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Analysis of Ohioans for Medical Marijuana's Proposed Ballot Initiative

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Late last week the Ohio ballot board certified a constitutional amendment (the "***Amendment***"), proposed by Ohioans for Medical Marijuana ("***OMM***"),[1] to create a comprehensive regulatory program for the provision and sale of medical marijuana in Ohio (the "***MMJ Program***").[2] This was the last step that OMM needed to launch its statewide signature gathering campaign, and the group now has until just after the 4th of July holiday to gather 305,591 signatures from voters across Ohio in order to put the Amendment on November's general election ballot.

This article focuses on the key structural and economic components of the MMJ Program that, if passed, would be of most interest to prospective patients and market participants. As the campaign progresses, we will provide further detail on other aspects of the Amendment as well as its potential intersection with medical-cannabis legislation currently being considered in the Ohio Statehouse.

1. Context and Path Forward.

Numerous polls over the past year suggest that Ohioans overwhelmingly support some form of patient access to medical cannabis, and that an initiative such as the Amendment would likely pass as long as it is not saddled with controversial provisions. Given the high-profile flameout of last year's Issue 3 ballot initiative (which failed, largely because it allocated to Issue 3's funders the only 10 cultivation licenses allowed by the proposal) and the legislative counterpunch of Issue 2 (which passed, largely because of public perception that it would prevent the cultivation oligopoly envisioned by Issue 3 and other similar ballot initiatives in the future), OMM made a curiously bold strategic choice by including in the Amendment a 15 license cap on the number of large cultivation facilities.

This single provision could hand the ballot board exactly the type of 'hook' it needs to label the Amendment as violative of Issue 2,[3] which would then require voters to approve not only the Amendment but also a separate ballot question that directly states the Amendment violates the Ohio Constitution because it grants a "monopoly, oligopoly, or cartel" not generally available to others.[4] While we have not seen polling on how this separate ballot question might impact the outcome of prior polls that asked for voters' opinion on medical cannabis, logic and the result of last year's vote on Issues 2 and 3 suggest that adding this Issue-2 question to the Amendment could generate a significantly different reaction from voters. Based on the questioning and commentary from ballot board members during the March 31, 2016 meeting at which it certified the Amendment, the fact that the Republican-led Ohio legislature is currently considering its own potentially competing medical cannabis legislation, and the overall political context of the Amendment during the general election, it seems likely that the conservative-controlled ballot board will seek to tack the Issue-2 question on to the Amendment if OMM gathers the signatures to put it on the ballot. While OMM would have solid arguments for challenging a decision by the ballot board to invoke 'Issue 2 treatment,' the conservative-leaning Ohio Supreme Court has exclusive jurisdiction over such challenges, and the language of Issue 2 grants the ballot board wide latitude to make this determination. It seems reasonably likely, therefore, that if OMM succeeds in putting the Amendment on the November ballot, that Ohio voters will also be asked to approve an Issue 2 question in addition to the Amendment.

Adding further complexity to the political landscape for the Amendment, members of both parties in the Ohio legislature are actively contemplating their own version of medical-cannabis legislation, and could move legislation quickly through committee to enactment by this summer (see our blog posts here, here and here). If the legislature is able to point to a well thought-out medical-cannabis system (the argument goes), it may be able to dissuade some voters from supporting a potentially broader market envisioned by the Amendment. Conversely, the legislature will also want to be careful in designing a program that won't be rendered entirely useless if the Amendment passes.[5]

Even after factoring in the likelihood that OMM will have to pass both the Amendment and an 'Issue 2' approval and that the legislature will likely adopt a more measured medical-cannabis program in the interim months, the Amendment should still have a decent chance of passage if OMM can gather the signatures to put it on the ballot and support it with an aggressive public education campaign.

2. Key Takeaways.

For Ohio residents considering operating or investing in a medical cannabis business, the MMJ Program could provide access to a large pool of potential patients and present significant new-market business opportunities. Industry experts outside of Ohio with cannabis-consulting businesses should also find ample opportunities to collaborate with Ohio medical marijuana establishments ("***MMEs***") licensed under the MMJ Program. The Amendment contains several provisions that could cause heartburn for some prospective market participants, however, such as entrepreneurs oriented to the 'connoisseur' or 'craft' end of the market as well as out-of-state businesses and investors looking for equity ownership.

If adopted by voters this November, the following elements of the MMJ Program should be of particular interest to potential market participants:

- **Speed to Open** – The MMJ Program should be open for patients to register and for certain business to open by as early as August 1, 2017, with storefront dispensaries open to patients by late Q1 2018. A year-and-a-half from passage may not sound like warp speed to potential patients, but this would be a very quick startup period based on recent experience in other states. Arizona and Massachusetts, for example, took just over two years from constitutional amendment to licensure of their first dispensaries, while Nevada took over 15 years (though under different procedural circumstances).
- **Broad Patient Access** – Comprehensive qualifying conditions are included, perhaps most notably "severe debilitating pain" and "severe nausea," which should provide a fairly broad patient pool with access to medicinal cannabis. The Amendment does not go as far as states such as California and Massachusetts, which allow doctors to determine the debilitating conditions for which they deem medical cannabis appropriate. But the Amendment does allow the Medical Marijuana Control Division (the "***Division***"), created by the Amendment to administer the MMJ Program, to add additional qualifying conditions as it sees fit.
- **Reciprocity** – The Amendment also provides a form of "reciprocity" whereby nonresidents can purchase medical cannabis if they are registered in another state's medical-cannabis program and their debilitating medical condition (as defined in Ohio) would allow them to qualify in Ohio. This could be an important feature for attracting residents of Ohio's three most populous neighboring states (Michigan, Illinois and New York), each of which have legalized medical marijuana but have not yet allowed for meaningful patient access and/or functioning commercial-distribution systems.
- **Homegrow Access** – "Homegrow" will be permitted, with up to six plants per patient. Patients who cannot or don't want to grow their own medical cannabis can specify a "designated caregiver" to grow up to the patient's limit on their behalf. A designated caregiver can serve up to five specified patients (30 total plants). This type of patient-caregiver has served as the foundation of the medical-cannabis industry since California legalized medicinal use 20 years ago and is thought to be a source of innovation and evolution of 'connoisseur' applications within the 'CannaTech' space.
- **Local Controls and Community Benefits** – The MMJ Program includes both state and local licensing components that will allow for extensive participation (up to the point of total bans) by local governments and communities. The Amendment requires certain application-evaluation criteria that consider how the benefits of the MMJ Program are being shared among disadvantaged populations and whether dispensaries will provide reduced-cost medicine for low-income patients.
- **Ohioans Only (for 2 years)** – Ohio residents will have at least a two year head start (until January 2020) to build their brands and businesses before non residents can start investing in and controlling Ohio medical marijuana establishments ("***MMEs***"). Out-of-state investors looking to participate in the Ohio market as well as some in-state operators seeking outside investment are likely to have a different perspective on this provision.
- **Federal Compliance** – The Amendment will quickly create a "robust" regulatory regime that, assuming faithful implementation by the parties involved, should easily satisfy the 'Cole Memo' criteria for non-enforcement of the federal Controlled Substances Act by the Department of Justice and Drug Enforcement Agency. This is essential for creating an environment where patients and businesses can operate without fear of raids and asset seizures by law enforcement.

Conversely, the following provisions could present significant barriers to entry for would-be market participants, particularly local entrepreneurs looking to enter the 'connoisseur' or 'craft' end of the cultivation market as well as out-of-state businesses and investors.

- **Fees and Limits on Large Cultivations** – The costs associated with large "Type 1" cultivations ("***Type 1 Grows***") – up to $500,000 initial and annual fees – and the limited number of licenses available – up to 15 – could create substantial barriers to entry for smaller cultivators and allow the holders of these licenses to quickly capture most, if not all, of the potential cultivation

market. The upfront and annual fees for all other types of MMEs, including the smaller "Type 2" cultivations ("***Type 2 Grows***") are up to $5,000 initially and annually, which are relatively affordable compared to other states.

- **Capital Requirements for All Cultivations** – Aside from the upfront and annual licensure fees, perhaps the most restrictive aspect of the Amendment will be the substantial capital requirements that it establishes for cultivation applicants (both Type 1 and the smaller Type 2 Grows). Cultivation applicants will have to show that they have sufficient capital "available" to pay their license fees and to build and operate the grow for one year without revenue. In addition, this capital must have been "seasoned" (a term the Amendment does not define or explain) for 180-days prior to the application. While other states have used financial criteria to assist in determining the *bona fides* of applicants in a competitive licensure process, these provisions go beyond most other states and could create insurmountable financial hurdles for small businesses and entrepreneurs seeking to enter the market.
- **Controlling Ownership Restrictions (and Ambiguities)** – The Amendment provides ownership restrictions applicable to cultivations (Type 1 and Type 2 Grows) and testing facilities. The cultivation ownership restrictions are intended to limit cultivators to ownership of just one Type 1 or Type 2 Grow license, in an effort to preserve the intent behind the canopy-size limitations (25,000 sq. ft. for Type 1 Grows and 5,000 sq. ft. for Type 2 Grows). Testing facilities are required to not have common ownership with any other type of MME, in an effort to encourage independence from the customers they test. The "controlling person" definition, however, appears to be drafted in a way that could allow applicants to avoid these restrictions altogether through simple legal structuring. We trust the Division will be sufficiently motivated and legally empowered to address these potential 'loop-holes' in developing its detailed regulations for cultivation and testing facilities. These ambiguities are discussed in more detail below.

The combined impact of these three provisions could result in the 'upstream' cultivation market being dominated by the holders of the 15 Type 1 Grow licenses. This may feel like de-ja-vu for those critical of last year's failed Issue 3 proposal. Some balancing factors in the Amendment may help to mitigate this impact, however, which we discuss in more detail below.

3. Qualifying Patients and Medical Conditions.

The overall size of the 'licensed' market created by the MMJ Program will in large part be driven by the number of patients who will be able to purchase cannabis for medicinal use from licensed dispensaries. The Amendment explicitly provides for a broad range of qualifying conditions, including several that make up the largest number of patients in other states: cancer, post-traumatic stress disorder (PTSD), autism, and any "chronic or debilitating disease or medical condition" that produces severe debilitating pain, severe nausea, seizures or severe and persistent muscle spasms.[6] The Division is also able to add new qualifying conditions as it sees fit through a rulemaking process.

MPP estimates that approximately 215,000 patients will qualify and register for the MMJ Program. This number is based on the assumption that the same proportion of qualifying patients registered under Michigan's medical cannabis program (about 1.85% of the state's total population [7]) would similarly register under Ohio's MMJ Program. This percentage is roughly consistent with other states that include some element of severe or chronic pain as a qualifying condition for access to medical cannabis. Variations of pain are typically the most prevalent qualifying condition in states that allow it and, therefore, one of the most important elements in predicting the size of a state's medical cannabis market.

The Amendment's list of qualifying conditions is very similar to those used in Colorado, and Michigan.[8] The "pain" threshold used in the Amendment, however, refers to only "severe debilitating pain" rather than the "severe pain" or "severe and chronic pain" thresholds used in Colorado's and Michigan's programs, respectively. The stringency of the Amendment's pain standard suggests that it should be interpreted to cover a narrower band of pain than available to patients in Michigan's and Colorado's programs. Ohio's market, as a result, could represent a lower percentage of the population than the 1.85% participation rate in Michigan.[9]

It is also worth noting that Michigan is not viewed as having a particularly 'healthy' medical cannabis program. For instance, it is among the three remaining states of the 23 total medical cannabis states, that has not yet established a state-wide commercial distribution program. By contrast, the Amendment creates a robust commercial distribution system similar to states such as Colorado, where approximately 1.98% of the population participate[10] in the medical cannabis program. It is possible that the functionality of the market could overcome a potential barrier posed by the number of patients who qualify based on some variety of pain. The ultimate number of patients that qualify for the MMJ Program would then largely be determined by the Division's rulemakings and enforcement decisions, and potentially court cases challenging such decisions.

One final feature that may enhance the scale and viability of the MMJ Program is that it allows for so-called 'reciprocity' of patients from other states. Most states with medical cannabis do not allow for nonresidents to purchase cannabis from in-state dispensaries. In 2015, Nevada adopted the first true form of reciprocity, which relies on the non resident's home-state qualifying condition to determine access. An interesting interaction between that provision

and California's notoriously open doctor-recommendation process has resulted in a medical-cannabis 'tourism' market emerging on the Las Vegas strip.

The Amendment takes a 'middle-ground' approach on this issue by providing reciprocity only to those nonresidents whose qualifying conditions would allow them to become qualifying patients in Ohio due to their debilitating medical condition (as defined by Ohio law). This should be a fairly straightforward determination for most medical conditions. Interesting questions could arise, however, for conditions such as pain and for patients who are registered in California, Massachusetts and Washington, D.C. Those jurisdictions allow doctors to determine qualifying conditions in addition to the list of qualifying conditions specified by in the statute. The potential patient pool could vary substantially depending on the level of specificity used by the Division in promulgating its regulations for nonresident patient access.

4. Timeline for Implementation.

If passed by voters in November 2016, the MMJ Program would be implemented in several phases, with the Division first developing detailed rules to govern the MMJ Program, then creating an online registry of qualifying patients, and finally issuing business licenses for six types of MMEs.

a. Months 6-8 – Rulemaking.

By July 1, 2017, the Division is required to propose detailed rules implementing the MMJ Program, including rules for patient registry, business licensure, security measures, record keeping and product tracking, health and safety standards, packaging, labeling, testing, and waste disposal. Most of the detailed operational elements of the MMJ Program, such as product labeling and track-and-trace system requirements, are left for the Division to determine through its regulations.

While these topics cover a broad swath of potential regulatory ground, the Amendment does not explicitly require more forward-thinking standards for MMEs. California's new medical marijuana regulations, for example, will set aggressive water, energy and environmental performance standards for its medical cannabis businesses, and eventually provide for an "organic" certification process and appellation designations to distinguish the origin of the product (think Humboldt cannabis, similar to Napa wine). The Division, or enterprising local governments, may choose to independently implement these types of "aspirational" licensure requirements.

b. Months 7-9 – Patient Registry & Homegrow Access.

By August 1, 2017, the Division is required to establish an online cardholder registry (the "***Registry***") for patients and their designated caregivers to obtain registry identification cards ("***Patient ID Cards***"). The Registry is required to be accessible by law enforcement and MMEs to determine patient eligibility and it otherwise provide for robust privacy restrictions applicable to patient data.[11]

The Patient ID Cards will cost no more than $40 per year and serve as the patient's authorization to purchase cannabis at dispensaries (once the dispensaries are opened) as well as protecting patients from arrest and jail for possessing and cultivating permitted amounts of medical cannabis.[12] As dispensaries would not likely open until Q1 2018 at the earliest, in the interim, Patient ID Cards will allow patients to start growing their own cannabis for their personal medical use. A registered patient may apply for authorization to grow up to six plants for such "***homegrow***" uses. See below for a more detailed description of the homegrow provisions of the Amendment.

c. Months 7-15 – Business Licensure.

The licensure process for the various types of MMEs will start at the top of the supply chain (with the Type 1 Grows) and move its way down to the storefront dispensaries. The stated purpose of this phased rollout of the MMJ Program is to avoid bottlenecks in the permitting process, similar to those experienced in Maryland where only a single deadline was used for all MME applications. OMM rationalizes giving the Type 1 Grows a three-month head start over the Type 2 Grows because it will provide patients with access to medication more quickly.

The Division is required to begin processing applications for the six types of MME licenses based on the following time schedule, and must act on the applications within 90 days of receipt.

Application Availability Date	MME License Type
August 1, 2017	Type 1 Cultivation (25k sq. ft.) Testing Facility Product Manufacturing Facility Patient ID Cards/ Homegrow Access
November 1, 2017	Type 2 Cultivation (5k sq. ft.) Distributors
February 1, 2018	Dispensaries

5. MME Licenses – Types, Quantities & Fees.

The Amendment provides "guidelines" for the Division to use in establishing fees for the different types of MME licenses as well as directives regarding certain attributes of MME licenses. These provisions effectively create two categories of license types: one

category for the costly, but limited number of Type 1 Grow licenses, and another category for every other type of MME license (including Type 2 Grows), which are unlimited in number (at least theoretically) but significantly cheaper to obtain.

A business can hold any combination of MME licenses that it is able to obtain, with only two exceptions: (1) cultivation facilities (both Type 1 and Type 2) cannot be controlled by a person who controls any other cultivation facility; and (2) testing facilities cannot be controlled by a person who controls any other type of MME. The cultivation ownership restrictions are intended to limit cultivators to ownership of just one Type 1 or Type 2 Grow license, in an effort to preserve the intent behind the canopy-size limitations (25,000 sq. ft. for Type 1 Grows and 5,000 sq. ft. for Type 2 Grows). Testing facilities are required to not have common ownership with any other type of MME, in an effort to encourage independence from the customers they test. The Amendment, therefore, will not have "vertical integration" restrictions (other than limits on horizontal accumulation of cultivation licenses) and will allow MMEs maximum flexibility to determine where they best fit in the supply chain.

The potential concern about this flexibility, however, is that the market is susceptible to being controlled by a few large companies that have the resources to open multiple facilities and acquire other MME businesses. California's new medical marijuana regulations, by contrast, provide highly complex requirements designed to limit vertical integration (and therefore the potential influence of "big weed"). California's regulations generally only allow market participants to hold licenses in two of the market segments (e.g. a grower can also manufacture, but not own a dispensary) with one exception being the "3-1-4 rule" that allows for integration of up to three dispensary licenses with one manufacturing license and up to four acres of cultivation licenses.

a. Type 1 Grows (25,000 sq. ft.)

Type 1 Grows are permitted to cultivate up to 25,000 square feet (over 1/2 acre) of flowering canopy. All cultivation will need to be done within an "enclosed, locked space." This specifically includes greenhouses, but no outdoor grow will be permitted. This requirement will likely preclude some small farmers and craft growers from entering the space who do not have sufficient funding to build an enclosed facility. California is one of the few states that allows outdoor growing, which if done properly can have a much smaller environmental and carbon footprint than indoor grows, as well as provide access to a broader range of small farmers.

The Division can only grant up to 15 licenses for Type 1 Grows. The Type 1 Grows are the only category of MME that has a cap on the number of licenses that can be granted. Several other states have implemented similar or more restrictive caps on cultivation and/or dispensary facilities (e.g. Illinois (22), Maryland (15), Minnesota (2), and New York (20)), though none of these states are viewed as having particularly functional MMJ Programs as they currently stand. The Division can increase the number of Type 1 Grows above 15 if it conducts an analysis showing that additional Type 1 Grows are "necessary" to meet patient demand. It seems fairly unlikely, however, that the Division would be able to show that additional Type 1 Grows are "necessary" if the Division already has the authority to issue an unlimited number of Type 2 Grows, which are only 5x smaller in size.

An 'initial fee' of $500,000 is due upon filing of an application for a Type 1 Grow license. Annual renewal fees are capped at a maximum of $500,000. These application fees are substantial in their own right.[13] When coupled with the significant capital requirements applicable to all cultivation facilities (discussed below) it seems reasonably clear that applicants for Type 1 Grows will need to have several million dollars of cash on hand when submitting their application in order to have much hope of receiving one of the 15 licenses. Due to the180-day capital "seasoning" requirements (discussed below), businesses that have this funding on hand if and when the Amendment passes in November 2016 will have a significant head start on the rest of the market. The application window for Type 1 Grows is, perhaps not coincidentally, timed to sync with this 180-day capital "seasoning" requirement.

b. Type 2 Grows (5,000 sq. ft) and All Other MMEs

The maximum application and annual fees for Type 2 Grows and all other types of MMEs is $5,000. No caps are set on the maximum quantity of these MME licenses. The Division, however, will have authority to establish its own caps in order to limit the number and location of these MMEs. Local governments also will wield substantial influence over the 'presence' of these businesses within the communities they operate.

In addition to the Type 1 Grows, the following types of MMEs are created by the Amendment:

i. Type 2 Grows

Type 2 Grows are cultivations with up to a maximum of 5,000 square feet of flowering canopy. Any grower that does not obtain the 25,000 sq. ft. Type 1 Grow license will have to fit under the much smaller Type 2 Grow size limit. As with Type 1 Grows, all cultivation must occur in a "closed, locked space" which includes greenhouses but not outdoor grows. Type 2 Grows are also subject to the same restrictions on controlling ownership as Type 1 Grows. See below for a description of the restrictions on ownership of Type 1 and Type 2 Grows.

ii. Testing Facilities

Testing facilities are (ideally) independent labs that test

cannabis and cannabis-derived products produced by growers or manufacturers. These third-party labs will play a critical gatekeeping function in the supply of safe and accurately labeled medical cannabis to Ohio patients. They will provide growers and manufacturers with certifications on potency (THC content, serving sizes for edibles, etc.) and absence of contaminants, as well as other measures to ensure accuracy of product labeling. In addition, the Division will establish a program for testing facilities to randomly test marijuana and marijuana products being transferred between MMEs for safety and accuracy of labeling.

Testing facilities are subject to restrictions on controlling ownership to encourage their independence from the customers they service. See below for a description of the restrictions on ownership of testing facilities.

iii. Manufacturing Facilities

Manufacturing facilities are the only businesses that can "manufacture" medical marijuana, which means converting it from plant form into oils, edibles, and other products. While Type 1 and Type 2 Grows are permitted to process, package and sell their marijuana to dispensaries without a manufacturing license, such sales would be limited to "flower" and a manufacturing license would be required to produce any extracts or concentrates. Manufacturers are permitted to transport and deliver product to and from other MMEs, but not to patients.

iv. Distributors

The licenses for growers, testers, manufactures, and dispensers all allow those businesses to transport and distribute product to other MMEs. The distinguishing characteristic of a distributor's license, therefore, is that it authorizes the licensed distributor to store medical marijuana and marijuana products at facilities that do not hold a MME license. Such distributor licenses are intended to allow unaffiliated third-party distributors to participate in the industry for efficiency purposes, but use of a third-party distributors is not required.

A distributors' license could be of interest to existing non-cannabis distribution businesses that are looking to provide storage and transfer capabilities for Ohio's medical cannabis markets. As with all other MMEs that are not dispensaries, distributors can transport and deliver product to and from other MMEs, but not to patients.

v. Dispensaries

Dispensaries are typically the most visible aspect of the medical cannabis distribution system, as they serve as the 'brick-and-mortar' storefront for patients to purchase medical cannabis. Dispensaries are the only MME that can conduct business-to-consumer ('B2C') sales; all other supply-chain transactions are business-to-business ('B2B') between MMEs. In addition to storefront sales, dispensaries will also be permitted to provide direct delivery services to patients.

Dispensaries are charged with tracking patients' purchases (through the Registry) and ensuring that a patient is not permitted to purchase more than its "allowable amount" of medicinal cannabis in any fourteen-day period.[14]

The Amendment does not set any limit on the number of dispensary licenses that may be granted. Local governments, therefore, will likely be the biggest determining factor of where and how many dispensaries open in Ohio. See below for a discussion regarding local zoning and permitting authority over MMEs.

6. Ohio Residency and Other Ownership Restrictions.

a. Ohio Residency.

The most significant ownership restriction contained in the Amendment is the Ohio residency requirement. Until January 1, 2020, only people who were Ohio residents as of January 1, 2016 will be permitted to "own part of" a licensed MME.[15] Once the MME applications are made available in August 2017, Ohio residents will have a two to two-and-a-half year head start on building their own businesses before non residents can start investing in and controlling Ohio MMEs.

This provision is likely to be viewed with hostility from out-of-state investors who wish to access the Ohio market as well as in-state operators seeking outside investment. States such as Oregon have recently repealed in-state ownership restrictions due to the limitations they can create on the ability of local medical-cannabis businesses to attract sufficient startup capital.

b. Other Ownership Restrictions.

A business can hold any combination of MME licenses that it is able to obtain, with only two exceptions: (1) cultivation facilities (both Type 1 and Type 2) cannot be controlled by a person who controls any other cultivation facility; and (2) testing facilities cannot be controlled by a person who controls any other type of MME.[16] The ownership restrictions on cultivation ownership presumably are intended to restrict monopolization of the cultivation market by a limited number of participants, which

could result in price gauging, market manipulation, and other unfair trade practices. The ownership restrictions on testing labs presumably are intended to limit conflicts of interest between the labs and their customers.

Only controlling persons are required to be disclosed on the MME's license application and be subject to the restrictions on cultivation and testing facility ownership. The wording of the "controlling person" definition, however, leaves several potential holes that could allow investors in these businesses to skirt the restrictions. A "controlling person" essentially means the management and any 10% or greater owners of any licensed MME. The Amendment language does not speak to "indirect" ownership, however, which is necessary to prevent applicants from structuring 'upstream' investment vehicles to hold their interests and avoid crossing the 10% ownership thresholds.17 Other than the cultivation and testing facility limits, no "controlling person" restrictions are placed on any other part of the market. One company, therefore, could theoretically own every dispensary, distributor and product manufacturer license.

We would expect the Division to address the above issues more thoroughly and thoughtfully in its rulemaking process. It is not clear from the face of the Amendment, however, how much authority the Division has to promulgate rules that further restrict ownership beyond what is stated in the Amendment. Even so, anti-competitive behaviors could be kept in check through the competitive evaluation process conducted by the Division for all MME applicants as well as the substantial local government authority over licensure and permitting.

7. MME License Criteria.

The Division is required to develop regulations to "quantitatively evaluate and rank" the businesses competing for MME licenses. Applications will be ranked based on the following factors, in addition to any others the Division may add: (1) local government preferences; (2) local suitability of dispensaries and plans for low-income access to medical marijuana; (3) certain capital requirements for cultivations (Type 1 and Type 2 Grows); (4) qualifications of certain "controlling persons" of the MME; (5) plans for including disadvantaged communities in the MMJ Program; (6) and the MME's business plan and safety and security plans.

We find it helpful to group these six criteria among their three overarching policy components. Essentially, MME applications will be ranked by: (a) the 'presence' of the MME in its local community; (b) the financial wherewithal of the MME; and (c) the merit of the MME's operational plans and qualifications of its "controlling persons."

a. Local 'Presence' of the MME.

Perhaps the most interesting provisions of the Amendment relate to the novel approach it takes to including local input and encouraging widespread community benefits in the MME licensure process. Local governments may find a lot to like in the Amendment, as they retain extensive authority to dictate whether and how MMEs will operate within their jurisdictions.

i. "Hands off" approach (zoning only)

Local governments can choose a 'hands off' approach, by not adopting any marijuana-specific local permit criteria, relying instead on generally applicable land use and zoning rules. Until recently, this has been the extent of state-to-local government interaction on medical cannabis in most of the states where it is legal.

i. "Hands on" approach (non-planning permits + zoning)

A more 'hands on' approach could entail a permitting process that, in addition to establishing where and when MMEs can operate, also leverages certain provisions of the Amendment to allocate local operating permits based on how the local community will benefit from the MME's operations.[18] Under the Amendment, all types of MMEs will have to submit "a plan to promote and encourage participation in the medical marijuana industry by people from communities that have been disproportionately harmed by marijuana prohibition and enforcement and to positively impact those communities." Dispensaries (but not any other type of MME) are also analyzed for the "suitability" of the proposed dispensary location and its accessibility to patients, as well as "any plan for making marijuana available at reduced cost to low-income qualifying patients."

These types of 'community benefit' requirements represent new policy mechanisms designed to distribute the benefits of the medical cannabis industry on a broader basis within the communities in which they operate. Massachusetts's medical marijuana program, for example, requires their dispensaries[19] to obtain letters of "non-opposition" from their local governments.[20] MPP's initiative to legalize adult-recreational use in Massachusetts this November, if passed, would also take a similarly novel approach, by requiring the newly created "cannabis control commission" to develop policies to "promote and encourage full participation in the marijuana industry by people from communities that have previously been disproportionately harmed by marijuana prohibition and enforcement."[21] The Amendment draws on both of these concepts, in requiring the Division to conduct a competitive analysis of MME applications that includes consideration of (1) local preference, (2) local "suitability" of

dispensaries and plans for providing discounted medicine to low-income patients, and (3) the MME's plan for encouraging broad-based community participation.

Entrepreneurial local governments could utilize these criteria, along with their extensive zoning authority, to "steer" the Ohio medical cannabis industry in a socially beneficial direction. For example, as part of its input into the Division's licensure decisions, cities like Cleveland could express their preference for local employee-owned cooperative businesses, perhaps inspired by the already celebrated "Evergreen Cooperative Model" pioneered in Cleveland.[22] These ownership attributes would help to satisfy the applicant's requirement to "promote and encourage" participation by those disproportionately harmed by the war on drugs. Other cities may choose to adopt something similar to Arcata, California, where a forward-thinking city council created a "Medical Marijuana Innovation Zone" where blighted and underutilized properties were identified and included in a land-use combining zone that pre-clears properties within the zone for special land-use permits that accommodate niche manufacturing, cultivation, and other marijuana-related businesses. A local government in Ohio could easily overlay this "innovation zone" concept with its preference for granting a local operating permit to employee-owned cooperative style businesses, or business that otherwise rely on new "social enterprise" or "conscious capitalism" operating and ownership models.

i. Nuclear Option (banning all MMEs)

Finally, local governments can choose the 'nuclear option' to ban all MMEs in the jurisdiction. The only limitation on this authority is that the local government cannot unilaterally ban all *dispensaries* without obtaining majority approval of the local voters. By restricting local authorities from banning all dispensaries (but allowing total bans on all other MMEs), the Amendment expresses a policy priority of ensuring that patients have access to at least one dispensary in the local jurisdiction. Local governments should carefully consider the consequences of banning MMEs, however, as local funds allocated from the MMR Fund (discussed below) will only be distributed to localities where MMEs are located.

b. Capital Requirements for Cultivations.

The Amendment contains unique, and potentially onerous, capital requirements for cultivations, including both Type 1 and Type 2 Grows. Any applicant for either cultivation license must demonstrate that it "has the capital available to it to build the facility and to operate with *no revenue for one year after licensure* based on the applicant's reasonable proposed operating budget and *evidence that the capital has been seasoned for at least one-hundred-eighty days*" (emphasis added).

As a result of these provisions, we estimate that applicants planning to operate a Type 1 Grow (up to 25,000 sq. ft. of flowering canopy), would likely need to raise at least $10-15 million by the end of 2016 in order to have any hope of obtaining one of the 15 licenses up for grabs and having product ready for sale at the earliest possible date. The $500,000 initial licensure fee is due upon filing of the application (not award of the license) and is non refundable. Add to that the expenses for build-out and one year of operations by a 25,000 sq. ft. indoor Type 1 Grow, which could easily exceed $10 million per year, and legal, accounting, lobbying and other costs commensurate with siting an industrial-scale cannabis business. On top of this steep capital hurdle, the Amendment layers on a 180-day capital "seasoning" requirement, which effectively requires this cash to be raised at least six months prior to even submitting its application for a license. The 180-day "seasoning" language means that only those applicants who had $10-15 million in hand by the end of 2016, when the legislation passes, will qualify to apply for the 15 licenses available to Type 1 Grow facilities. These capital requirements apply to all cultivation facilities, not just Type 1 Grows. The smaller Type 2 Grow operations, therefore, would likely need to have secured between $1-3 million in funding at least six months prior to submitting their license application to grow up to the maximum 5,000 sq. ft. of flowering canopy.

A consequence of the capital "seasoning" language is that prospective cultivators who are looking to open at the earliest possible date, but lacking a seven figure bank account, will need to start aggressively fundraising immediately after passage of the Amendment in November 2016, well before any regulations are developed by the Division or any license applications become available. Founders and sponsors pitching cultivation businesses, therefore, should be extremely cautious in explaining to potential investors the long and tenuous road that lies ahead for the business, as it burns through capital to seek a cultivation license that it may never obtain.

The fact that these specific capital requirements appear in a constitutional amendment, as one of the specified, mandatory criteria to be used by the Division in ranking competing applications for cultivation licenses, suggests that they are intended to be a competition-limiting "hurdle" for cultivators to clear in order to enter the Ohio market. If the drafting intent was simply to allow the Division to consider the financial wherewithal of cultivation applicants, and thus their ability to utilize the licenses, this provision would have been drafted in

a way that permitted the Division to fine-tune the criteria as called for over time.

That said, many other states have chosen to state some variation of a capital requirement for cultivators, several of which are more stringent than those provided in the Amendment. Massachusetts's regulations, for instance, require applicants for its vertically-integrated, nonprofit grows and dispensaries to demonstrate $500,000 in available capital upon application. Illinois's regulations required applicants for its 22 "pilot program" cultivation licenses to demonstrate $500,000 of "liquid assets" available to it prior to applying and that they post a $2,000,000 bond with the state to cover unanticipated liabilities. Nevada requires cultivation applicants to show $250,000 in available capital upon application. All of these are substantial upfront capital requirements that create certain hurdles to small business applicants. None are set forth in a constitutional amendment, however. In Massachusetts, Illinois and Nevada, if the state legislature or applicable regulatory agency later deems these fees too high, they can be more easily modified than a constitutional amendment, which can only be amended through another constitutional amendment.

While the Amendment does not fix an arbitrary amount of capital, it does arbitrarily decide that having sufficient capital for build-out and one year of operations without revenue, and having that capital "seasoned" for six months, is the appropriate metric for determining whether a cultivator is a legitimate applicant. An experienced grower would likely be able to demonstrate a reasonable business plan to go from licensure, to build out, to sale of its first harvest and establishment of sufficient recurring revenue within six months, but this will not be sufficient under the constitutionally mandated one-year capital requirement. Other states have been able to develop sufficient protections without using the blunt instrument of static capital requirements. Maryland's regulations, for example, take a more fluid approach on the financial analysis of applicants, requiring only that applicants demonstrate that they have "adequate capitalization" as part of the application-evaluation criteria. This could mean a few thousand dollars for small, craft cultivators who want to operate a grow that is well under the maximum Type 2 Grow limit of 5,000 sq.ft. and that will not require significant build and startup costs before first harvest and sales. Or it could mean tens of millions of dollars for large Type 1 Grows seeking to maximize every inch of the 25,000 sq.ft. canopy limit for these finite types of licenses.

c. Operational Plans and Qualifications of Controlling Persons. The final policy-category of the MME license criteria is the fairly straightforward requirements relating to business plans and background checks on "controlling persons."[23] The Division is required, as part of its criteria for issuing an MME license, to analyze the character, veracity, background, and qualifications of all controlling persons of the MME. Each controlling person of an MME must be at least twenty-one years old and not been convicted of certain disqualifying offenses. Each MME application is also required to include the business plan proposed by the applicant, which must include plans to ensure the safety and security of patrons and the community.

8. Homegrow

Once Patient ID Cards are rolled out in August 2017, patients will be able to commence growing up to six plants for their personal medical use ("***homegrow***").[24] The license process for homegrow is not fully described in the Amendment, but appears that it will only require the same Patient ID Card applicable to all patients, which can cost no more than $40 per year, and should be a simple election made during the application process for the Patient ID Card.

If the patient is unable or unwilling to homegrow on their own, they can solicit the assistance of a "***designated caregiver***" who can provide such cultivation services for up to five patients, a total of 30 plants. This type of patient-caregiver model has served as the foundation of the medical-cannabis industry since California legalized medicinal use 20 years ago and is thought to be a source of innovation and 'connoisseur' applications within the space. The fundamental tenant of this model is that it is not a commercial transaction – caregivers can only be reimbursed by patients for 'hard costs' (e.g. equipment, electricity, water, nutrient costs, etc.) and not the value of the caregiver's time in cultivating the plants. In order to prevent competition with the 'licensed' cultivation market under the MMJ Program designated caregivers are not allowed to co-locate at the same location. Larger patient "collectives" popularized under California's prior medical-cannabis laws, therefore, would be prohibited.

While homegrow has been prohibited by several states' medical marijuana laws (including Illinois, Maryland and New York),[25] it is viewed by many in the industry as critical for the equitable treatment of patients, particularly those who cannot afford to purchase medical cannabis from a dispensary. Homegrow is also viewed by some as a critical element for driving innovation in medical marijuana applications, business models and technologies, which could greatly increase the long-term sustainability and efficacy of a MMJ Program. Prohibiting homegrow is viewed by many to be akin to prohibiting home brewing of beer in small batches, an activity which has helped to spawn and drive innovation in a now sizable craft-brewing industry.

For patients who cannot homegrow and do not have access to a designated caregiver, they will likely need to wait until at least

February 2018 to obtain medication. February 1, 2018 is when the Division must begin processing applications for dispensary licenses, and dispensaries are the only MMEs permitted to make commercial sales of medical cannabis to patients.

9. Administration of the MMJ Program.

The MMJ Program will be administrated and overseen by two new regulatory bodies created by the Amendment: (1) a Medical Marijuana Control Division (the "***Division***"), and (2) a Medical Marijuana Advisory Board (the "***Advisory Board***").

a. Medical Marijuana Control Division.

The Division is the primary governing body responsible for developing and administering the detailed rules applicable to the MMJ Program. It is composed of five members appointed by the Director of the Department of Commerce. The five members will be salaried employees of the Division and are required to represent a broad spectrum of relevant experience for governing the MMJ Program: (1) a doctor, (2) a law enforcement officer, (3) an administrative lawyer, (4) a patient advocate, and (5) a public health expert.

The Director of Commence (currently Jacqueline T. Williams) is required to make the initial appointments to the Division within thirty days of passage of the Amendment. The terms of three Division members are generally four years each, but the terms of the initial members will be staggered. Staggering of the Division's composition should result in less erratic shifts in the Division's priorities, as gubernatorial cabinets and directors of commerce change over the years.

b. Medical Marijuana Advisory Board.

The Advisory Board is charged with "advising" the Division, either at the Division's request or on its own initiative, about various aspects of the MMJ Program. Other than consultation rights on the Division's rulemaking process, however, the Advisory Board does not have administrative or oversight authority over the MMJ Program.

The Advisory Board is composed of nine members, who are appointed by the Director of Department of Health for two-year terms. Seven of the nine Advisory Board members would represent each aspect of the medical cannabis supply chain (a cannabis doctor, a grower, a dispenser, a manufacturer, a tester, a patient, and a caregiver). The last two Advisory Board members are required to be experts in public health and law enforcement, respectively.

Unlike the members of the Division, members of the Advisory Board are not prohibited from having an interest in an MME. This is a logical extension of the fact that the Advisory Board is intended to provide each segment of the cannabis industry with a representative who can advise the Division in administering the MMJ Program.

c. Medical Marijuana Regulation Fund.

The MMJ Program is designed to be entirely self-funded based on fees generated from MME licenses and Patient ID Cards. All of the fees collected by the Division in administering the MMJ Program are required to be deposited into the Medical Marijuana Regulation Fund (the "***MMR Fund***") created within the state treasury. Revenues deposited in the MMR Fund, in turn, are used to implement and enforce the MMJ Program, including providing funds to local governments where MMEs are located. As a result, if a city, town or county chooses to ban MMEs in their jurisdiction, they will not receive any of the revenue generated from the MMJ Program.

The Amendment does not specifically address taxes applicable to the sale of medical cannabis under the MMJ Program. Presumably, the default state and local sales taxes would be the only additional taxes that would be applied to sales under the MMJ Program. The state sales tax rate is currently 5.75%, and counties can add up to 3%, for a maximum combined tax rate of 8.75%. The Division and legislature could potentially add additional taxes on various aspects of the MMJ Program, so long as they do not make licensing of MMEs "unreasonably impracticable" or "determine the price" of medical cannabis or "frustrate the purpose" of the Amendment or "reduce patient access" to medical cannabis.

A prior version of the Amendment specifically stated that the legislature was prohibited from enacting "any law that levies a new tax on marijuana for medical use." This language was removed in the final version of the Amendment approved by the ballot board, likely because OMM recognized that it could be an additional target for the ballot board to consider as violative of Issue 2. In addition to prohibiting ballot initiatives that create monopolies and oligarchies, Issue 2 also prohibited ballot initiatives that "specify or determine a tax rate." The prior language could theoretically be viewed as specifying a tax rate inasmuch as it guarantees that medical cannabis would not be targeted for higher tax rates by the legislature.

d. Agency "Hand-Forcing" Provisions.

A final but important component of the Amendment is that it provides "teeth" to the Division's obligations to open the patient Registry and promulgate rules to implement the MMJ Program and for the legislature not to overly restrict it. If the Registry is not open for applications by August 1, 2017, or if the Division fails to act on Patient ID Card applications within 20 days of submission, patients are able to rely on their doctor's recommendation alone as their Patient ID Card under the program. If the Division does not promulgate its regulations

implementing the MMJ Program by July 1, 2017, any taxpayer is permitted to bring suit to force the Division to do so through a mandamus action.

Regardless of whether the legislature and gubernatorial cabinet is supportive of implementing the MMJ Program, it will find ample incentive to work in good faith to do so and avoid the risk of these default constitutional rights from being enforced. An additional incentive for the Division not to "foot drag" on implementation is that these default provisions could have the effect of flipping the state into a regulatory regime that would violate the non-enforcement criteria set out by the Department of Justice's "Cole Memo," such as preventing "diversion" of Ohio cannabis to states without medical cannabis programs and preventing revenue from flowing to gangs and cartels.

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[1] OMM is the state-level political action committee of the national cannabis-prohibition reform organization, Marijuana Policy Project ("***MPP***") based out of Washington, DC. MPP has organized several successful campaigns over the past decade, including the 2012 campaign that legalized adult 'recreational' cannabis sales in Colorado and the 2008 Michigan ballot initiative, which legalized medicinal cannabis for Ohio's northerly neighbors. According to OMM's website, the campaign will need to raise $6 million by October 2016 to pass the Amendment, and that it plans to launch the signature drive on April 9th if it has raised $900,000 by mid-March.

[2] Ohio Attorney General Mike DeWine rejected OMM's first submission of the Amendment on March 11, 2016, citing several inconsistencies between the summary and the language of the Amendment. OMM submitted its second submission of the Amendment on March 15, 2016 and the Attorney General certified this version of the Amendment on March 25, 2016.

[3] We use "Issue 2" in the colloquial sense to refer to the new provisions added to Article II, Section 1e of the Ohio Constitution, which in pertinent part provides that "the power of the initiative shall not be used to pass an amendment to this constitution that would *grant or create a monopoly, oligopoly*, or cartel, *specify or determine a tax rate*, or *confer a commercial interest, commercial right, or commercial license* to any person, nonpublic entity, or group of persons or nonpublic entities, or any combination thereof, however organized, that is *not then available to other similarly situated persons* or nonpublic entities" (emphasis added).

[4] Article II, Section 1e(B)(2)(a) of the Ohio Constitution states that, if the ballot board determines the Amendment violates the language cited in footnote 4, then the ballot shall first ask voters the question: "Shall the petitioner, in violation of division (B)(1) of Section 1e of Article II of the Ohio Constitution, be authorized to initiate a constitutional amendment that grants or creates a monopoly, oligopoly, or cartel, specifies or determines a tax rate, or confers a commercial interest, commercial right, or commercial license that is not available to other similarly situated persons?" Then the voters will be asked the second question of whether the Amendment should be passed.

[5] For instance, if the legislature's program creates a new agency or utilizes an existing agency other than the Department of Health for administering its program, it will likely result in two overlapping administrative bodies responsible for regulating parallel markets. Also, if certain items like possession limits, doctor-patient relationship qualifications, prohibition on homegrow, taxation, etc. are threaded throughout the program, they could expose significant portions of the law to being struck down by courts as violative of broader constitutional rights provided by the Amendment.

[6] The full list of "debilitating medical conditions" stated in the Amendment is: "cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, ulcerative colitis, agitation of Alzheimer's disease, post-traumatic stress disorder, autism with aggressive or self-injurious behaviors, Sickle-Cell Anemia, severe fibromyalgia, spinal cord disease, spinal cord injury, traumatic brain injury or post-concussion syndrome, chronic traumatic encephalopathy, Parkinson's, muscular dystrophy, Huntington's Disease, or the treatment of these conditions; a chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome; severe debilitating pain; severe nausea; seizures, including but not limited to those characteristic of epilepsy; severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis; or any other medical condition or its treatment approved by the Division."

[7] See Procon.org's study, *Number of Legal Medical Marijuana Patients* (as of Mar. 1, 2016).

[8] The Amendment appears to be based on Michigan's definition, but adds a few new qualifying conditions that have become more widely accepted since 2008, including PTSD, MS, post-concussion syndrome and a few others.

[9] The nascent Illinois pilot program currently has about 0.03% of the population enrolled in its program, which does not allow for pain or PTSD as qualifying conditions. See Procon.org's study, *Number of Legal Medical Marijuana Patients* (as of Mar. 1, 2016).

[10] See Procon.org's study, *Number of Legal Medical Marijuana Patients* (as of Mar. 1, 2016).

[11] The information contained in the Registry can only be disclosed "when reasonably necessary" (1) to verify the authenticity of registry identification cards, (2) to notify state or local law enforcement of apparent criminal conduct, and (3) to notify the state medical board of Ohio if there is reason to believe that a "practitioner" violated the standard of care for evaluating the patient's medical conditions (i.e. allegations of malpractice by a prescribing doctor).

[12] The "allowable amount of marijuana" a patient can possess is 2.5 ounces of "usable" marijuana, with amounts for possession of concentrates, edibles and other derivative products being set by the Division. If the patient has been authorized to homegrow through its RID Card, the "allowable amount" also includes up to six plants and the marijuana produced from such plants.

[13] Interestingly, MPP took a different perspective on large license fees when Maryland's state legislature overhauled its medical cannabis program in 2014. Maryland's program requires growers to pay a $125,000 license fee for applicants seeking one of the 15 grow licenses available in that program. In reaction to the announcement of these fee amounts, a legislative analyst for MPP described Maryland's license fees as being "prohibitively high" and that such fees "are almost certainly going to be passed on to the patients, and these are already people who have expensive medical bills and are dealing with debilitating medical conditions. It's unfair they would have to pay the costs of the program." (See Timothy B. Wheeler, *Medical marijuana fees stir debate in Maryland*, The Baltimore Sun, Oct. 11, 2014). Presumably, the difference for Ohio is that an unlimited number of Type 2 Grow licenses are available, which could provide significant competition to the Type 1 Grows and help to mitigate the ability of Type 1 Grows to pass through the high licensing fees to patients.

[14] The "allowable amount of marijuana" a patient can possess is 2.5 ounces of "usable" marijuana, with amounts for possession of concentrates, edibles and other derivative products being set by the Division.

[15] Note that the Amendment language requiring Ohio residency in order to "own part of" an MME is a potentially broader scope of ownership than the "controlling person" standard used for limiting overlapping ownership among cultivations or testing facilities. The implication for enforcement of the Amendment, is that the residency requirement should be more easily measured and applied by the Division than, for instance, the limitation on overlapping "controlling persons" of Type 1 and Type 2 Grows.

[16] Doctors who prescribe medical marijuana are also prohibited from owning or controlling any part of any MME.

[17] For example, an investor syndicate of ten or more well-heeled investors could theoretically structure its ownership so that each investor would own up to 10% of every single Type 1 and Type 2 Grow. While effectively owning 100% of all cultivation licenses as a group, each of the investors would be considered passive, non-controlling investors in all of the cultivations and would neither violate the licensing restrictions nor be required to disclose this overlapping ownership in the application process. Similarly, the 100% owners of 10 different Type 1 Grows hypothetically could each hold a 10% interest in a testing facility (100% total interest) and would not be required to disclose their ownership interest in their application for the testing facility license, as they would not be controlling persons as to the testing facility.

[18] As with nearly every medical marijuana state, typical time, place and manner zoning restrictions are also a part of the local control over MMEs that is envisioned by the Amendment.

[19] Massachusetts's dispensaries are required by law to be nonprofit entities and to be vertically-integrated companies, with "seed-to-sale" ownership of the supply chain, which is not the case with the Amendment.

[20] It is worth noting, however, that Massachusetts's non-opposition letter program has been criticized by some in the industry, who feel the local governments are extracting ad-hoc payments and promises from applicants in the form of "host agreements" entered with the city. For example, through one host agreement with a dispensary, the city of Worcester will receive upfront payments of $450,000 for the next three years, plus a percentage of gross sales (1.5 percent, 2 percent and 2.5 percent in each of the next three years). In years four and beyond, the annual payment is reduced to $200,000, and the city still receives 2.5 percent of the company's gross revenue. See Allison Manning, *In exchange for approving pot dispensary applications*, cities demand lucrative cash perks, Boston.com, March 22, 2016.

[21] See Massachusetts campaign to Regulate Marijuana Like Alcohol, at http://www.regulatemassachusetts.org/about/initiative-text/.

[22] See Diana Olick, *A co-op that delivers on the American dream*, CNBC, Feb. 23, 2016.

[23] "Controlling person" means an officer, board member, managing member, manager, general partner, or an individual who has a financial or voting interest of ten percent or greater in a medical marijuana establishment or who has the power to direct or cause to be directed the management or control of a medical marijuana establishment.

[24] We note that the Amendment is not clear whether "six plants" means six "mature" plants, or the total number of plants allowed, including seedlings and vegetative non-flowering plants. Most states that authorize a small number of homegrow plants use six plants as the total and specifically state that only three can be mature (e.g. Maine, Colorado and Alaska).

[25] In the majority of medical marijuana states (15 of 23), some form of homegrow is permitted. Homegrow is not allowed in Connecticut, Delaware, Illinois, Maryland, Minnesota, New Hampshire, New Jersey, New York, or in Washington, D.C. In Massachusetts and New Mexico, patients can only cultivate if they receive a special approval, while in Arizona and Nevada patients can only homegrow if they live more than 25 miles from a dispensary.