Regulatory Impact Statement: Proposals for updates to ACC regulations dealing with treatment payments after 2020/21 review

Coversheet

Purpose of Document	
Decision sought:	Final Cabinet decisions are sought to increase ACC's treatment payments under the *Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003* in line with increases under the former DHB Multi Employer Collective Agreements (MECAs). The recommended increases for various occupational groups are between 4.60 percent and 9.36 percent. Audiology treatment was assessed separately and a nil increase is recommended. Also, Cabinet agreement is sought to include a new combined nurse practitioner and registered nurse treatment rate.
Advising agencies:	Ministry of Business, Innovation and Employment (MBIE) with input from ACC (the operational agency)
Proposing Ministers:	Minister for ACC
Date finalised:	1 December 2022

Problem Definition

The treatment payment rates that ACC contributes to rehabilitation and treatment service costs are generally prescribed in regulations made under the Accident Compensation Act 2001 (excluding treatments covered under contractual arrangements).

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. However, it is accepted (given the lack of better evidence) that the current level of co-payments provides a satisfactory base level of access.

To keep co-payments around the same relative level, regulated rates are required to be reviewed regularly (every two years and previously annually) and adjusted to reflect any changes in the costs of providing the regulated services.

The review therefore aims to determine the increase in regulated rates needed to offset the potential impact of rising costs on co-payments, so that the rising costs do not result in reduced access to treatment by claimants. 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).

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 2020/21 review, which was delayed by COVID-19:

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 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 approximately 6 percent to reflect changes in the LCI for health care and social assistance (reported by Statistics New Zealand) over the past two years to mid-2021;

c) **Option Three – Calculate flat rate increase using the average DHB MECA increase:** the rates under the Regulations are increased by approximately 6.61 percent to reflect the average former DHB Multi Employer Collective Agreement (MECA) increases from 2016 to 2021 (excluding the LCI uplifts previously applied by the 2017 and 2018 recommendations);

d) **Option Four – Calculate bespoke increases using DHB MECA increases for the relevant occupational groups:** bespoke increases are applied to professional groups based on former DHB MECA increases (for the same period as Option Three). These increases range between 4.60 and 9.36 percent.

Under all options there is a nil increase proposed for audiology treatment. At the time of completing the 2020/21 review, ACC considered that there had been no increase in cost-related access issues for audiologists. With ongoing technology changes, which include improving the ability of clients to self-programme hearing devices, an increase in device fitting fees was considered to be inconsistent with market trends. It is expected that ACC will assess whether audiology rate increases are warranted in the upcoming 2022 review due by 1 December 2022.

A proposal to introduce a new nurse practitioner and registered nurse combined treatment rate was also considered due to the increasing number of nurse practitioners operating in general practice. The proposed rate would cover a consultation involving both a nurse practitioner and a registered nurse, similar to the current combined treatment rate for a general practitioner and registered nurse. It was calculated from individual rates of both nurse practitioners (as a base) and registered nurses (as an additional top up).

MBIE undertook consultation on the proposals on behalf of the Minister for ACC from 21 September to 18 October 2022 and received 45 submissions from a variety of health professionals. Most submitters agreed with the need for an increase in payment rates to at least reflect wage increases in relevant occupational groups. Some submitters considered greater increases to rates were required to cover inflation until the next review takes effect, and others wanted more substantive increases to increase the proportion of cost covered

by ACC. All submissions mentioning the proposed combined rate for treatment by a nurse practitioner and registered nurse supported the proposal. Of the submissions which disagreed with the proposals, the majority were from audiologists opposing the proposed nil increase to audiology payments.

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.

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 $23 million annually under Option Four (similar to Option Two and Three), ACC has indicated that the impact of the cost would be immaterial and would not result in increased ACC levies or ACC appropriation. This is because cost increases have already been factored into ACC's levy, appropriation, and Outstanding Claims Liability calculations.

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 the impact of cost pressures, such as increases in labour costs, these proxy calculations will not completely match the actual rise in prices for treatment services.

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 different year to when ACC increases its regulated rates. 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 that 71 percent of providers surveyed had not raised their co-payments since the last increase to the regulated rates (that took effect in May 2021).

This indicates that the rise in regulated rates prevented or delayed providers from needing to raise co-payments in line with increasing cost pressures.

Responsible Manager(s) (completed by relevant manager)
Bridget Duley *Manger (Acting), Accident Compensation Policy* *Ministry of Business, Innovation and Employment*  *1/11/2022*

Quality Assurance (completed by QA panel)	
Reviewing Agency:	MBIE
Panel Assessment & Comment:	MBIE's Regulatory Impact Analysis Review Panel has reviewed this Impact Statement (Proposals for updates to ACC regulations dealing with treatment payments) prepared by MBIE. The panel considers that the information and analysis summarised in the Impact Statement partially meets the criteria necessary for Ministers to make decisions on the proposals, noting that this is an established process and the scope is constrained to offsetting the potential impact of increases in wages on costs of treatment. It is noted however, that limited information is available to support the cost of treatment regulations review.

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 the rates ACC contribute to treatment by regulated providers

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) prescribe the 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 and audiologists.
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 (that 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 $338 million on regulated treatment payments (excluding audiology) in the 2020/21 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. However, section 324A of the AC Act requires only that ACC reviews the regulated rehabilitation contributions to assess whether adjustment to any of the amounts is required to take into account any changes in the costs of rehabilitation (since previous changes). ACC must then recommend any changes to the Minister for ACC.

9. The reviews are relatively frequent, resulting in small and regular increases. Reviews had been required every year but from 2020 onwards it became every two years.

10. 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%

Various methods could be used to review the rates

11. 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.

12. In previous reviews, changes in the costs of rehabilitation were estimated by examining changes in 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.

13. For this review, consideration was given to using the MECAs used to set the remuneration of health professionals. While there are 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 are also not necessarily public like DHB MECAs.

14. However, at the time of the 2020/21 review, ACC considered that there had been no increase in cost-related access issues for audiologists. With ongoing technology changes, which include improving the ability of clients to self-programme hearing devices, an increase in device fitting fees was considered to be inconsistent with market trends. This resulted in a nil increase being recommended.

15. It is expected that ACC will assess whether audiology rate increases are now warranted in the upcoming 2022 review due by 1 December 2022.

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 considered whether to introduce a nurse practitioner and registered nurse combined treatment rate into the Regulations. This rate would cover a consultation involving both a nurse practitioner and a registered nurse, similar to the current combined treatment rate for a GP and registered nurse.

The process to review the regulated rates is a biennial process, however, COVID-19 delays mean that the next review is underway

17. The review that relates to the current Cabinet decisions (the 2020/21 review) was due from ACC to the Minister for ACC on 1 December 2020. However, due to COVID-19 constraints, and the opportunity to undertake more detailed work, the Minister agreed to postpone completing the review. ACC provided the final review in January 2022. There has therefore not been a review of the regulated rates since prior to COVID-19 (although the previous increase to the regulated rates from the 2018/19 review was also delayed by COVID-19 and was implemented in May 2021).

18. ACC is currently undertaking the 2022 review, with recommendations due to the Minister for ACC by 1 December 2022. Once this review is complete, Cabinet decisions and implementation will be some way off as consultation, approval of final recommendations and drafting of amendment regulations will still be required. Final implementation of the 2022 review is therefore unlikely be earlier than late 2023.

Status quo

19. If nothing is done, the current rates under the Regulations would continue to apply. Rising cost pressures would eventually 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.

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 sought 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. Since the last increase to regulated rates in May 2021, 71 percent of respondents said they left co-payments unchanged. This suggests that the increased rates off-set the need to raise co-payments in response to increasing cost pressures. However, with no increase in rates, it is likely that co-payments would be increased because cost pressures would not be offset.

22. Additionally, without introducing a combined nurse practitioner and nurse's rate, the current rates would continue to apply. Currently, consultation sessions that involve both a registered nurse and a nurse practitioner have only the nurse practitioner rate applied (i.e., the registered nurse component is not reimbursed). This means that there is less incentive for collegial work (as encouraged by Manatū Hauora, the Ministry of Health). Some health practices may bill these consultations incorrectly by billing each component separately (i.e., bill ACC for both a registered nurse rate and a nurse practitioner rate), which means ACC would pay two payments for the session and the claimant may be subject to two co-payments. When these are billed separately, ACC is not currently able to recognise that a combined treatment has occurred.

What is the policy problem or opportunity?

23. The co-payment that claimants usually need to pay to the ACC treatment provider deters 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 impacted by costs: Community Card Holders, Māori, Pacific Peoples, Adults (18-25 years) and Adults (65+).

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. There are therefore 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 percent) 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 (given the lack of better evidence) that the current level of co-payments provides a satisfactory base level of access. This assumption limits 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 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 in applying the Regulations, as used in past reviews, are to set ACC contributions 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; 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 pressures 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 trade-offs will have to be made in determining the recommended increases in regulated rates.

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 325A 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. 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.

34. Options are therefore limited to the status quo of doing nothing or increasing rates by various amounts and formulations.

35. A report is due to the Minister, including recommendations, by 1 December of the year the review is conducted (s 324A(3)(b)). These recommendations were due to the Minister of ACC by 1 December 2020, however, due to COVID-19 pressures and the risk that lockdowns would have skewed rate calculations, the Minister agreed to postpone the review and allow more work to be done. This meant the review was completed in January 2022. Because of the delay in completing the review, the review covers a time period of more than two years.

36. 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 combined rate for treatment by a nurse practitioner and nurse was considered. This rate would cover a consultation involving both a nurse practitioner and a registered nurse, similar to the current combined treatment rate for a general practitioner and registered nurse.

What options are being considered?

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

Option One – Status Quo

37. 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

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

39. 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.

40. 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, adjusting payment rates to make co-payment charges more equal (or at least prevent them becoming more unequal) should be beneficial for claimants overall by not encouraging one type of treatment over another purely for cost reasons.

Option Three – Use the average DHB MECA increase

41. The average DHB MECA increase from 2016 to 2021 was 6.61 percent after taking out regulated payment increases from past reviews (1.56 percent and 2.05 percent from the 2017/18 and 2018/19 reviews respectively).

42. This measure more accurately reflects the overall change in labour costs of those occupational groups in the Regulations, in comparison to using the LCI (under Option Two), because it is based on specific data from collective agreements in the health system rather than less specific labour market survey data. However, this option suffers from the same disadvantages of applying a flat rate increase that were outlined in Options Two.

43. This option would align with the approach ACC took in its 2020 annual review of contracted services. Additionally, this option addresses consultation submissions from the 2018/19 review. In the 2018/19 review, providers' primary concern was that that the MECA uplifts were not accounted for in the calculation. This option therefore remedies that concern. However, it does not recognise the individual labour cost pressures for each profession.

44. The cost of a 6.61% increase is a $23 million increase in annual spending.

Option Four – Use DHB MECA increases for relevant occupational groups

45. Option Four applies a bespoke pricing increase to the individual professions, based on MECA changes from 2016 to 2021 excluding the LCI uplifts previously applied from the 2017/18 and 2018/19 reviews.

46. The DHB MECA wage increases, grouped by similar occupational groups used in the Cost of Treatment Regulations, were:

    a. Counsellors and Specified Treatment Providers: 9.36%

    b. Medical practitioners, Hyperbaric Oxygen Treatment, Radiologists, Specialists and Dentists: 5.70%

    c. Nurses: 7.85%

    d. Medical practitioners and nurses combined consultation: 4.60%.

47. The combined treatment rate for a consultation that involves both a medical practitioner and a registered nurse is not purely salary based. It also includes components, for materials like bandages or sutures, which are Consumer Price Index (CPI) based. The CPI uplift was not applied by ACC to similar contract-funded treatment, so the same approach was followed for calculating comparable regulated payment rates for consistency. This is why the proposed increase for the combined treatment rate is a little lower than the other proposed increases.

48. 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.

49. The proposed increases would be the largest ever increases to the regulated rates, increasing spending by $23 million annually like Option Three. For Option Four, the payment increases would distributed differently between the different occupational groups.

Analysis of submissions obtained in public consultation

50. There were 28 submissions from treatment providers or their associations, and two from interested individuals, concerning the proposed bespoke increases. All of them supported the need for an increase in payment rates to at least reflect wage increases in relevant occupational groups. Some submitters considered a greater increase to rates is required to cover inflation until the next review takes effect. Other submitters wanted more substantive increases, sufficient to significantly increase the proportion of cost covered by ACC, to reduce the co-payments faced by claimants and improve access to treatment.

Options for increases under the Hearing Loss Regulations

51. All four options above include a nil increase for audiologists because with on-going technology changes, an increase in device fitting fees might be inconsistent with market trends. ACC also considered that there had been no increase in cost-related access issues. ACC will consider whether Audiologist rate increases are warranted in the upcoming 2022 review.

52. There were 11 submissions from the audiology sector concerning this proposal and all strongly opposed a nil increase. Most submissions argued that the proposal showed a lack of understanding of how the industry operates and what works best for those needing treatment for hearing loss. Most submissions also pointed to recent cost pressures facing the industry.

53. MBIE considers that the issues raised in the submissions need careful consideration so are best dealt with in the upcoming 2022 review (due to the Minister for ACC by 1 December 2022). We therefore propose a nil payment increase for audiology treatment in this review as consulted on.

Options introducing a nurse practitioner and registered nurse combined rate

Option One: Status Quo

54. Under the status quo option, ACC will continue to be billed for registered nurse consultations and nurse practitioner consultations separately. Where a consultation involves both a nurse practitioner and a registered nurse, standard practice is that only the nurse practitioner component is billed to ACC, which effectively under-compensates the provider.

55. Alternatively, if providers double bill ACC (once for the registered nurse rate and once for the nurse practitioner rate), ACC would over-compensate the provider for the session. There is also a risk that claimants are required to pay two co-payments for these consultations due to the fee structure the provider is required to use to bill ACC.

Option Two: Introduce a new combined treatment rate

56. Introducing a new combined treatment rate will mean that providers will be more appropriately reimbursed for consultations involving both a nurse practitioner and a registered nurse, and that claimants will only need to pay one co-payment.

57. To calculate the proposed new combined rate, ACC used the same methodology it used to set the medical practitioner and registered nurse combined rate. It considered the individual rates of both nurse practitioners (as a base) and registered nurses (as an additional top up) and calculated a combined treatment rate with variations for each class of claimant.

58. For a patient 14 years and over (and not a holder of a Community Services Card) the new rate for combined treatment from a nurse and nurse practitioner is proposed to be $29.33 (before the 4.6 percent uplift proposed for combined rates). In comparison, the corresponding medical practitioner and registered nurse combined rate is $35.74 and the nurse practitioner only rate is $28.02. Other variations of the combined treatment rate are similarly set.

Analysis of submissions obtained in public consultation

59. Nurse Practitioners New Zealand made a submission in support of the new combined rate, although considered the proposed increases in payment rates were insufficient because co-payments would still be unaffordable to some patients and cause health inequities. The Royal NZ College of GPs also supported the new combined rate, but were concerned the consultation reinforced an incorrect perception that nurse practitioners have the same skills as GPs. Several other submissions also supported the new combined rate. No submissions were made against the proposal.

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 the average DHB MECA increase	Four – Use DHB MECA increases for relevant occupational groups
Access to treatment	0	+ The regulated rates would all rise uniformly by around 6% (apart from nil for audiology rates) meaning that if providers raise their prices in relation to increased cost pressures, this increase would not be passed on to claimants.	+ The regulated rates would all rise uniformly by 6.61% (apart from nil for audiology rates) meaning that if providers raise their prices in relation to increased cost pressures, this increase would not be passed on to claimants.	++ The regulated rates would rise by a variable amount (nil for audiology rates and 4.6 to 9.36% for others), depending on the individual impact MECA increases have had on the provider type which should better match the rate increases to cost pressures.
Cost to ACC	0	0 The cost to ACC would be manageable and would not require levy increases.	0 The cost to ACC would be manageable and would not require levy increases.	0 The cost to ACC would be manageable and would not require 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.	++ This best aligns to cost changes across the health sector as it does so provider specifically rather than via a blanket rate change.
Overall assessment	0	++	++	++++

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

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

61. While the proposed increases in payment rates will increase spending by ACC by $23 million annually, ACC has indicated that the costs associated to Option Four would result in immaterial increases in ACC levies or ACC appropriation, as rising costs have been factored into ACC's

levy, appropriation, and Outstanding Claims Liability (OCL) calculations. This means that the key trade-off from this option has already been mitigated, and the costs of this option are the same or similar to the other options.

62. Option Four best addresses 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 proportions specific to provider type, ACC will best maintain access to treatment. In particular, because provider types with the greatest increased cost pressures (due to MECA increases) will receive the greatest rate increase, access to all treatment types will be better maintained compared to the Status Quo and the other options.

63. Option Four should 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. There was strong support from consultation respondents, with nearly all supporting an increase in payment rates to at least reflect wage increases in relevant occupational groups. Some considered a greater increase is required to cover inflation until the next review takes effect. Other submitters wanted more substantive increases, sufficient to increase the proportion of cost covered by ACC, to reduce the co-payments faced by claimants.

How do the options compare to the status quo/counterfactual? – Options to add a new combined nurse's rate

	Option One – Status Quo	Option Two – Introduce a new rate
Access to treatment	0	+ Access to combined nurse consultations would be more accessible if providers could bill for them appropriately. Currently providers (if billing correctly) are disincentivised to do combined consultations which disadvantages the claimant who may need two appointments instead, and therefore pay two co-payments. If the provider currently double bills for these consultations, the claimant may also need to pay two co-payments. Under Option Two, claimants would be limited to paying one co-payment
Cost to ACC	0	0 The cost to ACC would be greater than just paying the nurse practitioner rate. However, this cost is offset by stopping providers double billing for a combined consultation or by providers requiring that a patient books two appointments

Similarities with the health system	0	+ This option better recognises collegial work effort in the health system (as encouraged by Manatū Hauora)
Overall assessment	0	++

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

65. MBIE considers the option that best meets the policy objectives and that delivers the highest benefits is Option Two. While the differential impact of the costs to ACC between Option Two and the Status Quo is difficult to quantify (as ACC does not know the scale of providers that may be double billing for combined nurse consultations versus correctly billing for a nurse practitioner consultation), if providers are billing correctly then the cost to ACC of Option Two will be greater than the Status Quo.

66. Access to treatment is increased in Option Two compared to the Status Quo. This is because under the Status Quo, claimants are more like to pay a greater amount through co-payments by:

    a. Providers double billing ACC for both a nurse practitioner rate and a registered nurse rate for a combined nurse consultation, and also charging both co-payments to the claimant; or

    b. Providers being disincentivised to provide combined nurse consultations, and therefore asking claimants to attend two separate appointments.

67. Whether or not Option Two provides more similar payments between ACC and the wider health system compared to Status Quo is difficult to determine. It aligns with Manatū Hauora in terms of its intention to remove legislative, funding, custom, and practice barriers that prevent nurse practitioners from practising to the full breadth of their scope of practice. However, because rates structures are set by individual providers, it's not clear how well a combined treatment rate compares to non-ACC patient rates across different facilities. We believe that the inclusion of a combined rate from ACC will encourage its use more widely among providers that do not currently utilise a combined nurse practitioner and nurse treatment rate.

68. All submissions in MBIE's consultation process that mentioned the proposed combined rate for treatment by a nurse practitioner and registered nurse supported the proposal.

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

Affected groups *(identify)*	**Comment** *nature of cost or benefit (eg, ongoing, one-off), evidence and assumption (eg, 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	$23 million per annum	High
Total monetised costs	Negligible levy rate impacts and negligible impact to the Crown (via the Non-Earners Account) as already incorporated into ACC's baseline	$23 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	$23 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	
Non-monetised benefits		Low	

Section 3: Delivering an option

How will the new arrangements be implemented?

69. 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*. MBIE will be responsible for these amendments. The proposals are intended to take effect from 1 April 2023.

70. 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 2022 review) is underway.

    b. If Option Two or Option Three are chosen, ACC will need to notify providers of the changed rates, and how the rates were calculated (i.e., via LCI or average MECA increases). There will likely be some negative reaction from providers (e.g., Allied Health Professionals and Nurses) who will feel that this 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 and how the rates were calculated. ACC will need to explain why some professions are getting larger increases that others. There are not expected to be any negative reactions from providers (compared to Options Two or Three) because there was support from providers to increase the rates, and to use individual MECA rates to inform increases (this was feedback from the 2018/19 review).

    d. Under all of the options, ACC will need to communicate to audiologists the reasons for no change and how payments to Audiologists have been reviewed in the 2022 review.

71. The increased rates will be paid from the in-force date, which is expected to be 1 April 2023.

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

72. 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 2022, with any subsequent changes to rates not likely to take effect until late 2023.

73. 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.

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

75. The biennial cycle should allow 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 should be available to support the review, 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.

76. 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 the changes implemented from this review and the 2022 review have had on access to treatment.