State Regulation of the Commerce and Uses of Marijuana, a Federal Schedule I Drug[1]

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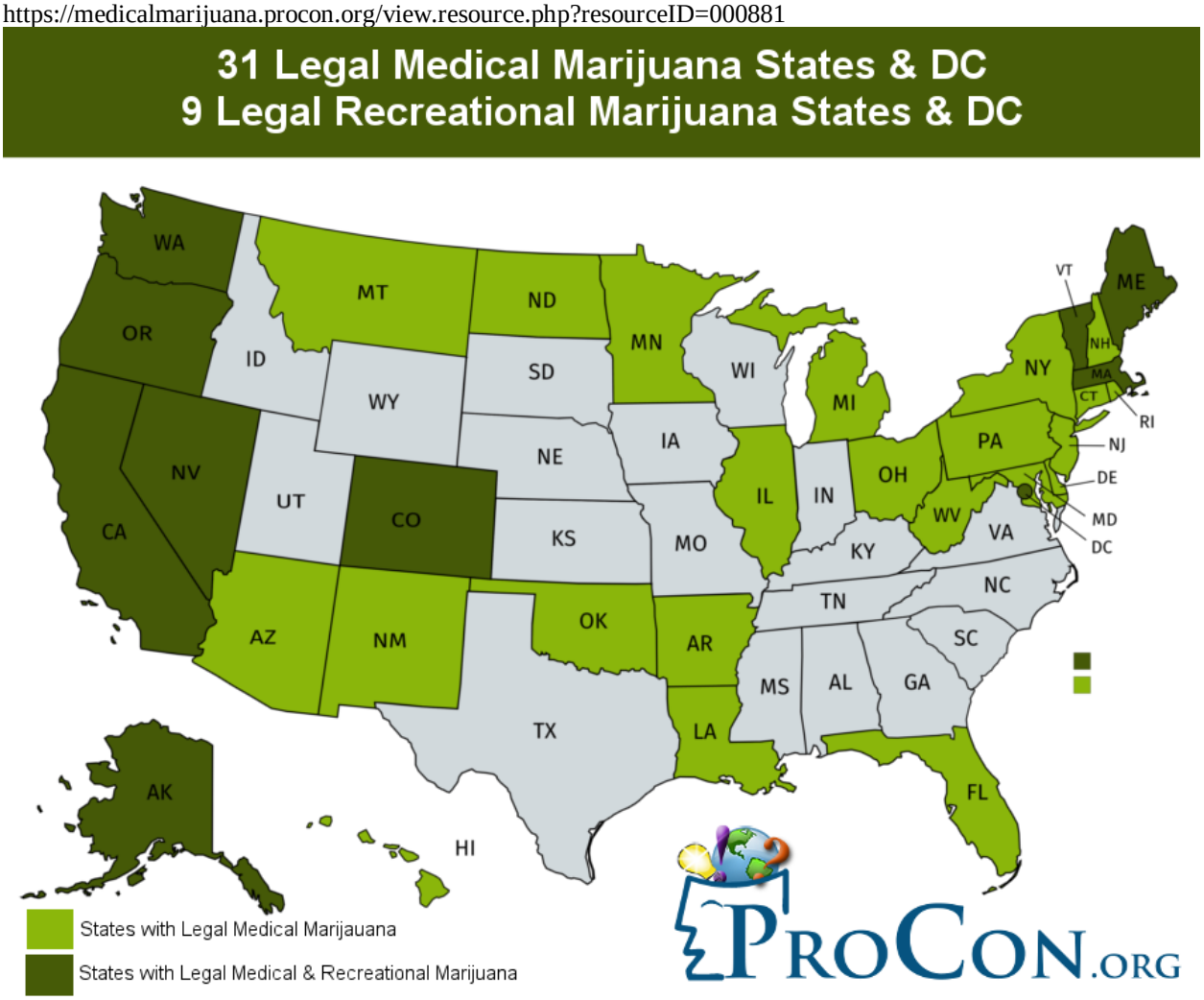
INTRODUCTION

Medical marijuana is currently legal in thirty-one of the fifty states of the United States of America[2]. Geographically, these states cover the four corners, - north, south, east and west of

[1] The analyses and opinions expressed here are that of the author and do not in any way reflect those of the law firm of Shumaker, Loop and Kendrick, LLP.
[2] 31 Legal Medical Marijuana States and DC
https://medicalmarijuana.procon.org/view.resource.php?resourceID=000881



the country, and politically, they include both "blue" (e.g., Washington, New York) and "red" (e.g., Louisiana, North Dakota) states, and the District of Columbia[3]. Starting with California in 1996 and ending with Oklahoma in 2018, thirty-one states have legalized medical marijuana[4]. Recreational use of marijuana is also legal in nine of these states and the District of Columbia[5]. Further, several states voted in the 2018 midterm elections to expand legalization of marijuana: Michigan legalized recreational marijuana, while Utah and Missouri voted to legalize medical marijuana[6].

Here is the problem for these "marijuana" states, the District of Columbia and tens of millions of residents of these jurisdictions: They are in violation of federal marijuana laws which prohibit any use and commerce in marijuana[7]. This huge (potential) problem stems from the fact that marijuana is classified as Schedule I drug, defined as one that "has no currently accepted medical use in treatment in the United States." [8]

The issues relating to marijuana include many key facets of American life – legal (constitutional), medical, economic and political. In this article, I shall develop arguments to support the proposition that states should have the right to legalize marijuana, especially its medical uses. In Part I, I briefly summarize the Controlled Substances Act (CSA) which provides the basis for scheduling of various drug with potential for abuse. An understanding of the provisions of this act is key to understanding the tension between state and federal marijuana laws. In part II, I address medical reasons for declassifying marijuana. Clearly, new and ongoing discoveries of the medicinal properties of cannabis-derived substances outdate the all-inclusive nature of the CSA classification relating to marijuana (proposals to amend the CSA to conform to this new knowledge is highly complex and outside the scope of this effort). In Part III, I present constitutional, legislative and pragmatic issues that make it virtually impossible for the federal government to implement CSA provisions that prohibit marijuana commercialization and uses by the various states and its residents. The last part (Part IV), I present pragmatic strategies for moving forward.

I. CSA DRUG SCHEDULES[9]

a. The Controlled Substances Act (CSA) OF 1970

[3] *Id.*
[4] 31 Legal Medical Marijuana States and DC https://medicalmarijuana.procon.org/view.resource.php?resourceID=000881 (visited October 10, 2018)
[5] *Id.*
[6] https://www.vox.com/a/midterms-2018/ballot-initiatives
[7] 21 U.S.C. §§ 811-812 (2007)
[8] *Id.*
[9] *Id.*

i. Policy Reasons: The CSA was passed in 1970 under the Nixon administration's "war on drugs"[10] " . . . a comprehensive new measure to more effectively meet the narcotic and dangerous drug problems at the federal level."[11] The success of this "war" during the ensuing almost 5 decades is mixed at best, especially in view of the current opioid crisis; in 2017, there were about 72,000 overdose deaths from drugs of abuse, mostly opioids.[12] These are classified as Schedule II drugs.[13]

Scheduling Criteria: This Act classifies drugs into five categories (Schedules) based on three criteria: 1. potential for abuse, 2. therapeutic value and 3. safety (or the lack of it). According to this scheme, Schedule I drugs have the highest potential for abuse, no therapeutic values, and lack safety. The statutory language for the various schedules quoted below (in pertinent part) will explain how this neat "cubbyhole" classification "cubbyholes" of drugs shows an increasing safety and usefulness as one moves down from Schedule I to Schedule V.

b. Schedule Criteria

i. Schedule I
   (A) The drug . . . has a high potential for abuse *(emphasis added).*
   (B) The drug . . . has no currently accepted medical use in treatment in the United States *(emphasis added).*
   (C) There is a lack of accepted safety for use of the drug . . .under medical supervision *(emphasis added).*

ii. Schedule II
   (A) The drug . . . has a high potential for abuse *(emphasis added).*
   (B) The drug . . . has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions *(emphasis added).*
   (C) Abuse of the drug . . . may lead to severe psychological or physical dependence *(emphasis added).*

iii. Schedule III
   (A) The drug . . . has a potential for abuse less than the drugs in schedules I and II *(emphasis added).*
   (B) The drug . . . has a currently accepted medical use in treatment in the United States (*emphasis added).*
   (C) Abuse of the drug . . . may lead to moderate or low physical dependence or high psychological dependence (*emphasis added).*

iv. Schedule IV

[10] David Schwartz, High Federalism: Marijuana Legalization and the Limits of Federal Power, 35 Cardozo L. Rev. 567, 577, (2013).
[11] Controlled Substances Act https://en.wikipedia.org/wiki/Controlled_Substances_Act (visited October 17, 2018)
[12] FEDERAL BUREAU OF INVESTIGATION, UNIFORM CRIME REPORTS: CRIME IN THE UNITED STATES (2007). http://www.fbi.gov/ucr/cius2007/index.html. (visited October 17, 2018)
[13] Fn10

(A) The drug . . . has a low potential for abuse relative to the drugs . . . in schedule III (*emphasis added).*
(B) The drug has a currently accepted medical use in treatment in the United States *(emphasis added).*
(C) Abuse of the drug . . . may lead to limited physical dependence or psychological dependence relative to the drugs . . . in schedule III *(emphasis added).*

v. Schedule V
(A) The drug . . . has a low potential for abuse relative to the drugs . . . in schedule IV *(emphasis added.)*
(B) The drug . . . has a currently accepted medical use in treatment in the United States *(emphasis added).*
(C) Abuse of the drug . . . may lead to limited physical dependence or psychological dependence relative to the drugs or others in schedule IV *(emphasis added).*

c. What is "marijuana"?

Though "marijuana" is commonly referred to as a drug and is so listed under Schedule I[14] , there is no drug termed marijuana[15], per se. A more specific and proper listing of cannabis is tetrahydrocannabinols, which includes the psychoactive THC (delta-9 tetrahydrocannabinol), popularized by the hippie culture in the 1960s. The broad nature of the inclusionary classification is informative[16]: The description preceding the listing for the group in which marijuana is placed clearly indicates that is psychoactive properties of drugs were the primary concern of the enactors of CSA:

> "Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following hallucinogenic substances, or which contains their isomers, and slats of isomers whenever the existence of such slats, isomers, and any slats of isomers is possible within the specific chemical designation." (*emphasis added*)

Therefore, reclassification of some non-hallucinogenic components of marijuana derived components should be in order, given the recent approval of cannabidiol (see infra, Epidiolex®) obtained or modified from cannabis. More than 100 compounds ("cannabinoids") have been identified from cannabis; recently, the dietary supplement CBD (cannabidiol, not to be confused with Epidiolex®), has been wildly promoted commercially and anecdotally as a "wonder" drug[17].

[14] 21 U.S.C. §812 (c)
[15] *Id*
[16] *Id.*
[17] Everything you need to know about CBD oil, Jon Johnson, updated 27 July 2018 medicalnewstoday.com

II. MEDICAL USES OF CANNABIS

1. The NAS Report[18]

Historically, cannabis use has been reported from time immemorial.[19] There is no doubt now that several components derived from of marijuana have important medical properties. In an exhaustive 2017 publication[20], the National Academy Press cited numerous studies which definitely show that some components of marijuana have important medicinal properties. To support this statement, the table below highlights some major conclusions from this report:[21]

[18] The National Academy Press, The Health Effects of Cannabis and Cannabinoids: THE CURRENT STATE OF EVIDENCE AND RECOMMENDATIONS FOR RESEARCH, A Report of the National Academies of SCIENCES.ENGINEERING.MEDICINE, 2017 (hereinafter the NAS Report)
[19] Russo, EB, GW Guy and P.J. Robson. 2007. Cannabis, pain and sleep. Lessons from therapeutic clinical trials of Sativex, a cannabis-based medicine. Chemistry and Biodiversity 4(8):1729-1743.
[20] The NAS Report
[21] Id at Part II, Therapeutic Effects

Indication	Certainty for Effective Treatment	Cannabis Component
Chronic pain in adults	Substantial evidence	Cannabis
Chemotherapy-induced nausea and vomiting	Conclusive evidence	Oral cannabinoids
Increasing appetite and decreasing weight loss with HIV/AIDS	Limited evidence	Cannabis and oral cannabinoids
Patient-reported MS spasticity symptoms	Substantial evidence (patient reports) Clinician-measured (limited evidence)	Oral cannabinoids
Tourette syndrome	Limited evidence	THC capsules
Traumatic brain injury or intracranial hemorrhage	Limited evidence for improving mortality and disability	Cannabinoids
Social anxiety disorder	Limited evidence	Cannabidiol
Sleep disturbance	Moderate evidence	Cannabinoids, primarily nabiximols
PTSD (post-traumatic stress disorder) _	Limited evidence	Nabilone

2. Ongoing Research

To add to the NAS report, more recent studies have reported exciting new therapeutic potential for cannabinoids, which have the potential to even addiction treatment[22], a key basis for the Schedule classification.

3. Epidiolex® Approval by FDA

This is a significant event that conclusively shows that cannabis has important medical properties and challenges its continued listing as a Schedule I drug. The laws and regulations of the drug approval process by the FDA are governed by the Federal Food, Drug and Cosmetic Act.[23] Most importantly, a drug candidate for approval must meet two major criteria: safety and efficacy. After extensive non-clinical and clinical testing under these criteria, the drug Epidiolex® (active ingredient: cannabidiol) indicated for hard to otherwise treat

[22] JF Cheer, and YL Hurd, A new in cannabinoid neurobiology: The road from molecules to therapeutic discoveries, Neuropharmacology 124, 1-2 (2017)
[23] 21 U.S.C. ch.9 §301 et seq.

"seizures related to Lennox-Gestaut syndrome or Dravet syndrome in patients 2 years or older"[24] was conditionally approved on June 25, 2018 as a Schedule I drug; the FDA made it clear that it had to be reclassified by the DEA before it could be marketed. On September 27, 2018, the Drug Enforcement Agency reclassified it as a Schedule V[25], the least "dangerous" of the five schedules (*supra*). It should also be noted that this reclassification applies only to CBD containing products with a maximum THC content of 0.1%. As had been expected, the drug is now commercially available.[26]. It is very encouraging to note that in the letter reclassifying Epidiolex®, the Acting DEA Administrator Uttam Dhillon wrote, "DEA will continue to support sound and scientific research that promotes legitimate therapeutic uses for FDA-approved constituent components of cannabis, consistent with federal law."[27] This statement should also promote future cannabis research and commercialization.

The information presented in Part II clearly shows that continued classification of all cannabinoids as Schedule I drugs is medically and scientifically untenable

III. Barrier to Federal Enforcement of CSA among the States and its Residents

Constitutional issues that support federal implementation of the prohibitory marijuana provisions of the CSA among the states and its residents are considerably weaker than such issues that oppose federal intervention in marijuana commercialization and uses within their respective jurisdiction. In addition, legislative and pragmatic issues provide additional hurdles for federal implementation of CSA among the states. These topics will be discussed in Part III..

a. Constitutional issues: State efforts to legalize marijuana are affected by two opposing issues:

i. the Supremacy Clause (i.e., preemption)[28]: Under this principle, federal laws (in this case, the CSA) which prohibit any use and commercialization of marijuana void state laws which permit such activities, and

ii. anti-commandeering principle of the Tenth Amendment[29] which limits the federal power to enforce of CSA among the various states.

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[24] https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2018/210365Orig1s000Ltr.pdf

[25] https://www.dea.gov/press-releases/2018/09/27/fda-approved-drug-epidiolex-placed-schedule-v-controlled-substance-act (visited December 3, 2018)

[26] https://cannabis.net/blog/medical/epidiolex-now-available-in-the-usa-5-things-to-know (visited December 3, 2018)

[27] *Id.*

[28] Under the supremacy clause of the constitution ((Article VI, Clause 2), "… the Laws of the United States shall be the supreme Law of the Land;".

[29] Tenth Amendment of the Constitution: "The powers not delegated to the United States by the Constitution, nor prohibited to it by the States, are reserved to the States respectively, or to the people."

b. Supremacy Clause: It appears the Supreme Court has clearly accepted the supremacy clause argument when it comes to interpreting CSA, based on its two decisions on medical marijuana.

   i. In 1996, California passed the Compassionate Use Act "to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes."[30] The Supreme Court decided that there is "no medical necessity exception [under the CSA]."[31]

   ii. In a second and rather surprising and split decision[32], it ruled that even intrastate, non-commercial (i.e., individual, small scale) cultivation and use of marijuana were prohibited by the CSA. It reasoned, rather interestingly, that "One need not have a degree in economics to understand why a nationwide exemption for the vast quantity of marijuana . . . locally cultivated for personal use . . . may have a substantial impact on the interstate market for this extraordinarily popular substance." *(emphasis added).*[33]

c. Anti-Commandeering Principle: In contrast to the Supremacy Clause, Supreme Court holdings under this principle have severely curtailed the power of the federal government to enforce its laws on the states; in this case, compelling states to enforce the CSA. In the first of the three such holdings, the case involved disposal of radioactive waste;[34] it held that "The Federal Government may not compel the State to enact or administer a federal program . . . The Constitution enables the Federal Government to pre-empt state regulation contrary to federal interests, and it holds out incentives to the States as a means of encouraging them to adopt suggested regulatory schemes" (*emphasis added).*[35] In the second case which required state actors to conduct background checks in connection with federal gun control laws[36], the Court extended this protection to state employees, stating "We held in *New York*[37] [the first case] that Congress cannot compel the States to enact or enforce a federal regulatory program." It added, "Today we hold that Congress cannot circumvent that prohibition by conscripting the States' officers directly."[38] This last holding is closer to the marijuana issue than the first two cases because it deals with the desires of one state (New Jersey) to legalize sports gambling prohibited by a pre-existing federal law, namely the Professional and Amateur Sports Protection Act (PASPA), that bans sports betting[39]. The Court held that PASPA is unconstitutional, overruling the Third Circuit, which, sitting *en banc* had ruled that PAPSA does not violate the anticommandeering principle. To further clarify and strengthen

[30] Cal. Health & Safety Code Ann. § 11362.5
[31] 532 U.S. 483 (2001)
[32] Gonzales v. Raich, 545 U.S. 1 (2005)
[33] *Id* 28.
[34] New York. v. United States, 505 U.S. 144 (1992)
[35] *Id* at 188
[36] Printz v. United States 521 U.S. 898 (1997)
[37] *Id* at 985
[38] *Id.*
[39] Murray v. National Collegiate Athletic Association, et al., 584 U.S.__ (2018).

reasons articulated in the previous two cases, the Court provided a primer on Tenth Amendment jurisprudence relating to the anticommandeering principle, which, when applied to the marijuana matter, strongly favors the right of states to regulate this drug.

1. "The legislative powers granted to the Congress are sizeable, but are not unlimited."
2. The Constitution confers on Congress not plenary powers t only certain enumerated powers.
3. Therefore, all other legislative power is reserved for the States, as the Tenth Amendment confirms.
4. And conspicuously, absent from the list of powers given to the Congresses the power to issue direct orders to the government of the States.
5. The anticommandeering doctrine simply represents the reconfirmation of this limit on congressional authority.

A resolution of the state-federal conflict on marijuana may be found if the underlined words from this quote[40] from the case "We now hold Congress lacks the authority to prohibit a State from legalizing sports gambling." are replaced by marijuana. The Court distinguishes between the States and private entities, by stating the federal law applies to the latter, not the former. In other words, it is legal for the federal authorities to prosecute private actors for violations of the CSA. As noted, going after such actors may run foul with the Rohrabacher Amendment *(infra)*, if the parties strictly adhere to their respective state marijuana laws, when it comes to medical marijuana.

This opinion discusses, as in the previous two cases[41] the interesting issue of "political "accountability"[42]. If the Congress compels states to follow a federal legal and regulatory paradigm, then the voters could be confused about who to blame, as in the situation if the Congress were to back the marijuana "clock". Confusion or no confusion, it is quite likely that there would be public backlash, given especially that many depend on cannabis derived medications to treat their otherwise intractable maladies, as exemplified with Epidiolex® (cannabidiol).

c. Legislative Hurdles

The Rohrabacher-Farr amendment (rider)[43], a bipartisan legislation enacted in December 2014 as a rider in the federal omnibus appropriations bill, prohibits the use of federal monies to enforce the prohibitory provisions of CSA in 32 states and the District of Columbia. Interestingly, the Schedule I status of marijuana was left unchanged. Being a rider, the law requires that it be renewed every fiscal year to remain effective. It was so renewed every during

[40] *Id* at
[41] Fn 33 and 35
[42] Fn 35
[43] https://en.wikipedia.org/wiki/Rohrabacher%E2%80%93Farr_amendment It is also known as the Rohrabacher-Blumenauer amendment (hereinafter, the Rohrabacher Amendment)

President Obama's administration, and for FY2018 in President Trump's administration. It appears it is headed for continuation at least till the end of FY2019[44], though Dana Rohrabacher lost his seat in 2018 midterm elections[45]. Incidentally, the growing political acceptance of marijuana can be seen in the amendments to this rider. The growing number of jurisdictions covered by the Rohrbach Amendment have been increasing indicating growing political acceptance of marijuana in the country. It was slightly amended in 2015 to include Guam and Puerto Rico with minor text edits[46]. As per the FY2017 budget, the Amendment added the states of Georgia, New York, North Carolina, Ohio, Ohio, Oklahoma, Oregon, West Virginia So, the running total of jurisdictions now include 44 states, the District of Columbia, Guam and Puerto Rico[47]. These changes likely reflect the corresponding societal acceptance of marijuana (see graphic)[48]. Note that this amendment covers only medical marijuana, not its recreational use.

Violators of the provisions of the CSA have used the Rohrbach Amendment to escape sanctions for such violations.[49] The court ruled that as long as an individual *strictly complies* with state marijuana laws, s/he will be protected from federal prosecution for violating CSA

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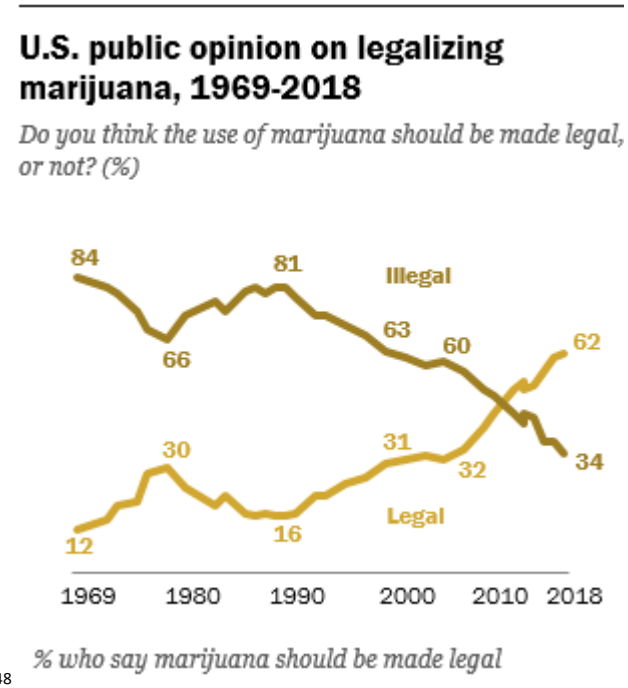
[44] By a voice vote the House appropriation committee approved its inclusion in the FY2019 appropriations bill. (https://en.wikipedia.org/wiki/Rohrabacher%E2%80%93Farr_amendment)

[45] Dana Rohrabacher, one the originators of the amendment lost his seat in the November 6, 2018 midterm elections (https://www.nytimes.com/2018/11/10/us/politics/dana-rohrabacher-loses-harley-rouda.html, visited November 30, 2018)

[46] Consolidated Appropriations Act, 2016, , Pub. L. No. 114-113, §542, 129 Stat. 2332-33 (2015)

[47] Fn41



[48]

[49] US v. McIntosh, 833 F.3d 1163 (2016) Court of Appeals 9th Circuit

prohibitions[50]. To better understand this case the pertinent wording Rohrbach is provided below[51]:

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

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At trial, the defendants had moved "to [either dismiss their indictments" the various infractions of the CSA, or "to enjoin their prosecutions on the grounds that the Department of Justice is prohibited form spending funds to prosecute them under the [Rohrabacher Amendment]." The district courts had denied these requests by the defendants in the consolidated case before the appeals court.[52].

The court rejected the DOJ's argument that "prosecuting private individuals" does not prevent the Medical Marijuana States from giving practical effect to their medical marijuana laws'[53]. Some of the defendants had argued for a more "expansive interpretation of the Amendment. Their position was that all related marijuana activities should be permissible, "unless a person's activities are clearly outside the scope of the state's medical marijuana laws that a reasonable doubt is not possible." The court following an analysis of the phrase "laws that authorize" by consulting language[54] and legal[55] dictionaries, concluded [56] that "at a minimum . . .[it] prohibits DOJ from spending funds from relevant appropriations acts for their prosecution of individuals who engaged in conduct permitted by the State Medical Marijuana Laws and who had strictly complied" with such laws (*emphasis added),* rejecting the argument for a broader view, at least for the moment. The cases, having reached it as interlocutory appeals were remanded to the district courts for the DOJ to continue these cases, if it so chooses. The court ruled that the defendants (appellants) are entitled to "evidentiary hearings to determine whether their conduct was completely authorized by the state law"[57].

The following case[58] illustrates the application of *McIntosh* case, especially, the meaning of the term *strict compliance* used and would be of particular interest to practitioners, both the

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[50] *Id*
[51] Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, §538, 128 Stat. 2130, 2217 (2014)
[52] Fn 49
[53] *Id*
[54] Webster's English Dictionary
[55] Black's Law Dictionary
[56] *Id.*
[57] Fn 49
[58] US v. Dalman, 2017 WL 1256743 (2017)

defense and prosecution sides. The defendant was charged with violations of conspiring or actually growing excessive quantities of marijuana plants possessing excessive quantities of marijuana plants, or "aiding and abetting" marijuana sale in violation of federal law [59] . The defendant moved to "enjoin the expenditure of funds on his federal prosecution under the Rohrabacher amendment. Since the McIntosh case had not ruled on these matters, the trial court, based on "plain text of the rider", and "consideration of fairness" decided that the defendant had the burden of t proving with a pre-ponderance of evidence that he was in *strict compliance* with California medical marijuana laws. Evidence at trial showed that there was "compelling evidence" that the defendant's sale of marijuana to an undercover detective was in violation of California Medical Marijuana Laws. The defendant's motion was denied and ordered to stand trial.

d. State Enforcement of CSA

i. Currently, the "heavy lifting" when it comes to enforcement of CSA is done by the states. In 2007, states handled 99% of the 800,000 marijuana cases.[60] As might be suspected, this is primarily due to lack of availability/allocation priority of resources for federal enforcement. In other words, without the full cooperation of the states enforcement of CSA would be almost impossible.

Therefore, enforcement of CSA becomes more a pragmatic problem than a constitutional one.

IV. STRATEGIES FOR STATES TO MOVE FORWARD WITH DECRIMINALIZING OF CANNABIS

I would make the following recommendations:

a. Strategies for Going Forward

i. States that have already legalized medical marijuana, and those that plan to do so, do not have much to do from a federal perspective. As discussed, there appears to be no real constitutional hurdles for such decriminalization of marijuana and, though minimal, the threat of federal enforcement remains. However, given the growing popularity of marijuana in that a majority of states have legalized marijuana for medical purposes, and a few for recreational purposes, federal attempts to turn

[59] 21 U.S.C. §§ 841 and 846, and 18 U.S.C.2

[60] Federal Bureau of Investigation, Uniform Crime Reports. Crime in the United States (2007)

back the “marijuana” clock.is likely to come with significant political costs.

ii. States should encourage the federal government to amend the CSA in keeping with the new findings of the medical properties of cannabis for the welfare of their citizens.

iii. States should convince the federal government that the marijuana commerce is critical to state economy.

In conclusion, I believe that, taking into consideration key issues, such as the medical benefit/risk ratio for patients who now, and may in the future, desperately need cannabis-derived substances, benefits to state economy of marijuana commerce [61] and federal government’s constitutional and financial infirmities in enforcing provisions of the CSA across the various states, it appears prudent to grant states more autonomy with respect marijuana laws and regulation.

[61] https://money.cnn.com/2018/01/31/news/marijuana-state-of-the-union/ (visited October 13, 2018)