CIRCULAR

Reference:	Guidance on benefit changes & contribution increases for 2022
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Circular 42 of 2021: Guidance on benefit changes and contribution increases for 2022

This Circular sets the requirements that must be adhered to by medical schemes when determining annual medical scheme contribution increases and benefit changes for the 2022 benefit year.

One of the primary mandates of the Council for Medical Schemes (CMS) as enshrined in section 7 of the Medical Schemes Act (131 of 1998), is to protect the interests of beneficiaries at all times. The CMS controls and co-ordinates the functioning of medical schemes in a manner that is complementary with the national health policy. To this end, CMS' key objective is to ensure that annual medical scheme contribution rate increases remain affordable to encourage equitable access to quality healthcare and long-term sustainability of the industry.

1. Macro-economic outlook

This section provides an abridged overview of key economic indicators such as Gross Domestic Product (GDP), employment statistics, consumer price index (CPI), interest rates, exchange rate, household income and expenditure, corporate earnings — that have a bearing on contribution increases in the industry. Overall, these factors have a direct and indirect impact on the affordability of medical scheme contributions, the financial performance of schemes, risk pooling, cross-subsidisation, membership growth and long-term sustainability.

1.1. Global economic outlook

Despite challenges posed by new coronavirus variants, economic prospects are improving for advanced economies, mainly due to their steady progress in the rollout of the vaccination. Overall, the International Monetary Fund (IMF) estimates that global economic growth will expand by 6% in 2021, moderating to 4.4% in 2022 (IMF, 2021). Nevertheless, global economic recovery is likely to be uneven with emerging markets lagging behind their counterparts in advanced economies, due to the slower pace of vaccinations. As such, emerging markets and low-income countries are likely to be more susceptible to future waves of infection and returns to more restricitive lockdowns measures, further delaying economic recovery.

1.2. South African economic outlook

Although the local economy has started to recover in response to supportive global conditions, the easing of lockdown restrictions and accelerated vaccine rollouts— uncertainties about the future trajectory of the COVID-19 pandemic will continue to weigh on domestic economic prospects. The recent social unrest and ensuing economic damage could further derail domestic economic recovery, constraining job creation.

1.2.1. Domestic Gross product

All other things being equal, the Gross Domestic Product is expected to grow by 3.3%, in 2021, moderating to 2.2% and 1.6% in 2022 and 2023 respectively (National Treasury, 2021). The table below provides economic growth projections between 2020–2023.

Table 1: Economic growth forecast

Real percentage growth	2020 Estimate	2021	2022 Forecast	2023
Household consumption	-5.9	2.9	2.4	2.0
Gross fixed-capital formation	-18.4	-2.4	3.9	3.9
Exports	-10.9	5.7	3.0	2.8
Imports	-16.5	6.3	4.6	2.5
Real GDP growth	**-7.2**	**3.3**	**2.2**	**1.6**
Consumer price index (CPI) inflation	3.3	3.9	4.2	4.4
Current account balance (% of GDP)	1.7	-0.1	-1.0	-1.4

Source: *National Treasury 2021 Economic Outlook*

1.2.2. Employment statistics

The unemployment rate correlates with the medical schemes membership increase or decrease and it has continued to increase over the past years. According to the Statistics South Africa's Quarterly Labour Force Survey, unemployment rates reached a high of 32.6% in the first quarter of 2021, compared to 30.1% during the same period in 2020 (Stats SA, 2020). Stats SA also noted that, compared to the same period last year, the above observation led to a net decrease of 1.4 million in total employment in Q1: 2021, largely due to losses in the number of employees in the Trade, Construction, Manufacturing, Community and Social Services, and Private households' industries (Stats SA, 2021). Social unrest and the resultant economic damage, together with extended lockdown restrictions, are likely to exacerbate the country's unemployment rate going forward.

1.2.3. The rand exchange rate

Although the favourable global conditions and strong commodity export prices have supported the domestic currency, the rand has depreciated in recent weeks compared to the US dollar. A weak domestic currency is likely to add to the high input cost in the pharmaceutical sector where most of the active ingredients and new medical technologies are generally imported.

1.2.4. Interest rates

The South African Reserve Bank (SARB), at its recent July Monetary Policy Committee (MPC) meeting, kept the repo rate unchanged at a record low of 3.5% per annum, reflecting a highly accommodative policy stance as the economy recovers from the pandemic. While this decision will somehow continue to alleviate the financial burden on indebted households, uncertainty remains about the normalisation path of interest rates.

2. Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2)

2.1. COVID-19 spread

South Africa is currently engulfed by the third wave of the virus infection, characterised by the deadly Delta variant. This variant is more transmissible and can resist the antibodies that human beings have within their bodies (WHO, 2021). NICD states that "…whilst the Beta variant was 25% more transmissible compared to original lineage, the Delta variant is 97% more transmissible and preliminary data from the UK suggests that the Delta variant has a propensity to cause more severe illness…." (NICD, 2021)

2.2. Demographic risk profile

As the trajectory of the pandemic continues to unfold in the coming months, some medical schemes may experience sudden spikes in high-cost claims, although the overall economic cost of the pandemic on the industry remains uncertain. The adverse impact of the pandemic on the industry also depends on schemes' demographic risk profile, the size of the population covered and the extent of existing cross-subsidies within benefit options or schemes. In addition, the individual financial position of a medical scheme pre-pandemic will determine the degree to which it is likely to absorb the possible high-cost claims related to the COVID-19. The CMS believes that medical schemes with high accumulated reserves should be well insulated against this spike. On the other hand, schemes that were already in a weak financial position pre-pandemic, may be vulnerable in the long-run, potentially requiring interventions such as amalgamating with other schemes.

2.3. Post-acute COVID-19 syndrome (Long COVID)

Scientific and clinical evidence is always evolving on COVID-19 whilst the long-term impact remains unknown. The persistence of COVID-19 symptoms or development of new symptoms late in the course of COVID-19 illness, is also an increasingly recognised health systems problem facing many countries (Mendelson et al, 2021). The National Institute for Communicable Disease (NICD) defines Long COVID as generally symptoms that are present 28 days after the onset of the acute COVID-19 infection (NICD, 2021).

Empirical evidence shows the prevalence of Long COVID where patients experience prolonged multi-organ symptoms and complications beyond the initial period of COVID-19 acute infection and illness, is also increasing. Specifically, clinicians and policy makers are worried about:

- ongoing symptomatic COVID-19 for people who still have symptoms between 4 and 12 weeks after the start of acute symptoms; and
- post-COVID-19 syndrome for people who still have symptoms for more than 12 weeks after the start of acute symptoms.

Accordingly, it is evident that Long COVID will likely have a material impact on utilisation although the actual cost of treating Long COVID remains unknown.

2.4. Deferred demand: elective surgeries and other non-urgent medical services

As COVID-19 infections continue to increase with each wave, there has been a significant reduction in non-COVID-19 admissions over the past year. Consequently, the pandemic has materially altered the health seeking behaviour of members. It is expected that on average, the claim ratio on healthcare services for the current 2021 benefit year, will be lower than the preceding years. However, it remains uncertain how long this unusual healthcare utilisation will continue. Accordingly, there may be future claims costs related to delayed treatment for conditions that were not diagnosed during the pandemic.

2.5. Pent-up demand

The theory behind pent-up demand states that after a period of lack of access to healthcare services, healthcare users would immediately seek care at a rate that exceeds the use of health services by patients who had continuous access, even after adjusting for other factors such as morbidity and demographics. In this regard it is expected that as the vaccination rate increases, and the number of COVID-19 cases abate, some of the minor medical conditions that were postponed, may potentially require complex and costly medical interventions to restore patients' initial health status. Studies also indicate that as countries move out of different COVID-19 waves, hospital visit volumes slowly recover, although the utilisation rates of different services remain well below pre-pandemic levels. It is also probable that some healthcare services will be completely forgone, leading to lower than budgeted claims cost. On the contrary, the catch-up of medical procedures after COVID-19 may also last longer and be more costly than assumed. Accordingly, medical schemes need to prepare for all these prospects and the possible higher claims in areas directly tied to the pandemic (including Long COVID).

2.6. Medical schemes reserves and Investment income

In 2019/2020 financial year, reserves increased by 10.37% and the solvency also increased by 3.10% to 2019's **R73.29 billion**. Regulation 29 of the Medical Schemes Act prescribes that the minimum accumulated funds of medical schemes should be at least 25% of gross contributions to ensure that members' interests are always protected and to guarantee continued operation of the scheme (CMS, 2019/2020). The prescribed solvency also acts as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities, or expenses.

While the utilisation of reserves to cushion members against increasing costs (such as due to COVID-19) is an appropriate strategy to protect members against unaffordable contribution increases, caution should always be exercised when making this decision to ensure that the financial sustainability of the medical schemes is protected. In this regard medical schemes are expected to also consider and apply cost pull mechanisms to address affordability challenges whilst complying with the provisions of the Medical Schemes Act.

Investment income grew substantially from 2018's low levels, ensuring a net surplus of **R7.07 billion** in 2019 (compared with 2018's R5.01 billion). The CMS also noted that investment income generally boosted the performance of schemes. The JSE All-Share Index grew by 8.24% during 2019. The primary obligation of a

medical scheme is to ensure that it has sufficient assets to pay benefits to its beneficiaries. The management of medical schemes assets must therefore be structured to cope with the demands, nature, and timing of its expected liabilities. In addition, the assets of a scheme should be spread in such a manner that they match its liabilities and minimum accumulated funds (reserves) at any point in time. Trustees need to always monitor investments closely, not only to ensure compliance with legal requirements, but also to diversify risk appropriately (CMS, 2019/2020).

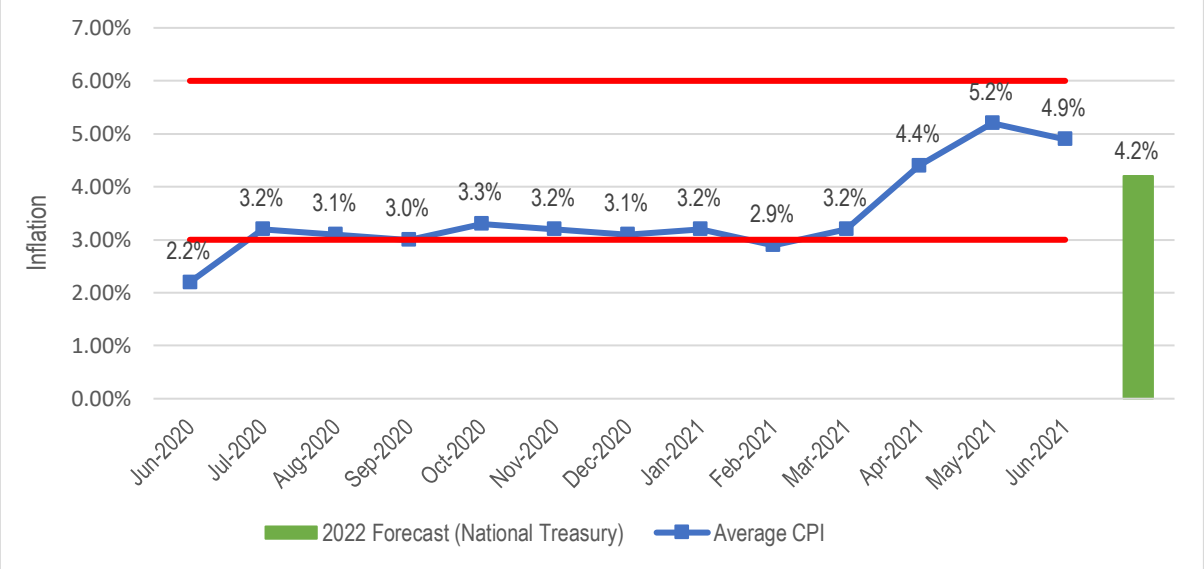
3. Guidance note on annual medical schemes cost increase assumptions

Outlined below are important industry-specific considerations that the CMS will consider when assessing the appropriateness of benefit changes, contribution rate increases, and overall cost increase assumptions for 2022 benefit year:

3.1. Headline inflationary expectations

The graph below depicts historical consumer price index (CPI) data as published by Stats SA for the twelve months up to June 2021 and National Treasury CPI forecast for 2022, against the inflation targeting framework of the SARB.

Figure 1: Headline inflation 2020– 2021



The year-on-year headline consumer inflation rate as measured by consumer price index (CPI) was 4.4% in April 2021, before accelerating sharply to 5.2% in May 2021 and then dipping marginally to 4.9% in June 2021. Overall, headline consumer inflation is projected to average 4.3% in 2021 (SARB, 2021).

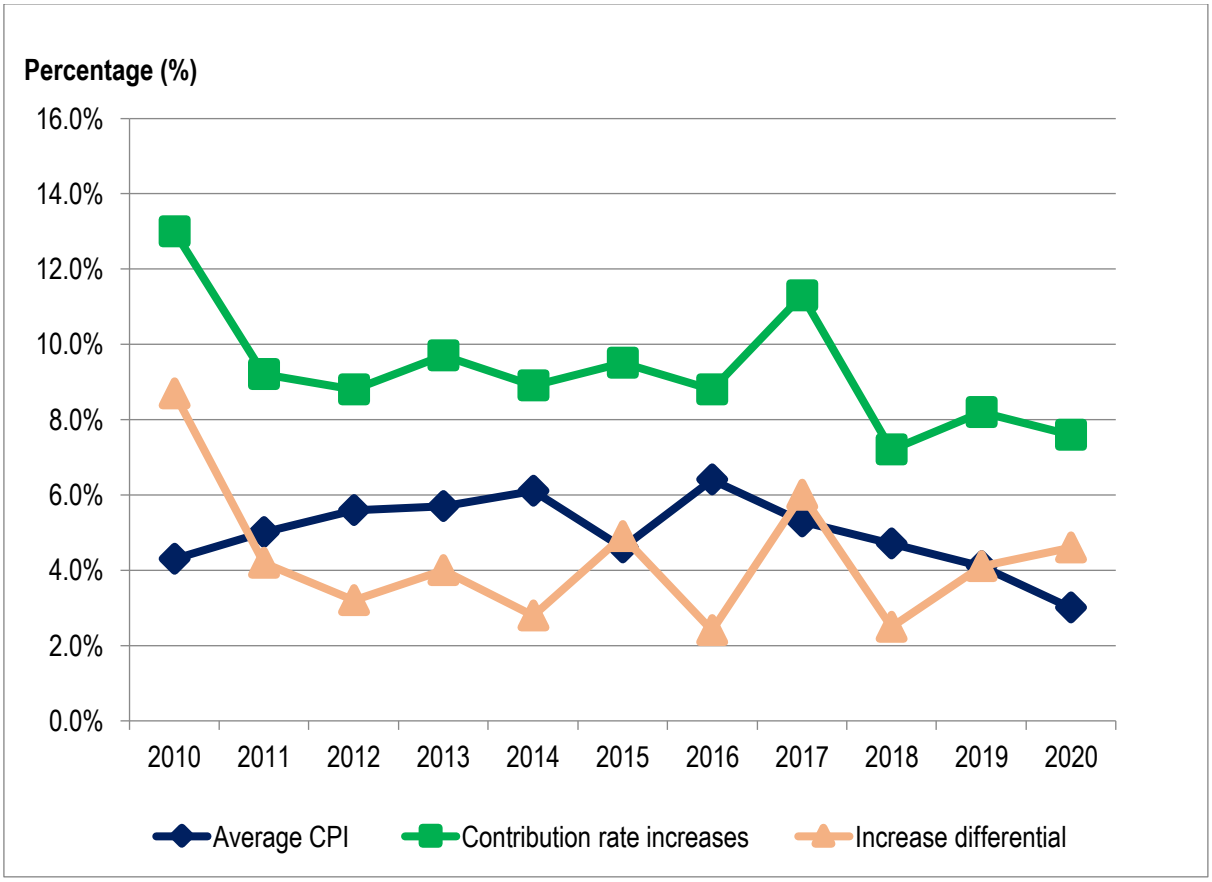
According to the latest inflation forecast of the SARB, as outlined in the July Monetary Policy Statement (MPC), headline inflation is expected to average 4.2% in 2022, before edging up to 4.5% in 2023 (SARB, 2021). Likewise, according to National Treasury's Economic Outlook, inflation is projected to average 4.2%

and 4.4% in 2022 and 2023 respectively (National Treasury, 2021). The CMS uses CPI, as a proxy measure for affordability.

3.2. Medical scheme contribution dynamics and consumer inflation

The graph below (figure 2) provides an illustration of trends of the contribution increase rate as reported in the 2019/2020 CMS Annual Report, relative to CPI. In addition, figure 3 incorporates medical schemes' contribution increases and CPI "health basket" as reported by Stats SA.

Figure 2: Medical schemes contributions and headline inflation (2010-2020)



It is evident from figure 2 above, that medical scheme contribution increase rates have consistently surpassed the CPI. The average contribution increase rate of 7.6 % for 2020, is 4.6% higher than the average CPI of 3.0%. CMS remains concerned about this trend, as this places an undue financial burden on members of medical schemes and further serves as a barrier to entry for potential new members. The high increase differential between medical scheme contributions increase rate and CPI, poses a serious affordability challenge for members, especially in the current and post COVID-19 economy, where annual salary adjustments are unlikely to keep pace with medical schemes contribution increases.

Figure 3: Medical schemes contributions and Stats SA health insurance (2009-2020)

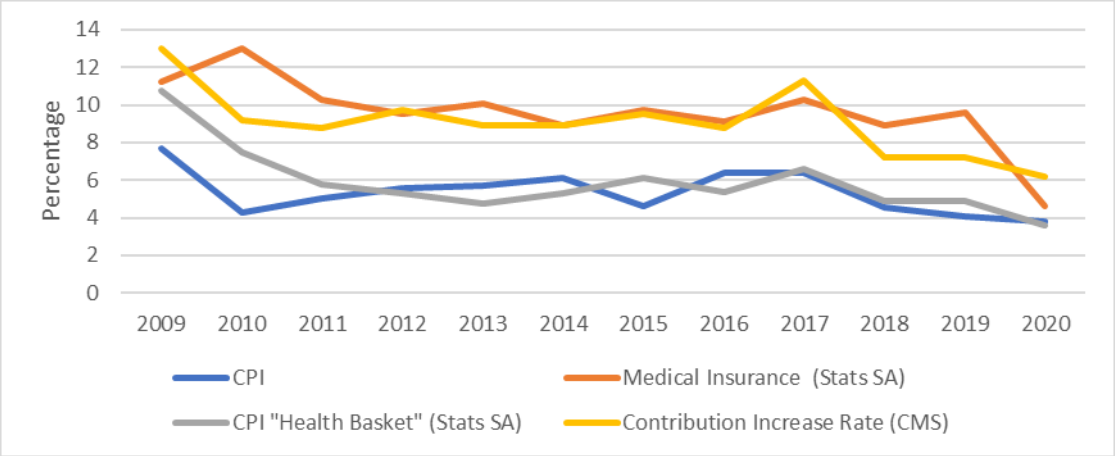


Figure 3 above, shows that the CMS contribution increase rate of **7.6%** is slightly higher than the Stats SA medical insurance rate of **4.6%,** representing a difference of **3.0%.** Whilst the CPI "health basket" rate of **3.6%** is the lowest rate over a 12-year period which is closer to **3.8%** CPI rate for the corresponding year. The CMS contribution increase rate is also **0.6%** lower than 2019 rate whilst the health basket is **1.3%** lower than the previous year. Further noted in this graph is that three of the four rates have declined over a year period whilst two are relatively closer to the CPI. This observation is consistent with the decline of inflation within South Africa and from other countries due to the impact of COVID-19.

3.3. Pre-COVID-19 utilisation and contribution increase trends

Table 2 below depicts changes between the years 2016 to 2021 on the actual contribution increase in relation to projected tariff and utilisation increases.

Table 2: Actual contribution increase and assumed rates

	2016	2017	2018	2019	2020	2021
Actual Contribution Increase rate	8.8	11.3	7.2	8.2	6.2	*
CPI	6.4	5.3	4.6	5.4	3.0	3.8
Assumed utilisation increase	3.05	3.9	3.3	3.9	3.7	4.36
Tariff	5.55	7.4	5.5	5.4	5.1	4.18
Total assumed increase	8.6	11.3	8.8	8.6	8.8	8.5

Note: **to be published in the 2020/2021 CMS Annual Report*

The overall cost increase assumption associated with utilisation was 4.36%, while assumed tariff increase was 4.18%, resulting in a total cost increase assumption of 8.5% for the 2021 benefit year. Cost increase assumptions analysis for 2021 showed that the combination of demographic and utilisation factors was projected to add about 4.36% points to the total cost increases for medical schemes, slightly higher than 3.7% for 2020 benefit year.

3.4. Single Exist Price (SEP) for medicines

The actual (and approved) adjustment to the Single Exist Price (SEP) is published by the Minister of Health towards the end of each year. The table below provides historical increases in SEP from 2017-2021. The Gazetted increase for 2021 is 3.7% whilst the SEP for 2022 will be published later in the year. Medical schemes are advised to assume a reasonable estimate for 2022 based on the historical figures below.

Table 3: SEP Publications (2017-2021)

Year	Average CPI	Approved SEP Increase
2017	5.3%	7.5%
2018	4.6%	1.26%
2019	4.6%	3.78%
2020	4.1%	4.53%
2021	3.8%	3.7%

Note: *SEP formula is published by the Pricing Committee*

4. Statutory requirements for submission of rule amendments

Due to the extra ordinary circumstances relating to the COVID-19 pandemic, all the 2022 rule submissions must be done electronically here. New users must first complete this authorisation form to be granted access.

To expedite the rule registration process, schemes are required to submit amendments to rules relating to the **changes to the contributions, and benefit changes only**. Changes to the main rules will not be prioritised unless they have a material impact on the benefit and contributions, for example an amendment relating to scheme tariffs. The rest of the changes to the main rules must only be submitted once the amendments to contribution and benefits changes have been approved by the Registrar.

The following process must be adhered to when submitting amendments in terms of section 31(3), section 33 (1) (2) (5), regulation 2(d) and regulation 4(b) & (d) of the Medical Schemes Act:

4.1. All schemes must submit a dated and certified resolution of their respective Board of Trustees (BoT) with the wording "*Certified as having been adopted in terms of the rules*" **together with** a summary of the changes and a of copy of rules with tracked changes of the proposed amendments to the respective benefits and/or contributions to fast track the review process. The format for tracked changes can either be shown in the margin in balloons or as underlined/strikethrough of the text to ensure that the submission is apparent.

4.2. Any rule amendments that the CMS requested in previous submissions must be incorporated into the current amendments, if not effected already.

4.3. No text should be underlined in the original documents or copies of the rules of each medical scheme.

4.4. **Appendix 1A or 1A (2)** must only be completed for each benefit option which was registered in 2021, and again for all benefit options which the scheme intends to register in 2022.

4.5. **Appendix C or C (2)** must be completed for each benefit option which was registered in 2021, with different contribution rates based on income band or **efficiency-discounted** (EDO) sub-options, in an instance where the benefit option is to be registered for 2022.

4.6. **Appendix 1B** must be completed for the entire medical scheme for both 2021 and 2022. Please note that schemes under close monitoring by the CMS need to provide input on the approved solvency ratio (row y) for 2021 and 2022 in Appendix B as per the approved business plan. The projected solvency ratio for 2021 and 2022 in Appendix 1B will be assessed in terms of the solvency ratio outlined in the business plan approved by the CMS, and any deviation must be explained in the scheme's submission.

4.7. **Appendix D** requires information about the assumptions on cost increases and utilisation that medical schemes used in determining their respective contribution increase for the 2022 benefit year. The Annexure has been updated in line with the CMS Annual Report 2019/20 Annexure J and O which separated the total risk benefits paid by discipline codes to be consistent with the schemes' annual return submissions. Each medical scheme must complete the spreadsheet **one time only**, and deviation(s) from the guideline assumptions must be explained in the motivation for increases.

4.8. All the Appendices must be submitted by the deadline date. Only the spreadsheet template provided should be used for the submission. The spreadsheet is available here.

4.9. Schemes seeking to register **efficiency-discounted sub-options** must have obtained an exemption from Section 29(1)(n) of the Medical Schemes Act. Section 8(h) stipulates that only the Council (the Board of the CMS) has the power to grant exemptions from any provision of the Act. It should be noted that an exemption must be granted by the CMS for each efficiency-discounted sub-option. An exemption is not granted at scheme level.

4.10. Applications for all **new benefit options** including **efficiency-discounted sub-options** taking effect from 1 January 2022 must reach the CMS by **1 September 2021** in terms of section 33(1) of the Medical Schemes Act. Applications received after 1 September 2021 will not be attended to until the CMS has considered all the benefit and contribution amendments of those medical schemes that submitted their amendments by the stipulated deadline.

4.11. Schemes are further required to indicate percentage changes on any benefits that are being amended in a tabular form (submitted in **word/excel format electronically**), as follows:

Name of benefit option			
Benefits/services	**2021**	**2022**	**% change**
e.g. day-to-day limit	e.g. R10 000 per beneficiary	e.g. R11 000 per beneficiary	10% increase

4.12. In instances where registered rules or rule amendments impose monetary limits on benefits, an explicit condition must be included indicating that the limit does not apply to the prescribed minimum benefit (PMB) conditions, and further stating that PMBs are paid in full when making use of a designated service provider (DSP). The submission of rule amendments with limits on PMB conditions will be amended to highlight the

fact that the PMBs are provided at no cost to beneficiaries. This is to ensure that rule amendments are compliant with the Medical Schemes Act and are fair to beneficiaries.

Any submission without **all** the above requirements will be deemed non-compliant and will not be attended to.

5. Key CMS recommendations

5.1. Contribution increases amidst COVID-19

The CMS would like to commend scheme BoTs for responding positively to the Registrar's call to provide financial relief to members grappling with economic fallout due to COVID-19, as per Circular 52 of 2020. In addition to several regulatory relief provided to medical schemes via exemption process, on average the industry implemented lower contribution increases for 2021 benefit year, with some schemes adopting innovative pricing strategies, such as keeping premiums constant for few months and providing much needed financial support to households.

Despite the country intensifying its vaccination roll-out in recent weeks, waves of infection are likely to continue until the population has developed sufficient herd immunity to curb transmission. This, together with social economic issues are threats to the speed of economic recovery. As such, household income is likely to remain under pressure for the foreseeable future, as consumers continue to bear the brunt of the COVID-19 economic contagion. As was the case with the 2021 benefit pricing cycle, the CMS would like to stress to Trustees to continue to adapt their pricing strategies, aimed at providing financial support to members, as the economy recovers from the pandemic.

It is against this background that the CMS recommends that contribution increase for 2022 benefit year, should be limited to **4.2%** in line with the National Treasury projected CPI increase. Furthermore, in instances where it is economically feasible to implement a lower contribution increase than the CMS recommended CPI-linked rate, Trustees are encouraged to adopt innovative pricing models, subject to an independent actuarial evaluation.

The CMS is also cognizant of the heightened uncertainty regarding the impact of the pandemic on healthcare claims costs, as well as how quickly member's health seeking behaviour will normalise. As such, pricing decisions for the 2022 benefit year should be largely data dependent and sensitive to the demographic risk profile and financial position of each scheme.

5.2. Medical schemes that were already in financial distress pre-COVID-19

Medical schemes that were already in financial distress pre-COVID-19, may require contribution increases higher than the recommended **4.2%**. Such schemes must provide the CMS with a detailed motivation for such increase. Furthermore, schemes must revise their current business plans, considering the shock of the pandemic and demonstrate their long-term viability. In instances where it is evident that the pandemic may pose an existential threat to the long-term sustainability of a scheme, Trustees must be proactive and start seeking efficiency enhancing amalgamation partners, in line with the prescripts of section 63 of the Act.

It is CMS' considered view that in an economic climate ravaged by a pandemic, with lower corporate earnings, higher government debt, rising unemployment and shrinking household earnings— medical schemes that

burden members with steep contribution increases that are unsustainable, are ill-suited to the conditions of a post-COVID economy.

5.3. Increase in managed care and administration fees

To further cushion medical schemes members, the CMS recommends that the assumed increases in non-healthcare expenditure (i.e. administration and managed care fees) for 2022 benefit year, must be kept constant at the current 2021 prices. Those schemes that have sufficient economies of scale are expected to continue using their strategic purchasing when contracting with all providers to ensure value-based contracting for the benefit of their members.

5.4. Actuarial review of perennial loss-making benefit options

Section 33(2) of the Act, prescribes that benefit options must be self-supporting in terms of both financial and membership performance, not jeopardise the financial soundness of any existing benefit option, in the medical scheme. Yet there are some benefit options that have historically continued to incur deficits and are inconsistent with the prescripts of section 33(2).

Consequently, all 2022 actuarial reports must include an additional section providing a detailed historical technical analysis of loss-making options. The report must clearly stipulate the reason(s) for underwriting deficit, a long-term turnaround strategy without igniting contribution inflation or decline in benefits. In addition, schemes are requested to provide a sensitivity analysis of the financial impact of closing such options from a member perspective as well as the medical scheme perspective.

5.5. Selection of DSPs and excessive co-payments

Following the publication of the publication of Government Gazette Notice 214 of 2021, read with Circular 31 of 2021, the CMS wishes to clarify that DSPs and co-payments are part of the key tenets of the Medical Schemes Act and will continue to be applicable until such time that the Act is amended.

In line with the gazette, the CMS is in consultation with the relevant role players to develop the guidelines to ensure that members of medical schemes are not charged excessive co-payment and that selected DSPs are in the best interest of members. Until such time that this process is completed, the current co-payments registered in terms of the scheme rules will remain applicable.

5.6. Application for registration of new benefit options

As evidenced by Health Market Inquiry findings, (2019), the current high number of benefit options and complex benefit design have an adverse effect on consumers and competition in the market. Consequently, the industry must continue to review their benefit options and consolidate those options that are not sustainable in terms of both membership and financial performance. In the aftermath of the COVID-19 economic meltdown and the likely drop in membership, consolidation of benefit options is even more critical.

The CMS is aware of the severe market disruptions caused by the onset of the COVID-19 pandemic and the need for the industry to innovate and evolve to adjust to the new normal and economic realities. As such, the CMS will only consider the application for registration of new benefit options under exceptional circumstances.

At the core of the medical scheme's business plan must be the need to improve risk pooling, cross-subsidisation, and affordability, while simultaneously offering members quality healthcare services, including **virtual care benefits**. The delivery model must be premised on the principles of strategic purchasing of healthcare through value-based contracting with cost-efficient providers.

5.7. Augmented actuarial evaluation and COVID-19

A detailed motivation for the required changes to benefits and contributions must accompany **all** submissions. The guidance provided above regarding the limit on the cost increase assumptions should be taken into consideration when determining the adequacy of contribution increases. As indicated in Circular 29 of 2012, a report that is sent together with the proposed amendments must take into account the requirements of the Advisory Practice Note (APN303) published by the Actuarial Society of South Africa (ASSA) called: "Advice to South African Medical Schemes on Adequacy of Contributions."

In the context of the uncertainty and unquantifiable impact of the COVID-19, all accompanying 2021 actuarial reports, must include an additional segment providing a detailed sensitivity analysis of the possible financial impact of COVID-19 pandemic on the short to long-term sustainability of each medical schemes. The report must be prepared by a person with the appropriate actuarial and/or statistical skills, and should include the following detailed information:

- benefit changes
- contribution increases
- non-healthcare expense
- assumptions
- financial projections

5.8. Conflict of interest

BoTs and Principal Officers are expected to promote the interests of members during the determination on contribution increases for 2022. The BoT should always ensure that their fiduciary duties are intact, and not convoluted by a conflict of interests. This expectation is consistent with the Medical Schemes Act and HMI findings which expects that Trustees shall take reasonable steps to ensure that the interest of beneficiaries are always protected.

5.9. Medium term cost increase assumptions for contribution increases

To assist the industry with future planning, the CMS therefore offers the industry with a two-year forward looking cost increase assumption for contribution increases. To this end, cost increase assumptions for contribution increase for the 2022 and 2023 benefit year, are projected to increase by 4.2% and 4.5% respectively, in line with the projected CPI. These projections are, however, subject to revision in line with the CPI inflation forecast by both the National Treasury and the SARB.

5.10. Deadline for submission and possible review and resubmission

The deadline for medical schemes to submit their rule amendments scheduled to take effect from 1 January 2022, is **1 September 2021** for new options or EDOs and **1 October 2021** for contribution and benefit changes. Due to uncertainty regarding the potential impact of pandemic on health care claims costs, medical schemes that may require additional time to finalise their 2022 pricing decision, must submit a request for an extension to the Registrar citing their unique individual circumstances. Nonetheless, the CMS still welcomes early submissions.

Trustees are further advised to constantly monitor their claims experience in the next coming months. Should the scheme's experience material change, with a possible deterioration of the scheme's financial position, the board is advised to review and revise their contribution increases and resubmit to the Registrar, in line with section 31(1) of the Act.

Queries may be directed to the Benefits Management Analyst responsible for your scheme at the CMS.

The CMS looks forward to your cooperation.

Yours sincerely,

Dr Sipho Kabane
Chief Executive & Registrar
Council for Medical Schemes