Analyzing the Differentiation among State Medical Marijuana Policies by Examining State Policies & Trends

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Political Science Senior Thesis
Bemidji State University
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April 2018

Abstract

Support for marijuana has been growing nationwide. This increased support has gained a lot of momentum since the late 1990s when California became the first state to legalize marijuana for medical use by enacting Proposition 215, or the Compassionate Use Act. Since the enactment of Proposition 215, 28 more states and the District of Columbia have legalized marijuana for medicinal use. I look into why states have begun to adopt these laws, and what makes these states differ throughout the country in the timeliness of their actions. I assembled data to examine a variety of state policies to attempt to explain its' policies towards medical marijuana. I chose to look specifically at economic and moral policies across states and internal factors within those states. I then took the information I found and determined what states that allow marijuana as a medicine have in common in these three areas.

Introduction

For hundreds of years, doctors and patients have been looking for solutions to things that ail them. These things range from simple pain pills like ibuprofen, to harder narcotics such as oxycontin, and in some cases even marijuana. At this point, one might ask themselves how doctors could use marijuana as a medicine with a federal prohibition still in place across the United States? According to a January study done by Pew Research center, 61% of Americans support the legalization of marijuana. This number has increased dramatically since around 1970 when the approval rating was only at 12% (Pew, 2018). With this exponential growth in support over the last 40 years, I began to wonder why the drug was still federally illegal and how states had the ability to get around that prohibition? With my deep interest in law, this question sparked my interest and drove me to want to figure out how and why states allow doctors and patients to use marijuana as a medicine. I began my research by doing a historical study about the usage of marijuana as a medicine and then began examining which states allow its usage, why they do, and what they have in common.

Literature Review

Historical Context

Marijuana has been used and studied all around the world as a medicinal and recreational drug, the first studying being done in the 1890s by the Indian Hemp and Drug Commission. As expected this commission found that heavy usage can have negative physical and mental affects but they also found that there was almost no harm in occasional use. Since the early 1900s marijuana has been a topic of high tension within the United States. According to the author John Charles Chasteen, these high tensions arose from the racism directed towards Mexican and African Americans. Marijuana gave the government another false pretense under which to degrade these groups (Chasteen, 2016). The reason given by individuals and the government was that smoking marijuana made Mexican and African Americans "mad" meaning that they go crazy when under the influence (Annas, 1997). As time went on and new studies came out, public opinion regarding marijuana became increasingly progressive. While there are still people who oppose the implementation of marijuana laws, both state and federal laws are beginning to reflect that progressive ideology. Since 1996, beginning in California, states began to legalize the use of medical marijuana, ultimately going against the federal prohibition that we still have today. In this paper, I will be using sources to describe historical change regarding marijuana, analyze which states allow medical marijuana, and determine what these states have in common that drives them to adopt such a policy. I will use empirical data to figure out what states that allow medical marijuana have in common in relation to political and social trends such as liberal versus conservative and incarceration rates by state, to name a few.

The origins of marijuana in the United States aren't completely clear. The best guess that we have is that marijuana arrived in the early 1900s with poor migrants who were trying to flee

the war or other injustice that was tearing their country apart. In the book, *Getting High: Marijuana Through the Ages*, John Chasteen (2016) discusses how the Mexican immigrants who brought this drug with them felt that it helped them to work and stay focused. It wasn't until 1906 when the Pure Food and Drug Act was made law during the Roosevelt administration, that the interstate and foreign commerce of marijuana was officially regulated. This act stated that any products containing dangerous drugs had to be labeled accordingly. This was the first step in the eventual federal prohibition on marijuana that is still in place today.

While this Act may have been primarily focused on the production and sale of opiates and coca leaves, the taxes were also implemented on marijuana, meaning any product containing marijuana had to be labeled and that product was taxed at a very high rate just like the other substances labeled in the Act. The point of this act was to regulate the production of these drugs and ensure that they only be used as needed. Around the time that this legislation was being passed, most people who used marijuana were Mexican Americans because it was a cheap drug that could be easily obtained (Chasteen, 2016). Its' counter parts, however, opium and cocaine, were drugs used primarily by rich whites who could afford the hefty prices. This trend continued until the 1920s when black men began using marijuana in New Orleans. The use by these African American men only furthered the resistance to marijuana. Whites could now tie marijuana usage to the African Americans that they had enslaved for years.

While there were many whites who strongly opposed its use, it didn't take long for acceptance to spread. In the 1920s and 30s African Americans began to migrate north to escape the oppression and poor work environments they faced in the south. This was the beginning of the jazz age and almost anywhere a person could hear jazz music they could smell the aroma of marijuana. By 1930 because of the high level of usage, states with significant minority

populations were the first to outlaw marijuana, beginning in Texas and California (Chasteen, 2016). This outlawing was due to the unverified assumption that smoking marijuana made people crazy, this jump started the idea of reefer madness which spread throughout the states and was particularly driven by a film with the same title.

Federal Laws

Shortly after this film was released, in 1937, the Marijuana Tax Act, was introduced (Annas, 1997). This was the first federal act to solely address marijuana. Following the status quo, this act was based on fear and racism. The Commissioner of Narcotics, Harry Anslinger, of the Roosevelt administration, even went "as far as to claim that marijuana actually caused insanity and violent crime" (Blumenfeld, 2017). This was not supported by much research. A few years later, in 1944, the mayor of New York, Fiorello la Guardia, sanctioned a five-year study on the medical, sociological, and criminal effects of marijuana. This study "found no evidence to support" the idea that marijuana made people crazy criminals but the laws remained in place (Chasteen, 2016).

A decade and a half later we come up to the sixties with the civil rights movement, the war in Vietnam, and the appearance of the hippies. All three of these events proved crucial to the development of marijuana in the United States, the people involved in these events, with their protesting, were also a crucial step towards what we see today regarding medical marijuana laws. Protests for civil rights and against the Vietnam War ultimately led to a culture of young men and women who were willing to do whatever it took to stand up for what they believed in. This included the excessive use of illegal drugs ranging from marijuana to LSD. This culture, among many things, is what led to the successful campaign of Richard Nixon. He and his administration

promised, “vigorous nation-wide drive against trafficking in narcotics and dangerous drugs” (Chasteen, 2017). In 1970 after two years in office his administration passed the Controlled Substances Act or CSA.

This act was made to label specific drugs based on whether it has medical use and its’ addiction rate. An article published by the *Vanderbilt Law Review,* written by Robert Mikos, describes what states can do to get around federal laws and in doing so does a great job in explaining the CSA. These labels go from Schedule I to V. Schedule I is drugs such as marijuana, heroin, and LSD. This means that these drugs are “the most severely restricted category, based on a determination that marijuana had no accepted medical use and a high potential for abuse” (Mikos, 2009). Any drug that is labeled as a Schedule I is federally illegal to possess, manufacture, or sell. However, for drugs with a lower schedule a person can obtain a license from the DEA to handle them, whether that be as a doctor, pharmacist, or scientist. This remains true today. With this obvious federal prohibition on the possession, cultivation, sale, and use of marijuana, I became very interested about how states could possibly allow something that is clearly illegal under federal statutes.

State Laws

The concept of state medical marijuana laws can be confusing to some people because marijuana is a federally illegal drug. How can a state permit something that the federal government clearly prohibits through the Controlled Substance Act? The Superior Court of the District of Columbia heard a case in 1975 that began to explain how states could allow such an act. Robert C. Randall was the first person to successfully articulate the medical necessity defense to a court. He was also the first person to be allowed to use marijuana for medical reasons, in this case his glaucoma, in the United States. In *United States v. Randall*, the court

ruled that Mr. Randall's need to maintain his eyesight outweighed the governments need to stop him from cultivating, possessing, and using marijuana. Over the years states have varied on their acceptance of medical necessity arguments regarding not only marijuana, but other substances as well. This case however was the opening states needed to begin their push toward legalization.

In 1996 California became the first state to legalize the use of medical marijuana. The legislation, Proposition 215, was passed and allowed doctors to recommend the use of marijuana as a treatment for certain debilitating diseases, they could not however assist in the acquisition of the drug. This law, however, did not change any of the buying or selling laws. It simply allowed for the possession and cultivation of marijuana if a person has a proven recommendation from a doctor. Proposition 215 allowed a patient named Stephen Jay Gould to acquire marijuana which cured his nausea that was caused by his chemotherapy. Stephen was undertaking chemo for his abdominal mesothelioma, he eventually became the first person to survive this disease and its extremely harsh treatment (Annas, 1997).

Obviously, this new law was in sharp contrast with the federal law under the CSA. Doctors, who were well within state laws, now faced possible prosecution from the DEA if they recommended marijuana to their patients. In 1996 a group of doctors took a suit against the DEA and the court ruled in their favor saying that the DEA can only charge the doctor if they are caught aiding the patient in acquiring the marijuana (Annas, 2014), which was still illegal in California even though its use wasn't. California paved the way for legalization within other states and as of September 14, 2017, 29 states and the District of Columbia had legalized the use of marijuana as a medical treatment under specific circumstances (Mead, 2017). For the sake of my research I will key in on 27 of those states as New York and Minnesota do not allow the combustion of marijuana.

Each state has its own individual laws regarding medical marijuana but for the most part there are commonalities across the country. Three examples of medical laws that most states have are; the ability for a doctor to recommend marijuana to their patients, for doctors to write prescriptions for medical marijuana, and removing penalties for patients or caretakers who have a doctors' approval. Each state also has its' own policies regarding these laws. One of which is the illnesses and symptoms that are covered in each state and allow for the use of medical marijuana. A piece printed in the *Journal of Public Health Policy* stated that marijuana "clearly seems to relieve some symptoms for some people," these symptoms include pain, nausea, vomiting, glaucoma, and many others (Roaslie, 2002). Most states require some form of these symptoms for patients to be able to use medical marijuana, but Iowa, New Hampshire, Wisconsin, and the District of Columbia have no restrictions on the prescribing of medical marijuana. This means that doctors can simply recommend marijuana to anyone they think it may help. States also regulate where people can acquire their marijuana to try to keep as much money out of the black market as possible.

Laws that state where marijuana must be purchased have become a way that states can generate tax revenue. According to an article posted by USA Today in March of 2014, Colorado had made over one million dollars in tax revenue from medical marijuana in January of that year alone (Lee, 2014). The places that sell these marijuana products are not protected from federal prosecution by the DEA. In 2001 the California Supreme Court decided against the Oakland Cannabis Buyers Cooperative and in favor of the United States. The Court stated that the medical necessity defense used by Robert Randall was not a defense that can be used at the federal level because of the CSA. This decision was later overturned by the Ninth Circuit Court and the Cooperative continued to operate. Even after this decision by the Ninth Circuit the DEA

continued to raid different distribution centers in California and around the country. In 2001 the DEA raided the Los Angeles Marijuana Resource Center which supplied some 900 plus patients with medical marijuana. The center worked in tandem with the sheriff's department to ensure safety and that regulations were followed, and had over 400 marijuana plants (Gerber, 2004).

Court cases like Robert Randalls', Stephen Goulds', and the Oakland Cannabis Buyers Cooperative have shed light on medical marijuana legalization and in 2008 with the election of Democratic candidate Barack Obama the possibility for federal reform looked good. From January 2009 to May 2010 the number of registered patients went up tenfold from ten thousand to one hundred thousand. At one point during this time 75% of patients were being seen by only 15 doctors (Kamin, 2013). In 2012 the Deputy Attorney General during the Obama Administration, David W Ogden, wrote a memorandum saying that the federal government will not prosecute users of marijuana who are using legally within their own state. This memorandum, however, did not protect recreational users or those who carry marijuana across state lines, even if they are a registered patient. The memo also stated that these people and the distribution centers were still subject to enforcement and investigation (Garvey, 2012). In 2013, Deputy Attorney General James Cole wrote another memorandum, which basically restated the Ogden memo, but it is good to keep in mind that this is just the policy of this administration not an actual law (Blumenfeld 2017).

Since these memorandums were given, a new administration has taken power and its view on medical marijuana has become somewhat unclear over its first year in power. A *New York Times* article posted January 7, 2018 says that a directive was given by Jeff Sessions to prosecutors and law enforcement officers that the Obama-era policies were no longer in practice and that the federal government would be cracking down on marijuana users. This clear

contradiction between administrations has lead me to try to understand how a state and in Obama's case even the federal government can simply ignore federal law.

The United States' Constitution clearly states in Article VI that the Constitution and the laws within it shall be the supreme law of the land and that no laws shall contradict those stated within it. Any state law contradicting the Constitution is preempted and shall be struck down and removed from law. The way that states get around this is by simply removing laws restricting marijuana from their statutes. Should a state encourage or require that citizens smoke marijuana, the law would be preempted by the Control Substance Act and deemed unconstitutional. The reason however that the federal government cannot force states to enforce these federal laws is because of the federalist ideals that our country was built on. The idea of commandeering is when the federal government steps in and takes control of the state government and forces it to enact federal laws. Luckily the federal government is not allowed to do such a thing, and as such must enforce federal laws on their own through the DEA or the FBI.

Previous Research

A dissertation completed by a Dr. Gook Jin Kim, who has a Ph.D in Public Management and Public Policy, looked into why states adopt medical marijuana laws and what they have in common. With the legal questions I have presented above and my interest in law, I too wanted to know what drove states to adopt medical marijuana laws and what these states have in common. This dissertation was arguably the most influential piece of literature I read regarding my research and my data construction.

Methods and Analysis

When beginning my research, there were so many variables to test. What exact variables I was going to test to see why states adopt the laws they do regarding medical marijuana was, at the beginning, still unclear. There were many things that came to mind such as; proposed laws, lobbying efforts, state liberalness, previously adopted policies, or personal identifiers such as race or religion. Many of these ideas came from previous research like that of Dr. Kim, that was mentioned earlier. Some of these variables to test why states adopt the laws they do were much easier to find than others. For example; lobbying efforts and money spent by lobbyists were very hard to find for more than five or six states while things like incarceration rates and minority population by state were much easier to find.

After having read through multiple book such as; *Why Should Marijuana be legal?* and *Getting High: Marijuana Through the ages,* legal doctrines, state policies, and research articles I decided to focus on previous policy implementation and the social indicators of the states. I chose these two specifically because they seemed to be the most relevant today with the divisiveness across the country and because they were the variables that provided the most incite to what I was studying. Since the late 1990s when California implemented the first medical marijuana laws, states have been learning, adopting, and adapting what laws might work for their state and how and when those laws should go into effect. Most of the legal literature such; as state laws and proposed legislation, I have read points to two main types of policies and why states adopt them. These policies are economic and moral. An economic policy is something that is implemented to create economic growth and prosperity, while a moral policy is one that is based on a person's morals and feelings about a topic rather than concrete statistics or science. Types of economic policies include taxes or tariffs, while moral policies include things like

abortion restrictions or gun rights. Economic policies, for the sake of my research, will be medical marijuana laws that are implemented to either save the state money or laws that are used to collect taxes. The other factors that I noticed in a lot of literature were internal factors and external factors such as; the infusion of ideas from neighboring states. Internal factors include things like race, religion, or sex and how those factors are represented within each state.

The economic policy I chose was the state's prison population calculated per 100,000 people. If a state were to implement medical marijuana laws, they would be able to take in tax revenue and save some at the same time, because they would no longer have to imprison users of medical marijuana. I chose this variable because I came across a statistic from the Bureau of Justice Statistics that stated that 42.1 of the 47.4 percent of the people who had been arrested on marijuana charges in 2007 had been for simple possession meaning that they were not attempting to cultivate or distribute the drug (Enforcement, 2018). Not all of the arrests were for medical marijuana, however states that legalize medical marijuana also tend to relax laws regarding marijuana as a whole. This relaxation of penalties can ultimately lower the prison population and save states millions of dollars on incarcerating people for minor possession charges. The prison population by state was obtained from the Bureau of Justice Statistics website, which listed all 50 states and their number of incarcerated citizens in 2015. I then took this number and divided it by the total population and then multiplied that number by 100,000 to get the incarceration rate per 100,000 people.

The moral policies I chose were a states level of gun restrictions and a states level of religiosity. The reason I chose to include religiosity in my research is that most people who consider themselves more religious tend to vote more conservative and medical marijuana policies are obviously very liberal. Many people consider medical marijuana laws a moral policy

because they believe that citizens should be allowed to take care of themselves and use whatever medicine is necessary to accomplish those goals.

The internal factors I chose were percentage of minorities and the states level of liberalness. The percentage of minorities was calculated by combining the percentage of African and Mexican Americans per state. I understand that there are many other minorities within our country but for the sake of my research I chose Mexican and African Americans because of the racial disparities I described in my literature and because of the clear racial disparities that we can see among arrest records for drug offenses.

For my economic policies I had assumed, based on previous research done, that states with high incarceration rates would be the most likely to implement medical marijuana laws. I had assumed this relationship because these states are spending the most money on incarcerating citizens and thus would have the most to save by limiting arrests for certain charges like marijuana. After collecting this data, I created a crosstabulation between states that allow medical marijuana and those states incarceration rates. Unfortunately, this crosstabulation did not tell me much. I then decided to turn my incarceration rate into a per capita variable and this changed my results quite substantially. A comparison that once showed a strong relationship now showed none once computed to per capita incarceration.

(Table 1 about here)

I then moved on to moral policies. I first chose to compare state level gun restrictions with state medical marijuana policies to see if there was any relationship between these two variables. My hypothesis for this variable comparison was that states with more gun restrictions, which tend to be more liberal, would be more likely to adopt medical marijuana laws then states

with less strict restrictions, that tend to be more conservative. I found this hypothesis to be correct, meaning that states with more restrictions were more likely to adopt medical marijuana laws.

(Table 2 about here)

My second moral policy, state level of religiosity, was a variable I had expected to see a strong relationship with regarding medical marijuana laws. I had assumed that states with a high level of religiosity would tend to be more conservative and as such, less likely to adopt medical marijuana laws. This assumption proved to be correct and the comparison between religiosity and medical marijuana laws showed a very strong negative relationship. The negative relationship in this case means that as religiosity goes up, the likelihood of adopting medical marijuana laws goes down.

(Table 3 about here)

My first internal factor was the states level of liberalness. The level of liberalness was rated on a four-point scale going from most conservative to most liberal. As many would, I had assumed that as states become more liberal they are also more likely to adopt medical marijuana laws. The adoption of medical marijuana laws, as history has shown, tend to happen first in some of the most liberal states such as California or Colorado. Like most of my other variables, this comparison showed a strong relationship between the liberalness and medical marijuana laws.

(Table 4 about here)

The final variable I tested came from an opposite idea proposed by Dr. Kim from his dissertation. Dr. Kim suggested that states with low a percentage of minorities would have a higher likelihood of adopting medical marijuana (Kim, 2016). His tests showed no relationship

so I decided to test the opposite and see if states with a high minority percentage would be more likely to adopt medical marijuana laws. Unfortunately, after comparing states with a high percentage of minorities with states that have adopted medical marijuana laws, I found no relationship between the two variables.

(Table 5 about here)

Conclusion

I began my research with an interest in medical marijuana laws and why they were increasing in number so dramatically. Unfortunately, I had a tough time finding relevant literature and research done on this topic because the laws have only been in place for around twenty years. This however, did not stifle my desire to find out exactly what drove the diffusion of these laws, it made it that much more interesting to me. I had to use information from so many different sources that this research gave me a better understanding on how to and ability to critically read multiple different mediums.

My data came from sources such as the National Conference of State Legislature (NCSL), the Department of Justice, the Bureau of Justice statistics, pro and anti-marijuana websites, data from a SAGE database, and many books and internet articles. I also had the ability to read, in depth, some very interesting legislation written by different states.

I decided to complete crosstabulation analysis with between five state level variables; incarceration rates, level of religiosity, gun restrictions, and liberalness, and percentage of minorities. I compared those to a variable that I created from data on the NCSL website regarding marijuana laws by state. Four of these five variables showed a strong relationship with states that had medical marijuana laws, specifically state that allowed the combustion, or

burning, of marijuana. I had to focus on these specific states, because almost all 50 states have some form of medical marijuana laws but about half of those are very strict and very few people can use medical marijuana in those states.

The only variable that did not have a strong relation was the percentage of minorities in the state. My research showed very similar numbers to that of Dr. Kim. If I were to continue my research I would like to complete a few specific case studies and possibly compile some more of my own data regarding state policies and internal factors. Compiling my own recent data would allow me to provide a more recent and in-depth picture of why states pass the laws they do regarding medical marijuana.

Appendix

Table 1 Crosstabulation State Combustion of Marijuana by Number of Incarcerated People Per Capita

			Incarceration per 100k persons					Total
			0-281	282-367	368-427	428-521	522+	
States that allow the combustion of marijuana for medical purposes	yes	Count	7	6	5	5	4	27
		Percent	70%	75%	55%	50%	40%	57.4%
	no	Count	3	2	4	5	6	20
		Percent	30%	25%	45%	50%	60%	42.6%
Total			10	8	9	10	10	47

Lambda=.088 Sig=.365 Chi Square=3.138 Sig=.535

Table 2 Crosstabulation State Combustion of Marijuana by State Level of Gun Restrictions

			Gun Rank 2011			Total
			More restrictions	Mid	Less restrictions	
States that allow the combustion of marijuana for medical purposes	yes	Count	13	6	8	27
		Percent	86.7%	46.2%	42.1%	57.4%
	no	Count	2	7	11	20
		Percent	13.3%	53.8%	57.9%	42.6%
Total		Count	15	13	19	47
		Percent	100.0%	100.0%	100.0%	100.0%

Lambda=.188 Sig=.273 Chi Square=7.747 Sig=.021

Table 3 Crosstabulation State Combustion of Marijuana by Level of Religiosity

			Religiosity			Total
			Low	Mid	High	
States that allow the combustion of marijuana for medical purposes	yes	Count	15	11	1	27
		Percent	88.2%	64.7%	7.7%	57.4%
	no	Count	2	6	12	20
		Percent	11.8%	35.3%	92.3%	42.6%
Total		Count	17	17	13	47
		Percent	100.0%	100.0%	100.0%	100.0%

Lambda=.420 Sig=.001 Chi Square=20.123 Sig=.000

Table 4 Crosstabulation State Combustion of Marijuana by State Level of Democrats

			Level of Democrats/Liberalness				Total
			Most Conservative	Conservative	Liberal	Most Liberal	
States that allow the combustion of marijuana for medical purposes	yes	Count	2	5	9	11	27
		Percent	18.2%	45.5%	69.2%	91.7%	57.4%
	no	Count	9	6	4	1	20
		Percent	81.8%	54.5%	30.8%	8.3%	42.6%
Total		Count	11	11	13	12	47
		Percent	100.0%	100.0%	100.0%	100.0%	100.0%

Lambda=.278 Sig=.069 Chi Square=14.071 Sig=.003

Table 5 Crosstabulation State Combustion of Marijuana by Percentage of Minority Residents

			Percentage of Minority Residents				Total
			0-11.8%	11.81-17.6%	17.7-32.5%	32.6+%	
States that allow the combustion of marijuana for medical purposes	Yes	Count	8	5	8	6	27
		Percent	66.7%	45.5%	66.7%	50.0%	57.4%
	No	Count	4	6	4	6	20
		Percent	33.3%	54.5%	33.3%	50.0%	42.6%
Total		Count	12	11	12	12	47
		Percent	100.0%	100.0%	100.0%	100.0%	100.0%

Lambda=.055 Sig=.6 Chi Square=1.754 Sig=.625

Works Referenced

Aggarwal, S., Carter, G. T., & Steinborn, J. J. (2005). Clearing the air: what the latest Supreme Court decision regarding medical marijuana really means

Annas, G. J. (2014). Medical marijuana, physicians, and state law. *New England Journal of Medicine*, *371*(11), 983-985.

Annas, G. J. (1997). Reefer madness-the federal response to California's medical-marijuana law. *New England Journal of Medicine*, *337*, 435-439.

Blumenfeld, J. D. (2017). State Legalization of Marijuana and Our American System of Federalism: A Historio-Constitutional Primer.

Chasteen, J. C. (2016). *Getting high: Marijuana through the ages*. Lanham, Maryland: Rowman & Littlefield.

Chemerinsky, E. (2017). Introduction: Marijuana Laws and Federalism. *Boston College Law Review*. Retrieved February 4, 2018.

Cole, J. M. (n.d.). *Guidance Regarding Marijuana Enforcement* (pp. 1-4) (United States , Department of Justice, Deputy Attorney General).

Enforcement. (2018, May 2). Retrieved from https://www.bjs.gov/content/dcf/enforce.cfm

Ferner, M. (2016, November 18). Jeff Sessions Could Reverse Years Of Progress On Marijuana Policy. *Huffington Post*. Retrieved October 12, 2017.

Fisher, M. (2014, June 22). Even as Marijuana Gains Ground, Some Tightly Enforce Laws. *The Washington Post*. Retrieved February 25, 2018, from http://www.highbeam.com/doc/1P2-36739514.html?refid=easy_hf

Garcia, K. H. (2017, September 14). State Medical Marijuana Laws. Retrieved October 24, 2017, from http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx

Garvey, T. (2012, March). Medical marijuana: The supremacy clause, federalism, and the interplay between state and federal laws. Congressional Research Service, Library of Congress.

Gerber, R. J. (. J. (2004). *Legalizing marijuana: Drug policy reform and prohibition politics*. Westport, Conn.: Praeger

Hanson, K., & Garcia, A. (2018, March 28). Retrieved April 5, 2018, from http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx

Hudak, J., & Wallack, G. (2016, July 29). How to reschedule marijuana, and why it's unlikely anytime soon. Retrieved January 17, 2018, from https://www.brookings.edu/blog/fixgov/2015/02/13/how-to-reschedule-marijuana-and-why-its-unlikely-anytime-soon/

Kamin, S. (2013). Medical marijuana in Colorado and the future of marijuana regulation in the United States.

Kim, G. J. (2016). *Policy Innovation and Diffusion Through Policy Typologies: Examining the Predictors of Medical Marijuana Legalization in State* (Unpublished doctoral dissertation). Florida State University.

Lee, J. (2014, March 10). Colorado makes $3.5M in pot revenue in January. *USA Today*. Retrieved February 6, 2018, from https://www.usatoday.com/story/news/nation-now/2014/03/10/marijuana-revenue-colorado-taxes/6261131/

Marijuana Timeline. (n.d.). Retrieved February 18, 2017, from http://www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.html

Mead, A. (2017). The legal status of cannabis (marijuana) and cannabidiol (CBD) under US law. *Epilepsy & Behavior*.

Miller, H. (2017, February 28). Jeff Sessions Warns Of An America With 'Marijuana Sold At Every Corner Grocery Store'. *The Huffington Post*. Retrieved February 28, 2017.

Mikos, R. A. (2013). MEDICAL MARIJUANA AND THE POLITICAL SAFEGUARDS OF FEDERALISM. *Denver University Law Review*. Retrieved February 20, 2018.

Mikos, R. A. (2009). On the Limits of Supremacy: Medical Marijuana and the States' Overlooked Power to Legalize Federal Crime.

Mikos, R. A. (2017). Risky Business? The Trump Administration and the State-Licensed Marijuana Industry. *Vanderbilt Law Review*. Retrieved September 23, 2017.

Ogden, D. W. (2009, October 19). *Mairjuana Policy Project* (United States , Department of Justice, Deputy Attorney General). Retrieved February 3, 2017 , from https://www.mpp.org/federal/ogden-memo/

Project, M. P. (n.d.). Colorado: The Economy After Legalization and Regulation. Retrieved February 22, 2017, from https://www.mpp.org/issues/legalization/colorado-the-economy-after-legalization-and-regulation/

Rosalie, L. P., Chriqui, J. F., Reichmann, D. A., & Terry-McElrath, Y. (2002). State medical marijuana laws: Understanding the laws and their limitations. *Journal of Public Health Policy, 23*(4), 413-39.

Rosenthal, E., Kubby, S., & Newhart, S. (2003). *Why marijuana should be legal* (2nd ed.). New York: Thunder's Mouth Press.

S. K. (2014). COOPERATIVE FEDERALISM AND STATE MARIJUANA REGULATION. *University of Colorado Law Review*. Retrieved April 20, 2017

State Populations. (n.d.). Retrieved March 20, 2018, from https://www.infoplease.com/us/population/us-population-state-1790-2015

The DEA Position on Marijuana. (2013, April). Retrieved January 15, 2018, from https://www.dea.gov/docs/marijuana_position_2011.pdf

Will States Lead the Way to Legalizing Marijuana Nationwide? (2013, January 28). *Times*. Retrieved October 26, 2017, from http://ideas.time.com/2013/01/28/will-states-lead-the-way-to-legalizing-marijuana-nationwide