



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Lawrence J. Hogan, Jr., Governor – Boyd K. Rutherford, Lt. Governor – Van T. Mitchell, Secretary

Natalie M. LaPrade Medical Marijuana Commission

February 7, 2015

The Honorable Thomas V. Mike Miller, Jr.
President, Maryland Senate
State House, H-107
Annapolis, Maryland 21401-1991

The Honorable Michael E. Busch
Speaker, Maryland House of Delegates
State House, H-101
Annapolis, Maryland 21401-1991

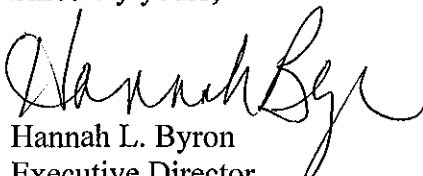
Re: Medical Marijuana Commission Report on Taxation of Medical Marijuana and Financial Transactions for Medical Marijuana

Dear President Miller and Speaker Busch:

In accordance with Section 5 of 2014 Maryland Laws Chapters 240 and 256, the Natalie M. LaPrade Medical Marijuana Commission is pleased to transmit its study and recommendations on taxation of medical marijuana and financial transactions for medical marijuana. We hope that this study is helpful to the General Assembly in its oversight of medical marijuana programs in Maryland.

Should you require additional information, please contact me at (410) 736-1185 or Hannah.Byron@Maryland.gov.

Sincerely yours,


Hannah L. Byron
Executive Director
MMC.Maryland.gov

Enclosure

cc: Eric Sterling, Maryland Medical Marijuana Commission
Andrew Schaufele, Office of the Comptroller
Allison Taylor, DHMH Office of Governmental Affairs

**Report to the Maryland General Assembly
on Taxation of Medical Marijuana
And Financial Transactions for Medical Marijuana
Submitted by the Natalie M. LaPrade Medical Marijuana Commission¹**

February 9, 2015

A. INTRODUCTION

I. Report Request

Section 5 of 2014 Maryland Laws Chapter 256 states, “(a) The Natalie M. Medical Marijuana Commission, in consultation with the Comptroller, shall study the taxation of medical marijuana and the impact that medical marijuana laws have had on banking and financial transactions in other states that have implemented medical marijuana laws. (b) The study required under subsection (a) of this section shall include an examination of federal laws and policies related to the taxation of medical marijuana and banking and financial transactions affected by medical marijuana laws. (c) On or before December 1, 2014, the Commission shall report its findings and recommendations to the General Assembly, in accordance with section 2-1246 of the State Government Article, regarding taxation of medical marijuana in this state and the impact of medical marijuana laws on banking and financial transactions.”

The Commission had no full-time staff until January 14, 2015. The Commission apologizes for not producing this report by the statutory deadline.

¹ Portions of this report were authored by Kellsy Wallace, Nate Titman, Sharon Bloom, Andrew Schaufele, Alison Marqusee, Eric E. Sterling and Hannah Byron.

II. Background on the Maryland Medical Marijuana Law

The State of Maryland has been working towards the legalization of medical marijuana for many years. In 2003, the General Assembly began this movement by enacting the Darrell Putman Compassionate Use Act.² The Act allowed persons charged with criminal possession of marijuana to mitigate the severity of any penalty by demonstrating medical necessity.³ However, patients could still be convicted of a misdemeanor offense and fined up to \$100. In 2011, the legislature amended the Darrell Putman Compassionate Use Act to provide additional protection for patients. This legislation removed the misdemeanor penalty, and recognized an affirmative defense for specific debilitating medical conditions that may benefit from the use of medical marijuana.⁴ The new law also created a workgroup to research the issue of medical marijuana and make recommendations for comprehensive medical marijuana legislation by the following year.

After a year of deliberation, the workgroup was unable to reach consensus on the best way to proceed and issued two different reports.⁵ Based on the workgroup's recommendations, a pair of competing medical marijuana bills were introduced in 2012 in the House and Senate.⁶ While neither was successful that session, the legislature decided on a unique approach to medical marijuana legislation. In 2013, the General Assembly passed the Academic Medical Center Medical Marijuana Act that allowed qualifying "Academic Medical Centers," i.e., large teaching and research hospitals, to make marijuana available to patients for medical use as a part

² 2003 Maryland Laws Ch. 442

³ Md. Code Ann., Crim. §5-601(c)(3)

⁴ 2011 Maryland Laws Ch. 215

⁵ Graves, Lucia. "Medical Marijuana Bills Introduced In Maryland House To Help Patients." *The Huffington Post*. HuffingtonPost.com, 10 Feb. 2012. Web. http://www.huffingtonpost.com/2012/02/10/medical-marijuana-maryland-two-bills-dan-morhaim_n_1269567.html (Accessed Jan. 25, 2015).

⁶ *Ibid.*

of a research program.⁷ The law, taking effect on Oct. 1, 2013, also established the Natalie M. LaPrade Medical Marijuana Commission (Commission) for the purpose of regulating and overseeing the programs.⁸ However, none of the State's potential Academic Medical Centers agreed to participate in the program. There was a consensus that patients were not going to be able to legally obtain medical marijuana under this approach.⁹

Unsatisfied with this result, in 2014, Maryland's General Assembly adopted a broader medical marijuana law. After several drafts with numerous amendments were considered, Senate Bill 923 was passed by the General Assembly with bipartisan support and was signed into law by Governor O'Malley.¹⁰ Under the new law, physicians who are approved by the Commission may issue written certifications to their patients with qualifying conditions to use medical marijuana. The Commission was directed to license growers and dispensaries to produce and distribute medical marijuana to patients. Patients who obtain written certifications from their physician may then obtain medical marijuana from licensed growers and dispensaries.

In addition to authorizing the Commission to adopt regulations, the new law also tasked the Commission with studying "the taxation of medical marijuana and the impact that medical marijuana laws have had on banking and financial transactions in other states," as well as "the federal laws and policies related to the taxation and banking and financial transactions affected by medical marijuana laws."¹¹ This report will provide a background of medical marijuana nationwide, discuss the potential impact of the medical marijuana laws and regulations on

⁷ 2013 MD H.B. 1101

⁸ *Ibid.*

⁹ *Ibid.*

¹⁰ 2014 Maryland Laws Ch. 256

¹¹ Senate Bill 923

banking and financial transactions in the state, and make recommendations regarding taxation of medical marijuana and financial transactions in Maryland.

B. BACKGROUND ON MEDICAL MARIJUANA

I. Medical Marijuana Control and Legal Conflict

The use of marijuana for medical purposes is a trend that has swept across the United States. At the time of this writing, 23 states and the District of Columbia beginning in 1996 have enacted laws to legalize medical marijuana.¹² Yet, the Federal Controlled Substances Act of 1970 continues to classify marijuana as a Schedule I drug.¹³ Since 1972, when the National Organization for the Reform of Marijuana Laws (NORML) first petitioned to the Drug Enforcement Administration (then the Bureau of Narcotics and Dangerous Drugs) to reschedule marijuana, every petition to reschedule marijuana has been rejected. This means that the federal government does not recognize any acceptable medical use of marijuana, and considers the drug to have a high potential for abuse.¹⁴ The development of state laws that conflict with federal law has created a complicated regulatory system in every state. For example, because a “prescription” is a legal order from a physician to a pharmacy, marijuana cannot be prescribed. Doctors, however, can recommend the use of marijuana to their patients, exercising their First Amendment rights.¹⁵ Maryland’s approach of using the term “written certification” for a physician to legally authorize a patient to use marijuana for medical purposes is an example of

¹² Alaska, Arizona, California, Colorado, Connecticut, D.C., Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington.

¹³ 21 U.S.C. 801 et seq.

¹⁴ 21 U.S.C. §812. Notwithstanding this statutory and regulatory position, beginning in the late 1970s, a very small number of patients successfully petitioned the federal government to admit them into a tiny compassionate use program to receive medical marijuana from the government’s research inventory. The first Bush Administration closed the program to any new patients. There are now only two patients who continue to receive marijuana under this program. Many patients have died. Some no longer can find physicians in their state who are willing to treat them.

¹⁵ Conant v. Walters, 309 F.3d 629 (9th Cir. 2002).

the complications of this legal conflict of law that required avoiding the use of the term “prescription.”

The Obama administration has taken a nuanced approach to enforcing the marijuana law in states that have chosen to legalize the drug. A series of four memoranda from the Deputy Attorney General to U.S. Attorneys, issued in 2009, 2011, 2013 and 2014, is evidence of the evolution of the position of the Department of Justice toward state marijuana programs.¹⁶

Transactions in the proceeds of marijuana violate federal money laundering and financial control statutes. The Obama Administration, once again not seeking to amend the underlying statutes or the promulgated regulations, issued “guidance” to financial institutions. In February 2014, memoranda were simultaneously issued by the Departments of Justice and the Treasury regarding financial crimes and the Bank Secrecy Act. The Cole 2014 Memo from the Department of Justice advised U.S. Attorneys that in instances in which a “financial institution or individual offer [for] services to a marijuana-related business whose activities do not implicate any of the eight priority factors [for federal enforcement]”¹⁷, prosecution for these offenses may not be appropriate.”¹⁸ The guidance to prosecutors in the Cole Memos of 2013 and 2014 was explicitly based “on the expectation that states that have enacted laws authorizing marijuana-related conduct will implement **clear, strong and effective regulatory and enforcement**

¹⁶ David W. Ogden, Deputy Attorney General, *Memorandum For Selected United States Attorneys: Investigations and Prosecutions in States Authorizing the Use of Medical Marijuana*, Oct. 19, 2009; James M. Cole, Deputy Attorney General, *Memorandum For United States Attorneys: Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use*, June 29, 2011; James M. Cole, Deputy Attorney General, *Memorandum For All United States Attorneys: Guidance Regarding Marijuana Enforcement*, August 29, 2013 (hereinafter “Cole 2013 Memo”); James M. Cole, *Memorandum For All United States Attorneys: Guidance Regarding Marijuana Related Financial Crimes*, Feb. 14, 2014 (hereinafter “Cole 2014 Memo”).

¹⁷ The eight enforcement priorities are to: prevent distribution of marijuana to minors, prevent revenue from going to criminal enterprises and cartels, prevent diversion of marijuana from a state where legal under state law to other states, prevent state-authorized marijuana activity from being a cover for other illegal activity, prevent violence and the use of firearms “in the cultivation and distribution of marijuana,” prevent drugged driving or other public health consequences, prevent growing marijuana on public lands and protect environment, and prevent marijuana possession or use on federal property.

¹⁸ Cole 2014 Memo, p. 3.

systems in order to minimize the threat posed to federal enforcement priorities.”¹⁹ The Financial Crimes Enforcement Network (FinCEN) of the Department of Treasury issued “Guidance: BSA [Bank Secrecy Act] Expectations Regarding Marijuana-Related Businesses” on Feb. 14, 2014 to clarify “how financial institutions can provide services to marijuana-related businesses” and to “enhance the availability of financial services for, and the financial transparency of, marijuana-related businesses.”²⁰ The FinCEN guidance to financial institutions requires the financial institutions to engage in vigilant customer due diligence to assess the risk that the marijuana-related business is not violating any of the eight enforcement priorities set forth in the Cole 2013 memo. Financial Institutions are directed to file specially marked “suspicious activity reports” (SAR) for marijuana-related businesses, and “continuing activity reports.” If a financial institution “reasonably believes” a marijuana-related business customer “implicates” an enforcement priority, it must file a “Marijuana Priority” SAR identifying its customer, and the guidance offers two pages of “red flags” to distinguish Priority SARs.

Further complicating analysis of medical marijuana laws is that two states with medical marijuana programs approved initiatives to legalize the adult use of marijuana for recreational purposes in 2012. Colorado and Washington have set up regulatory regimes to produce and distribute marijuana for non-medical purposes. These legal businesses must comply with state and federal tax laws, and need to integrate themselves into the legal economy and the financial system. With this background and the very rapid change in the regulation of the medical marijuana businesses and the financial institutions with which they do business, an up-to-date explication of transactions and tax policy implications is challenging.

¹⁹ *Ibid.* (Emphasis added).

²⁰ Financial Crimes Enforcement Network, “BSA Expectations Regarding Marijuana-Related Businesses,” FIN-2014-G001, Department of the Treasury, Feb. 14, 2014.

II. Definition and Context

Marijuana consists of “all parts of the plant *Cannabis sativa* L., whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin.”²¹

Cannabis is “one of humankind’s oldest cultivated crops,” used as a medicine since at least 2800 BCE, used as a textile since 7000 BCE, and for thousands of years was used to produce “fabric for sails, rope, paper, canvases, medicine, lamp oil and food.”²² It has been recognized for its medicinal properties around the world for thousands of years, and was commonly used in the late 19th and early 20th centuries in the United States for the treatment of bronchitis, rheumatism, and relief of headache pain.²³ In an article about the medical marijuana controversy, Eric E. Sterling observed, “During the twentieth century, however, marijuana’s medical use fell from fashion, and after the passage of the Marihuana Tax Act of 1937, its use in medicine became legally complex and rare.”²⁴ Marijuana was included in the medical reference book *United States Pharmacopeia*, in 1870 according to Bonnie and Whitebread²⁵ or as early as 1854, according to Martin Lee²⁶, and remained there until 1942 when it was removed due to “persistent concerns about its potential to cause harm.”²⁷

²¹ Definition of “marihuana,” 21 U.S.C. 802 (16).

²² Julie Holland, M.D., ed., “The Pot Book: A Complete Guide to Cannabis: Its Role in Medicine, Politics, Science, and Culture,” Park Street Press, Rochester, VT, 2010, pp. 6-7

²³ Martin A. Lee, “Smoke Signals: A Social History of Marijuana – Medical, Recreational, and Scientific.” Scribner, New York, 2012, p. 26.

²⁴ Eric E. Sterling, “Drug Policy: A smorgasbord of conundrums spiced by emotions around children and violence,” 31:2 Valparaíso Univ. Law Review 597, at 622, 1997.

²⁵ Richard J. Bonnie and Charles H. Whitebread II, “The Marihuana Conviction: A History of Marihuana Prohibition in the United States,” University Press of Virginia, Charlottesville, VA, 1974, p. 4.

²⁶ Lee, p. 25 (referring to “Indian hemp”).

²⁷ Allison Mack and Janet Joy, “Marijuana as Medicine? The Science Beyond the Controversy,” Washington, National Academy Press, 2001, p.17.

The medical use of marijuana in the United States began to decline with the development of more predictable and seemingly effective drugs, such as synthetic drugs by the 1930s.²⁸ Social reform movements simultaneously pushed for the eradication of all recreational drug use, and many state and local jurisdictions targeted marijuana. Congress then passed the Marijuana Tax Act in 1937, which effectively established a federal prohibition of marijuana.²⁹ Although the prescription of marijuana for medical use technically remained legal under federal law until 1970, possession of marijuana was a crime in every American state in the 1960s and was highly regulated at a federal level. Congress reorganized all federal drug laws, relying upon the Commerce Clause and treaty powers of the Constitution, instead of the taxing power when it passed the Controlled Substances Act as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.³⁰ Following in general the organization of the Single Convention on Narcotics of 1961, the Act created 5 categories (or “schedules”) of controlled substances. Schedule I is the most restrictive of the 5 categories. Schedule I drugs are defined as having a “high potential for abuse,” “no currently accepted medical use in treatment,” and a “lack of medical safety for use [...] under medical supervision.”³¹ The Act included marijuana, alongside other drugs like heroin, as a Schedule I drug and it remains there to this day.

The renewed interest in marijuana for medical purposes has been several decades in the making. Litigation to reschedule marijuana to Schedule II began in May 1972.³² That litigation

²⁸ Michael Aldrich, “History of Therapeutic Cannabis” in Mary Lynn Mathre (ed.) “Cannabis in Medical Practice: A Legal, Historical and Pharmacological Overview of the Therapeutic Use of Marijuana,” Jefferson, NC, McFarland & Co. 1997, p.49.

²⁹ Although the Act allowed for the medicinal use of marijuana, it imposed taxes and extensive record-keeping requirements that made the drug inconvenient to use. *Id.*

³⁰ P.L. 91-513, Oct. 27, 1970.

³¹ 21 U.S.C. §812

³² Sterling, p. 622.

dragged on. In September 1988 when DEA Administrative Law Judge Francis Young ruled following a number of evidentiary hearings in 1987 and 1988 that

“The overwhelming preponderance of the evidence in this record establishes that marijuana has a currently accepted medical use in treatment in the United States for nausea and vomiting resulting from chemotherapy treatments in some cancer patients. To conclude otherwise, on this record, would be unreasonable, arbitrary and capricious.”³³

Shortly after the Controlled Substances Act went into effect in 1970, marijuana law reform activists began a successful push to decriminalize possession of marijuana on the state level for a few years. Despite the war on drugs climate of the 1980s, 31 states and D.C. had passed legislation that pertained to the medical use of marijuana under limited circumstances by 1982. But, the rise of the “War on Drugs” in the 1980s produced an outpouring of state and federal laws aimed at curtailing the use and distribution of the entire spectrum of illegal substances – including marijuana.

However, in 1988, with the speech of Baltimore Mayor Kurt L. Schmoke to the U.S. Conference of Mayors, a movement to rethink that nation’s approach toward controlling drugs emerged on the national scene.³⁴

In 1996, as a result of an initiative, California became the first state to functionally legalize medical marijuana, albeit in a very loosely regulated context. Initially, the federal government took a hard stance against California’s medical marijuana law and attempted to block its implementation, by, among various proposals, threatening physicians who

³³ *In the Matter of Marijuana Rescheduling Petition, No. 86-22*, in 2 “Marijuana, Medicine & the Law: 391 (Robert C. Randall, ed., 1989).

³⁴ James A. Inciardi, “American Drug Policy: The Continuing Debate,” in Laura E. Huggins (ed), “Drug War Deadlock: The Policy Battle Continues,” Stanford, CA, Hoover Institution Press, 2005, p. 8.

“recommended” marijuana with the loss of their DEA registration.³⁵ Many leading doctors, already recommending the use of marijuana to their HIV and oncology patients sued to block these threats. The U.S. Court of Appeals for the Ninth Circuit recognized a physician First Amendment right to recommend medical marijuana to a patient.³⁶ Later, in the 2005 decision *Gonzales v. Raich*, the U.S. Supreme Court held that the federal government maintained its Constitutional power under the Commerce clause to regulate even purely intrastate cultivation, distribution and use of medical marijuana in states where it was legal because the cumulative effect of patients’ use of medical marijuana had an effect upon interstate commerce.³⁷ In that litigation, the validity of the California medical marijuana law was not challenged by the Federal government and it remained in effect after *Raich* was decided.

Dozens of states – including Maryland – have now followed California’s lead, and an estimate of the total number of medical marijuana patients is approximately 1 million patients throughout the United States (See Table 1 on the following page for a breakdown of by state).³⁸ Because medical marijuana laws were created and implemented on a state-by-state basis there is no unified or common body of law. The state policies vary greatly.

Federal statutory law regarding medical marijuana remains unchanged. However, in a very dramatic development in December 2014, in a rider to an omnibus appropriations bill, section 538, Congress barred the Department of Justice from “prevent[ing specified medical marijuana] States from implementing their own State laws that authorize the use, distribution,

³⁵ Sterling, pp. 627-639; Administration Response to Arizona Proposition 200 and California Proposition 215, 62 Federal Register 6164-66 (1997).

³⁶ See *Conant v. Walters*, 309 F.3d 629 (9th Cr. 2002).

³⁷ *Gonzalez v. Raich*, 545 U.S. 1 (2005).

³⁸ Additionally, four states and D.C. have now legalized recreational marijuana use by adults.

possession, or cultivation of medical marijuana.”³⁹ And as discussed above, the policy of the Administration continues to evolve.

³⁹ "SEC. 538. None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kentucky, Maine, **Maryland**, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin, to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." Consolidated and Further Continuing Appropriations Act, 2015, P.L. 113-235.

**Table 1 – Approximate Number of
Medical Marijuana Patients in the U.S.⁴⁰**

State	Year Introduced	# of Patients Registered
Alaska	1998	1,898
Arizona	2010	50,000
California	1996	553,684 ⁴¹
Colorado	2000	113,441
Connecticut	2012	2,000 ⁴²
DC	2010	400
Delaware	2011	55
Hawaii	2000	13,833
Maine	1999	17,274 ⁴³
Michigan	2008	121,151
Montana	2004	8,470
Nevada	2000	5,162
New Jersey	2010	1,670
New Mexico	2007	10,680
Oregon	1998	67,504 ⁴⁴
Rhode Island	2006	8,500
Vermont	2004	1,290
Washington	1998	103,444 ⁴⁵

*States with effective medical marijuana laws that do not yet have patient enrollment: Illinois (2013), New Hampshire (2013), New York (2014), Maryland (2014), Massachusetts (2012), and Minnesota (2014)

⁴⁰ The data for this table comes from a wide variety of sources, are based on different methodologies and covers different years. It is not an accurate statement of the number of patients for any state at any time, and cannot be used to compare states.

⁴¹ California has voluntary rather than mandatory registration. This number is an estimate provided by the State.

⁴² Connecticut is in the early stages of implementing its medical marijuana program. The state expects to see a drastic increase in patient registration once producers and dispensaries get up and running later this year.

⁴³ Maine has voluntary rather than mandatory registration. This number is an estimate provided by the Marijuana Policy Project.

⁴⁴ Oregon allows non-residents to register as patients, so this number is somewhat inflated.

⁴⁵ This is an estimate provided by the Medical Marijuana Policy Project. Washington allows patients to grow their own medical marijuana with a recommendation from a physician, but does not have licensed dispensaries or a patient registry.

C. MEDICAL MARIJUANA TAXATION

I. Federal and State Income Taxes

Although marijuana remains illegal under federal law, the federal government is benefitting fiscally from the production and sale of marijuana in states that have legalized its sale through the payment of federal income taxes by legal medical marijuana businesses that file income taxes that declare income, and on the income of employees of such businesses. Gross income includes “all income from whatever source derived,” including income derived from illegal businesses.⁴⁶ The tax code does not favor individuals involved in illegal activities and is particularly harsh to those dealing in controlled substances, such as marijuana.

In 1982, Congress enacted Section 280E of the Internal Revenue Code to deny all ordinary business deductions, other than costs of production for goods sold, to those who traffic in controlled substances.⁴⁷ The IRS has strictly enforced this provision against medical marijuana related businesses – even those operating under the authority of state law.⁴⁸ Section 280E is more exacting on medical marijuana dispensaries than growers because the rule allows businesses to deduct the “cost of goods sold” (COGS), such as the soil and fertilizer used to grow marijuana plants. However, the “general and administrative” (G&A) costs of a business – such as advertising, rent, payroll, and utilities, which are the biggest components of a dispensary’s operating costs – are not deductible.

In a 2002 Tax Court case involving a dispensary known as Californians Helping to Alleviate Medical Problems (CHAMP), the IRS denied all of the G&A deductions. However, the

⁴⁶ 26 U.S. Code §61; *James v. United States*, 366 U.S. 213 (1961).

⁴⁷ Tony Nitti, “IRS Further Limits Deductions For State-Legal Marijuana Facilities,” Jan. 24, 2015, [www.forbes.com](http://www.forbes.com/sites/anthonymitti/2015/01/24/irs-further-limits-deductions-for-state-legal-marijuana-facilities/), <http://www.forbes.com/sites/anthonymitti/2015/01/24/irs-further-limits-deductions-for-state-legal-marijuana-facilities/> Accessed Jan. 26, 2015.

⁴⁸ Joel S. Newman, “Deductions on a Higher Plane: Medical Marijuana Business Expenses.” *Lexis Federal Tax Journal Quarterly*. Sept. 2013. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2333969###. Accessed Feb. 2, 2015.

dispensary won a partial victory. Because the dispensary offered services in addition to the sale of marijuana, i.e., “counseling customers on which type of marijuana would best treat their particular ailment,” the court ruled that the expenses that could be allocated to those legal services were deductible. The court allowed 85 percent of the expenses to be deducted.⁴⁹

A 2011 Tax Court case resulted in a less favorable outcome to the dispensary operator, and rejected the view that the services or activities independent of the dispensing of medical marijuana were consequential, and it denied all of the G&A deductions.⁵⁰ On Jan. 23, 2015, the IRS General Counsel issued a memorandum further clarifying how the IRS will treat G&A deductions for marijuana-related businesses.⁵¹

Because of the start-up costs associated with opening a business and the licensing fees the state of Maryland is proposing medical marijuana growers and dispensaries will be required to pay,⁵² the denial of most business deductions will be very problematic for medical marijuana related businesses in Maryland. Many marijuana dispensary businesses in Colorado are operating at a loss, and paying more in taxes than they can afford.⁵³ In fact, Taylor West, Deputy Director of the National Cannabis Industry Association, estimates that her clients are paying more than 70% of their profits in taxes to the federal government alone.⁵⁴ This is in stark opposition to the 30-40% they would be paying if Section 280E were not in effect.⁵⁵

⁴⁹ *Californians Helping to Alleviate Medical Problems*, 128 T.C. 173 (2002); Tony Nitti, op cit.

⁵⁰ *Olive v. Commissioner*, 139 T.C. 2 (2011); Tony Nitti, op cit.

⁵¹ Memorandum from IRS Chief Counsel 201504011 re: Taxpayers Trafficking in a Schedule I or Schedule II Controlled Substance -- Capitalization of Inventoriable Costs, Released Jan. 23, 2015, <http://www.irs.gov/pub/irs-wd/201504011.pdf> Accessed Jan. 27, 2015.

⁵² 42 Maryland Register 214, Jan. 23, 2015, Proposed COMAR10.62.28.01 (Grower: \$125,000 per year; Dispensary: \$40,000 per year).

⁵³ Katie Kuntz, "Marijuana Profits up in Smoke under IRS Rules." *USA Today*. Nov. 5, 2014.

<http://www.usatoday.com/story/news/nation/2014/11/03/irs-limits-profits-marijuana-businesses/18165033/> Accessed Jan. 26, 2014.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

Since the federal adjusted gross income is the starting point for individual and business income taxes in Maryland, only the deductions that the federal government would allow can be claimed for state income tax purposes as well. Some states have attempted to work around this by requiring dispensaries to operate as nonprofit organizations. While marijuana related businesses cannot qualify as 501(c)(3) organizations for federal purposes, they can receive the tax benefits under state law. However, this design precludes the possibility of medical marijuana businesses turning a profit. The legislature could alternatively create a statutory exemption for medical marijuana related businesses, which would allow the deduction of all ordinary and necessary business expenses for medical marijuana related businesses licensed by the state and operating within the parameters of state law.

II. Other Opportunities for Taxation

In addition to income taxes, states are free to “impose any type of tax except those taxes that are clearly forbidden by the United States Constitution and their own state constitution.”⁵⁶ Local jurisdictions may also have the authority to levy taxes when granted by the state. Common local and state taxes include sales and use taxes, excise taxes, and privilege taxes on businesses. There is no consistent approach to the taxation of medical marijuana.

In most states, medical marijuana is subject to the general sales and use tax. A law authorizing a sales tax usually requires the seller of goods and services to collect the tax from the consumer at the point of purchase. However, a sales tax can also be imposed on a vendor – here, a medical marijuana grower or dispensary – in addition to the consumer. A vendor sales tax is usually based on the amount of goods sold. Medical marijuana related businesses in other states are often subject to taxes on wholesale sales. States can also apply an additional franchise or

⁵⁶ "State and Local Taxes." *Resource Center*. U.S. Department of the Treasury, 5 Dec. 2010. <http://www.treasury.gov/resource-center/faqs/Taxes/Pages/state-local.aspx>. Accessed Feb. 2, 2015

privilege tax for medical marijuana corporations that do business in their state. These taxes are generally based on a business's net worth, rather than income alone.

Other states have created specific excise taxes that apply to medical marijuana. An excise tax is a tax paid on a particular good, such as the sumptuary taxes imposed on tobacco and alcohol.⁵⁷ However, it should be noted here that an excise tax seems at odds with marijuana that has been legalized solely for medical use. Medical expenses generally receive favorable tax treatment.⁵⁸

Overall, the tax revenues generated by medical marijuana vary greatly depending on what taxes the state has chosen to impose, the number of registered patients within the state, the average sales price, and the number of medical marijuana related businesses authorized by statute. For example, the California State Board of Equalization (BOE) estimated in December 2009, based on 2007 receipts from businesses identified as medical marijuana dispensaries, that the sales of medical marijuana in that state have resulted in an estimated annual sales and use tax revenue of \$58 million to \$105 million.⁵⁹ In an undated "media resource," the BOE reports that a review of data in 2013 confirms the reliability of that estimate.⁶⁰ In Colorado, medical marijuana generated \$5.4 million in sales tax revenue in Fiscal Year 2012-13 alone.⁶¹ However, no medical

⁵⁷ Cole, Gail. "Taxing Sins." *TaxRates.com*, 25 July 2013. <http://www.taxrates.com/blog/2013/07/25/taxing-sins-2/> Accessed Jan. 28, 2015.

⁵⁸ Louise Sheiner, "Tax Treatment of Health Expenditures." *Tax Policy Center Tax Topics*. Undated, <http://www.taxpolicycenter.org/taxtopics/encyclopedia/Health-Expenditures.cfm>. Accessed Feb. 2, 2015.

⁵⁹ California State Board of Equalization, "Media Resource: Medical Marijuana/Legalization of Marijuana," undated webpage. <http://www.boe.ca.gov/news/marijuana.htm>. Accessed Jan. 28, 2015.

⁶⁰ *Ibid.*

⁶¹ Cole, Gail. "Marijuana: What Retailers Need to Know." *TaxRates.com*. July 15, 2013. <http://www.taxrates.com/blog/2013/07/15/marijuana-what-retailers-need-to-know/> Accessed Jan. 28, 2015.

marijuana programs have returned more than 0.5% of their states' budgets.⁶² For an overview of the tax structures in other states, see Table 2 below. Please note that this table does not include states that have legalized medical marijuana but have not yet decided how to tax it. The table also does not account for local surtaxes that may be imposed.

⁶² Loeb, Jonah, and Chris Graf. "Which States Budgets Are Benefitting From Medical Marijuana -- and Who Is Missing Out?" *Minyanville*, 8 Nov. 2012. <http://www.minyanville.com/sectors/biotech-pharma/articles/legal-marijuana-legalized-medical-marijuana-legalized/11/8/2012/id/45677?page=full>. Accessed Feb. 2, 2015.

Table 2 – Medical Marijuana Taxation in Other States^{69 70}

State	State Sales Tax	State Sales Tax on Medical Marijuana	State Level Excise Tax	Wholesale Tax	Gross Receipts Tax	Other Notes
Alaska	0% ⁷¹	N/A	N/A	N/A	N/A	Dispensaries not allowed. ⁷²
Arizona	5.6% ⁷³	6.1% ⁷⁴⁷⁵	0%	0%	See footnote 73.	Sales tax is a gross receipts tax.
California	6.5% ⁷⁶	7.5% ⁷⁷	0%	Varies. ⁷⁸	0%	
Colorado	2.9%	2.9% ⁷⁹	0% ⁸⁰	0%	0%	
Connecticut	6.35%	6.35% ⁸¹	0%	0%	0%	

⁶⁹ Compiled by Alison Marqusee, Haverford College '16. Websites accessed Jan. 13-16, 2015.

⁷⁰ "N/A" indicates that medical marijuana is not taxed because dispensaries are not allowed; only home cultivation. In contrast, "0%" indicates that medical marijuana may be sold at dispensaries but is not taxed by the state.

⁷¹ All state sales tax figures from www.taxrates.com.

⁷² <http://norml.org/legal/item/alaska-medical-marijuana>

⁷³ In Arizona the sales tax is known as a Transaction Privilege Tax and is a gross receipts tax.

⁷⁴ Opinion of the Attorney General Thomas C. Horne, Transaction Privilege Tax on Medical Marijuana, Opinion No. I11-004 (R11-001), July 7, 2011, <https://www.azag.gov/sgo-opinions/I11-004>, Accessed Feb. 2, 2015.

⁷⁵ Sales tax as of January 2015. Was 6.6%. Sales tax varies by county. http://www.azdor.gov/Portals/0/TPTRates/201501_Rev.pdf

⁷⁶ The state sales tax is 6.5%, but California adds a mandatory 1% local tax, for an effective rate of 7.5%.

⁷⁷ <http://www.boe.ca.gov/news/pdf/173.pdf>

⁷⁸ Localities in California can set their own regulations on wholesale and commercial cannabis production.

⁷⁹ <http://www.mpp.org/assets/pdfs/library/FeesAndTaxes.pdf>

⁸⁰ <https://www.colorado.gov/pacific/tax/marijuana-taxes-quick-answers>

⁸¹ <http://www.mpp.org/assets/pdfs/library/FeesAndTaxes.pdf>

Delaware	0%	0%	0%	0%	0.1037%- 2.0736% ⁸²	Gross receipts tax only applies after first \$1.2 million in income.
Hawaii	4%	N/A	N/A	N/A	N/A	Dispensaries not allowed. ⁸³ Hearings in early 2015 about potential changes to this. ⁸⁴
Illinois	6.25%	1% ⁸⁵	See footnote 87	7% ⁸⁶⁸⁷	0%	Medical marijuana is taxed at a reduced rate as a “prescription [or] nonprescription [medicine or drug].” ⁸⁸
Maine	5.5%	5.5% ⁸⁹	0%	0% ⁹⁰	0%	7% meals and rooms tax on edible products. ⁹¹
Michigan	6%	N/A	N/A	N/A	N/A	Dispensaries not allowed. ⁹²
Minnesota	6.875%	0% ⁹³	0%	0% ⁹⁴	0%	
Montana	0%	N/A	N/A	N/A	N/A	Dispensaries not allowed. ⁹⁵

⁸² http://revenue.delaware.gov/services/Business_Tax/Step4.shtml

⁸³ <http://norml.org/legal/item/hawaii-medical-marijuana>

⁸⁴ <http://mcchi.org/>

⁸⁵ <http://www2.illinois.gov/gov/mcpp/Documents/DOR%20-%20Occupation%20Tax.pdf>

⁸⁶ <http://www2.illinois.gov/gov/mcpp/Documents/DOR%20-%20Privilege%20Tax.pdf>

⁸⁷ This is called an excise tax, but it is levied on cultivators selling to dispensaries, rather than being explicitly added on to the sale price paid by the consumer.

⁸⁸ <http://medicalmarijuanalawillinois.com/>

⁸⁹ <http://www.mpp.org/assets/pdfs/library/Medical-Marijuana-Grid.pdf>

⁹⁰ http://www.mainelegislature.org/legis/bills/bills_126th/billtexts/HP086801.asp As Maine pursues a tax and regulate approach, it will impose an excise tax on marijuana sold from cultivators to dispensaries, but medical marijuana will be exempt.

⁹¹ <http://www.mpp.org/assets/pdfs/library/FeesAndTaxes.pdf>

⁹² <http://norml.org/legal/item/michigan-medical-marijuana>

⁹³ http://www.health.state.mn.us/topics/cannabis/manufacture/selection/meet_taxhandout.pdf

⁹⁴ http://www.health.state.mn.us/topics/cannabis/manufacture/selection/meet_taxhandout.pdf

Nevada	6.85%	6.85%	2% ⁹⁶	2% ⁹⁷	0%	
New Hampshire	0%	0%	0%	0%	0%	
New Jersey	7%	7% ⁹⁸	0%	0% ⁹⁹	0%	
New Mexico	5.125%	6%- 8.8125% ¹⁰⁰	0%	0% ¹⁰¹	See footnote 100.	Sales tax is a gross receipts tax.
New York	4%	4%	Gross tax called 'excise tax.'	0%	7% ¹⁰²	Called an excise tax, the 7% tax is levied on "gross income" of retailers, not on consumers. ¹⁰³
Oregon	0%	0% ¹⁰⁴	0%	0%	0%	
Rhode Island	7%	7% ¹⁰⁵	0%	0% ¹⁰⁶	0%	There is a 4% of net patient revenue

⁹⁵ Although Montana used to have dispensaries, a 2011 law forced them to close (<http://www.montanannorml.org/history>). Montana also has no sales tax. With no tax and only home cultivation permitted, Montana is largely irrelevant to determining the relationship between marijuana-related businesses and finance or tax policy. <http://norml.org/legal/item/montana-medical-marijuana>

⁹⁶ <http://www.mpp.org/media/press-releases/gov-sandoval-signs-medical.html>

⁹⁷ <http://www.mpp.org/media/press-releases/gov-sandoval-signs-medical.html>

⁹⁸ <http://www.mpp.org/assets/pdfs/library/FeesAndTaxes.pdf>

⁹⁹ Correspondence with New Jersey Department of Health, January 2015. All dispensaries in New Jersey cultivate their own marijuana; because they do not buy it wholesale, there can be no wholesale tax.

¹⁰⁰ New Mexico's sales tax is a gross receipts tax.

¹⁰¹ According to a January 2015 conversation with the New Mexico Department of Health, there are no wholesale marijuana cultivators in New Mexico. Each dispensary cultivates its own medical marijuana. Since there are no wholesale retailers, there is no wholesale tax.

¹⁰² <http://www.capitalnewyork.com/article/albany/2014/06/8547773/guide-nys-medical-marijuana-law>

¹⁰³ <http://www.capitalnewyork.com/article/albany/2014/06/8547773/guide-nys-medical-marijuana-law>

¹⁰⁴ <http://www.mpp.org/assets/pdfs/library/FeesAndTaxes.pdf>

¹⁰⁵ <http://www.leg.state.vt.us/jfo/reports/2012-02%20Medical%20Marijuana%20Fee%20and%20Tax%20Report.pdf>

¹⁰⁶ Conversation with Rhode Island NORM which consulted Compassion Centers. January 16, 2015.

						monthly surcharge for care centers. ¹⁰⁷
Vermont	6%	0%	0%	0%	0%	Vermont does not collect tax on medical marijuana because its laws on the subject do not specify a course of action. ¹⁰⁸
Washington St.	6.5%	6.5% ¹⁰⁹	0% ¹¹⁰	0% ¹¹¹	.138-.48% ¹¹²	
Washington, DC	5.75%	6.0% ¹¹³	0% ¹¹⁴		0%	

¹⁰⁷ <http://www.tax.ri.gov/regulations/other/CCS-01.pdf>

¹⁰⁸ <http://www.leg.state.vt.us/jfo/reports/2012-02%20Medical%20Marijuana%20Fee%20and%20Tax%20Report.pdf>

¹⁰⁹ <http://dor.wa.gov/Content/FindTaxesAndRates/marijuana/Default.aspx>

¹¹⁰ <http://www.bna.com/extras-excise-marijuana-b17179896945/>

¹¹¹ Conversation with Pioneer Nuggets marijuana growers, January 16, 2015 which represents that currently, medical marijuana in Washington is not very regulated. The Washington government is seeking to shut down the medical marijuana sector and shift everything to recreational, where regulations are tighter. Recreational marijuana is subject to a 25% tax at the wholesale level and 25% more at the consumer level, but these taxes may not apply to patients with a prescription, depending on the law that is ultimately passed.

¹¹² <http://www.seattlebusinessmag.com/article/infamous-bo-tax?page=0,1> B&O Tax. Unclear what medical marijuana falls under; however, see footnote 42

¹¹³ http://edr.state.fl.us/Content/constitutional-amendments/2014Ballot/UseofMarijuanaforCertainMedicalConditions/NotebookUpdates_10-28-13.pdf Sources say the "6% sales tax" will be applied because the provisions were written prior to 2013, when DC's sales tax dropped to 5.75%.

¹¹⁴ <http://www.theatlantic.com/politics/archive/2014/12/will-congress-let-washington-dc-legalize-weed/383276/> A proposal has been put forth to place an excise tax of 6% on medical marijuana, but has not yet passed.

III. Recommendations for Maryland

The Maryland medical marijuana statute does not provide for taxation of medical marijuana. While tax options discussed in the previous section are potentially available, general Maryland law regarding taxation must be considered.

While many states charge a sales tax on medical marijuana, Maryland exempts both prescription and non-prescription medications from the state sales and use tax.¹¹⁵ The term “medicine” as it is defined in the law means “a preparation or substance intended to cure, mitigate, treat or prevent illnesses.”¹¹⁶ This definition encompasses medical marijuana as the term is used in Senate Bill 923, and it is unlikely that the general sales and use tax will apply to medical marijuana.

Whether various paraphernalia associated with the medical use of marijuana meet the statutory exemption from the sales and use tax as “medical equipment for the home or on the person” is not obvious. In order to qualify for the exemption, the equipment must be able to “withstand repeated use,” is “used exclusively to serve a medical purpose,” and “is not useful to a person in the absence of illness or injury.”¹¹⁷ Most of the devices used to prepare or ingest medical marijuana are the same or substantially similar to those used for recreational purposes, although there are some products that are marketed solely for medical use. Thus these items might be subject to sales tax, even if sold in a medical marijuana dispensary.

¹¹⁵ Website: Spotlight on Maryland Taxes. Business Taxes>Business Tax Types>Sales and Use Tax>Tax Information>Special Situations>Medicine and Medical Equipment
[http://taxes.marylandtaxes.com/Business Taxes/Business Tax Types/Sales and Use Tax/Tax Information/Special Situations/Medicine and Medical Equipment.shtml](http://taxes.marylandtaxes.com/Business_Taxes/Business_Tax_Types/Sales_and_Use_Tax/Tax_Information/Special_Situations/Medicine_and_Medical_Equipment.shtml) Accessed Jan. 26, 2015.

¹¹⁶ *Ibid.*

¹¹⁷ *Ibid.*

The state could create a sales tax specifically for sales by growers and processing dispensaries to other dispensaries, as Washington State has done in imposing a 25% tax on wholesale transactions for producers, processors, and retailers. However, there is a strong argument that any additional tax of that scale imposed on growers and distributors would be unduly burdensome. Maryland growers and dispensaries are likely to be paying licensing fees to the state of \$125,000 and \$40,000 annually, as proposed.¹¹⁸ In addition, medical marijuana related businesses will generate new tax revenue in Maryland through income taxes due on their profits and their employees' wages. As mentioned above, most of these businesses will be paying more than the typical share of income taxes at both the federal and state levels paid by other businesses. There are no franchise or privilege taxes that are generally applicable to businesses in Maryland.

In lieu of sales and use taxes, Maryland could impose an excise tax on medical marijuana to be paid by patients. Although established public policy favors the exemption of medicines from taxation, medical marijuana is distinguishable from other medicines in one paramount criterion – it is illegal under federal law. It is not being regulated by the Food and Drug Administration or subject to the Federal Food, Drug, Cosmetic and Device Act.¹¹⁹ Thus, the state will incur substantial costs to carry out the regulations of its robust medical marijuana program. If the licensing fees alone do not meet the Commission's predicted expenditures, it would not be unreasonable to set an excise tax rate to cover operating costs. Nevada has taken this approach. Whether this tax should be on the value of the sale or on the potency of the THC/THCA in the marijuana is a question that should be addressed as well.

¹¹⁸ 42 Maryland Register 214, Jan. 23, 2015, Proposed COMAR 10.62.28.01.

¹¹⁹ 21 U.S.C. 301 *et seq.*

Ultimately, any tax at any level will be passed on to the patients, resulting in higher final prices. Medical marijuana is not inexpensive. The reference website www.procon.org published an estimate that an average dose of medical marijuana is 1 gram and that the average price of a gram of medical marijuana \$17.14. This converts to \$514 per month and \$6256 per year.¹²⁰ Patient purchases of medical marijuana are not currently being reimbursed by health insurance carriers. Considering Maryland's medical marijuana fee structure, the extraordinary cost of capital to enter into this market (high risk and few lenders), and the relatively strong proposed regulatory requirements, tax policy decision makers need to be mindful of the impact any tax will have on patients.

The worst outcome from the imposition of taxes would for legal medical marijuana to cost more at the retail level than illegal marijuana would cost in the illegal market.

If policy makers want to consider imposing a taxation scheme on medical marijuana, it would be sensible to wait until the market has been established and prices have been set in order to effectively model the revenues and consequences of such taxation.

D. BANKING AND FINANCIAL TRANSACTIONS

I. Exclusion of Medical Marijuana Businesses from Banking

As discussed in Part B.I. above, financial transactions of investment in the production of marijuana and in the proceeds of marijuana sales violate federal money laundering statutes. Thus most banks refuse to open accounts for medical marijuana businesses, and if they learn that an account has been opened by such a business, they close the account. Kristi Kelly, the owner of Good Meds in Lakewood, Colorado has had 23 bank accounts canceled.¹²¹ Perhaps 5 percent of

¹²⁰ "How does the cost of Marijuana compare to the Cost of Marinol?" in Medical Marijuana Pros and Cons (undated). <http://medicalmarijuana.procon.org/view.answers.php?questionID=000091> Accessed Feb. 4, 2015.

¹²¹ Mark Richtel, "The First Bank of Bud, *The New York Times*, Feb. 8, 2015, p. BU 1. <http://nyti.ms/1EJep9G>, Accessed Feb. 8, 2015.

Colorado's marijuana businesses use a financial institution, according to Don Childears, chief executive of the Colorado Bankers Association, but other estimates suggest a higher percentage but none estimate as many as half of the marijuana businesses in the state.¹²² The result is an industry that endures the costs and risks of operating exclusively in cash. The Karing Kind dispensary in North Boulder, Colorado holds \$80,000 to \$100,000 in cash in its nine 1,000 pound safes at any one time. It pays \$100,000 per year for armed guards to watch the premises, and to deliver payments to tax offices and vendors. Karing Kind has no bank account, having lost more than a dozen accounts, according to its owner, Dylan Donaldson.¹²³ Medical marijuana businesses must search far and wide to find banks that are willing to take on the risk, if they can find them at all.¹²⁴

II. Financial Institutions and “Guidance” from the Federal Government

Despite the guidance set forth in memoranda released by the Obama administration that seek to create a “safe harbor” for banks and financial institutions to offer financial services to marijuana-related industries, the financial industry remains hesitant to serve this burgeoning industry. Financial institutions are guided by the recognition of special responsibilities of trust and due diligence to be seen as reliable and in full compliance with the law. Due to the continued illegality of marijuana under federal law, and the illegality of financial transactions related to illegal drugs, every financial institution must be sensitive to the risks to its reputation as well as civil and criminal liability.

On February 14, 2014, the Justice Department issued another “Cole Memo” by Deputy Attorney General James Cole to U.S. Attorneys entitled “Guidance Regarding Marijuana Related

¹²² *Ibid.*

¹²³ *Ibid.*

¹²⁴ Joel S. Newman, “Deductions on a Higher Plane: Medical Marijuana Business Expenses,” *Lexis Federal Tax Journal Quarterly*, Sept. 2013, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2333969##. Accessed Feb. 2, 2015.

Financial Crimes.”¹²⁵ The Cole 2014 Memo sought to clarify instances in which the Department would pursue cases against financial institutions under federal law, restating that “prosecutors should apply the eight enforcement priorities” in determining whether to pursue a marijuana-related offense that were articulated in the Cole 2013 Memo.¹²⁶ However, the Cole 2014 Memo concluded with a routine “boilerplate” caveat that to a financial institution contemplating provides financial services to a marijuana-related business must be quite ominous: “Neither the guidance herein nor any state or local law provides a legal defense to a violation of federal law, including any civil or criminal violation of the CSA [Controlled Substances Act], the money laundering and unlicensed money transmitter statutes, or the BSA [Bank Secrecy Act], including the obligation of financial institutions to conduct customer due diligence.”¹²⁷

On the same day, the Treasury Department’s Financial Crimes Enforcement Network (“FinCEN”) issued its own guidance memorandum for financial institutions entitled “BSA Expectations Regarding Marijuana-Related Businesses.”¹²⁸ The memo “clarifies how financial institutions can provide services to marijuana-related businesses consistent with their BSA [Bank Secrecy Act] obligations, and aligns the information provided by financial institutions in BSA reports with federal and state law enforcement priorities.”¹²⁹ Under the new guidelines, a financial institution shall file a suspicious activity report (“SAR”) if any services are provided to “marijuana-related businesses,” using various reporting labels if:

- The business is in compliance with state law and in compliance with the 8 priorities of the Cole Memo;

¹²⁵ Cole 2014 Memo

¹²⁶ *Ibid.*, p. 2

¹²⁷ *Ibid.*, p. 3

¹²⁸ “BSA Expectations Regarding Marijuana-Related Businesses.” Department of the Treasury Financial Crimes Enforcement Network, FIN-2014-G001. February 14, 2014.

¹²⁹ *Ibid.*

- If the business is reasonably believed to be violating state law or the one of the Cole priorities; or
- If the business relationship is terminated due to money laundering concerns.¹³⁰

However, financial institutions are still reluctant to provide services to marijuana-related businesses. Frank Keating, president and CEO of the American Bankers Association said, “the guidance and regulation doesn’t alter the underlying challenge for banks... As it stands, possession or distribution of marijuana violates federal law, and banks that provide support for those activities face the risk of prosecution and assorted sanctions.”¹³¹ Some bankers fear the guidance in a harsher light. Don Childears, of the Colorado Bankers Association told *The New York Times*, the guidance, which requires the filing of suspicious activity reports, “raised the liability for the banks.”¹³²

The Administration’s memoranda of “guidance” to the financial industry’s dealings with the legal marijuana industry use the rubric of a “marijuana-related business,” and do not distinguish between medical marijuana and recreational marijuana businesses, both of which are illegal under federal law, but may be permitted under state law. In 2017, a new Administration may follow the Obama Administration on medical marijuana, but take a diametrically opposed position on recreational marijuana. “Guidance” can be reversed, and financial institutions could find themselves in legal and reputational jeopardy.

III. Consequences of Limited Availability of Financial Services

¹³⁰ *Ibid.*, p. 3-5.

¹³¹ Ferner, Matt. “House Votes To Allow Banking Access For Marijuana Businesses.” *Huffington Post*. July 16, 2014. http://www.huffingtonpost.com/2014/07/16/house-marijuana-banking_n_5592620.html Accessed Jan. 30, 2015.

¹³² Mark Richtel, “The First Bank of Bud,” *The New York Times*, Feb. 8, 2015, p. BU 1. <http://nyti.ms/1EJep9G>, Accessed Feb. 8, 2015.

The practical effects of not having access to basic financial services are numerous. If businesses are unable to use banks, they cannot establish checking accounts or credit card accounts.¹³⁴ As a result, most medical marijuana businesses operate as cash-only enterprises. Customers are seriously inconvenienced by having to make purchases only with cash. Landlords, utilities, and other vendors are loath to receive payment in cash. Having so much cash on hand leads to increased security costs, as well as the substantially increased risk of being victimized by crime with the attendant risks to employees and customers. The unwillingness of banks to deal with medical marijuana businesses may also make it more difficult for medical marijuana businesses to obtain loans from transparently legal sources to start their enterprises.

The financial transactions of medical marijuana patients are also affected by the federal government's rejection of the medical value of marijuana. Insurance companies do not cover medical marijuana expenses because marijuana continues to be classified as a schedule I drug, Susan Pisano, a spokeswoman for America's Health Insurance Plans, a trade group told NPR in 2012.¹³⁵ Medical marijuana treatment can cost a patient as much as \$1,000 a month.¹³⁶ Patients in Maryland do not have the option to grow their own medical marijuana as is permitted in many states.

IV. Recommendation for Maryland

¹³⁴ *Id.*; See also Jon Matonis, "Credit Card Processors Discriminate Against Medical Marijuana," *Forbes*, Sept. 29, 2012, <http://www.forbes.com/sites/jonmatonis/2012/09/29/credit-card-processors-discriminate-against-medical-marijuana/>. Accessed Jan. 27, 2015.

¹³⁵ Michelle Andrews, "When Your State Says Yes To Medical Marijuana, But Your Insurer Says No," NPR, Nov. 20, 2012, <http://www.npr.org/blogs/health/2012/11/20/165554172/when-your-state-says-yes-to-medical-marijuana-but-your-insurer-says-no>. Accessed Jan. 27, 2015.

¹³⁶ "Health Insurers Just Say No to Marijuana Coverage." CBS News. 8 May 2014. <http://www.cbsnews.com/news/health-insurers-just-say-no-to-marijuana-coverage/>. Accessed Jan. 27, 2015.

One approach to address this problem would be to work with Maryland's Commissioner of Financial Regulation in the Department of Labor, Licensing and Regulation to explore the feasibility of issuing a Maryland charter for a financial institution that could provide financial services to Maryland's medical marijuana industry.

The case for such this approach was detailed in *The New York Times* on February 8, 2015 in an article, "The First Bank of Bud," by Matt Richtel. Richtel describes the situation set forth above and details the effort of attorney Mark Mason to establish the Fourth Corner Credit Union in Denver, CO, which has been licensed by the state of Colorado.¹³⁷ Unfortunately state licensure by itself is insufficient to address the problem. In order to open for business, Fourth Corner Credit Union is awaiting the award of a "master account" by the Federal Reserve Bank of Kansas City, and insurance coverage by the National Credit Union Administration, a federal regulatory agency. Such approvals have profound consequences, according to Professor Peter Conti-Brown at Stanford Law School. He believes that such federal approvals "could let the cannabis industry blossom," according to Mark Richtel.¹³⁸

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¹³⁷ Mark Richtel, "The First Bank of Bud," *The New York Times*, Feb. 8, 2015, p. BU 1. <http://nyti.ms/1EJep9G>, Accessed Feb. 8, 2015.

¹³⁸ *Ibid.*