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nib's Response to Consultation 3: Expanding funding to at home and community based mental health care

nib health fund's (nib) purpose of "Your Better Health" ensures the alignment of our efforts to improve the health of our members while delivering private health insurance that is affordable and sustainable for all Australians.

Overall, nib views the proposed reforms as positive as we believe they will help our members maintain and improve their mental health and help prevent mental illness. nib already makes a considerable investment in addressing the current mental health crisis, which impacts many of our members. In addition to the work we do with hospitals and other providers, nib support programs such as Mindstep, offered by Remedy Healthcare.[1] Through this program nib personalises benefits and treatment for members who are either susceptible to mental health problems or require treatment.

As a health fund we also recognise the pressure the current pandemic has placed on our members and the importance of providing support during this time. That's why we have provided additional psychology benefits, for members with Extras cover, up to the value of $300 each, until 30 June 2021. We have also introduced permanent telehealth benefits for several services including psychology.

But with mental health problems likely to escalate as a share of the health care burden, it's critically important governments, and the public and private and community health bodies agree and unite on solutions and funding.

For this reason, nib supports the Department of Health's (DOH) reform agenda, particularly the proposal to allow private health funds to pay a benefit to members for preventative mental health treatment under hospital and general treatment benefits.

However, we suggest the following be considered as part of any final reforms and legislation:

- allow health funds flexibility to pay for preventative mental health services under both the hospital and general treatment tables.
- this reform should be optional in its scope and application, including the removal of default benefits. It should not be mandatory.
- allow health funds to pay a benefit to members for mental health treatment to manage an illness or disorder, in the right setting, including both in-patient and outpatient facilities.
- allow health funds access to member information relating to primary health information for diagnosed or potential mental illness, such as a GP mental health plan. This would allow, where relevant, eligibility under a Chronic Disease Management Plan (CDMP).

[1] https://www.remedyhealthcare.com.au/mental-health/

- allow health funds to ensure clinically proven treatment pathways are followed to support members identified with a mental illness. For example, health funds should be able to require that eligibility criteria for funding an elective mental health overnight admission includes an active GP mental health plan and referral from the member's regular GP.
- reforms should seek to reduce a reliance on hospital-based mental health services and seek to create opportunities for co-ordinated, connected patient-centred care.
- reduce risk of moral hazard, by removing incentives that drive hospital treatment, therefore allowing a broader range of community level mental health programs that are eligible for private health insurance benefits. In this example, these services are already available in community settings, and not required to be funded by in-hospital treatment, which increases pressure on health insurance premiums. An example of this is 'Triple P – Positive Parenting Program'.[2]
- treatment should be focused on the treatment type, rather than the setting, to ensure the correct access and funding.

At nib, we believe that prevention is important. We conduct a number of wellness initiatives with members to help them maintain their health. In line with this, we suggest that this reform should not elevate one disease state over another. This will ensure that, if approved, reforms could be extended to other preventative treatments. If the intent is to extend reforms to other disease states, this should be communicated at the outset and consideration given to any implications. If there are limitations, which apply only to mental health, then the reason for those limits should be clear to customers.

QUESTIONS FOR ALL STAKEHOLDERS: MENTAL HEALTH SERVICES

1. ***What additional mental health services funded by insurers under this proposal would be of value to consumers?***

   For CDMP, this proposal should seek to facilitate funding in the appropriate clinical setting where this is currently not available, commensurate with the patient's needs and preferences.

   Currently CDMPs have been coordinated with private health insurers' members, either over the telephone or face-to-face. Programs delivered digitally cannot be funded through CDMP. Over the last five years, programs that are "digital-first" have emerged and are showing positive treatment and clinical outcomes, despite the lack of funding. The prevalence and improved efficacy of digital-first will be further enhanced in the years to come. Examples include 'SilverCloud' [3] from the United States, and locally 'ThisWayUp',[4] which are focused on mental health.

   A common element of the above programs is a mechanism that allows escalation; consumers can take part either digitally (usually via their mobile phone) or with coaching

[2] Belmont Private Hospital 2021 Triple P – Positive Parenting Program. https://belmontprivate.com.au/uploads/belmontprivate.com.au/BPH-Program-Flyer_Triple-P.pdf Queensland Government 2021 Triple P – Positive Parenting Program. https://www.qld.gov.au/community/caring-child/positive-parenting
[3] https://www.silvercloudhealth.com/
[4] https://thiswayup.org.au/

from an expert. An integrated approach of online and clinician support has been shown to be the most effective way of delivering digital mental health interventions[5].

Expanding CDMP to accredited and clinically proven digital-first mental health care interventions would be a positive step to delivering better health outcomes, as well as promoting lower settings of care.

2. ***Should an expanded list of allied health services available for direct PHI benefits as part of a CDMP be limited to only mental health conditions?***

No, nib believes it should not be limited to mental health conditions only.

The list should be expanded and apply to all fund approved CDMPs. The proposal should not focus only on chronic diseases associated with poor mental health as other diseases and conditions can have equally devastating impacts on patients.

3. ***To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?***

Yes. We believe qualifications should match the approved therapy provided and professional competency must align with delivering services for the required health need, realising the intended goals of the agreed management plan.

4. ***How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-MBS related mental health services?***

There are two definitions required: mental disorder or illness, and mental health.

nib supports helping members maintain their mental health through prevention and adjunct therapies. Providing care meets certain conditions, these therapies can be part of General Treatment. We currently have partnerships with providers to support the mental health of our members.

When patients are diagnosed with a mental illness and require therapy, this can be covered by hospital treatment along with its substitution, or General Treatment. Each fund should decide the range of treatments and therapies offered.

Where coordination and planning is expanded to include private health benefits in either definition, the health funder should be an active partner with the member. nib is supportive of partnering with our members so they can access correct and timely care.

The definition should also be broadened to include direct care to members/patients either in the form of delivery of a clinically proven digital-only program or telephonic or face-to-face support from accredited professionals, e.g. registered nurses.

[5] Karyotaki E et al. 2021. Internet-Based Cognitive Behavioral Therapy for Depression- A Systematic Review and Individual Patient Data Network Meta-analysis. JAMA Psychiatry. Published online January 20, doi:10.1001/jamapsychiatry.2020.4364.

5. Are there any mental health services insurers should not be permitted to fund?

No. The insurer should be permitted to fund mental health services as an option for General Treatment extras product, regardless of the service provider. This includes multidisciplinary health services traditionally offered in the community, such as repetitive Transcranial Magnetic Stimulation (rTMS)[6] or the Triple P program.[7]

6. How should the relevant patient cohort be identified as eligible for services?

It should be up to health funds to define eligibility and services, as described. For example:

- all consumers should be able to maintain their own mental health using prevention and adjunct services of General Treatment so that this group can be self-identified. Health funds can identify the preventative measures they provide in their General Treatment extras cover.
- for consumers and members, access to these services should be via a GP mental health plan. The health fund can partner with the member and their GP to ensure access to non-MBS services that extend the plan of care, e.g. community psychology or group counselling from General Treatment. This bridges the gap between self-maintenance of general mental health and the diagnosed mental illness that can be managed in the community with supports and therapies, such as a Therapeutic Community[8] or a supportive CDMP, compared to those that may require hospitalisation or hospital-substitution therapies. CDMP partnerships should be extended for those with only one risk factor to the development of a chronic mental illness.
- consumers diagnosed with a mental illness who are directed to have treatment must be diagnosed by the appropriate healthcare professional. A patient having an elective admission to a hospital for management of their diagnosed mental illness should have a GP Mental Health plan and a referral from their treating GP. Hospital treatment and hospital substitution should partner with GPs for relevant treatment[9] and facilitate "coexisting physical health needs treated at the same time".[10]

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[6] Medical Scientific Advisory Committee (MSAC) 2019 Public Summary Document Application No. 1196.3 – Repetitive Transcranial Magnetic Stimulation (rTMS) for the treatment of depression – Resubmission. Available on http://www.msac.gov.au/internet/msac/publishing.nsf/Content/1196.3-Public.

[7] Belmont Private Hospital 2021 Triple P – Positive Parenting Program. https://belmontprivate.com.au/uploads/belmontprivate.com.au/BPH-Program-Flyer_Triple-P.pdf Queensland Government 2021 Triple P – Positive Parenting Program. https://www.qld.gov.au/community/caring-child/positive-parenting

[8] https://atca.com.au/

[9] For example; medication and depression https://www1.racgp.org.au/newsgp/clinical/ketamine-can-lift-treatment-resistant-depression-b

[10] RANZCP 2017 https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/private-health-insurance-policies-for-psychiatry

7. Who should identify relevant patient cohorts and should insurers set criteria for which members would be eligible?

There are relevant industry guidelines for determining benefits for private health insurance purposes for private mental health care.[11] This will help in the discussion between insurers and providers on patient cohorts and eligibility criteria.

These guidelines, circulated by the Department of Health, must be updated to reflect expanded mental health care coverage. Funds should also maintain the ability to define inclusion within product design, as outlined in individual insurer fund rules.

In order for any of these programs to be commercially sustainable, it is necessary for insurers to be able to set eligibility criteria and target the programs for members.

8. What are appropriate metrics for measuring the impact of this proposal?

nib believes there are two outcomes within the proposal that need to be measured and reported.

Firstly, "services provided to patients at home or in a community setting to reduce hospital admissions, readmissions, and reduce the length of hospital stay for some patients"[12] so that there must be a demonstrated reduction in admissions, readmissions and length of stay for participants.

Secondly, "services provided in the home or community can be significantly more cost effective than similar services provided in a hospital"[13] so there must be demonstrated decrease in benefit outlay. Performance metrics must be reported and compared to other forms of treatment (i.e. in hospital), as well as a determination made as to whether the treatment actually substituted for hospital level care.

Clinical outcomes (including adverse outcomes), Patient Reported Outcomes Measures (PROMs), Patient Reported Experience Measures (PREMs) and achievement of patient specific goals should also be used to ensure that any change in benefit outlay is achieved through the delivery of health services that are effective, efficient and focused on the patient.

Some simple metrics could be:

- volume of new programs offered to private health insurance members.
- clinical effectiveness of these programs, e.g. number of hospital episodes avoided, clinician measures like Health of the Nation Outcome Scales (HoNOS).
- PROMs and PREMs.
- commercial effectiveness of the program, e.g. return on investment.

9. What is the regulatory burden associated with this proposal?

The regulatory burden depends on the legislation drafted. The stricter the eligibility requirements for these programs, the higher the burden. With this stated, nib is supportive of this reform and is hopeful that further reform for other illnesses, disorders or conditions will be possible.

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[11] PHI Circular 22/15.
[12] DOH Budget 2020 (3) p. 20.
[13] DOH Budget 2020 (3) p. 20.

10. Service providers: what services would you deliver under this proposal?

This may be an opportunity for all to examine how we can work together to provide the correct benefit for services that exist but are not adequately addressed.

nib has a number of collaborative initiatives with a range of health management providers, as well as a joint venture with US health care company Cigna, called Honeysuckle Health. Honeysuckle Health offers health services and specialist data science to deliver a range of health programs and services.

Through these relationships, in particular Honeysuckle Health, we would expect to be able to access clinically proven:

1. health management programs that are digital only.
2. health management programs that are a combination of digital and asynchronous human-based coaching.

INSURER SPECIFIC QUESTIONS

1. In the context of this proposal, what changes do you intend to make to your current funding arrangements for mental health services and the timing of these changes?

Once the details of this reform are finalised, we will review the changes we would like to make to our current funding arrangements for mental health services. At this early stage, details for timings are currently unknown.

2. What will be your likely approach to pricing products with expanded mental health service benefits?

We intend to make programs available that will improve our members' health and help avoid future hospital admissions. Each will be assessed on a case-by-case basis, to ensure they are clinically proven, affordable and commercially sustainable. These programs should, in the medium-term, place downward pressure on health insurance premiums.

3. What will be the anticipated impact on your overall premium revenue if you implement this proposal?

Theoretically, these changes would reduce pressure on health insurance premiums, which will also deliver an enhanced private health insurance value proposition through better health care treatment and affordability. Over the longer term, this will benefit the private health insurance industry by increasing participation, and it will decrease the burden on the public healthcare system.

4. What will be the expected impact on the number of people and/or policies covered if you implement this proposal?

As per question 3, these reforms create the opportunity to increase overall private health insurance participation, by reducing pressure on future premiums and enhancing the value proposition.

Please don’t hesitate to contact me on 0428 903 824 or e.close@nib.com.au if you have any further questions.

Yours sincerely,

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