



MEDHARMONY

A CONFLUENCE OF HEALTHCARE LEADERS

Medical Insurance:
Challenges, Conflicts & Collaborative Solutions



CLOSED-DOOR STRATEGIC MEETING REPORT

Saturday, 13th June 2026



www.medharmony.org

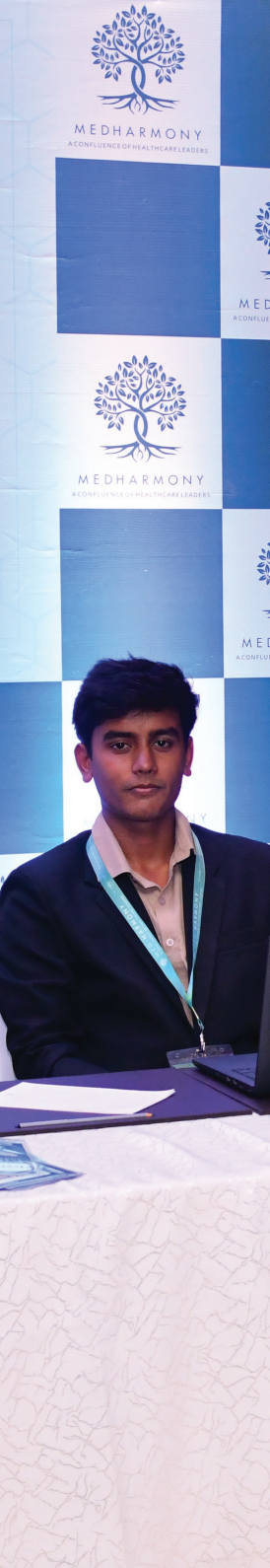


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1. Executive Overview

MedHarmony: Medical Insurance: Challenges, Conflicts & Collaborative Solutions was convened as a closed-door strategic meeting to bring healthcare providers, clinicians, hospital administrators, insurance leaders, TPAs and allied stakeholders into one constructive dialogue on the evolving relationship between hospitals, insurers and patients.

The meeting focused on a core question for the healthcare ecosystem: how can hospitals and insurance providers reduce operational friction, improve claim efficiency, strengthen patient communication and build a sustainable model that balances clinical quality, financial protection and institutional viability?

The discussions were deliberately framed as collaborative rather than adversarial. Participants acknowledged that delays, short settlements, documentation queries, coverage gaps and discharge uncertainty can arise at multiple points in the healthcare-insurance journey. The spirit of the meeting was to identify system-level improvements without placing blame on any one stakeholder.

A strong consensus emerged that hospitals and insurers ultimately serve the same beneficiary: the patient. When documentation is complete, policies are understood, communication is transparent and escalation mechanisms are clear, patients experience greater confidence and the ecosystem becomes more efficient for all parties.

The strategic meet therefore moved beyond listing challenges. It generated actionable recommendations around common documentation checklists, T-1 discharge planning, digital verification, one-touch approval for pre-agreed packages, transparent discharge approval communication, periodic claim reconciliation, MOU review cycles, advanced treatment coverage, NHCX adoption and structured provider escalation pathways.

The meeting treated medical insurance not simply as a payment mechanism, but as a critical pillar of modern healthcare access, affordability, predictability and patient trust.

2. Context: MEDHARMONY 2025 Recap

The closed-door strategic meeting of 13th June 2026 was situated within the larger journey of MedHarmony as a platform for healthcare leadership and knowledge exchange. The earlier edition of MedHarmony brought together more than 500 doctors representing over 50 medical specialties, creating a significant forum for multispecialty dialogue and collaborative reflection on the future of healthcare.

The 2025 programme explored a broad spectrum of healthcare themes, including artificial intelligence in healthcare, medical technology, medical tourism, clinical excellence, and the changing expectations of patients and providers. Among these themes, medical insurance emerged as one of the areas requiring deeper and more focused engagement because of its direct impact on hospital operations, patient experience and healthcare affordability.

The discussions from the earlier programme indicated that insurance is now deeply integrated into the healthcare delivery journey. It influences admission counselling, treatment planning, discharge timelines, billing, claim documentation, patient satisfaction and hospital cash flow. As insurance penetration grows, the relationship between hospitals and insurers becomes central to the quality and predictability of patient experience.

The 13th June 2026 strategic meeting was therefore designed as a more focused, closed-door conversation on medical insurance. Its purpose was to bring stakeholders into a candid but constructive setting where operational challenges could be examined in depth and translated into practical, collaborative solutions.

This continuity from the previous edition reinforced MedHarmony's larger purpose: to create a trusted forum where healthcare leaders can exchange perspectives, identify systemic gaps and co-create pathways for a more transparent, patient-centric and future-ready healthcare ecosystem.

3. Programme Flow and Participation

The meeting followed a structured format, beginning with registration and high tea, followed by the arrival of dignitaries, the introductory proceedings, two moderated panel discussions, an open house discussion, vote of thanks, National Anthem and dinner networking.

Time	Duration	Proceeding
1630 hrs	30 mins	Registration and High Tea
1700 hrs	5 mins	Arrival of the Hon'ble Dignitaries at Hall
1705 hrs	2 mins	Introduction by the Anchor, Ms. Akshita Saxena
1707 hrs	3 mins	Lighting of the Lamp
1710 hrs	2 mins	World Peace Prayer
1712 hrs	3 mins	Inaugural video depicting the theme of the meeting
1715 hrs	5 mins	Welcome Address by Dr. Aditi Karad
1720 hrs	10 mins	Address by Dr. Parag Sancheti
1730 hrs	45 mins	Panel Discussion 1: Decoding the Challenges - Perspectives from Hospitals, Insurers and Patients
1815 hrs	45 mins	Panel Discussion 2: Co-Creating Solutions - Building a Seamless Healthcare Ecosystem
1900 hrs	20 mins	Open House Discussion / Question and Answer
1920 hrs	5 mins	Vote of Thanks by Dr Shirish Prayag
1925 hrs	1 mins	National Anthem
1930 hrs onwards	-	Dinner Networking Session

The structure allowed the meeting to move from context setting to issue identification, solution-building and wider audience participation. The open house discussion gave additional stakeholders an opportunity to raise practical concerns and suggest mechanisms for long-term collaboration.

4. Inaugural Welcome Address - Dr. Aditi Karad

Executive Director, VishwaRaj Hospital;
Trustee & Joint Secretary General, MAEER's MIT Group, Pune.

Dr. Aditi Karad, Executive Director of VishwaRaj Hospital, welcomed participants on behalf of the MedHarmony organising team, framing the meeting as a platform for meaningful dialogue across the healthcare-insurance ecosystem.

She noted that medical insurance now directly impacts patient access, institutional sustainability, and overall healthcare experience — making deeper engagement across stakeholders essential. While hospitals and insurers operate under different constraints, she emphasized their shared purpose: enabling better health outcomes and financial protection for patients.

Dr. Karad acknowledged that post-COVID awareness around medical insurance has grown, yet penetration in India still has significant room to expand — presenting both a responsibility and an opportunity for closer collaboration.

She highlighted key friction points — claim processing, documentation, approvals, deductions, discharge delays, and patient communication — and called for structured dialogue over isolated problem-solving. Practical solutions she proposed included common documentation guidelines, standardised checklists, uniform communication protocols, and consistent training frameworks to reduce ambiguity and improve patient experience.

She also stressed that as hospitals adopt advanced treatments, insurance products and reimbursement frameworks must evolve in parallel to keep innovative care accessible and predictable for patients. Her address set the meeting's tone: collaborative, constructive, and patient-centric — aimed at building a healthcare-insurance framework that supports coexistence, mutual growth, and better outcomes.



5. Address by Dr. Parag Sancheti

Chairman, Sancheti Hospital.

Dr. Parag Sancheti welcomed the participants and expressed appreciation for the vision behind MedHarmony. He acknowledged the role of Dr. Aditi Karad and Dr. Rahul Karad in creating a platform that brings healthcare leaders together for serious dialogue on the future of healthcare delivery.

He noted that the idea of a dedicated meeting on medical insurance emerged from earlier conversations where insurance-related concerns generated significant interest among doctors and healthcare administrators. The subject required focused attention because it touches nearly every stage of the patient journey.

Dr. Sancheti highlighted the changing landscape of healthcare financing in India. The proportion of self-paying patients has reduced over time, while insurance-backed healthcare utilisation has increased. This transition means that hospitals and insurers must work in closer coordination than before.

He observed that medical insurance should not be seen only as a financial product. It is increasingly an essential pillar of modern healthcare security, providing families with financial confidence during unexpected medical emergencies, illnesses and accidents.

He encouraged participants to treat the meeting as a collaborative exercise rather than a debate between hospitals and insurers. The objective, he said, was to understand the concerns of all stakeholders and develop practical solutions that could strengthen relationships between healthcare providers and insurance organisations.

Dr. Sancheti also set the stage for the first panel by highlighting the real patient-facing challenge during discharge. In many cases, a doctor may declare the patient fit for discharge, but the family continues to wait for final insurance approval. This creates uncertainty, affects travel plans, delays bed availability and impacts the patient's perception of the hospital experience.

His address reinforced the importance of keeping the patient at the centre while improving claim settlement, documentation, discharge planning and insurer-hospital coordination.



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6. Panel Discussion 1: Decoding the Challenges Perspectives from Hospitals, Insurers and Patients

Role	Name and Designation
Moderator	Dr. Parag Sancheti - Chairman, Sancheti Hospital.
Moderator	Dr. Deepak Nikam - Assistant Vice President, Aditya Birla Health Insurance.
Panelist	Dr. H. K. Sale - Director, Noble Hospital.
Panelist	Dr. Vivek Lal - Group Medical Director, Ruby Hall.
Panelist	Ms. Sweetie Salve - Vice President - Health Insurance, Bajaj General Insurance Ltd.
Panelist	Dr. Rupali Thorat - Assistant Vice President, Maharashtra, Star Health.

The first panel examined the practical challenges experienced by hospitals, insurers and patients in the medical insurance process. The discussion covered claim settlement delays, communication gaps, documentation requirements, pre-authorisation, discharge waiting time, deductions, congenital coverage, emergency admissions and advanced treatment reimbursement.

The purpose of the discussion was not to determine who was right or wrong, but to identify practical approaches that can create a sustainable healthcare financing model for hospitals, insurers and patients.

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6.1 Regulatory Context, Claim Settlement and Patient Experience

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6.2 Hospital Perspective on Pending Claims and Communication Gaps

Dr. H. K. Sale highlighted that hospitals have established internal systems to submit claims promptly after discharge. However, even after timely submission, outstanding payments may remain unresolved for extended periods because of communication gaps, delayed query resolution or lack of clarity on next steps.

He emphasised that settlement timelines are often defined in Memorandums of Understanding between hospitals and insurers. When agreed timelines are not consistently met, hospitals face cash flow challenges and operational uncertainty. His comments framed timely settlement not only as a billing issue, but as an institutional sustainability issue for hospitals.

Dr. Vivek Lal added that hospitals generally submit bills and documents in time, but delays may arise in subsequent stages such as verification, medical scrutiny, query resolution and final approval. He noted that while the system has improved over the years, the extended turnaround between claim submission and final settlement remains an area for continued improvement.

The hospital-side perspective therefore centred on communication, adherence to agreed timelines, and the need for transparent status visibility once the claim has moved beyond the hospital's submission stage.

6.3 Insurance Perspective on Documentation and Medical Scrutiny

Ms. Sweetie Salve emphasised that complete and accurate documentation is one of the most important determinants of claim processing speed. She explained that insurers work within regulatory turnaround expectations and also maintain internal performance matrices to ensure timely processing.

She noted that many delays can be reduced when hospitals submit complete records, accurate treatment details, implant or consumable invoices where applicable, and clinical documentation aligned with the pre-authorisation request. When documentation is clean and treatment details are aligned with the policy, medical review can happen quickly; complex cases require more detailed clinical dialogue.

Dr. Rupali Thorat also underlined the importance of timely submission of complete discharge documents. She noted that insurers follow defined settlement timelines, but delays may occur in exceptional or complex cases, especially where implant invoices, supporting documents, enhancement details or clarification on short settlements are pending.

She further emphasised the need for continuous training of doctors, hospital insurance desks and operational teams so that policy requirements, documentation needs and clinical review processes are clearly understood. Specialist opinions and structured medical review mechanisms can help in complex cases.

The discussion therefore established documentation quality as a shared responsibility. Hospitals need clear checklists and clinical ownership of documentation, while insurers need timely and transparent query communication.

- Missing implant or mesh invoices;
- Mismatch in ICD coding or procedure details;
- Differences between pre-authorisation information and final discharge summaries;
- Incomplete explanation for complications, additional procedures or extended operative time;
- Delayed response to enhancement queries or short settlement clarification requests.



6.4 Discharge Experience and the Patient Journey

Dr. Parag Sancheti highlighted the patient-facing impact of delayed discharge approvals. A doctor may communicate that the patient is medically fit for discharge, after which families begin making travel and personal arrangements. However, final insurance approval may still be pending, creating uncertainty and inconvenience. The discussion acknowledged that this issue affects multiple stakeholders. Patients and families experience waiting and anxiety. Hospitals face bed-blocking and operational pressure. Insurers face customer satisfaction challenges.

The panel therefore treated discharge delay as an ecosystem process issue rather than a problem attributable to any one side.

A balanced point emerged during the discussion: discharge delays may begin even before the insurer receives the final documents. Hospital-side processes such as nursing handover, pharmacy closure, billing audit, document compilation and TPA desk submission can take two to three hours after the doctor announces discharge readiness. This reinforced the need to map the full discharge process from clinical clearance to physical exit of the patient. Dr. Rupali Thorat explained that discrepancies between pre-authorisation details and the final discharge summary can trigger additional queries. These may include differences in the initial diagnosis, procedures performed, clinical findings or final treatment requirements.

Ms. Sweetie Salve emphasised that proactive communication from hospitals, including early notification of expected discharge, can help insurers process claims faster and minimise patient inconvenience.



6.5 T-1 / Day Minus One Discharge Planning

The panel discussed T-1 discharge planning, also referred to as Day Minus One discharge planning, as a practical mechanism to reduce discharge-day pressure. Under this approach, hospitals initiate discharge preparation 24 hours before expected discharge in planned and predictable cases.

The approach allows hospitals to compile documents in advance and gives insurers time to review the file before the actual discharge day. Insurance representatives indicated that where hospitals trigger expected discharge 24 hours in advance, the pre-authorisation file may remain open for anticipated additional expenses until the actual discharge. This would allow early scrutiny without forcing premature closure of the bill, thereby reducing the pressure on patients, hospitals and insurers on the day of discharge.

A positive operational example was also discussed, where structured planned discharge protocols helped achieve a high proportion of discharges before noon. Such examples were treated as aspirational benchmarks for improving patient waiting time, bed availability and discharge predictability.

The panel also recommended clearer protocols for the transition window between clinical discharge readiness and the patient physically leaving the hospital. This is particularly important for outstation patients and families who may have already made travel arrangements. Clear communication during this period can help define responsibility, reduce anxiety and ensure continuity of care until the patient exits the hospital.

T-1 discharge planning converts discharge from a reactive same-day activity into a planned operational workflow involving the treating doctor, nursing team, billing team, TPA desk and insurer.





6.6 Verification Process and Digital Innovation

The panel discussed verification-related delays during discharge. Physical verification, where applicable, can prolong waiting if the representative is delayed or if there is uncertainty about whether and when verification will occur.

Digital verification through secure video links was discussed as a useful innovation. Such a model can reduce dependence on physical visits, enable real-time confirmation, create greater predictability and reduce patient waiting time during discharge.

The panel encouraged broader adoption of technology-enabled verification models wherever appropriate, while ensuring that patient consent, data security and procedural clarity are maintained.

6.7 One-Touch Approval for Pre-Agreed Packages

A significant operational recommendation from the first panel was the possibility of one-touch approval for pre-agreed surgical packages. The discussion focused on cases where hospitals and insurers have already agreed on a Schedule of Charges for defined procedures.

In such cases, the panel suggested that pre-authorisation approval may be aligned with the agreed package value, provided there is no significant change in diagnosis, procedure or clinical estimate. Simplified billing at settlement stage may reduce repeated itemised submissions and avoid unnecessary back-and-forth.

The panel also discussed that, where a package has been pre-agreed under the Schedule of Charges and there is no change in diagnosis or clinical estimate, simplified package-based billing may be considered instead of repeated itemised re-submission. This would need clear documentation, mutual agreement and defined exceptions for clinical variation.

The panel also noted that pre-authorisation forms are sometimes completed by team members other than the operating surgeon. Surgeon-verified clinical information at the pre-authorisation stage was therefore emphasised as a way to reduce discrepancies and enable faster approvals at discharge.

This recommendation was positioned as a process improvement opportunity that can benefit all stakeholders: patients receive clearer expectations, hospitals get predictable approvals and insurers receive better-aligned documentation.

6.8 Standardisation and Common Guidelines

Dr. Aditi Karad raised a major concern faced by hospitals: different insurers may have different documentation requirements, communication formats, query styles and process expectations. This creates complexity for hospital insurance desks managing multiple insurers at scale.

She suggested the need for common documentation guidelines, standardised checklists, uniform communication protocols and consistent training frameworks. Such measures can reduce confusion, improve claim preparedness and create a more predictable experience for patients.

Dr. Rupali Thorat agreed that standardisation would improve efficiency and recommended common training programmes for hospital insurance desks, better understanding of policy products and structured mechanisms to resolve enhancement queries faster.

The panel also discussed the value of a commonly accepted consumables framework. Ambiguity around consumables can create deductions, short settlements and patient dissatisfaction. A national-level or commonly accepted list can reduce disputes by creating a shared understanding of admissible and non-admissible items.

6.9 Deductions, Short Settlements and Patient Transparency

The panel discussed the sensitive issue of deductions, short settlements and out-of-pocket liability. It was noted that disputes often arise not only because deductions occur, but because patients and families do not always understand the reasons behind them.

Deductions may arise from policy terms, room rent limits, co-payment, sub-limits, non-payable items, exhausted benefits or agreed pricing arrangements. Hospitals often become the first point of patient dissatisfaction even when the deduction is linked to policy terms rather than hospital charges.

The panel recommended that discharge approval communications should include key financial details upfront, including applicable co-payment, sub-limits, exhausted benefits and likely out-of-pocket liability. This would allow hospital counsellors to explain the final payable amount before the patient is ready to leave.

Transparent communication was therefore identified as an important patient trust mechanism. The goal is not merely faster settlement, but a settlement process that patients can understand.

6.10 Congenital Conditions and Evolving Product Awareness

The panel discussed the evolving insurance coverage landscape for congenital conditions, particularly in newborns and early-life interventions. The discussion recognised that coverage terms may vary across retail policies, group policies and specialised product categories.

The panel noted that certain product structures may provide wider coverage for newborn-related interventions, while others may be subject to product-specific waiting periods, exclusions, limits or policy wording. Since families often face emotional and financial pressure when congenital conditions are detected, clearer awareness among hospitals and patients becomes essential.

The discussion also recognised that coverage for internal and external congenital conditions continues to evolve, and clearer product language would help hospitals and patients understand admissibility, waiting periods and exclusions more effectively.

Emerging specialised products for fetal and newborn care were discussed as examples of insurance product design beginning to respond to complex family healthcare needs. The panel recommended joint awareness initiatives between insurers and hospitals so that clinicians, hospital insurance teams and families can understand available options better.

The point was framed as an opportunity for product evolution, patient education and clearer communication rather than as a criticism of any existing product or insurer.

6.11 Emergency Cases and Pre-Authorisation

The panel acknowledged that emergency treatment cannot wait for administrative approvals. In emergency cases, clinical intervention must begin based on medical necessity, while documentation and approvals proceed in parallel.

The discussion highlighted that pre-authorisation works efficiently when packages are predefined, documentation is complete and hospital-insurer communication is proactive. For elective admissions, complete and accurate preauthorisation details can significantly reduce discharge-stage queries.

The panel also underlined the need for hospital insurance desks and admission teams to understand policy terms clearly so that patients receive accurate guidance at the time of admission, treatment planning and discharge.

6.12 Advanced Medical Technologies and Insurance Coverage

Dr. H. K. Sale highlighted challenges arising from advanced technologies such as robotics and other technology enabled procedures, where reimbursement may not always align with the cost or clinical value of newer treatment modalities.

Dr. Vivek Lal added that healthcare is moving towards clinical excellence, faster recovery and advanced treatment options. Insurance policies and claim evaluation frameworks should evolve to reflect these improvements where medically justified.

Ms. Sweetie Salve suggested that pre-agreed packages for advanced procedures could reduce disputes and improve efficiency. Where the clinical indication, treatment pathway and cost structure are well documented, insurers can evaluate such procedures more predictably.

Dr. Aditi Karad emphasised that hospitals are rapidly upgrading with advanced treatments and technologies, and insurance products need to adapt faster to meet changing patient expectations.

The panel suggested that surgeons and clinical teams should document medical necessity, patient benefit, expected recovery advantage and cost rationale at the pre-authorisation stage for advanced procedures. Such documentation can help insurers assess newer modalities in a structured and evidence-based way.

6.13 Escalation Mechanisms and Claims Review

The audience and panelists discussed the need for clear escalation mechanisms where unresolved claims, delayed settlements, recurring documentation concerns or disputed deductions remain pending. A structured mechanism would help hospitals and insurers resolve operational issues before they become prolonged disputes.

The panel also recognised the value of claims review mechanisms within insurance organisations, including Claims Review Committee-type structures for reviewing deductions, rejections and disputed decisions. Hospitals were encouraged to use available review pathways onstructively, especially in cases involving room rent limits, copayment issues, deductions or complex medical interpretation.

The broader suggestion was to create provider-facing channels through which systemic concerns can be raised with appropriate evidence, enabling policy and process evolution over time. A further suggestion was the creation of structured provider-facing channels through which hospitals can raise recurring systemic concerns, such as documentation standards, package interpretation, delayed operational closure or unresolved bottlenecks, with appropriate evidence. Such channels can complement policyholder grievance mechanisms and support evidence-based process improvement at the regulatory and ecosystem level.



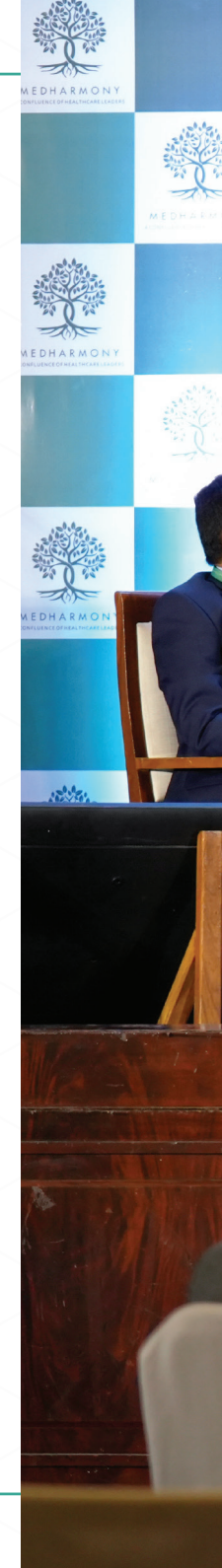
6.14 Key Outcomes from Panel Discussion 1

- ✦ Claim settlement efficiency depends on timely documentation, transparent query resolution and adherence to agreed timelines.
- ✦ Hospitals and insurers should jointly develop common documentation guidelines, claim checklists and training frameworks.
- ✦ T-1 discharge planning should be piloted in planned admissions to reduce same-day patient waiting time.
- ✦ Hospital internal discharge processes should be mapped and strengthened alongside insurer-side approval workflows.
- ✦ One-touch approval for pre-agreed SOC-based packages can reduce friction in routine package-based cases.
- ✦ Video verification and other digital verification models can improve predictability at discharge.
- ✦ Deductions, co-payments, sub-limits and exhausted benefits should be communicated transparently to patients.
- ✦ Common consumables guidelines can reduce ambiguity in short settlements.
- ✦ Advanced procedure claims require stronger clinical justification and structured review frameworks.
- ✦ Provider escalation mechanisms and claims review pathways should be strengthened.

7. Panel Discussion 2: Co-Creating Solutions - Building a Seamless Healthcare Ecosystem

Role	Name and Designation
Moderator	Mr. Vinod Sawantwadkar - CEO, Jehangir Hospital
Moderator	Dr. Pravin Kamble - Regional Head, Oriental Insurance
Panelist	Dr. Vyas Mourya - Unit Head, Medicovert Hospital
Panelist	Dr. Nitin Mahantshetty - Medical Director, Aditya Birla Memorial Hospital
Panelist	Dr. Santosh Sahu - Operation Head, VishwaRaj Hospital
Panelist	Dr. Anushree Kadam - Provider Head - Rest of Maharashtra, MD India

The second panel focused on solutions that could create a more seamless healthcare-insurance ecosystem. The discussion moved from operational challenges to structural reforms, including pricing frameworks, rate revision mechanisms, hospital categorisation, digital integration, NHCX readiness, advanced treatment coverage, patient communication and stakeholder collaboration.



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7.1 Pricing Framework as a System Design Challenge

Dr. Pravin Kamble opened the discussion by highlighting the need for a structured and uniform procedure for defining rates across private insurance networks. He noted that a more transparent pricing framework would improve efficiency and reduce ambiguity in claim processing.

Dr. Santosh Sahu emphasised the need for a collaborative approach towards developing common healthcare packages. He shared that VishwaRaj Hospital works with multiple insurance providers, making standardisation important for smoother operations.

Dr. Sahu suggested that regional variations should be considered while designing common packages, especially for Tier 2 and Tier 3 cities. He also proposed exploring a Diagnosis Related Group-based approach, through which hospitals and insurers can jointly develop a more systematic, outcome-oriented pricing model.

Dr. Anushree Kadam highlighted industry-level efforts towards common frameworks. She referred to standardised package models introduced through public schemes and broader initiatives to align hospitals and insurers around common pricing frameworks.

The panel characterised pricing not simply as a negotiation issue, but as a system design challenge. Sustainable pricing requires structural frameworks, collaborative package committees, regional benchmarks, hospital categorisation and periodic revision mechanisms.

7.2 Hospital Cost Structures and the Limits of Uniform Pricing

Dr. Nitin Mahantshetty explained that complete uniformity in healthcare pricing is difficult because hospitals differ significantly in their operating models and cost structures.

He identified key factors influencing hospital costs, including regional location, medical and surgical expertise, infrastructure, technology adoption, competition, market positioning and patient acquisition strategy. These factors make it difficult to apply one rate uniformly across all hospitals.

Mr. Vinod Sawantwadkar also emphasised that a one-size-fits-all pricing model may not be practical because hospitals operate in diverse environments with different cost structures, infrastructure commitments and service delivery models.

The discussion also noted that professional fee structures for clinicians remain relatively undefined in many package models. Clearer guidelines in this area could improve predictability for hospitals and insurers while reducing variability in package interpretation.

7.3 Hospital Categorisation and Common Portal

The panel discussed the need for reliable hospital categorisation on a common platform. Categorisation can help differentiate hospitals based on infrastructure, clinical capabilities, quality standards, location, technology adoption and service complexity.

Such categorisation should not be treated merely as an administrative exercise. It can become an important foundation for evidence-based pricing, fair package design, empanelment decisions and reimbursement alignment. A transparent categorisation framework can also support smaller and mid-sized hospitals by making expectations clearer and reducing the uncertainty associated with negotiation-heavy empanelment processes.

7.4 Rate Revision and MOU Review Mechanism

Dr. Pravin Kamble highlighted the challenge of outdated hospital rate lists and the absence of a structured revision mechanism between hospitals and insurers. He suggested the need for a trigger-based or periodic rate update process.

Dr. Nitin Mahantshetty explained that pricing varies because hospitals operate under different strategic and cost realities. Rising manpower expenses, infrastructure costs, technology investments and clinical advancements create pressure for periodic review.

Dr. Santosh Sahu added that patient volume and cash flow management influence hospital sustainability. While higher volumes may help hospitals operate within existing package rates, outdated terms can create long-term pressure if not reviewed.

The panel recommended periodic MOU review cycles, preferably at defined intervals, so that agreed rates and terms remain aligned with current operational costs, infrastructure investments and inflationary changes. This would benefit both hospitals and insurers by reducing uncertainty.

7.5 Digital Healthcare Ecosystem and NHCX

Mr. Vinod Sawantwadkar highlighted the importance of a common digital platform through the National Health Claims Exchange to address delayed claim processing, lack of transparency and communication gaps between hospitals and insurers.

Dr. Santosh Sahu emphasised that successful NHCX implementation will require hospitals to move towards FHIR-compliant systems for secure and seamless exchange of healthcare data. He also noted that policy support and wider adoption will be important for effective implementation.

Dr. Vyas Mourya stated that digital integration between hospital and insurance platforms can significantly improve processing speed, efficiency and transparency in claim settlement.

Dr. Nitin Mahantshetty highlighted practical challenges such as multiple insurance stakeholders, differing operational processes and the need to maintain turnaround times while transitioning to digital systems. The panel acknowledged that NHCX represents a transformative opportunity, but successful adoption requires ecosystem readiness. Hospitals will need upgraded HIS/HMIS systems, standardised data formats, secure data exchange, internal process alignment and staff preparedness.

The discussion also noted that digital health data exchange must be supported by consent, access control, data security and compliance readiness under India's evolving data protection environment.

Mr. Sawantwadkar concluded that NHCX can become an important step towards a connected healthcare ecosystem, provided all stakeholders collaborate to upgrade systems, ensure data security and align operational workflows. The discussion also recognised that patient expectations are moving beyond basic digitisation towards faster, more intelligent and more seamless healthcare experiences. This reinforces the need for hospitals and insurers to strengthen digital readiness before more advanced technology-enabled workflows become mainstream

7.6 Advanced Treatment Coverage and Product Evolution

Mr. Vinod Sawantwadkar highlighted that advanced treatments such as robotics and technology-driven procedures are increasingly becoming part of standard healthcare delivery. However, insurance coverage does not always evolve at the same pace.

Dr. Nitin Mahantshetty stated that hospitals are adopting advanced technologies and standardised care practices, but insurance packages may not always include newer treatments. He suggested a joint consortium or review mechanism through which hospitals and insurers can review treatment costs, revise packages and ensure appropriate coverage.

Dr. Anushree Kadam explained that insurance products are gradually evolving to include modern treatments, with specific conditions or limits depending on the product. She emphasised the need for continuous product evolution.

Dr. Pravin Kamble highlighted that insurance companies periodically upgrade policies and that advanced procedures may be covered under defined terms or sub-limits. He stressed the importance of hospital teams understanding policy terms accurately.

Dr. Santosh Sahu shared an example involving an advanced cardiac procedure where the approved amount was lower than the actual treatment cost. The example highlighted the need for clearer policy communication and better alignment between treatment cost and coverage.

Dr. Aditi Karad emphasised that hospitals are upgrading rapidly with advanced treatments and that insurance products need faster adaptation to meet changing patient expectations.

The panel proposed that advanced procedures should be reviewed through a common clinical and insurance framework. Such a framework can bring together clinical experts and insurance representatives to assess emerging procedures in a structured, evidence-based manner.

7.7 Patient Communication and Financial Transparency

Mr. Vinod Sawantwadkar highlighted the importance of transparent communication when patients face out-of-pocket expenses due to coverage limitations, exclusions, co-payment or sub-limits.

Dr. Vyas Mourya emphasised the role of financial counselling. He suggested that financial counsellors should clearly communicate coverage details during admission and discharge, ensuring that patients and families understand what is covered and what may remain payable.

Dr. Nitin Mahantshetty stressed the need for continuous communication regarding bills, exclusions and coverage. He recommended a three-way coordination model between hospital, insurer and patient.

Dr. Santosh Sahu highlighted the importance of counselling the key family member throughout the patient journey so that financial and policy-related expectations remain clear.

Dr. Anushree Kadam suggested appointing a Single Point of Contact for pre-authorisation and coverage clarification, particularly in cases where patients or hospital teams need quick interpretation of policy benefits. Dr. Pravin Kamble added that insurance agents also play an important role in guiding patients about policy benefits and limitations.

The panel identified insurance agents as an underutilised patient education resource. Since patients often purchase policies on the recommendation of agents and trust them for guidance, agents can help explain coverage realities before planned hospitalisations.

The panel recommended that discharge approval communication should include relevant financial details upfront, including co-payment, sub-limits, room rent restrictions and benefit exhaustion, so that patients do not face unexpected financial surprises at the final settlement stage.

7.8 Recommendations for a Future-Ready Healthcare Ecosystem

The second panel concluded that sustainable healthcare requires co-existence and collaboration among hospitals, insurers, TPAs, regulators, agents and patients. The healthcare-insurance ecosystem must become more transparent, digitally integrated and patient-centric.

The panel recommended continuous product upgradation, clear inclusion and exclusion criteria, faster adoption of digital platforms such as NHCX, stronger data readiness, regular rate review and structured stakeholder collaboration.

The central message was that hospitals and insurers must progress together. Clinical innovation, affordability, product design and patient expectations need to be aligned through ongoing dialogue and shared governance.



7.9 Key Outcomes from Panel Discussion 2

- Pricing standardisation should be treated as a system design challenge rather than only a bilateral negotiation issue.
- Common packages should be flexible enough to account for region, hospital category, infrastructure, expertise and technology investment.
- DRG-based models, collaborative package committees and hospital categorisation frameworks can support more objective pricing.
- Rate lists and MOUs should be reviewed periodically to reflect changing costs and clinical practices.
- NHCX adoption requires FHIR-compliant systems, upgraded HIS/HMIS infrastructure and data privacy readiness.
- Advanced treatments should be assessed through structured clinical-insurance review mechanisms.
- Patients need clear communication on coverage, exclusions, co-payment, sub-limits and out-of-pocket liability.
- Insurance agents can be better integrated into patient education, particularly for planned admissions.
- Stakeholder collaboration must become continuous, structured and outcome-oriented.

8. Open House Discussion - Audience Perspectives and Solutions

Following the two structured panels, the open house discussion provided an opportunity for hospital administrators, clinicians, insurance representatives and other stakeholders to raise additional points and suggest practical solutions. The discussion helped extend the conversation beyond the panel and brought forward operational issues that require ongoing follow-up.

8.1 SOC Adherence at Enhancement and Settlement Stages

Participants emphasised the importance of Schedule of Charges consistency across all stages of the claim journey. If a package or rate has been agreed, the same logic should ideally flow from pre-authorisation to enhancement and final settlement unless there is a clinical change, estimate change or policy-linked limitation.

Consistency in SOC adherence would reduce disputes, support clearer patient counselling and ensure that the amount communicated at discharge is better aligned with the final approved amount.

8.2 Regular Claim Reconciliation

A practical operational recommendation was to conduct monthly or fortnightly claim reconciliation meetings between hospital billing teams and insurance counterparts. Such meetings can help track pending claims, identify documentation gaps, review disputed deductions and ensure timely closure of outstanding matters.

The exchange of no-due confirmations and structured ageing reports was suggested as a way to prevent unresolved claims from becoming prolonged disputes. Regular reconciliation can also improve trust between institutions by making pending issues visible and jointly resolvable.



8.3 MOU Review Cycles

The open house discussion reinforced the importance of periodic MOU review cycles. Healthcare costs, infrastructure investments, technology adoption and manpower costs evolve over time. If agreed rates remain unchanged for long periods, operational misalignment can arise between hospitals and insurers.

A structured review cycle, recommended at defined intervals, would allow hospitals and insurers to revisit package rates, documentation clauses, escalation pathways and settlement timelines. This can support more sustainable long-term partnerships.

8.4 Inclusion of Smaller Hospitals and Common Empanelment

The discussion highlighted that a large number of smaller and Tier 2 hospitals may operate outside cashless networks because of rate-setting, administrative or documentation challenges. This limits access for patients who depend on cashless insurance facilities outside major metropolitan hospital networks.

The General Insurance Council's common empanelment approach was discussed as a constructive way to reduce administrative burden and expand cashless access. A single-window or common registration approach can help hospitals connect with multiple insurers more efficiently, provided quality standards, documentation expectations and pricing frameworks are clearly defined.

8.5 Clear Single Points of Contact

Participants recommended that hospitals should have clearly identified, accessible Single Points of Contact within insurance organisations for complex or time-sensitive cases. A defined escalation pathway can help resolve issues before they affect patient care or discharge timelines. The emphasis was on accessibility and accountability. The right person should be reachable at the right time, especially in cases involving complex approvals, enhancements, high-value procedures, pending settlements or patient-facing urgency.



8.6 Fraud, Over-Utilisation and Transparency

The open house discussion acknowledged that fraud and over-utilisation are ecosystem-level concerns that affect all stakeholders. Such issues can increase costs, weaken trust and affect policy sustainability.

The discussion framed transparency as the most sustainable response. Systemic initiatives such as Unified Health Identification, Electronic Health Records and interoperable digital systems can make healthcare data more accessible, verifiable and traceable over time. These measures can help reduce fraudulent activity, protect genuine patients and strengthen trust between hospitals and insurers.

The point was discussed as a systemic safeguard rather than as a concern directed at any particular group.

8.7 Pre-Existing Condition Disclosure

Participants also discussed the importance of complete and accurate disclosure of pre-existing conditions at the time of policy purchase. Proper disclosure protects policyholders from claim complications later and enables insurers to design appropriate terms upfront.

As insurance products evolve and underwriting models change, patient education at the time of policy purchase becomes increasingly important. Agents, insurers and hospitals all have a role in improving awareness around disclosure, waiting periods, exclusions and coverage limitations.

8.8 Closing Perspective from the Open House

The open house closed with a positive reflection on the strengths of Indian healthcare. While the discussion focused on areas that require improvement, participants also recognised that India is able to provide timely access to diagnostics, specialist care and procedures in many contexts. A speaker cited examples of patients abroad facing long waiting times for diagnostic and treatment access, while receiving faster care in Pune. The anecdote was used not as formal evidence, but as a reminder that India's healthcare foundation is strong and can be further strengthened through transparency, insurance integration and patient-centric processes.

The open house concluded around three broad principles: transparency, adherence to standards and open information sharing among stakeholders.

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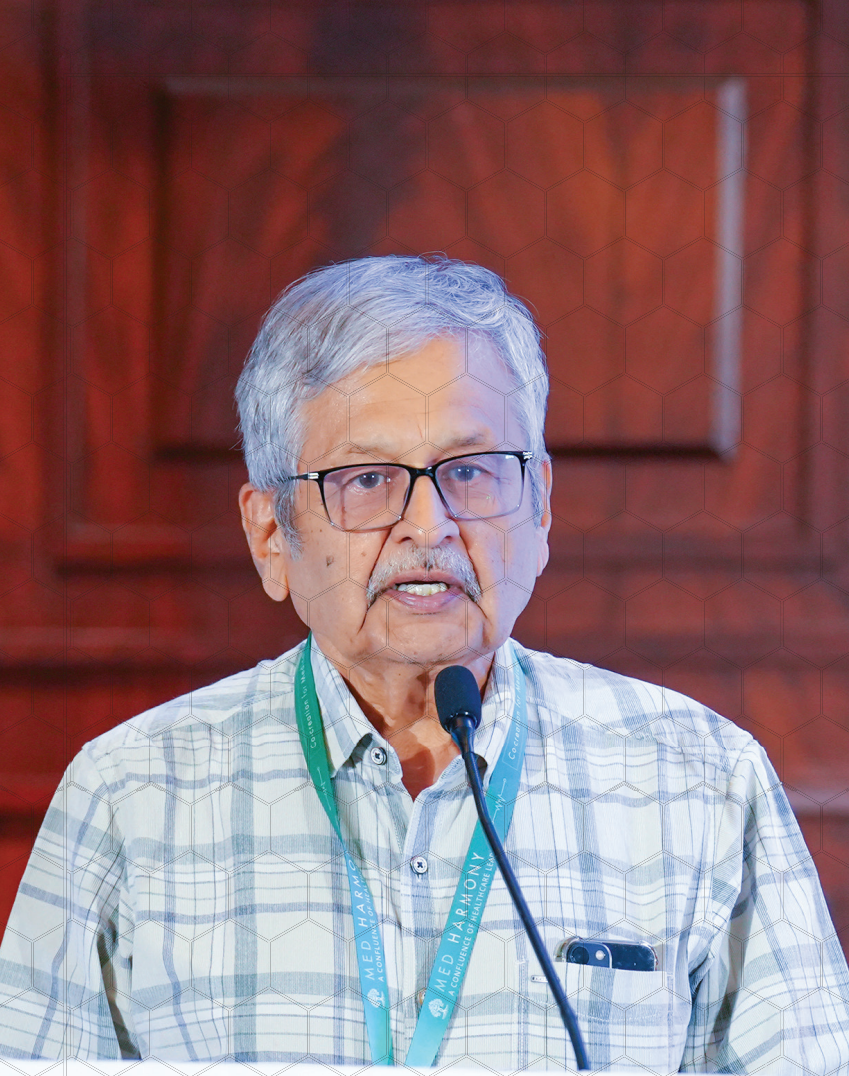
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9. Key Recommendations

The deliberations resulted in a set of recommendations that can guide follow-up action among hospitals, insurers, TPAs, agents and policy stakeholders. These recommendations are framed as collaborative ecosystem improvements rather than obligations placed on any single stakeholder.

	HOSPITALS	PATIENTS	INSURERS / TPAS
DO'S	1. Initiate pre-authorisation 24–48 hours prior to planned admissions and within 24 hours for emergencies 2. Submit clear, consistent, and legible records without overwriting or discrepancies, reflecting facts accurately across all documents 3. Establish medical necessity with ICD/PCS codes and attach all relevant supporting documents, such as FIR/MLC for accidents and investigation reports for infections 4. Provide itemised and rationalised billing, including implant invoices with stickers wherever applicable 5. Respond promptly to insurer queries and substantiate cost escalations with supporting medical records and OT notes 6. Admit patients only when there is a clear medical necessity	1. Accurately and fully declare complete medical history and prior conditions at the time of policy purchase 2. Understand policy coverage, exclusions, and limits before and during hospitalisation 3. Inform the hospital insurance desk in advance about insurance details to enable smooth coordination 4. Prefer network hospitals to avail cashless benefits and reduce documentation burden 5. Maintain complete and authentic records and respond promptly to verification queries 6. Submit redacted KYC documents as required and comply with all verification processes	1. Deliver standardised decisions within defined turnaround times, ensuring consistency and fairness across similar cases 2. Provide clear, reasoned explanations for all approvals, rejections, and deductions 3. Leverage medical audits and analytics to proactively identify risks and minimise leakages 4. Maintain a clear escalation matrix and ensure real-time coordination with hospitals and patients 5. Ensure uniform adjudication across comparable cases 6. Address inconsistencies promptly to ensure clean and controlled outcomes
DON'TS	1. Do not inflate or split bills artificially 2. Do not admit patients without medical necessity or pad the length of stay 3. Do not delay document submission or provide incomplete records 4. Do not carry out unjustified investigations or procedures 5. Do not alter records after submission 6. Do not misrepresent diagnosis or treatments	1. Do not hide pre-existing conditions or prior treatments 2. Do not embed non-medical or excluded costs within payable claim components 3. Do not submit forged documents or duplicate bills 4. Do not delay claim intimation without a valid reason 5. Do not misuse the policy for non-covered treatments 6. Do not make multiple claims for the same hospitalisation across insurers	1. Do not delay approvals or settlements in ways that impact patient experience and outcomes 2. Do not raise repetitive queries or apply unexplained deductions 3. Do not adopt inconsistent adjudication practices across similar cases 4. Do not delay identifying or acting on inconsistencies 5. Do not allow communication gaps with hospitals or patients that cause avoidable delays and confusion



10. Vision Forward

The future of healthcare financing lies in building a transparent, technology-enabled and patient-centric ecosystem where hospitals and insurance providers work together rather than operate in silos.

Hospitals require timely settlement, fair pricing, recognition of clinical complexity and operational predictability. Insurers require complete documentation, policy adherence, reliable medical information and sustainable claim management. Patients require timely care, financial clarity and confidence that the system will support them during medical need.

MedHarmony demonstrated that these priorities are not contradictory. With structured dialogue, common standards, digital platforms, transparent communication and shared accountability, the healthcare-insurance ecosystem can become more efficient and trustworthy.

The way forward requires continuous engagement, evidence-based policy evolution, operational discipline, patient education and willingness across stakeholders to co-create solutions. The next edition of MedHarmony can carry forward this momentum by deepening the conversation on trust, transparency, technology and transformation in healthcare.

A healthcare-insurance ecosystem where patients receive timely support, hospitals experience efficient and fair claim processes, and insurers maintain sustainable, transparent operations.



11. Conclusion

MedHarmony: Medical Insurance: Challenges, Conflicts & Collaborative Solutions served as a meaningful closed door platform for healthcare and insurance stakeholders to engage with issues that directly affect patient experience and institutional sustainability.

The discussions moved from problem identification to solution-building. Participants examined claim delays, documentation gaps, discharge challenges, pricing frameworks, advanced treatment coverage, digital integration, patient communication, escalation mechanisms and policy evolution in a constructive and balanced manner. The meeting reinforced that the patient remains the common beneficiary of the healthcare-insurance ecosystem. Every improvement in documentation, communication, pricing, verification, digital claims exchange or escalation ultimately contributes to better patient confidence and smoother healthcare delivery.

The recommendations that emerged are practical and actionable. They call for common documentation standards, T-1 discharge planning, one-touch approval for pre-agreed packages, transparent settlement communication, periodic reconciliation, MOU review cycles, NHCX readiness, advanced treatment review and stronger stakeholder collaboration.

The spirit of MedHarmony lies in transforming isolated concerns into shared solutions. By continuing this dialogue and converting recommendations into pilots and institutional practices, hospitals, insurers, TPAs, agents, regulators and patients can together build a more transparent, accessible and future-ready healthcare ecosystem.



Thought leaders and pioneers ready to s



shape tomorrow's healthcare narrative.





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