CONTROVERSIAL CANNABIS: HOW PASSAGE OF THE M.O.R.E. ACT CAN REMEDY THE DISPARATE IMPACT OF MARIJUANA PROHIBITION

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I. INTRODUCTION

Since 1996, states have seen a surge in marijuana legislation. As of February 2022, eighteen states and the District of Columbia have legalized adult recreational marijuana use, while thirty-six states and the District of Columbia have legalized medical marijuana.[1] Although marijuana is a Schedule I drug under the Controlled Substance Act ("CSA"), the federal government has exercised enforcement discretion to allow for state legalization

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[1] *Legal Medical & Recreational Marijuana States*, PROCON.ORG (Feb. 3, 2022), https://medicalmarijuana.procon.org/legal-medical-marijuana-states-and-dc/.

since 1996.[2]

The CSA classification effectively precludes citizens from qualifying for federally funded benefit programs, even where the use is legal under a state's recreational or medical marijuana program.[3] These applicants, as qualified beneficiaries of federal programs, are already disproportionately disadvantaged in the United States and are comprised of at-risk minority groups.[4] By restricting medical marijuana patients' access to federal benefits programs, the federal government disparately harms at-risk minority groups.

The COVID-19 pandemic has exposed and exacerbated these inequities by threatening access to affordable healthcare, food, and shelter. On December 4, 2020, the United States House of Representatives passed the Marijuana Opportunity Reinvestment and Expungement Act ("MORE Act" or "the Act").[5] This legislation marked the first time a chamber of Congress has voted to decriminalize marijuana use at the federal level,[6] a historic milestone for pro-cannabis organizations.[7]

This comment seeks to evaluate the strengths and weaknesses of the MORE Act as applied to resolving the disparities medical marijuana users face when seeking federal benefits. Part II will examine the legislative, political, and social roots of the MORE Act and highlight how marijuana has been used as a discriminatory tool against poor and minority communities. Part III discusses

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[2] Robert A. Mikos, *A Critical Appraisal of the Department of Justice's New Approach to Medical Marijuana*, 22 STAN. L. & POL'Y REV. 633, 638–39 (2011) (discussing the Obama Non-Enforcement Policy and the Ogden memorandum urging federal prosecutors not to enforce the federal marijuana ban against persons who act in "clear and unambiguous compliance" with state medical marijuana laws).

[3] *See generally* Afua S. Akoto, *From High to Homeless: The Cost of Smoking Medical Marijuana in Federally Funded Public Housing*, 31 CONN. J. INT'L L. 257 (2016).

[4] *21.3 Percent of U.S. Population Participates in Government Assistance Programs Each Month*, U.S. CENSUS BUREAU, (May 28, 2015), https://www.census.gov/newsroom/archives/2015-pr/cb15-97.html.

[5] MORE Act of 2020, H.R. 3884, 116th Cong. (2019), https://www.congress.gov/bill/116th-congress/house-bill/3884/actions.

[6] Veronica Stracqualursi & Lauren Dezenski, *House Passes Bill Decriminalizing Marijuana at Federal Level*, CNN POL. (Dec 4, 2020), https://www.cnn.com/2020/12/04/politics/house-vote-more-act-marijuana-legislation/index.html.

[7] David Downs, *The House Passed the More Act. Is Weed Legal Now?*, LEAFLY (Dec. 4, 2020), https://www.leafly.com/news/politics/more-act-vote-explained.

three types of federal benefit programs and their impact on medical marijuana patients. Part IV discusses the impact that the COVID-19 pandemic has had upon minority communities and evaluates the substance of the MORE Act. Part V critiques the gaps remaining in the MORE Act and offers potential solutions through both executive and legislative action.

II. BACKGROUND/LEGISLATIVE HISTORY

A. *Examining the Discriminatory Roots of Federal Marijuana Legislation*

Cannabis, commonly referred to as "marijuana," "weed," or "pot,"[8] has been used for centuries for medicinal, herbal, and industrial purposes.[9] Hemp, a fibrous material derived from the cannabis plant,[10] has numerous uses.[11] In 1611, the first settlers in Jamestown, Virginia, cultivated hemp to use for clothes, rope, and ship sails.[12] Medicinally, marijuana was used in patent medicines for various conditions, including pain, convulsions, menstrual cramps, lack of appetite, depression, and other mental illnesses.[13] Despite its multiple uses and benefits, marijuana has also been a conduit for racism, discrimination, and suppression against minority communities, dating back to the beginning of the twentieth century.[14]

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[8] Mariah Woelfel, *Pot? Weed? Marijuana? What Should We Call It?*, NPR (Sept. 19, 2019), https://www.npr.org/local/309/2019/09/19/762044859/pot-weed-marijuana-what-should-we-call-it.

[9] *Marijuana*, HISTORY.COM (Oct. 10, 2019), https://www.history.com/topics/crime/history-of-marijuana#:~:text=Marijuana%2C%20also%20known%20as%20cannabis,hemp%20for%20textiles%20and%20rope.

[10] *What's the Difference Between Hemp and Marijuana?*, WEED MAPS, https://weedmaps.com/learn/the-plant/hemp-vs-marijuana (last visited Mar. 19, 2022).

[11] *Marijuana Timeline*, PUB. BROAD. SERV.:FRONTLINE, https://www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.html (last visited Mar. 19, 2022).

[12] Sarah Simmons, *Medical Marijuana Use in Federally Subsidized Housing: The Argument for Overcoming Federal Preemption*, 48 U. BALT. L. REV. 117, 120 (2018).

[13] CANNABIS IN MEDICAL PRACTICE: A LEGAL, HISTORICAL, AND PHARMACOLOGICAL OVERVIEW OF THE THERAPEUTIC USE OF MARIJUANA 37–38 (Mary L. Mathre, ed., 1997).

[14] Alyssa Pagano, *The Racist Origins of Marijuana Prohibition*, BUS. INSIDER (Nov. 4, 2020), https://www.businessinsider.com/racist-origins-marijuana-prohibition-legalization-2018-2.

The denigration of marijuana began with the influx of Mexican immigration in the early 1900s following the Mexican revolution.[15] As cannabis use surged in Texas border towns, police "demonized the plant in racial terms as the drug of 'immoral' populations who were promptly labeled 'fiends.'"[16] Indeed, the U.S. government demonized marijuana use in order to control Mexican immigrants, which mirrored its attempts to control Chinese immigrants by criminalizing opium in the late nineteenth century.[17] This strategy of controlling populations by controlling their customs became the government's standardized method of monitoring and regulating minority groups.[18] During the 1930s, marijuana was further used as an instrument of racism against men of color by claiming that the substance caused these men to become violent and hyper-sexual toward white women.[19]

Against this backdrop, Congress passed the Marijuana Tax Act of 1937, which effectively criminalized marijuana nationally by imposing a regulatory tax on the importation, cultivation, possession, and distribution of marijuana.[20] Congress's attempt at criminalization through taxation quickly became futile, however, because the Tax Act was declared unconstitutional in 1969.[21] In *Leary*, the Supreme Court determined that the statute facially permitted the defendant to acquire marijuana legally if he paid the marijuana tax.[22] But, in paying the tax, the defendant was required to provide incriminating information about himself, which violated a host of state regulations prohibiting the

15 Simmons, *supra* note 12, at 120.

16 Brent Staples, *The Federal Marijuana Ban Is Rooted in Myth and Xenophobia*, N.Y. TIMES (July 29, 2014), https://www.nytimes.com/2014/07/30/opinion/high-time-federal-marijuana-ban-is-rooted-in-myth.html

17 *Id.*; *see also* Malik Burnett & Amanda Reiman, *How did Marijuana Become Illegal in the First Place?*, DRUG POL'Y ALL. (Oct. 8, 2014), https://drugpolicy.org/blog/how-did-marijuana-become-illegal-first-place [hereinafter Burnett & Reiman].

18 Burnett & Reiman, *supra* note 17.

19 *Id.*

20 *Did You Know . . . Marijuana Was Once a Legal Cross-Border Import?*, U.S. CUSTOMS & BORDER PROT. (Dec. 20, 2019), https://www.cbp.gov/about/history/did-you-know/marijuana#:~:text=His%20campaign%20against%20Cannabis%20led,an%20annual%20tax%20of%20%2424.

21 Leary v. United States, 395 U.S. 6 (1969), *reversing*, Leary v. United States, 383 F.2d 851 (5th Cir. 1967).

22 *Id.* at 26.

possession of marijuana under any conditions.[23] The Court, accordingly, held that defendant's plea of self-incrimination was a complete defense for statutory non-compliance.[24] The Court went on to hold that under 26 U.S.C. §§ 4744(a)(2) and 176(a), subsections of the Marijuana Tax Act, requiring knowledge of unlawful importation was unconstitutional as it violated the Fifth Amendment's due process clause.[25]

Thus, it was not until the 1970s that the federal government became heavily involved in regulating marijuana. At that time, federal enforcement had only occurred through tax codes, not criminal statutes.[26] In 1970, Congress took a firm stance against the legalization of marijuana through the passage of the CSA.[27] The CSA includes five schedules of controlled substances, each of which outlines a different degree of drug effectiveness and potential for abuse.[28] When the statute passed in Congress, cannabis was placed in the most restrictive category as a Schedule I drug.[29] Schedule I drugs have a high potential for abuse, and currently, there is no "accepted medical use in treatment in the United States, and '[t]here is a lack of accepted safety for use of the drug or other substance under medical supervision.'"[30]

Thereafter, "[President] Nixon declared drug abuse to be 'public enemy number one,'" resulting in an anti-drug era further popularized during President Reagan's tenure with his "War on Drugs" campaign.[31] In recent years, John Ehrlichman, Nixon's former domestic policy chief, revealed that the "War on Drugs" was created to demonize Black people and bohemians:

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23 *Id.*

24 *Id.* at 29.

25 *Id.* at 52–3.

26 Stephen Siff, *The Illegalization of Marijuana: A Brief History*, ORIGINS (May 2014), https://origins.osu.edu/article/illegalization-marijuana-brief-history?language_content_entity=en.

27 21 U.S.C. §§ 801–904.

28 *See generally Drug Scheduling*, U.S. DEA, https://www.dea.gov/drug-information/drug-scheduling (last visited Mar. 19, 2021).

29 21 U.S.C. § 812(b).

30 Samantha Everett, *Raich v. Ashcroft: Medical Marijuana and the Revival of Federalism*, 41 SAN DIEGO L. REV. 1873, 1880 (2004).

31 *War on Drugs*, ENCYCLOPEDIA BRITANNICA, https://www.britannica.com/topic/war-on-drugs (last accessed Mar. 7, 2022).

> We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.[32]

Notably, the "War on Drugs" era was juxtaposed against Reagan's infamous stereotype of the "Welfare Queen" as a symbol of the failed welfare state.[33] This inherently racist term depicted the stereotype of a single Black mother, living a life of luxury by fraudulently exploiting government benefit programs.[34] Yet, despite Reagan's assertions, it is estimated that fraud accounts for less than two percent of unemployment insurance payments.[35]

B. *The States' Response*

Though marijuana remains a Schedule I drug under the CSA, there has been much speculation as to whether it belongs in a category of drugs with no medicinal value.[36] Beginning in 1996 with the passage of the California Compassionate Use Act ("CCUA"), however, states launched initiatives ensuring that seriously ill individuals would have the right to use and possess marijuana for medicinal relief.[37] The CCUA specifies that a

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[32] H.R. Res. 933, 115th Cong. (2018).

[33] Gene Demby, *The Truth Behind the Lies of the Original 'Welfare Queen,'* NPR (Dec. 20, 2013, 5:03 PM), https://www.npr.org/sections/codeswitch/2013/12/20/255819681/the-truth-behind-the-lies-of-the-original-welfare-queen.

[34] Gillian Brockell, *She Was Stereotyped as 'The Welfare Queen.' The Truth Was More Disturbing, a New Book Says*, WASH. POST (May 21, 2019), https://www.washingtonpost.com/history/2019/05/21/she-was-stereotyped-welfare-queen-truth-was-more-disturbing-new-book-says/.

[35] Demby, *supra* note 33.

[36] Earl L. Carter & Earl Blumenauer, *If Marijuana Remains a Schedule I Substance, We Can Never Do the Research Everyone Knows We Need*, NBC NEWS (Apr. 19, 2019, 10:10 AM), https://www.nbcnews.com/think/opinion/if-marijuana-remains-schedule-i-substance-we-can-never-do-ncna997231.

[37] Scott C. Martin, *A Brief History of Marijuana Law in America*, TIME (Apr. 20, 2016, 9:10 AM), https://time.com/4298038/marijuana-history-in-america/.

physician may "recommend" the use of marijuana for the treatment of "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."[38]

The Food and Drug Administration ("FDA") has "approved one cannabis-derived drug product: Epidiolex (cannabidiol), and three synthetic cannabis-related drug products: Marinol (dronabinol), Syndros (dronabinol), and Cesamet (nabilone)."[39] Yet, the approval process itself is heavily regulated and extremely difficult to pass. To gain approval to conduct clinical research, "researchers must obtain marijuana through the National Institute on Drug Abuse, which has notoriously denied [such] request[s] when researchers are running trials attempting to show the positive effects of the drug."[40]

The Drug Enforcement Agency ("DEA") also has the power to facilitate FDA-approved marijuana research, much to the frustration of scientists.[41] Currently, the only institution in the United States that can legally produce marijuana for research is the University of Mississippi, despite the fact that thirty-seven other institutions have applied in the past three years and the DEA has failed to consider them.[42] This cannabis monopolization has prompted doctors and health officials, rather than federal law enforcement, to oversee the regulation of cannabis research.[43] Realistically, it makes much more sense for doctors and health officials to oversee cannabis research than it does for the DEA, especially when considering the inherent conflict of interest that arises with the agency's mandate to enforce the federal prohibition

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[38] CAL. HEALTH & SAFETY CODE, HSC § 6.11362.5(b)(1)(A) (1996).

[39] *FDA and Cannabis: Research and Drug Approval Process*, FDA (Oct. 1, 2020), https://www.fda.gov/news-events/public-health-focus/fda-and-cannabis-research-and-drug-approval-process.

[40] Simmons, *supra* note 12, at 123.

[41] Paul Armentano, *Three Years Ago the DEA Said They Would Remove Roadblocks to Cannabis Research—They Still Haven't*, THE HILL (July 31, 2019), https://thehill.com/opinion/civil-rights/455493-three-years-ago-the-dea-said-they-would-remove-roadblocks-to-cannabis.

[42] Alexander Lekhtman, *Cannabis Industry Demands That The DEA Keep Out of Marijuana Research*, FILTERMAG (May 13, 2020), https://filtermag.org/dea-marijuana-research/.

[43] *Id.*

of marijuana."[44]

Currently, thirty-six states and the District of Columbia have legalized medical marijuana either through legislative or voter action.[45] Initiatives such as these typically create a legal exemption for patients and their primary care providers, but they have no bearing on federal law. As a result, those who possess and use marijuana for any purpose still risk prosecution by federal authorities.[46] Additionally, federal law prohibits marijuana users from receiving support from federal benefit programs.[47] Thus, even when states explicitly allow medicinal or recreational use of marijuana, cannabis users may be subject to punishment by both the criminal justice system and the federal administrative state.

C. *Comparative Demographics*

Before discussing the disparities within federal benefits programs, it is important to note the communities that are affected by such programs. In 2019, the United States Census Bureau reported that although Black Americans represented 13.2 percent of the total population in the United States, they comprised 23.8 percent of the poverty population.[48] Similarly, Hispanics comprised only 18.7 percent of the total population but 28.1 percent of the population in poverty.[49] In contrast, Non-Hispanic Whites made up approximately sixty percent of the total population, but only 41.6 percent of the population in poverty.[50] Notably, women were thirty-six percent more likely to live in

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[44] Lekhtman, *supra* note 42.

[45] *What Are Other States Doing? Frequently Asked Questions*, MEDICAL MARIJUANA 2020: MISSISSIPPIANS FOR COMPASSIONATE CARE, https://www.medicalmarijuana2020.com/what-are-other-states-doing (last visited Mar. 20, 2022).

[46] *See generally* Gonzalez v. Raich, 545 U.S. 1 (2005).

[47] Akoto, *supra* note 3, at 259.

[48] John Creamer, *Inequalities Persist Despite Decline in Poverty for all Major Race and Hispanic Origin Groups*, U.S. CENSUS BUREAU (Sept. 15, 2020), https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in2019.html#:~:text=In%202019%2C%20the%20share%20of,23.8%25%20of%20the%20poverty%20population.&text=Non%2DHispanic%20Whites%20made%20up,of%20the%20population%20in%20poverty.

[49] *Id.*

[50] *Id.*

poverty than men.[51]

As of May 2021, there were an estimated 5,461,491 medical marijuana patients in the United States.[52] Because of a lack of a national database, little is known about the growing population of medical marijuana patients.[53] However, a 2011 study assessing nine medical marijuana clinics and comparing their demographics to the California Census provides some insight.[54] This study found that seventy-five percent of medical marijuana patients are male[55] and sixty percent are white.[56] Notably, the study indicated that the underrepresentation of women may correlate with the "double stigma women face in seeking [medical marijuana]—for using an illicit drug and for violating gender-specific norms against illegal behavior in general."[57] Regarding race, Black Americans were overrepresented in the sample, even though national surveys show that "Blacks generally do not have significantly higher prevalence of marijuana use than Whites."[58] The study concluded that "[Black people] may be more likely to seek [medical marijuana] for any of several reasons: because they are disproportionately poor, more often lack health insurance, [or] are significantly less likely to be prescribed other medication for pain."[59]

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[51] Amanda Fins, *National Snapshot: Poverty Among Women & Families, 2019*, NAT'L WOMEN'S L. CTR. (Oct. 2019), https://nwlc.org/wp-content/uploads/2019/10/PovertySnapshot2019-2.pdf.

[52] *Medical Marijuana Patient Numbers*, MARIJUANA POLICY PROJECT (May 27, 2021), https://www.mpp.org/issues/medical-marijuana/state-by-state-medical-marijuana-laws/medical-marijuana-patient-numbers/.

[53] Craig Reinarman et al., *Who Are Medical Marijuana Patients? Population Characteristics from Nine California Assessment Clinics*, J. OF PSYCHOACTIVE DRUGS 43, 128 (2011), https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.966.3757&rep=rep1&type=pdf.

[54] *Id.* at 130.

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] *Id.* at 131.

[59] Craig Reinarman et al, *Who Are Medical Marijuana Patients? Population Characteristics from Nine California Assessment Clinics*, J. OF PSYCHOACTIVE DRUGS 43, 128 (2011), https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.966.3757&rep=rep1&type=pdf.

In contrast, white men tend to use other controlled substances, such as cocaine.[60] Cocaine use is reportedly on the rise,[61] and the Centers for Disease Control estimates that the number of overdose deaths involving cocaine almost doubled between 2014 and 2016.[62] Nearly six million Americans over the age of twelve admitted to using cocaine in 2017, with an average of one million people using cocaine for the first time each year.[63] Looking at gender, approximately 1.3 percent of all women reported using cocaine in 2016, compared with 2.5 percent of men.[64] Lastly, with regard to race, cocaine use is similar across different races with approximately 1.2–2 percent of each race reporting use.[65] Comparatively, that equates to approximately 3,362,000 white individuals compared to 612,000 Black citizens.[66] To date, there are no recorded instances of anyone dying as a result of a marijuana overdose.[67]

III. DISCRIMINATORY PRACTICES WITHIN FEDERAL BENEFITS PROGRAMS

A. *Federally Subsidized Housing*

The current federally subsidized housing program is dictated by the Housing and Community Development Act, enacted in 1974.[68] By 2017, there were over five million low-income

60 Laura Close, *Addiction Among Different Races in the U.S.*, SUNRISE HOUSE TREATMENT CTR. (March 10, 2022), https://sunrisehouse.com/addiction-demographics/different-races/.

61 William S. John, *Trends and Correlates of Cocaine Use and Cocaine Use Disorder in the United States from 2011 to 2015*, 180 DRUG AND ALCOHOL DEPENDENCE 376 (Nov. 1, 2017), https://www.sciencedirect.com/science/article/abs/pii/S0376871617304726?via%3Dihub.

62 Chloe Reichel, *Cocaine Use is on the Rise: Research Highlights Troubling Trends*, JOURNALIST RES. (May 28, 2019), https://journalistsresource.org/studies/society/public-health/cocaine-research-fentanyl-overdose/.

63 *Cocaine Statistics by Age, Gender, Ethnicity, and More*, VERTAVA HEALTH (Aug. 16, 2019), https://vertavahealth.com/cocaine/statistics/.

64 *Id.*

65 *Id.*

66 *Id.*

67 Nick Wing, *The Exhaustive List of Everyone Who's Died Of a Marijuana Overdose*, HUFFPOST (Aug. 29, 2018), https://www.huffpost.com/entry/marijuana-lethal-dose_n_58f4ec07e4b0b9e9848d6297.

68 Housing and Community Development Act of 1974, Pub. L. 93-383, 88 Stat.

households using some form of federal rental assistance in the U.S.[69] Eighty-nine percent of federally subsidized households include children, the elderly, or the disabled.[70] Nationally, the heads of households in all housing programs are fifty-one percent white and forty-four percent Black.[71] But "these statistics change drastically when looking at states with legal medical marijuana that have large minority populations in subsidized housing."[72] For example, in Florida, forty percent of household participants are white and fifty-nine percent are Black.[73] Though public housing is generally managed by the Department of Housing and Urban Development ("HUD"), local public housing authorities ("PHAs") manage tenants with federal guidance. PHAs are issued federal funding by HUD and are "responsible for the management and operation of [their] local public housing program."[74]

One major program is the Housing Choice Voucher Program, commonly referred to as "Section 8 housing."[75] Section 8 housing allows eligible voucher holders to select their own choice of housing, so long as it meets the requirements of the program.[76] Once a voucher holder selects adequate housing, the PHA pays a housing subsidy directly to the landlord on behalf of the family.[77] The family then pays the difference between the rent charged by the landlord and the amount subsidized by the voucher, which is

633 (codified at 42 U.S.C. § 1437f (2018)).

69 *United States Fact Sheet: Federal Rental Assistance*, CTR. ON BUDGET & POL'Y PRIORITIES (Mar. 30, 2017), https://www.cbpp.org/sites/default/files/atoms/files/4-13-11hous-US.pdf.

70 *Id.*

71 *Resident Characteristics Report (RCR)*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/program_offices/public_indian_housing/systems/pic/50058/rcr (Select "All Relevant Programs," then select "National," and then select "Race/Ethnicity").

72 Simmons, *supra* note 12, at 128.

73 *Resident Characteristics Report (RCR)*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/program_offices/public_indian_housing/systems/pic/50058/rcr (Select program type as "All Relevant Programs," select level of information as "State," select "Florida," then select "Race/Ethnicity").

74 Simmons, *supra* note 12, at 124 (citing *HUD's Public Housing Program*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/topics/rental_assistance/phprog).

75 *Housing Choice Vouchers Fact Sheet*, HUD.GOV, https://www.hud.gov/topics/housing_choice_voucher_program_section_8 (last accessed Mar. 1, 2022).

76 *Id.*

77 *Id.*

typically thirty-to-forty percent of their monthly adjusted gross income.[78] Notably, voucher holders are not limited to units located in subsidized housing projects.[79]

Section 8 housing is distinguished from HUD's traditional public housing program in which the government owns the housing units, inasmuch as Section 8 housing is owned by private landowners.[80] Approximately two million residents live in traditional public housing units, whereas approximately 4.7 million residents live in Section 8 housing.[81] "More than half of these Section 8 households have a head or a spouse who is an elderly adult or a person with disabilities."[82]

"[M]edical marijuana patients are often unable to work due to their underlying condition, which forces them to rely on social safety nets such as disability and subsidized housing."[83] Disabled individuals who use medical marijuana as part of their treatment are precluded from public housing assistance. In the same year that Congress added protection against disability discrimination to the Fair Housing Act of 1988, it also specifically connected federal subsidies for housing to leasing provisions that permit landlords to evict tenants for illegal drug use involving themselves or others living in or visiting their homes.[84] The statute defines disability specifically to exclude "current, illegal use of or addiction to a controlled substance."[85] Under current federal guidelines, this includes marijuana.

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78 *Id.*

79 *Id.*

80 *See HUD's Public Housing Program*, HUD.GOV, https://www.hud.gov/topics/rental_assistance/phprog.

81 Leslie Francis, *Illegal Substance Abuse and Protection from Discrimination in Housing and Employment: Reversing the Exclusion of Illegal Substance Abuse as a Disability*, 19 UTAH L. REV. 891, 896 (2019).

82 *Id.*

83 Simmons, *supra* note 12, at 129.

84 Francis, *supra* note 81, at 893.

85 42 U.S.C. § 3602(h).

Subsidized housing regulations preclude marijuana users for a variety of other reasons, including a criminal record[86] or a history of alcohol or drug use.[87] Further, HUD grants broad discretion to PHAs and landlords to "create more severe restrictions."[88] These restrictions essentially "define those with alcohol, drug, or criminal histories as categorically undeserving" of housing assistance, which "undermines other important public policy goals" to support these individuals.[89] Thus, although many recipients of medical marijuana reside in federally subsidized housing,[90] medical marijuana patients are frequently denied access to and evicted from these programs as a result of federal regulations.[91]

Although marijuana is still considered a restricted substance, federal guidance to PHAs on how to manage medical marijuana applicants and tenants constantly changes, often resulting in confusion and contradiction. In 2011, HUD provided a memorandum to PHAs instructing them to deny all Section 8 housing applicants who used marijuana for any reason.[92] In 2014, an Obama Administration memo instructed landlords and PHAs to continue rejecting all applicants using medical marijuana and to establish policies allowing termination of tenancy for households with medical marijuana patients.[93] Notably, the memo

86 Elayne Weiss, *Housing Access for People with Criminal Records*, NAT'L LOW INCOME HOUS. COAL., 6–21 (2017), http://nlihc.org/sites/default/files/AG-2017/2017AG_Ch06-S06_Housing-Access-Criminal-Records.pdf.

87 Marah A. Curtis et al., *Alcohol, Drug, and Criminal History Restrictions in Public Housing*, 15(3) CITYSCAPE: J. POL'Y DEV. & RSCH. 37, 38 (2013), https://www.huduser.gov/portal/periodicals/cityscpe/vol15num3/ch2.pdf.

88 *Id.* at 38, 46 (noting three other common reasons for bans including "neighbor disturbance," "disorderly house," and "incarceration").

89 *Id.* at 38.

90 *See generally* Matthew Koehler, *Cannabis May Be Legal in the District, But Not in Federally-Subsidized Homes*, GGWASH (Nov. 8, 2017), https://ggwash.org/view/65484/cannabis-may-be-legal-in-the-district-but-not-in-government-subsidized-homes (explaining that federally subsidized housing is "often a final option for people in financial straits, 'You may get sick and lose your job, your house, and this is where you end up.'").

91 Simmons, *supra* note 12, at 124–25.

92 Memorandum from Sandra B. Henriquex, Assistant Sec'y, Pub. & Indian Hous., on Medical Marijuana Use in Public Housing and Housing Choice Voucher Programs to All Field Offices & Pub. Hous. of U.S. Dep't Hous. & Urban Dev. (Feb. 10, 2011), https://www.hud.gov/sites/documents/MED-MARIJUANA.PDF.

93 Memorandum from Benjamin T. Metcalf, Deputy Assistant Sec'y, Multifamily Hous. Programs, on Use of Marijuana in Multifamily Assisted Properties to

specified that landlords and PHAs may exercise their own discretion for terminating tenancy in these latter situations.[94] Thus, while HUD does not require that landlords automatically evict tenants who are in violation of these policies, the agency does provide landlords with discretion to decide whether to take action on a case-by-case basis.[95]

B. *SNAP Medical Deductions and TANF Restrictions*

The Supplemental Nutrition Assistance Program ("SNAP") is administered by the United States Department of Agriculture's Food and Nutrition Service ("USDA-FNS").[96] SNAP provides benefits that help supplement low-income families' food purchasing power, commonly referred to as food stamps.[97] In 2015, SNAP had an "average monthly participation of approximately 45.8 million individuals in 22.5 million households."[98] To qualify, "households must meet a gross income test . . . , net income test . . . and have liquid assets under $2,000."[99] Critically, households with elderly or disabled members do not have to meet the gross income test and may have assets up to $3,250.[100]

Under the current SNAP program, participants are barred from claiming deductions for their medical marijuana.[101] Previously, a number of states allowed elderly or disabled households to deduct the cost of medicinal marijuana from their income for SNAP purposes.[102] In Oregon, elderly or permanently disabled Oregonians who qualified for Social Security Disability

Multifamily Directors of U.S. Dep't Hous. & Urban Dev. (Dec. 29, 2014), https://www.hud.gov/sites/documents/USEOFMARIJINMFASSISTPROPTY.PDF.

94 *Id.*

95 Simmons, *supra* note 12, at 126.

96 MAGGIE MCCARTY, ET AL., CONG. RSCH. SERV., R42394, DRUG TESTING AND CRIME-RELATED RESTRICTIONS IN TANF, SNAP, AND HOUSING ASSISTANCE 5, 6 (2016) [hereinafter MCCARTY].

97 *Id.* at 5.

98 *Id.*

99 *Id.*

100 *Id.*

101 Judson Berger, *USDA Draws the Line on Food Stamps, Rules Against Medical Marijuana Deductions*, FOX NEWS (Dec. 23, 2015), https://www.foxnews.com/politics/usda-draws-the-line-on-food-stamps-rules-against-medical-marijuana-deductions.

102 *Id.*

Insurance could claim the deductions.[103] In 2012, Lizbeth Silbermann, then-Director of the USDA-FNS program development division, obliterated this exception by issuing a memo stating: "States that currently allow for the deduction of medical marijuana must cease this practice immediately and make any necessary corrections to their state policy manuals and instructions."[104] In 2014, the USDA-FNS amended the SNAP regulations to codify certain nondiscretionary provisions of the Agricultural Act of 2014.[105] The amendment excludes medical marijuana from being treated as an allowable medical expense for the purposes of determining the excess medical expense deduction under SNAP.[106] It states, in pertinent part: "SNAP is a Federal program and must conform to Federal law regarding illegal substances. Therefore, marijuana and other Schedule I controlled substances are not allowable medical expenses under SNAP."[107]

The potential use of a similar program, Temporary Assistance for Needy Families ("TANF"), to purchase marijuana has raised some concerns in Congress.[108] TANF benefits are typically paid onto a debit card that can be used to directly make purchases or withdraw cash.[109] The TANF program "predominately serves families with children headed by an able-bodied adult of working age,"[110] many of which are comprised of single-mother households.[111] The program generally serves "the poorest of families with children" because its state-determined income eligibility standards are typically lower than the federal standard

103 Noelle Crombie, *Oregon Kills Medical Marijuana Deduction for Food Stamp Applicants*, OREGON LIVE (Jul. 12, 2012, 1:31 AM), https://www.oregonlive.com/pacific-northwest-news/2012/07/oregon_kills_medical_marijuana.html.

104 *Id.*

105 FED. REG., SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP): AGRIC. ACT OF 2014 NONDISCRETIONARY PROVISIONS (Sept. 3, 2015), https://www.federalregister.gov/documents/2015/09/03/2015-21906/supplemental-nutrition-assistance-program-snap-agricultural-act-of-2014-nondiscretionary-provisions.

106 *Id.*

107 *Id.*

108 McCarty, *supra* note 96, at 25.

109 McCarty, *supra* note 96, at 25.

110 McCarty, *supra* note 96, at 27.

111 McCarty, *supra* note 96, at 4.

used for SNAP and federal housing.[112]

TANF has been the subject of much debate since its creation.[113] In 1996, President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA"), which ended the cash assistance entitlement and created TANF.[114] Critics argue that TANF assumes that "almost everyone who is willing to search for a job will get hired and be able to attain self-sufficiency."[115] This assumption ignores how changes in employer demands for less-skilled workers have made it difficult for TANF recipients to both obtain and retain employment.[116] Additionally, the program disproportionately impacts the typical TANF recipient: young, single mothers who are more likely to be less educated and have more children than their male counterparts.[117] Other factors, "such as physical and mental health, alcohol and drug problems, experiences of domestic violence, and other personal problems . . . are likely to be more common among [mothers enrolled in TANF] than among other women."[118] Another damaging provision of TANF concerns the sanctions applied against participants who are unable to comply with the work requirements and other rules.[119] Studies show that women who have left TANF due to sanctions are less likely to have jobs, less educated, and in poorer health than those who stay in the program.[120] Thus, it is likely that "sanctioning may often occur among women who are the most disadvantaged and have the greatest number of difficulties with work."[121]

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112 McCarty, *supra* note 96, at 27.

113 *See generally* Sheldon Danziger, *Welfare Reform Policy From Nixon to Clinton: What Role for Social Science?*, Prepared for Conference, "The Social Sciences and Policy Making," INST. FOR SOC. RSCH., U. MICH., Mar. 13–14, 1998, http://citeseerx.ist.psu.edu/viewdoc/download;jsessionid=C69C59DBA67F073F137D3A7C4FA33F7C?doi=10.1.1.529.3457&rep=rep1&type=pdf.

114 *Id.* at 2.

115 *Id.*

116 *Id.* at 28.

117 *Id.* at 30.

118 *Id.* at 33.

119 Robert A. Moffitt, *From Welfare to Work: What the Evidence Shows*, BROOKINGS (Jan. 2, 2002), https://www.brookings.edu/research/from-welfare-to-work-what-the-evidence-shows/.

120 *Id.*

121 *Id.*

With regard to marijuana, PRWORA gave states the option of requiring drug tests for TANF recipients.[122] At least thirteen states require some form of drug testing or screening for TANF benefits.[123] Although the states spent more than two hundred thousand dollars on drug screening in 2018, the data show that less than one percent of applicants were rejected from TANF for drugs.[124] Regarding states that have legalized medicinal marijuana, Missouri's approach may be instructive for resolving the inherent conflict between drug screening a substance that is legal at the state level but illegal under federal law. In 2019, the Missouri Department of Social Services announced that "[a]s long as a patient receiving TANF benefits has a medical marijuana card, there will be no risk of endangering the assistance, should they test positive for medical marijuana."[125]

The PRWORA also barred states from providing TANF assistance to persons convicted of a felony for possession, use, or distribution of illegal drugs.[126] This is problematic for state law-abiding marijuana users who have been convicted of federal cannabis-related crimes. However, states can opt out or modify the ban by enacting laws to the contrary.[127] As of 2016, most states have either opted out of or adjusted the drug felony ban, and only ten states have preserved the lifetime disqualification.[128] This suggests that most states are not in favor of punishing low-income individuals for prior drug offenses.

In recent years, Congress has addressed the issue of allowing TANF benefits to be used for marijuana expenses. In 2014, the House passed the Preserving Welfare for Needs Not Weed Act, which prohibited TANF recipients from electronically accessing their benefits in marijuana dispensaries and refused to distinguish

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122 McCarty, *supra* note 96, at 7.

123 Amanda M. Gomez & Josh Israel, *What 13 States Discovered After Spending Hundreds of Thousands Drug Testing the Poor*, THINK PROGRESS (Apr. 26, 2019, 11:59 AM), https://archive.thinkprogress.org/states-cost-drug-screening-testing-tanf-applicants-welfare-2018-results-data-0fe9649fa0f8/.

124 *Id.*

125 *Medical Marijuana Use Will Not Endanger State Social Services*, GREENWAY: THE MISS. CANNABIS INDUS. MAG. (Oct. 3, 2019), https://mogreenway.com/2019/10/03/medical-marijuana-use-will-not-endanger-state-social-services/.

126 McCarty, *supra* note 96, at 8.

127 McCarty, *supra* note 96, at 8.

128 McCarty, *supra* note 96, at 8–9.

between recreational and medical use of marijuana.[129] At that time, the bill was not considered by the Senate. It was reintroduced to Congress in 2015, and then again in 2018.[130] While none of these bills have been enacted into law,[131] they hold the potential of being passed in the future.

C. *Medicaid Beneficiaries and the Opioid Epidemic*

Proponents of cannabis reform also argue that the substance can alleviate the opioid epidemic by providing a natural alternative to chronic pain medication. A history of overprescribing opioids paired with a failure to effectively "effectively implement and monitor pharmaceutical therapies in patients" places Medicaid beneficiaries at high risk of developing an opioid addiction.[132] Recent studies indicate that medical marijuana can alleviate chronic pain and that it may be an appropriate alternative to opioids, without the risk of addiction or overdose.[133] In 2019, an estimated 10.1 million Americans aged twelve or older misused opioid prescriptions,[134] and approximately 2.1 million currently have an opioid use disorder.[135] Further, Medicaid beneficiaries have higher rates of opioid use disorder, which comprises twenty-five percent of the overall opioid use disorder population.[136] Critically, the rate of prescription overdose deaths of Medicaid beneficiaries is eight times higher than the average user.[137] Moreover, these beneficiaries tend to have higher

129 Preserving Welfare for Needs Not Weed Act, H.R. 4137, 113th Cong. (2014), https://www.gop.gov/bill/h-r-4137-preserving-welfare-for-needs-not-weed-act/ (last accessed Mar. 20, 2022).

130 Preserving Welfare for Needs Not Weed Act, H.R. 3010, 114th Cong. (2015), https://www.govtrack.us/congress/bills/114/hr3010 (last accessed Mar. 20, 2022).

131 Preserving Welfare for Needs Not Weed Act, H.R. 5853, 115th Cong. (2018), https://www.govtrack.us/congress/bills/115/hr5853 (last accessed Mar. 20, 2022).

132 Alesandra Hlaing, *Medical Marijuana Access for Medicaid Populations*, 28 ANN. HEALTH L. ADVANCE DIRECTIVES 115, 115 (2018).

133 *Id.*

134 Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., 24 (2020).

135 Nathan Yerby, *Statistics on Addiction in America*, Addiction Center (Nov. 24, 2020), https://www.addictioncenter.com/addiction/addiction-statistics/.

136 Hlaing, *supra* note 132, at 117.

137 Hlaing, *supra* note 132, at 117–18.

rates of mental health and substance abuse disorders, and they will likely be treated for pain management.[138]

Immutable characteristics, such as gender and race, are also known risk factors for opioid use disorders.[139] With regard to gender, women are more likely than men to experience chronic pain and are therefore more likely to be prescribed opioid medications.[140] Moreover, recent studies show that sixty-five percent of total opioid prescriptions are issued to women, and forty percent more women than men become persistent opioid users following surgery.[141] Notably, people of color are less likely to be prescribed opioids, due in large part to prescriber bias.[142] For Black women, prescriber bias means that patients are "perceived as not being knowledgeable about their bodies, that they are difficult to deal with, that they don't have insurance, and that they have higher levels of pain tolerance."[143] As a result, "Black people are chronically undertreated for pain."[144]

Studies show a correlation between medical marijuana laws and the reduction of opioid prescribing rates.[145] Despite the positive effect that medicinal marijuana may have on reducing the opioid epidemic, its classification as a Schedule I substance prohibits federally funded health insurers, such as Medicaid, from paying for or reimbursing the cost of its use.[146] Doctors within the Medicaid network must certify that they are in compliance with

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138 Hlaing, *supra* note 132, at 118.

139 *How Opioid Addiction Occurs*, MAYO CLINIC (Feb. 16, 2018), https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/how-opioid-addiction-occurs/art-20360372.

140 *Opioids and Women: From Prescription to Addiction*, NAT'L WOMEN'S HEALTH NETWORK (May 2018), https://nwhn.org/prescription-addiction-opioid-epidemic/#:~:text=Women%20and%20Opioids,persistent%20opioid%20users%20following%20surgery.

141 *Id.*

142 *Id.*

143 Vidya Rao, *What is Implicit Bias? The Invisible Racism That Makes Black Women Dread the Doctor's Office*, TODAY (Aug. 13, 2020), https://www.today.com/health/what-implicit-bias-invisible-racism-hurts-black-women-doctor-s-t189105.

144 *Id.*

145 Stanford Chihuri & Guohua Li, *State Marijuana Laws and Opioid Overdose Mortality*, INJURY EPIDEMIOLOGY 1, 9 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6717967/.

146 James G. Hodge, Jr., Walter G. Johnson, & Drew Hensley, *From Opioids to Marijuana: Out of the Tunnel and Into the Fog*, 67 U. KAN. L. REV. 879, 898 (2019).

state and federal law when billing for services.[147] This means that Medicaid beneficiaries are prohibited federally from purchasing medical marijuana.[148] Thus, because Medicaid doctors cannot refer or prescribe medical marijuana to their patients, these patients must see an out-of-network physician to receive a prescription.[149] This can cost anywhere from one hundred dollars to four hundred fifty dollars for the initial appointment alone, which insurance is unlikely to cover.[150] Unless marijuana is rescheduled, Medicaid populations have virtually no way to reasonably access cannabis for pain treatment.[151]

IV. COVID-19 AND THE PROMISE OF THE MORE ACT

A. *The Pandemic's Effect on Food, Housing, and Employment Hardships*

The novel coronavirus ("COVID-19") outbreak of 2020 is estimated to push an additional 198 million people worldwide into extreme poverty by the end of 2022.[152] In the United States, this means that Black, Latino, Indigenous, and immigrant households face particularly prevalent inequities in employment, housing, and health care.[153] Before the pandemic, the monthly poverty rate for white individuals was eleven percent, while the monthly poverty rate for Black and Hispanic individuals was twenty-four percent.[154]

147 Hlaing, *supra* note 132, at 121.

148 Hlaing, *supra* note 132, at 121.

149 Hlaing, *supra* note 132, at 121.

150 Hlaing, *supra* note 132, at 121.

151 Hlaing, *supra* note 132, at 121–22.

152 OXFAM International, *"Terrifying Prospect" of Over a Quarter of a Billion more People Crashing into Extreme Levels of Poverty and Suffering This Year*, (April 12, 2022), https://www.oxfam.org/en/press-releases/terrifying-prospect-over-quarter-billion-more-people-crashing-extreme-levels-poverty; *see also* The World Bank, *COVID-19 to Add as Many as 150 Million Extreme Poor by 2021*, (Oct. 7, 2020), https://www.worldbank.org/en/news/press-release/2020/10/07/COVID-19-to-add-as-many-as-150-million-extreme-poor-by-2021#:~:text=The%20COVID%2D19%20pandemic%20is,severity%20of%20the%20economic%20contraction.

153 *Tracking the COVID-19 Recession's Effects on Food, Housing, and Employment Hardships*, CTR. ON BUDGET AND POL'Y PRIORITIES, (Feb. 24, 2021), https://www.cbpp.org/sites/default/files/atoms/files/8-13-20pov.pdf.

154 Priyanka Boghani, *How COVID Has Impacted Poverty in America*, PBS: FRONTLINE (Dec. 8, 2020), https://www.pbs.org/wgbh/frontline/article/COVID-

In August 2020, that rate increased to 12.3% for White people, 26.3% for Black people, and 26.9% for Hispanic people.[155] Racial and ethnic minorities are more likely to have lost their jobs during the pandemic and less likely to be allowed to work from home than their white counterparts.[156]

Perhaps even more devastating than the loss of employment is the pandemic's impact on homelessness. The nation has already seen a rise in homelessness for the past four years.[157] Over 580,000 citizens were homeless as of January 2020, and the pandemic has exacerbated that number in unimaginable ways.[158] Similar to employment loss, a disproportionate share of those experiencing homelessness were either Black, Hispanic, or Latino.[159] Current reports indicate that more than six hundred thousand individuals may be added to the current number by 2023 due to the pandemic.[160]

Regarding food insecurity, the numbers are even more humbling. Food insecurity is defined as "limited or uncertain access to sufficient, nutritious food for an active, healthy life."[161] Before COVID-19, food insecurity was the lowest since the Great Recession, yet still included more than thirty-five million food-insecure citizens.[162] Experts estimate this number soared to fifty-

poverty-america/.

155 *Id.*

156 *Id.*

157 Pam Fessler, *HUD: Growth of Homelessness During 2020 was 'Devastating,' Even Before the Pandemic*, NPR (Mar. 18, 2021), https://www.npr.org/2021/03/18/978244891/hud-growth-of-homelessness-during-2020-was-devastating-even-before-the-pandemic.

158 *Id.* (statement from HUD Secretary Marcia Fudge signaling that the numbers were "devastating" and that the pandemic "has only made the homelessness crisis worse").

159 *Id.* (2020 report citing that thirty-nine percent of the homeless population were Black and twenty-three percent identified as Hispanic or Latino).

160 Jacob Passy, *COVID-19 Will Cause Twice As Much Homelessness As Great Recession, Researchers Say*, MARKET WATCH (Jan. 25, 2021), https://www.marketwatch.com/story/COVID-19-will-cause-twice-as-much-homelessness-as-great-recession-study-finds-11610482333.

161 Julia A. Wolfson & Cindy W. Leung, *Food Insecurity During COVID-19: An Acute Crisis With Long-Term Health Implications*, 110 AM. J. PUB. HEALTH 1763, 1763–65 (Dec. 1, 2020), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2020.305953.

162 Bridget Balch, *54 Million People in America Face Food Insecurity During the Pandemic. It Could Have Dire Consequences for Their Health*, ASS'N AM. MED. C.

four million people because of the pandemic.[163] SNAP expanded its caseload by over six million more participants in 2020 to accommodate this need.[164] Just as with the impact on unemployment and homelessness, low-income Americans and people of color were the most at risk for food insecurity during the pandemic.[165]

The pandemic's impact on mental health and other ailments that would be eligible for medical marijuana is especially relevant here. Understandably, the stress associated with the pandemic has exacerbated and increased mental health issues like depression, anxiety, and suicidal thoughts.[166] According to a study conducted by the Journal of Addictive Diseases,[167] medical marijuana users with mental health conditions increased their cannabis use on average by ninety-one percent.[168] With regard to physical health issues, medical cannabis patients are the most vulnerable cannabis consumers and the most at risk of serious complications from COVID-19.[169] Critically, while experts continue to explore the long-term health impacts that COVID-19 may have upon patients, the most commonly reported long-term symptoms overlap with many of the qualifying ailments that may qualify for medical

(Oct. 15, 2020), https://www.aamc.org/news-insights/54-million-people-america-face-food-insecurity-during-pandemic-it-could-have-dire-consequences-their; Monica Hake et. al., *The Impact of the Coronavirus on Food Insecurity in 2020 & 2021*, FEEDING AM. (Mar. 2021), https://www.feedingamerica.org/sites/default/files/2021-03/National%20Projections%20Brief_3.9.2021_0.pdf.

163 Balch, *supra* note 162.

164 Wolfson & Leung, *supra* note 161, at 1763.

165 Wolfson & Leung, *supra* note 161, at 1763.

166 Emily Earlenbaugh, *Medical Cannabis Use for Mental Health Increased During COVID-19 Pandemic, Study Finds*, FORBES (Sep. 25, 2020), https://www.forbes.com/sites/emilyearlenbaugh/2020/09/25/medical-cannabis-use-for-mental-health-increased-during-COVID-19-pandemic-study-finds/?sh=6da664266d3f.

167 *See generally* Denise C. Vidot, et. al., *The COVID-19 Cannabis Health Study: Results From An Epidemiologic Assessment of Adults Who Use Cannabis for Medicinal Reasons in the United States*, 39 J. ADDICTIVE DISEASES 26 (2020), https://doi.org/10.1080/10550887.2020.1811455.

168 Earlenbaugh, *supra* note 166.

169 Kris Krane, *How The Coronavirus Pandemic Will Affect The Cannabis Industry*, FORBES (Mar. 18, 2020), https://www.forbes.com/sites/kriskrane/2020/03/18/how-the-coronavirus-pandemic-will-affect-the-cannabis-industry/?sh=77a69ebd5adf.

marijuana use.[170] Thus, the pandemic will likely cause a surge in applications for medical marijuana use for both physical and mental health issues.[171]

B. *The MORE Act*

On December 4, 2020, the House of Representatives passed the first comprehensive marijuana decriminalization legislation since drug prohibition in 1970.[172] Heralded by Democrats as "an important racial justice measure," the MORE Act sought to repair the damages inflicted on primarily poor and minority communities who suffer disproportionate consequences as a result of bias in cannabis-related arrests and convictions.[173] At the time of its passing, the bill seemed likely to fail in the Republican-controlled Senate.[174] As the nation transitions further into the Biden Administration, so does the promise of progress for marijuana legislation.[175] During the late 1900s, Biden supported the War on Drugs.[176] In 2020, then-candidate Biden announced support for marijuana decriminalization and "said he would

[170] *Compare* Center for Disease Control and Prevention, *Long-Term Effects*, https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects.html (last updated Nov. 13, 2020) (listing long-term symptoms of COVID-19) *with* Leafly, *Medical Marijuana Laws in the United States: Common Qualifying Conditions*, https://www.leafly.com/learn/legalization/medical-states#qualifying-conditions (last accessed Mar. 20, 2022) (listing common qualifying conditions that are approved for medical marijuana use).

[171] *See* Zeninjor Enwemeka, *More People Are Seeking Medical Marijuana Cards Amid Coronavirus Outbreak*, WBUR (Apr. 03, 2020), https://www.wbur.org/bostonomix/2020/04/03/medical-marijuana-applications-increase-coronavirus-outbreak; Brad Dress, *More turning to medical marijuana during pandemic*, KENT CNTY. NEWS (Jan. 27, 2021), https://www.myeasternshoremd.com/kent_county_news/community/news/more-turning-to-medical-marijuana-during-pandemic/article_46532e68-86b3-5075-8e9b-7b1947a7d37c.html.

[172] Stracqualursi & Dezenski, *supra* note 6.

[173] Deirdre Walsh, *House Approves Decriminalizing Marijuana; Bill to Stall in Senate*, NPR, (Dec. 4, 2020), https://www.npr.org/2020/12/04/942949288/house-approves-decriminalizing-marijuana-bill-to-stall-in-senate.

[174] *Id.*

[175] Steve Rolles (@SteveTransform), TWITTER (Jan. 06, 2021, 10:45 AM), https://twitter.com/SteveTransform/status/1346845242239180802.

[176] Kim Lyons, *Will Democrats Keep Their Promise to Decriminalize Marijuana?*, THE VERGE, (Feb. 1, 2021), https://www.theverge.com/2021/2/1/22243311/democrats-biden-marijuana-policy-reschedule-drug.

'reschedule cannabis as a Schedule II drug so researchers can study its positive and negative impacts.'"[177] Vice-President Kamala Harris has echoed this sentiment and has added that she supports the expungement of past marijuana-related convictions.[178] Despite the pro-cannabis stance from the Executive Branch, it is unclear what that timeline might look like as the bill has yet to be reintroduced to Congress.[179]

The de-scheduling of cannabis is the most significant provision of the MORE Act.[180] The de-scheduling provision effectively resolves the existing conflict between state-level marijuana legalization and federal prohibition by turning the substance's legal status over to the individual states.[181] Additionally, this provision eliminates criminal penalties for manufacturing, distributing, or possessing marijuana. This decriminalization provision would not legalize marijuana throughout the nation—each state's legislative body is to determine whether to legalize the substance.

The MORE Act also makes several other changes that would help improve current information gaps concerning the cannabis industry. For example, one provision requires the Bureau of Labor Statistics to "regularly compile, maintain, and make public data" on the demographics of cannabis business owners and employees; this includes data on age, disability status, educational level, race, and ethnicity, veteran status, and sex.[182] Another provision directs the Government Accountability Office to study the societal impact of cannabis legalization, including its impact on federal welfare assistance applications and uses of marijuana for medicinal purposes.[183] These provisions are relevant because they could fill knowledge gaps about marijuana and its effects on

177 *Id.*

178 *Id.*

179 Rosalie L. Pacula, *Legalizing Marijuana, Once a Pipe Dream on Capitol Hill, Takes an Important Step Forward*, THE CONVERSATION, (Jan. 6, 2020), https://theconversation.com/legalizing-marijuana-once-a-pipe-dream-on-capitol-hill-takes-an-important-step-forward-152365.

180 H.R. 3884, 116th Cong. *supra* note 5, § 3(a).

181 Paul Armentano, *Four Reasons Why the MORE Act Vote Is a Really Big Deal,* NORML, (Sept. 10, 2020), https://norml.org/blog/2020/09/10/four-reasons-why-the-more-act-vote-is-a-really-big-deal/.

182 H.R. 3884, 116th Cong. *supra* note 5, at § 4.

183 H.R. 3884, 116th Cong. *supra* note 5, at § 15.

commerce, communities, and individuals.

The MORE Act also includes several provisions that directly resolve or improve eligibility issues around federal benefit programs. For example, Section 8 of the Act prohibits the denial of federal public benefits to a person "on the basis of any use or possession of cannabis, or on the basis of a conviction or adjudication of juvenile delinquency for a cannabis offense."[184] Similarly, Section 9 prohibits the denial of benefits and protections under immigration laws for any conduct or convictions due to marijuana.[185] These provisions ensure that individuals are no longer precluded from receiving federal benefits or immigration protection for conduct or convictions on the basis of marijuana, even if the individual lives in a state that continues to criminalize the substance.

The Act also addresses prior convictions. Section 10 establishes a process to expunge convictions and conduct sentencing review hearings for federal cannabis offenses.[186] While it would be unconstitutional for the Act to expunge convictions for state cannabis offenses, the Act's passage would allow states to draft their own expungement legislation. Finally, the Act acknowledges the damage caused by the War on Drugs and seeks to recompense individuals and communities. For example, Section 9512 of the Act establishes a trust fund to support various programs and services for individuals and businesses in communities impacted by the War on Drugs[187] and ensures continued funding of the trust fund by imposing a five percent tax on cannabis products deposited into the fund.[188]

Over 130 organizations currently support the Act, including the ACLU, the National Association of Social Workers, and the National Association of Criminal Defense Lawyers.[189] Despite such widespread support, the Act also faces opposition from several

184 H.R. 3884, 116th Cong. *supra* note 5, at § 8.

185 H.R. 3884, 116th Cong. *supra* note 5, at § 9.

186 H.R. 3884, 116th Cong. *supra* note 5, at § 10.

187 H.R. 3884, 116th Cong. *supra* note 5, at § 5.

188 H.R. 3884, 116th Cong. *supra* note 5, at § 5.

189 Press Release, House Committee on the Judiciary Chairman Jerrold Nadler, *What They Are Saying About the MORE Act*, (Dec. 4, 2020), https://judiciary.house.gov/news/documentsingle.aspx?DocumentID=3468.

organizations, including pro-cannabis organizations.[190] For example, Weed for Warriors, an organization that seeks to enhance access to medical marijuana for veterans, has raised concerns that the bill's passage will have drastic unintended consequences, including the addition of another layer of taxes on cannabis businesses.[191] According to the CEO of the organization, "state taxes on cannabis are already so high that many people, particularly disabled vets and other medical marijuana patients with limited incomes, have no access to legal [marijuana] and are forced to resort to unregulated sources."[192]

Another relevant concern involves a clause that states that prior felony marijuana convictions can be weighed against individuals during the application process to obtain a federal cannabis business permit.[193] This is considered problematic because it "cuts at the foundations of [the] bill and the principles that have guided the advocacy that moved [the] bill along."[194] Moreover, even if the federal government enacted the Act into law, a tremendous amount of regulatory work lies ahead.[195] For example, "[s]tates, banking authorities, the FDA and other regulators will have to put in place statutes and regulations to govern the industry."[196] Previous states that have legalized marijuana tend to show a timeline of six months to two years to create such a regulatory framework, and these entities would also face the added challenge of anticipating preemption concerns.[197]

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190 A.J. Herrington, *Some Cannabis Activists Are Urging Congress To Vote 'No' on the MORE Act*, FORBES, (Dec. 1, 2020), https://www.forbes.com/sites/ajherrington/2020/12/01/some-cannabis-activists-are-urging-congress-to-vote-no-on-the-more-act/?sh=329906e94005.

191 *Id.*

192 *Id.*

193 Lucy Geng, *How Some Problematic Provisions Got Added to the Historic MORE Act*, FILTER MAG, (Dec. 22, 2020), https://filtermag.org/problematic-provisions-more-act/.

194 *Id.*

195 Stanley S. Jutkowitz, *The House Passes the More Act and the Medical Marijuana Research Act. Will it Matter?*, Lexology: THE BLUNT TRUTH, (Dec. 15, 2020), https://www.lexology.com/library/detail.aspx?g=c80db304-3a6a-4a38-a537-c2967da56a91.

196 *Id.*

197 ACLU, *Cannabis Legalization: What it Means for You and Your Rights*, ACLU-NJ.Org, https://www.aclu-nj.org/en/know-your-rights/cannabis-legalization-what-it-means-you-and-your-rights (last accessed Aug. 6, 2022).

V. CONCLUSIONS AND RECOMMENDATIONS

The criminalization of marijuana can be directly tied to racist and discriminatory initiatives throughout history. From the Mexican Migration to the War on Drugs, the federal government has purposefully used marijuana to demonize minorities and impoverished communities. Simultaneously, the government has stigmatized the use of federal benefits programs by those very same communities, classifying beneficiaries as lazy, uneducated, unmotivated, and unproductive. These harmful stereotypes deter citizens from receiving the help that they need and cast them into the lowest caste of society. Indeed, wherever there is poverty discrimination, there are disparate impacts on subgroups that are more likely to be eligible for federal benefit programs.

As previously explained, there is a significant overlap between at-risk minority individuals who qualify for federal benefit programs and individuals who qualify for medical marijuana use. Like federal benefit recipients, medical marijuana patients are often comprised of low-income, disabled, at-risk minority groups. As a result, single mothers, elderly individuals with disabilities, and people of color are most likely to be affected by the federal marijuana prohibition. These otherwise-qualified applicants are restricted or completely disqualified from federal benefits programs based on their medicinal marijuana use, despite their actions being entirely legal and legitimate within their state.

While states can circumvent the federal prohibition through decriminalization and legalization of cannabis, it is more difficult to navigate the regulatory obstacles that inhibit or preclude citizens from receiving their benefits. Of significant importance is marijuana-related convictions, which disproportionately harm the Black community and preclude individuals from receiving federal benefits. This preclusion is not insubstantial—indeed, these restrictions can cost citizens access to housing, food, and TANF benefits. Further, it deprives disabled individuals of an alternative form of medical treatment and reinforces the opioid epidemic, which disproportionately harms individuals enrolled in Medicare.

The MORE Act is the most promising legislation to date, but it is still far from perfect. The Act would de-schedule marijuana, which will finally end a decades-long prohibition into much-needed cannabis research to explore potential medical benefits. These benefits could reduce or eliminate the opioid crisis by offering a natural, holistic alternative to pain management without the use of synthetic drugs that have devasted the American population. The Act also promises to expunge past marijuana-related convictions. Not only would this allow hundreds of thousands of citizens to re-enter society, but it will open doors for additional assistance and employment opportunities as they reintegrate. The Act is also significant in that it recognizes and attempts to resolve years of racial injustice that have forced minority communities into poverty. By creating a trust fund from cannabis revenue, the government will finally reinvest in these communities with the very substance that was used to discriminate against them in the first place. This also will allow impoverished individuals the opportunity to become business owners. Moreover, the Act promises to prohibit the denial of federal public benefits to persons on the basis of marijuana-related conduct or convictions. Ultimately, the beneficial components of the Act are far-reaching and address many of the current inequities that plague both minority communities and marijuana users.

On the other hand, it is highly uncertain whether the Act will be enacted into law. The Biden Administration has the potential to live up to its promises of marijuana decriminalization and pass meaningful legislation, but that could change with the next election cycle. Moreover, even if the Act is passed, it still leaves open several issues.

While many states would likely move forward with legalization if the substance were decriminalized, there are outlying states that will continue to criminalize and enforce convictions against marijuana use. In these states, marijuana users will continue to be disproportionately disadvantaged. Additionally, while the Act expunges most federal marijuana-related convictions, it has no power over state convictions. This will require each state to enact corresponding expungement legislation, which could take years. Finally, the regulatory components of the marijuana industry remain largely unaddressed, which effectively slows or impedes any minority-owned business growth.

Ultimately, while the 116th Congress transitions to a new administration and considers potential cannabis legislation, additional action should be taken immediately to resolve the disparities medical marijuana patients face in federal benefits programs. COVID-19 has exacerbated the current framework, and the importance of housing, food security, and access to proper medication and healthcare has never been so essential. The federal government must rectify the gross inequities that medical marijuana patients face when seeking federal benefits.

At an absolute minimum, the federal government must address the barriers to federal benefits programs that medical marijuana users face. Should President Biden need to act through executive power, he should begin by enacting a moratorium on all marijuana-related evictions from public housing. To evict someone from their house during this time because of legal activity in their state essentially serves as a death sentence for at-risk marijuana patients. To that end, HUD should permanently eliminate landlord discretion to evict tenants for marijuana use. Similarly, marijuana users should not be categorically denied from receiving food assistance through either SNAP or TANF, especially while millions of Americans struggle with food insecurity because of lost wages during the pandemic. As a society, we must recognize the danger of the current intersection between poverty and race with homelessness, food insecurity, and healthcare. Medical marijuana users unquestionably fall into all these categories, and their lives must not be devalued because of their conduct. Further, President Biden should issue a blanket pardon for all current marijuana convictions, or at least those stemming from minor possession. These convictions disproportionately harm people of color and act as barriers to the necessities of life.

Congress also should amend all federal benefits programs to defer drug scheduling to states, rather than the DEA. This will allow all licensed medical marijuana users access to resources without being discriminated against for their use. For states that do not allow legal or recreational marijuana, the Biden Administration should follow in the Obama Administration's footsteps and direct prosecutors to avoid convicting marijuana-related offenses. Finally, the Administration should require the DEA to allow additional research studies to enable administrative rescheduling. Until such comprehensive, meaningful change

occurs, medical marijuana patients will continue to be denied the federal benefits that are essential to their livelihood.