Emerging Public Health Law and Policy Issues Concerning State Medical Cannabis Programs

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Introduction

Thirty-four states, the District of Columbia, and Puerto Rico have adopted (or will soon adopt) comprehensive medical cannabis programs.[1] Nearly two-thirds of the United States population – 210 million people – currently live in a jurisdiction where medical cannabis use is legal, and 9 out of 10 adults nationwide support legalization for medical purposes.[2] Yet, cannabis remains a Schedule I drug under the federal Controlled Substances Act (CSA), meaning the cultivation, distribution, and use of cannabis are prohibited under federal law.

Continued federal prohibitions hinder clinical research and the development of uniform regulatory requirements. States have also been forced to regulate in areas where federal agencies traditionally take the lead, such as packaging and labeling, pesticides, and advertising. Commencing with an assessment of the underlying federal landscape surrounding cannabis, we examine prevalent law and policy issues among states seeking to protect patients and the public.

Assessing the Federal Legal Landscape

Extensive state-based legalization of medical cannabis use over the last two decades contrasts with a variable federal legal landscape. Since California first decriminalized medical cannabis use in 1996, federal agencies have raised significant law and policy obstacles. Cannabis has long been classified by the Drug Enforcement Agency (DEA) as a Schedule I drug under the federal CSA. Its distribution or sale for medicinal or other purposes is strictly prohibited. For decades DEA has operated an eradication and suppression program[3] targeting drug traffickers engaged in indoor cultivation of cannabis with higher potency than other forms of the drug.

During President Obama's administration the Department of Justice (DOJ) hammered out a series of conciliatory "look the other way" memos[4] allowing states to legalize cannabis without the specter of federal prosecution. On January 4, 2018, however, Attorney General Jeff Sessions rescinded Obama era guidance, tentatively allowing DOJ prosecutions for cannabis offenses. Sessions was immediately challenged by federal and state officials. Senator Cory Gardner, R-CO, temporarily blocked all nominees for DOJ posts until its policy was revised as applied to states legalizing cannabis. On April 13, 2018, President Trump directed DOJ to abandon its broad threats of federal prosecution. Sessions limited DOJ's crime fighting efforts to focus on drug gangs and conspiracies, and prohibited cannabis growing on federal lands (consistent with the recent Ninth Circuit Court of Appeals decision, *United States v. Gilmore*[5]). On November 8, Sessions resigned as Attorney General, which may further mitigate DOJ's "get tough" stance.

Other federal developments reflected a more favorable legal approach. The National Academies of Medicine opined that select medicinal uses of cannabis are efficacious.[6] The Food and Drug Administration (FDA) approved new drugs with cannabinoid ingredients.[7] Federal legislators evinced new attitudes toward cannabis as well. On May 8, 2018, the U.S. House Committee on Veterans' Affairs (VA) promoted

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the bipartisan VA Medicinal Cannabis Research Act[8] authorizing new research on "the efficacy and safety of certain forms of cannabis" for select VA patients. On September 13, 2018, the House Judiciary Committee supported the Medical Cannabis Research Act of 2018,[9] which would require federal issuance of more licenses to grow cannabis for research use.

Notched between these legislative developments was the June 2018 introduction of Senate and House companion bills known collectively as the Strengthening the Tenth Amendment Through Entrusting States (or "STATES") Act.[10] This monumental legislation would create a permanent CSA exemption essentially allowing cannabis use in states legalizing it, without federal interference. It would also enable financial institutions to lawfully transact with cannabis businesses. President Trump indicated his support for the STATES Act shortly after its introduction. If passed, these federal legislative developments will reflect continued state-based legalization trends (and Canada's national legalization of cannabis for both recreational and medical use).

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Packaging and Labeling, Advertising, and Pesticides

In the absence of federal regulation, states have had to establish their own cannabis regulatory framework, resulting in significant differences across jurisdictions. Medical cannabis programs vary by qualifying conditions, business licensing requirements, types of cannabis-infused products sold, and tetrahydrocannabinol (THC) dosing. These varied approaches have led to a patchwork of laws governing three areas essential to protecting the public health: packaging and labeling, advertising, and pesticides.

Edible cannabis products are an increasingly popular form of consumption. In some states, stringent child-resistant packaging and universal warning symbol requirements[11] for such products help prevent non-intentional consumption, particularly among minors. Edible product labeling regulations are essential to warn consumers against the dangers of driving after consumption,[12] and the potential for delay in the onset of psychoactive effects. Many states' labels must additionally list the date of manufacture and expiration, storage instructions, and the number of servings contained within a unit.[13]

Cannabis-specific advertising restrictions prevent the promotion and marketing of cannabis-infused products to minors. Many states restrict cannabis advertisements near schools, playgrounds, and other youth centers.[14] Some states require cannabis ads to receive content approval from a regulatory agency,[15] or prohibit false or misleading content in cannabis product advertising, particularly regarding unsubstantiated medical claims about the efficacy of medical cannabis products.[16]

The Environmental Protection Agency (EPA) has authority to regulate the registration, distribution, and use of all pesticides. Since cannabis cultivation remains illegal under federal law, however, EPA refuses to approve any pesticide application on the plant. Lacking federal guidance, Nevada and some other states provide a color-coded list of pesticides that are classified according to their level of risk and are not prohibited for use under state law.[17] Additionally, state-licensed laboratories conduct testing to ensure that products are free from contaminants, including pesticide residues in excess of the allowable limit.[18]

Protecting the public's health specifically requires (1) preventing children from non-intentional consumption of cannabis-infused edibles and the influence of youth-targeted advertisements, (2) educating adult consumers about responsible uses of cannabis, and (3) rigorously testing products to ensure that only safe products are sold or distributed.

Opioid Use and Medical Cannabis

Increasingly states are looking to medical cannabis as a tool in the fight against the nation's opioid epidemic. In 2018, Illinois and New York adopted laws allowing medical cannabis to be used in place of prescription opioids to treat severe and chronic pain.[19] These policy decisions were largely founded on the growing

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evidence-base that cannabis is an effective and safer alternative for pain treatment.[20] Recent data also indicate that implementation of medical cannabis laws significantly reduce distributions of opioid prescriptions among Medicaid and Medicare enrollees,[21] and that states with medical cannabis programs experience significantly fewer opioid overdose deaths.[22]

Consequently, policymakers are considering cannabis not only as an alternative pain treatment to opioids, but as an opioid replacement therapy to help ease withdrawal symptoms and aid in relapse prevention. On May 17, 2018, Pennsylvania became the first state to expressly approve cannabis for treatment of opioid use disorder (OUD), making cannabis available in cases where federally-approved OUD treatment options fail. Critically, certified research centers in that state may initiate clinical trials on the use of cannabis to treat OUD.

Continued high rates of opioid overdose deaths necessitate effective interventions, which may include cannabis use. Legislation authorizing cannabis-related OUD treatment has been introduced in at least a dozen states and passed in Hawaii,[23] Maine,[24] and New Mexico[25] (before being struck down by Governor veto). High-quality clinical research on the use of cannabis to combat OUD will better inform these important policy developments.

Racial Disparities with Respect to Cannabis

The criminalization of cannabis disproportionately impacts minority groups, especially African-Americans. Despite using cannabis at rates comparable to their white counterparts, African-Americans are more than four times as likely to be arrested for cannabis possession.[26] As states legalize cannabis, and businesses and investors rush to cash in, African-Americans are likewise being disproportionately excluded from the market. Fewer than 1% of cannabis dispensaries nationwide are owned by African-Americans.[27]

Many states and cities are looking to level the playing field for those groups and individuals disproportionately impacted by the criminalization of cannabis. Multiple jurisdictions have rescinded prior convictions for cannabis possession offenses. In 2018, Massachusetts, Los Angeles, Oakland, and San Francisco implemented programs prioritizing cannabis business applicants who were arrested or convicted for cannabis-related offenses.[28] Similarly, a growing number of states require applicants to submit a comprehensive plan to achieve diversity among owners, investors, and employees, or provide licensing preferences for minority groups and women.[29]

Time will tell whether these "social equity programs" increase diversity in the cannabis industry, but potential litigation risks for jurisdictions considering racial or ethnic preferences are significant. A 2016 Ohio law allocating 15% of all medical cannabis cultivator licenses to minority applicants was challenged on constitutional grounds.[30] On May 31, 2018, the trial court held initially that the aggrieved applicant had properly asserted a federal equal protection claim and that the statutory set-aside was subject to strict scrutiny.[31] Clearly any regulatory proposal providing preference for race, ethnicity, or gender must be carefully drafted to meet constitutional muster.

Conclusion

Conflicts between state-based legal authorization and federal prohibitions continue to chill the cannabis industry, inhibit research, and thwart public health regulation. Absent federal guidance, states face significant challenges attempting to regulate this rapidly-expanding billion-dollar industry while simultaneously protecting patients and the public. Until the federal government implements favorable legislation or re-assesses the scheduling of cannabis and cannabinoids, states must rely on proven policy measures from other regulated industries, such as child-resistant packaging, universal warning symbols, appropriate advertising restrictions, and limitations on pesticide use, to address emerging public health concerns related to medical cannabis.

Note

The authors have nothing to disclose.

References

1. National Conference of State Legislatures, *State Medical Marijuana Laws* (2018), *available at* <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx> (last visited May 8, 2019).
2. U.S. Census Bureau, State Population Totals and Components of Change: 2010-2017 (2018).
3. U.S. DEA, *Cannabis Eradication: Domestic Cannabis Eradication / Suppression Program*, *available at* <https://www.dea.gov/cannabis-eradication> (last visited May 8, 2019).
4. U.S. Department of Justice, "Guidance Regarding Marijuana Enforcement," August 29, 2013.
5. *United States v. Gilmore*, 886 F.3d 1288, 1289 (9th Cir. 2018).
6. National Academy of Medicine, *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research* (2017), *available at* <https://www.nap.edu/catalog/24625/the-health-effects-of-cannabis-and-cannabinoids-the-current-state> (last visited May 8, 2019).
7. D. Hoffmann, F. B. Palumbo, and Y. Tony Yang, *Will The FDA's Approval Of Epidiolex Lead To Rescheduling Marijuana?*, July 12, 2018, *available at* <https://www.healthaffairs.org/do/10.1377/hblog20180709.904289/full/> (last visited May 8, 2019).
8. H.R. 5520, 115th Cong. (2018).
9. H.R. 5634, 115th Cong. (2018).
10. S. 3032, 115th Cong. (2018); H.B. 6043, 115th Cong. (2018).

The Journal of Law, Medicine & Ethics, 47 S2 (2019): 108-111.

11. Washington State Liquor and Cannabis Board, Not for Kids Warning Symbol, *available at* <http://lcb.wa.gov/marj/warning-symbol-article> (last visited May 8, 2019).
12. Ariz. Admin. Code § R9-17-317 (2018).
13. Colo. Code Regs. § 212-1 (2018).
14. 006 02 Ark. Code. R. § 007 (2018).
15. Fla. Stat. § 381.986 (2018).
16. N.Y. Comp. Codes R. & Regs. tit. 10, § 1004.16 (2018).
17. State of Nevada Department of Agriculture, *Pesticide Use on Medical Marijuana*, *available at* <http://agri.nv.gov/uploadedFiles/agrinvgov/Content/Plant/Environmental_Compliance/MME%20Pesticide%20list-%2001-09-2017%20Updated.pdf> (last visited May 8, 2019).
18. 007 16 Ark. Code. R. § 005 (LexisNexis 2018).
19. N.Y. Comp. Codes R. & Regs. tit. 10, § 1004.2 (2018).
20. National Academies of Sciences, Engineering, and Medicine, *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research* (2017).
21. M. A. Bachhuber, B. Saloner, and C. O. Cunningham, "Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010," *JAMA Internal Medicine* 174, no. 10 (2014): 1668-1673.
22. A. C. Bradford, W. D. Bradford, and A. Abraham, "Association between US State Medical Cannabis Laws and Opioid Prescribing in the Medicare Part D Population," *JAMA Internal Medicine* 178, no. 5 (2018): 667-672.
23. S.B. 2407, 29th Leg., Reg. Sess. (Haw. 2018).
24. L.D. 1539, 128th Leg., Spec. Sess. (Me. 2018).
25. H.B. 527, 53rd Leg., Reg. Sess. (N.M. 2017).
26. American Civil Liberties Foundation, *The War on Marijuana in Black and White* (2013).
27. Marijuana Business Daily, *Women and Minorities in the Marijuana Industry* (2017), *available at* <https://mjbizdaily.com/wp-content/uploads/2017/10/Women-and-Minorities-Report.pdf> (last visited May 8, 2019).
28. 935 CMR 500.105 (2018); Los Angeles, California, Municipal Code § 104.20 (2018); Oakland, California, Municipal Code § 5.80.045 (2018).
29. 28 PA. Code § 1141.32 (2018).
30. Ohio Rev. Code Ann. §3796.09 (2018).
31. *PharmaCann Ohio, LLC v. Ohio Dept. of Comm.*, Franklin C.P. No. 17 CV 10962 (2018).

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