

CANNABIS ADOPTION AFTER LEGALIZATION: WHY MEDICAL PROGRAMS DEMONSTRATE PERSISTENT, IRREVERSIBLE GROWTH

State-level legalization of medical cannabis consistently follows a **predictable adoption pattern**: an initial surge in certified users, followed by a deceleration in growth rates—but **not** a collapse in usage. Instead, programs transition into a durable, renewal-driven phase characterized by persistent participation, high utilization, and expanding medical integration.

Using Pennsylvania, Missouri, and Utah as case studies, this paper demonstrates three core findings:

1. The first year of legalization accounts for only ~25% of today's active medical cannabis certifications.
2. Growth rates slow over time, but the absolute number of users and renewals remains large.
3. Once adoption reaches scale, utilization becomes persistent and structurally embedded.

These dynamics provide critical context for understanding the likely impact of President Donald Trump's executive action on December 18th, 2025 to reschedule cannabis from Schedule I to Schedule III. As research access, prescribing comfort, and institutional participation expand, cannabis is positioned to follow the same adoption trajectory observed in other newly legitimized medical therapies: accelerating use, deeper integration, and irreversibility.

I. The Medical Cannabis Adoption Curve: A Three-Phase Pattern

Across states, medical cannabis adoption follows a consistent lifecycle:

Phase 1 – Launch (Years 0–1)

- Rapid enrollment growth
- High percentage increases
- Public awareness and unmet demand are released

Phase 2 – Expansion (Years 2–5)

- Percentage growth slows (law of large numbers)
- Absolute net additions peak
- Renewal volumes rise sharply

Phase 3 – Maturity (Years 6+)

- Enrollment plateaus at scale
- Renewal and utilization dominate
- Program behaves like a chronic-care registry

Critically, slowing growth rates do not imply declining relevance. Instead, they signal maturation.

II. Case Studies: Pennsylvania, Missouri, and Utah

Pennsylvania: Scale Without Reversal

- Medical dispensaries opened in 2018
- Active certifications plateaued around ~440,000 by 2024–2025
- Only ~15% of current certifications originated in the first year

Despite flattening enrollment, Pennsylvania continues to process millions of dispensing events annually, demonstrating that mature programs sustain heavy medical utilization even when net growth stabilizes.

Key Insight: Plateau ≠ decline. Pennsylvania illustrates how medical cannabis reaches durable saturation rather than fading.

Missouri: Slowing Growth, Massive Additions

- First full program year: 2020
- Active patients grew from ~69,000 (2020) to ~206,000 (2022)
- First-year participants represent ~34% of the current base

Most notably, Missouri’s renewal volume doubled as the program matured, indicating that patient retention—not novelty—drives long-term scale.

Key Insight: Even after the fastest growth year passes, absolute patient additions remain substantial.

Utah: Persistent Growth and High Utilization

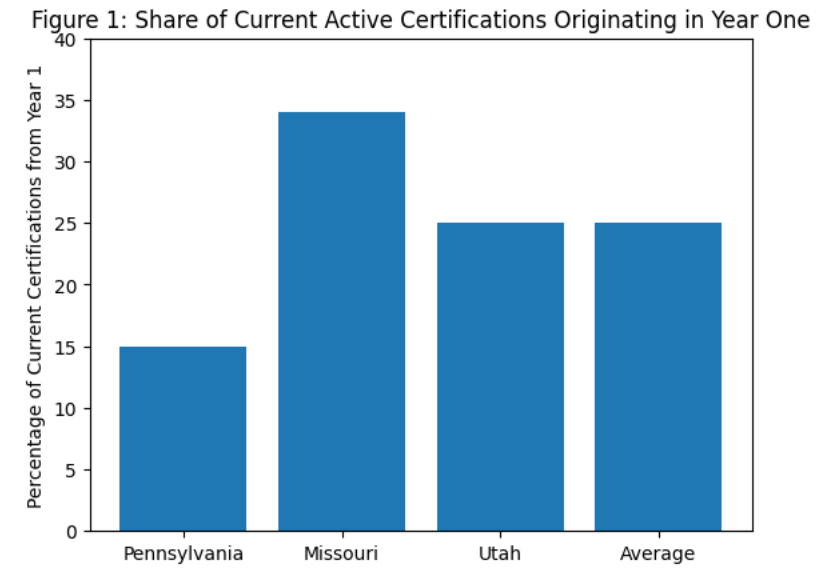
- Medical cards issued beginning 2020
- Active patients exceeded 106,000 by late 2025
- First-year users account for only ~23–28% of today’s base
- ~56% of active patients made a purchase in the prior 30 days

Utah demonstrates that even smaller, more restrictive programs sustain high ongoing usage intensity.

Key Insight: Medical cannabis behaves like a recurring-use therapy, not a one-time treatment.

III. First-Year Adoption Is Not the Story

Figure 1: Share of Current Active Certifications Originating in Year One



State	% of Current Certifications from Year 1
Pennsylvania	~15%
Missouri	~34%
Utah	~25%
Average	~25%

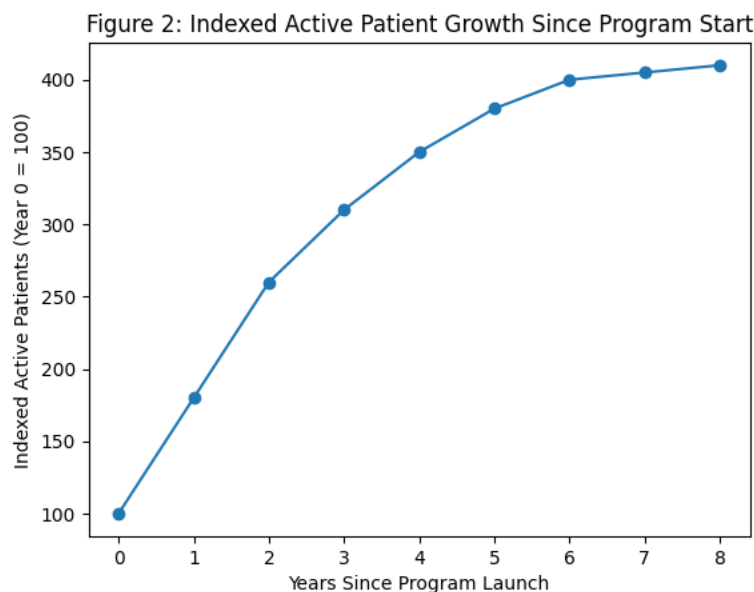
Figure 1 Note:

Data derived from publicly available state medical cannabis program reports and Advanced Training Products' analysis of active patient certification cohorts. Percentages reflect the estimated share of currently active medical cannabis certifications originating in each program's first full year of operation. Values are rounded and presented to illustrate cohort persistence rather than exact enrollment counts.

Conclusion: Approximately 75% of all medical cannabis users enter programs after the first year. This finding directly refutes the argument that legalization merely front-loads demand.

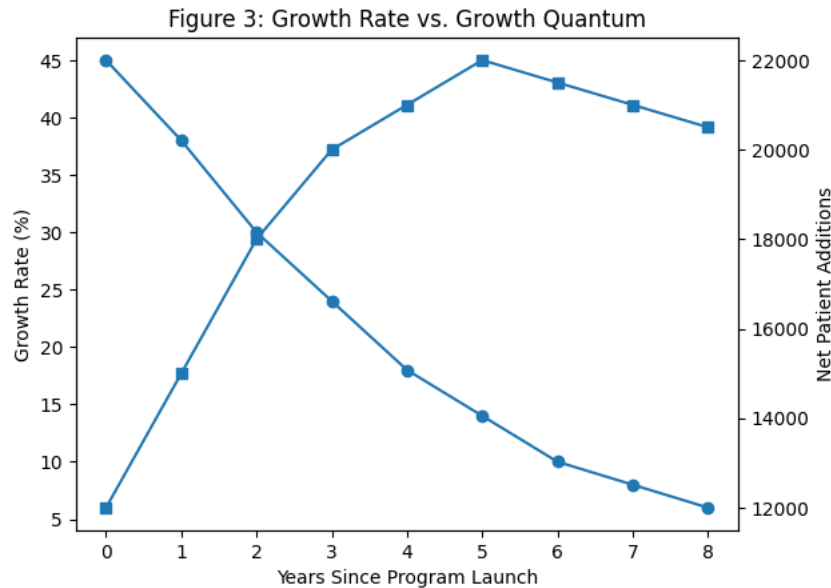
IV. Growth Rates Slow—But Growth Does Not Stop

Figure 2: Indexed Active Patient Growth Since Program Start

**Figure 2 Note:**

Active patient counts are indexed to Year 0 (program launch = 100) to enable comparison of growth trajectories independent of absolute program size. Indexed values reflect longitudinal program behavior rather than precise patient totals.

Figure 3: Growth Rate vs. Growth Quantum



- Growth rate (%): declines steadily
- Net additions (#): remain large well into maturity

This distinction is critical: slower growth does not mean shrinking relevance. Large installed bases generate renewals, utilization, and economic activity indefinitely.

Figure 3 Note:

Growth rate (%) represents year-over-year change in active patient counts. Net additions (#) reflect absolute increases in active certifications. This figure illustrates scale effects observed as medical cannabis programs mature, wherein percentage growth moderates while absolute participation remains substantial.

V. Federal Rescheduling as an Adoption Catalyst

President Trump’s executive action to reschedule cannabis from Schedule I to Schedule III fundamentally changes the trajectory outlined above.

Historically, when substances move into:

- formal research pipelines,
- reimbursable medical frameworks,
- physician-accepted treatment protocols, their adoption accelerates rather than contracts.

Schedule III status enables:

- Expanded clinical trials
- Increased physician comfort
- Institutional participation
- Insurance and reimbursement pathways

Medical cannabis is entering Phase 2 nationally—at the federal level. The state-level evidence strongly suggests this will add new adoption layers, not replace existing ones.

VI. Why This Cannot Go Backward

The persistence of cannabis adoption is not only clinical—it is structural.

Once millions of patients:

- hold certifications,
- transact legally,
- renew annually,
- and integrate cannabis into chronic care, the financial system adapts around them.

Conclusion

Medical cannabis adoption is durable, compounding, and persistent. State data from Utah, Pennsylvania, and Missouri show that legalization initiates—not completes—the adoption cycle. Federal rescheduling now extends this process nationally.

The evidence is clear: Cannabis adoption does not spike and fade. It scales, stabilizes, and embeds.

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FOOTNOTES & SOURCES:

1. PENNSYLVANIA DEPARTMENT OF HEALTH. *MEDICAL MARIJUANA PROGRAM ANNUAL REPORTS AND MEDICAL MARIJUANA ADVISORY BOARD UPDATES* (2018–2025).
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3. UTAH DEPARTMENT OF HEALTH AND HUMAN SERVICES. *MEDICAL CANNABIS PROGRAM ANNUAL AND QUARTERLY REPORTS* (2020–2025).
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5. CONGRESSIONAL RESEARCH SERVICE. *CONTROLLED SUBSTANCES ACT: OVERVIEW OF SCHEDULING AND RESCHEDULING PROCESSES*.
6. U.S. FOOD AND DRUG ADMINISTRATION. *HISTORICAL CASE STUDIES ON DRUG RESCHEDULING AND POST-RESCHEDULING ADOPTION DYNAMICS*.

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