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Anyone with questions regarding the Michigan Medical Marihuana Act 2009-2016 can also contact Doug Piggott directly at 800-837-9131 or DPiggott@rowepsc.com.

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LOCAL REGULATION UNDER THE MICHIGAN MEDICAL MARIHUANA ACT 2009 - 2016

By **Doug Piggott, AICP**, ROWE Professional Services Company, Flint

In the 32 years I have spent working with local municipalities on planning and zoning in Michigan, I have never experienced an issue that has generated such widespread confusion and frustration among local government officials as regulation of medical marijuana. When the residents of the State of Michigan approved Initiated Act 1 of 2008 in November of that year they placed the municipalities in the state on a long journey. Cities, villages, townships and counties have struggled to find an appropriate path in the regulation of medical marihuana. The purpose of this article is to help document their experience over the past 6 years.

The law as approved by the voters in 2008 seemed to lay out a fairly simple structure. A person with a doctor's verification that the person suffers from a *"debilitating medical condition"* that would benefit from the medicinal use of marihuana could apply to the Michigan Department of Community Health for a card identifying them as a qualifying patient which would protect them from prosecution under state or local laws or ordinances for the medical use of marihuana. They were allowed to raise up to 12 marihuana plants and possess up to 2.5 ounces of medical marihuana. It also allowed an individual known as a primary caregiver to grow 12 plants per patient on behalf of up to 5 qualifying patients.

But as local municipalities began to investigate the nuances of the law they discovered several unanswered questions:

- How were qualifying patients and primary caregivers to legally obtain the seeds necessary to grow their initial crop?
- The law required plants to be grown in an enclosed, locked facility. What did that mean?
- The state would create a list of people issued cards as qualifying patients or primary caregivers. Would local municipalities have access to that information?
- To what extent were local ordinances preempted under the law?

Home Occupation

As communities came to grips with the MMMA, a general consensus appeared to grow that local regulation of the qualifying patient was preempted by the law. A qualifying patient's right to grow and consume marihuana in their home seemed beyond the scope of local regulation. But what about the primary care giver? Although the MMMA stated that primary caregivers were allowed to be compensated for the cost associated with assisting a qualifying patient, it also specified that *"Any such compensation shall not constitute the sale of controlled substances."*

At the same time, the growing of medical marihuana appeared to be a commercial operation. So the initial response by many communities to this issue was to regulate primary caregivers as home occupations. A prominent example was the City of Grand Rapids, where the city's existing home occupation provisions in its zoning ordinance was amended to specifically allow the operation of a primary caregiver. The provisions included limiting the use to one primary caregiver per residence, location in the *"main building"* (presumably the residence vs. a garage or other accessory building) and compliance with local codes related to building, electrical and other issues. The ordinance also required such a use to be located at least 1,000 feet *"from any school including child care or day care facilities,"* to ensure compliance with Federal "Drug-Free School Zone" requirements. The city's regulation, also required the operation to obtain a Home Occupation – Class B business license, which was reviewed and renewed annually.

Some Michigan communities seriously considered this approach to regulate primary caregivers, although it raised some issues. One was that many residents were uncomfortable with allowing these operations in their neighborhoods, due to concerns over such businesses attracting illegal activities. In addition, many communities' existing home occupation provisions required home occupations to get special land use approval, which in turned required a public hearing, with notices in the paper and to surrounding properties. Primary caregivers objected to these requirements because they felt it made their residences vulnerable to criminals looking to steal the marihuana.

About the Author

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The Proliferation of Various Types of Facilities

As registration cards began to be issued following the adoption of state administrative rules that took effect in April 2009, local communities began to learn of operations that were not specifically authorized under the MMMA. I remember hearing radio ads about that time offering courses on how to make *"hundreds of thousands of dollars"* in the medical marihuana business, and thinking *"what kind of businesses were they talking about?"*

Grow shops – These establishments generally provide the materials needed to grow medical marihuana, particularly indoors. They offer *"grow lamps,"* containers, grow media, timers, water pumps and other products. Although most identify their services as hydroponic shops serving the needs of indoor gardeners of all types, these operations proliferated as the number of qualifying patients and primary caregivers in the state grew. Communities recognized that while some of these businesses directly associated their operations with medical marihuana, through their name or logo, the businesses were selling legal products and should be treated the same as any retail establishment

Compassion care clubs – Compassion care clubs began appearing around the state almost as soon as the MMMA went into effect. They were designed to help address many of the holes that existed in the medical marihuana *"program"* provided in the law and the administrative rules for the program adopted by the state. The clubs are generally non-profit organizations designed to support qualifying patients and primary caregivers. They assisted potential qualifying patients with physicians who might be able to diagnose their condition as one that met the definition of *"debilitating medical condition"* in the act. They assisted qualifying patients that chose not to grow their own medical marihuana in finding primary caregivers that would grow it for them. They provided information on the growing and processing of marihuana. And they educated qualifying patients and primary caregivers on their rights under the MMMA and the on-going series of laws, court decisions and other determinations that could affect them. Some communities would recognize these as legitimate activities of a *"club"* and would generally agree to regulate them under zoning regulations for that use.

More controversially, many of the clubs used their facilities for the transfer of marihuana from caregiver to patient, and for consumption of the marihuana on the premises. Because these are private establishments, there is no way for a community or law enforcement to verify that such *"transfers"* are occurring in compli-

ance with the MMMA or that they were not operating as non-profit dispensaries. Smoking marihuana in *"any public place"* is explicitly prohibited in the MMMA (Section 7 (b) (3) (B)) but because these are private clubs, the case was made that club members were permitted to *"light-up"* at their *"club."* But communities were concerned that allowing smoking in the clubs was not within the intent of the law.

Clinics – Another type of establishment that appeared in the early days of the MMMA were for profit operations that provided the same type of services as the compassionate care clubs, but for a fee. Communities could regulate these facilities as professional offices or medical clinics depending on the range of services provided, although they raised the same issues as compassionate care clubs.

Cooperative grow facilities – Shortly after the adoption of the administrative rules regarding medical marihuana in April 2009, I received a call from a young man convinced that the law provided an opportunity both for a new business opportunity and a way to reuse some of the vacant industrial buildings in his community. He was proposing a cooperative grow operation in which multiple caregivers and qualifying patients would pay the facility to grow their medical marihuana. I explained that I thought such an operation was beyond the scope of the MMMA. He could not understand how the law could not permit such a simple and straightforward approach to producing medical marihuana. He was not alone. In the coming months, many of our client communities received similar proposals for facilities under which primary caregivers and qualifying patients *"contracted out"* the growing of their *"medicine."*

Dispensaries – The most visible new use appearing in the wake of adoption of the MMMA was the dispensary, a facility that sold medical marihuana to primary caregivers or to qualifying patients. Many operated using a *"consignment shop"* model. A primary caregiver who grew more marihuana then they needed or a primary caregiver who grew more than their patient needed would lease a locker at the facility to store the excess marihuana. Another primary caregiver or qualifying patient could then come to the dispensary and select the locker from which they wished to purchase the marihuana. The dispensary employee would retrieve the marihuana from that locker, replacing it with the payment from the purchaser (minus the dispensary's share). The dispensary made money both from the leasing of the lockers and their portion of the sale price. Another approach proposed was for several primary caregivers to join together to cooperatively serve their respective patients.

I was continually surprised by the conversations I had with individuals proposing dispensaries and cooperative grow facilities. When I asked them why they thought such facilities were legal, they would simply point to other existing facilities in the state and say, *"They are allowed there, why not here?"* And while many would discuss the need to provide these facilities for the qualifying patients, others were much more direct. One individual proposing a facility told me, *"A friend of mine asked me to go in with him on a cell phone store a few years ago. I said 'no' and now he owns five stores and is making all kinds of money. I told myself, the next new thing that came up I was going to go for it."*

Other proponents of dispensaries and cooperative grow facilities would often address the issue of how they were legal with one of two responses:

- They do it in California!
- It's allowed under the MMMA as a medical use of marihuana.

The presumption that anything that was permitted in California was also permitted in Michigan was based on the mistaken perception that the laws in the two states were the same or very similar. While there are many similarities between the two state's laws, there were two important differences. As noted previously, the MMMA specifically limits primary caregivers to five patients, while the California law placed no such limitation. In addition, the California law specifically allowed cooperatives, while there was no such authorization in the MMMA. So the 100+ dispensaries in California in 2008 and their associated grow operations had a basis for their operation that was lacking in Michigan.

The other argument made by proponents of these facilities not specifically called for in the MMMA involved the interpretation of the act. Section 3 (e) defines *"medical use of marihuana"* as *"the acquisition, possession, cultivation, manufacture, use, internal possession, delivery, transfer, or transportation of marihuana or paraphernalia relating to the administration of marihuana to treat or alleviate a registered qualifying patient's debilitating medical condition or symptoms associated with the debilitating medical condition."* In addition, Section 8 of the act allows for Affirmative Defense and Dismissal for Medical Marihuana, specifying that *"Except as provided in section 7, a patient and a patient's primary caregiver, if any, may assert the medical purpose for using marihuana as a defense to any prosecution involving marihuana, and this defense shall be presumed valid where the evidence shows that..."* Proponents argued that operators of these various facilities were immune from prosecution for violations of local ordinances, including zoning ordinances, as long as they could prove that their operation constituted a valid medical use of marihuana. This argument served as the basis for several court cases.

To some extent these various facilities were a response to issues not adequately addressed in the MMMA. Among those is that there is a delay between the time the qualifying patient or primary caregiver is allowed to grow the plant and the point at which useable marihuana can be harvested. For a qualifying patient with a chronic condition with other medical treatments this might be an inconvenience, but for a patient suffering from a severe and/or terminal illness who needs the medical marihuana now, the delay could be much more serious. The other potential issue is a poor *"harvest"* resulting in an insufficient amount of the medical marihuana for the patient. Proponents of dispensaries and cooperative grow facilities point to them as a necessary *"safety net"* to address these issues.

Give Us Some Direction!

Local communities soon turned to the state to ask for help in determining what they could and could not do. There were four potential sources of direction:

The State Department of Community Health was identified as the administrative agency in the MMMA, However the responsibilities of the department were clearly defined as promulgating rules on how the department was to consider the addition of medical conditions or treatments to the list of debilitating medical conditions listed in the act and the procedure for review and approval of requests for registry identification cards for qualifying patients and primary caregivers. In addition, the department was identified as the body responsible for issuance (and revocation) of the cards and maintenance of a confidential list of card holders. The department viewed its role as prescribed by these responsibilities and although it publicly stated that it did not believe dispensaries were authorized under the MMMA, it did not see its role as the state's *"cop"* in determining whether or not specific operations were allowed under the act.

The state legislature was also looked upon as a source of clarification of the law. The difficulty here was that the original law was initiated by petition. It was not drafted or approved by the legislature. They were being asked to fix a law they did not write, and because it was an initiated law it could only be amended by a ¾ vote of both houses. In addition, the legislature appeared hesitant to modify a law that had been approved by 63% of the voters in the 2008 election. Initial legislative fixes did not appear to directly clarify the type of facilities that were allowed under the act.

The Michigan Attorney General was another potential source of clarification. However, during the first two years of the laws implementation the AG issued only one opinion, that dealing with the State Department of Community Health's ability to hire an outside contractor to assist in the administration of the Medical Marihuana Program.

That left it to the courts. Cases seemed to be initiated almost immediately on various issues related to local enforcement of the

law and what its provision meant. However, it took time for cases to make their way through the court system to the state Court of Appeals and the Michigan Supreme Court.

Moratorium

As confusion continued to reign in local communities over what they could and what they should do, they continued to receive requests for approval of various type of facilities or saw these establishments simply pop up, without any previous approval. Some municipalities took the approach that if the state was not going to tell them these facilities were prohibited, they would allow them, in some cases due to concerns that to attempt to block them might expose them to legal liability. But a large number of municipalities chose to adopt moratoriums.

Generally, moratoriums are adopted to provide a community with *"breathing room"* while they attempt to address an issue. An example would be a moratorium on building permits to provide the local jurisdiction with the time needed to prepare an ordinance or conduct a study. The key is that the community controls the length of time they need to figure out the appropriate course of action. In this case communities were adopting moratoriums of medical marihuana facilities until the state *"figured it out."* I recall many discussions with local elected official and their anger at the position they felt the law and the initial response to it by *"the state"* put them and their residents in. Many of them seemed to take a small bit of satisfaction in using the moratorium discussions to let their residents know who, in their opinion, had put them in this fix.

Prohibiting Illegal Uses

Just as the move towards adoption of moratoriums began to gather momentum, another potential approach began to be considered by municipalities throughout the state. This approach was based on the fact that the MMMA did not legalize the medical use of marihuana, it simply granted a person immunity from prosecution under state or local laws and ordinances. The growing, transfer and consumption was (and is) still illegal under federal law. So communities began adopting a provision in their local zoning ordinance that prohibited any use that was prohibited under state or federal law. Many communities have long had that provision in their zoning ordinance. Since any use involving the growing, transfer or consumption of marihuana would violate federal law, it would be prohibited under the zoning ordinance. The amendment was generally one or two lines in the general provisions section of the zoning ordinance.

Concerns were raised over the use of this approach, particularly if it were strictly enforced. Technically it would not only prohibit many of the facilities that were of concern to the communities but it would also prohibit primary caregivers and qualified patients from operating within the scope of the MMMA. None of the communities I spoke with that considered adopting this type of amendment seemed to intend to enforce their ordinance to prohibit qualifying patients or primary caregivers, but the ordinance language would imply that they could.

That approach was closed to municipalities by the **Ter Beek v the City of Wyoming** Court of Appeals case issued in July 2012 (297 Mich App 446). In the **Ter Beek** case the courts ruled that the approach was preempted under the MMMA because it would *"prohibit conduct permitted by the Michigan Medical Marihuana Act."* The Court further ruled that the MMMA was not in turn preempted by the federal Controlled Substances Act (CSA), because the MMMA did not presume to legalize medical marihuana, but simply protected individuals from prosecution under state and local laws and ordinances. The Michigan Supreme Court affirmed this decision in February 2014.

In the face of the **Ter Beek** case, many communities repealed their amendment and re-established their moratorium.

Finally, Some Direction!

Two decisions, one in 2011 and the other early in 2013 helped to provide clarity to communities. In 2011 the Attorney General issued an opinion that the MMMA *"prohibits the joint cooperative cultivation or sharing of marihuana plants because each patient's plants must be grown and maintained in a separate enclosed, locked facility that is only accessible to the registered patient or the patient's registered primary caregiver."*

Then on February 8, 2013 the Michigan Supreme Court ruled in the case of the **State of Michigan v McQueen** (493 Mich 135). The Court ruled that the dispensary operation using the consignment model did not constitute the medical use of marihuana and was not protected under the MMMA. In other words, they were illegal operations that did not have to be permitted in any Michigan municipality.

These two decisions provided support for communities that wished to prohibit cooperative grow operations and dispensaries. The major focus of many of our clients now returned to how to regulate primary caregivers.

Photo by Mark Wyckoff

Allowing Commercial Uses

By May 2013 there were 26,875 primary caregivers registered with the State of Michigan. Communities were concerned about the growth of these facilities within their communities and ways to regulate them. As noted earlier, some communities had concerns with a *"home occupation"* approach to their regulation. With the decisions by the AG and State Supreme Court, the concern with large scale commercial operations faded. Why not restrict primary caregivers in commercial zoning districts? Because such operations would be limited to serving five patients, there would be no need for their operators to adopt a high profile, and this approach would keep them out of residential districts. This continues to be a popular option for communities we work with in addressing primary caregivers.

It's Not a Dispensary, It's a Provisioning Center

Five days after the Supreme Court's decision **in State of Michigan v McQueen**, House Bill 4271, The Medical Marihuana Provisioning Center Regulation Act was introduced in the Michigan legislature. The bill would have allowed for the establishment of *"provisioning centers."* Under the proposed law these facilities would be allowed to purchase or sell medical marihuana from or to primary caregivers, patients or other provisioning centers and to grow medical marihuana, without prosecution under state or local ordinance. The bill would also allow for safety compliance facilities to grow and test medical marihuana. However, the bill specifically permitted municipalities to prohibit provisioning centers and safety compliance facilities in their jurisdictions.

In December 2013, the bill cleared the House of Representatives by a vote of 95 to 14 and went to the Senate. With that vote, the proponents of commercial transactions of medical marihuana were back. Numerous communities began to receive calls from individuals wanting to know if they were going to allow provisioning centers and safety compliance facilities. It seemed as though the passage of the bill was a forgone conclusion. At least one of

our clients moved ahead with adoption of an ordinance and began licensing provisioning centers in anticipation of the passage of HB 4271.

Then the bill stalled in the Senate. At the end of December, 2014 an effort to get the bill out of committee and on to the floor for a vote failed and with the expiration of the legislative session the bill died.

In February 2015, the bill was re-introduced as HB 4209. As modified during its journey through the legislature its name was changed to the Medical Marihuana Facilities Licensing Act and its scope was revised to address separate provisioning centers, grow facilities, testing labs, processing facilities and secure transport operations, rather than regulating all of the uses under the term *"provisioning center."*

Despite House Bill 4271's defeat in 2014, medical marihuana proponents continued to be confident that the bill's adoption was a matter of time and continued to approach local communities about permitting provisioning centers. An element of urgency was added when rumors spread that a limit on the number of facilities would be included in the bill with a *first come first serve* approach to be adopted in issuing the licenses. One of our communities was approached by a supporter of the legislation with a draft medical marihuana facilities ordinance for them to adopt, even though the bill was still sitting in the Senate after having been overwhelmingly approved by the House in 2015. Another community which had adopted an ordinance limiting primary caregiver operations to their commercial districts was approached by a caregiver wishing approval for use of a commercial storefront. The applicant freely admitted that they could not make a profit serving 5 patients out of the facility but hoped to be *"first in line"* for a state license once the Medical Marihuana Facilities Licensing Act was adopted.

Medical Marihuana Part 2?

On September 21, 2016 the Governor signed PA 281 (formerly HB 4209), the Medical Marihuana Facilities Licensing Act, along with two companion bills. These bills do not replace the MMMA but create an additional regulatory structure for facilities to grow, process and distribute medical marihuana. Individual qualifying patients may still grow their own plants and primary caregivers may still grow plants for up to five patients. Questions for local communities include: *will primary caregivers choose to do so or will they rely on the provisioning centers for their medical marihuana? Or will primary caregivers simply supplement the medical marihuana they grow with marihuana they can purchase at a provisioning center?*

An important element of the new law is the requirement that *facilities cannot be licensed in a municipality unless the municipality has adopted an ordinance allowing for that facility.* And municipalities may choose to permit some but not all types of facilities in their community, so they might allow secure transport, processing and testing facilities, but not allow provisioning or growing facilities. Another important element is the financial incentive provided to communities hosting a facility, Municipalities are allowed to levy a fee of up to $5,000 annually for each facility, and share in 3% tax levied on the gross receipts of the licensed provisioning centers in the state.

On a side note, the law did not set a limit on the number of facilities that could be granted a license and in fact Section 302 (d) of the Medical Marihuana Facilities Licensing Act specifically prohibits the Department of Licensing and Regulatory Affairs from adopting rules that establish a limit.

So communities throughout the state have a new set of questions to answer regarding medical marihuana. *Do they allow one or more types of facilities? If so, which ones? What provisions do they include in their local regulations?* This is left fairly open-ended in the act with the proviso that local regulations cannot include rules that conflict with state licensing requirements or that address the purity or pricing of marihuana. The scope of the state licensing regulations as outlined in Section 206 deal primarily with operational issues such as insurance, chain of custody, labeling and packaging, storage and advertising.

As with all other aspects of local medical marihuana, the extent of local regulation of medical marihuana facilities under PA 281 will probably take time to work out. It appears clear that localities may identify the zoning districts that various types of facilities may be located in as well as setbacks and buffering they may require. Separation distances from other uses such as schools and daycare facilities do not appear to be excluded. Some operational issues that do not appear to be part of the scope of the licensing regulations such as hours of operation may be allowed.

Photo by Mark Wyckoff

I assume many communities will view these new laws as an improvement over the current medical marihuana structure. It helps to address many of the concerns of qualifying patients over access to medical marihuana. If most qualifying patients and primary caregivers abandon growing plants themselves, it could significantly reduce the number of grow and distribution facilities that the community needs to keep track of. And the new seed to sale tracking system required for all of the facilities will help to address concerns over diversion of marihuana for non-medical purposes.

In any case, I suspect communities will continue on this wild ride for at least a few more years. ❑