No. 20-148

IN THE

Supreme Court of the United States

MARVIN WASHINGTON, *et al.*,

Petitioners,

v.

WILLIAM P. BARR, ATTORNEY GENERAL, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF *AMICI CURIAE* UNITED STATES REPRESENTATIVES IN SUPPORT OF PETITIONERS

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INTERESTS OF *AMICI CURIAE*[1]

Amici are seven United States Representatives who support the Petition asking this Court to find unconstitutional the rigid scheduling of cannabis, including medical cannabis, on Schedule I pursuant to the Controlled Substances Act, despite ample evidence that the qualifications for Schedule I classification are simply not met. Representative Earl Blumenauer represents Oregon's 3rd congressional district. Representative Tulsi Gabbard represents Hawaii's 2nd congressional district. Representative Jared Huffman represents California's 2nd congressional district. Representative Barbara Lee represents California's 13th congressional district. Representative Alan Lowenthal epresents California's 47th congressional district. Representative Mark Pocan represents Wisconsin's 2nd congressional district. And Representative Jamie Raskin represents Maryland's 8th congressional district.

The Representatives are concerned that the current scheduling system under the CSA creates an unconstitutional framework that unfairly burdens their constituents. Specifically, the scheduling of cannabis—including medical cannabis—on Schedule I infringes on constituents' Constitutional rights, including the right to seek life-saving medical care, the right to cross state lines with a medical

[1] This brief is filed pursuant to consent provided by all parties. No person other than amici and their counsel has authored this brief in whole or in part or made a monetary contribution toward its preparation or submission. By email dated September 1, 2020, counsel provided counsel of record for all parties the notice required by Rule 37.2.a.

cannabis prescription valid in the originating state, and even the right to access vital government financial assistance during a pandemic despite operation of state-legal cannabis-related businesses.

Amici are filing this brief to explain to this Court the extent to which the Second Circuit's failure to engage in the constitutional analysis requested by the Petition impacts amici's constituents, an impact that is far broader and more pervasive than the effect on Petitioners alone. Amici also wish to provide an explanation for why the Court should not wait for Congress to take action on descheduling cannabis. A potential legislative solution alone should not preempt this Court acting to resolve a constitutional concern. And in any event, decades of unsuccessful legislative action demonstrates that this politically rife issue is not likely to be resolved at the Congressional level in the near term.

SUMMARY OF ARGUMENT

Fifty years ago, the Controlled Substances Act ("**CSA**") established schedules reflecting the danger of—and attendant regulation and criminality associated with—the drugs on those schedules. Marijuana was initially placed on Schedule I. But the text and legislative history of the statute make clear that the designation on any schedule was intended to be temporary and revisited regularly as science and medical research advanced. Unfortunately, as a result of complicated politics, cannabis has never been moved from Schedule I—despite ample research reflecting not only the safety—but also the medicinal benefits associated

with—certain types of cannabis. Moreover, the current rigid scheduling of medical cannabis is at odds with the viewpoints of the vast majority of Americans; a recent Quinnipiac poll demonstrates that *93% of Americans* support the legalization of medical cannabis.[2]

The continued classification of cannabis as a Schedule I drug is irrational. The Drug Enforcement Administration ("**DEA**"), the federal body charged with enforcing CSA schedules, has repeatedly denied rescheduling petitions. And at least two of the three Schedule I findings relied upon by DEA in denying those petitions, are contradicted by extensive research demonstrating the legitimate and safe medicinal uses of cannabis, including medical marijuana. DEA's failure to follow the text and intent of the CSA as it relates to cannabis—especially medical cannabis that constitutes life-saving treatment for certain medical issues—has had a direct and far-reaching negative impact on American citizens—our constituents.

In light of the fact that many states have legalized medicinal (and recreational) uses of cannabis, the continued rigid federal criminalization of any cannabis use creates a system that infringes on Constitutional rights—the right to interstate travel, to participate in civic life, to contract and engage in interstate commerce, to make life-saving and life-sustaining medical decisions without government

[2] Quinnipiac Univ., QU Poll Release Detail QU Poll (2018), https://poll.qu.edu/national/release-detail?ReleaseID=2539 (last visited Sep 11, 2020).

intervention, and to make decisions guided by a clear, nationally-consistent regulatory scheme.

This Court must take action to remedy the unconstitutional system that has unfairly burdened Petitioners and similarly-situated patients who lawfully use medical marijuana under the supervision of a physician and pursuant to state law. While a legislative solution is theoretically possible, various unsuccessful Congressional attempts to deschedule marijuana have made clear that legislative action is made practically impossible by complicated political realities. Because the current federal scheme violates federal law and infringes on Constitutional rights, the Court should grant certiorari to resolve this matter.

A. Background on Schedule I of the Controlled Substances Act

In the Comprehensive Drug Abuse Prevention and Control Act of 1970, P.L. 91-114, 84 Stat. 1236, Congress consolidated various drug laws into a single statutory scheme, provided for increased regulation to prevent illicit drug use, and expanded law enforcement tools for possession, distribution, and use of certain drugs. H.R. Rep. 91-1444 (1970). Title II of the Act, referred to and known as the Controlled Substances Act, established various drug schedules (Schedules I to V). 84 Stat. at 1427 (now codified at 21 U.S.C. 812(a)).

Each schedule has its own criteria for inclusion, purportedly based on the risks of misuse for the drugs in question. 84 Stat. at 1247-48 (21 U.S.C. § 812(b)). Specifically, Schedule I was reserved for

drugs with "a high potential for abuse," "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety for use of the drug … under medical supervision." 84 Stat. 1247 (21 U.S.C. § 812(b)(1)).

Placement of drugs on the schedules was intended to be fluid and subject to regular review and evaluation. The initial scheduling was done via statute, but the Attorney General was granted authority to shift drugs among the schedules or to de-schedule a drug. Indeed, the initial schedules were supposed to be updated every six months for the first two years following enactment and then "updated and republished on an annual basis" thereafter. 84 Stat. at 1247. The Attorney General was authorized to act on his or her own Motion, at the request of the Secretary for Health and Scientific Affairs, or on "the petition of any interested party." 84 Stat. at 1245-46. (21 U.S.C. § 811(a)).

Marijuana was initially placed in Schedule I—but the statutory language and history make clear that its placement on that schedule was intended to be temporary. The Report accompanying the Act stated that the placement of marijuana was based on the recommendations of the Assistant Secretary for Health and Scientific Affairs, who advised that marijuana should be maintained in Schedule I "at least until the completion of certain studies now underway." H.R. Rep. 91-1444 (1970) at 4579. That was fifty years ago! The Act also established a Commission on Marihuana and Drug Abuse (the "**Commission**") to "conduct a study of marihuana," including a study on the pharmacology of marihuana

and its immediate and long-term effects, both physiological and psychological." 84 Stat. 1236, 1280-81. That Commission's first report unanimously recommended possession of marijuana for personal use should no longer be a criminal offense and that casual distribution of small amounts for no or insignificant remuneration not involving profit would no longer be an offense. Marihuana: A Signal of Misunderstanding at 191. In reporting the views of the medical community, the Commission notes that the "medical fraternity stresses the need for further research into health consequences." *Id.* at 151.

Three years after passage of the CSA, President Richard Nixon established the Drug Enforcement Administration ("**DEA**") with the approval of Congress. President's Reorganization Plan No. 2 of 1973, § 4, 38 F.R. 15932, 87 Stat. 1091; *see also* Reorganization Act of 1949, 63 Stat. 203, as amended 85 Stat. 574 (1971) (granting presidential authority for reorganization). And since 1973, the Attorney General has delegated to the DEA the drug scheduling authority granted by the CSA along with other significant enforcement powers. 28 C.F.R. § 0.100.

Today, under the DEA's authority, marijuana remains a Schedule I drug *despite* Congress's direction to review and evaluate the schedules regularly (and make appropriate changes based on medical data); *despite* Congress's *temporary* placement of marijuana on Schedule I (as made clear by the language of the CSA); and *despite* the new

consensus on safe and efficacious medicinal uses of cannabis.

Even as medical and social views on marijuana in particular (and cannabis generally) have evolved, the DEA has rejected multiple rescheduling petitions, each of which took years or decades to resolve. The first petition, filed in 1972, received its first hearing in 1986 and was not fully resolved in court until 1994. *See Alliance for Cannabis Therapeutics v. Drug Enforcement Admin.*, 15 F.3d 1131, 1133 (1994). In another example from 2016, just one year before the commencement of this action, the DEA rejected a 2009 petition to reschedule marijuana and concluded that all three Schedule I requirements were met, despite overwhelming evidence to the contrary. *Denial of Petition to Initiate Proceedings to Reschedule Marijuana*, No. DEA-427, 81 Fed. Reg. 53767 (Aug. 10, 2016). Relying on a report from the Department of Health and Human Services, the DEA concluded that there were no acceptable medical uses in treatment under Section 812(b) because "the drug's chemistry is not known and reproducible; there are no adequate safety studies; there are no adequate and well-controlled studies proving efficacy; the drug is not accepted by qualified experts; and the scientific evidence is not widely available." *Id.* at 53767. The DEA further ruled that there was no accepted safety for use under Section 812(b) because the Food and Drug Administration ("**FDA**") had not approved any marijuana products and there was no accepted use in medical treatment with or without restrictions. *Id.*

Those decisions by the DEA are irrational, and the unusual events that gave rise to the peculiar federal scheme currently in place make a typical challenge to those agency determinations nearly impossible to mount. Indeed, as the Petition points out, the question of *how* an aggrieved citizen can even make any challenge to the agency determination is the subject of a circuit split that this Court should resolve, with some courts requiring aggrieved parties to raise constitutional challenges before the responsible government agencies first, while others do not impose such an exhaustion requirement where constitutional rights are implicated. Brief of Americans for Safe Access as Amicus Curiae in Support of Petitioners, at 6-7, *Washington v. Barr*, No. 20-148.

Given the constitutional import of this matter to American citizens of all stripes, the Court should grant certiorari and review this case.

B. Research Demonstrates That Medicinal Cannabis—Including Medical Marijuana—Has Legitimate Medicinal and Therapeutic Benefits

The CSA anticipated further research to crystallize the proper scheduling of cannabis. The subsequent scientific evidence has made it abundantly clear that cannabis is a safe and effective treatment with *bona fide* medical benefits.

Two years after passage of the CSA, medical experts offered a consensus opinion to the congressional committee studying the legalization and criminalization of marijuana: "more research"

was needed. Marihuana: A Signal of Misunderstanding at 151-52. At the time, "the systematic study of the clinical pharmacology of cannabis" was in its nascent stages, yet the potential for safe medical use was recognized almost immediately. Department of Health, Education and Welfare, Fifth Annual Report to the U.S. Congress, Marihuana and Health at 112 (1975) (the "**1975 HEW Report**") (modern research was "less than ten years old," having been hampered by scientific limitations and federal regulation). Despite these limitations, the Department of Health, Education and Welfare found evidence of the possible medical use of cannabis for intraocular pressure reduction, anticonvulsant treatments for seizures, and cancer treatments. *Id.* at 112-115. A handful of states soon authorized trial programs involving medical cannabis. *See, e.g.*, Controlled Substances Therapeutic Research Act, N.M. Stat. § 26-2A-1 *et seq.* (eff. 1978); Va. Code § 18.2-251.1 (allowing prescription for glaucoma) (eff. 1979).

In 1985, the FDA approved a synthetic cannabis-related drug called dronabinol, which was shown to relieve nutritional complications suffered by patients with AIDS. Beal JE, et al. 1995; Beal JE, Olson R, Lefkowitz L, Laubenstein L, Bellman P, Yangco B, Morales JO, Murphy R, Powderly W, Plasse TF, Mosdell KW, Shepard KV. 1997. "Long-term efficiency and safety of dronabinol for acquired immunodeficiency syndrome-associated anorexia." *Journal of Pain Management* 14:7-14. By 1988, the growing evidence of state-sanctioned and surreptitious cannabis treatments—including the results of New Mexico's program—led an

Administrative Law Judge to recognize three "accepted medical use[s] in treatment": controlling the severe nausea and vomiting associated with chemotherapy; intraocular pressure reduction for relieving glaucoma; and treating the spasticity associated with multiple sclerosis, hyperparathyroidism, and other causes. *In re Marijuana Rescheduling Petition*, Opinion and Recommended Ruling, No. 86-22 (U.S.D.O.J. Sep't 6, 1988) (Francis L. Young, ALJ).

The medical uses of cannabis are well supported by other research. *See, e.g.*, Miles Herkenham *et al.*, *Cannaboid receptor localization in the brain*, PROCEEDINGS OF THE NAT'L ACAD. OF SCIS. (Mar. 1, 1990). In 1999, existing data led the National Academy of Sciences to publish a consensus report recommending clinical trials on cannabinoid compounds for use in future drug development. Institute of Medicine. 1999. Marijuana and Medicine: Assessing the Science Base. Washington, DC: The National Academies Press. Research on existing and potential new uses of cannabis continues today. *See, e.g.*, NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, THE HEALTH EFFECTS OF CANNABIS AND CANNABINOIDS, at 98-99, 116 (Washington, DC: The National Academies Press 2017) (cannabis as a treatment option for multiple sclerosis, and PTSD and chronic pain in military veterans).

Indeed, in recognition of the medical utility of cannabis, the United States government itself has ***two*** patents on medical cannabis—U.S. Patent No. 6,630,507 (issued Oct. 7, 2003) & Government of the

United States Patent, 1. WO1999053917-Cannabinoids As Antioxidants and Neuroprotectants, Patentscope, https://patentscope.wipo.int/search/en/detail.jsf?docId=WO1999053917 (last visited Sept. 11, 2020).

The medical consensus on safe therapeutic uses of cannabis led to an expansion of state laws permitting medical marijuana. Some of these laws were enacted by the people through referendums: *e.g.*, California voters approved the first full-fledged medical marijuana program in the country in 1996, and Oklahoma voters approved its program in 2018. Cal. Health & Safety Code § 11362.5; 63 Okla. Stat. § 420 *et seq*. Others were passed by state legislative bodies. *See, e.g.*, Pa. Stat. § 10231.101 *et seq*. Today, thirty-three states (along with Washington, D.C. Puerto Rico, and certain territories) have comprehensive medical marijuana programs. Nearly all of the remaining states allow low-THC-content products or cannabidiol oil, and/or have pending legislation expand access to medicinal cannabis.

The federal government has responded favorably to evidence of the medical benefits of cannabis even as marijuana remains a Schedule I drug. In addition to drobinol, the FDA approved cannabidiol (a cannabis-derived drug) and nabilone (another synthetic cannabis-related product), and the FDA's compassionate use programs for cannabis drug development reflect support for "sound, scientifically-based research into the medicinal uses of drug products containing cannabis or cannabis-derived compounds." *FDA and Cannabis: Research*

and Drug Approval Process, U.S. FOOD & DRUG ADMIN. (Aug. 3, 2020), https://www.fda.gov/news-events/public-health-focus/fda-and-cannabis-research-and-drug-approval-process (last accessed Sept. 10, 2020).

Despite this research, the raft of evidence showing the medical benefits of marijuana for certain patients, and despite the clear statutory language of (and the intent behind) the CSA, Congress failed to enact the Commission's original recommended course of action, and no Presidential administration or subsequent Congress has changed the placement of marijuana on Schedule I.

C. Failure to Deschedule Cannabis Has Directly and Negatively Impacted American Citizens Throughout the Country

While cannabis remains on Schedule I, the cost to American citizens—our constituents—has been tremendous and multifaceted. Blanket federal prohibition of cannabis continues to burden medical patients and market participants alike. This is particularly appalling in light of the glaring inconsistencies the Petition points out with respect to other federal policies including funding riders and non-enforcement policies by the Department of Justice. In addition to the individual plights described in the Petition and other amicus briefs, we want to focus on a few that demonstrate the manner in which American citizens have been harmed by the improper placement of cannabis on Schedule I.

The Cannabis Industry. Americans who are involved in state-legal cannabis-based businesses have been severely restricted in their ability to access capital and financing opportunities. Because cannabis is listed on Schedule I, most banks refuse to offer loans to cannabis-related enterprises for fear of finding themselves in violation of federal law. Most recently, cannabis businesses were denied relief under the Economic Injury Disaster Loan Program (offered by the Small Business Association to offset Covid-19 related business losses). SBA Policy Notice Re: Revised Guidance on Credit Elsewhere and Other Provisions in SOP 50 10 5(J) (Apr. 3, 2018) at 1-2 (citing 13 C.F.R. § 120.110(h), available at https://www.sba.gov/sites/default/files/resource_files/SBA_Policy_Notice_5000-17057_Revised_Guidance_on_Credit_Elsewhere_and_Other_Provisions.pdf; Colo. Dep't of Pub. Health and Envn't, Amended Public Health Order 20-24 at III.C.4 (Mar. 25, 2020) (defining "critical retail" to include "marijuana dispensary (only for the sale of medical marijuana or curbside delivery pursuant to an executive order). This limitation is particularly egregious give the fact that that many states designated certain cannabis-related businesses as "essential," *i.e.*, allowed to operate during many state's lockdown periods. *See, e.g., CommCan, Inc. v. Baker*, No. 2084CV00808-BLS2, 2020 WL 1903822 (Mass. Sup. Ct. Apr. 16, 2020).

Constituents who have experienced discrimination—in the workplace or otherwise—as a result of their medical cannabis use have limited legal recourse. For example, because of the technical

designation many are unable to bring suit under the Americans with Disabilities Act to redress their harm. *See, e.g.*, *James v. City of Costa Mesa*, 700 F.3d 394, 397 (9th Cir. 2012) ("Congress has made clear, however, that the ADA defines 'illegal drug use' by reference to federal, rather than state, law, and federal law does not authorize the plaintiffs' medical marijuana use. We therefore necessarily conclude that the plaintiffs' medical marijuana use is not protected by the ADA."); see also 42 U.S.C. § 12210(a), § 12210(d) (excluding an individual currently engaging in illegal use of drugs from definition of "qualified individual with a disability" and specifying illegal use of drugs as use prohibited by the Controlled Substances Act).

Veterans have been arrested for their use of medical cannabis, legally prescribed to address ailments that resulted from their service. For example, in 2016, Sean Worsley, a permanently disabled veteran who was honored with a Purple Heart after his service in Iraq, was arrested in Alabama for possession of medical cannabis. Mr. Worsley was on his way from Arizona—where he was legally prescribed the cannabis to treat PTSD—to North Carolina to assist his grandmother recovering from Hurricane Matthew. This 2016 arrest led to a spiral of legal and financial burdens for Mr. Worsley that continue to this day. *See* Teo Armus, *A disabled black veteran drove through Alabama with medical marijuana. Now he faces five years in prison*, WASH. POST, July 14, 2020; Andrew Keiper, *Disabled Iraq veteran faces five years in Alabama prison for legally prescribed medical marijuana,* FOX NEWS, Aug. 3, 2020.

REASONS FOR GRANTING THE WRIT

I. In Light Of Research Showing Medical Efficacy, Rigid Application Of Schedule I To All Uses Of Cannabis Presents Constitutional Concerns As Applied To Petitioners

Classifying cannabis as a Schedule I drug is now clearly improper under federal law. Indeed, Congress made clear that "the findings required for such schedule" must be made "with respect to such drug or other substance." 21 U.S.C. § 812(b). The medical consensus regarding the safe therapeutic uses of cannabis (including medical marijuana) is well developed in the relevant scientific literature, providing more than enough support for descheduling. Moreover, although the DEA could have granted one of the previously-filed petitions, it is permitted—and is in fact required—to initiate its own reviews and reconsider its position where appropriate by descheduling any drug which no longer satisfies the relevant criteria. See 21 U.S.C. § 812(a) (requiring annual updating and publishing of drugs listed on the schedules); *id.* at § 812(b) (prohibiting the listing of a drug "in any schedule unless the findings required for such schedule are made with respect to such drug…"). The DEA, in holding fast to its position that cannabis lacks of any "accepted medical use in treatment in the United States" or "accepted safety for use," is ignoring not only FDA-approved cannabis treatments, but also the innumerous studies demonstrating safe and effective uses of cannabis under medical supervision, the benefits of cannabis use, and the widespread acceptance of medical marijuana as a

treatment for emesis, glaucoma, spasticity, and other disorders and symptoms in thirty-three states.

The DEA's decision in 2016 to deny a rescheduling request is evidence of its overly-narrow view of the scientific record and legal landscape. In finding the absence of "acceptable medical use in treatment in the United States," DEA found that, *inter alia*, the "scientific evidence is not widely available" and that "the drug is not accepted by qualified experts, " despite the many peer-reviewed studies appearing in national medical and scientific journals and reported by the National Academies of Science and Medicine. 1 Fed. Reg. at 53767. With respect to "accepted safety for use," DEA relied primarily on the absence of FDA-approved or pending marijuana products as well as the existing conclusion that marijuana lacked an accepted medical use. *Id.* Given that more than two-thirds of the states have authorized medical marijuana on the advice of medical experts who have accepted it as a safe means of treatment, DEA's conclusions would seem to require *total acceptance nationwide* to approve a descheduling request or act on its own initiative to deschedule a drug.

To suggest that a Schedule I drug must be medically accepted in *every state* or, in this case, that all cannabis-related drugs must obtain *full approval* by the FDA to reschedule medical marijuana, is to add a requirement to Schedule I classification that ***does not exist***. *See, e.g., Grinspoon v. Drug Enforcement Admin.*, 828 F.2d 881, 886 (1st Cir. 1987) (FDA approval not required because Congress defined United States broadly to "regulate[] conduct

occurring *any* place, as opposed to *every place*, within the United States."); *see also* 21 U.S.C. § 812(b) (factors); 21 U.S.C. § 802(28) (definition of United States); *John Doe, Inc. v. Drug Enforcement Admin.*, 484 F.3d 561, 571 (D.C. Cir. 2007) (holding that FDA *approval* may establish "currently accepted medical use and accepted safety use" even if "the *absence* of FDA marketing approval may not be a reasonable proxy for a lack of currently accepted medical use" as found by the First Circuit in *Grinspoon*); *U.S. v. Piaget*, 915 F.3d 138 (recognizing holding in *Grinspoon* but accepted scheduling of drug based on thorough record beyond FDA's refusal to grant marketing approval).

Amici agree with the rule set forth in these cases, and DEA cannot find that cannabis should remain on Schedule I based on the absence of FDA approval or because cannabis is not authorized in every state.

For Petitioners in particular, this irrational treatment of cannabis as a Schedule I drug imposes an unconstitutional burden. As the Petition correctly argues, *Cruzan v. Missouri*, 497 U.S. 261 (1990) is directly on point. In that case, the constitutional issue was the right to refuse life-saving medical intervention under the Fifth Amendment's due process clause; here, the converse should be true as well. Indeed, *Cruzan* found that the right to refuse treatment arose out of the right to informed consent, itself derived from the long-standing principle of "bodily integrity:"

> "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual

> to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891).

497 U.S. at 269. Moreover, as recognized by Justice O'Connor in a concurring opinion, this Court has long recognized an individual's right to be free from "state incursions into the body repugnant to the interests protected by the Due Process Clause" and other constitutional limitations. *See Cruzan*, 497 at 287 (O'Connor, J., concurring) (citing *Rochin v. California*, 342 U.S. 165 (1952) (recognizing as impermissible the act of removing material from petitioner's mouth and stomach); *Winston v. Lee*, 470 U.S. 753 (1985) (compelled surgical intrusion may be unreasonable under Fourth Amendment)). The irrational classification of cannabis prevents Petitioners from continuing a course of safe and accepted medical treatment supervised by their physicians, without violating federal law or sacrificing constitutional rights, thus violating the Fifth Amendment.

II. The *Potential* For A Legislative Solution—While Theoretical—Does Not Alleviate This Court's Obligation to Resolve the Constitutional Concerns Identified In The Petition.

Congress has the authority to modify the placement of substances under the Controlled Substances Act by statute. But the mere ability of

Congress to act does not permit the Court to avoid its obligation to address the Constitutional concerns raised by the Petition. Indeed, given the history of Congressional inaction in this area, it would be inappropriate to presume that a theoretical legislative solution precludes the need for this Court to provide Constitutional redress to the Petitioners.

This Court has consistently adhered to the principle that its resolution of cases or controversies validly before it is not contingent on potential legislative solutions. Indeed, this past Term, in *Bostock v. Clayton County, Georgia*, Nos. 17-1618, 17-1623, 18-107, 140 S. Ct. 1731 (June 15, 2020), this Court considered whether the term "sex" as set forth in Title VII of the Civil Rights Act of 1964 extended the statute's reach to employment decisions affecting gay and lesbian employees. Notwithstanding the fact that the Court was aware that bills to clarify Title VII's definition of "sex" were pending at the time of the decision, *id.* at 1755 (Alito, J., dissenting), this Court rejected the proposition that Congressional inaction could support a decision to abstain from deciding the controversy. *Id.* at 1747 (majority opinion). Instead, this Court decided the statutory interpretation issue without waiting for Congress to act and resolve the issue legislatively. *Id.*

Similarly, in *United States v. Windsor*, 574 U.S. 744 (2013), this Court invalidated a portion of the Defense of Marriage Act as violations of the Due Process Clause and Equal Protection principles applicable to the Federal Government. *Id.* at 769-770. While one of the dissenting opinions identified

various pieces of legislation being considered to address the statute's definition of marriage, *id.* at 801 (Scalia, J., dissenting), this Court proceeded to invalidate the federal statute: "though Congress has great authority to design laws to fit its own conception of sound national policy, it cannot deny the liberty protected by the Due Process Clause of the Fifth Amendment." *Id.* at 774.

Here, the Petition presents the Court with a valid controversy challenging the irrational and unconstitutional effect of cannabis placement Schedule I of the CSA, both as applied to Petitioners and on the face of the statute. This Court should act to resolve the questions presented, regardless of Congress's ability to act.

Indeed, Congress's history of inaction in the area of cannabis legislation suggests more strongly that the prospect of a legislative solution cannot realistically be grounds for this Court not to act. In the 116th Congress alone, at least twelve separate bills[3] would re-schedule cannabis off of Schedule I or

[3] Ending Federal Marijuana Prohibition Act of 2019, H.R. 1588; Homegrown Act of 2019, H.R. 3544; H.R. 3754 (To amend the Controlled Substances Act to provide for a new rule regarding the application of the Act to marihuana, and for other purposes); Marijuana 1-to-3 Act of 2019, H.R. 4324; Marijuana Freedom and Opportunity Act, S. 1552 & H.R. 2843; Marijuana Justice Act of 2019, S. 597 & H.R. 1456; Marijuana Opportunity Reinvestment and Expungement Act of 2019, H.R. 3884 & S.2227; Marijuana Revenue and Regulation Act, S. 420 & H.R. 1120; Next Step Act of 2019, H.R. 1893 & S. 697; Regulate Marijuana Like Alcohol Act, H.R. 420; Substance Regulation and Safety Act of 2020, S. 4386; Veterans Medical Marijuana Safe Harbor Act, S. 445 & H.R. 1151.

permit veterans to use medical marijuana pursuant to a prescription; however, only ***one*** such bill has even received a vote in a committee.[4] Moreover, most of the bills introduced into the 116th Congress were also introduced in the 115th Congress, and met with similar inaction by Congress. And the Ending Federal Marijuana Prohibition Act has been introduced in every Congress since 2011—and yet never received a vote.[5]

The practical reality is that Congress's ability to act in this arena is made nearly impossible by various political and logistical causes. And the DEA, the only empowered federal agency, is simply ill-suited to address these constitutional claims; and, in any event, grievances would have to be part of yet another rescheduling petition, which, average *nine years* for resolution. Am. Compl. (Dkt. No. 23) at ¶ 357, *Washington v. Sessions*, No. 17-cv-5625-AKH (S.D.N.Y.). What these impediments fail to reflect is that over 90% of Americans support legalization of medical cannabis. For these Americans who are seeking justice—in the form of descheduling life-

[4] The Marijuana Opportunity Reinvestment and Expungement Act of 2019, H.R. 3884, was favorably reported by the House Committee on the Judiciary on November 21, 2019. Although media reports suggest the bill may be considered by the full House in September 2020, no rule providing for its consideration has yet been introduced. The Senate companion bill, S. 2227, was referred to the Senate Committee on Finance on the date of its introduction and neither the Senate nor its Finance Committee have taken further action on that bill.

[5] H.R. 2306 (112th Congress); H.R. 499 (113th Congress); S. 2237 (114th Congress); H.R. 1227 (115th Congress); H.R. 1588 (116th Congress).

saving cannabis—justice delayed is in fact justice denied. This Court is not required to—nor should it—rely upon Congress to remedy the Constitutional issues the Petition presents.

CONCLUSION

For the foregoing reasons, in addition to those in the Petition, the writ should be granted.

Respectfully submitted,

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