

CANNABIS FOR CASH ONLY:

The Lack of Insurance Coverage and Reimbursement for Medical Marijuana

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A man suffering from multiple sclerosis was convicted in 2009 of manufacturing marijuana in violation of New Jersey state law by maintaining a "marijuana grove" at his Somerset County home. At that time, he could not afford prescription medica-

tions for his multiple sclerosis because he had no medical insurance. The defendant unsuccessfully advanced a "personal use defense" to the criminal charge of growing marijuana. Following his conviction, the defendant appealed and argued that 1) his "personal use defense" was a proper affirmative defense and 2) the presumption of incarceration with a resulting five-year prison term and the need for deterrence as part of his sentence following conviction should have been refuted by the then recent enactment of the New Jersey Compassionate Use Medical Marijuana Act (Act). All of these contentions were rejected, with the court commenting that the Act "has no bearing on the disposition of the appeal." The conviction was affirmed.¹

Even if the defendant had had health coverage of some sort, it would have no bearing on his consumption of marijuana for medicinal purposes. The Act protects qualified marijuana users from criminal prosecution under state law. However, the Act does not entitle a medical marijuana user, or his or her prescribing physician, to any expectation of coverage or reimbursement for medical marijuana use under a health plan or insurance. Despite the many years of legislative lobbying and efforts to navigate the risks of criminal prosecution, especially by federal authorities, this gap in the medical marijuana laws leaves many for whom the alternative therapy might be of value without access to the potential benefits.

BACKGROUND OF NEW JERSEY AND COLORADO MEDICAL MARIJUANA LAWS

On January 18, 2010, then-Governor Jon Corzine signed the Act² on his last day in office. With that, New Jersey became the 14th state in the country to adopt a medical marijuana program. As of September 2013, a total of 20 states and the District of Columbia have adopted various medical marijuana programs with some differences in scope and structure.³ In accordance with the Act, the Department of Health (DOH) administers the New Jersey Medical Marijuana Program (Program). Various aspects of the Program, particularly the requirement for an ongoing physician-patient relationship, have been previously discussed in this journal.⁴

Colorado was one of the first states to pioneer the movement toward legalizing the use of medical marijuana. Colorado's first and oldest medical marijuana law took effect with the passage of Amendment 20 by Colorado voters in November 2000. Amendment 20 effectively legalized the purchase of limited amounts of medical marijuana by patients and their primary caregivers.⁵ However, Amendment 20 did not expressly authorize the commercial distribution of medical marijuana. In the years following the passage of Amendment 20, legislators became aware of the need for a state-regulated medical marijuana distribution system. During the legislative session of 2010, the Colorado Legislature enacted the Colorado Medical Marijuana Code (Code) that legitimized medical marijuana centers (dispensaries), subject to the rules and licensing procedures of counties and municipalities. Administrative responsibility is shared between the Colorado Department of Environment and Public Health and the Colorado Medical Marijuana Enforcement Division. Following passage of the Code in summer 2010, the state saw a "green rush of cannabis entrepreneurs" marked by the registration of 1,131 dispensaries and approximately 108,000 medical marijuana users with the Colorado Medical Marijuana Enforcement Division.⁶

Heavy regulation by the Enforcement Division and

the threat of prosecution under federal law proved to be a difficult hurdle for many entrepreneurs, and as a result, as of March 2013, there were only 675 operational dispensaries, the majority of them operating in Denver and Boulder.⁶ In November 2012, Colorado voters went one step further with the passage of Amendment 64, a constitutional amendment legalizing personal use of marijuana for adults at least 21 years of age.^{7,8} Similar action was taken in the State of Washington in 2011 to legalize possession and personal use of marijuana. The Attorney General of the United States has indicated that the Department of Justice would not challenge these state laws and, on August 29, 2013, issued a memorandum regarding the administration's approach to marijuana enforcement.⁹

Although New Jersey has not taken steps to fully legalize marijuana like Colorado, the New Jersey Act is similar to Colorado's Medical Marijuana Code in that the Act is

enacted into law on September 10, 2013.¹³

The DOH is authorized to approve additional medical conditions or their treatment as a basis for eligibility for the Program. However, the Commissioner of Health has indicated that no consideration will be given to approving other medical conditions before the completion of two annual report periods.¹⁴

Implementation of the New Jersey Compassionate Use Medical Marijuana Act has faced multiple delays. Initially, the effective date of six months from enactment in January 2010 was postponed and moved to October 1, 2010, to allow for further consideration by the new Governor, Chris Christie, and the development of the necessary regulations. The DOH proposed regulations beginning in February 2011, which were eventually adopted with a December 2011 effective date.¹⁵ The State Board of Medical Examiners adopted regulations in 2011 to

“According to Compassionate Care Foundation CEO Bill Thomas, ‘The Foundation is eager to bring pharmaceutical-grade medicinal Cannabis to eligible patients in New Jersey. We are particularly excited about the strain that we are growing that contains high levels of Cannabidiol (CBD).’”



intended to address “debilitating conditions,” which are listed in the statute as follows:

1. seizure disorder, including epilepsy; intractable skeletal muscular spasticity; or glaucoma, if resistant to conventional medical therapy
2. positive status for human immunodeficiency virus, acquired immune deficiency syndrome or cancer, if severe or chronic pain, severe nausea or vomiting, cachexia or wasting syndrome results from the condition or its treatment
3. amyotrophic lateral sclerosis, multiple sclerosis, terminal cancer, muscular dystrophy or inflammatory bowel disease, including Crohn's disease
4. terminal illness, if the physician has determined a prognosis of less than 12 months of life.¹⁰

On August 16, 2013, New Jersey's Governor Christie indicated a willingness to approve an expansion of the Program in a bill passed by the Legislature on June 10, 2013, if it were revised to meet the stipulations in his conditional veto. One of the Governor's recommended revisions would allow qualifying children to have access to edible forms of medical marijuana.¹² The Legislature concurred in the recommended amendments and the revisions were

implement the Act regarding the statutory requirement for physician licensees to provide certifications and written instructions for patients seeking marijuana for medical use.¹⁶

As provided in the statute, DOH has established a registry for qualifying patients or caregivers with approximately 1,000 persons having registered by this point. Similarly, DOH has a listing of registered physicians participating in the program.¹⁷ Regarding dispensaries, New Jersey has taken a strict stance on regulating state-approved dispensaries, referred to in the statute as alternative treatment centers (ATCs).

At present, DOH has limited its approval of ATC dispensaries to those operated by nonprofit entities. The statute requires that there be “at least” two ATCs in each of the three identified northern, central and southern regions of the state. The first two centers in a region must be nonprofit entities.¹⁸ A for-profit center recently sought approval through the DOH and was denied.¹⁹ The for-profit center filed a lawsuit to compel acceptance of its application, but the Appellate Division refused to issue such an order.¹⁹ The first approved ATC was Greenleaf Compassion Center in

Montclair, NJ, which opened in December 2012. DOH has issued approval for two more ATCs: Compassionate Care Foundation in Egg Harbor, opening in the fall of 2013, and Compassionate Care Centers of America Foundation in Woodbridge, opening perhaps late in 2013 or early 2014.²⁰

STATE-AUTHORIZED USE OF MEDICAL MARIJUANA AND INSURANCE COVERAGE

The New Jersey Act explicitly addressed the matter of reimbursement through government programs or private insurance: “Nothing in this act shall be construed to require a government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of marijuana, or an employer to accommodate the medical use of marijuana in any workplace.”²¹

The unavailability of insurance coverage or Medicaid and Medicare reimbursement is consistent across all states. This primarily results from federal law not recognizing a medicinal use for marijuana. It is still classified by the Drug Enforcement Administration (DEA) as a Schedule I drug—the same as heroin. Use of marijuana is still subject to criminal prosecution under federal law. It is common for insurance policies to not provide coverage for criminal acts or violations of statutes.²²

In addition, medicinal marijuana does not have FDA

approval. Unless and until the federal government decriminalizes medicinal marijuana and the FDA approves medicinal use, it is unlikely that any private insurer or government program will cover the cost of medicinal marijuana. An attempt at reclassification by the DEA was strongly rejected in January 2011.²³ That position was challenged with a petition filed with the United States Court of Appeals for the District of Columbia Circuit. In an opinion filed on January 22, 2013, the Court upheld the DEA’s decision declining to initiate proceedings to reclassify marijuana.²⁴ The Court noted the lack of “adequate and well-controlled studies” that supported the medical use of marijuana sufficient to overcome the presumption in favor of the federal agency’s action. In July 2013, the petitioners requested that the United States Supreme Court review the matter. This case is on the Court’s docket for consideration at its September 30, 2013, conference. Disposition of the petition for certiorari will likely be announced by early October. Since the Supreme Court denies the overwhelming majority of matters presented to it for review, the reclassification of marijuana may not be addressed at this time.

Because private insurers and the federal government will not subsidize the cost of medicinal marijuana, participation in the New Jersey Program is costly for patients and

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The graphic features a portrait of Steve Adubato on the left. To the right, it includes the following logos and text:

- NEW JERSEY CAPITOL REPORT** with STEVE ADUBATO & RAFAEL PI ROMAN (with a small image of the New Jersey State Capitol dome)
- CAUCUS NEW JERSEY** with Steve Adubato (with a yellow circular graphic)
- One on One** with Steve Adubato
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caregivers. Indeed, it has been described as the “most expensive” program in the nation.²⁵ The basic patient and caregiver registration fee is \$200. A reduced fee of \$20 is available for persons who qualify for Medicaid, Food Stamps, State Temporary Disability or Social Security Disability Benefits and Supplemental Security Income.²⁶ The registration is good for a two-year period.²⁷

The costs of regular medical use of marijuana can also be high. The basic enabling statute requires a “bona fide physician-patient relationship” to certify someone as being a “qualified patient.”²⁸ The implementing regulation of the Board of Medical Examiners mandates “ongoing responsibility” on the part of the physician, which is defined as having a physician-patient relationship of at least one year’s duration, assessments on at least four occasions or assuming responsibility for care and management after a comprehensive history and physical examination.²⁹ Adding to the cost of participation in the Program, the regulation requires a reassessment by the physician at least every three months.³⁰

Projecting the cost to the patient and the probability of effective relief is difficult to accomplish. Physician certificates are to set forth the total amount of marijuana that may be dispensed, but patients are permitted to purchase no more than two ounces of marijuana from an ATC in a 30-day period.³¹ At the same time, there is limited guidance on what volume of marijuana is effective for conditions within the Program’s coverage as well as the controversy regarding the effectiveness of marijuana in controlling such problems as chemotherapy-induced nausea.³² DOH regulations require that the ATCs keep records that provide the standards and procedures used to determine the price it charges and a record of the prices actually charged to eligible patients.³³ But each dispensary sets its own prices. Pricing in New Jersey ranges from \$400 to \$560 for an ounce of marijuana depending on the strain.²⁵ In Colorado, for comparison, dispensaries charge from \$50 to \$100 for a quarter ounce, with the price depending on the strain.³⁴ Additionally, Marinol (dronabinol), which contains the active ingredient THIC but is a Schedule III drug, is available by prescription, providing a benchmark for comparison. An average dose of Marinol is approximately \$6.00 more than an average dose of marijuana but is within the scope of insurance plan coverage³⁵; it is also covered by Medicare.³⁶

use of marijuana,³⁷ but the evidence remains subject to challenge and the conclusion controversial. It seems evident that the New Jersey Program provides for highly regulated access to medicinal marijuana but in a context that is inherently preferential to those who can afford this alternative treatment modality. The cautious development of standards for approval of ATCs as well as guidelines for the use and recognition of abuse of medicinal marijuana are grounded in prudent public policy. Nonetheless, the varying costs of medicinal marijuana, completely controlled by either nonprofit or for-profit entities, depending on state law, without the opportunity for health plan coverage will remain a barrier to full utilization of a potential resource for relief to patients with debilitating conditions and terminal illnesses.

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¹ *State v. Wilson*, 421 N.J. Super.301, 23 A.3d 489 (App. Div. 2011).

² Public Law 2009, c. 307 codified at N.J.S.A. 24:61-1 to 24:61-19.

³ Note: The jurisdictions legalizing or authorizing medical marijuana are Alaska (1998); Arizona (2010); California (1996); Colorado (2000); Connecticut (2012); Delaware (2011); District of Columbia (2010); Hawaii (2000); Illinois (2013); Maine (1999); Massachusetts (2012); Michigan (2008); Montana (2004); Nevada (2000); New Hampshire (2013); New Jersey (2010); New Mexico (2007); Oregon (1998); Rhode Island (2006); Vermont (2004); and Washington (1998).

⁴ Alaiigh, P. (2011). An ongoing physician-patient relationship defines New Jersey’s unique medical marijuana program. *MDAdvisor*, 4 (1),12–14; Bateman, C. (2010). Medical marijuana in New Jersey. *MDAdvisor*, 3(2),4–5.

⁵ Colo. Const. art. XVIII, § 14.

⁶ Ingold, J. (2013, March 3). Colorado medical-marijuana businesses have declined by 40 percent. *The Denver Post*. www.denverpost.com/news/marijuana/ci_22706453/colorado-medical-marijuana-businesses-have-declined.

⁷ Colo. Const. art. XVIII, § 16.

⁸ Note: Arguably, Colorado’s legalization of marijuana for per-

CONCLUSION

A number of controlled studies support a medical

sonal use renders it more of an “over-the-counter” medication as opposed to a physician-recommended medication, at least under state law.

- ⁹ See Perez, E. (2013, Aug. 30). No federal challenge to pot legalization in two states. www.cnn.com/2013/08/29/politics/holder-marijuana-laws/index.html; Cole, J. n.d. *Memorandum for all United States attorneys from James M. Cole, deputy attorney general, on subject of guidance regarding marijuana enforcement.* www.justice.gov/iso/opa/resources/3052013829132756857467.pdf.
- ¹⁰ N.J.S.A. 24:61-3.
- ¹¹ State of New Jersey. (2013). *Senate No. 2842.* www.njleg.state.nj.us/bills/BillView.asp.
- ¹² State of New Jersey. (2013, August 16). *Governor Chris Christie eases access to New Jersey’s Medical Marijuana Program for sick children.* www.state.nj.us/governor/news/news/552013/approved/20130816c.html.
- ¹³ Public Law 2013, c. 160.
- ¹⁴ N.J.A.C. 8:64-5.1(a).
- ¹⁵ N.J.A.C. 8:64-1.1 to 64-13-11.
- ¹⁶ N.J.A.C. 13:35-7A-1 to 7A-6.
- ¹⁷ New Jersey Department of Health. (n.d.). *New Jersey Medicinal Marijuana Program: Physician registry.* www.njmmp.nj.gov/docs/homepage/Physician_Registry.pdf.
- ¹⁸ N.J.S.A. 24:61-7(a).
- ¹⁹ *Natural Medical, Inc. v. New Jersey Department of Health & Senior Services*, 428 N.J. Super.259, 52 A.3d 207 (App. Div. 2012).
- ²⁰ New Jersey Department of Health. (2013). *Medicinal Marijuana Program: Alternative treatment centers.* www.state.nj.us/health/medicalmarijuana/find_atc_pat.shtml.
- ²¹ N.J.S.A. 26:61-14.
- ²² *Note: Compare Zurich American Ins. Co. v. O’Hara Regional Center for Rehabilitation*, 529 F.3d 916 (10th Cir. 2008)(applying Colorado law) with *Hampton Medical Group v. Princeton Insurance Co.*, 366 N.J. Super. 165, 840 A.2d 915 (App. Div. 2004).
- ²³ See generally, U.S. Department of Justice, Drug Enforcement Administration. (2013, April). *The DEA position on marijuana.* www.justice.gov/dea/docs/marijuana_position_2011.pdf.
- ²⁴ *Americans for Safe Access v. Drug Enforcement Administration*, 706 F.3d 438 (D.C. Cir. 2013), *rehearing en banc denied, petition for cert. filed*, (Docket No. 13-84 July 15, 2013).

- ²⁵ Livo, S. K. (2013, August 4). Is NJ medical marijuana program most expensive in the nation? *The Star-Ledger.* www.nj.com/politics/index.ssf/2013/08/is_nj_medical_marijuana_program_the_most_expensive_in_nation.html.
- ²⁶ N.J.A.C. 8:64-2.1
- ²⁷ N.J.A.C. 8:64-3.1.
- ²⁸ N.J.S.A. 24:61-3; N.J.A.C. 13:35-7A.2.
- ²⁹ N.J.A.C. 13:35-7A.2.
- ³⁰ N.J.A.C. 13:35-7A.5.
- ³¹ N.J.A.C. 8:64-2.5.
- ³² See, e.g., Torado, B. (2012). Cannabinoids in the treatment of chemotherapy-induced nausea and vomiting. *Journal of the National Comprehensive Cancer Network*, 10(4), 487.
- ³³ N.J.A.C. 8:64-9.3(a)(8).
- ³⁴ Livo, S. K. (2012, Nov.16). Q&A: Medical marijuana in NJ. *The Star-Ledger.* www.nj.com/politics/index.ssf/2012/11/qa_medical_marijuana_in_nj.html; Also see: The Clinic: Medical Marijuana Center. (2013). *The Clinic Capitol Hill’s menu.* www.theclinicolorado.com/menus/caphill-menu; The Dandelion Dispensary. (2012). *The Dandelion menu.* www.thedandelionco.com/products.
- ³⁵ ProCon.org. (2008 [updated]). How does the cost of marijuana compare to the cost of Marinol? *Medical Marijuana.* <http://medicalmarijuana.procon.org/viewanswers.asp?questionID=000091>.
- ³⁶ See, Centers for Medicare & Medicaid Services. (n.d.). *Is my test, item, or service covered?* www.medicare.gov/index.html.
- ³⁷ Abrams, D. I., Jay, C. A., Shade, S. B., Vizoso, H., Reda, H., Press, S., Kelly, M. E., Rowbotham, M. C., & Petersen, K. L. (2007). Cannabis in painful HIV-associated sensory neuropathy: A randomized placebo-controlled trial. *Neurology*, 68, 515–521; Ellis, R. J., Toperoff, W., Vaida, F., van den Brande, G., Gonzales, J., Gouaux, B., Bentley, H., & Atkinson, J. H. (2009). Smoked medicinal cannabis for neuropathic pain in HIV: A randomized, crossover clinical trial. *Neuropsychopharmacology*, 34, 672–680; Wilsey, B., Marcotte, T., Tsodikov, A., Millman, J., Bentley, H., Gouaux, B., & Fishman, S. A. (2008). A randomized, placebo-controlled, crossover trial of cannabis cigarettes in neuropathic pain. *The Journal of Pain*, 9, 506–521; Ware, M. A., Wang, T., Shapiro, S., Robinson, A., Ducruet, T., Huynh, T., Gamsa, A., Bennett, G. J., & Collet, J. P. (2010). Smoked cannabis for chronic neuropathic pain: A randomized controlled trial. *Canadian Medical Association Journal*, 182, E694–E701; Corey-Bloom, J., Wolfson, T., Gamst, A., Jin, S., Marcotte, T. D., Bentley, H., & Gouaux, B. (2012). Smoked cannabis for spasticity in multiple sclerosis: A randomized, placebo-controlled trial. *Canadian Medical Association Journal*, 184, 1143–1150.