POLICY CONSIDERATIONS FOR MEDICAL MARIJUANA AND ADULT USE PROGRAMS

CONTRASTING CANNABIS DISTRIBUTION MODELS

As reform of outdated marijuana (cannabis) laws spreads across the country, there remains a mistaken belief that recreational marijuana use (adult use) and therapeutic use (medical cannabis) are one and the same. Some policymakers, lobbying organizations, and even activists speculate that legalizing the sale and use of cannabis for adults sufficiently addresses the issues facing patients who use cannabis medicinally. This assumption is faulty in a number of ways. While adult use laws, such as those adopted in Colorado and Washington, may protect patients from prosecution or permit patients to legally purchase cannabis, they fail to address the genuine needs of this growing population.

Need vs Want

It is important to understand how the needs of medical cannabis patients differ from the desires of adult users. Some issues to consider include the route of administration, consumption patterns, and strain selection. For many patients, cannabis is the only medication that will work. Patients must maintain steady cannabinoid levels to obtain optimal health benefits, which may require higher doses that are administered more frequently. Any interruption in supply may trigger a severe decline in a patient's health, which is why patients need consistent sources of quality cannabis to reliably treat their medical conditions. Nor will just any cannabis do. Certain strains and preparations that are uniquely beneficial for medical use produce little to no intoxicating effect, making these products unlikely to be available in an adult use market. Similarly, while adult use consumers largely smoke cannabis, many patients must use a variety of preparations (topicals, tinctures, sublingual, transdermal, etc.), in addition to rapid delivery methods such as combustion and vaporization, to ensure proper cannabinoid absorption. Screening for environmental contaminants takes on added importance for patients due to the increased risk such contaminants pose to compromised immune systems and other serious health challenges.

Financial Burden

Recreational marijuana and cannabis dispensed medicinally are different products, so policymakers should address taxation differently. Since cannabis is a quasi-prescribed medicine, it should not be subject to sales tax, just as prescribed medicines are typically not taxed. Additionally, cannabis is not covered by health insurance. As a general rule, patients should not have to absorb undue costs. Policy makers must take into consideration the fact that patients already face unusual financial hardship, including lost earnings, annual enrollment fees in medical cannabis programs, and out-of-pocket expenses.

In Colorado and Washington, medical cannabis is subject to sales tax, much like over-the-counter medicines, while their adult use taxes are substantially higher. For example, the City of Denver levies a 7.6 percent sales tax on medical cannabis, while adult users pay 21.1 percent, on top of a 15 percent excise tax. Similarly, adult use in Washington State is taxed at 25 percent on three levels, in addition to sales tax. Known as excise or "sin taxes," these multi-tiered taxes can make cannabis prohibitively expensive and inadvertently force low-income patients back onto the illicit market.

Access to Medicine

Many patients cultivate their own medicine due to the significant costs associated with purchasing cannabis, as well as the need to maintain quality control and a consistent supply of specific strains. Current adult use models are more restrictive than estab-

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AmericansFor SafeAccess
Advancing Legal Medical Marijuana Therapeutics and Research

Headquarters: 1806 Vernon Street NW, Suite 300 | Washington, DC 20009
California Office: 770 L Street, Suite 950 | Sacramento, CA 95814

888-929-4367
www.AmericansForSafeAccess.org

lished medical use laws and include lower possession limits or elimination of personal cultivation altogether. This does not offer patients and caregivers the flexibility needed to provide an adequate supply of medicine. Patients are equally concerned about being forced to rely on adult use stores. Since adoption of Initiative 502 in Washington, for example, the state has tried to "harmonize" the two models by dismantling current methods patients use to obtain medicine. Within a year of I-502's passage, a trio of state regulatory agencies called for drastically reducing the defined 60-day medical supply of 24 ounces to a one-week supply of three ounces. Regulators also sought to limit home cultivation to no more than three mature plants, one-fifth the current cap of 15 plants per patient. Collective gardens would also be eliminated, even though many patients indicate that this is their primary means for obtaining medicine. "Harmonizing" medical and adult-use marijuana laws should be neither a pretext for dismantling effective medical access for the sake of greater tax revenue nor an excuse to simplify the lives of regulators.

Consumer Demand and the Free Market

Adult use laws do little to encourage production of low-yield strains that are rich in CBD and other therapeutic components. These types of products are more beneficial for medical purposes than the THC-rich cannabis favored by adult users. The same goes for topicals, tinctures, and transdermal remedies. Research should be encouraged to develop more therapeutic strains and provide patients with more options to meet their healthcare needs. This is unlikely in a marketplace focused on meeting the simpler demands of the larger adult use population. Edible cannabis provides another example of contrasting objectives. Under an adult use model, regulatory agencies seek to limit the amount of THC, similar to beer, wine, and liquor. However, limiting the primary active ingredient in cannabis edibles can deprive patients of a highly effective treatment option that may be uniquely suited to their needs.

Protection from Arrest and Civil Discrimination

Removing criminal penalties for adult use does not address issues arising from discrimination against patients. Lack of civil protections may force patients to decide between foregoing medical cannabis or losing their home, getting fired, or being stripped of child custody or visitation rights. Legal patients also face discrimination in access to health care, including potential denial of prescription pain medications or life-saving organ transplants. Medical cannabis laws often provide an affirmative defense in court to prevent unnecessary criminalization and imprisonment of patients, a vital legal protection that adult use laws lack.

Additionally, while per se intoxication limits have been shown to reduce alcohol-related crashes, the same is not always true for cannabis. Science linking THC concentration to actual motor impairment is controversial at best, often involving very small sample sizes and questionable usage metrics. Yet both Washington and Colorado laws subject all drivers to the same 5 ng/mL limit, even though patients tend to tolerate substantially higher THC concentrations without impairment. Intoxication limits based solely on THC concentration automatically punish anyone who tests positive, regardless of whether or not they are actually impaired. Zero tolerance policies for drivers under 21 are even more problematic, indiscriminately targeting vulnerable patients with disregard for their health. Unlike adult-use consumers, patients are seeking therapeutic relief rather than intoxication. Additionally, patients who regularly use medical marijuana are less likely to become impaired due to tolerance and compensatory mechanisms.

Regulatory Control

Another area of controversy stems from differing regulatory approaches. Medicines are regulated differently than alcohol for good reason, and cannabis should be no different. Generally speaking, alcohol regulators are interested in preventing negative outcomes, but this approach is ill-suited to caring for someone's health. While production and manufacturing medical and adult-use products may share some basic quality standards, distribution models are vastly different, as is the consumer demographic. While authority over adult-use cannabis might be appropriate for a state alcohol control agency, medical cannabis should be regulated similar to other botanical medicines.

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1. Denver Combined Tax Rates, Effective 1-1-2014, Denver Department of Finance, Treasury Division, Tax Compliance, www.denvergov.org/Portals/571/documents/Tax%20Rates%20effective%201-1-2014.pdf
2. See the Federal Alcohol Administration Act [27 U.S.C. 201 et seq.]. Note: states have their own similar alcohol administration laws that may be more restrictive than the federal law.