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Government

A Closer Look at Pennsylvania's Medical Marijuana Bill

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There is a good chance the General Assembly will pass legislation legalizing medical marijuana in 2015. On Jan. 26, Pennsylvania Sens. Daylin Leach, D-Montgomery, and Mike Folmer, R-Dauphin, introduced SB 3, which is virtually identical to the bill they introduced last year (SB 1182). It would legalize medical marijuana for qualifying medical conditions. That bill was not voted on in the state House of Representatives. Mere days after his inauguration, Gov. Tom Wolf gave an impromptu speech in which he vowed to support the new bill if and when it makes it to his desk. If it passes, Pennsylvania will become the 24th state to legalize medical marijuana, joining its neighbors in New York, New Jersey, Maryland and Delaware.

Medical marijuana advocates have criticized Pennsylvania legislators for moving too slowly on this issue. A review of SB 3, however, suggests Pennsylvania's patience may ultimately pay off. By waiting, the General Assembly can learn from medical marijuana experiments in other states and avoid the potential pitfalls that have stalled or even derailed other programs. Thus, Pennsylvania can stand apart, not by being first, but by enacting the most reasoned medical marijuana legislation to date.

According to a 2014 report prepared by Hawaii's Legislative Reference Bureau, all medical marijuana legislation accomplishes three things:

• They remove state criminal penalties for possession and medical use of marijuana.

• They require patients be certified by a physician as having a bona fide medical condition that can be treated with medical marijuana.

• They specify the type and maximum amount of medical marijuana a qualified patient may possess.

However, these elements represent a mere skeleton of a final bill. Medical marijuana legislation often controls the growing, processing, testing, taxing and distribution of medical marijuana throughout the state. Regulations are also implemented for the licensing,

operation and security of dispensaries, as well as protections for patients from civil discrimination in the courts or workplace. The issues are varied, and many fall beyond the scope of this article. Three specific areas, however, are likely to be the subject of debate surrounding SB 3, and therefore deserve a closer look.

Access: Regulated Distribution v. Patient Cultivation

How will patients access medical marijuana? The question is so foundational, it is often overlooked by those outside (and sometimes inside) the legislative process. States have taken different approaches to medical marijuana access, but most fall under two categories: state-regulated distribution systems and patient cultivation.

For example, 10 states, including Colorado and California, allow personal cultivation of medical marijuana by patients. Patients (or their caregivers) are allowed to grow their own medical marijuana to treat their illness. In other states, including New Jersey and New York, medical marijuana distribution is strictly regulated by a state health agency. Others still have no system of distribution whatsoever. For example, medical marijuana has been legal in Hawaii since 2000, yet the law is silent regarding how a qualifying patient is to obtain medical marijuana. Hawaii law does not authorize any medical marijuana sales or distribution.

Patient cultivation of medical marijuana has proven problematic in some states, particularly where it has a tendency to strengthen the black market for marijuana. According to a 2014 report from the Oregon Department of Justice, loopholes in Oregon's medical marijuana law allowed authorized caregivers to grow and possess medical marijuana for an unlimited number of patients. When a caregiver's harvest exceeded the limit under Oregon law, which is not uncommon, there was a temptation to sell the surplus on the black market. Similarly, medical marijuana growers in Michigan claim the state's medical marijuana statute practically facilitates illegal sales by allowing growers to possess more plants than can be legally harvested. Under Michigan law, growers can possess up to 12 plants, but only two-and-a-half ounces of dried marijuana. Twelve plants, however, will produce far more than two-and-a-half ounces of dried marijuana. As in Oregon, these "overages" can end up on the black market.

In California, county and local governments, not the state, regulate the distribution of medical marijuana, which predictably leads to a mosaic of rules and confusion. Different counties have different limits on the number of plants a patient may cultivate. Some counties have no limit at all. The end result has been widespread guerilla farming, particularly within the "Emerald Triangle"—a region in northern California that encompasses Mendocino, Humboldt and Trinity counties. In the Emerald Triangle, local economies are dependent on the cultivation of marijuana for both the legal and underground markets. The area has become the largest marijuana-producing region in the United States.

Wary of patient cultivation issues, other states strictly limit access through state-regulated distribution systems.

In New Jersey, while six dispensaries were authorized to serve the Garden State, only three have opened. The low participation rate in the program has raised concerns that it will not survive. To the west, Delaware, which also prohibits patient cultivation, has yet to open a

dispensary despite passing its own medical marijuana statute in 2011. In some states, limited access and concomitant high prices can create a system where black-market marijuana remains cheaper and more easily accessible.

Currently, SB 3 prohibits patient cultivation, which was removed from SB 3's predecessor bill, SB 1182, in 2014. Instead, SB 3 strictly regulates the growing, processing and distribution of medical marijuana throughout Pennsylvania. There is a cap on the number of licenses that will be issued to growers (65), processors (65) and dispensers (130), with a requirement that "licensees shall be geographically dispersed ... to allow all registered patients reasonable proximity and access to medical marijuana by a medical marijuana dispenser." In 2015, advocates may again push for patient cultivation to be included in a final bill, but it seems unlikely given the modern tendency to favor state-regulated distribution. Time will tell if the cap on growers, processors and dispensers needs to be amended. To ensure fair access, SB 3 could include a mechanism to permit the issuance of additional licenses if a particular part of the state is underserved.

Delivery Methods: Edibles, Oils and Vaporizers

Another likely area of contention is the method patients can use to consume medical marijuana. Medical marijuana can be smoked, vaporized or ingested through marijuana-infused food. Smoking and vaporizing remain the most familiar forms of using medical marijuana. Vaporization is the process of heating the active ingredients in marijuana below the point of combustion (392 degrees) yet hot enough to extract respirable vapor. Vaporizing is a popular alternative to smoking, as it eliminates the inhalation of carcinogens found in all forms of smoke. Moreover, vaporizing is a more efficient delivery system than smoking, as it permits greater absorption of the active ingredients in medical marijuana.

As currently drafted, SB 3 prohibits smoking and vaporizing medical marijuana. This is similar to the approach taken in New York and Minnesota, which ban smoking but not vaporizing medical marijuana. New York and Minnesota have come under criticism by medical marijuana advocates as the only two states that prohibit smoking of medical marijuana. Advocates argue smoking is the cheapest and often most effective way to consume the drug. Vaporizers are expensive—typically $160 to $500—and advocates contend that prohibiting smoking will leave many low-income patients behind.

SB 3 takes the New York/Minnesota approach a step further by prohibiting vaporizing as well. While studies from 2004, 2007 and 2010 suggest inhaling vaporized marijuana is safer than smoking marijuana, there are still unknowns when it comes to the safety of vaporization. For example, vapor composition can vary based on a number of factors, including, the quality of the marijuana, the temperature at which it is heated and how the vaporizer is constructed, including whether plastic materials are used in the vapor path. Heating plastic can release toxins, but it is unknown which toxins could be released and at what temperatures.

In the absence of smoking and vaporizing, Pennsylvania patients will be limited to ingestion (edibles) to consume medical marijuana. Patients report that the effect of ingested marijuana is very different from smoking or vaporizing. Edibles are slower to provide relief, often taking an hour or more before any effects are felt. This may make edibles an unlikely choice for pain relief. Moreover, the lag time between ingestion and relief can result in

overconsumption. Patients are instructed to start with a small amount and wait up to two hours before ingesting any more. Given these inherent difficulties in treating conditions through ingested marijuana, there could be a push to amend SB 3 to permit vaporization. Further research on the long-term effects of vaporization is needed before it can be established as a safe delivery method.

Expansion of Qualified Medical Conditions

Unsurprisingly, there is no consensus among medical professionals on the number of ailments that can be treated with medical marijuana. SB 3 currently limits "qualified medical conditions" to: cancer; epilepsy and seizures; amyotrophic lateral sclerosis; cachexia/wasting syndrome; Parkinson's disease; traumatic brain injury and post-concussion syndrome; multiple sclerosis; spinocerebellara ataxia; post-traumatic stress disorder; severe fibromyalgia; and any condition authorized by the state under Section 702.

This list includes several medical conditions other states omitted, for which there has been criticism. For example, Illinois only recently amended its medical marijuana law to grant minors suffering from epilepsy access to marijuana-derived oil. And, according to the Marijuana Policy Project, a national organization focused on marijuana policy reform, only 10 percent of New York patients have qualifying illnesses under that state's law. On the other hand, however, SB 3 does not include severe or debilitating pain as a separate qualifying condition. According to the Mayo Clinic, there is sound scientific evidence for the use of marijuana for chronic pain that does not respond to narcotics.

Medical marijuana advocates will likely argue that confining medical marijuana to a specific list of diseases has the effect of legislating a decision that is best handled by doctors, not politicians. Furthermore, drafting a finite list fails to consider the reasonable differences of opinion that may exist in the medical community. One doctor may determine that marijuana is the most appropriate treatment for a given disease, yet another may reasonably disagree based on his or her own education and experience. Neither may be wrong in coming to their conclusion.

In its defense, SB 3 would provide a mechanism for the expansion of medical conditions through the filing of a personal petition with the Pennsylvania Board of Medical Marijuana Licensing. Accordingly, there is some flexibility, albeit on a case-by-case basis. It is uncertain, however, whether this process would keep up with or accurately reflect the state of medical science.

The above analysis is merely a starting point. In the coming months, SB 3 will be under the microscope. As the bill is scrutinized from all angles, advocates should remain patient and remember that Pennsylvania is in a unique position to benefit from the failures and successes of the 23 states where medical marijuana is now legal.

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