



Reference: Guidance on contribution increases and benefits changes for 2026
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Circular 24 of 2025: Guidance on contribution increases and benefits changes for 2026

This Circular outlines the requirements that medical schemes are required to comply with when determining annual contribution increases and benefit amendments for the 2026 benefit year.

Section 7 of the Medical Schemes Act (131 of 1998) mandates the Council for Medical Schemes (CMS) to protect the interests of beneficiaries at all times and to coordinate the functioning of medical schemes. In line with this mandate, the CMS' key objective is to ensure that annual contribution rate increases remain affordable, promote equitable access to quality healthcare, and safeguard the long-term financial sustainability of the industry.

1. MACRO-ECONOMIC OUTLOOK

This segment provides a brief overview of the key macroeconomic indicators that impact the medical schemes industry, such as the consumer price index (CPI), gross domestic product (GDP), unemployment levels, interest trends, and currency exchange rates. Overall, these economic indicators have a direct and indirect bearing on the affordability of medical scheme contribution rates, the financial performance of schemes, membership growth, and the industry's long-term financial sustainability.

1.1. Global economic prospects

Global growth is facing a significant headwind with a substantial rise in trade barriers and an uncertain global policy environment induced by the decision of the United States to hike trade tariffs on its trading partners. According to the International Monetary Fund's (IMF) latest projections, global growth is forecast to decline from 3.3% in 2024 to 2.8% in 2025 (IMF, 2025). The economic outlook largely hinges on the evolution of the current trade wars. Growth could turn out to be worse if the trade restriction escalates. Furthermore, the ongoing geopolitical tension and heightened conflict in the Middle East imply that the downside risk to global growth will remain elevated. On the upside, global output could increase if major economies reach lasting trade agreements with the United States.

1.2. South African economic outlook

South Africa's economy has been stagnant for roughly a decade, mainly due to structural issues such as logistics inefficiencies and ageing infrastructure. This trend is poised to continue with gloomy economic growth prospects for both 2025 and 2026. According to the IMF, South Africa's GDP is projected to increase by a measly 1.0% in 2025 and 1.3% in 2026 (IMF, 2025). Similarly, according to the latest projections of the South African Reserve Bank (SARB), GDP is forecast to increase by a modest 0.9% and 1.3% for the same period (SARB, 2025). Uncertainty about the full economic impact of the trade tariffs imposed on the country's exports to the United States, coupled with the fact that SA's continued participation in the Africa Growth and Opportunity Act (AGOA) remains uncertain, implies that the downward risk to growth remains elevated.

1.2.1. The exchange rates

The South African Rand has recently exhibited notable strength against the US dollar, mainly due to a confluence of global and domestic factors. The recent appreciation of the domestic currency can be attributed primarily to the weaker US dollar amid ambiguity surrounding the effects of the US President-induced global trade wars. The Rand has also been buoyed by the continued stability of the Government of National Unity (GNU), despite the periodic episodes of political rumblings and bickering amongst leading GNU members. However, the Rand is also expected to remain highly volatile and vulnerable to near-term sharp depreciation due to possible ratcheting of global trade wars and geopolitical tension in the Middle East. A weak domestic currency poses a financial risk to the local pharmaceutical industry, which imports most active ingredients and new medical technologies.

1.2.2. Interest rates

At its recent meeting in July, the Monetary Policy Committee (MPC) of the SARB cut the repo rate by 25 basis points, to the relief of many indebted consumers. The repo rate, which is the rate at which the SARB lends money to commercial banks, decreased from 7.25% to 7.00%. Consequently, the prime lending rate for commercial banks to consumers also decreased from 10.75% to 10.50%. Overall, the SARB is expected to continue with the current monetary policy easing cycle due to the current lower inflation expectations. While consumers are expected to benefit from the current lower interest rate environment, escalating global trade wars may lead to an abrupt tightening of global financial conditions and hinder further domestic interest rate cuts.

1.2.3. Employment Statistics

According to Statistics South Africa Quarterly Labour Force Survey (QLFS), the official unemployment rate rose by 0.3 percentage points to 33.2% in the second quarter compared to 32.9% in the first quarter of 2025 (Stats SA, 2025). The membership growth rate of medical schemes is highly correlated with the unemployment rate. With a subdued economic growth forecast for the remainder of 2025 and 2026, membership growth in medical schemes is likely to remain stagnant. However, as the average age of the current risk pool continues to edge up and the corresponding worsening demographic profile, the industry's long-term sustainability remains a concern.

2. GUIDANCE NOTES ON ANNUAL MEDICAL SCHEMES COST INCREASE ASSUMPTIONS

Outlined below are key industry-specific factors that the CMS will consider when assessing the appropriateness of contribution increases, benefit changes, and overall cost increase assumptions for the 2026 benefit year:

2.1. Headline inflationary expectations

Figure 1 below depicts historical CPI data published by Statistics South Africa for the twelve months up to June 2025, against the inflation targeting framework of the South African Reserve Bank and the CPI forecast for 2026. South Africa does not have an official medical price index. Therefore, the CMS uses the Consumer Price Index to estimate annual price increases in the private healthcare sector. The CMS also uses CPI as a proxy measure for the affordability of annual contribution rate increases by medical schemes.

The year-on-year headline inflation, as measured by the consumer price index, remained constant at 2.8% for April and May before edging up to 3.0% in June 2025, still at the bottom of the Reserve Bank's target range of 3%-6%. Overall, inflation is projected to average 3.3% in 2025 (SARB, 2025). According to the latest inflation forecast of the Reserve Bank, as outlined in the July Monetary Policy statement, headline inflation is expected to average 3.3% in 2026, before moderating to 3.0% by the end of 2027 (SARB, 2025).

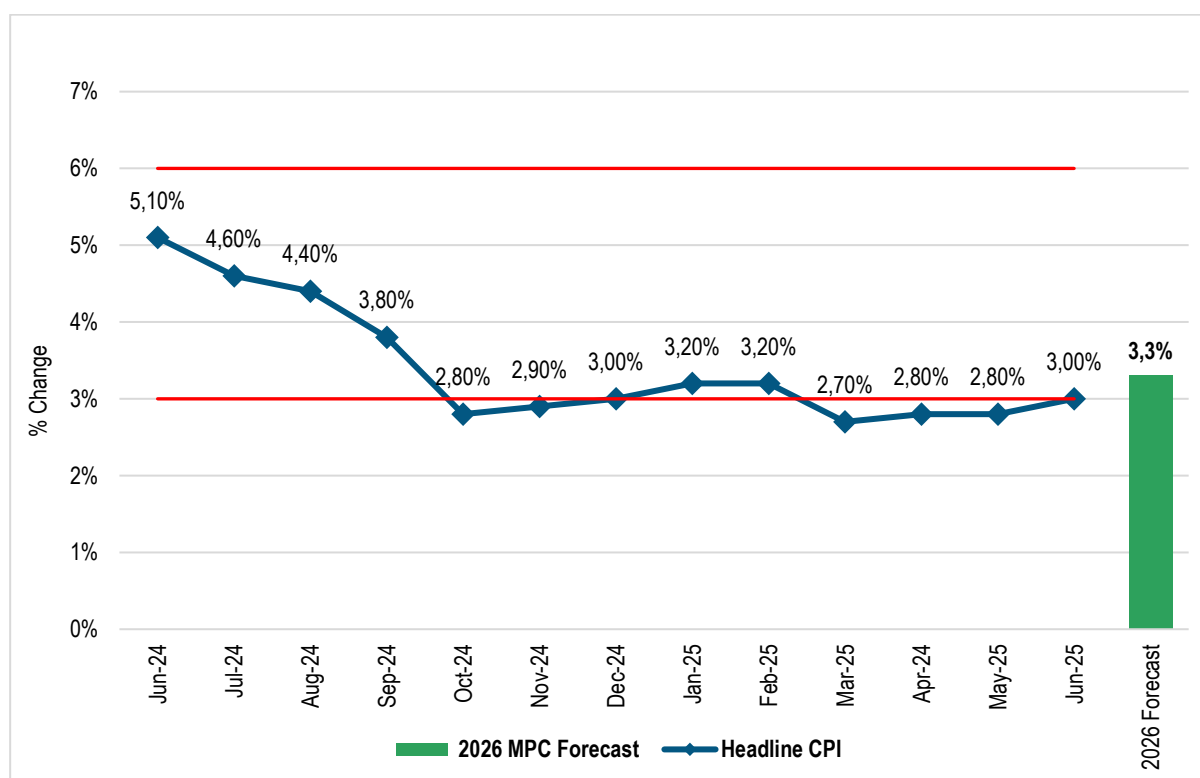


Figure 1: Headline inflation 2024–2025 and 2026 forecast

Data source: Stats SA and SARB

2.2. Medical schemes' contribution increase rate relative to consumer inflation

The graph below (Figure 2) illustrates the trends of medical scheme contribution increase rates relative to consumer inflation. The average industry contribution increase rate of 10.1% for the 2025 benefit year was 7.1% higher than the projected average CPI of 3%. The figure below demonstrates the return to the patterns that existed prior to the COVID-19 pandemic, when contribution increases consistently outpaced inflation.

The higher price differential between annual medical scheme contribution rate increases and CPI places an undue financial burden on cash-strapped consumers, especially when annual salary adjustments are unlikely to keep pace with CPI. Persistently above-inflationary contribution increases also serve as a barrier to entry for potential new members due to budgetary constraints. The trend demonstrates an urgent need for an innovative solution in the market to arrest the spiralling annual medical scheme contribution rate increases, in order to insulate members from the risk of losing their insurance cover due to affordability constraints.

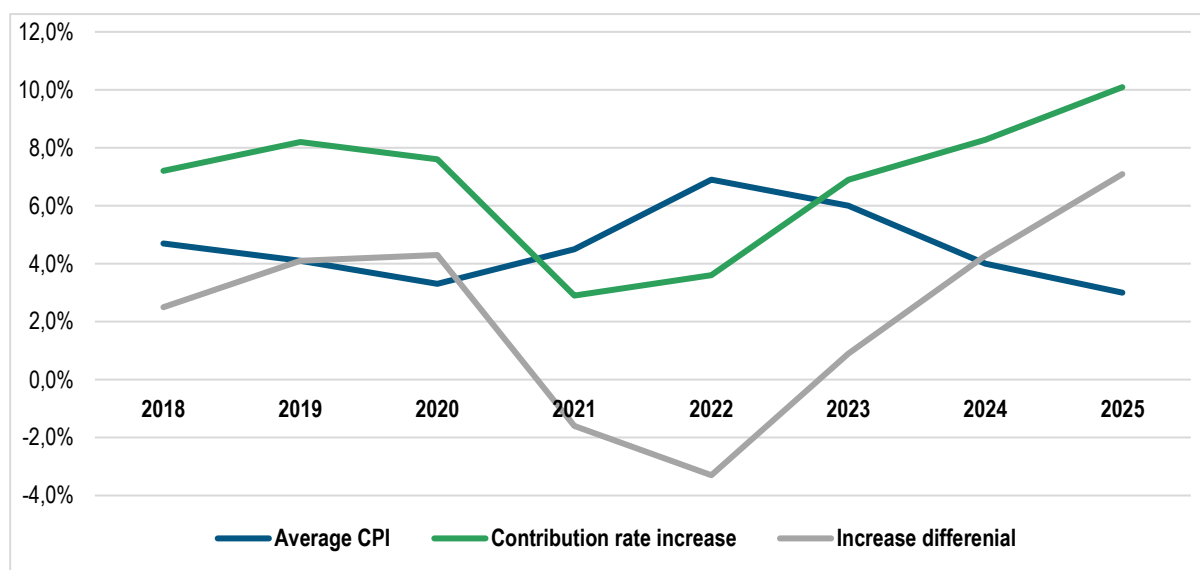


Figure 2: Medical scheme contribution rate increases and headline inflation (2018-2025)

Data source: CMS

2.3. Single Exit Price (SEP) relative to consumer inflation

Figure 3 below depicts the historical adjustment to the Single Exit Price (SEP) relative to inflation between 2018 and 2025. The Minister of Health publishes the approved SEP towards the end of each year. The SEP for 2026 will be published later in the year. Medical schemes are advised to assume reasonable estimates for the 2026 benefit year.

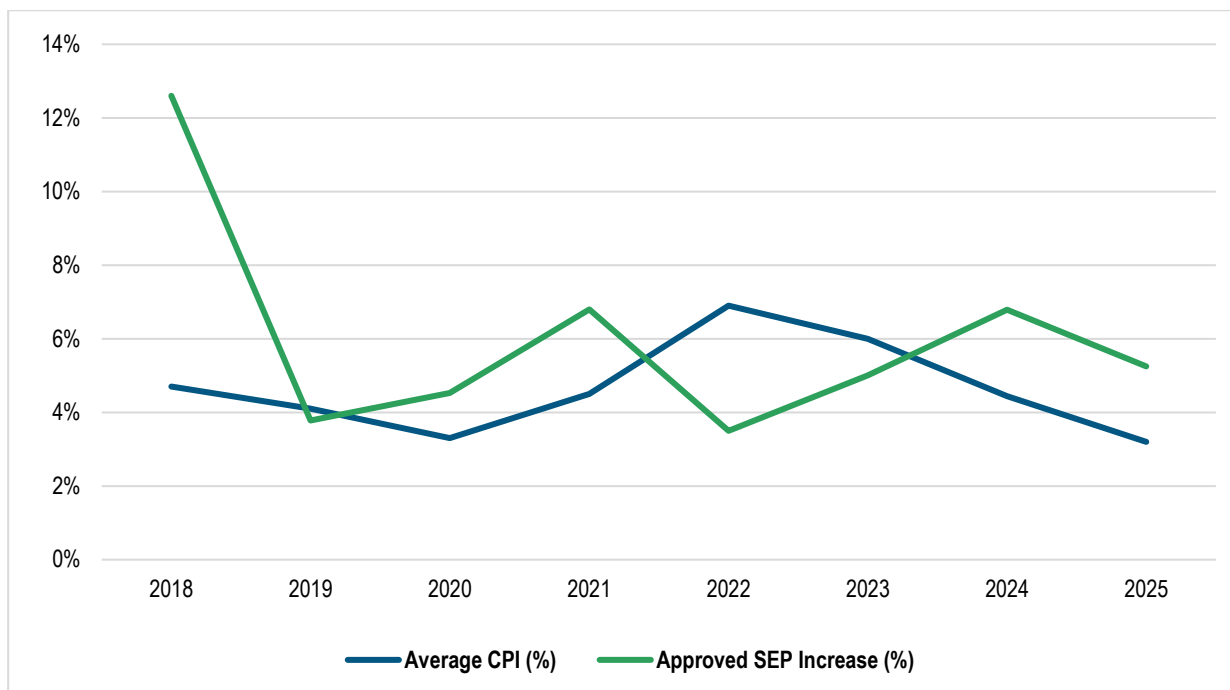


Figure 3: SEP and CPI (2018-2025)
Data source: Pricing Committee and Stats SA

2.4. Medical schemes expenditure trends

The utilisation of healthcare services by beneficiaries directly correlates with medical schemes' expenditure. Utilisation, often driven by factors such as an aging population and prevalence of chronic diseases, leads to a higher claims ratio and a subsequent increase in expenditure for medical schemes. Conversely, a reduction in service utilisation is associated with a decrease in medical scheme expenditure. When medical scheme expenditure persistently increases at a pace higher than inflation, this puts upward pressure on annual increases in contributions. This emphasises the critical nature of finding innovative ways to manage healthcare service usage to control costs and ensure that contribution increases remain affordable for members. In essence, monitoring and optimising the utilisation of healthcare services is crucial in maintaining the financial sustainability of medical schemes and the overall healthcare system.

Figure 4 depicts a progressive rise in expenditure across different expenditure categories between 2018 and 2023 benefit year. Notably, spending on specialist consultation services and hospital admissions has increased substantially post-COVID-19 pandemic, surpassing expenditure associated with GP visits and medicine. Despite the policy emphasis on strengthening primary healthcare, spending on GP consultations was the lowest during the period under review. The data highlights an unsustainable upward cost trajectory driven by high-cost specialist visits and hospital-based care, underscoring an urgent need for greater emphasis on primary healthcare, improved referral pathways, and strategic cost-containment measures within the medical schemes industry.

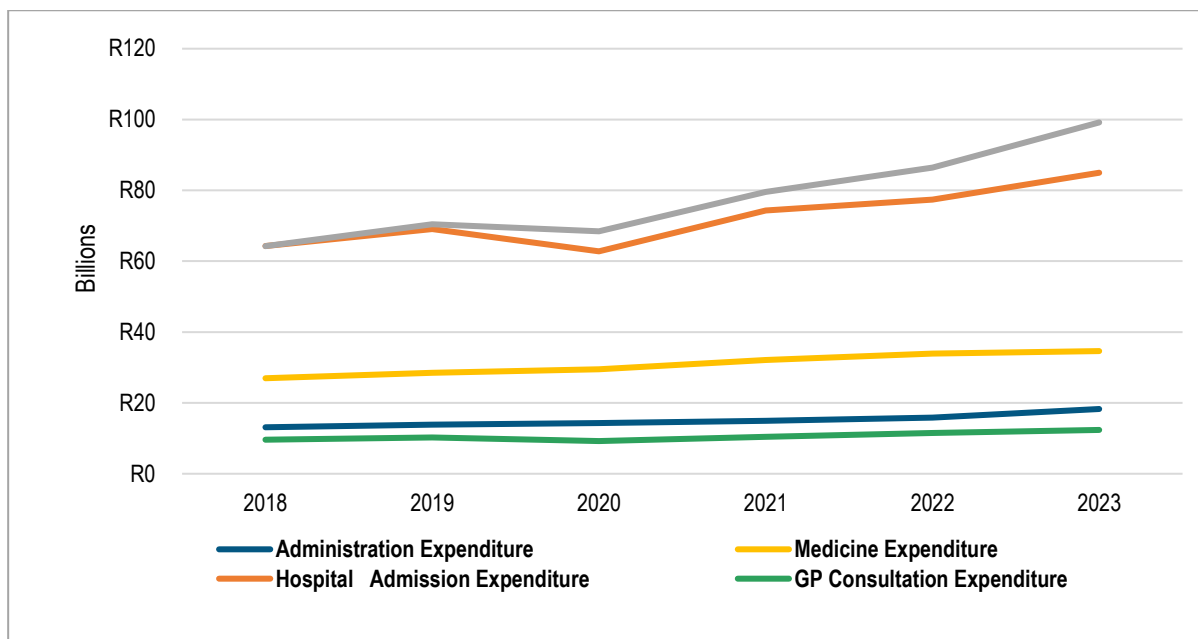


Figure 4: Medical schemes expenditure trends by category (2018 -2023)

Data source: CMS

Figure 5 below depicts medical schemes' spending on hospital admissions by age bands between 2018 and 2023. In line with the theoretical proposition, it is evident that healthcare expenditure increases with age. This is primarily because healthcare utilisation is driven by factors such as the increased prevalence of chronic diseases and multi-morbidity, which tends to rise with age, leading to a higher claims ratio and a subsequent increase in expenditure by medical schemes. Overall, the data shows that medical schemes incur higher healthcare costs amongst older age groups, peaking at the 60-64 years age group and then decelerating gradually thereafter. These trends highlight the need for innovative strategies such as the use of exclusive provider contracting to curb spiralling high-cost in-hospital claims and high utilisation in these age groups.

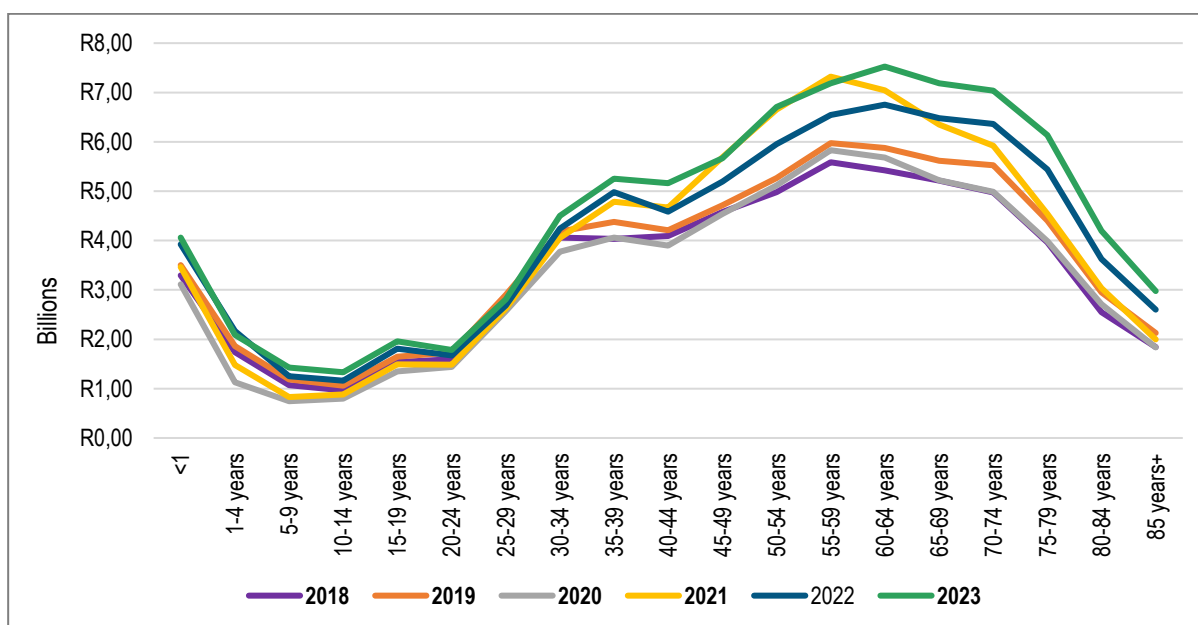


Figure 5: Hospital expenditure per age group (2018-2023)

Data source: CMS

Figure 6 below illustrates medical scheme expenditure on specialists across different age bands between 2018 and 2022. Similar to Figure 6 above, the graph shows a consistent upward trend in specialist expenditure among the 20-24 age group, before peaking in the 50-55 year age cohort and then decelerating gradually. The insights underscore the need for proactive cost-containment strategies, including risk-based care coordination and more robust referral pathways to manage the high-cost claims associated with specialist treatment.

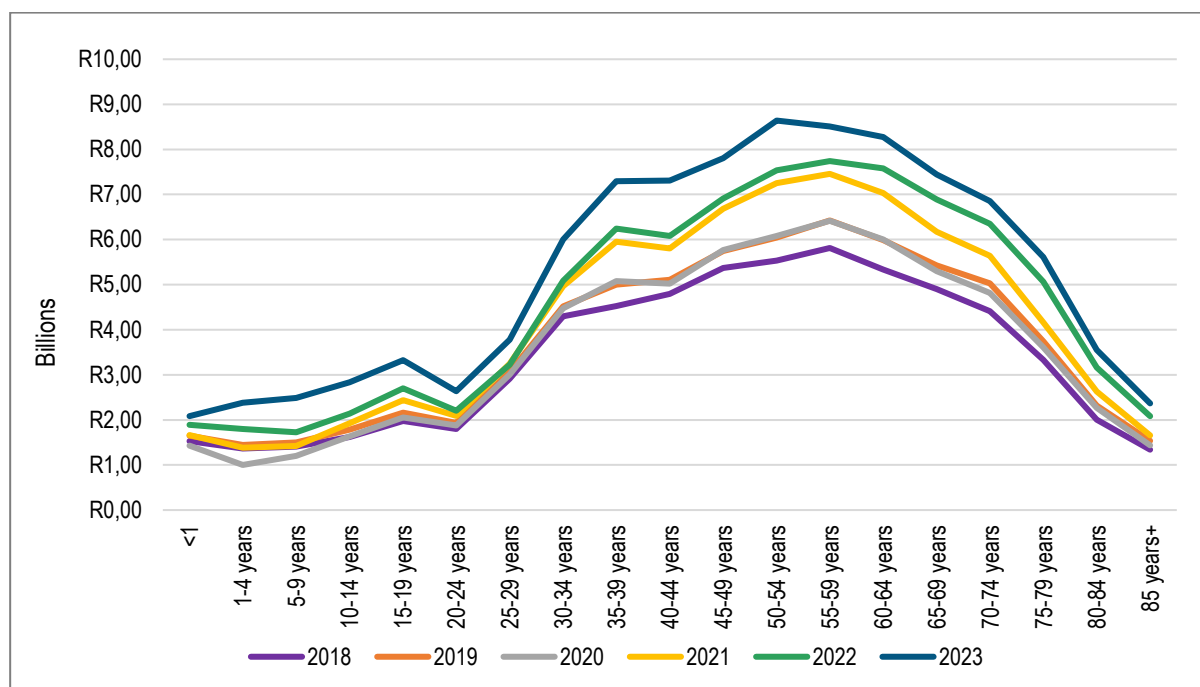


Figure 6: Specialist expenditure per age group (2018-2023)

Data source: CMS

Overall, healthcare expenditure in the medical schemes industry continues to rise faster than inflation. This trend is mainly attributed to unique industry factors such as technological advancement, the ageing population, and the increasing prevalence of chronic diseases. Managing spiralling healthcare costs remains a key priority for medical schemes to ensure members' affordability and the sustainability of healthcare coverage.

Trustees must, therefore, continue to seek efficient strategies to curb costs without compromising quality health outcomes. These strategies include prioritising selective contracting with cost-efficient healthcare providers and pharmaceutical suppliers, and the use of formularies.

2.5 Medical scheme reserves and investment income

Regulation 29 of the Medical Schemes Act prescribes that the minimum accumulated funds of medical schemes should be at least 25% of gross contributions. [Reserves](#) serve to protect members' interests and to guarantee the continued operations of medical schemes. They also serve as a buffer against unforeseen and adverse developments, whether from claims, assets, liabilities, or expenses. At the end of 2023, the industry recorded a solvency ratio of 43.45%, significantly above the minimum required level of 25% as set out in Regulation 29 of the Medical Schemes Act (CMS, 2023). The reserve levels show that despite substantial increases in healthcare expenditure, the industry remains in a sound financial position.

Trustees should continue with the current prudent financial risk management approach to ensure the industry's long-term sustainability. Similarly, they must use their schemes' favourable financial position to mitigate members against higher

medical inflation rates where appropriate, without immediately passing all costs to members through unreasonable contribution increases.

3. MANDATORY STATUTORY REQUIREMENTS FOR SUBMISSION OF RULE AMENDMENTS

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:

- 3.1. Schemes must submit a pdf (**not scanned**), dated and certified resolution of their respective Board of Trustees (BoTs) with the wording “*Certified as having been adopted in terms of the rules*” **together with** a summary of the changes and a copy of the rules with tracked changes of the proposed amendments to the respective benefits and/or contributions to expedite 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.
- 3.2. Any rule amendments that the CMS requested in previous submissions must be incorporated into the current amendments if they have not been effected already.
- 3.3. No text should be underlined in the original documents or copies of the rules of each medical scheme.
- 3.4. **Appendix 1A or 1A (2)** must only be completed for each benefit option that was registered in 2025, and again for all benefit options which the scheme intends to register in 2026. Schemes are required to include the scheme registration number (Scheme Ref No) and benefit option identifier (Benefit Option Id) in the respective cells of the Appendix.
- 3.5. **Appendix C or C (2)** must be completed for each benefit option that was registered in 2025, 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 2026. Schemes are required to include the scheme registration number (Scheme Ref No) and benefit option identifier (Benefit Option Id) in the respective cells of the Appendix.
- 3.6. **Appendix 1B** must be completed for the entire medical scheme for both 2025 and 2026. Please note that schemes under close monitoring by the CMS need to provide input on the approved solvency ratio (row y) for 2025 and 2026 in Appendix B as per the approved business plan. The projected solvency ratio for 2025 and 2026 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. Schemes are required to include the scheme reference number (Scheme Ref No) in the provided cell.
- 3.7. **Appendix D** requires information about the assumptions on cost increases and utilisation that medical schemes used in determining their respective contribution increases for the 2026 benefit year. Each medical scheme must complete the spreadsheet **one time only**, and deviations from the guideline assumptions must be explained in the motivation for increases. Schemes are required to include the scheme reference number (Scheme Ref No) in the provided cell.
- 3.8. 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 on the CMS [website](#).
- 3.9. 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 has the power to grant exemptions from any provision of the Act.

It should be noted that the CMS must grant an exemption for each efficiency-discounted sub-option. An exemption is not granted at the scheme level. All exemptions must follow the process outlined in [Circular 33 of 2021](#).

- 3.10.** Applications for all **new benefit options, including efficiency-discounted sub-options taking effect from 1 January 2026**, must reach the CMS by **16 September 2025** in terms of section 33(1) of the Medical Schemes Act. Applications received after 16 September 2025 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.
- 3.11.** 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	2025	2026	% Change
e.g., day-to-day limit	e.g., R10 000 per beneficiary	e.g., R11 000 per beneficiary	10% increase

- 3.12.** In instances where registered rules or rule amendments impose monetary limits on benefits, an explicit condition must be included indicating that the limits do not apply to the Prescribed Minimum Benefits (PMBs) 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.
- 3.13.** 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 or attended to once the amendments to the contribution and benefits changes have been approved by the Registrar.
- 3.14.** All the 2026 rule submissions must be made electronically [here](#). New users must first complete this [authorisation form](#) to be granted access.

4. KEY CMS RECOMMENDATIONS

4.1. 2026 contribution increases

The annual medical scheme contribution rates have consistently increased at a higher rate than consumer inflation. The CMS remains concerned by this trend as it places a significant financial burden on members of medical schemes. Coupled with steep increases in the price of electricity and high food inflation, it is evident that most household budgets are significantly constrained. To ease the financial strain on members of medical schemes and the risk of losing health insurance, the CMS hereby recommends that the contribution increase and cost assumptions for tariff increases for the 2026 benefit year be limited to **3.3%** plus reasonable utilisation estimates.

The recommendation is in line with the Reserve Bank's 2026 CPI forecast, as outlined in the July Monetary Policy Committee statement. The CMS uses salary inflation as a proxy measure for the affordability of annual contribution increases.

Although private medical inflation generally exceeds CPI by 2 to 3 percent, CMS believes that the annual industry price increase assumptions should be linked to inflation. With sash-strapped consumers grappling with the current cost-of-living crisis, raising contributions above CPI is simply unaffordable for most households. The high medical scheme contribution rates also serve as a barrier to entry, particularly for young people, posing a serious threat to the long-term sustainability of the industry.

The CMS is also cognisant that some medical schemes may require contribution increases higher than the CMS' recommended CPI-linked increments. In such cases, the Trustees must provide the Registrar with a comprehensive business plan with clear financial and actuarial justification. The business plan must fully comply with the stringent requirements of the [Advisory Practice Note](#) (APN303) on the adequacy of contribution increases, as prescribed by the Actuarial Society of South Africa (ASSA).

Due to the adverse financial impact on members, the Registrar may order a medical scheme to provide a second independent actuarial analysis to justify above-inflationary increases, particularly in instances where the pricing assumptions cannot be substantiated. The Registrar's decisions to approve or decline any proposed contribution increases will continue to be data-dependent and sensitive to each medical scheme's financial and demographic risk profile.

4.2. Increase in managed care and administration fees

To further insulate members against higher contributions increases, the CMS recommends that increases in non-healthcare expenditure (NHE) for the 2026 benefit year must be adjusted by only **3.3%** in line with inflation. In the current adverse macroeconomic climate, there is no economic justification for increases in NHE above CPI, as this cost is ultimately borne by members through higher monthly premiums. Medical schemes with sufficient economies of scale are expected to use strategic purchasing when contracting with all providers to ensure value-based contracting. Trustees must also strive to incorporate efficiency and performance metrics into managed care contracts to improve operational efficiencies and the overall quality and efficiency of patient care delivery.

4.3. Governance and conflict of interest

Medical scheme trustees are reminded of their fiduciary duties, as required by Section 57 of the MSA. To this end, trustees and Principal Officers must take reasonable steps to avoid conflicts of interest and ensure that the interests of beneficiaries are protected when determining contribution increases. Instead of simply saddling members with higher contribution increases, trustees must also periodically evaluate the efficiency justifications of existing contracts with service providers and, where possible, renegotiate and pass some of the efficiency gains from such agreements to members through lower annual increases. Where contracted third-party entities have failed to demonstrate value for money, the BoT must review such agreements and take the necessary remedial action.

4.4. Application for registration of new benefit options

Based on the findings of the Health Market Inquiry in 2019, the current high number of benefit options and complicated benefit structures have a negative impact on consumers and competition in the market. As a result, the industry needs to regularly review its benefit offerings and eliminate options that are not financially viable or sustainable in terms of membership. However, the CMS will still consider applications for new benefit options and will most likely consider favourably, new options aimed at rationalising the already existing high number of options and/or the options that are not self-sustaining.

The main focus of the medical scheme's business plan should prioritise enhancing risk pooling, cross-subsidisation, and affordability while providing members with high-quality healthcare services. This includes investing in preventative care

programs, building strong provider networks, and offering virtual care benefits. The delivery model should be based on the principles of strategic healthcare purchasing through value-based contracts with cost-effective providers.

4.5. Medium-term cost increase assumptions

The CMS further provides the industry with two-year forward-looking cost increase assumptions to assist the market with future planning. These assumptions aim to anchor cost increase assumptions in the private sector in line with consumer inflation to keep medical scheme contributions affordable. Persistent above-inflationary cost increases pose a significant risk to the industry's long-term financial sustainability, as consumers ultimately bear the financial burden. All things being equal, industry cost increase assumptions for the 2026 benefit year are projected to increase by 3.3% before decreasing slightly to 3.0% for the 2027 benefit year. These projections are subject to revision in line with the SARB MPC quarterly CPI projections.

4.6. Independent actuarial review pricing models

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.”](#)

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 expenses;
- Assumptions;
- Year-to-date financial performance;
- Financial projections

4.7. Deviation from the requirements of APN 303 on adequacy of contributions

The CMS has, in the past, noted with grave concern isolated incidents of deliberate under-pricing of annual contributions by some actuaries, possibly due to undue pressure from Trustees. Not only do such pricing models violate the requirements of APN 303, but such pricing also leads to erosion of reserves, predisposing such medical schemes to the risk of insolvency. The Registrar warns that in the future, there will be severe consequences for such conduct, including barring such individuals from rendering services to medical schemes and reporting such individuals to the Actuarial Society. Actuaries are required to remain independent at all times when providing professional services to medical schemes. The CMS further requires that all APN 303 medical scheme reports for the 2026 benefit year must be signed off by an actuary with a valid **Healthcare Practising Certificate**.

4.8. Actuarial review of 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 and not jeopardise the financial soundness of any existing benefit option in the medical schemes.

Yet there are some benefit options that have historically continued to incur deficits and are inconsistent with the prescripts of Section 33 (2). To this end, all actuarial reports for 2026 must include an additional section providing a detailed technical analysis of each loss-making option. The report must stipulate the reason(s) for the 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.

4.9. Communication of the 2026 benefits and contributions changes

As per Section 31(2) of the Act, it is essential to note that any amendments, rescissions, or additions to the rules of the medical scheme are only deemed valid once they have been approved by the Registrar. Furthermore, in compliance with Section 29(1)(l), medical schemes are required to provide their members with advanced written notice of any impending alterations to their contributions and benefits. In their communication with members, medical schemes are required to incorporate a disclaimer specifying **that the amendments will only be valid once approved by the Registrar.**

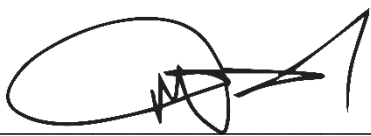
4.10. Deadline for submission

The deadline for submission of applications for new benefit options and EDOs to be implemented from 1 January 2026 is **16 September 2025**, and **1 October 2025** for contribution and benefit changes. Medical schemes that may require additional time to finalise their 2026 pricing decision must submit a request for an extension to the Registrar, citing their unique and individual circumstances. Nonetheless, the CMS still welcomes early submissions.

If you have any questions or concerns regarding the submission process and requirements, please do not hesitate to contact the Benefits Management Analyst assigned to your scheme at the CMS.

Your cooperation is greatly appreciated, and we look forward to providing any assistance you may require.

Yours sincerely,



Dr Musa Gumede
Chief Executive & Registrar
Council for Medical Schemes



Dr Thandi Mabeba
Chairperson of Council
Council for Medical Schemes