



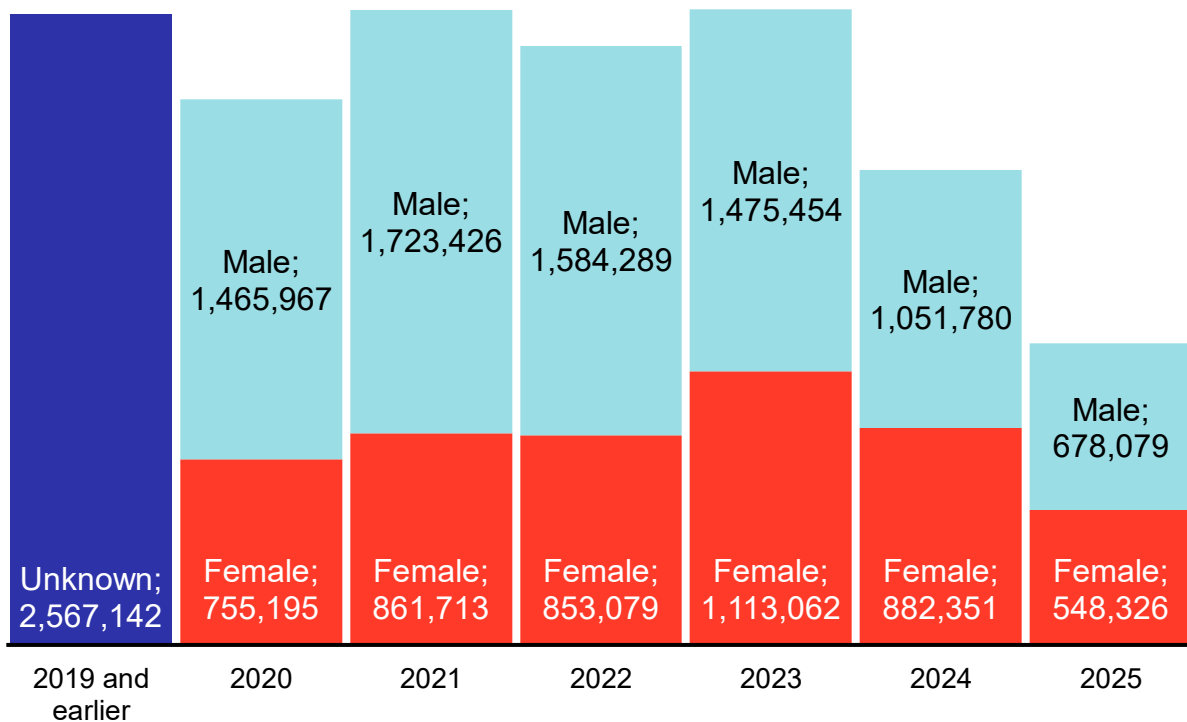
The leading end to end healthcare platform for India, with the largest network of providers, hospitals, pharmacies, labs, and insurers.

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I. FY2025 IMPACT METRICS

1. Unique patients by year and gender¹

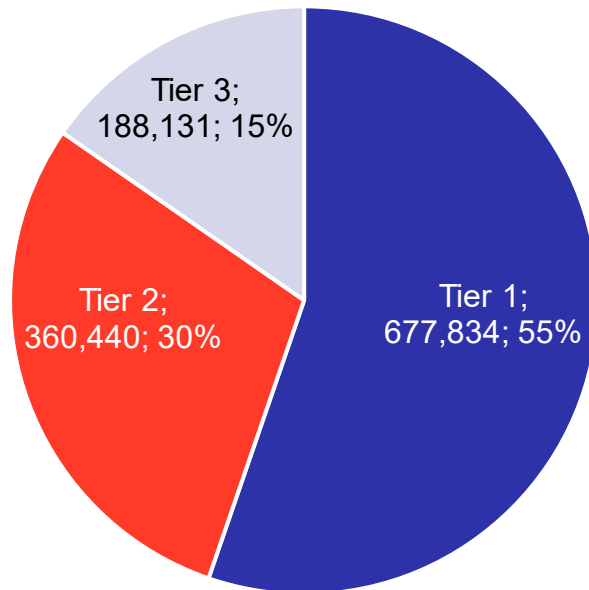
N = 1,226,405 (2025); 15,559,863 (cumulative)



¹ Breakdown on gender not available prior to FY2020

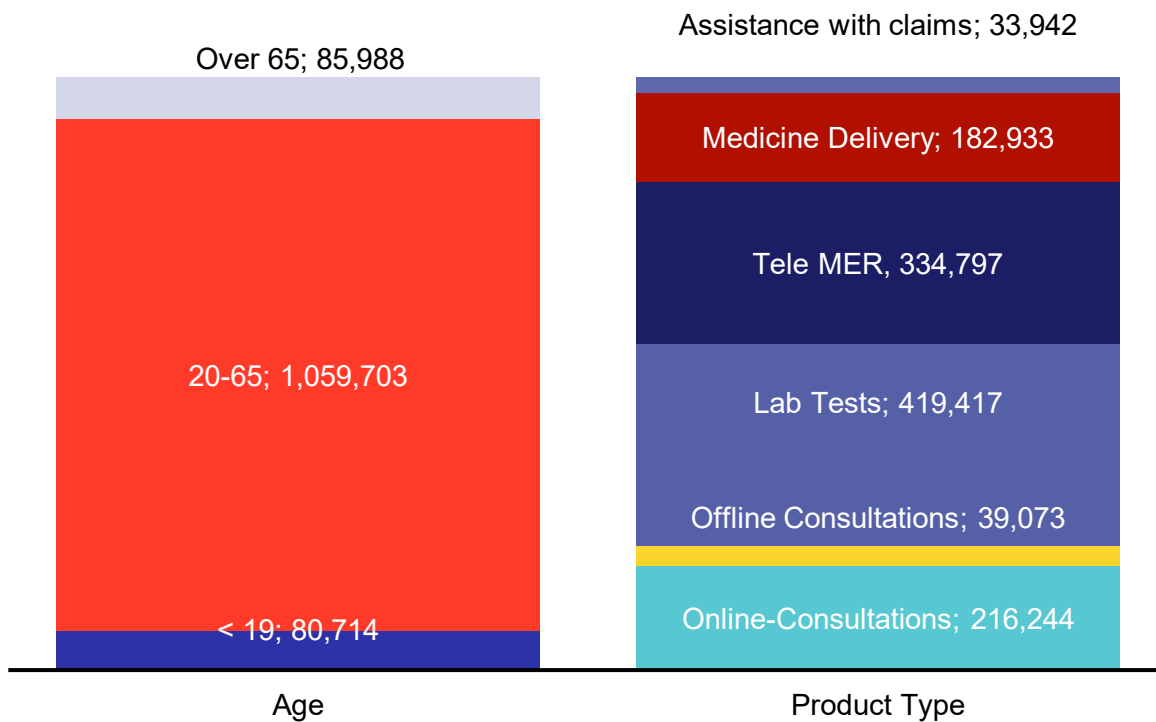
2. Unique patients by underserved status (2025)²

N = 1,226,405 (2025); 100+ cities represented



3. Unique patients by age and product service type

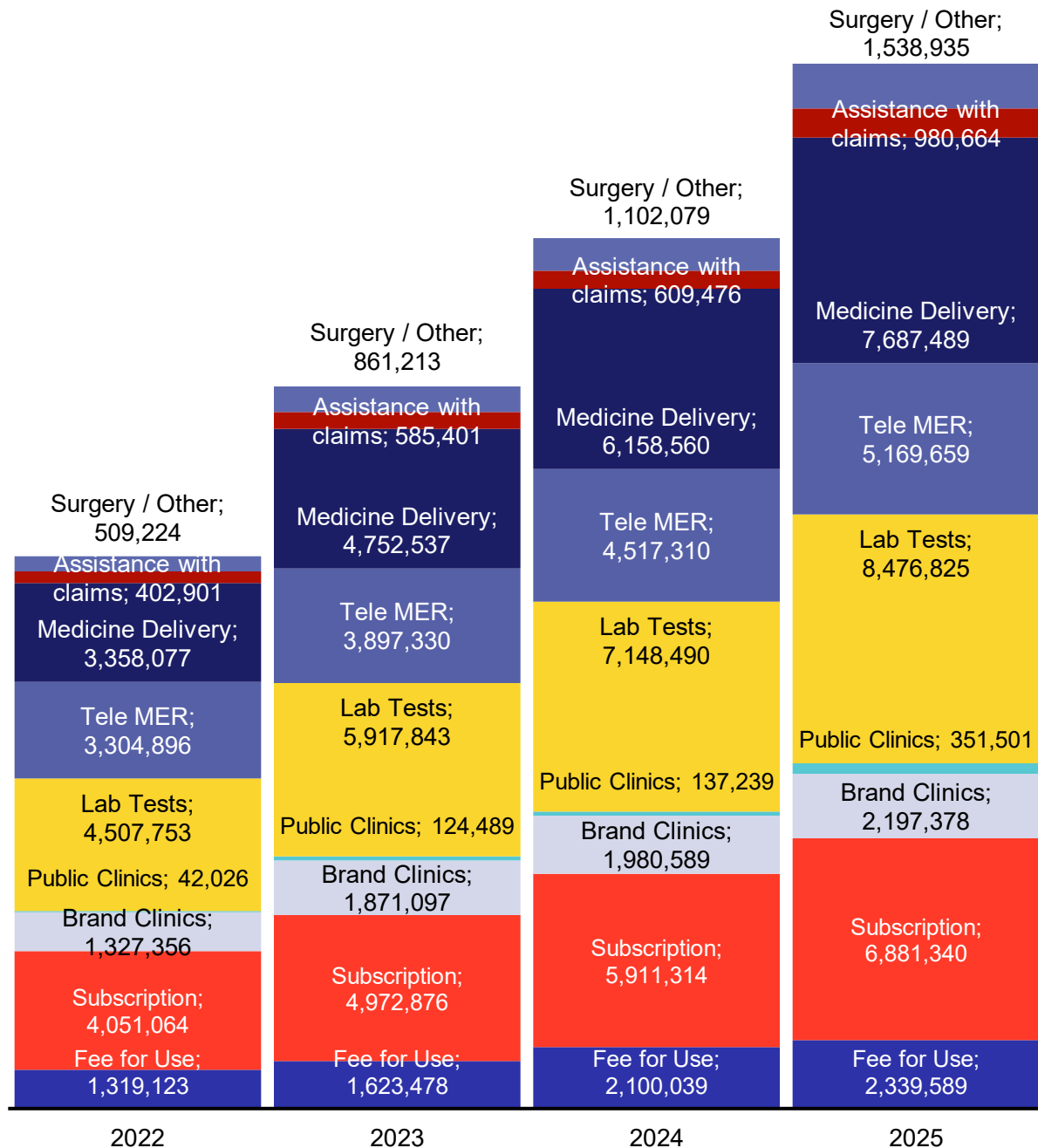
N = 1,226,405 (2025)



² Medibuddy defines underserved status based on the location of patients booking services. Tier 2, Tier 3, and Rural patients considered “underserved.”

4. Patient services by Product/Service Type (Cumulative)³

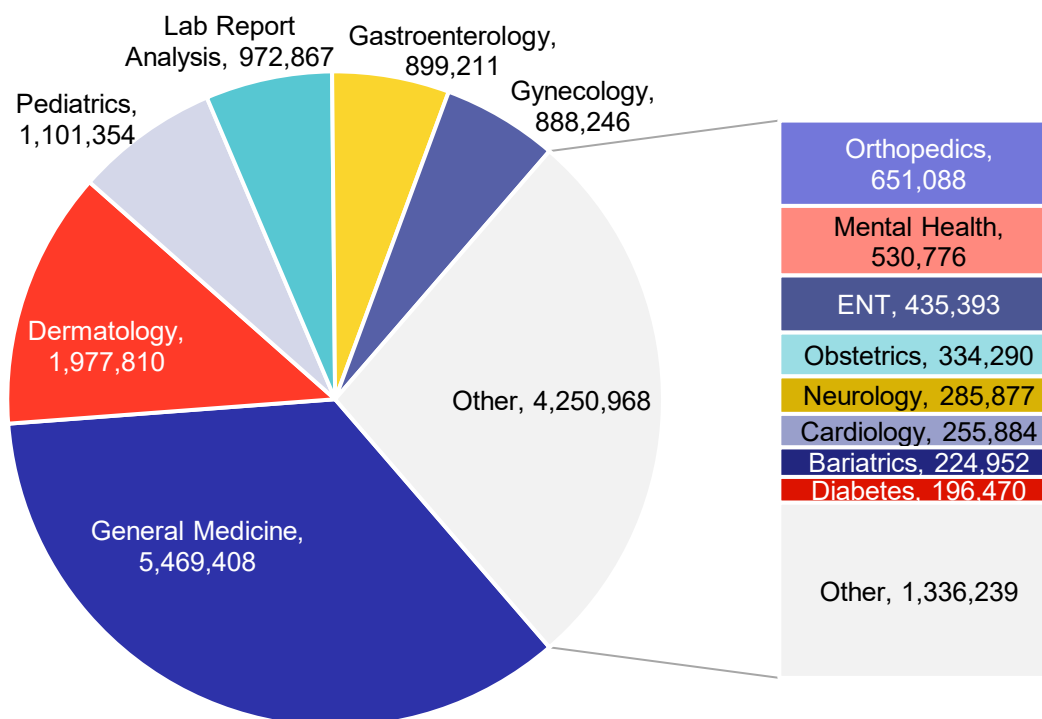
N = 5,958,284 (2025); 34,084,445 (cumulative)



³ TeleMER refers to tele-interviews with patients to gather risk related personal information and medical history.

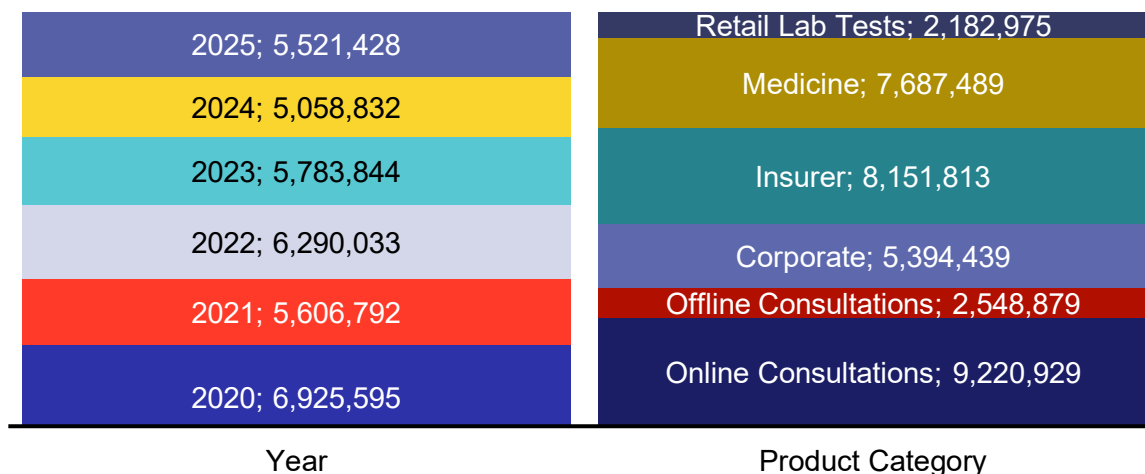
5. Unique Patients Profile by Disease (Cumulative)⁴

N = 15,559,863 (cumulative)



6. Units (Services) by year and Product Category (Cumulative)^{5,6}

N = 5,958,284 (2025); 35,623,380 (cumulative)



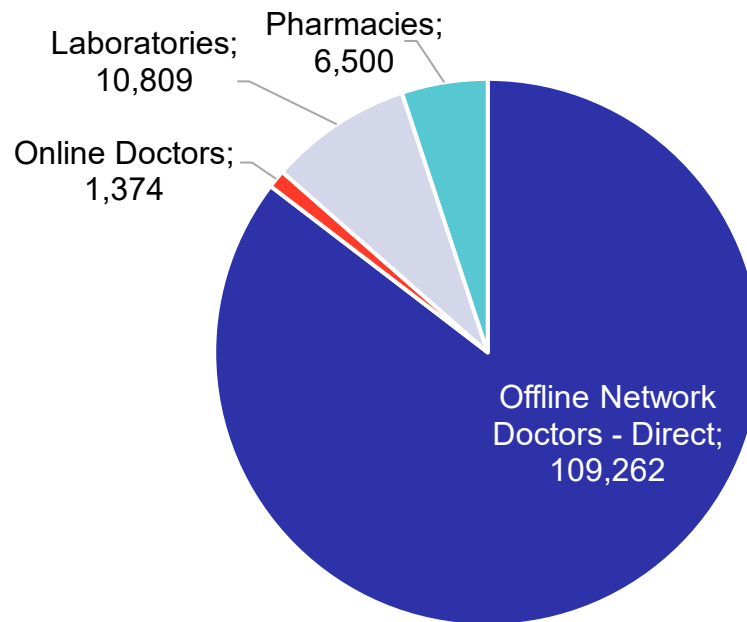
⁴ 42% of transactions were for primary care (pediatrics and general medicine)

⁵ Transaction services by category equal to those by type. Insurer = (Labs – retail labs – corporate) + Tele Mer + assistance with claims

⁶ Until FY2021, Medibuddy relied on third party aggregator to provide access to out of network physicians. In 2021, the company made the decision to focus on using providers from within their own network.

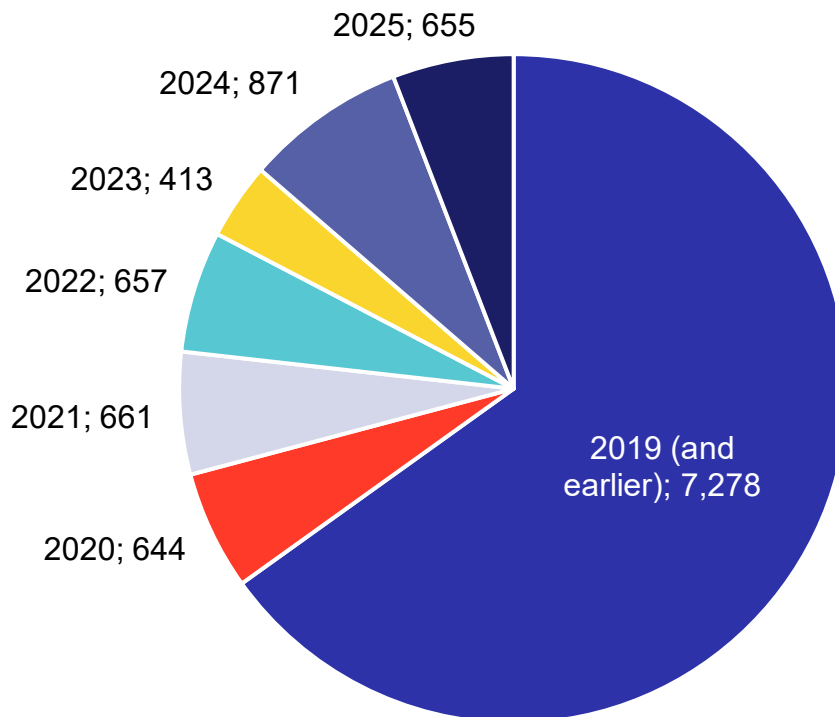
7. Provider Network Profile (Cumulative)⁷

N = 127,945 (cumulative)



8. Provider Training (number of people)

N = 11,179 (cumulative)



⁷ Pharmacy total includes external partner pharmacies.

II. BRIDGING INDIA'S INSURANCE GAP FOR FORMAL SECTOR WORKERS

A. BACKGROUND

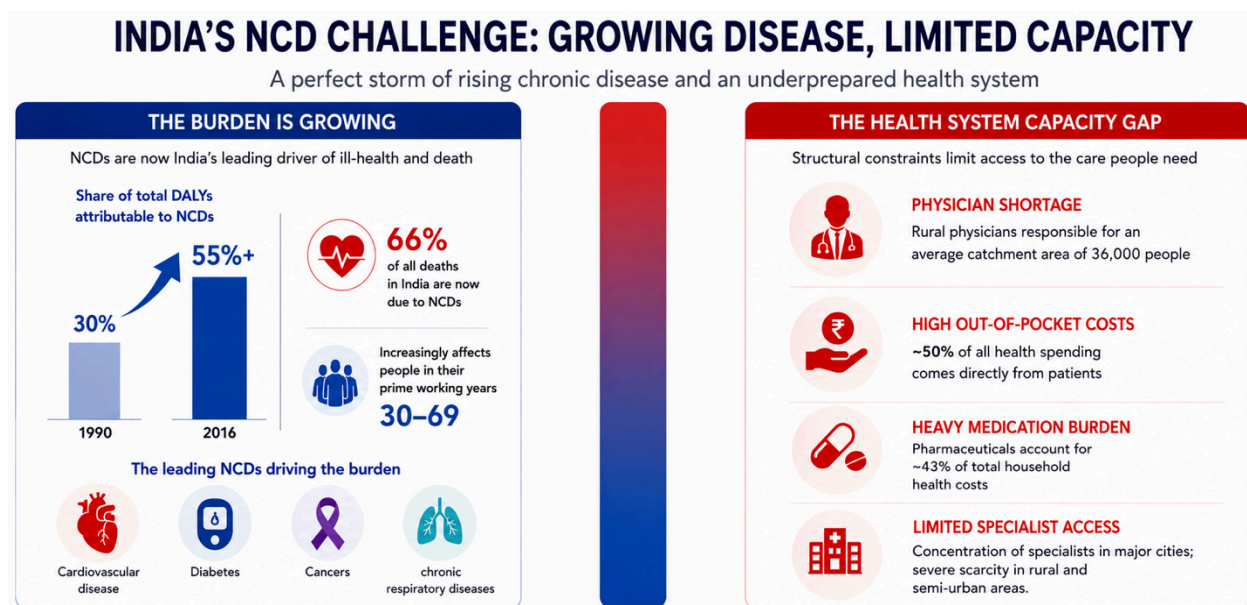
1. A Healthcare System Under Strain: NCDs, Access Gaps, and the Missing Middle

India is in the midst of a non-communicable disease (NCD) epidemic of historic proportions. Between 1990 and 2016, the share of total disability-adjusted life years (DALYs) attributable to non-communicable diseases rose from 30% to more than 55%, a shift driven principally by cardiovascular disease, diabetes, cancers, and chronic respiratory illness. NCDs now account for an estimated 50% of all deaths in India and, critically, are no longer primarily diseases of the elderly. The cardiovascular and metabolic conditions that dominate India's NCD burden are increasingly striking during the prime working years of 30-69, carrying with them not just individual suffering but substantial economic cost, as premature illness removes workers from the labor force, drives households into debt, and strains a healthcare system that was never designed to manage chronic conditions at population scale.¹

These are chronic conditions that require ongoing patient management, including regular physician consultations, periodic laboratory monitoring, and consistent medication adherence, rather than episodic acute care. Against this backdrop, India's health system is not yet sufficiently mature to provide such routine care for the majority of the population. As a whole, India has roughly one physician for every 834 patients (including traditional medicine practitioners), meeting the World Health Organization's recommended ratio of one per 1,000, but medical staff availability outside major cities is severely constrained. In rural regions, where over 70% of the population resides, a single physician is typically responsible for a catchment population of approximately 36,000 people, and specialist vacancy rates at rural Community Health Centers can exceed 80%.

¹ In the interest of more informal readability, literature references are provided at the end of this Report without sentence-by-sentence attribution. Should readers want specific references pertinent to information provided, they are encouraged to contact TEAMFund.

For most patients, this scarcity in the public system means they instead seek care in the private sector, often at full cost and without reimbursement. Out-of-pocket expenditure accounts for approximately 40% of all health spending, much of it related to chronic diseases, with pharmaceuticals alone representing an estimated 43% of total household health costs. For a working family managing chronic conditions, purchasing, for example, ongoing antihypertensives, a quarterly HbA1c test, and purchasing a specialist consultation, the cumulative cost of staying healthy can exceed a month's wages.



This is the backdrop against which India has spent the last decade attempting to adapt a universal health financing system to fit modern demands. The results are significant, but incomplete. At the bottom of the income distribution, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana ("AB-PMJAY") now provides hospital coverage to more than 360 million beneficiaries, and at the other end of the spectrum, salaried professionals in large corporations often receive employer-sponsored group health plans. Between these two poles, sits a large population with little or no insurance that researchers and policymakers have come to call the **"missing middle."**

Estimated to represent upwards of 30% of the Indian population (300-400 million individuals), the missing middle is not a single group but a configuration of circumstances: formal-sector employees earning above the income threshold for government schemes; informal workers not covered by employer benefits; self-employed individuals; and rural households with limited access to either public or private insurance products. What those in the missing middle share, is a combination of meaningful financial vulnerability and near-total exposure to the cost of serious illness. A single NCD-related hospitalization, including a cardiac event, a cancer diagnosis, or a diabetic complication, can consume months of household income and trigger a cycle of borrowing and impoverishment from which many families never fully recover.

Digital healthcare platforms, such as MediBuddy, help patients overcome four primary barriers that limit access to care for patients, particularly those in the “missing middle”:

- 1) **Navigational barriers** – Patients often face difficulty in identifying appropriate healthcare providers, services, and care pathways within a fragmented healthcare ecosystem. Digital platforms mitigate these challenges by enabling more user-friendly navigation, triaging patient needs, and guiding individuals to suitable providers and services in a timely manner.
- 2) **Administrative barriers** – Healthcare systems are frequently characterized by complex administrative processes, including appointment scheduling, medical documentation, and coordination among providers. These inefficiencies can delay care delivery and increase patient burden. Digital solutions streamline such processes through automation, centralized records, and improved coordination.
- 3) **Financial barriers** – The cost of healthcare services and lack of price transparency can limit access to care. Platforms address these constraints by integrating payment solutions, facilitating insurance coordination where applicable, and providing greater cost visibility, thereby improving affordability and financial planning for patients.
- 4) **Clinical (care delivery) barriers** – Access to timely, high-quality clinical care remains a significant challenge, particularly in

underserved or resource-constrained settings. Digital healthcare platforms expand access through teleconsultations, integrated pharmacy and diagnostics services, and continuity of care mechanisms, thereby enhancing both availability and quality of care.

Last year, TEAMFund examined how MediBuddy extended healthcare access to one segment of the missing middle, manufacturing workers, through its network of on-site clinics and employer-sponsored care programs. This year, we turn to a different mechanism with broader reach and longer-term significance: the expansion of formal health insurance to India's organized-sector workforce, and the role MediBuddy is playing as the delivery infrastructure that makes that coverage impactful.



2. India's Insurance Landscape: Coverage at Scale, Access in Name Only

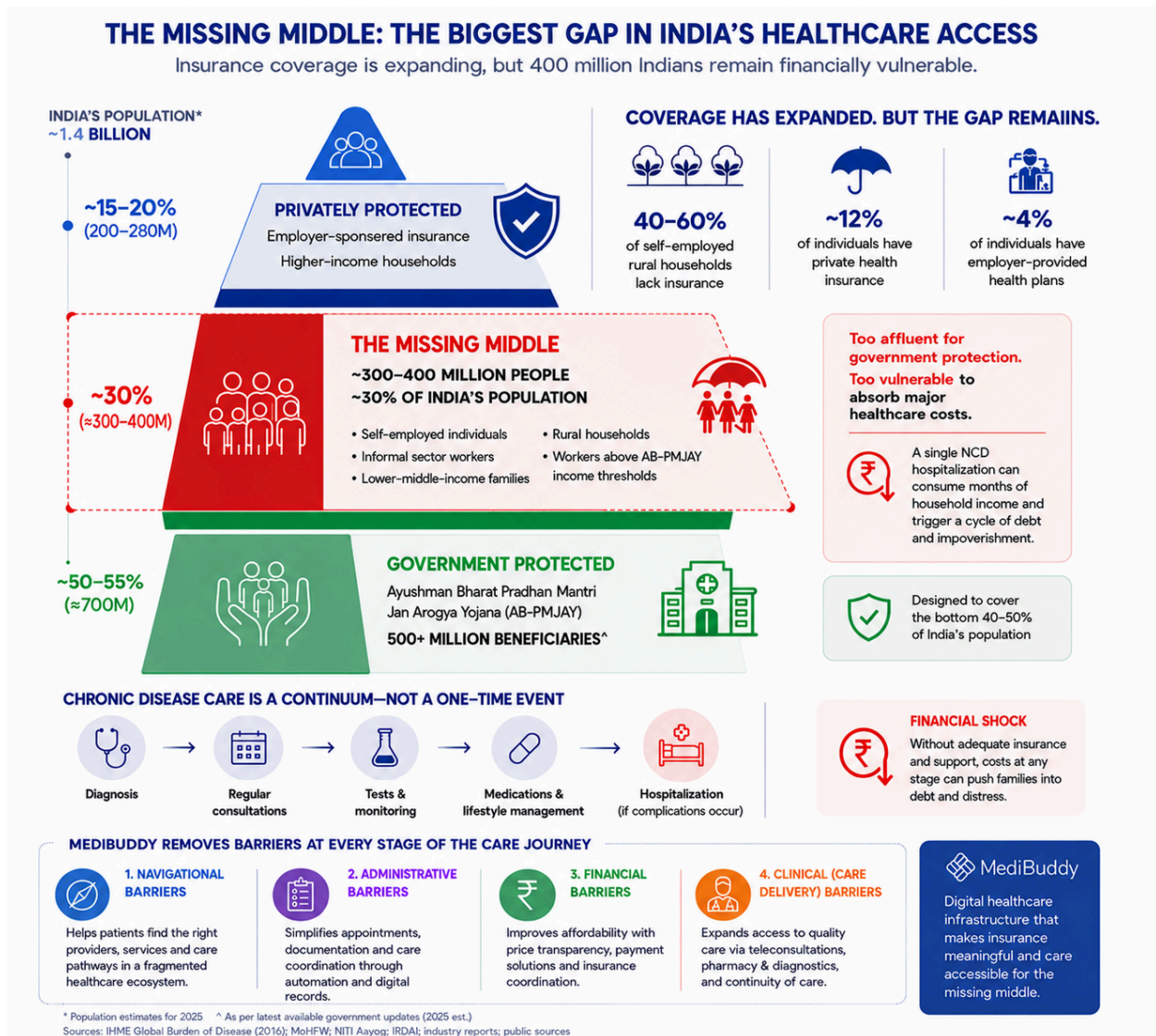
The headline statistics on India's health insurance coverage have improved markedly over the last decade, driven primarily by government investment. While consistent statistics are difficult to determine, it is estimated that fewer than 41% of Indian households had at least one member enrolled in any form of health insurance as of 2019–21. AB-PMJAY has since expanded substantially: as of late 2024, approximately 360 million of its 550 million eligible beneficiaries had been verified under the scheme.

Approximately 9% of the population holds private voluntary health insurance, and roughly 10% are covered through social health insurance schemes such as Employees' State Insurance Scheme (ESIS) and Central Government Health Scheme (CGHS). On paper, this represents a dramatic expansion. In practice, enrollment and meaningful financial protection are not the same thing: a peer-reviewed evaluation has found that among AB-PMJAY cardholders who sought care at private hospitals, 70–78% still incurred catastrophic health expenditure.

Private health insurance in India, despite its growth, remains fundamentally a product designed for urban, salaried, relatively high-income consumers. It is concentrated in metropolitan areas, purchased primarily by individuals with the financial literacy to compare products, the stability to pay annual premiums, and the access to private hospitals that insurers recognize. Even among formal-sector workers with access to employer group health plans, however, coverage is frequently limited to inpatient hospitalization, leaving the ongoing, outpatient management of chronic conditions entirely to the individual. **A worker with hypertension may have a policy that covers a cardiac event, yet no coverage for regular consultations, quarterly lab monitoring, or daily medications that would have prevented it.** Insurance structured around acute interventions rather than prevention is not a healthcare access tool; it is a financial backstop that arrives too late, without a proper incentive structure to encourage attention to the many behavioral risk factors that contribute to chronic disease.

Beyond what insurance may not cover, there is the question of whether patients can use it. Reimbursement-based models require patients to pay at the point of care, file paperwork, and navigate often-opaque insurer bureaucracy, processes that systematically disadvantage workers with lower health literacy, irregular income, or limited time away from shifts. The administrative burden of making a claim is not merely inconvenient; it functions as a gatekeeping reality that ensures insurance, even when nominally available, often goes unused. For a logistics worker on a rotating schedule or a garment worker paid daily, a policy that requires a half-day of administrative effort to access is often, in practical terms, no policy at all.

These structural limitations and access challenges have not gone unnoticed by policymakers. In February 2026, the Sabka Bima Sabki Raksha (Amendment of Insurance Laws) Act came into force, authorizing up to 100% foreign direct investment (FDI) in Indian insurance companies under the automatic approval route, a historic shift from the previous 74% cap. This reform is aimed explicitly at attracting global capital, technology, and expertise into a sector where non-life insurance penetration, at approximately 1% of GDP, remains well below the global average of 4.2%. Health insurance is the largest segment within non-life insurance, accounting for 41% of collected health premiums.



This reform builds on growing international interest in India's health insurance market while creating new opportunities for foreign insurers to invest more deeply in the sector. In March 2025, Prudential PLC announced a proposed 70:30 joint venture with HCL Group to establish a standalone health-insurance business in India, targeting underserved segments and supporting the government's goal of "Insurance for All by 2047." Following the enactment of the 100% FDI regime in February 2026, international insurers have continued to explore the market: QBE moved to acquire the remaining stake in Raheja QBE General Insurance, while global insurers including Chubb, AXA, Allianz, and Old Mutual have reportedly evaluated opportunities for entry or expansion. As of June 2026, Insurance Regulatory and Development Authority of India (IRDAI) has received three to four formal applications from global insurers seeking either joint ventures or full ownership approvals to establish or expand operations under the new regime.

The significance of this regulatory moment extends beyond capital flows. It signals India's recognition that the government cannot, alone, finance the insurance coverage needed to protect its working population. It likewise signals that the private sector, including global insurers with experience in chronic disease management and digital health delivery, must play a central role in order for access to be improved. MediBuddy, positioned as the largest integrated digital health platform in India with insurer partnerships across the ecosystem, is precisely the kind of infrastructure that makes this private-sector expansion viable.

B. TACKLING THE PROBLEM

MediBuddy's Insurance Architecture: Patient-Centric Navigation and Access Model

To remind our readers, MediBuddy operates across three go-to-market segments: 1) corporate/employer (B2B), 2) direct-to-consumer retail (B2C), and 3) insurance/insurer partnerships (B2B2C). Each strategy serves a distinct role in the patient access ecosystem. It is the insurer segment, and the cashless model that runs through all three, that represent MediBuddy's

most structurally significant contribution to India's health financing challenge.

The cashless model, though straightforward in concept, is transformative in effect. For patients enrolled through employer benefit programs or insurer partnerships, care is delivered at no upfront personal cost: MediBuddy settles claims directly with the corporate or insurance payer, eliminating the payment barrier at the point of service. This is not just a convenience feature. In a country where out-of-pocket expenditure is the primary reason patients delay or forgo care, removing the requirement to pay at the moment of need is a categorical change in access behavior. The impact data confirm this: cashless patients accessing care through MediBuddy's benefit programs spend **46% less out-of-pocket** on healthcare than comparable patients navigating the traditional system, with claims processed **60% faster** and at **51% lower cost per claim** than traditional reimbursement models. These are not merely efficiency metrics, but measures of financial protection for patients who are one serious illness away from debilitating household debt.

MediBuddy's TeleMER service, a digital tele-interview process through which patients provide medical history and risk-related personal information, functions as something more than a clinical intake tool. It is the data infrastructure that links patients to their insurance benefits, enabling rapid benefit activation, risk stratification for insurers, and the kind of longitudinal health monitoring that is essential for NCD management. By digitizing this process, MediBuddy is doing something that matters enormously for the missing middle: converting hard-to-access insurance coverage into activated, functional coverage. A worker enrolled in a group health plan administered through MediBuddy's platform does not need to know which benefits apply to their condition or how to file a claim; the platform manages those functions on their behalf.



As noted, administrative complexity is a well-documented barrier to insurance utilization across LMICs. Patients who lack the health literacy, time, or institutional familiarity to navigate insurer processes, frequently abandon their entitlements. MediBuddy's role as a “patient-side navigator” within the insurance system, means that entitled benefits — consultations, lab tests, and pharmaceutical coverage required for chronic disease — are received.

The Missing Middle and its NCD Burdens

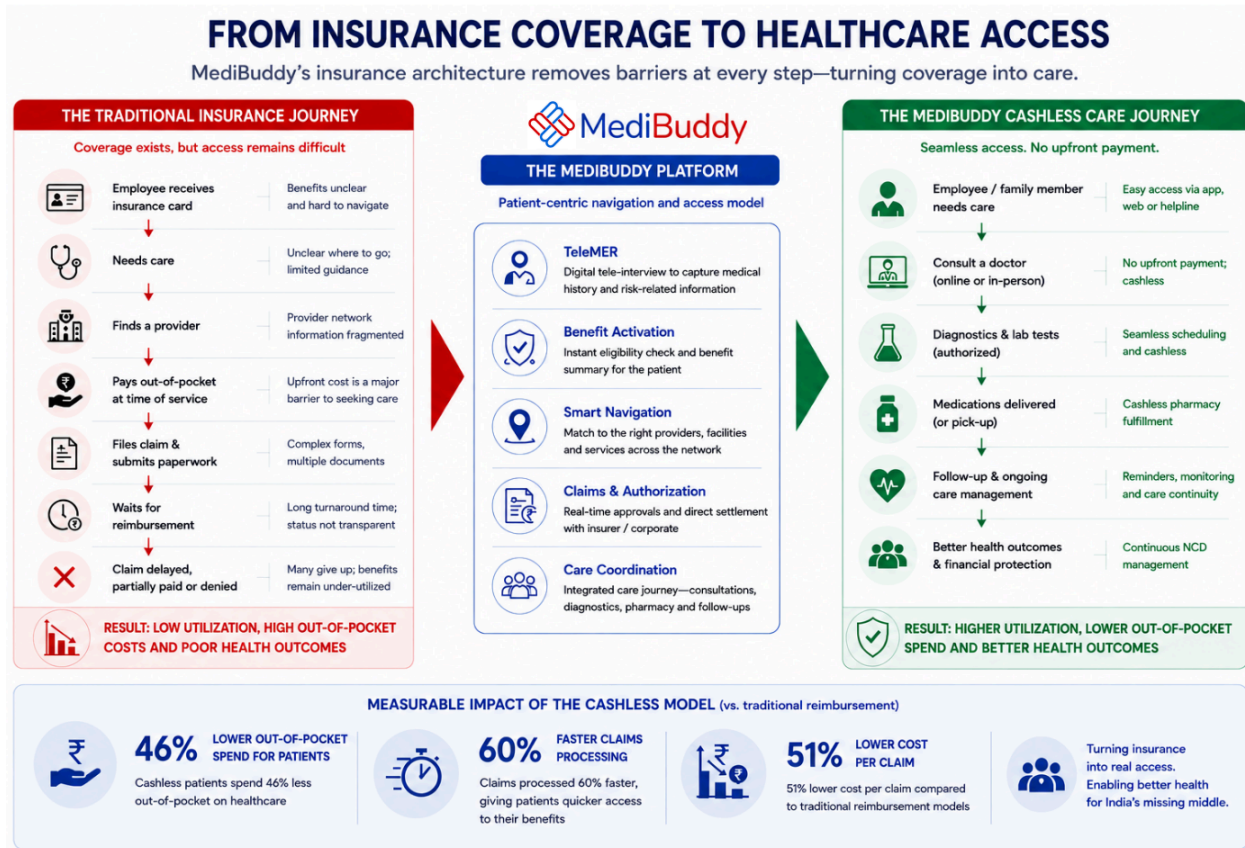
India's organized sector (e.g., manufacturing, logistics, retail, construction, and business services) employs hundreds of millions of workers who occupy precisely the coverage gap described above. These are not the poorest workers; they earn wages above the income thresholds that qualify households for AB-PMJAY and similar government programs. But they are

far from financially secure, and as we discussed in the 2024 MediBuddy impact spotlight, their exposure to NCD risk is substantial. Many work in environments characterized by chemical exposure, extreme temperatures, repetitive strain, noise, and sedentary desk work — conditions that compound the baseline metabolic, cardiovascular, respiratory, oncologic, and other burdens that India's NCD epidemic is producing across the population.

Estimating precisely how many Indians are covered by meaningful private health insurance is difficult, given the fragmentation of the market and the absence of consistent national data. What the available evidence does show is sobering: private voluntary health insurance reaches approximately 9% of the population, and employer-sponsored group plans, largely concentrated in the organized formal sector, cover a similarly small share. More importantly, coverage on paper does not translate to protection in practice. Standard group health insurance policies in India are structured around inpatient hospitalization, and typically exclude outpatient consultations, diagnostic tests, and ongoing medications — precisely the services that working-age NCD patients need most. A patient managing hypertension and diabetes may hold an employer insurance card and still pay entirely out-of-pocket for every physician visit, every HbA1c test, and every monthly prescription refill. The Insurance Regulatory and Development Authority of India (“IRDAI”) has itself publicly acknowledged this structural gap, calling on insurers to expand beyond hospitalization coverage to include outpatient and chronic disease management — a gap that, until closed, ensures that even the nominally insured remain financially exposed to the ongoing costs of serious illness.

MediBuddy's FY2025 patient data bring this NCD burden into sharp focus. Among the nearly 1.2 million unique patients served during the year, the leading diagnostic categories, general medicine, dermatology, gastroenterology, gynecology, cardiovascular conditions, and diabetes, are precisely what is expected from a working-age population managing the compounding effects of occupational exposure and insufficient preventive care. Most of these diseases, if caught early in the illness, become manageable conditions. Left unmonitored and untreated in a population

without meaningful access to regular outpatient care, they tend to become more complex, more costly for health systems, and more catastrophic for households.



For most of these workers, MediBuddy's employer-sponsored benefit is the primary, and sometimes the only, reliable source of medical access they have ever had. The employer-insurer bridge that MediBuddy enables is particularly significant for the NCD management use case, where the value of care lies almost entirely in its regularity. A hypertensive patient who consults a physician once during hospitalization, but has no mechanism for ongoing monitoring, is barely better off than one who receives no care at all.

We believe that as India's insurance market deepens, and as the FDI liberalization of 2026 draws global insurers into the market with more sophisticated chronic disease management products, the employer-insurer corridor that MediBuddy has built will become increasingly important as a

delivery channel. The missing middle is not static; it is a growing population, and one that a maturing insurance ecosystem must learn to serve if India is to address its insurance gaps and manage its ever-increasing NCD burden.

LOOKING TO THE FUTURE

MediBuddy's Role as India's Insurance Delivery Infrastructure

India's government has articulated an ambitious goal: "Insurance for All by 2047," the centenary of its independence. Meeting that goal will require not just expanded enrollment but expanded access, increasing the number of patients who can receive, afford, and use insurance consistently. MediBuddy's integrated model of consultations, diagnostics, pharmacy, and claims support on a single cashless platform is increasingly capable of becoming the private-sector delivery infrastructure for that vision. The insurer segment's growth trajectory signals that India's insurance market is beginning to recognize this: as outpatient benefits become standard in product design and as digital-first health insurance products gain traction among younger and semi-urban consumers, the platform's value as an insurance delivery channel will only deepen.

The Informal Sector and Geographic Reach: The Next Frontier

The population MediBuddy currently serves, predominantly formal-sector, urban and peri-urban workers in employer-sponsored benefit programs, is, by any measure, underserved relative to the care it needs. But it is not the most underserved. India's informal manufacturing sector, estimated to represent 70-80% of total manufacturing employment, is estimated to be ≈44% female, and concentrated in garment, tobacco, and electronics industries. This population faces all the same occupational exposures and NCD risks as formal-sector workers, with virtually none of the protections. Beyond the manufacturing context, geographic reach is itself a critical dimension of access: the average rural Indian travels over 40 kilometers for inpatient care, and only 15% of rural residents have a health facility of any kind within 5 kilometers of their home. Specialist availability is even more constrained — rural Community Health Centers, which serve populations of

approximately 160,000 people, operate with a nearly 80% specialist vacancy rate nationally, leaving the majority of rural India functionally without access to secondary care. MediBuddy's digitally delivered consultations — conducted via video or chat, lab samples collected at home, and medications delivered to the door — are structurally suited to serve patients regardless of their location.

The pathways MediBuddy has built in the formal sector are also directly applicable to informal-sector workers and rural populations if suitable payer structures can be mobilized: government insurance programs, NGO partnerships, or microinsurance products. This represents both the most important opportunity for MediBuddy's future impact and the most significant challenge remaining in its mission.

Spotlight References

1. Agarwal S, et al. "Miles to go before I seek": distance to the health facility and health care use among older adults in India. *Lancet Regional Health — Southeast Asia*. 2025;37:100579. doi:10.1016/j.lansea.2025.100579
2. Bhattacharya D, et al. Growth of unorganised manufacturing in India: implications for women workers. *Review of Agrarian Studies*. 2025. https://ras.org.in/index.php?Article=growth_of_unorganised_manufacturing_in_india
3. Binnendijk E, Koren R, Dror DM. Quantifying the financial burden of households' out-of-pocket payments on medicines in India. *BMJ Open*. 2018. PMC5988077.
4. Data for India. Women in manufacturing. [dataforindia.com](https://www.dataforindia.com/women-in-manufacturing/); 2025. <https://www.dataforindia.com/women-in-manufacturing/>
5. Garg S, Bebartha KK, Tripathi N. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana after four years of implementation — is it making an impact on quality of inpatient care and financial protection in India? *BMC Health Services Research*. 2024;24(1):919. doi:10.1186/s12913-024-11393-2. PMID: 39135015; PMCID: PMC11321205.
6. Ghani E, Kerr WR, Segura A. Rise of informality in India's tradable manufacturing sector. *Ideas for India / VoxEU*. 2015. <https://www.ideasforindia.in/topics/macroeconomics/rise-of-informality-in-indias-tradable-manufacturing-sector>
7. Government of India. Ayushman Bharat PM-JAY enrollment figures, March 2025. <https://pmjay.gov.in> (accessed April 2026).
8. India Briefing. India's insurance sector now open to 100% FDI. February 19, 2026. <https://www.india-briefing.com/news/india-insurance-100-percent-foreign-investment-42439.html/> (accessed April 2026).
9. Indian Council of Medical Research, Public Health Foundation of India, and Institute for Health Metrics and Evaluation. *India: Health of the Nation's States — The India State-Level Disease Burden Initiative*. New Delhi: ICMR; 2017.
10. Insurance Regulatory and Development Authority of India (IRDAI). Master Circular on Health Insurance Products. IRDAI; May 2024. <https://irdai.gov.in/health-dept>
11. International Institute for Population Sciences (IIPS). *National Family Health Survey (NFHS-5) 2019–21: India Report*. Mumbai: IIPS; 2022.
12. Kulothungan V, et al. Assessing progress of India in reduction of premature mortality due to four noncommunicable diseases. *Sustainable Development*. 2024. doi:10.1002/sd.2761.
13. Kumar A, Sarwal R. Health Insurance for India's Missing Middle. NITI Aayog; 2021. DOI: 10.31219/osf.io/s2x8r. Available from: https://www.niti.gov.in/sites/default/files/2021-10/HealthInsuranceforIndiasMissingMiddle_28-10-2021.pdf
14. Mahal A, Panwar V, Tiwari A, Reddy R, Kane S. The "missing middle": how to provide 300–350 million Indians with health coverage? *Health Policy and Planning*. 2024. doi:10.1177/00252921241284190
15. MediBuddy & Confederation of Indian Industry (CII). *Workplace Health Reimagined: Corporate India's Readiness for Digital Health Leadership*. 2025.
16. Ministry of Health and Family Welfare, Government of India. *Health Dynamics of India (Infrastructure and Human Resources) 2022–23*. New Delhi: MoHFW; 2024.
17. Ministry of Health and Family Welfare, Government of India. *National Health Accounts Estimates for India 2019–20*. New Delhi: National Health Systems Resource Centre; 2023.

18. Ministry of Health and Family Welfare, Government of India. National Health Accounts Estimates for India 2022–23. New Delhi: National Health Accounts Technical Secretariat; 2025. Available at: mohfw.gov.in
19. Mohanty SK, Iyengar SD, Mundu A, et al. Components of out-of-pocket expenditure and their relative contribution to economic burden of diseases in India. JAMA Network Open. 2022;5(5):e2210. PMC9107026.
20. National Health Authority, Government of India. Update on Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY). Press Information Bureau; November 2024. <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2086513>
21. NITI Aayog. Health Insurance for India's Missing Middle. New Delhi: NITI Aayog, Government of India; 2021. https://www.niti.gov.in/sites/default/files/2021-10/HealthInsurance_report_concept_1.pdf
22. Paidi G, Beesetty A, Lahmar A, Kop L, Sandhu R. Need of the hour: family medicine in India. Cureus. 2022;14(4):e24596. doi:10.7759/cureus.24596. PMID: 35651442; PMCID: PMC9138803.
23. Prudential plc. Prudential plc (UK) announces joint venture with HCL Group for health insurance in India. Press release; March 20, 2025. <https://www.prudentialplc.com/en/newsroom/company-news/2025/prudential-plc-uk-announces-joint-venture-with-hcl-group-for-health-insurance-in-india/> (accessed April 2026).
24. Rao M, et al. Human resources for health in India. Lancet. 2011;377(9765):587–598.
25. Singh SP, Khokhar A. Health insurance coverage and its associated factors amongst households of an urban village in Delhi. Journal of Family Medicine and Primary Care. 2025;14(6):2520–2526. doi:10.4103/jfmpc.jfmpc_1099_23. PMID: 40726699; PMCID: PMC12296281.
26. Sriram S, Albadrani M. Impoverishing effects of out-of-pocket healthcare expenditures in India. Journal of Family Medicine and Primary Care. 2022;11(11):7120–7128. doi:10.4103/jfmpc.jfmpc_590_22. PMID: 36993034; PMCID: PMC10041239.
27. Thakur JS, et al. Burden of noncommunicable diseases and implementation challenges of National NCD Programmes in India. Cardiovascular Endocrinology & Metabolism. 2020. doi:10.1097/XCE.0000000000000208.
28. WHO NCD Data Portal. India country profile. Geneva: World Health Organization; 2023. <https://ncdportal.who.int>