MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
HĪKINA WHAKATUTUKI

COVERSHEET

Minister	Hon Peeni Henare	**Portfolio**	ACC
Title of Cabinet paper	Updates to ACC Regulated Payments for Treatment: Final Proposals.	**Date to be published**	19 September 2023

List of documents that have been proactively released		
Date	**Title**	**Author**
10 July 2023	Final Proposals – Approval for Updates to ACC Regulates Payments for Treatment	Office of the Minister for ACC
18 August 2023	Updates for ACC Regulated Payments for Treatment: Final Proposals. SWC-23-SUB-0111 Minute	Cabinet Office
23 June 2023	Regulatory Impact Statement: Proposals for updates to ACC regulations dealing with treatment payments after 2022 review	MBIE

Information redacted YES / **NO** *[select one]*

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Regulatory Impact Statement: Proposals for updates to ACC regulations dealing with treatment payments after 2022 review

Coversheet

Purpose of Document	
Decision sought:	Final Cabinet decisions are sought to increase ACC's regulated treatment payment rates and add one new rate, following a regular review in 2022.
Advising agencies:	Ministry of Business, Innovation and Employment (MBIE) with input from the Accident Compensation Corporation (ACC) (the operational agency)
Proposing Ministers:	Minister for ACC
Date finalised:	23 June 2023

Problem Definition

Many of the treatment payments that ACC contributes to rehabilitation and treatment service costs are prescribed in regulations (regulated rates) made under the *Accident Compensation Act 2001* (excluding treatments, like major surgery, that are covered under contractual arrangements).

ACC's regulated rates have to be reviewed every two years to assess whether any adjustment is required to take account of changing costs. The review may also consider other changes to the regulations like adding new rates.

Claimants usually need to pay a co-payment to the treatment provider on top of ACC's contribution, which could deter some claimants from accessing treatment and work against an overriding goal of the Accident Compensation Scheme of minimising the impact of injury.

In assessing whether any adjustment to the regulated rates is required to take account of changing costs it is considered whether, to keep co-payments around the same relative level, regulated rates need to be adjusted to reflect any changes in the costs of providing treatment.

The regular review therefore aims to determine the increase in regulated rates needed to offset the potential impact of rising costs on co-payments, to avoid rising costs being passed on to claimants and potentially reducing access to treatment. There are also the interests of levy payers, taxpayers and the health system to consider, but it is not within scope to consider significantly changing the balance between the ACC contribution and the claimant contribution (i.e., reductions and very large increases to the ACC contribution are out of scope).

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Executive Summary

ACC is required to undertake a biennial review of the rates it pays or contributes towards treatment services under the *Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003* and the *Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010* (the Regulations). Rates are set for different types of treatment provided by different occupational groups. The review assesses whether an adjustment to any of the rates is required to take into account changes in the costs of rehabilitation since previous reviews (now every two years but previously were annual), and recommend the changes required to the Minister for ACC.

Four options for possible changes were considered in the 2022 review:

a) **Option One – Status quo:** the contributions ACC makes to treatment and rehabilitation services remain the same (as currently laid out in the Regulations) but may have to increase by a greater amount at a later date to address accessibility;

b) **Option Two – Calculate flat rate increase using Labour Cost Index (LCI) for health care and social assistance:** the rates under the Regulations are increased by 4.08% to reflect the increase in the LCI for health care and social assistance (reported by Statistics New Zealand) for the year to 30 June 2022;

c) **Option Three – Calculate flat rate increase using composite of LCI and the Consumer Price Index (CPI) indices for health services and medical equipment:** the rates under the Regulations are increased by 4.36% to reflect a combination of the increase in the LCI for health care and social assistance (60%) and the increase in the CPI indices for health services (20%) and medical equipment (20%) for the year to 30 June 2022;

d) **Option Four – Calculate bespoke increases using MECA increases for the relevant occupational groups:** bespoke increases are applied to professional groups based on health sector Multi-Employer Collective Agreements (MECA) increases (for the same period as Option Two). These increases range between 3.56 and 7.90%.

A proposal to introduce a GP internal examination procedure rate into the Regulations to assist with the new cover for maternal birth injuries was also considered. This rate covers the additional consumable and time requirements for GPs undertaking an internal examination where it is clinically appropriate, and would formalise what is already happening in practice.

ACC undertook targeted consultation on the proposals on behalf of the Minister for ACC from 3 April to 1 May 2023 and received 28 submissions from a variety of health professionals and their professional organisations. Nearly all submitters agreed with the need for an increase in payment rates but, with general inflation often being higher than sector wage increases for the period, most submitters thought the proposed increases were insufficient. Some submitters wanted much more substantive increases to increase the proportion of cost covered by ACC.

An analysis of the options indicates that **Option Four** best meets the policy objectives and delivers marginally higher benefits. Under Option Four, access to treatment and alignment between ACC and the wider health sector are best maintained by a more bespoke assessment of labour cost pressures (which is the main cost driver) that the different professions face.

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It is expected that by increasing ACC's rates for treatment services in line with increasing cost pressures, co-payments will either not rise when providers next review their prices or will not rise sufficiently to worsen access to treatment.

While spending by ACC is expected to increase by $17 million annually under Option Four (similar to Options Two and Three), ACC has indicated that the impact would be negligible on the future claims liability, levies and appropriations.

Limitations and Constraints on Analysis

Assessing the impact of increasing the rates for claimants

A key limitation is that it is difficult to determine the impact cost pressures have on co-payments charged to claimants. While we can estimate cost pressures, such as increases in labour costs, these proxy calculations will not completely match the rise in prices for treatment services that would be set by treatment providers were it not for a rise in payment rates.

A further important limitation is that we cannot quantify what impact rises in treatment costs have on access to treatment. While we know cost can be a barrier to access, we do not know how changes in costs change the extent to which people access treatment.

Overall, we consider these limitations are mitigated appropriately given the constrained nature of the problem we are trying to solve.

ACC used Research New Zealand to survey a sample of ACC treatment providers in 2021 (the RNZ survey) to better understand provider cost pressures and prices, and financial barriers to treatment.

The RNZ survey found that the cost of treatment was identified as a barrier for between 23% and 57% of specific groups of patients. Five groups in particular were identified as impacted by costs: Community Card Holders, Māori, Pacific Peoples, Adults (18-25 years) and Adults (65+).

The RNZ survey also indicated that provider costs were impacted by overheads, COVID-19, and staff costs, among others. To manage increased costs, most providers indicated that they had raised their prices in the last 12 months or within the last 2 years.

Providers do not change their rates on the schedule of this regular review. While providers do tend to increase their rates every year or two, this is often at a different time of year or a different year to when ACC's regulated rates are increased. This means that there isn't a direct change in provider prices in relation to increases in ACC's rates.

However, the RNZ survey found at the time of the survey (June and July 2021) that 71% of providers surveyed had not raised their co-payments since the last increase to the regulated rates (that took effect in May 2021). This may indicate the rise in regulated rates prevented or delayed providers from needing to raise co-payments in line with increasing cost pressures.

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Responsible Manager(s) (completed by relevant manager)
 Bridget Duley *Manager, Accident Compensation Policy* *Ministry of Business, Innovation and Employment* *23 / 06 / 2023*

Quality Assurance (completed by QA panel)	
Reviewing Agency:	MBIE
Panel Assessment & Comment:	MBIE's Regulatory Impact Analysis Review Panel has reviewed the attached Regulatory Impact Statement (RIS) on "Proposals for updates to ACC regulation dealing with treatment payments after 2022 review" prepared by MBIE. The panel has reviewed the revised RIS and considers that the information and analysis summarised in the Impact Statement meets the criteria necessary for Ministers to make informed decisions on the proposals in this paper.

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Section 1: Diagnosing the policy problem

What is the context behind the policy problem and how is the status quo expected to develop?

Context

ACC regulations prescribe rates ACC contributes to some treatment

1. Under the *Accident Compensation Act 2001* (AC Act), ACC must pay or contribute towards the cost of treatment for injured people so they can, to the extent possible, be rehabilitated. ACC contributions are funded by levy payers and the Crown.
2. ACC generally pays for treatment either under contracts or in accordance with the regulations made under the AC Act. Section 324 of the AC Act allows the making of regulations prescribing:
    a. the costs that ACC is liable to pay for rehabilitation (including treatment)
    b. when and how payment is made
    c. to whom the payments may be made.
3. The *Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003* and the *Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010* (the Regulations) prescribes rates that ACC contributes towards consultations, specified treatments, fitting, and imaging services provided to ACC claimants by treatment and rehabilitation providers. These providers include general practitioners (GPs), physiotherapists, audiologists and others.
4. The rates prescribed in the Regulations are not intended to cover the full cost of treatment. Claimants generally need to 'top up' the ACC payment to cover the balance of the cost of their treatment. The amount a provider charges over and above the ACC contribution (so has to be paid by the claimant) is called a co-payment.
5. Different provider types (e.g., radiologists, GPs, physiotherapists and audiologists) have different cost structures and are impacted by inflation and labour costs differently. Given there is no restriction on the amount that a provider can charge, co-payments vary significantly along with the proportion that ACC contributes towards the total treatment cost.
6. ACC spent $294 million on regulated rate payments in the 2021/22 year.

There are competing objectives applied to the Regulations

7. The objectives that were considered in assessing the increase in regulated rates were that the ACC contribution should be set at a level that balances the following:
    a. consultations and treatments are sufficiently affordable to facilitate access to these services
    b. costs to levy and taxpayers are financially sustainable
    c. payments are not too dissimilar between the health and ACC systems.
8. These are the objectives that have been used in previous reviews. The access objective supports an overriding goal of the Accident Compensation Scheme of minimising the impact of injury. The other objectives consider the interests of those who fund the scheme and the health system. Section 324A of the AC Act requires only that ACC reviews the regulated rehabilitation contributions to assess only whether adjustment to any of the amounts is required to take into account any changes in the

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costs of rehabilitation (since previous changes). ACC must then recommend any changes to the Minister for ACC.

9. The addition of new rates should be assessed similarly where they will make a difference to treatment providers or claimants.

10. The regular reviews have resulted in small and regular increases. Reviews had been required by section 324A of AC Act every year, but the provision was amended so that from 2020 onwards reviews were required every two years.

11. Recent reviews and their results are shown in the table below.

When treatment rate review undertaken	Level of increase made to rates
2015/16	2.22% to all rates excluding audiology
2016/17	Nil
2017/18	1.56% to all rates excluding audiology
2018/19	2.05% to all rates except Radiologists and Hyperbaric Oxygen Treatment which received 1.72%
2020/21	4.60% to 9.36% to rates for various occupational groups except audiology which received a nil increase

Various methods could be used to review the rates

12. It can be difficult to determine the impact any cost pressures are having on co-payments charged to clients. However, there are various ways to gauge probable changes to the cost of treatment and rehabilitation. The main component of rehabilitation costs, 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. There is a smaller component that includes any consumables used in treatment and overheads like the use of equipment and premises.

13. When reviews were annual, changes in the costs of rehabilitation were estimated by examining changes in Labour cost index (LCI) for the health care and social assistance industry group reported by Statistics New Zealand. The LCI aims to capture the overall rise in labour compensation after adjusting for any changes in quality. 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.

14. For the 2020/21 review, rehabilitation cost changes were estimated by referencing the former DHB MECAs used to set the remuneration of health professionals. While there were other MECAs in the health sector, it was considered that the former DHB MECAs were the main driver of labour costs for health professionals, with private sector MECAs tending to follow the DHBs. Private sector MECAs were also not necessarily public like DHB MECAs.

15. For the 2022 review, a similar approach to the 2020/21 review has been considered with changes in public health sector MECAs for various occupational groups referenced.

16. In addition to assessing whether to increase regulated rates, other minor regulatory changes related to regulated rates can be incorporated in the review. ACC have

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proposed introducing a GP internal examination procedure rate into the Regulations because it was identified as an addition needed for the new cover for maternal birth injuries. This rate would cover the additional consumable and time requirements for GPs undertaking an internal examination where it is clinically appropriate.

While the process to review regulated rates is biennial, COVID-19 delays with the prior review mean that the current review covers only one year

17. While initial recommendations on the prior review of regulated rates was provided by ACC by 1 December 2020, given COVID-19 constraints and the opportunity to undertake more detailed work, the Minister agreed to provide more time for the completion of more comprehensive analysis for that review. ACC therefore provided the final 2020/21 review recommendations in January 2022 and it considered increases in MECA rates up until mid-2021. This meant that the 2022 review, which was completed by 1 December 2022, could consider changes in cost for only one year to mid-2022.

18. Expediting the 2022 review will allow a more in-depth 2024 review covering a full two-year period.

Status quo

19. If nothing is done, the current rates under the Regulations would continue to apply. Rising cost pressures, which are high at the moment with inflation running at around 7% for the last year, would inevitably force providers to increase their prices, and price increases would be borne by claimants via increased co-payments. ACC's contribution to the cost of treatment services would stay the same in nominal terms but would fall in real terms.

20. Raised co-payment charges would reduce the ability of claimants to access treatment. While leaving payment rates unchanged would save ACC money in the short term, given the demonstrated cost pressures coming from sector wage increases, it would mean even larger increases in payment rates would likely be proposed at the next review.

21. The RNZ survey indicated that 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. The RNZ survey was undertaken in June and July 2021. Since the increase to regulated rates on 1 May 2021, 71% of respondents said they left co-payments unchanged. This suggests that the increased rates may have off-set the need to raise co-payments in response to increasing cost pressures.

22. With the new internal examination rate, the status quo is that the informal rate would continue to be paid, but if the new rate is not formally added as a regulated rate there is a legal risk that treatment providers may ask for full compensation for the service.

What is the policy problem or opportunity?

23. An overriding goal of the accident compensation scheme, as outlined in section 3 of the AC Act, is to minimise the impact of injury on the community. The co-payment that claimants usually need to pay to the ACC treatment provider works against this goal by deterring some claimants from seeking treatment. The RNZ survey found that the cost of treatment was identified as a barrier for between 23% and 57% of specific groups of patients. Five groups in particular were identified as most impacted by costs: Community Card Holders, Māori, Pacific Peoples, Adults (18-25 years) and Adults (65+).

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24. When people do not access health care when they should, injuries can deteriorate, which can push demand onto other health or social services (e.g., emergency departments, social welfare assistance). Untreated injuries can also result in avoidable disabilities (e.g., untreated concussion in some cases can have serious consequences).

25. Therefore, there are sound reasons why it is not desirable to deter ACC claimants (or potential claimants) from seeking treatment. However, there is insufficient data to determine how much a particular cost will deter treatment and what costs and benefits will arise from this level of deterrence.

26. The RNZ survey found that some providers (approximately 50%) vary co-payment rates by socio-economic status. This means that under the current framework where co-payments can vary greatly for the same services, many providers do subsidise their services for patients that face financial barriers to access treatment.

27. It is accepted by MBIE and ACC (given the lack of better evidence) that the current level of co-payments provides a satisfactory base level of access. This assumption limits the scope of the regular review to trying to determine the adjustments to payment rates needed to keep co-payments around the same relative level, so that access to treatment by claimants does not deteriorate.

28. The review therefore aims to determine the increase needed to offset the potential impact of rising costs on co-payments. It is not within the biennial review's scope to consider significantly changing the balance between the ACC contribution and the claimant contribution (i.e., reductions and very large increases to the ACC contribution are out of scope).

What objectives are sought in relation to the policy problem?

29. The objectives used in assessing changes to the Regulations, as used in past reviews, first reflect an overriding goal of the accident compensation scheme to minimise the impact of injury on the community, and then consider the interests of levy payers, taxpayers and the health system. Accordingly, the objectives are to choose the policy option that best balances the following:

    a. consultations and treatments are sufficiently affordable to facilitate access to services;

    b. costs to levy and taxpayers are financially sustainable; and

    c. payments are not too dissimilar between the health and ACC systems.

30. Some of these objectives are competing. For example, making services more affordable to claimants by increasing ACC's contributions will necessarily put more pressure on levy payers and the Crown.

31. However, the constraints on the analysis and the assumption that current co-payments are set to give a satisfactory level of access mean the review is limited to trying to ensure that access to treatment is maintained around the current level. This means it is less likely that significant trade-offs will have to be made in determining the recommended increases in regulated rates.

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Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

32. The criteria that the options will be assessed against are the following:

    a. **Access to treatment:** this relates to ensuring that treatment services remain accessible to ACC claimants (or potential claimants).

    b. **Cost to ACC:** this relates to ensuring that ACC remains a responsible steward of Crown and levy payer funding by ensuring that its costs are sustainable and predictable.

    c. **Similarities with the health system:** this relates to maintaining alignment across other non-ACC funded services to ensure fairness across the health system as a whole. This means that different people in the health system won't have significantly different Crown contributions depending on whether or not they are accessing the Accident Compensation Scheme.

What scope will options be considered within?

33. As laid out in section 324A of the AC Act, the purpose of the biennial review is to assess whether adjustment to any of the amounts is required to take into account changes in costs of rehabilitation. This means it was accepted that the level of co-payments (at least at the time reviews were instituted) provided a satisfactory base level of access.

34. Because the costs of rehabilitation tend to rise (with inflation), it would be out of scope and counter to the review objectives to propose lowering the rates ACC contributes to treatment and rehabilitation services. Furthermore, very large increases that aim to significantly increase the proportion of costs covered by ACC would also be out of scope.

35. Options are therefore limited to making no changes to regulated rates, which is the status quo, or increasing rates by various amounts and formulations.

36. A report is due to the Minister, including recommendations, by 1 December of the year the review is conducted (required by section 324A(3)(b) of the AC Act). This means the 2022 review recommendations were due to the Minister of ACC by 1 December 2022. These recommendations (being discussed in this paper) were delivered on 27 November 2022 and for the reasons discussed earlier could consider cost changes only for the year to mid-2022.

37. In addition to assessing whether to increase regulated rates, it is within scope to consider other regulatory changes. In this review, the introduction of a new rate for a GP internal examination, related to the extension of cover to maternal birth injuries, was also considered.

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What options are being considered?

Options to increase ACC's regulated treatment rates under the Regulations

Option One – Status Quo

38. The status quo is the do-nothing option with ACC's current contributions to various treatment and rehabilitation services remaining the same (as laid out in the Regulations).

Option Two – Use LCI for health care and social assistance

39. This option applies a blanket increase for all types of treatment provider based on the all-sectors combined LCI for health care and social assistance. This rose by 4.08% in the year to 30 June 2022.

40. Changes in the LCI measure for health care and social assistance give a broad measure of wage movements in this sector. While the LCI has been used in past reviews 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 Regulations.

41. The LCI cannot 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 Two will be less effective at meeting the objective of maintaining access to treatment compared to tailoring increases for each occupational group. As discussed above, tailored increases should be beneficial for claimants overall by not encouraging one type of treatment over another purely for cost reasons.

42. This option is estimated to cost $15.4 million per year.

Option Three – Use a composite of LCI and CPI

43. This option also applies a blanket increase but uses a composite calculation with a 60% weighting from the LCI (health subindex), a 20% weighting from the Consumer Price Index (CPI) medical products, appliances and equipment subindex, and a 20% weighting from the CPI hospital services subindex.

44. The aim of using the composite calculation is to take account of the other cost drivers apart from labour faced by treatment providers. As mentioned earlier, other costs include any consumables used in treatment and overheads to cover the use of equipment and premises.

45. Because of the higher rate of general inflation over the period, this composite calculation gives a slightly higher 4.36% annual increase than Option Two. However, a larger CPI movement for medical equipment is not usual given that medical products tend to have a reducing quality-adjusted price over time as later models generally give more 'bang for buck'.

46. As with Option Two, it will be less effective at meeting the objective of maintaining access to treatment compared to tailoring increases for each occupational group.

47. This option is estimated to cost $16.5 million per year.

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Option Four – Use MECA increases for relevant occupational groups

48. Option Four largely applies a bespoke pricing increase to the individual professions, based on MECA changes in the year to 30 June 2022 plus additional employer costs from new sick leave and public holiday obligations. For Hyperbaric Oxygen Treatment and Radiologists, a composite of LCI and CPI measures was used because a greater portion of the cost for these treatments is overheads for equipment use.

49. The following table outlines the proposed increases by occupational group and describes the methodology by which they have been calculated:

Service Provider Type, as identified in the regulations	Proposed price adjustor[1]	Methodology	New employer obligations	Impact of MECA increases
Audiology	**4.89%**	*Based on Step 12 of the Allied Health MECA, and new employer obligations*	1.83%	3.00%
Counsellors	**4.89%**	*Based on Step 12 of the Allied Health MECA, and new employer obligations*	1.83%	3.00%
Dentists	**3.56%**	*Based on Step 4 of the Medical Specialist MECA (less the 1.9% placeholder applied in 2020/21 recommendations), and new employer obligations*	1.83%	1.70%
Hyperbaric Oxygen Treatment	**4.36%**	*Based on a composite rate (using the Labour Cost Index and Consumer Price Index)*	NA	NA
Medical Practitioners	**3.56%**	*Based on Step 4 of the Medical Specialist MECA (less the 1.9% placeholder applied in 2020/21 recommendations), and new employer obligations*	1.83%	3.00%
Nurses	**7.90%**	*Based on Step 5 of the Community Nurse MECA (less the 2% placeholder applied in 2020/21 recommendations), and new employer obligations*	1.83%	5.95%
Nurse Practitioners	**7.90%**	*Based on Step 5 of the Community Nurse MECA (less the 2% placeholder applied in 2021 recommendations), and new employer obligations*	1.83%	5.95%
Combined Nurse and Medical Practitioner	**4.17%**	*Uses relevant MECAs and weighted average of GP workforce provided by TAS, and new employer obligations*	1.83%	2.29%
Combined Nurse and Nurse Practitioner	**7.90%**	*Based on Step 5 of the Community Nurse MECA (less the 2% placeholder applied in 2021 recommendations), and new employer obligations*	1.83%	5.95%

[1] The totals are based on a compounding percentage of the new employer obligations and MECA impacts, not a simple arithmetic total.

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Service Provider Type, as identified in the regulations	Proposed price adjustor[1]	Methodology	New employer obligations	Impact of MECA increases
Radiologists	**4.36%**	*Based on a composite rate (using the Labour Cost Index and Consumer Price Index)*	NA	NA
Specialists	**3.56%**	*Based on Step 4 of the Medical Specialist MECA (less the 1.9% placeholder applied in 2020/21 recommendations), and new employer obligations*	1.83%	1.70%
Specified treatment providers	**4.89%**	*Based on Step 12 of the Allied Health MECA, and new employer obligations*	1.83%	3.00%

50. Having tailored payment increases for each of the main occupational groups better reflects 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 limiting the increase in co-payments charged to claimants, compared to a blanket increase in treatment payments. This option should therefore best meet the objective of maintaining access to treatment.

51. The proposed increases would be one of the largest set of increases to the regulated rates given wage inflation, with spending estimated to increase by $17.4 million annually under this option.

Analysis of submissions obtained from targeted consultation

52. To undertake consultation, ACC distributed a consultation document to stakeholders like treatment provider associations. Some of these associations passed the document onto their members. This resulted in 28 submissions from treatment providers or their associations concerning the proposed bespoke increases.

53. Nearly all of the submissions supported the need for an increase in payment rates to compensate for increased costs. However, given that general inflation was often higher than the wage movements in the MECAs that were referenced, most submissions considered the proposed increases were insufficient to compensate for increased costs. No evidence was presented to support particular views apart from making general claims and quoting the inflation rate, and no fully developed alternative methodology was proposed.

54. Some submitters wanted far more substantive increases to significantly increase the proportion of cost covered by ACC and reduce the co-payments required to be charged to claimants. One respondent (from the audiology sector) opposed the proposed uplifts, citing the likely exacerbation of existing disparities in access between ACC funded treatment and health funded treatment, as well as the unsustainability of rising costs for the AC Scheme.

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Options for introducing a new internal examination rate related to maternal birth injuries

Option One: Status Quo

55. Under the status quo option, ACC will continue to pay the non-regulated rate it established for this service when it commenced covering maternal birth injuries on 1 October 2022.

Option Two: Introduce a new internal examination treatment rate

56. Introducing a new internal examination treatment rate will provide more certainty that providers will be appropriately reimbursed for consultations involving an internal examination related to a maternal birth injury, and that this rate will be regularly reviewed.

57. To calculate the proposed new rate, ACC considered the extra time and materials likely to be used for such an examination. It was set to be consistent with contracted rates for similar services.

Analysis of submissions obtained in targeted consultation

58. There were four submissions related to the proposed new rate. There was general support for covering the cost of such an examination, although some submitters thought the rate should be higher or available to a wider range of treatment providers but did not provide an alternative methodology.

59. Submitters appeared to misunderstand some aspects of the proposal. We note that the proposed procedure code could be billed by a GP, a Nurse or a Nurse Practitioner, as with procedure codes currently in the Regulations under “Medical practitioners’, nurses’, and nurse practitioners’ costs”. Allied health providers would not be qualified to perform the procedure.

60. We also note that the rate is the second part of a two-part calculation. The first part of the calculation is the rate for the consultation which has to be added to the internal examination rate, and means the total payment is nearly double or more than the new rate on its own.

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How do the options compare to the status quo/counterfactual? – Options to increase ACC's rates

	Option One – Status Quo	Option Two – Use LCI for health care and social assistance	Option Three – Use a composite of LCI and CPI	Option Four – Use DHB MECA increases for relevant occupational groups
Access to treatment	0	+ The regulated rates would all rise uniformly by around 4% so if providers need to raise their prices in response to increased cost pressures, this portion of the increase should not be passed on to claimants.	+ The regulated rates would all rise uniformly by a little over 4% so if providers need to raise their prices in response to increased cost pressures, this portion of the increase should not be passed on to claimants.	++ The regulated rates would rise by a variable amount of between 3.56 and 7.90%, depending on the individual impact MECA increases have had on the provider type, which should better match the rate increases to provider cost pressures.
Cost to ACC	0	0 The cost to ACC would be manageable and would not require material levy increases.	0 The cost to ACC, although slightly higher than Option Two, would be manageable and would not require material levy increases.	0 The cost to ACC, although slightly higher than Options Two or Three, would still be manageable and would not require material levy increases.
Similarities with the health system	0	+ Increasing ACC's contribution would better align with the increasing costs across the health sector.	+ Increasing ACC's contribution would better align with the increasing costs across the health sector, although in future the health CPI contributions may reduce the calculated increase.	++ This best aligns to cost changes across the health sector as it takes account of the wage increases applying in particular sectors rather than applying a blanket change.
Overall assessment	0	++	++	++++

Key for qualitative judgements:

++	+	0	-	- -
Much better than the status quo	Better than the status quo	About the same as the status quo	Worse than the status quo	Much worse than the status quo

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What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

61. MBIE considers the option that best meets the policy objectives and that delivers the highest benefits is **Option Four** – Use MECA increases for relevant occupational groups.

62. Option Four best facilitates access by addressing the findings of the RNZ survey. The RNZ survey indicated that cost is a barrier to treatment for many patients. It also found that providers will likely be increasing their rates in the next year if they haven't already, increasing the barrier to treatment for some. By increasing ACC's contribution to treatment by percentages specific to provider type, ACC will best maintain access to treatment. Particularly because provider types with the greatest increased cost pressures (due to MECA increases) will receive the greatest rate increase, and access to all treatment types will be better maintained compared to the Status Quo and the other options.

63. Option Four should best prevent co-payment increases for treatment or limit the amount that co-payments are raised sufficiently to ensure that barriers to treatment are not exacerbated.

64. Most submissions wanted a larger increase than that being proposed and more linked to general inflation. However, while current inflation is high, it is predicted that this is likely to be short-lived with the historic pattern of wage increases tending to outpace general inflation (as measured by the CPI) returning. Some submitters wanted much more substantive increases, sufficient to increase the proportion of cost covered by ACC, to reduce the co-payments faced by claimants.

65. While the proposed increases in payment rates will increase ACC spending by $17 million annually and a little more than the other options, ACC has indicated that the costs associated with Option Four would not result in material increases in ACC levies or ACC appropriation. This means that the costs to ACC are sustainable and a key trade-off from this option has already been mitigated.

66. This option does not disrupt similarities with the health system which also regularly increases its subsidies. For example, general practices which provide both health and ACC funded treatment receive annual increases in treatment subsidies for their health treatment. However, the full funding arrangements are more complex and can include fixed annual per-patient payments, which makes direct comparisons difficult.

67. Treatment for hearing loss under the health system provides both lesser or greater funding compared to ACC, depending on the situation of the claimant. In some situations, full funding is provided so increasing ACC funding does not necessarily exacerbate disparities.

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How do the options compare to the status quo/counterfactual? – Options to add a new internal examination rate related to maternal birth injuries

	Option One – Status Quo	Option Two – Introduce a new rate
Access to treatment	0 Access to maternal injury treatment has become more accessible because GPs can receive funding for the additional consumable and time requirements for undertaking an internal examination, where it is clinically appropriate.	+ With a new regulated rate, access to maternal injury treatment is likely to be more accessible given it is transparent that GPs can receive funding for undertaking an internal examination, and this rate will be regularly reviewed along with all the other regulated rates.
Cost to ACC	0 There is a very small additional cost to ACC, but this has already been budgeted for within the expected costs for maternal birth injury claims.	0 There would be a very small additional cost to ACC, but this has already been budgeted for within the expected costs for maternal birth injury claims.
Similarities with the health system	0	**0**
Overall assessment	0	+

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

68. MBIE considers the option that best meets the policy objectives and that delivers the highest benefits is Option Two.

69. Access to treatment is more sustainably increased in Option Two compared to the Status Quo. This is because under Option Two, the new rate is more transparent through being included in the list of regulated rates and will be regularly reviewed along with all the other regulated rates.

70. Both options are likely to provide more similar payments between ACC and the wider health system given most maternity related treatment is free.

71. Four submissions addressed the proposal and supported the new rate although some wanted wider coverage or a higher rate. There may have been confusion that the new rate applies as an addition to the standard consultation rate.

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What are the marginal costs and benefits of the package of preferred options?[2]

Affected groups *(identify)*	**Comment** *nature of cost or benefit (e.g., ongoing, one-off), evidence and assumption (e.g., compliance rates), risks.*	**Impact** *$m present value where appropriate, for monetised impacts; high, medium or low for non-monetised impacts.*	**Evidence Certainty** *High, medium, or low, and explain reasoning in comment column.*
Additional costs of the preferred option compared to taking no action			
Levy payers and Crown funding	Ongoing cost of initiative on ACC accounts	$17 million per annum	High
Total monetised costs	Negligible levy rate impacts and negligible impact to the Crown (via the Non-Earners' Account)	$17 million per annum	High
Non-monetised costs	*N/A*	*N/A*	*N/A*
Additional benefits of the preferred option compared to taking no action			
Health users	Maintains access to ACC cover and entitlements	Low	Medium
	Improved quality-adjusted life-years from increased treatment	Low	Low
	Reduces out of pocket health expenses	$17 million per annum	High
Health system & ACC	Reduced future costs due to earlier intervention from better access to initial treatment	Low	Medium
Total monetised benefits		Low	Medium
Non-monetised benefits		Low	

[2] There is no new cost associated with introducing the new internal examination rate since it is already budgeted for and being paid.

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Section 3: Delivering an option

How will the new arrangements be implemented?

72. If Status Quo is the chosen option, there would be no legislative implications. All other options, including MBIE's preferred option – Option Four – require amendments to the *Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003* and *Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010*. MBIE will be responsible for these amendments. The amendments are intended to take effect from 1 December 2023.

73. Operational implementation will be carried out by ACC. Providers will be notified of increased payments (unless Status Quo is the chosen option) through the usual channels, such as practice management systems (PMS) vendors, and professional bodies:

    a. If Status Quo is the chosen option, ACC will need to notify providers that rates will not be increased this round, and that the next review (the 2024 review) is underway.

    b. If Option Two or Three are chosen, ACC will need to notify providers of the changed rates, and how the rates were calculated (e.g., via LCI). There will likely be a negative reaction from some providers (e.g., nurses) who will feel a blanket rate rise does not reflect the greater cost pressures experienced by some professions.

    c. If Option Four is chosen (as recommended by MBIE), ACC will need to notify providers of the changed rates. ACC has already conducted targeted consultation on the proposed new rates, and the methodology of increases varying by profession is the same as that applied for the previous review, so providers should not be surprised although some may be disappointed the increase is not a much as they would have liked.

74. If agreed, the increased rates will be paid from the in-force date, which is expected to be 1 December 2023.

How will the new arrangements be monitored, evaluated, and reviewed?

75. The AC Act requires ACC to review the Regulations biennially to check whether ACC's contribution needs to change to meet changing rehabilitation costs. This includes looking at ACC co-payment surveys to assess the level of contribution being made by claimants for the covered treatments, including those provided by GPs, physiotherapists and others. The next review is due by 1 December 2024, with any subsequent changes to rates not likely to take effect until late 2025.

76. MBIE provides advice to the Minister for ACC to ensure that recommendations appropriately balance the need to maintain claimant access to treatment against ensuring costs remain sustainable and affordable, and payments remain similar between the health and ACC systems.

77. ACC's regular review of the Regulations would benefit from more evidence to support its conclusions and any proposed increases.

78. The biennial cycle allows ACC more time to collect data to better capture the underlying costs and needs of claimants, and to better understand the impacts of

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previous rate increases. ACC is currently planning for this work and also examining what sources of information and evidence it might be able to draw on to better understand the costs faced by providers and the impacts that those costs have on clients' access to treatment services.

79. A key element to support these reviews is a survey of co-payment rates and barriers to treatment. We propose that another survey is undertaken prior to the 2024 review that considers what impact, if any, the changes implemented from the 2020/21 and 2022 reviews have had on access to treatment.

80. We would like ACC to also explore capturing information on co-payments directly from treatment providers as claim filing is moved online and made more user friendly.

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