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The Hazy Rollout of Ohio's Medical Marijuana Control Program (MMCP)

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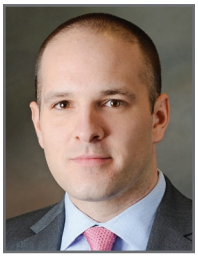

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When Ohio House Bill 523 (HB 523) became effective on September 8, 2016, Ohio joined the company of 25 other states, the District of Columbia, and several U.S. territories that have legalized cannabis for medicinal purposes. Modeled after highly restrictive regimes adopted by state legislatures in Illinois, Maryland, and New York, the Medical Marijuana Control Program (MMCP) envisioned by HB 523 has the potential to be one of the most complex and heavily regulated medical cannabis programs in the country. HB 523 relies on a tightly controlled 'Schedule II' pharmaceutical-style regulatory framework, but the Ohio legislature left some room for flexibility in the MMCP by punting to the rulemaking process several of the toughest issues it faced, such as determining the number of licenses available under the MMCP, the cost of licenses, the geographical distribution of medical cannabis businesses, and the hurdles doctors will face in order to recommend medical cannabis to patients with qualifying medical conditions.

The ultimate functionality of the MMCP – both in terms of the opportunity for seriously ill patients to access medicine, and the opportunity for market participants to create a sustainable program to serve those patients – will be determined by the extensive rulemaking and licensure process to be carried out by the Department of Commerce, the state Pharmacy Board, and the state Medical Board over the next two years. Several early indicators, however, have begun to cast doubt on the program's viability as written. This article recaps several recent developments in the MMCP and addresses specifically the Medical Board's recent guidance on the "affirmative defense" provision of HB 523, the only part of the law that is currently operational.

I. EARLY ACTIONS HAMPER IMPLEMENTATION OF THE MMCP

The Ohio Supreme Court's board of professional conduct, which is responsible for regulating Ohio lawyers, tossed a fireball into the lap of the Supreme Court in August by releasing a narrow reading of the ethics rules applicable to Ohio lawyers when advising clients involved in the cannabis industry. Just weeks before the effectiveness of HB 523, the board of professional conduct told Ohio lawyers that, among other things, it was unethical to assist clients in setting up medical cannabis businesses or to represent them in the rulemaking process. As a result, several of the largest law firms in the state were forced to suspend their activities in the space while the Supreme Court rushed through an amendment to the ethics rules. Such an amendment was adopted on September 20th, allowing doctors, patients and cannabis businesses to obtain legal representation in Ohio.

Adding further confusion to the mix, the Ohio Municipal League has launched a statewide effort to educate local governments about HB 523. Given the lack of clarity on how the state regulations will operate and where cannabis operations will be located throughout the state, dozens of local governments have chosen to preemptively adopt bans or moratoriums on all medical cannabis businesses within their jurisdictions. While most of the jurisdictions that have adopted such measures are small cities in rural areas, a growing number of larger cities with significant potential patient populations, such as Lakewood and Cleveland, have adopted or are considering moratoriums as well.[1] The rationale often cited by local officials when imposing these measures (essentially, that if cities don't act now, their Main Streets could be populated with unregulated cannabis businesses that would be 'grandfathered' out of later-adopted zoning restrictions) are inconsistent with how the MMCP and zoning laws actually function. An unintended consequence of these

measures is that cities with moratoriums on the books could be passed over entirely by businesses seeking to obtain licenses for significant cultivation and processing facilities, which could easily run into the tens of millions of dollars and thus will require certainty as to the viability of site selection by such businesses early on in the planning process.

Most recently, on September 24th, the state Medical Board, which is responsible for regulating Ohio doctors, dealt a significant blow to patients hoping to avail themselves of the protections provided by HB 523 prior to the opening of dispensaries two years from now.[2] While couched in the context of guidance to doctors, the carefully worded interpretation of Ohio doctors' ability to recommend medical cannabis during the "affirmative defense" period served only to highlight the gray area created by HB 523.

In its guidance, the Medical Board instructed physicians that they cannot issue a "*state of Ohio approved* written recommendation" to use medical cannabis until the Medical Board adopts rules for doing so, which could take up to a year. In the meantime, physicians who receive requests from patients for medical cannabis were encouraged to "consult with their private legal counsel and/or employer for interpretation of the legislation." In response to the Medical Board's guidance, representatives from the Ohio State Medical Association (OSMA) reiterated the association's previous stance that doctors should not recommend cannabis until the Medical Board adopts its formal rules.[3]

The OSMA's interpretation of the Medical Board's guidance, in turn, quickly drew widespread news coverage. One of the lead state legislators behind HB 523, Senator Dave Burke (R-Marrysville) responded in interviews that "willing physicians are in the free and clear" to recommend cannabis during the affirmative-defense period, and representatives from the Medical Board added that the Medical Board would "review a medical marijuana related complaint as they would any other... [and] would consider whether someone violated state law, including the immunity provision."[4] Another prominent backer of HB 523, Senator Kenny Yuko (D-Richmond Heights), issued a press release stating that "the affirmative defense section spells out everything a physician would need to do to provide patients with this limited, short-term protection without having to wait for the agencies. It simply wouldn't make sense to read it any other way."[5]

The affirmative defense provision and the varying interpretations of it by key actors has created quite a hairball for Ohio doctors and their patients to untangle with their lawyers. In an effort to facilitate discourse among the legal and medical professions regarding the affirmative defense provision (and by no means to provide legal advice to anyone), the rest of this article will cover some of the relevant considerations that doctors and their employers may want to evaluate with counsel in order to minimize risks when recommending cannabis to patients during the affirmative-defense period. While the recommendation and use of medical cannabis does pose at least some theoretical legal risk to all parties involved in the process, it is reasonably clear that Ohio physicians willing to face those risks do currently have the ability to recommend cannabis to patients with qualifying medical conditions.

II. UNDERSTANDING THE "AFFIRMATIVE DEFENSE"

A bit of background on the "affirmative defense" provision of HB 523 is helpful for understanding the Medical Board's reluctance to provide guidance on the topic. Recognizing that it would take up to two years to fully implement the MMCP, and hearing incredibly heart-wrenching and compelling testimony from seriously ill constituents in urgent need of access to legal sources of cannabis, the legislature attempted to create an alternative path for qualifying patients to obtain cannabis prior to the opening of dispensaries in Ohio.

According to Section 6(B) of HB 523, if a patient is arrested and charged with possession or use of cannabis in Ohio and can establish that she or he (1) received a written recommendation from a licensed physician[6] and (2) possessed and used cannabis only in the forms and by the methods permitted under HB 523 (namely, did not smoke it), the patient should be acquitted of the charges.[7] This sounds nice in theory, but two very significant practical hurdles have thus far rendered the affirmative defense nearly useless to Ohio patients: (1) the inability to find a doctor willing to provide a written recommendation for cannabis; and (2) the potentially severe legal consequences for obtaining cannabis on the black market or smuggling it into Ohio from other state-sanctioned markets.

A. The Doctor Recommendation Process

The most significant obstacle to a patient's ability to establish the affirmative defense is the requirement to obtain a written recommendation from a physician licensed in Ohio. For the written recommendation to qualify under the affirmative defense, the physician must certify *all* of the five following criteria:

(1) that a "bona fide physician-patient relationship"[8] exists between the physician and patient;

(2) that the patient has been diagnosed with a qualifying medical condition;[9]

(3) that the physician or physician delegate has requested from the Ohio Automated Rx Reporting System (OARRS) a report of information related to the patient that covers at least the twelve months immediately preceding the date of the report;

(4) that the physician has informed the patient or the patient's parent or guardian of the risks and benefits of

medical marijuana as it pertains to the patient's qualifying medical condition and medical history; and

(5) that the physician has informed the patient or the patient's parent or guardian that it is the physician's opinion that the benefits of medical marijuana outweigh its risks.

The last two criteria on this list are the reasons why you have not yet heard news reports of patients relying on the affirmative defense to use medical cannabis in Ohio. These criteria require a physician not only to enumerate "risks and benefits" of using cannabis for the patient's specific condition and medical history, but also to state their medical opinion that the benefits of using cannabis *outweigh* the risks.

While other states have similar requirements of their doctors, a restrictive reading of HB 523 could necessitate physicians seeking to recommend cannabis therapies for their patients to justify the risk/benefit determination at a higher standard.[10] Illinois is a particularly instructive example – in June 2016, the Illinois legislature amended their cannabis law specifically to remove the requirement that doctors make a risk/benefit determination in justifying their recommendation.[11] The risk/benefit determination required under prior Illinois law, which was less restrictive than the current provisions of HB 523, was specifically cited as the reason for unexpectedly low patient counts at the outset of the Illinois program.[12] In its first year of operation, a single physician certified nearly one-third of the 3,300 patients registered in Illinois.[13]

All that said, it is still possible for doctors who are knowledgeable of the pharmacology of cannabis to make this risk/benefit determination during the affirmative-defense period without presenting undue risk of legal or professional liability. The most direct risks posed to doctors in this setting are: loss of medical license, exposure to civil and criminal liability, and loss of their DEA registration to prescribe controlled substances. Luckily, HB 523 provides for broad protections of doctors against criminal, civil and professional liability, and the risk of a doctor losing his or her DEA registration for acting in compliance with HB 523 appears to be minimal.

Most relevant to Ohio doctors considering recommending cannabis during the affirmative-defense period, O.R.C. Section 4731.30(H) provides that:

> "a physician is immune from civil liability, is not subject to professional disciplinary action by the state medical board or state board of pharmacy, and is not subject to criminal prosecution for any of the following actions: (1) Advising a patient, patient representative, or caregiver about the benefits and risks of medical marijuana to treat a qualifying medical condition; (2) Recommending that a patient use medical marijuana to treat or alleviate the condition; (3) Monitoring a patient's treatment with medical marijuana."

This provision is broad and unqualified in its scope, and serves to insulate physicians from criminal, civil and professional liability for recommending cannabis during the affirmative-defense period and thereafter.[14] The immunity provided by this provision is unlike any other in state law in terms of the scope of liability protection that it provides to doctors. Not only does it allow doctors to recommend cannabis without fear of losing their medical license or facing criminal penalties in Ohio, including during the affirmative-defense period, but it could also protect them from potential civil malpractice liability to their patients or others.[15] Even with the broad immunity provided to physicians under HB 523, it would be wise for doctors to check with their malpractice insurance carrier to confirm that they are covered for claims that may arise related to recommending medical cannabis to patients. Of course, doctors who are not self-employed should also check with their employer regarding relevant policies and restrictions on their ability to recommend cannabis to patients.

The other major concern that many doctors have with recommending cannabis is the risk that the DEA will revoke the doctor's DEA registration to prescribe other controlled substances. As cannabis remains a federally illegal "Schedule I" controlled substance under the CSA, HB 523 follows most other states by relying on "recommendations" for cannabis instead of "prescriptions." This distinction is derived from the seminal *Conant v. Walters* decision, where the Ninth Circuit Court of Appeals found that the act of merely recommending medical cannabis constituted physician-patient speech that is protected under the First Amendment to the U.S. Constitution.[16] The mere act of discussing the risks and benefits of cannabis and recommending cannabis for qualifying medical conditions should not be grounds in itself for revoking a DEA registration. If a physician where to *prescribe* cannabis (meaning providing an order that cannabis be dispensed to the patient) or directly dispense cannabis to the patient, however, those acts could be viewed as aiding and abetting the patient's violation of the CSA and subject the physician to loss of his or her DEA registration (among other penalties). While the injunction imposed in the *Conant* decision is only directly binding in the Western states that are part of the Ninth Circuit, it is unlikely that the DEA would challenge similar actions by doctors in Ohio that amount only to recommending cannabis and not prescribing or dispensing it.

Doctors should be mindful that the *Conant* decision is grounded in the physician-patient relationship; it does not extend to physicians who own or are otherwise affiliated with cannabis businesses. Physicians who depend on their DEA

registration to run their practice should consult with counsel prior to entering any relationships with Ohio cannabis businesses seeking licenses to operate under the MMCP. A common tactic of license applicants in highly restrictive "Schedule II" style cannabis regimes is to enlist a doctor as a "medical director" of the business or similar titles. While this is often an effective way to establish the credibility of a license applicant for regulatory approval, it poses unique risks to the doctors entering the relationships. For example, in 2014, several Massachusetts doctors who held positions with licensed cannabis dispensaries in the state were visited by DEA agents and allegedly offered an ultimatum between relinquishing their DEA registrations or severing ties with the dispensaries.[17] Further, under HB 523, physicians who are certified to recommend cannabis in Ohio are explicitly prohibited from owning or having compensation arrangements with state-licensed cannabis businesses.

As a result of the broad liability protections provided to physicians under HB 523 and First Amendment protections of the act of recommending cannabis to patients, it seems unlikely that doctors would face much practical risk for recommending cannabis to patients in a manner that satisfies the affirmative-defense provisions.

B. Other Relevant Legal Concerns for Patients

Outside of the unwillingness of most doctors to issue written recommendations, the second biggest obstacle to patients availing themselves of the affirmative defense provision is the unknown and potentially unsafe process of obtaining medical cannabis for use in Ohio. Cannabis remains a Schedule I controlled substance under the CSA, and people who chose to engage in most of the activities permitted by HB 523 in Ohio will nonetheless be violating federal law in a manner that could subject them to potentially severe criminal and civil penalties, including life in prison and forfeiture of substantial personal assets. Through a series of memoranda (most recently, the 2013 "Cole Memorandum)[18] issued to federal prosecuting attorneys, the DOJ crafted a limited-enforcement policy that allows states to establish "strong and effective regulatory and enforcement systems" for regulating cannabis activity without federal interference. The Cole Memorandum strongly suggests that federal prosecutors should not prosecute those engaged in state-sanctioned cannabis activities, unless they implicate any of the DOJ's eight "enforcement priorities."[19]

While the MMCP will surely satisfy the Cole Memorandum non-enforcement criteria once fully implemented, the affirmative-defense provision may not be viewed as favorably by federal prosecutors.[20] If a patient is able to find a doctor willing to write a recommendation during the affirmative-defense period, he or she will then have to obtain cannabis either by purchasing it on the black market in Ohio or by smuggling it into Ohio from another state, such as Colorado. Either of those activities could implicate multiple of the enforcement priorities outlined in the Cole Memorandum and trigger federal prosecution. Further, the act of smuggling cannabis out of a state such as Colorado could entail crossing into states, such as Nebraska and Kansas, that still aggressively enforce harsh cannabis prohibition laws and have specifically implemented law enforcement programs to intercept cannabis being trafficked out of Colorado.

Despite the significant dilemma that patients face in deciding whether and how to obtain medical cannabis during the affirmative-defense period, most Ohio physicians will have a much smaller scope of legal concerns to address than their patients. As mentioned above, for physicians seeing patients in the normal course of a medical office practice, the mere act of recommending cannabis to treat qualifying medical conditions (even during the affirmative-defense period) is thoroughly protected from liability under HB 523 and likely would not put the physician's DEA registration in jeopardy.

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[1] See Jackie Borchardt, *Ohio lawmaker urges cities not to ban medical marijuana before state sets rules*, Cleveland.com, September 8, 2016; Leila Atassi, *Cleveland City Council proposes moratorium on issuing medical marijuana licenses*, Cleveland.com, September 15, 2016; and Jackie Borchardt, *Lakewood, other Ohio cities block medical marijuana business licenses months before any will be awarded*, Cleveland.com, August 8, 2016.

[2] State Medical Board of Ohio, *Affirmative Defense: What is required of a physician to recommend medical marijuana now that House Bill 523 is effective?*.

[3] See Jim Provance, *Ohio board deals blow to medical marijuana*, ToledoBlade.com, September 23, 2016 ("The Ohio State Medical Association had advised its members to wait for further guidance from their state licensing and disciplinary board. That position has not changed. "We would advise our members not to do anything until the rules and regulations have been drafted and promulgated," said spokesman Reginald Fields. "We understand that may not be for a year or so."").

[4] See Jackie Borchardt, *Ohio medical board: Doctors should talk to lawyers, employers about medical marijuana law*, Cleveland.com, September 23, 2016.

[5] See *Senator Yuko Responds to Medical Board Statement*, OhioSenate.gov, September 24, 2016.

[6] The term "physician" means an individual authorized to practice medicine and surgery or osteopathic medicine and surgery under O.R.C. 4731 (the statue establishing the state medical board).

[7] Note that the affirmative defense also applies to the parents or guardians of patients who are minors. The affirmative-defense provision automatically sunsets and becomes ineffective sixty days after the Pharmacy Board begins accepting applications for patient and caregiver registration.

[8] O.R.C. Section 4731.30(C)(1)(b) provides that a "bona fide physician-patient relationship" is established when all of the following occur: (i) an in-person physical examination of the patient by the physician; (ii) a review of the patient's medical history by the physician; and (iii) an expectation of providing care and receiving care on an ongoing basis. While this definition does not explicitly apply to the affirmative defense provision, it seems reasonable to assume that a court would look to this definition if it were asked to determine whether a bona fide physician-patient relationship was established.

[9] Per O.R.C. Section 3796.01(A)(6), a "qualifying medical condition" means any of the following: (a) Acquired immune deficiency syndrome; (b) Alzheimer's disease; (c) Amyotrophic lateral sclerosis; (d) Cancer; (e) Chronic traumatic encephalopathy; (f) Crohn's disease; (g) Epilepsy or another seizure disorder; (h) Fibromyalgia; (i) Glaucoma; (j) Hepatitis C; (k) Inflammatory bowel disease; (l) Multiple sclerosis; (m) Pain that is either of the following: (i) Chronic and severe; (ii) Intractable. (n) Parkinson's disease; (o) Positive status for HIV; (p) Post-traumatic stress disorder; (q) Sickle cell anemia; (r) Spinal cord disease or injury; (s) Tourette's syndrome; (t) Traumatic brain injury; (u) Ulcerative colitis; (v) Any other disease or condition added by the state medical board under section 4731.302 of the Revised Code.

[10] Under New York's medical marijuana program, for example, physicians are required to certify that they have discussed the risks and benefits of medical cannabis, but the basis for their recommendation is that the patient is "likely to receive therapeutic or palliative benefit from" treatment with medical cannabis (see 10 C.R.R.-N.Y. 1004.2(a)(11)). Illinois's cannabis law is even more favorable to its doctors, requiring that physicians issue a recommendation that merely provides a diagnoses of the qualifying condition, rather than requiring that the physician specifically recommend cannabis to the patient (see 410 I.L.C.S. 130, Section 10(y)).

The requirements of HB 523 reflect similar language used in Massachusetts and Maryland, both of which require the recommending physician to determine that benefits of cannabis *likely* outweigh its risks. Maryland's program has yet to become operational, is nearly a year behind on its scheduled implementation timeline, and will likely be held up in litigation for a while (see Fenit Nirappil, *Rejected medical marijuana grower seeks to join lawsuit against regulators*, WashingtonPost.com, September 28, 2016). Massachusetts's program, while operational, has not been warmly embraced by its medical community – as of this summer 13 doctors provided nearly 75% of the 31,818 medical cannabis recommendations in the state, two doctors recently had their medical licenses revoked by the state medical board, and the DEA allegedly threatened to revoke licenses to prescribe controlled substances from doctors who were affiliated with licensed cannabis businesses (see Kay Lazar, *Most Mass. doctors wary of approving marijuana use*, BostonGlobe.com, July 2, 2016; Kay Lazar, *Medical marijuana doctor loses license to practice, BostonGlobe.com, June 3, 2016; and Kay Lazar, DEA targets doctors linked to medical marijuana*, BostonGlobe.com, June 6, 2014).

Even under the highly restrictive programs in Maryland and Massachusetts, a physician is only required to determine that the benefits of medical cannabis likely outweigh the risks to the patient (see See Md. Code, Health-Gen §§13-3301(m); and Mass. St. 2012, c. 369, Section 2(n)). This is an easier professional liability standard for doctors to satisfy than the more stringent requirements of HB 523, which require Ohio doctors to make their risk/benefit determination in a definitive manner, rather than a probabilistic one. Ohio's MMCP, therefore, stands out even among the most highly restrictive medical cannabis regimes in the country in terms of the barriers that it imposes on doctors.

[11] See Illinois Public Act 099-0519, amending 410 I.L.C.S. 130, Section 10(y) as follows: "Written certification" means a document dated and signed by a physician, stating (1) ~~that in the physician's professional opinion the patient is likely to receive therapeutic or palliative benefit from the medical use of cannabis to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition; (2)~~ that the qualifying patient has a debilitating medical condition and specifying the debilitating medical condition the qualifying patient has; and (2) ~~(3)~~ that ~~the patient is under the physician's care for~~ the physician is treating or managing treatment of the patient's debilitating medical condition. A written certification shall be made only in the course of a bona fide physician-patient relationship, after the physician has completed an assessment of the qualifying patient's medical history, reviewed relevant records related to the patient's debilitating condition, and conducted a physical examination.

[12] See http://www.cannabispolicyadviser.com/illinois-sb10-physician-certification/

[13] See Robert McCoppin, *Is risk of state discipline scaring doctors away from medical marijuana?*, ChicagoTribune.com, February 10, 2016.

[14] It will be particularly interesting to see how this provision is interpreted in light of "the minimal standards of care when recommending treatment" with medical cannabis that the Medical Board is required to develop as part of its rules under the MMCP. As the immunity provided by O.R.C. Section 4731.30(H) is not explicitly qualified by the Medical Board's rules, it could provide doctors with a strong defense against liability even in cases of clear violations of the standard of care.

[15] Also note that O.R.C. Section 4731.30(B)(1) provides that, except for certain research and clinical trials, "a physician seeking to recommend treatment with medical marijuana *shall apply* to the state medical board for a certificate to recommend" in the manner provided by the medical board's rules. This requirement to obtain a certificate to recommend is not qualified by the affirmative defense provision. As highlighted by the medical board in its guidance, physicians may not be able to obtain a "certificate to recommend" cannabis until a year from now when the Medical Board adopts its rules. Physicians recommending cannabis during the affirmative-defense period, therefore, would be in technical violation of the requirement to obtain a certificate to recommend prior to recommending medical cannabis to a patient. Relatedly, O.R.C. Section 4731.22(B)(49) added a specific requirement that the Medical Board "shall, *to the extent permitted by law*, limit, revoke or suspend" a physician's certificate to practice medicine or certificate to recommend cannabis for "failure to comply with the requirements of [the provisions of requiring physicians to obtain a certificate to recommend] when recommending treatment with medical marijuana." The italicized language limiting the Medical Board's authority to revoke a medical license "to the extent permitted by law" is important. While a physician would be in technical violation of O.R.C. Section 4731.30(B)(1) for issuing a recommendation for cannabis during the affirmative-defense period, the physician would be immune from liability for doing so by operation of O.R.C. Section 4731.30(H), and the Medical Board therefore would not be "permitted by law" to revoke the physician's medical licenses (as otherwise would be required by O.R.C. Section 4731.22(B)(49)).

[16] See Conant, et al. v. Walters, et al., 309 F.3d 629 (9th Cir 2002).

[17] See Kay Lazar, *DEA targets doctors linked to medical marijuana*, BostonGlobe.com, June 6, 2014.

[18] Memorandum from Deputy Attorney General James M. Cole to All United States Attorneys, Guidance Regarding Marijuana Enforcement (August 29, 2013).

[19] *Id.* (1. Preventing the distribution of marijuana to minors; 2. Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels; 3. Preventing the diversion of marijuana from States where it is legal under state law in some form to other States; 4. Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity; 5. Preventing violence and the use of firearms in the cultivation and distribution of marijuana; 6. Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use; 7. Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and 8. Preventing marijuana possession or use on federal property.)

[20] Note that, while congress acted to prohibit the DOJ from spending money appropriated through the 2015 budget on efforts to prevent certain states from implementing their medical marijuana programs (referred to as the "Rohrabacher-Farr amendment"), this provision only restricts the DOJ from spending funds authorized in the 2016 budget and Ohio is not included in the list of states that it protects. See Consolidated Appropriations Act of 2016, PL 114-113, December 18, 2015, Sec. 542 ("None of the funds made available in this Act to the Department of Justice may be used, with respect to any of the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming, or with respect to the District of Columbia, Guam, or Puerto Rico, to prevent any of them from implementing their own laws that authorize the use, distribution, possession, or cultivation of medical marijuana.").

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