December 2014

Medical Cannabis

A Guide to the Minnesota Law and Legal Issues

Research Department
Minnesota House of Representatives

The Research Department of the Minnesota House of Representatives is a nonpartisan professional office serving the entire membership of the House and its committees. The department assists all members and committees in developing, analyzing, drafting, and amending legislation.

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Research Department

Minnesota House of Representatives

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This publication explains the Medical Cannabis Therapeutic Research Act passed by the Minnesota Legislature in 2014. The act established a patient registry program that allows qualifying patients to use and possess cannabis for medical purposes.

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Introduction

In May 2014, the Minnesota Legislature passed the Medical Cannabis Therapeutic Research Act, which allows qualifying patients to use and possess cannabis for medical use. This publication explains the law, called the Medical Cannabis Therapeutic Research Act, beginning with a basic explanation of the program (see Overview of the Law, beginning on page 2).

The law establishes a patient registry program, in which patients with qualifying medical conditions can register to use cannabis. The program is administered by the Minnesota Department of Health (MDH), but there are a number of different entities that are involved in the program. This publication describes the program, including the roles of MDH, patients, manufacturers, and health care practitioners (see The Patient Registry Program, beginning on page 6).

There are a variety of legal issues associated with the medical use of cannabis. Under both Minnesota and federal law, possession and sale of cannabis are illegal. Under Minnesota law, patients and others involved in the registry program are exempt from certain possession and sale crimes for medical cannabis. Under federal law, patients and others involved in the registry program are not exempt from criminal penalties. The legal issues are evolving as states adopt legislation, the federal government reacts to state legislation, and courts decide various legal issues surrounding medical cannabis. This publication explores some of the legal issues associated with the medical cannabis and reviews some recent case law on the issue (see Legal Issues, beginning on page 24).

Additionally, there are three appendices that provide more information on medical cannabis. Appendix I provides a brief history of medical cannabis legislation in Minnesota (see page 43). Appendix II provides information on current Minnesota law on cannabis use and possession (see page 45). Lastly, Appendix III provides a summary of the medical cannabis laws in the 23 states, and the District of Columbia, that have medical cannabis programs (see page 48).

Author's note: *This publication is not intended to provide legal advice and should not be used as a substitute for consulting with a private attorney. To the best of the author's knowledge, the law discussed here is current as of the date of publication. The laws cited in this publication are subject to frequent change and new case law interpreting the laws are published regularly. Serious criminal and civil consequences can follow a possession or distribution of cannabis charge. If readers have any concerns about consequences to the possession or distribution of medical cannabis, they should consult an experienced private attorney before possessing or distributing medical cannabis.*

I. Overview of the Law

In May 2014, the Medical Cannabis Therapeutic Research Act was passed by the Minnesota Legislature and signed into law by Gov. Mark Dayton.[1] The law establishes a patient registry program, administered by the Minnesota Department of Health (MDH), which allows qualifying patients to use and possess cannabis for medical use.

The law allows for two manufacturers to be registered in the state. Both manufacturers will have one manufacturing facility and four distribution sites throughout the state.

The manufacturers may only distribute medical cannabis in the form of a pill or liquid, and patients may only possess medical cannabis in those limited forms.

Qualifying medical conditions include:

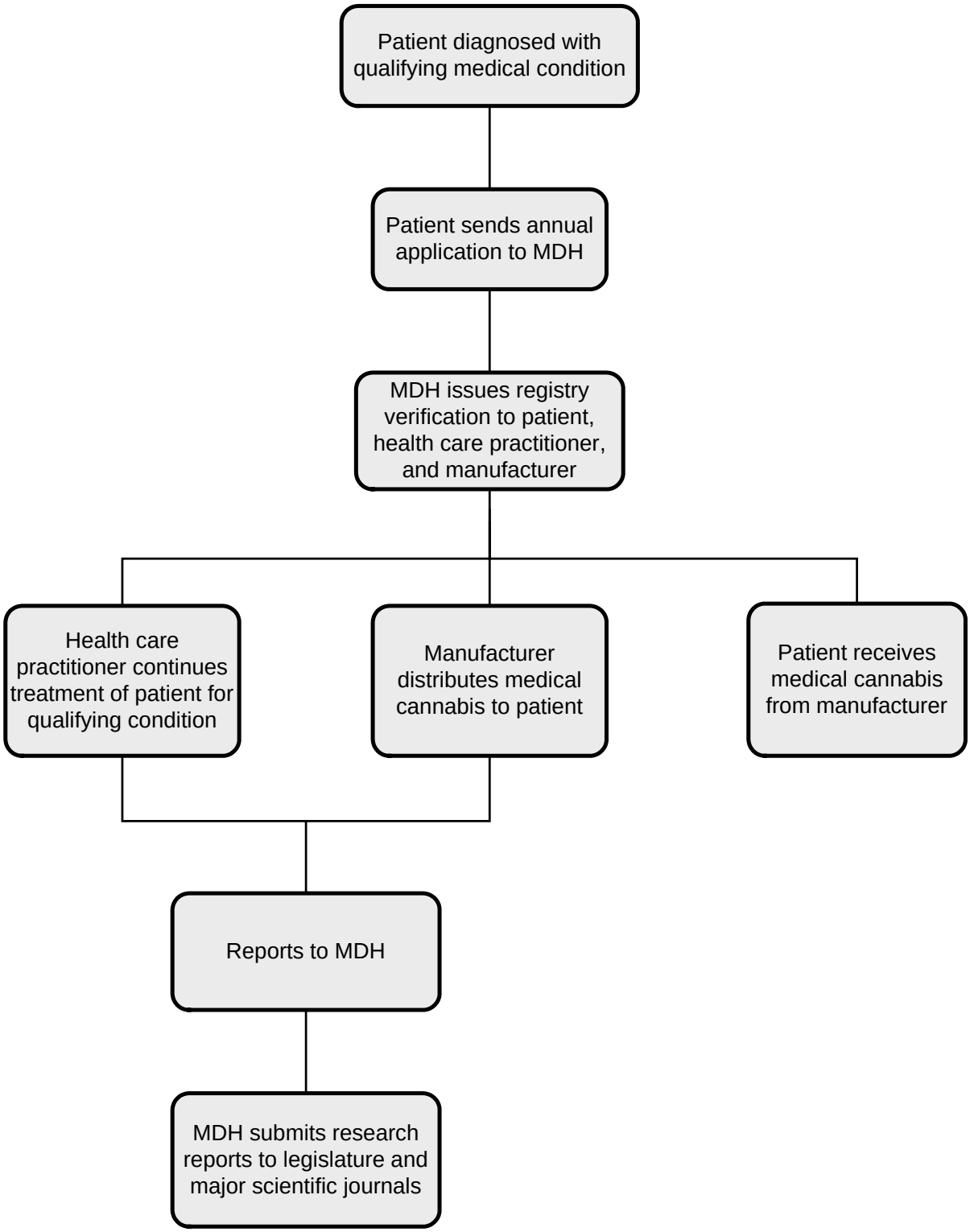
1. Cancer*
2. Glaucoma
3. HIV/AIDS
4. Tourette's
5. ALS
6. Seizures
7. Severe and persistent muscle spasms
8. Crohn's disease
9. Terminal illness with life expectancy of under one year*
10. Any other condition or its treatment approved by the commissioner (subject to legislative overview)

*Illness or treatment must produce one or more of the following: (1) severe or chronic pain; (2) nausea or severe vomiting; or (3) cachexia or severe wasting.

The general design of the registry program is as follows:

[1] Laws 2014, ch. 311; codified as Minn. Stat. §§ 152.22 to 152.37.

General Design of the Registry Program



General Design of the Registry Program

Patient diagnosed with qualifying medical condition

Prior to applying to be a part of the registry program, a patient must be diagnosed by a health care practitioner with one or more of the qualifying medical conditions. See *Patients – Qualifying medical conditions* (page 8) for details regarding qualifying medical conditions and *Health Care Practitioners* (page 17) for details on which practitioners qualify as a health care practitioner.

Patient sends annual application to MDH

Once the patient receives a certification of diagnosis from a health care practitioner, the patient will then apply to be a part of the registry program with the Minnesota Department of Health (MDH). The patient must submit this application, along with an application fee, on an annual basis. For more details regarding patient participation in the registry program, see *Patients – Participation in the registry program* (page 8).

MDH issues a registry verification to patient, health care practitioner, and manufacturer

Once the patient has been accepted into the registry program, MDH will issue a registry verification listing the patient's information, along with the information of the registered designated caregiver or parent or legal guardian, if applicable. The registry verification is issued to the patient, the patient's listed health care practitioner, and the manufacturer as proof of the patient's participation in the registry program.

Health care practitioner continues treatment of qualifying condition

As part of the health care practitioner's duties, the practitioner must continue to treat the qualifying medical condition of the patient. For more on health care practitioner duties, see *Health Care Practitioners – Participation* (page 17).

Manufacturer distributes medical cannabis to patient

A manufacturer may only distribute medical cannabis to a person listed on the patient's registry verification. Distribution must be made by a licensed pharmacist after a consultation with the patient. For more on distribution of medical cannabis, see *Manufacturers – Distribution* (page 15).

Patient retrieves medical cannabis from manufacturer

A patient may only obtain medical cannabis from a registered manufacturer. If a patient has a registered designated caregiver or parent or legal guardian listed on the registry verification, that person may also obtain the medical cannabis from the manufacturer on the patient's behalf. For more on distribution of medical cannabis, see *Manufacturers – Distribution* (page 15).

Reports to MDH

The health care practitioner is required to report the patient's health to MDH through the registry program. The manufacturer is also required to submit a report to MDH containing various information. For more on a health care practitioner's reports, see *Health Care Practitioners – Participation* (page 17). For more on a manufacturer's reports, see *Manufacturers – Regulation* (page 12).

MDH submits reports to legislature and major medical journals

MDH is required to conduct research on the information in the registry program and submit reports to certain legislative committees as well as major medical journals.

II. The Patient Registry Program

A. MDH Program Development

MDH and its commissioner are tasked with the development, implementation, and management of the patient registry program.

Range of compounds[2]

MDH must review existing medical and scientific literature on the recommended range of dosages and chemical compounds for each of the qualifying medical conditions and publicly report that review. MDH made the original review on December 1, 2014, and must update the information on an annual basis. Once compiled, the list of recommended ranges and chemical compounds will be posted on the MDH website.[3]

Rulemaking authority[4]

MDH was given rulemaking authority by the legislature in Minnesota Statutes, section 152.26. MDH is required to have rules necessary for the manufacturer to begin distributing medical cannabis to patients by July 1, 2015. The rules must be published in the State Register by January 1, 2015, and MDH may use the expedited rulemaking process under Minnesota Statutes, section 14.389, for those rules.

Adverse incidents[5]

MDH must adopt rules that establish reporting requirements for incidents when individuals not authorized to use medical cannabis are found in possession of medical cannabis. The rules must establish reporting requirements by law enforcement and health care professionals for incidents involving an overdose of medical cannabis and methods for the commissioner to collect and tabulate reports on the unauthorized use of medical cannabis.

Adding additional allowable forms and qualifying medical conditions[6]

The commissioner may add to the list of qualifying medical conditions and also add to the list of allowable forms of medical cannabis. The commissioner is prohibited, however, from adding smoking as an allowable form of medical cannabis. To add an additional form or condition, the commissioner must notify the chairs and ranking minority members of the legislative committees having jurisdiction over health and human services as to the reasons for the addition. This notice

[2] Minn. Stat. § 152.25, subd. 2.

[3] http://www.health.state.mn.us/topics/cannabis/.

[4] Minn. Stat. § 152.26.

[5] Minn. Stat. § 152.261.

[6] Minn. Stat. § 152.27, subd. 2, para. (b).

must include any public comments the commissioner has received and any guidance the commissioner has received from the task force on medical cannabis research. The notification must be given by January 15 of the year the commissioner wishes to make the change. The change will become effective August 1 of that year unless the legislature by law provides otherwise.

Intractable pain[7]

The commissioner is required to consider adding intractable pain to the list of qualifying medical conditions prior to the consideration of adding any other condition to the list.[8] The commissioner must report findings on the need to add intractable pain to the task force by July 1, 2016.

Deadline extensions[9]

The December 1, 2014, deadline for registering manufacturers and the July 1, 2015, deadline for the manufacturer providing medical cannabis to patients may both be extended under certain circumstances. The December 1, 2014, deadline for registration of manufacturers was met by MDH. For more on the extension of these deadlines, see *Operation of the Program – Task Force on Medical Cannabis Therapeutic Research* (page 22).

Financial audit

MDH may inspect the manufacturer's financial documents through a financial audit by a certified annual audit or through an examination of its business affairs. For more on manufacturer financial audits, see *Manufacturers – Regulation* (page 12).

Reports[10]

The commissioner is required to regularly update the task force on medical cannabis therapeutic research regarding any changes in federal law or regulation of medical cannabis. The commissioner may also submit medical research collected through the registry program to federal agencies with regulatory authority over medical cannabis in order to demonstrate the effectiveness of medical cannabis for treating qualifying conditions. The commissioner must also submit findings from the registry program to both the legislature and major scientific journals.

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[7] Laws 2014, ch. 311, § 20.

[8] Intractable pain is defined in Minnesota Statutes § 152.125, subdivision 1 as, "a pain state in which the cause of the pain cannot be removed or otherwise treated with the consent of the patient and in which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. Reasonable efforts for relieving or curing the cause of the pain may be determined on the basis of, but are not limited to, the following: (1) when treating a nonterminally ill patient for intractable pain, evaluation by the attending physician and one or more physicians specializing in pain medicine or the treatment of the area, system, or organ of the body perceived as the source of the pain; or (2) when treating a terminally ill patient, evaluation by the attending physician who does so in accordance with the level of care, skill, and treatment that would be recognized by a reasonably prudent physician under similar conditions and circumstances."

[9] Minn. Stat. § 152.25, subd. 3.

[10] Minn. Stat. § 152.25, subd. 4.

B. Patients

Qualifying medical conditions

Qualifying medical conditions include:[11]

1. Cancer*
2. Glaucoma
3. HIV/AIDS
4. Tourette's
5. ALS
6. Seizures
7. Severe and persistent muscle spasms
8. Crohn's disease
9. Terminal illness with life expectancy of under one year*
10. Any other condition or its treatment approved by the commissioner (subject to legislative overview)

*Illness or treatment must produce one or more of the following: (1) severe or chronic pain; (2) nausea or severe vomiting; or (3) cachexia or severe wasting.

Participation in the registry program

A patient's first step is to consult with a health care practitioner regarding whether or not the patient suffers from one or more of the qualifying medical conditions. If the patient has been diagnosed with a qualifying medical condition, the patient must submit an application to MDH to enroll in the registry program.[12] The application must include a doctor's certification of diagnosis and other forms required by MDH. Once the application is approved by MDH, the patient will receive a registry verification.

Reasons for denial of participation in the registry program[13]

The law requires that a patient only be denied entry into the registry program if the patient:

- does not have a certification of a qualifying medical condition from a health care practitioner;
- does not provide the required information or signed disclosures;
- has previously been removed from the registry program for a violation of patient duties; or
- provides false information.

[11] Minn. Stat. § 152.22, subd. 14. [12] Minn. Stat. § 152.27, subd. 3. [13] Minn. Stat. § 152.27, subd. 6.

If a patient is denied entry, the commissioner must give the patient a written reason for the denial. A denial is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act.

Responsibilities during participation[14]

The patient is required to resubmit a copy of the certification of diagnosis to MDH on a yearly basis. As part of the yearly application, the patient is required to pay an application fee of $200. If the patient attests to receiving Social Security disability, Supplemental Security Insurance payments, or being enrolled in Medical Assistance or MinnesotaCare, the patient's yearly fee is $50.[15] Patients must also continue to receive regularly scheduled treatment for that qualifying medical condition and report changes in that condition to their health care practitioner throughout enrollment in the registry program.

Registered designated caregivers[16]

A patient is permitted to have a registered designated caregiver if the patient's health care practitioner certifies that the patient suffers from a developmental or physical disability that prevents the patient from either self-administering the medication or acquiring the medication from a distribution facility. The registered designated caregiver must agree, in writing, to act as the patient's caregiver. As a condition of registration, the caregiver must:

- be at least 21 years of age;
- agree to only possess medical cannabis for purposes of assisting the patient; and
- agree to not be a caregiver for more than one patient, unless the patients reside in the same residence.

Registered designated caregivers are subject to a criminal background check. If the caregiver has a disqualifying felony offense, the commissioner is prohibited from registering that caregiver. Disqualifying felony offenses include violations of any state or federal controlled substance law that would be a felony in Minnesota, regardless of the sentence imposed, unless the commissioner determines that the conviction was for either the use or assistance with use of medical cannabis. Registered designated caregivers are also subject to criminal sanctions for diversion of medical cannabis in the same way as patients. For more information on that criminal sanction, see *Patients – Criminal sanctions* (page 10).

Parents or legal guardians[17]

A parent or legal guardian may act as the patient's caregiver without registering as a designated caregiver. Parents or legal guardians, if listed on the registry verification, are also subject to

[14] Minn. Stat. § 152.30.

[15] Minn. Stat. § 152.35.

[16] Minn. Stat. § 152.27, subd. 4.

[17] Minn. Stat. § 152.27, subd. 5.

criminal sanctions for diversion of medical cannabis in the same way as patients. For more information on that criminal sanction, see *Patients – Criminal sanctions* (page 10).

Civil and criminal protections[18]

Once a patient enrolls in the registry program, the patient is presumed to be engaging in the authorized use of medical cannabis. Possession of medical cannabis by a patient, registered designated caregiver, or, in some cases, the parent or legal guardian of the patient, is exempt from criminal sanctions under Minnesota law. Medical cannabis and associated property is also not subject to forfeiture under Minnesota law. A patient's possession of a registry verification or application does not constitute probable cause or reasonable suspicion and cannot be used to support a search of the person or property. Because the statutory definition of medical cannabis currently excludes any form of medical cannabis other than pills or liquids, a patient found in possession of any other form of cannabis may be subject to criminal penalties.

Although a patient is exempt from criminal sanctions for possession under Minnesota law, the patient is not exempt from penalties for:

(1) undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice;

(2) possessing or using medical cannabis:

   a. on a school bus or van;
   b. on the grounds of any preschool or primary or secondary school;
   c. in any correctional facility; or
   d. on the grounds of any child care facility or home daycare;

(3) vaporizing medical cannabis:

   a. on any form of public transportation
   b. where the vapor may be inhaled by a nonpatient minor child; or
   c. in a public place, including any indoor or outdoor area used by or open to the general public or a place of employment;[19] and

(4) operating, navigating, or being in actual physical control of any motor vehicle, aircraft, train, or motorboat, or working on transportation property, equipment, or facilities while under the influence of medical cannabis.[20]

Criminal sanctions[21]

A patient who intentionally sells or otherwise transfers medical cannabis to a person other than a patient, registered designated caregiver, or, if listed on the registry verification, a parent or legal

[18] *See generally* Minn. Stat. § 152.32, subd. 2.

[19] *See* Minn. Stat. § 144.413, subd. 1b.

[20] Minn. Stat. § 152.23.

[21] *See generally* Minn. Stat. § 152.33, subd. 2.

guardian, is guilty of a felony. This crime is punishable by imprisonment for not more than two years or payment of a fine of not more than $3,000, or both.

Criminal penalties for false statements[22]

A new criminal penalty was created for any person who intentionally makes a false statement to law enforcement about any fact or circumstance relating to the use of medical cannabis in order to avoid arrest or prosecution. Such a false statement makes the person guilty of a misdemeanor, punishable by imprisonment for up to 90 days, a fine of not more than $1,000, or both, in addition to any other applicable penalty under the law. A patient or a registered designated caregiver convicted of this crime is disqualified from any further participation in the registry program.

Patient discrimination prohibited[23]

A patient is protected from discrimination in a variety of circumstances.

School/Landlord. Neither a school nor a landlord may refuse to either enroll or lease to a patient solely because a person is enrolled in the registry program. This prohibition does not apply if failing to either lease or enroll the patient would cause the school or landlord to violate federal law or lose a monetary or licensing-related benefit under federal law.

Medical care. A patient's use of medical cannabis under the registry program is considered the authorized use of medication for purposes of medical care, including organ transplants. For more on discrimination of a patient's medical care, see *Health Care Practitioners – Other* (page 20).

Employment. An employer is prohibited from discriminating against a person in hiring, termination, or any term or condition of employment, or otherwise penalize the employee based on:

- the employee's status as a patient in the registry program; and
- a patient's positive drug test for cannabis components or metabolites, unless the patient used, possessed, or was impaired by medical cannabis while on the employer's premises or during the hours of employment.

An employer is not required to take actions, however, that would violate federal law or cause the loss of a federal monetary or licensing-related benefit. If an employee is required to take a drug test for the employer pursuant to section 181.953, the employee may present verification of enrollment in the patient registry as part of the employee's explanation under section 181.953, subdivision 6.

Custody/Visitation. The law precludes custody or visitation rights to a minor child from being denied based on a person's status as a patient enrolled in the registry program. The law also

[22] Minn. Stat. § 152.33, subd. 3.

[23] Minn. Stat. § 152.32, subd. 3.

requires that there is no presumption of neglect or child endangerment for conduct allowed under the registry program, 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.

C. Manufacturers

1. Registration[24]

On December 1, 2014, MDH registered two medical cannabis manufacturers that are subject to an annual reregistration and a onetime $20,000 application fee. As a condition of registration, a manufacturer must agree to begin distribution of medical cannabis to patients by July 1, 2015, and comply with other requirements under the law.

MDH must take the following factors into consideration when determining which manufacturers to register:

- Technical expertise in cultivation and conversion into allowable forms of medical cannabis
- The qualifications of the manufacturer's employees
- The long-term financial stability of the manufacturer
- The ability to provide appropriate security measures on the premises of the manufacturer
- Whether the manufacturer has demonstrated an ability to meet the medical cannabis production needs required by the registry program
- The manufacturer's projection and ongoing assessment of fees on patients

2. Regulation

Fees[25]

Manufacturers will be charged an annual fee for the cost incurred by MDH for the regulation and inspection of the manufacturer for that year. The yearly fee will be established and collected by the Commissioner of Health. Each manufacturer is allowed to charge patients enrolled in the program a "reasonable fee" for operating costs of the manufacturer. Manufacturers are allowed to establish a sliding scale of patient fees based on a patient's household income but are not required to establish the scale. Manufacturers may also accept private donations in order to reduce patient fees.

[24] Minn. Stat. § 152.25, subd. 1.

[25] Minn. Stat. § 152.35.

Operating documents[26]

Procedures for oversight must be included in the manufacturer's operating documents to ensure accurate recordkeeping and that appropriate security measures are in place to deter theft.

Location of facilities[27]

Each manufacturer will have four distribution facilities and one production facility (the production facility may be at the same location as a distribution facility). The distribution facilities must be located throughout the state based on geographical need in order to improve patient access. No facility may be within 1,000 feet of a school, public or private, that was in existence prior to the manufacturer's registration with MDH.

Employees[28]

A manufacturer is prohibited from employing any person under the age of 21 or any person who has been convicted of a disqualifying felony offense. A disqualifying felony offense includes any state or federal controlled substance crime that would be a felony under Minnesota law, whether or not the offense was committed in Minnesota and regardless of the sentence imposed. A manufacturer may employ a person who has been convicted of a disqualifying felony offense if the Commissioner of Health determines the conviction was for the use of or assistance with the use of medical cannabis. All potential employees must undergo a criminal history background check through the Bureau of Criminal Apprehension prior to working with the manufacturer.

Due to distribution requirements, manufacturers must also employ at least one pharmacist licensed in Minnesota. The pharmacist employee(s) must be the only employee(s) distributing medical cannabis after a consultation with the patient.[29]

Any employee of the manufacturer involved in delivering medical cannabis or medical cannabis products from one location to another must carry identification showing that the person is an employee of the manufacturer.[30]

Security[31]

Manufacturers must have certain security measures on all distribution sites as well as the production site. These security measures include:

- a fully operational security alarm system;

[26] Minn. Stat. § 152.29, subd. 1, para. (c).

[27] Minn. Stat. § 152.29, subd. 1, paras. (a) and (j).

[28] Minn. Stat. § 152.29, subd. 1, para. (i).

[29] Minn. Stat. § 152.29, subd. 3, para. (a).

[30] Minn. Stat. § 152.29, subd. 3, para. (d).

[31] Minn. Stat. § 152.29, subd. 1, para. (d).

- facility access control;
- perimeter intrusion detection systems; and
- a personnel identification system.

Contract with an independent laboratory[32]

Each manufacturer must contract with an independent laboratory that has been approved by the Commissioner of Health. The laboratory will test the manufacturers' medical cannabis for content, contamination, and consistency in order to verify that it meets the requirements under the law. The cost of this contract will be paid by the manufacturer and is subject to any additional requirements set by the Commissioner of Health.

Inspections[33]

Manufacturers are subject to reasonable inspections by the Commissioner of Health. Each manufacturer must keep detailed financial records in a manner approved by the commissioner and make these records available for the commissioner's review. In addition, the manufacturers must submit to the commissioner the results of an annual financial audit conducted by an independent certified public accountant, paid for by the manufacturer. The commissioner may require a second financial audit by a certified public accountant chosen by the commissioner, which would also be at the expense of the manufacturer.

The commissioner or the commissioner's designee may examine the business affairs of the manufacturer, including, but not limited to, review of the financing, budgets, revenues, sales, and pricing. The commissioner may retain outside professionals, such as attorneys and certified public accountants, but may not retain the same certified public accountant as used in the annual audit. If the commissioner conducts this examination, the commissioner must complete a report and provide a copy to the manufacturer and post a copy on the department's website. All data collected during this examination, except for the public report, are private data on individuals or nonpublic data.

Monthly report to MDH[34]

Each manufacturer must submit a monthly report to MDH. The report must include:

- the amount and dosages of medical cannabis distributed;
- the chemical composition of the medical cannabis; and
- the tracking number assigned to any medical cannabis distributed.

[32] Minn. Stat. § 152.29, subd. 1, para. (b).

[33] Minn. Stat. §§ 152.29, subd. 1, para. (g); 152.37.

[34] Minn. Stat. § 152.29, subd. 4.

3. Production

Requirements[35]

Each manufacturer must produce a reliable and ongoing supply of medical cannabis to patients and is required to produce medical cannabis in the forms allowed under the law prior to any distribution. Production of medical cannabis must be done in one location and must be in an enclosed and locked facility.

Allowable forms[36]

Medical cannabis may not be distributed in any form other than:

- pill; or
- liquid, including oil.

The Commissioner of Health may allow other forms, except smoking. Any addition by the commissioner is subject to legislative oversight.

Deadlines[37]

Each manufacturer must begin distribution to patients from at least one distribution site by July 1, 2015. Distribution must occur from all four distribution sites by July 1, 2016.

4. Distribution

What may be distributed[38]

A manufacturer may only distribute medical cannabis as a pill or liquid. The manufacturers are allowed, but not required, to distribute medical cannabis products, such as delivery devices and educational material.

All medical cannabis must be assigned a tracking number and be in packaging that complies with the United States Poison Prevention Packing Act. All medical cannabis must also be labeled with the following information:

- All active ingredients
- Individually identifying information, including:
    - the patient's name and date of birth

[35] Minn. Stat. § 152.29, subd. 2.

[36] Minn. Stat. § 152.22, subd. 6.

[37] Minn. Stat. § 152.29, subd. 1, para. (a).

[38] Minn. Stat. §§ 152.22, subd. 6; 152.29, subd. 3.

- if applicable, the name and date of birth of the patient's registered designated caregiver or parent or legal guardian
- the patient's registry identification number
- the chemical composition
- the dosage

People allowed to receive medical cannabis[39]

A manufacturer may distribute medical cannabis only to a person listed on the patient's registry verification that the manufacturer received from MDH. The manufacturer may not distribute any medical cannabis until the registry verification has been received. The registry verification will include patient information and may also include a registered designated caregiver or a parent or guardian of the patient. If a person is listed on the registry verification, the manufacturer may distribute the medical cannabis after verifying the person's identification by photographic identification, unless the individual distributing the medical cannabis personally knows the recipient.[40]

Who may distribute the medical cannabis[41]

Only employees of the manufacturer who are licensed pharmacists in Minnesota may distribute medical cannabis. Distribution by the pharmacist may only occur after the pharmacist has consulted with the patient to determine the proper dosage and range of chemical compositions for that individual patient.

Amount of medical cannabis that can be distributed[42]

A maximum of a 30-day supply of the dosage determined for the individual patient may be distributed at one time.

5. Other

Relationship with health care practitioners[43]

A manufacturer must not share office space with a health care practitioner. A manufacturer is also prohibited from referring patients to a health care practitioner or having any financial relationship with a health care practitioner.

[39] Minn. Stat. § 152.29, subd. 3.

[40] Minn. Stat. § 152.11, subd. 2d.

[41] Minn. Stat. § 152.29, subd. 3, para. (a).

[42] Minn. Stat. § 152.29, subd. 3, para. (c), cl. (6).

[43] Minn. Stat. § 152.29, subd. 1, para. (e).

Marketing restrictions[44]

Manufacturers must comply with reasonable restrictions set by the Commissioner of Health relating to signage, marketing, display, and advertising of medical cannabis.

Criminal and civil liability[45]

The law establishes several new criminal penalties that may apply to manufacturers or employees of manufacturers in addition to any other applicable penalty in law. Any manufacturer or agent of a manufacturer who intentionally transfers medical cannabis to a person other than one listed on a registry verification or submits false records or documentation required by MDH to register as a manufacturer is guilty of a felony punishable by up to two years of imprisonment, a fine of not more than $3,000, or both. A manufacturer may also be fined up to $1,000, in addition to any other applicable penalty in law, for any violation of laws or regulations relating to the registry program where no penalty is specified.

Criminal protections[46]

Employees of the manufacturer and the independent laboratory are exempted from criminal liability under Minnesota law for the possession, dosage determination, and sale of medical cannabis as permitted under the registry program.

D. Health Care Practitioners

A health care practitioner, for purposes of the registry program, is defined as a Minnesota-licensed doctor of medicine, a Minnesota-licensed physician assistant acting within the scope of practice, or a Minnesota-licensed advanced practice registered nurse, with the primary responsibility of care and treatment of the underlying qualifying medical condition.[47]

1. Participation

MDH training/notification[48]

The Commissioner of Health must notify all eligible health care practitioners in the state about the registry program. This notice must include an explanation of the purposes and requirements of the program. If a health care practitioner meets the requirements and requests to participate in the program, the commissioner must allow that participation. However, no health care practitioner is required to participate in the program.[49] In addition to notification, the

[44] Minn. Stat. § 152.29, subd. 1, para. (k).

[45] Minn. Stat. § 152.33, subds. 1 and 6.

[46] Minn. Stat. § 152.32, subd. 2.

[47] Minn. Stat. § 152.22, subd. 4.

[48] Minn. Stat. § 152.27, subd. 2, para. (a).

[49] Minn. Stat. § 152.28, subd. 1, para. (c).

commissioner also must provide practitioners with explanatory information and assistance in the understanding of the therapeutic uses of medical cannabis under the program requirements. The practitioner will receive the patient applications from the commissioner in order to provide those applications to patients.

Advice to patients[50]

Once a health care practitioner is working with a patient in the program, the law requires the practitioner to provide the patient, registered designated caregiver, or parent/legal guardian with information on nonprofit support groups or organizations. The practitioner is also required to provide the explanatory information that was received from MDH. The law requires the explanatory information to disclose:

- the experimental nature of therapeutic use of medical cannabis;
- the possible risks, benefits, and side effects of the proposed treatment;
- the application for participation in the program;
- other materials from the commissioner; and
- the Tennessen warning.[51]

Certifications[52]

In order for a patient to participate in the registry program, a health care practitioner must provide a certification of diagnosis for at least one of the qualifying medical conditions. The patient's application must include this certification in order to participate in the registry program, and the certification must have been given by the practitioner within the previous 90 days of the patient's application. The Commissioner of Health must develop the certification form and provide it to practitioners.

In certain circumstances, the practitioner may also provide a certification of a patient's disability. The law allows for patients in the registry program to have a registered designated caregiver if the patient is either unable to self-administer medication or is unable to acquire medical cannabis from a distribution facility due to a developmental or physical disability. If the practitioner determines that the disability prevents the patient from doing either one of those activities, the practitioner will provide that determination on the patient's certification of diagnosis.

Responsibilities during participation[53]

The law requires that if a health care practitioner agrees to participate in the registry program, the practitioner must continue treatment of the patient for the qualifying condition. The practitioner

[50] Minn. Stat. § 158.28, subd. 1, para. (a), cls. (3) and (4).

[51] *See* Minn. Stat. § 13.04, subd. 2 (explaining the Tennessen warning).

[52] Minn. Stat. § 152.28, subd. 1, para. (a), cls. (1) and (2).

[53] Minn. Stat. § 152.28, subd. 1, para. (b).

must report the health records of the patient throughout that ongoing treatment to the commissioner. The reporting of health records must be made in a manner set by the commissioner and is subject to data privacy provisions. Each year, the practitioner also must determine if the patient continues to suffer from a qualifying medical condition and, if so, issue a new certification of that diagnosis.

Medical Assistance/MinnesotaCare[54]

Medical Assistance (MA) and MinnesotaCare are not required to reimburse an enrollee or a provider for "costs associated with the medical use of cannabis." MA and MinnesotaCare are, however, still required to reimburse for services related to the treatment of the patient's qualifying medical condition if that service is covered under applicable statutes.

2. Legal Issues

Health records[55]

All data collected on patients and reported to the patient registry are health records under the Health Records Act and are considered private data on individuals. The data may, however, be used or reported in an aggregated, nonidentifiable form as part of the scientific, peer-reviewed publication of research required under the law or in the creation of summary data.

Civil/disciplinary[56]

The law prohibits the Board of Medical Practice, the Board of Nursing, or any other professional licensing board from subjecting a health care practitioner to any civil or disciplinary penalties solely for participation in the registry program. This protection also extends to pharmacists under the Board of Pharmacy. The protection does not prevent a professional licensing board from taking action in response to violations of any other section of law. The law also does not provide any civil protections for health care practitioners for claims of malpractice, negligence, or any other civil claim.

Criminal[57]

Although the law creates exemptions from criminal liability for certain actions by patients, caregivers, and manufacturers, it does not create criminal liability exemptions for health care practitioners. Under the registry program, a health care practitioner does not possess or distribute medical cannabis and is therefore not exempted from criminal controlled substance possession laws.

[54] Minn. Stat. § 152.23, para. (b).

[55] Minn. Stat. § 152.31.

[56] Minn. Stat. § 152.32, subd. 2, para. (c).

[57] Minn. Stat. § 152.33, subd. 5.

A health care practitioner is subject to a misdemeanor penalty, punishable by up to 90 days in jail or payment of a fine up to $1,000, or both, for the following actions:

- knowingly referring patients to a manufacturer or a designated caregiver
- advertising as a manufacturer
- issuing a certification while holding a financial interest in a manufacturer

A case decided by the federal Court of Appeals for the Ninth Circuit addressed whether a health care practitioner may be criminally liable for aiding and abetting a federal crime for his or her "recommendation" to a patient to use marijuana for medicinal purposes. In *Conant v. Walters,* the court held that a doctor's "recommendation" alone did not amount to aiding and abetting.[58] The case was based on California law that required a doctor to "recommend" a patient's use of medical marijuana. Minnesota law differs from California law in that respect, as a practitioner in Minnesota is providing a "certification of diagnosis" and not a "recommendation." It is also important to note that the Ninth Circuit Court of Appeals does not have jurisdiction over Minnesota and therefore this decision would not be binding on Minnesota courts. For more information on *Conant v. Walters*, see *Medical Cannabis Case Law* (page 41)**.**

3. Other

Federally approved clinical trials[59]

The Commissioner of Health must provide information to all patients about the existence of any federally approved clinical trials for the treatment of that patient's qualifying condition with medical cannabis. The commissioner may prohibit enrollment of a patient in the registry program if that patient is simultaneously enrolled in a federally approved clinical trial for the treatment of the patient's qualifying condition with medical cannabis.

Prescription Monitoring Program[60]

Medical cannabis will not be eligible to be entered into the Prescription Monitoring Program (PMP).[61] Under Minnesota and federal law, cannabis is a Schedule I controlled substance, and therefore the medical cannabis is not dispensed under a prescription drug order, as required by statute to be entered in the PMP.

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[58] *Conant v. Walters,* 309 F.3d 629 (9th Cir. 2002).

[59] Minn. Stat. § 152.24.

[60] Minn. Stat. § 152.126.

[61] The Prescription Monitoring Program (PMP) is codified in Minnesota Statutes, section 152.126. The PMP allows health care practitioners with prescribing authority to check the database for a patient's history of controlled substance prescriptions. The information in the PMP is generally inputted by the pharmacist who delivers the controlled substance. Among the included substances in the PMP are all substances classified as a Schedule II through V.

Discrimination for purposes of medical care[62]

The law prohibits discrimination against patients for the purpose of medical care. The law states that a patient's use of medical cannabis is considered the equivalent to the authorized use of any other medication and does not constitute the use of an illicit substance or otherwise disqualify a patient from needed medical care, including organ transplants.

Nursing facilities[63]

Under the law, nursing facilities may adopt reasonable restrictions on the use of medical cannabis by a patient who resides at the facility. For purposes of this provision, nursing facilities include those licensed under chapter 144A, boarding care homes licensed under section 144.50, and assisted living facilities. Restrictions may include that the facility will not store or maintain the patient's medical cannabis supply, that the facility is not responsible for providing the medical cannabis for patients, and that medical cannabis may only be used in specified places within the facility. The facilities are not required to adopt any restrictions and are prohibited from unreasonably limiting a patient's access to or use of medical cannabis.

E. Operation of the Program

1. Appropriations[64]

Health Department

MDH was appropriated $2,795,000 from the general fund for fiscal year 2015. The base of that appropriation in fiscal year 2016 is $829,000 and in fiscal year 2017 is $728,000. MDH was also appropriated $100,000 from the state government special revenue fund in fiscal year 2015. The base for that appropriation in fiscal year 2016 is $834,000 and in fiscal year 2017 is $729,000.

Appropriations to MDH

	Appropriation	Appropriation Base	
Fiscal year	**2015**	**2016**	**2017**
General Fund	$2,795,000	$829,000	$728,000
Special Revenue Fund	$100,000	$834,000	$729,000

Legislative Coordinating Commission

The Legislative Coordinating Commission was appropriated $24,000 from the general fund in fiscal year 2015 for administration of the task force on medical cannabis therapeutic research.

[62] Minn. Stat. § 152.32, subd. 3, para. (b).

[63] Minn. Stat. § 152.34.

[64] Laws 2014, ch. 311, § 21.

2. Task Force on Medical Cannabis Therapeutic Research[65]

The Task Force on Medical Cannabis Therapeutic Research was established to conduct an impact assessment of the registry program on Minnesota. The task force is also involved in certain deadline extensions for the program. The 23-member task force consists of representatives from:

- the House of Representatives and the Senate;
- consumers or patients enrolled in the registry program;
- health care providers;
- law enforcement and prosecutors;
- substance use disorder treatment providers; and
- the commissioners of health, human services, and public safety.

All members, except the members from the House of Representatives and the Senate, are appointed by the governor. Two members of the House of Representatives and two members of the Senate will also be appointed, with one member of each body serving as a co-chair. The co-chairs are appointed by the Senate majority leader and the Speaker of House. The second member from each body is appointed by the minority leader of that body. All members serve at the pleasure of their appointing authority.

Deadline extensions

The task force is involved in extending two deadlines required under statute.

Had the Commissioner of Health requested a deadline extension for the registration of two manufacturers, the request would have gone through the task force. However, MDH did register two manufacturers by the December 1, 2014, deadline so no extension was needed. The Commissioner of Health must also notify the task force if a manufacturer notifies the commissioner that it will not be able to distribute medical cannabis to patients by July 1, 2015. Upon notification from the commissioner, the task force must grant a single six-month extension to the manufacturer.

Impact assessment

The task force must complete an impact assessment and make multiple reports to the legislature. The impact assessment must be conducted by holding hearings to evaluate the impact of medical cannabis use and evaluate Minnesota's and other states' activities involving medical cannabis. The impact assessment must include analysis of:

- the program design and implementation;

[65] Minn. Stat. § 152.36.

- the impact on the health care provider community;
- patient experiences;
- the impact on the incidence of substance abuse;
- access to and quality of medical cannabis and medical cannabis products;
- the impact on law enforcement and prosecutions;
- public awareness and perception; and
- any unintended consequences.

Reports to the legislature

The task force must make the following reports to the legislature:

- February 1, 2015: report on the design and implementation of the registry program
- Every two years thereafter (starting in 2017): a complete impact assessment report
- Upon receipt from a commissioner of a state agency: a cost assessment report (assessing the financial impact the registry program has had on that state agency)

At any time, the task force may recommend to the legislature whether to add or remove conditions from the list of qualifying medical conditions.

III. Legal Issues

Author's Note: *The legal issues surrounding medical cannabis are changing at a rapid pace as more states adopt legislation, the federal government reacts to state legislation, and courts decide various legal issues surrounding medical cannabis. The following is a summary of a portion of the legal issues related to medical cannabis. As the laws and case law continue to change, so too will the legal analysis applied to these and other issues.*

A. Executive Summary

Criminal penalties

Under both Minnesota and federal law, possession or sale of cannabis are crimes. Under Minnesota law, patients and others involved in the registry program are exempt from certain possession and sale crimes for medical cannabis. Under federal law, however, patients and others involved in the registry program are not exempt from criminal penalties. In *Gonzales v. Raich*, the U.S. Supreme Court has held that Congress has the power under the Commerce Clause to regulate local, intrastate uses of medical cannabis.[66] After the U.S. Supreme Court's decision in *Raich*, there is no longer a question that a patient or other participant in a state medical cannabis program could potentially be charged criminally under federal law.

The United States Attorney General's Office has released several memorandums, most recently in 2013, directing the office to focus attention only on certain cannabis offenses. In December 2014, Congress passed a restriction on the Department of Justice's use of funds to prevent states from the implementation of the state medical marijuana program. See *Cannabis under Federal Law* (page 25) for more information.

Preemption

Aside from criminal liability, a court may also determine that federal law supersedes the Minnesota registry program. This can happen in either a civil or criminal case if a person were to assert a right under either the registry program or under federal law that potentially conflicts with the registry program. If the federal law supersedes a state medical cannabis law, the state law would become ineffective. No court with jurisdiction over Minnesota has decided the issue of whether state medical cannabis laws are superseded, otherwise known as "preempted," by federal law.

Preemption is a constitutional doctrine that determines when federal law supersedes state law. A state law may be preempted by a federal law under three theories: (1) express preemption; (2) field preemption; or (3) conflict preemption, either by making it impossible to comply with both laws, or if the purpose of the federal law has been frustrated. Courts that have decided the issues

[66] *Gonzales v. Raich*, 545 U.S. 1 (2005).

of whether federal law preempts state medical cannabis law have tended to focus on conflict preemption. Although no federal court of appeals has decided the issues, both the Oregon and Michigan Supreme Courts have decided cases resolving whether the federal law preempts one or more provisions of their state medical cannabis law. The Oregon court held that under conflict preemption, the affirmative authorization of the use of medical cannabis portion of the state law was preempted by federal law. The Michigan court, however, held that the state law was not preempted by federal law. See *Preemption – 4. Conflict Preemption* (page 31) for details on the courts' holdings.

Although there is no binding case law on Minnesota on the preemption issue, see *Preemption – 5. Consequences of Preemption on Minnesota's Medical Cannabis Registry Program* (page 36) for issues that a court may consider when considering whether the Minnesota's registry program would be preempted by federal law.

Medical cannabis case law

Several state and federal courts have decided several issues relating to medical cannabis laws. These issues include whether the medical necessity defense is available to users of medical cannabis, a physician's liability under federal law for recommending the use of medical cannabis, and a variety of other issues. See *Medical Cannabis Case Law* (page 38) for a survey of some cases that have been decided. There are currently several other cases related to a variety of legal issues that are in court in jurisdictions outside of Minnesota that have not yet been decided.

B. Cannabis under Federal Law

Under federal law, there are criminal and civil penalties associated with the possession of cannabis. In 1970, Congress enacted the federal Controlled Substances Act (CSA).[67] Under CSA, cannabis is listed as a Schedule I narcotic.[68] By definition, a Schedule I narcotic has a "high potential for abuse," "no currently accepted medical use in treatment," and "a lack of accepted safety for use of the drug…under medical supervision."[69]

Under CSA, it is a crime "to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense…" cannabis.[70] Penalties for manufacturing, distributing, dispensing, or possessing cannabis with the intent to distribute, vary depending on the amount of cannabis a person possesses.[71] However, even if a person does not have the intent to distribute cannabis, a person may still be convicted of simply possessing the cannabis.[72] There are also

[67] Controlled Substances Act, 21 U.S.C. §§ 801 et seq.

[68] 21 U.S.C. § 812.

[69] 21 U.S.C. § 812(b)(1).

[70] 21 U.S.C. § 841(a)(1).

[71] 21 U.S.C. § 841.

[72] 21 U.S.C. § 844.

criminal penalties for persons over the age of 18 who distribute cannabis to persons under the age of 21[73] and importing cannabis into the United States.[74] Under CSA, no additional penalties apply for crossing state lines with cannabis.[75]

In 2005, the U.S. Supreme Court considered whether CSA's regulation of local and personal medical uses of cannabis was authorized by Congress's power under the Commerce Clause in *Gonzales v. Raich*.[76] In deciding that Congress does have the power to regulate personal medicinal uses of cannabis, the Court stated that "Congress had a rational basis for concluding that leaving home-consumed marijuana outside federal control would…affect price and market conditions."[77] Congress's authority to regulate purely local uses of cannabis allows CSA to extend to cases that do not cross state lines or to individuals growing cannabis only for their personal consumption.[78]

After the Court held that federal power extended to local uses of medical cannabis, the U.S. Department of Justice and the Office of the Attorney General responded with guidance for how to deal with states that had enacted medical cannabis legislation or adopted ballot referendums. In October 2009, Deputy Attorney General David W. Ogden issued a memorandum to U.S. attorneys (hereinafter Ogden Memorandum).[79] In the Ogden Memorandum, U.S. attorneys were instructed not to focus resources on "individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana" and listed situations where "clear and unambiguous compliance" with state law may produce federal interest.[80]

In June 2011, however, another memorandum was released from Deputy Attorney General James M. Cole (hereinafter Cole Memorandum I).[81] Although the Cole Memorandum I did not override the Ogden Memorandum, it did state that the Ogden Memorandum was "never intended to shield" medical cannabis activities within a state from federal enforcement, even if persons

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[73] 21 U.S.C. § 859.

[74] 21 U.S.C. § 952.

[75] *See generally*, 21 U.S.C. § 801 et seq.

[76] *Gonzales v. Raich*, 545 U.S. 1 (2005).

[77] *Id.* at 19; *see also Wickard v. Filburn*, 317 U.S. 111, 128-129 (1942) (holding that Congress has the power to regulate purely local activities if those activities are of a "class of activities" that have a substantial effect on interstate commerce).

[78] *Id.* at 57-58 (Thomas, J., dissenting) (recognizing that the majority's holding allows Congress to regulate marijuana that had never crossed state lines).

[79] Memorandum for selected United States Attorneys from David W. Ogden, Deputy Attorney General, *Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana*, October 19, 2009, available at: http://www.justice.gov/sites/default/files/opa/legacy/2009/10/19/medical-marijuana.pdf.

[80] *Id.*

[81] Memorandum for United States Attorneys from James M. Cole, Deputy Attorney General, *Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use*, June 29, 2011, available at: http://www.justice.gov/sites/default/files/oip/legacy/2014/07/23/dag-guidance-2011-for-medical-marijuana-use.pdf.

were in compliance with state law.[82] This memorandum reiterated that local laws allowing for the use of medical cannabis were not a defense to criminal or civil penalties under federal law.[83]

Deputy Attorney General Cole issued another memorandum in August 2013 (hereinafter Cole Memorandum II).[84] The Cole Memorandum II listed eight priorities of the Justice Department and instructed that law enforcement and prosecution would focus on "persons or organizations whose conduct interferes with any one or more of th[o]se priorities, regardless of state law."[85] Although the Cole Memorandum II made clear that distribution or possession of cannabis was still a federal crime, it stated that the eight priorities for enforcement were:

- "Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
- Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property."[86]

In December 2014, Monty Wilkinson, the Director of the Executive Office for the United States Attorneys, released a memorandum addressing the federal regulation of medical marijuana (hereinafter the Wilkinson Memorandum).[87] The Wilkinson Memorandum addressed the policy of the U.S. Attorney's Office on prosecutorial resources used for marijuana violations of CSA in Indian Country. The Wilkinson Memorandum cited back to the Cole Memorandum II and the

[82] *Id.*

[83] *Id.*

[84] Memorandum for United States Attorneys from James M. Cole, Deputy Attorney General, *Guidance Regarding Marijuana Enforcement*, August 29, 2013, available at: http://www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf.

[85] *Id.*

[86] *Id.*

[87] Memorandum for United States Attorneys and others from Monty Wilkinson, Director of the Executive Office for the United States Attorneys, *Policy Statement Regarding Marijuana Issues in Indian Country*, October 28, 2014, available at: http://www.justice.gov/sites/default/files/tribal/pages/attachments/2014/12/11/policystatementregardingmarijuanaissuesinindiancountry2.pdf.

eight priorities of enforcement and stated that those priorities would "guide United States Attorneys' marijuana enforcement efforts in Indian Country, including in the event that sovereign Indian nations seek to legalize the cultivation or use of marijuana in Indian Country." However, the Wilkinson Memorandum did reiterate that nothing in the Cole Memorandum II limited the federal government's ability to prosecute under CSA.

On December 16, 2014, President Barack Obama signed the Consolidated and Further Continuing Appropriations Act, 2015 into law.[88] Contained within the Appropriations Act was a section relating to funding for the Department of Justice's enforcement of federal law in states with medical marijuana programs. Section 538 of the Appropriations Act states:

> None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin, to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.[89]

This limitation on the Department of Justice's use of funds is attached to the funding appropriated to the Department of Justice (DOJ). Because the provision is written as a limitation on the use of funding, it is a "rider." A rider allows or disallows the recipient of the money to use the money in certain ways. As a result, the limitation on DOJ will expire with the funding to which it was attached. Congress will either have to adopt a similar rider in the next appropriation to DOJ or the limitation will expire and no longer be effective.

The exact scope of the Appropriations Act provision is unclear, in particular the meaning of "implementing" and the effect it will have on a court's preemption analysis. It is possible that "implementing their own State laws" will be interpreted to apply only to state officials who are mandated under the state law to put in place administrative or governmental mechanisms that enable private entities to produce, distribute, and use marijuana for medical purposes under state law, but not those private entities themselves. In this sense, it would mean something akin to "administration" or "execution" of the state laws. However, it is also possible that the phrase will be interpreted more broadly to apply to all of the actions contemplated by the state, such as manufacturing, distributing, and using medical marijuana. As for a court's preemption analysis, it is possible that a court may interpret the limitation on the use of DOJ funds as an indication of congressional intent to lessen the tension between CSA and state medical marijuana laws. A court may also, however, see that Congress enacted a limitation on the use of funding instead of implementing a change to CSA and interpret the lack of congressional action in CSA as congressional intent to maintain the CSA prohibitions.

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[88] Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 538 (2014).

[89] *Id*.

C. Preemption

1. Preemption Generally

The constitutional doctrine of preemption is based in the Supremacy Clause of the United States Constitution. The Supremacy Clause states:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.[90]

Preemption begins with the central question of whether Congress intended to exercise its power to set aside state laws.[91] If Congress did so intend, then courts are required to follow the federal law instead of state law.[92]

The U.S. Supreme Court has recognized three ways in which a federal law will preempt a state law. First, Congress may expressly indicate in the statute or regulation that it intends to preempt state law.[93] Second, Congress may intend to "occupy an entire field of regulation, in which case the States must leave all regulatory activity in that area to the Federal Government."[94] Finally, a state law may be preempted if it conflicts with the federal law. Conflict preemption exists if it is either physically impossible for the laws to coexist or if the state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."[95]

No decision of the U.S. Supreme Court, any federal court of appeals, or the Minnesota Supreme Court has held that a state medical cannabis law is preempted by CSA.[96] The following is an overview of the three types of preemption as they may apply to medical cannabis laws.

2. Express Preemption

Express preemption occurs when Congress specifically states its intent, in the words of a federal statute, to preempt state law. Express preemption may indicate Congress's intent to completely preempt any state law on that topic or only to preempt under certain circumstances. If Congress has indicated an intent to only preempt under certain circumstances, a court will apply a preemption analysis consistent with Congress's expressed intent. The U.S. Supreme Court has

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[90] U.S. Const. art. IV, cl. 2.

[91] *Barnett Bank v. Nelson*, 517 U.S. 25, 30 (1996).

[92] *Id.*; *see also Hillsborough Cnty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 712 (1985) (quoting *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 211, 6 L.Ed. 23 (1984)).

[93] *Michigan Canners & Freezers Ass'n, Inc. v. Agric. Mktg. & Bargaining Bd.*, 467 U.S. 461, 469 (1984). [94] *Id.*

[95] *Id*. (citing *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)).

[96] *See generally* Controlled Substances Act, 21 U.S.C § 801 et seq.

held that scope of the intent expressed by Congress in the law supports "a reasonable inference…that Congress did not intent to pre-empt other matters."[97] For example, the Employee Retirement Income Security Act (ERISA) specifically states that its provisions will supersede any state law unless otherwise indicated in the act.[98]

CSA specifically states:

> No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any state law on the same subject matter which would otherwise be within the authority of the state, unless there is a positive conflict between that provision of this subchapter and that state law so that the two cannot consistently stand together.[99]

Although not specifically deciding a preemption case, the U.S. Supreme Court has held, "[t]he CSA explicitly contemplates a role for the states in regulating controlled substances, as evidenced by its pre-emption provision."[100]

3. Field Preemption

If Congress has not expressed its intent to preempt a state law, a court may still be able to imply preemption. Field preemption may occur when, although Congress has been silent as to preemption, the federal statutes or regulations are so pervasive as to occupy the entire field that a state is attempting to regulate.[101] As with other types of preemption, field preemption is "a question of ascertaining the intent underlying the federal scheme."[102]

In *Rice v. Santa Fe Elevator Corp.*, the U.S. Supreme Court considered whether an Illinois statute relating to public utilities, including just and reasonable rates and discrimination against the public, would be preempted by the United States Warehouse Act.[103] Recognizing that Congress had legislated in a field traditionally occupied by the states, the Court stated that the preemption analysis begins with "the assumption that the historic police powers of the States [are] not to be superseded by the Federal Act unless that [is] the clear and manifest purpose of Congress."[104] The Court went on to explain that the purpose of Congress may be demonstrated by

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[97] *Lorillard Tobacco Co. v. Reilley* 533 U.S. 525, 541 (2001).

[98] 29 U.S.C. § 1144(a).

[99] 21 U.S.C. § 903.

[100] *Gonzales v. Oregon*, 546 U.S. 243, 251 (2000) (holding that CSA did not authorize the United States Attorney General to administratively prohibit physicians from prescribing regulated drugs for use in physician-assisted suicide which was authorized by state law).

[101] *Barnett Bank*, 517 U.S. at 31 (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

[102] *Hillsborough Cnty.*, 471 U.S. at 714.

[103] *Santa Fe Elevator Corp.*, 331 U.S. at 220-26.

[104] *Id.* at 230 (citing *Napier v. Atl. Coast Line R.R. Co.*, 272 U.S. 605, 611 (1926); *Allen-Bradley Local v. Wisconsin Empt. Relations Bd.*, 315 U.S. 740, 749 (1942)).

the pervasiveness of the federal scheme, if the federal law touches a field that is dominant in the federal system, the object of the federal law, or if the state policy may produce inconsistent results with the federal law.[105]

The Court expanded on its holding in *Rice* in *Hillsborough Co. v. Automated Medical Labs, Inc.* There, the Court stated that, "the supremacy of the national power in the general field of foreign affairs…is made clear by the Constitution…and the regulation of that field is 'intimately blended and intertwined with responsibilities of the national government.'"[106] In *Hillsborough*, however, the Court was considering plasma regulation. The Court held that, "[t]here is also no merit in appellee's reliance on the national Blood Policy as an indication of the dominance of the federal interest in this area. Nothing in that policy takes plasma regulation out of the health-and-safety category and coverts it into an area of overriding national concern."[107]

Both the Michigan and the Oregon Supreme Courts have ruled on whether their respective state's medical cannabis program is preempted by CSA.[108] Both agreed that the state laws were not preempted under the theory of field preemption and instead, CSA requires there to be a positive conflict between state and federal law for preemption to occur.[109] See below for more information on the holdings of those two cases.

4. Conflict Preemption

Conflict preemption may also be applied if Congress has indicated an intent to only preempt state law if there is a conflict or, if Congress has been silent as to preemption, conflict preemption may be implied. The doctrine of conflict preemption generally takes two alternative forms:

- **Impossibility preemption** where is it impossible to comply with both federal and state law;[110] or
- **Obstacle or frustrated purpose preemption** where state law presents an obstacle to or frustrates the purpose of Congress's intent in enacting a particular law.[111]

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[105] *Id.* at 230 (citing *Pennsylvania R.R. Co. v. Pub. Serv. Comm'n.*, 250 U.S. 566, 569 (1919); *Cloverleaf Butter Co. v. Patterson*, 315 U.S. 148 (1942); *Hines*, 312 U.S. at 61; *S. R.R. Co. v. R.R. Comm'n.*, 236 U.S. 439 (1915); *Charleston & W.C.R. Co. v. Varnville Furniture Co.*, 237 U.S. 597 (1915); *New York Central R.R. Co. v. Winfield*, 244 U.S. 147 (1917); *Napier v. Atl. Coast Line R.R. Co.*, 272 U.S. 605; *Hill v. Florida*, 325 U.S. 538, 65 (1945)).

[106] *Hillsborough Cnty.*, 471 U.S. at 719 (citing and quoting *Hines*, 312 U.S. at 62, 66).

[107] *Hillsborough Cnty.* at 720.

[108] *Ter Beek v. Wyoming*, 846 N.W.2d 531 (Mich. 2014); *Emerald Steel Fabricators, Inc., v. Bureau of Labor & Indus.*, 230 P.3d 518 (Or. 2010).

[109] *Ter Beek*, 846 N.W.2d at 538; *Emerald Steel*, 230 P.3d at

528. [110] *Michigan Canners*, 467 U.S. at 469.

[111] *Id.* (quoting *Hines*, 312 U.S. at 67).

Impossibility conflict preemption

In its strongest form, impossibility preemption occurs when it is physically impossible to comply with both federal and state law. The Court has described the conflict as, for example, "if the federal law said, 'you must sell insurance,' while the state law said, 'you may not.'"[112] However, apparent conflicts may not rise to the level of impossibilities. In *Florida Lime & Avocado Growers, Inc. v. Paul,* the U.S. Supreme Court held that, although a California law had different percentage standards for acceptable avocados than the federal law, it was not impossible to comply with both laws.[113] The Court specifically held that the "record demonstrate[d] no inevitable collision between the two schemes of regulation, despite the dissimilarity of the standards."[114] More recently, the Court has held that "[i]mpossibility is a demanding defense."[115] Impossibility preemption has been referred to by the Court as an "irreconcilable conflict."[116]

In 2009, the U.S. Supreme Court considered whether a negligence claim against a drug manufacturer was preempted by the Food and Drug Administration's (FDA) drug labeling regulations.[117] In analyzing the preemption issue, the court recognized that congressional intent was the primary factor in preemption and that, particularly in cases where federal law touched a field traditionally occupied by the states, the Court starts with the assumption that Congress did not intend to preempt state law.[118] The Court looked to the legislative history of the statutory framework developing the FDA's powers and found that Congress had specifically added a provision indicating that a "state law would only be invalidated upon a 'direct and positive conflict' with the [Federal Food, Drug, and Cosmetic Act].'"[119] The Court also noted that Congress had enacted express preemption provisions for medical devices, but left the provision pertaining to prescription drugs unchanged.[120] After its review of congressional intent, the Court ultimately held that there was no evidence presented to indicate that it was impossible to comply with both state and FDA regulations.[121]

In 2010, the Oregon Supreme Court considered whether the Oregon Medical Marijuana Act was preempted by CSA in *Emerald Steel*.[122] The preemption issue began as an employment discrimination case when an employee was terminated after advising his employer that he had been issued a medical marijuana registry card and did engage in the use of medical marijuana,

[112] *Barnett Bank*, 517 U.S. at 31.

[113] *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 143 (1963).

[114] *Id.*

[115] *Wyeth v. Levine*, 555 U.S. 555, 573 (2009).

[116] *Barnett Bank*, 517 U.S. at 31.

[117] *Wyeth*, 555 U.S. at 563.

[118] *Id.* at 565 (citing *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (quoting *Santa Fe Elevator Corp.*, 331 U.S. at 230)).

[119] *Id.* at 567 (citing the Food, Drug, and Cosmetic Act, 21 U.S.C. § 202).

[120] *Id.* at 567.

[121] *Id.* at 571-73.

[122] *Emerald Steel*, 230 P.3d at 526-29.

although not at work.[123] The employer argued that Oregon employment law should be construed in the same manner as the Americans with Disabilities Act and that, therefore, the employee was not entitled to a reasonable accommodation for his disability because he was using an illegal substance.[124] The court, however, concluded that the use of medical marijuana in Oregon was excluded from "the 'illegal use of drugs'" under Oregon employment law.[125] The employer then raised the issue of preemption to the extent that Oregon law affirmatively authorized the use of a Schedule I controlled substance under federal law.[126] The employer argued that "federal law preempts [the portion of Oregon law that affirmatively authorizes the use of medical marijuana] and that, without any effective state law authorizing the use of medical marijuana, [the] employee's use of that drug was an 'illegal use of drugs' " and he was therefore not entitled to a reasonable accommodation.[127]

In *Emerald Steel*, the court looked to the preemption language in CSA and determined preemption required there to be a positive conflict between CSA and the state law.[128] Citing the U.S. Supreme Court's decision in *Wyeth v. Levine*, the Oregon court concluded that the CSA language required either a physical impossibility between the two laws or a frustration of the federal purpose.[129] For the physical impossibility prong, the court recognized that the U.S. Supreme Court has applied this type of preemption narrowly.[130] The court then looked to the U.S. Supreme Court's decision in *Barnett Bank*, which held that "[a]lthough…two statutes were logically inconsistent….it was not physically impossible to comply with both."[131] Although the court ultimately decided that the Oregon Medical Marijuana Act was preempted under the frustrated purpose prong, the court stated that a person can comply with both the state and federal law by "refraining from any use of marijuana" and, therefore, it was not preempted under the impossibility prong.[132]

In 2014, the Michigan Supreme Court also considered both impossibility conflict preemption and frustrated purpose conflict preemption for the Michigan Medical Marihuana Act (MMMA) in *Ter Beek v. City of Wyoming*.[133] In *Ter Beek*, the challenge was filed by a property owner against a city that prohibited land to be used in manner contrary to federal law, including the CSA.[134]

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[123] *Id*. at 520-21.

[124] *Id*. at 522.

[125] *Id*. at 525.

[126] *Id*. at 526.

[127] *Id*.

[128] *Id*. at 527-28.

[129] *Id*.

[130] *Id*. at 527 (citing *Wyeth*, 555 U.S. at 573).

[131] *Id*. at 528 (citing *Barnett Bank*, 517 U.S. at 31).

[132] *Id*. at 528.

[133] *Ter Beek*, 846 N.W.2d at 536-41.

[134] *Id*. at 534.

The city of Wyoming had adopted the ordinance two years after the MMMA went into effect.[135] Similarly to the Oregon court in *Emerald Steel*, the Michigan court recognized that the U.S. Supreme Court has held that impossibility preemption is narrowly applied and "requires more than '[t]he existence of a hypothetical or potential conflict.'"[136] The Michigan court went further and held that "[s]uch impossibility results when state law requires what federal law forbids, or vice versa."[137] The court held that because the MMMA did not require any person to commit a federal offense and did not attempt to prohibit punishment of possession of marijuana under federal law, that there was no physical impossibility between the two statutes.[138]

Obstacle or frustrated purpose conflict preemption

The U.S. Supreme Court has described conflict preemption under the theory of a frustrated federal purpose by holding, "[i]f the purpose of the act cannot otherwise be accomplished—if its operation within its chosen field else must be frustrated and its provisions be refused their natural effect—the state law must yield to the regulation of Congress within the sphere of its delegated power."[139] Congress's delegated power to legislate on and preempt areas typically a matter of state concern was considered not only in *Rice*, but also in *Boyle v. United Technologies Corporation*.[140] In *Boyle*, the Court cited *Rice*'s holding that a court must presume Congress did not intend to preempt areas typically reserved for the state and further held, "the fact that the area in question *is* one of unique federal concern changes what would otherwise be a conflict that cannot produce pre-emption into one that can."[141]

In 1984, the Court considered whether a Michigan law that permitted agricultural producers associations and provided for further regulation than federal law, was preempted by the federal Agricultural Fair Practice Act (AFPA) in *Michigan Canners & Freezers Association, Inc. v. Agricultural Marking & Bargaining Board*.[142] Under the Michigan law, agricultural producers associations were allowed to do "precisely what the federal Act forbid[] them to do."[143] The *Michigan Canners* Court held that because the Michigan act "authorize[d]" the associations to do

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[135] *Id*.

[136] *Id*. at 537 (citing *Wyeth*, 555 U.S. at 573) (quoting *Rice v. Norman Williams Co.*, 458 U.S. 654, 659 (1982)).

[137] *Id*. at 537 (citing *Mut. Pharm. Co., Inc. v. Bartlett*, 133 S.Ct. 2466, 2476-77 (2013); *PLIVA Inc. v. Mensing*, 131 S.Ct. 2567, 2577-28 (2011); *Geier v. Am. Honda Motor Co., Inc.*, 529 U.S. 861, 873 (2000); *Barnett Bank*, 517 U.S. at 31).

[138] *Id*. at 537.

[139] *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 373 (2000) (quoting *Savage v. Jones*, 225 U.S. 501, 533 (1912) (quoted in *Hines*, 312 U.S. at 52)).

[140] *Boyle v. United Techs. Co.*, 487 U.S. 500 (1988); *see also supra* text accompanying notes 103 - 105 (explaining the Court's holding in *Rice*).

[141] *Id*. at 508-07.

[142] *Michigan Canners*, 467 U.S. at 464-68.

[143] *Id*. at 477-78.

what federal law prohibits, that the Michigan act stood as "'an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'"[144]

The next year, the Court held that a county ordinance in Florida regulating plasma donations was not preempted by the federal Public Health Service Act.[145] In *Hillsborough County, Florida v. Automated Medical Laboratories, Inc.*, the Court first recognized that plasma donation regulation was in the category of health and therefore historically a matter of local concern.[146] Even though there was a national blood policy, the Court stated there was nothing to convert plasma donation regulation "into an area of overriding national concern" for preemption purposes.[147] Next, the Court looked to whether the county's regulations, which were more stringent than federal regulations, presented "a serious obstacle to the federal goal of ensuring an adequate supply of plasma."[148] The agency with regulatory authority over plasma donations, the FDA, had not suggested that the ordinance interfered with federal goals and the Court was therefore "reluctant in the absence of strong evidence to find a threat to the federal goal of ensuring sufficient plasma."[149]

The preemption analysis by the Oregon and Michigan Supreme Courts differed under the frustrated purpose prong of conflict preemption. In *Emerald Steel*, the Oregon Supreme Court found that part of the Oregon Medical Marijuana Act was preempted by CSA.[150] The portion of the act in question for preemption purposes was Oregon Statutes, section 475.306(1), which "authorized" the use of medical marijuana for persons holding a registry identification card.[151] Given that the specifically challenged portion of the act affirmatively authorized the use of what the federal law prohibits, the court relied on *Michigan Canners* to hold that the portion of the act that authorized use was preempted under the frustrated purpose prong of conflict preemption.[152] The court made clear, however, that the holding was limited to that portion of the act: "we do not hold that the Controlled Substances Act preempts provisions of the Oregon Medical Marijuana Act that exempt the possession, manufacture, or distribution of medical marijuana from state criminal liability."[153]

In *Ter Beek*, however, it was the exemption from criminal liability for patients that the Michigan Supreme Court held was not preempted by CSA.[154] In its analysis, the court noted that in *Raich*, the U.S. Supreme Court noted that the main objective of CSA was "to conquer drug abuse and to

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[144] *Id.* at 478 (quoting *Hines*, 312 U.S. at 67).

[145] *Hillsborough Cnty.*, 471 U.S. at 722.

[146] *Id.* at 719-20.

[147] *Id.*

[148] *Id.* at 720 (internal quotations omitted).

[149] *Id.* at 721.

[150] *Emerald Steel*, 230 P.3d at 529.

[151] *Id.* at 161; *see also* Or. Rev. Stat. § 475.306(1) (2013).

[152] *Id.* at 529.

[153] *Id.* at 536.

[154] *Ter Beek*, 846 N.W.2d at 541.

control the legitimate and illegitimate traffic in controlled substances."[155] The court then noted that Michigan has parted ways with Congress regarding only medical marijuana for a "limited class of individuals" for the purposes of "the health and welfare of Michigan citizens."[156] In addition, the court noted, Congress had "explicitly contemplate[d] a role for the States," and there was nothing in CSA to indicate that Congress's intent was to require states to enforce the federal marijuana prohibitions.[157]

Unlike the Oregon court in *Emerald Steel*, the *Ter Beek* court distinguished *Michigan Canners* from the Michigan Medical Marijuana Act.[158] The court reasoned that the criminal exemptions for possession of marijuana did not prevent the federal government from enforcing CSA, unlike *Michigan Canners* where the state law denied a right that federal law had given agricultural associations.[159] The court then pointed out that in *Emerald Steel*, the Oregon Supreme Court was addressing a substantively different issue in that the law had specifically authorized use and further noted the *Emerald Steel* court did not decide the issue of preemption in relation to exemptions for criminal liability.[160]

Aside from the Michigan and Oregon Supreme Courts, there have been several lower state courts that have looked at the issue of preemption in relation to medical cannabis.[161] No Minnesota appellate court has directly addressed whether CSA preempts medical cannabis laws.[162]

5. Consequences of Preemption on Minnesota's Medical Cannabis Registry Program

The central question in any preemption case is congressional intent. From there, a court would need to determine how a challenged provision of a medical cannabis law fits with the CSA. A court would then apply one of the above mentioned types of preemption. Essentially, a

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[155] *Id.* at 539 (quoting *Raich*, 545 U.S. at 12).

[156] *Id.* at 539 (internal quotations omitted).

[157] *Id.* at 539 (quoting *Gonzales v. Oregon*, 546 U.S. 243, 251 (2006).

[158] *Id.* at 539-40.

[159] *Id.* at 540.

[160] *Id.*

[161] *See generally City of Garden Grove v. Superior Court*, 157 Cal. App.4th 355 (2007) (holding that the return of seized medical marijuana was not preempted by federal law); *Cnty. of San Diego v. San Diego NORML*, 165 Cal.App.4th 798 (2008) (holding that the identification card provisions do not positively conflict with CSA and are therefore not preempted); *Qualified Patients Ass'n v. City of Anaheim*, 187 Cal.App.4th 734 (2010) (holding that the exemptions from criminal liability for medical marijuana were not preempted by CSA).

[162] *But see*, *Haumant v. Griffin*, 699 N.W.2d 744 (Minn. Ct. App. 2005). At issue in *Haumant* was a charter amendment proposed by a citizen for the city of Minneapolis to allow medical marijuana distribution centers. The Minneapolis City Council refused to put the charter amendment on the ballot on the basis that it would be preempted by federal law and was therefore unconstitutional. The Court of Appeals held that the charter amendment would be preempted by state law. The court did address federal preemption but noted, however, that the topic of federal preemption "need not be reached in light of the [holding of preemption based on state law]." While discussing federal preemption in dicta, however, the court stated that if the charter proposal were to pass, it would "conflict with current federal law and would thus be without effect."

preemption case would focus mainly on (1) which provision of the medical cannabis law was challenged; (2) how the court views Congress's intent under the preemption clause of CSA; and (3) which type of preemption the court applies.

If a court with jurisdiction over Minnesota[163] decides that a federal law, such as CSA, does preempt the registry program, the registry program's continued existence would depend on what type of preemption the court applied and to which parts of the program. As previously discussed, it is more likely that a court will apply conflict preemption rather than either express or field preemption.[164]

If a court applies impossibility conflict preemption, the court would be deciding that it is impossible to comply with federal law and, at least part of, the Minnesota law. If the court decides it is impossible to comply with the *entire* registry program and a federal law, such as CSA, then the registry program statutes would become ineffective.

However, a court could decide that it is only impossible to comply with both federal law and parts of the registry program. For example, a court could decide that it is impossible to comply with the employment discrimination protections under the registry program and federal employment statutes. A court could also potentially decide that it is impossible to comply with the conditions to maintain registration in the program as a patient, such as only obtaining medical cannabis from a manufacturer, and CSA, which prohibits the possession of cannabis. Under either scenario, or any other partial preemption, only that portion of the law would be preempted and the rest of the registry program would continue to exist. However, if the portion of the law that was preempted was essential to the existence to the registry program, such as patient participation, then although the entire program had not been preempted, the program would likely become ineffective.

The same is true if a court were to apply frustrated purpose conflict preemption. As previously discussed, the Oregon Supreme Court held that the provision in the Oregon Medical Marijuana Act that specifically allowed for the use of medical marijuana frustrated the purpose of CSA and was therefore preempted.[165] However, the court made clear that it was not applying preemption to the criminal exemptions portion of the law. Therefore, only the part of the law that was preempted would be ineffective, and the rest of the program would be able to continue.

A court with jurisdiction over Minnesota could decide similarly to the Oregon court and hold that only part of the law frustrates the purposes of CSA, or any other federal law. If that happened, only that portion of the law would be preempted. However, a court could also find that the purpose of CSA was to fully regulate marijuana as a controlled substance and decide that the entire Minnesota registry program frustrates the purpose of CSA and therefore the two cannot coexist. If that were the decision, the entire registry program would become ineffective.

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[163] Courts with jurisdiction over Minnesota include the Minnesota Court of Appeals, Minnesota Supreme Court, the federal District Court for the District of Minnesota, the Eighth Circuit Court of Appeals, and the U.S. Supreme Court.

[164] *See generally* text accompanying notes 97 to 109.

[165] *See* text accompanying notes 150 to 153.

Unless a court having jurisdiction over Minnesota decides the issue of preemption as applied to medical cannabis laws, the Minnesota registry program will continue to exist as written. Although a court may look to other decisions already published on the issue, it is not bound to follow the same holdings or the same reasoning. Under the current federal law, the issue of preemption as applied to the Minnesota registry program will not be answered until a court having jurisdiction over Minnesota decides the issue. If the federal law were to change, so too would the preemption analysis.

D. Medical Cannabis Case Law

1. Medical Necessity Defense

In 2001, the U.S. Supreme Court held that there was no implied medical necessity defense to federal criminal charges under CSA in *U.S. v. Oakland Cannabis Buyers' Cooperative*.[166] The Court reasoned that the necessity defense could not be invoked if the legislature has made a determination of values.[167] Under CSA, the legislature had determined that cannabis had no currently accepted medical use by scheduling cannabis as a Schedule I controlled substance.[168] The cooperative argued that even though Congress and the attorney general, who has the authority to reschedule controlled substances under CSA, had determined while there was no medical benefit to cannabis, there may nonetheless be a medical benefit to some patients.[169] The Court rejected this argument, stating that it was "[u]nwilling to view [the omission of a medical necessity defense in CSA] as an accident, and unable in any event to override a legislative determination manifest in a statute…"[170]

Prior to the *Oakland Cannabis Buyers'* decision, the Minnesota Court of Appeals decided that the medical necessity did not apply to a Minnesota controlled substance charge in *State v. Hanson*.[171] The court held that the legislature had classified marijuana as a Schedule I substance, which meant that there was "no currently accepted medical use in the United States."[172] After recognizing that there was only one statutory exception to that classification, the THC Therapeutic Research Act, the court held that the legislature had clearly considered the possible

[166] *U.S. v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 494 (2001); *but see State v. Kurtz*, 246 P.3d 283 (Wash. 2013) (holding that the state legislature's acts of classifying marijuana as a Schedule I controlled substance and passing medical marijuana laws did not abrogate the common law medical necessity defense. This case does not cite to *Oakland Cannabis Buyers'*).

[167] *Id*. at 491 (internal citation omitted).

[168] *Id*. at 491; *see also* 21 U.S.C. § 812.

[169] *Id*. at 492-93.

[170] *Id*. at 493.

[171] *State v. Hanson*, 468 N.W.2d 77 (Minn. Ct. App. 1991).

[172] *Id*. at 78 (internal quotations omitted).

medical uses of marijuana and had not codified the defense of medical necessity for marijuana use.[173]

2. Rescheduling of Cannabis

Author's Note: *The remaining cases discussed were decided in jurisdictions outside of Minnesota courts or federal courts having jurisdiction over Minnesota. Therefore, the following case law is not binding on Minnesota courts and represents only a portion of the cases decided across the United States regarding medical cannabis.*

Several courts have addressed rescheduling of cannabis from a Schedule I controlled substance to a lower schedule. In 1984, both the Seventh and Eleventh Circuit Courts of Appeals held that the federal trial court did not err by refusing to reclassify cannabis based on testimony that there was a medical benefit.[174] The Seventh Circuit specifically pointed out that, under CSA, it was the job of Congress and the attorney general to reschedule controlled substances.[175]

More recently, the U.S. Court of Appeals for the District of Columbia Circuit has held that the Drug Enforcement Agency's decision to continue to classify cannabis as a Schedule I controlled substance was supported by substantial evidence.[176] The next year, the court held that a prisoner was not entitled to a writ of mandamus compelling the attorney general to reclassify cannabis from a Schedule I to a Schedule V.[177] The prisoner argued that there were accepted medical uses for cannabis and that a writ of mandamus was warranted due to the attorney general having "deliberate indifference" towards his suffering in violation of his Eighth Amendment rights.[178] The court held that a writ of mandamus was inappropriate because the attorney general did not have a clear duty to act and the prisoner did not show any evidence he could succeed on the merits of his case.[179]

The Second Circuit Court of Appeals has also held that the Department of Justice memorandums did not de facto reschedule marijuana.[180] The defendant in the case argued that his charges for a controlled substance crime could not stand because of the both the Ogden Memorandum and the Cole Memorandum I (See *Cannabis under Federal Law* for a discussion of these memorandums) had implicitly rescheduled cannabis so that it was no longer a Schedule I controlled substance.[181]

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[173] *Id*. at 78-79.

[174] *U.S. v. Wables*, 731 F.2d 440, 450 (7th Cir. 1984); *U.S. v. Astling*, 733 F.2d 1446, 1453 (11th Cir. 1984) (citing *U.S. v. Middleton*, 690 F.2d 820, 822-24 (11th Cir. 1982), *cert. denied*, 460 U.S. 1051 (1983); *U.S. v. Gramlick*, 551 F.2d 1359, 1364 (5th Cir. 1977), *cert. denied*, 434 U.S. 866 (1977)).

[175] *Wables*, at 450.

[176] *Ams. for Safe Access v. D.E.A.*, 706 F.3d 439, 449 (D.C. Cir. 2013).

[177] *Thomas v. Holder*, 750 F.3d 899, 903 (D.C. Cir. 2014).

[178] *Id*. at 903-04.

[179] *Id*. at 904.

[180] *U.S. v. Canori*, 737 F.3d 181, 185 (2d. Cir. 2013).

[181] *Id*. at 184.

The court held that the memorandums not only specifically stated that cannabis remained a Schedule I controlled substance, but also that there were specific provisions in CSA dictating how the attorney general could reschedule cannabis.[182]

3. Effect on Conditions of Supervised Release

In 2010, the U.S. District Court for the Eastern District of Michigan held that a defendant who was on federal probation violated his terms of release by possessing cannabis even for medicinal purposes.[183] The defendant's terms of release prohibited him from committing any federal, state, or local crime.[184] The court reasoned that it is "indisputable that state medical-marijuana laws do not, and cannot, supersede federal laws that criminalize the possession of marijuana."[185] Therefore, the defendant, even though his application for registration under the Michigan Medical Marihuana Act was valid, was in violation of his conditions of supervised release.[186]

The U.S. District Court for the District of Maine made a similar holding in 2011.[187] There, the defendant had been issued a registry card allowing him to possess and use cannabis for medicinal purposes under Maine law, and, although prohibited from using controlled substances under the terms of his federal supervised release, he petitioned the court to be allowed to use medical cannabis.[188] The terms of the defendant's release allowed the use of a controlled substance if prescribed by a physician, but the court noted that a physician is not allowed to prescribe a Schedule I controlled substance under federal or Maine law.[189] The court also noted that the defendant had a history of substance abuse during his supervised release and had misrepresented that abuse to his probation officer.[190] Therefore, regardless of his possession of a Maine registry identification card, the court refused to grant permission to the defendant to use medical cannabis in violation of his conditions of supervised release.[191]

In 2008, the Montana Supreme Court held that the trial court had exceeded its authority when it imposed conditions of release on a defendant that limited his use of medical cannabis to only pill

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[182] *Id*.

[183] *U.S. v. Hicks*, 722 F.Supp.2d 829, 834 (E.D. Mich. 2010).

[184] *Id*. at 831.

[185] *Id*. at 833 (citing *Raich*, 545 U.S. at 29; *U.S. v. $186,416.00 in U.S. Currency*, 590 F.3d 942, 945 (9th Cir. 2010) (holding that the federal government has not made an exception for the medical use of cannabis under CSA); *U.S. v. Scarmazzo*, 554 F.Supp.2d 1102, 1109 (E.D. Cal. 2008) (holding that CSA is valid despite state law to the contrary); *U.S. v. Landa*, 281 F.Supp.2d 1139, 1145 (N.D. Cal 2003) (holding that Congress has criminalized cannabis even for medicinal purposes).

[186] *Id*. at 832, 834.

[187] *U.S. v. Barnard*, 770 F.Supp.2d 366 (D. Maine 2011); *see also Reed v. Michaus*, 489 Fed.Appx 767 (10th Cir. 2012).

[188] *Id*. at 367.

[189] *Id*. at 368.

[190] *Id*.

[191] *Id*. at 369.

form when the law allowed for use in more forms.[192] The court specifically held "…that a district court does not have the statutory authority to impose a sentencing condition which denies a qualifying patient the right to use medical marijuana in accordance with the [state law]…"[193] The court did state, however, that conditions such as place of use or use around children would be acceptable.[194] In the same case, the court held that a sentencing condition requiring the defendant to obey all federal laws, including CSA, also exceeded the trial court's authority.[195] The court cited the U.S. Supreme Court in holding that Congress does not have the authority to force federal regulatory schemes on states and that the Montana Medical Marijuana Act was a valid exercise of the state's police powers.[196]

4. Physician Participation in Medical Cannabis Programs

In *Conant v. Walters*, the Ninth Circuit Court of Appeals considered a federal policy that revoked a physician's license to prescribe controlled substances if that physician recommended the use of medical cannabis to a patient pursuant to state law and ultimately upheld an injunction prohibiting the federal policy.[197] The federal policy was based on the premise that a physician's recommendation of the use of medical cannabis was against the public interest.[198]

The court held that a physician's "recommendation" was not analogous to a "prescription," which the court agreed would be prohibited under federal law.[199] The court stated that a prescription, given to the patient with the intent that the patient obtain cannabis, would constitute aiding and abetting a federal crime.[200] The injunction upheld by the court did not prohibit the federal government from investigating or prosecuting physicians if there was probable cause to believe the physician had been aiding and abetting a federal crime.[201]

According to the court, aiding and abetting requires proof:

> (1) that the accused had the specific intent to facilitate the commission of a crime by another, (2) that the accused had the requisite intent of the underlying substantive offense, (3) that the accused assisted or participated in the commission

[192] *State v. Nelson*, 195, P.3d 826, 833 (Mont. 2008).

[193] *Id.*

[194] *Id*.

[195] *Id*.

[196] *Id*. at 833-34 (citing *Printz v. U.S.*, 521 U.S. 898, 935 (1997)).

[197] *Conant v. Walters*, 309 F.3d 629, 632 (9th Cir. 2002).

[198] *Id*.

[199] *Id*. at 635.

[200] *Id*.

[201] *Id*.

> of the underlying substantive offense, and (4) that someone committed the underlying substantive offense.[202]

In holding that a physician was not aiding and abetting by issuing a recommendation, the court stated that a physician's "anticipation of patient conduct" did not translate into the intent necessary for aiding and abetting.[203] The court applied the same reasoning to a physician's criminal liability for conspiracy to commit a federal crime.[204] The court came to the same conclusion that a physician would not have the requisite intent for liability under the theory of conspiracy.[205]

Ultimately, the court held that a physician's conversations with a patient were protected under the First Amendment as free speech.[206] The court noted the U.S. Supreme Court has "recognized that physician speech is entitled to First Amendment protection because of the significance of the doctor-patient relationship" and that "professional speech may be entitled to 'the strongest protection our Constitution has to offer.'"[207]

The court analogized the case to *Thompson v. Western States Medical Center*.[208] In *Thompson*, the U.S. Supreme Court had held that a regulation prohibiting physicians and pharmacists from certain advertisements of compound drugs was a violation of the First Amendment and rejected the argument that people would make bad decisions based on a physician's truthful information.[209] The *Conant* court stated it too would refuse the government's argument that a physician's recommendation to a patient may lead to the patient making a poor choice and was not protected under the First Amendment.[210] Quoting *Thompson*, the court stated, "'[i]f the First Amendment means anything, it means that regulating speech must be a last—not first—resort. Yet here it seems to have been the first strategy the Government thought to try.'"[211]

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[202] *Id*. (citing *U.S. v. Gaskins*, 849 F.2d 454, 459 (9th Cir. 1988)).

[203] *Id*. at 635-36.

[204] *Id*.

[205] *Id*.

[206] *Id*. at 637.

[207] *Id*. at 636-37 (citing *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 884 (1992)) (quoting *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 634 (1995)).

[208] *Id.* at 637 (citing *Thompson v. W. Med. Ctr.*, 535 U.S. 357 (2002).

[209] *Id*. at 637 (citing *Thompson*, at 360).

[210] *Id*. at 637.

[211] *Id*. (quoting *Thompson*, at 373).

Appendix I: Legislative History of Medical Cannabis in Minnesota

In 1980, the THC Therapeutic Research Act was adopted and signed into law. The purpose of the act was to research whether cannabis could alleviate the effects of chemotherapy during the treatment of cancer.[212] The act required the Commissioner of the Department of Health to appoint a principal investigator.[213] The principal investigator was required to obtain cannabis only from the National Institute on Drug Abuse and comply with federal laws and regulations while conducting the research program.[214] In 1980, $100,000 was appropriated by the legislature to the Commissioner of Health to administer the act but the appropriation was vetoed by Gov. Al Quie.[215]

In 2001, Rep. Phyllis Kahn introduced House File 2164, known as the Compassionate Use Act. That act would have allowed for the medical use of cannabis after a patient had been diagnosed by a physician as having a debilitating medical condition. The House bill, and its companion bill in the Senate, were both introduced but not heard in committee.

In 2007, Rep. Thomas Huntley introduced House File 655 and Sen. Steve Murphy introduced Senate File 345. Both bills would have allowed the use of medical cannabis for treatment of a debilitating medical condition. The Senate file passed the Senate floor and was transferred to the House where it was given a second reading, but not ultimately passed.

In 2009, the first medical cannabis law that would have allowed patient possession of medical cannabis passed both bodies of the legislature. The act allowed patients to possess and use cannabis if diagnosed with a terminal illness that was accompanied by a variety of symptoms. The act passed both the House and the Senate and was vetoed by Gov. Tim Pawlenty on May 22, 2009.

In 2013, Rep. Carly Melin and Sen. Scott Dibble introduced House File 1818 and Senate File 1641, respectively, both allowing for the use and possession of medical cannabis by patients with a specified list of conditions. House File 1818 was referred to committee but did not pass the House floor. Senate File 1641 did ultimately pass the Senate on May 6, 2014, and was referred to the House for consideration, but was not heard in committee.

On April 24, 2014, Senate File 2470, originally a bill relating to education, passed the Senate and was referred to the House for consideration. The bill was heard in the Rules and Administration Committee where an amendment was offered and adopted that allowed for the medical use of cannabis through a clinical trial model. The bill was then heard in the Ways and Means Committee where another amendment was offered and adopted, altering the program to a registry program. The bill was ultimately sent to the House floor where it was passed by the

[212] Minn. Stat. § 152.21, subd. 1 (2014).

[213] Minn. Stat. § 152.21, subd. 4 (2014).

[214] Minn. Stat. § 152.21, subd. 5 (2014).

[215] Laws 1980, ch. 614, § 30.

House with additional amendments. Due to the bill having originated in the Senate and having already passed the Senate, the Senate was able to either concur on the bill as amended or refuse to concur. The Senate refused to concur and the bill was heard in conference committee and ultimately passed by both the Senate and House as amended in conference committee. Gov. Mark Dayton signed the bill into law on May 29, 2014.

Appendix II: Cannabis under Minnesota Law

Outside of the Medical Cannabis Registry Program, Minnesota law imposes criminal and civil penalties for the possession or sale of cannabis. Under Minnesota law, cannabis and tetrahydrocannabinol, the psychoactive ingredient found in cannabis, are Schedule I controlled substances. The penalties vary based on the quantity possessed or sold and the circumstances.

Level of Offense	Crime	Punishment
1st Degree - § 152.021	• Sale - On one or more occasions within a 90-day period, selling one or more mixtures of a total weight of **50 kilograms or more**; or - On one or more occasions within a 90-day period selling one or more mixtures of a total weight of **25 kilograms or more in a school zone, park zone, public housing, or drug treatment facility** • Possession - One or more mixtures of **100 kilograms or more**	Imprisonment of **not *more* than 30 years**, or a fine of not more than **$1,000,000**, or **both.** If the conviction is a subsequent controlled substance conviction, mandatory imprisonment of **not *less* than four years** nor more than **40 years**, a fine of not more than **$1,000,000**, or **both.**
2nd Degree - § 152.022	• Sale - On one or more occasions within a 90-day period, selling one or more mixtures of a total weight of **25 kilograms or more**; or - One or more mixtures of **5 kilograms or more in a school zone, park zone, public housing zone, or drug treatment facility** • Possession - One or more mixtures of **50 kilograms or more**	Imprisonment of **not *more* than 25 years**, or a fine of not more than **$500,000**, or **both.** If the conviction is a subsequent controlled substance conviction, mandatory imprisonment of **not *less* than three years** nor more than **40 years**, a fine of **$500,000**, or **both.**

Level of Offense	Crime	Punishment
3rd Degree - § 152.023	• Sale - Sells a mixture to a person under age 18; or - On one or more occasions within a 90-day period, selling one or more mixtures of **5 kilograms or more** • Possession - On one or more occasions within a 90-day period, possessing one or more mixtures of **10 kilograms or more**	Imprisonment of **not more than 20 years** or a fine of not more than **$250,000**, or **both.** If the conviction is a subsequent controlled substance conviction, mandatory imprisonment of **not *less* than two years** nor more than **30 years**, a fine of **$250,000**, or **both.**
4th Degree - § 152.024	• Sale - Sale of **any amount in a school zone, park zone, public housing zone, or drug treatment facility,** except a small amount (42.5 grams or less) for no payment. • Possession - None	Imprisonment of **not *more* than 15 years** or a fine of not more than **$100,000**, or **both.** If the conviction is a subsequent controlled substance conviction, mandatory imprisonment of **not *less* than one year** nor more than **30 years**, a fine of not more than **$100,000**, or **both.**
5th Degree - § 152.025	• Sale - **Any amount,** *unless* it is 42.5 grams or less and sold for no payment • Possession - **Any amount over 42.5 grams**; or - **Any amount** due to means including, but not limited to, fraud, deceit, using a false name, or giving false credit	Imprisonment of **not *more* than five years** or a fine of not more than **$10,000**, or **both**. If the conviction is a subsequent controlled substance conviction, mandatory imprisonment of **not *less* than six months** nor more than **ten years**, a fine of not more than **$20,000**, or **both** (mandatory sentencing may be waived).

Level of Offense	Crime	Punishment
Importation - § 152.0261	• Crossing into Minnesota with while possessing an amount that would be a first-degree controlled substance possession crime; or • With intent to obstruct the criminal justice process, conspiring with or employing a person under 18 to import a controlled substance, while the person or person under 18 is in possession of an unlawful amount of a controlled substance	Imprisonment of **not more than 35 years**, or a fine of **$1,250,000**, or **both.**
Possession in a motor vehicle - § 152.027, subd. 3	• **More than 1.4 grams**, if the person is the owner of the vehicle or driver of the vehicle, and marijuana is on the person, or knowingly kept in an area of the vehicle normally occupied by the driver or passengers (not including trunk).	Misdemeanor (imprisonment of up to **90 days** or a fine of not more than **$1,000**, or **both**).
Possession or sale of a small amount of marijuana - § 152.027, subd. 4	• Sale for no payment or possession of **42.5 grams or less**	Petty misdemeanor, with required drug education programming, unless the court finds the programming to be inappropriate. Sale for no payment twice within two years – Misdemeanor with required chemical dependency evaluation and treatment. Failing to comply with sentencing for petty misdemeanor will be treated as a misdemeanor conviction.

Appendix III: Summary of State Laws

The following information is a survey of state medical cannabis laws from across the country. As of the date of publication, there are 23 states and the District of Columbia that have a medical cannabis program. This does not include the states that have passed limited medical cannabis programs that allow for the use of medical cannabis with a particular ratio of compounds. The following are meant to be summaries of the 24 medical cannabis programs and do not encompass all of the regulations or laws associated with each state's medical cannabis program.

Alaska

Act Title	Medical Uses of Marijuana for Persons Suffering from Debilitating Medical Conditions Act
Statutes	Alaska Stat. §§ 17.37.010 to 17.37.080
Rules	Alaska Admin. Code title 7, §§ 34.010 to 34.990
Year First Adopted	1998
Ballot Initiative	Yes
Patient Qualifying Conditions	• Cancer, glaucoma, and HIV/AIDS (condition or treatment) • Any chronic or debilitating disease or treatment that produces one of more of the following symptoms and the patient's physician's professional opinion is that the use of medical marijuana may alleviate: - cachexia - severe pain - severe nausea - seizures - severe muscle spasms • Any other medical condition or treatment approved by the Department of Health and Social Services
Patient Participation	Apply to the Department of Health and Social Services for an identification card. The application must include a statement from a physician dated within the previous 16 months indicating a debilitating medical condition or medical need.
Child Patients	The child's parent or legal guardian must agree to be the primary caregiver and to control acquisition, possession, dosage, and frequency.
Identification/Registry Cards	Required

Caregiver Regulations	• One primary caregiver and one alternate caregiver are allowed. • Caregivers must be at least 21 years old without any convictions for certain felony offenses or actively on probation or parole. A caregiver is limited to one patient, but can care for two or more patients who are related to the caregiver by at least the fourth degree of kinship by blood or marriage.
Manufacturers/ Distributors	Not allowed
Patient Cultivation	Allowed
Quantity a Patient May Possess	One ounce of usable marijuana and six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at one time.
Physician Involvement	Requires a bona fide physician-patient relationship and a full examination. Physician must diagnose the patient with a debilitating medical condition and state that it is the physician's opinion, after considering other medications and treatments, that the patient might benefit from the medical use of marijuana.
Patients from Other States	Not allowed (requires Alaska identification for application)

Arizona

Act Title	Arizona Medical Marijuana Act
Statutes	Ariz. Rev. Stat. §§ 36-2801 to 36-2819
Rules	Ariz. Admin. Code §§ R9-17-101 to R9-17-323
Year First Adopted	2010
Ballot Initiative	Yes
Patient Qualifying Conditions	• Cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Crohn's disease, and agitation of Alzheimer's disease • Chronic or debilitating disease or treatment if it produces one or more of the following: - cachexia or wasting syndrome - severe and chronic pain - severe nausea - seizures - severe and persistent muscle spasms

Patient Participation	Submit an application and written certification from a physician within 90 days of that application.
Child Patients	Requires certifications from two physicians and consent from a parent or legal guardian to use medical cannabis; parent or guardian serves as a caregiver and controls acquisition, dosage, and frequency.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 21 years old and not have been convicted of an excluded felony offense.
Manufacturers/ Distributors	Allowed; limited to one dispensary for every ten pharmacies registered in the state with at least one in each county where an application has been approved. Dispensary must be a nonprofit entity.
Patient Cultivation	Allowed, if a registered nonprofit dispensary is not located within 25 miles of the patient's home.
Quantity a Patient May Possess	A patient or his or her caregiver may possess up to 2.5 ounces of usable medical cannabis and, if allowed to cultivate, may possess up to 12 plants per patient.
Physician Involvement	A physician provides a written certification that the patient has a qualifying medical condition and is likely to receive therapeutic or palliative benefit from the use of medical cannabis.
Patients from Other States	Allowed, but they may not obtain medical cannabis from a dispensary and must possess a registry card or its equivalent.

California

Act Title	Compassionate Use Act/Medical Marijuana Program
Statutes	Cal. Health & Safety § 11362.5 Cal. Health & Safety §§ 11362.7 to 11362.9
Rules	---
Year First Adopted	1996
Ballot Initiative	Yes

Patient Qualifying Conditions	• AIDS, anorexia, arthritis, cachexis, cancer, chronic pain, glaucoma, migraines, persistent muscle spasms, seizures, and severe nausea • Any other chronic or persistent medical symptom that either: - substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990; or - if not alleviated, may cause serious harm to the patient's safety or physical or mental health
Patient Participation	Submit an application to the county and provide written documentation from a physician stating the patient's diagnosis and that the use of medical cannabis is appropriate.
Child Patients	Must have a birth certificate as identification. Parents can complete the application on the child's behalf.
Identification/Registry Cards	Identification cards are voluntary.
Caregiver Regulations	• Allowed • Must be at least 18 years old unless the caregiver is the parent of a minor child who is a qualifying patient.
Manufacturers/ Distributors	Allowed, subject to city and county ordinances.
Patient Cultivation	Allowed
Quantity a Patient May Possess	An amount necessary for the patient (See *People v. Kelly*, 222.P.3d 186 (Cal. 2010)).
Physician Involvement	Required to conduct an exam of the patient prior to recommending the use of medical cannabis.
Patients from Other States	Not allowed (ballot initiative addresses "Californians" and patient must be a resident to obtain an ID card)

Colorado

Act Title	Colorado Medical Marijuana Code
Statutes	C.O. Const. art. 18, § 14 Colo. Rev. Stat. § 21-1.5-106 Colo. Rev. Stat. §§ 12-43.3-101 to 12-43.3-1102
Rules	Colo. Code Regs. §§ 212-1:1.101 to 212-1:1.1401 Colo. Code Regs. §§ 1006-2:1 to 1006-2:14

Year First Adopted	2000
Ballot Initiative	Yes
Patient Qualifying Conditions	• Cancer, glaucoma, and HIV/AIDS • A chronic or debilitating disease or medical condition or treatment, which produces one or more of the following: - cachexia - severe pain - severe nausea - seizures - persistent muscle spasms • Any other medical condition, or treatment for such condition, approved by the state health agency
Patient Participation	Submit an application along with a physician's written documentation that the patient has been diagnosed with a qualifying condition. The patient is required to indicate whether the patient will cultivate or obtain marijuana from a caregiver or licensed medical marijuana center, or both.
Child Patients	Must have two physicians diagnose the child with a qualifying condition. A parent residing in Colorado must agree to serve as the child's primary caregiver and control the acquisition, dosage, and frequency of marijuana use by the patient.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 18 years old and serve no more than five patients at a given time, unless the state health agency determines in an exceptional circumstance that more patients may be served.
Manufacturers/ Distributors	Allowed. All licenses are subject to local regulations.
Patient Cultivation	Allowed, either by the patient or the patient's caregiver.
Quantity a Patient May Possess	No more than two ounces of usable marijuana and no more than six marijuana plants, with three or fewer being mature. If a patient possesses more than the allowable amount, the patient may raise an affirmative defense that the amount possessed was medically necessary.
Physician Involvement	Certify that a patient has a chronic or debilitating medical condition and may benefit from the use of medical marijuana.

Patients from Other States	Not allowed (constitution requires applications be made available to Colorado residents; rules allow denial of applications if the applicant is not a Colorado resident)

Connecticut

Act Title	Palliative Use of Marijuana
Statutes	Conn. Gen. Stat. §§ 21a-408 to 21a-408q
Rules	Conn. Agencies Regs. §§ 21a-408-1 to 21a-408-70
Year First Adopted	2012
Ballot Initiative	No
Patient Qualifying Conditions	• Cancer, glaucoma, HIV/AIDS, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, and post-traumatic stress disorder • Any medical condition, treatment, or disease approved by the Department of Consumer Protection
Patient Participation	Submit application to the Department of Consumer Protection with written certification from a physician.
Child Patients	Patients must be at least 18 years old.
Identification/Registry Cards	Patients must obtain a registration certificate.
Caregiver Regulations	• Allowed • Must be at least 18 years old and a physician must approve the necessity of a caregiver. If the patient lacks legal capacity, the caregiver must be a parent, guardian, or person having legal custody of the patient.
Manufacturers/ Distributors	Allowed, at least three but no more than ten.
Patient Cultivation	Not allowed
Quantity a Patient May Possess	The amount necessary for that patient for one month of treatment.
Physician Involvement	Provide a written certification that a patient has been diagnosed with a debilitating medical condition that would receive palliative benefit from the use of medical cannabis.

Patients from Other States	Not allowed (qualifying patients must be a resident of Connecticut)

Delaware

Act Title	The Delaware Medical Marijuana Act
Statutes	Del. Code Ann. tit. 16, §§ 4901A to 4926A
Rules	16-4000-44000 Del. Admin. Code §§ 4470 to 4470-10.0
Year First Adopted	2011
Ballot Initiative	No
Patient Qualifying Conditions	• Cancer, HIV/AIDS, decompensated cirrhosis, ALS, agitation of Alzheimer's disease, post-traumatic stress disorder • 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 that has not responded to medication or surgical measures for more than three months or for which other treatment options produced serious side effects - intractable nausea - seizures - severe and persistent muscle spasms • Additional conditions or treatments added by the Delaware Department of Health and Social Services, subject to judicial review
Patient Participation	Apply through the Department of Health and Social Services with a signed statement pledging not to provide marijuana to anyone not allowed to possess it. Must also submit a written certification from the physician.
Child Patients	Patients must be at least 18 years of age
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 21 years old and not have been convicted of certain felony offenses. Caregivers must also agree to assist each patient and have a maximum of five patients.
Manufacturers/ Distributors	Allowed, but must be nonprofit agencies.

Patient Cultivation	Not allowed
Quantity a Patient May Possess	No more than six ounces of usable marijuana. Compassion centers (manufacturers/distributors) are not allowed to dispense more than three ounces to a patient or caregiver in any two-week period.
Physician Involvement	Provide a written certification that the patient's medical history and medical condition indicate that that patient would receive therapeutic or palliative benefit from the use of medical marijuana. A patient with post-traumatic stress disorder must also see a psychiatrist.
Patients from Other States	Allowed, after obtaining a Delaware registry ID card by showing the required information to the Department of Health and Social Services.

District of Columbia

Act Title	Use of Marijuana for Medical Treatment
Statutes	D.C. Code §§ 7-1671.01 to 7.1671.13
Rules	D.C. Mun. Regs. tit. 22-C, §§ 100 to 9900
Year First Adopted	2010
Ballot Initiative	No
Patient Qualifying Conditions	• HIV/AIDS, glaucoma, cancer, and severe or persistent muscle spasms • Any other condition, determined by rulemaking, that is: - chronic or long lasting; - debilitating or interferes with the basic functions of life; and - a serious medical condition for which the use of medical marijuana is beneficial: ▪ that cannot be effectively treated by any ordinary medical or surgical measures; or ▪ for which there is scientific evidence that the use of medical marijuana is likely to be significantly less addictive than the ordinary medical treatment for that condition • Qualifying medical treatments: - chemotherapy - the use of azidothymidine or protease inhibitors - radiotherapy

	- any other treatment, as determined by rulemaking, whose side effects require treatment though the administration of medical marijuana in the same manner as a qualifying medical condition
Patient Participation	Obtain a signed, written recommendation from a physician and register with the mayor. Patients may only use medical marijuana in their home or if permitted at a medical treatment facility while receiving care for a qualifying condition.
Child Patients	Parent or guardian must sign consent for the child's use of medical marijuana, understanding of the qualifying condition or treatment, understanding of the potential benefits and adverse effects, and consent to be or designate a caregiver for the child.
Identification/Registry Cards	Allowed
Caregiver Regulations	• Allowed • Must be at least 18 years old and register with the Department of Health. Caregivers are limited to serving one patient.
Manufacturers/ Distributors	Allowed, but there may be no more than five dispensaries in the District and no more than two within any election ward. The mayor can increase the number to eight through rulemaking. Only one dispensary may operate in an election ward if there are five or more cultivation centers in that election ward.
Patient Cultivation	Not allowed
Quantity a Patient May Possess	Patients or caregivers may possess up to two ounces of dried marijuana. The mayor may approve up to four ounces or another form. Dispensaries are only allowed to dispense up to two ounces to a patient or caregiver in a 30-day period, but the mayor may approve up to four ounces.
Physician Involvement	Recommend the use of medical marijuana based on the physician's assessment of the patient's medical history, current condition, and review of other approved medications and treatments that alleviate a qualifying condition or side effects of a qualifying treatment. The Board of Medicine has authority to audit any physician who provides more than 250 recommendations.
Patients from Other States	Not allowed (qualifying patients must be residents of D.C.)

Hawaii

Act Title	Medical Use of Marijuana
Statutes	Haw. Rev. Stat. §§ 329-121 to 329-128
Rules	Haw. Code R. §§ 23-202-1 to 23-202-15
Year First Adopted	2000
Ballot Initiative	No
Patient Qualifying Conditions	Starting January 2, 2015 • Cancer, glaucoma, HIV/AIDS, or the treatment of these conditions • Chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: - cachexia or wasting syndrome - severe pain - severe nausea - seizures - severe and persistent muscle spasms - any other medical condition approved by the Department of Health
Patient Participation	Pay a fee and provide identification information, a written certification from a physician, and the address of where the marijuana will be grown.
Child Patients	Child patients must have a parent, guardian, or person with legal custody be their primary caregiver. Effective January 1, 2015, regulations will require a physician to explain the risk and benefits of medical marijuana use to the patients and caregivers. The caregiver will also need to provide written consent and agree to control the acquisition, dosage, and frequency of use by the child patient.
Identification/Registry Cards	Required; a registry certificate is issued
Caregiver Regulations	• Allowed • Must be at least 18 years of age and must agree to be responsible for the patient's use of medical marijuana. If the patient is an adult and lacks legal capacity, the primary caregiver must be a parent, guardian, or person with legal custody. Primary caregivers may only care for one patient at a time.

Manufacturers/ Distributors	Not allowed
Patient Cultivation	Allowed
Quantity a Patient May Possess	Effective January 2, 2015, patients and their caregivers may jointly possess seven marijuana plants, which may be immature or mature, and up to four ounces of usable marijuana.
Physician Involvement	Provide a written certification stating that in their professional opinion, the patient has a debilitating medical condition and the potential benefits of using medical marijuana are greater than the potential risks.
Patients from Other States	Not allowed (per the Hawaii Department of Public Safety)

Illinois

Act Title	Compassionate Use of Medical Cannabis Pilot Program Act
Statutes	410 Ill. Comp. Stat. 130/1 to 130/999
Rules	Ill. Admin. Code tit. 8, §§ 1000.10 to 100.700 Ill. Admin. Code tit. 68, §§ 1290.10 to 1290.620 Ill. Admin. Code tit. 77, §§ 946.10 to 946.500 Ill. Admin. Code tit. 86, § 100.2060; § 130.745; § 130.801; §§ 429.105 to 429.145
Year First Adopted	2013
Ballot Initiative	No
Patient Qualifying Conditions	• Cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Crohn's disease, agitation of Alzheimer's disease, cachexia or wasting syndrome, muscular dystrophy, severe fibromyalgia, spinal cord disease, Tarlov cysts, hydromyelia, syringomyelia, rheumatoid arthritis, fibrous dysplasia, spinal cord injury, traumatic brain injury and post-concussion syndrome, multiple sclerosis, Arnold-Chiari malformation and Syringomyelia, Spinocerebellar Ataxia, Parkinson's, Tourette's, Myoclonus, dystonia, reflect sympathetic dystrophy, complex regional pain syndromes Type I and II, neurofibromatosis, chronic inflammatory demyelinating polyneuropathy, Sjogren's syndrome, lupus, interstitial cystitis, myasthenia gravis, hydrocephalus, nail-patella syndrome, residual limb pain, seizures (starting in 2015), or the treatment of these conditions.

	• The Department of Public Health may add additional debilitating conditions or treatments
Patient Participation	Submit an application that includes written certification and documentation of diagnosis of a debilitating medical condition issued by a physician. Must also designate a registered medical cannabis-dispensing organization.
Child Patients	Starting in 2015, only patients suffering from seizures, including those characteristic of epilepsy, may qualify if the patient is under 18 years of age.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 21 years old and not have convictions for an excluded offense. Must agree to assist only one patient.
Manufacturers/ Distributors	Allowed, up to 22 cultivation centers in the state, but not more than one in each Illinois State Police District boundary. There may be up to 60 dispensing organization registrations issued, which must be dispersed throughout the state.
Patient Cultivation	Not allowed; patients must list a designated dispensary on their application.
Quantity a Patient May Possess	Two and one-half ounces of usable cannabis for a 14-day period. A patient may possess more if a waiver is signed by a physician stating that 2.5 ounces is not a sufficient supply for that patient.
Physician Involvement	Provide a written certification stating a patient's qualifying debilitating medical condition and the likely therapeutic or palliative benefit of the treatment or alleviation that medical cannabis may provide and conduct a physical examination as well as an assessment of the patient's medical history.
Patients from Other States	Not allowed (per Illinois Department of Public Health)

Maine

Act Title	Maine Medical Use of Marijuana Act
Statutes	Me. Rev. Stat. tit. 22, §§ 2421 to 2430
Rules	10-144-122 Me. Code R. §§ 1 to 11
Year First Adopted	1999

Ballot Initiative	Yes
Patient Qualifying Conditions	• Condition or treatment of cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, agitation of Alzheimer's disease, and nail-patella syndrome • Post-traumatic stress disorder, inflammatory bowel disease, dyskinetic and spastic movement disorders, and other diseases causing severe and persistent muscle spasms • Chronic or debilitating disease or medical condition or their treatment, which produce one or more of the following: - cachexia or wasting syndrome - severe nausea - seizures - intractable pain • The Department of Health and Human Services may approve or deny petitions to include additional debilitating medical conditions.
Patient Participation	Submit an application, including a written certification from a medical provider, indication of intent to cultivate marijuana, and, if desired, the names of one or two primary caregivers.
Child Patients	The primary caregiver for a child patient must be the child's parent, guardian, or person with legal custody. That person must provide consent in regards to the child's use of medical marijuana and control the acquisition, dosage, and frequency of use.
Identification/Registry Cards	Required (Rules allow some patients to be removed from the registry and still have legal protections as a nonregistered qualifying patient if in possession of a written certificate from a physician)
Caregiver Regulations	• Allowed; a patient may list two primary caregivers in his or her application. • Must be at least 21 years old and not have been convicted of a disqualifying drug offense. May not assist more than five patients and are allowed monetary compensation for costs associated with cultivating or assisting patients.
Manufacturers/ Distributors	Allowed; must be a not-for-profit entity.
Patient Cultivation	Allowed
Quantity a Patient May Possess	A patient or caregiver may possess up to 2.5 ounces of prepared marijuana and an incidental amount of marijuana. He or she may possess up to six mature plants and may have harvested

	marijuana in various stages of processing. Dispensaries may not dispense more than 2.5 ounces to a patient or his or her caregiver in a 15-day period.
Physician Involvement	Inform patients of the risks and benefits of medical marijuana use. Physicians must submit an annual written certification stating that in their professional opinion, medical marijuana will likely provide therapeutic benefit, treatment, or alleviation of the patient's debilitating medical condition.
Patients from Other States	Allowed, with a valid written certification from a physician, a valid medical marijuana certification from patient's home jurisdiction, and photographic identification.

Maryland

Act Title	Natalie M. LaPrade Medical Marijuana Commission
Statutes	Md. Code Ann., Crim. Law § 5-601 (affirmative defense) Md. Code Ann., Health-Gen. §§ 13-3301 to 3316 (Compassionate Use Programs)
Rules	---
Year First Adopted	2003: § 5-601, affirmative defense legislation 2013: Compassionate Use Program legislation
Ballot Initiative	No
Patient Qualifying Conditions	• Chronic or debilitating diseases or medical conditions or the treatment of a chronic or debilitating disease or medical condition producing one or more of the following: - cachexia or wasting syndrome - severe or chronic pain - severe nausea - seizures - severe or persistent muscle spasms • Any other condition that is severe and resistant to conventional medicine
Patient Participation	Affirmative defense: Obtain a written certification from a physician that the use of marijuana was for a medical purpose. Compassionate Use Program: Obtain a written certification from a physician and meet the physician's inclusion, but not exclusion, criteria, and enroll with a registered academic medical center.

Child Patients	Child patients enrolled in the Compassionate Use Program require a caregiver.
Identification/Registry Cards	Required, for the Compassionate Use Programs
Caregiver Regulations	• Allowed • Must be a Maryland resident who is at least 21 years old and an immediate family member, spouse, or domestic partner of the patient and has not been convicted of certain offenses.
Manufacturers/ Distributors	Allowed, for the Compassionate Use Programs. Up to 15 dispensaries may provide marijuana to the programs. The commission may increase that number beginning June 1, 2016, if necessary to meet the demand for medical marijuana.
Patient Cultivation	Not allowed
Quantity a Patient May Possess	Up to a 30-day supply, as determined by the commission.
Physician Involvement	Provide a written certification of the patient's medical condition. Physicians must also apply to be approved as a certifying physician. The application must list inclusion and exclusion criteria for patients, a screening plan for dependence, and plans for ongoing assessment and follow-up care.
Patients from Other States	Not allowed (qualifying patients are required to be residents of Maryland)

Massachusetts

Act Title	An Act for the Humanitarian Medical Use of Marijuana
Statutes	Mass. Gen. Laws, ch. 94C, §§ 1-1 to 1-17
Rules	105 Mass. Code Regs. 725 801 Mass. Code Regs. 4.02 (fees)
Year First Adopted	2012
Ballot Initiative	Yes
Patient Qualifying Conditions	• Cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Crohn's disease, Parkinson's disease, multiple sclerosis, and other conditions as determined in writing by the patient's physician

Patient Participation	Provide a written certification confirming a debilitating medical condition diagnosis by a licensed physician.
Child Patients	Parent or legal guardian must grant permission and act as the designated personal caregiver. Requires diagnosis from two physicians, at least one of whom is a board-certified pediatrician or board-certified pediatric subspecialist.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 21 years old and must agree to provide assistance to the patient. Caregivers are prohibited from using medical marijuana for their own personal use. Employees of a hospice provider, or nursing or medical facility who are providing care to a patient may serve as a caregiver.
Manufacturers/ Distributors	Allowed; up to 35 nonprofit medical marijuana treatment centers were allowed in the first year. At least one treatment center shall be in each county, without more than five in any one county. The Department of Public Health of the Commonwealth of Massachusetts can modify the number of centers.
Patient Cultivation	Allowed, if a patient lacks the financial means, access to transportation, or is not within a reasonable distance of a treatment center, he or she may apply for a cultivation registration.
Quantity a Patient May Possess	Up to a 60-day supply of marijuana as defined by the Department of Public Health of the Commonwealth of Massachusetts.
Physician Involvement	Advise the patient about the risks and benefits of medical marijuana and provide a written certification that confirms that a patient may benefit from medical marijuana based on a full assessment of the patient's medical history and condition.
Patients from Other States	Not allowed (rules require qualifying patients to be a resident of Massachusetts)

Michigan

Act Title	Michigan Medical Marihuana Act
Statutes	Mich. Comp. Laws, ch. 333, §§ 26421 to 26430
Rules	Mich. Admin. Code r.333.101 to 333.133
Year First Adopted	2008
Ballot Initiative	Yes
Patient Qualifying Conditions	• Cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Crohn's disease, agitation of Alzheimer's disease, nail patella, or the treatment of these conditions • A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: - cachexia or wasting syndrome - severe and chronic pain - severe nausea - seizures - severe and persistent muscle spasms • Any other condition approved by the Department of Licensing and Regulatory Affairs
Patient Participation	Apply to the Department of Licensing and Regulatory Affairs after obtaining a written certification from a physician. Must provide proof of Michigan residency.
Child Patients	The physician must explain the potential risks and benefits to the patient and parent or legal guardian. The application requires written certifications from two physicians and the parent or guardian consents to allow the use of medical marihuana, serve as the primary caregiver, and control the acquisition, dosage, and frequency of use.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be 21 years old and agree to assist the patient. Not allowed to have been convicted of any felony in the past ten years and have never been convicted of a felony involving illegal drugs or a felony that is an assaultive crime.
Manufacturers/ Distributors	Not allowed

Patient Cultivation	Allowed
Quantity a Patient May Possess	No more than 2.5 ounces of usable marihuana. Patients, or their designated caregiver, may have up to 12 marihuana plants.
Physician Involvement	Must issue a written certification after conducting a full assessment of the patient that the patient has a debilitating medical condition and that in the physician's professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana.
Patients from Other States	Allowed, if in possession of a registry card or its equivalent from the patient's home state.

Minnesota

Act Title	Minnesota Medical Cannabis Registry Program
Statutes	Minn. Stat. §§ 152.22 to 152.37
Rules	Proposed Rules
Year First Adopted	2014
Ballot Initiative	No
Patient Qualifying Conditions	• Cancer or terminal illness, with a probable life expectancy of under one year, if the underlying condition or treatment produces one or more of the following: - cachexia or wasting syndrome - severe or chronic pain - nausea or severe vomiting • Glaucoma, HIV/AIDS, Tourette's syndrome, ALS, seizures, severe and persistent muscle spasms, or Crohn's disease • The Commissioner of Health may add more conditions, subject to legislative oversight
Patient Participation	Submit an application to the Department of Health with a written certification from a health care practitioner stating the patient has been diagnosed with a qualifying medical condition.
Child Patients	No special requirements
Identification/Registry Cards	Required; registration verifications will be issued to the patient.
Caregiver Regulations	• A nonparent or legal guardian caregiver is allowed if the patient's health care practitioner certifies that the patient has

	a physical or developmental disability that either limits the patient's ability to self-administer the medical cannabis or the patient's ability to retrieve the medical cannabis from a manufacturer. • Must be at least 21 years old, not have been convicted of a disqualifying felony offense, and approved by the Commissioner of the Health. Only patients who qualify may have a caregiver, and the caregiver is limited to one patient unless the patients reside in the same residence.
Manufacturers/ Distributors	Two manufacturers are allowed and are required to operate four distribution facilities each by 2016. Each manufacturer is only allowed to operate one cultivation/production facility.
Patient Cultivation	Not allowed
Quantity a Patient May Possess	Patients may only possess medical cannabis in pill or liquid form. They may possess up to a 30-day supply, as determined by the patient and pharmacist at the manufacturer.
Physician Involvement	A health care practitioner certifies whether or not the patient has a qualifying medical condition and provides the patient with the application and information provided by the Department of Health. The health care practitioner may also certify that the patient has a physical or developmental disability that does not allow the patient to either self-administer the medical cannabis or acquire the medical cannabis alone. If so certified, the patient may have a registered designated caregiver.
Patients from Other States	Not allowed (patients are required to be a resident of Minnesota)

Montana

Act Title	Montana Marijuana Act
Statutes	Mont. Code Ann. §§ 50-46-301 to 50-46-344
Rules	Mont. Admin R. 37.107.101 to 37.107.135
Year First Adopted	2004
Ballot Initiative	Yes
Patient Qualifying Conditions	• Cancer, glaucoma, and HIV/AIDS when the condition or disease results in symptoms that seriously and adversely affect the patient's health status

- Cachexia or wasting syndrome
- Severe chronic pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician and by:
  - objective proof of the etiology of the pain; or
  - confirmation of that diagnosis from a second physician who is independent of the treating physician and who conducts a physical examination
- 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, admittance into hospice care in accordance with rules adopted by the Department of Public Health and Human Services, or any other medical condition or treatment approved by the legislature.

Patient Participation

Apply to the Department of Public Health and Human Services after obtaining a written certification from a physician.

Child Patients

Only allowed to use marijuana-infused products and not smoke marijuana. Requires parent or legal guardian consent, agreement to serve as the child's marijuana-infused products provider, and agreement to control the acquisition of marijuana and the dosage and frequency of the use. The parents or guardian must also submit fingerprints to undergo a background check and pledge not to divert the marijuana.

Identification/Registry Cards

Required

Caregiver Regulations

- Allowed
- Must be a Montana resident age 18 or older and agree to be the patient's provider of marijuana and not to divert marijuana. Must not have a felony conviction or a conviction for a drug offense, be in the custody or under supervision with the Department of Corrections or a youth court, or be convicted of fraudulent representation to law enforcement of medical marijuana use.
- May also not have failed to pay taxes, interest, penalties, or judgments due to a government agency, stay out of default on a government-issued student loan, pay child support, or remedy an outstanding delinquency for child support or taxes or judgments owed to a government agency.

Manufacturers/ Distributors	Not allowed
Patient Cultivation	Cultivation is allowed by the provider (caregiver). They can be either a marijuana-infused products provider or a marijuana provider.
Quantity a Patient May Possess	Up to four mature plants, 12 seedlings, and one ounce of usable marijuana.
Physician Involvement	Issue a written certification that, among other things, describes the patient's debilitating medical condition and states that the physician has a reasonable degree of certainty that the person's debilitating medical condition would be alleviated by the use of marijuana and that, as a result, the patient would be likely to benefit from the use of marijuana. The physician must also, among other things, list restrictions on the use of marijuana, specify a time period where use is appropriate, up to one year, and continue to serve as the patient's treating physician.
Patients from Other States	Not allowed (registered cardholders are required to be a resident of Montana)

Nevada

Act Title	Medical Use of Marijuana
Statutes	Nev. Rev. Stat. §§ 453A.010 to 453A.810
Rules	Nev. Admin. Code §§ 372A.100 to 372A.180 Nev. Admin. Code §§ 453A.010 to 453A.240
Year First Adopted	2001
Ballot Initiative	Yes
Patient Qualifying Conditions	• AIDS, cancer, glaucoma, cachexia, persistent muscle spasms, seizures, severe nausea, or severe pain • Any other medical condition or treatment for a medical condition that is classified as a chronic or debilitating medical condition by regulation of the Division of Public and Behavioral Health of the Department of Health and Human Services or approved as a chronic or debilitating medical condition pursuant to a submitted petition
Patient Participation	Submit application to the division with written documentation from a physician of the patient's medical condition along with

	caregiver information and the name of the patient's designated medical marijuana dispensary.
Child Patients	The custodial parent or guardian must sign a written statement that the physician has explained the possible risks and benefits of using medical marijuana, consent to the child's use of marijuana, agree to serve as the designated primary caregiver, and control the acquisition, dosage, and frequency of use.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 18 years old and must be approved by the patient's attending physician.
Manufacturers/ Distributors	Allowed; limited to a certain number of dispensaries per county population and pharmacies located in the county.
Patient Cultivation	Allowed, only if the patient was cultivating prior to July 1, 2013, the dispensaries in the county of the patient or caregiver are unable to supply for the needs of the patient, the patient or caregiver cannot reasonably travel to a dispensary due to illness or lack of transportation, or there is no dispensary operating within 25 miles of the patient's residence.
Quantity a Patient May Possess	A patient and caregiver collectively may not possess more than 2.5 ounces in a 14-day period, 12 marijuana plants, and a maximum allowable quantity of edible marijuana products as set by the division.
Physician Involvement	Must give written documentation that the patient has been diagnosed with a chronic or debilitating medical condition and the medical use of marijuana may mitigate symptoms or effects of that condition. The physician must also explain the possible risks and benefits and sign a statement approving the patient's caregiver designation.
Patients from Other States	Allowed, if the other state grants criminal exemptions, requires a physician's advisement, the nonresident's ID card has not expired, the visiting patient signs an affidavit stating he or she is entitled to use medical marijuana in his or her home state, and agrees to abide by the Nevada legal limits on possession.

New Hampshire

Act Title	Use of Cannabis for Therapeutic Purposes
Statutes	N.H. Rev. Stat. Ann. §§ 126-X:11 to 11
Rules	Proposed Rules
Year First Adopted	2013
Ballot Initiative	No
Patient Qualifying Conditions	• Cancer, glaucoma, HIV/AIDS, hepatitis C and currently receiving antiviral treatment, ALS, muscular dystrophy, Crohn's disease, agitation of Alzheimer's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, or one or more injuries that significantly interferes with daily activities as documented by the patient's provider • A severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: - Elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe and persistent muscle spasms
Patient Participation	Submit an application with the name of the patient's designated alternative treatment center and written certification from a provider.
Child Patients	Custodial parent/guardian must provide two written certifications, one being from a pediatrician. Providers must explain the potential risks and benefits. The custodial parent must submit a written consent and serve as the child's designated caregiver.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 21 years old and can assist up to five patients, or up to nine patients if the patient and caregiver live more than 50 miles from the nearest alternative treatment center.

Manufacturers/ Distributors	Up to four alternative treatment centers are allowed at one time.
Patient Cultivation	Not allowed
Quantity a Patient May Possess	No more than two ounces of usable cannabis during a ten-day period.
Physician Involvement	Must have a provider-patient relationship of at least three months, unless the patient developed the condition within the previous three months, and conduct an in-person, full medical assessment prior to issuing a written certification that the patient has been diagnosed with a qualifying medical condition.
Patients from Other States	Allowed, with a valid registry card from another state. Must be able to provide the written certification from the physician and cannot cultivate or purchase cannabis in New Hampshire.

New Jersey

Act Title	New Jersey Compassionate Use Medical Marijuana Act
Statutes	N.J. Stat. Ann. §§ 24:6i-1 to 16.
Rules	N.J. Admin. Code §§ 8:64-1.1 to 8:64-13.11 N.J. Admin. Code §§ 13:35-7A.1 to 13:35-7A.6
Year First Adopted	2009
Ballot Initiative	No

Patient Qualifying Conditions	• One of the following conditions, if resistant to conventional medical therapy:
	  - seizure disorder
	  - intractable skeletal muscular spasticity
	  - glaucoma
	• HIV/AIDS or cancer, if the condition or treatment produces:
	  - severe or chronic pain;
	  - severe nausea or vomiting; or
	  - cachexia or wasting syndrome
	• ALS, multiple sclerosis, terminal cancer, muscular dystrophy, or inflammatory bowel disease, including Crohn's disease
	• Terminal illness with less than 12 months of life
	• Any other medical condition or its treatment that is approved by the Department of Health and Senior Services

Patient Participation	Submit a certification from his or her physician stating that he or she has a qualifying medical condition, information on patient and caregiver, and information on the patient's physician.
Child Patients	The custodial parent or guardian of the child patient must consent in writing that the patient may use medical marijuana and that the parent or guardian will control the acquisition and possession of the medical marijuana and any related paraphernalia.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be 18 years of age, agree to assist the patient, not serve as caregiver to another patient or be the patient's physician, not have a conviction for possession or sale of a controlled dangerous substance, and register with the Department of Health and Senior Services after satisfying a criminal history background check.
Manufacturers/ Distributors	There must be at least two alternative treatment centers in each of the northern, central, and southern regions of the state. The first two centers in each region shall be nonprofit entities, and centers subsequently issued permits may be nonprofit or for-profit entities.
Patient Cultivation	Not allowed
Quantity a Patient May Possess	No more than two ounces of usable marijuana in a 30-day period.
Physician Involvement	Must have a bona fide physician-patient relationship and provide a certification that authorizes the patient to apply for registration. The physician may provide written instructions to the patient to present to an alternative treatment center stating the total usable amount of marijuana that a patient may be dispensed, which may not exceed two ounces.
Patients from Other States	Not allowed (rules require qualifying patients to be a resident of New Jersey)

New Mexico

Act Title	The Lynn and Erin Compassionate Use Act
Statutes	N.M. Stat. Ann. §§ 26-2B-1 to 26-2B-7
Rules	N.M. Code R. §§ 7.34-2 to 7.34.4
Year First Adopted	2007
Ballot Initiative	No
Patient Qualifying Conditions	• Cancer, glaucoma, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, HIV/AIDS, admittance into hospice care in accordance with rules promulgated by the Department of Health, or any other medical condition, medical treatment, or disease as approved by the Department of Health • Through rule, the department also recognizes: - severe chronic pain - painful peripheral neuropathy - intractable nausea/vomiting - severe anorexia/cachexia - hepatitis C currently receiving antiviral treatment - Crohn's disease - post-traumatic stress disorder - inflammatory autoimmune-mediate arthritis - ALS
Patient Participation	Submit a written certification from a practitioner and personal information.
Child Patients	The practitioner must explain the potential risks and benefits to the parent, guardian, or person with legal custody. The parent, guardian, or person with legal custody must consent in writing to allow the child patient's use of medical cannabis, serve as the patient's primary caregiver, and control the dosage and the frequency of the medical use of cannabis by the qualified patient.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be a resident of New Mexico and be at least 18 years of age. The caregiver is designated by the patient's practitioner as being necessary to take responsibility for managing the

	well-being of a patient with respect to the medical use of cannabis.
Manufacturers/ Distributors	Allowed; must be a nonprofit organization.
Patient Cultivation	Allowed, if the patient applies and receives a license for personal production.
Quantity a Patient May Possess	Any amount determined by the Department of Health to be reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months. Rules state it shall be no more than six ounces of useable cannabis. If in possession of a personal production license, then four mature plants and 12 seedlings, or a three-month supply of topical treatment. The Department of Health can allow more than six ounces upon proof of a special need for the patient.
Physician Involvement	Issue the patient a written certification stating that in the practitioner's professional opinion, the patient has a debilitating medical condition and the practitioner believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for a patient.
Patients from Other States	Not allowed (qualifying patients are required to be residents of New Mexico)

New York

Act Title	Medical Use of Marihuana
Statutes	N.Y. Pub. Health §§ 3360 to 3369-e
Rules	Rules allowed under statute, not yet proposed
Year First Adopted	2014
Ballot Initiative	No
Patient Qualifying Conditions	• Cancer, HIV/AIDS, ALS, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, inflammatory bowel disease, neuropathies, Huntington's disease, or as added by the Commissioner of Health • Any of the following conditions where it is clinically associated with, or a complication of, a condition under this paragraph of its treatment:

- cachexia or wasting syndrome
- severe or chronic pain
- severe nausea
- seizures
- severe or persistent muscle spasms
- such conditions as are added by the Commissioner of Health

Patient Participation	Obtain a certification from a health care practitioner, which is then provided to the Department of Health so that the patient may be issued a registry identification card. The patient may designate up to two caregivers.
Child Patients	The application must be made by an appropriate person over age 21 and the designated caregiver shall be a parent or legal guardian, a person designated by a parent or legal guardian, or an appropriate person approved by the Department of Health upon a sufficient showing that no parent or legal guardian is appropriate or available.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be over 21 years old unless shown that the person should be permitted to serve as a designated caregiver. Caregivers are limited to five certified patients at one time.
Manufacturers/ Distributors	Limited to no more than five registered organizations that manufacture medical marihuana and no more than four dispensing sites per organization.
Patient Cultivation	Not allowed
Quantity a Patient May Possess	Up to a 30-day supply, as determined by the practitioner. No individual dose may have more than ten milligrams of tetrahydrocannabinol. Patients are not allowed to smoke marihuana.
Physician Involvement	Practitioners must be registered with the Department of Health before issuing certifications to patients. A certification may be issued to a patient with a qualifying condition by a practitioner who is qualified to treat the condition and is continuing care for the condition. The practitioner must certify that it is the practitioner's professional opinion that the patient is likely to receive therapeutic or palliative benefit from the primary or adjunctive treatment with medical use of marihuana. The commissioner also must consider the form of medical marihuana

	the patient should consume and state any recommendation or limitation in the certification on form and dosage.
Patients from Other States	Not allowed (patients are required to be a resident of New York)

Oregon

Act Title	Oregon Medical Marijuana Act
Statutes	Or. Rev. Stat. §§ 475.300 to 475.375
Rules	Or. Admin. R. 333-008-000 to 333-008-1400
Year First Adopted	1998
Ballot Initiative	Yes
Patient Qualifying Conditions	• Cancer, glaucoma, agitation incident to Alzheimer's disease, HIV/AIDS, or side effects related to those conditions • Medical conditions or their treatment may qualify if they produce one or more of the following: - cachexia - severe pain - severe nausea - seizures - persistent muscle spasms • Post-traumatic stress disorder • Any other medical condition or side effect related to the treatment of a medical condition approved by the Oregon Health Authority
Patient Participation	Provide a valid, written document from a physician and include a written statement indicating who will produce medical marijuana for their use and where it will be produced.
Child Patients	Statement from the custodial parent or legal guardian indicating the physician has explained the risks and benefits of use, consent of use, agreement to serve as the primary caregiver, and agreement to be responsible for controlling the acquisition, dosage, and frequency of use.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 18 years old and have significant responsibility for caring for the well-being of the patient. A

	patient must have designated the caregiver in the patient's application and must not be the patient's attending physician. A caregiver may only serve one patient at any given time.
Manufacturers/ Distributors	Allowed
Patient Cultivation	Allowed
Quantity a Patient May Possess	Up to six mature marijuana plants and 24 ounces of usable marijuana per patient.
Physician Involvement	Provide written documentation that the patient has a qualifying medical condition based on the physician's assessment of the patient's medical history and current medical condition.
Patients from Other States	Allowed (the statute and rules are silent on this issue but the Oregon Medical Marijuana Program states it does accept out-of-state residents)

Rhode Island

Act Title	The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act
Statutes	R.I. Gen. Laws §§ 21-28.6-1 to 21-28.6-14
Rules	31-2-7 R.I. Code §§ 1.0 to 11.0 60-1-209 R.I. Code § 1 60-1-224 R.I. Code § 5
Year First Adopted	2005
Ballot Initiative	No
Patient Qualifying Conditions	• Cancer; glaucoma; HIV/AIDS; hepatitis C; cachexia or wasting syndrome; severe, debilitating, chronic pain; severe nausea; seizures; severe and persistent muscle spasms; agitation of Alzheimer's disease; or any other medical condition or its treatment approved by the Rhode Island Department of Health.
Patient Participation	Submit an application with a written certification from a practitioner and personal information.

Child Patients	The practitioner is required to explain the potential risks and benefits to the patient and the patient's parent or legal guardian. The parent or legal guardian is required to consent in writing to the child's use of medical marijuana, serve as one of the patient's primary caregivers, and control the acquisition of the marijuana, the dosage, and the frequency of the use.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 21 years old or a compassion center. An individual person may not assist more than five qualifying patients. Caregivers must pass a background check and not have been convicted of a felony drug offense, unless the Department of Health waives the restriction for that specific individual.
Manufacturers/ Distributors	Allowed; compassion centers must be a not-for-profit entity. No more than three compassion centers may hold valid registration certificates at one time.
Patient Cultivation	Allowed
Quantity a Patient May Possess	No more than 12 mature marijuana plants and 2.5 ounces of usable marijuana. Patients are allowed to cooperative cultivate marijuana in a residential or nonresidential location subject to certain restrictions.
Physician Involvement	Issue a written certification stating the debilitating medical condition and that in the practitioner's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient.
Patients from Other States	Allowed, if in possession of a registry identification card.

Vermont

Act Title	Therapeutic Use of Cannabis
Statutes	Vt. Stat. Ann. tit. 18 §§ 4471 to 44741.
Rules	17-2 Vt. Code R. §§3:1 to 3:12
Year First Adopted	2004
Ballot Initiative	No

Patient Qualifying Conditions	• After reasonable medical efforts have been made over a reasonable amount of time without relieving symptoms, a patient may use medical cannabis if he or she suffers from: - cancer, multiple sclerosis, HIV/AIDS if the treatment results in severe, persistent, and intractable symptoms; or - a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent, and one or more of the following intractable symptoms: ▪ cachexia or wasting syndrome ▪ severe pain ▪ severe nausea ▪ seizures
Patient Participation	Submit an application with contact information and the patient's designated dispensary, if any. Submit a medical verification form indicating a professional-patient relationship of at least six months has been established, the patient has a qualifying medical condition, and the health care professional is licensed and in good standing.
Child Patients	The application must be signed by both the patient and the parent or guardian.
Identification/Registry Cards	Required
Caregiver Regulations	• Allowed • Must be at least 21 years old and submit an application verifying he or she will only service on registered patient at a time and have no drug-related convictions.
Manufacturers/ Distributors	Allowed; must be a nonprofit entity, and no more than four dispensaries may be licensed by the Department of Public Safety at one time.
Patient Cultivation	Allowed, but only if the patient did not designate a dispensary.
Quantity a Patient May Possess	A patient and the patient's caregiver may not collectively possess more than two mature plants, seven immature plants, and two ounces of usable marijuana.

Physician Involvement	Confirm a patient's medical verification form stating that they have had a professional-patient relationship of at least six months, a full assessment and examination of the patient was conducted, and the patient suffers from a debilitating medical condition that has not been alleviated from reasonable medical efforts over a reasonable amount of time.
Patients from Other States	Not allowed (registered patients are required to be residents of Vermont)

Washington

Act Title	Washington State Medical Use of Cannabis Act
Statutes	Wash. Rev. Code §§ 69.51A.005 to 69.51A.903
Rules	Wash. Admin. Code §§ 314-55-005 to 314-55-540
Year First Adopted	1998
Ballot Initiative	Yes
Patient Qualifying Conditions	• Cancer, HIV, multiple sclerosis, epilepsy or other seizures disorder, spasticity disorder, intractable pain, glaucoma, Crohn's disease, and hepatitis C with debilitating nausea or intractable pain • Diseases including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when these symptoms are unrelieved by standard treatments or medications • Any other medical condition approved by the Washington State Medical Quality Assurance Commission in consultation with the board of osteopathic medicine and surgery
Patient Participation	Must be a patient of a health care professional and have been diagnosed with a debilitating medical condition.
Child Patients	No special requirements
Identification/Registry Cards	Required, but a patient who is not registered in the registry program may raise an affirmative defense if the person has valid documentation, including a statement from a health care provider, and complies with the other terms of the law.
Caregiver Regulations	• Allowed

	• Must be at least 18 years old and be designated by the patient to serve as a designated provider. A provider is only allowed to care for one patient at a time.
Manufacturers/ Distributors	Not allowed
Patient Cultivation	Allowed; may participate with other patients (no more than ten) in a collective garden.
Quantity a Patient May Possess	No more than: • 15 cannabis plants; • 24 ounces of usable cannabis; • an amount of cannabis product than what could reasonably be produced with no more than 25 ounces of useable cannabis; or • a combination of useable cannabis and cannabis product that does not exceed a combined total representing possession and processing of no more than 24 ounces of useable cannabis
Physician Involvement	Must give a statement stating that in the physician's professional opinion, the patient may benefit from the medical use of marijuana. Physician must also inform the patient of the risks and benefits of use and that the patient may benefit from use.
Patients from Other States	Not allowed (qualifying patients are required to be Washington residents at the time of the diagnosis of a qualifying condition)