

FLYING HIGH IN THE REGULATORY STATE:
AN ANALYSIS OF STATE REGULATORY
SYSTEMS FOR THE DISTRIBUTION OF
MEDICAL CANNABIS

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INTRODUCTION

The legalization of medical cannabis has sparked intense debate throughout the United States in recent years. While states such as Colorado and Alaska have boldly legalized cannabis for recreational use,¹ other states have passed legislation that legalizes cannabis or some of its derivatives for specified medical uses.² Against the backdrop of federal illegality of cannabis in all of its forms, states that have legalized medical cannabis have adopted different regulatory systems that seem to have a common nucleus.

As of June 2017, twenty-nine states, the District of Columbia, Guam, and Puerto Rico have legalized cannabis for medical use.³ An additional sixteen states have legalized cannabidiol (CBD) oil for certain medical conditions.⁴ CBD, unlike tetrahydrocannabinol (THC), is a non-psychoactive part of the cannabis plant and is commonly used in an oil form.⁵ Thus, while using cannabis that contains THC may have psychoactive as well as medical effects on its users, users of CBD oil can still reap many of the medical benefits of cannabis without experiencing the psychoactive effects resulting from the THC.⁶ This key distinction may be the biggest reason many states that have traditionally opposed legalizing cannabis for medical purposes have legalized the use of CBD oil for limited medical purposes (commonly for the treatment of epilepsy).⁷

In 2013, the Department of Justice released a memo stating it had made a policy decision to not prosecute individuals lawfully using medical cannabis under state law so long as those state systems conform to eight

1. COLO. CONST. art. XVIII, § 16(5)(a); ALASKA STAT. § 11.71.190 (1999).

2. *See State Medical Marijuana Laws*, NATIONAL CONFERENCE OF STATE LEGISLATORS, <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx> (last visited Jan. 27, 2017).

3. *See id.*

4. *See 16 States With Laws Specifically About Legal Cannabidiol (CBD)*, PROCON, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=006473> (last visited Jan. 27, 2017).

5. *See* John Ingold, *Non-Psychoactive CBD Oil Made From Marijuana Plants Poised To Be Game-Changer* (Oct. 2, 2016), <http://www.denverpost.com/2014/03/29/non-psychoactive-cbd-oil-made-from-marijuana-plants-poised-to-be-game-changer/>.

6. *Id.*

7. *See* PROCON, *supra* note 4.

general criteria (e.g., ensuring doctors do not participate in drug trafficking, ensuring children do not have easy access to cannabis, etc.).⁸ This announcement has led to persisting state experimentation in the area of regulating cannabis for medical use.

States that have legalized some form of medical cannabis (“legalized states”) have different systems of distribution. Nevertheless, most legalized states have a reasonably similar system of regulation.⁹ Generally, patients seeking to treat their health conditions with medical cannabis must go to a health care professional with recommendation privileges (governed by state statute) and get a recommendation from that professional to use medical cannabis. Patients will only be able to get such a recommendation if they have a “qualifying medical condition” listed by state statute. Once a patient with a qualifying medical condition gets a recommendation from a privileged health care professional, the patient usually must register with the state’s Department of Health. All legalized states issue ID cards to patients upon verification of a privileged physician’s recommendation, proof of in-state residency, and payment of an application fee, and put the patient in a confidential state registry containing all cardholders. For states that allow qualifying minor children to use medical cannabis in some form, that minor child must designate a “caregiver” (generally the child’s parent or legal guardian), and the caregiver is the one to whom the ID card is assigned and has the privilege of purchasing, possessing, and in some cases, cultivating the medical cannabis. Adults may also appoint caregivers to assist them in their treatment plans. Once a patient or her caregiver has an ID card, she may go to an approved dispensary and purchase medical cannabis, subject to certain possession limits and the presentation of her ID card. Generally, dispensaries also must register with the state’s Department of Health, and additional fees and licensure requirements apply to individuals seeking to start a dispensary.¹⁰ Some states allow patients to personally cultivate medical cannabis for their own use, again subject to certain restrictions.¹¹ Patients generally must carry their ID cards with them while they are traveling with medical cannabis in their possession. Finally, patients must periodically renew their ID cards with a new recommendation from a privileged health care professional and the payment of a renewal fee.¹²

A number of factors comprise the variations found in each distribution system. This Note examines a variety of factors common to existing state regulatory systems to identify the best ways to regulate the distribution of medical cannabis. These factors include: (1) the number and type of qualifying medical conditions, (2) patient access to medical cannabis

8. Guidance Regarding Marijuana Enforcement, Op. Att’y Gen. 1, 1-4 (2013).

9. See *Medical Marijuana*, THE NATIONAL ORGANIZATION FOR THE REFORM OF MARIJUANA LAWS, <http://norml.org/legal/medical-marijuana-2> (last visited Jan. 27, 2017).

10. *Id.*

11. *Id.*

12. *Id.*

through personal cultivation and dispensaries, (3) privileged health care professionals and recommendations of medical cannabis to patients, and (4) patient registration requirements and state reciprocity. In analyzing each factor, this Note discusses existing state systems that excel in relation to each factor and existing state systems that perform poorly in relation to each factor. Finally, this Note argues that the best regulatory scheme for the distribution of medical cannabis is ultimately a mixture of several aspects of existing systems and some aspects that no system has yet adopted. This Note will also argue that this ideal regulatory system should be adopted by all states to increase patient access and choice, decrease costs, improve efficiency, and maximize the individual liberty for patients, while simultaneously protecting the public.

The best regulatory system for the distribution of medical cannabis should embody an expansive list of qualifying medical conditions with the ability to be easily expanded as new medical and scientific discoveries pertaining to the use of medical cannabis emerge. Second, the ideal regulatory system should allow for personal cultivation and easy establishment of dispensaries, so to improve patient access to medical cannabis and achieve lower prices through market competition. Third, to ensure patients have enough ascertainable health care professionals to serve their needs, the model regulatory system should grant recommendation privileges to a broad array of health care professionals that are easily identified within the state through a published list of all professionals with recommendation privileges. Finally, the ideal regulatory system should include an efficient, cheap, and compassionate registration system through low application fees and reciprocity provisions.

I. MODEL ACT FOR STATE SYSTEMS OF DISTRIBUTION

(1) Purpose and Findings.¹³

(a) The recorded use of cannabis as medicine goes back nearly 5,000 years. Modern medical research has confirmed the beneficial uses of cannabis in treating or alleviating the pain, nausea, and other symptoms associated with a variety of debilitating medical conditions, including cancer, multiple sclerosis, and HIV/AIDS, as found by the National Academy of Sciences' Institute of Medicine in March 1999.

(b) Studies published since the 1999 Institute of Medicine report continue to show the therapeutic value of cannabis in treating a wide array of debilitating medical conditions. These include relief of the neuropathic pain caused by multiple sclerosis, HIV/AIDS, and other illnesses that often fail to respond to conventional treatments and relief of nausea, vomiting, and other

13. This model section uses the statutory language found in § 5 of the Compassionate Use of Medical Cannabis Pilot Program Act, the statute legalizing cannabis for medical purposes in Illinois. 410 ILL. COMP. STAT. 130/5 (2016).

side effects of drugs used to treat HIV/AIDS and hepatitis C, increasing the chances of patients continuing on life-saving treatment regimens.

(c) Cannabis has many currently accepted medical uses in the United States, having been recommended by thousands of licensed physicians to at least 600,000 patients in states with medical cannabis laws. The medical utility of cannabis is recognized by a wide range of medical and public health organizations, including the American Academy of HIV Medicine, the American College of Physicians, the American Nurses Association, the American Public Health Association, the Leukemia & Lymphoma Society, and many others.

(d) Data from the Federal Bureau of Investigation's Uniform Crime Reports and the Compendium of Federal Justice Statistics show that approximately 99 out of every 100 cannabis arrests in the U.S. are made under state law, rather than under federal law. Consequently, changing state law will have the practical effect of protecting from arrest the vast majority of seriously ill patients who have a medical need to use cannabis.

(2) Definitions.

(a) "Qualifying medical condition" means one or more of the following:

(A) cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, cachexia/wasting syndrome, muscular dystrophy, severe fibromyalgia, spinal cord disease, including but not limited to arachnoiditis, 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 (SCA), Parkinson's, Tourette's, Myoclonus, Dystonia, Reflex Sympathetic Dystrophy, RSD (Complex Regional Pain Syndromes Type I), Causalgia, CRPS (Complex Regional Pain Syndromes Type II), Neurofibromatosis, Chronic Inflammatory Demyelinating Polyneuropathy, Sjogren's syndrome, Lupus, Interstitial Cystitis, Myasthenia Gravis, Hydrocephalus, nail-patella syndrome, residual limb pain, seizures (including those characteristic of epilepsy), post-traumatic stress disorder (PTSD), or the treatment of these conditions;¹⁴ or

14. This is the list of "debilitating medical conditions" found in § 10(h) of Illinois' Compassionate Use of Medical Cannabis Pilot Program Act. 410 ILL. COMP. STAT. 130/10. This is perhaps the largest statutory list of qualifying medical conditions currently available in any legalized state.

(B) Any other chronic or persistent medical symptom that either:¹⁵

(i) 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

(ii) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.

(b) "Department of Health" means the governmental department and any of its relevant agencies authorized to promulgate rules and regulations pertinent to this Model Act.

(c) "Qualified individual" means an individual duly licensed and authorized under the requirements of this Model Act to possess and purchase medical cannabis in this state.

(d) "Registered dispensary" means a corporation, partnership, limited liability company, or other legally authorized entity that acts as a dispensary that meets the requirements of § 4 of this Model Act and distributes medical cannabis in one or more of its forms.

(e) "Practitioner" means any physician licensed to practice medicine in any state in the United States or any registered and licensed nurse practitioner or any registered and licensed physician assistant in any state in the United States.¹⁶

(f) "Recommendation privileges" means the right of a Practitioner to provide a patient with a recommendation for medical cannabis within this state.

(g) "Recommendation" means a recommendation to use medical cannabis to a patient by a Practitioner for the treatment of the individual's qualifying medical condition.

(h) "Registered Identification Card" means an identification card issued by the Department of Health to a Qualified Individual or the Qualified Individual's caregiver.

(3) Personal cultivation.¹⁷

(a) To cultivate cannabis in this state, a qualified individual must:

(A) Be twenty-one (21) years of age or older; and

15. This subsection is based on the statutory language found in CAL. HEALTH & SAFETY CODE § 11362.7(12)(A)-(B) (West 2004), a part of California's statutory scheme defining "serious medical conditions."

16. This definition is intended to extend recommendation privileges within the state to nurse practitioners, physician assistants, or physicians that are licensed in *any other state* in the United States.

17. This section's language has been taken from OR. ADMIN. R. 333-008-0025 (2005) and OR. ADMIN. R. 333-008-1030 (2005), part of Oregon's regulatory scheme legalizing medical cannabis, and modified to fit the purposes of the Model Act.

(B) Not have been convicted of a Class A or Class B felony under this state's criminal code for the manufacture or delivery of a controlled substance in Schedule I or Schedule II:

- (i) Within the previous two years; or
- (ii) More than once.

(b) In addition to the application review required by this state's law, the Department of Health must:

- (A) Conduct a criminal background check on any individual;
- (B) Verify the individual's age;
- (C) Verify the zoning of the grow site address if the grow site is within city limits; and
- (D) Determine the number of plants that are permitted at the grow site address.

(c) Unless the Department of Health has received a request for a grandfathered grow site address under state law, the grow site plant limits, on and after March 1, 2017¹⁸, are as follows:

- (A) A maximum of twelve (12) mature marijuana plants if the grow site location is within city limits and zoned residential; or
- (B) A maximum of forty-eight (48) mature marijuana plants if the grow site location is within city limits but not zoned residential or outside city limits.

(4) Incorporation of Dispensaries.¹⁹

(a) To register a medical marijuana dispensary a person must:

(A) Submit an initial application on a form prescribed by the Department of Health that includes but is not limited to:

- (i) The name of the individual who owns the dispensary or, if a business entity owns the dispensary, the name of each individual who has a financial interest in the dispensary;
- (ii) The name of the individual or individuals responsible for the dispensary, if different from the name of the individual who owns the dispensary, with one of the individuals responsible for the dispensary identified as the primary person responsible for the dispensary;
- (iii) The physical and mailing address of the medical marijuana dispensary; and

(B) Application and registration fee.

18. This date could be changed by any state legislature adopting this Model Act to reflect the date at which it wishes the new grow site plant limits to take effect.

19. This section is based on OR. ADMIN. R. 333-008-1020 (2005) and addresses the requirements for the licensing of a dispensary as well as some areas where dispensaries are not allowed.

(b) An initial application for the registration of a dispensary must be submitted electronically via the Department of Health's website, [*insert URL to the State Department of Health's website here*]²⁰.

(c) If an initial application is submitted along with the required fees, the Department of Health will notify the applicant in writing that the application has been received. Within thirty (30) calendar days of the mailing of the written notice of acceptance, the following information must be received by the Department of Health:

(A) For each individual named in the application:

(i) A legible copy of the individual's valid government issued photographic identification that includes last name, first name, and date of birth;

(ii) Information, fingerprints, and fees required for a criminal background check in accordance with this state's law; and

(iii) An individual history form and any information identified in the form that is required to be submitted in accordance with the rules promulgated by the Department of Health;

(B) A written statement from an authorized official of the local government that the proposed location of the dispensary is not located in an area that is zoned for residential use as that term is defined in under this state's law;

(C) Proof that the business is registered or has filed an application to register as a business with this state's Office of the Secretary of State, including proof of registration for any doing business as (DBA) registration;

(D) Documentation, in a format prescribed by the Authority, that the proposed location of the dispensary is not within 1,000 feet of:

(i) The real property comprising a public or private elementary or secondary school, except as otherwise provided by the laws of this state; or

(ii) A registered dispensary.

(E) A scaled site plan of the parcel on which the premises proposed for registration is located, including:

(i) Cardinal directional references;

(ii) Bordering streets and the names of the streets;

(iii) Identification of the building or buildings in which the proposed dispensary is to be located;

(iv) The dimensions of the proposed premises of the dispensary;

20. The URL for the state's Department of Health should be inserted here.

(v) Identification of other buildings or property owned by or under the control of the applicant on the same parcel or tax lot as the premises proposed for registration that will be used in the business; and

(vi) Identification of any residences on the parcel or tax lot.

(F) A scaled floor plan of all enclosed areas of the premises at the proposed location that will be used in the business with clear identification of walls, partitions, counters, windows, all areas of ingress and egress, intended uses of all spaces and all limited access areas; and

(G) Documentation that shows the applicant has lawful possession of the proposed location of the dispensary.

(d) The Department of Health shall have the authority to promulgate all rules and regulations pertaining to the fee schedule for applications under this section, provided that the fee for an application under this section shall not exceed \$4,000.

(5) Practitioner Recommendation Privileges.

(a) Any Practitioner has the privilege to recommend medical cannabis to a patient who is domiciled in this State and has a qualifying medical condition within the meaning of this Model Act.²¹

(b) The Department of Health shall, on its Internet website, publish and maintain a current list of all Practitioners within this state that have recommendation privileges under this Model Act.²²

(6) Registered Identification Cards and Reciprocity.

(a) An individual shall not be exempt from criminal penalties for possession or cultivation of marijuana in this state unless such individual registers with the Department of Health after receiving a Recommendation from a Practitioner and receives a Registered Identification Card from the Department of Health.²³

(b) Upon presentation of a valid in-state photo ID, a \$25 registration fee, and a Practitioner's Recommendation, the Department of Health shall issue the presenting individual (or, if the Recommendation is for a minor, to the caregiver) a Registered Identification Card. A Registered Identification Card expires two (2) years after it is issued.

21. This provision is intended to automatically grant recommendation privileges to physicians, registered nurse assistants, and physician assistants duly licensed and registered in any state in the United States.

22. This section is intended to ensure that a state's Department of Health will publish a current list of all practitioners within the state who have recommendation privileges.

23. This provision is intended to only give criminal protection to Qualified Individuals within the meaning of the Model Act.

(c) A Qualified Individual or a Qualified Individual's caregiver may renew an expired Registered Identification Card by presenting a valid in-state photo ID, a \$25 renewal fee, and a Practitioner's Recommendation to the Department of Health.

(d) Notwithstanding the other provisions of this Model Act, if a Practitioner determines that an individual's qualifying medical condition is incurable and permanent, a Registered Identification Card issued to such individual shall not expire.

(e) The Department of Health shall not issue a Registered Identification Card to an individual under the age of eighteen (18). If an individual under the age of eighteen (18) presents two (2) Recommendations from two (2) different Practitioners and designates a parent or guardian as a caregiver to the Department of Health, the Department of Health shall issue a Registered Identification Card to the designated caregiver of such individual at no cost. A Registered Identification Card issued under this subsection shall expire six (6) months after it is issued, and may only be renewed in the same manner that it is issued.²⁴

(f) A registry identification card, or its equivalent, that is issued under the laws of another state, district, territory, commonwealth, or insular possession of the United States that allows the medical use of marijuana by a visiting qualifying patient, or allows a person to assist with a visiting qualifying patient's medical use of marijuana, shall have the same force and effect as a registry identification card issued by the department.²⁵

(g) Notwithstanding the other provisions of this Model Act, a valid registry identification card under the laws of another state shall not receive reciprocity in this state unless the health care professional that issued the certification or recommendation for the out-of-state registry identification card would be considered a Practitioner within this State.²⁶

II. AREAS OF AGREEMENT AND DISAGREEMENT AMONG LEGALIZED STATES

A. Variations Among Legalized States Regarding the Number and Type of Qualifying Medical Conditions

One of the most fundamental aspects of any regulatory system for the distribution of medical cannabis is the list of medical conditions that allow patients to use cannabis legally. Often called "qualifying medical

24. This section is intended to embody the additional safety protections for minor patients that this paper discusses.

25. This subsection is based on MICH. COMP. LAWS ANN. § 333.26424(k) (West 2016), part of Michigan's regulatory scheme for medical cannabis.

26. This provision is intended to ensure that out-of-state identification cards will only receive reciprocity if the health care professional that issued the recommendation for it in the other state would have been considered a Practitioner within the meaning of the Model Act.

conditions,” “debilitating medical conditions,” or “qualifying health conditions,” this list, usually created by statute, ballot initiative, or regulation, determines which health conditions qualify any given patient for the use of medical cannabis in that state.²⁷ While having a larger and more numerous list is not necessarily indicative of a superior distribution system, it does generally indicate that patients in states with broader lists will have a better chance at getting access to medical cannabis.²⁸ Indeed, it seems axiomatic that any regulatory system for the distribution of medical cannabis should place the ability of patients to use cannabis to treat their health conditions as one of its highest priorities.²⁹

Every legalized state lists cancer and HIV/AIDS as a qualifying medical condition.³⁰ Most legalized states also list cachexia (wasting syndrome), glaucoma, multiple sclerosis, and epilepsy and other seizure disorders as qualifying medical conditions.³¹ A handful of legalized states list post-traumatic stress disorder (PTSD) as a qualifying medical condition, and a few states list severe pain, nausea, or terminal illness as qualifying medical conditions.³² New Mexico law states that hospice patients are automatically considered to have a qualifying medical condition,³³ and the District of Columbia catalogs “any condition for which treatment with medical marijuana would be beneficial, as determined by the patient’s physician” as a qualifying medical condition.³⁴

Illinois has perhaps the largest and most inclusive list of qualifying medical conditions, encompassing forty different diseases and disorders that allow patients to utilize medical cannabis to treat their health conditions.³⁵ Lupus, Lou-Gehrig’s Disease (ALS), muscular dystrophy, and Parkinson’s disease are all included in Illinois’ list, as are spinal cord injuries and Tourette syndrome.³⁶ Noticeably absent from Illinois’ list is a qualifying health condition for chronic or severe pain, a broader category that California, Arizona, and others have adopted.³⁷

Another interesting legalized state in terms of its qualifying medical conditions is California. The Compassionate Use Act of 1996—also known

27. Andrew J. Boyd, *Medical Marijuana and Personal Autonomy*, 37 J. MARSHALL L. REV. 1253, 1258-69 (2004).

28. *See id.*

29. *Patient Access to Medical Marijuana in Washington State*, WASH. STATE DEP’T OF HEALTH, at 20 (2008).

30. 28 *Legal Medical Marijuana States and DC*, PROCON, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881&print=true> (last visited Jan. 27, 2017).

31. *Id.*

32. *Id.*

33. N.M. CODE R § 7.34.3.7 (LexisNexis 2015).

34. D.C. CODE § 7-1671.01(17) (2015).

35. 410 ILL. COMP. STAT. 130/10 (2016).

36. *Id.*

37. CAL. HEALTH & SAFETY CODE § 11362.7(h)(6) (West 2004); ARIZ. REV. STAT. § 36-2801(3)(b) (LexisNexis 2010); N.H. REV. STAT. ANN. § 126-X:1(IX)(a)(2) (2016); OR. REV. STAT. § 475B.410(6)(b)(B) (2016).

as Proposition 215, a successful ballot initiative—allows Californians to use medical cannabis upon the recommendation of a physician for the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or “any other illness for which marijuana provides relief.”³⁸ The last item in the list, “[a]ny other chronic or persistent medical symptom that either: (A) 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 . . . (B) [or] [i]f not alleviated, may cause serious harm to the patient’s safety or physical or mental health,” offers patients unique latitude for acquiring medical cannabis to treat a vast array of health conditions.³⁹ A plethora of various health conditions could theoretically constitute a qualifying medical condition under the California statute.

The most restrictive legalized state’s list of qualifying medical conditions is probably that of New Hampshire’s, which allows patients to use medical cannabis for only chronic or terminal diseases, cachexia, severe pain, nausea, vomiting, seizures, and severe, persistent muscle spasms. While only seven conditions are listed as qualifying medical conditions under New Hampshire’s list, it is noteworthy that the list includes severe pain as a qualifying medical condition—a condition that is not on Illinois’ list.⁴⁰

B. The Ideal Regulatory System’s Rules Pertaining to the Number and Type of Qualifying Medical Conditions

State regulatory systems with the greatest numbers of qualifying medical conditions give a more expansive number of patients the best opportunities to use medical cannabis to treat their medical conditions.⁴¹ Thus, patients living under state distribution systems with more qualifying medical conditions have greater choice in treatment plans than those living under state distribution systems with a smaller number of qualifying medical conditions.⁴² While the advantages of greater patient choice remain unclear in certain respects, at least some patients are likely able to use medical cannabis *instead* of conventional pharmaceutical drugs, particularly opioids.⁴³ This may mean that patients could use medical cannabis as an alternative to potentially more expensive pharmaceutical drugs that also carry unwanted side-effects, including higher risks of addiction.⁴⁴ Indeed, in light of the recent media coverage of the opioid epidemic sweeping the

38. CAL. HEALTH & SAFETY CODE § 11362.7(h)(12)(A)-(B) (West 2004).

39. *Id.*

40. N.H. REV. STAT. ANN. § 126-X:1(IX.)(a) (2016); 410 ILL. COMP. STAT. 130/10 (2016).

41. *Clinical Implications and Policy Considerations of Cannabis Use*, AMA, <https://assets.ama-assn.org/sub/meeting/documents/i16-resolution-907.pdf> (last visited Jan. 27, 2017).

42. Boyd, *supra* note 27, at 1278.

43. *Id.*; See also AMA, *supra* note 41.

44. Boyd, *supra* note 27, at 1278; See also AMA, *supra* note 41.

United States, medical cannabis appears increasingly more attractive as a substitute treatment option for patients who would otherwise treat their health conditions using opioids.

The best regulatory system for the distribution of medical cannabis should encompass a broad list of qualifying medical conditions to allow patients greater diversity in their treatment options. Allowing for more qualifying medical conditions for patient access to medical cannabis could save patients money in treating their health conditions or reduce traditional risks associated with prescription drugs.⁴⁵ Particularly in the area of chronic pain, using medical cannabis as an alternative to prescription opioids could reduce the risk of drug addiction and lead to better treatment outcomes for patients.⁴⁶

Accordingly, Illinois' list of qualifying medical conditions is probably the best list currently existing in the United States. An ideal regulatory system for distributing medical cannabis would adopt a list similar to Illinois', with an eye toward expanding the list of qualifying medical conditions when any future medical research identifies new medical conditions that, with reasonable certainty, could be treated successfully with medical cannabis. Finally, the preferred list of qualifying medical conditions should include a provision like that found in California, giving privileged health care professionals broad discretion to recommend medical cannabis to patients for other health conditions not specifically enumerated in the list of qualifying health conditions, so long as the physician has reason to believe that medical cannabis could help treat the patient's health condition within her sound medical judgment. Including such a provision in a state's regulatory system for the distribution of medical cannabis could encourage health care professionals to engage in innovative treatment plans and participate in new research and development projects exploring the additional uses and safety risks of using medical cannabis.⁴⁷

C. Variations Among Legalized States Regarding Patient Access to Medical Cannabis Through Personal Cultivation and Dispensaries

Another important aspect of any state's regulatory system for the effective distribution of medical cannabis is a patient's access to medical cannabis, either through personal cultivation or in-person purchases from approved dispensaries.⁴⁸ Some states, such as New York, have restrictive

45. Boyd, *supra* note 27, at 1278; See AMA, *supra* note 41.

46. LESTER GRINSPOON & JAMES B. BAKALAR, *MARIHUANA: THE FORBIDDEN MEDICINE* 110 (rev. ed. 1997).

47. INSTITUTE OF MEDICINE, *MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE* 177 (Janet E. Joy, et al. eds., 1999).

48. See Karen O'Keefe, *State Medical Marijuana Implementation and Federal Policy*, 16 J. HEALTH CARE L. & POL'Y 39, 50-57 (2013).

systems that do not allow for personal cultivation and only allow purchases at a limited number of dispensaries throughout the state.⁴⁹ Other states, such as Colorado and Oregon, employ the opposite approach, allowing patients to cultivate a certain amount of their own medical cannabis or purchase medical cannabis at a large number of different dispensaries sprawled throughout each respective state.⁵⁰

Oregon currently has 521 dispensaries throughout the state where patients can obtain cannabis.⁵¹ In addition, Oregonian patients can cultivate up to twelve plants in residential zones and forty-eight plants in non-residential zones, provided that they register as a grower for only themselves and meet certain criteria (a patient must be twenty-one years of age or older, not have been convicted of a Class A or Class B felony for the manufacture or delivery of a controlled substance in the previous two years or more than once, and pass a criminal background check).⁵² Individuals seeking to apply for licenses to create medical cannabis dispensaries in Oregon must pay a \$4,000 application fee, get fingerprinted, and pass a criminal background check.⁵³ Finally, a dispensary may not be located in a residential zone, within 1,000 feet of a school, or within 1,000 feet of another medical marijuana dispensary.⁵⁴

Colorado currently has 525 dispensaries throughout the state,⁵⁵ and patients or their caregivers can jointly cultivate up to six plants.⁵⁶ Colorado permits three different kinds of medical cannabis dispensaries: (1) “Center Type I,” which may serve 1-300 patients and costs \$9,000 to apply for and obtain state licensing; (2) “Center Type II,” which may serve 301-500 patients and costs \$16,000 to apply for and obtain state licensing; and (3) “Center Type III,” which may serve 501 or more patients and costs \$22,000 to apply for and obtain licensing.⁵⁷

In stark contrast to Oregon and Colorado, both of which contain hundreds of dispensaries throughout their respective states, New York currently has only twenty dispensaries throughout the entire state, and only

49. N.Y. PUB. HEALTH LAW § 3364 (McKinney 2014).

50. COLO. REV. STAT. ANN. § 18-18-406 (2016); OR. REV. STAT. § 475B.428 (2016).

51. Oregon Health Authority, *Approved Marijuana Licensed Retailers*, OREGON.GOV, <http://www.oregon.gov/olcc/marijuana/pages/default.aspx> (last visited Feb. 21, 2018).

52. OR. ADMIN. R. 333-008-0025 (2005).

53. OR. ADMIN. R. 333-008-1030; OR. ADMIN. R. 333-008-2020.

54. OR. ADMIN. R. 333-008-1110.

55. Colo. Dep’t of Revenue, *MED Licensed Centers as of January 5, 2017*, COLORADO.GOV, <https://www.colorado.gov/pacific/sites/default/files/Centers%2001052017.xlsx> (last visited Feb. 21, 2018).

56. COLO. REV. STAT. § 18-18-406(3)(b)(I)–(II) (2013).

57. Colo. Dep’t of Revenue, *Application and Licensing – Marijuana Enforcement*, COLORADO.GOV, <https://www.colorado.gov/pacific/sites/default/files/MED%20Fee%20Table%20Color%20May%202017%20%281%29.pdf> (last visited Jan. 5, 2017); *See also* COLO. CONST. art. IXX, § 16(5)(a).

ten companies have been approved to operate those dispensaries.⁵⁸ In fact, under New York's current statutory regime, no more dispensaries can currently be created.⁵⁹ In addition, New York imposes heavy application and registration fees for companies wishing to open a medical cannabis dispensary—companies must pay a non-refundable \$10,000 application fee and a \$200,000 registration fee (the registration fee is refunded if the company is denied registration).⁶⁰ Finally, New York does not allow patients to personally cultivate medical cannabis.⁶¹

In keeping with New York, Illinois has only forty-seven dispensaries located throughout the state, and patients may only purchase medical cannabis from one dispensary at a time.⁶² Patients must select the dispensary they wish to use and register it with the Illinois Department of Health; patients may change their dispensary later on, but patients have to fill out a form to change their dispensary and the change must also be registered with the Illinois Department of Health before it becomes effective.⁶³ The Illinois Department of Health must approve individuals wanting to open a dispensary, and such individuals must pay a \$5,000 application fee and a \$30,000 registration fee.⁶⁴ In addition, annual renewal fees for dispensaries total \$25,000.⁶⁵ The enabling statute, the Compassionate Use of Medical Cannabis Pilot Program Act, sunsets on July 1, 2020, and does not allow for more than a total of sixty dispensaries throughout the state.⁶⁶ Finally, and perhaps most significantly, neither Illinois nor New York allows patients to personally cultivate medical cannabis.⁶⁷

58. New York State Medical Marijuana Program: Registered Organizations, N.Y. STATE, https://www.health.ny.gov/regulations/medical_marijuana/application/selected_applicants.htm (last visited Feb. 21, 2018).

59. N.Y. PUB. HEALTH LAW § 3365(9) (2014). See *Medical Marijuana Program Applications*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/regulations/medical_marijuana/application/applications.htm (last visited Jan. 27, 2017).

60. *Instructions for Application or Registration as a Registered Organization*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/regulations/medical_marijuana/docs/app_instructions.pdf (last visited Jan. 27, 2017).

61. N.Y. COMP. CODES R. & REGS. tit. 10, § 1004.21 (2015).

62. *Licensed Medical Cannabis Dispensaries*, ILL. DEP'T OF FIN. AND PROF. REG., <http://www.idfpr.com/Forms/MC/ListofLicensedDispensaries.pdf> (last visited Jan. 27, 2017).

63. *Id.*

64. Joint Committee on Administrative Rules, *Fees*, ILL. GEN. ASSEMBLY, <http://www.ilga.gov/commission/jcar/admincode/068/068012900C00800R.html> (last visited Jan. 27, 2017).

65. *Id.*

66. 410 ILL. COMP. STAT. 130/220, 130/115 (2016).

67. See 410 ILL. COMP. STAT. 130/10.

D. The Ideal Regulatory System's Rules Pertaining to Patient Access to Medical Cannabis Through Personal Cultivation and Dispensaries

An examination of Colorado, Oregon, New York, and Illinois illuminates the spectrum of efficiency of state regulatory attempts for the distribution of medical cannabis in terms of personal cultivation and dispensary facilities. Both Colorado and Oregon have hundreds of dispensaries throughout their respective states, and applying for and registering a new dispensary is relatively cheap. Additionally, both Colorado and Oregon allow for some kind of personal cultivation, with Oregon's system being particularly generous for patients with a "green thumb." Illinois, on the other hand, requires significant capital to start a dispensary and can only have sixty dispensaries by statute. New York is even more restrictive on both of these points, since it only allows one-third the number of dispensaries as Illinois, and requires even more capital to start a dispensary. Moreover, both Illinois and New York prohibit personal cultivation, which may restrict access to medical cannabis for poorer individuals.⁶⁸

The best regulatory system should adopt an approach similar to Colorado's or Oregon's pertaining to the issues of personal cultivation and dispensary registration, because allowing for more dispensaries is likely to reduce the geographical distances patients will need to travel to purchase medical cannabis, and encourage more efficient practices for delivery of medical cannabis to patients at individual dispensaries through market competition and banking services.⁶⁹ In addition, allowing patients to cultivate their own medical cannabis could give poorer or extremely sick patients a cheaper and easier alternative for acquiring the necessary medical cannabis to treat their conditions.⁷⁰ Nevertheless, even a free market approach to distribution should have enough regulation to ensure that only qualifying patients can purchase medical cannabis and that patients cannot acquire more medical cannabis than they are allowed to purchase at any given time. If these bare-bones regulations did not exist in a state's regulatory system for the distribution of medical cannabis, that state may risk the DOJ enforcing federal marijuana prohibition in that state, as the 2013 DOJ memo on this topic suggests.⁷¹

Several additional factors support the notion that the ideal regulatory system should reflect that of Colorado's or Oregon's. First, allowing personal

68. See Walt Hickey, *Medical Marijuana is Still the Best Deal in Colorado*, FIVETHIRTYEIGHT (Apr. 29, 2014), <https://fivethirtyeight.com/features/medical-marijuana-is-still-the-best-deal-in-colorado>.

69. David Bronfein, *Maryland State Bank: The Responsible Solution for Fostering the Growth of Maryland's Medical Cannabis Program*, 47 U. BALT. L.F. 28, 56 (2016).

70. Boyd, *supra* note 27, at 1285-86.

71. See Guidance Regarding Marijuana Enforcement, *supra* note 8.

cultivation for patients is a crucial aspect of the most effective regulatory system for medical cannabis. Allowing personal cultivation would likely expand patient access to medical cannabis because it allows for poorer individuals or individuals unable to travel to dispensaries to grow their own cannabis instead of purchasing it.⁷² Personal cultivation also increases patient choice, since patients can elect to grow their own cannabis in customized amounts or types (so long as the individual does not exceed the statutory limits or requirements) and at times that are more convenient to them.⁷³ Some patients may also have qualifying medical conditions that make it difficult for them to travel to dispensaries or caregiver arrangements that make it difficult for them to regularly get the medical cannabis they need from dispensaries to treat their health conditions. Personal cultivation could provide an alternative to patients in these situations, especially if they are an adult and are unable to secure a caregiver to assist them.

Second, the most effective regulatory system for distributing medical cannabis should provide for an easy, cheap, and efficient process for individuals and companies to open new dispensaries. While the regulations should incorporate criminal background checks and certain licensing and zoning requirements on aspiring dispensary owners (as Colorado and Oregon do, for example) to protect the public,⁷⁴ the application, registration, and renewal fees for dispensaries should not be unreasonable. It appears that the more capital a state requires for dispensaries to open and operate, the more likely it is that that state will have fewer dispensaries and less industry growth.⁷⁵ Geographically large or populous states are likely to need a substantial number of dispensaries to provide adequate access to medical cannabis for patients.⁷⁶ To the extent that patients have to travel long distances to reach a dispensary, or there are not enough dispensaries to meet patient needs in a geographic area, patient choice and access is undermined.⁷⁷ Additionally, if there are too few dispensaries throughout a state, a lack of

72. *But see* Vicky Uhland, *The Truth About Growing Your Own Pot*, THE DENVER POST (Feb. 22, 2013), <http://www.denverpost.com/2013/02/22/marijuana-the-truth-about-growing-your-own-pot>.

73. *Id.*

74. AMA, *supra* note 41.

75. *Compare New York State Medical Marijuana Program*, N.Y. STATE, https://www.health.ny.gov/regulations/medical_marijuana/ (20 dispensaries, 1,469 registered practitioners, and 45,350 patients throughout New York as of February 21, 2018) *with* Colo. Dep't of Revenue, *Medical Marijuana Centers*, COLORADO.GOV, <https://www.colorado.gov/pacific/sites/default/files/Centers%2001052017.xlsx> (525 dispensaries as of February 21, 2018).

76. *See* Tess Owen, *How New York Totally Screwed Up Legalizing Medical Marijuana*, VICE NEWS (Jan. 11, 2016), <https://news.vice.com/article/how-new-york-totally-screwed-up-legalizing-medical-marijuana> (finding that with the restrictive number of only 20 dispensaries throughout all of New York, there is only one dispensary for every 2,700 square miles).

77. *Id.*

supply or competition may drive up the price of medical cannabis, thus further undermining patient access through prohibitive prices.⁷⁸

Third and finally, the best regulatory system should avoid statutory limits on the number of dispensaries that a state can have unless there is a compelling reason to do so. Allowing for dynamic growth in a state's number of dispensaries is more likely to increase patient choice and access because of increased market competition, greater medical cannabis supply, and broader geographic coverage.⁷⁹ While some state regulatory systems may wish to ensure that a particular geographic area does not become flooded with dispensaries, this mechanism could be accomplished by regulating dispensaries in a similar way as hospitals—states could require dispensaries to acquire a certificate of need for a particular geographic region before allowing them to open.⁸⁰ This kind of approach—requiring a certificate of need for dispensaries to open rather than imposing a flat statutory maximum on the number of dispensaries allowed to operate in the state—is more particularized and still likely to accomplish the goal of preventing an undesirable flood of dispensaries in any one geographic region.⁸¹

E. Variations Among Legalized States Regarding Privileged Health Care Professionals and Recommendations of Medical Cannabis to Patients

Under the federal Controlled Substances Act, cannabis is a Schedule I substance—the same scheduling as heroin, ecstasy, and LSD.⁸² A Schedule I substance is a substance that (1) “has a high potential for abuse,” (2) “has no currently accepted medical use in treatment in the United States,” and (3) “[has] a lack of accepted safety for use of the drug or other substance under medical supervision.”⁸³ Thus, in legalized states, health care professionals do not directly prescribe cannabis to patients. Instead, legalized states generally

78. See Hickey, *supra* note 68; See also ADAM SMITH, *THE WEALTH OF NATIONS* 79 (1776).

79. See Hickey, *supra* note 66; See also ADAM SMITH, *THE WEALTH OF NATIONS* 79 (1776).

80. For example, Tennessee law states that “[n]o certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards and will contribute to the orderly development of adequate and effective health care facilities or services.” TENN. CODE ANN. § 68-11-1609(b) (West 2016).

81. Owen, *supra* note 76. Of course, requiring that dispensaries be a certain distance away from each other may often serve as a *de facto* limitation on the number of overall dispensaries in any given state. Nevertheless, limiting the number of dispensaries by geographic region and demand within that region would likely still prove more effective than the debilitating (and often arbitrary) limitation on the number of dispensaries via a flat statutory maximum

82. Schedule I, 21 C.F.R. § 1308.11 (2017).

83. 21 U.S.C. § 812(b)(1) (2012).

require *recommendations* or *certifications* of medical cannabis to patients with a qualifying medical condition from health care professionals with recommendation privileges.⁸⁴

Physicians have a First Amendment right to recommend medical cannabis to patients within honest medical judgment made in good faith.⁸⁵ In *Conant v. Walters*, California physicians had recommended medical cannabis to patients under the Compassionate Use Act of 1996. The DEA had stated that it would seek enforcement actions against the recommending physicians—specifically, the DEA threatened revocation of the physicians’ registration to write prescriptions for controlled substances.⁸⁶ The physicians and their patients receiving the recommendations mounted a class action First Amendment challenge to the DEA’s response to the Compassionate Use Act.⁸⁷ The United States District Court for the Northern District of California held in favor of the physicians and patients, reasoning that the doctrine of constitutional doubt protected a physician’s right to recommend medical cannabis to qualifying patients based on his honest medical judgment made in good faith.⁸⁸ The United States Court of Appeals for the Ninth Circuit affirmed, further emphasizing that the government could not prohibit a physician from speaking about the medical benefits of marijuana with his patient because the prohibition targeted the physician’s speech on content and viewpoint grounds.⁸⁹

Legalized states differ in their regulations concerning health care professionals recommending medical cannabis to patients, but their differences concerning this issue are less pronounced than in other legal issues related to regulating medical cannabis. State differences in this area mainly focus on what types of health care professionals are allowed to recommend medical cannabis to patients and whether health care professionals must register with the state in order to obtain recommendation privileges.⁹⁰ The existence of a physician-patient relationship is generally required for a physician to recommend medical cannabis to a patient.⁹¹

In New York, for example, any physician licensed in the state and in good standing may recommend medical cannabis to patients, so long as they also comply with the course and registration requirements.⁹² Specifically, New York physicians must pay \$250 and complete a 4-hour course before registering with the New York Department of Health to qualify for medical

84. See PROCON, *supra* note 30.

85. See *Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002).

86. *Id.* at 632.

87. *Id.* at 634.

88. *Conant v. McCaffrey*, No. C 97-00139 WHA, 2000 WL 1281174, at *16 (N.D. Cal. Sept. 7, 2000).

89. *Walters*, 309 F.3d at 637.

90. See NAT’L CONFERENCE OF STATE LEGISLATORS, *supra* note 2.

91. See *Walters*, 309 F.3d at 636.

92. N.Y. COMP. CODES R. & REGS. tit. 10, § 1004.1(a) (2015).

cannabis recommendation privileges.⁹³ As of June 6, 2017, only 1,043 physicians in New York have medical cannabis recommendation privileges.⁹⁴ Because of the small number of physicians that have fulfilled the statutory requirements to receive recommendation privileges and the lack of a published list of physicians with recommendation privileges whom do not wish to be published on the list, many patients in New York have complained of difficulty in finding a physician that can recommend medical cannabis to them.⁹⁵ Indeed, this may explain why barely 21,000 patients in New York have currently taken advantage of medical cannabis to treat their debilitating health conditions.⁹⁶ Nevertheless, some private organizations are taking steps to list privileged New York physicians on the Internet, and this may prove useful to some New York patients.⁹⁷

In Arizona, any doctor of medicine (MD), doctor of osteopathy (DO), naturopathic physician (ND), or homeopathic physician (MD(H) or DO(H)) who is licensed in the state and in good standing may recommend medical cannabis to patients.⁹⁸ A physician's recommendation takes the form of a written certification by the physician to the patient in the course of the physician-patient relationship, and certifies that "in the physician's professional opinion the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition."⁹⁹

Some states broaden the scope of individuals who can recommend medical cannabis to patients with qualifying health conditions. New Mexico, for example, allows any "person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act" to recommend medical cannabis to qualifying patients.¹⁰⁰ Thus, MDs, DOs, and nurse practitioners and physician's assistants may recommend medical cannabis in New Mexico. Washington also broadens the scope of individuals with recommendation privileges in a similar fashion.¹⁰¹

In addition, Rhode Island and Vermont allow certain licensed healthcare professionals from other states to recommend medical cannabis to

93. *Id.*

94. *New York State Medical Marijuana Program*, N.Y. DEP'T OF HEALTH, https://www.health.ny.gov/regulations/medical_marijuana (last visited June 6, 2017).

95. Caroline Lewis, *Patients Say They Can't Find A Medical-Marijuana Doc In New York* (Feb. 4, 2016), http://www.crainsnewyork.com/article/20160204/HEALTH_CARE/160209928/its-tough-finding-a-new-york-doc-who-can-administer-medical-marijuana.

96. N.Y. DEP'T OF HEALTH, *supra* note 94.

97. *New York Medical Marijuana Doctors*, MARIJUANA DOCTORS, <https://www.marijuanadoctors.com/medical-marijuana-doctors/NY> (last visited Jan. 27, 2017).

98. ARIZ. REV. STAT. ANN. § 36-2801(12) (2010).

99. *Id.* § 36-2801(18).

100. N.M. STAT. ANN. § 26-2B-3 (2007).

101. WASH. REV. CODE § 69.51A.010(5) (2016).

qualifying patients within their respective states. Rhode Island allows any licensed physician in good standing from Rhode Island, Massachusetts, or Connecticut to recommend medical cannabis to qualifying patients.¹⁰² Rhode Island also extends recommendation privileges to physician assistants and registered nurse practitioners from within Rhode Island, a similar extension to those seen in New Mexico and Washington.¹⁰³ Vermont gives recommendation privileges to any licensed MD, DO, ND, physician's assistant, or advanced practice registered nurse in good standing from Vermont, New Hampshire, Massachusetts, or New York, thereby incorporating a broader scope of individuals with recommendation privileges from within *and* outside the state.¹⁰⁴

F. The Ideal Regulatory System's Rules Pertaining to Privileged Health Care Professionals and Recommendations of Medical Cannabis to Patients

The best regulatory system for distributing medical cannabis should emulate Vermont's or Rhode Island's regulatory system while taking care to avoid the burdensome regulations found in New York's regulatory system. Indeed, New York's onerous regulations that require physicians to pay a fee and take a course to gain recommendation privileges may be one reason why there appears to be a shortage of physicians in New York with recommendation privileges.¹⁰⁵ Additionally, New York's statutory refusal to publish a list of non-consenting physicians with recommendation privileges gives rise to additional barriers to patient access and choice, since patients simply cannot find a physician who can recommend medical cannabis to them legally.¹⁰⁶ The optimal design of a regulatory system for distributing medical cannabis should be to protect the interests of patients and the safety of the public without placing undue burdens on patients to get the treatment they need for their health conditions.¹⁰⁷ In sum, New York's regulatory system places substantial obstacles in the path of patients with qualifying health conditions through its refusal to extend recommendation privileges to other health care professionals besides physicians, its barriers to physicians from acquiring recommendation privileges, its prohibition of out-of-state physicians with recommendation privileges from recommending medical cannabis in New York, and its lack of a complete published list of physicians with recommendation privileges. Thus, restrictions of this kind ought to be avoided to achieve the optimal regulatory system for distributing medical cannabis to qualifying patients—that is, a system that makes it as simple as

102. 21 R.I. GEN. LAWS § 21-28.6-3(16) (2016).

103. *Id.*

104. VT. STAT. ANN. tit. 18, § 4472(6) (2012).

105. Owen, *supra* note 76.

106. *Id.*

107. AMA, *supra* note 41.

possible for any health care professionals adequately trained and licensed to obtain recommendation privileges in a way that is also visible to the public.

Additionally, the best regulatory system should incorporate an extension of recommendation privileges to health care professionals beyond physicians. Many of the qualifying medical conditions in the legalized states are reasonably within the ability of health care professionals other than physicians to diagnose.¹⁰⁸ Chronic pain or nausea, for example, probably does not require a licensed physician to diagnose.¹⁰⁹ Thus, allowing physician assistants or registered nurse practitioners to have recommendation privileges for at least some qualifying medical conditions is likely to improve efficiency in the medical cannabis corner of the health care industry, allowing a greater number of qualifying patients to get medical cannabis in a faster and easier way. Indeed, if a state did not want to allow non-physician health care professionals to recommend medical cannabis for more complicated diseases (e.g., cancer), then it could create exceptions in its regulatory scheme for specific qualified health conditions that it deems more important to have physicians diagnose. Any remaining qualifying health conditions that are more easily diagnosed could trigger a statutory allowance for other health care professionals to recommend medical cannabis as to those qualified health conditions.

Moreover, the best regulatory system should provide for a public disclosure of health care professionals with recommendation privileges to give qualifying patients a better idea of which health care professionals they can go to in order to receive a recommendation for medical cannabis. Many qualifying patients have serious medical conditions, such as cancer or terminal illness, and a public list of all health care professionals with recommendation privileges could help improve the efficacy of the distribution system because more patients will know which health care professionals they can visit to get the recommendation they need to register for a medical cannabis ID card, and patients will have more choices in deciding which health care professional they wish to see.¹¹⁰ The alternative to such a system would likely be riddled with problems similar to those which New York is currently facing from its lack of a published list.¹¹¹ Thus, patient convenience and access could be greatly enhanced by such a public disclosure.

Finally, the best regulatory system should incorporate reciprocity provisions that allow health care professionals with recommendation privileges in other states to recommend medical cannabis in the regulating state, provided that the regulating state's relevant provisions pertaining to qualifying health care professionals are sufficiently similar to the provisions

108. *What Roles Does a Nurse Practitioner Have?*, NURSE JOURNAL, <http://nursejournal.org/nurse-practitioner/what-does-a-msn-nurse-practitioner-do> (last visited Jan. 27, 2017).

109. *Id.*

110. Owen, *supra* note 76.

111. *Id.*

of the states receiving reciprocity. While this may not have a large impact on increasing the number of health care professionals with recommendation privileges accessible to qualifying patients in state groupings that are large in geographic area (e.g., Montana or Idaho), it has the potential to increase patient access to health care professionals with recommendation privileges in tighter state groupings (e.g., Maryland and Delaware or New York and New Jersey), since privileged health care professionals in tighter state groupings may be more likely to travel, live, or work in a cluster of states where there may be shortages of particular types of health care services.¹¹²

G. Variations Among the Legalized States Regarding Patient Registration Requirements and State Reciprocity

All legalized states require some form of patient registration or identification (ID) cards.¹¹³ Generally, once a qualifying patient has received a recommendation from a privileged health care professional, the patient can register with the state's Department of Health in order to receive an ID card which allows the patient to purchase medical cannabis at authorized places of distribution.¹¹⁴ Registration usually requires the presentment of the patient's medical records (including the privileged physician's recommendation), a valid in-state photo ID (e.g., a driver's license), and proof of in-state residency.¹¹⁵ Registration lists or databases are usually maintained by the state's Department of Health and contain confidentiality protections.¹¹⁶ If a patient wishes to renew their ID card upon expiration, or if it is lost or stolen, she must generally acquire another recommendation from a privileged health care professional and pay a renewal fee.¹¹⁷ One major issue among legalized states is whether any given legalized state's regulatory system recognizes ID cards from other states and, if so, what the legal significance of that recognition is. Another issue is the amount of money a patient must pay to get an ID card and to annually renew the ID

112. *Recent Studies and Reports on Physician Shortages in the US*, ASS'N OF AM. MED. COLLEGES, (2012), <https://www.aamc.org/download/100598/data>.

113. In Washington, however, patients with qualifying health conditions may purchase medical cannabis without a "recognition card," so long as they comply with the purchasing, possession, and cultivation standards set out in the statute for individuals who do not register in Washington's database. WASH. REV. CODE ANN. § 69.51A.210(3) (West 2016).

114. *See* MICH. COMP. LAWS ANN. § 333.26426(a) (West 2016).

115. Some states, such as Michigan, also allow voter registration cards in lieu of a driver's license. Presenting either document is considered sufficient proof of in-state residency. *Id.*

116. *See* WASH. REV. CODE ANN. § 69.51A.230 (West 2015).

117. Provided that the patient's card has been lost or stolen, Washington allows a patient to get a new "recognition card" without getting another recommendation from a privileged health care professional; however, if the patient does not get another recommendation, the replacement "recognition card" will expire at the same time as the original card would have. *Id.* § 69.51A.230(5).

card. Finally, states may have additional requirements for minor patients and their caregivers, including a higher registration fee.¹¹⁸

New York requires patients to pay a \$50 registration fee in order to get an ID card for medical cannabis, although the New York Department of Health may waive the fee in cases of financial hardship.¹¹⁹ Additionally, New York does not recognize ID cards from outside the state.¹²⁰ Cardholding patients in New York must pay \$50 annually to renew their ID cards.¹²¹ Furthermore, a cardholding patient must receive another recommendation from a privileged health care professional before he or she can renew their ID card.¹²² New York does not allow for personal cultivation, so cardholding patients may only purchase medical cannabis from dispensaries within the state.¹²³ Finally, recommended patients must be eighteen years of age or assign a caregiver that is at least twenty-one years of age in order to acquire an ID card.¹²⁴

Oregon has a higher registration fee than New York, requiring recommended patients to pay \$200 in order to get an ID card for the purchase of medical cannabis from dispensaries.¹²⁵ Persons participating in the Supplemental Nutrition Assistance Program (“SNAP”) are only required to pay \$60 to get an ID card, and persons receiving SSI benefits or who are veterans are only required to pay \$20 to get an ID card.¹²⁶ An ID card in Oregon allows for both purchase and personal cultivation.¹²⁷ To get an ID card, a qualifying patient must present proof of residency in Oregon, medical records (including the privileged physician’s recommendation), and be eighteen years of age, unless the patient designates at least one caregiver who is a parent or legal guardian.¹²⁸ ID cards must be renewed annually with an additional privileged physician’s recommendation, and the fee for renewal is \$200.¹²⁹ Oregon does not recognize ID cards from other states.¹³⁰

Michigan has a \$60 registration fee for both applications and renewals of ID cards. A patient must be at least eighteen years of age, unless the patient designates his parent or legal guardian as his primary caregiver

118. See ARIZ. ADMIN. CODE § R9-17-102 (2017).

119. N.Y. PUB. HEALTH LAW § 3363(2)(f).

120. N.Y. Dep’t of Health, *Information for Patients*, HEALTH.NY.GOV, https://www.health.ny.gov/regulations/medical_marijuana/faq.htm (last visited Jan. 27, 2017).

121. N.Y. PUB. HEALTH LAW § 3361(7).

122. *Id.* § 3363(2)(a)(i).

123. AMA, *supra* note 41.

124. N.Y. PUB. HEALTH LAW § 3363(3).

125. Oregon Health Authority, *OMMP Cardholder Fees*, OREGON.GOV, <http://www.oregon.gov/oha/ph/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/OMMP-Fees.aspx> (last visited June 22, 2017).

126. *Id.*

127. OR. ADMIN. R. 333-008-0020.

128. OR. REV. STAT. § 475B.415.

129. OR. REV. STAT. § 475B.415(6)(b); Oregon Health Authority, *supra* note 125.

130. OR. REV. STAT. § 475B.415.

and the primary caregiver gets certifications from at least two privileged physicians.¹³¹ The patient must also show proof of in-state residency for every application or renewal.¹³² Another written certification from a privileged physician is required every time a patient wants to renew his or her ID card.¹³³ A patient's ID card must be renewed every two years.¹³⁴ Michigan does not offer discounts on application or renewal fees for poor patients. Michigan allows for registered patients without caregivers to personally cultivate up to twelve plants at a time.¹³⁵ An interesting aspect of Michigan's regulatory system is that it recognizes ID cards from outside the state, so long as that ID card is valid under the state laws of the state that issued it. Valid out-of-state ID cards are legally recognized as if they had been issued by the state of Michigan, and carry the same force and effect as Michigan ID cards.¹³⁶

Arizona has a \$150 registration and renewal fee for its ID cards.¹³⁷ Arizona requires registered patients to renew their ID cards annually.¹³⁸ A qualified patient must be at least eighteen years of age to obtain an ID card, unless the patient designates his parent or legal guardian as his primary caregiver and the patient receives two certifications from privileged physicians.¹³⁹ If the patient is under the age of eighteen and must designate his parent or guardian as his primary caregiver, he must pay an increased registration fee of \$350 (renewal fees are also \$350 in this case).¹⁴⁰ For all applications and renewals, the patient must present a new certification from a privileged health care professional (or two certifications, if the patient is under the age of eighteen).¹⁴¹

Additionally, all patients must present proof of in-state residency and photo identification for registration or renewal.¹⁴² Qualifying patients of at least eighteen years of age that are in the SNAP program only have to pay \$75 for registration or renewal fees, and qualifying patients under the age of eighteen that are in the SNAP program only have to pay \$275 for registration or renewal fees.¹⁴³ Patients over the age of eighteen and the primary caregivers of patients under the age of eighteen may cultivate up to twelve plants if they indicate on their application or renewal form that there is not a dispensary within twenty-five miles of the patient's home, provided the

131. MICH. COMP. LAWS ANN. 333.26426(b) (West 2016).

132. *Id.* § 333.26426(a)(6).

133. *Id.* § 333.26426(a)(1).

134. *Id.* § 333.26426(e).

135. *Id.* § 333.26424(a).

136. *Id.* § 333.26424(k).

137. ARIZ. ADMIN. CODE § R9-17-102 (2012).

138. *Id.* § R9-17-108(A).

139. ARIZ. REV. STAT. §§ 36-2804.02-.03 (2014).

140. ARIZ. ADMIN. CODE § R9-17-102.

141. ARIZ. REV. STAT. §§ 36-2804.02-.03.

142. *Id.* § 36-2804.02(A)(3)(a).

143. ARIZ. ADMIN. CODE § R9-17-102.

Department of Health verifies that the information provided on the application or renewal form is accurate.¹⁴⁴ Finally, Arizona recognizes out-of-state ID cards, provided that they are valid under the laws of the state in which they were issued; however, valid out-of-state ID cards may not be used to purchase medical cannabis at any Arizona dispensary (thus only protecting card-carrying out-of-state patients from criminal penalties for possession of medical cannabis).¹⁴⁵

H. The Ideal Regulatory System's Rules Pertaining to Patient Registration Requirements and State Reciprocity

As to the issues pertaining to registration, renewal, and reciprocity of ID cards, the best regulatory system for distributing medical cannabis should incorporate various elements found in New York, Oregon, Michigan, and Oregon. First, the regulatory system should keep registration and renewal fees as low as is practicable. New York's low registration and renewal fee of \$50 is a good starting point, but the best regulatory system should seek to lower the fee even more, since lowering the fee would increase patient access to medical cannabis. Another positive aspect of New York's regulatory system that should be emulated in an ideal regulatory system is the ability of the state to completely waive the fee for indigent patients. Rather than simply lowering the cost of the fee for specific individuals (SNAP participants, veterans, etc.), the ideal regulatory system should also provide for a complete waiver of the fee for low-income patients. A showing of low-income should not be overly difficult to prove; a showing of Medicaid eligibility or SNAP eligibility should be sufficient.¹⁴⁶ If the state cannot afford to completely waive the fee for such individuals, it should make the fee as minimal as possible to the extent that it is financially practicable. Indeed, to the extent that patients cannot afford the fees necessary to obtain or renew the necessary ID cards, the fundamental goal of allowing patients access to medical cannabis to treat their health conditions is undermined, since patients will be unable to purchase medical cannabis without an ID card. Additionally, the best regulatory system should avoid charging higher registration or renewal fees for minors (as Arizona does), because the caregivers of minor patients (parents or legal guardians) are already managing the debilitating medical conditions of their children.¹⁴⁷ Imposing an extra cost on parents who are already shouldering the burdens of treating their child's medical conditions is an unnecessarily depraved act, absent a compelling state financial need to do so.

144. ARIZ. REV. STAT. § 36-2804.02(A)(3)(f).

145. *Id.* § 36-2804.03(C).

146. For example, Arizona lowers its registration fees if a qualifying patient participates in SNAP. ARIZ. ADMIN. CODE § R9-17-102.

147. *Id.*

Second, the ideal regulatory system should allow for the automatic right of personal cultivation of medical cannabis immediately upon the issuance of an ID card, provided that the patient is at least eighteen years old. If the patient is not eighteen years old and the ID card is instead procured upon the designation of a caregiver, the caregiver should have the right to personally cultivate medical cannabis on behalf of the minor-patient. Geographic distance from dispensaries can provide a barrier to patient access to medical cannabis in the absence of the ability to personally cultivate.¹⁴⁸ Thus, allowing for personal cultivation upon the issuance of an ID card can help alleviate the challenges geographically isolated patients face.¹⁴⁹

Further, allowing for personal cultivation increases patient choice and even patient access to medical cannabis, since personal cultivation allows for patients to conveniently retrieve medical cannabis within their own home without spending time and money on travel to reach the nearest dispensary. Some patients may even have debilitating medical conditions that make it difficult for them to travel to dispensaries, and caregivers may not always be available to procure the medical cannabis for patients to which they are assigned; personal cultivation can alleviate these problems as well. Lastly, the reasonably standardized system of ID cards adopted in legalized states can sufficiently ensure that minor patients are not personally cultivating medical cannabis through the restriction that only a minor patient's caregiver may cultivate medical cannabis. Thus, an automatic right to personally cultivate medical cannabis upon the issuance of an ID card would not pose a substantial enough risk of minors illegally cultivating medical cannabis to outweigh the benefits of allowing automatic personal cultivation. This strongly supports the notion of adopting a more unified body of law, such as the Model Act in this Note, as doing so would help protect minor children and the broader public.

Third, the best regulatory system should, at least in some cases, require renewal of ID cards less frequently than annually. Michigan's regulatory system (requiring renewal every two years) takes a better approach than Oregon's, Arizona's, or New York's (all of which require annual renewal), but it is still too standardized to be ideal. For example, patients with qualifying medical conditions such as epilepsy or AIDS should not be required to renew their ID cards every year, for several reasons. First, qualifying medical conditions such as epilepsy or AIDS are currently incurable. Patients with incurable conditions are using medical cannabis to *manage* their health conditions on a *permanent* basis.¹⁵⁰ While the renewal process usually requires a new certification from a privileged physician on an annual basis—presumably to check in on the patient's continuing need for medical cannabis—requiring annual renewal for patients with incurable

148. Morrison et al., *The Economic Geography of Medical Marijuana Dispensaries in California*, 25 INT'L J. OF DRUG POLICY 508 (2014).

149. *Id.*

150. AMA, *supra* note 41.

qualifying medical conditions does nothing but impose additional costs on those patients. In addition to a patient with an incurable qualifying medical condition having to pay for the renewal fee each year, the patient must also pay for an additional doctor's visit to a privileged health care professional to receive a new certification for the renewal. Thus, the standardized requirement that *all* qualifying patients (including patients with incurable qualifying health conditions) renew their ID cards each year imposes undue financial burdens and at least some unnecessary costs on unfortunate patients with incurable qualifying health conditions.

In addition, cardholding patients with incurable conditions could simply meet with a privileged physician as they need to—changes in their medical condition or symptoms or desires for changes in their treatment plan could prompt additional visits to physicians rather than a universal requirement that they meet with a privileged physician once every year when it may be unnecessary to do so. As a result, an ideal regulatory system should impose more frequent renewal requirements only for those patients that have qualifying medical conditions that are not incurable or unlikely to remain constant. Third, cardholding patients with qualifying medical conditions that are not incurable may still economically benefit from a longer issuing period for their IDs because they would not have to pay as many renewal fees. In sum, the best regulatory system for the distribution of medical cannabis to patients should tailor its ID card issuing period to its list of qualifying medical conditions instead of imposing a universal requirement. If a universal requirement is unavoidable, the issuing period for ID cards should still be longer than one year.

Another pillar of the best regulatory system for the distribution of medical cannabis should constitute mandatory caregiver delegations for qualifying patients who are minors. Furthermore, the ideal regulatory system should include the requirement that caregivers for qualifying minor-patients be the minor's parent or legal guardian. All legalized states currently require some person at least eighteen years of age to preside over the purchase, cultivation, and treatment aspects of qualifying patients that are not yet adults. Legalized states also generally require that the caregiver be either a parent or guardian of the qualifying minor-patient. New York's regulatory system requires that a minor's caregiver be at least twenty-one years old, but this may not completely optimal. Most parents or legal guardians of qualifying minor-patients will be twenty-one years old, but there may be some situations where that is not the case.

Specifically, very young children sometimes use medical cannabis for the treatment of severe epilepsy (usually after exhausting conventional prescription drugs).¹⁵¹ There may be some situations in which a very young child could have severe epilepsy as a qualifying medical condition and the

151. Epilepsy Foundation, *Medical Marijuana and Epilepsy*, EPILEPSY.COM, <http://www.epilepsy.com/learn/treating-seizures-and-epilepsy/other-treatment-approaches/medical-marijuana-and-epilepsy> (last visited July 7, 2017).

child's only parent is not yet twenty-one years of age. Assuming, *arguendo*, that the child also has no extended family (such as grandparents) that could assume the role of caregiver under the relevant state statute, the child would be denied access to what could be his best or last hope in treating a severe seizure disorder. In these narrow situations, the best regulatory system ought to include either an exception to the requirement that the caregiver parent or guardian be twenty-one years of age, or simply make the age requirement for caregiver parents or guardians eighteen instead of twenty-one.

Setting aside the age requirement for caregivers, a state has an especially strong interest in protecting the health and safety of children, and medical cannabis should never be used to treat children without the approval of both a privileged physician and the minor-patient's parent or legal guardian. Requiring the consent of parents or guardians in such situations, and requiring the consenting parent or guardian to assume the duty of becoming the child's caregiver, ensures that children do not get access to medical cannabis in situations the law does not allow. By requiring parents or guardians to become caretakers for the minor-patient, minors are removed from any cultivation and purchasing activities related to medical cannabis. Thus, the state fulfills its interest in protecting children and reduces the risk of illegal drug possession or trafficking resulting from allowing children to use medical cannabis to treat their debilitating health conditions. While mandatory caregiver provisions for qualifying minor-patients are an essential element of the ideal regulatory scheme for distributing medical cannabis, a regulating state should also take care to not impose extra fees on registration and renewal of ID cards for qualifying patients who are minors.

Finally, the preeminent regulatory system for the distribution of medical cannabis should include mandatory dual-certification from privileged health care professionals for qualifying patients who are minors. This dual-certification requirement should apply to both a qualifying minor-patient's initial registration and to every renewal of the minor-patient's ID card. Because of the heightened state interest in protecting children, requiring at least two privileged health care professionals to provide recommendations before issuing the minor-patient an ID card under the supervision of a caregiver parent or guardian is appropriate. The ideal regulatory system may also want to include a requirement that the privileged health care professionals issuing recommendations for children have a higher degree of specialty (*i.e.* only allow licensed physicians recommendation privileges for children rather than nurse practitioners or physician assistants).

CONCLUSION

The legalization of medical cannabis throughout the United States has presented several key legal issues, and is likely to introduce more issues as some states legalize cannabis for recreational use. From the ability of health care professionals to recommend medical cannabis to the way a state

creates and manages dispensaries for patients with qualifying medical conditions, several states have already tried a multitude of approaches. Thousands of patients around the nation now use medical cannabis to treat dozens of health conditions, and some parents and physicians are boldly using medical cannabis to try to treat sick children in innovative ways that produce fewer negative results than conventional treatments.¹⁵²

As more states legalize medical cannabis, the regulatory styles and schemes concerning these issues will invariably mutate and shift in new and interesting directions. Nevertheless, it remains clear that the best regulatory system is a blend of the existing state experiments. The best regulatory system for the distribution of medical cannabis must focus on expanding patient access and choice while protecting the dignity and individual liberty of patients so they can live the best lives in light of their unfortunate physical circumstances. The first way this is best accomplished is by having an expansive list of qualifying medical conditions with the potential for growth so any medical condition which a physician believes medical cannabis could help alleviate can be legally treated with medical cannabis. Second, an effective regulatory system for distributing medical cannabis must allow for generous personal cultivation and easily- and cheaply-established dispensaries so market competition improves the effective delivery of medical cannabis to patients while reducing its price and lessening a patient's burden on acquiring it.¹⁵³ Third, the ideal regulatory system must allow recommendation privileges to a broad swath of health care professionals that are easily identified and accessed by qualifying patients to ensure that patients know who they can go to in order to discuss the possibility of using medical cannabis as a treatment in a timely manner. Finally, the best regulatory system must break down the barriers of patient registration by reducing the cost of application and renewal and providing for generous reciprocity between and among the various state registration systems.

If these processes are implemented correctly, states can effectively protect the public in the face of legalized medical cannabis while ensuring that those who are most sick in our society have easy, effective, fast, cheap, and safe access to an incredible treatment that our society is just beginning to understand. The evolving decency of our society demands an end to the unwarranted attacks on the dignity of dying patients who use medical cannabis as nothing more than an effort to experience a brief reprieve from their quiet desperation and physical torment. If an individual can derive medical benefit from the use of cannabis, our constitutional system of ordered liberty affords that individual the right to use it.

152. Boyd, *supra* note 27.

153. SMITH, *supra* note 78.