



Insuring the Missing Middle: The Structural Roadmap to Universal Health Coverage in India

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<https://doi.org/10.47814/ijssrr.v9i8.3561>

Abstract

India has committed to Universal Health Coverage by 2033, yet roughly 40% of its population — the "missing middle," too affluent for public safety nets but unable to afford private care — remains effectively uninsured, and household out-of-pocket expenditure stands at ~43% of health spending, more than double the global average and rising. This report reconstructs the affordability lens by measuring affordability in terms of household savings rather than income. Healthcare, which appears low-cost in absolute terms, proves unaffordable once measured against a household's savings - a lens that captures how one-time hospitalization can wipe out life-time savings. A single major procedure such as a CABG can erase a lifetime of savings for over 60% of households. It further projects that demographic ageing, the rising and earlier onset of non-communicable disease, and persistent double-digit medical inflation will push health spending from ~3% of GDP today toward 4.5–8% by 2047, mirroring the trajectory the United States travelled from ~7% to ~18% over five decades. The report locates the core obstacle in a pervasive trust deficit rooted in the sector's structural peculiarities — information asymmetry at underwriting, near-zero demand elasticity under third-party payment, provider control over most of the cost base, cohort-level pricing that results in adverse selection, and India-specific distortions such as treatment costs linked to room category. Against this diagnosis it advances five structural reforms: building the ABDM digital backbone to enable longitudinal, consent-based data for better underwriting; policy design using co-pay, deductibles, value-based insurance design, and narrow networks to cut premiums by an estimated 10–30%; group negotiation and standardised, evidence-based treatment protocols; integrated (payer-provider) care to shift from activity-based to outcome-based delivery; and unbundling real estate from healthcare services to lower the cost of treatment by ~25%. It concludes that a dedicated healthcare regulator is a structural necessity — healthcare providers operate under a fragmented and relatively loose oversight and will require coordinated efforts across states its status as a state subject — to enable transformational changes across all three axes of the WHO framework and make UHC by 2033 attainable.

Keywords: *Universal Health Coverage; Health Insurance; Healthcare Affordability; Out-of-Pocket Expenditure; Health Policy Reform*

Executive Summary

India has set itself a target to achieve Universal Health Insurance Coverage (UHC) by the year 2033. To achieve full coverage, the government will need to expand on all three axes simultaneously – population coverage, service coverage, and financial protection. Over the last decade, the Indian healthcare system has made significant progress – higher public spending (increasing coverage through Ayushman Bharat), expanding hospital bed capacity, and delivering quality treatment at a fraction of the global healthcare costs. Despite these gains, significant vulnerabilities remain, most significantly, the population coverage deficit known as the 'missing middle'—a demographic comprising approximately 40% of the population that is too affluent to qualify for public safety nets but unable to comfortably afford private care. Consequently, household out-of-pocket expenditure (OOPE) remains unsustainably high at ~43% (National Health Accounts, FY2022-23), more than double the 18-20%⁽¹⁾ global average. Tellingly, it rose from ~39% a year before, interrupting a decade of steady decline. The core problem is not the absolute price of care but its cost relative to household income – a coronary artery bypass graft (CABG) can erase a lifetime of household savings for more than 60% of Indian households (*Figure 5*).

India's health cost is likely to increase multi-fold as its population ages, as healthcare cost increases non-linearly with increase in life expectancy, as treatments become more complex, as co-morbidities rise, and with the rise and early onset of chronic diseases. While medical inflation is a global challenge, it is particularly pronounced in India. On current trends, healthcare spending in India is projected to increase from ~3% of GDP currently to 4.5-8% by 2047 (*Figure 11*) – the same path that the United States travelled from ~7% to ~18%⁽²⁾ of GDP over the last 5 decades. Left unaddressed, the financing gap and the household burden will widen.

Private health insurance is the natural instrument to close this gap, yet it remains underpenetrated and weighed down by a deep trust deficit within the key stakeholders. Elevated treatment costs stem from misaligned provider-insurer incentives, market distortion (fraud, waste, abuse), and market inefficiency (lack of longitudinal health records at time of policy underwriting, lack of standardisation of medical and billing procedures).

The healthcare industry is unique in multiple ways, with some factors unique or exaggerated in India. Combined, they explain a large part of the trust deficit that plagues the ecosystem

- The seller (Insurer) knows less than the buyer (Policyholder)
- Very low demand elasticity, particularly when third-party pays
- Technology increases cost
- High variability in the quality of care, treatment procedure, and cost
- Conflict of Interest; Neither the seller (Insurer) nor the buyer (Policyholder) controls or makes decisions regarding 80% of the cost structure (Healthcare provider does)
- Guaranteed renewability but price increase at the cohort level and not at the individual level, resulting in the risk of adverse selection
- Cross-subsidy by insured for uninsured

Bridging the trust deficit to realise affordable healthcare for all will require policy intervention, leveraging technology for superior health underwriting, and experimenting with innovative healthcare and financing models. This report recommends a few possible solutions

- Building the digital backbone (Ayushman Bharat Digital Mission) as an interoperable "digital highway" bridging the gap between various healthcare stakeholders, including patients, doctors, and hospitals, for seamless, continuous care across the country and providing clean, longitudinal data required for better underwriting and unlocking true AI innovation.
- Policy design that includes co-pay and deductibles, including value-based insurance design (zero or low co-pay on high-value care such as chronic medication and screening, higher co-pay on low-value care) and a cap on co-pay for catastrophic exposure, narrow network, can reduce health premiums by 10-30% (*Figure 18*), significantly easing the financial burden on "middle India".
- IRDAI holds a critical role in ensuring a level playing field, which directly safeguards policyholders by establishing standard, evidence-based treatment protocols backed by rigorous medical evaluations.
- Integrated care can help drive outcome-based instead of activity-based medical care and can also solve the conflict between healthcare providers and health insurers by bringing both on the same side. It can materially reduce OOPE by covering outpatient care and reducing claim rejection

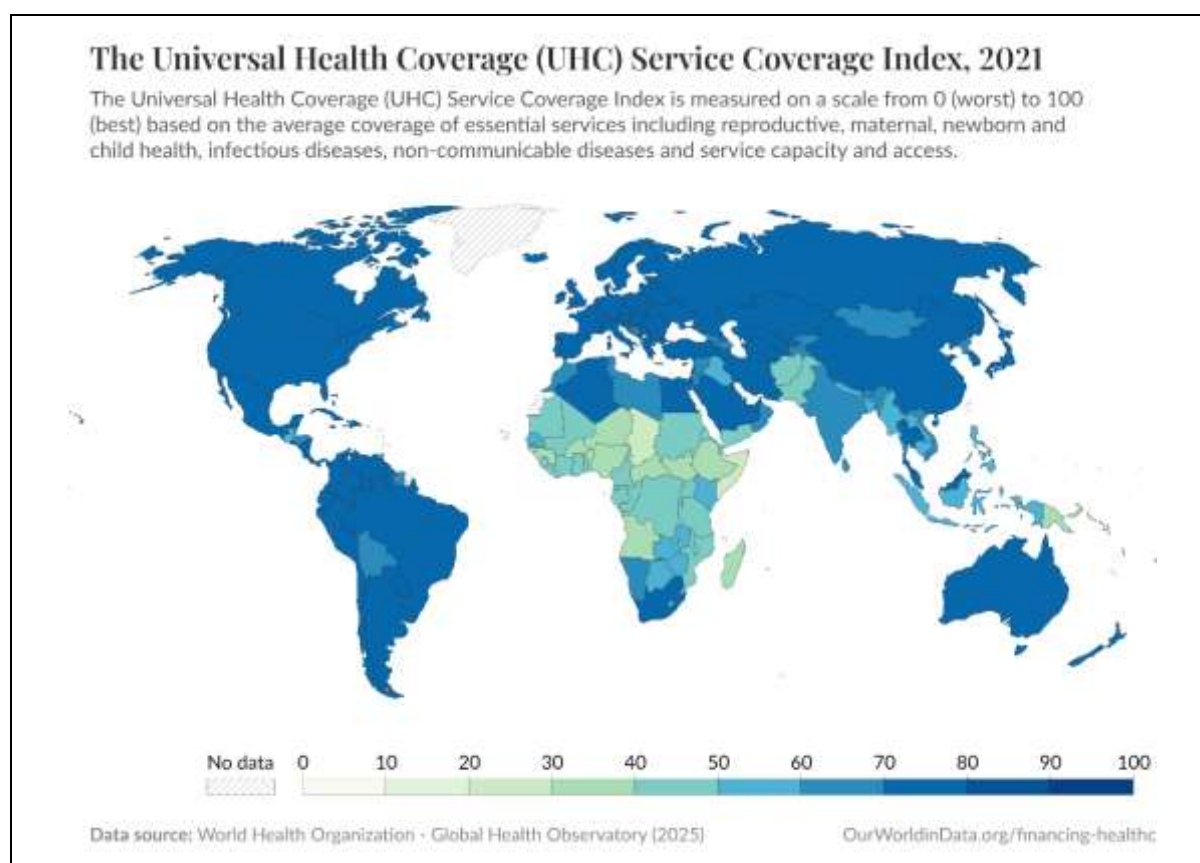
- Unbundling commercial real estate from healthcare providers (as is the case with value retailers or even diagnostic companies) can significantly reduce the capital requirements and thereby the cost of treatment (~25%) (Figure 25-26).

Establishing a healthcare regulator is a policy imperative given the essential nature of the service, likely to be the 3rd largest expenditure within household budget (surpassed only by food and housing). While the payor side (insurers) is well regulated by the IRDAI, healthcare providers operate under a fragmented and relatively loose oversight framework. Furthermore, healthcare service providers are a state subject, and the federal nature makes the need for a regulator imperative to enable transformational changes that are required to make UHC by 2033 achievable.

These recommendations advance IRDAI's goal of "Insurance for All by 2047" by linking three pillars of the "Five A" framework—Affordability, Assurance, and Accountability—to realise the goal of UHC.

Introduction

India has made massive strides up from a score of just 53 in the year 2014 to 69 currently, driven by aggressive national healthcare campaigns. However, the reality of UHC inside the country is a complex story of rapid progress mixed with heavy financial challenges.



India in March 2026, set for itself the target to achieve Universal Health Insurance Coverage by the year 2033.

Over the last decade, India has made significant progress —successfully lowering out-of-pocket health expenses (OOPE) from over 60% down to approximately 43% over the 2014-23 period (NHA) due to various measures by government and regulatory bodies, including

- Insurance & Universal Coverage: The Ministry of Health spearheads the Ayushman Bharat PM-JAY, providing up to Rs. 5 lakhs in annual coverage to 12 crore vulnerable families. It has also been expanded to cover all senior citizens aged 70+, regardless of income.
- Medicine & Medical Device Pricing: The National Pharmaceutical Pricing Authority (NPPA) actively caps the prices of essential medicines, cardiac stents, and knee implants. Additionally, the Pradhan Mantri Bhartiya Janaushadhi Pariyojana (PMBJP) provides generic drugs at 50%- 80% lower prices.

- Tax Relief: The government reduced GST to zero on health insurance premiums as well as eliminated basic customs duty on essential cancer drugs to make critical therapies more affordable.
- Government & IRDAI: The Finance Ministry and the Insurance Regulatory and Development Authority of India (IRDAI) continually mandate standardised treatment expenses and broader cashless networks to shield citizens from catastrophic medical debt.

However, at ~43% OOPe, India remains far higher than the global average of 18-20%, including other emerging countries (China: 32%, Brazil: 27%, South Africa: 7%)⁽³⁾.

Figure 1: Why India's Out-of-Pocket Expenditure Is So High: Four Structural Drivers

Factor	Driver
Higher share of private sector in healthcare delivery	- Strained public hospitals and lower quality of medical service, has driven a heavy reliance on private sector for healthcare delivery
Under-penetration of insurance	- High cost of healthcare treatment translates into higher health premium - Lack of trust that insurer will reimburse healthcare cost - Lack of awareness
Exclusion	- Out-patient care is usually not covered by insurer or government schemes
Rejection/Disallowance by insurer	- Lack of standardisation, transparency and trust deficit between healthcare provider and insurer - Lack of disclosures from policy holder to insurer and lack of longitudinal medical data regarding policyholder at time of policy purchase - Opaque insurance policy

The WHO evaluates a country's progress toward UHC using a three-dimensional matrix, often referred to as the "UHC Cube." To achieve full coverage, the government will need to expand on all three axes simultaneously – population coverage, service coverage, and financial protection.

a) Population Coverage: The "Missing Middle" Paradox

Currently, only the top 15-20% of households in India can afford quality healthcare, in India while the bottom 40% are covered by various government schemes (even though both quantity and quality of coverage may leave a lot to be desired). This leaves a massive "missing middle" of 40% — too affluent to be eligible for public safety nets, yet unable to comfortably afford private health care. Because medical inflation consistently outpaces growth in household income, the financing burden is likely to aggravate further.

Figure 2: The "Missing Middle": ~40% of Households Fall Outside Both Public Schemes and Private Insurance

Insurance Scheme	Income Profile	mm Households	Comment
Central government flagship health scheme - Pradhan Mantri Jan Arogya Yojana (PMJAY) scheme	Bottom 40% of the Pyramid	~120	
State Health Schemes	Bottom 40% of the Pyramid	~44	Many states run schemes that are co-branded or expanded versions of PM-JAY (e.g., Ayushman Asom, Mahatma Jyotirao Phule Jan Arogya Yojana in Maharashtra).
Government and PSU employees (including ex-employees)	Top 40% of the Pyramid	~34	
Private health insurance (group, individual)	Top 20% of the Pyramid	~57	Salaried formal sector employees covered under employer-employee health plans frequently purchase supplemental private family floater policies. Some overlap as multiple salaried within the same household
Total		255	
Unique Households		~200	Assumption
Total Households		~325	
Missing Middle	Primarily in the 20-60% part of the Pyramid	~40%	

Source: Mahal, Panwar, Tiwari, Reddy, & Kane, 2024

b) Service Coverage

Note that government schemes offer wide but shallow coverage. Claim frequency for government-sponsored business at 27 per thousand is far lower than 98 per thousand for retail insurer, even though intuitively, claim frequency should have been higher in government schemes due to inferior living conditions. This reflects inadequate coverage and a higher ask on the government budget if the coverage were to increase.

Figure 3: Government Schemes Provide Wide but Shallow Cover: Claim Frequency and Ticket Size by Segment

	Govt sponsored business	Insurance		Total
		Group business	Retail business	
Primary target segment	Lower income household	Employer-Employee	Affluent	
Average claim amount per incidence (Rs 000s)	14-16	30-33	50-55	30-33
Average claim frequency (per 1,000 lives)	27	55	98	47
Premium per life covered (Rs)	400-450	2,000-2,500	7,500-8,000	2,000-2,500
Incurred claim ratio	115	94	75	88

Source: IRDAI, Annual Report, BCG, Rebuilding Trust

c) Financial Protection: OOP Challenge

~43% rate represents a massive humanitarian and economic burden. Because of India's vast population and lower per-capita income, a ~43% OOP rate is enough to push an estimated 55million (Ministry of Health and Public Welfare, 2018)⁽⁴⁾ citizens into poverty annually due to sudden medical crises. While one may argue that India has made substantive progress since the Ministry of Health and Public Welfare data (2018) or NSSO data (2014) as reflected in declining share of OOP, recent research highlight that total poverty headcount in the population increased by 2.6% after making OOP payment⁽⁵⁾. Our hypothesis for the same is that while OOP has reduced as a percentage of Healthcare Expenditure, it has not reduced materially in context of household savings. As we discuss in Fig 5, nearly 60% of Indian households have almost zero lifetime savings. A simple CABG surgery can wipe away more than 5 years of annual savings for the 20-40th percentile household (by income). In other words, the challenge is that cost of treatment has increased at a faster pace than growth in income and growth in household saving.

On the other hand, once a household secures coverage, features like guaranteed renewability and cumulative no-claim bonuses help the sum insured keep pace with high medical inflation. Consequently, continuous enrolment ensures lifelong financial protection, highlighting the vital role of health insurance.

While India has made significant progress, a lot needs to be done on the 3 axes to achieve the goal of UHC.

Affordability of healthcare treatment in India

Healthcare treatment in India is cheaper than in most other countries, and yet most Indians cannot afford private healthcare. This is because the cost of treatment remains very high in the context of the per capita income. While the Coronary Artery Bypass Graft (CABG) treatment cost is 6.5x in the US as compared to India, it is still 33% of the per capita income in the US as compared to 180% of the per capita income in India. Hence, relative to per-capita income, CABG is around 6x more expensive in India as compared to the US.

Figure 4: Low in Absolute Terms, High Relative to Income: Key Procedure Tariffs, India vs Global

In US\$	Total Knee Replacement (TKR)	Percutaneous Transluminal Coronary Angioplasty (PTCA)	Coronary Artery Bypass Graft (CABG)	Per Capita Income	TKR/Per Capita	CABG/Per Capita
US	12,200	12,900	29,300	~90,000	0.1x	0.3x
UK	18,200	13,800	34,000	~67,500	0.3x	0.5x
Singapore	15,100	21,200	34,000	~95,000	0.2x	0.4x
Thailand	8,900	5,900	10,400	~8,000	1.1x	1.3x
Malaysia	7,100	5,900	14,200	~14,000	0.5x	1.0x
India	3,100	2,500	4,500	~2,500	1.2x	1.8x

Source: EY-P Analysis; published tariff lists from private insurers and key hospitals (as publicly available); Ayushman Bharat; NHS, Ministry of Health, Singapore; 'Inpatient Reimbursement Prospectus' Medicare 2025, Abbott

Higher the ratio of cost of treatment/per capita income, lower is the percentage of Indian households who can afford the treatment. The below table illustrates how CABG treatment cost will therefore erase lifetime of annual savings for more than 60% of the households and 50% of the missing middle (20-60% percentile by Income Level) (Fig 5).

Figure 5: A Single CABG Erases a Lifetime of Savings for ~60% of Households (by Income Level)

Income Level	Population Mix	Annual Household Income ⁽¹⁾	Annual Household Saving ⁽²⁾	Years of Annual Saving ⁽³⁾
Richest 10%	10%	27,500	11,000	0.4
10-20%	10%	13,750	2,750	1.6
Next 20%	20%	8,750	875	5.1
Middle 20%	20%	5,000	0	Lifetime
Next 20%	20%	2,500	0	Lifetime
Poorest 20%	20%	1,250	0	Lifetime
	100%			

(1) Source: ICE Survey

(2) Source: ICE Survey including broader assumption around household saving basis household income

(3) Calculated basis CABG treatment cost of US\$4,500

The Compounding Crisis of Unchecked Medical Inflation

While medical inflation is a global challenge, it is particularly pronounced in India. Medical trends have been high across countries for years (around 700 bps higher than the annual general inflation rate) and are expected to continue to be double digits in most markets.

Figure 6: Medical Inflation by Region, CY19–CY26E: India Among the Highest

	CY19-CY24	CY24	CY25(E)	CY26(E)
US		4.5%	9.0%	9.5%
Canada		7.0%	7.4%	8.3%
Asia	9.7%	12.2%	11.1%	11.3%
- China		8.7%	8.0%	7.8%
- India		9.9%	13.0%	11.5%
- Indonesia		15.9%	16.2%	16.9%
- Malaysia		14.0%	15.0%	16.0%
Europe	9.5%		8.9%	8.2%
Latin America	10.4%		10.7%	10.3%
MENA	10.6%		15.5%	15.2%
Global		10.5%	10.0%	9.8%

Source: MercerMarsh Benefits, Health Trends 2026, Balancing Cost control with benefits optimization

Elevated and persistent high medical inflation is attributable to a mix of factors.

Figure 7: What Drove ~9% Annual Hospitalisation-Cost Growth, FY05–18 (Decomposition)

Factor	Impact
Like-for-like price increase	3%-4%
Payer mix	(0.1%-0.5%)
Higher share of private and organized players	0.5%-1%
Changes in service mix	
- Improved share of tertiary procedures	4%-5%
- Higher realisation specialities	
- Evolution in acuity mix	
Overall, Price Increase (CAGR during FY05-18)	9%-9.5%

Source: NSSO 2004 and 2018, realisation growth across key players, EY-P Analysis

While the preceding analysis implies a benign historical medical inflation rate of just 3–4% on a like-for-like basis, critical nuances warrant a cautious approach to future forecasting:

- **The Post-COVID Structural Shift:** The baseline data spans FY05–18. Medical inflation has accelerated sharply post-COVID. For instance, Apollo's Average Revenue Per Inpatient (ARP-IP) growth increased by ~380 basis points; annual growth rates increased from 5.4% p.a. pre-COVID to 9.2% p.a. post-COVID (Company disclosures). Anecdotally, the pre-COVID era was characterized by lower capacity utilization in corporate hospitals, which naturally suppressed inflationary pressures compared to the post-pandemic period.
- **The Organized Sector Premium:** Organized private hospitals comprise less than 15%⁽⁹⁾ of the total provider market but contributed a disproportionate 0.5–1.0% to the overall medical inflation. This indicates that price inflation is significantly higher within the organized sector. As the share of organized private hospitals increases, the contribution to medical inflation will be higher.

India's health cost is likely to increase multi-fold as the population ages, as healthcare cost increases non-linearly with increase in life expectancy, as treatments become more complex, as co-morbidities rise, and with the rise and early onset of chronic diseases.

a) Ageing Population

Healthcare demands are likely to escalate sharply, driven by demographic shifts and rising life expectancy. India's 60+ population is projected to expand ~1.5x between 2025 and 2047. This aging trend will disproportionately compound costs. Annual healthcare spends increase by ~1.5x for individuals as they age by around 10 years (age group of 45-54 -> 55-64 -> 65-74 -> 75-84 -> 85+ years)⁽⁶⁾

Figure 8: India's Ageing Profile: 60+ Share Rising from 7% (2001) to ~20% (2047E)

	2001	2025	2047(E)
60+	7%	12%	20%
40-59	16%	22%	29%
20-39	31%	33%	27%
0-19	45%	33%	23%
	100%	100%	100%
Population	1.02 bn	1.47 bn	1.65 bn
Median age	~21 years	~29 years	~38 years
Life expectancy	~67 years	71 years	77-78 years

Source: Report of the Technical Group on Population Projections for India and States 2011-2036, Ministry of Health & Family Welfare, July, 2020; Census Data 2001, 2011; EY-P Analysis; UN World Population Prospects

b) Rapid increase in incidence of non-communicable diseases (NCD)

Prevalence of co-morbidity has grown nearly 20x between 1995-2018 (as per NSS). Longitudinal Ageing Study (2019) pegged the prevalence at ~6% of the population. Comorbidity prevalence has been found to drive 2-3x higher hospitalisation rates

Figure 9: The NCD Shift: Non-Communicable Disease Share of India's Disease and Death Burden, 2001 vs 2021

	2001	2021
Share of NCDs in India's disease profile	40-45%	~60%
Share of NCDs in India's death profile	~43%	65-70%

Source: NFHS 4, 5, WHO, EY-P Analysis

c) Earlier than the global onset of chronic diseases

Indians are living longer but getting sick younger – NCDs are on the rise, along with early onset. Growing urbanization, lifestyle and dietary changes, alongside worsening environmental conditions, have catalysed growth in chronic disease

Figure 10: Earlier Onset, Rising Numbers: Major NCDs by Age of Onset (India vs Global) and Case Count

	Age of onset (years)		Number of cases (mm)	
	India	Global	Previous	Recent
CVD	52	65+	~26 (1990)	~55 (2016)
Hypertension	56	62	~89 (2001)	~220 (2021)
COPD	60	60	~28 (1990)	~58 (2016)
Cancer (5-year prevalence)	60	65	~2.3 (2018)	~3.3 (2022)
Diabetes	47	50	~32 (2001)	~101 (2021)
Chronic Kidney Disease	50	60	~82 (2001)	~128 (2021)

Source: Global Disease Burden Report, 2021, Projections Tool 2025; Lancet 2001, 2021, National Family Health Survey-2021, WHO 2002-2025, WHO x GloboCan 2018, 2022; ICMR-INDIAB study, EY-P Analysis

d) Late-stage detection continues to be a formidable challenge

India's diagnosis gap drives wide survival gaps in later stages of disease. For instance

Breast Cancer	- NHS (UK) routinely screens 50-80%⁽¹⁾ of eligible women for breast cancer. In contrast, India's mammogram uptake is only ~1-2%⁽²⁾ - Only ~29% cases in India diagnosed at stages I-II vs ~65% in US - 5 year breast cancer survival rate is ~90%⁽¹⁾ in the US and Australia vs 66%⁽³⁾ in India
Chronic Kidney Disease	- Only 52% cases in India diagnosed at early stages (pre-4) vs ~80% in a high-income country (Denmark)
Glaucoma	- Only ~10% cases diagnosed vs ~25% in other low and middle-income countries
Heart Failure	- ~23% of heart failure patients die within a year of diagnosis vs ~9% in China

Source: "Making cancer care more accessible and affordable in India", EY, 2022; CDC 2022; India CKD Registry, 2005, Indian Society of Nephrology; "Prevalence and incidence of chronic kidney disease stage 3-5- results from KiDiCo", BMC Nephrol. 2023 Jan ; "Glaucoma in India", 2022, Glaucoma Today, EY-P Analysis

(1) Nuffield Trust, 2024, NHS 2018-2020

(2) Cancer Samiksha, India Cancer Registry, 2012-2015

(3) Financial toxicity of cancer care in India; towards closing cancer gap, 2023, Frontiers in Public Health

Combining the above, India's healthcare expenditure is expected to increase 10-20x over the next 2 decades and increase from ~3% of GDP to 4.5-8% of GDP. While this may appear as a staggering increase, do note that healthcare expenditure in the US has witnessed a similar journey of escalation, from ~7% of GDP in 1970 to ~18% currently over the last 5 decades.

Figure 11: Healthcare Spending Projected to Rise from ~3% of GDP (2025) to 4.5-8% by 2047

	2025	2025-2047	2047
Healthcare Expenditure (Rs tr)	10		121-216
Nominal GDP growth rate		10%	
Medical inflation		12-15% (200-500 bps higher)	
Healthcare expenditure as % of GDP	3% of GDP		4.5-8% of GDP

Source: EY-P Analysis

Key assumptions

- Share of population > 60 years increases from ~12% currently to ~20% by 2047
- Hospitalisation rates in the >60 year cohort could grow from 10-11% at present to 27-30% by 2047 (resembling present-day Kerala ~25%)

One could argue that as India's per capita income rises from ~US\$ 2,500 today to ~US\$ 9,000–10,000 by 2047, the household's capacity to absorb higher healthcare costs will naturally increase. While this holds for affluent households, escalating medical costs will simultaneously strain government finances and disproportionately squeeze the middle class. Consequently, rather than resolving the issue, this risks further aggravating the healthcare affordability crisis for the vast majority of "middle India."

The Funding Architecture of Indian Healthcare

Globally, 3 broad archetypes define healthcare systems

Figure 12: Funding Mix Compared: India's Heavy Reliance on Out-of-Pocket vs the US and UK

	Government	OOPE	Insurance	Total
US	48	10	42	100
UK	80	15	5	100
India ⁽¹⁾	43	43	13	100

Source: WHO, NHA, OECD

(1) Updated for NHA (FY23)

The US, with its mature insurance plus public model, relies heavily on federal programs such as Medicare and Medicaid to provide healthcare support for the elderly and low-income households, and insurance coverage for the rest, while OOPE costs are contained to about 10%, supported by both private insurers and federal programs such as Medicare and Medicaid. The UK on the other hand represents a public-dominated model where government funding (80% of payor mix) underpins universal access, and Out of Pockets (OOPE) costs remain modest at around 15% of the healthcare spending. India is a public-plus-OOPE model where limited insurance penetration leaves households bearing a greater financial burden.

India's healthcare expenditure (Rs 10 tr) at ~3% of GDP (~US\$ 85 per capita) is relatively low compared to other developing countries (~5% of GDP). On current trends, healthcare spending in India is projected to increase from ~3% of GDP currently to 4.5-8% by 2047.

Government funding faces severe fiscal constraints, and therefore a critical policy challenge - either spend more on healthcare coverage for the bottom 40% households or curtail benefits (to avoid a US type strain) i.e. either government will have to step up spend from ~1.4% of GDP currently (NHA) to ~3-4% of GDP or curtail coverage for the bottom 40% households, a measure that will widen social inequity.

Within the Insured segment in India, around 2/3rd are driven by employer-employee schemes, which cover the salaried. Employer-employee insurance is restricted to the salaried workforce—a minor segment in India's overwhelmingly self-employed economy. There is a high overlap between the salaried segment and the more affluent households in India, thereby leaving the large self-employed segment fending for themselves.

Figure 13: Employer Cover Misses the Self-Employed: Share of Salaried Households by Income Quintile

Households	% of Households with regular salary i.e. Salaried Households
Richest 20%	50%
Next 20%	30%
Middle 20%	15%
Next 20%	10%
Poorest 20%	7%
	22%

Source: Rama Bijapurkar, ICE 360 data

Medical inflation higher than growth in household income results in households dipping into their savings or borrowing to pay for medical treatment. Out-of-pocket medical expenses push an estimated 55 to 63 million Indians into poverty every year, according to data from the World Health Organization (WHO) and India's Ministry of Health and Family Welfare.

Structural limitations in public and employer-backed healthcare leave a massive coverage gap that private health insurance must address. While the share of retail health insurance is rising, its growth has been constrained by low underwriting profit (high claims ratio) and high medical inflation, which requires a similar sharp increase in health premiums.

Current Challenges to UHC (2033)

A recent report by the Insurance Regulatory and Development Authority of India (IRDAI) highlighted escalating healthcare expenses as a core structural challenge. The regulator noted that medical inflation, fraud risks, and elevated treatment costs continue to exert severe financial pressure on insurers and policyholders alike.

The healthcare industry is unique in multiple ways, with some factors unique or exaggerated in India. They highlight the underlying drivers for the Trust deficit that plagues the broader ecosystem.

Seller knows less than the buyer	Since the information is about the buyer in absence of interoperable, longitudinal data availability, the seller is pricing with incomplete information
Very low demand elasticity	Healthcare demand exhibits exceptionally low-price elasticity due to the intrinsic value of human life. This inelasticity is amplified when the patient (the policyholder) is insulated from the direct financial burden because a third-party insurer covers the bill
Technology increases cost	In most industries technological advancement boosts productivity and lowers unit costs. Healthcare is a distinct exception; advanced tools like robotic surgery improve medical outcomes but simultaneously escalate treatment costs
High variability in quality of care, treatment procedure and cost	Very few offerings have variability in process, approach, outcomes and cost. Lack of standardisation and lack of transparency compound the problem
Conflict of Interest	There is a high influence of the doctor on the course of the treatment (and rightly so, given they are experts). However, the doctor or healthcare provider has limited incentive to do a trade-off between cost and treatment outcomes. On the contrary, the financial interest of the healthcare provider is at cross-purpose with the health insurer
Neither the buyer (Insurer) nor the seller (Policyholder) control or make decisions regarding 80% of its cost structure	Cost is not determined by either the buyer (Policyholder) or the seller (Insurer) While insurers are seeking greater standardisation in protocols and seek packages for common treatment, they know the bill about the cost is incurred, resulting in disputes between healthcare provider and insurer, partial rejection of claim resulting in unexpected out-of-pocket expense for patient/policy holder and loss of overall trust within the ecosystem
Price increase at cohort level and not at individual level resulting in risk of adverse selection	Higher-risk individuals - who are more likely to fall ill and file claims - will prioritize maintaining their coverage, while healthier policyholders often choose to drop out (adverse selection)
Cross-subsidy by insured for uninsured	In India, the core treatment cost is linked to the room category as the room category is taken as proxy to ability to pay. This is an implicit cross-subsidy by those who can pay to those who can't pay. Insurance though enables those who can't pay to step-up the room category. This results in cross-subsidy from insured to uninsured, which is at cross-purpose to the objective of insurance for all. This is also very different from say US, where cost of treatment for insured is generally 2-3x that of uninsured

It is a pertinent question to reflect - Why are only 60mm people covered by a retail health insurance policy?

Given the extremely low penetration level, arguably different reasons apply for different segments

Figure 14: Root-Cause Analysis of Low Retail Penetration: Premium vs Household Income and Savings, by Decile

Income Level	Population (mm)	Household		Insurance Premium ⁽³⁾ as % of		Possible Reason	Factor
		Income ⁽¹⁾	Saving ⁽²⁾	Household Income	Household Saving		
Richest 10%	140	27,500	11,000	1%	2%	Assuming 40 out of the 60mm insured are from this income category, it implies ~30% penetration Adjusted for those who are old or already sick (and therefore health premiums would be ineffectively high), penetration ratio of the addressable space is likely to be ~50% Note that round 50% of households in this category are outside the Metros and Tier 1, where insurance distribution reach is relatively limited	Accessibility beyond the top 100 cities/towns
10-20%	140	13,750	2,750	2%	9%	Assuming 20mm out of the 60mm insured are from this income category, it implies ~15% penetration Adjusted for those who are old or already sick (and therefore health premiums would be ineffectively high), penetration ratio of the addressable space is likely to be ~25% While on the lower side, do note health premium accounts for ~9% of annual household saving (which is not an insignificant share). The average saving is likely to be lower for those in the 15-20% income distribution band and therefore health premium as a share of their annual saving would be higher than 9%	Trust deficit or lack of assurance Accessibility beyond the top 100 cities/towns
Next 20%	280	8,750	875	3%	29%	Health premiums are a very high share of annual household saving	Affordability
Middle 20%	280	5,000	0	5%	N.A.	No savings for the households to consider investing in a health insurance plan	Trust deficit or lack of assurance
Next 20%	280	2,500	0	10%			Accessibility
Poorest 20%	280	1,250	0	20%			Awareness
	1,400						

(1) Source: ICE Survey

(2) Source: ICE Survey including broader assumption around household saving basis household income

(3) Insurance Premium of US\$200 p.a. for a family of 4 is considered for the calculation

We summarise the above as 3 problems statement and in the following sections seek to address them

- **Information asymmetry**
- **Product design**
- Fraud, Waste, and Abuse

1. Information asymmetry

Indian underwriting is overwhelmingly self-declaration and occasionally, a point-in-time medical test. Data deficits and structural fragmentation severely constrain underwriting sophistication in the Indian health insurance market. Information asymmetry, along with the scarcity of both initial and longitudinal policyholder data, prevents the deployment of advanced predictive pricing models. This problem is compounded by a highly fragmented healthcare ecosystem that lacks systematic data capture, standardized classification metrics, and uniform medical coding. These systemic barriers create persistent data blind spots, ultimately restricting insurers to primitive, static risk pricing factors like age, gender, and BMI.

	Score	Ongoing Data
Health Insurer	Health Score does not exist	Only at time of Claim
Lender	Individual CIBIL Score	- CIBIL score refreshed on a 15 day basis - Account Aggregator for regular and holistic detail - Some lenders seek and get access to mobile data via apps

Insurance fraud stands at around 4% of all claims—a higher rate than in unsecured lending or credit cards, highlighting deep information asymmetry and a fragile legal framework.

2. Product design

There are 3 key challenges in the product design

- Price inelasticity and third-party pays
 - Healthcare demand exhibits exceptionally low price elasticity due to the intrinsic value of human life. This inelasticity is amplified when the patient (the policyholder) is insulated from the direct financial burden because a third-party insurer covers the bill. While medical staff are uniquely qualified to dictate clinical treatment pathways, a fundamental conflict of interest persists between healthcare providers and health insurers.
- Guaranteed renewability (despite information asymmetry), but price increase at the cohort level and not the individual level (challenge of adverse selection)
 - Guaranteed renewability is a fundamental and indispensable feature of health insurance. However, while it successfully insulates the policyholder, it severely exposes the insurer. This exposure is intensified by acute information asymmetry at the time of underwriting and the insurer's minimal control over actual healthcare costs.
 - Persistent medical inflation, compounded by Fraud, Waste, and Abuse (FWA), continually forces health insurers to increase annual premium rates. These pricing hikes trigger an adverse selection problem. Higher-risk individuals, who are more likely to fall ill and therefore claim, are more likely to maintain their coverage, while healthier policyholders often choose to drop out in the face of rising health premiums (adverse selection). This structural exit systematically degrades the overall risk quality of the remaining insurance cohort, inevitably necessitating even sharper premium increases in subsequent cycles (cohort spiral).
- Cost of treatment linked to room category (specific to India)

In India, the core cost of treatment or surgical procedure scales directly up or down based on the patient's choice of hospital room, unlike other countries such as the US, UK, Germany, or Singapore, where medical billing is based on actual resource consumption. A surgery like a CABG has a standardized, base cost determined by the operating room time, surgical complexity, anaesthesia, and disposable medical equipment

used in the US/UK/Germany/Singapore. This fee remains identical whether you stay in a 4-bed ward or a luxury private suite. In Indian private healthcare, though, hospitals often link the core treatment cost to the room category. If a patient can afford a single private room, the hospital assumes a higher ability to pay and escalates doctor consultation fees, surgeon fees, and operating theater charges proportionally (Ability to Pay).

- This billing structure is what creates a major friction point for Indian health insurers. Most Indian insurance policies feature a "Room rent limit" (e.g., 1% of the sum insured). If a policyholder chooses a room above their eligibility limit, the insurer applies a proportionate deduction penalty to the entire surgical bill because the surgery itself was priced higher due to the premium room, thereby creating a negative OOPe surprise for the patient.
- Decouple core treatment fees from room categories will result in like-to-like comparison across hospitals - a vital step to control medical inflation and protect policyholders from unexpected out-of-pocket expenses
- The wide gap in treatment between a higher category room (eg, single occupancy room) vs a lower category room (eg, general ward) is in effect a cross-subsidy from insured to uninsured or government scheme patients.

This is different from the US, where uninsured patients are charged $>2.5x^{(7)}$ for hospital care than those covered by health insurance. Higher treatment costs for insured individuals will necessitate higher health premiums, impacting financial inclusion.

The structural risks of excessive cross-subsidization are well-documented across other sectors of the Indian economy. Higher freight rail tariffs have subsidized passenger travel, thereby pushing cargo transport toward roads and inflating overall logistics costs for domestic manufacturers. Similarly, inflated commercial and industrial electricity tariffs subsidize agricultural and household power, eroding industrial competitiveness and pushing larger industries to build their own captive power. While a degree of cross-subsidization is indispensable in a developing nation with a vast low-income population, excessive imbalances generate severe, unintended economic distortions.

3. Fraud, Waste and Abuse (FWA)

Fraud, Waste, and Abuse (FWA) represent one of the most persistent and costly challenges faced by health insurance systems worldwide.

Figure 15: Global Insurers' Top Plan - Affordability Concerns (% Citing Each Factor)

Factors	Details	
Inefficient and Wasteful	Unnecessary diagnostic or treatment Low value or ineffective care Administrative waste Inefficient use of site of care	76%
High-cost claimants	Individuals with complex medical needs who require extensive and expensive treatments	72%
Technological advancement		72%
Aging population		71%
New cancer therapies		68%

Source: MercerMarsh Benefits

The combined effect of the above erodes financial sustainability, inflates premiums, and undermines trust across the value chain. Rather than driving product innovation, insurers are caught in a cycle of investigation, disallowance, and disputes.

Key reasons for FWA include

- Data Fragmentation
- Limited standardised processes and protocols

- Manual and reactive audits
- Operational inefficiencies
- Weak legal framework

A comparison of relative fraud risk across policy and claim types highlights how retail-reimbursement claims show up to 20x higher risk than group-cashless ones due to weaker verification and higher opportunity for post-event manipulation.

Figure 16: Fraud Risk Is Up to 20x Higher in Retail Reimbursement than Group Cashless Claims

Policy Type	Claim Type (Relative Intensity)	
	Cashless	Reimbursement
Retail	8x	20x
Group	1x	9x

Source: BCG, *Rebuilding Trust*

Over-package billing, unbundling of procedures, tariff deviation, and protocol non-compliance are emerging as dominant drivers of Waste and Abuse by inflating healthcare costs and compromising system integrity

Figure 17: Most Prevalent Waste and Abuse Categories

Comparison of Relative Risk Intensity (Relative Intensity)	Treatment Protocol Deviation	Tariff Deviation and Excess Billing	Unbundling of Procedures
Waste & Abuse	1x	3x	10x

Source: BCG, *Rebuilding Trust*

The lack of open pricing, third-party reimbursement, with insulated local markets that reduce traditional competitive pressures and differential treatment protocols, and billing practices create enough room for trust deficit. This was reflected in the ability of healthcare providers to bypass the caps that the Central government had introduced on stents and knee caps in 2016 by unbundling treatment and charging for other services. Rand Health Insurance study estimates the price elasticity of demand for health services of -0.2 only (i.e., 8% nominal increase p.a. in out-of-pocket cost resulted in a decline in utilisation of about 1.3% p.a. among patients of private plans. The trust deficit is reflected in frequent disputes between healthcare providers and health insurers, as was the case in CY25, when the Association of Healthcare Providers threatened to suspend cashless services for policyholder insurers such as Star Health, Bajaj Allianz, and Care Health, alleging claim rejection. Where does this conflict emerge from? It emerges from a lack of trust due to the inherent conflict of interest between healthcare providers (higher treatment cost = higher revenue) vs health insurers (higher treatment cost = higher health claims), and ambiguity with respect to the line of treatment. This friction is worsened by asymmetric regulation. Regulators increasingly enforce stringent oversight regarding claim disallowances against insurers, yet there remains a distinct lack of penalties for Fraud, Waste, and Abuse (FWA) committed by either policyholders or healthcare providers.

In India, 47.5%⁽⁸⁾ of births in private hospitals are by C-section, compared to 14.3%⁽⁹⁾ in public hospitals. ~50% in private hospitals is higher than even the US (~32%)⁽¹⁰⁾. In the US, higher standardisation of treatment puts the onus of justifying C-section surgery onto the doctor/hospital, unlike India, where standardisation of protocol is still non-existent.

Inability to price correctly due to information asymmetry and leakages due to fraud, abuse, and Wastage restricts financial inclusion (health insurance penetration), resulting in the missing middle class from insurance coverage (“missing middle”).

High and rising insurance premiums hinder insurance penetration, pushing citizens to pay out-of-pocket (OOPE), thus worsening the overall health outcomes—people are forced to resort to non-compliance in treatment, delayed/avoided care, and underutilization of preventive care—further deepening the spiral of higher costs, reduced access, and declining system resilience.

Structural Reforms to deliver UHC (2033)

Realising optimal healthcare for all will require policy intervention, leveraging technology, and experimenting with other healthcare models

	Challenge	Possible Solution	Primary Responsibility
1	Data for better underwriting Information asymmetry	- Mandate digital adoption through ABDM - Create legal and regulatory frameworks for data sharing, privacy (DPDP Act) and outcome-linked reimbursements - Invest in digital infrastructure to enable longitudinal patient records and consent-based architecture to share data via ABDM architecture	- Regulator working with Ministry of Health
2	Reducing healthcare cost	- Delinking cost of treatment from room category will help bring transparency in cost of procedures across hospitals, reduce friction between healthcare provider and health insurer and reduce out of pocket expenses for insured patients	- Regulator working with Ministry of Health
		- Group negotiations with healthcare providers, pharma and implant providers	- Health insurers with active support of Regulator
		- Unbundling the Commercial Real Estate business from Healthcare Services	
3	Fraud, Waste, Abuse	- Product design that incentivises co-pay, deductibles or narrow network plans	- Health insurers
		- Prevention: Early diagnosis, telemedicine to move healthcare from reactive to proactive and preventive approach	- Health insurer
		- Detection: Standardised protocols to enhance transparency, digital records and consent-based sharing ecosystem along with AI-led intelligence to identify irregularities	- Health insurers with active support of Regulator
		- Deterrence: Strengthen Legal Framework; Hospital scoring on parameters such as Readmission rate, Disallowance	
		- Integrated Healthcare	- Health insurers with active support of Regulator
4	Sector Regulator	- While the payor side (insurers) is well regulated by the IRDAI, healthcare providers operate under a fragmented and relatively loose oversight framework. - Healthcare is a state subject and therefore any transformational change requires co-ordination across states	- Ministry of Health and IRDAI

We discuss select solution (shaded above) in some detail below

1. Digital Adoption (ABDM) : Foundation for Longitudinal Care and Leveraging AI

The Ayushman Bharat Digital Mission (ABDM) is India's national digital health initiative that seeks to create an integrated, interoperable digital health infrastructure, allowing citizens to securely access and share their digital health records (like prescriptions, lab reports). It acts as a "digital highway" bridging the gap between various healthcare stakeholders, including patients, doctors, and hospitals, for seamless, continuous care across the country.

Key components include

- Digital Health ID (ABHA): A unique health account for citizens to link and manage their health records.
- Electronic Health Records (EHRs): Enable the creation of longitudinal health records for individuals, accessible anywhere.
- Health Information Exchange & Consent Manager (HIE-CM): Facilitates data sharing after receiving explicit consent from the patient.

To transition Indian health insurance from static, limited pricing variables into dynamic, predictive risk models, the government and regulator must mandate data capture standards that enable a clean, interoperable data

baseline required to unlock true AI innovation in health insurance. Leveraging predictive AI requires standardized, granular, and continuous electronic health records (EHR). The greater the capture of clinical history, diagnostic data, and lifestyle indicators, the greater is the ability to leverage AI/ML. A critical hurdle to building these AI training models is the current lack of a unified language across hospitals and between hospitals and insurers. Systemic data capture requires the mandatory adoption of global classification standards, such as ICD-11 (International Classification of Diseases) and CPT (Current Procedural Terminology) codes across all healthcare providers.

Government and IRDAI have existing platforms such as insurance Information Bureau (IIB) and work-in-progress platforms such as HCX (Health Claim Exchange) and PIR (Public Information Registry). The power of the platforms is dependent on the quality of data (granularity of data that can be captured, reliability of data). However, lack of regulatory mandate on healthcare service provider to share data in standardised format has significantly constrained adoption and roll-out. Collaboration across different stakeholders will therefore require a firm regulatory mandate, mirroring the historic intervention that established credit bureaus in the financial sector.

2. Product Design

Healthcare insurance represents a unique industry wherein there exists almost zero price elasticity. Because a third-party insurer bears the financial burden, patients are insulated from—and often oblivious to—the actual costs of care, neutralizing the consumer's role as the primary defence against waste and abuse.

We discuss a few possible policy-design considerations

- a) **Co-pay**
- b) Deductible
- c) **Narrow network**
- d) Delinking the cost of treatment from the room category

Also, as illustrated in Figure 14, healthcare premium affordability should be evaluated against annual household savings rather than annual household income. Consequently, lowering premium costs is a critical step toward making health insurance more affordable. Some of the policy-design considerations discussed below can help achieve the objective.

a) Co-Pay

The US vs Singapore divergence underscores the power of altering these consumer incentives. Both countries have similar GDP per capita (~US\$ 94k in the US and ~US\$ 108k in Singapore); similar life expectancy (around 80 years in the US and around 84 years in Singapore), if at all, slightly higher on both counts for Singapore. The US spends ~18% of GDP on health care, while Singapore spends only ~5%⁽¹¹⁾. The sustained gap is primarily driven by consumer incentives. Singapore leverages powerful cost-sharing mechanisms such as compulsory co-pay, while government subsidies provide a safety-net floor, and Medishield caps co-pay exposure via catastrophic insurance.

To systematically prevent the zero-price-elasticity trap common in third-party payor models, Singapore explicitly blocks first-dollar coverage - making it illegal for insurers to pay 100% of a bill - thereby ensuring patients always retain financial exposure through mandatory deductibles and co-payments. To enforce this block, the Singaporean Ministry of Health mandates two financial barriers before insurance pays out the rest:

- The Deductibles: The patient must pay an initial fixed amount (e.g., the first \$ 2,500 to \$ 3,500 of a hospital bill) before the insurance kicks in at all.
- The Co-payment: Once the deductible is met, the patient must still pay a fixed percentage (typically 5% to 10% under current regulations for newer riders) of the remaining balance

From a public policy standpoint, blocking first-dollar coverage solves the "buffet syndrome" (or moral hazard)

- The foundational RAND Health Insurance Experiment proved that when healthcare is free, patients consume significantly more care, including low-value care or unnecessary "convenience" visits. Co-payments introduce "skin in the game," which dramatically slashes unnecessary patient-initiated utilization (abuse of the system). Providers occasionally engage in "abuse" by suggesting excessive testing or marginally necessary follow-up visits. When patients face a co-pay, they act as a natural check and balance, questioning or declining unnecessary extra procedures due to immediate out-of-pocket costs.
- By making first-dollar coverage illegal, Singapore forces consumers to act like rational shoppers. Patients ask doctors if a test is truly necessary, choose more affordable ward categories, and help the regulator keep a check on hospital overcharging. This design introduces an average 30% reduction in premium costs while ensuring consumers retain a vested interest in preventing medical over-utilization.

To mitigate the risk of high co-pay expenses in case of a catastrophic event, products can include a cap on the co-pay amount.

While co-pays reduce short-term insurer spending, research shows that they can paradoxically drive up the long-term, total cost of treatment. A study published in the Quarterly Journal of Economics confirms that patients are price-sensitive but medically blind. When a co-pay is increased, patients do not just cut out "wasteful" care; they cut out all care equally because they cannot distinguish between high-value and low-value treatments. Multiple studies on PubMed show that even small increases in co-pays cause chronically ill patients (e.g., diabetics, hypertensive patients) to stop taking their life-saving medications. To solve this problem, modern health economics research promotes Value-Based Insurance Design (VBID) as an alternative to the standard co-pay, which is a "blunt instrument". Instead of a flat co-pay for everything, VBID sets zero co-pays for high-value services (like insulin, asthma inhalers, or cancer screenings) to ensure compliance, while imposing high co-pays on low-value services (like unnecessary MRIs for minor back pain) to eliminate waste.

b) Deductible insurance program

The insurer bears the responsibility for treatment costs beyond say, Rs 2.5 lakhs) (Note: Fraud risk is highest in the Rs 50k-250k segment⁽¹⁴⁾; this will therefore reduce the fraud risk for the insurer)

c) Narrow Network

The treatment costs can be ~20% lower in a tier II hospital (Shalby vs Apollo in Ahmedabad, Chandan vs Medanta in Lucknow, Arihant vs Max in Nagpur without a material change in quality of medical treatment.

These policy designs can reduce health premiums by ~10-30% (*Figure 18*), significantly easing the financial burden on "middle India" while simultaneously onboarding currently excluded demographics.

Figure 18: Co-Pay and Deductible Options Cut Premiums by ~10–30% (Illustrative)

	Detail	Annual Premium (Rs)	Saving
Premium	1 year Sum Insured = Rs 10 Lakh	23,561	
Voluntary Co-Payment	10-30% co-pay	(2,509 – 7,396)	11-31%
Deductible	5-10% of Sum Insured i.e. 50,000 – 1 Lakh	(3,962 - 6,603)	17-28%

Source: www.policybazaar.com

Policy: Niva Bupa, Reassure 3.0 Elite Value, Family of 4 with highest age of 49 years

Illustration below:

There is an argument that co-pay and/or deductible will increase the cost of healthcare for the insured and hence does not reduce the financial burden on the household. The counterarguments are

- We are not recommending compulsory co-pay, as is the case in Singapore. So, a policyholder who desires 0% co-pay can choose to pay a higher health premium and purchase a policy that does not require co-pay. However, certain segments may view the reduction in health insurance premiums due to co-pay/deductible/narrow network as an attractive option that helps them manage their premium outgo.
- Co-pay can be applicable for higher room categories only. Note that India is unique in that the core cost of treatment or surgical procedure scales directly up or down based on the patient's choice of hospital room. Therefore, the policyholder can choose to forego the comfort of a superior room category, save the insurer on the treatment cost, while the policyholder saves on co-pay.

We address the concern related to increase in cost of healthcare for household in case of co-pay policies

- We argue that co-pay does not increase the overall cost of healthcare for an insured person over a cycle, while reducing the upfront cost of insurance coverage (financial protection) and therefore driving inclusion.

Figure 19: Co-Pay Does Not Raise Total Household Cost Over a Full Cycle (Illustrative)

In Rs	Standard Policy	Co-Pay (20%)
Annual Premium	25,000	20,000
Frequency of Hospitalisation	1 in 5 years	
Total Premium Paid (a)	125,000	100,000
Average Claim	100,000	
Deduction/Rejection	10%	10%
Out of Pocket Expense due to Deduction/Rejection (c)	10,000	10,000
Co-Pay (c)	0	18,000
Overall Cost to Household (d) = (a) + (b) + (c)	135,000	128,000

- Enabling coverage via affordable plans helps insure the “missing middle” with low savings from catastrophic health expense. The table below explains that what the policyholder pays will be between 10-20% of the treatment cost for CABG (US\$4,500) and even lower in the case of Narrow Network. This implies that an uninsured household that would have lost 10 years of savings can now manage with 1-2 years of annual savings, thereby providing significant financial protection

Figure 20: Illustrative Comparison of Cost to Insured Household in Co-Pay or Deductible

Treatment Cost	What Policyholder Pays		
Rs 000s	Deductible (100k)	Co-Pay (20%)	Co-Pay with Cap (150k)
100	100	20	20
...			
300	100	60	60
...			
450	100	90	90
(Policyholder pays as %)	22%	20%	20%
...			
1000	100	200	150
(Policyholder pays as %)	10%	20%	15%

However, implementation will likely face resistance regarding distributor incentives. Because lower premium rates directly translate to lower absolute commissions, the success of this model hinges on whether aggregate volume growth can expand fast enough to offset the decline in individual distributor payouts. Alternatively, there is a soft incentive approach that can be considered if the market pull is not strong. Modest market pull would suggest that despite superior affordability, awareness and accessibility (distribution) are the key challenges and the distributor needs to be adequately compensated as his/her efforts to sell co-pay/deductible health insurance policy is not materially lower. Protect the distributor's earnings (as in the table below) will suggest a 17% reduction in Premium to Policyholder, albeit a little lower than 20%, but an optimised solution to achieving twin goals of affordability and accessibility. Do note that this will optically increase the commission and expenses incurred by insurer and IRDAI may have to revisit its Expense of Management guidelines to ensure that insurers are incentivised and not penalised for introducing affordable plans

Figure 21: Illustrative Reduction in Premium while Protecting Distributor Incentives

Premium		100	Indexed
Distributor Commission	15%	15	
Net to Insurer		85	
Reduction in Net to Insurer due to Policy Changes	20%	(17)	Due to Co-Pay or Deductible or Narrow Pay
Revised Net to Insurer		68	
Distributor Commission		15	The commission % to distributor has increased from 15% to 18% to ensure the absolute amount to the distributor remains the same
Revised Premium		83	
Reduction in Premium		17%	

d) Delink the cost of treatment from the room category

It is unique to India, where the cost of treatment is linked to the room category. There is a case for the regulator to work with the Ministry of Health and mandate the unbundling of core medical procedure costs from hospital room classifications, as is the case in the US/UK/Germany/Singapore.

- Cross-subsidy by insured to uninsured impacts health insurance adoption

Consider an uninsured patient undergoing a CABG procedure in a double-occupancy room, costing approximately Rs 0.5 million. Health insurance allows this patient to upgrade to a single room. Although the room rent itself only increases by Rs 5,000 per day—adding roughly Rs 20,000 to Rs 25,000 for a standard 4-to-5-day stay—the overall treatment cost escalates to around Rs 0.8 million. This higher cost for insured patients effectively serves as an unintended cross-subsidy for the uninsured. Consequently, this dynamic creates a dual challenge: it disincentivizes insurance adoption by artificially lowering costs for the uninsured, while inflating premium costs for the insured, ultimately hindering health insurance penetration.

- This can help avoid unexpected surprises to patients from out-of-pocket expenses arising from partial denial by insurance companies.
- Decouple core treatment fees from room categories will result in like-to-like comparison across hospitals - a vital step to control medical inflation and protect policyholders from unexpected out-of-pocket expenses
- Higher transparency is expected to reduce friction between the healthcare provider and the health insurer

Group Negotiation to ensure fair practices and fair cost

Given asymmetric equation between the healthcare provider and the individual patient/policy holder, the health insurance companies will need to collaborate actively in the interest of the policyholder.

The table below comparing tariffs (NABH hospitals in the metro) suggests sufficient room for private health insurers to negotiate as a group to ensure a level playing field and fair cost.

Figure 22: Group Negotiation Lowers Tariffs: Negotiated/GIPSA vs Cash and Private Rates

In Rs lakhs	Cash/Private Health Insurance	Negotiated
		GIPSA
PTCA inclusive of Angiogram and 1 Stent	2.7-2.8	2.0-2.1
CABG Off Pump with IABP	3.8-4.0	3.4-3.5
Total Knee Replacement with Implant	2.7-2.8	2.4-2.5
Laparoscopic Cholecystectomy without CBD Exploration	1.0-1.1	0.8-0.9
Lower Segment Cesarean Section	1.2-1.3	0.6-0.7

Source: PMJAY, CGHS, MJPJAY, RGS, Swasthyasathi, Dr NTR Vaidya seva-Portals, EY-P Analysis

We don't view this as anti-competitive behaviour on the part of the insurers as

- Lack of open pricing with insulated local markets that reduce traditional competitive pressures and differential treatment protocols, and billing practices results in high opaqueness regarding medical treatment cost. These negotiations at best moderate the medical inflation trend translating to lower premium increase instead of higher profitability for the insurers as reflected in the modest profitability ratios for health insurers as well as the regulator's ability to step in case of excessive premium increase
- This is not different from association of trade bodies and associations including AMFI (Association of Mutual Funds in India) or CAIT (Confederation of All India Traders), GIPSA as a body representing the public sector insurers is playing a similar role already

IRDAI holds a critical role in ensuring a level playing field, which directly safeguards policyholders. Ultimately, making health insurance sustainable relies not on capping premium rates, but on managing and lowering the foundational cost of healthcare.

The health insurance sector should also collaborate to establish standard, evidence-based treatment protocols backed by rigorous medical evaluations.

These initiatives can help bring about higher transparency, standardization of care and care pathways, and cost embedded in these care pathways, thereby improving affordability. This therefore results in lower rejection, resulting in lower surprise out of the expense burden on the policyholder/patient.

To ensure patients receive the right treatment for the right condition, global systems use health technology and economic assessments to weigh extra health benefits against extra costs. For instance, studies comparing robotic surgery to conventional laparoscopy for minor procedures—such as fibroid removal—show that robotics add significant financial cost without offering meaningful clinical improvements for the patient. Note that customers can always choose to follow a different treatment protocol by choosing to pay out of pocket or under a co-pay

In the US, commercial health insurers negotiate treatment protocols and costs, tightly monitor adherence, and ensure medical necessity guardrails

- Prior Authorization & Medical Necessity Rules: Insurers mandate that doctors submit treatment plans for approval *before* performing expensive procedures. They benchmark these requests against evidence-based proprietary databases to decide if a treatment is "medically necessary."
- Step Therapy ("Fail First" Protocols): Insurers enforce protocols requiring patients to try cheaper, generic, or standard drugs/treatments first. The hospital can only "step up" to an expensive, branded treatment if the lower-cost option fails to work.
- Formulary Exclusion Lists: Payers negotiate directly with pharmaceutical companies. Drugs that do not offer a deep volume discount are excluded or placed on expensive payment tiers, forcing hospitals to default to preferred alternative protocols.
- Peer-to-Peer Clinical Reviews: If a provider disagrees with an insurer's protocol denial, the hospital's doctor must sit through a formal "peer-to-peer" review with a medical director employed by the insurance company to argue the clinical data.

Unlike the US, where most hospitals are government-owned or non-profit, most Indian hospitals operate on a for-profit-basis. This commercial landscape in India makes it essential for health insurers to collaborate to ensure policyholder protection.

Integrated Healthcare

There are multiple benefits of pursuing integrated healthcare:

- The trust deficit between the health care providers and payors (retail health insurers) has its roots in the differing or misaligned incentives - a classic example of the power of these incentives is the differing effects of activity-based pay and capitated pay. Activity-based systems, in which providers are paid for each unit of activity they deliver, tend to overproduce (as many charge-based hospitals do, for example). Capitated pay systems, in which providers are given a set fee per patient, tend to underproduce.
- Not addressing the longitudinal health needs of the population can lead to a steep toll on both the overall health of the population and on the financial quantum of its remedy.

The Kaiser model is an integrated healthcare approach combining insurance (Kaiser Foundation Health Plan) and medical care delivery (Permanente Medical Groups) into a single, non-profit system. It emphasizes prioritizing preventive measures, chronic disease management, and evidence-based medicine to improve patient outcomes and control costs. Benefits of the model include

- Improved health outcomes due to coordinated care - patients experience seamless care across different settings, from clinics to hospitals and home-based care
- Lower cost - reduces the total cost of care through efficient, coordinated services and reduced duplication
- At approximately 43%, India's Out-of-Pocket Expenditure (OOPE) remains disproportionately higher than the global benchmark of 18–20%. This is partly driven by the exclusion of outpatient care as retail pharmaceuticals, routine consultations, and diagnostics are generally excluded from insurance policy coverage and government schemes. Historically, insurers have avoided outpatient coverage due to severe information asymmetry and moral hazard—specifically, the challenge of auditing the legitimacy of high-frequency, low-ticket clinical claims. However, this oversight barrier can be effectively mitigated through an integrated healthcare delivery system that unifies payer-provider networks and digitizes clinical tracking.
- There is a case for insurers to therefore consider managed care or integrated care in the healthcare provider space to drive outcome-based instead of activity-based medical care. While retail health insurers are loss-making at an aggregate level, healthcare providers enjoy healthy profitability, making a stronger financial case for integrated healthcare. Higher profitability of healthcare providers can provide the required profit pool to drive growth besides solving for some control over the key cost (treatment cost) and cushion from sharp increase in healthcare cost.

Figure 23: Healthcare Providers Earn Healthy Returns (FY26)

		RoE (FY26)
Apollo Healthcare	Super speciality Tertiary care	18%
Medanta	Super speciality Tertiary care	25%
Rainbow Hospitals	Mother & Care	18%

Source: Company Disclosures

(1) Apollo: $PBT \times (1-T) / \text{Average Capital Employed in Health Care Services including CWIP}$

(2) Medanta: $EBIT \times (1-T) / \text{Average Net Worth; Average Net Worth exclude excess net cash}$

Figure 24: Retail Health Insurers Have Weaker Profitability (FY26)

	RoE (FY26)
New India Assurance	Loss making
ICICI Lombard (Health only)	~0%
Star Health ⁽¹⁾	10%
Niva Bupa ⁽¹⁾	11%

Source: Company Disclosures

(1) IFRS disclosures

Illustrative Math below:

	Healthcare Provider (Retail Health Insurer segment only)		Retail Health Insurer		Integrated Healthcare
Revenue	90		113		113
EBITDA	25	+	5	=	30
PAT	16		4		20
Net Worth	64		40		104
RoE	25%		10%		19%

To highlight an example of how integrated healthcare can help make the optimally correct decision.

In most industries, technological advancement boosts productivity and lowers unit costs. Healthcare is a distinct exception; advanced tools like robotic surgery improve medical outcomes but simultaneously escalate treatment costs. It therefore requires a holistic examination of the trade-off between care quality and affordability. While cutting-edge technology may offer slightly superior medical outcomes, its high cost drives up health insurance premiums. This inflation in health insurance premiums can force lower-income households to defer insurance entirely. Consequently, the uncritical adoption of advanced medical technology risks worsening financial exclusion in healthcare.

For example: A robotic surgery machine cost with da Vinci systems costs between US\$ 1.5-2.5 mm⁽¹²⁾, an annual maintenance contract, and expensive disposable. The cost of surgery is around 1.5x⁽¹³⁾ for robotic knee replacement. In the current industry structure where healthcare providers and health insurers are not on the same side, the healthcare provider sees merit in robotic surgery as it reduces the recovery time for patient results in lower ALOS (Average Length of Stay), resulting in higher hospital revenue (higher number of patients that can be treated with the same capacity), whereas health insurer sees this as higher cost and its benefit only in limited cases. An integrated healthcare solves the above conflict by bringing both the healthcare provider and health insurers on the same side.

Unbundling the commercial real estate business from healthcare services

The business model today of a healthcare provider is a combination of commercial real estate (land and building) and healthcare service (medical service). The cost of land and building accounts for around 75% of the capital requirement.

Figure 25: Illustrative Unit Economics of a Healthcare Provider with Owned Land and Building:

	Rs	Comment
Average Revenue per Bed per day		
- Reported	60,000	
- Private Beds	69,000	Non-Scheme/GIPSA beds Assumption: ARPoB = 15% higher than Reported ARPoB
Revenue	26,280,000	Assumption: Out-Patient Revenue = 20% of In-Patient Revenue
Cost of Service	19,710,000	
EBITDA margin	25%	Leading Corporate Hospitals ~25% margin
EBITDA	6,570,000	
Depreciation	1,000,000	5% depreciation
EBIT	5,570,000	

	Rs	Comment
Tax	1,392,500	25% tax rate
PAT	4,177,500	
Gross Block	20,000,000	Rs 2mm per bed
Net Working Capital	0	Negative working capital for leading corporate hospitals
Capital Employed	20,000,000	
RoE (post-tax)	21%	

Unbundling commercial real estate from healthcare service (as is the case with value retailers like Vishal Mega Mart/ V2 Retail or even Diagnostic companies) can significantly reduce capital requirement and the cost of treatment. In the example below, the cost of treatment can reduce by ~27% if the healthcare service provider were to unbundle real estate.

Figure 26: Unbundling Real Estate Cuts Treatment Cost ~27%: Leased-Model Unit Economics (Illustrative)

	Rs	Comment
Gross Block	5,000,000	Rs 5 mm per bed excluding cost of Land and Building
Net Working Capital	0	Negative working capital for leading corporate hospitals
Capital Employed	5,000,000	
Target RoE (post-tax)	21%	Same as Above
PAT	1,044,375	
PBT	1,392,500	25% Tax Rate
Depreciation	500,000	10% depreciation
Rental	1,050,000	7% lease rental on Land and Building
EBITDA	1,892,500	
Cost of Treatment	19,710,000	Same cost of treatment as above
Revenue	18,272,500	Assuming similar OP revenue
Average Revenue per Bed per day		
- Reported	50,062	Assumption: Since integrated model, Insurance will drive patients for healthcare service provider, which can then reduce its dependence on government schemes
- Private Bed	50,062	27% lower cost of treatment (as compared to Rs 69,000 in the above table)

Lower capital requirement (Rs 5 mm instead of Rs 20 mm per bed) can result in rapid growth of healthcare facilities.

The above unit economics can then support smaller, largely secondary care hospitals, distributed closer to communities instead of large, super specialty, destination hospitals. This is particularly important for a country like India, where hospital bed capacity at 1.5 per 1,000 people lags the National Health Policy goal of 2 beds per 1,000 people.

Existing hospitals can adopt the REIT model to sell and lease back the owned land and building premises to unlock capital and fund growth.

Coronary Artery Bypass Graft (CABG) can cost ~US\$ 4,700 in hospitals like Breachcandy, HN Reliance, and Asian Heart (South/Central Mumbai) as compared to ~US\$ 3,200 in hospitals like Wochardt, Fortis, and Hirandani (suburban Mumbai). A large part of the difference in the cost of treatment has to do with the higher cost of land and building. By separating real estate from healthcare services by unbundling the cost of infrastructure and funding it from investors who seek a lower rate of return, it can reduce the cost of healthcare.

The government, though, cannot force the unbundling. It can, however, create a favourable environment, including incentives that encourage some market participants to adopt unbundling of land and building. Lower cost of treatment by those who adopt will force other participants to consider this option.

Healthcare Regulator

There is a need for a healthcare regulator – a regulator for the sector like the Reserve Bank of India for the banking system, SEBI for capital markets, IRDAI for insurance or TRAI for telecom.

This is particularly important as

- Healthcare is an essential service, and healthcare cost is becoming a larger part of the household expenses, likely to be the 3rd largest expenditure within household budget (surpassed only by food and housing).
- A significant regulatory asymmetry stalls structural progress in India's healthcare ecosystem. While the payor side (insurers) is well regulated by the IRDAI, healthcare providers operate under a fragmented and relatively loose oversight framework. This creates a glaring transparency gap: While there is a high level of disclosures from all insurers (loss ratio, commission, claims settlement, complaints), the same is missing from healthcare providers. A dedicated healthcare regulator is indispensable to drive systemic reforms—such as mandating Ayushman Bharat Digital Mission (ABDM) adoption and curbing Fraud, Waste, and Abuse (FWA). The urgency of this issue was highlighted in November 2025, when the Ministry of Finance advised insurers and hospitals to collaborate to bring down health insurance costs and work together to ensure transparency, including measures such as devising standardised treatment protocols and common empanelment norms, and ensure efficiency to make healthcare affordable and accessible for policyholders. However, without a centralized regulatory body to enforce this agenda, the government's ability to execute these vital reforms will remain fundamentally restricted.
- Unlike the US and UK, where private healthcare is a smaller part of the healthcare system, in India, private healthcare contributes to a majority of the beds and is growing faster. A higher role of for-profit private sector necessitates the role of a regulator

Figure 27: India's Majority-Private Provider Mix vs the US and UK (Delivery by Ownership Type)

	US	UK	India
Not for profit	~58%		
Government	~18%	~80%	~40%
Private	~24%	~20%	~60%
	100%	100%	100%

- Healthcare is a state subject, and therefore, a uniform policy across states will require coordination by a sector regulator

The regulator can drive policy making through coordination across the Centre and States (given healthcare is a State subject), with the ultimate objective of making healthcare affordable, extending financial inclusion by ensuring coverage of the “missing middle” under government scheme or health insurance, and preventing people from slipping into poverty due to healthcare treatment cost.

Most countries have separate regulators for hospitals and health insurers because the two sectors require entirely different types of oversight. Germany, on the other hand, seeks to avoid the separate-regulator conflict

by using a unique "joint self-governing" model where hospitals and insurers regulate the healthcare system together under strict federal laws.

While it is not within the scope of this report to comment on the mandate of regulatory bodies, IRDAI can recommend to government on the role and mandate of a healthcare regulator.

Conclusion

India's healthcare challenge is neither a problem of clinical capability nor of the absolute cost of treatment. It is a problem of affordability i.e., healthcare cost relative to the income of the household, and a financing system that leaves the missing middle exposed, and above all, trust. The trust deficit runs in 3 directions – between policyholder and insurers (information asymmetry and opaque policy terms), between provider and insurer (limited standardisation in medical and billing, FWA) and between the citizen and the system (apprehension that a claim will not be honoured when it matters most).

UHC by 2033 will be reached only by advancing on all 3 axes of the WHO framework at once – population coverage, service depth, and financial protection. No single axis suffices – wider coverage without financial protection still bankrupts households, while financial protection without service depth leaves real needs unmet. The appropriate model to achieve this is moderate profit at the unit level x large scale = larger profit pool, which can support investment to drive coverage, affordable and high-quality care, instead of higher profit x small scale = low profit pool that restricts the quantum of investment. This requires transparency, which requires technology and policy intervention

The levers reinforce one another. Digitisation, which enables interoperable, longitudinal patient data available to insurers with policyholder consent, can enable greater trust, superior underwriting, and lower rejection at the time of claim. Policy design that includes co-pay and deductibles reduces moral hazard and aligns policyholders with the insurer, reducing the rejection risk at the time of claim. Achieving a common ground on medical protocols, billing procedures, and unbundling the cost of treatment from the room category will significantly enhance trust between the healthcare provider and insurer. Put together, these steps can reduce the cost of treatment while reducing the rejection ratio at the time of claim, thereby enhancing trust of citizens in the broader healthcare system – trust is the variable that ultimately converts health insurance from a product that must be sold into one people actively seek, mirroring the transition that turned mutual funds into a mass-market "pull" product in India.

With healthcare set to become the third-largest call on the household budget after food and housing, and constitutionally a state subject, within a federal system, a coordinating healthcare regulator is not a luxury but a structural necessity. The window to act is now, as each year of delay compounds medical inflation, widens the coverage gap, and pushes an estimated 55-63 mm Indians into poverty. Solving the structural gap and regulatory gaps in private healthcare delivery is the precondition for Universal Health Coverage, which India has promised itself by 2033.

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