Members Health
FUND ALLIANCE

4 September 2026

General Manager
Policy and Frameworks
Policy and Advice Division
Australian Prudential Regulation Authority

By email: PolicyDevelopment@apra.gov.au

Dear General Manager,

Re: Governance Review – Consultation Response – August 2026

Members Health Fund Alliance (Members Health) welcomes the opportunity to provide feedback on the Australian Prudential Regulation Authority (APRA's) Governance Review Consultation Paper which contains a series of proposals to strengthen APRA's core prudential standards and guidance on governance.

Members Health represents more than 20 private health insurers, comprising of not-for-profit, member-owned, regional, and community-based funds for over 5.4 million Australians. Our member funds are committed to providing quality and affordable health insurance to key communities and industry groups, including military families, teachers, police, nurses and midwives, transport, mining and doctors.

Members Health funds are owned by their members, not shareholders. As mutual not-for-profit organisations, any surpluses are reinvested in the business by returning greater benefits to policyholders.

Members Health acknowledges APRA's role to maintain fit for purpose prudential standards and guidance on governance across regulated industries. We also wish to acknowledge and put on record our appreciation to APRA for being forthcoming with briefings on these important matters both for Members Health's management team and members of the Members Health Governance Risk and Compliance Committee.

Our member funds are committed to a strong, stable, and consumer focused private health insurance sector, and we recognise the critical role of robust governance practices in achieving this.

Members Health generally supports APRA's objective of strengthening governance outcomes and appreciates APRA's willingness to reduce prescription in several areas following earlier consultation. We consider that many elements of the draft standard reflect contemporary governance practices already adopted by private health insurers. However, we recommend further refinement in the areas raised under Attachment A – Response to Key Questions and Attachments B and C which relate to specific requirements under CPS-510 and CPS001 respectively.

A consistent theme throughout our submission is the need for greater recognition of proportionality and flexibility in the application of any new requirements. As this submission will further detail, assigning proportionality based on an entity either identifying as significant or a non-significant institution, inadvertently creates unintended consequences for healthcare consumers and risks imposing undue burden on health funds, separating them from their communities of interest and reducing their accountability and connection to their member communities.

In reviewing the governance proposals, without consideration of further proportionality reform, Members Health encourages APRA to maintain a degree of flexibility in developing guidance to allow for proportionality and practicality in application. This is particularly the case for smaller, regional, member owned and restricted access health insurance funds. Members Health believe it is crucial for APRA to consider the unique operating models, ownership structures, and community-focused objectives of not-for-profit and member-owned health insurers when developing prudential standards and guidance on governance.

The prudential risk profile of private health insurers is significantly lower than the risk profile of other APRA regulated industries. It is difficult to foresee a situation where the failure of a private health insurer could result in a significant direct financial loss for a consumer, which is in stark comparison to the failure of a bank, life insurance or superannuation fund - which could result in the loss of a customer's life savings or the inability of the customer to access cash to fund the most basic living expenses. If APRA is seeking to take a risk-based approach to regulation, there is strong argument that the level of regulation applied to private health insurers in almost all areas should be lower than that applied to other APRA regulated industries.

Members Health's submission outlines our collective response to the key amendments proposed within the draft standards. These have been developed in close consultation with our member funds. It should be noted that the points raised may not apply equally - or at all - to every individual Members Health fund but rather, represent the broad feedback of our member funds.

General Feedback

Robust governance has been foundational to the stability, integrity and success of the not-for-profit and member-owned health insurance sector, and Members Health commends APRA for initiating this important review of its governance Prudential Standards, noting that this is the first material revision for CPS-510 and CPS-520 since 2019.

Our members' governance frameworks are long established, and mature practices are well entrenched. With the implementation of CPS-511 and FAR, our members built on those strong foundations to further uplift practices and ensure high-performing governance frameworks that are resilient to changes in the business.

Members Health generally supports APRA's objective of further strengthening governance practices and encourages APRA's intention to reduce prescription in several areas following past consultation. We consider that many elements of the draft standard reflect contemporary governance practices already adopted by private health insurers.

We believe the consultation process has materially improved the draft standard and encourage APRA to further recognise the unique characteristics of mutual private health insurers by ensuring the final framework remains focused on measurable governance outcomes rather than additional procedural or documentary requirements. We support seeing appropriate enhancements implemented where there is a demonstratable need.

We have identified areas that would benefit from further refinement and have set out our recommendations below.

1. Implementation Date (CPS-520 will remain in effect for the first half of FY28)

Members Health does not support that the implementation date will reduce burden.

The proposed implementation date of 1 January 2028 will substantially, and unnecessarily, increase the regulatory burden on private health insurers during FY28.

Under HPS-310 (paragraph 11(b)(ii)), *a private health insurer must engage the Appointed Auditor to prepare an annual report that at a minimum, must address: (b) limited assurance regarding … (ii) the private health insurer's systems, procedures and internal controls that are designed to ensure that the private health insurer has complied with all applicable prudential requirements are adequate, has operated effectively throughout the year of income*.

Meaning, the current requirements under both CPS-510 *and CPS-520* will be in effect during the first half of FY28 (until 31 December 2027), and the new requirements for CPS-510 will come into effect for the 2nd half of FY28 (commencing 1 January 2028).

This poses an impractical burden for demonstrating regulatory compliance during FY28.

For example – if a new director commences any time prior to 31 December 2027, they will still be subject to all prudential requirements under CPS-520, and the Appointed Auditor will expect that adequate controls were in place during this time to ensure compliance with CPS-520.

Members Health recommends moving the commencement date to 1 July 2028.

2. Transition period for effective Board renewal

Members Health does not support that the implementation date will allow for effective Board renewal where the majority of directors on a Board are near, have reached or already exceed the 12-year tenure limit.

Particularly for community-based, member-owned, not-for-profit, restricted and regional health insurers, there are nuanced challenges in recruiting suitable candidates. Even if funds start recruiting now, there would be little time to attract, nominate, elect (at the next AGM), onboard and build sufficient corporate, industry and regulatory knowledge to support effective board renewal without compromising the overall performance of the Board, and ultimately the Board's capability to act in the best interests of the entity and its policyholders.

Effective Board renewal relies on a staggered approach where the retirement of a number of directors falls into a cycle and there is a crossover period with onboarding a number of new directors. The remainder of the Board has approximately three to nine years' experience which ensures continuity and established high-performance. This approach allows for sufficient time to transfer knowledge, share invaluable insights and context, and maintain continuity as a high-performing Board.

For Boards with the majority of directors nearing or exceeding a 12-year tenure limit now, there is a risk that a Board hurrying to comply with the new requirement will result in an abrupt loss of significant corporate knowledge which would be sufficiently detrimental to the Board's skills mix that renewal would ultimately be futile. The risk of having a Board with the majority of directors exceeding a 12-year tenure is not commensurate with jeopardising the Board's performance.

Members Health recommends allowing entities to apply for exemptions which would grant sufficient time to implement a practical transition plan for Board renewal.

3. Proportionality should extend beyond the SFI/non-SFI distinction

Members Health does not support that there is a sufficient distinction for proportionality.

The draft standard relies heavily on the distinction between SFIs and non-SFIs. While this is a useful starting point, it does not adequately recognise the materially different governance, prudential and systemic risk profiles that exist across APRA-regulated industries.

Under the *Financial Services Reform Act* 2001 (subdivision D 765A), health insurance provided by a health insurance business was specifically excluded as a financial product. The products of all other regulated-industries, including general and life insurance, were included. This sets a precedent that a distinction has already been recognised in legislation between the private health industry and all other regulated-industries who sell *financial products*.

Categorising private health insurers as financial institutions (significant or non-significant) suggests that a private health insurer should be treated as if they sell financial products and pose the same level of threat to the stability of Australia's financial system as banks, superannuation funds, general and life insurers.

In recognition of APRA's announcement (27 May) with regards to formalising a three-tiered approach to proportionality in the banking prudential framework, for the benefit of small and medium-sized banks, Members Health strongly encourages APRA to consider further proportionality reform to get the balance right between its primary mandate for financial safety and stability with other considerations such as competition and efficiencies that would ease the burden for private health insurers.

The proposal to introduce a third tier for Most Significant Financial Institutions (banks with total assets greater than $300 billion), could be complemented by introducing a fourth tier for Least Significant Non-SFI (private health insurers with total assets less than $amount[1]), noting that the entire private health industry holds total assets around $20 billion.

Furthermore, Members Health funds are member-owned and not-for-profit. Meaning they fundamentally present different governance and financial stability risks to those represented by other industries and organisation types.

Rather than rely primarily on SFI status, we encourage APRA to expressly consider that proportionality should take into account the systemic differences between private health insurers and other regulated-entities, noting that:

- private health insurers do not sell financial products[2];
- health insurance businesses are inherently different to other financial institutions;
- the prudential risk profile for a private health insurer is substantially lower than an ADI, Superannuation fund, General or Life Insurer;
- the total assets across the private health industry are substantially lower[3];

[1] Further consultation will be required across the private health insurance industry to determine a reasonable threshold for total assets commensurate with a fund's size, complexity and business mix.

[2] as stated in the *Financial Services Reform Act* 2001.

[3] according to the RBA (March 2024) ADIs held $6,260b; superannuation $3,695b; general insurers $297b; life insurers $124b; and private health insurers $20b

- organisational complexity is substantially different for not-for-profit organisations;
- ownership structure is substantially different for mutual organisations;
- business models must meet legislative nuances under the Private Health Insurance Act 2007, that do not apply to other regulated-entities and have a direct impact on how a private health insurer can achieve efficiencies and competitive advantages (e.g. under community rating, health insurers can't refuse coverage or charge more based on a person's health or medical history – everyone pays the same price for the same policy. Life insurers can charge more based on a person's health and medical history – different people can pay different prices for the same policy.); and
- governance maturity across the private health industry is already high given the fundamental aspects of CPS-510 have been in place since 2019.

Without further guidance to differentiate proportionality for health insurance businesses there is a likelihood that governance obligations, designed principally in response to issues identified in financial institutions, will impose disproportionate compliance burdens on not-for-profit, mutual health insurers.

Members Health acknowledges that APRA is willing to consider further engagement in relation to proportionality reform and looks forward to collaborating in the near future.

4. Board effectiveness should not be equated with director tenure

Members Health does not support that tenure should be equated with Board effectiveness.

Members Health supports orderly board renewal and succession planning. However, director tenure should be viewed as only one component of broader Board effectiveness.

We believe that a focus on outcomes – a high-performing, well-governed board – should take precedence over rigid prescriptive rules on tenure limits, especially when such rules could negatively impact the ability of member-owned funds to serve their communities effectively.

Longer-serving Board directors of regional health funds often embody and reinforce this critical community connection, bringing invaluable local insights and relationships that are fundamental to a fund's ability to effectively serve its members in these areas. These funds, face particular challenges in recruiting and retaining skilled directors. The pool of available talent with relevant expertise and a connection to the local community is often limited, making strict tenure limits particularly problematic. It is integral that these Members Health funds maintain their deep connection to the local communities they serve.

In mutual organisations, board effectiveness is driven through a combination of:

- annual performance assessment;
- director independence assessment;
- independent Board reviews;
- board skills and capability reviews;
- succession planning; and
- structured renewal processes.

Members Health encourages APRA to avoid creating an implicit presumption that longer-serving directors necessarily present governance concerns, particularly where there is evidence of ongoing effectiveness, independence, strong performance outcomes and appropriate succession planning.

Our members raised a number of concerns that would impact a Board's effectiveness if a strict 12-year tenure was imposed. Such scenarios include:

- a director is temporarily appointed mid-term and due to the timing of the AGM, their planned retirement would exceed a 12-year tenure by more than 12 months;
- a director, who was recruited to replace the skills and capabilities of a retiring director, unexpectedly resigns due to unforeseen circumstances, and the retiring director agrees to stay beyond their 12-year tenure to allow for the recruitment and transfer of corporate knowledge to a new director;
- the Constitution of a not-for-profit, restricted fund, requires its directors to be sourced from the community-base, and to volunteer their services (without remuneration). The time required to attract, appoint and onboard appropriately skilled directors, transfer corporate knowledge, develop industry-specific and regulatory experience, and then achieve a high-performing Board while staggering renewal, is foreshadowed to be a significant challenge that is unlikely to serve the members' best interests or would be commensurate with the entity's risk exposure;
- staggering Board renewal to meet tenure limits creates a disproportionate challenge for small, regional funds with a significantly reduced pool of suitably qualified directors, particularly where directors require APRA, PHI and mutual governance experience, familiarity with the industry nuances (such as community rating) together with the knowledge of regional communities and localised member needs;
- misaligned terms and tenures where staggered renewal falls outside of election cycles and would benefit from limits to the number of terms a director can serve, rather than limit the number of years a director can serve;
- within a corporate group, cross-appointed directors may serve for 12 years on appointment to the group and subsequently to a group entity (i.e. could serve for 12-years on one group entity, and then be appointed to another group entity);
- in a merger transaction, a director on a current Board needs sufficient experience to act as an effective steward to represent the current entity's best interests, participate in the merger process (concept > settlement) and possibly be appointed to the successor entity's Board. If the majority of directors from both merging entities have already served nine years, and the terms of the merger require ongoing appointments to ensure continuity of corporate knowledge and member representation, the majority of the Board's tenure would expire within three years of forming the successor entity. In that case, a 12-month extension would not be sufficient to ensure the ongoing effectiveness of a high-performing Board.

Members Health acknowledges provisions have been included in the proposed requirements to allow a Board to extend a term by up to 12 months in exceptional circumstances, or by applying for an exemption from APRA setting out the reasons for the request.

Members Health recommends allowing for flexibility in director tenure, acknowledging the unique organisational complexity of not-for-profits and ownership structure of mutual organisations, and recognising that board renewal can be achieved through mechanisms other than mandatory tenure limits. The guidance would benefit from including examples of exceptional circumstances where an exemption would be granted.

5. Mutual governance models require specific recognition

Members Health does not support that there is a one-size-fits-all governance model that would be suitable to apply to all regulated-entities considering many private health insurers

operate under constitutional arrangements that differ significantly from listed companies and large institutional groups.

For mutual organisations (registered health insurer businesses):

- directors are elected by members whose primary interests relate to accessing affordable health care, as opposed to shareholders whose primary interests are financial returns through dividends and capital growth;
- appointment processes may be prescribed by constitutions, such as elections and member voting at annual general meetings;
- director recruitment pools may be more limited, particularly for restricted funds or community-based funds in regional areas;
- directors often require specialised prudential, mutual and industry experience; and
- board renewal must be balanced against member representation and continuity of organisational knowledge.

Members Health encourages APRA to recognise these factors when developing final requirements relating to tenure, renewal and succession planning to ensure that governance outcomes remain practical and proportionate for mutual and not-for-profit organisations.

6. The test for independence should distinguish between interfering and influencing

Members Health does not support that the new definition of independence will improve the Board's composition that enforces a majority of independent directors, and the directors' capability to apply independent judgement to bear on issues or act in the best interests of the regulated entity.

Under CPS-510 (*current* and *proposed*), the Board composition must have a majority of independent directors, and a chair that is an independent director.

The *current* test of independence relies on a non-executive director being free from any business or other association (including a substantial shareholding, involvement in past management or as a supplier, customer or advisor) that could materially interfere with the exercise of independent judgement.

Materially interfering with the exercising of independent judgement would require a director to behave in a manner that secretly, coercively or deceptively exerts pressure to manipulate an outcome in their favour.

The *proposed* amendment for test of independence relies on a non-executive director being free of any interest, position or relationship that might materially influence their capacity to exercise independent judgement to bear on issues and to act in the best interests of the entity as a whole rather than the interests of another party.

Materially influencing the exercising of independent judgement would require a director to behave in a manner that shapes opinions or decisions through open, honest and transparent discussion.

Members Health deems an effective Board should be comprised of directors who are encouraged to exercise independent judgement by influencing outcomes through sharing opinions, ordinary persuasion and participating in open, honest and transparent discussions.

Changing the test of independence, from interfering to influencing, fundamentally changes the threshold for a director to be considered an independent director.

Currently, the majority of directors on our members' Boards are considered to be independent. Although many of the directors on community-based Boards are likely to also be policyholders (customers) of their funds, they pass the test of independence as long as there is no material interference with their exercise of independent judgement.

Under the proposed change, those same directors are unlikely to pass the test of independence as presumably their interest, position or relationship with the entity as a policyholder (customer) would materially influence their exercise of independent judgement as the membership would have elected them to represent their interests, as well as the entity as a whole.

We wish to emphasise that for not-for-profit and member-owned health funds, the concept of independence can carry nuances. Members Health funds have inherent connection to their membership and local communities, particularly as policyholders advocating for outcomes that will benefit the member-base as a whole.

While independent judgement is important, so too is the inherent independence of thought and action that comes from a director's obligation to act with a duty of care by sharing opinions, and participating in open, honest and transparent discussions to influence decisions that, when exercising their independent judgement, they believe is acting in the best interests of the membership and inherently the entity as a whole.

Members Health recommends the test of independence reverts to using the term interfering, or replaces the term influence with undue influence.

7. Governance uplift should focus on outcomes rather than additional documentation

A number of proposed requirements appear likely to drive the creation of new governance documents, policies and plans despite many entities already meeting the underlying governance objective through existing frameworks.

For example, entities should not be required to create standalone governance documents where the relevant requirements are already addressed through:

- board charters;
- committee charters;
- governance frameworks;
- risk management frameworks;
- policy frameworks; or
- Board reporting standards.

The focus should remain on governance effectiveness rather than document proliferation.

For example – Conflicts Management – the proposed further requirement to maintain and disclose disclosure registers of duties and interests will place further undue burden on health funds without any tangible benefit. Members Health funds already have strong and robust mechanisms in place to manage the overall integrity of their governance arrangements.

We encourage APRA to clarify that entities may rely on existing governance artefacts where they substantively satisfy the relevant requirement.

8. Greater clarity is required regarding the interaction between FAR, CPS-511, Responsible Persons and Senior Managers

The draft standard introduces, or expands upon, several overlapping concepts including:

- accountable persons;
- responsible persons;
- officers;
- 'persons in specified roles'; and
- senior managers.

The overlaps are set out under different legislation with slight variations to the meaning and intent of the requirements.

In practice, the same individual may fall into multiple categories, creating uncertainty regarding:

- defining responsibilities for a specific position description – such as a chief executive officer who is also a director;
- applicable obligations under various legislation including the FAR Act, Corporations Act, Private Health Insurance Act, Private Health Insurance Prudential Supervision Act;
- assessment requirements;
- reassessment triggers; and
- governance accountability.

For example, a chief executive officer role has responsibilities as an Accountable person (under FAR Act), a fit and proper person (under CPS-510), an Officer (under the Corporations Act and the PHI Act), a 'person in a specified role' (under CPS-511); and a senior manager (under CPS-001, unless they are also a director).

Members Health recommends further consideration for to the intended interaction between these regimes and reducing implementation complexity by simplifying the application across overlapping legislation.

9. Fit and Proper requirements should remain focused on suitability rather than performance management

The draft standard appears to create a closer connection and cross-over between:

- annual performance assessments;
- board skills matrices; and
- fit and proper assessments.

Members Health supports rigorous assessment of fitness and propriety. However, we are concerned that the final framework should clearly distinguish between:

- a capability development opportunity or performance improvement matter; and
- a genuine fitness and propriety concern.

The existence of a performance issue, skills gap or development need should not automatically trigger conclusions regarding a person's fitness and propriety unless there is evidence that the person no longer satisfies the relevant suitability criteria.

Having fit and proper assessments rely on performance assessments will undermine a Board's autonomy in dealing with performance matters and, separately, determining whether the severity and extent of the performance issues warrant the re-assessment of a director's fitness and propriety.

Members Health recommends that fit and proper assessments and performance assessments are treated separately, as is current practice.

10. Guidance should recognise entities with mature governance frameworks

Members Health does not support the prescriptive requirements for governance frameworks where these would require a substantial redesign of already embedded and mature practices.

Many private health insurers already maintain mature governance frameworks that incorporate:

- board and committee evaluations
- board skills matrices
- succession planning
- fit and proper assessments
- conflicts management frameworks; and
- governance reporting requirements.

Members Health recommends that the requirements allow for entities to implement the requirements in a manner consistent with their existing governance framework rather than requiring substantial redesign of practices that are already operating effectively.

11. Duplicated requirements across different prudential standards

Members Health does not support that the compliance burden has been sufficiently reduced as many of the proposed requirements appear to restate and 'codify' governance elements which are existing requirements and guidance across a number of other Standards and related legislation.

There are a number of requirements across CPS-220, CPS-230, CPS-234, and CPS-511, that cross-over and create a more complex regulatory framework without achieving any practical benefits.

For example – under CPS-220, *the Board must provide APRA with an annual risk management declaration stating that, to the best of its knowledge and having made appropriate enquiries, there are systems for compliance with all prudential requirements*.

Under the proposed requirements for CPS-510, this is repeated that the Board must *make the annual risk management declaration*.

The proposed change duplicates the existing CPS-220 requirement without achieving any practical benefits. It unnecessarily increases the regulatory burden where a governance audit or review of either CPS-220 or CPS-510 now needs to include consideration of the cross-over requirements.

Members Health recommends that the final standard takes into consideration the overlapping relationships with requirements, and guidance, already set out under other prudential standards and provides clarity on transitional arrangements where further reform is intended for related requirements.

Conclusion

Members Health commends APRA for initiating this important review of its governance prudential standards. Robust governance has been foundational to the stability, integrity and success of the not-for-profit and member owned health insurance sector, and we are committed to seeing appropriate enhancements implemented where there is a demonstratable need.

Members Health believes that effective governance is achieved not through rigid prescription, but by empowering boards to adapt best practices to their specific circumstances while upholding the highest standards of accountability.

We strongly urge APRA to avoid introducing prescriptive requirements that could lead to redundant efforts and unnecessary compliance costs, without a demonstrable improvement in governance outcomes, and to recognise the unique operating models and community focus of the member owned and not-for-profit health insurers, especially concerning director recruitment and retention and the preservation of crucial institutional knowledge and connection to community that often comes with longer-serving directors.

If you have any questions or wish to discuss our submission further, please contact Members Health Head of Policy and Research, [redacted]

We look forward to continued engagement on these important matters.

Yours sincerely,

[redacted]

[redacted]

Attachment A – Response to Key Questions

The following responses are intended to provide feedback for specific questions asked by APRA. The MHFA has answered the questions from the perspective of its members and the various stages in terms of pre-implementation readiness activities, and compliance once the changes come into effect.

Members Health's submission outlines our collective response to the key questions posed in relation to the draft standards. These have been developed in close consultation with our member funds. It should be noted that the points raised may not apply equally - or at all - to every individual Members Health fund but rather, represent the broad feedback of our member funds.

Proposed Prudential Standard CPS 510 Governance	
Members Health offers specific advice on the following questions posed by APRA.	
Question	MEMBERS HEALTH Response
1 (a)	***Proportionality and transition*** ***Do the draft CPS-510 requirements operate proportionately across different entity types, sizes and structures?*** Further to the general feedback provided in our letter, there are specific areas that would benefit from further proportionality reform by acknowledging the substantially lower risk that private health insurers pose to the stability of the Australian financial system. The wins we were anticipating in reduced regulatory burden have been exchanged with new requirements that will increase regulatory burden. By simplifying the regulatory framework to consolidate the number of standards, many of the requirements that previously only applied to other regulated-industries will now apply to private health insurers. For example: HPG-520 already sets minimum expectations for a written fit-and-proper policy addressing requirements for a fit and person to be assessed as competent. HPG-520 is widely considered to set appropriate guidelines for private health insurers to meet fit and proper requirements. The proposed draft consolidates cross-industry requirements and now increases the burden on private health insurers to include assessment criteria such as performance objectives, performance assessments, professional references, findings from courts/tribunals/regulators, and alignment with the skills matrix for directors, rather than the collective Board. Another example: introducing a new requirement that a lead auditor or review auditor cannot be appointed to the role of a director or senior manager until two years have passed, would have a disproportionate impact to a small, community-based private health insurer who is challenged to find candidates with the relevant skills, expertise and knowledge (corporate, industry and regulatory) to take on a

director or senior manager role, compared to a large SFI with a significantly larger recruitment pool.

Applying the same level of burden across other regulated-industries and private health insurers is not commensurate with the level of risk a private health insurer poses to the stability of the Australian financial system.

While proportionality typically allows for compliance with requirements to be 'commensurate' with an entity's business mix, size and complexity, the word 'commensurate' does not exist in the draft. Rather requirements rely on whether an entity is considered to be an SFI or non-SFI, which doesn't go far enough to ensure the requirements are proportionate across different entity types, sizes, structures, finance industries (banking, superannuation, life or general insurers) and private health insurers.

MEMBERS HEALTH Recommendation

Members Health strongly recommends APRA considers further engagement with private health insurers to improve proportionality across the broader prudential framework and to further consider the practicality of adding unnecessary regulatory burden to health insurers.

1 (b)

Proportionality and transition

Are transitional arrangements needed in specific areas to support orderly and timely implementation?

Further to the general feedback provided in our letter, in relation to the implementation date and board renewal challenges to meet the proposed 12-year tenure limit, the transition arrangements need to consider how duplicated requirements across different Standards will be treated, as well as allowing sufficient time for entities to amend their Constitutions, once the final requirements have been published, and transition to meet the new *auditor independence test* requirements and the new *test of independence* for directors.

The transition timing will be a challenge for some funds should they need to amend their Constitution, allow for the orderly execution of the appropriate resignation, nomination and appointment processes for directors (beyond 12-year tenure) and Lead / Review Auditors (beyond five-years in a significant role).

A number of requirements have been duplicated across other standards – mostly CPS-511. APRA has advised that CPS-511 will be amended to remove the duplication. Ideally a timeline would be helpful for the transition of requirements that will be in effect simultaneously and when the duplication will be resolved.

Those whose current maximum tenure limit exceeds 12 years, and will require an amendment to their Constitution to support the changes, are concerned that there may not be enough time to present the changes at their AGM for approval by

	members, particularly if the review will be out-of-cycle or the next AGM date is not due until 2027, or if there are unrelated changes that must be made to the Constitution and the Fund wishes to present all changes at the one AGM. More broadly, sufficient implementation time will be required after the issuance of final guidance in CPG 510 to ensure the guidance can be properly considered and incorporated into compliance activities. Our concern is that the proposal has the potential to create considerable complexity in Board administration and member elections, with limited obvious prudential benefit, and it seems reasonably clear that some refinement is warranted. **MEMBERS HEALTH Recommendation** *Members Health recommends:* *1. Allow funds to apply for exemptions that:* *(i) extend the 12-year tenure limit for directors;* *(ii) allow funds sufficient time to amend their Constitutions to meet requirements that are yet to be finalised.* *2. Allow funds to exempt Lead and Review Auditors from the 'auditor independence test' (five-year rule) and appointment to a Senior Manager or director role (within two years since acting as the Lead or Review Auditor).* *3. Clarify how new requirements will be treated where the consequence is existing requirements will be duplicated in related Standards.* *4. Clarify the treatment of existing fit and proper information held by APRA. Will this be retained or returned to a Fund's data custodians?*
2 (a)	***Reviews and assessments*** ***Are the reviews and assessments required by the draft standard appropriately scoped?*** The reviews and assessments will introduce new compliance burdens, particularly in relation to the new requirements for a fit and proper assessment to include a director's performance objectives and performance assessment, and new annual assessments of policies and performance. Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members. While removing the routine reporting for fit and proper is supported, there are concerns that the effort required to implement the new requirements around reviews and assessments will outweigh the anticipated benefits. **MEMBERS HEALTH Recommendation**

Proposed Prudential Standard CPS 510 Governance	
	Members Health recommends considering whether the requirements for private health insurers to conduct annual reviews and assessments are commensurate with the risks posed by health insurers, particularly small, member-owned, not-for-profit entities already with mature governance frameworks.
2 (b)	***Reviews and assessments*** ***Do the mechanics provide sufficient flexibility to allow reviews to be combined where this supports efficiency and effectiveness?*** The mechanics allow reviews to be combined, however the timing and number of the annual reviews could be less prescriptive, particularly for health insurers who are member-owned and not-for-profit. **MEMBERS HEALTH Recommendation** *Members Health recommends reviewing the number of reviews and assessments that must be completed each year and whether this is commensurate with the risk exposure of a member-owned, not-for-profit, private health insurer.*
3 (a)	***Fit and proper streamlining and FAR alignment*** ***Do the proposed changes appropriately reduce duplication, including the removal of routine reporting and the narrowing of the responsible person cohort?*** Members Health supports the removal of routine fit and proper reporting. Streamlining and alignment could go further where there is still overlapping legislation for the identification and treatment of accountable persons (under the FAR Act), responsible persons (under the PHIPS Act new CPS-510), officers (under the Corporations Act), 'persons in specified roles' (CPS-511), and the newly introduced requirements for senior managers (defined under the PHIPS Act CPS-001). There are different compliance obligations for each of those roles that are likely to apply to the same person – for example, a CEO would be an accountable person, a responsible person, an officer, and a senior manager (unless they are also a director). There is also substantial duplication of requirements across the proposed changes for CPS-510 and the current CPS-511. **MEMBERS HEALTH Recommendation** *Members Health recommends considering bundling a revision of CPS-511 into the CPS-510 amendments to avoid duplication of the requirements and confusion about which one takes precedent.*

Proposed Prudential Standard CPS 510 Governance	
3 (b)	***Fit and proper streamlining and <u>FAR alignment</u>*** ***Are there any risks or unintended consequences APRA should consider?*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members. We have detailed these as general comments in our letter and within the clause-by-clause feedback. **MEMBERS HEALTH Recommendation** *Members Health recommends further consideration to reduce prescriptive language that hinders ensuring proportionality is commensurate with an entity's type, ownership structure, business mix, size, complexity and overall risk exposure within the broader regulatory framework.*
4	***Areas where further detail in guidance would assist*** ***APRA will release a prudential practice guidance to accompany the final governance standard CPS 510. What further information would assist entities to confidently implement the standard?*** Guidance on how to effectively apply proportionality, particularly with respect to the various assessments, reviews, policies, registers and disclosures. A number of areas would benefit from clarification. These have been noted in the detailed clause-by-clause feedback. **MEMBERS HEALTH Recommendation** *Members Health recommends providing a draft version of the guidance for consultation as early as possible to help finalise any comments about the proposed amendments to CPS-510. We are keen to assist with this process and would be happy to follow-up our comments with more information.*

Proposed Prudential Standard CPS 510 Governance	
5	***Compliance costs and net impact*** ***What are the expected compliance costs and benefits of the proposed changes, including the net impact once reductions from consolidation and streamlining are considered?*** Taking into consideration consolidation and streamlining, if the current wording is maintained for the new prescriptive requirements, no cost or time efficiencies will be achieved by small, member-owned, not-for-profit health insurers. For larger organisations, the reduction is anticipated to be more apparent. There will be a moderate amount of effort required to uplift existing policies and procedures, prepare new ones where needed, and implement and embed them into BAU. This may require external support that will incur one-off consultancy fees. There will be an ongoing additional administrative overhead to fulfil obligations and monitor their compliance / effectiveness as a result of the increase in the specificity of minimum requirements. As organisations seek cost efficiencies for compliance activities, the burden to retain corporate knowledge becomes critical for business continuity where it takes significant time to onboard new people without having a transition period to handover fundamental aspects for how the business operates. The urgency of the recruitment process to replace directors with more than 12 years' tenure, and lead / review auditors with more than five years', is anticipated to incur additional costs as, without exemptions, the recruitment would be required to meet a regulator-imposed deadline rather than a realistic plan for transition. **MEMBERS HEALTH Recommendation** *Members Health recommends cost efficiencies can be achieved by further consideration of proportionality looking beyond an SFI and non-SFI, and removing prescriptive requirements that aren't fit for small health insurers who are member-owned and not-for-profit.*
6 (a)	***Artificial intelligence governance*** ***Do the draft CPS 510 requirements adequately support the oversight and use of AI and related technologies?*** Structurally the oversight for the use of AI and related technologies is sufficient – less specificity in the standard is preferred to provide APRA regulated entities sufficient flexibility to govern the use of AI and related technologies as appropriate to their adoption and use of them. Requirements relating to AI governance for the oversight and use of AI and related technologies would be a better fit with an Information Security Framework (under CPS-234) which already sets out requirements for managing usage, access, authorisation, sanctioned tools, custodians, owners, etc.

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	MEMBERS HEALTH Recommendation *Members Health recommends not specifically including requirements relating to AI governance in CPS-510 as the technology is evolving more quickly than a Standard can be reviewed and finalised. A Prudential Practice Guide would be preferable to codifying practices that are likely to change before future versions of the Standard are published.*
6 (b)	***Artificial intelligence governance*** ***Are there areas where additional expectations or guidance would assist?*** Guidance setting out APRAs view of good practice as it evolves over time would be more helpful than including specific requirements in the Standard addressing AI and related technologies. Governance to support the oversight and use of any new technology, including AI, would be better addressed by amending the prudential practice guidelines for CPG-234 (information security), or publishing a dedicated practice guide similar to CPG-229 (climate change financial risks). As AI risks and mitigation strategies are evolving so quickly, it would be preferable to provide guidelines rather than prescriptive regulatory requirements that are likely to become outdated and outpaced by the speed of AI evolution, and are unlikely to be commensurate with how each entity adopts or uses AI. The regulatory framework is becoming more complex where there are similar requirements across different prudential standards. For example, requirements relating to information security are spread across CPS-234, CPS-230, and now proposed in the draft CPS-510. **MEMBERS HEALTH Recommendation** *Members Health recommends APRA considers publishing a Prudential Practice Guide for AI Governance, similar to CPG-229 Climate Change Financial Risks.*

Attachment B – Clause-by-clause feedback for the draft CPS-510

Members Health has compiled specific clause-by-clause feedback in the table below.

Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members.

Paragraph	Draft Prudential Standard CPS 510 Governance
8 (b) (i), (ii)	***A person is a 'responsible person' of a regulated entity if they are, in relation to the regulated entity: (i) an Accountable Person under FAR; (ii) a Chief Risk Officer (CRO) or equivalent.*** Noting that an entity may have already classified a CRO as an 'accountable person' under Section 10 of the FAR Act. However, for entities, particularly small member-owned and not-for-profit entities that have determined that their CRO does not meet the threshold for classification as an 'accountable person' (meaning that they may hold a position in the accountable entity, but do not have actual or effective executive responsibility for the management or control of the accountable entity, or the management or control or a significant or substantial part or aspect of the operations of the accountable entity), this requirement removes an entity's discretion to classify a CRO role as a 'responsible person position' based on whether a CRO has the decision-making authority to manage or control an entity, in particular the entity's strategic objectives, business plan and risk appetite. CRO roles are typically limited to the second level of defence, which is designed to 'review and challenge' decisions, and typically does not hold any decision-making authority to manage or control an entity. Particularly for small non-SFIs, the CRO role is more likely aligned to the definition for a senior manager, as set out under section *Senior Managers and management information* (paragraphs.18-24), where the responsibilities are limited to carrying out and managing the implementation of activities (including business strategies, risk management systems, risk culture, processes and controls for managing the risks to which the regulated entity is exposed), and providing information to support the Board's decision-making. Under the proposed amendments for CPS-001, a new term has been added for 'senior manager responsibilities' and 'senior manager' which specifically includes a chief executive officer and any other person who has or exercises senior management responsibilities. The reference to the PHIPS Act, subsection 4(1)(c), provides a definition for an 'Officer', meaning a *chief executive officer or any other person who has or exercises senior management responsibilities (within the meaning of*

Paragraph	Draft Prudential Standard CPS 510 Governance
	prudential standards). Noting that the definition also includes a director, however CPS-001 excludes a director. In relation to the 'senior management responsibilities', CPS-001 sub-paragraphs (d) and (e)) are intended to be consistently interpreted with the definition of a 'senior manager' under the Corporations Act, section 9, meaning a person (other than a director or secretary) who (i) makes, or participates in making, decisions that affect the whole, or a substantial part, of the business, or (ii) has the capacity to affect significantly the corporation's financial standing. This introduces complexity in a chief executive officer now being an Accountable person (under FAR Act), a fit and proper person (under CPS-510), a senior manager (under CPS-001 and the Corporations Act) and an Officer (under PHI Act). In contrast, the specific requirements to classify an auditor or actuary as 'responsible person positions' are appropriate where these roles have higher thresholds of duty to provide regulatory reporting for submission to APRA under HPS-310 (to prepare an annual report) and CPS-320 (to prepare a financial condition report). **MEMBERS HEALTH Recommendation** *Members Health recommends removing the requirement for an entity to treat a CRO as a 'responsible person' if they are not already considered to be an 'accountable person'.*
8 (d)	***An 'Interest' refers to any interest or benefit, whether pecuniary or non-pecuniary, vested or non-vested, directly or indirectly held (including an interest to favour or benefit a third party, such as a close family member of a responsible person of the regulated entity), of a regulated entity, an employee or associate of the regulated entity, or a responsible person of the regulated entity.*** There is a difference is how an 'indirect holding' and an 'indirect interest' can be interpreted. A holding is not directly held by a person legally or beneficially but significantly correlates with that person's actions and interests – for example, a holding of a family member which the person controls. An interest is not directly held by a person legally or beneficially but there is a real likelihood that a person will receive some benefit – for example, where that person's family member has an interest in a transaction or entity that will benefit the person. Essentially – an *indirect holding* represents a perceived, potential or actual benefit from a related-person's holding that is controlled by that responsible person – an *indirect interest* represents a perceived, potential or actual benefit to a responsible person from a holding controlled by a related-person.

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	MEMBERS HEALTH Recommendation *Members Health recommends providing clarification for the difference between an indirect interest and indirect holding, where an indirect interest is controlled by a related person but may benefit the responsible person, and an indirect holding is controlled by the responsible person, on behalf of a related person, and may benefit the responsible person.* *The responsible person may receive benefits from holdings controlled by the responsible person (on behalf of a related party) or holdings controlled by a related party.*
8 (e)	***A 'close family member of a responsible person of the regulated entity' includes the following:*** - ***a child, grandchild, sibling, parent, grandparent, uncle, aunt, nephew, or niece of the responsible person or of their spouse;*** - ***a spouse of the responsible person or of any other individual mentioned in paragraph 8(e)(i) above.*** The definition for a 'close family member' is limited to a 'spouse' and doesn't acknowledge the close relationships that may also exist with an 'ex-spouse' or a 'de facto spouse' (or partner). **MEMBERS HEALTH Recommendation** *Members Health recommends updating the definition of a 'close family member' to include ex-spouse and de facto spouse (or partner).*
17 (c)	***In delegating any authority, the Board must ensure that: (c) there are mechanisms in place for monitoring the proper and effective exercise of delegated authority, and for reporting to the Board any material issues or changes;*** Given the inherent nature of delegation, the requirement to report material issues should be implicit in the act of delegation. Regulated entities are already likely to have mechanisms in place via a Delegation Plan and an Incident Management Policy and procedures. Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members where new policies need to be created or existing policies need to be amended to explicitly state an implicit requirement. **MEMBERS HEALTH Recommendation**

Paragraph	Draft Prudential Standard CPS 510 Governance
	Members Health recommends not adding prescriptive reporting requirements unless they are materially different to existing requirements already set out under CPS-220, CPS-230 and CPS-234 notifications, and an entity's existing governance framework /delegation plans.
18	***Senior managers of a locally incorporated regulated entity are responsible for carrying out and managing the regulated entity's activities in a manner consistent with (a) – (d).*** The proposed CPS-510 doesn't include a definition for 'senior manager'. If it is intended to have the same meaning that has been added to the proposed changes for CPS-001, these requirements do not apply to a chief executive officer who is also a director. **MEMBERS HEALTH Recommendation** *Members Health recommends providing clarification for:* *(i) whether the new meaning for 'senior manager' under CPS-001 is intended to apply to these requirements; and* (ii) *whether the meaning of a senior manager is intended to purposefully exclude these obligations for a chief executive officer, where the chief executive officer is also a director.*
20	***A locally incorporated regulated entity must have a policy setting out the Board's expectations in relation to the reporting of management information. This policy must include expected content, quality and frequency to support the Board's informed and risk-based decision-making.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members where new policies need to be created or existing policies need to be amended without any distinguishable benefit. Prescribing that entities must have a dedicated Board policy detailing the type, content and frequency of management information it requires, undermines existing frameworks that already meet this requirement where it is baked into the relevant policies that provide the relevant context for the different content, quality and frequency required for particular management information. For example – an Information Security Framework is likely to already set out the Board's expectations for reporting, and these will be different to those set out under the Risk Management Framework or the Product Management Framework. To extract each of the specific requirements into one policy means that information will appear to be missing from the context-specific policies, or it will

Paragraph	Draft Prudential Standard CPS 510 Governance
	need to be duplicated across all of the policies. There would be an outlay in administrative costs to update the entire policy framework, with no added value. Our members consider that having a dedicated policy would be overly prescriptive and unnecessarily complicated where the Board's expectations have already been set out within an existing policy framework. **MEMBERS HEALTH Recommendation** *Members Health recommends replacing the requirement for an entity to have a separate management information policy, that sets out the Board's expectations in relation to the reporting of management information, with a requirement for an entity to set out the content, quality and frequency of reporting within their Policy Framework. This will allow entities who already meet this requirement to either (i) not have to rewrite each policy to remove the reporting requirements or (ii) create a new policy that duplicates the reporting requirements and becomes inefficient to maintain.*
21	***A locally incorporated regulated entity must have processes in place to ensure management information, strategy, risk appetite, conflicts and the best financial interests of beneficiaries (for RSE licensees) are considered and recorded in all relevant decision-making.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, including the duplication of requirements across other standards or related legislation. Requiring an entity to have processes in place to consider and record relevant decision-making overlaps with obligations that are already set out in the Corporations Act., in relation to recording proceedings and resolutions in a minute book. **MEMBERS HEALTH Recommendation** *Members Health recommends removing the requirement, at least for non-SFIs, as it's already codified into an entity's obligations as a registered corporation under the Corporations Act. It's implicit that all entities, as registered corporations, already have processes in place.*
29	***The Board of a regulated entity must: (a) have a majority of independent directors at all times; (b) have a chair that is an independent director.***

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	As the proposed amendment to CPS-510 (paragraph 30) changes the definition of an independent director, the majority of directors on our members' Boards will not be considered to be independent. Directors are considered to be independent if their interest, position or relationship wouldn't materially influence their judgement. Previously, directors would be considered independent if their association wouldn't materially interfere with their judgement. Changing the *test of independence*, from interfering to influencing, fundamentally changes the criteria for a director to exercise independent judgement, and consequently be considered an independent director. Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members by potentially reshaping the fundamental ways the directors interact when discussing issues. For example – restricted funds often require directors to be selected from their community-base. As a member of the community-base, directors are often also policyholders. As a policyholder, the director would have an interest, position or relationship with the regulated entity. As a mutual fund, the member-owners purposefully elect directors to represent their best interests by influencing issues relevant to policyholders, and consequently the entity as a whole. Members Health deems an effective Board should be comprised of directors who are encouraged to exercise independent judgement by influencing outcomes through sharing opinions, ordinary persuasion and participating in open, honest and transparent discussions. **MEMBERS HEALTH Recommendation** *Members Health recommends the test of independence reverts to using the term interfering, or replaces the term influence with undue influence.*
45(c), (d), and (e)	***A Board Risk Committee must:*** ***(c) monitor the regulated entity's current and future risk position relative to its risk appetite;*** ***(d) monitor and advise the Board on the regulated entity's risk culture;*** ***(e) monitor and advise the Board on senior manager implementation of the risk management strategy;*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences

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	for our members, particularly where a requirement blurs the delineation between a director's role from overseeing governance to monitoring operations. Changing "oversight" to "monitor" can have significant implications as to the meaning of the obligation. "Oversight" is aligned to expected Committee level governance and allows for some flexibility in application. "Monitor" implies a prescriptive approach which includes additional reporting and requirements to meet the obligation at more of an operational level. Members Health strongly recommends that Board and Board Committees should not be involved in the operational management of the business. This wording change implies that there is a change in expectations in the standard and doesn't reflect feedback, noted in the Consultation Paper, that Boards are spending too much time on operational matters that take their focus from governance and oversight responsibilities. Particularly where 'monitoring' is typically the responsibility of a senior manager, who would then report any changes to the Risk Committee for their oversight. **MEMBERS HEALTH Recommendation** *Members Health recommends reverting the requirement for a Risk Committee to 'monitor' back to maintaining 'oversight' of the entity's risk position relative to its risk appetite, risk culture, and senior management implementation of the risk management strategy. 'Monitoring' creates ambiguity by implying a Risk Committee should be more focused on operational matters rather than on governance and oversight matters.*
46(e)	***Make annual recommendations to the Board on the remuneration arrangements and variable remuneration outcomes for persons in specified roles in accordance with CPS 511.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, including the duplication of requirements across other standards or related legislation. Under CPS 511 50 a) and b) The Board Remuneration Committee must make recommendations to the Board annually on the remuneration arrangements and variable remuneration outcomes for persons in specified roles as follows: "individually for senior managers and executive directors; and on a cohort basis for *highly-paid material risk-takers, other material risk-takers and risk and financial control personnel.*" The categories of "*highly-paid material risk-takers*", "*other material risk-takers*", and "*risk and financial control personnel*" are not clearly defined and may be subject to inconsistent interpretation. Greater alignment with the CPS

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	510 definitions of responsible persons or accountable persons would improve clarity, consistency, and implementation across regulated entities. **MEMBERS HEALTH Recommendation** *Members Health recommends removing this requirement as it duplicates a requirement set out under CPS-511 for the Remuneration Committee to annually make recommendations to the Board on the remuneration arrangements and variable remuneration outcomes for persons in specified roles. Should there be a future review of CPS-511, Members Health recommends consideration to align "persons in specified roles" to the meaning of either an accountable person or a responsible person.*
48	***The Board skills matrix must include clear assessment criteria and rating scales of proficiency that can be measured and verified.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, particularly when it comes to rating scales of proficiency and how these are expected to be measured and verified. A key concern is how a skills matrix would benefit from rating scales of proficiency when there is an expectation that specific directors will be recruited for specialist skills to uplift and balance out the overall proficiency of the Board as a collective. It's not clear whether the scales of proficiency are intended to apply to a director's skills or the Board's collective skills. In a scenario where an AI specialist was appointed as a director – their scale of proficiency would be high for AI, but maybe lower for the other skills. Would this make the director's overall proficiency low in terms of the personal rating against the Board skills mix, or high in terms of rating against the skill itself, or low in terms of the collective Board's proficiency against the skill. Overly prescribing needing a methodology to set out the assessment criteria and how it is intended to be used to measure and verify scales of proficiency, is likely to be unnecessarily complicated, particularly for non-SFIs who are already clear on what skills are important to their Board, whether there is a sufficient proficiency across the Board as a collective, and whether the proficiency can be improved through professional development and succession planning. Further, this approach introduces a risk that rating director's proficiencies against one another could send a message to directors, brought on for specialist skills, that their specialist skill isn't considered to be as important as other skills.

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	MEMBERS HEALTH Recommendation *Members Health strongly recommends simplifying how Boards should be using their skills matrix, and otherwise providing clarification for how the assessment criteria, proficiency scales and measurement verification for the Board Skills Matrix are intended to be put into practice with distinguishable benefits and added value to offset the administrative outlay to design and implement the new approach.*
49(b)	***The Board must take all reasonable steps to ensure it: ... (b) can demonstrate how it is actively addressing any current or future skill and capability deficiencies.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, particularly when setting expectations that a Board will be able to address any deficiencies for a future skill or capability. Including a reference to the future in the requirement is too open ended. The requirement seems to imply that Boards are required to anticipate and actively address any potential future need as opposed to ensuring the current Board skills mix doesn't have any deficiencies, which would include succession planning to protect the current skills and capabilities. For example – if this requirement was in place 10 years ago, any entity that wasn't already actively addressing a deficiency in their skills and capabilities for AI, would be in breach. **MEMBERS HEALTH Recommendation** *Members Health recommends providing clarification that the requirement doesn't mean that a Board is required to actively address any 'future' skill or capability deficiencies by anticipating what skills it might need in the 'future'.*
59	***A non-executive director of a locally incorporated regulated entity must not be a non-executive director of that entity or its successor[22] for more than 12 years in total.*** ***[22] For the purposes of this paragraph, a reference to 'successor entity' includes the acquiring entity in a merger or other similar corporate restructure, or the RSE licensee of a successor fund. Successor fund has the meaning given by regulation 1.03(1) of the Superannuation Industry (Supervision) Regulations 1994.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, particularly when setting a maximum tenure limit for Boards with a majority of directors who are nearing, have reached, or have already

Paragraph	Draft Prudential Standard CPS 510 Governance
	exceeded the limit, without allowing sufficient time to arrange and implement a board renewal plan to protect the Board's ongoing performance during the transition. Members Health set out an extensive list of scenarios that were raised by members in the General Comments of this submission. The key concern is that the proposed hard 12-year tenure limit commences from the date of appointment. Unless exceptional circumstances apply, the Board approves an extension, and APRA is notified within 10 days of that approval. In determining whether exceptional circumstances exist, Boards must have regard to policyholders' (members') interests. For member-based or ASX-listed organisations, this approach does not align neatly with the interaction between casual vacancy appointments, member elections and AGM cycles. Directors are commonly elected by members for fixed three-year terms, often following a period of service commencing through a casual vacancy appointment. This is consistent with the Corporations Act and the organisation's constitution. Under the proposed framework, a director could reach the 12-year tenure limit part-way through a term for which they have been elected by members. This creates the possibility that a director would be required to retire before completing their elected term, notwithstanding the members' decision to appoint that individual for a specified period. In those circumstances, the director would be unable to fulfil their role for the balance of the elected term and members would be denied the opportunity to engage with, question and hold accountable a director whom they had elected for that term, particularly at the AGM immediately following the director's 12-year appointment anniversary. At its most extreme, a director could be elected at an AGM and, due solely to the timing of the AGM cycle 12 years later, be required to retire immediately before the AGM at which their tenure would otherwise have ended. In that scenario, the director would be unavailable to attend the AGM in their capacity as a director and to answer questions from members, despite having been elected by those members to serve until that point. It is unclear whether APRA would regard the completion of an existing member-elected term as an "exceptional circumstance". If the proposal remains unchanged, entities would need to carefully manage appointment and tenure expiry dates, obtain board approval for extensions where necessary, document the policyholder interest rationale supporting those extensions (that is, the policyholder expects a director to serve their elected term), and notify APRA within the required timeframe. This would create an ongoing administrative burden for both regulated entities and APRA, with limited apparent prudential benefit.

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	In addition, the draft is not clear on how the proposed tenure limit is intended to operate for directors who are cross-appointed across a corporate group. It is common for directors to serve concurrently on the board of a Head of Group and one or more APRA-regulated subsidiary entities. The draft does not make clear whether service on one group entity counts towards the tenure limit for all entities within the group, or whether tenure is assessed separately for each legal entity. For example, it is unclear whether a director who has served 12 years on a Head of group entity could then be appointed to a regulated subsidiary for a further 12-year period, or vice versa. Equally, if APRA's intention is that tenure be measured from a director's first appointment to any entity within the group, the draft would benefit from expressly stating this. Similarly, where a cross-appointed director reaches the applicable tenure limit on one group entity, it is unclear whether that director may continue to serve on other group boards until the expiry of the relevant tenure period. This issue becomes particularly important if APRA adopts an alternative approach that permits directors to remain until the first AGM following the 12-year anniversary of their appointment. In those circumstances, we consider it would be appropriate for a cross-appointed director to be permitted to continue serving across all relevant group entities until the expiry of that period, rather than requiring staggered resignations from individual boards at different times. Greater clarity on APRA's intended treatment of cross-appointed directors would assist boards with succession planning, governance arrangements and orderly board renewal across complex group structures. **MEMBERS HEALTH Recommendation** *Members Health recommends allowing entities to apply for exemptions which would grant sufficient time to implement a practical transition plan for Board renewal, as well as providing clarification on APRA's intended treatment of cross-appointed directors would assist boards with succession planning, governance arrangements and orderly board renewal across complex group structures.*
74	***A regulated entity must:*** ***(a) identify and assess all actual and potential conflicts in connection to the business operations of the regulated entity, including those arising from structural, funding or remuneration arrangements (including intra-group arrangements);*** ***(b) implement appropriate controls to effectively identify, manage and monitor conflicts having regard to the associated***

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	risks and potential impacts on the interests of, or duties owed to its policyholders, depositors or beneficiaries; ***(c) avoid conflicts where required by law, or where the regulated entity reasonably concludes that the conflict cannot be effectively managed to protect the interests of depositors, policyholders or beneficiaries;24*** ***(d) take reasonable steps to ensure that responsible persons and employees understand their obligations under the conflicts management policy required by paragraph 75;*** ***(e) assess and monitor the effectiveness of controls implemented to identify and manage conflicts and take steps to remediate controls where the risks or impact of a conflict change;*** ***(f) maintain a current register of potential and actual conflicts, including the Interests and duties that could reasonably be considered to give rise to or have the potential to give rise to a conflict, and the associated controls to monitor and manage those conflicts;*** ***(g) record in the minutes of the Board, Board committees and other relevant meetings, details of conflicts disclosed at the respective meeting and the action taken to avoid or manage those conflicts;.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, particularly where new policies need to be created or existing policies need to be amended within an existing framework that is already embedded and effective. Members Health funds already have strong and robust mechanisms in place to manage the overall integrity of their governance arrangements. The proposed further requirement to maintain and disclose registers of duties and interests will place further undue burden on health funds without any tangible benefit. By introducing this section, APRA is applying a blanket view of risk based on the largest superannuation funds to every entity in the financial services industry - only the largest banks in Australia are comparable to superannuation funds in terms of assets vs funds under management. General Insurance is significantly smaller with the largest industry participants (e.g. IAG, Suncorp, QBE and Allianz) collectively holding $141bn in assets compared to over $1trillion for each of the banks and ~$200-400bn for the largest super funds. Private Health Insurers hold a fraction of these assets with the two largest funds with less than $4bn.

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	The inclusion of these requirements is not appropriate for most Private Health Insurers especially non-SFIs because of the existing legislative and regulatory restrictions funds are subject to which mitigate the type of conflict of interest risk these clauses address. Imposing these requirements simply adds to the demonstrable compliance burden rather than contributing to the governance of the entity. The above state is supported by the fact that PHIs are subject to defined product offerings, entry is subject to community rating and pricing increases are subject to Ministerial approval for which management expenses and administrative waste is actively considered. The nature of the fund and its management as well as Board makeup is inherently different to superannuation, and other regulated-industries. **MEMBERS HEALTH Recommendation** *Members Health recommends replacing the requirement for an entity to have a separate conflict of interest policy, that sets out the Board's expectations in relation to the reporting of conflict management, with a requirement for an entity to set out the processes, systems and controls within their Policy Framework. This will allow entities who already meet this requirement to either (i) not have to rewrite each policy to remove the reporting requirements or (ii) create a new policy that duplicates the reporting requirements and becomes inefficient to maintain.* *Further, Members Health recommends providing clarification on whether the disclosure of potential and actual conflicts is expected to remain confidential within an entity or APRA may request access.*
74(j)	***Ensure that the appropriateness and effectiveness of its conflicts management policy is reviewed by operationally independent, appropriately trained and competent persons at least annually. This review may be incorporated into a regulated entity's board annual performance assessment, independent performance assessment or, for all regulated entities other than RSE licensees, review of the risk management framework.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, particularly where the time, cost and effort to conduct an annual review of an existing will place further undue burden on health funds without any tangible benefit. Conducting an annual review of a policy when there have been no material changes to the organisation's operations, regulatory obligations, or conflict risk profile appears to be particularly onerous.

Paragraph	Draft Prudential Standard CPS 510 Governance
	Small non-SFIs may go from year to year with no updates to conflicts register, let alone a conflicts policy. In practice, there would be little value for a Board to review a policy unless there were material changes to how conflicts were to be managed, or to review a register unless there were any new declarations or changes to a declaration. **MEMBERS HEALTH Recommendation** *Members Health strongly recommends that this requirement should only apply to SFIs who are more likely to see sufficient changes to their organisation's operations, regulatory obligations, or conflict risk profile, that would justify the cost, time and effort to conduct an annual review.* *Members Health recommends providing clarification as to whether the requirement for a conflicts management policy is to be reviewed at least annually where the policy is unlikely to change once it has been implemented. Also, whether policy reviews should only be triggered by material changes to conflict management practice, and consider whether a risk-based review cycle would be more appropriate.* *If an annual review is retained, clearer guidance would be helpful to understand who qualifies as an 'operationally independent, appropriately trained and competent person' for the purposes of conducting the review.*
75(b)	***A regulated entity must have a conflicts management policy that applies to the regulated entity, all responsible persons and all employees, and at a minimum:*** ***(a) defines roles, responsibilities and resources for conflicts management and oversight;*** ***(b) documents processes, systems and controls to fulfil the obligations set out in paragraph 74; and*** ***(c) is proportionate to and consistent with the regulated entity's strategic objectives, risk profile, size, business mix and complexity.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, particularly where new policies need to be created or existing policies need to be amended within an existing framework that includes processes, systems and controls that are already embedded and effective. Members Health funds already have strong and robust mechanisms in place to manage the overall integrity of their governance arrangements. The proposed

Paragraph	Draft Prudential Standard CPS 510 Governance
	further requirement to maintain and disclose registers of duties and interests will place further undue burden on health funds without any tangible benefit. The inclusion of these requirements is not appropriate for most Private Health Insurers especially non-SFIs because of the existing legislative and regulatory restrictions funds are subject to which mitigate the type of conflict of interest risk these clauses address. Imposing these requirements simply adds to the demonstrable compliance burden rather than contributing to the governance of the entity. **MEMBERS HEALTH Recommendation** *Members Health recommends replacing the requirement for an entity to have a separate conflict of interest policy, that sets out the Board's expectations in relation to the reporting of conflict management, with a requirement for an entity to set out the processes, systems and controls within their Policy Framework. This will allow entities who already meet this requirement to either (i) not have to rewrite each policy to remove the reporting requirements or (ii) create a new policy that duplicates the reporting requirements and becomes inefficient to maintain.* *Further, Members Health recommends providing clarification on whether the disclosure of potential and actual conflicts is expected to remain confidential within an entity or APRA may request access.*
77	***Fit and Proper*** ***A regulated entity must take all reasonable steps to ensure their responsible persons are fit and proper.*** Although the fit and proper reporting requirements have been reduced, there are a number of new requirements that will create a disproportionate burden and previously only applied to financial institutions. For example – in assessing a person's fitness and propriety, an entity must now consider the Board's skills mix, performance objectives, performance assessment, personal references, the findings of any court, tribunal, regulator, Board, arbitrator, public enquiry or other body whose responsibility it is to make findings of the relevant kind that the person has been subject to. For small funds, to undertake such a rigorous process, and be able to demonstrate they have verified the information, will require additional resourcing (cost, time and effort) and will carry at least the same burden as the current reporting without the additional assessment criteria. Would like to see further alignment in definitions and requirements between the FAR Accountable Persons and APRA Responsible Persons. **MEMBERS HEALTH Recommendation**

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	Members Health recommends maintaining the current expectations for private health insurers that are set out in HPG-520. Consider further alignment with definitions and requirements between legislation for accountable persons and responsible persons, where paragraph 8 (b) states that a person is a responsible person if they are an accountable person (under FAR Act).
78	***A regulated entity must complete a fit and proper assessment for a person before appointment to a responsible person position, except in cases set out in paragraphs 79 and 80.*** Under paragraph.8, an 'accountable person' is a 'responsible person'. Under paragraph.78, appointment to a 'responsible person position' would trigger a fit and proper assessment, but there isn't a definition clarifying what a 'responsible person position' is. This is important as the requirement to complete a fit and proper assessment, now relies on whether the 'person' is a responsible person, not whether the 'position' they are being appointed to is a responsible person position. Under the current CPS-520, a 'responsible person position' means the responsibilities or activities of a responsible person that would lead to the person being a responsible person under Attachment G, which includes a director, an officer, Appointed Auditor, Appointed Actuary, or any person who performs activities for a subsidiary. Essentially the concept of a 'responsible person position' becomes redundant as the requirement for a fit and proper assessment can only be driven by whether someone is 'responsible person' rather than their position. For lack of definition under the proposed CPS-510, the interpretation of a 'responsible person position' can only be derived from the definition of a 'responsible person', meaning that if someone is identified as a responsible person, then their position would be classed as a 'responsible person position'. Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members. As identifying a responsible person is now aligned to the criteria for identifying an accountable person, it isn't clear whether the requirement for conducting a fit and proper assessment, prior to appointment, would be triggered by a position or the accountability of a person (regardless of the position). **MEMBERS HEALTH Recommendation** *Members Health recommends amending the requirement to either trigger a fit and proper assessment, prior to appointment, based on whether the person is intended to be a 'responsible person' or add a definition for a 'responsible person position'. Clarify whether a 'responsible person position' has the same*

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	meaning as the current CPS-520 (this is not defined in CPS-510), or whether it has the same meaning as a 'specified role' (which is referred to under requirement 46, and includes a senior manager which is referred to under CPS-001).
81	***A regulated entity must validate a responsible person's fitness and propriety at least annually following their appointment to a responsible person position. For responsible persons who are directors, annual validation of fitness and propriety must have regard to directors' performance objectives and the Board skills matrix and may be done as part of the annual performance assessment.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members. The current process is for a director to complete a fit and proper declaration which is then assessed against criteria to validate whether a director is fit and proper (i.e. the person possesses the skill, character, care, etc.). The current process to assess a director's performance is typically managed separately by the Board chair and any concerns with regards to a director's performance are typically managed discreetly by the chair, unless there were material performance issues and the Board decided to take action to remove that director. Introducing a new requirement that a fit and proper assessment must (i) validate a director's declaration that they are fit and proper, and (ii) validate the Board chair's annual performance assessment, is too prescriptive. Implementing the requirement will be impractical as it will remove the Board's discretion in managing a director's performance in accordance with the severity and extent of the failure to meet performance objectives, and the decision to remediate or remove the director for performance issues. Noting that the performance issues may not reflect at all on whether they would be fit and proper to otherwise continue in that role under different circumstances. **MEMBERS HEALTH Recommendation** *Members Health strongly recommends delineating between incorporating performance assessments as part of fit and proper assessments, and providing clarification regarding the annual fit and proper assessment, particularly how performance objectives and the Board Skills Matrix are to be considered and applied when assessing an individual's fitness and propriety.*

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86	***In assessing a person's fitness and propriety, a regulated entity must consider: (a) for a director role, the Board's skills needs under the Board skills matrix.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, particularly when it's unclear as to whether the fit and proper criteria for a director role must consider whether the person meets the Board's skills needs or whether they have met their performance objectives as part of their annual performance assessment. For example – is a director considered to be fit and proper because their skills contribute to the Board's collective skills mix? **MEMBERS HEALTH Recommendation** *Members Health recommends providing clarification for the extent to which the skills mix should be relied upon in determining whether someone is fit and proper.*
87	***In applying the fit and proper criteria, a regulated entity must be able to demonstrate that it has undertaken a rigorous process and verified information as appropriate.*** Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members, particularly when it's unclear as to how to demonstrate a rigorous process has been undertaken and how information should be verified. **MEMBERS HEALTH Recommendation** *Members Health recommends providing clarification as to what extent an entity must be able to demonstrate it has undertaken a rigorous process and verified information as appropriate with regards to an annual performance assessment.*
88	***Where a regulated entity becomes aware of information that may result in a responsible person no longer meeting the fit and proper criteria, it must take all reasonable steps, including collecting sensitive information as defined in the Privacy Act if relevant, to determine if a material fitness and propriety concern exists within a timely manner. Where a material concern exists, a fit and proper reassessment must be conducted.*** By combining the fit and proper assessment with a performance assessment, should the director not meet their performance objective, the entity must acknowledge that it has become aware of information that may result in that

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	director no longer meeting the fit and proper criteria. The entity must take reasonable steps to collect information to determine if a material concern exists, and if so, a reassessment must be conducted. More information is requested to determine whether the time it might take to manage (remediate) a performance issue would allow the entity to determine whether a material fitness and propriety concern exists within a timely manner, and whether a reassessment must be conducted – noting that under paragraph 90, APRA may require an entity to conduct a reassessment where APRA's concerns are not addressed in a timely manner or APRA forms the view that the process was not undertaken in accordance with paragraph 87. If a director is under performance management, it is likely that this will be a highly confidential process and such information shouldn't be recorded in a fit and proper register unless the severity and extent of the issues were considered to be material, and the Board decided to terminate the director through triggering a re-assessment of their fitness and propriety. Realistically, if a director's performance was of such concern, it is unlikely that the Board would work the dismissal process through a fit and proper assessment as it's more likely that other factors and extenuating circumstances would drive the decision process. **MEMBERS HEALTH Recommendation** *Members Health recommends refining the requirement to ensure it doesn't inadvertently trigger a fit and proper re-assessment because minor performance issues had been identified and were currently under review.* *More information would be helpful to understand whether the time it might take to manage (remediate) a performance issue would allow the entity to determine whether a material fitness and propriety concern exists within a timely manner, and whether a reassessment must be conducted – noting that under paragraph 90, APRA may require an entity to conduct a reassessment where APRA's concerns are not addressed in a timely manner or APRA forms the view that the process was not undertaken in accordance with paragraph 87.*
91	***Consequences of adverse assessments.*** The fit and proper assessment must now regard a director's performance objectives, performance assessment and outcomes of the annual performance review. In a scenario where a director has been cautioned for performance issues and is currently undergoing performance management, this would be required to be documented as part of their performance assessment, which would then go towards their annual fit and proper assessment.

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	Combining the annual fit and proper assessment with a director's performance assessment doesn't allow for a Board to treat the performance issues commensurate with the severity and extent *before* making a decision as to whether the performance issues should be escalated to a matter worthy of a fit and proper re-assessment. Essentially, tying a performance assessment with a fit and proper assessment takes away the Board's expectation that they can deal with minor performance issues discreetly (typically managed by the Board Chair) and not documented in a manner that would reflect on whether a director is fit and proper. Our members believe that performance issues should be dealt with as a separate matter to whether someone has the integrity and honesty Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members. **MEMBERS HEALTH Recommendation** *Members Health recommends separating the obligations for performance assessments and fit and proper assessments to avoid any confusion about which assessment might trigger a director being declared unfit or improper.*
94	***Annually review the appropriateness and effectiveness of the fit and proper policy. This may form part of the annual performance assessment or the independent performance assessment.*** The requirement appears potentially onerous, particularly where there have been no material changes to regulatory requirements, governance arrangements, or the organisation's fit and proper framework. Consider whether a risk-based review cycle would be more appropriate, with annual reviews triggered by significant legislative, prudential or organisational changes. **MEMBERS HEALTH Recommendation** *Members Health recommends providing clarification whether the annual review of the policy, as part of the annual performance assessment or the independent performance assessment, means each director would review the appropriateness and effectiveness of the policy as part of their own performance assessment?*
104	***A person who was an employee of an audit company, other than a director of that company, and who acted as the lead auditor or review auditor in the audit of a regulated entity in relation to the Prudential Acts, prudential standards or reporting standards, cannot be appointed to the role of director or senior manager of***

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	that regulated entity until at least two years have passed since they acted as the lead auditor or review auditor. Lead / Review Auditors have extensive knowledge (corporate, industry, regulatory) of a fund's business systems and processes. Introducing a requirement that specifically restricts the appointment of a Lead / Review Auditor to a director or senior manager role, is only likely to detrimentally impact small member-owned, not-for-profit health insurers, who are typically challenged to find a suitable candidate from small recruitment pools. **MEMBERS HEALTH Recommendation** *Members Health recommends adding an exemption criteria that allows a Lead / Review Auditor to be appointed to a director or senior manager role where the Board considers there are exceptional circumstances, including the suitability of a candidate.*

Paragraph	Draft Prudential Standard CPS 510 Governance
Attachment A	***Auditor Independence Test*** ***Subject to Attachment A (paragraph 4), an individual who plays a <u>significant role</u> in the audit of … (b) the regulated entity in relation to the Prudential Acts, prudential standards or reporting standards, cannot continue in the role for more than five years out of seven successive years, or until a further two years have passed.*** The meaning of a 'significant role' has been expanded under CPS-001 to include a new definition for a <u>Lead Auditor</u> and a <u>Review Auditor</u>. *An individual plays a 'significant role' if the person … is a <u>lead or review auditor</u> where such audit work is performed by an audit company or firm.* In a current setting, a Lead / Review Auditor may help coordinate the audit team in performing audit work on behalf of an audit company represented by an Appointed Auditor, Special Purpose Auditor and/or the Internal Auditor, or may[4] in fact be the Appointed Auditor, Special Purpose Auditor or the Internal Auditor. For member-owned, not-for-profit health insurers, the Lead / Review Auditor of that audit company is often relied upon to oversee audit activities and final reviews to help maintain business continuity through their familiarity with the business' systems and processes, and corporate knowledge (history, industry and regulatory) as this evolves over a number of years. Under the new *auditor independence test*, both the Appointed Auditor and the Lead / Review Auditor cannot continue in the role for more than 5 years. To swap both the Appointed Auditor and Lead / Review Auditor every 5-years would create significant challenges for small health insurers in maintaining business continuity to optimise efficiencies in conducting audits for industry-specific regulatory reporting. To otherwise meet this requirement, small funds would need to stagger onboarding for a new auditor and separately for a Lead / Review Auditor to ensure there is continuity of corporate knowledge. The loss of corporate knowledge during a transition period wouldn't be commensurate with the risk exposure of allowing a Lead Auditor to continue in that role for more than five years. **MEMBERS HEALTH Recommendation** *Members Health recommends adding an exemption criteria that allows a Lead / Review Auditor, who is not also the Appointed Auditor, to continue in that role indefinitely (for more than five years).* *Otherwise, add an exemption criteria for Lead / Review Auditors of audit firms who will not meet the auditor independence test, due to exceeding the five-year term (or seven successive years), and the audit firm will need to recruit, onboard and rebuild that knowledge to support the audit team.*

Attachment C – Clause-by-clause feedback for the draft CPS-001

Members Health has compiled specific clause-by-clause feedback in the table below.

In general, Members Health is committed to seeing appropriate enhancements implemented where there is a demonstratable need, however it is also cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for private health insurers, particularly our funds who are member-owned, not-for-profit entities.

Definition	Draft Prudential Standard CPS 510 Governance
General	***Amendments to change 'institution' to 'entity'.*** There are inconsistencies with amendments changing existing terms 'institution' to 'entity', and some of the new terms (e.g. senior management responsibilities) which use 'institution' rather than 'entity'. **MEMBERS HEALTH Recommendation** *Members Health recommends checking consistency where 'institution' is intended to be replaced by 'entity'.*
Lead Auditor Review Auditor	***New terms – 'lead auditor' and 'review auditor'.*** Under CPS-001, a 'lead auditor' means the registered company auditor who is primarily responsible to the audit firm or the audit company for the conduct of audit work. Under CPS-001, a 'review auditor' means the registered company auditor who is primarily responsible to the individual auditor, audit firm or audit company for reviewing audit work. CPS-510 is silent on whether the new requirements would apply to an Appointed Auditor, or whether an Appointed Auditor is inherently considered to also be a lead auditor or review auditor. Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members. For example – an auditor with specific corporate knowledge and a minimum of five years' relevant experience in the private health industry, could be the best candidate for a director or senior manager role at a small fund, but couldn't be considered before two years has passed since they acted in the role of lead or review auditor. **MEMBERS HEALTH Recommendation**

[4] Subject to clarification from APRA.

Definition	Draft Prudential Standard CPS 510 Governance
	Members Health recommends providing clarification the difference between an Appointed Auditor, lead auditor and review auditor, and the significance of adding the new terms rather than amending the existing term for an Appointed Auditor.
Senior Manager	***New term – Senior Manager.*** Under CPS-001, a 'senior manager' of a private health insurer means (a) a chief executive officer; or (b) a person specified in paragraph (c) of the definition of officer in subsection 4(1) of the PHIPS Act, but does not include a director, even where the director is also a chief executive officer. The reference to the PHIPS Act, subsection 4(1)(c), provides a definition for an 'Officer', meaning a *chief executive officer or any other person who has or exercises senior management responsibilities (within the meaning of prudential standards).* Noting that the definition also includes a director, however CPS-001 excludes a director and a chief executive officer who is also a director. Members Health is cautious that adding requirements that are overly prescriptive or unnecessarily complicated may have unintended consequences for our members. For example, a chief executive officer role has responsibilities as an Accountable person (under FAR Act), a fit and proper person (under CPS-510), an Officer (under the Corporations Act and the PHI Act), and a senior manager (under CPS-001, unless they are also a director). While the changes to fit and proper reporting requirements are welcomed, introducing a new type of role to be regulated doesn't alleviate the regulatory burden. **MEMBERS HEALTH Recommendation** *Members Health recommends providing clarification the significance of introducing a definition for a 'senior manager', which has introduced new requirements for senior managers.* *Members Health recommends providing clarification how a senior manager is different to an accountable person or responsible person, other than it doesn't relate to a director or a CEO who is a director.*
Senior Management Responsibilities	***New term – Senior Management Responsibilities.*** Under CPS-001, *senior management responsibilities* mean (d) making, or participating in making, decisions that affect the whole, or a substantial part, of the business, (e) responsibilities significantly affecting the institution's financial standing; or (f) responsibilities materially affecting the whole, or a substantial part, of the business or its financial standing by: (i) enforcing

Definition	Draft Prudential Standard CPS 510 Governance
	policies and implementing strategies approved by the Board; (ii) the development and implementation of systems used to identify, assess, manage or monitor risks in relation to the business of the institution; or (iii) monitoring the appropriateness, adequacy and effectiveness of risk management systems. Sub-paragraphs (d) and (e) are intended to be interpreted consistently with the definition of 'senior manager' (in relation to a corporation) in section 9 of the Corporations Act. The reference to the PHIPS Act, subsection 4(1)(c), provides a definition for an 'Officer', meaning a *chief executive officer or any other person who has or exercises senior management responsibilities (within the meaning of prudential standards).* Noting that the definition also includes a director, however CPS-001 excludes a director and a chief executive officer who is also a director. In relation to the 'senior management responsibilities', CPS-001 sub-paragraphs (d) and (e)) are intended to be consistently interpreted with the definition of a 'senior manager' under the Corporations Act, section 9, meaning a person (other than a director or secretary) who (i) makes, or participates in making, decisions that affect the whole, or a substantial part, of the business, or (ii) has the capacity to affect significantly the corporation's financial standing. This introduces complexity in a chief executive officer role now being an Accountable person (under FAR Act), a fit and proper person (under CPS-510), an Officer (under the Corporations Act and the PHI Act), a senior manager (under CPS-001, unless they are also a director). **MEMBERS HEALTH Recommendation** *Members Health recommends providing clarification how 'senior management responsibilities are different to 'responsible person responsibilities', and the significance of defining a CEO as a senior manager, unless the CEO is also a director.*