MINISTRY OF BUSINESS,
INNOVATION & EMPLOYMENT
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Consultation paper

Proposed updates to ACC regulated payments for treatment

September 2022

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How to have your say

Submissions process

On behalf of the Minister for ACC, the Ministry of Business, Innovation & Employment (MBIE) seeks written submissions on the changes proposed in this document by **18 October 2022.**

Your submission may respond to any or all of the questions. Where possible, please include evidence to support your views, for example, references to independent research, facts and figures, or relevant examples.

Please use the submission template provided at: ***https://www.mbie.govt.nz/have-your-say/consultation-on-acc-regulated-payments-for-treatment-2022***. This will help us to collate submissions and ensure that your views are fully considered. Please also include your name and (if applicable) the name of your organisation in your submission.

You can make your submission by:

- sending your submission in as Microsoft Word document or Adobe Acrobat, or a compatible format as an attachment to ***ACregs@mbie.govt.nz***
- mailing your submission to:

  The Manager, Accident Compensation Policy
  Ministry of Business, Innovation & Employment
  PO Box 1473
  Wellington 6140
  New Zealand

Please direct any questions that you have in relation to the submissions process to ***ACregs@mbie.govt.nz***

Use of information

The information provided in submissions will be used to inform MBIE's policy development process and will inform advice to Ministers on any proposed updates to the Cost of Treatment Regulations. We may contact submitters directly if we require clarification of any matters in submissions.

Release of information

MBIE intends to upload PDF copies of submissions received to MBIE's website at www.mbie.govt.nz, to make them publicly available. MBIE will consider you to have consented to your submission being uploaded, unless you clearly specify otherwise in your submission.

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- indicate this on the front of the submission, with any confidential information clearly marked within the text
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Executive summary

On behalf of the Minister for ACC, the Ministry of Business, Innovation & Employment is consulting on the Minister's proposal to increase the amounts, prescribed by regulation, that ACC is liable to pay towards the cost of rehabilitation. These payment rates apply where ACC does not have contracts with treatment providers, and includes rates for consultations, treatments, imaging and devices.

When ACC claimants seek treatment from treatment providers who receive regulated payments, the claimant usually has to pay a co-payment to cover the difference between what the provider charges and the payment rate. When the treatment provider's costs rise, the co-payment charged to the claimant is likely to increase unless the payment rate also rises. Increased co-payments may deter claimants from seeking or completing a course of treatment.

The proposed increase in regulated rates follows a review by ACC that assessed cost pressures in the health sector. Various options to address the cost pressures were developed and these have been assessed against the following policy objectives:

- Claimants have access to treatment, meaning co-payments should be affordable
- Costs to ACC are sustainable, affordable and predictable (gradual increases)
- Payments are not too dissimilar between the health and ACC systems

The review also provides an opportunity to make other changes to payments rates to better meet the needs of stakeholders.

The ACC review was delayed, at various stages, by COVID-19 and undertaking more detailed work to tailor the increases to the wage movements applying to different occupational groups in the health sector.

Our proposals are those recommended from ACC's review, and we invite feedback on them from any stakeholders who may be affected, including treatment providers and population groups who have difficulty in accessing treatment. Specific questions on which we seek feedback are in sections 3 and 4 of the document (pages 14-18).

Increase in treatment payment rates

We propose that treatment payment rates be increased according to the categories in Table 1 below:

Table 1: Proposed increases to treatment rates

Treatment provider type	Proposed increase to treatment rate
Counsellors	9.36%
Dentists	5.70%
Hyperbaric Oxygen Treatment	5.70%
Combined Nurses and Medical Practitioners	4.60%
Medical Practitioners	5.70%
Nurses	7.85%
Radiologists	5.70%
Specialists	5.70%
Specified treatment providers	9.36%
Audiology	0.00%

The proposed increases are expected to apply from 1 December 2022 until the next review takes effect, which is likely to be between one year and 18 months later.

Proposal for a Nurse Practitioner and Registered Nurse combined rate

We also propose to introduce a new combined treatment rate for a consultation involving both a nurse practitioner and registered nurse. This is similar to the current combined treatment rate for a general practitioner and registered nurse.

Process and timeline

The anticipated timeline for the consultation process is set out below.

1 Introduction

Background

ACC contributes to the cost of treating the injuries of claimants

1. ACC pays, or contributes towards, the cost of treating and rehabilitating claimants who have been injured. These payments are set through contracts with treatment providers, prescribed under regulations, or set at an appropriate agreed amount if not covered by regulation or contract.

2. In the 2020/21 year, ACC spent $1.23 billion on injury treatment whose cost was set by contract and $338 million on injury treatment whose cost was set by regulation.

Cost of treatment regulations

3. Section 324 of the Accident Compensation Act 2001 (AC Act) allows the making of regulations prescribing:

    - the costs ACC is liable to pay for goods and services related to rehabilitation (which includes treatment)
    - when and how payment is made, and
    - the people those payments are made to.

4. The regulations set the amount of the payment made to providers by ACC on behalf of the claimant for particular rehabilitation services. How the treatment is provided may differ between providers of the same service.

5. Providers have discretion to set what they charge claimants, so in most cases claimants need to make an additional payment directly to the treatment provider (referred to as a co-payment) to cover the portion of the cost of the treatment not met by ACC.

ACC has to regularly review these regulations

6. ACC has a statutory obligation under section 324A of the AC Act to review, every second year, the amounts prescribed by regulations made under section 324.

7. The purpose of the review is to assess whether adjustment to any of the amounts is required to take into account changes in the costs of rehabilitation. After completing the review, ACC must make appropriate recommendations to the Minister for ACC, which may include various options.

8. The recommendations are assessed to see how well they fit the Government's policy objectives. After determining which recommendations from ACC to consider adopting, the Minister must consult with appropriate parties before finalising the recommended changes to the regulations. To meet this consultation requirement, MBIE is publishing this consultation document on behalf of the Minister for ACC.

What regulations are proposed to be changed?

9. The proposals discussed in this document affect providers listed under the Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 (Cost of Treatment Regulations).

10. The Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010, which prescribes the payments able to be made for the assessment of hearing loss and the provision of hearing devices, including servicing, fitting and repair, are not proposed to be changed in this review round.

11. Final recommendations on changes to the regulations were originally intended to be provided by ACC to the Minister in December 2020. However, it was agreed that further work be undertaken to develop pricing adjustments to take account of differences between professional groups. This allowed the proposed increases to be tailored to reflect wage movements in the relevant occupational groups in the health sector. At various times the work was also delayed by the impact of COVID-19.

2 Options for payment increases and how they were assessed

What is the policy problem?

12. The purpose of the Cost of Treatment Regulations is to help contain scheme costs by capping the amount per treatment that ACC pays for various types of treatment needed by claimants.
13. The cap means that when claimants seek treatment from providers who receive regulated payments, the claimant usually has to pay a co-payment to cover the difference between what the provider charges and the payment rate the provider receives. For example, ACC used Research New Zealand to survey a sample of treatment providers in 2021 (RNZ survey) and found the average physiotherapy co-payment charged for a follow-up consultation of normal duration for an adult was $32.[1]
14. When the treatment provider's costs rise, the co-payment charged to claimants is also likely to increase (within a year or two) unless the payment rate similarly rises.
15. Increased co-payments may mean some claimants are not able to afford to access treatment when it is required in order to complete their rehabilitation.

What are the policy objectives?

16. To assess options to address changes in the cost of rehabilitation we apply the following policy objectives:
    - Claimants are able to access treatment, meaning co-payments should be affordable
    - Costs to ACC are sustainable, affordable and predictable (gradual increases)
    - Payments are not too dissimilar between the health and ACC systems.

Objective 1: Claimants are able to access to treatment

17. Claimants need to be able to afford to pay the co-payment for treatment that most providers charge in addition to the ACC contribution. The New Zealand Health Survey shows that cost is a reason why people do not seek treatment from their GP.[2] Although these findings are about seeking general medical treatment, we expect they would be similar for seeking accident treatment. The RNZ survey found treatment providers considered cost was a barrier to seeking treatment for between 23% and 57% of their client groups.

[1] https://www.acc.co.nz/assets/provider/co-payments-survey-report.pdf
[2] https://www.health.govt.nz/publication/annual-update-key-results-2020-21-new-zealand-health-survey

18. Co-payments can vary between the same type of treatment provider, depending on how the treatment is provided, the business model used and the location of the treatment provider. For example, the RNZ survey found the co-payment charged by physiotherapists for a follow-up consultation for adults aged 26-64 years varied between $5 and $100.

19. Co-payments also vary according to the type of treatment provider, depending on how close the regulated payment rate is to the fee normally charged by that type of treatment provider. For example, the RNZ survey found the average co-payment charged by GPs for a follow-up consultation or normal duration for adults aged 26-64 years was $35 while for osteopaths it was $50.

20. Adjusting payment rates to make co-payment charges more equal (or at least prevent from becoming more unequal) should be beneficial for claimants overall. The difference in co-payment charges might be causing the under use of more expensive services compared to cheaper services.

Objective 2: Costs to ACC are sustainable, affordable and predictable

21. Increases made to payments under the regulations should be kept to a level that means increases in ACC levies and appropriations (allocated through the ACC Non-Earners' Account) are reasonable. Small, regular increases are more affordable and predictable than ad hoc larger increases.

22. The increases to payments proposed are larger than previous increases but their total cost is still relatively modest. The cost will be absorbed by existing budgets. However, if the cost of the preferred option was passed through, it is estimated it would have the following impact in 2023:

    i. no change in the Work levy
    ii. a one cent increase in the Earners' levy
    iii. a 19 cent increase in the Motor Vehicle levy
    iv. a $15 million increase in the Non-Earners' Appropriation.

Objective 3: Payments are not too dissimilar between the health and ACC systems

23. Any increases in rehabilitation payments made by ACC need to take into account payments being made in the health sector, particularly in those areas where ACC and the health sector provide similar services, like payments to GPs and nurses. If payments are too dissimilar, that could cause market tensions by affecting the co-payment charged and distort behaviour. For example, it could encourage the mischaracterisation of borderline injuries to attract the largest treatment payment to enable a lower co-payment to be charged.

What drives the cost of healthcare?

24. The main component of the cost of rehabilitation, that is the cost of treating the injuries of claimants and rehabilitating them, is the cost of labour for the medical professionals who provide this treatment.

25. In previous reviews, changes in the costs of rehabilitation were estimated by examining changes in the labour cost index (LCI) for health care and social assistance industry group. The LCI aims to capture the overall rise in labour compensation after adjusting for any changes in quality.

26. The use of the LCI to estimate labour cost changes meant blanket increases were given that covered all, or nearly all, occupational groups in the health sector. This would not have been as accurate as tracking the actual pay increases of these groups. It may have over-compensated some occupational groups and under-compensated others.

27. Consideration had also been given to using the multiple employer agreements (MECAs) that the former District Health Boards (DHBs) used to set the remuneration of their health professionals. While there are other MECAs in the health sector, it is considered that the DHB MECAs were the main driver of labour costs, with private sector MECAs tending to follow the DHBs.

What options for payment increases were considered?

28. Options can be developed only if they are feasible and practical. For example, the most accurate measure of changing rehabilitation costs would be to track the average cost across the country of every type of treatment covered under the regulations. However, this would be difficult, expensive and time consuming, so this option was not developed.

29. The following options for updating regulated treatment payments, to account for increases in the costs of rehabilitation, were developed and considered:

    a. Leave rates unchanged

    b. Use the LCI for health care and social assistance to calculate increases, as has been done for previous reviews

    c. Use an average of all the DHB MECA increases for relevant medical professionals to calculate increases

    d. Use DHB MECA increases to calculate specific increases for relevant occupational groups

30. The difference between the options, in how well they meet the three objectives, is examined in a discussion of each of the options below and summarised in **Table 3**.

Option A: Leave rates unchanged

31. The RNZ survey indicates that most treatment providers tend to review their fees and adjust their co-payment rates to take account of cost pressures at least every one to two years. This appears to be done at a different time to when payment rates are changed because 71% of respondents said they left co-payments unchanged after the last increase in payment rates.

32. The implications of the RNZ survey are that if payment rates are not regularly adjusted upwards to take account of the cost pressures faced by treatment providers, then providers will likely raise co-payment charges within a year or two.

33. Raised co-payment charges will reduce the ability of claimants to access treatment.

34. While leaving payment rates unchanged would save ACC money in the short term, given the demonstrated cost pressures coming from sector wage increases, even larger increases in payment rates are likely to be sought at the next review.

Option B: Use LCI for health care and social assistance

35. The LCI for health care and social assistance rose by approximately 6% in the two years to mid-2021.

36. Changes in the LCI measure for health care and social assistance give a broad measure of wage movements in this sector. While it has been used in the past to estimate cost changes, the broadness of the measure means it may not be totally accurate in measuring the overall change in labour costs of those occupational groups covered by the Cost of Treatment Regulations.

37. The LCI can't be used to give separate estimates of wage increases for each occupational group. If wages are rising at different rates for the different occupational groups, then applying a flat increase will over-compensate some groups and under-compensate others. This means Option B will be less effective at meeting the objective of giving claimants access to treatment compared to tailoring increases for each occupational group. As was discussed above, adjusting payment rates to make co-payment charges more equal (or at least prevent becoming more unequal) should be beneficial for claimants overall by not encouraging one type of treatment over another purely for cost reasons.

Option C: Use the average DHB MECA increase

38. The average DHB MECA increase from 2016 to 2021, after taking out regulated payment increases from prior reviews, was 6.61%.

39. This measure should more accurately reflect the overall change in labour costs of those occupational groups covered by the Cost of Treatment Regulations, in comparison to using the LCI, because it is based on specific data from industry awards rather than less specific labour market survey data.

40. However, this option suffers from the same disadvantages of applying a flat rate increase that were outlined for the LCI option above.

Option D: Use DHB MECA increases for relevant occupational groups

41. The DHB MECA wage increases grouped by similar occupational groups used in the Cost of Treatment Regulations are shown in **Table 2** below:

Table 2: Proposed increases to treatment rates by MECA group

Treatment provider type	Proposed increase to treatment rate
Allied health professionals	9.36%
Medical practitioners, specialists and dentists	5.70%
Nurses	7.85%
Medical practitioners and nurses combined consultation	4.60%

42. Wage movements since 2016, in the main occupational groups used in the Cost of Treatment Regulations, were calculated from the wage scales agreed in the relevant multiple employer collective agreements (MECAs) used by the former District Health Boards. These were MECAs for Doctors, Nurses and Allied Health professionals. As a final step to avoid double counting, the blanket increases in payment rates given in prior reviews since 2016 were deducted. These were the increases of 1.56% from the 2017 review and 2.05% from the 2018/19 review.

43. The combined treatment rate for a consultation that involves both a medical practitioner and a registered nurse is not purely salary based. It also includes components, for materials like bandages or sutures, which are CPI based. The CPI uplift was not applied by ACC to similar contract funded treatment, so the same approach was followed for calculating comparable regulated payment rates for consistency. This is why the proposed increase for the combined treatment rate is a little lower than the other proposed increases. The CPI uplift component can be examined as part of the next review.

44. Having tailored payment increases for each of the main occupational groups should better reflect the cost pressures being faced by treatment providers. These tailored payment increases for treatment providers should flow through to give a more even effect on holding or reducing co-payments charged to claimants, compared to a blanket increase in treatment payments. This option should therefore best meet the objective of enabling claimants to access treatment.

45. A summary of how all the options have been evaluated and compared to the status quo is shown in **Table 3** below:

Table 3: Evaluation of options to update treatment payment rates

	Option A: Leave rates unchanged	Option B: Use LCI increase like past reviews	Option C: Use average DHB MECA increase	Option D: Use occupational group increases from DHB MECAs
Claimants are able to access treatment because it is affordable	0 Highly likely that co-payments will increase and decrease affordability	+ Affordability for some occupational groups could worsen	+ Affordability for some occupational groups could worsen	++ Affordability better maintained across occupational groups
Costs to ACC are sustainable	0 Likely to be even larger cost increases proposed in the next review	+ Costs to ACC are bearable	+ Costs to ACC are bearable	+ Costs to ACC are bearable
Payments are not too dissimilar between the health and ACC systems	0 ACC payments will fall behind those made by Health	+ Overall, payments should keep up with Health	+ Overall, payments should keep up with Health	++ Payments should more closely reflect Health increases
Key: ++ much better than status quo + better than status quo **0** about the same as status quo - worse than status quo - - much worse than status quo				

3 Proposed increases to regulated payment rates

Cost of Treatment Regulations

46. Based on the evaluation of options summarised in **Table 3** above, we propose that option D be adopted and payments made under the Cost of Treatment Regulations increase by between 4.6% and 9.36% for the services detailed in **Table 4** below. These increases were calculated from wage movements in relevant occupational groups in the health sector since 2016, as set by DHB MECAs, less the general increase in payment rates already given of 1.56% from the 2017 review and 2.05% from the 2018/19 review.

47. The current regulations can be viewed at:

http://www.legislation.govt.nz/regulation/public/2003/0388/latest/DLM235778.html/

Question 1

Do you agree that adopting option D, with tailored payment increases reflecting wage increases in the main occupational groups, as detailed in Table 4 below, best meets the objectives set? If not, why not? Please provide reasons for your view.

Question 2

Do you have any concerns about the impact the regulated payment regime has on particular population groups who have difficulty in accessing treatment? If so, please provide examples and reasons for your view.

Table 4: Services eligible for payment increases

Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003			
Provider	**Regulation**	**Service**	**Proposed Increase**
Counsellors	9	Consultation	9.36%
Dentists	10 and Schedule	Consultation and treatment costs	5.70%
Medical practitioners	13 and Schedule	Consultation and treatment	5.70%
Nurses	14 and Schedule	Consultation and treatment	7.85%

Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003			
Medical practitioners and nurses	15 and Schedule	Combined consultation and treatment	4.60%
Nurse practitioners	15A and Schedule	Consultation and treatment	7.85%
Specialists	16 and Schedule	Consultation and treatment	5.70%
Hyperbaric oxygen	11 and Schedule	Treatment costs	5.70%
Radiologists	12 and Schedule	Consultations and imaging	5.70%
Specified Treatment Provider	**Regulation**	**Service**	**Proposed Increase**
Acupuncturists	17 and Schedule	Treatment costs	9.36%
Chiropractors	17 and Schedule	Consultation, treatment and imaging	9.36%
Occupational therapists	17 and Schedule	Treatment costs	9.36%
Osteopaths	17 and Schedule	Consultation, treatment and imaging	9.36%
Physiotherapists	17 and Schedule	Consultation, treatment and imaging	9.36%
Podiatrists	17 and Schedule	Consultation, treatment and imaging	9.36%
Speech therapists	17 and Schedule	Treatment costs	9.36%

Hearing Loss Regulations

48. The payments made under the Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010 would have a nil increase for the services detailed in **Table 5** below. The regulations can be viewed at:

http://www.legislation.govt.nz/regulation/public/2010/0424/latest/DLM3344620.html

49. ACC recommended that no increase be made to prescribed rates payable to audiologists this review round. With on-going technology changes, which include improving the ability of clients to self-programme hearing devices, an increase in device fitting fees might be inconsistent with market trends.

50. ACC also considers that there has been no increase in cost-related access issues for clients with injury-related hearing loss but intends to assess whether a rate increase is warranted in the upcoming 2022 review.

51. Historically, adjustments to the hearing loss regulations are not generally made as frequently as other rates. In part, this is because ACC is such a large purchaser of audiology services that increases to the rates can shape the market by having an inflationary effect, without benefits to claimants. There is also wider ongoing work on hearing loss settings which is likely to affect the provision of audiology services. It is considered more appropriate to review audiologists' costs at the next review, following the likely implementation of these wider changes.

Question 3

Do you have a view on the proposed nil increase to the payments listed in Table 5? Please provide reasons for your view.

Table 5: Hearing Loss Services

Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010 (the Hearing Loss Regulations)			
Provider	**Regulation**	**Service**	**Increase**
Audiologists	5, 5A, 6, 8, 9, 10, 10A	Assessment, consultations, fittings, service, repairs and replacement ear moulds	0.00%

4 Proposed new Nurse Practitioner and Nurse combined rate

52. There is an increasing number of nurse practitioners operating in general practice. They play a vital role in the delivery of primary health care, particularly in rural and lower socio-economic areas.

53. A minor policy change, we are proposing on ACC's recommendation, is to introduce a new combined treatment rate for a consultation that involves both a nurse practitioner and registered nurse. This will allow easier billing for these consultations.

54. The new combined treatment rate would operate in a similar manner to the current combined treatment rate for a medical practitioner and registered nurse consultation.

55. To calculate the proposed new combined rate, ACC used the same methodology it uses to set the medical practitioner and registered nurse combined rate. It considered the individual rates of both nurse practitioners (as a base) and registered nurses (as an additional top up)[3] and calculated a combined treatment rate for each class of claimant as shown in **Table 6** below (before the 4.6% uplift proposed for combined rates). In comparison, the current medical practitioner and registered nurse combined rate (for a patient 14 years and over) is $35.74 and the current nurse practitioner only rate (for a patient 14 years and over) is $28.02.

56. The new combined rate will be simple to implement with only minor changes required to ACC processes. It is expected to reduce administration costs for medical practices, and should also reduce billing errors.

Question 4

Do you agree with introducing a new nurse practitioner and nurse combined treatment rate, and the specific rates (before the general increase proposed in section 3) listed in Table 6 below? Please provide reasons for your view.

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[3] Currently if a combined consultation took place, ACC would pay the full amount of the registered nurse rate and 50% of the registered nurse rate, but these amounts would have to be separately itemised.

Table 6: Nurse Practitioner and Nurse combined treatment rates

Definition	Treatment rate
If the claimant is 14 years old or over when the visit takes place and is not the holder of a community services card or the dependent child of a holder	$29.33
If the claimant is under 14 years old when the visit takes place	$54.21
If the claimant is 14 years old or over when the visit takes place and is the holder of a community services card	$50.88
If the claimant is 14 years old or over but under 18 years old when the visit takes place and is the dependent child of a holder of a community services card	$55.71

5 What happens next?

57. Submissions on the proposed updates to the regulations close on 19 September 2022. The submissions will be reviewed for any insights they can provide for further analysis of the proposals. All the submissions will be published on MBIE's website. A summary of submissions and responses may also be provided.

58. After due consideration of the submissions has been given, MBIE will advise the Minister for ACC on how to proceed. The Minister will then seek Cabinet agreement on what is decided.

59. Should Cabinet agree to new rates, amending regulations will be drafted and approved, with the updates coming into force at least 28 days after the approved regulations are gazetted.