

AN INDUSTRY WHITE PAPER

FOR CONCIERGE, MEMBERSHIP, AND CONSUMER HEALTH PRACTICES

State of Concierge and Consumer Medicine, 2026

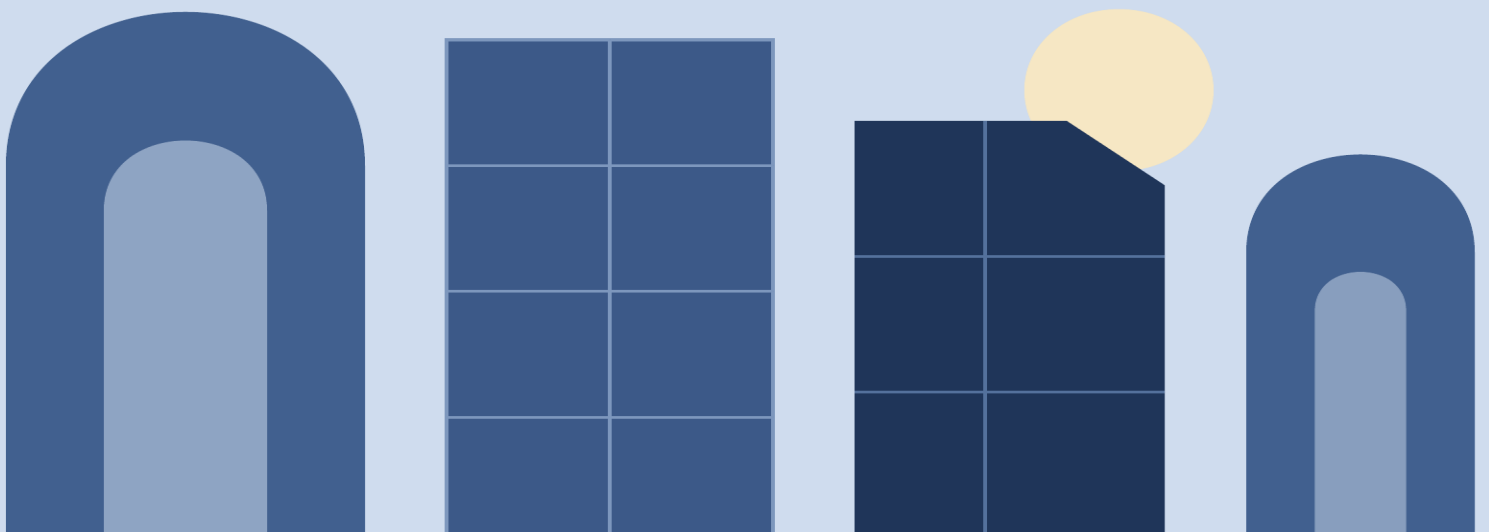
*Membership Economics, Capital, and Strategic Considerations
for Physician- and Founder-Led Practices*

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with strategic commentary from:

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INTRODUCTION

Concierge Medicine Has Moved From a Niche Practice Style to a Capital-Backed Category

Membership-based primary care, direct primary care, and the consumer-health businesses growing up alongside them — longevity clinics, biomarker testing, hormone optimization, medical weight management — are attracting sustained attention from private equity firms, family offices, insurers, and consumer-health strategics.

What began as a way for individual physicians to shrink their panels and practice differently has become an investable category with national brands, regional platforms, and a deep bench of enablement companies.

Five years ago, concierge practice physician-owners were asking whether membership medicine works, and now they are asking where their practice fits as this segment of the industry undergoes substantial growth, investment, and consolidation.

MARKET FORCES DRIVING INTENSIFIED INTEREST IN CONCIERGE AND CONSUMER MEDICINE

Concierge and consumer-health practices sit where cash-pay economics, unmet demand for access, and clinical credibility intersect — a combination that continues to pull capital toward the category.

• Primary Care Economics

Traditional primary care practice is becoming difficult to sustain due to patient panels of 2,000 or more, rising documentation burden, and reimbursement that has not kept pace with rising costs. Membership models restore time per patient and produce predictable income, which is why conversions are increasingly led by experienced, highly reputable physicians.

• Recurring, Cash-Pay Revenue

Annual and monthly memberships are prepaid, largely insulated from reimbursement risk, and historically low-churn. They generate favorable working capital dynamics and revenue visibility that few provider specialties offer — the single most cited reason investors describe the category as highly attractive.

• Consumer Demand and Behavior

Patients who cannot get a timely appointment, or who want prevention rather than problem-based visits, are willing to pay out of pocket for direct access and one-on-one relationships with their providers. Younger consumers track real-time health data through wearables and biomarker panels, pursue metabolic therapies, and then look for a physician to interpret and manage what they find.

• Room to Consolidate

A handful of national brands sit above a much larger population of regional groups and independent, single-site practices, many of which are run by a physician who converted their practice to a concierge model on their own. The result is genuine whitespace for platform formation, regional density, and multistate scale.

THE PRACTICE LANDSCAPE

The category spans a wider range of structures than the term "concierge" suggests:

- full-conversion practices that don't bill any insurance carriers at all;
- hybrid programs in which a subset of a panel buys membership while the practice continues to bill payors;
- direct primary care practices priced for the middle market;
- ultra-premium family models (with under 50 households per physician);
- urgent and acute-care clubs; and
- longevity clinics selling diagnostics, hormone optimization, and performance programs on a subscription basis.

Around all of them sits a services layer — conversion consultants, management companies, and consolidator platforms — that lets a physician adopt the model that best fits their short- and long-term goals and objectives.

Investors evaluate these models through a consistent lens: membership retention, panel discipline, conversion yield, dependence on any single physician, compliance posture, and whether the economics scale beyond the founder. No single structure is right for every practice, and the strongest response depends on market, brand, payor mix, and the owner's time horizon.

How to use this paper. The sections that follow set out how membership economics create enterprise value, who is buying and building in the category today, regulatory compliance considerations, what capital partners underwrite when they evaluate a practice, and the strategic paths available to owners, including remaining independent.

BUSINESS MODEL

The Membership Flywheel and the Integrated Concierge – Longevity Practice

Investor-backed concierge platforms expand through three strategic models:

- 1. converting established primary care practices to membership;
- 2. acquiring or affiliating with practices that have already converted; and
- 3. building de novo clinics in markets with demonstrated willingness to pay.

Most national brands employ more than one model. More recently, longevity and functional medicine practices have scaled from boutique clinics into regional networks. As a result, concierge groups have begun adding these services too.

The revenue model has followed. Where the membership fee once purchased access alone, it increasingly functions as the base layer of a broader relationship that includes advanced diagnostics, hormone and metabolic care, and aesthetics. Investor platforms are not buying a book of patients; they are buying a renewing relationship (i.e., recurring revenue), the brand and care model that sustains it, and the infrastructure required to expand into other markets.



In membership medicine, the asset is not patient volume — it is a renewing relationship. Retention, panel discipline, and physician alignment are the economics, and everything else is downstream.

— VECTOR MEDICAL GROUP × BAKER DONELSON, STATE OF CONCIERGE & CONSUMER MEDICINE 2026

WHERE VALUE IS CREATED IN THE INTEGRATED MODEL

- 1 Convert access into recurring revenue.** A well-priced annual prepaid membership produces revenue visibility and predictability, reduces collection risk, and materially changes how the practice is valued relative to a fee-for-service primary care practice of the same size.
- 2 Extend the relationship beyond the membership fee.** Add-on services, such as diagnostics, hormone optimization, weight management, wellness, and aesthetics, raise revenue per member without raising panel size.
- 3 Protect panel discipline.** Small panels are the product. Groups that let panels drift upward to chase short-term revenue erode the differentiation that members value and pay for, and that erosion is reflected in the next renewal cycle.
- 4 Build enterprise value that outlives any one physician.** Brand, care model, specialist network, technology, and central operations are what a buyer can underwrite when a founding physician retires; personal reputation alone is not transferable.

SEGMENTATION: FEES, PANELS, AND WHAT EACH TIER IMPLIES

SEGMENT	TYPICAL ANNUAL FEE	PANEL PER PHYSICIAN	STRATEGIC CHARACTERISTICS
Standard/DPC	Under roughly \$5,000; often monthly	400 – 600+	Broadest addressable market; most exposed to employer, ICHRA, and HSA-linked payment rails. Scale depends on conversion and marketing efficiency.
Premium/Deluxe	Roughly \$5,000–\$15,000	Approximately 150 – 400	Where most sponsor-backed platform formation is concentrated; supports ancillary services and the strongest renewal economics.
Ultra-Premium	Above \$15,000, often materially	Fewer than 50 members or families	Scarce and brand-dependent; growth is constrained by physician recruitment rather than demand.
Longevity and Functional	Program- or subscription-priced	Not panel-based	Highest marketing intensity and least settled regulatory terrain; increasingly built or acquired as a service line inside concierge platforms.

CAPITAL AND CONSOLIDATION

Select Concierge and Membership Primary Care Platforms

Consolidation Platforms (Actively Acquiring)

PLATFORM	INVESTOR(S) / START DATE	LOCATIONS & OTHER DETAILS	SELECT AFFILIATED GROUPS
	Privately owned (2026)	4 clinics in IN & NY 20+ MDs ~250 members/MD	 
	Revelstoke Capital Partners (2025)	3 clinics in FL; 11 MDs; ~300 members/MD	
	Privately owned (2025)	3 clinics in FL & NJ 6 MDs	
	Boyne Capital, Platt Park Capital & Capitala Group (all 2025)	3 clinics in CO; 3 MDs Focus on longevity	
	Shore Capital Partners (2024)	14 clinics in MO WI, OH, IA, MI, NE Longevity-focused model	  
	L Catterton (2026); Blue Sea Capital (2019)	National (35 states); 250 MDs; 300-600 members /MD	Many in multiple states on website in “find doctors”. Major acquisitions:  
	Markel Corp (2011)	8 clinics in VA, MD, NC, SC & GA; 40+ MDs 200-400 members/MD	

Source: Vector Medical Group x Baker Donelson platform tracking based on multiple press releases, articles, and platform websites.

CAPITAL AND CONSOLIDATION

Select Concierge and Membership Primary Care Platforms

Corporate/De Novo Growth and Franchise Models

*Several are open to growth acquisitions

PLATFORM	INVESTOR(S) / START DATE	LOCATIONS & OTHER DETAILS	SELECT AFFILIATED GROUPS
	FUSE; Aurum Partners, and other VC investors (2026)	National – virtual telemedicine, direct primary care model supported by AI Platform; 9 MDs	
	Shore Capital Partners (2023)	17 clinics in CO, TX, IL, VA & WI; 100+ MDs ~500 members/MD Concierge and Direct Primary Care Model	
	Privately Owned (2022)	9 clinics in NY, NJ & FL 30 MDs Proprietary App for patient communication 24/7 Open 365 days in person	
	Private individuals and venture capital (2020)	Multiple corporate-owned and JV locations in: TX, FL, CA, NY	
	Privately owned (2016) Concierge urgent care and pediatric primary care	14 clinics in NY, CA & FL 15+ MDs 400-500 members/MD	
	Private individuals and venture capital (2016)	Multiple franchise locations in: CA, NY, HI, TN, FL, IL, AZ, CO, MA, NV	
	Private individuals and venture capital (2015)	2 corporate-owned locations in CA	

Source: Vector Medical Group x Baker Donelson platform tracking based on multiple press releases, articles, and platform websites.

CAPITAL AND CONSOLIDATION

Select Concierge and Membership Primary Care Platforms

Management & Conversion Consulting Companies

PLATFORM	INVESTOR(S) / START DATE	LOCATIONS & OTHER DETAILS	SELECT AFFILIATED GROUPS
	NexPhase Capital (2025)	41 clinics in AZ, CA, CO, CT, IL, MA, MD, NJ, NV, NY, OR, PA, TN, TX, VA & WA 82 MDs (2 MDs/clinic) 50 families/MD	High-end model: \$30,000/yr base fee per member (extra per additional family member)
	Privately owned (2022)	Manages elite concierge and longevity practices in 14 states	   
	Shore Capital Partners (2015); founded in 2022	Consultants nationally for medical practices converting to concierge model, as well as ongoing practice support	
	Goldman Sachs and Charlesbank (2021); Leonard Green (2017); Summit Ptrs (2014); P&G (2009); Summit Ptrs (2004)	National (45 States); 1,400 MDs; 450,000 members (pts); ~600 members/MD “Conversion model”	Hundreds identified on website under “Find a Doctor” (dozens in many states)
	Privately owned (2014)	Many states including: NY, NJ, FL, AZ, DC, CO, CT, WA, DE & PA 70 clinics; 18,000+ members 500+ MDs; 400 members /MD	    
	Privately owned (2005)	Administrative services to concierge practices and hospitals in over 30 states (over 1,000 MDs) Hybrid and FullFlex models	

Why the enablement layer matters to owners. A physician or group evaluating conversion now has three genuine choices: self-convert with a consultant and keep full ownership; affiliate with a national brand and trade a revenue share for marketing, technology, and conversion expertise; or sell into a platform. Each produces a different ownership position, a different risk profile, and a very different outcome at exit. The decision is frequently made on the basis of the first-year conversion economics alone, which is the wrong frame.

Source: Vector Medical Group x Baker Donelson platform tracking based on multiple press releases, articles, and platform websites.

REGULATORY AND STRUCTURE

Compliance Considerations In Membership Medicine

Cash-pay does not mean unregulated. Membership medicine sits inside a set of overlapping federal and state frameworks that are being applied more actively as the category grows and as adjacent services, such as compounded therapies, consumer diagnostics, and virtual prescribing, draw heightened enforcement. For owners, the practical consequence is that compliance considerations have become a valuation input. The issues below are the ones most likely to surface in diligence, and the ones most expensive to remediate after a letter of intent is signed.

- **Membership Fee Design**

A fee that promises defined services in exchange for a periodic payment can implicate state insurance regulation. Most states have adopted direct primary care statutes that create room for these arrangements, but the safe harbors are drafted narrowly and vary; agreement terms, refund and termination provisions, and marketing language all matter.

- **Corporate Practice and MSO Structure**

Platform transactions are typically executed through friendly-professional-entity and management services organization models, depending on the applicable state law. The management fee structure under this model can draw scrutiny. An increasing number of states have established notice, review, or approval requirements for physician practice transactions, making structure a true diligence item rather than a formality.

- **Telehealth and Remote Prescribing**

Multistate licensure, standards for establishing a virtual patient relationship, and controlled substance prescribing rules govern how far a virtual or hybrid model can extend. This can be a constraint for programs built around testosterone, stimulant, or other scheduled therapies.

- **Diagnostics, Labs, and AI Interpretation**

Consumer-initiated biomarker panels and advanced imaging can require laboratory certification and a need for oversight for laboratory-developed tests, including a clear understanding of who reviews results, how incidental findings are handled, and what duty follows the findings of a study.

- **Medicare and Payor Overlay**

Membership fees generally may not be charged for items and services already covered by a patient's insurance. Programs need clean documentation of what services are covered under the membership fee, disciplined separation between covered care and non-covered amenities, and deliberate decisions about participation status — hybrid programs especially.

- **Referrals, Ancillaries, and Fee Splitting**

If federal programs (e.g., Medicare, Tricare, etc.) are being billed, federal referral and anti-kickback rules can apply to in-office labs, imaging, dispensing, and specialist arrangements. Similar state laws, including fee-splitting prohibitions, also apply regardless of payor and are frequently overlooked in revenue-share affiliation models.

- **Compounded Therapies and Peptides**

The shortage-era latitude for compounded metabolic drugs has narrowed substantially, and the compounding pathway for peptides continues to evolve. Programs that depend on these therapies need documented clinical rationale, defensible sourcing, and an honest view of how much revenue sits on a shifting foundation.

- **Marketing Claims and Health Data**

Longevity, anti-aging, hormone, and weight-loss claims are squarely within federal and state consumer protection attention, including testimonial and endorsement practices. Consumer health data privacy statutes add another layer for groups running digital acquisition funnels and app-based member engagement.

A tailwind worth planning around. Payment rails are moving in the category's favor: expanded health savings account treatment of direct primary care arrangements and continued growth in individual coverage reimbursement arrangements both widen the population that can pay for membership care with pre-tax or employer dollars. Groups positioned to accept those dollars — with pricing and contracting built accordingly — will reach a materially broader market than those priced only for self-pay households.

VALUE AND DILIGENCE

What Capital Partners Actually Underwrite

Owners frequently prepare for a process by assembling financial statements and a growth story. In this category, buyers spend most of their time somewhere else — on the durability of the membership base and the degree to which value is attached to the enterprise rather than to individual physicians. The questions below come up in nearly every concierge and consumer-health process, and each of them can be answered well only with data that takes quarters, not weeks, to assemble.

- **Retention by cohort, not in aggregate.** Blended renewal rates conceal the number that matters: how a cohort behaves in years two, three, and five, and what happens at each price increase.
- **Conversion yield and its cost.** For conversion models, what share of a legacy panel buys a membership, how long the ramp takes, and what was spent per converted member.
- **Physician concentration and retirement horizon.** How much revenue follows one name, what the retention and non-compete posture is, and whether a departing physician's members stay with the practice.
- **Organic versus inorganic growth.** De novo ramp-up curves and same-clinic membership growth, separated cleanly from acquired revenue — a distinction buyers test directly.
- **Fee architecture and pricing power.** Tiering, family and spousal pricing, annual escalators, prepayment behavior, and demonstrated elasticity at the last increase.
- **Ancillary and longevity attach rate.** Revenue per member beyond the membership fee, and whether that revenue is recurring or episodic.
- **Specialist network and care navigation.** The referral relationships and coordination capability that members cite as a reason they renew — often the least documented and most defensible asset in the practice.
- **Compliance posture.** Membership agreements, payor overlay, corporate structure, marketing claims, and therapy sourcing, assembled before diligence rather than during it.
- **Infrastructure and scalability.** Scheduling, CRM, member experience technology, revenue operations, and whether the leadership bench extends past the founder.

Concierge practices that can evidence cohort-level retention, disciplined panels, and value that survives a physician's departure command a different conversation — and a different structure — than practices that cannot.

WHAT THIS MEANS FOR VALUATION CONVERSATIONS

Buyers pay for predictability. In practice, that means a membership base with demonstrated renewal behavior is valued differently from a fee-for-service book of similar size, and a platform with several physicians producing consistent economics is valued differently from a single-physician practice with an exceptional reputation. It also means the preparation window matters: the data sets buyers ask for, such as cohort retention, conversion yield, attach rates, and physician-level contribution, are generated by operating discipline over time, not by a data room assembled in six weeks. Owners who intend to transact within three years should be building those data sets now, regardless of whether they ultimately partner, affiliate, or stay independent.

ALIGNMENT AND PARTNERSHIP

What Capital and Strategic Partners Bring — and What They Cost

Many concierge, direct primary care, and longevity groups are weighing whether to remain independent or align with a larger organization. Investor-backed platforms, national affiliation brands, health systems, and consumer-health strategics each bring capabilities that are difficult for an independent practice to build alone.

- **Conversion and Demand Generation**

Proven conversion methodology, member acquisition marketing, and CRM infrastructure — the difference between a conversion that fills a panel in one year and one that takes three.

- **Physician Recruitment and Retention**

Clearly defined career pathways, equity participation, and coverage structures that are highly desirable in a market where experienced primary care physicians have many options and panel-building takes time.

- **Member Data and Analytics**

Retention modeling, pricing and tier design, attach-rate optimization, and lifetime value measurement that most independent practices cannot generate from a scheduling system alone.

- **Succession Planning**

Continuity strategy for member relationships and brand when a founding physician steps back — the single largest source of value erosion in owner-dependent practices.

- **Capital Access**

Funding for de novo clinics, physician recruitment and guarantee packages, diagnostic equipment, and expansion into longevity and advanced testing service lines.

- **Compliance Infrastructure**

Corporate structure, membership agreement architecture, payor overlay discipline, supervision protocols, and readiness for tightening regulatory oversight of compounded therapies and wellness claims.

- **Purchasing and Vendor Leverage**

Lower costs for laboratory and imaging services, supplements and therapies, malpractice coverage, health insurance benefits, technology licensing, and payment processing.

- **Executive Bench and Operations**

Access to experienced leadership, human resources, information technology, cybersecurity, and revenue operations built for multisite scale.

THE TRADE-OFFS OWNERS SHOULD PRICE HONESTLY

Partnerships do come with a cost. Revenue-share affiliation reduces margin permanently in exchange for infrastructure. Platform transactions typically involve governance concessions, rollover equity whose value depends on the timing and outcome of a sponsor's exit rather than on the practice's own performance, and standardization that can conflict with the service differentiation members are paying for. Concierge groups that succeed in their partnership negotiations go in with a clear view of which decisions they are prepared to give up, whether it be pricing, panel size, service mix, or hiring; and which they are not. They negotiate those points before the economics are settled rather than after.

STRATEGIC OPTIONS

Choosing a Path Forward — Intentionally

Concierge and consumer-health practices have several viable paths. The right one depends on local market density, brand position, payor mix, physician age distribution, and how long the owners intend to practice.

Groups that thrive will be those who understand where the category is heading and align their clinical, operational, and financial decisions with that direction.

OPTIONS FOR CONCIERGE AND CONSUMER-HEALTH GROUPS

Remain independent, which requires:

- A defined retention strategy — renewal measurement by cohort, deliberate price escalation, and a member experience that justifies it;
- Panel discipline held consistently, with growth pursued through additional physicians, locations, or revenue per member rather than larger patient panels;
- Service-mix decisions made intentionally — adding diagnostics, hormone optimization, or weight management as structured programs rather than as ad hoc menu extensions; and
- Preparation for tightening regulatory oversight of compounded therapies, virtual prescribing, consumer testing, and wellness marketing claims.

Convert or expand the membership model and move a payor-based practice to full or hybrid membership, or extend an existing program into a second market, with conversion economics modeled before commitment.

Affiliate with a national brand or enablement platform, trading a revenue share for conversion expertise, marketing, and technology while retaining ownership of the practice.

Join or build a regional group, aggregating physicians and locations to create the density and management depth that a single practice cannot support on its own.

Partner with an investor-backed platform with a demonstrated record of brand stewardship, physician satisfaction, and operational improvement which have been diligenced by the owners as carefully as the platform diligences them.

Sell to a corporate-owned concierge medicine company and receive a payout that is often upfront in exchange for years of developing goodwill as an exit strategy for retirement.

Join a franchise model that offers an established brand and operating system while keeping some local ownership.

Expand deliberately into longevity and consumer diagnostics, as a structured service line with its own clinical governance, compliance review, and economics rather than as an appended set of offerings.

THE TIME IS NOW: ALIGN AND EXECUTE ON A STRATEGY

Concierge medicine, direct primary care, and longevity are converging into a single consumer-health economy, and capital is being invested in this sector at a significant pace. National brands are converting physicians in markets where local groups have not yet defined a position. Groups without a defined strategy will be shaped by those forces rather than by their own priorities.

A thoughtful approach requires:

- An honest assessment of current position, membership economics, and dependence on individual physicians;
- A clear view of local competitive density — who is converting physicians in the market, and at what price point;
- A realistic plan for retention, physician recruitment, and compliance readiness;
- A succession roadmap that protects the brand, member relationships, and operational stability; and
- Engagement with experienced advisors who understand capital, governance, and the specific dynamics of membership and consumer medicine.

ABOUT THIS WHITE PAPER

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Dana Jacoby is CEO and Founder of Vector Medical Group, a strategic health care consulting firm specializing in physician-enterprise strategy, M&A advisory, and value-based care design. Her work centers on the structures that determine whether specialty, primary care, and consumer-health enterprises thrive amid consolidation — joint-venture and partnership design, provider alignment and governance, service-mix and recurring-revenue strategy, alternative payment models, and succession planning. Her commercial background spans leadership roles at Johnson & Johnson, GE Healthcare, and Allergan, including the commercial launch of Botox.

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