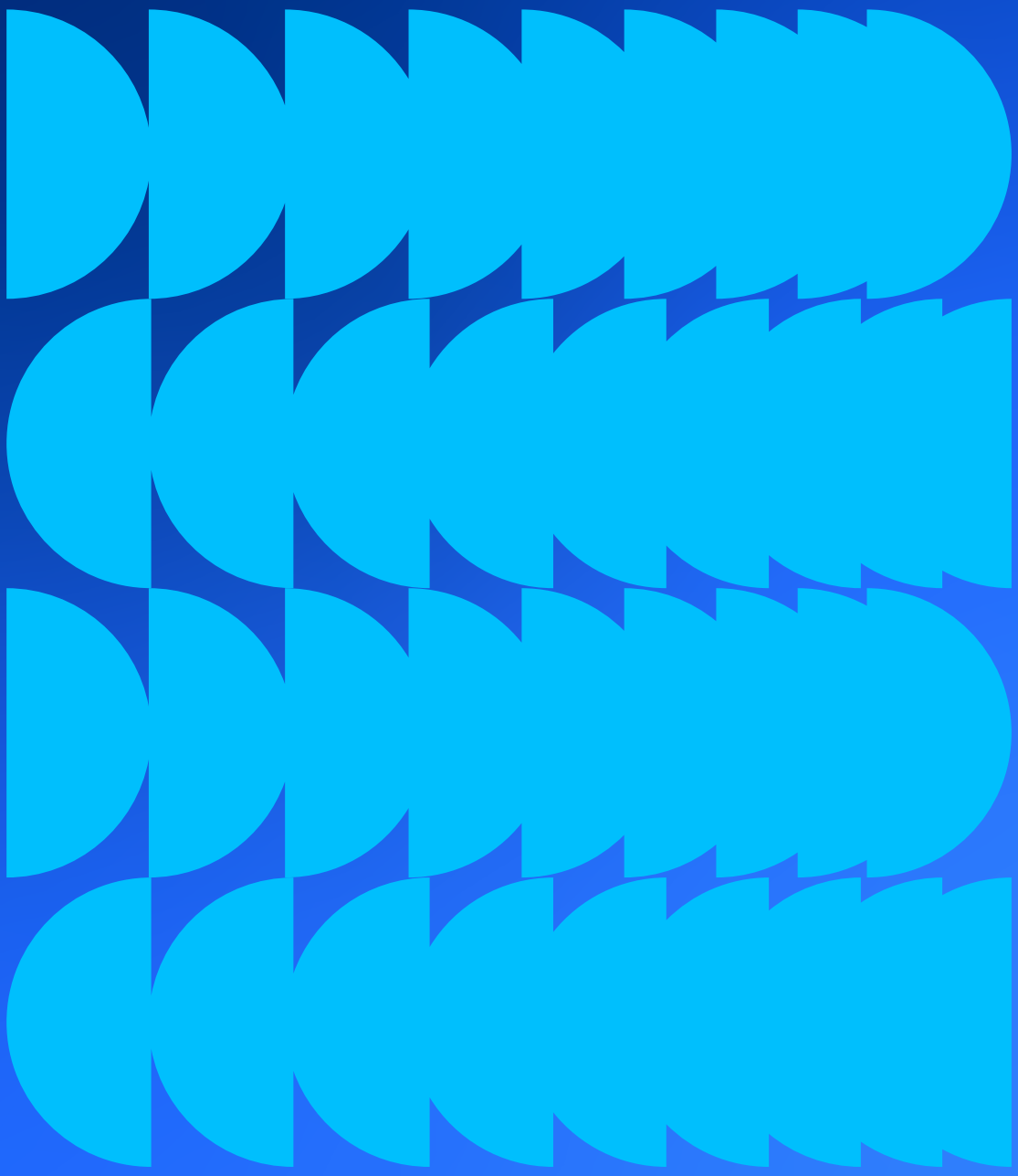
hint health

TRENDS IN DPC '26



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KEY TAKEAWAYS

Patients are staying. Clinicians are thriving. Employers are buying in.

After nearly a decade of steady growth, Direct Primary Care has moved well beyond a niche alternative into a demonstrable force reshaping primary care in the United States.

The Hint Health Data Analytics team compiled data from over 2,700 DPC clinicians and their 1.4 million members to document how this model is scaling.

Here's what the data shows:

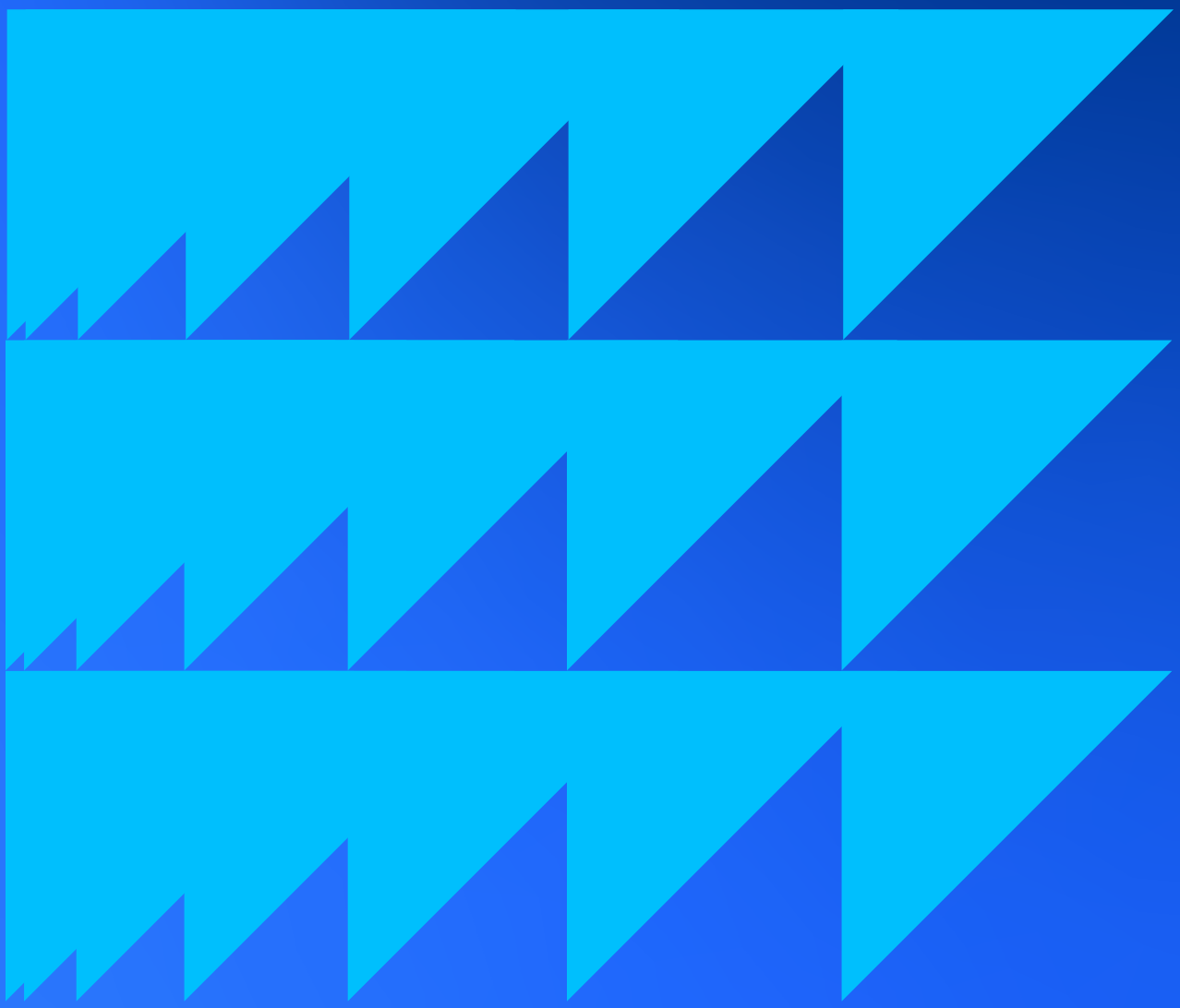
837% growth in DPC Members

555% growth in DPC clinicians

60% of DPC memberships are funded by Employers

49↑ states in the US have a DPC network presence, up from 21 in 2019

DEMAND SIDE TRENDS



CURRENT STATE OF U.S. HEALTHCARE

The traditional primary care system is not meeting the moment. Long wait times, rushed visits, fragmented referrals, and rising costs have eroded patient trust across the board. For many Americans, a meaningful relationship with a primary care clinician has become the exception rather than the rule.

DPC was built to fix that.
And the data suggests it is working.

The Hint DPC Patient Experience Benchmark Report evaluated DPC performance using the Person-Centered Primary Care Measure (PCPCM), a nationally recognized patient-reported survey that measures the four core functions of primary care: access, comprehensiveness, coordination, and continuity. Patients rate 11 questions about their care experience on a scale of 1 to 4, and those responses are converted into an overall performance score from 0-100%, with 100% meaning all respondents gave the experience the highest possible score.

Drawing on 1,534 completed surveys from patients across 12 DPC clinics in eight states over a 14-month period, the results are striking. DPC practices achieved a Total PCPCM Performance Score of 89%. Patient experience with Contact/Access to their DPC reached a score of 97%, a near-perfect score reflecting how easy it is for DPC patients to reach their doctor and get care when they need it, one of the most persistent pain points in conventional medicine.
For DPC patients, that friction has largely disappeared.

These findings position DPC as a model that appears to reverse many of the dissatisfaction trends seen in the broader U.S. healthcare system by delivering measurable gains in access, relationship continuity, and whole-person care.

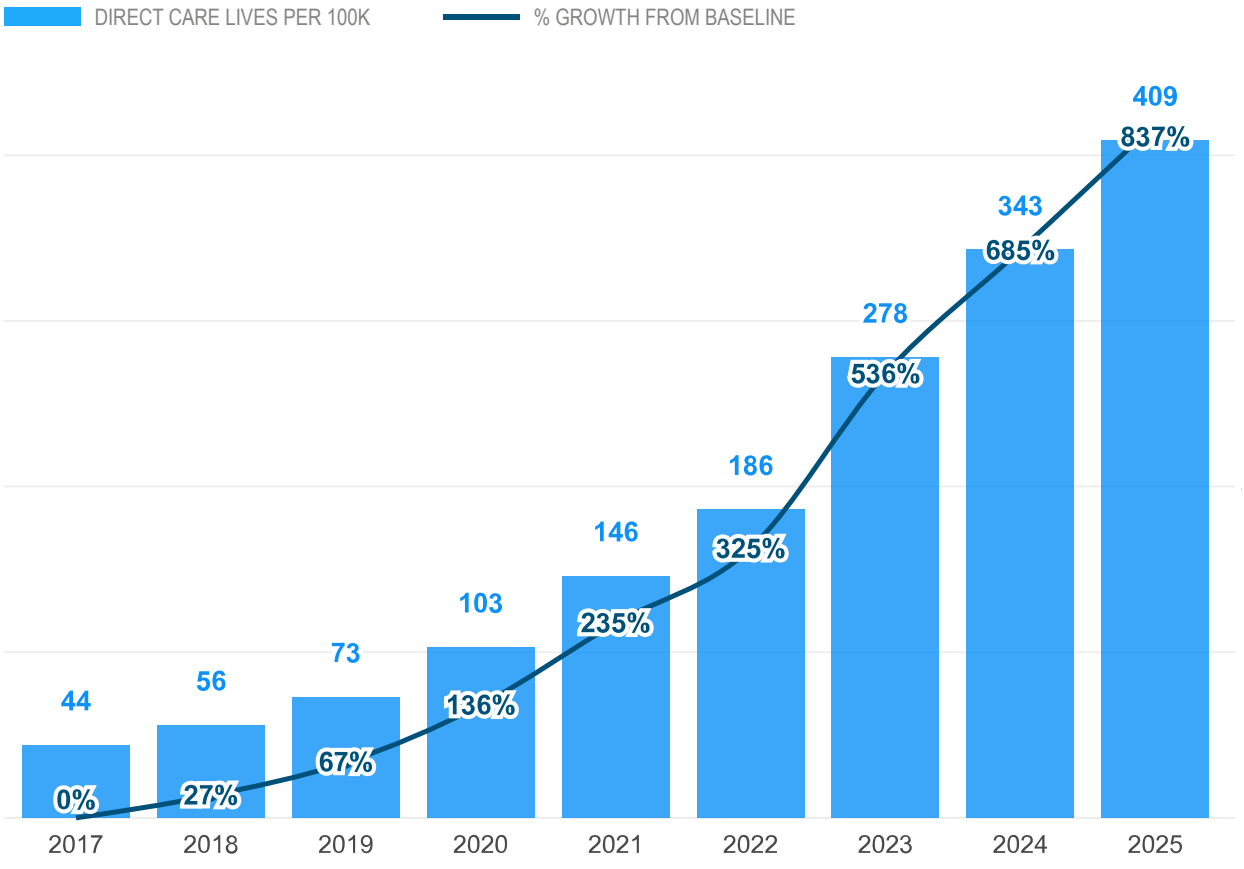
That satisfaction is translating directly into growth.

GROWTH IN DPC MEMBERS

DPC membership increased from 44 patients per 100,000 Americans in 2017 to 409 per 100,000 in 2025, representing a 837% increase, and an average annual growth rate of approximately 33%.

This upward trend, demonstrating that DPC membership is increasing faster than the population, points to sustained structural growth in DPC, positioning the model as an increasingly important component of the U.S. primary care landscape.

FIG. 1:
ACTIVE DPC MEMBERS[1] PER 100K PEOPLE[2] IN THE U.S. FROM 2017-2025

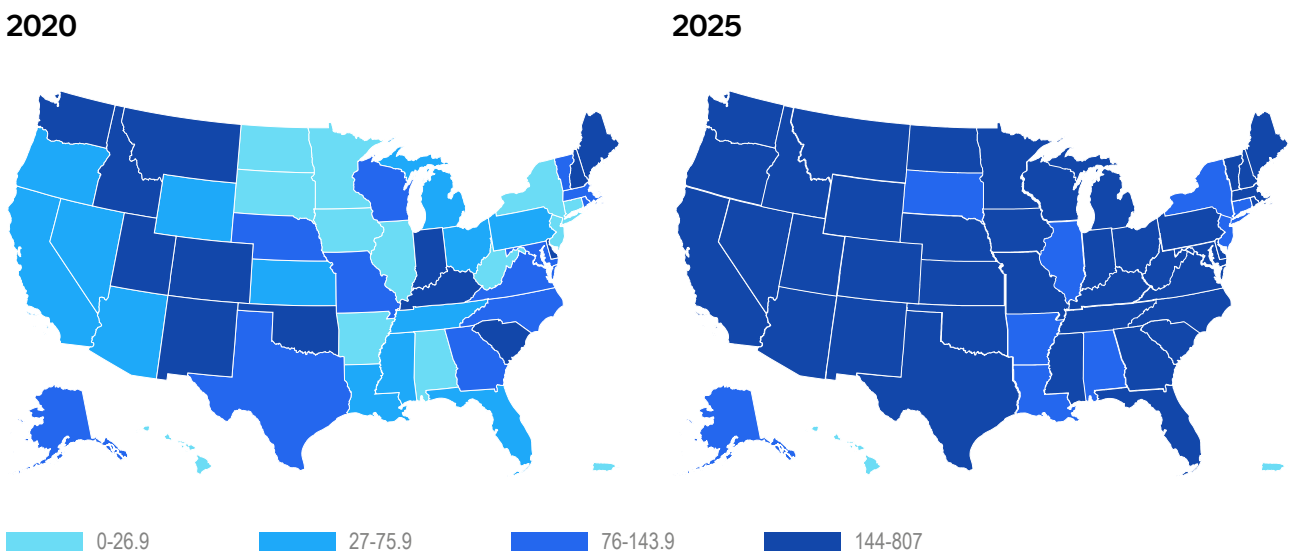


Source: 1) Hint Health Database 2) U.S. Census
Note: Active DPC member is any patient with an active DPC membership at some point during the census year.

Growth in DPC membership is not confined to a few regional pockets, it reflects a broad nation-wide expansion of the model. In 2025, Minnesota (2,077 DPC members per 100,000 people) and Colorado (1287.5 DPC members per 100,000 people) have the highest concentration of DPC members, with Minnesota recording the largest increase, expanding more than 38,000% from just 5.4 DPC members per 100,000 people in 2020 to 2,077 in 2025.

The maps below tell the broader story. States that once sat in the lowest adoption tiers now exceed the highest benchmarks of 2020, signaling not incremental adoption, but a structural expansion of DPC across the U.S.

FIG. 2:
ACTIVE DPC MEMBERS[1] PER 100K PEOPLE[2] IN THE U.S. BY STATE IN 2020 AND 2025



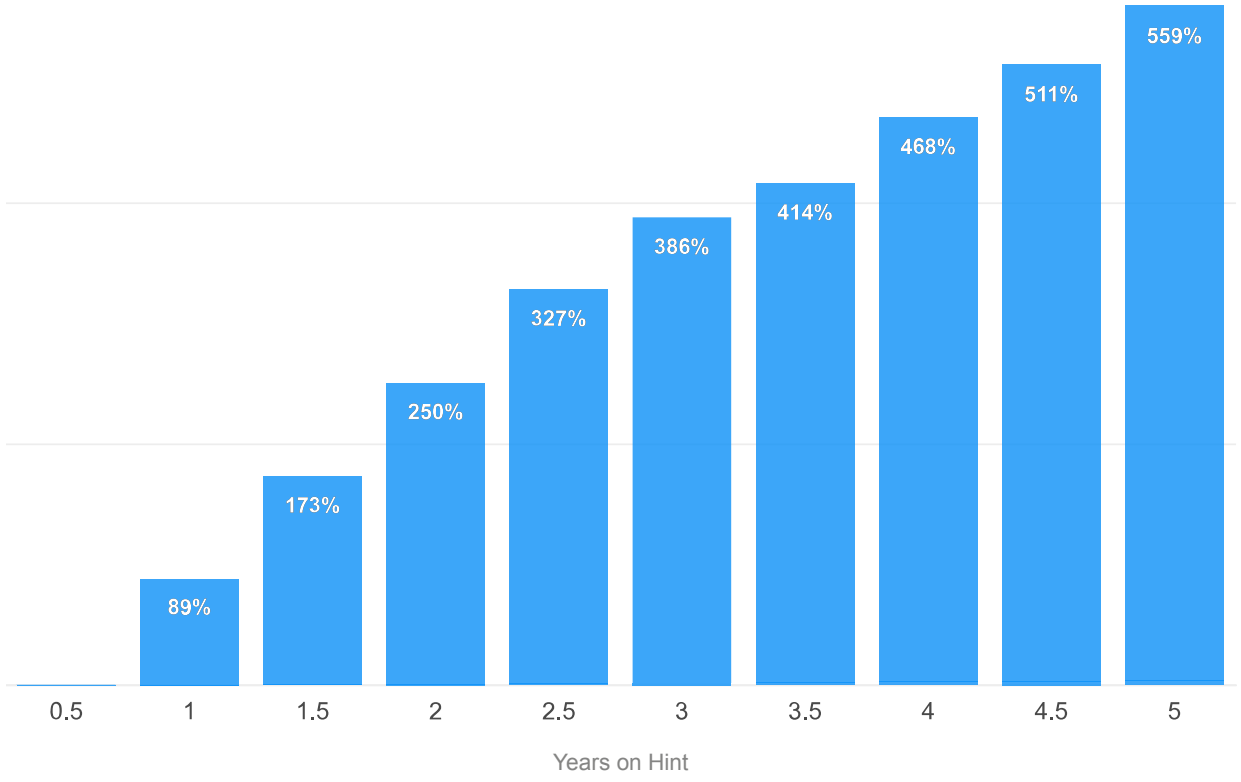
Source: 1) Hint Health Database 2) U.S. Census
Note: An active DPC member is any patient with an active DPC membership at some point during the census year.

DPC practices that remain active beyond their first year continue to grow at a sustained pace over time. Using month six as a baseline to account for initial launch and ramp-up, median membership growth increases consistently at each semiannual checkpoint. By five years on Hint Core, the median practice has expanded its panel by 559% relative to month six.

Importantly, growth is not limited to the early launch period. Median membership growth reaches 89% by year one, 250% by year two, and 386% by year three; this demonstrates that the typical practice has more than quadrupled its panel relative to its first six months. Growth continues through years four and five, reaching 468% and 559%, respectively.

In practical terms, this trajectory is significant. A practice with 45 members at month six would reach approximately 218 members by year three at the median growth rate and more than 297 members by year five. Taken together, these data indicate that DPC panel expansion is durable and cumulative among established practices, consistent with sustained growth as practices mature over time.

FIG. 3:
MEDIAN PERCENT CHANGE IN DPC MEMBERS PER PRACTICE FROM MONTH SIX AND SEMI-ANNUALLY AFTER



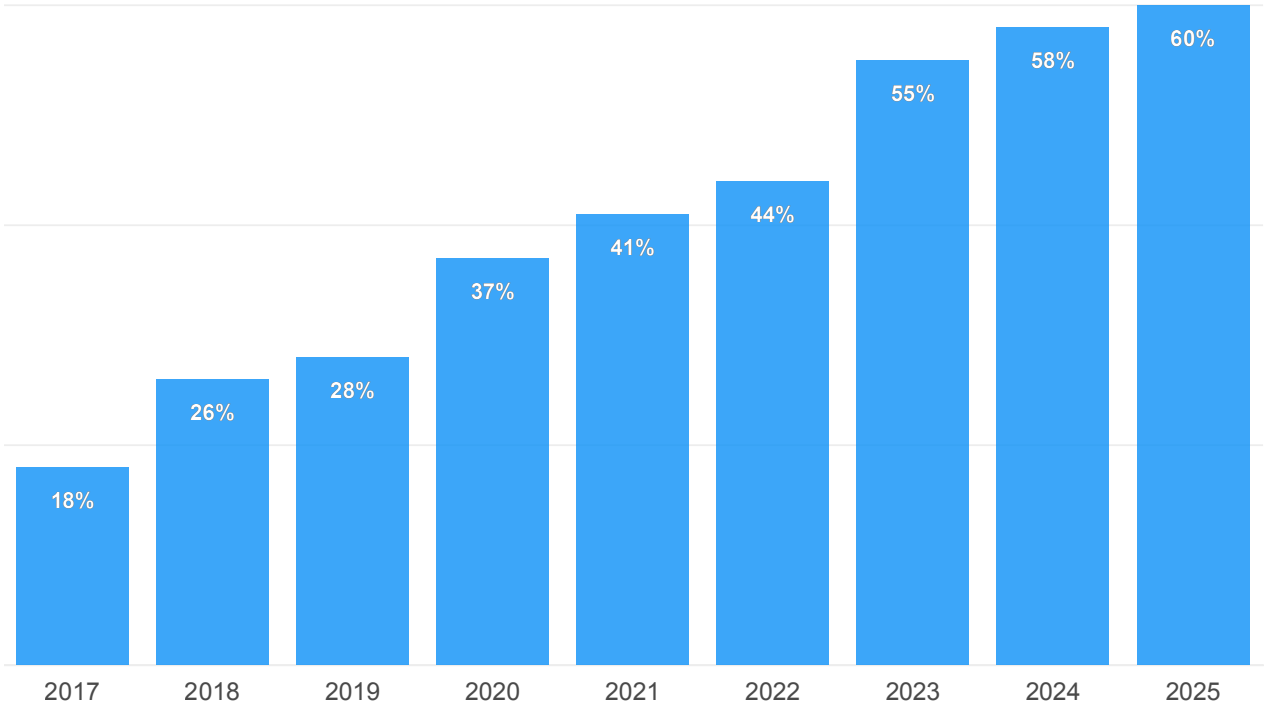
Source: Hint Health Database
Notes:
- An active DPC member is any patient with an active DPC membership at some point during the time period.
- Only includes established DPC practices that have been active for at least 6 months to account for any increase in members resulting from account setup.

GROWTH IN EMPLOYER SPONSORED DPC MEMBERS

Similar to the steady rise in DPC membership overall, employer-sponsored memberships have expanded significantly, reflecting growing recognition that the relationship-based, continuous care model at the heart of DPC drives measurable improvements in workforce health, productivity, and cost stability.

In 2017, just 18% of active memberships on Hint Core were paid for by an employer. By 2020, that share had increased to 37%, and it continued rising through the pandemic and recovery period, reaching nearly 60% of memberships in 2025. Employer-sponsored membership now represents the majority of active DPC memberships on Hint Core.

FIG. 4:
PERCENT OF ACTIVE MEMBERSHIPS PAID FOR BY AN EMPLOYER FROM 2017 TO 2025



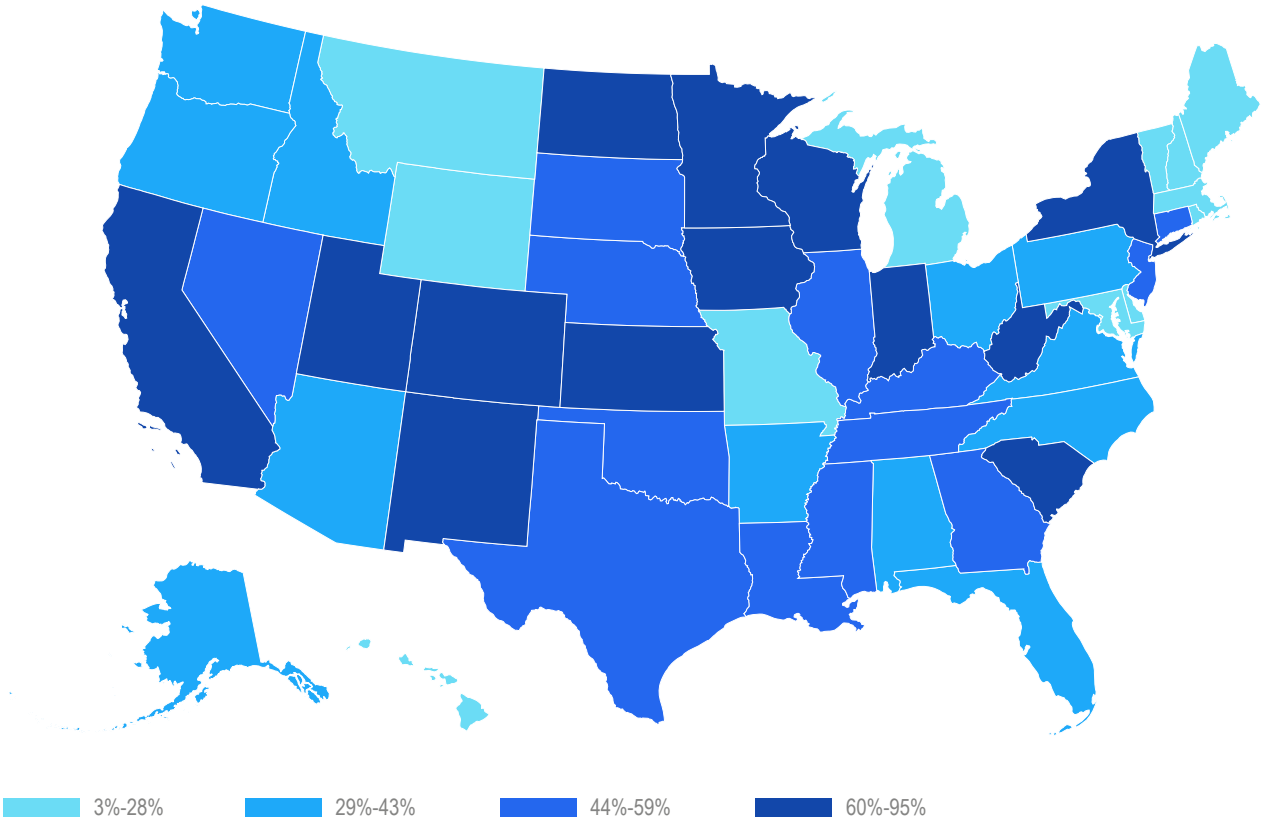
Source: Hint Health Database

Employer-sponsored DPC memberships are concentrated in a subset of states, particularly across parts of the Midwest and West, where a small number of large practices have successfully developed employer sales strategies that have accelerated growth. Minnesota leads the nation, with 95% of DPC members covered through an employer. This is followed by North Dakota (94%), Wisconsin (93%), and California (88%). The pattern suggests that the strong membership growth observed in several of these states since 2020 has been closely tied to employer adoption, and to the infrastructure those practices built to support it.

In contrast, employer-sponsored participation is materially lower across much of the Northeast. Several states in the region report employer-sponsored shares well below one-quarter of total DPC membership, including Vermont (3%), New Hampshire (6%), Rhode Island (7%), and Massachusetts (12%). The Northeast also has relatively few DPC clinicians overall, meaning that even employers interested in offering DPC as a benefit may struggle to find local practices with the capacity to cover their workforce. The result is a compounding gap: low clinician supply constrains employer adoption, and low employer adoption limits the demand signal that would otherwise attract more clinicians to the model.

For more insights on employer-sponsored DPC, check out the Employer Trends in Direct Primary Care Report

FIG. 5:
PROPORTION OF ACTIVE DPC MEMBERS THAT ARE EMPLOYER-SPONSORED[1] PER 100K PEOPLE[2] BY STATE IN THE U.S. IN 2025.



Source: 1) Hint Health Database 2) U.S. Census
Note: Active, employer-sponsored DPC member is any patient with a DPC membership that is paid for by an employer and is active at some point during the census year

CHANGE IN DPC MEMBER DEMOGRAPHICS

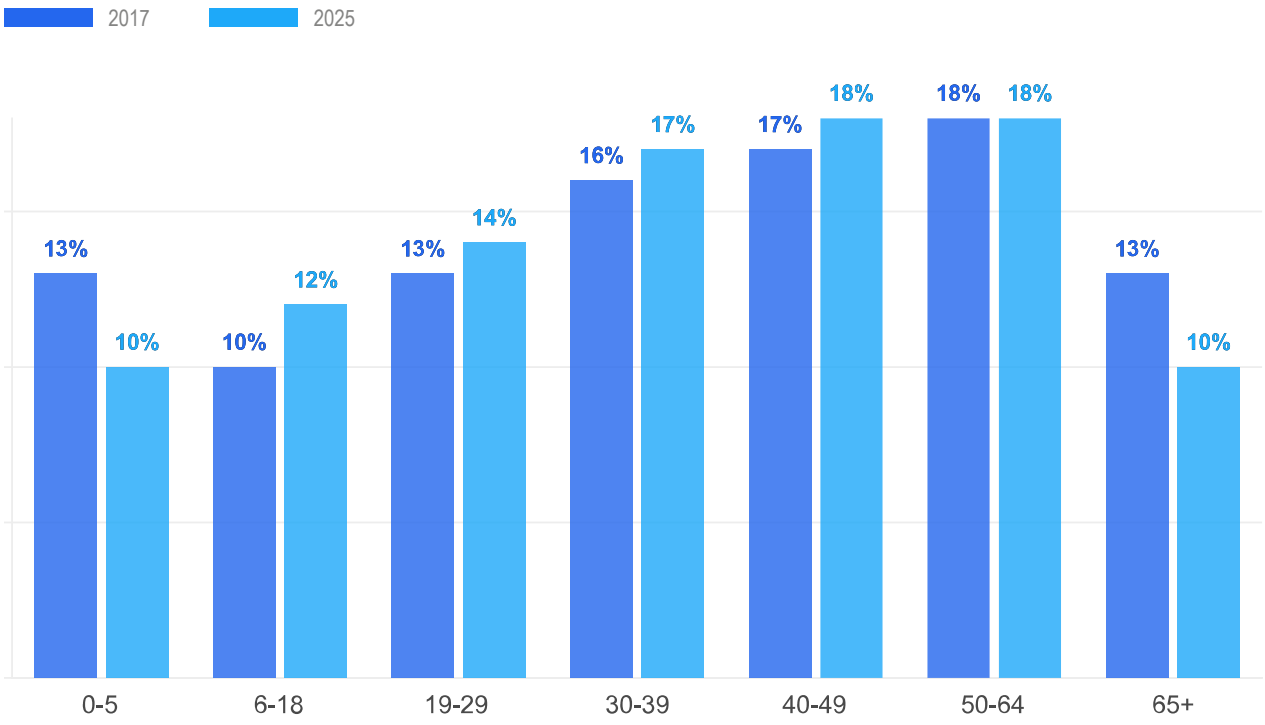
Despite substantial growth in DPC since 2017, the demographic composition of patients has remained remarkably stable. Women consistently account for just over half of the DPC population, while the average patient age has remained between 41 and 43 throughout the nine-year period. Membership growth of that magnitude without a meaningful demographic shift is a strong indicator of product-market fit. DPC has found its patient, and that patient keeps coming back.

FIG. 6:
AVERAGE AGE OF DPC MEMBERS AND PERCENT FEMALE FROM 2017 TO 2025

Reporting Year	Age	Percent Female
2017	43	54%
2018	42	54%
2019	42	53%
2020	41	53%
2021	41	52%
2022	41	53%
2023	41	54%
2024	41	54%
2025	42	54%

The overall age distribution of DPC members has also remained largely stable between 2017 and 2025, with only minor percentage-point changes across cohorts and a slight skew towards patients 30 - 64.

FIG. 7:
DISTRIBUTION OF ACTIVE DPC MEMBERS BY AGE GROUP IN 2017 AND 2025



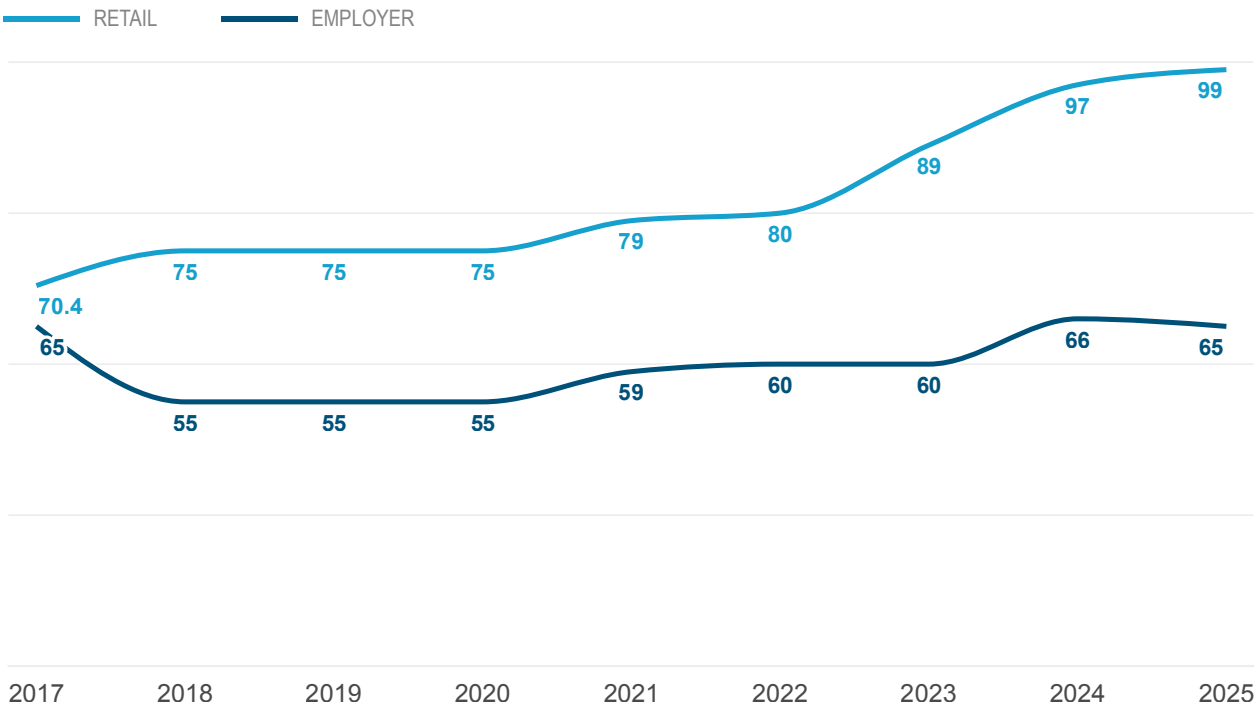
Source: Hint Health Database

WHAT DPC CLINICIANS CHARGE

By 2025, median retail DPC membership reached $99/month, up from the mid-$70s in 2020, a 32% increase that reflects the direct-to-consumer segment moving upmarket. Employer-sponsored rates tell a different story: holding within a narrow $55–$66 range over the same period, representing just 18% growth and offering employers a stable, predictable benefit.

This pricing gap matters in context. The Kaiser Family Foundation 2024 Employer Health Benefits Survey found that between 2016 and 2024, employer premium contributions rose 43%, nearly double the 22% increase borne by employees. Traditional insurance is a cost that compounds every year, and employers absorb the larger share of every increase. Employer-sponsored DPC offers an alternative: transparent, stable monthly pricing that doesn't move with traditional premium volatility, a meaningful advantage as employers face growing pressure to maintain competitive benefits in a tight labor market.

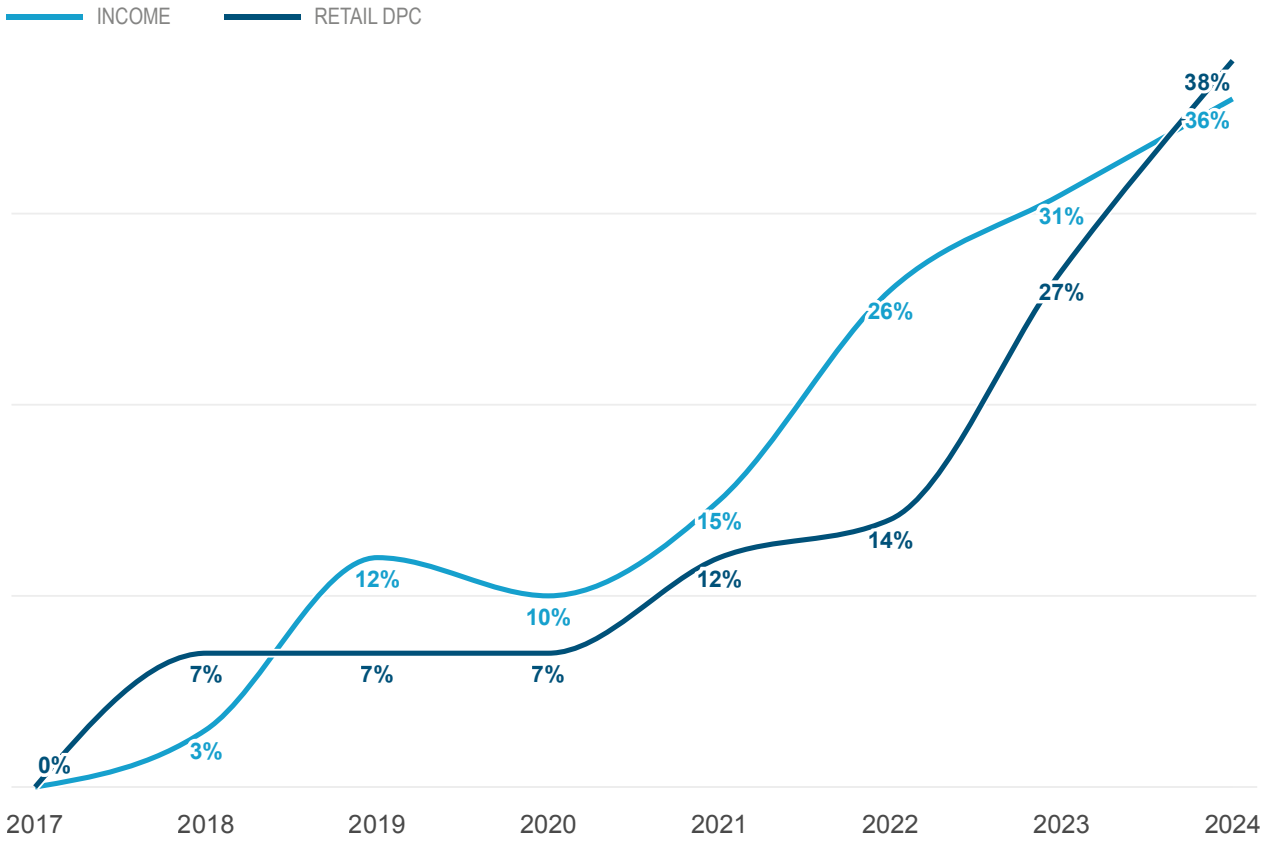
FIG. 8:
MEDIAN RETAIL AND EMPLOYER-SPONSORED MEMBERSHIP PRICE FROM 2017 TO 2025



Source: Hint Health Database
Note: Membership price is the median monthly price during the time period for an individual DPC membership. This excludes virtual-only memberships.

While retail membership prices have increased, they have kept pace with what the market can afford. From 2017 to 2025, median household income rose 36%, and retail membership prices rose 38%, tracking closely enough to suggest that affordability has not been a barrier to DPC's growth.

FIG. 9:
PERCENT CHANGE IN MEDIAN HOUSEHOLD INCOME[1] AND RETAIL DPC MEMBERSHIP[2] PRICE FROM 2017 TO 2024



Source: 1) U.S. Census 2) Hint Health Database
Note: Membership price is the median monthly price during the time period for an individual, retail DPC membership. This excludes virtual-only memberships.

DPC pricing varies considerably by region, with the Northeast commanding the highest rates and the Midwest offering the most affordable access.

In the Midwest, employer-sponsored memberships are among the most competitively priced in the country, with the majority falling below $75/month. Retail pricing is similarly accessible, though a meaningful share of practices price at the premium tier.

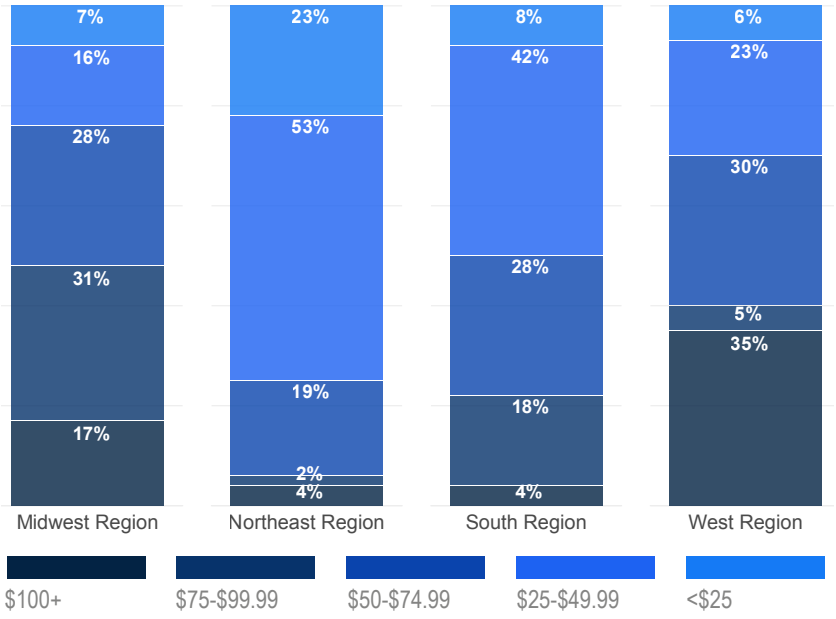
The South follows a comparable retail pattern, while employer-sponsored pricing clusters heavily in the mid-tier range, the strongest such concentration of any region, suggesting a market that has standardized around moderate, predictable employer costs.

The West presents a more polarized landscape. Employer-sponsored pricing splits between a large budget tier and a mid-range concentration, while retail skews somewhat higher, with nearly a third of memberships in the top pricing tier.

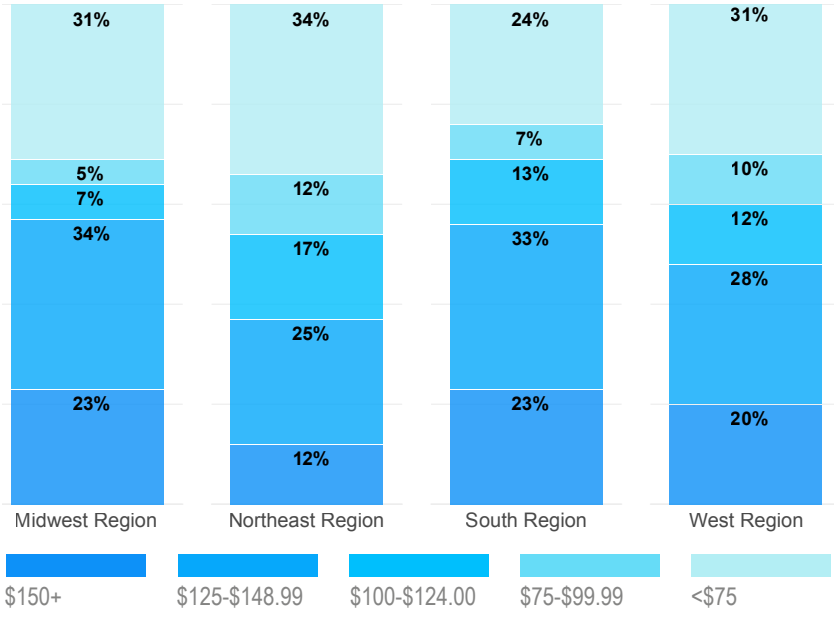
The Northeast is the premium market. Retail pricing reflects this most clearly, with the highest concentration of top-tier memberships nationally. Yet even here, employer-sponsored DPC remains competitive, nearly three-quarters of employer memberships fall in the mid-price range, underscoring that the employer channel maintains cost discipline even in the country's most expensive region.

FIG. 10:
DISTRIBUTION OF RETAIL AND EMPLOYER-SPONSORED MEMBERSHIP PRICE BY REGION IN 2025

EMPLOYER-SPONSORED



RETAIL



Source: Hint Health Database
Notes: Regions are defined by the Census.
Membership price is the median monthly price during the time period for an individual DPC membership.
This excludes virtual-only memberships.

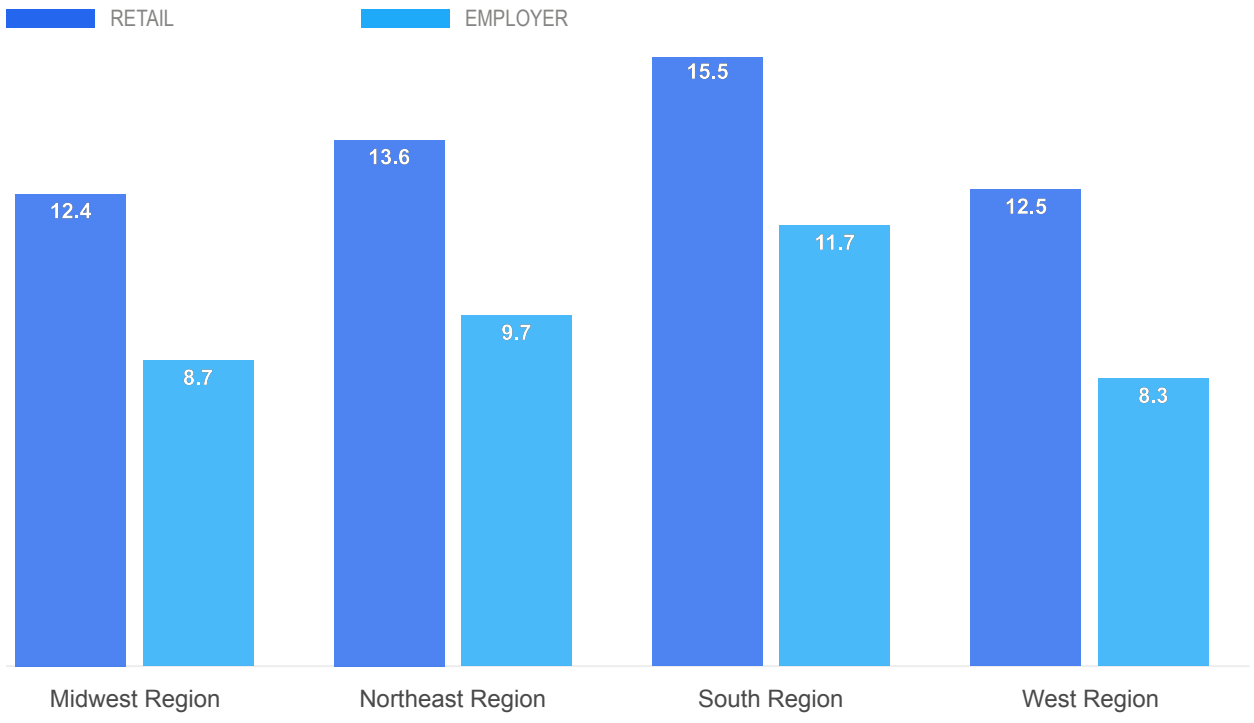
When adjusted for income, regional affordability patterns shift. The Midwest emerges as one of the most affordable regions, with employer-sponsored memberships averaging $8.7 per $1,000 of median household income and retail memberships at $12.4, keeping the region among the most accessible markets for both segments.

The West shows a similarly favorable profile. Employer-sponsored memberships average $8.3 per $1,000 of income, the lowest among all regions, while retail pricing at $12.5 per $1,000 closely mirrors the Midwest.

The South tells a different story. Despite relatively moderate nominal pricing, retail memberships reach $15.5 per $1,000 of median income, and employer-sponsored memberships reach $11.7, both the highest among regions, indicating that affordability relative to local incomes may be a more meaningful barrier to DPC adoption in the South than the nominal pricing alone would suggest.

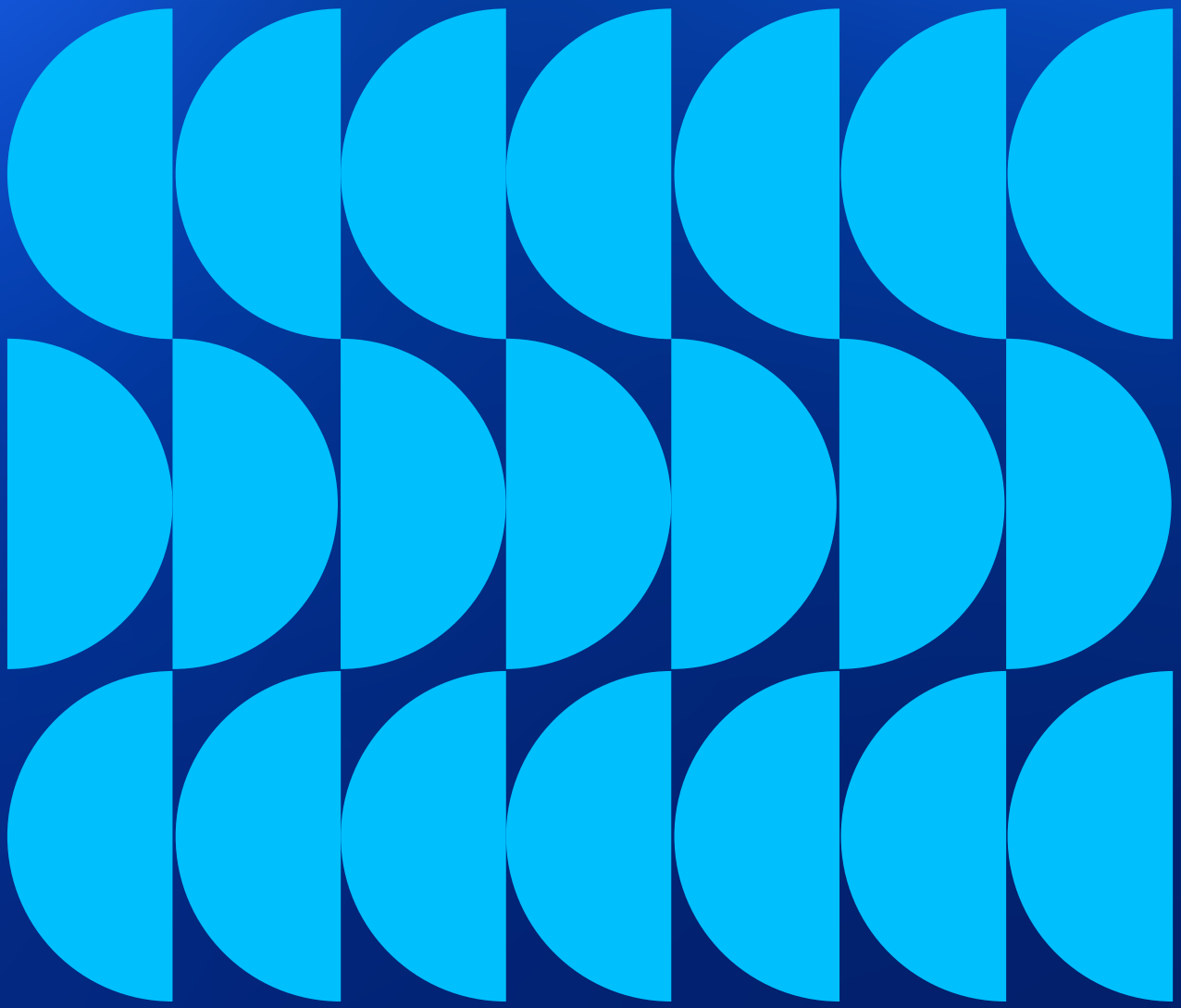
The Northeast falls between these extremes, with retail memberships at $13.6 per $1,000 of income and employer-sponsored memberships at $9.7, higher than the Midwest and West, but below Southern levels.

FIG. 11:
MEDIAN RETAIL AND EMPLOYER-SPONSORED MEMBERSHIP PRICE[1] PER $1K MEDIAN ANNUAL INCOME[2] BY REGION IN 2025



Source: 1) Hint Health Database 2) U.S. Census
Notes:
- Membership price is the median monthly price during the time period for an individual DPC membership. This excludes virtual-only memberships.
- Annual income is the median household income per the census during the time period.

SUPPLY SIDE TRENDS



The U.S. clinician workforce continues to grow, but the system remains structurally misallocated away from primary care.

The Association of American Medical Colleges projects a shortfall of 20,200 to 40,400 primary care physicians by 2036, while the Health Resources and Services Administration projects a shortage of 70,610 FTE primary care physicians by 2038, with gaps expected to be particularly acute in nonmetro areas.

Economic and operational realities compound the problem. Compensation in primary care remains far below that of many specialties, with family medicine averaging roughly $281K in family medicine compared to ~$564K in orthopedics, while most medical graduates continue to carry a median debt of $205K and 23% with $300K or more. Burnout completes the picture: family medicine and pediatrics both rank among the top five specialties for burnout in 2023.

DPC is emerging as a meaningful response to all three pressures. In 2025, Phyx, a nonprofit innovation lab dedicated to improving the primary care experience, conducted a case study of Anovia Health, Hint Health's 2024 DPC Growth Award, surveying all 18 providers across 7 physicians, 9 nurse practitioners, and 2 PAs over six months. After transitioning to DPC, clinicians reported a 48% reduction in burnout and a 68% increase in overall job satisfaction.

Operational improvements were equally striking. Average visit length increased from 14.9 minutes to 29.4 minutes, a 98% increase, allowing for deeper, more patient-centered care. Additionally, while individual clinician panel sizes decreased by 74%, reflecting the intentionally smaller, more manageable panels central to the DPC model, total clinic capacity expanded with only a one-third increase in providers and staff.

PHYX VITAL SIGNS: BEFORE AND AFTER DPC

Primary Care Vital Signs	Before	After	% Changed	P Value
Burnout (1-5)	3.4	1.8	-48	0.0028340
Satisfaction (1-5)	2.6	4.4	68	0.0001885
Average Visit Time (min)	14.9	29.4	98	0.0000000
Care Time Rating (1-4)	1.8	2.9	58	0.0000002
After-hours EHR Time (hr)	1.9	0.7	-64	0.0035396
Patient Panel Size (pt)	2050.0	525.5	-74	0.0017040

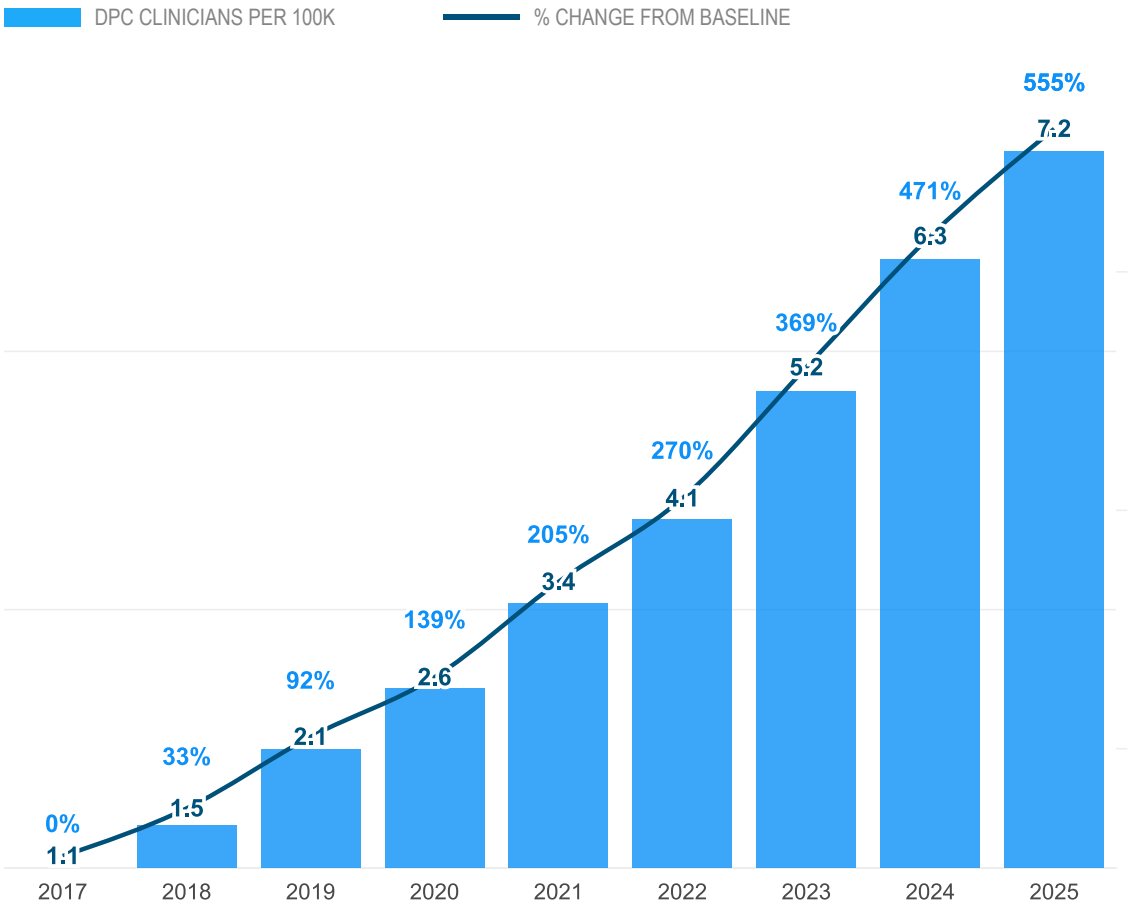
Burnout measured using the MINI-Z burnout Scale. Physician practice satisfaction measured on a 5 pt scale with 5 very satisfied.
Care Time Rating measured time for caring for patients from 1 inadequate to 4 ample.

GROWTH IN DPC CLINICIANS

While the broader primary care workforce faces ongoing shortages, the DPC clinical workforce is growing steadily with active DPC clinicians per 100,000 people increasing 555% between 2017 and 2025, a rate that reflects rising demand for the model across the country.

By 2025, that equates to approximately 7.2 DPC clinicians per 100,000 people. But DPC membership has grown even faster, up 837% since 2017. For clinicians considering DPC, the patient demand is already there and growing faster than the supply of providers to meet it, pointing to significant opportunity for additional clinicians to enter the model.

FIG. 12:
PERCENT CHANGE IN DPC CLINICIANS[2] PER 100K PEOPLE[1] FROM 2017 TO 2025



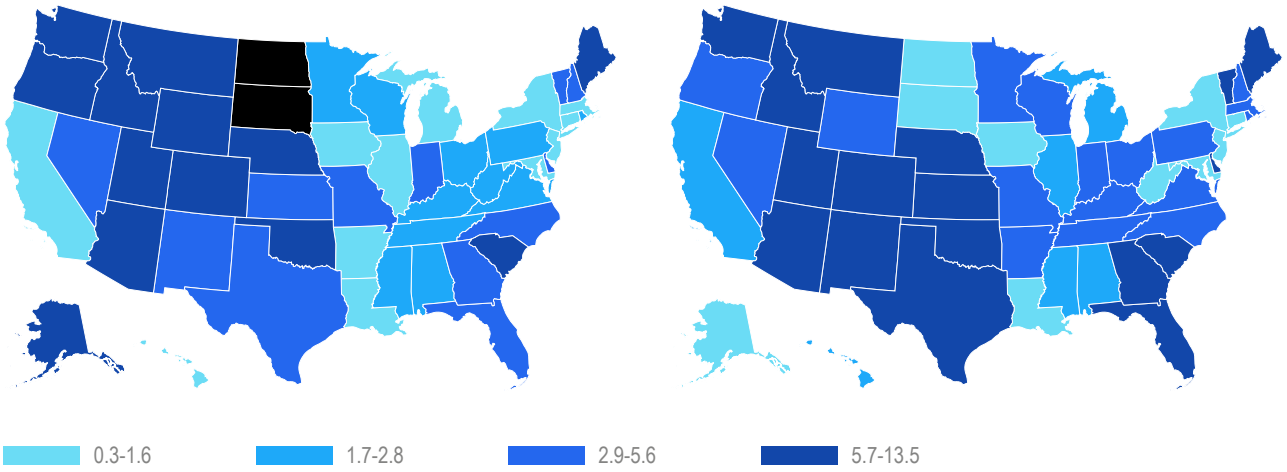
Source: 1) U.S. Census, 2) Hint Health Database
Notes: Includes all clinicians at a DPC practice who were active for more than one month during the time period.

DPC clinician adoption remains uneven across the United States, but the map is shifting. South Carolina leads the country with 25.2 DPC clinicians per 1,000 PCPs, and the highest concentrations overall are found across the Mountain West and parts of the South—regions where DPC has moved beyond early adoption into structural integration within the primary care landscape.

In contrast, clinician-dense states like New York, New Jersey, Illinois, and California still fall in the middle or lower quartiles of DPC penetration. The gap, however, is closing. Illinois, New York, and California were among the top five states for DPC clinician growth relative to PCPs from 2022 to 2025, expanding by 233%, 167%, and 133%, respectively, suggesting that the largest primary care markets may represent the next phase of growth for the model.

This accelerating growth in large states signals that national adoption is underway.

FIG. 13:
DPC CLINICIANS[1] PER 1000 PCPS[2] BY STATE IN 2022 AND 2025



Source: 1) Hint Health Database 2) Kaiser Family Foundation, Professionally Active Physicians
Notes:
- DPC clinician state is identified as the mailing address of the Hint Account associated with the clinician.
- Hint Core does not specify clinician specialty. Includes all clinicians at a DPC practice.

GROWTH OF DPC NETWORKS

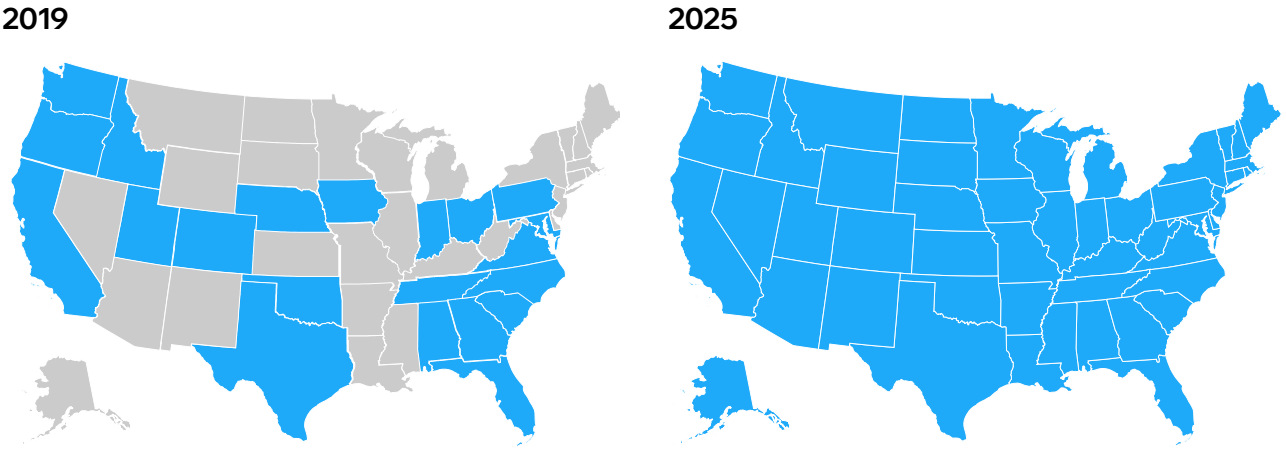
As DPC continues to gain momentum, the market still grapples with a mismatch between clinician capacity and demand. Some practices struggle to fill their patient panels, while others reach capacity quickly when partnering with a single local employer. Larger, geographically distributed employers, meanwhile, need consistent coverage across multiple locations, something no single practice can provide.

DPC networks have stepped in to address that gap. By assuming the administrative responsibilities of employer sales, contracting, and ongoing relationship management, these networks connect independent DPC practices with employers at scale, aggregating practices locally and increasingly across state lines, while allowing clinicians to remain focused on patient care.

Networks such as Tri DPC, KerixHealth, Primary Health Partners, and Persona Healthcare Direct operate their own clinics while partnering with independent practices to expand employee access across wide geographies. Hint Connect follows a similar model as Hint's national network of independent DPC practices, designed to provide a single access point for larger employers seeking to implement DPC while preserving the autonomy of independent providers and working alongside established networks to expand employer access nationwide.

The data reflects that shift directly. In 2019, only 21 states (42%) had at least one patient enrolled in a network-sponsored DPC membership. By 2025, that number had reached 49 states (98%), with Hawaii the lone exception.

FIG. 14:
STATES WITH A DPC NETWORK IN 2019 VS. 2025



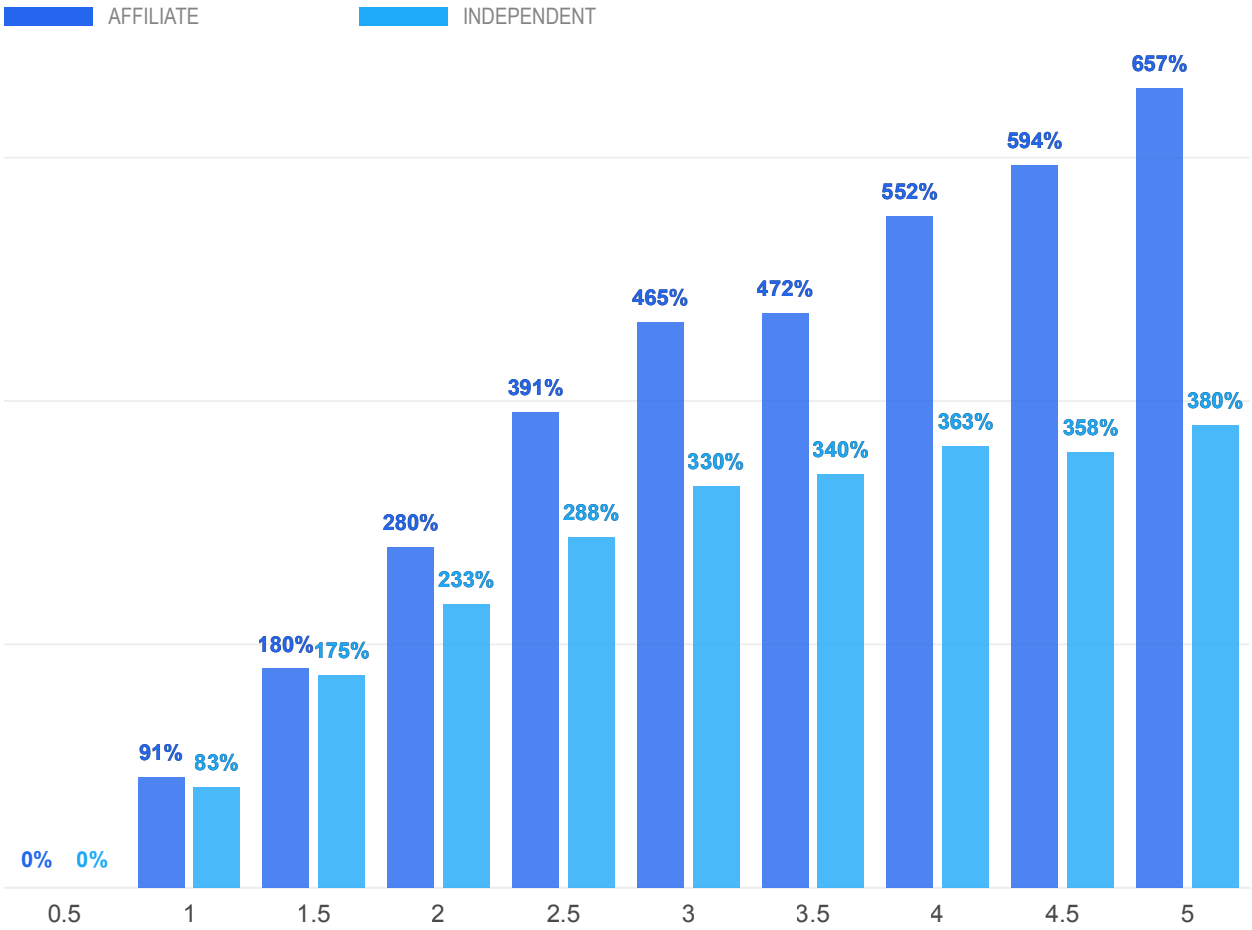
Source: Hint Health Database
Note: Network presence is defined as a state with 10 or more active members affiliated with a network operating on Hint Core.

Network affiliation appears to materially accelerate growth for DPC practices. While both affiliated and independent practices expand their membership over time, those participating in a network scale faster and more consistently, with the performance gap widening each year.

The advantage emerges early and compounds over time. After the first year, affiliated practices grow their median panel size by 91%, compared with 83% for independent practices. By year three, the gap becomes even more pronounced: affiliated practices increase their median panel size by 465%, compared with roughly 330% for independent practices.

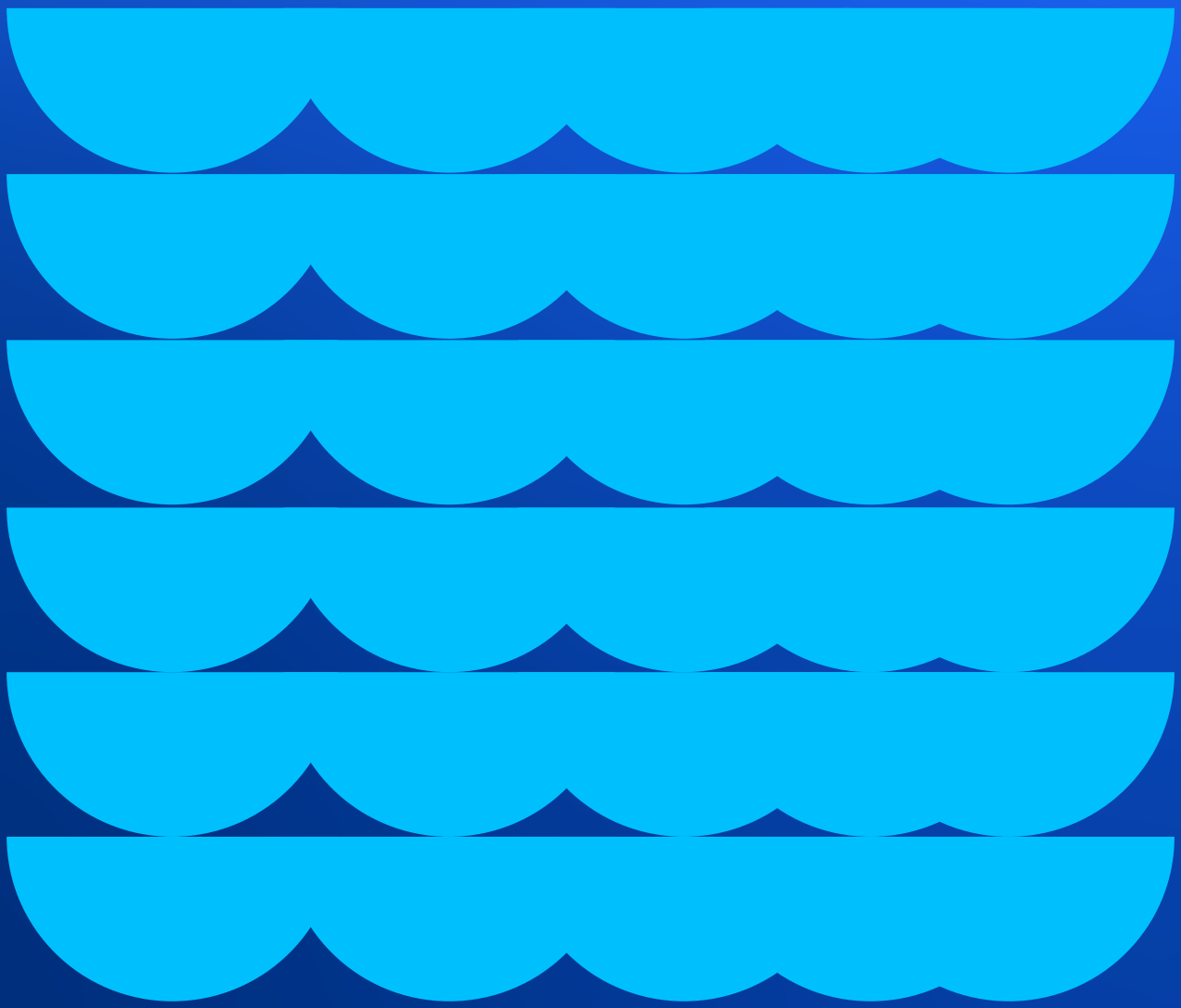
These patterns reflect the structural benefits of network participation: shared infrastructure, referral channels, and marketing reach, combined with a broader openness to multiple membership acquisition channels.

FIG. 15:
MEDIAN PERCENT CHANGE IN DPC MEMBERS PER PRACTICE FROM MONTH SIX AND ANNUALLY AFTER AMONG AFFILIATE AND INDEPENDENT PRACTICES.



Source: Hint Health Database
Note: An affiliate is a practice with at least one patient affiliated with a Network.

DPC UTILIZATION

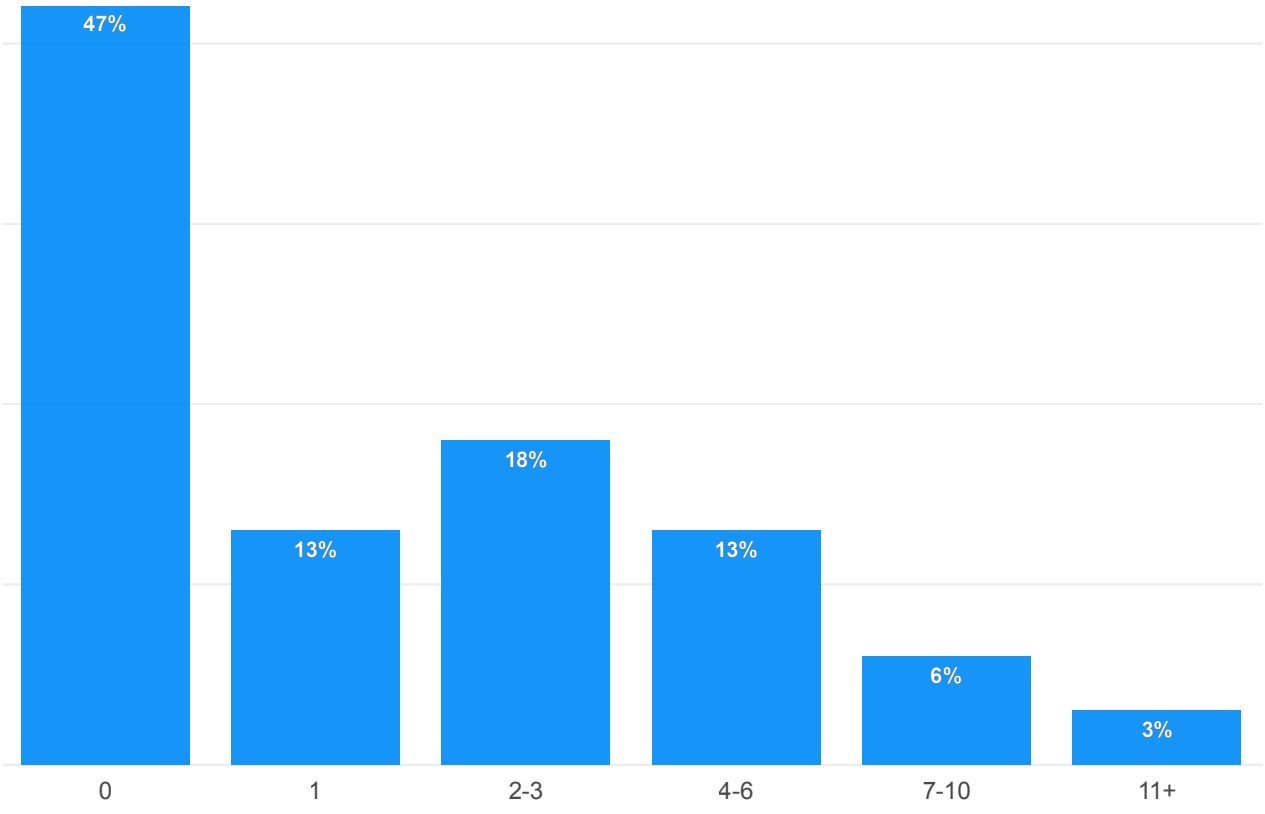


Utilization patterns in DPC show that access is built into the model. Patients can reach their clinician directly and quickly, resolving questions before they become referrals and concerns before they become emergency room visits.

Nearly half of members (47%) do not have a formal in-person or virtual visit in a given year, while about one-third (31%) have between one to three visits annually.

High-frequency visit utilization is uncommon: 6% of members have 7–10 visits per year and just 3% exceed 11 visits. Among visits that do occur, the majority are conducted in person, with virtual visits representing roughly 10% of total encounters.

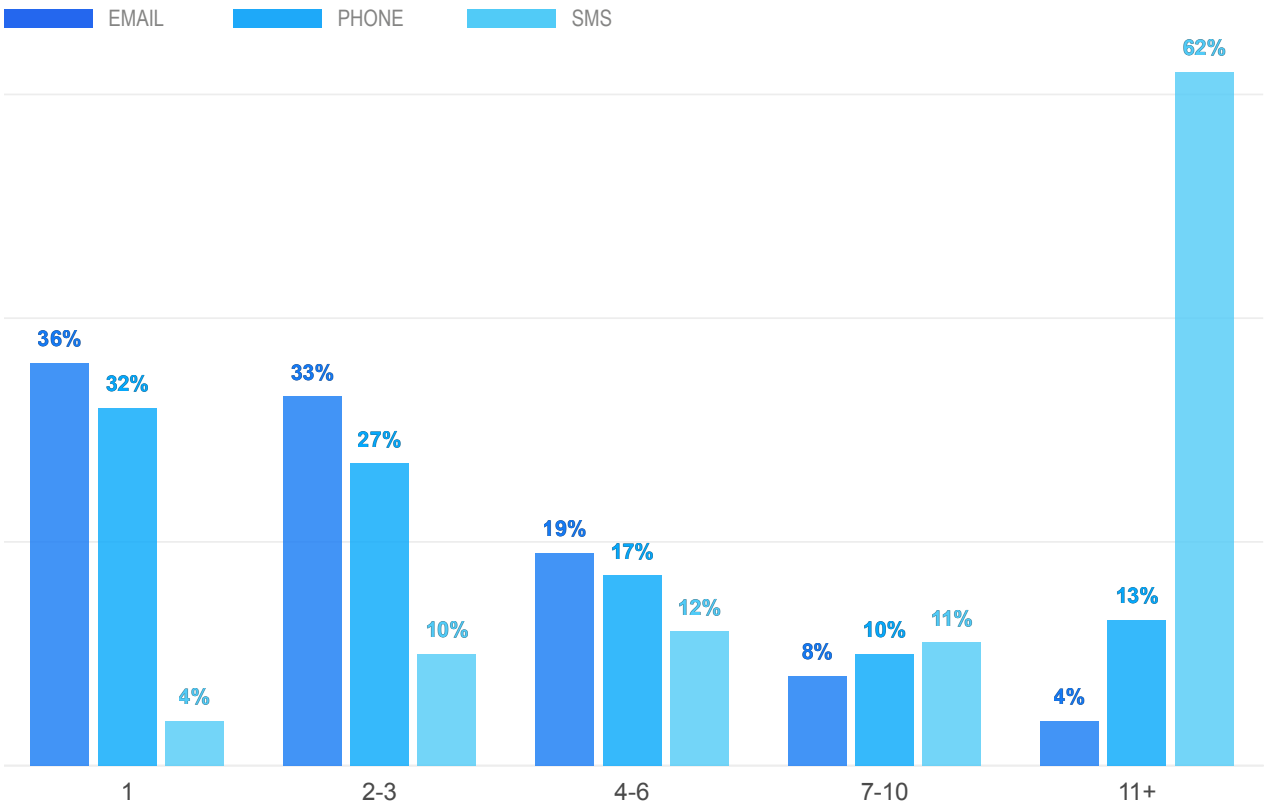
FIG. 16:
DISTRIBUTION OF ANNUAL NUMBER OF DPC VISITS (VIRTUAL OR IN-PERSON) IN 2025



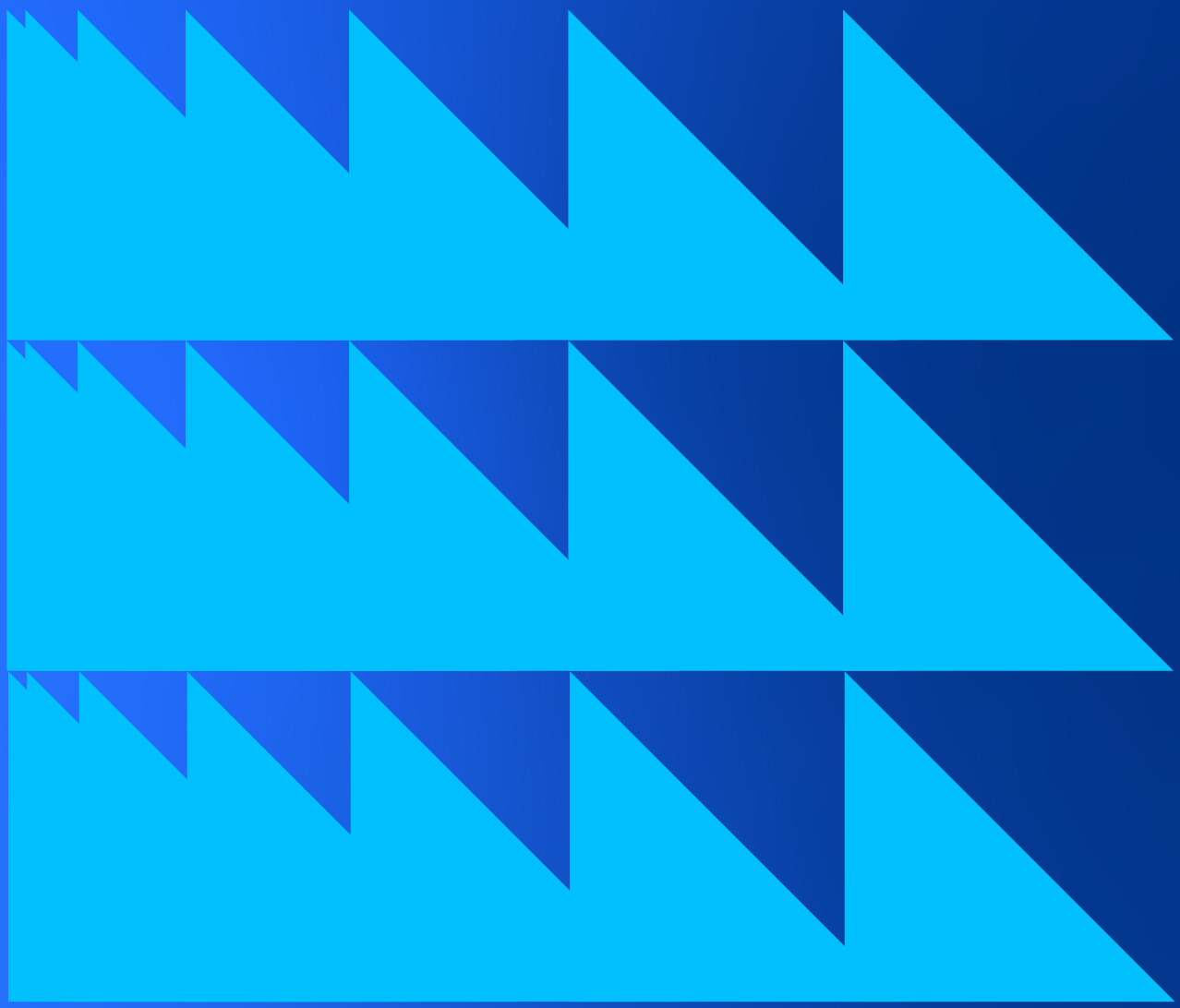
The typical DPC member is not in the waiting room.

They are in their doctor's text thread, with 62% exchanging messages 11 or more times a year with 93% of active members having communicated with their provider via SMS, email, or phone at least once during the year.

FIG. 17:
DISTRIBUTION OF ANNUAL NUMBER OF DPC INTERACTIONS BY TYPE (EMAIL, SMS, OR PHONE) IN 2025



LOOKING AHEAD



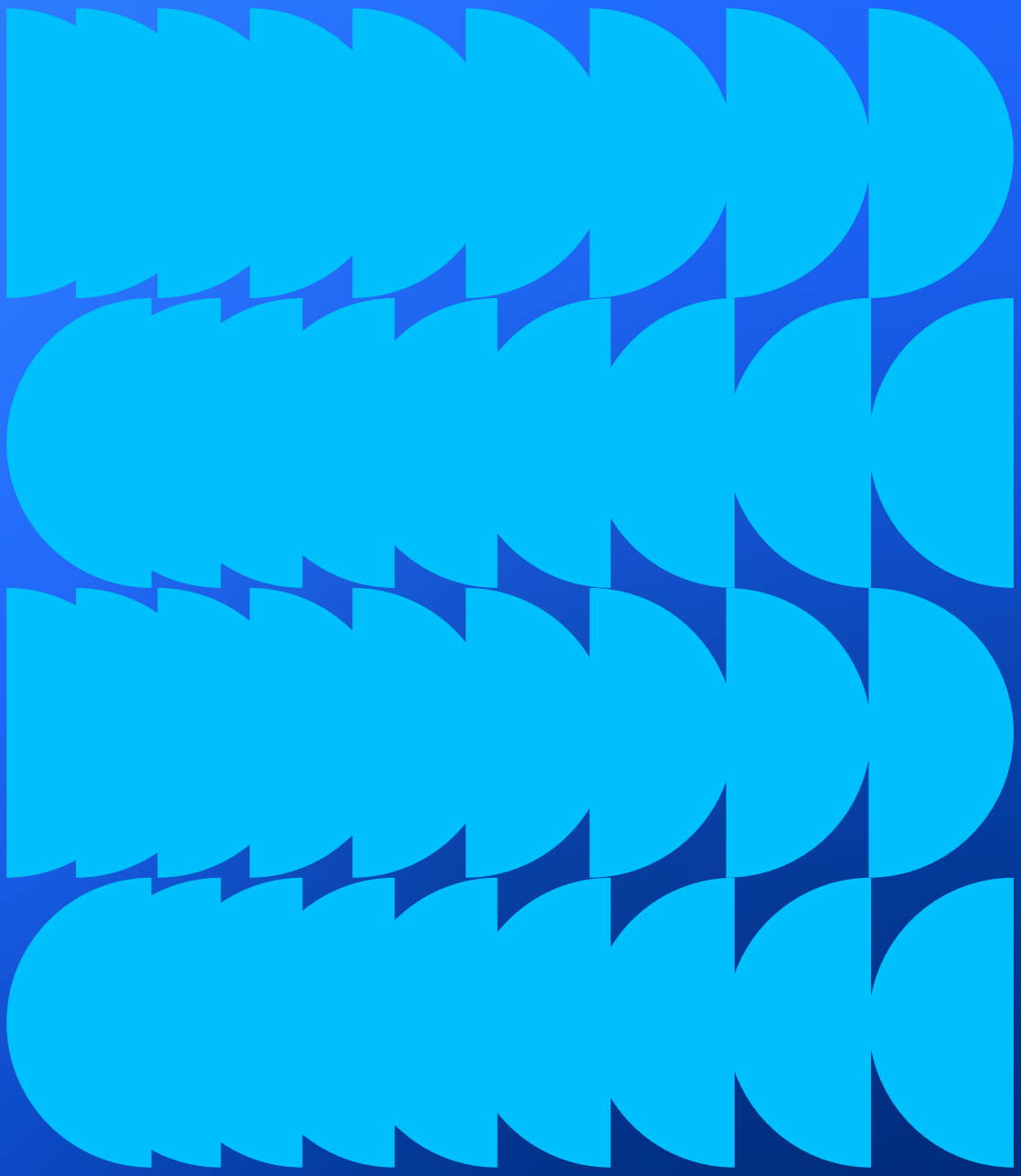
The data in this report reflects nearly a decade of compounding growth: membership up 837%, the DPC clinical workforce up 555%, and network presence now spanning 49 states. What began as a movement is becoming infrastructure.

The opportunity ahead is equally clear: a model once viewed as niche or fringe is increasingly recognized as a practical, scalable employer strategy. Recent federal policy developments have accelerated that normalization. Legislative changes now allow employers and employees to pair DPC memberships with HSA-eligible High Deductible Health Plans (HDHPs), removing a significant structural barrier that previously limited adoption and signaling growing bipartisan recognition that subscription-based primary care belongs in mainstream benefit design.

For employers, the case is straightforward. DPC offers a stable, predictable alternative to rising healthcare costs, and paired with complementary wraparound plans, it is becoming a complete benefits strategy rather than a standalone offering.

The horizon extends beyond primary care as well. As direct care models expand into additional specialties and services, the infrastructure being built today positions DPC not just as a better way to deliver primary care, but as the foundation for a fundamentally different approach to healthcare.

Hint Health remains committed to growing the evidence base for DPC.
The data speaks for itself, and it is getting louder.



TRENDS IN DPC '26

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