

Group Health in India: Choosing Insurers and Fixing the Claim Journey

Business and product strategy case study, framed for Plum · IRDAI Annual Report 2024-25

Data: IRDAI Annual Report 2024-25, 29 general and standalone health insurers

Methods: market sizing, partner screening with sensitivity, renewal-price stress test, claims funnel, prioritisation

Independent outside-in analysis on public data. Not affiliated with or endorsed by Plum.

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1. Executive summary

Plum designs and services group health insurance for Indian employers and places the risk with insurers. Its renewal rate depends on two things it does not directly control: how insurers price at renewal, and how employees experience claims. Using the regulator's 2024-25 annual report, this paper answers two questions for Plum's leadership: **which insurers should carry its book, and where should its product team intervene in the claim journey?**

The answer in one line: concentrate placements on ten insurers that are profitable, solvent and growing, flag clients sitting with loss-making insurers before renewal, and attack deductions, the largest and least visible leak in the claim journey.

1. **Group health is large, growing and thin-margin.** It is ₹61,435 crore of premium (52.3% of health), up 10.4% in a year, covering 27.5 crore lives. Insurers paid out 92.4% of group premium as claims, against 77.9% on individual policies.
2. **Public-sector insurers are a renewal risk.** They write 36.0% of health premium but ran group business at a 103.6% claims ratio, after 103.1% the year before; three of the four report negative solvency. To reach an 85% claims ratio they would need to raise group premiums by about 22%.
3. **A strong partner panel exists.** Ten insurers combine a health claims ratio of 90% or less, solvency of at least 1.8 and over ₹1,000 crore of health premium. They write 48.0% of the market at a weighted claims ratio of 76%, and grew 11.2% against 5.3% for the public sector. The panel is stable when the thresholds move.
4. **Deductions, not rejections, are where employees lose money.** Of ₹1,32,488 crore claimed, 8.6% was rejected but 14.0% was deducted from claims that were otherwise paid: about ₹5,700 for every claim paid, against an average payment of ₹28,900. Count-based reporting, which says 87.5% of claims were paid, hides this completely.

Recommendations: build the placement strategy on the ten-insurer panel with a renewal-risk alert; make deductions visible before admission; push cashless by default using the regulator's new one-hour pre-authorisation rule; and run the business on a renewal KPI tree and dashboard (sections 6 to 8).

2. Situation, complication and question

Summary	
Situation	Group health is India's largest commercial health segment and is growing about 10% a year. Platforms such as Plum compete on plan design, service and claims support, not on carrying risk.
Complication	The insurers carrying a large share of the market lose money on group business and are thinly capitalised. Employees judge the plan on claims, and the regulator's headline claims statistic, 87.5% of claims paid, hides where money is lost.
Question	Which insurers should Plum build on, and which claim-journey fixes will do most for renewal?

Table 1. Situation, complication and question.

The analysis follows a KPI tree for the outcome that matters most to a group-health platform: employer renewal (Figure 1). Renewal depends on price stability, which is driven by the insurer's economics, and on the claim experience, which is driven by deductions, cashless access and turnaround. The first branch is a partnership question; the second is a product question.

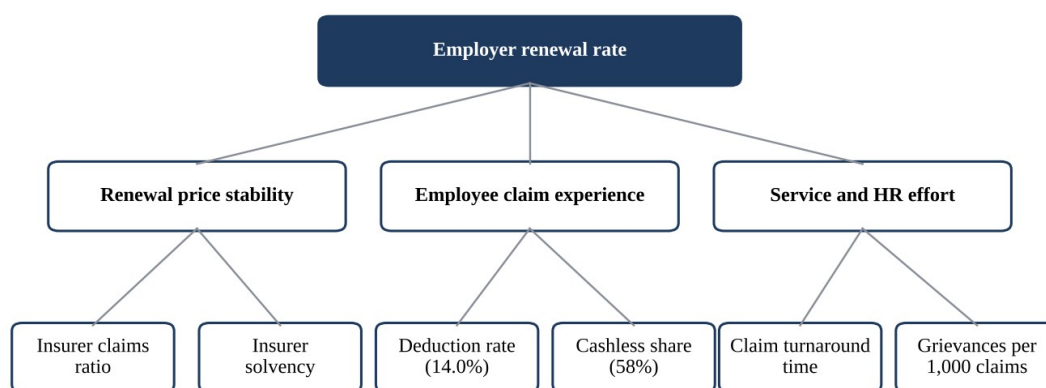


Figure 1. KPI tree for employer renewal, with the 2024-25 market values where IRDAI publishes them.

3. Data and approach

IRDAI source	Content	Used for
Statement 8	Health premium by insurer, 2023-24 and 2024-25	Insurer scale and growth
Statement 10	Claims ratio by insurer (health, personal accident and travel)	Insurer profitability
Statement 12	Solvency ratio at 31 March 2025	Financial strength
Tables I.26 and I.27	Lives, premium and claims ratio by class	Market sizing
Table I.28	Claims paid by settlement mode, TPA and in-house	Cashless versus reimbursement
Table I.29	Status of claims by number and amount	Claims funnel

IRDAI source	Content	Used for
Section III.5.5	Master Circular on Health Insurance, May 2024	Regulatory levers

Table 2. Data used. Figures were extracted from the report and checked against its stated totals.

Claims ratio is claims incurred divided by premium earned. **Solvency ratio** is available divided by required solvency margin; the legal minimum is 1.5. **Repudiated** claims are rejected outright; **disallowed** amounts are deductions on claims that are otherwise paid, such as room-rent caps, consumables and co-payments. Insurer-level figures combine health, personal accident and travel, because IRDAI does not publish group-only figures per insurer.

4. The market: big, growing and thin-margin



Figure 2. Share of covered lives and of health premium by class, 2024-25.

Group health covers 47.4% of insured lives and brings in 52.3% of health premium. Government schemes cover almost as many lives (42.3%) for 8.0% of premium, and individual policies are the reverse: 10.4% of lives and 39.7% of premium. For a platform, group health is where the volume is, and it grew 10.4% in 2024-25 to ₹61,435 crore.

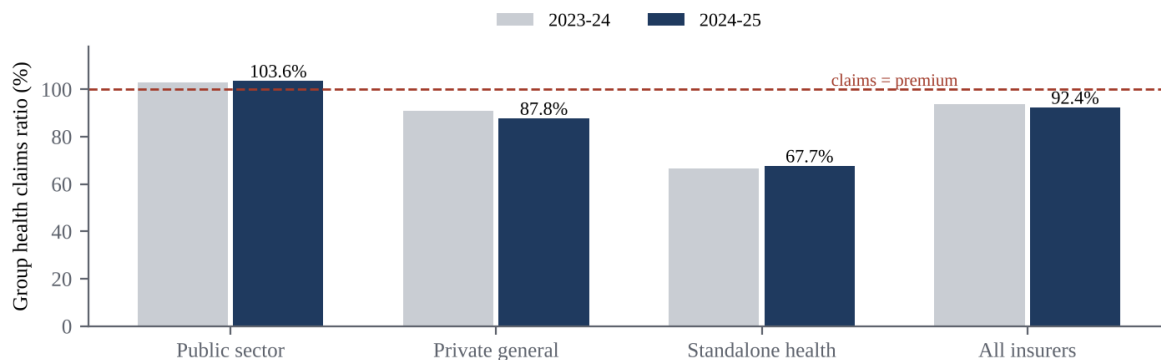


Figure 3. Group health claims ratio by insurer type, 2023-24 and 2024-25.

The economics are tight. Across all insurers, 92.4% of group premium went straight back out as claims, before commissions, administration and TPA fees. Standalone health insurers ran at 67.7% and private general insurers improved from 90.8% to 87.8%. The public sector lost money on claims alone for the second year running.

5. Partner strategy: which insurers to build on

5.1 The renewal-price stress test

An insurer losing money on group business has two ways back: raise prices at renewal or tighten claims. Both land on the employer, and therefore on the platform's renewal rate. To size the risk, I calculated the premium change each insurer type would need to bring its group claims ratio to 85%, a level that leaves room for expenses. This is illustrative: insurers price individual schemes, not segments, and may accept losses for growth.

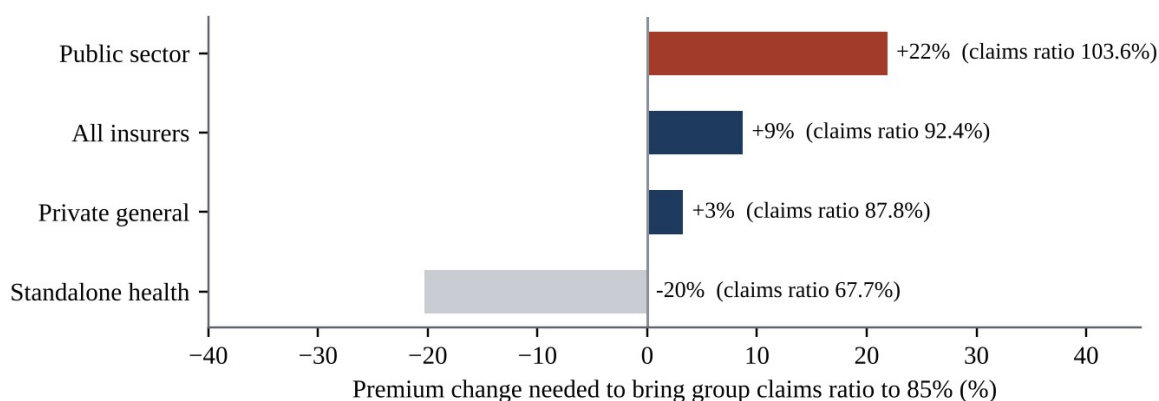


Figure 4. Premium change needed to reach an 85% group claims ratio, by insurer type, 2024-25.

A client placed with a public-sector insurer faces an implied **22% renewal increase**, against about 3% with a private general insurer. Standalone health insurers have room to cut. For an employer, that is the difference between a routine renewal and a budget conversation, and the platform is the one blamed for it.

5.2 The partner screen

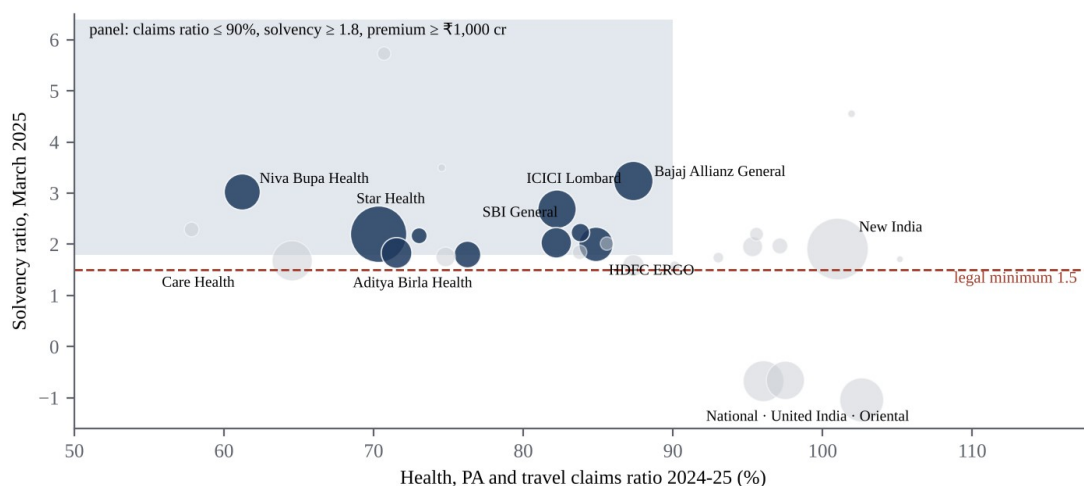


Figure 5. Insurers by claims ratio and solvency, 2024-25. Bubble size is health premium; the shaded area is the panel.

Insurer	Type	Premium (₹ cr)	Claims ratio	Solvency
Star Health	Standalone health	16,716	70.3%	2.21
Bajaj Allianz General	Private general	8,043	87.3%	3.25
ICICI Lombard	Private general	7,636	82.2%	2.69
Niva Bupa Health	Standalone health	6,762	61.2%	3.03
HDFC ERGO	Private general	6,100	84.9%	2.00
Aditya Birla Health	Standalone health	4,822	71.5%	1.84
SBI General	Private general	4,731	82.2%	2.03

Insurer	Type	Premium (₹ cr)	Claims ratio	Solvency
Tata AIG	Private general	3,592	76.2%	1.81
Go Digit	Private general	1,626	83.8%	2.24
Cholamandalam MS	Private general	1,156	73.0%	2.18

Table 3. The panel: claims ratio of 90% or less, solvency of at least 1.8, health premium over ₹1,000 crore.

Segment	Share of health premium	Premium growth	Weighted claims ratio
Panel (10 insurers)	48.0%	+11.2%	76.2%
Public sector (4)	36.0%	+5.3%	99.8%
All 29 insurers	100%	+9.2%	84.8%

Table 4. The panel against the public sector. Insurer-level figures include personal accident and travel.

The panel is not a niche: it writes nearly half the market, is growing faster than the public sector, and runs a claims ratio 24 points lower. Each threshold is tied to a risk: the claims ratio to renewal pricing, solvency to the insurer's ability to absorb a bad year, and premium size to claims capacity for large employers.

Claims ratio at most	Solvency 1.5	Solvency 1.8	Solvency 2.0
85%	11 · 49.6%	9 · 41.7%	7 · 35.1%
90%	13 · 57.7%	10 · 48.0%	8 · 41.4%
95%	13 · 57.7%	10 · 48.0%	8 · 41.4%

Table 5. Sensitivity: number of insurers and share of premium as thresholds move (premium over ₹1,000 crore throughout).

The result is robust. Loosening the claims ratio to 95% adds nobody, because the next insurers are above 95%. Solvency is the threshold that matters: lowering it to the legal minimum adds Care Health, ManipalCigna Health and Reliance General, while raising it to 2.0 removes Aditya Birla Health and Tata AIG, which sit just above 1.8.

6. Product strategy: fixing the claim journey

6.1 Where the money leaks



Figure 6. Health claims funnel by amount, all general and health insurers, 2024-25.

By count, the journey looks healthy: 87.5% of claims paid, 7.9% rejected and 4.6% pending. By amount it does not. Of ₹1,32,488 crore claimed, 8.6% was rejected outright and a further **14.0% was deducted** from claims that were paid. On average about ₹5,700 is deducted for every claim paid, against an average payment of ₹28,900, so a typical employee who claims gets back roughly 84% of what they were charged. A claim with a deduction still counts as paid, so dashboards built on claim counts miss the largest leak entirely.

6.2 Cashless is the lever the regulator has handed over



Figure 7. Paid claims by settlement mode, by number and amount, 2024-25.

Cashless settlement covers 58.0% of paid claims and 66.4% of the amount; reimbursement covers 36.7% of claims, where the employee pays first and waits. Reimbursement is concentrated in smaller bills (average ₹23,100 against ₹33,100 for cashless), which is where employees are most likely to give up. TPAs settle 69% of claims and achieve a higher cashless share than insurers' in-house teams (60.8% against 51.6% by number).

IRDAI's Master Circular of May 2024 changes the economics of fixing this: insurers must decide cashless pre-authorisation within **one hour** and discharge within **three hours**, bearing extra costs themselves if they miss it, and may not ask policyholders for documents. A platform that routes planned admissions through pre-authorisation and tracks these timelines turns a regulatory requirement into a visible service advantage.

6.3 Prioritising the initiatives

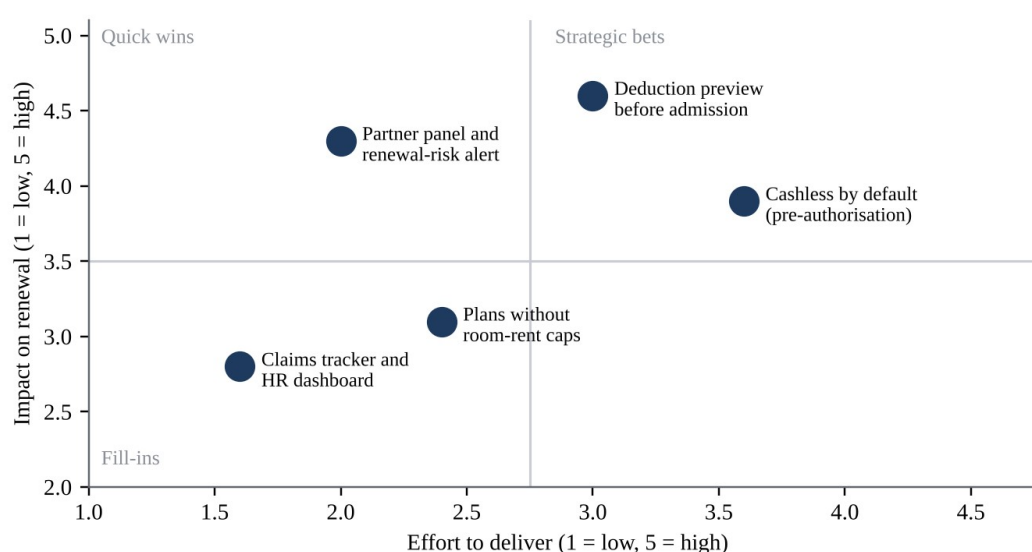


Figure 8. Initiatives by estimated impact on renewal and effort to deliver. Placement is a judgement based on the findings above.

Initiative	What it does	Primary KPI
Partner panel and renewal-risk alert	Place new business with the panel; flag clients with insurers above 100% claims ratio or below 1.5 solvency 90 days before renewal	Renewal rate; average renewal price change
Deduction preview before admission	Show room-rent limits, co-payments and non-payable items for the planned hospital before admission	Deductions as % of amount claimed
Cashless by default	Route planned admissions to network hospitals with in-app pre-authorisation; track the 1-hour and 3-hour rules	Cashless share of claims; pre-authorisation time
Plans without room-rent caps	Offer employers a plan tier without the caps that drive most deductions	Deduction rate in that tier
Claims tracker and HR dashboard	Live claim status for employees; claim KPIs for HR	Grievances per 1,000 claims; HR tickets

Table 6. Initiatives and the KPI each one is accountable for.

7. Recommendations and roadmap

1. **Build placements on the ten-insurer panel.** Use Table 3 as the default shortlist and present it to employers as evidence-based insurer selection.
2. **Launch a renewal-risk alert.** Flag every client whose plan sits with an insurer above a 100% claims ratio or below the solvency minimum, and offer a panel quote 90 days before renewal.
3. **Make deductions the product team's north-star claims metric.** Report deductions as a share of the amount claimed, per insurer and per plan, and show employees their likely deduction before admission.

4. **Push cashless by default.** Route planned admissions through in-app pre-authorisation and publish turnaround against the regulator's one-hour and three-hour rules.
5. **Run the business on one renewal dashboard** (section 8), so partnerships, product and account teams manage the same KPIs.

Horizon	Actions	Success measure
0 to 3 months	Panel shortlist; renewal-risk alert; dashboard v1 on existing claims data	Every renewal at risk flagged 90 days ahead
3 to 6 months	Deduction preview and cashless routing for planned admissions; pilot with selected employers	Deduction rate and cashless share versus control employers
6 to 12 months	Room-rent-free plan tier; scale what the pilot proves	Renewal rate and grievances per 1,000 claims

Table 7. Twelve-month roadmap.

8. BI dashboard specification

Page	Visuals and KPIs	Key measures
Partner risk	Insurer scatter (claims ratio against solvency); panel share of book; clients by insurer risk band	Book on Panel % = DIVIDE([Premium on Panel], [Premium])
Renewals	Renewals due in 90 days by risk band; renewal rate; average price change	At-risk Renewals = CALCULATE([Clients], Insurer[ClaimsRatio] > 1 Insurer[Solvency] < 1.5)
Claim journey	Funnel by amount and count; deduction rate by insurer, plan and hospital	Deduction Rate = DIVIDE([Amount Disallowed], [Amount Claimed])
Service	Cashless share; pre-authorisation and discharge times against 1 and 3 hours; grievances per 1,000 claims	Pre-auth within SLA % = DIVIDE([Pre-auths ≤ 60 min], [Pre-auths])

Table 8. Dashboard pages and measures.

9. Limitations

- **Insurer level is not group only.** Insurer premium and claims ratios include personal accident and travel; IRDAI does not publish group-only figures per insurer.
- **One year, backward-looking.** A high claims ratio can reflect a deliberate push for growth, and solvency can change with a capital injection.
- **Market-wide funnel.** The claims funnel covers all health claims, not group claims alone, and pending claims may still be paid.
- **The stress test is illustrative.** It shows the size of the pricing gap, not what any insurer will charge a specific employer.
- **Outside-in.** Plum's own book, pricing and claims data are not public, so the panel and priorities would need validating on its data.

10. References

- Insurance Regulatory and Development Authority of India (2025) *Annual Report 2024-25*. Hyderabad: IRDAI. Available at: <https://irdai.gov.in> (Accessed: October 2026).
- Insurance Regulatory and Development Authority of India (2024) *Master Circular on Health Insurance Business*, IRDAI/HLT/CIR/PRO/84/5/2024, 29 May 2024.