STATE OF VERMONT
DEPARTMENT OF LABOR

Michael Hall

v.

Safelite Group, Inc.

Opinion No. 06-18WC

By: Phyllis Phillips, Esq.
Administrative Law Judge

For: Lindsay H. Kurrle
Commissioner

State File No. FF-58850

OPINION AND ORDER

Hearing held in Montpelier on October 30, 2017
Record closed on January 2, 2018

APPEARANCES:

Charles Powell, Esq., for Claimant
James O'Sullivan, Esq., for Defendant

ISSUES PRESENTED:

1. Does Claimant's use of medical marijuana constitute reasonable treatment for his January 8, 2014 compensable work injury?

2. If yes, consistent with the provisions of Vermont's medical marijuana law, 18 V.S.A. §4471 *et seq.*, and/or the federal Controlled Substances Act, 21 U.S.C. §801 *et seq.*, can the Commissioner compel Defendant to reimburse Claimant for his medical marijuana purchases?

EXHIBITS:

Joint Exhibit I:	Medical and vocational rehabilitation records filed February 26, 2016 (pp. 1-240)
Claimant's Exhibit 1:	Medical records from February 2016 forward (pp. 241-435)
Claimant's Exhibit 2:	New Hampshire Cannabis Registry Patient ID card
Claimant's Exhibit 3:	Lebanon, NH Temescal receipt ($365.00, March 21, 2017)
Claimant's Exhibit 4:	Temescal customer history printout (October 25, 2016 – August 29, 2017), and receipt for purchase (October 13, 2017)
Claimant's Exhibit 5:	Workers' Compensation and Employer's Liability policy #WLR C4 78 77 15 5, effective 12/31/2013 – 12/31/2014
Claimant's Exhibit 6:	*Curriculum vitae,* Mark A. Horton, MD
Claimant's Exhibit 7:	Dartmouth-Hitchcock Medical Center, Janice E. Gellis, MD, "About me"

Defendantôs Exhibit A:	Dr. Ross record review and addendum, July 13, 2017 and August 5, 2017
Defendantôs Exhibit B:	*FDA and Marijuana: Questions and Answers*, http://www.fda.gov/NewsEvents/PublicHealthFocus/ucm421168.htm (12/13/2016)
Defendantôs Exhibit C:	Memorandum from Acting Commissioner of Food and Drugs to Acting Assistant Secretary for Health, ñRecommendation to Maintain Marijuana in Schedule I of the Controlled Substances Act,ò May 20, 2015
Defendantôs Exhibit D:	Letter from Karen B. DeSalvo, MD, MPH, MSc, Acting Assistant Secretary for Health, U.S. Department of Health and Human Services, to Hon. Chuck Rosenberg, Acting Administrator, Drug Enforcement Administration, June 3, 2015
Defendantôs Exhibit E:	Sample letter from State of New Hampshire, Department of Health and Human Services, Therapeutic Cannabis Program, approving registration as Qualifying Patient, July 21, 2016
Defendantôs Exhibit F:	State of New Hampshire, Department of Health and Human Services, Therapeutic Cannabis Program, Notice of Opening of Alternative Treatment Centers

CLAIM:

Medical benefits pursuant to 21 V.S.A. §640
Interest, costs and attorney fees pursuant to 21 V.S.A. §§664 and 678

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was his employer as those terms are defined in the Vermont Workersô Compensation Act.

2. Judicial notice is taken of all forms and correspondence in the Departmentôs file relating to this claim. Judicial notice is also taken of the Commissionerôs Opinion and Order in *Hall v. Safelite Group*, Opinion No. 10-16WC (July 15, 2016).

3. Claimant, a New Hampshire resident, worked at Defendantôs Brattleboro, Vermont location as a windshield installer. On January 8, 2014 he injured his left elbow while removing a windshield from a glass rack. Defendant accepted the injury, initially diagnosed as a left elbow strain, as compensable and began paying workersô compensation benefits accordingly.

4. Claimant has treated continuously for his injury since January 2014, first with his primary care providers and, beginning in December 2014, with Dr. Horton. Dr. Horton is board certified in both anesthesiology and pain management, though his clinical practice is focused solely on the latter discipline.

5. Dr. Horton has diagnosed Claimant with Complex Regional Pain Syndrome (CRPS), causally related to his January 2014 work injury. This diagnosis is based on the so-called Budapest criteria, which consider both objective signs and subjective symptoms evidencing abnormal changes in the affected limb(s) that no other diagnosis can explain. Dr. Minsinger, an orthopedic surgeon, and Dr. Gellis, a pain management specialist to whom Dr. Horton referred Claimant for consultation, have also confirmed this diagnosis, which I find accurately characterizes his condition.

6. In the years since his injury, Claimant has undergone multiple conservative treatments, including rest, anti-inflammatories, physical and occupational therapy, nerve blocks, non-narcotic and opioid medications, compounded topical ointments and scrambler therapy. Unfortunately, none of these have provided any lasting relief. Claimantôs symptoms have persisted and remain debilitating. He experiences shooting pains and stiffness from his neck down his entire left arm and into his hand. He is hypersensitive to light touch. His arm ñfeels like it is 500 pounds,ò and his hand is alternately ñnumb, or on fire, or freezing.ò Until recently, his sleep was markedly disturbed, his appetite was poor, and he suffered from anxiety, headaches and abdominal pain. As documented in an October 2017 functional capacity evaluation, his severe pain complaints limit his tolerance for sustained activity of any kind.

7. The only measurable symptom relief Claimant has realized comes from his use of therapeutic cannabis, commonly referred to as medical marijuana. Dr. Gellis first suggested medical marijuana as a pain management option in May 2016. Having done some research on his own, Claimant had obtained some medical marijuana from a friend who was terminally ill with cancer and reported that it was helpful. After Dr. Gellis voiced her support, in August 2016 Dr. Horton issued the medical certification required under New Hampshireôs Therapeutic Cannabis Program.[1] Claimantôs application was approved, and he received his certification card in October 2016.

8. Since becoming certified to use medical marijuana, Claimant has demonstrated a responsible approach to its use. He typically travels to the Lebanon, NH dispensary at which he is registered every four to six weeks, and depending on his financial circumstances, pays between $190 and $300 for a half ounce to an ounce of marijuana.[2] He has experimented with various strains and prefers those that are geared more toward pain relief than a euphoric ñhigh.ò On average, he smokes between four and six marijuana joints daily. He is careful not to smoke on days when he has to drive.

[1] As a New Hampshire resident, Claimant qualifies for registration under that stateôs medical marijuana statute. NH R.S.A. 126-X:1.X. Because he does not live here, he is ineligible for registration in Vermont. 21 V.S.A. §4472(17).

[2] This is well within the two-ounce limit that a qualifying patient is allowed to possess under New Hampshire law. NH R.S.A. 126-X:2.I(a).

9. At hearing, Claimant credibly described the relief medical marijuana affords him. It reduces his stomach upset so he is better able to eat. His sleep is vastly improved ï though still variable, he might now sleep for three to five hours nightly, whereas before he might get only two hours of fitful sleep over a three-day period. His arm still hurts, but smoking marijuana ñcalms the pain down enoughò so that he can go to the grocery store, do some laundry, wash dishes or visit his next-door neighbor. As it has helped him physically, he has become stronger emotionally, with improved mood, less anxiety and more energy. ñPot doesnôt take anything away,ò he says, ñit just helps it to be doable.ò I find this testimony credible in all respects.

10. Dr. Horton also credibly commented on the salutary effect that medical marijuana has had on Claimantôs pain and function. He has personally observed the change in the way Claimant carries himself, with a more relaxed manner and brighter affect.

11. Both Dr. Horton and Dr. Gellis offered credible accounts of the advantages of medical marijuana over opioids, particularly in the context of managing CRPS-related chronic pain. Opioids excite the pain receptors that play a role in the pathophysiology of CRPS. Long-term use may cause a phenomenon known as hyperalgesia, in which the patient feels more pain rather than less. Opioids also carry a risk of serious side effects, including addiction, tolerance and dependence, and problematic physiological effects as well, including respiratory depression and constipation. In Claimantôs case, brief courses of hydrocodone (an opioid pain medication) caused severe nausea and provided only minimal pain relief.

12. Medical marijuana carries its own risks, as Dr. Horton credibly acknowledged. Possible side effects include tachycardia, paranoia, withdrawal, addiction, dependence and tolerance, though the potential for these is likely far less than with opioids. A more problematic concern with medical marijuana is the inability to accurately monitor and control dosage levels. Nevertheless, after weighing the risks and benefits in Claimantôs case, and particularly given the failure of all first- and second-line treatments, in Dr. Hortonôs opinion medical marijuana represents a safe, personalized and reasonable chronic pain management option for him. I find this analysis credible.

13. Defendantôs medical expert, Dr. Ross, concluded otherwise. Dr. Ross is affiliated with the Pain Management Center at Brigham and Womenôs Hospitalôs Department of Anesthesiology. At Defendantôs request, in July 2017 he reviewed Claimantôs medical records and issued a written opinion whether medical marijuana was reasonable treatment for his chronic pain condition. Dr. Ross has never personally examined Claimant.

14. Dr. Ross acknowledged that aside from medical marijuana, the treatments Claimant has undergone for his chronic pain condition[3] have provided only minimal short-term benefit in terms of either decreased pain or increased function. In his opinion, Claimant now requires an interdisciplinary treatment approach, one that utilizes rehabilitative therapies, psychological support and medical management concurrently. Given the long-standing, refractory nature of his symptoms, Dr. Ross anticipates that such a program may have to be conducted in an in-patient setting.

15. As for medical marijuana, Dr. Ross had this to say:

> Medical marijuana is not a reasonable or necessary treatment for [Claimantôs] condition. There is no evidence that medical marijuana has any efficacy for [the] clinical picture presented by [Claimant]. It is of note that [Claimant] has significant psychological history and the chronic use of marijuana in that setting has significant long-term risk to his mental well-being.

16. In an August 2017 addendum to his report, Dr. Ross asserted that unless Claimant agreed to undergo a comprehensive inpatient pain program, he should be considered to have reached an end medical result. Notably, in reiterating this treatment recommendation, Dr. Ross added that any such program should include ñtreatment of [Claimantôs] substance abuse.ò

17. When asked to comment on Dr. Rossô report and addendum, Dr. Horton stated that he would ñfully supportò Claimantôs participation in an intensive inpatient program. However, he characterized Dr. Rossô claims that Claimant has ñsignificant psychological historyò and ñsubstance abuse,ò as ñgeneral, overstated and stigmatizing.ò Claimantôs ñpsychological history,ò Dr. Horton noted, consists of grief related to his sonôs untimely death in a motor vehicle accident some years ago[4] and depression related to his current medical condition. His ñsubstance abuseò encompasses tobacco dependence and more recently, his use of medical marijuana as a certified patient under New Hampshireôs therapeutic cannabis statute. Dr. Rossô concerns notwithstanding, in Dr. Hortonôs analysis, which I find credible in all respects, there are no contraindications to Claimantôs continued use of the drug.

[3] Dr. Ross questioned whether Claimantôs pain condition has been appropriately diagnosed as CRPS. I have found that the diagnosis is adequately supported, Finding of Fact No. 5 *supra*, and therefore reject his opinion on this issue as unpersuasive.

[4] The record does not indicate when this event occurred, but it was at least prior to December 9, 2014, the date when Dr. Hortonôs medical records first referenced it.

18. Dr. Horton acknowledged the paucity of research regarding medical marijuanaôs efficacy. He cited to one meta-analysis involving a systematic review of 18 high-quality randomized controlled trials that examined the use of cannabis in the treatment of chronic non-cancer pain. Fifteen of the 18 studies demonstrated that the drug had a significant analgesic effect, and several documented improvements in sleep as well, all without serious adverse side effects.[5] A follow-up meta-analysis completed in 2015 reviewed 11 additional high-quality studies; of these, seven showed moderate to significant improvements in pain, sleep, stiffness and spasticity, again without serious adverse effects.[6]

19. Still, Dr. Horton agreed with Dr. Ross that the lack of scientific evidence to support the use of medical marijuana remains ñproblematic.ò Indeed, the need for more ñefficient and scientifically rigorous researchò has been a critical factor in the federal governmentôs decision to maintain marijuana as a Schedule 1 drug under the Controlled Substances Act. Letter from Karen B. DeSalvo, MD, MPH, MSc, Acting Assistant Secretary for Health, U.S. Department of Health and Human Services, to Hon. Chuck Rosenberg, Acting Administrator, Drug Enforcement Administration, June 3, 2015 *(Defendant's Exhibit D)*; *see* Conclusion of Law No. 12 *infra*. The governmentôs position on this issue reflects an unfortunate catch-22 situation: marijuanaôs continued classification as a Schedule 1 drug makes it extremely difficult for researchers to undertake the high-quality research necessary to support its reclassification, which would make research far easier to undertake.[7]

20. In the meantime, Dr. Horton relies on the fact that the state of New Hampshire has approved marijuanaôs use as a reasonable treatment option for patients who meet the criteria, as Claimant has. Dr. Horton described Claimant as a ñthoughtfulò patient who has ñgood insightò into his medical condition and has ñcarefully contemplatedò his treatment options. Having followed him on a regular basis, Dr. Horton has personally observed how effective medical marijuana has been, with no concomitant concerns to undermine its continued use. In Dr. Hortonôs opinion, medical marijuana remains a reasonable and necessary pain management tool in Claimantôs case, therefore. I find this analysis persuasive.

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[5] Lynch, M.E. and Campbell, F., ñCannabinoids for treatment of chronic, non-cancer pain; a systematic review of randomized trials,ò *Br. J. Clin. Pharmacology* 2011 Nov; 72(5):735-744, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3243008/.

[6] Lynch, M.E. and Ware, M.A., ñCannabinoids for the Treatment of Chronic Non-Cancer Pain: An Updated Systematic Review of Randomized Controlled Trials,ò *J. Neuroimmune Pharmacology* (published on-line 22 March 2015), https://pdfs.semanticscholar.org/2308/7a4dd6d66410cdb70968c01db3dd8a956051.pdf. The researchers concluded that their review ñadds further support that currently available cannabinoids are safe, modestly effective analgesics that provide a reasonable therapeutic option in the management of chronic non-cancer pain.ò *Id.*

[7] ñNew Documents Reveal why the FDA Says Marijuana isnôt Medicine,ò *Vice News*, October 19, 2016, https://news.vice.com/en_us/article/59wz98/new-documents-reveal-why-the-fda-says-marijuana-isnt-medicine.

CONCLUSIONS OF LAW:

1. In workersô compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). He or she must establish by sufficient credible evidence the character and extent of the injury as well as the causal connection between the injury and the employment. *Egbert v. The Book Press,* 144 Vt. 367 (1984). There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the resulting disability, and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. The disputed issues in this case are both medical and legal. Medically, the question is whether Claimantôs use of medical marijuana constitutes reasonable treatment for his injury-related chronic pain condition. Legally, the question is whether Defendant can be compelled to reimburse him for his marijuana purchases, given the restrictions that both state and federal law arguably impose.

   Does Claimant's Use of Medical Marijuana Constitute Reasonable Treatment for His Compensable Injury?

3. Vermontôs workersô compensation statute obligates an employer to furnish only those medical treatments that are determined to be ñreasonable.ò 21 V.S.A. §640(a). The Commissioner has discretion to determine what constitutes ñreasonableò medical treatment given the particular circumstances of each case. *MacAskill v. Kelly Services*, Opinion No. 04-09WC (January 30, 2009). A treatment can be unreasonable either because it is not medically necessary or because it is not causally related to the compensable injury. *Baraw v. F.R. Lafayette, Inc.*, Opinion No. 01-10WC (January 20, 2010); *Veillette v. Pompanoosuc Mills Corp.*, Opinion No. 23-12WC (September 14, 2012).

4. Unless the employer is seeking to discontinue a previously accepted medical treatment, the claimant has the burden of proving that a proposed medical treatment is reasonable. *Merriam v. Bennington Convalescent Center*, Opinion No. 55-06 (January 2, 2007). In determining what is reasonable, the decisive factor is not what the claimant desires but what is shown by competent expert evidence to be reasonable to relieve the claimantôs symptoms and maintain his or her functional abilities. *Quinn v. Emery Worldwide,* Opinion No. 29-00WC (September 11, 2000).

5. The parties here proffered conflicting expert medical opinions as to whether medical marijuana is a medically appropriate, and therefore reasonable, treatment option for his work-related chronic pain condition. In such cases, the commissioner traditionally uses a five-part test to determine which expertôs opinion is the most persuasive: (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (September 17, 2003).

6. I conclude that Dr. Hortonôs opinion is the most persuasive on this issue. As the treating physician for all but the first year following the injury, he has followed Claimantôs failure to respond to a wide range of conservative treatment options, including physical therapy, nerve blocks, anti-inflammatories, topical ointments, narcotic medications and scrambler therapy. More recently, he has observed how effective medical marijuana has been at decreasing Claimantôs pain and improving his sleep, mood, appetite and general ability to function. Dr. Horton is thus well-positioned to evaluate Claimantôs success with marijuana as compared with the failure of the other pain management strategies he has attempted over the past four years.

7. Dr. Horton bolstered his analysis with reference to research demonstrating that medical marijuana is a safe and at least moderately effective chronic pain treatment option. While cognizant of the troublesome issues that attend its use ï the need for more high-quality research, for example, and the inability to precisely monitor and control dosage levels ï Dr. Horton concluded that the risk/benefit analysis weighed in favor of Claimantôs continued usage. His opinion was thus clear, thorough and objectively supported. I accept it as credible in all respects.

8. In contrast, Dr. Rossôanalysis was based solely on his review of Claimantôs medical records. With no opportunity to personally observe and interact with him, Dr. Rossô remarks as to Claimantôs ñsignificant psychological historyò and need for ñsubstance abuseò treatment seem strikingly inaccurate and significantly undermine his opinion. I therefore dismiss it as unpersuasive.

9. I conclude that Claimant has sustained his burden of proving that his use of medical marijuana as a means of managing his chronic pain condition is medically appropriate and necessary. It therefore qualifies as ñreasonableò treatment under §640(a).

Consistent with State and Federal Law, Can Defendant be Compelled to Reimburse Claimant for his Medical Marijuana Purchases?

10. Were the treatment at issue here not one involving medical marijuana, a finding of reasonableness under §640(a) would necessarily trigger Defendantôs obligation to pay.[8] As it is, however, both federal and state laws may require a different result.

[8] Section 640(a) states, ñAn employer subject to the provisions of this chapter *shall furnish to an injured employee* reasonable surgical, medical, and nursing services and supplies, including prescription drugs . . .ò (emphasis added).

(a) The Federal Controlled Substances Act

11. Medical marijuanaôs legal status under federal law is controversial. The federal Controlled Substances Act, 21 U.S.C. §801 *et seq.*, has long classified marijuana as a Schedule I drug, meaning that it has (a) a high potential for abuse; (b) no currently accepted medical use in treatment in the United States; and (c) a lack of accepted safety for use under medical supervision. 21 U.S.C. §812(b)(1).[9] As such, it is illegal under federal law for any person to knowingly and intentionally manufacture, distribute, dispense or possess marijuana, *id.* at §§841(a) and 844(a), to attempt or conspire to do so, *id.* at §846, or to aid or abet someone who does so, 18 U.S.C. §2(a).

12. Over the years, there have been repeated attempts either to repeal the rules and regulations that place marijuana in Schedule I or to re-classify it as a Schedule II substance, which would allow for its medical use.[10] Nevertheless, as recently as 2015 the U.S. Department of Health and Human Services recommended to the Drug Enforcement Administration that it continue to be maintained in Schedule I.[11] The DEA accepted this recommendation in 2016, refusing once again to legalize marijuanaôs use for medical purposes.[12]

13. Notwithstanding its status as an illegal drug under federal law, as of this writing 29 states (including Vermont) and the District of Columbia now sanction marijuanaôs use for medicinal purposes; of these, nine states (including Vermont) and the District of Columbia have legalized its recreational use as well.[13] Until now, the federal governmentôs response to these developments has been to signal its acquiescence on two fronts ï one emanating from the U.S. Department of Justice, the other coming from Congress itself.

(i) Justice Department Action – The "Cole Memorandum"

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[9] In addition to marijuana, other Schedule 1 drugs include heroin, ecstasy, peyote and LSD. *Id.*

[10] *See, e.g.,* Memorandum from Acting Commissioner of Food and Drugs to Acting Assistant Secretary for Health, ñRecommendation to Maintain Marijuana in Schedule I of the Controlled Substances Act,ò May 20, 2015 *(Defendant's Exhibit C)*. Other Schedule II drugs include oxycodone, fentanyl, cocaine and methamphetamine. 21 U.S.C. §812(b)(1); *see* U.S. Drug Enforcement Administration Drug Schedules, https://www.dea.gov/druginfo/ds.shtml.

[11] Letter from Karen B. DeSalvo, MD, MPH, MSc, Acting Assistant Secretary for Health to Hon. Chuck Rosenberg, Acting Administrator, Drug Enforcement Agency, June 3, 2015 *(Defendant's Exhibit D)*. In taking this action, the Assistant Secretary relied on recommendations from both the Food and Drug Administration and the National Institutes of Healthôs National Institute on Drug Abuse. *Id.*

[12] ñUS Affirms Its Prohibition on Medical Marijuana,ò *The Washington Post*, August 11, 2016.

[13] *See* http://www.businessinsider.com/legal-marijuana-states-2018-1.

14. Beginning in 2009, the Justice Department issued a series of guidance memoranda for U.S. Attorneys regarding the enforcement of federal drug laws in states that had legalized medical and/or recreational marijuana. The first one, known as the ñOgden Memorandum,ò[14] applied specifically to federal investigations and prosecutions in states that had enacted laws authorizing the medical use of marijuana. In pertinent part, it stated as follows:

- ñCongress has determined that marijuana is a dangerous drug, and the illegal distribution and sale of marijuana is a serious crime and provides a significant source of revenue to large-scale criminal enterprises, gangs, and cartels.ò

- ñThe Department [of Justice] is . . . committed to making efficient and rational use of its limited investigative and prosecutorial resources.ò

- ñThe prosecution of significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and trafficking networks continues to be a core priority in the Departmentôs efforts against narcotics and dangerous drugs, and the Departmentôs investigative and prosecutorial resources should be directed towards these objectives.ò

- ñAs a general matter, pursuit of these priorities should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana.ò

15. The Ogden Memorandum thus set the stage for what would become federal law enforcementôs ñhands-offò approach towards those who distributed or possessed marijuana in compliance with their own statesô medical marijuana laws. Nevertheless, the memo cautioned that its guidance neither ñlegalizedò marijuana nor provided a legal defense to a violation of the Controlled Substances Act. Rather, it was intended ñsolely as a guide to the exercise of investigative and prosecutorial discretion.ò[15]

[14] ñMemorandum for Selected United States Attorneys on Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana,ò David W. Ogden, Deputy Attorney General, October 19, 2009, https://www.justice.gov/sites/default/files/opa/legacy/2009/10/19/medical-marijuana.pdf.

[15] *Id.*

16. In subsequent memoranda issued in 2011,[16] 2013[17] and 2014,[18] the Justice Department sought to clarify its enforcement priorities in light of an increasing number of state initiatives legalizing first medical, and later recreational, marijuana. The most significant of these, issued in August 2013 and now commonly referred to as the ñCole Memorandum,ò established eight enforcement priorities aimed, for example, at preventing distribution to minors, thwarting the diversion of revenues to gangs and cartels, and inhibiting violence and the use of firearms in the cultivation and distribution process.[19] Outside of those priorities, the memo directed federal prosecutors to leave less serious violations ï an individualôs possession of small amounts of marijuana for personal use on private property, for example ï to state and local authorities.[20]

17. As it did in the 2009 Ogden Memorandum, in each of the three memoranda that followed the Justice Department reiterated that its guidance was meant solely to aid U.S. attorneys in exercising their investigative and prosecutorial discretion. The memos neither altered the Departmentôs ability to enforce federal law nor provided a legal defense to any violation of federal law.

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[16] ñMemorandum for United States Attorneys,ò James M. Cole, Deputy Attorney General, June 29, 2011, https://www.justice.gov/sites/default/files/oip/legacy/2014/07/23/dag-guidance-2011-for-medical-marijuana-use.pdf. By this memorandum, the Justice Department continued to advise against targeting individual medical marijuana users, but stated that enforcement actions against large-scale, for-profit commercial growers and distributors might still be an appropriate use of federal resources. The 2013 ñCole Memorandum,ò *n.17 infra*, rescinded the latter guidance, advising that the size of a marijuana operation itself should not determine the exercise of prosecutorial discretion.

[17] ñMemorandum for All United States Attorneys,ò James M. Cole, Deputy Attorney General, August 29, 2013, https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf.

[18] ñMemorandum for All United States Attorneys,ò James M. Cole, Deputy Attorney General, February 14, 2014, https://www.justice.gov/sites/default/files/usao-wdwa/legacy/2014/02/14/DAG%20Memo%20-%20Guidance%20Regarding%20Marijuana%20Related%20Financial%20Crimes%202%2014%2014%20(2).pdf. This memorandum provided guidance regarding whether and under what circumstances financial institutions that provide banking services to marijuana-related businesses should be prosecuted for financial crimes such as money laundering.

[19] The other listed priorities were: preventing marijuana from being diverted from states where it is legal to other states; preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs; preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use; preventing the growing of marijuana on public lands; and preventing marijuana possession or use on federal property. Cole Memorandum, *supra* at pp.1-2.

[20] *Id.,* p.2.

(ii) *Congressional Action – The Rohrabacher-Farr Amendment*

18. Separate from the Justice Departmentôs efforts, in 2014 Congress acted to protect medical marijuana patients in particular from prosecution under federal law. The Rohrabacher-Farr Amendment, passed as a rider to an omnibus appropriations bill,[21] prohibited the Justice Department from spending any of its appropriated funds to prevent a state from implementing its own laws authorizing the use, distribution, possession or cultivation of medical marijuana. The legislation thus did not prohibit medical marijuana prosecutions *per se*; it simply made it impossible for the Justice Department to pay for them.

19. Because it originated as part of a spending bill, the Rohrabacher-Farr Amendment (now known as the Rohrabacher-Blumenauer Amendment) must be renewed with every new appropriations bill. As of this writing, the amendment has been extended through September 2018, when the current appropriations bill expires.[22]

(iii) *Recent Developments*

20. Recent developments at the federal level demonstrate the tenuous nature of the protections afforded to those who participate in a stateôs medical marijuana program. Neither the Rohrabacher-Blumenauer Amendment nor the Cole Memorandum have changed marijuanaôs legal status as a Schedule I controlled substance. With the passage of the most recent budget rider, Congress continues to restrict federal law enforcement officials from spending appropriated funds to prosecute individuals who are acting in compliance with state law. But what protection Congress gives today, it can take away at any time. As one federal appeals court recently noted, ñCongress could restore funding tomorrow, a year from now, or four years from now, and the government could then prosecute individuals who committed offenses while the government lacked funding.ò *U.S. v. McIntosh*, 833 F.3d 1163, 1179 n.5 (9th Cir. 2016).[23]

[21] Consolidated and Further Continuing Appropriations Act, 2015, *Pub. L.* No. 113-235, §538.

[22] https://www.forbes.com/sites/tomangell/2018/03/21/congress-protects-medical-marijuana-from-jeff-sessions-in-new-federal-spending-bill/#291e33003575.

[23] Noting that federal law allows for the prosecution of federal crimes for up to five years after they occur, 18 U.S.C. §3282, the *McIntosh* court admonished the district courts to consider the ñtemporal natureò of the Justice Departmentôs lack of funds in the context of the criminal defendantsô right to a speedy trial. *Id.*

21. The same holds true for the Justice Departmentôs enforcement priorities. Indeed, as the *McIntosh* court presciently observed in 2016, ñ[A] new president will be elected soon, and a new administration could shift enforcement priorities to place greater emphasis on prosecuting marijuana offenses.ò *Id.* This is precisely what has occurred. In January 2018 the Justice Department issued a new memorandum, which now requires federal prosecutors deciding which marijuana activities to prosecute ñto weigh all relevant considerations, including federal law enforcement priorities set by the Attorney General, the seriousness of the crime, the deterrent effect of criminal prosecution, and the cumulative impact of particular crimes on the community.ò[24] Given the Justice Departmentôs ñwell-established general principles,ò the memo asserts, ñprevious nationwide guidance specific to marijuana enforcement is unnecessary and is rescinded, effective immediately.ò[25] Simply put, under the current administration, individuals who possess marijuana for personal use in states where doing so is now legal are no longer afforded any specific protection from prosecution under federal law.

(b) *Adjudications in Other States regarding Workers' Compensation Insurance Coverage for Medical Marijuana*

22. The Justice Departmentôs decision to rescind the Cole Memorandumôs previous guidance has important implications for the case now pending before me. Other states have struggled with the question whether to require an employer (or its workersô compensation insurance carrier) to pay for an injured workerôs use of medical marijuana. In every case in which a court or administrative body has ordered payment, the Cole Memorandum has been an integral part of the debate.

23. The discussion began in New Mexico, with *Vialpando v. Ben's Automotive Services*, 331 P.3d 975 (N.M.App. 2014), *cert. denied*, 331 P.3d (24 (N.M. 2014). There, the employer challenged a workersô compensation judgeôs order that it reimburse the injured worker for money spent on medical marijuana under New Mexicoôs Compassionate Use Act, N.M. Stat. §26-2B-1 *et seq*. It argued that the order was contrary to federal public policy as reflected in the Controlled Substances Act.

[24] ñMemorandum for All United States Attorneys,ò from Jefferson B. Sessions, III, Attorney General, January 4, 2018, http://www.justice.gov/opa/press-release/file/1022196/download.

[25] *Id.* In a footnote, the memorandum specifically referenced the 2009 Ogden Memorandum and the 2011, 2013 and 2014 Cole memoranda as the ñprevious guidanceò to be rescinded.

24. The appellate court rejected the argument, with specific reference to the Cole Memorandum, as follows:

> Although not dispositive, we note that the Department of Justice has recently offered what we view as equivocal statements about state laws allowing marijuana use for medical and even recreational purposes. On the one hand, the Department of Justice affirmed that marijuana remains illegal under the [Controlled Substances Act] and that federal prosecutors will continue to aggressively enforce the statute. But, on the other hand, and in the same documents, the Department of Justice identified eight areas of enforcement priority and indicated that outside of those priorities it would generally defer to state and local authorities.ò

Id. at 980.

25. Faced with the federal governmentôs apparent deference on the issue and noting that New Mexicoôs public policy in favor of allowing ñthe beneficial use of medical cannabis in a regulated systemò was clear, the court declined to reverse the workersô compensation judgeôs order on the basis of federal law or public policy and affirmed the employerôs obligation to pay. *Id.*

26. Relying on *Vialpiando*, in *Lewis v. American General Media*, 355 P.3d 850 (N.M.App. 2015), the New Mexico appellate court reaffirmed its commitment to medical marijuana. This time, the court referenced both the Cole Memorandum and the Rohrabacher-Farr Amendment in support of its holding. ñIn view of the equivocal federal policy and the clear New Mexico policy as expressed in the Compassionate Use Act,ò the court held that it would allow the workersô compensation judgeôs reimbursement order to stand.

27. A line of cases decided at the administrative level in Maine has used the same rationale to approve an injured workerôs right to reimbursement for medical marijuana under the Maine Medical Use of Marijuana Act (MMUMA), 22 M.R.S.A. §2421 *et seq*. The starting point for the Appellate Division Workersô Compensation Boardôs decision in *Noll v. LePage Bakeries, Inc.*, 082316 MEWC, 16-25, was to acknowledge that the MMUMA ñauthorizes conduct that would otherwise be illegal under federal law.ò *Id.* at ¶12 (internal citation omitted). Nevertheless, with reference to both the Cole Memorandum and the New Mexico appellate courtôs decision in *Vialpando*, the board approved the determination below. ñWe find no basis in federal law or policy identified by the parties that would preclude a self-insured employer from reimbursing an injured employee for costs associated with medical marijuana use pursuant to the MMUMA and the Workersô Compensation Act.ò *Id.* at ¶15; *see also, Bourgoin v. Twin Rivers Paper Co., LLC*, 082316 MEWC, 16-26 (reaching the same conclusion ñfor the reasons set forthò in *Noll*).[26]

[26] The *Bourgoin* case is currently on appeal to the Maine Supreme Court. *See* ñJudges Hear Landmark Case for Pot Reimbursements under Workersô Comp,ò Portland Press Herald, September 13, 2017, https://www.pressherald.com/2017/09/13/judges-hear-landmark-case-for-pot-reimbursements-under-workers-comp/. In the meantime, three lower level Workersô Compensation Board decisions have approved the rationale

28. As one court has observed, ñthe proverbial elephant in the roomò in any state court decision that upholds the legality of a medical marijuana statute is whether such laws are preempted by the federal Controlled Substances Act under the Supremacy Clause, *U.S. Const. Art. VI, Clause 2*. *Montana Cannabis Industry Association v. State*, 368 P.3d 1131, 1138 (MT 2016); *see also, U.S. v. McIntosh, supra* at 1179 n.5 (citing the Supremacy Clause, noting that ñwhile the [Controlled Substances Act] remains in effect, states cannot actually authorize the manufacture, distribution, or possession of marijuana,ò as such activity ñremains prohibited by federal law.ò). The issue was raised, but largely ignored, in *Vialpando*, *supra* at 980, *Lewis, supra* at 859, and *Noll, supra* at ¶14. Instead, the primary focus in each of these cases has been on the Cole Memorandum, which the Montana court described as the Justice Departmentôs ñapparent effort to minimize conflict with state actions while maintaining the primacy of federal law.ò *Montana Cannabis Industry Association*, *supra*.

29. Whether the federal government will continue to maintain its ñhands-offò policy with respect to the manufacture, distribution and possession of medical marijuana in states where it is legal to do so remains to be seen. If nothing else, the Justice Departmentôs recent decision to rescind the Cole Memorandum is an indication that it may be poised to take a more aggressive posture.[27] Given that possibility, it is perhaps not as unrealistic as it was in the past for an employer, or its workersô compensation insurance carrier, to fear federal prosecution if it provides reimbursement for an injured workerôs medical marijuana purchases.

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stated in *Bourgoin* and *Noll*. *Crandall v. University of Maine System*, WCB No. 08-00-33-14 (July 15, 2015) (holding that given the Justice Departmentôs stated enforcement priorities, the employerôs argument that it risked federal criminal prosecution by reimbursing the claimant for his medical marijuana purchases was ñnot realisticò); *Doten v. Domtar Industries, Inc.*, WCB No. 09-02-37-96 (July 8, 2015) (accepting the proposition that ñthe federal government has the power to shut down Maineôs medical marijuana program,ò but concluding that ñas long as the policy of the U.S. Department of Justice remains that actions in compliance with existing state [medical marijuana] laws shall not be prosecuted,ò ordering reimbursement was proper); *but see, Genest v. Independent Medical Associates, Inc.*, WCB No. 05-029180 (February 4, 2016) (affirming the rationale stated in the above cases, but denying reimbursement because the injured worker had failed to satisfy her burden of proving that her use of medical marijuana was ñreasonable and properò).

[27] The same may hold true for the current administrationôs willingness to acquiesce to the provisions of the Rohrabacher-Blumenauer Amendment. In early May 2017, Attorney General Sessions wrote to congressional leaders urging that the amendment not be renewed as part of the $1 trillion spending bill Congress was considering at the time. On May 5, 2017, when President Trump signed the bill into law, he added a signing statement that read: ñ[The Rohrabacher-Farr Amendment] provides that the Department of Justice may not use any funds to prevent implementation of medical marijuana laws by various States and territories. I will treat this provision consistently with my constitutional responsibility to take care that the laws be faithfully executed.ò https://en.wikipedia.org/wiki/Rohrabacher%E2%80%93Farr_amendment (internal citations omitted). Whether this signals the administrationôs intent to ignore the amendment and enforce federal law is unclear.

(c) Vermont's Medical Marijuana Statute

30. No matter how the federal government's response plays out, Claimant here faces a more specific challenge to his request that Defendant be required to reimburse him for his medical marijuana purchases. This obstacle arises from the language of Vermont's medical marijuana statute, 18 V.S.A. §4471 *et seq*. Specifically, §4474c(b) states:

> (b) This chapter shall not be construed to require that coverage or reimbursement for the use of marijuana for symptom relief be provided by:
>
> (1) a health insurer as defined by section 9402 of this title, or any insurance company regulated under Title 8;
>
> (2) Medicaid or any other public health care assistance program;
>
> (3) an employer; or
>
> *(4) for purposes of workers' compensation, an employer as defined in 21 V.S.A. §601(3)* (emphasis added).[28]

31. Many of the states that have legalized medical marijuana have adopted provisions purporting to exempt private health insurers from any obligation to pay for its use. 8 Lex K. Larson, *Larson's Workers' Compensation* §94.06 (Matthew Bender Rev. Ed.) at p. 94-71. Professor Larson has described these statutes, most of which contain the same or similar introductory language as §4474c(b), as "acknowledging the inconsistency between state and federal law," and thus "making it clear" that an insurer "may not be compelled to reimburse a patient for costs associated with the use of medical marijuana." *Id.*

32. Claimant argues that while the first two words of §4474c(b) – "this chapter," meaning the medical marijuana statute itself – cannot be read to require workers' compensation insurance coverage, the section still does not preclude compelling coverage as reasonable medical treatment under §640(a) of the Workers' Compensation Act. In support, he cites to cases from other jurisdictions in which a workers' compensation insurer or self-insured employer was ordered to reimburse an injured worker for medical marijuana purchases. None of the statutes at issue in these cases provide a specific coverage exclusion for workers' compensation insurers, as Vermont's medical marijuana law does.[29] For that reason, they are inapposite.

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[28] The term "employer" as defined in 21 V.S.A. §601(3) includes the employer's workers' compensation insurer.

[29] Vermont is one of only six states that specifically exclude workers' compensation insurers. The other states are Arizona (A.R.S. §36-2814(A)(1)), Florida (Fla. Stat. §381.986), Michigan (M.C.L. §418.315a), Montana (M.C.A. §50-46-320(4)(a)) and Washington (W.A.C. 296-20-03010).

33. In *Noll*, for example, the Maine Workersô Compensation Appeals Board squarely addressed whether self-insured employers or workersô compensation insurance carriers were covered by the statuteôs general coverage exclusion for private health insurers. The board carefully parsed the statuteôs language and concluded that the concept of a private health insurer was qualitatively different from either a self-insured employer or a workersô compensation insurer. Had the legislature intended to exempt the latter, the board observed, it could have explicitly done so. Because it did not, it was appropriate to impose coverage. *Noll, supra* at ¶22.

34. The lack of a specific statutory coverage exclusion for workersô compensation insurers was similarly critical to the Connecticut Workersô Compensation Boardôs decision requiring reimbursement in *Petrini v. Marcus Dairy, Inc.*, 2016 WL 6659149 (May 12, 2016), *see* Conn. Gen. Stat. §21a-408o. As for the other cases upon which Claimant relies, *Vialpando* and *Lewis* were decided under New Mexicoôs medical marijuana statute, N.M. Stat. 26-2B-1 *et seq.*, which does not address insurance coverage exclusions at all. The Michigan Workerôs Compensation Boardôs decision in *Todor v. Northland Farms*, 2011 WL 4674784 (September 28, 2011), was overturned legislatively in 2012, with the addition of a coverage exclusion specific to workersô compensation insurers. M.C.L. §418.315a. [30]

35. As the board in *Noll* correctly observed, a stateôs workersô compensation act ñsubjects employers and carriers to an entirely different set of legal and regulatory obligations with respect to liability for medical treatment.ò *Noll,* supra at ¶21. By itself, Vermontôs Workersô Compensation Act does not list any specific restrictions on the types of medical services or supplies that can be deemed ñreasonable,ò and therefore covered, *see* 21 V.S.A. §640(a). Considered in this context, Claimantôs interpretation of §4474c(b)ôs introductory clause would render §4474c(b)(4) meaningless. Absent the limitation that that subsection imposes, a workersô compensation carrierôs responsibility to pay for medical marijuana would stand on the same footing as any other reasonably prescribed drug. The ñgeneralò statute ï §640(a) ï would end up controlling the ñspecificò one ï §4474c(b)(4) ï rather than the other way around. *See In re Kelscot, Ltd.*, 152 Vt. 579, 582 (1989).

36. I interpret the language of §4474c(b) to mean just what it says. The fact that medical marijuana can now be legally prescribed, distributed and used means that an insurer who wants to cover its costs on behalf of a registered patient can do so without violating Vermont law. However, given the uncertainties engendered by the drugôs continued illegality under federal law, it cannot be compelled to do so.

[30] The New Hampshire case to which Claimant referred, *Panaggio v. W.R. Grace & Co.*, Docket #2017-L-0248 (June 6, 2017), is not reported and was not attached to Claimantôs brief, but there too, the applicable statute, N.H. Rev. Stat. Ann. §126-X:3III(a), does not specifically exempt workersô compensation insurers.

37. Prior to the Cole Memorandumôs rescission, that a workersô compensation insurer might agree voluntarily to reimburse an injured worker for his or her medical marijuana purchases was not farfetched. Almost 30 percent of the workersô compensation prescriptions written in Vermont in 2016 were for opioids, at a cost of approximately one million dollars.[31] Once billed as safe and miraculously effective pain management tools, opioids are now widely viewed as a deadly scourge. To a workersô compensation insurer, marijuana may present a treatment alternative that offers far greater potential for managing pain, improving function and facilitating return to work.[32]

38. Vermontôs medical marijuana statute was enacted in 2004. The landscape has changed significantly in the years since. Medical marijuana is now legal in more than half the states, and Vermont recently became the ninth state to legalize the use of recreational marijuana as well. Changes may also be afoot at the federal level, though it remains difficult to discern what direction those will take. It seems inevitable that state and federal policy regarding legalization will eventually coalesce. When that occurs, the uncertainty that now exists as to insurance coverage for medical marijuana will likely be resolved.

39. Until then, and particularly given the shadow cast by the federal Justice Departmentôs most recent enforcement guidance, the specific language of 18 V.S.A. §4474c(b)(4) permits only one result. Notwithstanding that Claimantôs use of the drug is medically appropriate, necessary and therefore reasonable under 21 V.S.A. §640(a), I cannot compel Defendant to reimburse him for his medical marijuana purchases.

40. As Claimant has failed to prevail on his claim for benefits, he is not entitled to an award of costs or attorney fees under 21 V.S.A. §678.

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[31] ñMedical Data Report, Opioid Utilization Supplement (Vermont),ò *National Council on Compensation Insurance*, September 2017.

[32] Recent data suggests that more extensive opioid prescribing leads to significantly longer durations of temporary disability ï according to one study, more than three times that found in claims involving only short-term (or no) opioid prescriptions. ñThe Impact of Opioid Prescriptions on Duration of Temporary Disability,ò *Workers' Compensation Research Institute* March 2018, https://www.wcrinet.org/images/uploads/files/wcri4823.pdf. And the National Council on Compensation Insurance has reported research that provides ñhighly suggestive evidenceò showing decreases in opioid-related deaths, fewer admissions for opioid addiction treatment, lower prescribed quantities of opioids and even fewer fatally injured drivers in states that have legalized medical marijuana as compared to those that have not. ñMedical Marijuana, Occupational Injuries, and the Workplace: 2017 Status Update,ò David Deitz, MD, PhD, January 19, 2018, pp.6-7 and n.23-27, https://www.ncci.com/Articles/Pages/II_Insights_MedMarijuana-OccupInjuries.aspx; *see also*, ñBalance on cannabis may lead to answers on opioids,ò *Boston Globe*, March 1, 2018, https://www.bostonglobe.com/opinion/2018/03/01/balance-cannabis-may-lead-answers-opioids/sxf6QvVfQ10u9GICPQnqlJ/story.html.

ORDER:

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby **ORDERED**:

1. Claimantôs claim for reimbursement from Defendant for his medical marijuana purchases in accordance with 21 V.S.A. §640(a) is hereby **DENIED**.

DATED at Montpelier, Vermont this 28th day of March 2018.

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Lindsay H. Kurrle
Commissioner

Appeal:

Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§670, 672.