PUBLIC VERSION

SOUTHERN CROSS MEDICAL CARE SOCIETY

9 NOVEMBER 2026

CROSS-SUBMISSION ON

THE COMMERCE COMMISSION'S

DRAFT DETERMINATION

IN RELATION TO THE

NEW ZEALAND GYNAECOLOGY ASSOCIATION INC

AUTHORISATION APPLICATION



PUBLIC VERSION

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1. INTRODUCTION

1.1 This cross-submission is made by Southern Cross Medical Care Society (trading as Southern Cross Health Insurance) ("**SCHI**") in response to the submissions on the Commerce Commission's Draft Determination ("**DD**") in relation to the application by the New Zealand Gynaecology Association Inc ("**NZGA**") for authorisation to engage in collective bargaining and a collective boycott (together the "**Competitor Coordination**") with SCHI and / or hospitals (the "**Application**").[1]

1.2 This cross-submission focuses on responding to the NZGA submission dated 20 October 2026 (the "**NZGA Submission**") and the Link Economics ("**Link**") submission dated 20 October 2026 (the "**Link Submission**"). This cross-submission is supported by a further report from NERA (the "**NERA November Report**").

1.3 SCHI considers that this cross-submission provides important information, clarifications, and corrections in relation to those submissions to assist the Commission as it works towards its final determination (the "**Final Determination**").

2. EXECUTIVE SUMMARY

2.1 This cross-submission shows that, when the NZGA Submission and Link Submission are tested against the evidence and against the Application NZGA actually made, they give the Commission no reason to depart from the preliminary view in its DD. The NZGA and Link Submissions contain no new evidence of any public benefit that depends on authorisation. Rather, they confirm that the Application must be declined.

2.2 The question remains whether everyday New Zealanders would be better off if ~130 competing gynaecology surgeons were permitted to negotiate their prices together, supported by a collective boycott. Nothing in the NZGA Submission or the Link Submission changes the answer the DD reached: they would not.

2.3 Both the NZGA and Link Submissions rest on a series of premises that do not withstand scrutiny:

(a) **They analyse an arrangement NZGA has not applied for.** Link assumes that "gynaecologists will not engage in collective bargaining", and NZGA now describes the Application as "collective advocacy". The Application, however, seeks authorisation to collectively bargain "to the broadest extent necessary", including "negotiated common pricing", backed by a Standstill Agreement. "Benchmark" negotiation by competitors is collective price-setting. Submissions in relation to a different arrangement are irrelevant to the Commission's assessment.

[1] As the Commission is aware, SCHI filed its primary submission on the SOPI on 16 June 2026 (the "**SOPI Submission**"), its cross-submission on 3 August 2026 ("**SOPI Cross-Submission**"), an economist report prepared by NERA on 3 August 2026 (the "**NERA August Report**"), and its submission on the Commission's Draft Determination on 7 October 2026 (the "**DD Submission**"). SCHI does not repeat those submissions (or the NERA August Report), but will cross-refer to them where relevant in this cross-submission. For the avoidance of doubt, SCHI wishes it to be recorded that it considers all the points it raised in its original SOPI Submission, SOPI Cross-Submission, and DD Submission (and the evidence presented by NERA in the NERA August Report) still stand.

(b) **SCHI is not a "monopsonist".** SCHI funds only around [ ] of gynaecology surgeries in New Zealand. Gynaecologists have extensive outside options (Health NZ, ACC, other insurers, self-funded patients and, according to NZGA's arguments, Australia). In other specialties where SCHI has transitioned services to its Affiliated Provider Scheme ("**APS**"), the DD records that SCHI has had to raise its prices to secure coverage. A funder that cannot "walk away" and has to pay more to secure supply is not a monopsonist. Indeed, if gynaecological prices were depressed below sustainable levels, the result would be reduced access to services for SCHI's own members – the very people it exists to serve. SCHI, therefore, has a structural incentive to ensure that fees are set at levels that maintain an adequate supply of high-quality gynaecological services for its members.

(c) **The asserted "~48%" fee reduction is incorrect.** This assertion is based on out-of-date and [ ] information [ ]. On SCHI's modelling using 2024 data, the average amount paid per episode would decrease by only ~[ ]. [ ], and [ ] gynaecologists would earn more under the proposed APS. Applying the NZGA's arithmetic (which does not even account for consultation and rooms-based revenue), the effect on a typical practice's total surgeon fee revenue is at most [ ], not the 25–30% NZGA asserts.

(d) **The APS is neither new nor untested.** It has operated since 1997 with more than 2,500 providers across more than 30 specialties, [ ]. Gynaecology is not being treated differently. The proposed gynaecology APS flexibility mechanisms are the same ones already used routinely in other specialties.

(e) **There is no evidence that SCHI's APS reduces supply or quality.** Volumes have continued to grow in every specialty that has transitioned to SCHI's APS. SCHI has found no correlation between surgical price and patient-reported outcomes. The clinical concerns NZGA cited in its Application have been discussed and resolved through consultation with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists ("**RANZCOG**") and the Aotearoa New Zealand Society of Urology ("**ANZSU**"), without collective bargaining.

(f) **NZGA's assertions of a "costly counterfactual" are incorrect, and delays to date have been due to the Application.** Hospitals / facilities have been unable to finalise arrangements with gynaecology surgeons because the Application is on foot. An applicant cannot seek to strengthen its case by threatening unlawful coordination or appeals in the counterfactual.

(g) **NZGA's survey is unreliable.** NZGA's survey falls well short of recognised good practice. It still provides no quantification of any incremental benefit of authorisation.

2.4 By contrast, the record before the Commission contains substantial quantified evidence of detriment. Gynaecology surgeon costs to SCHI would reach $243 million a year by FY2036 with authorisation, compared with $105 million under the APS. That would be borne by approximately 935,000 SCHI members [ ] and, through higher reference prices, by other insurers' customers, Health NZ, ACC and self-funded women.

2.5 NZGA's mooted conditions would not change this. They do not constrain the price effects that drive the detriments, and they would add further cost and complexity.

2.6 Accordingly, SCHI submits that the Commission should confirm its preliminary view and decline the Application in full.

3. THE LINK SUBMISSION DOES NOT REFLECT THE AUTHORISATION APPLICATION

3.1 There is a fundamental error with the Link Submission. It is premised on an assertion that in the factual "gynaecologists will not engage in collective bargaining",[2] will only be "armed with the knowledge of a benchmark",[3] and will "continu[e] to negotiate as individuals".[4] That proposition is inconsistent with the Application and the Link Submission itself:

(a) The Application specifically seeks authorisation to:

(i) "[c]ollectively bargain with SCHI and / or hospital(s) for the provision of private gynaecological services"[5]… "to the broadest extent necessary to enable effective collective bargaining of the provision of private gynaecological services",[6] including "structured engagement on both price and non-price terms"[7] and "negotiated common pricing".[8] One of NZGA's claimed benefits in its Application is "[c]ollectively negotiated prices";[9]

(ii) engage in a collective boycott (the **"Standstill Agreement**") "to encourage meaningful engagement by SCHI of any collective negotiation authorised".[10] The existence of the Standstill Agreement is inconsistent with Link's assertion that gynaecology surgeons would "not be able to collectively refuse to treat SCHI-funded patients."[11] A refusal to treat SCHI-funded members would be the practical effect of a collective refusal to agree to funding mechanisms in relation to SCHI members.

(b) Elsewhere, the Link Submission says that the purpose of the Application is to "set efficient prices for procedures"[12] (i.e. that the purpose of the Application is to establish prices), but that "gynaecologists will not engage in collective bargaining, beyond NZGA's benchmark negotiations".[13] This is a false distinction. Benchmark negotiations to set common prices is collective bargaining. An agreed rate negotiated by ~130 competitors is collective price-setting, whether it is called a "benchmark" price or not. The Commission's DD reflects the correct perspective on this: "Once members had established a collectively

[2] Link Submission at [34].
[3] Link Submission at [35].
[4] Link Submission at [29].
[5] NZGA Application at [2.3(a)].
[6] NZGA Application at [2.4(e)].
[7] NZGA Application at [4.7].
[8] NZGA Application at Table 1.
[9] NZGA Application at Table 3.
[10] NZGA Application at [2.12].
[11] Link Submission at [34].
[12] Link Submission at [8].
[13] Link Submission at [34].

negotiated reference price, that would become a price floor below which no surgeon would charge, with a particularly strong inflationary effect on prices given the wide variation in surgeon pricing".[14]

3.2 This fundamental error undermines the entire Link Submission. For example, Link seeks to discredit SCHI's modelling of the price impacts of Competitor Coordination by stating that SCHI "assume "full surgeon participation in collective bargaining, but in the factual there is not collective bargaining, so these estimates are not relevant".[15] The Commission's DD was correct in analysing the effects of the conduct that NZGA has sought authorisation for (i.e. collective bargaining to the "broadest extent necessary" and a collective boycott "Standstill Agreement"), and not an artificial and illusory distinction between "collective bargaining" and "collective… benchmark negotiations". It is also not accurate for Link to seek to dismiss SCHI's modelling of price increases in the factual because it adopted "an assumption of full collective bargaining".[16] It is appropriate for SCHI to model the effects of the conduct that NZGA has sought authorisation for, and for the Commission to then take that modelling into account.

3.3 Accordingly, the Link Submission does not even seek to analyse the conduct for which authorisation is sought, and therefore any analysis contained in it is irrelevant for the Commission's assessment.

4. THE NZGA SUBMISSION DOES NOT REFLECT THE AUTHORISATION APPLICATION

4.1 The NZGA Submission similarly recasts the Application as seeking only "a lawful mechanism for collective advocacy, so that SCHI's proposal is clinically informed and the specialty remains sustainable."[17] Again that characterisation is misleading:

(a) If all NZGA sought was clinical advocacy, no authorisation would be required. SCHI has engaged, and continues to engage, with RANZCOG and ANZSU on clinical matters, and had been willing to engage with NZGA on clinical matters until [ ].

(b) NZGA's reference to seeking that the specialty "remains sustainable" is a euphemism for NZGA's intention to use collective bargaining to collectively bargain in relation to prices. The reason NZGA requires authorisation is precisely because the Application involves conduct (collective price setting and a collective boycott) that would otherwise be cartel conduct under the Commerce Act.

(c) Elsewhere in its submission NZGA seeks to dismiss SCHI's engagement with RANZCOG on the basis that such "engagement on the code set is clinical only", whereas NZGA seeks to engage in "the commercial aspects of its members' work".[18]

[14] DD at [346].
[15] Link Submission at [37].
[16] NZGA Submission at [72(a)].
[17] NZGA Submission at [28].
[18] NZGA Submission at [70].

4.2 Accordingly, as with the Link Submission, the NZGA Submission is similarly premised on seeking to misdescribe and downplay the very conduct for which authorisation is sought.

5. NZGA'S ASSERTIONS IN RELATION TO SCHI'S APS ARE INCORRECT

5.1 The NZGA Submission makes a number of incorrect assertions in relation to SCHI's APS, including that the APS is "new and untested",[19] disputing that the APS has "existed for several decades",[20] that the "APS proposed for gynaecology differs from the historic arrangements other specialties moved onto",[21] and that when the APS started it was "only as a prior approval mechanism".[22] None of those assertions are correct:

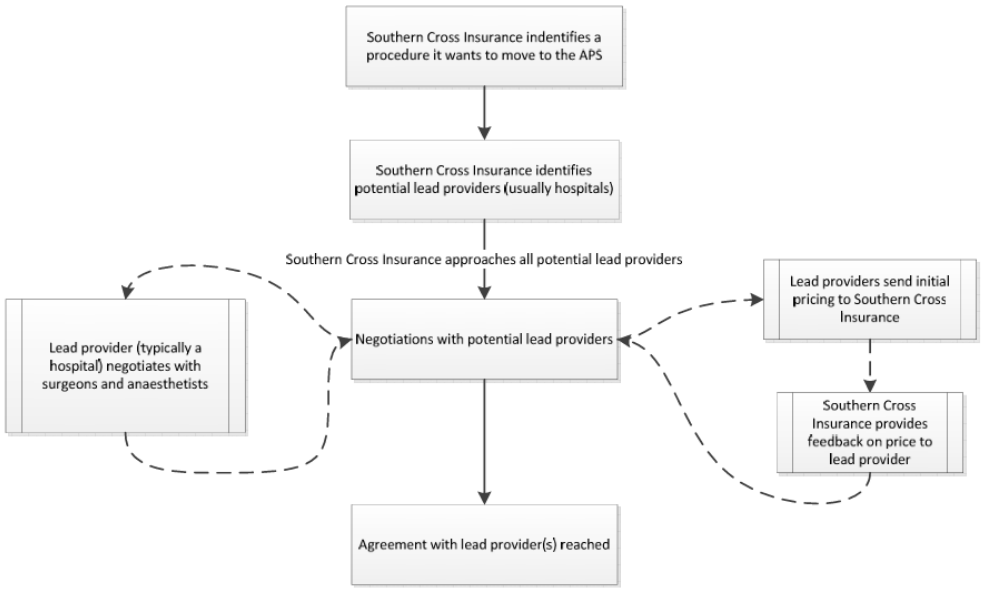
(a) SCHI's APS has been in place in its current form since 1997, and it is not correct that it was previously "only as a prior approval mechanism". It is also not correct to assert in relation to surgical procedures that "in some cases APS simply refers to the setting of standard prices paid by SCHI to surgeons rather than adopting the back-to-back contracting model with hospitals".[23] Demonstrating this, the way in which the Commission described the APS in 2014 remains accurate today, including in relation to the proposed gynaecology surgery APS transition:[24]

> Under the APS Southern Cross Insurance agrees a fixed price for a procedure with a lead provider. The lead provider is usually a private hospital. Southern Cross Insurance negotiates APS pricing with the hospital, with renegotiation typically occurring every two or three years. The hospital is responsible for obtaining and paying for the other services necessary to provide the procedure, such as the surgeon and anaesthetist. The negotiations between the hospitals and the surgeon and anaesthetist are held independently of Southern Cross Insurance. There are either formal contracts or verbal agreements between the hospital and the surgeon, and the hospital and the anaesthetist, which determine the price each is paid.

The Commission's diagram from that time summarising the process of SCHI seeking to move a Fee for Service (**"FFS"**) procedure to its APS also remains accurate (including with respect to the process that SCHI is seeking to go through in relation to gynaecology surgery).[25] See Figure [1] below.[26]

[19] NZGA Submission at [7(b)].
[20] NZGA Submission at [7(b)].
[21] NZGA Submission at [7(b)].
[22] NZGA Submission at [4(b)].
[23] Link Submission at [69].
[24] *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at [70] and [71].
[25] *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at Figure 2.
[26] The fact this APS model is long-standing also demonstrates that the assertion made at paragraph 25 of the NZGA Submission is incorrect. Namely, at that paragraph NZGA asserts: "If SCHI intends to roll the head-contractor model out across the sector, it is all the more important that the model is clinically informed and workable, or SCHI will face the same pushback in each specialty". As the Commission is aware, SCHI has already rolled-out the same APS model to many other specialties, and has not faced the same push-back (and attempted Competitor Coordination) that it has faced from the gynaecology surgeons.

Figure [1] – Commission illustration of moving fee-for-service procedures to the AP programme



Source: Commerce Commission

(b) As previously outlined to the Commission, it is also not correct to assert that the "APS proposed for gynaecology differs from the historic arrangements other specialties moved onto"[27] or that "APS is currently limited to a confined set of procedures for most specialties".[28] Gynaecology is not being treated differently from other specialties.

(i) Other specialties are not confined to a narrow set of APS-only procedures. In most of them, nearly all claims go through APS. [ ]

(ii) Transitions of other specialties were just as broad when they began. [ ] Transitioning a substantial share of a specialty's procedures at once is therefore consistent with SCHI's established practice. It is not a unique approach for gynaecology. Furthermore, to the extent some specialties, for example, [ ][29] [ ].

(iii) Since its earlier submissions, SCHI has worked with RANZCOG and ANZSU to develop specific procedure funding codes for gynaecological oncology and urogynaecology surgery. These replace the open codes that were first proposed for gynaecology surgeons. Gynaecology procedures will therefore be funded through defined codes, in the same way as other specialties. There are two open codes that have been kept as a safeguard for the rare case where no procedure funding code applies. SCHI does not expect the open codes to be needed,

[27] NZGA Submission at [7(b)].
[28] NZGA Submission at [24].
[29] [ ]

as the procedure funding code set covers the full range of gynaecology procedures.

(iv) The flexibility mechanisms are the same ones that other specialties already use. Add-on codes, risk corridors, top-ups and open codes are well understood and used regularly across specialties.

(c) As previously outlined to the Commission, it is also not correct to assert that the "[g]ynaecology is also clinically different"[30] to other specialties. The gynaecology surgical specialty is not an outlier (in terms of complexity or breadth) compared to other surgical specialties already operating with the APS.[31] To the contrary, the gynaecology surgical specialty is smaller (in terms of required codes) than several specialties already routinely coded,[32] and many other surgical specialties where the APS has already been successfully implemented (colorectal, urology, upper gastrointestinal, hepatobiliary, vascular, orthopaedic and others) involve unexpected anatomy, adhesions, bleeding, conversion of approach, additional findings, co-morbid patient factors, prolonged operating time, or changes in resource use.

(d) Furthermore, while the evidence (as set out above) shows that gynaecology is not clinically different from other specialties, even on NZGA's own description, NZGA's arguments support an "all of specialty" transition, not a partial one. NZGA submits that gynaecological surgery "is often diagnostic and unpredictable", that surgeons commonly find additional pathology and decide mid-operation how to proceed, and that complex operations commonly combine procedures.[33] By contrast, NZGA argues that some APS procedures in general surgery and orthopaedics are "mostly discrete, single site, high volume operations with predictable operating times".[34] NZGA's argument (i.e. that in gynaecology it is common for different procedures to be combined) in fact further supports an "all of specialty" transition. Namely, if only some gynaecology procedures were moved to the APS but not others, operations could start under an APS code and finish partly under FFS, depending on what the surgeon found. That would mean:

(i) no certainty for members before surgery about how their surgery will be funded;

(ii) split claims for a single gynaecological operation, with separate prior approvals, two pricing bases to reconcile, and a risk of overlap and double-counting;

(iii) an incentive to code towards whichever model pays more, undermining the consistency the APS is designed to deliver (in

[30] NZGA Submission at [23].
[31] See SCHI's SOPI Cross-Submission at [4.2(f)].
[32] SCHI's proposed gynaecology surgical procedure funding code set has 89 codes (including the specific urogynaecology and oncology-gynaecology). That compares with 165 in ophthalmology, 135 in oral and maxillofacial, 148 in general surgery/gastro (endoscopy) and 120 in general surgery/skin and superficial.
[33] NZGA Submission at [23] and [68].
[34] NZGA Submission at [22].

particular, given the significant variation in gynaecology claiming SCHI has already seen); and

(iv) risk corridors, top-ups and open codes could not work properly if part of the operation sits outside the APS.

These would be the very administrative burdens and funding uncertainties that NZGA purportedly objects to.[35] An "all of specialty" transition removes these administrative burdens and funding uncertainties. Through an "all of specialty" transition, every procedure, including those decided mid-operation, sits within one framework with one set of rules. Additional pathology is funded through add-on codes, the staged endometriosis codes, risk corridors and additional time blocks, and codes can be updated after surgery prior to claiming payment to reflect what was actually performed. The result is one prior approval, one pricing basis and one claim. The "all of specialty" approach therefore does not ignore complexity (which is inherent in any specialty), it responds to it, with less administration and more certainty for surgeons and members.

(e) The NZGA Submission further asserts, inconsistently, both that the Commission has not tested "whether SCHI's current proposed form of APS is in fact efficient or working well for other specialties", but also that "experience in other specialties is no comparator or evidence that APS will be implemented smoothly for gynaecology".[36] For the record, SCHI considers that the proven track-record in other specialties is the best available evidence of how a competitive transition to APS in relation to gynaecology would occur, and in this respect notes:

(i) Since 1997 SCHI has agreed APS agreements with more than 2,500 healthcare providers nationwide, spanning more than 30 clinical specialties, including in relation to gynaecology consultations and rooms-based services since 2017.

(ii) The Commission has previously recognised the pro-competitive and consumer benefits of the AP programme:[37]

(aa) In *Southern Cross Hospitals / Aorangi Hospital* (2011), the Commission found that the APS programme "provides all parties with certainty in respect of pricing" and would limit the ability of the merged hospital entity to raise prices.[38]

(bb) In *Connor Healthcare / Acurity* (2014), the Commission described the APS programme as "an important development in the provision of private health insurance" and recorded SCHI's submission that "historical comparisons suggest future inflation is better moderated within a contracted procedure compared to that previously charged under a fee-for-

[35] NZGA Submission at [68(b) to (c)].
[36] NZGA Submission at [7(b)].
[37] See SCHI's SOPI Submission at [4.15].
[38] *Southern Cross Hospitals Limited and Aorangi Hospital Limited* NZCC Decision No. 729 at [81] and [107].

service."[39] The Commission found that "by making the procedures AP only, Southern Cross Insurance is aiming to bring outlying prices closer to the market rate."[40]

SCHI's experience is that the APS significantly moderates cost escalation: [ ], whereas services funded on a fee-for-service basis are not subject to agreed escalation constraints and have increased far more sharply over time. For example, SCHI's claims data shows that the gynaecology surgeon fees for a number of gynaecology procedures (for example, hysteroscopy, hysterectomy, endometriosis surgery) have increased by more than [ ] cumulatively since 2013, compared with cumulative CPI[41] growth of approximately 40% over the same period. By contrast, two comparable surgeries in the [ ] that are funded through the APS have only faced cost increases of [ ] during that same period (i.e. broadly in line with CPI).

At the same time, these other specialties have been successfully transitioned to the APS without any adverse impact on member healthcare:

(iii) SCHI's survey data shows that APS-only surgeries in other specialties receive more positive patient-reported outcomes than FFS gynaecology surgery;

(iv) There is no evidence that SCHI's APS has resulted in a reduction of procedures performed in other specialties. To the contrary, the evidence demonstrates that when procedures transition to the APS, the volumes of those procedures performed continue to increase.

(f) In relation to gynaecology surgery specifically, there are already [ ] gynaecology surgeons working within [ ] existing surgical APS agreements. [ ]

5.2 Contrary to NZGA's assertions, the APS is a proven mechanism for delivering efficient and pro-competitive outcomes that support affordability and access, and there is no evidence that gynaecology surgery is distinct from the other surgical specialties where the APS has already been in operation for a number of years.

6. NZGA'S ASSERTION THAT SCHI IS A "MONOPSONIST" IS NOT CORRECT

6.1 Most of the NZGA and Link Submissions are based on an assertion that SCHI is a "monopsonist". That assertion is not correct:

(a) First, as outlined to the Commission previously, SCHI is only one of multiple funders and accounts for only a minority of all gynaecology procedures in New Zealand.

[39] *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at [65] and [67].
[40] *Connor Healthcare Limited and Acurity Health Group Limited* [2014] NZCC 39 at [69].
[41] Consumer Price Index.

(b) Second, NZGA's (and Link's) submissions are premised on an assertion that SCHI's market share in private health insurance reflects SCHI members' share of demand for gynaecology surgery. That is not correct. As the Commission is aware, SCHI estimates that it funds only approximately [ ] of gynaecology surgeries in New Zealand.

(c) Third, under SCHI's "UltraCare" policies, a member with an "UltraCare" policy can choose to use FFS providers even if that specialty has become an APS-only specialty (and UltraCare policies account for [ ]% of all SCHI's female health insurance members).[42]

(d) Fourth, NZGA's own survey of its members shows that only 31% do 60% or more of their work privately.[43] This further demonstrates that gynaecology surgeons operate in a multi-channel funding environment and are not dependent on SCHI (or private insurers) alone.

(e) Fifth, the observed market evidence and bargaining dynamics are not consistent with any assertion that SCHI has a "monopsony" position. As the Commission set out previously, the "relative bargaining power" of the negotiating parties depends on "several factors", including "the quality of each party's outside options" and "the payoffs either party derives from walking away from negotiations".[44] On these points SCHI notes:

(i) As the Commission found in its DD, SCHI cannot "walk away".[45] SCHI has contractual obligations to its members.[46]

(ii) SCHI has advised the Commission that there is "[ ]".[47] There are also numerous examples where SCHI has had to increase the prices it pays under its APS where member access has been at risk (as has occurred in the case of [ ] in [ ], [ ] in [ ] and [ ] in [ ]). This is also reflected in SCHI's initial modelling of gynaecology surgery fees, where it has used higher percentiles for [ ], where maintenance of adequate coverage at [ ] prices was considered less likely given the number of surgeons charging well in excess of [ ]. [ ] were used for those [ ] outlier regions instead.[48] Such outcomes are inconsistent with any suggestion of SCHI having monopsony power - a buyer / funder able to dictate terms would not need to do so.

(iii) NZGA's Submission itself acknowledges this reality – its submission notes that "SCHI would in any event raise its offer in the counterfactual until it has sufficient coverage",[49] which it notes "the Commission's Manawatu ophthalmology example shows".[50]

[42] [ ]
[43] NZGA Submission at footnote 81.
[44] *New Zealand Banking Association* [2026] NZCC 14 at [337].
[45] DD at [147].
[46] DD at [155.3].
[47] DD at [184].
[48] DD at [173].
[49] NZGA Submission at footnote 4.
[50] NZGA Submission at [15(b)]. NZGA makes the same point at [29], noting that: "The Commission's own ophthalmology example confirms [that there would be] pushback until SCHI raises its prices."

(iv) NZGA argues that Australian roles are available to New Zealand-trained gynaecologists without further training,[51] and that gynaecologists would move to Australia if they considered New Zealand prices were below competitive levels. If that were accurate, then in addition to Health NZ, ACC and the range of other funders in New Zealand, it would represent an additional "outside option" for gynaecology surgeons. Or to put this another way, it is not consistent for NZGA to attempt to argue that SCHI has "monopsony" power, but also that there are "marginal"[52] NZGA members who have the option to move to Australia if they are not happy with fee levels in New Zealand (as the Commission will be aware, economic logic dictates those marginal customers/suppliers with additional options also protect infra-marginal customers/suppliers).[53]

(v) The extended period over which SCHI has negotiated and consulted on the proposed gynaecology APS transition, and the fact that hospitals have been unable to finalise agreements while the Application has been on foot because "they need gynaecologists to agree",[54] is inconsistent with SCHI being a "monopsonist" that can dictate terms on a "take-it-or-leave-it" basis.

(f) Sixth, the Link Submission's main claimed "evidence" that "SCHI has monopsony power and is exercising it"[55] is the fact that SCHI is seeking, through the APS transition, to reduce gynaecology surgery fee prices from their current FFS levels. Specifically, the Link Submission asserts that "[n]o competitive firm can unilaterally force one of its suppliers to reduce their prices by such amounts by simply changing how it deals with those suppliers".[56] That assertion is incorrect - it treats current FFS prices as the competitive benchmark. However, as previously outlined to the Commission, current FFS prices are above competitive levels, including due to market failure and a lack of any ability for SCHI to engage in any prospective fee negotiations:

(i) Where prices start above competitive levels, a reduction is consistent with the removal of supra-competitive rents, not the exercise of monopsony power; and

(ii) The proposed APS transition does not just reflect a "change in how SCHI deals with suppliers", but reflects a mechanism to introduce competitive fee negotiations where there is currently none. Therefore, reductions in fee levels would reflect competition in action, not the exercise of monopsony power.

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[51] NZGA Submission at [35] and [47].
[52] NZGA Submission at [7(d)].
[53] Furthermore, Link's assertion at [65] that "according to RANZCOG approximately 50% of gynaecological oncologists who went overseas for training did not return" indicates that there are multiple other factors, aside from remuneration, that determine whether or not a gynaecologist wishes to live in New Zealand. In particular, the evidence SCHI has presented to the Commission demonstrates that gynaecologists in New Zealand are, on the whole, already charging SCHI surgery fees that significantly exceed competitive levels. Yet, despite that, there have already been gynaecology surgeons who have chosen to emigrate.
[54] DD at [145].
[55] Link Submission at [17].
[56] Link Submission at [18].

6.2 The above demonstrates that SCHI is not a monopsonist that will be able to dictate terms, and also demonstrates that Link's assertion that Competitor Coordination would result in "bilateral monopolists"[57] is incorrect.

7. SCHI DOES NOT GRANT "EXCLUSIVITY" TO HOSPITALS / FACILITIES

7.1 NZGA asserts that "the exclusivity SCHI grants to its affiliated hospitals that gives them monopsony power over gynaecologists".[58] Link similarly seeks to assert that SCHI makes hospitals / facilities its "exclusive agents".[59] These assertions are incorrect:

(a) First, as immediately above, SCHI does not have monopsony power as a funder (given the range of other funders and outside options available to gynaecology surgeons), so it would not be possible for SCHI to somehow confer monopsony power to hospitals / facilities.

(b) Second, as outlined to the Commission previously, in any transition to APS-only, SCHI seeks to contract with all willing providers on commercial terms that ensure SCHI can continue to offer sustainable cover for its members' healthcare. Because SCHI seeks to contract with all willing providers, it is not correct to assert that SCHI seeks to grant exclusivity to certain hospitals / facilities.

(c) Third, as set out at paragraph 6.1(c) above, even if specialists are not participants in the APS, they still have the ability to service SCHI's UltraCare members who do not have to seek services from Affiliated Providers.

(d) Fourth, APS agreements between SCHI and a hospital / facility are negotiated bilaterally between SCHI and the relevant hospital / facility, and they do not restrict hospitals / facilities from contracting with other funders (including Health NZ, ACC, or other private insurers) or from treating non-SCHI patients on different terms.

(e) Fifth, individual gynaecologists remain free to contract (or not to contract) with hospitals / facilities that propose to participate in the APS.

(f) Sixth, SCHI's proposed APS transition does not impact or diminish the incentives on hospitals / facilities to compete to attract gynaecologists. As the DD notes, "regardless of the funding model, hospitals compete vigorously to attract surgeons to their facilities, as surgeons ultimately decide which patients to treat at which hospital".[60] Irrespective of the funding model adopted by SCHI, gynaecologists will continue to have the same ease of switching as they do now[61] (as is the case for other specialties).

[57] Link Submission [6].
[58] NZGA Submission at [18].
[59] See for example, Link Submission at [22], [42] and [44].
[60] DD at [382.1].
[61] The DD described this in the following terms, which SCHI agrees with: "Surgeons can move frictionlessly between hospitals. Surgeons are often (at least in major centres) credentialled at, and actively work across, multiple hospitals." DD at [382.1].

7.2 Accordingly, NZGA's assertion that SCHI confers monopsony power on hospitals / facilities, and Link's assertion that SCHI operates the APS through "exclusive agents", are incorrect and not supported by any evidence. In the context of SCHI's APS, hospitals / facilities compete with one another for surgeons, and there are no requirements of exclusivity.

8. NZGA'S ASSERTION THAT SCHI WILL CUT GYNAECOLOGY SURGERY FEES BY ~48% IS NOT CORRECT

8.1 Much of the NZGA and Link Submissions are premised on an assertion that SCHI will, in the counterfactual, reduce gynaecology surgery fees by ~48% compared to current FFS fees. That figure is not correct and is not supported by the evidence before the Commission:

(a) First, it appears to be an assertion based on an out-of-date [ ].

(b) Second, the Link Submission assertion does not reflect that SCHI has further updated its proposed procedure funding code set based on further consultation with RANZCOG and ANZSU;

(c) Third, it is premised on an inaccurate comparison by Link of [ ] headline procedure prices, and ignores the impact of the multiple services rule, add-on codes, risk corridors, open codes and top-ups that apply in practice.

8.2 As the Commission is aware, on SCHI's initial modelling based on a 2024 dataset, the estimated average amount paid per episode in SCHI's proposed APS (compared to 2024 FFS prices) falls by only [ ], and total savings are approximately $[ ] million a year (only [ ]% of spend).[62] Furthermore, [ ]

8.3 This demonstrates the fallacies that underpin NZGA's assertion that the APS transition would "likely remove roughly 25-30% of a private practice's total revenue".[63] As outlined elsewhere, SCHI estimates that across both the private and public health systems it funds only ~[ ] of all gynaecology surgeries in New Zealand. However:

(a) even assuming that in terms of privately funded surgeries SCHI funds ~[ ] of such surgeries; and

(b) setting aside gynaecology surgeons' other non-surgical revenues (such as consultation and rooms-based revenues that would not be affected by the APS transition),

given SCHI's initial modelling shows, based on a 2024 dataset, the estimated average amount paid per episode falling by only [ ]% once the proposed procedure funding code set, multiple services rule, add-on codes and risk corridors are applied, the proposed APS transition would only reduce, on average, a private gynaecology practice's total revenue by approximately [ ], not the 25–30% NZGA

[62] [ ]

[63] NZGA Submission at [34]. It also needs to be emphasised that gynaecology surgery fees are only a portion of a gynaecologists' overall practice revenue. Gynaecologists also earn consultation and rooms-based revenue. It is not apparent that NZGA's calculations account for that.

claims (and, as noted, a number of practices would receive higher revenue from SCHI).

8.4 In this respect, it must also be emphasised that there is no evidence for NZGA's assertion that some practices would become "unviable".[64] First, the assumed reduction in "total practice revenue by around 25-30%"[65] is without foundation, and as above would be less than [ ] based on a 2024 dataset. Furthermore:

(a) While NZGA asserts that increases in "nursing salaries" could require higher surgeon fees, it must be reiterated that the current APS negotiations are only in relation to gynaecology surgery procedures. For example, pre-operative consultations are already covered under a separate consultation APS agreement – they are not part of the surgical episode. In other words, the currently proposed APS transition for gynaecology surgical procedures would not prevent gynaecology surgeons from offering or charging for wrap-around services – it is simply the case that they should be billed separately. That is how specialties and health insurance are supposed to operate. [ ]

(b) The evidence demonstrates that gynaecology surgeons are highly paid and earn more than enough to maintain viable practices:

(i) [ ]

(ii) One surgeon recently billed SCHI [ ] (incl. GST) for approximately [ ] hours of their time performing surgery, or approximately [ ] per hour.

8.5 As both the NZGA and Link Submissions are premised on fundamentally incorrect figures, their assertions need to be dismissed accordingly.

9. NO ADVERSE IMPACTS ON HOSPITAL MARKETS

9.1 In its submissions NZGA makes references to "the impact on hospital markets"[66] and that "under the head-contractor model hospitals no longer compete with one another for surgeons".[67] These assertions are incorrect. As previously outlined to the Commission, the APS does not in any way restrict or reduce competition between hospitals / facilities:

(a) The APS is optional to enter and does not impact hospitals / facilities competing for specialists who deliver care within their hospital / facility. Rather, through the APS, SCHI can negotiate a competitively agreed price for the procedure as a whole, within which the relevant hospital / facility retains discretion to structure delivery, manage costs, determine the specialists who they contract with, and compete on efficiency and service quality with other hospitals/facilities.

(b) Within the context of the APS, hospitals / facilities still need to ensure that they offer competitive surgery fees to gynaecologists to ensure that they

[64] NZGA at [36(c)].
[65] NZGA at [36(c)].
[66] For example, NZGA Submission at [4(f)].
[67] For example, NZGA Submission at [57].

can attract gynaecology surgeons and, therefore, patient flows. This means surgeons' fees would be subject to competitive negotiations between hospitals / facilities and surgeons with hospitals / facilities competing to attract surgeons as Listed Providers to their hospital / facility.

(c) The evidence from hospitals / facilities confirms this. For example, Allevia states in its submission to the Commission that it "competes vigorously to attract and retain specialists in all specialities regardless of model", and that specialists commonly "play off" hospitals holding APS agreements, negotiating hard over fees, equipment, theatre access and service levels.[68] Specialists are not contracted to any one hospital, and are commonly credentialled at several, so they can move work between hospitals "without impediment".[69] By contrast, gynaecologists are a key source of patient flows for Allevia, which has made gynaecology-specific investments in equipment, instrumentation and specialist nursing staff.[70]

(d) Furthermore, the reference to "evidence of near-identical hospital price lists"[71] is misguided. SCHI understands that NZGA is purporting to refer to [ ]

10. SCHI HAS PROVIDED QUANTIFICATION OF THE DETRIMENTS – NZGA HAS PROVIDED NO QUANTIFICATION AT ANY POINT OF THE PROCESS

10.1 NZGA's assertion that "the detriments relied on to decline authorisation are not quantified"[72] is incorrect. SCHI has provided significant volumes of quantitative evidence to the Commission. That includes:

(a) SCHI's quantification of the evidence of the current excess billing by certain gynaecology surgeons in New Zealand (with reference to comparators, such as overseas comparators and [ ]).

(b) SCHI's initial quantification of the estimated savings of the proposed gynaecology surgery APS compared to the status quo: approximately [ ] million per annum (excl. GST), which equates to approximately [ ] million over five years.

(c) SCHI's quantification of the estimated increases in gynaecology surgical fees arising from Competitor Coordination.

(d) SCHI's quantification of the estimated detriments from a 6-month standstill.

(e) SCHI's quantification of the estimated impacts on premiums arising from Competitor Coordination.

(f) SCHI's quantification of the estimated insurance retention and policy downgrade impacts of such premium increases.

[68] Allevia Hospitals submission, at [28].
[69] Allevia Hospitals submission, at [8.2].
[70] Allevia Hospitals submission, at [8.2].
[71] NZGA Submission, at [7(c)(iv)].
[72] NZGA Submission at [3].

(g) SCHI's quantification of its estimated increased transaction costs.

10.2 It is NZGA that has failed to provide any quantification of its claimed benefits and, therefore, this assertion from NZGA should be readily dismissed by the Commission.

11. THERE IS NO DISJUNCT BETWEEN THE COMMISSION'S FINDING THAT SCHI CANNOT "WALK AWAY" AND ITS OTHER FINDINGS

11.1 NZGA seeks to make much of an apparent disjunct between the Commission's findings that SCHI cannot "walk away" and other findings of the Commission.[73] In reality, there is no such disjunct:

(a) First, as set out at paragraph 6.1(e) above, the evidence shows that SCHI cannot in practice "walk away", with there being a number of examples of where it has had to increase the prices it pays under its APS where member access has been at risk.

(b) Second, the NZGA seeks to assert an inconsistency between the finding in the DD that SCHI cannot "walk away" and an asserted finding in the DD that SCHI would "set a hard transition date".[74] There is no such finding in the DD. To the contrary, the DD states:

(i) that setting a hard transition date "would also pose significant risks to SCHI", including "significant financial and legal risk, as well as significant reputational damage", and the risk of "breaching contractual obligations to its members";[75]

(ii) "SCHI has not imposed an ultimatum of this nature so far and has instead opted to extend the transition period several times."[76]

Contrary to NZGA's assertion, the DD's findings in relation to a transition date (namely, that SCHI could not set a "hard transition date" without significant risk and has not done so to date) are entirely consistent with the DD's finding that SCHI cannot "walk away". It should also be noted that NZGA's own submission recognises that there has been no hard transition date: "SCHI has discarded its original indicative timeframe of around seven months and extended the transition several times".[77]

(c) Third, the NZGA seeks to assert an inconsistency between the finding in the DD that SCHI cannot "walk away" and an asserted finding in the DD that SCHI would "not deal with NZGA". Again, there is no inconsistency. The finding that "SCHI does not generally directly negotiate with surgeons",[78] and "would continue to resist direct discussions with NZGA",[79] is not a finding about SCHI's bargaining power – it is a

[73] For example, the NZGA Submission notes, at [4(a)], that the DD "inconsistently assumes that SCHI can both dictate terms and cannot "walk away".
[74] NZGA Submission at [15(a)].
[75] DD at [186].
[76] DD at [186].
[77] NZGA Submission at [29].
[78] DD at [165].
[79] DD at [166].

reflection of the relevant place in the overall health sector that SCHI sits.[80] As the evidence before the Commission states, that "wouldn't be [SCHI's] place".[81] Under the APS model, SCHI contracts with hospitals and facilities as lead providers for the overall surgical episode. Those lead providers in turn contract with and remunerate the surgeons and other clinicians required to deliver the service. The hospital / facility therefore remains the appropriate commercial counterparty for SCHI, while individual surgeons or NZGA may negotiate with hospitals / facilities regarding the remuneration the hospital / facility offers them. SCHI considers that negotiating the surgeon component separately with NZGA would cut across this established structure, reduce the hospital / facility's ability to manage the overall procedure funding envelope, and introduce an additional layer of negotiation involving SCHI, NZGA, hospitals / facilities and potentially different categories of surgeons. It is also unnecessary to achieve meaningful clinical engagement: as the Commission is aware, SCHI has engaged in significant clinical consultation to date, including making changes to proposed codes in light of clinical feedback received, which again is inconsistent with any NZGA assertion that SCHI can make decisions without regard to surgeon feedback.

(d) Fourth, the NZGA seeks to assert an inconsistency between the finding in the DD that SCHI cannot "walk away" and an asserted finding in the DD that SCHI "dictates prices".[82] There is no such finding in the DD. To the contrary, the DD specifically referred to examples of SCHI needing to negotiate price to secure coverage. For example, the DD notes:

(i) "In previous AP transitions (eg, for ophthalmology), we understand SCHI eventually raised the bundled prices it was willing to offer to a level acceptable to hospitals and clinicians when they received feedback that the prices were unacceptably low for clinicians."[83]

(ii) "Ophthalmologists in the Manawatu refused to do cataract surgery because the prices offered through the APS were too low. Eventually, SCHI raised the prices it was willing to offer and ophthalmologists resumed offering cataract surgery services to SCHI patients."[84]

11.2 Accordingly, it is important that the Commission dismiss these NZGA assertions as not reflecting (and, in fact, actively misstating) the Commission's findings.

12. NZGA'S SUBMISSION IGNORES THE PRICING IMPACTS OF COLLUSION

12.1 The NZGA Submission, in seeking to argue against the findings in the DD, states:[85]

[80] For completeness, it is also noted that NZGA's submission at [25] is incorrect. Namely, NZGA asserts that the Commission cannot put "weight" on SCHI's "wider commercial strategy" in relation to other specialties as that would "predetermine future applications". This conflates two entirely different points. Of course it is relevant to consider the commercial decisions that SCHI would take in the factual, including in light of SCHI's wider commercial strategy. That is distinct from, and entirely unrelated to, the prospect of any future authorisation applications in relation to other specialties.
[81] DD at [164].
[82] NZGA Submission at [18].
[83] DD at [147].
[84] DD at footnote 193.
[85] NZGA Submission at [18]. [Emphasis added]

> "the Commission assumes that essentially the same hospital-led negotiation process produces sharply lower fees in the counterfactual, but materially higher fees in the factual (even more so than Fee for Service (FFS)) **merely because it says NZGA has developed collective benchmarks**. It gives no explanation for why SCHI's control over price disappears only when NZGA is at the table."

12.2 In making this statement, it is apparent that NZGA is overlooking that the differences that the Commission is finding between the factual and the counterfactual are because of the collective price collusion between the NZGA members. That is not a "mere" factor that can be overlooked. That is at the heart of the Commission's finding that the Competitor Coordination would result in materially higher gynaecology surgeon fees. This finding is consistent with all orthodox economic theory, as well as Commission statements and findings in other contexts. For example:

(a) In the Commission's overview of "Anti-competitive behaviour by businesses" it states that "Anti-competitive behaviour is bad for consumers and businesses as they can **end up paying higher prices** or having reduced choice of goods or services."[86]

(b) In the Commission's Competitor Collaboration Guidelines it states: "Anti-competitive agreements – including cartels – are prohibited because they can **result in higher prices**, resources being misallocated, and firms having a decreased incentive to innovate. These outcomes are not in the long term interests of New Zealand consumers."[87]

(c) In the Commission's Cartel Leniency and Immunity FAQ it states that: "Cartels are a priority for the Commission because they harm New Zealand consumers and businesses. International studies show **cartels can cause prices to rise by (on average) between 18–20%**."[88]

(d) In the Commission's Technical Note in relation to the "Estimated harm from bid rigging in public procurement",[89] the Commission referred to an OECD paper that states that the "most extensive database and most recently published paper on price-fixing overcharges finds **cartel overcharge estimates average 121% with a median of 23%**."[90]

(e) In relation to collusion between health specialists specifically, the Commission has previously stated that: "By fixing prices instead of competing with each other on price, the surgeons effectively created a

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[86] Commerce Commission "Anticompetitive conduct by businesses". Retrieved from: https://www.comcom.govt.nz/consumers/dealing-with-typical-situations/anti-competitive-behaviour-by-businesses/ [Emphasis added].
[87] Commerce Commission "Competitor Collaboration Guidelines" (January 2018) at [3]. Retrieved from: https://www.comcom.govt.nz/__data/assets/pdf_file/0036/89856/Competitor-Collaboration-guidelines.pdf [Emphasis added]
[88] Commerce Commission "Cartel Leniency and Immunity FAQ". Retrieved from: https://www.comcom.govt.nz/business/avoiding-anti-competitive-behaviour/what-is-a-cartel/cartel-leniency-faq/ [Emphasis added]
[8989]Commerce Commission "Technical note: Estimated harm from bid rigging in public procurement" (September 2026). Retrieved from: https://www.comcom.govt.nz/assets/Uploads/Technical-note-Estimated-harm-from-bid-rigging-in-public-procurement-28-September-2026.pdf [Emphasis added]
[90] OECD "Assessing the impact of competition authorities' activities" (2025) at section 3.3.1. Retrieved from: https://www.oecd.org/content/dam/oecd/en/publications/reports/2025/04/assessing-the-impact-of-competition-authorities-activities_4faf82a6/eaafdba8-en.pdf [Emphasis added]

monopoly, potentially **resulting in higher prices** for eye surgery in the Palmerston North area."[91]

12.3 The Commission's finding that the Competitor Coordination would result in materially higher gynaecology surgery prices is consistent with (and supported by) all orthodox economic theory and Commission statements and findings in other contexts.

12.4 Further, NZGA asserts that "Engagement in the factual has only upside (a better-informed SCHI) and, at worst, no downside: if SCHI rejects NZGA's position, nothing changes from the counterfactual beyond any standstill period".[92] Again, this assertion is incorrect, and ignores economic realities:

(a) Once gynaecology surgeons have established a collectively negotiated "reference price" in relation to SCHI, that price will become an anchor - a floor below which no gynaecology surgeon will be willing to charge any funder. Even if SCHI rejects (via hospitals / facilities) a collective approach at that price, by enabling the exchange of competitively sensitive information between competitors, that reference price risks permanent damage to the competitive process and higher costs to health insurers, their customers, and other purchasers / funders of gynaecology surgery services.

(b) It is not correct to assert that the exchange of competitively sensitive information between competing gynaecology surgeons is merely "cheap information" that makes those competitors "mildly better informed".[93] In other contexts, the Commission warns that if "businesses are sharing competitively sensitive information with one another" then that is "likely to raise competition concerns".[94]

(c) It is not correct for NZGA to seek to dismiss the adverse detriments of any standstill (collective boycott) period. As outlined to the Commission previously:

(i) SCHI estimates that a six-month delay would cost an additional ~[ ] million from a delayed transition to APS; and

(ii) based on current FFS increases, SCHI estimates that a six-month delay would cost an additional ~[ ] million from fee increases alone through a six-month delay.

12.5 For the record, SCHI also rejects the assertion that Competitor Coordination could make it "better informed" regarding relevant matters. SCHI has already undertaken a careful and considered consultation process in relation to its proposed transition of gynaecology surgery to the AP programme. Since commencing the project in August 2025, SCHI has now allowed more than 13 months for consultation and negotiation, including multiple face-to-face and online meetings with individual gynaecology surgeons and hospitals/facilities, and consultation with RANZCOG

[91] Commerce Commission "Eye surgeons to pay $85,000 for breaching Commerce Act" (28 October 2005). Retrieved from: https://www.comcom.govt.nz/news-and-media/news-and-events/archive/eyes-surgeons-to-pay-85000-for-breaching-commerce-act/. [Emphasis added]
[92] NZGA Submission at [15(a)].
[93] Link Submission at [9].
[94] Commerce Commission "Collaboration and Sustainability Guidelines" (November 2023) at p 5.

and ANZSU. SCHI has taken on feedback, and made changes. SCHI considers that the process has made it fully informed of the factors relevant to it as a funder in making the proposed APS transition.

13. THERE IS NO EVIDENCE THAT TRANSITION TO THE APS WILL REDUCE VOLUMES

13.1 NZGA asserts that transition to the APS (and the associated introduction of competitive pricing discipline through the APS) will reduce supply.[95] However, as previously outlined to the Commission, there is no evidence that the transition of procedures to SCHI's APS results in a reduction of services being performed. To the contrary, the evidence demonstrates that when specialties transition to SCHI's APS, volumes of procedures performed continue to increase. This point was addressed in SCHI's SOPI Submission, but to reiterate this point the diagram from that SOPI Submission is included again as Figure [2] below.

Confidential Figure [2] – Volume of procedures over time and fee-for-service percentage by [ ] over time

[ ]

13.2 Furthermore, as set out at paragraph 6.1(e) above, to the extent NZGA is seeking to argue that gynaecology surgeons could leave New Zealand (or threaten to leave New Zealand) due to SCHI seeking to negotiate competitive fees, (if considered accurate) this further demonstrates that gynaecology surgeons have credible "outside options" – further mitigating any suggestion that SCHI has monopsony power.

14. SCHI'S STRUCTURE PROVIDES IT WITH THE RIGHT INCENTIVES

14.1 Another key premise of the NZGA Submission is that, despite SCHI's friendly society status, SCHI does not have incentives to fund gynaecology at competitive / efficient levels because of so-called "management incentives"[96] or because "SCHI's incentive is to secure sufficient coverage for its own members", which it asserts is "not the same as the supply New Zealand needs".[97] Neither assertion withstands scrutiny:

(a) First, NZGA has not pointed to any specific "management incentives" that could mean that management's incentives are against the long-term interests of its members. Due to SCHI's structure there is no separate owner whose interests management could prefer over those of members. SCHI's Board governs SCHI for the benefit of its members under the friendly society's rules.[98] SCHI has no shareholders, distributes no dividends, and exists solely to serve its members' interests. In theory, a profit-maximising insurer might have an incentive to depress specialist fees below sustainable levels, because the resulting cost savings would

[95] NZGA Submission at[4(d)].
[96] NZGA Submission at [4(e)].
[97] NZGA Submission at [38].
[98] Being rules that are required under the Friendly Societies and Credit Unions Act 1982, and that can only be changed by way of a membership vote.

accrue as profit to shareholders. However, SCHI has no such incentive. Indeed, SCHI's management is directed by a Board approved member-centric strategy that is built around trust, retention and long-term relationships, and on helping members access quality care and achieve better health outcomes. Management's performance is measured against those member outcomes, and SCHI's financial measures are directed at its long-term sustainability for members, not against generating returns for owners. Under SCHI's friendly society model, value created is returned to members through more affordable cover. SCHI's objectives would be undermined, not advanced, if SCHI paid fees that were too low to sustain private gynaecology services. Members who cannot access timely, quality treatment are less likely to value or keep their cover. The incentives that NZGA seeks to attribute to SCHI's management are inconsistent with how SCHI's management is directed and measured.

(b) Second, there is no evidence of SCHI agreeing / paying "fees [that are] inefficiently low"[99] or using the APS to achieve prices below sustainable levels. As outlined above, the evidence demonstrates that when specialties transition to SCHI's APS programme, volumes of procedures performed continue to increase.

(c) Third, NZGA's claim that SCHI's incentive is limited to "sufficient coverage for its own members" does not undermine the Commission's findings in relation to SCHI's structural incentives. Namely, as a member-focused society with approximately [ ] female members, SCHI's incentives are to play its part (amongst the range of other funders) to support sustainable private gynaecology services more generally.[100] (That said, as set out at paragraph 28 below, it is not appropriate for NZGA to expect SCHI members to cross-subsidise other funders, or to subsidise gynaecology surgeons to obtain returns above competitive levels).

14.2 Further, while Link seeks to argue that SCHI's management "are neither all-knowing nor unbiased" for the premise that "weaken[s] the link between SCHI's mission and mission implementation",[101] scrutiny of incentives and bias in fact argues against NZGA's position. Namely, while NZGA seeks to position itself as having altruistic reasons for the Application, [ ][102]

(a) [ ]

(b) [ ]

(c) [ ]

14.3 Elsewhere the Link Submission acknowledges that the incentives of gynaecology surgeons can differ from those of their patients: "This is not to say that gynaecologists' incentives are exactly aligned with those of patients… A gynaecologist… would in general prefer a higher price for a given quality, while a

[99] NZGA Submission at [7(e)(ii)].
[100] Further, in response to [38(b)] of the NZGA Submission, it is noted that these incentives apply equally to specialty and "subspecialty numbers".
[101] Link Submission at [3].
[102] [ ]

fully informed patient… would prefer the opposite".[103] Compared to SCHI (a member-focused friendly society), it is apparent that it is NZGA that has incentives that conflict with the interests of, and outcomes for, SCHI's members.

15. THERE IS A DIRECT LINK BETWEEN INCREASED HEALTHCARE COSTS AND PREMIUMS

15.1 The NZGA Submission makes a number of incorrect assertions regarding SCHI's financial performance, position, and its ability to absorb increasing healthcare costs:

(a) NZGA states that the Commission has "accept[ed] SCHI's account that gynaecologists' fees are driving SCHI's financial losses (a narrative SCHI's FY2026 surplus no longer can assert)".[104]

(i) First, that is a broad overstatement of SCHI's evidence to the Commission, and the Commission's findings based on that evidence. SCHI has not stated that gynaecologists' fees alone have driven SCHI's financial losses. In SCHI's SOPI Submission SCHI was clear that it has been experiencing "sustained and unprecedented claims cost escalation in recent years" across the board and that gynaecology surgery cost escalation, while significant, is not the only cause of recent deficits:[105]

> That claims cost escalation peaked at approximately 17% in FY23. In FY25 alone, SCHI paid a record 3.8 million claims, up 16% on the prior year and resulting in SCHI reporting a $56.9 million deficit from its health insurance operations, following a $99.1 million deficit in FY24. Alongside increased utilisation, this escalation has been driven by rapid and uneven growth in specialist and surgical costs, with impacts already flowing through to higher premiums for ordinary New Zealanders.

Nor did the Commission's DD ever conclude or assert that gynaecologists' fees alone have driven SCHI's financial losses.

(ii) Second, as the Commission found in the DD, SCHI was only able to [ ][106] This reinforces SCHI's evidence that members bear the cost of increased healthcare prices, and that cost containment measures (such as expanding the APS) are necessary to achieve sustainable outcomes.

(b) NZGA states that "SCHI cannot simply assert, and the Commission cannot simply accept, that any cost increase must be passed on to members. Like all insurers, SCHI routinely runs unders and overs, and manages them through its reserves and investment portfolio."[107] NZGA's

[103] Link Submission at [28] and footnote 11.
[104] NZGA Submission at [9].
[105] SOPI Submission at [1.3(b)].
[106] DD at [60].
[107] NZGA Submission at [56].

statement here does not reflect financial reality. Drawing on reserves only defers the cost, because those reserves must then be rebuilt through future premium increases or reduced benefits. Nor can investment returns be treated as an open-ended source of funding for higher claims costs: investment returns are finite, variable and outside SCHI's control. For example, across FY2024 to FY2026, they were insufficient to cover SCHI's cumulative operating deficit of $148.7 million, leaving a cumulative deficit of $12.6 million. Accordingly, there is a direct link between healthcare costs and SCHI's premiums.

(c) Finally, despite NZGA's submissions, as set out in SCHI's DD Submission,[108] SCHI's recent surplus does not alter the Commission's analysis, including its assessment that SCHI's "premiums are set to meet expected claims costs, operating expenses and solvency requirements" and therefore there is a direct "relationship between expected claims costs and premiums".[109] In summary:[110]

(i) the FY2026 surplus follows deficits of $99.1 million (FY2024) and $56.9 million (FY2025), and SCHI's cumulative result across FY2024 to FY2026 is a deficit of $12.6 million (and a cumulative operating deficit before investment returns of $148.7 million);

(ii) at 30 June 2026, SCHI's capital ratio was 30.3%, below its Board-approved target range of 35% to 40%; and

(iii) as a friendly society, "absorbing" a cost means members funding it from increased premiums or any existing reserves (which must then, in any event, be rebuilt through future premium increases or benefit reductions). The cost falls on members either way.

15.2 In summary, SCHI has never contended that gynaecology fees alone drove its recent deficits. The point is that SCHI's premiums are set to meet expected claims costs, operating expenses and solvency requirements, so that materially higher gynaecology fees will flow through to members.[111] NZGA's statement, that "as a not-for-profit, SCHI should always pass on efficient costs and avoid inefficient ones",[112] proves SCHI's point – namely, that as a friendly society SCHI cannot absorb higher costs itself, and that it should implement cost containment measures such as the APS to mitigate costs that are above competitive levels (as the evidence demonstrates gynaecology surgery fees are on the whole).

16. LINK'S WAGE TRANSPARENCY ANALOGY DOES NOT FIT

16.1 Link's assertion that authorisation would only improve gynaecologists' position by "less than 2-4%" assumes no collective bargaining and comes from literature on employers publishing wages. That literature has no application to a horizontal agreement between competitors. Specifically, as set out in the NERA November

[108] DD Submission at [11.2].
[109] DD at [334.3].
[110] DD Submission at section 11.
[111] DD at [334.3] and [336.2]; DD Submission at [11.2]-[11.3].
[112] NZGA Submission at [56].

Report, the literature on which the Link Submission seeks to rely, examines the effect of an employer publishing wage rates for its own employees within a firm that the employer pays. Gynaecologists are not wage-earning employees of SCHI, but independent service providers who set their own prices, and the Application concerns a horizontal agreement between ~130 of those competitors to negotiate prices jointly and to withhold supply while they do so.

16.2 Furthermore:

(a) Link's submission, via a purported analogy to wage transparency, that the Competitor Coordination would, in fact, "weaken [gynaecologists'] bargaining position"[113] is nonsensical. First, it would beg the question why NZGA is seeking authorisation to engage in Competitor Coordination in the first place. Second, it would be contrary to all orthodox economic theory, and prior Commission statements, regarding the impacts of price collusion between competitors. See further at paragraph 12 above.

(b) Even if the analogy could be considered apt (which it is not), it does not support NZGA's arguments. According to Link's analysis, Competitor Coordination would improve gynaecologists' bargaining position by only 2 to 4%. A claimed gain of that size cannot support the Link / NZGA claims that Competitor Coordination would make a material difference to the viability of gynaecologists, or to the supply of gynaecology services in New Zealand.

17. LINK'S CRITIQUE OF NERA'S ANALYSIS IS INCORRECT

17.1 The Link Submission seeks to critique the NERA August Report.[114] However, as set out in the NERA November Report, the Link Submission's critiques of the NERA August Report are incorrect in a number of respects. Those critiques either mischaracterise an analysis that already controls for the factors Link raises, or rest on speculation unsupported by evidence or on Link's own unrepresentative data.[115] Therefore, those critiques in the Link Submission should be dismissed by the Commission.

18. ALLOCATIVE EFFICIENCY DETRIMENTS ARE SIGNIFICANT AND LIKELY

18.1 NZGA and Link assert that the allocative efficiency detriments are unfounded because SCHI's proposed fees cannot be assumed to be an "efficient benchmark", such that higher fees in the factual would be an "allocative gain".[116] Those assertions depend entirely on the proposition that SCHI is a monopsonist setting

[113] Link Submission at [36].

[114] Link Submission at [7].

[115] SCHI also notes that the Link Submission says that "[t]he most comprehensive dataset we received from a gynaecologist included all operations conducted from [ ] to 2026 for 2 procedures" (at [86]). Beyond this, Link refers only to general comments from some other gynaecologists about how their prices have changed. Those comments are largely redacted and are not presented as data that can be analysed. Link itself says the information it collected is "by no means representative or conclusive" (at [88]). SCHI agrees. Evidence about two procedures from one practitioner cannot support conclusions about pricing trends across the gynaecology profession. It is also not a reliable basis for questioning analysis drawn from SCHI's claims data. By comparison, when SCHI analyses the two highest-volume standalone procedures (hysterectomy and hysteroscopy), SCHI's claims data covers approximately 300 gynaecology surgeons over a 20-year period and more than 50,000 procedures.

[116] NZGA Submission at [50] and [72(b)]; Link Submission at [45] and [52].

fees below competitive levels. For the reasons in paragraph 6 above, that proposition is not supported by the evidence. Furthermore:

(a) The evidence instead indicates that current FFS fees are above competitive levels, with that being a result of the fact that under FFS gynaecology surgeons unilaterally determine their price to patients, with the patient (in the case of SCHI members) then remitting the invoice to SCHI for reimbursement. There is no mechanism for prospective price negotiation and no meaningful competitive constraint on how prices change over time. As a result, FFS pricing is not the product of workable competition, but of a model in which the absence of effective competitive negotiation allows fees to escalate without effective scrutiny or constraint. NERA's independent economic assessment (in the NERA August Report) similarly concluded that observed FFS outcomes are consistent with fees above competitive levels. Further demonstrating this, SCHI has shown that FFS FY2024 gynaecology surgeon fees are substantially higher than every relevant comparator:

   (i) they are on average [ ] higher than [ ];

   (ii) the median FFS billing rate is [ ] per hour, compared with [ ] for [ ] surgeons and [ ] for [ ];

   (iii) they have risen by more than [ ] since 2013, against cumulative CPI of about 40%;

   (iv) for laparoscopic hysterectomy, the ACC equivalent fee of approximately [ ] is less than [ ] the fee charged in more than [ ] of claims;

   (v) one surgeon recently billed SCHI [ ] (incl. GST) for approximately [ ] hours of their time performing the surgeries, or approximately on average [ ] per hour.

(b) SCHI has provided the Commission with significant evidence justifying its reasons for the view that the prices it proposes contracting with hospitals / facilities at are set at competitive and efficient levels. That evidence includes the following:

   (i) **SCHI's proposed prices sit above available domestic benchmarks.** The total procedure prices SCHI has proposed to hospitals / facilities (which include the surgical fee component) are [ ], and [ ] than the average prices SCHI currently pays hospitals/facilities for [ ][117]

   (ii) **SCHI's surgeon allowance exceeds [ ].** [ ][118]

   (iii) **The reduction SCHI seeks is reasonable and targets only outlier pricing.** SCHI estimates savings of approximately [ ] million per year, around [ ]% of its approximately $[ ] million annual gynaecology surgeon expenditure.[119] Although the

[117] SCHI SOPI Submission at [6.2(i)]; see also DD at [278].
[118] SCHI SOPI Submission Confidential Figure [15].
[119] SCHI SOPI Submission at [5.3(a)]; SCHI RFI response (27 August 2026), Question Two.

target weighted average rate per theatre minute falls from approximately $[ ] to approximately $[ ],[120] the multiple services rule, add-on codes and risk corridors mean the average amount paid per episode would fall by only approximately [ ]%, from $[ ] to $[ ].[121]

(iv) **Experience in other specialties confirms SCHI's approach is sustainable.** As outlined at paragraph 2.3(e) above, procedure volumes have continued to grow in specialties that moved to the APS, which demonstrates that SCHI contracts at sustainable and efficient pricing levels within its APS arrangements.

18.2 In addition:

(a) In response to NZGA's assertion that "[i]n healthcare, the lowest fee will rarely be the efficient one",[122] SCHI notes that it is not arguing that the lowest fees are necessarily the efficient ones. As set out above, SCHI's proposed APS prices are not the lowest prices; they sit above every relevant benchmark, and as the DD recorded, under the APS SCHI expects a number of gynaecology surgeons to receive higher fees than they are currently receiving under FFS:

(i) "SCHI has submitted that its proposed pricing [ ] is based on the [ ], suggesting that some gynaecologists will be financially better off under SCHI's current APS proposal";[123]

(ii) "SCHI's modelling suggests that its proposed APS pricing will result in it paying more in total gynaecology surgeon fees in [ ] out of 15 identified regions in New Zealand, and making only relatively small savings in a further [ ] regions";[124] and

(iii) "This means that at least [ ] gynaecologists (out of [ ] gynaecologists in New Zealand) would earn more under AP than under FFS and [ ] would earn less."[125]

(b) NZGA provides no evidence for its assertion that higher FFS fees reflect higher quality.[126] NZGA says that FFS price differences "often reflect real differences in what is supplied", but it does not show this for any surgeon or procedure. The evidence on the record points the other way – namely:

(i) For over 10 years SCHI has run a quality / outcome survey programme through which SCHI seeks to understand the value its members find in healthcare treatment,[127] and (consistent with international experience) SCHI has observed no correlation between surgical price and these quality/outcome metrics.

[120] [ ]
[121] SCHI RFI response (27 August 2026), Question Two(c).
[122] NGZA Submission at [7(e)(i)].
[123] DD at [144].
[124] DD at [144].
[125] DD at [187].
[126] NZGA Submission, paragraph 52.
[127] On average SCHI collects 20,000 results from across 30 hospitals / facilities and 1,000 clinics per year. The survey results represent a member perspective of value for the $1.7 billion paid out in healthcare claims each year.

(ii) In relation to gynaecology surgery specifically, SCHI's member survey data shows that:

(aa) Despite gynaecology surgery prices significantly increasing over the past decade in New Zealand, SCHI has seen no material shift in patient-reported outcomes to match the rising cost of service.

(bb) Despite gynaecology surgery prices being [ ] in New Zealand, gynaecology patients rate their outcome and experiences [ ].

(c) While Link states, in seeking to explain the wide existing fee dispersion observed, that "[i]f markets are geographic, as they are for gynaecology, and production involves fixed costs, as setting up a practice does for gynaecology, smaller markets will see higher prices",[128] in reality the evidence shows the opposite. Namely:

(i) SCHI's data shows the reverse. Based on the 2024 dataset [ ] of the highest-charging gynaecologists [ ] practise in New Zealand's two largest markets, [ ], and more than half of [ ] gynaecologists sit in the top fee band. Fees also range from about [ ] per hour within the same regions, so neither market size nor fixed set-up costs can explain them.

(ii) A number of the highest-volume gynaecology surgeons also charge the highest gynaecology surgery fees to SCHI under FFS. See Figure [3] below.

Confidential Figure [3] – The distribution of gynaecology surgeons' billed per minute and billed per episode (for "fee for service" gynaecology surgery procedures)[129]

[ ]

(d) While NZGA states that it is difficult for SCHI to monitor "quality (surgeon skill, procedure length, the need for out-of-the-ordinary procedures and patient interaction)", SCHI reiterates that [ ]

18.3 Finally, in response to NZGA's assertion that "the size of any fee increase" between the factual and counterfactual has not been measured,[130] SCHI reiterates that it has provided significant quantitative evidence to the Commission modelling that fee difference. Specifically, SCHI has provided quantitative analysis that models the fee gap that a competitive and efficient transition of gynaecology surgery to SCHI's APS will result in annual gynaecology surgeon costs to SCHI of $105 million by FY2036, compared to annual costs of $243 million by FY2036 if

[128] Link Submission at [90(a)].
[129] [ ]
- [ ]
- [ ]
- [ ]

[ ]
[ ]
- [ ]; and
- [ ].

[ ]
[130] NZGA Submission at [16].

NZGA and gynaecology surgeons are authorised to engage in Competitor Coordination. That is a $138 million annual difference, which would necessarily manifest in either higher premiums to SCHI members (affecting affordability and retention) or reductions in policy coverage to maintain sustainability – being outcomes that in turn also place increased pressure on the publicly funded health system.

19. NZGA'S CODING AND HEALTH CLAIMS ARE INCORRECT

19.1 The NZGA Submission contains a number of incorrect claims in relation to SCHI's proposed procedure funding code set and health outcomes.

19.2 Specific responses to a number of NZGA's incorrect clinical assertions are set out in **Appendix One**. In addition to that Appendix One, SCHI notes the following:

(a) The NZGA Submission asserts that "open codes, risk corridors, add-ons and top-ups" would place work on "hospitals, gynaecologists and their practices" and that "[n]egotiated, objective criteria for those mechanisms in the factual would reduce it".[131] This is not correct. NZGA describes all four mechanisms as working through "case-by-case applications" and "insurer-defined criteria". However, only top-ups work that way:

(i) Risk corridors provide additional funding under the APS agreement when theatre time exceeds the agreed durations built into the standard codes.

(ii) Add-on codes are a published set of codes for commonly performed additional procedures and can be claimed alongside primary procedures.

(iii) Open codes are paid at an agreed rate per minute.

The objective criteria NZGA says require collective negotiation therefore already exist and have been documented. Furthermore, compared with FFS, the APS reduces the total cost of administration. APS claims are administered online by contract holders and paid on average [ ] days after the date of service. FFS claims are submitted manually and paid on average after [ ] days. Under the APS, surgeons do not have to invoice members for non-covered amounts, chase shortfalls and bad debt, prepare fee estimates, or arrange prosthetic invoicing.

(b) The NZGA Submission asserts that several procedures have "no code at all"[132]. This is not correct. Each of the procedures listed by NZGA now has its own procedure funding code in the revised procedure funding code set, which have been developed following the RANZCOG and ANZSU review. These are colpocleisis, fascial sling repair, vaginal suspension of the uterus or vaginal vault, the Manchester operation, Burch colposuspension (with separate laparoscopic and open codes), bladder Botox, pelvic floor Botox and pudendal block, destruction of vulval lesions, and wide local excision of the vulva. This also means that

[131] NZGA Submission at [54].
[132] NZGA Submission at [66(c)].

NZGA's assertion "that around 80% of prolapse patients would need to proceed under open code AP1487 with a justification letter"[133] is no longer correct.

(c) As set out to RANZCOG and ANZSU in SCHI's correspondence dated 23 September 2026, after consultation with these associations, SCHI has developed 14 urogynaecology-specific procedure funding codes and 16 gynae-oncology-specific procedure funding codes, which include each of those procedures set out above. This has left only two remaining open codes, as explained in paragraph 5.1(b)(iii).

(d) NZGA asserts that the code set "has not moved" since June 2026, and that gynaecologists were "not involved" in designing it. Neither is correct:

(i) SCHI's gynaecology procedure funding code set has been developed over several years, with clinical input at each stage. Contrary to NZGA's assertion, gynaecologists were involved in its design. SCHI first developed the procedure funding code set in 2019 [ ]. Also in 2019, SCHI discussed the proposed procedure funding code set with RANZCOG as part of the development process. In 2022, SCHI then piloted the procedure funding code set in a live clinical setting with two providers. SCHI amended the procedure funding code set using feedback from the gynaecologists and facilities involved in the pilots. This included adding procedure funding codes and restructuring the hysterectomy procedure funding codes to use simple and complex categories instead of solely uterine size in weeks. Both pilot providers then entered into APS agreements, which remain in operation. When SCHI prepared to rollout the procedure funding code set nationally, [ ]. In 2025 SCHI socialised the procedure funding code set with providers and met with gynaecologists and facilities / hospitals across the country. Through that engagement, it became clear that gynaecologists wanted greater involvement in the procedure funding code set. As part of the consultation process, it was considered that RANZCOG and ANZSU were the appropriate independent clinical bodies for that engagement. SCHI has since completed a further detailed review of the procedure funding code set with these bodies, including the urogynaecology and gynae-oncology procedure funding codes, and changed it in response to their recommendations. RANZCOG itself acknowledged "the careful consideration given to our advice and the improvements made to the code set".[134] Those bodies are independent of SCHI and provide exactly the independent clinical input that NZGA asserts has been lacking.[135]

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[133] NZGA Submission at [66(c) - (d)].

[134] Cross-Submission at [6.2(e)], citing a letter from RANZCOG to SCHI dated 5 March 2026.

[135] The process that SCHI has engaged in relation to the proposed APS transition for gynaecology surgery, with significant clinical consultation both with surgeons, RANZCOG and ANZSU, is also consistent with the processes that SCHI has rolled out in relation to APS transitions in other specialties where NZGA itself acknowledges that: "where head contractor models have been introduced in other specialties, surgeons were given reasonable opportunities to provide into those contracts before implementation" (at paragraph 25).

(ii) The procedure funding code set has “moved” since June 2026. As part of the RANZCOG and ANZSU review described in paragraph (i) above, SCHI worked through three further matters after June 2026, which were settled in September 2026.

(e) The pelvic floor / urogynaecology concerns that NZGA identified in its Application as a key reason for seeking authorisation have now been resolved through the consultation with RANZCOG and ANZSU, and without collective bargaining.[136]

(f) The APS is a funding and claims administration framework. It is not a clinical protocol, and clinical decisions remain with the treating clinician and patient.[137] SCHI is not changing its coverage for gynaecology surgery through the transition: the same procedures that are currently covered and funded will continue to be so.[138] The Commission was therefore correct to conclude that there would be no health benefits from the Competitor Coordination.[139] To the contrary, as SCHI has explained, the higher premiums and likely reduced cover that would result from the Competitor Coordination would themselves adversely affect health outcomes and place additional pressure on the public health system.[140]

(g) NZGA asserts that "in the counterfactual gynaecologists bear the risk of unfunded complexity and are reliant on SCHI's discretion (through open codes, risk corridors and top ups)."[141] That assertion is incorrect. Open codes, add-on codes, risk corridors and top-ups are not novel or untested, but are established features of SCHI's AP programme that are well understood and used regularly across more than 30 specialties. They allow complexity to be funded through agreed rules (most of them form part of the APS agreement, such as risk corridors triggered once the maximum theatre time is exceeded and open codes reimbursed per minute at agreed unit rates), not through "vague mechanisms applied at SCHI's discretion".[142] Open codes and risk corridors do not depend on SCHI's discretion: they are specific contractual mechanisms documented in the APS agreements. Top-ups are the only mechanism assessed case by case, and each top-up request is reviewed for medical necessity, consistency with the member's policy and whether the fee sought is reasonable.

(h) It is also incorrect for NZGA to assert that "SCHI has not shown that [such mechanisms] work reliably in practice".[143] As noted above, these mechanisms are established features of SCHI's AP programme that are well understood and used regularly across more than 30 specialties.

(i) NZGA asserts an inconsistency in the DD's treatment of innovation, stating that "[n]o considered reason is given for treating the two 'investors'

[136] DD Submission at footnote 84.

[137] Cross-Submission at [3.3] and [12.3(a)].

[138] Cross-Submission at [2.6(e)] and [3.20(a)(ii)].

[139] DD at [36.1].

[140] DD Submission at [6.1(c)], citing DD at [37], [336.4] and [342].

[141] NZGA Submission at [7(h)].

[142] As asserted at [69] of the NZGA Submission.

[143] NZGA Submission at [68].

differently".[144] However, a considered reason is given for the Commission's findings. Namely, the Commission finds that:

(i) "Hospitals bear the financial burden of investment in new technologies and equipment";[145] and

(ii) in relation to gynaecology surgeon training, "for those that work within public hospitals it will likely be publicly funded… We understand that this would be the case for many of NZGA members as there is a shared workforce between public and private hospitals."[146]

In other words, the DD explains why the Commission finds that the cost of innovation is not borne by gynaecology surgeons. Furthermore, NZGA's assertion that fellowships or investments in innovations are "self-funded" by surgeons is incorrect.[147] While SCHI is not privy to the specific commercial arrangements that hospitals / facilities have with surgeons, SCHI understands that:

(iii) fellowships are typically funded by hospitals / facilities where surgeons are training, or by a hospital / facility where there are particular skills that they want to offer at their hospital / facility;

(iv) funding in innovations such as robotics (and the associated training) can be funded by a combination of hospitals / facilities and robotics vendors.

(j) There is no basis for NZGA's assertion that the APS would lead to a reduction in complex procedures being performed.[148] SCHI's procedure funding code set is tiered by complexity across the main gynaecological procedures:

(i) Hysterectomy is coded as simple or complex for each surgical approach (laparoscopic, open, vaginal and VNOTES). The complex codes apply where the uterus is over 12 weeks in size or 250g, where fibroids are over 4cm, or where stage 2 or 3 endometriosis is treated at the same time, and they include ureterolysis. Where stage 4 endometriosis is treated at the same time as a hysterectomy, the appropriate stage 4 endometriosis code can be claimed alongside the hysterectomy code.[149] SCHI confirmed this to hospitals / facilities and surgeons in July 2026.

(ii) Myomectomy is coded as simple, intermediate or complex by fibroid size (up to 4cm, over 4cm to 7cm, and over 7cm) for laparoscopic surgery, and as simple or complex for open surgery.[150]

[144] NZGA Submission at [76].
[145] DD at [395].
[146] DD at [395].
[147] NZGA Submission at [76(a)].
[148] NZGA Submission at [48(a)].
[149] APS Codes AP1204 to AP1211; AP1083, AP1084.
[150] APS Codes AP1089 to AP1092, AP1106.

(iii) Ovarian cystectomy, and oophorectomy and salpingectomy, each have simple and complex codes. For example, the complex ovarian cystectomy codes cover bilateral cysts over 5cm and previous hysterectomy, and the complex oophorectomy and salpingectomy code covers pelvic side wall dissection and ureteric exposure.[151]

(iv) Endometriosis is funded through a staged pathway from stage 1 to stage 4, including stage 4 with discoid rectal resection.[152]

(v) Urogynaecology has specific procedure funding codes for complex pelvic floor and continence procedures. These include colpocleisis, vaginal vault or uterine suspension, the Manchester operation, laparoscopic and open Burch colposuspension, fascial and mid-urethral slings, and laparoscopic and open sacrocolpopexy.[153]

(vi) Gynaecological oncology procedure funding codes increase in complexity with the extent of surgery. They run from laparoscopic or robotic hysterectomy with lymph node assessment, with or without omental biopsy, through to open radical hysterectomy, and from wide local excision of the vulva through to radical vulvectomy with unilateral or bilateral inguinofemoral lymph node dissection.

(vii) Add-on codes cover additional procedures performed in the same operation, including cystoscopy with ureteric catheter insertion, omentectomy, sentinel lymph node biopsy, vulval flap reconstruction and appendicectomy. Where a relevant procedure exceeds the agreed risk corridor, additional theatre time can be claimed in 15-minute blocks and additional inpatient stay per night.[154] Open codes are available for procedures that fall outside the listed procedure funding codes. Procedure funding codes can be changed or added after surgery to reflect what was actually performed.

SCHI further reiterates that the proposed APS does not reduce members' healthcare funding cover. The same procedures that are currently covered and funded will continue to be so. The only aspect that would change is the funding pathway through which SCHI funds covered procedures.

20. LINK'S CRITIQUE OF SCHI'S INTERNATIONAL PRICE BENCHMARKING IS WITHOUT FOUNDATION

20.1 Link asserts that SCHI's comparison to Australian pricing data may not be comparable because:

[151] APS Codes AP1085 to AP1088, AP1482, AP1483.
[152] APS Codes AP1080 to AP1084.
[153] APS Code Numbers to be confirmed.
[154] APS Codes AP0157, AP0155.

(a) it has been "unable to test whether there was a difference in mix of procedures".[155] However, this critique does not hold because [ ].

(b) "[i]t is not clear whether the comparisons are inclusive or exclusive of GST".[156] However, SCHI has already explained to the Commission that, because GST does not apply to these healthcare costs in Australia, the New Zealand surgeon fees in its Australian comparison exclude GST, so GST is treated consistently in both jurisdictions.

(c) The Link Submission asserts that "mandatory medical chaperones" are a relevant difference between New Zealand and Australia[157]. However, SCHI has not identified any factor that would make the comparison inappropriate, and notes that gynaecologists in both countries are trained and accredited through the same college, RANZCOG. To the extent a chaperone is needed, it would be in rooms during consultations, not during surgery. Consultations are not part of the surgical episode and are already funded under a separate consultation APS agreement. Medical chaperone costs therefore have no bearing on the gynaecology surgical procedure funding codes or the prices being negotiated.

21. SCHI IS ADVOCATING FOR WOMEN'S INTERESTS AND HEALTH OUTCOMES

21.1 SCHI agrees with the NZGA statement that "[w]omen's health and wellbeing are at stake"[158] in this authorisation process. However, it is SCHI that is advocating for women's interests and health outcomes – not NZGA, who the evidence indicates has a self-interested fee-related rationale for the Application. In particular:

(a) **Women would pay for authorisation.** The cost of the Competitor Coordination would be a lasting transfer from approximately 935,000 SCHI members [ ] to ~130 highly paid surgeons. SCHI has modelled that a 30-year-old [ ] member on a Wellbeing 2 plan would pay [ ] (12.4%) more in premiums over the next decade, or more than $535 a year on average.

(b) **Authorisation would put surgery out of reach for some women.** Female RegularCare members who need gynaecological surgery would face co-payments for the surgeon component that are, on average, [ ] (133%) higher in 2027, rising to [ ] higher by 2036. That could be expected to put gynaecology surgery out of reach for a number of female RegularCare members.

(c) **Health harms of authorisation would also reach women outside SCHI's membership.** Higher reference prices would increase costs for other insurers, Health NZ, ACC and self-funded patients. For Health NZ, that means fewer outsourced operations. For self-funded patients, it means delayed or abandoned self-funded surgery and increased switching to the public system. Members who drop or downgrade their cover may forgo or delay treatment, and the effects on health outcomes

[155] Link Submission at [95].
[156] Link Submission at [98].
[157] Link Submission at [99].
[158] NZGA Submission at [12].

may extend beyond gynaecological services to all procedures for which customers were previously insured.

(d) **SCHI's object is to preserve women's access to affordable care, not to reduce cover.** SCHI is not changing its gynaecology cover through the APS transition. The same procedures will continue to be funded. If SCHI does not address non-competitive increases in gynaecology surgery costs, its female members' access to affordable and timely gynaecology surgical care would be compromised. [ ]

(e) **The APS model is designed to fund complex women's health conditions.** The proposed procedure funding code set includes a staged endometriosis pathway (ASRM Stage 1 to Stage 4, including Stage 4 with discoid rectal resection). Codes can be changed after surgery to reflect what was actually found, and top-ups, add-on codes, risk corridors and open codes are mechanisms to fund additional complexity. Treatment decisions remain with the clinician and their patient.

(f) **SCHI has obtained clinical input through the proper channels.** SCHI consulted RANZCOG and ANZSU and adopted their clinical feedback on urogynaecology and gynae-oncology codes, with one reasoned exception. The pelvic floor concerns that NZGA cited as a key reason for its Application have been resolved without collective bargaining.

21.2 It is SCHI that is committed to supporting a high-quality and sustainable healthcare system, and supporting women to access timely, good value, and high-quality gynaecological surgical care is a priority for SCHI. Those are the very outcomes SCHI is seeking to achieve through its proposed APS transition.

21.3 In this respect, SCHI considers that the Endo Warriors Aotearoa ("**EWA**") submission further supports declining authorisation. EWA accepts that coding improvements "may be achievable through clinical consultation without collective bargaining authorisation",[159] being consultation that has already happened through RANZCOG and ANZSU, including a staged endometriosis pathway that funds complex and combined surgery. EWA also identifies the real risk to patients: that "increased insurance premiums, reduced coverage or higher patient costs arising from collective bargaining"[160] create barriers to treatment. That is exactly the harm authorisation would cause, and which SCHI is arguing against.

22. THE NZGA SUBMISSION IS INCONSISTENT WITH ITS OWN PRIOR SUBMISSIONS

22.1 The NZGA Submission now claims that the factual could be "a simple and largely low-cost exercise"[161] from a transaction costs perspective. That assertion does not reflect what NZGA previously told the Commission in its RFI response. Previously, NZGA advised the Commission that Competitor Coordination would involve surveys, fee and cost data collection, benchmarking, consensus-building, external competition counsel, quarterly reporting and multiple negotiation rounds.

[159] EWA "Submission to the Commerce Commission"(14 October 2026) at p 3 **(**"**EWA Submission**"**).**

[160] EWA Submission at p 4.

[161] NZGA Submission at [28].

22.2 NZGA now seeks to distance itself from that description, stating that it was "not an exhaustive statement of what NZGA would likely negotiate or how negotiations may play out in reality", and that "how simple the process is depends on SCHI's willingness to engage".[162] But the Commission did not "select" the most costly version of the factual; it assessed the process that NZGA itself described when asked how the Competitor Coordination would operate. NZGA has not withdrawn that description, has not provided an alternative one, and continues to seek authorisation of the same arrangement — collective negotiation of price and non-price terms by ~130 competing surgeons, backed by a Standstill Agreement — for a period of 10 years. The Commission should assess the arrangement NZGA has applied for, not a hypothetical "light-touch" version described only after the Commission identified the resulting transaction costs as a detriment.

22.3 Furthermore, NZGA's newly proposed additional conditions would add further process (staged negotiation of non-price terms before fees, information protocols administered at board level, and a review point), on top of the external competition counsel and quarterly reporting it proposed earlier.

23. TRANSACTION COSTS ARE STILL DETRIMENTS EVEN IF THEY FALL ON THE COLLUDING PARTIES

23.1 Nor is it correct for NZGA to assert that most of the increased transaction costs would "[fall] on those choosing to bear it",[163] or that costs that are incurred "by choice" should not be given the "greatest weight".[164]

(a) There would also be significant additional transaction costs on SCHI and other hospitals / facilities. The factual would require SCHI and hospitals / facilities to manage multiple negotiation streams in parallel, would incentivise higher-charging surgeons to prolong negotiations while FFS continues, and would recur in each negotiation round across the 10-year term sought.[165] SCHI estimates its own costs at [ ] to [ ] per negotiation round, and a six-month delay at approximately [ ] million in additional FFS fee increases alone.[166] These are real resource costs that would ultimately be borne by SCHI's members.

(b) It is irrelevant that NZGA and its members would be "choosing" those increased transaction costs: increased transaction costs on NZGA and its members are a use of resources that is properly counted as a detriment.

(c) Further, Link's assertion that transaction costs are "not usually considered critical" unless they "prevent ... efficient contracting" is not the test the Commission applies: again, increased transaction costs need to be taken into account (irrespective of how they flow through to contracting) as they are a use of resources that is properly counted as a detriment.

[162] NZGA Submission at [27].

[163] NZGA Submission at [33]; Link Submission at [72].

[164] NZGA Submission at [33].

[165] DD Submission at [7.2].

[166] DD Submission at [7.2(a)] and [7.2(c)].

24. THERE IS NO INCONSISTENCY IN THE COMMISSION'S FINDINGS REGARDING THE HETEROGENEITY OF NZGA'S MEMBERS

24.1 The heterogeneity of NZGA's members – on price, claiming and billing practices, surgical approach, pricing rules and recording of complexity – means that internal transaction costs within any collective bargaining group will inevitably be significant.[167] NZGA's assertion that the Commission has treated heterogeneity inconsistently is not correct.[168] Heterogeneity raises the cost of reaching a collective position; it does not prevent members from collectively seeking higher fees once a benchmark price floor is collectively set, as the Commission found.[169]

25. THERE IS NO INCONSISTENCY IN THE COMMISSION'S FINDINGS REGARDING REFERENCE PRICES

25.1 NZGA asserts an inconsistency in the Commission's findings regarding reference prices, by asserting that the Commission "dismisses waterbed effects in the counterfactual, but accepts upward spillovers in the factual, without explaining why one would apply and not the other".[170] The Commission does explain this in its DD, at paragraphs 181 and 378:

> "a key difference between the factual and counterfactual is that the experience of NZGA and its members entering into a Standstill Agreement and collective bargaining discussions within the NZGA would have facilitated a greater understanding of price differences and expectations between members, both nationally and regionally…
>
> … it is unclear if waterbed effects would occur in the counterfactual arising from gynaecologists seeking to recover lost revenue. Firstly, the ability of gynaecologists to raise prices to other funders appears to be unchanged between the FFS and APS, secondly the likely squeeze on profit does not seem likely to be sufficient, and lastly the market does not appear to have the features that commonly facilitate waterbed effects. In contrast, we consider that the Proposed Arrangements will establish reference points that increase the likelihood gynaecologists charge higher fees to other funders. "

25.2 The reasons for the conclusions are obvious – in the factual the Competitor Coordination would enable competing gynaecology surgeons to discuss, agree and exchange pricing information in relation to SCHI, which would then transparently inform all members of prices that competitors are generally willing to accept or seek. Higher reference prices to other funders would seem inevitable in that scenario. By contrast, in the counterfactual, gynaecology surgeons would not have transparency and agreement on target prices, so there would remain the usual "unknown" of competitor pricing information in relation to other funders (as well as the factors that the Commission found – i.e. that "the ability of gynaecologists to raise prices to other funders appears to be unchanged between the FFS and APS, secondly the likely squeeze on profit does not seem likely to be sufficient, and

[167] DD Submission at [7.1(a)] and footnote 61.

[168] NZGA Submission at [31].

[169] In relation to the heterogeneity of NZGA's members, SCHI also notes that NZGA's Submission itself states that the Commission should not assume that NZGA members are "homogenous". See paragraph 12(b). This reinforces the submissions that SCHI has made regarding the heterogeneity of NZGA's members.

[170] NZGA Submission at [72(e)].

lastly the market does not appear to have the features that commonly facilitate waterbed effects").[171]

25.3 NZGA also asserts that in the counterfactual "other insurers (and potentially ACC and Health NZ) are likely to follow any significant SCHI-driven fee reduction".[172] However, for the same reason as above, this logic does not follow. In the counterfactual those other funders will not have transparency of SCHI's prices agreed with hospitals / facilities, so there will not be a published or known benchmark that could serve as a reference price (which distinguishes this scenario from the higher reference prices in the factual).

26. NZGA'S ASSERTIONS DO NOT ESTABLISH THAT THERE WOULD BE A "COSTLY" COUNTERFACTUAL

26.1 NZGA seeks to assert that in the absence of authorisation there would be a "costly" counterfactual. However, those assertions do not withstand scrutiny:

(a) First, NZGA's assertion of a "costly" counterfactual appears primarily premised on an argument that if the Commission does not authorise the Competitor Coordination, gynaecologists will coordinate anyway, and the cost of that disruption should count in favour of authorisation. That is not a public benefit of the Competitor Coordination. It is an assertion of illegal collusion in the absence of authorisation.[173] Accepting it would reward the prospect of unlawful conduct and weaken the authorisation regime, because any applicant could inflate the costs of its counterfactual by pointing to the unlawful conduct it might otherwise organise, and such an assertion would assume away the very issue in question (i.e. the benefits and detriments of illegal competitor coordination in the factual). Furthermore, the NZGA's apparent condoning of the ophthalmology specialty engaging in illegal cartel conduct as "unsurprising" is a concern. The Commission specifically said that the ophthalmology specialists acted "without any regard to the public good at all" and that it is "particularly repugnant that the defendants used the language of patient safety as a convenient excuse to disguise their own self interest".[174] It should also be noted that while NZGA appears to somehow relate that prior illegal conduct to SCHI, the prior illegal collusion between ophthalmology specialists has not, in any way, related to SCHI as a funder. Namely:

[171] DD at [378].
[172] NZGA Submission at [73].
[173] The NZGA Submission's allusion to the ophthalmology specialty engaging in illegal cartel conduct as "unsurprising", stating that they "have encountered Commerce Act issues in trying to navigate those purchasers" is unusual. First, the collusion between ophthalmology specialists has not, in any way, related to SCHI as a funder. Namely:

- One instance has related to the relevant District Health Board, MidCentral Health Limited. See: https://www.comcom.govt.nz/news-and-media/news-and-events/archive/eyes-surgeons-to-pay-85000-for-breaching-commerce-act/
- The other instance related to the Southern Health CHE. https://www.comcom.govt.nz/news-and-media/news-and-events/archive/ophthalmological-society-of-new-zealand-to-pay-100000-for-breaching-commerce-act/

In either case, the conduct was illegal. The Commission said, in relation to the Southern Health CHE, that the ophthalmology specialists acted "without any regard to the public good at all" and that it is "particularly repugnant that the defendants used the language of patient safety as a convenient excuse to disguise their own self interest".
[174] Commerce Commission "Ophthalmological Society of New Zealand to pay $100,000 for breaching Commerce Act" (30 June 2004). Retrieved from: https://www.comcom.govt.nz/news-and-media/news-and-events/archive/ophthalmological-society-of-new-zealand-to-pay-100000-for-breaching-commerce-act/.

(i) One instance has related to the relevant District Health Board, MidCentral Health Limited.[175]

(ii) The other instance related to the Southern Health CHE.[176]

(b) Second, the observation that the gynaecology transition has been slower than originally anticipated reflects, in significant part, that hospitals have been unable to finalise agreements while the Application has been on foot.[177] It is not evidence that the counterfactual would be disorderly. The NZGA's assertion of a costly counterfactual of "staggered refusals, hospital-by-hospital renegotiation, alternative practice structures and continued disputes",[178] or of "local impasses",[179] is not borne out by the in-market evidence:

(i) [ ][180] [ ] As the Commission has found, negotiations between SCHI and hospitals "have been unable to be finalised while this authorisation application process has been underway, as they need gynaecologists to agree".[181] [ ] Any delay or cost is, therefore, not a feature of the counterfactual.

(ii) Furthermore, contrary to NZGA's submission, it is not correct that these counterfactual negotiations would be occurring in circumstances of gynaecology surgeons being "[f]aced with a fee reduction of around ~48%".[182] See further at paragraph 8.

(c) Third, NZGA asserts that the Commission would need to take into account the costs of "NZGA and its members pursuing further regulatory and legal (including appeal) processes".[183] This assertion is misconceived. The costs of challenging the Commission's Final Determination would not be a market cost of the decline of authorisation, but rather would be at NZGA's election. Further:

(i) If an applicant's stated willingness to litigate could weigh against declining authorisation, every applicant could seek to strengthen its case simply by threatening to appeal.

(ii) NZGA has fallen so far short of substantiating its case for authorisation that it seems highly unlikely, if properly advised, that it would incur the costs of an appeal.

(iii) A grant of authorisation could similarly be appealed by SCHI, so even if such threatened costs could be considered relevant to

[175] See: https://www.comcom.govt.nz/news-and-media/news-and-events/archive/eyes-surgeons-to-pay-85000-for-breaching-commerce-act/
[176] https://www.comcom.govt.nz/news-and-media/news-and-events/archive/ophthalmological-society-of-new-zealand-to-pay-100000-for-breaching-commerce-act/ Commerce Commission "Ophthalmological Society of New Zealand to pay $100,000 for breaching Commerce Act" (30 June 2004). Retrieved from: https://www.comcom.govt.nz/news-and-media/news-and-events/archive/ophthalmological-society-of-new-zealand-to-pay-100000-for-breaching-commerce-act/.
[177] DD at [145]; DD Submission at [9.2(a)].
[178] NZGA Submission at [26].
[179] NZGA Submission at [29].
[180] This also demonstrates that NZGA's assertion at paragraph 65 of its Submission is incorrect.
[181] DD at [145].
[182] NZGA Submission at [29].
[183] NZGA Submission at [7(c)(ii)].

the counterfactual, they would need to be "netted off" by the prospect that the same costs would be incurred in the factual.

27. NZGA'S SURVEY RESULTS ARE SELF-SERVING, INCONSISTENT WITH GOOD PRACTICE, AND UNRELIABLE

27.1 While much of the NZGA Submission is premised on survey results, those surveys should not be given weight by the Commission. While SCHI has not been provided with the details of the surveys,[184] their results, or their methodology, on its face it would appear to fall well short of recognised good practice for survey evidence:

(a) For example, the UK Competition and Markets Authority ("**CMA**") guidance on survey evidence says that properly-designed surveys must be "neutral and not biased towards one outcome or another".[185] NZGA's member surveys fail this fundamental requirement of survey design. The applicant ran them among its own members, while authorisation was pending, on a question in which every respondent has a direct financial stake: how they would respond to lower fees. It also asked respondents to predict their own future behaviour. The CMA notes that surveys should not be designed to influence respondents to express opinions that are not proper representations of their views or behaviours and identifies a number of biases that could arise in surveys. SCHI encourages the Commission to scrutinise NZGA's survey questions for the following biases:

(i) Acquiescence bias occurs where the question is framed in a way that suggests to the respondent that they should be agreeing with the premise of the question. Acquiescence bias appears to be present in the NZGA survey. For instance, the description of survey results at [39] of NZGA's Submission suggests that when asked about the counterfactual, respondents were given the options of "stop complex procedures", "reduce workload by around 30%", "retire", "move overseas" or "no change". If the question was asked in the way [39] suggests, then the question itself is encouraging respondents to suggest that they would be taking action in the counterfactual, even if the respondent would likely make no changes in the counterfactual.

(ii) Restrictive bias occurs where the question leads the respondent to only consider certain options. Without having seen the questions asked by NZGA, SCHI is concerned that the question discussed at [39] shows that the NZGA surveys may have been designed to purposefully restrict and guide respondents to give particular answers.

[184] It is noted that SCHI requested external counsel / expert access to NZGA's surveys on 23 October 2026, but copies had not been received in time for preparation of this cross-submission.
[185] CMA "Good practice in the design and presentation of customer survey evidence in merger cases" (23 May 2018). Retrieved from: https://www.gov.uk/government/publications/mergers-consumer-survey-evidence-design-and-presentation/good-practice-in-the-design-and-presentation-of-customer-survey-evidence-in-merger-cases

(iii) The CMA also warns that survey questions are prone to "hypothetical bias", where stated changes in behaviour do not reflect what people would actually do.

(iv) Surveys are also prone to "inertia bias", where respondents overstate their reaction because they ignore switching costs and inconvenience.[186]

(b) The surveys also lack the transparency the CMA requires before giving survey evidence weight. NZGA has not provided the questionnaire wording, how respondents were invited, the response rate, any piloting, a respondent-level dataset or a technical report. The onus should rest on NZGA to demonstrate that its surveys are consistent with good survey design, and to date NZGA has provided no evidence that suggests that this is the case.

(c) While it is not clear to SCHI what questions were put to NZGA members through the surveys, given the NZGA and Link Submissions contain a number of incorrect assertions, including an incorrect assertion that SCHI intends to implement prices that are ~48% lower than current FFS prices, it is safe to assume that the questions posed in the surveys also contained a number of incorrect and over-stated assumptions.

(d) The follow-up survey that NZGA relies on to "test the robustness" of its main results had only 49 respondents. NZGA admits that not all members were surveyed "due to time constraints", but does not explain how those 49 were chosen, nor does NZGA seek to address any self-selection bias in its follow-up survey (noting NZGA members who are billing above competitive levels would face the largest reduction in surgeon fees following a move from FFS to APS and therefore have the greatest financial incentive to complete the follow-up survey, skewing those results).

(e) Further, by waiting until after the publication of the DD to undertake its survey, the survey is prone to bias as survey participants (surgeons with a direct financial stake in the Application) are aware of the Commission's DD and are then incentivised to provide responses which they perceive will support the Application but do not reflect the steps they would necessarily take in the counterfactual. For instance, a respondent who had read the DD may consider it would support NZGA's position (and by extension the respondent's own financial position) by stating that they would retire or leave New Zealand when in fact they would make no such move in the counterfactual. A biased respondent would also act to amplify any other biases inherent in the survey design.

27.2 Furthermore, even if the survey results could be considered to provide any probative weight, NZGA's own survey found that more than 95% of respondents were willing to accept some reduction from FFS rates.[187] This finding (along with NZGA's assertion that it "does not seek a fee increase and would accept a

[186] For similar reasons, NZGA's reliance on four letters from individual gynaecologists (for example, at paragraph 37(a)) asserting that they would retire, close or relocate overseas is a thin (and self-serving) evidentiary basis on which to assert a systemic risk to the supply of gynaecological services. The DD was right to not place significant weight on such self-serving letters, that similarly would be prone to "hypothetical bias" and "inertia bias".

[187] NZGA Submission at [72(a)].

reduction from current [FFS] levels"[188]) is difficult to reconcile with the proposition that fee reductions would cause widespread exit, and that apparent widespread willingness to accept some reduction from FFS rates is, in fact, more consistent with SCHI's evidence that current FFS gynaecology surgery fees are significantly above competitive levels.

28. NZGA'S ASSERTION THAT SCHI MEMBERS SHOULD CROSS-SUBSIDISE OTHER FUNDERS IS INCORRECT

28.1 The NZGA Submission asserts that income from private funders, such as SCHI, "cross-subsidises lower New Zealand public pay".[189] SCHI submits that a desire for a cross-subsidy is an inappropriate basis on which to assess the public benefits of the Proposed Arrangements:

(a) It is an admission that gynaecology surgeons set their private fees above the cost of the private service. A fee that includes an amount to cross-subsidise an employee's remuneration from public work is not an efficient price for the private service. Removing that element is not a detriment. It is the kind of efficiency the APS is designed to achieve.

(b) SCHI's members are not responsible for public sector pay. The remuneration of public sector gynaecologists is a matter for Health NZ, the Government and the relevant employment arrangements. That is not a matter for SCHI's members to cross-subsidise through their premiums. SCHI is a friendly society. Any amount SCHI pays above the efficient cost of private care is funded by its members. NZGA is in substance asking SCHI's members, most of whom also pay tax that funds the public system, to also pay more a second time for public sector remuneration through their private health insurance. Any concerns about public sector remuneration should be raised with the employer, not addressed by an authorisation that allows competing gynaecologists to negotiate collectively the prices private patients have to incur.

(c) In assessing NZGA's request for a cross-subsidy from SCHI's members to gynaecology surgeons, it needs to be borne in mind that Health NZ estimates that the average salary package for employed obstetricians and gynaecologists in New Zealand is $343,500,[190] [ ][191] [ ]. By contrast, the median annual earnings for [ ] in New Zealand (being an average that would likely be more reflective of the average earnings of SCHI's [ ] member cohort) was estimated at [ ] in June 2025.[192] It would result in a significant transfer of value from a large pool of everyday SCHI members (approximately 935,000 SCHI members [ ]) to a small number (~130) of highly paid gynaecology surgeons to expect those SCHI members to cross-subsidise the earnings of the much more highly paid gynaecology surgeons.

28.2 SCHI therefore submits that the Commission should give no weight to NZGA's "top-up" argument.

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[188] NZGA Submission at footnote 4.
[189] NZGA Submission at [35(b)].
[190] Health NZ "International Obstetricians and Gynaecologists - New Zealand roles". Retrieved from https://jobs.tewhatuora.govt.nz/jobs/OBGYN
[191] [ ]
[192] https://www.stats.govt.nz/information-releases/labour-market-statistics-income-june-2025-quarter/

28.3 Furthermore, while NZGA seeks to make much of the fact that public pay in Australia is higher than in New Zealand,[193] it needs to be recognised that [ ]

29. OTHER CONDITIONS WOULD NOT PREVENT THE DETRIMENTS

29.1 NZGA's mooted conditions would not prevent the core detriments identified by the Commission:

(a) Fee safeguards: NZGA proposes that it would be open to capping fees at current FFS levels. However, that would lock in fees at above-competitive levels, thereby crystallising the "materially higher costs for gynaecology surgery on an ongoing basis"[194] that the Commission has already found.

(b) Information protocols: NZGA proposes that it would be open to "Member-level pricing and NZGA's prepared prices [being] not circulated to members and [being] kept at the board level" on the basis that "board members do not compete".[195] However, that is based on a false premise. NZGA's board members are practising gynaecologists who compete with other members. Accordingly, this would provide board members with sensitive pricing information about their competitors, and in circumstances where they are then tasked with establishing a collectively negotiated “reference price” in relation to SCHI, that price will become an anchor - a floor below which no gynaecology surgeon will be willing to charge any funder. It also needs to be borne in mind that [ ][196]

(i) [ ]

(ii) [ ]

(iii) [ ]

[ ]

(c) Non-price terms first: NZGA proposes that it would be open to changing the order of the Collective Bargaining, namely to "settling non-price terms before fees".[197] However, changing the order of discussions does not change where they end, which is the collective negotiation of fees that the Commission has already found "would result in materially higher costs for gynaecology surgery on an ongoing basis".[198]

(d) Shorter term: NZGA proposes that it would be open to "a shorter authorisation period". However, even if a shorter authorisation period reduced the harm, it would not remove it and it creates no benefit. Furthermore, SCHI does not consider that a shorter period would reduce the harms to just the period of authorisation – once pricing coordination and information exchanges have taken place, that will result in permanent damage to the competitive process, escalate prices further above

[193] NZGA Submission at [35(a)].
[194] DD at [16]. See also DD at [178].
[195] NZGA Submission at [83(b)].
[196] [ ]
[197] NZGA Submission at[11].
[198] DD at [16]. See also DD at [178].

competitive levels, and remembering that prices increase year-on-year result in higher costs to members on an ongoing basis.

30. NZGA'S BIAS ALLEGATION IS UNFOUNDED – NZGA HAS PROVIDED INACCURATE, INCONSISTENT, AND INSUFFICIENT EVIDENCE

30.1 The NZGA Submission makes various allegations of bias in the Commission's process. From SCHI's perspective, such allegations are wholly unfounded. The Commission has rigorously tested the information that SCHI has submitted to it, including making multiple requests for information of SCHI and seeking validation of the quantification evidence that SCHI has provided to the Commission.

30.2 The reality is that:

(a) the onus is on NZGA to satisfy the Commission that there are sufficient public benefits to outweigh the competitive harm arising from otherwise illegal Competitor Coordination;

(b) the Commission's Authorisation Guidelines and authorisation application form encourage "expert economic evidence"[199] and "quantitative and qualitative evidence of the benefits and detriments that may result from the agreement or unilateral conduct".[200]

30.3 Despite that, NZGA did not file any such expert economic evidence with its original Application, and the belated Link Submission does not provide any meaningful economic evidence or quantification in support of the NZGA Application (see further in this cross-submission). A failure by NZGA to provide evidence to the Commission does not reflect bias on the Commission's behalf.

30.4 Furthermore, throughout the process there has been a concerning lack of consistency between NZGA's various submissions, a changing articulation of what it is NZGA is seeking authorisation for, indications of pre-existing or non-authorised illegal collusion, and a concerning lack of accuracy in a number of instances. To take but a few examples:

(a) As outlined at paragraphs 3 and 4 above, the way both NZGA and Link now characterise the scope of the Application is directly inconsistent with the terms of the Application itself.

(b) As outlined at paragraph 5.1 above, it is not correct to state that the APS is "new and untested" or that the approach to gynaecology surgery is novel.

(c) As set out at paragraph 5.2(b) of SCHI's DD Submission, NZGA's assertions throughout the process of the fees its members would be willing to agree if authorisation were granted appear to be the expression of a collective position on price prior to any authorisation being granted.

(d) As outlined at paragraph 26 above, it is not appropriate for NZGA to suggest illegal collusion would be the outcome in the absence of authorisation being granted.

[199] Authorisation Guidelines at [102].
[200] NZGA Application at [10].

(e) As set out at footnote 35 of SCHI's DD Submission, NZGA's assertion (in its 4 August 2026 cross-submission) that SCHI's submission on ACCC's decision in *Catholic Health Australia* is "inaccurate" was itself incorrect.

(f) NZGA's references to the Commission's 2000 clearance decision and the Court of Appeal's 2001 judgment do not accurately reflect the Commission's views or the Court's findings.

(i) First, NZGA seeks to present as findings of the Commission what were in fact opinions of third parties. The Commission's clearance decision did not contain the statements that NZGA purports to attribute to the Commission, and the Commission's decision did not find that SCHI operated, or could operate, inefficiently.[201]

(ii) Second, while NZGA refers to a dissenting judge's observation of third party statements, the Court of Appeal in fact found that "the ability of [SCHI] to price or otherwise behave in a supra-competitive manner will, on the balance of probabilities, be sufficiently constrained by the threat of or the happening of new entry or expansion".[202] In other words, the Court of Appeal found that SCHI operated in a competitive market. Further, the Court of Appeal found that it did not "see any justification in the evidence for taking the view that the question of concealed inefficiencies is a material factor in this case".[203]

30.5 In these circumstances, the record demonstrates that the Commission's preliminary decision in its DD does not reflect any bias on behalf of the Commission, but inaccurate, inconsistent, and insufficient evidence from NZGA in support of its Application.

31. THE NZGA'S PROPOSED CLINICAL ADVISER IS NOT "INDEPENDENT"

31.1 The NZGA asserts a process concern that SCHI's confidential information has not been provided to "NZGA's independent clinical adviser" and, therefore, SCHI's "clinical evidence" has not been tested. Neither assertion is correct:

(a) [ ] A market participant with a direct financial interest in the outcome cannot properly be called an "independent" adviser. The Commission was right not to disclose SCHI's confidential information to this person.

(b) NZGA's underlying premise, that SCHI's clinical evidence has not been clinically tested, is also wrong. SCHI has consulted extensively on clinical matters with the bodies that have the clinical mandate to advise on them. These are RANZCOG, the accredited professional college for obstetrics and gynaecology, and ANZSU, whose members also perform certain urogynaecology procedures. That consultation process ran for more than twelve months. RANZCOG itself acknowledged "the careful consideration given to our advice and the improvements made to the

[201] Decision No. 399. The Southern Cross Medical Care Society and Aetna Health (NZ) Limited. (25 August 2000).
[202] *Commerce Commission v Southern Cross Medical Care Society* CA89/01, 21 December 2001 at [93].
[203] *Commerce Commission v Southern Cross Medical Care Society* CA89/01, 21 December 2001 at [61].

code set". SCHI adopted all clinical feedback it received on the urogynaecology and gynae-oncology codes, with one reasoned exception. The pelvic floor / urogynaecology concerns that NZGA identified as a key reason for seeking authorisation have now been resolved through that process, without collective bargaining. The clinical evidence has therefore been tested by independent clinical experts. That process did not need, and would not have been helped by, disclosing SCHI's commercially sensitive information to a market participant with a direct financial interest in the outcome. The above also means that, contrary to NZGA's assertion, the engagement by the Commission of its "own independent clinical specialist"[204] is not necessary - the Commission has already conducted an interview with RANZCOG (on 30 June 2026) and with other gynaecologists.

32. THE NZGA SUBMISSION AND LINK SUBMISSION WERE AFTER THE COMMISSION'S ORIGINAL DEADLINE, SO THEY SHOULD NOT BE GIVEN WEIGHT

32.1 Finally, it is noted that both the NZGA Submission and the Link Submission were provided to the Commission on 20 October 2026, which is 13 days after the Commission's originally specified deadline of 7 October 2026.

32.2 As the Commission will be aware, its Authorisation Guidelines are clear that its timetable depends on applicants and interested parties adhering to it. Those Authorisation Guidelines state:[205]

> "To achieve our investigation timeline, we rely on the full cooperation of the applicant throughout the process. **Applicants must provide complete, concise and relevant information promptly**. **We also require interested parties to comply with strict timeframes for submissions and consultation**."
>
> "Submissions and cross-submissions **will generally only be accepted if received within the notified submission timeframe**. We will only grant extensions to the deadline in exceptional circumstances. This ensures that we continue to progress the investigation in a timely fashion."
>
> "**We may refuse to accept or place less weight on submissions received after our deadline**. Parties wishing to make a submission that are unlikely to meet our deadline should let us know as soon as possible and explain the reasons for the delay, and when the submission is likely to be filed."

32.3 SCHI trusts that, in addition to the substantive inaccuracies in the NZGA Submission and Link Submission, NZGA's departure from the Commission's specified timetable will be appropriately taken into account from a process perspective in weighing both the NZGA Submission and the Link Submission.

32.4 NZGA's threatened "member survey on contract terms"[206] must also not be given weight. If that is presented to the Commission, that will be outside of the Commission's allowed submission timeframe, and not within any timeframe that would enable SCHI to respond with a cross-submission. NZGA has had ample

[204] NZGA Submission at [61].
[205] Authorisation Guidelines at [123], [134], and [135] respectively. [Emphasis added]
[206] NZGA Submission at [77(c)].

opportunity to conduct such a survey – for example, when it lodged its Application on 19 May 2026, in submissions on the SOPI, in cross-submissions on the SOPI, in its various supplemental submissions during August 2026, or prior to the Commission's specified 7 October 2026 deadline for submissions on the DD. It would be inconsistent with natural justice for the Commission to rely on evidence that the applicant chose to hold back until other parties could no longer respond.

33. CONCLUDING COMMENTS

33.1 Ultimately, the NZGA Submission and Link Submission do not engage with the Application NZGA made, the evidence before the Commission, or the Commission's actual findings. They recast collective price negotiation backed by a boycott as "advocacy" and "benchmarking". They attribute to the DD findings it does not contain, and they rest on figures, most notably the "~48%" fee reduction, that SCHI's evidence shows to be wrong. Above all, NZGA depends on the premise that SCHI is a "monopsonist". It is not: SCHI funds only around [ ] of gynaecology surgeries in New Zealand, gynaecologists have extensive outside options, and the DD records that SCHI has had to raise its prices to secure coverage.

33.2 Stripped of those mischaracterisations, nothing remains to displace the Commission's preliminary view. NZGA has still not quantified a single benefit from authorisation. The non-price issues the Application was premised on have been resolved through RANZCOG and ANZSU without collective bargaining. The only material obstacle to hospitals / facilities concluding arrangements in relation to the APS with gynaecology surgeons is the Application itself.

33.3 The detriments, meanwhile, are quantified and clear. Authorisation would replace competitive price discipline with a collectively agreed price floor, set by those with the most to gain from it. The result would be a lasting transfer from approximately 935,000 SCHI members [ ], and from other funders and self-funded women, to ~130 highly paid surgeons, for the full 10-year period sought. NZGA's mooted conditions would not change this: they do not constrain the price effects that drive the detriments, and they would add further cost and complexity.

33.4 The public benefit test requires the Commission to be satisfied that the benefits outweigh the detriments. On the evidence, that test is not close to being met. SCHI therefore submits that the Commission should confirm its preliminary view and decline the Application.

APPENDIX ONE

RESPONSE TO SPECIFIC NZGA CLINICAL ASSERTIONS

In addition to the points raised in SCHI's cross-submission, for accuracy of the record before the Commission, it is necessary to set out (as **below**) responses to a number of additional incorrect clinical assertions in NZGA's submission on the Draft Determination.

NZGA's assertion that the code set is not "largely settled" is incorrect

- **SCHI's procedure funding code set is now "largely settled".** NZGA argues that there is a disjunct between the Commission accepting SCHI's description of the procedure funding code set as "largely settled" but also stating that the code set will "evolve over time as SCHI acquires more data". NZGA asserts that this is an acknowledgement that "gaps remain".[207] That is not correct. SCHI's procedure funding code sets in every APS specialty are kept under review so they can adapt to changes in clinical practice. That is a normal and important feature of the APS, not evidence of gaps. In any event, the "gaps" that NZGA purports to identify have been addressed following consultation with RANZCOG and ANZSU, and SCHI's procedure funding code set is now settled. SCHI's procedure funding code set is designed to cover the full range of gynaecological services that SCHI's insurance policies cover. Following the most recent RANZCOG and ANZSU consultation process, the gynaecology procedure funding code set has a total of 89 codes. This includes specific gynaecological oncology and urogynaecology codes. NZGA's assertion that "SCHI's code set has around only 55 codes"[208] does not reflect the current procedure funding code set. In any case, the number of codes is not a measure of coverage.

- **Codes following RANZCOG consultation.** NZGA asserts that SCHI added only two codes following RANZCOG's consultation, against the 84 codes RANZCOG proposed.[209] That is not correct. Following consultation with RANZCOG and ANZSU, SCHI adopted the majority of RANZCOG and ANZSU's recommendations and added 28 codes and revised 3 existing codes, including specific gynaecological oncology and urogynaecology codes. Where SCHI did not adopt a RANZCOG or ANZSU recommendation, SCHI explained its reasons to RANZCOG and ANZSU in correspondence on 23 September 2026.

- **Australian comparison.** NZGA asserted in its submission that "By comparison, there are more than 150 gynaecology codes in Australia."[210] NZGA does not say where the figure of "more than 150 Australian gynaecology codes" comes from. It does not identify the schedule, funder or code set it relies on, or explain how the codes were counted. Without that information, the figure cannot be assessed and should be given little weight. SCHI's 89 codes are surgical procedure funding codes only. The asserted Australian figure is very likely to include the gynaecology specialty as a whole rather than gynaecology surgical services only. The asserted Australian figure is likely to include consultation services and rooms-based services and other non-surgical items, which are not part of the gynaecology surgical APS procedure funding code set. If so, it does not compare like with like. A higher number of codes in another schedule would

[207] NZGA Submission at [65].

[208] NZGA Submission at [65].

[209] NZGA Submission at [65].

[210] NZGA Submission at [65(a)].

also not show that SCHI's procedure funding code set leaves any gynaecological surgery unfunded.

SCHI reiterates that there are no gaps in the procedure funding code set.

NZGA's assertions in relation to laparoscopic hysterectomy are incorrect

- In relation to laparoscopic hysterectomy, NZGA has asserted that "RANZCOG proposed three codes (simple, complex, and complex with fibroid morcellation for uteri over 500 grams). SCHI's framework acknowledges only two (uteri under and over 250 grams) with no provision for a uterus over 500 grams with stage 2–3 endometriosis. SCHI also provides no clarity on whether stage 4 endometriosis requiring hysterectomy is a primary code with an add-on".[211] These assertions are not correct as explained below.
    - **Simple and complex codes.** SCHI's procedure funding code set distinguishes between simple and complex laparoscopic hysterectomy, and that distinction was in place before RANZCOG's involvement. NZGA describes SCHI's codes as divided only by uterine size, which understates the procedure funding code set. As well as uterine size, complexity is reflected in fibroid size and endometriosis stage, and ureterolysis has been removed from the simple codes so it can only be claimed under the complex codes. The risk corridor also provides additional reimbursement where a case takes longer than the agreed theatre time for the primary code.
    - **Morcellation over 500g.** RANZCOG recommended a separate code for laparoscopic or vaginal morcellation of uterus or fibroids over 500g. SCHI carefully reconsidered this recommendation and did not adopt it. This is a reasoned decision and SCHI set out its position to RANZCOG in its letter of 23 September 2026. Morcellation is accounted for in the average pricing of the relevant hysterectomy and myomectomy procedure funding codes. Where a case is more complex than average and theatre time exceeds the agreed duration for the primary code, the risk corridor or top-up mechanism in SCHI's APS agreement allows additional reimbursement above the total procedure price. Funding for these more complex cases is therefore already provided for, and a separate procedure funding code is not required.
    - **Stage 4 endometriosis.** SCHI has provided clear guidance on this point in its letter to gynaecology surgeons on 1 July 2026. SCHI advised that when stage 4 endometriosis is treated alongside a hysterectomy, two primary codes are available (AP1083 Lap Endometriosis ASRM Stg4 and AP1084 Lap Endo Stg4 + Discoid Resection). These can be claimed alongside the applicable hysterectomy code, with funding applied under the Multiple Services Rule for multiple procedures performed in the same episode.

NZGA's assertions in relation to pelvic floor surgery are incorrect

- In relation to pelvic floor surgery, NZGA has asserted that "Despite multiple discussions, the pelvic floor codes remain deficient. Open or laparoscopic sacrocolpopexy with a TVT is coded as a single procedure although it treats two separate conditions. There is a combined anterior and posterior colporrhaphy code, but no code for sacrospinous fixation or any vaginal vault or uterine suspension procedure. As the Urogynaecological Society of Australasia (**UGSA**) submitted, around 80% of women with advanced prolapse have occult stress urinary incontinence requiring a combined procedure, and 85% of women with stage 3 (and all women with stage 4) anterior prolapse have clinically significant apical prolapse. Repairing the anterior

[211] NZGA Submission at [66(a)].

wall alone leaves the apex untreated, so symptoms persist and a second operation is often needed soon after: two surgeries and two recoveries for the patient, with each further operation more complex and higher risk."[212] These assertions are incorrect as set out below.

- **Sacrocolpopexy with TVT.** SCHI accepted RANZCOG and ANZSU's feedback that mesh removal and TVT sling should not form part of the sacrocolpopexy procedure descriptions. In SCHI's letters to RANZCOG and ANZSU dated 23 September 2026, SCHI confirmed that these are clinically distinct procedures with separate indications and that it has amended the relevant procedure funding code descriptions to reflect this. Where a TVT sling is performed at the same time as a sacrocolpopexy, it is funded as a separate procedure rather than being included in the sacrocolpopexy code. This procedure is now covered in the revised urogynaecology procedure funding code set as part of the most recent RANZCOG / ANZSU review.
- **Sacrospinous fixation and vault or uterine suspension**. These procedures are now covered in the revised urogynaecology procedure funding code set as part of the most recent RANZCOG / ANZSU review.

NZGA's assertions in relation to the process for agreeing the procedure funding code set are incorrect

- NZGA has asserted that "Further, when SCHI and hospitals agree a fee for a procedure, surgeons receive the code description only after the agreement is made (so surgeons are bound by a fee agreed on their behalf by others, for a procedure whose scope they had no opportunity to review)". [213] This assertion is not correct, as explained below.

  Under the APS, SCHI contracts with the hospital / facility as the contract holder. Surgeons are not bound by a fee agreed on their behalf by others. Each surgeon negotiates their own surgery fee directly with the hospital / facility.[214] Surgeons are fully informed of the code descriptions and contracting mechanisms that apply to them before they agree to be a listed provider with a hospital / facility. As SCHI has explained, surgeons have also had the opportunity to review and provide feedback on the procedure funding code set.

  SCHI has communicated to gynaecology surgeons, on several occasions, not only the code descriptions but also the wider contracting mechanisms that apply under the APS. As part of the transition process to the APS, SCHI has sent the gynaecology surgeons the procedure funding code set with all the detailed code descriptions each time the procedure funding code set has been updated, most recently on 1 July 2026. SCHI will also send surgeons the updated procedure funding code set shortly, to further facilitate the contracting process.

  In its letter of 1 July 2026, SCHI also sent gynaecology surgeons information on the criteria for risk corridors, top-ups, multiple services and open codes as set out in the Affiliated Provider Agreements (AP Agreements). In addition, SCHI explained in this letter that "As per the AP Agreements for gynaecological consultations and rooms-based procedures, when there is an unforeseen change in the procedure, the code originally applied for should be changed, or additional codes added, to reflect the actual procedure performed using the appropriate code(s) prior to the facility claiming payment. For gynaecological surgery, this will be managed for you by the facility under the AP arrangement. As an example, a member may present with normal pre-operation imaging indicating Stage 3 endometriosis requiring ureterolysis, but the

[212] NZGA Submission at [66(b)] (original footnotes omitted).
[213] NZGA Submission at [66(e)].
[214][ ].

gynaecology surgeon may also identify a need for a vaginal hysterectomy for prolapse repair once the member is undergoing the procedure. In those circumstances, the facility would originally have applied for the code "AP1082 Laparoscopic Endometriosis ASRM Stage 3". However, the facility would subsequently change the claim to code "AP1210 Vaginal Hysterectomy Complex" (which includes both Stage 3 endometriosis, ureterolysis and vaginal hysterectomy)".

In its claiming guidance to gynaecology surgeons as part of the letter dated 1 July 2026, SCHI included a claiming matrix because, as stated to gynaecologists, "We recognise that clinical care is tailored to individual patient needs and may involve a range of clinical considerations. The matrix does not prescribe or restrict clinical practice. It clarifies how the new gynaecology AP codes are structured for our funding purposes, including where services are considered part of a comprehensive procedure rather than separately claimable. This reflects standard coding principles, where certain components of care are incorporated within primary procedure codes. It also helps avoid double charging for work that is already included in another service description. The aim is to provide transparency on how these services are recognised when we fund claims, support consistency in that claims assessment, and reduce ambiguity or unexpected claims outcomes".

Relevant information on eligibility and policy requirements was also communicated to gynaecology surgeons on 2 February 2026. Surgeons are therefore aware, before they agree to be a listed provider, of how the APS operates in practice, including the code descriptions, risk corridors, top-ups, the Multiple Services Rule, open codes, how codes are changed where the procedure changes unexpectedly, the claiming matrix, and eligibility and policy requirements.

NZGA's assertions regarding the scope of the APS code set are incorrect

- NZGA has asserted that certain procedures still have no appropriate code: (1) 14-week uterus hysterectomy, stage 4 endometriosis, sigmoid resection, cystoscopy and ureteric catheters, ~360 mins, two surgeons; (2) laparoscopic excision of severe endometriosis including diaphragmatic disease, two surgeons; (3) anterior and posterior repair with sacrospinous colpopexy; (4) robotic hysterectomy with endometriosis excision and in-bag morcellation.[215]

  There is no such gap. Each of NZGA's asserted examples can be funded under SCHI's procedure funding code set and contractual mechanisms. This is shown as follows:

  - **Case (1)** would be claimed under the complex laparoscopic hysterectomy code [AP1208] together with the stage 4 endometriosis code [AP1083] and the new AP add-on code for cystoscopy with ureteric catheter insertion (this add-on code is yet to be assigned a code number). Adhesiolysis and ureterolysis are already included in the complex hysterectomy codes. A colorectal second surgeon is subject to prior approval, which in a case of this nature would likely be granted up to the member's policy limits. Theatre time beyond the defined maximum is funded through the risk corridor and additional 15-minute blocks [AP0157]. Contrary to NZGA's assertion, these blocks are not capped. Each block is funded in full even where the additional time is less than 15 minutes. For example, 16 minutes of additional theatre time is funded as two 15-minute blocks. Additional length of stay can be claimed under the length of stay code.
  - **Case (2)** would be claimed under the stage 4 endometriosis code [AP1083]. An upper gastrointestinal second surgeon is subject to prior approval, which in a case of this nature would likely be granted up to the member's policy limits. Additional theatre time

[215] NZGA Submission at [67] and Table 1.

is funded through the risk corridor via uncapped 15-minute blocks [AP0157]. The defined average time is set out in each hospital / facility's APS agreement. NZGA's reference to a surgeon not receiving extra payment for robotic surgery is not relevant to this laparoscopic case – that is because standalone robotic endometriosis surgery is not a current benefit under SCHI's insurance policies.

- **Case (3)** would be claimed under the combined colporrhaphy code [AP1533] together with the new AP code for vaginal vault or uterine suspension (this code is yet to be assigned a code number).
- **Case (4)** would be claimed under the robotic hysterectomy code together with the applicable incidental findings of endometriosis add-on codes. NZGA asserts that the robotic code covers stage 2 endometriosis. In fact, it covers incidental endometriosis up to stage 3, as NZGA itself accepts at paragraph 68(d)(i) of its submission. Morcellation cases were included when the robotic hysterectomy codes were priced.

NZGA's assertions that surgeons would "absorb the cost" are incorrect

- NZGA has asserted that surgeons must perform unfunded treatment or return the patient for a second operation; surgeons "fight" for cover or pay "out of pocket" for second surgeons; barriers to a second gynaecologist as expert assistant increase surgical risk.[216] These assertions are not correct. SCHI has clear, established processes for funding additional surgical support. Surgeons are not required to absorb these costs.
  - **Surgical assistants.** SCHI recognises that safe and effective gynaecological surgery may need additional surgical support in some circumstances. For example, RANZCOG identified 12 gynaecological oncology procedure funding codes where an assistant is either required or may be required. As SCHI confirmed to RANZCOG in its letter of 23 September 2026, where one of those procedures requires a surgical assistant, the cost is negotiated with the facility as part of the facility portion of the procedure price. The agreed amount is paid to the facility, which then pays the appropriate parties.
  - **Second gynaecologist.** Where a second gynaecologist is medically required to perform part of the procedure, prior approval should be sought through the facility before the procedure date. This allows the additional surgeon cost to be assessed against the member's policy terms and conditions. If approved, the agreed amount is paid to the facility, which then pays the appropriate parties. This addresses NZGA's concern about expert assistants: where a second gynaecologist is clinically indicated, there is a defined pathway for funding them.
  - **Second surgeons from other specialties.** Where a surgeon from another specialty, such as a general or colorectal surgeon, performs part of the procedure alongside the gynaecologist where medically appropriate, prior approval should be sought before the procedure date. The additional surgeon component is then assessed against the member's policy terms and conditions and paid via FFS. SCHI has explained this process to gynaecologists on several occasions. Where a second surgeon from another specialty is likely to be needed, SCHI requires this to be raised before surgery so that cover can be confirmed.
  - **Funding and informed financial consent.** Funding arrangements do not dictate clinical practice. The code used can be changed or added after surgery and before

[216] NZGA Submission at [68(b)].

claiming to reflect the procedure actually performed, so a surgeon is not required to stop surgery or bring the patient back for a second operation because of how a case was coded. Where complexity can be foreseen, as is standard practice, SCHI expects providers to ensure the member is informed before surgery of any costs not covered under their policy that they would need to self-fund. This reflects providers' existing obligations under Rights 6 and 7 of the Code of Health and Disability Services Consumers' Rights, including the right to information about the costs of each option.[217]

NZGA's assertions that the "administrative burden" would fall disproportionately on surgeons are incorrect

- NZGA asserts that under the APS "administrative burden" disproportionately falls on surgeons, including that: "For gynaecology procedures already under the APS, surgeons must spend scarce clinical time applying to SCHI to exercise its discretion on risk corridors and top-ups, providing clinical input to explain why the procedure changed or how cover applies (this cannot be done by administrative staff alone as it requires clinical judgment)."[218]

  Those assertions are not correct as NZGA overstates the administrative burden on surgeons. That burden does not fall disproportionately on them.

  - Under the gynaecology surgical APS, the hospital or facility, as the contract holder, handles administration such as claiming, prior approvals, risk corridor claims and top-up requests. Surgeons are not required to do this work. The agreed risk corridor is applied for by the contract holder where theatre time exceeds the agreed maximum duration for the primary code, so no clinical time from the surgeon is required.
  - NZGA's claim about the frequency of applications is unsupported: it provides no data on how often they are made. In any event, the frequency of applications does not show that the base codes are insufficient. Risk corridors and top-ups are available under the APS to appropriately fund procedures that exceed maximum durations or are more complex than the primary code allows for. Their use shows the APS working as designed, not that the base codes are deficient.
  - SCHI accepts that some requests need clinical input, but this does not amount to a substantial demand on clinical time. Where clinical input is needed (e.g. for a top-up), a short clinical summary is usually enough for SCHI to assess the claim, because the claim has already been through prior approval.
  - A decision not to pursue an application is a choice for the contract holder, not a burden the APS imposes. The risk corridor is applied for by the contract holder, and codes can be changed or added after surgery and before claiming to reflect the procedure actually performed.

NZGA's assertions regarding cover and clinical care are incorrect

- NZGA makes two incorrect assertions about SCHI's funding of robotic procedures. Firstly, NZGA asserts that "SCHI's robotic hysterectomy code covers incidental endometriosis only up to stage three, which often cannot be confirmed before surgery. Despite this, where stage three or four disease is found, top-up applications have been declined on a number of cases, leaving

[217] Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, Right 6(1)(b).
[218] NZGA Submission at [68(c)].

surgeons completing robotic surgeries unfunded."[219] Secondly, NZGA purports to describe a case in which SCHI agreed to fund a robotic hysterectomy on condition that the endometriosis excision be completed laparoscopically after undocking the robot.[220] NZGA says the robotic approach was abandoned as a result and the patient lost their benefits, and that SCHI has declined repeated requests to review its terms, offering only a case-by-case health technology application that cannot help a surgeon deciding mid-operation.[221]

These assertions are not correct. Within gynaecology, SCHI policies currently cover robotic surgery for two procedures only: hysterectomy and sacrocolpopexy. NZGA accepts that incidental endometriosis up to stage 3 is covered by an add-on code to the robotic hysterectomy code, which contradicts NZGA's own Table 1. Following feedback from gynaecologists that endometriosis is commonly identified incidentally during a robotic hysterectomy, SCHI worked with gynaecologists to create separate add-on codes for the treatment of incidental stage 1, stage 2 and stage 3 endometriosis. This avoids the clinically inappropriate situation where a surgeon would otherwise need to stop using the robot and treat the endometriosis laparoscopically. Gynaecologists advised SCHI that stage 4 disease should not be an incidental finding, because disease of that extent would ordinarily be identified before surgery. Robotic surgery for known stage 4 endometriosis is, therefore, not a current benefit under SCHI's policies, and NZGA accepts that the scope of cover is a matter for SCHI. Where more extensive disease is possible, SCHI expects the surgeon to discuss this with the member before surgery as part of informed financial consent, including whether the member wishes to self-fund the robotic component or proceed laparoscopically.

NZGA's assertions regarding gynaecology being "clinically different" are incorrect

- NZGA asserts that complex operations can take up to 8 hours while similar codes take under an hour; and asserts that international evidence shows fixed-fee systems undervalue women's procedures.[222] These assertions do not show that SCHI's procedure funding code set undervalues gynaecological procedures, for the reasons below.
    - **Long cases are extremely rare.** In SCHI's historical claims data, cases of up to eight hours are extremely rare in gynaecological surgery. Over the last 6 financial years, where the provider has supplied theatre times, there have only been 5 cases with theatre times greater than 420 mins. This equates to less than 0.03% of gynaecology surgical claims.
    - **Long cases attract additional funding.** A very small number of exceptional cases does not show that the procedure funding code set as a whole undervalues gynaecological procedures. In any event, where a case runs beyond the agreed duration for the relevant primary code (e.g. for hysterectomy or endometriosis), the risk corridor applies, followed by additional 15-minute time blocks [AP0157]. These blocks are not capped, and each block is funded in full even where the additional time is less than 15 minutes, so a longer case attracts more funding.
    - **Prices reflect variation in case length.** SCHI sets its prices using the average theatre time for each code. That average is drawn from historical claims data, which includes both shorter and longer procedures.

[219] NZGA Submission at [68(d)(i)].
[220] NZGA Submission at [68(d)(ii)].
[221] NZGA Submission at [68](d)(ii)].
[222] NZGA Submission at [23].

- **International evidence.** The international articles NZGA cites do not consider SCHI's procedure funding code set or its pricing methodology.

NZGA's assertions that its broader membership does not have experience of the APS are incorrect

- NZGA has asserted that "Very few [NZGA] members have experience of the APS in gynaecology".[223] NZGA's assertion is incorrect. Gynaecologists, who treat SCHI members under their insurance policies, hold APS agreements for consultations (since 2017) and rooms-based services (since 2024), and [ ] gynaecology surgeons already work within [ ] surgical APS agreements.

[223] NZGA Submission at [77(c)].