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July 22, 2024

The Honorable Merrick Garland
Attorney General of the United States
U.S. Department of Justice
950 Pennsylvania Avenue N.W.
Washington, D.C. 20530

Submitted electronically via Regulations.gov

Re: Comments of the States of Nebraska, Alabama, Arkansas, Indiana, Iowa, Kansas, Louisiana, Mississippi, Montana, South Carolina, and South Dakota on the notice of proposed rulemaking *Schedule of Controlled Substances: Rescheduling of Marijuana* (DEA-2024-0059; A.G. Order No. 5931-2024; Docket No. DEA-1362; 89 Fed. Reg. 44597 (May 21, 2024)).

Dear Attorney General Garland:

The undersigned States submit the following comments to the notice of proposed rulemaking ("NPRM") entitled "Schedule of Controlled Substances: Rescheduling of Marijuana" (DEA-2024-0059) which was published in the Federal Register on May 21, 2024. 89 Fed. Reg 44597 (May 21, 2024). *See also* Docket No. DEA-1362. The NPRM preliminarily endorses the recommendation of the Department of Health and Human Services ("HHS") that marijuana's status under the Controlled Substances Act ("CSA"), 21 U.S.C. § 801 *et seq*,[1] be changed from CSA Schedule I to Schedule III. *See* Letter to Anne Milgram, Administrator of the Drug Enforcement Administration, *Basis for the Recommendation to Reschedule Marijuana into Schedule III of the Controlled Substances Act* (Aug. 29, 2023) ("HHS Basis for Rec.").

A Final Rule should not issue for five reasons. *First*, the NPRM is invalid because the NPRM is not signed by the Administrator of the Drug Enforcement Administration ("DEA"). The Attorney General has long delegated numerous statutory duties, textually committed to him by the CSA, to DEA by regulation. *See* Drug Enforcement Administration, 38 Fed. Reg. 18380 (July 10,

[1] *See* Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (1970).

1973), *as amended by* Reorganization Regulations, 46 Fed. Reg. 52339, 52348 (Oct. 27, 1981).[2] That regulation "assign[s]" and provides that the DEA Administrator "shall . . . conduct[], handle[], or supervise[]" CSA rescheduling decisions. 28 C.F.R. § 0.100. So long as it remains in effect, the Attorney General cannot lawfully exercise the power delegated by regulation to the DEA Administrator. *See Black v. Snow*, 272 F. Supp. 2d 21, 26 (D.D.C. 2003). Because this NPRM was not signed by the DEA Administrator, any Final Rule that issues will be the product of an ultra vires act and thus would be "not in accordance with law" under the Administrative Procedure Act ("APA"). 5 U.S.C. § 706(2)(A).

Second, a Final Rule rescheduling marijuana would violate the United States' international treaty obligations. Until this year, the Department of Justice understood the Single Convention on Narcotic Drugs ("Single Convention" or "Convention")[3] —a treaty signed by 186 countries[4] and ratified by the U.S. Senate in 1967[5]—to require marijuana to be controlled on CSA Schedule I or Schedule II. *See* Memorandum to Director of Bureau of Narcotics & Dangerous Drugs from Deputy Assistant Attorney General Mary C. Lawton, Office of Legal Counsel (Aug. 21, 1972) ("Lawton Memo")[6]; *see also* Preliminary Note Regarding Treaty Considerations, 81 Fed. Reg. at 53688–89 (July 19, 2016). Courts considering the question have agreed. *See*, *e.g.*, *Nat'l Org. for Reform of Marijuana L. v. Drug Enf't Admin. ("NORML")*, 559 F.2d 735, 750–51 (D.C. Cir. 1977). It is undisputed that placing marijuana on Schedule III, without further action, would violate the Single Convention. *See* Office of Legal Counsel, *Questions Related to Potential Rescheduling of Marijuana*, 48 Op. O.L.C. ---, 2024 WL 2412009 at *19, 23 (Apr. 11, 2024) ("OLC Op.").[7] The Office of Legal Counsel recently concluded that the United States could comply with its Single Convention obligations by placing marijuana on Schedule III and taking supplemental regulatory action ostensibly authorized by the CSA, *see* OLC Op. at *3, 18–24, but that would violate the CSA by creating a new schedule. Nothing in the CSA empowers the Attorney General or DEA to create a hybrid "Schedule 2.5."

Third, the NPRM wrongly asserts that "significant deference" is owed to HHS's determinations. The CSA requires that "HHS's scientific and medical determinations . . . be binding . . . until an NPRM is published." 89 Fed. Reg. at 44599; *see* 21 U.S.C. § 811(b). The NPRM proposes, consistent with HHS's recommendation, to promulgate a Final Rule

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[2] Codified at 28 C.F.R. § 0.100(b).

[3] Single Convention on Narcotic Drugs, July 12, 1967, T.I.A.S. No. 6298, 18 U.S.T. 1407, 1967 WL 90243, *also available at* https://www.unodc.org/pdf/convention_1961_en.pdf. In addition to the text of the Convention itself, the United Nations has produced an Official Commentary, available at https://www.unodc.org/documents/treaties/organized_crime/Drug%20Convention/Commentary_on_the_single_convention_1961.pdf.

[4] *See infra* note 17.

[5] *See infra* note 18.

[6] Available at https://www.justice.gov/olc/media/1359191/dl?inline.

[7] Available at https://www.dea.gov/sites/default/files/2024-05/2024-04-11%20-%20AAG%20Fonzone%20-%20Marijuana%20Rescheduling.pdf.

rescheduling marijuana to Schedule III. That said, because the Attorney General retains "ultimate responsibility" for scheduling decisions under the CSA, neither you nor DEA (to whom all CSA scheduling and rescheduling decisions have been delegated)[8] is ultimately obligated to defer to HHS's recommendation. *See* OLC Op. at *15; *see also* 21 U.S.C. §§ 811(a), 812(b). Instead, DEA is obligated to consider the "whole record" and all "reliable, probative, and substantial evidence." OLC Op. at *17 (quoting 5 U.S.C. § 556(d)); *see also* 5 U.S.C. § 553(c); *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 96 (2015) ("An agency must consider and respond to significant comments received during the period for public comment"). In short, in this rulemaking, DEA is under no obligation to concur with HHS's recommendation that marijuana be rescheduled.

Fourth, a Final Rule rescheduling marijuana would be unlawful because DEA has consistently and repeatedly rejected requests to move marijuana off Schedule I, and the relevant facts have not changed.[9] When an agency reversal "rests upon factual findings that contradict those which underlay its prior policy" the agency is obliged to "provide a more detailed justification than what would suffice for a new policy created on a blank slate." *FCC. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). This heightened standard requires the agency to "show that there are good reasons for the new policy." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016) (quoting *Fox Television*, 556 U.S. at 515). As recently as 2016, DEA concluded that "marijuana continues to meet the criteria for Schedule I control under the CSA." Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 81 Fed. Reg. 53688 (Aug. 12, 2016). Federal agencies are, of course, not permanently locked into a prior position—they can chart a new course in appropriate circumstances. But here, the requisite "good reasons" do not exist.

Nothing material—in either the realm of science or law—has changed since 2016 when DEA last concluded that it was appropriate to maintain marijuana's placement on Schedule I. Indeed, HHS implicitly recognizes as much, insofar as it advocates for the jettison of a longstanding, data-driven-and-science-based standard employed by DEA in 2016 and its replacement by a much less rigorous test of its own creation, tailor-made to permit marijuana's rescheduling. That advocacy, embraced by OLC's recent opinion, is seriously misguided. It threatens to undermine the federal regulatory regime that ensures the medicine Americans rely on is safe and effective rather than false cures peddled by snake-oil salesmen.

Ultimately, because there has been no material change in facts or law, rescheduling marijuana (after DEA has previously and consistently declined to do so for more than half a

[8] *See* 28 U.S.C. § 510; 28 C.F.R. § 0.100(b); *see also Touby v. United States*, 500 U.S. 160, 164 (1991). The impact of the Attorney General's delegation of his statutory authority to DEA by regulation is discussed further below, *see infra* Section I.

[9] *See* Schedule of Controlled Substances, 37 Fed. Reg. 18097 (Sept. 7, 1972); Marijuana Scheduling Petition; Denial of Petition, 54 Fed. Reg. 53767 (Dec. 29, 1989); Marijuana Scheduling Petition; Denial of Petition; Remand, 57 Fed. Reg. 10499 (Mar. 26, 1992); Notice of Denial of Petition, 66 Fed. Reg. 20038 (Apr. 18, 2001); Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 76 Fed. Reg. 40552 (July 8, 2011); Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 81 Fed. Reg. 53688 (Aug. 12, 2016).

century) would be agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

Fifth, even if these legal impediments could be overcome, rescheduling marijuana is not warranted by the statutory factors set forth in the CSA. Section 811(c) sets eight factors for the scheduling of controlled substances. These include a drug's "actual or relative potential for abuse," "[i]ts history and current pattern of abuse," "[t]he scope, duration, and significance of abuse," "risk . . . to the public health," "dependence liability," and "[w]hether the substance is an immediate precursor of [another controlled] substance." 21 U.S.C. § 811(c). These factors weigh against rescheduling marijuana. Even HHS recognizes that the "abuse of marijuana produces clear evidence of harmful consequences" and its consumption creates a "risk to public health." HHS Basis for Rec. at 7, 8. It is difficult to deny that increasing lawful access to marijuana—something rescheduling it to Schedule III would undoubtedly accomplish—will damage the public health and exacerbate serious societal ills already plaguing the Nation.

The harm inflicted by rescheduling will be especially acute in States like Nebraska, where state law makes marijuana illegal in all circumstances. Although Nebraska law does not authorize the consumption of marijuana, many of Nebraska's neighboring States do. Colorado, for instance, has long been at the forefront of the movement to expand access to marijuana.[10] The harms that flow into Nebraska from its more marijuana-friendly neighbors have been recounted before, *see, e.g.*, *Nebraska v. Colorado*, 577 U.S. 1211, 136 S. Ct. 1034, 1036 (2016) (Thomas, J., dissenting from denial of motion for leave to file original jurisdiction complaint),[11] and are reiterated below. Suffice to say, moving marijuana to Schedule III will turbocharge the existing marijuana industry

[10] *See* Colo. Const. art. XVIII, § 16. (Sometimes referred to as "Amendment 64," the name of the ballot initiative that resulted in its enactment, *see* Colorado Secretary of State, *Amendments and Propositions on the 2012 Ballot*; *Amendment 64 – Use and Regulation of Marijuana*, https://www.sos.state.co.us/pubs/elections/Initiatives/ballot/contacts/2012.html.) As the Supreme Court of Colorado has explained, "Amendment 64 did more than just legalize personal marijuana use, possession, and growth. The initiative also created a marijuana industry." *People v. McKnight*, 446 P.3d 397, 408 (Co. 2019).

[11] As Justice Thomas explained, in 2014 Nebraska and Oklahoma sought to invoke the Supreme Court's original jurisdiction to pursue a claim that Colorado's 2012 legalization of marijuana for recreational use had "'increased trafficking and transportation of Colorado-sourced marijuana' into their territories" and caused the complaining States to "expend significant 'law enforcement, judicial system, and penal system resources' to combat the increased trafficking and transportation of marijuana." *Nebraska*, 136 S. Ct. at 1036 (quoting proposed Complaint and Brief in Support of Motion for Leave to File Complaint). Notably, an amicus brief in support of Nebraska's effort to hold Colorado accountable for those harms was filed by what was, at the time, "All Nine Former Administrators" of the DEA, spanning the administrations of President Nixon to President George W. Bush. *See* Amicus Brief, *Nebraska*, 577 U.S. 1211, 136 S. Ct. 1034 (No. 144, Orig.), 2015 WL 1262747, at *1. Copies of Nebraska and Oklahoma's Complaint, Motion for Leave, and Brief in Support are available here: https://perma.cc/5TTV-K6RF.

Because the Supreme Court declined to exercise its original jurisdiction and a federal court of appeals concluded that *only* the Supreme Court could exercise jurisdiction over the dispute, *see Safe Streets Alliance v. Hickenlooper*, 859 F.3d 865, 913 (10th Cir. 2017), Nebraska's claims have never received consideration on the merits in a judicial forum.

in States where legalization has already taken root. That, in turn, will compound the harms already flowing from the increased availability of "state-legal" marijuana that Nebraska and similarly situated States have and will continue to suffer.

That said, the public health damage resulting from expanded access to marijuana will not be confined to States where it remains fully illegal under state law.[12] Moving marijuana to Schedule III will effectively provide the marijuana industry with a substantial tax cut—in some respects, a rescheduled marijuana will receive more favorable federal tax treatment than alcohol, tobacco, and gambling. This will cause a tremendous expansion of the existing marijuana industry. And that expansion will lead to the increased consumption of marijuana, which in turn causes a panoply of negative effects.

A few examples suffice to illustrate the gravity of the problem. Marijuana causes myriad health problems. It is particularly harmful to child and adolescent development and has links to both mental health conditions like schizophrenia as well as physical ailments such as cancer and heart disease. Expanded marijuana access also increases motor vehicle accidents and creates difficult problems in enforcing laws that prohibit driving while intoxicated. Nor are its second-order effects much better—marijuana is linked to rising homelessness and welfare dependance, reduced workplace productivity, and increases in anxiety and suicidal ideation.

In sum, a Final Rule rescheduling marijuana to Schedule III would be both unlawful and ill-advised. We offer the following comments in support of both assertions, and urge the Attorney General and DEA to decline to issue any Rule that would move marijuana off Schedule I.

BACKGROUND

Marijuana has, as the NPRM recognizes, been subject to federal restriction for nearly a century. 89 Fed. Reg. at 44607 (recounting the history of federal marijuana law, beginning with the Marihuana[13] Tax Act of 1937). State-level restrictions have existed for even longer. *Gonzales*

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[12] *See*, *e.g.*, Letter from Alabama Attorney General Steve Marshall to Alabama Legislature Concerning Medical Marijuana Legalization (January 6, 2020), https://perma.cc/J7EK-CBNW.

[13] Federal law contains numerous references to "marihuana," a spelling that has fallen out of favor in contemporary usage. This Comment uses the more widely adopted "marijuana" throughout. Both spellings refer to the same plant, *Cannabis sativa L.*

Some sources, including many scientific sources, some periodicals, and the Single Convention use "cannabis" as a catch-all term for any plant of the genus *Cannabis*. However, in 2018, the United States Congress established a legal distinction between "marijuana" (cannabis strains that have a concentration of Delta-9 THC greater than 0.3 percent on a dry weight basis) and "hemp" (cannabis strains, usually rich in non-intoxicating cannabidiol aka "CBD," that contain less than 0.3 Delta-9 THC). *See* Agriculture Improvement Act of 2018, Pub. L. 115-334, 132 Stat. 4490, *codified in relevant part at* 7 U.S.C. § 1639o. Because, by definition, "hemp" strains of cannabis contain very little Delta-9 THC—the primary intoxicant found in the cannabis plant—hemp is expressly exempted from the definition of marijuana in the CSA; "hemp," therefore, is not a federally controlled substance. *See id.* Most importantly for present purposes,

v. Raich, 545 U.S. 1, 11 n.14 (2005). In *Raich*, the Supreme Court noted that by the time the first federal effort to control marijuana was enacted, "all States had in place some form of legislation regulating the sale, use, or possession of marijuana." *Id*. Nor were American States the first expositors or adopters of anti-marijuana laws. Strict regulations and even outright prohibition were enacted in a variety of locations across the globe throughout the nineteenth century.[14] As increasing world trade and other modern trends in the early twentieth century caused marijuana to become more widely accessible worldwide, laws prohibiting its cultivation, importation, and consumption proliferated.[15]

The twentieth century trend toward greater marijuana prohibition eventually produced the Single Convention. The international discussions that spawned the Convention began in 1948 and were the product of extensive negotiation and revision.[16] Ultimately adopted in 1961 (and amended in 1972), nearly every country in the world—there are currently 186 signatories—is party to the treaty.[17] The Single Convention was ratified by the U.S. Senate in 1967 and went into effect the same year.[18]

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as a matter of botany, all marijuana is cannabis, but legally (under federal law at least) not all cannabis is marijuana.

Although many references to "cannabis" may facially encompass hemp, context almost always reveals that such references are implicitly intended to refer to "intoxicating cannabis." *See*, *e.g.*, Single Convention Art. 28, § 2 (exempting from control "cultivation of the cannabis plant exclusively for industrial purposes"). To avoid confusion, this Comment uses the term "marijuana" rather than "cannabis" whenever possible.

[14] In 1830, the city of Rio de Janeiro banned the importation of cannabis, imposing fines on all sellers and sentencing individuals in possession to three day's imprisonment. Robert Clarke & Mark Merlin, *Cannabis: Evolution and Ethnobotany* 182 (2013). In 1840, the British colony of Mauritius banned the cultivation, sale, and distribution of "Gandia," (a local name for cannabis) on penalty of fine or imprisonment. 4 *A Collection of the Laws of Mauritius and Its Dependencies* 541 (John Rouillard ed. 1867), *available at* https://books.google.com/books?id=0ktHAQAAMAAJ&pg=PA541#v=onepage&q&f=false. In 1877 the Sultan of Turkey ordered the nationwide confiscation and destruction of all marijuana found in Egypt. Ernest L. Abel, *Marihuana: The First Twelve Thousand Years* 133 (1980). Two years later, the importation of marijuana was banned, followed five years after that with the imposition of a criminal offense for its cultivation. *Id.* In 1890 Greece outlawed cultivation, importation, and usage of marijuana. *Id.* at 135.

[15] Several representative examples: Canada criminalized marijuana in 1923, *see* Martin A Lee, *Smoke Signals: A Social History of Marijuana – Medical, Recreational, and Scientific* 325 (2012); Indonesia outlawed marijuana in 1927, *see* Thomas H. Sloane, *Prokem* 26–27 (2003); and Great Britain prohibited cannabis in 1928, *see* Paul Manning, *Drugs and Popular Culture* 136 (2007).

[16] *See NORML*, 559 F.2d at 739.

[17] *See* Int'l Narcotics Control Bd., *Report of the International Narcotics Control Board for 2021*, E/INCB/2021/1 at 15, (Mar. 10, 2022), https://www.incb.org/documents/Publications/AnnualReports/AR2021/Annual_Report/E_INCB_2021_1_eng.pdf ("The 1961 [Single] Convention as amended has been ratified or acceded to by 186 States").

[18] *See* The American Presidency Project, *Message to the Senate Transmitting the Single Convention on Narcotic Drugs, 1961*, https://www.presidency.ucsb.edu/documents/message-the-senate-transmitting-

The Single Convention declares that "[t]he use of [marijuana][19] for other than medical and scientific purposes must be discontinued as soon as possible" and set 1986 as the aspirational date for the elimination of non-medical or industrial use of marijuana. Single Convention Art. 49, § 2(f); *see also* Official Commentary on the Single Convention ("Official Commentary"), *supra* note 3, at 110 ("The object of the international narcotics system is to limit exclusively to medical and scientific purposes the trade in and use of controlled drugs."). The Convention requires signatories to "limit production, distribution, and possession of [marijuana] to authorized medical and scientific purposes," to "license and control all persons engaged in [its] manufacture or distribution," prepare "detailed estimates of national drug requirements," and collect certain statistics. *NORML*, 559 F.2d at 739–40 (citing Articles 19, 20, 29, and 30 of the Convention). Further, signatories must not "permit possession of the drugs 'except under legal authority'" and "impose certain penal sanctions" for the cultivation, manufacture, possession, or distribution of marijuana. *Id*. (citing Articles 33 and 36); *see also* Official Commentary at 111–12 ("Parties must take the required legislative and administrative measures to limit exclusively to medical and scientific purposes the possession of [controlled] drugs"). In particular, the cultivation and manufacture of marijuana must be "under license except where such manufacture is carried out by a State enterprise or State enterprises." Single Convention Art. 29, § 1. Similar restrictions apply to trade and distribution. *Id*. Art. 30. And, critically, the "total quantit[y] of [marijuana] manufactured . . . shall not exceed . . . the quantity consumed . . . for medical and scientific purposes." *Id.* Art. 21, § 1.

In 1970, three years after ratifying the Single Convention, Congress enacted the CSA. *See* Pub. L. No. 91-513, 84 Stat. 1236 (1970).[20] A comprehensive overhaul of federal drug policy, the CSA "was intended to replace the some 50 pieces of legislation dealing with drugs that had been enacted by Congress since 1914." *United States v. Rosenberg*, 515 F.2d 190, 196 (9th Cir. 1975). Congress "repealed most of [its] earlier antidrug laws" replacing them with a "comprehensive regime" aimed at combating the "international and interstate traffic in illicit drugs." *Raich*, 545 U.S. at 12.

The centerpiece of the CSA is its five schedules. "Each schedule is associated with a distinct set of controls regarding the manufacture, distribution, and use of the substances listed therein." *Id.* at 14 (citing 21 U.S.C. §§ 821–830). Substances are "grouped together based on their accepted medical uses, the potential for abuse, and their psychological and physical effects on the body." *Id*. at 13 (citing 21 U.S.C. §§ 811, 812). "Schedule I drugs are categorized as such because of their high potential for abuse, lack of any accepted medical use, and absence of any accepted safety for use in medically supervised treatment." *Id*. at 14 (citing 21 U.S.C. § 812(b)(1)). "These

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the-single-convention-narcotic-drugs-1961 (last visited July 18, 2024). *See also* T.I.A.S. No. 6298, 18 U.S.T. 1407, 1967 WL 90243 (July 12, 1967).

[19] As noted above, *supra* note 13, the Single Convention does not use the term "marijuana," instead referring to "cannabis," which it defines as the "flowering or fruiting tops of the cannabis plant." Single Convention Art. 1, § 1(b). "Cannabis plant," in turn, is defined to mean "any plant of the genus Cannabis." *Id.* Art. 1, § 1(c). As the NPRM recognizes, the Single Convention's definition of cannabis includes what federal law calls "marijuana." 89 Fed. Reg. 44620.

[20] Currently codified at 21 U.S.C. §§ 801–904. *See also supra* note 1.

three factors, in varying gradations, are also used to categorize drugs in the other four schedules. For example, Schedule II substances also have a high potential for abuse which may lead to severe psychological or physical dependence, but unlike Schedule I drugs, they have a currently accepted medical use." *Id.* (citing 21 U.S.C. § 812(b)(2)). A Schedule III substance "has a potential for abuse less than the drugs or other substances in schedules I and II," a "currently accepted medical use in treatment in the United States," and its abuse "may lead to moderate or low physical dependence or high psychological dependence" rather than "severe" dependence characteristic of a Schedule II or Schedule I substance. 21 U.S.C. § 812(b)(3).

Marijuana was placed on Schedule I by Congress as part of the initial set of classifications adopted when the CSA was enacted. *Raich*, 545 U.S. at 14. The CSA "provides for the periodic updating of schedules and delegates authority to the Attorney General, after consultation with the Secretary of Health and Human Services, to add, remove, or transfer substances to, from, or between schedules." *Id*. "Despite considerable efforts to reschedule marijuana"—beginning in 1972, in the immediate wake of the CSA's enactment, and continuing periodically in the decades since—"it remains a Schedule I drug." *Id*. at 15. As noted in *Raich*, DEA has "routinely denied petitions to reschedule" marijuana. *Id*. at 15 n.23. Thirty years ago, the U.S. Court of Appeals for the D.C. Circuit remarked that it had addressed petitions to reschedule marijuana on "four prior occasions" before going on to conclude, for a fifth time, that DEA had acted lawfully when it refused to move marijuana from Schedule I. *All. for Cannabis Therapeutics v. Drug Enf't Admin.*, 15 F.3d 1131, 1133 (D.C. Cir. 1994). And as noted above, just eight years ago, DEA again rejected a petition to reschedule marijuana. 81 Fed. Reg. 53688.

In its 2016 decision, DEA explained that marijuana continued to meet all three criteria for inclusion in Schedule I. After reviewing an HHS recommendation, DEA concluded it has "a high potential for abuse," "no currently accepted medical use," and lacks "accepted safety for use under medical supervision." 81 Fed. Reg. at 53688. Notably, at the time DEA issued that decision, more than 30 States had authorized some form of medicinal cannabis[21] and another 8 States had either authorized recreational use or otherwise decriminalized cannabis possession. Indeed, in 2016, California's authorization of medical marijuana was celebrating its twentieth anniversary.[22] Nevertheless, there were "no marijuana products approved by the U.S. Food and Drug Administration" ("FDA") and the "known risks of marijuana use have not been shown to be outweighed by specific benefits in well-controlled clinical trials that scientifically evaluate safety and efficacy." 81 Fed. Reg. at 53688.

[21] *See* Katy Steinmetz, *How the 2016 Election Became a Watershed for Weed*, Time (Nov. 10, 2016), https://time.com/4557472/marijuana-2016-states-legalized/.

[22] *See People v. Mower*, 49 P.3d 1067, 1070 (Cal. 2002) ("At the General Election held on November 5, 1996, the electors approved an initiative statute designated on the ballot as Proposition 215 and entitled Medical Use of Marijuana."); *see also* Cal. Health & Safety Code § 11362.5.

Very little, if anything, has changed in the eight years since. The number of States that have expanded access to marijuana has increased.[23] But FDA still has not approved a single "drug product containing botanical marijuana for any therapeutic indication." 89 Fed. Reg. at 44602. And even HHS admits that the most recent scientific evidence in favor marijuana's medical efficacy is, at best, "inconclusive or mixed." HHS Basis for Rec. at 25–26. HHS further noted that "vast majority of professional [medical] organizations did not recommend the use of marijuana in their respective specialty" and that the American Psychiatric Association "specifically recommended against it" because "marijuana is known to worsen certain psychiatric conditions." HHS Basis for Rec. at 27–28. This relatively static state of affairs is hardly surprising, given that "[t]he psychological, behavioral, and subjective responses to marijuana in humans have been known and characterized since antiquity." 89 Fed. Reg. at 44604. Nothing fundamental about marijuana has changed since 2016.[24]

The only thing that has changed is HHS's recommendation. *Compare* HHS Basis for Rec. *with* 81 Fed. Reg. at 53689 (reproducing HHS's recommendation, from June 25, 2015, that "marijuana continue to be maintained in Schedule I of the CSA"). For the reasons outlined below, that is not enough to warrant rescheduling marijuana.

DISCUSSION

I. The NPRM is Invalid Because it was Not Signed by the DEA Administrator

Because a regulation places the Attorney General's CSA scheduling and rescheduling authority in the DEA Administrator, the Attorney General lacked authority to issue this NPRM. He also cannot issue a Final Rule rescheduling marijuana. The NPRM acknowledges that "[t]he Attorney General has delegated [his relevant] authority [under the CSA] to the DEA Administrator." 89 Fed. Reg. 44601 (citing 28 C.F.R. 0.100). The cited regulation provides that the "functions vested in the Attorney General by the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended" (which includes the Attorney General's Section 811(a) scheduling and rescheduling authority) "are assigned to, and shall be conducted, handled, or supervised by, the Administrator of the Drug Enforcement Administration." 28 C.F.R. 0.100.

Two features of the regulation clarify the delegation's divestment of authority from the Attorney General. *First*, the regulation "assign[s]" the Attorney General's rescheduling function. *Id.* "Assign" means "to transfer" and is used when something is "convey[ed]." Bryan A. Garner, Garner's Dictionary of Legal Usage 87 (3d ed. 2011). The Attorney General's issuance of the NPRM violates this aspect of the regulation because the relevant authority was transferred to

[23] *See* Kate Bryan, *Cannabis Overview*, National Conference of State Legislature, https://www.ncsl.org/civil-and-criminal-justice/cannabis-overview (last updated June 20, 2024).

[24] The only possible exception is that the concentration of Delta-9 THC, the psychoactive chemical responsible for marijuana's intoxicating effect, continues to skyrocket. "In the past 30 years, the potency of marijuana with regard to [Delta]9-THC has increased dramatically." 89 Fed. Reg. at 44604. Because the intoxicating effect of Delta-9 THC unquestionably plays a major role in marijuana's high potential for abuse, the only material factual change since 2016 cuts *against* moving marijuana off Schedule I.

someone else. *Second*, the regulation states that these functions "*shall be* conducted, handled, or supervised by" the DEA Administrator. 28 C.F.R. 0.100 (emphasis added). "Unlike the word 'may,' which implies discretion, the word 'shall' usually connotes a requirement." *Kingdomware Techs., Inc. v. United States*, 579 U.S. 162, 171 (2016). The Attorney General's issuance of the NPRM violates the regulation's mandate that rescheduling "shall be conducted [or] handled" by someone else. 28 C.F.R. 0.100.

Despite this delegation, the NPRM contends the Attorney General "retains the authority to schedule drugs under the CSA in the first instance." 89 Fed. Reg. 44601. The NPRM cites two statutes, neither of which override the regulation's delegation. One statute provides that "[a]ll functions of other officers of the Department of Justice and all functions of agencies and employees of the Department of Justice are vested in the Attorney General" with certain exceptions. 28 U.S.C. § 509. But this statute addresses Congress's delegations of authority—not the Department's regulatory delegations. It does not turn Section 0.100's "shall be" into a "may be." The second statute states that "[t]he Attorney General may from time to time make such provisions as he considers appropriate authorizing the performance by any other officer, employee, or agency of the Department of Justice of any function of the Attorney General." 28 U.S.C. § 510. This statute authorizes the Attorney General to delegate his functions, but nothing in the statute prevents the Attorney General from making such a delegation exclusive. As courts have recognized, Sections 509 and 510 are little more than codifications of the "Attorney General's broad power to make appointments and delegate his duties to subordinates." *Rivera v. Garland*, No. 23-2351, --- F.4th ---, 2024 WL 3309265, at *3 (8th Cir. July 5, 2024); *see also Trump v. United States*, 144 S. Ct. 2312 (2024) (Thomas, J., concurring) ("Sections 509 and 510 are generic provisions concerning the functions of the Attorney General and his ability to delegate authority to 'any other officer, employee, or agency.'").

Case law likewise recognizes a delegation's divestment of authority from the delegator, here the Attorney General. "[O]nce a regulation has been issued delegating power from one officer to a subordinate, the former may not thereafter invoke the delegated power himself, at least as long as the regulation remains in effect." *Black v. Snow*, 272 F. Supp. 2d 21, 26 (D.D.C. 2003). In *Black*, a convicted felon sought relief from the federal statute that makes it unlawful for felons to possess a firearm. Federal law directly authorizes the Attorney General to grant individualized relief from that prohibition. 18 U.S.C. § 925(c). That authority, however, had long been delegated to the Bureau of Alcohol, Tobacco, Firearms, and Explosives ("ATF"). *Black*, 272 F. Supp. 2d at 23. And Congress had repeatedly enacted an appropriations rider that prohibited ATF from expending any funds "in connection with applications made by individuals under § 925(c)," which imposed on ATF a "legal duty *not* to act." *Id*. at 23, 25 (emphasis in original). A felon seeking Section 925(c) relief sued the Attorney General, arguing that because the statutory text authorized the Attorney General to act directly, the appropriation rider did not prevent *the Attorney General* (as opposed to ATF) from addressing his rights restoration petition. *Id*. at 25–26. *Black* rejected that argument. Finding that the "Attorney General's delegation to ATF with respect to § 925(c) is still operative," the Court explained that "[a]s long as this is so . . . the authority (and any concomitant duty) to act upon applications for relief belongs exclusively to ATF." *Id*. at 26. It did not matter that the Attorney General undeniably had the power to "rescind that delegation." *Id*. "[U]nless and until that happens" the Attorney General "lacks the power to grant or deny § 925(c) applications

on his own." *Id*. And further, if the Attorney General did act prior to recission, his action "would . . . be ultra vires." *Id*.

Black followed the Supreme Court's reasoning in *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954) and *United States v. Nixon*, 418 U.S. 683 (1974). *Accardi* dealt with "regulations of the Attorney General [that] delegated certain of his discretionary powers to the Board of Immigration Appeals and required that Board to exercise its own discretion on appeals in deportation cases." *Nixon*, 418 U.S. at 695–96; *see Accardi*, 347 U.S. at 266. That delegation gave to the Board "discretionary authority as broad as the statute confers on the Attorney General." *Accardi*, 347 U.S. at 266. And critically, the relevant regulations, "applie[d] with equal force to the Board and the Attorney General." *Id.* at 267. Which meant that "as long as the regulations remain operative, the Attorney General denies himself the right to sidestep the Board or dictate its decision in any manner." *Id*. A similar conclusion carried the day in *Nixon*. There, the Attorney General had issued a regulation, "pursuant to his statutory authority," appointing a special prosecutor to oversee investigations and litigation related to the Watergate scandal and the 1972 Presidential election. *Nixon*, 418 U.S. at 694 n.8. *Nixon* recognized that it was "theoretically possible for the Attorney General to amend or revoke the regulation defining the Special Prosecutor's authority." *Id*. at 696. But because the Attorney General "ha[d] not done so," the "Executive Branch [wa]s bound by it." *Id*. This followed, the *Nixon* court explained, from *Accardi*. There, it had been held that "so long as the Attorney General's regulations [delegating his authority] remained operative, he denied himself the authority to exercise the discretion delegated to [a subordinate] even though the original authority was his and he could reassert it by amending the regulations." *Id*.

In sum, so long as the delegation regulation remains in effect, the Administrator of the DEA is the only person who can lawfully issue this NPRM or a Final Rule under this NPRM. The absence of that official's signature from this NPRM renders it ultra vires.

II. Moving Marijuana to Schedule III Would Violate the Single Convention

The Single Convention requires signatory nations to enact certain specified controls on the drugs and other substances to which the Convention applies. *See* Single Convention Art. 2, Art. 4. As discussed above, marijuana is subject to control under the Convention under its botanical name, "cannabis."

To the extent a signatory of the Convention "permits the cultivation of the cannabis plant for the production of cannabis or cannabis resin," Single Convention Art. 28, it must enact certain specified controls regarding cultivation, production, manufacture, possession, and distribution.[25]

[25] The Convention distinguishes between "cultivation" (the agriculture which results in growth of the cannabis plant), Single Convention Art 1, § 1(i), "production" (the "separation of . . . cannabis and cannabis resin from the plants from which [it is] obtained), Single Convention Art 1, § 1(t), and "manufacture" (encompassing "all processes, other than production, by which [cannabis] may be obtained and includes refining as well as the transformation of [cannabis] into other drugs"), Single Convention Art 1, § 1(n). *See also* Official Commentary at 26–27 (discussing the distinction between "production" and "manufacture" and confirming that cannabis and cannabis resin are two of "only four substances . . . directly

All cultivation and production—the actual agriculture that results in marijuana plants and the separation of the intoxicating plant material from the non-intoxicating portions[26]—must be overseen by a government agency. Single Convention Art. 23, § 1. "Only cultivators licensed by the Agency shall be authorized to engage in such cultivation." Single Convention Art. 23, § 2. All licensed cultivators shall be "required to deliver their total crops . . . to the Agency" and the Agency shall "have the exclusive right of importing, exporting, wholesale trading and maintaining stocks" of marijuana, with the only exception being for "manufacturers of . . . medicinal [marijuana]." Single Convention Art. 23, § 2; *see also* Official Commentary at 278. Moreover, the Convention encourages (but does not require) signatories to "prohibit cultivation" of the cannabis plant when doing so would be the "most suitable measure . . . for protecting the public health and welfare and preventing the diversion of drugs into the illicit traffic." Single Convention Art. 22.

The Convention further requires regulation of the manufacture of marijuana (its transformation from raw plant material into a consumable substance with intoxicating or pharmaceutical effect). The trade and distribution of finished marijuana products must also be regulated. All manufacture must take place "under license" and "licensed manufactures" must be required to "obtain periodical permits specifying the kinds and amounts of [marijuana] which they shall be entitled to manufacture." Single Convention Art. 29, §§ 1–2. Similarly, all "trade in and distribution of [marijuana]" must be "under license" unless it is carried out by a government entity or related to "therapeutic or scientific functions." Single Convention Art. 30. The Convention also requires signatories to report to the International Narcotics Control Board estimates regarding the "quantity of [marijuana] to be consumed for medical and scientific purposes," statistics regarding the signatories "production or manufacture" of marijuana, and, particularly relevant here, requires signatories to limit their manufacture or importation of marijuana to (with limited exception) the "quantity consumed . . . for medical and scientific purposes." Single Convention. Arts. 19, 20, 21. Finally, the Convention requires the imposition of controls on the import and export of marijuana, including requiring also such commercial activity be conducted under license. Single Convention Art. 31.

Only CSA Schedules I and II satisfy the Single Convention. *See* Lawton Memo at 12 (identifying regulations which "apply on to drugs listed on Schedules I and II"). For example, with limited exception (expressly provided for in the text of the CSA), only Schedule I and Schedule II substances are subject to production quotas based on the aggregate "medical, scientific, research, and industrial needs of the United States." *See* 21 U.S.C. § 826. Substances located on CSA Schedule III are not subject to any production quota. Similarly, Schedule I and II substances are subject to import limitations, but Schedule III and below substances can be imported without restriction. *See* 21 U.S.C. §§ 952(a), 953(c).

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obtained by a separation from plants [that are] entered in [the Convention's "Schedule I" Annex] and thus are 'drugs' within the meaning of the Single Convention").

[26] The Convention distinguishes between marijuana cultivation and "cultivation of the cannabis plant exclusively for industrial purposes (fibre and seed) or horticultural purposes." Single Convention Art. 28, § 2. The Convention "shall not apply" to the latter category (purely industrial or horticultural cannabis). *Id*.

It had been the longstanding position of the Department of Justice that only Schedules I and II satisfy the requirements of the Single Convention. *See* Lawton Memo at 12–13 ("It would appear that full compliance with our obligations under the Single Convention could not be achieved unless marihuana is listed under Schedule I or Schedule II of the [CSA]"). That position was endorsed by the D.C. Circuit in *NORML*, which held that "several requirements imposed by the Single Convention would not be met if cannabis and cannabis resin were placed in CSA schedule III, IV, or V." 559 F.2d at 751. The D.C. Circuit specifically highlighted the Convention's requirements of "import and export permits" and the "quota and recording requirements of Articles 19 through 21" that would not be satisfied by placement of marijuana outside CSA Schedules I or II. *Id*. at n.71. That position was reiterated by the DEA in its 2016 rejection of a request to reschedule marijuana. *See* 81 Fed. Reg. 53689 (because of the requirements of the Convention, "schedules I and II are the only possible schedules in which marijuana may be placed"). And the fact that placement on Schedule III or below would cause the United States to be in violation of the Convention was recently confirmed by the State Department. *See* OLC Op. at *23 (relying on State Department's representation that "if marijuana were listed in Schedule III most"—but not all—"of the United States' Single Convention obligations would . . . be met").

OLC's recent opinion nevertheless concluded that the United States could satisfy the Single Convention by placing marijuana on Schedule III and engaging in supplemental regulatory action. *See* OLC Op. at *23–24. That legal conclusion, however, is wrong for two reasons. *First*, it ignores the plain text command of the CSA that requires the Attorney General to prioritize satisfaction of the United States' treaty obligations under the Convention over other considerations. *Second*, it wrongly concludes that DEA can deviate from the CSA's five-tier scheduling scheme and effectively creating a new hybrid Schedule not contemplated by Congress.

A.

Congress enacted the CSA, in no small part, to bring the United States into compliance with the Convention. To ensure compliance, Section 811(d) instructs the Attorney General how to proceed when control of a substance, like marijuana, is "required by United States obligations under international treaties, conventions, or protocols in effect on October 27, 1970." 21 U.S.C. § 811(d)(1). In that case, the Attorney General:

> shall issue an order controlling such drug under the schedule he deems most appropriate to carry out such obligations, **without regard to the findings required by subsection (a) of this section or section 812(b) of this title and without regard to the procedures prescribed by subsections (a) and (b) of this section**.

Id. (emphasis added). This statute makes the United States' treaty obligations a first-order priority. And the Department of Justice has long understood the text in this way. Indeed, in response to a petition to reschedule marijuana filed shortly after the CSA was enacted, the Director of the Bureau of Narcotics and Dangerous Drugs (the precursor agency to the current DEA) declared that:

> the Attorney General is directed [by the CSA's text] to ensure consistency 'with United States obligations under international treaties, conventions, or protocols in

> effect on the effective date of [the CSA] . . . [t]he references indicate not only a congressional awareness of international obligations, but an affirmative desire on the part of Congress to ensure that United States laws comply with them . . . Therefore, I find that since the United States is obligated to control marihuana under the Single Convention, the explicit language [now codified at § 811(d)] **imposes the sole responsibility on the Director of BNDD to control marihuana in the schedule most appropriate to carry out international obligations of the United States.** Further, it is concluded that any determination of the proper schedule consistent with such international obligations may be made without regard to the procedures prescribed in [other] subsections [of the CSA] and the responsibility is fixed regardless of whether the initial scheduling of marihuana, the transfer of marihuana from one schedule to another, or the removal of marihuana from all schedules, is involved.

37 Fed. Reg. 18097–98 (emphasis added). This declaration is buttressed by the Lawton Memo, which concluded that the Convention requires marijuana be placed in Schedule I or II. Lawton Memo at 9, 12–13; *see also* OLC Op. at *23–24 (acknowledging prior Department of Justice position espoused in Lawton Memo). Indeed, in the Lawton Memo, OLC explained that the CSA "imposes on the Attorney General the obligation to control a drug under the schedule most appropriate to carry out our international obligations," further said that the determination of "the proper schedule . . . should be made without regard to the procedures proscribed in [what is now codified as Sections 811 and 812 of the CSA]," and eventually concluded that obligation would only be met by placement of marijuana on Schedule I or II. Lawton Memo at 9, 12–13.

It is also the only position endorsed by a court. The D.C. Circuit has said that placing marijuana no lower than CSA Schedule II was "necessary as well as sufficient to satisfy [the United States'] international obligations." *NORML*, 559 F.2d at 751. How to best satisfy those obligations, the Court explained, "is based on a legal judgment as to the controls mandated by the Single Convention" and does not require "the Attorney General to consider [the] creation of a hybrid schedule each time an interested party files a petition to reschedule a substance controlled by treaty." *Id*. at 752.

OLC's recent opinion suggests that subsequent developments have changed the relevant legal landscape such that pairing rescheduling to Schedule III with complementary regulatory action would allow the United States to satisfy the Convention. *See* OLC Op. at *23. But none of the identified developments relate to or alter the text of Section 811(d)'s statutory command that makes ensuring treaty compliance the Attorney General's first priority when considering scheduling or rescheduling. *See id*. at 33–34.[27] That language, OLC admits, "could be read to mean

[27] After all, the Attorney General must control marijuana by placing it "*under the schedule* he deems *most appropriate* to carry out such [treaty] obligations." 21 U.S.C. § 811(d)(1). Congress could have written 21 U.S.C. § 811(d) to say, simply: "the Attorney General shall carry out such the United States' treaty obligations." Language to that effect would have granted the Attorney General the discretion OLC's opinion has claimed on his behalf. But that is not the path Congress chose to take. For the CSA's "under the schedule . . . most appropriate" language—the language employed by Congress—to be meaningful, it must be read as requiring the Attorney General to choose the *particular schedule* that ensures

that DEA must select a schedule without resort to regulatory supplementation." OLC Op. at *20. Indeed, OLC goes on to acknowledge that interpretation would be congruent with the CSA's foundational definition of "control," which means "to add a drug . . . to a *schedule*." *Id*. (quoting 21 U.S.C. § 802(5). *See* Lawton Memo at 9 ("It is our conclusion that language of [the CSA] . . . imposes on the Attorney General the obligation to control a drug under *the schedule* most appropriate to carry out our international obligations.") (emphasis added). The syllogism is there, begging to be completed: Section 811(d) commands the Attorney General to "issue an order controlling" marijuana in the manner "most appropriate to carry out" the United States treaty obligations, control is defined to mean adding a drug to a schedule, and placement on Schedule III would only satisfy *most* (not *all*) of the United States treaty obligations. Clearly then, placement of marijuana on Schedule III would require the Attorney General to ignore the command of Section 811(d). OLC's rejection of this seemingly obvious answer, *see* OLC Op. at *22, cannot be squared with the most relevant statutory text.

The absurdity of this position is made manifestly apparent by even the briefest consideration of practical reality. According to the OLC Opinion, when the Attorney General is weighing the relative merits of placement on Schedule I or II (which would unquestionably satisfy the requirements of the Single Convention) and placement on Schedule III (which unquestionably does not), he is free to choose the latter despite operating under a statutory command to place marijuana on "the schedule he deems most appropriate to carry out [the United States' treaty] obligations without regard" to any other scheduling consideration set forth in the CSA. Merely articulating that proposition is sufficient to refute it.

B.

Even if the Attorney General had the latitude to place marijuana on Schedule III, doing so would cause the United States to violate the Single Convention because DEA lacks authority to promulgate the complementary regulations needed to comply with the Convention. As discussed above, when Congress enacted the CSA, it established five schedules, each "associated with a distinct set of controls regarding the manufacture, distribution, and use of the substances listed therein." *Raich*, 545 U.S. at 14 (citing 21 U.S.C. §§ 821–830). OLC's proposal to allow DEA to impose via regulation prominent features—most notably, manufacturing quotas—associated with some Schedules but not others would permit DEA to create a "hybrid" Schedule, more lenient than Schedule I or II but stricter than Schedule III. Doing so goes beyond the permissible bounds of regulation; it would rewrite the CSA. Neither the Attorney General nor DEA are imbued with that power.

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compliance with the substance of the Convention. *See* Lawton Memo at 9. Reading that language to permit the Attorney General to choose a lesser schedule and then rely on a questionable assertion of regulatory authority to backfill any gaps would rewrite the statute. Such a rewrite is something neither OLC nor DEA has the power to do. *See Landstar Exp. Am., Inc. v. Fed. Mar. Comm'n,* 569 F.3d 493, 498 (D.C. Cir. 2009) ("[N]either courts nor federal agencies can rewrite a statute's plain text to correspond to its supposed purposes").

Administrative agencies can lawfully promulgate a regulation only if that regulation coheres with the statute the agency is charged with administering. It is a "core administrative-law principle" that an agency may not rewrite a clear statute "to suit its own sense of how the statute should operate." *Util. Air Regul. Grp. v. Env't Prot. Agency*, 573 U.S. 302, 328 (2014). Instead, a regulation "must be consistent with the statute under which [it is] promulgated." *United States v. Larionoff*, 431 U.S. 864, 873 (1977). "Regardless of how serious the problem an administrative agency seeks to address . . . it may not exercise its authority in a manner that is inconsistent with the administrative structure that Congress enacted into law." *Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 125 (2000) (internal quotation marks omitted). A regulation that "create[s] a rule out of harmony with [its authorizing] statute" is "a mere nullity." *Manhattan Gen. Equip. Co. v. Comm'r of Internal Revenue*, 297 U.S. 129, 134 (1936).

Any effort by DEA to create a hybrid "Schedule 2.5" would be a nullity. The CSA's five-tier structure is one of its defining features. The gradations between the Schedules were established by Congress. *See Raich*, 545 U.S. at 14. The CSA "places in the Attorney General the power to schedule, reschedule, or deschedule drugs," *Washington v. Barr*, 925 F.3d 109, 115 n.3 (2d Cir. 2019), not the power to rewrite or restructure the Schedules themselves. Assuming he follows the CSA's "specified procedures" he can "add or remove substances, or . . . move a substance from one schedule to another." *Touby*, 500 U.S. at 162. But nothing in the text of the CSA empowers him to create a *new schedule* in its entirely.

In its opinion, OLC asserts that nothing in the "CSA expressly foreclose[s] DEA from satisfying the United States international obligations with a combination of scheduling and regulatory actions." OLC Op. at *22. But it is wrong to "presume that an agency's promulgation of a rule is permissible because Congress did not expressly foreclose the possibility." *New York Stock Exch. LLC v. Sec. & Exch. Comm'n*, 962 F.3d 541, 546 (D.C. Cir. 2020) (internal quotation marks omitted). OLC also argues that the existence of the "broad regulatory authority provided by the CSA" means "DEA need not rely on scheduling decisions alone to comply with the Single Convention." OLC Op. at *21. It points to, as an example, 21 U.S.C. § 821, which authorizes the Attorney General to "promulgate rules and regulations and to charge reasonable fees relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances and to listed chemicals." The existence of such a provision does not, however, guarantee that an agency has the power it claims. "A court does not simply assume that a rule is permissible because it was purportedly adopted pursuant to an agency's rulemaking authority." *New York Stock*, 962 F.3d at 546. The CSA provides the Attorney General (and via subdelegation, the DEA) with a variety of rulemaking powers that help effectuate DEA's administration and enforcement of the statute. *See* OLC Op. at *21. But at a structural level, the CSA imposes aggregate manufacturing quotas *only* on substances controlled on Schedules I and II. *See* 21 U.S.C. § 826. The DEA cannot impose, through the exercise of ancillary regulatory powers, a regulatory requirement that would defy the plain text of the statute. *See West Virginia v. Env't Prot. Agency*, 597 U.S. 697, 721–24 (2022).

In sum, OLC was wrong to conclude that DEA can lawfully engage in the supplemental regulatory action necessary to place marijuana on Schedule III and not run afoul of the

requirements of the Single Convention. It follows that issuing a Final Rule placing marijuana on Schedule III would be "not in accordance with law." 5 U.S.C. § 706(2)(A).

III. After the Notice of Proposed Rulemaking, No Deference is Owed to HHS

The NPRM incorrectly asserts that DEA must give HHS's determinations "significant deference" in reviewing and responding to public comments. 89 Fed. Reg. 44599. That position has no basis in law and violates the APA.

The CSA provides that "recommendations of the Secretary [of HHS] to the Attorney General shall be binding on the Attorney General as to [certain] scientific and medical matters." 21 U.S.C. § 811(b). OLC interprets this to mean that the Secretary's recommendations bind the Attorney General until a rescheduling NPRM is issued. OLC Op. at *17–18. We do not dispute that conclusion. But OLC also concludes that after the Attorney General receives comments from the NPRM, "DEA must continue to accord HHS's scientific and medical determinations significant deference, and the CSA does not allow DEA to undertake a *de novo* assessment of HHS's findings at any point in the process." OLC Op. at *3, 15, 24. There is no statute that requires "significant deference"—or any deference for that matter—after an agency issues a notice of proposed rulemaking. Without a statute saying otherwise, giving HHS deference over and above any public comments DEA receives would be arbitrary and capricious as a matter of law.

There is no legal authority suggesting that any interagency deference is mandated after the NPRM is issued. Any form of deference effectively negates what notice and comment rulemaking requires under the APA. As OLC recognized, DEA is obligated by the APA to consider the "whole record" and all "reliable, probative, and substantial evidence." OLC Op. at *17 (quoting 5 U.S.C. § 556(d). Putting a thumb on the scale for some evidence, regardless of the persuasiveness and veracity of its substance, would be an abdication of APA's command that DEA consider all reliable, probative, and substantial evidence.

The APA also requires agencies to "give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments." 5 U.S.C. § 553(c). DEA must consider and respond to significant comments received during this period of public comment. *See Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 416 (1971); *see also Perez*, 575 U.S. at 96. When the DEA promulgates the Final Rule, it must include in the rule's text "a concise general statement of [its] basis and purpose." 5 U.S.C. § 553(c).

The basis and purpose statements required under the APA must enable a reviewing court to see the objections and why the agency reacted to them as it did. Agencies cannot shirk that responsibility by claiming deference to another agency. "One of the basic procedural requirements of administrative rulemaking is that an agency must give adequate reasons for its decisions." *Encino Motorcars, LLC v. Navarro,* 579 U.S. 211, 221 (2016). In the statement, the agency must rebut significant comments because it is "required to respond to significant comments that cast doubt on the reasonableness of the rule the agency adopts." *Baltimore Gas & Elec. Co. v. United States*, 817 F.2d 108, 116 (D.C. Cir. 1987). "Significant deference" is an insufficient response to a significant comment—nor can it make a weak response stronger. The purpose of notice-and-

comment rulemaking is to "give[ ] affected parties fair warning of potential changes in the law and an opportunity to be heard on those changes" while "afford[ing] the agency a chance to avoid errors and make a more informed decision." *Azar v. Allina Health Services*, 587 U.S. 566, 582 (2019). In the face of significant comments that cast doubt on the decision of the DEA to reschedule marijuana, to rebut those comments by citing "significant deference" owed HHS would be to shirk the DEA's duty under the APA. The DEA must "engage with the substance" of the comment, not just claim its hands are tied and move on. *Chamber of Commerce of United States v. United States Sec. & Exch. Comm'n*, 85 F.4th 760, 775 n.17 (5th Cir. 2023) (noting oral argument is too late to engage with the substance of significant comments).

To be sure, the DEA must consider HHS's views, especially its opinion on medical and scientific questions. *See Gonzales v. Oregon*, 546 U.S. 243, 269 (2006) (holding that the lack of medical expertise and the "absence of any consultation with anyone outside the Department of Justice who might aid in a reasoned judgment" means the Department's prohibition of doctors from prescribing medications for assisted suicide is undeserving of *Skidmore* deference); *City of Boston Delegation v. FERC*, 897 F.3d 241, 255 (D.C. Cir. 2018) ("Agencies can be expected to 'respect [the] views of such other agencies as to those problems' for which those 'other agencies are more directly responsible and more competent.'") (quoting *City of Pittsburgh v. Fed. Power Comm'n*, 237 F.2d 741, 754 (D.C. Cir. 1956)). But the necessity of taking HHS's views into account does require placing a thumb on the scale that favors those views, especially if DEA receives meaningful public commentary expressing countervailing evidence and expert opinion. The statutory dictate that HHS's recommendation is "binding on the Attorney General as to such scientific and medical matters," 21 U.S.C. § 811(b), when promulgating a proposed rule, does not relieve the DEA (exercising the delegated authority of the Attorney General) of its independent APA obligation to consider and respond to significant comments received during the notice and comment rulemaking process. To conclude otherwise would mean, any time one agency's decision depends on the recommendation or views of another agency, there is a license to sidestep the normal requirements of the APA and automatically discount public comments the agency receives. That flies in the face of what the APA requires and contravenes the very purpose of notice and comment rulemaking. *See United States v. Morton Salt Co.*, 338 U.S. 632, 644, (1950); *see also Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 109 (2015) (Scalia, J., concurring) (explaining that the notice and comment process "guards against excesses in rulemaking").

Courts have repeatedly rejected the notion of interagency deference, or any other interpretative rule that would thumb on the scale of another agency's determination over significant comments received in notice and comment rulemaking. *See Grand Canyon Tr. v. Provencio*, 26 F.4th 815, 823 (9th Cir. 2022) ("We have consistently applied the arbitrary and capricious standard to cases in which an agency relies on or defers to the opinions or interpretations of another agency.") (collecting cases); *Rybachek v. U.S. E.P.A.*, 904 F.2d 1276, 1296 (9th Cir. 1990) ("The prospect of various agencies contending in court, each claiming that another must defer to it in some particular area, is not a happy one."); *Alaska Miners Ass'n v. U.S. E.P.A.*, 931 F.2d 896 (9th Cir. 1991) (unpublished) ("[W]e consider the Bureau's estimate solely on its merits, and not on any supposed interagency deference."); *Defenders of Wildlife v. U.S. EPA*, 420 F.3d 946 (9th Cir. 2005), *rev'd on other grounds and remanded sub nom. Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644 (2007) (one agency prepared a biological opinion that relied on

legal errors, EPA relied on the biological opinion, EPA was arbitrary and capricious when it relied on the flawed opinion). And to the extent the Department of Justice's interpretation of the CSA (via OLC's opinion) suggests that it can defer to HHS in light of important countervailing comments, that interpretation is subject to de novo review. *See Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244 (2024). DEA's plan to accord HHS's recommendations "significant deference," *see* 89 Fed. Reg. 44601, would render its rulemaking arbitrary and capricious and otherwise "not in accordance with law." 5 U.S.C. § 706.

IV. Nothing Material has Changed Since 2016, When DEA Last Refused to Reschedule Marijuana

When an administrative agency adopts a rule that reverses longstanding agency policy and is predicated on a repudiation of the agency's prior factual findings, the agency is held to a higher standard. *Fox Television*, 556 U.S. at 515. As the Court explained in *Fox*, when a "new policy rests upon factual findings that contradict those which underlay its prior policy" the agency must "provide a more detailed justification than what would suffice for a new policy created on a blank slate." *Id*. This requires the agency to "show that there are good reasons for the new policy." *Encino Motorcars*, 579 U.S. at 221. This requirement does not freeze prior agency determinations in place. Instead, this heightened standard simply vindicates the APA's demand that an agency provide a "satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (internal quotation marks omitted); *see also Dep't of Homeland Sec. v. Regents of the Univ. of California*, 140 S. Ct. 1891, 1933 (2020) (Kavanaugh, J., concurring in the judgment) ("The APA's arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained."). When an agency "offer[s] an explanation for its decision that runs counter to the evidence before [it]" or the explanation presented is "so implausible that it could not be ascribed to a difference in view or the product of agency expertise," then the agency's action is arbitrary and capricious and should be set aside. *Motor Vehicle Mfrs.*, 463 U.S. at 43.

In 2016, adhering to the consistent position the agency has maintained for more than four decades (and across presidential administrations from both major political parties), DEA denied a petition asking to reschedule marijuana. 81 Fed. Reg. 53688. DEA issued its denial after soliciting and receiving a recommendation from HHS. *Id*. HHS's recommendation at that time was that "marijuana continue to maintained in Schedule I." 81 Fed. Reg. 53689. After consideration of both HHS's submission and "all other relevant data," DEA reached the conclusion that there was "no substantial evidence that marijuana should be removed from Schedule I." *Id*. at 53688. Marijuana was found to have:

- a high potential for abuse;
- no currently accepted medical use in treatment in the United States;
- no accepted safety for use under medical supervision.

Id. In other words, marijuana met all three criteria set forth in the CSA for inclusion on Schedule I. *See* 21 U.S.C. § 812(b)(1).

What was true in 2016[28] remains true today. Marijuana has not, in the intervening eight years, suddenly become safer. If anything, the opposite is true: Concentrations of Delta-9 THC, the primary psychoactive chemical found in marijuana (and the one largely responsible for its addictive, intoxicating effect) have been "increas[ing] dramatically" since 1990. 89 Fed. Reg. 44604. This trend has only accelerated in recent years as the continued expansion of legal access to marijuana drives market demand for ever more potent strains of marijuana and marijuana-containing products.[29] Nor has there been a revolution in the medical sphere. FDA had not then and still has not now approved any "cannabis, cannabis-derived, or cannabidiol (CBD) products currently available on the market."[30] Furthermore, in 2016, 31 States had some form of medical marijuana and another 8 had legalized recreational use of marijuana either directly or via decriminalization.[31] By comparison, at present, 38 States have a medical marijuana law, while 24 allow some form of recreational use.[32] These numbers illustrate a simple point: In 2016 (just like today), hundreds of millions of Americans across a diverse set of jurisdictions had access to "state-legal" marijuana either medically or recreationally. Despite this, after a comprehensive review of the relevant information before it, 2016 DEA determined that there was "no substantial evidence" warranting a rescheduling of marijuana away from CSA Schedule I.

Despite this DEA, having accepted HHS's newly issued recommendation, proposes in this NPRM to overturn the position it has adhered to for 50 years and issue a Final Rule moving marijuana from Schedule I to Schedule III. As discussed below, issuing such a Rule would be arbitrary and capricious agency action that abused DEA's discretion. Any such Rule would therefore be susceptible to legal challenge under the Administrative Procedure Act ("APA"). *See* 5 U.S.C. § 706.

Once DEA is no longer bound by HHS's recommendation and is permitted to undertake a holistic review of all relevant evidence, it will be clear that there are no "good reasons" to deviate from its longstanding position and move marijuana off Schedule I. Issuing a Final Rule that rescheduled marijuana would run counter to the weight of the evidence before DEA and be implausible enough that it cannot be ascribed to agency expertise.

A.

Consider the first factor under the CSA DEA to evaluate—marijuana's potential for abuse. 21 U.S.C. § 812(b)(1)(A). In 2016, DEA concluded that marijuana has a high potential for abuse.

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[28] And 2011 and 2001 and 1992 and 1989 and 1972. *See supra* note 9.

[29] *See* Kevin Sabet, *Lessons learned in several states eight years after states legalized marijuana*, 38 CURRENT OPINION IN PSYCHOLOGY 25 (2021). https://doi.org/10.1016/j.copsyc.2020.07.018.

[30] U.S. Food & Drug Administration, *FDA and Cannabis: Research and Drug Approval Process* (February 24, 2023), https://www.fda.gov/news-events/public-health-focus/fda-and-cannabis-research-and-drug-approval-process.

[31] *See* Steinmetz, *supra* note 21.

[32] National Conference of State Legislatures, *State Medical Cannabis Laws*, https://www.ncsl.org/health/state-medical-cannabis-laws (last updated June 4, 2024).

81 Fed. Reg. 53688. Underlying that determination were facts set forth in a recommendation provided by HHS to the DEA in 2015. Ultimately, HHS concluded that "marijuana has a high potential for abuse based on a large number of people regularly using marijuana, its widespread use, and the vast amount of marijuana that is available through illicit channels." 81 Fed. Reg. 53761; *see also id*. at 53740 ("evidence of actual abuse of a substance is indicative that a drug has a potential for abuse"). Each aspect of that conclusion is as true now as it was when HHS made its 2015 recommendation.

It is widely recognized that marijuana is the "most commonly used federally illegal drug in the United States."[33] More than 52 million Americans, nearly 20% of the country, reported using marijuana at least once in 2021.[34] And despite the substantially increased access to state-legal marijuana in many jurisdictions, the vast majority of the marijuana consumed by Americans is illicitly-sourced.[35] Consider California, which first legalized medical marijuana by ballot initiative in 1996 (and has long had lax standards about who can obtain a "medical" permit) and has had permitted recreational use since 2016. Estimates suggest that as much as "eighty percent of the marijuana sold in California comes from the black market" and that the size of the black market remains "four times the size of the legal market."[36] Nor is California a remarkable outlier—similar percentages can be found in States across the Nation.[37]

HHS has not proffered new data that substantially undermines its 2015 conclusion. HHS noted that "a large number of individuals use marijuana" and "evidence shows that some individuals . . . tak[e] marijuana in amounts sufficient to create a hazard to their health and to the safety of other individuals and the community." 81 Fed. Reg. 53691. Undergirding those statements were statistics from 2011 showing that marijuana abuse accounted for "18.1 percent of non-private substance-abuse treatment facility admissions" and "36.4 percent of illicit drug related [emergency room] visits." *Id*. And in its 2024 recommendation, HHS continues to acknowledge the high prevalence of emergency room visits attributable to marijuana use—annual visits "involving a marijuana related disorder" increased from 1.3 million in 2016 to 1.7 million in 2020—and recognized that marijuana has "the second-highest utilization-adjusted rate of estimated [emergency room] visits" during the same time period, behind only cocaine. HHS Basis for Rec. at 42. HHS also reported statistics that show marijuana is the third most likely "primary

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[33] Centers for Disease Control, *Cannabis Facts and Stats* (Feb. 22, 2024), https://www.cdc.gov/cannabis/data-research/facts-stats/index.html.

[34] *Id*.

[35] *See* Nick Noonan, *High Time for Change: Combatting the Black Market for Cannabis in Canada*, 44 Man. L.J. 257 (2021); William J. Meadows, *Cannabis Legalization: Dealing with the Black Market*, Drug Enforcement and Policy Center (October 2019), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3454635.

[36] Meadows, *supra* note 35, at 3.

[37] *See id*. at 8 (estimate from the Nevada Dispensary Association that "sixty percent of Nevadans are purchasing their cannabis products from the black market"); *id*. (reproducing prediction that despite recently legalizing recreational marijuana, "[s]eventy-five percent of cannabis sales are expected to go to the [Massachusetts'] black market").

drug of admission" in a dataset tracking admissions to substance-abuse rehabilitation facilities. HHS Basis for Rec. at 41. It is also the most likely "secondary drug of admission" (ahead of cocaine, alcohol, and heroin). HHS Basis for Rec. at 41.

Overall, the evidence that marijuana has a high potential for abuse is difficult to gainsay. As one report, prepared for the World Health Organization in 2015 and submitted to the U.S. Senate Judiciary Committee in 2016 succinctly states: "There is strong scientific support for concluding that marijuana has high potential for abuse, is actually abused, and is addictive."[38] In other words, scientifically speaking, marijuana's addictive nature is essentially uncontested. For example, the Centers for Disease Control points to research that approximately 30 percent of individuals who consume marijuana develop "cannabis use disorder," or marijuana addiction in other words.[39]

In its recommendation, HHS does not attempt to refute the scientific consensus that marijuana can be—and often is—addictive. Indeed, HHS notes that "physical dependence may occur in up to 40-50% of individuals who use marijuana on a regular basis" and cites a large-scale study that found nearly half (47 percent) of regular users of marijuana experienced symptoms of marijuana withdrawal once they discontinued use. HHS Basis for Rec. at 60. In short, it is clear that many "humans utilize marijuana for its rewarding properties," HHS Basis for Rec. at 13, a trademark sign of a substance with a high potentiality of addiction.[40] *Cf.* 81 Fed. Reg. 53739 ("Preclinical and clinical data show that [marijuana] has [the] reinforcing effects characteristic of drugs of abuse."); *id*. at 53740 ("Marijuana's main psychoactive ingredient, [Delta-9 THC] is an effective reinforcer in laboratory animals . . . Such reinforcing effects can account for the repeated abuse of marijuana.").

Ultimately, HHS's recommendation is not that marijuana's potential for abuse is low, but rather that its potential for abuse is "less than the drugs [and] other substances in Schedules I and II." HHS Basis for Rec. at 62. Of course, the same contention laid at the heart of the rejected 2016 petition to reschedule marijuana. 81 Fed. Reg. 53739 ("[P]etitioners claim that [marijuana] . . . has a relatively low potential for abuse, especially in comparison with other schedule II drugs"). DEA rejected that contention then and should reject it again now. DEA should reject HHS's relative framing of marijuana's potential for abuse because the evidence that HHS has marshalled, even

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[38] Bertha K. Madras, *Cannabis and Medicinal Properties* at 7 (July 13, 2016), https://perma.cc/RM2Z-YX8N.

[39] *Cannabis Facts and Stats*, *supra* note 33. Cannabis use disorder is officially defined as the "continued use of cannabis despite significant negative impact on one's life and health." Yale University School of Medicine, *Cannabis/Marijuana Use Disorder*, https://www.yalemedicine.org/conditions/marijuana-use-disorder.

[40] *See* Leigh Panlilio & Steven R. Goldberg, *Self-administration of drugs in animals and humans as a model and an investigative tool*, Addiction Vol. 102, Issue 12 (Dec. 2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2695138/

when viewed through a deferential lens, *see* OLC. Op. at *3, 15, 17–18,[41] does not provide the requisite "good reason" needed to overturn DEA's longstanding factual determination that marijuana has a high potential for abuse. Indeed, it is difficult to see how an objective review of the relevant evidence—including not only the evidence presented by HHS, but the "whole record," including the evidence included in this comment and many others—could lead a reasoned decisionmaker to reach a contrary conclusion. And, as a matter of logic, if marijuana's potential for abuse is "high" and, by definition, the potential for abuse of substances listed on Schedules I and II must also be "high," *see* 21 U.S.C. §§ 812(1)(A), (2)(A), it is hard to see how HHS can reasonably conclude that marijuana's potential abuse is "less than the drugs or other substances in schedules I and II." *See* 21 U.S.C. § 812(3)(A). Such a conclusion would imply that marijuana's potential for abuse is "not high," which would "run counter to the evidence before the agency." *Motor Vehicle Mfrs.*, 463 U.S. at 43. Such an implausible conclusion need not and should not be adopted by DEA; indeed, doing so would be arbitrary and capricious. Instead, DEA should, on the basis of the entire record before it, decline to adopt HHS's recommendation and adhere to its longstanding position that marijuana has a high potential for abuse. Doing so would, by itself, foreclose rescheduling marijuana to Schedule III.

B.

The second factor DEA must consider is whether marijuana has a currently accepted medical use ("CAMU") for treatment in the United States. 21 U.S.C. § 812(b)(1)(B). In 2016, DEA, echoing the recommendation of HHS, concluded the answer was "no." 81 Fed. Reg. 53688; *see also id*. at 53689 ("[T]he medical and scientific evaluation and scheduling recommendation issued by the Secretary of Health and Human Services concludes that marijuana has no currently accepted medical use in treatment in the United States, and the DEA Administrator likewise so concludes.").

A CAMU can be established in two ways. First, a drug has a CAMU if it has received regulatory approval from FDA. *See* 89 Fed. Reg. 44616; *see also* 57 Fed. Reg. 10503. Second, in the absence of FDA approval, a CAMU will nevertheless be found if the drug or substance satisfies a five-part test. *Id*.; *see also All. for Cannabis Therapeutics v. Drug Enf't Admin*., 15 F.3d 1131, 1135 (D.C. Cir. 1994). Under that test, which was derived from "the core [Federal Food Drugs and Cosmetics Act, ('FDCA')][42] standards for acceptance of drugs for medical use," it can be established that a drug or other substance has a CAMU if:

1. There are adequate safety studies;
2. The drug's chemistry is known and reproducible;
3. There are adequate and well-controlled studies proving efficacy;
4. The drug is accepted by qualified experts; and
5. The scientific evidence is widely available.

[41] For the reasons discussed above, DEA is under no obligation to defer to HHS once the NPRM has issued. *See* Section III, *supra*. But even if HHS was owed deference, the countervailing evidence is strong enough to overcome HHS's recommendation.

[42] 21 U.S.C. § 301 *et seq*.

89 Fed. Reg. 44616–17 (citing 57 Fed. Reg. 10503–06).

This five-part test, which replaced an earlier (and similar but ultimately flawed) eight-part framework, received judicial approval from the D.C. Circuit in *Cannabis Therapeutics*. 15 F.3d at 1135. As *Cannabis Therapeutics* explained, the new test was congruent with the lodestar of drug and medical device approval in the United States in the wake of the enactment of the FDCA—the triumph of science over anecdote. *Id.* at 1137. As DEA had explained in its 1992 denial of a petition to reschedule marijuana, where the five-part test was born: "A century ago many Americans relied on stories to pick their medicines, especially from snake oil salesmen. Thanks to scientific advances and to the passage of the [FDCA] in 1906, we now rely on rigorous scientific proof to assure the safety and effectiveness of new drugs." 57 Fed. Reg. 10502 (internal citation omitted).[43] DEA's five-part test fit neatly in this framework; capable of being satisfied (not impossible like its eight-part predecessor), but only with "rigorous scientific proof." *Cannabis Therapeutics*, 15 F.3d at 1137.

In 2016, because FDA had not given marijuana or any-botanical marijuana derived drugs regulatory approval, DEA and HHS applied the five-part test to assess if marijuana had a CAMU. 81 Fed. Reg. 53700–702. After analysis of all five factors, it was determined that "[m]arijuana does not meet any of the five elements" necessary for finding a CAMU. *Id*. at 53700.

Although it does not say so explicitly, the HHS recommendation underlying this NPRM does not disagree with the 2016 determination that marijuana cannot satisfy the five-factor test. Instead, HHS implicitly concedes the absence of the "rigorous scientific proof" needed to survive application of the five-part test by instead evaluating whether marijuana has a CAMU under a novel test of its own creation. *See* HHS Basis for Rec. at 2 (discussing HHS's two-part "CAMU test"); *see also id*. at 24–25. Under HHS's novel standard, a drug or other substance has a CAMU if:

1. There is "widespread current experience" with the substance by licensed health care providers "operating in accordance with implemented state-authorized programs" and medical use of the substance is "recognized by entities that regulate the practice of medicine" in those state jurisdictions; and
2. Whether there exists some credible scientific support for at least one of the medical conditions for which Part 1 is satisfied.

HHS Basis for Rec. at 2. Unsurprisingly, given that HHS concocted this test out of whole cloth without even a pretense tying it to existing principles or precepts of federal law, HHS concluded that marijuana satisfies its novel two-part analysis and thus has a CAMU. HHS Basis for Rec. at 28.

[43] *See also Weinberger v. Hynson, Westcott & Dunning, Inc.*, 412 U.S. 609, 630 (1973) (discussing 1962 amendments to the FDCA that gave FDA the power to "scrutinize and evaluate drugs for effectiveness as well as safety" and noting that the evidentiary "substantial evidence" standard was intended "to be a rigorous one").

HHS's proposed two-part test is a striking deviation from the otherwise cohesive, science-based federal scheme for ensuring that the drugs and medical devices Americans rely on are safe and effective. The centerpiece of that regulatory scheme is the FDCA, the statute that governs and is administered by FDA. As explained at length by DEA in 1992, when Congress enacted the CSA it could have devised a novel standard for determining whether a drug had a CAMU. 57 Fed. Reg. 10503. But there is "nothing in the [CSA] . . . that . . . indicate[s] Congress intended to depart radically from existing federal law." *Id*. On the contrary, compelling circumstantial evidence illustrates that Congress instead "intend[ed] to rely on standards it had developed over the prior 64 years under the FDCA." *Id*. When undertaking the initial scheduling that coincided with the enactment of the CSA, Congress placed every drug and substance with FDA regulatory approval into Schedule II or higher. *Id*. Similarly, drugs with well-established medical uses (such as morphine, phenobarbital, and amphetamines) that had not yet received FDA's final regulatory blessing under the FDCA were also placed on Schedule II or higher. *Id*. Ultimately, no drug or substance with either FDA regulatory approval or a well-established, indisputable history of medical use was placed on Schedule I. *Id*. By contrast, "[d]rugs recognized under the FDCA for research use only, not for use in treatment, such as alphacetylmethadol and marijuana, were placed by Congress into Schedule I." *Id*. at 10504. This "pattern of initial scheduling" illustrates that when it enacted the CSA, "Congress equated the term 'currently accepted medical use in treatment in the United States' [CAMU] . . . with the core FDCA standards for acceptance of drugs for medical use." *Id*.

HHS's proposed two-part framework jettisons entirely any notion of congruence with the principles of the FDCA—indeed, HHS freely admits that its test is "not meant to be, nor is it, a determination of safety and efficacy under the [FDCA]," HHS Basis for Rec. at 24—and substitutes in its place a tendentious two-part test that boils down, in essence, to a singular inquiry: "Has a State passed a medical marijuana law?" HHS's proposed test effectively collapses into that singular *legal* rather than *scientific* inquiry because of the shockingly low evidentiary threshold applied in the ostensible second half of the test. Despite concluding, after a review of the "available information," that the evidence regarding marijuana's medical efficacy was largely "mixed" and "inconclusive," HHS Basis for Rec. at 25–26,[44] HHS ultimately concluded that because there is "*some* credible scientific support for the use of marijuana" as a treatment for a handful of medical conditions, marijuana has a CAMU for purposes of scheduling under the CSA. HHS Basis for Rec. at 28 (emphasis added). In practice, then, the bar to clear the second half of HHS's test is set so low as to be non-existent; only blatantly fraudulent drugs or substances will be unable to muster "some" minimum quantum of "mixed" or "inconclusive" evidence of medical efficacy. (And given

[44] To provide just one concrete example, HHS asked University of Florida epidemiologists to undertake a "systematic review of scientific and medical literature" examining marijuana's effectiveness for treating pain. HHS Basis for Rec. at 25–26. Those epidemiologists "ultimately concluded the results" of their review were inconclusive or mixed. *Id*. at 26. The University of Florida findings were mirrored by FDA, which "conducted a separate review of published scientific" literature. *Id*. FDA's review "drew conclusions similar to [Florida's]." *Id*. Unwilling to accept this inconvenient conclusion from either source, HHS resorted to relying on earlier literature reviews conducted by other parties to support its desired conclusion: "[T]hat there is some support for the use of marijuana-related products in the treatment of pain." *Id*.

the well-known power of the "placebo effect,"[45] the possibility that even a completely ineffective substance could muster "some" credible evidence cannot be entirely ruled out.)

Thus, satisfaction of HHS's test turns almost entirely on the first prong. That prong, however, is largely coextensive with the legal question of whether a State has enacted a state-level authorization of medical marijuana. In States where such a law has been enacted, there will be the requisite "widespread use" of medical marijuana under the supervision of a licensed health care professional; in States where no such law has been enacted, there will not be. The notion that the system of State medical licensure provides a stringent and totally effective screening mechanism against unsafe and ineffective drugs is belied by history. State medical licensing schemes had, by the late nineteenth century, begun to come into existence. *See Dent v. West Virginia*, 129 U.S. 114 (1889). And yet that very time period is well known as the heyday of the "snake oil salesmen," an era when "the determination of what drugs to accept as medicine was totally democratic . . . totally standardless," *see* 57 Fed. Reg. 10503, and frequently fraudulent.[46] It was a state of affairs that "became unsatisfactory to a majority of the American people" and led directly to the enactment of the FDCA. 57 Fed. Reg. 10503. The FDCA, as DEA has previously recognized, represented a "shift . . . away from anecdotal evidence . . . [and the] opinions . . . [of] local doctors" and toward the "expert opinions of specialists trained to evaluate the safety and effectiveness of drugs . . . [and] oversight by the Federal Government." *Id*.

OLC's recent opinion attacks DEA's five-part test for this very reason, saying that it "rel[ies] exclusively on certain scientific evidence and the views of some experts and FDA." OLC Op. at *9. The most appropriate rejoinder to that assertion is: "Yes and for good reason." The FDA's commitment to data-driven analysis and scientific rigor ensures that Americans can have the utmost confidence that the drugs that they consume are safe and medically effective.[47] Maintaining FDA's quasi-monopoly on determinations of this sort is a boon to public policy and the public health; eroding it—which an embrace of HHS's proposed two-part CAMU test does—would be unwise.

As discussed above, the Attorney General (and via delegation, DEA) is the final arbiter of CSA scheduling and rescheduling decisions. As Justice Scalia once noted, when Congress commits enforcement of a statute to an agency, it commits the "initial . . . interpretation" of the

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[45] *See, e.g.*, Swapna Munnangi et al., *Placebo Effect*, StatPearls, https://www.ncbi.nlm.nih.gov/books/NBK513296/ (last updated Nov. 13, 2023).

[46] *See* Lakshmi Gandhi, *A History of 'Snake Oil Salesmen,'* National Public Radio (Aug. 26, 2013), https://www.npr.org/sections/codeswitch/2013/08/26/215761377/a-history-of-snake-oil-salesmen (explaining that "[t]he origins of snake oil as a derogatory phrase trace back to the latter half of the 19th century, which saw a dramatic rise in the popularity of 'patent medicines.' Often sold on the back pages of newspapers, these tonics promised to cure a wide variety of ailments including chronic pain, headaches, 'female complaints' and kidney trouble. In time, all of these false 'cures' began to be referred to as 'snake oil.'").

[47] The FDA's unofficial motto is: "In God we trust, all others bring must bring data." *See, e.g.*, Robert M. Califf, *Novartis violated FDA's sacred principle: In God we trust, all others must bring data*, Stat News (Aug, 14, 2019), https://www.statnews.com/2019/08/14/fda-novartis-zolgensma-data-integrity/.

statute to the agency as well. *United States v. Mead Corp.*, 533 U.S. 218, 241 (2001) (Scalia, J., dissenting). DEA should exercise its interpretive authority, reject HHS's proposed two-part test for determining if marijuana (or any other drug or substance) has a CAMU, and adhere to the five-part test it announced in 1992, adhered to in 2016, and that was blessed by the D.C. Circuit in *Cannabis Therapeutics* because of its fidelity to the lodestar of federal law regarding the safety and efficacy of drugs, the FDCA. Then, DEA should apply that test. Once it is clear, as the reasons outlined in 2016 illustrate, *see* 81 Fed. Reg. 53700–702, that marijuana cannot meet the elements of that test, DEA should declare that marijuana does not have a CAMU. Such a declaration would foreclose placing marijuana anywhere other than Schedule I.

C.

The last factor DEA must consider is whether there is a "lack of accepted safety for use" of marijuana under medical supervision. 21 U.S.C. § 812(b)(1)(C). This factor is largely, though perhaps not entirely, coextensive with the determination of whether marijuana has a CAMU, especially in circumstances when it is determined that a substance has no CAMU. *See All. for Cannabis Therapeutics v. Drug Enf't Admin.*, 930 F.2d 936, 940 n.4 (D.C. Cir. 1991).

In 2016, DEA concluded that there was a lack of accepted safety for the use of marijuana under medical supervision. 81 Fed. Reg. 53707. It explained that "[t]here are currently no FDA-approved marijuana drug products" and that marijuana did not have a CAMU. *Id*. The explanation also noted the problems with studying the medical efficacy of marijuana without the assurance of a "consistent and predictable dose." *Id*. This latter concern reflects the unavoidable fact that marijuana is of a botanical origin and its many different strains (also known as "chemovars") frequently "vary in their composition and concentration of various chemical constituents" and thus "have differing biological and pharmacological profiles." 89 Fed. Reg. 44603; *see also* HHS Basis for Rec. at 21 (noting that "marijuana has hundreds of chemovars" and further recognizing that "marijuana is not a single chemical with a consistent and reproducible chemical profile or predictable and consistent clinical effects"); *id*. at 19 (recognizing that "marijuana products developed from diverse chemovars will have different safety, biological, pharmacological, and toxicological profiles").

HHS offers only a cursory analysis of this factor, stating that given its "evaluation of [and determination that there is a] CAMU" it could conclude that "there is accepted safety for the use of marijuana under medical supervision." HHS Basis for Rec. at 64. At the threshold, for the reasons articulated above regarding a CAMU, DEA should reject HHS's conclusion and adhere to its prior determination that marijuana lacks accepted safety for use under medical supervision. Furthermore, HHS's failure to seriously grapple with the ramifications of dosage unpredictability stemming from marijuana's myriad chemovars would likely render reliance on its cursory conclusion regarding this factor arbitrary and capricious. DEA's longstanding position is that marijuana has no accepted safety for use under medical supervision, in part because of marijuana's botanical nature. 89 Fed. Reg. 44603; *see also* 66 Fed. Reg. 20052 (DEA "cannot conclude that marijuana has an acceptable level of safety without assurance of a consistent and predictable potency"). An "[u]nexplained inconsistency" is a "reason for holding an interpretation to be an arbitrary and capricious change from agency practice under the Administrative Procedure Act."

Nat'l Cable & Telecommuns. Ass'n v. Brand X Internet Servs., 545 U.S. 967, 981 (2005). Because HHS does not offer a reasoned explanation as to *why* there is an accepted safety for use that accounts for the varying potency and dosage size of different marijuana chemovars, a Final Rule that relies on its conclusion would violate the APA.

V. Moving Marijuana to Schedule III Would Exacerbate Harms Suffered by Nebraska and Inflict Damage to the Nation's Public Health

Even if none of the legal impediments discussed above preclude moving marijuana from Schedule I to Schedule III, DEA should decline to do so in applying the statutory factors. When determining which schedule a drug or other substance should be placed, the CSA requires consideration of several factors including a drug's "actual or relative potential for abuse," "[i]ts history and current pattern of abuse," "[t]he scope, duration, and significance of abuse," "risk . . . to the public health," "dependence liability," and "[w]hether the substance is an immediate precursor of [another controlled] substance." 21 U.S.C. § 811(c). Applying these factors points away from rescheduling marijuana. Indeed, because of the magnitude of the harm that would result from the corresponding expansion of access (discussed in greater detail below), moving marijuana to Schedule III has been described by Harvard psychobiology professor Bertha Madras, one of the Nation's foremost experts on the science of marijuana, as "tragic" and a "colossal mistake."[48] Fortunately, that mistake has not yet been made. DEA can—and should, consistent with the textual dictate of Section 811(c)—decline to make it.

A.

1.

The public health harms of marijuana are legion. For example, expanded access to marijuana increases both the occurrence of motor vehicle accidents[49] and the percentage of those accidents that result in fatalities.[50] After recreational marijuana was legalized in Canada,

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[48] Allysia Finley, *What You Aren't Hearing About Marijuana's Health Effects*, Wall Street Journal (May 10, 2024), https://www.wsj.com/articles/what-you-arent-reading-about-marijuana-permanent-brain-damage-biden-schedule-iii-9660395e. *See also* Madras, *supra* note 38.

[49] Samantha Marinello & Lisa M. Powell, *The impact of recreational cannabis markets on motor vehicle accident, suicide, and opioid overdose fatalities*, 320 SOC. SCI. & MED. (Mar. 2023), https://www.sciencedirect.com/science/article/abs/pii/S0277953623000357.

[50] *See* Charles M. Farmer, et al., *Changes in Traffic Crash Rates After Legalization of Marijuana: Results by Crash Severity*, 83 J. STUD. ON ALCOHOL & DRUGS 494 (July 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9318699/#B15 ("[T]he estimated increase in traffic crash rates after marijuana legalization is consistent with earlier studies: a 5.8% increase in injury crash rates and a 4.1% increase in fatal crash rates."). *See also The Legalization of Marijuana in Colorado*, Rocky Mountain High Intensity Drug Trafficking Area (Aug. 2013), https://www.sheriffs.org/sites/default/files/FINAL%20Legalization%20of%20MJ%20in%20Colorado%20the%20Impact_0.pdf (explaining that after the legalization of medical marijuana in Colorado, marijuana-involved traffic "fatalities involving drivers testing positive for marijuana increased 114 percent").

"marijuana-related traffic accidents that required treatment in an emergency room rose 475%."[51] The physiological explanation is simple: consuming marijuana "slows reaction time, hampers road tracking and lane keeping, and impairs one's ability to maintain attention."[52] Despite this—and *unlike* the widespread understanding of the danger of driving while under the influence of alcohol—"[m]any people don't realize driving while stoned can be dangerous — they even see it as safe."[53]

This danger is further compounded because there is no widely accepted "medical cutoff" for marijuana that helps individuals determine when their ability to safely drive has been compromised and helps law enforcement objectively determine that an individual is driving impaired.[54] Nor is an analogue to alcohol's "cutoff"—in most States, a blood alcohol concentration of 0.08%—likely to be developed, due to differences in the pharmacokinetic properties of the two substances. As Dr. Madras has explained, while the human body efficiently filters alcohol from the bloodstream, marijuana is "soaked up" by brain tissue, causing the effects of marijuana to linger even after an individual's blood levels "go way down."[55] Madras's lab work "unequivocally" shows that for marijuana, "blood levels and brain levels don't correspond at all."[56]

Marijuana's propensity to linger in the human brain is one of the likely causes of another serious harm its use inflicts on the public health—inhibiting child and adolescent development. Marijuana use during pregnancy harms fetal development. It increases the incidence of pre-term labor, frequently causes low birth weight, and is correlated with a rise in the number of admissions

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[51] Sandee LaMotte, *Driving While Stoned Leads to More Traffic Accidents in a Country Where Marijuana is Legal*, CNN (Sept. 6, 2023), https://www.cnn.com/2023/09/06/health/marijuana-traffic-accidents-wellness/index.html (citing study by Dr. Daniel T. Myran). *See also* Daniel T. Myran et al., *Cannabis-Involved Traffic Inquiry Emergency Department Visits After Cannabis Legalization and Commercialization*, JAMA Network Open (July 24, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2808961.

[52] Farmer, *supra* note 50.

[53] LaMotte, *supra* note 51. *See also* Kaylin M. Green, *Perceptions of Driving after Marijuana Use Compared to Alcohol Use among Rural American Young Adults*, 37 DRUG & ALCOHOL REVIEW 637 (July 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6028284; Christine M. Wickens, et al., *Risk perceptions of driving under the influence of cannabis: Comparing medical and non-medical cannabis users,* 95 TRANSP. RES. PART F: TRAFFIC PSYCHOL. AND BEHAV. 36 (May 2023), https://www.sciencedirect.com/science/article/abs/pii/S1369847823000347.

[54] *See* Finley, *supra* note 48.

[55] *Id.*

[56] *Id*. *See also* Erin J. Farley & Stan Orchowsky, *Measuring the Criminal Justice System Impacts of Marijuana Legalization and Decriminalization Using State Data*, Justice Research and Statistics Association (July 2019), https://www.ojp.gov/pdffiles1/nij/grants/253137.pdf (discussing the "complicat[ions]" of testing drivers for marijuana intoxication, noting the fact that "traces of marijuana use can remain in the human body for days," and emphasizing the "challenge" faced by "law enforcement officers . . . trying to determine an individual's current level of intoxication").

to neonatal intensive care units.[57] And the negative impacts of in-utero marijuana exposure are not transitory. Study after study expounds on the serious developmental consequences: "At school age, heavy prenatal marijuana exposure predicts challenges in executive function (specifically, memory and reasoning) and externalizing behavior (e.g., hyperactivity and inattention)."[58] "There [is] a significant nonlinear relationship between marijuana exposure and child intelligence. Heavy marijuana use (one or more [marijuana] cigarettes per day) during the first trimester [is] associated with lower verbal reasoning [test] scores . . . Heavy use during the second trimester predicted deficits in the composite, short-term memory, and quantitative [test] scores."[59] "Offspring of heavier marijuana users were significantly more likely to report delinquent behavior at age 14 . . . [T]here is a significant effect of [prenatal marijuana exposure] on the rate of delinquency in adolescence."[60] Despite findings like these, many women "believe there is [only] slight or no risk of harm from using marijuana" during their pregnancy.[61]

Adolescent use of marijuana has similarly harmful developmental impacts. Marijuana "use during youth is of particular concern, as the developing brain may be particularly susceptible to harm during this period."[62] One study concluded that persistent, long-term marijuana use, beginning in adolescence, is associated with "a clinically significant eight-point decline" in an

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[57] Mohammad R. Hayatbakhsh, et al., *Birth outcomes associated with cannabis use before and during pregnancy*, 71 PEDIATRIC RES. 215 (2012), https://www.nature.com/articles/pr201125. *See also* Christopher McPherson, *Up in Smoke: The Impacts of Marijuana During Pregnancy*, 42 NEONATAL NETWORK 222 (July 2023), https://doi.org/10.1891/nn-2022-0040 ("Robust follow-up studies suggest that marijuana use during pregnancy contributes to suboptimal fetal growth."); Marie C. McCormick et al., THE HEALTH EFFECTS OF CANNABIS AND CANNABINOIDS: THE CURRENT STATE OF EVIDENCE AND RECOMMENDATIONS FOR RESEARCH, National Academies of Sciences, Engineering, and Medicine (2017), https://doi.org/10.17226/24625 ("There is substantial evidence of a statistical association between maternal cannabis smoking and lower birth weight of the offspring").

[58] McPherson, *supra* note 57.

[59] Lidush Goldschmidt, et al., *Prenatal Marijuana Exposure and Intelligence Test Performance at Age 6*, 47 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 254 (Mar. 2008), https://www.sciencedirect.com/science/article/abs/pii/S089085670962308X.

[60] Nancy L. Day et al., *The effects of prenatal marijuana exposure on delinquent behaviors are mediated by measures of neurocognitive functioning*, 33 NEUROTOXICOLOGY & TERATOLOGY 129 (Jan-Feb. 2011), https://www.sciencedirect.com/science/article/abs/pii/S0892036210001571.

[61] Jean Y. Ko et al., *Prevalence and patterns of marijuana use among pregnant and nonpregnant women of reproductive age*, 213 AM. J. OBSTETRICS & GYNECOLOGY 201 (Aug. 2015), https://www.sciencedirect.com/science/article/abs/pii/S0002937815002410.

[62] Emmet Power et al., *Intelligence quotient decline following frequent or dependent cannabis use in youth: a systematic review and meta-analysis of longitudinal studies*, 51 PSYCHOL. MED., 194 (Jan. 2021), https://www.cambridge.org/core/journals/psychological-medicine/article/intelligence-quotient-decline-following-frequent-or-dependent-cannabis-use-in-youth-a-systematic-review-and-metaanalysis-of-longitudinal-studies/26BEC9CBD2A39010C26100278F8CA813. *See also* Dan Lubman, et al., *Cannabis and adolescent brain development*, 148 PHARMACOLOGY & THERAPEUTICS 1, (April 2015), https://pubmed.ncbi.nlm.nih.gov/25460036/.

individual's intelligence quotient (IQ) when measured later in life.[63] A robust meta-analysis of studies examining use and intelligence found consistent evidence that "[y]oung people who use cannabis frequently or dependently by age 18," on average, lose approximately two points of IQ.[64] Such findings are bolstered by evidence that marijuana use negatively impacts the physiological development of the human brain. For example, chronic marijuana use has been shown to be "associated with structural differences in [the thickness of] white and gray matter" in the brain.[65] Also, "compared with unexposed controls, adults who smoked marijuana regularly during adolescence have impaired neural connectivity (fewer fibers) in specific brain regions" including "the precuneus, a key node that is involved in functions that require a high degree of integration (e.g., alertness and self-conscious awareness), and the fimbria, an area of the hippocampus that is important in learning and memory."[66]

Youth and adolescent marijuana use and exposure is also correlated with an increased prevalence (and may contribute to the development) of certain psychiatric disorders, such as schizophrenia. A "meta-analysis of all available published data . . . confirm[ed] a positive association between the extent of cannabis use and the risk for psychosis."[67] Scientists have even been able to use Delta-9 THC, the primary psychoactive and intoxicating chemical compound found in marijuana,[68] to induce symptoms of psychosis reminiscent of schizophrenia in human test subjects. In a "3-day, double-blind, randomized, and counterbalanced study," numerous test subjects who received intravenous injections of Delta-9 THC (rather than the placebo control) "experienced transient but significant psychotic symptoms" "similar to those seen in schizophrenia and other endogenous psychoses" despite having been carefully screened for latent psychiatric disorders.[69] This experimental result lends credence to the "growing body of literature" that suggests the consumption of marijuana can contribute to the development of (as well as contribute

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[63] Power, *supra* note 62. *See also* Madeline Meier, et al., *Persistent cannabis users show neuropsychological decline from childhood to midlife*, 109 PROCEEDINGS OF THE NATIONAL ACADEMIES OF SCIENCE 2657 (Oct. 2012), https://pubmed.ncbi.nlm.nih.gov/22927402/.

[64] Power, *supra* note 62.

[65] Peter Manza, et al., *Brain structural changes in cannabis dependence: association with MAGL*, 25 MOLECULAR PSYCHIATRY 3256 (2020), https://www.nature.com/articles/s41380-019-0577-z.

[66] Nora D. Volkow, et al., *Adverse Health Effects of Marijuana Use*, 370 NEW ENGLAND J. MED. 2219 (June 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4827335/.

[67] Arianna Marconi, et al, *Meta-analysis of the Association Between the Level of Cannabis Use and Risk of Psychosis*, 42 SCHIZOPHRENIA BULLETIN 1262 (Sept. 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4988731/. *See also* Marta Di Fort, et al., *High-potency cannabis and the risk of psychosis*, 195 BRITISH J. OF PSYCHIATRY 488 (Dec. 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2801827/ (concluding that the "risk of psychosis is much greater among people who are frequent cannabis users").

[68] *See* McCormick, *supra* note 57, at 44 (describing Delta-9 THC as "being responsible for the intoxicated state sought after by recreational cannabis users").

[69] Deepak Cyril D'Souza, et al., *The Psychotomimetic Effects of Intravenous Delta-9-Tetrahydrocannabinol in Healthy Individuals: Implications for Psychosis*, 29 NEUROPSYCHOPHARMACOLOGY 1558 (2004), https://www.nature.com/articles/1300496.pdf.

to acute incidents of) psychosis or schizophrenia.[70] This connection is particularly troubling given that "[i]ndividuals suffering from medical conditions, including mental health illnesses, report using marijuana more than healthy people."[71] And this concern is heightened even further when factoring in the link between marijuana use and suicidal ideation.[72] Efforts to self-medicate with marijuana may, in many circumstances, be causing more harm than good.

All that said, the negative health effects of marijuana are hardly limited to the brain. Given that smoking and vaping are two of the most popular ways marijuana is consumed, it is hardly surprising that marijuana consumption is harmful to cardiovascular health.[73] Indeed, one study, published in the Journal of the American Heart Association, concluded that "smoking [marijuana] and smoking tobacco have similar independent additive risks" to cardiovascular health.[74] It might be somewhat more surprising to marijuana use increases the risk of testicular cancer.[75] And cervical cancer (and possibly laryngeal and breast cancer too).[76] Perhaps most surprising (given

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[70] *Id.*

[71] Catherine A. Marco, et al., *The perils of recreational marijuana use: relationships with mental health among emergency department patients*, 1 J. AM. C. OF EMERGENCY PHYSICIANS OPEN 281 (Mar. 2020), https://onlinelibrary.wiley.com/doi/10.1002/emp2.12025.

[72] *See* Jan C. van Ours, et al., *Cannabis use and suicidal ideation*, 32 J. HEALTH ECON. 524 (May 2013), https://www.sciencedirect.com/science/article/pii/S016762961300009X.

[73] Harsh Jain, et al., *Marijuana Use Associated With Increased Risk of Coronary Artery Disease and Percutaneous Coronary Intervention, A Nationwide Study*, 2 J. SOC'Y FOR CARDIOVASCULAR ANGIOGRAPHY & INTERVENTIONS (May 2023), https://www.jscai.org/article/S2772-9303(23)00126-6/fulltext. *See also* Abra M. Jeffers, et al., *Association of Cannabis Use With Cardiovascular Outcomes Among US Adults*, 13 J. AM. HEART ASS'N (Feb. 2024), https://www.ahajournals.org/doi/10.1161/JAHA.123.030178 ("Cardiovascular-related death is the leading cause of mortality, and cannabis use could be an important, unappreciated risk factor leading to many preventable deaths."); McCormick, *supra* note 57, at 165 ("The role of cannabis as a trigger of [acute myocardial infarction, the medical term for what is colloquially known as a 'heart attack'] is plausible . . . smoking cannabis may put individuals, particularly those at high risk for cardiovascular disease, at increased risk for [a heart attack]").

[74] Jeffers, *supra* note 73. *See also* Lugain Khoj, et al., *Effects of cannabis smoking on the respiratory system: A state-of-the-art review*, 221 RESPIRATORY MED. (Jan. 2024), https://pubmed.ncbi.nlm.nih.gov/38056532 ("[U]nequivocal evidence establishe[s] that [marijuana] smoking is harmful to the respiratory system. [Marijuana] smoking has a wide range of negative effects on respiratory symptoms in both healthy subjects and patients with chronic lung disease"); *see also* McCormick, *supra* note 57, at 192 ("There is substantial evidence of a statistical association between long-term cannabis smoking and worse respiratory symptoms and more frequent chronic bronchitis episodes').

[75] Jason Gurney, et al., *Cannabis exposure and risk of testicular cancer: a systematic review and meta-analysis*, 15 BMC CANCER (2015), https://link.springer.com/content/pdf/10.1186/s12885-015-1905-6.pdf.

[76] Peng Huang, et al., *Causal relationship between cannabis use and cancer: a genetically informed perspective*, 149 J. CANCER RES. & CLINICAL ONCOLOGY 8631 (Sept. 2023), https://pubmed.ncbi.nlm.nih.gov/37099198/.

the popular association between medical marijuana and glaucoma)[77] marijuana consumption is "associated with negative effects on visual function."[78]

2.

The harms discussed above represent just some of the myriad threats to public health posed by expanding legal access to marijuana. There are many more. As the next section illustrates, many second-order effects (e.g., increased crime, homelessness, reduced workplace productivity, the "gateway drug" effect) associated with expanding access to marijuana cause as much (or more) damage to America's public health, safety, and wellbeing.

That said, in addition to the direct effects of the harms recounted above, it is critical not to discount the *signaling effect* of moving marijuana to Schedule III. A common thread linking the harms discussed in the prior subsection is the *public misperception* regarding the dangers of marijuana consumption. It is unfortunately "quite common to find misperceptions of the cannabis-use-associated risks."[79] There is a "concerning gap between public perception and scientific evidence on the risks and benefits of cannabis."[80]

There can be little doubt that the trend toward state-level legalization has contributed to the widespread misperception that using marijuana is not dangerous. As one study, published in 2017 noted, "in recent years, [the] perceived risk [of marijuana use] has decreased markedly."[81] And that perception has a significant real-world impact. A nationwide study of more than 275,000 U.S. high school seniors, for example, concluded that "perceived risk was a strong protective factor against adolescent marijuana use."[82] But, as another study indicates, "adolescents' cannabis use has risen and their overall perception that cannabis use is harmful has declined over the past two

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[77] *See, e.g.*, The Simpsons, S13E16, *Weekend at Burnsie's*, 20TH TELEVISION (April 7, 2002), https://youtu.be/j3OkACPnKlM?t=70.

[78] Sonia Ortiz-Peregrina, et al., *Effects of cannabis on visual function and self-perceived visual quality*, 11 SCI. REP. (2021), https://www.nature.com/articles/s41598-021-81070-5.

[79] *Id*. *See also, e.g.*, John A. Cunningham, et al., *Normative Misperceptions About Cannabis Use in a Sample of Risky Cannabis Users*, 17 SUBSTANCE ABUSE: RES. & TREATMENT (April 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10084580/.

[80] Yoshiko Kohlwes, et al, *Perceptions of Risks of Cannabis Use in a National Sample of US Adults*, 38 J. GEN. INTERNAL MED. 1094 (Mar. 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10039152/.

[81] Yvonne M. Terry-McElrath, et al., *Risk is still relevant: Time-varying associations between perceived risk and marijuana use among US 12th grade students from 1991 to 2016*, 74 ADDICTIVE BEHAVS. 13 (Nov. 2017), https://www.sciencedirect.com/science/article/abs/pii/S030646031730206X.

[82] *Id*.

decades. These shifts could be attributed to the rapidly changing policies regarding cannabis legalization."[83]

Moving marijuana to Schedule III would only further ingrain in the public psyche the pernicious myth that marijuana is harmless. And the stories that society collectively tells itself matter. The story that many want to tell about marijuana is a comforting one: "The playbook [of marijuana proponents] is always to say it's safe and effective and nonaddictive in people."[84] But that story is not backed by evidence; it simply isn't true. To quote Dr. Madras: "The benefits have been exaggerated [and] the risks have been minimized."[85]

DEA has long recognized the truth and declared it with unshaking clarity: Marijuana is a dangerous drug that deserves to be on Schedule I. Fashionable though it may be in some quarters, there is no good reason to change course now.

B.

In addition to directly harming the public health as described above, rescheduling marijuana to Schedule III will exacerbate trends, traceable to the state-level expansions of access to marijuana, that undermine our Nation's general welfare. DEA should not throw gasoline on an already roaring fire.

1.

State-authorized marijuana (both medical and recreational) is already a big business, with sales measured in the billions.[86] It is important to remember that significant revenue figure has been achieved despite the numerous operational hurdles and obstacles currently faced by marijuana enterprises. The marijuana industry is predominately cash-based because most financial institutions, including banks and payment processors, refuse to provide services related to a substance that is fully illegal under federal law.[87] Access to capital markets, including the ability

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[83] *See also* Abigail Cadua Mariani & April R. Williams, *Perceived risk of harm from monthly cannabis use among US adolescents: National Survey on drug Use and Health, 2017*, 23 PREVENTIVE MED. REP. (Sept. 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8209744/.

[84] *See* Finley, *supra* note 48.

[85] *Id.*

[86] *See* Jennifer Maloney & Richard Rubin, *Reclassifying Marijuana Could Unlock Billions in Tax Savings for Cannabis Companies*, Wall Street Journal (May 5, 2024), https://www.wsj.com/business/cannabis-companies-profits-taxes-3f8bbee0 (estimating legal U.S. marijuana sales to be $31.4 billion in 2024).

[87] *See* Associated Press, *New Era for Pot Regulation Leaves Old Problem: Many Cannabis Companies Can't Find a Bank*, U.S. News & World Report (May 1, 2024), https://www.usnews.com/news/us/articles/2024-05-01/new-era-for-pot-regulation-leaves-old-problem-many-cannabis-companies-cant-find-a-bank; Alexander Saeedy, *The Big Problem for Marijuana Companies? What to Do With All That Cash*, Wall Street Journal (Apr. 1, 2024),

to list on America's most prominent stock exchanges, is largely restricted or nonexistent for the same reason.[88] Most health insurance providers decline to reimburse patients who seek out medical marijuana treatment.[89] And potential cross-industry synergies—partnerships with firms in related business spaces, such as the tobacco and pharmaceutical industries—are few and far between because of the attendant legal risks.[90] Although moving marijuana from Schedule I to Schedule III does not entirely remove the legal roadblock that prevents the marijuana industry from taking full advantage of the aforementioned benefits of the modern American economy, it would still represent a significant step toward "normalizing" marijuana enterprises.[91]

Rescheduling marijuana would not, however, be an entirely symbolic gesture from a business standpoint. On the contrary, rescheduling marijuana *would* represent a seismic shift in the way the marijuana industry is taxed. It is a long-established principle of federal law that all income, including income from illegal sources is subject to federal taxation. *See James v. United States*, 366 U.S. 213, 218 (1961); *see also* 26 U.S.C § 61 ("[G]ross income means all income from whatever source derived."). Normally, businesses are permitted to deduct various "ordinary business expenses" when calculating their federal taxable income. Section 280E of the Internal Revenue Code, however, prohibits such deductions by "any trade or business" that "consists of trafficking in controlled substances (within the meaning of schedule I and II of the Controlled Substances Act) which is prohibited by Federal law." 26 U.S.C. § 280E. Numerous courts have confirmed that because marijuana remains a Schedule I controlled substance, marijuana businesses are subject to Section 280E and cannot take the usual operating expenses deduction. *See, e.g.*, *Feinberg v. C.I.R.*, 916 F.3d 1330, 1338 (10th Cir. 2019); *Olive v. C.I.R.*, 792 F.3d 1146, 1151 (9th Cir. 2015). The Internal Revenue Service ("IRS") itself has recently issued a public statement, reiterating that "Section 280E disallows all deductions or credits for any amount paid or incurred in carrying on any trade or business that consists of illegally trafficking in a Schedule I or II

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https://www.wsj.com/finance/banking/the-big-problem-for-marijuana-companies-what-to-do-with-all-that-cash-09d81fc3.

[88] *See* A.J. Herrington, *JPMorgan Chase To Restrict Trading In Some U.S. Cannabis Stocks*, FORBES (Nov. 5, 2021), https://www.forbes.com/sites/ajherrington/2021/11/05/jpmorgan-to-restrict-trading-in-some-us-cannabis-stocks/.

[89] *See generally* 28 U.S.C. § 828(a). *See also* Glenn Jones, *Is It Time for Health Insurers to Cover Medical Marijuana?*, NBC Boston (Mar. 24, 2023), https://www.nbcboston.com/news/local/is-it-time-for-health-insurers-to-cover-medical-marijuana/3005331/. *See also, e.g.*, *Spira EPO Product, on the BlueSelect Plus Network*, Blue Cross and Blue Shield of Kansas City, https://perma.cc/59BJ-TSUV (archived July 13, 2024) (example of common insurance coverage exclusion—C7 in this particular policy—for "Medications with no approved FDA indications").

[90] *Cf.* Amanda Chicago Lewis, *The Half-Legal Cannabis Trap*, Politico (Feb. 9, 2021) https://www.politico.com/news/magazine/2021/02/09/los-angeles-legalization-cannabis-criminalization-467572 (discussing the "vast gray area" surrounding many marijuana business and the danger of sudden legal upheavals)

[91] Maloney & Rubin, *supra* note 86 ("[Marijuana] [i]ndustry leaders [say] they are . . . optimistic that the policy shift [rescheduling marijuana] could reduce the stigma around cannabis, bring more investors into the sector and make federal lawmakers more open to legalizing marijuana.")

controlled substance within the meaning of the federal Controlled Substances Act" and emphasizing that until a Final Rule that reschedules marijuana is published, "marijuana remains a Schedule I controlled substance and is subject to the limitations of Internal Revenue Code Section 280E." IR-2024-177, *IRS: Marijuana remains a Schedule I controlled substance; Internal Revenue Code Section 280E still applies* (June 28, 2024), https://www.irs.gov/newsroom/irs-marijuana-remains-a-schedule-i-controlled-substance-internal-revenue-code-section-280e-still-applies.

Because Section 280E applies, most marijuana businesses pay an effective tax rate of 70% or more.[92] The heavy tax burden means many legally operating marijuana firms —perhaps as few as twenty five percent—fail to turn a profit.[93] By some estimates, allowing marijuana businesses to take the "normal" operating deduction[94] would save those businesses more than $2 billion in federal taxes.[95]

Those tax savings would immediately enable marijuana business to significantly expand their operations. Marijuana firms would almost certainly use their tax savings to "invest more in marketing, offer better benefits to employees and expand into newly opened markets."[96] Perhaps most notably, moving marijuana to Schedule III would result in it having a "more favorable federal tax treatment than alcohol and tobacco, which are subject to federal excise taxes on top of income taxes."[97] In other words, moving marijuana to Schedule III would give many marijuana enterprises a major tax cut that would supercharge the marijuana industry.

2.

Even laboring under heavy tax burden imposed by application of Section 280E, state legal marijuana businesses have operated with great success, generating tens of billions of dollars in revenue. In jurisdictions with state-authorized marijuana, States invariably impose their own state-level taxes and fees on marijuana businesses. Some of those taxes and fees are primarily intended to raise revenue. But for "vice" products like marijuana—and comparable products like alcohol, tobacco, and gambling—another important role played by state taxes and fees is providing a dedicated revenue source that can be dedicated to the mitigation of the negative externalities associated with commerce in such goods or services.

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[92] *Id.*

[93] *Id.*

[94] The impact is most pronounced for retail operations. *See id.* (explaining that the relevant federal tax rules permit marijuana cultivators to "deduct their cost of goods sold" but prevents marijuana retailers from taking deductions for "rent, marketing and wages when calculating taxable income").

[95] *Id.*

[96] *Id.*

[97] *Id. See, e.g.*, 26 U.S.C. § 5001 (federal excise tax on consumable alcohol); 26 U.S.C. § 5701 (federal excise tax on tobacco).

Expanded access to legal marijuana generates numerous negative externalities that harm the public welfare. "[L]egalization [of marijuana has] economic and social costs. On the social side, [there is the] increase in the number of heavy marijuana users . . . and knock-on effects such as rising homelessness and crime."[98] Economic effects include "lower labor force participation and worker productivity."[99]

The evidence that marijuana legalization increases homelessness is fairly robust. As one study indicates, an analysis of nationwide data from 2007 to 2020 "strongly suggests" that legalizing recreational marijuana causes "an increase in aggregate rates of homelessness."[100] One study found that in legalizing jurisdictions "chronic homelessness" increased by 35 percent, possibly as a side effect of concomitant increases in substance abuse disorder.[101] That hypothesis is consistent with other research indicating that drug use is a frequent precipitating cause of homelessness.[102] This dovetails with evidence that shows marijuana can be a "gateway drug" that leads some of its users to eventually transition to other "hard drugs,"[103] and with evidence that

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[98] Jason P. Brown et al., *Economic Benefits and Social Costs of Legalizing Recreational Marijuana*, Federal Reserve Bank of Kansas City kcFED Research Working Papers (June 7, 2024), https://www.kansascityfed.org/Research%20Working%20Papers/documents/9825/rwp23-10browncohenfelix.pdf.

[99] *Id*. *See also* Andrew Lac, et al., *Testing the Amotivational Syndrome: Marijuana Use Longitudinally Predicts Lower Self-Efficacy Even After Controlling for Demographics, Personality, and Alcohol and Cigarette Use*, 19 PREVENTION SCI. 117 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5732901/ (finding that "marijuana (but not alcohol or tobacco) intake significantly and longitudinally prompted lower initiative and persistence" among test subjects, which "underscore[s] marijuana as a risk factor in decreased general self-efficacy").

[100] James A. Sanderson, *Recreational Cannabis Legalization and Homelessness in the U.S.: A Quasi-Experimental National Policy Analysis*, Clemson University (May 2022), https://tigerprints.clemson.edu/cgi/viewcontent.cgi?article=4760&context=all_theses.

[101] Brown, *supra* note 98.

[102] *See*, e.g., Shelley Mallett, et al., *Young people, drug use and family conflict: Pathways into homelessness*, 28 J. ADOLESCENCE 185 (Apr. 2005), https://pubmed.ncbi.nlm.nih.gov/15878042/ ("20% of our total sample indicated that their own drug and/or alcohol use was either the first or second link in the chain leading to homelessness").

[103] *See* Hans Olav Melberg, et al., *Is cannabis a gateway to hard drugs?*, 38 EMPIRICAL ECONOMICS 583 (2010), https://doi.org/10.1007/s00181-009-0280-z (finding a "statistically significant" gateway effect that "doubles the hazard of starting to use hard drugs" for certain "troubled youths"); John Macleod, et al., *Psychological and social sequelae of cannabis and illicit drug use by young people: a systematic review of longitudinal, general population studies*, 363 THE LANCET 1579 (May 2004), https://pubmed.ncbi.nlm.nih.gov/15145631/ (reviewing nearly 50 studies that reported "[f]airly consistent associations . . . between cannabis use and . . . increased reported use of other illicit drugs"). *See also* Jeffrey DeSimone, *Is Marijuana a Gateway Drug?*, 24 E. ECON. J. 149 (1998), https://www.jstor.org/stable/40325834 (finding "strong confirmation of the gateway hypothesis" with data suggesting that "past marijuana use increases the probability of cocaine use by twenty nine percentage points").

marijuana can contribute to relapse of individuals who have received substance abuse treatment.[104] Nor is marijuana a solution to the ongoing opioid crisis—recent research indicates that States "with medical-marijuana laws experienced *an increased rate* of opioid overdose deaths."[105] It also tracks with research indicating that marijuana use (especially during adolescence) is correlated with lower educational attainment, weaker economic performance, and higher levels of welfare dependence and unemployment.[106]

Individual State examples also illustrate the connection between marijuana use and increased homelessness. On a nationwide basis, homelessness decreased in 2013 and 2014 as the United States emerged from an economic recession.[107] One of the few States where homelessness increased, however, was in Colorado, which had just legalized recreational marijuana.[108] As Colorado's legal market matured, its homelessness problem only grew—statistics reflect a "thirteen percent increase in Colorado's homeless population from 2015 and 2016" even as the "rest of the country saw a three percent decrease in homelessness."[109]

Statistics related to crime are less definitive but still concerning. Data from the CATO Institute, considering the impacts of legalization in multiple States, concluded that there had been no discernable impact on violent crime, in either a positive or negative direction.[110] On the other hand, a study focused on the aftermath of Oregon's 2014 decriminalization concluded that there were "substantial increases" in the rates of property crime, burglary, and motor vehicle theft when measured against crime rates in comparator jurisdictions.[111] Another localized study, focusing on individual neighborhoods in Denver, Colorado, concluded that neighborhoods with legal marijuana dispensaries (of either medical or recreational marijuana) had "statistically significant increases in rates of neighborhood crime and disorder."[112] But a competing study, also focused on

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[104] McCormick, *supra* note 57, at 365 ("[C]annabis use . . . [is] associated with reduced odds of achieving abstinence from alcohol, cocaine, or polysubstance [drug] use after inpatient hospitalization and treatment for substance use disorders.").

[105] *See* Letter from Alabama Attorney General Steve Marshall to Alabama Legislature, *supra* note 12 (citing research from Stanford University).

[106] David M. Fergusson & Joseph M. Boden, *Cannabis use and later life outcomes*, 103 ADDICTION 969 (2008), https://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2008.02221.x.

[107] Kevin Sabet, *Marijuana and Legalization Impacts*, 23 Berkeley J. Crim. L. 84, 93 (2018).

[108] *Id*.

[109] *Id*.

[110] Angela Dills, et al., *The Effect of State Marijuana Legalizations: 2021 Update*, CATO Institute (Feb 2021), https://www.cato.org/policy-analysis/effect-state-marijuana-legalizations-2021-update.

[111] Guangzhen Wu, et al., *Impact of recreational marijuana legalization on crime: Evidence from Oregon*, 72 J. CRIM. JUST. (Feb. 2021), https://www.sciencedirect.com/science/article/abs/pii/S0047235220302361.

[112] Lorine A Hughes, et al., *Marijuana Dispensaries and Neighborhood Crime and Disorder in Denver, Colorado*, 37 JUST. Q. 461 (March 2018), https://www.tandfonline.com/doi/full/10.1080/07418825.2019.1567807.

crime statistics at the neighborhood level in the vicinity of Denver dispensaries, came to the opposite conclusion, finding an "overall reduction in crime when a dispensary is added to a neighborhood."[113] And a third study suggests that Denver's marijuana dispensaries do increase crime, but only in "spatially adjacent blocks" rather than in the immediate vicinity of the dispensary itself.[114]

No matter what effect legalization has on crime rates in the legalizing jurisdiction, there is clear evidence that negative spillover effects into adjacent jurisdictions (where marijuana remains illegal) are real and substantial. As Nebraska explained in its attempted invocation of the U.S. Supreme Court's original jurisdiction in 2014, Colorado's legalization presented "a direct threat to the health and safety of the residents of [Nebraska], drains [Nebraska's] treasur[y], and stresses [Nebraska's] criminal justice system." *See* Br. in Supp. of Mot. for Leave to File Compl., *supra* note 11, at *67. This is the inevitable result of Nebraska's continued commitment to prohibition of marijuana and physical proximity to Colorado—a "significant increase in the trafficking" of "Colorado-sourced marijuana" that requires repeated outlay of resources including "personnel time, budget and [allocations of Nebraska's] law enforcement, judicial system, and penal system" to effectively combat. *Id*. at *69. Nebraska's claims of harm are also backed by empirical data. Recreational marijuana legalization in a State adjacent to another State where marijuana remains illegal "causes a sharp increase in marijuana possession arrests in border counties . . . relative to non-border counties."[115] This is exactly what happened in Nebraska—in the wake of Colorado's legalization in 2012, Nebraska saw its arrest rate for marijuana-related offenses increase by 11 percent and expenditures on marijuana-related enforcement correspondingly increased by 11 percent, with the largest increase in both arrests and expenditures being concentrated in Nebraska's southwestern counties that border Colorado border.[116]

Those statistics are consistent with the anecdotal experience from rural Nebraska. For example, Cheyenne County has frequently had so many arrestees that it has run out of space to house them, running up significant transfer and detention expenses.[117] Similar increases in law

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[113] Jeffrey Brinkmann, et al., *Not in my backyard? Not so fast. The effect of marijuana legalization on neighborhood crime*, 78 REGIONAL SCI. & URB. ECON. (Sept. 2019), https://www.sciencedirect.com/science/article/abs/pii/S016604621830293X

[114] Bridget Freisthler, et al., *From Medical to Recreational Marijuana Sales: Marijuana Outlets and Crime in an Era of Changing Marijuana Legislation*, 38 J. OF PRIMARY PREVENTION 249 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6651729.

[115] Zhuang Hao, et al., *The Cross-Border Spillover Effects of Recreational Marijuana Legalization*, National Bureau of Economic Research (May 2017), https://www.nber.org/system/files/workingpapers/w23426/w23426.pdf.

[116] Ryan E. Spohn, *Marijuana Enforcement in Nebraska (2009 –2014)*, Nebraska Center for Justice Research (2016), https://www.unomaha.edu/college-of-public-affairs-and-community-service/nebraska-center-for-justice-research/documents/marijuana-enforcement-in-nebraska.pdf.

[117] *See* Grant Schulte, *Western Nebraska Law Enforcement Cheers Colorado Pot Lawsuit*, CBSNews.com (Dec. 28 2014), https://www.cbsnews.com/colorado/news/western-nebraska-law-enforcement-cheers-colorado-pot-lawsuit/.

enforcement costs threatened to bankrupt Deuel County.[118] And the problem has persisted. In 2017, years after Colorado's recreational marijuana market initially opened for business, Deuel County's sheriff estimated that approximately 60 percent of highway traffic stops in the county involved marijuana.[119] A member of the Nebraska State Patrol, Sergeant Dana Korell, summed things up succinctly: "Marijuana out of Colorado is having a local impact . . . . It is flooding, just flooding the market place. It's everywhere."[120] Noting that law enforcement efforts were being diverted away from other "serious drug problems," Korell said that the influx of marijuana was "just running us ragged."[121] "What do we do? We have limited manpower. We've got limited financial resources to make buys. What do we want to focus on? It's still a felony. It's still a felony in Nebraska."[122]

If there is one critical takeaway from the above—both the statistics and the anecdotes—it is this: Placing marijuana on Schedule III will send a tidal wave of legal marijuana flooding into Nebraska (and similarly situated States that have yet to legalize recreational marijuana but border States that have), that will make previous access expansions look like a drop in the bucket. States like Nebraska, that have no legal marijuana market and thus collect no tax revenue that could help defray the related torrent of increasing costs, shoulder a disproportionate share of the societal burden that flows from expansions of access to legal marijuana. We urge DEA to carefully consider the harms associated with rescheduling and give due consideration to the hardships it would impose on Nebraska and States similarly situated.

* * *

The undersigned States respectfully ask, for the reasons outlined above, that DEA decline to issue a Final Rule that would move marijuana off CSA Schedule I.

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[118] Dave Roberts, *Reefer road trips getting high-priced for Nebraska authorities*, KETVOmaha (Nov. 20, 2013), https://www.ketv.com/article/reefer-road-trips-getting-high-priced-for-nebraska-authorities/7643095.

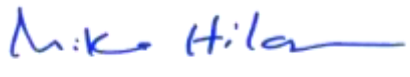
[119] Max Rivlin-Nadler, *This Is Probably the Most Stoned Stretch of Highway in All America*, VICE (April 19, 2017), https://www.vice.com/en/article/53v3kn/buzzkill-county-weed-nebraska-colorado-border-deuel-weedweek2017.

[120] Bill Kelly, *Colorado's medical marijuana is headache for Nebraska law enforcement*, Nebraska Public Media (March 6, 2013), https://nebraskapublicmedia.org/en/news/news-articles/colorados-medical-marijuana-is-headache-for-nebraska-law-enforcement/.

[121] *Id.*

[122] *Id.*

Sincerely,



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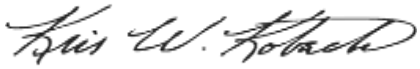

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