



RAKSHA
SUMMIT
2025

REBUILDING TRUST

Combating Fraud, Waste, and Abuse in
India's Health Insurance Ecosystem

November 2025



Foreword

India's health insurance ecosystem stands at the cross-roads of extraordinary promise and pressing responsibility. The sector's rapid transformation—fueled by digital innovation, expanded coverage, and public-private collaboration—has laid the foundation for equitable access to care. Yet, as the system scales, the silent and systemic challenge of fraud, waste, and abuse (FWA) threatens to erode the very trust and financial resilience it seeks to build. This report, **"Rebuilding Trust - Combating Fraud, Waste, and Abuse in India's Health Insurance Ecosystem"**, is a call to action for leaders across insurers (including TPAs acting on their behalf), providers, corporates and government / regulator to collectively safeguard the integrity of India's healthcare promise.

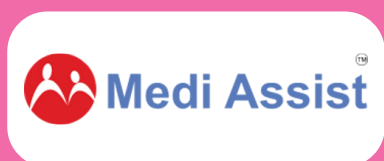
The findings in this report go beyond diagnosis—they outline a national roadmap for integrity. Anchored in data, technology, and shared accountability, the framework proposed advocates for a transition from reactive oversight to proactive prevention. It urges us to see connected care, interoperability, and generative AI not as distant innovations, but as present tools to build transparency and efficiency at scale. By embedding trust, standardization, and deterrence into the fabric of our health-financing system, India can set a global benchmark for equitable and sustainable healthcare / health insurance governance.

Ultimately, this is not merely about curbing inefficiency—it is about restoring faith, about rebuilding trust. Every rupee saved from fraud strengthens the nation's capacity to extend protection to another family; every act of accountability brings us closer to the vision of **"Insurance for All by 2047"**. The journey from suspicion to solution begins with collective intent and coordinated action. This report serves as both a blueprint and a beacon—reminding us that integrity is not a compliance obligation, but the cornerstone of a resilient and inclusive healthcare future.



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Chapter 1

Indian Health Insurance - A Journey of Transformation and Growth

The Indian healthcare ecosystem stands at a defining juncture. It is at the cusp of a major transformation, with the last decade marked by rapid digitization, improvements in quality of care, rising insurance penetration and coverage, expansion of provider networks, strengthened government initiatives, and growing public-private partnerships. Together, these developments are shaping the foundation of a more resilient healthcare system. The path ahead presents further opportunities, supported by sustained policy momentum, technological progress, continued investment in health infrastructure, and the expanding scope of insurance coverage.

A key driver of this momentum is the Government's [Viksit Bharat 2047](#) vision. It seeks to transform healthcare by removing barriers to access and affordability through its goal of [Insurance for All by 2047](#). The agenda aims to make world-class healthcare attainable by expanding government schemes such as [Ayushman Bharat](#), which now covers 58 crore citizens¹, accounting for almost 40% of the Indian population. It also focuses on increasing private insurance penetration and strengthening preventive and primary care through a wider network of Health and Wellness Centers. In parallel, the government is accelerating the adoption of digital health platforms such as ABHA² and ABDM³ (with over 74 crore⁴ ABHA IDs issued as of earl 2025). Together with reforms like GST 2.0, which enhances affordability, these initiatives aim to close the insurance coverage

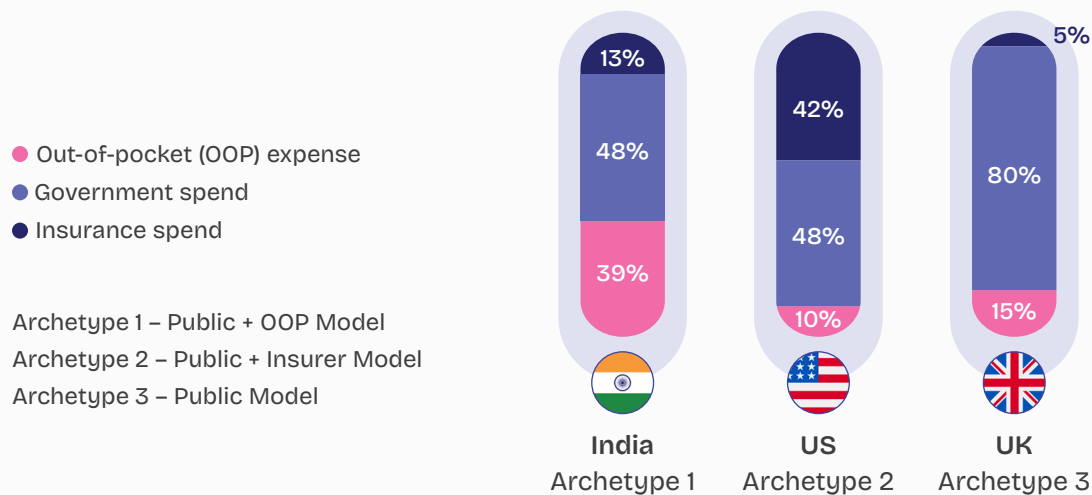
gap, reduce out-of-pocket spending, and build a resilient, inclusive, and future-ready healthcare system for all Indians. Powered by Viksit Bharat initiatives, Indian healthcare is growing rapidly with total spending nearing ₹9 lakh crore⁵. The industry is evolving beyond urban hospitals into a nationwide network of care.

Globally, three broad archetypes define healthcare systems: UK represents a public-dominated model, where government funding underpins universal access and out-of-pocket (OOP) costs remain modest at around 15% of total healthcare spending. The United States, with its mature insurance-plus-public model, relies heavily on insurance coverage, which contributes over 40% of total health expenditure, while OOP costs are contained to about 10%, supported by both private insurers and federal programs such as Medicare and Medicaid. India, by contrast, still reflects a public-plus-OOP model, where limited insurance penetration leaves households bearing a greater financial burden. Today, government spending accounts for about 48% of total health expenditure, OOP spending stands at 39%, and insurance contributes approximately 13%, a share that continues to rise.

This evolving landscape underscores India's opportunity to strengthen financial protection and risk pooling through deeper insurance penetration and sustained public investment, as illustrated in the exhibit 1.

1. Ministry of Health and Family Welfare Press Release on July 28, 2025; 2. Ayushman Bharat Health Account; 3. Ayushman Bharat Digital Mission; 4. Ministry of Health and Family Welfare Press Release on February 10, 2025; 5. As per latest NHA estimates (FY21-22)

EXHIBIT 1: Healthcare Spending Pattern Across India, US and UK



Source: WHO, NHA, OECD
 Note: Percentage splits are for FY22'

As India's healthcare spending accelerates, the share financed through health insurance—currently about 13%—is expected to rise further, positioning insurance as a critical enabler of access and affordability. This would be driven by the proliferation of both public and private coverage models. Measured by Gross Written Premium (GWP), the health insurance industry has grown to ₹1.27 lakh crore⁶ as of 2025, reflecting an annualized growth rate of around 17% over the past 5 years. The next 5 years continue to be promising with the industry continuing its growth momentum by growing at a similar 16–18% ballpark, reaching approximately ₹2.6–3 lakh crore⁷ by 2030 as shown in the exhibit 2.

Future market-shaping developments such as composite licenses and health VAS will be strong enablers of this sustained growth, leading to augmented coverage and redefined services offered by insurers. This is bound to create significant opportunities for all players across the value chain. It is important to note, the growing dominance of private insurers in Indian healthcare insurance; from an almost equal split in 2020 to a current split of 36% PSU insurers v/s. 64% private insurers. However, the split between retail insurance v/s. group insurance v/s. government insurance schemes has been stable for the past 5 years and is expected to continue to be in a similar range.

6. IRDAI Data; 7. BCG Analysis;

EXHIBIT 2: India Health Insurance Market (FY20-FY30E)



Source: IRDAI, BCG Analysis

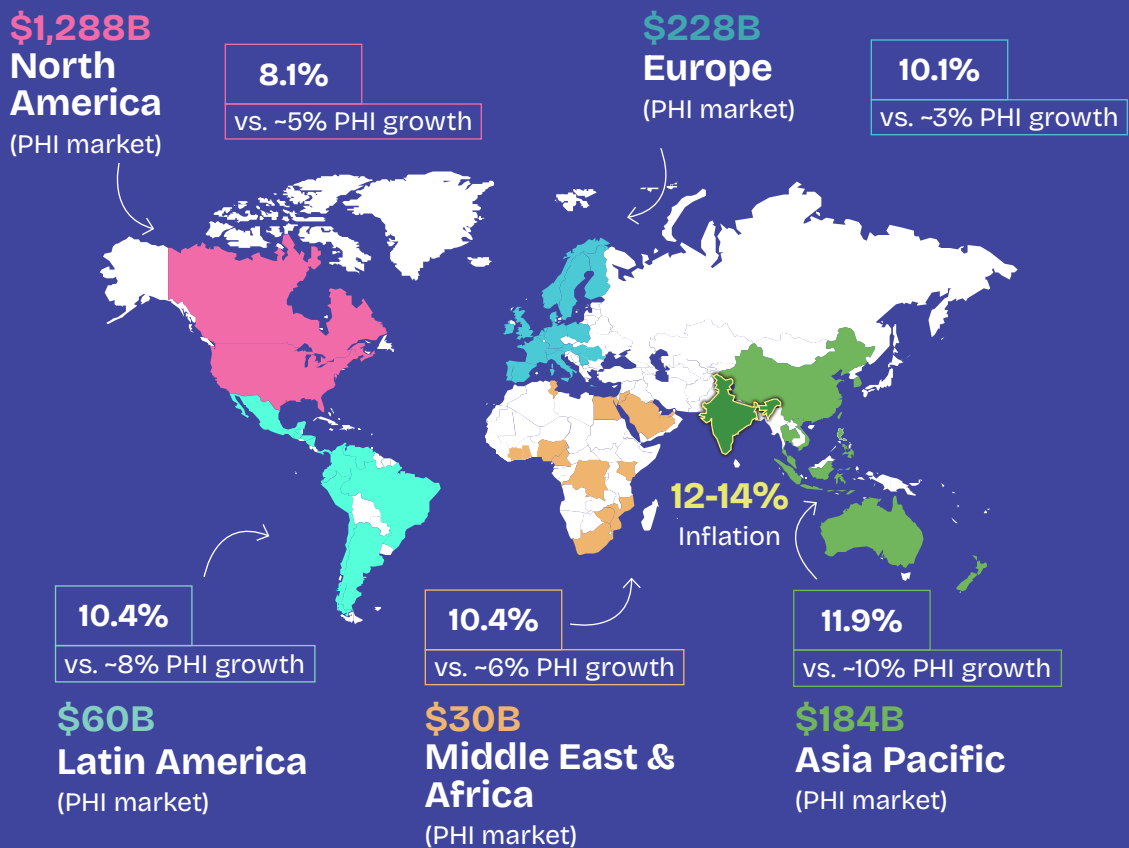
Health insurance penetration has steadily improved, with more than 60 crore⁸ people now estimated to hold a health insurance policy (with 29 crore people covered under government schemes, approximately 26 crore under group insurance and balance around 5 crore under the retail insurance), a notable rise from less than 50 crore, 5 years ago. Sustaining this momentum is essential, as the landscape remains underpenetrated relative to India's population size and healthcare burden.

While the augmented penetration and industry growth is encouraging, it also brings to light rising claim complexity and systemic inefficiencies

that can threaten sustainability. Globally, medical inflation has been accelerating sharply, with overall healthcare costs rising by around 10% in 2024, compared to an average of ~8% over the past decade. The Asia Pacific region, home to some of the world's fastest-growing healthcare markets, is witnessing the steepest increase at nearly 12%, as illustrated in the exhibit below, driven by expanding demand, higher treatment costs, and growing private health insurance utilization. India reflects this broader regional trend—its healthcare inflation has averaged around 12-14%⁹ year-on-year over the past five years, far outpacing the country's general inflation rate of ~5%¹⁰.

8. IRDAI Data 9. Medi Assist CEO comments on CNBC TV18 article published on May 28, 2025; 10. India CPI Data (2013-25)

EXHIBIT 3: Surge in Global Medical Spendings Globally



Note: Global, Latin America and Europe numbers for 2024 exclude Argentina, Venezuela and Turkey; Color coding indicative based on countries of Willis Tower Watsons 2024 Global Medical Trends Survey report
Source: Willis Tower Watsons Global Medical Trends Survey reports 2016, 2019, 2021, 2024 and 2025
PHI – Private Health Insurance

This sustained cost escalation in the Indian healthcare space has translated into a 40% increase in Average Claim Size (ACS) over the same period, reaching approximately ₹32,000¹¹ in FY2024. These dynamics indicate an increased flow of insurance payouts, posing a challenge to the long-term financial sustainability and resilience of insurers. To make growth sustainable, keep premiums under control, and increase penetration in smaller towns, it is imperative for insurers to ensure efficiency in claims payout. However, the sector's ability to sustain this growth depends on addressing key inefficiencies, chief among them, Fraud, Waste, and Abuse (FWA)—that quietly erode financial resilience. Fraudulent claims directly impact claims frequency, eventually increasing the number of undesirable claims getting paid. Waste and Abuse, in turn, have a direct correlation

with claims severity or the ACS. Last year's Raksha Summit Report on 'Borderless Health' also highlighted that identifying and eliminating inefficiencies in claims processing, which manifest as higher levels of FWA, is critical to achieve the Viksit Bharat 2047 mission of 'Insurance for All'.

This year's report focus is on structurally addressing FWA, that is critical to unlocking the full value of the initiatives under the government charter, driving insurance penetration through growth in untapped segments and improving the quality of healthcare across the country. We will establish the prevalence of FWA in insurance across the country, explore its root causes and outline how we can structurally address its drivers within the Indian healthcare space.

11. IRDAI Data

Chapter 2

The Growing Threat of Fraud, Waste and Abuse in Indian Health Insurance

FWA together represent one of the most persistent and costly challenges faced by health insurance systems worldwide. While each stems from

different behaviors, their combined effect erodes financial sustainability, inflates premiums, and undermines trust across the value chain.

2.1 Understanding Fraud, Waste and Abuse

Fraud refers to intentional deception or misrepresentation for financial gain, for instance, when a hospital submits claims for procedures that were never performed. Waste arises from inefficiencies or avoidable costs, such as delayed discharges caused by the unavailability of doctors over the weekend. Abuse, though not always fraudulent, involves practices inconsistent with accepted business or clinical standards, for example, overcharging for routine services or billing for a higher category of room than what was provided.

Beyond intentional fraud, waste from preventable spending and abuse via non-compliant policy or clinical practices, further exacerbate the issue. They may not always involve intent to deceive, they distort healthcare utilization patterns and inflate costs, creating persistent financial leakage

across India's health ecosystem. Together, these practices represent the underlying inefficiencies and unethical practices that distort true healthcare utilization, drain insurer resources, and compromise the affordability and credibility of the insurance ecosystem.

Comprehensive data on Waste and Abuse remains limited due to the absence of standardized measurement frameworks. On the other hand, Fraud-related data provides a clearer and more quantifiable lens into the broader problem of FWA. Examining patterns within fraudulent activity allows us to infer the systemic vulnerabilities that also enable Waste and Abuse.

Refer to the exhibit for illustrations of FWA across the health insurance ecosystem, along with the key actors involved in each.

EXHIBIT 4: Real-world Scenarios Demonstrating The Specific Behaviors and Process Gaps that Contribute to Systemic Leakage

	Fraud	Waste	Abuse
	The Weekend Admission	The Waiting Game	Routine Check, Runway Bill
Case involving FWA	A healthy person checks into a hospital for a three-day stay, racks up bills for tests and monitoring that never happen, then splits the insurance payout with the obliging doctor	A man declared fit to leave is still on the hospital bed waiting for a discharge slip that is waiting for an insurer's nod , lost in email inbox at the insurer, while there is a new patient waiting for a bed	A patient suffering a routine cough is led to numerous scans, blood and vitamin tests instructed by the clinic which were never needed. The insurer foots a bill three times higher for health, but for habit
Actors involved	 Patient, Provider, Doctor	 Insurer, Provider	 Provider, Doctor

The exhibit 5 further presents case examples depicting FWA in health insurance practices. Each example is designed to make the distinctions between FWA clear and relatable to real-world contexts.

EXHIBIT 5: Real-world Instances of Fraud, Waste and Abuse in The Health Insurance Sector



Fraud

Ravi, a long-time smoker with high blood pressure, applies for a new health policy. When asked if he uses tobacco or has ever been treated for hypertension, he ticks "No" for both. **By hiding the truth, he gets a lower premium than he should have**



Waste

After being treated for heart failure, Rajesh is discharged without a clear follow-up schedule or medication review. Within a few days, his symptoms worsen, and he is readmitted to the hospital. **Timely follow-up and coordinated discharge planning could have avoided the repeat admission and unnecessary cost**



Abuse

A gallbladder surgery covered under a fixed package of ₹45,000 is billed as separate charges, operating room, anesthesia, consumables, and recovery bed adding up to ₹80,000. **The operation was real, but the billing was stretched beyond what's fair**

When Arun needs urgent medical care but has no insurance, he borrows his brother's ID card and pretends to be him. **The hospital processes the claim in his brother's name, and the insurer unknowingly pays for someone else's treatment**

Meena recovers well from her infection and is ready to go home on Saturday. But with no senior doctors available for discharge rounds, she stays till Monday. **Nothing changes medically except a higher bill for the same bed**

After a small ligament strain, a patient is booked for daily physiotherapy for several weeks. The therapist's notes hardly change, and the patient has recovered long before the sessions end. **The treatments continue mainly to exhaust the policy limit**

A fraudster rents a small mailbox in a commercial complex and sets up a fake company called City Wellness Center. **Using stolen doctor and patient IDs, they start billing insurers for fake treatments worth lakhs**

Ramesh repeats his blood tests just two days after getting them done elsewhere, because the new hospital cannot access his earlier reports. **He pays twice for the same results, and his treatment stays the same**

At a diagnostic clinic, even a mild headache earns a full CT scan and a panel of blood tests. **Most results are normal, and the doctor still prescribes only paracetamol and rest, yet the insurer foots an inflated bill**

A district hospital submits a claim for a hernia operation using a PM-JAY e-card. Weeks later, the insurer discovers that the supposed patient had passed away months before. **The admission papers and discharge summary were fabricated to claim payment**

Saira's follow-up appointment after surgery is missed because her discharge summary didn't include clear post-operative instructions. A minor infection worsens, requiring a short readmission. **This avoidable relapse adds extra room, medication, and investigation charges to the claim**

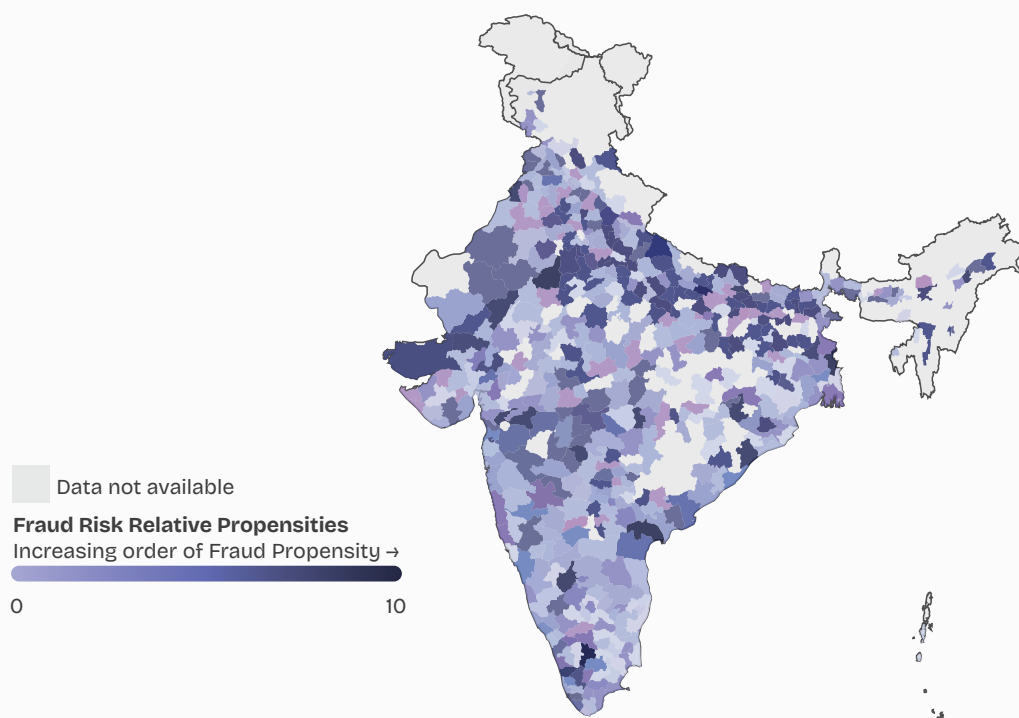
For a simple, uncomplicated delivery, the hospital adds extra charges for cardiology, gastroenterology, and dietician consultations that weren't really needed. All the paperwork looks correct, **so the insurer pays its legitimate care, just overdone**

2.2 Assessing Fraud Risk Propensity: Scale and Hotspots

In health insurance, **fraud risk propensity** denotes the relative likelihood of fraudulent or abusive claims within a given region or segment, derived from historical claims data, treatment patterns, and ecosystem behaviors. The higher the fraud propensity, greater is the probability of fraud. It reflects the probability that claims may involve misrepresentation, non-disclosure, or other forms of fraud, helping insurers identify clusters or regions where systemic vulnerabilities are higher. Fraud risk propensities used in this report are relative within a segment (e.g., within cashless-reimbursement; or within care settings: IPD-OPD) and are intended for comparison only within the same segment.

To take effective measures to curb fraud, we must first understand its scale. India's health insurance sector is expanding rapidly. However, this expansion also heightens exposure to fraud risk as a larger and more interconnected system inherently amplifies both opportunity and risk. Our analysis of fraud propensity across India indicates that fraud has become ubiquitous across the ecosystem. There is no single concentrated hotspot but a pattern of repeatable clusters with areas exhibiting both high and low provider density that are geographically dispersed. In short, fraud prevails across the country, albeit with varying intensity and it continues to grow.

EXHIBIT 6: Geographic Distribution of Health Insurance Fraud Risk Propensity in India

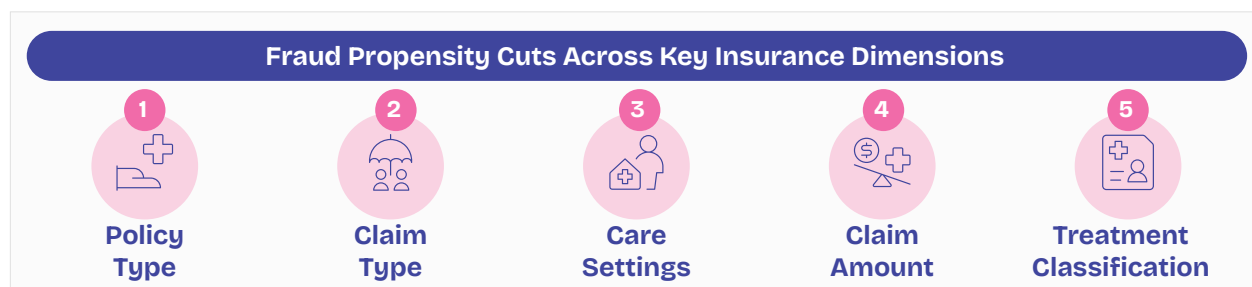


Source: Medi Assist Data

2.3 Fraud Propensity Across Key Insurance Dimensions

A data-driven view of fraud across key insurance dimensions helps pinpoint where leakages occur and uncover the root causes behind inefficiencies.

Below are some illustrative cuts that show how FWA propensity differs across key drivers and segments:

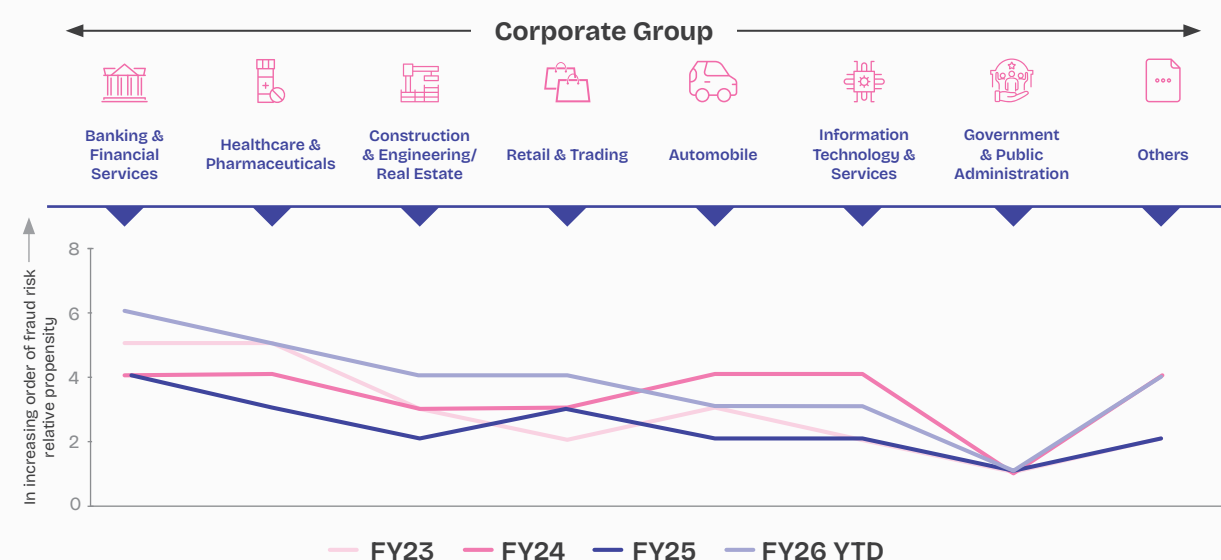


1 Policy Type

Retail health insurance refers to individual or family policy purchased directly from insurer while Group health insurance is predominately an employer-sponsored coverage for employees. In India, approximately 256 million lives are covered under Group insurance, whereas only 56 million lives are covered under Retail insurance¹. Majority group policies cover diseases from day-1, thereby leaving no room for concealment of pre-existing conditions to secure coverage, avoid higher premiums, or bypass waiting periods. In addition, there is differential severity of consequences. Fraudulent behavior in group health insurance can entail significant professional and reputational risks, while in retail policies, the perceived risk remains minimal, often limited to the cancellation of a claim or policy. Thus, **retail health portfolios consistently exhibit higher fraud propensity over group health portfolios.**

In recent years, group health portfolios have also begun to see rising instances of irregularities, indicating that fraud risks are evolving with market dynamics. A deeper cut of group policies by employer-industry segment reveals fraud risk being consistently higher in the banking and financial services as well as the healthcare industry over the past 5 years. Fraud in group insurance can also be characterized by behavioral factors, where coworkers, emboldened by colleagues, engage in similar behavior. For example, once an inflated OPD reimbursement passes without scrutiny, others in the same team begin submitting similar bills, normalizing the practice across the group. This is commonly termed “social fraud”.

EXHIBIT 7: Fraud Risk Relative Propensities for Employer - Industries Across the Years



Note: Scale represents indexed, relative fraud risks within that segment — for example, in FY25, claims from employees in the Banking and Financial Services sector carried nearly 4x the fraud risk of those from Government and Public Administration employees.
Source: Medi Assist Data

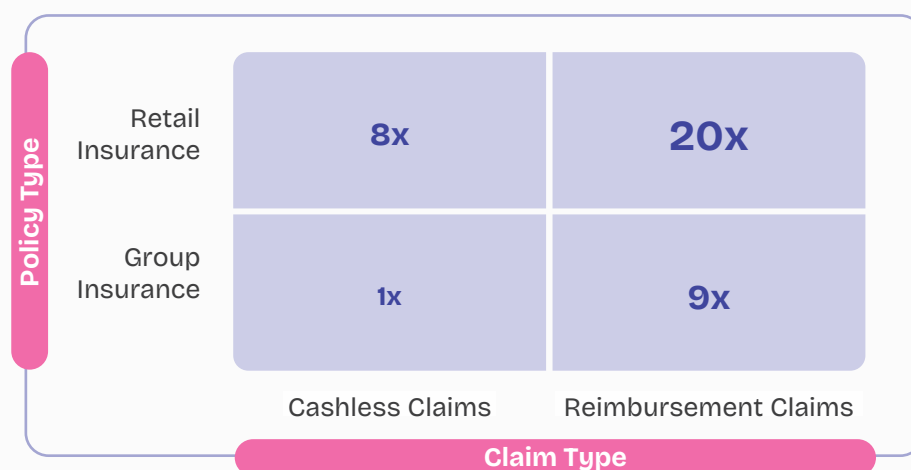
2 Claim Type

Reimbursement claims involve a post-treatment settlement process, where policyholders initially bear the medical expenses and subsequently get them reimbursed by the insurer post document submission and retrospective evaluation. Cashless claims, conversely, operate on a direct-settlement model, enabling policyholders to access treatment at network hospitals without out-of-pocket payment (other than those excluded by the cover), as insurers directly disburse payments to healthcare providers based on pre-approved eligibility and policy terms. Consumption is moving towards more cashless claims over reimbursements. The proportion of cashless to reimbursement claims has shifted from approximately 60:40² in FY23 to around 65:35 at present.

A deeper analysis of fraud risk propensities by claim type shows that **reimbursement claims**

have higher fraud risks compared to cashless claims. This disparity stems from the absence of hospital involvement in the transaction process, with funds flowing directly to the member and supporting documentation typically being compiled retrospectively, increasing opportunities for manipulation. Conversely, cashless claims tend to exhibit lower fraud propensity, as the due diligence undertaken by insurers during the empanelment of network hospitals establishes an additional layer of scrutiny and reduces the likelihood of fraudulent activity. 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.

EXHIBIT 8: Comparison of Fraud Risk Propensities by Policy and Claim Type



Source: Medi Assist Data

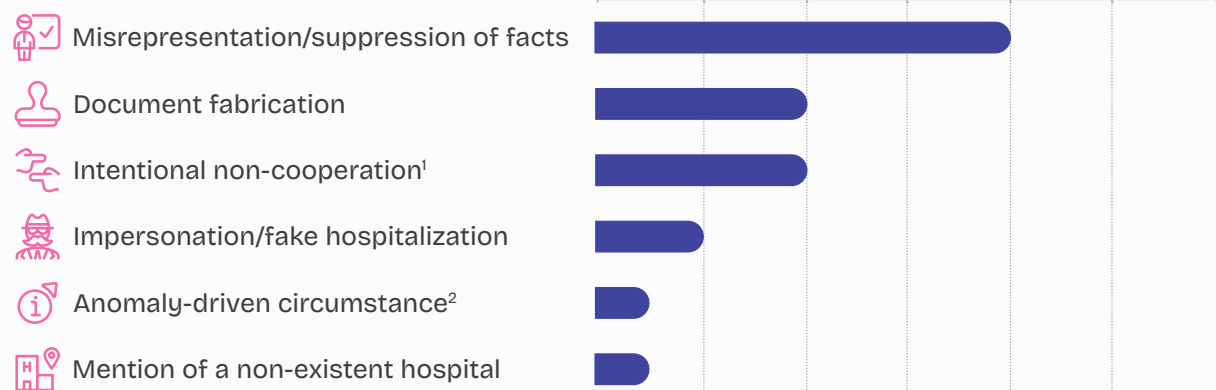
3 Care Settings (IPD v/s. OPD)

Across care settings, fraud persists in both IPD and OPD, though with distinct patterns. In IPD, fraud is typically larger, primarily due to higher claim size, and more structured ranging from upcoding or fabricated hospitalization. These cases often pose patient safety risks and attract higher regulatory scrutiny. In contrast, OPD frauds tend to be dispersed and repetitive, driven by small, frequent claims for routine doctor visits, lab tests, or pharmacy expenses. These typically involve fake bills, duplicate submissions or inflated

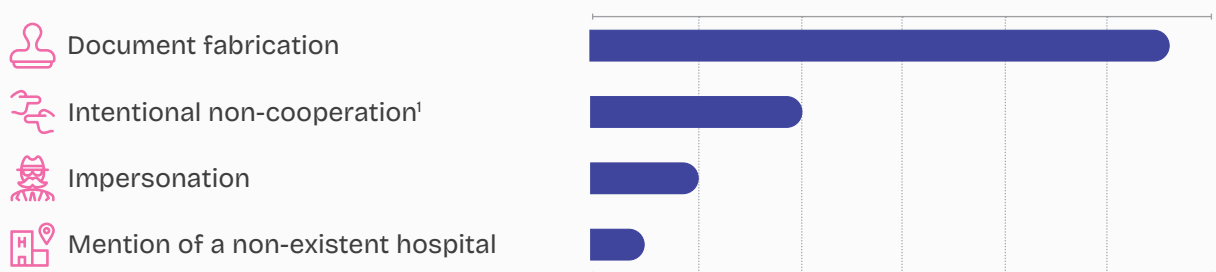
receipts. The reimbursement-driven nature of low value OPD claims makes verification particularly challenging. However, cashless OPD models have demonstrated significantly lower instances of fraud, enabled by real-time verification and digital traceability. The model is still picking up but shows strong potential for wider adoption. Despite these positive developments, **misrepresentation of facts and fabrication of claim documents continue to present the highest fraud risk across both IPD and OPD claims.**

EXHIBIT 9: Fraud Risk Relative Propensities Across Scenarios in Each of the Care Setting

A. Scenarios in IPD Claims



B. Scenarios in OPD Claims



¹Intentional non-cooperation by patient or hospital or both;

Eg: An insurer's investigation unit flags INR 500,000 claim for a patient's two-week hospital stay. When the investigator calls the patient to verify the dates and services, the patient repeatedly hangs up or claims no recollection of medical details. Simultaneously, the hospital's records' department refuses to provide the medical charts, claiming they are lost.

²Circumstantial evidence that suggests fraud incidence;

Eg: An insurer's data system flags a dentist who is suddenly billing for an unusually high number of complex surgical extractions. A review shows that the dentist billed for 40 surgical extractions on a Saturday alone, a number that is physically impossible to perform in one day. While there's no single fabricated bill, the circumstances strongly suggest fraud.

Note: Scale represents indexed, relative fraud risks within that segment — for example, in OPD claims, document fabrication accounted for nearly 6x more fraudulent cases than the mention of non-existent hospitals.

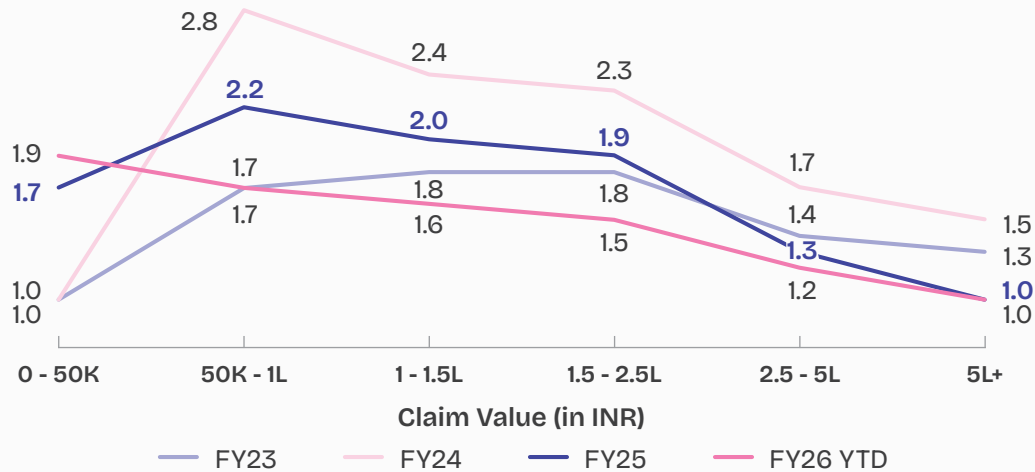
Source: Medi Assist Data

4 Claim Amount

Claim analytics reveal that **fraud risk is most concentrated in the mid-ticket claim segment, typically between claim value ₹50k and ₹2.5 lakh**, where the financial incentive is high enough to justify manipulation, yet the oversight intensity remains moderate. This is also the range where most standardized tariffs for common procedures typically fall, creating fertile ground for inflation or code manipulation without raising red flags. Claims below ₹50k generally involve lower financial stakes and simpler approvals, while those exceeding ₹2.5 lakh undergo rigorous pre-authorization and audit scrutiny, thus the fraud risk in these segments

is lower. Additionally, certain insurers have also focused their fraud mitigation efforts on high-value claims, inadvertently nudging fraudulent actors to shift their activities toward lower-ticket categories. Interestingly, the ₹0–50k segment also shows moderate fraud propensity, primarily due to minimal documentation checks, low scrutiny, and infrequent audits, making it easier to inflate consumables, charge for minor non-rendered services, or submit repetitive low-value claims. Notably, fraud risk within this category has shown an increasing trend over the past three years, indicating growing exploitation of low-value claim segments.

EXHIBIT 10: Fraud Risk Relative Propensities Basis Claim Values Across The Years



Source: Medi Assist Data

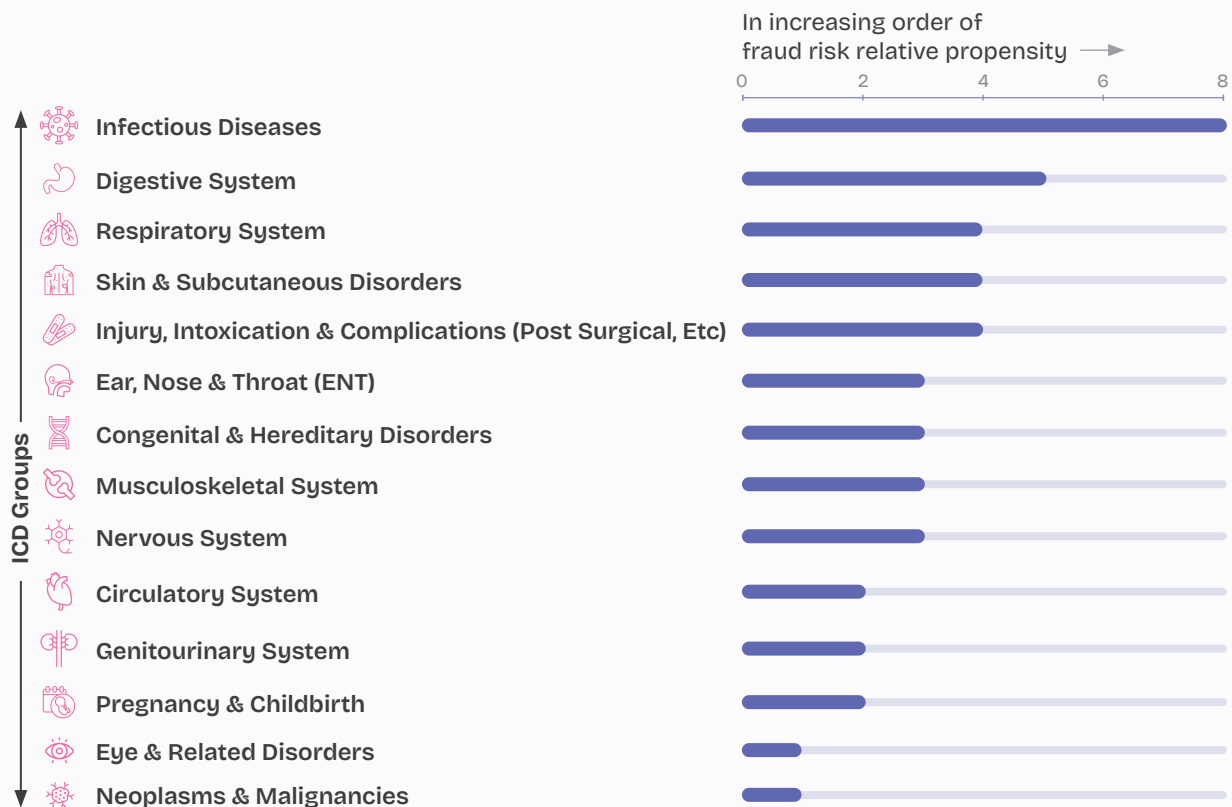
Note: Scale represents indexed, relative fraud risks within that segment — for example, in FY25, claims valued between ₹1-1.5 lakh carried nearly 2× the fraud risk of claims above ₹5 lakh.

5 Treatment Classification

Our analysis highlights that fraud propensity is not uniform across medical categories, typically coded by the industry using ICD (short for International Classification of Diseases, an industry standard), certain treatments exhibit much higher risk than others due to differences in the ease of verification, documentation requirements, and the subjective nature of diagnosis and treatment. High fraud risk in

the Infectious Diseases category can be attributed to high volume, vague symptoms, and test-heavy billing. In contrast, ICD groups that lead to surgical claims tend to face lower fraud propensity owing to the inherent complexity of procedures, mandatory pre-approvals, and the multi-layered documentation they generate, which makes fabricated claims more easily identifiable during audits.

EXHIBIT 11: Fraud Risk Relative Propensities Across ICD Groups



Source: Medi Assist Data

Note: International Classification of Diseases(ICD); Scale represents indexed, relative fraud risks within that segment — for example, infectious disease claims carried nearly 6× the fraud risk of eye and related disorder claims

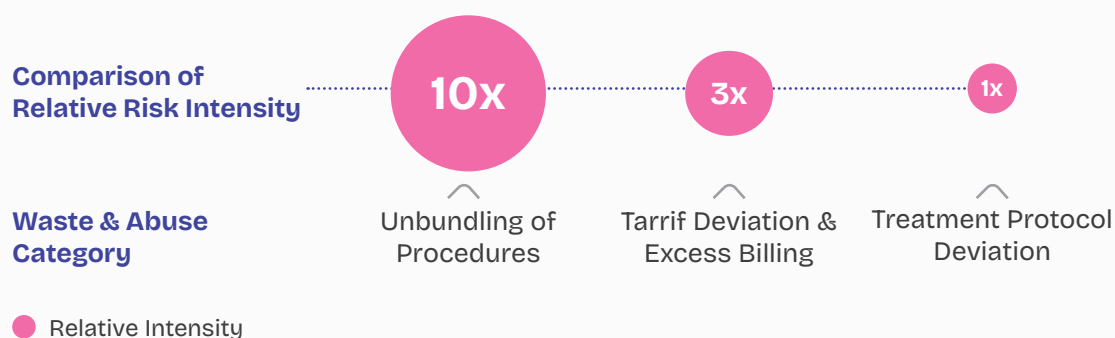
2.4 Risk Intensity for Waste & Abuse Categories

Waste and Abuse accompany fraud, manifesting through inefficiencies, procedural lapses, and non-adherence to clinical standards. Each scenario, from deliberate overbilling to deviations from approved medical protocols, carry a distinct risk intensity.

Public schemes like PM-JAY³ and CGHS⁴ pay hospitals a single, all-inclusive 'package rate', a case-based bundled payment, for a defined treatment, while private insurers use negotiated 'package rates' with network hospitals or collaborate with Third-Party Administrators (TPAs) to authorize amounts as per mutually agreed hospital package or tariffs. This is to simplify claims, standardize prices, and

curb over-itemization compared with fee-for-service. Under the PM-JAY, NHA⁵ publishes package-specific STGs⁶, commonly known as 'treatment protocols', used by hospitals and audit teams to standardize documentation and processing. Over-package billing, unbundling of procedures, tariff deviation, protocol non-compliance, are emerging as the dominant drivers of Waste and Abuse by inflating healthcare costs and compromising system integrity. A deeper study of the most prevalent categories of Waste and Abuse show that unbundling of procedures has the highest fraud risk.

EXHIBIT 12: Most Prevalent Waste & Abuse Categories



2.5 FWA: A Structural Drag on Profitability, Affordability, and Sector Growth

Every year upto 8–10% of total claim payouts are estimated to be lost to FWA, translating to leakages amounting to approximately ₹8,000–₹10,000 crore annually. These losses are not merely operational inefficiencies. Such significant leakages have a direct and measurable impact on the sector's profitability and long-term sustainability. By curbing these losses, insurers can directly preserve profitability—recovering margins that are currently eroded by avoidable inefficiencies. Our analysis of insurance profitability indicates that a

100-basis point reduction in FWA could uplift sectoral RoE by ~70–80 basis points, thereby making the sector more attractive, enabling greater capital realization, expanding coverage, and improving risk pool resilience.

Thus, reducing FWA by only 50% could also drive an approximately 35%⁷ improvement in sectoral RoE, thereby enhancing overall profitability and sustainability.

3. Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana; 4. Central Government Health Scheme;

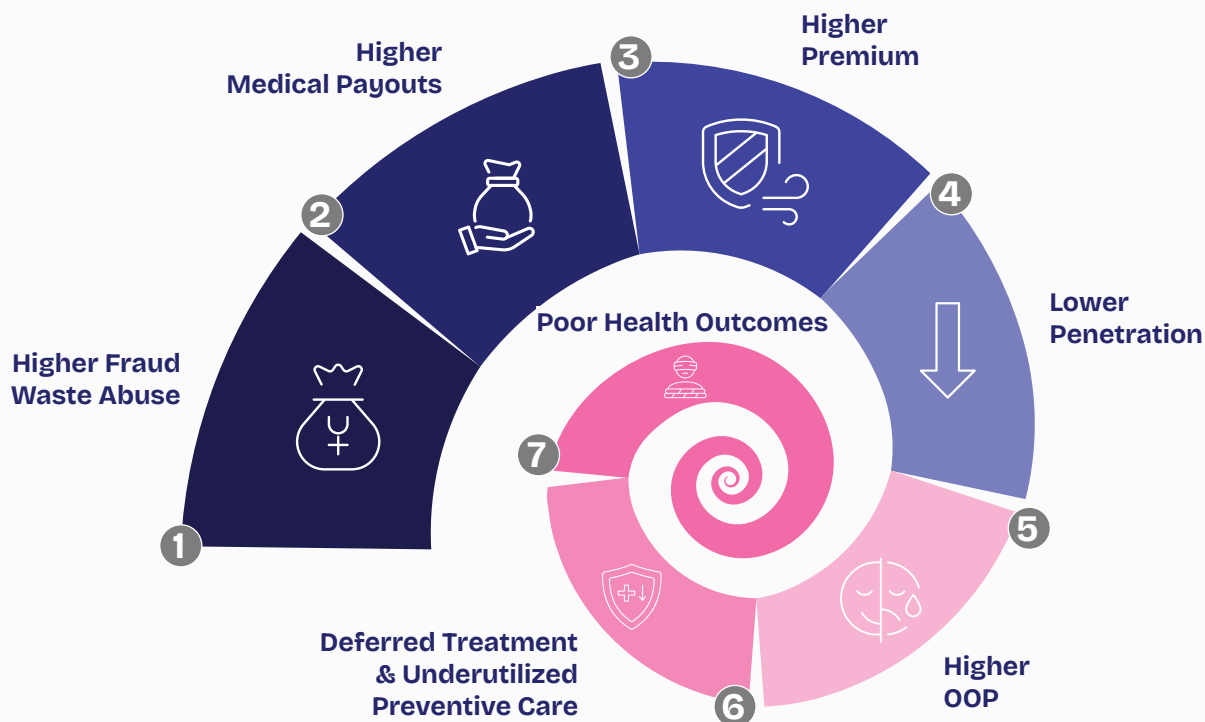
5. National Health Authority in India; 6. Standard Treatment Guidelines; 7. Assumed 20% of claim-payout savings from reduced FWA, being allocated to regulating and controlling FWA

This magnitude of leakage represents one of the largest inefficiencies in India's health financing system. These losses act as a double-edged sword by increasing insurance premiums for customers on the one hand and reducing insurer margins on the other. Thus, the Indian insurance sector finds itself caught in a downward spiral.

The compounding effect of FWA contributes directly to rising healthcare inflation, which then

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

EXHIBIT 13: Spiral Effect of Higher FWA Leading to Poor Health Outcomes



This downward spiral weakens key government initiatives and keeps insurer finances under strain. Margins remain thin, with most standalone and general insurers posting single-digit returns. The loss of input tax credit (ITC) under GST 2.0 has further squeezed profitability. Even with 100% FDI now permitted, thin returns continue to make the sector less attractive for sustained investment. This also blocks capital that could otherwise be reinvested in digital infrastructure, distribution expansion, new product innovation, and enhanced processing capabilities. Beneath the surface, FWA creates substantial hidden costs that reverberate across the ecosystem. As fraudulent activity rises, more claims are flagged for investigation, and in the process, even legitimate claims undergo extended scrutiny, thereby diluting the experience for genuine policyholders. This erosion of trust

between insurers, providers, and customers gradually weakens confidence in the system, discouraging participation and further leading to lower insurance penetration.

FWA has become systemic rather than sporadic, eroding trust, profitability, and access across India's health insurance value chain. The financial and social costs are substantial, constraining growth. Yet, this challenge also presents an opportunity: even a modest reduction in FWA can significantly improve profitability, lower premiums, and expand coverage, enabling reinvestment into innovation and digital infrastructure. The time is ripe to move from recognition to resolution—through coordinated, multi-stakeholder action that embeds integrity, transparency, and accountability at the core of India's health insurance ecosystem.



*This is an AI generated image

Chapter 3

The Systemic Barriers: Why FWA Persists

Across the insurance journey, FWA persists because of issues like limited visibility, uneven processes, and misaligned incentives. When information is scattered, steps vary across players, and consequences are uncertain, misuse becomes easier and more likely. These conditions allow errors, overuse, and opportunistic behavior to keep recurring. As we move from incidence patterns to underlying causes, it becomes clear that there are systemic barriers that allow FWA to persist, explaining why the problem remains pervasive despite repeated industry efforts. Some of the major root causes of FWA are as follows:

Data Fragmentation: India's health-data landscape remains deeply fragmented, with critical information both siloed and limited in availability across stakeholders. Each party sees only a partial view, insurers hold proposal, policy, and claims data but lack access to prior clinical histories. This combination of fragmentation and constrained data access creates a disconnected ecosystem—one that breeds inefficiencies, duplication, and systemic opacity.

Data Fragmentation can lead to misrepresentation of facts, document manipulation and undetected fake hospitalizations. These are among the top

four causes of fraud risk. When data streams are connected, facts can be instantly cross-verified, documentation reconciled automatically, and hospital admissions authenticated through live provider logs—creating a single, verifiable source of truth. Thus, a unified, real-time data framework could create a single, verifiable source of truth, that strengthens transparency and prevents misuse across the value chain.

Manual and Reactive Audits: Current FWA controls in India's health insurance ecosystem remain largely reactive rather than preventive, with detection efforts beginning only after the incident has occurred. Limited real-time data during pre-authorization and adjudication keeps investigation protocols rules-based and non-adaptive, reliant on legacy rules that yield low sample coverage, high false positives and inconsistent results. Fraud intelligence sharing remains weak. Although the Insurance Information Bureau (IIB) provides useful data across insurers, the lack of a unified feedback loop—like a CIBIL-type system—limits insight and accountability.

The introduction of the ABHA marks a significant milestone in India's journey toward building a digitally integrated healthcare ecosystem. By

EXHIBIT 14: Fraud Risk Relative Propensities by Root-Causes



Source: Medi Assist Data

Note: Scale represents indexed, relative fraud risks within that segment — for example, document fabrication accounted for nearly 7× more fraudulent cases than the mention of non-existent hospitals.

providing everyone with a unique health identifier, ABHA has laid the foundation for seamless data continuity across payers, providers, and patients, enabling better coordination of care and more informed decision-making. When fully realized, this system can dramatically improve efficiency, transparency, and personalization within health insurance and service delivery. However, ABHA's full potential is still untapped. It must integrate deeply with hospitals, insurers, TPAs, and digital platforms to evolve from an ID into a true enabler of a connected, insight-driven ecosystem. Strengthening interoperability, ensuring consistent adoption, and embedding ABHA within claims and care workflows will allow it to become the true backbone of India's health data infrastructure—empowering preventive care, improving fraud detection, and advancing equitable access to quality healthcare.

Significant institutional progress has been made under AB-PMJAY¹, governed by a zero-tolerance policy towards Fraud and Abuse. National Anti-Fraud Unit (NAFU) has been established at NHA which works in close coordination with State Anti-Fraud Units (SAFU) to investigate and take joint action against issues related to Fraud and Abuse. A total of 3,167² hospitals have been reported guilty of irregularities/violations since the inception of this scheme. Suitable actions have been taken against these entities, including the de-empanelment of over 1,000 hospitals, penalties amounting to ₹122 crore on more than 1,500 errant hospitals, and the suspension of over 500 hospitals, as reported by the respective States and Union Territories. These mechanisms are welcome moves in the context of reducing FWA. However, these measures continue to be reactive in nature. The low adoption of AI-driven detection and predictive analytics, limits the use of advanced capabilities like smart sampling and self-learning models, leaving the ecosystem reactive, static and unable to evolve alongside emerging fraud risks.

Minimal Risk Sharing Between Stakeholders: In the current ecosystem, providers are rewarded for treatment volumes (dependent on the number of procedures performed and the corresponding treatment amounts), not on quality or outcomes. Providers face strong pressure to maintain profitability, while payers remain focused on controlling loss ratios and containing payouts. This misalignment creates a self-reinforcing cycle of control and counter-control, where both sides

work at cross-purposes instead of collaborating. The absence of outcome-linked contracts, trust infrastructure, and meaningful financial disincentives allows these practices to persist unchecked. What began as marginal excesses has evolved into a culture of quiet tolerance—where claim inflation, overuse and tactical upcoding have become normalized behaviors. Over time, this has dulled the industry's sensitivity to Waste and Abuse, undermining trust and preventing the payer-provider relationship to be built on shared accountability and aligned goals.

Limited Standard Protocols: India's healthcare ecosystem continues to operate with limited standardization across key operational and clinical dimensions. Treatment protocols, procedure coding, invoice templates, tariff structures and data-sharing mechanisms vary widely across states, insurers and provider networks, resulting in inconsistencies in how care is delivered, recorded and reimbursed. This variability creates space for inefficiencies, billing discrepancies, and interpretation gaps that contribute to Waste and Abuse. Encouragingly, India has already made important strides toward greater uniformity through initiatives such as the NHCX³ payload schemas, ABDM data standards, successive PM-JAY Health Benefit Package updates and early DRG⁴ pilots. These are crucial building blocks toward harmonized coding, documentation and tariff frameworks. However, adoption and enforcement remain uneven and local customizations often reintroduce ambiguity into otherwise standardized processes. As a result, differences still exist even for identical treatments, leaving grey zones that complicate transparency.

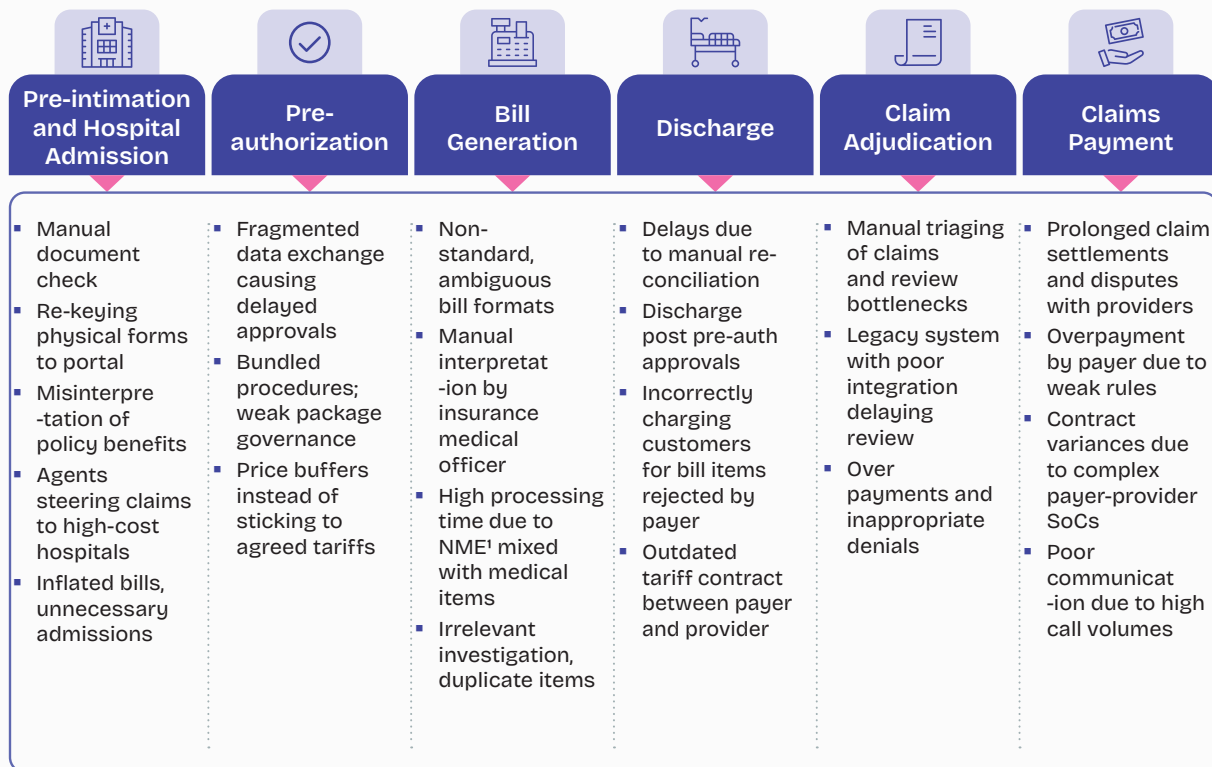
Operational Inefficiencies: India's healthcare and insurance ecosystem continues to grapple with deep operational inefficiencies across both hospitals and claims processing systems and value chain. At the end of the provider, manual workflows dominate admission, billing and discharge processes. Hospitals apply non-standard billing formats and mix non-medical expenses with clinical charges, thus, creating ambiguity and administrative friction. Limited automation and weak package governance result in redundant investigations, inflated estimates and billing errors. On the payer side, fragmented data exchange, subjective case assessments and legacy adjudication systems, slow down approvals and increase inconsistency. Manual eligibility checks, poor integration between

1. Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana; 2. Ministry of Health and Family Welfare Press Release on August 19, 2025; 3. National Health Claims Exchange; 4. Diagnosis-Related Group

hospital and insurer systems, and outdated tariff contracts further compound the challenge. Even at the payment stage, prolonged settlements, weak reconciliation mechanisms and frequent disputes strain payer-provider relationships. Together, these inefficiencies create a reactive, error-prone

ecosystem that inflates costs, drives Waste and undermines patient and provider trust, reinforcing the urgent need for digitization and standardized operating protocols across the value chain. These micro failures create predictable leak paths and honest errors.

EXHIBIT 15: Operational Inefficiencies Across The Claim Lifecycle



1. Nonmedical Items
Source: BCG Analysis

Weak Legal Framework: India's insurance ecosystem lacks robust legal deterrents against Fraud by customers, providers, or intermediaries. There is no dedicated penal code for Insurance Fraud; cases are typically pursued under general provisions, which do not map neatly to sector-specific offenses or workflows. For policyholders, actions like falsifying medical history or inflating claims often result in claim rejection or policy cancellation, consequences that are rarely accompanied by financial or criminal penalties, making it appear as a low-risk, high-reward act. For providers, the theoretical risks are greater. Fraudulent practices like overbilling, document tampering, or fabricated hospitalizations can lead to blacklisting by insurers or de-empanelment from government schemes such as PM-JAY and state-sponsored programs. Yet, enforcement remains patchy and largely driven by internal insurer protocols rather than a unified legal framework. This lack of systematic accountability weakens

deterrence and leaves the system vulnerable to repeat abuse.

In contrast, countries like the United States have set up stringent, well-enforced legal frameworks for both government and private insurance. The **U.S. False Claims Act** targets fraudulent claims against government schemes by imposing penalties including treble damages and civil penalties for each claim. The **NAIC⁵ Model Insurance Fraud Act**, adopted by most states in the US, has provisions to distinguish misdemeanors from felony-level offenses and penalize insurance fraud with substantial fines, multi-year prison sentences, and license revocation for doctors, insurance agents, and insurers involved in fraudulent practices. Nearly every state operates a dedicated Insurance Fraud Bureau or Division, equipped with specialized investigators and forensic auditors to detect, investigate, and prosecute such cases.

5. National Association of Insurance Commissioners

Customer Mindset: Over time, minor misuse in health insurance, such as inflated billing, exaggerated claims, or benefit manipulation, has been normalized, with many customers viewing it as acceptable or inconsequential. Small-ticket fraud and abuse are often rationalized as harmless, given their limited financial impact and low detection risk. This mindset has turned into a systemic behavioral challenge, as misuse is increasingly seen as an inherent part of the system rather than an exception, contributing materially to the broader issue of FWA in the health insurance ecosystem. Such normalization, fueled by governance challenges and misaligned incentives may have contributed to inefficiency and erosion of trust. Shifting this mindset, from passive acceptance to collective accountability, is essential for building a transparent, high-integrity ecosystem.

We have now established that FWA is a systemic outcome of the current health insurance environment and have identified the root causes driving them. Addressing their scale and complexity demands more than isolated interventions. Standalone solutions will not suffice in a system where financial, operational and behavioral dynamics are deeply interconnected; we need a coordinated, systemic framework to rebuild trust and accountability.



Chapter 4

From Suspicion to Solution: Strategic Framework to Combat FWA

India stands at a critical inflection point in the evolution of its health insurance ecosystem, one where policy reform, digital infrastructure, and technology maturity have converged to create unprecedented opportunity. Recent sectoral reforms, the rollout of ABDM-ABHA digital health stack, the creation of NHCX, and policy incentives such as GST exemptions have built a strong foundation for transformation. The digital and regulatory backbone required to reimagine the sector is now in place.

Simultaneously, rapid technological advancements, especially in Artificial Intelligence (AI) and generative AI (GenAI) have dramatically expanded the capacity to detect and prevent FWA. These tools can now analyze millions of claims in real time, identify

patterns of duplication, impersonation, or inflated billing, and automatically flag high-risk claims for targeted investigation. When integrated through secure, interoperable data platforms connecting insurers, TPAs, providers, and regulators, these capabilities can shift India's ecosystem from reactive investigation to proactive, real-time risk prevention.

The moment, therefore, is **not just opportune but imperative**. India possesses both the policy architecture and technological capability, to tackle FWA at scale and integrity. What remains is 'coordinated execution', bringing together all stakeholders to operationalize this vision through shared responsibility, aligned incentives, and data-driven governance.

4.1 JAM Framework from Raksha Summit Report 2024

Last year's Report for Raksha Summit titled 'Borderless Health' focused on allowing every citizen access to appropriate healthcare packages and health benefits anywhere in the country. To realize this vision, the JAM framework, via its initiatives, Joined Health Data, Automation of claims assessment, Mobile enablement to increase accessibility, was the key enabler for delivering integrated and accessible healthcare nationwide. These also contribute to curbing FWA in India's healthcare insurance system through transparency, automation, and accountability.

The Joined Health Data, created by integrating ABDM, ABHA, and NHCX into a unified, consent-based, digital infrastructure connects patients, providers, and insurers. This real-time data

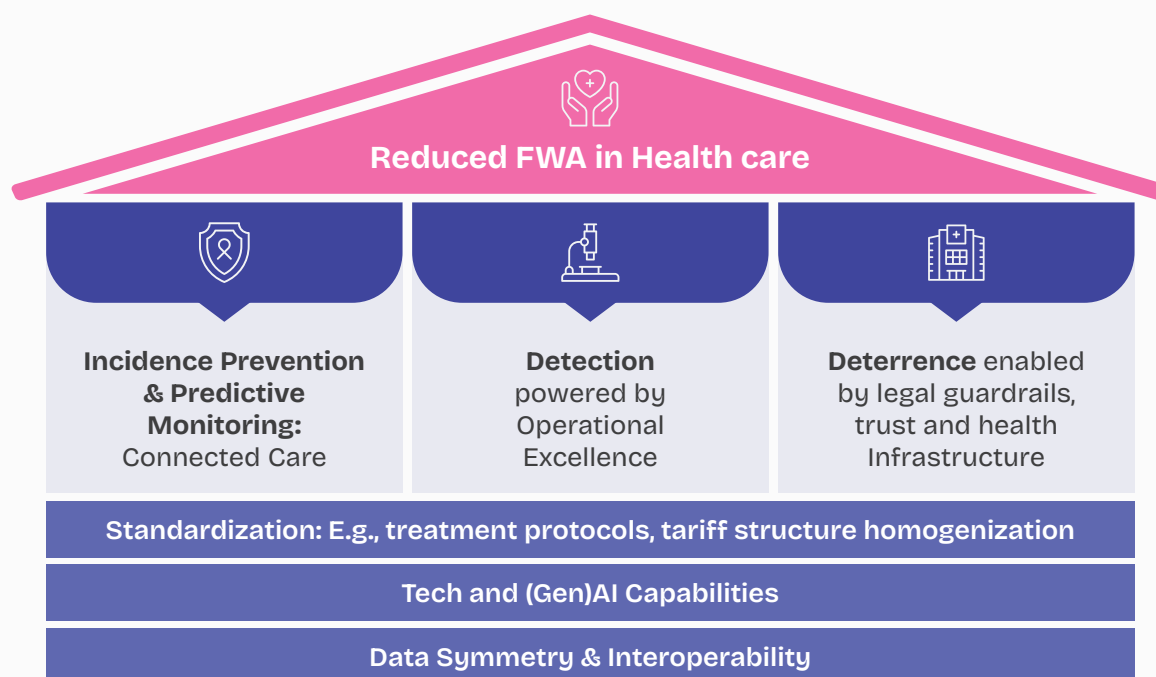
exchange prevents claim duplication and document falsification. Automated adjudication and AI-driven analytics instantly flags anomalies such as inflated bills, impersonation, or upcoding, reducing human error and making fraud prevention proactive rather than reactive. AI-powered fraud analytics further enhances detection by learning from historical patterns to predict and prevent misuse. Mobile-enabled platforms bring visibility and accountability to customers through real-time claim tracking, digital health cards, and cashless transactions. Together, these levers—data integration, automation, and digital participation—create a transparent, self-correcting ecosystem that can significantly reduce FWA and strengthen trust across India's health insurance value chain.

4.2 Strategic Framework to Combat FWA

To effectively combat FWA, India needs a cohesive national strategy anchored in a structured framework that unites technology, policy, and accountability. The rapidly evolving power of AI/ GenAI and computing offer more powerful, forward-looking and automated interventions to prevent FWA. A connected ecosystem that runs on unified and universal consent-driven data will be the key foundational enabler to truly harness

these technologies. However, technology solely may not suffice. Broader interventions, re-aligning incentives across the Patient-Provider-Payer spectrum and new social/ legal sanctions would be equally critical. The role of our policymakers and governmental/ regulatory bodies would be seminal in framing a national approach cutting across these siloed interests.

EXHIBIT 16: Strategic Framework to Combat FWA



The three pillars of this framework—Prevention, Detection, and Deterrence are interdependent and together create a culture of integrity and trust. **Prevention** begins with shifting the system from reactive to proactive care, where digital ecosystems, data-led insights, and continuous engagement foster early intervention and minimize inefficiencies before they occur. **Detection** builds on this, through intelligent automation and operational discipline, using technology to enhance transparency and identify irregularities seamlessly across the value chain. Finally, **Deterrence** reinforces long-term accountability by combining strong legal guardrails with behavioral incentives

that reward compliance and ethical conduct. Working in harmony, these pillars transform FWA management from a transactional exercise into a sustained ecosystem commitment. These three pillars deliver results only when reinforced by strong foundations. **Standardized protocols, AI-led intelligence, and interoperable data ecosystems** tie the framework together and sustain its impact. Standardization closes manipulation gaps, AI and automation detect suspicious activity in real time, while interoperability ensures everyone works from the same verified data—making FWA easier to spot and stop. This anchors the framework to transparency, trust, and shared responsibility.

4.2.1 Incidence Prevention & Predictive Monitoring: Connected Care

India's healthcare ecosystem continues to function in a largely reactive mode, intervening typically after illness manifests or claims are raised. A proactive and preventive approach, leveraging digital health technologies such as telemedicine, remote patient monitoring, wearables, EHRs, and mobile health apps bringing together patients and care teams represents the novel system of '**Connected Care**'. An out-of-turn, contradictory and potentially suspicious care recommendation would thus be easily flagged and rooted out in such a Connected Care model anchored by payers and/or providers. Hence, Connected Care transforms the traditional care model, by fostering proactive, continuous health management, limiting

unnecessary hospitalization and delivering superior outcomes, reducing the net out-of-pocket burden on citizens. Leading global Connected Care models have not only improved outcomes but also generated rich continuum of data across preventive and therapeutic touchpoints. These insights can be leveraged to curb FWA by identifying anomalies, eliminating inefficiencies and promoting evidence-based decision-making. By emphasizing early intervention, preventive screening and longitudinal health monitoring, Connected Care reduces unnecessary admissions, repetitive diagnostics and over-utilization—the primary drivers of Waste and Abuse.

The exhibit below illustrates a few examples where Connected Care and data integration help prevent FWA. As part of a Connected Care ecosystem, access to a patient's recent test or lab results through the Health Information Exchange (HIE) helps clinicians **avoid repeating tests**, saving both patient's cost and time. Remote Patient Monitoring (RPM) and telehealth follow-ups similarly catch early signs of post-surgical complications, **preventing avoidable readmissions** and reducing unnecessary spending, while curbing Waste from redundant procedures. On the Fraud front, cross-verification

of telehealth claims against EHR logs and patient-consent data, blocks **phantom billing**, while AI algorithms that compare claimed visit durations with actual telehealth logs prevent **upcoding** and inflated charges. Finally, analytics that benchmark prescribing patterns across providers, flag outliers who **overuse high-cost drugs or prescribe unnecessary services**, addressing Abuse driven by profit or poor practice. Together, these Connected Care mechanisms transform FWA control into a proactive, data-driven safeguard that promotes efficiency, transparency, and patient trust.

EXHIBIT 17: Illustrative Examples of How Connected Care Helps Solve FWA

Duplicate Testing

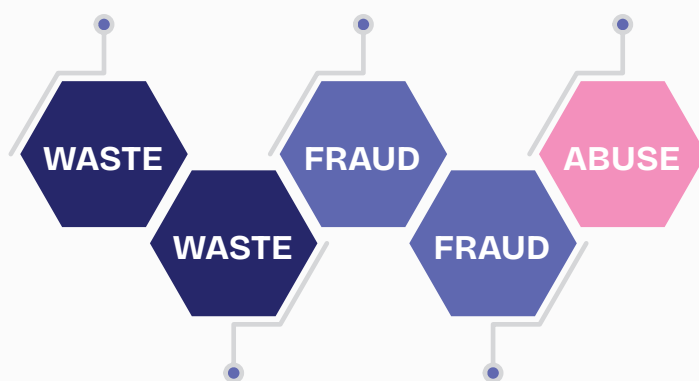
A doctor sees a patient's recent MRI or lab results in the shared Health Information Exchange (HIE) and does not order a new one.

Phantom Billing

The insurer's system finds no corresponding telehealth log, EHR entry, or patient-flagged event for a submitted claim.

Unnecessary Services

Analytics identify a provider who prescribes high-cost brand-name drugs at 5× the rate of their peers for patients with the same diagnosis in the EHR.



Preventable Readmissions

Remote Patient Monitoring (RPM) and telehealth follow-ups for a post-surgery patient catch a complication early, preventing a costly ER visit.

Upcoding

An AI algorithm flags a claim for a 45-minute "complex" visit when the connected telehealth platform's log shows the call lasted 5 minutes.

To shift from reactive claim management to proactive health-risk prevention, payers must embed Connected Care within a predictive, data-driven framework. As wellness programs and digital health tools expand, they generate a unified digital footprint across diagnostics, prescriptions, and claims. When analyzed through AI, ML, and GenAI, this data enables early identification of health risks, inconsistencies, and potential FWA—transforming static information into a real-time early-warning system that guides timely intervention.

To implement Connected Care, it is recommended that insurers integrate continuous member engagement with predictive analytics at every stage of the health journey. Establishing digital

risk assessments and preventive screenings and connecting them through ABDM and NHCX, would enable creation of verifiable health records. Linked to ABHA-IDs, these records can power dynamic AI models that anticipate disease progression and flag anomalous utilization. To boost its implementation and effective usage, insurers can embed behavioral incentives to strengthen the model. Wellness-linked rewards, for instance, premium discounts, cashbacks, or loyalty benefits, will encourage preventive behavior and adherence to validated care pathways, thereby reducing incidence and claims frequency. This approach is strongly aligned with IRDAI's guidelines on wellness and preventive features, which explicitly permits insurers to offer reward points to health-promoting

behaviors². Collaboration with providers to standardize protocols, promote teleconsultations, and strengthen post-discharge follow-up further minimizes overuse and duplication. Finally, a 'Health Integrity Dashboard' that consolidates member and provider data can institutionalize transparency, reward ethical conduct, and reinforce accountability across the ecosystem.

A standout global example is Ping An Good Doctor in China, which has built a tightly integrated Connected Care model through its **Ping An Good Doctor (PAGD) platform**; with over 373 million registered users and more than one million daily consultations³, the platform combines telemedicine, AI triage, chronic-care management and seamless claims integration. From a network⁴ of 4,000+ hospitals, 106,000+ service providers and 240,000+ pharmacies, PAGD has installed its "7+N+1" AI product system and achieved its first net profit⁵ (Approximately ¥60.6 million) in mid-2024. The result: early intervention,

reduced avoidable hospitalizations and lower claim incidence; automated diagnostics and AI-powered adjudication reduce false positives, while continuous backend analytics monitor for overtreatment, duplicate billing and other FWA drivers – together driving significant cost savings, improved claims integrity and stronger patient trust, reduced false positives, and materially enhanced claims integrity across the value chain.

Together, Connected Care and predictive monitoring can redefine the economics of healthcare. Continuous engagement, real-time analytics, and preventive incentives create a virtuous cycle of healthier members, lower claim outflows and reduced FWA. Beyond financial efficiency, this approach aligns stakeholders around health outcomes and advances India's journey toward affordable, equitable and sustainable healthcare for all.

4.2.2 Detection Powered by Operational Excellence

Operational excellence starts by building an intelligent health claims processing flow that can be powered by skilled resources, advanced technology, sharp models that can increase FWA detection. Given the pressure to process claims within stringent turnaround time SLAs, manual claims processors often operate under significant workload constraints. In the effort to meet timelines, they may inadvertently omit critical verification checks—not out of negligence, but because of the practical trade-offs between speed and thoroughness. These honest efforts, while well-intentioned, can unintentionally create vulnerabilities that allow errors or instances of FWA to slip through the system. With new age advancements in AI/ GenAI, a lot of the checks, traditionally done by manual processors can now be enabled more accurately and with zero human operations.

Instead of post-facto manual checks, technology enables multiple proactive interventions like document parsing, medical treatment code reconciliation, anomaly scoring and digital forensics in real time, like reading invoices and discharge summaries, mapping them to ICD/DRG and tariff packages and auto-flagging deviations from standard treatment guidelines. AI can further enhance these capabilities by detecting entity collusion, identifying pattern drifts, and running similarity checks across claims to uncover hidden fraud patterns. To make this discipline repeatable,

standardized SOPs across payers, TPAs, and providers, should be made universally accessible. This approach would enable every claim to be machine readable, traceable and auditable end-to-end, significantly strengthening fraud control across the healthcare ecosystem.

To operationalize this model and realize the full savings of FWA, there are multiple stakeholders who need to act in tandem.

Payers and TPAs need to institutionalize checks and balances across the claims value chain through multiple toolsets such as AI agents, predictive models, and standardized rules to govern pre-authorization and adjudication processes. Any deviations—such as code mismatches, consumable cost anomalies, or misaligned treatment guidelines—can automatically raise alerts for exception handling through human-in-loop mechanisms. Using historical claims data, they can jointly develop predictive and prescriptive models that augment human intelligence, identify fraud typologies, estimate the probability of misuse, and prioritize high-risk claims for manual investigation.

At the same time, both payers and TPAs can strengthen this framework by enabling seamless, machine-readable information exchange with providers through API-driven workflows for eligibility verification, document validation, and anomaly escalation. Such collaboration minimizes

2. IRDAI Circular on Guidelines on Wellness and Preventive Features out on Sept 4, 2020; 3. Ping An Group, Bridges to Health for China's People, Ping An Group Media Center, 2023; 4. HealthTech Asia, August 202; 5. Ping An Good Doctor Turns Profit in Mid-2024, CTOL Digital, July 2024

manual touchpoints, enhances data integrity, and builds an integrated, intelligent ecosystem for FWA prevention. Increasingly, these technologies are being deployed at scale by payer-TPA partnerships to foster tighter, objective, and scalable controls across the claims lifecycle—ensuring consistency, transparency, and early risk detection.

Providers can focus on digitizing their clinical and billing data end-to-end, integrating with systems that flag inconsistencies in real time and connect seamlessly with shared national claims infrastructures. Embedding automated checks within hospital information systems, ensuring coding accuracy, and maintaining complete data traceability from admission to discharge will further improve transparency and operational efficiency.

It is recommended that stakeholders' emphasis should be on automation, interoperability and auditability, embedding technology and discipline so deeply into daily operations that FWA detection becomes a natural by-product of how the system functions. These measures would create a system where FWA is intercepted before it matures into losses. Standardized rule engines and predictive analytics would ensure that anomalies are surfaced early, reducing discretionary loopholes and data blind spots. Real-time flagging and interoperable workflows would make every claim transparent and verifiable, cutting opportunities for manipulation. Over time, automation and shared accountability would make FWA detection self-sustaining—embedding integrity directly into everyday operations.

EXHIBIT 18: Prudential Achieved 7–8% Reduction in Claim Payouts through Systemic FWA Controls

	 Distribution & Underwriting	 Claims & Provider Management	 Payment Settlement
Key Issues	▪ Non-disclosure: Unrevealed pre-existing conditions ▪ Inadequate risk scoring	▪ Misrepresentation: Misuse of patient identity ▪ Out-of-policy coverage: Claims for uncovered services, claims during the waiting period ▪ Overutilization: Unnecessary diagnostics, unwarranted doctor visits, over-prescriptions, excessive re-admissions ▪ Improper Billing: Overbilling, upcoding, unbundling, phantom procedures	▪ Incorrect payments: Mis-payments ▪ Unreconciled TPA settlements: Possible leakages through rounding, timing, or duplicate credits ▪ Weak audit trails: Inadequate post-payment review, delayed fraud detection
Interventions Made	▪ AI-based disclosure checks and predictive underwriting scorecards ▪ Automated verification of pre-existing conditions and risk disclosures ▪ Reduction in adverse selection and hidden exposure through data-driven underwriting	▪ Standardized pre-authorization and coding protocols to ensure claim consistency ▪ Risk models and real-time anomaly detection ▪ Early-warning alerts for duplicate or inflated claims ▪ Provider-risk scoring with automated billing audits ▪ Hospital payouts linked to quality and cost-compliance	▪ Fraud triggers embedded in payment workflows ▪ Automated digital reconciliation ▪ Eliminated duplicate or misdirected payments

Source: BCG Analysis

A noteworthy example at the global level is **Optum's Payment Integrity Program**, which embeds fraud, waste, and error detection directly into claims adjudication using AI-driven analytics, clinical-rules engines, and real-time coding validation. The program processes more than 1.3 billion claims annually across payers and providers, applying over 16,000 clinical edits and 400 million automated validations each year to prevent improper payments before disbursement. One case study showed a large U.S. commercial health plan partnering with Optum to achieve US \$30.5 million in savings in the first year and US \$77 million in the second year, driven by pre-payment review and automated claim-edit implementation. These outcomes demonstrate how embedded AI and analytics can strengthen

adjudication accuracy, cut administrative overheads, and deliver measurable, multi-million-dollar reductions in waste and fraud.

Another example is that of **Prudential Insurance**, which implemented a comprehensive, analytics-driven FWA control program spanning underwriting, claims, and payments. By introducing AI-based risk screening, predictive anomaly detection, provider-risk scoring, and automated fraud checks, the initiative achieved higher accuracy, faster processing, and a 7–8% reduction in claim payouts. The exhibit below outlines the key FWA vulnerabilities across the insurance value chain and the targeted interventions implemented at each stage to address them through analytics-led process improvement and governance controls.

4.2.3 Deterrence Enabled by Legal Guardrails and Trust Infrastructure

A potentially fatal flaw of India's health insurance ecosystem is the absence of effective deterrents against Fraud, Waste and Abuse (FWA). Today, the system neither rewards integrity nor penalizes misconduct. Honest participants gain no tangible benefit for compliance, while those engaging in malpractice face little consequence. The harshest action typically available to insurers is claim rejection or policy cancellation. In addition, these measures are inconsistently applied and lack standardization. Unlike sectors such as Banking or Financial Services, where fraud attracts codified civil and criminal penalties, health insurance fraud has no formal legal definition or prosecutable framework. Most instances are dismissed as clerical errors or "honest mistakes," and even deliberate fraud often goes unpunished due to lack of evidence or standardized processes.

This gap underscores the need for a dual approach—legal deterrence complemented by behavioral trust infrastructure—that changes the cost-benefit equation for malpractice. Together, these mechanisms can introduce accountability, strengthen integrity and build long-term trust across the ecosystem.

4.2.3.1 Legal Guardrails

Legal deterrence is best initiated by codifying FWA as a defined and punishable offense under India's insurance regulations. This entails setting out clear definitions for Fraud, Waste and Abuse; differentiating willful intent from procedural lapses; and aligning penalties with the gravity of the violation. Minor infractions, such as repeated documentation errors, can warrant financial penalties or temporary blacklisting, while deliberate

fraud merits criminal prosecution under dedicated insurance law provisions.

The recent Insurance Fraud Monitoring Framework Guidelines, 2025, issued by IRDAI in October 2025, provides a crucial foundation for this effort. The guidelines introduce a comprehensive, zero-tolerance approach to insurance fraud, mandating every insurer to establish a Fraud Monitoring Committee (FMC) and an independent Fraud Monitoring Unit (FMU), adopt standardized fraud classifications, and implement structured processes for deterrence, detection, and reporting. They also institutionalize industry-wide intelligence sharing by requiring participation in the Insurance Information Bureau of India's (IIB) fraud-monitoring ecosystem and maintenance of a central "caution repository" of high-risk entities. By formalizing governance structures, board-level accountability, and shared data infrastructure, the framework elevates fraud control from an operational safeguard to a strategic regulatory priority—aligning directly with the broader vision of embedding integrity, transparency, and accountability in India's health insurance ecosystem.

In the United States, the Health Care Fraud and Abuse Control (HCFA) Program—established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996—stands as one of the most comprehensive deterrence frameworks globally. Operated jointly by the Department of Justice (DOJ) and the Department of Health and Human Services (HHS), it coordinates federal, state, and private-sector efforts to detect, investigate, and prosecute healthcare fraud. In FY 2023, the program recovered over US \$3.4 billion

through civil and criminal enforcement, including US \$1.8 billion from civil settlements under the False Claims Act, and excluded more than 2,100 individuals and entities from federal healthcare programs.⁶

Similarly, the **United Kingdom's NHS⁷ Counter Fraud Authority (NHSCFA)** functions as a statutory body dedicated to preventing, detecting, and investigating fraud within the National Health Service. Operating under the Fraud Act 2006, the NHSCFA combines data analytics, targeted audits, and cross-agency intelligence sharing to curb misuse. Its 2023–24 report recorded **£184.6 million** in counter-fraud savings, contributing toward its three-year target of £500 million, while its Strategic Intelligence Assessment estimated

around **£1.3 billion** of NHS funding remains vulnerable to fraud, bribery, and corruption.⁸

Empowering regulators such as IRDAI and NHA to establish dedicated investigative and adjudication units can strengthen oversight, enabling them to audit, prosecute, and refer proven cases to legal bodies. A national fraud registry, managed by a neutral governing entity, can record verified cases and prevent repeat offenders, whether individuals or hospitals, from moving freely across insurers. Serving as both a reference and deterrent, the registry introduces reputational and financial consequences for fraudulent conduct. Collectively, these measures advance efforts to curb FWA while fostering a culture of integrity and trust.

EXHIBIT 19: Determinants of Provider and Member Trust Score

Factors determining provider trust score

Institutional Governance & System Integration

Whistleblower policy, accreditation/empanelment with NABH, NHA, system linkage with ABDM, ABHA, NHCX

Medical Outcomes and Infrastructure

Mortality rates, patient outcomes, readmission, facilities at the provider, availability of machines & beds

Documentation & Data Transparency

Completeness and digitalization of claim records with audit trail, process for matching with ABHA records

Administrative Process & Reputation

Registered patient complaints, insurer feedback, public reviews, affiliation to declared frauds

Clinical Ethics & Patient Treatment Patterns

Evidence-based patient treatment, third-party clinical audits, identifiers for package pushing, prolonged stays, etc

Factors determining member trust score

Claim patterns & behavior

Repetition in claims, duplicate records, frequent claims, expensive claims post new policy purchase

Claim Purpose & Intent

Check for genuine health needs, disguised cosmetic/elective medical procedures

Claim Documentation & Authenticity

Submission of original, verifiable documents, inconsistencies in signature & documentation

Disclosure & Honesty in Policy Information

Transparency in occupation, lifestyle details, health conditions, ABHA-link for medical records

Collusion & Network Behavior

Linkage to past frauds, linked billing patterns to other flagged patients



6. U.S. Department of Health and Human Services / Department of Justice. Health Care Fraud and Abuse Control Program Report – Fiscal Year 2023; 7. National Health Service; 8. NHS Counter Fraud Authority. Annual Report and Accounts 2023–2024. Published July 23, 2024

4.2.3.2 Trust Infrastructure

Alongside regulation, a trust infrastructure can drive self-regulation through transparency and data-driven accountability. A Provider Trust Score can measure hospital integrity and operational discipline using parameters like readmission rates, pricing variance, claim resubmissions and audit compliance. High-scoring hospitals could receive faster claim approvals, fewer documentation requirements and public recognition as “Recommended Providers”. Conversely, lower scores would trigger additional scrutiny and slower processing. This becomes even more important, as credible providers today risk being perceived on par with less compliant peers due to the lack of standardized benchmarks for performance and behavior. Establishing a consistent, data-backed evaluation framework would not only differentiate high-performing providers but also create tangible incentives for compliance and quality improvement, helping to restore trust, ensure fair treatment, and build a culture where integrity and performance are objectively recognized across the healthcare ecosystem. Similarly, a Member Health Score can promote responsible behavior among insured individuals, assessing preventive care participation, claim frequency and adherence to policy norms. Members demonstrating healthy behavior could earn premium discounts or loyalty rewards, while repeated misuse could invite monitoring or reduced coverage. A comprehensive list of key determinants of Provider and Member Trust Score is crucial. Governance, transparency, and clinical integrity drive provider credibility, while claim behavior, authenticity, and disclosure practices determine member reliability within the health insurance ecosystem.

To make this operational, payers and TPAs, must collaborate with regulators to create a shared data exchange, aggregating anonymized claims, utilization and clinical information across payers. It is recommended that the data be governed by a neutral body ensuring accuracy, algorithmic fairness and transparency. Over time, these trust scores can integrate into empanelment standards, underwriting and pricing, ensuring accountability becomes institutionalized.

Embedding deterrence in both law and behavior will shift FWA from a low-risk, high-reward act to a high-risk, low-reward exception. When fraud invites real

consequences and integrity delivers clear benefits, the system becomes self-correcting. Over time, this framework will reduce FWA incidence, enhance public confidence and create a transparent, high integrity health insurance ecosystem—one that strengthens, rather than strains, India's path towards ‘Insurance for All’.

This model has been adopted at scale in advanced economies and has yielded significant outcomes. On the payer front, the **US Centers for Medicare and Medicaid Services (CMS)** launched the **Merit-based Incentive Payment System (MIPS)**. Under MIPS, provider compensation is adjusted based on a composite performance score incorporating factors such as quality of care, clinical outcomes, cost efficiency and adherence to evidence-based protocols. Physicians and hospitals that deliver superior performance receive positive payment adjustments, while those falling short face reduced reimbursements.

The **NHS in the UK** employs the **Care Quality Commission (CQC)** rating framework to assess healthcare providers on five core domains—safety, effectiveness, care quality, responsiveness, and leadership. The system assigns transparent ratings such as Outstanding, Good, Requires Improvement, and Inadequate, which are published for public access. These ratings guide patient choice, enhance accountability, and motivate hospitals to continuously improve care delivery and governance standards, reinforcing trust and transparency across the health system.⁹

In **Australia**, the **MyHospitals platform**—developed by the Australian Institute of Health and Welfare—publishes comparative hospital performance data across indicators such as infection rates, readmissions, and patient experience. In tandem with the **National Safety and Quality Health Service (NSQHS) Standards**, this framework fosters accountability, enhances public trust, and drives data-led performance improvement.

Collectively, these systems have demonstrated that transparent, data-driven provider evaluation not only elevates care quality and efficiency but also curbs instances of FWA by aligning incentives and strengthening accountability across the healthcare value chain.

9. Care Quality Commission. Our Ratings and How We Work. CQC, 2024

4.2.4 Standardization and Policy

Every robust healthcare system is built on a stable foundation of uniform standards and policy coherence. Well-defined policy frameworks establish the structure upon which all other interventions—preventive, predictive or deterrent—can operate effectively. By implementing common clinical protocols, standardized billing codes, standardized bill templates widely used by hospitals and harmonized tariff structures, the ecosystem gains a transparent and predictable framework for care delivery and claims processing. Such standardization forms a critical defense against FWA by eliminating inconsistencies that create opportunities for misuse. When every stakeholder operates under the same coding, documentation and pricing standards, deviations become easier to identify, transparency improves, and accountability is embedded into day-to-day operations.

To effectively address FWA and strengthen overall coherence, all stakeholders, especially regulators, could consider implementing the following set of actions:

4.2.4.1 Mandate a Unified Pharma Code

Regulators may mandate a single pharma codebook for procedures and diagnoses that all insurers and providers must use. While India already follows the World Health Organization's ICD-10 standard for disease classification, its adoption across insurers and providers remains uneven, and procedure coding is still not fully harmonized. A harmonized coding system (for example, based on ICD for diagnoses and a unified procedure coding set) would eliminate the current “codes mismatch” between hospitals and insurers. Consistent codes bring clarity to claims data, making it easier to spot anomalies. By enforcing one pharma codebook, India can ensure that every claim speaks the same language. This could lead to clean data available for analysis, comparisons and identifying inconsistencies. For example, establishing a standardized coding framework for common treatments and procedures—and mandating its use across all provider invoices—can create uniformity and transparency in billing. These codes can serve as the foundation for tariff alignment between payers and providers, ensuring consistency in pricing for identical services. During claims adjudication, the standardized codes would function as a unique reference key, enabling automatic matching between submitted invoices and approved tariffs. This would introduce a uniform, verifiable mechanism that significantly reduces opportunities for Waste and Abuse within the system.

Several advanced health systems have demonstrated the transformative impact of unified coding standards on transparency, efficiency, and fraud control. In the **United States**, the use of the ICD-10-CM for diagnoses and the Current Procedural Terminology (CPT) codes for medical procedures is mandated across all payers and providers. This harmonization enables automated claims adjudication, standardized reimbursement, and advanced fraud analytics, minimizing disputes and reducing manual intervention.

The **NHS** in UK similarly employs a national coding system known as OPCS-4¹⁰ for procedures, used in conjunction with ICD for diagnoses, to ensure uniformity in billing, activity reporting, and tariff-setting under the national payment framework.

These global precedents underscore that coding consistency is critical for a transparent and efficient health financing ecosystem. For India, implementing a unified national codebook would be a decisive step toward a cleaner, smarter, and more trustworthy insurance ecosystem.

4.2.4.2 Create a Framework-based Centralized Tariff Repository

Developing a framework-based common tariff repository can significantly enhance transparency, comparability, and consistency in healthcare pricing across the ecosystem. The repository would serve as a structured reference model that defines the process and principles for developing and maintaining tariffs—covering how procedures are categorized, coded, and periodically updated. It would enable insurers, TPAs, and providers to work within a shared framework that promotes clarity, accountability, and evidence-based pricing across the value chain.

By providing a unified reference for tariff methodology, the repository would foster informed, data-driven dialogue among stakeholders. It would also improve interoperability by harmonizing coding standards, service definitions, and documentation practices, ensuring that pricing information is transparent and comparable across networks while maintaining the agility of a competitive market environment.

The National Health Authority (NHA) has already highlighted the importance of such a framework through its consultation on Diagnosis Related Groups (DRG)–based Case Payment Framework and annual inflation-linked revisions under

10. Office of Population Censuses and Surveys Classification of Interventions and Procedures, version 4

PM-JAY¹¹. Building on these initiatives, a framework-based tariff repository can integrate current pricing systems into a transparent, data-backed model that supports better governance and reinforces stakeholder confidence.

International experience underscores the value of this approach. In Germany, and several European nations, DRG-based case payment frameworks

have established a consistent methodology for classifying hospital services and linking reimbursements to standardized definitions. This alignment has enhanced transparency in hospital financing, improved efficiency, and reduced opportunities for overbilling or unjustified cost variation—strengthening trust and integrity across healthcare systems.

4.2.5 Tech and Gen (AI) Capabilities

In a modern health insurance system, technology is not an accessory—it is the foundation. Digital platforms and automation form the rails on which transactions move, while AI and GenAI provide the intelligence that powers prevention, prediction and precision. Together, these capabilities create an adaptive digital backbone.

Technology serves as both a predictive and diagnostic instrument in combating FWA across the health insurance value chain. Advanced AI and GenAI models not only flag fraudulent claims and anomalies in real-time but also detect deeper patterns of misuse by continuously learning from historical data—identifying outliers in provider behavior, claim frequency, or cost patterns.

Predictive analytics anticipate issues like redundant tests or inflated billing, enabling early, preventive action. On the detection front, automation and AI-enabled adjudication engines validate claims data against standard codes, historical benchmarks and clinical pathways to uncover inconsistencies and potential fraud. Automated document verification, image and text recognition and anomaly detection systems ensure coding accuracy and data authenticity at scale. Combining traditional AI with GenAI can revolutionize claims management, from a reactive process to a real-time, self-monitoring ecosystem, enhancing fraud detection, adjudication accuracy, and overall efficiency through intelligent automation and interpretation.

EXHIBIT 20: AI Outpacing Legacy Approaches

Predictive AI/ML

Rigorous Analytical Tasks

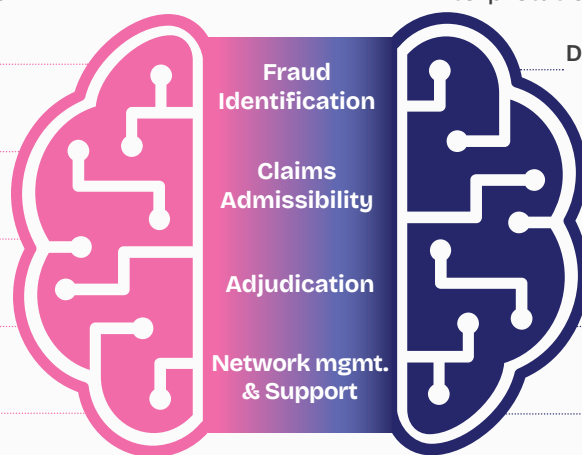
Advanced Fraud Models Flagging

NLP Claim Auditing

Real-time Claim Monitoring

Risk-based Claim Triage

Hospital Trust Scores



Use the combination of Traditional AI & GenAI to maximize impact

Document Interpretation & Synthesis

Claims Adjudication

Deepfake Evidence Detection

Investigative Report Generation

Conversational Analytics Assistant

To build this digital backbone, every stakeholder must take ownership of capability development while contributing to shared infrastructure. Payers and TPAs, and providers each need to strengthen their internal technology stacks by investing in AI capabilities, advanced analytics and automated

decision engines that support real-time data capture and validation. At the same time, these players must collaborate with government and regulators to build on top of common platforms that enable secure data exchange, unified standards and transparent governance.

11. Annual Inflation-Linked Health Benefit Package (HBP) Price Revision Mechanism

Payers and TPAs: Together form the operational and technological core of India's health insurance ecosystem and to curb FWA effectively, both must evolve into digitally empowered entities operating on interoperable, data-driven, and AI-enabled platforms. Both, payers and TPAs should focus on upgrading to modern, interoperable systems capable of real-time data exchange and advanced analytics. They must invest in AI-driven tools, such as fraud detection algorithms, predictive modeling, and pattern-recognition engines, to identify anomalies early and proactively manage risk. Establishing secure API-based connectivity with hospitals and providers can enable real-time capture of clinical and billing data, facilitating instant validation of claims and early detection of irregularities. Automation of claims workflows through rule-based engines and machine learning can help auto-approve simple claims, flag suspicious ones in real time, and minimize manual intervention. In parallel, both must strengthen data management and governance, building internal analytical expertise, developing shared dashboards to monitor claim patterns and fraud indicators, and adopting secure digital tools such as e-signatures and encrypted document systems to eliminate paper-based inefficiencies.

Working in tandem, payers and TPAs can establish a shared digital backbone that enables real-time data capture, automated verification, and predictive fraud analytics, transforming claims processing from a reactive function into an intelligent, self-

monitoring system that strengthens the industry's collective defense against FWA.

Providers: Strengthen hospital information systems and electronic health records (EHRs) to ensure they can share data seamlessly with insurers and other providers. Utilize advanced analytics in clinical care and billing departments to track treatment patterns, outcomes and billing accuracy (which helps flag irregularities or unnecessary procedures). Deploy automated decision support tools for clinicians and administrative staff – for example, alerts for duplicate tests or AI-driven coding assistants – to ensure real-time validation of procedures and claims before they are submitted.

In essence, technology is the connective tissue that transforms India's health insurance ecosystem from fragmented to future-ready. When payers and TPAs as well as providers, align their digital capabilities and integrate around common data standards, the system evolves into a unified, intelligent network that learns and improves continuously. Every transaction becomes traceable, every anomaly detectable and every decision, evidence based. This collective investment in digital infrastructure, anchored in AI, automation and interoperability—will not only strengthen individual institutions but also create a shared digital backbone that underpins prevention, detection and deterrence of FWA. This foundation will ensure that efficiency, transparency and trust define India's health-financing system.

4.2.6 Data Symmetry and Interoperability

A transparent and efficient health insurance ecosystem depends on data symmetry where every stakeholder operates with consistent, verified and timely access to the same information. Today, healthcare data remains fragmented across providers, payers and TPAs, and regulators each maintaining siloed systems with limited visibility into one another's records. A system where data can communicate seamlessly through standardized formats and secure APIs is essential to build trust, speed and accuracy across the value chain.

Data symmetry and interoperability form the foundation for every other layer of transformation, enabling Connected Care, powering Predictive Monitoring and underpinning Trust and Health Scorecard frameworks. Seamless, consented data exchange across providers, payers and TPAs ensures all stakeholders operate from a single, verified version of truth. Stakeholders must work

together with each other and with public agencies to build common digital infrastructure. This means co-creating platforms that enable secure data exchange and transparent oversight across the industry.

4.2.6.1 Leverage Common Data Exchange Platform

Rather than building new rails, stakeholders can scale usage of the NHCX as the shared backbone that connects hospitals, insurers, TPAs and government schemes on a single, standards-based platform. NHCX is owned and governed by NHA, which operates under the Ministry of Health and Family Welfare, Government of India. The platform should enable real-time, bi-directional data flow – for example, allowing a hospital to send electronic medical records to an insurer instantly and the insurer to respond with coverage decisions just as fast.

Complementing these efforts, IRDAI has recently mandated the participation of all insurers in the **IIB Fraud Monitoring Technology Framework**, marking a critical step toward establishing an integrated, industry-wide defence mechanism against financial leakages. The framework seeks to create a unified repository of fraud-related intelligence—encompassing confirmed and suspected cases across hospitals, intermediaries, and distribution channels—enabling insurers to identify and act on repeat or collusive patterns of misconduct. By institutionalizing shared data access, the initiative enhances cross-insurer visibility and standardizes the tracking of high-risk entities, thereby strengthening the industry's collective ability to prevent and detect fraud.

In parallel, IIB's **QUEST system** (Query System for Underwriting, Evaluation, and Search Tool) acts as both a data-sharing and fraud-detection platform. By allowing insurers to query shared policy and claims data, QUEST helps identify duplicate policies, overlapping claims, and collusive patterns that might otherwise go undetected. Its shared information model promotes transparency and coordination among insurers, reducing information silos that enable fraud migration. Together, the Fraud Monitoring Framework and QUEST form a complementary ecosystem that combines centralized intelligence with transaction-level analytics—enhancing data integrity, underwriting diligence, and claims oversight across the insurance value chain.

To truly realize the full potential of these connected frameworks, the ecosystem must strengthen and expand consistent, standardized data standards. This includes ensuring timely and harmonized data submission across insurers and integrating platforms such as ABDM, NHCX, and IIB to enable interoperable, real-time insights across healthcare and insurance systems. Global examples such as the **U.S. HL7/FHIR** (Fast Healthcare Interoperability Resources) framework demonstrate that true interoperability depends less on centralized data exchanges and more on common, standardized data formats that enable seamless connectivity across disparate systems and registries. FHIR provides a globally recognized structure for representing clinical, administrative, and financial data, allowing hospitals, insurers, and digital health applications to communicate efficiently while maintaining privacy and security.

This framework underpins initiatives like the **U.S. Centers for Medicare and Medicaid Services' Blue Button 2.0**, which enables patients to securely share their health data with insurers, providers,

and third-party apps — promoting transparency, reducing duplication, and improving fraud detection through consistent, machine-readable data. In parallel, NHCX can carry structured clinical attachments discharge summaries, diagnostics, itemized bills, giving payers and providers the same machine-readable detail. Together, these steps create true data symmetry with same facts, same time, same format, enabling faster, more consistent adjudication and fewer rework loops.

4.2.6.2 Implement Secure Data Sharing Protocols

With increased data exchange comes responsibility to protect patient privacy and data security. Stakeholders should collaboratively develop security and privacy protocols under the guidance of regulators. This includes agreeing on encryption standards for data in transit, authentication mechanisms (like digital signatures or health IDs) and role-based access controls so that each party only accesses necessary information. Regular joint audits and penetration testing of the shared infrastructure can help maintain trust. All partners can therefore agree to common data governance policies (covering consent, usage and breach responses) as part of the infrastructure.

4.2.6.3 Embed Data Privacy under The DPDP Act, 2023

As India's health-insurance ecosystem becomes increasingly digital and data-centric, the Digital Personal Data Protection (DPDP) Act, 2023 forms the legal foundation for responsible data usage. Any framework for fraud prevention, claims analytics, or tariff management must embed privacy safeguards that align with the Act's principles of lawfulness, fairness, and transparency. The DPDP requires that personal information be collected and processed only for legitimate, well-defined purposes, with explicit consent that is both informed, and revocable.

Within the health-insurance value chain, every stakeholder—insurer, TPA, hospital, and digital intermediary—acts as a data fiduciary, accountable for ensuring that patient and provider data are handled responsibly. This includes setting up robust consent-management systems, defining clear data-sharing boundaries, and maintaining auditable records of how information is accessed or used. Effective compliance will also depend on data minimization, ensuring that only the information strictly necessary for claims validation, fraud detection, or regulatory review is processed or retained.

Equally important are the operational and technological safeguards. Data exchanged across entities must be secured through encryption, access controls, and independent audit trails. As advanced technologies such as AI and machine learning increasingly drive fraud-detection models, they must be designed for algorithmic transparency and explainability, allowing oversight bodies to validate decisions and address potential bias or misuse. Collaborative frameworks between insurers, TPAs, and regulators should formalize inter-entity data-sharing protocols, clearly assigning fiduciary responsibilities and breach-response mechanisms.

Together, these measures ensure that innovation and governance evolve in harmony—creating a privacy-by-design architecture where efficiency, ethical use, and public trust strengthen the foundation of India's digital health ecosystem

4.2.6.4 Form a Joint Governance Council

To ensure transparent governance, stakeholders and regulators can set up a governing body for the national digital health-insurance backbone. This council would oversee the development of standards, manage the evolution of the common platform and address any disputes or policy changes. It should include representatives from payers, providers, TPAs, government health

authorities such as the NHA, the insurance regulator IRDAI, the General Insurance Council (GIC), and domain experts from technology and data governance. The participation of the NHA is essential, as it serves as the nodal body for implementing the ABDM and governing national digital health platforms such as ABHA and NHCX. Its inclusion ensures that the Council's governance aligns with the country's broader health-data strategy, promotes interoperability between health and insurance systems, and upholds privacy and data security standards across the ecosystem.

For example, the regulator might chair a quarterly forum where issues like data quality, system uptime, or new analytical capabilities are discussed openly with all parties. India already demonstrates elements of this collaborative model. For instance, the NHCX platform was jointly developed under NHA with support from IRDAI and the GIC. Building on such examples, a formal governance council can institutionalize cooperation and trust.

Healthcare fraud would drop fast when systems act as one. When payers, technology partners and oversight bodies operate on shared, real-time intelligence, fraud becomes visible before losses occur. In India, trusted data collaboration between public and private players can turn fragmented oversight into a unified, preventive shield against leakage.



Chapter 5

A Call to Action for Stakeholders

Along with a comprehensive framework, India needs to a multi-stakeholder roadmap, to address the complex, multi-faceted and deep-rooted challenge of FWA in India. To fully tackle this issue, we must equip, educate and empower key stakeholders

5.1 Roadmap

Working towards a high-integrity, data-driven health insurance ecosystem will require a clear, measurable roadmap to progressively reduce FWA. Over the next decade, it is recommended that insurers, providers, TPAs, regulators, and customers, via their collective efforts, reduce FWA levels to approximately 5% by 2030, driven by digital enablement, standardized processes, and strong enforcement mechanisms. With deeper data integration, predictive analytics, and trust-based governance, it will be further targeted to be reduced to around 3% by 2040. The ultimate objective is to achieve near-zero FWA by 2047, as transparency, accountability, and integrity become fully institutionalized across the health insurance ecosystem.

This phased trajectory balances ambition with practicality—focusing first on structural reform and digital adoption, and later on sustained behavioral change and intelligence-led monitoring. Achieving near-zero FWA by 2047 will not only secure financial resilience but also reinforce public trust, paving the way for a transparent, equitable, and sustainable health insurance ecosystem aligned with the vision of Viksit Bharat 2047

In the near term, all stakeholders must focus on operationalizing Connected Care and predictive monitoring through digital integration and AI adoption. Interoperable systems under ABDM and NHCX, unified coding and tariff standards, and AI-driven analytics together will form the digital backbone for prevention and detection. Parallely, capacity-building programs to upskill personnel in data management, analytics, and compliance will be essential to ensure smooth adoption and operational continuity.

across the ecosystem. Concerted efforts by providers, payers and TPAs, policymakers and customers will be crucial to building a system rooted in transparency, accountability, and trust.

In the medium term, the roadmap calls for institutionalizing trust infrastructure and legal guardrails that reinforce behavioral accountability. This includes codifying FWA under national insurance law, setting up a fraud registry, and developing Provider and Member Trust Scores that transparently reward integrity and penalize malpractice. Thus the system can gradually shift from reactive oversight to proactive self-regulation. Moreover, forming a Joint Governance Council comprising of regulators, payers, providers, and technology experts will ensure continued monitoring, and iterative policy evolution.

Over the longer horizon, India must strive to create a unified, intelligent, and self-learning health ecosystem—where every claim, transaction, and intervention is traceable, standardized, and driven by real-time data. This will require continued investment in GenAI and automation to move from rule-based compliance to autonomous, integrity systems. As interoperability matures and data symmetry deepens, stakeholders will operate on a common foundation of truth, ensuring that efficiency, transparency, and accountability become the defining hallmarks of India's healthcare architecture.

Through this phased implementation plan, India can not only curb FWA but also set a global benchmark for ethical, equitable, and technology-driven healthcare governance. Within the broader Viksit Bharat 2047 vision, this roadmap must anchor financial prudence and operational resilience—leveraging AI-driven, real-time FWA control systems to protect value, strengthen public confidence and sustain the affordability of India's healthcare promise.

5.1.1 Target Outcomes

The objective is to minimize FWA losses, with the system **progressively advancing towards a near-zero threshold—targeting FWA levels less than 1% of total claims**. Beyond quantitative reduction, the broader ambition is to establish a trusted, transparent, and ethically resilient health insurance ecosystem that upholds integrity and accountability across all stakeholders.

Reducing FWA within the health insurance ecosystem will generate downstream benefits for patients and the broader economy. Lower leakage and inefficiency will allow insurers to pass on savings through more affordable

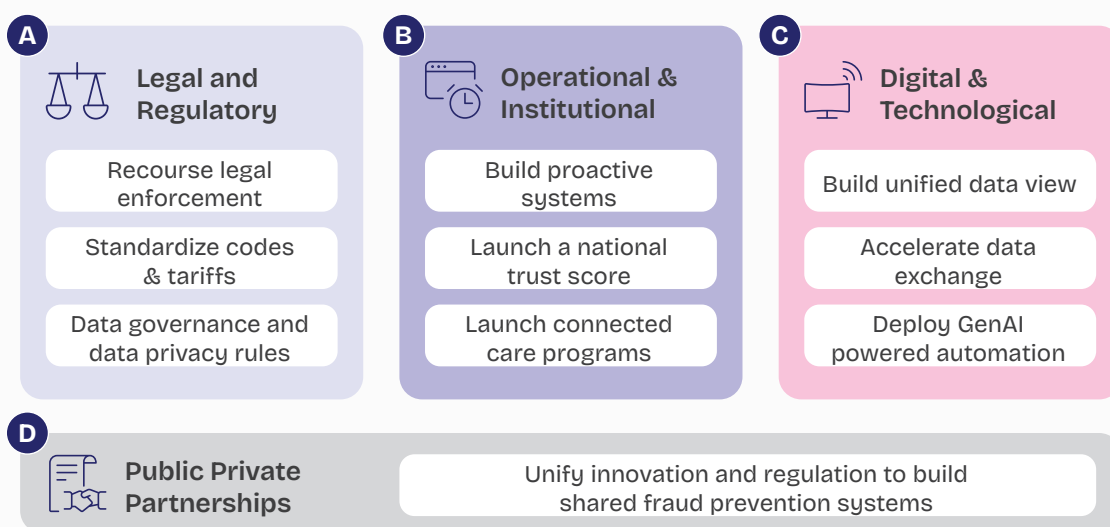
premiums and enhanced coverage options, thereby increasing public confidence and participation in health insurance. This, in turn, will attract greater investment into the sector, expand risk pools, and accelerate progress toward universal coverage, narrowing the insurance gap that remains a key barrier to equitable healthcare access. Such systemic efficiency aligns directly with the 'Insurance for All' mission under Viksit Bharat 2047, fostering a virtuous cycle where integrity drives affordability, affordability drives inclusion, and inclusion strengthens the overall resilience of India's health system.

5.1.2 Key Initiatives

To strengthen integrity across India's health insurance ecosystem, stakeholders must adopt a holistic strategy that combines legal, operational, and digital reforms to standardize processes,

strengthen governance, and enable data-driven fraud prevention to build a high-integrity health insurance ecosystem.

EXHIBIT 21: Key Initiatives



A Legal and Regulatory Initiatives

- **Strengthen legal recourse and enforcement** by codifying FWA offences, penalties, and investigation processes within insurance law to ensure deterrence and accountability.
- **Standardize codes, tariffs, and claim protocols** through a national codebook and central tariff repository to promote uniformity and regulatory consistency.
- **Define data governance rules and establish data privacy frameworks** that define who owns health data, who can access it, and under what consent—protecting patient privacy while allowing responsible use for care delivery, claims processing, and fraud prevention

B Operational and Institutional Initiatives

- **Build proactive and predictive FWA systems** to move from reactive policing to continuous, intelligence-led surveillance.
- **Launch a national trust score**, one for provider and payer to track performance, efficiency, and compliance, linking metrics to incentives.
- **Introduce connected care and preventive health programs** to reduce avoidable claims and align incentives toward wellness and long-term outcomes.

C Digital and Technological Initiatives

- **Develop a unified data view** connecting payers, providers, and TPAs for real-time risk analysis and cross-validation.
- **Accelerate secure and seamless data exchange** by integrating with ABDM, NHCX, and other national digital rails.
- **Deploy GenAI-powered automation** and advanced analytics for early anomaly detection and continuous learning.

D Public Private Partnerships

Public-private partnerships (PPPs) can be instrumental in combating health insurance fraud by uniting the innovation and technological capabilities of the private sector with the regulatory oversight and standard-setting authority of the government. Private insurers, analytics firms, and technology partners can jointly build AI-driven fraud detection tools, predictive algorithms, and digital verification systems, while public bodies ensure standardization, interoperability, and ethical governance. To translate this collaboration into impact, three actions are critical:

- **Establish a shared national fraud intelligence platform** to enable real-time data exchange and risk scoring.
- **Develop a unified 'Health Integrity Score'**, similar to CIBIL—benchmarking provider and member behavior across insurers.
- **Create joint innovation labs and pilot programs** to continuously refine fraud detection models and set industry-wide protocols.

Such partnerships can institutionalize integrity, enhance transparency, and make India's health insurance ecosystem more secure and trusted. Across the world, we've seen how industry collaboration and data sharing can transform the fight against FWA. For example, in the United States, the **Coalition Against Insurance Fraud (CAIF)** brings together more than 250 insurers, consumer-advocate groups and regulatory agencies to pool fraud-intelligence, coordinate investigations and share best practices. According to CAIF, total insurance-fraud losses in the U.S. are estimated at approximately US \$308.6 billion annually, of which healthcare fraud alone exceeds US \$105 billion¹. The value of real-time data-sharing and industry alignment is clear: by enabling earlier detection and eliminating duplicate investigations, insurers reduce costs, help hold bad actors accountable and protect policyholders from higher premiums

In Brazil, the **Agência Nacional de Saúde Suplementar (ANS)** (Brazilian federal agency, linked to the Ministry of Health, responsible for regulating and overseeing the private health insurance sector) regulates the private health insurance sector and has increasingly enabled public-private intelligence and data-collaboration platforms. Although Brazil-specific fraud-loss figures are scarce, ANS has overseen a private health insurance segment covering over 50 million beneficiaries and representing nearly one-third of the country's total health expenditure². Through regulatory mandates and shared data frameworks, ANS is shaping a model where public oversight and private innovation converge to deliver real-time visibility, coordinated analytics and evidence-based decision-making—offering a blueprint for integrity-driven ecosystems in other markets.

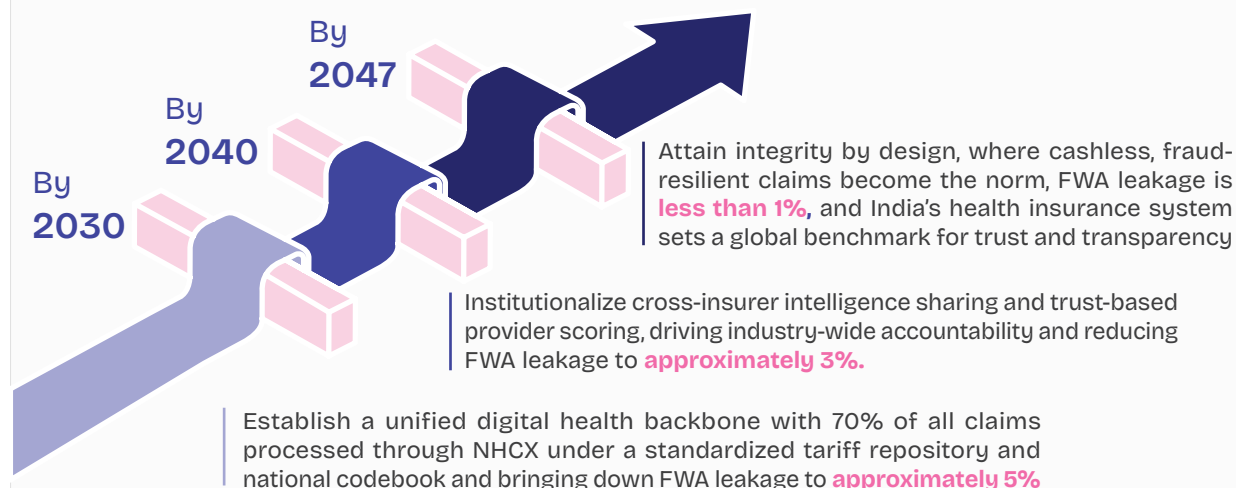
1. Coalition Against Insurance Fraud. Facts + Statistics: Fraud = Ill; 2. Ahangar Atashi, Z. "Brazil's ANS Strengthens Health Plan Regulations Over Two Decades." Market Access Today, 13 February 2025

5.1.3 Key Milestones

India's roadmap for building a fraud-resilient health insurance ecosystem is structured around a phased reduction of FWA through progressive digital integration and governance reforms to chart the journey towards achieving the Viksit Bharat 2047 vision of 'Insurance for All'. By 2030, the goal is to reduce FWA levels to approximately 5%, driven by digital enablement, standardized codes and tariffs,

and strong enforcement mechanisms, and adopting a unified health data backbone. By 2040, the target is to further reduce FWA to around 3%, fostering industry-wide accountability. The ultimate vision for 2047 is to achieve an almost near-zero FWA—positioning India's health insurance ecosystem as a global benchmark for transparency, efficiency, and trust.

EXHIBIT 22: Roadmap to 2047: Key Milestone



5.2 Call to Action

Delivering on this bold ambition of building a high integrity, data-driven health insurance ecosystem will require all stakeholders to come together and act in unison. The actions should be mutually reinforced to multiply the impact and leverage synergies across underwriting standards, claims

procedures, approvals, systems integrations, doctors' and insurers' practices and government policies. Outlined below are stakeholder-specific initiatives identified for prompt execution to drive systemic impact:

Insurers and TPAs: Institutionalizing Integrity and Intelligence through Robust Systems

Insurers and TPAs together must lead the transformation of India's health insurance ecosystem by embedding proactive, data-driven FWA controls into daily operations. Acting as a unified operational and digital backbone, they play a critical role in enabling seamless data exchange, real-time validation, and intelligence-led decision-making. This transformation requires:

- Standardizing codes and tariffs and ensuring all claims are machine-readable and rule-based, enabling consistency across insurers and TPAs.
- Creating a unified data view and interoperable frameworks that connect insurers, TPAs, and

providers for real-time anomaly detection and predictive monitoring.

- Accelerating integration with national digital rails such as ABDM and NHCX to enable instant eligibility checks, pre-authorization, and adjudication through AI-based rule engines.
- Partnering with providers to digitize claims workflows and improve accuracy in documentation and discharge processes.
- Maintaining unified, immutable audit trails and deploying secure APIs for eligibility verification and anomaly escalation across multiple insurers and provider networks.

- Deploying GenAI-powered adjudication engines to augment human review, automate document verification, and enhance pre-payment risk scoring.
- Developing analytics dashboards that track claims turnaround times, rejection reasons, and fraud indicators, strengthening transparency and accountability.
- Launching connected care initiatives and shared health scoreboards linking provider and member behavior to compliance and incentive structures.
- Building secure, analytics-driven data rails in partnership with regulators and technology partners to enable continuous fraud monitoring and intelligence sharing.
- Partnering with technology firms and regulators to build connected care ecosystems and secure, analytics-driven data rails for early fraud detection.

Together, these measures enable insurers and TPAs to evolve from reactive policing to preventive, intelligence-led governance, institutionalizing integrity, strengthening trust, and enhancing efficiency across the health insurance value chain.

Providers: To Lead and Follow Digital Discipline and Trust at The Point of Care

Hospitals and clinics must anchor integrity at the front line by digitizing their clinical and billing workflows end-to-end. Key imperatives include:

- Adopting standardized codes, tariffs, and documentation templates to ensure interoperability and transparency.
- Integrating with shared health data exchanges and participating in Connected Care programs to improve outcomes while reducing duplication and misuse.
- Aligning with trust score frameworks through real-time dashboards that monitor coding accuracy, compliance, and audit readiness.
- Strengthening operational efficiency and governance by partnering with payers and TPAs, and technology partners to co-develop streamlined claims management, pre-authorization, and audit processes.
- Collaborative pilots on automation and analytics can help identify systemic inefficiencies, improve turnaround times, and reduce manual errors.

By working together to design standardized digital interfaces and feedback loops, providers can build mutual trust with insurers, enhance process predictability, and ultimately deliver faster, fairer, and more transparent patient journeys.

By institutionalizing digital and operational rigor, providers can establish themselves as preferred, high-integrity partners and set new benchmarks for ethical care delivery. However, it is equally important that providers across the ecosystem collectively adopt and adhere to these standards. In the absence of a uniform framework to assess performance and ethical conduct, reputable providers often risk being perceived on par with non-compliant peers, eroding trust and diminishing the incentives for maintaining high standards. Establishing transparent, data-driven benchmarks for quality and integrity will therefore be critical to safeguarding the reputation of credible providers while elevating overall sectoral accountability.

Policy Makers and Regulators: To Codify and Govern FWA Systemically

Embedding FWA within the formal framework of insurance regulation is a critical step toward systemic governance. This approach involves:

- Codifying offences, penalties, and investigation procedures to establish a strong legal deterrent.
- Implementing a national codebook and central tariff repository to ensure uniformity across the sector.
- Accelerating development of a unified Health Stack that integrates clinical, claims, and administrative data layers to enable real-time validation and interoperability.
- Institutionalizing standardized data and process protocols across insurers, TPAs, and hospitals, to promote consistency in reporting, coding, and claims adjudication.
- Building a secure, interoperable data infrastructure that connects payers, providers, and TPAs within a unified governance framework.
- Creating a national health performance scoreboard and model governance standards for transparency and benchmarking.
- Embedding privacy-by-design principles and robust data governance protocols that safeguard information while ensuring accessibility.

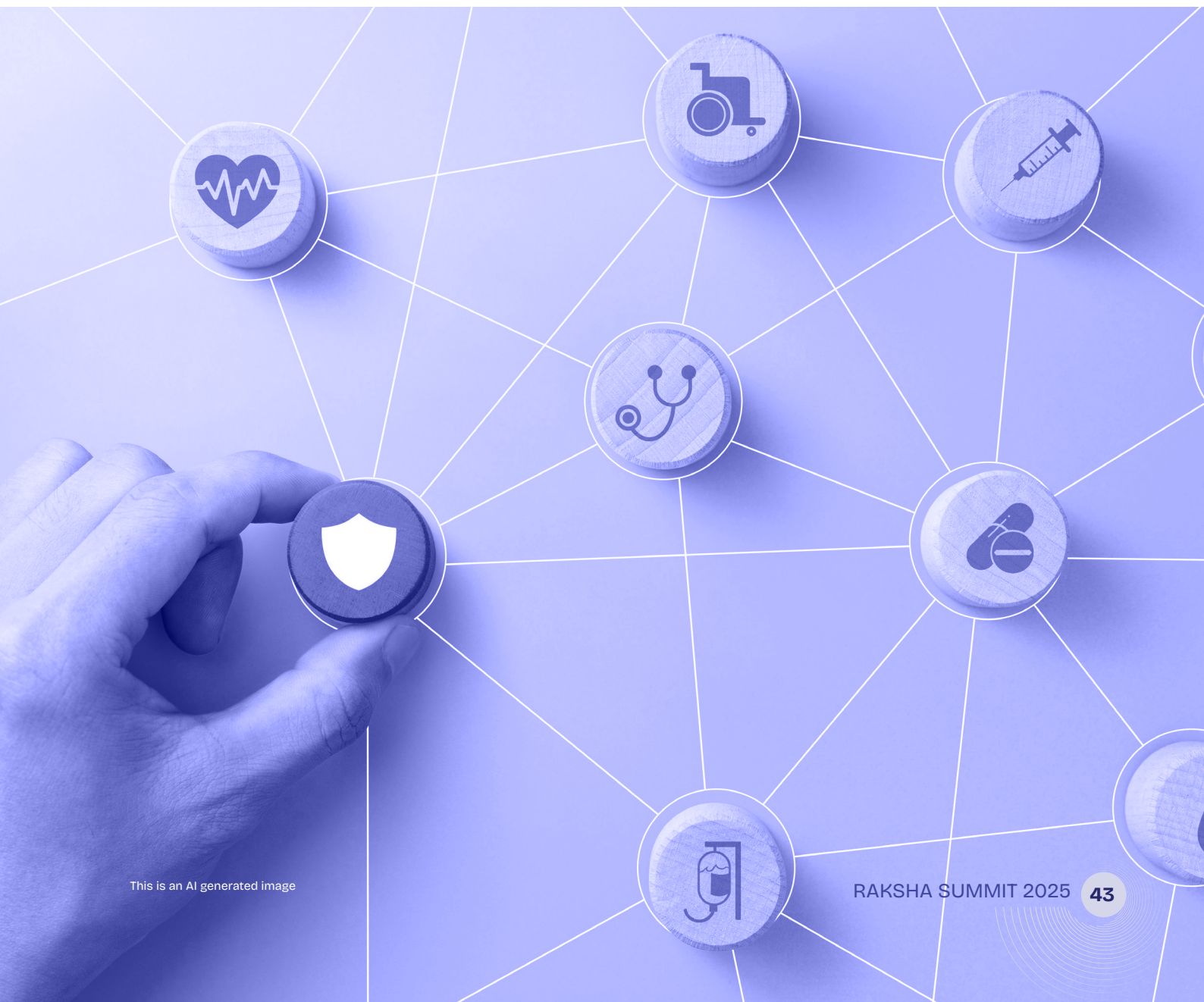
Collectively, these measures enable regulators to replace fragmented oversight with a cohesive, resilient governance architecture that rebuilds trust and integrity across India's health insurance ecosystem.

Customers: To Shift Mindsets and Champion Responsible Participation

Building a high-integrity health insurance ecosystem also depends on customers taking ownership of ethical participation. Individuals must stop seeing fraud and misuse—like inflated bills or false claims—as harmless. These actions raise costs, erode trust, and weaken the system for everyone. Key imperatives include:

- Recognizing that every instance of misuse contributes to higher premiums and reduced coverage quality.
- Ensuring honesty and accuracy in health declarations, claim submissions, and documentation.
- Reporting suspected fraud or overcharging through designated insurers or regulatory channels.
- Actively engaging in preventive care and responsible healthcare utilization as indicators of good citizenship.

By rejecting complacency and embracing accountability, customers can become active partners in preserving integrity ensuring India's health insurance system evolves into one that is transparent, fair, and sustainable.



This is an AI generated image

Conclusion

The analysis throughout this report underscores that FWA in healthcare and health insurance are not isolated lapses or mere operational inefficiencies. They are systemic, multi-layered challenges that lie at the very core of India's healthcare affordability and access crisis. FWA silently inflates healthcare costs, distorts incentives, and erodes the fundamental trust between patients, providers, and payers. It drains limited public and private resources that could otherwise be directed toward expanding coverage, improving care quality, and strengthening the health system's resilience. Left unaddressed, it risks undermining the promise of Ayushman Bharat and weakening the broader vision of universal health coverage. Conversely, addressing FWA is among the most powerful and achievable levers to make health insurance truly inclusive, transparent, and sustainable. By curbing leakages and inefficiencies, India can stabilize insurance premiums, reduce fiscal pressures, and make protection accessible to millions of currently uninsured citizens—building the foundation for a fair, efficient, and trustworthy healthcare ecosystem.

The goal is clear and urgent: to make health insurance the financial and ethical backbone of Viksit Bharat 2047, not a barrier to it. This requires reimagining the ecosystem where every Indian has access to affordable, dependable, and equitable coverage; where out-of-pocket expenditure is minimal; and where fraudulent or wasteful practices become anomalies rather than systemic norms. Achieving this vision demands not only technological modernization but also a fundamental cultural and institutional shift toward accountability, integrity, and shared responsibility.

If implemented with urgency, discipline, and collaboration, the roadmap outlined in this report can deliver transformative dividends for India's health system and economy alike. A fraud-resilient, data-driven, and interoperable insurance ecosystem will not only strengthen financial protection but also catalyze productivity, innovation, and trust across the healthcare value chain. It will enable policy coherence, attract private investment, and nurture an environment where ethical conduct and efficiency reinforce one another. Ultimately, eliminating FWA is not merely an industry reform—it is a national mission.

A reduction in FWA can trigger a **virtuous cycle** that strengthens the foundations of India's health system. As FWA declines, overall claims stabilize, curbing healthcare inflation and allowing insurers to offer more affordable premiums. Lower premiums enhance accessibility, drawing more citizens into the insurance fold and reducing their dependence on out-of-pocket expenditures. With broader risk pools and higher coverage, the financial health of insurers improves, enabling greater reinvestment in innovation, digital transformation, and preventive health programs. Over time, better affordability fosters inclusion—ensuring equitable access to quality healthcare—while improved compliance and preventive care lead to healthier populations and more resilient communities. This integrity-driven cycle reflects the **Viksit Bharat 2047 vision**—where integrity ensures affordability, affordability drives inclusion, and inclusion builds a resilient, self-sustaining health system.

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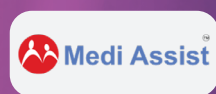
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