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# Americans for Safe Access

August 10, 2005

Mr. Jeffrey L. McGuire
Chief, Tax Policy Division
Sales and Use Tax Department
State Board of Equalization
450 N Street
Sacramento, CA 94279-0092

Dear Mr. McGuire:

Americans for Safe Access ("ASA"), a medical marijuana advocacy organization in Oakland, California, submits the following position paper regarding the taxation of sales of medical marijuana. In particular, because the tax scheme requires dispensary operators to incriminate themselves and others, it is unconstitutional and unrealistic, as is discussed in Part II.

## I. Not All Sales of Medical Marijuana Are Illegal

As an initial matter, it is important to note that the California Legislature has explicitly authorized the payment of compensation to primary caregivers, which includes "reasonable compensation incurred for services provided" and out-of-pocket expenses. (See Health & Safety Code § 11362.765(c)).[1] Separately, it has authorized "collectives" and "cooperatives" to

[1] Health & Safety Code § 11362.7 provides as follows:

> (c) A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided to an eligible qualified patient or person with an identification card to enable that person to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, shall not, on the sole basis of that fact, be subject to prosecution or punishment under Section 11359 or 11360.

form within the state to distribute marijuana. (See Health & Safety Code § 11362.775).[2] Thus, in determining the legality of marijuana sales, different types of relationships must be considered.

*First,* there are "primary caregivers," which are defined by statute as "the individual[s] designated by [qualified patients] who [have] consistently assumed responsibility for the housing, health, or safety of [those] person[s]." (Health & Safety Code § 11362.5(e)). The Legislature has authorized payments of compensation to primary caregivers for their expenses, including reasonable compensation for their labor. To the extent that such exchanges be construed as "sales," they are legal and exempt from taxation because they do not operate on a "retail" basis. (Cf. Health & Safety Code § 11362.765(a) ["nothing in this section shall authorize the individual to smoke or otherwise consume marijuana unless otherwise authorized by this article, nor shall anything in this section authorize any individual or group to cultivate or distribute marijuana for profit"]).

*Second*, there are "medical marijuana patient collectives," or "patient collectives," which are organizations of multiple qualified patients and/or primary caregivers who associate together to cultivate and distribute marijuana to each other without the direct exchange of money. Again, since these types of collectives do not operate on a "retail" basis, they are exempt from the sales and use tax.

*Third*, there are "medical marijuana dispensing collectives," hereinafter "dispensaries," which are the same as patient collectives, except that they conduct retail sales of medical marijuana. This category of medical marijuana distribution is the primary focus of the remainder of this position paper.

## II. It Would Violate the Constitutional Right against Self-Incrimination to Require the Sales Tax

Regardless whether medical marijuana sales by dispensaries comport with state law, they remain illegal under federal law. Because the Board of Equalization can offer no assurance that it will not turn over the highly incriminating information it collects from dispensaries to federal authorities, it would violate the right against self-incrimination to require the individuals who operate the dispensaries to report their gross receipts and other information.

When analyzing whether a tax statute violates the Fifth Amendment, the principal issue is whether compliance with the statute confronts the taxpayer with a "real and appreciable" hazard of self-incrimination. (*Marchetti v. United States* (1968) 390 U.S. 39, 48, 88 S.Ct. 697,

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[2] Health & Safety Code § 11362.775 provides as follows:

Qualified patients, persons with valid identifications cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570.

701). In *Marchetti*, the United States Supreme Court established a three-part test for determining the issue. This three-part test is as follows:

> *First*, whether the conduct being regulated is part of "an area permeated with criminal statutes" and whether the individuals who engage in that conduct are part of a group "inherently suspect of criminal activities." (390 U.S. at 47, 88 S.Ct. at 702). *Second*, whether the statutory tax requires the taxpayer, under penalty of criminal prosecution, to disclose information "he might reasonably suppose would be available to prosecuting authorities." (390 U.S. at 48, 88 S.Ct. at 703). *Third,* whether the required information would prove a "significant 'link in a chain' of evidence tending to establish his guilt." (*Ibid.*).

Applying this test to the proposed tax on the sale of medical marijuana reveals that this tax scheme would be unconstitutional.

As for the first prong of the test, it hardly bears stating that the possession, manufacture, and delivery of marijuana is an area replete with criminal statutes under both state and federal law. Furthermore, as applied here, the sales and use tax targets a group of individuals whose activities are inherently suspect of criminality. The tax scheme fails this first prong.

With respect to the third part of the test, the proposed tax requires the taxpayer to provide extensive information that could be used to incriminate him and may well be passed along to prosecuting authorities. As stated by the Board in its Second Discussion paper on the subject, an operator of a medical marijuana dispensary is required to complete an application for a permit (Form BOE-400-SPA, *California Seller's Permit*), which requests such information as: the owner and business names, address, type of business, start date, list of vendors, banking information, and what items would be sold. (See Second Discussion Paper, dated July 25, 2005, at 7). This information is highly incriminatory and would be, to say the least, useful to the investigation of a dispensary operator's activities and may constitute a direct admission of his guilt under federal law. Such information is far more extensive and incriminating than that required for marijuana tax stamps, which have been found to be unconstitutional due to their incriminating character. (See, e.g., *State v. Smith* (1991) 120 Idaho 77, 79, 813 P.2d 888, 890). This factor counsels strongly in favor of a finding that the proposed tax scheme would be unconstitutional.

Finally, with respect to the second prong of the *Marchetti* test -- confidentiality -- the Board not only will not provide any assurance that the incriminating information required of dispensaries will remain confidential, but, to the contrary, it expressly notes the risk of a leak. Its Second Discussion Paper states as follows:

> As set forth in the privacy notice the Board furnishes all applicants, the Board has entered into information-sharing agreements with various federal, state, and local government agencies, and may disclose information to the proper officials of these agencies. In addition, an existing Governor's Order authorizes disclosure of information to local law enforcement and the United States Attorney. Moreover, this agency may be compelled to produce information or

> documents in court proceedings by means of a subpoena or subpoena duces tecum. (See, e.g., Code of Civil Procedure section 1985, et seq.) While staff recommends revising Board policy to issue seller's permits to sellers engaged in unlawful sales, staff believes it does not have the authority to protect a group of taxpayers from disclosure, pursuant to information-sharing agreements, Governor's Order, and statute, of available information, or the authority to override the statutory requirements to maintain records and collect the information necessary to administer the sales and use tax program.

(Second Discussion Paper, dated July 25, 2005, at 7-8). To require the reporting of incriminating information in this manner, with no assurances that such information will not be turned over to the federal authorities for federal prosecution, would violate the constitutional right against self-incrimination. (See *State v. Smith* (1991) 120 Idaho 77, 79, 813 P.2d 888, 890 [tax stamp requirement for controlled substances found unconstitutional; although purchaser of drug stamps was not required to give identifying information when paying the tax, there was no penalty for disclosure of information by tax commission employees or agents and there was no express prohibition against using the information obtained through the purchase of the stamps in criminal proceedings or investigations, which rendered taxing regulation unconstitutional; unconstitutionality later cured by stature requiring confidentiality of information provided by taxpayer]; cf. *Leary v. United States* (1969) 395 U.S. 6, 29, 89 S.Ct. 1532, 1544 [petitioner's noncompliance with transfer tax provisions of Marijuana Tax Act would have exposed defendant to prosecution under state narcotics laws, so plea of self-incrimination was complete defense to prosecution for noncompliance; information gathered was to be given to state and local law enforcement upon request]; *Marchetti*, *supra*, 390 U.S. at 61 [holding that timely assertion of privilege against self-incrimination operated as complete defense to prosecution for failure to register and pay federal tax on gambling]; *People v. Duleff* (1973) 183 Colo. 213, 218, 515 P.2d 1239, 1241 [holding that requirement of license to cultivate marijuana violates defendant's right against self-incrimination]).

## III. Medical Marijuana Sales By Dispensaries Are Exempt from Taxation Under Revenue and Taxation Code § 6369(a)(3)

In addition to the constitutional questions presented, medical marijuana sales by dispensaries are exempt from taxation as "medicine" dispensed by a "health care facility," pursuant to Revenue & Taxation Code § 6369(a)(3). Revenue and Taxation Code section 6369, and functionally identical Sales and Use Tax Regulation 1591, provide: "Sales of medicines are exempt from sales and use taxes if . . . (3) furnished by a health facility for patient treatment pursuant to the order of a licensed physician." Medical marijuana sales by dispensaries meets this definition.

### A. Marijuana Is "Medicine"

Through their enactment of California Health and Safety Code section 11362.5, the "Compassionate Use Act," the California electorate declared as the public policy of this State that marijuana is medicine. (See Health & Safety Code § 11362.5(b)(1)(A) [declaring as purpose of Act to "ensure that seriously ill Californians have the right to obtain and use

marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician"]). Indeed, to qualify as "medicine" for purposes of the Revenue and Taxation Code, a substance need not be dispensed by prescription. (*Purdue Frederick Co. v. State Board of Equalization* (1990) 218 Cal.App.3d 1021, 1028). Rather, the Legislature has defined "medicine" to encompass "any substance or preparation intended for use by external or internal application to the human body in the diagnosis, cure, mitigation, treatment or prevention of disease and which is commonly recognized as a substance or preparation intended for that use." (Revenue & Taxation Code § 6369(b)).

In addition to the California's electorate's declaration, the facts establish that marijuana is a "substance or preparation intended for use by . . . internal application to the human body in the . . . treatment . . . of disease and which is commonly recognized as a substance or preparation intended for that use." (Cf. *Purdue, supra,* 218 Cal.App.3d at 1028 and fn.4 [rejecting Board's construction of "treatment" as too narrow; adopting dictionary definition of "treatment" as "to care for or deal with medically or surgically" and "to act upon with some agent esp. to improve or alter. . . ."] [citing Webster's New Collegiate Dict. (9th ed. 1983) p. 1257]). Numerous peer-reviewed studies, including a National Institute of Medicine ("IOM") study commissioned by the federal government, establish that marijuana is effective in treating various illnesses. For instance, more than 6,500 published scientific articles on medical applications for marijuana are found in the National Library of Medicine's database (http:/pubmed.com). Of these, many are clinical studies that show marijuana's efficacy for treating pain, nausea, loss of appetite and spasticity.

Specifically, with respect to pain management, the IOM cited three double-blind, placebo-controlled studies on treating cancer pain, which found marijuana's primary psychoactive component to be comparable to codeine in effectiveness, but without the nausea and other debilitating side effects. (Noyes Jr R, Brunk SF, Baram DA, Canter A 1975a; Noyes R, Jr, Brunk SF, Avery DH, Canter A 1975b; Staquet M, Gantt C, Machin D 1978). The IOM also reports that an experimental study on pain showed that "cannabinoids were comparable with opiates in potency and efficacy. . . ."

Other research on marijuana's efficacy for pain management includes a human study showing statistically significant increases in pain threshold after smoking marijuana (Milstein, MacCannell, Karr & Clark 1975), as well as numerous case studies of patients who voluntarily employed marijuana to treat painful conditions, including a woman whose severe juvenile rheumatoid arthritis was resistant to standard medicine but responsive to marijuana therapy (Grinspoon & Bakalar 1997, Randall 1991, Noyes & Baram 1974). As noted in the chapter on "The Role of Cannabis and Cannabinoids in Pain Management" in the sixth edition of *Pain Management: A Guide for Clinicians* (Russo 2003), "these accounts fulfill criteria of 'N-of-1 studies' and have been accepted by epidemiologists as proof of efficacy in rare conditions or ones in which blinded controlled trials are technically difficult (Guyatt, et al 1990, Larson 1990)." On the basis of these studies and other research published before the HHS response, a review of indications for medical treatment with marijuana concluded "any patient with pain unrelieved by conventional analgesics should have access to smoked marijuana" (Hollister 2000).

On treating nausea, the IOM reported on numerous clinical studies – including "a carefully controlled double-blind study" and a "a double-blind, cross-over, placebo-controlled study" – showing that both marijuana and select cannabinoids are effective antiemetics for patients suffering nausea and lack of appetite related to both cancer treatment and HIV/AIDS. In fact, the IOM concluded that marijuana is not only effective, but "[f]or patients such as those with AIDS or who are undergoing chemotherapy and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad-spectrum relief not found in any other single medication."

Moreover, a review of clinical studies conducted in several states during the past two decades has shown that, in 768 patients, marijuana was a highly effective antiemetic in chemotherapy (Musty and Rossi 2001). Recent double-blind, placebo-controlled studies of HIV/AIDS patients showed that marijuana both reduced neuropathic pain and produced weight gain without immunological compromise (Abrams et al. 2003). Clinical studies of Multiple Sclerosis, for which there are few effective treatments, have shown cannabis extracts to be effective for spasticity and other symptoms (Wade et al. 2003; Zajicek et al. 2003), as well as chronic pain (Notcutt and Rangappa 2004). Three additional articles supporting the benefit of marijuana in treating MS patients for spasticity (Vaney), pain, sleep and spasticity (Wade) and bladder function (Brady) appear in the August 2004 issue of the journal *Multiple Sclerosis.* The non-psychoactive marijuana component cannibidol (CBD) has also been shown to have numerous medical applications as an anti-inflammatory and neuroprotective agent (Mechoulam, Parker, and Gallily 2002; Pertwee 2004; Russo 2003) (Mechoulam, Parker, and Gallily 2002; Pertwee 2004; Russo 2003) and as a treatment for rheumatoid arthritis (Malfait et al. 2000).

Lastly, a study of patients who have used standardized, heat-sterilized, quality-controlled medical marijuana as part of the federal government's Compassionate Investigational New Drug Program demonstrated the long-term clinical effectiveness of marijuana in treating chronic musculoskeletal pain, spasm and nausea, and spasticity of Multiple Sclerosis (Russo 2002). After using medical marijuana supplied by the federal government for periods ranging from 11 to 27 years, these patients showed no functionally significant problems in their physiological systems, as determined by MRI scans of the brain, pulmonary function tests, chest X-ray, neuro-psychological tests, hormone and immunological assays, electroencephalography, P300 testing, and neurological clinical examination.

This nonexhaustive list of studies evidencing marijuana's usefulness in treating various illness shows that marijuana is "commonly recognized as a substance . . . intended for" medical use. Through their enactment of the Compassionate Use Act, the voters of California have confirmed this.

### B. Dispensaries Are "Health Facilities"

As "medicine," marijuana sales are exempt from taxation if "[f]urnished by a health facility for treatment of any person pursuant to the order of a licensed physician and surgeon, dentist, or podiatrist." (Revenue & Taxation Code § 6369(a)(3)). Contrary to the Board of Equalization's narrow definition of a "health facility" as limited to in-patient facilities defined under Health and Safety Code section 1250 (see Regulation 1591(a)(4)), the Revenue and

Taxation Code also includes "clinics" under Health and Safety Code section 1250 within this definition. (Revenue & Taxation Code § 6369(d)).[3] Section 1250, in turn, defines a "clinic" as any "organized outpatient health facility which provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours, and which may also provide diagnostic or therapeutic services to patients in the home as an incident to care provided at the clinic facility." (Health & Safety Code § 1200).[4]

Dispensaries meet this definition, as they provide direct medical services and treatment to qualified patients. Although the marijuana is not "dispensed on prescription filled by a registered pharmacist," as required for exemption under Revenue and Taxation Code section 6369, subdivision (a)(1), it is furnished pursuant to the "order," or written recommendation, of a licensed physician, at least from the perspective of the provider. Thus, medical marijuana sales by dispensaries are exempt from taxation under Revenue and Taxation Code section 6369, subdivision (a)(3).

## CONCLUSION

For the foregoing reasons, it is the position of ASA that medical marijuana sales by dispensaries should not be taxed.

Sincerely,

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Americans for Safe Access

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[3] Revenue & Taxation Code § 6369(d) provides:

> (d) "Health facility" as used in this section has the meaning ascribed to it in Section 1250 of the Health and Safety Code, and also includes any "clinic" as defined in Section 1200 of the Health and Safety Code.

[4] By comparison, the statute explicitly excludes from its definition of a "clinic" "[a] place, establishment, or institution which solely provides advice, counseling, information, or referrals on the maintenance of health or on the means and measures to prevent or avoid sickness, disease, or injury, where such advice, counseling, information, or referrals does not constitute the practice of medicine, surgery, dentistry, optometry, or podiatry, shall not be deemed a clinic for purposes of this chapter." (*Ibid.*)