ANABAPTIST BROTHERHOOD

A Third-Party Service for Church Medical Aid Plans

Two Service Levels — A Board Briefing

Reference-Based Pricing · Truth · Transparency · Trust

Prepared for the boards of prospective sharing plans considering Brotherhood's third-party service.

> This service is a third-party administrative solution. It is **not insurance and is not an insurance product.** It does not use insurance contractors. Each plan and its members retain ultimate responsibility for their own medical bills.

Purpose of This Briefing

Anabaptist Brotherhood offers a third-party service that helps church sharing plans and medical aid programs administer the cost of medical care. This briefing explains what the service does, lays out the two available service levels, and describes what a plan can expect if it chooses to participate. It is intended to give a board enough information to weigh the decision in principle; full terms and tentative costs. Onboarding dates are provided when a formal service agreement is offered.

The Burden Plans Carry Today

Church leaders and medical aid administrators face a medical billing system that is complex, opaque, and often priced far above what is fair. Two patterns make stewardship especially difficult:

- **Inflated charges.** Listed prices frequently bear little relationship to the actual cost or value of care.
- **Deceptive discounts.** A large "discount" off an inflated charge can still leave a price well above fair and reasonable norms, giving the illusion of savings.
- **Administrative strain.** Processing bills, negotiating balances, and answering collection notices pulls boards away from governance and shepherding their members.

Brotherhood's service is designed to carry that administrative load behind the scenes, so a plan's leadership can focus on oversight and care for its people. This enables churches keep the autonomy of their closely held aid plans while outsourcing the complex work of medical bill administration to a trusted partner.

What the Service Is

The service furnishes accounting, bill processing, negotiation, and payment on a plan's behalf. It operates on a Reference-Based Pricing model: rather than accepting discounts off inflated charges, it anchors payment to reliable benchmarks — including Medicare rates plus a percentage set by the plan's own rules — to arrive at a fair and reasonable price.

The work runs on dedicated software and a trained office team. Brotherhood operates its own Medical Aid and Alms Plan, and this service extends that same infrastructure.

Our Approach: Truth, Transparency, Trust

Truth. Pricing is anchored to dependable benchmarks rather than to inflated charges or the illusion of a discount. Software analyzes billing codes and medical pricing data to establish a price with integrity.

Transparency. Every payment is accompanied by an Explanation of payment that shows how the bill was evaluated and priced — demystifying the numbers for both providers and members.

Trust. When truth and transparency guide pricing, trust can grow — with members, with providers, and within the brotherhood.

Two Service Levels

The service levels differ in size, structure, allowing administration to keep part of the work in-house. The service is therefore offered at two levels:

Plan Management Service — full administration. The Service handles the bills *and* the surrounding plan administration: contribution invoicing and reconciliation, deductible and eligibility processing, direct provider payment, and complete financial and medical reporting.

Bill Management Service — a bill-level service. The Service reprices, processes, and pays medical bills and advocates on balance billing and collections, while the plan keeps all of its own contribution administration, sharing and reimbursement to members. It receives summary reporting on billing

Both levels share the same core: member ID cards, eligibility verification, coding review, Reference-Based Pricing, balance-billing and collections advocacy, and provider agreements.

Side-by-Side Comparison

Feature	Bill Management	Plan Management
Member ID cards	**Included**	**Included**
Electronic eligibility verification	**Included**	**Included**
Medical coding review & error correction	**Included**	**Included**
Reference-Based Pricing	**Included**	**Included**
Bill processing	**Included**	**Included**
Provider payment	included	included
Balance billing & collections advocacy	**Included**	**Included**
Provider Pricing Agreements	**Included and set to Plan's agreements with providers**	**Included and set to Plan's agreements with providers**
Deductible & eligibility rules processing	Excluded	**Included**
Reimbursement to member	Excluded	**Included**
Sharing among members	Excluded	**Included**

Feature	Bill Management	Plan Management
Explanation/Invoice to member	Explanation/invoice of Payment	Explanation/invoice/reimbursement of Payment per sharing guidelines
Contribution / dues administration	Retained by your plan	Managed by the Service
Financial reporting	Summary of bills paid	Complete Balance Sheet and P/L reports
Medical report	Included	Included
Optional pharmacy program	Available	Available
Quarterly magazine (Our Health)	Included	Included

Plan Management Service (Full Administration)

Best suited to plans that want the Service to run the day-to-day administration end to end. The Service:

- Pays providers directly from the plan's dedicated account, within 10 business days of a correctly coded bill.
- Issues a full Explanation of Payment and Sharing to members showing paid, shared, ineligible, reimburses eligible amounts and invoices personal-responsibility amounts.
- Manages contribution (dues) invoicing, receipting, and reconciliation.
- Calculates deductible, eligibility, and sharing under the plan's rules.
- Provides complete financial and medical reporting to the board.

The board retains governance, plan guidelines and eligibility interpretation, financial reserves, and member shepherding. *Amish Mennonite Church Aid is served at this level.*

Bill Management Service (Bill-Level Service)

Best suited to plans that wish to keep their own contribution and sharing administration but want expert help with the bills themselves. The Service:

- Reprices and processes medical bills using Reference-Based Pricing, then pays the fair price to providers when a member has paid at the time of service.
- Issues an Explanation of Payment to the member or administrator showing services rendered and the fair price paid.
- Advocates on balance billing and collections on the member's behalf.
- Provides summary financial (paid bills only) and medical reporting.

The plan retains its own contribution (dues), reconciliation and sharing. This level carries a correspondingly lighter administrative footprint for the Service but heavier for the plan.

How the Service Operates, Day to Day

1. **A member presents the ID card.** The card gives the provider what they need to verify eligibility and bill the Service electronically or by mail on a standard CMS-1500/HCFA or UB-04 form (or equivalent) with procedure codes.

2. **The Service reprices it** against benchmarks to a fair and reasonable amount, correcting coding errors along the way.
3. **Payment is made** — directly to the provider (Bill Management) or also paid/reimbursed/shared as appropriate (Plan Management).
4. **Explanations are issued** to the provider and to the member, showing how the bill was priced.
5. **If a balance is billed or sent to collections,** the Service responds and negotiates on the member's behalf.

Getting Started: Onboarding

1. **Sign the service agreement.**
2. **Provide a member roster** and contact information so Member ID cards can be issued.
3. **Provide the plan's rules** — eligible and ineligible expenses, caps, and member responsibilities — to be embedded in the software. (if choosing Plan Management)
4. **Software configuration.** Embedding a plan's unique rules takes time to program and test.
5. **Designate a point of contact** to liaise with the Brotherhood office team.
6. **Establish a dedicated bank account** for receiving contributions and making payments.

What Your Plan Brings

The service supports a plan; it does not replace it. To participate, a plan should be prepared to:

- **Maintain adequate financial reserves or credit** so large bills can be paid promptly; the Service holds no reserves and assumes no legal responsibility for payment.
- **Honor the alms-support expectation.** Plans serving Social Security–exempt members are expected to provide reasonable economic support for widows, disabled members, and the low-income.
- **Retain governance** of guidelines, eligibility, and reserves, and designate a point of contact.

Pricing

The service fee for *Plan Management* is five to seven percent (5% to 7%) of paid bills — or an equivalent flat amount per household per year. The service fee for *Bill Management* is four to six percent (4% to 6%). Service fee is invoiced quarterly.

An optional pharmacy program is available at additional cost of $20 per year per household and confirmed in the service agreement.

Where the Service Stands Today

In fairness to every plan considering this, the current status is presented plainly:

- **Pilot underway.** A pilot launched January 1, 2026 with Amish Mennonite Church Aid, serving roughly 525 households — the first live user of the Plan Management service.
- **Software still being built.** A dedicated team is building the platform; a full year of programming is anticipated. An exact onboarding date for the next plan cannot yet be promised.

- **Full publication targeted for January 2027,** when scope and limits, detailed costs and procedures, onboarding capacity, and launch dates will be published.
- **Waiting list open.** Plans on the list — in order of placement — will have the first opportunity to review and decide whether to onboard.

Next Steps

If your board has genuine interest, ask to be placed on the waiting list. Placement establishes priority; it is not a service agreement and may be withdrawn at any time. When the service is published, those on the list will be first to review the features and decide whether to sign.

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Appendix: Reference-Based Pricing, Balance Billing, and Debt Collections

Why this matters to your board. Reference-Based Pricing typically saves a plan 10–20% compared with paying "discounted" hospital prices. Those savings are real — but they are not free. They are earned by paying a fair price and then standing behind it when a provider pushes back. Brotherhood does the front-line work — the repricing, the dispute letters, the negotiation — but members will at times receive balance bills or collection notices in the meantime. They need to understand why, and what to do. Adopting this approach is therefore a shared commitment that calls for education at both the board and member level.

1. The Pricing Problem: The Illusion of the Discount

Hospitals maintain a "chargemaster" — an internal price list often set at 400% to 1,000% of the actual cost of care. A "self-pay discount" (sometimes marketed to plain communities as a 45–50% courtesy) is a discount off that inflated number, so even a large discount can leave the price far above fair. It is like marking a $20 item up to $200, then offering it for the "special price" of $100. Rising chargemaster prices — not greater use of care — account for the majority of recent healthcare inflation.

The same three services, priced three ways:

Service	Medicare + 50% (Brotherhood)	Chargemaster	50% "discount"
CT scan	**$975**	$3,250	$1,625
ER visit	**$570**	$1,900	$950
Lab work	**$210**	$700	$350

Read across each row: the "50% discount" still costs far more than a fair, Medicare-anchored price. A discount off a phony number is not a bargain.

2. Reference-Based Pricing (RBP): A Fair Price, Built on Three Benchmarks

Rather than anchor to the chargemaster, Brotherhood names a fair and reasonable price using a "triangle" of objective reference points:

- **Medicare — the gold standard.** The one U.S. pricing system that is transparent, publicly audited, and rooted in the actual cost of care (designed to cover a hospital's variable cost at roughly 108%, plus margin, and adjusted for quality outcomes). Paying 150% of Medicare on facility bills is generous — on the order of a 58% margin on facility services and 28% on physician services.
- **Cost-to-Charge Ratio — the truth-teller.** Every hospital reports its costs to the government; that data lets Brotherhood see through obscure pricing to actual cost plus a fair profit.
- **Competitive pricing.** Paid prices are compared hospital-to-hospital within a region, with a plan to publish regional rates so members can see real pricing.

The result: providers are paid a fair, even generous price — averaging roughly 40% above their actual cost — while the plan preserves 10–20% compared with discount-off-chargemaster pricing. RBP cannot be done well by an individual; it takes pricing data, software, and an organization that understands the economics.

3. Balance Billing: The Pushback — and the Shield

After Brotherhood pays a fair, Medicare-anchored price, a provider may reject it as full settlement and bill the member directly for the "balance." This is not a clerical error; it is a tactic to treat a fair payment as a mere deposit and recover the inflated charge. It is, however, uncommon — roughly 2–4% of bills — and often a "paper tiger."

Brotherhood's advocacy (the FCRA shield). On the member's behalf, the office issues a formal Fair Credit Reporting Act dispute letter contesting the accuracy and fairness of the balance bill, invites the provider to justify a charge already paid ~40% above cost, and asserts that providers are restrained from sending unverified balances to collections while the dispute is active (generally at least 90 days). Members receive regular updates while a dispute is open.

> **The member's part: never pay a balance bill.** Forward it to the office and let Brotherhood respond. If a provider calls, the member can simply say their Brotherhood representative will respond on their behalf.

4. Debt Collections: Validation Under the FDCPA

If a disputed balance is sold to a collection agency, the strategy shifts from pricing justification to regulatory validation. Brotherhood issues a Debt Validation Notice under the Fair Debt Collection Practices Act, which legally compels the collector to cease collection efforts until it proves the debt's legitimacy and the pricing behind it. An unvalidated debt cannot lawfully be reported to credit agencies. Because a fair, data-backed payment was already made, these alleged debts generally cannot be validated — to date, such efforts have resulted in elimination of the alleged debt.

> **The member's part: never pay a collection notice on a disputed bill.** Forward every notice to the office immediately; Brotherhood keeps the member updated as it works with the collector.

5. What This Means for Your Board and Members

Choosing RBP is choosing a fairer, more transparent way to steward the church's resources — and accepting that the savings come with a process. A board that adopts it should be ready to lead its members through that process:

- **Expect occasional pushback.** A minority of bills will draw a balance bill or, rarely, a collection notice. This is normal and anticipated, not a sign something went wrong.
- **Prepare members for the fear tactics.** Notices marked "past due" or "final notice" are designed to create alarm. Members need reassurance that a fair payment was already made and that the office is standing in the gap.
- **Watch for uncoded bills.** Some providers send simplified, uncoded statements to bypass transparency. Brotherhood requests properly coded bills (CMS-1500 / UB-04); a bill stays unpaid until correctly coded. Members should forward these too.
- **Front line vs. local care.** Brotherhood handles the disputes and negotiations; the board's role is to set expectations, reassure members, and reinforce the basics — present the Member ID card, forward every bill or notice to the office, and never pay a balance bill or a collection notice on a disputed bill.

The payoff. Fair, prompt payment earns provider goodwill over time, preserves the plan's resources for the next generation, and lets members rest in a clear conscience — honoring the call to "fair weights and measures."

Further Reading & Resources

Boards and members who want to go deeper will find Brotherhood's explainers under the Resources tab at anabaptistbrotherhood.org:

- Reference-Based Pricing — how a fair, benchmark-based price is determined.
- Frequently Asked Questions — balance billing, paying at the time of service, reimbursement, and more.
- Sharing Reports — actual pricing results and the reductions achieved with Brotherhood's Medical aid and Alms Plan

The quarterly newsletter carries in-depth articles on these issues. Recent articles include:

- *"It's Not Broken — It Was Built That Way: Understanding the Economics of the Medical Industry"*
- *"What Is Reference-Based Pricing and Why It Matters?"*
- *"Member Advocacy: Understanding and Responding to Balance Billing"* (the FCRA and FDCPA dispute processes)
- *"Member Advocacy: Uncoded Bills and Lack of Transparency"*