FIRST OPINION

Insurance companies should pay patients when they make cost-effective health care choices

People should capture some of the savings they generate

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By Jared Rhoads Feb. 10, 2026

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The American health care system suffers from many misalignments of incentives, but one is particularly irksome: When individual patients make prudent decisions about their care,

choosing reasonable but less costly alternatives, they capture none of the savings they generate.

This disconnect between individual choice and individual benefit represents not merely an economic inefficiency but a philosophical failure to respect the rational agency of health care consumers. When a patient makes a prudent health care decision, the financial benefit shouldn't redound to someone else, or the group as a whole. It should redound to the person who made the choice.

Consider the example of a 45-year-old man who sees his doctor for an annual physical and learns that he is now eligible for colorectal cancer screening. His physician explains that there are several evidence-based options, including a colonoscopy and the fecal immunochemical test, or FIT, which is administered at home and then mailed to a laboratory for analysis. The patient in this case has insurance, so the out-of-pocket difference between the two options for the patient is essentially zero, even though behind the scenes, the cost of colonoscopy is about $2,750 versus about $50 for the FIT.

For average-risk people, choosing a FIT and proceeding to colonoscopy only if indicated is a perfectly reasonable decision. Yet under current insurance structures, patients who choose the less expensive FIT pathway keep none of the financial benefit stemming from their decision. The savings are diffused across all premium payers in the insurance pool. The patient who thoughtfully researches his options, consults with his physician about individual risk factors, and selects a more prudent option gets no benefit over the patient who reflexively accepts the most expensive option without consideration (though he does avoid an uncomfortable procedure).

Preventive care is just one place to look for examples. This pattern repeats throughout the health care system. Patients choosing generic medications over brand-name equivalents, selecting ambulatory surgery centers over hospital outpatient departments for identical procedures, or opting for telehealth visits when appropriate for their condition all generate real savings that they cannot access.

If the only effect of this were that the prudent among us occasionally lose out on some savings, it might simply be frustrating. But there's another negative: Just as individuals do

not capture the full benefit of their own judicious decisions, they also do not bear the full cost of their own non-judicious decisions.

"If you're paying, I'll have top sirloin" is the title of a 1995 opinion piece in The Wall Street Journal by economist Russ Roberts, now host of the popular podcast "EconTalk." In that op-ed, he examines how self-restraint goes unrewarded when splitting the check at a restaurant with friends. That's roughly the attitude endorsed in American health care: "If I've already paid to be covered for the more expensive option, I might as well get it."

Over the years, conventional policy experts and academics have scrambled to propose patches for this problem. They've published lists of high-value versus low-value procedures, hoping that information alone will change behavior. They've designed value-based insurance schemes in which experts determine the appropriate cost-sharing for each service. They've imposed prior authorization requirements and utilization review, substituting bureaucratic gatekeeping for genuine price signals. They've constructed accountable care organizations and bundled payment arrangements that reward providers for efficiency while leaving patients indifferent to cost.

Each of these approaches treats the patient as an object to be managed rather than an agent to be empowered. None restore the fundamental connection between prudent choice and personal benefit that would make the system self-correcting.

The Affordable Care Act's elimination of cost-sharing for preventive services, while well-intentioned in removing barriers to beneficial care, exacerbated this dynamic. When the marginal cost of choosing the expensive option over the less expensive option is zero, we should not be surprised when patients systematically choose without regard to cost. This is not exactly irrational on the part of patients. It's behavior that makes sense given the incentive structure they face.

The remedy is conceptually straightforward: Patients need to benefit financially when they make cost-effective health care choices. Price sensitivity is the one thing that reliably disciplines spending in every other sector of the economy. The restaurant patron who would be equally happy with the $25 salmon entree and the $40 top sirloin may be guided to the salmon by price. Having a price changes the context to highlight that the real comparison is between salmon plus $15 in his wallet versus just the sirloin.

Implementing this change would take some work, but there is no reason to deem it impossible.

Some amount of insurance deregulation is likely the best way to start. While nothing explicitly prevents insurers from rewarding certain choices with discounts or rebates, the current regulatory environment creates enough ambiguity and compliance risk that insurers rationally avoid such innovations. The ACA's zero-cost-sharing mandate for preventive services, wellness program regulations, anti-kickback concerns in the Medicare context, and the lack of clear tax guidance all combine to make shared savings arrangements legally uncertain. If an insurer pays a patient $2,700 for choosing FIT over colonoscopy, is that payment taxable income to the patient? Is it a reduction in the cost of insurance? Is it a rebate?

Insurers and employers will be slow to experiment with novel shopper initiatives if they cannot be confident those designs will survive regulatory scrutiny. If we want these arrangements to emerge, we need affirmative regulatory clarity that they are permitted.

Perhaps a better approach is to not think of it as a shopper initiative with a payment but rather to encourage insurers to design new plans with these types of "judicious moments" built into them from the start. Plans could identify a set of moments that follow the colonoscopy/FIT pattern described above, offer coverage for the cheaper option, and then make those savings fully reflected in the price of the plan. That could play out as an instant $2,700 reduction in insurance premiums for every screening-eligible individual.

Nobody wants patients to be induced to forgo necessary care. Critics might argue, for instance, that offering financial incentives to forgo care is inherently coercive, particularly for lower-income patients for whom savings or incentives might prove irresistible.

However, this kind of rethinking of coverage is not about coercing people to accept worse care in exchange for money. Our patient in the FIT example is not accepting worse care in exchange for money. He is selecting one of several clinically appropriate alternatives and being rewarded for selecting a less expensive option. Patients who chooses the FIT over a colonoscopy is not declining screening; they are selecting a different screening modality that is better aligned with their goals and values in the full context of their life, which includes financial constraints, which all but the wealthiest among us have.

Moving from concept to practice would require addressing at least one other significant challenge: price transparency.

For this kind of patient-centered system to emerge, patients must have access to clear information about their options, the clinical evidence supporting each alternative, and the financial implications of their choices. Shared decision-making tools that present options in balanced, comprehensible formats can support informed choice without nudging patients toward any particular decision. Doctor's offices, hospitals, and other providers need to be able to supply real price information, not at the checkout station but *in the exam room*.

Beyond immediate cost savings, embracing this idea would foster a broader cultural shift toward health care stewardship. Currently, patients are largely passive recipients of care. This passivity serves the interests of providers whose income depends on volume and insurers who can pass costs through to premiums, but it does not serve patients.

When patients have a financial stake in cost-effective care, they become active participants in their health care decisions. They ask questions, research alternatives, and develop the health literacy that can serve them throughout their lives. They become real value-pursuers rather than supplicants, and a system that has grown insulated from the normal market pressures that drive efficiency and innovation gets the discipline it needs. By clearly signaling to insurers that they are allowed to pay patients for judicious decision-making or that they are allowed to design plans more creatively, we might also usher in a new era of price competition between insurers.

This vision of active, engaged health care consumers aligns with the broader project of building a health care system fit for a free and liberal society. The overprotection of patients, the concentration of decision-making authority in the hands of experts and administrators, and the systematic elimination of price signals all reflect a technocratic vision fundamentally at odds with individual flourishing. A health care system that trusts patients to make reasonable decisions about their own care and rewards them for making those decisions well is one that respects human dignity and agency in ways that centralized control cannot.

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