sidecar health

The rise and fall of *insurance networks*

For decades, networks were sold as the solution to healthcare cost control. Introduced in the 1970s and marketed to rein in spending, insurance networks promised negotiated savings and more affordable care. But today, those promises have unraveled. Networks haven't just failed to contain costs — they've helped fuel healthcare's most frustrating problems.

A brief history: why networks were created

Before networks, insurance followed a fee-for-service model. Providers set their own prices. Insurers typically paid them. There were few mechanisms to control costs or ensure care was necessary, which contributed to rising healthcare spending.

As spending surged, the government and insurers pushed for a solution. This led to the 1973 HMO Act, which launched the era of managed care. HMOs introduced tight provider networks, required referrals, and prioritized preventive services — all in the name of cost control. PPOs followed, offering broader networks and more flexibility, but still relied on the same core principle: insurers negotiate with providers, and members are financially rewarded for staying "in-network."

By the 1990s, networks were everywhere. They were marketed as smarter, leaner, and more cost-effective. But this system came with tradeoffs: confusion, restrictions, and surprise bills. What began as an effort to manage costs evolved into a maze of in-network rules, referrals, denials, and opaque pricing. And in many ways, the original promise of networks — better value and better care — never really materialized.

The myth of better networks

For years, employers and members were sold on the idea that one carrier's network was better than another's — offering more choice, better doctors, or wider access. But today, those distinctions are almost meaningless in the employer market. In most markets, networks are nearly identical. Every major plan contracts with the same hospitals and medical groups. Whether you're on one legacy plan or another, you're playing in the same sandbox.You're not choosing between networks. You're choosing between nearly identical versions of the same system — and expecting different results.

The network pricing game *where nobody wins*

Employers try to do the right thing. You set up a plan, steer employees to in-network providers and hospitals, and hope that means savings. But network pricing isn't consistent. It's a shell game — and one that's costing your company and your employees. One hospital might be the most expensive option for a spinal surgery but the cheapest for a knee replacement. Just a few miles away, another hospital flips that script. Same metro area. Same "in-network" label. Wildly different costs. That's not value. That's volatility disguised as savings. Behind every negotiated rate is a "discount" off a sticker price that was inflated to begin with. It's why a heart surgery can cost $259,000 at one facility and $182,000 at another — with no link to quality, efficiency, or outcomes. So even if you try to steer employees to the "right" place, networks can't deliver predictable value. What they're really offering is a guessing game. And if a network can't guarantee consistency or savings, then what's the point of having one at all? If networks can't deliver value, what are they doing? Networks were created to control costs.

Today, they often fail to deliver meaningful savings, price consistency, or quality oversight. Employers want predictability. Members want clarity. Everyone wants care that makes financial sense. But networks aren't delivering that. They've become a system where price is hidden behind contracts, where "in-network" means little, and where the rules are designed to protect profits — not patients.

The future of insurance isn't a network — *it's price transparency and consumerism*

Sidecar Health was built to fix the problems networks created. In fact, we eliminated the network entirely. Instead of restricting care to a provider list, we give members a Benefit Amount — an upfront transparent dollar value for every service based on the average local cost for every service. Members can see any provider they choose. If they pick one that charges less, they keep a portion of the savings. If it costs more, they pay the difference. It's simple, honest, and fair — and it keeps costs down by using natural consumer behavior to steer people away from egregious prices. Our model turns patients into empowered healthcare consumers:

- **No networks**. No restrictions on who members can see. They're in total control.
- **No prior authorization**. Care decisions stay between doctor and patient.
- **No surprise bills**. The model ensures members always know the costs in advance and protects them from surprises when they can't know the costs in advance, like in an emergency.
- **Real savings**. 90% of claims result in money back or cost less than a typical copay.[1]

This isn't a patch on a broken network model. It's a redesign from the ground up — one that trades provider lists for price transparency, and complexity for clarity. It's healthcare built to make sense.

Where we're *headed*

Networks never lived up to their promise. They were built for an outdated system — one where information was scarce and insurance companies controlled the rules. That system no longer works. Sidecar Health offers a new blueprint. One that puts members in control, delivers real cost transparency, and rewards smart decisions — driving down costs across the board, for employees and employers alike. The future of health insurance isn't about controlling access. It's about unlocking value.

[1] Co-pays not utilized by Sidecar Health. This describes member cost above the Benefit Amount similar to traditional plan co-pay levels. Claims processed from 4/1/24-4/22/25. Deductible excluded