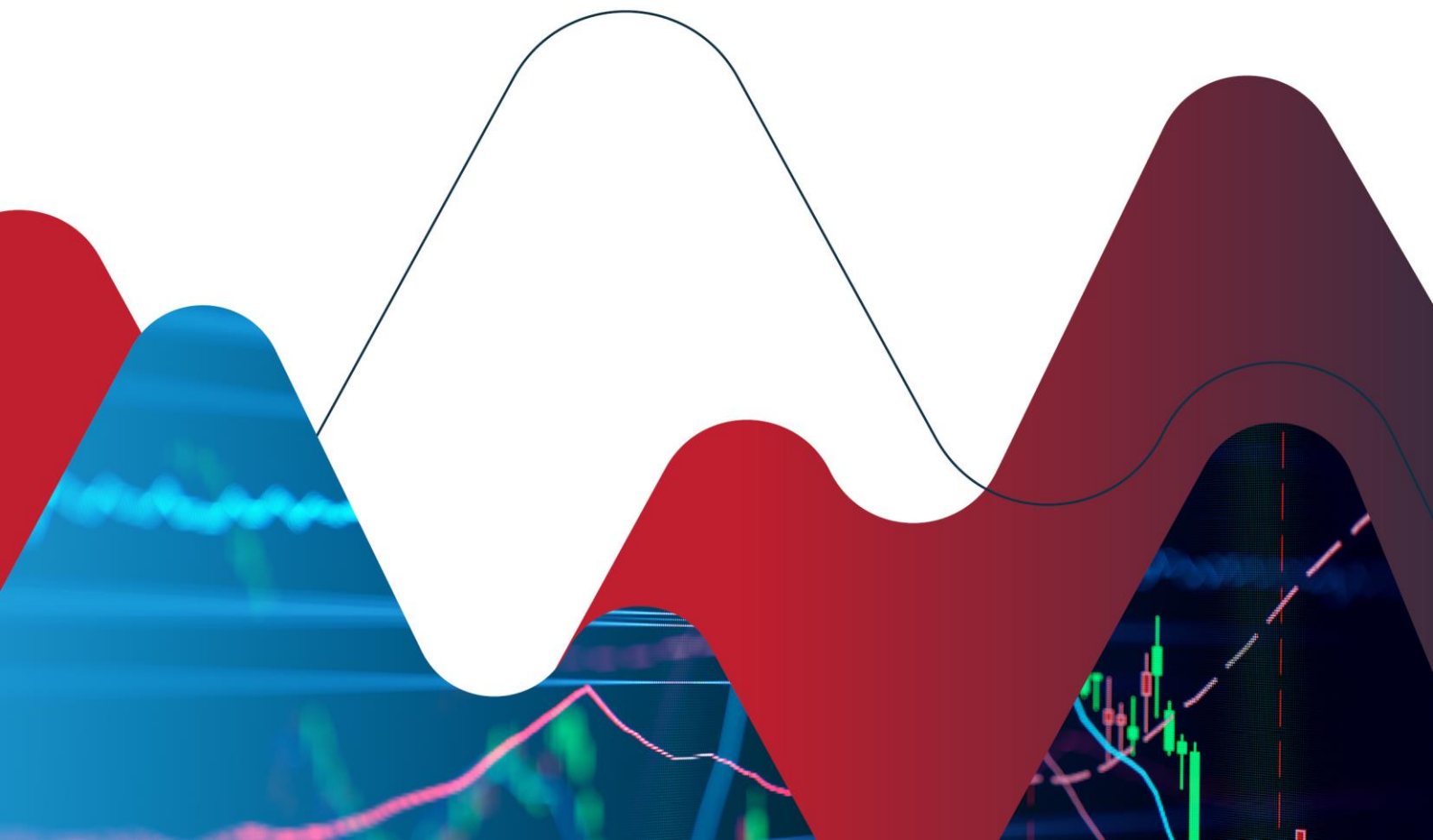




Australian Government
Australian Government Actuary

Actuarial Investigation into the Costs of Military Compensation

30 June 2024



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1 Executive Summary

1.1 Background

- 1.1.1 This report has been prepared by the Australian Government Actuary (AGA) for the Department of Veterans' Affairs (DVA). It examines the liabilities in respect of Australian Defence Force (ADF) personnel as at 30 June 2024 under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA). Together these two schemes are known as the Military Compensation Scheme (MCS).
- 1.1.2 The MCS provides support and compensation to ADF personnel who sustain physical or psychological impairment or incapacity that is related to their defence service. This support ranges across income replacement for those who are unable to maintain full-time employment, coverage for medical, rehabilitation and related costs, financial compensation for permanent impairment, and benefits payable to dependents upon death.
- 1.1.3 The valuation methodologies used for different types of payments reflect the particular characteristics of those payments and the nature of the available data.
- 1.1.4 The reported cashflows and liabilities have been divided between the run-off of the obligations under the DRCA and liabilities arising under the MRCA for claims attributable to service occurring on or after 1 July 2004 where relevant.
- 1.1.5 On 13 February 2025, the *Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) Act 2025* (VETS Act) was passed by Parliament. The new legislation means that from 1 July 2026, all compensation and rehabilitation claims will be determined under a single Act, the amended MRCA. From 1 July 2026, the VEA and DRCA will be closed to all new compensation and rehabilitation claims.
- 1.1.6 As the VETS Act passed Parliament after 30 June 2024 (the reporting date of this valuation), any changes expected from 1 July 2026 have not been incorporated into the 30 June 2024 valuation result.
- 1.1.7 The actuary responsible for the preparation of this report and the underlying analysis is Jane Miao, FIAA.

1.2 Scope of the Report

- 1.2.1 The analysis in this report looks at a number of financial measures of the scheme, including:
- the estimated liability as at 30 June 2024 for all outstanding claims under the DRCA, including those which have not yet been reported, and outstanding claims under the MRCA where the service giving rise to the claim predates the valuation date, again including those that have not yet been reported;
 - the projected outstanding claims liability under the DRCA and MRCA for the 10 years following the valuation date, including the allowance for claims which are expected to occur over that period;
 - the estimated cash flow for benefit payments over the same period; and

- the annual notional premium required to fully fund the estimated claims liability arising from service undertaken during 2024–25.

1.2.2 We have included additional benefits payable on death and costs related to financial assistance where these have been paid for a DRCA claimant but are payable under the Defence Act 1903. We have not included any other benefits payable under the Defence Act 1903.

1.2.3 Our report does not include allowance for any costs associated with:

- The Veteran Payment, an interim income replacement payment that may be paid while a claim for a mental health condition is assessed;
- Non-Liability Health Care, whereby DVA may cover the costs of treatment of some mental health conditions, without the need to prove that ADF service caused these conditions;
- The Veterans' Provisional Access to Medical Treatment payment, enabling eligible veterans who have submitted a claim for one or more of the 20 most commonly DVA accepted conditions to receive provisional medical and allied health treatment for those conditions while their claims are being considered.

Our valuation does not include allowance for these costs as liability has not been accepted for the conditions associated with these payments.

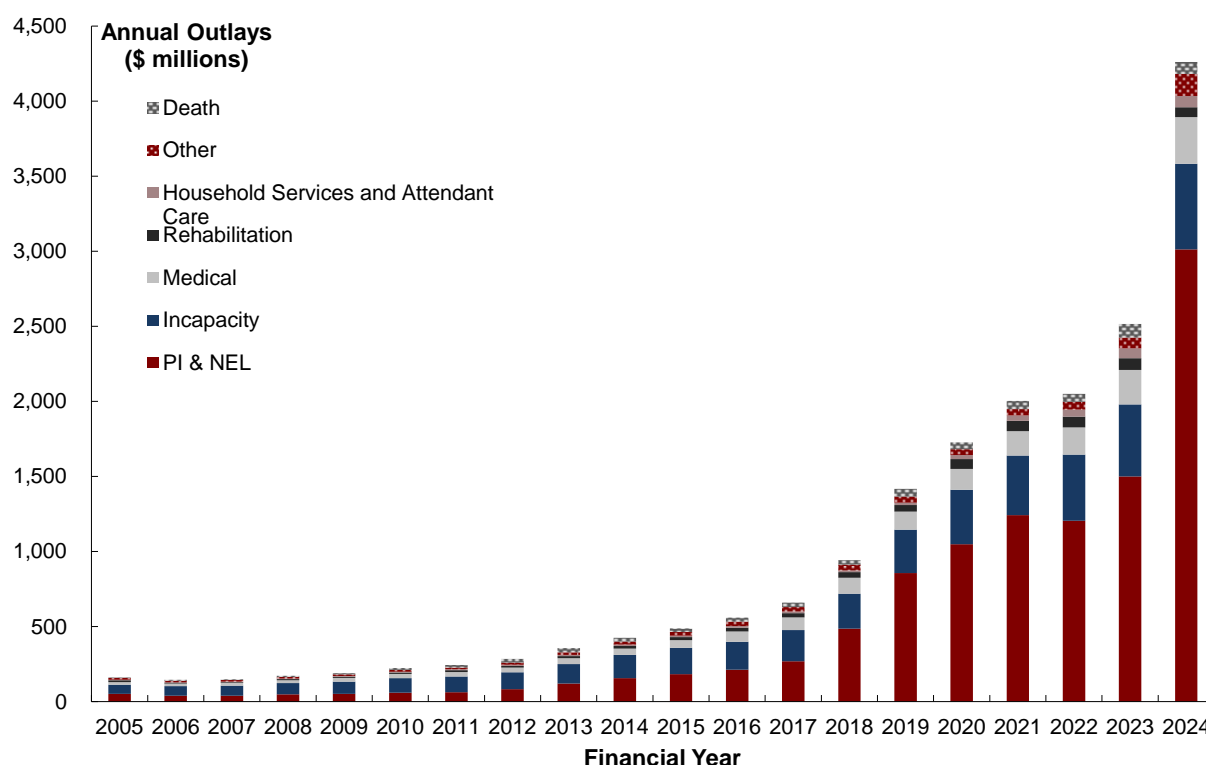
1.2.4 This report has been prepared for the purpose of advising Government of the nature and quantum of its liabilities in respect of compensation for military personnel injured in the course of service. This report also forms the basis for our advice to DVA on reporting for financial statement purposes for the year following the valuation date. Adjustments are made to the results presented here to allow for the use of a discount rate which is considered to comply with the relevant Australian Accounting Standard (AASB 137). Additional adjustments in respect of the impact of the VETS Act will also be made to the results for financial statements at 30 June 2025.

1.2.5 Any proposed use of this report or parts of this report which go beyond its stated purpose should be discussed first with AGA.

1.3 Recent Claim Experience

1.3.1 Figure 1.1 below shows the total expenditure in each financial year by benefit type to 30 June 2024. Please note the incapacity expenditure included in this graph is from the transactional payments data set and does not include any repayments or offsets made in the year. The repayments are small in the context of MCS expenditure and are discussed further in Chapter 8 of the report.

Figure 1.1: Recent Payment Experience - DRCA and MRCA Combined



- 1.3.2 Growth in total expenditure has been rapid since Veteran Centric Reform in 2018. The stabilisation in outlays observed in 2022 was a result of processing constraints rather than a genuine stabilisation in the underlying experience. In 2023, DVA received additional funding for staffing increases which resulted in an increase in the number of initial liability (IL) claims completed with a subsequent flow on impact to benefit payments. The level of IL completion significantly increased from the second half of the 2023 calendar year which has driven the significant increase in outlays seen in the 2024 financial year. Although processing capacity has increased, the level of new IL claim lodgements has also increased over the last two years. As such, there remains a notable volume of open IL claims as at 31 December 2024. As there can be a delay between IL claim completion and when any subsequent benefit claims are made, the full impact of the recent IL claims experience will not be seen in the expenditure until the following financial years.
- 1.3.3 Permanent impairment (PI) payments have increased substantially over the last decade and may have been impacted by ADF operational activity, and the introduction of Veteran Centric Reform. Expenditure in the latest financial year increased substantially with increasing processing capacity at DVA. This is expected to continue over the short to medium term as the current group of open IL and PI claims are processed. The increase has been driven by both uplifts in the number of PI claims and the average size of PI benefits (notably due to a higher proportion of PI recipients being assessed at over 80 whole person impairment points, thus qualifying for the Section 80 eligible young person lump sum).
- 1.3.4 Payments have also grown in other benefit categories, most notably medical benefits and medico-legal expenses in the latest year. Total medical expenditure increased by approximately 35 per cent over the year to 2024, increasing from approximately \$230 million in 2023 to \$311 million in 2024. The increase in medical expenditure has been driven by a

significant increase in the number of claimants, in particular those with access to the MRCA Gold Card. MRCA Gold Cards provide veterans with coverage for all medical expenses for life, including private hospital costs and travel for treatment expenses, irrespective of whether treatment is for a liability accepted injury. As such, the long-term costs associated with Gold Cards are significant. Medico-legal expenses form the majority of expenses in the Other category. These expenses relate to the costs of supporting medical exams required as part of the claims process and have driven the increase in the Other payment category. Other expenditure has more than doubled between 2023 and 2024, increasing from approximately \$73 million to \$147 million.

- 1.3.5 The following tables compare actual payments over the last year with the amounts projected in the 2023 valuation. In total, actual payments were 0.4 per cent higher than those projected. The largest difference, in dollar terms, was for medical benefits where outlays were approximately \$33 million higher than projected and Other benefits where payments were approximately \$31 million higher than projected. Medical payments were driven by higher than expected numbers of new entrants and average expenditure per active claimant whilst the increase in Other payments was primarily in relation to medical exam fees which increased with the higher numbers of IL and PI claims processed in the year

Table 1.1: Comparison of Actual and Projected Payments for 2023–24

Category	Projected \$m	Actual \$m	Difference \$m	% Difference
Incapacity	564.2	570.3	6.0	1.1%
Permanent Impairment & Non-economic Loss (PI & NEL)	3,009.6	3,012.6	2.9	0.1%
Medical	277.8	311.3	33.5	12.0%
Household Services and Attendant Care (HSAC)	91.0	74.9	(16.1)	(17.7)%
Rehabilitation	86.7	65.0	(21.7)	(25.1)%
Death	100.8	80.7	(20.1)	(20.0)%
Other	115.1	146.6	31.5	27.3%
Total	4,245.3	4,261.2	15.9	0.4%

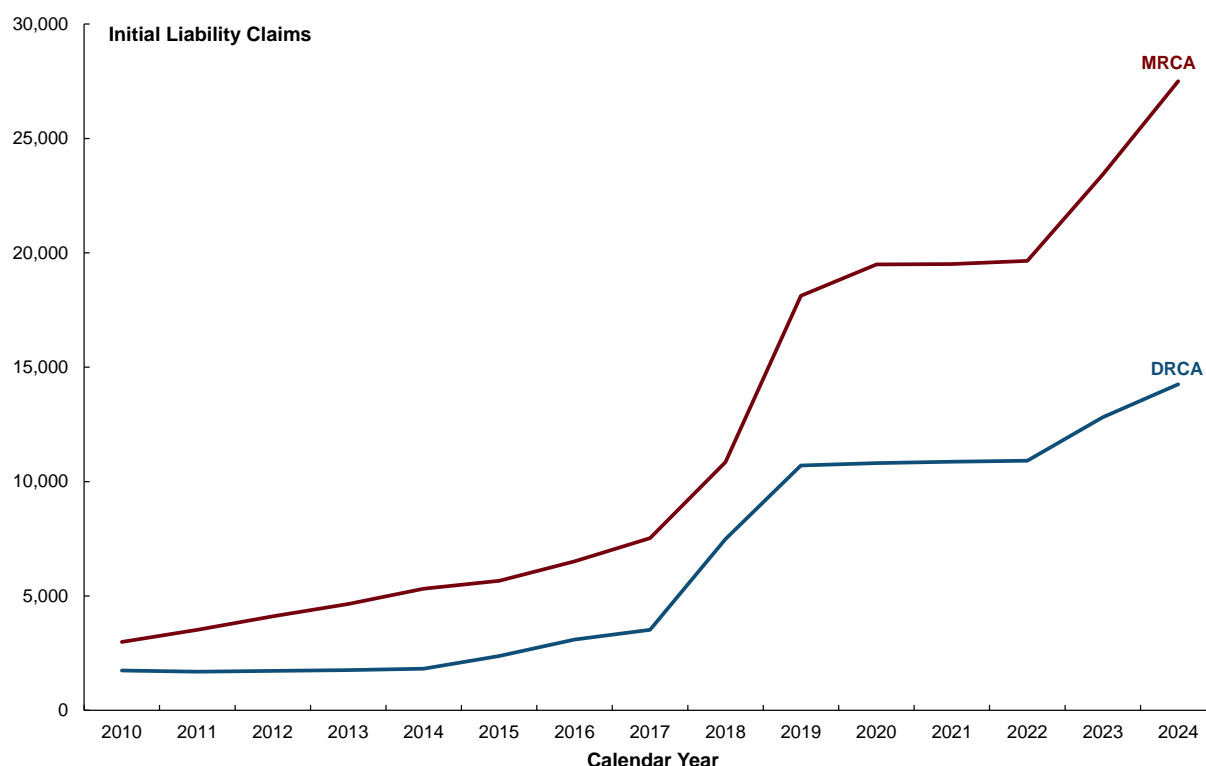
- 1.3.6 Between calendar years 2020 and 2022, the level of IL claim¹ lodgements for DRCA and MRCA remained relatively stable after a period of rapid growth between 2017 and 2019. This stabilisation in experience stopped in 2023, where we saw increasing numbers of IL claim lodgements over the calendar year which has continued into 2024. This trend in increasing lodgements is especially concerning for DRCA, a scheme which has been closed for 20 years.
- 1.3.7 An IL claim can consist of one or more underlying conditions. The number of conditions lodged per claim has increased over time. The average number of lodged conditions per person has

¹ A claim in a given year is summarised to the person level. That is, a claimant who lodges multiple IL claims in a year will only be counted once in that year. As such, claim level and person level are synonymous in our report when discussed in the context of the same year.

increased from approximately 3.7 in the 2019 calendar year to 4.7 in the 2024 calendar year for MRCA. Similar experience is also seen in DRCA, where the average number of conditions lodged per person has increased from 4.1 to 5.4 over the same period despite the scheme being closed to injuries sustained beyond 30 June 2004. The proportion of new claimants has also declined over time with approximately 35 per cent of claimants for MRCA and 45 per cent of claimants for DRCA being new to the schemes who lodged claims in calendar year 2024. This is not unexpected as a scheme matures over time but the relatively high proportion of new entrants for DRCA, a 'closed' scheme, is atypical. The experience in our data shows that there is still a significant number of veterans claiming with DVA for the first time, at a minimum of 20 years post their injury date.

1.3.8 Figure 1.2 below shows the number of IL claim lodgements for DRCA and MRCA by calendar year.

Figure 1.2: Initial Liability Claims - DRCA and MRCA



1.3.9 DVA increased processing capacity in the 2023 year, resulting in a noticeable increase to the rate of IL claim completion and benefit payments in the second half of the 2023 calendar year and into 2024. The increase to processing capacity included the hiring of additional claims delegates as well as claim support officers, who collate any relevant claims information prior to the claim reaching the delegate. However, as at the end of December 2024, there remains a significant number of open DRCA and MRCA IL claims. As with prior years, a key assumption in this valuation relates to the timing of when these claims are likely to be cleared and when they eventuate in benefit payments. In previous years, we relied on DVA's Demand Driven Funding Model (DDFM) to provide a guide to processing capacity over the short to medium term. At the time of writing this report, the Department's funding plan has yet to be finalised. As such, we have assumed processing will remain at similar levels going forward as that seen in the latest calendar year in the absence of any additional information.

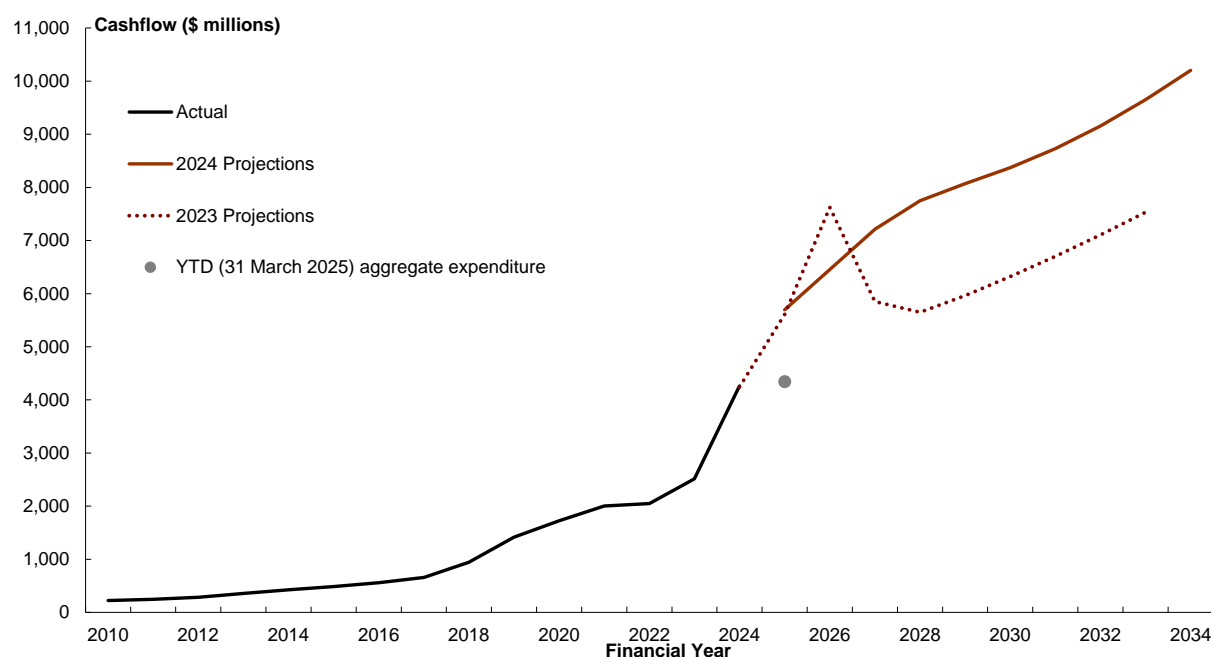
1.4 Valuation Results

SUMMARY

The liability for the MCS as at 30 June 2024 is \$98,391.0 million. This is significantly higher than what was projected at the previous valuation of \$69,878.0 million. The almost \$29 billion increase was largely driven by:

- an increase in the level of expected future initial liability claims which has a flow-on impact to expected future benefit payments;
- an increase to the expected number of Gold Card recipients under MRCA medical benefits which has led to an increase of almost \$9.7 billion;
- an increase to the level of expected future MRCA and DRCA PI claims and the average size of these claims which has led to an increase of approximately \$6.9 billion;
- an increase to the number of expected future medico-legal payments and supports for dependants as a result of higher claim numbers and higher severity conditions which has led to an increase of approximately \$1.3 billion;
- an increase to the level of expected future Household Services claimants and the inclusion of superimposed inflation for catastrophically injured Attendant Care recipients which led to an increase of approximately \$0.8 billion; and
- the inclusion of a provision for MRCA death compensation payments and access to the Gold Card for widows of existing and projected veterans with 80 or more impairment points or SRDP eligibility which led to an increase of approximately \$9.3 billion.

- 1.4.1 Figure 1.3 shows the projected cashflows aggregated across all categories from the 2024 valuation compared to cashflows projected at the 2023 valuation. We have also included the year-to-date aggregate 2024–25 outlays to 31 March 2025 (9 months of expenditure) from the general ledger data.

Figure 1.3: Cashflow Projection for DRCA and MRCA

1.4.2 The projected cashflows are significantly higher than those projected at the last valuation, driven by increases across most benefit types. The largest increases were across MRCA medical, permanent impairment, household services and death benefits. The shape of the cashflows differ to those from last year over the short term as no allowances have been made for any increases in processing capacity. We have assumed recent rates of processing will continue into the future. This may change going forward as the Department reaches new funding agreements with the Department of Finance.

1.4.3 Table 1.2 below shows the 30 June 2024 outstanding claims liability by payment type as at this valuation and the expected liability from the previous valuation.

Table 1.2: Outstanding Claims Liability as at 30 June 2024

Benefit Type	Current Valuation (\$ million)	Previous Valuation (\$ million)	Difference (\$million)
Permanent Impairment	28,992.1	22,129.4	6,862.6
Incapacity	14,515.0	13,800.1	714.9
Medical	34,508.3	24,775.5	9,732.9
Rehabilitation	1,273.2	1,510.6	-237.4
HSAC	6,636.1	5,820.2	816.0
Other	2,739.6	1,394.8	1,344.8
Death	9,726.7 ²	447.4	9,279.3
Total	98,391.0	69,878.0	28,513.0

² Note the death benefit includes a liability provision for MRCA death compensation benefits. This was not included in the liability from the previous valuation. This is discussed further in section 15 of the report.

- 1.4.4 During the roll forward process for the 30 June 2024 financial statements, we saw an escalation in the level of IL claim lodgements between 31 December 2023 (the end date of the available data for the 30 June 2023 valuation) and 31 May 2024. To account for this increase in experience, an adjustment was made to MRCA PI benefits for the financial statements provision as PI claim lodgements have exhibited the strongest correlation to IL claim lodgements in recent years. We increased our MRCA PI liability by approximately 6 per cent to account for the increase in IL claim experience, an increase of approximately \$1.1 billion to the 30 June 2023 liability. Where appropriate, the charts and tables included in this report will include both the results adopted at the 30 June 2023 valuation and the results from the adjustment made for the financial statements provision.
- 1.4.5 In the latest calendar year, the number of initial liability claim lodgements have continued to increase for both DRCA and MRCA. Discussions with DVA point to a number of possible reasons for this, including increased awareness of DVA benefits through greater media exposure, engagement with the veteran community on potential legislative reform, and Department communications around the clearance of the current claims backlog which may encourage veterans to lodge new claims. More recently, there has also been an increase in fee-for-service advocates assisting veterans with their claim lodgements. Anecdotally we have heard that the claims lodged by these advocates often encompass a higher number of conditions and can result in higher levels of benefit payment.
- 1.4.6 It is difficult to ascertain whether the current level of lodgements will continue into the future. The possible drivers of experience could be temporary or result in a genuine shift in future experience. In our projection this year, we have assumed that the current level of initial liability claim lodgements will continue over the long term and claims processing levels will remain at recent levels. Should processing speeds or lodgement levels change in future, the cashflows will differ from expected. It is important to note that there is substantial uncertainty as to the timing and magnitude of these impacts as they are also partially subject to funding decisions that can be outside of DVA's control.
- 1.4.7 Table 1.3 shows the estimates of the key cost indicators broken down by Service Arm.

Table 1.3: Valuation Results

Overall Cost Estimates Shown by Service				
Service	Outstanding Claims Liability \$m	Notional Premium \$m (% salaries ³)		Projected Cashflows \$m
Current Report	at 30 June 2024	for 2024–25		for 2024–25
Army	65,855.5	6,881.6		4,164.2
Navy	17,684.3	1,321.3		799.6
RAAF	14,851.2	1,203.7		728.4
Total	98,391.0	9,406.6	126.3%	5,692.2
Previous Report	at 30 June 2023	for 2023–24		for 2023–24
<i>Expected (30/6/2024)</i>	69,764.9	6,447.9		5,609.5
Total	64,764.9	6,075.0	(86.4%)	4,245.0

3 Estimate of salaries and allowances for 2024-25 provided by the Department of Defence.

- 1.4.8 The outstanding claims liability as at 30 June 2024 represents the estimated present value of future claim payments to be made in respect of injuries sustained prior to 30 June 2024. The split of liabilities between the DRCA and MRCA is detailed in section 16.
- 1.4.9 The notional premium represents the estimated cost of compensation for claims arising from service rendered during 2024–25. It is the amount which, if paid over the course of the 2024–25 financial year and invested to earn the valuation discount rate of 5 per cent per annum, would be expected to meet the future cost of these claims. The cashflows represent the amount projected to be paid in the 2024–25 financial year for claims attributable to any service prior to and including 2024–25. The final rows show the comparable figures from the previous valuation, that is, the expected figures as at 30 June 2024 and the reported results as at 30 June 2023. The changes to modelling approach and assumptions have resulted in a 41 per cent increase to the expected liability and 46 per cent increase to the expected notional premium.

1.5 Comments on Results

- 1.5.1 At the last review, we projected that the liability would grow to \$69,878m by 30 June 2024. The current liability is \$98,391.0m. This is almost \$29 billion higher than expected and has been driven by increases across almost all benefit types, with the largest dollar increases in MRCA medical benefits, permanent impairment benefits, and death benefits.
- 1.5.2 One of the key uncertainties in the MRCA medical projection is in the projection of new claimants. With limited exposure data available, we had previously relied on total ADF numbers within a year as the exposure basis for projecting new entrants. However, this method had become increasingly problematic in recent years due to volatility in the pattern of new claimant emergence driven administrative and cultural changes. At this year's valuation, we have modelled the expected new medical entrants based on the projection for MRCA IL claims to better reflect the chain of events which lead to entry into medical benefits. This method also allows for any processing capacity changes to flow into expected new medical claimants. The change in methodology resulted in an increase of almost \$4 billion to the medical liability.
- 1.5.3 The growth in the number of Gold Card holders has continued to increase over the latest calendar year, with almost 4,700 new Gold Cards issued in the 12 months to 31 December, an increase of 40 per cent. At the last valuation, we incorporated information on lodged IL and PI claims to estimate the proportion of veterans who might be eligible for a Gold Card on reaching 60 or more impairment points based on the conditions currently lodged with DVA. At this valuation, we have also incorporated additional analysis to estimate future PI lodgements for the existing DVA medical population which would contribute to a veteran's overall impairment score. We have used the result of this analysis to select an ultimate proportion of veterans who will receive a Gold Card. The selected assumption is significantly higher than the selected rates from the prior valuation and reflects the increase in claimant experience, particularly in the number of new Gold Cards issued, seen in the latest year. The increase to projected claimants and Gold Card recipients contributed almost \$4 billion to the increase in medical liabilities.
- 1.5.4 Pharmaceutical benefits have increased as a proportion of total medical expenditure in recent years. Previously, we included pharmaceutical expenditure as a loading to total medical expenditure but increasing experience over recent years prompted further analysis this year. Discussions with DVA program areas and analysis of the transactional level pharmaceutical data showed the uplift was primarily driven by an increase in expenditure associated with

medicinal cannabis. In 2024, medicinal cannabis accounted for approximately 56 per cent of total pharmaceutical expenditure. At this valuation, we disaggregated our average size assumption into the main underlying benefit categories and pharmaceuticals, selecting separate assumptions for each category. For pharmaceutical benefits, we have also allowed for additional growth in medicinal cannabis based on our discussions with the DVA program area. The MRCA medical liability increased overall from an expected liability of \$24,688 million as at 30 June 2024 to \$34,508 million at this valuation, an overall increase of over \$9.7 billion. Further details are provided in Section 10 of the report.

- 1.5.5 At last year's valuation, we developed an additional model to project future IL claim lodgements, completions, and acceptances for MRCA. We have extended this analysis to DRCA this year. IL claim lodgements have continued to increase in the latest calendar year and future lodgements are expected to remain at heightened levels. This has a flow on impact to all benefit types (due to IL claims being the precursor to all other benefit claims). We note that this valuation is the final valuation where new compensation and rehabilitation claims can still be lodged under the DRCA from 1 July 2026. Although this report discusses the usage of the DRCA IL model in the context of DRCA benefits only, the DRCA IL model will continue to provide the basis for projecting claimants with eligibility under the DRCA prior to the commencement of the VETS Act and likely into the early years following 1 July 2026 where experience may be unstable.
- 1.5.6 We have continued to see an increase in the PI average claim size over the last year, likely driven by high levels of medically separated veterans and claims with increased numbers of conditions. In particular, the increase in the number of veterans receiving Section 80 benefits has been significant. At this year's valuation, we have explicitly selected assumptions on the projected proportion of future PI recipients receiving a Section 80 benefit. We have also retained our superimposed inflation for the first three years of the projection⁴ to account for continuing increases in average size as claims are completed from the backlog. Overall, the liability for MRCA PI has increased from an expected liability of \$18,835 million to \$22,517 million, an increase of approximately \$3.7 billion.
- 1.5.7 At this year's valuation, we have leveraged the DRCA IL claims model to update the DRCA PI claims model. The revised DRCA PI claims model follows the same methodology as that used for MRCA PI claims with the exception that claims are projected grouped by year of birth rather than accident year. Limitations in the recording of accident year data has meant that this variable is less meaningful for DRCA, with a large proportion of conditions assigned more recent onset or assessment dates rather than accident dates. These dates are often beyond DRCA's 30 June 2004 closure date. The update to the DRCA projection methodology, coupled with the high claims and payment experience in the year, resulted in an increase to the DRCA PI liability from \$3,294 million as at 30 June 2024 from last year's valuation to \$6,475 million at this valuation, an increase of approximately \$3.2 billion.
- 1.5.8 Death compensation under MRCA is provided to dependent partners for veterans with Special Rate Disability Pension (SRDP) eligibility or impairments points greater than 80. In light of the growing proportion of veterans with greater than 80 impairment points seen in the recent MRCA PI experience, we have explicitly estimated a provision for death compensation at this year's valuation, including costs associated with access to the Gold Card for the dependent partner. We have also included allowance for benefits for dependent children if the death is

⁴ For clarity, at the previous valuation we allowed for superimposed inflation for the first four projection years. This year, we have allowed for superimposed inflation for the first three years, thus the superimposed inflation is assumed to cease at the same point as in the previous valuation.

projected to occur before age 65. The additional provision for death compensation benefits and associated Gold Card costs is approximately \$9.1 billion.

- 1.5.9 Interpreting experience in a rapidly changing environment poses significant challenges. It is important to note that the estimates given in this report are actuarial central estimates. This means, in broad terms, that the estimates are just as likely to be too high as too low. However, the true liability cannot be known with certainty and the range of factors which might impact on future claim numbers and sizes means that estimates presented here are subject to considerable uncertainty.
- 1.5.10 The very long term over which these liabilities will be paid out makes the results very sensitive to relatively small changes in assumptions. This is particularly the case for payments that are expected to persist over an extended period, such as medical expenses. As noted in previous reports, determining the extent to which we should set assumptions in response to the most recent experience requires considerable judgement. For the current valuation, we have, for the most part, set assumptions based on the most recent experience.
- 1.5.11 With the recent growth in experience and changes in claims behaviour, there remains a question as to what proportion of veterans will ultimately seek support from DVA and what the average cost of those benefits will be. The current data available to the AGA does not allow us to accurately form this view. Additional information from Defence and DVA detailing the demographics of the veteran and serving population, including date of and reason for separation, and injuries sustained during service could assist in forming a view.

2 Background

2.1 The Military Compensation Scheme

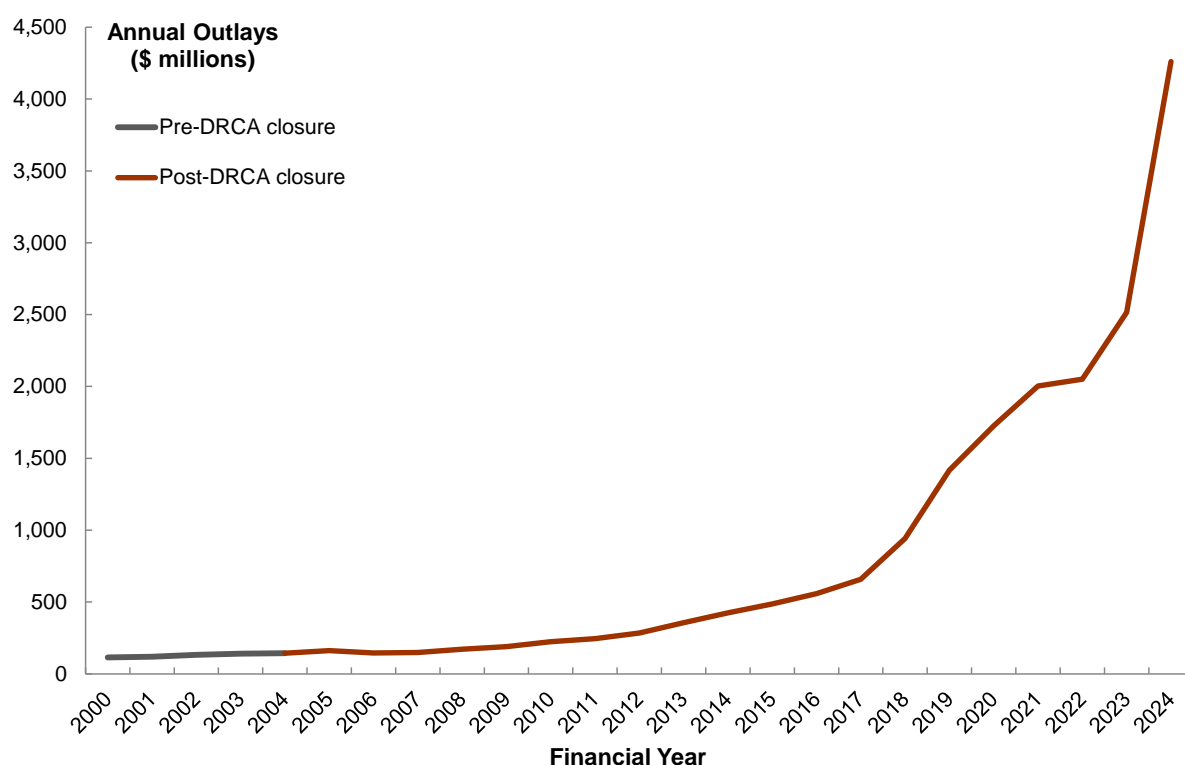
- 2.1.1 Compensation for military personnel injured in the course of their duties is provided under 4 separate pieces of legislation:
- the *Military Rehabilitation and Compensation Act 2004* (MRCA);
 - the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA);
 - the *Veterans' Entitlements Act 1986* (VEA); and
 - the *Defence Act 1903*.
- 2.1.2 MRCA provides rehabilitation and compensation coverage for service with the Australian Defence Force on or after 1 July 2004.
- 2.1.3 DRCA provides similar rehabilitation and compensation to that provided under the MRCA, but only covers:
- injuries and diseases that arose from peacetime and peacekeeping service up to and including 30 June 2004; and
 - operational service between 7 April 1994 and 30 June 2004.
- 2.1.4 Operational service prior to 7 April 1994 (which includes World War II, the Korean War and the Vietnam War) is not covered by DRCA. Operational service on or after 7 April 1994 gives rise to 'dual eligibility', that is, the option of applying for benefits under either or both the VEA and DRCA. This could be expected to affect the comparability of DRCA and MRCA experience.
- 2.1.5 This report covers liabilities arising from payments under the MRCA and the DRCA only.
- 2.1.6 The MRCA included some differences in benefits relative to the DRCA. The most significant differences in terms of their impact on costs were:
- the introduction of a loading on incapacity payments to compensate for the loss of non-salary elements of ADF remuneration packages;
 - removal of the offset against incapacity payments for the member's superannuation contributions;
 - the use of health care cards for medical treatment; and
 - changes to the assessment process and payment options for permanent impairment claims. Under the MRCA, permanent impairment benefits can be taken as a periodic benefit or be converted to a lump sum using age-based factors.
- 2.1.7 It should be noted that, in actuarial terms, MRCA is not a fully mature with experience limited to a maximum of 20 and a half years after the injury date. This compares with payment obligations that may continue for 60 or more years after the date of injury.

2.1.8 Furthermore, it has been apparent for some time that the early MRCA data has been affected both by data deficiencies and by the deferral of claims associated with the availability of deployment opportunities over most of the first decade following its introduction. In more recent years, the introduction of Veteran Centric Reform amongst other cultural and administration changes have seen experience shift dramatically from earlier periods. It may be some time before MRCA experience settles into a pattern that we can reasonably assume will provide a robust basis for projecting future claim behaviour. Nonetheless, given the differences between DRCA and MRCA experience that have become increasingly evident in the data, we are, as far as possible, relying on the MRCA data in setting assumptions for the MRCA scheme. In some cases, DRCA experience is considered where no MRCA experience currently exists.

2.2 Trends in Expenditure

2.2.1 Figure 2.1 shows total outlays of the MCS since 2000. Prior to 2004, expenditure had grown at a steady but moderate pace, averaging around 5 per cent per annum. The introduction of MRCA from 1 July 2004 led to a significant disruption in expenditure. Although early experience was relatively stable, with some growth between 2005 and 2010, experience from 2011 accelerated at a much higher rate than had been seen previously in the scheme. From 2011 to 2023, outlays increased at a rate of approximately 21 per cent per annum with the largest single increase of 50 per cent occurring between 2018 and 2019. Growth in expenditure slowed considerably between 2021 and 2022, however this was driven by limitations in processing capacity which resulted in backlogs of both initial liability claims and claims for permanent impairment benefits (rather than an actual stabilisation of experience). In 2023, DVA began to increase their processing capacity in order to administer the significant number of open claims on hand. This increase ramped up over the 2024 year, resulting in the largest expenditure increase seen to date. Expenditure in the 2024 financial year reached approximately \$4.3 billion, an increase of 69 per cent from the previous year.

Figure 2.1: Total Cash Outlays



- 2.2.2 There are a number of possible interpretations of this data. An earlier view was that the growth from 2011 to 2015 was, in part, compensating for the very low growth in the years after the introduction of MRCA. However, the more rapid increase in recent years challenges this view. Whilst there are differences in the benefits provided under MRCA, there have also been changes in the environment in which the schemes operate, including changing attitudes and modifications to DVA administrative practices. It now seems more likely that the most recent experience is what could be expected to persist indefinitely. This latter interpretation would imply that the behaviour of MRCA claimants is fundamentally different from that observed for DRCA claimants prior to the scheme's closure. It is important to note that recent experience is still changing year-on-year and currently far from a stable, mature state.
- 2.2.3 Continued increases in recent experience have led us to believe that we are not dealing with a temporary anomaly but rather a genuine shift in experience that needs to be taken into account in setting valuation assumptions. The change from a regime where claims could be made under either the DRCA or the VEA to one where all claims must come through the MRCA is likely to be playing some part, but so is the introduction of the single claim process, the availability of online claim facilities and the increasing involvement of ex-service organisations and advocates in supporting veterans' claims under DRCA and MRCA. However, it is also not unreasonable to assume that these recent initiatives may have resulted in veterans approaching DVA earlier than they otherwise would have and experience over the long term could vary again from the experience observed in recent years. As such, there remains considerable uncertainty when interpreting recent experience for long term future projections.
- 2.2.4 In February 2025, the Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) Act 2025 (VETS Act) was passed by Parliament. From 1 July 2026, all compensation and rehabilitation claims will be determined under a single Act, the amended MRCA. This may have some impact on the scheme experience in the short term where veterans may come forward prior to the change or postpone lodging claims until the new legislation commences. There is significant uncertainty surrounding both the short term and long term impacts of this legislation on scheme costs. The potential impacts from the legislative change have not been incorporated into this report as the legislation passed Parliament after the valuation date.

2.3 Scope of the Valuation

- 2.3.1 The objectives of the valuation were to:
- estimate the outstanding claims under the DRCA and MRCA (including claims incurred but not reported) as at 30 June 2024;
 - project the outstanding claims liability under the DRCA and MRCA for the following 10 years;
 - estimate the cash flow for benefit payments over the same period; and
 - calculate the annual notional premium required to fully fund the estimated claims liability arising from service rendered in 2024–25.
- 2.3.2 Liabilities are split between run-off liabilities under the DRCA and liabilities under the MRCA and we have projected the liabilities and cashflows under each Act. Note that some expenditure related claims made under the DRCA will be met under MRCA appropriations due to the arrangements applying to health care cards. Specifically, clients with an accepted claim under both schemes will be issued with a MRCA health care card and all expenditure arising from use of the card will be MRCA expenditure. Going forward, this could be expected to reduce DRCA liabilities, with a compensating increase in MRCA liabilities.

- 2.3.3 This report does not consider liabilities arising from common law actions against the Department of Defence. Any awards made as a result of these actions will be funded by the Department of Defence outside the MCS.
- 2.3.4 This report has been prepared for the purpose of advising Government of the nature and quantum of its liabilities in respect of compensation for military personnel injured in the course of duty. It is also intended to comply with the requirements of the Actuaries Institute's Professional Standard 302 (PS302), which deals with actuarial reports and advice on general insurance technical liabilities, where appropriate.
- 2.3.5 This report also forms the basis for our separate advice to DVA on reporting for financial statement purposes for the year following the valuation date. For that advice, adjustments are made to the results presented here to allow for the use of a discount rate which is considered to comply with the relevant Australian Accounting Standard (AASB 137). This year, an additional provision will also be included for the anticipated impact of the VETS Act on the MCS liability as at 30 June 2025.
- 2.3.6 Any proposed use of this report, in whole or in part, which goes beyond its stated purpose should be discussed first with AGA.

2.4 The Military Operational Environment

- 2.4.1 There are four characteristics of the MCS that distinguish it from other workers' compensation schemes:
- the risks faced by ADF personnel will depend upon external factors, most notably the Government's national and international security policies;
 - the unique nature of military service which involves an unavoidable exposure to high levels of risk;
 - the absence of any limit on the period in which a claim must be made; and
 - the unlimited support provided under some benefits, most notably medical services.
- 2.4.2 Each of these features introduces significant uncertainty into any estimate of future costs. One factor that is likely to have influenced recent experience is the relatively high level of deployments on warlike operations.
- 2.4.3 When ADF units were deployed in East Timor in 1999, it marked the start of a period of relatively intense activity for the ADF, which subsequently saw forces deployed in Iraq, Afghanistan and the Solomon Islands. Overall, more than 50,000 people have been deployed on warlike/non-warlike service over the period. This may have created a large pool of people who may have a higher probability of making a successful claim and, where they do make a claim, may be eligible for higher benefits.
- 2.4.4 The availability of deployment opportunities has almost certainly altered the pattern of separations. Both DVA and Defence have advised that separation rates fall when there are opportunities for deployment. This is because there is both a very strong financial incentive (in the form of substantial tax-free allowances) and because it is an opportunity for Defence personnel to make use of their training.
- 2.4.5 Many claims for injuries, which are not sufficiently severe to warrant an immediate discharge on medical grounds, are made at the time of exit from the forces. Considering potential claims

for compensation is part of the process of a normal separation. As a result, when separation rates increase, as has happened following the end of deployment opportunities, a higher number of claims would be expected to emerge, reflecting those who have deferred their exit. We think it is likely that deployments affected the claim rates in the early years of operation of MRCA.

- 2.4.6 We currently do not have access to Defence data which could provide more detailed information regarding the magnitude of the exposure. For example, records related to incidents while in service, service length, deployments, and separation date might provide further insight into the total number of veterans expected to emerge in future and what proportion of these veterans have already claimed for DVA support.
- 2.4.7 Exposure to hazards that may not have been recognised as dangerous at the time is a further factor in the operational environment. Asbestos is an obvious example that has impacted on DRCA expenditure. It is possible that currently unrecognised hazards will be identified in future and give rise to claims.
- 2.4.8 Changes in ADF recruitment can also play a part in the observed pattern of claims. Peaks in enlistments, for example, would be expected to lead to a corresponding jump in separations, and associated claims. The planned expansion to the ADF announced by Government in March 2022, is likely to have an impact on the quantum of liabilities going forward.
- 2.4.9 More recently, we have been informed of higher numbers of medically discharged veterans by DVA Data and Insights. Figures provided by DVA show a significant increase in the number of medically discharged veterans from 2020 onwards compared to previous years. Experience to 2022 suggests that this trend could continue into the future. Medically discharged veterans are more likely to have higher numbers and severity of injuries than other separating ADF personnel and could have led to some of the experience changes seen in the most recent MRCA permanent impairment data.

2.5 Administrative Environment

- 2.5.1 A second factor which is likely to have played an important role in changing claim behaviour is the administrative environment. The closure of DRCA (and the VEA) for injuries incurred after 1 July 2004 is the most obvious change. It seems clear from the data that the early experience for MRCA was affected by delays as both claimants and DVA adjusted to the introduction of a new scheme. The interaction between entitlements under the DRCA and the VEA which existed prior to the introduction of MRCA could also be expected to impact on the claim experience.
- 2.5.2 More recently, there have been significant changes in the approach taken by Defence and DVA to manage claims. For example, DVA now have advisers on base to assist personnel in making claims, including those who are transitioning out of Defence. Defence also work closely with DVA to ensure that there is continuity of treatment on separation from the ADF. The introduction of health care cards for DRCA claimants with long-term treatment needs in 2013 may also have changed the incentives to make a claim under DRCA.
- 2.5.3 The introduction of an online claim facility in 2015 has almost certainly impacted on the volume of claims received, while the single claim process is likely to have affected the mix of VEA, DRCA and MRCA claims. The initiatives around non-liability healthcare, while not directly impacting on DRCA or MRCA expenditure, are likely to have increased the level of contact between veterans and DVA and might, in due course, result in increased liability claims.

2.5.4 Legal decisions can also have an impact on claim numbers and amounts. There have been 3 key decisions that appear to have generated a surge in DRCA permanent impairment payments:

- the 2006 High Court decision in *Canute* which found that in assessing the degree of permanent impairment when more than one injury is present, a separate assessment must be made for each injury that results in permanent impairment;
- the 2009 High Court decision in *Fellowes* which reinforced the *Canute* decision and established that separate injuries which result in separate impairments must be independently assessed; and
- the 2013 decision by the Full Federal Court in *Robson* which reiterated that separate injuries and their associated impairments must be assessed separately and in isolation, even if they relate to the same body part or if there is a causal relationship between the 2 injuries.

3 Data Used for the Valuation

3.1 Data Sources

- 3.1.1 An actuarial investigation of the experience of a compensation scheme relies on the capacity to analyse the available information about the scheme. The more reliable and comprehensive the data, the greater the confidence that can be placed in the models developed from that data.
- 3.1.2 For the MCS, incapacity payments and fortnightly payments to dependent children prior to 1 July 2017 came from the PMKEYS system and all other DRCA payments, apart from healthcare card data which are handled under the TAS system, are processed through the DOLARS system. Individual claims data prior to 1 July 2017 which provides details on the demographic characteristics of DRCA claimants and the nature and timing of the injury giving rise to the claim was held on the DEFCARE system.
- 3.1.3 There were changes in the administrative systems as a result of the introduction of MRCA which have impacted on the data provided to AGA. As has been noted in previous reports, a new claims database (CADET) was developed but took some time to be fully implemented. As a result, there is a permanent gap in the MRCA claims information covering the first 2 years after the introduction of the scheme.
- 3.1.4 MRCA data is stored and processed through various systems including PMKEYS for incapacity payments prior to 1 July 2017, DOLARS for some general and medical payments, and IPS for other payments including permanent impairment entitlements. Many of the MRCA payments for medical and other services which are provided to those holding a repatriation health care card are processed through Medicare Australia.
- 3.1.5 From 1 July 2017, the ISH system was implemented by DVA for both DRCA and MRCA claims and payments. Data received from 1 July 2017 to 31 December 2024 is a combination of extracts from legacy systems and ISH.

3.2 Data Provided

- 3.2.1 We were provided with unit record payment data and claims data related to initial liability and PI claims which covered the period to 31 December 2024. The payments data for the 2023-24 financial year was checked and reconciled as far as possible against aggregate data sources. We have incorporated unit record payments data up to 31 December 2024 into the analysis for all heads of damage.
- 3.2.2 For data security reasons, veteran IDs used by DVA and any identifying personal data were not provided in our unit record extract. To enable analysis of the data, DVA created hashed unique identifiers on the dataset and provided the calendar year of birth and gender for claimants.
- 3.2.3 In addition to the unit record payments and claims data, DVA also provided the following datasets:
- De-identified data for MRCA medical card holders which provide the issue date and type of medical treatment card held by the veteran;

- Unit record MRCA pharmaceutical data which allowed for the separation of pharmaceutical expenditure between Gold and White card holders.
 - Periodic incapacity data which provided the fortnightly payment rate and incapacity start and end dates. To the extent possible, this was reconciled against the transactional incapacity payments data received and was found to be broadly consistent;
 - Incapacity repayments which included repayments relating to superannuation offsets, overpayments etc.;
 - PI conditions data which provided some high level attribution of impairment points to associated body regions; and
 - Dependent data which included the dependent's year of birth.
- 3.2.4 Access to VEA data via DVA's systems was also provided this year. This data was used in our modelling of the impact of Harmonisation. We also used VEA Gold Card expenditure experience to assist in setting assumptions for average MRCA Gold Card expenditure for veterans at older ages where there is currently limited MRCA experience.
- 3.2.5 DVA also provided aggregate payment data up to the third quarter of 2024–25. Aggregate data can be distorted by timing issues and advances which are paid to other agencies. As a result it cannot be treated as entirely reliable.
- 3.2.6 The unit record data for DRCA provided payments which covered the period from 2005 to 31 December 2024 for incapacity payments and from 2001 to 31 December 2024 for non-incapacity benefits. We have relied primarily on unit record data over the most recent calendar years to 31 December 2024 to set assumptions in the DRCA valuation.
- 3.2.7 The unit record data for MRCA provided payments for the period from 1 July 2004 when the MRCA scheme began to 31 December 2024. MRCA data was problematic in the early years; reliable data is not available and is unlikely to ever become available in relation to the first 2 years of operation of the scheme. For all MRCA payments, including the health care card data, the transaction data is recorded by claimant rather than claim.
- 3.2.8 Our two main points of validating or assessing the suitability of the data for valuation purposes are that we are able to match a very large proportion of payment and claim records and that the totals calculated from the unit record files are consistent with the general ledger aggregate expenditure data provided by DVA. For the most part, both the DRCA and MRCA data satisfied these conditions.

3.3 Data Quality

- 3.3.1 The tables below show the results of two data checks which were conducted as part of the valuation process for DRCA and MRCA for the latest financial year. Prior year reconciliations are provided in previous valuation reports. The first is a reconciliation between the aggregate general ledger expenditure and the unit record payment data by benefit type. There are some discrepancies between the general ledger data and the unit record data due to timing differences and the recording of repayments against incapacity benefits which are recorded in the general ledger only.
- 3.3.2 The second data check performed is to determine the proportion of unit record payments which could be matched to a claim or dependent record. For some benefits such as legal expenses under DRCA, only aggregate expenditure is received and thus cannot be matched to any corresponding claims.

Table 3.1: DRCA Data – Reconciliation of Payments

2023–24 Financial Year				
Usage	DVA General Ledger Aggregate Payments (\$m)	Sum of Unit Record Payments (\$m)	Unit Record Payments Matched to Claim Records (\$m)	Proportion Matched (%)
Incapacity	148.0	157.4	157.4	100
Permanent Impairment	303.6	303.6	303.6	100
Medical	9.4	9.5	10.0	105
HSAC	32.1	32.1	32.0	100
Rehabilitation	9.5	9.4	9.2	98
Other	11.3	11.3	10.2	90
Death	37.9	38.3	38.0	99
Total	551.7	561.7	560.5	100

3.3.3 For other benefits, a proportion of medical examination payments and legal payments are provided without a unique identifier and thus cannot be matched to individual claim records. Overall, we consider that the DRCA data is suitable for the purposes of setting the assumptions for this review.

3.3.4 Table 4.2 shows the equivalent information for the MRCA data.

Table 3.2: MRCA Data - Reconciliation of Payments

2023–24 Financial Year				
Usage	DVA General Ledger Aggregate Payments (\$m)	Sum of Unit Record Payments (\$m)	Unit Record Payments Matched to Claim Records (\$m)	Proportion Matched (%)
Incapacity	414.5	412.8	411.8	100
Permanent Impairment	2,694.0	2,708.9	2,708.1	100
Medical	300.4	301.8	309.9	103
HSAC	43.0	42.9	42.8	100
Rehabilitation	54.7	55.6	54.2	98
Other	140.7	135.3	134.1	99
Death	43.1	42.3	42.3	100
Total	3,690.4	3,699.5	3,703.2	100

3.3.5 Overall, we were able to match the majority of records to a claimant and are satisfied that the MRCA data is suitable for analysis.

4 Valuation Approach and Common Assumptions

4.1 Projection Models and Exposure

- 4.1.1 The actuarial valuation process relies on projecting future payments and then discounting them back to a present value. The method adopted to generate these projections varies between the different types of payment and are discussed in turn in each benefit chapter.
- 4.1.2 The majority of our projection models use year of accident exposure based on the number of serving members within that year. Although this is a broad exposure measure, it is currently the only data available to AGA. Should injury or separations data become available to AGA in future, these could assist in refining our exposure measure and selected model assumptions.
- 4.1.3 In March 2022, the Government announced an increase to the Defence workforce, increasing the permanent ADF to approximately 80,000 by 2040. The 2025 Budget included forward estimates of the number of permanent ADF expected in each year to 2028-29. We have then assumed the expected ADF personnel will increase linearly to an exposure of around 80,000 by 2040. We have increased the expected number of reservists proportionately. Although this increase in personnel does not impact on the 30 June 2024 liability, it does impact on the 10 years of future projected cashflows presented in this report.

4.2 Economic Assumptions

- 4.2.1 To project future cashflows, it is necessary to adopt assumptions regarding the rate of growth in nominal payments. A discount rate assumption is also required to arrive at a meaningful estimate of the present value of the outstanding liability.
- 4.2.2 Claim payments will tend to increase for many reasons. For example, incapacity payments are linked to earnings, the limits for PI and NEL lump sums are indexed to CPI and other benefits are subject to indexation as set out in the rules of the scheme.
- 4.2.3 However, policy initiatives, changes in the external environment or other influences could all be expected to impact the claims costs. Examples of such factors include:
- an altered approach to impairment assessment (such as the move from using independent specialists to using the veteran's general practitioner to make medical assessments) or changing community norms around mental illness leading to a higher impairment rating;
 - a policy decision to increasingly rely on health care cards rather than reimbursement arrangements for medical examinations; and
 - impacts of the coronavirus pandemic in 2020 to 2022 on access to services and type of services offered.
- 4.2.4 These phenomena contribute to what is known as superimposed inflation in the cost of the scheme – that is, the extent to which the rate of growth in the overall cost of the scheme exceeds the rate of general inflation in the community.
- 4.2.5 In setting inflation assumptions, we have had regard to any statutory guidelines on indexation, in conjunction with the observed experience.

- 4.2.6 The maximum DRCA PI payment for a single claim is indexed in line with CPI. All else being equal, therefore, we might expect the average payment to also increase in line with the CPI. In practice, the average payment has increased considerably faster than prices. Over the calendar years 2006 to 2024, the annual rate of growth has been approximately 8 per cent with some years exhibiting little growth and others with significant increases. DRCA PI saw rapid growth in the average size following Veteran Centric Reform between 2017 and 2019 where the annual rate of growth reached almost 20 per cent. The rate of growth then slowed over 2020 to 2022. However, growth in the most recent two years has been 10 per cent and 24 per cent. The causes of this very high level of growth in 2024 are discussed further in Section 7. At this valuation, we have retained the total inflation rate assumption of 5 per cent adopted at the last valuation for DRCA PI, equivalent to 2.5 per cent per annum for CPI and 2.5 per cent per annum for superimposed inflation.
- 4.2.7 MRCA PI has seen significant increase in average size over recent years. DVA postulates that this could be driven by increasing numbers of medically discharged veterans who are presenting with higher injury severity. There has been a strong increasing trend in the proportion of MRCA PI recipients accessing the Section 80 eligible young person benefit, accessible if the claimant's whole person impairment assessment is over 80 points. There is also the possibility that the claims processing backlog has resulted in higher numbers of conditions being considered in a PI claim, which is highly correlated with the resulting benefit payment. At this valuation, we have explicitly allowed for the proportion of those accessing Section 80 benefits to increase (but no allowance for superimposed inflation in the Section 80 claim size). We have also incorporated additional superimposed inflation of 2 per cent per annum over the next three financial years in the average size of interim and non-interim lump sums, consistent with our allowance at the previous valuation.
- 4.2.8 For incapacity benefits, indexation follows the rate of military pay. Over the short-term, we have adopted the terms of Defence's Workplace Remuneration Arrangement 2023-26 which sets out salary increases of 4 per cent in November 2023, 3.8 per cent in November 2024, and 3.4 per cent in November 2025. From financial year 2028 onwards, expected long term wage growth of 3.7 per cent is adopted.
- 4.2.9 MRCA death payments are expected to increase in line with expected future price inflation of 2.5 per cent. This is consistent with the legislated benefits. DRCA death benefits include weekly payments to dependents which are indexed with average weekly earnings. For service-related benefits such as medical treatment, rehabilitation, and household and attendant care services, we have used 3.7 per cent expected long term wage growth to index future payments.
- 4.2.10 The following table summarises the combined nominal rate of inflation (that is, normal inflation plus superimposed inflation) used for the current valuation and the previous valuation. The rates shown are the long-term assumptions.

Table 4.1: Rates of Inflation

Category	2024 Valuation	2023 Valuation
Incapacity payments	3.7%	3.7%
PI and NEL (DRCA)	5.0%	5.0%
PI (MRCA)	2.5%	2.5%
Medical	3.7%	3.7%
Rehabilitation (DRCA)	3.7%	3.7%
Rehabilitation (MRCA)	3.7%	3.7%
Death (DRCA)	3.7%	3.7%
Death (MRCA)	2.5%	2.5%
Household Services & Attendant Care	3.7%	3.7%
Other – Medico-Legal	3.7%	3.7%
Other – Supplements	2.5%	n/a
Other – Education & Training Scheme	2.5%	2.5%

- 4.2.11 The estimation process involves projecting the future claim payments allowing for normal inflation and superimposed inflation as described above. To calculate the liability, the payments are then discounted to a present value. This discounting recognises the time-value of money and enables the realistic assessment of long-term financial arrangements such as the MCS.
- 4.2.12 The Australian Accounting Standard (AASB 137) which would apply for financial reporting purposes specifies that the discount rate used in preparing estimates of claim liabilities should be a pre-tax rate that reflects current market assessments of the time value of money and the risks specific to the liability. In an arrangement such as the MCS, this might be interpreted as the return on Commonwealth securities of appropriate durations and, for financial statement purposes, we use a yield curve derived from the yields on Commonwealth securities as at the relevant 30 June for discounting purposes.
- 4.2.13 Such an approach can lead to major changes in the estimate of the liability due solely to changes in interest rates. For the full actuarial review that we are reporting on here, we regard a stable interest rate assumption to be preferable as it allows other changes in experience, which are more important from a policy perspective, to be observed. We have retained the 5 per cent long term interest rate for discounting cashflows used at the previous valuation. The 5 per cent long term interest rate is consistent with the rate used to discount other long term Commonwealth liabilities, in particular, the cost of military superannuation benefits. This is based on long term expectations of 2.50 per cent CPI growth, 1.20 per cent productivity growth, and 1.25 per cent population growth.
- 4.2.14 Note that an additional letter of advice will be provided to DVA for financial statement purposes. This letter will include the result of the roll forward process which provides the liability as at 30 June 2025 and will discount cashflows using a yield curve derived from Commonwealth securities as described in 5.3.12.

4.3 Administrative Expenses

- 4.3.1 DVA reports administrative expenditure, including claims handling expenses for all claims under all 3 compensation Acts through separate systems. We currently have no data relating explicitly to claims handling expense for MRCA and DRCA claims available and have made

no explicit allowance for claims handling expenses in our valuation of MCS liabilities. Our understanding is that a separate provision for administrative expenses in relation to all Acts is made in DVA's internal budget projections.

4.4 Risk Margins and Risk Assessment

- 4.4.1 The estimates provided in this report represent our best estimates of the liability and projected cashflows. That is, it is intended to be equally likely that they are too low as that they are too high. We have not calculated a risk margin (prudential margin).
- 4.4.2 The relevant Accounting Standard for reporting the liability is AASB 137. This Standard does not explicitly require a risk margin to be included. It is also arguable that the inclusion of a risk margin would be inconsistent with the requirement set out in paragraphs 36 and 37 of AASB 137 that the estimate be based on the amount that the entity would rationally pay to settle the obligation. In the context of the Commonwealth's balance sheet, it can be argued that the Commonwealth would be irrational to pay more than the central estimate to settle the liability. The fact that the Commonwealth chooses to self-insure many of its risks rather than pay a premium to transfer them off the balance sheet adds support for this view.
- 4.4.3 However, the considerable uncertainty associated with the estimates should not be disregarded in considering the results. The true liability is unknown and the cashflow projections become increasingly uncertain the longer the projection period.
- 4.4.4 To help illustrate the uncertainty, we have included some sensitivity and scenario analysis around key assumptions in section 17. The analysis focuses on the largest benefit types, the key assumptions which contribute to the liability result, and areas of significant uncertainty.

4.5 Reinsurance and Non-Reinsurance Recoveries

- 4.5.1 DVA has no reinsurance contracts in place relating to MCS liabilities. As such, provisions have not been made for expected reinsurance recoveries.
- 4.5.2 Veterans can claim for benefits relating to the same injuries under the Military Superannuation system. In these circumstances, benefits can be offset between the MCS incapacity benefits and benefits received from superannuation. A range of other recoveries are also possible should any overlap occur with other social security supports. AGA was provided with repayment data from DVA which covered a range of recoveries ranging from superannuation offsets to corrections to previous over payments. We have made an allowance for future recoveries for both DRCA and MRCA incapacity benefits. This is further discussed in Section 8 of the report.

5 Initial Liability Claims

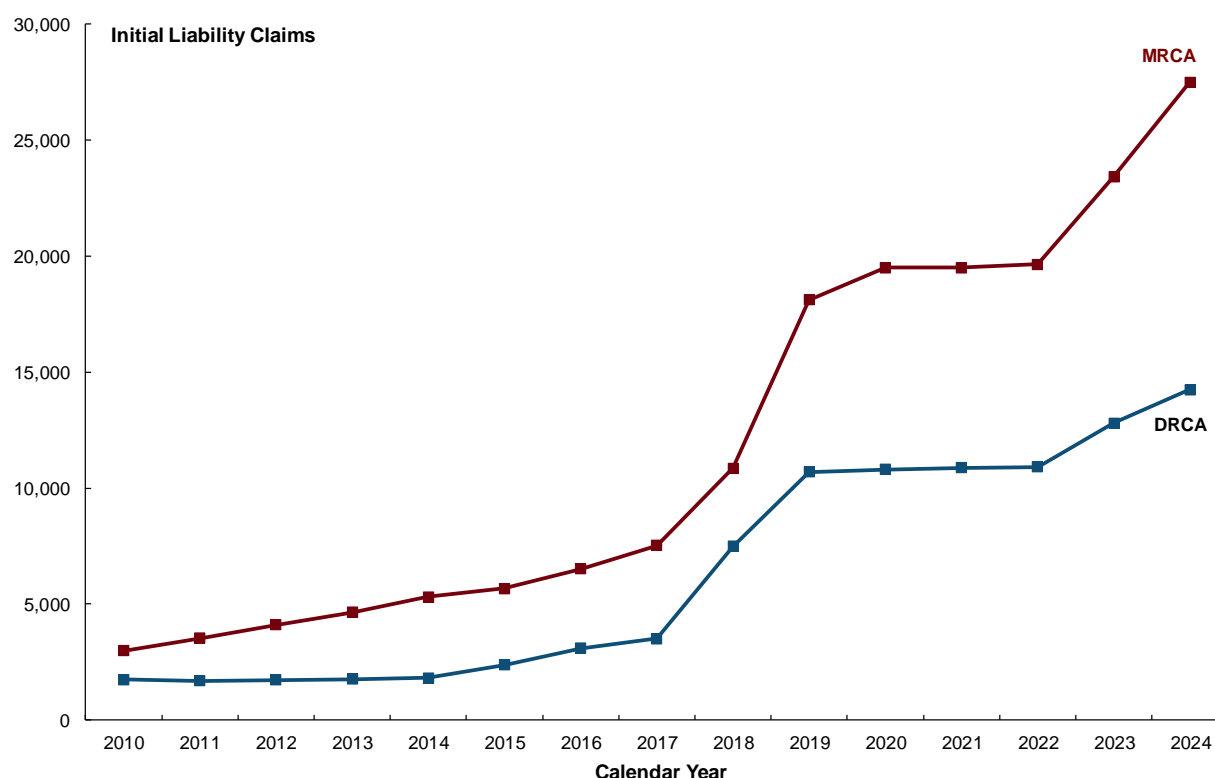
5.1 Background

- 5.1.1 Initial Liability (IL) is the first step in the compensation process and establishes whether the Commonwealth is liable for an injury, illness, or death. Under the DRCA and MRCA, liability must be accepted prior to any claims for treatment or benefits, excluding services provided under Non-Liability Healthcare (NLHC) or Provisional Access to Medical Treatment (PAMT). IL claim lodgements have increased substantially in recent years as a result of administrative and cultural changes within DVA and the veteran community. Combined with limited information on exposure, projecting IL claim lodgements has become increasingly challenging in recent years.
- 5.1.2 The administrative changes made within DVA have increased the accessibility of services and benefits to the veteran community. Policy initiatives such as Veteran Centric Reform have encouraged veterans to claim earlier for DVA benefits and have also increased awareness of these benefits amongst existing ADF members and the veteran population. This may have a short-term effect in bringing forward claimants who may otherwise have claimed for a benefit in later years, and captured existing veterans who may have faced barriers to claiming in previous years. The exact impact of these changes will not be known for a number of years and there is currently not enough data to help determine the magnitude or length of the impact. In this valuation, we have not made any adjustments to the projections to allow for a potential bringing forward of reporting of claims.
- 5.1.3 A key uncertainty in determining the level of initial liability claims is the level of exposure, that is, the total population of existing veterans and serving ADF personnel who may eventually make a claim. We currently have data relating to the number of active personnel in each year but this encompasses the entire active force. To allow for more nuanced analysis, information regarding the number of people injured and the type of injuries incurred could provide a more robust picture of the exposure as it would provide visibility on the upper limit of claimants likely to arise from a particular accident year.
- 5.1.4 Claims also arise from the existing population of veterans who may have separated from Defence a number of years ago and where the severity of injuries has increased over time. Improved access to DVA services and greater awareness of benefits might be influencing the propensity of these veterans to make a claim and potentially claiming earlier than they otherwise would have. Information regarding discharges and the likely total veteran population may be useful in helping to narrow the exposure for claimants from the existing veteran population who might make a claim in future and provide an upper limit to the number of potential claimants likely to emerge over time from this cohort.

5.2 Lodgements

- 5.2.1 Figure 5.1 shows the number of initial liability (IL) claims lodged in each calendar year under both DRCA and MRCA. The IL claims have been counted as unique individuals with lodged claims within the calendar year i.e. if a veteran has lodged multiple IL claims within the year, they are only counted once in that year. This definition differs from that used by DVA.

Figure 5.1: DRCA and MRCA Lodged Initial Liability Claims



5.2.2 For both DRCA and MRCA, the number of IL lodgements has grown considerably in the last two years. For DRCA, the growth in IL lodgements was 17 per cent in 2023 and 11 per cent in 2024. For MRCA, the corresponding figures are 19 per cent and 17 per cent.

5.2.3 From discussions with DVA delegates, we understand that several factors may be contributing to this growth. Anecdotally, increased activity by fee-for-service advocates was thought to be the main reason driving the increase. In recent years, there has been a shift away from volunteers and ex-servicemen organisations (ESO) assisting veterans with their claims to more widespread use of fee-for-service advocates who are paid (by the veteran) a proportion of any resulting compensation. The fee-for-service advocates find claimants via word of mouth, a heavy social media presence and contacts via ESOs. The increased activity of the fee-for-service advocates has repercussions on several benefit types as discussed in the relevant sections of this report.

5.2.4 At the time of IL claim lodgement, DVA collects the names of any representatives who may be assisting the claimant with their IL claim and the organisation the representative is from. In cases where a family member or friend is the nominated representative or where the claimant is acting on their own behalf, no organisation is recorded. The data is collected in free-text fields and the quality of the information may have changed over time. Noting these data limitations, we have performed some preliminary analysis on these fields over time. Our analysis shows that around 4 to 6 per cent of MRCA IL claims had a fee-for-service advocate involved for 2020 and 2021 lodgements. This had increased to around 25 per cent for 2024 lodgements. The corresponding figures for DRCA are 2 to 3 per cent for 2020 and 2021, increasing to almost 10 per cent for 2024. Over the same period, the proportion of claims that were supported by ESO advocates has remained fairly stable at around 25 to 30 per cent for

MRCA and 45 to 50 per cent for DRCA. This would indicate that, while fee-for-service advocate involvement may be a driver of higher claim lodgements, it is not the only factor.

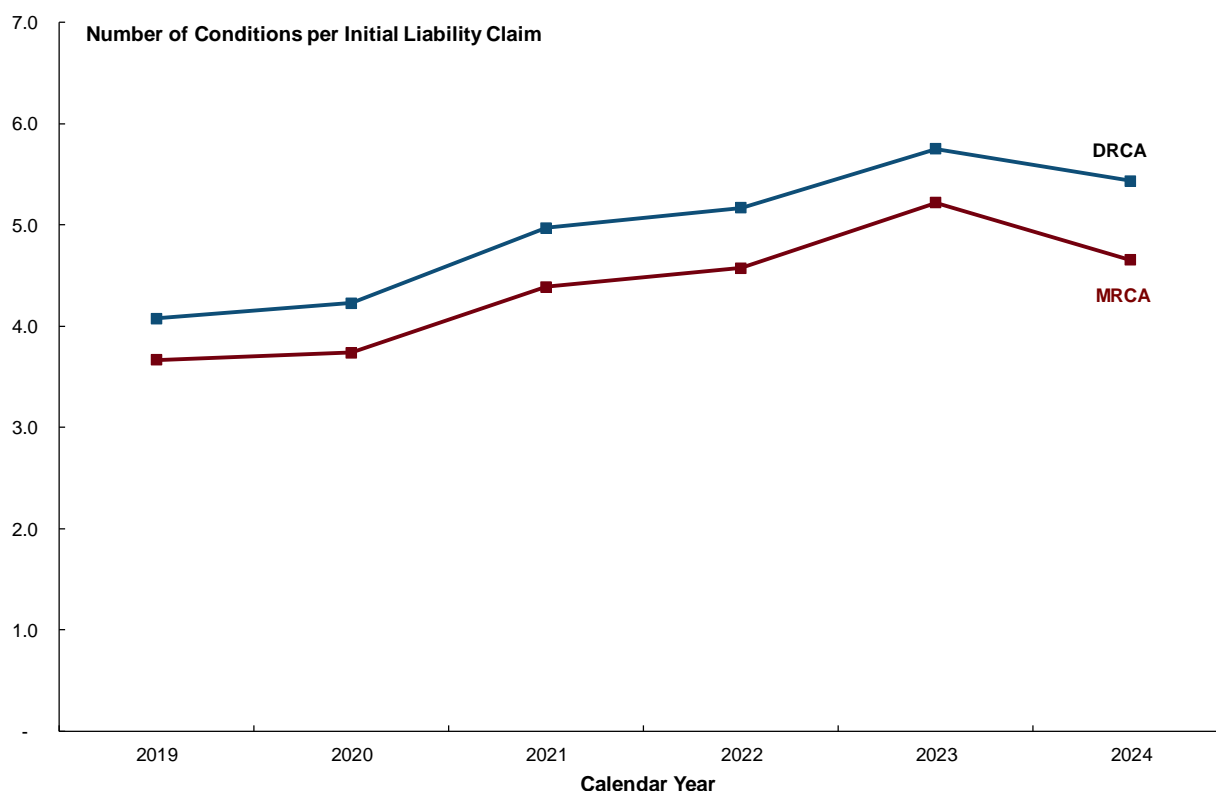
5.2.5 Other reasons that are also thought to be contributing to the increase in the number of IL claims lodged are:

- increased awareness and reduced stigma around claiming as a result of the recent Royal Commission into Defence and Veterans Suicide, which began in 2021. This brought increased public awareness and media attention to both Defence and DVA.
- Increased on-base activity of Veteran Support Officers, who try to encourage separating members to lodge any IL claims prior to separation. As such, this may result in some “bringing forward” of claims relative to the claim pattern of earlier years.
- Word of mouth within friendship/cohort groups within the veteran community, with DVA noticing that certain birth year cohorts have made claims for similar injuries at similar times.

5.3 Number of Conditions per Person

5.3.1 A single IL claim lodged can include claims for multiple conditions/injuries. Figure 5.2 shows the number of conditions lodged per person who has lodged an IL claim in each calendar year under both DRCA and MRCA (i.e. calculated as the total number of conditions lodged divided by the number of unique individuals who have lodged an IL claim as shown in Figure 5.1 above).

Figure 5.2: DRCA and MRCA Number of Conditions per Person per Year

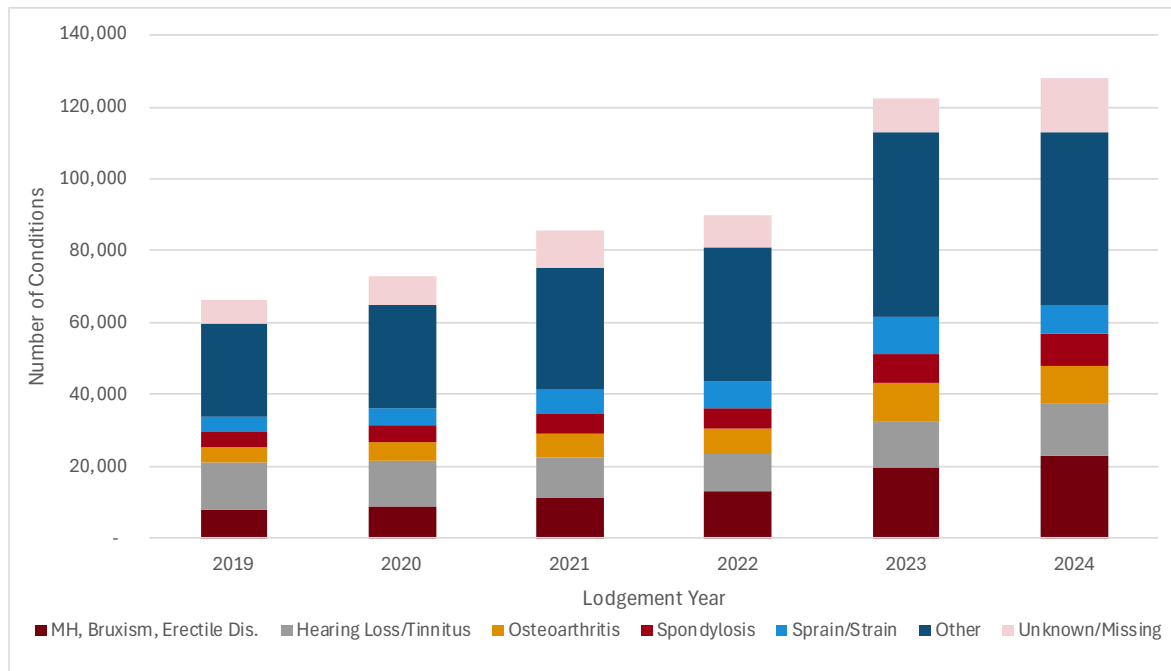


5.3.2 After increasing between 2020 and 2023, the number of conditions lodged per claim under both DRCA and MRCA has reduced a little in 2024 compared with 2023.

5.4 Types of Conditions Lodged

5.4.1 Figure 5.3 shows the number of conditions lodged in each calendar year by type of condition under MRCA.

Figure 5.3: MRCA Number of Conditions by Injury Type



5.4.2 DVA program areas have also noted that certain conditions are highly correlated. For example, a mental health condition is often accompanied by a claim for bruxism (a common symptom of a mental health condition) and erectile dysfunction (as some medications prescribed to treat mental health conditions can cause erectile dysfunction). The Statement of Principles (SOPs), designed by the Repatriation Committee, include causal factors to acknowledge these correlations when claims are assessed.

5.4.3 There have been increases across all types of conditions, with the greatest proportional increase in mental health and two of its associated conditions (bruxism and erectile dysfunction).

5.5 Completions

5.5.1 In the years following Veteran Centric Reform, we have seen that processing constraints have been an issue at DVA, resulting in long delays between IL lodgement and completion, and a large number of open IL claims under both DRCA and MRCA. Over the last two years, DVA have expanded their processing capacity to try to clear the existing number of open claims. However, as shown above, the number of new IL claims lodged has also increased over this period and the increased processing capacity has not been sufficient to make inroads into the number of open claims. There remain around 26,000 open IL claims awaiting completion under MRCA as at 31 December 2024, similar to the number at 31 December 2023. For DRCA, the number of open IL claims has increased by around 3,500 over the last year.

5.5.2 Figure 5.4 and Figure 5.5 below show the level of lodged, completed and accepted IL claims under DRCA and MRCA to the end of calendar year 2024. Completed claims in a year are

counted should at least 1 condition be completed e.g. if a veteran lodged 2 conditions in an IL claim in 2023 and one of those conditions is completed in 2023, they will appear as 1 count in the 2023 completed number. These definitions differ from those used by DVA. Please note, completed figures below also include claims that have been withdrawn.

Figure 5.4: DRCA Lodged and Completed Initial Liability Claims

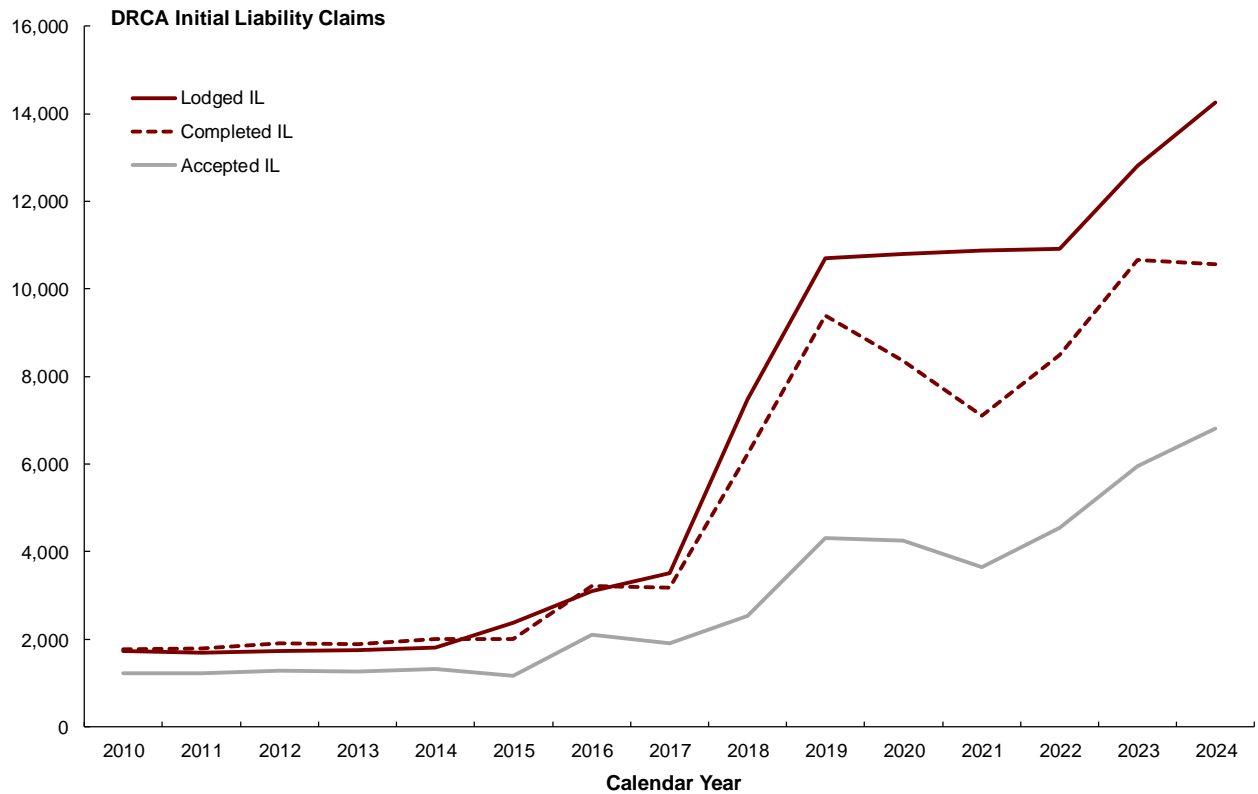
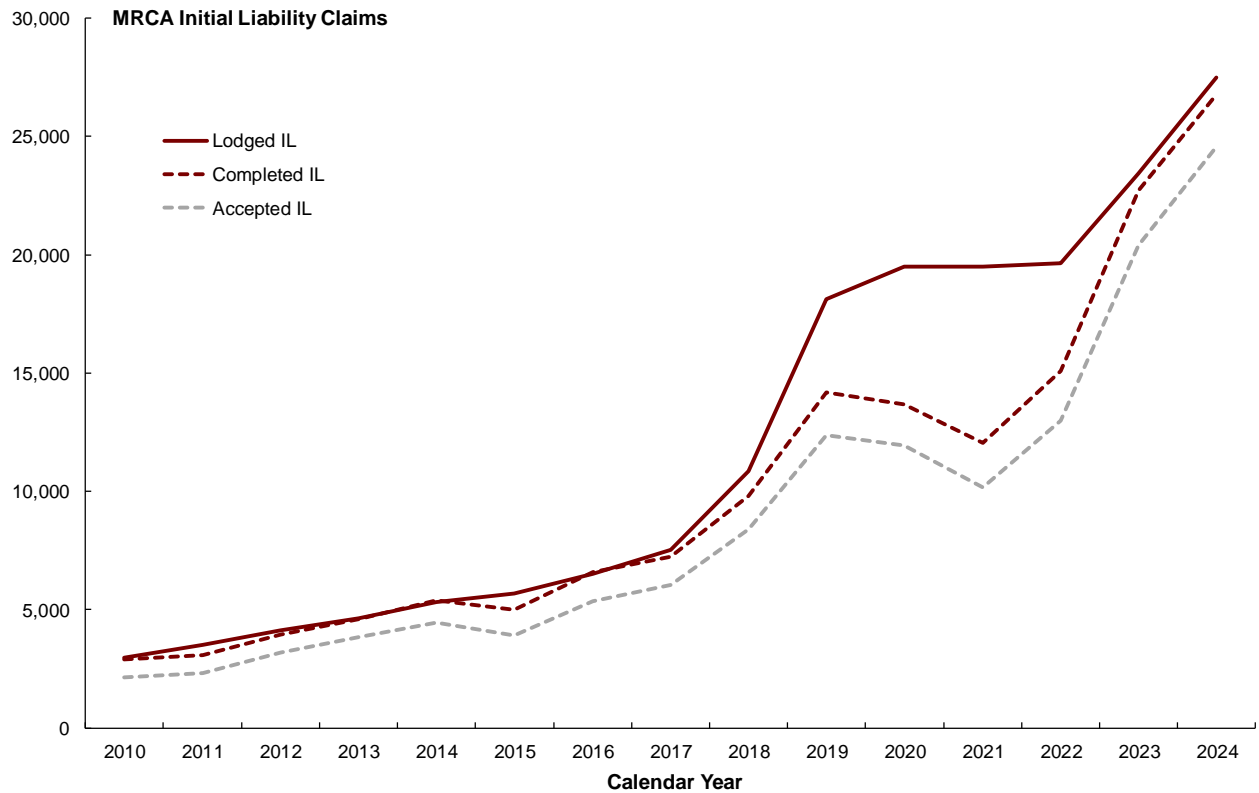


Figure 5.5: MRCA Lodged and Completed Initial Liability Claims



- 5.5.3 The level of completed claims in the last calendar year has been significantly higher than previous years for MRCA, with DRCA completions at the same (high) level as for 2023. However, there still remains a substantial number of open claims.
- 5.5.4 Figures 5.3 and 5.4 below show the number of completed and withdrawn claims by the calendar year of lodgement. The graphs below differ from Figures 5.4 and 5.5 above as they are on a lodgement year basis, rather than calendar year basis. For example, in Figures 5.4 and 5.5, the number of completed IL claims for 2024 represents the total number of completed claims in that year, regardless of when they were lodged. In Figures 5.6 and 5.7, the completed IL claims for 2024 represents the number of completed IL claims that were lodged in 2024 only, regardless of when they were completed.

Figure 5.6: DRCA Lodged and Completed Initial Liability Claims by Lodgement Year

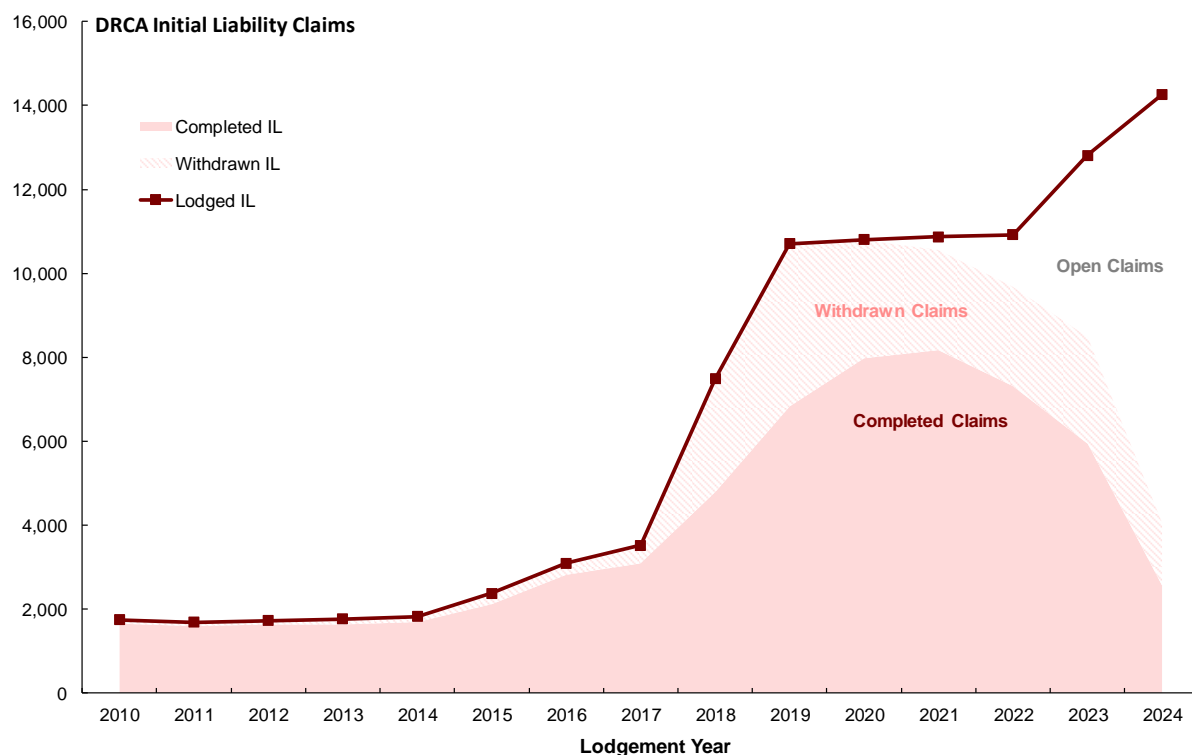
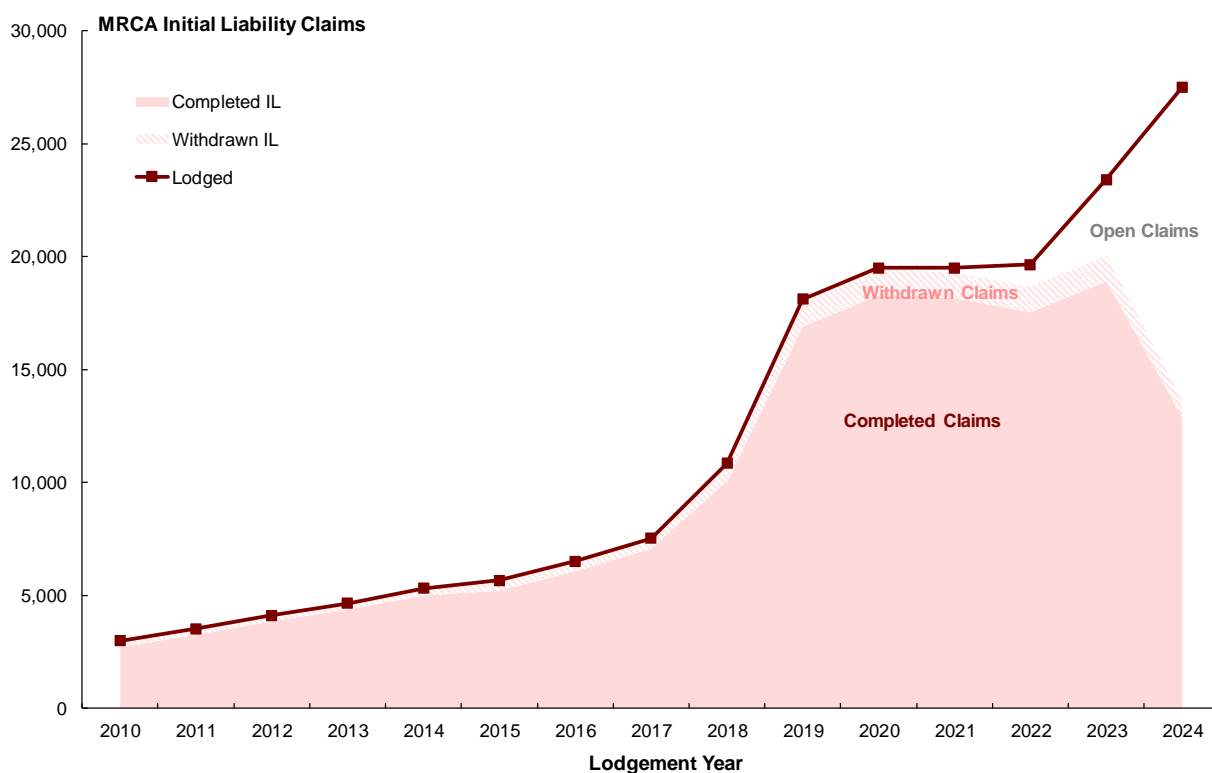


Figure 5.7: MRCA Lodged and Completed Initial Liability Claims by Lodgement Year



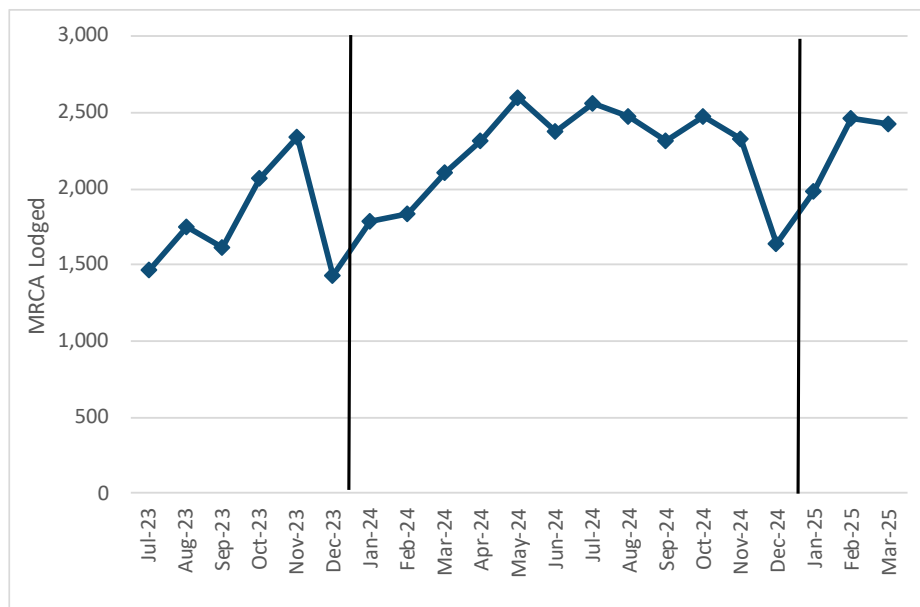
- 5.5.5 For both DRCA and MRCA, almost all claims lodged in 2021 and prior have been completed at the end of 2024. For the 2022 lodgement year, 85 per cent and 95 per cent of claims for DRCA and MRCA respectively have been completed or withdrawn. The majority of current outstanding claims are from the 2023 and 2024 lodgement years.
- 5.5.6 The valuation models adjust the observed payment experience for some benefit types to account for the impact of processing constraints at the initial liability stage. These require assumptions relating to how current open claims will transition to a particular benefit and what long term experience may be without the impact of processing constraints. These adjustments are discussed in detail under each benefit section.

5.6 Projected Future IL Claims - MRCA

- 5.6.1 At this valuation, we have explicitly modelled future expected IL claims for both MRCA and DRCA (last year we modelled MRCA IL claims only). As all benefit payments require an IL claim, future projected IL claims provide a guide to the level of potential benefit payments that could emerge. This section discusses the methodology used and the resulting projections for the MRCA IL claim analysis and the next section discusses the same for DRCA. How this analysis is used by each of the benefit models will differ and further details are provided under each benefit section.
- 5.6.2 For MRCA, lodged IL claims are summarised by accident year and lodgement year at the person level. As the majority of IL claims contain multiple conditions, the accident year for the claim is assigned as the average of the accident dates related to the lodged conditions for that IL claim. If a person lodges multiple IL claims in the same lodgement year, only one IL claim is counted with the accident year assigned as the average accident date across all conditions lodged within that year. For the latest lodgement year, a substantial number of conditions have missing accident dates (as accident dates are often not recorded until the claim has been processed/completed). For these claims, we have used the latest lodgement data to assign a year of accident.
- 5.6.3 Withdrawal rates are calculated based on historic withdrawals to arrive at the number of lodgements. Withdrawal rates have been relatively stable over the last 10 years, ranging between 6 per cent and 7 per cent of claims lodged by accident year. We have adopted a withdrawal rate of 6.8 per cent for 2024 lodgements, up a little from 6.5 per cent for 2023 lodgements. We understand that fee-for-service advocate behaviour may be driving the observed small increase in the withdrawal rate; some advocates advertise based on their very high claim acceptance rates. To maintain these high rates, the advocate may pre-emptively withdraw the condition prior to DVA's decision if it appears that DVA is likely to decline that condition.
- 5.6.4 A chain ladder model is used to project future IL lodgements for accident years 2008 and prior. For accident years after 2008, claim frequencies are used to project future lodged IL claims. The selected claim frequencies are based on experience in the most recent year, plus an allowance for a further 4 per cent increase in claim frequency in 2025. The 4 per cent increase is based on analysis of the monthly pattern of IL claim lodgement over calendar year 2024 and the first quarter of 2025.
- 5.6.5 Figure 5.8 uses DVA's claim processing statistics to 31 March 2025, showing the number of ILs lodged in each month since July 2023. Noting that December and January are seasonally low months, there does appear to be some stability in the number of IL claims lodged since April 2024. If we assume that IL claim lodgements in the remaining nine months of 2025 are

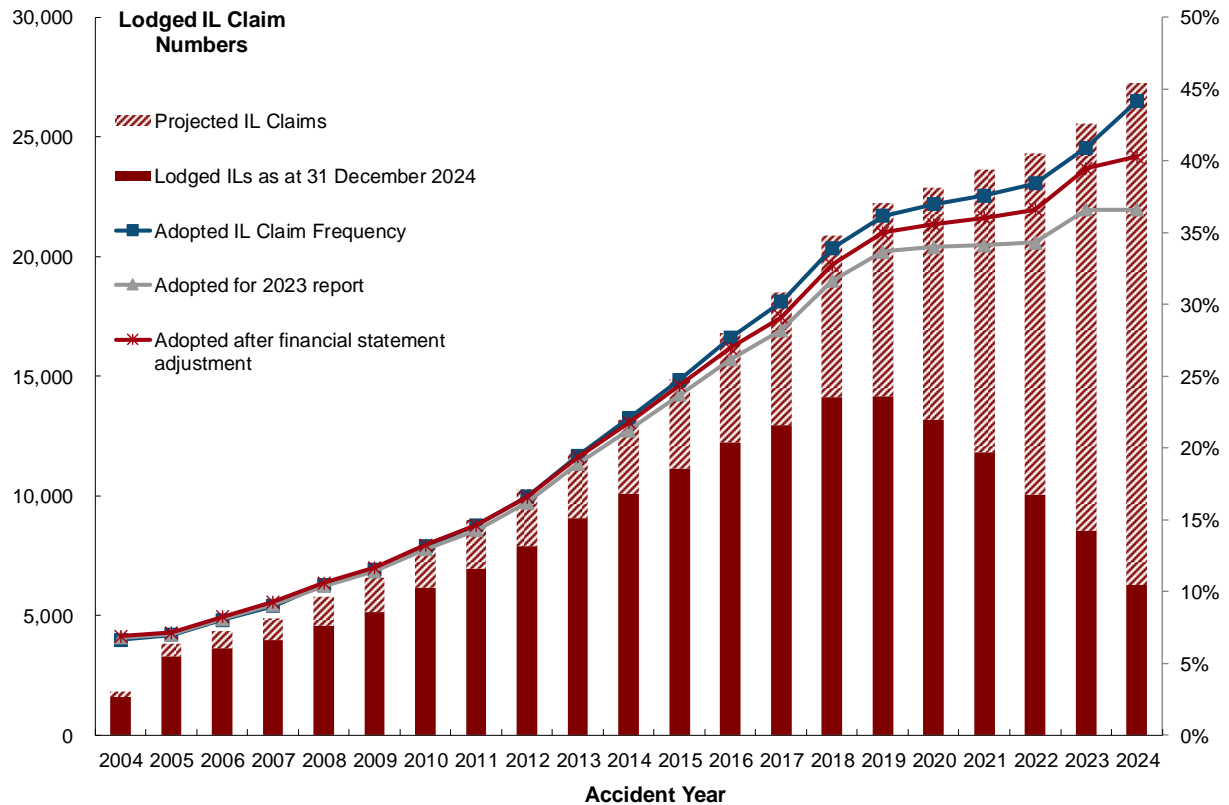
at the same level as for April to December 2024, this results in 2025 lodgements being 4 per cent higher than in 2024.

Figure 5.8: MRCA Actual and Projected Lodged ILs by Accident Year



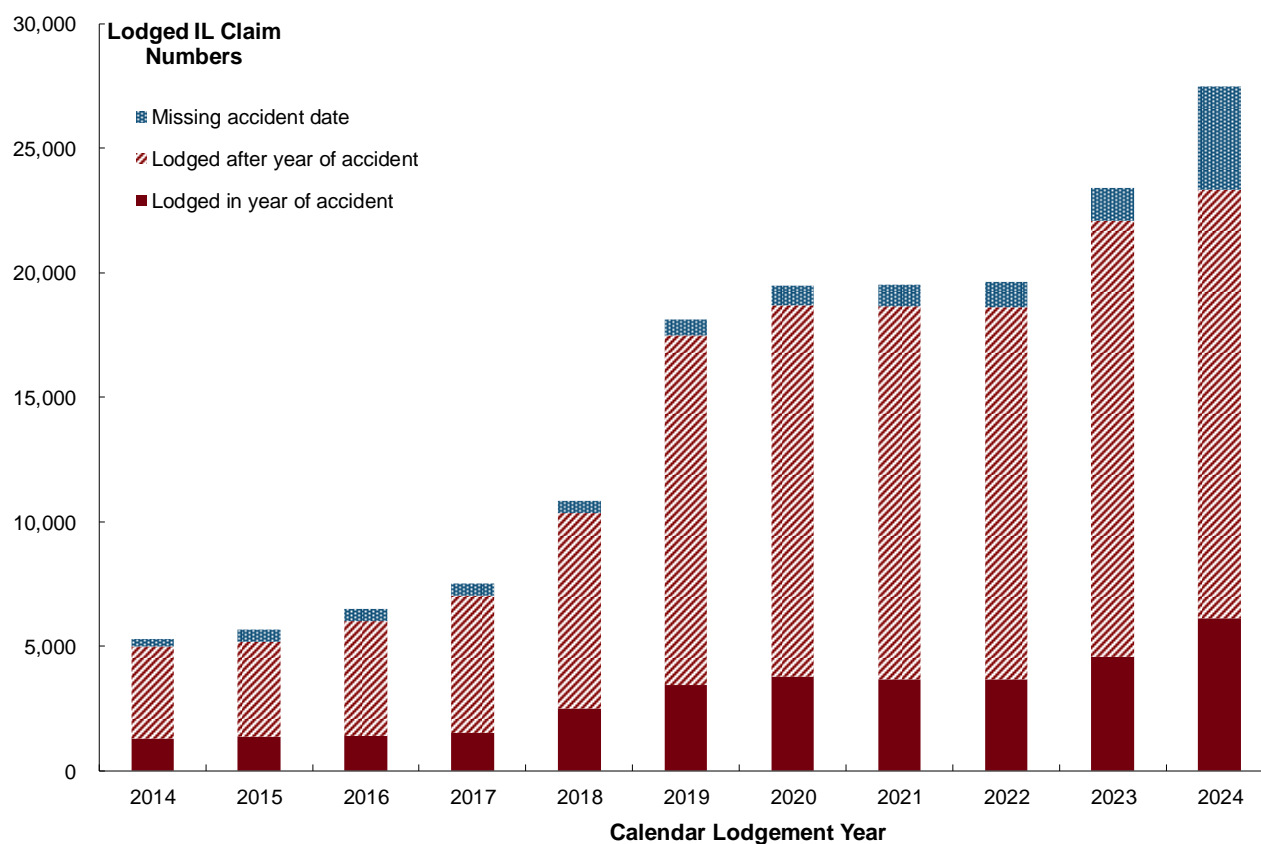
- 5.6.6 Given the recent large increases in IL lodgements, there is considerable uncertainty surrounding assumed future changes in claim frequency. However, we believe it is reasonable to assume that there will be no further increase in IL lodgements beyond present levels given that a large portion of the increase in frequency has been due to increased fee-for-service advocate activity and that DVA has a number of initiatives in train to address some of the behaviours adopted by these firms.
- 5.6.7 Figure 5.9 shows the number of lodged IL claims as at 31 December 2024 and projected IL claims by accident year. Future lodgements are lower for earlier accident years as these have had the most time to develop. The use of average accident year also means the exposure for earlier years is lower than for later years as MRCA only commenced from 1 July 2004. For example, an IL claim lodged with an average accident year of 2004, can only have associated injury dates in 2004 or later, whereas a claim with average accident year of 2010, can have a range of injury dates before and after 2010 which average to 2010. As such, the projected ultimate numbers of IL claim lodgements will be lower for earlier years of accident than later accident years.
- 5.6.8 Our estimate of ultimate claim frequency for each accident year is also shown, along with the claim frequencies adopted in our June 2023 report and the frequencies adopted after adjustment for the June 2024 financial statements. Our adopted claim frequencies at this valuation are substantially higher than adopted previously for the 2016 and later accident years. IL claim frequency over the 2018 to 2022 accident years (post Veteran Centric Reform) are projected to have increased modestly. However, frequency is estimated to have increased substantially for both the 2023 and 2024 accident years.

Figure 5.9: MRCA Actual and Projected Lodged IL Claims by Accident Year



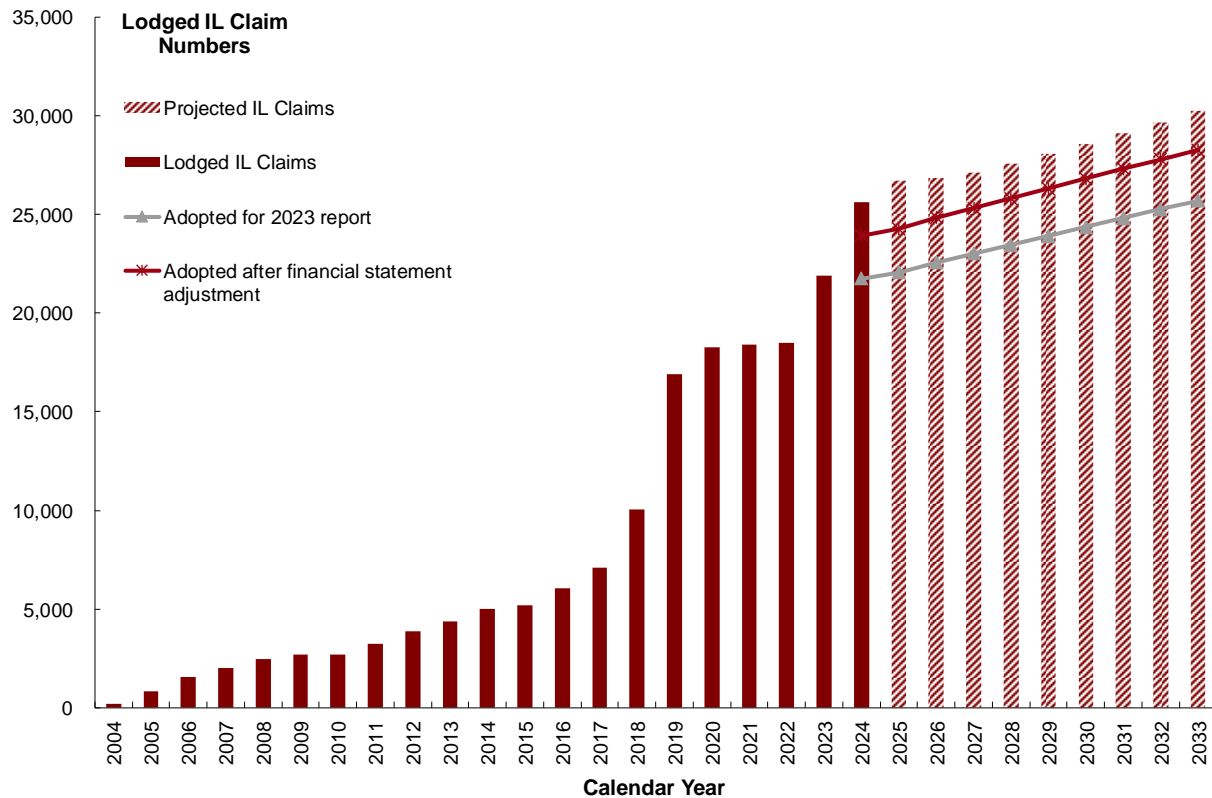
5.6.9 Figure 5.10 shows the number of IL claims lodged in each calendar year since 2014, split between those that were lodged in the year the accident occurred, those that were lodged after the year of accident, and those where no accident date has so far been recorded on the IL claim (noting that the accident date is often not recorded until the IL claim has been completed). As at 31 December 2024, a large number of the 2024 claims did not have any associated injury dates. The number of IL claims lodged in 2024 in respect of accidents that occurred in 2024 is already higher than for prior years, even before the claims with missing injury dates are taken into account i.e. the 2024 accident year appears significantly higher than prior years at this early stage of development.

Figure 5.10: MRCA Lodged ILs by Lodgement Year



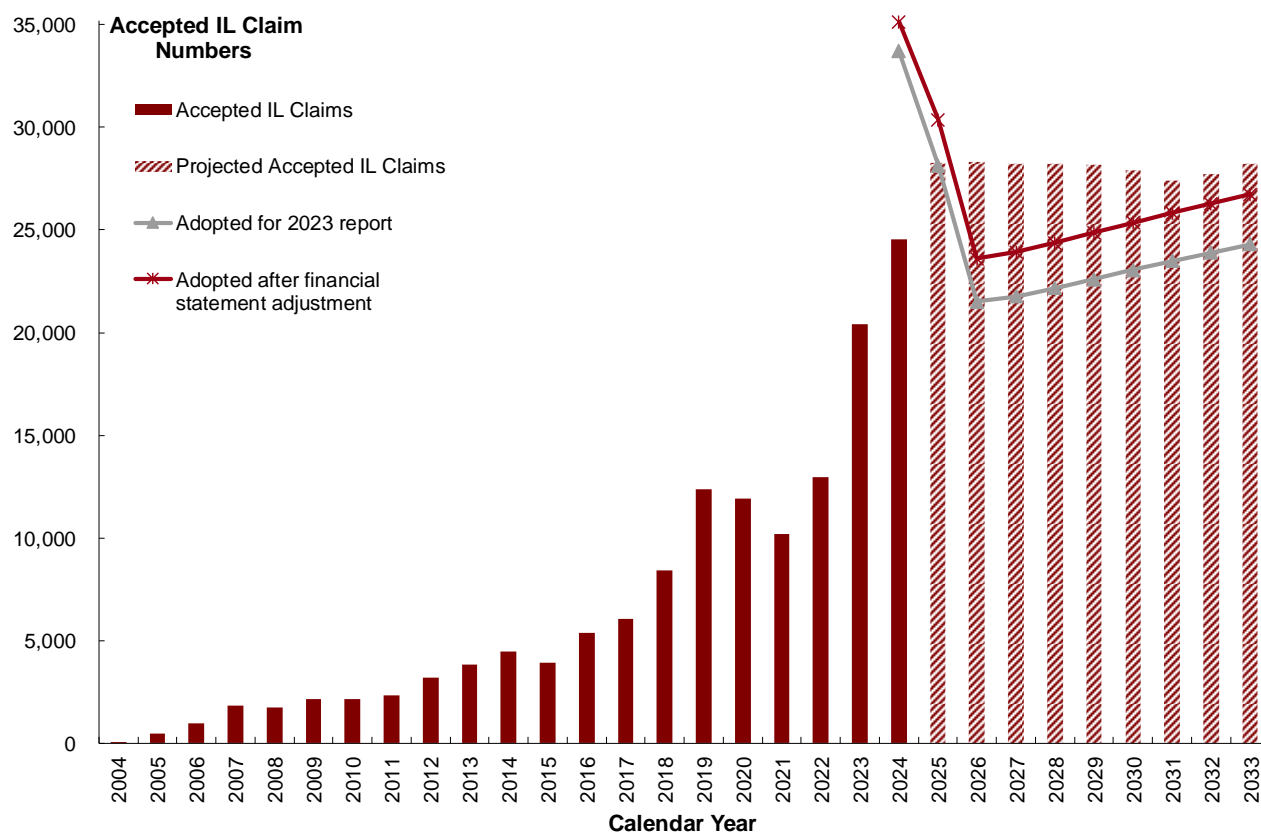
5.6.10 Figure 5.11 shows the actual and projected IL claim lodgements by calendar year. We have also shown the projected IL lodgements adopted in our June 2023 report and the lodgements adopted after adjustment for the June 2024 financial statements.

Figure 5.11: MRCA Actual and Projected Lodged IL Claims by Lodgement Year



- 5.6.11 An average injury year was imputed for claims with missing dates based on the prior year experience. The resulting figures show a significantly higher number of lodgements with average accident years of 2023 and 2024. The ultimate projected claim frequencies are also higher for these years to reflect the heightened experience seen to date.
- 5.6.12 A completion rate is then selected and used to project the number of completed IL claims in each future period. Historic rates of completion were calculated based on the number of completed IL claims compared to the number of open IL claims in a period. We have used these historic completion rates as the basis of our projection and have then adjusted the expected completion rates so that DVA completes around 30,000 IL claims per annum. This estimate of 30,000 completions per annum is based on the number of completions processed in recent months; we understand that these months are representative of current staffing levels and productivity, and that at the time of writing this report, there are no further recruitment plans in place.
- 5.6.13 Acceptance rates are then applied to the completed claims to arrive at the number of projected accepted IL claims. Acceptance rates have been relatively stable since Veteran Centric Reform, averaging 93 to 96 per cent. We have selected future acceptance rates of 94 to 97 per cent, varying by delay from the time of accident, with an overall rate of 94 per cent adopted.
- 5.6.14 Figure 5.12 shows the projected number of accepted IL claims by calendar year. We have also shown the projected accepted IL claims adopted in our June 2023 report and the accepted claims adopted after adjustment for the June 2024 financial statements. Last year we assumed that processing capacity in 2024 and 2025 was going to be sufficient to clear a substantial number of open IL claims, hence the unusual pattern of expected accepted IL claims.

Figure 5.12: MRCA Actual and Projected Accepted ILs by Calendar Year



5.6.15 In the absence of any changes in recruitment plans, we anticipate that around 28,000 accepted IL claims will be processed each year going forward.

5.7 Projected Future ILs - DRCA

5.7.1 For DRCA, the approach is similar to MRCA, however rather than summarising data by accident year, the lodged IL claims are summarised by year of birth of the claimant. As for MRCA, if a person lodges multiple IL claims in the same lodgement year, only one IL claim is counted. We have modelled the DRCA IL claims based on year of birth rather than accident year as the vast majority of conditions being lodged for DRCA now are late onset conditions where the accident/effective date is recorded as the date the condition first presented or was diagnosed, rather than being linked to a specific time when the member was serving. Around 75 per cent of DRCA IL claim lodgements in each of the last four years have an average accident date that is after the scheme closed in 2004.

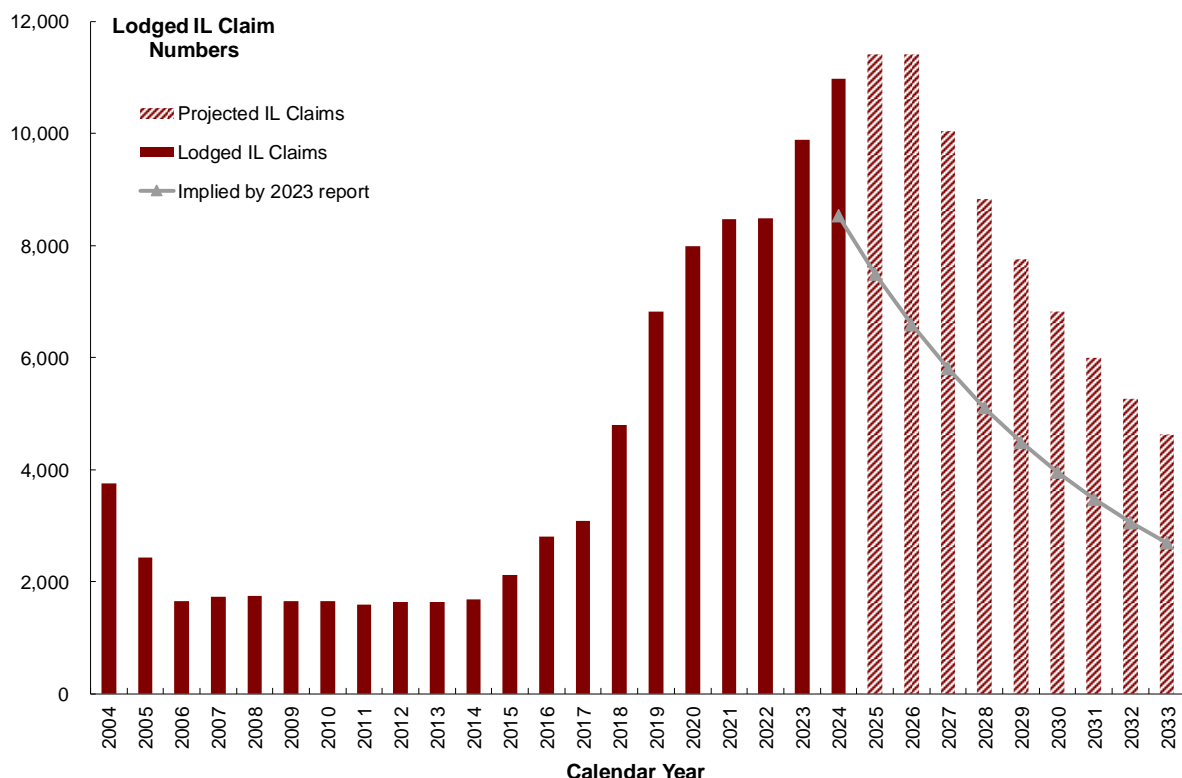
5.7.2 Withdrawal rates for DRCA are significantly higher than for MRCA. We understand that this is due to the overlapping nature of the various Acts (a member may have served over a period that spans both the DRCA and MRCA Acts, and/or the member may have coverage under the VEA) and due to offsetting provisions between the Acts that may come in to play (a veteran may be worse off if their DRCA claim is accepted so they withdraw it). Withdrawal rates are lower for older DRCA members and higher for younger members (who are more likely to have overlapping coverage with MRCA). Withdrawal rates have been relatively stable over the last 4 to 5 years at around 22 to 26 per cent of claims lodged. We have adopted overall withdrawal rates of 23 per cent for 2023 and 2024 lodgements (with rates that vary by year of birth).

5.7.3 Projecting future IL claim lodgements for DRCA is even more difficult than for MRCA. We do not have quality exposure statistics (given the exposure period overlaps with VEA) nor a current estimate of the DRCA population who may still be alive. DVA's Data and Insights team provided us access to DVA's Veteran Population Model (VPM) which attempts to estimate populations by conflict. However, this model does not include an explicit DRCA population estimate and our attempts to estimate this population using the available data within VPM did not produce reasonable results. As such, we have taken a pragmatic approach to the run-off of the DRCA IL claim lodgements and have assumed that:

- lodgements in 2025 will be 4 per cent higher than in 2024. This is based on the same monthly analysis of DVA claims processing statistics used for MRCA as described above;
- lodgements in 2026 will be at the same level as for 2025. This, combined with the adopted higher reports in 2025, implicitly assumes that there is some bringing forward of claim reporting prior to the start of the VETS Act;
- lodgements will then reduce at a rate of 12 per cent per annum. The reduction is assumed to be greater if indicated by mortality decrements of each age cohort modelled. While we did not explicitly model DRCA IL claims in our previous valuation, the 12 per cent reduction was implicit in the assumptions adopted for the PI benefits. We test the sensitivity to this key assumption in section 17.2.

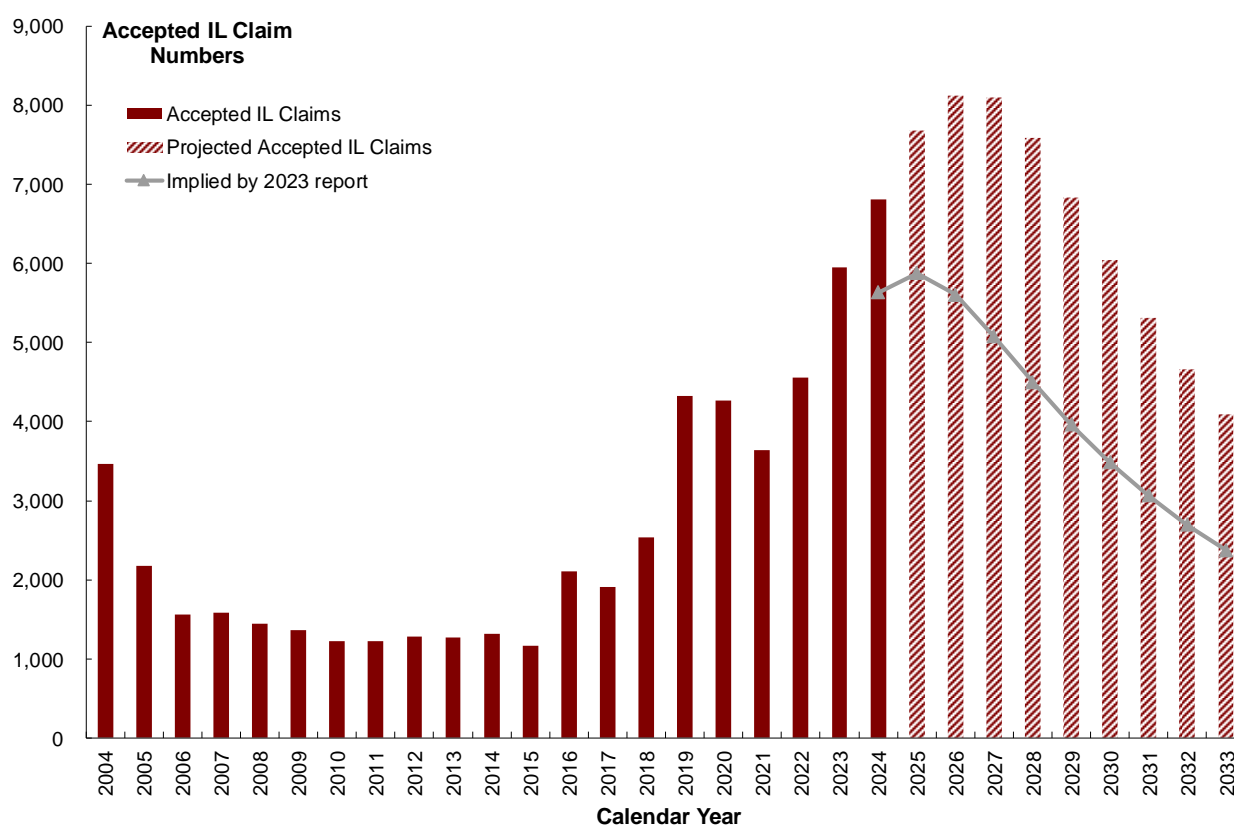
5.7.4 Figure 5.13 shows the actual and projected IL claim lodgements by calendar year. We have also shown the numbers implied by our previous valuation (noting that these numbers have been “backed out” of the valuations of DRCA PI benefit type and were not used directly in the previous valuation). Our previous valuation assumptions implied that IL claims lodged would decrease from 2023 levels. The current valuation assumptions assume substantially higher numbers of future IL claim lodgements.

Figure 5.13: DRCA Actual and Projected Lodged IL Claims by Lodgement Year



- 5.7.5 Completion rates are then selected and used to project the number of completed IL claims in each future period. Historic rates of completion were calculated based on the number of completed IL claims compared to the number of lodged IL claims (after withdrawals) in a period. We have used these historic completion rates as the basis of our projection (without any adjustment for processing constraints).
- 5.7.6 Acceptance rates are then applied to the completed claims to arrive at the number of projected accepted IL claims. Acceptance rates have been relatively stable over the last five years, averaging 73 to 77 per cent. We have selected future acceptance rates that vary by age cohort, with acceptance rates of the youngest cohort close to 50 per cent and the oldest cohorts at almost 80 per cent, with an overall rate of 74 per cent adopted.
- 5.7.7 Figure 5.14 below shows the projected number of accepted IL claims by calendar year and the numbers implied by our previous valuation.

Figure 5.14: DRCA Actual and Projected Accepted ILs by Calendar Year

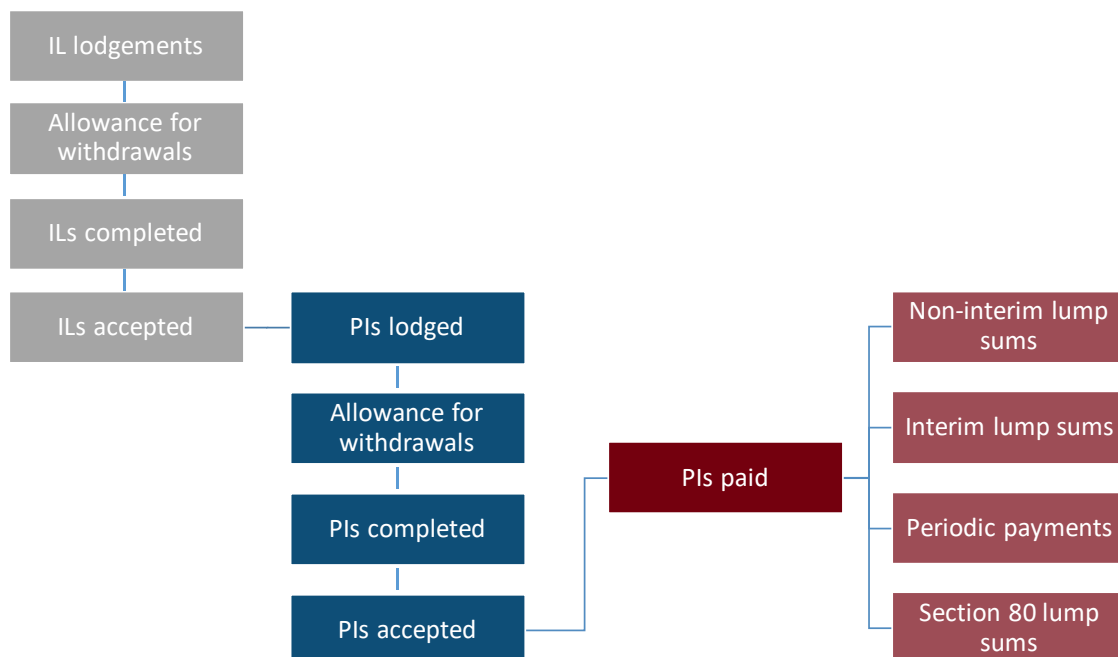


6 MRCA Permanent Impairment

6.1 Modelling Approach

- 6.1.1 For this valuation, we have used the same modelling approach for MRCA permanent impairment (PI) benefits as used at the previous valuation. That is, we use our model that converts accepted IL claims (from Section 5) to expected numbers of PI lodgements. Our model then projects the numbers of PI lodgements that will be completed, accepted and ultimately paid.
- 6.1.2 Under MRCA, the default entitlement to compensation for a permanent impairment is an income stream which can be converted to an age-related lump sum (reflecting the duration for which the income stream would have been expected to be paid). A small number of MRCA PI payments are being taken as an income stream (periodic payment) but the majority of veterans elect to be paid a lump sum. Further, claimants may seek an interim permanent impairment benefit, which is a benefit paid prior to the claimant's injury stabilising. Dependents of claimants who have a whole person impairment score of more than 80 points are also entitled to lump sum compensation under Section 80 of the MRCA (eligible young persons, or EYP payments). We have therefore allowed for a proportion of benefits to be paid as periodic payments, a proportion to be interim lump sum payments, and a proportion being non-interim lump sums. We have then assumed that a proportion of all PI claimants will also have Section 80 payments.
- 6.1.3 Our modelling approach is summarised schematically below.

Figure 6.1: PI Model Approach



- 6.1.4 The amount of benefit payable depends upon a number of factors:

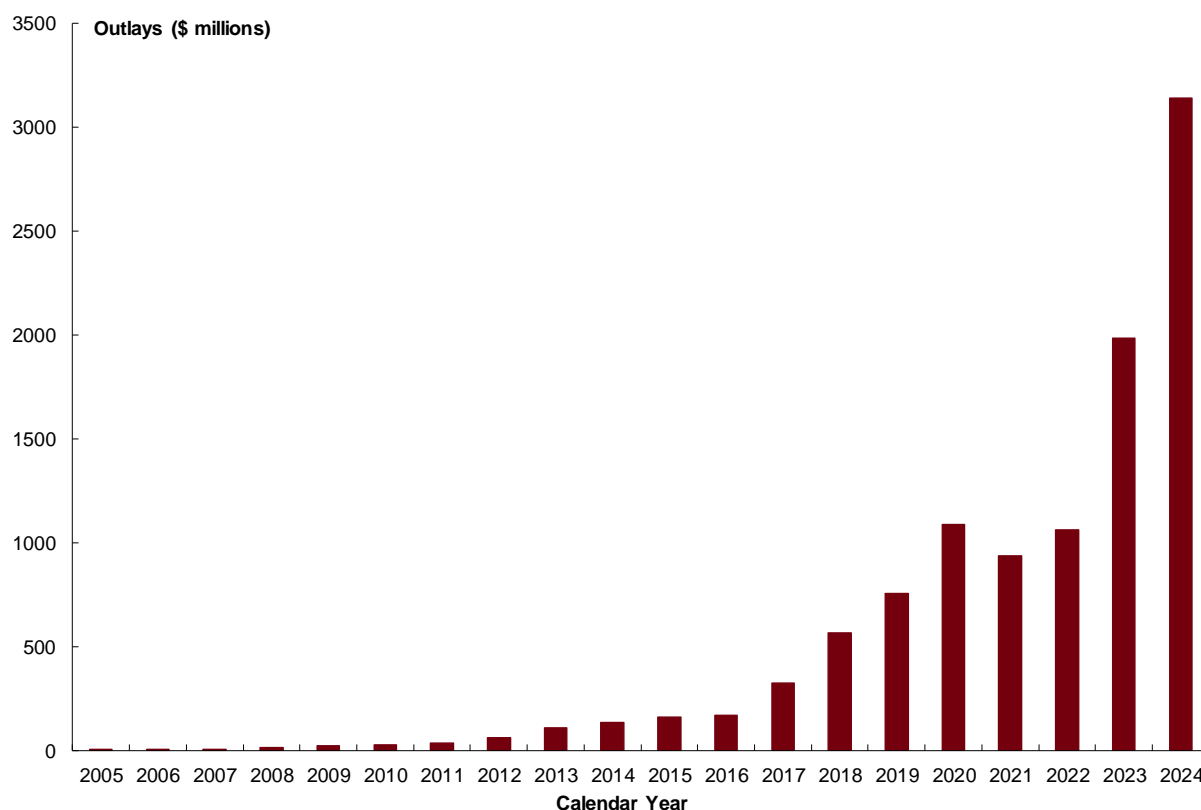
- the age of the claimant;
- the assessed impairment points;
- the lifestyle rating;
- whether the incident giving rise to the impairment was related to warlike service or not; and
- in the case of Section 80 payments, the number of eligible dependants.

We have adopted average claim sizes that vary by duration since accident for each of the interim lump sum, non-interim lump sum and EYP components of the valuation. For periodic payments, we have adopted an annuity method with decrements based on mortality only.

6.2 Recent Experience

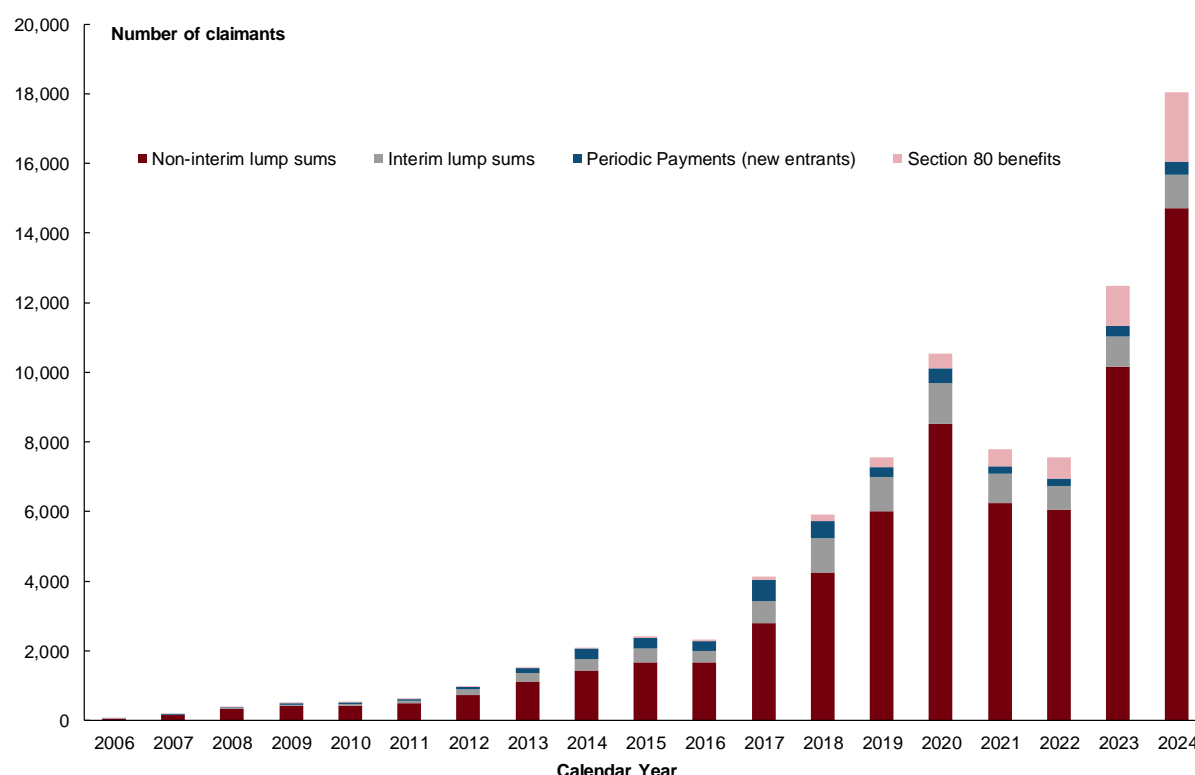
6.2.1 Figure 6.2 shows expenditure on permanent impairment payments since the inception of MRCA (noting these are payments in each calendar year rather than financial year). Outlays have increased year on year, with particularly marked growth occurring since 2017. The growth in experience since 2017 can, in part, be attributed to significant administrative and cultural changes within DVA, which have led to an increase in the number of claimants seeking compensation. Expenditure somewhat stabilised in 2021 and 2022, however this does not fully reflect the underlying claims experience; payments were impacted by limited processing capacity rather than a change in underlying experience. With the expansion of processing capacity in 2023 and again in 2024, payments almost doubled in 2023 and increased by another 60 per cent in 2024 to \$3.1 billion.

Figure 6.2: Expenditure on Permanent Impairment Benefits



6.2.2 The significant increases in PI payments have been driven by both an increase in claimant numbers and an increase in the average payment amount. Figure 6.3 shows the number of claimants by the type of PI payment. Those receiving non-interim lump sums make up the bulk of payments, and we observe the high number of such payments in 2023 and 2024 after the processing-impacted lower years of 2021 and 2022. Claimants electing to receive periodic payments make up only around 3 per cent of lump sum recipients. We can also see that the number of PI claimants in receipt of Section 80 benefits (as a result of having more than 80 WPI) has increased substantially over the last five years, from 4 per cent in 2020 to 12 per cent in 2024 (or just over 2,000 claimants).

Figure 6.3: Number of MRCA PI Claimants by Type of Payment

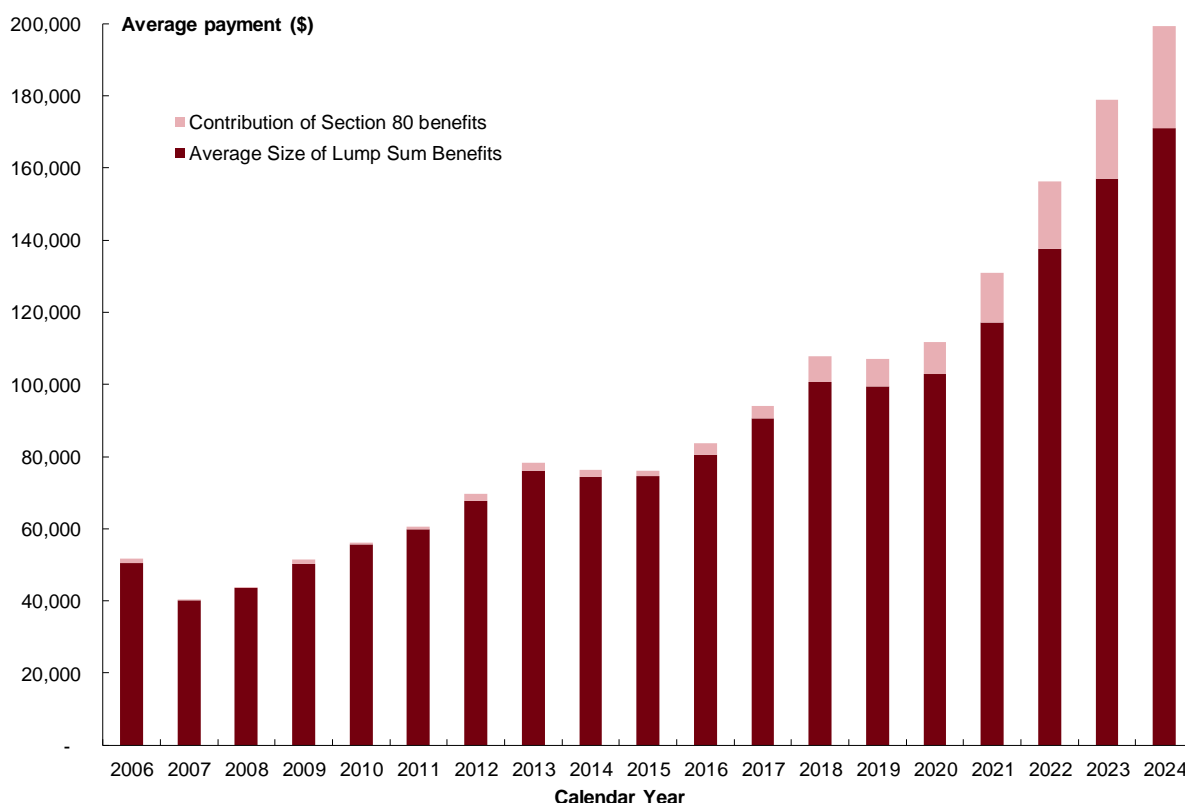


6.2.3 Figure 6.4 shows the average lump sum payment (in original dollars) for those electing to receive either an interim or non-interim lump sum. The contribution to the average claim size of Section 80 benefits is shown separately (claimants receiving periodic payments and the amounts associated with those payments are not included).

6.2.4 Indexation applied to MRCA lump sum benefits from 1 July 2024 was 4.1 per cent (compared with our previous valuation assumption for CPI of 2.5 per cent per annum). Nevertheless, the average claim size for 2024 (excluding Section 80 benefits) has increased by significantly more than inflation (by 9 per cent, including the indexation change). This followed substantial increases in 2021 (14 per cent), 2022 (17 per cent) and 2023 (14 per cent).

6.2.5 Including Section 80 benefits in the average claim size added 17 per cent to the size in 2024. This percentage addition is higher than for 2021 (12 per cent), 2022 (13 per cent) and 2023 (14 per cent), and clearly substantially higher than for earlier years.

Figure 6.4: Average Lump Sum Payment (Actual Values)



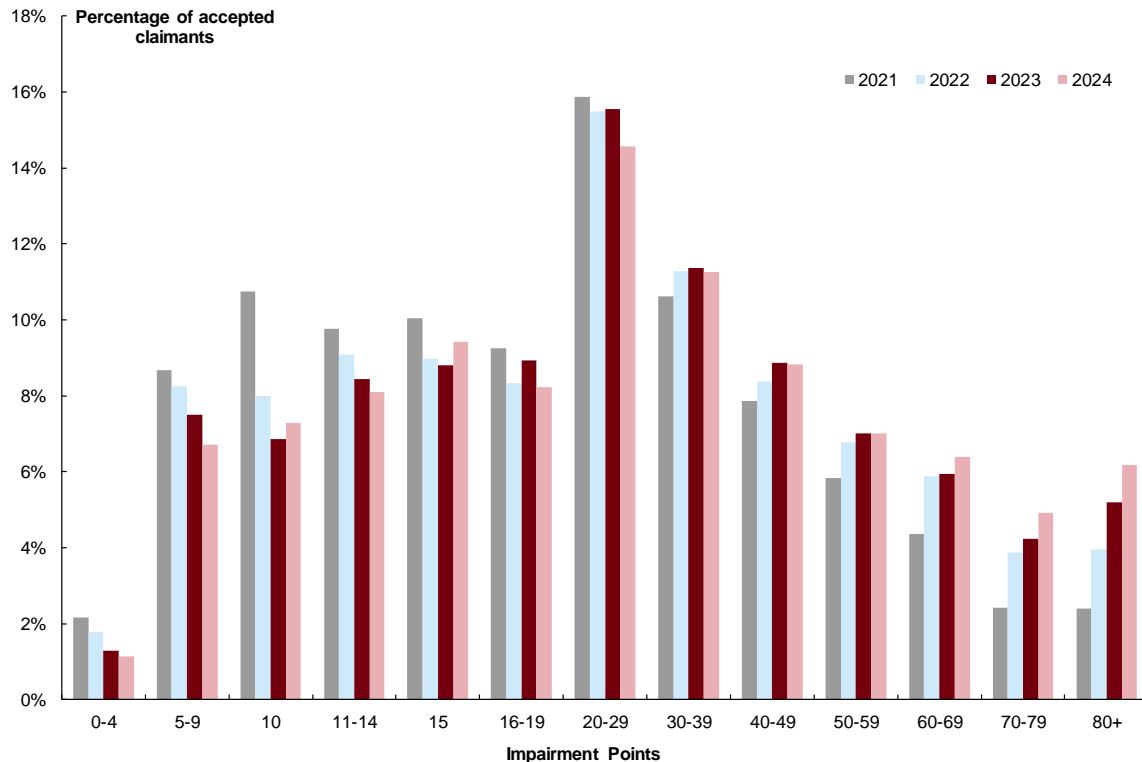
6.2.6 There are several factors which may have driven this increase in average claim size over the last several years, including policy and cultural changes within the organisation, or an increase in the level of injuries sustained by claimants while at Defence:

- analysis previously conducted by DVA showed the number of medically separated veterans had increased. This group is more likely to be severely impaired and to have higher payment amounts. This group was also more likely to be prioritised for claims processing in 2021 to 2023, which may be distorting the observed experience over those years where processing delays were significant. However, it does not explain the further increase in 2024 when processing volumes have been large.
- delays in processing in recent years may be having an impact on average claim size; if a veteran has lodged multiple conditions for initial liability assessment over a period, the conditions may be bundled and processed at the same time. That is, any additional claims accrued over a period are now being processed at the same time as the first lodged claim and may be contributing to the higher average size observed in recent experience. This suggests that the average size may reduce once processing capacity is commensurate with lodgements.
- Counter to the point above, as we saw in section 5.2, the number of conditions lodged per initial liability claim has increased over time and this will flow through to PI claims. With more conditions per claim, it is likely that the whole person impairment assessments will result in higher numbers of points being awarded. Further, much of the growth in conditions lodged has been in mental health and their associated conditions, where the number of impairment points awarded can be very high. We understand that claimants can received up to 72 impairment points for a mental health condition, with more than 50 points being common.

Further, we understand that it is common to receive 25 points for erectile dysfunction, a condition often claimed as a result of medications associated with mental health conditions.

- 6.2.7 We have looked at the distributions of individual impairment points awarded to those in receipt of permanent impairment benefits. Figure 6.5 below shows, for the last four calendar years, the distribution of impairment points for PI claims accepted. The impairments points shown are incremental impairment points awarded in the year, so while not representative of overall impairment, they are direct drivers of payments made in each year.

Figure 6.5: Distribution of Claim Severity over the Last Four Years

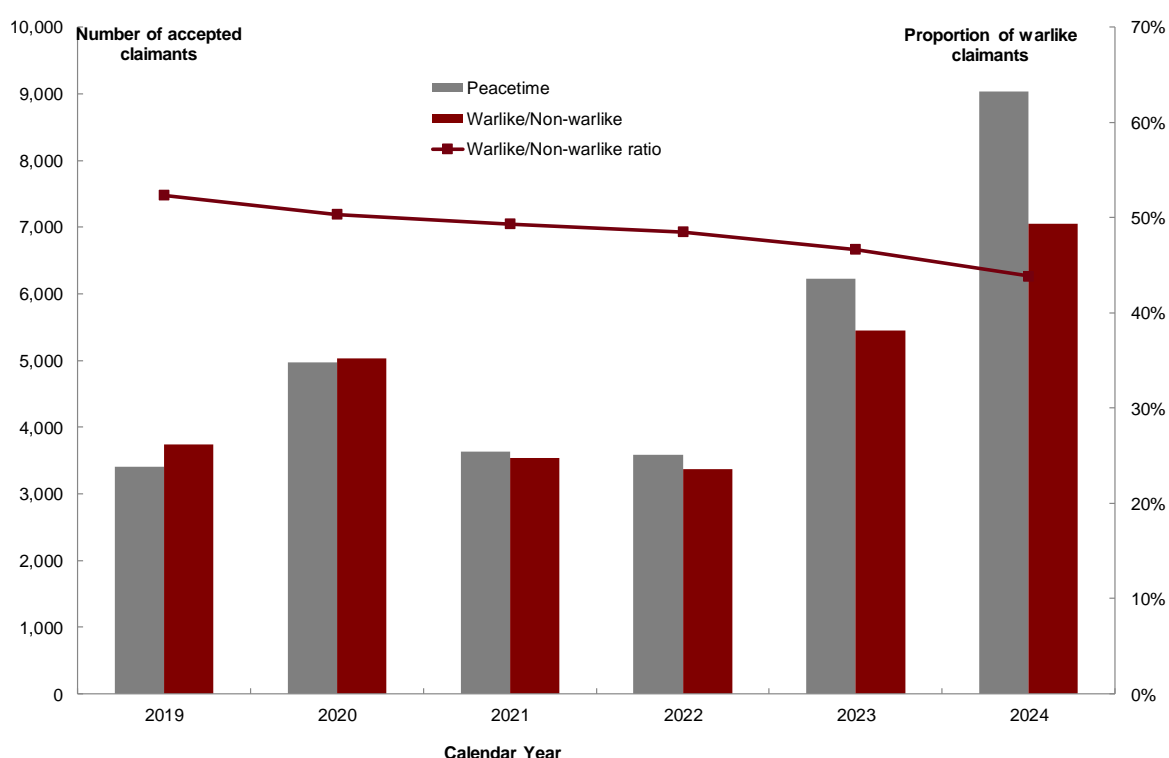


- 6.2.8 Over the past four years, there has been a shift in the distribution of impairment points towards higher levels of impairment, consistent with the increase in the observed average size. Substantially fewer claimants have been awarded 10 points or less, and substantially more claimants have been awarded more than 70 points with a large increase in the proportion awarded more than 80 points.
- 6.2.9 In 2020, 15 per cent of claimants had 50 or more (incremental) impairment points awarded compared to 24 per cent in 2024. Achieving an assessment of at least 50 impairment points brings with it a number of benefits; notably potential access to the Gold Card (which covers all health care costs, not just those related to the compensable injury), potential entitlement to the Special Rate Disability Pension and reimbursement of expenses for financial and legal advice to assist in making a choice between receiving PI compensation in the form of a lump sum or continuing periodic payments.
- 6.2.10 As mentioned in Section 7.1, veterans can receive an additional lump sum payment under MRCA if they are severely impaired and have dependents. This additional Section 80 payment is available to veterans who have been assessed at 80 or more impairment points and are entitled to compensation for a permanent impairment. The additional payment is payable for each eligible young person that depends on the veteran for economic support at the

assessment date. The increase in the number of veterans assessed at 80 or more impairment points has increased the number of Section 80 payments.

6.2.11 Claims arising from warlike service typically involve higher payments as the legislated compensation factors applying to warlike service are higher than for peacetime service. Figure 6.6 shows the number of recipients by nature of service over the last six years⁵. Note that in most cases it is not possible to unambiguously identify whether a claim is related to warlike or peacetime service. We have assumed warlike service if a claimant sustains injuries during both wartime and peacetime service. The number of warlike and peacetime claims was quite similar in the first four years shown, but in 2023 and in 2024 the number of peacetime claims exceeded warlike, and by a substantial margin in 2024. This will act to put downward pressure on the average claim size.

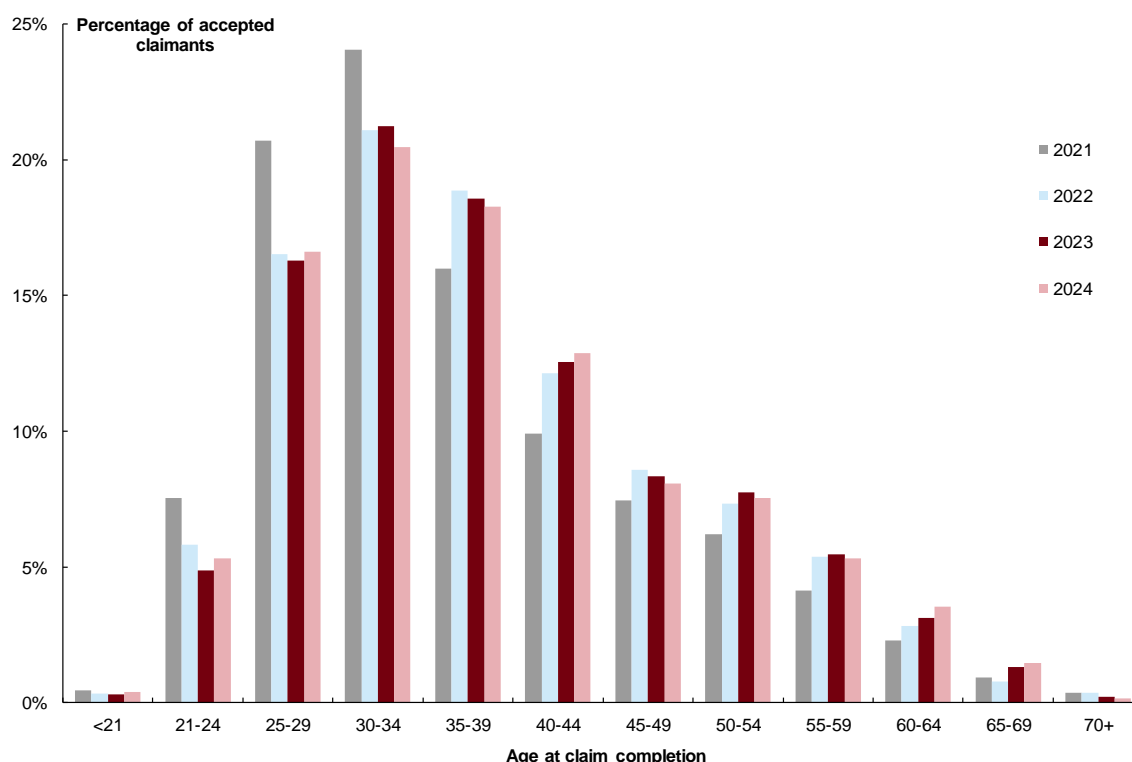
Figure 6.6: Number of Recipients by Nature of Service



6.2.12 We have also looked at the age distribution of claimants who have an accepted PI claim in the last four years. Figure 6.7 shows the number of claimants in each age band (being their age at time of PI acceptance). The age of claimants at the time of PI acceptance increased substantially between 2021 and 2022 (by around 1.5 years) but has been fairly stable since then.

⁵ Note we have used a different data source to construct the chart this year so the figure differ. Previously we only had conditions listed on initial liability claims. This year, we received information on the conditions directly contributing to the PI claim.

Figure 6.7: Age Distribution Chart



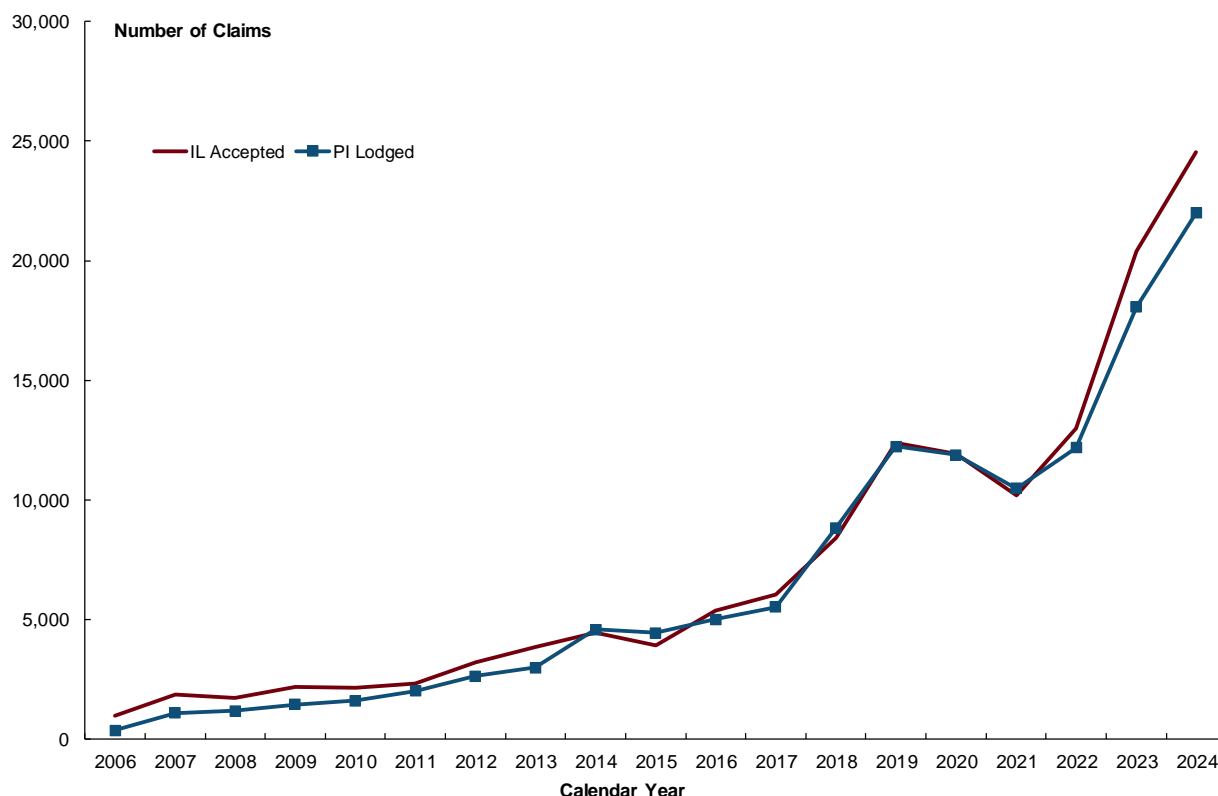
6.2.13 For this valuation, we have set assumptions based on the most recent experience separately for non-interim lump sums, interim lump sums and Section 80 benefits. This implicitly assumes that the mix of warlike and peacetime claims, the severity distributions, and the age distributions will remain at current levels into the future.

6.3 Valuation Assumptions – Numbers of PI Claims

6.3.1 The high numbers of open claims in both IL and PI persist. While there have been inroads made into processing, the increase in the number of IL claims lodged has meant a large number of unprocessed MRCA IL claims remain. This has flow on effects to the numbers of PI claims lodged, and the limitations on processing capacity also impacts the numbers of PI claims completed once they have been lodged, and therefore paid.

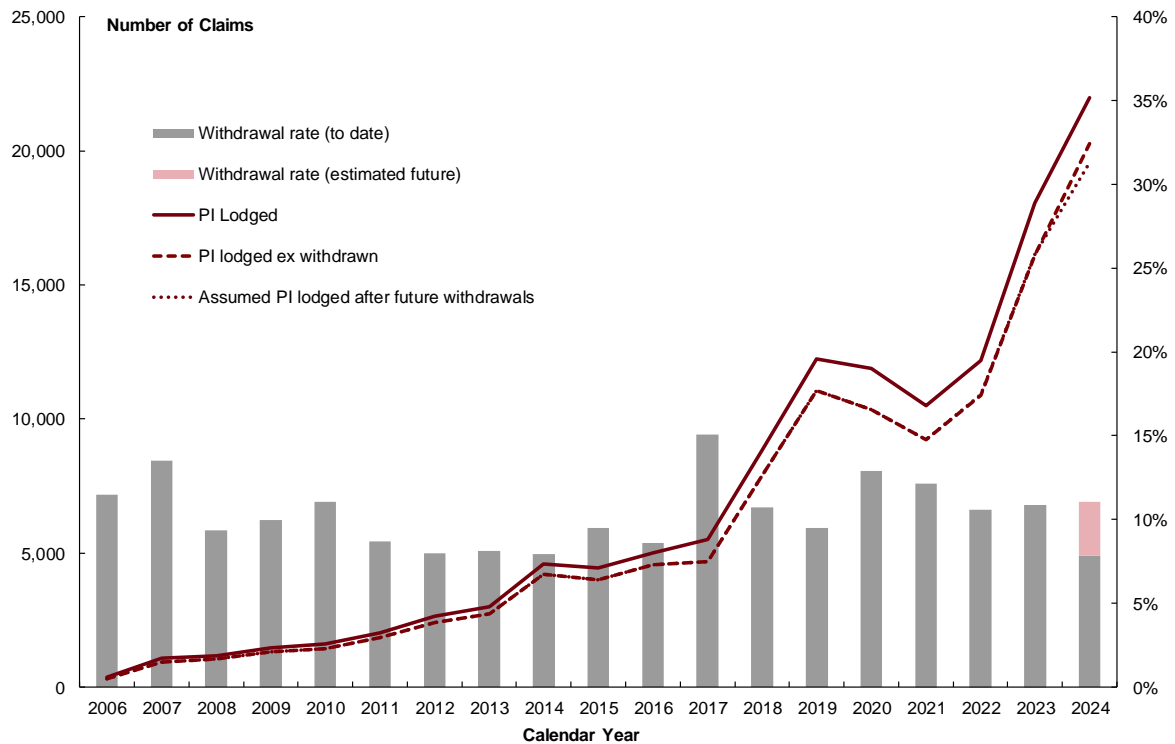
6.3.2 Figure 6.8 shows the number of initial liability claims accepted and the number of permanent impairment claims lodged (before withdrawals) by calendar year. Note that it is possible for the number of PI claims to exceed the number of IL claims in a given year, due to potential timing lags and the ability to submit a PI reassessment without an additional IL claim. Nonetheless, IL claims accepted and PI claims lodged have tracked closely. PI claims lodged have increased dramatically in the past two years, a direct result of the increase in IL claims accepted during this time.

Figure 6.8: IL Claims Accepted and PI Claims Lodged, by Calendar Year



- 6.3.3 We note that due to the way MRCA claims are assessed, we cannot readily link the transition of IL claims into PI claims. Under the MRCA scheme, claims are assessed on a whole person basis, rather than individual injury assessments as for DRCA. As such, where a veteran has multiple injuries and multiple claims, it is not possible to determine which of the injuries led to a specific PI claim.
- 6.3.4 Figure 6.9 shows the number of permanent impairment claims lodged by calendar year; we have shown the number before withdrawals, the number after withdrawals that have been made so far, and the number after we have incorporated assumed future withdrawals. We have also shown the withdrawn rate to date and our assumed future withdrawal rate. We have assumed that around 11 per cent of PI claims lodged in 2024 will ultimately be withdrawn, similar to levels for 2022 and 2023.

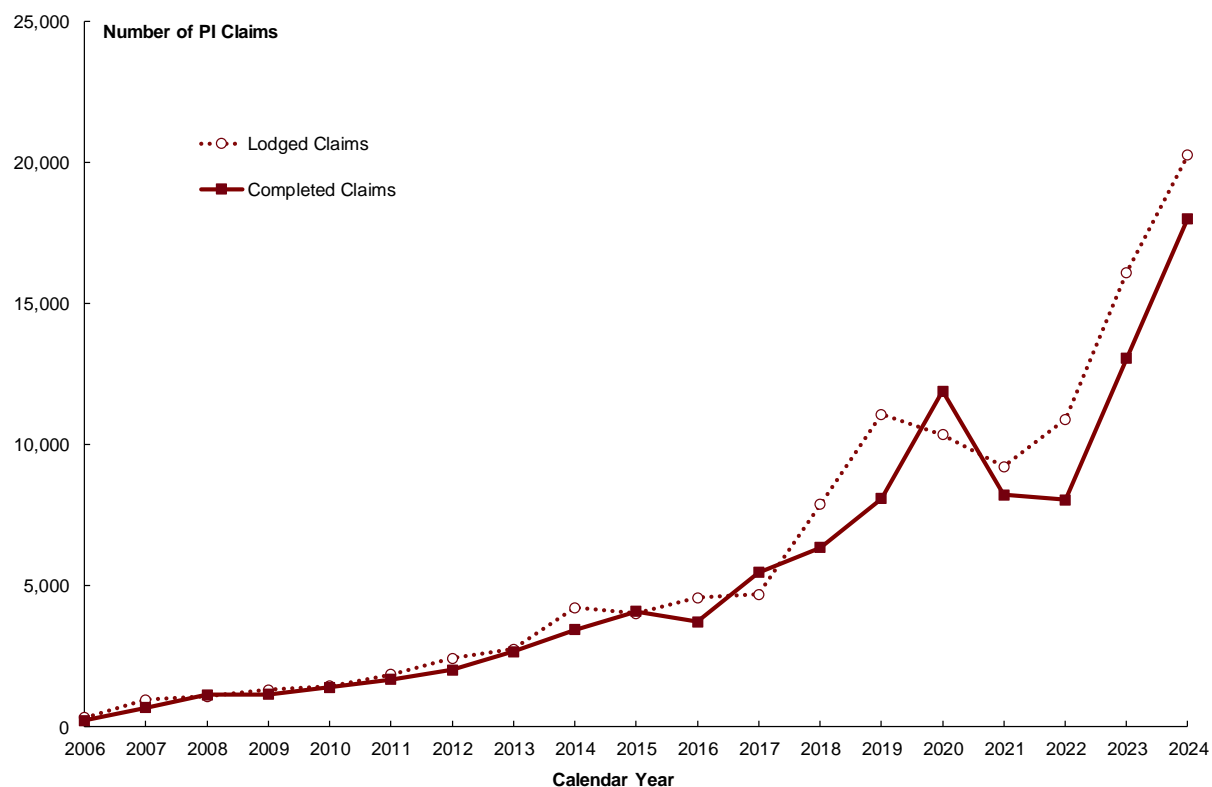
Figure 6.9: PI Claims Lodged Including and Excluding Withdrawn Claims, by Calendar Year



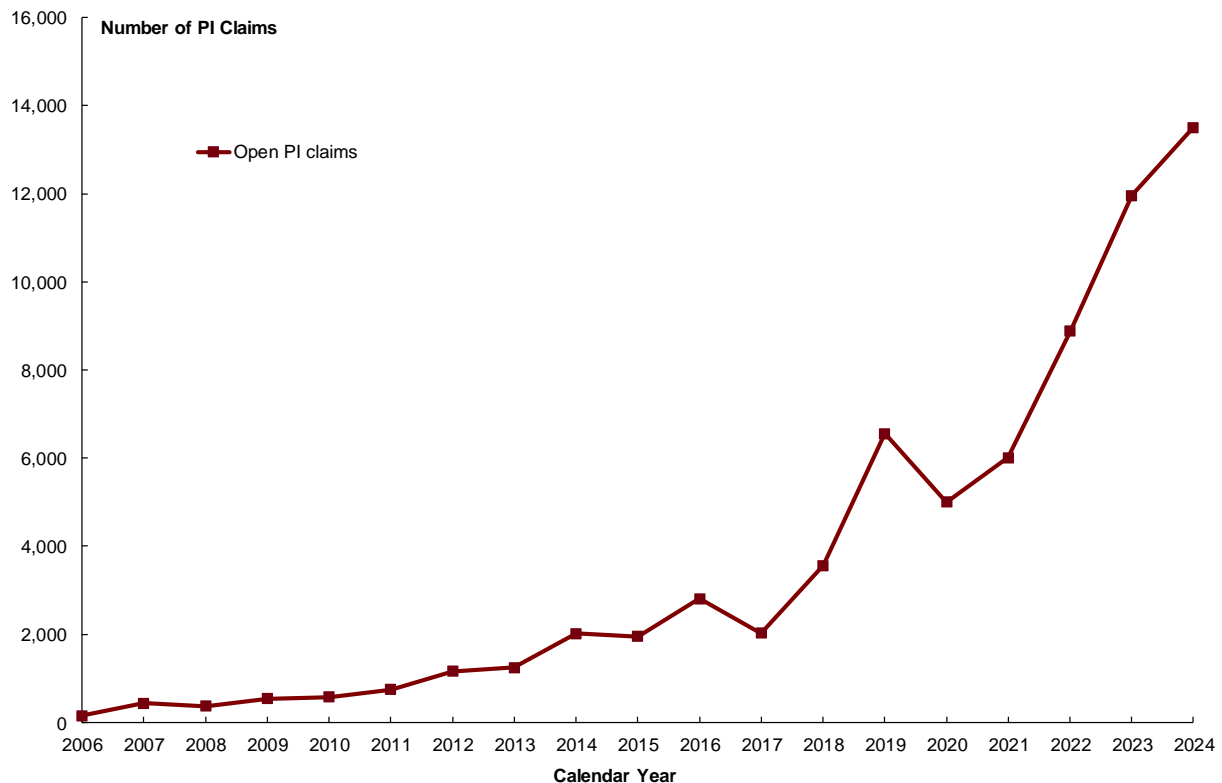
6.3.5 The combination of our assumptions around the conversion rate from IL claim accepted to PI claim lodged and our assumed ultimate PI claim withdrawal rate, results in around 80 per cent of IL claims accepted resulting in a non-withdrawn PI claim lodgement.

6.3.6 Figure 6.10 below shows the number of PI claims lodged (after withdrawals) and completed by calendar year. PI claims lodged in the last 2 years have increased dramatically, but the number of PI claims completed has not kept pace with lodgements. Completions have been below lodgements for the last four years.

Figure 6.10: Lodged (After Withdrawals) and Completed PI Claims

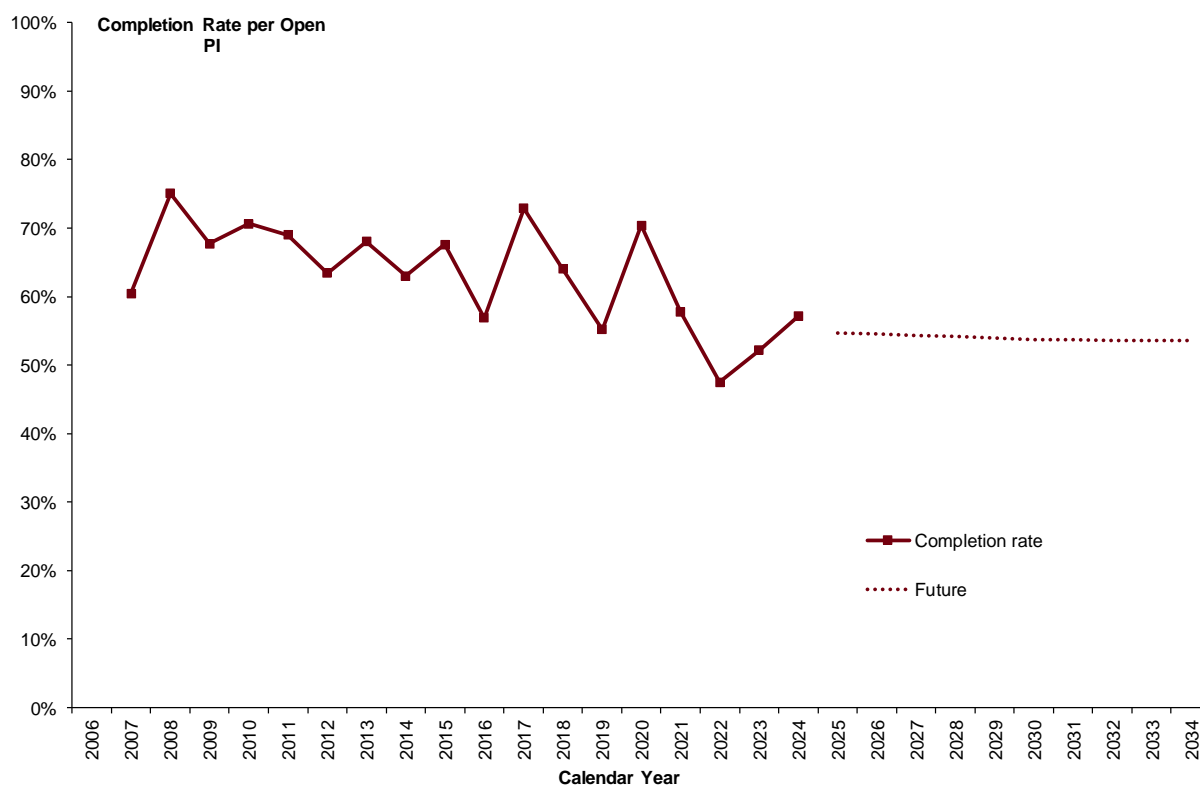


6.3.7 As a result of the significant gap between PI claim lodgements and PI claim completions in the last four years, the number of open PI claims has grown dramatically as shown in Figure 6.11. The number of open PI claims has continued to grow since the previous valuation; last year there were around 12,000 open PI claims as at 31 December 2023 and there are now around 13,500 as at 31 December 2024 despite increases in processing capacity.

Figure 6.11: Open PI Claims

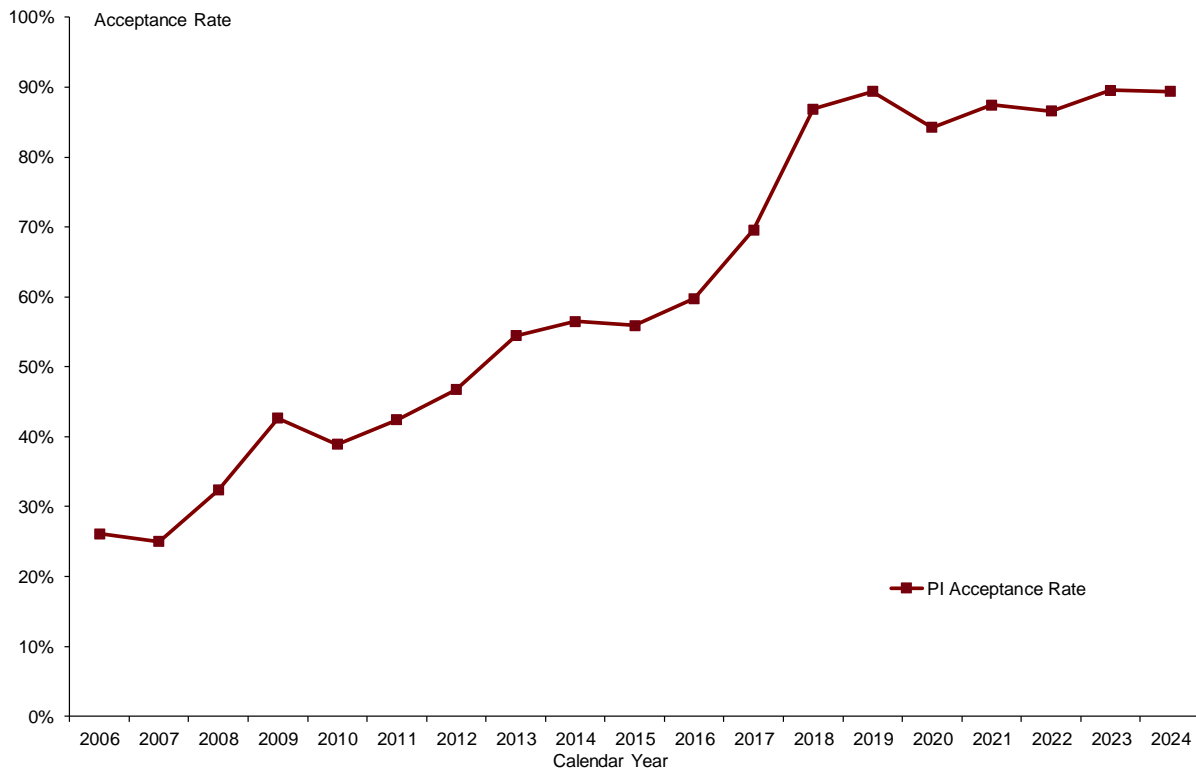
- 6.3.8 In our valuation model, the number of future PI lodgements are directly linked to the number of IL claims accepted, which are in turn directly linked to IL claims completed. As discussed in Section 5, our model projects IL claim completions per open IL claim, therefore directly incorporating an allowance for the current open IL claims and the anticipated completion of these claims over the coming years.
- 6.3.9 PI claim completions are then projected per open PI claim. This approach directly incorporates allowance for the current open PI claims, expected new PI claim lodgements, and the completion of current open claims.
- 6.3.10 Figure 6.12 shows the completion rates per open claim. While the completion rates have varied a little over time, the completion rate was particularly low in 2022 (due to processing constraints). The completion rate was higher in 2023 and again in 2024 but low relative to historical levels. We have projected completion rates for 2025 and later years that are similar to 2023 and 2024 levels. This is quite a different shape to the completion rates we adopted last year, where we assumed that processing capacity would increase and be directed to processing permanent impairment claims in 2025 and 2026, and then a higher long term completion rate was adopted assuming that the higher level of resourcing would be maintained in the future. With no immediate plans for further staffing increases at the time of writing this report, we have reduced our assumed completion rates at this valuation.
- 6.3.11 This change in adopted completion rates has only a small impact on our estimated liability at 30 June 2024, but does impact the timing of expected cashflows (with outlays expected to be further in the future now compared with our previous valuation).

Figure 6.12: PI Completion Rates



6.3.12 Figure 6.13 below shows the acceptance rates for PI claims since 2006. Acceptance rates have been stable (and high) at an average of 88 per cent since 2018, coinciding with Veteran Centric Reform. We have assumed a permanent impairment acceptance rate consistent with this experience.

Figure 6.13: PI Acceptance Rates



6.3.13 Figure 6.14 shows, by accident year, the number of accepted PIs as at 31 December 2024 and our projected future accepted PIs. Figure 6.15 shows the same information summarised by acceptance year (including allowance for new accidents). We have also shown our adopted ultimate numbers from our previous valuation (both before and after incorporation of an adjustment to the figures for financial statement purposes). The adjustment for financial statement purposes increased our projected number of accepted PI claims by between 3 per cent and 8 per cent for all accident years. The main difference between our adopted ultimate assumptions for this valuation compared with the post-financial statements adjustment assumptions is for the 2024 year, where we have increased our assumptions. This is primarily due to the increase in new IL claims lodged in the last year that are expected to flow through to more PI claims.

Figure 6.14: MRCA Actual and Projected Accepted PIs by Accident Year

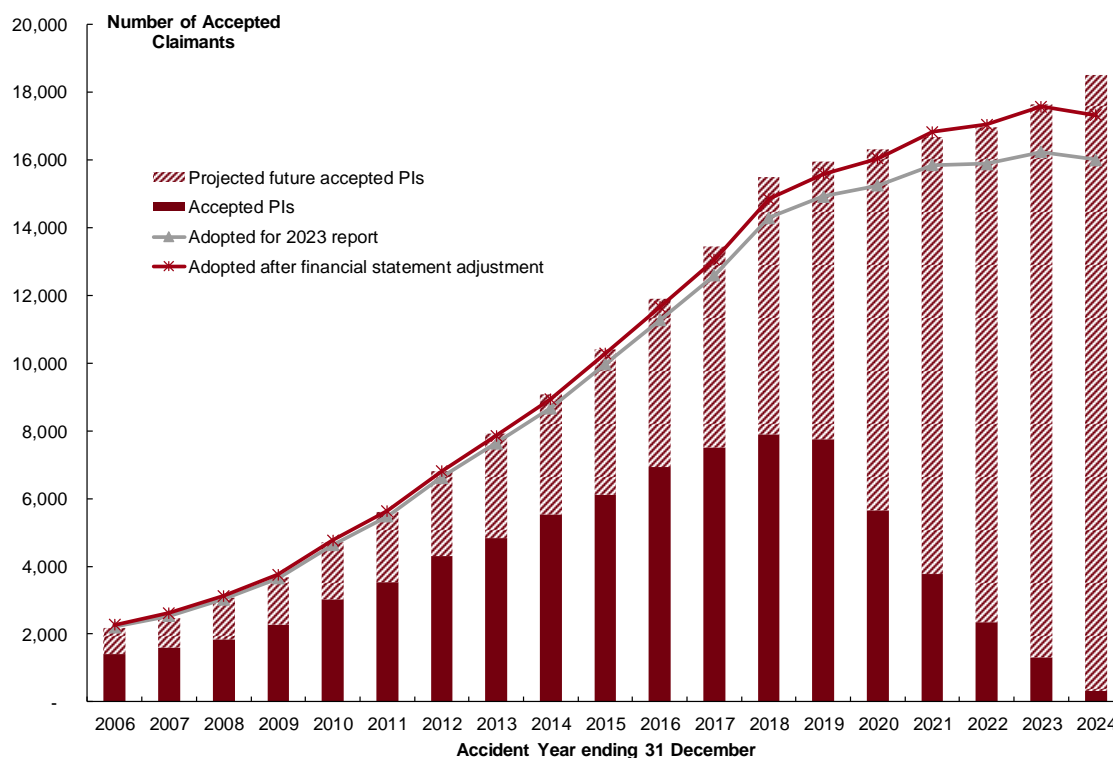
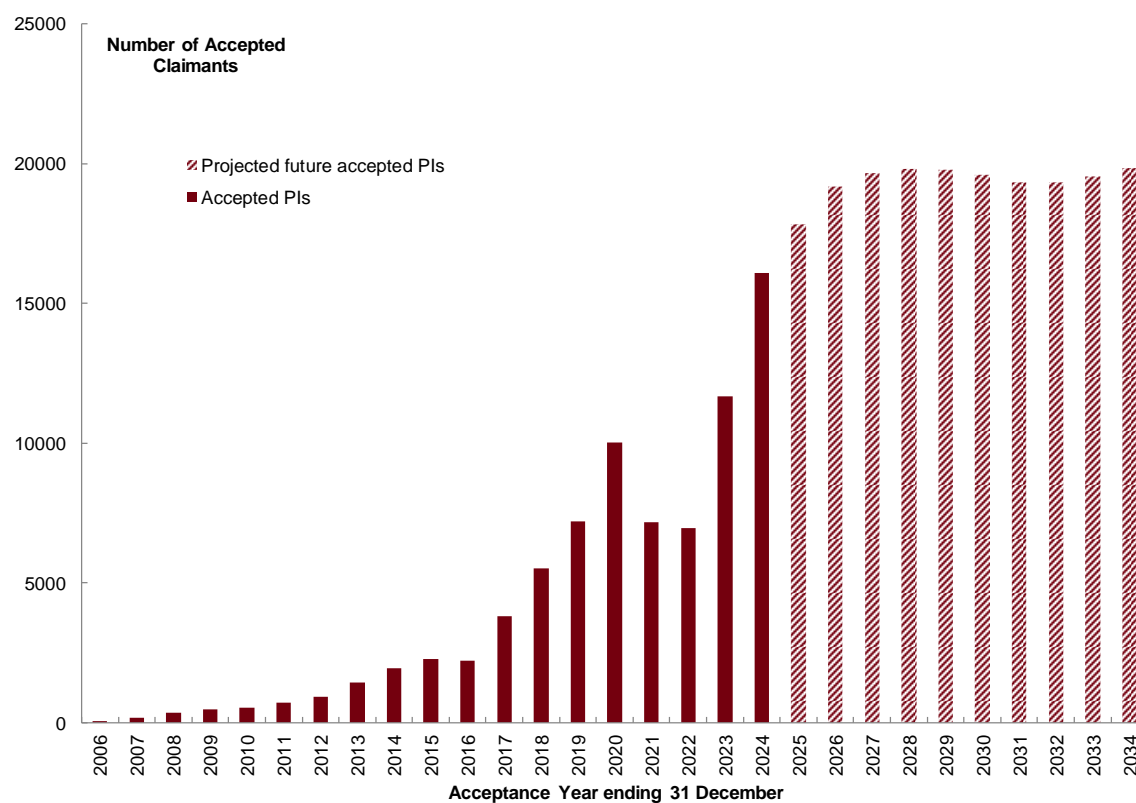


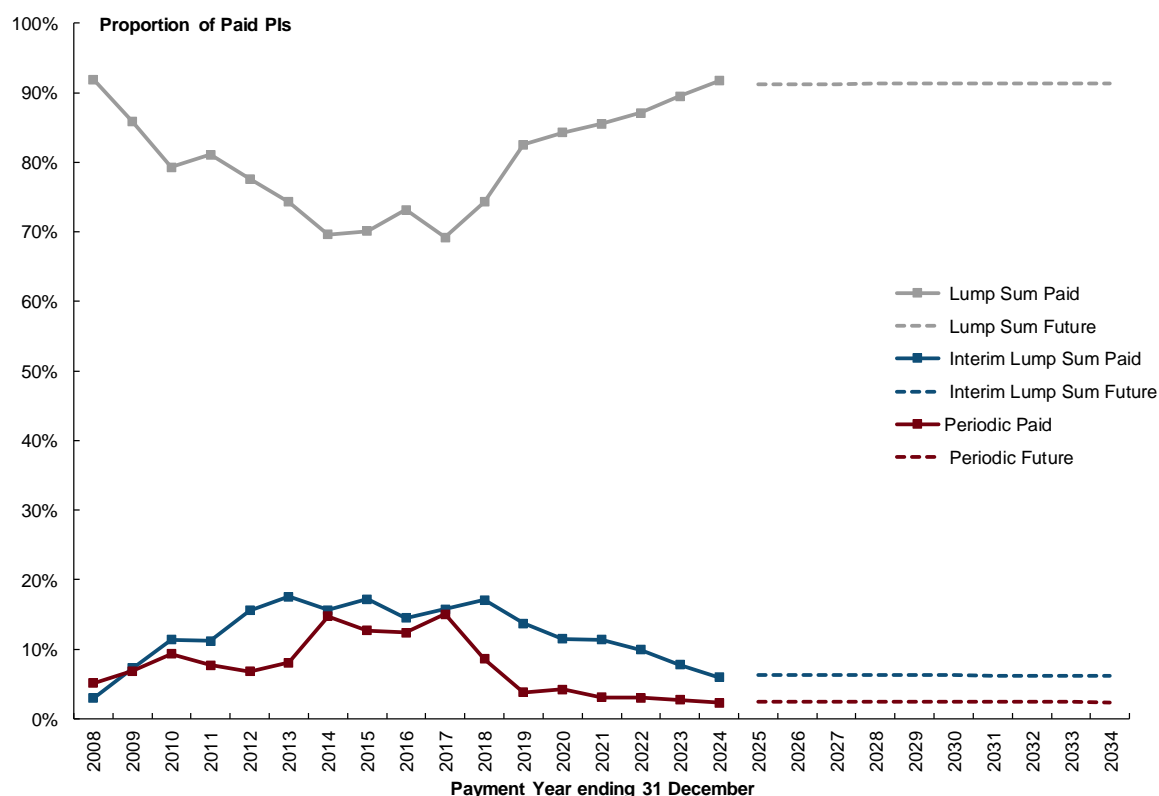
Figure 6.15: MRCA Actual and Projected Accepted PIs by Acceptance Year



6.4 Valuation Assumptions – Average Claim Size

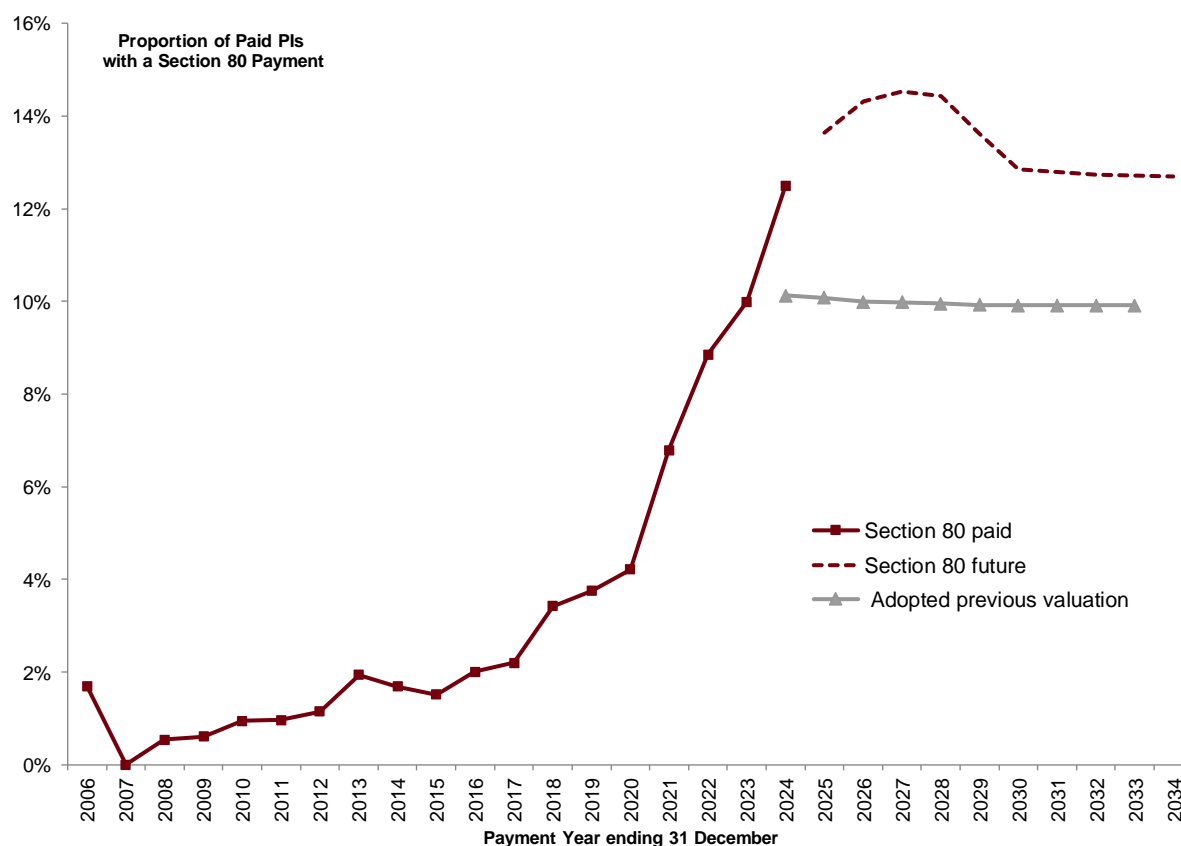
- 6.4.1 Our overall adopted average claims size is comprised of the following assumptions:
- the mix of payments by type i.e. non-interim lump sum, interim lump sum and periodic payments;
 - allowance for a proportion of claimants to receive Section 80 benefits;
 - an average claim size for each payment type, including an average size for Section 80 benefits.
- 6.4.2 For each of the assumptions, we have adopted assumptions that vary by delay since accident. The average claim size tends to be lower at early delays (as those with less complex injuries are able to be finalised more quickly), increasing with delay since accident, before reducing again at later delays (as claimants at these later delays will include those receiving a “top up” or additional lump sum if their condition has deteriorated i.e. some lump sum payments at later durations are only partial lump sums).
- 6.4.3 Figure 6.16 shows the historical and projected mix of payments by type of PI. The proportion of PI claims paid as non-interim lump sums has increased over the last six years while the numbers electing to choose a periodic payment has reduced with only 2 per cent of claimant electing this payment type. The number of interim lump sums has also reduced which may be impacted by processing delays; if claimants have to wait longer for their PI claim to be assessed, then there is a higher likelihood that the injury would have stabilised before assessment. We have assumed the mix of PI payments by payment type will be similar to the most recent experience.

Figure 6.16: Mix of PIs by Type of Payment



6.4.4 Figure 6.17 shows the historical and projected loadings assumed for the number of claimants in receipt of a Section 80 benefit, including the assumptions adopted in the previous valuation. At our previous valuation, we assumed that the proportion receiving Section 80 benefits would remain at the same level as the 2023 experience. However, we have continued to observe increasing proportions of claimants receiving Section 80 benefits, with the level at 12 per cent for 2024. For this valuation, we have allowed for further growth in the proportion receiving Section 80 benefits over the next three years before reducing again to around 13 per cent of claimants.

Figure 6.17: Proportion of PI Claimants in Receipt of a Section 80 Benefit

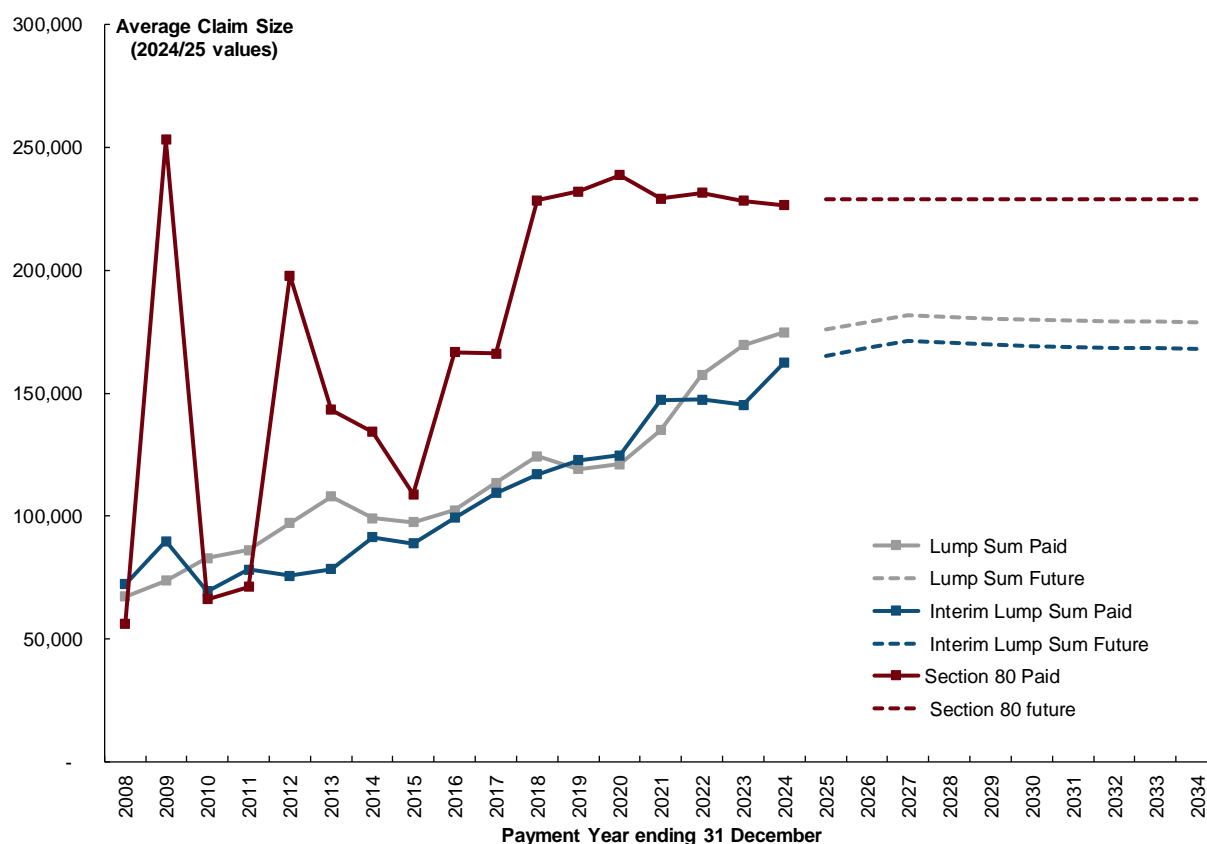


6.4.5 Figure 6.18 shows the historical and projected average claim sizes for each of the PI payment types. The average size for periodic benefits is not shown as we use an annuity method to value these payments as discussed below. All amounts shown include any arrears payments and in 2024/25 values i.e. past payments have been inflated to current values, and future amounts do not yet have indexation added. We have however included superimposed inflation in the adopted average claim sizes of 2 per cent per annum over the next three years. This superimposed inflation allowance is included in the projected average claim sizes for non-interim and interim lump sums (but not for Section 80 benefits) and is discussed further in section 7.5 below.

6.4.6 We have adopted average claim sizes for each PI payment type for 2025 based on the experience in the most recent 1 to 2 years.

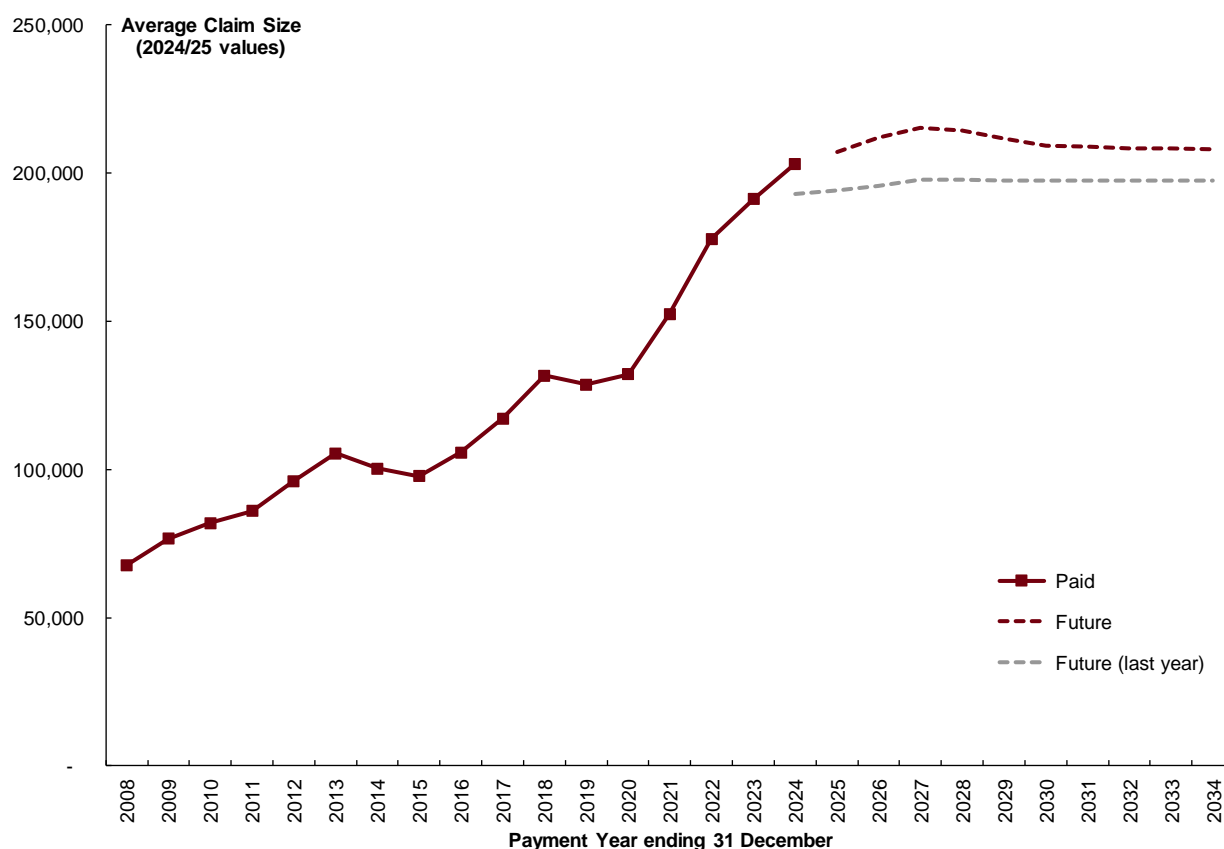
6.4.7 The selected average claim size for Section 80 payments represents an average of two dependants per claimant.

Figure 6.18: Average Size of PIs by Payment Type



6.4.8 Combining the above assumptions on the mix of claims by type and the selected average claim sizes results in an overall average claim size as shown in Figure 6.19. The average claim size shown includes all payments in respect of non-interim lump sums, interim lump sums and Section 80 benefits, divided by the number of non-interim and interim lump sums only. We have also shown our adopted overall average claim size from our previous valuation (inflated to 2024/25 values). Our adopted average claim sizes at this valuation are around 7 per cent higher than at the previous valuation. This reflects the experience that has emerged in the last year and our expectation that the proportion of claimants receiving Section 80 benefits will continue to increase.

Figure 6.19: Overall Average PI Claim Size



6.5 Valuation Assumptions – Periodic Benefits

6.5.1 For periodic payments, the valuation uses an annual annuity method, and values separately those currently in receipt of periodic benefits (“known claimants”) and anticipated new entrants.

6.5.2 For known claimants:

- the number of known claimants included in the 30 June 2024 valuation are defined as those who started receiving periodic benefits prior to 30 June 2024 and have been in receipt of payments for more than 180 days (as claimants have 180 days to elect to take a lump sum instead of a periodic benefit), excluding any claimant who did not receive a payment in the latest fortnightly payment run. We have allowed for 2,996 known claimants as at 30 June 2024, compared with 2,764 at 30 June 2023.
- The amount of benefit valued is the person’s most recent periodic payment i.e. the latest fortnightly amount is annualised (multiplied by 365/14).
- The claimant’s year of birth is supplied and the approximate age as at 30 June 2024 is calculated as 2024 less year of birth. This is used as the input to the mortality decrements.

6.5.3 For new entrants:

- The future number of new entrants are derived by combining the projected number of accepted PI claims (from Figure 6.15) by the assumed proportion electing to receive a periodic payment (from Figure 6.16). We have allowed for 3,633 future new entrants claims at 30 June 2024, compared with 3,303 at 30 June 2023. We note that the timing of when

new entrants will commence period payments is later on average than assumed in our previous valuation.

- The average benefit amount assumed is \$187 per fortnight, the same as for new entrants in 2024. This is a small increase of \$2 per fortnight compared with our 2023 valuation assumption.
- the average age of new entrants is assumed to be the same as the age of new entrants in 2024 i.e. that they are all aged 51 in the 2024 year. As such, the age of new entrants increases by one year with each new year of entry (so new entrants in 2025 are assumed to be 52, new entrants in 2025 are assumed to be 53, etc.). At our previous valuation we assumed new entrants were aged 47 in the 2023 year, therefore this represents a three year increase in the assumed average age of new entrants.

6.5.4 For both known claims and new entrants

- Benefits are assumed to increase with inflation of 2.5 per cent per annum (applied on 1 July of each year). No allowance is made for deterioration of injuries or additional injuries (i.e. the amount is assumed to increase with inflation only).
- Mortality is the only assumed decrement. Mortality rates used are the same as those used for invalidity pensioners in the AGA's report "Military Superannuation Schemes Review of Long Term Costs as at 30 June 2023". Our previous valuation used the mortality assumptions from the June 2020 Long Term Costs report; the current assumptions have higher assumed mortality than the previous assumptions, acting to reduce the liability a little. No allowance is made for future mortality improvement.

6.6 Valuation Assumptions – Inflation Assumptions

6.6.1 Under MRCA, rates of payment for permanent impairment at a given level of impairment are indexed in line with price inflation. We have assumed that the underlying payment rates to which the severity distributions will apply will increase by 2.5 per cent per annum, that is, the midpoint of the Reserve Bank of Australia target range for inflation. This is the same as the rate assumed in the 2023 valuation.

6.6.2 We have included an allowance for superimposed inflation at this valuation of 2 per cent per annum over the next three years. Allowance for superimposed inflation involves significant judgment and we have assumed this allowance based on:

- the very high levels of superimposed inflation observed over the history of the scheme, which warrants inclusion of some superimposed inflation.
- the historical drivers of superimposed inflation may not continue into the future. DVA postulates that recent superimposed inflation may be driven by increasing numbers of medically discharged veterans who are presenting with higher injury severity. There is also the possibility that processing constraints have resulted in higher numbers of conditions being considered in a PI claim, which is highly correlated with the resulting benefit payment. Further, the proportion of PI claims with warlike service is expected to further reduce in the future which may act to reduce future average claim size. Average whole person impairment scores have also increased over time, however there is a natural upper limit on impairment levels.

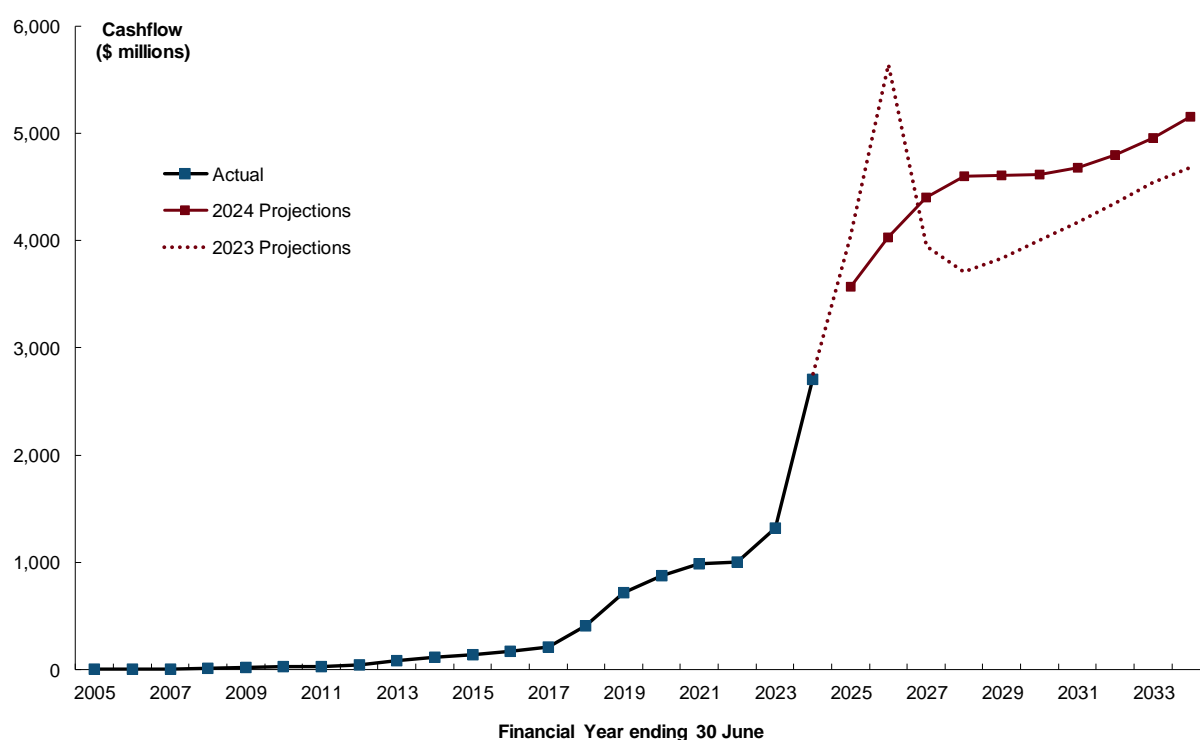
- benefit levels are pre-determined given a claimant's age, whole person impairment, lifestyle rating and warlike/peacetime exposure. There is no scope for benefit levels to increase other than due to these factors.

6.6.3 On balance, we have adopted 2 per cent per annum superimposed inflation for the next three years for this valuation and have applied it to non-interim and interim lump sums only. This is the same as adopted for the 2023 valuation, noting however, that we have removed the superimposed inflation from the Section 80 benefits and have instead explicitly increased the assumed proportions of claimants receiving these benefits.

6.7 Cashflows

6.7.1 Figure 6.20 shows the historical and projected cashflows for MRCA permanent impairment payments generated by these assumptions. We note that the level of future cashflows will be influenced by the level of processing capacity available and the level of future claims experience. Unlike our previous valuation, we have not included a timing adjustment to the cashflow projection; the previous adjustment assumed increased processing capacity would eventuate and was based on DVA's internal DDFM. For this valuation, in the absence of planned staffing increases, we have assumed that processing capacity will continue at the level achieved towards the end of 2024.

Figure 6.20: Historic and Projected MRCA Permanent Impairment Payments



6.8 Liability Estimate

6.8.1 Table 7.1 shows the outstanding liability at 30 June 2024 in respect of permanent impairment claim payments broken down by year of accident.

Table 6.1: Outstanding Claims Liability for Permanent Impairment Claims by Year of Accident

Year of accident – year ending 30 June	Liability (\$'m)
2005	110.1
2006	115.7
2007	130.9
2008	167.8
2009	208.2
2010	245.2
2011	317.6
2012	403.1
2013	513.2
2014	637.3
2015	767.8
2016	937.2
2017	1,128.6
2018	1,434.4
2019	1,704.9
2020	2,025.0
2021	2,502.2
2022	2,848.0
2023	3,074.7
2024	3,245.0
Total	22,517.1
<i>Expected at 30/06/2024</i>	<i>18,835.0</i>
Total at 30/06/2023 (taken from previous report)	17,969.5

6.8.2 The 2023 review projected that the MRCA liability as at 30 June 2024 would be \$18,835.0m. The current estimate is \$22,517.1m. Table 7.2 reconciles the liability estimate for PI payments with the corresponding estimate at the previous valuation.

Table 6.2: Reconciliation of Liability for Permanent Impairment Payments

	\$m
Liability estimate at 30/06/23 (previous report)	17,969.5
Assumed Interest	832.1
Projected Payments	(2,689.7)
Notional Premium	2,723.2
Projected liability as at 30 June 2024 (previous valuation)	18,835.0
Post report change for financial statements	1,349.6
Projected liability as at 30 June 2024 (as per financial statements)	20,184.6
Experience effects and assumption changes	
Change in claim numbers	517.4
Change in completion rates	(411.4)
Change in mix of lump sum payment types	97.2
Change in proportion receiving EYP	1,221.6
Change in average claim size for lump sums	944.3
Changes in periodic benefits	(36.6)
Current Estimate	22,517.1

6.8.3 The main items contributing to the increase in the liability are:

- \$1,350 million addition to the projected liability after we had completed our 2023 report for financial statement purposes, to reflect the higher number of claims lodged in the first five months of 2024 compared with the allowances in our 2023 report;
- A further \$520 million addition due to higher adopted claim numbers. As discussed in Section 6.3.13, this is primarily due to the substantial increase in new ILs lodged in the 2024;
- A \$410 million reduction due to changes in the assumed completion rates. This is due to the impact of discounting, with a larger volume of payments expected to be paid a later durations;
- A small increase of \$100 million due to some minor changes in our assumptions around the mix of lump sums by type;
- A \$1,220 million increase due to increasing the assumed the proportion of claimants expected to receive Section 80 benefits to current levels, and that the proportion will continue to increase over the next few years;
- A \$940 million increase to the average claim size assumptions for lump sums, reflecting the experience in the last year;
- A small \$40 million reduction in the annuity valuation of periodic payments.

7 DRCA Permanent Impairment and Non-Economic Loss

7.1 Modelling Approach

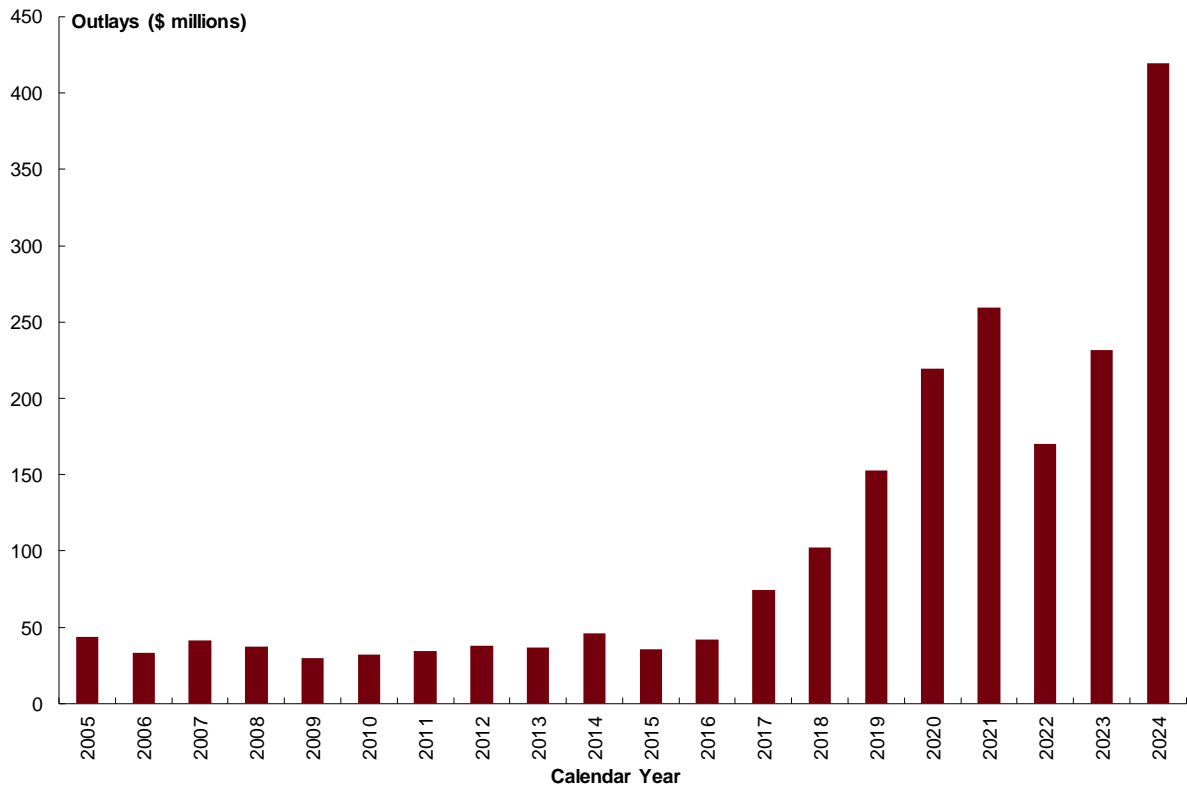
- 7.1.1 Under DRCA, lump sum payments are made where a service person suffers a permanent impairment. The amount of benefit payable depends upon the assessed level of impairment for the injury/condition being assessed⁶. In most cases, a further lump sum payment is made to compensate for non-economic loss which is itself paid in two components, one directly related to the claimant's impairment level ("NEL A") and the other that uses a scoring approach to assess the impact of the impairment on the claimant's life/lifestyle ("NEL B"). Due to the strong correlation between the two payments, we model the combined payment.
- 7.1.2 We have adopted a new modelling approach at this valuation that is a simplified version of the MRCA PI modelling approach. That is, we use our model that converts accepted IL claims (from Section 5) to expected numbers of PI lodgements. Our model then projects the numbers of PI lodgements that will be completed, accepted and ultimately paid. The key differences to the MRCA approach are:
- We have subdivided the historical data based on the year of birth of the claimant rather than average accident date as used for MRCA PI;
 - We have adopted a simplified approach to claim completions, calculating completion rates per claim lodged (rather than per open claim);
 - The DRCA PI benefits are simpler than for MRCA so there is no need to analyse the DRCA claims experience by payment type.

7.2 Recent Experience

- 7.2.1 Figure 7.1 shows the expenditure on permanent impairment (including non-economic loss payments for DRCA) over the last two decades. Despite the closure of DRCA for injuries occurring after 1 July 2004, expenditure has increased significantly since 2017, noting the impact of processing constraints on payments made in 2022 and 2023. Payments in 2024 were very large at over \$400 million, around double the level of 2022 and 2023.

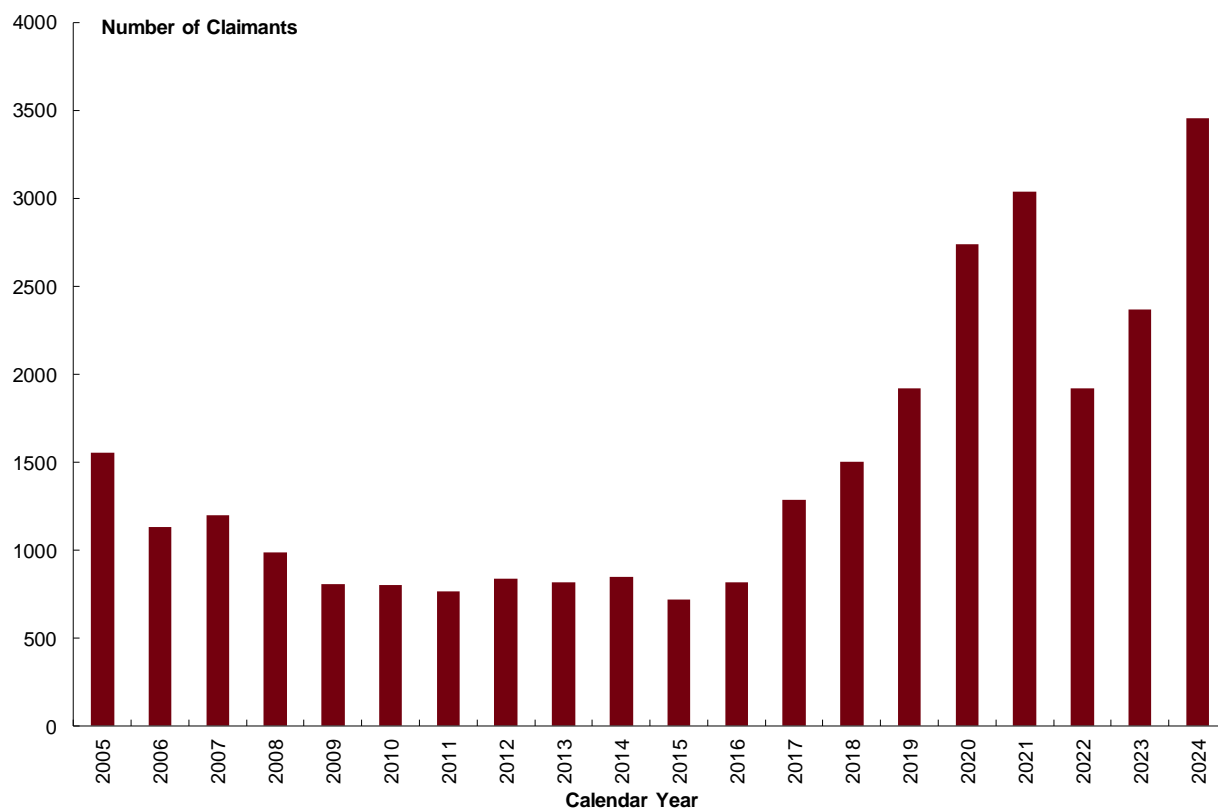
⁶ We note that the impairment guides used to assess DRCA impairments differ from those used for MRCA. The scoring of injuries can differ between the two guides and DRCA injuries are assessed in isolation whereas with MRCA injuries are assessed on a "whole person" basis (with multiple injuries being combined).

Figure 7.1: Expenditure on DRCA Permanent Impairment Payments



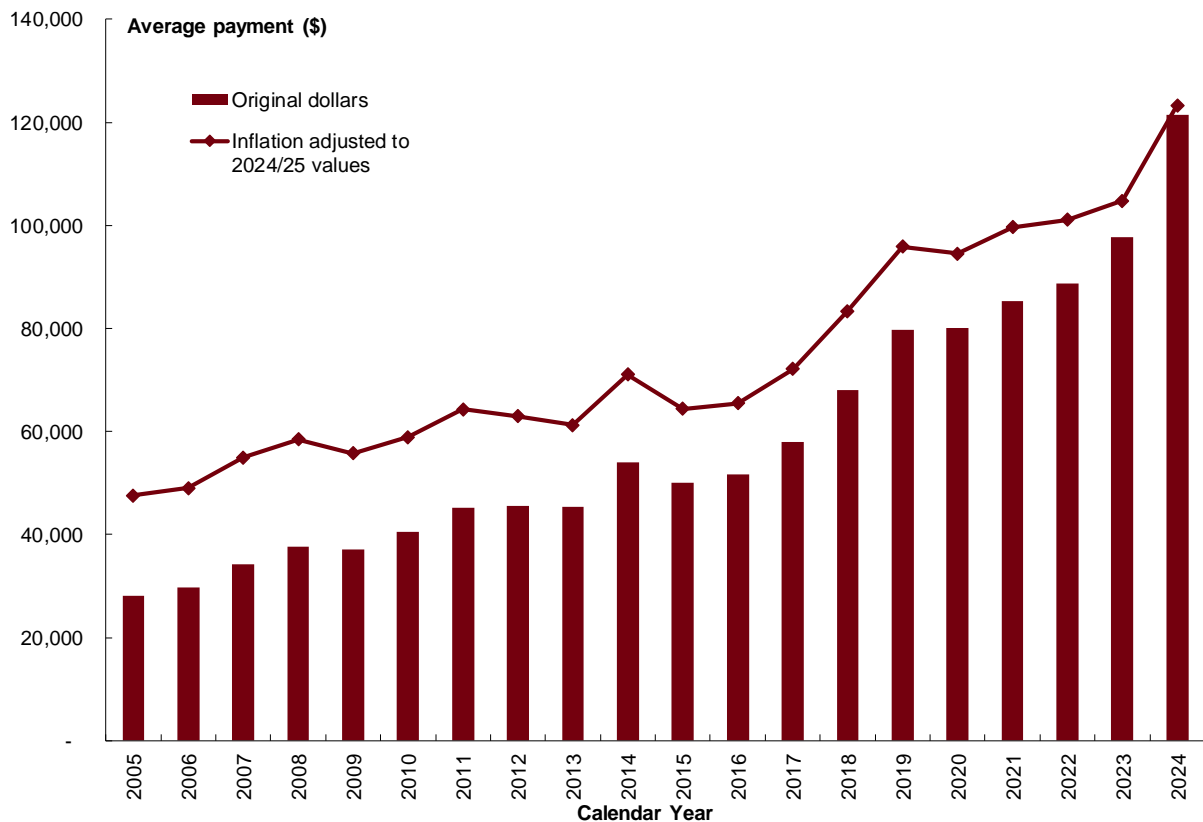
7.2.2 Figure 7.2 shows the number of people in receipt of a DRCA PI payment in each calendar year, noting the graph is a count of people who have received a PI, not the number of PI claims paid. The number of people in receipt of a PI payment can be seen to be a key driver of the payments in Figure 7.1, with the shape of the two graphs broadly similar i.e. lower numbers of people receiving PI payments in 2022 and 2023 due to processing constraints, followed by a large number in 2024.

Figure 7.2: Number of DRCA PI Claimants



7.2.3 Figure 7.3 shows the average size of permanent impairment payments per claimant. The average sizes shown reflect the total amount a veteran is awarded over a whole year (i.e. if a veteran has multiple permanent impairment payments in a year, all of the payments are included and the veteran is counted only once). We have shown the averages in the dollars paid at the time, and also inflated to 2024/25 values using the prescribed indexation of the maximum available payment. The average amount paid per person has increased over time, with increases over and above the level of indexation of the maximums. The increase in the average size per person in 2024 was 18 per cent more than indexation; this compares to our superimposed inflation allowance in our previous valuation of 2.5 per cent.

Figure 7.3: Average Size of DRCA Permanent Impairment Payments



7.2.4 Table 7.1 decomposes the increases in average claim size over the last five years into its component parts. The average size can increase due to three factors:

- claimants receiving a greater number of PI payments per person in a single year – this increased from 1.73 claims per person to 1.88 claims per person between 2023 and 2024, contributing 9 percent of the 18 per cent growth in 2024. We expect that part of this is due to the processing constraints in 2022 and 2023, and that there may be some element of catch-up in 2024;
- the average number of impairment points awarded per permanent impairment claim – this increased from 19.4 to 20.4 point per PI claim between 2023 and 2024, contributing 5 per cent towards the 2024 growth;
- the average payment per impairment point - this has increased from \$3,115 to \$3,207 between 2023 and 2024, contributing 3 per cent towards the 2024 increase. As the majority of the amounts awarded for PI claims is linked to the number of impairment points, this implies that the average scores claimants have received for the lifestyle impacts for the NEL B component have increased.

7.2.5 We have taken these factors into account when selecting our average claim size.

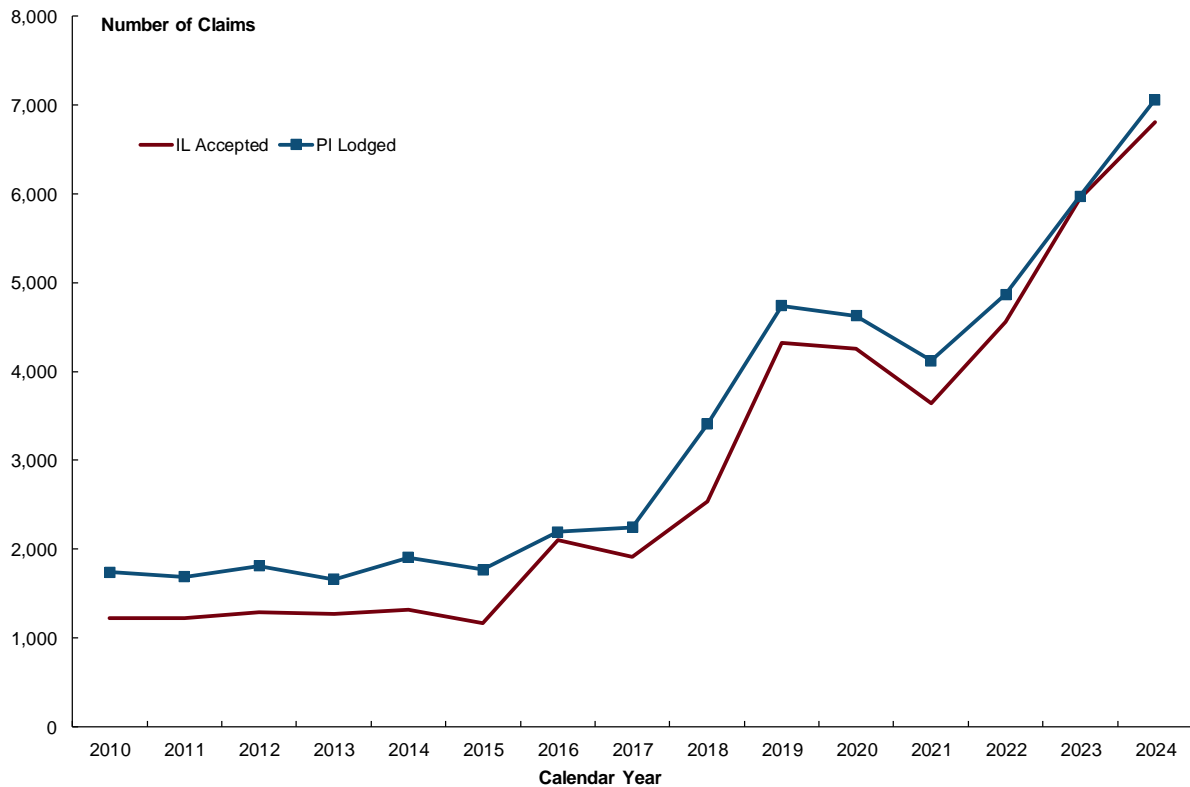
Table 7.1: Components Contributing to the Change in Average Claim Size

Component	2020	2021	2022	2023	2024
Average Size per person (\$000, current values)	94.5	99.6	101.1	104.8	123.3
<i>Increase</i>	-1%	5%	2%	4%	18%
Number of PIs per person	1.66	1.80	1.76	1.73	1.88
<i>Increase</i>	-2%	8%	-2%	-2%	9%
Average impairment points per PI	18.5	18.3	19.0	19.4	20.4
<i>Increase</i>	3%	-1%	4%	2%	5%
Average payment per point (current values)	3,072	3,028	3,018	3,115	3,207
<i>Increase</i>	-3%	-1%	0%	3%	3%

7.3 Valuation Assumptions – Numbers of PI Claims

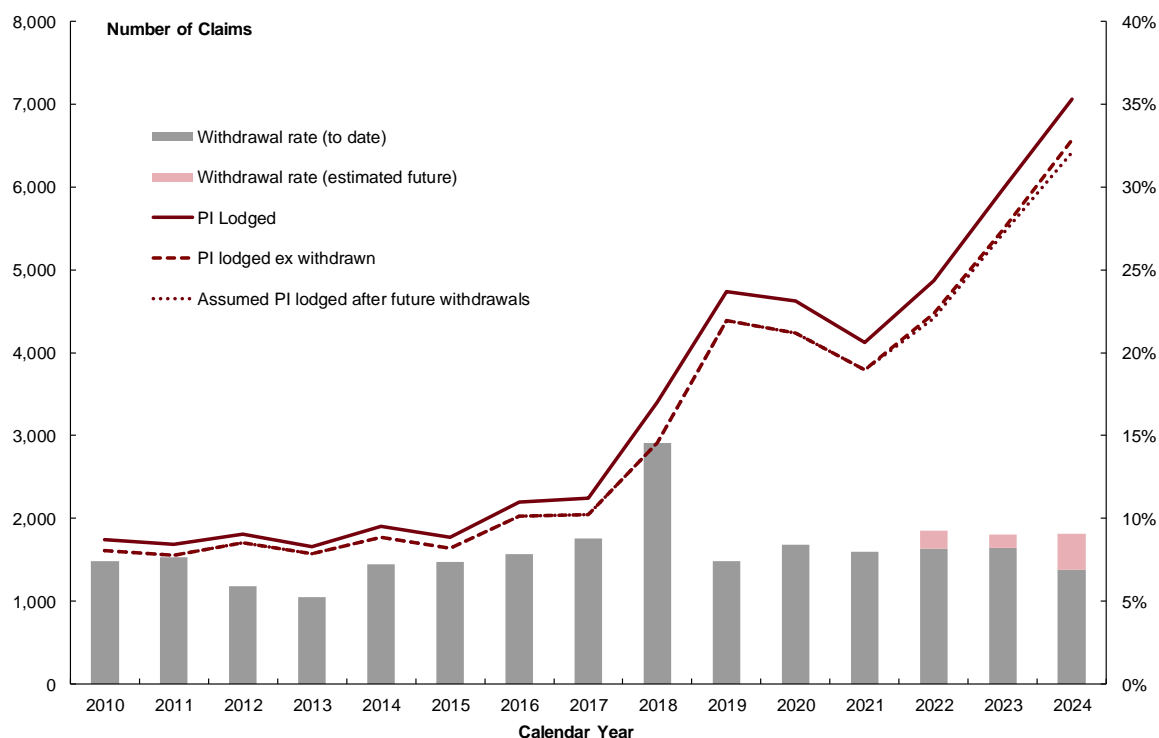
- 7.3.1 As for MRCA, high numbers of open claims in both IL and PI persist, with flow on effects to the numbers of PI claims lodged, completed and paid.
- 7.3.2 Figure 7.4 shows the number of initial liability claims accepted and the number of permanent impairment claims lodged (before withdrawals) by calendar year. As for MRCA, it is possible for the number of PI claims to exceed the number of IL claims in a given year due to potential timing lags and the ability to submit a PI reassessment without an additional IL claim. For DRCA, it is also possible for a single IL condition to result in multiple PI claims as each body part must be assessed separately (for example, an IL claim may be lodged for a “bilateral” shoulder injury that is impacting both the left and right shoulder, but there needs to be PI claim lodged for each shoulder).
- 7.3.3 DRCA IL claims accepted and PI claims lodged have tracked closely. PI claims lodged have increased dramatically in the past two years, a direct result of the increase in IL claims accepted during this time.

Figure 7.4: IL Claims Accepted and PI Claims Lodged, by Calendar Year



7.3.4 Figure 7.5 shows the number of permanent impairment claims lodged by calendar year; we have shown the number before withdrawals, the number after withdrawals that have been made so far, and the number after we have incorporated assumed future withdrawals. We have also shown the withdrawn rate to date and our assumed future withdrawal rate. We have assumed that around 9 per cent of PI claims lodged in 2024 will ultimately be withdrawn, similar to levels for 2022 and 2023.

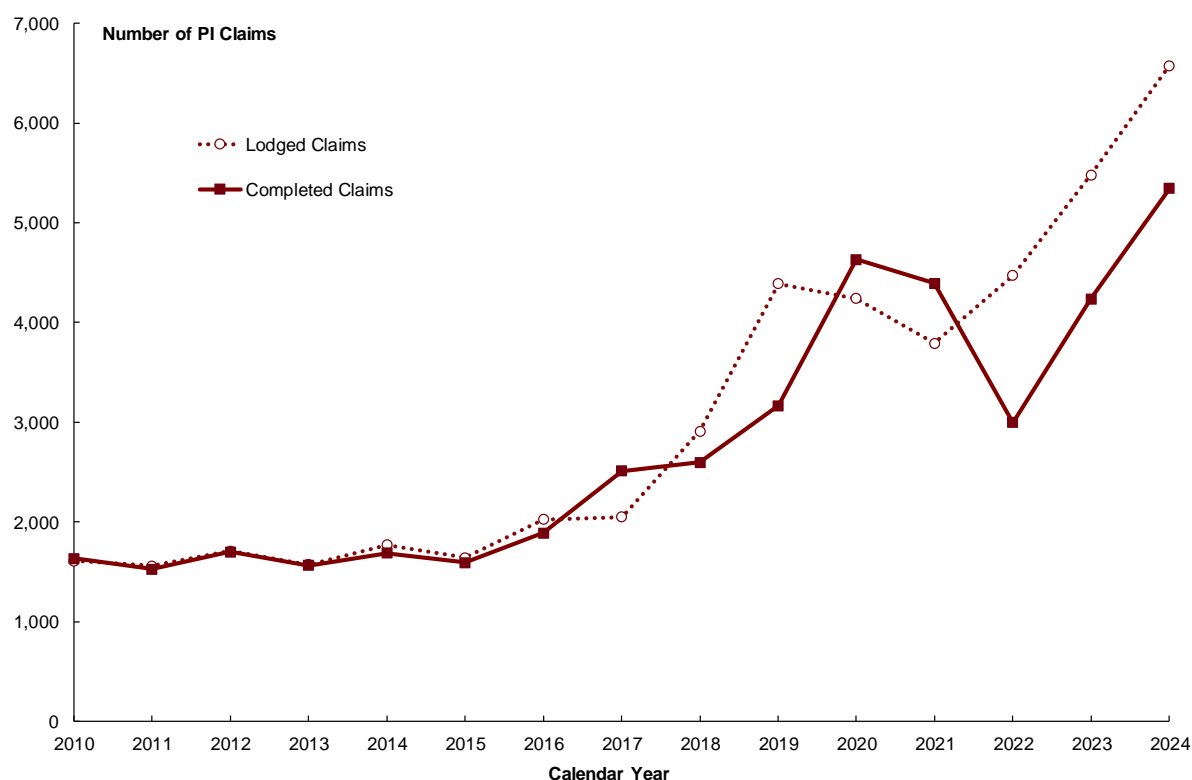
Figure 7.5: PI Claims Lodged Including and Excluding Withdrawn Claims, by Calendar Year



7.3.5 The combination of our assumptions around the conversion rate from IL claim accepted to PI claim lodged and our assumed ultimate PI claim withdrawal rate, results in around 95 per cent of IL claims accepted resulting in a non-withdrawn PI claim lodgement.

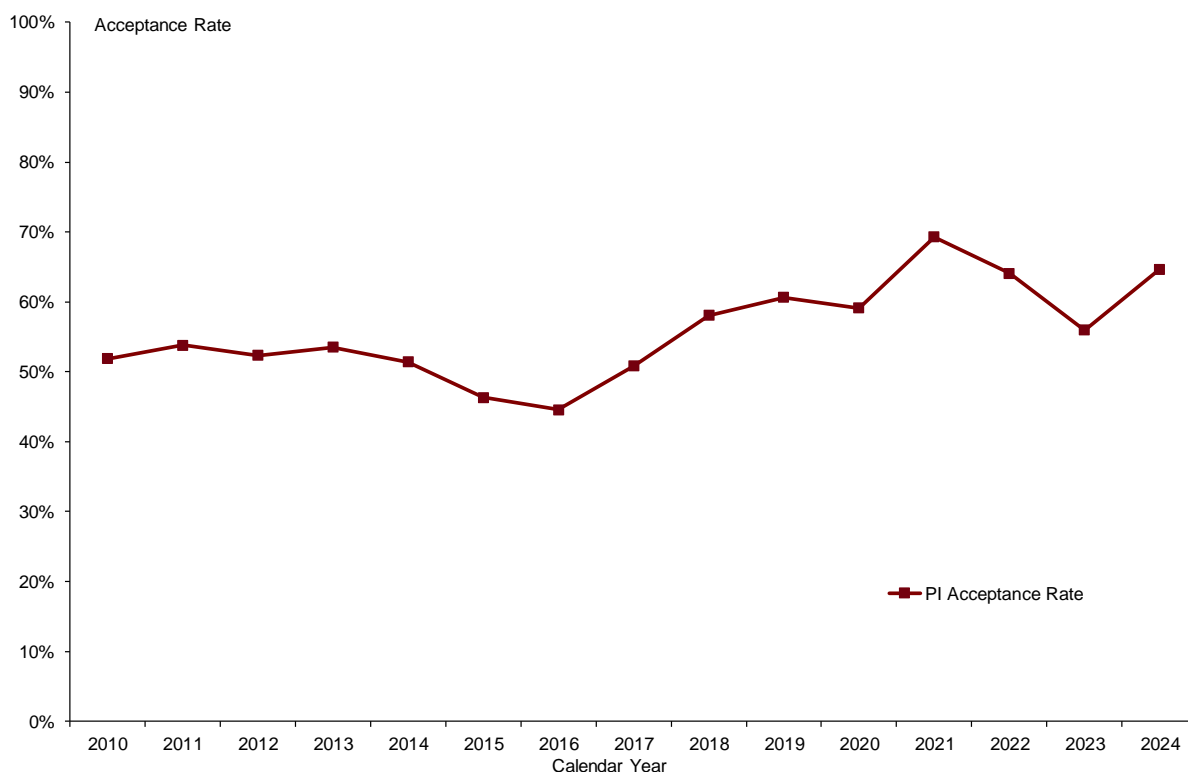
7.3.6 Figure 7.6 below shows the number of PI claims lodged (after withdrawals) and completed by calendar year. PI claims lodged in the last 2 years have increased dramatically, but, as for MRCA, the number of PI claims completed has not kept pace with lodgements. Completions have been 1,200 to 1,500 below lodgements in each of the last three years.

Figure 7.6: Lodged (After Withdrawals) and Completed PI Claims



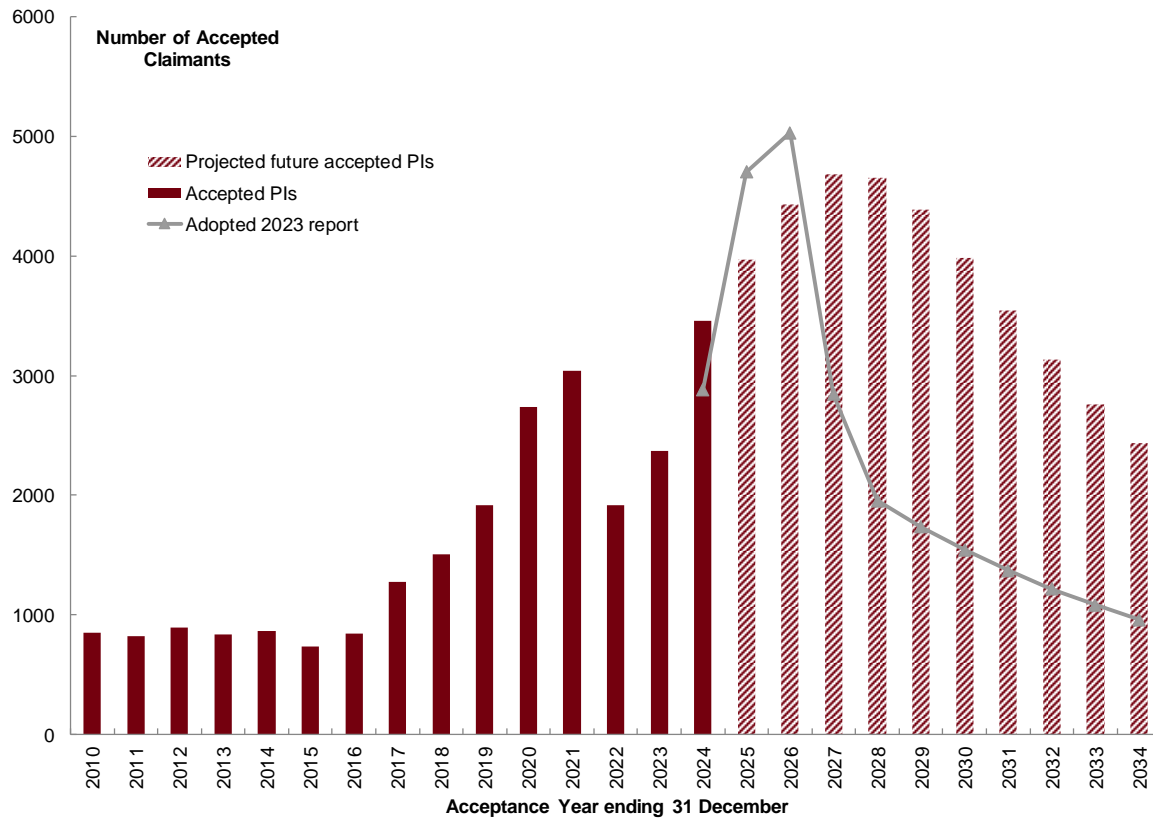
- 7.3.7 As a result of the significant gap between PI claim lodgements and PI claim completions in the last three years, the number of open PI claims has grown dramatically from around 3,200 at 31 December 2022, to 4,100 at 31 December 2023, to 5,400 at 31 December 2024.
- 7.3.8 In our new DRCA valuation model, the number of future PI lodgements is directly linked to the number of IL claims accepted, which are in turn directly linked to IL claims completed. As discussed in Section 5, our model projects IL claim completions, therefore directly incorporating an allowance for the current open IL claims and the anticipated completion of these claims over the coming years.
- 7.3.9 PI claim completions are then projected per lodged PI claim (after withdrawals). This approach directly incorporates allowance for the current open PI claims, expected new PI claim lodgements, and the completion of current open claims.
- 7.3.10 Figure 7.7 below shows the acceptance rates (per completed claim) for PI claims since 2010. Acceptance rates have varied somewhat over the last five years at between 56 per cent and 69 per cent (lower than for MRCA at 88 per cent). By year of birth, the acceptance rates are higher for the oldest cohorts (73 per cent) reducing to around 50 per cent for the youngest cohorts. We have adopted permanent impairment acceptance rates that vary by year of birth, with the overall proportion being 61 per cent for 2025, increasing to 73 per cent in future years as clients age. This is a substantial increase on 56 per cent adopted at the previous valuation.

Figure 7.7: PI Acceptance Rates



7.3.11 Figure 7.8 shows the actual and projected number of accepted PI claims by acceptance year (including allowance for new accidents). We have also shown our adopted ultimate numbers from our previous valuation. The number of future accepted PI claims adopted for this valuation is dramatically higher than those adopted at the previous valuation. This is primarily due to the much higher number of future IL claims expected to be lodged compared with at our previous valuation (as discussed in Section 5). The impact of other changes in the valuation basis on the number of PI claims expected to be paid is small.

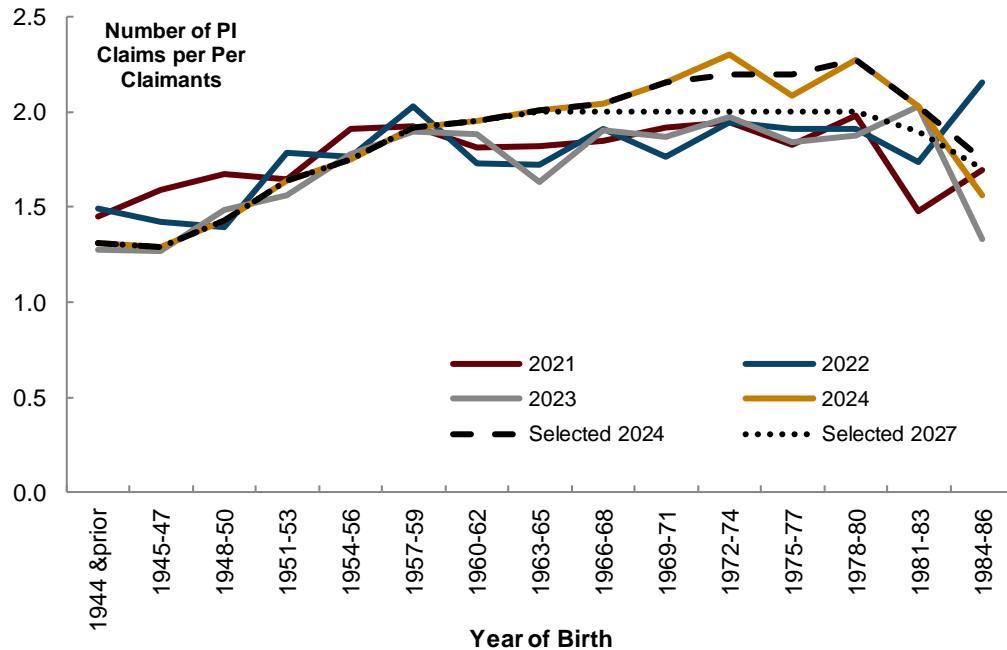
Figure 7.8: DRCA Actual and Projected Accepted PIs by Acceptance Year



7.4 Valuation Assumptions – Average Claim Size

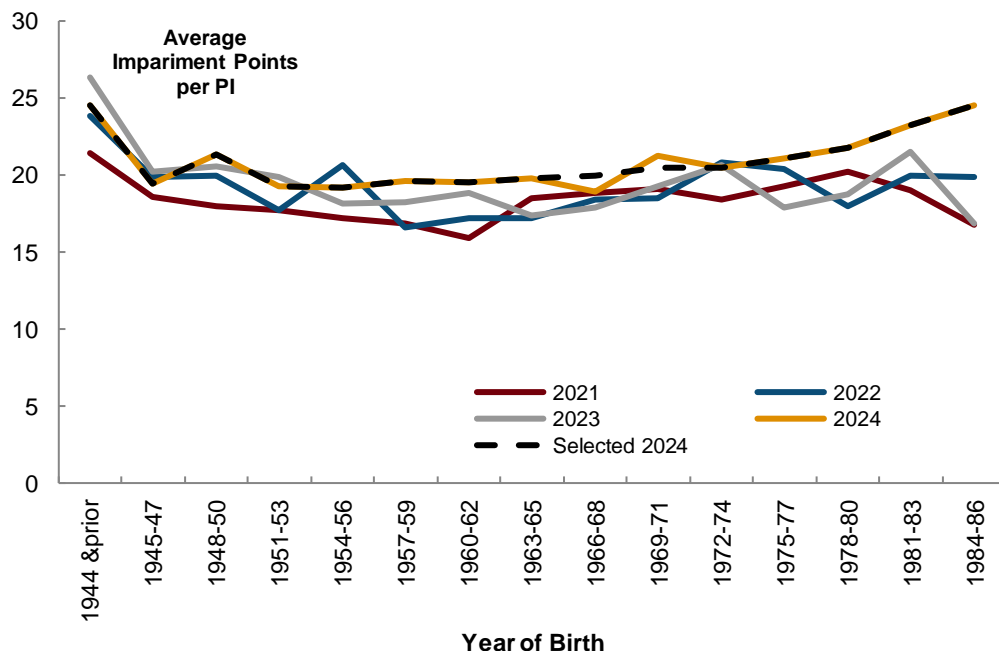
- 7.4.1 At our previous valuation, we adopted a single average claim size for all future PI claims. For this valuation, we have adopted average claim sizes that vary by year of birth, with allowance for claimants to age. Given the changes we have seen in some of the drivers of the average PI claim paid per person in 2024 in particular, we have selected average claim sizes with reference to the number of PI claims per person, the average number of impairment points per PI claim, and the average amount paid per PI claim.
- 7.4.2 Figure 7.9 shows the number of PI claims per person, by year of birth, for each of the last four years along with our selected assumptions. The number of PIs per person increased dramatically in 2024 for those born after 1960. We have assumed that part of this is a temporary impact due to the processing constraints in recent years and have assumed that the number of PI claims per person will reduce over 2025, 2026 and 2027 to expected long term levels.

Figure 7.9: DRCA Number of PI Claims per Person

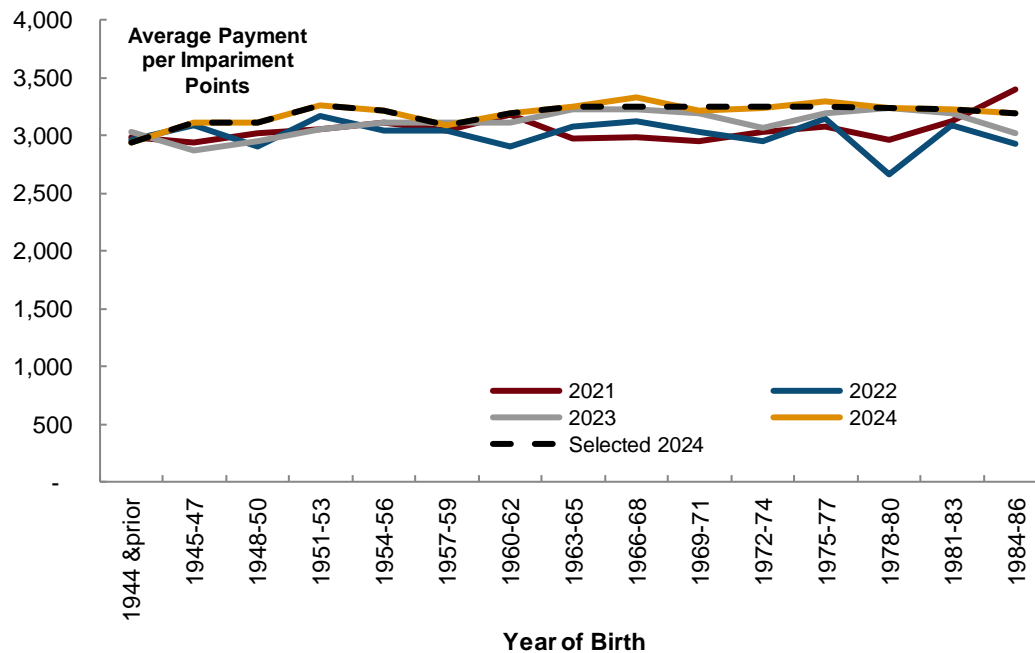


7.4.3 Figure 7.10 shows the average number of impairment points awarded per PI claim, by year of birth, for each of the last four years along with our selected assumptions. The average number of impairment points per PI claim increased in 2024 for those born after 1975. We have assumed that this higher level of impairment will be an ongoing feature of the experience.

Figure 7.10: DRCA Average Impairment Points per PI

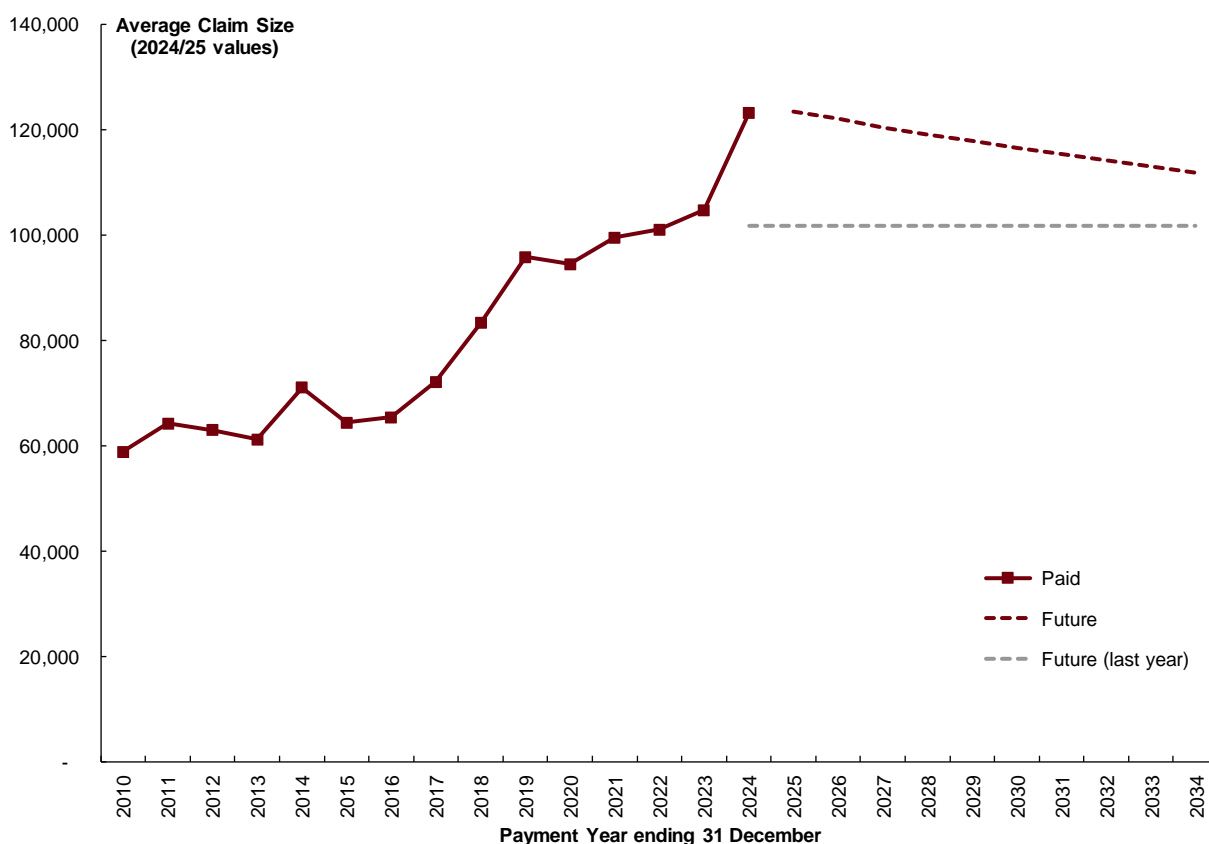


7.4.4 Figure 7.11 shows the average amount paid per impairment point, by year of birth, for each of the last four years along with our selected assumptions. The average amount paid per impairment point increased across all age groups. We have also assumed that this will be an ongoing feature of the experience.

Figure 7.11: DRCA Average Amount Paid per Impairment Point

- 7.4.5 Combining the above assumptions results in overall average claim sizes as shown in Figure 7.12. We have also shown our adopted overall average claim size from our previous valuation (inflated to 2024/25 values). Our adopted average claim sizes at this valuation are around 20 per cent higher than at the previous valuation for the 2025 payment year, reducing to around 10 per cent higher by 2034 (as we assume the average claim size reduces as the population ages due to a lower number of PI claims per person). This reflects the experience that has emerged in the last year, moderated to a small extent by an expectation that the number of PI claim payments per person will reduce over the next three years.

Figure 7.12: Overall Average PI Claim Size

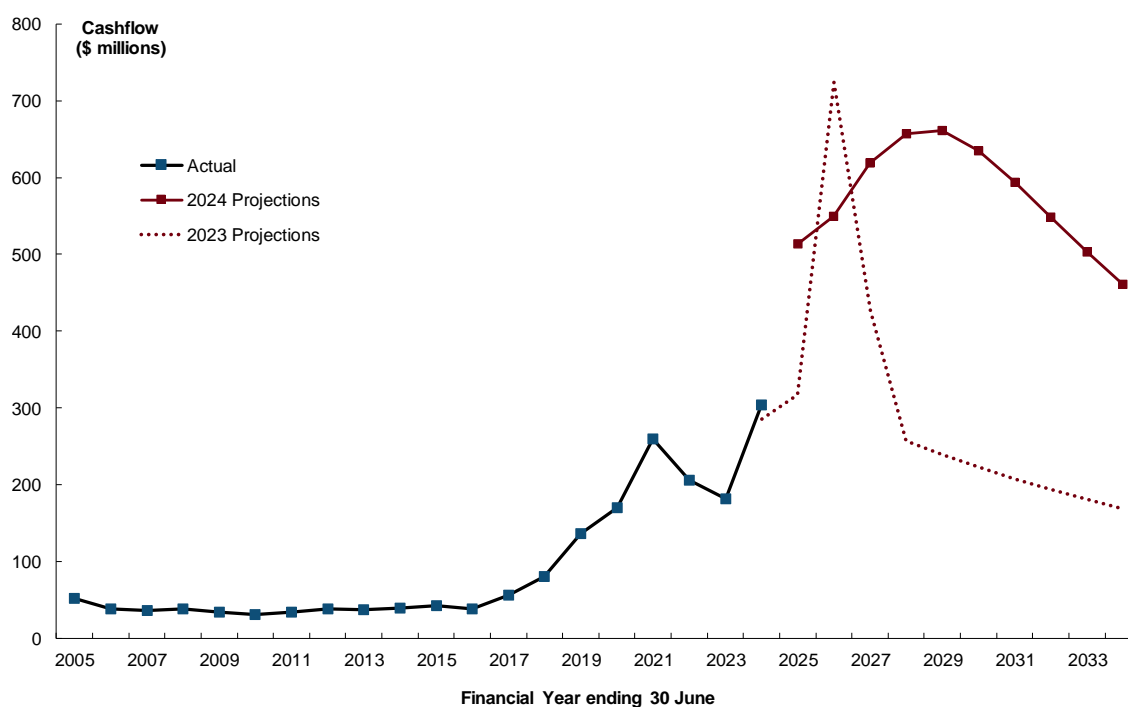


7.5 Valuation Assumptions – Inflation Assumptions

- 7.5.1 While, in theory, DRCA PI payments are indexed in line with the price inflation, in practice, the average payment has increased by more than double this index over the last 15 years. As such, we have retained the 2023 assumption that average claims will increase by 5 per cent per annum in the long term (comprised of 2.5 per cent per annum for price inflation and 2.5 per cent per annum for superimposed inflation).

7.6 Cashflows

- 7.6.1 Figure 7.13 below shows the historic and projected cashflows for DRCA permanent impairment payments resulting from these assumptions. Payments in 2024/25 look high relative to actual payments in 2023/24 and expected payments included in our previous valuation. However, we note that DVA's aggregate payments data for the first nine months of 2024/25 shows DRCA PI payments of \$382 million, which is around three quarters of the full year payments included in our projection.

Figure 7.13: Historic and Projected DRCA Permanent Impairment Payments

7.7 Liability Estimate

7.7.1 Table 9.1 shows the outstanding liability at 30 June 2024 in respect of permanent impairment and non-economic loss claim payments broken down by year of birth. The total estimated liability for DRCA claims is \$6,475.0m. The 2023 valuation projected that the DRCA liability as at 30 June 2024 would be \$3,294.4m.

Table 7.2: Outstanding Claims Liability for Permanent Impairment and Non-Economic Loss Claims by Year of Accident

Year of birth – year ending 30 June	Liability (inflated and discounted) (\$'m)
1944 & prior	175.3
1945-50	605.8
1951-56	671.0
1957-62	1,057.3
1963-68	1,274.2
1969-74	1,446.9
1975-80	878.4
1981 & later	366.2
Total	6,475.0
<i>Expected at 30/06/2023</i>	<i>3,294.4</i>
Total (30/06/2023)	3,416.3

7.7.2 We have increased the DRCA PI liability by a multiple of around two times the projected liability. Table 6.2 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 7.3: Reconciliation of Liability for Permanent Impairment Payments

	\$m
Liability estimate at 30/06/23 (previous report)	3,416.3
Assumed Interest	163.8
Projected Payments	(285.6)
Notional Premium	0.0
Projected liability as at 30 June 2023 (previous valuation)	3,294.4
<i>Experience effects and assumption changes</i>	
Change in future IL lodgements	1,588.8
Change in PI acceptance rates	722.2
Other minor adjustments to claim number assumptions	223.1
Change due to average size	646.5
Current Estimate	6,475.0

7.7.3 By far the largest movement in the liability is due to our assumptions around future numbers of IL claims and their subsequent conversion into PI claims. This adds \$1,588.8 million to the liability (and increase of almost 50 per cent).

7.7.4 Increasing the acceptance rates to reflect the latest experience, coupled with assuming that acceptance rates will increase as the DRCA cohort ages, has increased the liability by another \$722.2 million.

7.7.5 Small adjustments to other claim number assumptions have overall increased the liability by \$223.1 million.

And finally, increases in the adopted average claim size increased the liability by \$646.5 million.

8 Incapacity Benefits

8.1 Benefit Overview

- 8.1.1 Incapacity payments are compensation for economic loss due to the inability or reduced ability to work as a result of service-related conditions. Payments are made fortnightly and are paid at a level related to the recipient's salary prior to injury. Incapacity payments are initially payable at a replacement rate of 100 per cent of pre-injury earnings. After 45 weeks on incapacity payment, the replacement rate decreases to between 75 and 100 per cent, depending on the number of hours worked each week. Veterans fully incapacitated from work receive 75 per cent of pre-injury earnings. Actual employment earnings and any Commonwealth superannuation (including both pension and lump sum) payments received by the veteran are offset against incapacity benefits. Incapacity benefits cease at Age Pension age in most cases.
- 8.1.2 Veterans must provide current medical evidence and employment information when required to remain on incapacity payments. Incapacity recipients may also be expected to participate in a rehabilitation program designed to increase their capacity for suitable employment. Rehabilitation programs may involve both vocational and non-vocational assistance, including a period of facilitated job search assistance for veterans assessed as having the potential to return to work. The success of these rehabilitation programs will impact the duration which veterans remain on incapacity benefits. The modelling of rehabilitation benefits is discussed further in Chapters 11 and 12.
- 8.1.3 Veterans eligible under the MRCA with significant restrictions to their capacity to work are eligible for the Special Rate Disability Pension (SRDP) which is an alternative form of compensation. Veterans that have been assessed at 50 or more impairment points and are unable to undertake paid work for more than 10 hours per week and where rehabilitation is unlikely to be effective are offered a choice between receiving incapacity payments or receiving SRDP. SRDP payments are tax-free and continue indefinitely past retirement age, provided the recipient continues to maintain a whole person impairment score of 50 or more and are unable to undertake remunerative work of 10 hours or more per week. The offsetting arrangements that apply to SRDP (including full or partial offset of any permanent impairment or Commonwealth superannuation payments) may mean that the SRDP amount payable is less than that available under incapacity. Veterans must seek financial advice before commencing SRDP payments, and reimbursement is available for the costs incurred in obtaining this advice.

8.2 Modelling Approach

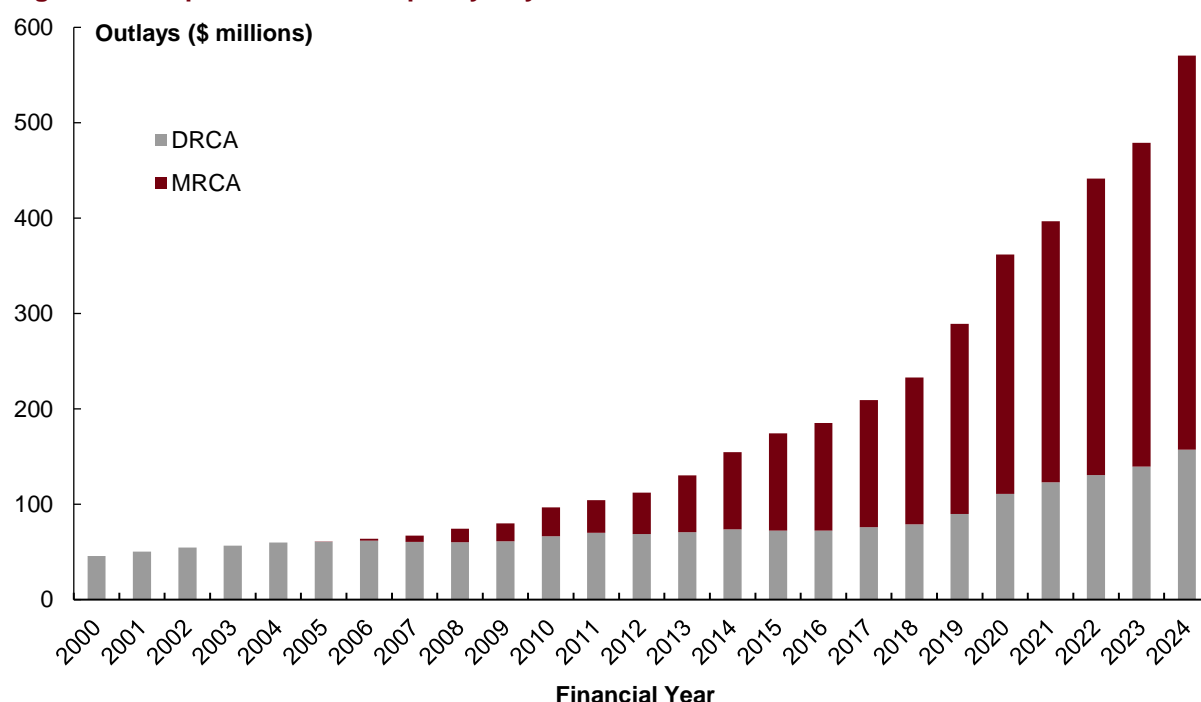
- 8.2.1 A fortnightly deterministic projection model has been employed to model incapacity payments by projecting the number of recipients and the amount received by each recipient in each period. The model has been constructed on an episode basis, where an episode is defined as a period of continuous receipt of incapacity payments. The model projects both existing episodes (that is, incapacity recipients that are receiving incapacity payments as at 31 December 2024, where the age distribution, current duration in receipt of benefits and current rates of payment are known) as well as future new episodes (which may relate to prior or future injuries). The continuance rates and fortnightly payment amounts are assumed to vary by the

duration of the episode and the age of the recipient at the beginning of the episode. The same model has been used for both DRCA and MRCA to reflect the similarity in benefits offered and experience observed.

8.3 Recent Experience

8.3.1 Figure 8.1 shows the expenditure on incapacity payments since 2001. The payments to 2011 reflect a period of relatively slow growth; DRCA outlays remained stable and the MRCA scheme, which was introduced from 1 July 2004, was beginning to increase. From 2012 to 2018, there has been a strong upward trend in expenditure, mainly driven by growth in outlays paid under MRCA. From 2019, outlays increased significantly for both MRCA and DRCA, largely driven by the changes brought about during Veteran Centric Reform. These increases have continued in the most recent year. Please note that these figures are gross of any repayments made as a result of superannuation offsets or other debts.

Figure 8.1: Expenditure on Incapacity Payments



8.4 Valuation Assumptions – Incapacity Recipient Projection

8.4.1 Broadly speaking, the incapacity model relies on three main assumptions:

- the new episode projection (a projection of people commencing episodes of incapacity payments in each future period, including their age and accident year);
- continuance probabilities (to determine the number of people remaining on incapacity benefits in each future period); and
- average fortnightly payment rates (to calculate the amount paid to incapacity recipients in each future period).

Combining the existing incapacity recipient population, the projection of people commencing incapacity episodes and the assumed continuance probabilities yields a projection of

incapacity recipients in each future period. The assumed average fortnightly payment rates can then be applied to calculate the expected outlays in each future period. Each model component will be discussed in turn.

- 8.4.2 Figure 8.2 and Figure 8.3 below show the number of IL claims accepted and new incapacity recipients since 2018 for DRCA and MRCA respectively. While there appears to be a relationship between the number of IL claims accepted and new incapacity episodes in a period, the conversion rate is relatively low (in comparison to PI claims for example) and the correlation is not particularly strong. This is not necessarily surprising as not all accepted conditions are expected to result in reduced capacity to work and a loss of income. Moreover, a veteran can only have a single open incapacity claim at a given time but may lodge multiple IL claims in any given year. Over the last two years, the higher volume of IL claims accepted has not translated into a commensurate number of new incapacity claims. This may suggest that the current claims being processed have a lower propensity to require income replacement benefits.

Figure 8.2: Number of DRCA IL Claims Accepted and New Incapacity Episodes

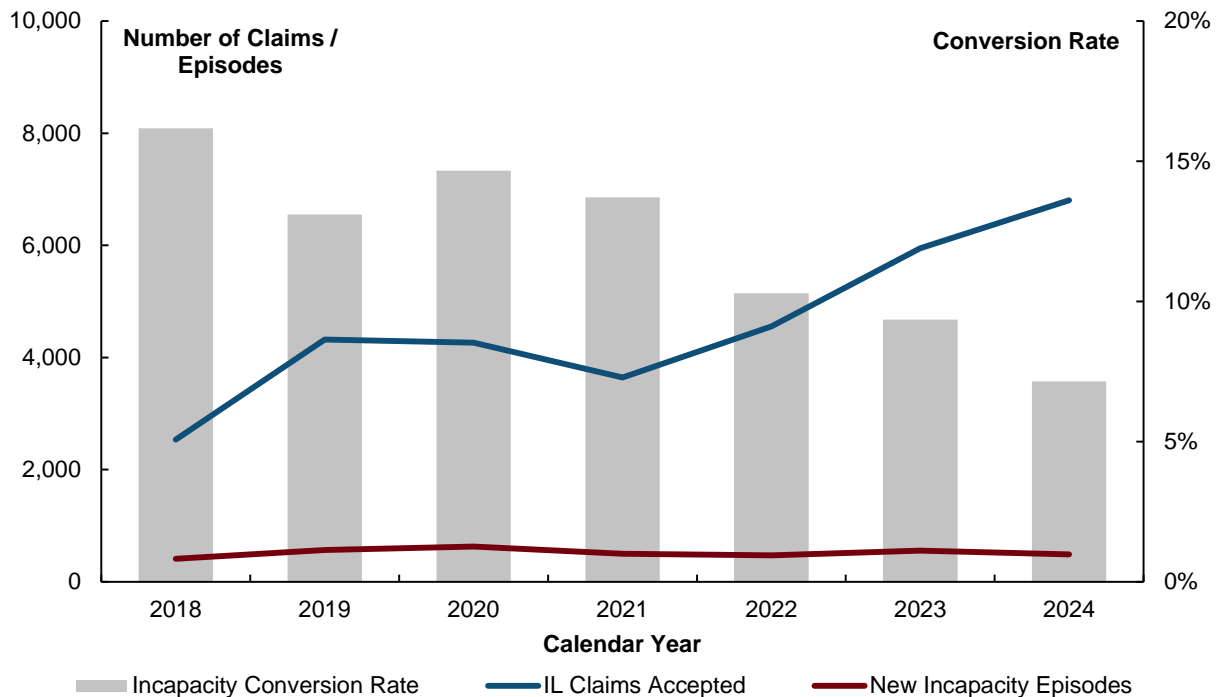
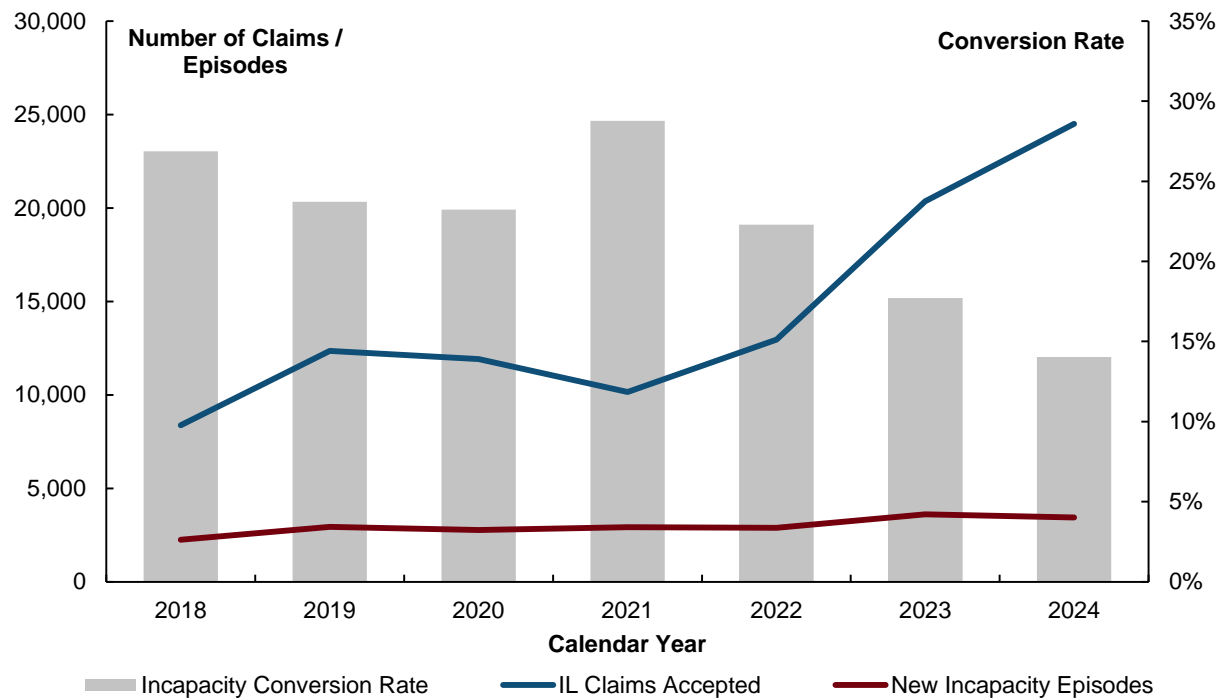


Figure 8.3: Number of MRCA IL Claims Accepted and New Incapacity Episodes



8.4.3 To project future incapacity claim numbers, we determined a pattern of episode emergence by accident year. Figures 8.4 and 8.5 show the rates of incapacity commencements per unit of exposure for DRCA and MRCA respectively. The fitted curves are based on experience from the last two calendar years. We have continued to rely on DRCA experience for development periods where none is available for MRCA. We have assigned injury dates for each incapacity episode based on the average effective date across all of a veteran's accepted IL conditions that occurred prior to the commencement of the episode. For DRCA, we have applied a proportional loading to account for episodes where a pre-2004 injury date was unable to be determined.

Figure 8.4: DRCA Incapacity Commencements by Development Year

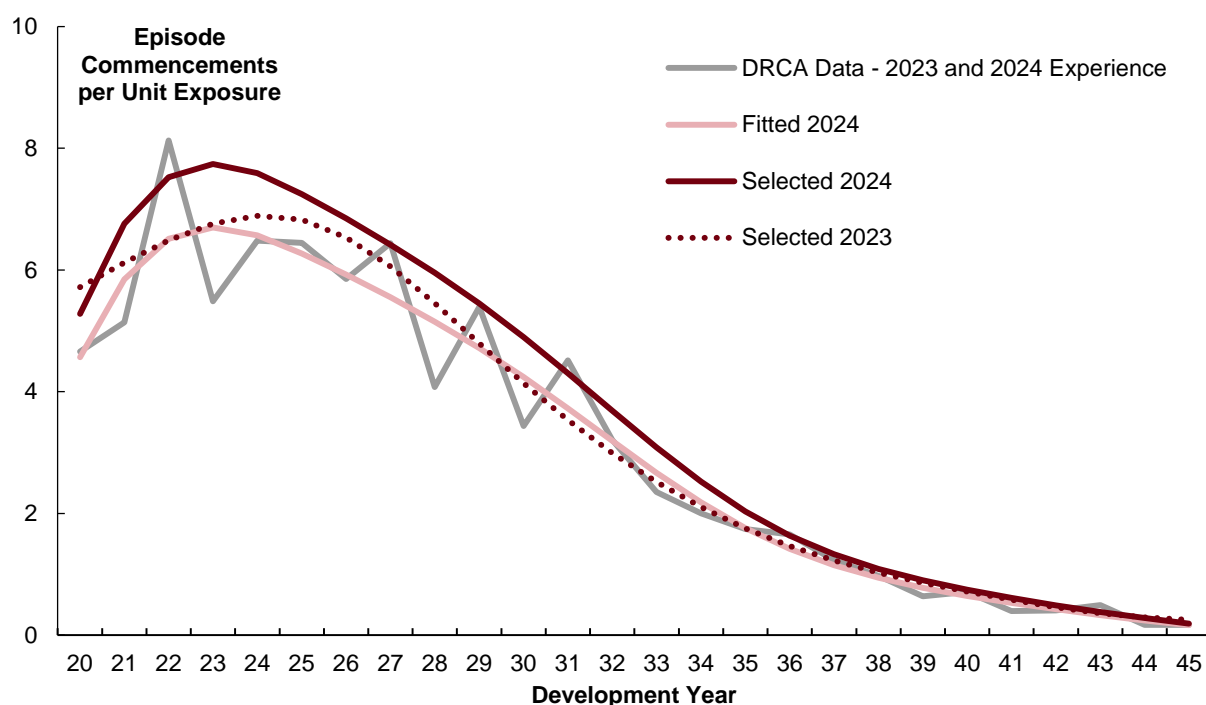
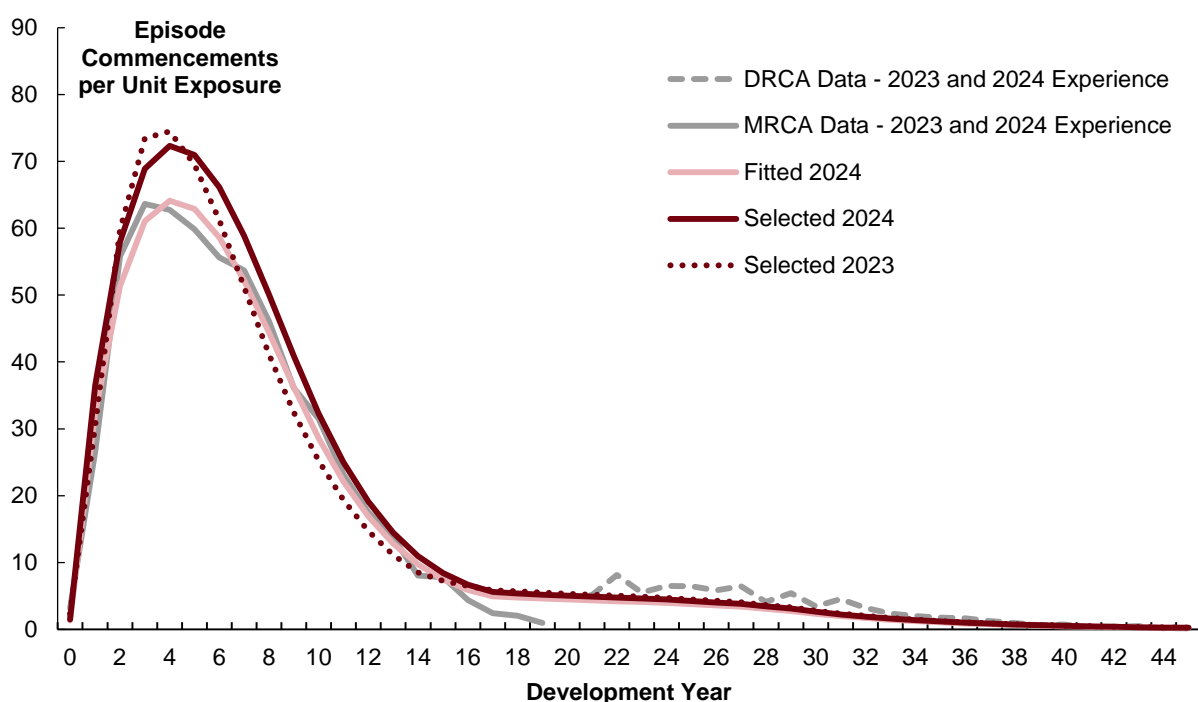


Figure 8.5: MRCA Incapacity Commencements by Development Year



8.4.4 As with last year, we have applied a proportional increase to the rates of commencement per unit exposure, to account for the impact of processing constraints on incapacity new entrants. This adjustment recognises that the level of IL claim completions, and thus incapacity new entrants, was incommensurate with the level of IL claim lodgements over the period used to calculate the commencement rates. The adjustment also allows for assumed future increases to IL claim lodgements. The proportional increases have been determined by applying IL claim

acceptance and incapacity conversion rates to the assumed level of IL claim lodgements, compared with actual incapacity commencements. For this valuation, the proportional increases are 16 per cent and 13 per cent for DRCA and MRCA respectively. These adjustments have been applied to the fitted curves, resulting in the selected curves shown in Figures 8.4 and 8.5 above. The assumed commencement rates give rise to the projections of DRCA and MRCA new incapacity episodes shown in Figures 8.6 and 8.7 below.

Figure 8.6: Projected IL Claims Accepted and New Incapacity Episodes – DRCA

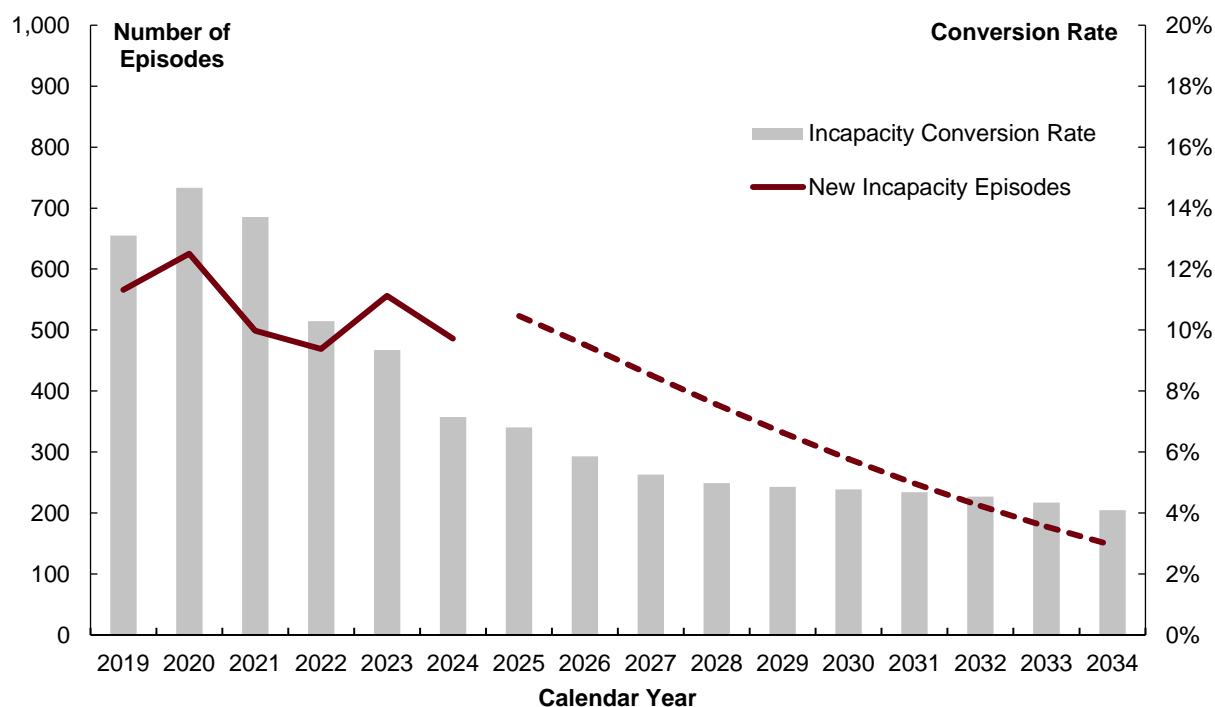
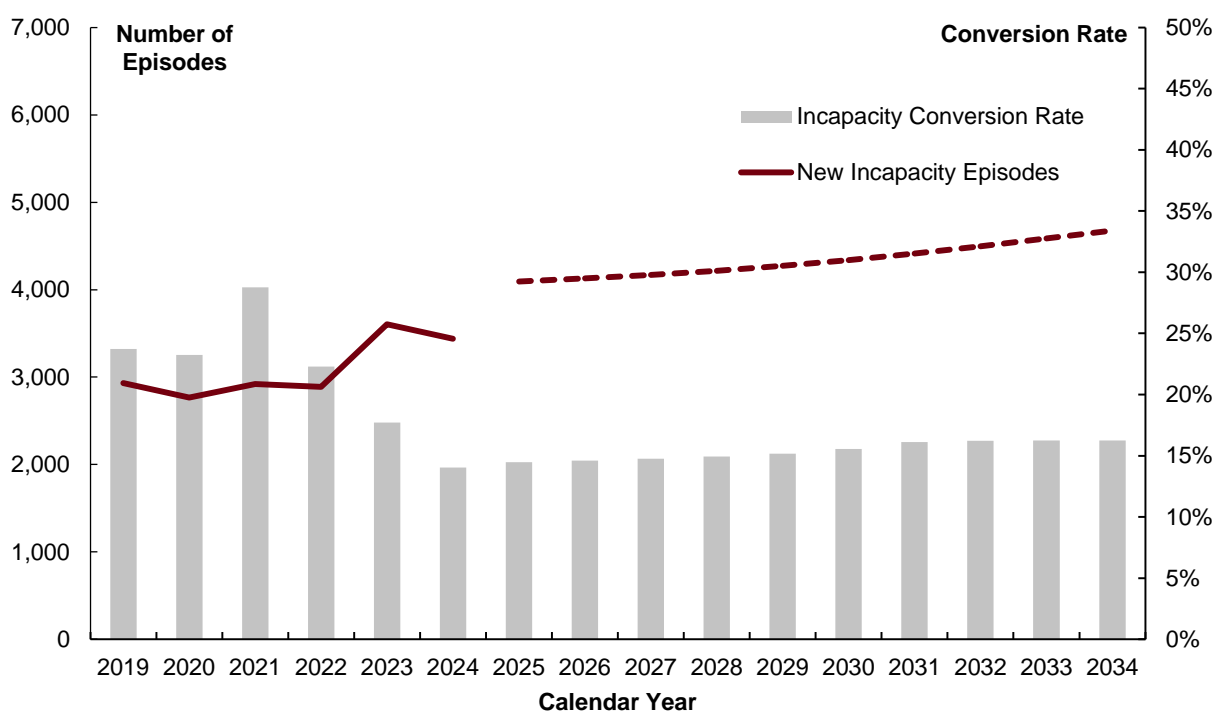
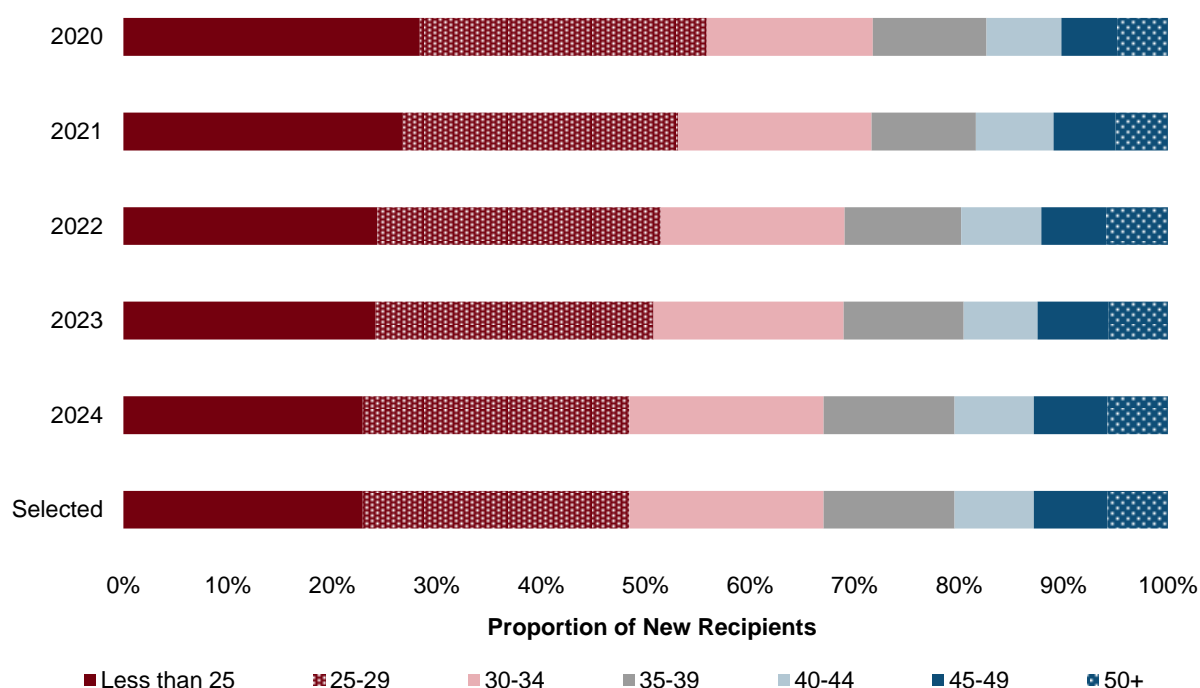


Figure 8.7: Projected IL Claims Accepted and New Incapacity Episodes – MRCA



- 8.4.5 DRCA new incapacity commencement numbers are expected to decline relative to DRCA IL claims accepted over time, reflecting the fact that incapacity benefits do not continue past retirement age whereas there is no age limit on lodging IL claims. For MRCA, the implied conversion rate between IL claim and incapacity is assumed to remain broadly consistent at current levels.
- 8.4.6 Having projected future episode commencements, we need to assign an age distribution to new entrants. Figure 8.8 shows the age at injury distribution of recipients commencing an incapacity episode for the past five calendar years, along with the selected distribution which is based on experience from the previous calendar year. Age at episode commencement is then calculated based on the assigned age at injury and the delay from injury to episode commencement. This takes account of the increasing age of new recipients as duration between incident and claim increases.

Figure 8.8: Age at Injury Distribution for New Incapacity Recipients



- 8.4.7 Continuance rates are then applied to both existing and future episodes to project the number of recipients remaining on incapacity payments in each future period. Continuance rates refer to the probability of remaining on incapacity benefits. The assumed continuance rates have been set based on the duration of the episode and the age of the recipient at episode commencement quantised into three bands: those aged less than 35, those aged between 35 and 49 inclusive, and those aged 50 or more. The Act under which incapacity eligibility has been determined does not appear to significantly impact the exit rates, after controlling for age and duration.
- 8.4.8 In setting the continuance rate assumptions, we have used data from the previous six calendar years with higher continuance rates selected for the first 23 fortnights to reflect the experience of the more recent cohorts. The following three figures show the proportion of recipients still in receipt of benefits at each duration for each age cohort since 2018, along with the selected proportions. Note that the charts show this proportion at each duration for the first 26 fortnights and then at intervals of 26 fortnights (yearly) thereafter.

Figure 8.9: Incapacity Survival Curves – Less Than 35 years Old at Episode Commencement

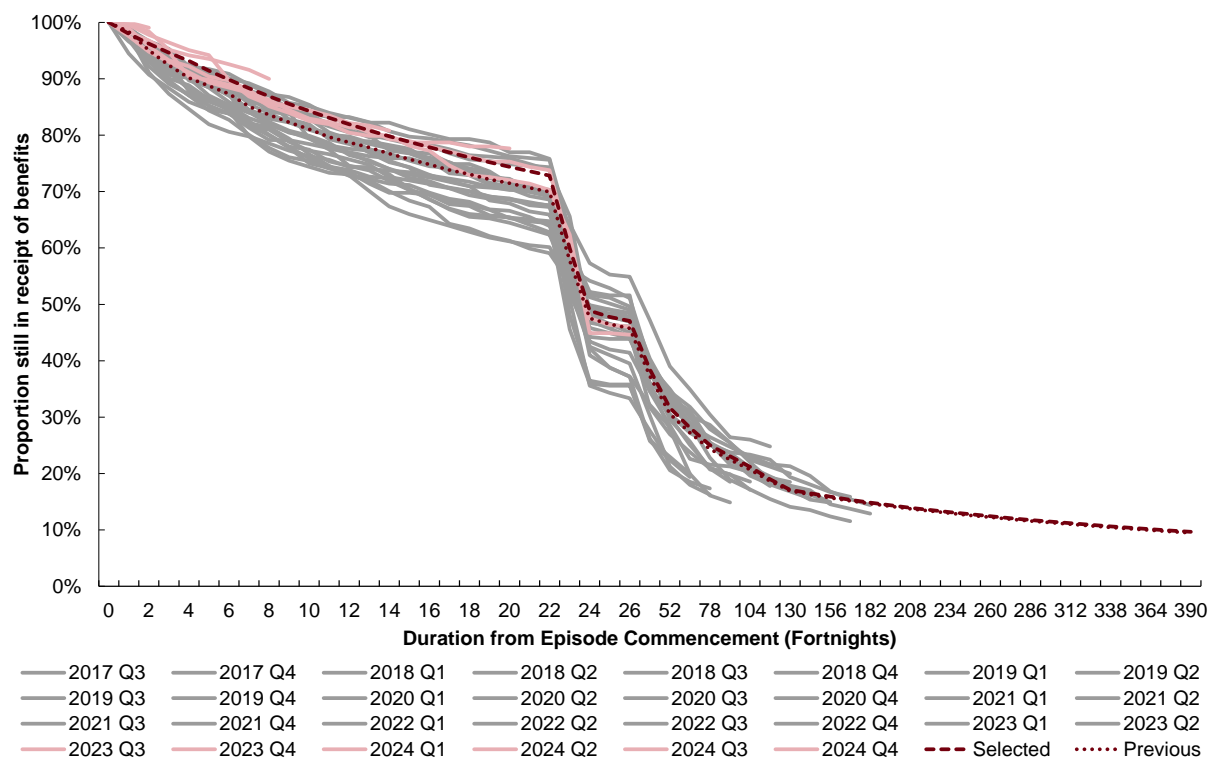


Figure 8.10: Incapacity Survival Curves – 35 to 49 Years Old at Episode Commencement

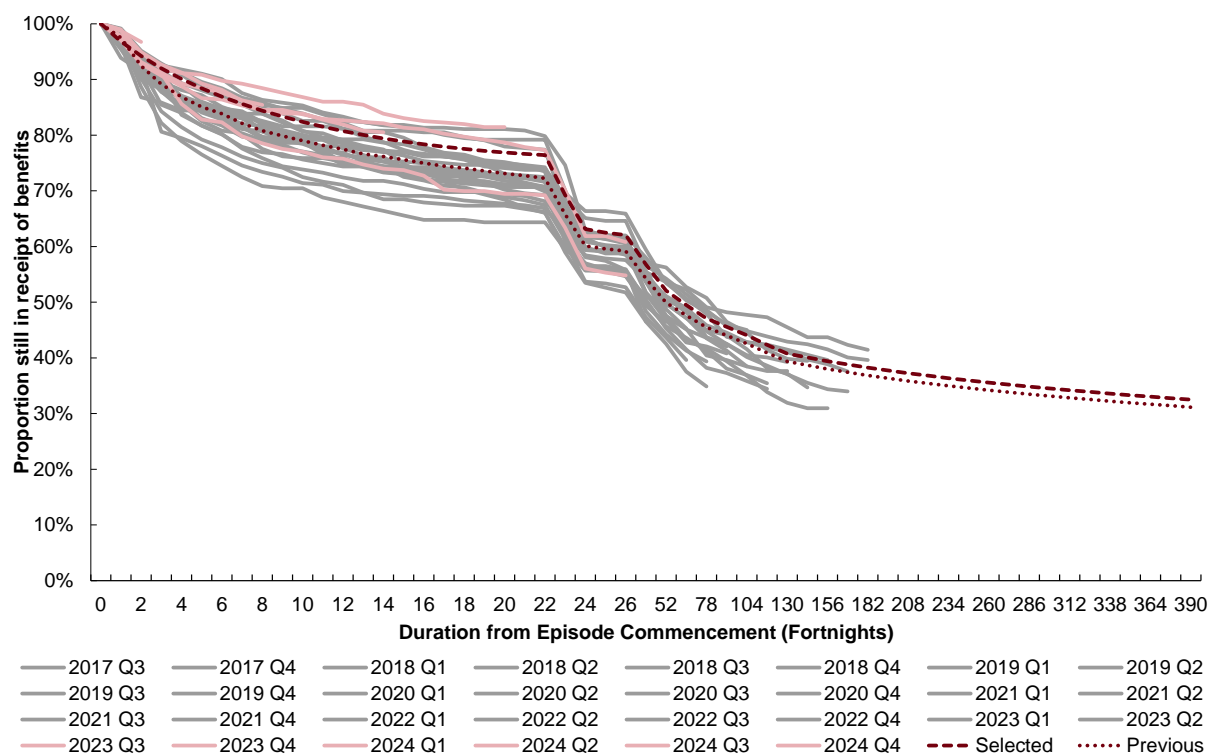
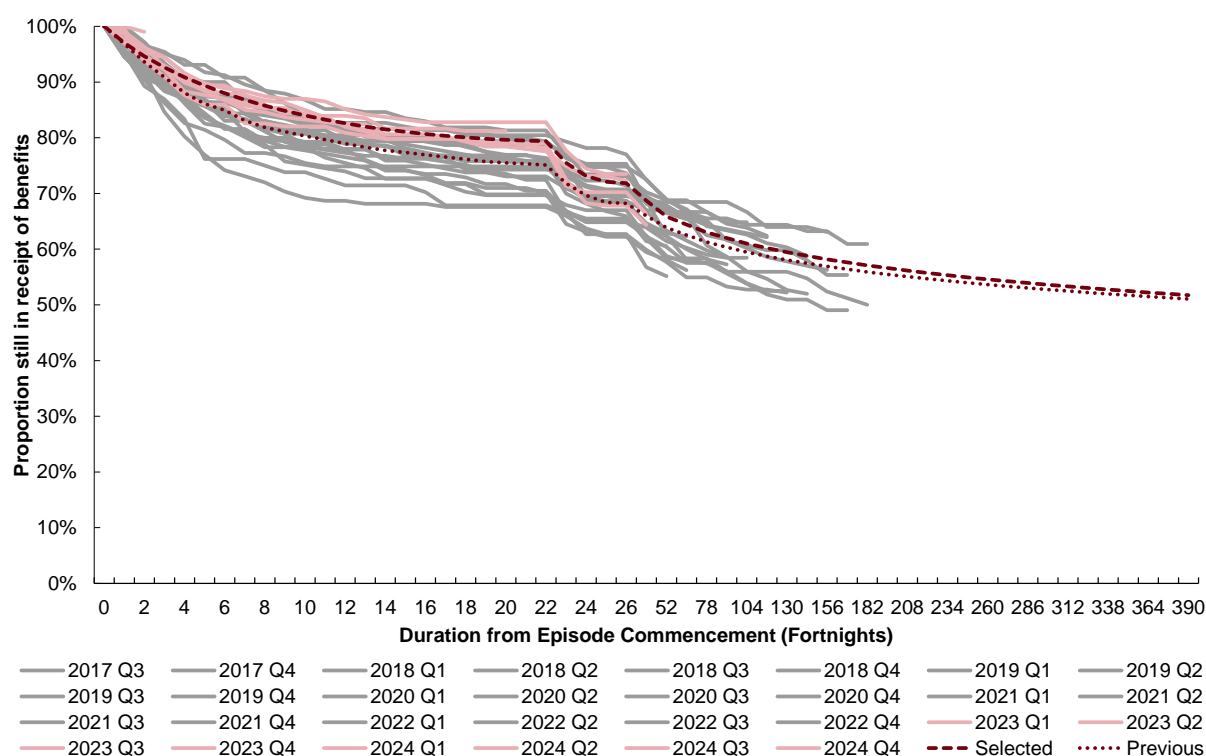


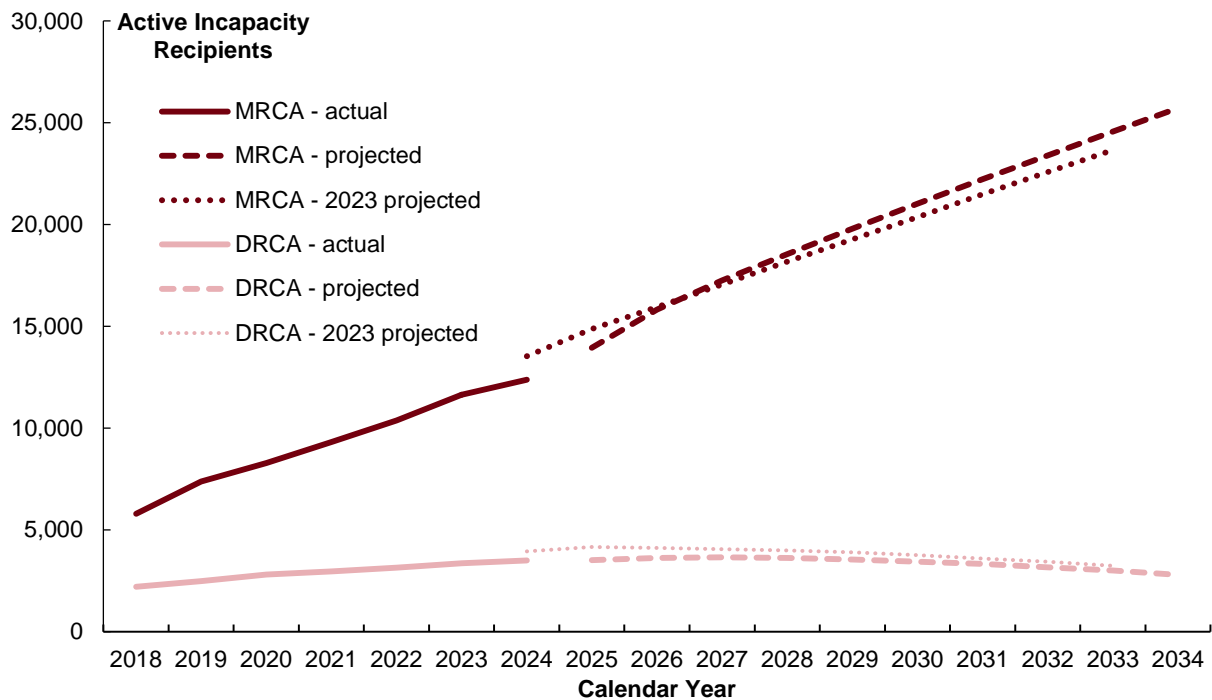
Figure 8.11: Incapacity Survival Curves – Greater Than 49 years Old at Episode Commencement



8.4.9 The proportion of recipients still receiving incapacity payments decreases substantially during the first year on benefits. There is a marked drop in the 23rd fortnight which corresponds to the decrease in the replacement rate from 100 per cent of pre-injury income to between 75 per cent and 100 per cent. From the second year onwards, the probability of ceasing incapacity payments declines with duration. There is a clear difference between continuance rates for each age band at episode commencement. Those aged less than 35 years old at episode commencement have the lowest continuance probabilities while those aged 50 and older have the highest continuance probabilities. This could be driven by a number of factors correlated with age such as injury severity, levels of pre-injury income, employment prospects post injury and the effectiveness of rehabilitation programs. The experience of individual episode commencement quarter cohorts can be volatile, reflecting the uncertainty inherent in the continuance probability assumptions.

8.4.10 Combining the existing incapacity recipient population, the new entrant projection and the assumed continuance rates results in a projection of the future incapacity recipient population, shown in Figure 8.12 for MRCA and DRCA. The projections are lower than that from the previous review over the short term, due to fewer than expected new incapacity commencements in 2024 and a less sanguine outlook on processing capacity relative to the ongoing high level of IL claim lodgements. The number of MRCA incapacity recipients is then expected to surpass the previous projections from 2027 onwards, mainly due to the assumed increase in the continuance rates for all ages.

Figure 8.12: Incapacity Recipient Population Projection



8.5 Valuation Assumptions – Incapacity Payment Rates

- 8.5.1 The final element needed for projecting future outlays is the assumed payment rates, which have also been set based on the recipient's age at episode commencement and the duration of the episode. Age at episode commencement is not a direct determinant of incapacity payment rates but is likely correlated with rank and thus pre-injury income. The Act under which eligibility has been determined does not appear to significantly impact on the fortnightly payment rates, after controlling for age and duration.
- 8.5.2 The following three figures show the payment experience for each age cohort since 2018, along with the selected fortnightly payment rates. Note that historical payment rates have been inflated to 2025 dollars in line with the indexation of ADF salaries.

Figure 8.13: Incapacity Payment Rates – Less Than 35 years Old at Episode Commencement

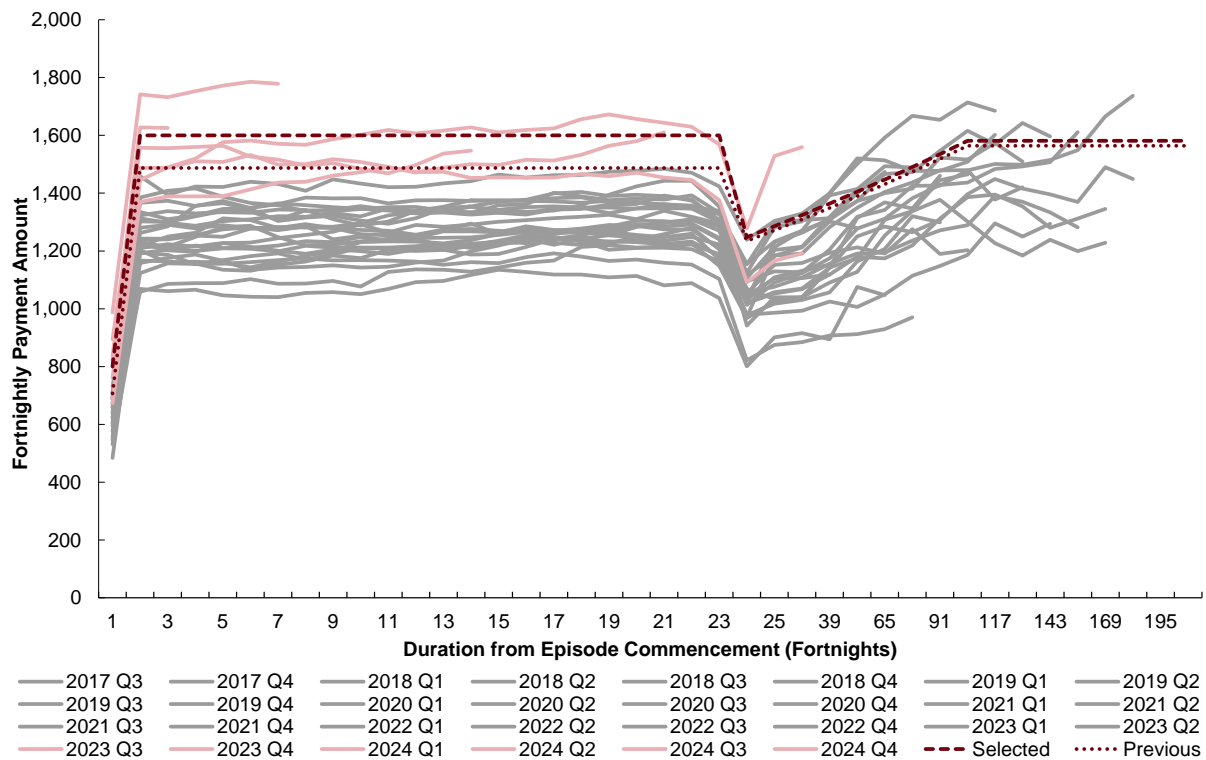


Figure 8.14: Incapacity Payment Rates – 35 to 49 years Old at Episode Commencement

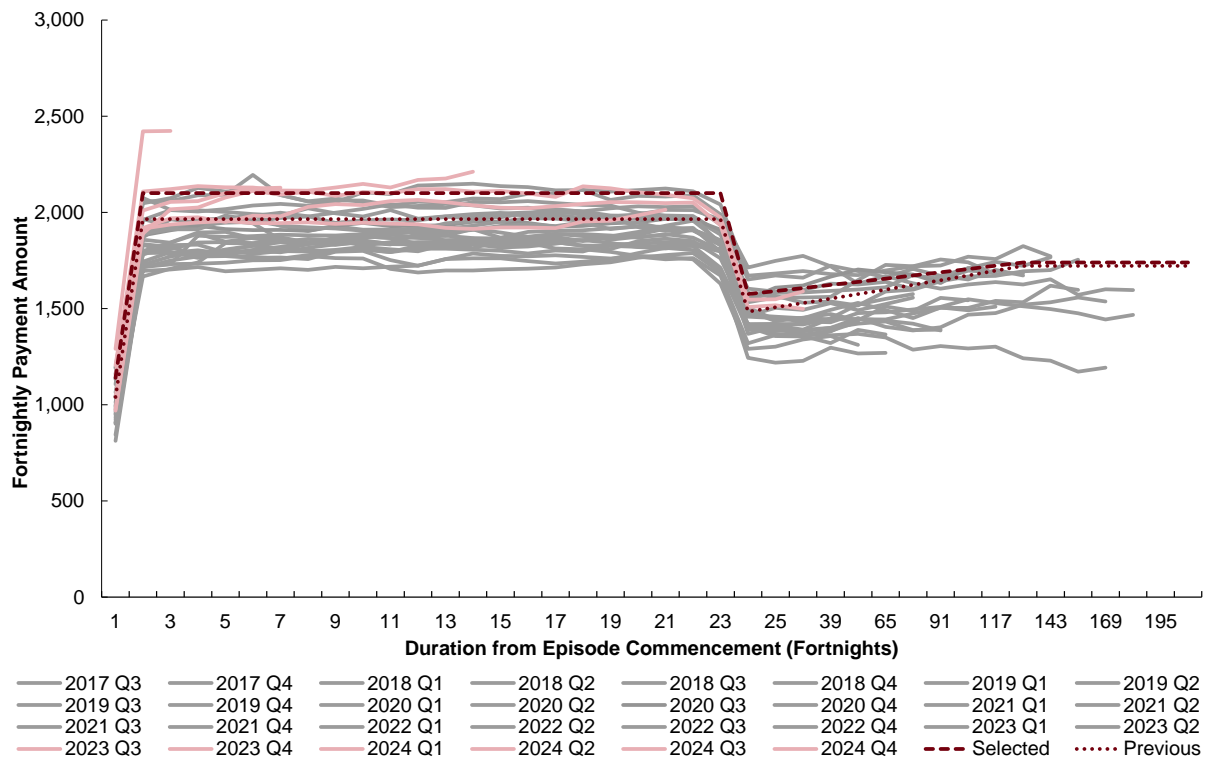
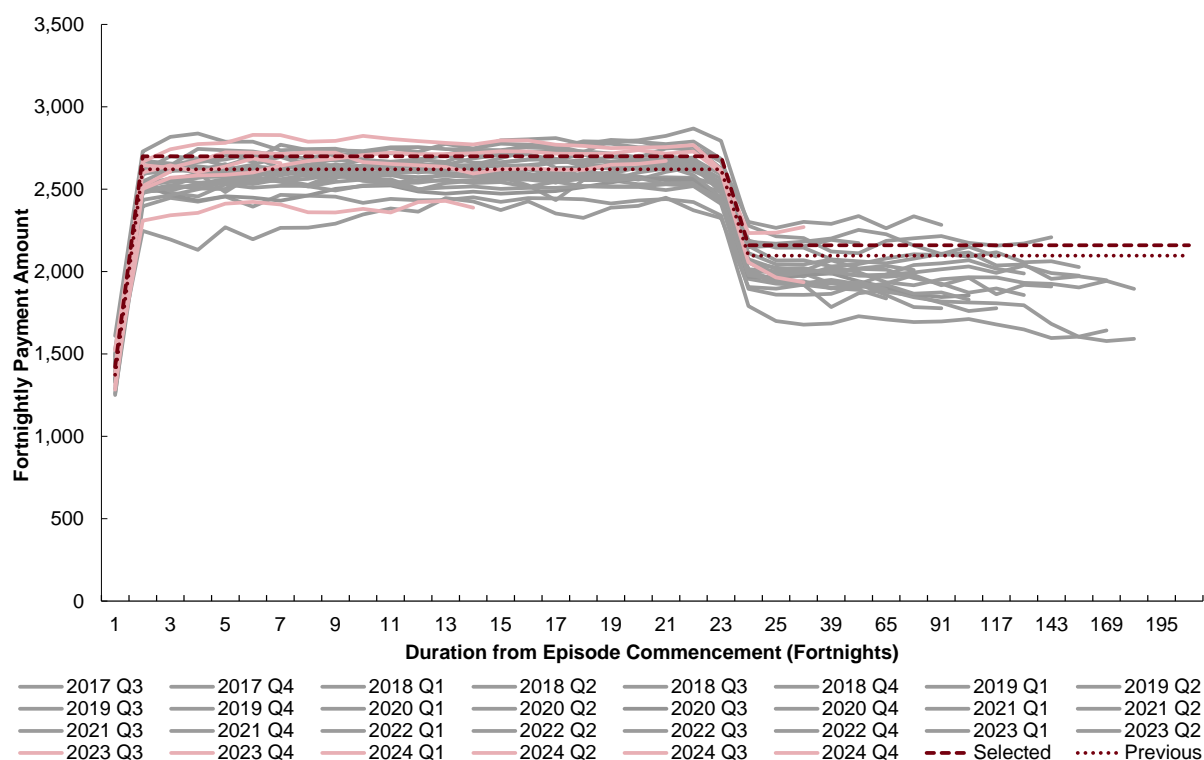


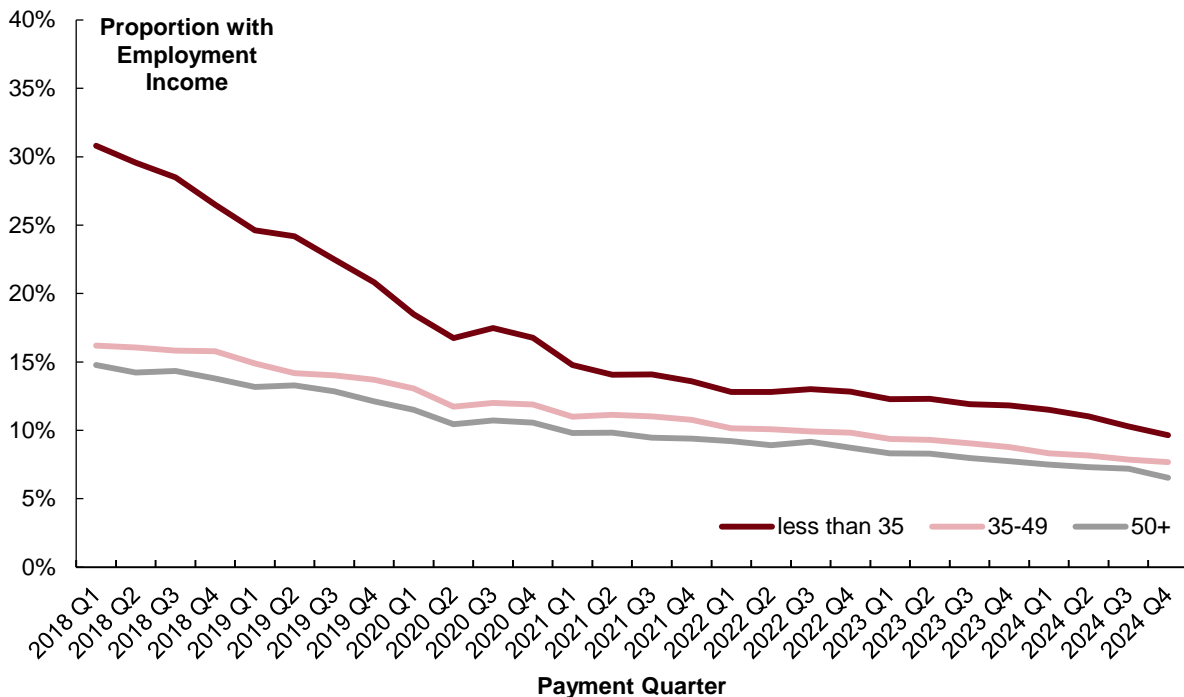
Figure 8.15: Incapacity Payment Rates – Greater Than 49 years Old at Episode Commencement



8.5.3 The payment rates in the first fortnight are around half of that of the second fortnight, as episodes commence in the middle of a pay cycle on average. Payment rates are then relatively stable until 45 weeks when the income replacement rate decreases from 100 per cent to between 75 per cent and 100 per cent of pre-injury income. Interestingly, for those aged less than 50 years old at commencement, and particularly those aged less than 35, we see that average fortnightly payment rates tend to increase over time. There are two likely reasons for this. The first being that capacity to work may deteriorate over time, leading to reduced employment income to be offset. The second is that there is an interaction effect between the amount paid and the propensity to continue receiving fortnightly payments, which would lead to an increasingly biased pool of recipients with higher payment rates over time. To account for this phenomenon, we have allowed the assumed average fortnightly payment rates to increase over time in line with the observed experience. For those aged 49 and older at episode commencement, there is no similar increase observed with duration.

8.5.4 Average incapacity payment amounts have been increasing beyond the rate of inflation in ADF salaries for recipients under the age of 35 at episode commitment, and this is primarily due to a decline in the number of incapacity recipients earning employment income, which would otherwise be offset against their incapacity payments. This may also explain the deterioration observed in the continuance rate experience as recipients not earning any employment income may be less likely to return to full time employment, and thus cease receiving incapacity payments, compared with recipients that are able to work in a partial capacity. Figure 8.16 below shows the proportion of incapacity recipients whose payments were reduced due to employment income by payment quarter. The trend is particularly pronounced for veterans under the age of 35 at episode commencement, where the proportion of incapacity recipients with employment income has decreased from 30 per cent to under 10 per cent over the same period.

Figure 8.16: Proportion of Incapacity Episodes with Employment Income Offset



- 8.5.5 This is a worrying trend, as lower workforce participation for incapacity recipients may be correlated with poorer rehabilitation outcomes, reduced likelihood of returning to full time employment and higher long term incapacity costs (as employment earnings are offset against any incapacity payable). This trend also raises concerns about the effectiveness of DVAs rehabilitation programs which are intended to support veterans to return to work. Anecdotal evidence also suggests that some fee for service advocates may be discouraging veterans from returning to work in order to maximise impairment and lifestyle assessments, (which take into account ability to work) and thus any PI compensation amounts payable.
- 8.5.6 For new episodes, we have applied the assumed fortnightly payment rates. Existing recipients are assumed to continue to receive their current payment rate, with an allowance for these payment rates to change over time in line with the pattern assumed for new episodes. These payment rates are assumed to increase annually in line with wage inflation rates. Specifically, we have adopted the terms of Defence's Workplace Remuneration Arrangement 2023-26 which sets out salary increases of 3.8 per cent in November 2024 and 3.4 per cent in November 2025, with expected long term wage growth of 3.7 per cent assumed thereafter.
- 8.5.7 As previously mentioned, former members with a high level of disability may elect to receive SRDP in lieu of incapacity payments. There also exists a small number of DRCA incapacity recipients that have lifetime entitlements to incapacity payments. These former members are a grand parented group in the legislation whereby they can remain on incapacity payments beyond the retirement age.
- 8.5.8 We have modelled the DRCA lifetime entitlement (currently 24 recipients) and MRCA SRDP (currently 131 recipients) populations using an annuity model. We have made an allowance for future SRDP entrants to emerge, assuming that 1 per cent of future incapacity entrants will elect to receive SRDP. We have also assumed that future SRDP entrants will have the same accident year distribution and average age as incapacity new entrants. While these payments cease if the recipient no longer meets the eligibility criteria, we believe that this is unlikely due

to the high levels of impairment for the SRDP cohort and the advanced age of the DRCA lifetime entitlement cohort. As such, both populations are expected to gradually decline in line with mortality as the only decrement applied.

- 8.5.9 We have assumed that existing recipients will continue to receive their current payment rate. New SRDP entrants are expected to receive an average fortnightly payment rate of \$860 per fortnight. Veterans must seek financial advice before commencing SRDP payments, and reimbursement is available for the costs incurred in obtaining this advice. We have assumed that approximately 8 per cent of veterans that receive financial advice will elect to receive SRDP payments and that the average cost of financial advice is \$2,900.

8.6 Projected Cashflows and Liability Estimate

- 8.6.1 Combining these assumptions yields the projection of cashflows shown in Figure 8.17 and Figure 8.18 for DRCA and MRCA respectively. The projections from the previous year's valuation are included for comparison. The projected payments are gross of any repayments made as a result of superannuation offsets or other debt recoveries.

Figure 8.17: Historic and Projected Incapacity Payments – DRCA

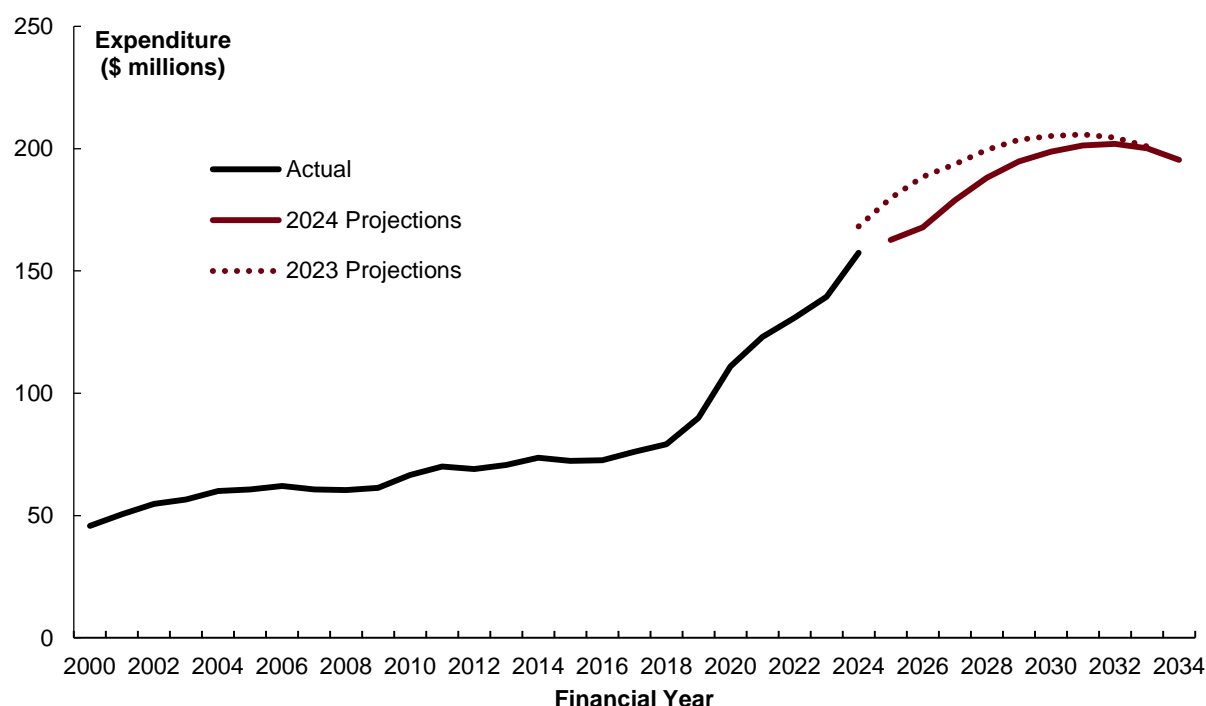
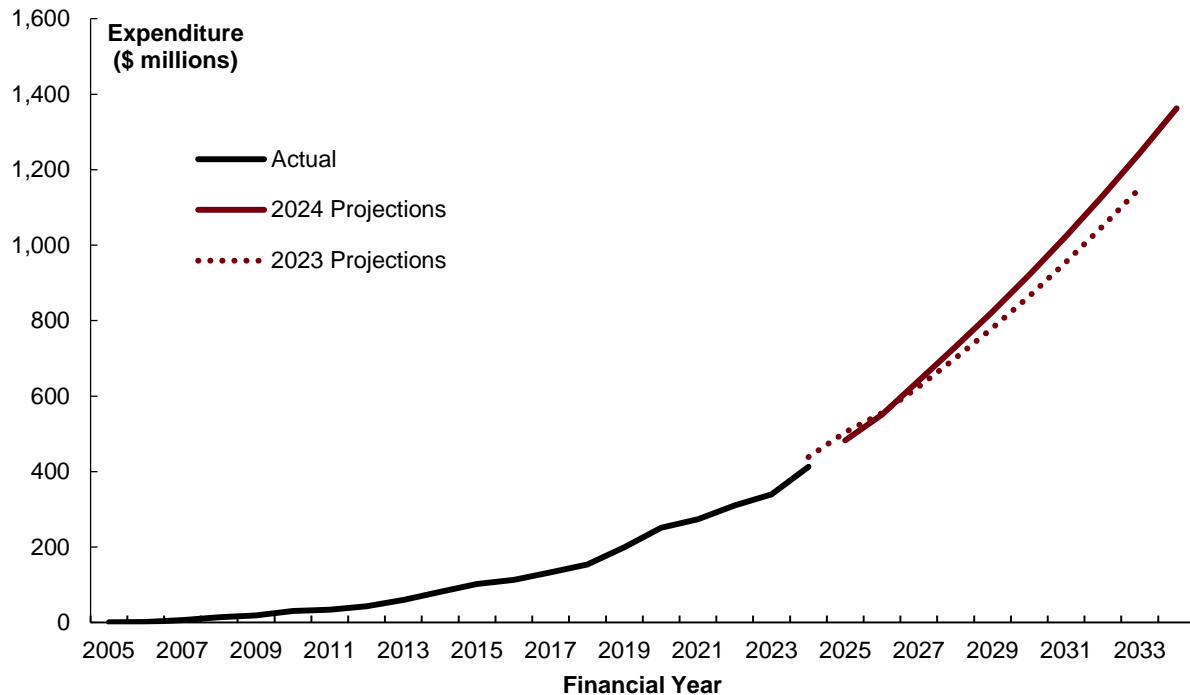
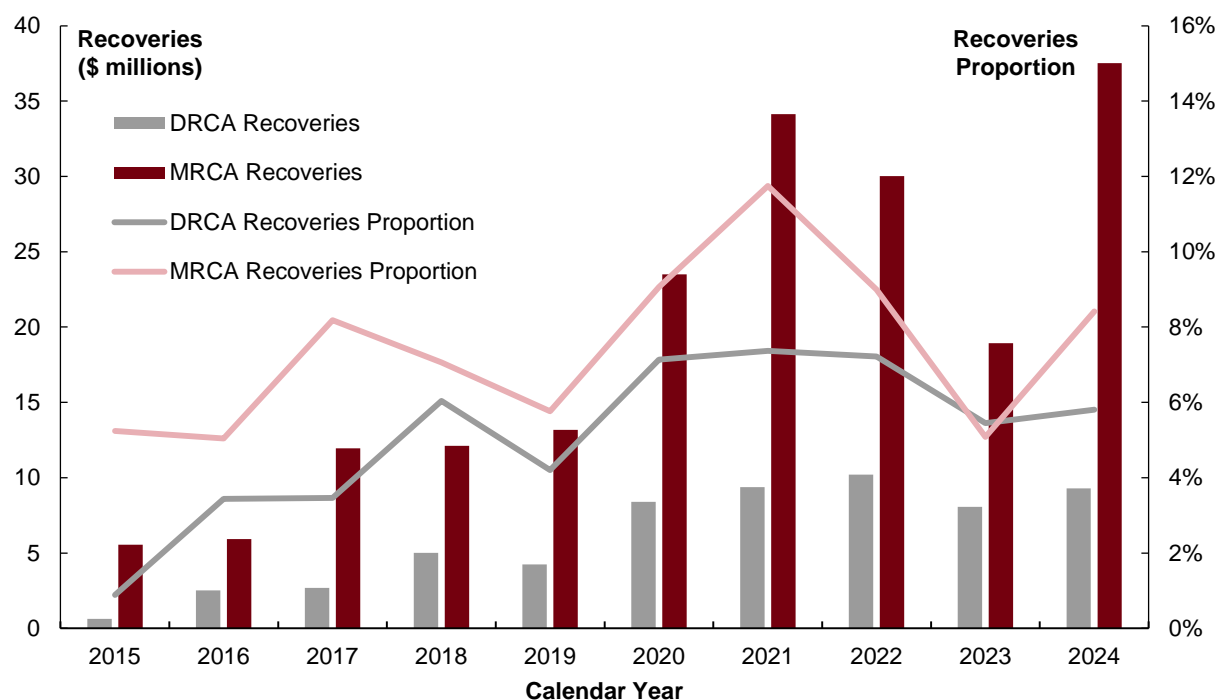


Figure 8.18: Historic and Projected Incapacity Payments – MRCA



8.6.2 The final component of the projection is an allowance for incapacity debt recoveries. Actual employment earnings, superannuation benefits and VEA benefits for the same condition causing the incapacity are offset against incapacity benefits. These offsetting arrangements can give rise to an overpayment of incapacity benefits, for example where evidence of earnings or change of circumstance information has not been provided in a timely manner, an application for retroactive invalidity benefit has been approved or any other miscalculation of incapacity benefits in previous periods has occurred. When an overpayment has occurred, DVA will raise a debt to be recovered. There are various mechanisms available to DVA to recover overpayments, including deductions to other DVA pensions or lump sum payments, recovery from CSC arrears amounts (which is common for veterans receiving a retrospective superannuation invalidity benefit) or repayment by the veteran. DVA cannot garnish wages or tax refunds to recover a debt.

8.6.3 We received unit record incapacity repayments data that sets out the repayment date and amount received by DVA. Figure 8.19 shows the amount of incapacity recoveries received since 2015, for DRCA and MRCA. Recoveries received are quite volatile from year to year. For this valuation, we have selected a recoveries rate of 6 per cent and 7 per cent for DRCA and MRCA respectively.

Figure 8.19: Incapacity Debt Recoveries


8.6.4 Table 8.1 shows the current estimate of the liability broken down by year of accident together with the liability estimated in the 2023 valuation. The estimated liability values, gross of recoveries, have also been included, to satisfy the requirements of PS302. In the 2023 valuation, we projected a liability as at 30 June 2023 of \$13,800.1m. The revised estimate of the liability is \$14,515.0m, which is \$714.9m higher than projected. Table 8.2 provides a reconciliation between the liability estimate as at 30 June 2023 and the current estimate at 30 June 2024.

Table 8.1: Outstanding Claims Liability as at 30 June 2024

Year of accident	Liability (\$m)		
	DRCA	MRCA	Total
1989 and before	126.5		126.5
1990 – 1994	298.3		298.3
1995 – 1999	778.7		778.7
2000 – 2004	855.6		855.6
2005 – 2009		1,015.7	1,015.7
2010 – 2014		2,371.8	2,371.8
2015 – 2019		3,913.1	3,913.1
2020 – 2024		5,155.3	5,155.3
Total	2,059.1	12,455.9	14,515.0
Total (gross of recoveries)	2,190.5	13,393.4	15,583.9
<i>Expected at 30/06/2024</i>	<i>2,095.5</i>	<i>11,707.6</i>	<i>13,800.1</i>

Table 8.2: Reconciliation of Liability Estimates for Incapacity Payments

	DRCA	MRCA
Liability estimate as at 30 June 2023 (previous valuation)	2,145.5	10,623.1
Assumed interest	103.4	544.5
Notional premium	-	947.8
Projected payments	(156.5)	(407.7)
Liability estimate as at 30 June 2024 (previous valuation)	2,092.5	11,707.6
Experience effects and assumption changes		
Change due to experience	(159.6)	(576.6)
Change due to new entrant projection	36.0	578.0
Change due to new entrant age distribution	(9.7)	51.3
Change due to continuance probabilities	23.3	252.5
Change due to payment rates	54.6	443.0
Change due to recoveries assumption	21.9	-
Current liability estimate	2,059.1	12,455.9

9 MRCA Medical Costs

9.1 Benefit Overview

- 9.1.1 Serving ADF personnel are entitled to medical treatment provided by ADF health services. Thus, DVA typically only becomes involved in providing medical services at the time an individual is discharged⁷. A broad range of health care benefits are available to veterans under the MRCA. These include general practitioner services; medical specialist services such as pathology and radiology; allied health services such as podiatry and physiotherapy; dental care, optical and hearing aids; public and private hospital; subsidised pharmaceuticals; and medical aids and appliances⁸.
- 9.1.2 Veterans entitled to medical benefits under MRCA are issued with one of two types of medical treatment cards. The White Card provides veterans with entitlement to medical treatment, including subsidised pharmaceuticals, for accepted service related conditions, as well as all mental health conditions (for veterans with continuous full time service or certain reserve service). The Gold Card provides veterans with entitlement to clinically required treatment for all medical conditions, regardless of whether the condition is related to defence service. Veterans may also receive reimbursements for medical expenses privately incurred.
- 9.1.3 Veterans may receive a MRCA Gold Card if they:
- have impairment points of at least 60 from service related conditions; or
 - have impairment points of at least 50 from service related conditions and are eligible for the Special Rate Disability Pension.
- 9.1.4 A wholly dependent partner, eligible young person or other dependent who is eligible for compensation in respect of a veteran's death under MRCA may also receive a Gold Card.

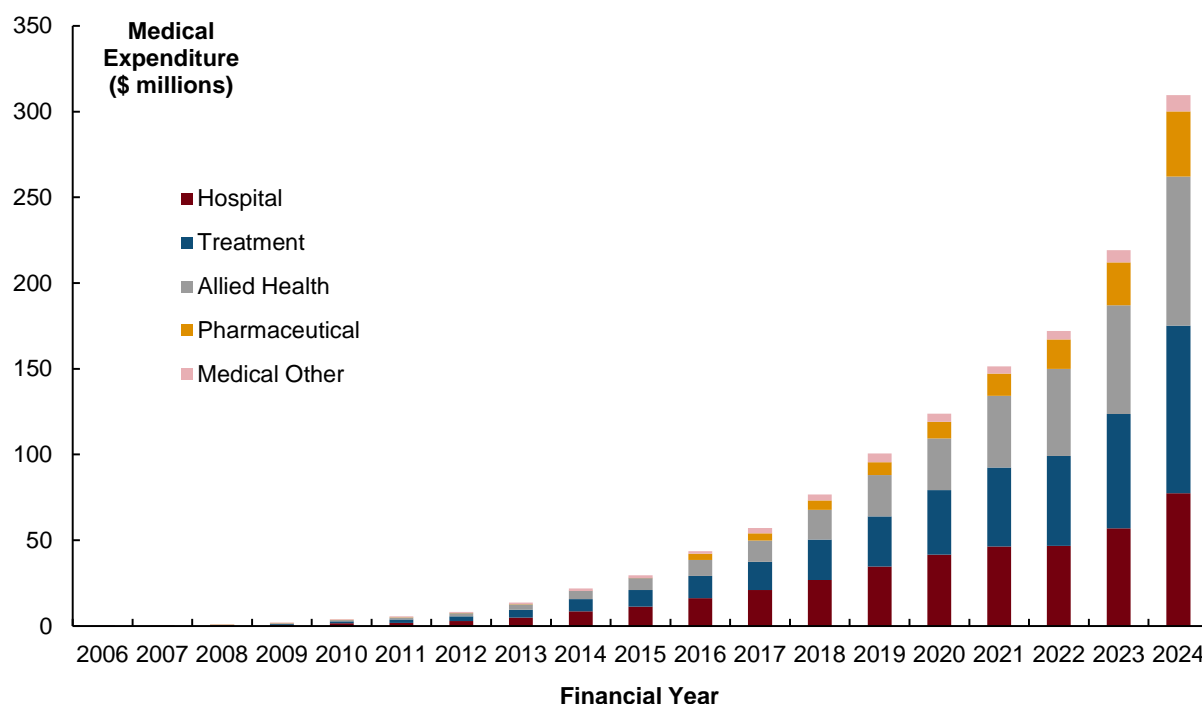
9.2 Recent Experience

- 9.2.1 Figure 9.1 shows MRCA expenditure with the outlays for pharmaceutical benefits separately identified. Outlays grew very slowly over the early years of operation of the scheme but have increased rapidly over the last few years with an increase of 41 per cent in the latest financial year. The largest component of increase was in pharmaceutical benefits, where expenditure increased by over 50 per cent from 2023 to 2024. Over the period from 2022 to 2024, pharmaceutical expenditure increased significantly as a proportion of total medical expenditure. Discussions with DVA program areas have highlighted that this growth has been driven by increased take-up of medicinal cannabis for treatment of chronic pain amongst veterans. This is discussed in further detail later in this chapter.

⁷ An exception applies for reservists whose health care costs related to a compensable injury may be covered by DVA.

⁸ Note that aids and appliances benefits have been modelled separately as described in Chapter 12.

Figure 9.1: MRCA Medical Expenditure



9.2.2 Figure 9.2 shows the MRCA medical expenditure separated by card type. Payments have been allocated based on the claimant's card eligibility within the year. Gold Cards originally contributed a relatively small proportion to overall MRCA Medical outlays. Since 2013 however, expenditure arising from Gold Cards has exhibited substantial growth, reaching 73 per cent of MRCA medical outlays in the 2024 financial year. Figure 9.3 provides further insights into the experience over this period. The proportion of medical claimants with a Gold Card increased gradually from 2010 to 2017, with growth accelerating from 2017 onwards. In the most recent financial year, around 45 per cent of claimants accessing medical benefits had a Gold Card.

Figure 9.2: MRCA Medical Expenditure by Card Type

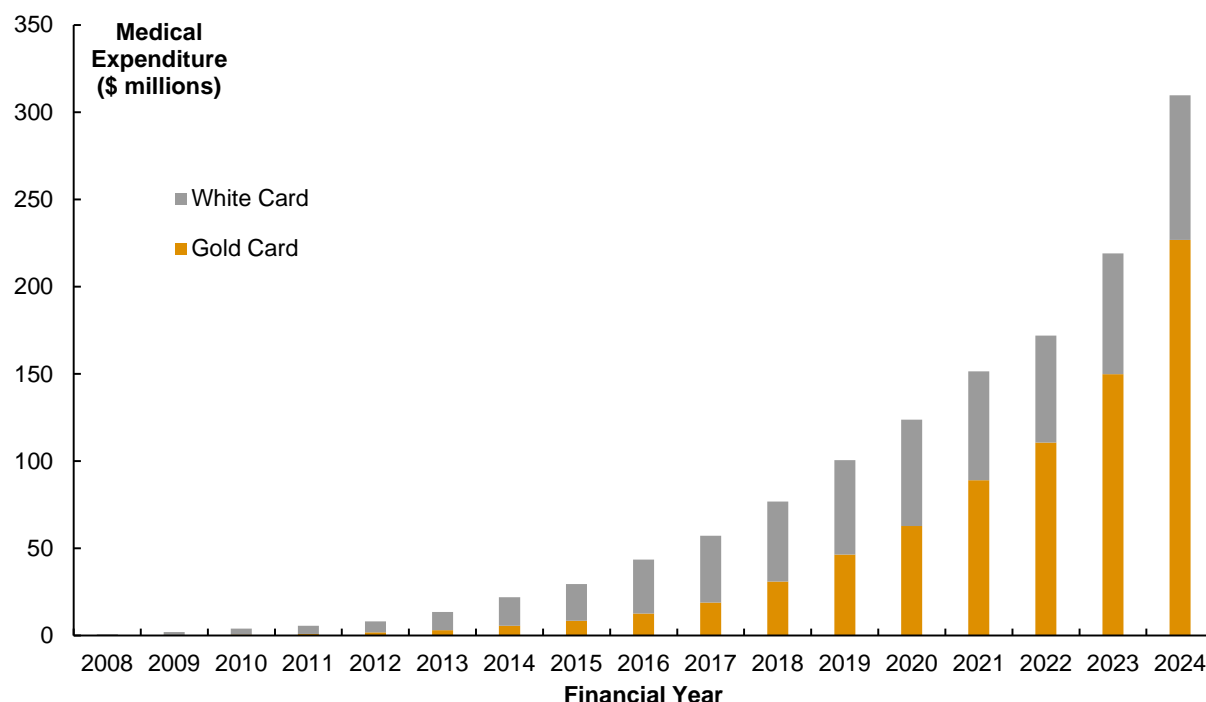
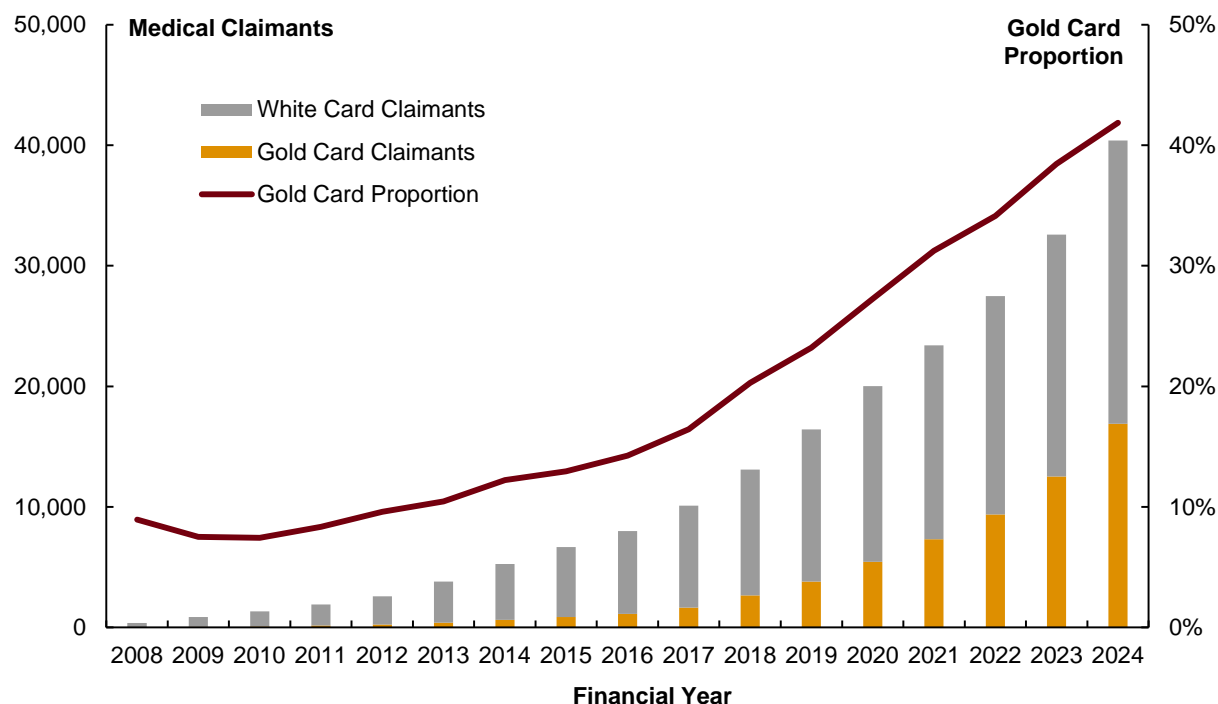


Figure 9.3: MRCA Medical Claimants by Card Type



9.3 Modelling Approach

9.3.1 A person-level deterministic projection model has been employed to estimate future medical costs by projecting the number of active claimants and the medical costs incurred by active claimants in each future period. The model projects both the existing population of medical recipients as well as a further population of potential claimants who have already suffered an

incident that could be expected to lead to future medical expenditure but have not incurred any such expenditure to date. Utilisation rates are assumed to vary by card type and duration from first medical payment, and the average cost per active medical claimant assumption takes into account the age of the veteran as well as the card type.

- 9.3.2 Historically, we did not make a distinction between Gold Card and White Card entitlements, adopting overall average cost and usage assumptions to model medical expenditure in aggregate. This approach was originally adopted as the number of MRCA veterans with Gold Card entitlements was small, and there was limited experience to derive separate assumptions that vary by card type. Over the past few years however, the number of MRCA veterans with Gold Card entitlements has increased substantially, largely driven by the increase in the number of veterans reaching higher levels of whole person impairment in PI.

- 9.3.3 In 2022, we received additional data from DVA setting out a list of White Card and Gold Card holders including card issue dates. This data allowed us to investigate the experience of White Card and Gold Card holders separately. Experience varies substantially by card type, reflecting not only the expanded range of benefits available under a Gold Card, but also the higher levels of impairment associated with Gold Card eligibility. The average size across all age groups is higher for veterans with Gold Card entitlements, and claimants with Gold Cards are more likely to utilise their card on an ongoing basis.

- 9.3.4 This led us to revise our methodology for modelling future MRCA medical costs for the 2022 valuation. This revised methodology projects the proportion of medical recipients with Gold Card entitlements in each future period, based on assumptions that vary by duration from first medical payment. Separate utilisation rate and average cost per active claimant assumptions by card type are also used to reflect differences in usage patterns between the two cohorts. We have again received this card data for the 2024 valuation and have continued to explicitly model both White Card and Gold Card holders in the valuation.

- 9.3.5 In previous years, a veteran's first injury was used for the purpose of assigning an accident year. Claim rates based on delay from the date of earliest accident were then derived and used to estimate the number of claimants we might expect to see in future who have an earliest accident year prior to the valuation date. An accrual proportion was then applied to the resulting projection to only capture future costs associated with injuries which occurred prior to the valuation date. In the absence of any additional exposure data, we relied on this method to estimate the emergence of future claimants but have found emergence patterns to be increasingly volatile over recent years. Changes in claimant behaviour and administrative processes have led to greater volumes of claims emerging across all accident years. At a high level, for more recent accident years, there are greater numbers of claimants at earlier delays and for older accident years, there are larger numbers of new claimants at longer delays. This could reflect a 'catch-up' effect for older accident years, where increasing awareness and lower barriers to claim have encouraged more veterans to come forward. For newer accident years, greater awareness and on-base activity might be encouraging veterans to seek access earlier than they have in the past. This, in turn, might have a 'bring forward' effect and we might not then expect to see the same level of claimants at later delays as we have seen in the older accident year cohorts. The volatility in recent experience has made selecting reasonable assumptions increasingly difficult.

- 9.3.6 For this valuation, we have considered the relationship between IL claims and entitlement for medical benefits, projecting new medical claimants over the short term as a proportion of IL claims accepted in each year based on the IL claim projections set out in Chapter 5. Approaching the modelling in this way makes intuitive sense as a veteran must first have

liability accepted for their conditions before they are entitled to medical benefits⁹. We have thus assigned accident years for medical claimants based on the average accident date across all conditions from the veteran's most recent IL claim at the point of first medical expenditure, consistent with the accident year basis adopted in the projection of IL claim lodgements set out in Chapter 5. If a person lodges multiple IL claims in the same lodgement year, the average accident date across all conditions lodged within that year is assigned. This approach also has the advantage of directly incorporating an allowance for the current level of open IL claims, the anticipated completion of these claims over subsequent years and the resulting entrance of medical claimants as a result.

- 9.3.7 While we have taken steps to refine the projection for future medical claimants, it is important to emphasise the considerable ambiguity inherent in assigning accident dates for medical claimants. This is because most MRCA veterans have multiple conditions spanning a range of accident years, some of which may be psychosocial conditions where it is not meaningful to assign a single accident date. Furthermore, expenditure is generally incurred through the use of health care cards and the data does not record the particular condition to which a service relates. For those with Gold Cards, all medical expenditure is covered, not just that related to compensable conditions. A high degree of actuarial judgement is required in setting the assumptions.
- 9.3.8 The final change of note is to the average expenditure per active claimant assumption. In previous years, we assumed an average cost in respect of non-pharmaceutical expenditure and applied a loading to the projected cashflows to account for pharmaceutical expenditure in line with the historical relationship between the two components of expenditure. In 2024, we received unit record pharmaceutical transactions data, where previously only aggregate general ledger pharmaceutical payments information had been available. For the 2023 valuation, this new data allowed us to analyse the pharmaceutical experience for White Card and Gold Card holders separately.
- 9.3.9 Substantial growth in pharmaceutical benefits was seen again in 2024, driven by increasing expenditure associated with medicinal cannabis for the treatment of chronic pain conditions. We have been informed by DVA program areas that the take up of these drugs have increased significantly since its addition to the Repatriation Pharmaceutical Benefits Scheme (RPBS), with further growth still expected going forward.
- 9.3.10 For this valuation, we have explicitly modelled future pharmaceutical benefits by setting assumptions for the proportion of active claims utilising benefits and the average cost. The assumptions adopted vary by age and card type. We have analysed the experience in respect of medicinal cannabis separately, with an assumption on the ultimate proportion of veterans that will access medicinal cannabis and additional growth assumed over the short term. The experience of other categories of medical expenditure has also been explored this year for completeness.
- 9.3.11 The MRCA medical model consists of four main components:
- the future medical entrant projection (a projection of veterans first receiving medical benefits in each future period, including their age and accident year);

⁹ This is largely the case for medical benefits under the White and Gold Card. We note that exceptions exist for Non-Liability Health Care (NLHC) and Provisional Access to Medical Treatment (PAMT), where treatment is provided without establishment of liability or prior to the establishment of liability. Costs associated with these programs are not included as part of the MCS.

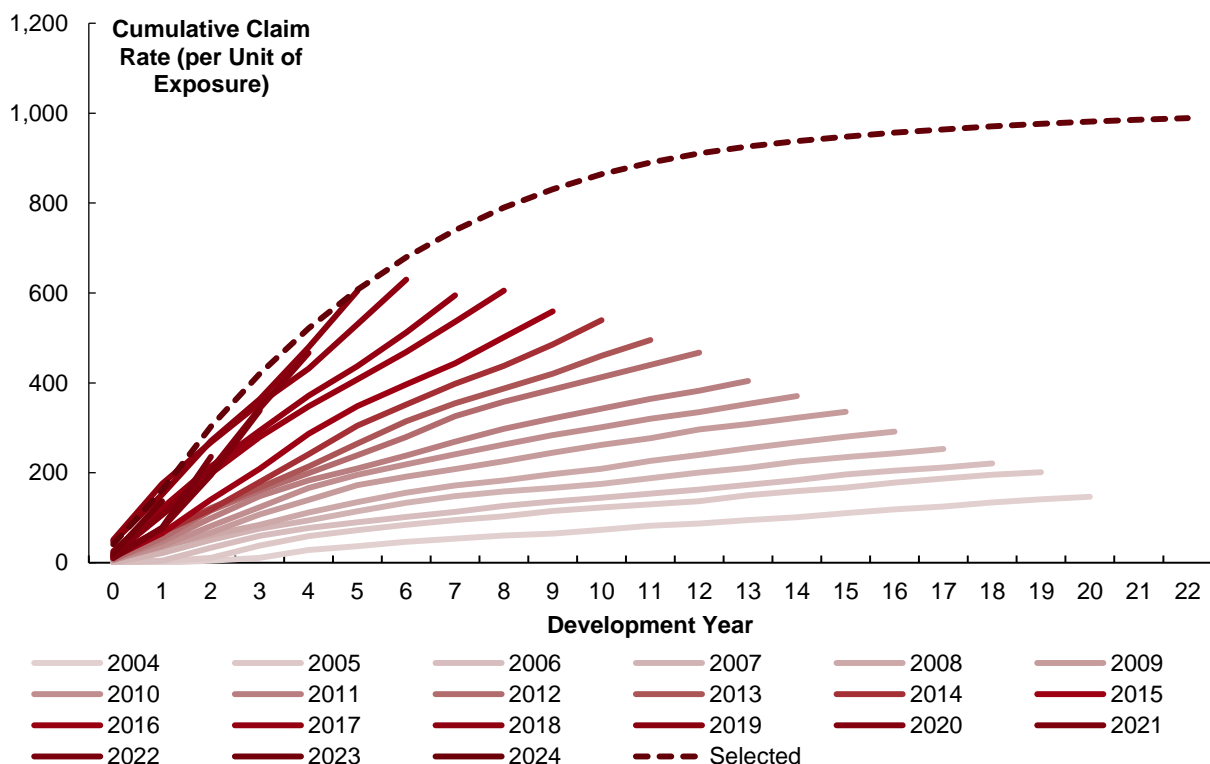
- Gold Card issuance rates (to determine the proportion of veterans with Gold Card eligibility over time);
- utilisation rates (to calculate the number of active claimants that are accessing medical benefits in each future period); and
- the average expenditure per active claimant (to estimate the amount paid to medical recipients in each future period).

9.3.12 Combining the existing medical claimant population, the projection of future medical entrants, the Gold Card issuance rates and the utilisation rates yields a projection of active medical claimants in each period. We allow for mortality to gradually reduce this population over time. The average expenditure per active claimant is then applied to calculate the expected medical costs incurred in each future period. Each model component will be discussed in turn.

9.4 Valuation Assumptions – Active Claimant Projection

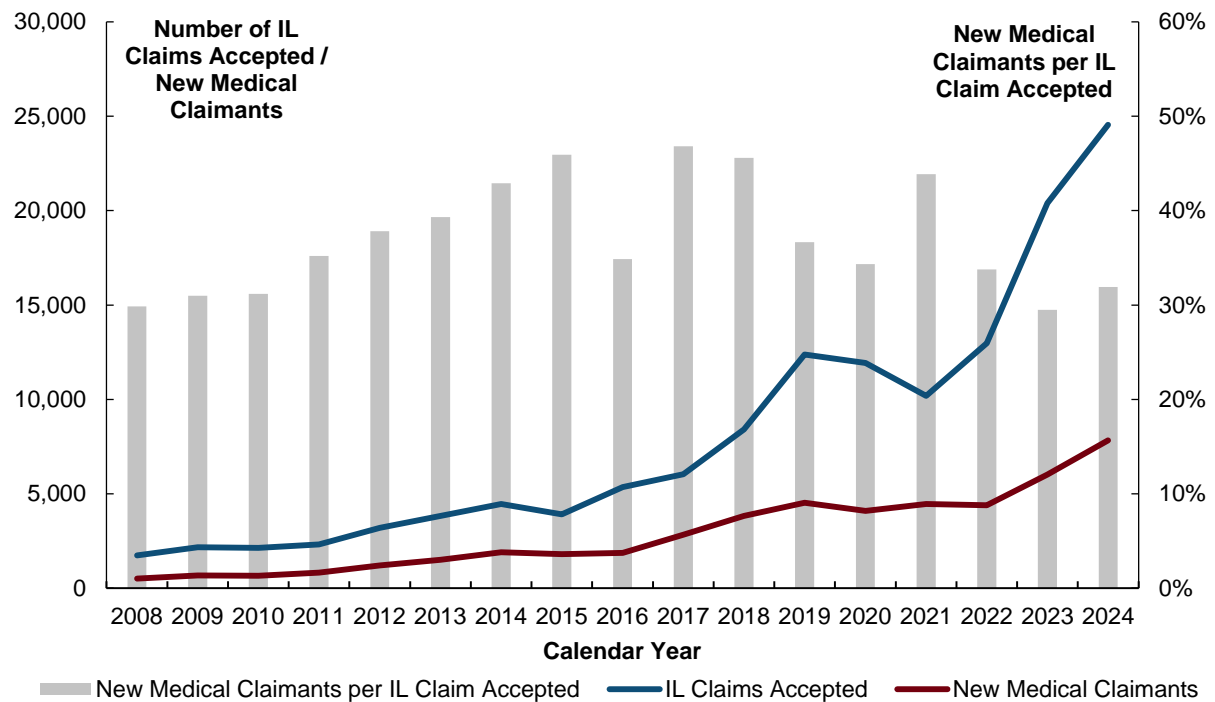
9.4.1 The first component of the active claimant projection is the projection of new medical entrants. Figure 9.4 shows the cumulative rate of new medical claimants, by the delay from accident year to the year in which medical expenditure is first incurred (henceforth referred to as development year). The pattern of claims emerging has changed substantially since the commencement of MRCA. For the more recent accident years, there has been an increase in the number of new claimants emerging only a few years after their first injury. At the same time, older accident years also have new claimants emerging many years after the first injury.

Figure 9.4: Cumulative Rate of New Medical Claimants by Development Year



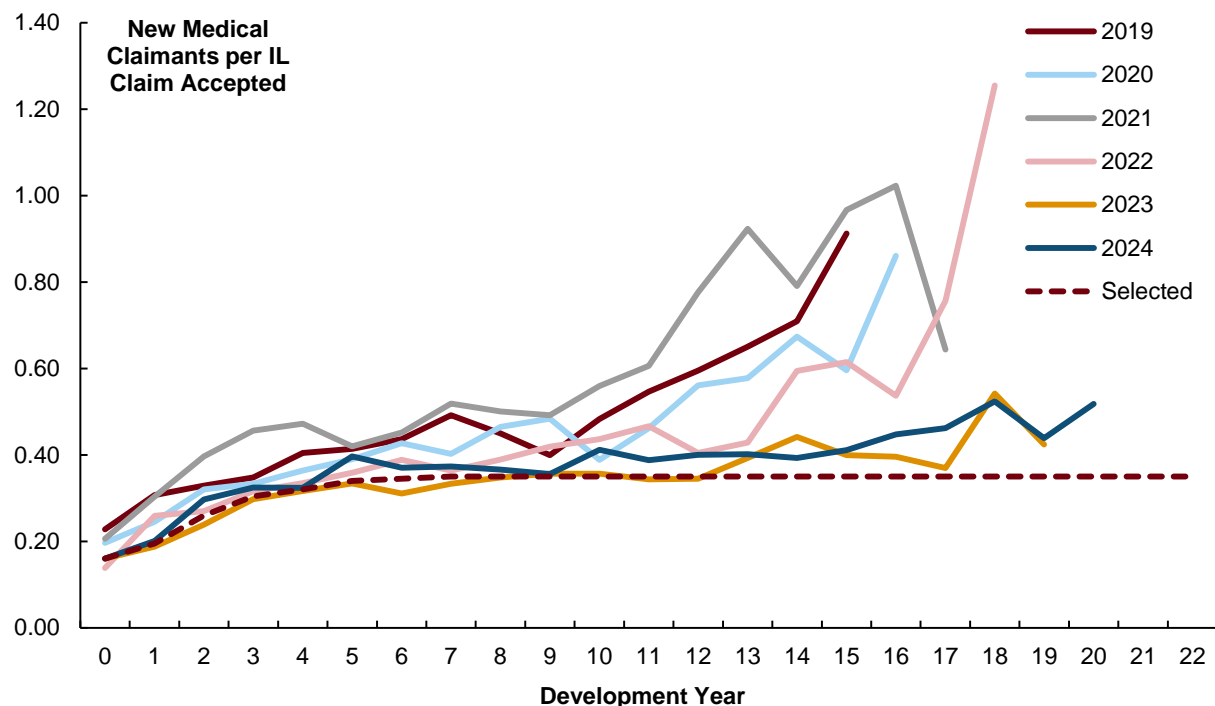
9.4.2 For this valuation, we have considered the relationship between the number of IL claims accepted and the number of new medical claimants each year as shown in Figure 9.5. The number of new medical claimants per IL claim accepted has varied between 30 and 50 per cent, with lower conversion rates observed over the past two years.

Figure 9.5: Number of New Medical Claimants and IL Claims Accepted



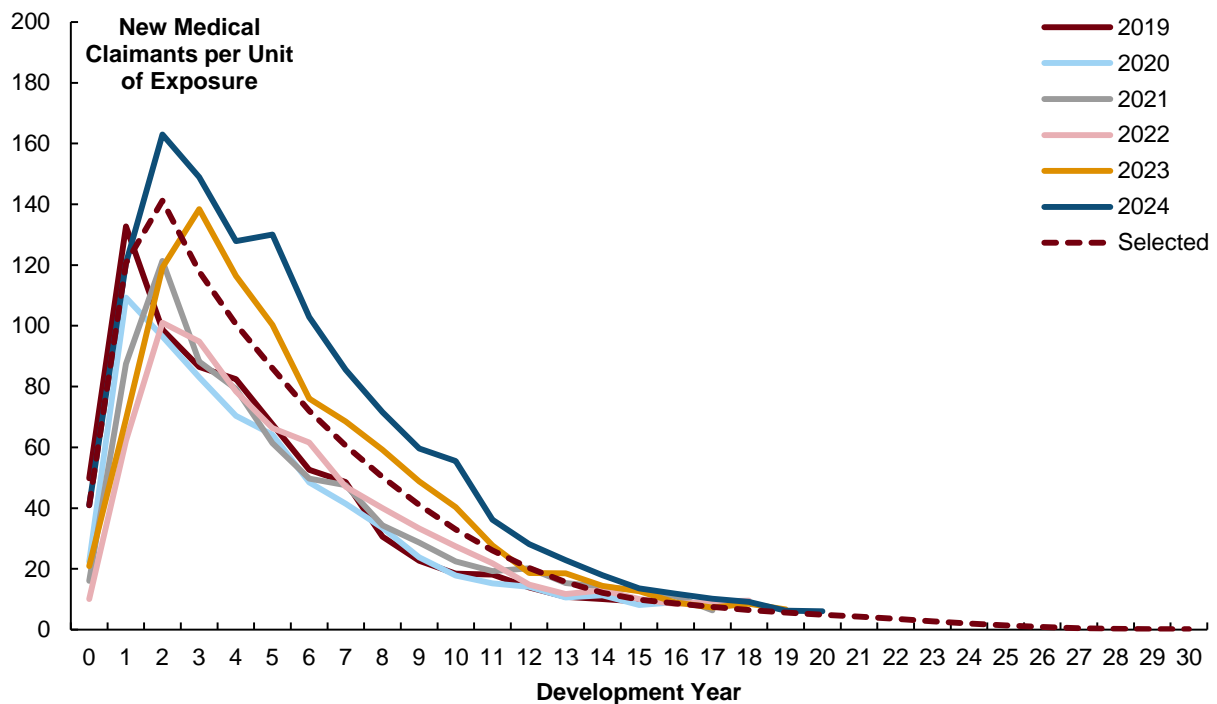
9.4.3 The adopted approach for this valuation projects the number of new medical claimants over the short term as a proportion of IL claims accepted. Approaching the modelling in this way makes intuitive sense as a veteran must first have liability accepted for their conditions before they are entitled to medical benefits. This approach also has the advantage of directly incorporating an allowance for the current level of open IL claims, the anticipated completion of these claims over subsequent years and the resulting entrance of new medical claimants as a result.

Figure 9.6: Rate of New Medical Claimants per IL Claim Accepted



9.4.4 Figure 9. shows the rates of new medical claimants per IL claim accepted by development year, along with the selected rates adopted. The selected rates sit slightly below the current experience at later development years to account for potential changes to the pattern of emergence over time. For example, a veteran injured in 2024 is expected to approach DVA much sooner than someone who was injured in the earliest years of the scheme; we can see some evidence of this trend by comparing the 2019 to 2022 rates with the rates from the last two years. Hence, lower rates of new medical claimants per IL claim accepted are assumed at the later development years compared with historic experience. We have used this approach to project the number of new medical claimants in the 2025 and 2026 calendar years.

Figure 9.7: Incremental New Medical Claimants per Unit of Exposure



9.4.5 For the longer-term projection of new medical claimants, we have calculated incremental rates of new medical claimants per unit of exposure; these are set out in Figure 9.7 below, along with the selected assumption which is applied from the 2028 calendar year onwards. The cumulative claim rate implied by these incremental rates is also shown in Figure 9.4. The resulting accident year total claimant numbers and the calendar year new medical claimant projections are shown in Figures 9.8 and 9.9 respectively.

Figure 9.8: Projected Ultimate Medical Claimants by Accident Year

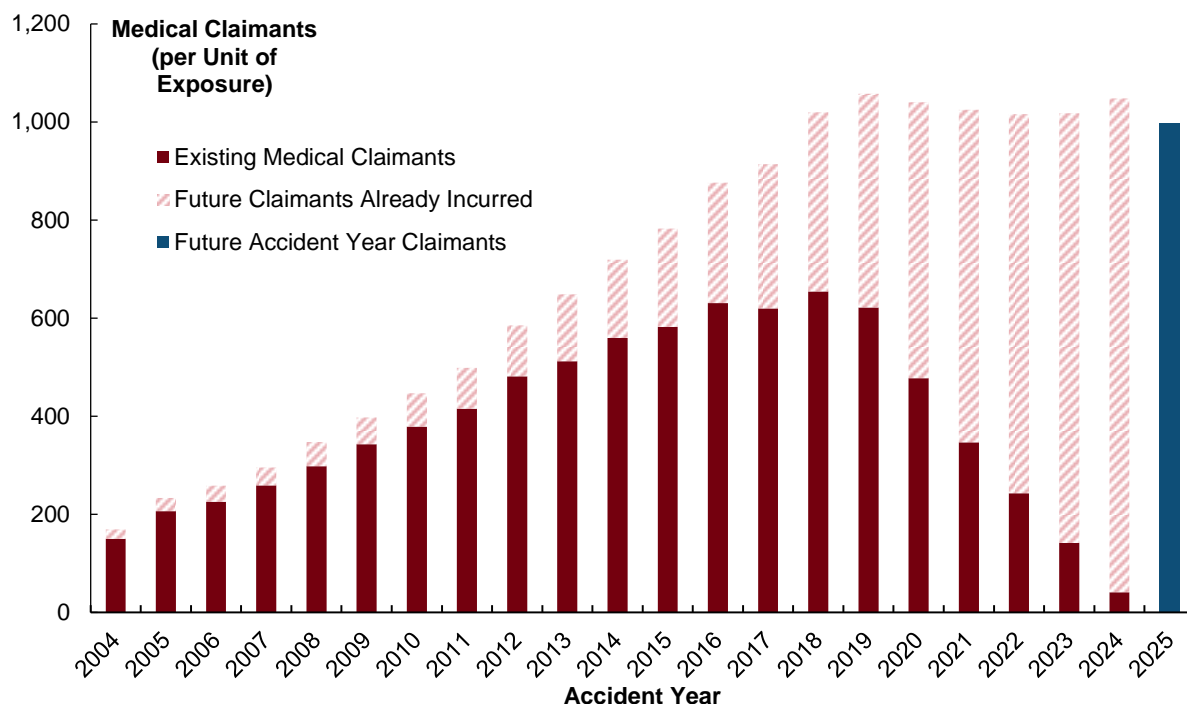
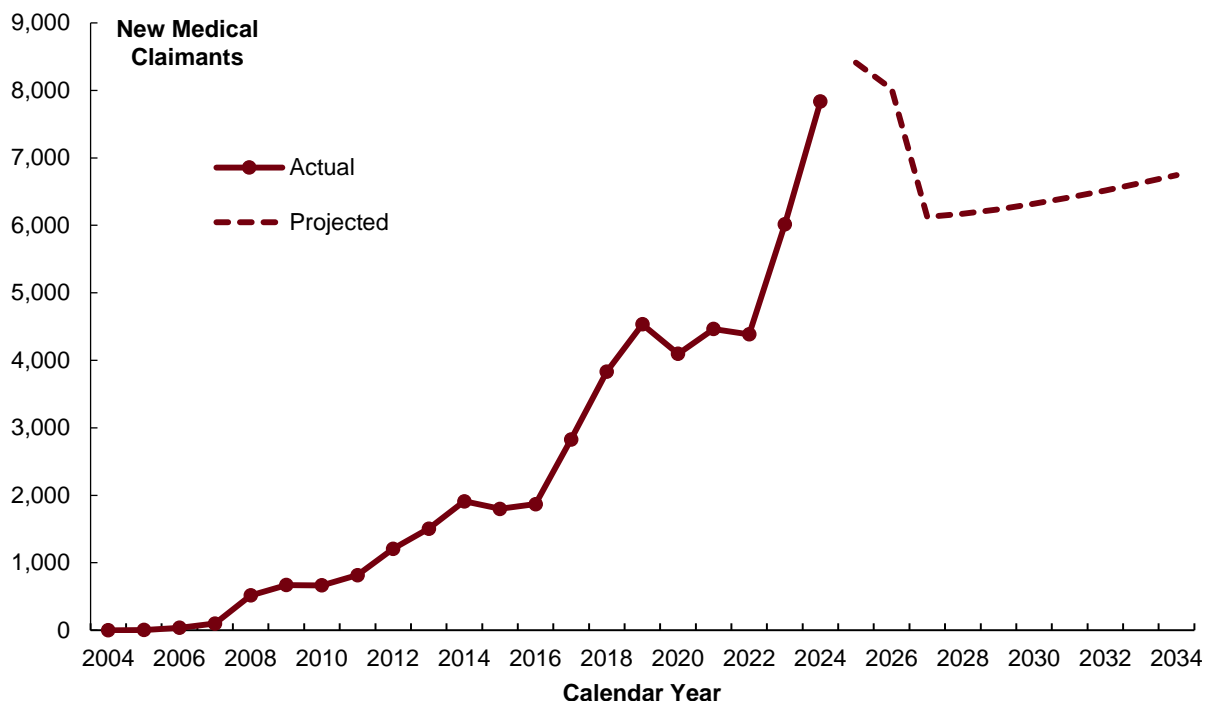


Figure 9.9: Projected New Medical Claimants by Calendar Year

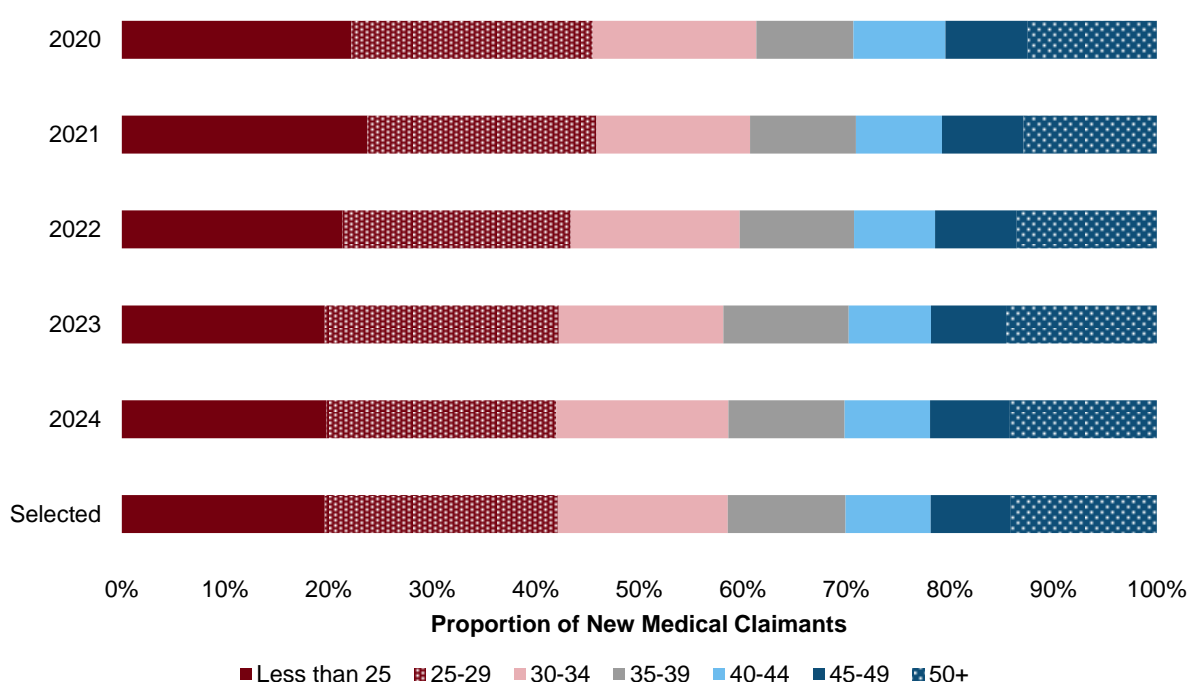


9.4.6 We note that there is a very high level of uncertainty inherent in the medical new entrant projection and it might be some time before experience is mature enough to set development factors with more certainty. Our limited access to exposure data also hinders any further analysis on potential claimant emergence patterns. While we have access to the number of serving members in each accident year from publicly available information, we currently do not have access to data relating to dates of separation or reason for separation. Such information could be used to support the new entrant projections in the future and elucidate

the underlying exposure to some extent, for example by considering the delay from separation to first medical expenditure or the separation type (in particular medically discharged members).

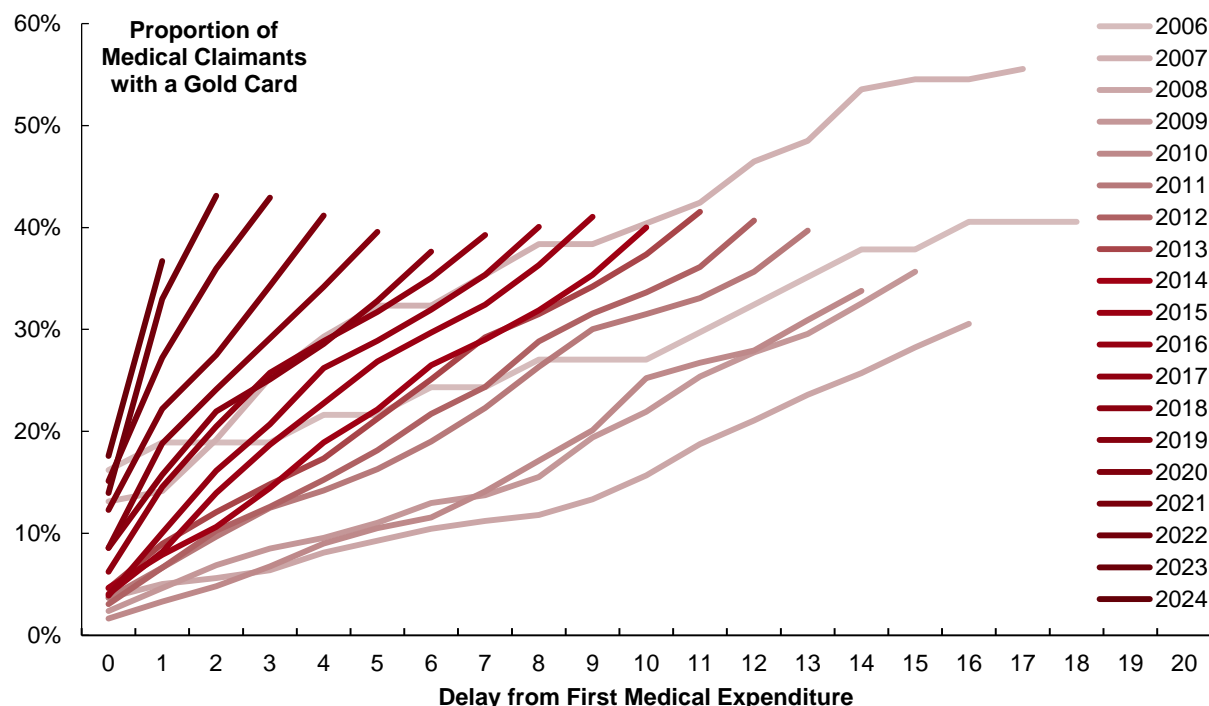
- 9.4.7 Having projected the number of future medical new entrants, we need to assign an age distribution to new entrants. Figure 9.10 shows the age at injury distribution for veterans first accessing medical benefits in each of the past five calendar years, along with the selected distribution which is based on experience over the same period. We have assumed a minimum age at injury of 16, and a maximum age at injury of 64 based on the compulsory retirement age for the ADF. Age at first medical payment is then calculated based on the assigned age at injury and the delay from injury to entry into medical. This takes account of the increasing age of new entrants as duration between incident and claim increases.

Figure 9.10: Age at Injury Distribution for New Medical Claimants



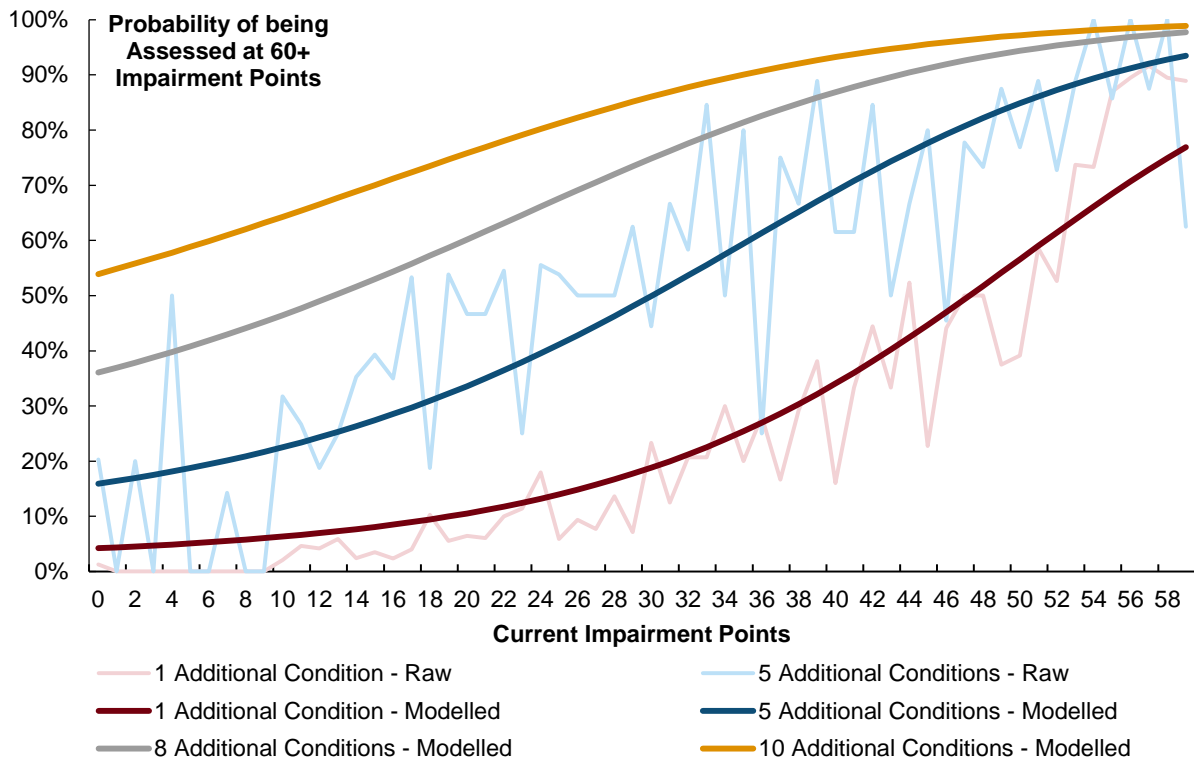
- 9.4.8 The next component of the model is a projection of the proportion of medical claimants with a Gold Card over time. Most Gold Cards are issued as a result of the veteran being assessed at 60 impairment points, or 50 impairment points if the veteran has SRDP eligibility. As such, it may take medical claimants several years to accumulate the level of impairment points required for Gold Card eligibility. Figure 9.8 shows the cumulative proportion of medical recipients with a Gold Card by duration from first medical expenditure and entry year cohort. The pattern of issuance has changed considerably over the period presented. Older cohorts displayed low issuance rates initially, but have exhibited significantly higher issuance rates at later durations. Conversely, more recent cohorts are seeing higher issuance rates at earlier durations. This likely reflects policy changes within DVA as well as the growth observed in PI claims over recent years. A considerable number of Gold Cards have been issued in the last year.

Figure 9.11: Proportion of MRCA Medical Claimants with a Gold Card by Duration from First Medical Expenditure



9.4.9 As with the previous valuation, we conducted additional analysis to quantify the potential impact the currently outstanding IL and PI claims may have on the whole person impairment ratings of existing medical claimants. We received additional MRCA PI conditions data from DVA which describes the relative contribution of each accepted IL condition to the PI impairment point assessment. This allowed us to examine the relationship between the number of conditions assessed and resulting changes to impairment point scores. Specifically, we utilised a generalised linear model to model the probability of being assessed as having 60 or more impairment points (which would grant Gold Card eligibility), based on a veteran's current level of impairment as well as the number of outstanding PI claims and IL conditions yet to be finalised, using experience data from the past two year. Figure 9.9 shows the raw data for veterans with two and five additional conditions assessed in a PI claim and modelled probabilities for veterans with a wider range of additional conditions assessed.

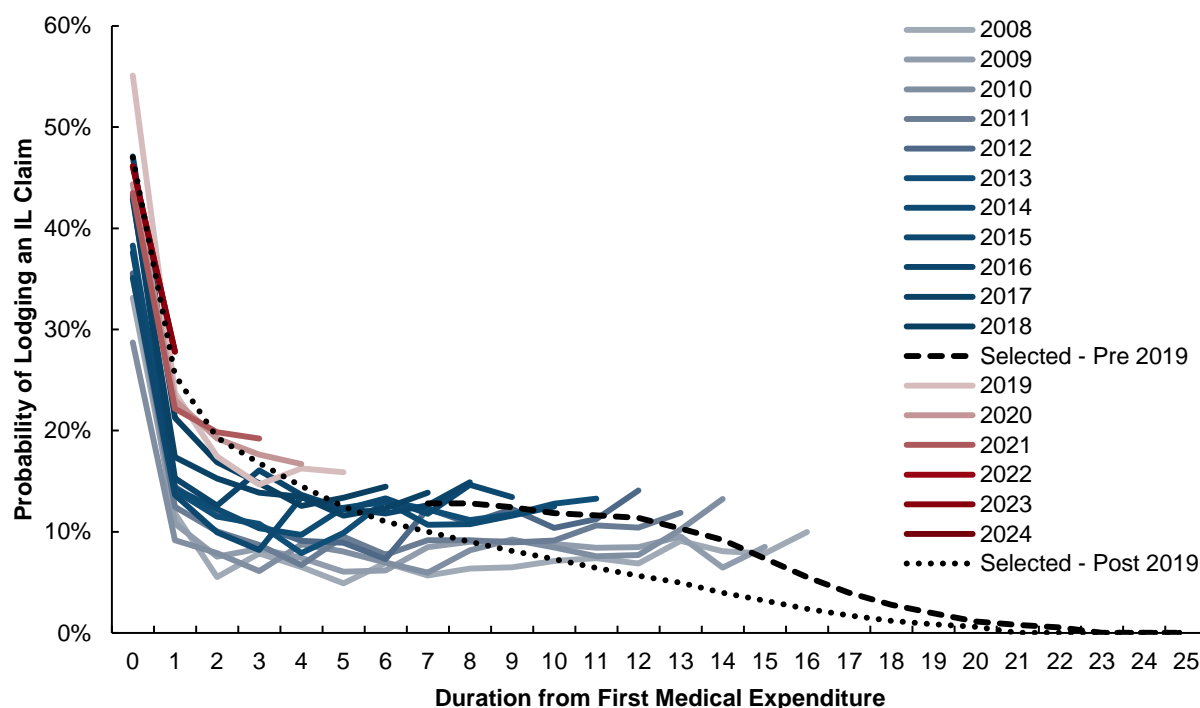
Figure 9.12: Probability of Being Assessed at 60 or More Impairment Points



9.4.10 Although the raw data shows volatility in experience, the resulting fitted probabilities are broadly in line with expectations. That is, higher probabilities are expected of reaching 60 or more impairment points with higher numbers of outstanding IL and/or PI conditions and these probabilities also increase with the level of the veteran's current whole person impairment points.

9.4.11 We have applied these modelled probabilities to the existing medical claimant population given their current impairment points, the number of accepted IL conditions not yet assessed in a PI claim and the number of IL conditions waiting to be processed (adjusted for an IL condition acceptance rate of 84 per cent). This yields an estimate of the number of medical claimants expected to reach 60 or more impairment points and thus receive a Gold Card as a result of their lodged IL conditions to date as shown in Figure 9.15 (represented by the blue bars).

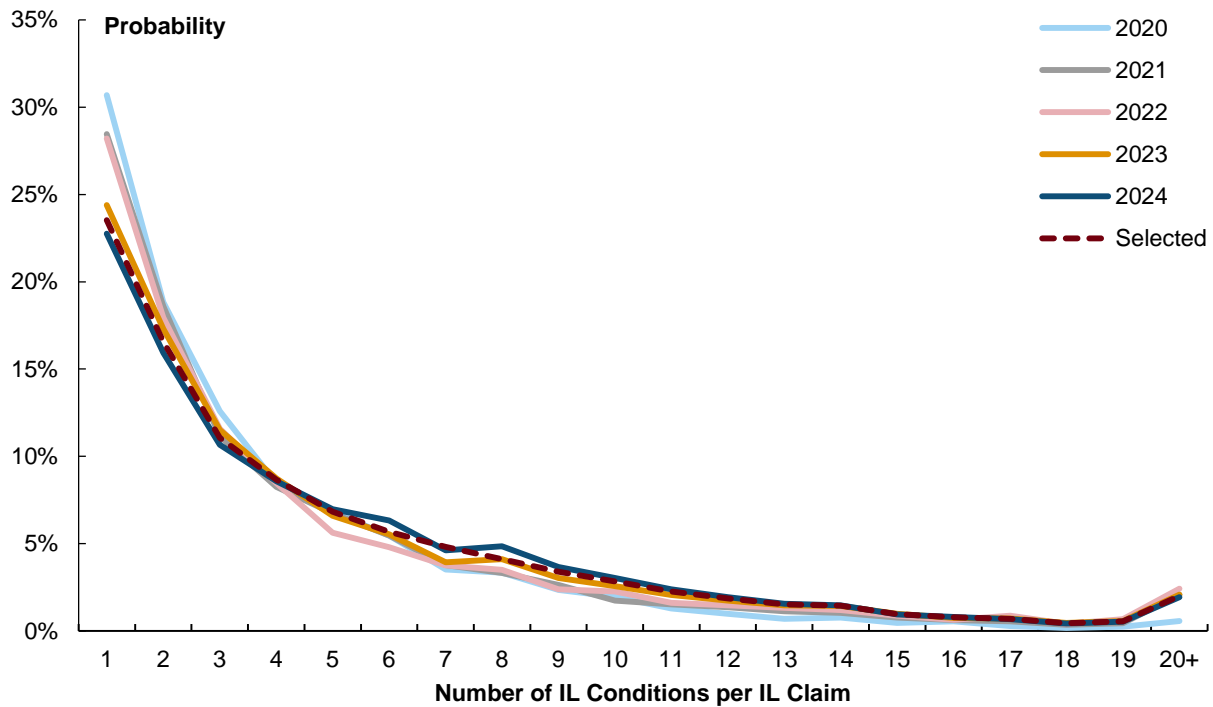
9.4.12 For this valuation, we have expanded this modelling to also incorporate the potential impact from further IL claims expected to be lodged by these veterans in the future (which are also likely to give rise to a claim for PI compensation) and the flow on impacts to whole person impairment points and Gold Card numbers. We have assumed a probability of lodging IL claims that decreases by duration from first medical expenditure as well as a number of conditions per claim distribution. Figure 9.13 shows the actual and assumed rates of lodging IL claims by duration from first medical experience for White Card holders. If a veteran has lodged multiple IL claims in the same lodgement year, only one IL claim is counted.

Figure 9.13: Probability of Lodging an IL Claim for White Card Holders


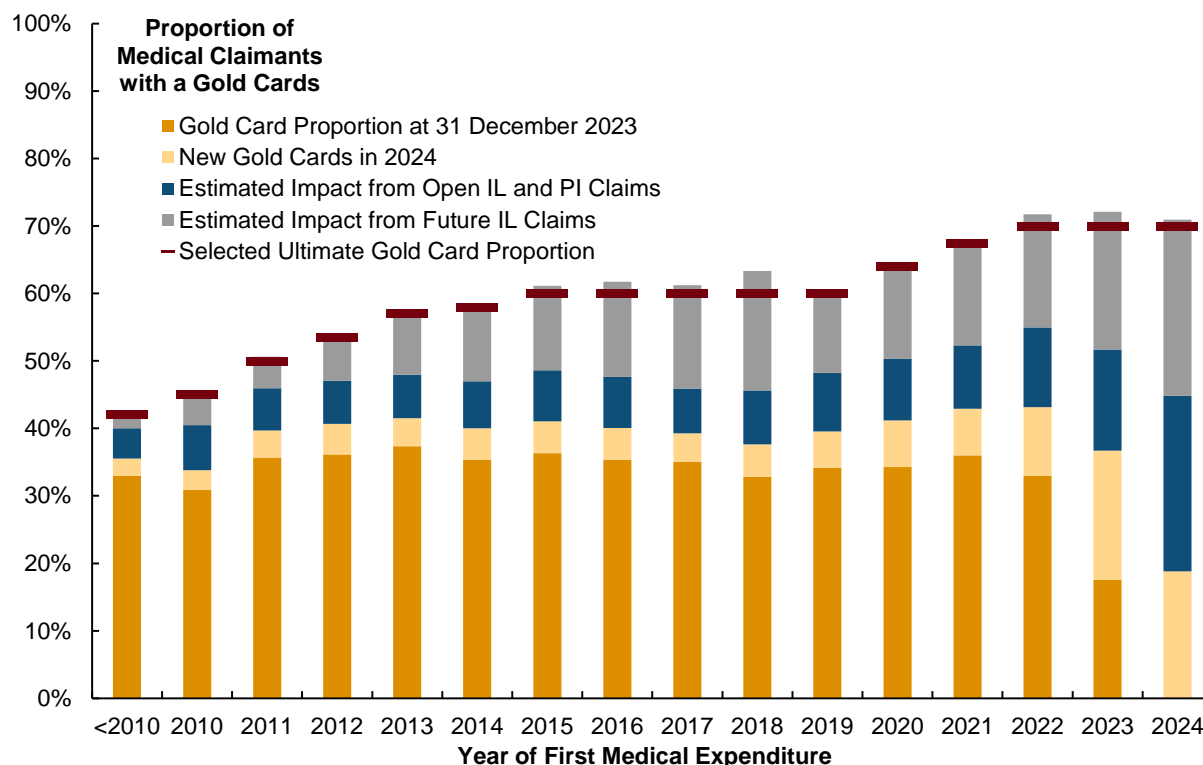
9.4.13 The experience shows that White Card holders that incurred their first medical expenditure in the earliest years of the Scheme are still exhibiting high IL claim lodgement rates. At the same time, recent medical claimants are exhibiting much higher IL claim lodgement rates at the earlier durations compared with older cohorts at these same durations, potentially reflecting some level of 'bringing forward' of IL claims compared with the previous experience. Hence, we have selected a difference runoff pattern for veterans that incurred their first medical expenditure before 2019 compared with after 2019, which attempts to account for these potential changes to the pattern of emergence. The selected pattern for veterans that incurred their first medical expenditure in 2019 or later is initially much higher than the experience for older cohorts, but runs off at a faster rate. The selected IL claim lodgement rates for veterans that incurred their first medical expenditure before 2019 is expected to remain at current levels before gradually decaying to zero.

9.4.14 We have also assumed a distribution for the number of conditions per IL claim lodged, shown in Figure 9.14. If a person has lodged multiple IL claims in the same lodgement year, only one IL claim is counted and the total number of conditions lodged in that year is used. The selected distribution is based on the experience of White Card holders over the last two years, adjusted for an ultimate withdrawal rate.

Figure 9.14: Probability of Lodging an IL Claim for White Card Holders



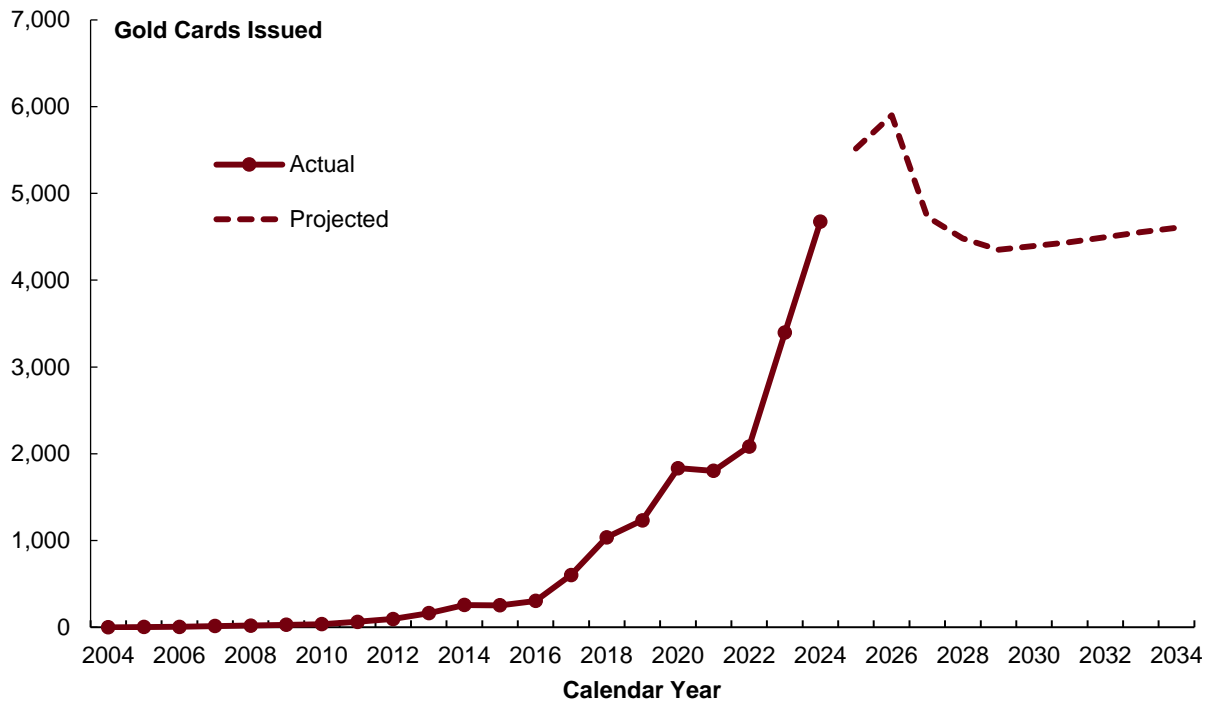
9.4.15 Based on the assumed rates of IL claim lodgement, the distribution of number of conditions per IL claim and an assumed IL condition acceptance rate of 84 per cent, we have simulated the future IL lodgement behaviour of each existing White Card holder. We have then combined this projection of future IL conditions lodged with the probabilities of being assessed at 60 or more impairment points set out in Figure 9.12 to estimate the ultimate number of existing veterans that will gain Gold Card entitlements. This is shown in Figure 9.15, where the orange bars represent the proportion of medical claimants with Gold Card entitlements at 31 December 2023, the light orange bars represent the proportion that received a Gold Card in the 2024 calendar year, the blue bars represent the anticipated number of medical claimants that will reach 60 or more whole person impairment points and thus receive a Gold Card once their open IL and PI claims are completed and the grey bars represent the additional component due to further projected IL claims from this group.

Figure 9.15: Proportion of Medical Claimants with a Gold Card by Year of First Medical Expenditure

9.4.16 The proportions of medical claimants with a Gold Card are likely to exceed the previously adopted ultimate proportions (which were 40 per cent for the 2005 to 2010 first payment year cohorts, increasing to 55 per cent for the most recent cohorts) if the assumptions around open IL and PI claims and future IL claim lodgement behaviour are borne out. For this valuation, we have adopted the ultimate proportions set out in Figure 9.15. An ultimate Gold Card proportion of 70 per cent has also been assumed for future medical claimants. We note the significant uncertainty inherent in setting the ultimate proportion of medical claimants that will receive Gold Card entitlements, and it may be some time until the experience is stable enough to provide more certainty. We will continue to review this assumption as experience emerges.

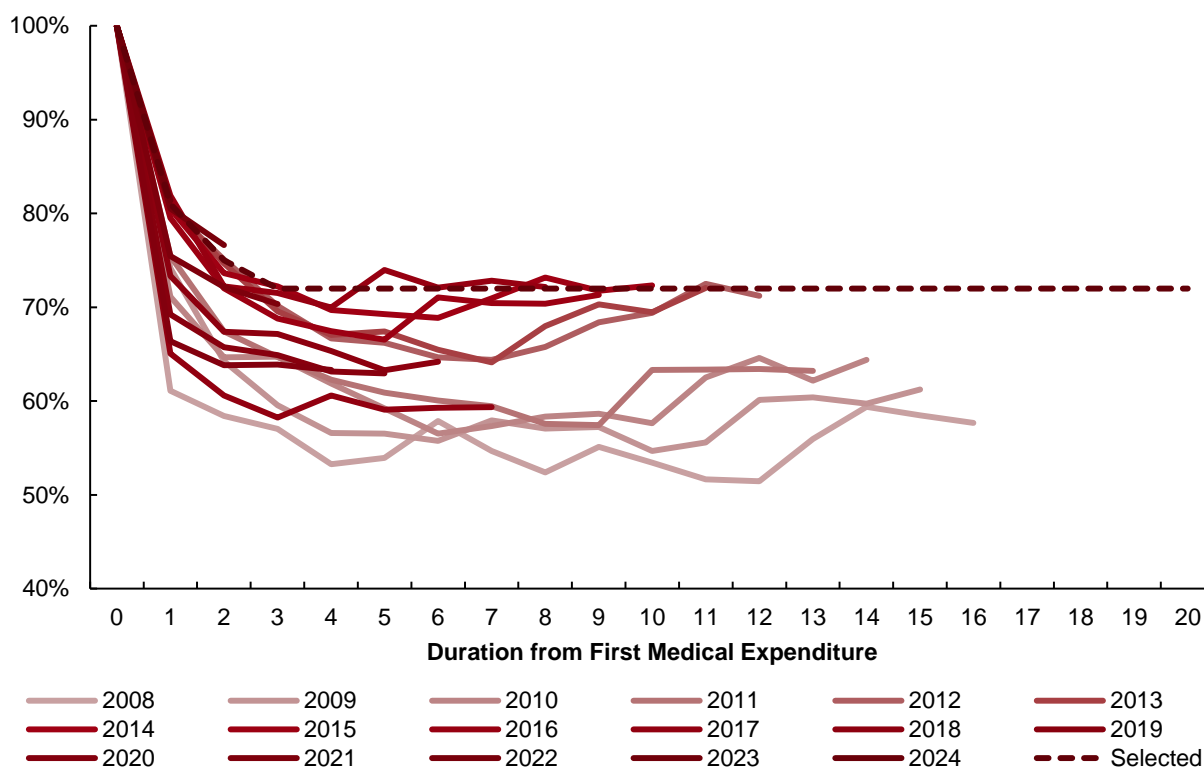
9.4.17 Figure 9.16 shows the actual and projected number of new Gold Cards issued. To inform the timing of new Gold Cards, we have assumed approximately 60 per cent of currently open IL and PI claims will be processed in the 2025 calendar years, with the remaining claims processed in the following year, based on the PI projections set out in Chapter 5. For the component relating to future IL claims lodged, Gold Cards are assumed to be issued in the year following the IL lodgement.

Figure 9.16: Projected New Gold Cards by Calendar Year



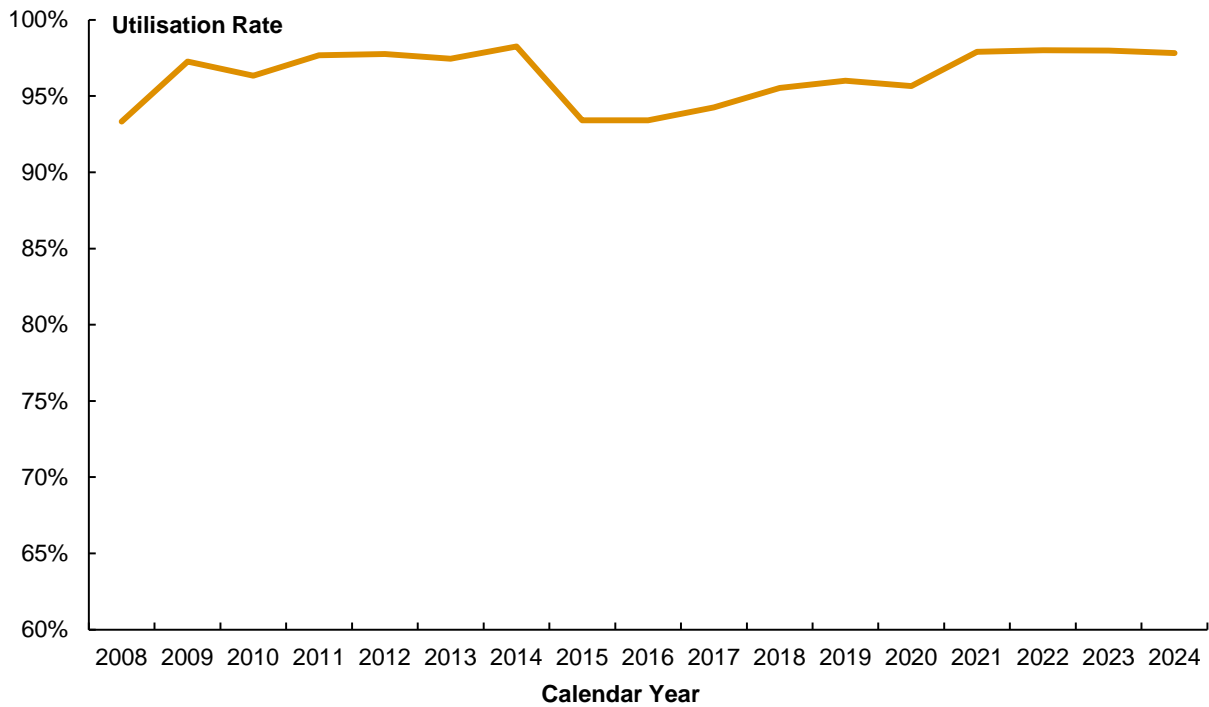
9.4.18 Once the future claimant population has been projected, a utilisation rate is applied to estimate the number of active medical claimants in each future period. The utilisation rates by duration from first medical expenditure for White Card holders are shown in Figure 9.17, along with the selected utilisation rates for future new medical claimants. Utilisation rates for White Cards are volatile and vary across cohorts. The selected utilisation rates begin at 100 per cent (by definition), decrease to 81 per cent in the second year and stabilise at 72 per cent from the fourth year. For existing active claimants, the implied rates of decay from the selected assumption are applied.

Figure 9.17: White Card Utilisation by Duration from First Medical Expenditure



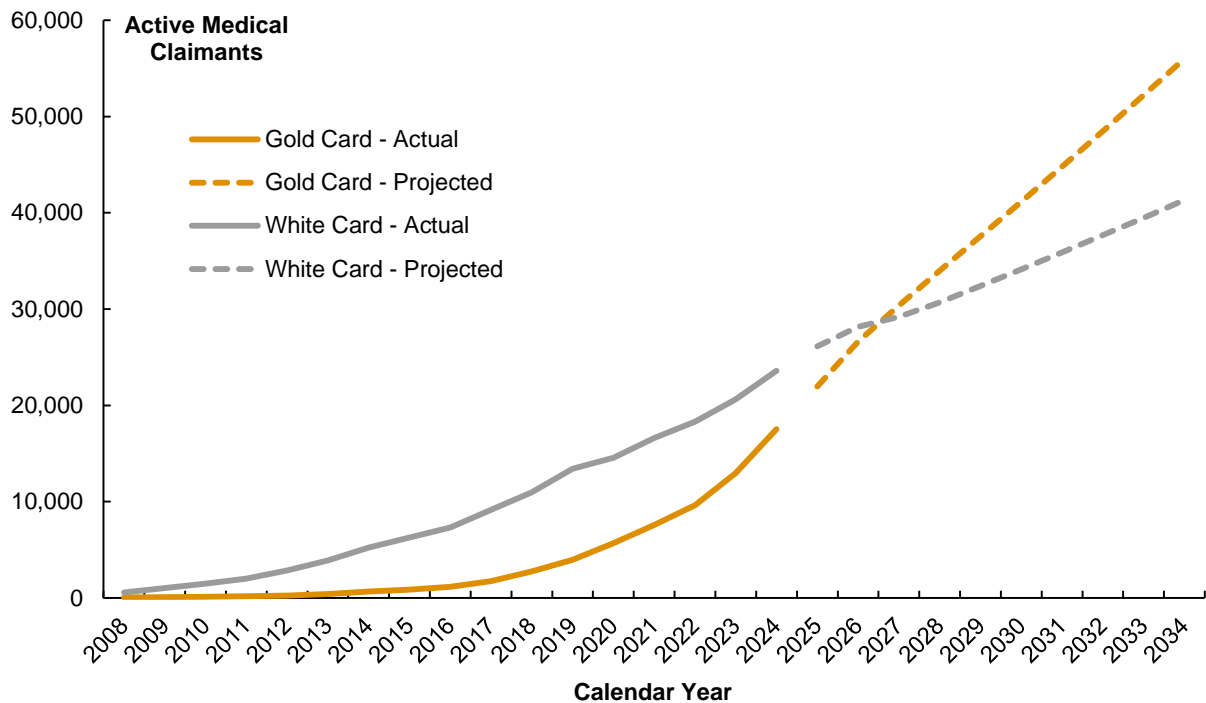
9.4.19 Figure 9.18 below shows historical Gold Card utilisation rates by calendar year. Utilisation rates are significantly higher for claimants with a Gold Card, reflecting the expanded range of benefits provided under a Gold Card as well as the higher levels of impairment implied by Gold Card entitlements. Gold Card utilisation rates have been relatively stable over time. We have selected a Gold Card utilisation rate of 98 per cent.

Figure 9.18: Gold Card Utilisation Rate by Calendar Year



9.4.20 Combining these assumptions, along with population mortality, yields a projection of active medical claimants over time, as shown in Figure 9.19.

Figure 9.19: Active Medical Claimant Number by Calendar Year



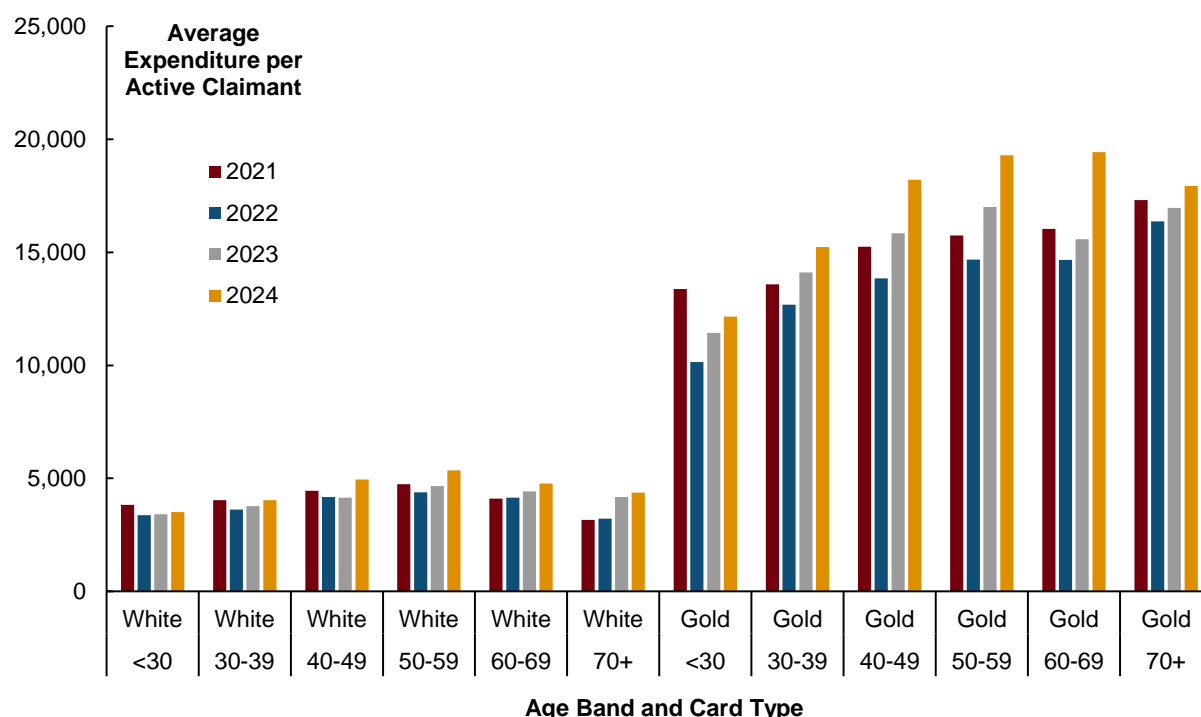
9.5 Valuation Assumptions – Average Cost per Active Claimant

9.5.1 The final assumption required is the average expenditure per active claimant. For this valuation, we have considered the average expenditure assumption by service category, namely hospital (including public and private), treatment (which mainly includes GP and specialist consultations), allied health, pharmaceutical and medical other (which mainly includes travel reimbursements for medical appointments). Figure 9.20 shows the proportion of MRCA medical expenditure by service category since 2015. Over the period, the proportion of hospital expenditure has decreased from around 38 per cent of expenditure to under 25 per cent. The proportion of expenditure on allied health services has increased from around 22 per cent to 28 per cent in the most recent year. Expenditure on treatment and medical other has remained relatively consistent, while the proportion of expenditure related to pharmaceutical benefits has increased substantially, particularly in recent years.

Figure 9.20: Proportion of MRCA Medical Expenditure by Service Category

9.5.2 The average expenditure per active claimant, that is the average annual expenditure for claimants utilising medical benefits, is assumed to vary by card type and age band. We have selected assumptions for each service type, separately considering the proportion of active claimants utilising each service and the average cost per active claimant utilising the service. Figure 9.21 below shows the average expenditure per active medical claimant over the last four calendar years. The average expenditure is substantially higher for Gold Cards across all ages, reflecting the fact that all medical expenditure is covered as well as the higher levels of impairment required for eligibility. The average expenditure has increased slightly for all age bands over the most recent calendar year.

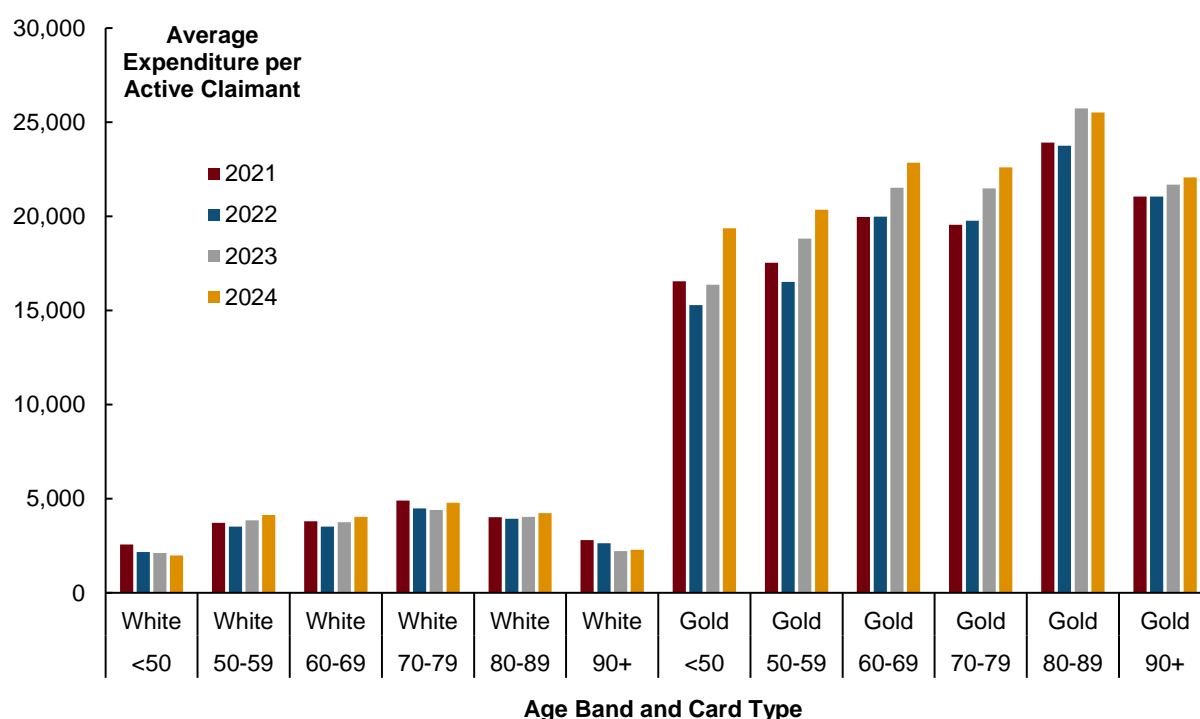
Figure 9.21: Average Expenditure per Active MRCA Medical Claimants



9.5.3 As MRCA commenced in 2004, there is very little experience currently available for those aged over 70. For this valuation, we received data on VEA claimants where there are significantly

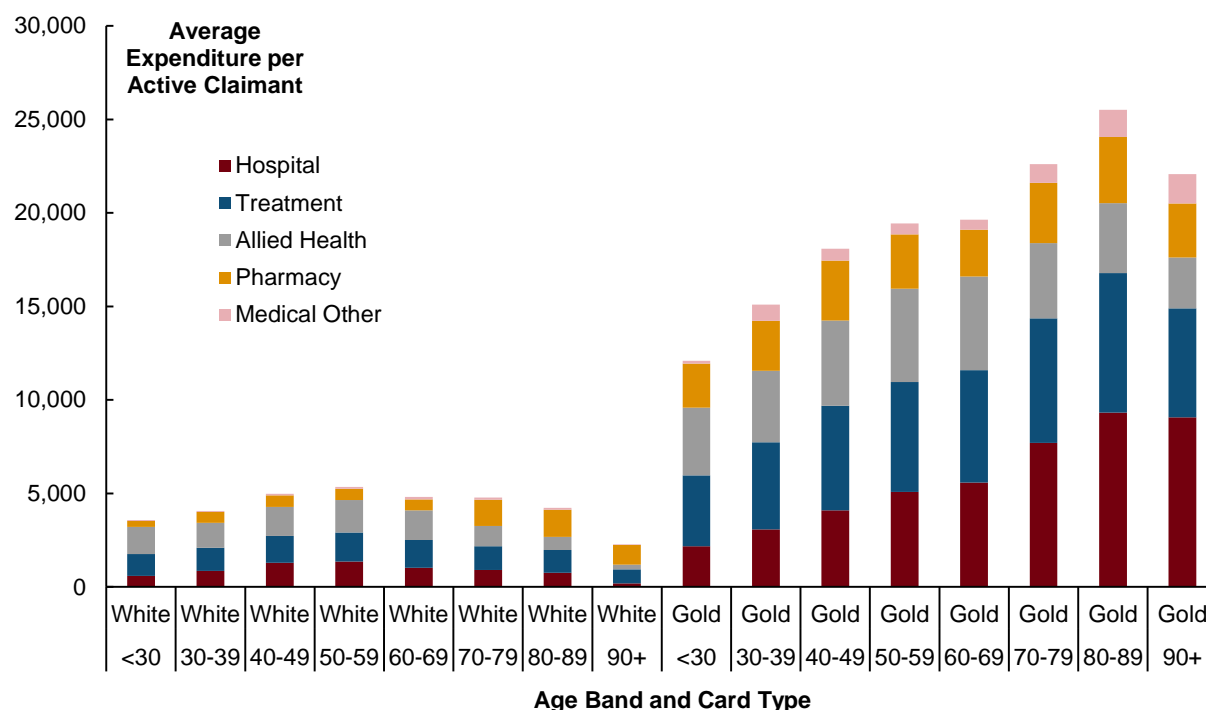
higher numbers of veterans with Gold Cards at older ages. Figure 9.22 shows the average expenditure per active claimant for veterans with VEA health care cards. Please note that these figures are different from those used in the previous report, which were based on calculations performed by the DVA Data Insights Branch. We have included fewer expenditure categories to align with the benefits modelled in the medical benefit, resulting in lower average costs at older ages. VEA veterans receive a Gold Card if they are eligible for the general rate or above general rate of Disability Compensation Payments (DCP). DCP is paid to compensate veterans for injuries and diseases caused as a result of war service rendered before 1 July 2004 and the amount paid depends on the level of incapacity. Veterans aged 70 or over with qualifying service (QS70) may also receive a VEA Gold Card. The average expenditure for VEA Gold Card holders increases at older ages before a decrease beyond age 90 which may be due to care costs moving to other categories such as attendant care services or aged care.

Figure 9.22: Average Expenditure per Active VEA Medical Claimants



9.5.4 Figure 9.23 shows the selected average expenditure per active medical claimant, aggregating the individual assumptions by service category and combining data from both MRCA and VEA. The assumed amounts are based on the most recent experience. For this valuation, we have assumed that MRCA average expenditure per active Gold Card claimant will follow the VEA experience at older ages. These amounts are assumed to grow by 3.7 per cent per annum in line with expected long term wage growth. For new claimants, we assume expenditure commences in the middle of the year and accordingly, have applied a ratio of 50 per cent to usage for these claimants in their first year.

Figure 9.23: Selected Average Cost per Active Medical Claimants (2024 dollars)



9.5.5 Substantial growth in pharmaceutical benefits was seen again in 2024, driven by increasing expenditure associated with medicinal cannabis for the treatment of chronic pain conditions. We have been informed by DVA program areas that the take up of these drugs have increased significantly since its addition to the Repatriation Pharmaceutical Benefits Scheme (RPBS), with further growth still expected going forward. Figure 9.23 shows the proportion of active medical claimants accessing medicinal cannabis. The proportions have increased significantly over the period presented, particular for veterans with Gold Card entitlements. We have assumed the proportion of medical claimants accessing medicinal cannabis will continue to increase over the next three calendar years before stabilising at the proportions set out in Figure 9.23. This has been applied as superimposed inflation to the average expenditure per active claimant amounts in Figure 9.22. These rates of superimposed inflation are 3.0 per cent, 2.2 per cent and 1.5 per cent in 2025, 2026 and 2027 respectively.

Figure 9.24: Proportion of Active Medical Claimants Accessing Medicinal Cannabis

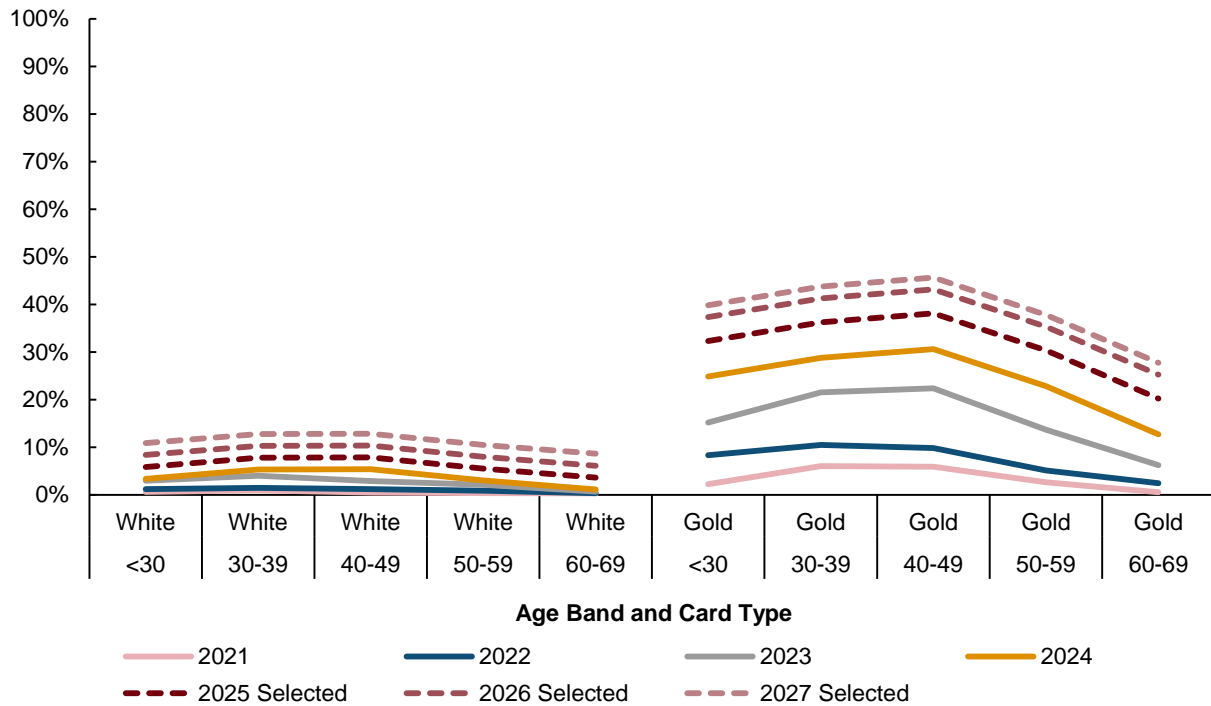
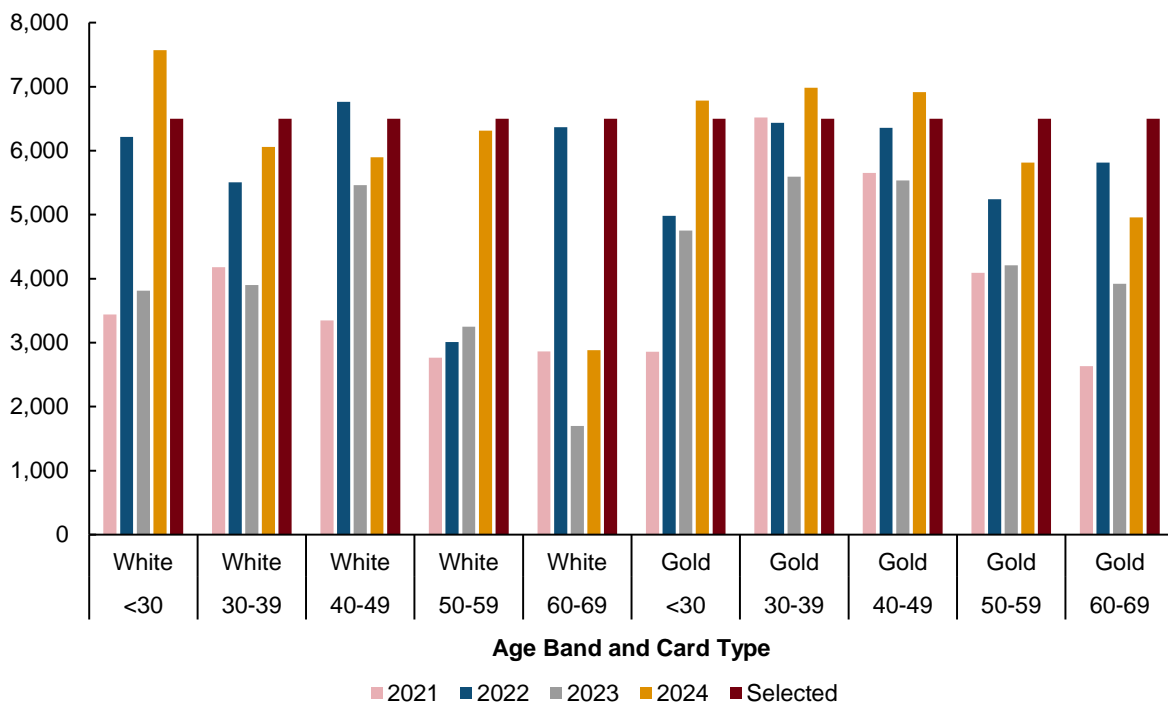
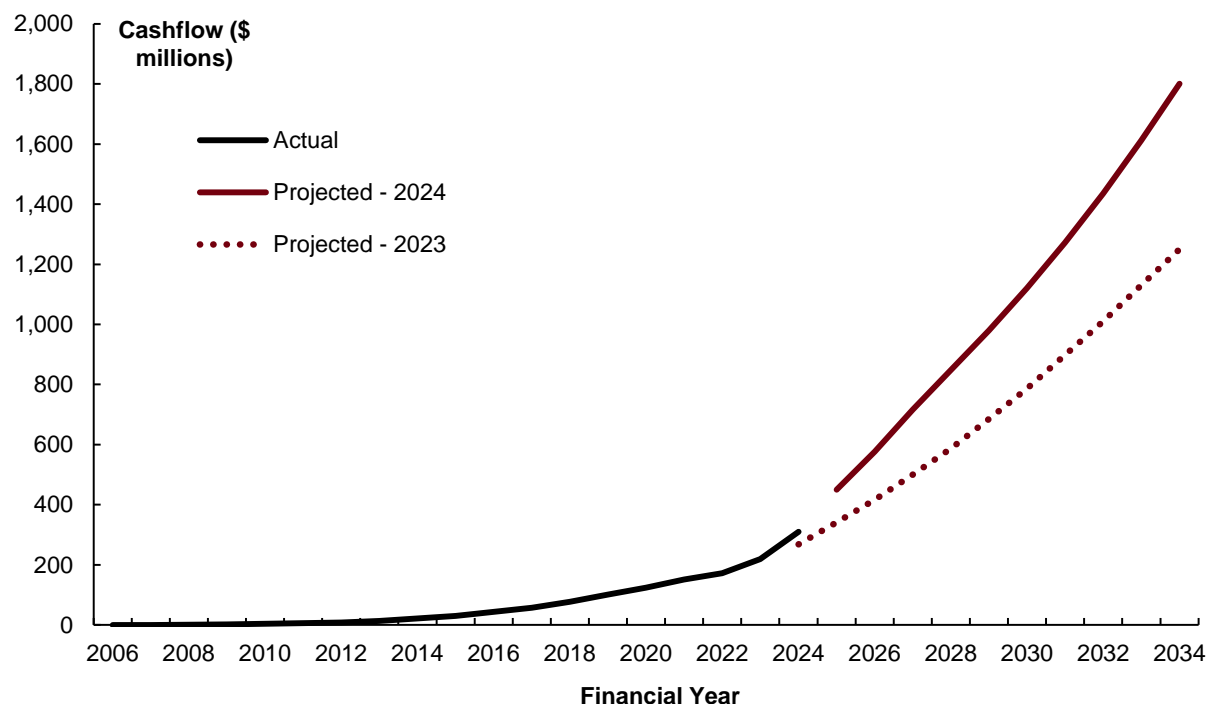


Figure 9.25: Average Cost per Active Medical Claimants Accessing Medicinal Cannabis



9.6 Projected Cashflows and Liability Estimate

9.6.1 Applying the average expenditure per active claimant and future inflation assumptions to the projection of active medical claimants gives an estimate of future medical expenditure as shown in Figure 9.25.

Figure 9.26: Historical and Projected Cashflows for MRCA Medical


9.6.2 Table 9.1 shows the estimate of the MRCA liability for medical costs broken down by year of accident. The estimated liability at 30 June 2024 is \$34,395.3m. The projected liability in the 2023 valuation for 30 June 2024 was \$24,688m. Table 9.2 below provides a reconciliation of this movement.

Table 9.1: Outstanding Claims Liability for MRCA Medical Costs

Year of accident	Liability (\$m)
2005 – 2009	2,756.8
2010 – 2014	6,171.7
2015 – 2019	11,121.4
2020	2,828.4
2021	2,888.1
2022	2,894.9
2023	2,863.7
2024	2,870.2
Total	34,395.3
<i>Expected at 30/06/2024</i>	<i>24,688.0</i>

Table 9.2: Reconciliation of the Liability for MRCA Medical Costs

	\$m
Liability estimate as at 30 June 2023 (previous valuation)	21,991.6
Assumed Interest	1,138.1
Projected Payments	(268.3)
Notional Premium	1,826.6
Liability estimate as at 30 June 2024 (previous valuation)	24,688.0
<i>Experience effects and assumption changes</i>	
Difference between actual and projected payments	(41.2)
Change due to experience	766.9
Change due to claimant projection	3,807.6
Change due to gold card proportions	3,977.0
Change due to utilisation rates	233.5
Change due to average cost per active claimant	(1,202.9)
Change due to assumed growth in medicinal cannabis usage	2,166.5
Current Estimate	34,395.3

10 DRCA Medical Costs

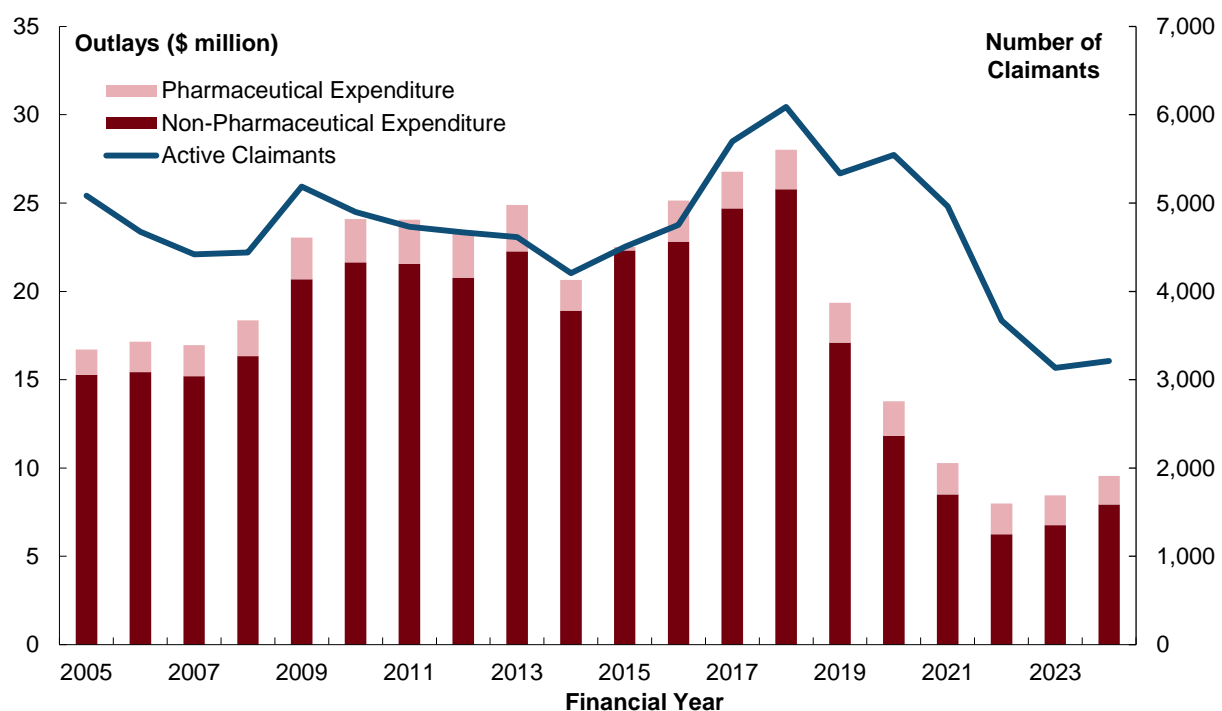
10.1 Benefit Overview

10.1.1 Veterans are entitled to a range of health care benefits for the treatment of service-related conditions under the DRCA. This can include general practitioner and specialist services; allied health services such as physiotherapy; dental care, optical and hearing aids; treatment at a hospital or day procedure facility; subsidised pharmaceuticals; pathology and medical imaging; medical aids and appliances; and reimbursed travel for treatment. DRCA veterans with a White Card are also eligible for treatment for mental health conditions, cancer (malignant neoplasm) and pulmonary tuberculosis. Note that Gold Cards, which cover clinically necessary treatment for all medical conditions, are not available to veterans under the DRCA.

10.2 Recent Experience and Valuation Assumptions

10.2.1 Figure 10.1 shows the annual expenditure on DRCA medical and pharmaceutical payments along with the number of active claimants since 2005. Under DVA's hierarchy of cost classification for medical expenditure, if a DRCA claimant is issued a health card under the VEA or MRCA (as a result of overlapping eligibility), any medical expenditure is recorded under that Act going forward. Although there was some growth in DRCA medical expenditure in earlier years, expenditure has declined significantly in recent periods. The sharp reduction in both active claimants and expenditure most likely reflects the transition of previous DRCA medical recipients to MRCA health care cards. More recently, this decline appears to have ceased, with expenditure increasing over the last two years.

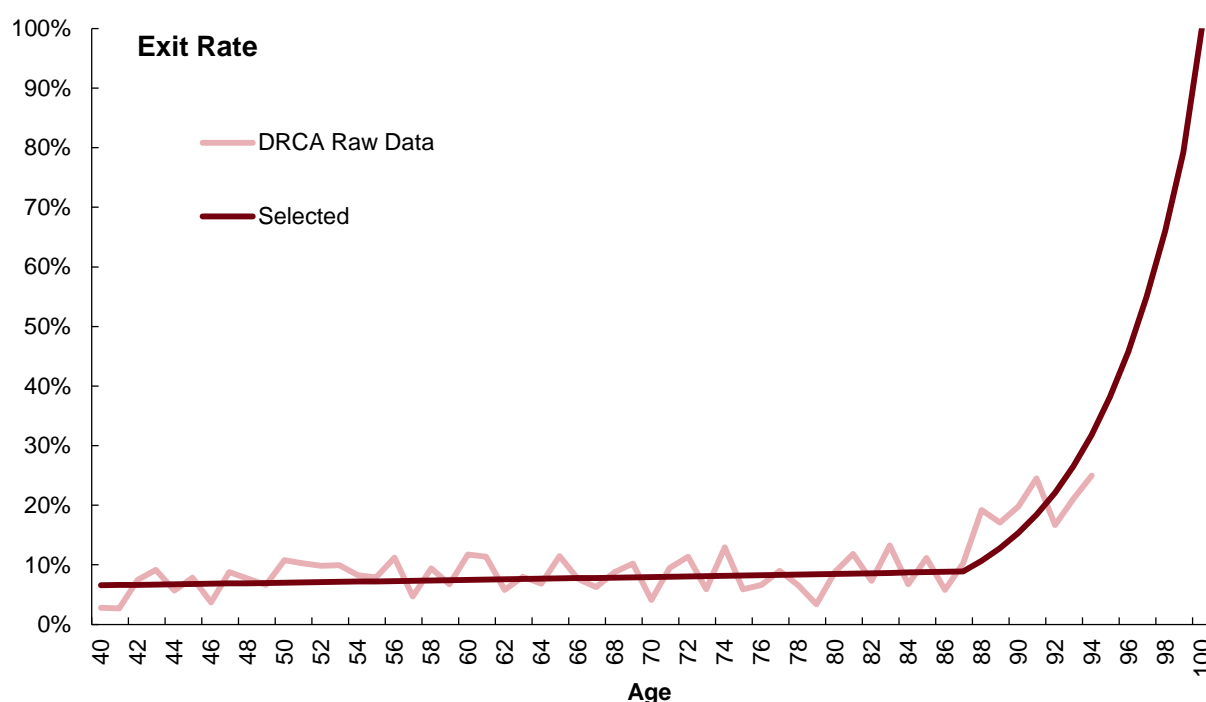
Figure 10.1: Expenditure on DRCA Medical Payments and Number of Active Claimants



10.2.2 To project the number of active claimants, we apply an exit rate to the current claimant population. An average size is then applied to the active claimant population in each year to estimate expected future payments. As in previous years, we have not included those receiving only pharmaceutical benefits in the claimant population, but instead applied a loading to projected non-pharmaceutical cashflows in line with the historical relationship between the two components of expenditure. For the current review, a loading of 30 per cent has been applied, compared with 25 per cent at the previous valuation.

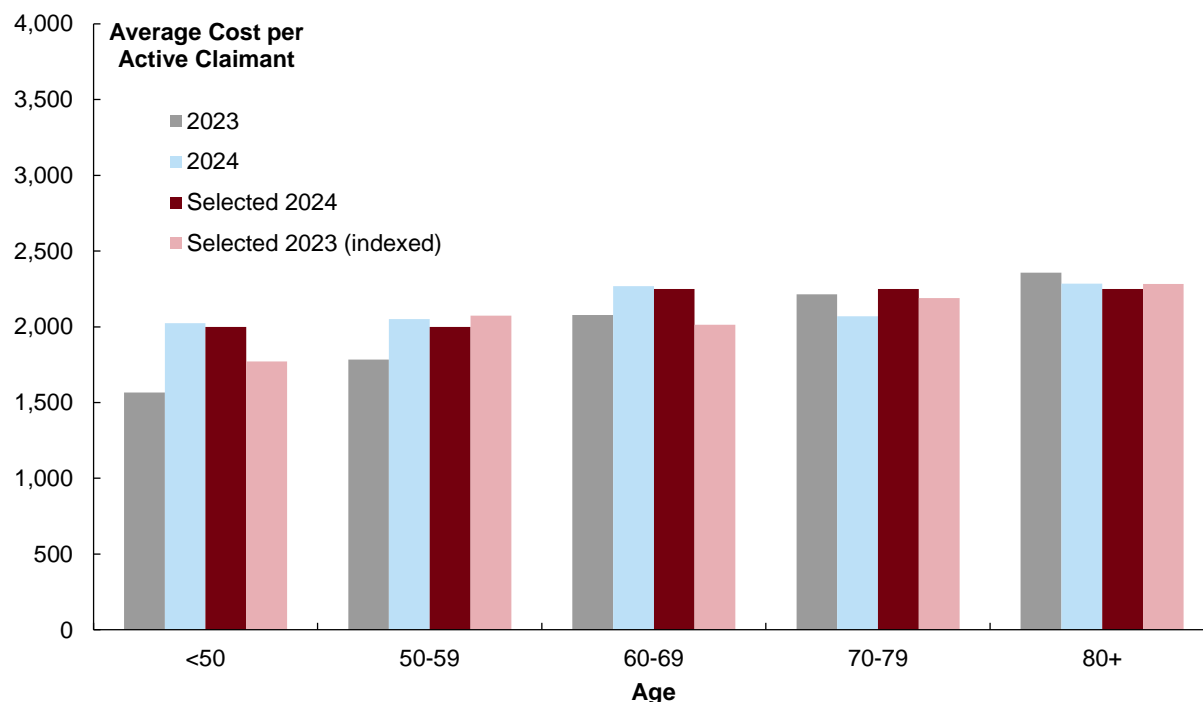
10.2.3 We have derived age-based exit rates from the DRCA medical experience. Figure 10.2 shows the raw data and the fitted age-based exit rates. In fitting the exit rates, a longer period of ten years has been used to avoid placing undue weight on the recent marked decline in active DRCA medical claimants.

Figure 10.2: Assumed Exit Rates for Active DRCA Medical Claimants



10.2.4 Future cashflows are then calculated by multiplying the resulting projections of active claimants with the average cost per active claimant. Figure 10.3 shows the average cost per active claimant over the last two calendar years and the selected assumption, together with the assumption adopted in 2023. A large claim of over \$1m has been excluded from the experience and modelled separately. We have assumed that the average cost per active claimant will increase by 3.7 per cent per annum in future as costs are likely to be largely driven by wages.

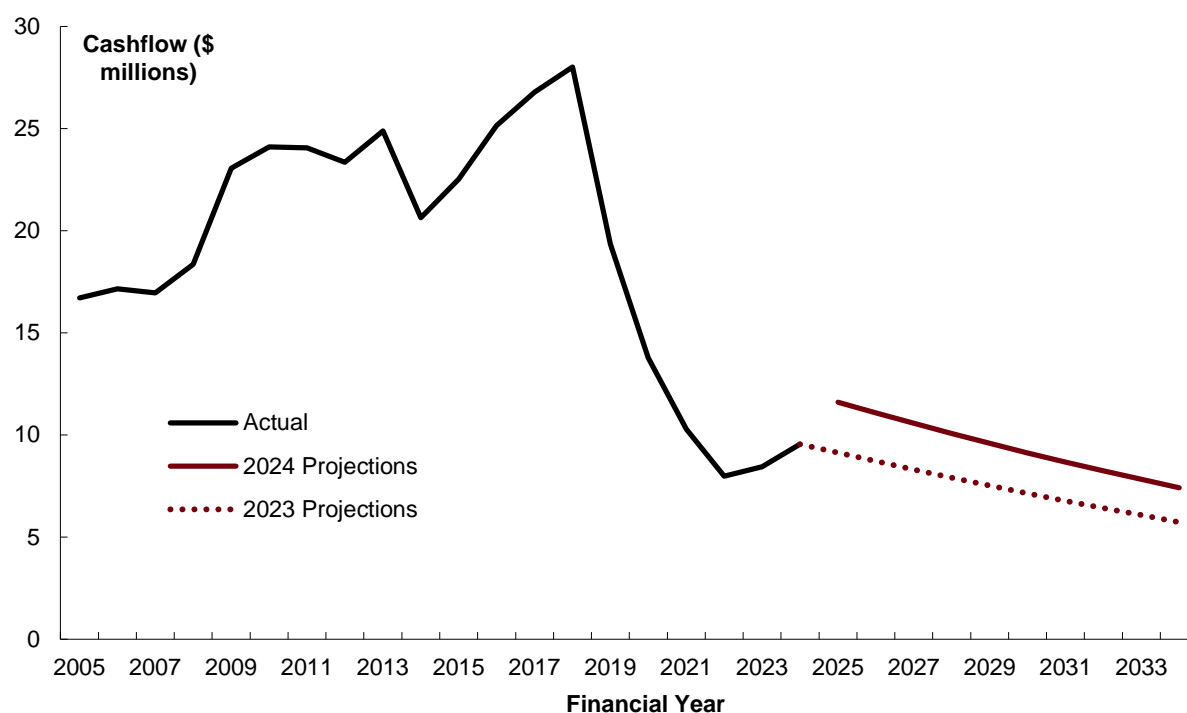
Figure 10.3: Average Annual Costs per Active Claimant by Age



10.3 Projected Cashflows and Liability Estimate

10.3.1 Figure 10.4 shows the historical and projected cashflows for DRCA medical claims.

Figure 10.4: Historic and Projected DRCA Medical Payments



10.3.2 Table 10.1 shows the estimate of the DRCA medical liability broken down by year of accident. The projected liability as at 30 June 2024 in the 2023 valuation for DRCA medical claims was

\$87.4m. The liability at the 2024 valuation is \$113.0m, which is \$25.6m higher than expected, reflecting the increase in projected cashflows seen in Figure 10.4. The difference between these two figures is reconciled in Table 10.2 below.

Table 10.1: Outstanding Claims Liability for Medical Costs by Year of Accident

Year of accident	Liability (\$'m)
1979 and before	18.2
1980 – 1984	23.2
1985 – 1989	10.5
1990 – 1994	17.9
1995 – 1999	24.7
2000 – 2004	18.5
Total	113.0
<i>Expected at 30/06/2024</i>	<i>87.4</i>

Table 10.2: Reconciliation of Liability for DRCA Medical Cost

	\$m
Liability estimate as at 30 June 2023 (previous valuation)	92.6
Assumed Interest	4.4
Projected Payments	(9.5)
Notional Premium	-
Projected liability as at 30 June 2024 (previous valuation)	87.4
<i>Experience effects and assumption changes</i>	
Difference between actual and projected payments	0.0
Change due to experience	8.5
Change due to exit rates	2.3
Change due to average cost	11.0
Change due to pharmaceutical loading	3.8
Current Estimate	113.0

11 MRCA Rehabilitation

11.1 Benefit Overview

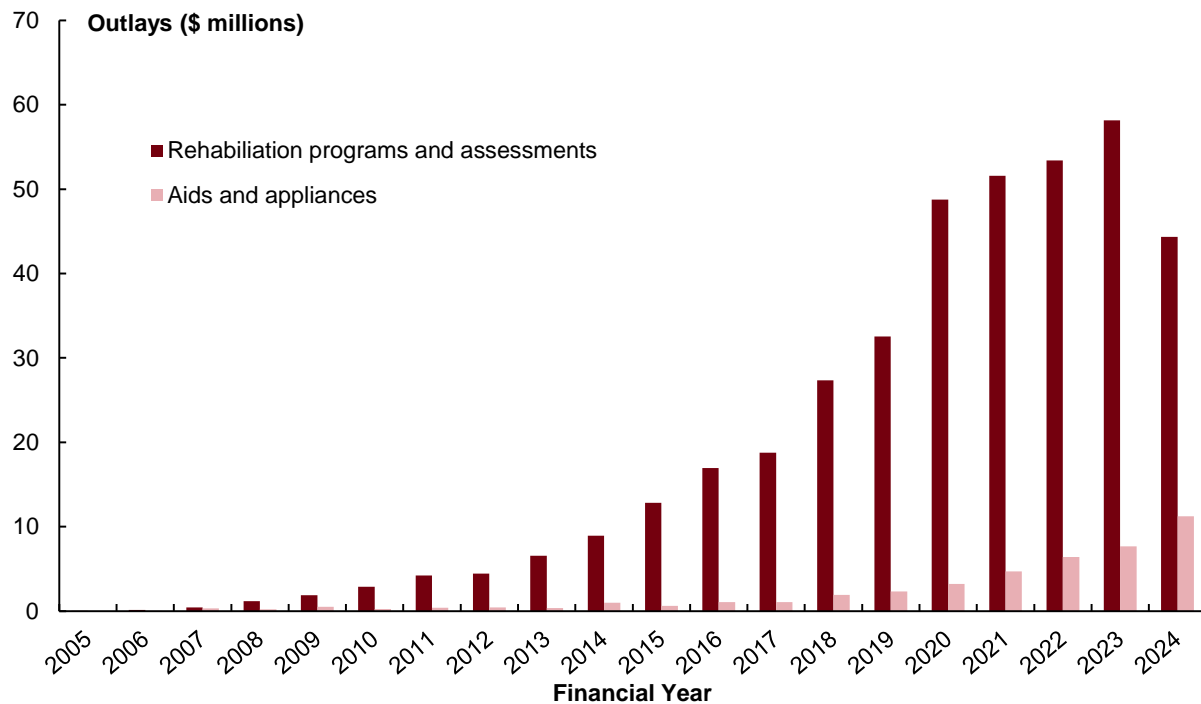
- 11.1.1 As with the previous review, we have separated MRCA rehabilitation benefits into two categories which we refer to as rehabilitation programs and aids and appliances.
- 11.1.2 The first category includes payments in respect of rehabilitation programs and assessments. DVA's rehabilitation approach is different to traditional workers compensation schemes that focus mainly on return to work. Rehabilitation programs can include both vocational and non-vocational (which includes medical management and psychosocial rehabilitation) support to maximise recovery and improve wellbeing. Vocational rehabilitation aims to support medically able veterans to increase their capacity for suitable employment. Vocational rehabilitation can include assistance with getting skills and prior learning assessed, engaging in job readiness and job seeking assistance activities, taking part in a work trial and learning new skills via training courses. Some medically able veterans receiving incapacity payments must take part in rehabilitation to continue receiving payments. Medical management does not include medical treatment but does include support for veterans to find and access health professionals in their local area, find and access veteran and family specific assistance programs and build health literacy to proactively manage health and wellbeing. Psychosocial rehabilitation aims to assist veterans in improving their general wellbeing and ability to function independently in society, including programs designed to enhance life management skills, engagement with family and community and social connections.
- 11.1.3 We have also included payments made under the Acute Support Package with the rehabilitation programs and assessments. The Acute Support Package provides short-term support to eligible veterans and their families to help them adjust to new and challenging life circumstances that may result in the family being at risk of experiencing crisis. A veteran family may be eligible for a MRCA Acute Support Package where the veteran is under 65 years old and has eligibility for incapacity payments or SRDP.
- 11.1.4 The second category consists of payments made under the Rehabilitation Appliances Program (RAP). The RAP provides aids, equipment and modifications to help veterans to live safely and independently. The aids, equipment and modifications available can be classified into the following broad categories: speech, hearing, cognition and vision devices; feeding appliances; personal hygiene products; diabetes products; assistance dogs; respiratory home therapy devices; beds, chairs and other supports; lifting and mobility devices; orthoses and prostheses; palliative care appliances; home modifications and vehicle modifications. Veterans are eligible for RAP if they have an assessed clinical need and either a Gold Card, or a White Card and the equipment is for an accepted condition. As such, the RAP benefits can be considered as an extension to the MRCA medical benefits.

11.2 Recent Experience and Valuation Assumptions

- 11.2.1 Figure 11.1 shows the expenditure on rehabilitation for MRCA since 2005. Expenditure grew slowly during the early years of the scheme and began to increase from 2012 onwards. Rehabilitation payments have increased rapidly since 2017 with significant increases seen in 2018 and 2020. However, in the most recent year, a decline in rehabilitation expenditure was

observed, primarily driven by a reduction in rehabilitation programs and assessments. Discussions with DVA's policy and program areas informed us of a program review which took place in 2024. The review included both reassessments of individual programs for efficacy and outcomes and a review of service providers. The review resulted in a number of existing rehabilitation programs ceasing as well as a change to the number of contracted service providers.

Figure 11.1: Expenditure on MRCA Rehabilitation



11.2.2 MRCA rehabilitation is modelled using a Payments per Active Claimant model. New claims are projected using a chain ladder model and utilisation rates are applied to determine the number of active claimants in each future period. Mortality rates are applied to decay the active claimant population over time. Combining the projection of the active claimant population with an average expenditure per active claimant assumption yields a projection of future rehabilitation payments. This approach is applied for both the rehabilitation programs and the aids and appliances benefits.

11.2.3 A chain ladder method has been adopted to project future rehabilitation entrants. Figures 11.2 and 11.3 show the relationship between average accident year and the year in which rehabilitation expenditure is first incurred, for rehabilitation programs and aids and appliances respectively. The pattern of claims emerging has changed substantially since the commencement of MRCA and in particular since the introduction of Veteran Centric Reform. Successive accident years are experiencing higher numbers of new entrants, particularly in the initial development years. However, the few most recent accident years do appear to be emerging at similar levels, suggesting that the pattern of claims emerging may be beginning to stabilise.

Figure 11.2: Cumulative Claimant Numbers – Rehabilitation Programs

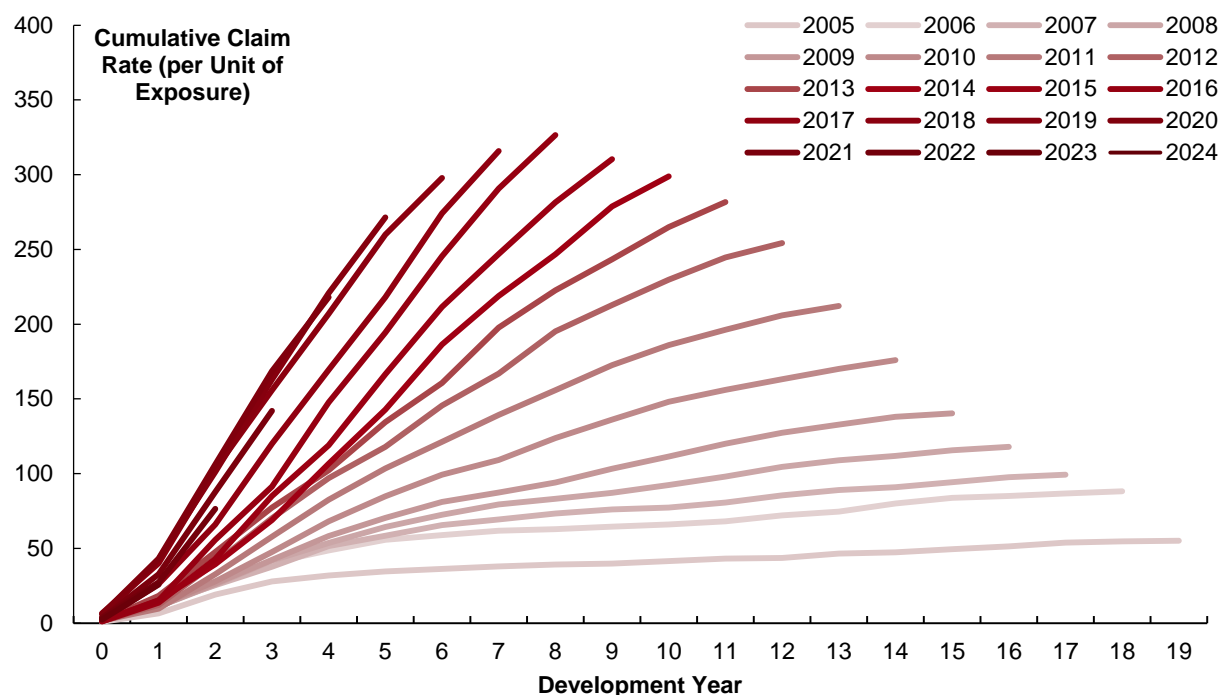
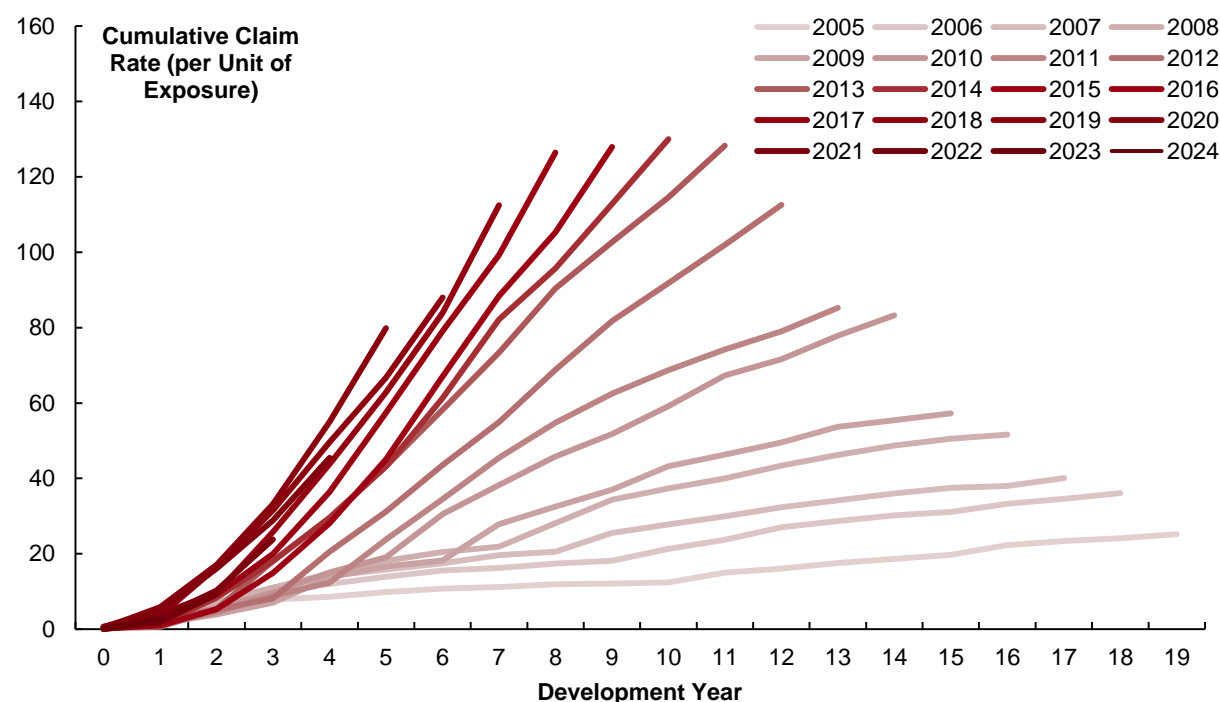
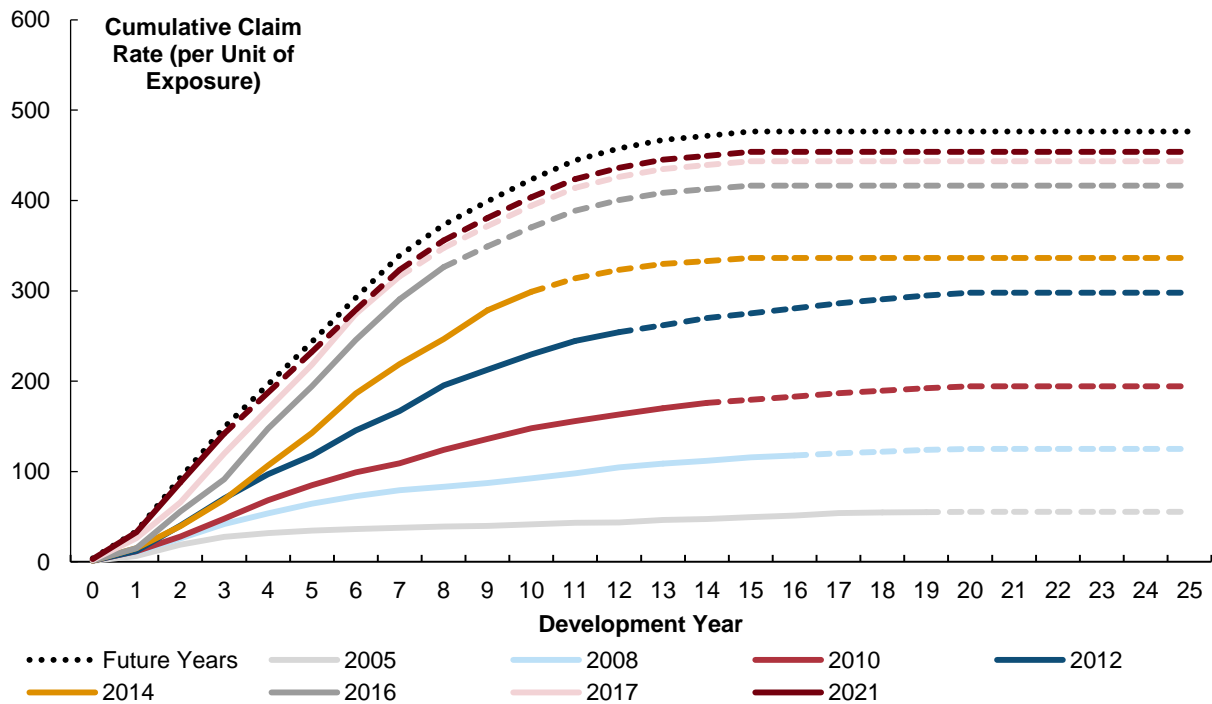
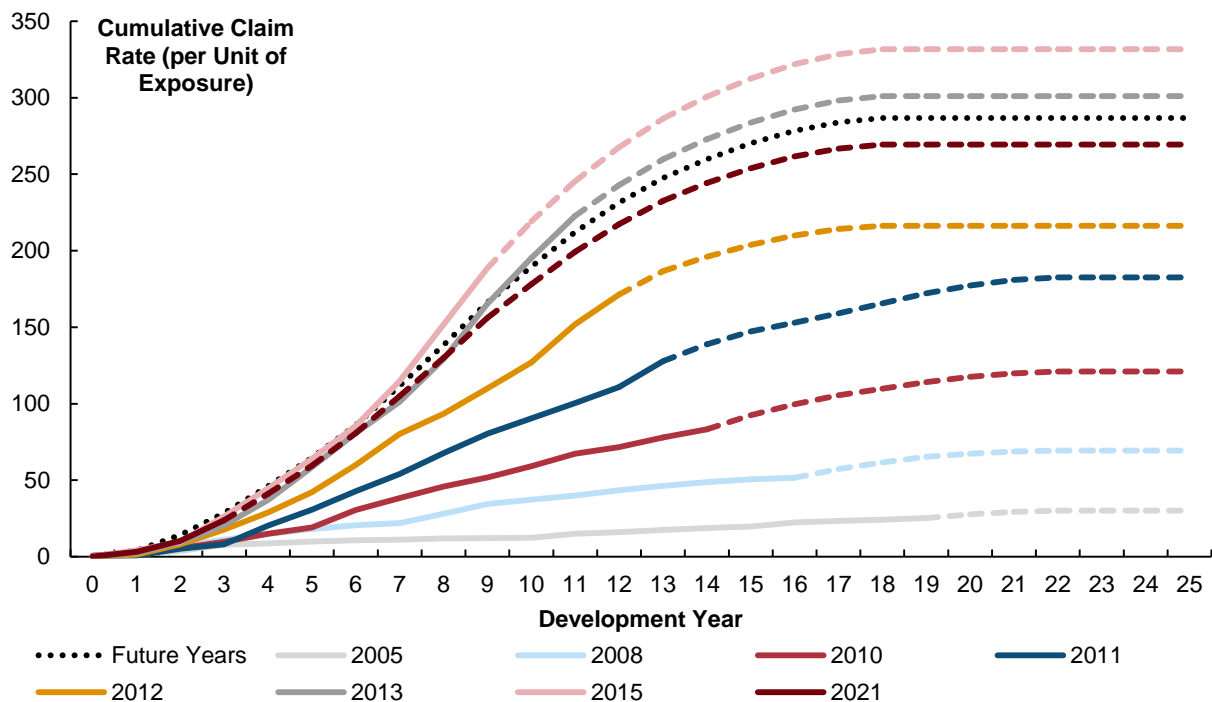


Figure 11.3: Cumulative Claimant Numbers – Aids and Appliances



11.2.4 We have selected separate development factors for the initial accident years to 2012 and the accident years from 2013 onwards to account for these changes in the pattern of reporting. We have also made proportional adjustments to the selected development factors over the short term to acknowledge the impact processing constraints have had on the development of these accident years. Figures 11.4 and 11.5 show the projected cumulative claimant numbers for a subset of accident years, for rehabilitation programs and aids and appliances respectively.

Figure 11.4: Projected Cumulative Claimant Numbers – Rehabilitation Programs

Figure 11.5: Projected Cumulative Claimant Numbers – Aids and Appliances


11.2.5 Once we have projected the cumulative claimant numbers, we then need to project the number of claimants receiving benefits in each future period. Figures 11.6 and 11.7 show the utilisation rates by duration from first rehabilitation payment for each entry year cohort, for rehabilitation programs and aids and appliances respectively. The utilisation rates start at 100 per cent by definition and decrease significantly in the first and second year after entry. For rehabilitation programs the utilisation rates appear to gradually decline over time. For aids and appliances however, after the initial decline, utilisation tends to remain stable over time, suggesting that

veterans continue to utilise aids and appliances benefits year on year. Notably, for older first entry cohorts, utilisation of aids and appliances benefits decreased initially but has since increased which suggests that claimants have recommenced the Rehabilitation Appliances Program after a period of not utilising these benefits.

Figure 11.6: Utilisation Rate by Duration from First Payment – Rehabilitation Programs

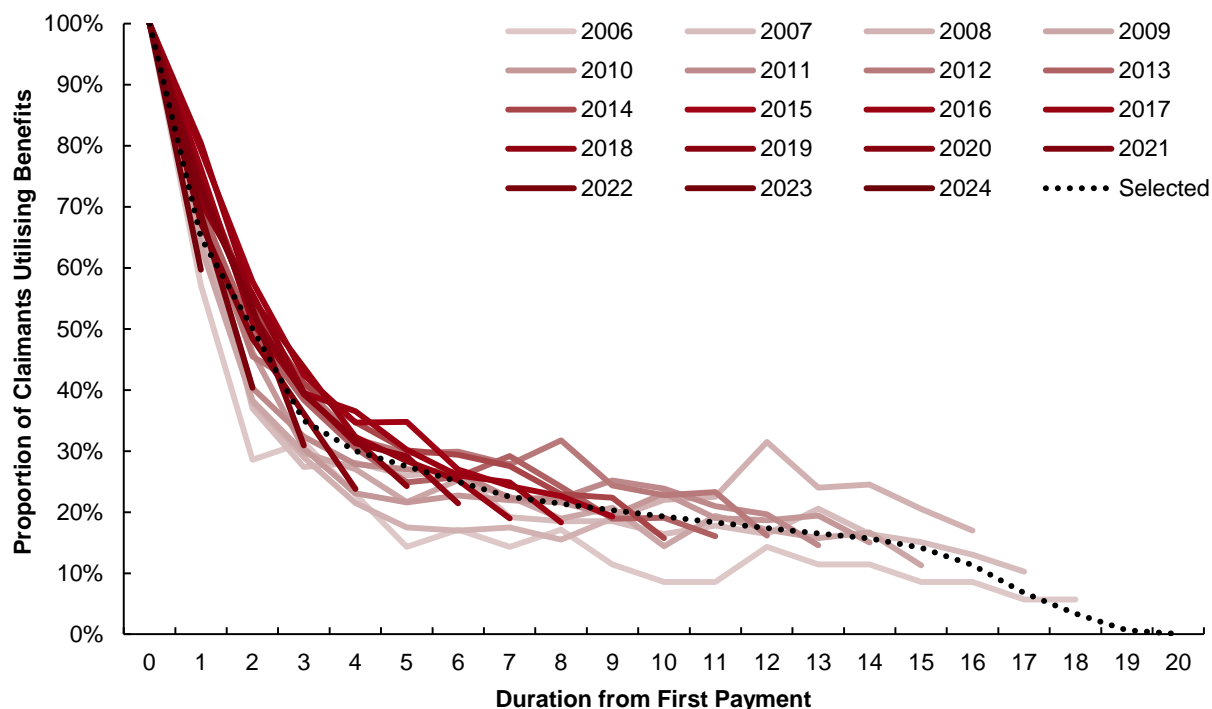
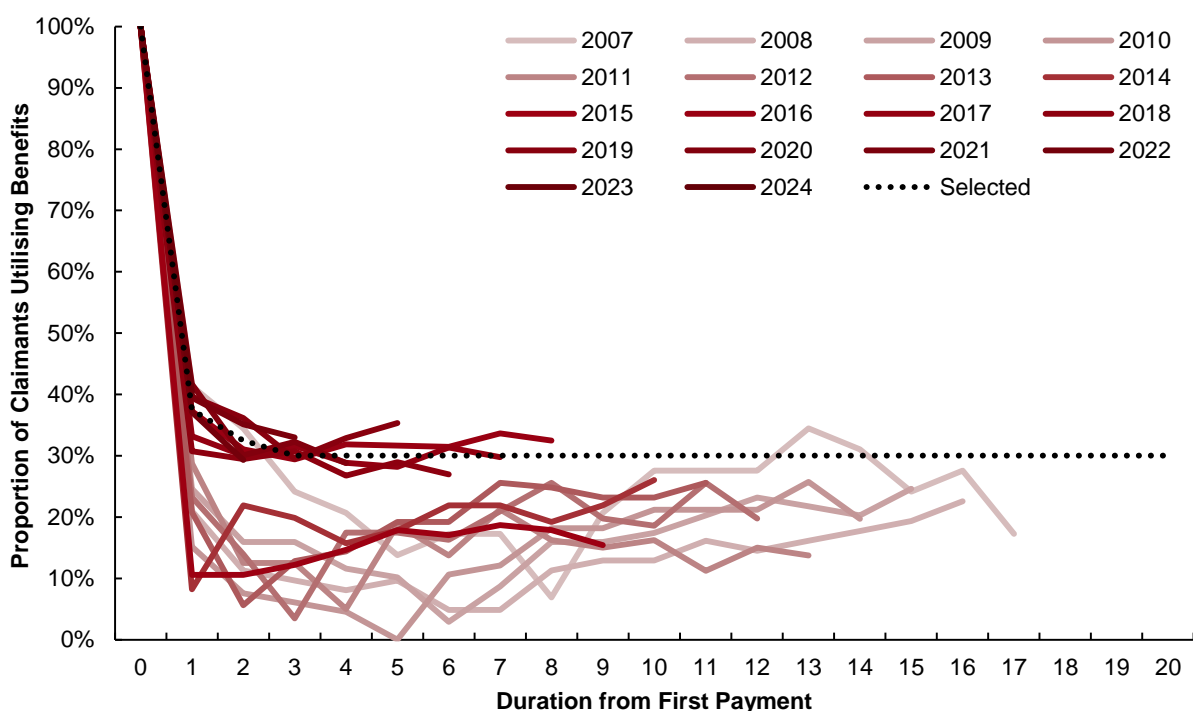


Figure 11.7: Utilisation Rate by Duration from First Payment – Aids and Appliances

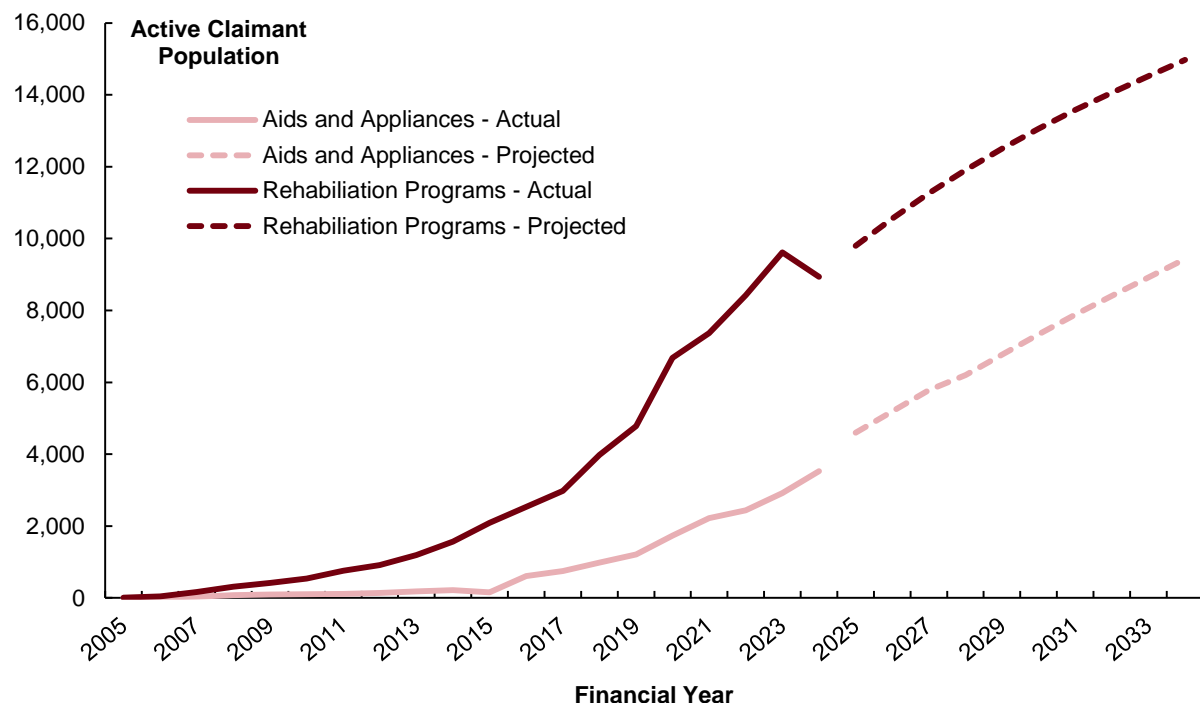


11.2.6 For rehabilitation programs, we have assumed that utilisation declines over time and ceases after 20 years from the first payment. This reflects the nature of rehabilitation programs which

close once the veteran has achieved all the goals of the rehabilitation plan, no longer have capacity to participate in rehabilitation or decide to stop participating in the plan. For the aids and appliances benefit, we have assumed that utilisation will decline in the first few years after first payment and remain constant thereafter. At this point, those still utilising benefits are assumed to continue utilising benefits indefinitely, with an allowance for mortality to reduce the active claimant population over time. This also reflects the ongoing costs associated with medically required aids and appliances, such as replacement costs, maintenance and repairs. RAP is also available to veterans in residential aged care where a facility is unable to provide the item, thus assuming benefits may continue until death is not an unreasonable assumption.

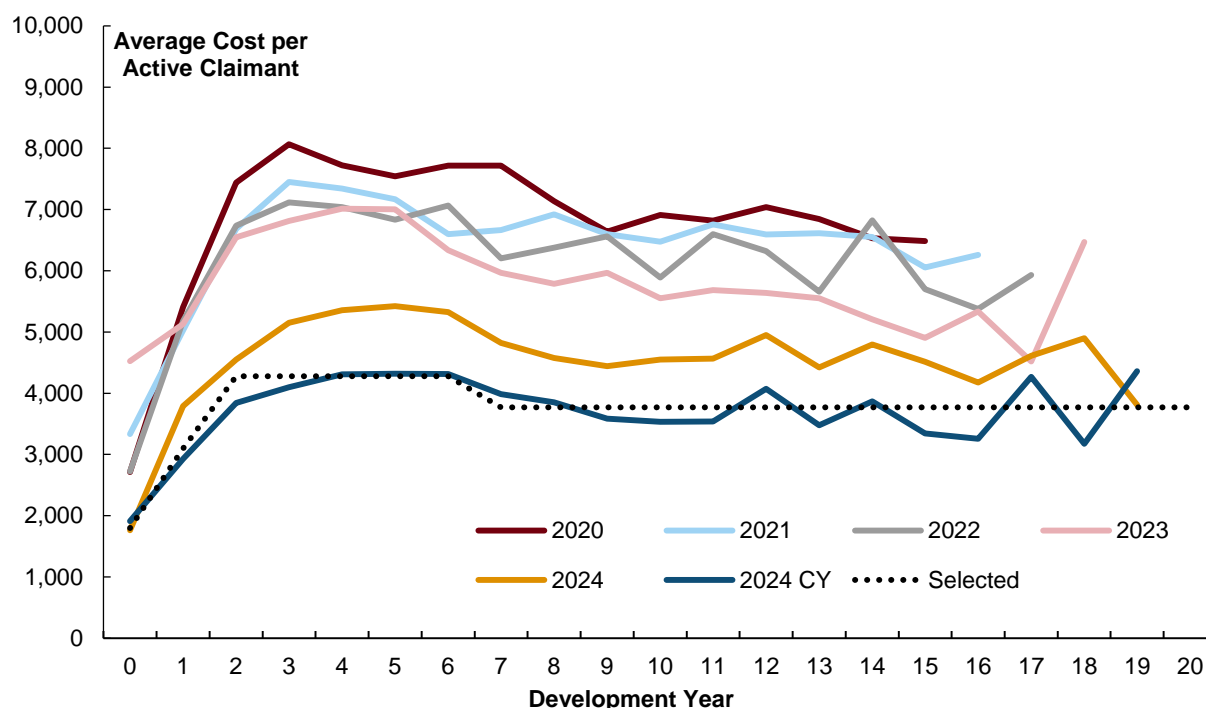
- 11.2.7 Combining the new entrant projection and the assumed utilisation rates results in a projection of the active claimant population for both rehabilitation programs and aids and appliances, shown in Figure 11.8 below.

Figure 11.8: Active Claimant Projection



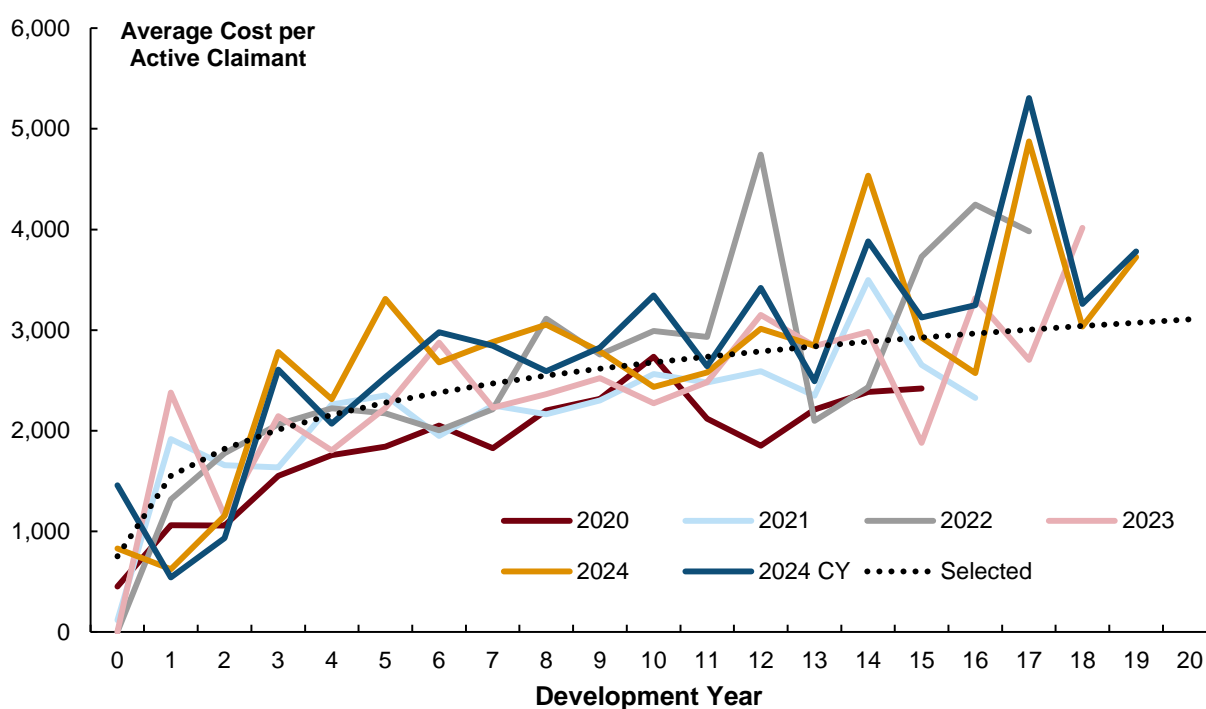
- 11.2.8 The final assumptions required relate to the average payment per active claimant. Figure 11.9 below shows the average payment amounts for the past five financial years as well as the most recent calendar year for rehabilitation programs, along with the selected assumption. Note that payments have been indexed to 2024 dollars. We have adopted the most recent experience, which is lower than observed in prior years after discussions with the DVA rehabilitation policy and program areas. DVA indicated that a recent review of rehabilitation programs had taken place where reassessment of individual veteran needs was conducted and service contracts with new suppliers had been established. There has also been a move away from an 'incremental' approach to service approvals towards baseline packages. As such, recent experience may be more indicative of future experience.

Figure 11.9: Average Payment per Active Claimant – Rehabilitation Programs



11.2.9 Figure 11.10 below shows similar information for aids and appliances. We have allowed the selected average payment amounts to increase over time in line with the observed experience and the adopted assumption is based on the previous two years. We have assumed that the average payment per active claimant remains constant after development year 20 in the absence of information otherwise. We have assumed that the average cost per claimant will increase by 3.7 per cent per annum in future.

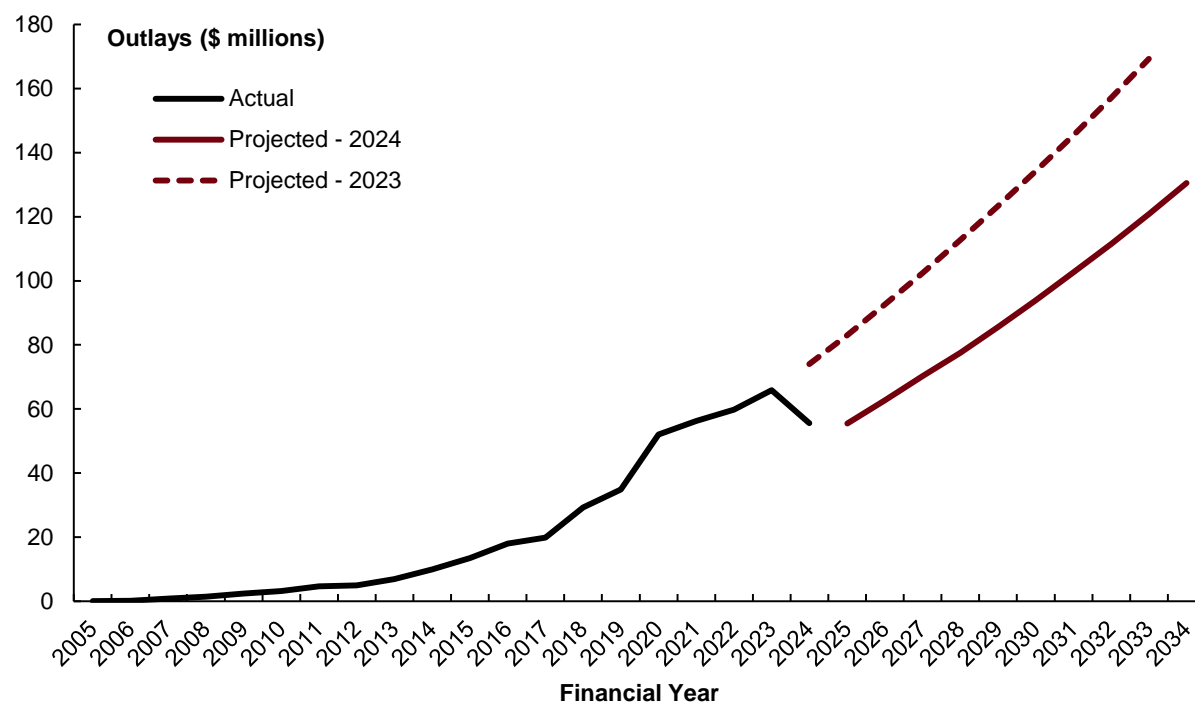
Figure 11.10: Average Payment per Active Claimant – Aids and Appliances



11.3 Projected Payments and Liability Estimate

11.3.1 Figure 11.11 shows the historical and projected cashflows for MRCA rehabilitation, together with the projections from the 2023 valuation.

Figure 11.11: Historic and Projected MRCA Rehabilitation Payments



11.3.2 Table 11.1 shows the estimate of the liability for MRCA rehabilitation costs broken down by accident year. The 2023 valuation projected a liability of \$1,407.1m as at 30 June 2024. The liability at 30 June 2024 is \$1,206.6m; this is \$200.6m lower than projected last year. Table 11.2 reconciles the current liability estimate with the 2023 valuation.

Table 11.1: Outstanding Claims Liability for Rehabilitation Costs by Year of Accident

Year of accident	Liability (\$'m)
2005 – 2009	45.9
2010 – 2014	202.3
2015 – 2019	435.5
2020	109.3
2021	99.0
2022	104.7
2023	104.6
2024	105.3
Total	1,206.6
Expected at 30/06/2023	1,407.1

Table 11.2: Reconciliation of Liability for MRCA Rehabilitation Costs

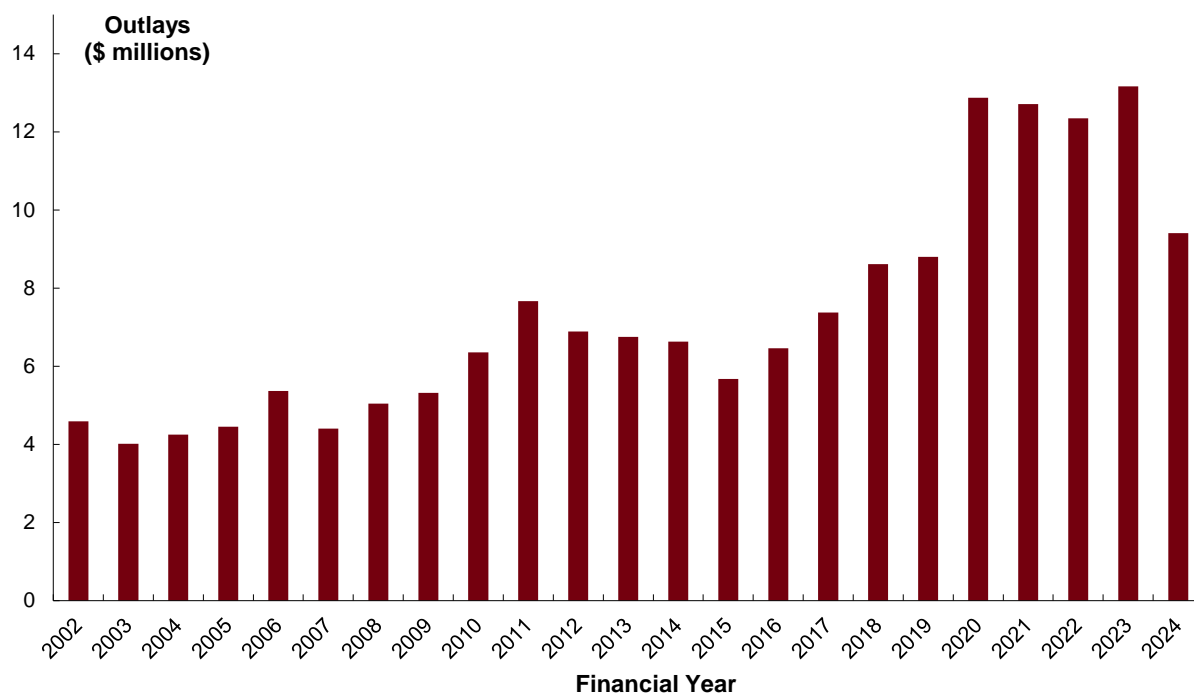
	\$m
Liability estimate as at 30 June 2023 (previous valuation)	1,290.7
Assumed Interest	65.8
Projected Payments	(74.0)
Notional Premium	124.6
Projected liability as at 30 June 2024 (previous valuation)	1,407.1
<i>Experience effects and Assumption changes</i>	
Difference between actual and projected payments	18.4
Change due to experience	(66.1)
Change due to new entrant projection	182.6
Change due to utilisation and mortality rates	(42.4)
Change due to average cost	(293.1)
Current Estimate	1,206.6

12 DRCA Rehabilitation

12.1 Recent Experience

- 12.1.1 The main objective of rehabilitation expenditure is to return the veteran to work. This tends to primarily be through socialisation and retraining with some expenditure also related to minimising claimants' functional impairments, for example through the provision of aids and appliances. DVA clients receiving incapacity payments are required to participate in the rehabilitation program in some cases. DRCA claimants, due to their higher average age, will tend to have reduced prospects for a return to the labour force. At the same time, the degree of functional impairment is likely to increase with advancing age.
- 12.1.2 Figure 12.1 shows the expenditure on rehabilitation for DRCA since 2002. The relative importance of the two objectives in DVA's approach to rehabilitation is likely to have influenced DRCA outlays in this area. For example, DVA advised that the period of rapid growth between 2007 and 2011 was the result of an increased focus on rehabilitation for all veterans, not just those with a prospect of returning to work. Subsequently, rehabilitation efforts became more focussed on return to work programs and, given the older age profile of DRCA claimants, this is likely to have resulted in the decline in outlays from 2011 to 2015. Following Veteran Centric Reform in 2017, expenditure continued to increase until 2020, remaining at similar levels until 2023. Over this period, claimants who were studying were able to retain 100 per cent of their incapacity benefit past the initial 45 week period. DVA staff advised that this led to increasing numbers of claimants remaining on rehabilitation programs than they had seen historically and could have contributed to the high levels of expenditure. This scheme has since closed.
- 12.1.3 Similar to MRCA rehabilitation, a review of existing programs and service providers took place in 2024. The review also revised the way in which programs were offered to veterans, including more homogenous packages of support over incremental approvals which were used previously. This resulted in a significant reduction in expenditure in the latest financial year which is expected to continue going forward.

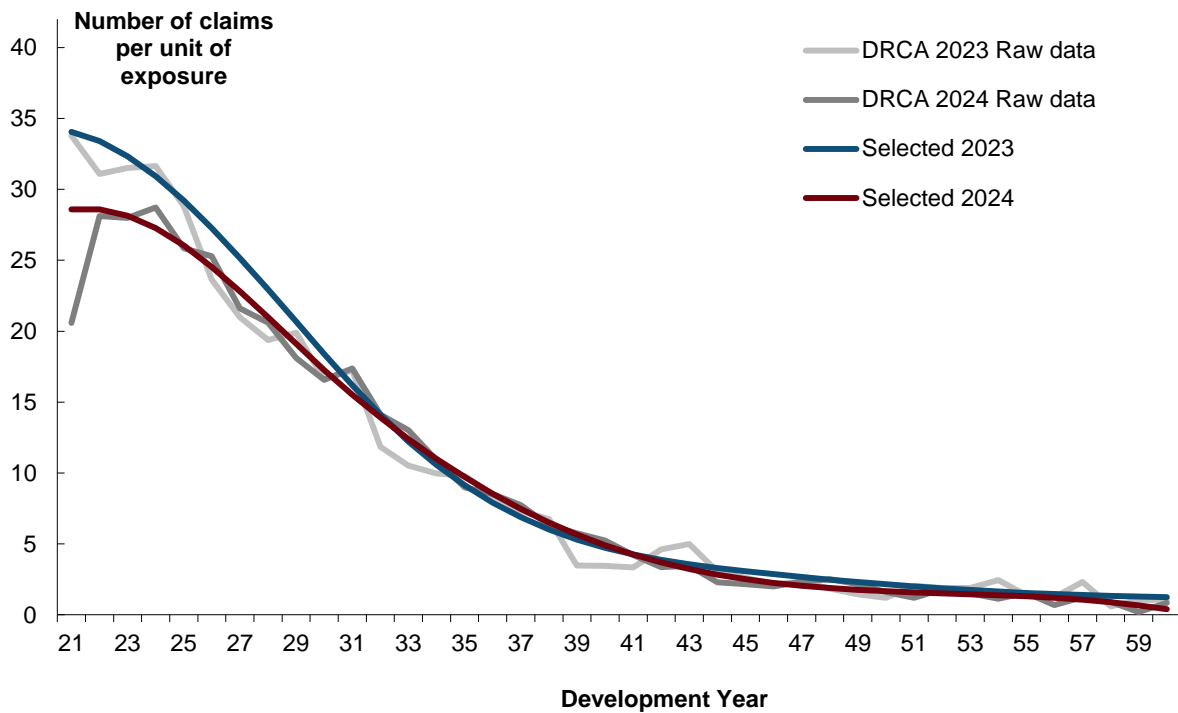
Figure 12.1: Expenditure on DRCA Rehabilitation



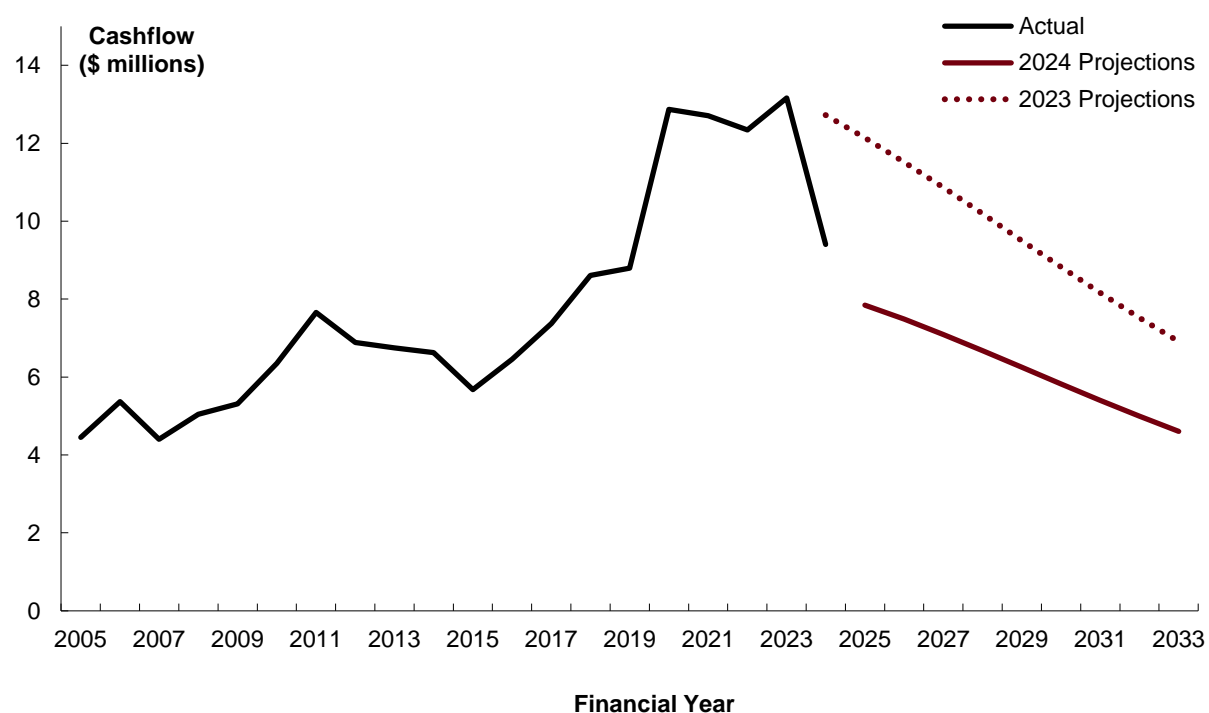
12.2 Valuation Assumptions

- 12.2.1 Our modelling approach involves fitting a cubic spline to the pattern of claims per unit exposure by development year observed over the last two years, and then applying an assumption on average amounts paid per claim.
- 12.2.2 Figure 12.2 compares the number of claims per unit of exposure over the most recent calendar year with the assumptions adopted for the current valuation and the 2023 valuation. The claim rates per unit of exposure are lower compared with the selected assumption from last year's valuation.

Figure 12.2: Number of DRCA Rehabilitation Claimants per unit of Exposure



- 12.2.3 The average cost per claimant was selected to be \$3,200, based on experience over the most recent year. We have assumed that the average cost per claimant will increase by 3.7 per cent per annum in future. This is somewhat higher than the inflation seen over the past few years but we regard it as a reasonable assumption going forward given that costs are expected to be driven in large part by wages.
- 12.2.4 The resulting projected cashflows are shown in Figure 12.3, together with the historic cashflows and the projections from the 2023 valuation.

Figure 12.3: Actual and Projected DRCA Rehabilitation payments


12.3 Liability Estimate

12.3.1 Table 12.1 shows the estimate of the liability for DRCA rehabilitation costs broken down by year of accident.

Table 12.1: Outstanding Claims Liability for Rehabilitation Costs by Year of Accident

Year of accident (year ending 30 June)	Liability (inflated and discounted) (\$'m)
1979 and before	3.3
1980 – 1984	3.5
1985 – 1989	6.2
1990 – 1994	11.1
1995 – 1999	17.1
2000 – 2004	25.6
Total	66.7
<i>Expected at 30/06/2024</i>	103.5

12.3.2 The 2023 valuation projected a liability of \$103.5m as at 30 June 2024. The current estimate is \$66.7m, which is \$36.8m lower than expected. Table 12.2 reconciles the current liability estimate with the earlier figure.

Table 12.2: Reconciliation of Liability for DRCA Rehabilitation Costs

	\$m
Liability estimate at 30 June 2023 (previous report)	111.0
Assumed Interest	5.2
Projected Payments	(12.7)
Notional Premium	0.0
Projected liability as at 30 June 2024 (previous valuation)	103.5
Experience effects and assumption changes	
Difference between actual and projected payments	3.3
Change due to claimant projection	(15.8)
Change due to average cost	(24.4)
Current Estimate	66.7

13 Household Services and Attendant Care

13.1 Benefit Overview

- 13.1.1 Household Services and Attendant Care provide compensation for personal care and domestic assistance and are available under both DRCA and MRCA. Household services (HS) provide essential assistance to individuals who are unable to manage everyday tasks due to a service-related injury or condition. These services can be short-term, aiding recovery after surgery, or long-term for those with complex health issues. Common household services include help with domestic cleaning, shopping, laundry and ironing, lawn mowing, gardening window and gutter cleaning and meal preparation.
- 13.1.2 Attendant care (AC) offers personal care services to meet essential and ongoing needs for individuals affected by service-related conditions. This care includes activities such as bathing, toileting, grooming, dressing, and feeding. Attendant care may be provided on a short-term basis, such as during recovery from surgery, or on a long-term basis for those with chronic health conditions. Some Attendant Care clients have sustained injuries that are classified as catastrophic injuries. These recipients require a higher level of care than other Attendant Care clients, and usually on a long-term basis.
- 13.1.3 DVA can reimburse the veteran (or pay the service provider directly) for approved services up to a maximum rate. If the services are being provided under the DRCA, the maximum amount is currently \$574.76 per week. If the services are being provided under the MRCA the maximum rate is currently \$597.13 per week. Note that this maximum amount is applicable to both household and attendant care services. For catastrophically injured veterans, these maximum rates are waived, and the veteran is reimbursed for all approved services.

13.2 Modelling Approach

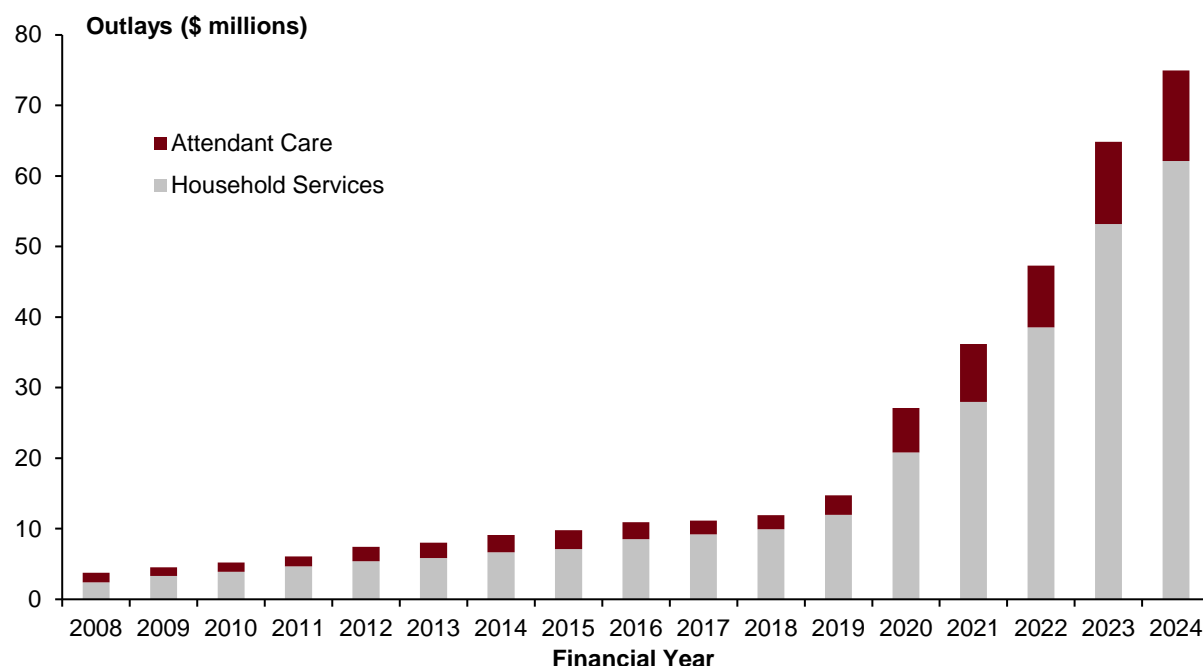
- 13.2.1 Historically, DRCA Household Services and Attendant Care (HSAC) benefits were modelled independently and separately from MRCA HSAC benefits. This year's report combines the HSAC benefits under both acts. Expenditure related to HSAC in the last calendar year was just over \$36 million under DRCA and \$53 million under MRCA. Combined, the expenditure was an increase of more than 25 per cent from the previous calendar year, primarily driven by increased numbers of new entrants.
- 13.2.2 Last year, MRCA AC was accounted for through a loading applied to MRCA HS cashflows, whereas DRCA AC was modelled separately from DRCA HS. This year, AC is modelled separately from HS under both Acts, and DRCA and MRCA AC are modelled together, except for the new entrants model which is separated by Act.
- 13.2.3 The main challenge in separately modelling AC arises from the small number of claimants. In 2024 there were a total of 107 new claimants using AC benefits. The small number of new entrants provides a challenge in constructing a robust claims curve. As such, we have modelled new entrants for HS alone, then scaled up the curve as a proxy for HSAC, taking the difference to be those allocated as new AC claimants. Once new claimants have been projected, AC-specific utilisation rates and average annual costs are adopted to project future expenditure. The process is similar to that used for HS.

- 13.2.4 In the most recent financial year, there were 52 Attendant Care clients under DRCA or MRCA who have had annual costs above \$29,000 (the approximate annual maximum amount; see paragraph 13.1.3). This represents approximately 21 per cent of the current active AC client population. We have separated out AC clients whose annual payments have been over \$29,000 and deemed them to be in the group of catastrophically injured veterans. A separate average cost assumption has been used for these clients.
- 13.2.5 We have separately modelled the number of new claimants and the probability of remaining on benefit for existing and new claimants for household services. New claimants are projected using a claims curve derived from recent experience. Once the number of claimants is established, their ages are determined based on an age distribution, and they are combined with the existing cohort of claimants. Following this, their future utilisation rates and annual average costs are projected. This projection is then overlaid with mortality to derive the liability for the benefit. The assumptions for age distribution and utilisation rates are made separately under DRCA and MRCA for HS. The approach used for modelling household services is similar to the methodology used from the previous valuation.
- 13.2.6 A provision for the current level of open IL claims was also included in our modelling for HS benefits by adjusting the claims curve of new entrants in line with the expected clearance of IL claims under DRCA and MRCA. The adjustment is not made to the AC new entrants model, as it is assumed that new claimants receiving attendant care are prioritised in the IL claim process.

13.3 Recent Experience

- 13.3.1 Figure 13.1 shows the expenditure since 2008, split by benefit type. In total, HSAC expenditure shows a gradual increase from 2008 to 2019. Since 2020, there has been significant year on year growth in total expenditure, largely driven by a higher number of new claimants and greater costs per client. Notably, the expenditure on HS has increased significantly, which may have been due to policy changes in 2019 where household services payments were brought into the needs assessment process and the maximum reassessment period was extended to 5 years. Further, AC expenditure has more than quadrupled since 2019, driven by an increase in new clients deemed critically injured who were previously categorised under Medical benefits and classified as 'Big Medical' in our valuation.

Figure 13.1: Expenditure on HSAC Payments by Benefit



13.4 Valuation Assumptions

13.4.1 The HSAC model requires three main assumptions:

- The new client projection (a projection of people beginning to receive HSAC benefits in each future year, including their age and accident year);
- Utilisation rates (to determine the number of active HSAC clients in each future year);
- Average annual cost per client (to calculate the amount paid for each HSAC benefit client in each future year).

Combining the existing HSAC client population, the projection of HSAC clients in the future and the assumed utilisation rates yields a projection of active HSAC clients in future years. The assumed average annual costs per client can then be applied to calculate the expected outlays in future years. Each model component will be discussed in turn.

13.4.2 Figures 13.2 and 13.3 show the new HS claimant rates per unit of exposure for DRCA and MRCA respectively. We have set our long-term assumption in line with experience over the two most recent calendar years. DRCA experience has been used for development years where none is available for MRCA. Injury dates have been assigned based on average effective dates across a veteran's accepted IL conditions. For both Acts, a proportional loading was applied to account for claimants where a valid injury date was not available. Under both Acts, we have observed a higher number of new HS clients in the most recent calendar year, consistent with the higher number of IL claims processed and accepted this year.

Figure 13.2: New DRCA Household Services Clients by Development Year

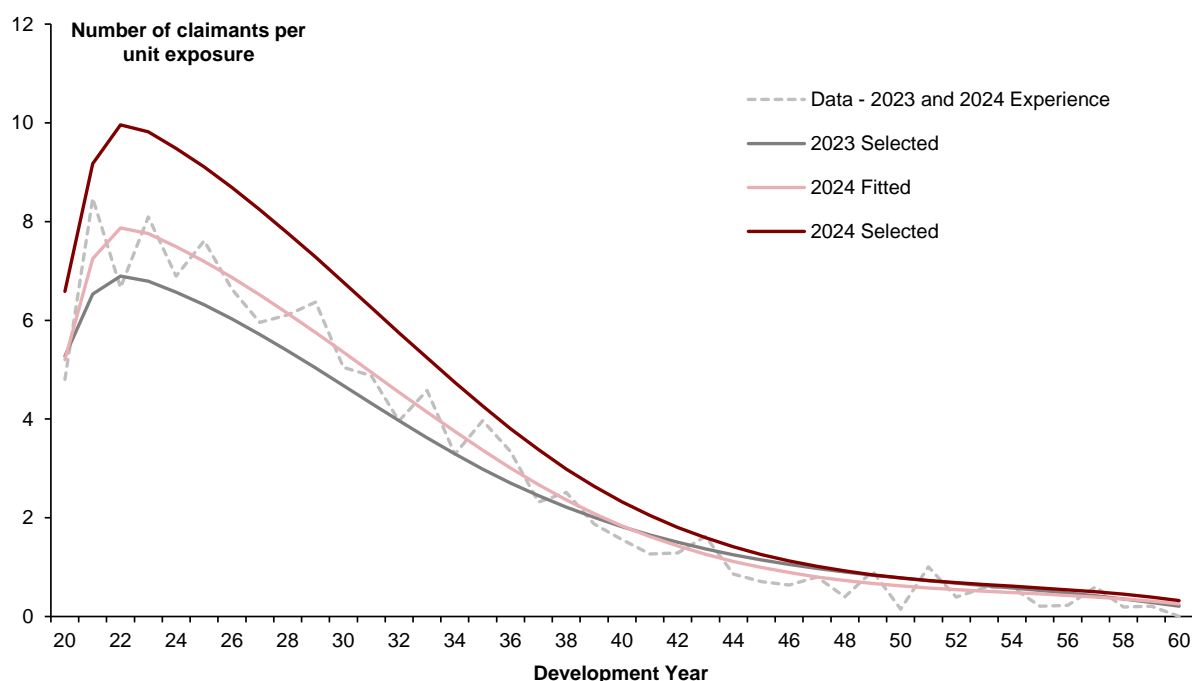
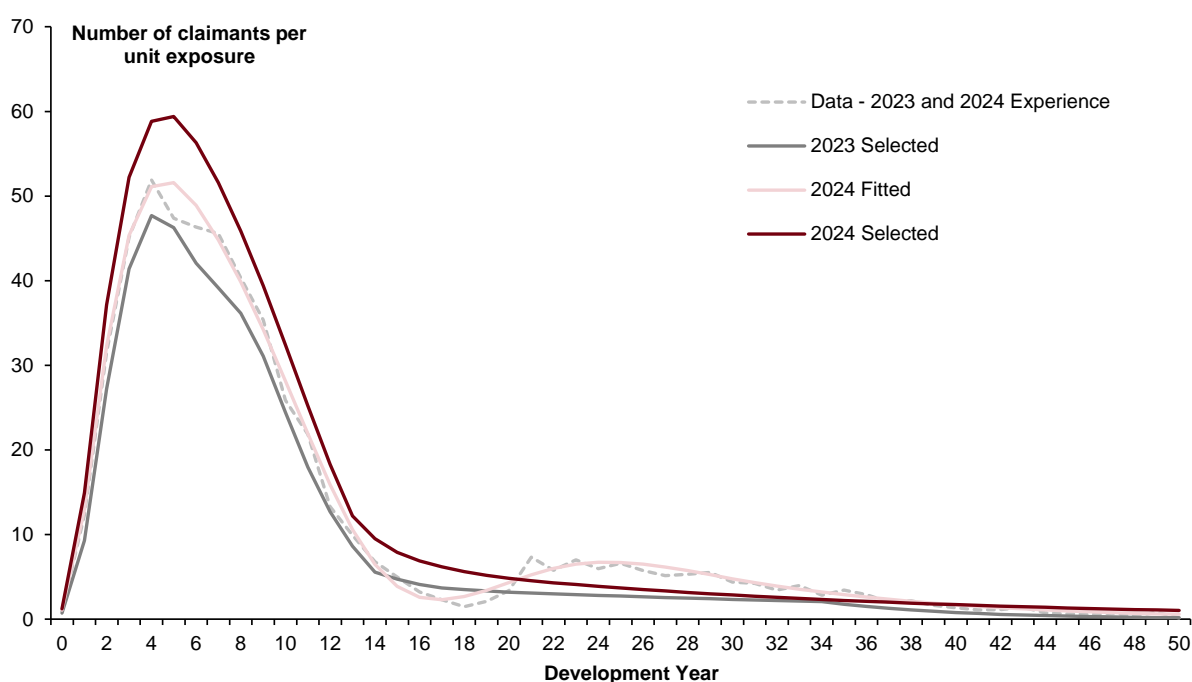


Figure 13.3: New MRCA Household Services Clients by Development Year



13.4.3 We have included an adjustment to the new HS entrant projection, namely, a proportional increase to the new HS claimant rates to account for the impact of processing constraints on HS new entrants. The adjustment recognises that the level of IL claim completions and thus HS new entrants were incommensurate with the level of IL lodgements over the period used to calculate the entrant rates. The proportional increase has been determined by applying IL claim acceptance and HS conversion rates to the level of IL claim lodgements, compared with actual HS entrant numbers. For this valuation, the proportional increases are 27 per cent and

15 per cent for DRCA and MRCA, respectively. These adjustments have been applied to the fitted HS curves, resulting in the selected curves shown in figures 13.2 and 13.3.

13.4.4 Figures 13.4 and 13.5 show the number of accepted IL claims and new household services recipients over time, as well as the conversion rate between the two, for DRCA and MRCA respectively. We have also included the projected level of accepted IL claims based on the IL claims projection, which is broadly based on processing levels seen in recent periods. The adjusted new HS client projections are based on the proportional increases in the claims curves as discussed in section 13.4.3.

Figure 13.4: Projected IL claims accepted and new Household Services clients – DRCA

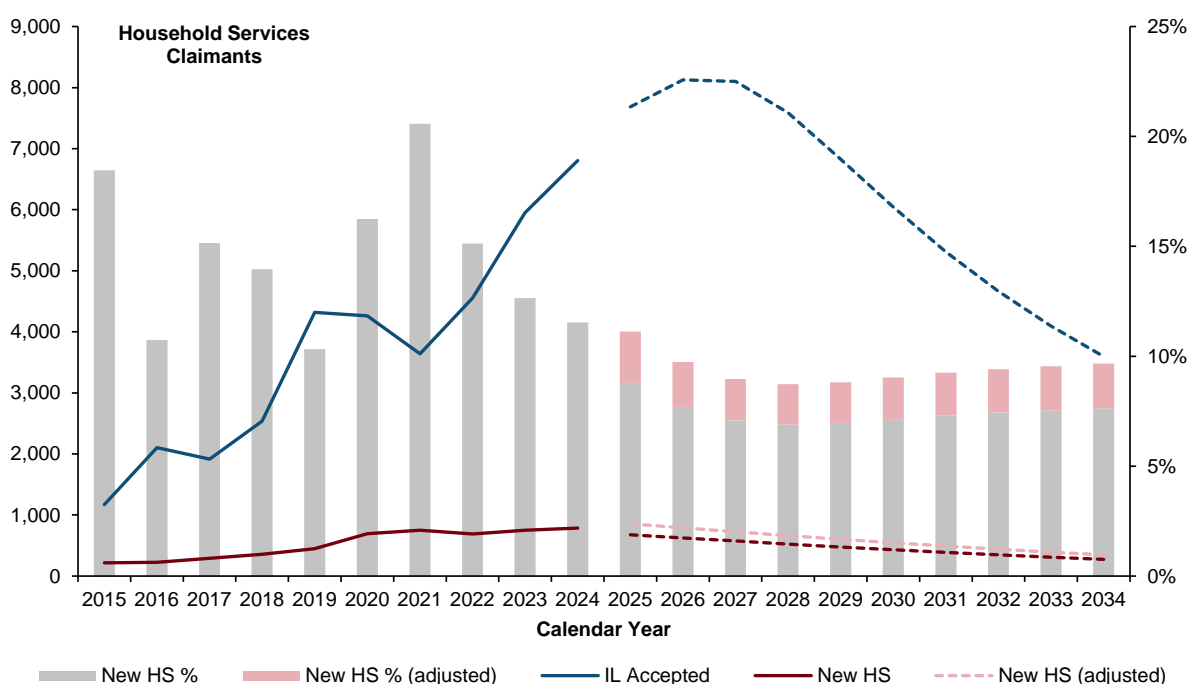
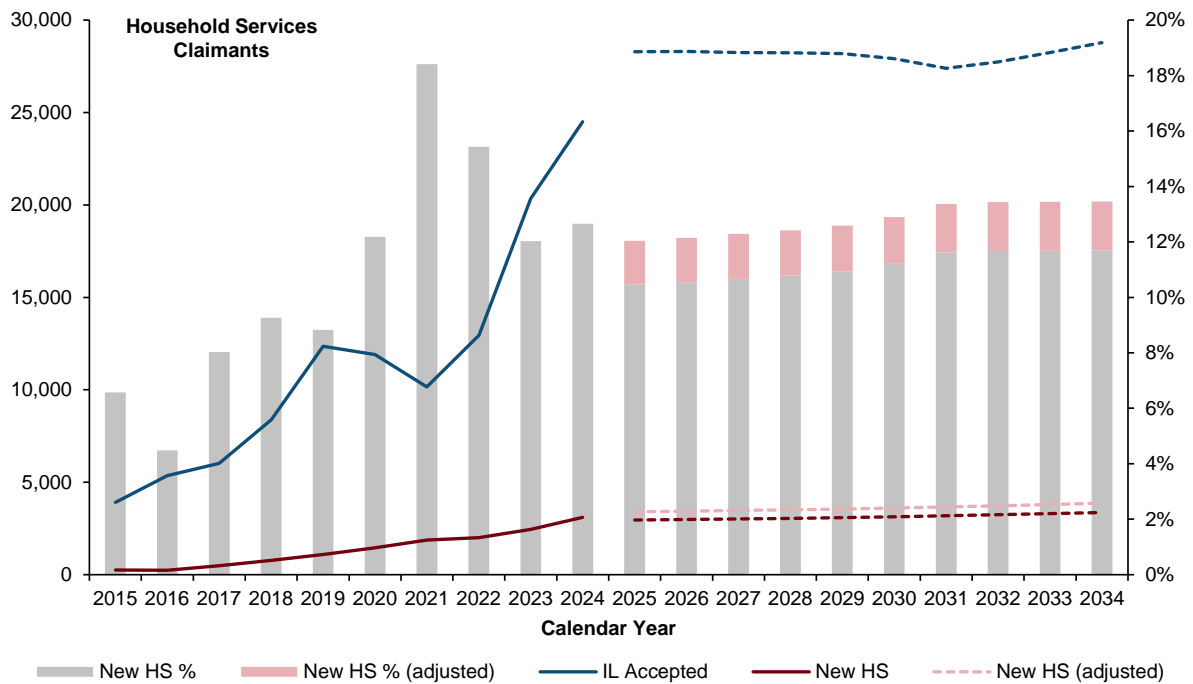
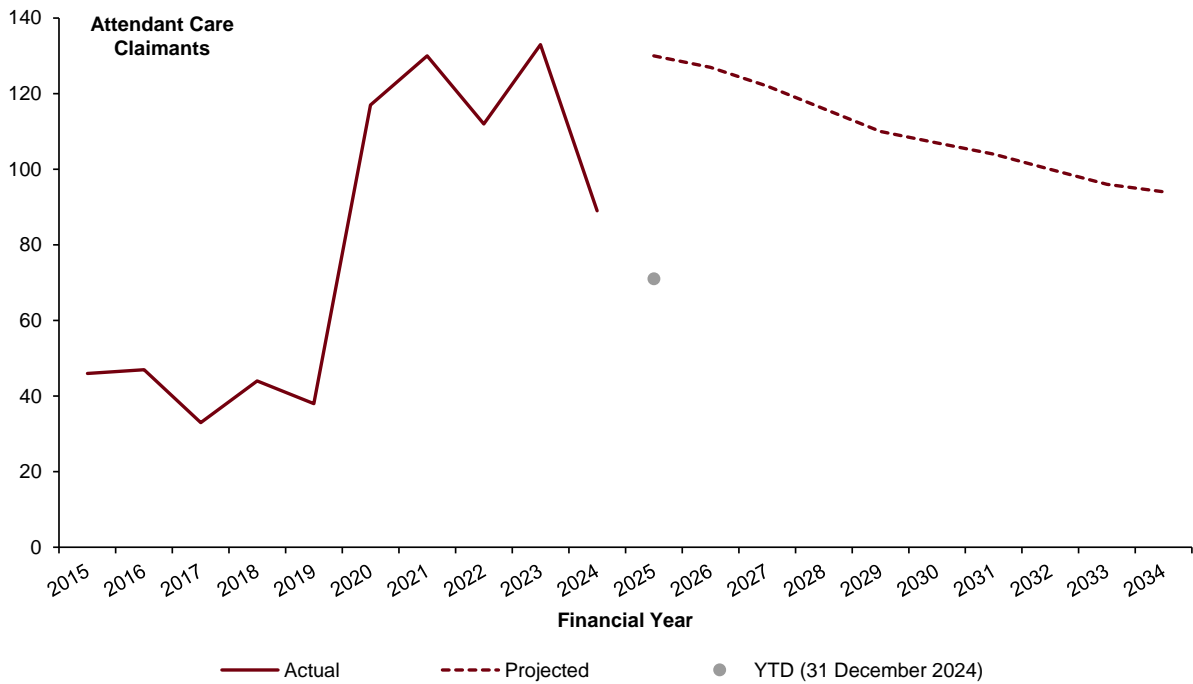


Figure 13.5: Projected IL Claims Accepted and New Household Services Clients – MRCA



- 13.4.5 AC new entrants have been projected as a proportion of HS new entrants. We have assumed that there are no processing constraints on new AC entrants, and thus no adjustments have been made to the new AC entrant projection. Figure 13.6 shows the past and projected new Attendant Care clients under DRCA and MRCA combined. The projected number of new clients is decreasing over time as the projected number of new clients under DRCA is falling more quickly than the projected number of new clients under MRCA. The level of uncertainty is relatively high for these projections as the numbers are small.

Figure 13.6: New Attendant Care Clients



- 13.4.6 Figures 13.7 and 13.8 show the age at injury distribution of HS clients beginning to receive household services for the past five calendar years, and the selected distribution which is based on experience from the two most recent calendar years, for DRCA and MRCA respectively. The age of new clients is calculated based on the age at injury and the delay from injury to the first HS payment for the client. By separating the DRCA and MRCA claimants, we account for the differences in the patterns of age at injury between the two populations. The Attendant Care assumption is the same as Household Services.

Figure 13.7: Age at Injury Distribution for New Household Services Clients – DRCA

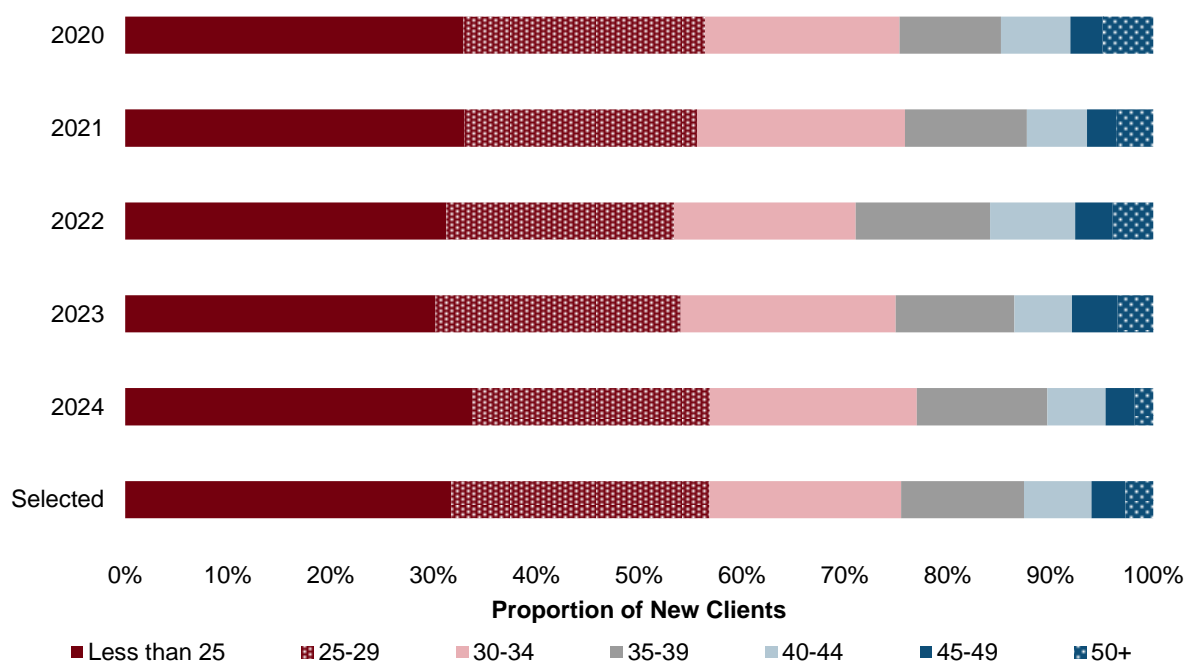
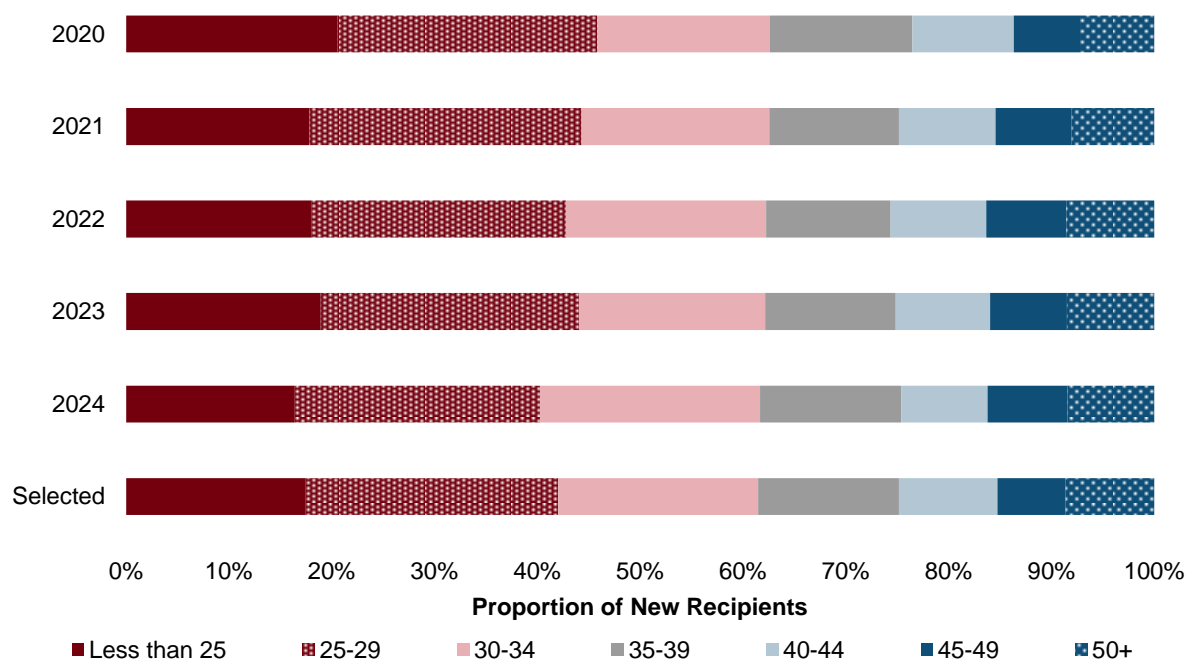


Figure 13.8: Age at Injury Distribution for New Household Services Clients – MRCA



13.4.7 The historic utilisation rates by duration and first payment year for HS benefits under DRCA and MRCA are shown in Figure 13.9 and Figure 13.10 respectively, with the selected utilisation assumptions. The selected DRCA utilisation rates begin at 100 per cent by definition and decrease to 82 per cent at duration 1 for new entrants. This means that if 100 new claimants accessed benefits for the first time in 2025, we would anticipate 82 to continue accessing benefits one year later, in 2026. Utilisation rates have shown an increasing trend in recent payment years, particularly since the introduction of Veteran Centric Reform and the 2019 policy changes. However, it is also important to note that there is limited experience from recent years and there remains uncertainty in how utilisation experience might emerge over

the long term. At this valuation, for new claimants we have set a long-term utilisation rate assumption under DRCA of 70 per cent which is reached by duration 5. The long-term utilisation rate under MRCA is set at 63 per cent, which is reached by duration 3. These reflect trends seen in the more recent experience. All claimants remaining after 5 years of usage will only exit from HS benefits as a result of mortality.

Figure 13.9: Household Services Utilisation Rates - DRCA

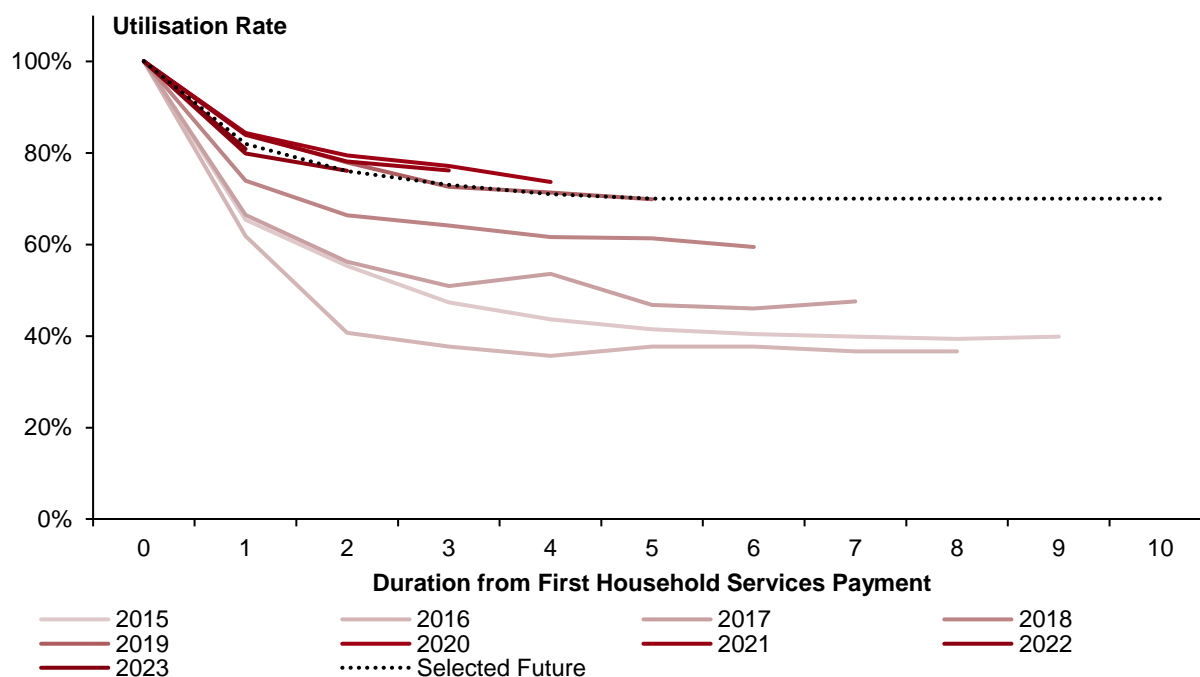
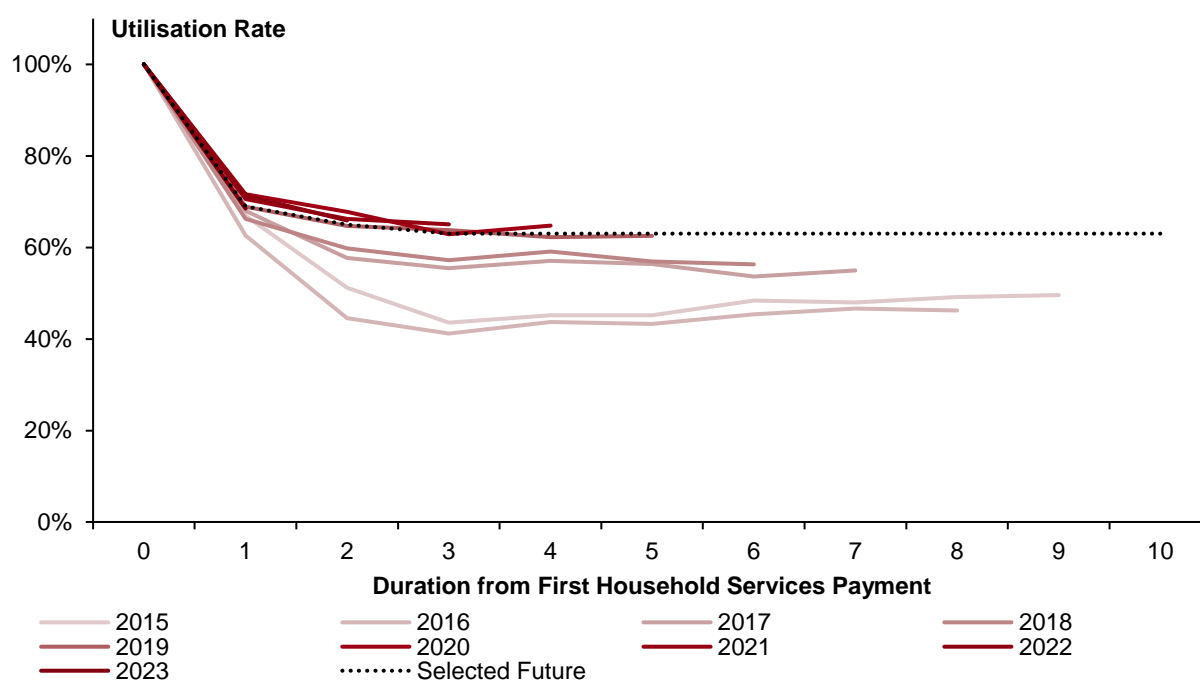


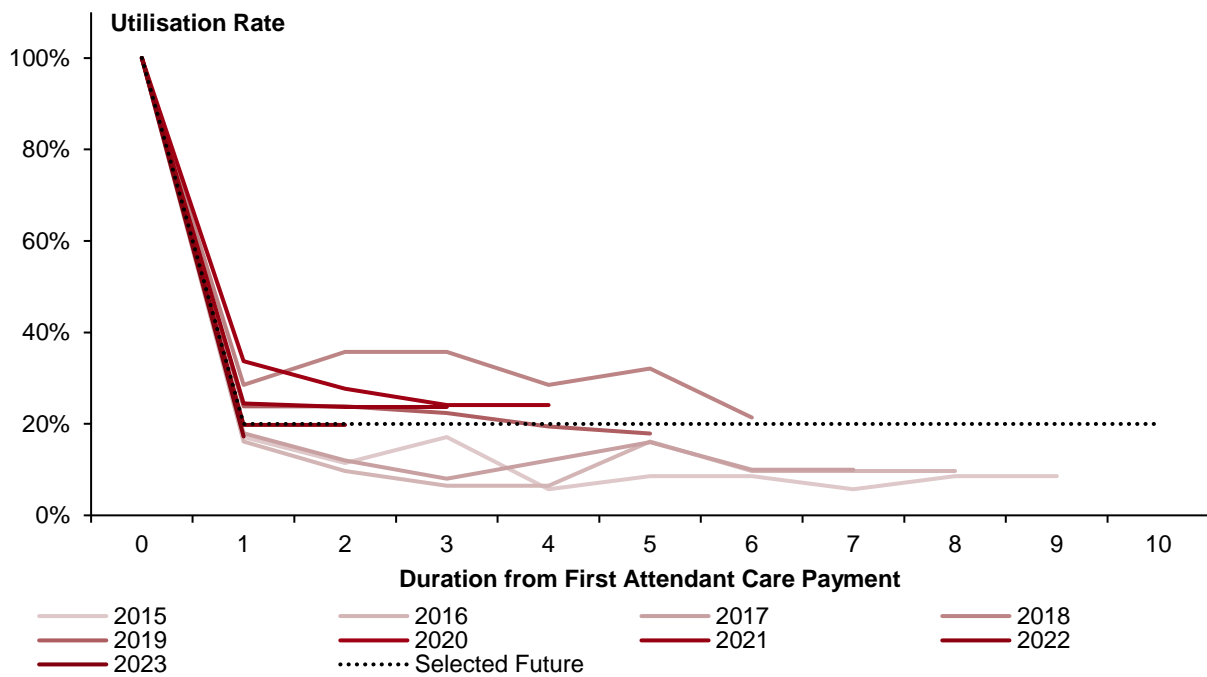
Figure 13.10: Household Services Utilisation Rates - MRCA



13.4.8 Figure 13.11 shows the utilisation rates for AC under both DRCA and MRCA. The data have been grouped together as the AC client numbers are small. The graph shows a deep decline

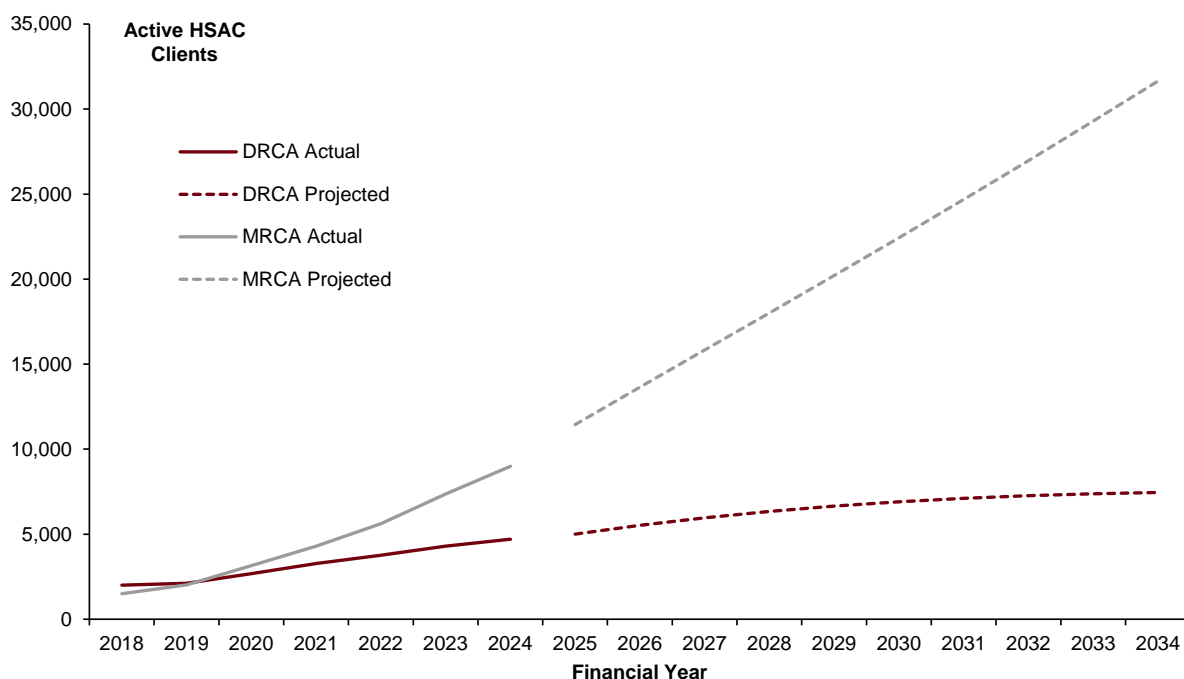
in utilisation after the first year of payment. There is also limited experience for new claimants from recent years and the data is volatile due to the small number of claimants. At this valuation, we have set a long-term utilisation rate assumption of 20 per cent which is reached by duration 1, under both DRCA and MRCA. That is, we assume 20 per cent of the new claimants in each year will continue receiving benefits after the first year, with future exits driven by mortality only.

Figure 13.11: Attendant Care Utilisation Rates



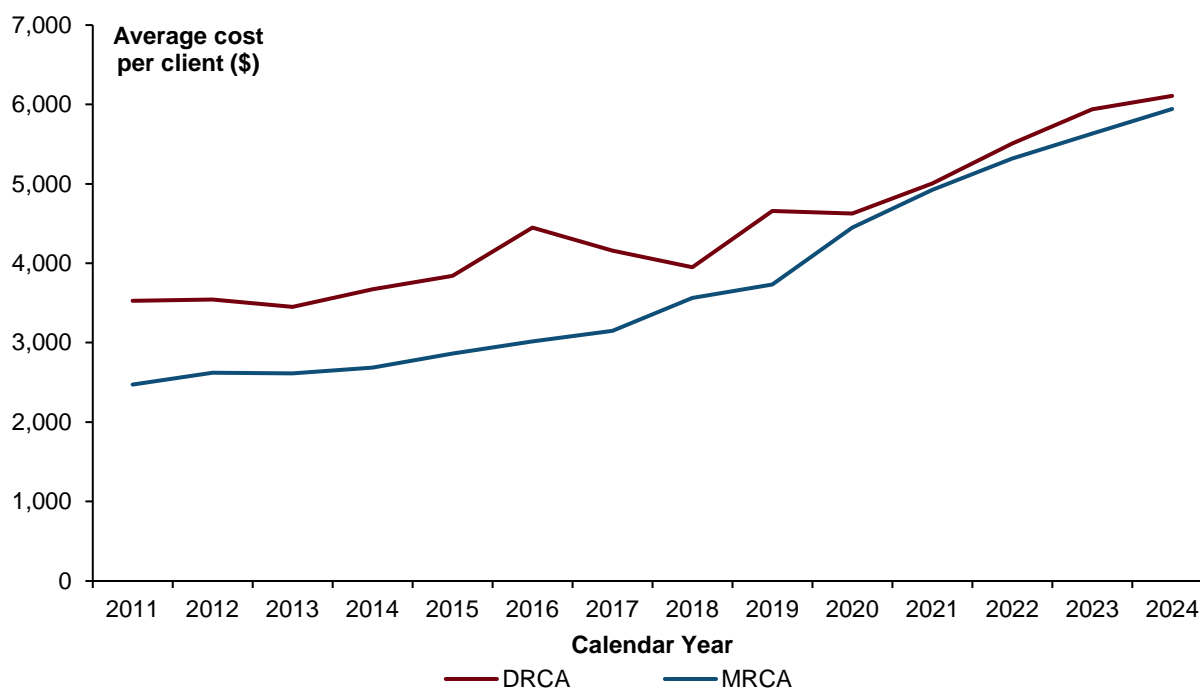
13.4.9 Combining the existing HSAC client population, the new claimant projection and the assumed utilisation rates results in a projection of the future HSAC client population, shown in Figure 13.12 for DRCA and MRCA.

Figure 13.12: Household Services and Attendant Care Client Population Projection



13.4.10 The average annual cost per HS client is shown in Figure 13.13. Since 2020, the average cost under DRCA and MRCA have been very similar, increasing steadily and in line with inflation in the most recent calendar year. For HS, we have assumed an average cost of \$6,000 under both DRCA and MRCA.

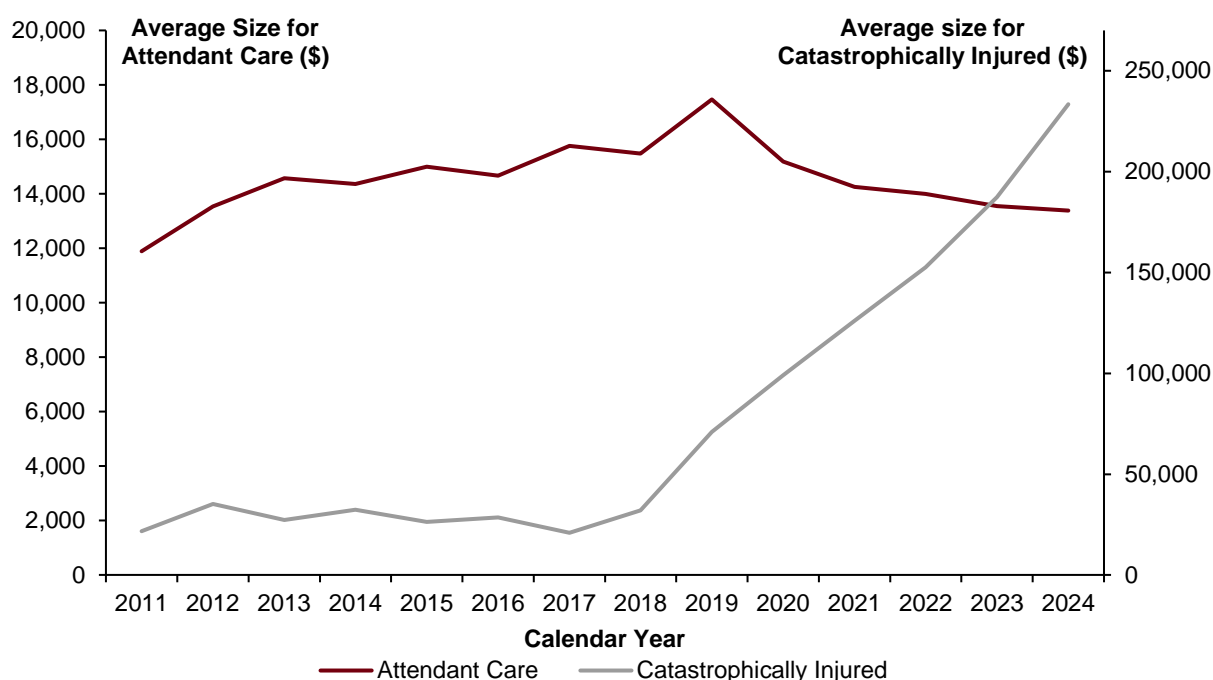
Figure 13.13: Average Annual Cost for Household Services Clients



13.4.11 Figure 13.14 shows the average annual cost for AC clients. In the previous valuation, the average size assumption grouped together the clients that were catastrophically injured with the other AC clients. Since 2019, the average cost for catastrophically injured clients has been

increasing significantly and consistently above inflation. As a result, this year we have made separate assumptions for catastrophically injured clients and other attendant care clients. We have assumed an average size of \$13,500 for AC clients who are not catastrophically injured, and \$233,500 for catastrophically injured clients. We have also assumed that the average cost for catastrophically injured veterans will increase by 5 per cent above the assumed level of inflation each year. We have adopted the same assumptions for DRCA and MRCA AC clients.

Figure 13.14: Average Annual Cost for Attendant Care Clients

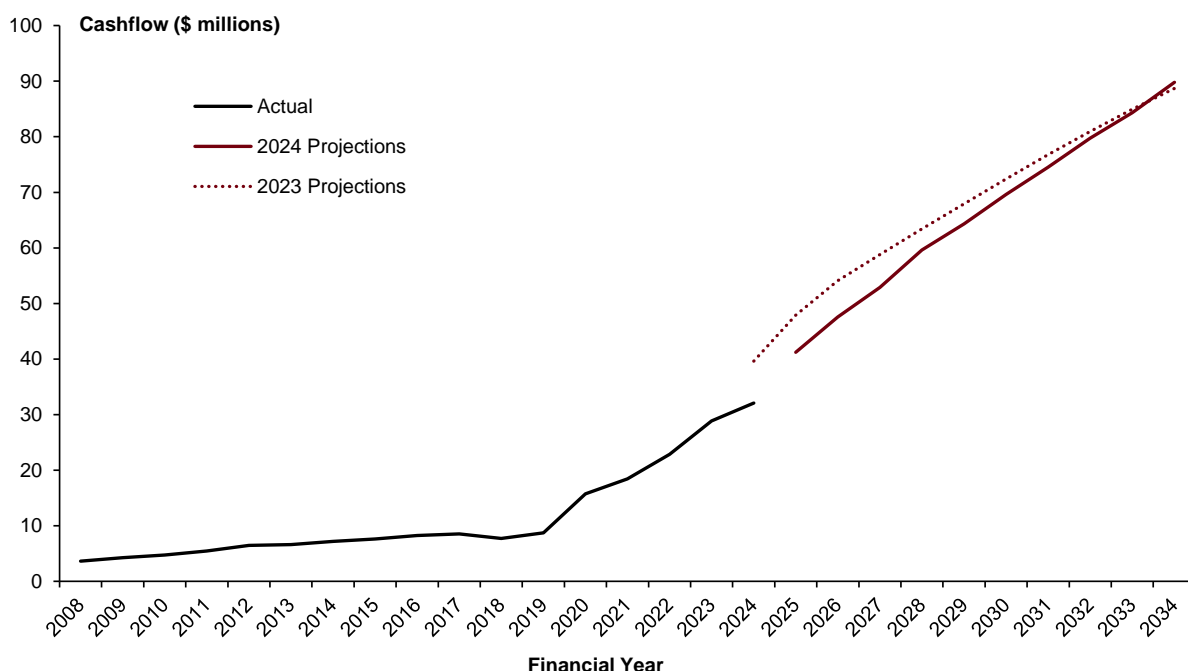


- 13.4.12 As with previous years, the average cost assumptions are based on the experience for clients not in their first year of payments such that only clients with a full year of benefits are included. For new HS and AC clients, we assume entry occurs in the middle of the year, thus only half of the selected average cost is applied in the first year.
- 13.4.13 For AC clients, Defence Superannuation invalidity pensioner mortality rates have been used, as veterans requiring attendant care services are expected to be more impaired and thus have higher mortality rates compared with the general population. For catastrophically injured veterans, we have assumed that they experience a mortality rate of 3 per cent regardless of age, or the mortality rates for invalidity pensioners from the latest available actuarial review of military superannuation, whichever is higher. This assumption has been set on the basis that the injuries suffered by this group are such as to make normal age-related mortality rates largely irrelevant.

13.5 Projected Cashflows and Liability Estimate

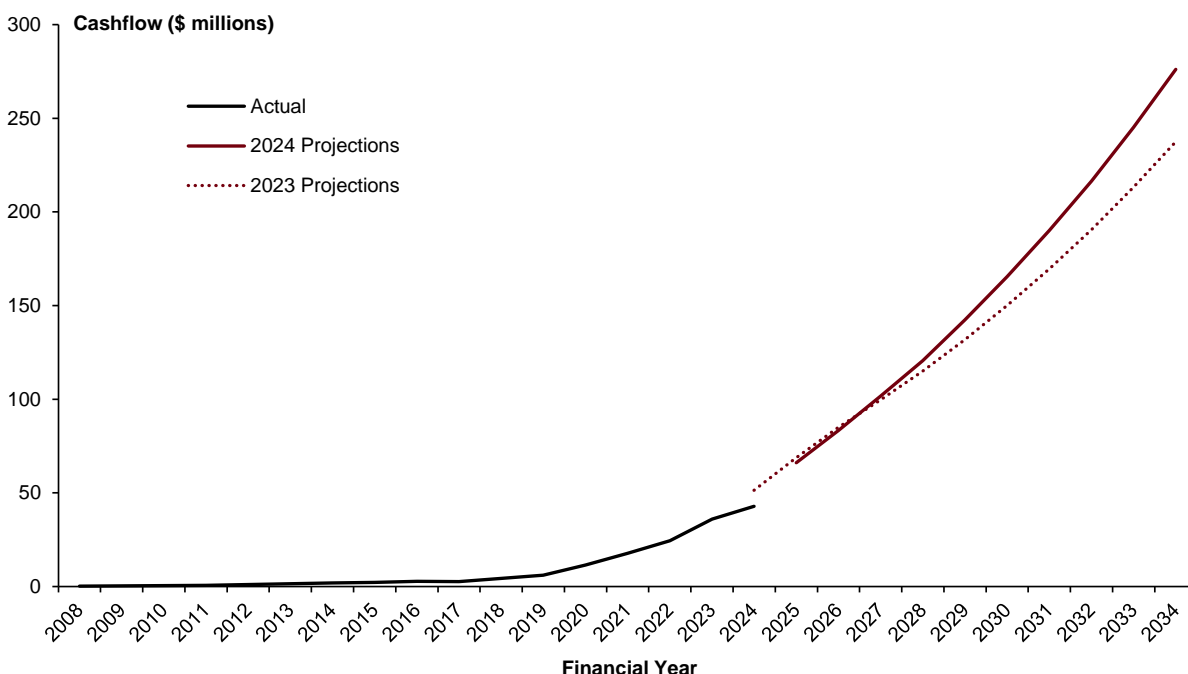
- 13.5.1 Figure 13.15 below shows actual outlays together with projected cashflows for the next 10 years for HSAC under DRCA. The projected cashflows for the next 10 years are lower than last year's projections, as a result of lower expected IL processing capacity in the short term. As the open IL claims are cleared out gradually, the payments related to Household Services are shifted to later years, resulting in a sharper increase in cash outflows.

Figure 13.15: Historical and Projected HSAC Payments – DRCA



13.5.2 Figure 13.16 shows the actual outlays and projected cash flows for the next 10 years for HSAC under MRCA. The steep increase in cashflows is largely driven by large numbers of new HS clients each year.

Figure 13.16: Historical and Projected HSAC Payments – MRCA



13.5.3 Table 13.1 shows the estimate of the liability in relation to HSAC payments broken down by year of accident. The expected liability as at 30 June 2024 from the 2023 valuation was \$5,820.2m. The liability at this valuation is \$6,636.1m, an increase of \$816.0m driven by

changes in the assumptions for new entrants and average cost. Table 13.2 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 13.1: Outstanding Claims Liability for HSAC Payments by Year of Accident

Liability (\$m)			
Year of accident			
1979 and before	43.5		43.5
1980 – 1984	58.1		58.1
1985 – 1989	162.0		162.0
1990 – 1994	270.8		270.8
1995 – 1999	451.0		451.0
2000 – 2004	582.7		582.7
2005 – 2009		283.9	283.9
2010 – 2014		835.9	835.9
2015 – 2019		1,728.9	1,728.9
2020 – 2024		2,219.3	2,219.3
Total	1,568.0	5,068.1	6,636.1
<i>Expected at 30/06/2024</i>	<i>1,543.1</i>	<i>4,277.1</i>	<i>5,820.2</i>

Table 13.2: Reconciliation of Liability for HSAC Payments

	DRCA	MRCA
Liability estimate at 30 June 2023 (previous report)	1,508.3	3,827.7
Assumed Interest	74.4	197.6
Projected Payments	(39.6)	(51.4)
Notional Premium	0.0	303.1
Projected liability as at 30 June 2024 (previous valuation)	1,543.1	4,277.1
Experience effects and Assumption changes		
Difference between actual and projected payments	7.6	8.5
Change due to experience	(118.6)	(113.3)
Change due to new entrant projection	45.1	709.9
Change due to new entrant age distribution	(13.1)	162.7
Change due to utilisation and mortality assumptions	(99.6)	(126.2)
Change due to average cost assumptions	(34.6)	129.5
Change due to modelling methodology for AC	0.0	(288.6)
Change due to superimposed inflation for catastrophically injured veterans	238.3	308.5
Current Estimate	1,561.7	5,352.7

14 Other Benefits

14.1 Benefit Overview

- 14.1.1 The remaining category of Other includes medical examinations, medico-legal reports, legal services, education payments, supplements payments, and smaller ancillary benefits. The costs associated with medical examinations and medico-legal reports dominate this category.
- 14.1.2 Education payments refer to the expenses paid via the MRCA Education and Training Scheme (MRCA ETS) to eligible dependents of ex-service personnel who meet certain criteria (i.e. eligible for the Special Rate Disability Pension, impairment resulting in 80 or more impairment points, or had a service-related death). MRCA ETS payments are paid to eligible dependents under 16, between 16 and 25 if they are undertaking full-time education, and after 25 only if the course commenced prior to turning 25. The main education benefit paid is the Education Allowance (making up 90% of these payments), with other payments for scholarships, income support bonuses and energy supplements (we have valued these energy supplements with the education payments rather than with energy supplements paid to veterans as discussed below). Education allowance payments vary depending on the age of the child and their living arrangements, varying from around \$330 per annum for a primary school child to \$650 per fortnight for secondary/tertiary students living away from home. (No education payments are available to DRCA dependents.)
- 14.1.3 The supplements paid to veterans include:
- The MRCA veteran supplement, that replaces the telephone (and internet) allowance and pharmaceutical allowance for eligible MRCA claimants. It may be payable to a person who is the holder of a White Card or Gold Card, eligible for the Special Rate Disability Pension, or assessed as having a permanent impairment at or above 80 points. It is currently paid at a rate of either \$7 or \$14 per fortnight, depending on eligibility.
 - The MRCA energy supplement, to assist with energy payments. Members may be eligible for the MRCA energy supplement if they receive a Special Rate Disability Pension or a permanent impairment payment. It is currently paid at a rate of between \$0.90 per fortnight and \$10.75 per week, depending on eligibility.
 - The DRCA supplement, designed to compensate DRCA clients who are required to make a co-contribution to the cost of the pharmaceuticals needed for conditions that have been accepted under the DRCA. It is currently paid at a rate of \$7 per fortnight.
- 14.1.4 We have included the veteran and energy supplements paid to dependent spouses in the death benefits part of our valuation (Section 15); the dependent spouse weekly benefit valued as part of the death benefits includes these supplements.

14.2 Modelling Approach

- 14.2.1 For medical examinations, medico-legal reports and legal expenditure, in our previous valuation we modelled these categories separately. There have been some changes in the usage of the various medical and legal payment sub-categories over the years, and so for this valuation we have modelled all of these categories combined. The approach we have taken is to link the number of medical/legal expenses to the number of IL claims completed and PI

claims completed, and utilise the IL claim and PI claim projections discussed in Sections 5, 6 and 7. We have then adopted an average cost based on the most recent experience.

- 14.2.2 For MRCA ETS payments, the child dependent receives periodic payments until reaching age 16 or 25 if studying full time. We have assumed that any child currently in receipt of an education allowance will cease receiving payments on attainment of certain ages, with the assumed decrements similar to the recent past. We have assumed that new entrants for the education allowance are linked to the number of claimants receiving Section 80 payments (as included in our MRCA PI valuation), and have assumed an age at entry distribution similar to recent experience. We have allowed for the amount of the education allowance to vary with the assumed age of recipients, and for the other education payments to be a fixed amount per claimant. MRCA ETS payments are assumed to increase with price inflation every year.
- 14.2.3 The MRCA veteran and energy supplements are ongoing, small periodic payments. We understand that it is rare for a claimant to stop receiving these supplements once eligible. As such, we have assumed that any veteran currently in receipt of a supplement will continue to do so until death. Mortality rates used are the same as those used for invalidity pensioners in the AGA's report "Military Superannuation Schemes Review of Long Term Costs as at 30 June 2023". We have assumed that new entrants for the veteran supplement are linked to the number of claimants exceeding 80 whole person impairment points for the first time, and that new entrants for the energy supplement are linked to the number of MRCA PI claims completed. Energy supplements are not indexed, but the veteran supplement is indexed with price inflation every year.
- 14.2.4 Supplement payments under DRCA are relatively small. As for the previous valuation, we have accounted for supplement payments through the use of a loading applied to the projected cashflows for medical examinations and legal expenses.

14.3 Recent Payment Experience

- 14.3.1 Figure 14.1 shows for MRCA the expenditure on other payments for each of the three subcategories modelled since 2006. Figure 14.2 shows the same for DRCA (noting there are no education payments under DRCA).

Figure 14.1: Expenditure on Other Payments by Category (MRCA)

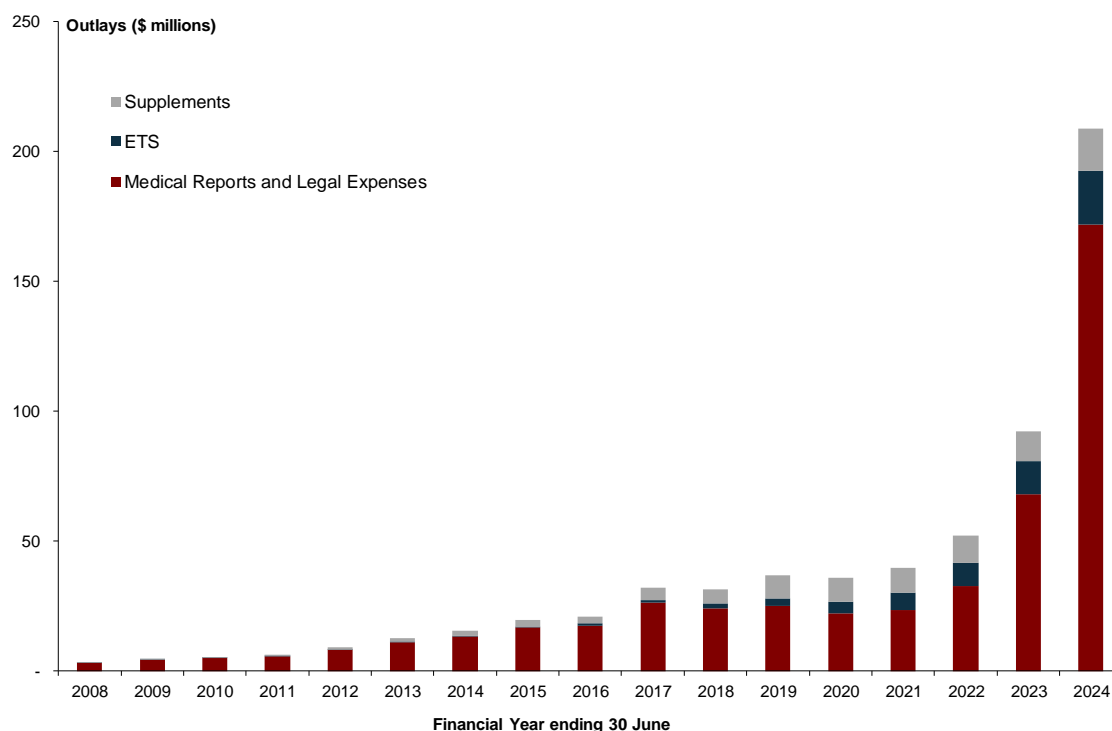
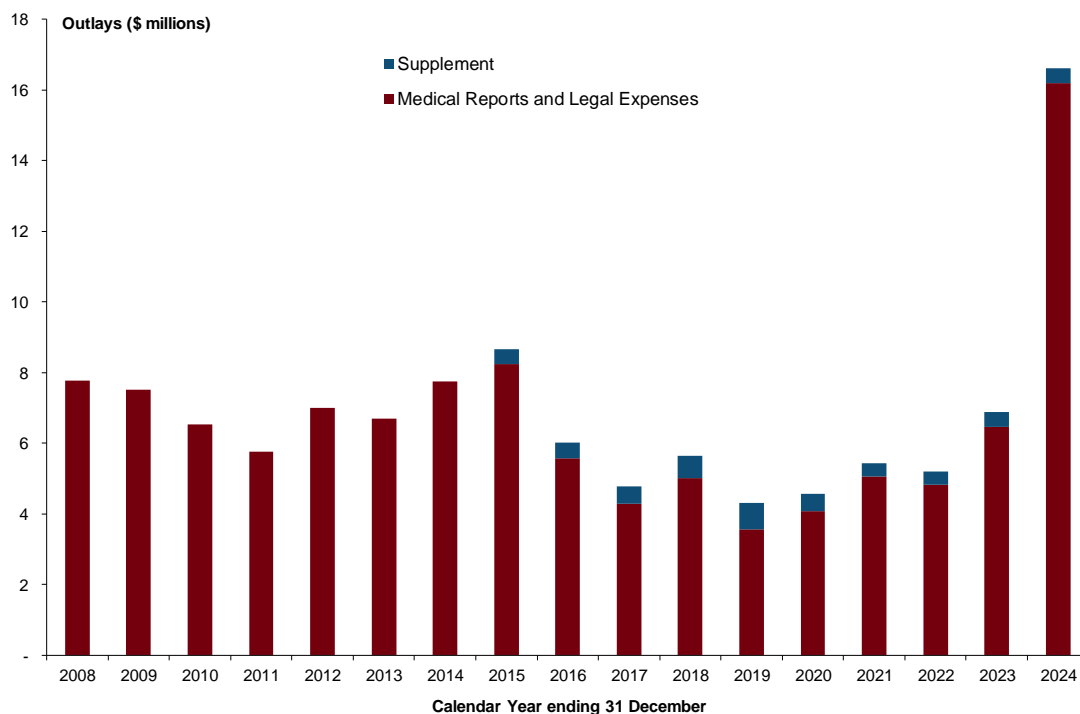


Figure 14.2: Expenditure on Other Payments by Category (DRCA)



14.3.2 For both MRCA and DRCA, there has been an extremely dramatic increase in payments made for medical reports and legal expenditure in 2024, with payments in 2024 being 2.3 times higher than in 2023 for MRCA and 2.5 times for DRCA. Part of this will be due to higher

numbers of IL claim lodgements, IL claim completions and PI claim completions in the last year (and higher numbers of conditions per claim). Anecdotally we have heard from DVA program areas that the increased involvement of fee-for-service advocates might also be contributing to some of the increase.

- 14.3.3 While a relatively small component compared with medical reports and legal expenditure, MRCA ETS payments have increased substantially over recent years, driven by increasing numbers of eligible dependents entering the scheme and the ongoing nature of benefits which last for the duration a dependent is studying. The higher proportion of veterans receiving Section 80 payments under MRCA PI (discussed in Section 6) is likely a driver of the increase in ETS claimant numbers.
- 14.3.4 MRCA supplement payments, while again a small component, have also increased substantially in 2024. This is primarily in the energy supplement payable to those qualifying under the PI criteria and is not surprising given the large number of PI claims completed in the last year. DRCA supplement payments were similar to 2023 levels.

14.4 Valuation Assumptions - Medical Reports and Legal Expenses

- 14.4.1 Figure 14.3 shows for MRCA, over the last five years, the number of claimants with a payment for a medical report/legal expense, and the number of payments made for any medical report/legal service (noting a claimant may have multiple medical examinations, thus payments, in a year). Figure 14.4 shows the same information for DRCA.
- 14.4.2 A large part of the increase in expenditure for medical reports/legal expenses in the last year has been due to growth in the number of claimants receiving such a service. The number of MRCA claimants receiving such a service in 2024 was 40 per cent higher than the number in 2023. For DRCA, the number of claimants in 2024 was double the number in 2023.
- 14.4.3 For MRCA, growth in the number of payments has outstripped the number of claimants over the last five years, with the number of such services per claimant increasing steadily from 1.7 to 2.8 payments per claimant over that period. For DRCA the number of such services per claimant has been stable over the last four years at just over 1.5 services per person.

Figure 14.3: Number of Claimants and Number of Payments (MRCA)

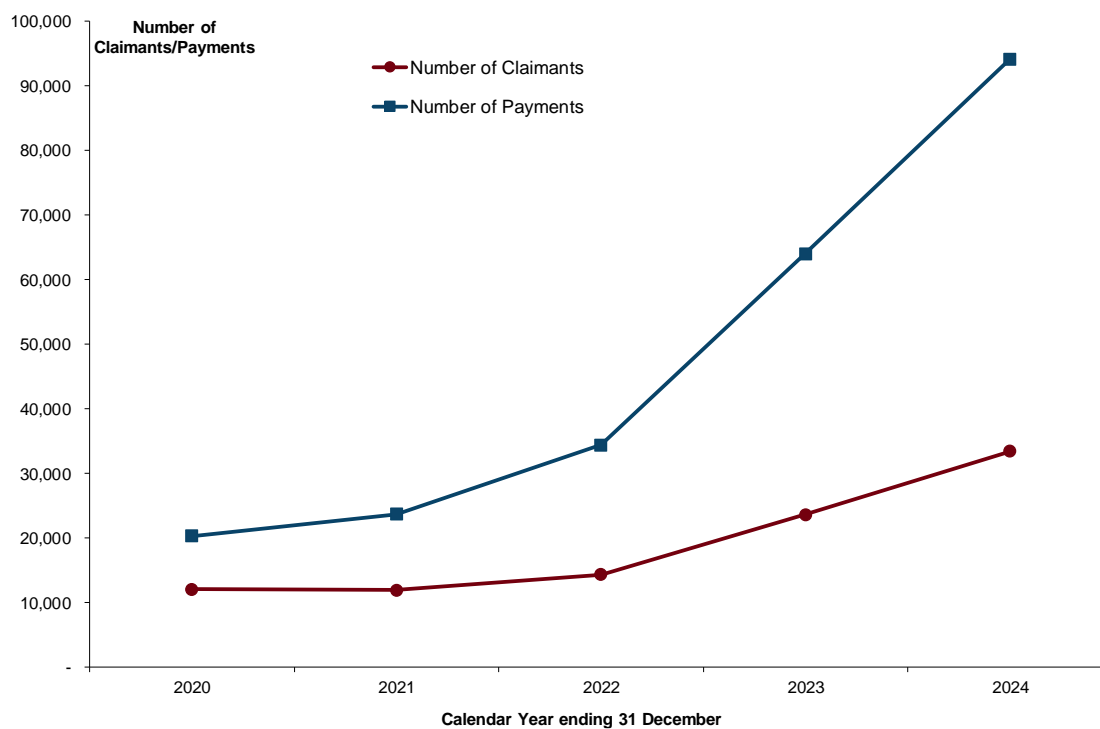
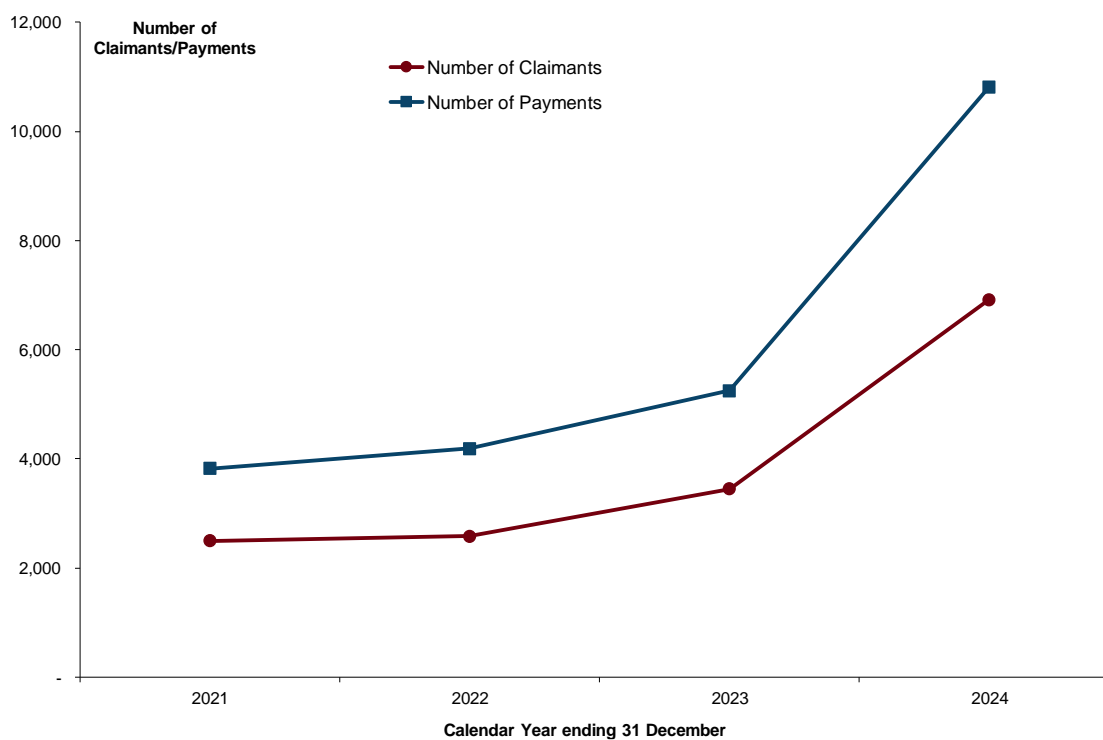


Figure 14.4: Number of Claimants and Number of Payments (DRCA)



14.4.4 Figure 14.5 shows for MRCA, over the last five years, the average amount of expenditure on medical reports/legal expenses both per claimant and per payment while Figure 14.6 shows the same information for DRCA.

14.4.5 The average payment per claimant and the average per payment in 2024 were both substantially higher than in 2023 for both MRCA and DRCA. For MRCA, the average amount per claimant increased by around \$2,300 (79 per cent) while the average amount per payment was \$800 (73 per cent) higher. For DRCA, the average payment per claimant in 2024 was around \$460 (25 per cent) higher than in 2023 while the average amount per payment was \$260 (21 per cent) higher. This compares to our inflation allowance included in the previous valuation of 3.7 per cent.

14.4.6 We have adopted an average cost per claimant equal to the average paid in 2024 i.e. \$5,100 per claimant for MRCA and \$2,400 per claimant for DRCA.

Figure 14.5: Average Payment Per Claimant (MRCA, \$)

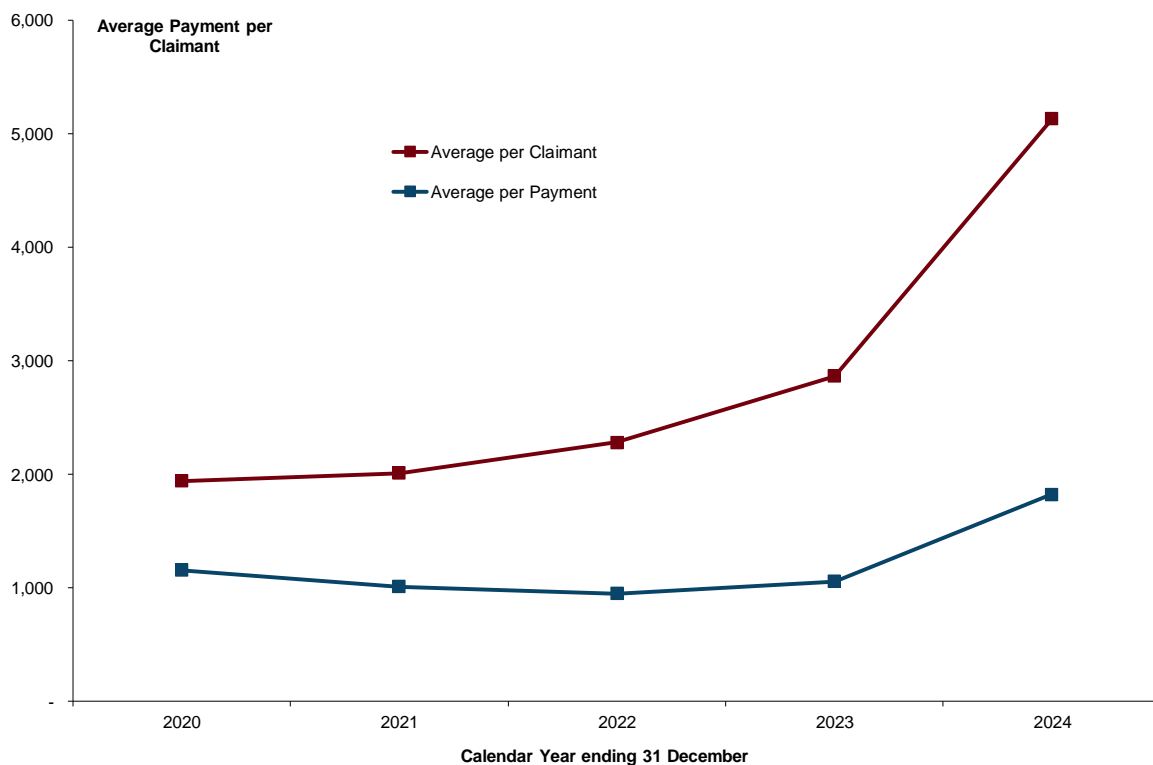
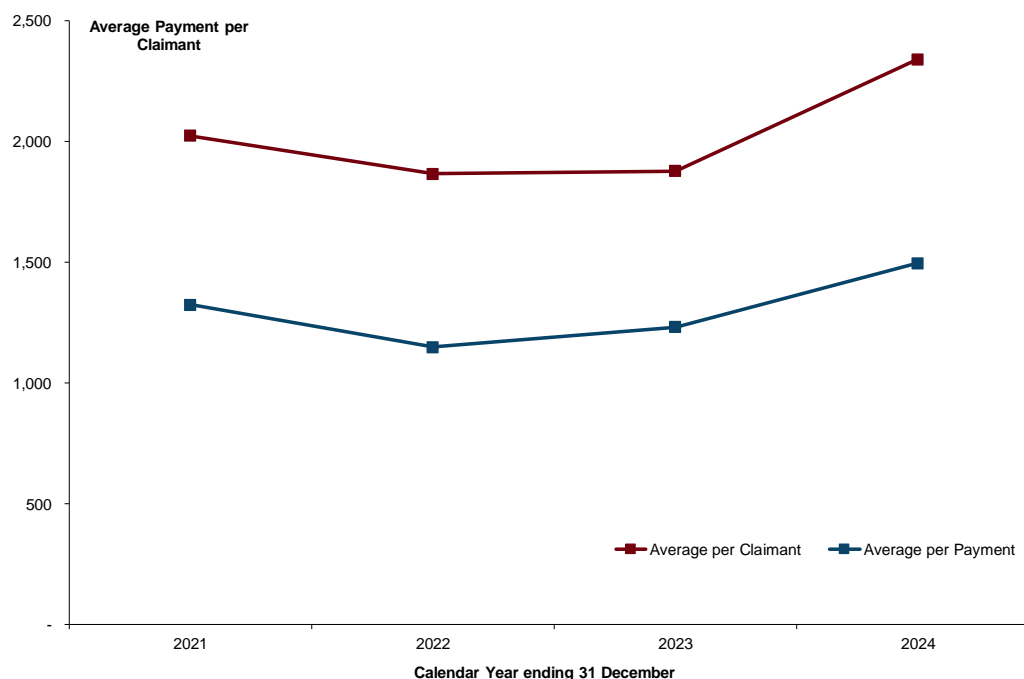


Figure 14.6: Average Payment Per Claimant (DRCA, \$)



14.4.7 Figure 14.7 shows for MRCA the trend in the number of IL claims lodged, IL claims completed and PI claims completed along with the number of claimants in receipt of medical reports or legal expenses. Figure 14.8 shows the same information for DRCA.

14.4.8 While the IL claims lodged/completed and PI claims completed are correlated with the numbers of medical reports sought, the relationship is not perfect as reimbursement for examinations can occur prior to when a claim is finalised and the need for exams will vary between claimants.

Figure 14.7: Number of IL Completed and Medical Examinations (MRCA)

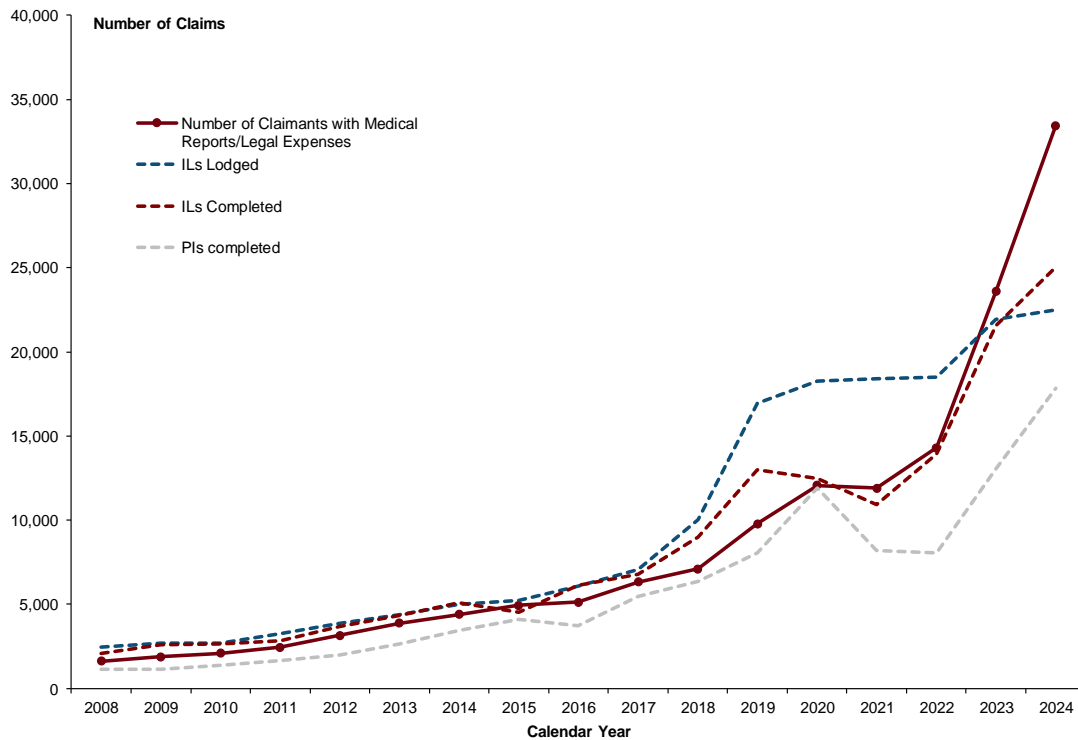
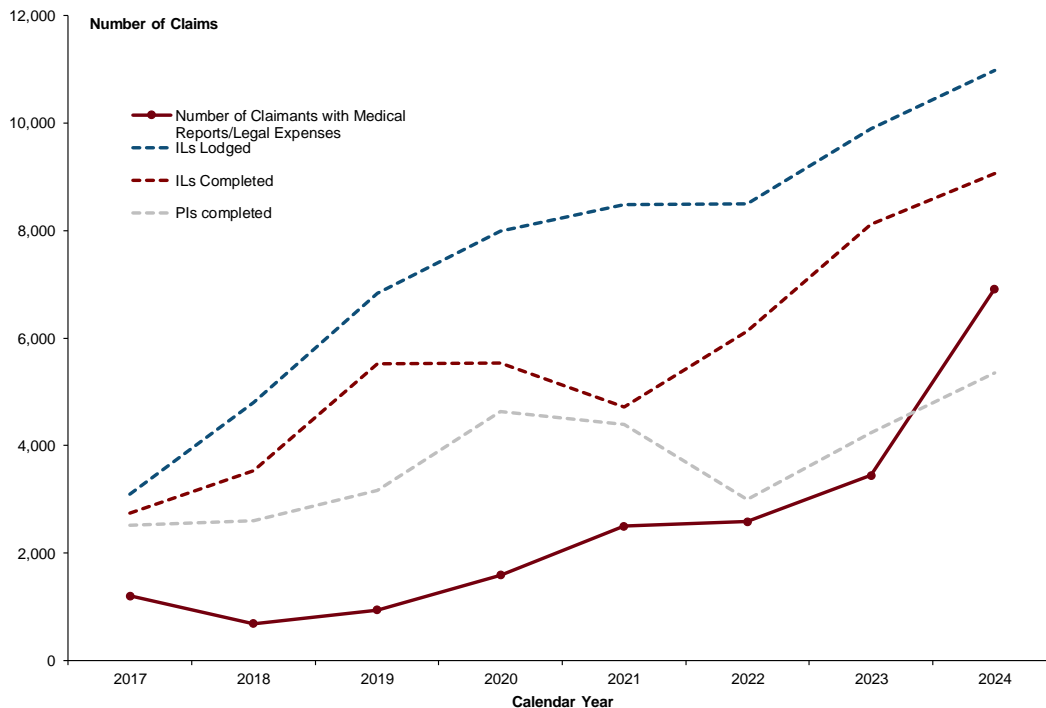


Figure 14.8: Number of IL Completed and Medical Examinations (DRCA)



14.4.9 For this valuation, we have assumed that the future number of claimants in receipt of medical reports/legal expenditure will be proportional to the number of IL claims completed combined with the number of PI claims completed. Figures 14.9 and 14.10 show the historical and adopted proportions for MRCA and DRCA respectively. We have adopted proportions for each

scheme that are equal to the 2024 experience. These proportions could reduce in the future as we expect that the recent heightened experience is likely caused (to some extent) by increased fee-for-service advocacy involvement in the claims process. This may moderate going forward with initiatives such as the establishment of the Veteran Advocacy Institute amongst other measures. We will monitor this metric closely in future valuations.

Figure 14.9: Number of Claimants per Completed IL Claim and Completed PI Claim (MRCA)

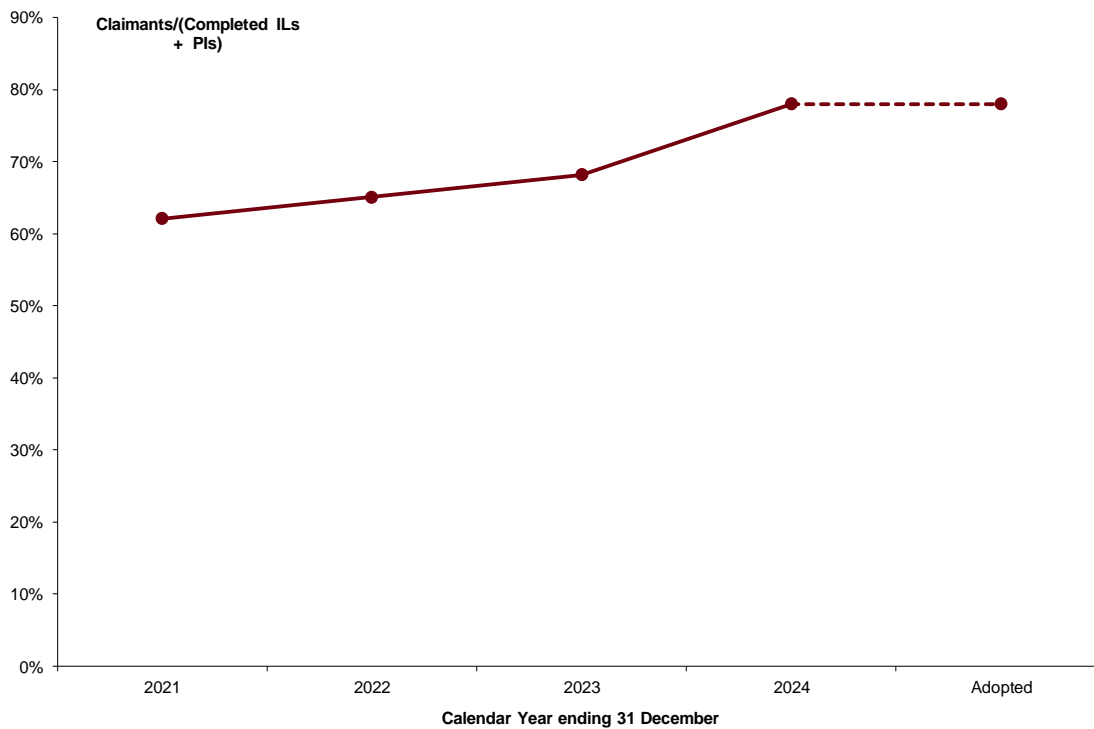
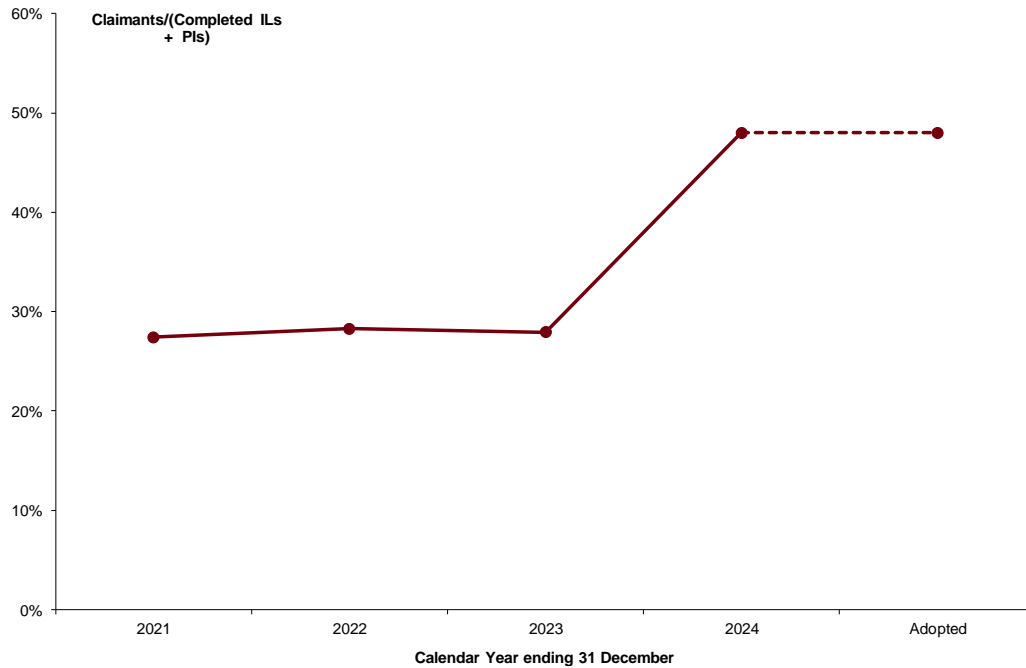


Figure 14.10: Number of Claimants per Completed IL Claim and Completed PI Claim (DRCA)



14.4.10 Figures 14.11 and 14.12 shows the actual and projected number of claimants in receipt of medical reports or legal expenses for each of MRCA and DRCA.

Figure 14.11: Actual and Projected Number of Claimants (MRCA)

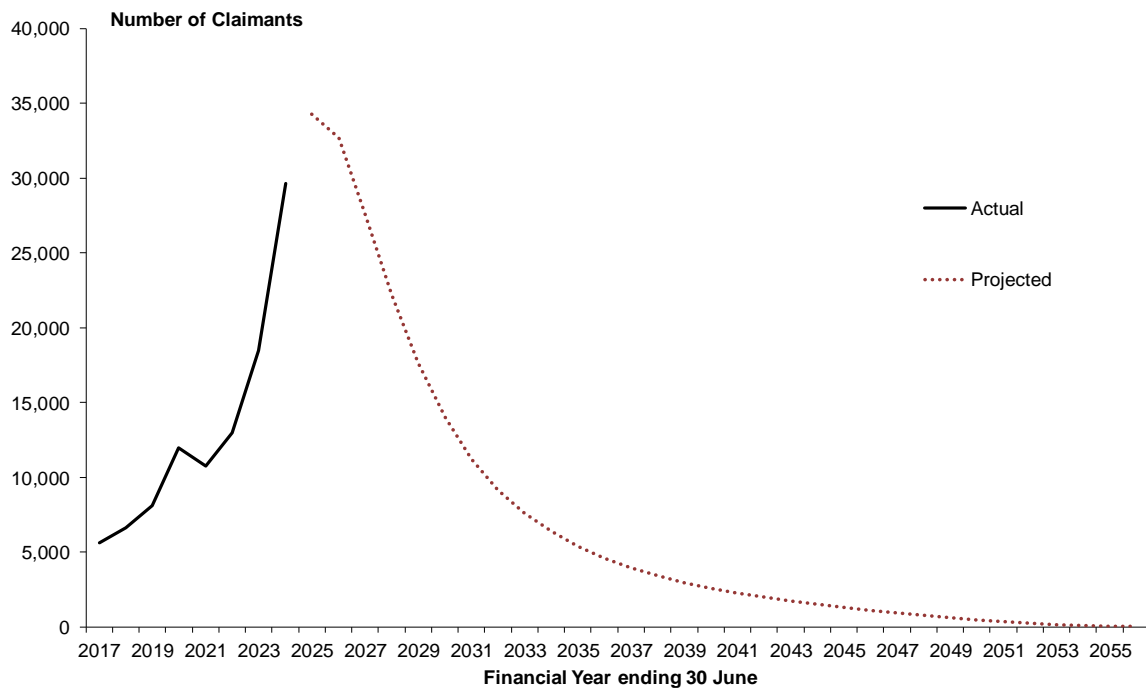
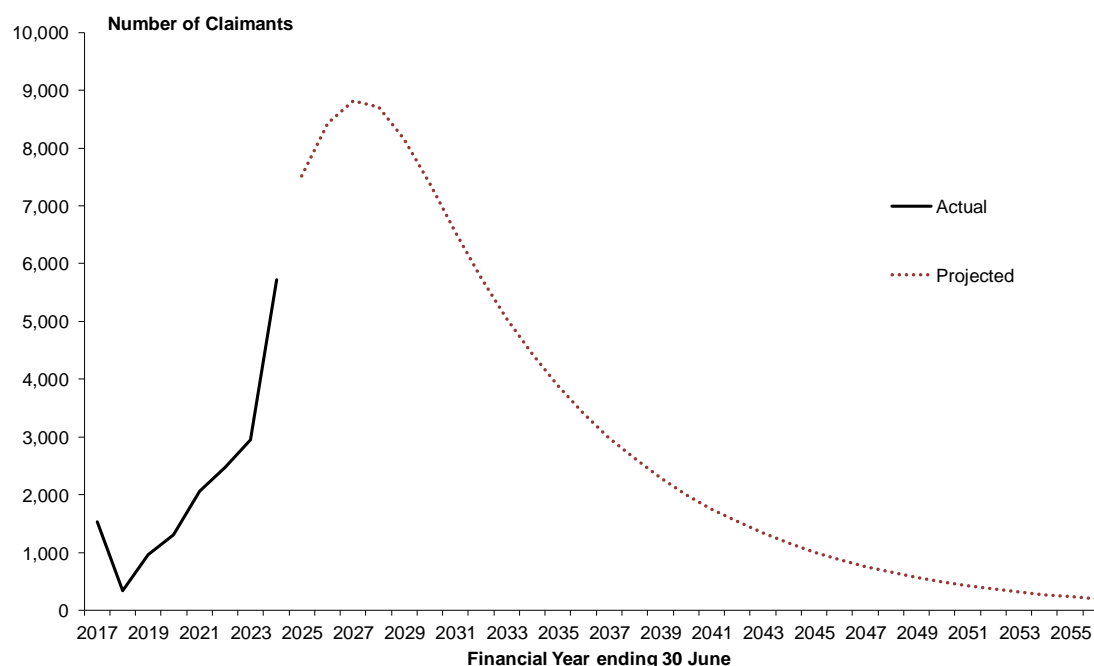


Figure 14.12: Actual and Projected Number of Claimants (DRCA)


14.5 Valuation Assumptions - ETS Payments

14.5.1 Table 14.1 shows the number of recipients of ETS payments in the 2024 financial year and their estimated age (noting we are only supplied with their year of birth).

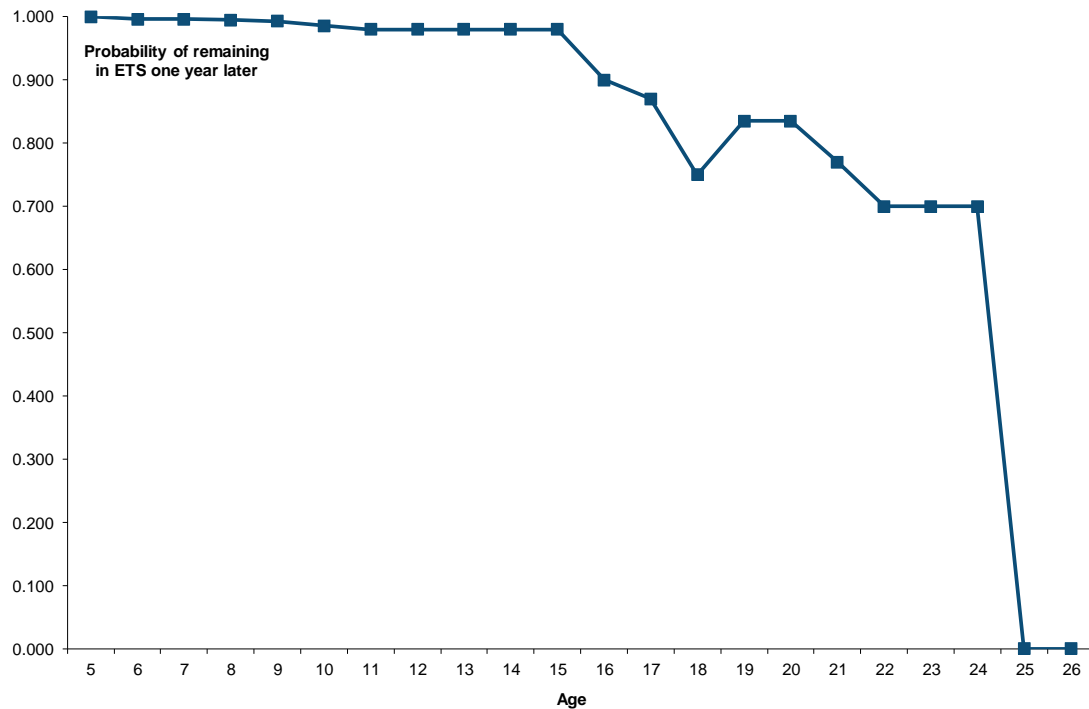
Table 14.1: MRCA ETS recipients

Age in FY2024	Number of Recipients
5 and under	203
6-7	452
8-9	586
10-11	641
12-13	615
14-15	629
16-17	545
18-19	294
20-21	206
22-23	95
24+	51
Total	4,317

14.5.2 We have assumed that these recipients will cease receiving ETS payments in accordance with recent experience as shown in Figure 14.13. The graph shows the probability that an ETS recipient will remain in the scheme for another year. Very few recipients cease receiving benefits prior to age 16. There are then higher decrements associated with the ages children typically leave high school (ages 16 to 18) and again at the typical ages of ceasing tertiary

education (ages 21 and 22). We have truncated the distribution after age 25 to align with the age eligibility criteria for ETS payments, noting that there are very small numbers of recipients receiving benefits beyond this age (currently less than 10).

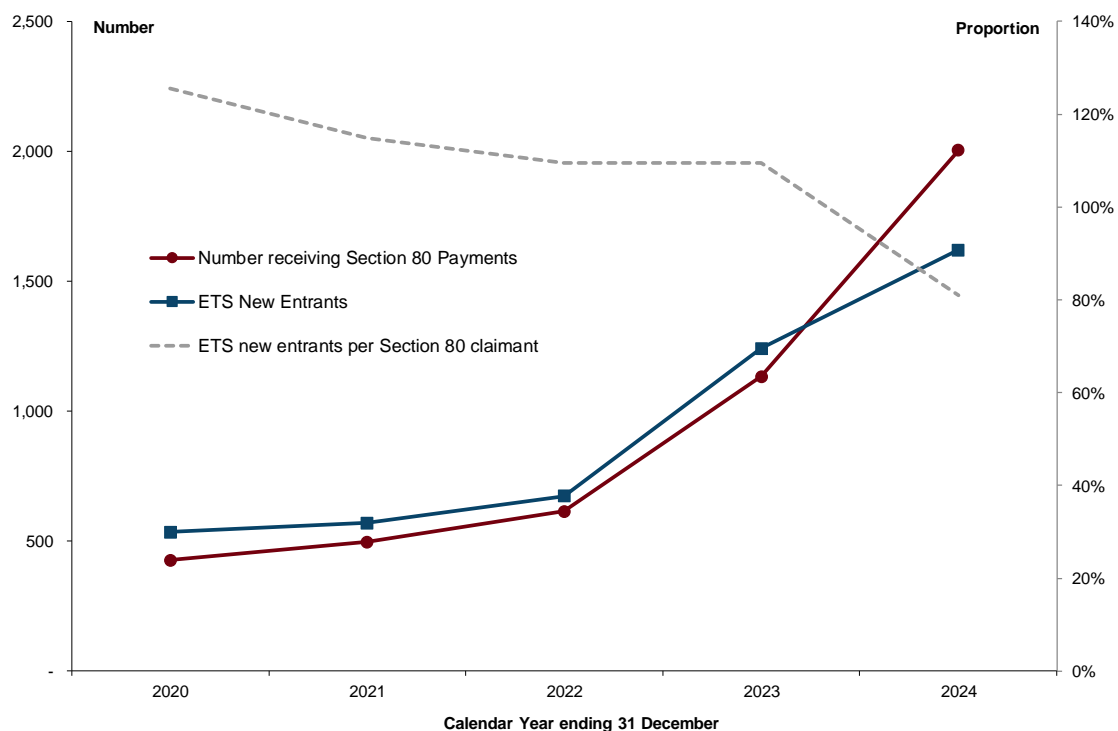
Figure 14.13: Probability of Remaining in the ETS from one Age to the next



14.5.3 Figure 14.14 shows the number of new entrants to the ETS scheme in each of the last five years and the number of claimants who have received a Section 80 PI payment. We have also shown the ETS new entrants as a proportion of those receiving Section 80 benefits.

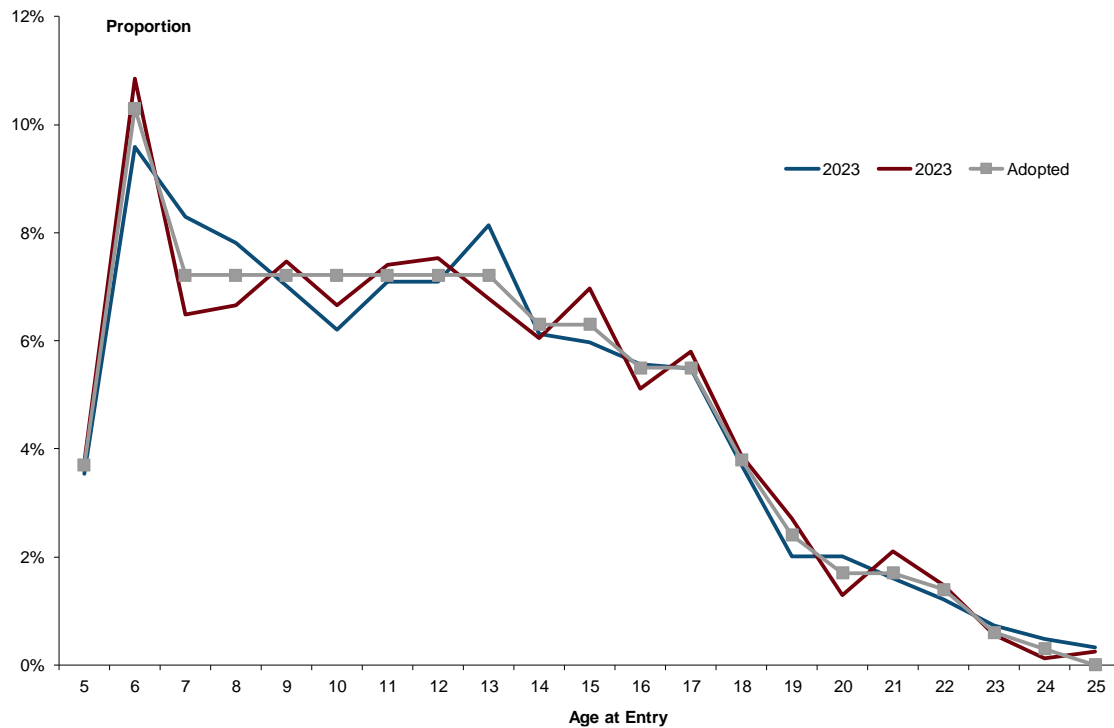
14.5.4 Over the last two years, both the number of claimants receiving Section 80 benefits and the number of ETS new entrants have increased substantially, although the number of ETS new entrants has not kept pace with the number of claimants receiving Section 80 benefits in 2024; the number of ETS new entrants has fallen from about 110 per cent to 81 per cent of the number claimants receiving Section 80 benefits. We are unsure why this proportion has fallen; it may be because those receiving Section 80 benefits in 2024 have younger children than those who received the benefit previously, thus a lower proportion of dependents are of school age/eligible for the ETS in the year the Section 80 benefit was paid. We have assumed that future new entrants to the ETS will be 95 per cent of claimants receiving Section 80 payments i.e. the average of the two most recent years.

Figure 14.14: ETS new entrants per new claimants exceeding 80 WPI points



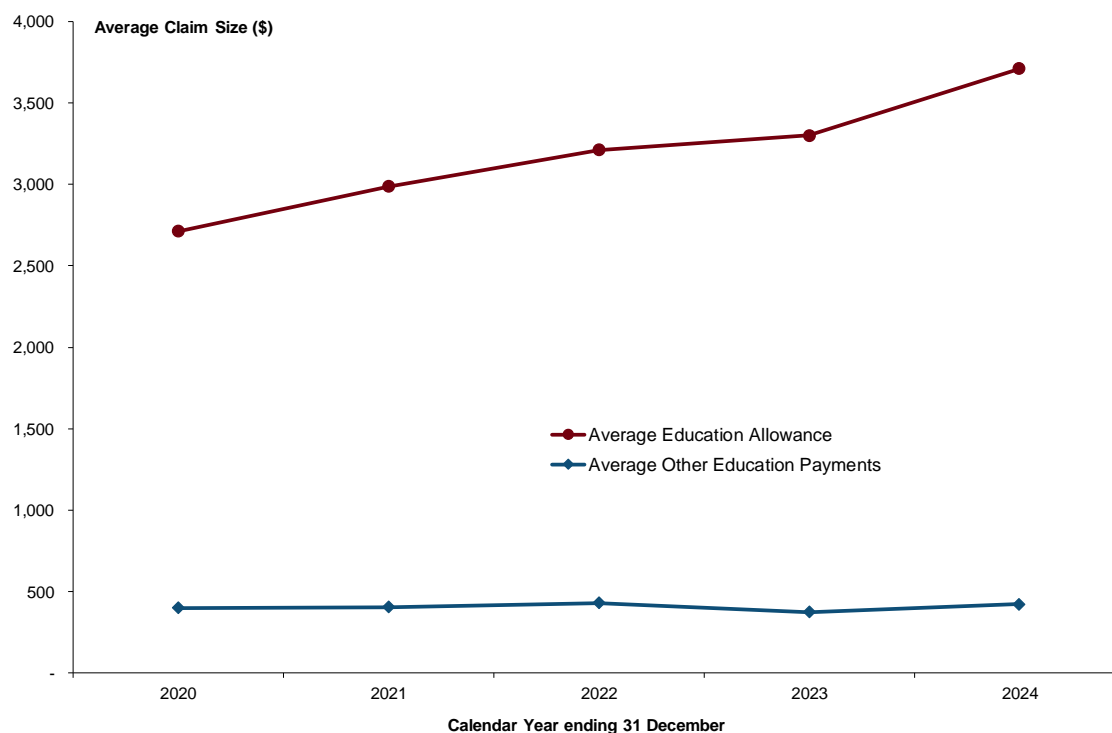
14.5.5 We have assumed an age distribution for new entrants that is consistent with recent experience as shown in Figure 14.15. The age distribution of new entrants has been largely unchanged over the last six years, with an average age at entry of 12 years old.

Figure 14.15: ETS new entrants assumed Age at Entry



14.5.6 Figure 14.16 shows the historical average claim size claim for the ETS education allowance and other education payments. The average education allowance has increased over time (as recipients have aged) while the average amount paid for other education payments has been reasonably stable at around \$400 per ETS claimant. We have adopted an average size for other education payments of \$400 per ETS claimant (assumed to increase in line with price inflation of 2.5 per cent per annum). The adopted average size for the education allowance is discussed further below.

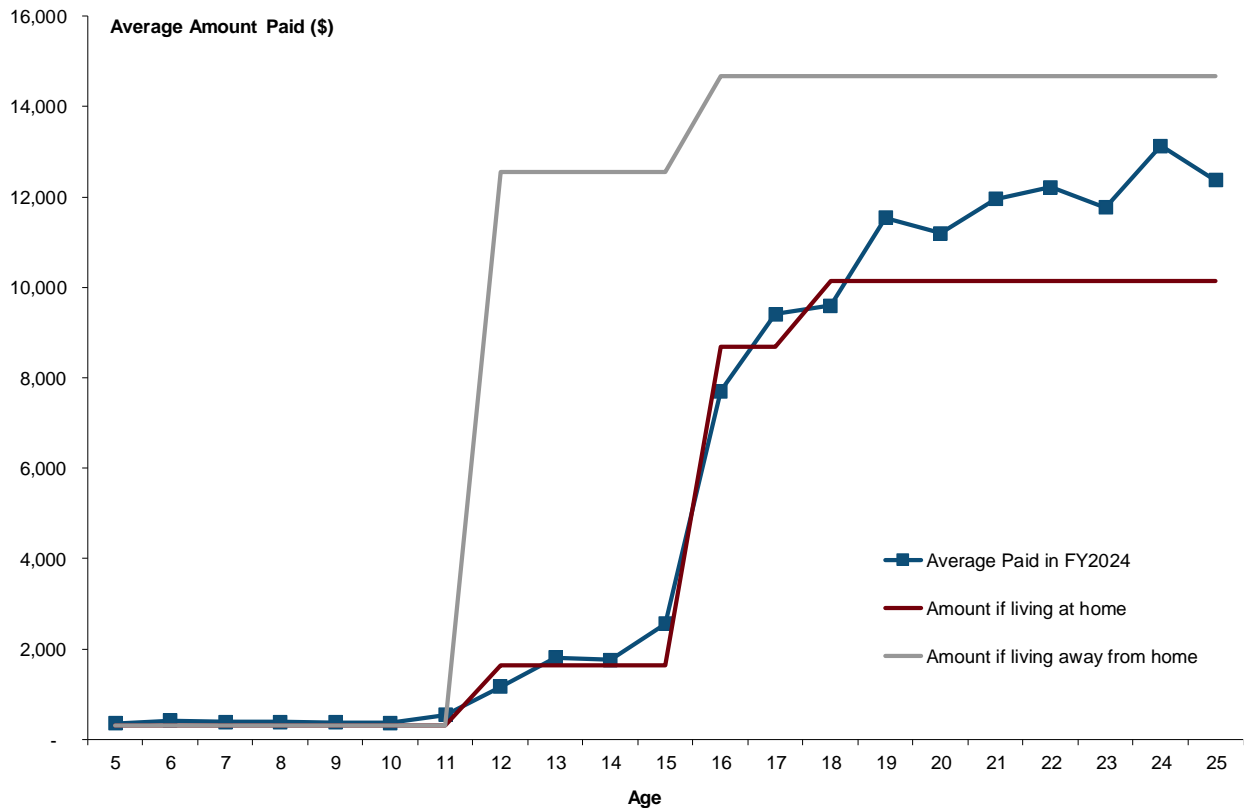
Figure 14.16: Average ETS Amounts Paid per ETS Recipient



14.5.7 Figure 14.17 shows the average education allowance paid in the 2024 financial year for each age. We have also shown the legislated amounts that would be paid if the dependent child was living at home or living away from home. The graph shows that the amount paid in 2024 at age 13 was around 5 times the amount paid for primary school age children, with a very steep increase in the amount paid for those aged 16 and above. This reflects the legislated benefits.

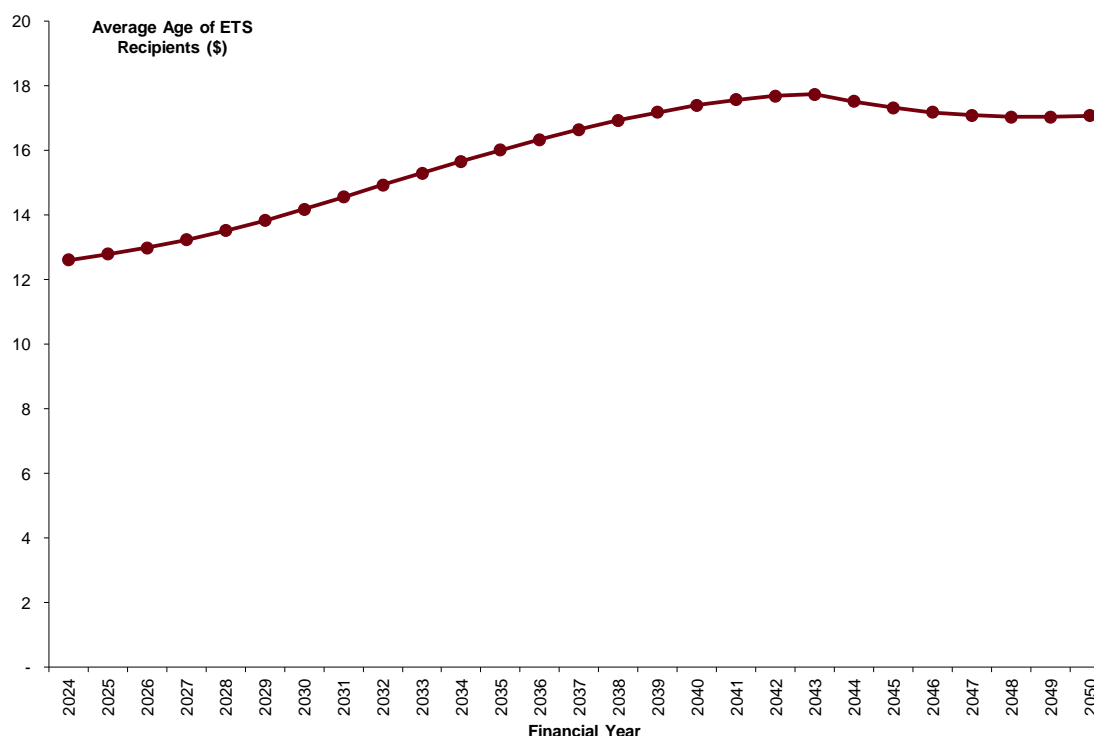
14.5.8 The graph also indicates that very few children are living away from home prior to age 19 (the amount paid is close to the living at home amounts), with the benefits increasing from age 19 as a higher proportion of children move out of home and qualify for the higher benefit.

Figure 14.17: Average Education Allowances and Other Education Payments



14.5.9 We have adopted average claim sizes for each age that are consistent with the average amounts paid in 2024. The overall average claim size is projected to vary each year as the age of the ETS population changes, consistent with the age profile of the current population (Table 14.1), the assumed ages of new entrants (Figure 14.15), and the assumed decrement rates (Figure 14.13). The overall average age implied by these assumptions is shown in Figure 14.18.

Figure 14.18: Projected Average Age of ETS Recipients



14.5.10 As ETS payments increase with age and our assumptions imply an increase in the average age of the ETS population, our adopted average claim size is projected to increase. We have further assumed the average claim size will increase with price inflation of 2.5 per cent per annum.

14.6 Valuation Assumptions – Supplements

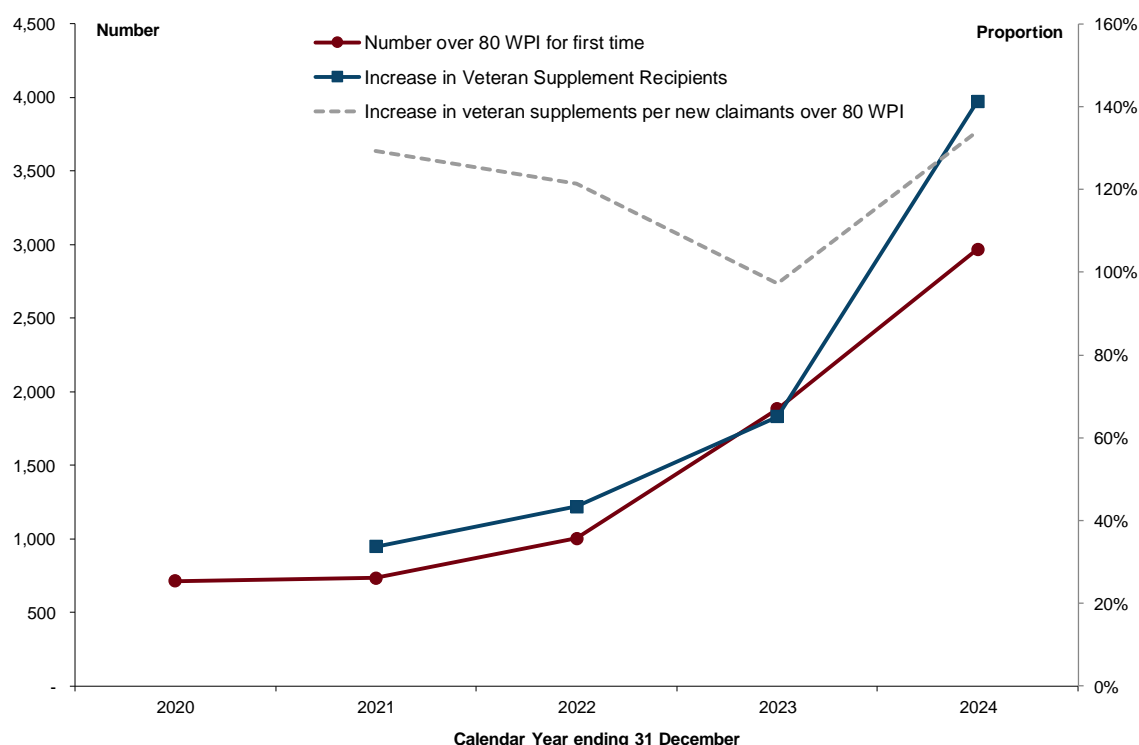
14.6.1 Table 14.2 shows the number of recipients of either the MRCA veteran supplement or energy supplement in the 2024 financial year and their estimated age (noting we are only supplied with their year of birth).

Table 14.2: MRCA Supplement recipients

Age in FY2024	Veteran Supplement	Energy Supplement
25 and under	155	676
26-30	1,424	4,481
31-35	3,362	7,518
36-40	4,015	7,478
41-45	3,285	5,732
46-50	2,267	3,988
51-55	1,878	3,614
56-60	1,379	2,588
61-65	1,062	1,826
66-70	399	882
71+	108	401
Total	19,335	39,184

- 14.6.2 We have assumed that these recipients will continue to receive supplements until death. Mortality rates used are the same as those used for invalidity pensioners in the AGA's report "Military Superannuation Schemes Review of Long Term Costs as at 30 June 2023".
- 14.6.3 Figure 14.19 shows the increase in the number of recipients of the veteran supplement and the number of claimants who have exceeded 80 whole person impairment points for the first time. We have also shown the increase in the veteran supplement recipients as a proportion of those exceeding 80 WPI points for the first time.
- 14.6.4 The increase in the number of recipients of the veteran supplement tracks closely to the number of claimants exceeding 80 WPI points for the first time, which is to be expected given the criteria for receiving the veteran supplement (i.e. the veteran needs to be the holder of a White Card or Gold Card, eligible for the Special Rate Disability Pension, or assessed as having a permanent impairment at or above 80 points). We have assumed that future increases in the number of veteran supplement recipients will be 120 per cent of those exceeding 80 WPI points for the first time.

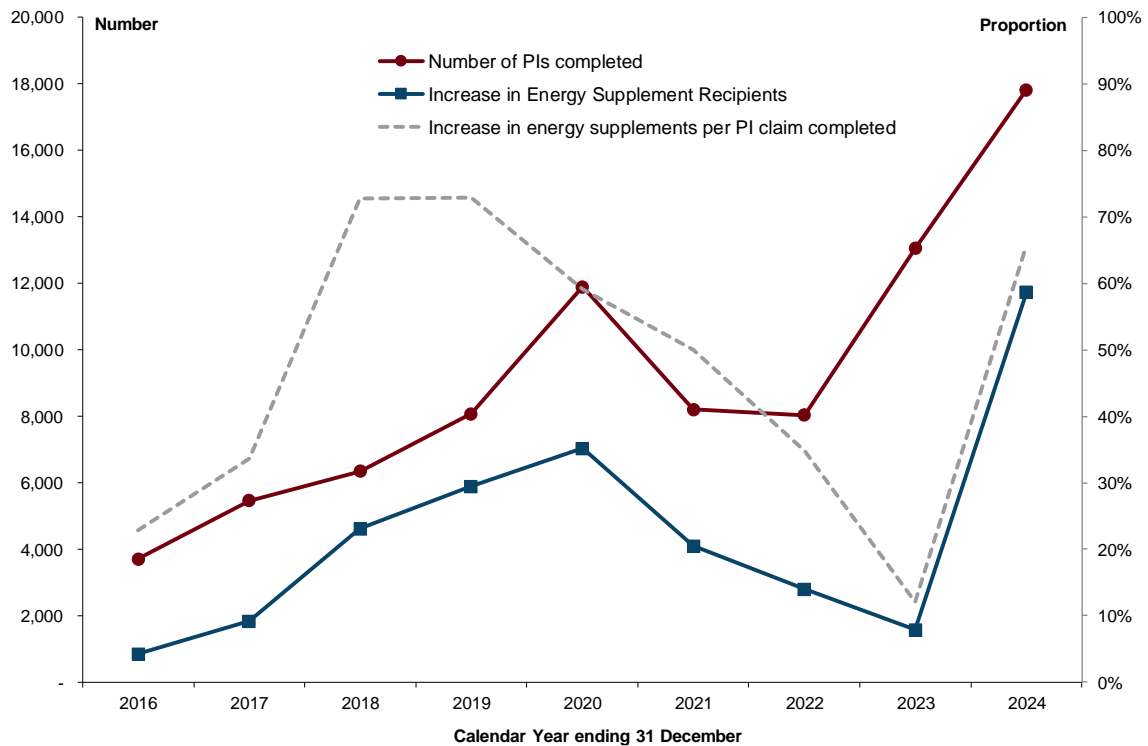
Figure 14.19: Increase in veteran supplement recipients per new claimants exceeding 80 WPI points



14.6.5 Figure 14.20 shows the increase in the number of recipients of the energy supplement and the number of PI claims completed. We have also shown the increase in the energy supplement recipients as a proportion of PI claims completed.

14.6.6 The increase in the number of recipients of the energy supplement has broadly moved in parallel with the number of PI claims completed, which is, again, to be expected given the criteria for receiving the energy supplement (i.e. receive a Special Rate Disability Pension or a permanent impairment payment). We have assumed that the increase in the number of energy supplement recipients will be 40 per cent of PI completions in FY2025, consistent with the experience over the last three years. We have assumed that this proportion will reduce linearly over the next 10 years to 20 per cent, noting that claimants can receive multiple PI claims (but will only commence receiving the energy supplement once).

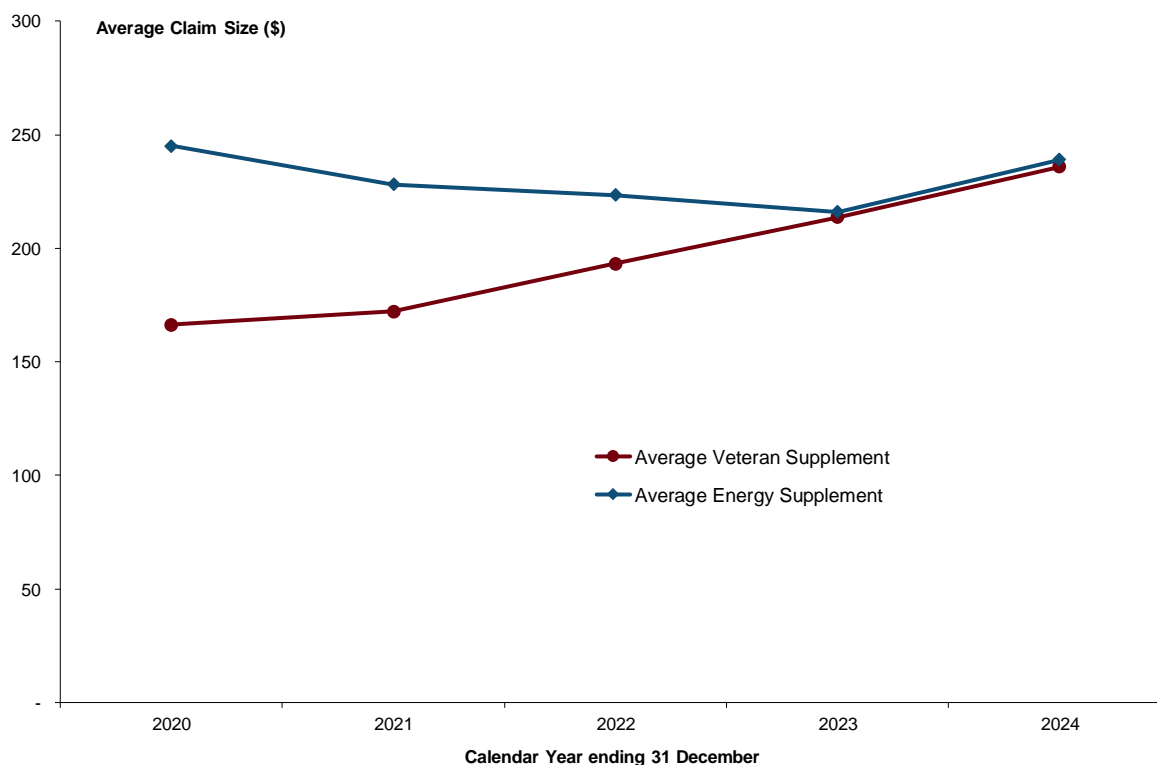
Figure 14.20: Increase in energy supplement recipients per PI claim completed



14.6.7 We have assumed an age distribution for new entrants that is the same as the age distribution of current recipients of the veteran and energy supplements.

14.6.8 Figure 14.21 shows the historical average claim size claim for the veteran supplement and the energy supplement. The average amounts paid for each supplement have been similar over the last two years. We have adopted an average size of \$230 for the veteran supplement (assumed to increase in line with price inflation of 2.5 per cent per annum) and \$236 for the energy supplement (with no future indexation).

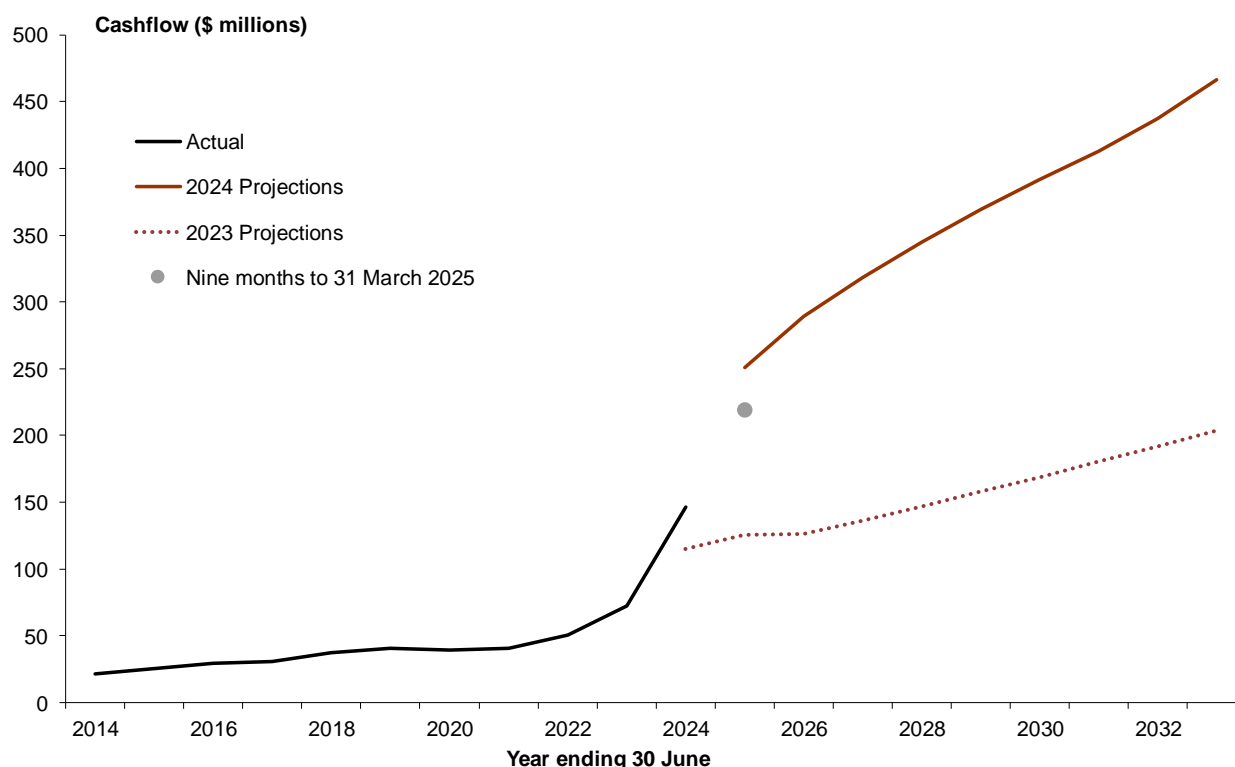
Figure 14.21: Average Supplements per Annum



14.6.9 For DRCA, we have adopted a loading factor of 2.7 per cent to account for supplement payments, based on the experience in the most recent year. This is lower than the 6 per cent adopted in our previous valuation; while expenditure on medical reports has increased dramatically, supplement payments have remained stable, hence a lower assumption this year.

14.7 Cashflows

14.7.1 Figure 14.22 shows actual outlays over the last decade together with projected cashflows for the next 10 years for MRCA and DRCA combined. We have also shown the actual payments made in the nine months to 31 March 2025. Our projection is clearly much higher than that adopted in our previous valuation, however, we note that actual payments in the first nine months of 2025 are 87 per cent of our full year projection for 2025 i.e. the latest experience is higher than our short-term projection.

Figure 14.22: Historical and Projected Other Payments


14.8 Liability Estimate

14.8.1 Table 14.3 shows the estimate of the liability in relation to other payments, with each component shown separately. The liability as at 30 June 2024 for MRCA is \$2,523.3m, compared with a projected liability of \$1,332.8m from the 2023 valuation. The liability as at 30 June 2024 for DRCA is \$216.3m, compared with a projected liability of \$62.5m from the 2023 valuation. The increases are driven by the much higher experience in the latest year, particularly for medical reports/legal costs and the number of new MRCA ETS recipients. In addition, changes in our modelling approach to directly allow for future expected numbers of IL claims and PI claims have led to further increases.

Table 14.3: Outstanding Claims Liability for Other Payments

Component	MRCA Liability (inflated and discounted) (\$'m)	DRCA Liability (inflated and discounted) (\$'m)
Medical reports and legal expenses	1,053.5	210.5
ETS	919.1	n/a
Supplements	550.8	5.8
Total	2,523.3	216.3
<i>Expected at 30/06/2024</i>	<i>1,332.8</i>	<i>62.0</i>
Total (30/06/2023)	1,245.7	67.9

14.8.2 Table 14.4 reconciles the liability estimate with the corresponding estimate at the previous valuation. We note that, with our change in approach, the impact of each item is approximate only.

Table 14.4: Reconciliation of Liability for Other Payments

	MRCA \$m	DRCA \$m
Liability estimate at 30/06/23 (previous report)	1,245.7	67.9
Assumed Interest	59.7	3.2
Projected Payments	(105.1)	(9.1)
Notional Premium	132.5	0.0
Projected liability as at 30 June 2024 (previous valuation)	1,332.8	62.0
Experience effects and Assumption changes		
Number of medical reports legal expenses	200	120
Average size of medical reports legal expenses	370	30
Number of ETS recipients	210	n/a
Average size of ETS payments	250	n/a
Number of supplement recipients	160	2.0
Current Estimate	2,523.3	216.3

15 Death Benefits

15.1 Benefit Overview

- 15.1.1 Death benefits are the smallest liability among the various heads of damage and the number of deaths can be highly variable from year to year. The assumptions made therefore involve a more significant degree of judgement relative to the other components of the liability.
- 15.1.2 Under DRCA, lump sum benefits are payable to surviving spouses on death “significantly caused by service”, noting that deaths from asbestos and smoking are presumptively assumed to be service-related (see below). Several benefits are available to dependents:
- A lump sum death benefit, the amount of which is prescribed based on the year of death, with the benefit payable for deaths occurring in 2024/25 being \$643,667. Three-quarters of this amount is paid to the spouse, with the remainder split between other dependents;
 - An “additional lump sum benefit” is paid to the spouse in the amount of \$71,062 (2024/25 deaths) and to each dependent child in the amount of \$104,449 (2024/25 deaths);
 - Fortnightly benefits are payable to dependent children until they reach the age of 16, or 25 if in full time education;
 - dependents are also entitled to claim death-related expenses for funeral expenses and financial advice. These are subject to maximum amounts of \$14,639 and \$2,072 respectively (for 2024/25 deaths).
- 15.1.3 Benefits available under MRCA are:
- A death benefit payable to a dependent spouse where the death was service related, or if the deceased had been eligible for the Special Rate Disability Pension, or if the deceased had suffered impairment as a result of service assessed at 80 or more impairment points. The death benefit is currently \$582.65 per week (including energy supplements) and is broadly equivalent to the VEA war widow’s pension. It can be taken as a periodic payment, a lump sum, or a mixture of both, with the lump sum amount dependant on the age of the spouse;
 - An additional benefit payable to a dependent spouse where the death has been accepted as having been related to ADF service, with the amount varying based on the age of the spouse (the maximum amount for those aged 40 or under is \$180,926 for 2024/25 deaths);
 - A further lump sum benefit payable in respect of each dependent child, regardless of whether the death was service-related (\$108,568 for 2024/25 deaths);
 - Fortnightly benefits are payable to dependent children until they reach the age of 16, or 25 if in full time education;
 - As for DRCA, dependents are also entitled to claim for funeral expenses and financial advice. The maximum funeral benefit payable is the same as for DRCA however the maximum financial assistance amount is higher at \$3,202 (for 2024/25 deaths).
- 15.1.4 DVA do not record cause of death on their claims system. Apart from deaths due to long latency diseases, such as asbestos related illnesses, the main compensable cause of death is likely to be accidental.
- 15.1.5 From September 2017, the smoking policy was amended to allow claims for smoking-related illnesses if they satisfy certain criteria under the DRCA scheme. Further to this, policy changes

were made in November 2018 to lower the level of evidence required in relation to asbestos exposure for veterans who served on certain RAN ships from 1940 to 2003. In addition, changes to straight through processing for mental health conditions related to operational service could mean posthumous mental health diagnoses become easier to determine for suicide cases. Anecdotal evidence from the DVA policy area suggests that the broader suite of services provided by Service Coordination within DVA could have been proactively seeking out potential death payment claimants. All these factors could have led to the sustained high levels of death payments seen in recent years.

15.2 DRCA Approach and Assumptions

- 15.2.1 For this valuation we have allowed for future payments on service-related deaths that have occurred but have not yet been paid (IBNR) and future deaths expected to be service related. These components are the same as for the previous valuation, however our approach to forming our assumptions is a little different this year. Previously our analysis was performed on the number of deaths that had received a payment, with the data sub-divided by year of payment. This year, we have sub-divided the data by year of occurrence and have also utilised DVA data that shows the numbers of death claims that have been lodged but not yet paid.
- 15.2.2 We have estimated the number of IBNR claims at 30 June 2024 using a simple chain ladder model on a development triangle of the number of deaths by calendar year of occurrence and duration until financial year of payment. Similar to last year, only the calendar year of death was provided in our data.
- 15.2.3 As a cross check on our IBNR estimate, we have taken the number of lodged but not yet paid death claims and made allowances for a portion of these claims being withdrawn (historically around 5 per cent), some being declined as the death is found not to be service-related (historically around 20 per cent), and some not having dependents thus a death benefit is not paid (historically around 15 per cent), noting that this data is at 31 December 2024 (not 30 June 2024). The two approaches gave consistent results.
- 15.2.4 Table 15.1 summarises the data and our assumptions, noting that the 2024 year shown is a half year only (for deaths occurring between 1 January 2024 and 30 June 2024). We have allowed for 98 IBNR death claims at 30 June 2024.

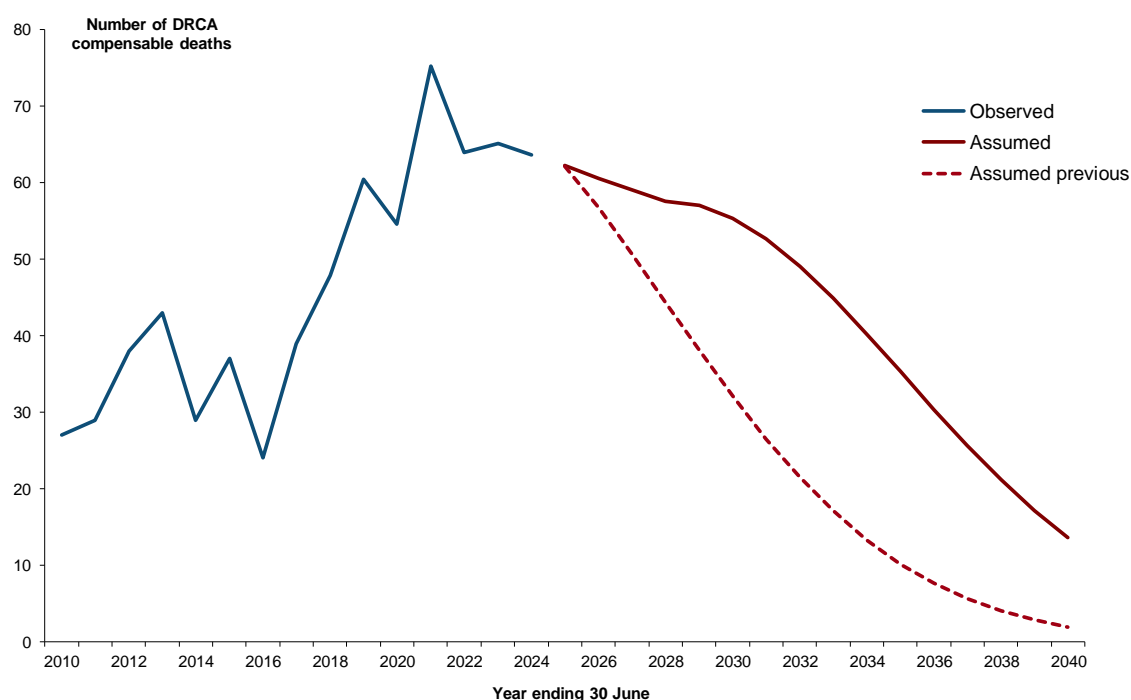
Table 15.1: DRCA Estimated Number of IBNR Death Claims at 30 June 2024

Calendar Year of Death	Number of Death Claims Paid at 30 June 2024	Adopted IBNR	Estimated Total Compensable Deaths
2004	10	0	10
2005	13	0	13
2006	16	0	16
2007	20	0	20
2008	18	0	18
2009	31	0	31
2010	27	0	27
2011	33	0	33
2012	38	0	38
2013	38	0	38
2014	32	0	32
2015	38	0	38
2016	23	0	23
2017	40	0	40
2018	56	1	57
2019	57	4	61
2020	60	6	66
2021	56	9	65
2022	55	15	70
2023	30	32	62
2024	1	30	31
Total		98	

- 15.2.5 It is likely that recent policy changes (such as the change in coverage of service-related smoking and mental health claims), combined with Veteran Centric Reform, could have contributed to the increase in the number of compensable death claims seen in 2018. The number of compensable deaths under DRCA since 2018 is estimated to have been reasonably stable at between 57 to 70 deaths each year.
- 15.2.6 It is likely that most of these claims have arisen from long latency diseases such as those related to asbestos exposure and cancers. The future trajectory of these claims is quite uncertain. However, other information on claim patterns for asbestos related diseases suggests that such claims are likely to continue for an extended period and the liability for these claims will be material. The possibility that a number of future claims could be linked to exposure to jet fuel or other toxic chemicals increases the level of uncertainty around these assumptions.
- 15.2.7 Figure 15.1 shows the run-off in compensable death claims assumed in 2024 compared with recent experience. The assumptions adopted at our previous valuation are also shown. We have increased our assumed number of future claims substantially at this valuation. While we do not have a reliable estimate of the DRCA population, if we assume the population

distribution by age is the same as for those who have lodged a DRCA IL claim, the total number of expected deaths in future years is expected to be unchanged from current levels for some years to come. However, we do expect that service-related deaths would make up a reducing proportion of all DRCA deaths over time with the run-off of asbestos exposure, hence the compensable death claims should run-down more quickly than this indicative population would suggest. On balance, we took the view that our previous assumptions ran-off too sharply. There is a high degree of judgment involved in selecting these assumptions and we provide sensitivities around these assumptions in section 17.

Figure 15.1: Observed and Assumed Number of DRCA Compensable Deaths Claims from Long Latency Diseases



15.2.8 For each of the types of death benefits available, we need to adopt assumptions for the proportions receiving the benefit and the amount received:

- For the lump sum benefit, all dependents are assumed to receive the defined amount;
- For the additional death benefit available to spouses, all are assumed to receive the defined amount;
- For the additional death benefit available to dependent children, we have assumed that the ratio of child dependents per death is 10 per cent i.e. for every 10 deaths, there is assumed to be one dependent child. Each child is assumed to receive the defined amount;
- For funeral benefits and financial assistance, only a portion of compensable death claims have these expenses, and the average benefit is lower than the maximum. We have assumed that 95 per cent of death claims will have funeral expenses paid at 60 per cent of the maximum. For financial assistance, we have assumed 20 per cent of dependants will seek financial assistance and will claim the full amount. These metrics have been stable over time and the assumptions are consistent with recent experience;

15.2.9 Each of these benefits is assumed to increase in future in line with the relevant statutory provisions i.e. the lump sums with general wage growth (assumed to be 3.7 per cent per

annum, applied on 1 July of each year) and funeral and financial assistance with price inflation (assumed to be 2.5 per cent per annum, applied on 1 July of each year). Lump sum benefits payable on death are generally paid within a relatively short time after the death. Based on past payment patterns, we have assumed that 25 per cent of lump sums will be paid in the year of death, 40 per cent in the year following death, 20 per cent in the year after that, and 15 per cent in the third year after the death occurs.

- 15.2.10 For the fortnightly benefits paid to dependent children, we have separately valued existing recipients and expected new entrants using an annual annuity method. Existing recipients are defined as those who received a dependent benefit in the last payment run. There were only 15 children in receipt of dependent benefits at 30 June 2024. The future number of new entrants are assumed to be the same as the number receiving a lump sum benefit (i.e. 10 per cent of the number of compensable deaths).
- 15.2.11 The fortnightly benefit valued is \$177.02 as defined in the legislation. Benefits are assumed to increase with general wage growth of 3.7 per cent per annum (applied on 1 July of each year).
- 15.2.12 For existing recipients, the dependent's year of birth is supplied and the approximate age at 30 June 2024 is calculated as 2024 less year of birth. The average age of new entrants is assumed to be 14 years, this reflects the average age of new dependents over the last five years. This is used as the input to mortality decrements, and benefits are assumed to cease at age 25. Mortality rates used are those from the Australian Life Tables 2020-22.
- 15.2.13 Table 15.2 shows a summary of the components making up the DRCA death benefits liability valuation at 30 June 2024.

Table 15.2: DRCA Death Benefits Liability at 30 June 2024

Component	Estimated Liability (\$m)
Dependent lump sum	450.2
Additional lump sum - spouse	49.7
Additional lump sum - children	7.3
Period benefits - existing children	1.4
Period benefits - new children	6.2
Funeral benefits	5.5
Financial assistance	0.3
Total Liability	521.4

15.3 MRCA Approach and Assumptions – Deaths occurring prior to 30 June 2024

- 15.3.1 This section documents our liability estimate for MRCA deaths that occurred prior to 30 June 2024 but had not yet been paid at that date (IBNR).
- 15.3.2 As for DRCA, we have estimated the number of IBNR claims using a chain ladder model and cross checked against lodged but not yet paid death claims. Table 15.3 summarises the data and our assumptions in respect of all MRCA deaths, again noting that the 2024 year shown is a half year only. We have allowed for 33 IBNR death claims at 30 June 2024.

Table 15.3: MRCA Estimated Number of IBNR Death Claims at 30 June 2024

Calendar Year of Death	MRCA Death Claims Paid at 30 June 2024	Adopted IBNR	Estimated All MRCA Deaths
2004	2	0	2
2005	7	0	7
2006	7	0	7
2007	7	0	7
2008	4	0	4
2009	7	0	7
2010	15	0	15
2011	14	0	14
2012	11	0	11
2013	14	0	14
2014	8	0	8
2015	13	0	13
2016	16	0	16
2017	23	0	23
2018	14	0	14
2019	26	0	26
2020	27	0	27
2021	21	1	22
2022	19	3	22
2023	28	11	39
2024	4	18	22
Total		33	

- 15.3.3 As for DRCA, the number of deaths increased at around the time of recent policy changes and Veteran Centric Reform, although the smaller number of MRCA deaths means the numbers are more volatile from year-to-year. This also appears to have been around the time that non-service-related deaths began to be compensated as shown in Table 15.4 (we have defined a service-related death as one where the dependants have been paid the additional death benefit).
- 15.3.4 Prior to 2018 almost all deaths were service-related and after 2018 around 75 per cent of deaths were service-related. We have assumed 75 per cent of the IBNR claims are service-related (25 deaths) and the remainder are non-service-related (8 deaths).

Table 15.4: MRCA Number of Service-Related vs Non-Service-Related Death Claims at 31 December 2024

Calendar Year of Death	Service-related deaths	Non-service-related deaths	All Deaths	Proportion service-related
2004	2	0	2	100%
2005	7	0	7	100%
2006	7	0	7	100%
2007	7	0	7	100%
2008	4	0	4	100%
2009	7	0	7	100%
2010	14	1	15	93%
2011	14	0	14	100%
2012	11	0	11	100%
2013	13	1	14	93%
2014	8	0	8	100%
2015	11	2	13	85%
2016	15	1	16	94%
2017	23	0	23	100%
2018	10	4	14	71%
2019	22	6	28	79%
2020	23	4	27	85%
2021	16	6	22	73%
2022	16	7	23	70%
2023	23	9	32	72%
2024	14	9	23	61%

15.3.5 For each of the types of death benefits available, we need to adopt assumptions for the proportions receiving the benefit and the amount received:

- For the dependent spouse benefit, all dependents are assumed to take the benefit as a lump sum. We have assumed that all spouses are female (thus the female lump sum conversion factors are used) and have adopted an age distribution based on the age of MRCA spouses at time the MRCA member died (with an implied average age of 41.5 years);
- For the additional death benefit available to spouses where the death is service-related, we have again assumed all spouses are female with an average age of 41.5 years, receiving around 93 per cent of the maximum available amount (using the age-based conversion factors and our assumed age distribution);
- For the additional death benefit available to dependent children, we have assumed that there are 1.4 child dependents per death, consistent with the experience. Each child is assumed to receive the defined amount;
- For funeral benefits, we have assumed that 50 per cent of death claims will have funeral expenses paid at 70 per cent of the maximum. For financial assistance, we have assumed 20 per cent of dependants will seek financial assistance and will claim the full amount. These assumptions are consistent with the experience over 2018 to 2024;

- Each of these benefits is assumed to increase in line with the relevant statutory provisions i.e. price inflation of 2.5 per cent per annum (applied on 1 July of each year).
- 15.3.6 Lump sum benefits payable on death tend to be paid a little more quickly for MRCA compared with DRCA. Based on past payment patterns, we have assumed that 45 per cent of lump sums will be paid in the year of death, 35 per cent in the year following death, 10 per cent in the year after that, and 10 per cent in the third year after the death occurs.
- 15.3.7 We have valued existing recipients of fortnightly benefits paid to spouses who do not elect to convert to a lump sum (or take only a partial lump sum) using an annual annuity method. Existing recipients are defined as those who received a dependent benefit in the last payment run of the 2023/24 financial year. There were 119 spouses in receipt of dependent benefits at 30 June 2024. The fortnightly benefit value is \$582.65, reduced for those who have elected to take a partial lump sum. Benefits are assumed to increase with inflation of 2.5 per cent per annum (applied on 1 July of each year). The dependent's year of birth is supplied and the approximate age at 30 June 2024 is calculated as 2024 less year of birth. This is used as the input to mortality decrements, with mortality rates taken from the Australian Life Tables 2020-22.
- 15.3.8 For the fortnightly benefits paid to dependent children, we have also used an annuity method and have separately valued existing recipients and expected new entrants. There were 305 children in receipt of dependent benefits at 30 June 2024. The future number of new entrants are assumed to be the same as the number receiving a lump sum benefit (i.e. 1.4 times the number of compensable deaths). The fortnightly benefit value is \$180.57, assumed to increase by 2.5 per cent per annum. For existing recipients, the dependent's year of birth is supplied and the approximate age at 30 June 2024 is calculated as 2024 less year of birth. The average age of new entrants is assumed to be 9 years, lower than 14 years assumed for DRCA (noting the average age of DRCA members is older than MRCA members). Benefits are assumed to cease at age 25; this is an increase from our previous valuation where we assumed benefits would cease at age 21 except if the child was already over age 21 (in which case we assumed they would cease at 25).
- 15.3.9 Table 15.5 shows a summary of the components making up the MRCA death benefits liability valuation in respect of deaths occurring prior to 30 June 2024.

Table 15.5: MRCA Death Benefits Liability for Deaths Occurring Prior to 30 June 2024

Component	Estimated Liability (\$m)
Dependent lump sum	24.6
Additional lump sum - spouse	3.7
Additional lump sum - children	4.5
Period benefits - existing spouses	64.6
Period benefits - existing children	26.3
Period benefits - new children	4.1
Funeral benefits	0.2
Financial assistance	0.0
Total Liability	127.9

15.4 MRCA Approach and Assumptions – Deaths occurring after 30 June 2024

- 15.4.1 Death compensation under MRCA is provided to dependent partners for veterans with SRDP eligibility or whole person impairments points greater than 80 ("80 WPI"). In light of the growing proportion of veterans with greater than 80 impairment points seen in the recent MRCA PI experience, we have explicitly estimated a provision for death compensation at this year's valuation.
- 15.4.2 For the number of future such deaths we have separately allowed for:
- the MRCA population at 31 December 2024 who have 80 WPI (taken from our impairments database) and/or are eligible for SRDP (as indicated on the cards database). This gives a population of around 10,300 people at 31 December 2024, with a known age distribution;
 - the expected number of people who will become eligible for the death compensation benefit in the future (in respect of injuries/conditions acquired prior to the valuation date). We have estimated the number of such people through utilising our projection of the number of people expected to receive a Section 80 payment (see Section 5) and comparing this to the number of people who first exceeded 80 WPI in each of the last 6 six years. Around 64 per cent of people exceeding 80 WPI for the first time received a Section 80 payment. We have then estimated the number eligible for SRDP using the same ratio as in our existing population (21 per cent). This gives a future number of people expected to become eligible for death compensation of around 34,400. We have assumed the age distribution of these people are the same as our existing population of eligible claimants;
 - Mortality rates used are the same as those used for invalidity pensioners in the AGA's report "Military Superannuation Schemes Review of Long Term Costs as at 30 June 2023".
 - not all of the estimated eligible population will be paid a death benefit; it is only payable if the person has a dependent spouse. We have assumed partnering rates at age of death based on the rates assumed for male invalidity pensioners in the most recent actuarial review of military superannuation schemes, with the rates varying from less than 5 per cent for those in their early 20s to 70 per cent for those in their 40s to 70s, before declining again. The overall implied partnering rate is around 60 per cent. This results in around 25,900 people expected to be paid death compensation benefits in respect of injuries/conditions acquired prior to 30 June 2024.
- 15.4.3 For death claims that are accepted as service-related, an additional lump sum benefit is also payable. It is likely that a proportion of the deaths projected to receive death compensation benefits may also be accepted as service-related deaths. We have not attempted to estimate the proportion of deaths which may be service-related due to the significant uncertainty involved in setting such an assumption. As such, we have assumed that this population will receive the wholly dependent partner benefit only, without any provisions for the additional death benefit. We have also only allowed for benefits to be paid to dependent children if the death is projected to occur prior to age 65. Death benefits are assumed to increase by 2.5 per cent per annum as per the legislated indexation.
- 15.4.4 We have also included an allowance for the costs associated with access to the Gold Card for the dependent partner. Wholly dependent partners eligible for death compensation are also entitled to receive a Gold Card which covers all clinically necessary treatment for medical conditions. To value this component, we have applied the partnering rates mentioned above and assumed that spouses are one year younger than the veteran on average. We have

assumed an average cost of medical benefits of \$17,500 per year, based on the recent experience of war widows with Gold Card entitlements under the VEA.

- 15.4.5 The additional provision for death compensation benefits and associated Gold Card costs is approximately \$9.1 billion. Around \$5.0 billion is for death compensation and \$4.1 billion for associated Gold Cards.

15.5 Liability Estimate

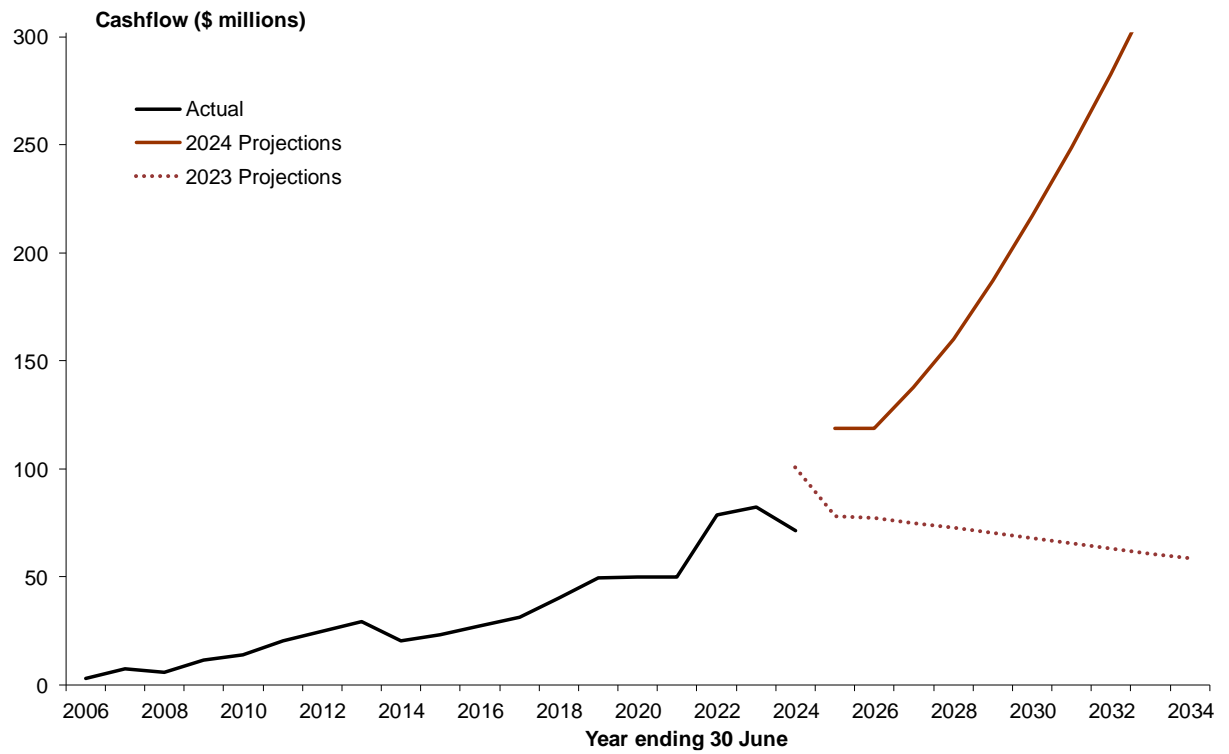
- 15.5.1 Table 15.6 summarises the death benefits liability at 30 June 2024.

Table 15.6: Death Benefits Liability at 30 June 2024

Component	Estimated Liability (\$m)
DRCA deaths	521.4
MRCA deaths occurring prior to 30 June 2024	127.9
MRCA deaths occurring after 30 June 2024	9,077.4
Total Liability	9,726.7

- 15.5.2 The liability estimate for death benefits amounts to \$9,726.7m. This is an increase of \$9,251.7m from the liability estimate at 30 June 2023. The addition of the new liability for MRCA death compensation benefits occurring after 30 June 2024 is driving this large increase. Increasing the assumed future number of DRCA deaths added a further \$170m to the liability.
- 15.5.3 The bulk of the liability now relates to future MRCA death compensation claims. It is a large number and is extremely sensitive to the assumptions used, notably the assumed future number of claimants expecting to become eligible and the mortality assumptions used. It is important to note that death benefits are extremely volatile and the degree of uncertainty around this estimate cannot be overstated.
- 15.5.4 The projected cashflows have increased significantly this year, driven by higher claimant assumptions adopted for both DRCA and MRCA.
- 15.5.5 Figure 15.2 below shows the projected cashflows for both schemes combined.

Figure 15.2: Projected Cashflows – DRCA and MRCA Death Benefits



16 Summary of overall outstanding liability, cashflows and notional premium estimate

16.1 Summary of Outstanding Claims Liability

16.1.1 Table 16.1 shows the overall outstanding claims liability split between benefit types as at 30 June 2024.

Table 16.1: Outstanding Claims Liability as at 30 June 2024

Payment Type	Liability (inflated and discounted)	
Permanent Impairment ¹⁰	28,992.1	29%
Incapacity	14,515.0	15%
Medical Expenses	34,508.3	35%
Rehabilitation Costs	1,273.2	1%
Benefits Payable on Death ¹¹	9,726.7	10%
Household Services and Attendant Care	6,636.1	7%
Other ¹²	2,739.6	3%
Total	98,391.0	100%

16.1.2 Table 16.2 shows the outstanding claims liability as at 30 June 2024 by payment type and service arm.

10 Includes non-economic loss payments.

11 Includes lump sums and fortnightly payments to dependent children.

12 Travel, legal costs, general services/medical examinations, MRCA education supports, supplements, surveillance, damage to property and funeral expenses.

Table 16.2: Outstanding Claims Liability as at 30 June 2024

Payment Type	Liability (Inflated and Discounted) \$'m			
	Army	Navy	RAAF	Total
PI and NEL	22,326.7	3,372.1	3,293.4	28,992.1
Incapacity	9,449.4	2,826.1	2,239.5	14,515.0
Medical Expenses	23,078.0	5,753.8	5,676.6	34,508.3
Rehabilitation Costs	836.0	238.2	199.0	1,273.2
Death Benefits	4,235.6	3,647.9	1,843.1	9,726.7
Household Services and Attendant Care	4,241.9	1,320.2	1,074.0	6,636.1
Other	1,687.8	526.1	525.7	2,739.6
Total	65,855.5	17,684.3	14,851.2	98,391.0

16.1.3 Table 16.3 shows the outstanding claims liability for 2024, and projected for 10 years, split between DRCA and MRCA claims. The proportion of MRCA claim related liabilities are projected to increase from about 89 per cent of the total as at the valuation date to over 96 per cent by the end of the projection period.

Table 16.3: Outstanding Claims Liability Split between DRCA and MRCA

As at 30 June	DRCA (\$m)	MRCA (\$m)	Total (\$m)
2024	11,019.5	87,371.5	98,391.0
2025	10,748.7	96,368.1	107,116.7
2026	10,424.9	105,310.2	115,735.2
2027	9,997.0	114,408.2	124,405.2
2028	9,492.0	124,026.0	133,518.0
2029	8,947.6	134,406.1	143,353.7
2030	8,394.5	145,575.4	153,969.9
2031	7,850.6	157,502.3	165,352.9
2032	7,323.6	170,161.1	177,484.7
2033	6,817.1	183,578.0	190,395.0

16.1.4 Table 16.4 reconciles the overall liability estimate given in our 2023 report with the current estimate of the outstanding claims liability. In total, the various adjustments made to assumptions have increased the liability by almost \$29bn compared with that projected in the 2023 valuation.

Table 16.4: Reconciliation of Overall Liability Estimate

	\$m
Liability estimate at 30/06/23 (previous report)	64,764.9
Assumed Interest	3,283.4
Projected Payments	(4,245.3)
Notional Premium	6,075.0
Projected liability as at 30 June 2024 (previous valuation)	69,878.0
Experience effects and assumption changes	
difference between actual and projected payments	(15.9)
increase to MRCA medical claimant projection	3,807.6
increase to MRCA medical Gold Card proportions	3,977.0
addition of superimposed inflation for medicinal cannabis	2,166.5
increase to MRCA PI claim numbers	1,349.6
increase to MRCA PI section 80 payments	1,221.6
increase to MRCA PI average size	944.3
increase to DRCA PI claim numbers	2,610.5
increase to DRCA PI size	646.5
increase to incapacity payment rates	497.7
inclusion of MRCA death compensation payments	9,077.4
increase to MRCA HSAC claimants	709.9
increase to medico-legal claims	720.0
increase to ETS and supplement payments	620.0
Other adjustments	180.6
Current Estimate	98,391.0

16.2 Summary of Projected Cashflows

- 16.2.1 This section combines the projected cashflows for incapacity and non-incapacity payments for the following decade allowing for future injuries. Table 16.5 shows the projected cashflows in respect of injuries sustained before the valuation date under the DRCA, while Table 16.6 shows the cashflows arising from injuries sustained before the valuation date under the MRCA. Table 16.7 shows the projected cashflows for those injuries occurring after 30 June 2024. Note that all figures are in nominal dollars, that is, they have not been discounted to 2024 dollars.

Table 16.5: Projected Payments for DRCA Claims as at 30 June 2024

Year ending 30 June	Payments (future dollars) \$'m							
	PI and NEL	Incapacity	Medical Expenses	Rehab	Death	HSAC	Other ¹³	All ¹⁴
2025	513.9	153.0	11.6	7.8	56.4	41.2	18.1	802.0
2026	550.0	157.7	11.1	7.5	45.6	47.6	21.0	840.4
2027	618.7	168.2	10.6	7.1	46.0	52.9	22.8	926.3
2028	657.1	176.9	10.1	6.7	46.9	59.6	23.4	980.7
2029	660.8	183.1	9.6	6.3	47.7	64.3	22.7	994.4
2030	635.3	186.8	9.1	5.8	48.5	69.6	21.3	976.4
2031	594.1	189.3	8.7	5.4	48.9	74.5	19.6	940.4
2032	548.2	189.8	8.2	5.0	48.6	79.8	17.8	897.4
2033	503.2	188.1	7.8	4.6	47.3	84.3	16.2	851.6
2034	461.3	183.6	7.4	4.2	45.2	89.8	14.8	806.4

Table 16.6: Projected Payments for MRCA Claims Incurred as at 30 June 2024

Year ending 30 June	Payments (future dollars) \$'m							
	PI	Incapacity	Medical Expenses	Rehab	Death	HSAC	Other	All
2025	3,543.0	448.9	448.7	55.9	49.3	66.1	219.6	4,831.6
2026	3,667.7	507.7	569.0	62.4	49.3	82.8	230.5	5,169.3
2027	3,528.1	577.0	694.7	67.2	62.9	99.8	220.8	5,250.6
2028	3,090.2	636.0	803.2	70.5	77.8	116.0	207.5	5,001.1
2029	2,555.4	686.4	900.3	73.6	98.3	132.4	195.3	4,641.7
2030	2,066.7	729.2	995.1	76.0	119.0	147.5	185.4	4,318.9
2031	1,660.2	765.5	1,088.4	77.4	139.4	161.8	178.2	4,070.9
2032	1,349.9	794.9	1,180.2	78.4	159.9	175.5	173.3	3,912.2
2033	1,120.4	817.8	1,270.7	78.9	180.9	188.8	170.0	3,827.6
2034	941.9	836.1	1,359.7	79.0	202.5	201.0	166.7	3,786.8

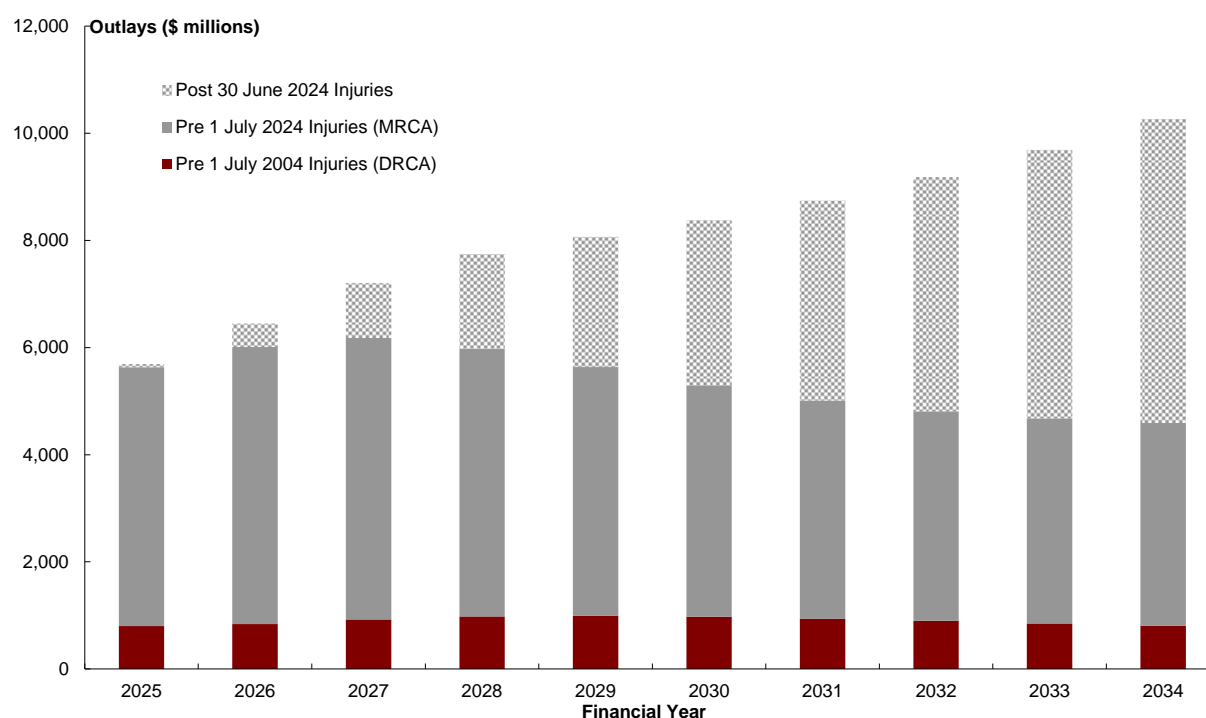
13 Legal costs, general services/medical examinations, surveillance, damage to property, supplements.

14 Excludes incapacity payments.

Table 16.7: Projected Payments for MRCA Claims Incurred After 30 June 2024

Year ending 30 June	Payments (future dollars) \$'m							
	PI	Incapacity	Medical Expenses	Rehab	Death	HSAC	Other	All
2025	30.3	0.2	1.6	0.0	13.1	0.0	13.3	58.6
2026	360.8	5.4	7.8	0.8	24.1	0.5	38.0	437.3
2027	876.8	20.4	21.8	3.4	28.8	2.0	74.9	1,028.0
2028	1,510.5	46.9	45.3	7.3	35.3	4.6	113.8	1,763.6
2029	2,053.0	85.6	79.5	12.2	41.1	9.9	151.2	2,432.5
2030	2,548.0	136.9	125.4	18.2	49.5	18.0	185.1	3,081.1
2031	3,018.1	200.8	183.7	25.4	60.6	28.3	215.4	3,732.3
2032	3,444.6	276.8	255.4	33.3	74.3	41.1	246.0	4,371.5
2033	3,836.8	364.6	340.9	42.1	90.9	56.3	280.4	5,012.0
2034	4,211.3	463.4	441.2	51.7	110.1	75.2	317.6	5,670.5

16.2.2 Figure 16.1 shows this information graphically.

Figure 16.1: Projected Payments


16.2.3 Table 16.8 shows the projected cashflows split between payments made under the DRCA and payments made under the MRCA. Note that all figures are in nominal dollars, that is, they have not been discounted to 2024 dollars.

Table 16.8: Projected Payments Split between DRCA and MRCA Injuries

Year ending 30 June	Total	
	DRCA (\$'m)	MRCA (\$'m)
2025	802.0	4,890.2
2026	840.4	5,606.7
2027	926.3	6,278.6
2028	980.7	6,764.6
2029	994.4	7,074.2
2030	976.4	7,400.0
2031	940.4	7,803.2
2032	897.4	8,283.7
2033	851.6	8,839.5
2034	806.4	9,457.3

16.3 Estimated Notional Premium

- 16.3.1 The notional premium is an estimate of the lifetime compensation cost of work related injuries occurring during 2024–25. It is the amount which if paid over the course of the year, together with assumed investment income, would be sufficient to meet the eventual claim costs arising from injuries which occur during 2024–25 if experience unfolded in line with the valuation assumptions. The notional premium for 2024–25 relates entirely to MRCA claims. It is important to note the distinction between the notional premium for 2024–25 and the actual claim payments which will be made during 2024–25.
- 16.3.2 It is convenient to break the notional premium into the same components as the outstanding claims liability. The components of the notional premium include the cost of:
- incapacity payments;
 - permanent impairment and non-economic loss lump sums;
 - medical expenses;
 - rehabilitation;
 - death and payments to dependent children;
 - household services and attendant care; and
 - other benefits;
- that is attributable to claims arising from service rendered during 2024–25.
- 16.3.3 The estimate of the notional premium is calculated as the present value of the cashflows arising from the 2024–25 accident year adjusted for half a year's interest to give the amount that would need to be paid over the course of 2024–25.
- 16.3.4 Administration costs have not been included for this review, as they are considered outside the scope of the review itself.

16.3.5 Table 16.9 sets out the estimates of the notional premium, broken down by Service Arm, and by payment type. The notional premium for 2024–25 is \$9,406.6m.

Table 16.9: 2024–25 Notional Premium by Service and Payment Type

Payment Type	ARMY (\$'m)	NAVY (\$'m)	RAAF (\$'m)	Total (\$'m)
Permanent Impairment	2,608.0	393.9	384.7	3,386.6
Incapacity	766.1	229.1	181.6	1,176.8
Medical	1,927.9	480.7	474.2	2,882.8
Rehabilitation	69.2	19.7	16.5	105.4
Death	426.9	367.6	185.8	980.3
HSAC	294.6	91.7	74.6	460.8
Other	255.0	79.5	79.4	413.9
Total	6,881.6	1,321.3	1,203.7	9,406.6

16.3.6 Table 16.10 shows the overall notional premium estimates, expressed as percentages of the total military salary expenditure expected to be paid during 2024–25. Salary estimates for this review were provided by Defence.

Table 16.10: 2024–25 Notional Premium by Service (Percentage of Salary)

	ARMY	NAVY	RAAF	Total
Notional Premium (\$ m)	6,881.6	1,321.3	1,203.7	9,406.6
Forecast salaries 2024–25 (\$m)	3,403.4	2,065.4	1,978.5	7,447.2
Notional Premium (%)	202.2%	64.0%	60.8%	126.3%

16.3.7 Defence advised overall estimated salaries of approximately \$7.0bn for 2024–25. This was around \$415m higher than the salary roll for 2023–24, an increase of 5.9 per cent. The notional premium has increased by around 46 per cent and this has resulted in an increase in the premium expressed as a percentage of salary of approximately 40 percentage points compared to last year's valuation. Most of the premium is attributable to the Army, which accounts for over 73 per cent of the total premium.

17 Scenario Analysis

17.1 Background

- 17.1.1 As discussed throughout the report, there remains great uncertainty in estimating the MCS liability. The very long term over which these liabilities will be paid out makes the results very sensitive to relatively small changes in assumptions. Interpreting experience in a rapidly changing environment also poses significant challenges. We have included a range of sensitivity tests and scenarios to show the impact of changes in key modelling assumptions and the impact of wider scheme experience changes. Please note that the sensitivities and scenarios included in this section are a subset of possible outcomes and are not intended to be an exhaustive list of all possible future outcomes. The results are not intended to represent lower and upper bounds to all possible future outcomes.
- 17.1.2 The choice of the interest rate used to discount future cashflows to determine the present value of liability has a major impact on the results. This is the result of the very long time period over which payments are projected combined with the relatively high rates of payment inflation. We have taken the view that changes in the interest rate from year to year have the potential to confuse rather than clarify understanding of the trends in the experience. However, for financial statement purposes an estimate of the liability based on prevailing yields on Commonwealth securities is required. In providing advice for the 2024 DVA financial statements, therefore, we discounted the cashflows generated by the 2023 model using a yield curve for Commonwealth securities as at 30 June 2024. We have recalculated the liability based on the cashflows from the current valuation using that same yield curve.
- 17.1.3 One of the key uncertainties at this valuation is the level of future initial liability claims. Although the level of lodged IL claims remained relatively stable over the 2020 to 2022 calendar years, there have been significant increases in each of the last two years across both DRCA and MRCA. As the level of future expected IL claims has an impact on a number of the major benefits, we have included scenarios to show the liability if IL lodgement levels were to return to those seen in previous periods or continue to escalate beyond current levels.
- 17.1.4 In selecting scenarios for analysis, we have focused on the largest benefit categories, focusing particularly on assumptions where experience has been changing or volatile. We have focused our scenario tests around MRCA and DRCA PI, incapacity, MRCA medical, MRCA household services benefits, and MRCA death benefits. The scenarios tested are discussed in turn under each section. For some benefits, we have also included sensitivity tests to show the impact on the liability with small movements in the adopted assumptions.

17.2 Results

Discount Rate Scenario

- 17.2.1 The following table shows the liabilities as at 30 June 2024 by head of damage and Act using the yield curve adopted for the 2023–24 financial statements.

Table 17.1: Estimated Liability Using 2024 Yield Curve

Payment Type	DRCA (\$'m)	MRCA (\$'m)	Total (\$'m)
Permanent Impairment	6,739	23,206	29,945
Incapacity	2,148	13,048	15,195
Medical	118	36,077	36,195
Rehabilitation	69	1,262	1,331
HSAC	1,644	5,316	6,960
Other	225	2,627	2,852
Death	542	9,664	10,206
Total	11,485	91,200	102,685

- 17.2.2 The total liability increases by over \$4bn when the June 2024 yield curve is used, relative to the result using the 5 percent discount rate. The items which are most sensitive to the change in discount rate are the medical, incapacity, and household services categories. These payments have a thicker 'tail' than other heads of damage in terms of the pattern of cashflows.
- 17.2.3 Cashflows are not affected by the choice of discount rate but the notional premium is. Using the June 2024 yield curve, the calculated notional premium increases to around \$9.8bn, or approximately 131 per cent of estimated ADF salaries for 2024-25.

Initial Liability Scenarios

- 17.2.4 As discussed in the report, the most recent year of experience saw another significant increase in the level of lodged DRCA and MRCA IL claims. For our valuation, we have adopted the most recent experience as our assumption for future levels of IL lodgements (i.e. we adopted the experience since April 2024, resulting in the 2025 calendar year projection being 4 per cent higher than the 2024 calendar year actual experience).
- 17.2.5 We have spoken to DVA policy areas around the potential drivers of this experience which suggests possible reasons such as greater involvement of fee-for-service advocates, heightened awareness through the Royal Commission into Defence and Veteran Suicide, "on base" activities informing veterans of their entitlements, word of mouth within friendship/cohort groups within the veteran community, all of which may encourage veterans to lodge new or further claims. Some of these impacts may be temporary and lodgements could return to previous levels or they may persist or accelerate further.
- 17.2.6 We have performed two scenarios around IL lodgement experience for MRCA, noting these are not exhaustive of all possible outcomes nor are they intended to represent a floor or ceiling in outcomes:
- a reduction in lodgement levels i.e. that lodgements in 2025 will be 10 per cent lower than our central estimate assumption, namely a 6 per cent reduction in 2025 (rather than a 4 per cent increase adopted as our central estimate) and that this lower level will be maintained in future years; and
 - a higher increase in lodgement levels i.e. that lodgements in 2025 will be 10 per cent higher than assumed, namely a 14 per cent increase in 2025 (rather than 4 per cent adopted), and that this higher level will be maintained in future years.

17.2.7 The MRCA IL scenarios have been implemented for the three largest benefit types of permanent impairment, medical, and incapacity only.

17.2.8 For DRCA, we have tested the same IL scenarios but have only shown the impact on permanent impairment benefits which is shown in the next section.

Table 17.2: MRCA Liability Under Modelled Initial Liability Scenarios¹⁵

Scenario	Description	MRCA Liability (\$'m)	Change in Liability (\$m)	% Change
Base		87,371.5		
1	IL lodgements reduce by 10%	85,033.8	(2,337.7)	(2.7%)
2	IL lodgements increase by 10%	89,708.7	2,337.1	2.7%

Permanent Impairment Scenarios

17.2.9 We have provided the following scenarios to illustrate the impact on the MRCA permanent impairment liability should assumptions be different to those selected:

- Changes in the average size of interim and non-interim lump sums (the average size of Section 80 benefits and the amounts received in periodic benefits are assumed unchanged in these scenarios). We have shown the impact on the liability of both a 10 per cent increase in the average claim size and a 10 per cent reduction;
- Changes in the proportion of claimants receiving Section 80 benefits. Our central estimate basis assumes that the proportion of claimants receiving Section 80 benefits will increase over the next three years to 14 per cent before reducing again to 13 per cent. We have shown the impact on the liability if the proportion remains unchanged from 2024 levels (12 per cent), or if the proportion increases to 15 per cent over the next three years and then remains at that level;
- Changes in our superimposed inflation allowance. Our adopted rate of superimposed inflation included in the valuation result is for three years of superimposed inflation at a rate of 2.0 per cent per annum. We have provided scenarios where there is no superimposed inflation, and also where superimposed inflation is 2.5 per cent per annum for all future years.

¹⁵ Note that for MRCA models where there are existing claimants such as medical, only the IBNR component of the liability has been adjusted for the scenario analysis.

Table 17.3: MRCA Permanent Impairment Liabilities Under Modelled Scenarios

Scenario	Description	MRCA PI Liability (\$'m)	Change in Liability (\$m)	% Change
Base		22,517.1		
1	Average size of lump sums is 10% lower	20,839.0	(1,678.1)	(7.5%)
2	Average size of lump sums is 10% higher	24,195.1	1,678.1	7.5%
3	Lower proportion of claimants receiving Section 80 benefits	22,150.9	(366.2)	(1.6%)
4	Higher proportion of claimants receiving Section 80 benefits	22,801.5	284.4	1.3%
5	No superimposed inflation	21,712.7	(804.4)	(3.6%)
6	Higher superimposed inflation (2.5% for all future years)	23,917.9	1,400.8	6.2%

17.2.10 For DRCA, we have performed the same two scenarios around IL lodgement experience as show for MRCA above (i.e. a 10 per cent reduction in lodgement levels and a 10 per cent increase in lodgement levels) and measure the impact on PI benefits. We have also performed two additional scenarios around the rate at which IL lodgements will reduce. Our central estimate assumption was that IL lodgements would reduce at a rate of 12 per cent per annum from 2027. We have shown the impact on our results of both a higher reduction (i.e. 15 per cent per annum) and a lower reduction (i.e. 7 per cent per annum).

17.2.11 We have also shown the impact on the liability of both a 10 per cent increase in the average claim size and a 10 per cent reduction.

Table 17.4: DRCA Permanent Impairment Liability Under Modelled Scenarios¹⁶

Scenario	Description	DRCA PI Liability (\$'m)	Change in Liability (\$m)	% Change
Base		6,475.0		
1	IL lodgements reduce by 10%	5,984.8	(490.2)	(7.6%)
2	IL lodgements increase by 10%	6,965.2	490.2	7.6%
3	IL lodgements run-off more quickly i.e. 15% rather than 12%	5,670.6	(804.4)	(12.4%)
4	IL lodgements run-off more slowly i.e. 7% rather than 12%	8,775.4	2,300.4	35.5%
5	Average size of lump sums is 10% higher	5,827.5	(647.5)	(10.0%)
6	Average size of lump sums is 10% lower	7,122.5	647.5	10.0%

Incapacity Scenarios

17.2.12 The main drivers for the incapacity liability are continuance rates and average size assumptions. We have provided sensitivity tests and scenarios to illustrate the impact on the liability should these drivers be different to what was assumed. We have also included results

¹⁶ As for the MRCA models, where there are existing DRCA claimants, only the IBNR component of the liability has been adjusted for the scenario analysis.

should the conversion rate from IL differ to what was adopted. Table 17.5 below shows the resulting liability impact.

Table 17.5: Incapacity Liability Scenario and Sensitivity Test Results

Scenario	Description	Incapacity Liability (\$'m)	Change in Liability (\$m)	% Change
Base		14,515		
1	Average size is 10% higher	15,967	1,452	10.0%
2	Average size is 10% lower	13,063	(1,452)	(10.0%)
3	Continuance rates 10% lower	13,613	(841)	(6.2%)
4	Continuance rates 10% higher	15,523	1,008	6.9%
5	New entrant numbers 10% higher	15,410	806	6.2%
6	New entrant numbers 10% lower	13,620	(806)	(6.2%)

MRCA Medical Scenarios

17.2.13 Table 17.6 below contains the results for the sensitivity and scenario analysis on the MRCA medical liability. One of the key drivers of the increase to the MRCA medical liability at this valuation has been the increase in the projected number of claimants who will eventually obtain a Gold Card. There has been rapid growth in the number of claimants receiving Gold Cards in recent years and there remains great uncertainty around the level to which this will continue going forward. We have included scenarios where the ultimate proportion of Gold Card recipients is higher or lower than what was adopted. We have also included sensitivity tests on the key assumptions of claimant numbers and average cost of benefits, and a scenario around the use of heavier mortality rates.

Table 17.6: MRCA Medical Liability Sensitivity and Scenario Analysis

Sensitivity/ Scenario	Description	MRCA Medical Liability (\$'m)	Change in Liability (\$m)	% Change
Base	-	34,395		
1	Average size increases by 10%	37,815	3,420	10.0%
2	Average size decreases by 10%	30,974	(3,420)	(10.0%)
3	Claimant projection increases by 10%	35,899	1,504	4.4%
4	Claimant projection decreases by 10%	32,891	(1,504)	(4.4%)
5	Defence Superannuation invalidity mortality applied	30,228	(4,167)	(12.1%)
6	Ultimate Gold Card proportion is 10% lower than adopted ultimate	31,187	(3,208)	(9.3%)
7	Ultimate Gold Card proportion is 10% higher than adopted ultimate	37,615	3,220	9.4%

MRCA Household Services Scenarios

17.2.14 There has been significant growth in the usage of household benefits under MRCA, particularly since 2019 when benefits were moved to the needs assessment process after IL claims acceptance. We have seen increasing numbers of new claimants, as well as high proportions of claimants continuing usage of benefits over long periods. There remains considerable uncertainty as to whether these trends will continue indefinitely. We have provided results for sensitivity tests on the key assumptions of the modelling and scenarios around future mortality rates and superimposed inflation in Table 17.7.

Table 17.7: MRCA HSAC Liability Sensitivity and Scenario Analysis

Sensitivity/ Scenario	Description	MRCA HSAC Liability (\$'m)	Change in Liability (\$m)	% Change
Base	-	5,068		
1	Average size is 10% higher	5,575	507	10%
2	Average size is 10% lower	4,561	(507)	(10%)
3	New claimants are 10% higher	5,484	415	8.2%
4	New claimants are 10% lower	4,736	(332)	(6.5%)
5	Usage is 10% higher	5,433	365	7.2%
6	Usage is 10% lower	4,703	(365)	(7.2%)
7	Utilisation rate reduces by 10%	4,732	(336)	(6.6%)
8	Utilisation rate increases by 10%	4,871	336	6.6%
9	Defence Superannuation invalidity mortality is used	4,570	(498)	(10%)
10	Superimposed inflation of 1.3% (5% nominal inflation)	6,929	1,861	37%

MRCA Death Benefits Scenarios

17.2.15 For this valuation we have included a new liability in respect of MRCA members who are expected to receive an auto-grant death benefit due to being assessed as over 80 whole person impairment points or being eligible for SRDP. There is a high degree of uncertainty around the key assumptions of:

- The number of members expected to meet the eligibility criteria in the future – this is based on both the number of new ILs expected to be lodged and the proportion expected to meet the eligibility criteria for the death benefit;
- The number of members who have a partner at the time of death;
- The annual cost of Gold Cards granted to widows;
- The timing of when benefits will be paid i.e. when the members are likely to die, which is based on our assumed mortality rates.

17.2.16 In the Initial Liability Scenarios section above, we showed the impact on the three largest benefit types of scenarios where IL lodgements were either 10 per cent lower or 10 per cent higher than our central estimate; we have shown the impact of these same scenarios on the MRCA death benefit in Table 17.8.

- 17.2.17 In the MRCA Permanent Impairment Scenarios section above, we showed scenarios where the proportion of claimants receiving Section 80 benefits was either higher or lower than our central estimate. We have used these same scenarios in testing the proportion of claimants who may meet the criteria for an auto-grant death benefit (i.e. if the proportion receiving Section 80 benefits remains unchanged from the 2024 levels of 12 per cent, or if the proportion increases to 15 per cent over the next three years and then remains at that level).
- 17.2.18 In our valuation we assumed partnering rates consistent with the rates assumed for male invalidity pensioners in the most recent actuarial review of military superannuation schemes. We have provided scenarios assuming that these partnering rates are 10 per cent lower and 10 per cent higher.
- 17.2.19 In our valuation we assumed that widows who received a Gold Card following the death of their spouse would receive \$17,500 per annum in medical benefits. We have tested the impact of assuming a 10 per cent lower annual cost (\$15,750) or a 10 per cent higher annual cost (\$19,250).
- 17.2.20 In our valuation we adopted mortality rates for invalidity pensioners as used in the AGA's report "Military Superannuation Schemes Review of Long Term Costs as at 30 June 2023", with no allowance for mortality improvement. We have tested the impact of using population mortality taken from the AGA's Life Tables 2020-22, also with no allowance for mortality improvement. This mortality scenario results in substantially lower liabilities (despite assuming the same number of members receive the auto-grant death benefit) as, with lower mortality assumptions, deaths are assumed to occur further into the future. Our discount rate assumption of 5 per cent per annum is higher than our assumed future rate of indexation of the death benefit (2.5 per cent per annum), thus resulting in a lower discounted liability than our central estimate.

Table 17.8: MRCA Death Benefit Liabilities Under Modelled Scenarios

Scenario	Description	MRCA Death Benefit Liability (\$'m)	Change in Liability (\$m)	% Change
Base		9,205.3		
1	IL lodgements reduce by 10%	8,808.1	(397.3)	(4.3%)
2	IL lodgements increase by 10%	9,602.6	397.3	4.3%
3	Lower proportion of claimants receiving Section 80 benefits	8,515.5	(689.8)	(7.5%)
4	Higher proportion of claimants receiving Section 80 benefits	9,758.8	553.5	6.0%
5	Lower proportion of partnered members	8,297.6	(907.7)	(9.9%)
6	Higher proportion of partnered members	10,113.0	907.7	9.9%
7	Lower cost of widow Gold Cards	8,792.9	(412.4)	(4.5%)
8	Higher cost of widow Gold Cards	9,617.7	412.4	4.5%
9	Mortality in accordance with ALT2020-22	6,799.4	(2,405.9)	(26.1%)

18 Compliance with Professional Actuarial Standards

- 18.1.1 The Actuaries Institute issues Professional Standards to provide guidance to actuaries in carrying out their professional role. Professional Standard 302 (PS302) deals with actuarial reports and advice on general insurance technical liabilities. Section 1.1.2 of PS302 defines general insurance claims to include liabilities imposed by legislation and section 1.1.3 sets out situations under which PS302 applies. These include a valuation conducted to prepare financial statements under accounting standards. In this case, the valuation report supports the preparation of financial statements under Accounting Standard AASB137. A separate letter on the methodology used in estimating the provision as at 30 June 2025 for financial statement purposes will be provided to DVA in July of 2025. This report, in conjunction with the financial statements letter provided to DVA in July, has been produced to comply with the requirements of PS302.
- 18.1.2 Some aspects of PS302 are outside the scope of this report. These include risk margins, claim handling expenses, and reinsurance recoveries associated with the estimates. As discussed in section 5.6, AASB137 does not explicitly require a risk margin to be included. In the context of the Commonwealth's balance sheet, the requirements set out in AASB137 would argue against the inclusion of a risk margin since it would be irrational for the Commonwealth to pay more than the central estimate to settle the liability. This view is consistent with the fact that the Commonwealth chooses to self-insure many of its risks rather than pay a premium to transfer them off the balance sheet. Section 5.5 discusses claims handling expenses and section 5.7 discusses the provision for any expected recoveries.
- 18.1.3 The valuation and this report have been subject to internal technical and peer review. The technical review focuses on the data, calculations, and results whilst the peer review focuses on the approach, assumptions and judgements, and results.



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27 June 2025