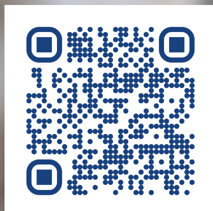
OPENWELL · RESOURCE BRIEF

PRACTICE MODELS

How to Transition From Insurance-Based to Direct Primary Care

Transitioning to DPC: model attrition first, choose gradual or clean conversion, notify payers, communicate early with patients, and plan 6–12 months of runway.



SCAN TO BOOK A CALL

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To transition an insurance practice to direct primary care: model your membership price and panel target, decide between a gradual conversion (build a DPC panel alongside the insurance practice) and a clean cutover (one switch date), terminate payer contracts per their notice terms, settle your Medicare position, and communicate with patients early and repeatedly. **Plan 6–12 months of financial runway and assume only a fraction of your existing panel converts — that assumption drives every other decision.**

Converting an existing practice is harder than starting fresh because you're changing the engine mid-flight: revenue, staffing, and patient relationships all move at once. It's done successfully all the time, but the physicians who do it well treat it as a modeling problem first and an announcement second.

Gradual or clean: which conversion path?

This is the first decision, and it's mostly a function of your runway and risk tolerance.

EXHIBIT

	GRADUAL CONVERSION	CLEAN CUTOVER
How it works	Build a DPC membership panel alongside the insurance practice; convert patients over time	Set a switch date, stop insurance billing, re-enroll patients as members
Revenue dip	Shallower, spread out	Sharper, concentrated
Speed	Slower — months to a year-plus of running both	Faster — you're DPC on day one of the new model
Operational load	Highest — two billing models, two workflows at once	High at the switch, then simpler
Best for	Thin runway, risk-averse, panel loyalty uncertain	Solid runway, strong patient relationships, low tolerance for running parallel systems

The honest trade: gradual lowers financial risk but extends the most painful operating period — the hybrid stretch where you're running claims and memberships simultaneously. Clean concentrates the pain into a shorter, sharper dip. Neither is wrong; pick the one your cash position can survive.

Start early — months before the switch, not weeks.

FROM THE BRIEF

What is the conversion sequence?

1. **Model the new economics before announcing anything.** Your DPC panel will be smaller — commonly 400–800 members versus a 2,000+ insurance panel — at a flat monthly fee. Build conservative, expected, and best-case scenarios for conversion and ramp (attrition modeling below). If the conservative case doesn't survive your runway, fix the model before you set a date.
2. **Review your payer contracts and your obligations.** Each payer contract has its own termination-without-cause notice period, and you may have continuity-of-care obligations to

patients mid-treatment. List every contract, its notice terms, and its effective end date — these dates anchor your timeline.

3. **Settle your Medicare position.** Most physicians converting to DPC who want to keep Medicare-age patients opt out of Medicare and use private contracts; the opt-out is a formal affidavit process with a fixed renewing term. The decision framework is the same as a from-scratch launch — see How to Start a Direct Primary Care Practice — but in a conversion the timing must line up with your payer termination dates.
4. **Stop taking on new insurance commitments.** Don't sign or renew payer contracts once you've decided; every renewal extends the hybrid period.
5. **Stand up the DPC infrastructure.** Membership agreements (state rules on DPC agreements vary — have a healthcare attorney licensed in your state review them), recurring billing, and software built for memberships. Your insurance-era EHR almost certainly handles recurring billing poorly; decide whether to replace or pair before the switch, not during it. See Best EMR for a Small Independent Practice (and How to Choose).
6. **Run the patient communication campaign.** Detailed below — this is the make-or-break step.
7. **Execute the switch (or the phased conversions).** Enroll members, terminate contracts on their effective dates, and convert workflows.
8. **Manage the dip without panicking.** Revenue falls before it recovers. The physicians who transition well planned for the dip financially and didn't flinch during ramp.

How do you model attrition?

Start with the arithmetic that makes conversions feel survivable: you don't need most of your panel. A 2,000-patient insurance panel converting to a 500-member DPC practice needs a 25% conversion rate. At 600 members it's 30%. Losing 70–75% of your panel sounds like failure; in a DPC conversion it's the plan.

Build three scenarios:

- **Conservative:** a low conversion rate from your existing panel, slow outside enrollment. Published benchmarks for what share of an existing panel typically converts vary and should be pulled from current DPC community data rather than asserted.
- **Expected:** your engaged core converts — the patients who already use you heavily and value access — plus modest new-member growth from the community.
- **Best case:** strong conversion plus referral-driven growth.

Then map each scenario against monthly overhead to find the month memberships cover the practice. That month, in the conservative case, is the runway you need — for most conversions, plan 6–12 months. Two patterns worth building into the model: your heaviest-utilizing, most-attached patients convert at the highest rates, and conversions continue to trickle in for months after the switch as patients hit the friction of finding a new physician.

The deeper cost framework for the transition period is in How Much It Costs to Start a Private Medical Practice (Real Numbers).

How do you tell your patients?

Your existing patients are your first members, and how you communicate determines your conversion rate more than your price does.

Start early — months before the switch, not weeks. Patients need time to process the change, ask questions, and make arrangements either way. A single letter two weeks out reads as abandonment.

Lead with the why, then the how. The why is concrete: longer visits, same-day access, direct messaging, a physician who isn't watching a clock. The how is equally concrete: what the membership costs, what it includes, what it doesn't (it's not insurance; keep coverage for hospital and specialty care), and exactly what happens to patients who don't join.

Use multiple channels and repetition. A letter, an in-visit conversation, a website FAQ, and a follow-up before the deadline. The in-visit conversation converts best; the letter alone converts worst.

Be straight with non-converting patients. Tell them the date, help them transfer records promptly, and don't guilt them. Some of your patients will be angry; most who leave do so for budget reasons, not loyalty reasons. Handled respectfully, departing patients still refer.

Expect to lose patients and keep your most engaged — that's normal, and it's the model working as designed, not a rejection of you.

What do people get wrong in the transition?

They panic during the dip. The single most common failure mode isn't bad math — it's abandoning good math. Revenue falls after the switch, the physician loses nerve at month four of a modeled six-month trough, and re-signs payer contracts or discounts memberships in a way that breaks the model.

If the conservative scenario said the trough lasts six months and you funded six months, month four is on schedule.

They underestimate the hybrid period's load. Running claims and memberships simultaneously means two billing workflows, two sets of rules, and staff doing both jobs. Gradual converters routinely report the parallel period as the worst stretch of the whole transition — budget energy for it, and set a hard end date so it can't drift.

More general launch failure modes are in The Biggest Mistakes Doctors Make When Starting a Practice.

Reality check

- **The revenue dip is real and unavoidable.** You are trading a full fee-for-service panel for a membership base that builds over 6–18 months. No communication strategy eliminates the trough; runway absorbs it.
- **Staffing gets uncomfortable.** A practice with billing and coding staff converting to a model with no claims has a hard conversation coming. Plan it deliberately — retrain into membership operations and patient experience, or restructure — rather than letting it happen by attrition mid-transition.
- **Some patients will feel abandoned, and a few will say so publicly.** Early, honest, repeated communication shrinks this group; nothing eliminates it.
- **Compliance risk concentrates in two places:** charging Medicare beneficiaries incorrectly during or after the transition, and membership agreements that don't meet state requirements. Both are healthcare-attorney money well spent — consult one licensed in your state.
- **Local demand still rules.** A loyal panel in a market that can't afford memberships converts poorly. If you're unsure, test pricing with a patient survey or a small pilot cohort before terminating contracts.
- **If you're employed rather than a practice owner,** this article isn't your path — you can't convert a panel you don't own, and your non-compete likely constrains where you launch. Start with Burned Out as an Employed Physician? Your Actual Options, Ranked.

Frequently asked

How long does it take to transition a practice to DPC?

Plan 6–12 months of runway, with the full membership panel typically building over 6–18 months. The mechanical switch is governed by payer termination notice periods and your Medicare opt-out timing; the economic recovery is governed by conversion and ramp.

What percentage of patients convert to DPC?

It varies widely with market, price, and patient mix, and you should model conservative/expected/best cases rather than rely on one number. The useful arithmetic: a 500-member target from a 2,000-patient panel needs only 25% to say yes.

Can I keep some insurance contracts and run DPC alongside?

Operationally yes — that's the gradual path, and some practices run hybrid long-term. But the parallel period is the most demanding configuration: two billing models and two workflows. Most physicians treat hybrid as a bridge with an end date, not a destination.

Do I have to opt out of Medicare to run a DPC practice?

Not necessarily, but if you stay enrolled, charging Medicare beneficiaries membership fees for covered services creates compliance exposure, so most DPC physicians who want Medicare-age members opt out and use private contracts. Get attorney guidance before enrolling your first Medicare-eligible member.

Should I tell patients before I terminate payer contracts?

Sequence them together: know your contract termination dates first, then announce to patients months ahead of the effective date. Announcing before you know the dates forces you to revise the story; announcing too late reads as abandonment.

This article is general information, not legal or financial advice. Have a healthcare attorney licensed in your state review your payer terminations, Medicare position, and membership agreements.

HOW OPENWELL CAN HELP

Done-for-you, end to end.

If you want the conversion executed rather than just explained — membership billing, agreements, compliance, and the operating platform stood up while you keep seeing patients — Openwell does this as a done-for-you launch for cash-pay practices.

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SCAN TO BOOK

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