Disclosure Statement

This Regulatory Impact Statement (RIS) has been prepared by the Ministry of Business, Innovation and Employment.

This RIS examines options to update the rates paid for treatment under these regulations to ensure that accident compensation claimants have continued access to appropriate treatment. The payments in these regulations do not cover the full cost of treatment. To encourage appropriate usage claimants need to pay a co-payment.

A range of options was considered including the status quo, an across the board increase and an increase targeting specific groups of providers. Funding of around $5 million each year is available so the options were limited by the funding amount.

Analysis has been based on information relating to published indices showing the likely cost increases in the health sector with reference to available co-payment surveys showing the cost to claimants and to payment increases made in ACC contracts with similar providers.

A full review of co-payments and provider costs (with analysis of co-payments paid by claimants for specific treatment and specific provider costs) was not done in 2012 as a full review was completed in 2011. The full range of information was therefore not available for consideration of options. However we are satisfied the recommended option is the best option in the circumstances.

The Ministry is satisfied that, aside from the risks, uncertainties, and caveats already noted in this Regulatory Impact Statement, the regulatory proposals recommended in this paper are required in the public interest.

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Executive summary

There is evidence that accident compensation claimants are paying more for treatment for injury and that the costs for treatment providers have risen more than the increase in payments for treatment made by ACC. This means that if costs continue to rise ACC may not be able to fully meet its statutory obligations and that claimant access to treatment is likely to be reduced.

Options for addressing this situation are the status quo, an across the board increase in payments and an increase targeted to specific providers.

The analysis considered whether the options would enable ACC to meet its statutory obligations and government policy, would improve claimant access to appropriate treatment, would be equitable, would not affect claimant behaviour and would not affect costs or labour market conditions in the rest of the health sector.

All proposed options except the status quo would go some way to meeting the objectives however the targeted solution met most objectives to a lesser extent than the across the board increase. The across the board increase was chosen because it was equitable, went some way to improving claimant access to appropriate treatment and met ACC's statutory obligations.

There would be some minor costs to providers to change invoicing systems, costs to ACC to implement the price changes and potential costs to claimants who were unable to access treatment if the increase was not passed on to claimants. Benefits are likely to be slightly improved access to claimants with a $5 million increase in payments and/or more income for providers.

There is a risk that increased payments will not be passed through to claimants as there is no mechanism to ensure that pass through occurs.

ACC will be implementing the proposed increase by notifying providers and providers of practice management systems.

Status quo and problem definition

Background

1 Under the Accident Compensation Act 2001 (AC Act) the Accident Compensation Corporation (ACC) is liable to pay or contribute to the cost of treatment and rehabilitation for covered personal injuries. ACC services are funded by levy payers and the Crown.[1]

2 ACC may either pay for treatment under a contractual arrangement, under regulations or at the market rate. Regulations are preferred for larger groups of treatment providers as they are transparent and easy to administer.

[1] Employers fund the Work Account, workers fund the Earners' Account, motor vehicle owners fund the Motor Vehicle Account, the Crown funds the Non-Earners' Account and treatment injury is funded by contributions from the Earners' and Non-Earners' Accounts.

3 Regulations setting the payments for treatment and rehabilitation are made under section 324 of the Accident Compensation Act 2001. The regulations prescribe costs ACC is liable to pay for rehabilitation (including treatment), how the costs are to be paid and to whom. The relevant regulations are the:

- Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 (the Treatment Regulations) and
- Accident Compensation (Apportioning Entitlements for Hearing Loss) Regulations 2010 (the Hearing Loss Regulations).

4 Under section 324 of the AC Act, the Minister for ACC is required to consult people or organisations that the Minister considers appropriate, having regard to the subject matter of the proposed regulations.

5 Under section 324A of the AC Act, ACC must review existing amounts prescribed by regulations made under section 324 every year, to assess whether an adjustment is necessary to take into account changes in costs of rehabilitation. Other changes may also need to be made to the Regulations. The provision does not indicate what form the review should take.

6 This Regulatory Impact Statement relates to changes proposed to both regulations made under section 324.

7 The Treatment Regulations specify payment for consultations and treatments payable to counsellors, dentists, radiologists, providers of hyperbaric oxygen treatment, medical practitioners (GPs), nurses, nurse practitioners, medical specialists, and specified treatment providers (acupuncturists, chiropractors, occupational therapists, osteopaths, physiotherapists, podiatrists, and speech therapists). Most of these providers are paid under the Treatment Regulations.

8 Contracts are used where there is a shortage of providers such as rural GPs or where providers or treatments are not included in these Regulations.

9 The Hearing Loss Regulations prescribe the payments to be made for assessment of hearing loss and provision of hearing devices including servicing, fitting and repair. The Ministry of Health provides funding under these regulations for the health-related component while ACC provides for the injury-related hearing loss.

10 Claimants generally need to pay an amount in addition to the ACC payment (a co-payment) which is the amount a provider charges over and above the ACC contribution.

Current situation

11 Table 1 shows the actual increases in regulated payments made in recent years to payments in the Treatment Regulations. The table shows that there has only been an increase of 3.95% per cent in ACC payments since 2008/09 and not to all regulated payments.

Table 1: Actual increases in recent years

Year	Outcome of pricing review
2008-09	No price adjustment. (ACC recommended a 3.3% price adjustment which was initially agreed to but not implemented following a re-focus on improving financial management in ACC)
2009-10	No price adjustment. (ACC recommended that no adjustment be made)
2010-11	2% adjustment to GPs and nurses, which came into effect 1 April 2012. (ACC adjusted its recommendation to 2% as this was the actual increase that District Health Boards (DHBs) passed on to providers)
2011-12	A 1.9% adjustment to the consultation rates for some treatment providers but excluding radiologists. A full review of dental payments was undertaken with rationalisation of the Schedule of dental treatments focussing on increasing payments for most commonly used treatments. This change meant a more than 1.9% increase as Cabinet decided that dental implants should be almost fully funded. Came into effect in July 2013.

12 There have been no changes to the payments under the Hearing Loss Regulations since introduction on 1 January 2011.

13 Table 2 shows results from some recent co-payment surveys[2] which show the changes in co-payments over recent years. These surveys were chosen because the information has been collected on a consistent basis over recent years.

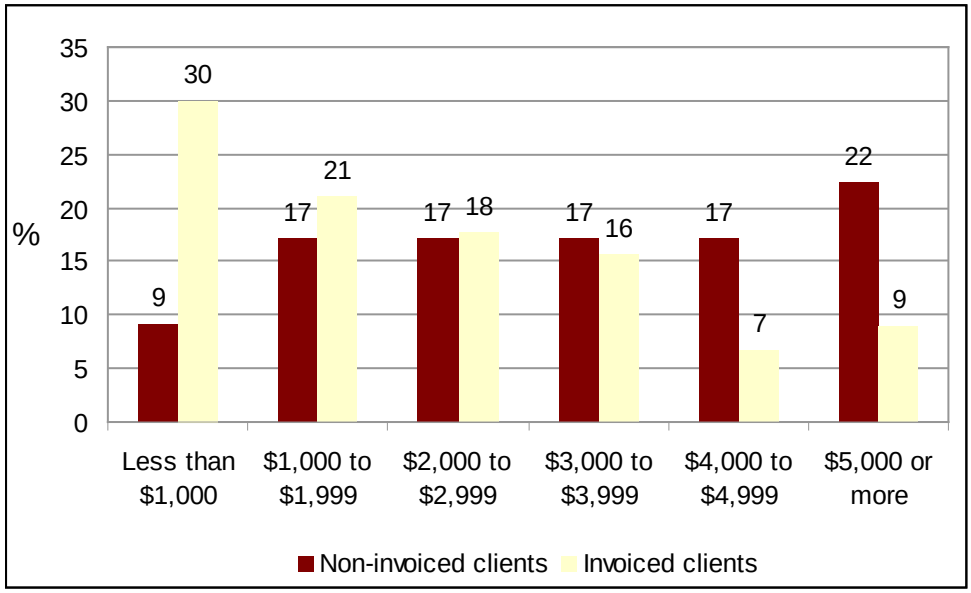
Table 2: Co-payment survey results ($2011) – 18 years and over (includes GST)

Provider	2011	2012	2013	% change	ACC contribution
Urban GPs[3]/nurses combined initial consultation	$18.78	$23.57	$24.51	30.5%	$38.11
Osteopaths – initial consultation	$40.20	$41.69	$42.18	4.93%	$25.50 per treatment or $64.14 per hour
Osteopaths – initial consultation – complex	$37.51	$39.91	$42.31	12.8%	$25.50 per treatment or $64.14 per hour

[2] Research New Zealand, *2013 Co-payments Survey Urban GPs FINAL REPORT, June 2013*
[2] Research New Zealand, *2013 Co-payments Survey Osteopaths FINAL REPORT*, June 2013
[3] The GPs survey had a response rate of 35% and a margin of error of ±4.8% and the osteopaths survey had a response rate of 35% and a margin of error of ±7%

14 A recent audiologist client satisfaction survey shows that cost is a major barrier for those who choose to defer, or to not go ahead with their hearing aid purchase.[4] Figure 1 shows the range of payments claimants were asked to make for hearing devices. Non-invoiced claimants are those who had funding approved for their hearing devices but who did not proceed to purchase or delayed purchasing hearing devices This seems to indicate that the level of co-payments is making hearing devices unaffordable for some claimants. Most hearing loss claimants are over 65 so the co-payment is likely to be less affordable as they are unlikely to be earners. The contribution offered by ACC ranges from $172.00 to $1725.00 (including GST) per device depending on the percentage of injury-related hearing loss.

Figure 1: Co-payments made by claimants for new hearing devices[5]



15 There is limited funding available to increase payments because of budget constraints in the ACC Non-Earners Account which is funded by the Crown and pays for entitlements for people out of the workforce including children. As ACC has an equity policy of paying the same contribution to treatment for all claimants whether working or not this constraint also affects the other ACC Accounts.

Problem definition

16 Co-payment surveys show that the level of co-payments is rising and may be affecting claimants' access to appropriate timely treatment. In most cases the information is not available to determine whether or how much access is being affected. In the case of hearing devices it does appear to be affecting claimant's access. Timely and appropriate treatment ensures that claimants are rehabilitated at a faster rate and are able to return to work or independence sooner.

[4] Research New Zealand, *Audiology Client Satisfaction Survey 2013*, p 5, 73% response rate
[5] These percentages are calculated on the number of clients who could recall the co-payment quoted or charged ie excludes those who did not respond or did not know.

17 Over the period since 2008 there have been only minor increases to payments specified in the Treatment Regulations and in some cases no increases. Most treatment payments other than for consultations have not been increased for about 10 years. Evidence from co-payment surveys shows that many providers are absorbing cost increases which have been between 10.76% (LCI healthcare) and 17.02% (CPI – healthcare) since 2008.

Objectives

18 The objectives of this policy in order of priority (developed by the Ministry and ACC) are:

- ***Statutory obligations*** - meets ACC's statutory obligations to provide treatment and rehabilitation to claimants
- ***Access*** - maintains claimant access to treatment by ensuring that rates are affordable. Payments made to treatment providers in addition to the ACC subsidy are affordable by claimants and treatment is available in most geographical areas. Claimants therefore recover more quickly.
- ***Affordable*** - to ensure that payments made are affordable to ACC, that is payments give good value for money. In this case the funding available is limited to around $5 million each year and the analysis assumes this is a given.
- ***Equity*** -ensures that claimants with similar injury-related needs are treated equitably and consistently
- ***Appropriate*** - ensures that claimants have the right kind of treatment given their needs and over treatment does not occur
- ***Consistent*** within the health sector (does not set precedents in the health sector and affect claimant behaviour or provider behaviour in the labour market) and ACC contracts.

19 While statutory obligations and access for claimants are important the limits set by the available funding restrict the degree to which these objectives can be met.

Regulatory Impact Analysis

20 In past reviews, ACC undertook a full review of the payments for treatment under regulations. This involved looking at each provider group to see where the cost pressures were being felt by providers and claimants and what adjustments needed to be made. For the 2012 review, which is being implemented in 2013, ACC has not undertaken a review of costs across every provider group. A full review is complex and is not necessary as a full review was undertaken in 2011.

21 The scale of the review is also commensurate with the funding that is available for changing the payments made under regulations.

22 ACC has looked at general inflationary measures as an indicator of the cost of treatment under regulations. This approach has the benefit of allowing ACC to consider cost pressures in the health sector, manage costs and expectations for

change within existing funding, and provides a more efficient mechanism for reviewing pricing adjustments.

Options

23 All options assume that there is a funding limit of around $5 million each year. Since this limit is binding for both options, the affordability criterion is not considered further in the options assessment.

24 Options considered include:

- Status quo
- Option 1: An across the board increase within funding levels. All payments in the Treatment and Hearing Loss Regulations would be increased by 1.78%
- Option 2: A targeted increase – increase only to targeted groups of providers such as general practitioners. The targeted payment could focus on consultation rates and for those providers such as general practitioners, nurses and physiotherapists who are the most commonly used providers.

25 Table 4 shows the options' analysis

Table 4: Options' analysis

Option	Statutory obligations	Equity	Access	Appropriate	Consistent
Status quo	√	√	X	√	X
1: Increase across the board	√√√	√√	√√	√√	√√
2: Targeted increase	√√	√√	√	√	√

Conclusions and recommendations

26 Option 1 best meets most objectives. The Status quo is no longer meeting the access objective because claimants have to pay more for treatment than is acceptable. There is a risk that if costs continue to rise ACC may not be able to meet its statutory obligations to provide treatment because of the cost to claimants. While all claimants are still being treated the same, claimants in metropolitan areas may not find treatment as affordable under the Status quo. The Status quo is also not consistent with increases made in Ministry of Health payments or in ACC contracts so that services may be affected if payments do not continue to match other funders.

27 Option 2 meets most other objectives including access, appropriate treatment and consistency with the health sector less well than Option 1. In particular access to treatment of the claimant's choice is an important factor in rehabilitating a claimant. It is important that the claimant has treatment from a provider that provides the

appropriate service and that the claimant trusts. Spreading the increased payment across all providers improves claimant access to more treatment options and thus more appropriate treatment. Option 2 meets ACC's statutory obligations better than the status quo but not as well as Option 1 because it does not include all treatments.

28 Consistency with the health sector and ACC contracts is also an issue with Option 2. Increasing the rates at a higher level for selected providers particularly general practitioners may create price pressures in the rest of the health sector such as PHOs. Option 1 also meets statutory obligations better than Option 2 as it will improve ACC's ability to meet its statutory obligations across a wider range of claimants. Option 1 is therefore the preferred option.

Costs and Benefits

Costs (preferred option only)

29 For Option 1 the financial cost to ACC is around $5 million each year. There is a very small possibility that the increase proposed in Option 1 may result in providers in other parts of the health sector such as general practitioners seeking similar increases for non-ACC treatment. However this is unlikely as the increase proposed is not very different from that given by the Ministry of Health to district health boards. District health boards provide funding for non-ACC treatment.

30 There will be a one-off cost to providers to alter the payment amounts in invoicing systems. This cost is not significant because most providers use standard practice management systems.

Benefits

31 For Option 1 the benefits are not likely to be increased but should be maintained at their present level. Claimants should have continued access to treatment they need. Treatment providers will continue to offer treatment and not feel they have been overlooked[6]. Claimants will return to work or independence more quickly and benefit the wider economy. Claimants should benefit by $5 million providing the benefit is passed on from providers.

32 An injury can be prolonged and aggravated if a claimant does not receive adequate and appropriate treatment in a timely manner because of the cost of treatment. A delay in treatment which increases injury time has an effect on the economy with fewer people available in the workforce or people at home requiring assistance from people in the workforce. This effect is not generally quantifiable however there has been some research that shows that people who have been injured are likely to have a reduced income following a prolonged injury.[7] While there is little research on the affordability in New Zealand of health care to claimants, in general, more expensive items are less affordable.

[6] Providers such as specified treatment providers such as physiotherapists and osteopaths periodically complain that the ACC subsidy is too small and could put them out of business.
[7] Statistics New Zealand *Returning to Work from Injury: Longitudinal Evidence on Employment and Earnings (Update)*

Risks

33 There is a risk that access to treatment for claimants will not be maintained as the increased payment may not be sufficient to achieve this objective. There is also no mechanism to ensure that providers limit their co-payment charges. Limits are not feasible as most providers have private businesses. Individual contracts, which are expensive to use, would be needed to implement a restricted co-payment policy. Earlier attempts to provide nearly free treatment with co-payment restrictions have resulted in large increases in the number of treatments being undertaken by people in higher socio-economic groups.

Consultation

Public consultation

34 A public consultation took place from 4 September to 4 October 2013. Approximately 150 organisations and individuals were emailed both by the Ministry of Business, Innovation, and Employment and ACC advising of the consultation. The consultation document was available on the MBIE labour website with links on the main MBIE website and on the ACC website. Seven submissions were received from a professional organisation, a district health board, a claimant organisation, a sector body and individuals. All agreed that there should be an increase in treatment payments with four submitters expressing the view that the amount was too small and did not reflect the actual increase in costs and others considering the amount was adequate. One expressed the view that paramedics should be added to the definition of treatment providers once they are registered.

35 The Ministry will consider any applications from treatment provider groups to be added as treatment providers provided the treatment provider group is registered under the Health Practitioners Competence Assurance Act 2003.

Departmental consultation

36 ACC assisted with the preparation of this Regulatory Impact Statement. The Treasury, Te Puni Kōkiri, Ministry of Health, Ministry of Social Development and the Ministry of Women's Affairs were consulted and their views incorporated. The Department of Prime Minister and Cabinet were informed.

Implementation

37 Implementation will be carried out by ACC. Providers will be notified of increased payments through the usual channels, such as practice management systems. The increased rates will be paid from the in-force date which is expected to be on 1 April 2014.

38 In the past ACC has experienced issues where providers have been notified of the changes but have not changed their systems. Consequently incorrect invoices are sent to ACC. For this round of regulation changes ACC have put in place specific actions to ensure this does not happen again as outlined below.

39 Table 6 sets a timeline for implementation.

Action	Timeframe
MBIE consultation document sent to provider organisations	4 September 2013
ACC follow up with provider organisations to ensure they have received the consultation document	20 September 2013
Submissions close	4 October 2013
Agreement from the Cabinet Social Policy Committee	6 November 2013
Agreement from Cabinet to promulgate Regulation changes	17 February 2014
ACC finalise internal communication plan	
ACC to update their website with information about the changes	17 February 2014
ACC to notify treatment provider groups, including District Health Boards, Government agencies and ACC's electronic billing system suppliers (eg PMS)	17 February 2014
ACC contact PMS suppliers to find out which providers have not yet downloaded updates to their software	17 February 2014
ACC print reminder of the changes on provider remittance statements	17 February 2014
ACC contact provider organisations and request them to put information about the changes on their websites	17 February 2014
ACC contact DHBs to ensure that they are aware of the changes	17 February 2014
Gazette	20 February 2014
28 days end after Gazette	19 March 2014
Regulation changes become effective.	1 April 2014
Monitoring the changes is carried out annually. ACC are statutorily required to report the findings to the Minister of ACC	Annually (1 December)

Monitoring, evaluation and review

40 The Regulations are reviewed annually to check whether there are increasing costs to rehabilitation and whether ACC's treatment contribution needs to change to meet rehabilitation costs. This includes looking at co-payment surveys to assess the level of contribution being made by claimants.

41 The annual review may benefit from better information on the affordability of various treatments and also the effect that poor access to treatment has on the recovery rate of claimants.