How State Medical Marijuana Laws Vary
A Comprehensive Review

Although the federal government formally opposes using marijuana for medicinal purposes, many states have had laws enabling such use since the mid-1970s. Driven by the attitudes of various medical, professional, and policy groups, these state laws have evolved in support of different positions, resulting in a patchwork of approaches. As of December 31, 2000, 26 states and the District of Columbia had laws enabling the medicinal use of marijuana under specific circumstances.

Voters, policymakers, and advocates of various policy provisions need a comprehensive review of the medical marijuana provisions currently in use, as well as insights into the policy implications of those provisions. RAND researcher Rosalie Pacula and her colleagues have undertaken such a review, determining that three main policy dimensions influence the ultimate scope of the state laws: (1) type of provision; (2) illnesses and symptoms covered; and (3) source of marijuana supply.

How Do the Types of Provision Vary?

Table 1 shows the four types of provision—therapeutic research program (TRP), rescheduling, physician prescription, and medical necessity—with TRPs providing the narrowest protection and physician prescription and medical necessity laws providing the broadest. As the table shows, 14 of the 27 states have authorized TRPs—research programs or protocols to study the medicinal value of marijuana for certain patient types and/or diseases—but, as shown by the shading, only six are operational; thus, TRPs offer little protection because they are so difficult to get up and running.

The three states with rescheduling provisions have reclassified marijuana out of their state’s Controlled Substance Act (CSA), which lists it as a Schedule I drug, to a lower schedule that recognizes its medicinal value. While such provisions appear to provide broad access to medical marijuana, they are still subordinate to the federal CSA; moreover, because the federal government is responsible for administering (and revoking) physicians’ licenses for prescribing medicine, physicians have a strong incentive to not write a marijuana prescription.

Thirteen states have physician prescription laws; while they are similar to rescheduling provisions in protecting doctors who write a prescription for marijuana, they can have a much broader effect because many of those laws also enable doctors to discuss medicinal benefits with their patients. Medical necessity laws are in some ways a complement to physician protection laws because they extend a legal defense to patients and, in some cases, their caregivers. Interestingly (as Table 1 shows), all nine states that have medical necessity laws also have physician protection laws.

How Do Covered Illnesses Vary?

Table 2 shows the most frequently specified illnesses covered: cancer (21 states), glaucoma (19 states), pain/chronic illness (8 states), and HIV/AIDS (7 states). Seven states enacted laws that apply to all conditions, and four (the shaded states) enacted their laws after a 1999 Institute of Medicine report advocated the efficacy of medicinal marijuana to relieve some symptoms for some people. Four states do not specify any illnesses or symptoms to which their statutes apply.
How Do Sources of Supply Vary?

The supply source of licit marijuana has only recently been explicitly addressed in state laws. Most early state laws ignored the issue entirely or designated the National Institute of Drug Abuse (NIDA) or some state agency as the primary source of marijuana. Table 3 shows the variation across NIDA, state supply, pharmacy authorization, home cultivation, any means appropriate, and source unmentioned, and the type of provision.

As Table 3 shows, NIDA is still the most frequent source of marijuana, although mostly under the auspices of TRPs. Because of the complexities in establishing legitimate supply chains, the vast majority of laws passed since 1995 (the shaded states in the table)—laws with both physician prescription and medical necessity provisions (the italicized states)—allow patients, and in some cases their caregivers, to use home cultivation. To reduce patients’ risks of federal prosecution, all the “home cultivation” states except California specify limits of no more than three mature plants.

Policy Implications

Looking across the three dimensions of medical marijuana policy reveals nuances in the state laws. For example, one can identify states taking the broadest, most liberal approach and states that appear to be taking broad approaches but are actually more conservative and cautious.

Given the significant variation in the state approaches and that elements of each approach could be subject to federal opposition, the determination of the legality and the viability of these laws will be made on a state-by-state basis.

Policymakers and advocates should be aware of two major hurdles. First, federal courts have not accepted the medical necessity exception when patients have been tried in federal courts, but cases invoking this defense have been highly specific; thus, federal court rulings have not invalidated the defense per se. Second, states need to create a legitimate supply mechanism for patients that does not create a bigger burden for law enforcement. Nine of the 27 states do not explicitly identify a licit source of marijuana for patients; four simply state that patients should obtain marijuana “by any means appropriate,” implicitly encouraging patients to obtain marijuana through illegal channels, and five are completely silent on the issue, forcing law enforcement to pursue both legitimate and illegitimate users until legitimate ones can be identified and legitimizing the black market supply of marijuana.