Impact Summary: Proposals for updates to ACC regulations dealing with treatment payments

Section 1: General information

Purpose

The Ministry of Business, Innovation and Employment (MBIE) is responsible for the analysis and advice set out in this Regulatory Impact Summary, with reliance on advice from ACC where indicated. This analysis and advice has been produced for the purpose of informing Cabinet's final decisions to proceed with regulatory changes.

It provides an analysis of the proposed updates to 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) which prescribe contributions made by ACC for consultations, treatments and imaging and fitting services, provided by prescribed health professionals to ACC claimants.

The update to the Regulations results from ACC's 2018 review (these reviews were annual but are now biennial so the next review is due by the end of 2020) of its treatment contributions to assess whether any adjustment is required to take account of changes in treatment costs.

The proposed updates are:

- a general increase of 2.05% for treatment providers and 1.72% for Radiologists and providers of Hyperbaric Oxygen Treatment, to cover the two year review period
- to remove provisions in the regulations that require funding deductions for dental treatment, where a claimant has received previous treatment on the same tooth for a non-accident related purpose
- to separate 'specified treatment providers' in the regulations to provide separate payment rates for acupuncturists, chiropractors, occupational therapists, osteopaths, physiotherapists, podiatrists, and speech therapists

Key Limitations or Constraints on Analysis

This analysis is limited in some respects by the lack of data available. There are limitations to estimating the impact of the proposed cost adjustment because it applies to a broad group of treatment provider types and the claimants who use them. We have only limited information on how the increase in rates will be passed through to claimants and how costs affect their access.

ACC has work underway to improve the information available about co-payments and the extent to

which price affects claimants' access to treatment across different treatment provider types. Over time, this information is expected to improve analysis of how proposed payments and payment structures can best balance the objectives of supporting better ACC claimant access and managing costs. It will also assist MBIE with its role of assisting ACC to meet its objectives.

ACC's review that produced the proposals being analysed could now be considered significantly out of date, having been carried out in 2018. The review was held up for various reasons. At the end of 2018 the review was suspended for a few months awaiting the outcome of a health sector pay settlement. The review recommenced in early 2019 but progressed slowly, with ACC delivering its findings to the Minister in August 2019. The required public consultation occurred from mid-November 2019 to mid-December but the Christmas break meant submissions were not published until February 2020. The Cabinet paper summarising submissions and seeking permission for enabling regulations to be drafted was about to be sent to the Minister in March 2020 when the move to COVID-19 Alert Level 4 was announced.

After business-as-usual Cabinet processes recommenced in May 2020, it was apparent that there was insufficient time to complete the process of getting recommended updates to treatment payment regulations approved, drafted, authorised and implemented before the 2020 election in September. This left two options – cancelling the proposed 2018 updates and taking the findings into account in the 2020 review, or progressing the 2018 updates as much as possible before the election.

The accumulated delays mean the findings of the 2018 review might be somewhat underestimating cost pressures. However, progressing the 2018 updates is the preferred option because it will be more beneficial for affected parties to receive increased payments as soon as practicable rather them waiting longer (likely at least another 10 months) for a more accurate assessment of cost pressures from the 2020 review. The option of recalculating the 2018 findings to try to make them more accurate would mean essentially restarting the process and redoing the required public consultation, so is not considered viable.

Responsible Manager (signature and date):

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25/06/2020

Section 2: Problem definition and objectives

2.1 What is the policy problem or opportunity?

What are the Regulations for?

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.

ACC 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:

- the costs that ACC is liable to pay for rehabilitation (including treatment)
- when and how payment is made
- to whom the payments may be made.

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) prescribe the rates that ACC pays or contributes for consultations, specified treatments fitting and imaging services provided to ACC claimants by, for example, Radiologists, General Practitioners (GPs), Physiotherapists and Audiologists.

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 is called a co-payment. The existence of co-payments reflects the scheme's purpose of being sustainable.

The objectives of the Regulations are to set ACC contributions at a level that balances the following:

- consultations and treatments are sufficiently affordable to facilitate access to these services
- costs to levy and tax payers are financially sustainable
- there is reasonable alignment with funding in the wider health sector.

Previously, the rates have been reviewed annually but have not necessarily been raised every year. This review is the last annual review, with future reviews being undertaken on a biennial basis.

People will avoid or delay treatment if the cost is too high

Primary health care providers are the main point of contact most people have with the New Zealand health system, and they provide the main entry point to the ACC scheme when people are injured, which could include referral on to secondary treatment providers such as physiotherapists. It is important that access is facilitated so the aims of the scheme are met in terms of minimising the impact of injury on the community (including economic, social, and personal costs).

When people do not access primary and secondary health care when they should, injuries can deteriorate, which can push demand onto other health or social services (eg, emergency

departments, social welfare assistance). Untreated injuries can also result in avoidable disabilities (eg, untreated concussion in some cases can have serious consequences).

Over half a million adults (13.4% of the adult population) cited cost as a barrier to accessing a GP in the 12 months to June 2019 (New Zealand Health Survey 2019). Breaking this number down, cost was a barrier for 21.9% of Māori, 19.2% of adults who were living in the most socioeconomically deprived areas, and 19.4% of Pacific adults (overlapping, not cumulative numbers). This level of unmet need has been relatively stable over the past 6 years for adults, but this is not unexpected as policy settings related to adults' access to primary care have also been stable over that period.

Overall, children's access to health care has improved over the past four years, with unmet GP need due to cost reducing from around 6% to 2% for under 15 year olds (New Zealand Health Survey data). This is attributable to the introduction of free children's visits which was recently extended from under 6 year olds to under 13 year olds. Unmet GP need due to cost for 13 to 14 year olds stands at 5.1%, an estimated 6,000 children.

ACC treatment contribution values have eroded, potentially undermining access

Section 324A of the AC Act requires ACC to review the regulated rehabilitation contributions, to assess whether adjustment to any of the amounts is required to take into account changes in costs of rehabilitation, and recommend any changes to the Minister for ACC. The review period is now two years so any increase proposed has to cover two years.

ACC does not currently collect regular co-payment data from providers under the Regulations. This means it is difficult to determine the impact any cost pressures are having on co-payments charged to clients, and therefore on access to services.

However, given that the estimated costs of health services have increased (judging by CPI and LCI data) but ACC's contributions have not increased since 1 December 2018, the increased cost is being met in some combination by clients, through higher co-payments, and providers, by absorbing costs, (eg through either improved efficiency or reduced profit).

Increasing ACC's contributions to the cost of treatment may reduce co-payments charged to claimants, or prevent the likely rise in co-payments if contributions are not increased when expected. This ensures cost does not become more of a barrier for claimants to seek treatment for their injuries in a timely manner.

The level of co-payment tends to vary by the socio-economic status of the area in which the clinic providing the treatment is located. Some GP practices in low socio-economic areas do not charge a co-payment at all (but this means the GPs accept lower remuneration and this is only sustainable if payments increase regularly) while the highest co-payments tend to be charged by GPs in high socio-economic areas. This means that ACC contributions towards the cost of treatment tend to facilitate proportional assistance to low socio-economic areas, which also tend to have a higher proportion of Māori and Pasifika.

2.2 Who is affected and how?

Increasing ACC contributions will help to offset increases in treatment costs

In the 2018/19 financial year ACC paid $290 million to treatment providers for general treatment and another $35 million for hearing-related treatment, under the cost of treatment regulations. This compared to approximately $1.68 billion spent on rehabilitation services purchased via commercial contracts with treatment providers.

ACC's regulated payments for treatment are not indexed for inflation. If the value of ACC's contributions are not maintained this creates pressure on providers to raise co-payments charged to claimants. This may result in treatment being delayed or avoided, as was discussed above.

Delayed treatment can exacerbate and prolong the effects of an injury. This can worsen long-term outcomes for injured individuals and result in higher overall costs to ACC, other government agencies, the patient and to the economy. Health providers will be impacted if they have to deal with secondary health issues arising from treatment of the primary injury being delayed or avoided.

2.3 Are there any constraints on the scope for decision making?

With regulated treatment payments there is no mechanism to ensure that treatment providers will pass on increased treatment payments via reduced co-payments for claimants. Nor is there a mechanism for broader control of co-payments in general.

ACC and MBIE are looking at legislative and purchasing design options to better ensure regulated contributions are passed on to claimants in the future.

Section 3: Options identification

3.1 What options have been considered?

Proposals to increase regulated ACC contributions for treatment vs status quo

It is proposed to increase regulated ACC contributions to account for cost pressures, and make other minor changes to make some treatments more affordable. Adjustments apply only to ACC contributions. It is up to the treatment provider to adjust or maintain the co-payment charged in addition to the ACC contribution.

Although various options were considered in the initial analysis, no options were offered to Cabinet or included in the consultation document. For the purposes of this assessment the proposals will therefore be considered on their own merits compared to maintaining the status quo.

The main proposal is for a 2.05% general increase across most treatment providers, apart from Radiologists and providers of Hyperbaric Oxygen Treatment who get a 1.72% increase. These increases were based on recognised inflation indexes as an indicator of cost of treatment and rehabilitation increases, as they have been in prior reviews. For labour costs, this was the Labour Cost Index (LCI) for health care and social assistance.

There is also a proposal to remove provisions in the regulations that require funding deductions for dental treatment, where a claimant has received previous treatment on the same tooth for a non-accident related purpose. This will increase the payments made for dental treatment in some circumstances and therefore likely decrease the cost to the claimant.

Finally, there is a proposal, with no immediate financial implications, to separate 'specified treatment providers' in the regulations to provide for separate payment rates for acupuncturists, chiropractors, occupational therapists, osteopaths, physiotherapists, podiatrists, and speech therapists. Being able to specify different rates for these professions in future, if appropriate, should improve access to some of these services by making them more affordable (relative to the others) and enable more efficient use of ACC resources.

Calculation of proposed increase to regulated treatment payments

In the time period used for reference for the review (the year to June 2018) the LCI was affected by the large upwards impact of the care and support workers' pay equity settlement. Those workers do not provide ACC funded treatment so that effect was excluded. However, public sector nurses and allied public sector health workers were still negotiating multiple employer collective agreements (MECAs). Their wages were largely frozen, so that had a downward impact that was also excluded. The adjustments calculated by ACC are shown in Table 1 below.

Table 1: Labour index calculations used for 2018 review

Annual movement		Calculation	
Index name	Movement	Adjustments	Adjusted annual movement
Labour Cost Index (LCI) Health care and social assistance (SG51Q9)	3.36%	*1. Adjustment to exclude impact of Care and Support Workers' Pay Equity Settlement* *+* *2. Estimated inflation component had there not been a freeze on Allied Health and Nursing pay due to ongoing MECA negotiations*	1.10%

ACC initially proposed waiting until the public sector MECAs had been settled before completing the review. As a result, the review was effectively put on hold for several months. After the public sector MECAs were settled, ACC recommenced the review process.

During this process ACC came to the conclusion that as the treatment it funded under the regulations was usually performed by private sector health workers, factoring in the MECA increases could over-compensate ACC treatment providers. While the MECAs could have a flow-through effect to private sector treatment providers, the impact was considered difficult to estimate. As such, ACC advised it was prudent to wait to see evidence of any impact before adjusting treatment rates, and address the evidence through the next regulated rates review due in late 2020.

Some services are impacted by both changing labour costs and equipment costs, such as radiology. For assessing these services, ACC uses a composite of price indices. These indices show different movements – for example, the cost of medical products, appliance and equipment has been decreasing. While medical equipment will generally have a life of longer than one year, some medical equipment will be replaced each year. Adjusting the payment rate at each review means the rate should reflect any change in equipment costs when equipment is replaced. When the relevant indices are appropriately weighted and added together, the annual adjusted movement is 0.78%. This calculation by ACC is shown in Table 2:

Table 2: Composite index calculations used for 2018 review

Annual movement		Calculation	
Index name	Movement	Weighting	Composite
LCI Health care and social assistance (adjusted)	1.10%	60%	0.66%
CPI Medical products, appliances, and equipment	-1.60%	20%	-0.32%
CPI Hospital services	2.20%	20%	0.44%
Total			**0.78%**

Added to LCI and composite index calculations was six months of expected inflation (0.95%) to cover the additional year until the next review takes effect (2021). The rationale for using six months of inflation to cover one extra year was due to the extra amount being paid from the very start of the two year period. The additional 0.5 years of inflation to be paid from the start of the first year of the period was to be an advance payment balanced out by the 0.5 years of inflation being all that applied in the second year of the period.

In practice, the delays in implementing the increase in payment rates will mean the increase will start to apply just after the end of the two-year period (and could have been based on actual rather than estimated inflation). However, it will be more beneficial for affected parties to receive increased payments as soon as practicable rather than waiting longer (likely at least another 10 months for the 2020 review) for a more accurate increase. Recalculating the increase to try to make the 2018 review increases more accurate would mean essentially restarting the process and redoing the required public consultation, and this is not considered to be a viable option.

The proposed total general increase was calculated by ACC as the adjusted annual movement of the LCI of 1.10% (as calculated in Table 1) plus six months forecast inflation of 0.95% to give a total increase of 2.05%.

The increase for Radiologists and providers of Hyperbaric Oxygen Treatment of 0.78% was calculated by ACC as the composite index annual movement (as calculated in Table 2 because their charges include use of equipment) plus the 0.95% of six months forecast inflation to give a total increase of 1.72%.

Radiologists and providers of Hyperbaric Oxygen Treatment are secondary treatment providers who provide a critical part of the treatment of some injuries.

Options analysis for increasing treatment payments by 1.72% and 2.05%

Table 3 shows the options analysis for increasing treatment payments using the objectives mentioned earlier.

Table 3: Options analysis for increase to treatment payments	**Treatment sufficiently affordable to facilitate access**	**Crown and levy costs are financially sustainable**	**There is reasonable alignment with the wider health sector**
Status Quo: No increase	×	✓	×
Proposed Increase: 2.05% apart from 1.72% for Radiologists and providers of Hyperbaric Oxygen Treatment	✓	✓	✓

The proposed increase in payments compared to the status quo is preferred because it will:

- be more likely to facilitate access to primary and secondary treatment by keeping co-payments lower than they otherwise would be
- while imposing extra costs, remain financially sustainable to levy and tax payers because of the modest size of the increase
- improve alignment with funding in the wider health sector which has had similar or larger increases in recent years.

The proposal has impacts on the Crown's funding of the ACC Non-Earners' Account and also the Earners' and Work Accounts funded by levy payers. However, the impacts are minimal and do not have visible levy rate implications.

Table 4 sets out the cost impact of increasing regulated treatment contributions by 2.05% in general and 1.72% for Radiologists and providers of Hyperbaric Oxygen Treatment.

Table 4: Additional funding required by accounts to fund the 2.05 % general increase

$million	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Non-Earners' Account	1.4m	2.9m	2.9m	3.0m	3.0m	13.2m
Levied accounts	2.0m	4.3m	4.4m	4.6m	4.7m	20.1m
Total	3.4m	7.2m	7.3m	7.6m	7.7m	33.3m

Options analysis for removing dental deduction

Table 5 shows the options analysis for removing dental deduction.

Table 5: Options analysis for removal of dental deduction	**Treatment sufficiently affordable to facilitate access**	**Crown and levy costs are financially sustainable**	**There is reasonable alignment with the wider health sector**
Status Quo: No change	×	✓	-
Proposed Removal: Remove provisions that require funding deductions for dental treatment	✓	✓	-

The proposed removal of the dental deduction compared to the status quo is preferred because it will:

- be more likely to facilitate access to dental treatment for people who sustain damage to their teeth as a result of an accident by significantly lowering co-payments for treating teeth that have had previous dental work for a non-accident related purpose
- while imposing extra costs, remain financially sustainable to levy and tax payers because of the very modest size of the increase.

Wider health sector alignment is not affected by this proposal.

There are limited impacts on the Crown's funding of the ACC Non-Earners' Account and also the Earners' and Work Accounts funded by levy payers. These changes are not expected to have any impact on levies or ACC appropriation.

Table 3 sets out the estimated annual costs of removing the dental deductions provisions.

Table 3: Cash costs of removing dental deductions provisions

$million	2020/21	2021/22	2022/23	2023/24	Total
Non-Earners' Account	0.15m	0.79m	0.84m	0.89m	2.68m
Levied accounts	0.30m	0.35m	0.38m	0.40m	1.43m
Total	0.45m	1.15m	1.22m	1.29m	4.11m

Analysis of separating specified treatment providers

Separating specified treatment providers in the regulations to provide for separate payment rates has no immediate financial impact. It is the first step in allowing for different payment rates to be specified for treatment by each of the professions making up the group.

The specified treatment providers classification currently includes acupuncturists, chiropractors, occupational therapists, osteopaths, physiotherapists, podiatrists, and speech therapists. These health professionals are all quite different to each other in the types of treatment offered, the average treatment duration, how recognised the efficacy of their treatment is and the market in which they operate.

These differences mean it is likely to be appropriate to have different payment rates for the various different specified treatment providers. Different payment rates would also likely affect the co-payments being charged by the different treatment providers, making some more affordable compared to the others. The change in relative affordability is likely to improve access to some types of treatment, while possibly discouraging access to other types of treatment shown to have less efficacy. Overall, this should improve the welfare of claimants and enable more efficient use of ACC resources.

Section 4: Impact Analysis

4.1 Summary table of costs and benefits of updates to regulations

Affected parties *(identify)*	**Comment**: nature of cost or benefit (eg ongoing, one-off), evidence and assumption (eg compliance rates), risks	**Impact** *$m, for monetised impacts; high, medium or low for non-monetised impacts*
Additional costs of proposed approach, compared to taking no action		
Levy payers and Crown funding	Ongoing cost of initiative on ACC accounts	$38.8m over five years
Total Monetised Cost	Negligible levy rate impacts and negligible NEA impact as already incorporated	$38.8m over five years
Non-monetised costs	*N/A*	*N/A*
Expected benefits of proposed approach, compared to taking no action		
Health users	Health users – Improved quality-adjusted life-years from increased treatment	Low
	Health users – maintains access to ACC cover and entitlements	Low
Health system & ACC	Reduced future costs due to earlier intervention from better access to initial treatment.	Low
Health users	Health users – Reduces out of pocket health expenses (assuming 60-80% passed through from providers)	$23.3 to $31.0m over five years
Regulated parties	Treatment providers paid by ACC under regulations net additional revenue for workforce development, etc (assuming 20-40% of increase retained)	$7.8 to $15.5m over five years
Total Monetised Benefit		$38.8m over five years
Non-monetised benefits		*Low*

4.2 What other impacts is this approach likely to have?

The main risk involved with the proposals is that some providers may not pass on the increased contribution or delay price increases. As noted in section 2.3, with regulated treatment payments there is no mechanism to ensure that additional funding reduces co-payments.

Section 5: Stakeholder views

5.1 What do stakeholders think about the problem and the proposed solution?

Public Consultation

Public consultation took place from 19 November to 13 December 2019. This sought feedback on proposals to:

- provide a 2.05% general increase to the regulated rates for treatment providers apart from payments to Radiologists and providers of Hyperbaric Oxygen Treatment which get a 1.72% increase
- end the ACC deduction to some payments for dental treatment, and
- increase the number of classes of treatment provider used in the regulations

The consultation document was published on the MBIE website. Nineteen relevant submissions were received, nearly all from primary and secondary health providers. All the submissions either supported in principle or did not comment on proposals to the increase the number of classes of treatment provider and to end the ACC dental deduction.

Some submissions supported the proposed general increase in regulated payment rates but most did not and wanted a higher increase, claiming that increases in treatment payments had not kept up with inflation over the years so co-payments made by claimants to providers had increased.

It is difficult to ascertain how accurate the concerns are, but we expect the new biennial cycle will allow ACC to collect more comprehensive data on the cost pressures affecting providers. It will also enable ACC to better understand the impacts of previous rate increases. This should allow for more accurate and robust pricing recommendations in future that better capture the underlying costs and needs of claimants.

Departmental consultation

The Ministries of Health, Social Development, and Women, Te Puni Kōkiri, and The Treasury have been consulted. No substantive comments were received.

Section 6: Implementation and operation

6.1 How will the new arrangements be given effect?

The proposals are intended to now take effect from 1 February 2021 via 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*.

Operational implementation will be carried out by ACC. Providers will be notified of increased payments through the usual channels, such as practice management systems (PMS) vendors, and professional bodies. The increased rates will be paid from the in-force date which is now expected to be 1 February 2021.

Section 7: Monitoring, evaluation and review

7.1 How will the impact of the new arrangements be monitored?

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

MBIE has reasonable information on primary health service co-payment and utilisation rates for different populations from the Ministry of Health, which we consider are applicable to ACC. ACC and MBIE will continue to work with the Ministry of Health to understand the impacts of the Government's primary care initiatives on primary health service utilisation and whether updates are necessary for primary care contributions more generally. ACC also undertakes an annual ACC National Provider Survey to understand how providers consider ACC's engagement and funding.

However, MBIE has less information on the market dynamics relating to treatment providers such as Chiropractors and Acupuncturists that ACC pays under the regulations. ACC does not currently collect regular co-payment data from providers who provide services under the Regulations. This means it is difficult to determine the level of impact that any cost pressures are having on co-payments charged to clients, and therefore on access to services or any cost-shifting elsewhere including on social services agencies.

In 2018, ACC reinstated a limited survey on co-payment rates, and this is proposed to be expanded in 2020. The new biennial cycle also allows ACC more time to collect other data to better capture the underlying costs and needs of claimants, and to better understand the impacts of previous rate increases. This means more information will be available to support the cost of treatment regulations review from 2020 onwards, and should improve analysis of how proposed payments and payment structures can best balance the objectives of supporting better ACC claimant access and managing costs.

7.2 When and how will the new arrangements be reviewed?

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 treatments provided by General Practitioners, Physiotherapists and others. The next review is due by 1 December 2020, with any subsequent changes to rates not likely to take effect until at least 1 December 2021 or later.

MBIE provides secondary advice to the Minister for ACC to ensure that recommendations appropriately balance the need to support claimant access to treatment against ensuring costs remain sustainable and affordable, and do not cause alignment issues in the health sector.