19 June 2026

Via email: PHIconsultation@health.gov.au

Catholic Health Australia Submission: Consultation on the remaking of private health insurance instruments (sunsetting) – April and October 2027

Thank you for the opportunity to provide feedback on the Department of Health, Disability and Ageing's consultation on the remaking of seven private health insurance legislative instruments due to sunset in April and October 2027. Catholic Health Australia (CHA) supports the disciplined operation of the sunsetting framework under the *Legislation Act 2003* and welcomes the Department's commitment to ensuring these instruments remain fit for purpose, necessary and relevant.

CHA is Australia's largest non-government grouping of health, community, and aged care services. Catholic providers have a vital interest in working with the Australian Government to ensure the sustainable provision of healthcare services, and our members operate a substantial share of the private hospital sector that relies directly on the instruments under review.

Consistent with the administrative focus of this consultation, and to keep our response targeted and useful, CHA has confined its detailed comments to the instruments that bear directly on the operation, funding and regulation of hospitals and on our members' ability to deliver care. We agree that the underlying laws giving effect to all seven instruments remain required, and we support their remaking. Where we identify scope for improvement, our recommendations are directed at restoring or preserving fitness for purpose through administrative correction, clarification and consolidation as opposed to re-opening settled policy.

We would welcome the opportunity to discuss this submission further. If you wish to discuss anything further, please contact Dr Katharine Bassett, Interim Chief Executive Officer on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

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Catholic Health Australia

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Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Background

The *Legislation Act 2003* provides that legislative instruments are automatically repealed (they "sunset") ten years after they are made. An instrument that is still required beyond its sunset date must be remade rather than extended. The purpose of sunsetting is to ensure that the statute book is kept up to date and that instruments remain in force only for so long as they are fit for purpose, necessary and relevant.

This consultation concerns seven private health insurance instruments made under the *Private Health Insurance Act 2007* (the Act) that are scheduled to sunset. Six are due to sunset in April 2027: the Ac*creditation Rules 2011*, the *Benefit Requirements Rules 2011*, the *Complying Product Rules 2015*, the *Incentives Rules 2012 (No. 2)*, the *Lifetime Health Cover Rules 2017* and the H*ealth Insurance Business Rules 2018,* and one, the *Risk Equalisation Levy Rules 2017*, is due to sunset in October 2027. The Department proposes that the instruments remain fit for purpose and that the laws they express are still required. The consultation is expressly limited to administrative amendments for the purpose of replacement; significant policy change, including broader sector reform, is stated to be outside its scope.

The grouping of related instruments for a single, sequenced review of this kind is, in substance, a thematic review of the framework governing one sector. Consistent with the Attorney-General's guidance on such reviews, the relevant question is not merely whether an instrument can be re-registered, but whether it continues to achieve its objects, whether it aligns with current government policy, and whether there are opportunities to simplify or streamline it so that it is clearer and does not impose unnecessary regulatory burden.

Overarching comments

CHA supports the disciplined operation of the sunsetting framework and agrees that the underlying laws giving effect to all seven instruments remain required. Consistent with the administrative focus of the consultation, and to keep this response targeted and useful, CHA has confined its detailed comments to the instruments that bear directly on the operation, funding and regulation of hospitals and on our members' ability to deliver care. Where we identify scope for improvement, our recommendations are directed at restoring or preserving fitness for purpose through administrative correction, clarification and consolidation as opposed to reopening settled policy.

The questions engaged

The consultation poses two questions for each instrument – whether it is fit for purpose, and whether the law is still required – and limits itself to administrative amendments. In CHA's view, three distinct questions are engaged, and they should not be collapsed:

1. Is the underlying law still required? That is, does the subject-matter still need to be regulated at all. For every instrument relevant to hospitals, CHA's answer is unequivocally yes.
2. Is the instrument fit for purpose in its current form? A higher bar than mere continuing need. An instrument can be necessary in principle yet contain spent transitional provisions, outdated cross-references, or drafting that no longer reflects current models of care or current government policy.

3. What administrative amendments should be made on remaking? This is the question the consultation is principally directed to.

The administrative and policy boundary

CHA accepts that this process is limited to administrative amendments and that significant policy change and broader sector reform are properly pursued through separate avenues. We do not ask the sunsetting process to make new policy. We do, however, ask the Department to take an appropriately purposive view of what is "administrative." Where current drafting produces outcomes that are inconsistent with the objects of the enabling Act, or that no longer align with decided government policy and current models of care, correcting that drafting is properly characterised as restoring fitness for purpose rather than as introducing new policy. The alternative – an unreflective remake – would re-enrol known defects for a further decade, which is difficult to reconcile with the fit-for-purpose standard the Legislation Act 2003 exists to uphold.

Sequencing with reform processes already underway

Several of the hospital-relevant instruments are the subject of, or are directly adjacent to, reform processes that are already underway: the Department's review of private health insurance default benefit arrangements (informed by the Ernst & Young study), the review of clinical categories, and the reform package being progressed through the Private Health CEO Forum in response to the Private Hospital Sector Financial Health Check. CHA recommends that the remaking of the affected instruments be sequenced with those processes. The *Legislation Act 2003* includes mechanisms by which the Attorney-General may defer a sunsetting date, or align the sunsetting dates of related instruments, precisely so that instruments can be remade once, in a form that reflects decided reform, rather than remade twice.

The context of private hospital viability

CHA's comments are made against the backdrop of well-documented pressure on private hospital viability, which the Government has acknowledged through the Private Hospital Sector Financial Health Check and the CEO Forum. The hospital benefits ratio (the share of hospital-treatment premium revenue returned to hospitals as benefits) fell from around 90 per cent before the pandemic to a low of about 83 per cent in 2022–23, and has only partially recovered to around 86 per cent. The instruments under review are not neutral technical machinery: the benefit, product and hospital-definition rules in particular shape the flow of funds to hospitals and the certainty on which our members plan and invest. Remaking them is therefore an opportunity to ensure the framework supports, rather than undermines, the Government's stated commitment to a viable private hospital sector.

Submission

CHA provides detailed comment below on the four instruments that directly govern what hospital treatment is covered, what hospitals are paid where there is no agreement, what facilities qualify as hospitals, and the risk-equalisation arrangements that shape insurer behaviour and reimbursement. It then addresses, more briefly, the three instruments that are primarily consumer- and insurer-facing, before setting out cross-cutting recommendations to improve administrative efficiency.

Private Health Insurance (Benefit Requirements) Rules 2011

Is the law still required? Yes.

Are the Rules fit for purpose in their current form? Substantially, but with administrative deficiencies that should be remedied on remaking.

These Rules give content to the minimum (default) benefits payable for hospital treatment, the nursing-home type patient (NHTP) accommodation benefits in Schedule 4, the second-tier default benefit arrangements (which operate together with sections 121-8A to 121-8D of the Act and Part 2A of the *Health Insurance Business Rules*), and the published categorisation of private hospitals in Schedule 5. For CHA members, this is the single most important instrument in the package. The minimum and second-tier default benefit framework is a core protection for both consumers and providers: it places a floor under reimbursement where a hospital and an insurer do not have a negotiated agreement. That floor matters most to the smaller, regional, specialist and mission-driven facilities (many of them CHA members serving under-served communities) that have the least bargaining power against large, increasingly consolidated insurers. The law is plainly still required.

CHA nonetheless considers that the Rules are not fully fit for purpose in their current form and recommends the following administrative improvements on remaking.

(a) Removal of spent and transitional provisions

The Rules carry transitional provisions that are now spent, including provisions tied to the commencement of the *Private Health Insurance (Reforms) Amendment Rules 2018* and to admissions in defined windows during 2019. Spent provisions clutter the instrument, obscure the operative law and create avoidable interpretive uncertainty for hospitals and insurers applying it. Their removal on remaking is an administrative improvement and is squarely within scope.

(b) Transparency and indexation of default benefits

The minimum default benefits, and the NHTP accommodation benefits in Schedule 4, are expressed as fixed dollar amounts that are adjusted periodically. Because these amounts are set in nominal terms, their real value erodes between adjustments, and the methodology and timing of indexation are not expressed in the instrument in a way that is transparent or predictable to providers. Within the administrative scope of this process, CHA recommends that the remade instrument state the indexation methodology and adjustment schedule clearly on the face of the Rules, so that providers can anticipate the floor that applies to them. Greater transparency of an existing mechanism is administrative in character; it does not require any change to the level of benefits.

Analysis by CHA members illustrates the scale of this erosion. The relevant default benefit rates have risen at a compound annual growth rate of approximately 2.5 per cent over the period from October 2011 to March 2026, which is below both the general Consumer Price

Index (approximately 2.73 per cent) and the health-specific CPI (approximately 3.4 per cent) over the same period. Had the rates instead been indexed to the health CPI, they would now be in the order of $612 and $424, rather than the current $540 and $376; yet the direct cost of an overnight stay alone, before any indirect or overhead costs, is approximately $680. Even health-CPI indexation would therefore fail to meet the direct cost of care. CHA recommends that the remade Rules adopt and disclose a transparent indexation methodology, for example an approach analogous to that used to set Department of Veterans' Affairs rates, on the face of the Rules.

(c) Second-tier default benefit calculation and categorisation

The second-tier default benefit is calculated by reference to the average negotiated charge for the relevant category of hospital, and a hospital's placement in a category is determined under Schedule 5 through an annual process. The Ernst & Young study of default benefit arrangements identified anomalies in the way second-tier rates are calculated, which can produce gaps and volatility in the schedules, and the categorisation process can place a hospital in a category that does not reflect its actual casemix. CHA distinguishes carefully here between policy and administration. Whether the second-tier percentage should change, and whether minimum default benefits for private patients in public hospitals should continue, are policy questions for the default benefits reform process, not for this remake. But the transparency of the calculation methodology, the timing and review mechanics of categorisation, and the correction of drafting that produces anomalous averages are administrative matters that can and should be addressed now. Remaking the instrument without addressing the calculation anomalies the Department's own commissioned review has already identified would re-enrol a known defect for a further decade.

As a concrete means of improving transparency within the administrative scope of this process, CHA suggests the second-tier benefit could be derived from the prior year's Hospital Casemix Protocol and private hospital data, disaggregated by State, with the current year's uplift percentage applied to like-for-like services. The present methodology is difficult to audit and to reconcile across differing funding models, DRG versions and MBS bundling arrangements, which makes a single industry-wide translation into a second-tier rate unreliable. Anchoring the calculation to published prior-year data for comparable services would make the methodology transparent, replicable and capable of independent verification.

(d) Sequencing with default benefit reform

Because the default benefit arrangements are under active review, CHA recommends the Department consider using the deferral or alignment mechanisms in the *Legislation Act 2003* so that the *Benefit Requirements Rules* can be remade in a form that gives effect to the outcome of that review, rather than remade now and amended again shortly afterwards. If deferral is not adopted, the remade instrument should at minimum be drafted so as not to entrench arrangements that the reform process may shortly change.

(e) Readmission 'Step Down' rules and the counting of continuous periods of hospitalisation across changes in care type

The minimum benefit tables in the Schedules to these Rules are calculated by reference to days of hospital treatment. Rule 3 of Part 1 defines a "continuous period of hospitalisation" to include any two periods of hospital treatment separated by not more than seven days, and Schedule 1 directs that, in counting days to determine the minimum benefit, days forming part of a continuous period of hospitalisation are counted together. The practical effect is a

readmission rule: a patient readmitted within seven days for a related condition is treated as a single, continuous episode, and the day count carries across the two admissions.

The difficulty is that the operative interpretation of this rule continues to rest on a Departmental circular issued several decades ago (circular HBF125/78) which on its own terms addresses readmission only as between episodes of the same care type (Medical (Other) to Medical (Other)). The Rules themselves are silent on whether, and how, a change in care type affects the counting of a continuous period. That silence is now being resolved administratively in a way that lacks a clear basis in the instrument. CHA understands that advice has been given to at least one insurer to the effect that days are counted continuously across a sequence of different care types (for example, a rehabilitation episode, followed within seven days by a related acute (Other Medical) episode, followed by a further rehabilitation episode, with all days aggregated regardless of the changes in care type).

CHA does not consider that outcome to be supported by the structure of the Rules. The Rules already recognise, in the nursing-home type patient context, that a change in care type is significant for the counting of days: where a nursing-home type patient is provided with acute care, clause 4 of the relevant Schedule provides that the patient ceases to be a nursing-home type patient for the days on which acute care is provided, and resumes that status when the acute care ends. The principle that a change in care type interrupts the relevant count is therefore already embedded in the instrument, but it is applied to a single transition only, and the position for other transitions, most importantly between rehabilitation and acute care, is left to a circular of considerable age and to inconsistent administrative advice. An instrument whose central day-counting concept depends on a circular that does not address the situations now routinely arising, and whose application to changes in care type is contested and unresolved, is not fit for purpose in the sense the *Legislation Act 2003* requires.

CHA therefore recommends that the readmission ‘step down’ rule be formalised on the face of the remade Rules – that the treatment of continuous periods of hospitalisation be set out in the Schedule in a way that expressly addresses changes in care type. Consistent with the principle already reflected for nursing-home type patients, and with the clinical reality that rehabilitation, acute and other care types are distinct episodes of care, the remade Rules should provide that a change in care type starts a new period for the purpose of counting days, rather than aggregating days across care types. Formalising the rule in this way is properly characterised as administrative: it resolves an existing ambiguity, codifies the matter in the instrument rather than in an obsolete circular, and gives hospitals and insurers a single, transparent and consistent rule to apply. To the extent any substantive element is involved, it is better settled now than left to contested, case-by-case interpretation for a further decade.

(f) Absence of a default benefit for hospital-in-the-home and hospital-substitute care

The *Benefit Requirements Rules* are presently silent on hospital-in-the-home: the term does not appear in the Rules, and there is accordingly no default benefit scheduled for hospital treatment delivered in this way, and no clear obligation on an insurer to pay one where there is no agreement. The Ernst & Young study identified this silence. The consequence for CHA members is that a hospital delivering clinically appropriate care in a patient's home, precisely the shift in models of care that the Private Health CEO Forum reforms are intended to encourage, does so without the statutory floor that applies to equivalent facility-based care.

CHA accepts that setting a default benefit for hospital-in-the-home, including its level and the methodology for calculating it, is a substantive matter for the default benefits reform process rather than for this remake. Our request is consistent with the approach taken elsewhere in this submission: that the remade Rules not be drafted so as to entrench a facility-only structure for a further decade, and that they be capable of accommodating a default benefit for hospital-in-the-home and other hospital-substitute care once that reform is decided. This point should be read together with our comments on the definition of hospital treatment (section 3.3) and on product coverage of out-of-hospital care (section 3.2).

There is also a clear historical precedent for such a benefit. Until the commencement of the Private Health Insurance Act 2007, an out-of-hospital ("outreach") default rate existed, set through a transparent approval process administered by the Department. CHA recommends that, rather than designing a new mechanism from first principles, the remade Rules reinstate a schedule analogous to the one that was omitted, updated for current costs. CHA notes that simply inflating the former rate by a compound annual growth rate of about 2.5 per cent would produce a figure (on members' analysis, in the order of $251) that falls a long way short of the present cost base. CHA's position is that a default benefit should at least meet the direct cost of the service provided – recognising that, even then, a hospital would remain approximately 20 to 25 per cent short on indirect and overhead costs.

Private Health Insurance (Complying Product) Rules 2015

Is the law still required? Yes.

Are the Rules fit for purpose in their current form? Yes in architecture, subject to updating to reflect decided reform.

These Rules define the clinical categories and the Gold, Silver, Bronze and Basic product tiers. They are central to hospitals because they determine, for any given admission, whether a complying policy is required to cover the treatment, and therefore whether the member hospital will be paid. The tier-and-clinical-category architecture introduced in 2018–19 is now embedded and underpins both consumer comparability and a degree of revenue certainty for providers. The law is required and the framework should be remade.

CHA's recommendations relate to keeping the instrument current and ensuring it does not foreclose decided reform.

(a) Alignment with the Clinical Categories Review and the MBS

The clinical categories have been the subject of a dedicated review, and the categories are defined by reference to Medicare Benefits Schedule (MBS) items that change over time. Where outcomes of that review have been settled, and where MBS item changes have occurred, updating the clinical-category definitions to match them is administrative maintenance. Remaking the instrument without these updates would lock outdated definitions in place for a decade and create unnecessary divergence between the categories and the MBS to which they refer.

CHA enters one important qualification to this alignment. MBS mapping should operate as a guide to, not a constraint on, the scope of a clinical category: aligning category definitions with the MBS must not be used to narrow or reclassify the cover a category provides. The Complying Product Rules specify the categories and tier requirements; they do not, and should not, define the detailed clinical content of treatment, which sits in the clinical category definitions and associated reform instruments. CHA further recommends that the remade Rules strengthen and clarify the consumer's position that other sub-classification systems

cannot override the plain meaning of a clinical category and its definition. In practice, some insurers narrow cover by applying diagnosis-related group (DRG) rules to reject claims, most commonly where coding assigns an admission to a mental health DRG even though the patient was admitted to an acute hospital for a different acute condition and, in many cases, underwent surgery. The remade Rules should make clear that such sub-classifying systems do not displace a clinical category and its definition.

(b) Compatibility with decided reform: maternity and out-of-hospital care

The reform package before the Private Health CEO Forum includes making maternity cover a standard inclusion across a greater number of policies, rather than effectively confining comprehensive maternity cover to the Gold tier, and requiring insurers to cover clinically appropriate, hospital-run models of care delivered outside the traditional inpatient setting, such as hospital-in-the-home. CHA strongly supports both directions on access and sustainability grounds, consistent with our long-standing position that the next major productivity opportunity for the sector lies in well-supported out-of-hospital care. We recognise that moving maternity down the tiers, or mandating coverage of particular models, are policy decisions outside the scope of this consultation. Our request is narrower and properly within scope: that the remade *Complying Product Rules* be drafted so that their clinical-category and product-tier definitions do not inadvertently exclude or disadvantage clinically appropriate out-of-hospital and hospital-substitute care, and that the remaking timetable be capable of accommodating these reforms as the vehicle for them once Government decides them.

Private Health Insurance (Health Insurance Business) Rules 2018

Is the law still required? Yes.

Are the Rules fit for purpose in their current form? Yes, subject to clarification of the boundaries of “hospital treatment.”

These Rules are foundational for CHA members. Among other things, they qualify the definition of hospital treatment, set out matters to which the Minister must have regard in declaring or revoking a facility’s declaration as a hospital under section 121-5 of the Act, and contain Part 2A, which is relevant to second-tier eligibility. The definition of hospital treatment and the hospital-declaration framework determine whether a facility is recognised as a hospital at all, and whether the care it provides attracts hospital-treatment benefits. For our members these are existential questions. The law is required and the instrument should be remade.

(a) The definition of hospital treatment and emerging models of care

The current definition, and its exclusions, were framed largely around facility-based inpatient care. As care increasingly shifts to hospital-substitute, same-day, virtual and hospital-in-the-home models, the boundaries of “hospital treatment” have become a live and recurring source of dispute between hospitals and insurers about what attracts a benefit. CHA recommends that the remade instrument clarify the treatment of clinically appropriate hospital-substitute and hospital-in-the-home care so that it is not excluded by drafting designed for an earlier model of care. Where clarification merely aligns the definition with how care is now safely and appropriately delivered, and with decided government policy, it is properly characterised as restoring fitness for purpose. Where a substantive coverage mandate is involved, CHA again asks that the remade Business Rules be the vehicle for it once Government decides the matter.

The definition of hospital treatment and hospital-substitute treatment must also be aligned with adjacent legislation that bears on cost-effective models of care. In particular, section 94 of the National Health Act 1953 permits a hospital authority to supply pharmaceutical benefits only to patients receiving treatment in or at the hospital, which technically restricts a hospital from supplying medicines for use in out-of-hospital care. Unless this interaction is addressed, the instruments will continue to work at cross-purposes – the private health insurance framework recognising hospital-substitute care while the National Health Act impedes the supply of the medicines that such care requires. CHA recommends the remaking be coordinated so that the definition of hospital treatment and the pharmaceutical-supply provisions operate consistently. CHA also asks the Department to consider whether hospital treatment should be expanded to include a benefit for attendance at a private hospital emergency department.

(b) Telehealth and other exclusions

The Business Rules exclude certain MBS telehealth and phone-service items from the definition of hospital treatment, a number of which derive from temporary items introduced during the COVID-19 period. Given that telehealth now has a permanent place in care delivery, CHA recommends the Department review whether these exclusions remain appropriate and current. Updating exclusions that derive from spent or temporary measures is an administrative correction.

This review should also address the absence of appropriate MBS arrangements for hospital-in-the-home. Because the definition of hospital treatment and its exclusions are framed by reference to MBS items, hospital-in-the-home cannot be properly recognised or billed without a relevant MBS item. CHA recommends that the remaking be progressed in tandem with the development of appropriate MBS arrangements for hospital-in-the-home care.

(c) Hospital declaration criteria

CHA asks that the matters to which the Minister must have regard in declaring or revoking a hospital declaration be reviewed to ensure they remain workable and do not impose avoidable administrative burden on smaller and charitable facilities seeking or maintaining declaration. Any change here should be minor and administrative.

CHA further recommends that the Department be made responsible for publishing, and keeping up to date, the declared specialties and bed numbers of declared hospitals. A current, public register of this kind would materially improve transparency across the sector and would support the operation of the second-tier and categorisation arrangements discussed above.

Private Health Insurance (Risk Equalisation Levy) Rules 2017 (sunsetting October 2027)

Is the law still required? Yes.

Are the Rules fit for purpose in their current form? Yes as to levy mechanics; CHA records a connected observation about the underlying design.

These Rules support the risk equalisation levy framework, which underpins community rating. Community rating is what allows older Australians to obtain private cover without being priced out by age, and it is therefore directly connected to the demand for the private hospital care that CHA members provide. The law is required and the instrument should be remade. CHA notes that this instrument concerns the levy itself, and is distinct from the Risk

Equalisation Policy Rules and the Risk Equalisation Administration Rules on which CHA commented in its March 2025 submission to the earlier sunsetting consultation.

CHA confines itself to one hospital-relevant observation, carried forward from that earlier submission. The retrospective design of risk equalisation influences the way insurers weight revenue across procedures, tending to over-weight procedures more commonly used by older patients, such as joint replacements, while under-weighting services used by younger patients, such as maternity and mental health care. That weighting flows through to hospital reimbursement and contributes to private hospital payment rates that do not reflect the actual cost of services. CHA acknowledges that fundamental redesign of risk equalisation, including a prospective or hybrid model that better matches expected differences in claim costs by age and sex, as identified in the Finity review, is a policy matter outside the scope of this consultation. Our point is a legal one directed at the remaking itself: a finding that the Levy Rules are fit for purpose as administrative machinery should not be read across as a finding that the underlying risk equalisation design is optimal, and CHA asks that its continuing support for reform of that design be recorded.

Instruments on which CHA does not provide detailed comment

The remaining three instruments (the P*rivate Health Insurance (Accreditation) Rules 2011*, the *Private Health Insurance (Incentives) Rules 2012 (No. 2)*, and the *Private Health Insurance (Lifetime Health Cover) Rules 2017*) are primarily consumer- and insurer-facing. They concern, respectively, the accreditation of those who broker private health insurance, the administration of the private health insurance rebate and related incentive payments, and the Lifetime Health Cover loading. They have limited direct application to the operation of hospitals.

Consistent with the focus of this submission, CHA does not provide detailed comment on these three instruments. We confirm that, in our view, the underlying laws remain required – community rating, the Lifetime Health Cover loading and the rebate and incentive architecture are integral to participation in private health insurance, and participation in turn sustains demand for the services CHA members provide – and we support their remaking.

We make one connected observation. The value of these participation settings to private hospital viability cannot be assessed in isolation from other recent decisions, including the 2026 Budget measure to remove the age-based rebate uplift for Australians aged 65 and over. While that measure is a separate policy matter, it reinforces the case for remaking the incentive and Lifetime Health Cover instruments in a form that preserves maximum administrative flexibility to adjust settings as participation pressures evolve, rather than in a form that entrenches arrangements that may need to respond to changing participation.

Other changes to improve administrative efficiency

In response to the consultation's final question, CHA makes the following cross-cutting recommendations to make the instruments administratively more efficient on remaking. Each is administrative in character and directed at clarity, currency and avoidance of duplicated process:

1. Remove spent and transitional provisions from each hospital-relevant instrument, so that the operative law is clear on its face.
2. Consolidate accumulated amendments into clean principal instruments, rather than carrying forward layers of amending rules that make the law harder to apply.
3. Update and align all cross-references and definitions – to the Act, to the Medicare Benefits Schedule, to settled clinical-category definitions, and between the Benefit

Requirements, Complying Product and Health Insurance Business Rules – so that the instruments remain internally and externally consistent.

4. Use the deferral and alignment mechanisms in the *Legislation Act 2003* to sequence the remaking of the *Benefit Requirements Rules* (and, where relevant, the *Complying Product and Health Insurance Business Rules*) with the default benefits and clinical categories reform processes, so that these instruments are remade once in a reform-ready form rather than remade and then promptly amended.
5. Adopt a purposive view of "administrative," so that drafting corrections required to keep the instruments aligned with current models of care and decided government policy are made on remaking rather than deferred.
6. Formalise the readmission 'Step Down' rules in the Schedule to the *Benefit Requirements Rules*, expressly addressing how continuous periods of hospitalisation are counted across changes in care type, so that the rule no longer depends on the ageing circular HBF125/78 and so that, consistent with the treatment of nursing-home type patients already in the Rules, a change in care type is recognised in the day-count.