office visits with no copayments; and free prescription refills, house calls, and preventive care services. Most concierge medicine services also bill patients' insurance.

The woman also described DPC, which, like concierge medicine, charges a monthly or annual fee to patients for enhanced services and access. DPC differs from concierge medicine, as practices do not bill insurance for medical visits, and generally no third-party involvement occurs. Therefore, all of the work associated with billings, claims, and coding is eliminated (Qamar 2014). DPC services also generally include basic lab tests, vaccinations, and generic drugs at or near cost. Practices using either model derive most of their revenues from membership fees and generally experience an increase in profitability.

The proponents at the conference suggested that both models would work well for patients with complex medical conditions needing careful monitoring and help coordinating multiple specialists. As both are relatively new practice models, only a few studies exist, and they suggest better outcomes. One study showed patients in a DPC model had 27 percent fewer visits to the emergency department and 60 percent fewer hospital days, and their healthcare costs their employers 20 percent less (Beck 2017). A study on concierge medicine showed decreases in preventable hospital use, with 56 percent fewer nonelective admissions and more than 90 percent fewer readmissions (Goodman 2014).

Concierge practices generally charge monthly fees beginning at $175 a month, but they can cost more than $5,000 per year. Most practices that move to concierge medicine retain only 15–35 percent of their existing patients. A concierge physician generally maintains a patient panel of only 300 to 600 patients. DPC practices charge a bit less, however, with monthly fees of about $100. Therefore, DPC practices tend to have larger patient panels of 600–800 per physician (Colwell 2016).

Even though concierge medicine and DPC practices often target upper-middle-class families, some seek higher-income families and maintain an even more restrictive and expensive practice. A few very restrictive practices charge $40,000 to $80,000 per family for an extensive, immediate array of services. These practices may include only 50 families in their patient panels. These high-end practices can increase a primary care physician's annual income to about $600,000 (Schwartz 2017).

General Medical Clinic's primary care physicians each currently serve 2,000–3,000 active patients. The older physicians have enjoyed a relationship with many of their patients for more than 20 years. Moving to either model would mean each physician would lose over 1,000 patients— more than 22,000 individuals for the full clinic.