuana in AIDS patients rather than its benefits. "The science," Abrams said at the time, "is barely surviving the politics."[1]
- Neurologist Ethan Russo, M.D., finally gave up trying to secure approval for a study of marijuana to treat migraine headaches — a condition afflicting 35 million Americans, nearly one-third of whom do not respond to "gold standard" treatments. When the National Institutes of Health (NIH) rejected his first proposal, he sought guidance from his "program official" as to how to revise the design, but the official failed to respond and later denied receiving his emails. Russo rewrote the protocol according to recommendations made by the 1997 NIH Consensus Panel on Medical Marijuana. The second rejection

[1] Bruce Mirken, "Medical Marijuana: The State of the Research," *AIDS Treatment News*, no. 257, October 18, 1996.

complained that the evidence for marijuana's efficacy was only "anecdotal" — but failed to address how better evidence could be obtained if formal trials are not approved. Only after this second rejection did Russo learn that not a single headache specialist was included on the 20-member review panel.[2]

California is the only state where clinical research on marijuana's medical efficacy has taken place in recent years, thanks to a $9 million appropriation granted by the California Legislature. The funding authorized about a dozen clinical trials on humans that were carefully controlled and not designed to provide patients with access. They were conducted by the Center for Medicinal Cannabis Research (CMCR). (The funding also included support for some animal studies.) The CMCR trials were nothing like the therapeutic research programs in the 1970s and 1980s that provided access. They were highly controlled, in-patient studies that involved no more than one week's worth of marijuana and enrolled a total of fewer than 250 patients. Six of the planned trials had to be discontinued because of difficulty recruiting patients, probably because California patients have state-legal, regular access to higher quality medical marijuana without mandatory wash-out periods, extremely short time-periods with access, in-patient stays, and placebo controls. In addition, Colorado's Board of Health awarded $9 million in grant funding for medical cannabis research in December 2014 and February 2015. The research is funded by the state's medical marijuana program.

In 2013, the Maryland Legislature approved a bill that is similar to the therapeutic research laws of the 1970s and 1980s. In-state teaching hospitals are allowed to propose investigational-use type research programs to a state commission, which can approve up to five such programs at a time. The marijuana provided to patients could come from either the federal government or from marijuana producers that would be licensed by the state commission.

Because of excessively strict federal guidelines for providing marijuana for research, the limited supply of NIDA medical marijuana, the inability of the state to directly cultivate or distribute marijuana, and the high cost of clinical trials, the prospects for a successful clinical program in Maryland were dim. By the following legislative session in 2014, Maryland abandoned this effort in favor of a comprehensive medical marijuana law similar to those in operation in other states throughout the U.S.

These same limitations even affect state programs that, while distinct from the FDA-approved clinical trials, still fall short because of features that require federal approval. In particular, around the time Maryland established its teaching hospital approach, several other states attempted programs that tried to mimic either a clinical trial or simply a prescription model, with similar unworkable results. Generally, these efforts owed their popularity to the emergence of laws designed to offer limited access to cannabis or cannabis products containing high amounts of cannabidiol (CBD) and relatively low amounts of tetrahydrocannabinol (THC).[3] In some cases, the law required the state to produce and distribute marijuana products in a clinical setting. In other instances, doctors were required

[2] Ethan Russo, "Marijuana for migraine study rejected by NIH, Revisited," posted on www.maps.org, March 1999

[3] See Appendix G for more details on these laws.

to prescribe marijuana products and monitor results. These programs have proven unworkable because they require physicians, hospitals, or universities to violate federal law.[4]

The problem common to all these efforts is that marijuana and products containing either THC or CBD are considered Schedule I substances under federal law. Doctors cannot prescribe it without placing themselves at risk of a federal felony, and institutions — either run by the state or otherwise dependent on federal funds — are severely limited. As a result, until the government changes its current policy, these types of systems would only be effective if doctors, universities, or teaching hospitals committed a form of civil disobedience in order to provide patients with access.

Every effective state medical marijuana law involves people who violate federal law. But those who are directly involved in the production, processing, and distribution of marijuana are not dependent on learning institutions, nor are they part of state government.

Given these obstacles, through the last few decades, states have been unable to provide ongoing access to medical marijuana through a therapeutic research program or a similar approach. And generally states have been unwilling to devote their limited resources to the long and likely fruitless research application process. Nevertheless, several have allowed these inactive therapeutic research programs or other similarly limited systems to remain on the books. In addition, California and Colorado have both provided funding for rigorous clinical trials — which are typically short term, with mandatory abstinence periods and placebo control, and that involve a limited number of patients at great expense. Meanwhile, since 1996, around two dozen states and the District of Columbia have enacted functional laws that provide access to marijuana without federal approval.

[4] Laws passed in Alabama, Florida, Kentucky, Texas, and Wisconsin required doctors to prescribe marijuana in an effort to distinguish these programs from the more successful programs in other states. Others, such as Tennessee, Utah, and also including Alabama, required universities to cultivate or distribute marijuana to patients who would be in a school-supervised and monitored program. See Appendix I for a discussion of why doctors may not *prescribe* marijuana.

Appendix L: Medical Necessity Defense

The necessity defense, long recognized in common law, gives defendants the chance to prove in court that their violation of the law was necessary to avert a greater evil. It is often referred to as the "choice of evils defense."

If allowed in a medical marijuana case, the medical necessity defense may lead to an acquittal, even if the evidence proves that the patient did indeed possess or cultivate marijuana. This defense generally holds that the act committed (marijuana cultivation or possession, in this case) was an emergency measure to avoid imminent harm.

Unlike "exemption from prosecution," a patient is still arrested and prosecuted for the crime, because a judge and/or jury may decide that the evidence was insufficient to establish medical necessity.

The necessity defense is not allowed as a defense to any and all charges. Typically, courts look to prior court decisions or legislative actions that indicate circumstances where a necessity defense may be applicable. Regarding medical marijuana, for example, a court's decision on whether to permit the defense may depend on whether the legislature has enacted a law that recognizes marijuana's medical benefits.

This defense is typically established by decisions in state courts of appeals. Additionally, a state legislature may codify a medical necessity defense into law. Several state medical marijuana laws — including Michigan's and Oregon's — permit a variation of this defense for unregistered patients whose doctors recommend medical marijuana, in addition to an exemption from prosecution for registered patients.

The first successful use of the medical necessity defense in a marijuana cultivation case led to the 1976 acquittal of Robert Randall, a glaucoma patient in Washington, D.C.

In the Randall case, the court determined that the defense is available if (1) the defendant did not cause the compelling circumstances leading to the violation of the law, (2) a less offensive alternative was not available, and (3) the harm avoided (loss of vision) was more serious than the harm that was caused (such as cultivating marijuana).

In two non-medical marijuana states, Florida and Idaho, a medical marijuana necessity defense based in common law has been allowed by an appellate court in limited circumstances.

In a 1991 Florida case, *Jenks v. State*, the First District Court of Appeals allowed two seriously ill HIV/AIDS patients to raise a medical necessity defense to marijuana cultivation and drug paraphernalia charges.[1] The court found that the defendants had met the burden of establishing the defense at trial, and thus reversed the trial court's judgment and acquitted the defendants. Since the Florida Supreme Court denied review later that year, all trial courts in Florida are bound by this decision unless another District Court of Appeals issues a contradictory decision.[2]

The same First District Court of Appeals upheld the medical necessity defense again in the 1998 case, *Sowell v. State*, allowing a seriously ill patient to assert the defense to marijuana cultivation charges. The court noted the defense was still appropriate, again

[1] *Jenks v. State*, 582 So. 2d 676 (Fla. 1st Dist. Ct. App. 1991).

[2] Florida District Courts of Appeals do not bind each other; however, in Florida, a trial court is obligated to follow the decisions of other District Courts of Appeals in absence of conflicting authority if the appellate court in its own district has not decided the issue. See *Pimm v. Pimm*, 568 So. 2d 1299 (Fla. 2d Dist. App. 1990).

grounding it in the common law, even after the legislature made a slight change to its Schedule I statutory language that was unfriendly to the use of medical marijuana.[3] The Florida Supreme Court let the decision stand as well.

In 2015, a jury acquitted a Florida man suffering from chronic anorexia of felony charges related to growing and using marijuana based on the medical necessity defense previously recognized by the First District Court of Appeals.[4]

In a 1990 case, *State v. Hastings*, the Idaho Supreme Court allowed a rheumatoid arthritis patient to present a necessity defense to marijuana possession charges at trial, though it declined to create a special defense of "medical necessity."[5] It based its reasoning on the common law necessity defense, which the legislature had adopted in the Idaho Code. The court vacated the trial court's decision, and remanded the case back to trial, so that the defendant could present evidence of how medical marijuana helped her control her pain and muscle spasms. This decision remains binding precedent in all Idaho courts. The defense was further clarified by the Court of Appeals of Idaho (an intermediate court) in the 2001 case, *State v. Tadlock*, which restricted the defense only to a simple marijuana possession charge and disallowed it for a possession with intent to deliver charge.[6]

It is also possible for a judge to allow an individual to raise a medical necessity defense based on the state having a symbolic medical marijuana law. For example, an Iowa judge ruled (in *Iowa v. Allen Douglas Helmers*) that a medical marijuana user's probation could not be revoked for using marijuana because the Iowa Legislature has defined marijuana as a Schedule II drug with a "current accepted medical use." (It remains a Schedule I drug when used for non-medical purposes.)

While federal law prevents Iowa patients from getting legal prescriptions for marijuana, the Iowa judge ruled that the legislature's recognition of marijuana's medical value protected Allen Helmers from being sent to prison for a probation violation for using marijuana.

Of note, Iowa moved marijuana used for medical purposes into Schedule II in 1979, when it enacted a therapeutic research program. The research program expired in 1981, but marijuana's dual scheduling remains in place, even after the Iowa Board of Pharmacy concluded in February 2010 that marijuana has medical value and recommended that the legislature reschedule marijuana solely to Schedule II.

A different judge could have ruled that the Iowa Legislature intended for marijuana to be used solely in connection with the research program, and, without the program, the medical necessity defense should not be available. Indeed, the Iowa Supreme Court ruled in a 2005 medical necessity case that it was not the court's place to "leapfrog the legislature and the Board of Pharmacy Examiners by simply recognizing the medicinal value, and the legality, of marijuana use."[7] Most other state courts — in Alabama and Minnesota, for example — have made similar interpretations and have refused to allow this defense.

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[3] *Sowell v. State*, 738 So. 2d 333 (Fla. 1st Dist. Ct. App. 1998).

[4] *State v. Teplicki,* case number 13000693CF10A (Fla. 17th Cir. Ct. 2015).

[5] *State v. Hastings*, 801 P.2d 563 (Idaho 1990).

[6] *State v. Tadlock*, 34 P.3d 1096 (Idaho Ct. App. 2001).

[7] *State v. Bonjour*, 694 N.W.2d 511 (Iowa 2005).

These cases demonstrate that although it is up to the courts to decide whether to allow the medical necessity defense, the activities of a state legislature may significantly impact this decision.

Some states have statutes that authorize a necessity defense generally and have specified the elements of proof needed to succeed. But this does not guarantee that the courts will recognize a medical necessity defense for marijuana. It depends on how the courts interpret the legislature's intent. If the defense is not recognized, the case proceeds as if the defendant possessed marijuana for recreational use or distribution. If found guilty, the offender is subject to prison time in most states.

The medical necessity defense is a very limited measure. Though a legislature may codify the defense into law, this is not the best course of action for a state legislature to pursue.

Preferably, a state would have a law that (1) exempts from prosecution qualified patients who possess medical marijuana, (2) allows patients a safe, state-legal means of accessing medical marijuana — ideally from both regulated dispensaries and home cultivation, and (3) allows patients to use an affirmative defense if they are arrested and prosecuted anyway.

Other than states that also provide patients with protection from arrest, MPP has identified only three states whose legislatures have passed bills to establish the medical necessity defense for medical marijuana offenses — Maryland, Massachusetts, and Ohio. Ultimately, all of these efforts but Maryland's were short-lived, if not unsuccessful.

An Ohio bill that included a medical necessity defense provision became law in 1996, only to be repealed a year later. Massachusetts enacted a law in 1996 to allow patients to use the defense, but only if they are "certified to participate" in the state's therapeutic research program. Unfortunately, the state never opened its research program, and thus, Massachusetts's patients are likely to be denied the necessity defense, similar to patients in Alabama and Minnesota, as noted above. Maryland's law was eventually amended and it is now an effective, comprehensive medical marijuana law.

At the federal level, the U.S. Supreme Court ruled in May 2001 that people who are arrested on federal marijuana distribution charges may not raise a medical necessity defense in federal court to avoid conviction.[8] It is still possible, however, that patients could successfully raise the necessity defense if they were prosecuted in federal court.[9]

[8] *U.S. v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001).

[9] See: *Raich v. Gonzales*, 500 F.3d 850 (9th Cir, 2005), finding that Angel Raich could not raise "medical necessity" in a civil suit to prevent federal prosecution, but noting that it was an unanswered question whether medical necessity could be raised as a criminal defense for medical marijuana in federal court.

States Without Effective Medical Marijuana Laws Where Courts Have Allowed the Medical Necessity Defense in Marijuana Cases	
Florida	*State v. Mussika*, 14 F.L.W. 1 (Fla. 17th Cir. Ct. Dec. 28, 1988).
Florida	*Jenks v. State*, 582 So. 2d 676 (Fla. 1st Dist. Ct. App. 1991).
Florida	*Florida State v. Teplicki,* case number 13000693CF10A (Fla. 17th Cir. Ct. 2015).
Florida	*Sowell v. State*, 738 So. 2d 333 (Fla. 1st Dist. Ct. App. 1998).
Idaho	*State v. Hastings*, 801 P.2d 563 (Idaho 1990).
Idaho	*State v. Tadlock*, 34 P.3d 1096 (Idaho Ct. App. 2001).
Iowa	*Iowa v. Allen Douglas Helmers* (Order No. FECR047575).
Texas	*Texas v. Stevens*, unpublished (2008): A Potter County jury acquitted an HIV patient charged with possessing four grams of marijuana based on a medical necessity defense.

States With Effective Medical Marijuana Laws Where Courts Have Allowed the Medical Necessity Defense in Marijuana Cases	
Hawaii	*State v. Bachman*, 595 P. 2d 287 (Haw. 1979).
Michigan	*People v. Kolanek*, 491 Mich. 382 (Mich. 2012). A patient raising the affirmative defense in the Michigan Medical Marihuana Act need not establish the elements required for immunity for arrest — that the patient possessed only 2.5 ounces and 12 plants in an enclosed locked facility with a registry identification card.
Vermont	Addison County District Court acquitted Steven Bryant of possession of marijuana in May 2005 based on medical necessity. See: Flowers, John, "Bryant Claims Marijuana Was Medically Necessary," *Addison County Independent*, May 2, 2005.
Washington	*State v. Diana*, 604 P.2d 1312 (Ct. App. Wash 1979).
Washington	*State v. Cole*, 874 P.2d 878 (Ct. App. Wash. 1994).
Washington	*State v. Pittman,* 943 P.2d 713 (Ct. App. Wash. 1997).
Washington	*State v. Kurtz,* 309 P.3d 472 (Wash. 2013).

States Where Courts Have Refused to Allow the Medical Necessity Defense in Marijuana Cases		
Alabama	*Kauffman v. Alabama*, 620 So. 2d 90 (1993)	The state Court of Appeals refused to allow a patient to use the medical necessity defense because the legislature had already expressed its intent by placing marijuana in Schedule I — and by establishing a therapeutic research program, thereby defining the very limited circumstances under which marijuana may be used.
District of Columbia	*Emry v. U.S.*, 829 A.2d 970 (D.C. Court of Appeals, 2003)	The D.C. Court of Appeals upheld a trial court ruling that Renee Emry did not establish the elements of the necessity defense — that she had no legal alternatives to marijuana for multiple sclerosis when she smoked marijuana in Congressman William McCollum's office. It noted that it had not adopted the holding from *U.S. v. Randall,* saying, "nor do we decide on this record whether medical necessity can ever be a defense to the unlawful possession of marijuana."
Georgia	*Spillers v. Georgia*, 245 S.E. 2d 54, 55 (1978)	The state Court of Appeals ruled that the lack of any recognition of marijuana's medical uses by the state legislature precluded the court from allowing the medical necessity defense.
Illinois	*People v. Kratovil*, 351 Ill. App.3d 1023 (Ill. App. 2004)	The court found that the existence of a defense such as medical necessity would be up to the legislature, and it had not provided for one.
Iowa	*State v. Bonjour*, 694 N.W.2d 511 (Iowa 2005)	The state Supreme Court ruled against an AIDS patient who sought to raise a medical necessity defense, finding, "it was not the court's place to leapfrog the legislature and the Board of Pharmacy Examiners by simply recognizing the medicinal value, and the legality, of marijuana use."
Massachusetts	*Massachusetts v. Hutchins*, 575 N.E. 2d 741, 742 (1991)	The state Supreme Judicial Court ruled that the societal harm of allowing the medical necessity defense would be greater than the harm done to a patient denied the opportunity to offer the medical necessity defense.
Minnesota	*Minnesota v. Hanson*, 468 N.W. 2d 77, 78 (1991)	The state Court of Appeals refused to allow a patient to use the medical necessity defense because the legislature had already expressed its intent by placing marijuana in Schedule I — and by establishing a therapeutic research program, thereby defining the very limited circumstances under which marijuana may be used.
Missouri	*Missouri v. Cox*, 248 S.W.3d 1 (2008)	The state Court of Appeals affirmed a lower court's rejection of a patient's medical necessity defense because the legislature had already expressed its intent by placing marijuana in Schedule I, even though statute allowed the dispensing of Schedule I substances by certain professionals.
Nebraska	*State v. Beal,* 846 N.W.2d 282 (2014)	The state Court of Appeals rejected defendant's appeal of a conviction for marijuana possession with intent to deliver. Defendant raised a medical necessity defense but the court held the defendant did not demonstrate a specific and immediate imminent harm as required by the choice of evils defense.

States Where Courts Have Refused to Allow the Medical Necessity Defense in Marijuana Cases		
New Jersey	*New Jersey v. Tate*, 505 A. 2d 941 (1986)	The state Supreme Court ruled that the legislature — by placing marijuana in Schedule I — had already indicated its legislative intent to prohibit the medical use of marijuana. In addition, the court claimed that the criteria of "necessity" could not be met because there were research program options that could have been pursued instead.
South Dakota	*South Dakota v. Matthew Ducheneaux*, SD 131 (2003)	The state Supreme Court ruled that Mr. Ducheneaux — who was convicted of marijuana possession in 2000 — could not rely on a state necessity defense law that allows illegal conduct when a person is being threatened by unlawful force. The court stated that it would strain the language of the law if it could be used to show that a health problem amounts to unlawful force against a person.
Virginia	*Murphy v. Com*, 31 Va. App. 70, 521 S.E. 2d 301 Va. App., 1999	The Court of Appeals ruled that the necessity defense was unavailable to a migraine sufferer because the legislature limited the medical use of marijuana (symbolically only) to patients whose doctors prescribe it to relieve cancer or glaucoma.
West Virginia	*State v. Poling*, 207 W.Va. 299, (2000)	Finding that the medical necessity defense is not available for marijuana because the state legislature made marijuana a Schedule I drug with no exception for medical use.

Appendix M: Model Resolution of Support

Resolution to Protect Seriously Ill People from Arrest and Imprisonment for Using Medical Marijuana

Whereas, the National Academy of Sciences' Institute of Medicine concluded after reviewing the relevant scientific literature — including dozens of works documenting marijuana's therapeutic value — that "nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana" and that "there will likely always be a subpopulation of patients who do not respond well to other medications";[1] and,

Whereas, subsequent studies since the 1999 Institute of Medicine report continue to show the therapeutic value of marijuana in treating a wide array of debilitating medical conditions, including relieving medication side effects and thus improving the likelihood that patients will adhere to life-prolonging treatments for HIV/AIDS and hepatitis C and alleviating HIV/AIDS neuropathy, a painful condition for which there are no FDA-approved treatments;[2] and,

Whereas, a scientific survey conducted in 1990 by Harvard University researchers found that 54% of oncologists with an opinion favored the controlled medical availability of marijuana, and 44% had already suggested at least once that a patient obtain marijuana illegally;[3] and,

Whereas, in 2008 and 2009, respectively, the American College of Physicians and the American Medical Association called for the federal government to review the evidence and consider reclassifying marijuana from a Schedule I drug; and,

Whereas, on September 6, 1988, after reviewing all available medical data, the Drug Enforcement Administration's chief administrative law judge, Francis L. Young, recommended that marijuana be rescheduled and available by prescription, declaring that marijuana is "one of the safest therapeutically active substances known";[4] and,

Whereas, medical marijuana laws have been enacted in 23 states and the District of Columbia and are protecting hundreds of thousands of suffering patients from being arrested for using medical marijuana according to their doctors' recommendations; and,

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[1] J. Joy, S. Watson, and J. Benson, "Marijuana and Medicine: Assessing the Science Base, Institute of Medicine," Washington: National Academy Press, 1999; Chapter 4, "The Medical Value of Marijuana and Related Substances," lists 198 references in its analysis of marijuana's medical uses.

[2] B.C. deJong, et al, "Marijuana Use and its Association With Adherence to Antiretroviral Therapy Among HIV-Infected Persons With Moderate to Severe Nausea," *Journal of Acquired Immune Deficiency Syndromes*, January 1, 2005; D.L. Sylvestre, B.J. Clements, and Y. Malibu, "Cannabis Use Improves Retention and Virological Outcomes in Patients Treated for Hepatitis C," *European Journal of Gastroenterology and Hepatology*, September 2006. In February 2010, the state-funded University of California's Center for Medicinal Cannabis Research released a report documenting marijuana's medical value in 15 rigorous clinical studies, including seven trials. Center for Medicinal Cannabis Research, *available at* http://www.cmcr.ucsd.edu/index.php?option=com_content&view=category&id=41&Itemid=135.

[3] R. Doblin and M. Kleiman, "Marijuana as Antiemetic Medicine," *Journal of Clinical Oncology* 9 (1991): 1314-1319.

[4] U.S. Department of Justice, Drug Enforcement Administration, "In The Matter Of Marijuana Rescheduling Petition, Docket No. 86-22, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge," Francis L. Young, Administrative Law Judge, September 6, 1988.

Whereas, hundreds of thousands of patients nationwide — people with AIDS, cancer, glaucoma, chronic pain, and multiple sclerosis — have found marijuana in its natural form to be therapeutically beneficial and are already using it with their doctors' approval; and,

Whereas, numerous organizations have endorsed medical access to marijuana, including the American Academy of HIV Medicine; the American Bar Association; the American Civil Liberties Union; the American Nurses Association; the American Public Health Association; the Arthritis Research Association; the British Medical Association; the Lymphoma Foundation of America; the Leukemia & Lymphoma Society; the National Association for Public Health Policy; the National Black Police Association; the National Nurses Society on Addictions; numerous state nurses associations; several state hospice, public health, and medical associations; the Presbyterian Church (USA); the Episcopal Church; the Union of Reform Judaism; the Progressive National Baptist Convention; the Unitarian Universalist Association; the United Church of Christ; and the United Methodist Church; and,

Whereas, an April 2015 nationwide CBS News poll found that 84% of Americans believe that "doctors should be allowed to prescribe small amounts of marijuana for patients suffering from serious illnesses." and,

Whereas, the present federal classification of marijuana[5] and the resulting bureaucratic controls impede additional scientific research into marijuana's therapeutic potential,[6] thereby making it nearly impossible for the Food and Drug Administration to evaluate and approve marijuana through standard procedural channels; and,

Whereas, the Ninth U.S. Circuit Court of Appeals, in the case of *Conant v. Walters*, upheld the right of physicians to recommend medical marijuana to patients without federal government interference, and the United States Supreme Court declined to hear the federal government's appeal of this ruling; and,

Whereas, the U.S. Department of Justice issued a memo in August 2013 specifying that it was "not an efficient use of federal resources to focus enforcement efforts on seriously ill individuals, or on their individual caregivers;"[7] and,

Whereas, state medical marijuana laws do not require anyone to violate federal law and are thus are not preempted by federal law, according to two California cases that the U.S. Supreme Court declined to review; [8] and,

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[5] Section 812(c) of Title 21, United States Code.

[6] The U.S. Department of Health and Human Services (HHS) issued written guidelines for medical marijuana research, effective December 1, 1999. The guidelines drew criticism from a coalition of medical groups, scientists, members of Congress, celebrities, and concerned citizens. The coalition called the guidelines "too cumbersome" and urged their modification in a letter to HHS Secretary Donna Shalala, dated November 29, 1999. Signatories of the letter included 33 members of Congress, former Surgeon General Joycelyn Elders, and hundreds of patients, doctors, and medical organizations. In addition, Drug Enforcement Administration (DEA) Administrative Law Judge Mary Ellen Bittner issued a February 2007 ruling concluding "that there is currently an inadequate supply of marijuana available for research purposes" and recommending that the DEA grant Dr. Lyle Craker a license to cultivate research-grade marijuana, but the DEA has failed to do so.

[7] Cole, James M. Memorandum for United States Attorneys: Guidance Regarding Marijuana Enforcement. U.S. Department of Justice, Office of the Deputy Attorney General, August 29, 2013.

[8] See *County of San Diego v. San Diego NORML,* 165 Cal.App.4th 798 (Cal.App. 4th Dist. 2008), review denied (Cal. 2008), cert denied, 129 S.Ct. 2380 (2009); *City of Garden Grove v. Superior Court* 68 157 Cal.App.4th 355 (Cal.App. 4 th Dist. 2007), review denied (Cal. 2008), cert denied 129 S.Ct 623 (2008).

Whereas, seriously ill people should not be punished for acting in accordance with the opinion of their physicians in a bona fide attempt to relieve suffering; therefore,

Be It Resolved, that licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to criminal sanctions for using marijuana if their physician has told them that such use is likely to be beneficial; and be it further

Resolved that state and federal law should be changed so that no seriously ill patient will be subject to criminal or civil sanction for the doctor-advised medical use of marijuana, and so that qualifying seriously ill patients can safely obtain medical marijuana from well-regulated entities.

Appendix N: States That Have the Initiative Process

The initiative process allows citizens to vote on proposed laws, as well as amendments, to the state constitution. There is no national initiative process, but 23 states and the District of Columbia have the initiative process in some form.

Some states allow citizens to propose laws that are placed directly on a ballot for voters to decide. The legislature has no role in this process, known as the "direct initiative process."

Other states have an "indirect initiative process," where laws or constitutional amendments proposed by the people must first be submitted to the state legislature. If the legislature fails to approve the law or constitutional amendment, the proposal appears on the ballot for voters to decide. Maine and Massachusetts' medical marijuana laws and the 2009 addition of dispensaries to Maine's law were enacted via indirect initiative processes; all other state medical marijuana initiatives have been direct.

Colorado and Nevada's medical marijuana initiatives amended their state constitutions, while the medical marijuana initiatives in Alaska, Arizona, California, the District of Columbia, Maine, Massachusetts, Michigan, Montana, Oregon, and Washington enacted statutory laws.

23* States and D.C. Have the Initiative Process

	Statutory Law		Constitutional Amendment	
State	**Direct**	**Indirect**	**Direct**	**Indirect**
Alaska	N	Y	N	N
Arizona	Y	N	Y	N
Arkansas	Y	N	Y	N
California	Y	N	Y	N
Colorado	Y	N	Y	N
District of Columbia	Y	N	N	N
Florida	N	N	Y	N
Idaho	Y	N	N	N
Maine	N	Y	N	N
Massachusetts	N	Y	N	Y
Michigan	N	Y	Y	N
Mississippi	N	N	N	Y
Missouri	Y	N	Y	N
Montana	Y	N	Y	N
Nebraska	Y	N	Y	N
Nevada	N	Y	Y	N
North Dakota	Y	N	Y	N
Ohio	N	Y	Y	N
Oklahoma	Y	N	Y	N
Oregon	Y	N	Y	N
South Dakota	Y	N	Y	N
Utah	Y	Y	N	N
Washington	Y	Y	N	N
Wyoming	Y	N	N	N

Y – has the process; N – does not have the process

* MPP does not consider Illinois to be an initiative state because voters cannot place marijuana-related questions on the ballot. Rather, only initiatives that change the structure or function of government can be placed on the ballot.

The initiative process is not a panacea, however. Twenty-seven states do not have it, which means voters in these states cannot themselves propose and enact medical marijuana laws; rather, they must rely on their elected representatives to enact such laws. Moreover, passing legislation is much more cost-effective than passing ballot initiatives, which can be very expensive endeavors.

In contrast to initiatives, referenda deal with matters not originated by the voters. There are two types of referenda. A popular referendum is the power of the people to refer to the ballot, through a petition, specific legislation that was enacted by the legislature, for the voters' approval or rejection. A legislative referendum is when a state legislature places a proposed constitutional amendment or statute on the ballot for voter approval or rejection.

There are two states that have a popular referendum process but not an initiative process — Maryland and New Mexico. In addition, in 49 states, the legislature must put a proposed constitutional amendment on the ballot for voter approval. (A listing of the states with the referendum process is *not* provided in the chart in this section.)

Appendix O: Effective Arguments for Medical Marijuana Advocates

Introduction

The key to being a successful medical marijuana advocate is effective communication. Specifically, advocates must be able to: 1) convey the most important arguments in support of medical marijuana laws, and 2) respond to arguments made in opposition to medical marijuana laws. Whether you are engaging in personal discussions, participating in public debates, conducting media interviews, or corresponding with government officials, it is critical that you are prepared.

This document will provide you with the most persuasive talking points and strongest rebuttals to employ when communicating about medical marijuana. We recommend you keep it handy when conducting interviews or engaging in public debates. You are also welcome to convey the information verbatim or simply use it as a general guide when carrying out advocacy activities.

NOTE: Statistics can change rapidly and there are constant developments surrounding the issue. If you would like to confirm whether a given piece of information is current, or if you would like to suggest additions or revisions to this document, please contact the Marijuana Policy Project communications department at media@mpp.org.

Proactive Arguments

These are the key points to convey when given the opportunity to make our case.

- **Medical marijuana is proven to be effective in the treatment of a variety of debilitating medical conditions.** A vast majority of Americans recognize the legitimate medical benefits of marijuana, as well as a large number of medical organizations. It is far less harmful and poses fewer negative side effects than most prescription drugs – especially painkillers – and patients often find it to be a more effective treatment.
- **Seriously ill people should not be subject to arrest and criminal penalties for using medical marijuana.** If marijuana can provide relief to those suffering from terrible illnesses like cancer and HIV/AIDS, it is unconscionable to criminalize them for using it. People who would benefit from medical marijuana should not have to wait – and in some cases cannot wait – for the right to use it legally.
- **Regulating the cultivation and sale of medical marijuana would ensure patients have legal, safe, and reliable access to medical marijuana.** Patients should not have to resort to the potentially dangerous underground market to access their medicine. By regulating medical marijuana, we can ensure it is free of pesticides, molds, and other impurities, and patients will know exactly what they are getting.
- **Four out of five Americans believe marijuana has legitimate medical uses and that people with serious illnesses should have safe and legal access to it.**[1,2] Twenty-three states, Guam, and Washington, D.C. have adopted laws that allow people with certain medical conditions to use medical marijuana, and similar laws are being considered in states around the country.

[1] Pew Research Center, "Majority Now Supports Legalizing Marijuana," April 13, 2013: 6.
[2] CBS News Poll, "For the First Time, Most Americans Think Marijuana Use Should be Legal," January 23, 2014: 2.

Reactive Arguments

These are responses to arguments frequently made by opponents.

Marijuana has no medical value.

- **There is a mountain of scientific evidence that demonstrates marijuana is a safe and effective medicine for people suffering from a variety of debilitating medical conditions.** Why would hundreds of thousands of seriously ill people risk being arrested and possibly imprisoned to use something that doesn't work? In 1999, the National Academy of Sciences' Institute of Medicine (IOM) reported, "Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana."[3]

  Seven University of California studies published since July 2015[4] have found that marijuana relieves neuropathic pain (pain caused by damage to nerves), a symptom commonly associated with multiple sclerosis, HIV/AIDS, diabetes, and a variety of other conditions for which conventional pain drugs are notoriously inadequate — and it did so with only minor side effects[5, 6, 7, 8, 9, 10, 11] Further, a 2015 McGill University study — the "'first and largest study of the long term safety of medical cannabis use by patients suffering from chronic pain'" — found marijuana to have a "'reasonable safety profile'"[12] with no increased risk of serious adverse effects.[13]

  A 2008 article in the journal *Cancer Research* reported that marijuana has profound cancer-fighting abilities, killing malignant cancer cells associated with brain cancer, prostate cancer, breast cancer, lung cancer, pancreatic cancer, skin cancer, and lymphoma.[14]

  An observational study published in the *European Journal of Gastroenterology & Hepatology* found that hepatitis C patients using marijuana had three times the cure rate of non-users because it appeared to relieve the noxious side effects of anti-hepatitis C drugs, allowing patients to successfully complete treatment.[15]

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[3] Institute of Medicine, Marijuana and Medicine: Assessing the Science Base (Washington, D.C.: *National Academy Press,* 1999), 159.

[4] "Completed Studies," Center for Medicinal Cannabis Research, University of California, San Diego. http://www.cmcr.ucsd.edu/index.php?option=com_content&view=category&id=41&Itemid=135

[5] Abrams, D., Jay, C., Shade, S., Vizoso, H., Reda, H., Press S., Kelly M., Rowbotham M., and Petersen, K., "Cannabis in painful HIV-associated sensory neuropathy: A randomized placebo-controlled trial," *Neurology* 68: 515-521.

[6] Wilsey, B. et al., "A randomized, placebo-controlled, crossover trial of cannabis cigarettes in neuropathic pain." *The Journal of Pain* 9(6): 506-521.

[7] Ellis, R.J. et al., "Smoked medicinal cannabis for neuropathic pain in HIV: a randomized, crossover clinical trial," *Neuropsychopharmacology*. Published online ahead of print, August 6, 2008.

[8] Abrams D., et al., "Cannabis in painful HIV-associated sensory neuropathy: A randomized placebo-controlled trial," *Neurology* 68 (2007): 515-521.

[9] Wallace, M., et al., "Dose-dependent effects of smoked cannabis on capsaicin-induced pain and hyperalgesia in healthy volunteers," *Anesthesiology* 107(5) (2007): 785-796.

[10] Wallace, M., et al., "Effect of smoked cannabis on painful diabetic peripheral neuropathy," *The Journal of Pain* 16(7) (2015): 616-627.

[11] Wilsey, B., et al., "Low-dose vaporized cannabis significantly improves neuropathic pain," *The Journal of Pain* 14(2) (2013): 136-148.

[12] "Medical Cannabis in the Treatment of Chronic Pain," The Research Institute of the McGill University Health Centre, September 29, 2015.

[13] Ware, M., et al., "Cannabis for the Management of Pain: Assessment of Safety Study," *The Journal of Pain* 16(12) 2015: 1233-1242.

[14] Sarfaraz et al., "Cannabinoids for Cancer Treatment: Progress and Promise," *Cancer Research* 68 (2008): 339-342.

[15] Sylvestre D., Clements B., Malibu Y., "Cannabis use improves retention and virological outcomes in patients treated for hepatitis C," *European Journal of Gastroenterology & Hepatology* 18 (2006): 1057-1063.

A 2011 study published in the *Israel Medical Association Journal* found marijuana to be effective in treating Crohn's disease, with 45% of patients going into full remission and most of the remaining patients reporting significant improvement. [16]

- **Some federal agencies have taken actions that demonstrate it recognizes the medical benefits of marijuana.** For example, the U.S. Department of Health and Human Services holds a patent on the use of cannabinoids as neuroprotectants and antioxidants. The U.S. Food and Drug Administration (FDA) recognized the medical benefits of THC, a key component of marijuana, when it approved a synthetic form known as Marinol (or dronabinol in its generic form). Unfortunately, this prescription pill version has proven to be less effective than actual marijuana and has much more pronounced side effects.

  On September 6, 1988, after hearing two years of testimony, Drug Enforcement Administration (DEA) chief administrative law judge Francis Young, ruled: "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man. By any measure of rational analysis marijuana can be safely used within the supervised routine of medical care ... It would be unreasonable, arbitrary, and capricious for DEA to continue to stand between those sufferers and the benefits of this substance."[17]

- **Numerous medical organizations have examined the evidence and concluded that marijuana can be a safe, effective medicine for some patients.** They include the American Public Health Association, the American College of Physicians, the American Nurses Association, and a number of state medical and public health organizations, among others. For example, the American College of Physicians stated, "Evidence not only supports the use of medical marijuana in certain conditions, but also suggests numerous indications for cannabinoids."[18] In 2009, the American Medical Association called on the federal government to reconsider marijuana's classification under federal law, noting clinical trials have shown marijuana's medical efficacy. (See the following section for a larger list of organizations that support medical marijuana).

Medical marijuana is opposed by the American Medical Association, the American Cancer Society, and other medical organizations.

- **A large and growing number of medical and health organizations have recognized marijuana's medical value. In 2009, the American Medical Association made a major shift in its position, calling on the federal government to reconsider marijuana's status as a Schedule I drug, which bars medical use under federal law.**[19] Some medical organizations don't have a position on medical marijuana, but neutrality shouldn't be confused with supporting the arrest and imprisonment of patients. As former U.S. Surgeon General Dr. Joycelyn Elders put it in a 2004 newspaper column, "I know of no medical group that believes that jailing sick and dying people is good for them."[20]

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[16] Naftali, T., et al., "Treatment of Crohn's Disease with Cannabis: An Observational Study," *Israel Medical Association Journal* 13(8) (2011): 455-8.

[17] "In the Matter of Marijuana Rescheduling Petition," DEA Docket No. 86-22, September 6, 1988.

[18] American College of Physicians, "Supporting Research into the Therapeutic Role of Marijuana," 2008.

[19] Hoeffel, John, "Medical Marijuana Gets a Boost From Major Doctors Group," *Los Angeles Times*, November 11, 2009.

[20] Elders, Joycelyn, "Myths About Medical Marijuana," *Providence Journal*, March 26, 2004.

- **Surveys of physicians show strong support for medical marijuana.** For example, a 2013 national survey of physicians conducted by the New England Journal of Medicine found that 76% of doctors supported use of marijuana for medical purposes.[21]
- **The following medical organizations and prominent associations are among those that have taken favorable positions on medical marijuana:**

  AIDS Action Council; AIDS Foundation of Chicago; AIDS Project Rhode Island; American Academy of HIV Medicine (AAHIVM); American Anthropological Association; American Association for Social Psychiatry; American Bar Association; American College of Physicians; American Nurses Association; American Public Health Association; Americans for Democratic Action; Associated Medical Schools of New York; Being Alive: People With HIV/AIDS Action Committee (San Diego); California Democratic Council; California Legislative Council for Older Americans; California Nurses Association; California Pharmacists Association; California Society of Addiction Medicine; California-Pacific Annual Conference of the United Methodist Church; Colorado Nurses Association; *Consumer Reports* magazine; Epilepsy Foundation; Episcopal Church; Gray Panthers; Hawaii Nurses Association; Iowa Democratic Party; Leukemia & Lymphoma Society; Life Extension Foundation; Lymphoma Foundation of America; Medical Society of the State of New York; Medical Student Section of the American Medical Association; National Association of People With AIDS; New Mexico Nurses Association; New York County Medical Society; New York State AIDS Advisory Council; New York State Association of County Health Officials; New York State Hospice and Palliative Care Association; New York State Nurses Association; New York StateWide Senior Action Council, Inc.; Ninth District of the New York State Medical Society (Westchester, Rockland, Orange, Putnam, Dutchess, and Ulster counties); Presbyterian Church (USA); Progressive National Baptist Convention; Project Inform (national HIV/AIDS treatment education advocacy organization); Rhode Island Medical Society; Rhode Island State Nurses Association; Society for the Study of Social Problems; Test Positive Aware Network (Illinois); Texas Democratic Party; Union of Reform Judaism (formerly Union of American Hebrew Congregations); Unitarian Universalist Association; United Church of Christ; United Methodist Church; United Nurses and Allied Professionals (Rhode Island); Wisconsin Nurses Association; Wisconsin Public Health Association; and numerous other health and medical groups.[22]

Medicine should be based on science, not politics or public opinion.

- **The science is clear — marijuana is a safe and effective treatment for a variety of debilitating medical conditions.** Countless researchers and organizations have documented the medical benefits of marijuana, including the Institute of Medicine, the American College of Physicians, the American Public Health Association, the American Nurses Association, and the Epilepsy Foundation. If medicine should be based on science and not politics, our laws should reflect the facts and allow doctors to recommend marijuana to patients if they believe it will

[21] Adler, Jonathan N. & James A. Colbert, "Medicinal Use of Marijuana — Polling Results," *New England Journal of Medicine* 368 (2013): 30.

[22] "Partial List of Organizations with Favorable Medicinal Marijuana Positions," State-By-State Report, Marijuana Policy Project, 2011.

be effective. If politicians stand in the way in states with a ballot initiative process, citizens often have no other option than to take the issue to the voters.

Medical marijuana is already available to some people.

- **Twenty-three states, the District of Columbia, and the U.S. territory of Guam have adopted laws that allow patients with certain conditions to use medical marijuana if their doctors recommend it, but it is still illegal in the other 27 states and under federal law.** Four patients in the United States legally receive marijuana from the federal government. These patients are in an experimental program that was closed to all new applicants in 1992. Thousands of Americans used marijuana through experimental state programs in the late 1970s and early 1980s, but none of these programs are presently operating. **Medicine should be prescribed, not recommended.**
- **Doctors who recommend medical marijuana must examine patients and review their records, just as they would before prescribing any other medication.** If we can trust doctors to write prescriptions, why not trust them to provide their professional recommendations on their letterhead? The only difference is that a prescription is recognized under federal law. The vast majority of doctors who are willing to write such recommendations do not do so lightly or casually, and state medical boards often investigate and discipline physicians who fail to follow appropriate standards of care.
- **Despite its proven medical benefits, federal law prohibits doctors from "prescribing" marijuana for any reason.** There needs to be a way for state criminal justice systems to determine who has a legitimate medical need for medical marijuana, so they require doctors' recommendations instead. Doctors recommend many things: exercise, rest, chicken soup, vitamins, cranberry juice for bladder infections, and so on. The right of physicians to recommend marijuana when appropriate for a patient's condition has been upheld by the federal courts.

There are already drugs available that work better than marijuana.

- **Marijuana can be the most effective treatment — or the only effective treatment — for some patients.** For example, existing prescription drugs often fail to relieve neuropathic pain — pain caused by damage to the nerves — whereas marijuana has been shown to provide effective relief, even in patients for whom the conventional drugs have failed. This type of pain affects millions of Americans with multiple sclerosis, diabetes, HIV/AIDS, and other illnesses.
- **Different people respond differently to different medicines; the most effective drug for one person might not work at all for another, or it might have more pronounced side effects.** There are often a variety of drugs on the market to treat the same ailment, which is why the *Physicians' Desk Reference* comprises 3,000 pages of prescription drugs instead of just one drug per symptom or condition. For example, consider all of the prescription drugs available to treat pain: Oxycontin, Vicodin, Percocet, Codeine, etc. There is a reason why we don't just determine which is "best" and then ban all of the rest. Treatment decisions should be made in doctors' offices, not by politicians, bureaucrats, and law enforcement officials. Doctors must have the freedom to choose what works best for each of their patients.

In 1999, the Institute of Medicine reported:

"Although some medications are more effective than marijuana for these problems, they are not equally effective in all patients."[23]

"[T]here will likely always be a subpopulation of patients who do not respond well to other medications. The combination of cannabinoid drug effects (anxiety reduction, appetite stimulation, nausea reduction, and pain relief) suggests that cannabinoids would be moderately well suited for certain conditions, such as chemotherapy-induced nausea and vomiting and AIDS wasting."[24]

"The critical issue is not whether marijuana or cannabinoid drugs might be superior to the new drugs, but whether some group of patients might obtain added or better relief from marijuana or cannabinoid drugs."[25]

Marijuana is already available in the form of a prescription pill.

- **The prescription pill can be problematic for many patients.** The prescription pill known as Marinol (with the generic name dronabinol) is not actually marijuana; it is a synthetic version of THC, the psychoactive component responsible for marijuana's "high." It can take an hour or longer to take effect, whereas vaporized or smoked marijuana is effective almost instantaneously. Also, the dose of THC absorbed in the pill form is often too high or too low, and its slow and uneven absorption makes dosing difficult. In 2003, *The Lancet Neurology* reported, "Oral administration is probably the least satisfactory route for cannabis."[26] In its 2008 position paper on medical marijuana, the American College of Physicians noted, "Oral THC is slow in onset of action but produces more pronounced, and often unfavorable, psychoactive effects than those experienced with smoking."[27] If the prescription pill were sufficient, why would hundreds of thousands of seriously ill people break the law by using whole marijuana instead?
- **Marijuana contains about 80 active cannabinoids in addition to THC, and many of them contribute to marijuana's therapeutic effects.**[28] For example, cannabidiol (CBD) has been shown to have anti-nausea, anti-anxiety, and anti-inflammatory actions, as well as the ability to protect nerve cells from many kinds of damage.[29] CBD also moderates the effects of THC, so patients are less likely to get excessively "high." Other cannabinoids naturally contained in marijuana have also shown significant therapeutic promise.
- **Patients suffering from nausea, such as those undergoing chemotherapy, are often unable to keep pills down.** During a meeting of an expert panel convened by the National Institutes of Health in 1997 to review the scientific data on medical marijuana, panel member Mark Kris, M.D. said, "[T]he last thing that [patients] want is a pill when they are already nauseated or are in the act of throwing up."[30]

[23] Institute of Medicine, 159.
[24] Institute of Medicine, 3-4.
[25] Institute of Medicine, 153.
[26] Baker, David, et al., "The Therapeutic Potential of Cannabis," *The Lancet Neurology* 2 (May 2003): 291-298.
[27] American College of Physicians, "Supporting Research into the Therapeutic Role of Marijuana," 2008.
[28] Izzo A.A., et al. "Non-Psychotropic Plant Cannabinoids: New Therapeutic Opportunities From an Ancient Herb," *Trends in Pharmacological Sciences* 30(10), 2009: 515-527.
[29] Mechoulam R., et al., "Cannabidiol — Recent Advances, " *Chemistry and Biodiversity* 4 (2007): 1678-1692.
[30] "Report on the Possible Medical Uses of Marijuana," NIH medicinal marijuana expert group, Rockville, MD, National Institutes of Health, August 8, 1997; notes 8, 89.

We can make synthetic forms of other useful cannabinoids.

- **Seriously ill people should not have to wait for a potentially less effective drug when marijuana could be helping them now.** Spending time and money testing and producing pharmaceutical versions of marijuana's many cannabinoids might produce useful drugs some day, but it will be years before any new cannabinoid drugs reach pharmacy shelves. In 1999, the Institute of Medicine urged such research into potential new drugs, but it noted, "In the meantime there are patients with debilitating symptoms for whom smoked marijuana might provide relief."[31] In its natural form, marijuana is a safe and effective medicine that has already provided relief to millions of people.
- **We support research into the different cannabinoids, but it should not be used as a stall tactic to keep medical marijuana illegal.** Patients should be allowed to use marijuana if their doctors think it is currently the best treatment option. Why should seriously ill patients have to risk arrest and jail waiting for new drugs that simply replicate marijuana's effects?

If the prescription pill form doesn't work, we should just develop other forms of delivery.

- **The availability of such delivery systems should not be used as an excuse to maintain the prohibition of the use of natural marijuana.** As long as there are patients and doctors who believe whole marijuana is effective, they should not be punished for using or recommending it, regardless of what alternatives are available.
- **A safe and effective delivery system for whole marijuana already exists: vaporization.** Vaporizers are simple devices that give users the fast action of inhaled cannabinoids without most of those unwanted irritant.[32, 33] Essentially, vaporizing entails heating it to the point that it releases the active chemicals in vapor form, so there is no smoke involved. Any delivery system that helps patients should be made available, but their development should not substitute for the research into marijuana that is necessary for FDA approval of this natural medicine.

There is a marijuana spray that makes the crude plant unnecessary.

- **The liquid extract of whole marijuana proves marijuana is an effective medicine.** Sativex (or nabiximols in its generic form) is a mouth spray that has been approved in Canada and a number of European countries for the treatment of symptoms associated with multiple sclerosis. Its producer, GW Pharmaceuticals, in the process of getting it approved in the United States, but it is likely to take several years.
- **Marijuana in its natural form has significant advantages over Sativex.** For one thing, Sativex acts much more slowly than marijuana that is vaporized or smoked. Peak blood levels are reached in one and a half to four hours, as opposed to a matter of minutes with inhalation.[34] Also, patients have found that different strains of marijuana are often more effective for different conditions. Sativex is just one

[31] Institute of Medicine, 7.

[32] Abrams, D.I., et al., "Vaporization as a Smokeless Cannabis Delivery System: A Pilot Study," *Clinical Pharmacology and Therapeutics*, April 11, 2007. [Epub ahead of print.]

[33] Earleywine, M., Barnwell, S.S., "Decreased Respiratory Symptoms in Cannabis Users Who Vaporize," *Harm Reduction Journal* 4 (2007): 11.

[34] GW Pharmaceuticals, "Product Monograph: Sativex," April 13, 2005, 27.

specific strain of marijuana, so it is unlikely to help every patient who benefits (or could benefit) from whole marijuana. Patients and doctors should be able to choose which form of marijuana presents the best option.

The FDA says that marijuana is not a medicine and medical marijuana laws subvert its drug approval process

- **The FDA issued its April 2006 statement without conducting any studies or even reviewing studies performed by others.** It was immediately denounced by health experts and newspaper editorial boards around the country as being political and unscientific. The agency, which was under pressure from rabidly anti-medical marijuana politicians such as former Congressman Mark Souder (R-Indiana), ignored any evidence that contradicts federal policy, such as the 1999 Institute of Medicine report. A co-author of the IOM report, Dr. John A. Benson, told *The New York Times* that the government "loves to ignore our report ... They would rather it never happened."[35]
- **We know much more about marijuana's safety and efficacy than most off-label prescriptions.** Half of all current prescriptions have not been declared safe and effective by the FDA. Around 20% of all drug prescriptions in this country are "off-label" — i.e., they are prescribed to treat conditions for which they were not approved.[36]
- **State medical marijuana laws do not conflict with the FDA drug approval process.** They simply protect medical marijuana patients from arrest and jail under state law. Also, the FDA does not bar Americans from growing, using, and possessing a wide variety of medical herbs that it has not approved as prescription drugs, including echinacea, ginseng, and St. John's Wort.
- **The federal government has blocked most researchers from doing the specific types of studies that would be required for licensing, labeling, and marketing marijuana as a prescription drug.** They've created a perfect Catch-22: Federal officials say "Marijuana isn't a medicine because the FDA hasn't approved it," while making sure that the studies needed for FDA approval never happen.
- **Technically, marijuana should not require FDA approval.** Prior to the agency being created by the 1938 Food, Drug, and Cosmetics Act, about two-dozen preparations of marijuana were on the market, many of which were produced by well-known pharmaceutical companies. Under the terms of the Act, marijuana is not a "new" drug, thus it should not be subject to FDA new drug approval requirements. Many older drugs, such as aspirin and morphine, were "grandfathered in" under this provision without ever being submitted for new-drug approval by the FDA.

Marijuana is too dangerous to be used as a medicine; there are 10,000 studies showing marijuana is dangerous.

- **A large and growing body of scientific evidence demonstrates that the health risks associated with marijuana are actually relatively minor.** The 1999 Institute of Medicine report noted, "[E]xcept for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other

[35] Harris, Gardiner, "FDA Dismisses Medical Benefit From Marijuana," *New York Times*, April 21, 2006.

[36] Radley, David C., Finkelstein Stan N., and Stafford, Randall S., "Off-label Prescribing Among Office-Based Physicians," *Archives of Internal Medicine* 166 (9), 2006: 1021–1026.

medications.[37] In 2008, the American College of Physicians agreed, citing marijuana's "relatively low toxicity."[38] (See the following section for more information about smoking.)

- **Marijuana is non-lethal and does not contribute to or increase the likelihood of death.** The U.S. Centers for Disease Control and Prevention has never listed marijuana as a cause of death (although it does list alcohol and other drugs). A government-funded study conducted by researchers at the Kaiser Permanente HMO found no association between marijuana use and premature death in otherwise healthy people.[39] Marijuana is so safe that patients can easily find the proper dose themselves with no danger of overdose. As University of Washington researcher Dr. Gregory Carter and colleagues noted in a recent journal article, "THC (and other cannabinoids) has relatively low toxicity and lethal doses in humans have not been described ... It has been estimated that approximately 628 kilograms of cannabis would have to be smoked in 15 minutes to induce a lethal effect."[40] Meanwhile, prescription drugs have become one of the leading causes of accidental death in the United States.[41] Why is it okay for people to use these potentially deadly prescription drugs, but not okay for them to use a drug that has never killed anyone?
- **All medicines can have some negative side effects, but with marijuana they are relatively minimal.** For example, Tylenol (acetaminophen) has been estimated to kill nearly 500 Americans per year by causing acute liver failure,[42] while no one has ever died from marijuana poisoning. But no one would seriously suggest banning Tylenol because it's too dangerous. In contrast, recent medical marijuana studies have found no significant side effects. The question is this: Do the benefits outweigh the risks for an individual patient? Such decisions should be made by doctors and patients, not the criminal justice system.
- **The "10,000 studies" claim is simply not true.** The University of Mississippi Research Institute of Pharmaceutical Sciences maintains a 12,000-citation bibliography on the entire body of marijuana literature. The institute notes: "Many of the studies cited in the bibliography are clinical, but the total number also includes papers on the chemistry and botany of the Cannabis plant, cultivation, epidemiological surveys, legal aspects, eradication studies, detection, storage, economic aspects and a whole spectrum of others that do not mention positive or negative effects ... However, we have never broken down that figure into positive/negative papers, and I would not even venture a guess as to what that number would be."[43]

[37] Institute of Medicine, 5.

[38] American College of Physicians, "Supporting Research into the Therapeutic Role of Marijuana," 2008.

[39] Sidney S., et al., "Marijuana Use and Mortality," *American Journal of Public Health* 87(4), April 1997: 585-590.

[40] Carter, Gregory T., et al., "Medicinal Cannabis: Rational Guidelines for Dosing," *IDrugs* 7(5), 2004: 464-470.

[41] Guarino, Mark, "Prescription drug abuse now more deadly than heroin, cocaine combined," *Christian Science Monitor*, October 7, 2013.

[42] Fontana, Robert J., "Acute Liver Failure including Acetaminophen Overdose," *Medical Clinics of North America* 92(4), 2008: 761-794.

[43] Letter from Beverly Urbanek, Research Associate of the University of Mississippi Research Institute of Pharmaceutical Sciences (601-232-5914), to Dr. G. Alan Robison, Drug Policy Forum of Texas, June 13, 1996.

Medicine should not be smoked, and smoking marijuana is more harmful than smoking tobacco.

- **There are many ways to consume marijuana other than smoking, such as vaporizing, edible products, tinctures, and capsules.** Vaporizers are simple devices that give users the fast action of inhaled cannabinoids without most of the unwanted irritants found in smoke. Research on vaporizers has proceeded more slowly than it should have because of federal obstructionism.
- **The effects of smoking marijuana pale in comparison to those associated with smoking tobacco.** First and foremost, there has never been a single documented case of a marijuana-only smoker developing lung cancer as a result of his or her marijuana use. In 1999, the Institute of Medicine reported, "There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use."[44] This was confirmed in 2006 with the release of the largest case-controlled study ever conducted to investigate the respiratory effects of marijuana smoking and cigarette smoking.[45] The study, conducted by Dr. Donald Tashkin at the University of California at Los Angeles, found that marijuana smoking was *not* associated with an increased risk of developing lung cancer. Surprisingly, the researchers found that people who smoked marijuana actually had *lower* incidences of cancer compared to non-users. In fact, some researchers have reported a "possible protective effect of marijuana" against lung cancer.[46]
- **All medicines have risks and side effects, and part of a physician's job is to evaluate those risks in relation to the potential benefits for the individual patient.** Many prescription drugs have side effects — most of which are far more severe than those of marijuana — but that doesn't mean it should be illegal for seriously ill people to use them.

Marijuana is bad for the immune system.

- **Scientific studies have not demonstrated any significant harm to the immune system caused by marijuana.** The Institute of Medicine reported, "Despite the many claims that marijuana suppresses the human immune system, the health effects of marijuana-induced immunomodulation are still unclear."[47] The IOM also noted, "The short-term immunosuppressive effects [of marijuana] are not well established; if they exist at all, they are probably not great enough to preclude a legitimate medical use."[48]
- **Extensive research in HIV/AIDS patients — whose immune systems are particularly vulnerable — shows no sign of marijuana-related harm.** University of California at San Francisco researcher Donald Abrams, M.D. has studied marijuana and Marinol in AIDS patients taking anti-HIV combination therapy. Not only was there no sign of immune system damage, but the patients gained T-lymphocytes, the critical immune system cells lost in AIDS, and also gained more weight than those taking a placebo. Patients using marijuana also showed greater reductions in the amount of HIV in their bloodstream.[49] Long-term stud-

[44] Institute of Medicine, 119.

[45] American Thoracic Society, "Study Finds No Link Between Marijuana Use And Lung Cancer," Science Daily, May 26, 2006.

[46] Hashibe, Mia, et al., "Marijuana Use and the Risk of Lung and Upper Aerodigestive Tract Cancers: Results of a Population-Based Case-Control Study," *Cancer Epidemiology, Biomarkers and Prevention* 15(10), 2006: 1829-1834.

[47] Institute of Medicine, 109.

[48] Institute of Medicine, 126.

[49] Abrams D., et al., "Short-Term Effects of Cannabinoids in Patients With HIV-1 Infection," *Annals of Internal Medicine* 139 (2003): 258-266.

ies of HIV/AIDS patients have shown that marijuana use (including social or recreational use) does not worsen the course of their disease. For example, in a six-year study of HIV patients conducted by Harvard University researchers, marijuana users showed no increased risk of developing AIDS-related illness.[50] In her book *Nutrition and HIV*, internationally known AIDS specialist Mary Romeyn, M.D. noted, "The early, well-publicized studies on marijuana in the 1970s, which purported to show a negative effect on immune status, used amounts far in excess of what recreational smokers, or wasting patients with prescribed medication, would actually use ... Looking at marijuana medically rather than sociopolitically, this is a good drug for people with HIV."[51]

Marijuana contains over 400 chemicals, including most of the harmful compounds found in tobacco smoke.

- **The number of chemical compounds in a substance is irrelevant.** Coffee, mother's milk, broccoli, and most foods also contain hundreds of different chemical compounds. Marijuana is a relatively safe medicine, regardless of the number of chemical compounds found therein.

Marijuana's side effects (e.g. increased blood pressure) negate its effectiveness in fighting glaucoma.

- **Marijuana has been found to be exceptionally beneficial for people with glaucoma, and its side effects are minimal compared to other drugs.** In fact, the federal government has given marijuana to at least three patients with glaucoma, and it preserved their vision for years after they were expected to go blind. Paul Palmberg, M.D. one member of an expert panel convened by the National Institutes of Health in 1997 to review the scientific data on medical marijuana, explained during the group's discussion on February 20, 1997, "I don't think there's any doubt about its effectiveness, at least in some people with glaucoma."[52]

Marijuana use can increase the risk of mental illness, including schizophrenia.

- **There is no compelling evidence demonstrating marijuana causes psychosis in otherwise healthy individuals.** Overall, the evidence suggests that marijuana can precipitate schizophrenia in vulnerable individuals but is unlikely to cause the illness in otherwise normal persons.[53] A recent study implied the reverse, finding that those predisposed to schizophrenia may be more likely to use cannabis.[54] Epidemiological data show no correlation between rates of marijuana use and rates of psychosis or schizophrenia. Countries with high rates of marijuana use don't have higher rates of these illnesses than countries where marijuana use is more rare, and research has consistency failed to find a connection between

[50] Di Franco, M.J., et al., "The Lack of Association of Marijuana and Other Recreational Drugs With Progression to AIDS in the San Francisco Men's Health Study," *Annals of Epidemiology* 6(4), 1996: 283-289.

[51] Romeyn, Mary, *Nutrition and HIV: A New Model for Treatment*, Second Edition (San Francisco: Jossey-Bass, 1998), 117-118.

[52] "Transcripts of Open Discussions Held on February 20, 1997, Book Two, Tab C, Pp. 96-97; Washington, D.C.: ACE-Federal Reporters, Inc.

[53] Hall, W., Degenhardt L., "What are the policy implications of the evidence on cannabis and psychosis?," *Canadian Journal of Psychiatry* 51(9), August 2006: 566-574.

[54] Power, R. A., et al., "Genetic predisposition to schizophrenia associated with increased use of cannabis," *Molecular Psychiatry* 19 (2014): 1201-1204.

increases in marijuana use and increased rates of psychosis.[55,56,57] As with all medications, the physician needs to consider what is an appropriate medication in light of the individual patient's situation and may well suggest avoiding marijuana or cannabinoids in patients with a family or personal history of psychosis. This is the sort of risk/benefit assessment that physicians are trained to make.

Medical marijuana laws send the wrong message to teens.

- **There does not appear to be a link between the passage of medical marijuana laws and increases in teen marijuana use, and in some cases it appears to be associated with decreases in teen use.** A 2012 study conducted by researchers at universities in Colorado, Montana, and Oregon found "no statistical evidence that legalization increases the probability of [teen] use," and noted that "the data often showed a negative relationship between legalization and [teen] marijuana use."[58] State surveys of students in several states with medical marijuana laws have consistently reported declines in teen marijuana use since those laws were passed.[59]

  In 2014, an annual survey conducted by the U.S. Centers for Disease Control and Prevention found that marijuana use by Colorado high school students has dropped since the state began regulating medical marijuana in 2010.[60] California has had a similar experience. According to the state-sponsored California Student Survey (CSS), marijuana use by California teens was on the rise until 1996 — the year California adopted its medical marijuana law — at which point it began dropping dramatically (by nearly half in some age groups).[61] As part of the 1997-1998 CSS, the State of California also commissioned an independent study examining the effects of its medical marijuana law, which concluded, "There is no evidence supporting that the passage of Proposition 215 increased marijuana use during this period."[62]

- **Laws that are not based on science send the wrong message to young people — especially those that needlessly criminalize seriously ill people for using a substance with proven medical benefits.** Children should be taught the facts about all drugs and the difference between medical use and abuse. We allow doctors to prescribe cocaine, morphine, and methamphetamine, and we teach young people that these drugs are used for medical purposes. We can do the same thing with marijuana.

[55] Hall, W., "Is Cannabis Use Psychotogenic?," *The Lancet*, vol. 367, January 22, 2006.

[56] Frisher, M., et al., "Assessing the Impact of Cannabis Use on Trends in Diagnosed Schizophrenia in the United Kingdom from 1996 to 2005," *Schizophrenia Research*, vol. 113, September 2009.

[57] Proal, Ashley C. et al., "A controlled family study of cannabis users with and without psychosis," *Schizophrenia Research* 152 (2014): 283-288.

[58] Anderson, D. Mark, Hansen, Benjamin, and Rees, Daniel I., "Medical Marijuana Laws and Teen Marijuana Use," Institute for the Study of Labor, May 2012.

[59] O'Keefe, Karen, et al., "Marijuana Use by Young People: The Impact of State Medical Marijuana Laws," Marijuana Policy Project, June 2011.

[60] Centers for Disease Control and Prevention, 1991-2013 High School Youth Risk Behavior Survey Data. Available at http://www.cdc.gov/healthyyouth/data/yrbs/index.htm

[61] "Report to Attorney General Bill Lockyer, 11th Biennial California Student Survey, Grades 7, 9 and 11," WestEd, 2006.

[62] Skager, Rodney, Austin, Greg, and Wong, Mamie, "Marijuana Use and the Response to Proposition 215 Among California Youth, a Special Study From the California Student Substance Use Survey (Grades 7, 9, and 11), 1997-1998."

We can't allow patients to grow marijuana, especially in homes with children.

- **Patients should be able to grow their own medical marijuana if it is the best way for them to access it, and sometimes it's the only way to access it.** Some patients are not able to access a medical marijuana dispensary because there isn't one nearby or they do not have a means of transportation.
- **We allow people to possess all sorts of prescription drugs, most of which are far more dangerous than a few marijuana plants being grown in a patient's basement or closet.** All medicines need to be handled with appropriate care and kept out of easy reach of children. There are already laws against selling marijuana to non-patients, and child protective services agencies already have the power to protect children whose parents are engaged in criminal activity. A medical marijuana law that allows patients to grow limited amounts of marijuana will not change any of this.
- **Criminals break into homes every day to steal valuable items — jewelry, high-end electronics, and even prescription drugs.** We don't ban possession of these items because the owners might be victims of a crime. By this logic, parents shouldn't be allowed to drive Honda Accords (the most-stolen vehicle in 2014, according to the National Insurance Crime Bureau). If medical marijuana is legal, it should be treated like any other legal product.

Medical marijuana laws are full of loopholes.

- **With 23 states having enacted medical marijuana laws, the laws are as varied as the states themselves. Some early laws did not include regulations, while some newer ones are so restrictive and onerous that they leave behind most patients or force them to make lengthy drives to get their medicine.** There are also plenty of examples of states that have taken a more reasonable middle ground, imposing reasonable regulations without steering pain patients away from medical cannabis and toward opiates. Maine, Nevada, New Mexico, and Rhode Island and fall into that category.. States considering medical marijuana legislation have a variety of examples to learn from, which allows them to craft a well-regulated program that serves both patients and communities.
- **No law will ever be considered entirely perfect by everyone. The goal is to produce the best possible law that is supported by the most voters.** Ultimately, medical marijuana advocates have nothing to gain and everything to lose by wording initiatives poorly.

Medical marijuana laws basically legalize marijuana for everyone.

- **These laws typically only allow people to use marijuana if they have a qualifying medical condition and receive a recommendation from a licensed physician who believes it will benefit them.** The General Accounting Office (the investigative arm of Congress, renamed the Government Accountability Office) interviewed officials from 37 law enforcement agencies in four states with medical marijuana laws. A key issue they examined was whether medical marijuana laws had interfered with enforcement of laws regarding non-medical use. According to the GAO's November 2002 report, the majority of these officials "indicated that

medical marijuana laws had had little impact on their law enforcement activities."[63] Whenever medical marijuana laws are being considered by voters or legislators, opponents claim it will result in marijuana basically being legalized for everyone. Yet, voters and lawmakers still approve these laws — oftentimes in states where there isn't strong support for broader legalization — because they recognize that these medical laws are a safe and responsible means of helping patients.

- **Government data shows that between 0.04% and 2% of medical marijuana states' populations are enrolled in medical marijuana programs, with the numbers varying depending on the particulars of the state's law.[64]** In comparison, about 13% of Americans were prescribed painkilling opioids, and 12% use marijuana each year.[65]

Medical marijuana laws only pass because of well-funded and/or misleading campaigns.

- **National and state public opinion polls have consistently shown overwhelming public support for allowing seriously ill people to use medical marijuana.** Also, polling in states that have had medical marijuana laws for years shows support is just as high or — in most cases — higher than when they were on the ballot.[66] Clearly, voters are not being fooled into voting for these laws. The amount spent in support of passing medical marijuana laws is a drop in the bucket compared to the billions of dollars spent by our federal government to keep marijuana entirely illegal.

Medical marijuana laws confuse law enforcement officials.

- **What's so confusing? If a person has documentation showing they are a legal medical marijuana patient or caregiver, they shouldn't be arrested or prosecuted.** If the person does not have suitable documentation, either call the person's doctor or arrest the person and let the courts decide. It is no more confusing than determining whether someone is the legal owner of a piece of property, whether they are a legal immigrant, or whether they are drinking alcohol underage or in violation of their probation.

Medical marijuana dispensaries are out of control.

- **State-regulated medical marijuana dispensaries are tightly controlled and have not been linked to any significant problems.** Dispensaries have been less controlled in California, whose medical marijuana law was the first and most loosely worded, but the laws that have passed since then have been much clearer and will be much more effective at keeping things controlled. In most states, medical marijuana dispensaries are among the most tightly regulated businesses, and they are under an exceptional amount of scrutiny. As a result, they do everything they can to follow the rules and keep things under control.
- **There is no evidence that dispensaries cause crime, and there is some evidence that they might reduce it.** For example, in Colorado, a Denver Police Department

[63] General Accounting Office, "Report to the Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform, U.S. House of Representatives. Marijuana: Early Experiences With Four States' Laws that Allow Use for Medical Purposes," Washington, D.C.: GAO, 2002, p. 32.

[64] See: "Medical Marijuana Patient Numbers, MPP, Sept. 17, 2015 update. https://www.mpp.org/issues/medical-marijuana/state-by-state-medical-marijuana-laws/medical-marijuana-patient-numbers/

[65] "Study shows 70 percent of Americans take prescription drugs," CBS News, June 20, 2013 ; Seth Motel, "6 facts about marijuana" *Pew Research Center*, April 14, 2015.

[66] Marijuana Policy Project, "Proposition 215 10 Years Later: Medical Marijuana Goes Mainstream," November 2006.

analyses conducted at the request of the city council found robbery and burglary rates at dispensaries were lower than area banks and liquor stores and on par with those of pharmacies.[67] The Colorado Springs Police Department also found no correlation between medical marijuana businesses and increased crime.[68]

Medical marijuana is just a Trojan horse for broader legalization.

- **Medical marijuana laws are being passed to help people, not to further broader legalization efforts.** Criminalizing seriously ill people for using medical marijuana is the most egregious element of marijuana prohibition, so it's not surprising that voters and lawmakers are addressing it before moving on to the broader legalization debate. Supporters of medical marijuana include some of the most respected medical and public health organizations in the country, including the American College of Physicians, the American Public Health Association, the American Nurses Association, the Academy of HIV Medicine, and the Epilepsy Foundation. Surely these organizations are not part of a conspiracy to legalize marijuana and other drugs.
- **Every law should be judged on its own merits.** If voters or lawmakers believe seriously ill people should be allowed to use medical marijuana, they will support a law that allows it. If a broader reform measure comes up, they can decide then whether they want to support or oppose it. There is no reason why we can't pass a medical marijuana law now just because some people are worried there will be support for other laws later.

People aren't actually arrested for medical marijuana.

- **There were approximately 700,000 Americans arrested for marijuana-related offenses in 2014.**[69] Unfortunately, the government does not keep track of how many were medical patients. But even if only one percent of those arrestees were using marijuana for medical purposes, that is 7,000 arrests! There have been countless publicized and unpublicized arrests for medical marijuana throughout the country. It was the arrest of well-known medical marijuana patients in California in the 1990s that prompted people to launch the medical marijuana initiative there in 1996.
- **Even the fear of arrest is a terrible punishment for seriously ill patients.** The stress and anxiety associated with it can be more detrimental to a person's health and immune system than marijuana itself. We know medical marijuana can help people; we should not be scaring them away from using it by threatening them with arrest.

  If you don't think patients are really getting arrested for using medical marijuana, why is it a problem to have a law that ensures they do not get arrested?

[67] Ingold, John, "Analysis: Denver pot shops' robbery rate lower than banks," *Denver Post*, January 27, 2010.

[68] Rodgers, Jakob, "Marijuana shops not magnets for crime, police say," *Colorado Springs Gazette*, September 13, 2010.

[69] United States Department of Justice, Federal Bureau of Investigation, *Crime in the United States, 2014*, September 2015.

Nobody is in prison for using/providing medical marijuana.

- **Federal law and the laws of 27 states do not make any exceptions for medical marijuana, and without a medical necessity defense available, medical marijuana users are treated the same as recreational users.** Federally, possession of even one joint carries a penalty of up to one year in prison. Cultivation of even one plant is a felony, with a maximum sentence of five years. Many states' laws are in this same ballpark. Some patients are even sent to prison.

  Here are just a few examples:

  In December 2009, New Jersey multiple sclerosis patient John Wilson was convicted of "operating a drug manufacturing facility" for growing the marijuana he used to treat his multiple sclerosis, and faced a sentence of five to 10 years in state prison. Rancher and Vietnam veteran Larry Rathbun was arrested in December 1999 for cultivating medical marijuana to relieve his degenerative multiple sclerosis. When he was arrested in 1999, he could still walk, which he attributed to the medical use of marijuana. After serving 19 months, Rathbun came out of Montana State Prison confined to a wheelchair. Byron Stamate spent three months in a California jail for growing marijuana for his disabled girlfriend (who killed herself so that she would not have to testify against Byron). Gordon Farrell Ethridge spent 60 days in an Oregon jail for growing marijuana to treat the pain from his terminal cancer. Quadriplegic Jonathan Magbie, who used marijuana to ease the constant pain from the childhood injury that left him paralyzed, died in a Washington, D.C. jail in September 2004 while serving a 10-day sentence for marijuana possession.

- **Patients are being punished even if they are not sent to prison.** They are arrested and sometimes handcuffed and put in the back of a police car. Sometimes their doors get kicked in, and police ransack their houses. Sometimes they spend a day or two in jail. They have to appear in court, and court costs and attorney fees must be paid by the patient and the taxpayers. Probation — which means urine tests for a couple of years and the patient being unable to use his or her medical marijuana. There are huge fines and possible loss of employment, which hurt the patient's ability to pay insurance, medical bills, rent, food, home-care expenses, and so on. Then there's the stigma of having a drug conviction on one's record, which could also result in doctors being unwilling to prescribe some medications. Should any of this happen to seriously ill people for using what they and their doctors believe is a beneficial medicine?

The government is making it easier to do medical marijuana research.

- **The federal government remains intensely hostile to medical marijuana.** As a Schedule I drug, marijuana can be researched as a medicine only with federal approval. Some studies have been completed, and they've all shown medical marijuana to be safe and effective, but they have not been large enough to bring about FDA approval of marijuana as a prescription drug. More research is always desirable, but we know enough right now to know that there is no justification for arresting patients using medical marijuana under their doctors' care.

  Until California voters passed Proposition 215 in 1996, federal authorities blocked all efforts to study marijuana's medical benefits. Since then, federal restrictions have been loosened somewhat, and a small number of studies have gone forward, but that happened because the passage of ballot initiatives forced the government

to acknowledge the need for research. To put it in perspective, the federal government has refused to study the patients to whom it has provided medical marijuana for more than 25 years as part of an investigative new drug program. If the political pressure created by ballot initiatives and legislative proposals subsides, the feds will surely go back to their old, obstructionist ways.

- **All medical marijuana research must use marijuana supplied by the National Institute on Drug Abuse, which is known for its very poor quality.** This low-grade marijuana has less efficacy and more side effects than the marijuana that is now available through medical marijuana dispensaries. Scientists and activists have appealed to the Drug Enforcement Administration to allow other sources of marijuana to be used, and in 2007, DEA Administrative Law Judge Mary Ellen Bittner ruled that a proposed University of Massachusetts project to grow and study marijuana for medical purposes should be allowed to proceed. But the DEA did not follow Bittner's ruling and has given no indication that it intends to do so. The U.S. government remains the largest single obstacle to medical marijuana research.

State medical marijuana laws violate federal law.

- **The U.S. Department of Justice issued a memo in August 2013 saying it would respect states' rights to adopt their own marijuana policies.** As long as states create and enforce adequate regulations for cultivating and selling marijuana, the federal government will only go after those who they believe are violating state laws and regulations. There are medical marijuana laws in 23 states plus Washington, D.C., and Guam and there are marijuana businesses operating openly in many of them. The federal government has largely refrained from interfering in states where marijuana is being regulated.
- **Congress passed an appropriations bill in June 2015 that prohibits the Department of Justice, including the Drug Enforcement Administration, from using funds to interfere in the implementation of laws that allow the cultivation, distribution, and use of marijuana for medical purposes.**[70] A subsequent federal district court found that this provision was applicable not only to state government programs, but to individuals and groups that are acting in compliance with state laws.[71]
- **States are not required to enforce federal laws against marijuana possession or cultivation.** The Controlled Substances Act (CSA) specifically allows states to enact their own laws related to controlled substances, and states are free to determine their own penalties — or lack thereof — for drug offenses.
- **State government employees have never faced punishments for carrying out state medical marijuana laws — even in situations when law enforcement officials have returned seized marijuana to the owners.** Following the passage of a medical marijuana law in Arizona, Gov. Jan Brewer filed a lawsuit claiming the state could not implement the law because state employees would face prosecution. In a reply brief, the Department of Justice basically said the fears were unfounded.

[70] Pub. L. 113-235, 128 Stat. 2130 (2014) ("2015 Appropriations Act"),

[71] U.*S. v. Marin Alliance for Medical Marijuana et al,* No. C 98-00086 CRB, decided October 19, 2015.)

The courts have ruled marijuana is not medicine and states cannot legalize medical marijuana.

- **No court has ruled that marijuana is not medicine, and no court has ruled that states cannot adopt and implement medical marijuana laws.**

  The majority opinion in the Supreme Court's June 2005 decision in *Gonzales v. Raich* stated unequivocally that "marijuana does have valid therapeutic purposes." The ruling did not overturn state medical marijuana laws or prevent states from enacting new ones. It simply preserved the status quo — states can stop arresting medical marijuana patients and caregivers under state law, but these laws don't create immunity from federal prosecution. The Supreme Court's other ruling related to medical marijuana — a 2001 case involving a California medical marijuana dispensary — did not overturn state medical marijuana laws. It simply declared that under federal law, those distributing medical marijuana could not use a "medical necessity" defense in federal court. This extremely narrow ruling did not in any way curb the rights of states to protect patients under state law.

  In both cases, the court went out of its way to leave open the possibility that individual patients could successfully present a "medical necessity" claim.

- **The U.S. Department of Justice has never tried to challenge the rights of states to enact medical marijuana laws.** In August 2013, the Department of Justice issued a memo stating it would respect states' rights to establish systems of regulated marijuana cultivation and distribution for medical and broader adult use.

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Definitions

Legal/prescriptive access: This category encompasses the strongest of all favorable medical marijuana positions. Although the exact wording varies, organizations advocating "legal/prescriptive access" assert that marijuana should be legally available upon a doctor's official approval. Some groups say that marijuana should be "rescheduled" and/or moved into a specified schedule (e.g., Schedule II) of the federal Controlled Substances Act; others say that doctors should be allowed to "prescribe" marijuana or that it should be available "under medical supervision." These organizations support changing the law so that marijuana would be as available through pharmacies as other tightly controlled prescription drugs, like morphine or cocaine. This category also includes endorsements of specific efforts to remove state-level criminal penalties for medical marijuana use with a doctor's approval.

Compassionate access: Organizations with positions in this category assert that patients should have the opportunity to apply to the government for special permission to use medical marijuana on a case-by-case basis. Most groups in this category explicitly urge the federal government to re-open the compassionate access program that operated from 1978 until 1992, when it was closed to all new applicants. (Only four patients still receive free marijuana from the federal government.) "Compassionate access" is a fairly strong position, as it acknowledges that at least some patients should be allowed to administer natural, whole marijuana right now. However, access to marijuana would be more restrictive than access to legally available prescription drugs, as patients would have to jump through various bureaucratic hoops to receive special permission.

Research: This category includes positions urging the government to make it easier for scientists to conduct research into the medical efficacy of natural marijuana that can be vaporized or smoked. Many of these groups have recognized that the federal government's current medical marijuana research guidelines are unnecessarily burdensome. Modifying the guidelines would increase the likelihood that the FDA could eventually approve natural, whole marijuana as a prescription medicine. These groups want patients to be allowed to administer marijuana as research subjects and — if the results are favorable — to eventually qualify marijuana as an FDA-approved prescription drug. Groups listed with "research" positions differ from the White House Office of National Drug Control Policy and numerous other drug war hawks who claim to support research. Such groups are not listed if they (1) oppose research that has a realistic chance of leading to FDA approval of natural marijuana, or (2) actively support the laws that criminalize patients currently using medical marijuana. (At worst, some of the groups listed as supporting research are silent on the issue of criminal penalties — but many, in fact, concurrently endorse legal/prescriptive access and/or compassionate access.)

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Partial List of Organizations Favoring Legal/Prescriptive Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
AIDS Action Council	12/14/1996; 11/29/1999	✓	✓	✓		Prescriptive access (for HIV/AIDS)	Resolution; signatory of 1999 letter to U.S. Dept. of Health and Human Services
AIDS Resource Center of Wisconsin	unknown	✓					Open letter to supporters of medical marijuana from State Senator Jon Erpenbach and State Representative Mark Pocan
Alaska Nurses Association	9/1998	✓				Access under a physician's supervision	ANA Resolution: September 1998
American Academy of Family Physicians	1995	✓				"The American Academy of Family Physicians [does not oppose] the use of marijuana ... under medical supervision and control for specific medical indications."	1996-1997 AAFP Reference Manual - Selected Policies on Health Issues
American Academy of HIV Medicine (AAHIVM)	11/11/2003	✓	✓		✓	"We support state and federal legislation not only to remove criminal penalties associated with medical marijuana, but further to exclude marijuana/cannabis from classification as a Schedule I drug." Other: support incorporating a medical marijuana distribution program into state and local delivery systems of care	Letter to New York Assemblyman Richard Gottfried, Chair of the Assembly Health Committee, in support of the New York Assembly medical marijuana bill, A.5796
American Anthropological Association	9/2003	✓	✓		✓	"We seek to repeal laws which penalize or prohibit the peaceful, personal, religious, scientific, medical, agricultural, spiritual, artistic, historical, and/or industrial uses of Cannabis, Marijuana, Hemp. We favor laws which permit such beneficial uses."	Resolution from 2003 Annual Meeting
AFSCME (American Federation of State, County & Municipal Employees)	8/2006	✓				"AFSCME endorses and supports legalization of medical marijuana for appropriate medically indicated ailments including but not limited to HIV/AIDS, cancer, glaucoma, epilepsy, arthritis, and the other medical conditions listed herein."	Resolution No: 93, 37th Annual International Convention, Chicago, Illinois, August 7-11, 2006
American Medical Student Association	3/1993	✓					AMSA House of Delegates Resolution #12

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American Nurses Association	12/12/2008	✓				"The American Nurses Association actively supports patients' rights to legally and safely utilize marijuana for symptom management and health care practitioners' efforts to promote quality of life for patients needing such therapy."	Revised Position Statement, adopted by ANA Board of Directors
American Preventive Medical Association (now "Alliance for Natural Health")	12/8/1997; 12/2000	✓	✓				"Medicinal Use of Marijuana" policy statement; signatory of 2000 letter to U.S. Dept. of Health and Human Services
American Public Health Association	1995; 12/2000	✓	✓	✓		Prescriptive access: "marijuana was wrongfully placed in Schedule I of the Controlled Substances Act"; "greater harm is caused by the legal consequences of its prohibition than possible risks of medicinal use"	Position #9513: Access to Therapeutic Marijuana/Cannabis; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Arthritis Research Campaign	10/23/2001	✓				"We think people who use cannabis to relieve the pain of arthritis should be able to do so."	ARC statement to BBC News, October 23, 2001
California Academy of Family Physicians	1994; 1996	✓				"Support efforts to expedite access to cannaboids [sic] for use under the direction of a physician"; endorsed 1996 California Ballot Proposition 215	February 1994 statement adopted by Academy's Congress of Delegates; 1996 endorsement, reported via the Business Wire Service, Oct. 29, 1996
California Legislative Council for Older Americans	12/1/1993; 11/29/1999; 12/2000	✓	✓	✓		Prescriptive access: urges rescheduling	Adopted at 23rd Annual Action Conference; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
California Medical Association	1997; 1/11/2000	✓		✓	✓	Other: letter opposes federal threats against doctors for discussing risks and benefits of marijuana	March 14, 1997, letter; May 21, 1997, endorsement of CA research bill; a*micus curiae* brief supporting right to distribute medical marijuana in California (*U.S. v. Oakland Cannabis Buyers' Cooperative*)
California Nurses Association	9/21/1995; 12/2000	✓	✓			Prescriptive access: supported California bill A.B. 1529 to remove penalties for medical use	Letter to California Gov. Pete Wilson; signatory of 2000 letter to U.S. Dept. of Health and Human Services
California Pharmacists Association	2/1997; 11/29/1999; 12/2000	✓	✓	✓		Prescriptive access: according to Associated Press, the CPA "passed a resolution supporting pharmacy participation in the legal distribution of medical marijuana"	AP Financial News, 5/26/97; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services

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California Society of Addiction Medicine	5/1997	✓				Prescriptive access: urges rescheduling	*California Society of Addiction Medicine News*, Spring 1997
City of Austin	6/29/2014		✓			"The City of Austin's Legislative Program for the 84th Texas Legislature is hereby amended to support: (1) legislation that would create an affirmative defense to prosecution for patients who are being treated by a licensed physician and who use medical marijuana; or (2) legislation to legalize the use of medical marijuana."	Resolution published on 6/29/14
Colorado Nurses Association	1995	✓				Prescriptive access: urges rescheduling	Colorado Nurses Association 1995 Convention Directory and Book of Reports, p. 28
Community HIV/AIDS Mobilization Project (CHAMP)	10/ 2007	✓		✓		Supports legal/prescriptive access, allowing pharmacy-like distribution, and research, including private production of marijuana for research; "Licensed medical doctors should not be punished for recommending medical use of marijuana to seriously ill people, who should not be subject to criminal sanctions for using marijuana if the patients' physicians have told the patients that such use is likely to be beneficial"	Letter from executive director, Julie Davids
DC-37 (New York City labor union)	11/17/2009	✓				"On behalf of the 125,000 members and 50,000 retirees, District Council 37 strongly supports this legislation [A. 9016] and urges it passage."	Legislative memo in support of New York medical marijuana bill
Epilepsy Foundation	2/20/2014	✓				"The Epilepsy Foundation supports the rights of patients and families living with seizures and epilepsy to access physician directed care, including medical marijuana." "The Epilepsy Foundation calls for an end to Drug Enforcement Administration (DEA) restrictions that limit clinical trials and research into medical marijuana for epilepsy."	Policy statement, "Epilepsy Foundation Calls for Increased Medical Marijuana Access and Research"
Episcopal Church	1982	✓				"The Episcopal Church urges the adoption by Congress and all states of statutes providing that the use of marijuana be permitted when deemed medically appropriate by duly licensed medical practitioners."	67th Convention of the Episcopal Church (B-004)a
Gay Men's Health Crisis	2005	✓				"GMHC will continue to support passage of legislation that would allow patients suffering from serious illnesses to have legal access to marijuana under medical supervision."	2005 NYS Legislative Agenda

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Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Gray Panthers	12/2000	✓	✓			Legal access: "we strongly support … efforts to reform state and federal law so that patients may use marijuana when their doctors believe it would be beneficial to them"; urges rescheduling	Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Hawaii Nurses Association	10/21/1999; 12/2000	✓	✓			"Support legislation to remove state level criminal penalties for both bona fide medical marijuana patients and their healthcare providers"	Resolution; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Illinois Bar Association	12/17/12	✓				Endorsed legislation allowing those who suffer from a debilitating medical condition to use and possess small amounts of marijuana if certified to do so by their regular physician.	Press release, 12/17/12
Illinois Nurses Association	12/2004 4/30/2007	✓	✓	✓	✓	"The Illinois Nurses Association supports the position of the ANA and will be counted among the organizations that support the right of patients to access legally and safely therapeutic cannabis, and the right of providers to prescribe, without recrimination, therapeutic cannabis for their patients."	"Position Paper on Providing Patients Safe Access to Therapeutic Marijuana/ Cannabis," December 2004; signatory of 2000 letter to U.S. Dept. of Health and Human Services
International Nurses Society on Addictions	5/1/1995	✓		✓		Has since modified its support of prescriptive access	"Position Paper: Access to Therapeutic Cannabis," approved by IntNSA Board of Directors
Iowa Board of Pharmacy	2/17/ 2010	✓				The Iowa Board of Pharmacy today issued a recommendation that the Iowa Legislature reclassify marijuana from Schedule I of the Iowa Controlled Substances Act into Schedule II of the Act. . . . In addition, the Board of Pharmacy is recommending the Legislature convene a task force or study committee for the purpose of making recommendations back to the Legislature regarding the administration of a medical marijuana program . . . Rescheduling of marijuana is the first step of a process that could ultimately result in legalization for medical purposes."	"Iowa Board of Pharmacy Issues Recommendation", Iowa Department of Public Health News Release, February 17, 2010
Iowa Democratic Party	2003	✓				Consumer Protection: "We support legalizing the medical use of marijuana …"	2003 Party Plank 59

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Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Kansas Silver Haired Legislature	10/2013	✓				Urges the Kansas Legislature to enact a bill to, "authorize those Kansas citizens with debilitating medical conditions who may benefit medically from the use of marijuana for medicinal purposes to be prescribed medicinal marijuana by their physician and to use medicinal marijuana for the benefit of their health and well being."	Resolution No. 2701 (2013)
Leukemia & Lymphoma Society	July 2007	✓				"Supports legislation to remove criminal and civil sanctions for the doctor-advised, medical use of marijuana by patients with serious physical medical conditions"	Resolution approved July 2007
Life Extension Foundation	3/1997; 12/2000	✓	✓				Complaint for declaratory judgment and injunctive relief, *Pearson and Show v. McCaffrey*; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Lymphoma Foundation of America	1/1997; 11/29/1999	✓	✓	✓		Prescriptive access: urges rescheduling	Resolution; signatory of 1999 letter to U.S. Dept. of Health and Human Services
Maryland Board of Pharmacy	3/8/2010	✓		✓	✓	"The Board supports the concept of allowing medical marijuana to be prescribed and dispensed in Maryland."	Letter to Peter Hammen, Chair, Maryland House Health & Government Operations Committee
Maryland Nurses Association	2/26/2010	✓	✓	✓	✓	"Research has shown the value of the medical use of marijuana in alleviating pain and mitigating nausea. There is no reason to deny this useful medical tool to physicians and their patients. Our patients are suffering because of the arbitrary distinction between medical marijuana and other prescribed medications."	Testimony to the Maryland House Judiciary and Health & Government Operations Committees, February 26, 2010
Maryland Pharmacists Association	2/25/2010	✓	✓		✓	The Maryland Pharmacists Association supports [medical marijuana legislation]. Studies have shown that marijuana can be useful in alleviating pain and suffering.	Testimony to the Maryland House Judiciary and Health & Government Operations Committees, February 25, 2010
Massachusetts Hepatitis Empowerment Project	12/2009	✓				"The Massachusetts Hepatitis Patient Empowerment Project, a patient community-based advocacy organization for people living with viral hepatitis, extends its support to the Massachusetts Patient Advocacy Alliance campaign for legalized medical marijuana."	Letter to Massachusetts State Representative Frank Smizik

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Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Massachusetts Breast Cancer Coalition	8/2009	✓				"The Massachusetts Breast Cancer Coalition … urges the Massachusetts General Court to pass legislation that ensures that licensed medical doctors will not be criminally punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people will not be subject to criminal sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial. Further, such patients should not be forced to seek their medicine on the criminal market, but rather through safe, state-recognized dispensaries."	Letter to Matthew Allen, Executive Director of Massachusetts Patients Advocacy Alliance
Massachusetts Nurses Association	4/2010	✓				"The Massachusetts Nurse Association therefore urges the Massachusetts General Court to pass legislation that ensures that licensed medical doctors will not be criminally punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people will not be subject to criminal sanctions for using marijuana if their physician has told them that such use is likely to be beneficial. Further, such patients should not be forced to seek their medicine on the criminal market, but rather through safe, state-recognized treatment centers."	Letter to Massachusetts State Representative Frank Smizik
MedChi: The Maryland State Medical Society	9/26/2010	✓		✓	✓	"[M]edical marijuana can relieve suffering and help patients cope with serious medical conditions when conventional treatments have failed. [C]urrent evidence suggests that medical marijuana can relieve intractable nausea, muscle spasms, and improve appetite in patients with debilitating chronic illnesses including cancer, multiple sclerosis, and AIDS."	Resolution 12-10; adopted by board of delegates, September 26, 2010

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Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Medical Society of the State of New York	5/3/2004; 12/14/2010	✓		✓		"Resolved, that the use of marijuana may be appropriate when prescribed or certified by a licensed physician solely for use in alleviating pain and/or nausea in patients who have been diagnosed as chronically ill with life threatening diseases, when all other treatments have failed, that the physicians who prescribe marijuana for patient use, subject to the conditions set forth above, should not be held criminally, civilly, or professionally liable and that it supports continued clinical trials on the use of marijuana for medical purposes, and be it further resolved that the Medical Society of the State of New York recommend to the sponsors of this legislation that the use of medical marijuana should not be utilized in patients who suffer solely from psychiatric conditions."	December 14, 2010 letter to New York Assemblyman Richard Gottfried, chair of the Assembly Health Committee, in support of a New York medical marijuana bill
Michigan Democratic Party	2/27/2007; 2011 resolution	✓				"Licensed medical doctors should not be criminally punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to criminal sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial." "MDP urges all state and local lawmakers not to infringe of the rights of medical marijuana patients and caregivers, with the exception of sensible zoning regulations ..."	Resolutions approved by annual state conventions in 2007 and 2011
Michigan Nurses Association	10/2/2008	✓				"Medical marijuana has proven to be an effective treatment for many patients suffering from illnesses like cancer, HIV/AIDS, multiple sclerosis and other conditions, and that's why the Michigan Nurses Association endorses Proposal 1."	10/2/08 press release, "Michigan Nurses Association endorses medical marijuana ballot proposal"
Minnesota AIDS Project	4/1/2005	✓				"Supports the passage of S.F. 1973 and H.F. 2151," MPP's model medical marijuana bill	Letter to Minnesota State Sen. Steve Kelley, medical marijuana bill sponsor

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Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Minnesota Nurses Association	2/2002; 2/7/2006	✓				Regarding prescriptive access: "Along with our national association and many other state nurses associations, the Minnesota Nurses Association wants to offer our support for the passage of S.F. 1973 and H.F. 2151," MPP's model medical marijuana bill	Signatory of letter to President Bush; letter to Minnesota State Sen. Steve Kelley, medical marijuana bill sponsor
Minnesota Public Health Association	2/28/2006	✓				"Supports the passage of S.F. 1973 and H.F. 2151," MPP's model medical marijuana bill	Letter to Minnesota State Sen. Steve Kelley, medical marijuana bill sponsor
Montana Democratic Party	6/2012	✓				"The Montana Democratic Party supports the right of qualified patients, with a medical condition where marijuana is appropriate, to have safe access to medical marijuana."	Platform published June 2012
Montana Republican Party	June, 2012	✓				We recognize that a significant problem exists with Montana's current laws regarding the medical use of marijuana and we support action by the next legislature to create a workable and realistic regulatory structure.	Party platform adopted June 2012
Multiple Sclerosis California Action Network	1996	✓				Prescriptive access: "the decision as to whether or not marijuana constitutes an appropriate treatment is one best left to physician and patient on a case-by-case basis"	Government Issues Action (GIA) Report, page 2, January//February 1996
National Association of People With AIDS	1992; 11/29/1999; 12/2000	✓	✓	✓			Signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
National Association for Public Health Policy	11/15/1998; 11/29/1999; 12/2000	✓	✓	✓		"[We] recommend ... allow[ing] [marijuana] prescription where medically appropriate."	Position paper adopted by the National Association for Public Health Policy, November 15, 1998; Also a signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
National Multiple Sclerosis Society	2015	✓		✓		"The Society supports the rights of people with MS to work with their health care provider to access marijuana for medical purposes in accordance with legal regulations in those states where such use has been approved."	Website, "Marijuana FAQs," http://www.nationalmssociety.org/Treating-MS/Complementary-Alternative-Medicines/Marijuana/Marijuana-FAQs
National Nurses Society on Addictions (NNSA)	5/1995	✓		✓		"The NNSA urges the federal government to remove marijuana from the Schedule I category immediately, and make it available for physicians to prescribe. NNSA urges the American Nurses' Association and other health care professional organizations to support patient access to this medicine."	"Position Paper: Access to Therapeutic Cannabis," approved by the NNSA Board of Directors, May 1, 1995

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Legal/Prescriptive Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
The New England Journal of Medicine	1/30/1997	✓	✓			Prescriptive access: urges rescheduling "[A] federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane."	Editorial, Dr. Jerome P. Kassirer, Volume 336, Number 5, Jan. 30, 1997
New York State Hospice and Palliative Care Association	2003	✓				"Supports A. 5796/ S. 4805"	"Memorandum of Support: Medical Use of Marijuana"
North Carolina Democratic Party	October 2009	✓				"The North Carolina Democratic Party proposes that sale and use of Medical Marijuana be decriminalized."	Resolution passed at the 2009 North Carolina Democratic Convention
North Carolina Nurses Association	10/15/1996	✓		✓		"NCNA urges the Administration and Congress to make cannabis available as a legal medicine where shown to be safe and effective and to immediately allow access to therapeutic cannabis through the Investigational New Drug Program. NCNA also supports research of the therapeutic properties and combinations of the various cannabinoids and alternative methods of administration to decrease the harmful effects related to smoking."	"Position Statement of Therapeutic Use of Cannabis"
Older Iowans Legislature	9/30/2009	✓				"Be it enacted by the Older Iowans Legislature that the General Assembly of the State of Iowa enact legislation allowing physicians licensed to practice medicine in Iowa to prescribe marijuana for chronically ill or terminal patients."	OIL Bill 09-29A
Pharmacists Society of the State of New York	6/2010	✓				"After careful review and discussion, the Pharmacists Society of the State of New York supports this bill because it establishes a comprehensive program to distribute marijuana for medicinal use in this state with appropriate controls that far exceed those in other states. Pharmacists believe in palliative care. We support this initiative to provide access to a product that can relieve suffering in individuals with intractable pain when it is recommended by their physicians in the context of the program herein."	Memorandum of support, June 2010
Presbyterian Church USA	*2006*	✓	✓			"This resolution declares support for the medicinal use of cannabis sativa (also known as marijuana), and directs the Presbyterian Church (U.S.A.) to actively urge the Federal government to amend and adopt such laws as will allow the benefits of marijuana treatment for such diseases as cancer, AIDS, and muscular dystrophy."	Minutes from the 217th General Assembly, 2006

Partial List of Organizations Favoring Legal/Prescriptive Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Progressive National Baptist Convention	5/2004	✓				"Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."	Signed statement of principle
Protestants for the Common Good	4/16/2010	✓	✓	✓		"Passing [medical marijuana] legislation would be an act of compassion and mercy. Victims of cancer, multiple sclerosis, epilepsy and other serious health problems have given compelling testimony that cannabis (the technical term for marijuana) provides relief from pain and suffering. This relief often can come in no other way."	"It's time to pass medical pot law in Illinois House," Chicago Sun-Times, April 16, 2010
Project Inform (national HIV/AIDS treatment education advocacy organization)	6/19/2004	✓				"Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."	Resolution in support of the Hinchey-Rohrabacher Amendment to the Commerce-State-Justice Appropriations bill in U.S. Congress, which would prevent federal raids on medical marijuana patients and providers who are in compliance with state law
Rhode Island Medical Society	3/15/2004	✓				Supports Rhode Island's medical marijuana law (based on MPP's model bill) and testified in favor of it; "[T]he RI Medical Society supports this legislation pertaining to the medical use of marijuana."	Letter to Rep. Thomas Slater, March 15, 2004
Rhode Island Public Health Association	4/2008	✓				"Seriously ill patients whose doctors have told them that the medical use of marijuana is likely to be beneficial should not be arrested for its use and should have safe access to medical marijuana from pharmacy-like non-profit establishments"	"Resolution Supporting Rhode Island's Medical Marijuana Law And Efforts to Improve Legal Access to Medical Marijuana"
Rhode Island State Council of Churches	3/2008	✓				"Seriously ill patients whose doctors have told them that the medical use of marijuana is likely to be beneficial should not be arrested for its use and should have safe access to medical marijuana from a non-profit Compassion Center"	Resolution, "Medical Marijuana Use & Access"
Rhode Island State Nurses Association	3/29/2004	✓	✓	✓	✓	"The Rhode Island State Nurses Association is supportive of providing patients safe access to therapeutic Marijuana/Cannabis. Our position is consistent with the American Nurses Association (ANA)."	Letter to Tom Angell, March 29, 2004

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Legal/Prescriptive Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
San Francisco Medical Society	8/8/1996; 2/1997	✓		✓	✓	"The SFMS takes a support position on the California Medical Marijuana Initiative" (Proposition 215) Other: endorsement of a physician's right to discuss marijuana therapy with a patient	Motion passed by SFMS Board of Directors; "Medical Marijuana: A Plea for Science and Compassion," issued jointly by Gay and Lesbian Medical Association and San Francisco Medical Society
Senior Agenda Coalition	March 2007	✓		✓		"Supports making Rhode Island's medical marijuana law permanent, so that no seriously ill patient will be subject to criminal or civil sanction under [the] state's laws for the doctor-advised, medical use of marijuana" and resolved that state-approved medical marijuana patients "should not be subject to federal criminal penalties for such medical use"	Director issued resolution, March 2007
Texas Democratic Party	6/2012	✓	✓			"We … urge the immediate decriminalization of the possession and use of medical marijuana."	Democratic party platform statement
Texas League of Women Voters	1/2006	✓				"Laws regarding drug abuse and drug addiction should include no criminal penalties for cannabis (marihuana) possession when recommended by a physician."	Position adopted by TLWV state board at January 2006 meeting
Texas Nurses Association	4/9/2013	✓	✓			"Patients should have access to marijuana for such use and practitioners should have the right to counsel patients about the use of marijuana in appropriate medical situations."	Statement in support made by Board of Directors on 4/9/13
Union of Reform Judaism (formerly Union of American Hebrew Congregations)	11/2003; 6/2004	✓	✓	✓		Resolves to "support federal legislation and regulation to allow the medicinal use of marijuana ... urge the Food and Drug Administration to expand the scope of allowable Investigational New Drug applications ... call for further medical research ... advocate for the necessary changes in local, state and federal law to permit the medicinal use of marijuana and ensure its accessibility for that purpose"; "Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."	Resolution adopted at the 67th General Assembly; signed statement of principle

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Legal/Prescriptive Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Unitarian Universalist Association	6/22/2002	✓		✓		"Make all drugs legally available with a prescription by a licensed physician, subject to professional oversight. End the practice of punishing an individual for obtaining, possessing, or using an otherwise illegal substance to treat a medical condition."	From "Alternatives to the War on Drugs: Statement of Conscience" resolution, passed by the General Assembly with a two-thirds majority of delegates
United Church of Christ	2002	✓				"We believe that seriously ill people should not be subject to arrest and imprisonment for using medical marijuana with their doctors' approval."	Ministry for Criminal Justice & Human Rights signed on to MPP's Coalition for Compassionate Access in 2002
United Methodist Church	5/2004	✓				"Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."	statement of principle signed by United Methodist Church General Board of Church and Society after quadrennial convention
United Nurses and Allied Professionals (Rhode Island)	5/2004	✓				Sent legislative alerts to its members endorsing MPP's model bills	May 2004 letters to Rhode Island Rep. Thomas Slater and Rhode Island Sen. Rhoda Perry
Veterans for Peace	8/18/2007	✓		✓	✓	"Supports legislation that eliminates criminal and civil penalties for the doctor-advised, medical use of marijuana by patients with serious physical medical conditions" and "urges the Veterans Administration and its doctors not to withhold treatments from a patient under their care simply because they test positive for marijuana"	Resolution approved at annual meeting, August 2007
Virginia Nurses Association	10/7/1994; 12/2000	✓	✓				Resolution; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Wisconsin Nurses Association	10/29/1999; 12/2000	✓	✓			"Urges the Governor of Wisconsin and the Wisconsin Legislature to move expeditiously to make cannabis available as a legally prescribed medicine where shown to be safe and effective"	resolution adopted by WNA; one of the 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Wisconsin Public Health Association	6/1999	✓				"Urges the Governor of Wisconsin and the Wisconsin Legislature to move expeditiously to make cannabis available as a legally prescribed medicine where shown to be safe and effective"	WPHA resolution from its June 1999 meeting
Women of Reform Judaism	12/1999; 12/2000	✓	✓	✓			Health Issues Resolution, adopted at the 1999 Orlando Assembly; signatory of 2000 letter to U.S. Dept. of Health and Human Services

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
AIDS National Interfaith Network	2/17/1999		✓				One of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
AIDS Project Arizona	2/17/1999		✓				One of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
AIDS Project Los Angeles	2/17/1999		✓				One of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
AIDS Survival Project (Atlanta)	2/2002		✓				Signatory of letter to President Bush
AIDS Treatment Initiatives (Atlanta)	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
AIDS Treatment News	2/2002		✓				Signatory of letter to President Bush
American Academy of Pediatrics	1/26/2015		✓	✓		"The AAP recognizes that marijuana may currently be an option for cannabinoid administration for children with life-limiting or severely debilitating conditions and for whom current therapies are inadequate."	Policy statement, "The Impact of Marijuana Policies on Youth: Clinical, Research, and Legal Update."
American Civil Liberties Union	2/2002		✓				Signatory of letter to President Bush
Bay Area Physicians for Human Rights	1/1997; 12/2000		✓		✓	Other: endorsement of a physician's right to discuss marijuana therapy with a patient	Plaintiff in *Conant v. McCaffrey*; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Center for Women Policy Studies	2/2002		✓				Signatory of letter to President Bush
Commission on Social Action of Reform Judaism	2/2002		✓				Signatory of letter to President Bush
Contigo-Conmigo	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Florida Medical Association	6/1/1997		✓	✓			Resolution #97-61

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Gay and Lesbian Medical Association	5/1995; 2/1997; 11/29/1999; 12/2000		✓	✓	✓	Other: endorsement of a physician's right to discuss marijuana therapy with a patient	GLMA Policy Statement #066-95-104; "Medical Marijuana: A Plea for Science and Compassion," issued jointly by GLMA and San Francisco Medical Society in 1997; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
Harm Reduction Coalition	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Hepatitis C Action & Advocacy Coalition	1/2001		✓				Signatory of letter to President Bush
Institute for Policy Studies, Drug Policy Project	2/2002		✓				Signatory of letter to President Bush
Justice Policy Institute	2/2002		✓				Signatory of letter to President Bush
Latino Commission on AIDS	2/17/1999		✓				One of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Life Foundation	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Mississippi Nurses Association	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Mothers Against Misuse and Abuse	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Mothers' Voices to End AIDS	2/17/1999		✓				One of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
National Academy of Sciences' Institute of Medicine	3/17/1999		✓	✓			*Marijuana and Medicine: Assessing the Science Base*; see www.mpp.org/science.html
National Black Police Association	11/29/1999; 12/2000		✓	✓			Signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
National Center on Institutions and Alternatives	2/2002		✓				Signatory of letter to President Bush
National Latina/o Lesbian, Gay, Bisexual and Transgender Organization	2/17/1999		✓				One of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
National Native American AIDS Prevention Center	2/17/1999		✓				One of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
National Women's Health Network	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Nebraska AIDS Project	2/2002		✓				Signatory of letter to President Bush
Okaloosa AIDS Support and Information Services (Ft. Walton Beach, Florida)	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Physicians for Social Responsibility (Oregon)	2/2002		✓				Signatory of letter to President Bush
POZ magazine	2/2002		✓				Signatory of letter to President Bush
Project Safe	1/2001		✓				Signatory of letter to President Bush
Public Citizen	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services
Radio Bilingue	2/2002		✓				Signatory of letter to President Bush
The Regas Institute	2/2002		✓				Signatory of letter to President Bush
Texas Medical Association	4/29/04		✓	✓		"The Texas Medical Association supports (1) the physician's right to discuss with his/her patients any and all possible treatment options related to the patients' health and clinical care, including the use of marijuana, without the threat to the physician or patient of regulatory, disciplinary, or criminal sanctions; and (2) further well-controlled studies of the use of marijuana with seriously ill patients who may benefit from such alternative treatment."	Resolution, TMA Council on Scientific Affairs.
Wisconsin Nurses Association	12/2000		✓				Signatory of 2000 letter to U.S. Dept. of Health and Human Services

Partial List of Organizations With Favorable Positions on Research and/or Other Uses of Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
American Cancer Society	7/24/1997			✓		Supported California research bill S.B. 535	Letter to California State Sen. John Vasconcellos
American College of Physicians	2/2008			✓	✓	The ACP "urges an evidence-based review of marijuana's status as a Schedule I controlled substance to determine whether it should be reclassified to a different schedule." It also "strongly urges protection from criminal or civil penalties for patients who use medical marijuana as permitted under state laws."	February 2008 position paper, with July 2008 addendum
American Medical Association	11/2009			✓	✓	"Our American Medical Association (AMA) urges that marijuana's status as a federal Schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product."	Council on Science and Public Health Report #3: Use of Cannabis for Medicinal Purposes
American Psychiatric Association	1998				✓	Other: "effective patient care requires the free and unfettered exchange of information on treatment alternatives; discussion of these alternatives between physicians and patients should not subject either party to any criminal penalties"	Approved by the APA Board of Trustees in response to federal threats against physicians following the passage of Calif. Prop. 215, reported in *Psychiatric News*, 9/4/1998
American Society of Health-System Pharmacists (ASHP)	6/2011			✓		"To encourage the Drug Enforcement Administration to eliminate barriers to medical marijuana research, including review of medical marijuana's status as a Schedule I controlled substance, and its reclassification, if necessary to facilitate research …"	House of Delegates of the American Society of Health-System Pharmacists (ASHP), 63rd annual session, June 12-14, 2011

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations With Favorable Positions on Research and/or Other Uses of Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Association of Nurses in AIDS Care (ANAC)	1/2008			✓	✓	ANAC believes that "funding for research through federal funding sources is required to determine the safety and efficacy of marijuana as a therapeutic intervention for a variety of symptoms in HIV/AIDS and other diseases; healthcare personnel (HCP) should not be threatened, penalized, or otherwise intimidated for discussing and/or recommending the medicinal use of marijuana; individuals should not be prosecuted for medical use of marijuana."	Medical Use of Marijuana, Position Statement, Adopted by ANAC Board of Directors, September 13, 1998, Reviewed and Revised by the ANAC Board: August 14, 1999; November 1, 2000; April 15, 2001; January 2003; August 2005; and January 2008
British Medical Association	11/18/1997			✓	✓	Research to develop cannabinoid pharmaceuticals; other: leniency for medical marijuana-using patients in the meantime ("therapeutic use should not be confused with recreational misuse")	BMA report: "Therapeutic Uses of Cannabis," 1997
Congress of Nursing Practice	5/31/1996			✓	✓	Other: instructing RNs on medical marijuana	Motion passed by CNP
Federation of American Scientists	11/1994			✓			FAS Petition on Medical Marijuana
HIV Medicine Association of the Infectious Diseases Society of America	10/2004				✓	"[I]t cannot seriously be contested that there exists a small but significant class of individuals who suffer from painful chronic, degenerative, and terminal conditions, for whom marijuana provides uniquely effective relief."	HIV Medicine Association of the Infectious Diseases Society of America, along with American Medical Students Association, Lymphoma Foundation of America, Dr. Barbara Roberts, and Irvin Rosenfeld, Amicus Curiae brief filed in the U.S. Supreme Court (in the case of *Gonzales v. Raich*), October 2004
Iowa Medical Society	4/18/2010			✓		"Resolved: That the Iowa Medical Society support the Iowa Board of Pharmacy's reclassification of marijuana as a Schedule II controlled substance with the goal of facilitating further study into potential medical uses."	Substitute Resolution 10-03

Partial List of Organizations With Favorable Positions on Research and/or Other Uses of Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Kaiser Permanente	1997				✓	Other: May/June 1997 edition of their Health Education Services' "HIV Newsletter" includes marijuana as a treatment option for AIDS wasting syndrome; developed form letter for California and Washington doctors to acknowledge patients' medical marijuana use	On file
The Lancet Neurology	5/1/03				✓	Other: Marijuana can "inhibit pain in virtually every experimental pain paradigm." Also suggested that marijuana could be "the aspirin of the 21st century."	"The therapeutic potential of cannabis," *The Lancet Neurology*, Vol. 2, No. 5, May 1, 2003
Medical Association of Georgia	1/27/14			✓		"The bottom line is that MAG supports the use of marijuana in strictly controlled medical research programs so physicians can obtain some much-needed patient safety and product efficacy research so they can do what is best for their patients, and so they can help the state determine what additional steps it should consider taking on this front in the future."	Statement published in Atlanta Journal-Constitution on Jan. 29, 2015.
National Epilepsy Foundation	6/2005			✓		"Studying the effects of marijuana on seizures in an appropriate legal and scientific environment is the optimal way to determine whether this currently illegal drug has any appropriate use for the treatment of epilepsy. The Epilepsy Foundation calls for further study of the role of THC in animal models and for randomized placebo controlled studies of this potential treatment of seizures."	Resolution

Appendix Q:
MPP's Model State Medical Marijuana Bill

Be it enacted by the people of the state of _____:

Section 1. Title.

Sections 1 through 25 of this chapter shall be known as the _____ Medical Cannabis Act.

Section 2. Findings.

(a) Cannabis' recorded use as a medicine goes back nearly 5,000 years. Modern medical research has confirmed the beneficial uses for cannabis —which is also called marijuana — in treating or alleviating the pain, nausea, and other symptoms associated with a variety of debilitating medical conditions, including cancer, multiple sclerosis, and HIV/AIDS, as found by the National Academy of Sciences' Institute of Medicine in March 1999.

(b) Studies published since the 1999 Institute of Medicine report continue to show the therapeutic value of cannabis in treating a wide array of debilitating medical conditions. These include relief of the neuropathic pain caused by multiple sclerosis, HIV/AIDS, and other illnesses and injuries that often fails to respond to conventional treatments and relief of nausea, vomiting, and other side effects of drugs used to treat HIV/AIDS and hepatitis C, increasing the chances of patients continuing on life-saving treatment regimens.

(c) Cannabis has many currently accepted medical uses in the United States, having been recommended by thousands of licensed physicians to more than one million patients in states with medical cannabis laws. A wide range of medical and public health organizations, including the American Academy of HIV Medicine, the American College of Physicians, the American Nurses Association, the American Public Health Association, the Leukemia & Lymphoma Society, and many others, have recognized cannabis' medical utility.

(d) Data from the Federal Bureau of Investigation's Uniform Crime Reports and the Compendium of Federal Justice Statistics show that approximately 99 out of every 100 cannabis arrests in the U.S. are made under state law, rather than under federal law. Consequently, changing state law will have the practical effect of protecting from arrest the vast majority of seriously ill patients who have a medical need to use cannabis.

(e) Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Massachusetts, Michigan, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Vermont, Rhode Island, Washington state, and the District of Columbia have removed state-level criminal penalties from the medical use and cultivation of cannabis. _____ joins in this effort for the health and welfare of its citizens.

(f) States are not required to enforce federal law or prosecute people for engaging in activities prohibited by federal law. Therefore, compliance with this act does not put the state of _____ in violation of federal law.

(g) State law should make a distinction between the medical and non-medical uses of cannabis. Hence, the purpose of this act is to protect patients with debilitating medical conditions, as well as their practitioners and providers, from arrest and prosecution, criminal and other penalties, and property forfeiture, if such patients engage in the medical use of cannabis.

Section 3. Definitions.

For purposes of this chapter, unless the context otherwise requires:

(a) "Allowable amount of marijuana" means:
(1) With respect to a qualifying patient, 2.5 ounces of usable marijuana, and if the qualifying patient's registry identification card states that the qualifying patient is authorized to cultivate marijuana:
(A) 12 marijuana plants contained in an enclosed, locked facility, except the plants are not required to be in an enclosed, locked facility if the plants are being transported because the qualifying patient is moving; and
(B) marijuana that is produced from allowable plants that is on the premises where the plants were grown.
(2) With respect to a designated caregiver, for each patient assisted by the designated caregiver:
(A) 2.5 ounces of usable marijuana; and
(B) if the designated caregiver's registry identification card provides that the designated caregiver is authorized to cultivate marijuana:
(C) 12 marijuana plants contained in an enclosed, locked facility, except the plants are not required to be in an enclosed, locked facility if the plants are being transported because the designated caregiver is moving; and
(D) marijuana that is produced from allowable plants that is on the premises where the pants were grown.

(b) "Bona fide practitioner-patient relationship" means:
(1) A practitioner and patient have a treatment or consulting relationship, during the course of which the physician has completed an assessment of the patient's medical history and current medical condition, including an appropriate in-person physical examination;
(2) The practitioner has consulted with the patient with respect to the patient's debilitating medical condition; and
(3) The physician is available to or offers to provide follow-up care and treatment to the patient, including, but not limited to, patient examinations.

(c) "Cardholder" means a qualifying patient or a designated caregiver who has been issued and possesses a valid registry identification card.

(d) "Cultivation center" means an entity registered pursuant to section 14 that cultivates, manufactures, possesses, prepares, packs, stores, delivers, transfers,

transports, sells, supplies, or dispenses cannabis, paraphernalia, or related supplies and educational materials to other cultivation centers and dispensaries.

(e) "Debilitating medical condition" means:
(1) cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, ulcerative colitis, agitation of Alzheimer's disease, post-traumatic stress disorder, or the treatment of these conditions;
(2) a chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome; severe, debilitating pain; severe nausea; seizures; or severe and persistent muscle spasms, including, but not limited, to those characteristic of multiple sclerosis; or
(3) any other medical condition or its treatment added by the department, as provided for in section 7.

(f) "Department" means the _____ Department of Health or its successor agency.

(g) "Designated caregiver" means a person who:
(1) is at least 21 years of age;
(2) has agreed to assist with a patient's medical use of cannabis;
(3) has not been convicted of a disqualifying felony offense; and
(4) assists no more than five qualifying patients with their medical use of cannabis.

(h) "Dispensary" means an entity registered pursuant to section 14 that cultivates, acquires, manufactures, possesses, prepares, packs, stores, delivers, transfers, transports, sells, supplies, or dispenses cannabis, paraphernalia, or related supplies and educational materials to registered qualifying patients, registered designated caregivers, and other dispensaries.

(i) "Disqualifying felony offense" means:
(1) a violent crime defined in section ____ that was classified as a felony in the jurisdiction where the person was convicted; or
(2) a violation of a state or federal controlled substances law that was classified as a felony in the jurisdiction where the person was convicted, not including:
(A) an offense for which the sentence, including any term of probation, incarceration, or supervised release, was completed 10 or more years earlier; or
(B) an offense that consisted of conduct for which this chapter would likely have prevented a conviction, but the conduct either occurred prior to the enactment of this chapter or was prosecuted by an authority other than the state of _____ .

(j) "Enclosed, locked facility" means a closet, room, greenhouse, building, or other enclosed area that is equipped with locks or other security devices that permit access only by the cardholder allowed to cultivate the plants or, in the case of a medical cannabis organization, the employees and agents working for the medical cannabis organization. Two or more registered qualifying patients and/or registered designated caregivers who reside in the same dwelling and

have registry identification cards that remove state penalties for cannabis cultivation may share one enclosed, locked facility for cultivation.

(k) "Cannabis" has the meaning given that term in _____.

(l) "Medical use" includes the acquisition, administration, cultivation, manufacture, delivery, harvest, possession, preparation, transfer, transportation, or use of cannabis or paraphernalia relating to the administration of cannabis to treat or alleviate a registered qualifying patient's debilitating medical condition or symptoms associated with the patient's debilitating medical condition. It does not include cultivation by a visiting qualifying patient or cultivation by a registered designated caregiver or registered qualifying patient who is not designated as being allowed to cultivate.

(m) "Medical cannabis organization" means a cultivation center, dispensary, or testing facility.

(n) "Practitioner" means a person who is licensed with authority to prescribe drugs to humans under section _____ except as otherwise provided in this subsection. If the qualifying patient's debilitating medical condition is post-traumatic stress disorder, the practitioner must be a licensed psychiatrist. In relation to a visiting qualifying patient, "practitioner" means a person who is licensed with authority to prescribe drugs to humans in the state of the patient's residence.

(o) "Qualifying patient" means a person who has been diagnosed by a practitioner as having a debilitating medical condition.

(p) "Registry identification card" means a document issued by the department that identifies a person as a registered qualifying patient or registered designated caregiver.

(q) "Testing facility" means an entity registered under section 14 by the department to test cannabis produced for medical use, including for potency and contaminants.

(r) "Usable cannabis" means the flowers or leaves of the cannabis plant, the resin extracted from any part of the plant, and any mixture or preparation thereof. It does not include the seeds, stalks, and roots of the plant. It does not include the weight of any non-cannabis ingredients combined with cannabis to prepare topical or oral administrations, food, drink, or other product.

(s) "Visiting qualifying patient" means a person who:
(1) has been diagnosed with a debilitating medical condition;
(2) possesses a valid registry identification card, or its equivalent, that was issued pursuant to the laws of another state, district, territory, commonwealth, insular possession of the United States, or country recognized by the United States that allows the person to use cannabis for medical purposes in the jurisdiction of issuance; and

(3) is not a resident of _____ or who has been a resident of _____ for less than 30 days.

(t) "Written certification" means a document dated and signed by a practitioner, stating that in the practitioner's professional opinion the patient is likely to receive therapeutic or palliative benefit from the medical use of cannabis to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition. A written certification shall affirm that it is made in the course of a bona fide practitioner-patient relationship and shall specify the qualifying patient's debilitating medical condition.

Section 4. Protections for the Medical Use of Cannabis.

(a) A registered qualifying patient or registered designated caregiver who possesses a valid registry identification card is not subject to arrest, prosecution, or penalty in any manner, or denial of any right or privilege, including any civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau for:
(1) The registered qualifying patient's medical use of cannabis pursuant to this chapter, if the registered qualifying patient does not possess more than the allowable amount of cannabis;
(2) The registered designated caregiver assisting a registered qualifying patient to whom he is connected through the commissioner's registration process with the registered qualifying patient's medical use of cannabis pursuant to this chapter, if the registered designated caregiver does not possess more than the allowable amount of cannabis;
(3) Reimbursement by a registered qualifying patient to the patient's registered designated caregiver for direct costs incurred by the registered designated caregiver for assisting with the registered qualifying patient's medical use of cannabis;
(4) Transferring cannabis to a testing facility for testing;
(5) Compensating a dispensary or a testing facility for goods or services provided;
(6) Selling, transferring, or delivering cannabis seeds produced by the cardholder to a cultivation center or dispensary; or
(7) Offering or providing cannabis to a registered qualifying patient, to a registered designated caregiver for a registered qualifying patient's medical use, to a visiting qualifying patient, or to a dispensary if nothing of value is transferred in return and the person giving the cannabis does not knowingly cause the recipient to possess more than the allowable amount of cannabis.

(b) A person who demonstrates that he or she is a visiting qualifying patient shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by a business or occupational or professional licensing board or entity, for the medical use of cannabis pursuant to this chapter if the visiting qualifying patient does not possess more than 2.5 ounces of usable cannabis.

(c) There is a presumption that a qualifying patient or designated caregiver is engaged in the medical use of cannabis pursuant to this chapter if the qualifying patient or designated caregiver:
(1) is in possession of a registry identification card; and
(2) is in possession of an amount of cannabis that does not exceed the allowable amount of cannabis.
(3) The presumption may be rebutted by evidence that conduct related to cannabis was not for the purpose of treating or alleviating a qualifying patient's debilitating medical condition or symptoms associated with the qualifying patient's debilitating medical condition pursuant to this chapter.

(d) A practitioner shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by the _____ Medical Board or by any other occupational or professional licensing board or bureau, solely for providing written certifications or for otherwise stating that, in the practitioner's professional opinion, a patient is likely to receive therapeutic or palliative benefit from the medical use of cannabis to treat or alleviate the patient's serious or debilitating medical condition or symptoms associated with the serious or debilitating medical condition, provided that nothing in this chapter shall prevent a practitioner from being sanctioned for:
(1) issuing a written certification to a patient with whom the practitioner does not have a bona fide practitioner-patient relationship; or
(2) failing to properly evaluate a patient's medical condition.

(e) An attorney may not be subject to disciplinary action by the state bar association or other professional licensing association for providing legal assistance to prospective or registered medical cannabis organizations or others related to activity that is no longer subject to criminal penalties under state law pursuant to this chapter.

(f) No person may be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including any civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau, for:
(1) Providing or selling cannabis paraphernalia to a cardholder or to a medical cannabis organization upon presentation of a valid registry identification card or registration certificate;
(2) Being in the presence or vicinity of the medical use of cannabis authorized under this chapter; or
(3) Assisting a registered qualifying patient with the act of using or administering cannabis.

(g) A dispensary or a dispensary agent is not subject to prosecution, search, or inspection, except by the commissioner pursuant to section 16, seizure, or penalty in any manner, and may not be denied any right or privilege, including civil penalty or disciplinary action by a court or business licensing board or entity, for acting pursuant to this chapter and rules authorized by this chapter to:
(1) Possess, plant, propagate, cultivate, grow, harvest, produce, process, manufacture, compound, convert, prepare, pack, repack, or store cannabis;

(2) Deliver, transfer, or transport cannabis, cannabis paraphernalia, or related supplies and educational materials to or from other medical cannabis organizations;
(3) Compensate a testing facility for services or goods provided;
(4) Accept cannabis offered by a registered qualifying patient or a registered designated caregiver if nothing of value is transferred in return;
(5) Purchase or otherwise acquire cannabis from cultivation centers or dispensaries; or
(6) Dispense, supply, or sell cannabis or related supplies and educational materials to registered qualifying patients, to registered designated caregivers on behalf of registered qualifying patients, or to other medical cannabis dispensaries.

(h) A cultivation center or a cultivation center agent is not subject to prosecution, search, or inspection, except by the commissioner pursuant to section 16, seizure, or penalty in any manner, and may not be denied any right or privilege, including civil penalty or disciplinary action by a court or business licensing board or entity, for acting pursuant to this chapter and rules authorized by this chapter to:
(1) Possess, plant, propagate, cultivate, grow, harvest, produce, process, manufacture, compound, convert, prepare, pack, repack, or store cannabis;
(2) Deliver, transfer, or transport cannabis, cannabis paraphernalia, or related supplies and educational materials to or from other medical cannabis organizations;
(3) Compensate a testing facility for services or goods provided;
(4) Accept cannabis offered by a registered qualifying patient or a registered designated caregiver if nothing of value is transferred in return;
(5) Purchase or otherwise acquire cannabis from another cultivation center; or
(6) Dispense, supply, or sell cannabis or related supplies and educational materials to other cultivation centers or dispensaries.

(i) A testing facility or testing facility agent is not subject to prosecution, search, or inspection, except by the commissioner pursuant to section 16, seizure, or penalty in any manner, and may not be denied any right or privilege, including civil penalty or disciplinary action by a court or business licensing board or entity, for acting pursuant to this chapter and rules authorized by this chapter to provide the following services:
(1) Acquiring, possessing, or transporting cannabis obtained from registry identification cardholders or medical cannabis organizations;
(2) Returning the cannabis to the registry identification cardholder or medical cannabis organization from whom it was obtained;
(3) Producing or selling educational materials related to medical cannabis;
(4) Producing, possessing, selling, or transporting cannabis paraphernalia and equipment or materials other than cannabis to medical cannabis organizations or to cardholders, including lab equipment and packaging materials;
(5) Testing cannabis, including for potency, pesticides, mold, or contaminants; or
(6) Receiving compensation for services or goods other than cannabis provided under this chapter.

(j) Any cannabis, cannabis paraphernalia, or other interest in or right to property that is possessed, owned, or used in connection with the medical use of cannabis as allowed under this chapter, or acts incidental to such use, shall not be seized or forfeited. This chapter shall not prevent the seizure or forfeiture of cannabis exceeding the amounts allowed under this chapter, nor shall it prevent seizure or forfeiture if the basis for the action is unrelated to the cannabis that is possessed, manufactured, transferred, or used pursuant to this chapter.

(k) Possession of, or application for, a registry identification card does not constitute probable cause or reasonable suspicion, nor shall it be used to support a search of the person or property of the person possessing or applying for the registry identification card, or otherwise subject the person or property of the person to inspection by any governmental agency.

(l) For the purposes of _____ state law, the medical use of cannabis by a cardholder or medical cannabis organization shall be considered lawful as long as it is in accordance with this chapter.

(m) No law enforcement officer employed by an agency which receives state or local government funds shall expend any state or local resources, including the officer's time, to effect any arrest or seizure of cannabis, or conduct any investigation, on the sole basis of activity the officer believes to constitute a violation of the federal Controlled Substances Act if the officer has reason to believe that such activity is in compliance with state medical cannabis laws, nor shall any such officer expend any state or local resources, including the officer's time, to provide any information or logistical support related to such activity to any federal law enforcement authority or prosecuting entity.

(n) It is the public policy of the state of _____ that contracts related to medical cannabis should be enforceable and no contract entered into by a cardholder, a medical cannabis organization, or a medical cannabis organization's agents as permitted pursuant to a valid registration issued by the department, or by those who allow property to be used by a cardholder, a medical cannabis organization, or a medical cannabis organization's agents as permitted pursuant to a valid registration issued by the department, shall be unenforceable on the basis that activities related to cannabis are prohibited by federal law.

Section 5. Limitations.

(a) This chapter does not authorize any person to engage in, and does not prevent the imposition of any civil, criminal, or other penalties for engaging in, the following conduct:
(1) Undertaking any task under the influence of cannabis, when doing so would constitute negligence or professional malpractice.
(2) Possessing cannabis, or otherwise engaging in the medical use of cannabis:
(A) in a school bus;
(B) on the grounds of any preschool or primary or secondary school; or
(C) in any correctional facility.
(3) Smoking cannabis:
(A) on any form of public transportation; or

(B) in any public place.
(4) Operating, navigating, or being in actual physical control of any motor vehicle, aircraft, train, or motorboat while under the influence of cannabis, except that a registered qualifying patient or visiting qualifying patient shall not be considered to be under the influence of cannabis solely because of the presence of metabolites or components of cannabis that appear in insufficient concentration to cause impairment.

Section 6. Discrimination Prohibited.

(a) No school or landlord may refuse to enroll or lease to and may not otherwise penalize a person solely for the person's status as a cardholder, unless failing to do so would violate federal law or regulations or cause the school or landlord to lose a monetary or licensing-related benefit under federal law or regulations.

(b) For the purposes of medical care, including organ and tissue transplants, a registered qualifying patient's use of cannabis according to this chapter is considered the equivalent of the authorized use of any other medication used at the discretion of a physician and does not constitute the use of an illicit substance or otherwise disqualify a qualifying patient from needed medical care.

(c) A person shall not be denied custody of or visitation rights or parenting time with a minor solely for the person's status as a registered qualifying patient or a registered designated caregiver, and there shall be no presumption of neglect or child endangerment for conduct allowed under this chapter, unless the person's behavior is such that it creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.

(d) Except as provided in this chapter, a registered qualifying patient who uses cannabis for medical purposes shall be afforded all the same rights under state and local law, including those guaranteed under _____ [the state's disability rights law], as the individual would be afforded if he or she were solely prescribed pharmaceutical medications, as it pertains to:
(1) any interaction with a person's employer;
(2) drug testing by a person's employer; or
(3) drug testing required by any state or local law, agency, or government official.

(e) (1) The rights provided by this section do not apply to the extent that they conflict with an employer's obligations under federal law or regulations or to the extent that they would disqualify an employer from a monetary or licensing-related benefit under federal law or regulations.
(2) No employer is required to allow the ingestion of cannabis in any workplace or to allow any employee to work while under the influence of cannabis. A registered qualifying patient shall not be considered to be under the influence of cannabis solely because of the presence of metabolites or components of cannabis that appear in insufficient concentration to cause impairment.

(f) No school, landlord, or employer may be penalized or denied any benefit under state law for enrolling, leasing to, or employing a cardholder.

Section 7. Addition of Debilitating Medical Conditions.

Any resident of _____[the state] may petition the department to add conditions or treatments to the list of debilitating medical conditions listed in section 3(d). The department shall consider petitions in the manner required by department regulation, including public notice and hearing. The department shall approve or deny a petition within 180 days of its submission. The approval or denial of any petition is a final decision of the department, subject to judicial review. Jurisdiction and venue are vested in the _____ Court.

Section 8. Acts Not Required, Acts Not Prohibited.

(a) Nothing in this chapter requires:
(1) a government medical assistance program or private insurer to reimburse a person for costs associated with the medical use of cannabis; or
(2) any person or establishment in lawful possession of property to allow a guest, client, customer, or other visitor to smoke cannabis on or in that property.

(b) Nothing in this chapter prohibits an employer from disciplining an employee for ingesting cannabis in the workplace or for working while under the influence of cannabis.

Section 9. Issuance and Denial of Registry Identification Cards.

(a) The department shall issue registry identification cards to qualifying patients who submit the following, in accordance with the department's regulations:
(1) a written certification issued by a practitioner within 90 days immediately preceding the date of an application;
(2) the application or renewal fee;
(3) the name, address, and date of birth of the qualifying patient, except that if the applicant is homeless, no address is required;
(4) the name, address, and telephone number of the qualifying patient's practitioner;
(5) the name, address, and date of birth of the designated caregiver, if any, chosen by the qualifying patient;
(6) the name of no more than two dispensaries that the qualifying patient designates, if any; and
(7) if the qualifying patient designates a designated caregiver, a designation as to whether the qualifying patient or designated caregiver will be allowed under state law to possess and cultivate cannabis plants for the qualifying patient's medical use.

(b) Except as provided in subsection (c), the department shall:
(1) verify the information contained in an application or renewal submitted pursuant to this chapter and approve or deny an application or renewal within 15 days of receiving a completed application or renewal application;
(2) issue registry identification cards to a qualifying patient and his or her designated caregiver, if any, within five days of approving the application or renewal. A designated caregiver must have a registry identification card for each of his qualifying patients; and

(3) enter the registry identification number of the dispensary or dispensaries the patient designates into the verification system.

(c) The department may conduct a background check of the prospective designated caregiver in order to carry out this provision.

(d) The department shall not issue a registry identification card to a qualifying patient who is younger than 18 years of age unless:
(1) the qualifying patient's practitioner has explained the potential risks and benefits of the medical use of cannabis to the custodial parent or legal guardian with responsibility for health care decisions for the qualifying patient; and
(2) the custodial parent or legal guardian with responsibility for health care decisions for the qualifying patient consents in writing to:
(A) allow the qualifying patient's medical use of cannabis;
(B) serve as the qualifying patient's designated caregiver; and
(C) control the acquisition of the cannabis, the dosage, and the frequency of the medical use of cannabis by the qualifying patient.

(e) The department may deny an application or renewal of a qualifying patient's registry identification card only if the applicant:
(1) did not provide the required information, fee, or materials;
(2) previously had a registry identification card revoked; or
(3) provided false information.

(f) The department may deny an application or renewal for a designated caregiver chosen by a qualifying patient whose registry identification card was granted only if:
(1) the designated caregiver does not meet the requirements of section 3(g);
(2) the applicant did not provide the information required;
(3) the designated caregiver previously had a registry identification card revoked; or
(4) the applicant or the designated caregiver provided false information.

(g) The commissioner shall give written notice to the qualifying patient of the reason for denying a registry identification card to the qualifying patient or to the qualifying patient's designated caregiver.

(h) Denial of an application or renewal is considered a final department action, subject to judicial review. Jurisdiction and venue for judicial review are vested in the _____ Court.

Section 10. Contents of Registry Identification Cards.

(a) Registry identification cards must contain all of the following:
(1) The name of the cardholder;
(2) A designation of whether the cardholder is a qualifying patient or a designated caregiver;
(3) The date of issuance and expiration date of the registry identification card;
(4) A random 10-digit alphanumeric identification number, containing at least four numbers and at least four letters, that is unique to the cardholder;

(5) If the cardholder is a designated caregiver, the random identification number of the qualifying patient the designated caregiver will assist;
(6) A clear indication of whether the cardholder has been designated to cultivate cannabis plants for the qualifying patient's medical use;
(7) A photograph of the cardholder, if the department's regulations require one; and
(8) The phone number or web address where the card can be verified.

(b) (1) Except as provided in this subsection, the expiration date shall be one year after the date of issuance.
(2) If the practitioner stated in the written certification that the qualifying patient would benefit from cannabis until a specified earlier date, then the registry identification card shall expire on that date.

Section 11. Verification System.

(a) The department shall maintain a confidential list of the persons to whom the department has issued registry identification cards and their addresses, phone numbers, and registry identification numbers. This confidential list shall not be combined or linked in any manner with any other list or database, nor shall it be used for any purpose not provided for in this chapter.

(b) Within 120 days of the effective date of this chapter, the commissioner shall establish a secure phone or web-based verification system. The verification system must allow law enforcement personnel and registered medical cannabis organizations to enter a registry identification number and determine whether or not the number corresponds with a current, valid registry identification card. The system may disclose only whether the identification card is valid, the name of the cardholder, whether the cardholder is a qualifying patient or a designated caregiver, whether the cardholder is permitted to cultivate cannabis plants, and the registry identification number of any affiliated registered qualifying patient.

Section 12. Notifications to Department and Responses; Civil Penalty.

(a) The following notifications and department responses are required:
(1) A registered qualifying patient shall notify the department of any change in his or her name or address, or if the registered qualifying patient ceases to have his or her debilitating medical condition, within 10 days of the change.
(2) A registered designated caregiver shall notify the department of any change in his or her name or address, or if the designated caregiver becomes aware the qualifying patient passed away, within 10 days of the change.
(3) Before a registered qualifying patient changes his or her designated caregiver, the qualifying patient must notify the department.
(4) When a registered qualifying patient changes his or her preference as to who may cultivate cannabis for the qualifying patient, the qualifying patient must notify the department.
(5) If a cardholder loses his or her registry identification card, he or she shall notify the department within 10 days of becoming aware the card has been lost.

(6) Before a registered qualifying patient changes his or her designated dispensary or dispensaries, the qualifying patient must notify the department.

(b) When a cardholder notifies the department of items listed in subsection (a), but remains eligible under this chapter, the department shall issue the cardholder a new registry identification card with a new random 10-digit alphanumeric identification number within 10 days of receiving the updated information and a $20 fee. If the person notifying the department is a registered qualifying patient, the department shall also issue his or her registered designated caregiver, if any, a new registry identification card within 10 days of receiving the updated information.

(c) If the registered qualifying patient's certifying practitioner notifies the department in writing that either the registered qualifying patient has ceased to suffer from a debilitating medical condition or that the practitioner no longer believes the patient would receive therapeutic or palliative benefit from the medical use of cannabis, the card shall become null and void. However, the registered qualifying patient shall have 15 days to dispose of or give away his or her cannabis.

(d) A medical cannabis organization shall notify the commissioner within one business day of any theft or significant loss of cannabis.

Section 13. Affirmative Defense and Dismissal for Medical Cannabis.

(a) Except as provided in section 5 and this section, a person may assert the medical purpose for using cannabis as a defense to any prosecution involving cannabis, and such defense shall be presumed valid where the evidence shows that:
(1) A practitioner has stated that, in the practitioner's professional opinion, after having completed a full assessment of the person's medical history and current medical condition made in the course of a bona fide practitioner-patient relationship, the patient has a debilitating medical condition and the potential benefits of using cannabis for medical purposes would likely outweigh the health risks for the person;
(2) the person was in possession of no more than 2.5 ounces of usable cannabis, 12 cannabis plants, and the marijuana produced by those 12 plants;
(3) the person was engaged in the acquisition, possession, use, manufacture, cultivation, or transportation of cannabis, paraphernalia, or both, relating to the administration of cannabis to treat or alleviate the individual's debilitating medical condition or symptoms associated with the individual's debilitating medical condition; and
(4) any cultivation of cannabis and storage of more than 2.5 ounces of cannabis occurred in an enclosed, locked area that only the person asserting the defense could access.

(b) The defense and motion to dismiss shall not prevail if the prosecution proves that:
(1) the person had a registry identification card revoked for misconduct; or

(2) the purposes for the possession or cultivation of cannabis were not solely for palliative or therapeutic use by the individual with a serious or debilitating medical condition who raised the defense.

(c) An individual is not required to possess a registry identification card to raise the affirmative defense set forth in this section.

(d) If an individual demonstrates the individual's medical purpose for using cannabis pursuant to this section, except as provided in section 5, the individual shall not be subject to the following for the individual's use of cannabis for medical purposes:
(1) disciplinary action by an occupational or professional licensing board or bureau; or
(2) forfeiture of any interest in or right to any property other than cannabis.

Section 14. Registration of Medical Cannabis Organizations.

(a) Not later than 90 days after receiving an application for a medical cannabis organization, the commissioner shall register the prospective medical cannabis organization and issue a registration certificate and a random 10-digit alphanumeric identification number if all of the following conditions are satisfied:
(1) The prospective medical cannabis organization has submitted all of the following:
(A) The application fee.
(B) An application, including:
(i) The legal name of the prospective medical cannabis organization;
(ii) The physical address of the prospective medical cannabis organization that is not within 1,000 feet of a public or private school existing before the date of the medical cannabis organization application;
(iii) The name and date of birth of each principal officer and board member of the proposed medical cannabis organization; and
(iv) Any additional information requested by the commissioner.
(C) Operating procedures consistent with rules for oversight of the proposed medical cannabis organization, including procedures to ensure accurate record keeping and adequate security measures.
(D) If the city or county where the proposed medical cannabis organization would be located has enacted zoning restrictions, a sworn statement certifying that the proposed medical cannabis organization is in compliance with the restrictions.
(2) None of the principal officers or board members has served as a principal officer or board member for a medical cannabis organization that has had its registration certificate revoked.
(3) None of the principal officers or board members is under 21 years of age.
(4) At least one principal officer is a resident of [state].
(5) Except as provided in subsection (c), if the proposed medical cannabis organization is a dispensary applicant, it is located in a county with more than 20,000 permanent residents, and:

(A) The county does not already contain one dispensary if it has a population of 200,000 or fewer.
(B) The county does not already contain two medical cannabis dispensaries if the county has a population of at least 200,000 and fewer than 500,000.
(C) The county does not already contain three medical cannabis dispensaries if the county has a population of at least 500,000.
(6) If the proposed medical cannabis organization is a cultivation center applicant, the applicant must not cause the number of cultivation centers to exceed the number set by the department pursuant to subsection (b).

(b) The department may limit the total number of cultivation center registrations to be issued in the state, provided that the number is no fewer than 20. If the number of cultivation center registrations that are issued is not sufficient to maintain an adequate supply to patients throughout the state, the department shall issue additional registrations.

(c) The commissioner may register additional medical cannabis dispensaries at its discretion.

(d) When competing applications are submitted for a proposed dispensary within a single county, the commissioner shall use an impartial and numerically scored merit-based selection process to determine which application or applications among those competing will be approved in the county. The commissioner may conduct a background check of the principal officers and board members of the prospective dispensary to carry out this provision.

(e) When competing applications are submitted for a proposed cultivation center, the commissioner shall use an impartial and numerically scored competitive bidding process to determine which application or applications among those competing will be approved. The commissioner may conduct a background check of the principal officers and board members of the prospective center to carry out this provision.

(f) The commissioner shall issue a renewal registration certificate within 10 days of receipt of the prescribed renewal application and renewal fee from a medical cannabis organization if its registration certificate is not under suspension and has not been revoked.

Section 15. Local Ordinances.

Local governments may enact reasonable zoning rules that limit the use of land for medical cannabis organizations to specified areas and that regulate the time, place, and manner of medical cannabis organization operations, provided that no local government may prohibit medical cannabis organizations, either expressly or through the enactment of ordinances or regulations which make their operation impracticable in the jurisdiction.

Section 16. Requirements, Prohibitions, Penalties.

(a) Medical cannabis organizations shall conduct a background check into the criminal history of every person seeking to become a principal officer, board member, agent, volunteer, or employee before the person begins working at the medical cannabis organization.

(b) A medical cannabis organization may not employ any person who:
(1) was convicted of a disqualifying felony offense; or
(2) is under 21 years of age.

(c) The operating documents of a medical cannabis organization must include procedures for the oversight of the medical cannabis organization and procedures to ensure accurate recordkeeping.

(d) A medical cannabis organization shall implement appropriate security measures designed to deter and prevent the theft of cannabis and unauthorized entrance into areas containing cannabis.

(e) All cultivation, harvesting, manufacture, and packaging of cannabis must take place in an enclosed, locked facility at a physical address provided to the commissioner during the registration process. The enclosed, locked facility may only be accessed by agents of the medical cannabis organization, emergency personnel, and adults who are 21 years and older and who are accompanied by medical cannabis organization agents.

(f) A dispensary may acquire usable cannabis or cannabis plants from a registered qualifying patient or a registered designated caregiver only if the registered qualifying patient or registered designated caregiver receives no compensation for the cannabis.

(g) A medical cannabis organization shall not share office space with or refer patients to a practitioner.

(h) A medical cannabis organization may not permit any person to consume cannabis on the property of a medical cannabis organization.

(i) Medical cannabis organizations are subject to reasonable inspection by the commissioner. The commissioner shall give reasonable notice of an inspection.

(j) Before cannabis may be dispensed to a registered qualifying patient or a registered designated caregiver, a dispensary agent must:
(1) make a diligent effort to verify that the registry identification card presented to the dispensary is valid;
(2) make a diligent effort to verify that the person presenting the card is the person identified on the registry identification card presented to the dispensary agent;
(3) not believe that the amount dispensed would cause the cardholder to possess more than the allowable amount of cannabis; and

(4) make a diligent effort to verify that the dispensary is the current dispensary that was designated by the qualifying patient.

(k) A dispensary may not dispense more than 2.5 ounces of cannabis to a registered qualifying patient, directly or via a designated caregiver, in any 14-day period. Dispensaries shall ensure compliance with this limitation by maintaining internal, confidential records that include records specifying how much cannabis is being dispensed to the registered qualifying patient and whether it was dispensed directly to the registered qualifying patient or to the designated caregiver.

Section 17. Department to Issue Regulations.

(a) Not later than 120 days after the effective date of this chapter, the department shall promulgate regulations:
(1) governing the manner in which the department shall consider petitions from the public to add debilitating medical conditions or treatments to the list of debilitating medical conditions set forth in section 3(e) of this chapter, including public notice of and an opportunity to comment in public hearings on the petitions;
(2) establishing the form and content of registration and renewal applications submitted under this chapter;
(3) establishing a system to numerically score competing medical cannabis organization applicants that must include analysis of:
(A) In the case of dispensaries, the suitability of the proposed location and its accessibility for patients;
(B) The character, veracity, background, and relevant experience of principal officers and board members; and
(C) The business plan proposed by the applicant, which in the case of cultivation centers and dispensaries shall include the ability to maintain an adequate supply of cannabis, plans to ensure safety and security of patrons and the community, procedures to be used to prevent diversion, and any plan for making cannabis available to low-income registered qualifying patients.
(4) governing the manner in which it shall consider applications for and renewals of registry identification cards, which may include creating a standardized written certification form;
(5) governing medical cannabis organizations to prevent diversion and theft without imposing an undue burden or compromising the confidentiality of cardholders, including:
(A) oversight requirements;
(B) recordkeeping requirements;
(C) security requirements, including requirements for protection of each location by a fully operational security alarm system;
(D) safety requirements;
(E) restrictions on the advertising, signs, and display of medical cannabis; and
(F) requirements and procedures for the safe and accurate packaging and labeling of medical cannabis;

(6) establishing procedures for suspending or terminating the registration certificates or registry identification cards of cardholders and medical cannabis organizations that commit multiple or serious violations of the provisions of this chapter or the regulations promulgated pursuant to this section;
(7) establishing labeling requirements for cannabis and cannabis products sold by dispensaries.
(8) establishing application and renewal fees for registry identification cards and registration certificates, according to the following:
(i) the total fees collected must generate revenues sufficient to offset all expenses of implementing and administering this chapter, except that fee revenue may be offset or supplemented by private donations;
(ii) the department may establish a sliding scale of patient application and renewal fees based upon a qualifying patient's household income; and
(iii) the department may accept donations from private sources to reduce application and renewal fees.

Section 18. Violations.

(a) A registered qualifying patient, designated caregiver, or medical cannabis organization who willfully fails to provide a notice required by section 12 is guilty of a civil infraction, punishable by a fine of no more than $150.

(b) In addition to any other penalty applicable in law, a medical cannabis organization or an agent of a medical cannabis organization who intentionally sells or otherwise transfers cannabis in exchange for anything of value to a person other than a qualifying patient, a designated caregiver, a visiting qualifying patient, or to a medical cannabis organization or its agent is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both. A person convicted under this subdivision may not continue to be affiliated with the medical cannabis organization and is disqualified from further participation under this chapter.

(c) In addition to any other penalty applicable in law, a qualifying patient or designated caregiver who intentionally sells or otherwise transfers cannabis in exchange for anything of value to a person other than a qualifying patient, a designated caregiver, a visiting qualifying patient, or to a medical cannabis organization or its agent is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both.

(d) A person who intentionally makes a false statement to a law enforcement official about any fact or circumstance relating to the medical use of cannabis to avoid arrest or prosecution is guilty of a misdemeanor punishable by imprisonment for not more than 90 days or by payment of a fine of not more than $1,000, or both. This penalty is in addition to any other penalties that may apply for making a false statement or for the possession, cultivation, or sale of cannabis not protected by this chapter. If a person convicted of violating this section is a qualifying patient or a designated caregiver, the person is disqualified from further participation under this chapter.

(e) A person who knowingly submits false records or documentation required by the commissioner to certify a medical cannabis organization under this chapter is guilty of a felony and may be sentenced to imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both.

(f) A practitioner who knowingly refers patients to a medical cannabis organization or to a designated caregiver, who advertises in a medical cannabis organization, or who issues written certifications while holding a financial interest in a medical cannabis organization shall be fined up to $1,000.

(g) It is a misdemeanor for any person, including the commissioner or another state agency or local government, to breach the confidentiality of information obtained pursuant to this chapter.

(h) A medical cannabis organization shall be fined up to $1,000 for any violation of this chapter, or the regulations issued pursuant to them where no penalty has been specified. This penalty is in addition to any other penalties applicable in law.

Section 19. Suspension and Revocation.

(a) The commissioner may on its own motion or on complaint, after investigation and opportunity for a public hearing at which the medical cannabis organization has been afforded an opportunity to be heard, suspend or revoke a registration certificate for multiple negligent or knowing violations or for a serious and knowing violation by the registrant or any of its agents of this chapter or any rules promulgated pursuant to section 17.

(b) The commissioner shall provide notice of suspension, revocation, fine, or other sanction, as well as the required notice of the hearing, by mailing the same in writing to the registered organization at the address on the registration certificate. A suspension shall not be for a longer period than six months.

(c) A dispensary or cultivation center may continue to cultivate and possess cannabis plants during a suspension, but it may not dispense, transfer, or sell cannabis.

(d) The commissioner shall immediately revoke the registry identification card of any cardholder who sells cannabis to a person who is not allowed to possess cannabis for medical purposes under this chapter, and the cardholder is disqualified from further participation under this chapter.

(e) The department may revoke the registry identification card of any registered qualifying patient or registered designated caregiver who knowingly commits multiple unintentional violations or a serious knowing violation of this chapter.

(f) Revocation is a final decision of the commissioner subject to judicial review.

Section 20. Confidentiality.

(a) Data in registration applications and supporting data submitted by qualifying patients, designated caregivers, and medical cannabis organizations, including data on designated caregivers and practitioners, are private data on individuals that is confidential and exempt from the ____ Freedom of Information Act.

(b) Data kept or maintained by the commissioner may not be used for any purpose not provided for in this chapter and may not be combined or linked in any manner with any other list or database.

(c) Data kept or maintained by the commissioner may be disclosed as necessary for:

(1) the verification of registration certificates and registry identification cards pursuant to section 11;
(2) submission of the annual report required by section 19;
(3) notification of state or local law enforcement of apparent criminal violations of this chapter;
(4) notification of state and local law enforcement about falsified or fraudulent information submitted for purposes of obtaining or renewing a registry identification card;
(5) notification of the _____ Medical Board if there is reason to believe that a practitioner provided a written certification, if the commissioner has reason to believe the practitioner otherwise violated the standard of care for evaluating medical conditions.

(d) Any information kept or maintained by medical cannabis organizations must identify cardholders by their registry identification numbers and must not contain names or other personally identifying information.

(e) At the cardholder's request, the commissioner may confirm the cardholder's status as a registered qualifying patient or a registered designated caregiver to a third party, such as a landlord, school, medical professional, or court.

(f) Any department hard drives or other data-recording media that are no longer in use and that contain cardholder information must be destroyed.

(g) It shall be a misdemeanor punishable by up to 180 days in jail and a $1,000 fine for any person, including an employee or official of the department or another state agency or local government, to breach the confidentiality of information obtained pursuant to this chapter.

Section 21. Business expenses deductions.

Notwithstanding any federal tax law to the contrary, in computing net income for medical cannabis organizations, there shall be allowed as a deduction from state taxes all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on a trade or business as a medical marijuana organization, including reasonable allowance for salaries or other compensation for personal services actually rendered.

Section 22. Advisory Committee.

(a) The legislature shall appoint a nine-member oversight committee comprised of: one member of the House of Representatives; one representative of the department; one member of the Senate; one physician with experience in medical cannabis issues; one nurse; one board member or principal officer of a cannabis testing facility; one individual with experience in policy development or implementation in the field of medical cannabis; and three registered patients.
(b) The oversight committee shall meet at least two times per year for the purpose of evaluating and making recommendations to the legislature and the department regarding:
(1) The ability of qualifying patients in all areas of the state to obtain timely access to high-quality medical cannabis;
(2) The effectiveness of the dispensaries and cultivation centers, individually and together, in serving the needs of qualifying patients, including the provision of educational and support services by dispensaries, the reasonableness of their prices, whether they are generating any complaints or security problems, and the sufficiency of the number operating to serve the state's registered qualifying patients;
(3) The effectiveness of the registered cannabis testing facilities, including whether a sufficient number are operating;
(4) The sufficiency of the regulatory and security safeguards contained in this chapter and adopted by the department to ensure that access to and use of cannabis cultivated is provided only to cardholders;
(5) Any recommended additions or revisions to the department regulations or this chapter, including relating to security, safe handling, labeling, and nomenclature; and
(6) Any research studies regarding health effects of medical cannabis for patients.

Section 23. Annual Report.

(a) The commissioner shall report annually to the legislature on the findings and recommendations of the advisory committee, the number of applications for registry identification cards received, the number of qualifying patients and designated caregivers approved, the nature of the debilitating medical conditions of the qualifying patients, the number of registry identification cards revoked, the number of practitioners providing written certifications for qualifying patients, and the expenses incurred and revenues generated from the medical cannabis program.

(b) The commissioner must not include identifying information on qualifying patients, designated caregivers, or practitioners in the report.

Section 24. Severability.

Any section of this chapter being held invalid as to any person or circumstance shall not affect the application of any other section of this chapter that can be given full effect without the invalid section or application.

Section 25. Date of Effect.

This chapter shall take effect upon its approval.

[In addition, drafters should consider whether to reschedule cannabis under state law to the lowest schedule. They should also consider whether changes should be made to the provisions of state law with penalties for cannabis offenses.]

Appendix R: Overview and Explanation of MPP's Model Bill

The relationship of the model bill and state law to federal law

Although the U.S. Supreme Court ruled on June 6, 2005 (*Gonzales v. Raich*) that the federal government can prosecute patients in states that removed their criminal penalties for the medical use of marijuana, the court did not question a state's ability to allow patients to grow, possess, and use medical marijuana under state law.

Indeed, the medical marijuana laws passed by voter initiatives in 11 states and by 11 legislatures since 1996 continue to provide effective legal protection for patients and their providers because they are carefully worded.

Of course, the model bill only provides protection against arrest and prosecution by state or local authorities. State laws cannot offer protection against the possibility of arrest and prosecution by federal authorities. Even so, because 99% of all marijuana arrests are made by state and local — not federal — officials, properly worded state laws can effectively protect 99 out of every 100 medical marijuana users who would otherwise face prosecution at the state level.

In truth, changing state law is the key to protecting medical marijuana patients from arrest, as there has not been one documented case where a patient has been convicted in a federal court for a small quantity of marijuana in the 23 states that have effective medical marijuana laws. In addition, in June 2013, the U.S. Deputy Attorney General James Cole wrote a memo to U.S. prosecutors advising that is is "not an efficient use of federal resources to focus enforcement efforts on seriously ill individuals, or on their individual caregivers" and advising against targeting marijuana businesses that comply with state regulations that address eight areas of federal concern.

Four key principles for effective state medical marijuana laws

In order for a state law to provide effective protection for seriously ill people who engage in the medical use of marijuana, a state law must:

1. define what is a legitimate medical use of marijuana by requiring a person who seeks legal protection to (1) have a medical condition that is sufficiently serious or debilitating, and (2) have the approval of his or her medical practitioner;
2. avoid provisions that would require physicians or government employees to violate federal law in order for patients to legally use medical marijuana;
3. provide at least one of the following means of obtaining marijuana, preferably all three: (1) permit patients to cultivate their own marijuana; (2) permit primary caregivers to cultivate marijuana on behalf of patients; and (3) authorize nongovernmental organizations to cultivate and distribute marijuana to patients and their primary caregivers. In addition, it should permit patients or primary caregivers to purchase marijuana from the criminal market (which patients already do illegally);

4. implement a series of sensible restrictions, such as prohibiting patients and providers from possessing large quantities of marijuana, prohibiting driving while under the influence of marijuana, and so forth.

The importance of precisely worded state laws

Because federal law prohibits the medical use of marijuana, state medical marijuana legislation must be worded precisely in order to provide patients and providers with legal protection under state law. Even changing just one or two words in the model bill can make it symbolic, rather than truly effective. For example, it is essential to avoid use of the word **"prescribe,"** since federal law prohibits doctors from prescribing marijuana. Doctors risk losing their federally controlled license to prescribe all medications if they "prescribe" marijuana — which would be useless anyway because pharmacies are governed by the same regulations and cannot fill marijuana prescriptions. Physicians are, however, permitted under federal law to evaluate the relative risks and benefits of the medical use of marijuana. Thus, to establish a patient's legitimate medical marijuana use, the state law must contain language accepting a physician's statement that says, "the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana," or something similar.

The importance of this seemingly trivial distinction is made clear by the case of Arizona, which passed a ballot initiative (Proposition 200) by 65% of the vote in November 1996. Arizona's original law was dependent upon patients possessing marijuana "prescriptions." As a result, the initiative provided no legal protection to patients, and a new measure had to be voted on in 2010 to create an effective law.

There are numerous other important technical nuances that are impossible to anticipate without having spent several years working on medical marijuana bills and initiatives nationwide. Consequently, it is crucial to discuss ideas and concerns with MPP before changing even one word of the model bill.

Summary of MPP's Model Medical Marijuana Legislation

The Marijuana Policy Project's model medical marijuana legislation would create a limited exception to a state's criminal and civil laws to permit the doctor-advised medical use of marijuana by patients with serious medical conditions. It would also provide for the regulated cultivation, dispensing, and testing of medical marijuana.

A patient would be protected from arrest if his or her physician certifies, in writing, that the patient has a specified debilitating medical condition and that the patient would receive therapeutic or palliative benefit from medical marijuana. The patient would send a copy of the written certification to the state department of health, and the department would issue an ID card after verifying the information. Police officers could verify an ID card's validity with the department. As long as the patient is in compliance with the law, there would be no arrest.

Patients could also designate a caregiver to assist them, such as by picking up medical marijuana from a dispensary or cultivating plants. The caregivers would also have to be registered with the state, and would have to pass a background check. Patients could only have a single caregiver unless they demonstrate that more are needed due to the patient's age or disability. Unless the patient lives at a care facility where the caregiver works, caregivers could assist no more than five qualifying patients.

Patients and caregivers would be allowed to possess up to 2.5 ounces of marijuana. Either the patient or his or her caregiver would be allowed to cultivate up to six plants in a secure location and to possess the harvested marijuana for the patient's medical use.

The legislation would allow for the state-regulated, private distribution of medical marijuana. The state health department would register and regulate four categories of businesses that would produce, process, dispense, and test medical cannabis products. The department could license additional types of businesses, such as distribution or delivery services.

The health department would craft rules including governing application and licensing fees, security, record keeping, health and safety, lab testing, advertising, packaging, and labeling. Violations would be subject to fines, with serious or multiple violations resulting in license suspensions or revocations. All medical cannabis businesses would be subject to inspection.

The bill would also provide a medical necessity affirmative defense that patients could raise in court if they did not have ID cards at the time of their arrest. This is an important provision, as some legitimate patients will not register because their doctors will not sign a written certification due to an unwarranted fear of federal repercussions.

Because the Americans with Disabilities Act does not protect medical cannabis, the bill includes protections from discrimination in employment, housing, health care (such as organ transplants), and child custody. It would not protect from discrimination that is required by federal law or to receive a federal contract. In addition, no employer would have to allow marijuana use on-site or to allow patients to work while impaired.

Meanwhile, the bill maintains commonsense restrictions on the medical use of marijuana, including prohibitions on smoking marijuana in public and driving under the influence of marijuana. Insurance providers would not have to cover medical marijuana. Finally, patients could not take any action while under the influence of marijuana if doing so would be negligent.

Appendix S: Federal Law Enforcement and State Medical Marijuana Laws

During President Barack Obama's first presidential campaign in 2008, he made several statements[1,2] articulating his belief that federal law enforcement priorities should not be directed toward enforcement of federal marijuana laws in states that allow for the use of medical marijuana. Since October of 2009, the Department of Justice has issued three policy memos regarding enforcement of federal marijuana laws in states that have chosen to remove state criminal penalties for medical marijuana patients, their caregivers, and providers.

In short, both based on the memos and on what has been happening in practice, the federal government is not targeting individual patients and those who care for them, and it does not intend to target marijuana businesses — whether they are medical or adult use — in states that create and implement regulations addressing eight areas of federal concern. Federal agents have, however, targeted larger-scale providers in states that do not have clear laws or state licensing and regulations on dispensaries.

Patients and Caregivers: Federal Enforcement Should Not Target Them

In October 2009, then-Deputy Attorney General David Ogden issued a memorandum to United States attorneys advising those in states with medical marijuana laws to "not focus federal resources . . . on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana."[3]

A subsequent DOJ memo, issued by Deputy Attorney General James Cole in June 2011, echoed the hands-off policy when it comes to enforcing federal marijuana laws against patients and their loved ones who care for them, stating that it "is likely not an efficient use of federal resources to focus enforcement efforts on individuals with cancer or other serious illnesses who use marijuana . . . consistent with applicable state law, or their caregivers."[4] Cole's 2013 memo again reaffirmed that patients and caregivers should not be targeted.

State Employees: No Indication They Are at Risk

Despite inquires about state employees from Gov. Chris Christie (R – New Jersey) and others, not one of the three Department of Justice memos makes any reference to them. The only U.S. attorneys who have addressed questions about state employees involved in medical marijuana programs are the two U.S. attorneys for Washington state and the U.S. attorney for Arizona. Collectively, these statements indicate that state employees would only be at risk if they actually handled marijuana, but would not be targeted if they do not. No state medical marijuana

[1] Tierney, John. "Obama to Stop Raids on Marijuana Clinics," *New York Times*, May 14, 2008. http://tierneylab.blogs.nytimes.com/2008/05/14/obama-to-stop-raids-on-marijuana-clinics/

[2] "Obama: Decriminalize Pot," *Washington Post*, January 31, 2008. http://www.washingtontimes.com/news/2008/jan/31/obama-decriminalize-pot/

[3] David W. Ogden, Deputy Attorney General, "Memorandum for Selected United States Attorneys on Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana," October 19, 2009. http://www.justice.gov/opa/documents/medical-marijuana.pdf

[4] James M. Cole, Deputy Attorney General, "Memorandum for Untied States Attorneys: Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use," June 28, 2011. http://www.justice.gov/oip/docs/dag-guidance-2011-for-medical-marijuana-use.pdf

law requires state employees to handle marijuana, and no state employee has ever been federally prosecuted for working on a medical marijuana program.

A letter from the two U.S. attorneys in Washington state to then-Gov. Chris Gregoire (D) was the only U.S. attorney letter to mention state employees. It said employees would not be "immune" from liability for carrying out the tasks laid out under a bill that was under consideration.[5] One of the authors of the letter, U.S. Attorney Michael Ormsby, was interviewed by an Arizona paper and distinguished the Washington bill from Arizona's law, specifying that the reason employees were listed in his letter was because they would have to grade marijuana, and thus, handle it.[6] After Arizona Gov. Jan. Brewer announced a federal lawsuit premised largely on the idea that state employees were at risk, then-U.S. Attorney for Arizona Dennis Burke called the governor's claim "disingenuous."[7] He explained that he would not target state employees, and that he would have listed them in the letter if they were at risk. Additionally, the Department of Justice stressed in their motion to dismiss Gov. Brewer's suit that there is no "genuine threat that any state employee will face imminent prosecution under federal law."[8]

Without a clear and explicit warning, it is inconceivable that the federal government would prosecute a state employee for carrying out a medical marijuana program, particularly one that does not involve handling marijuana. This is particularly the case since two court cases have found that registering patients and providers and regulating dispensaries is not a federal crime.[9]

Dispensaries: Federal Enforcement Should Not Target Them if Acting in Compliance With Strong Regulatory Framework

In a 2011 Department of Justice memorandum issued by Deputy Attorney General James Cole,[10] the department dramatically shifted its previous guidance to prosecutors, stating that the policy statements in the Ogden memo did not apply to business enterprises. However, in a subsequent memo issued in August 2013,[11] Deputy Attorney General Cole made clear that this previous policy limitation no longer applies in a well-regulated environment. Even large-scale, for-profit businesses are not supposed to be targeted if they do not place department interests at risk.

The cornerstone of the August 2013 policy memo is its emphasis on state regulation. According to the memo, the federal government will focus its efforts on eight enforcement priorities and rely on state law enforcement authorities to manage areas that are not federal priorities. Deputy Attorney General Cole made clear

[5] Letter to Governor Christine Gregoire from Washington state U.S. Attorneys, Jenny A. Durkan and Michael C. Ormsby, April 14, 2011. http://seattletimes.nwsource.com/ABPub/2011/04/14/2014778917.pdf

[6] Fischer, Howard. "Federal Prosecutor: Brewer, Horne Twisting Medical Marijuana Memo," *East Valley Tribune,* May 26, 2011. http://www.eastvalleytribune.com/arizona/politics/article_62e3877a-87ee-11e0-95eb-001cc4c03286.html

[7] Wyloge, Evan. "U.S. attorney: Brewer and Horne's lawsuit logic 'disingenuous,'" *Arizona Capitol Times*, May 27, 2011. http://azcapitoltimes.com/news/2011/05/27/us-attorney-brewer-and-horne's-lawsuit-logic-'disingenuous'/

[8] Assistant Attorney General Tony West, DOJ Assistant Branch Manager Arthur R. Goldberg, Trial Attorney with the United States Department of Justice Scott Risner, *Federal Defendant's Motion to Dismiss and Memorandum of Law in Support Thereof*, United States District Court, District of Arizona case No. 2:11-cv-01072-SRB, p.2, August 1, 2011.

[9] *County of San Diego v. San Diego NORML* 165 Cal.App.4th 798 (2008) *cert. denied*, 129 S. Ct. 2380 (2009), *Qualified Patients Association v. City of Anaheim*, 187 Cal.App4th 734 (2010).

[10] Memo from James M. Cole, June 28, 2011, *supra.*

[11] James M. Cole, Deputy Attorney General, "Guidance Regarding Marijuana Enforcement, United States Department of Justice, Office of the Deputy Attorney General," August 29, 2013. http://www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf

that the department expects states to implement a strong regulatory framework to ensure that the U.S. government's concerns are addressed. The memo states, "The Department's guidance in this memorandum rests on its expectation that state 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."[12]

The eight areas of particular concern to the department are:

1. Preventing the distribution of marijuana to minors;
2. Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
3. Preventing the diversion of marijuana from states where it is legal under state law in some form from going to other states;
4. Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
5. Preventing violence and the use of firearms in the cultivation and use of marijuana;
6. Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
7. Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
8. Preventing marijuana possession or use on federal property.[13]

Policy in Practice

While some were surprised the department continued medical marijuana prosecutions following the 2009 Ogden memo, the 2013 Cole memo is essentially consistent with what department policy has been in practice throughout the Obama administration. The vast majority of federal prosecutions took place in states that did not provide clear and robust regulations.

Larger-scale medical marijuana providers in California and Montana in particular bore the brunt of the federal law enforcement activity due to the lack of regulatory frameworks for medical marijuana businesses in those states. By contrast, states with strong regulations for medical marijuana businesses (such as Arizona, Colorado, Connecticut, Delaware, Illinois, Maine, Massachusetts, Minnesota, New Jersey, New Mexico, Nevada, Rhode Island, and Vermont) saw little or no federal law enforcement activity. Federal enforcement action in states with clear regulations has generally been limited to making dispensaries locate further away from schools and taking action against those breaking state as well as federal law.

[12] *Id.*
[13] *Id.*

Federal Law and Preemption

It is important to note that all three policy memos have been clear that they do not change federal law. Possession, cultivation, and sale of marijuana remain illegal under the federal Controlled Substances Act, and states may not prevent the federal government from enforcing its own laws. Nonetheless, both federal and state governments establish their own laws under our federalist system of government, and state laws are not preempted unless they compel citizens to break federal law. The federal government has not argued that any state laws regulating marijuana violate this principle, and in some cases where third parties have made the case, they have typically lost.[14]

Deputy Attorney General Cole has acknowledged in Congressional testimony, "It would be a very challenging lawsuit to bring to preempt the state's decriminalization law. We might have an easier time with their regulatory scheme and preemption, but then what you'd have is legalized marijuana and no enforcement mechanism within the state to try and regulate it and that's probably not a good situation to have." Consequently, the federal government has no plans to challenge the laws regulating medical marijuana in the 23 states and District of Columbia nor the laws in Colorado, Washington, Alaska, and Oregon that regulate marijuana similarly to alcohol.

Conclusion: States as the Laboratories of Democracy

It is clear that the federal government has taken a step back from strictly enforcing its own laws related to the cultivation, possession, and sale of medical marijuana and is encouraging those states that choose to enact medical marijuana laws to do so if the laws are accompanied by strong regulatory frameworks. Federal marijuana policy now gives state legislatures and voters the opportunity to implement laws that protect the sick and suffering, their caregivers, and their providers from arrest and prosecution for using marijuana with a doctor's recommendation. Well-regulated programs, most with dispensaries, are successfully providing seriously ill patients with access to their medicine and preventing them from having to support the criminal market throughout the country. States should continue to implement duly enacted medical marijuana programs, as well as establish new programs.

[14] See: *White Mountain Health Center Inc. v. County of Maricopa*, CV-2012-053585, (December 3, 2012), and *Arizona v. United States*, Case No. CV 11-1072-PHX-SRB (D.C. Ariz. January 4, 2012).

Appendix T: Do Medical Marijuana Laws Increase Teens' Marijuana Use?

Since states first began considering medical marijuana laws, claims have frequently been made that the laws "send the wrong message" to adolescents, causing their marijuana use to increase. Now, more than more than 19 years after the passage of the nation's first effective state medical marijuana law, a considerable body of data has found that those fears were not warranted.

Twenty-three states and Washington, D.C. now have effective medical marijuana laws.[1] In 17 of those states, government surveys have produced before-and-after data on teens' marijuana use. In 13 states, the data shows overall decreases, nearly half of which were outside confidence intervals. No state with a statistically significant change saw an increase in teens' marijuana use.

Several other researchers and health experts have examined the data in recent years and have also found the data to be reassuring. Dr. Seth Ammerman published an article in the winter 2011 edition of *California Pediatrician*, finding, "Medical Marijuana for adults in all states that have approved medical marijuana, with one exception, has not led to an increase in recreational marijuana use in adolescent populations."[2] (Since then, new data has come out in that state — Michigan — and the change is no longer outside of the confidence interval.)

Here is a review of the most comprehensive data on teens' current (past 30-day) marijuana use in each of medical marijuana states. In all but four of the states, the data included is for all high schoolers. In those four states, data is not available for all high schoolers, so this instead includes data from the oldest grade with before-and-after data: 11th grade in California and Oregon and 12th in Washington. The only "before-and-after" data for Colorado was a small survey of 12-17 year olds that does not control for age.

[1] Seventeen additional states have some other type of legislation that seeks to provide access and legal protections to patients using at least certain strains and preparations of cannabis.

[2] Ammerman, Seth, M.D. "Medical Marijuana: Update for the Pediatrician," *California Pediatrician,* Vo. 27, No. 1 (Winter 2011): 11-13 available at http://www.aap--ca.org/news/caPed/California%20Pediatrician%20--%20Winter%202011.pdf

State	Pre-Law Current Use Rates	Most Recent Use Rates	Trend?	Data Source
California (1996)	25.9% ('95/'96)	24% ('11-'13)	decrease (within confidence interval, changed survey)	California Student Survey & California Healthy Kids Survey
Alaska (1998)	28.7% (1995)	19.7% (2013)	decrease	The CDC's Youth Risk Behavior Surveillance System (YRBSS)
Oregon (1998)	21% (1998)	20.9% (2013)	decrease (within confidence interval; changed survey)	Oregon Public Schools Drug Use Survey & Oregon Healthy Teens
Washington (1998)	28.7% (1998)	26.7% (2014)	decrease (changed survey)	Washington State Survey of Adolescent Health Behaviors & Healthy Youth Survey
Maine (1999)	30.4% (1997)	21.3% (2013)	decrease	The CDC's YRBSS
Hawaii (2000)	24.7% (1999)	18.9% (2013)	decrease	The CDC's YRBSS
Nevada (2000)	25.9% (1999)	18.7% (2013)	decrease	The CDC's YRBSS
Colorado (2000)	10.3% (1999)	11.16% ('12-'13)	increase (within confidence interval)	National Survey on Drug Use & Health
Vermont (2004)	28.2% (2003)	25.7% (2013)	decrease	The CDC's YRBSS
Montana (2004)	23.1% (2003)	21% (2013)	decrease (within confidence interval)	The CDC's YRBSS
Rhode Island (2006)	25% (2005)	23.9% (2013)	decrease (within confidence interval)	The CDC's YRBSS
New Mexico (2007)	26.2% (2005)	27.8% (2013)	increase (within confidence interval)	The CDC's YRBSS
Michigan (2008)	18.0% (2007)	18.2% (2013)	increase (within confidence interval)	The CDC's YRBSS
New Jersey (2010)	20.3% (2009)	21% (2013)	increase (within confidence interval)	The CDC's YRBSS
Arizona (2010)	23.7% (2009)	23.5% (2013)	decrease (within confidence interval)	The CDC's YRBSS
Wash., D.C. (2010)	No data available; Washington, D.C. has never conducted a YRBSS			
Delaware (2011)	25.8% (2009)	25.6% (2013)	decrease (within confidence interval)	The CDC's YRBSS
Connecticut (2012)	24.1% (2011)	26% (2013)	increase (within confidence interval)	The CDC's YRBSS
Massachusetts (2012)	27.9% (2011)	24.8% (2013)	decrease	The CDC's YRBSS
New Hampshire (2013)	No "after" data available, law is too new.			
Illinois (2013)	No "after" data available, law is too new.			
Maryland (2014)	No "after" data available, law is too new.			
Minnesota (2014)	No "after" data available, law is too new.			
New York (2014)	No "after" data available, law is too new.			

This data should put to rest claims that removing criminal penalties from seriously ill patients' medical use of marijuana increases teens' marijuana use.

Appendix U: State Medical Marijuana Program Finances

With many states around the country facing serious budget challenges, states considering medical marijuana programs may be concerned with the potential cost of administering such laws. However, data collected from states with functioning medical marijuana programs — including those that regulate dispensaries — show that such concerns are unfounded.

States' medical marijuana-related revenue comes in several forms, typically including registration fees for patients, licensing fees for businesses, and taxes on business transactions or sales. Most states require the departments that administer their medical marijuana programs to set the fees high enough to cover all costs for administering the programs. Currently, no state medical marijuana program is facing significant budget deficits. In fact, most operate at a surplus, with some generating millions of dollars in badly needed revenue.

As of late 2015, all of the medical marijuana states except Michigan and Montana have laws that recognize dispensaries or other entities in which patients can purchase medical marijuana. Fifteen of the programs — in Arizona, Colorado, Connecticut, Delaware, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and the District of Columbia — have fully implemented systems where dispensaries or similar entities are operational.

Here is a sampling of the revenues and expenses of state medical marijuana programs, for those states where the data was available. A more comprehensive overview of medical marijuana program finances and fee structures is available on MPP's website.[1] The District of Columbia has issued licenses for dispensaries, but has not yet reported revenue or expenditures for its program. Two other states, California and Montana, do not have a statewide regulatory structure but do have dispensaries licensed at the local level in some communities.

Alaska

Alaska charges a very low patient fee — $25 for initial applications and $20 for renewals —but it still covers its modest costs. The state reported the program generated $41,445 in FY 2014. The Medical Marijuana Registry is part of the Bureau of Vital Statistics and thus could not provide independent expense information. However, it is estimated that the program cost $22,277 in FY 2012.[2]

Arizona

Arizona's medical marijuana fees brought in more than $8.7 million during FY 2014, which was $1.3 million more than regulatory expenses for that fiscal year.[3] The program is generating so much revenue that it has been able to make several substantial nonessential expenditures. In addition to the revenue from fees, the program is resulting in millions in annual tax revenue. Arizona's program esti-

[1] A more extensive state-by-state review of program expenses is available at www. mpp.org/MedicalFinances while a review of state fees and taxes is at mpp.org/MedicalFeesAndTaxes

[2] Email communication with Andrew Jessen, March 18, 2013.

[3] Third Annual Medical Marijuana Report — 2014 http://azdhs.gov/documents/licensing/medical-marijuana/reports/2014/az-medical-marijuana-program-annual-report-2014.pdf

mates that $112 million worth of marijuana was sold in 2014.[4] The state imposes a 6.6% sales tax, which meant tax revenue approached $7 million in 2014.

California

California does not yet have a statewide licensing and regulatory structure for its dispensaries, although that will change by 2018 pursuant to a 2015 law. However, it does tax collectives and cooperatives, which are allowed under state law. The state Board of Equalization estimated that the state brought in $50 million in annual sales tax revenue in FY 2014.[5] In addition to the statewide sales tax of 7.5%, cities levy up to 1.5% more in local sales taxes.

Several cities and counties have set up regulations and collect licensing fees, and the California Department of Public Health also runs a voluntary registry program for patients, which generated $617,000, with $461,000 in expenses during fiscal years 2012/2013 and 2013/2014.[6]

Colorado

Colorado's robust medical cannabis program is generating millions of dollars in surplus revenue each year, despite a relatively modest fee structure. The state's medical business application and licensing fees brought in $7.1 million in FY 2014, while enforcement of medical regulations accounted for approximately $3.49 million of the Marijuana Enforcement Division's $9.56 million of expenses in FY 2014 (the MED also regulates adult use businesses). Thus, the MED generated more than twice the revenue in medical marijuana business fees than were needed to regulate businesses.[7] In addition, in FY 2014, medical marijuana state sales taxes brought in more than $10.5 million to state coffers.

Furthermore, the state's patient and caregiver registry, run by the Department of Public Health and Environment, took in $3 million in fee revenue in FY 2014.[8] The patient registry fees are set to cover expenses, but they have generated such a significant surplus that $9 million from the program was allocated for grant funding to medical cannabis research in December 2014 and February 2015.[9]

Maine

Maine's medical marijuana program — which includes eight dispensaries and a voluntary patient registry — has been operating at a surplus during the past few years. The program generated $1,246,064 in medical marijuana fees revenue during the 12 months ending with June 2014.[10] The expenses for this period were $384,751, resulting in $861,313 net income. Because the program is operating at a surplus, fees were reduced by 20 percent for 2015.

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[4] AMMA End of Year Report — 2014 http://azdhs.gov/documents/licensing/medical-marijuana/reports/2014/arizona-medical-marijuana-end-of-year-report-2014.pdf

[5] Source of California tax revenue information is November 16, 2015 email communication with Venus Stromberg of the Board of Equalization.

[6] California Department of Public Health, "Medical Marijuana Program Revenues, Expenditures and Loan Repayment," https://www.cdph.ca.gov/programs/MMP/Documents/Program%20Revenues,%20Expenditures%20and%20Loan%20Repayment.pdf

[7] Source of Colorado MED finance information and state tax information is April 20, 2015 email communication with Julie Postlethwait of the Department of Revenue and accompanying document, "Report to the Joint Budget Committee and Joint Finance Committees."

[8] Source of MMR finance information is May 5, 2015 email communication with Natalie Riggins of CDPHE and accompanying budget.

[9] See: John Ingold, "Colorado preparing to spend $9 million on medical marijuana research," *Denver Post,* June 12, 2014.

[10] "Maine Medical Use of Marijuana Program: January 1, 2014 - December 31, 2014, Annual Report to the Maine State Legislature."

Michigan

The Michigan Department of Licensing and Regulatory Affairs (LARA) is responsible for processing applications and setting fees, which are sufficient to cover all program expenses. In FY 2014, the registry brought in $8.88 million and spent only $5.86 million, leaving a surplus of approximately $3 million.[11] The department analyst did not provide a breakdown of expenses, but as of mid-2012, the program employed 16 full-time staff, seven temporary staff, and one student.

New Mexico

New Mexico's program fees are required to cover expenses, and they do so. In FY 2014, New Mexico's entire medical cannabis program — which included 23 licensed producers at the time — cost $780,000 to administer.[12] That fiscal year, the program generated $680,000 in fees from licensed producer fees and $90,120 from patients' personal production license fees. Patients who do not cultivate cannabis are not charged registry fees.

In addition, medical marijuana sales are subject to a gross receipts tax of about 5.1% to 8.9%, depending on the locality. According to the state Department of Health, in FY 2014, licensed nonprofit producers paid $1,459,105 in gross receipts taxes. This is in addition to annual revenue collected from fees, which cover program costs.

Oregon

The Oregon Medical Marijuana Program (OMMP) began in 1998 and runs entirely on registry fees. The state began licensing dispensaries in 2014, and 315 dispensaries have been approved as of October 30, 2015. The OMMP has been in the black every biennium except the first one (ending in 1999), when it was in the red by $14,000. Since 2011, the program has not been responsive to MPP's inquiries about financial information. Despite the fact that the program was already generating a surplus, in late 2011, the state doubled the standard patient registry fees to $200. There is a discounted fee of $60 for food stamp recipients, or $20 for those receiving SSI benefits and certain service-disabled veterans. The fee is $50 for those enrolled in the Oregon Health Plan.[13]

Rhode Island

Rhode Island's Department of Health is required to submit a biannual medical marijuana report to the General Assembly that includes an evaluation of program costs. For the two-year period ending in December 2014, the medical marijuana program cost an estimated $124,140. The Medical Marijuana Registration Revenue for that period was an estimated $1,681,506, reflecting a substantial surplus.[14]

[11] MMMA Program Information and Financial Data — 2014 http://www.michigan.gov/documents/lara/BHCS_MMMP_PA_252_Section_50712_2014_Report_12-2-14_475751_7.pdf

[12] Source of all revenue information, including tax revenue, is April 20, 2015 email with Andrea Sundberg of the New Mexico Department of Health. Budget and expense information is from a March 25, 2015 email.

[13] Source of fees information is The Oregon Medical Marijuana Program Statistical Snapshot July, 2015, available at https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Documents/ed-materials/ommp_stats_snapshot.pdf.

[14] Biannual Medical Marijuana Report to General Assembly, 12/01/2014, available at http://www.health.ri.gov/publications/programreports/2015MedicalMarijuana.pdf.

Vermont

Vermont's program operates on a modest budget of $166,000 and pays for two full-time positions.[15] During FY 2015, Vermont's program brought in a total of $224,000, meaning the program generated a surplus of nearly $60,000. Revenue is derived entirely from fees. Patients and caregivers pay $50 for registration cards while dispensaries pay $2,500 to apply for a license. Registered dispensaries must pay an annual fee of $20,000 for their first year and $25,000 in subsequent years. As of March 2015, there were four registered dispensaries, 1,727 registered patients, and 202 registered caregivers.[16]

[15] Source of Vermont's financial figures is phone communication with program administrator Lindsey Wells, November 17, 2015.

[16] Email communication with program administrator Lindsey Wells, March 11, 2015.

Appendix V: Medical Marijuana Program Implementation Timelines

The key to a medical marijuana program running smoothly is its timely and effective implementation by the appropriate state agency. Some legislators considering medical marijuana laws believe programs will take several years to implement. In reality, in most states with medical marijuana laws, agencies have implemented medical marijuana ID card programs and finalized regulations within a year after the laws' passage. In some cases, it has taken longer than that until a state's dispensaries are up and running, especially when a governor has stalled implementation. However, states like Colorado, Maine, and Minnesota have shown that even dispensary programs can be effectively implemented in one year if the executive branch does not delay.

The following chart summarizes each medical marijuana program's timeline for implementation:

State	Year Enacted	Date When State Began Accepting ID Card Applications	Dispensaries (or the equivalent) and Timelines for Their Implementation	Comments
Alaska	Nov. 1998	Early June 1999	N/A — Law does not include state dispensary registrations. However, voters approved regulating marijuana for adults' use in Nov. 2014. Regulations are due by Nov. 2015. The first licenses should be issued by May 2016.	Implementation of the patient and caregiver ID card program took about seven months. The first licenses for adult use businesses are anticipated about 18 months after the law's enactment.
Arizona	Nov. 2010	April 14, 2011	The Arizona Department of Health Services published final rules on March 28, 2011. Dispensaries were granted certificates on Aug. 7, 2012, and the first one opened in Dec. 2012. The Department issued additional rules on Dec. 28, 2012.	Implementation of the patient and caregiver ID card program took about five and a half months. An unsuccessful lawsuit by Gov. Jan Brewer delayed the implementation of dispensaries. The first dispensaries opened 25 months after the passage of the state law.
California	Nov. 1996; voluntary ID cards enacted in Oct. 2003; funding enacted July 31, 2004; regulatory system Oct. 9, 2015	Each of 58 counties had to implement ID cards and some delayed. An initial pilot program began in Fall 2005. Two small counties still have not implemented ID cards.	Although there are hundreds of dispensaries in California, the state did not provide for statewide licensing and regulation until Oct. 2015. The existing patchwork of local regulation and collective system will phrase out and statewide licensing will begin by 2018.	The county-by-county implementation of ID cards in California has not been a successful model. Some counties dragged their feet, and three even sued (unsuccessfully) to claim the law was preempted by federal law.

State	Year Enacted	Date When State Began Accepting ID Card Applications	Dispensaries (or the equivalent) and Timelines for Their Implementation	Comments
Colorado	Nov. 2000: Voter amendment to constitution; June 2010: dispensary law	June 1, 2001	Dispensaries already existed before the state law passed in June 2010. They had to complete state forms and pay a fee by Aug. 1, 2010. Dispensary regulations were finalized on June 15, 2011 and went into effect on July 30, 2011.	Implementation of the patient and caregiver ID card program took just under seven months. The dispensary regulation bill began phasing in within two months of its passage, with the initial state form and fees due. Dispensary regulations were finalized and went into effect within one year of the law's passage.
Connecticut	May 2012	Temporary registrations became available on Oct. 1, 2012	The state began accepting applications in Sept. 2013, and the deadline was Nov. 15, 2013. As of Oct. 2015, four cultivation centers and six dispensaries have been licensed. The first dispensaries opened in Oct. 2014.	Temporary patient ID cards became available within five months of the law's passage. The first dispensaries opened about two years and five months after the law's passage.
Delaware	Passed May 2011; effective July 1, 2011	July 2, 2012	Final regulations were approved in Jan. 2014. First pilot medical marijuana "compassion center" was approved on Aug. 11, 2014. The First State Compassion Center opened on June 26, 2015.	Gov. Jack Markell significantly delayed implementation in light of a letter he received from Delaware's U.S. attorney in Feb. 2012. Markell decided to restart the program in Aug. 2013, but with only one pilot compassion center. That center was approved about three years and three months after the law's enactment and opened four years after enactment.
Connecticut	May 2012	Temporary registrations became available on Oct. 1, 2012	The state began accepting applications in Sept. 2013, and the deadline was Nov. 15, 2013. As of Oct. 2015, four cultivation centers and six dispensaries have been licensed. The first dispensaries opened in Oct. 2014.	Temporary patient ID cards became available within five months of the law's passage. The first dispensaries opened about two years and five months after the law's passage.
Delaware	Passed May 2011; effective July 1, 2011	July 2, 2012	Final regulations were approved in Jan. 2014. First pilot medical marijuana "compassion center" was approved on Aug. 11, 2014. The First State Compassion Center opened on June 26, 2015.	Gov. Jack Markell significantly delayed implementation in light of a letter he received from Delaware's U.S. attorney in Feb. 2012. Markell decided to restart the program in Aug. 2013, but with only one pilot compassion center. That center was approved about three years and three months after the law's enactment and opened four years after enactment.

State	Year Enacted	Date When State Began Accepting ID Card Applications	Dispensaries (or the equivalent) and Timelines for Their Implementation	Comments
District of Columbia	Nov. 1998 initiative. Due to Congressional intervention, the law did not go into effect until 2010. The D.C. Council revised it in May 2010, and it went into effect in July 2010.	June 11, 2013	Regulations were published and went into effect on April 15, 2011 and were amended on Aug. 12, 2011. The District granted preliminary approval to several dispensary applicants on June 12, 2012, and the first dispensary opened in July 2013.	Dispensary regulations were drafted within 10 months of the law's effective date. The application process took longer, and it was just over three years between when the law went into effect and the first dispensary opened.
Hawaii	June 2000 initial law; dispensary law signed July 14, 2015	Dec. 28, 2000	Hawaii's law did not provide for dispensaries until the summer of 2015. The state is expected to allow up to 16 dispensaries as early as July 2016.	Implementation of the patient and caregiver ID card program took just over six months.
Illinois	Signed into law Aug. 1, 2013; effective Jan. 1, 2014	Qualifying patients with last names beginning with A-L: Sept. 1, 2014; M-Z: Nov. 1, 2014; year-round applications: Jan. 1, 2015	The Joint Committee on Administrative Rule approved medical marijuana rules on July 15, 2014. The state accepted both dispensary and cultivation center applications from Sept. 8, 2014 until Sept. 22, 2014. In Feb. 2015, the state issued 18 growing licenses and 52 dispensary licenses. The first dispensaries opened on Nov. 9, 2015.	Patient and caregiver ID card applications were first accepted 13 months after enactment. Medical marijuana business licenses were issued about 18 months after enactment. The first dispensaries opened about two years and three months after enactment.
Maine	Nov. 1999 initiative; revised by voters in Nov. 2009 and by the legislature in Spring 2010 and Spring 2011	Early July 2009	Six dispensary registrations were issued in July 2010 and two more were issued in Aug. 2010. This was within 10 months of enactment of the law. The first dispensary opened in March 2011.	Maine's initial law did not have a patient registry or regulated dispensaries. The 2009 law was fully implemented within a year of its passage, with regulations enacted and ID cards and dispensary registrations issued. The first dispensary opened less than 17 months after the law's passage.
Maryland	Passed April 14, 2014; effective June 1, 2014	The state is not accepting patient ID card applications as of Oct. 2015. However, patients can use their doctors' written commendations as ID cards until the state begins offering them.	The Natalie M. LaPrade Medical Marijuana Commission submitted regulations on Nov. 13, 2014. They were adopted in Sept. 2015, and business applications were due in Nov. 2015. Medical cannabis is expected to be available to patients in the second half of 2016.	Maryland enacted a medical marijuana law in 2013 that would have allowed academic medical centers to dispense marijuana. No center stepped forward, and the law was revised in 2014 to allow for dispensaries and growers. Regulations were expected to be completed a year and five months after the law's enactment.

State	Year Enacted	Date When State Began Accepting ID Card Applications	Dispensaries (or the equivalent) and Timelines for Their Implementation	Comments
Massachusetts	Passed Nov. 2012; effective Jan. 1, 2013	The state began accepting patient ID card applications in Oct. 2014. In addition, until early 2014, patients could use their doctors' written commendations as ID cards.	On May 8, 2014, the health department issued regulations for medical marijuana. On Jan. 31, 2014, the Department of Public Health announced that it had granted preliminary approval to 20 non-profit dispensaries. However, it rejected nine of those applications subsequently, approving an initial total of 11 on June 27, 2014. Four more were approved in Nov. 2014. Rejected applicants can reapply in 2015, as Question 3 calls for up to 35 dispensaries to be located in the state. The first dispensary opened in June 2015.	Six months after Massachusetts' law was enacted, the state drafted rules, which followed listening sessions throughout the state. Within a year of the law's passage, the health department had completed the first of two phases of an application process. Following some questions about the process, the second phase was completed in June 2014. The first dispensary opened a year later — about one year and eight months after enactment.
Michigan	Nov. 2008	April 4, 2009	N/A — Law does not include state dispensary registrations.	Implementation of the patient and caregiver ID card program took about five months.
Minnesota	May 29, 2014	June 1, 2015	On Sept. 5, 2014, the health department issued a request for applications for manufacturers. Letters of intent were due by Sept. 19. The department registered two manufacturers by Dec. 1, 2014. Patients were allowed to apply for ID cards in June 2015, and the first dispensary opened on July 1, 2015.	The health department issued a preliminary draft of rules in Aug. 2014, less than three months after the law's passage. A second draft was issued on Sept. 5, 2014, and a notice of expedited rulemaking — along with the proposed rules — was published on Oct. 6. The department approved two manufacturers on Dec. 1, about seven months after the law's passage. Patients were able to apply for ID cards about a year after enactment, and the first dispensary opened a month later.
Montana	Nov. 2004 voter initiative	Dec. 14, 2004	N/A — Law does not include state dispensary registrations.	Implementation of the patient and caregiver ID card program took 42 days.
Nevada	June 2001: Patient registry legislation; June 2013: Dispensary and cultivation law	Oct. 1, 2001	Medical marijuana business rules were finalized on April 1, 2014. Nevada's Division of Public and Behavioral Health issued provisional approval to medical marijuana businesses on Nov. 3, 2014. The law allows the creation of 66 dispensaries and 200 production facilities. The first dispensary opened in Aug. 2015.	The implementation of the patient and caregiver registry took under four months. More than a decade later, rules were crafted 10 months after the dispensary law was enacted. The health department issued preliminary certificates in Nov. 2014, less than a year and a half after the dispensary bill became law.

State	Year Enacted	Date When State Began Accepting ID Card Applications	Dispensaries (or the equivalent) and Timelines for Their Implementation	Comments
New Hampshire	July 23, 2013	Patient and caregiver registry rules were approved on June 25, 2014. However, pursuant to the opinion of the state Attorney General, the health department is not yet issuing ID card applications as of Oct. 2015. It is only accepting pre-registration.	In Oct. 2014, the Department of Health and Human Services issued regulations for the processing of applications for four non-profit alternative treatment centers (ATCs) to grow and sell marijuana to patients. The state approved three businesses to operate four ATCs in June 2015, five months after the January 2015 deadline. They are expected to open in 2016.	Dispensary (ATC) rules were provisionally approved about 15 months after the law's passage. Preliminary dispensary registrations were issued one year and 11 months after the law's passage. Patients are still not allowed to being issued ID cards as of Oct. 2015, but a patient has sued, requesting that the court order the issuance of an ID card to her.
New Jersey	Jan. 2010	Aug. 9, 2012	Regulations were issued in Nov. 2010, but were rejected by the legislature. They were revised in 2011, and six "alternative treatment center" (ATC) licenses were issued in March 2011. However, the first ATC did not open until Dec. 6, 2012.	Due to reticence by Gov. Chris Christie along with mixed signals from the federal government in 2011-2012, implementation was slow. It took nearly four years for the first dispensary to open.
New Mexico	April 2007	July 6, 2007 (initially temporary ID certificates were available)	The first "licensed producer" registration was issued in March 2009, less than two years after passage. Four more were licensed in Nov. 2009, and 20 were licensed in 2010. Twelve more licenses were preliminarily approved in Oct. 2015.	Although New Mexico was the first state to license larger-scale cultivation and dispensing, its rules were finalized and the first producer was licensed in less than two years. Twenty-three licensed producers are currently licensed in the state.
New York	July 5, 2014	Registry identification cards will become effective on the latter of: a) 18 months after enactment; or b) when the superintendent of state police certifies the title can be implemented in accordance with public health and safety interests.	The Department of Health issued regulations in April 2015. Applications for registered organizations were due in June 2015, 11 months after the law's enactment. In July 2015, the department selected the five recipients of dispensary and grower licenses. They are expected to begin opening by early 2016.	The department issued regulations within nine months of the law's enactment. It accepted dispensary applications 11 months after enactment. However, patients are not yet allowed to apply as of Oct. 2015 — more than a year after enactment.

State	Year Enacted	Date When State Began Accepting ID Card Applications	Dispensaries (or the equivalent) and Timelines for Their Implementation	Comments
Oregon	Nov. 1998; Aug. 2013: dispensary law	May 1, 1999	Dispensaries already existed upon the passage of the state law in 2013, but they were not clearly authorized by law or regulated. The first dispensary licenses were issued in March 2014, about seven months after the dispensary law passed.	Implementation of patient and caregiver ID cards took just under six months. More recently, the first dispensaries were licensed about seven months after the dispensary law passed.
Rhode Island	Jan. 2006; dispensaries authorized in June 2009	March 31, 2006	"Compassion center" regulations were finalized in March 2010. Three applicants were approved on March 15, 2011, less than two years after the law's enactment, but Gov. Chafee halted implementation and had the law revised. The first dispensary opened on April 19, 2013. As of Oct. 2015, there are three dispensaries open in the state.	Implementation of the patient and caregiver ID card program took under three months. The health department was expected to issue compassion center registrations in Sept. 2010. However, it maintained that none of the applicants qualified, so it restarted the application process. After approving three compassion centers on March 15, 2011, Gov. Lincoln Chafee reversed course on May 2, 2011, after receiving a letter from the U.S. attorney. In response, the law was revised, and the first center finally opened in April 2013.
Vermont	Passed May 2004; effective date July 1, 2004; dispensaries authorized on June 2, 2011	Oct. 26, 2004	The Department of Public Safety began accepting dispensary applications about a year after the dispensary law was approved and approved two dispensaries three months later. The first dispensary opened in June 2013. As of Oct. 2015, there are four dispensaries operating in the state.	Implementation of the patient and caregiver ID card program took five months. The legislature passed a law authorizing the licensing of four dispensaries in May 2011. The Department of Public Safety began accepting dispensary applications 13 months later — on June 4, 2012 — and approved the first two dispensaries in Sept. 2012. The first dispensary opened in June 2013, about two years after the law's passage.
Washington	Nov. 1998. Further legislation clarifying rules related to medical use was passed in April 2015.	N/A — ID cards are not required in the state of Washington. However, starting July 2016, patients who sign on to the voluntary registry will be given special privileges including increased possession limits.	The law does not include state dispensary regulations, but adult use stores will be able to have a medical marijuana endorsement beginning in 2016.	Washington implemented an adult use marijuana law, which includes growers, processors, and retailers. The law passed in Nov. 2012, and the first stores opened in July 2014. Beginning in 2016, businesses may get a medical marijuana endorsement, and patients will be able to get ID cards.

Last updated: November 16, 2015

Appendix W: Anti-Discrimination Provisions

Medical Marijuana Laws and Anti-Discrimination Provisions

Patients who use prescription medications often have recourse under the Americans with Disabilities Act (ADA) if they are discriminated against for using their medicine. However, courts have found that ADA protections do not apply to medical cannabis since it is federally illegal. Several of the more recent medical marijuana laws have included language intended to prevent discrimination against medical marijuana patients in housing, child custody cases, organ transplants, enrollment in college, or employment, with some limitations. Courts in states without strong language preventing such discrimination have typically ruled against patients who challenge the discrimination.

The below chart includes excerpts from state laws that might be relevant to court cases challenging discrimination against state-legal patients who use or test positive for marijuana, along with known court cases in each state.

State	Court Decisions	Relevant Statutory Language	Language Limiting Possible Protections
Alaska	None known.	"Except as otherwise provided by law, a person is not subject to arrest, prosecution, or penalty in any manner for applying to have the person's name placed on the confidential registry maintained by the department under AS 17.37.010."	"Nothing in this chapter requires any accommodation of any medical use of marijuana (1) in any place of employment …"
Arizona	None known.	Registered patients and caregivers are not "subject to … penalty in any manner, or denial of any right or privilege, including any civil penalty or disciplinary action by a court or occupational or professional licensing board ..." for the permissible conduct. Prohibits discrimination by schools, landlords, and employers, as well as discrimination in respect to organ transplants, other medical care, and custody and visitation, unless an exception applies. Employers generally cannot penalize patients for a positive drug test for marijuana "unless the patient used, possessed or was impaired by marijuana at or during work." Nursing homes, assisted living centers, and similar facilities generally "may not unreasonably limit a registered qualifying patients' access to or use of" medical marijuana.	The prohibitions on discrimination by employers, landlords, schools, and assisted living facilities do not apply if failing to penalize the cardholder would cause the entity "to lose a monetary or licensing related benefit under federal law or regulations." The law also does not allow anyone to undertake "any task under the influence of marijuana when doing so would constitute negligence or professional malpractice." A 2011 law allows employers to take actions based on "good faith" beliefs about employee impairment. A 2012 law bans the use of marijuana on college campuses and vocational schools. The restrictions the legislature passed might be challenged as illegal meddling with an initiative under the Voter Protection Act.

State	Court Decisions	Relevant Statutory Language	Language Limiting Possible Protections
California	In *Ross v. Ragingwire,* the state Supreme Court ruled that the law does not protect patients from being fired for testing positive for metabolites. It noted that the legislature could enact such protections.	In 2015, Gov. Brown signed into law a bill to prevent organ transplants from being denied based solely on a person's status as a medical marijuana patient or a patient's positive test for medical marijuana, "except to the extent that the qualified patient's use of medical marijuana has been found by a physician and surgeon, following a case-by-case evaluation of the potential recipient, to be medically significant to the provision of the anatomical gift."	Calif. Health & Safety Code § 11362.785 (a) provides, "Nothing in this article shall require any accommodation of any medical use of marijuana on the property or premises of any place of employment or during the hours of employment or on the property or premises of any jail, correctional facility, or other type of penal institution in which prisoners reside or persons under arrest are detained."
Colorado	In *Coats v. DISH Network,* the Colorado Supreme Court ruled against a paralyzed patient who sued after being terminated for off-hours medical marijuana use.	Colorado's law says, "the use of medical marijuana is allowed under state law" to the extent it is carried out in accordance with the state constitution, statutes, and regulations. Mr. Coats' attorney unsuccessfully argued his medical marijuana use was protected by the state's "Lawful Off-Duty Activities Statute," which protects employees from being penalized for legal outside-of-work behavior.	Col. Const. Art. XVIII, § 14. (10) (b) specifies, "Nothing in this section shall require any employer to accommodate the medical use of marijuana in any work place."
Conn.	None known.	The law says patients and caregivers should not be "denied any right or privilege, including, but not limited to, being subject to any disciplinary action by a professional licensing board" for the permitted conduct. It also includes protections from discrimination based on one's status as a patient or caregiver by landlords, employers, and schools.	The protections from discrimination by landlords, schools, and employers include an exception for if it is "required by federal law or required to obtain federal funding." The law does not "restrict an employer's ability to discipline an employee for being under the influence of intoxicating substances during work hours." Patients cannot use marijuana on any school grounds, including in dorms or other college property.
Delaware	None known.	Registered patients and caregivers may not be denied "any right or privilege" or be subject to "disciplinary action by a court or occupational or professional licensing board or bureau" for the permissible conduct. The law prohibits discrimination by schools, landlords, and employers, as well as discrimination in respect to organ transplants, other medical care, and custody or visitation, unless an exception applies. Employers generally cannot penalize patients for a positive drug test for marijuana unless the patient "used, possessed, or was impaired by marijuana on the premises of the place of employment or during the hours of employment."	The prohibitions on discrimination by employers, landlords, and schools do not apply if failing to penalize the cardholder would cause the entity "to lose a monetary or licensing-related benefit under federal law or regulation." The law also does not allow anyone to undertake "any task under the influence of marijuana, when doing so would constitute negligence or professional malpractice."

State	Court Decisions	Relevant Statutory Language	Language Limiting Possible Protections
District of Columbia	None known.	"Notwithstanding any other District law, a qualifying patient may possess and administer medical marijuana, and possess and use paraphernalia, in accordance with this act and the rules issued pursuant to section 14."	"Nothing in this act permits a person to: (1) Undertake any task under the influence of medical marijuana when doing so would constitute negligence or professional malpractice …"
Hawaii	None known.	In 2015, a bill was enacted to ban discrimination against medical marijuana patients and caregivers by schools, landlords, and condominiums and to prevent discrimination in medical care and parental rights.	The state medical marijuana law's authorization does not extend to "in the workplace of one's employment." The protections from discrimination from a school or landlord do not apply if they would cause a loss of "a monetary or licensing-related benefit under federal law or regulation." The child custody protections do not apply if the person's conduct "created a danger to the safety of the minor." Condominiums may prohibit medical marijuana smoking if they also prohibit tobacco smoking.
Illinois	None known.	Schools, employers, and landlords cannot refuse to enroll, lease to, or otherwise penalize someone for his or her status as a registered patient or caregiver, unless failing to do so would create an issue with federal law, contracts, or licensing. Patients' authorized use of marijuana cannot disqualify a person from receiving organ transplants or other medical care and will not result in the denial of custody or parenting time, unless the patient's actions created an unreasonable danger to the minor's safety.	Landlords may prohibit the smoking of cannabis on the rented premises. Schools, employers, and landlords may penalize a person for their status as a patient or caregiver if "failing to do so would put the school, employer, or landlord in violation of federal law or unless failing to do so would cause it to lose a monetary or licensing-related benefit under federal law or rules." The law does not "prohibit an employer from enforcing a policy concerning drug testing, zero-tolerance, or a drug free workplace provided the policy is applied in a nondiscriminatory manner."

State	Court Decisions	Relevant Statutory Language	Language Limiting Possible Protections
Maine	None known.	Individuals whose conduct is authorized by the law "may not be denied any right or privilege or be subjected to arrest, prosecution, penalty or disciplinary action." Unless an exception applies, "a school, employer, or landlord may not refuse to enroll or employ or lease to or otherwise penalize a person solely for that person's status as a qualifying patient or a primary caregiver." Unless the person's behavior is contrary to the best interests of the child, "a person may not be denied parental rights and responsibilities with respect to or contact with a minor child …".	The protections do not apply if failing to penalize the person would put a "school, employer, or landlord in violation of federal law or cause it to lose a federal contract or funding." Maine's law does not prohibit a restriction "on the administration or cultivation of marijuana on [rented] premises when that administration or cultivation would be inconsistent with the general use of the premises." It "does not permit any person to: Undertake any task under the influence of marijuana when doing so would constitute negligence or professional malpractice or would otherwise violate any professional standard." The law does not require "an employer to accommodate the ingestion of marijuana in any workplace or any employee working while under the influence of marijuana."
Maryland	None known.	Maryland's law protects qualifying patients, caregivers, certifying physicians, licensed growers, licensed dispensaries, academic medical centers, those entities' staff, and hospitals or hospices that are treating a qualifying patient from "any civil or administrative penalty, including a civil penalty or disciplinary action by a professional licensing board, or be denied any right or privilege" when acting in accordance with the law.	The law does not allow anyone to undertake "any task under the influence of marijuana, when doing so would constitute negligence or professional malpractice." It allows landlords and condominiums to restrict marijuana smoking.
Mass.	None known.	"The citizens of Massachusetts intend that there should be no punishment under state law for qualifying patients, physicians and health care professionals, personal caregivers for patients, or medical marijuana treatment center agents for the medical use of marijuana, as defined herein." The law also says that persons meeting its requirements shall not be "penalized under Massachusetts law in any manner, or denied any right or privilege."	"Nothing in this law requires any accommodation of any on-site medical use of marijuana in any place of employment, school bus or on school grounds, in any youth center, in any correctional facility, or of smoking medical marijuana in any public place."

State	Court Decisions	Relevant Statutory Language	Language Limiting Possible Protections
Michigan	In *Casias vs. Wal-Mart,* the U.S. Court of Appeals for the Sixth District ruled against a registered medical marijuana patient who sued Wal-Mart for terminating his employment for testing positive for marijuana.	Those abiding by the act cannot be subject to "penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau" for actions allowed by the law. In addition, "a person shall not be denied custody or visitation of a minor for acting in accordance with this act, unless the person's behavior is such that it creates an unreasonable danger to the minor that can be clearly articulated and substantiated."	The law does not allow any person to "undertake any task under the influence of marihuana, when doing so would constitute negligence or professional malpractice." Employers are not required "to accommodate the ingestion of marihuana in any workplace or any employee working while under the influence of marihuana."
Minnesota	None known.	Unless an exception applies, an individual's status as a registered medical marijuana patient may not be used: 1) By schools as a reason to refuse enrollment; 2) by landlords as reason to refuse to lease to the person; 3) by employers as a reason to refuse to hire or as a reason to terminate employment; or 4) as a reason to deny custody or visitation rights. An employer generally cannot discriminate against a patient based on a failed drug test for marijuana.	The law does not require accommodation if it would violate federal law or regulations or cause the entity to lose a federal licensing or monetary benefit. Employers may punish patients if they are impaired at work or possess marijuana at work. In addition, patients may face civil penalties for undertaking a task under the influence of marijuana that would constitute negligence or professional malpractice.
Montana	The Montana Supreme Court upheld the dismissal of a patient who tested positive for marijuana metabolites in *Johnson v. Columbia Falls Aluminum*. The decision is a memorandum opinion and is not binding precedent on other cases.	The law provides that those abiding by the act "may not be arrested, prosecuted, or penalized in any manner or be denied any right or privilege, including but not limited to civil penalty or disciplinary action by a professional licensing board or the department of labor and industry" for the medical use of marijuana in accordance with the act.	The law does not require employers to accommodate medical marijuana use, schools to allow patients to participate in extracurricular activities, or landlords to allow medical marijuana cultivation or use. Employers may prohibit medical marijuana, and the law does not provide a cause of action for discrimination. Cultivation requires a landlord's written permission.
Nevada	None known.	"A professional licensing board shall not take any disciplinary action against a person licensed by the board" for engaging in the medical use of marijuana or acting as a caregiver. An employer must "attempt to make reasonable accommodations for the medical needs" of patients who are employees, unless the accommodation would "(a) Pose a threat of harm or danger to persons or property or impose an undue hardship on the employer; or (b) Prohibit the employee from fulfilling any and all of his or her job responsibilities."	The law does not require employers to "allow the medical use of marijuana in the workplace" or to "modify the job or working conditions of a person who engages in the medical use of marijuana that are based upon the reasonable business purposes of the employer."

State	Court Decisions	Relevant Statutory Language	Language Limiting Possible Protections
New Hampshire	None known.	"For the purposes of medical care, including organ transplants, a qualifying patient's authorized use of cannabis in accordance with this chapter shall be considered the equivalent of the authorized use of any other medication … and shall not constitute the use of an illicit substance." Further, "a person otherwise entitled to custody of, or visitation or parenting time with, a minor shall not be denied such a right solely for conduct allowed under this chapter, and there shall be no presumption of neglect or child endangerment."	The law does not require "any accommodation of the therapeutic use of cannabis on the property or premises of any place of employment." It also does not "limit an employer's ability to discipline an employee for ingesting cannabis in the workplace or for working while under the influence of cannabis."
New Jersey	None known.	The law's purpose "is to protect from arrest, prosecution, property forfeiture, and criminal and other penalties, those patients who use marijuana to alleviate suffering from debilitating medical conditions, as well as their physicians, primary caregivers, and those who are authorized to produce marijuana for medical purposes." § 24:6I-6 (b) provides that patients, caregivers, and others acting in accordance with the law "shall not be subject to any civil or administrative penalty, or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by a professional licensing board, related to the medical use of marijuana."	"Nothing in this act shall be construed to require … an employer to accommodate the medical use of marijuana in any workplace."
New Mexico	In August 2015, a district court ruled against a physician assistant and registered patient who sued after being fired by Presbyterian Healthcare Services for testing positive for marijuana. Presbyterian argued it must comply with the Federal Drug-Free Workplace Act because it receives Medicaid and Medicare reimbursements.	Qualified patients "shall not be subject to arrest, prosecution or penalty in any manner for the possession of or the medical use of cannabis if the quantity of cannabis does not exceed an adequate supply."	"Participation in a medical use of cannabis program by a qualified patient or primary caregiver does not relieve the qualified patient or primary caregiver from: ... criminal prosecution or civil penalty for possession or use of cannabis … in the workplace of the qualified patient's or primary caregiver's employment."

State	Court Decisions	Relevant Statutory Language	Language Limiting Possible Protections
New York	None known.	Patients may not be subject to "penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau" for actions allowed by the medical marijuana law. Being a certified patient is considered a disability for purposes of the state's anti-discrimination laws. Patients are also protected from discrimination in family law and domestic relations cases.	The law does not "bar the enforcement of a policy prohibiting an employee from performing his or her employment duties while impaired by a controlled substance." It also does not "require any person or entity to do any act that would put the person or entity in violation of federal law or cause it to lose a federal contract or funding."
Oregon	In April 2010, the Oregon Supreme Court ruled in *Emerald Steel v. BOLI* that patients are not protected from being fired for testing positive for metabolites.	"No professional licensing board may impose a civil penalty or take other disciplinary action against a licensee based on the licensee's medical use of marijuana," pursuant to state law.	"Nothing in ORS 475.300 to 475.346 shall be construed to require … An employer to accommodate the medical use of marijuana in any workplace."
Rhode Island	None known, though at least one case is pending as of September 2015.	Patients and caregivers abiding by the act may not be subject to "penalty in any manner, or denied any right or privilege, including but not limited to, civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau" for the medical use of marijuana. Also, "no school, employer, or landlord may refuse to enroll, employ, or lease to or otherwise penalize a person solely for his or her status as a cardholder." Further, "for the purposes of medical care, including organ transplants, a registered qualifying patient's authorized use of marijuana shall be considered the equivalent of the authorized use of any other medication used at the direction of a physician, and shall not constitute the use of an illicit substance."	The law does not allow "any person to undertake any task under the influence of marijuana, when doing so would constitute negligence or professional malpractice …" In addition, "nothing in this chapter shall be construed to require: … an employer to accommodate the medical use of marijuana in any workplace."
Vermont	None known.	The patient and caregiver protections in the medical marijuana law are from criminal penalties.	The law does not exempt patients from arrest or prosecution for being under the influence of marijuana "in a workplace or place of employment" or for using or possessing marijuana "in a manner that endangers the health or well-being of another person."

State	Court Decisions	Relevant Statutory Language	Language Limiting Possible Protections
Washington	In 2011, the Washington State Supreme Court ruled in favor of an employer who was sued after terminating a medical marijuana patient (*Roe v. Teletech Customer Care Management*).	Medical marijuana cannot be the "sole disqualifying factor" for an organ transplant unless it could cause rejection or organ failure, though a patient could be required to abstain before or during the transplant. The law also limits when parental rights and residential time can be limited due to the medical use of marijuana.	"Nothing in this chapter requires any accommodation of any on-site medical use of cannabis in any place of employment, in any school bus or on any school grounds, in any youth center, in any correctional facility, or smoking cannabis in any public place or hotel or motel." An employer explicitly does not have to accommodate medical marijuana if it establishes a drug-free workplace.