ETHOS BENEFITS

Reference-Based Pricing

The Model, the Math, and the Reality

Donovan Ryckis | Co-Founder & CEO, Ethos Benefits

45-Minute Educational Session

What We'll Cover Today

01

The Problem

PPO pricing, broker limits, fiduciary duty

02

How Your Plan Is Built

Four components, three funding models

03

Reference-Based Pricing

History, definition, and policy trend

04

How It Works in Practice

Setup, experience, pros and cons

05

Vendors & Real Claims

Evaluating partners + three case studies

06

Making It Work

Communication, decision, and next steps

Donovan Ryckis

Employee Benefits + Fiduciary, CEO, Ethos Benefits

BACKGROUND

- Series 65 Registered Investment Advisor
- Fiduciary background — retirement planning before benefits
- Co-founded Ethos with wife Chelsea Ryckis

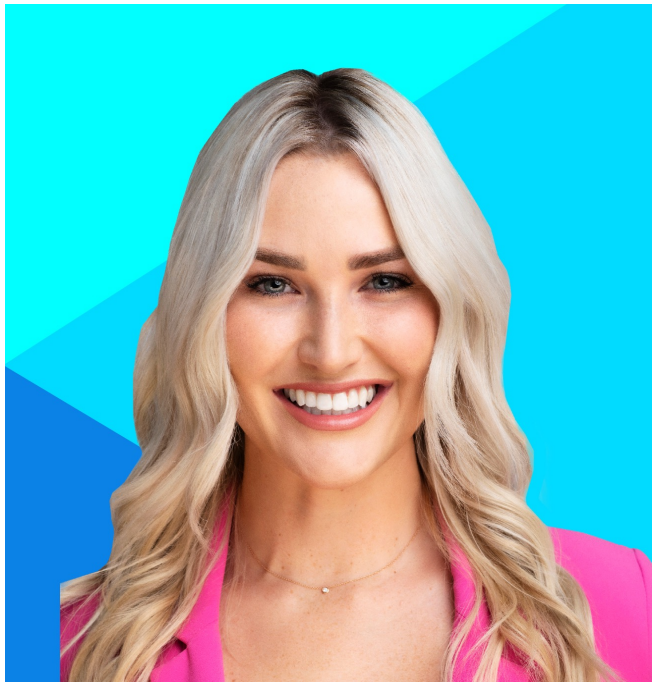
ETHOS BENEFITS

- Fiduciary-first employee benefits consulting
- large self-funded employers, nationwide
- Transparent Fee based model
- Producers of the Business of Benefits podcast and documentary films

Chelsea Ryckis

Co-Founder & President, Ethos Benefits

- Co-Founder of Ethos Benefits — built the firm on zero carrier compensation and full fee transparency
- BenefitsPRO Advisor of the Year & Most Innovative Healthcare Consultant
- Series 65 fiduciary background — applies investment-grade standards to employer health plans
- Regular speaker: BenefitsPRO Broker Expo, SHRM Arizona, HR Florida, National Alliance
- Co-host: Business of Benefits podcast
- Producer: “It’s Not Personal, It’s Just Healthcare” documentary
- Certifications: Certified Self-Funded Specialist, Certified Exit Planning Advisor



Beau Ryckis

BEFORE WE BEGIN

On their worst day,

what do you want to happen?

The day their child ends up in the NICU.

The day they need emergency surgery.

The day the $951,000 hospital bill arrives.

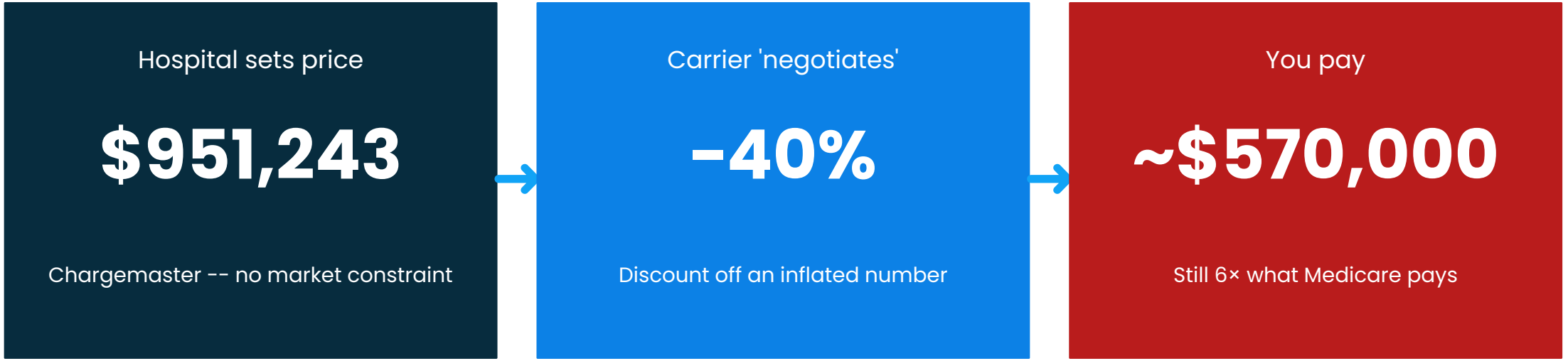
Everything in this deck is a supporting answer to that question.

01

The Problem We're Solving

Why the current model is structurally broken — and why it's your problem to solve

The PPO Discount Is Built on a Number Nobody Chose



The question this session answers: What is a fair price for care -- and who gets to define it?

Medicare Is America's Largest Insurer — RBP Uses It as the Starting Point

WHAT HOSPITALS CHARGE VS. WHAT MEDICARE PAYS VS. RBP

Billed charges

Hospital's made-up number

$100,000

PPO 'discount' (40% off)

Still based on a fiction

$60,000

Medicare pays

What hospitals already accept from America's largest insurer

$18,000

RBP pays (Medicare + 50%)

Fair markup above a real benchmark

$27,000

FLORIDA REALITY

346%

of Medicare — the HIGHEST in the nation.

Commercial PPOs paid Florida hospitals 346% of Medicare in 2022.

CHECK YOUR OWN HOSPITALS

SageTransparency.org

Free tool from Employers' Forum of Indiana + RAND. Search any hospital. See what commercial plans actually pay as a % of Medicare.

The simple idea:
use a REAL price as a reference, add a fair markup. Don't accept a fictional price, then celebrate a fictional discount.

02

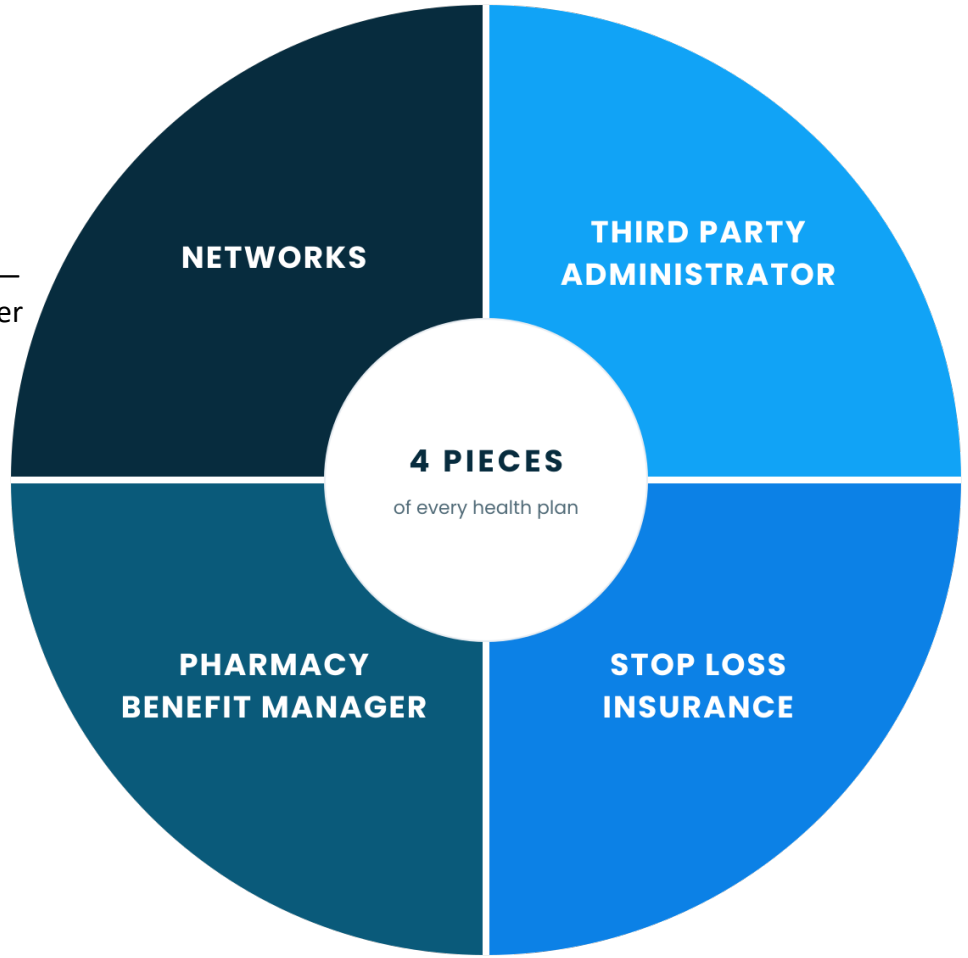
How Your Health Plan Is Actually Built

Four components, three ways to fund them, and who gets to choose

Every Health Plan Is Built From the Same Four Pieces

Administrative Services Only

”ASO” A self-funded health plan where the employer pays claims directly from company funds and hires a carrier to administer the plan — process claims, rent the network, handle member services — for a flat per-employee fee.

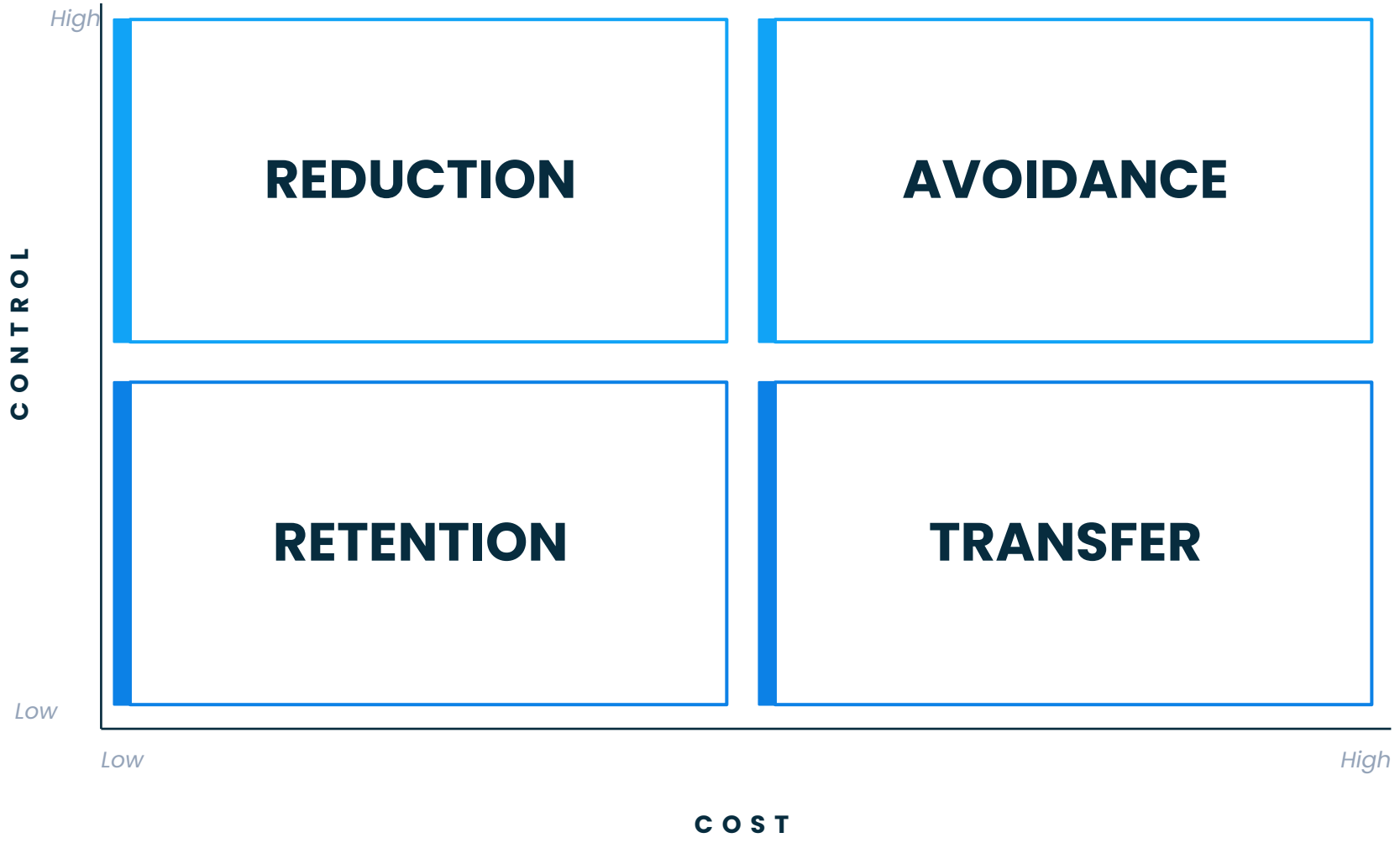


”The claims are the claims”

A Claim is a reimbursement for a covered incident. While medical conditions are fixed and we can’t change them occurring, you can very much change the cost for that incident, the claim.

Claims ≠ Claims

The Risk Matrix – What can be done?



← ***Most brokers start & stop here***

The real savings live in REDUCTION and AVOIDANCE — the quadrants most brokers were never structured to work in.

03

Reference-Based Pricing

The Medicare reference, the Florida reality, and what it actually does

Reference-Based Pricing — The Basics

RBP sets a fair, defensible reimbursement rate based on a public reference — instead of accepting whatever a hospital decides to charge, minus a mystery discount.

WHY MEDICARE?

It's the largest insurer in America.

65M+ Americans covered by Medicare — more than any private insurer, nationwide

Public Every Medicare rate is published, predictable, and tied to a documented formula

Accepted Hospitals already accept Medicare every day, on a majority of their admissions

Objective Nothing is negotiated behind closed doors — it's the same rate for every patient

HOW IT WORKS

Pick a percentage of Medicare. Pay that.

1. **Your plan picks the reference**

   Typically 125-175% of Medicare for hospital care — a fair markup above the public benchmark.

2. **Claims are paid at that rate**

   When a claim comes in, the plan pays the benchmark amount — transparently, every time.

3. **That becomes the reasonable price**

   The hospital either accepts it or negotiates. Most accept. Outliers are handled by the advocate.

4. **Members keep using their plan**

   Same doctors. Same hospitals for emergencies. Same ID card. The mechanics change; the experience doesn't.

The pricing model shifts from "discount off a fictional price" to "markup above a real one."

RBP Is Not New. We Just Forgot What We Used to Call It.

Pre-1980s

Indemnity Era

Plans paid claims at a % of UCR -- Usual, Customary & Reasonable. Medicare was the primary reference. Employers had control.

1980s-2000s

Managed Care Takeover

HMOs and PPOs replaced UCR. The new model: negotiate a 'discount' off inflated hospital charges. Employers lost visibility.

Today

The Return of Logic

RBP re-anchors payment to Medicare -- the same reference used in the indemnity era. Same concept. Same math. The name changed.

"Most resistance to RBP comes from unfamiliarity, not evidence. It's a pricing methodology with a 50-year track record." -- Bob McCollins

13 States Have Now Mandated This Logic in Their Own Plans

WHY STATE POLICY MATTERS HERE

State employee health plans are run by the largest employer in each state: the government itself.

When 13 states have adopted reference-based pricing for their own workforces — and seven of them in the last three years — they're making a public fiduciary statement: the PPO discount model does not hold up under scrutiny. Medicare-referenced pricing is a defensible alternative. This is the same logic private self-funded employers have used for decades, now being mandated at the government level.

California	2011	State employee plan, specific procedures
Montana	2016	Now at 180% of Medicare
South Carolina	2016	Radiology, lab, ASC, medications
Oregon	2019	200% in-network / 185% out-of-network
Washington	2021	Public option at 160% of Medicare
Colorado	2023	155% floor for hospitals
West Virginia	2023	110% floor for all in-state providers
Delaware	2025	All commercial + Medicaid + state at 250%
Indiana	2025	Commercial to 250-300% by 2029*
New Mexico	2025	200% in-network / 175% out-of-network
Nevada	2026	Public option at Medicare-comparable rates
Vermont	2027	All commercial plans, GMCB to set rates
Oklahoma	-	State employee plan, above Medicare rates

**Indiana: hospitals that fail to comply lose nonprofit status — the most aggressive enforcement mechanism yet enacted.*

Private employers have been doing this voluntarily for 40+ years. Now 13 states are mandating it.

BRIEF INTERLUDE

How hospitals try to explain Medicare Reimbursements

04

How It Works in Practice

Setup, member experience, and an honest look at pros and cons

Choosing Your RBP Vendor: What Matters and What to Ask

Two Structural Models

Integrated TPA + RBP

- ✓ Single point of contact
- ✓ Built-in advocacy
- ✓ Simpler member experience
- -- Less flexibility to swap components
- -- Harder to benchmark performance separately

Network Replacement Model

- ✓ Works with your existing TPA
- ✓ More control over each component
- ✓ Easier to benchmark separately
- -- Requires tighter TPA + vendor coordination
- -- More moving parts

Questions to Ask Any RBP Vendor

Balance bill resolution rate?
Benchmark: 95%+

Average resolution time?
Benchmark: under 30 days

Balance bill defense tenure?
Should be: life of the claim

Balance bill defense tenure? → Best practice: life of the claim, even years later

Member advocacy line staffed and accessible before care is received -- not just post-claim

How a Reference-Based Pricing Plan Is Set Up

Four structured decisions, in order. This is not a leap of faith — it is a sequence of evaluable choices.

01 Feasibility Study

START HERE. Your RBP vendor runs this before you commit. They take your paid claims 12-24 months, run the CPT code (current procedural terminology) and compare your price, to their average price in the same hospitals or average.
They show you percentage of claims that needed advanced negotiations, re-directs or balance bills.

02 Wrap PPO Networks

For physician and ancillary care, keep a traditional network 'wrap' — same in-network experience members expect for routine care. RBP focuses on hospital and facility pricing where the outsized margin lives.

03 Direct Contracts

Where the real savings compound. Three places to pursue them:

→ Centers of Excellence — transplants, orthopedics, cardiac

→ Hospital direct contracts — bypass the network entirely

→ Advanced imaging — MRI, CT, specialty radiology

04 Carve-Outs

Transplants, NICU, oncology, and specialty cases are typically carved out at a higher multiplier or managed via single case agreements. Standard practice — not a weakness.

The Member Experience: What Actually Changes Day-to-Day

Your plan works the same way for most of your healthcare. The difference is that when you're going to a hospital, we ask you to make one phone call first -- and that call protects you.

Service Type	Member Experience	What's Different vs. PPO
PCP / Specialist Visit	Use network -- show card -- standard cost share	Nothing. Same as today.
Urgent Care	In-network facilities available -- standard process	Nothing. Same as today.
Elective Surgery / Outpatient	Pre-auth required -- call advocacy line before scheduling	**Facility calls for Pre-auth rather than approval online**
Inpatient Admission	Pre-auth required -- advocate engaged proactively	**Facility calls for Pre-auth rather than approval online**
Emergency Room	Go immediately -- pre-auth NOT required	NSA protections apply after the fact
Balance Bill Received	Call advocacy line -- DO NOT pay	**Vendor defends -- member pays $0 in 95%+ of cases**

The Case For RBP

✓ Cost Savings

20-40% reduction vs. traditional PPO or fully-insured plans -- consistently documented across employer groups.

✓ Real Transparency

Employer sees actual claim cost vs. the benchmark. No mystery 'discounts' on inflated numbers.

✓ Eliminates the PPO Illusion

No more paying $273K because the hospital billed $951K and your carrier 'negotiated' it to a number still 3× Medicare.

✓ Fiduciary Alignment

Paying a reasonable, defensible benchmark is exactly what ERISA fiduciary duty looks like in practice.

✓ Predictability

Pricing anchored to Medicare makes plan costs more forecastable than network arrangements with variable allowed amounts.

✓ Historical Credibility

This isn't experimental. Employers did this for decades before managed care crowded it out -- and 13 states now mandate it.

The Real Risks -- And How to Think About Them

Balance Billing

Risk: Low

Overstated and misunderstood. 98%+ resolution rate with a quality vendor. Worst case: paying a PPO-equivalent rate on a percentage of claims.

Member Friction

Risk: Medium

No in-network card to wave for facility services. Employees need to understand the plan before they use it -- not in the waiting room.

Provider Pushback

Risk: Low-Medium

Large hospital systems will push back. Some refuse members initially. Manageable with the right advocacy tools and a prepared HR team.

HR Burden Shifts

Risk: Low

Escalations don't disappear -- they move. Volume is typically lower than expected, but HR needs a clear protocol and responsive vendor support. Plan sponsors should not be seen as decision makers.

Stop-Loss Misalignment

Risk: High if missed

The silent killer. A plan that hasn't confirmed stop-loss support before implementation is exposed in ways most employers don't realize until a large claim hits.

Not Right for Everyone

Risk: Context-dependent

Small headcount, high-utilization populations, limited HR support, or fragmented geographies all increase risk. Run a feasibility study first.

Geographical Considerations

Risk: Highest

There are legitimate geographical restrictions where it would be more RBP would be problematic than helpful. Get a feasibility study to eliminate this concern.

It doesn't mean RBP is right for every employer. It means the conversation deserves to start from an accurate baseline -- not from fear of something that feels foreign.

05

Vendors & Real Claims

How to evaluate partners — and three real case studies

Case Study 1 -- The Scale Story: HCA / 37-Day ICU Admission

| 37-day inpatient ICU admission | December 2024 - January 2025

$951K
Provider billed charges

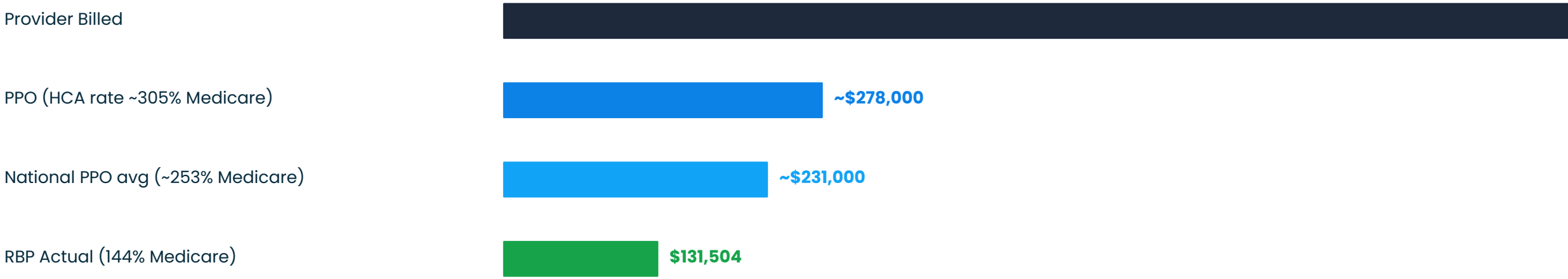
1,043%
of Medicare (10.4×)

$131K
Plan paid (144% Medicare)

86%
Savings vs. billed charges

$0
Balance bills / legal action

The More Important Number: What Would a PPO Have Paid?



Real savings vs. a commercial network: ~$147,000 in actual plan dollars -- not savings vs. a fictional billed charge.

Case Study 2 — Same Physician. No Delay. 96% Less.

Outpatient surgery (CPT 15275 — finger skin graft) | Hospital outpatient department → Ambulatory Surgical Center | Same surgeon. Same procedure. Same day of care.

Hospital Billed

$84,516

5,037% of Medicare

Hospital 'Discounted' Ask (30% off)

$59,161

3,524% of Medicare
35× the Medicare rate

ASC Redirect (what actually happened)

$2,098

125% of Medicare
Member paid $0

WHAT THE INTERVENTION DID

Same surgeon

Care navigation kept the original treating physician. Patient didn't have to change doctors.

No delay in care

Single case agreement negotiated in days. Procedure performed on schedule.

Different facility

Procedure moved from hospital outpatient department to an independent ASC.

Member paid $0

No balance bill. No deductible. No out-of-pocket exposure.

On their worst day — a surgery needed — the plan kept the same doctor, avoided the delay, and saved the member $0 out-of-pocket. The procedure cost 96% less than the hospital asked for.

Case Study 3 — Same Doctor. Same Procedure. $50K Back to the Plan.

Complex ankle reconstruction | Hospital → Independent ambulatory surgical center | Same surgeon. 9-day reschedule.

HOSPITAL PATH (scheduled)

~$80,000

Estimated cost to plan at the original hospital booking. Employee on track to hit $9,000 family out-of-pocket max.

ASC REDIRECT (what happened)

< $30,000

Single case agreement at an independent ASC. Same surgeon, same procedure. Delayed one week.

WHAT HAPPENED

1 Pre-auth flagged

Care navigation caught the case during pre-authorization review.

2 2-day turnaround

Navigator contacted member, reviewed records, confirmed 4-hour OR + overnight stay.

3 SCA negotiated

Single case agreement executed with same surgeon at independent surgical center.

4 Surgery performed

Rescheduled 9 days later. Member kept same doctor. Same procedure.

On their worst day — major surgery needed — care navigation found $50K of savings for the plan and thousands of out-of-pocket for the employee. Same doctor. Same procedure. Most members don't know this is possible. The plan has to be built to find it.

Case Study 4 — The Kind of Transparency a PPO Plan Can't Deliver

This is not a reference-based pricing story. It is included because the intervention on this slide is impossible on a PPO plan — and because it illustrates what owning your plan architecture actually buys you.

Earlier plan year

Employer absorbs a NICU claim near $450K. The kind of hit that rewrites renewal math for two cycles.

→

Months later

Another employee calls HR. Premature baby in the NICU. Baby not yet enrolled. Default PPO path: add baby, send ID cards, wait for claims.

→

The intervention

HR connects family to a real member advocate. Advocate maps all options — including a Medicaid pathway the family qualifies for and didn't know existed.

→

The outcome

Family chose Medicaid. Baby spent 21 days in NICU. Plan cost: $0 on this claim. Member out-of-pocket: $0. Baby went home healthy.

THE MATH — MINIMUM SAVINGS FLOOR: $175,000

$175K
Specific stop-loss deductible NOT written (minimum savings floor)

$150K
Medicaid bill (actual cost, plan paid $0)

~$402K
Commercial equivalent (2.68× Medicaid, per Oregon HHS)

~$227K
Stop-loss reimbursement claim NOT filed

On their worst day — their child's life in a NICU — a human advocate intervened before a claim was paid. That kind of transparency does not happen on a traditional PPO. It requires owning your plan architecture.

06

Making It Work

Communication, decision framework, and three concrete next steps

What Members Actually Experience — And How You Communicate It

Communication is the whole game. If employees understand what their plan does for them — before they need it — everything else works.

OPEN ENROLLMENT

The pitch

Plain-language explanation: 'You have access to the same doctors, same hospitals, same care — plus a real person who helps you navigate it.'

AT HIRE & ANNUALLY

Showing the network

How to find in-network facilities. Interactive provider lookup. What to do if your doctor says they won't accept it.

FIRST 90 DAYS

Training on advocacy

Call the advocate BEFORE scheduling surgery, not after. A 5-minute call before care prevents 90% of problems.

ONGOING

What they actually get

Lower premiums. Lower deductibles. A real human on the phone. No mystery bills. Care coordinated for them.

What you get premium control, common sense pricing, risk avoidance and risk reduction strategies for the same care.

HOW IT BENEFITS THEM

Same doctors. Lower cost. Real human advocacy instead of a 1-800 number. No mystery bills because the advocate intervenes BEFORE care, not after.

If a balance bill does arrive: call the advocate. Resolved in 95%+ of cases without member cost.

ETHOS BENEFITS

Thank You

Questions? Let's talk about what this looks like for your organization.

Donovan Ryckis

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