The effect of marijuana legalization on the workplace
Medical marijuana (MM) has been described in the media as a drug with questionable medical benefits, which has long been embroiled in controversy, cultural traits and political entanglements.

The federal government first made cannabis illegal in 1937. Since that time, there have been multiple organized efforts to legalize it. California was the first state to take this action when it made the substance legal for medical use in 1996. Over the next 20 years, 43 states and the District of Columbia legalized the use of medical marijuana or a derivative thereof for medical purposes, and four states and the District of Columbia have legalized it for recreational use. (See Figure 1 below.)

Figure 1: State marijuana laws

2016 was viewed as a big year for proponents of marijuana. Five states had ballot initiatives to legalize the plant for recreational use with four passing (AZ was the lone exception). Several other states had initiatives to either make marijuana legal for medical use for the first time, or to relax the laws on the books by expanding use, with all those initiatives passing. (See Figure 2 below.)
The driving force behind legalization has been public opinion, which has reached historical levels of approval.

Over the last decade, the percentage of those in favor of full legalization has jumped from 32% to 57%, with the largest support coming from millennials. (See Figures 3 and 4.)
The effect of marijuana legalization

According to a Quinnipiac University Poll released on June 6, 2016 this support grows to 87% on the narrow question of legalizing marijuana for veterans suffering from PTSD.

While the American public is largely behind legalization, according to an evaluation by the National Organization for the Reform of Marijuana Laws (NORML), support from elected officials is more tepid. Given this disparity in views and the legal issues discussed below, it is likely full legalization will continue as a contested issue for the foreseeable future.

NORML gives congressional members a letter grade rating based on their support for the legalization of marijuana. Although grades are all over the board for both parties, governors are heavily partisan, creating a much more pronounced political divide among the grades for the nation’s governors. Of the 18 Democratic governors rated, 17 received a grade of C or higher while only 11 of the 31 Republican governors received that mark. Thus it is reasonable to conclude that the march towards legalization is likely to be slower in strongly Republican states.

The statutory collage

The 800-pound gorilla in the debate on marijuana use is the Federal Controlled Substances Act. Passed in 1970, the law has listed marijuana as a Schedule I drug since its passage, meaning that the federal government views the substance as highly addictive and with no known medical use. On August 11, 2016 the Drug Enforcement Administration refused to reclassify the drug despite overwhelming support of the public for this move.

Legal use of a banned substance as a medication on a wide scale is not without precedent. During the time between the passing and repeal of Prohibition, “medicinal whiskey” was available by prescription for uses stated by the U.S. Department of Treasury and Internal Revenue. The difference between that system and current marijuana use is that the federal government controlled the regulation of and use of whiskey. Any questions about the federal government being able to enforce the provisions of the Federal Controlled Substances Act were put to rest in Gonzales v. Raich (2005). In that case, the Supreme Court ruled that the Commerce Clause of the U.S. Constitution authorizes the federal government to enforce the provisions of this act, despite any state laws that legalize its use.
The different state laws and regulations have been enacted to differing results. Colorado has a well-regulated system that covers sales, possession, maximum tax rates and the rights of cities and counties to exclude shops in their jurisdictions (similar to a “dry county” prohibiting alcohol sales). By contrast, Washington State started with a market that was far less regulated, leading to significant issues with enforcement and confusion in the industry. A review of marijuana laws and regulations in your state is highly encouraged and any questions should be directed to a qualified legal advisor.

Given the illegality of the drug on a federal level, different strategies have been used to allow the marijuana industry to operate openly in states where it has been legalized. However, none of these strategies are guaranteed to continue to be effective and can change depending on actions taken by Congress and/or the President of the United States.

In order for a state to remain compliant, they must first legalize marijuana for limited use. All other mechanisms hinge on this taking place. Once this happens, state entities are barred from prosecuting persons in compliance with state laws, leaving federal prosecution as the only criminal concern. Please note however, that while this bars a state prosecution, it does not bar law enforcement agencies from using federal law as a basis for arrest, search or detainment.

In the absence of federal legalization, there are two mechanisms the federal government has used to avoid prosecutions. The first is a statement, available to the public, that the Department of Justice does not consider prosecution of individuals who are in compliance with state law to be good use of limited resources. This was done through a series of memos within the Department of Justice.5

The second mechanism is to pass laws aimed at restricting the use of government funds for a particular purpose, particularly prosecution efforts. Multiple bills have been proposed and some passed for this purpose. The Rohrabacher-Farr Amendments, passed as part of the 2014 and 2015 spending bills, specifically prohibit the Drug Enforcement Agency (DEA) from using funds to prosecute those in compliance with state laws. The Rohrabacher-Farr amendment has to be passed into law each year (see Legislation table below).

The DEA tested the language of this amendment in the U.S. v. McIntosh (a consolidation of 10 appeals by growers and distributors)6. Their argument that the language of the amendment only restricted state actions was rejected by the 9th Circuit Court of Appeals. The Supreme Court refused to take up the case, leaving the DEA without further recourse. Shortly after this decision, the DEA announced it would consider removing marijuana from its list of Schedule I drugs; a move they most recently rejected in late 2016.

Synthetic cannabinoids
First synthesized in the 1960s, synthetic cannabinoids continue to present special problems regarding their use:
• Drug detection tests cannot keep pace with the new derivatives.
• They are more potent than cannabis.
• They are unregulated, so effects and dosing is unknown.
• Biggest risk may be the perceived safety by the public.
The effect of marijuana legalization

Surveys indicate that public opinion supports full legalization. That support climbs to nearly three-fourths of those surveyed when it is legalized for use in coordination with a physician.  

One major concern with reclassification is a significant impact on drug-free workplaces. Once it is accepted as having medicinal value, marijuana would have to be treated like other prescription medications; necessitating a move from zero tolerance to not allowing use if it causes impairment. Without a legally defined level for impairment and an easy test for measurement, there will be challenges.  

Because of the perceived public support, marijuana legalization will continue to be an issue on ballots for the foreseeable future, and it is not unreasonable to conclude that it might just be a matter of time before elected officials start displaying the same support for legalization as the public.  

The ongoing state of limbo makes addressing this area difficult, but necessary even for states that have yet to legalize it in any form. It would be prudent to begin making plans for how to deal with full legalization.

Table 1: Recent legislative action on marijuana legalization

<table>
<thead>
<tr>
<th>LEGISLATION (latest legislative action)</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rohrbacher-Farr Amendment (Passed and signed into law annually 2014 – Present)</td>
<td>Attached to annual budget appropriations bill. Prohibits the DEA from using funds to enforce federal law against those in compliance with state laws.</td>
</tr>
<tr>
<td>Veteran’s Equal Access Act (House – in committee)</td>
<td>Allows physicians affiliated with the Department of Veterans Affairs to recommend cannabis in states where legal.</td>
</tr>
<tr>
<td>Daines-Merkley Amendment (Senate – in committee)</td>
<td>Prohibits the Department of Justice from interfering with state-specific medical marijuana programs that license the production and dispensing of cannabis to qualified patients.</td>
</tr>
<tr>
<td>McClintock-Polis Amendment (failed in the House)</td>
<td>Prohibits the Department of the Treasury from using federal funds to take punitive actions against banks and other financial institutions that provide services to marijuana-related businesses that are operating legally under state laws.</td>
</tr>
<tr>
<td>Mikulski Amendment (passed the Senate Committee)</td>
<td>Amends the Controlled Substances Act so that control and enforcement of provisions relating to marijuana not apply to any person acting in compliance with state law. Transfers marijuana from Schedule I to Schedule II.</td>
</tr>
<tr>
<td>Merkley Amendment (introduced in the Senate)</td>
<td>Removes marijuana from the Controlled Substance’s Act Schedule. Transfer oversight from the DEA to the Bureau of Alcohol, Tobacco, Firearms and Explosives.</td>
</tr>
<tr>
<td>CARERS Act (Introduced in the Senate)</td>
<td>Sets up a federal excise tax for regulated marijuana.</td>
</tr>
<tr>
<td>Compassionate Access, Research Expansion, and Respect States Act</td>
<td></td>
</tr>
<tr>
<td>Regulate Marijuana Like Alcohol Act (Proposed by Rep. Jared Polis; D-CO)</td>
<td></td>
</tr>
<tr>
<td>Marijuana Tax Revenue Act (Proposed by Rep. Earl Blumenauer; D-OR)</td>
<td></td>
</tr>
</tbody>
</table>
If legalization follows the same pattern as the repeal of Prohibition, commentators say that America could see an uptick in its use followed by a decline back to baseline levels. To get an idea of how large this market could be, some estimates are that if marijuana is legalized in the U.S. that by 2020, it would be a $35 billion a year industry. 

Impact of the 2016 presidential election

Donald Trump’s administration may have a significant impact on federal marijuana policy, though President Trump himself has been largely quiet on this topic. He has previously indicated his support for allowing states to decide the issue, but there has been no formal announcement of policy. Press Secretary Sean Spicer has implied in press conferences that he believes there will be increased enforcement against recreational marijuana use.

Attorney General Jeff Sessions has made multiple public comments, while a sitting Senator, indicating a strong opposition to the use of marijuana for any reason. Since his confirmation, Sessions has spoken about increased enforcement against recreational use, while maintaining his belief that there is no accepted medical use.

The continuing Federal funding resolution passed by Congress and signed by President Trump on May 5, 2017 provides that the Department of Justice may not use funds to prevent implementation of medical marijuana laws by various states and territories.

Workers’ Compensation

Background

Similar to alcohol use, most states with laws legalizing some aspect of marijuana use allow employers to regulate the use of marijuana at their facilities even though its use may be legal. This, combined with the fact that marijuana remains illegal under Federal law, provides some challenges for businesses as they consider workplace drug policies. The U.S. Department of Transportation continues to consider marijuana unacceptable under its Drug and Alcohol Testing Regulations, so safety-sensitive positions like pilots, bus and truck (CDL) drivers, locomotive engineers, subway operators, aircraft maintenance personnel, ship captains and others must comply with the guidelines. Also, businesses functioning as federal government contractors must comply with The Drug-Free Workplace Act. Most states with laws legalizing some aspect of marijuana use do not preclude businesses from setting workplace drug policies, particularly in safety-sensitive positions.

What other types of jobs might be considered a safety-sensitive position?

Here are some example job duties:

- Driving motorized vehicles, including highway, off-road, industrial forklifts, or construction equipment
- Working with heavy machinery
- Exposure to machinery that might represent entanglement or entrapment hazards
- Working at heights
- Working with hazardous chemicals/materials or hazardous processes

Job descriptions should clearly define these types of characteristics. Most white collar type jobs can be difficult to classify as safety-sensitive, unless driving a vehicle for business is required.
New complications associated with the legalization of marijuana provide employers with adequate cause to begin a review of their existing workplace drug policy. It is important to review and possibly adjust policies to align provisions with current regulation, particularly if operations occur in states with legalized marijuana.

**Policy review**

As a review of the workplace drug policy begins, one aspect that should be considered is whether to implement a policy which outlines zero tolerance to specified drugs or a policy that prohibits employees from being impaired while working. Zero tolerance may be the easiest to enforce and most protective. Testing looks for presence of a specified drug, and if detected, the employee may be found in violation of the company policy. This approach provides more test options: blood, urine, hair, saliva, etc. Enforcement of disciplinary actions may be more straightforward.

Stating that employees are prohibited from being impaired at work may make sense in some situations, such as in states with legalized recreational use of marijuana. Testing looks for documentation of a specified drug level above a documented impairment amount. Since a more specific result is needed to substantiate impairment, testing options may be limited to the use of a blood test. For example, urine testing, the most common test for tetrahydrocannabinol (THC) levels (the active ingredient in marijuana), may not be sensitive enough to provide the degree of certainty required to prove impairment. OSHA has acknowledged that the only common drug test used in the workplace that can determine impairment is testing for alcohol. For policies that stipulate a lack of impairment, supervisors and employees must clearly understand the policy and be trained in the signs and symptoms of impairment.

For policies that stipulate a lack of impairment, supervisors and employees must clearly understand the policy and be trained in the signs and symptoms of impairment. Here is one definition of impairment, taken from the Illinois medical marijuana statute: “The employer can have a ‘good faith’ belief that an employee is impaired if he/she exhibits behaviors such as decreased job performance or symptoms of employee’s speech, physical dexterity, agility, coordination, demeanor, irrational or unusual behavior, negligence or carelessness in operating equipment or machinery, disregard for the safety of the employee or others, or involvement in an accident that results in serious damage to equipment or property, disruption of a production or manufacturing process or carelessness that results in any injury to the employee or others.”

Also, the level of THC that indicates impairment is open to interpretation. Some states that have legalized recreational marijuana suggest 5 ng/ml of active tetrahydrocannabinol (THC) in their whole blood plasma as the level, above which would indicate impairment. This level has generally been set for driving under the influence for Colorado laws.

**Policy components**

Any workplace drug policy should outline when testing would be conducted. Possible testing times could include:

- Pre-employment, such as post-offer but pre-hire testing
- Random testing
- Testing in the event of suspected impairment, sometimes called “reasonable suspicion”
- Testing after an incident that involves property damage or injury, sometimes called post-accident (or post-incident) drug tests

* Zurich can take no position on what approach is appropriate for any particular business as that decision should be made only after consultation with qualified legal advisors.
OSHA’s update to their recordkeeping standard (29 CFR 1904) released in May 2016 included several anti-retaliation provisions. One such provision involves mandatory post-accident drug testing. OSHA’s documentation indicates that blanket mandatory post-accident tests could be a deterrent to injury reporting and, as such, would be forbidden under these provisions.

For a negative employment action that has been taken following a post-accident drug test to be considered “valid,” the employee’s potential impairment would need to be a contributing factor in the incident or accident. For example, if the injury involves an employee being struck by an object from above, the injured employee’s impairment probably would not contribute to the incident. In this case, a mandatory drug test may discourage the employee from reporting the injury if the employee had reason to be concerned about the test result. In another example, if an employee was injured while ignoring or violating a work rule, such as bypassing a machinery guard to speed up production, the employee’s possible impairment could be a contributing factor to the accident. In this event, the individual’s potential impairment is pertinent to the accident and a mandatory drug test may be justified. Only drug test protocols that can quantify and validate impairment are acceptable, such as a blood alcohol test (BAC). As noted earlier, as of the writing of this white paper, OSHA acknowledges only drug tests for blood alcohol level can determine impairment. Other tests that only note the presence of an illegal drug, but not its quantity as related to possible impairment, may be useful, but would not meet the full intent of the standard update. For example, many tests for marijuana identify usage within certain timeframes depending on the test, but may not show current impairment.

When drug testing is part of a workplace drug policy, additional aspects of the testing program will need to be specified:

- Who will be tested (all employees or only those in production or safety-sensitive positions)?
- What type of testing will be done (which and what number of drugs, such as a 5-panel or 10-panel test)?
- Testing occasions (as noted above)
- Consequences of a positive test (termination, disciplinary action, etc., depending on whether the policy is zero tolerance or impairment-based)
- Testing specifics, such as collection protocols, analytical cut-offs, confirmation tests, etc.

In addition to the drug testing timing/occasions and procedures noted above, workplace drug policies may also contain the following components:

- Rationale for the policy. This may outline the importance of a drug-free workplace to promote the safety, health and well-being of employees, maintaining appropriate production activities and assuring product quality.
- Prohibited behaviors. This would outline those activities or conditions that are to be avoided as part of the policy. This may include prohibiting drug use (zero tolerance) or an outline of the expectation that workers will not come to work in an impaired state.
- Substances that are covered. This will specify the substances that are included on the prohibited substance list, such as marijuana, cocaine, opiates, amphetamines and PCP. Other substances, such as alcohol and some prescription medicines may be added as appropriate.
- Drug thresholds. This will specify level at which impairment will be confirmed.
Some court cases in selected states with medical marijuana provisions have required employers or workers’ compensation carriers to pay for treatment.

All aspects of the company’s workplace drug policy should be communicated to all employees through clear educational messages. Select employees, such as supervisory and management staff may need specialized education that covers the details of the enforcement of the policy, such as:

- Policy effective date (e.g., lead time for communication)
- Circumstances for enforcement
- Special training on identifying potential impairment, if appropriate
- When/how medical reviews/testing will be done
- Handling disciplinary actions
- Reasonable suspicion protocols (DOT regulation)

Training and educational efforts will be particularly important if any changes have been made to the workplace drug policy.

**Medical reimbursement**

As marijuana is still considered illegal under federal law, that status under federal law has been the general guidance preventing medical reimbursement of marijuana therapy by workers’ compensation carriers. Some court cases in selected states with medical marijuana provisions have required employers or workers’ compensation carriers to pay for treatment. Some of these cases are under appeal. The direction that this trend will take has not been clearly defined and will demand monitoring by healthcare providers, employers and workers’ compensation carriers.

**Summary**

Workplace drug policies are an important aspect of many companies that can outline the company’s goals for keeping employees safe, production sound and customers served with high quality products and services. Given the recent changes in marijuana legalization and continued legislative efforts, it is important for companies to review their workplace drug policies, exploring if zero tolerance or impairment-based approaches are appropriate. They should reevaluate drug testing protocols, if present, to see if they match the goals of the policy, meet local or federal standards, and clearly educate all parties on the requirements of the policy. Any changes in workplace drug policies should be thoroughly reviewed with human resources and legal counsel familiar with local statutes and the jurisdictions involved. Finally, stakeholders should monitor legislative activities and case law to stay up to date on changing trends.
Department of Transportation (DOT) Regulations

Federal restrictions
The Department of Transportation (DOT), which oversees the many ways people and goods are transported in the United States, has not wavered in its position regarding marijuana use of any kind — medical or recreational — since states began legalizing the drug. In fact, Jim Swart, Director for the Office of Drug and Alcohol Policy and Compliance, reiterated his office’s position in December 2012 when he said, “The state initiatives will have no bearing on the Department of Transportation’s regulated drug testing program. The Department of Transportation’s Drug and Alcohol Testing Regulation – 49 CFR Part 40 – does not authorize the use of Schedule I drugs, including marijuana, for any reason.”

While the DOT has yet to reference specific research findings to support their position, laws or voter initiatives legalizing the possession of small amounts of marijuana for personal use have created confusion and controversy about the status and safety of marijuana, including its use in relation to safety-sensitive functions and operating a motor vehicle.

Impairment
The National Highway Transportation Safety Administration (NHTSA) Drug and Human Performance Fact Sheets highlight the effects of marijuana use and its relationship to performance, tolerance and dependency. Unlike alcohol, impairment by marijuana is oftentimes difficult to accurately measure and enforcement can vary state-to-state, but short-term effects of marijuana use may include:

- Problems with memory and learning
- Distorted perception
- Difficultly in thinking and problem-solving
- Loss of coordination

For heavy users the effects may include:
- Increased difficulty sustaining attention
- Shifting attention to meet the demands of changes in the environment
- Registering, processing and using information

Significant performance impairments are usually observed for at least 1-2 hours following marijuana use and residual effects have been reported up to 24 hours.

Currently, laws governing the use of a motor vehicle following the use of marijuana fall into one of three categories:
- Effect-based laws
- Per se driving under the influence of drugs (DUID) laws
- Zero tolerance laws

Effect-based laws require evidence of impairment to be presented in order to convict someone of driving under the influence. Under per se laws, a person is assumed to have committed a violation if the drug concentration exceeds a defined concentration (typically in the blood) and there is no requirement to obtain evidence of impairment beyond that required for the probable cause to obtain the specimen. Under zero tolerance laws, any detectable amount of the proscribed substance in the blood constitutes the offense.
Marijuana has been shown to impair performance on driving simulator tasks and on open and closed driving courses for up to approximately three hours. Decreased car control performance, increased reaction times, impaired time and distance estimation, inability to maintain headway, lateral travel, subjective sleepiness, motor incoordination, and impaired sustained vigilance have all been reported.

Furthermore, marijuana may particularly impair monotonous and prolonged driving. Decision times to evaluate situations and determine appropriate responses increase. Mixing alcohol and marijuana may dramatically produce effects greater than either drug on its own.21

In 2016, the American Automobile Association (AAA) Foundation for Traffic Safety study examined the prevalence of marijuana involvement in fatal crashes in the state of Washington from 2010-2014, and investigated whether the prevalence changed after Washington Initiative 502, which legalized recreational use of marijuana, took effect on December 6, 2012. The study estimated that an average of 10% of all drivers involved in fatal crashes in Washington between 2010 and 2014 had detectable THC in their blood at the time of the crash. There was evidence that the proportion of drivers in fatal crashes who were positive for THC increased after Initiative 502 legalized recreational use of marijuana for adults aged 21 years and older; however, the increase was not immediate and appeared to have begun approximately nine months after the initiative’s effective date. In 2014, the number and proportion of drivers in fatal crashes who were positive for THC were both more than double the averages from the prior four years.22

Healthcare professional liability

The driving force behind the legalization of marijuana as a medication has been popular opinion, not the traditional route of medical knowledge.23 This has led to many providers being uneasy about recommending its use.

Of special concern is the possibility of approval for use of medical marijuana by children as states begin to change their laws.24 The impact of long-term use on the brain development of a child is unknown. Also, because pediatric patients are much more sensitive to dosing amounts, the unknown interactions and effects have a heightened risk. These problems are complicated by the fact that the last few decades have seen a dramatic increase in potency.

Figure 5: Potency

Average THC content of submitted samples

Source: Potency Monitoring Program, Quarterly Report Number 132, National Center for Natural Products Research (NCNPR) at the University of Mississippi, under contract with the National Institute on Drug Abuse.
There is also risk in the dispensing, prescribing/recommending and interactions with patients who choose to use marijuana.

Per the Colorado Department of Public Health and Environment, patients with medical marijuana recommendations in that state described the following medical conditions (patients could choose more than one condition, therefore the totals do not add up to 100%). See Figure 6 below.

**Figure 6:**
Percent of medical marijuana patients based on reporting condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cachexia</td>
<td>1</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>1</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>1</td>
</tr>
<tr>
<td>Seizures</td>
<td>2</td>
</tr>
<tr>
<td>Cancer</td>
<td>4</td>
</tr>
<tr>
<td>Severe Nausea</td>
<td>12</td>
</tr>
<tr>
<td>Muscle Spasms</td>
<td>20</td>
</tr>
<tr>
<td>Severe Pain</td>
<td>93</td>
</tr>
</tbody>
</table>

*Source: Colorado Department of Public Health and Administration*

To get an idea of the amount of use, the state of Colorado reported the following statistics:

- The potential range of demand is between 104.2 – 157.9 metric tons per year (229,719.32 – 348,106.34 pounds). Visitors are estimated to contribute about 6% of the total.
- There are an estimated 485,000 regular users (at least once per month) equaling 9% of the population of all ages (5.363 million).
- Out-of-state visitors represent 44% of the metro-area retail sale of marijuana and about 90% of the sales in heavily-visited mountain communities.
- 23% of Colorado users consume daily compared to 17% of users nationally.25

**Dispensing risks**

**Failure to validate:** In June of 2011, the California Medical Board sent a notice to dispensaries directing them in their responsibility to ensure that a physician who issues a medical marijuana letter is practicing legally before dispensing. Dispensaries can verify if the name is fictitious by checking with the California Medical Board. Only physicians are allowed to own medical clinics and must be organized under California law.
While this is specific to California, many states have similar provisions regarding ownership and dispensing. Most state laws explicitly express that a person who holds a valid card is protected from prosecution. However, it is unclear what criminal or regulatory violations occur if a dispensary fails to properly validate the card of a purchaser. Many experts have commented that this would likely be treated similarly to the illegal obtaining of other controlled substances.

**Drug diversion:** Drug diversion is a medical-legal concept involving the transfer of a legally prescribed controlled substance from the person to whom it was prescribed to another person. While not specific to marijuana, it is a well-known risk for many drugs with psychotropic effects and/or a high street value. In the cases of marijuana dispensaries, this risk is higher as some estimates state that up to 90% of product and financial loss in the medical marijuana industry is due to employee theft.

**Interstate commerce considerations:** While marijuana may be legal in neighboring states, transportation of the substance across state lines is still illegal. While there are no cases to date concerning medical marijuana, a healthcare provider who advises a patient about availability across state lines may be in violation of trafficking laws.

**Prescribing/recommending cannabis use**

**Failure to perform a good faith exam:** State laws vary on what is required for a physician to be able to legally recommend cannabis use by their patients. Most require a “good faith” exam to ensure that the patient qualifies, especially in those states which restrict its use to the treatment of listed conditions. The question of whether telemedicine can be used for this exam also varies by state. Readers are encouraged to research their state’s requirements and seek qualified legal advice.

**Figure 7: State laws related to telemedicine use for marijuana**

Finally, failing to follow the law may leave open the possibility of prosecution by the DEA and/or Department of Justice. The 9th Circuit U.S. c. McIntosh decision only prohibits prosecution of those in compliance. It is an untested question whether or not non-compliance due to negligence would be sufficient for prosecution. Given the DEA’s history of challenges to the Rohrbacher-Farr Amendment (see above) and other attempts at restricting its authority, it is not unreasonable to suspect that this could be used as a tactic to allow them to continue their pursuit of physicians.
Facility risks
Dispensing of medication: Many facilities have decided that the laws are too unclear and/or contradictory to allow them to take the risk of dispensing/storing marijuana (derivatives) for their patients. Since most pharmacies have policies that all medications dispensed must be FDA approved, this is a strong basis for refusal. However, some hospitals in Minnesota, with the help of the state legislature, are exploring the possibility of distribution.26

Also, some patients may bring the substance to the hospital with them; especially those who use a topical derivative for control of pain. Allowing patients to use this substance while at the facility (similar to patients using their home meds) may cause issues with FDA and DEA regulations.

A note on nursing home use: Elderly patients are increasingly using marijuana and its derivatives to alleviate pain. In most states where medical marijuana is legal, the laws do not expressly address the use of the plant in long-term care and assisted living facilities. However, Michigan, Rhode Island and some other states list “agitation of Alzheimer’s” as a qualifying condition. While this provides some protection for a facility, it is far from the level of protection most administrators should want. Providers should seek qualified legal advisors for questions of this nature.

For those facilities that do allow it, dosing can be a problem. Most pills come in a single pack that can be “popped” for use. Marijuana typically comes in a small bag and it is impossible to tell if someone took one or two pinches. This makes diversion a much tougher activity to detect. Facilities should be working with local dispensaries to address the packaging issue.

In addition, the issues with out-of-state patients and medical marijuana migrants discussed earlier in this paper would have similar impacts on facilities.

Conclusion
The seemingly growing momentum toward marijuana legalization has been called emblematic of a time of transition in social norms and attitudes. Such moments in history can be particularly unsettling for corporations seeking to establish and maintain realistic protocols for dealing with the ramifications of social change in the workplace. Debate over marijuana legalization is certain to drive controversy in a shifting landscape of conflicting laws and regulations. Indeed, present and future federal drug classification of marijuana will make clarification a complicated path.

In this environment, effective policy development will require oversight by legal counsel, human resources and safety officers to ensure that all of the perspectives tied to the issues discussed in this paper are represented. Variables related to medical versus recreational use, workers’ compensation challenges and safety-sensitive occupations versus other positions are just a few of the myriad of potential risks facing employers. Companies should schedule any marijuana use policies for frequent review, no less than annually, to ensure that they reflect changes due to revised guidelines provided by state and federal agencies, court decisions and other influencers affecting legalization in jurisdictions where they have operations.

While the workplace risks represented by the legalization of marijuana are relatively new, responding to new and evolving risks is one of the markers of a successful business. With understanding and insight, enlightened organizations can adapt effectively to this and other societal paradigm shift, reducing loss potential, controlling costs, and ensuring that the interests and safety of all employees are represented.
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