Medical Marijuana and Workers’ Compensation

Tom Swiatek | August 18, 2014 | Utilization Review

For some time now, medical marijuana use has been a hot topic in workers’ compensation. Many fine articles, including discussions about recent case law from states like Colorado, have covered various aspects of this issue. However, few articles have delved into the details about why smoking marijuana is unlikely to become an FDA-approved treatment, and subsequently, a treatment that would be approved in Utilization Review. This article will provide the reader with a brief history of marijuana in the United States, discuss the state of the drug today, and set forth many of the obstacles to marijuana ever becoming an FDA-approved treatment.

A Brief History of Marijuana

Smoking cannabis has an ancient history of ritual and recreational use in many cultures, including the ancient Assyrians, Chinese, and even the Egyptians. Cannabis users in these cultures generally embraced cannabis because of its psychoactive properties.

Cannabis was criminalized in various countries beginning in the early 20th century. It was first banned in South Africa in 1911. This was followed by a ban in Jamaica (at the time a British colony) in 1913. In the 1920s, cannabis was banned in the United Kingdom and in New Zealand. Canada criminalized cannabis in the Opium Drug Act of 1923.

In the United States, the first state to ban cannabis (listing it as a poison) was California. In 1907, the California Poison Act, amended in 1909, 1911, and 1913, made possession of cannabis, as well as “other narcotic preparations of hemp,” a misdemeanor. Other states soon followed their lead: Wyoming in 1915, Texas in 1919, Iowa in 1923, Nevada in 1923, and Nebraska in 1927.

The first national marijuana law in the United States was the Marihuana Tax Act of 1937. The Act is now commonly referred to, using the modern spelling, as the 1937 Marijuana Tax Act. This law levied
taxes on the sale of marijuana and marijuana products like hemp. However, it was not until 1970 that the federal government banned marijuana via the Controlled Substances Act. By way of this act, Marijuana was classified as a Schedule I substance. Other Schedule I drugs include heroin, Quaaludes, LSD, and ecstasy. The purpose of Schedule I is to categorize drugs that are dangerous and addictive and have no accepted medical use. This is different than Schedule II, which lists drugs that are dangerous and addictive but have some accepted medical benefits.

**Marijuana Today**

The first state to legalize marijuana for medicinal use was California, in 1996. Oregon and Washington passed similar initiatives in 1998, followed by Maine in 1999. As of August 2014, 23 states and the District of Columbia have passed laws legalizing medical marijuana. In implementing these laws, each state has had a similar theme, allowing individuals suffering from AIDS, cancer, glaucoma, Alzheimer’s, epilepsy, and other ailments, to smoke marijuana when no other prescription drug offers the relief marijuana provides. This was viewed by lawmakers as an act of compassion, and the California law passed in 1996 was called “The Compassionate Use Act of 1996.” Also, in 2013, Colorado and Washington legalized recreational use of marijuana; possession was allowed for up to one ounce by a person at least 21 years old.

Despite state laws allowing marijuana for medicinal use, and for recreational use in Colorado and Washington, marijuana remains a Schedule I controlled substance. There has been little, if any, movement from the Obama Administration to push for legalization. The administration’s position on marijuana, as of August 2014, is listed on the WhiteHouse.gov web page.

The Obama Administration states that marijuana’s main active chemical, delta-9-tetrahydrocannabinol (THC), significantly impacts the brain, specifically the cannabinoid receptors. This chemical reaction causes distorted perceptions, impairs thinking and problem solving, and creates problems with learning and memory. It also states that addiction among young adults is a special risk and concern. The web page describes how chronic marijuana use increases the risk of schizophrenia in vulnerable individuals. The web page makes it clear that the federal government is opposed to both medical and recreational marijuana use.

On August 29, 2013, a memo from the Department of Justice set forth a guide for federal prosecutors. First, the memo explains that Congress has determined that marijuana is a dangerous drug. The memo states that the Department of Justice is committed to enforcing the Controlled Substances Act of 1970. While “low level use”—use of relatively small amounts by individuals on private property—has traditionally been left to the states, the federal government reserves the right to prosecute the sale and possession of marijuana pursuant to the Controlled Substances Act.

The takeaway is simple. A person who smokes marijuana in a state where it is legal under state law may still be prosecuted under federal law. This is especially true if a person is in the business of growing, selling or distributing marijuana, or is in any way involved with individuals associated with gangs or cartels or in making marijuana available to minors. Anyone who believes that the federal government won’t prosecute marijuana possession should closely read this memo.

An example of federal enforcement, involves the Harborside Health Center in Oakland, California, one of the largest marijuana dispensaries since 2006. On July 9, 2012, the U.S. Attorney’s Office filed a Complaint for Forfeiture in the Northern District of California. The purpose of the lawsuit was to seize the property that Harborside rents from property owner Ana Chretien. The complaint seeks forfeiture of the property because Chretien has allowed the property to be “used to facilitate
cultivation, sale or distribution of marijuana.” The fact that Harborside’s activities are legal under California law appears irrelevant.

The complaint cites Title 21, United States Code, Section 841(a), which prohibits “the manufacture, distribution, dispensing, and possession with intent to manufacture, distribute, or dispense a controlled substance, to wit: marijuana.” The complaint also cites Title 21, United States Code, Section 856, which makes it unlawful to “rent, lease, profit from or make available for use, with or without compensation, a place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance, to wit: marijuana.” As this case continues its way through the justice system, one takeaway is clear: an individual or organization that is in any way involved in growing, manufacturing, distributing or selling marijuana should be concerned – The federal government is watching.

Another problem faced by the marijuana industry is the limited access to banking. Banks in the United States are strictly regulated by the federal government. As such, most national and regional banks are cautious because they fear they could lose their charter, attract unwanted attention from regulators and even risk prosecution for money laundering. For example, as of August 2014, Bank of America, Wells Fargo, JP Morgan Chase and Citibank refuse to accept customers with businesses relating to marijuana. This extends to building owners who lease retail space to marijuana dispensaries. Few financial institutions will provide a loan to a commercial property buyer if a tenant in the building is a marijuana dispensary. Furthermore, Visa, MasterCard and American Express are on the list of companies that will not allow transactions at marijuana dispensaries, although these companies have allowed some flexibility for individual banks that wish to allow marijuana purchases from legal dispensaries.

On February 14, 2014, the Treasury and Justice departments issued guidelines for banks seeking to do business with marijuana customers. As part of banking operations, banks must review state marijuana licenses and monitor the business for any of the 20 “red flags” that may indicate a violation of state or federal law. Banks must file suspicious activity reports as follows: “Marijuana Limited” for those businesses the bank believe complies with the Treasury Department’s guidelines, “Marijuana Priority” for those businesses for which they have reservations, and “Marijuana Termination” for those believed to be engaging in criminal activity. For example, if a bank has more than one marijuana customer, the bank will need to monitor to see if the business receives substantially more revenue than its local competitors. Presumably, the federal government is deeply suspicious that illegal drug money will be laundered into a marijuana dispensary that is otherwise legal under state law. Few banks are willing to take on this level of maintenance and risk.

For the marijuana industry, the problems do not stop there. The Internal Revenue Service, under 26 United States Code Sec. 280E, does not allow businesses that “traffic in controlled substances” to deduct business expenses like payroll taxes, rent, utilities and workers’ compensation insurance. As a result of this Reagan-era law, the IRS has refused to accept the business deductions of dispensaries including the Harborside Health Center, referenced above, the El Camino Wellness dispensary, and Canna Care dispensary. These marijuana dispensaries now have millions of dollars in tax liability. As a result of the law, these dispensaries, along with many others, are effectively being put out of business.

Looking to the Future

It may seem that there is no significant probability that smoking marijuana will ever be an approved treatment. While that is probably correct, there are things to watch for when making business plans.
There is an emerging trend to consider. From 1970 until 1996, no state sanctioned any type of marijuana use. Now 23 states allow possession and consumption for medicinal purposes. Once this list passes 25 states, the phrase “The majority of states allow marijuana for medicinal use.” will dramatically increase pressure on the federal government to remove marijuana from its Schedule I list of controlled substances.

In some ways, this parallels the prohibition era. Prohibition lasted from 1920 to 1933. By the early 1930s, many states began legislative efforts to end enforcement of the ban on alcohol. By 1930, the citizens in Massachusetts voted to repeal the enforcement of the prohibition laws, effectively making it legal to drink alcohol. In 1933, the 18th Amendment was overturned by the 21st Amendment. Prohibition became known as “The noble experiment that failed.”

Congress, under pressure from a majority of states, could remove marijuana from the list of Schedule I controlled substances, and instead regulate marijuana as it does tobacco via the Family Smoking Prevention and Tobacco Control Act of 2009. Or it could regulate marijuana as it does alcohol under Title 27, United States Code Sec. 201. This would remove a major barrier to marijuana becoming an approved drug.

Decriminalizing marijuana at the federal level would change the entire landscape. Federal marijuana prosecutions as we know them would cease. IRS code 280E would be deemed inapplicable to marijuana dispensaries. Banks would be allowed to do business with marijuana dispensaries as they do with distilleries, breweries and tobacco companies. Increased marijuana testing by the FDA would likely follow. This is currently almost impossible given marijuana’s Schedule I classification.

Another possibility is for the federal government to move marijuana from Schedule I to Schedule II status. As stated earlier, Schedule II status designates dangerous drugs, with a high probably for addiction and abuse, but also with medical benefits. For example, opioids, including morphine, derived from the sap of the opium poppy, are powerful painkillers. Cocaine, a product of the leaves of the erythroxylum coca plant, is used as a topical anesthetic and vasoconstrictor. If marijuana joined these Schedule II drugs, then laboratory testing could be increased. This is what the American Medical Association, the Institute of Medicine, and the American College of Physicians have advocated.

The Smoking Gun That Ultimately Blocks FDA Approval

Assuming marijuana is removed from Schedule I and made legal but heavily regulated, like tobacco, or is removed from Schedule I and moved to Schedule II, one key problem remains: the smoke. Smoking in the United States, in general, is in decline. Both the federal and state governments are largely hostile towards smoking. State-sponsored commercials, billboards and Internet ads tout the dangers of smoking, and the ads are pervasive. This same attitude is seen in the private sector. Several large companies, like AT&T, Coca Cola, General Electric, State Farm and 3M all tout their “no smoke” or “no tobacco” campus policy. Whether it is tobacco or marijuana, individuals who inhale smoke into their lungs are taking in 33 cancer-causing chemicals and substantial amounts of tar. Therein lies a major problem with medical marijuana usage.

Dr. J. Michael Bostwick’s Mayo Clinic February, 2012 article titled Blurred Boundaries: The Therapeutics and Politics of Medical Marijuana, gives a candid view on the problems surrounding FDA approval. In the article, he points out that unlike eaten botanical cannabis (for example, Alice B. Tokla’s legendary brownies) smoking marijuana affords rapid and predictable effects that allow the smoker to maximize the desired psychotropic effects and minimize the negative ones. In other words,
the most effective way to feel the effects of THC, for the vast majority of medicinal marijuana users, is to smoke it.

This is compared to, for example, Marinol, a synthetic THC-based pill which received FDA approval in 1985, and is listed as a Schedule III controlled substance. While smoking marijuana affords predictable effects, Marinol, along with its cousin, Cesament, do not. For example, cancer patients using Marinol and Cesament experience inconsistent results partly due to different absorption rates. Another problem is that cancer patients suffer from nausea and often vomit, greatly reducing the effectiveness of any pill.

The bottom line is that any drug that is smoked and causes asthma, bronchitis, emphysema and lung cancer is highly unlikely ever to receive FDA approval. The only possible exception Dr. Bostwick cites would be for the terminally ill, who represent only a tiny fraction of medicinal marijuana users.

**Conclusion**

While the trend toward legalization continues, medical marijuana advocates must take pause when thinking that the FDA will ever approve smoking pot. Even if fully legalized, without FDA approval it is highly unlikely that any request for authorization in Utilization Review would be approved. Of course, technology is rapidly advancing. In the years to come, advanced vaporizers, diffusers, and other sophisticated methods could render the traditional smoking of marijuana obsolete. At that point, the workers’ compensation insurance industry may have a new fight on its hands. But for the foreseeable future, insurance companies paying for injured workers to smoke pot is not likely.

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As Assistant Vice President of Regulatory Services and General Counsel, Tom Swiatek draws on his experience as an insurance attorney on both the general liability side, as well as on workers’ compensation matters. With his passion for regulatory issues, Tom is leading the discussion with respect to the regulatory challenges and opportunities facing the workers’ compensation system.