

BRIDGING THE MISSING MIDDLE: AN ADAPTIVE UNIVERSAL COVERAGE FRAMEWORK FOR ADVANCING HEALTH EQUITY AND CONTINUOUS ACCESS TO CARE: EVIDENCE FROM INDIA AND LESSONS FROM MEDICARE, MEDICAID, AND THE AFFORDABLE CARE ACT

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ABSTRACT

Background: India's Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY), the world's largest publicly financed health insurance program, has extended catastrophic-expenditure protection to over 500 million people. Yet a vast population of 300–400 million informal-sector workers, gig-economy labourers, and lower-middle-income households remains stranded between the poor covered by PM-JAY and the affluent insured through private markets. This structural exclusion, commonly termed the 'missing middle,' exposes a critical blind spot in India's architecture for Universal Health Coverage (UHC).

Objective: This paper develops a theoretically grounded, comparative health policy framework to explain the structural persistence of the missing middle and to derive actionable design lessons from four major United States financing models, Medicare, Medicaid, the Affordable Care Act (ACA) marketplaces, and regulated private insurance, for a sustainable, equitable, and administratively feasible Indian health financing architecture. It also argues that the central limitation of PM-JAY is not simply incomplete insurance coverage, but the persistence of outpatient exclusion as a mechanism of stratified access, delayed treatment, and uneven therapeutic security across class, geography, and social position

Methods: I employ a multi-layered comparative institutional analysis, integrating strategic purchasing theory, principal–agent frameworks, health economics, and equity frameworks (Andersen Behavioural Model; horizontal and vertical equity). Secondary data from official government sources, peer-reviewed literature, regulatory publications, and international organizations are triangulated across six analytical dimensions: target population, benefit design, financing, delivery model, financial protection outcomes, and system weaknesses.

Findings: The missing middle persists because of the interaction of five structural forces:

1. labour market informality rendering contributory mechanisms infeasible;
2. the complete absence of an income-linked subsidy architecture;
3. fragmented risk pools driving adverse selection;
4. the exclusion of outpatient and pharmaceutical coverage from all public schemes, which accounts for ~60% of out-of-pocket expenditure; and
5. weak consumer protection and federal-state fiscal misalignment.

A 2024 BMC Health Services Research study (Garg et al.) confirms that despite scale, PM-JAY has not measurably improved utilisation, quality, or financial protection after four years. The ACA reduced the US uninsured rate to a historic low of 7.7% by 2023, with 44 million enrolled in ACA-linked programmes by 2024. Medicaid expansion reduced racial disparities in infant and cardiovascular mortality. Medicare's prospective payment system introduced efficiency-aligned incentives that PM-JAY's administrative package-rate system conspicuously lacks.

Proposed Framework: I introduce the Multi-Tiered Universal Health Coverage Architecture (MT-UHCA) for India, comprising four interlocking tiers: a tax-funded entitlement for the poor and elderly (anchored in PM-JAY); a subsidised 'Ayushman Marketplace' for the missing middle; regulated private insurance integrated through the National Health Claims Exchange (NHCX); and a cross-cutting outpatient and pharmaceutical benefit. The framework is operationalised through India's Ayushman Bharat Digital Mission (ABDM), which by 2026 has created over 90 crore ABHA health IDs, providing the digital public infrastructure to enable portability, risk adjustment, fraud control, and efficient subsidy delivery.

Conclusions: Bridging the missing middle is simultaneously a moral imperative and a prerequisite for India achieving UHC. No single financing instrument, whether tax-funded, contributory, or market-based, can resolve this structural challenge in isolation. A hybrid model combining public financing, regulated private markets, income-linked subsidies, outpatient coverage, and digital infrastructure offers the most feasible pathway. This paper contributes a

replicable conceptual and policy framework for other lower-middle-income countries grappling with analogous coverage-gap challenges. It also reframes outpatient exclusion as a health equity problem rather than a narrow issue of benefit incompleteness. It explains why insurance expansion does not automatically translate into equitable access when the most frequently used services remain outside effective protection. It develops a comparative access-centered argument showing that the most relevant international lessons for India concern benefit comprehensiveness, continuity of care, consumer protection, portability, and protection against underinsurance rather than payment architecture alone. This paper argues that scale and financial protection are not synonymous. Despite covering over 500 million people, a 2024 peer-reviewed study found that PM-JAY has not significantly improved healthcare utilisation or financial protection. The paper identifies PM-JAY's principal limitation as the exclusion of outpatient and pharmaceutical services, which account for nearly 60% of household health expenditure. It therefore reframes the policy challenge from expanding enrolment to redesigning insurance benefits, offering a more realistic assessment of what the world's largest publicly funded health insurance programme has achieved and what reforms are needed.

KEYWORDS: *Universal Health Coverage; PM-JAY; Ayushman Bharat; Missing Middle; Affordable Care Act; Medicaid; Medicare; Health Equity; Financial Protection; Strategic Purchasing; Risk Pooling; India; Comparative Health Policy*

1. INTRODUCTION

Universal Health Coverage (UHC), the aspiration that all individuals receive essential health services without financial catastrophe, sits at the apex of contemporary global health policy. The World Health Organization's normative framework articulates three interrelated dimensions of UHC: the breadth of population covered, the depth of services included, and the height of financial protection afforded (WHO, 2010)¹⁸. For a lower-middle-income country of India's scale and heterogeneity, achieving UHC is not merely a policy goal but a civilisational undertaking of enormous technical and political complexity.

The launch of Ayushman Bharat in 2018 represented India's most ambitious attempt to expand financial protection. The Economic Survey 2024–25 credits the programme with generating savings of over ₹1.25 lakh crore in out-of-pocket expenditure (OOPE), and government health expenditure as a proportion of total health spending rose from 29% in 2015 to 48% in 2022, while OOPE declined from 62.6% to 39.4% (MoHFW, 2023)¹⁴. By any measure, PM-JAY represents an extraordinary operational achievement.

Yet this achievement is haunted by a structural paradox. Despite unprecedented scale, a 2024 rigorous evaluation published in *BMC Health Services Research* found that PM-JAY had not made a measurable impact on improving utilisation, quality, or financial protection after four years of implementation with private hospitals continuing to overcharge patients, and purchasing remaining ineffective in regulating provider behaviour (Garg et al., 2024)⁵. Moreover, India's dominant source of household health impoverishment, outpatient care, medicines, and diagnostics, accounts for approximately 60% of OOPE, yet remains entirely uncovered by PM-JAY's inpatient-only benefit design. The result is a structural vacuum: a population of 300–400 million people, informal workers, gig-economy labourers, self-employed households, urban migrants, and lower-middle-income families, who are ineligible for PM-JAY yet cannot afford private insurance. Mahal et al. (2024)¹¹ rigorously estimate the missing middle at a minimum of 300–350 million, with the NITI Aayog placing approximately 30% of India's total population in this unprotected zone (NITI Aayog, 2021). NFHS data reveal that only 9.7% of people in the poorest income quintile carry any health insurance, compared to 36.4% in the richest, underscoring the equity dimension of this failure.

This paper argues that resolving the missing middle requires a fundamental rearchitecting of India's health financing system, not incremental adjustments. The United States, despite being a fragmented, high-income system far removed from India's context, has generated a century of institutional experimentation across distinct financing archetypes: Medicare (age-based universal entitlement), Medicaid (income-based federal–state financing), the ACA (regulated competitive marketplaces with income-linked subsidies), and private insurance. Each offers analytically separable design lessons that can be adapted, not transplanted, to India's political economy, labour market realities, and digital health ecosystem.

Our central contribution is threefold. First, we develop a conceptual framework, the Three Structural Gaps Model (eligibility, affordability, portability), to explain why the missing middle persists despite India's impressive UHC investments. Second, we apply a six-dimensional comparative institutional analysis across PM-JAY, Medicare, Medicaid, the ACA, and Indian private insurance to extract design principles for each gap. Third, we introduce the **Multi-Tiered Universal Health Coverage Architecture (MT-UHCA)**, a four-tier policy framework grounded in India's fiscal constraints, federal structure, and rapidly maturing digital public infrastructure.

This paper argues that PM-JAY's remarkable scale should not be equated with effectiveness, as operational achievements (cards issued and hospitals empanelled) have often been mistaken for financial protection. It further reframes the "missing middle" as a structural consequence of benefit design, labour market characteristics, and

financing architecture rather than a simple coverage gap, offering important lessons for other LMICs pursuing universal health coverage.

2. Background: India's Health Financing Architecture

2.1 Historical Trajectory

India's post-independence health policy was shaped by the 1946 Bhore Committee Report's vision of a tax-funded, prevention-oriented, universally accessible system (Bhore Committee, 1946)¹. This vision was never realised. Decades of fiscal constraints and competing developmental priorities produced a structurally fragmented health system characterized by underfunded public healthcare facilities, with government health expenditure remaining around 1–1.5% of GDP for many years. At the same time, the private sector emerged as the dominant provider of healthcare, accounting for approximately 70% of outpatient care and 55% of inpatient care. Furthermore, out-of-pocket expenditure (OOPE) exceeded 60% of total health expenditure until the mid-2010s. Together, these features placed the primary financial burden of healthcare on households, contributing to catastrophic health expenditure and pushing millions of families into poverty (National Health Accounts, MoHFW; NSS 75th Round, 2019; WHO Global Health Expenditure Database). Together, these structural characteristics shifted a substantial share of healthcare costs onto households, contributing to catastrophic health expenditure and driving millions of families into poverty.

The Rashtriya Swasthya Bima Yojana (RSBY), launched in 2008, introduced important innovations, cashless hospitalisation, smart-card-based beneficiary identification, private provider inclusion, but remained constrained by low coverage limits, exclusion of outpatient care, and fragmented state-level implementation (La Forgia and Nagpal, 2012)⁹. These limitations directly informed the design of PM-JAY.

2.2 Persistent Fragmentation and the Limits of Coverage

Despite this progress, India's health financing architecture remains fragmented across: central schemes (PM-JAY, CGHS, ESIC); state-specific schemes (Aarogyasri, Karunya, BSKY); private insurance markets regulated by IRDAI; employer-provided group insurance; and out-of-pocket payments. This fragmentation produces uneven coverage, duplication, and administrative inefficiencies. OOPE still constitutes approximately 39.4% of total health spending — among the highest in comparable economies — and a 2025 study found that out-of-pocket expenditure accounts for 49.8% of total health spending, among the highest globally.

2.3 Digital Infrastructure: ABDM and NHCX

The Ayushman Bharat Digital Mission (ABDM), launched in 2021, introduced a foundational digital layer: ABHA unique health identifiers, Personal Health Records, Health Information Exchange protocols, and provider registries. By 2026, over 90 crore ABHA IDs had been created, positioning ABDM as one of the world's largest digital health ecosystems. Complementing ABDM, the National Health Claims Exchange (NHCX) developed in collaboration with IRDAI aims to standardise claims processing across PM-JAY and private insurers, enabling portability, fraud control, risk adjustment, and future subsidy delivery. This digital infrastructure represents a uniquely enabling context for health financing reform not available to most LMICs.

3. Conceptual Framework: Understanding the Missing Middle

The persistence of India's missing middle is not an administrative accident. It is a predictable structural outcome of the country's labour market composition, income distribution, and institutional design. This section develops a multi-dimensional conceptual framework synthesising health economics, political economy, and comparative social policy to articulate the mechanisms of exclusion.

3.1 Adverse Selection and Market Failure

Voluntary health insurance markets are inherently vulnerable to adverse selection: individuals with higher expected healthcare needs are disproportionately likely to enrol, driving up premiums and deterring healthier individuals (Cutler and Zeckhauser, 1998)⁴. In India, this dynamic is intensified by limited actuarial data for informal workers, high chronic disease prevalence among middle-aged populations, weak regulatory enforcement, and low financial literacy. Private insurers respond by increasing premiums, imposing waiting periods, excluding pre-existing conditions, and designing products with high deductibles. Without a risk adjustment mechanism, a central design feature of the ACA marketplaces, insurers cannot pool risk across heterogeneous populations, reinforcing the exclusion cycle (McWilliams, 2016)¹².

3.2 The Three Structural Gaps Model

We introduce the **Three Structural Gaps Model** to systematically organise the barriers preventing the missing middle from accessing financial protection:

3.3.1 Eligibility Gap:

The eligibility gap reflects one of the inherent trade-offs of targeted social protection programmes. Although targeting improves fiscal efficiency by concentrating public resources on the poorest households, it can also generate exclusion errors, whereby financially vulnerable households that do not meet formal eligibility criteria remain without adequate financial protection (Ravallion, 2016)¹⁵.

3.3.2 Affordability Gap: According to IRDAI (2023), average annual premiums for family floater health insurance plans range from ₹20,000 to ₹35,000 equivalent to 10–20% of annual income for many lower-middle-income households. Without subsidies, tax credits, employer contributions, or community-rated premiums, the affordability gap persists. This stands in stark contrast to the ACA, where sliding-scale premium tax credits significantly increased enrolment among middle-income American households (Sommers et al., 2015)¹⁶.

3.3.3 Portability Gap: India's internal migration patterns — estimated at over 450 million internal migrants — create a coverage continuity challenge exacerbated by geographic network restrictions and differential reimbursement rates in private insurance products. While PM-JAY offers national portability, the absence of a unified claims exchange (until NHCX's emergence) has contributed to insurance discontinuity for migrant workers, an issue of growing health equity significance in rapidly urbanising India.

3.3 Political Economy Constraints

The missing middle problem is structurally shaped by political economy dynamics. Targeted schemes like PM-JAY generate concentrated, visible benefits for identifiable groups (the poor), creating strong political incentives for continued expansion. In contrast, subsidising the missing middle requires significant fiscal outlays for a diffuse, heterogeneous, and politically under-mobilised population. These dynamics closely mirror the contested political economy of the ACA's passage, where middle-class subsidies faced substantial legislative opposition. In India, expanding coverage to the missing middle requires political incentives that do not yet exist at scale.

3.4 The Need for a Multi-Tiered Architecture

The Three Structural Gaps Model demonstrates that the missing middle persists due to the interaction of labour market informality, adverse selection, absent subsidies, high premiums, fragmented risk pools, portability challenges, limited outpatient coverage, and political economy constraints. These mutually reinforcing barriers imply that no single financing mechanism, whether tax-funded, contributory, or market-based, can insure the missing middle in isolation. India requires a multi-tiered architecture that integrates the strengths of each financing modality: tax-funded entitlement for the poor and elderly; subsidised insurance for the missing middle; regulated private insurance; and comprehensive outpatient and pharmaceutical coverage.

This section introduces the **Three Structural Gaps Model (Eligibility, Affordability, and Portability)** as a replicable framework for diagnosing the "missing middle" in health coverage. It argues that structural exclusion is driven not only by policy design but also by political economy, requiring institutional reforms that explicitly address these barriers. The framework provides lessons for LMICs designing universal health coverage systems.

4. Comparative Institutional Analysis

4.1 Medicare: Age-Based Universalism and Strategic Purchasing

Medicare, established in 1965, provides near-universal coverage for adults aged 65 and older. Its most significant structural feature is categorical universality — all individuals above the age threshold are eligible regardless of income or employment status, eliminating means-testing, exclusion errors, and political contestation over eligibility. India's 2024 extension of PM-JAY to all citizens aged 70+ directly mirrors this logic.

Medicare's Prospective Payment System (PPS), introduced in 1983, replaced cost-based reimbursement with fixed payments per hospitalisation based on Diagnosis-Related Groups (DRGs). Each DRG carries a relative weight derived from national cost data, adjusted for case-mix, geographic wage variation, teaching hospital status, and hospital characteristics. PPS created strong incentives for efficiency, reduced average length of stay, and enabled substantial cost containment without compromising quality (Cutler, 2019)³. Over time, Medicare layered value-based purchasing mechanisms: the Hospital Readmissions Reduction Program (HRRP) penalises avoidable readmissions; the Hospital Value-Based Purchasing (HVBP) programme links 2% of base payments to quality performance; and the Hospital-Acquired Condition Reduction Program (HACRP) penalises hospitals in the lowest-performing quartile on safety indicators. PM-JAY's administratively-set, case-mix-unadjusted package rates stand in stark contrast to this sophisticated incentive architecture.

Medicare's Fraud Prevention System (FPS) deploys predictive analytics, real-time claims monitoring, and provider profiling to detect suspicious billing before payment, a model directly applicable to PM-JAY's evolving anti-fraud infrastructure under ABDM.

4.2 Medicaid: Federal-State Financing, Managed Care, and Health Equity

Medicaid's joint federal-state financing architecture, the Federal Medical Assistance Percentage (FMAP), ranging from 50% to 83% based on state per-capita income — represents one of the most important fiscal equity mechanisms in comparative social policy. By providing higher federal matching rates to lower-income states, FMAP incentivises participation while protecting against fiscal inequity. India's PM-JAY uses a uniform 60:40 (90:10 for northeastern states) cost-sharing formula that does not account for state fiscal capacity, a structural weakness that produces systematic inequity in coverage quality across Indian states.

More than 70% of Medicaid beneficiaries are now enrolled in Managed Care Organisations (MCOs) that receive capitated payments to deliver services (MACPAC, 2022)¹⁰. Capitation with risk adjustment ensures actuarially sound

rates, prevents cream-skimming, and incentivises care coordination and preventive care. MCOs are held accountable through network adequacy rules, HEDIS quality metrics, patient experience scores, performance-based withholds and bonuses, and contractual sanctions including payment withholding and contract termination. This accountability architecture is substantially more sophisticated than PM-JAY's current monitoring mechanisms.

Evidence on Medicaid expansion's equity impact is compelling. Studies demonstrate significant reductions in racial disparities in infant mortality, cardiovascular mortality, and end-stage renal disease outcomes in expansion states (KFF, 2024)⁷. The ACA's Medicaid expansion to adults with incomes up to 138% of the federal poverty level has yielded measurable reductions in mortality and uncompensated care (Miller et al., 2021)¹³. However, a 2024 UNC Gillings study¹⁷ cautioned that racial equity benefits were not uniform; white individuals experienced three times the all-cause mortality reduction compared to Black individuals in the context of Medicaid expansion post-incarceration, underscoring that insurance expansion alone cannot resolve structural racism in healthcare delivery (UNC Gillings, 2024).

4.3 The ACA Marketplace: Subsidies, Standardised Benefits, and Risk Architecture

The Affordable Care Act (2010) addressed the US coverage gap, millions of Americans too poor for private insurance yet not poor enough for Medicaid, through a marketplace architecture that directly parallels India's missing middle challenge. By 2024, ACA-linked programmes enrolled 44 million people, roughly 1 in 6 Americans under 65 (KFF, 2024)⁶. The national uninsured rate fell to 7.7% by Q4 2023, with 21.4 million selecting marketplace plans in 2024 — 4 out of 5 paying \$10 or less per month after subsidies (CBPP, 2024)². Between 2013 and 2022, uninsured rates among Latino people fell from 29.7% to 17.8%, among Black people from 18.7% to 9.9%, and among American Indian/Alaska Native people from 23.8% to 14.1% — demonstrating the equity power of subsidised marketplace mechanisms.

The ACA's four foundational design levers are directly transferable in principle to India's missing middle challenge:

1. **Essential Health Benefits (EHBs)** mandate outpatient services, prescription drugs, mental health, and preventive care across all marketplace plans;
2. **Income-linked premium tax credits** stabilise premiums and incentivise enrolment of healthier individuals;
3. **Community rating** prohibits pricing based on health status; and
4. **Risk stabilisation mechanisms** — risk adjustment, reinsurance, and risk corridors — prevent adverse selection and ensure insurer solvency.

The critical lesson for India: the ACA's success derived not from any single lever but from their coordinated, simultaneous deployment.

However, recent evidence reveals the ACA's vulnerabilities under political pressure. In 2026, with enhanced premium tax credits threatened by legislative expiration, 9% of marketplace enrollees became uninsured and 17% expressed uncertainty about affording their premiums for the full year (KFF, 2026)⁸. This underscores a crucial lesson: subsidy architecture must be institutionally protected, not politically contingent.

4.4 Indian Private Insurance: Market Failures and Regulatory Gaps

India's private health insurance sector, regulated by IRDAI, covers approximately 20% of the population, primarily formal-sector workers and upper-income households. Medical underwriting excludes high-risk individuals; waiting periods of 30–90 days delay access to care; network restrictions limit portability; and claims denial rates remain elevated. Private family floater health insurance premiums often fall around ₹20,000–₹35,000 a year for many households, depending on age and coverage. For families earning ₹1–3 lakh annually, this can be a major affordability barrier, which is why private insurance access remains limited for India's 'missing middle'.

In contrast to the ACA's prohibitions on medical underwriting, community rating mandates, guaranteed issue requirements, and standardised benefits, India's private insurance market operates with far weaker consumer protections. The emerging NHCX platform has the potential to create an interoperability layer analogous to US Marketplaces but only if accompanied by parallel regulatory reform.

Comparative analysis shows that **PM-JAY, Medicare, Medicaid, ACA, and Indian private insurance all have structural gaps in outpatient and pharmaceutical coverage**, with the ACA coming closest to comprehensive OPD coverage through its Essential Health Benefits. This suggests that outpatient exclusion is a common weakness of insurance-based UHC models rather than an India-specific problem. The ACA's 2026 enrolment challenges demonstrate that insurance subsidies must be protected through legislation, not annual budgets, to ensure sustainability. Medicaid's experience further shows that expanding insurance alone does not guarantee health equity, highlighting the need for policies that also address structural social inequalities such as caste, gender, geography, and provider bias.

5. Implementation Pathway

5.1 Digital Infrastructure Integration

India's ABDM and NHCX provide a distinctive implementation advantage unavailable to previous generations of health reform. The pathway begins with:

1. mandatory ABHA linkage for all PM-JAY beneficiaries and Ayushman Marketplace enrollees;
2. NHCX integration for all public and private insurers to standardise claims;
3. digital pre-authorisation protocols for fraud control; and
4. unified provider registries for network adequacy enforcement.

These digital rails would enable income-linked subsidy calculation, DBT premium delivery, real-time eligibility verification, and inter-state portability closely analogous to the role played by HealthCare.gov and Medicare's claims infrastructure in the United States.

5.2 Fiscal and Federal Alignment

Drawing on Medicaid's FMAP formula, India should introduce a variable Centre-State cost-sharing arrangement calibrated to: state per-capita income; fiscal deficit levels; health system performance indicators; and coverage expansion targets. This would incentivise fiscally weaker states to expand coverage while reducing interstate inequities — one of the most persistent failures of the current PM-JAY architecture. Co-financing for Tier 2 Marketplace subsidies should follow a tri-partite model: central government base subsidy, state top-up contributions, and household income-linked premiums.

5.3 Provider Payment Reform

PM-JAY's administrative package-rate system must evolve toward case-mix-adjusted payments drawing on Medicare's DRG model: package rates updated based on national cost studies; case-mix and severity adjustments; quality-linked bonuses and penalties for readmissions or complications; and enhanced fraud control using predictive analytics. At the district level, pilot District Health Management Organisations (DHMOs) in 50 districts should receive capitated funding analogous to Medicaid MCOs, coordinating care across Ayushman Arogya Mandirs, community health centres, district hospitals, and empanelled private facilities.

5.4 Sequenced Reform Implementation

Reforms should be sequenced to maximise political feasibility and build momentum:

- **Phase 1 (Years 1–2):** Expand universal elderly PM-JAY coverage; pilot OPD sub-cap in 5 states; launch NHCX integration for all public insurers; update eligibility databases.
- **Phase 2 (Years 3–4):** Launch Ayushman Marketplace pilots in 5 geographically diverse states; introduce income-linked subsidies; establish risk adjustment mechanism; implement DHMO pilots in 50 districts.
- **Phase 3 (Years 5–7):** National rollout of Ayushman Marketplace; mandatory NHCX integration for all private insurers; DRG-based package rate reform; national OPD and drug benefit.
- **Phase 4 (Year 8+):** Full risk adjustment and managed care architecture; variable FMAP-style fiscal formula; independent evaluation and iterative refinement.

A critical political economy lesson from the ACA is that subsidy architecture must be institutionally entrenched, not legislatively precarious. The enhanced premium tax credits that drove the ACA's record 2024 enrollment nearly expired in 2026, creating significant uncertainty for millions of enrollees (KFF, 2026)⁸. India's Ayushman Marketplace subsidies must be embedded in a statutory framework, not annual budget allocations.

This section presents a phased implementation roadmap for the MT-UHCA, emphasizing that successful health financing reform depends on political sequencing as much as policy design. It proposes a three-level co-financing model for the Ayushman Marketplace and argues that health subsidies must be protected through legislation to ensure long-term sustainability across political cycles.

6. DISCUSSION

6.1 Theoretical Implications

The MT-UHCA contributes to three bodies of scholarship. First, it extends strategic purchasing theory beyond provider payment reform to encompass the full population-level architecture of health financing recognising that strategic purchasing requires not only how to pay providers but whom to insure, what to cover, and how to subsidise access. Second, the Three Structural Gaps Model (eligibility, affordability, portability) offers a replicable analytical framework for diagnosing coverage-gap populations in other LMICs characterised by labour market informality including Indonesia, Kenya, Nigeria, and Brazil. Third, the MT-UHCA demonstrates how rapidly maturing digital public infrastructure (DPI) can transform the feasibility calculus for complex, multi-payer health financing reforms in the Global South.

6.2 Limitations

This paper is primarily a comparative institutional analysis rather than an empirical evaluation. The policy recommendations are framed as design hypotheses grounded in existing evidence rather than new econometric identification. Crucially, the US context differs substantially from India's: per-capita income, state administrative capacity, health system maturity, political economy, and population heterogeneity are not comparable in magnitude. The MT-UHCA's design principles can be adapted not transplanted to India's context, and each tier requires rigorous context-specific piloting and evaluation before national scale-up.

7. CONCLUSION

India's pursuit of Universal Health Coverage stands at a structural inflection point. The launch of Ayushman Bharat in 2018 was a transformative achievement of historical significance extending the promise of cashless hospitalisation to over half a billion people in a lower-middle-income economy. Yet the persistence of the missing middle, 300 to 400 million people structurally excluded from both public and private insurance reveals that India's current health financing architecture is fundamentally incomplete. The missing middle is not an administrative oversight; it is a predictable outcome of labour market dualism, adverse selection, affordability barriers, benefit design failures, and fragmented risk pools.

This paper has demonstrated that the path toward insuring the missing middle cannot be found in any single financing instrument. Tax-funded universalisation alone is fiscally unsustainable; contributory insurance is administratively infeasible for informal workers; and unregulated private markets perpetuate exclusion through adverse selection and medical underwriting. The resolution requires a coherent multi-tiered architecture that simultaneously addresses all three structural gaps: eligibility, affordability, and portability.

The comparative analysis of Medicare, Medicaid, the ACA, and U.S. private insurance provides a rich repertoire of institutional design lessons not to transplant an American model to India, but to extract design principles for specific structural problems. Medicare's age-based universalism informs India's extension of PM-JAY to all 70+ citizens. Medicaid's variable federal-state FMAP formula offers a template for India's inter-state fiscal equalisation challenge. The ACA's marketplace architecture with income-linked subsidies, standardised benefit tiers, guaranteed issue, community rating, and risk stabilisation mechanisms provides the closest functional analogue to the Ayushman Marketplace proposed in this paper. Medicare's DRG-based prospective payment system illuminates the purchasing architecture reform PM-JAY urgently needs.

The MT-UHCA framework synthesises these lessons into a four-tier architecture, tax-funded entitlement, subsidised marketplace, regulated private insurance, and universal outpatient and pharmaceutical coverage operationalised through India's uniquely enabling digital public infrastructure: ABDM and NHCX. India in 2026 possesses something no previous generation of health reformers could rely upon: 90 crore ABHA health identifiers, a nascent national health claims exchange, and the world's largest digital beneficiary transfer infrastructure in the Direct Benefit Transfer system. These digital rails dramatically reduce the administrative cost and complexity of implementing a sophisticated, income-linked, risk-adjusted health financing architecture.

Ultimately, bridging the missing middle is not merely a technical policy challenge. It is a moral and developmental imperative. The daily reality of 300–400 million Indians delaying care because they cannot afford outpatient consultations, selling assets to pay for medicines, or avoiding hospitalisation until conditions become emergencies represents a structural failure of the Indian state's commitment to its citizens' dignity and wellbeing. The MT-UHCA offers a coherent, evidence-grounded, and contextually feasible roadmap toward a health financing system that truly leaves no Indian behind.

The paper concludes that achieving universal health coverage for India's missing middle requires a multi-tier financing approach rather than a single insurance scheme, and that India's digital health infrastructure now makes such a model feasible. Drawing on lessons from the U.S., it argues that layered financing institutions are essential for UHC and positions the MT-UHCA as a framework that can guide both India's reforms and health financing strategies in other LMICs.

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