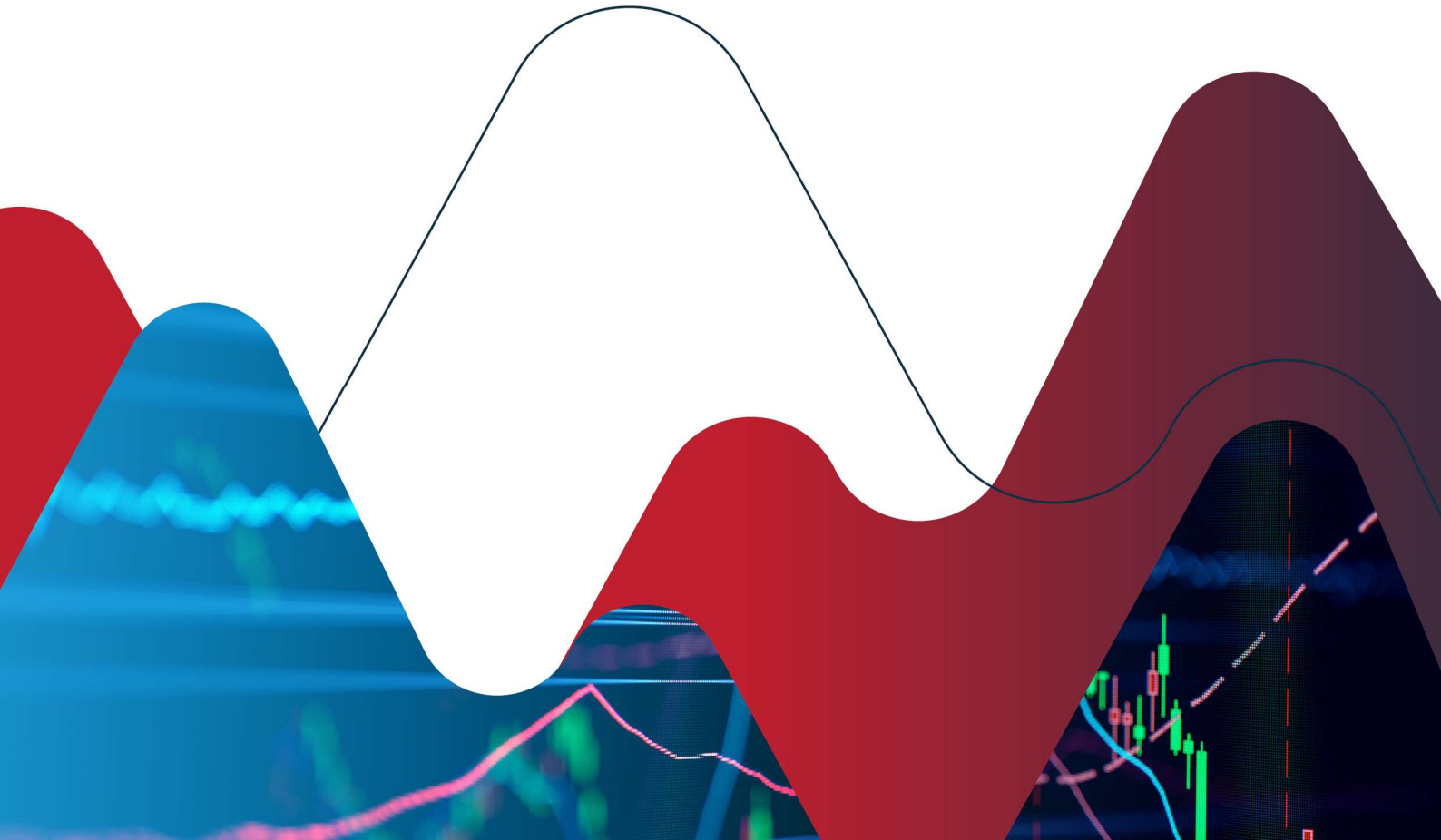
Australian Government

Australian Government Actuary

Actuarial Investigation into the Costs of Military Compensation

30 June 2025



Contents

1 Executive Summary 4
1.1 Background 4
1.2 Scope of the Report 5
1.3 Recent Claim Experience 5
1.4 Valuation Results 9
1.5 Comments on Results 11

2 Background 14
2.1 The Military Compensation Scheme 14
2.2 Trends in Expenditure 15
2.3 Scope of the Valuation 17
2.4 The Military Operational Environment 17
2.5 Administrative Environment 19

3 Data Used for the Valuation 20
3.1 Data Sources 20
3.2 Data Provided 20
3.3 Data Quality 22

4 Valuation Approach and Common Assumptions 24
4.1 Projection Models and Exposure 24
4.2 Economic Assumptions 24
4.3 Administrative Expenses 27
4.4 Risk Margins and Risk Assessment 27
4.5 Reinsurance and Non-Reinsurance Recoveries 27

5 Initial Liability Claims 29
5.1 Background 29
5.2 Lodgements 29
5.3 Number of Claimed Conditions per Person 31
5.4 Types of Conditions Lodged 32
5.5 Completions 33
5.6 Actual versus Expected Experience 36
5.7 Projected Future IL Claims – MRCA 37
5.8 Projected Future ILs - DRCA 41

6 MRCA Permanent Impairment 45
6.2 Modelling Approach 45
6.3 Recent Experience 46
6.4 Valuation Assumptions – Numbers of PI Claims 52
6.5 Valuation Assumptions – Average Claim Size 58
6.6 Valuation Assumptions – Periodic Benefits 63
6.7 Valuation Assumptions – Inflation Assumptions 64
6.8 Impact of the VETS Act – MRCA Veterans 65
6.9 Impact of the VETS Act – DRCA Veterans 65
6.10 Impact of the VETS Act – VEA Veterans 68
6.11 Liability Estimate 69
6.12 Cashflows 71

7 DRCA Permanent Impairment and Non-Economic Loss 72
7.2 Modelling Approach 72
7.3 Recent Experience 72
7.4 Valuation Assumptions – Numbers of PI Claims 75
7.5 Valuation Assumptions – Average Claim Size 80
7.6 Valuation Assumptions – Inflation Assumptions 83
7.7 Impact of the VETS Act 83
7.8 Liability Estimate 84
7.9 Cashflows 85

8 Incapacity Benefits 87
8.1 Benefit Overview 87
8.2 Modelling Approach 88
8.3 Recent Experience 88
8.4 Valuation Assumptions – Incapacity Recipient Projection 88
8.5 Valuation Assumptions – Incapacity Payment Rates 96
8.6 Impact of the VETS Act – DRCA Veterans 102
8.7 Impact of the VETS Act – VEA Veterans 103
8.8 Liability Estimate 104

9 Medical Costs 106
9.1 Benefit Overview 106
9.2 Recent Experience 107
9.3 Modelling Approach 109
9.4 Valuation Assumptions – Active Claimant Projection 110
9.5 Valuation Assumptions – Average Cost per Active Claimant 123
9.6 Impact of the VETS Act – DRCA Veterans 128
9.7 Impact of the VETS Act – VEA All Conditions Treatment Cards 132
9.8 Impact of the VETS Act – VEA Specific Conditions Treatment Card 138
9.9 Impact of the VETS Act – Travel for Treatment Reimbursements 141
9.10 Liability Estimate 143

10 Rehabilitation 145
10.1 Benefit Overview 145
10.2 Recent Experience 145
10.3 Valuation Assumptions – Rehabilitation Programs and Assessments 146
10.4 Valuation Assumptions – Aids and Appliances 151
10.5 Impact of the VETS Act – DRCA Rehabilitation 155
10.6 Impact of the VETS Act – VEA Aids and Appliances 158
10.7 Liability Estimate 158

11 Household Services and Attendant Care 160
11.1 Benefit Overview 160
11.2 Recent Experience 160
11.3 Modelling Approach 161
11.4 Valuation Assumptions – Active Claimant Projection 161
11.5 Valuation Assumptions – Average Cost per Active Claimant 169
11.6 Impact of the VETS Act – DRCA Veterans 171
11.7 Impact of the VETS Act – VEA Veterans 171
11.8 Liability Estimate 175

12 Other Benefits 177
12.1 Benefit Overview 177
12.2 Modelling Approach 177
12.3 Recent Payment Experience 178
12.4 Valuation Assumptions - Medical Reports and Legal Expenses 180
12.5 Valuation Assumptions - ETS Payments 187
12.6 Valuation Assumptions – Supplements 192
12.7 Impact of the VETS Act – ETS benefits 195
12.8 Impact of the VETS Act – Medical Reports and Legal Expenses 196
12.9 Liability Estimate 196
12.10 Cashflows 198

13 Death Benefits 199
13.1 Benefit Overview 199
13.2 DRCA Approach and Assumptions 200
13.3 MRCA Approach and Assumptions – Deaths occurring prior to 30 June 2025 203
13.4 MRCA Approach and Assumptions – Deaths occurring after 30 June 2025 206
13.5 Impact of the VETS Act – DRCA Veterans 208
13.6 Impact of the VETS Act - VEA Veterans 209
13.7 Liability Estimate 210
13.8 Cashflows 211

14 Summary of overall outstanding liability, cashflows and notional premium estimate 213
14.1 Summary of Outstanding Claims Liability 213
14.2 Summary of Projected Cashflows 214
14.3 Estimated Notional Premium 216

15 Scenario Analysis 219
15.1 Background 219
15.2 Results 219
Discount Rate Scenario 219
Permanent Impairment Scenarios 220
Incapacity Scenarios 222
Medical Scenarios 223
Household Services Scenarios 226
MRCA Death Benefits Scenarios 227

16 Compliance with Professional Actuarial Standards 229

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 2025 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 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 received by DVA will be determined under a single Act, the amended MRCA. From 1 July 2026, the *Veterans' Entitlements Act 1986* (VEA) and DRCA will be closed to all new compensation and rehabilitation claims. The liability result as at 30 June 2025 presented in this report incorporates this change.

1.1.3 In order to estimate the impact of the VETS Act on veterans with DRCA eligibility, we have first modelled what they would look like under the DRCA legislation and subsequently modelled the impact on benefits as a result of the VETS Act changes and future claims being assessed under the MRCA.

1.1.4 Please note, where references are made to "DRCA claims" after 1 July 2026 in the report, they are in reference to claims lodged by the "DRCA cohort". The DRCA cohort refers to veterans who were eligible for compensation under the DRCA prior to 1 July 2026, and who will lodge new compensation and rehabilitation claims under the MRCA from 1 July 2026. All projections of DRCA expenditure after 1 July 2026 relate to existing benefits remaining under the DRCA after this date or for setting a comparative baseline for the transition of costs to MRCA from 1 July 2026 only.

1.1.5 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.

1.1.6 The valuation methodologies used for different types of payments reflect the particular characteristics of those payments and the nature of the available data.

1.1.7 The MCS valuation is based on recent historical experience, which is then projected across the timeline of support that is provided to veterans. The valuation does not reflect recent policy changes that are not yet in effect or have had insufficient time to influence experience.

1.1.8 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 2025 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. From 1 July 2026, all new compensation and rehabilitation claims reported to DVA will be assessed under the MRCA. This will include claims arising from service which pre-dates the start of the MRCA on 1 July 2004;
- 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 2025–26.

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).

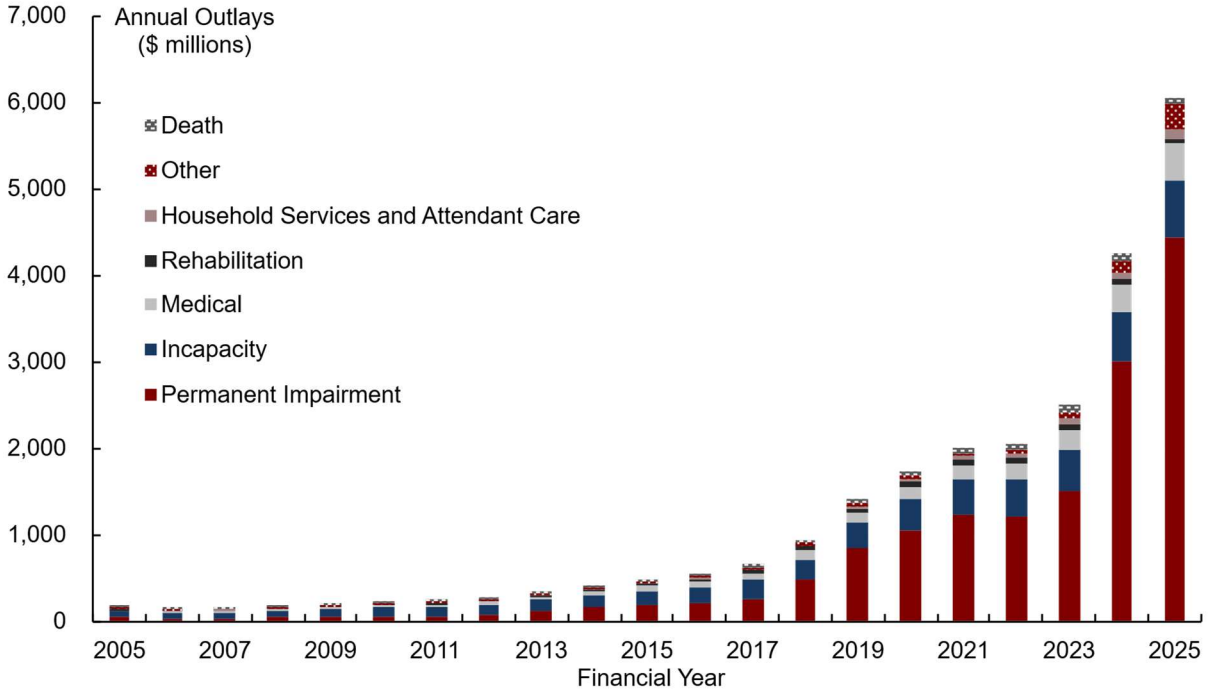
1.2.5 Any proposed use of this report or parts of this report which go beyond its stated purpose should be discussed first with AGA.

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 2025. 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 across 2021 and 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 2024 and again in 2025. Although processing capacity has increased in recent years, the level of new IL claim lodgements also increased in both 2023 and 2024 (before stabilising in 2025). New IL lodgements have outstripped IL completions. As such, there remains a notable volume of open IL claims as at 31 December 2025. 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 lodgement experience will not be seen in the expenditure for some years yet.

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 last two financial years in particular has increased substantially, partially due to increasing processing capacity at DVA. Expenditure is expected to continue to be high 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 receiving high average PI payments and 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, household services and attendant care benefits, and medico-legal expenses in the latest two

years. Total MRCA medical expenditure increased by approximately 38 per cent over the year to 2025, increasing from approximately $309 million in 2024 to $425 million in 2025. The increase in medical expenditure has been driven by a significant increase in the number of veterans with access to the MRCA All Conditions Treatment Card. MRCA All Conditions Treatment 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 All Conditions Treatment Cards are significant. Household services and attendant care expenditure increased by approximately 45 per cent from $75 million to $108 million in the last year, primarily driven by significant increases to the average size of expenditure and the continued propensity for claimants to remain on benefits for an extended period of time. 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 quadrupled between 2023 and 2025, increasing from approximately $73 million to $292 million.

1.3.5 The following tables compare actual payments over the last year with the amounts projected in the 2024 valuation. In total, actual payments were 6.5 per cent higher than those projected. The largest difference, in dollar terms, was for PI benefits where outlays were approximately $357 million higher than projected. This was primarily driven by a significantly higher than expected average payment size across both DRCA and MRCA.

Table 1.1: Comparison of Actual and Projected Payments for 2024–25

Category	Projected $m	Actual $m	Difference $m	*% Difference*
Incapacity	602.1	647.2	45.1	7.5%
Permanent Impairment & Non-economic Loss (PI & NEL)	4,087.2	4,444.0	356.8	8.7%
Medical	461.9	436.9	-25.1	-5.4%
Household Services and Attendant Care (HSAC)	107.3	108.3	0.9	0.9%
Rehabilitation	63.8	57.3	-6.6	-10.3%
Death	118.8	75.5	-43.3	-36.5%
Other	251.0	292.0	40.9	16.3%
Total	**5,692.2**	**6,061.1**	**368.8**	**6.5%**

1.3.6 Between calendar years 2020 and 2022, the level of IL claim[1] 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

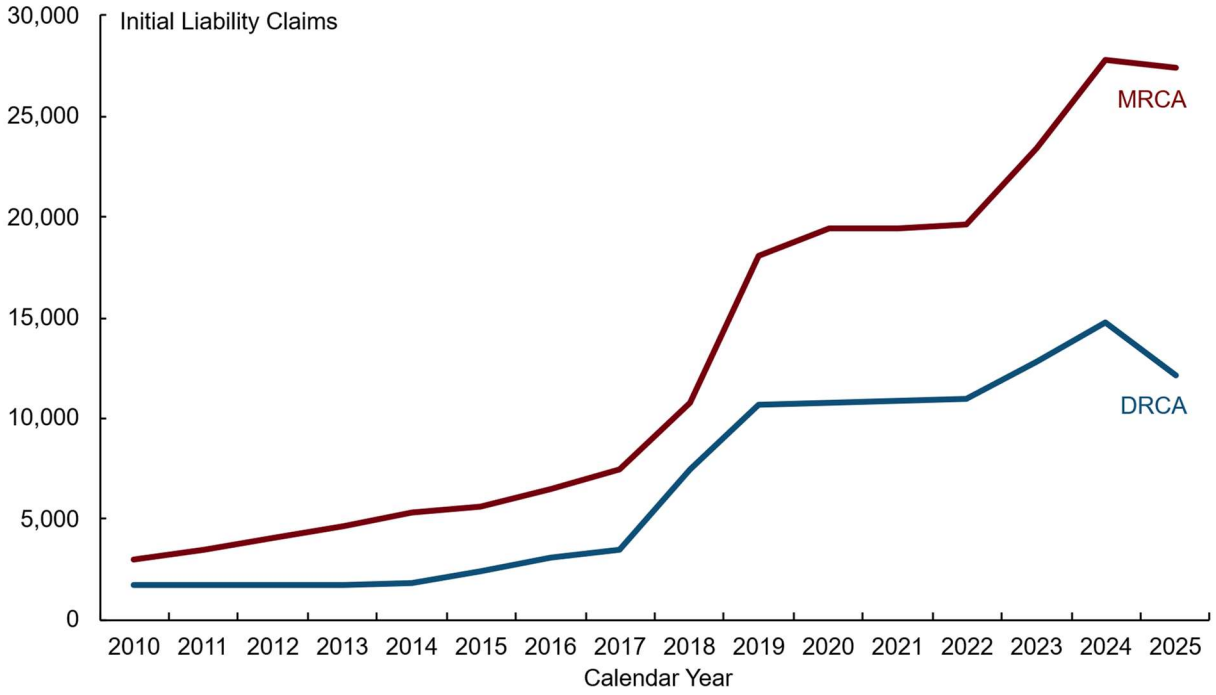
[1] A claim in a given year is summarised to the person level. That is, a claimant who lodges multiple IL claims in a year will only be counted once in that year. As such, claim level and person level are synonymous in our report when discussed in the context of the same year.

lodgements over the calendar year which continued into 2024. The latest year has seen a slight decrease in the level of lodgements across both DRCA and MRCA.

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 increased from approximately 3.5 in the 2020 calendar year to 5.1 in the 2025 calendar year for MRCA. Similar experience is also seen in DRCA, where the average number of conditions lodged per person has increased from 3.5 to 4.3 over the same period despite the scheme being closed to injuries sustained beyond 30 June 2004.

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 Lodged - 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, processing rates have declined in 2025 and as at the end of December 2025, 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. We have assumed processing will remain at similar levels over the short term as that seen in the latest calendar year but will return to the levels seen in 2023 and 2024 over the long term.

1.4 Valuation Results

SUMMARY

The liability for the MCS, excluding the impact of the VETS Act, as at 30 June 2025 is $130.2 billion. This is significantly higher than what was projected at the previous valuation of $107.1 billion. The $23 billion increase was largely driven by:

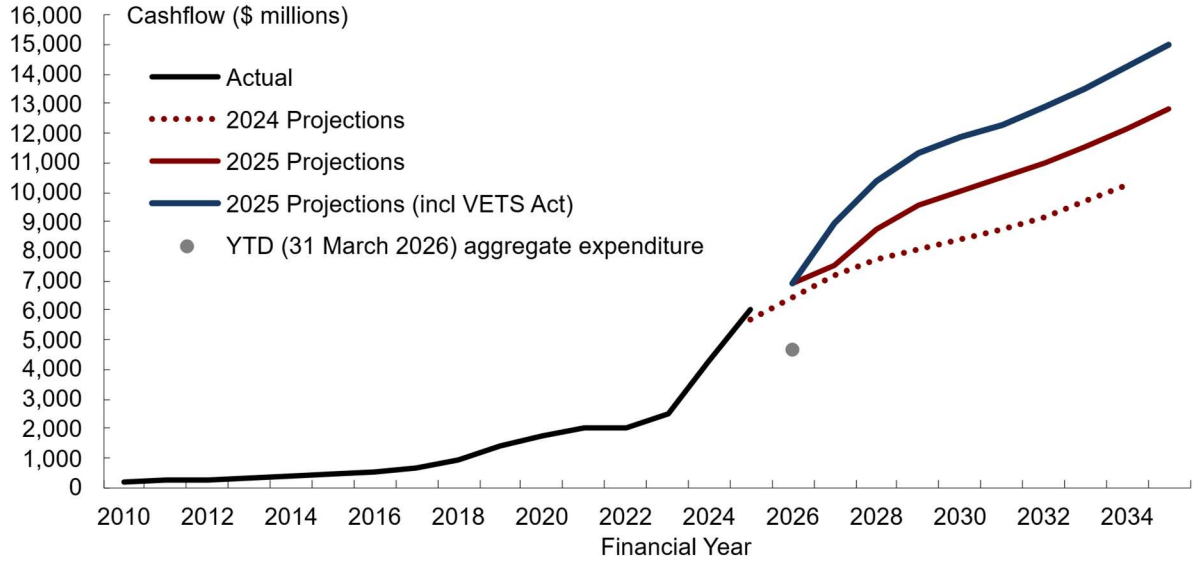
- an increase in the expected number of All Conditions Treatment Card recipients and increases to the average size of expenditure under MRCA medical benefits. Combined, this has led to an increase of almost $11.5 billion;
- an increase in the average size of MRCA PI benefits, including provisions for continued high proportions of claimants receiving Section 80 benefits. This led to an increase of approximately $4.9 billion;
- increased expected numbers of spouses entitled to the MRCA death compensation benefits as a result of the higher proportion of claimants receiving WPI scores of 80 or more. This resulted in an increase of approximately $4 billion; and
- an increase in the level of utilisation of aids and appliances which led to an increase of approximately $1.6 billion.

The liability as at 30 June 2025 including the impact of the VETS Act is $165.9 billion, $35.7 billion higher than under the current legislative basis. This additional increase to the liability primarily comprises of the following:

- $16.5 billion provision for Specific Conditions Treatment Cards and All Conditions Treatment Cards anticipated to accrue under MRCA from current and future VEA clients;
- $6.6 billion provision for future PI benefits for VEA clients;
- $4.3 billion provision for death compensation and liability benefits for spouses of current and future DRCA and VEA clients;
- $3.1 billion provision for household services and attendant care benefits for current and future VEA clients; and
- $2.3 billion provision for rehabilitation benefits for current and future VEA clients, primarily related to aids and appliances.

1.4.1 Figure 1.3 shows the projected cashflows aggregated across all categories from the 2025 valuation, both excluding and including the impact of the VETS Act, compared to cashflows projected at the 2024 valuation. We have also included the year-to-date aggregate 2025–26 outlays to 31 March 2026 (9 months of expenditure) from the general ledger data.

Figure 1.3: Cashflow Projection for DRCA and MRCA



1.4.2 Please note, in order to compare results with the previous valuation, the following discussion sections will focus primarily on the projected result excluding impacts from the VETS Act.

1.4.3 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, and death benefits.

1.4.4 Table 1.2 below shows the 30 June 2025 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 2025

Benefit Type	Current Valuation *(incl VETS Act)* ($ million)	Current Valuation *(excl VETS Act)* ($ million)	Previous Valuation ($ million)	Difference ($ million)
Permanent Impairment	42,116.9	36,045.4	29,723.8	6,321.7
Incapacity	15,771.4	14,461.2	15,829.7	-1,368.4
Medical	67,128.8	50,217.4	38,714.5	11,502.9
Rehabilitation	5,276.9	2,963.5	1,379.5	1,584.0
HSAC	11,266.6	8,122.7	7,330.2	792.5
Other	4,777.2	3,301.1	3,043.5	257.6
Death	19,600.2	15,050.7	11,095.8	3,955.0
Total	**165,937.9**	**130,162.0**	**107,116.7**	**23,045.3**

1.4.5 Initial liability claim lodgements have slowed in the latest calendar year for both DRCA and MRCA. Discussions with DVA point to a number of possible reasons for this, including uncertainty in the veteran community surrounding legislative reform and communication from the Department on fee-for-service advocates, who have been increasingly representing veterans in recent years.

1.4.6 It is difficult to ascertain whether the current level of lodgements will continue into the future. 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 over the short term before increasing to levels seen in 2023 and 2024. 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, excluding impact of the VETS Act, 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[2])**	**Projected Cashflows $m**
Current Report			for 2025–26
Army	85,264.7	8,960.1	4,990.2
Navy	23,637.5	1,798.9	1,001.9
RAAF	21,259.8	1,624.1	904.5
Total	**130,162.0**	**12,383.1 (152.7%)**	**6,896.7**
Previous Report			**for 2024–25**
Expected (30/6/2025)	*107,116.7*	*9,631.1*	*6,447.1*
Total	**98,391.0**	**9,406.6 (126.3%)**	**5,692.2**

1.4.8 The outstanding claims liability as at 30 June 2025 represents the estimated present value of future claim payments to be made in respect of injuries sustained prior to 30 June 2025. 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 2025–26. It is the amount which, if paid over the course of the 2025–26 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 2025–26 financial year for claims attributable to any service prior to and including 2025–26. The final rows show the comparable figures from the previous valuation, that is, the expected figures as at 30 June 2025 and the reported results as at 30 June 2024. The changes to modelling approach and assumptions have resulted in a 22 per cent increase to the expected liability and 29 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 $107.1 billion by 30 June 2025. The current liability, excluding impacts from the VETS Act, is $130.2 billion. This is approximately $23 billion higher than expected and has been driven by increases across a

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

number of benefit types, with the largest dollar increases in MRCA medical benefits, permanent impairment benefits, and death benefits.

1.5.2 The growth in the number of All Conditions Treatment Card holders has continued to increase over the latest calendar year, with over 6,600 new All Conditions Treatment Cards issued in the 12 months to 31 December 2025, an increase of 40 per cent in the number of new cards issued. All Conditions Treatment Card holders accounted for almost 50 per cent of active MRCA medical claimants in the last calendar year, with their costs accounting for almost 80 per cent of total expenditure in the year. At this valuation, we have continued to utilise available information on open IL and PI claims, in combination with a veteran's estimated future propensity to make additional claims in order to estimate the proportion of the current MRCA medical population likely to reach 60 or more impairment points in the future. The results of this analysis was used to select an ultimate proportion of veterans who will receive a All Conditions Treatment Card. The selected assumption, at 80 percent for more recent cohorts, is significantly higher than the selected rates from the prior valuation and reflects the increase in claimant experience, particularly in the number of new All Conditions Treatment Cards issued, seen in the latest year. The increase to projected claimants and All Conditions Treatment Card recipients contributed almost $8 billion to the increase in medical liabilities.

1.5.3 Medical expenditure has also increased over recent years, primarily driven by the increase in pharmaceutical expenditure related to medicinal cannabis. In 2025, medicinal cannabis accounted for almost 60 per cent of total pharmaceutical expenditure. Another contributor to the increase in the assumed average cost this year was the inclusion of public hospital and community nursing costs. These categories had been previously excluded from the transactional payments dataset provided to AGA. At this year's valuation, we have used information provided in DVA's quarterly payments dataset which includes information on benefit payments across all three Acts to estimate costs related to public hospital expenditure and community nursing. Although community nursing costs are relatively low in the current MRCA cohort, they are material in the VEA cohort, particularly at older ages. The MRCA medical liability increased overall from an expected liability of $38.6 billion to $50.1 billion at this valuation, an overall increase of approximately $11.5 billion.

1.5.4 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 higher 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 retained our superimposed inflation for the first three years of the projection[3] 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 $23.5 billion to $28.8 million, an increase of approximately $5.3 billion.

1.5.5 Death compensation under MRCA is provided to dependent partners for veterans with Special Rate Disability Pension (SRDP) eligibility or impairment 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, a commensurate increase in the number of spouses who currently have eligibility for death compensation or maybe have eligibility in the future is also expected. This has driven the increase in the death liability, from $11.0 billion expected to $15.1 billion at 30 June 2025, an increase of $4.1 billion.

[3] At the previous valuation we allowed for superimposed inflation for the first three projection years. This year, we have allowed for superimposed inflation for the first three years, thus the superimposed inflation is assumed to cease one year beyond what was assumed at the previous valuation.

1.5.6 The introduction of the VETS Act is expected to increase the provision by a further $35.7 billion. A large proportion of costs is expected to accrue under the MRCA from 1 July 2026 from current and expected future VEA expenditure. In particular, costs associated with Specific Conditions Treatment Card and All Conditions Treatment Card recipients which may have otherwise accrued under VEA, will now be considered under MRCA. We estimate this component to be approximately $16.5 billion. VEA veterans who may have otherwise accessed Veterans' Home Care are expected to access household services and attendant care benefits under the MRCA. This is estimated to add approximately $3.1 billion to the MRCA liability. Access to new benefits such as MRCA PI and death compensation benefits for VEA and DRCA clients is expected to increase the liability by a further $11 billion.

1.5.7 Interpreting experience in a rapidly changing environment, including legislative changes, 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.

1.5.8 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 available to us. Please note that liabilities related to VEA have not been previously valued. As such, any experience analysis related to VEA contains a significant amount of uncertainty as AGA has less familiarity with this data.

2 Background

2.1 The Military Compensation Scheme

2.1.1 Compensation for military personnel injured in the course of their duties has been provided by DVA 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 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.

2.1.6 It should be noted that, in actuarial terms, MRCA is not a fully mature with experience limited to a maximum of 21 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.

2.1.7 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

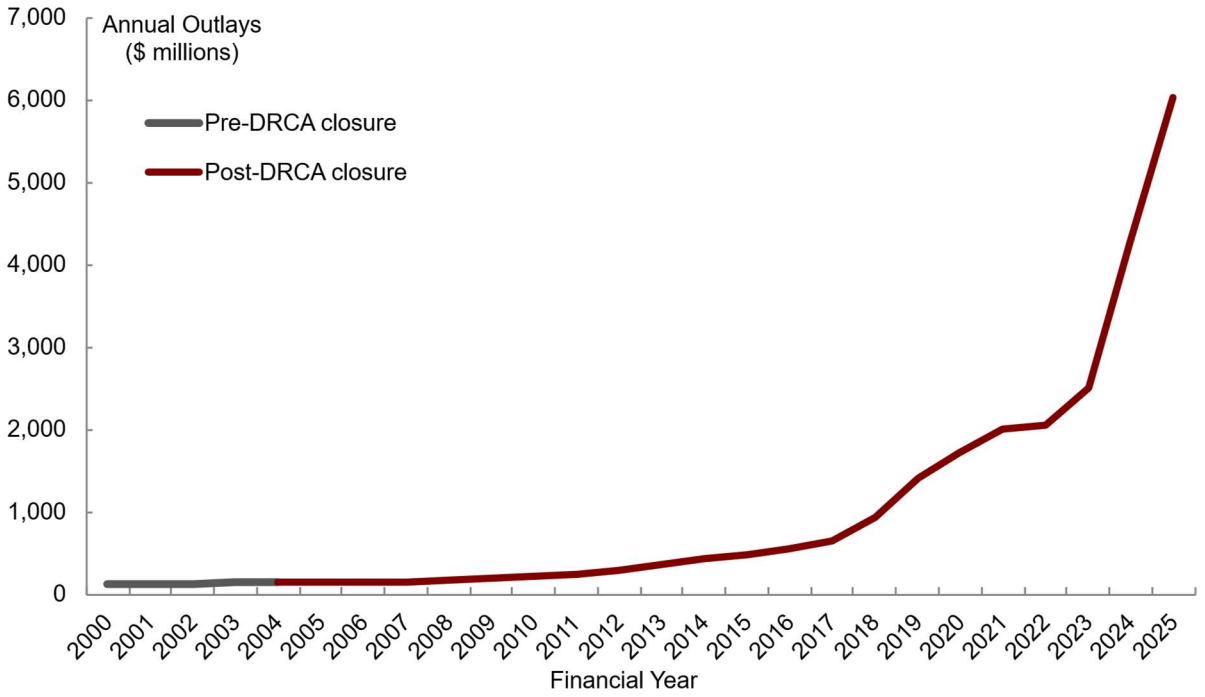
changes have seen experience shift dramatically from earlier periods. It may be some time before MRCA experience settles into a pattern that we can reasonably assume will provide a robust basis for projecting future claim behaviour. Nonetheless, given the differences between DRCA and MRCA experience 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.

2.1.8 On 13 February 2025, the *Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) Act 2025* (VETS Act) was passed by Parliament. As such, from 1 July 2026, all new compensation and rehabilitation claims made to DVA will be assessed under the MRCA. This will include claimants who would otherwise have been assessed under the VEA or DRCA prior to the enactment of the legislation. For some benefits, including incapacity payments and travel for treatment reimbursements, all payments from 1 July 2026 will immediately accrue under the MRCA i.e. a separate claim to establish liability under the MRCA is not required. MRCA expenditure experience from the 2027 financial year onwards will likely exhibit a significant increase and be subject to different trends as the underlying cohort changes over time. It may be some time before any stabilisation in experience becomes evident.

2.2 Trends in Expenditure

2.2.1 Figure 2.1 shows total outlays of the MCS since 2001. Prior to 2004, expenditure had grown at a steady but moderate pace. 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 before slowing considerably between 2021 and 2022. 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, an uplift in processing capacity saw the single largest expenditure increase to date in the following 2024 financial year with growth continuing into 2025. Total expenditure in financial year 2025 exceeded $6 billion, an increase of over 40 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. We have included the liability as at 30 June 2025 both excluding and including the impact of the legislation change.

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 2025;
- 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 2025–26.

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. We have included results both including and excluding the impact of the VETS Act.

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).

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 experience.

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 2025 is a combination of extracts from legacy systems and ISH.

3.1.6 In November 2025, DVA migrated to a new accounting system, TechOne. This changed the mapping of payment transactions from nominal codes to cost centres for transactions from November 2025. Additional reconciliations were conducted by AGA to ensure the accurate capture of benefits using cost centre numbers. Although most cost centres had a one-to-one mapping to the nominals previously used, some represented combined nominals. Further investigation was conducted to manually map these payments to our modelling categories using the provided descriptions and through consultations with DVA. Overall, the new system did not cause any material issues for the valuation.

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 2025. The payments data for the 2024-25 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 2025 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 All Conditions Treatment Card and Specific Conditions Treatment 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;
- Dependent data which included the dependent's year of birth; and
- Early Engagement Model (EEM) data which includes de-identified data on separations and movements from the ADF since 2019.

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 All Conditions Treatment Card expenditure experience to assist in setting assumptions for average MRCA All Conditions Treatment 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 2025 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 2025 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 2025. 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

2024 25 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	155.0	164.0	163.9	100
Permanent Impairment	532.2	531.4	531.1	100
Medical	10.7	10.5	10.5	100
HSAC	42.4	42.6	42.5	100
Rehabilitation	7.1	7.2	6.9	95
Other	18.2	18.2	16.6	92
Death	32.0	32.7	32.1	98
Total	**797.7**	**806.5**	**803.7**	**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

2024 25 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	432.2	483.3	481.0	100
Permanent Impairment	4,033.6	3,912.6	3,911.0	100
Medical	450.5	426.3	425.8	100
HSAC	65.5	65.7	65.6	100
Rehabilitation	49.9	50.1	48.9	98
Other	274.9	273.8	272.4	100
Death	41.6	42.8	42.4	99
Total	**5,348.2**	**5,254.5**	**5,247.1**	**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 more comprehensive injury or separations data become available to AGA in future, these could assist in refining our exposure measure and selected model assumptions. A 'unit of exposure' in our modelling refers to 10,000 full-time serving members or equivalent.

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 2026 Budget included forward estimates of the number of permanent ADF expected in each year to 2029-30. 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 2025 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. More recently, experience across a number of benefits in the MCS has shown significant growth in average size, above what could be expected from indexation. A driver of this experience is the increased number of conditions lodged across DRCA and MRCA in recent years. As these conditions are processed and accepted by DVA, a flow on impact is seen across a number of benefit types, including MRCA PI where this is reflected in increasing proportions of claimants with higher WPI scores. In a number of benefits this year, we have applied superimposed inflation over the short term to capture the impact of these conditions as they are processed by DVA.

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 2011 to 2025, the annual rate of growth has been approximately 9 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 2023. However, growth in the most recent two years has been 24 per cent and 17 per cent. The causes of this very high level of growth in 2024 and 2025 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 with a whole person impairment assessment over 80 points; the impact of this is twofold – higher average lump sums and higher proportions of veterans accessing the Section 80 eligible young person benefit. 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 again 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 5 per cent per annum in 2026 and 2 per cent per annum in 2027 and 2028 in the average size of interim and non-interim lump sum. This is a higher allowance than that included in our previous valuation (2 per cent per annum in each of 2025 to 2027) and reflects the higher numbers of conditions lodged in recent years that have not yet flowed through the PI payments.

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 2027 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 HSAC average costs have been increasing significantly and consistently above inflation. The Household Services program area suggests that provider behaviour may be contributing to this experience. For HS and AC, we have assumed this higher rate of inflation will continue over the short term, adopting superimposed inflation assumptions of 5 per cent above the assumed level of wage inflation for three years. For catastrophically injured clients, where superimposed inflation is more likely reflecting the increasing levels of care needed over time, we have assumed that the average annual cost will increase by 5 per cent above the assumed level of wage inflation indefinitely.

4.2.11 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.

Table 4.1: Rates of Inflation

Category	2025 Valuation	2024 Valuation
Incapacity payments	3.7%	3.7%
PI and NEL (DRCA)	5.0%	5.0%
PI (MRCA)	7.5% in 2026, 4.5% in 2027 and 2028, 2.5% thereafter	4.5% in 2025 to 2027, 2.5% thereafter
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%, 5.0% SI for 3 years, 5.0% SI for catastrophically injured claimants indefinitely	3.7%, 5.0% SI for catastrophically injured claimants indefinitely
Other – Medico-Legal	3.7%	3.7%
Other – Supplements	2.5% for veterans, 0% for energy	2.5% for veterans, 0% for energy
Other – Education & Training Scheme	2.5%	2.5%

4.2.12 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.

4.2.13 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.

4.2.14 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.

4.2.15 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 2026 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 based on the information available at the time of completing the report. 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 15. 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.

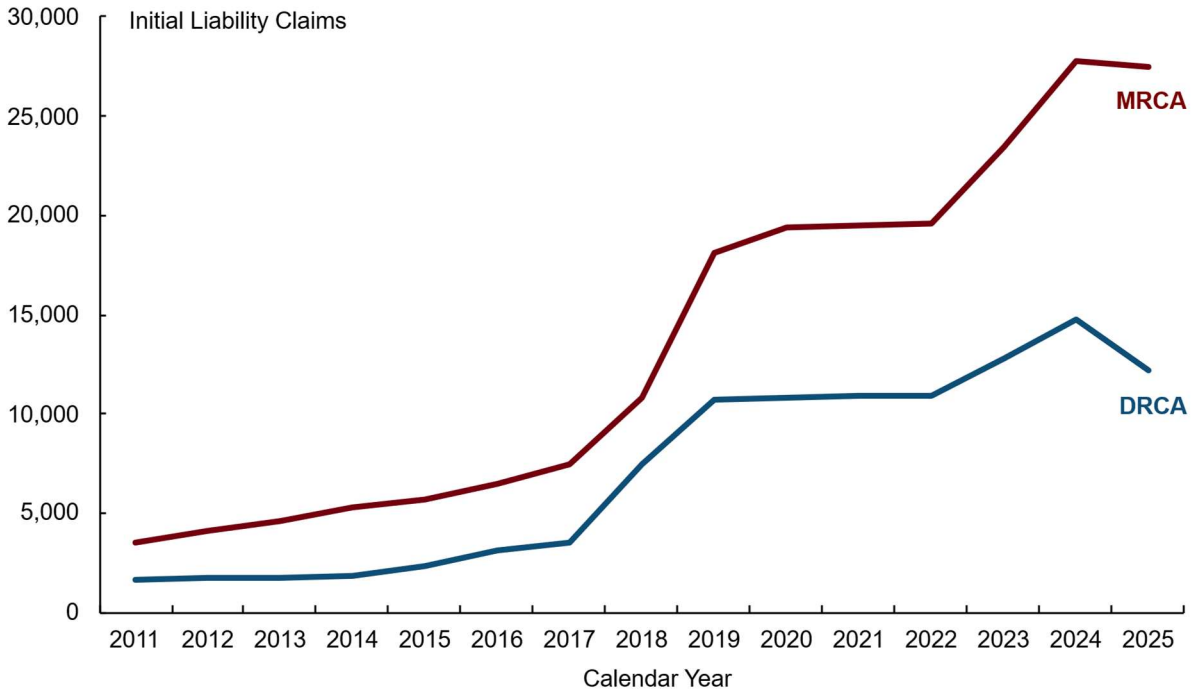
5.1.3 A key uncertainty in determining the level of initial liability claims is the level of exposure, that is, the total population of existing veterans and serving ADF personnel who may eventually make a claim. We currently have data relating to the number of active personnel in each year but this 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 separations 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. AGA were provided with EEM data by DVA this year which includes separations and movements of personnel within the ADF since 2019. Although this data is a positive step towards gaining a better understanding of the veteran population, it may still be some time before enough data is captured in this dataset to enable its meaningful incorporation into any predictive modelling.

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

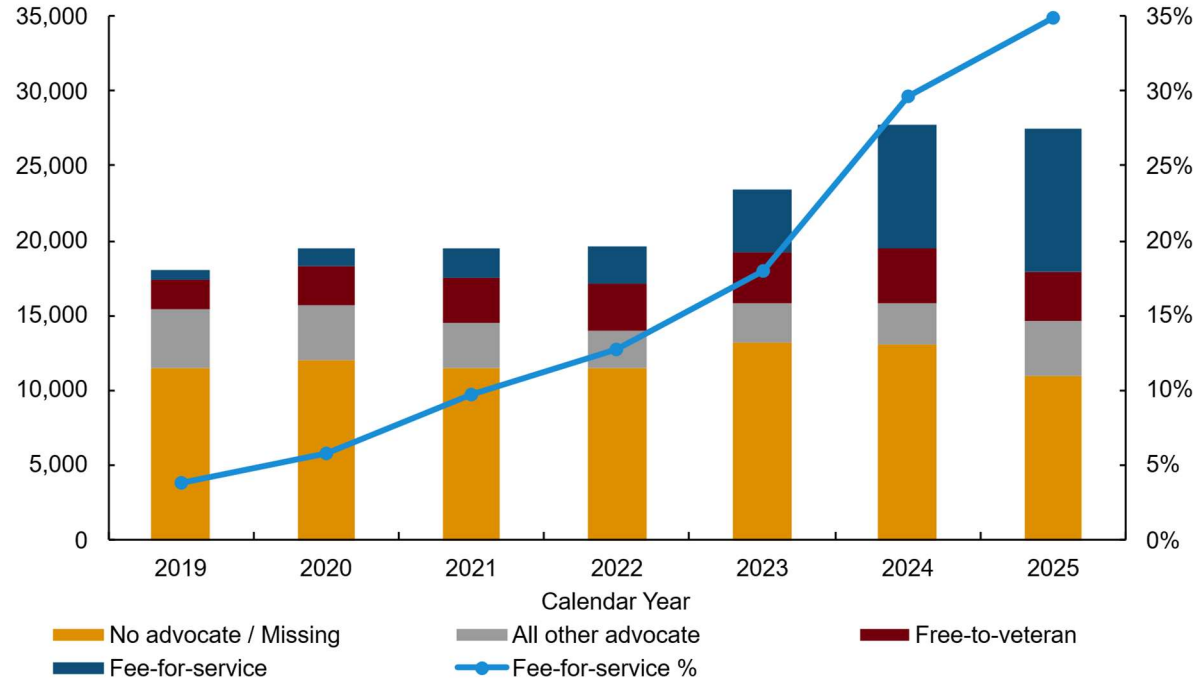


5.2.2 For both DRCA and MRCA, the number of IL lodgements grew considerably between 2022 and 2024. In 2025, the number of IL lodgements for DRCA were 18 per cent lower than in 2024 and for MRCA were 1 per cent lower.

5.2.3 From discussions with DVA delegates, we understand that several factors may be contributing to the growth between 2022 and 2024. 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 through a number of avenues, including 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. For this valuation, DVA have provided an additional data item that records whether the member has a fee-for-service advocate, a free-to-veteran advocate (including ESOs), any other advocate or no advocate. Figure 5.2 shows, for MRCA, that the number of IL claims with fee-for-service advocates has increased over the period shown with particularly large increases in 2023 and 2024. In 2025, 35 per cent of IL claims were supported by fee-for-service advocates. The number of claims with no advocate involvement also increased in 2023 and remained stable in 2024 before falling in 2025. The number of claims that were supported by free-to-veteran advocates has remained relatively stable.

Figure 5.2: MRCA Initial Liability Claims by Advocate Involvement



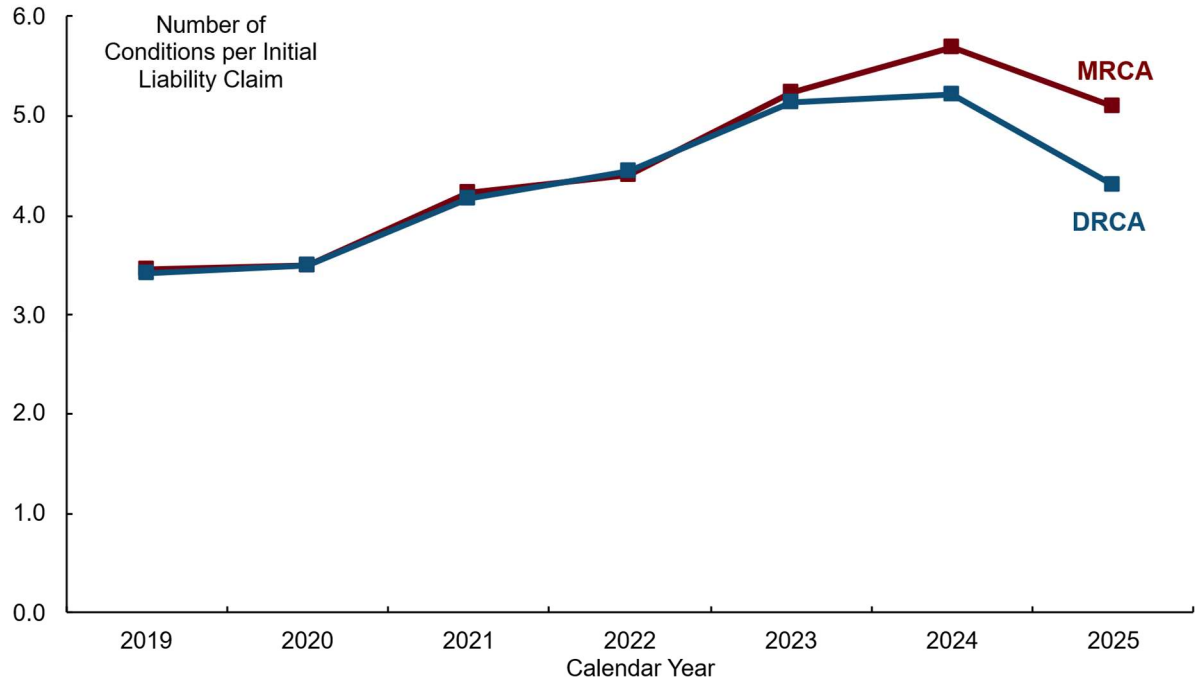
5.2.5 Other reasons that are also thought to be contributing to the increase in the number of IL claims lodged are:

- 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 is 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 Claimed Conditions per Person

5.3.1 A single IL claim lodged can include claims for multiple conditions/injuries. Figure 5.3 shows the number of claimed 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). Note this differs from the chart included in last year's report where we included the number of diagnosed conditions per person. The number of conditions attached to an IL increases over time as conditions are diagnosed (for example, a claimed condition may be a single condition of "mental health" which on diagnosis becomes three conditions of "PTSD", "erectile dysfunction" and "bruxism").

Figure 5.3: DRCA and MRCA Number of Conditions per Person per Year



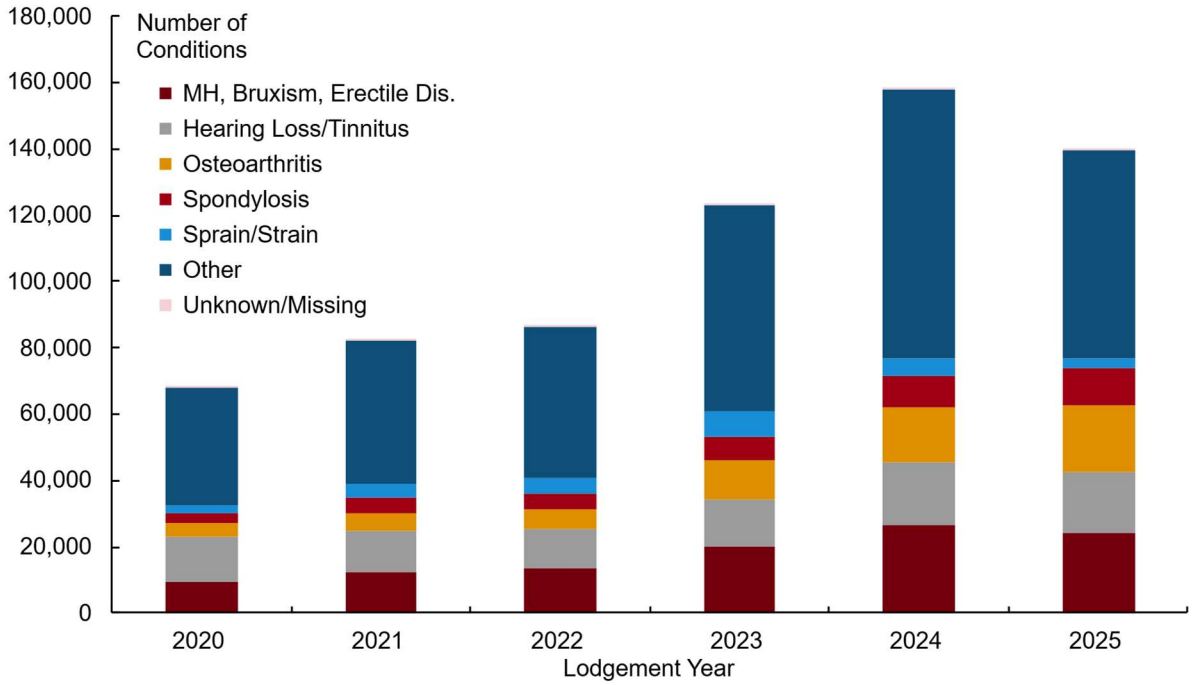
5.3.2 After increasing between 2020 and 2024, the number of conditions lodged per person under both DRCA and MRCA has reduced in 2025 compared with 2024. We understand DVA has implemented policies aimed at curbing the lodgement of conditions by fee-for-service advocates that are unlikely to result in liability being accepted.

5.3.3 The average number of conditions lodged under the two Acts was very similar across 2019 to 2023, but in 2024 and 2025, the average number of conditions lodged by DRCA veterans has been lower than the number of MRCA veterans.

5.4 Types of Conditions Lodged

5.4.1 Figure 5.4 shows the number of claimed conditions lodged in each calendar year by type of condition under MRCA.

Figure 5.4: 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 Across the period shown, 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). In 2025, the greatest reduction in the type of conditions lodged has been in “other” conditions i.e. not in the types of conditions that are most frequent.

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 2023 and 2024, DVA 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. In 2025 for MRCA, there were around 1,800 fewer IL completions than there were ILs lodged (net of expected future withdrawals), thus increasing the pool of open claims. We understand that this may be due to natural attrition of the workforce over 2025 leading to fewer resources available to process claims. There remain around 28,000 open IL claims awaiting completion as at 31 December 2025, around 7 per cent higher than the number at 31 December 2024. For DRCA, the number of open IL claims has reduced by around 2,400 over the last year; there are currently around 11,400 open DRCA ILs.

5.5.2 Figure 5.5 and Figure 5.6 below show the level of lodged, completed and accepted IL claims under DRCA and MRCA to the end of calendar year 2025. 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 5.5: DRCA Lodged and Completed Initial Liability Claims

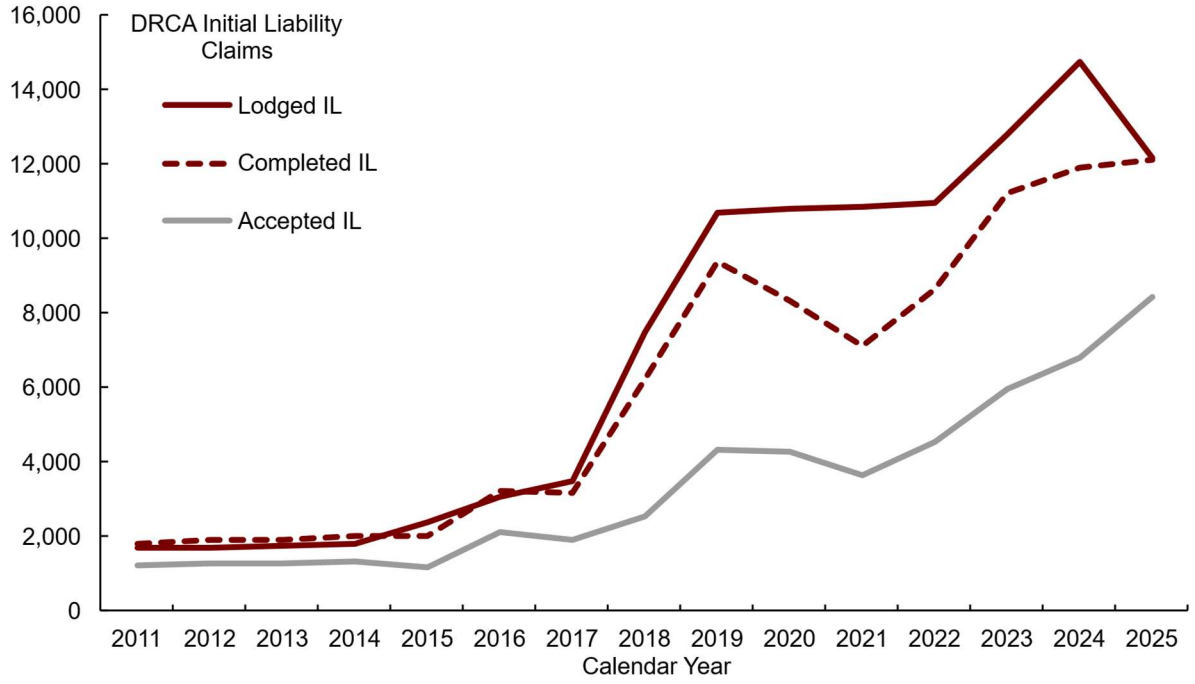
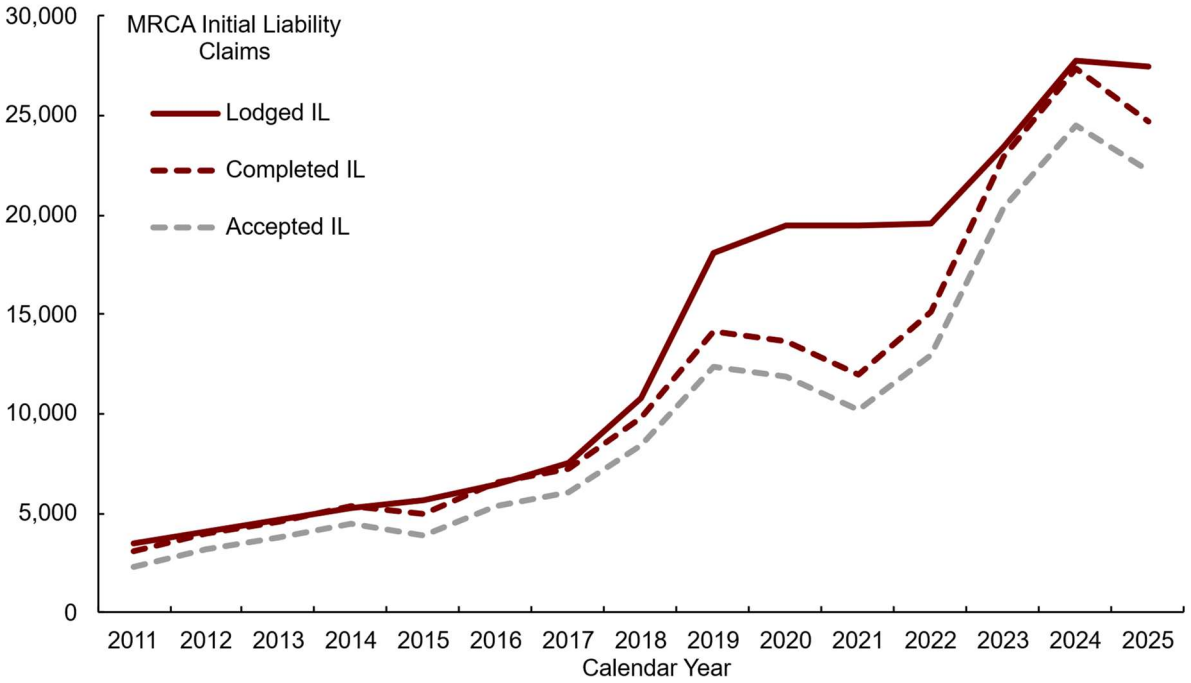


Figure 5.6: MRCA Lodged and Completed Initial Liability Claims



5.5.3 The level of completed claims in 2025 has been 10 per cent lower than in 2024 for MRCA, with DRCA completions at the same (high) level as for 2023 and 2024. However, there still remains a substantial number of open claims.

5.5.4 Figures 5.7 and 5.8 below show the number of completed and withdrawn claims by the calendar year of lodgement. The graphs below differ from Figures 5.5 and 5.6 above as they are on a lodgement year basis, rather than calendar year basis. For example, in Figures 5.5 and 5.6, the number of completed IL claims for 2025 represents the total number of completed claims in that year, regardless of when they were lodged. In Figures 5.7 and 5.8, the completed IL claims for 2025 represents the number of completed IL claims that were lodged in 2025 only, regardless of when they were completed.

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

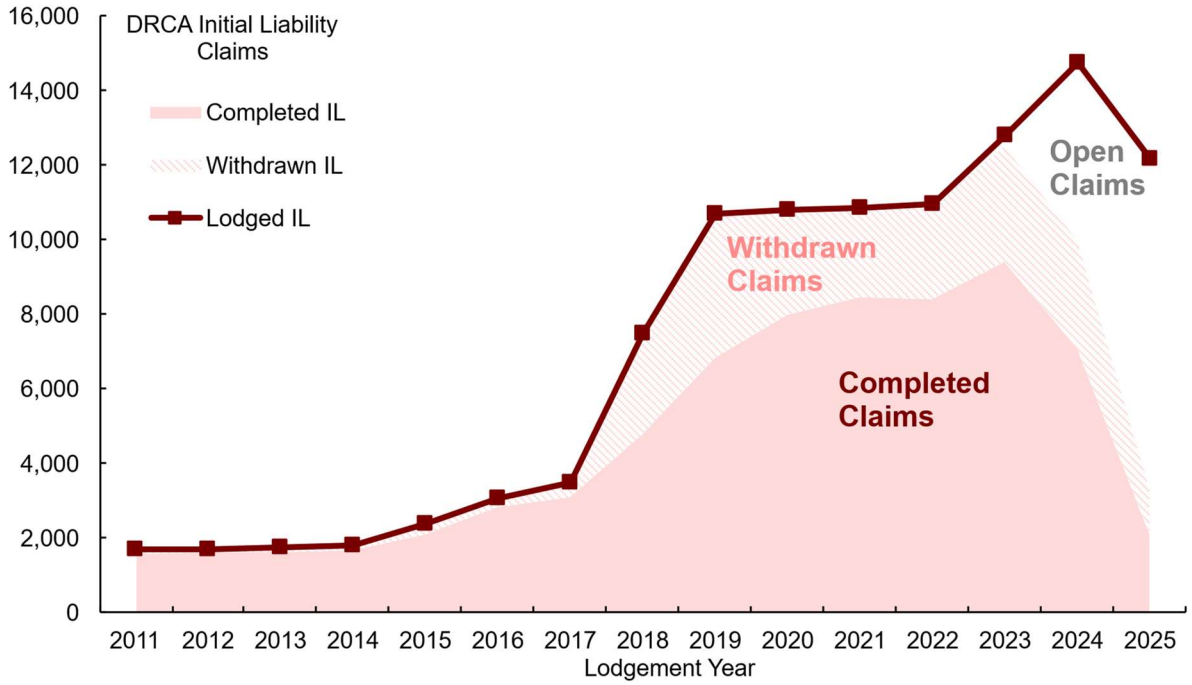
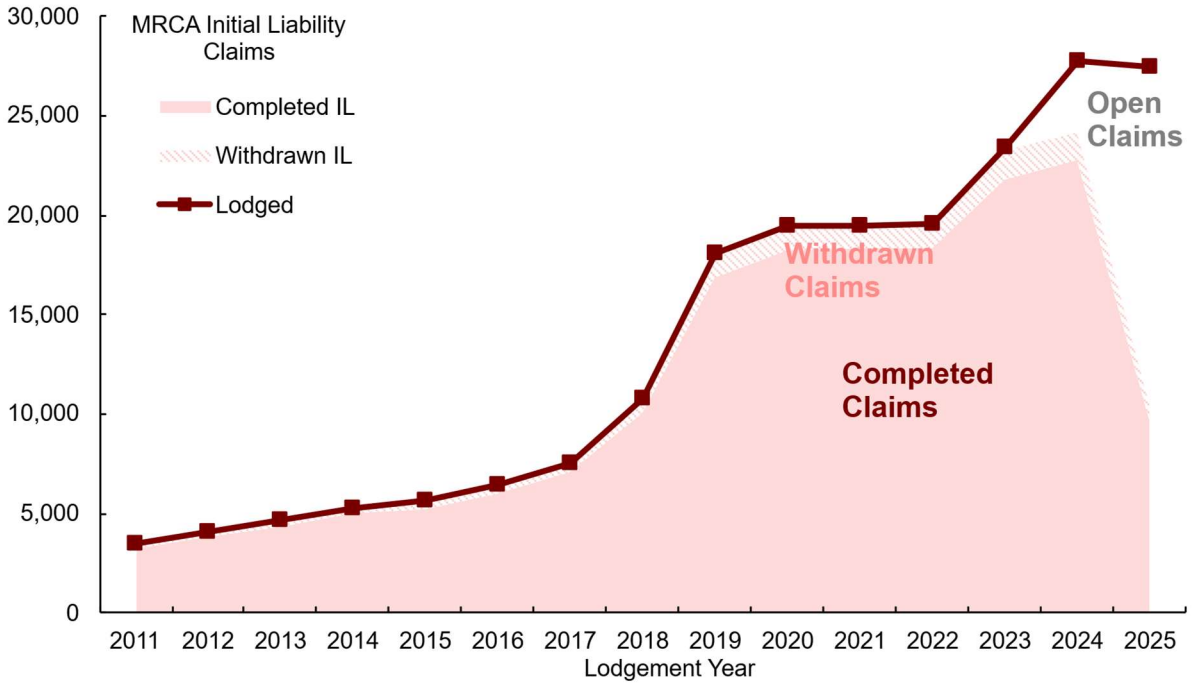


Figure 5.8: MRCA Lodged and Completed Initial Liability Claims by Lodgement Year



5.5.5 For both DRCA and MRCA, almost all claims lodged in 2023 and prior have been either completed or withdrawn at the end of 2025 (98 per cent for DRCA and 99 per cent for MRCA). The majority of current outstanding claims are from the 2024 and 2025 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 Actual versus Expected Experience

5.6.1 Table 5.1 shows the actual IL experience that has emerged in the 2025 calendar year compared with that expected at our previous valuation.

Table 5.1: Actual versus Expected Experience

	Actual	Expected	Difference	% Difference
IL lodgements				
MRCA	27,441	28,660	-1,219	-4%
DRCA	12,174	14,822	-2,648	-18%
IL completions				
MRCA	23,899	29,817	-5,918	-20%
DRCA	10,942	10,410	532	5%
ILs Accepted				
MRCA	22,243	28,281	-6,038	-21%
DRCA	8,427	7,686	741	10%

5.6.2 For both MRCA and DRCA, the number of ILs lodged has been lower than expected. For MRCA, at our previous valuation we assumed that IL lodgements would increase by 4 per cent in 2025, however the actual number lodged was very similar to 2024 levels, hence actual lodgements being 4 per cent lower than expected. For DRCA, we had assumed that lodgements in 2025 would be the same as in 2024, however the actual number lodged was substantially lower. The impact of the VETS Act on claim behaviour, combined with the long timeframe since the DRCA scheme has been closed, makes estimating the future number of ILs from DRCA members highly uncertain.

5.6.3 The number of ILs completed was well below expected for MRCA and a little higher than expected for DRCA. We understand that less ILs have been completed overall than expected due to natural attrition of processing staff that has not been replaced i.e. the number of processing staff across the year was lower than assumed in our previous valuation.

5.6.4 The number of accepted ILs was lower than expected for MRCA, and is a direct flow on from the lower numbers of ILs completed i.e. the acceptance rate was similar to our valuation assumptions. For DRCA, the number of ILs accepted was 10 per cent higher than expected, a combination of both higher completions and a higher acceptance rate than assumed.

5.7 Projected Future IL Claims – MRCA

5.7.1 At this valuation, we have again explicitly modelled future expected IL claims for both MRCA and DRCA. 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.

5.7.2 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.

5.7.3 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 6.4 per cent for 2025 lodgements, up marginally from 6.2 per cent for 2024 lodgements.

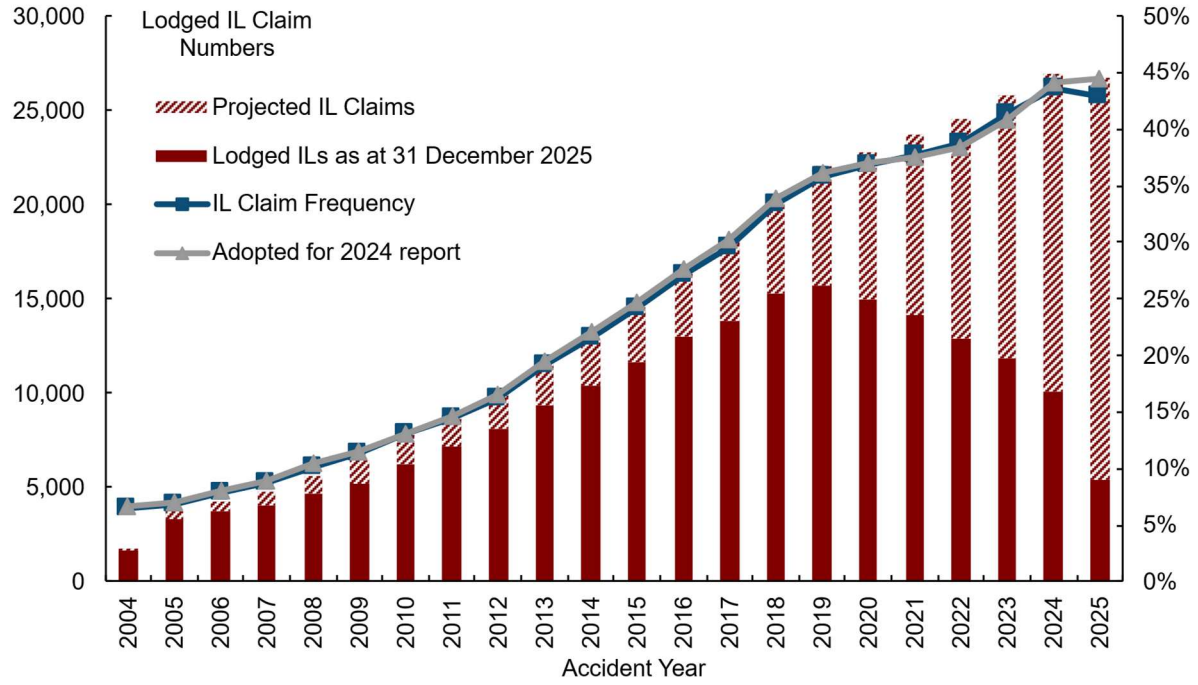
5.7.4 A chain ladder model is used to project future IL lodgements for accident years 2008 and prior. For accident years after 2009, claim frequencies are used to project future lodged IL claims. The selected claim frequencies are based on experience in the most recent year. We have assumed that claim frequency will be at 2025 levels for all future lodgement years. Analysis of DVA claims statistics for the first quarter of 2026 supports this assumption for the 2026 year.

5.7.5 Given the large increases in IL lodgements in 2023 and 2024 followed by a small reduction in 2025, 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.

5.7.6 Figure 5.9 shows the number of lodged IL claims as at 31 December 2025 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.

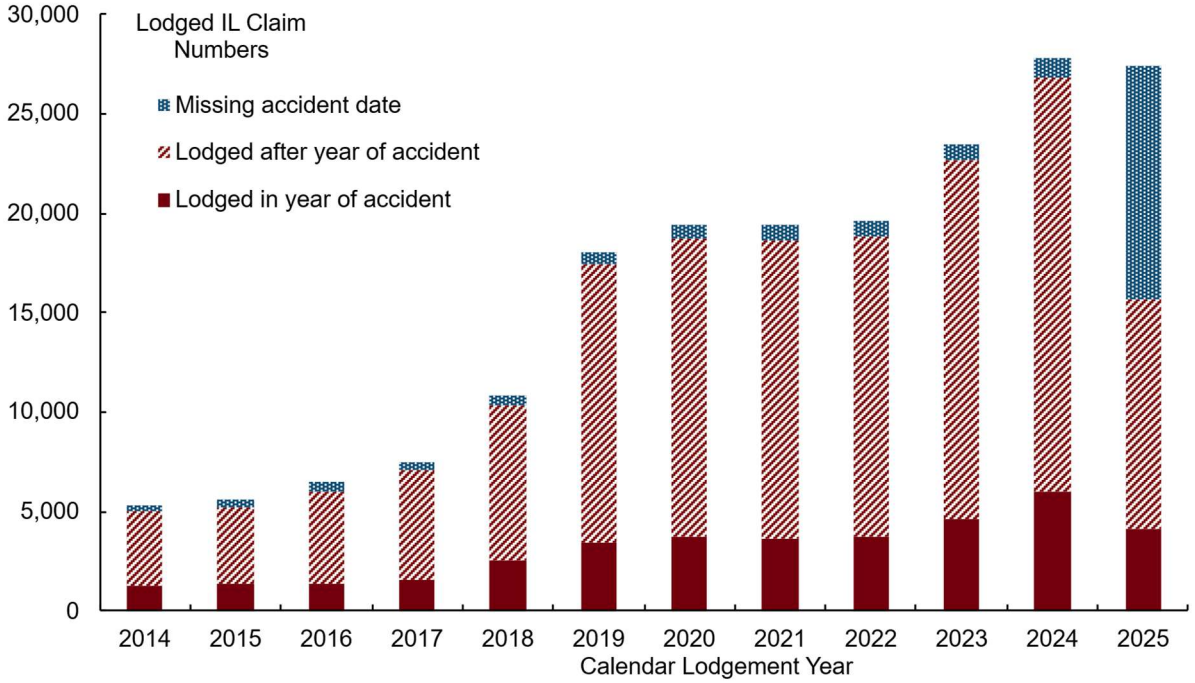
5.7.7 Our estimate of ultimate claim frequency for each accident year is also shown, along with the claim frequencies adopted in our June 2024 report. Our adopted claim frequencies at this valuation are similar to those adopted previously, other than for the 2025 accident year which is slightly lower at this valuation.

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



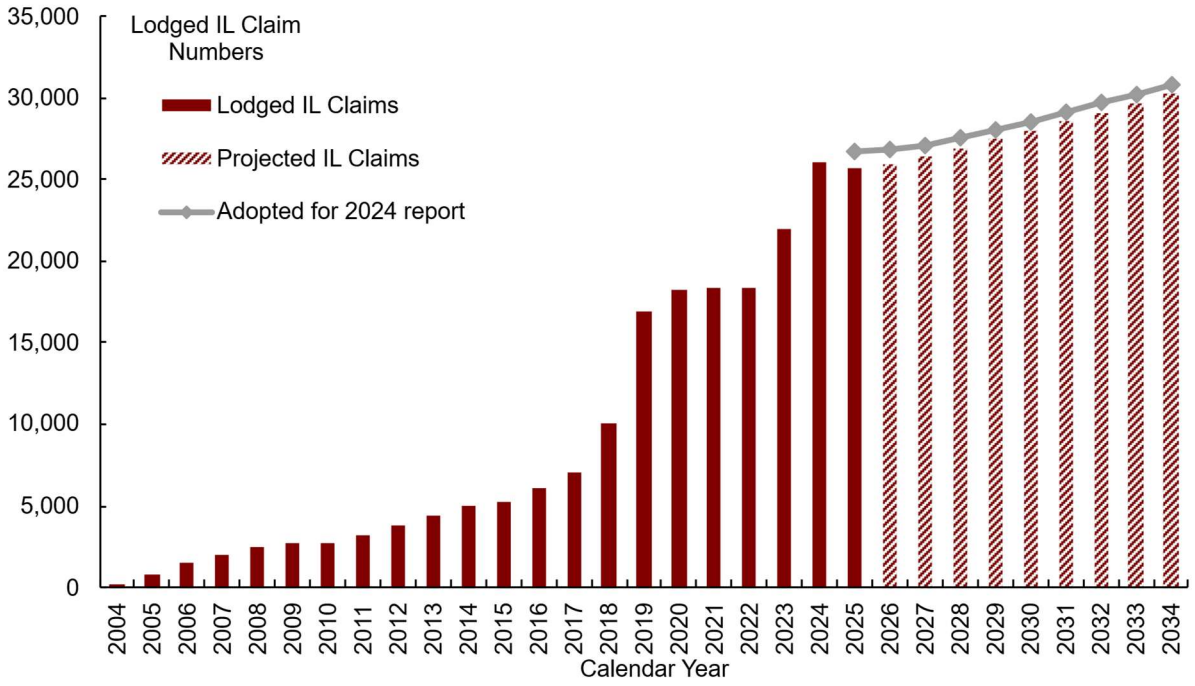
5.7.8 Figure 5.10 shows the number of IL claims lodged in each calendar year since 2014, split between those that were lodged in the year the accident occurred, those that were lodged after the year of accident, and those where no accident date has so far been recorded on the IL claim (noting that the accident date is often not recorded until the IL claim has been completed). As at 31 December 2025, a large number of the 2025 claims did not have any associated injury dates, and a much higher proportion than 2024 year at the same stage of development (43 per cent for 2025 compared with 15 per cent for 2024 last year). This adds more uncertainty to our projections compared with last year.

Figure 5.10: MRCA Lodged ILs by Lodgement Year



5.7.9 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 2024 report. Our current projection is a little lower than that included in the 2024 valuation, reflecting the lower than expected 2025 lodgement experience.

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



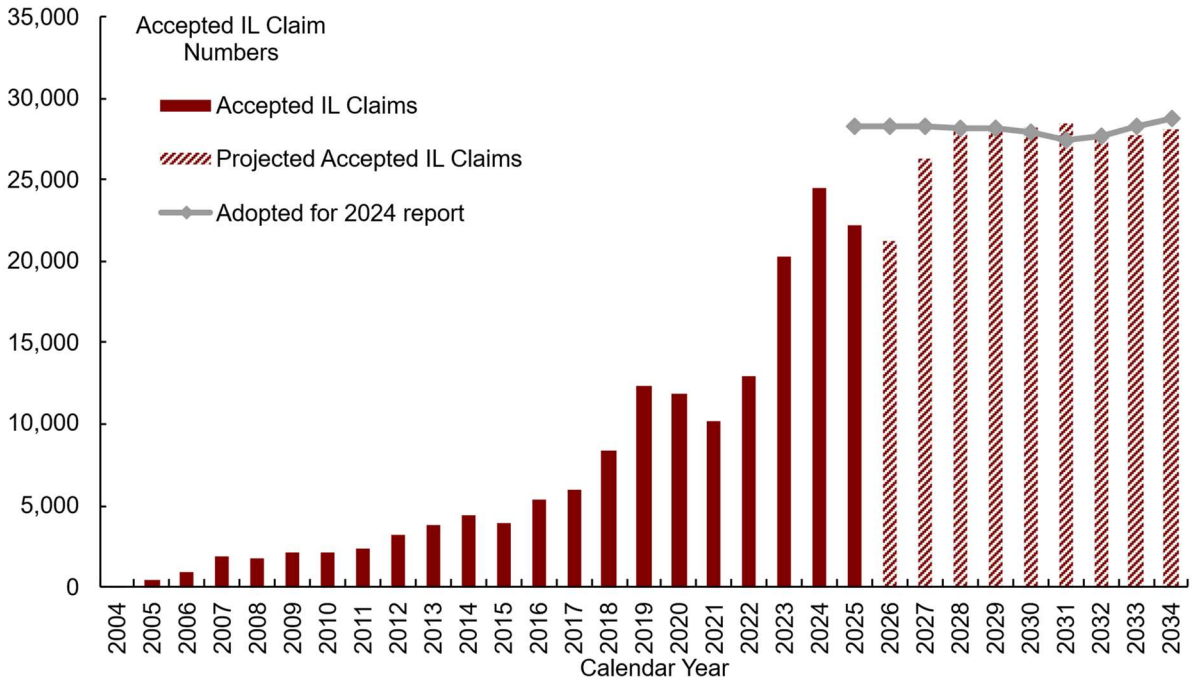
5.7.10 A completion rate is then selected and used to project the number of completed IL claims in each future period. Historic rates of completion were calculated based on the number of

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 7 per cent fewer IL claims in 2026 compared with 2025 (based on the lower level of IL completions in the first quarter of 2026 in the DVA claims processing statistics). We have then assumed that completions will increase over 2027 and 2028 to a level of around 30,000 completions per annum. This is the same level as assumed in our previous valuation and was based on the number of completions processed in the latter half of 2024; we understand that these months are representative of budgeted staffing levels and productivity i.e. we have assumed that recruiting will be carried out to return to budgeted levels.

5.7.11 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, ranging between 93 and 96 per cent. We have selected future acceptance rates that varying by delay from the time of accident, with an overall rate of 94 per cent adopted.

5.7.12 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 2024 report.

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



5.7.13 We have assumed that around 28,000 accepted IL claims will be processed each year from 2028.

5.8 Projected Future ILs - DRCA

5.8.1 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 recent years have an average accident date that is after the scheme closed in 2004.

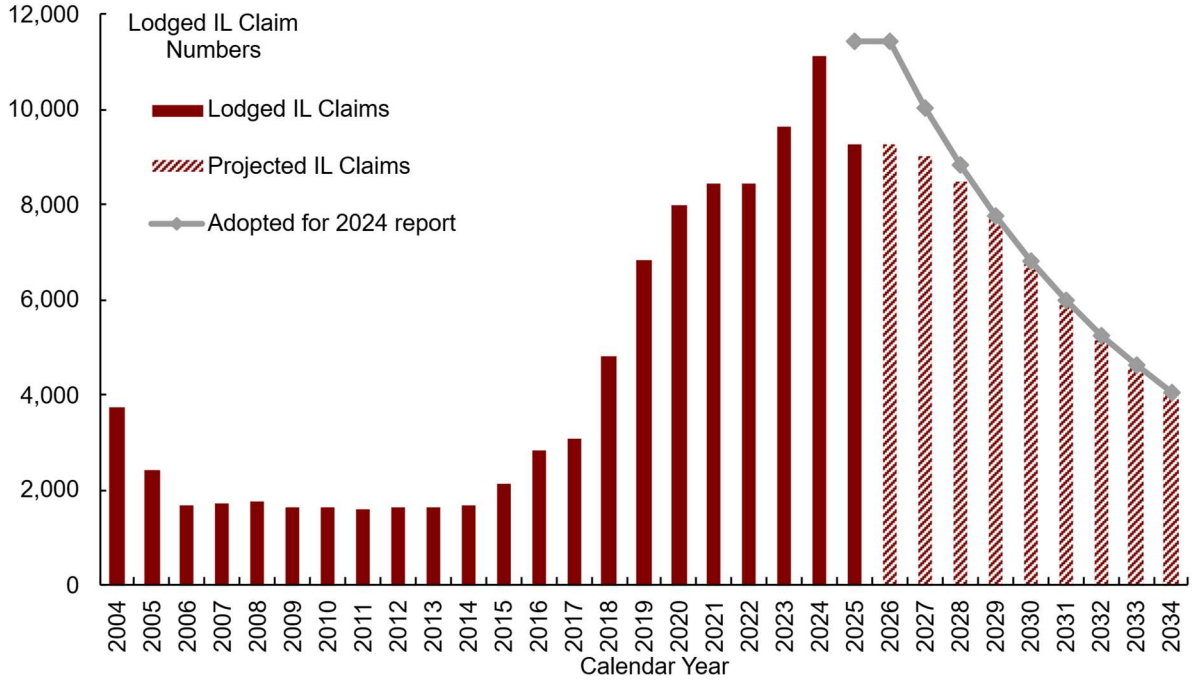
5.8.2 Withdrawal rates for DRCA are significantly higher than for MRCA. We understand that this is due to the overlapping nature of the various Acts (a member may have served over a period that spans both the DRCA and MRCA Acts, and/or the member may have coverage under the VEA) and due to offsetting 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 5 to 6 years at around 22 to 26 per cent of claims lodged. We have adopted overall withdrawal rates of 24-25 per cent for recent lodgement years (with rates that vary by year of birth).

5.8.3 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. As such, we have taken a pragmatic approach to the run-off of the DRCA IL claim lodgements and have assumed that:

- lodgements in 2026 will be the same as in 2025. This is based on the same monthly analysis of DVA claims processing statistics used for MRCA;
- lodgements will then reduce at a rate of 3 per cent in 2027, 6 per cent in 2028, 9 per cent in 2030 and 12 per cent per annum thereafter. The reduction is assumed to be greater if indicated by mortality decrements of each age cohort modelled. The 12 per cent long term reduction is the same as adopted in our previous valuation. We test the sensitivity to this key assumption in section 17.2.

5.8.4 Figure 5.13 shows the actual and projected IL claim lodgements (before the impact of the VETS Act) by calendar year. We have also shown the numbers implied by our previous valuation. The current valuation assumptions are lower than previous for the 2026 to 2028 years, reflecting the lower than anticipated lodgements for 2025), but are the same thereafter.

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

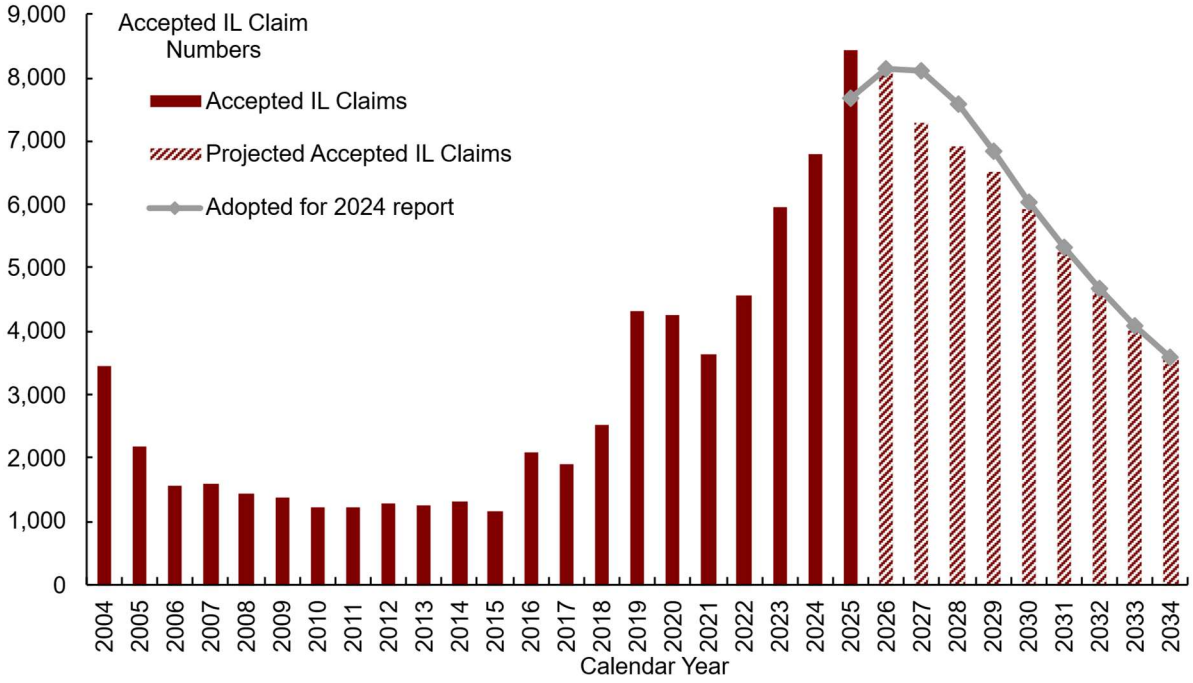


5.8.5 Completion rates are then selected and used to project the number of completed IL claims in each future period. Historic rates of completion were calculated based on the number of completed IL claims compared to the number of lodged IL claims (after withdrawals) in a period. We have used these historic completion rates as the basis of our projection (without any adjustment for processing constraints).

5.8.6 Acceptance rates are then applied to the completed claims to arrive at the number of projected accepted IL claims. Acceptance rates were 77-78 per cent in 2019 to 2021 and then lower at 73-75 per cent in 2022 to 2024. In 2025, the acceptance rate returned to the higher level of 77 per cent and we have responded to this experience by increasing the future acceptance rate. 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 77 per cent adopted (up from 74 per cent at the previous valuation).

5.8.7 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

6.1.1 This section sets out our estimate of the liability for MRCA permanent impairment benefits. The changes introduced by the VETS Act are expected to have only a negligible impact on the current MRCA members' PI benefits. However, the MRCA PI liabilities will increase through the addition of liabilities in respect of both DRCA and VEA members. Section 7 discusses the DRCA permanent impairment and non-economic loss benefits, including our assessment of the impact of the VETS Act on DRCA PI liabilities. Included in this section (6.8) is the expected impact of the VETS Act on VEA members.

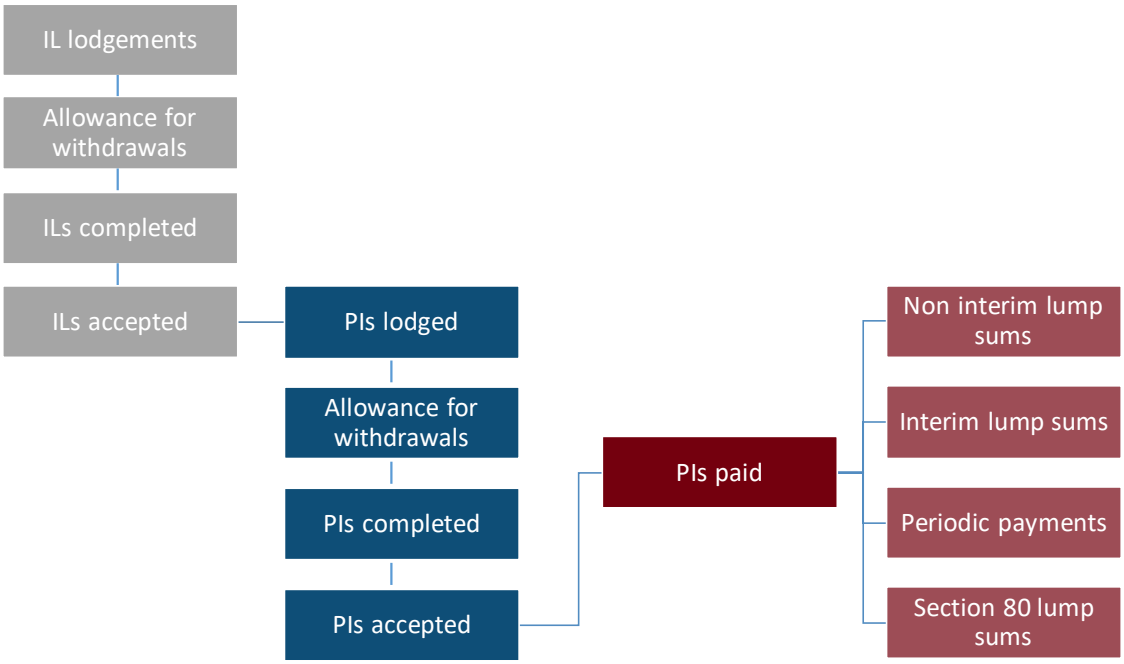
6.2 Modelling Approach

6.2.1 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.

6.2.2 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.

6.2.3 Our modelling approach is summarised schematically below.

Figure 6.1: PI Model Approach



6.2.4 The amount of benefit payable depends upon a number of factors:

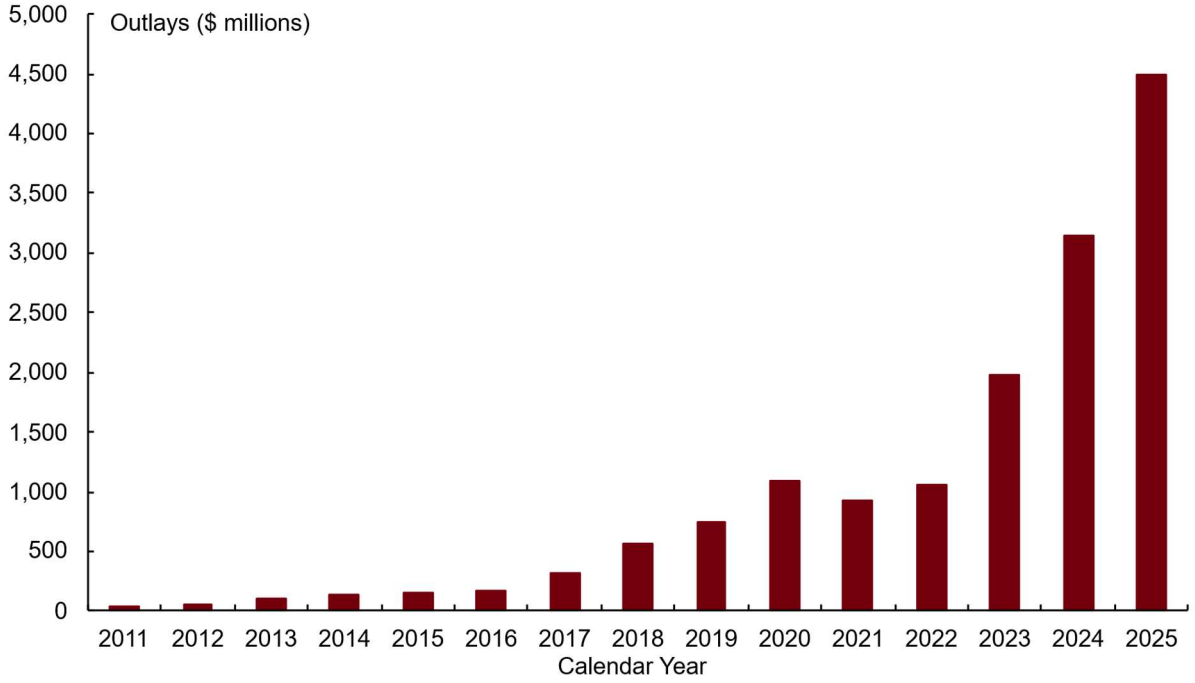
- the age of the claimant;
- the assessed impairment points;
- the lifestyle rating;
- whether the incident giving rise to the impairment was related to warlike service or not; and
- in the case of Section 80 payments, the number of eligible dependants.

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.

6.3 Recent Experience

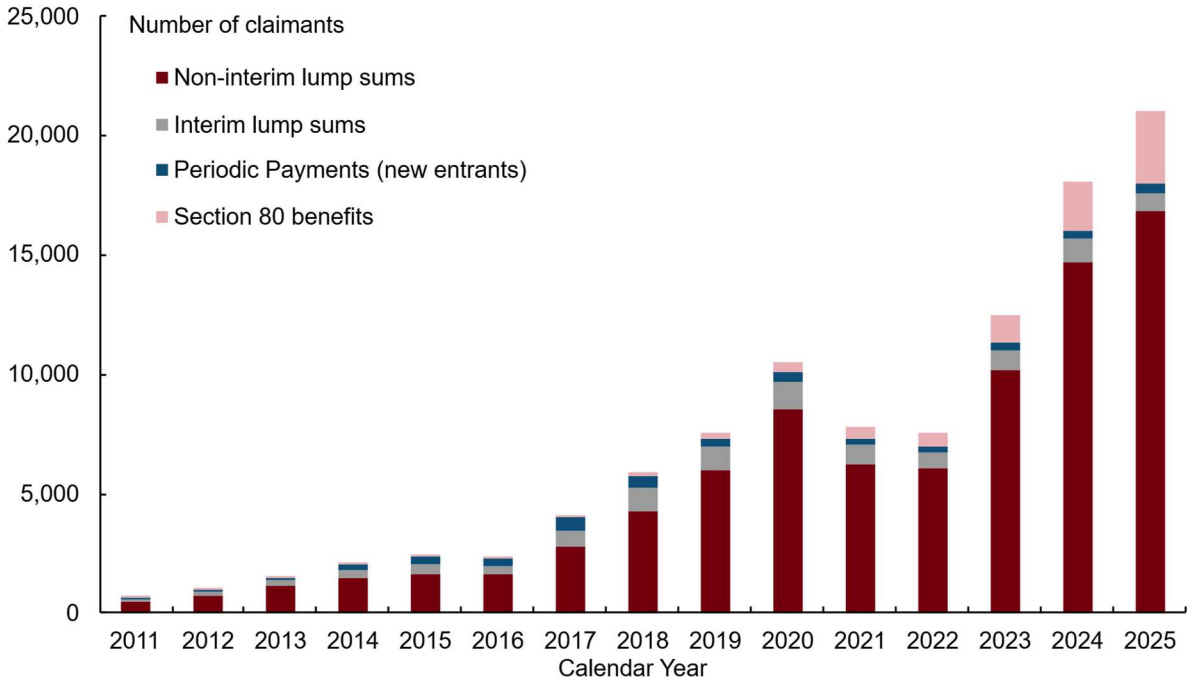
6.3.1 Figure 6.2 shows expenditure on permanent impairment payments since 2011 (noting these are payments in each calendar year rather than financial year). Outlays have increased year-on-year, with particularly marked growth occurring since 2017. The growth in experience since 2017 can, in part, be 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. In 2025, payments were $4.5 billion, another large increase of 43 per cent.

Figure 6.2: Expenditure on Permanent Impairment Benefits



6.3.2 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, 2024 and 2025 after the processing-impacted lower years of 2021 and 2022. Claimants electing to receive periodic payments make up only around 2-3 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 six years, from 4 per cent in 2020 to 17 per cent in 2025 (or around 3,100 claimants).

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

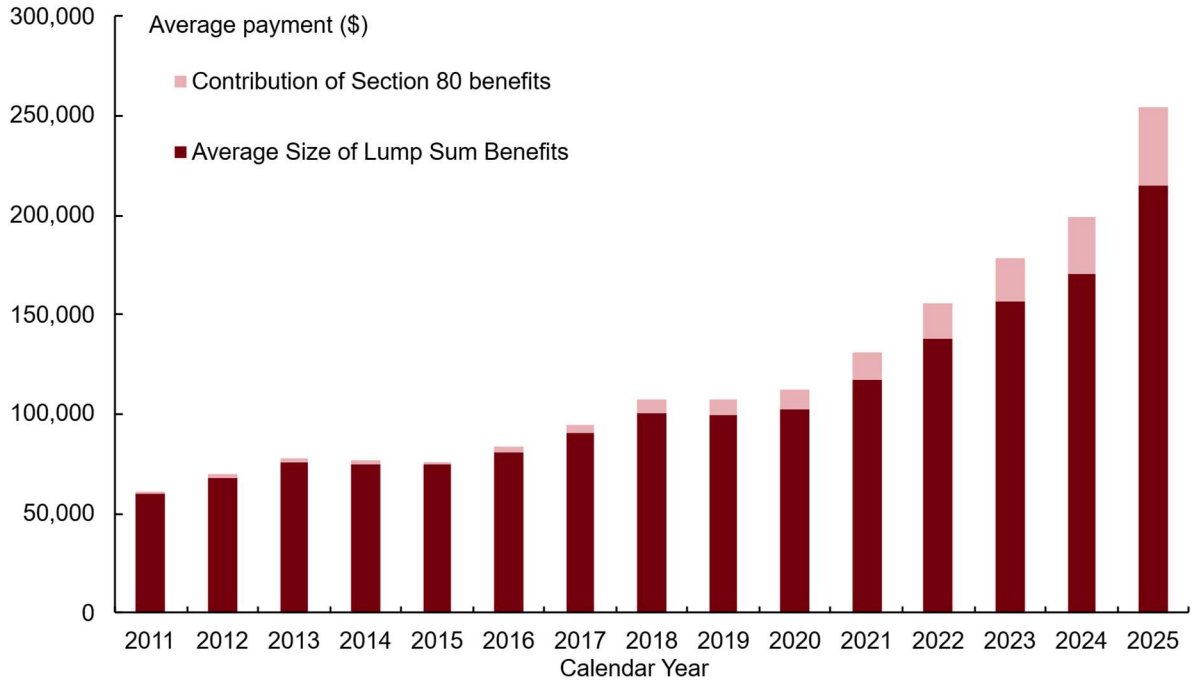


6.3.3 Figure 6.4 shows the average lump sum payment (in original dollars) for those electing to receive either an interim or non-interim lump sum. The contribution to the average claim size of Section 80 benefits is shown separately (claimants receiving periodic payments and the amounts associated with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

6.3.4 Indexation applied to MRCA lump sum benefits from 1 July 2025 was 2.4 per cent (compared with our previous valuation assumption for CPI of 2.5 per cent per annum). The average claim size for 2025 (excluding Section 80 benefits) has increased by significantly more than inflation (by 26 per cent, including the indexation change). This followed substantial increases in each of 2021 to 2024 (averaging 14 per cent per annum over this four-year period).

6.3.5 Including Section 80 benefits in the average claim size added 18 per cent to the average claim size in 2025. This percentage addition is similar to that for 2024 (17 per cent), but 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)

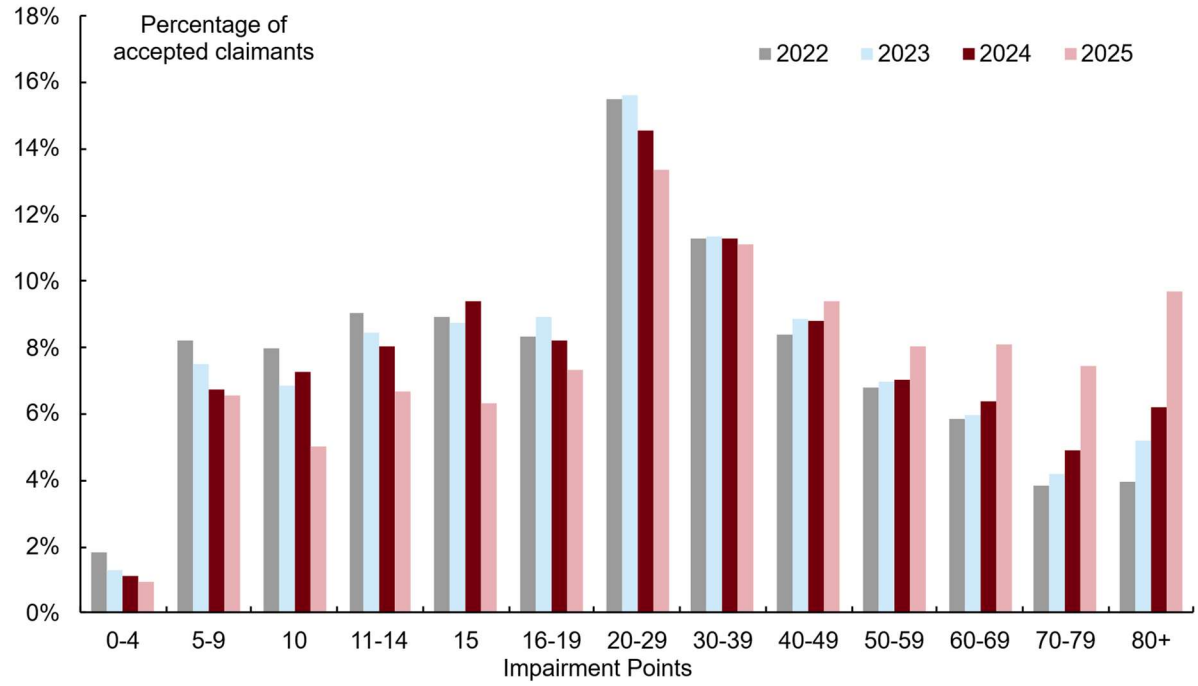


6.3.6 There are several factors which may have driven this increase in average claim size over the last several years, including policy and cultural changes within the organisation, or an increase in the level of injuries sustained by claimants while at Defence:

- 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 increases in 2024 and 2025 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 to 2024 before falling a little in 2025. This will flow through to PI claims, with the average delay from IL lodgement to PI accepted currently around 2 years. 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.

6.3.7 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



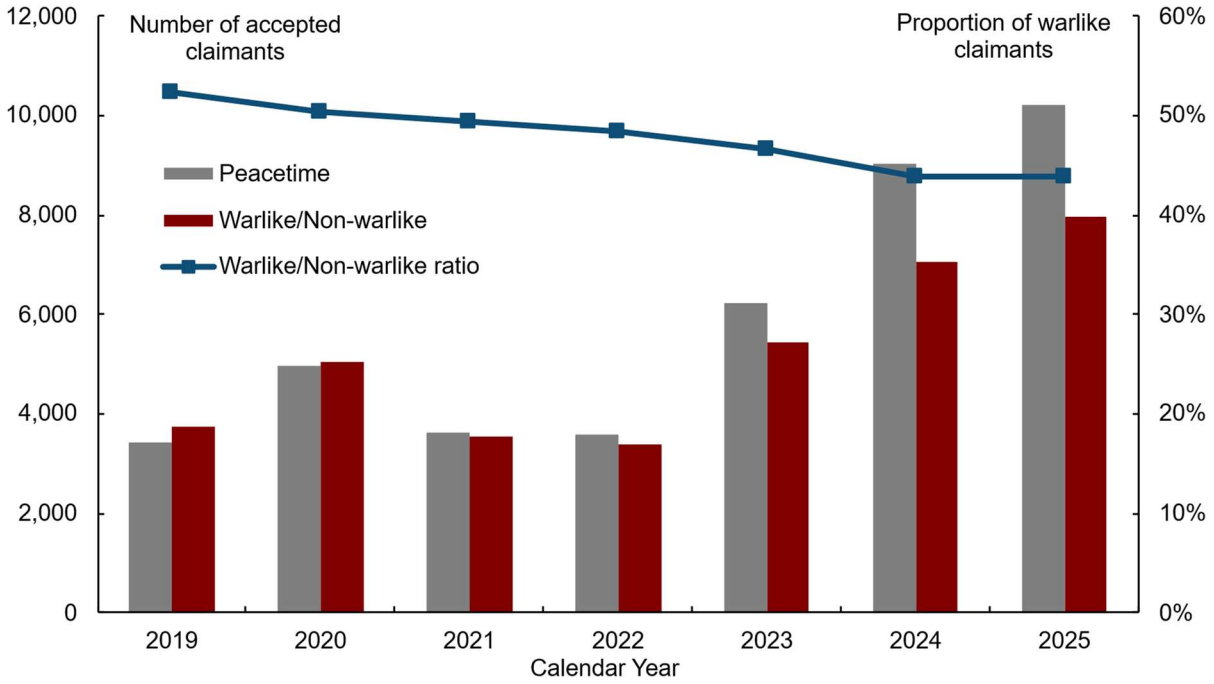
6.3.8 Over the past four years, there has been a shift in the distribution of impairment points towards higher levels of impairment, consistent with the increase in the observed average size. In the last year in particular, the shift has been large. In 2025, substantially fewer claimants have been awarded 30 points or less, and substantially more claimants have been awarded more than 50 points. There was a large increase in the proportion awarded more than 80 points.

6.3.9 In 2021, 20 per cent of claimants had 50 or more (incremental) impairment points awarded compared to 33 per cent in 2025. Achieving an assessment of at least 50 impairment points brings with it a number of benefits; notably potential access to the All Conditions Treatment 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.

6.3.10 As mentioned in Section 6.1, 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.

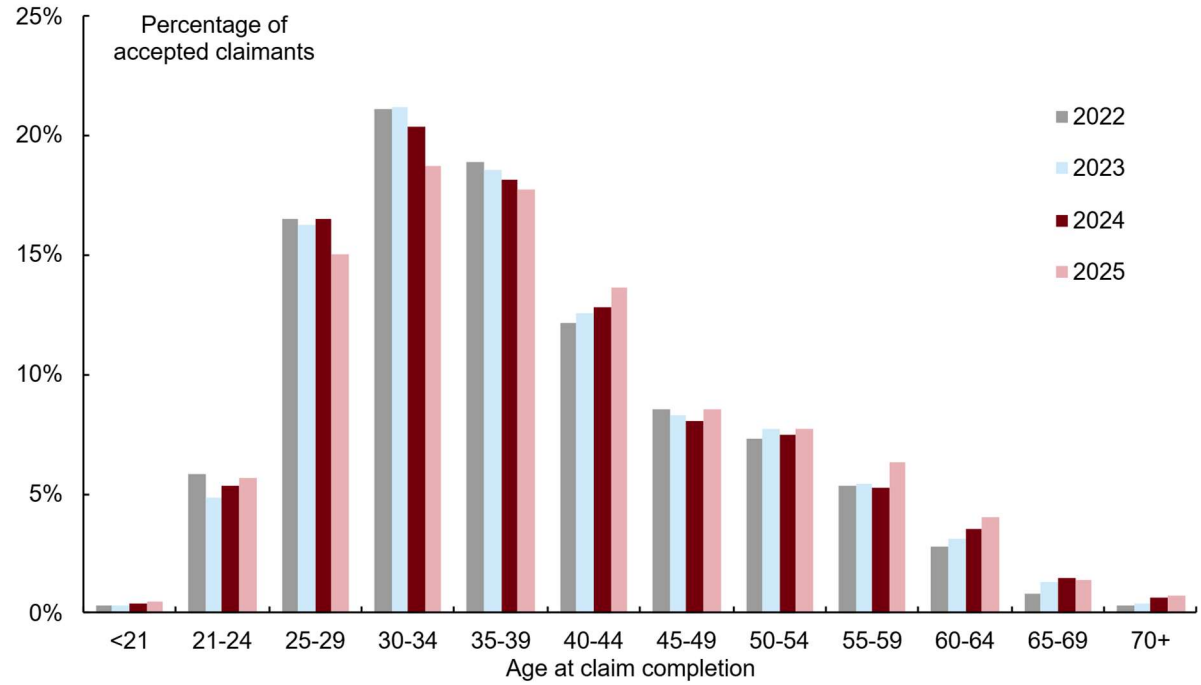
6.3.11 Claims arising from warlike service typically involve higher payments as the legislated compensation factors applying to warlike service are higher than for peacetime service. Figure 6.6 shows the number of recipients by nature of service over the last six years. Note that in most cases it is 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 to 2025 the number of peacetime claims exceeded warlike, and by a substantial margin in both 2024 and 2025. Although this is expected to put downward pressure on the average claim size, the granting of higher impairment points on average has far outweighed this effect.

Figure 6.6: Number of Recipients by Nature of Service



6.3.12 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 has increased by about 0.6 years for PIs accepted in 2025 compared with those in 2024. The proportion of claimants aged 25 to 34 has reduced while the proportions aged 40 to 44 and 55 to 64 have increased.

Figure 6.7: Age Distribution Chart



6.3.13 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.

6.4 Valuation Assumptions – Numbers of PI Claims

Actual versus Expected Experience

6.4.1 Table 6.1 shows the actual PI number experience that has emerged in the 2025 calendar year compared with that expected at our previous valuation.

Table 6.1: Actual versus Expected Experience – PI Numbers

	Actual	Expected	Difference	% Difference
PI lodgements	20,890	26,110	-5,220	-20%
PI completions	20,031	20,101	-70	0%
PIs Accepted	18,148	17,846	302	2%

6.4.2 The number of MRCA PIs lodged in 2025 was 20 per cent lower than expected. This is a direct result of the lower-than-expected accepted PIs shown in Table 5.1 (21 per cent lower). The rate of conversion from IL accepted to PI lodgement was close to expected.

6.4.3 The number of PI completions were very close to expected.

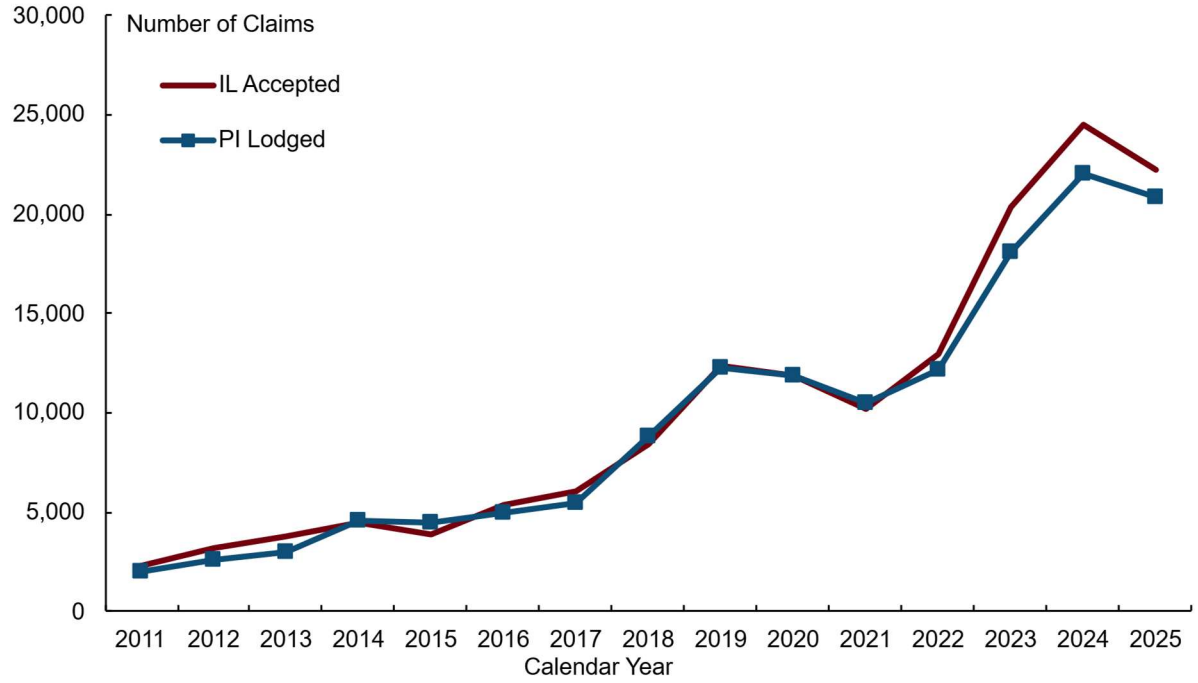
6.4.4 The number of PIs accepted were a little higher than expected, with the acceptance rate being slightly higher than our previous valuation assumption.

Future Assumptions

6.4.5 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 in recent years 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.

6.4.6 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 three years, a direct result of the increase in IL claims accepted during this time.

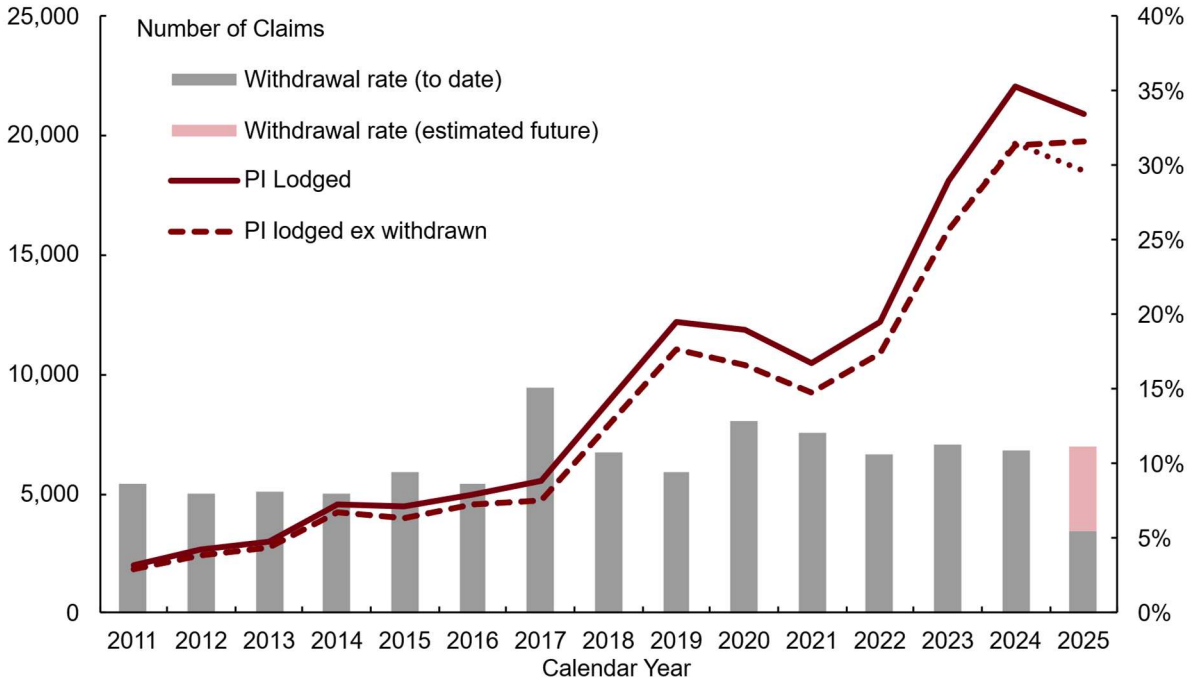
Figure 6.8: IL Claims Accepted and PI Claims Lodged, by Calendar Year



6.4.7 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.

6.4.8 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 2025 will ultimately be withdrawn, similar to levels for 2022 to 2024.

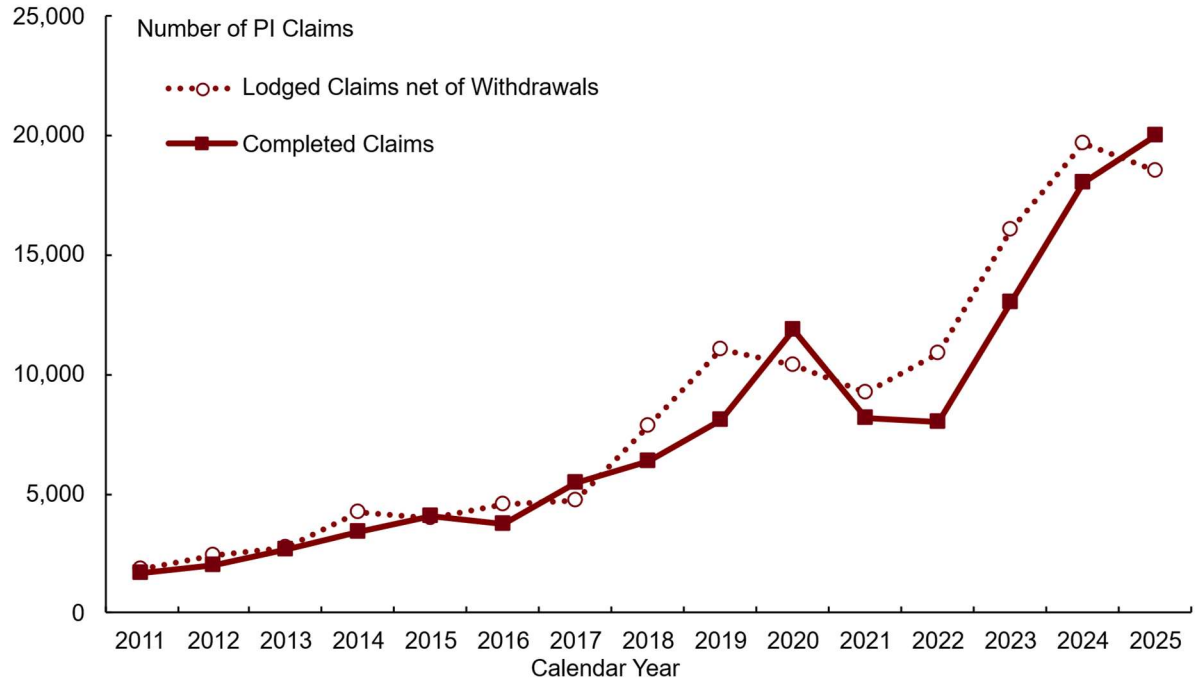
Figure 6.9: PI Claims Lodged Including and Excluding Withdrawn Claims, by Calendar Year



6.4.9 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.

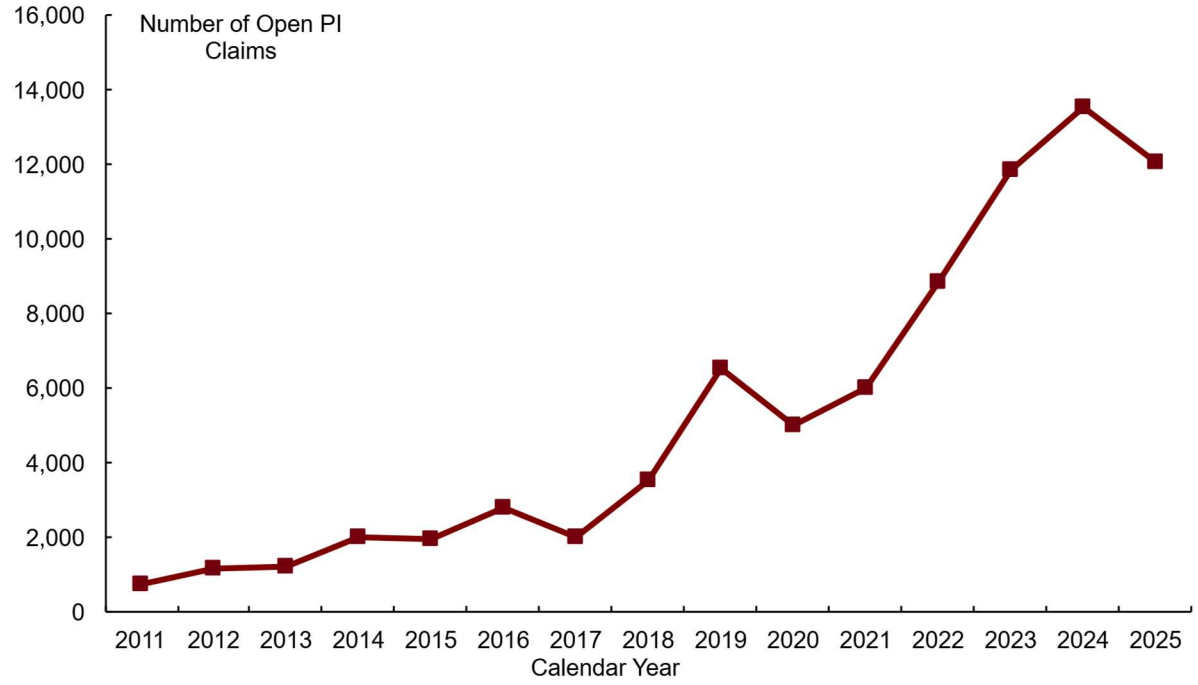
6.4.10 Figure 6.10 below shows the number of PI claims lodged (after actual and expected future withdrawals) and completed by calendar year. PI claims lodged in the last 3 years have increased dramatically, but the number of PI claims completed has only been above lodgements in the last year. Completions were below lodgements for the previous four years, resulting in a growing pool of open PI claims.

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



6.4.11 As a result of the significant gap between PI claim lodgements and PI claim completions in 2021 to 2024, the number of open PI claims grew dramatically as shown in Figure 6.11. The number of open PI claims has reduced over 2025; last year there were around 13,500 open PI claims as at 31 December 2024 and there are now around 12,100 as at 31 December 2025.

Figure 6.11: Open PI Claims



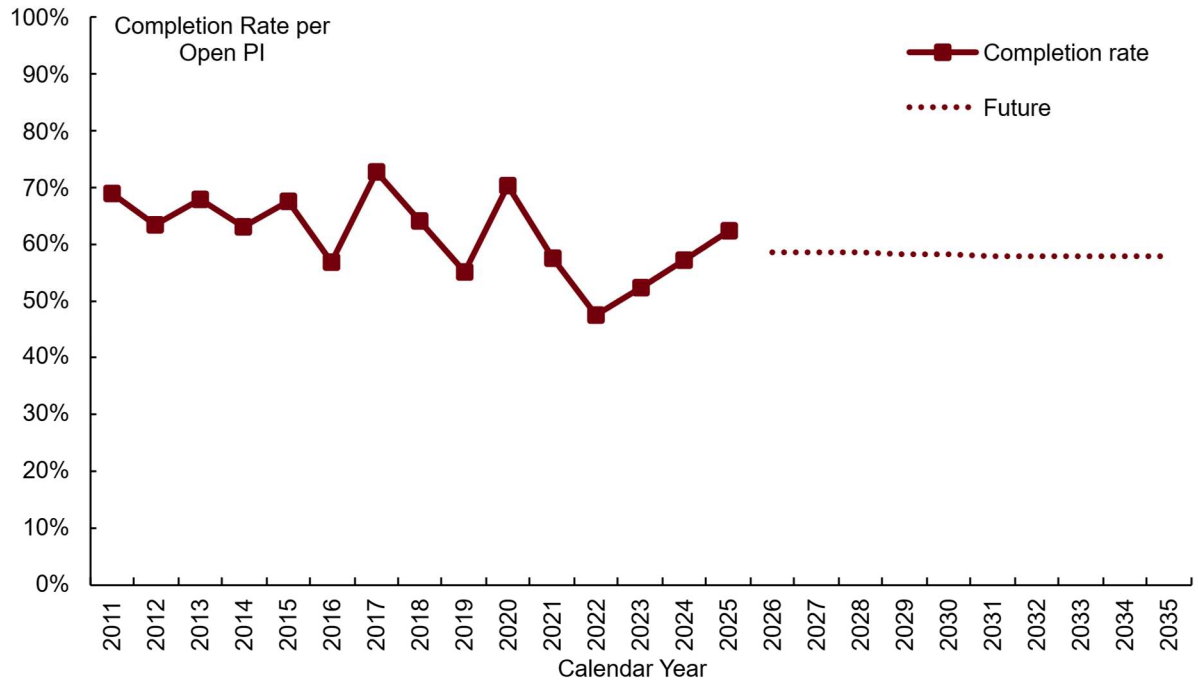
6.4.12 In our valuation model, the number of future PI lodgements are directly linked to the number of IL claims accepted, which are in turn directly linked to IL claims completed. As discussed in

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.

6.4.13 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.

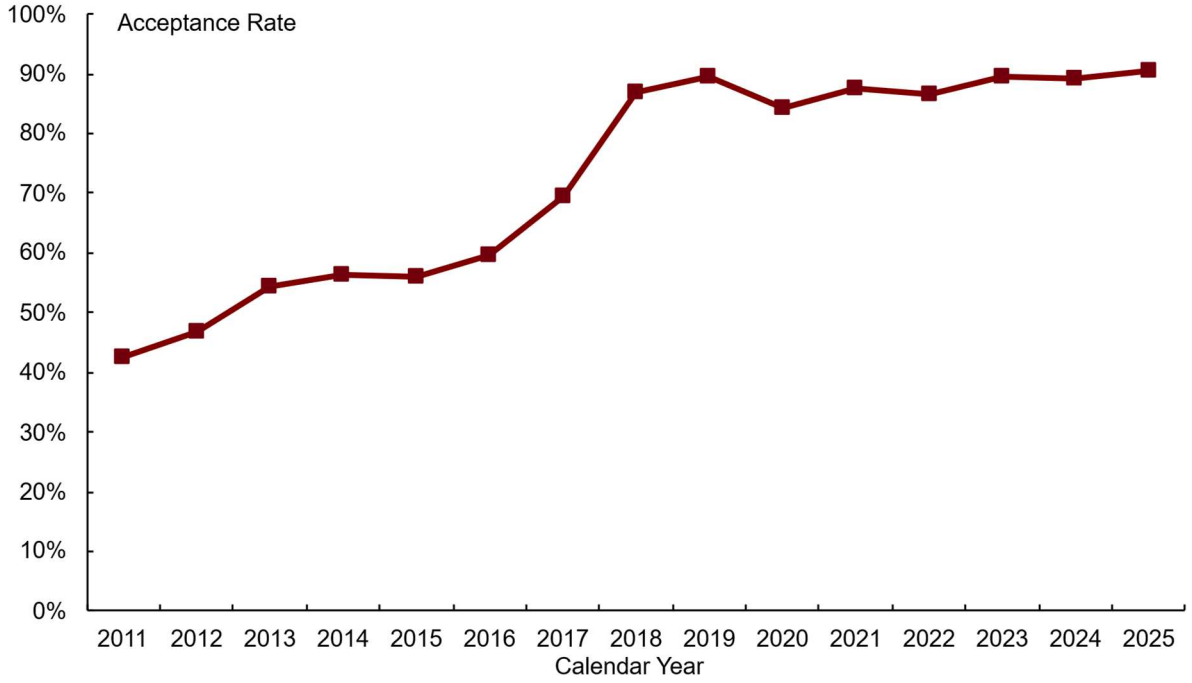
6.4.14 Figure 6.12 shows the completion rates per open claim. While the completion rates have varied a little over time, the completion rate was particularly low in 2022 (due to processing constraints). The completion rate was higher in 2023 and again in 2024 but low relative to historical levels. Completion rates for 2025 were back at historical levels. We have projected completion rates for 2026 and later years that are similar to the average of 2024 and 2025 levels (around 59 per cent overall), a little higher than 55 per cent adopted at our previous valuation).

Figure 6.12: PI Completion Rates



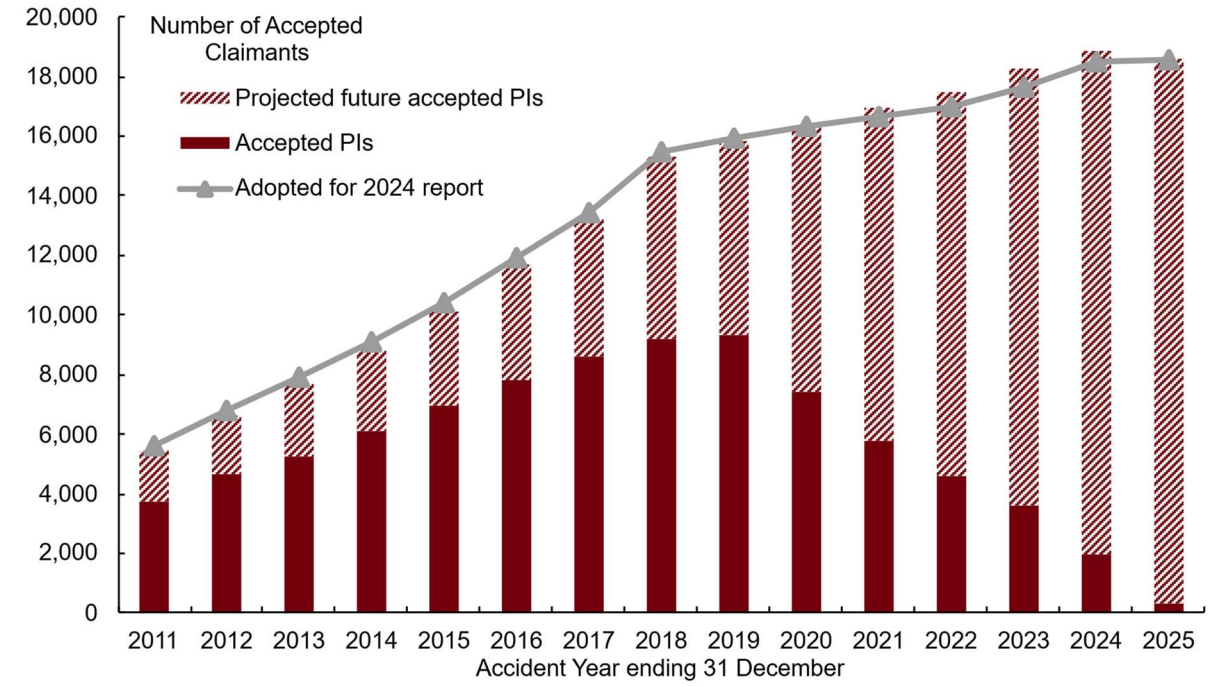
6.4.15 Figure 6.13 below shows the acceptance rates for PI claims since 2011. Acceptance rates have been stable (and high) at an average of 88 per cent since 2018, coinciding with Veteran Centric Reform. We have assumed a permanent impairment acceptance rate consistent with this experience.

Figure 6.13: PI Acceptance Rates



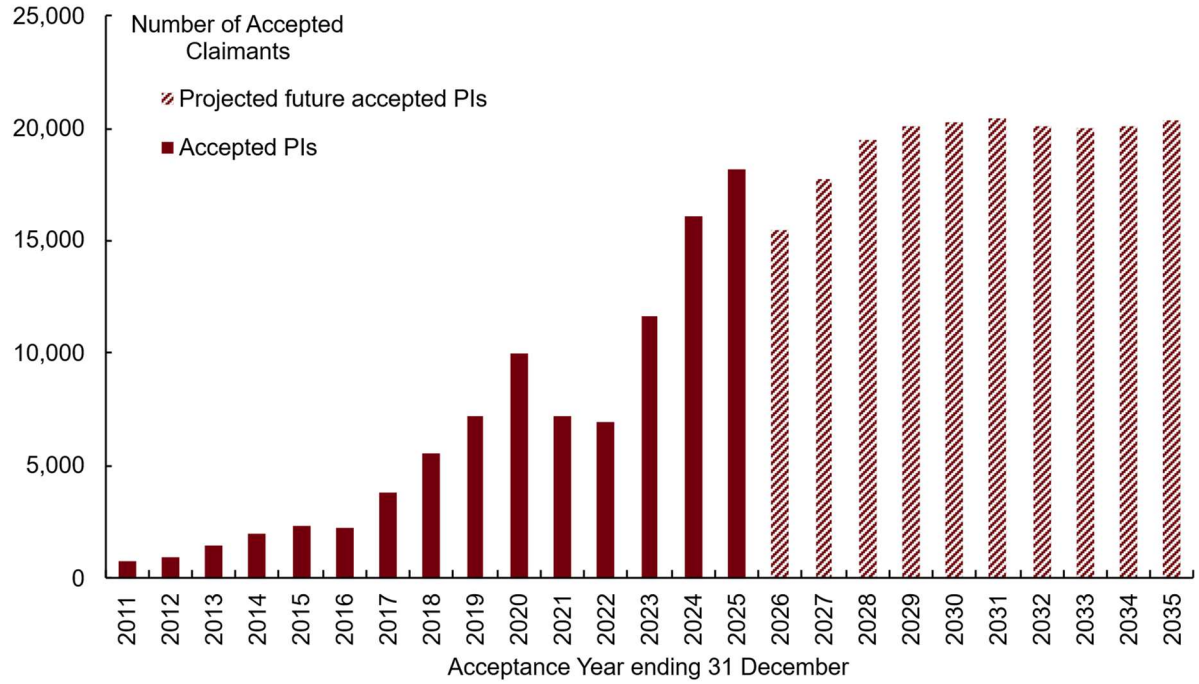
6.4.16 Figure 6.14 shows, by accident year, the number of accepted PIs as at 31 December 2025 and our projected future accepted PIs. We have also shown our adopted ultimate numbers from our previous valuation. The main difference between our adopted ultimate assumptions for this valuation compared with the previous valuation is for the 2022 to 2024 accident years, where we have increased our assumptions by 1-2 per cent. This is primarily in response to the PI acceptance rate in 2025 (a little higher than expected); we have increased our valuation assumptions in response.

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



6.4.17 Figure 6.15 shows the same information as Figure 6.14, however with the data summarised by acceptance year (including allowance for new accidents). There is a projected reduction in the number of PIs accepted in 2026, a flow on from the lower numbers of ILs accepted in 2025.

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



6.5 Valuation Assumptions – Average Claim Size

Actual versus Expected Experience

6.5.1 Table 6.2 shows the actual PI payment experience that has emerged in the 2025 calendar year compared with that expected at our previous valuation (noting periodic benefits are excluded).

Table 6.2: Actual versus Expected Experience – PI Payment Experience

	Actual	Expected	Difference	% Difference
Number of Payments				
Non-interim lump sums	16,806	16,797	9	0%
Interim lump sums	809	1,166	-357	-31%
Section 80 payments	3,090	2,512	578	23%
Payments ($m)				
Non-interim lump sums	3,688.8	2,991.1	697.7	23%
Interim lump sums	137.1	195.0	-57.9	-30%
Section 80 payments	704.7	582.2	122.5	21%
Average claim size				
Non-interim lump sums	219,491	178,078	41,413	23%
Interim lump sums	169,423	167,228	2,195	1%
Section 80 payments	228,068	231,758	-3,690	-2%

6.5.2 The number of non-interim lump sums paid was only 9 different to expected. The number of interim lump sums was lower than expected, noting the small volumes of such payments compared to non-interim lump sums. The number of Section 80 payments was substantially higher than expected.

6.5.3 Payments for non-interim lump sums were 23 per cent higher than expected, as were the associated average claim sizes, driven by higher average whole person impairment scores. Payments for interim lump sums were lower than expected, driven by lower numbers; the actual average claim size was close to expected. Payments for Section 80 benefits were higher than expected, again driven by the numbers of such payments (which were in turn driven by higher proportions of veterans receiving WPI scores of 80 or more); the actual average claim size was close to expected.

Future Assumptions

6.5.4 Our overall adopted average claims size is comprised of the following assumptions:

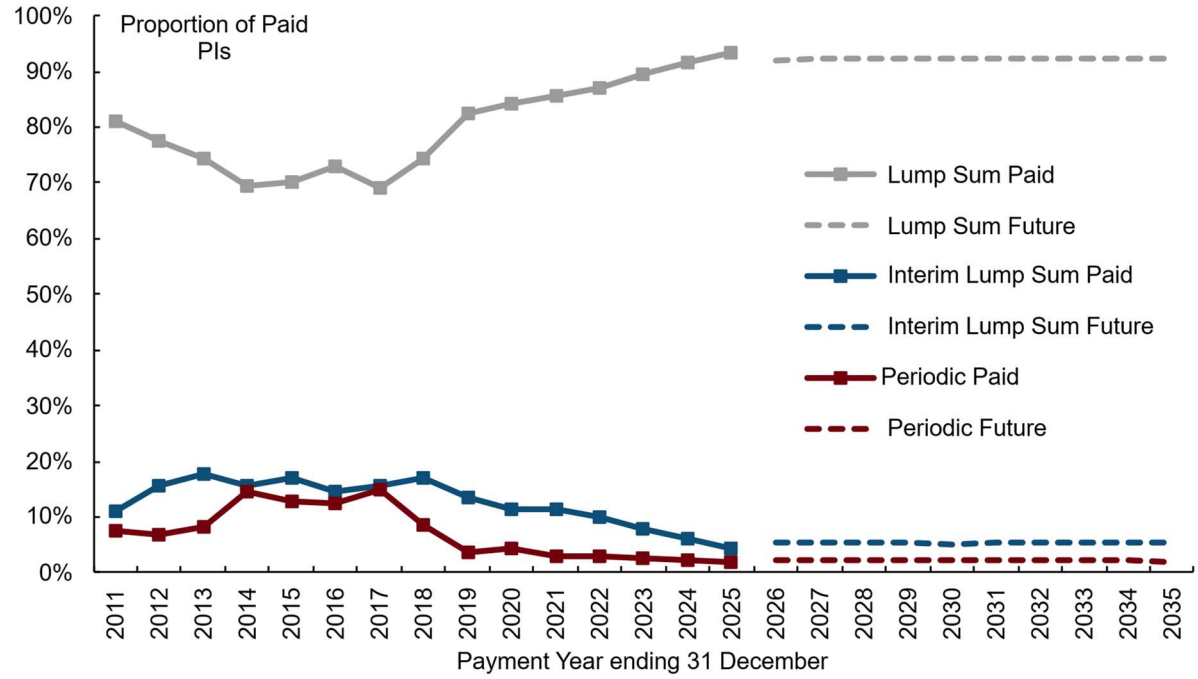
- the mix of payments by type i.e. non-interim lump sum, interim lump sum and periodic payments;
- allowance for a proportion of claimants to receive Section 80 benefits;
- an average claim size for each payment type, including an average size for Section 80 benefits.

6.5.5 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).

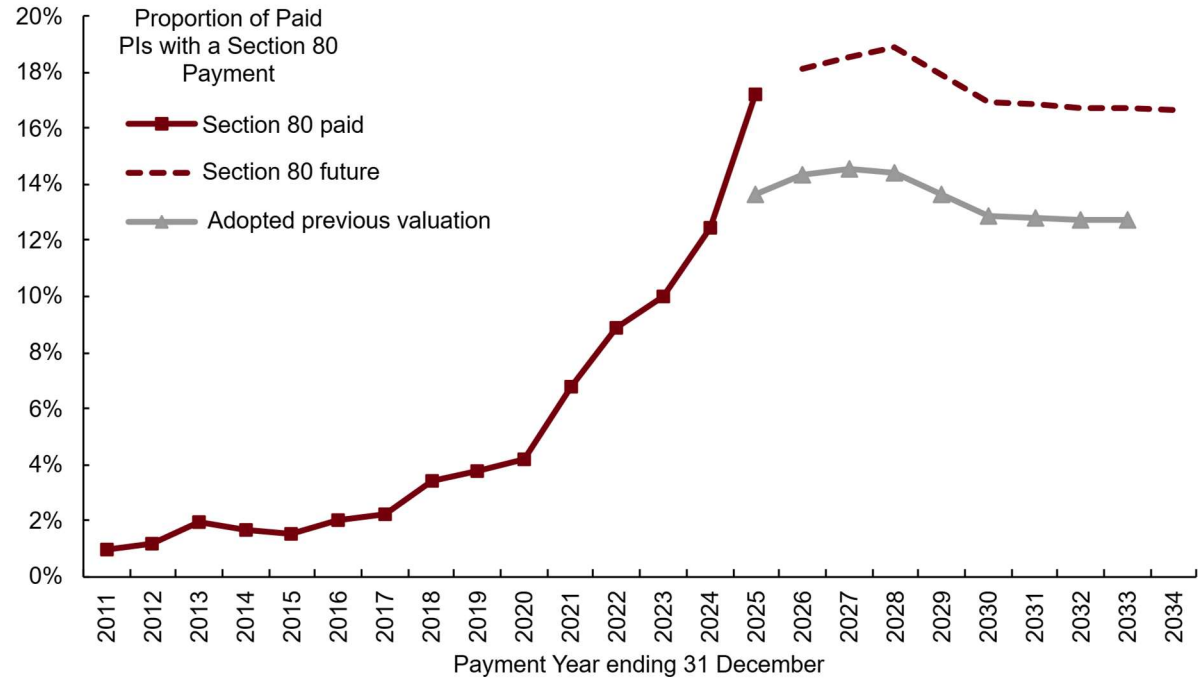
6.5.6 Figure 6.16 shows the historical and projected mix of payments by type of PI. The proportion of PI claims paid as non-interim lump sums has increased over the last six years. Conversely, the proportion of interim lump sums has reduced which may be impacted by processing delays; if claimants have to wait longer for their PI claim to be assessed, then there is a higher likelihood that the injury would have stabilised before assessment. The numbers electing to choose a periodic payment has been low at only 2-3 per cent since 2019. 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



6.5.7 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 increase from the 2024 experience. However, our allowance was too low with the actual experience (17 per cent) well above our previous assumption (14 per cent). 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 17 per cent of claimants.

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

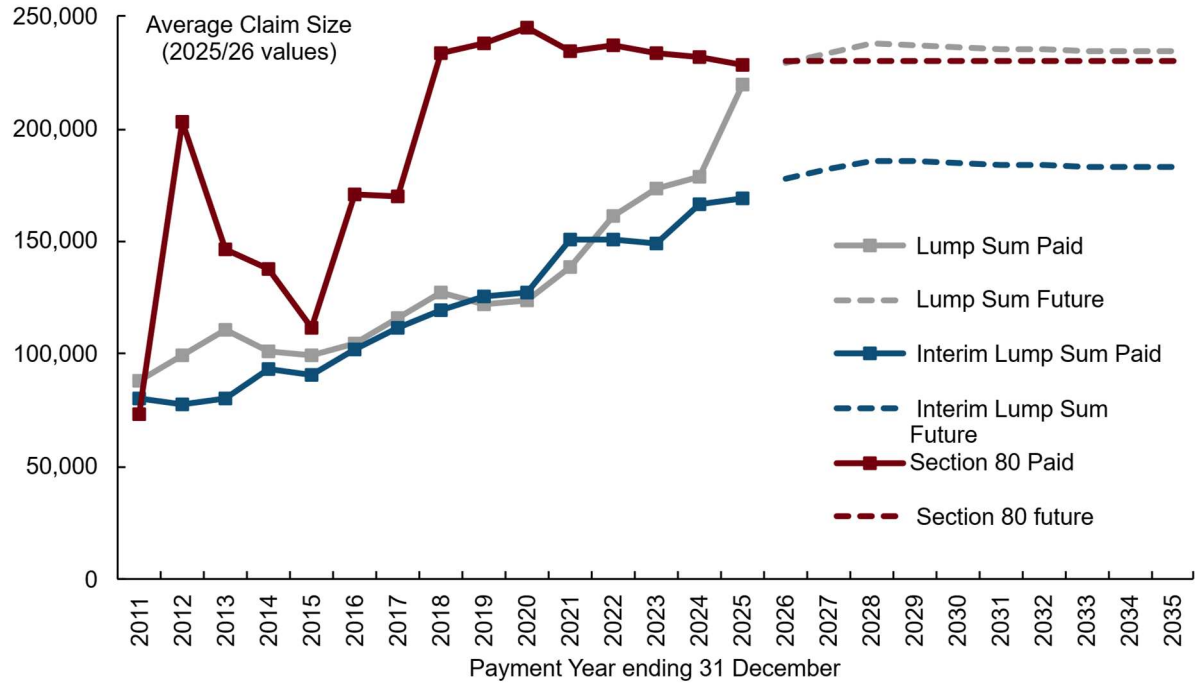


6.5.8 Figure 6.18 shows the historical and projected average claim sizes for each of the PI payment types. The average size for periodic benefits is not shown as we use an annuity method to value these payments as discussed below. All amounts shown include any arrears payments and in 2025-26 values i.e. 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 5 per cent per annum in 2026 and 2 per cent per annum in 2027 and 2028. 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.

6.5.9 Given the very large increase in average claim size observed in the most recent year, we have adopted average claim sizes for each PI payment type that rely heavily on the most recent year.

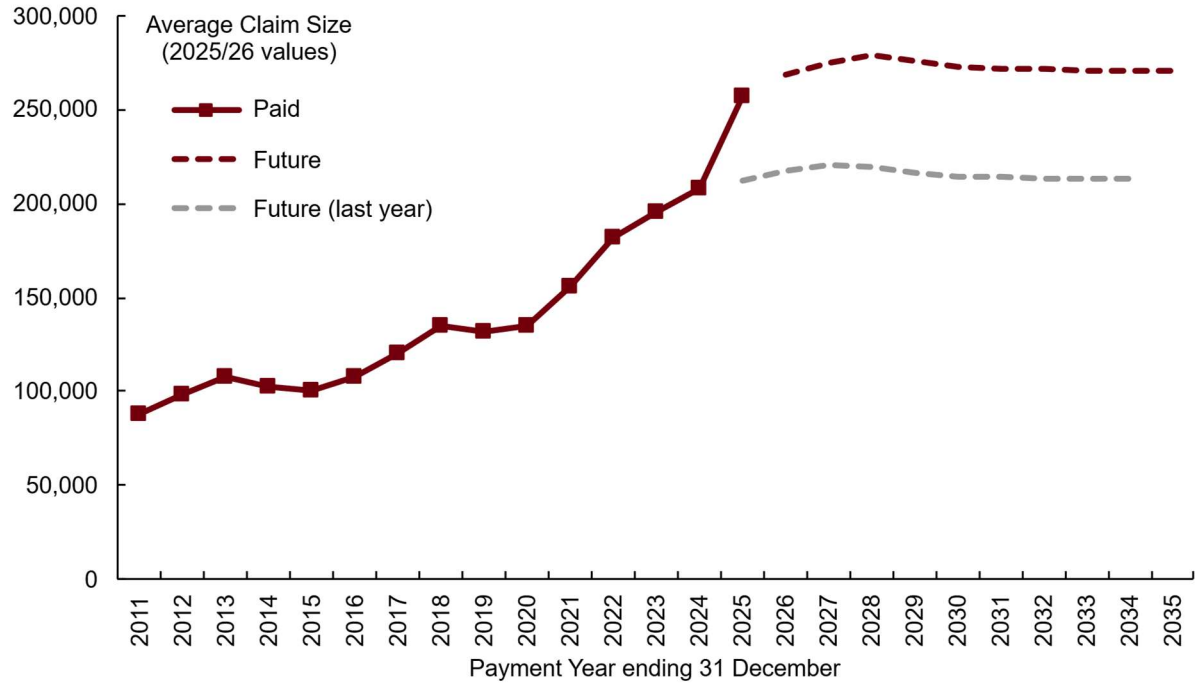
6.5.10 The selected average claim size for Section 80 payments represents an average of two dependants per claimant.

Figure 6.18: Average Size of PIs by Payment Type



6.5.11 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 2025-26 values). Our adopted average claim sizes at this valuation are around 25 per cent higher than at the previous valuation. This reflects the very high 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



6.6 Valuation Assumptions – Periodic Benefits

6.6.1 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.

6.6.2 For known claimants:

- the number of known claimants included in the 30 June 2025 valuation are defined as those who started receiving periodic benefits prior to 30 June 2025 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 clamant who did not receive a payment in the latest fortnightly payment run. We have allowed for 3,328 known claimants as at 30 June 2025, compared with 2,996 at 30 June 2024.
- 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 2025 is calculated as 2025 less year of birth. This is used as the input to the mortality decrements.

6.6.3 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 3,033 future new entrants claims at 30 June 2025, compared with 3,633 at 30 June 2024.
- The average benefit amount assumed is $201 per fortnight, the same as for new entrants in 2025. This is an increase of $14 per fortnight compared with our 2024 valuation assumption. The increase reflects the change in mix of partial payment arrangements in 2025, where

veterans may elect to receive a portion of their entitlement as a lump sum alongside an ongoing periodic payment.

- The average age of new entrants is assumed to be the same as the age of new entrants in 2025 i.e. that they are all aged 50 in the 2025 year. As such, the age of new entrants increases by one year with each new year of entry (so new entrants in 2026 are assumed to be 51, new entrants in 2027 are assumed to be 52, etc.). At our previous valuation we assumed new entrants were aged 51 in the 2024 year, therefore this represents a one-year decrease in the assumed average age of new entrants.

6.6.4 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 unchanged since our previous review and are those used for invalidity pensioners in the AGA's report "Military Superannuation Schemes Review of Long Term Costs as at 30 June 2023".

6.7 Valuation Assumptions – Inflation Assumptions

6.7.1 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 2024 valuation.

6.7.2 We have included an allowance for superimposed inflation at this valuation of 5 per cent in 2026 and 2 per cent in 2027 and 2028. 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 a natural upper limit on impairment levels is expected.
- 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.

6.7.3 On balance, we have adopted 5 per cent superimposed inflation in 2026 and 2 per cent in 2027 and 2028 for this valuation and have applied it to non-interim and interim lump sums only. We have adopted a higher rate for 2026 after consideration of the higher number of conditions lodged in recent lodgement years that have not yet flowed through to accepted PI

claims. This is higher than 2 per cent adopted for the 2025, 2026 and 2027 years at the last valuation.

6.8 Impact of the VETS Act – MRCA Veterans

6.8.1 In our previous costing advice, we concluded that the two material impacts of the VETS Act on permanent impairment benefits were:

- Permanent impairment assessments for DRCA members moving from the use of the DRCA impairment assessment guides to the MRCA GARP; and
- VEA veterans becoming eligible for MRCA PI benefits rather than the DCP (discussed in the following section).

6.8.2 Other changes, namely service-related smoking being covered by MRCA, introduction of a new Additional Disablement Amount, allowing presumptive liability, compensation for conditions occurring while on duty, posthumous permanent impairment claims and changed date of effect for permanent impairment claims, are expected to have a negligible impact on permanent impairment costs. As a result, we do not expect the VETS Act to have a material impact on the liabilities of current MRCA members.

6.9 Impact of the VETS Act – DRCA Veterans

6.9.1 Section 7.7 shows our estimate of the impact of the VETS Act on DRCA PI liabilities, with the DRCA liability reducing to $2.0 billion on 1 July 2025 and the remaining liabilities transferring to MRCA PI. Under the DRCA benefit regime, these liabilities are estimated to be $5.2 billion. However, the benefits available under the amended MRCA differ from those available under DRCA. Changes to permanent impairment benefits for DRCA veterans under the new legislation are:

Impairment assessments:

- DRCA veterans will be assessed on all injuries combined on a whole person impairment basis (rather than individual injuries assessed in isolation) in accordance with the MRCA GARP rather than the DRCA impairment guides;
- DRCA members currently assessed under the 1971 Act (table of maims) are also moving to MRCA GARP;
- Some conditions that are compensable under MRCA are not compensable under DRCA (e.g. tinnitus), and for some conditions the level of impairment assessed under DRCA is significantly lower than under MRCA (e.g. mental health conditions);
- Currently under DRCA some conditions require the level of contribution to be “significant” to be compensable whereas MRCA conditions require a lesser “material” contribution;
- Some DRCA veterans will have had conditions that did not meet the WPI threshold of 10 per cent for compensation under DRCA. These conditions may now be compensable if, combined with other injuries, the DRCA veteran is assessed at over 10 per cent on a “whole person” impairment basis under MRCA (i.e. the combination of multiple conditions may allow the lower level impairments to be compensated);

Compensation:

- The MRCA compensation amounts will be applied (including age-based commutation factors and eligibility for Section 80 eligible young person benefits if over 80 per cent WPI);
- Compensation under DRCA is currently paid as a lump sum. Under MRCA, compensation is paid as a fortnightly benefit with the option to convert to an age-based lump sum;
- Veterans will need to have either a new condition or a 5 point deterioration in an existing condition to access a MRCA PI (and any other benefits that may come with it e.g. Section 80 benefits). Only the additional injury/deterioration is compensated under MRCA – any existing compensation is grandparented;
- The overall impact on benefits available to DRCA veterans is complex; some of the changes increase the potential PI benefit (mainly for younger veterans and those with tinnitus) and some reduce it (mainly for older veterans and those with multiple conditions).

6.9.2 In the last six months, detail about how the transition arrangements will be implemented in practice have emerged. A "baseline" MRCA whole person impairment assessment will be calculated based on the member's existing DRCA impairment assessments, on the assumption that a MRCA assessment would have resulted in the same score for the same body part. Multiple impairments will then be combined using the formula in GARP M. This is likely to result in most DRCA members having a baseline MRCA WPI assessment that is lower than their true MRCA WPI score, thus it is likely to be easier for DRCA members to exceed the 5 point deterioration required to access MRCA PI benefits.

6.9.3 For this report, we have estimated the impact on DRCA payments by assessing the potential impact on PI payments made in the 2025 payment year. The following calculation estimates the amount each DRCA recipient would have received in 2025 if they had been subject to the MRCA benefits regime from the outset. We have:

- Calculated the MRCA-equivalent WPI at 31 December 2024 for each individual. We have calculated the "baseline" MRCA-equivalent WPI as described above, plus allowed for a) anyone with mental health conditions to receive an additional 13 impairment points for the first condition and 5 points for each additional condition, recognising that mental health conditions result in higher average impairment points under MRCA compared with DRCA, b) anyone with a hearing loss claim to receive an additional 15 impairment points for tinnitus, recognising that tinnitus is not compensable under DRCA, and c) anyone with a rejected tinnitus claim (but no accepted hearing loss claim) to receive an additional 15 points, again recognising that tinnitus is not compensable under DRCA;
- Calculated the MRCA-equivalent WPI at 31 December 2025 for each individual by adding in any new DRCA impairment points awarded in 2025, and making any additional allowances for mental health or tinnitus conditions if not already allowed for in the 31 December 2024 calculation;
- Determined the MRCA-equivalent compensation amount the veteran would have received in 2025 based on the difference between the 31 December 2025 and 31 December 2024 MRCA-equivalent WPI scores calculated above, as well as the veteran's age and gender. We have used the non-warlike/peacetime compensation factors in GARP M for this calculation;
- Included allowance for a portion of those assessed as over 80 WPI for the first time in 2025 to receive Section 80 benefits. We have allowed for the proportion receiving Section 80 benefits to vary with age of the veteran (based on MRCA experience) and an average Section 80 benefit amount of $230,000 (as used in the MRCA PI valuation). Given the older

age of DRCA veterans, the proportion receiving Section 80 benefits is estimated to be small compared to that for MRCA members.

6.9.4 Actual DRCA PI payments in 2025 were $574 million. Following the approach outline above, the MRCA-equivalent payments are estimated to be $438 million i.e. we estimate that veterans awarded PI compensation under DRCA in 2025 would have received 24 per cent less if they had been compensated under MRCA. We have applied this 24 per cent reduction to the $5.2 billion DRCA liabilities to estimate a MRCA-equivalent liability of $4.0 billion. This is essentially the "business as usual" cost of DRCA benefits had veterans been compensated under MRCA instead. In addition, we expect that there will be further costs as DRCA members who have previously been compensated seek additional compensation under the amended MRCA.

6.9.5 We understand that DRCA members will be encouraged to submit a MRCA IL claim in order to test their eligibility for MRCA benefits. We expect that the majority of DRCA members would follow this process and that the outcomes would be:

- Some additional permanent impairment benefits for some DRCA veterans. With the way the MRCA baseline is calculated, we expect that some DRCA members will have more than a 5 point MRCA-equivalent WPI deterioration by virtue of having a formal MRCA WPI assessment (even if they have not actually had a deterioration in their injures). Some of these veterans will be unable to access MRCA PI benefits due to offsetting arrangements i.e. their total DRCA PI payments received exceeds the MRCA maximum benefit. However, younger members (where the MRCA maximum is higher) and those with fewer conditions/past DRCA PI payments may receive MRCA PI compensation.

  We have estimated this likely impact, again using the 2025 payment year as the basis. This would have resulted in around $190 million of additional payments in 2025 (mainly due to our allowance for higher impairment points for those with mental health and tinnitus conditions). We have assumed that there will be additional payments in the first four years after the VETS Act is implemented as DRCA members test their eligibility: around $190 million in 2026/27, $175 million in 2027/28, $165 million in 2028/29 and $160 million in 2029/30. These allowances are approximate and highly uncertain.

  Some members will exceed 80 WPI points, thus will be eligible for a Section 80 benefit if they have child dependents. We understand that Section 80 benefits are not included in any offsetting arrangements. Using our calculations of MRCA equivalent WPI points, we estimate that of the 17,800 DRCA veterans with accepted PI claims since 2017 (where we have impairment scores), that around 1,650 will have a MRCA WPI score of more than 80 points. Allowing for the proportion receiving Section 80 benefits to vary with age of the veteran (based on MRCA experience), we estimate that around 400 of these veterans would have child dependents, equivalent to around 2 per cent of all veterans. In total, there are around 28,600 DRCA veterans with accepted PI claims (including those with accepted PI claims prior to 2017), giving around 600 veterans who may be eligible for Section 80 benefits. With an average size of $230,000, we estimate the liability could increase by around $140 million for this component. We have spread this amount over the next four years. This allowance is approximate and highly uncertain.
- Some members will exceed 60 WPI points, thus will be eligible for a MRCA All Conditions Treatment Card. The estimated cost of these benefits is included in the Medical Benefits valuation in Section 9.6.
- Child dependents of those who exceed 80 WPI points will be able to access the MRCA ETS. The estimated cost of these benefits are included in the Other Benefits valuation in Section 12.8;

- Dependent partners of those who exceed 80 WPI points will be able to access death compensation benefits on the death of the member. The estimated cost of these benefits is included in the Death Benefits valuation in Section 13.2;

6.9.6 In total, we expect the impact of the VETS Act on MRCA PI benefits, being the value of DRCA PI benefits transferred to MRCA, to be an addition of $4.7 billion ($4.0 billion of business as usual cost plus $600 million of additional PI costs and $140 million in respect of Section 80 benefits).

6.10 Impact of the VETS Act – VEA Veterans

6.10.1 Under the new legislation, VEA veterans will be able to lodge a MRCA PI claim. We note:

- The way impairment assessments are conducted for VEA are the same as those used for MRCA however the conversion of impairment points into a compensation amount will change. The MRCA compensation amounts are age-based (unlike the DCP) and veterans are able to elect to take a lump sum under MRCA (rather than periodic benefits). The option of a lump sum may be attractive to many veterans.
- Veterans need to have either a new condition or a 5 impairment point deterioration in an existing condition to access a MRCA PI (and any associated benefits e.g. Section 80 benefits). Only the additional condition/deterioration is compensated under MRCA – the existing compensation is grandparented i.e. VEA veterans are only able to receive a lump sum permanent impairment payment for the additional condition/deterioration. They cannot convert an existing DCP pension into a lump sum.

6.10.2 Veterans that are impacted fall into the following groups:

- Those with new conditions that emerge post 1/7/2026 (or deterioration of an existing condition) that will be assessed under new MRCA rules. We have estimated the future number of such claims based on the number of new DCP claims and applications for increase experienced by VEA veterans over the recent past. This model allows for the age of the veteran at the time of making the DCP claim/application for increase, and for the aging of the VEA population in the future. We have allowed for the severity of claims to vary based on whether it is a new or repeat claim, with the proportion of new claims also varying by the age of the veteran. We have applied the MRCA compensation factors for warlike/non-warlike service to estimate future benefits and have assumed that all take the benefit as a lump sum;
- Those who are incentivised to try to obtain a WPI assessment of more than 80 WPI points in order to access a Section 80 benefit (noting they must have dependent children). We expect that a significant portion of VEA claimants will be unable to claim for Section 80 benefits due to them being an older cohort and no longer having dependent children. We have estimated the number of VEA claimants who may access a Section 80 benefit by applying the 2025 MRCA proportions of accepted PI claimants who accessed Section 80 benefits (by age), to the VEA projected numbers of claimants. We have adopted an average claim size of $230,000, consistent with the MRCA experience.

6.10.3 VEA veterans might be more inclined to make a MRCA PI claim than a VEA DCP claim as they will be able to access a lump sum payment under the amended MRCA. Current DCP recipients may be more inclined to claim for subsequent claims (for an existing or additional condition) post 1 July 2026 to receive an upfront lump sum compared to a smaller increase to their DCP under current arrangements. To allow for this potential behavioural change, we have added a loading of 20%.

6.10.4 Our expected liability as at 30 June 2025 for VEA veterans, after incorporating behavioural changes, is $6.6 billion.

6.11 Liability Estimate

6.11.1 Table 7.1 shows the outstanding liability at 30 June 2025 in respect of permanent impairment claim payments broken down by year of accident. The results by accident year are shown are before the impact of the VETS Act on the MRCA liabilities, and the VETS Act impact shown separately.

Table 6.3: Outstanding Claims Liability for MRCA Permanent Impairment Claims by Year of Accident

Year of accident year ending 30 June	Liability ($ m)
Prior	906.2
2011	311.7
2012	384.4
2013	479.1
2014	591.9
2015	711.7
2016	885.1
2017	1,088.5
2018	1,414.1
2019	1,713.9
2020	2,110.7
2021	2,752.6
2022	3,302.6
2023	3,748.3
2024	4,128.3
2025	4,320.5
Total before VETS Act	**28,849.5**
Expected at 30/06/2025 before VETS Act	23,451.6
VETS Act Impact – DRCA members	4,687.7
VETS Act Impact – VEA members	6,560.2
Total after VETS Act	**40,097.4**
Total at 30 June 2024 (taken from previous report)	22,517.1

6.11.2 Before the impact of the VETS Act, the 2024 review projected that the MRCA liability as at 30 June 2025 would be $23.5 billion. The current estimate is $28.9 billion, an increase of $5.4 billion or 23 per cent.

6.11.3 After the impact of the VETS Act, the MRCA PI liability as at 30 June 2025 is estimated at $40.1 billion.

6.11.4 Table 7.2 reconciles the liability estimate for MRCA PI payments with the corresponding estimate at the previous valuation.

Table 6.4: Reconciliation of Liability for MRCA Permanent Impairment Payments

	$m
Liability estimate at 30 June 2024 (previous report)	**22,517.1**
Assumed Interest	1,038.4
Projected Payments	(3,543.0)
Notional Premium	3,439.2
Projected liability as at 30 June 2025 (previous valuation)	**23,451.6**
Experience effects and assumption changes	
Change in claim numbers	(511.6)
Change in proportion receiving EYP	1,209.3
Change in average claim size for lump sums	3,727.7
Change in future superimposed inflation	905.1
Change in mix of lump sum payment types	90.3
Changes in periodic benefits	(23.0)
Liability at 30 June 2025 (before VETS Act)	**28,849.5**
Change due to VETS Act	11,247.9
Liability at 30 June 2025 (after VETS Act)	**40,097.4**

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

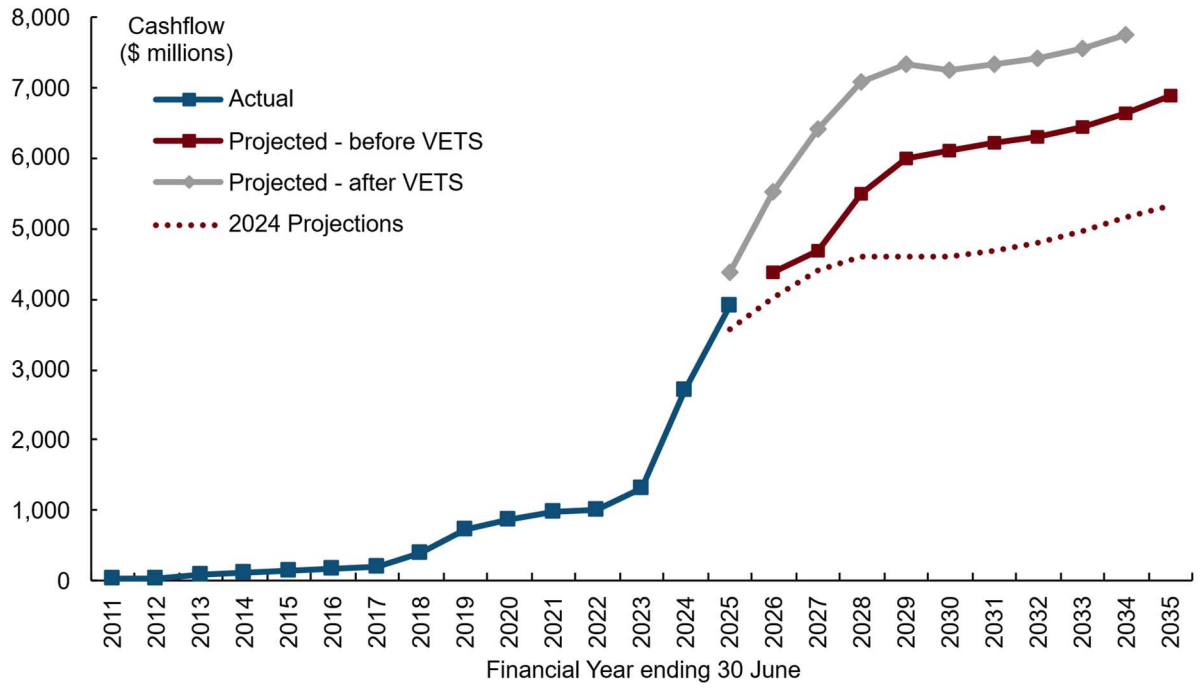
- A reduction of $512 million due to lower adopted claim numbers. This is primarily due to the lower-than-expected new ILs lodged in 2025, and our assumption that this lower level will be maintained in the future;
- A $1,209 million increase due to increasing the assumed the proportion of claimants expected to receive Section 80 benefits to current levels, and that the proportion will continue to increase over the next few years;
- A $3,728 million increase to the average claim size assumptions for lump sums, reflecting the much higher than expected experience in the last year;
- A $905 million increase due to assuming a higher rate of superimposed inflation in 2026, and that superimposed inflation will continue into 2028;
- A small increase of $90 million due to some minor changes in our assumptions around the mix of lump sums by type;
- A small $23 million reduction in the annuity valuation of periodic payments
- An increase of $11.2 billion due to the impact of the VETS Act.

6.12 Cashflows

6.12.1 Figure 6.20 shows the historical and projected cashflows for MRCA permanent impairment payments. We have shown the projected cashflows both before and after the expected impact of the VETS Act.

6.12.2 Before the impact of the VETS Act, projected payments are expected to increase quite sharply in 2028 and 2029, a result of our assumption that the number of PI completions will increase in those years. After the impact of the VETS Act, the projected cash flows are expected to reach over $7 billion by 2029. We note that the level of future cashflows will be highly dependent on the level of processing capacity available and the level of future claims experience.

Figure 6.20: Historic and Projected MRCA Permanent Impairment Payments



7 DRCA Permanent Impairment and Non-Economic Loss

7.1.1 This section sets out our estimate of the liability for DRCA permanent impairment and non-economic loss benefits. Most of this section discusses the approach and assumptions to estimating the liability prior to the introduction of the VETS Act. We also have a separate section (7.7) that discusses the impact of the VETS Act on DRCA PI liabilities.

7.2 Modelling Approach

7.2.1 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 assessed[4]. 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 lump sum payment and the NEL components, we model all the payments combined.

7.2.2 We have adopted the same modelling approach as for the previous valuation, being a simplified version of the MRCA PI modelling approach. That is, we use a 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:

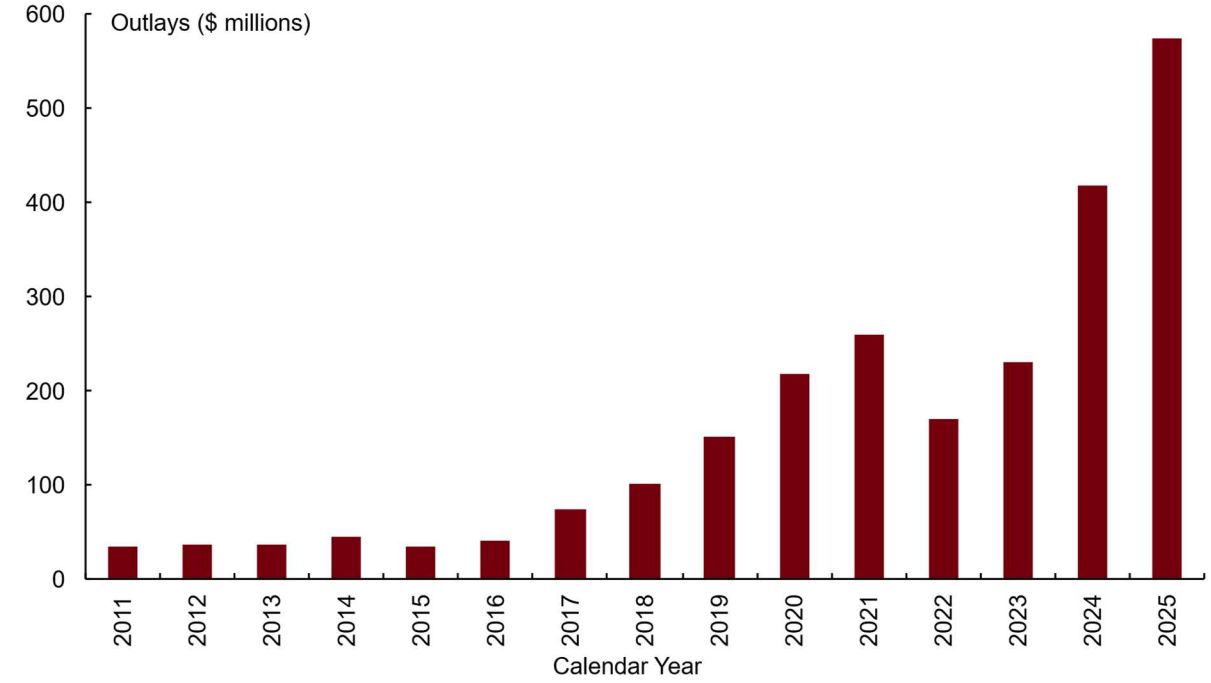
- We have subdivided the historical data based on the year of birth of the claimant rather than average accident date as used for MRCA PI;
- We have adopted a simplified approach to claim completions, calculating completion rates per claim lodged (rather than per open claim);
- The DRCA PI benefits are simpler than for MRCA so there is no need to analyse the DRCA claims experience by payment type.

7.3 Recent Experience

7.3.1 Figure 7.1 shows the expenditure on permanent impairment (including non-economic loss payments for DRCA) since 2011. 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. Payments in 2025 have increased again and were around $575 million.

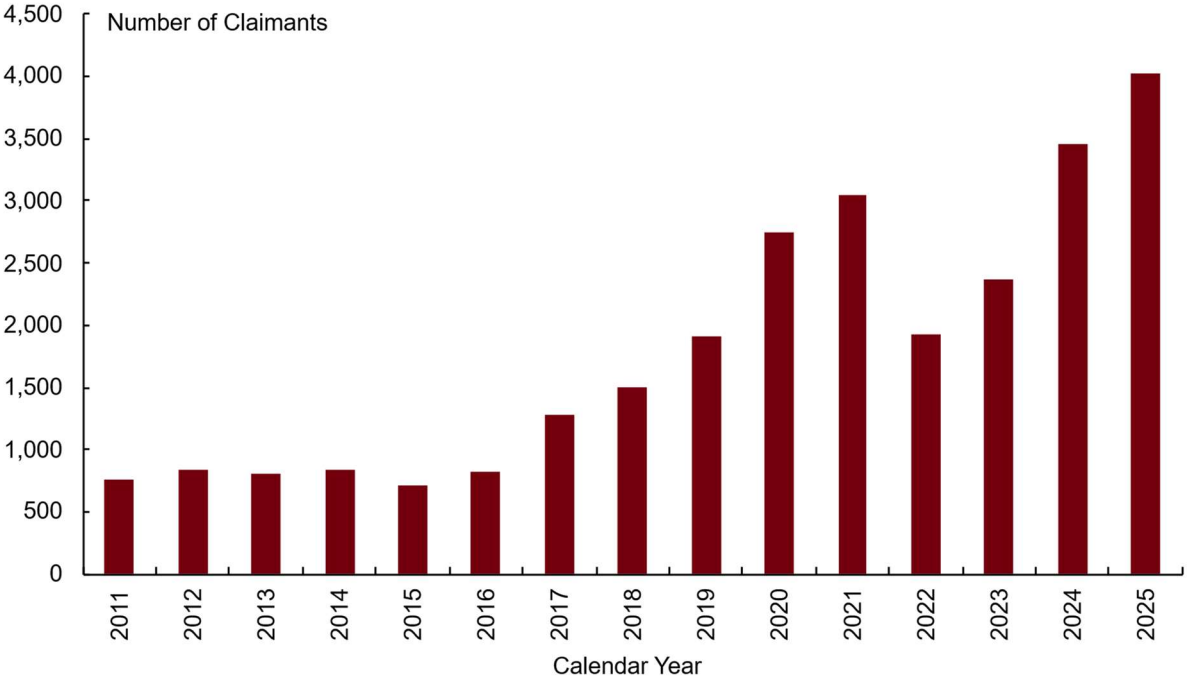
[4] We note that the impairment guides used to assess DRCA impairments differ from those used for MRCA. The scoring of injuries can differ between the two guides and DRCA injuries are assessed in isolation whereas with MRCA injuries are assessed on a "whole person" basis (with multiple injuries being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

Figure 7.1: Expenditure on DRCA Permanent Impairment Payments



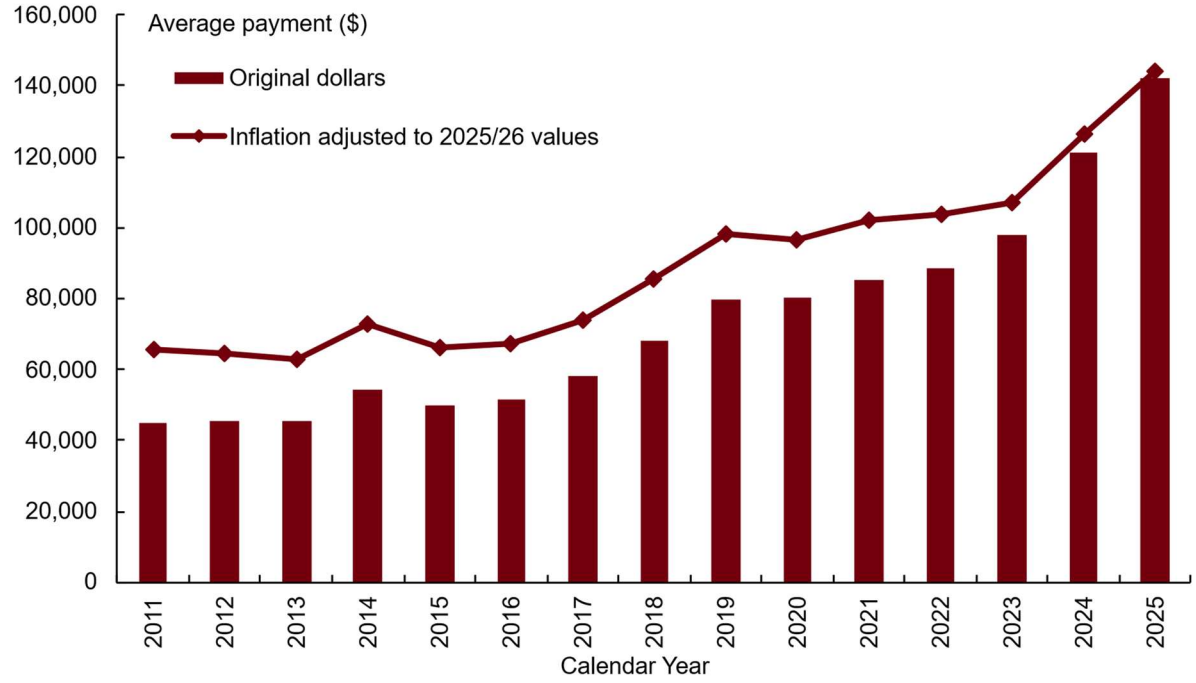
7.3.2 Figure 7.2 shows the number of people in receipt of a DRCA PI payment in each calendar year, noting the graph is a count of people who have received a PI, not the number of PI claims paid. The number of people in receipt of a PI payment can be seen to be a key driver of the payments in Figure 7.1, 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 large numbers in 2024 and 2025.

Figure 7.2: Number of DRCA PI Claimants



7.3.3 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 both the averages in dollars paid at the time and inflated to 2025-26 values using the prescribed indexation of the maximum available payment. The average amount paid per person has increased over time, with particularly large increases in the two latest years. The increase in the average size per person in 2024 was 18 per cent higher than indexation and in 2025 was 14 per cent higher than indexation; this compares to our superimposed inflation allowance of 2.5 per cent.

Figure 7.3: Average Size of DRCA Permanent Impairment Payments



7.3.4 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 2.04 claims per person between 2023 and 2025, contributing 9 per cent to growth in average claim size in 2024 and 8 per cent in 2025. 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 and 2025. Further, with the implementation of the VETS Act commencing on 1 July 2026, some veterans who may be better off under the existing DRCA legislation may be bringing forward their claims and lodging multiple PIs;
- the average number of impairment points awarded per permanent impairment claim – this increased from 19.4 to 21.1 points per PI claim between 2023 and 2025, contributing 4-5 per cent towards the growth in 2024 and 2025;
- the average payment per impairment point - this has increased from $3,189 to $3,349 between 2023 and 2025, contributing 2-3 per cent towards the 2024 and 2025 increases. As the majority of the amounts awarded for PI claims are 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.

7.3.5 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	2021	2022	2023	2024	2025
Average Size per person ($000, current values)	102.0	103.5	107.3	126.2	144.0
Increase	*5%*	*2%*	*4%*	*18%*	*14%*
Number of PIs per person	1.80	1.76	1.73	1.88	2.04
Increase	*8%*	*-2%*	*-2%*	*9%*	*8%*
Average impairment points per PI	18.3	19.0	19.4	20.4	21.1
Increase	*-1%*	*4%*	*2%*	*5%*	*4%*
Average payment per point (current values)	3,100	3,090	3,189	3,284	3,349
Increase	*-1%*	*0%*	*3%*	*3%*	*2%*

7.4 Valuation Assumptions – Numbers of PI Claims

Actual versus Expected Experience

7.4.1 Table 7.2 shows the actual PI number experience that has emerged in the 2025 calendar year compared with that expected at our previous valuation.

Table 7.2: Actual versus Expected Experience – PI Numbers

	Actual	Expected	Difference	% Difference
PI lodgements	8,500	7,972	528	7%
PI completions	5,895	6,496	-601	-9%
PIs Accepted	4,030	3,971	59	1%

7.4.2 The number of DRCA PIs lodged in 2025 was 7 per cent higher than expected. This is due to the higher-than-expected accepted PIs shown in Table 5.1 (10 per cent higher). The rate of conversion from IL accepted to PI lodgement was broadly as expected.

7.4.3 The number of PI completions were lower than expected.

7.4.4 The number of PIs accepted were a little higher than expected, with the acceptance rate being higher than our previous valuation assumption.

Future Assumptions

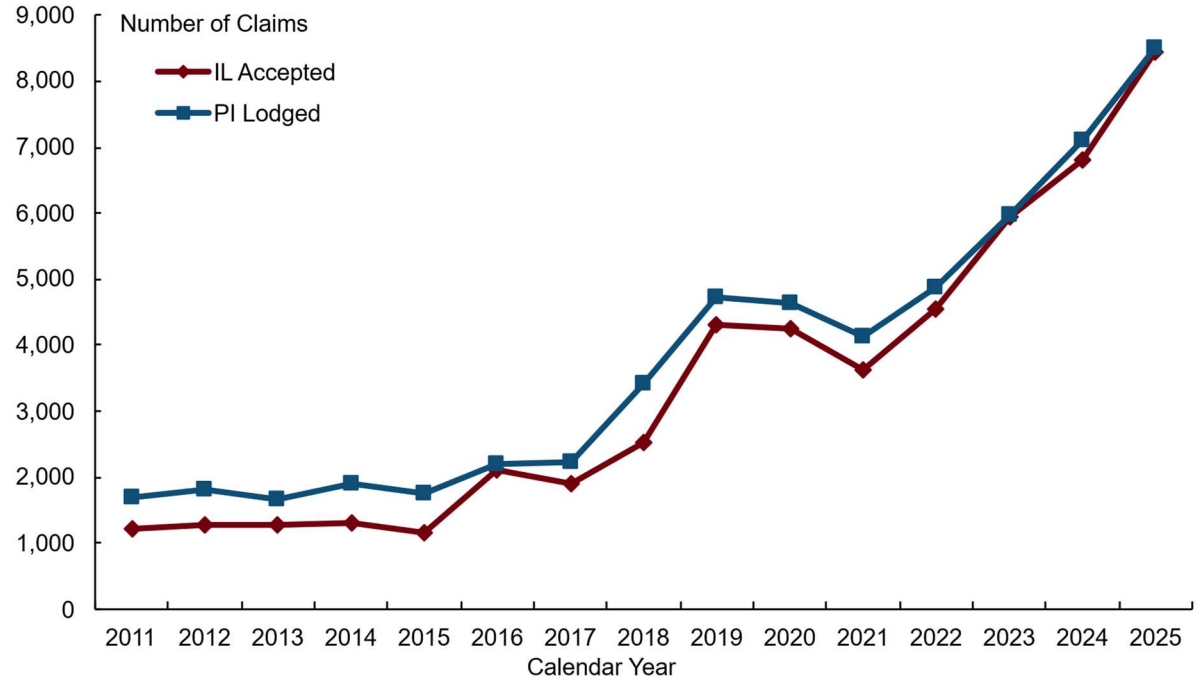
7.4.5 Please note the following section discusses modelled assumptions and results for DRCA PI in the absence of any changes as a result of the VETS Act. This forms the underlying basis of modelling the impact for the VETS Act which is discussed in section 6.9.

7.4.6 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.

7.4.7 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).

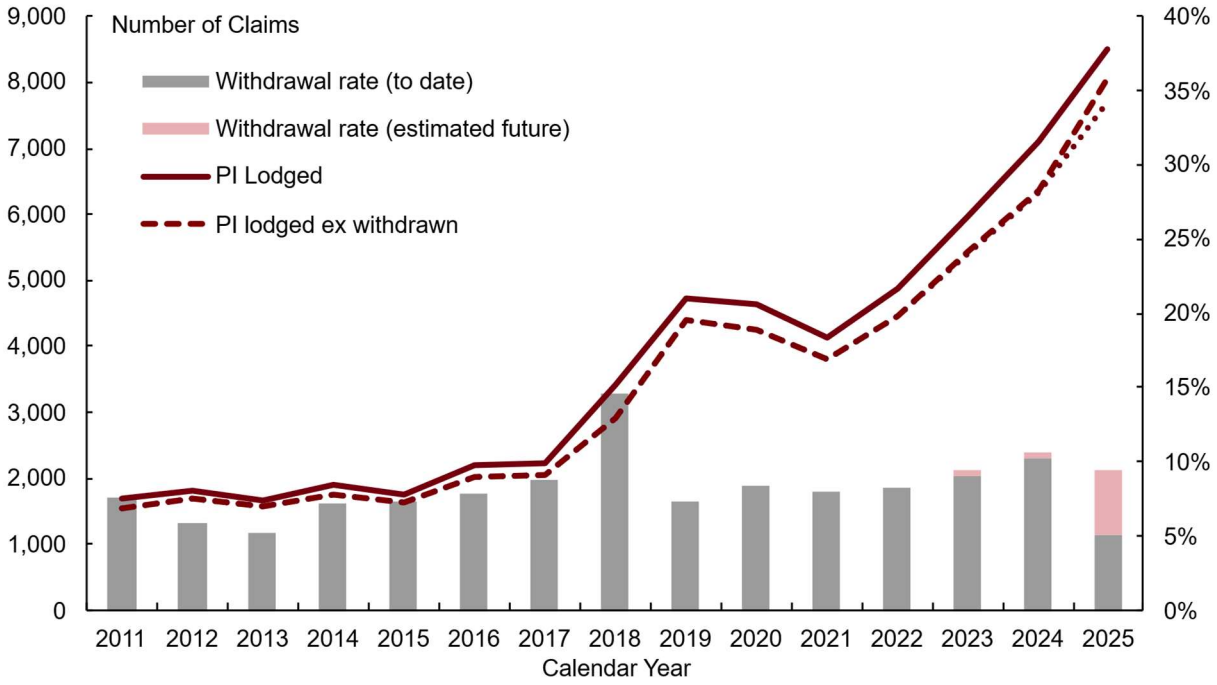
7.4.8 DRCA IL claims accepted and PI claims lodged have tracked closely. PI claims lodged have increased dramatically in the past three years, a direct result of the increase in IL claims accepted during this time.

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



7.4.9 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 2025 will ultimately be withdrawn, similar to levels for 2023 and 2024.

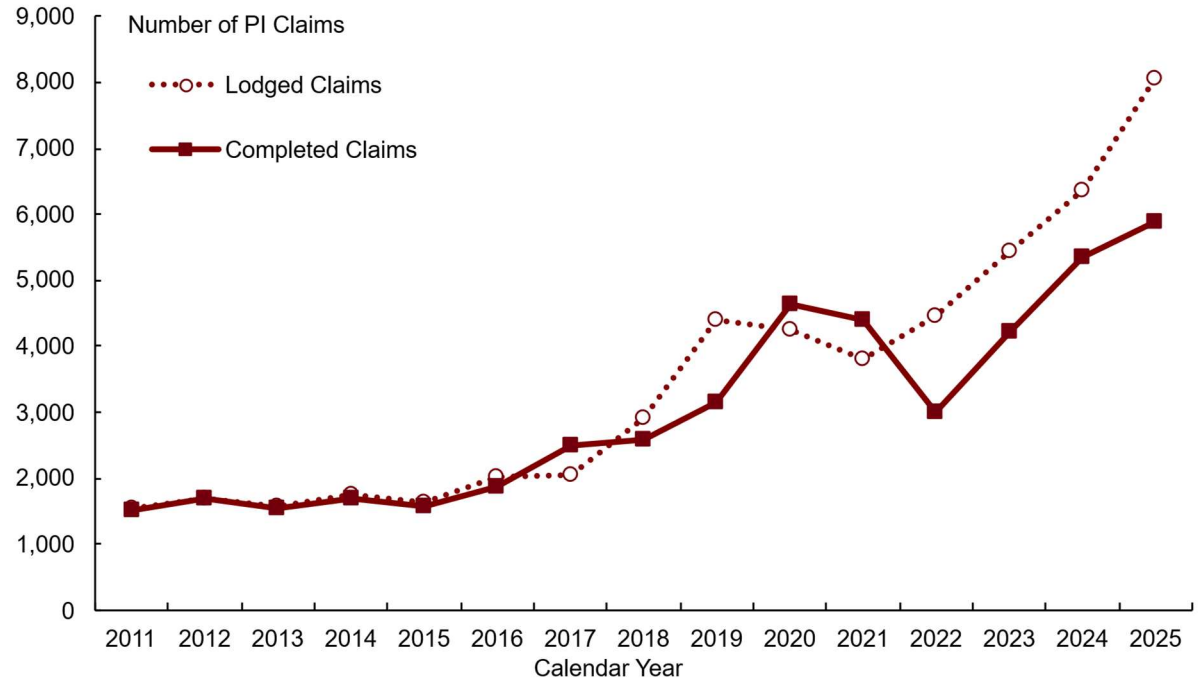
Figure 7.5: PI Claims Lodged Including and Excluding Withdrawn Claims, by Calendar Year



7.4.10 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 92 per cent of IL claims accepted resulting in a non-withdrawn PI claim lodgement.

7.4.11 Figure 7.6 below shows the number of PI claims lodged (after withdrawals) and completed by calendar year. PI claims lodged in the last 3 years have increased dramatically, but the number of PI claims completed has not kept pace with lodgements. Completions have been 1,000 to 2,200 below lodgements in each of the last four years.

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



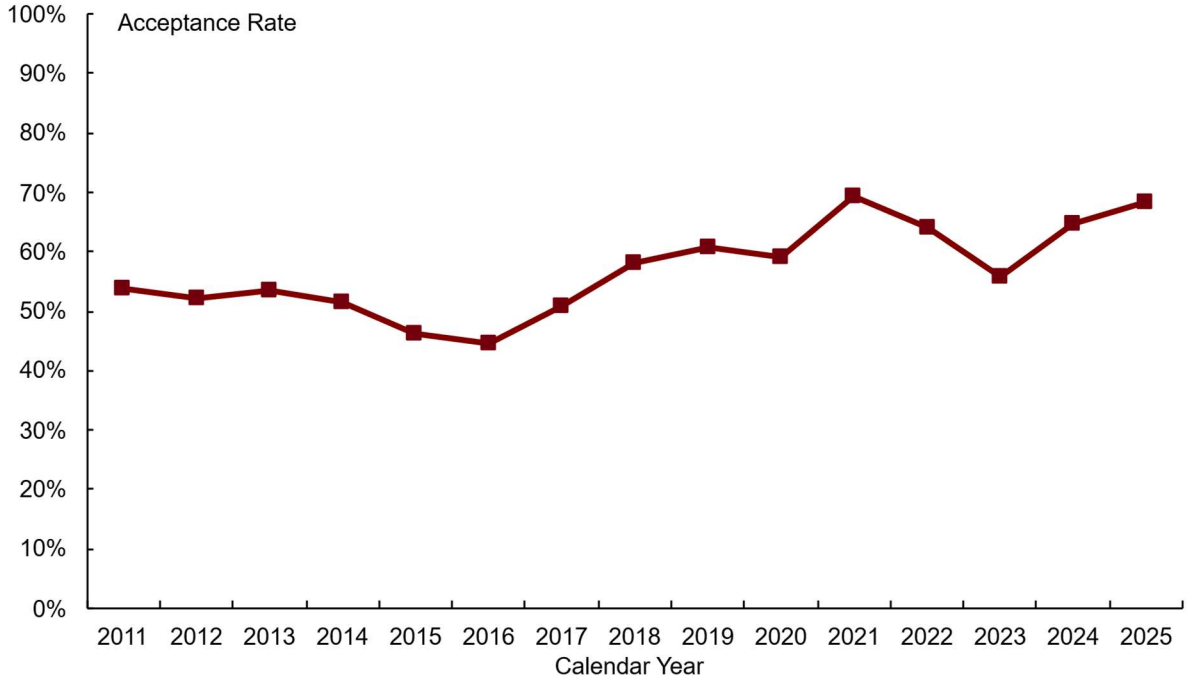
7.4.12 As a result of the significant gap between PI claim lodgements and PI claim completions in the last four years, the number of open PI claims has more than doubled, from around 3,200 at 31 December 2022 to 7,400 at 31 December 2025.

7.4.13 In our 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.

7.4.14 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.

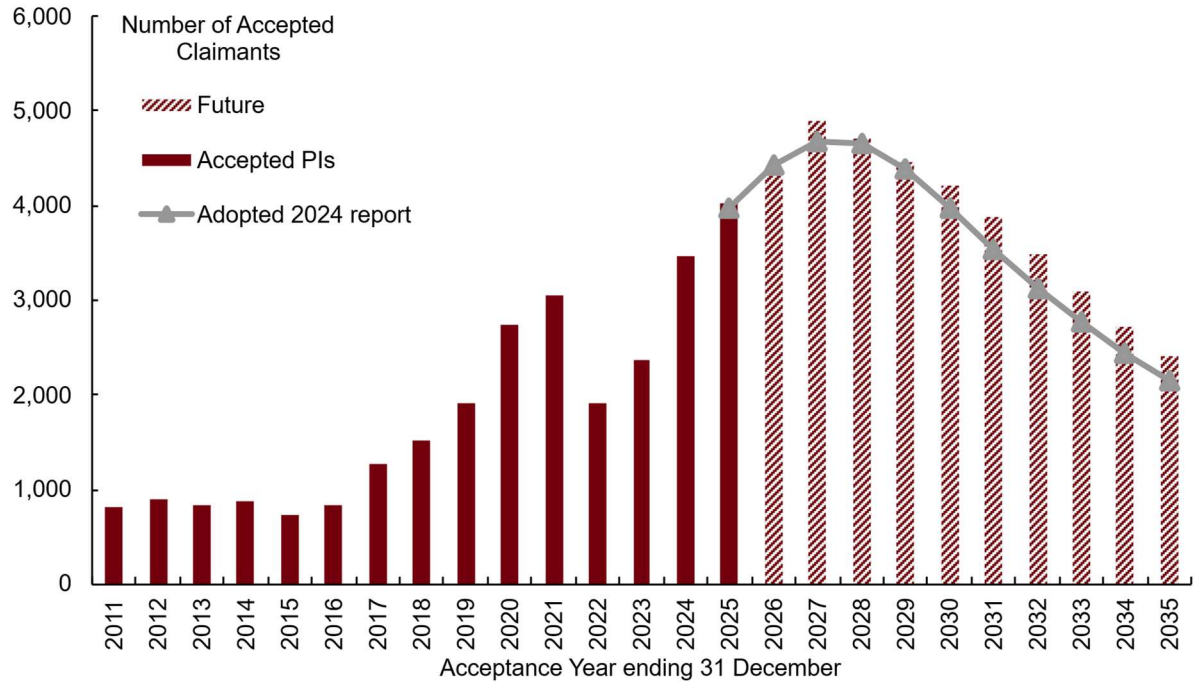
7.4.15 Figure 7.7 below shows the acceptance rates (per completed claim) for PI claims since 2011. Over the last five years, acceptance rates have averaged 67 per cent, excluding the low of 56 per cent for 2023 (lower than for MRCA at 88 per cent). By year of birth, the acceptance rates are higher for the oldest cohorts (78 per cent) reducing to around 55 per cent for the youngest cohorts. We have adopted permanent impairment acceptance rates that vary by year of birth, with the overall proportion being 66 per cent for 2026 (up from 62 per cent adopted last year), increasing to 78 per cent in future years as clients age.

Figure 7.7: PI Acceptance Rates



7.4.16 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 higher than those adopted at the previous valuation. This is due to a combination of more open PI claims at 31 December 2025 and a higher assumed PI acceptance rate.

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



7.5 Valuation Assumptions – Average Claim Size

Actual versus Expected Experience

7.5.1 Table 7.3 shows the actual PI payment experience that has emerged in the 2025 calendar year compared with that expected at our previous valuation (noting periodic benefits are excluded).

Table 7.3: Actual versus Expected Experience – PI Payment Experience

	Actual	Expected	Difference	% Difference
Number of Payments	4,029	3,971	58	1%
Payments ($m)	573.8	509.1	64.7	13%
Average claim size	142,413	128,220	14,193	11%
Number of PIs per person	2.04	1.89	0.15	8%
Average impairment points per PI	21.1	21.0	0.2	1%
Average payment per point	3,311	3,239	72	2%

7.5.2 The number of DRCA lump sums paid was close to expected. Total payments were 13 per cent higher than expected, almost solely due to higher average claim size.

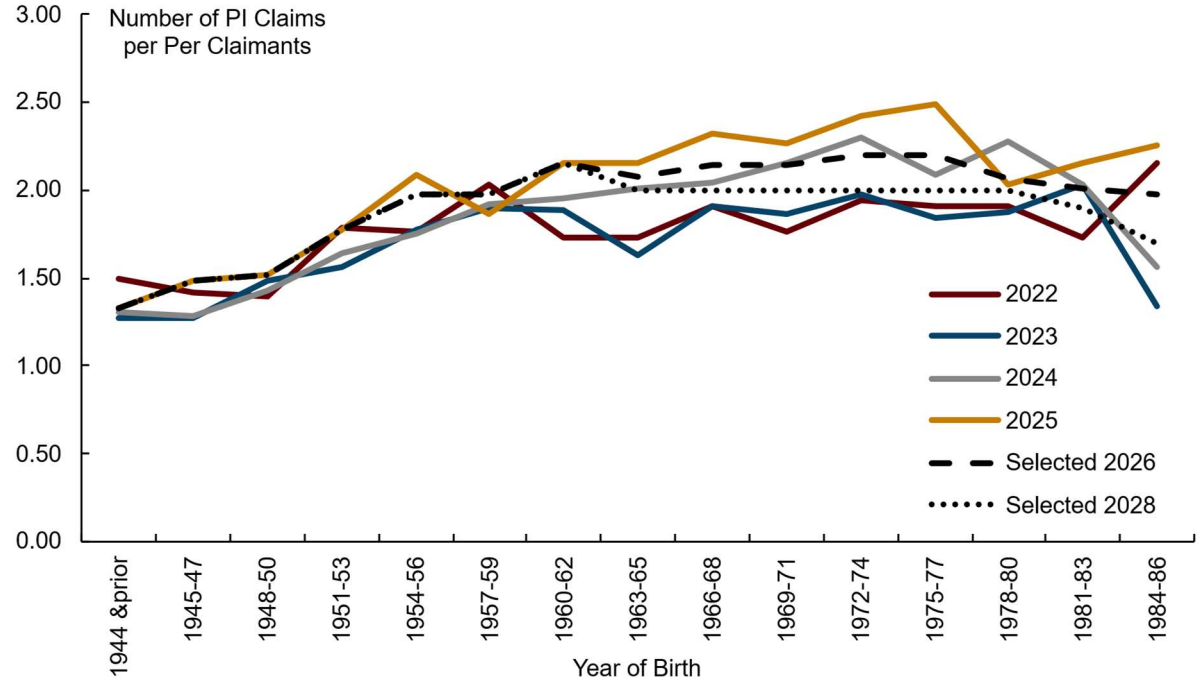
7.5.3 The higher average claim size was mostly due to higher numbers of PI claims per person, contributing 8 per cent of the 11 per cent difference in actual versus expected average claim size. The average number of impairment points awarded per PI was up only slightly, as was the average payment per point.

Future Assumptions

7.5.4 At our previous valuation, we 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 and 2025 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.

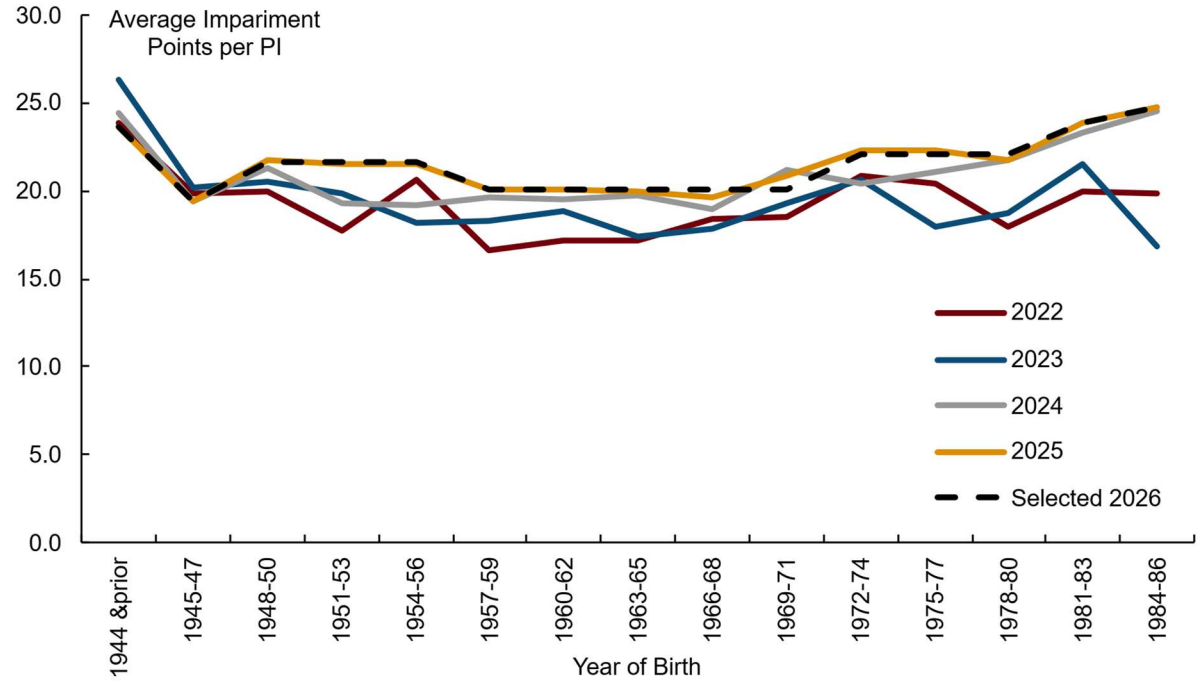
7.5.5 Figure 7.9 shows the number of PI claims per person, by year of birth, for each of the last four years along with our selected assumptions. The number of PIs per person increased dramatically in 2024 and again in 2025 for those born after 1960. We have assumed that part of this is a temporary impact due to the processing constraints in recent years and the imminent introduction of the VETS Act, and have assumed that the number of PI claims per person will reduce over 2026 and 2027 to expected long term levels.

Figure 7.9: DRCA Number of PI Claims per Person



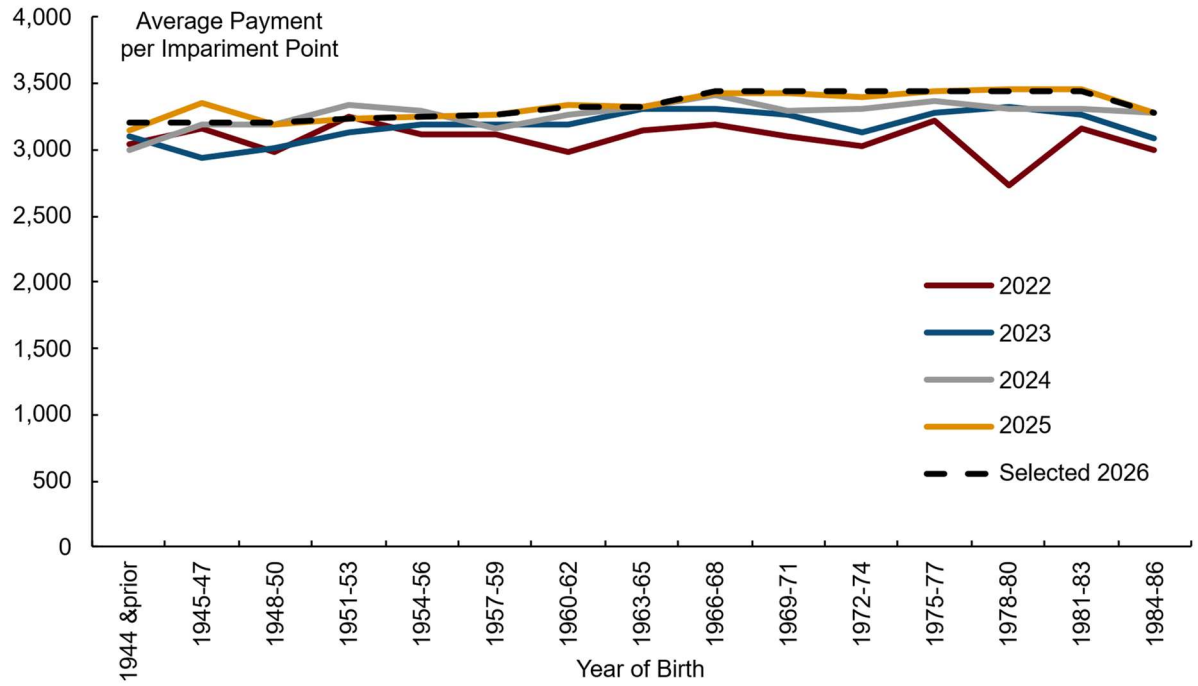
7.5.6 Figure 7.10 shows the average number of impairment points awarded per PI claim, by year of birth, for each of the last four years along with our selected assumptions. The average number of impairment points per PI claim increased in 2024 for those born after 1975 and also increased in 2025 for those born between 1951 to 1956 and 1972 to 1977. 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



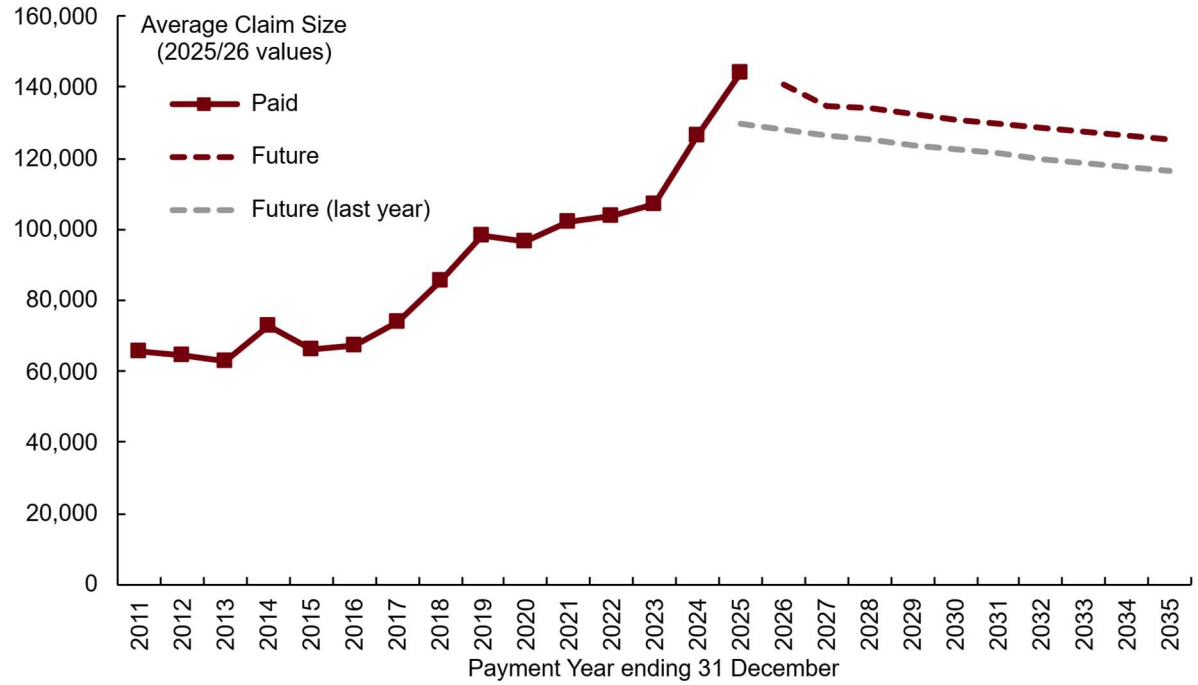
7.5.7 Figure 7.11 shows the average amount paid per impairment point, by year of birth, for each of the last four years along with our selected assumptions. The average amount paid per impairment point has increased across all age groups. We have also assumed that this will be an ongoing feature of the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

Figure 7.11: DRCA Average Amount Paid per Impairment Point



7.5.8 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 2025/26 values). Our adopted average claim sizes at this valuation are around 10 per cent higher than at the previous valuation for the 2026 payment year, reducing to around 7 per cent higher thereafter (noting that the average claim size is projected to reduce over time 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 two years.

Figure 7.12: Overall Average PI Claim Size



7.6 Valuation Assumptions – Inflation Assumptions

7.6.1 While, in theory, DRCA PI payments are indexed in line with 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 2024 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).

7.7 Impact of the VETS Act

7.7.1 We have been advised that any PI claims arising from ILs that are open prior to 30 June 2026 (as well as PIs that are open at that date) will be processed under the existing DRCA legislation. These are referred to as “in flight” DRCA claims. As such, a portion of the DRCA PI liabilities will remain as DRCA liabilities after the VETS Act commences on 1 July 2026. PI claims arising from ILs lodged after 1 July 2026 will be processed under the amended MRCA legislation, hence the remaining liability will be transferred to MRCA.

7.7.2 The way our model is configured, it is quite straightforward to run the model excluding any future IL lodgements and the PI claims that would result from those IL claims. As such, we estimate that the in flight claims account for $2.0 billion of the total $7.2 billion of pre-VETS Act DRCA PI liabilities.

7.7.3 The remaining liability in respect of future IL lodgements, prior to the impact of the VETS Act, is $5.2 billion. These claims will be assessed under the amended MRCA legislation, with the benefits available to members different from the DRCA benefits. Section 6.8 shows our estimate of these liabilities under the amended MRCA legislation.

7.8 Liability Estimate

7.8.1 Table 7.4 shows the outstanding liability at 30 June 2025 in respect of permanent impairment and non-economic loss claim payments broken down by year of birth. The results by year of birth year are shown are before the impact of the VETS Act on the DRCA liabilities, and the VETS Act impact shown separately.

Table 7.4: Outstanding Claims Liability for DRCA Permanent Impairment and Non-Economic Loss Claims by Year of Birth

Year of birth year ending 30 June	Liability (inflated and discounted) ($ m)
1944 &prior	179.8
1945-50	657.7
1951-56	812.0
1957-62	1,230.1
1963-68	1,423.4
1969-74	1,575.4
1975-80	958.8
1981 &later	358.8
Total before VETS Act	**7,196.0**
Expected at 30/06/2025 before VETS Act	*6,272.2*
VETS Act Impact (transferred to MRCA)	(5,176.4)
Total after VETS Act	***2,019.5***
Total at 30 June 2024 (taken from previous report))	**6,475.0**

7.8.2 Before the impact of the VETS Act, the 2024 review projected that the DRCA liability as at 30 June 2025 would be $6.3 billion. The current estimate is $7.2 billion, an increase of $0.9 billion or 15 per cent.

7.8.3 After the impact of the VETS Act, the DRCA liability as at 30 June 2025 is estimated at $2.0 billion. This liability is in respect of any PI claims arising from ILs that are open prior to 30 June 2026 (as well as PIs that are open at that date). We have been advised that these PIs will be processed under the existing DRCA legislation.

7.8.4 Table 6.2 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 7.5: Reconciliation of Liability for DRCA Permanent Impairment Payments

	$m
Liability estimate at 30 June 2024 (previous report)	6,475.0
Assumed Interest	311.1
Projected Payments	(513.9)
Notional Premium	0.0
Projected liability as at 30 June 2025 (previous valuation)	**6,272.2**
Experience effects and assumption changes	
Change in claim numbers	(488.1)
Change in IL acceptance rates	228.9
Change in PI acceptance rates	443.1
Change due to average claim size	739.9
Liability estimate at 30 June 2025 (before VETS Act)	**7,196.0**
Change due to VETS Act	(5,176.4)
Liability estimate at 30 June 2025	***2,019.5***

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

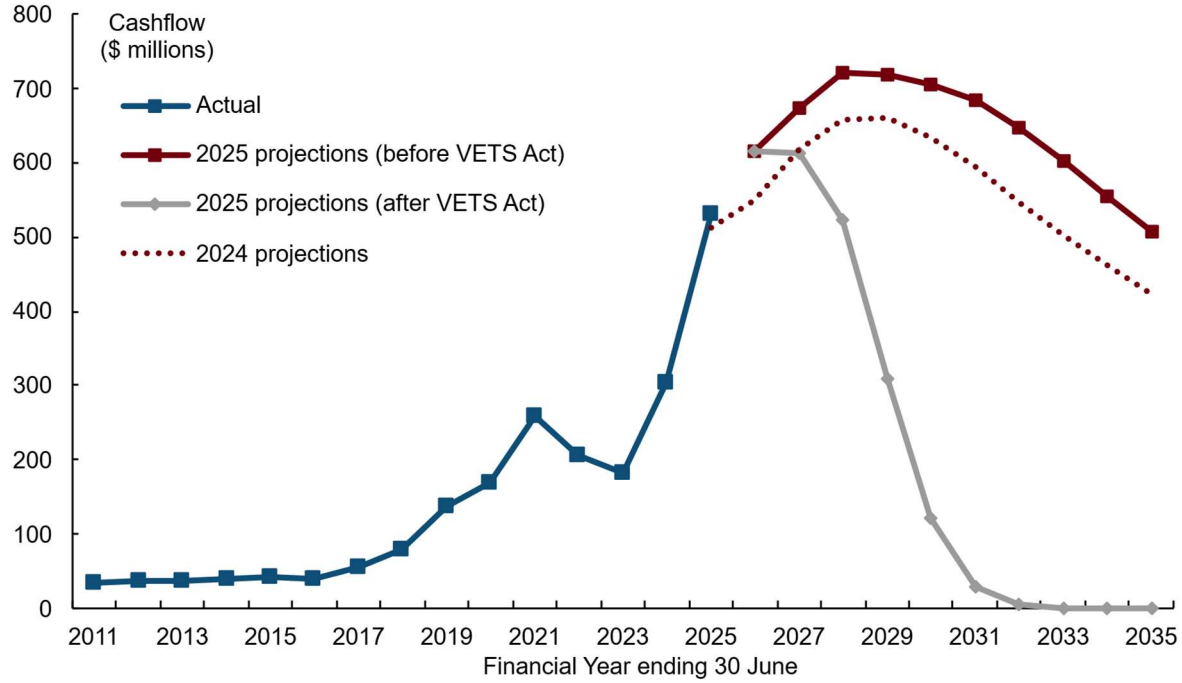
- A reduction of $488 million due to lower adopted claim numbers. This is due to the lower-than-expected new ILs lodged in 2025, and our assumption that the ILs lodged in 2026 to 2028 will be lower than previously assumed;
- An increase of $229 million due to higher assumed IL acceptance rates as discussed in Section 5.8.6;
- An increase of $443 million due to higher assumed PI acceptance rates as discussed in Section 7.4.14;
- An increase of $740 million due to higher average claim size assumptions, reflecting the much higher than expected experience in the last year;
- An reduction of $5.2 billion due to the impact of the VETS Act, with around three quarters of the liabilities transferring to MRCA.

7.9 Cashflows

7.9.1 Figure 7.13 below shows the historic and projected cashflows for DRCA permanent impairment payments. We have shown the projected cashflows both before and after the expected impact of the VETS Act.

7.9.2 Before the impact of the VETS Act, projected payments are expected to increase from 2026 to 2028 before declining. After the impact of the VETS Act, the projected payments run-off quickly as the in flight claims are processed. The DRCA liability is expected to be negligible from 30 June 2031. We note that the level of future cashflows will be highly dependent on the level of processing capacity available and the level of future claims experience.

Figure 7.13: Historic and Projected DRCA Permanent Impairment Payments



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 Section 10.

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.

8.1.4 From 1 July 2026, Veterans in receipt of DRCA Incapacity payments will automatically have their incapacity payments transferred to the MRCA as a result of the VETS Act. There are several differences in how incapacity payments are calculated under the MRCA compared with the DRCA, which is anticipated to result in an overall increase to incapacity benefits payable to this group. Veterans with eligibility under the VEA will gain access to incapacity payments, which were previously not available under the VEA, from 1 July 2026. These changes are discussed in more detail in the following sections. Veterans receiving MRCA incapacity will be unaffected by the VETS Act changes.

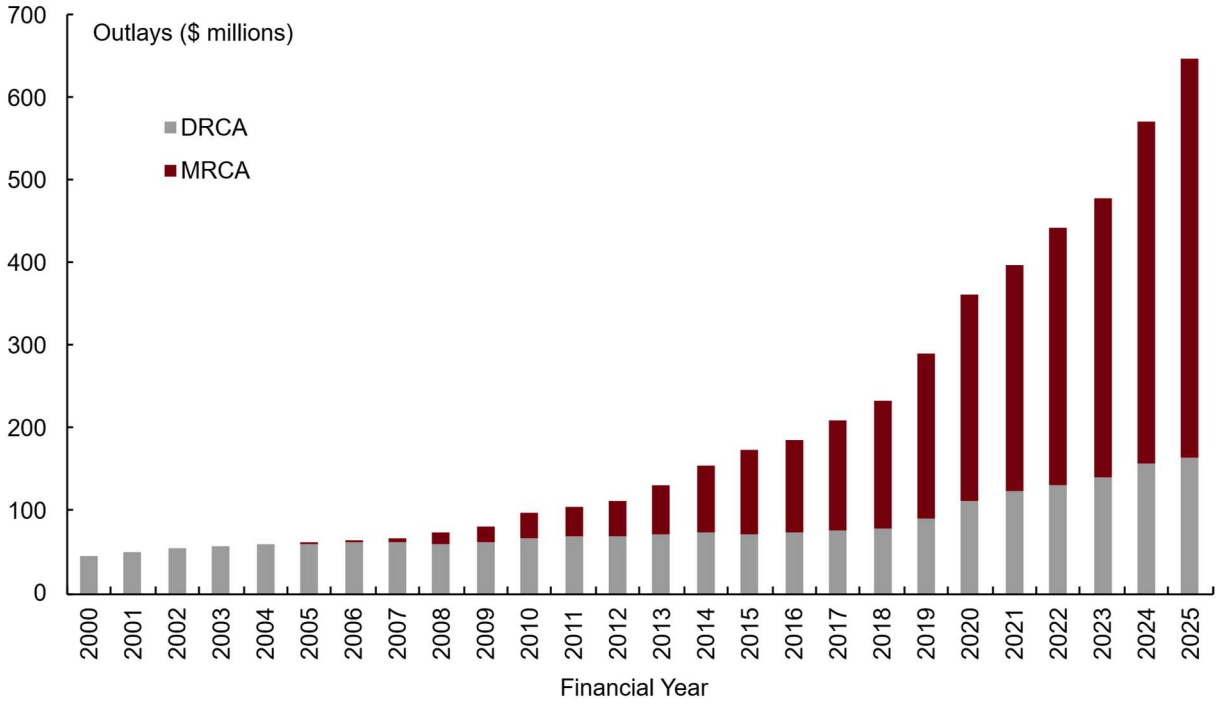
8.2 Modelling Approach

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 2025, 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.

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 was 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. There is only a weak relationship between the number of IL claims accepted and new incapacity episodes in a period. 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 can lodge multiple IL claims. Over the last three 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

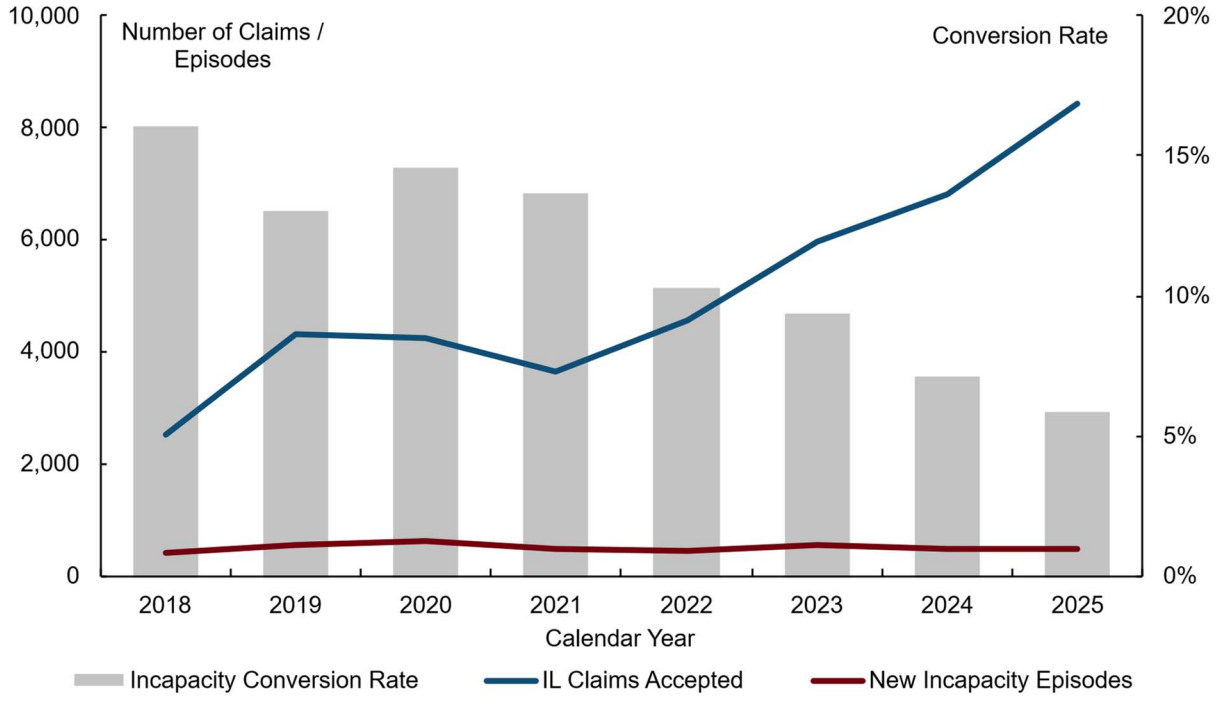
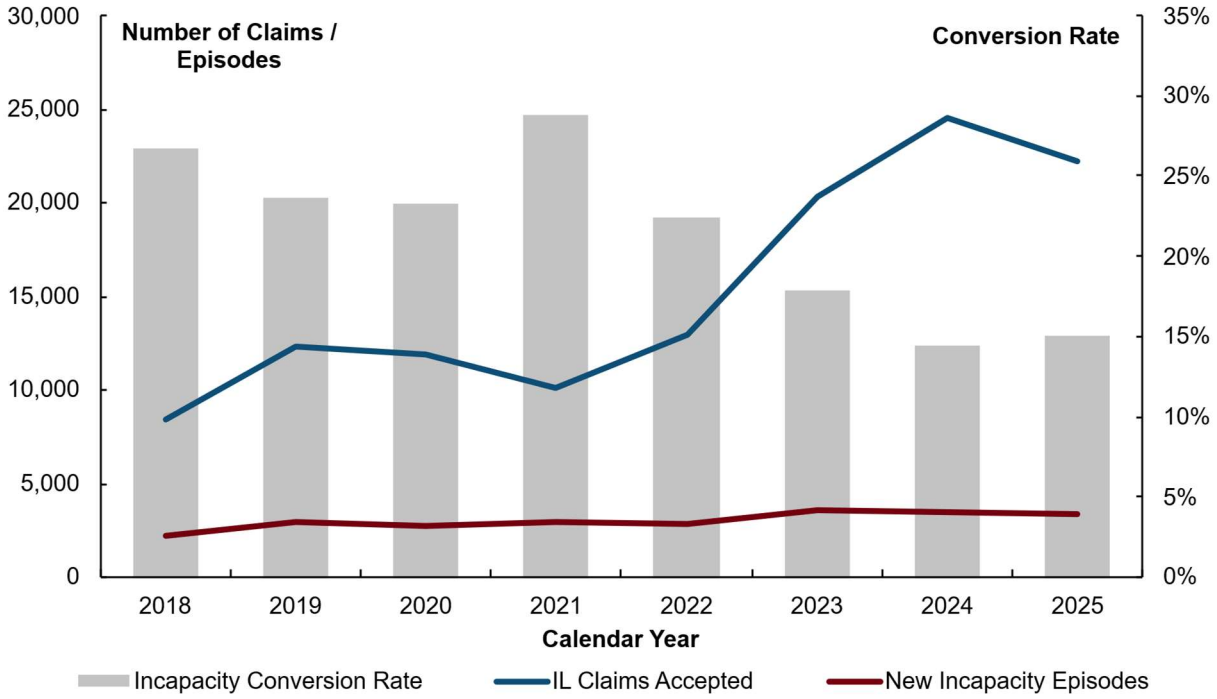


Figure 8.3: Number of MRCA IL Claims Accepted and New Incapacity Episodes



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. 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

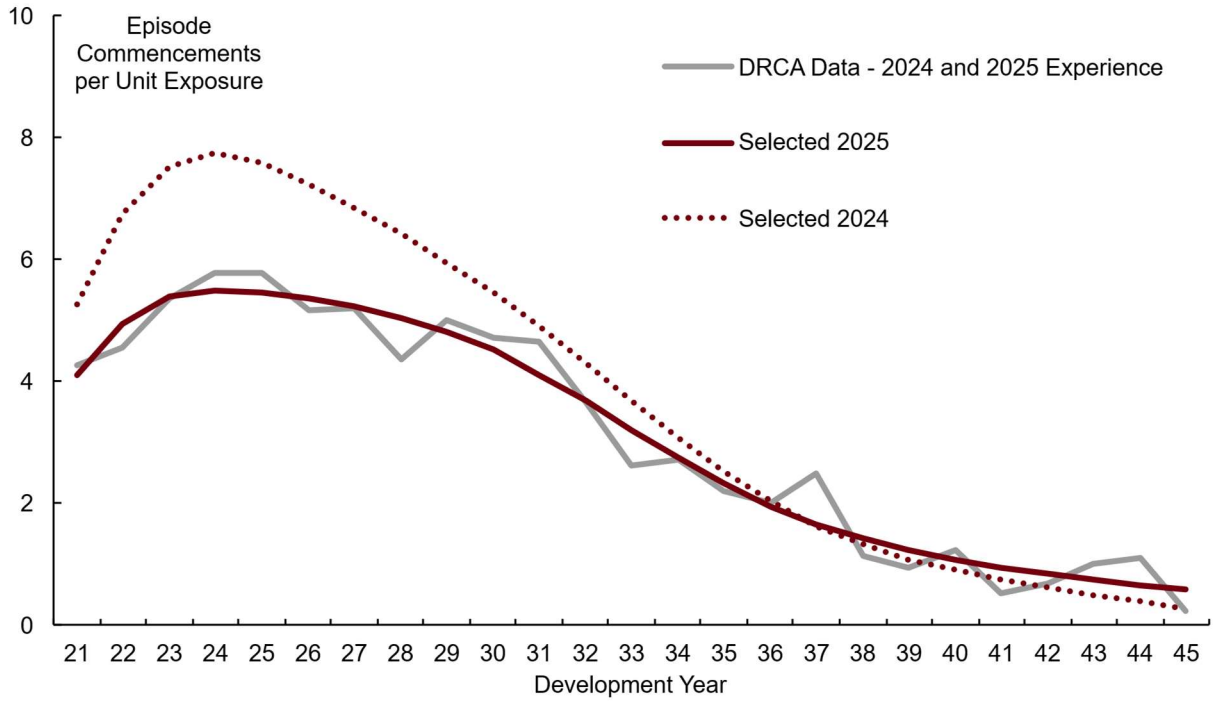
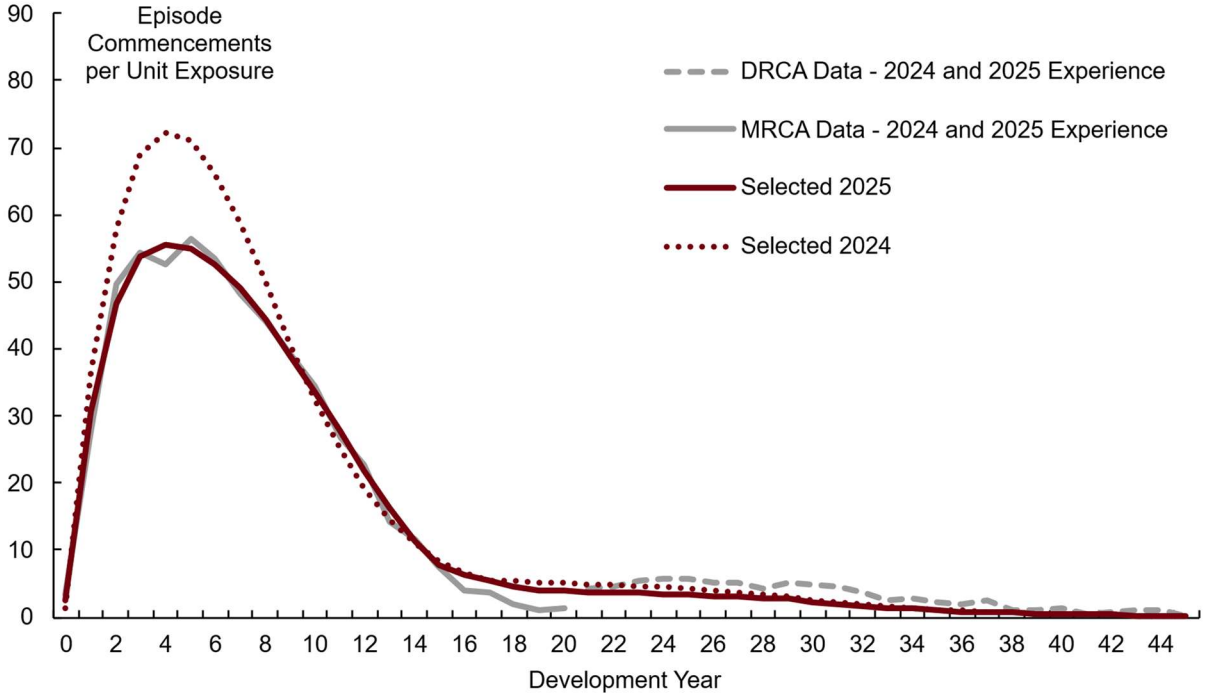


Figure 8.5: MRCA Incapacity Commencements by Development Year



8.4.4 The assumed commencement rates result in 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

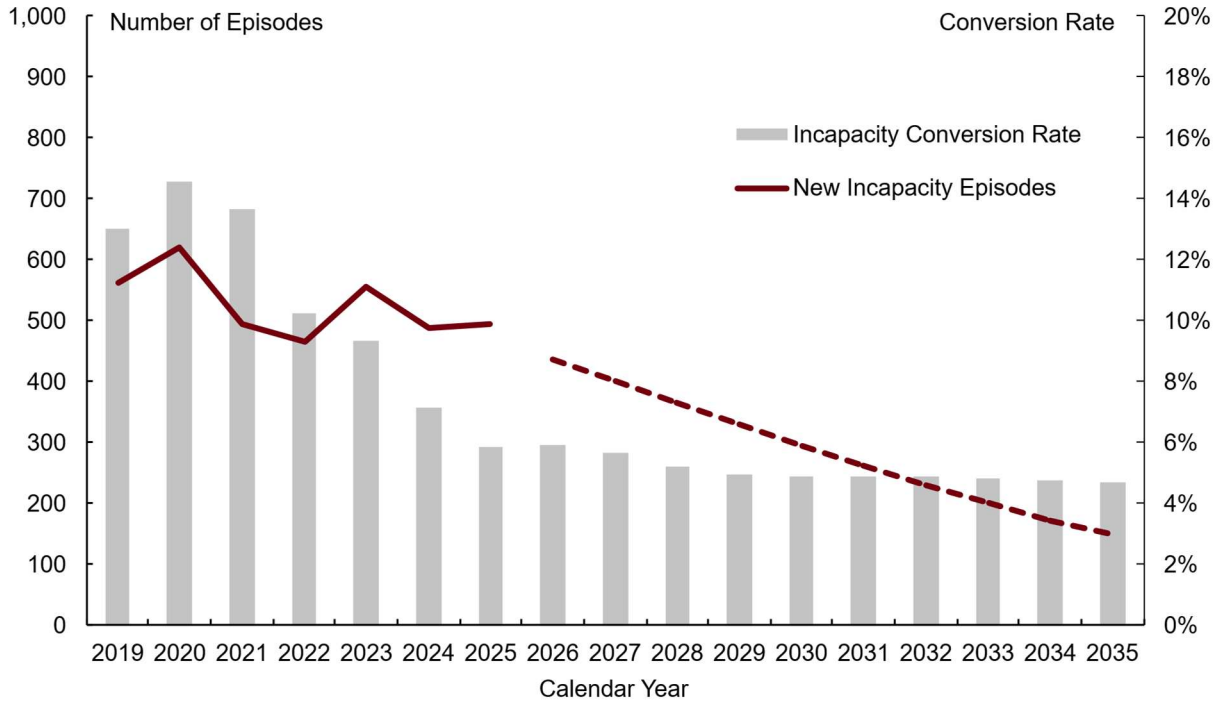
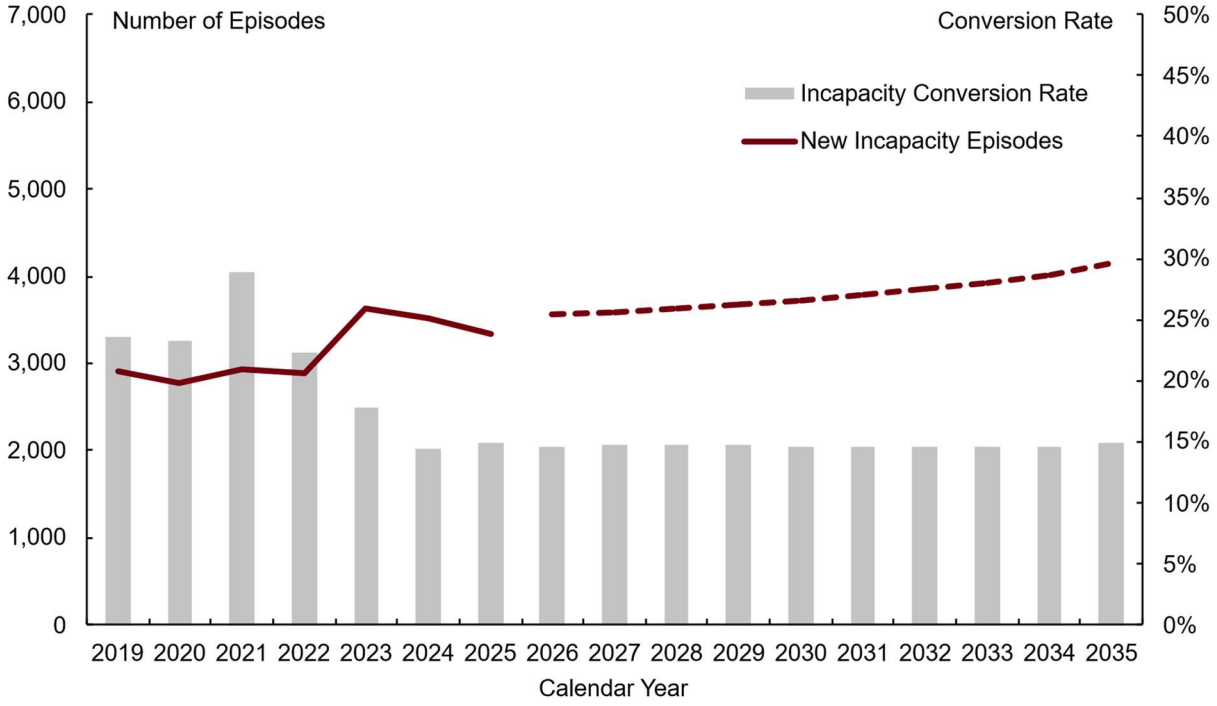


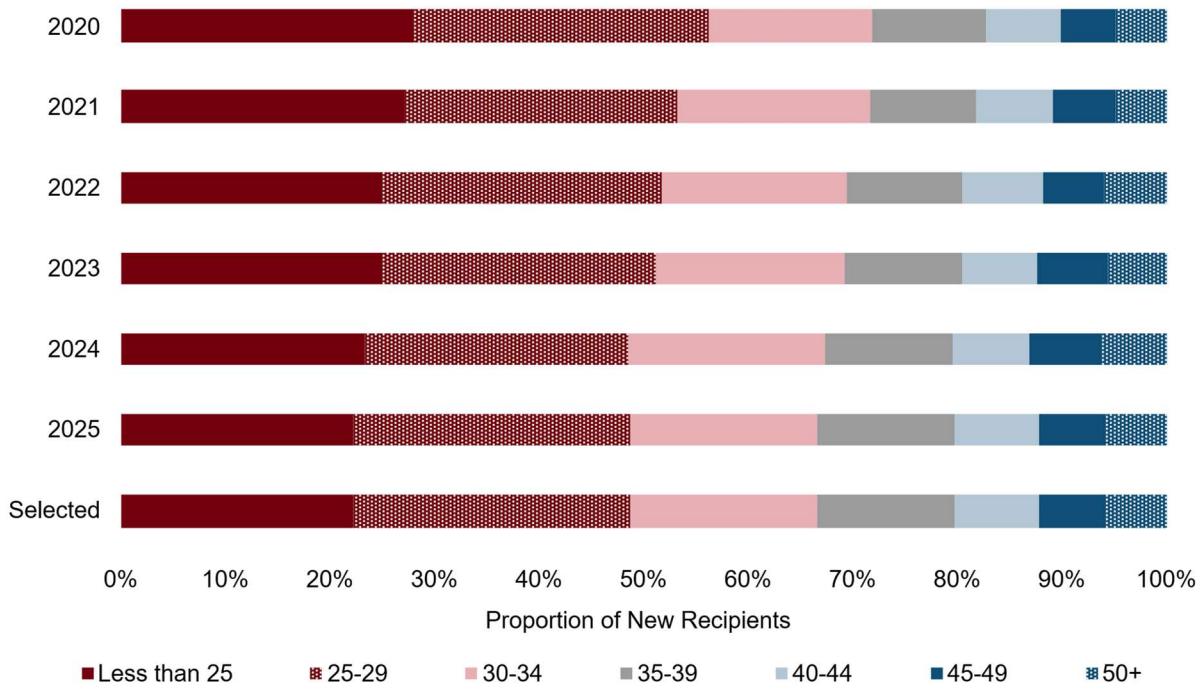
Figure 8.7: Projected IL Claims Accepted and New Incapacity Episodes – MRCA



8.4.5 DRCA new incapacity commencements 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 claims and incapacity is assumed to remain consistent with recent experience.

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 over the last 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 two calendar years, with higher continuance rates selected for those aged less than 35 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

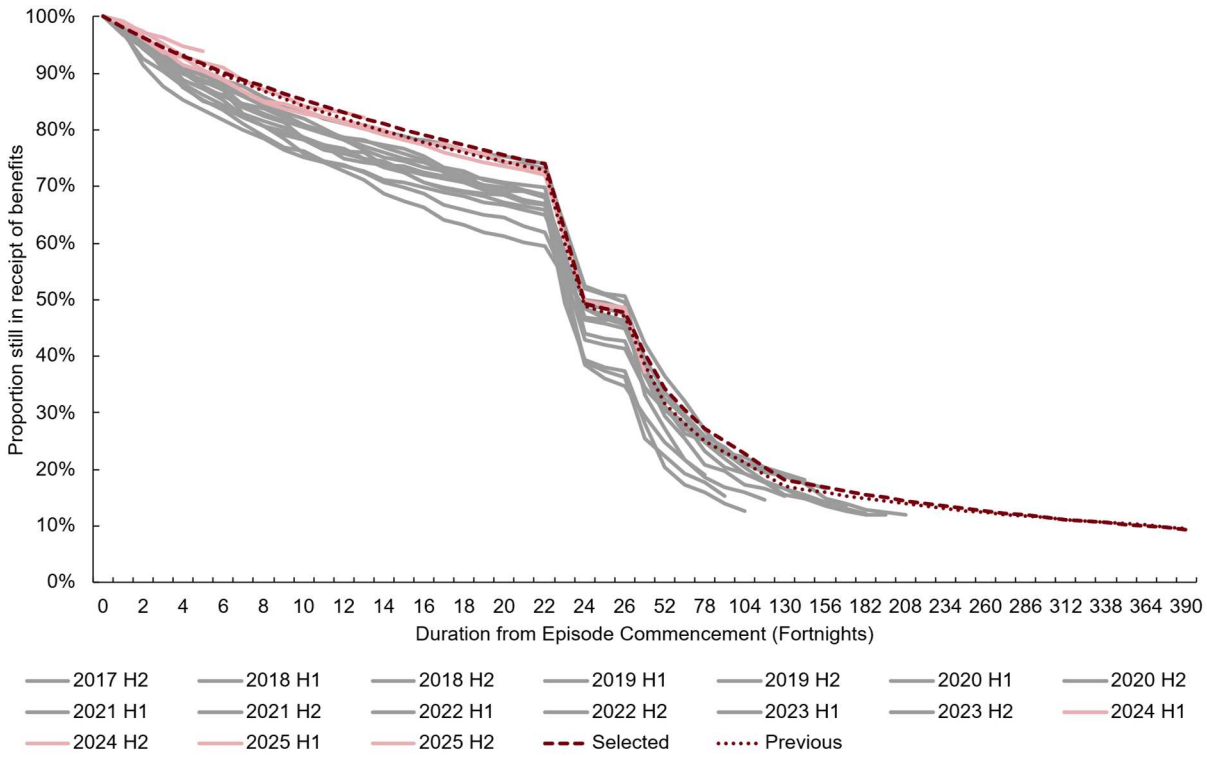


Figure 8.10: Incapacity Survival Curves – 35 to 49 Years Old at Episode Commencement

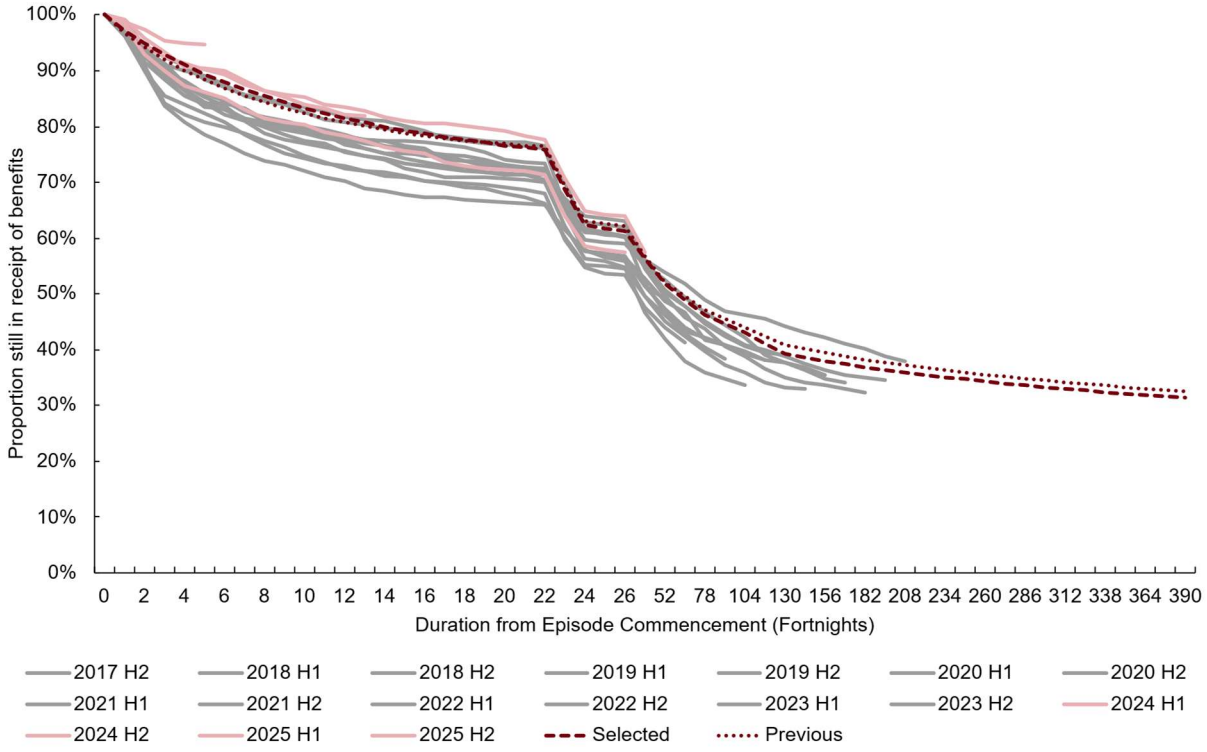
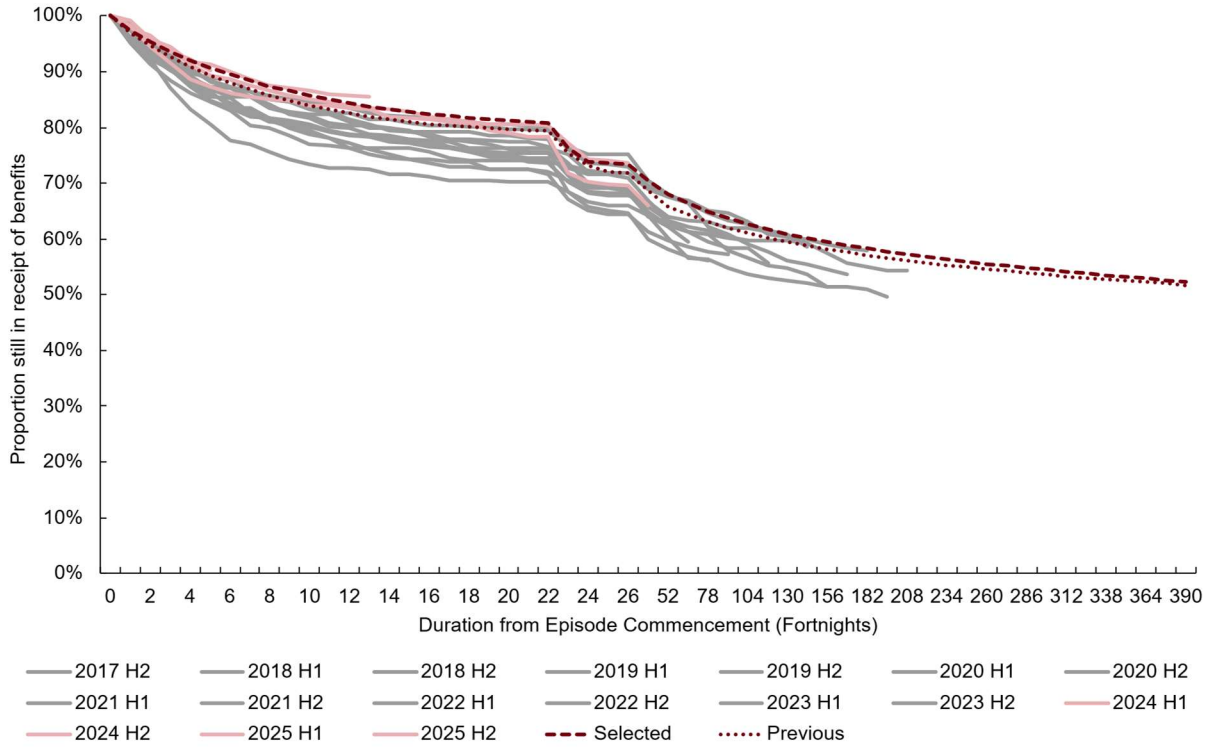


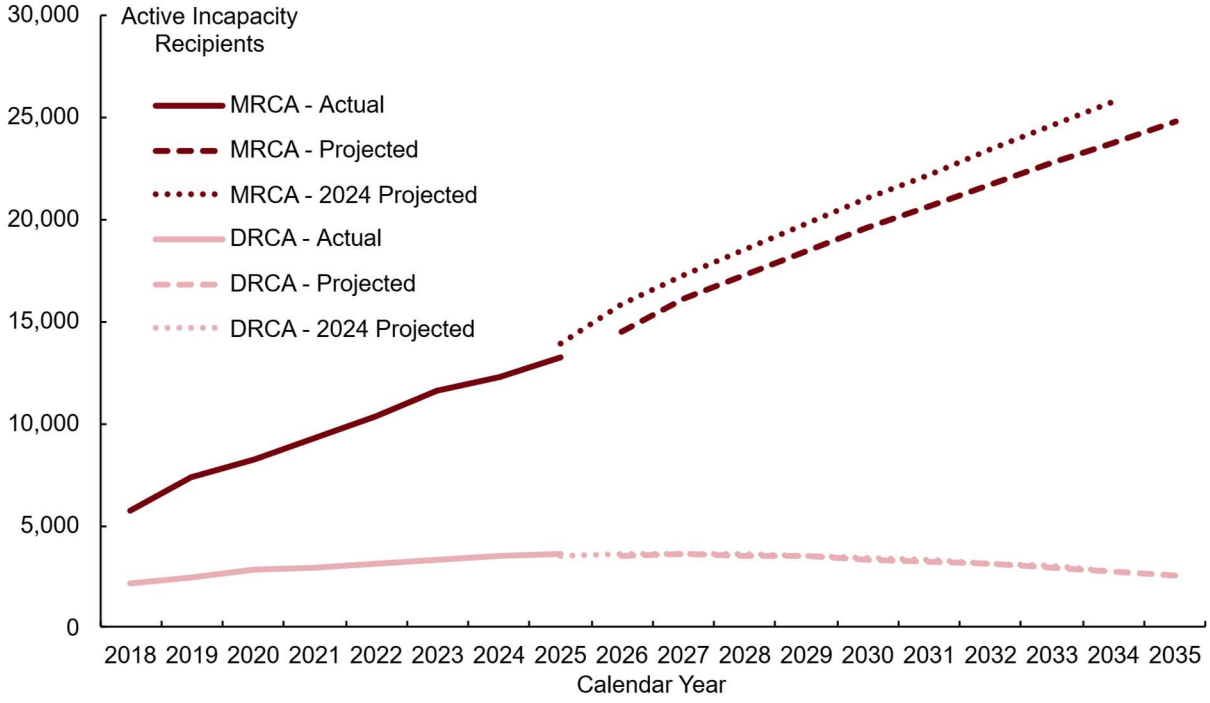
Figure 8.11: Incapacity Survival Curves – Greater Than 49 years Old at Episode Commencement



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 half year 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 for MRCA are lower than that from the previous valuation, due to fewer than expected new incapacity commencements in 2025 and lower projected IL completions. DRCA projections remain similar to results from the previous valuation.

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 by age band since 2018, along with the selected fortnightly payment rates. Note that historical payment rates have been inflated to 2026 dollars in line with the indexation of ADF salaries.

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

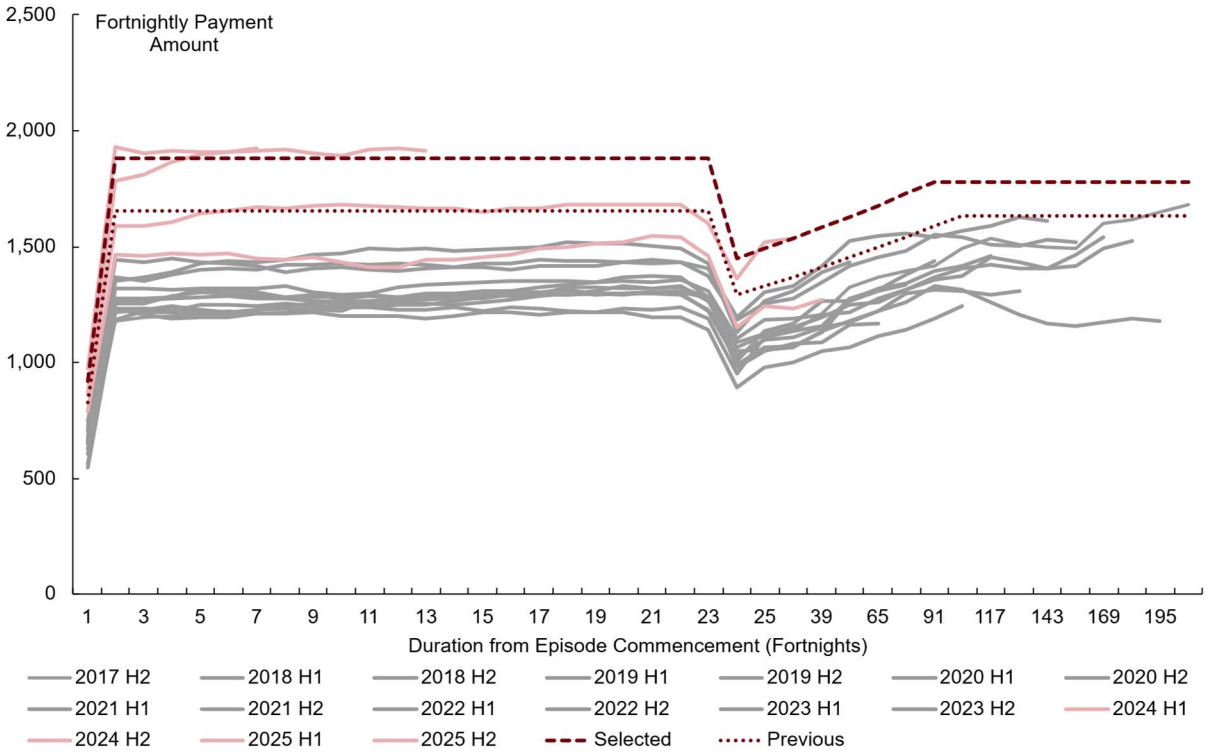


Figure 8.14: Incapacity Payment Rates – 35 to 49 years Old at Episode Commencement

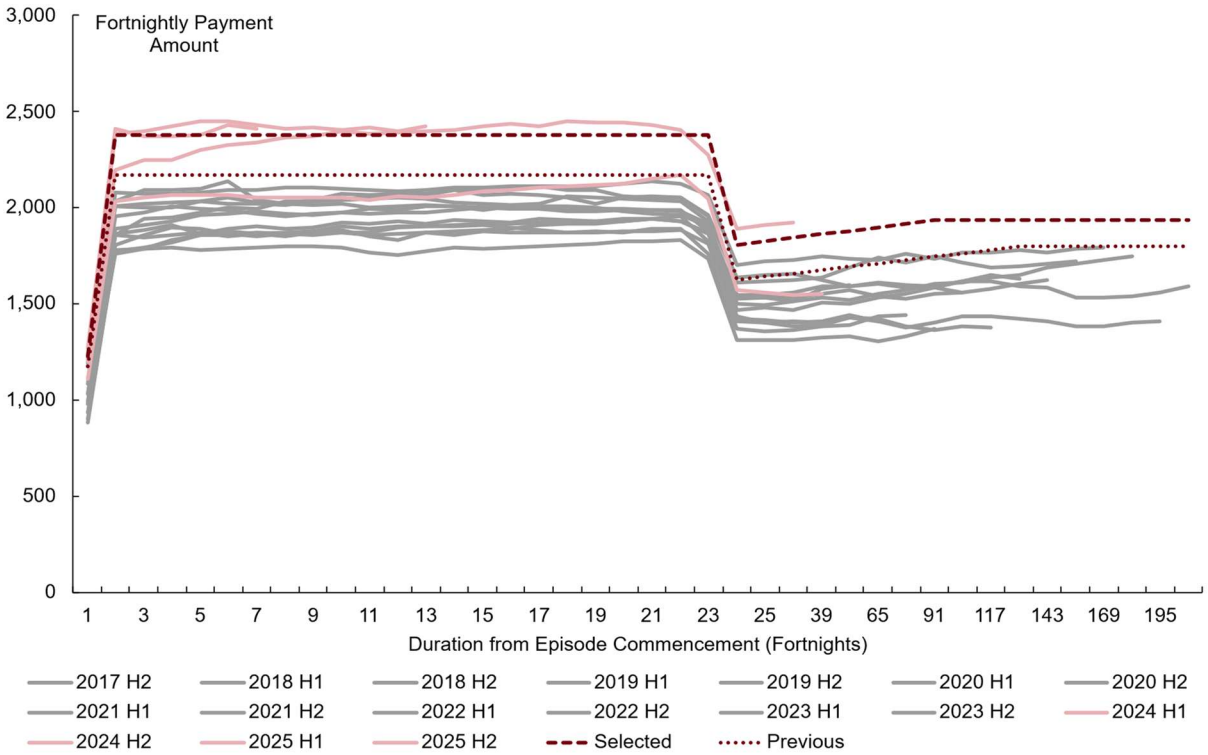
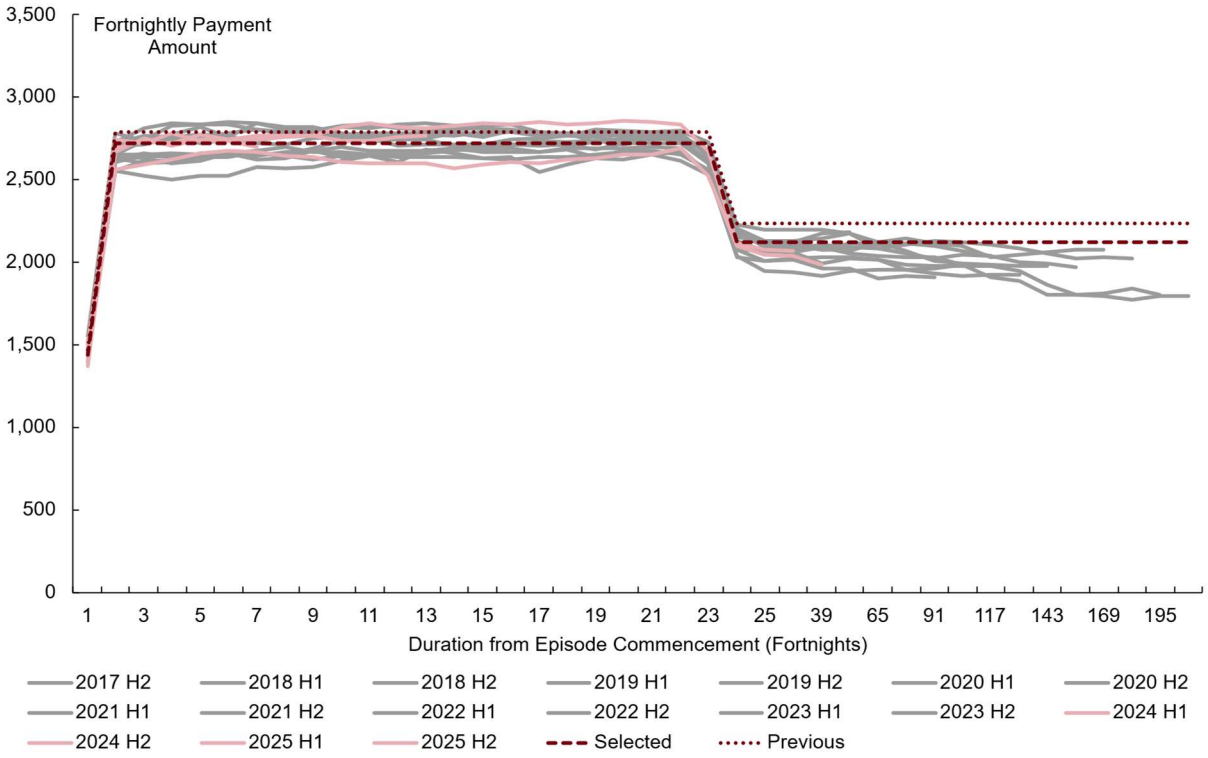


Figure 8.15: Incapacity Payment Rates – Greater Than 49 years Old at Episode Commencement



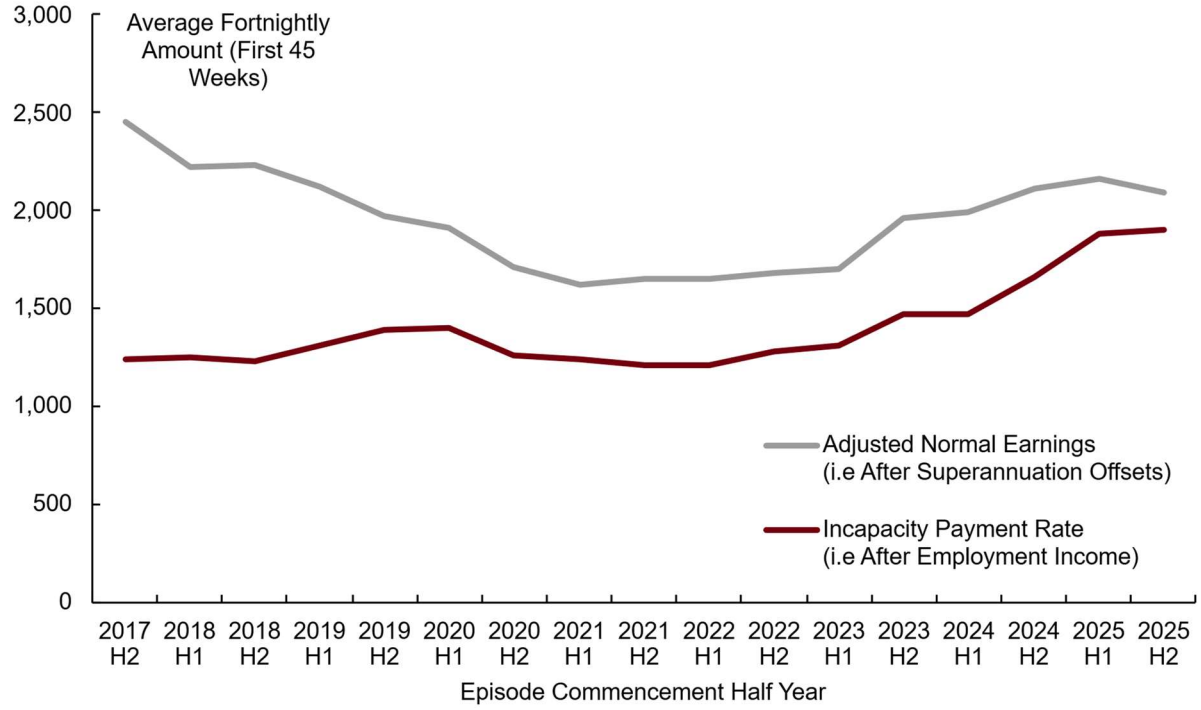
8.5.3 The payment rates in the first fortnight are around half of that of the second fortnight, as episodes commence in the middle of a pay cycle on average. Payment rates are then relatively stable until 45 weeks when the income replacement rate decreases from 100 per cent to between 75 per cent and 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 with duration on benefit. 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 50 at episode commencement. Further investigations indicated that this is explained by two factors. The first is a decline in the number of incapacity recipients earning employment income, which would otherwise be offset against their incapacity payments. The second factor is a reduction in the amount of offsets seen from superannuation benefits, potentially reflecting lower levels of impairment assessed under the superannuation schemes and the mix of Class A and B Invalidity pensions being awarded.

8.5.5 Figure 8.16 below shows the average fortnightly adjusted normal earnings and Incapacity payment rates across the first 45 weeks of incapacity episodes for veterans under the age of 50 at episode commencement by episode commencement half year. An increase in adjusted normal earnings (due to a reduction in the amount of offsets seen from superannuation) and

Incapacity payment rates (due to a reduction in employment income offsets) can be observed for recent episode commencements.

Figure 8.16: Average Adjusted Normal Earnings and Incapacity Payment Rates for the First 45 Weeks – Less Than 50 years Old at Episode Commencement



8.5.6 The decline in incapacity recipients earning employment income is a concerning 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. 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.

8.5.7 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 of 3.7 per cent per annum.

8.5.8 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 grandparented group in the legislation whereby they can remain on incapacity payments beyond the retirement age.

8.5.9 We have modelled the DRCA lifetime entitlement (currently 19 recipients) and MRCA SRDP (currently 212 recipients) populations using an annuity model. We have made an allowance for future SRDP entrants to emerge, assuming that 2 per cent of future incapacity entrants will

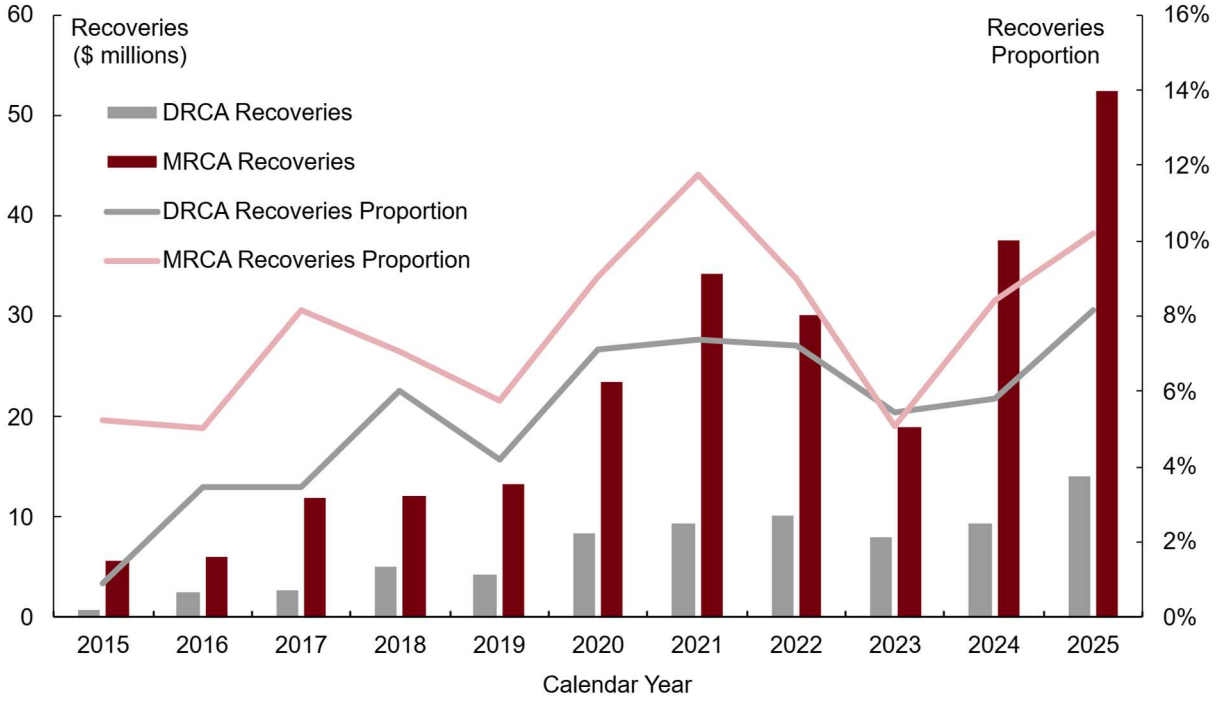
elect to receive SRDP. We have also assumed that future SRDP entrants will have the same accident year distribution and average age as incapacity new entrants. While these payments cease if the recipient no longer meets the eligibility criteria, we believe that this is unlikely due to the high levels 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.

8.5.10 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 $820 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 10 per cent of veterans that receive financial advice will elect to receive SRDP payments and that the average cost of financial advice is $3,000.

8.5.11 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.

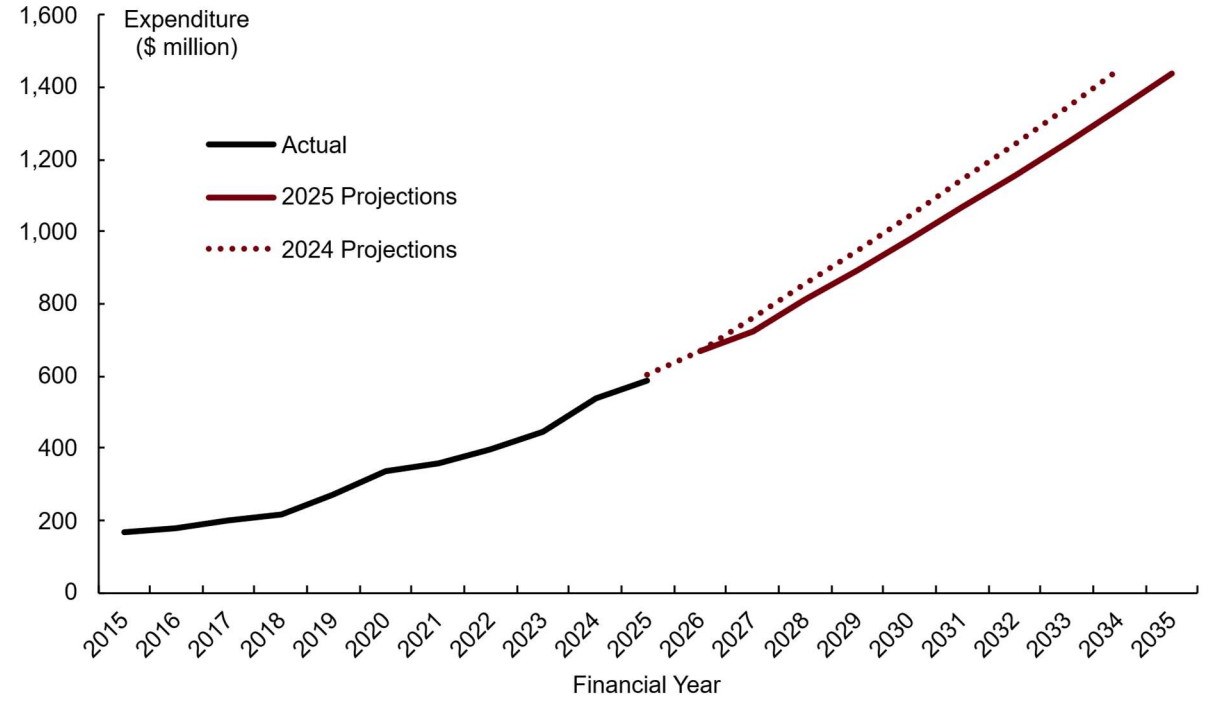
8.5.12 We received unit record incapacity repayments data that sets out the repayment date and amount received by DVA. Figure 8.17 shows the amount of incapacity recoveries received since 2015, for DRCA and MRCA. Recoveries received are quite volatile from year to year. For this valuation, we have selected a recoveries rate of 7 per cent and 8 per cent for DRCA and MRCA respectively.

Figure 8.17: Incapacity Debt Recoveries



8.5.13 Combining these assumptions with the active claimant projection yields the projection of cashflows shown in Figure 8.18 for DRCA and MRCA. The projections from the previous year's valuation are included for comparison. The projected payments are net of any repayments made as a result of superannuation offsets or other debt recoveries, and before the impact of the VETS Act has been considered.

Figure 8.18: Historic and Projected Incapacity Payments



8.6 Impact of the VETS Act – DRCA Veterans

8.6.1 From 1 July 2026, veterans in receipt of DRCA incapacity payments will automatically have their incapacity payments transferred to the MRCA. There are three main differences in how incapacity payment rates are calculated under the MRCA and the DRCA.

8.6.2 Firstly, under the MRCA, incapacity payments are based on current military salaries for the eligible rank and pay level, whereas DRCA uses the member's salary at discharge, adjusted for growth in the Wage Price Index, as the basis for calculating incapacity payments.

8.6.3 Secondly, there are differences in how Commonwealth superannuation benefits are offset against incapacity payment rates. The DRCA deducts a notional superannuation contribution amount of 5 per cent from normal weekly earnings where the veteran is in receipt of a superannuation pension. MRCA does not deduct a notional superannuation contribution amount from normal earnings. The offsetting of Commonwealth superannuation lump sum benefits is also different under the MRCA. Under the DRCA, Commonwealth superannuation lump sum amounts are offset from DRCA incapacity payments using a formula based on a specified interest rate, which is currently 4.29 per cent. Under the MRCA, the conversion of lump sum superannuation benefits is calculated using actuarial factors based on the veteran's gender and age at the time of receipt of the payment.

8.6.4 Lastly, MRCA includes a remuneration loading on top of base salaries for members and former members with permanent service or continuous full-time reservist service to compensate for the loss of non-salary benefits a person receives while serving in the ADF. The DRCA does not include any loading to compensate for non-salary benefits. The remuneration loading is currently $396 per fortnight.

8.6.5 To estimate the impact of DRCA incapacity payments being transferred to the MRCA, we received additional variables identifying each veteran's rank, pay group, normal earnings, actual earnings and any Commonwealth superannuation offsets. Using these variables, we were able to replicate the calculation of incapacity payments for over 99 per cent of incapacity recipients in the data as at 31 December 2025.

8.6.6 Firstly, normal earnings for existing DRCA incapacity recipients were recalculated using the MRCA calculation methodology. Current military salaries for each rank and pay group were determined with reference to *Defence Force Remuneration Tribunal Determination No. 11 of 2025, ADF Workplace Remuneration Arrangement 2023-2026*, and the MRCA incapacity remuneration loading was applied at the current rate of $396 per fortnight. Where the relevant salary could not be determined, or where the rank and/or pay group information was missing, the average increase in normal earnings was applied. As it was not possible to identify veterans with permanent or continuous full-time reservist service, all DRCA veterans were assumed to receive the remuneration loading.

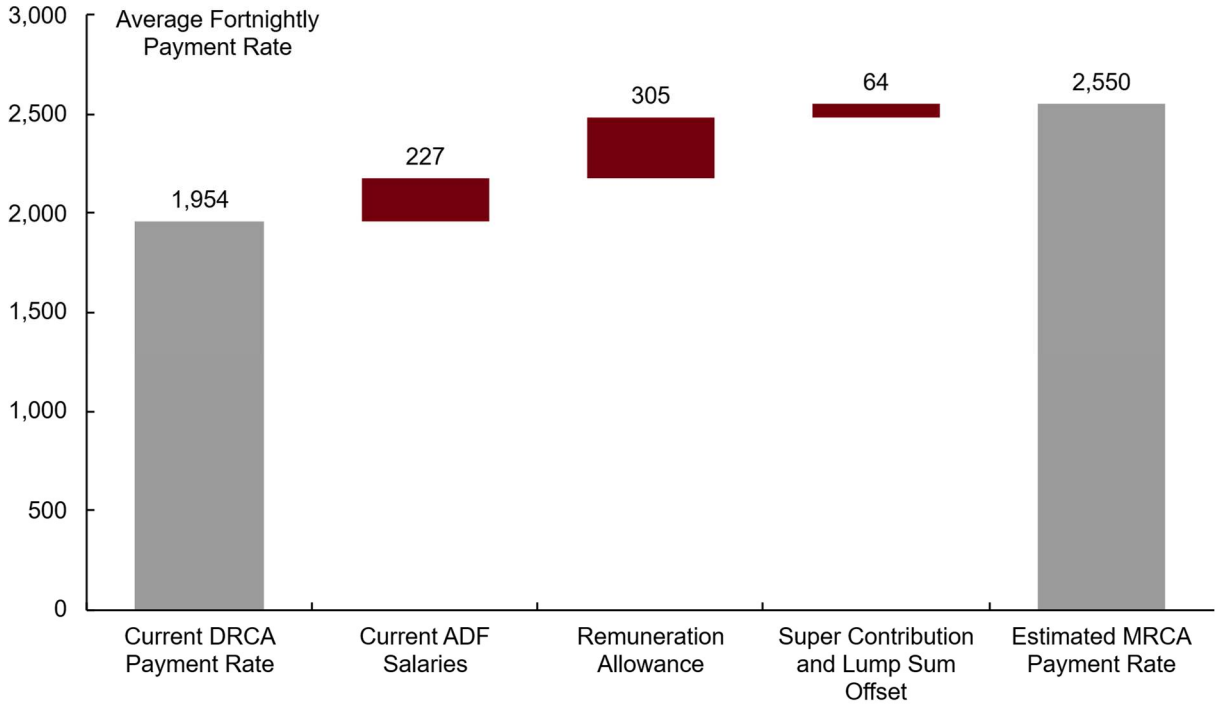
8.6.7 The calculation of normal earnings includes a component for compensation for lost allowances, reflecting allowances that the member was receiving prior to the injury. We were unable to identify, from the data provided, which DRCA veterans have normal earnings amounts that include compensation for lost allowances and therefore could not account for this component when calculating normal earnings under MRCA. Based on discussions with DVA incapacity processing delegates, we understand that most allowances do not continue indefinitely. As such, this simplification is not expected to have a material impact on the

projections, as most DRCA veterans are likely to have separated from Defence several years ago.

8.6.8 To reflect the change in how Commonwealth superannuation lump sum payments are offset under MRCA, we derived the implied lump sum payment amount from the current deductions applied under DRCA (using the specified interest rate) and then calculated the equivalent MRCA deduction using the actuarial factors. The actuarial factor depends on the veteran's age at the time the superannuation lump sum was received; however, this information is not available in the data. As such, we assumed an average age based on the age at which veterans commenced their current incapacity episode. The notional 5 per cent superannuation contribution reduction was also removed when calculating the adjusted normal earnings under MRCA

8.6.9 Figure 8.19 below shows the average incapacity payment rate for current DRCA recipients under the current legislation and the estimated average payment rate from 1 July 2026. The addition of the remuneration loading is expected to have the largest impact on incapacity payment rates for DRCA veterans, followed by changes to the salaries used to calculate normal earnings. The changes to the treatment of superannuation are anticipated to have a modest impact. We have increased the projected payment rates for existing and future DRCA incapacity recipients by 31 per cent from 1 July 2026 onwards, based on the average percentage increase shown in Figure 8.19.

Figure 8.19: Average Incapacity fortnightly payment rates under DRCA and MRCA



8.7 Impact of the VETS Act – VEA Veterans

8.7.1 Veterans with eligibility under the VEA will gain access to Incapacity compensation payments for the first time from 1 July 2026 as a result of the VETS Act.

8.7.2 We have first estimated the number of VEA veterans currently receiving Disability Compensation Payment (DCP) that may be eligible for incapacity benefits under the MRCA from 1 July 2026. For the existing DCP recipient population, we have considered the age profile (as Incapacity benefits cease at retirement age) and any existing eligibility under MRCA and/or DRCA (as these veterans already have access to incapacity benefits and are not gaining new eligibility under the VETS Act). To estimate the proportion of these veterans that may access incapacity benefits, we have compared the DRCA 'compensation' (that is, veterans with an accepted PI claim) and incapacity populations and assumed incapacity take-up rates that vary by age.

8.7.3 We have also considered veterans that are not currently receiving DCP but would have otherwise lodged DCP claims in the future. These veterans will instead be eligible for MRCA PI and MRCA Incapacity from 1 July 2026. For this group, we have referred to the VEA PI claimant projections discussed in Section 6.10 and assumed a proportion of these veterans will be eligible for MRCA Incapacity, based on the DRCA experience.

8.7.4 Overall, these assumptions result in 927 new Incapacity claims from current DCP recipients being lodged following the legislation reforms and that these veterans will commence Incapacity during the 2027 financial year. For the 2,395 new Incapacity claims from VEA veterans not receiving DCP, we have assumed these veterans will commence Incapacity payments in the same year as they receive their MRCA PI payment. We have assumed these veterans will be subject to the same average size and exit rates as DRCA veterans.

8.7.5 It is important to note that MRCA Incapacity compensation for the same incapacity must be offset against the amount of pension paid under the VEA. This means that the costs set out in the section are not entirely 'new' costs and may be offset to some extent by reductions applied to DCP payment rates.

8.8 Liability Estimate

8.8.1 Table 8.1 shows the current estimate of the liability broken down by year of accident. The estimated liability values, gross of recoveries, have also been included. In the 2024 valuation, we projected a liability as at 30 June 2025 of $15,829.7m. The revised estimate of the liability is $14,461.2m before the VETS Act, which is $1,368.4m lower than projected. The liability at 30 June 2025 after the VETS Act is $15,771.4m. Table 8.2 provides a reconciliation between the liability estimate as at 30 June 2024 and the current estimate at 30 June 2025.

Table 8.1: Outstanding Claims Liability as at 30 June 2025

	Liability ($m)		
Year of accident	**DRCA**	**MRCA**	**Total**
1989 and before	131.6	-	131.6
1990 – 1994	302.8	-	302.8
1995 – 1999	736.3	-	736.3
2000 – 2004	755.8	-	755.8
2005 – 2009	-	841.7	841.7
2010 – 2014	-	2,144.4	2,144.4
2015 – 2019	-	3,778.5	3,778.5
2020 – 2024	-	4,773.5	4,773.5
2025	-	996.7	996.7
Total (before VETS Act)	**1,926.4**	**12,534.8**	**14,461.2**
Total (before VETS Act, gross of recoveries)	2,071.4	13,624.8	15,696.2
VETS Act Impact – DRCA Veterans	(1,767.4)	2,306.8	539.3
VETS Act Impact – VEA Veterans	-	770.9	770.9
Total (after VETS Act)	**159.0**	**15,612.4**	**15,771.4**
Total (after VETS Act, gross of recoveries)	170.9	16,970.0	17,141.0

Table 8.2: Reconciliation of Liability Estimates for Incapacity Payments

	DRCA	MRCA	Total
Liability estimate as at 30 June 2024 (previous valuation)	2,059.1	12,455.9	14,515.0
Assumed interest	99.2	640.8	739.9
Notional premium	-	1,176.8	1,176.8
Projected payments	(153.0)	(449.1)	(602.1)
Liability estimate as at 30 June 2025 (previous valuation)	2,005.3	13,824.3	15,829.7
Experience effects and assumption changes			
Change due to experience	(10.0)	(142.8)	(152.7)
Change due to new entrant projection	(15.2)	(1,045.6)	(1,060.8)
Change due to continuance probabilities	1.6	(237.6)	(236.0)
Change due to payment rates	(34.7)	272.7	238.1
Change due to recoveries assumption	(20.7)	(136.2)	(157.0)
Liability at 30 June 2025 (before VETS Act)	**1,926.4**	**12,534.8**	**14,461.2**
Change due to VETS Act	(1,767.4)	3,077.6	1,310.2
Liability at 30 June 2025 (after VETS Act)	**159.0**	**15,612.4**	**15,771.4**

9 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 separates from the ADF[5]. 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; reimbursed travel for treatment; and medical aids and appliances[6].

9.1.2 Veterans entitled to medical benefits under MRCA are issued with one of two types of medical treatment cards. The Specific Conditions Treatment Card (previously referred to as 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 All Conditions Treatment Card (previously referred to as the 'Gold Card') provides veterans with entitlement to clinically required treatment for all medical conditions, regardless of whether the condition is related to ADF service. Veterans may also receive reimbursements for medical expenses privately incurred.

9.1.3 Veterans may receive a MRCA All Conditions Treatment 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 an All Conditions Treatment Card.

9.1.5 Specific Conditions Treatment Cards and All Conditions Treatment Cards are also available under the VEA, but only Specific Conditions Treatment Cards are currently available for DRCA veterans. From 1 July 2026, DRCA veterans could gain access to the All Conditions Treatment Card, subject to meeting the conditions for assessment under the VETS Act and the MRCA eligibility criteria.

9.1.6 AGA does not estimate a liability provision for the VEA. However, from 1 July 2026, new claims for compensation will be assessed under the MRCA. As such, existing VEA Specific Conditions Treatment Card and All Conditions Treatment Card holders may gain eligibility for a MRCA Specific Conditions Treatment Card or All Conditions Treatment Card following this date. Due to the legislated hierarchy for cost allocation, VEA cards are superseded by MRCA cards and thus this group must be provisioned for in the MCS liability under the MRCA.

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

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

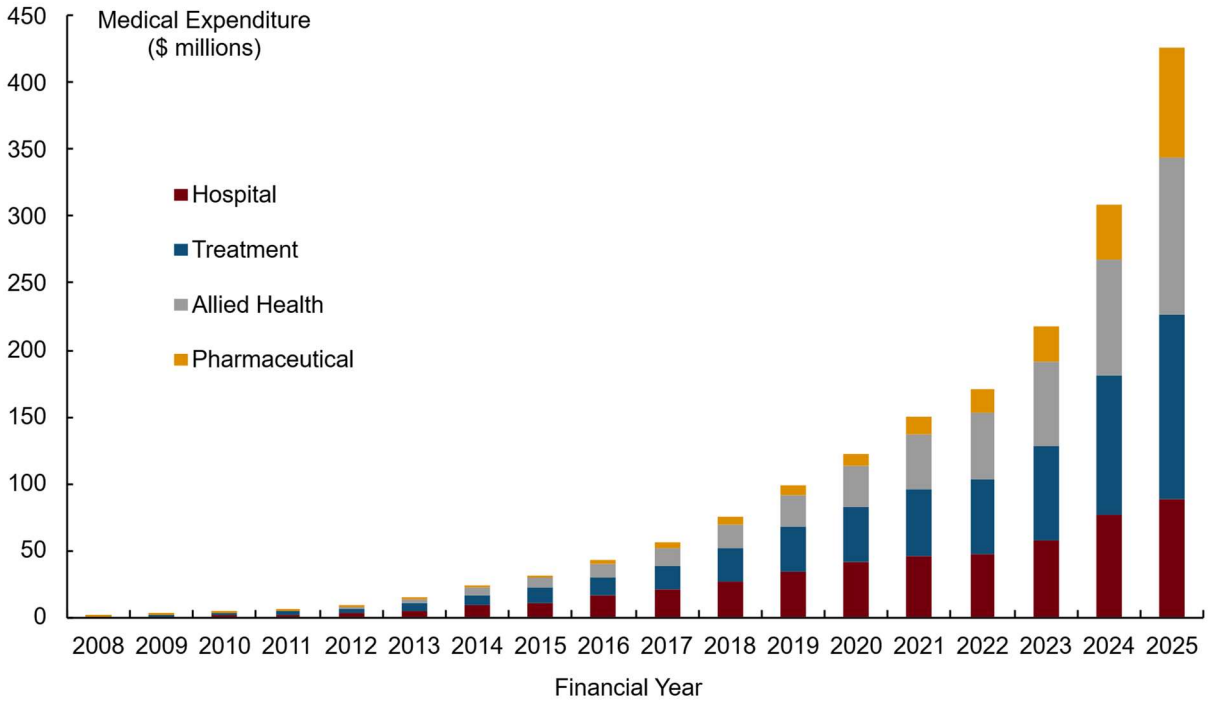
9.1.7 From 1 July 2026, all treatment-related travel reimbursement claims will be paid under the MRCA. While travel for treatment is available under all three Acts, the eligibility criteria and level of entitlements differ. The VETS Act standardised these entitlements under the MRCA.

9.1.8 These changes are discussed in more detail in the following sections.

9.2 Recent Experience

9.2.1 Figure 9.1 shows MRCA expenditure by service category, namely hospital[7], treatment (including GP, specialist consultations and travel reimbursements for medical appointments), allied health and pharmaceutical. 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 38 per cent in the latest financial year. The largest proportional increase was in pharmaceutical benefits, where expenditure doubled from 2024 to 2025. The significant growth in pharmaceutical expenditure as a proportion of total medical expenditure has been driven by increased take-up of medicinal cannabis for treatment of chronic pain amongst veterans.

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. All Conditions Treatment Cards originally contributed a relatively small proportion to overall MRCA Medical outlays. Since 2013 however, expenditure arising from All Conditions Treatment Cards has exhibited substantial growth, reaching 78 per cent of MRCA medical outlays in the 2025 financial year. Figure 9.3 provides further insights into the experience over this period. The proportion of medical claimants with an All Conditions Treatment Card increased gradually from 2010 to

[7] Please note that MRCA public hospital costs are not included in these amounts. This is discussed further in Section 9.5.

2017, with growth accelerating from 2017 onwards. In the most recent financial year, around 48 per cent of claimants accessing medical benefits had an All Conditions Treatment Card.

Figure 9.2: MRCA Medical Expenditure by Card Type

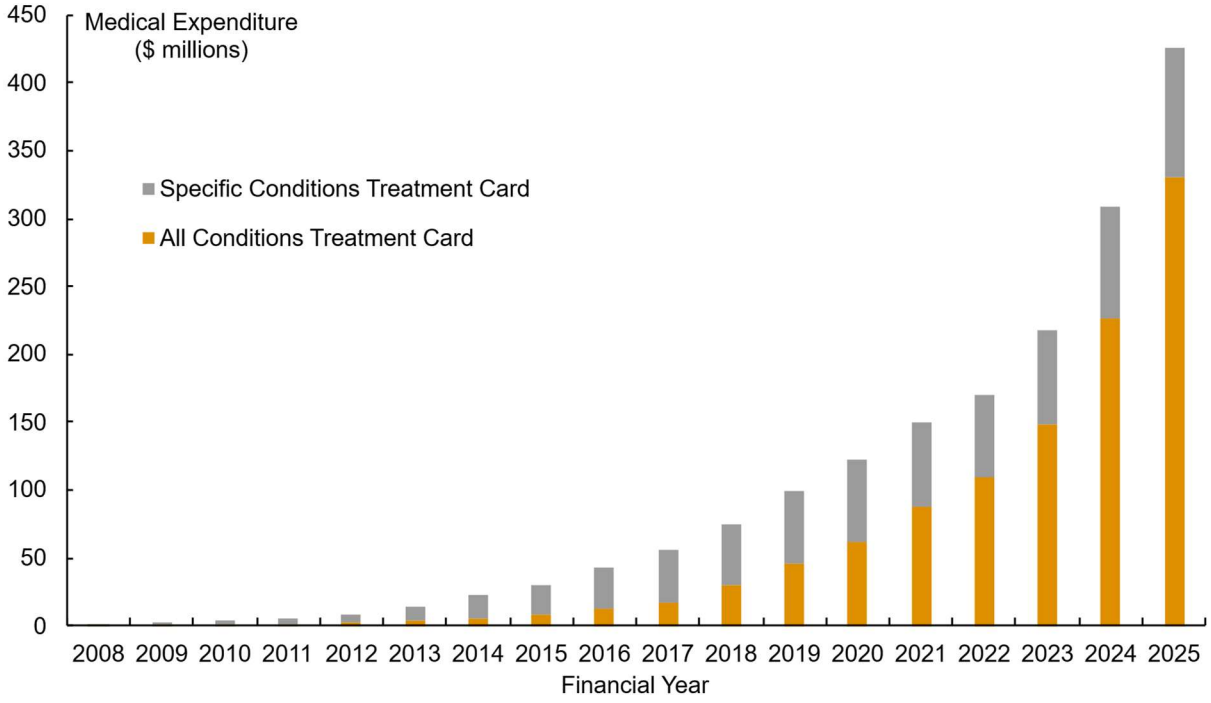
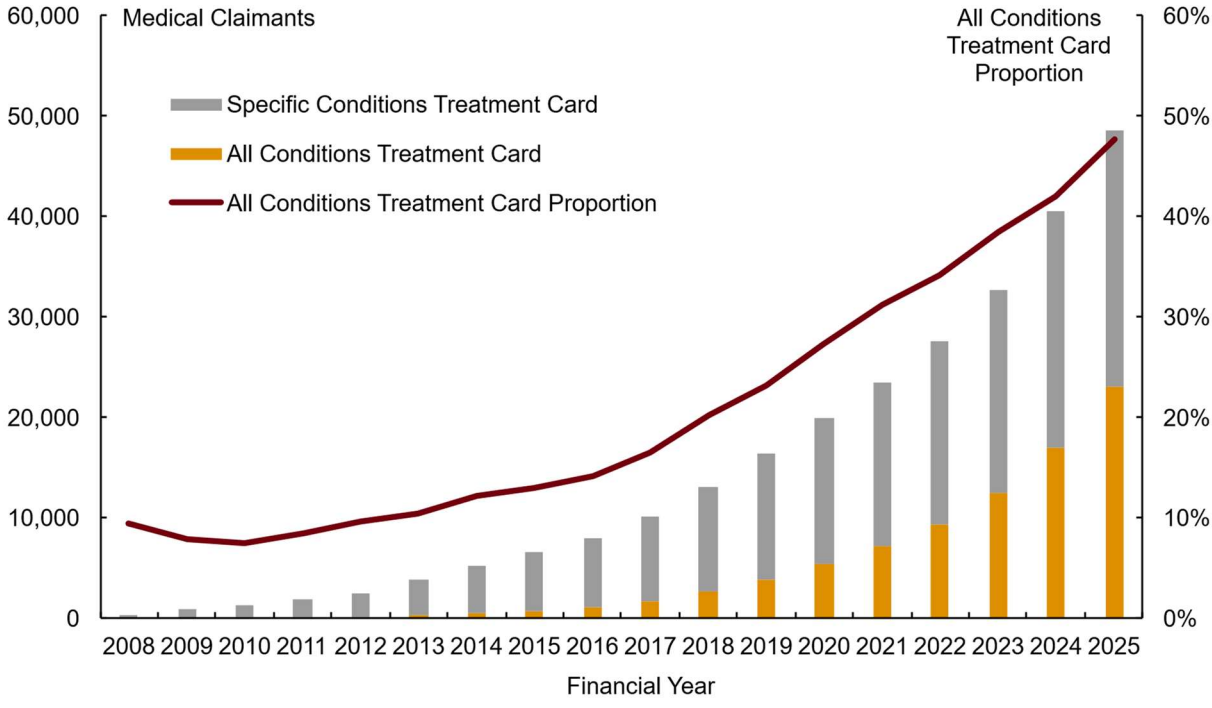


Figure 9.3: MRCA Medical Claimants by Card Type



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 assumed average cost per active medical claimant considers the age of the veteran as well as the card type.

9.3.2 Historically, we did not make a distinction between All Conditions Treatment Card and Specific Conditions Treatment 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 All Conditions Treatment 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 All Conditions Treatment 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 Specific Conditions Treatment Card and All Conditions Treatment Card holders including card issue dates. This data allowed us to investigate the experience of Specific Conditions Treatment Card and All Conditions Treatment Card holders separately. Experience varies substantially by card type, reflecting not only the expanded range of benefits available under an All Conditions Treatment Card, but also the higher levels of impairment associated with All Conditions Treatment Card eligibility. The average size across all age groups is higher for veterans with All Conditions Treatment Card entitlements, and claimants with All Conditions Treatment 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 All Conditions Treatment 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 this valuation and have continued to explicitly model both Specific Conditions Treatment Card and All Conditions Treatment Card holders in the valuation.

9.3.5 We have continued to assign 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. 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, the data does not record the particular condition to which a service relates. For those with All Conditions Treatment 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.

9.3.6 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);
- All Conditions Treatment Card issuance rates (to determine the proportion of veterans with All Conditions Treatment 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).

9.3.7 Combining the existing medical claimant population, the projection of future medical entrants, the All Conditions Treatment 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 (hereafter referred to as the development year). Figure 9.5 shows the relationship between the number of IL claims accepted and the number of new medical claimants over time, which has stabilised at around 30 per cent over the last few years. Veterans must first have liability accepted for their conditions before they are entitled to medical benefits[8].

[8] This is largely the case for medical benefits under the Specific Conditions Treatment Card and All Conditions Treatment 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.

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

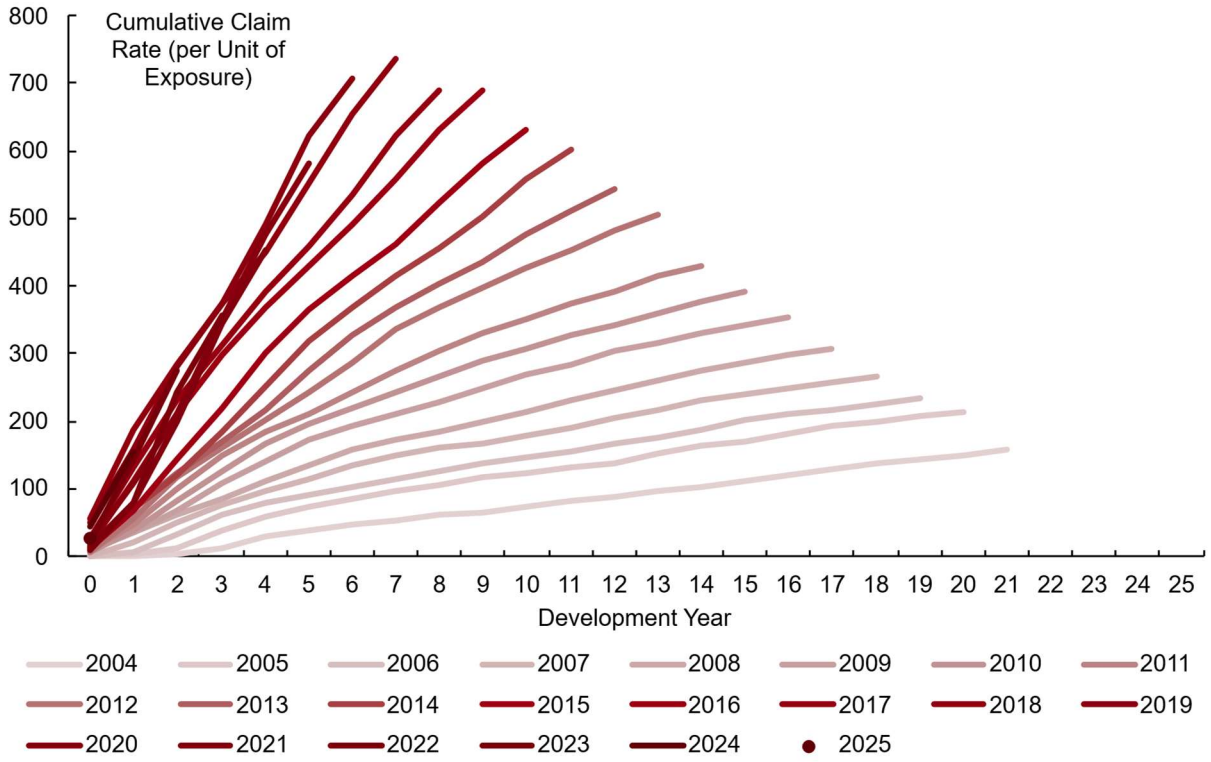
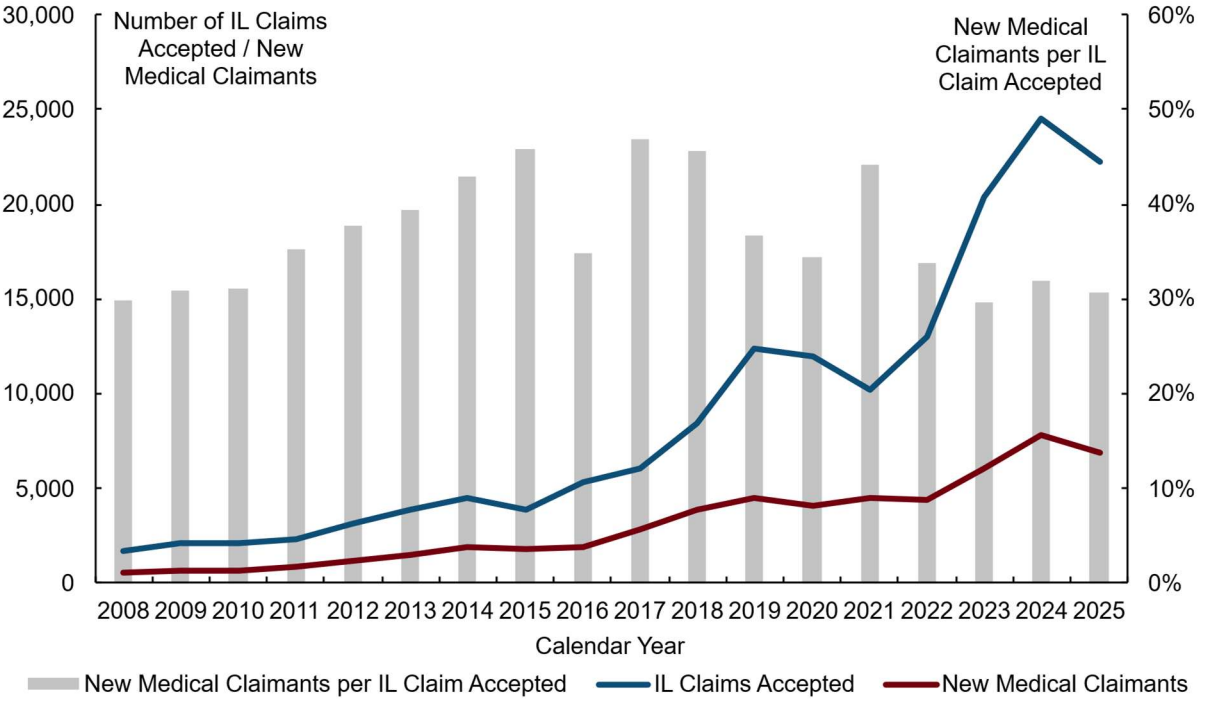


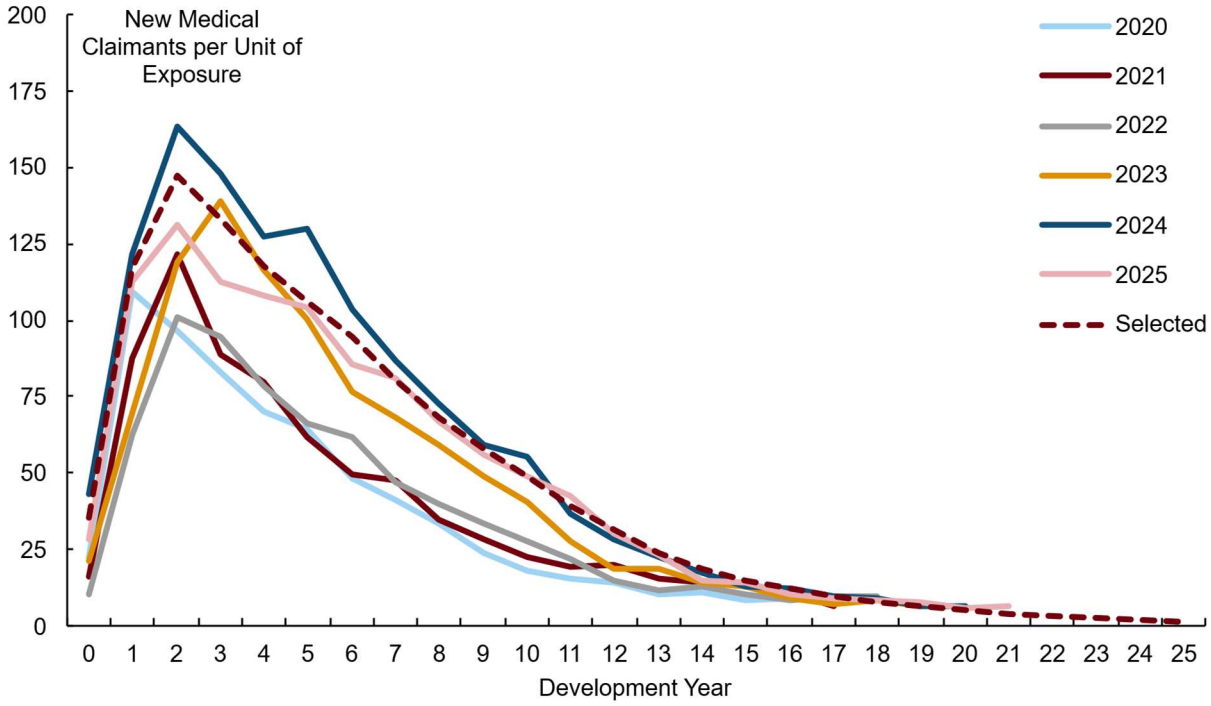
Figure 9.5: Number of New Medical Claimants and IL Claims Accepted



9.4.2 The pattern of claims emerging has changed considerably since the commencement of MRCA. For more recent accident years, a greater number of claimants are emerging within a few years of their initial injury, while older accident years continue to have new claimants emerging many years after injury.

9.4.3 These shifts are likely driven by changes in claimant behaviour and administrative processes, resulting in increased claim volumes across all accident years. For older accident years, this may reflect a 'catch-up' effect, where increased awareness and reduced barriers to claim have encouraged more veterans to come forward. For more recent accident years, greater awareness and on-base activity may be leading veterans to seek access earlier than in the past. This may be a 'bring forward' effect where we might expect to see fewer new claimants emerge at longer delays for these compared with older accident years.

Figure 9.6: Incremental New Medical Claimants per Unit of Exposure



9.4.4 We have projected the number of new medical entrants using incremental rates per unit of exposure, where the exposure is defined as the serving population in each year. Figure 9.6 shows the incremental rates of new medical claimants by development year since 2020, along with the selected rates adopted for the valuation. The selected rates are based on the experience over the last three calendar years. The resulting accident year total claimant numbers are shown in Figure 9.7, and Figure 9.8 sets out the calendar year new medical claimant projections along with the implied conversion rate from accepted IL claims.

Figure 9.7: Projected Ultimate Medical Claimants by Accident Year

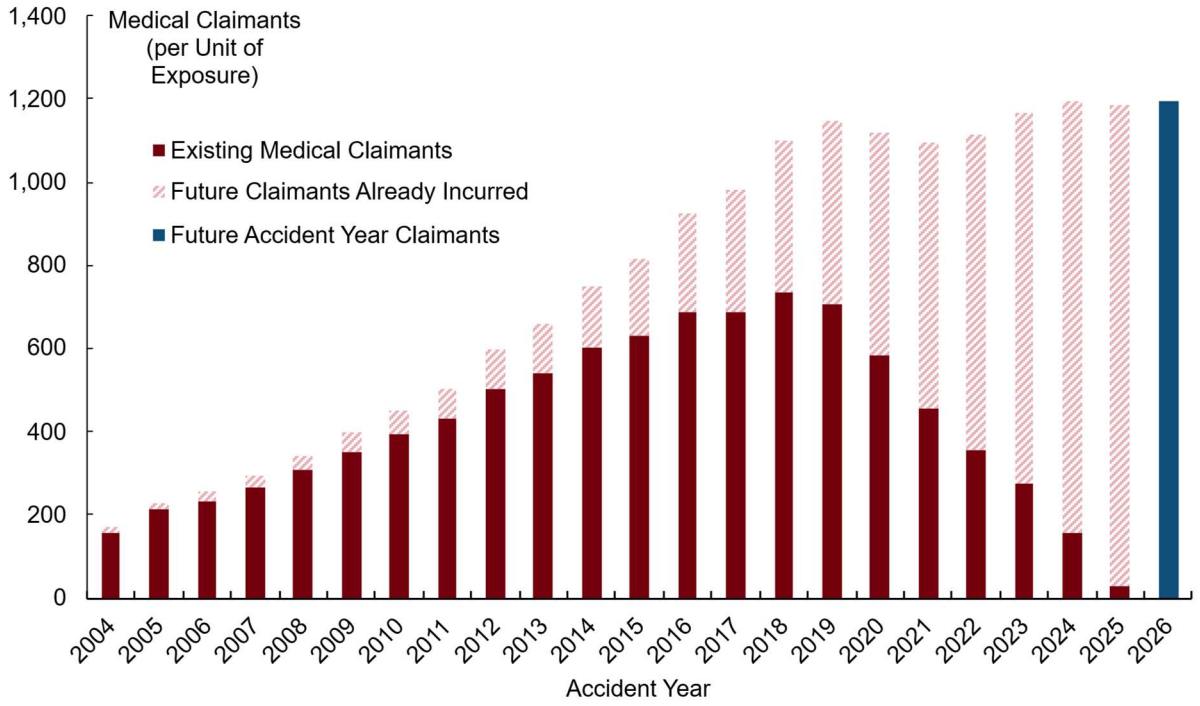
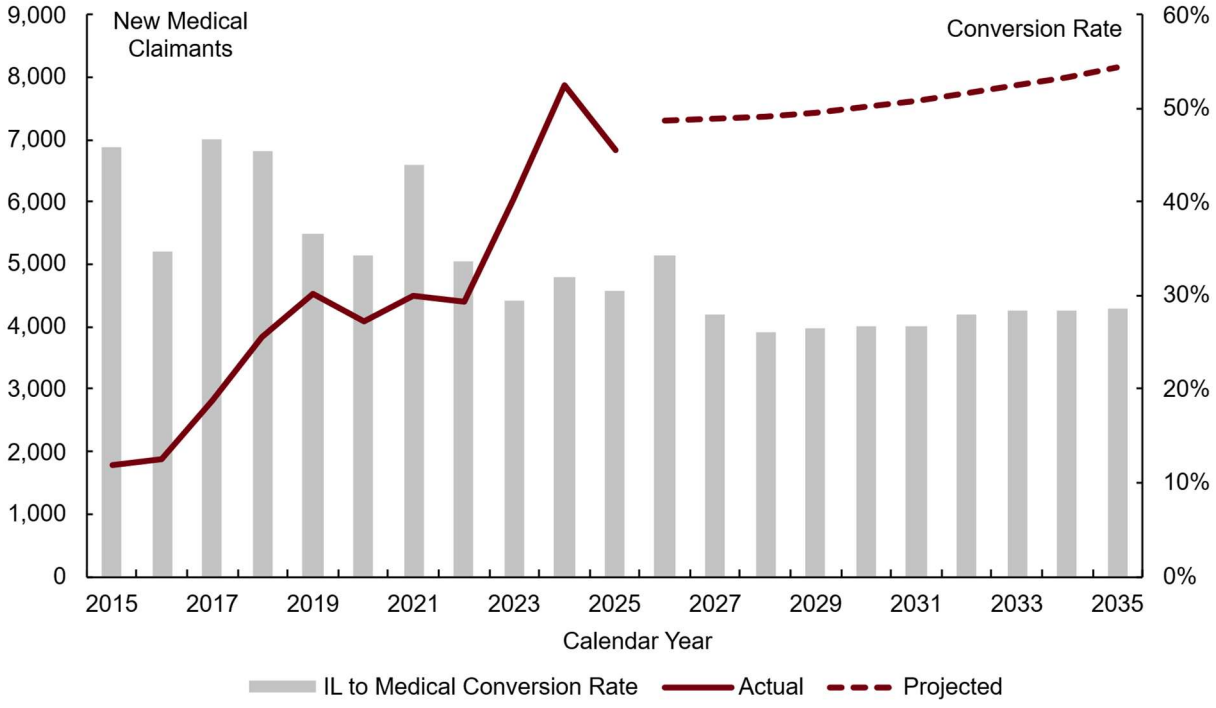


Figure 9.8: Projected New Medical Claimants by Calendar Year

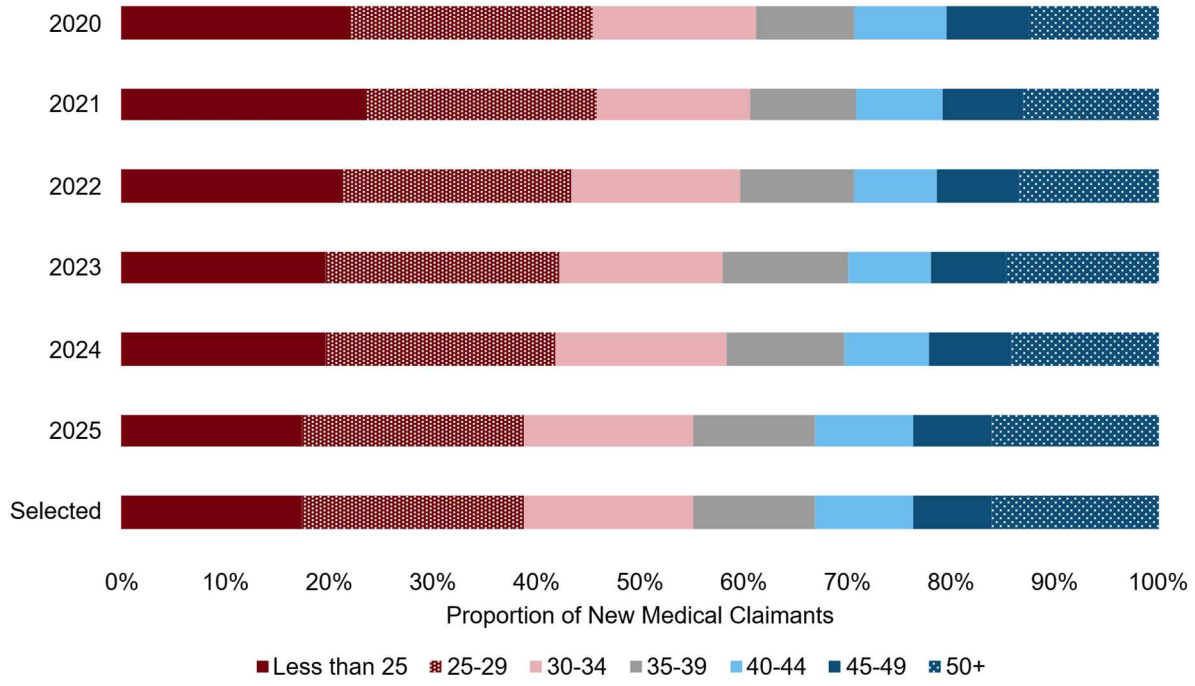


9.4.5 We note that there is a very high level of uncertainty inherent in the medical new entrant projection, and it might be some time before experience is mature enough to set development factors with more certainty. Limitations in the exposure data also hinder any further analysis on potential claimant emergence patterns. For this valuation, we received early engagement model data for the first time. This dataset includes information on veterans and serving members, such as their enlistment and separation dates, as well as mode of exit (e.g. voluntary, involuntary and medical discharge). However, the dataset only included records

from 2019 onwards. Analysis indicated that the data only captures approximately 64 per cent of new medical entrants in 2025, with the remaining 36 per cent assumed to have separated prior to 2019. This limited coverage of new entrants reduces the usability of the data for modelling and, as such, it has not been incorporated into the modelling for this valuation.

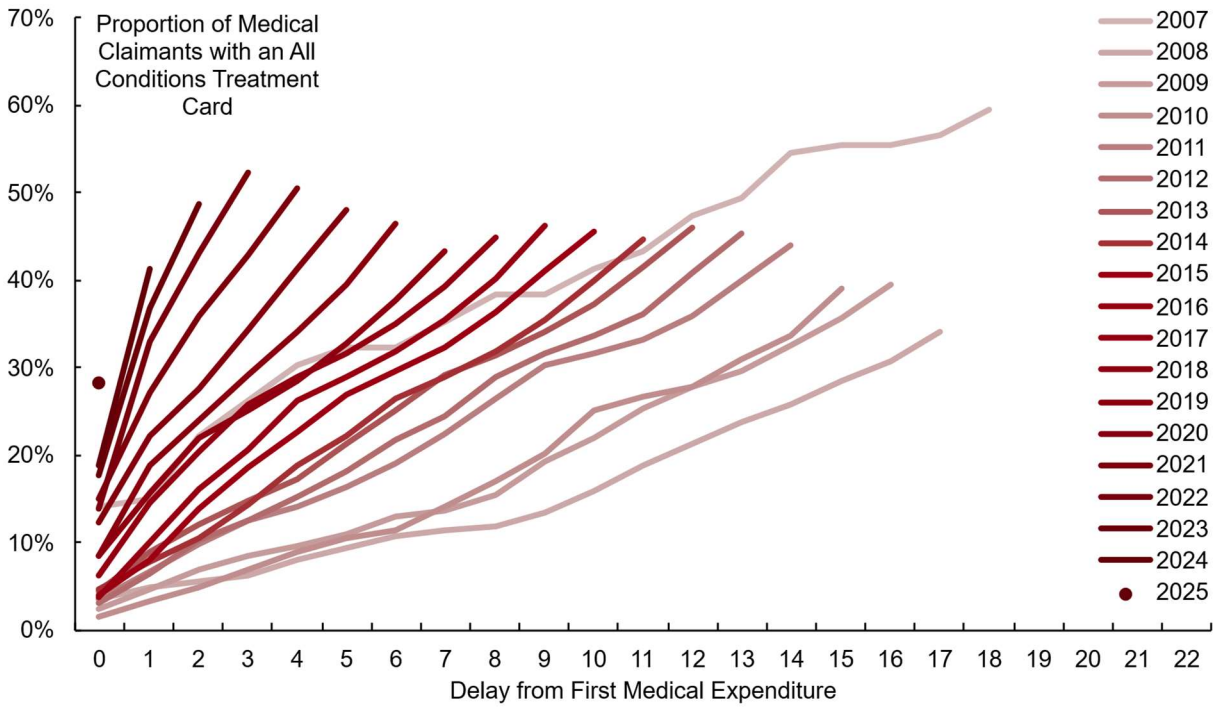
9.4.6 Having projected the number of future medical new entrants, we need to assign an age distribution to new entrants. Figure 9.9 shows the age at injury distribution for veterans first accessing medical benefits in each of the past six calendar years, along with the selected distribution which is based on 2025 experience. 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 9.9: Age at Injury Distribution for New Medical Claimants



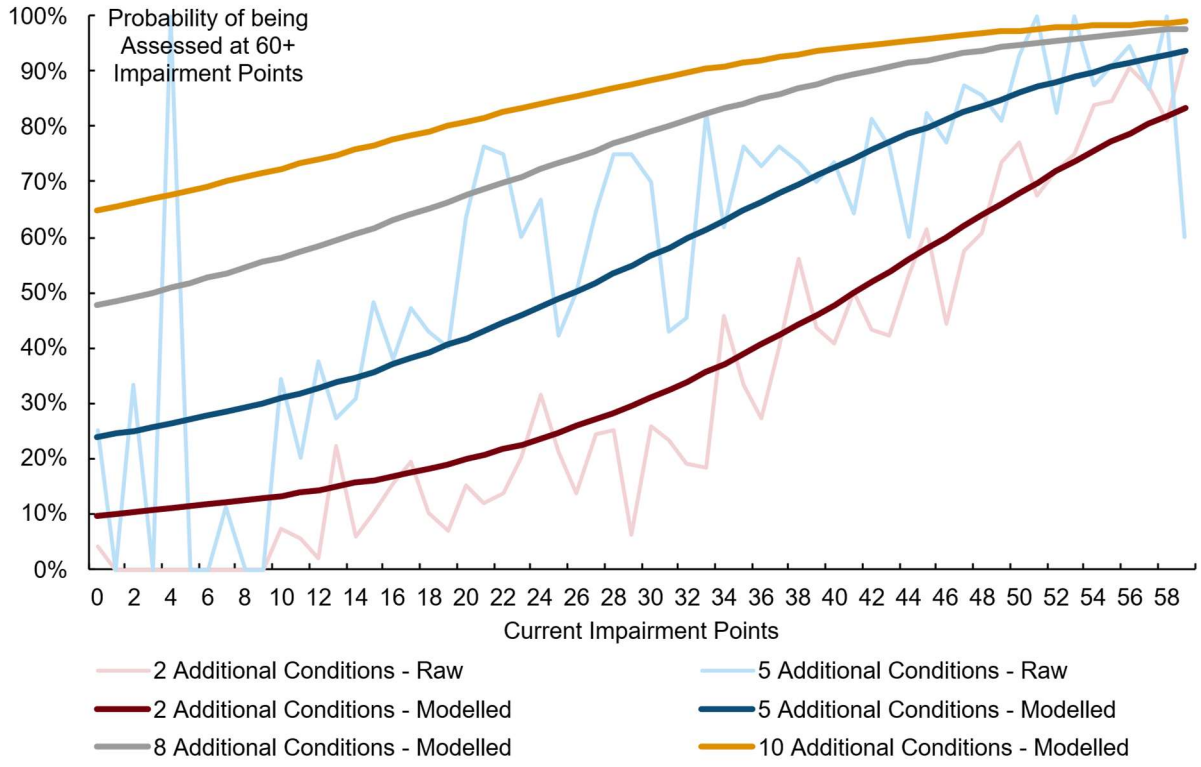
9.4.7 The next component of the model is a projection of the proportion of medical claimants with All Conditions Treatment Cards over time. Figure 9.10 shows the cumulative proportion of medical recipients with an All Conditions Treatment Card by duration from first medical expenditure and entry year cohort. The pattern of progression to All Conditions Treatment Card eligibility has changed considerably over time. Earlier cohorts exhibited relatively low rates of All Conditions Treatment Card eligibility initially, with proportions increasing at later durations. Conversely, more recent cohorts are exhibiting markedly higher rates of All Conditions Treatment Card eligibility at earlier durations. This shift likely reflects policy changes within DVA as well as the significant growth in PI over recent years. A substantial number of veterans received an All Conditions Treatment Card in the last year.

Figure 9.10: Proportion of MRCA Medical Claimants with an All Conditions Treatment Card by Duration from First Medical Expenditure



9.4.8 As with the previous valuation, we conducted additional analysis to attempt 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 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 receiving an assessment of 60 or more impairment points (granting All Conditions Treatment Card eligibility), based on a veteran's current level of impairment and the number of open PI claims and IL conditions, using experience data from the most recent year. Figure 9.11 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 9.11: Probability of Being Assessed at 60 or More Impairment Points

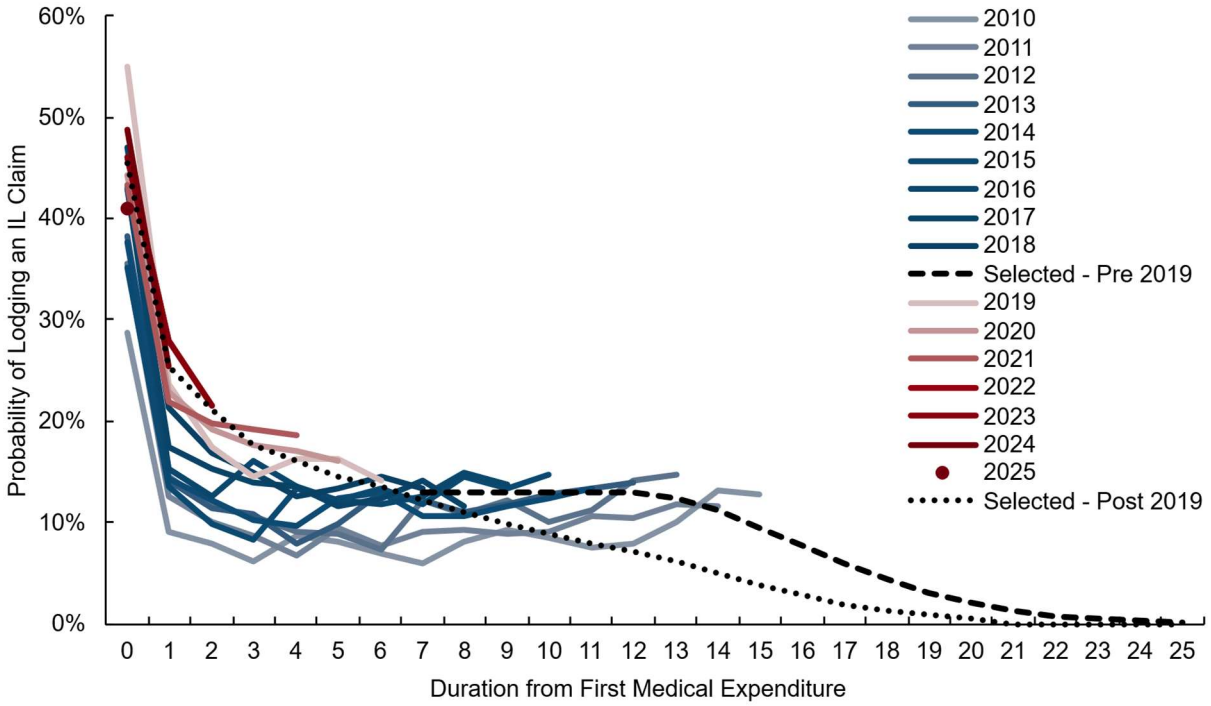


9.4.9 Although the raw data shows some volatility in experience, the resulting fitted probabilities are broadly in line with expectations. That is, higher probabilities are expected of reaching 60 or more impairment points with higher numbers of outstanding PI and/or IL conditions and these probabilities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

9.4.10 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 81 per cent). This yields an estimate of the number of medical claimants expected to reach 60 or more impairment points and thus receive an All Conditions Treatment Card as a result of their lodged IL conditions to date as shown in Figure 9.14 (represented by the blue bars).

9.4.11 In addition, we have attempted to incorporate the potential impact of future IL claims expected to be lodged by these veterans and the flow on impacts to whole person impairment points and All Conditions Treatment Card numbers. We have assumed a probability of lodging IL claims by duration from first medical expenditure and a number of conditions per claim distribution. Figure 9.12 shows the actual and assumed rates of lodging IL claims by duration from first medical experience for Specific Conditions Treatment Card holders. If a veteran has lodged multiple IL claims in the same lodgement year, only one IL claim is counted.

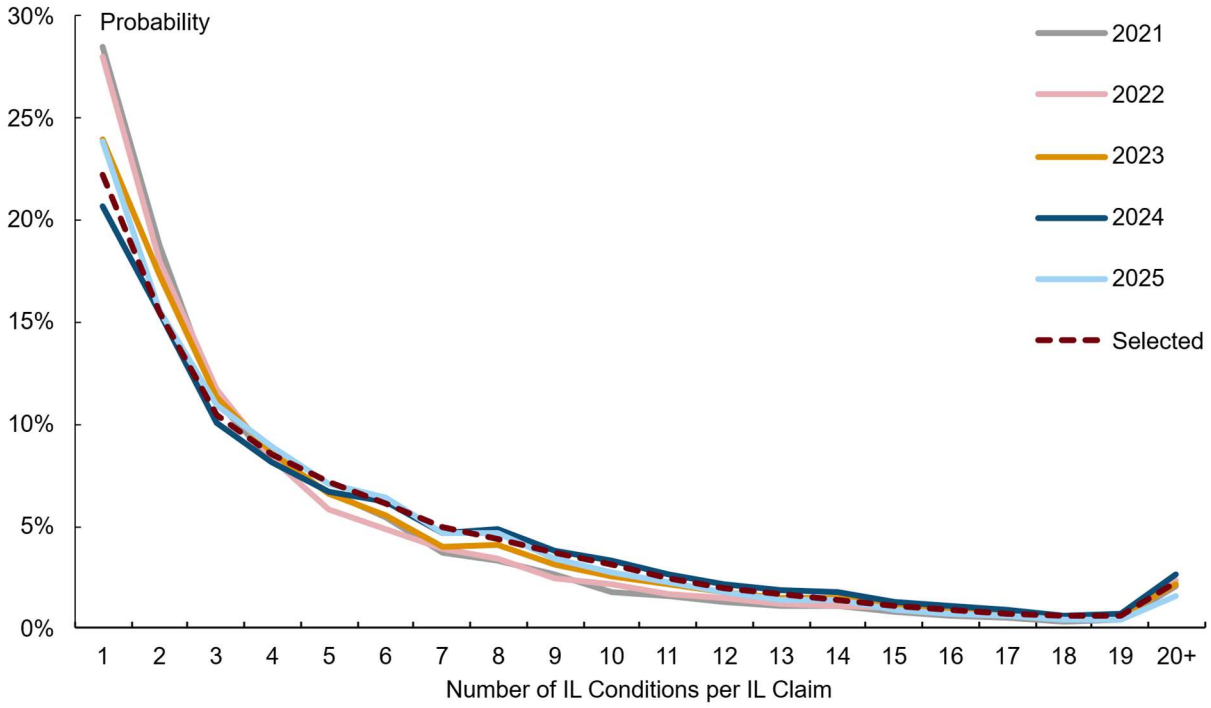
Figure 9.12: Probability of Lodging an IL Claim for Specific Conditions Treatment Card Holders



9.4.12 The experience shows that Specific Conditions Treatment 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 different 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.

9.4.13 We have also assumed a distribution of conditions per IL claim lodged, shown in Figure 9.13. 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 Specific Conditions Treatment Card holders over the last two years, adjusted for an ultimate withdrawal rate.

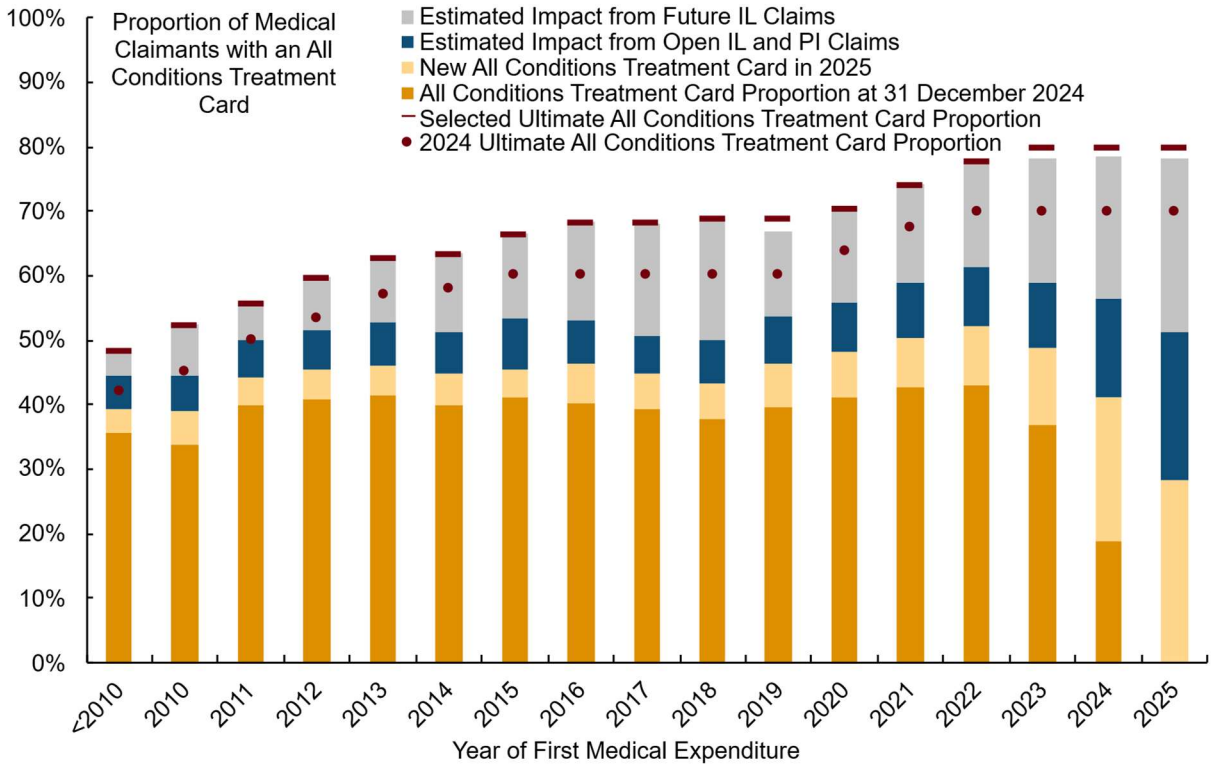
Figure 9.13: Probability of Lodging an IL Claim for Specific Conditions Treatment Card Holders



9.4.14 Based on the assumed IL claim lodgement rates, the distribution of conditions per IL claim and an assumed IL condition acceptance rate of 81 per cent, we have simulated the future IL lodgement behaviour of each existing Specific Conditions Treatment Card holder. This projection of future IL conditions was then combined with the probabilities of veterans being assessed at 60 or more impairment points (as shown in Figure 9.11) to estimate the ultimate number of existing veterans who will qualify for All Conditions Treatment Card entitlements. A two year delay between IL lodgement and PI completion, and thus All Conditions Treatment Card eligibility, has been assumed.

9.4.15 Figure 9.14 summarises this analysis: the orange bars represent the proportion of medical claimants with All Conditions Treatment Card entitlements at 31 December 2024; the light orange bars represent the proportion that received an All Conditions Treatment Card in the 2025 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 an All Conditions Treatment Card once their open IL and PI claims are completed; and the grey bars represent the additional component due to future IL claims projected from this group.

Figure 9.14: Proportion of Medical Claimants with an All Conditions Treatment Card by Year of First Medical Expenditure

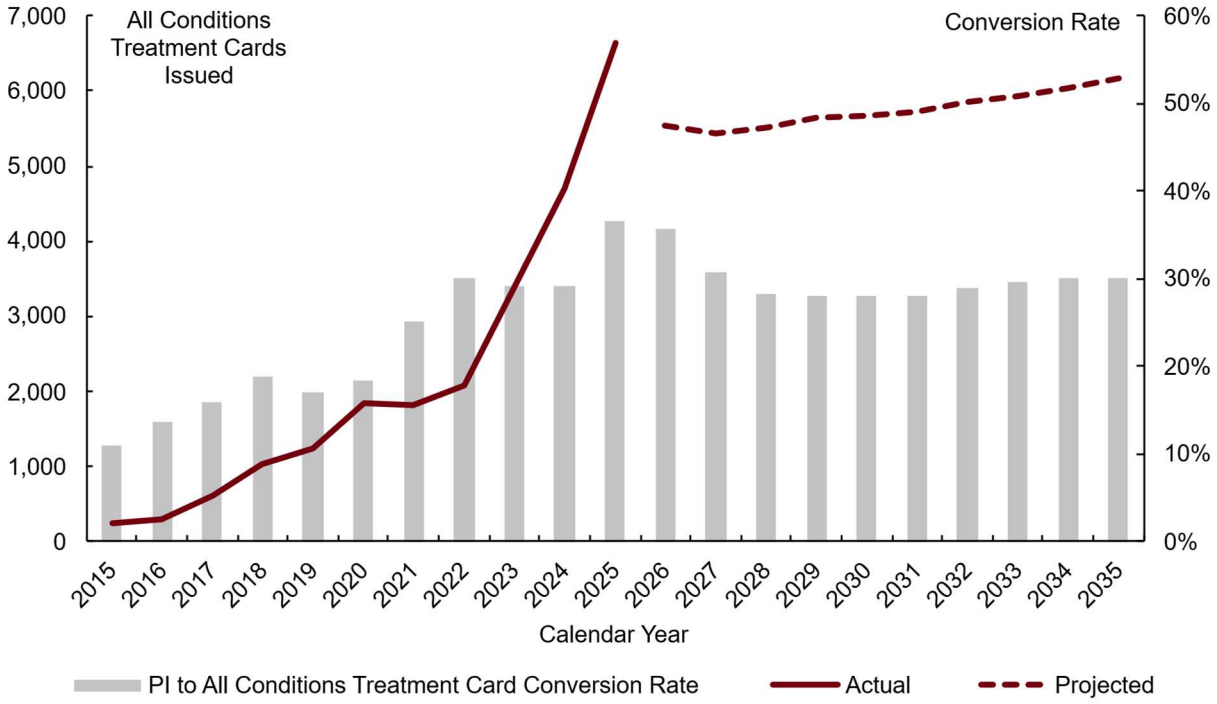


9.4.16 The proportions of medical claimants with an All Conditions Treatment Card are now anticipated to exceed the previously adopted ultimate proportions (which were assumed to increase from 42 per cent for the earlier cohorts to 70 per cent for the most recent cohorts) if the assumptions around open 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 9.14. An ultimate All Conditions Treatment Card proportion of 80 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 All Conditions Treatment 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 We have updated the methodology used to apply the All Conditions Treatment Card probabilities to existing Specific Conditions Treatment Card holders. The previous approach calculated incremental increases in projected All Conditions Treatment Card proportions and applied these to the active Specific Conditions Treatment Card claimant population. The updated approach explicitly allows for the impact of Specific Conditions Treatment Card utilisation rates on the active claimant population to which the All Conditions Treatment Card probabilities are applied. This change results in an increase in the projected number of future All Conditions Treatment Card holders in the model.

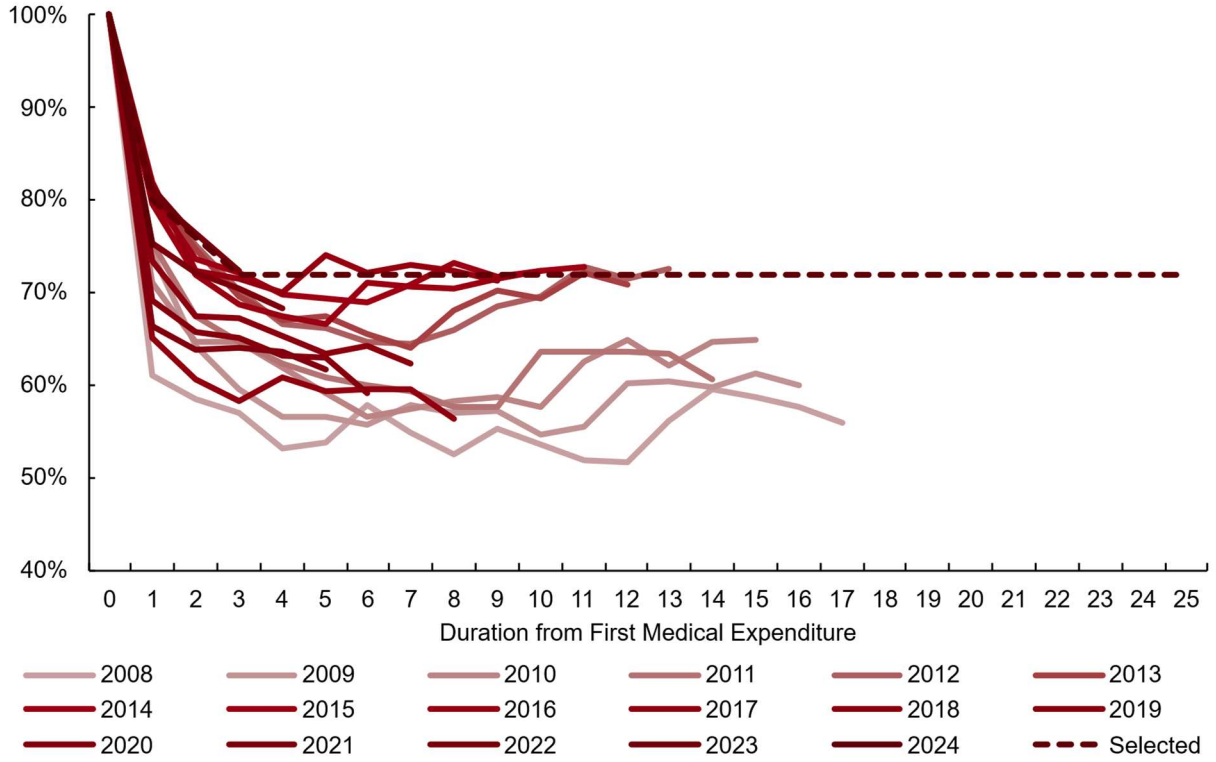
9.4.18 Figure 9.15 shows the actual and projected number of new All Conditions Treatment Cards, as well as the implied conversion rate from MRCA PI.

Figure 9.15: Projected New All Conditions Treatment Cards by Calendar Year



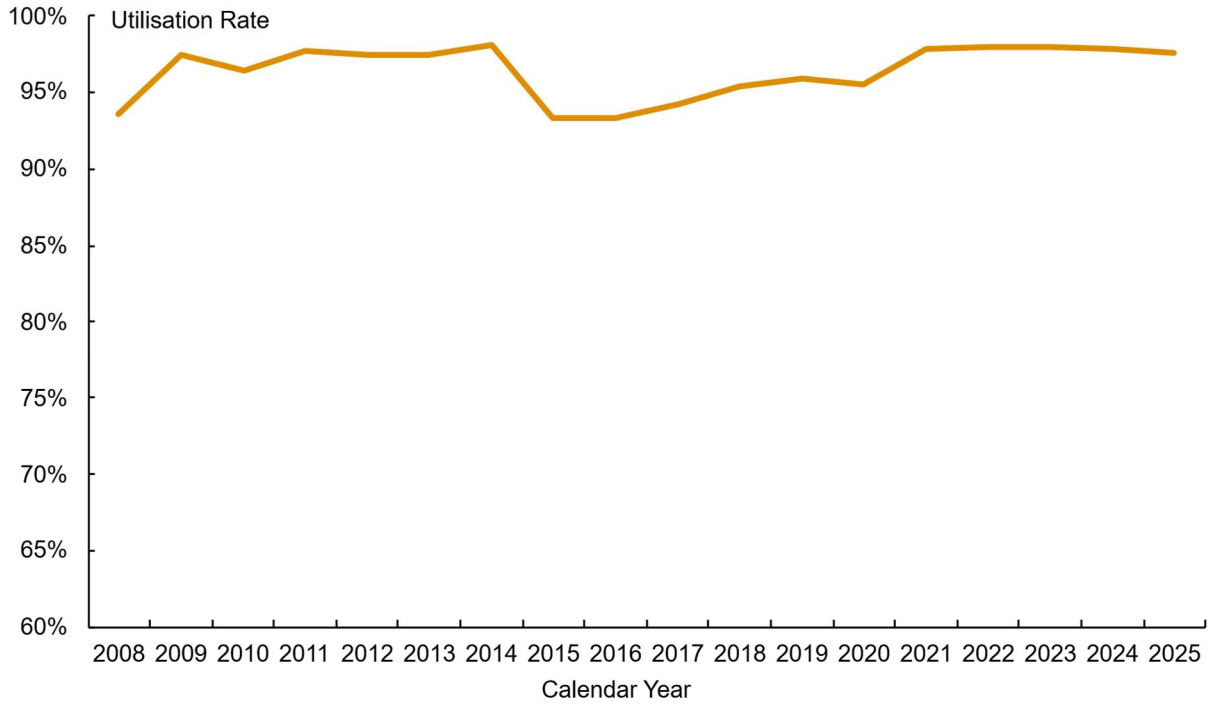
9.4.19 Once the future claimant population has been projected, a utilisation rate is applied to estimate the number of active medical claimants in each future period. The utilisation rates by duration from first medical expenditure for Specific Conditions Treatment Card holders are shown in Figure 9.16, along with the selected utilisation rates for future new medical claimants. Utilisation rates for Specific Conditions Treatment Cards are volatile and vary across cohorts. The selected utilisation rates begin at 100 per cent (by definition), decrease to 80 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 9.16: Specific Conditions Treatment Card Utilisation by Duration from First Medical Expenditure



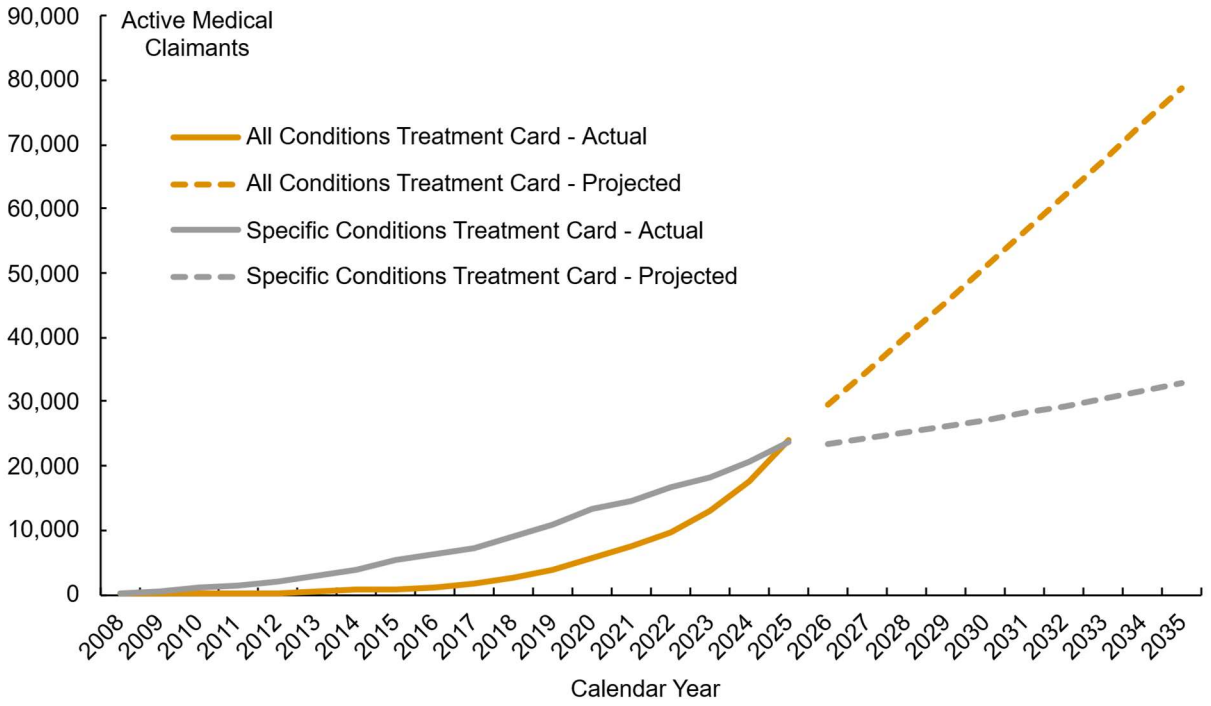
9.4.20 Figure 9.17 below shows historical All Conditions Treatment Card utilisation rates by calendar year. Utilisation rates are significantly higher for claimants with an All Conditions Treatment Card, reflecting the expanded range of benefits provided under an All Conditions Treatment Card as well as the higher levels of impairment implied by All Conditions Treatment Card entitlements. All Conditions Treatment Card utilisation rates have been relatively stable over time. We have selected an All Conditions Treatment Card utilisation rate of 98 per cent.

Figure 9.17: All Conditions Treatment Card Utilisation Rate by Calendar Year



9.4.21 Combining these assumptions, along with population mortality, yields a projection of active medical claimants over time, as shown in Figure 9.18.

Figure 9.18: Active Medical Claimant Number by Calendar Year

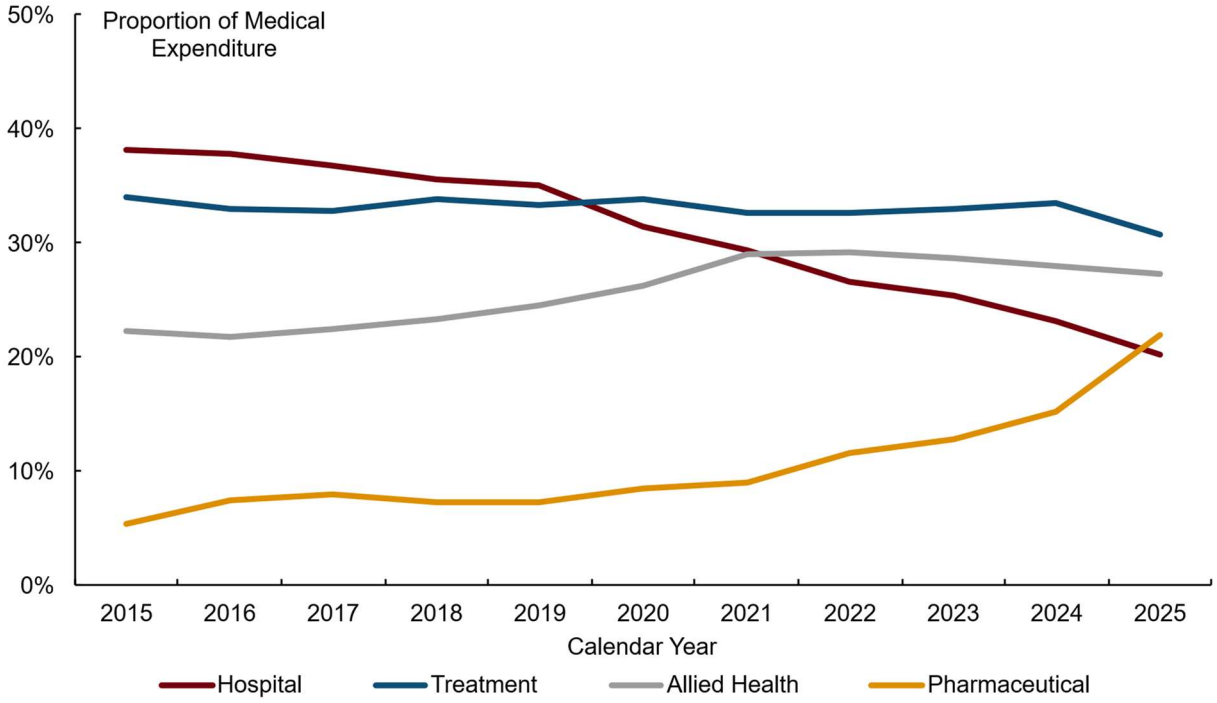


9.5 Valuation Assumptions – Average Cost per Active Claimant

9.5.1 The final assumption required is the average expenditure per active claimant. We have considered the average expenditure assumption by service category, namely hospital (including public and private), treatment (including GP, specialist consultations and travel reimbursements for medical appointments), allied health and pharmaceutical.

9.5.2 Figure 9.19 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 20 per cent. The proportion of expenditure on allied health services has increased from around 22 per cent to 27 per cent in the most recent year. Expenditure on treatment has remained relatively consistent, while the proportion of expenditure related to pharmaceutical benefits has increased substantially, particularly in recent years due to the increased use of medicinal cannabis for the treatment of chronic pain conditions.

Figure 9.19: Proportion of MRCA Medical Expenditure by Service Category

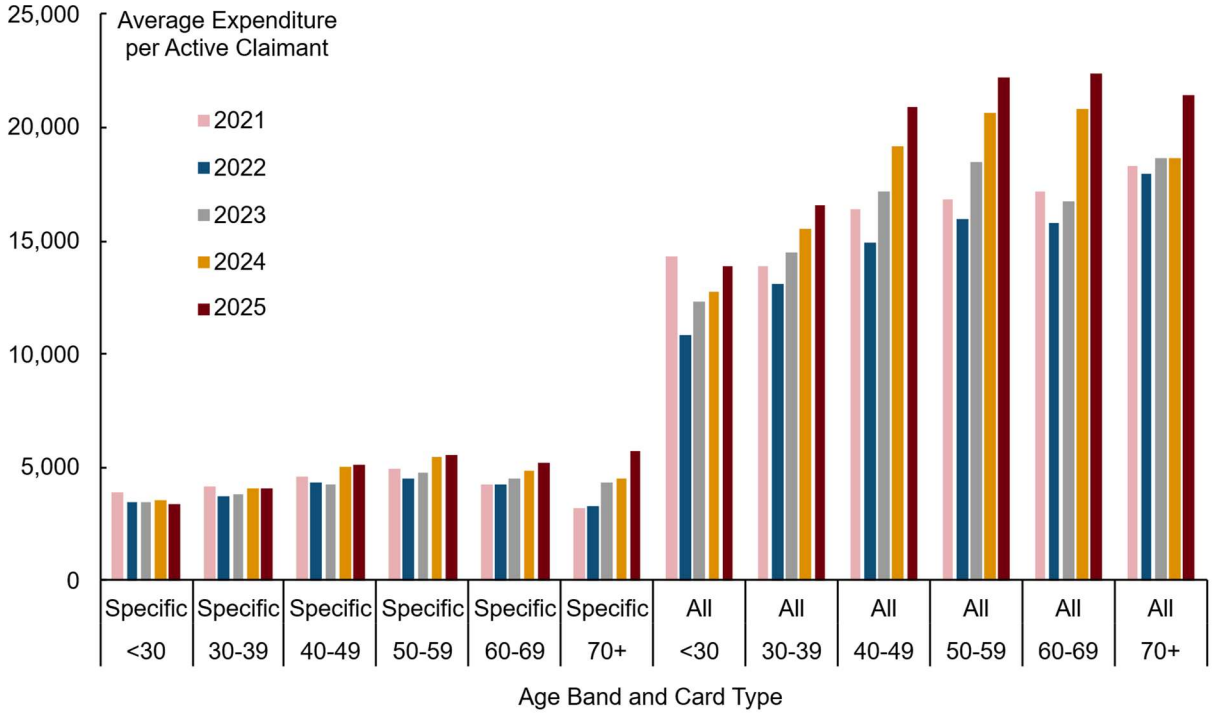


9.5.3 As part of this year's valuation, we identified that the unit record payments data excludes public hospital and community nursing expenditure. We have used additional data sources (namely the person combined dataset) to incorporate an allowance for these costs in the adopted average expenditure amounts. We will work with DVA to investigate whether it is possible to include these payments in the unit record data for next year's valuation.

9.5.4 The average medical expenditure per active claimant is assumed to vary by card type and age band. We have selected assumptions for each medical service category, separately considering the proportion of active claimants utilising each service and the average cost per active claimant utilising that service. Figure 9.20 below shows the average expenditure per active medical claimant over the last five calendar years. The average expenditure is substantially higher for All Conditions Treatment Cards across all ages, reflecting the fact that all medical expenditure is covered as well as the higher levels of impairment required for

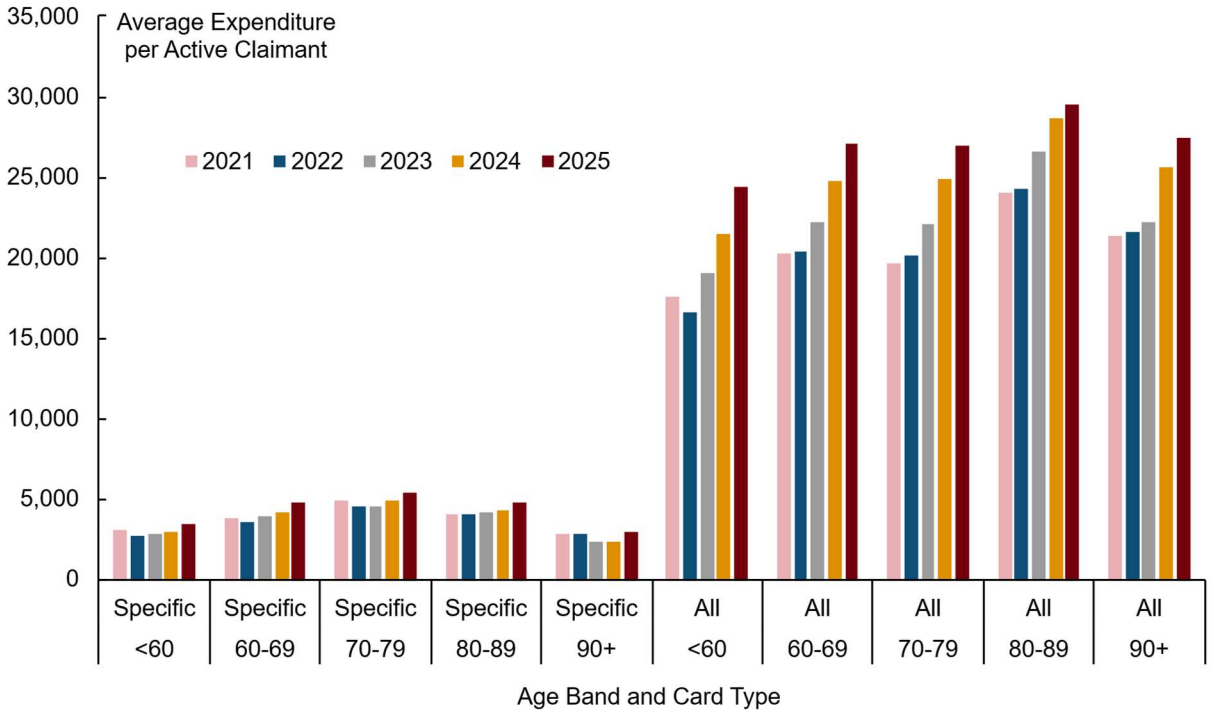
eligibility. The average expenditure has increased for almost all age bands over the most recent calendar year, driven by increases in pharmaceutical expenditure.

Figure 9.20: Average Expenditure per Active MRCA Medical Claimants



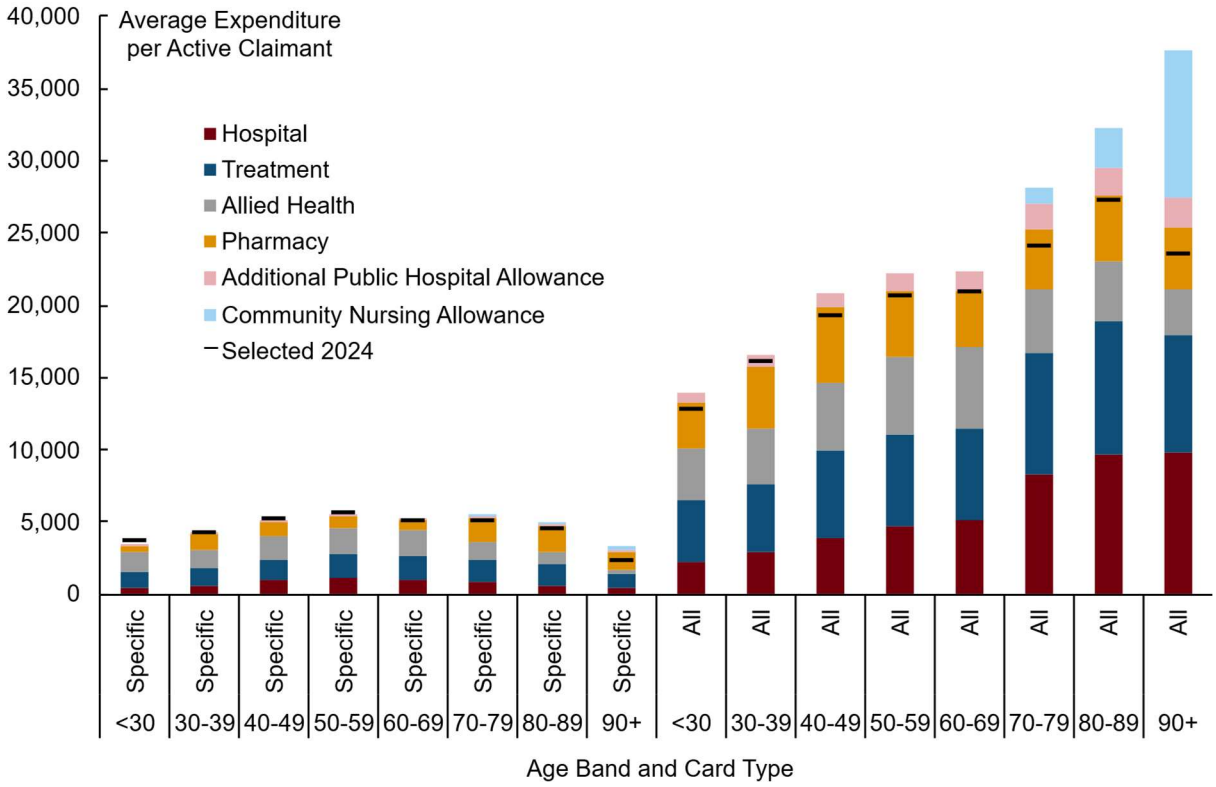
9.5.5 As MRCA commenced in 2004, there is very little experience currently available for those aged over 70. We also received data on VEA claimants where there are significantly higher numbers of veterans with All Conditions Treatment Cards at older ages. Figure 9.21 shows the average expenditure per active claimant for veterans with VEA health care cards. VEA veterans receive an All Conditions Treatment 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 All Conditions Treatment Card. The average expenditure for VEA All Conditions Treatment Card holders increases at older ages before a decrease beyond age 90. VEA All Conditions Treatment Card costs have been increasing at older ages, largely due to marked growth in community nursing costs.

Figure 9.21: Average Expenditure per Active VEA Medical Claimants



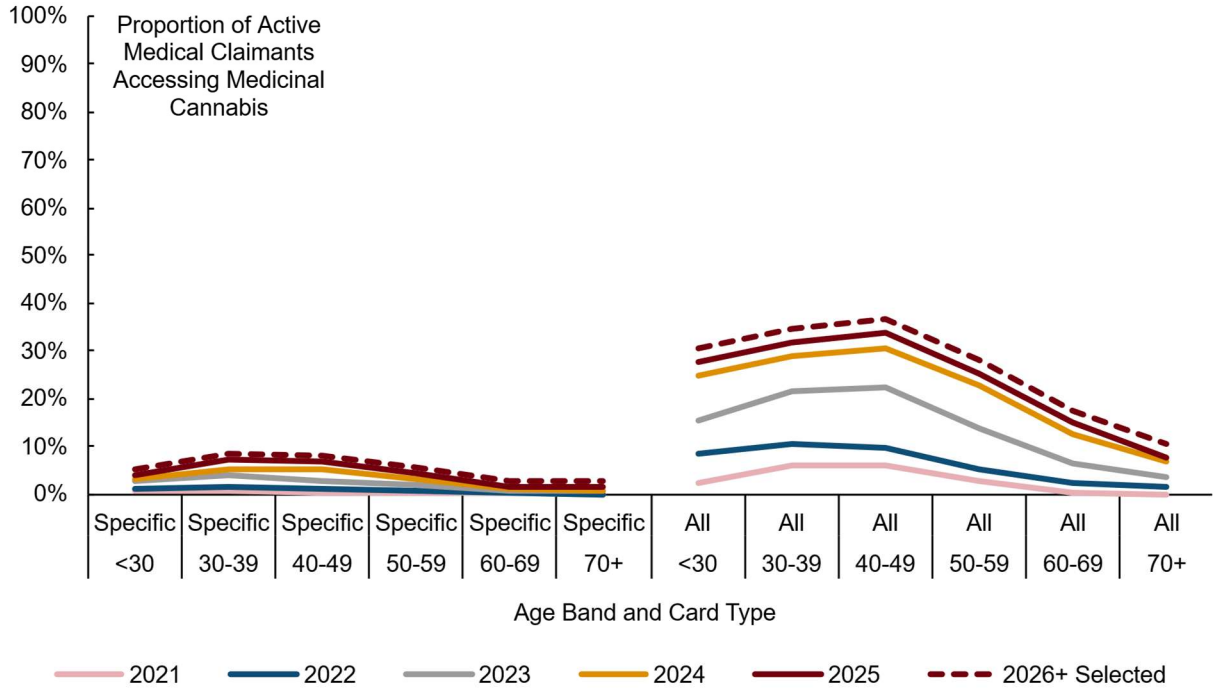
9.5.6 Figure 9.22 shows the selected average expenditure per active medical claimant, aggregating the individual assumptions by service category and combining data from both MRCA and VEA. The assumed amounts are based on the most recent experience. We have assumed that MRCA average expenditure per active All Conditions Treatment 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 9.22: Selected Average Cost per Active Medical Claimants (2025 dollars)



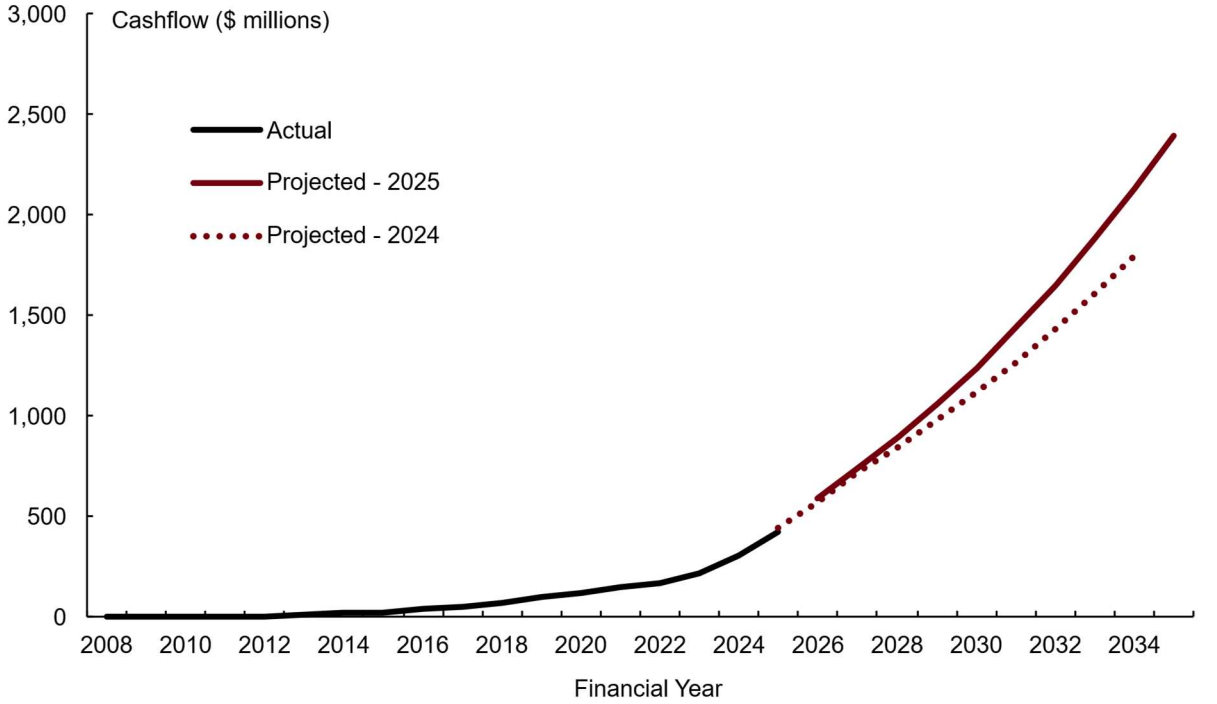
9.5.7 Substantial growth in pharmaceutical benefits was seen again in 2025, driven by increasing expenditure associated with medicinal cannabis for the treatment of chronic pain conditions. We have been informed by DVA program areas that the take up of these drugs have increased significantly since their addition to the Repatriation Pharmaceutical Benefits Scheme (RPBS). 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 All Conditions Treatment Card entitlements. We have assumed the proportion of medical claimants accessing medicinal cannabis will continue to increase over the next calendar year before stabilising. This assumption results in superimposed inflation applied to the average expenditure per active claimant of 1.5 per cent in 2026.

Figure 9.23: Proportion of Active Medical Claimants Accessing Medicinal Cannabis



9.5.8 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 9.24.

Figure 9.24: Historical and Projected Cashflows for MRCA Medical



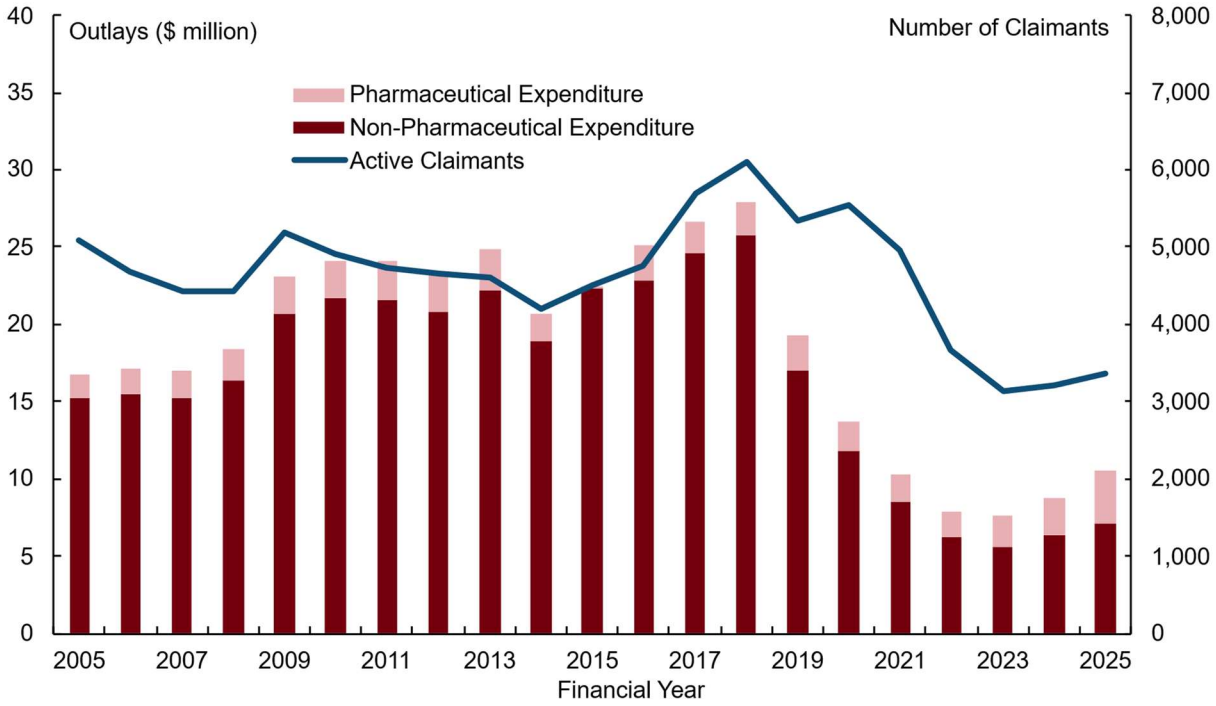
9.6 Impact of the VETS Act – DRCA Veterans

9.6.1 All Conditions Treatment Cards are not available to veterans under the DRCA. From 1 July 2026, veterans with high levels of impairment under the DRCA will become eligible for an All Conditions Treatment Card for the first time, subject to meeting the MRCA eligibility criteria (i.e. be assessed to have permanent impairment of at least 60 points from service-related injuries or diseases or be eligible for SRDP). This will, however, require acceptance of a new Initial Liability claim after 1 July 2026, or for a previous impairment to deteriorate by at least five impairment points as a trigger for eligibility under the MRCA.

9.6.2 We have first projected current DRCA medical claimants under the existing DRCA legislation and then attempted to estimate the proportion of these veterans that will receive a MRCA All Conditions Treatment Card from 1 July 2026.

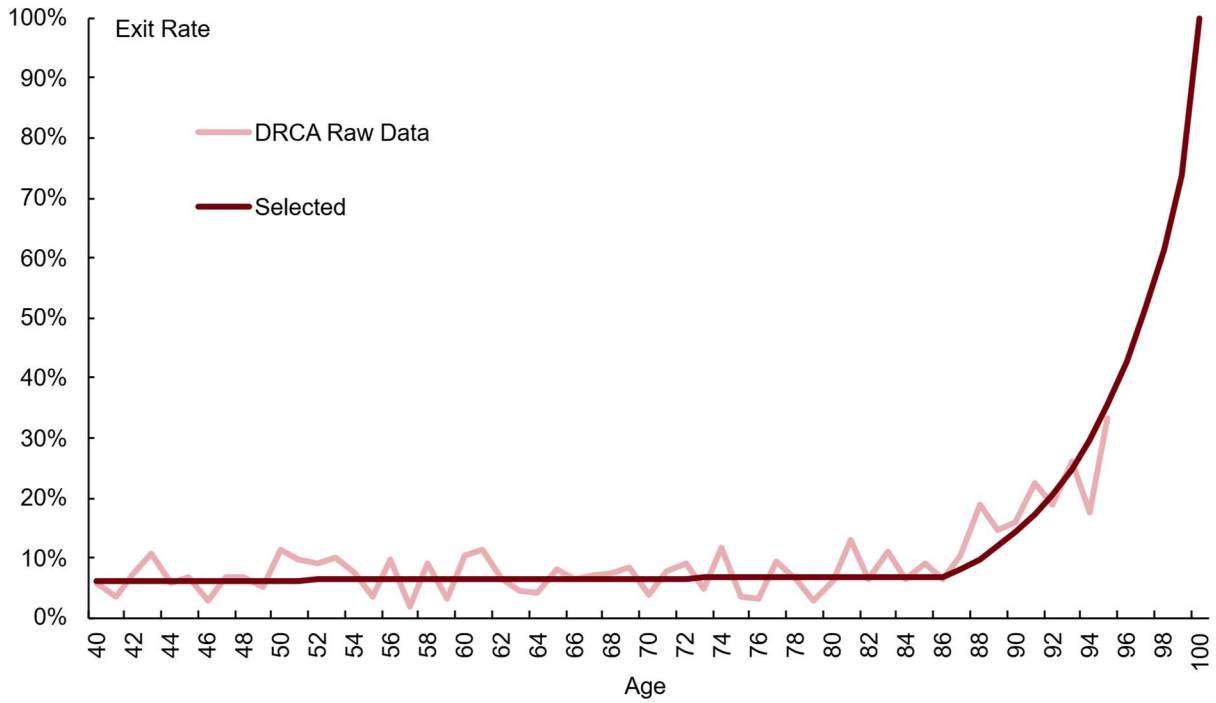
9.6.3 Figure 9.25 shows the annual expenditure on DRCA medical and pharmaceutical payments along with the number of active claimants since 2005. There was a significant decline in expenditure and active claimants from 2017. Under DVA's cards hierarchy, if a DRCA claimant is issued a health card under the VEA or MRCA, any medical expenditure is recorded under that Act going forward. More recently, this decline appears to have ceased, with expenditure increasing over the last two years.

Figure 9.25: Expenditure on DRCA Medical Payments and Number of Active Claimants



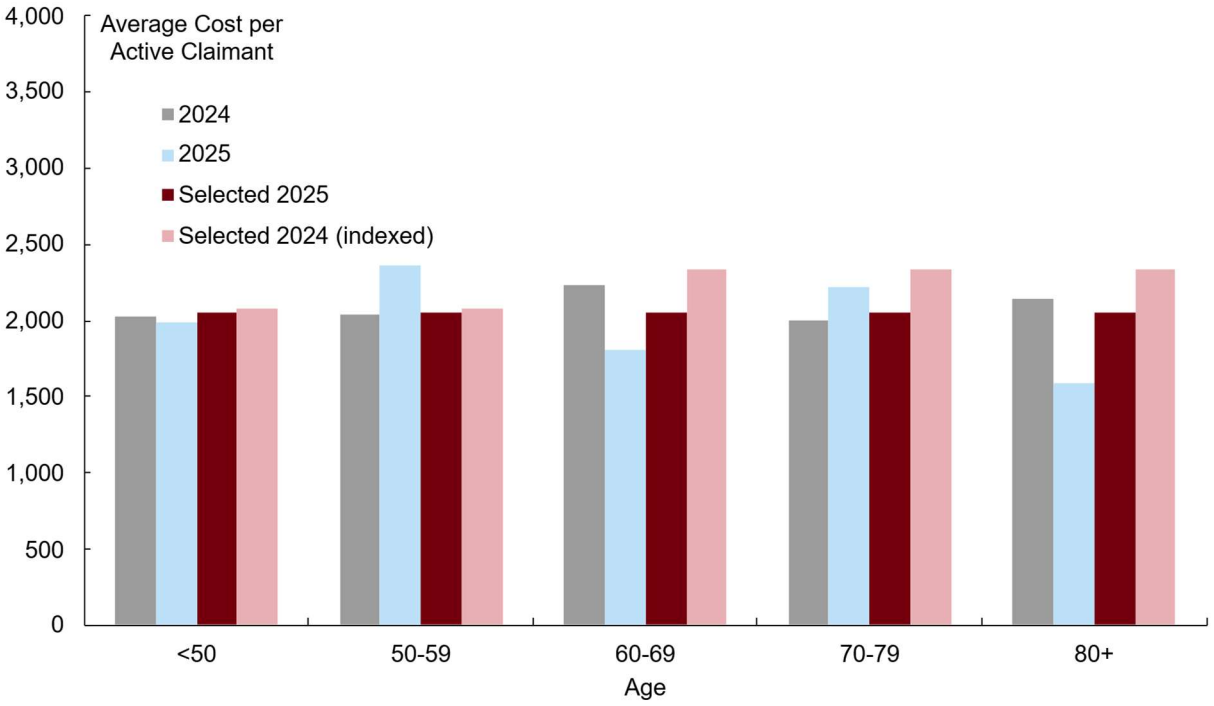
9.6.4 To project the number of active claimants, we have applied age-based exit rates to the current claimant population. Figure 9.26 shows the raw data and the fitted age-based exit rates. In fitting the exit rates, a longer period of ten years has been used to avoid placing undue weight on the recent marked decline in active DRCA medical claimants. Given the recent increase in active claimant numbers, we have assumed DRCA medical active claimants will continue to increase at 3.5 per cent over the next three years, before applying the decay rates thereafter.

Figure 9.26: Assumed Exit Rates for Active DRCA Medical Claimants



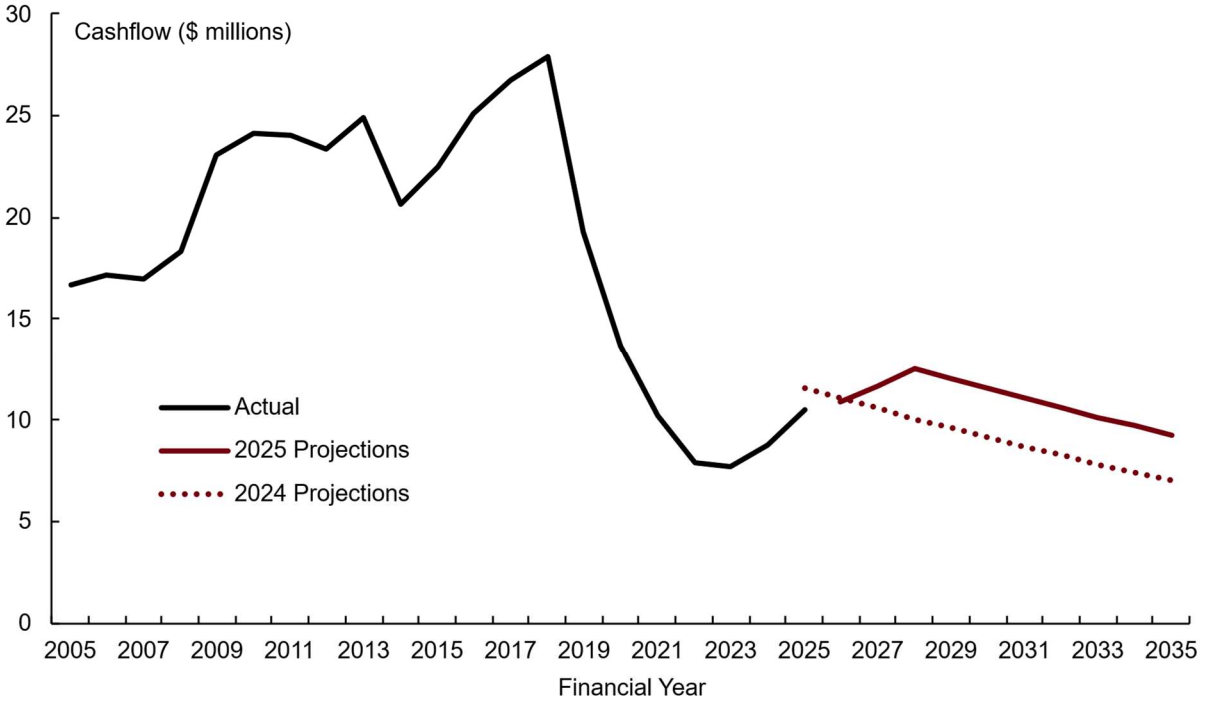
9.6.5 An average cost per active claimant is then applied to the active claimant population in each year to estimate expected future payments. Figure 9.27 shows the average cost per active claimant over the last two calendar years and the selected assumption, together with the assumption adopted in 2024. 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 50 per cent has been applied. This results in an average annual expenditure of $3,075 per active claimant across all ages. 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 9.27: Average Annual Costs per Active Claimant by Age



9.6.6 Figure 9.28 shows the historical and projected cashflows for DRCA medical claims before accounting for the impact of the VETS Act.

Figure 9.28: Historic and Projected DRCA Medical Payments



9.6.7 From 1 July 2026, veterans with high levels of impairment under the DRCA will become eligible for an All Conditions Treatment Card. When a DRCA veteran is issued with an All Conditions Treatment Card under MRCA, all their future medical expenditure will be recorded under MRCA. As such, we have estimated the proportion of DRCA medical claimants who will be

eligible for a MRCA All Conditions Treatment Card by considering the types of conditions and levels of impairment of existing DRCA veterans receiving medical benefits under the DRCA. To do this, we have used MRCA data to analyse the relationship between accepted conditions and impairment points, and have assumed similar relationships would apply for DRCA veterans.

9.6.8 We have considered all veterans with accepted MRCA PI claims and thus impairment point assessments under the MRCA. We then examined the types of accepted IL conditions these veterans have, grouped into broad injury categories of mental health conditions (including erectile dysfunction and bruxism), hearing loss and tinnitus conditions, physical injuries (including spondylosis, osteoarthritis and other physical injuries), skin conditions and other conditions. We have used a cutoff of 45 impairment points, as eligibility for SRDP requires 50 or more impairment points and to allow for the requirement that veterans must either lodge a new IL claim or demonstrate a worsening of at least five impairment points of an existing condition. Table 9.1 below shows the calculated probabilities of exceeding 45 impairment points under MRCA based on the various combinations of condition types:

Table 9.1: Assumed Probabilities of Exceeding 45 MRCA Impairment Points

Mental Health	Hearing Loss/Tinnitus	Physical Injuries	Skin Conditions	Other Conditions	Average MRCA IP	Proportion above 45 MRCA IP
×	✓	×	×	×	16	4%
×	×	×	×	✓	24	11%
×	×	×	✓	×	28	21%
×	×	✓	×	×	31	23%
✓	×	×	×	×	40	41%
×	✓	×	×	✓	24	9%
×	✓	×	✓	×	27	13%
×	×	✓	×	✓	34	27%
×	✓	✓	×	×	37	32%
×	×	×	✓	✓	41	34%
✓	×	×	✓	×	45	47%
×	×	✓	✓	×	46	49%
✓	✓	×	×	×	47	55%
✓	×	×	×	✓	51	60%
✓	×	✓	×	×	54	66%
×	✓	×	✓	✓	28	11%
×	✓	✓	×	✓	43	44%
×	✓	✓	✓	×	46	51%
×	×	✓	✓	✓	48	57%
✓	×	×	✓	✓	51	71%
✓	✓	×	✓	×	53	68%
✓	✓	×	×	✓	57	72%
✓	×	✓	×	✓	63	78%
✓	×	✓	✓	×	63	75%
✓	✓	✓	×	×	66	83%
×	✓	✓	✓	✓	52	63%
✓	✓	×	✓	✓	61	77%
✓	✓	✓	✓	×	71	90%
✓	✓	✓	×	✓	72	89%
✓	×	✓	✓	✓	73	90%
✓	✓	✓	✓	✓	76	93%

9.6.9 The table above shows that veterans with conditions across all injury types are much more likely to exceed 45 impairment points compared with veterans with conditions under fewer categories. For veterans with conditions falling under one category only, mental health conditions have the highest probability of exceeding 45 impairment points and hearing loss conditions have the lowest probability.

9.6.10 Based on these probabilities, we anticipate that around 1,180 DRCA veterans currently receiving medical treatment under the DRCA will have impairment points under MRCA of 45 or more. We have assumed all these veterans will either lodge a new Initial Liability claim after 1 July 2026 or have a previous impairment worsen by five or more impairment points to trigger an assessment and thus eligibility under MRCA, and receive a MRCA All Conditions Treatment Card. The VEA veteran average All Conditions Treatment Card expenditure, as shown in Figure 9.34, has been adopted.

9.6.11 DRCA medical claimants who do not meet the impairment point thresholds for a MRCA All Conditions Treatment Card may be issued a MRCA Specific Conditions Treatment Card if they lodge a condition under the MRCA which is then accepted. In this case, the veteran's future medical costs will also accrue under the MRCA. Given the small size of the DRCA medical cohort and the lower costs associated with a Specific Conditions Treatment Card. We have not explicitly modelled this interaction.

9.7 Impact of the VETS Act – VEA All Conditions Treatment Cards

9.7.1 AGA does not currently estimate a liability provision for VEA. From 1 July 2026, all new claims for compensation will be assessed under the MRCA. VEA Specific Conditions Treatment Card and All Conditions Treatment Card holders may gain eligibility for a MRCA Specific Conditions Treatment Card or All Conditions Treatment Card due to the legislated hierarchy for cost allocation, where VEA cards are superseded by MRCA cards. Thus, this group must be provisioned for in the MRCA liability.

9.7.2 Our interpretation of the VETS Act is that a VEA Specific Conditions Treatment Card will be reclassified to a MRCA Specific Conditions Treatment Card if the veteran lodges an IL claim after 1 July 2026 and that condition is accepted. We also understand that VEA All Conditions Treatment Cards will be reclassified to MRCA All Conditions Treatment Cards if the veteran meets the conditions for assessment under the VETS Act (i.e. a new condition or a 5 impairment point deterioration of existing conditions) and if a MRCA eligibility criteria for a MRCA All Conditions Treatment Card is met.

9.7.3 To estimate the potential impact of the reclassification of VEA All Conditions Treatment Card expenditure on the MRCA liability, we have first projected future VEA All Conditions Treatment Card expenditure under the VEA, and then attempted to estimate the proportion of these cashflows that will accrue under MRCA as a result of the VETS Act. We have considered the following VEA All Conditions Treatment Card cohorts: veterans with a VEA All Conditions Treatment Card, spouses with a VEA All Conditions Treatment Card, veterans expected to receive a VEA All Conditions Treatment Card in the future under the old legislation and spouses expected to receive a VEA All Conditions Treatment Card in the future under the old legislation.

9.7.4 To model the existing population of veterans and spouses with a VEA All Conditions Treatment Card, we have considered the All Conditions Treatment Card population that accessed medical benefits in the 2025 financial year and applied ALT mortality rates to estimate the decline in this population over time.

9.7.5 We have used the Veteran Population Model (VPM) VEA ex-service population projections shown in Figure 9.29 as well as age-based entry rates in order to project VEA veterans that would have received an All Conditions Treatment Card in the future under the previous

legislation. As the VPM projections only extend to 2040, we have extrapolated the projections using ALT male mortality rates. The actual and selected entry rates are shown in Figure 9.30.

Figure 9.29: VPM VEA Veteran Population

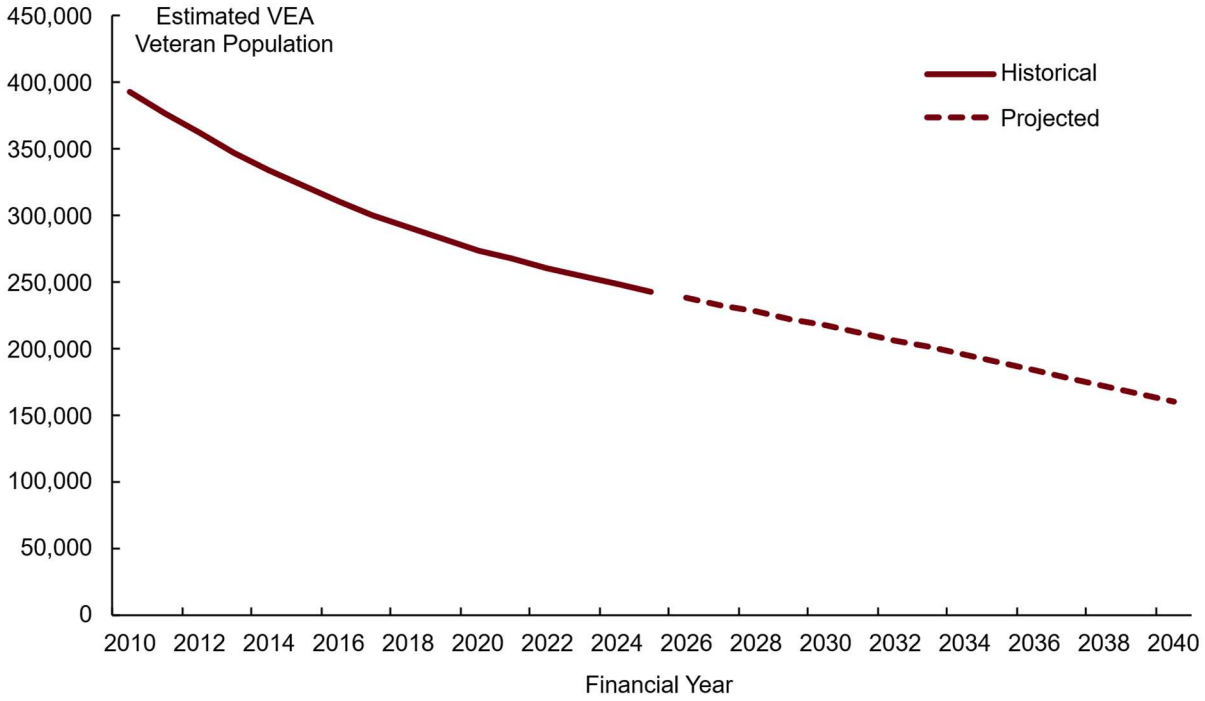
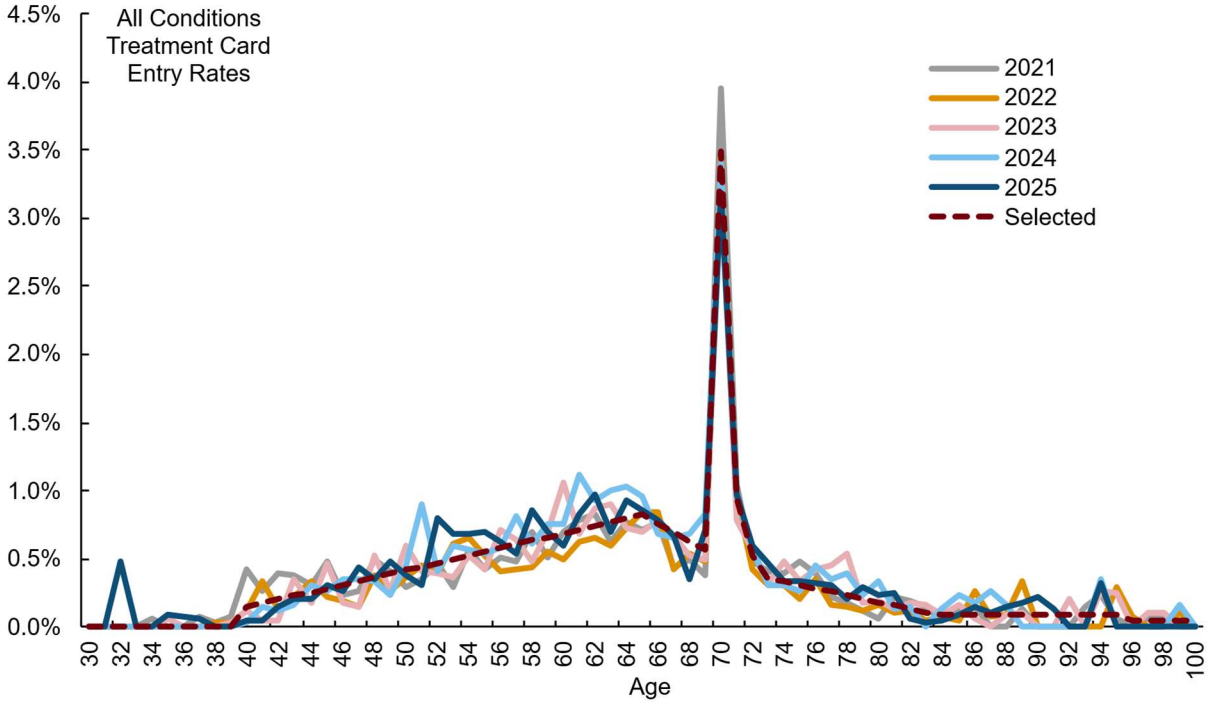


Figure 9.30: Actual and Selected VEA All Conditions Treatment Card Entry Rates (Veterans Only)

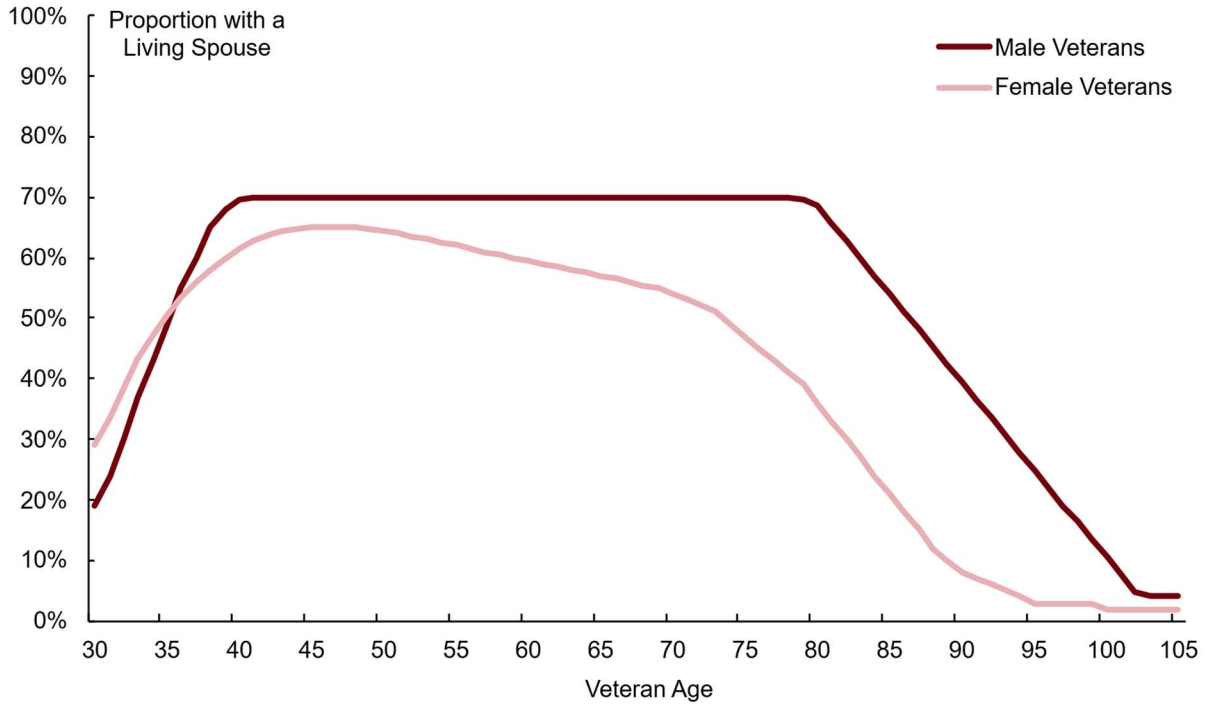


9.7.6 To project the number of future spouses receiving All Conditions Treatment Cards, we have relied on the proportions of veterans with a living spouse by age and gender and the age differences at death assumptions from the 2023 Military Superannuation Long Term Card

Report (LTCR). The proportion of veterans with a living spouse are shown in Figure 9.31. The assumed age differences are as follows:

- Male veterans: three years older than their spouse.
- Female veterans: three years younger than their spouse.

Figure 9.31: Assumed Proportion of Veterans with a Living Spouse



9.7.7 We understand that not all spouses will receive an All Conditions Treatment Card following the death of the veteran. Spouses can receive All Conditions Treatment Cards either through the auto grant provision of the death benefit under the VEA or if the death is deemed to be service related. Automatic access to death benefits is granted to widow(er)s where the veteran was on Above General Rate of DCP, a Prisoner of War (POW) or in receipt of a Specific Disability Allowance (SDA) in relation to certain listed items. For veterans who receive an All Conditions Treatment Card solely because they have reached age 70 and have Qualifying Service, and who do not meet any other eligibility criteria, their spouse may not receive an All Conditions Treatment Card if the veteran's death is not service-related. To account for this, we have applied an experience adjustment and assumed that 65 per cent of surviving spouses will receive an All Conditions Treatment Card. Figure 9.32 below shows the actual and projected number of veterans and spouses receiving a VEA All Conditions Treatment Card under the current VEA legislation. Figure 9.33 summaries the actual and projected VEA All Conditions Treatment Card population (including veterans and spouses).

Figure 9.32: Actual and Projected New VEA All Conditions Treatment Card Holders (Veterans and Spouses)

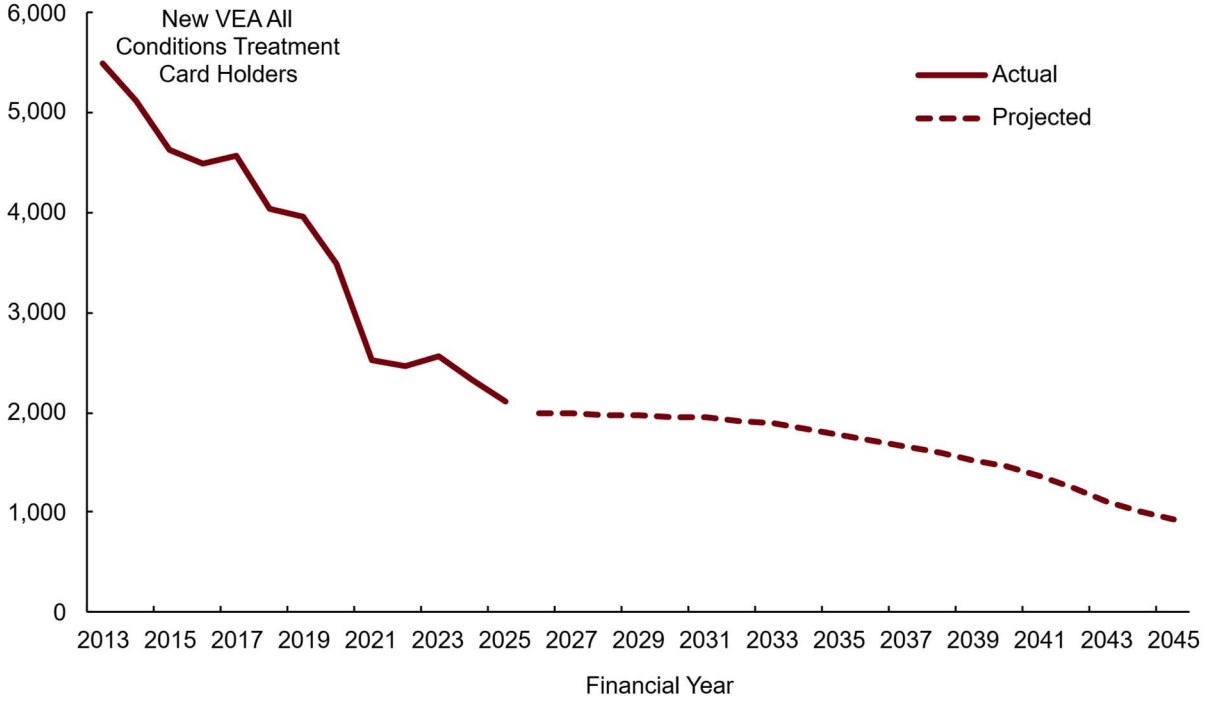
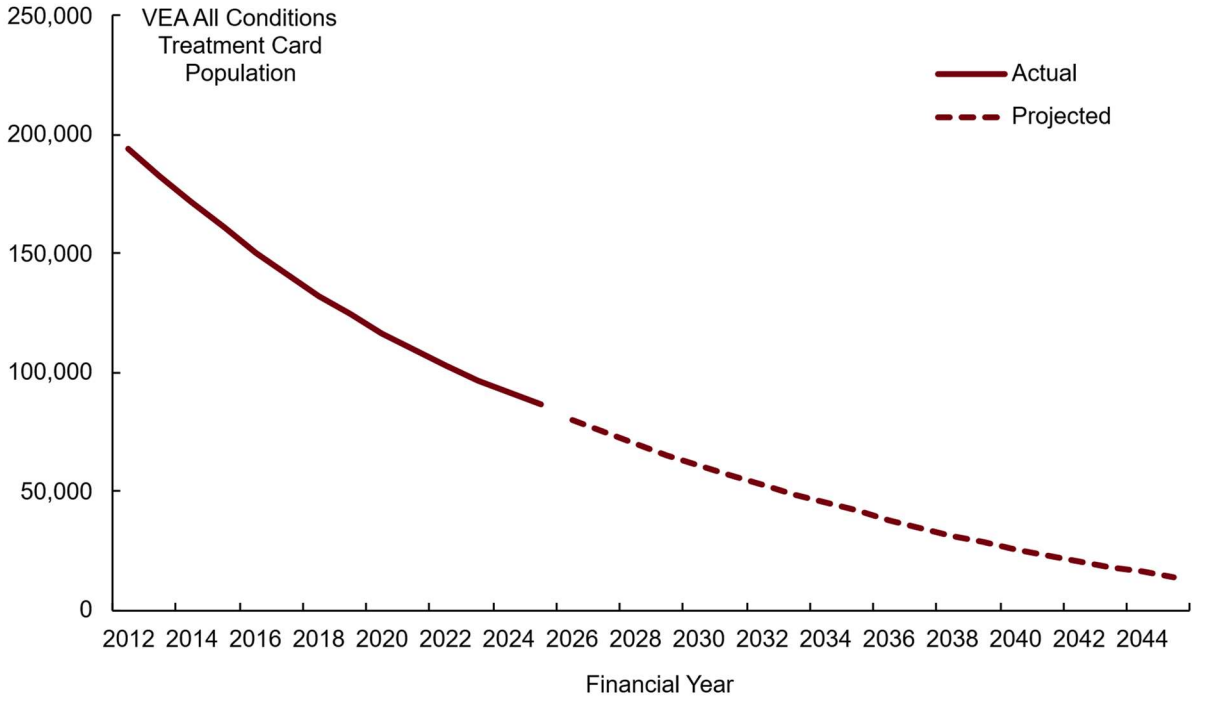


Figure 9.33: Actual and Projected VEA All Conditions Treatment Card Population (Veterans and Spouses)



9.7.8 The next assumption required is the average annual expenditure per cardholder. For the average size assumption, we have included medical treatment (including GPs and specialists); hospital (including public and private, with a maturity adjustment applied to public hospital expenditure); allied health; pharmaceutical; and community nursing expenditure. We have included aids and appliances costs in these projections, but the associated liabilities have

been included in Rehabilitation benefits discussed in Section 10. We have not included travel for treatment as this is covered later in Section 9.9. Figure 9.34 below shows the average expenditure per All Conditions Treatment Card cardholder since 2021 for veterans. Figure 9.35 shows the similar information for spouses. We have selected average costs based on the most recent financial year.

Figure 9.34: Average Annual Expenditure per VEA All Conditions Treatment Card Holder – Veterans

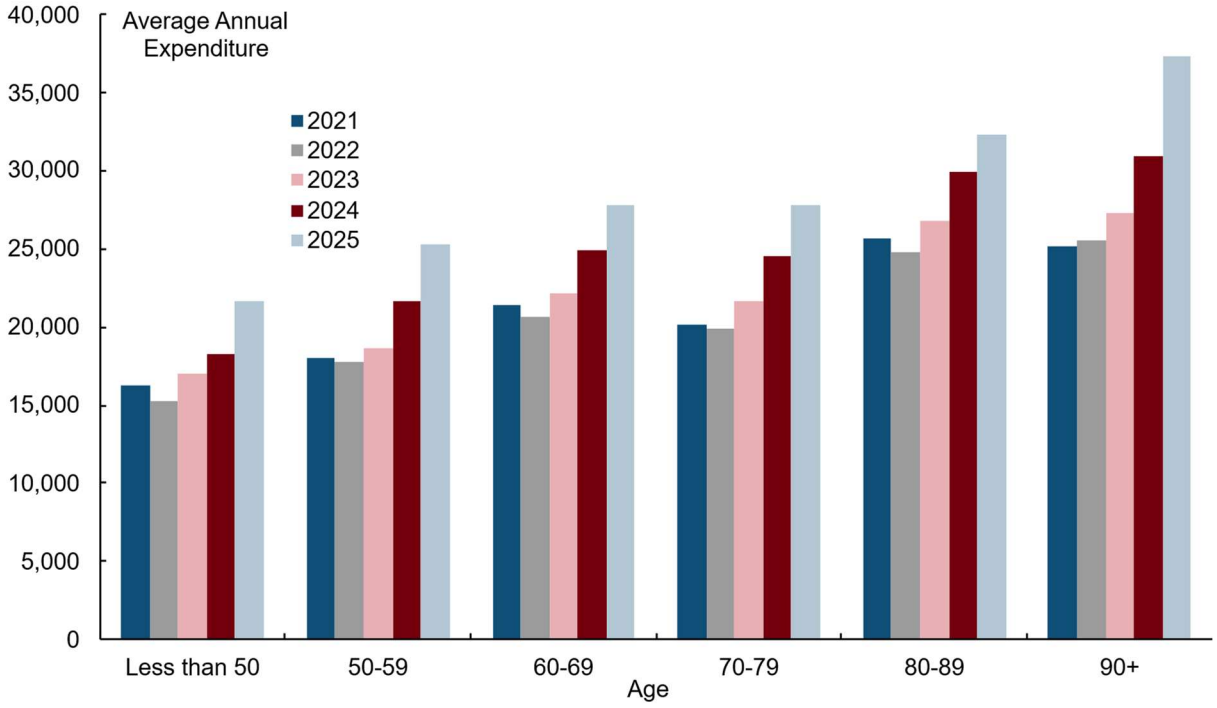
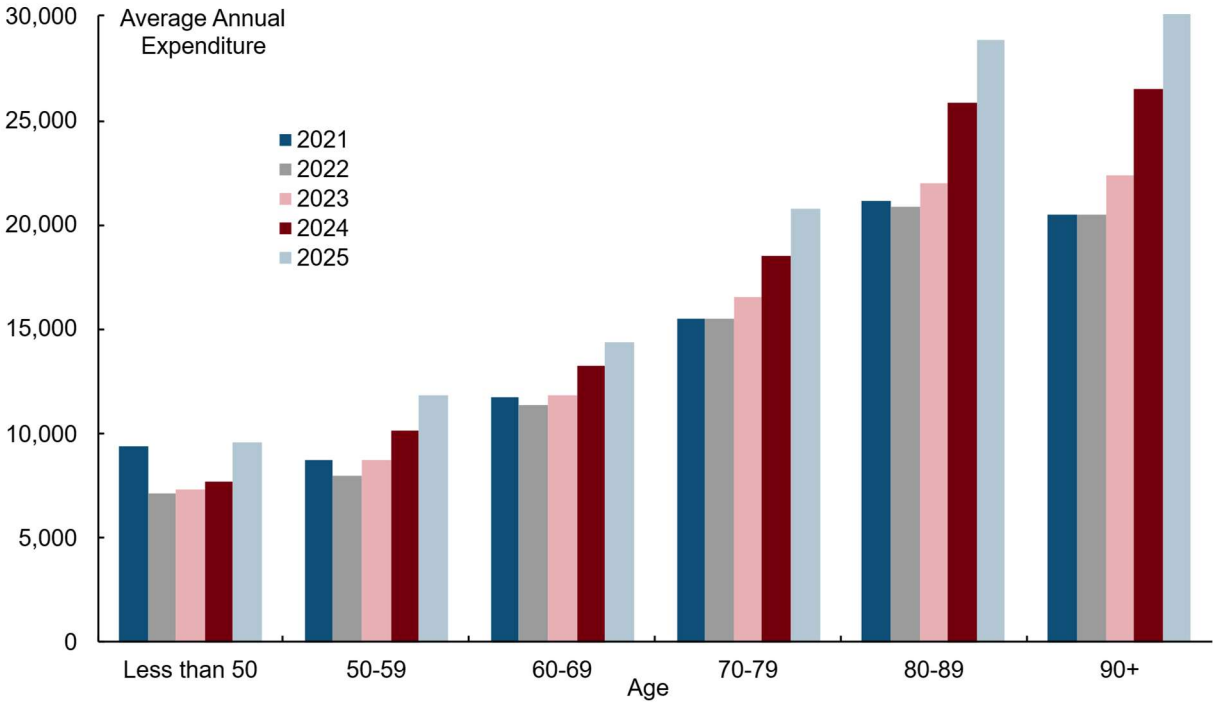


Figure 9.35: Average Annual Expenditure per VEA All Conditions Treatment Card Holder – Spouses



9.7.9 Combining the projected VEA All Conditions Treatment Card population with the average cost assumptions yields a projection of future VEA All Conditions Treatment Card expenditure. However, not all of these costs are to be accrued under the MRCA as a result of the VETS Act.

9.7.10 For veterans already with a VEA All Conditions Treatment Card, they will be issued with an All Conditions Treatment Card under MRCA if they meet one of the MRCA All Conditions Treatment Card eligibility criteria, that is, be assessed at 60 or more impairment points from service-related conditions or be SRDP eligible. We have used the projections of MRCA PI claims from VEA veterans combined with the assumed proportion of subsequent claims set out in Section 6.10, to estimate the proportion of future MRCA PI claims arising from veterans already with a VEA All Conditions Treatment Card. We have assumed that all these veterans will gain All Conditions Treatment Card eligibility under MRCA and thus have their card and future expenditure reclassified under MRCA.

9.7.11 For spouses already with a VEA All Conditions Treatment Card, their eligibility will remain under the VEA and their card won't be transferred across to MRCA. As such, none of these costs are to be accrued under MRCA.

9.7.12 For veterans that would have received a VEA All Conditions Treatment Card in the future under the old legislation, we have distinguished between those projected to receive a VEA All Conditions Treatment Card via the age 70 with Qualifying Service provision, as these veterans will continue to be issued an All Conditions Treatment Card under the VEA. All other veterans that are projected to have received a VEA All Conditions Treatment Card in the future under the old legislation are assumed to receive a MRCA All Conditions Treatment Card instead.

9.7.13 Widows of VEA veterans currently receive All Conditions Treatment Cards through the auto grant provision of the death benefit under the VEA or where the death is deemed to be service-related. For widows who would have received a VEA All Conditions Treatment Card in the future through the auto grant provision, access to a VEA All Conditions Treatment Card will continue. Where the veteran's death is service-related, the spouse will now be eligible for a MRCA death liability claim and a MRCA All Conditions Treatment Card. For non-service-related deaths, spouses may be eligible for death compensation benefits under the MRCA if the veteran is assessed at 80 impairment points or is found eligible for SRDP prior to their death.

9.7.14 To estimate the proportion of medical expenditure in respect of spouses projected to receive an All Conditions Treatment Card in the future that will be accrued under the MRCA, we have assumed that 20 per cent of deaths are service-related, and thus will be eligible for a MRCA death liability claim, a MRCA All Conditions Treatment Card and have their future medical costs accrued under the MRCA. For death compensation, we have assumed that 22 per cent of the VEA veterans who lodge a MRCA PI claim from 1 July 2026 will be assessed at 80 or more impairment points and, as a result, their spouse will be eligible for MRCA death compensation and a MRCA All Conditions Treatment Card. This proportion is based on the proportion of VEA veterans with 80 or more impairment points relative to those with 60 or more impairment points. While there is likely to be some overlap between those eligible for MRCA death compensation and death liability claims, this has been ignored for modelling purposes.

9.7.15 Table 9.1 shows the estimated present value of future medical costs from 1 July 2026 in respect of each All Conditions Treatment Card group described above, as well as the assumed proportion of these costs expected to be reclassified under MRCA following the legislation reform. There is significant uncertainty inherent in these assumptions. Please note that costs

associated with spouse All Conditions Treatment Cards because of MRCA Death Liability or Death Compensation claims have been included in the MRCA Death liability in Section 13.

Table 9.1: Present Value of Future All Conditions Treatment Card Costs and Proportion to be Accrued under MRCA

	Present Value of Future Medical Costs ($m)	Assumed Proportion Accrued	MRCA Liability ($m)
Veterans with a VEA All Conditions Treatment Card	16,843.9	21%	3,487.6
Widows with a VEA All Conditions Treatment Card	5,517.5	0%	-
Veterans projected to receive a VEA All Conditions Treatment Card in the future under VEA	9,242.4	74%	6,867.7
Future spouses projected to receive a VEA All Conditions Treatment Card in the future under VEA	4,406.9	31%	1,379.5
Total	36,010.7	33%	11,734.8

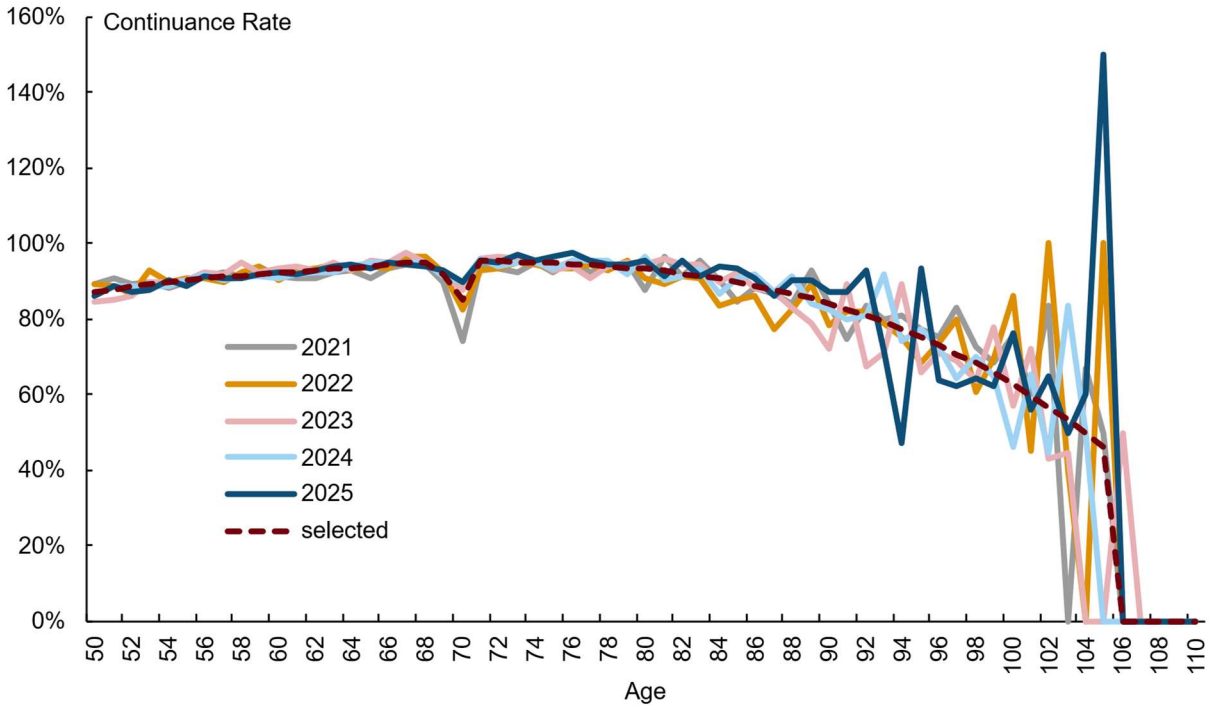
9.8 Impact of the VETS Act – VEA Specific Conditions Treatment Card

9.8.1 VEA Specific Conditions Treatment Cards will also be reclassified to MRCA from 1 July 2026 if the veteran lodges an IL claim for service-related condition(s) under the MRCA and has that condition accepted. Similar to the VEA All Conditions Treatment Card projection, we have projected total VEA Specific Conditions Treatment Card costs under the old legislation and then estimated the proportion of these costs that are anticipated to accrue under the MRCA as a result of the VETS Act.

9.8.2 We understand that veterans that receive a Specific Conditions Treatment Card for non-liability health care for mental health conditions are issued a VEA Specific Conditions Treatment Cards. As such, it is possible that existing VEA Specific Conditions Treatment Card holders also have MRCA service and are thus already accounted for in the MRCA medical future claimant projection. To avoid potential double counting of this group, we have restricted the VEA Specific Conditions Treatment Card population to those born in 1974 or earlier (i.e. aged 30 or older in 2004); veterans younger than this are more likely to have MRCA service. Additional data could help refine this assumption.

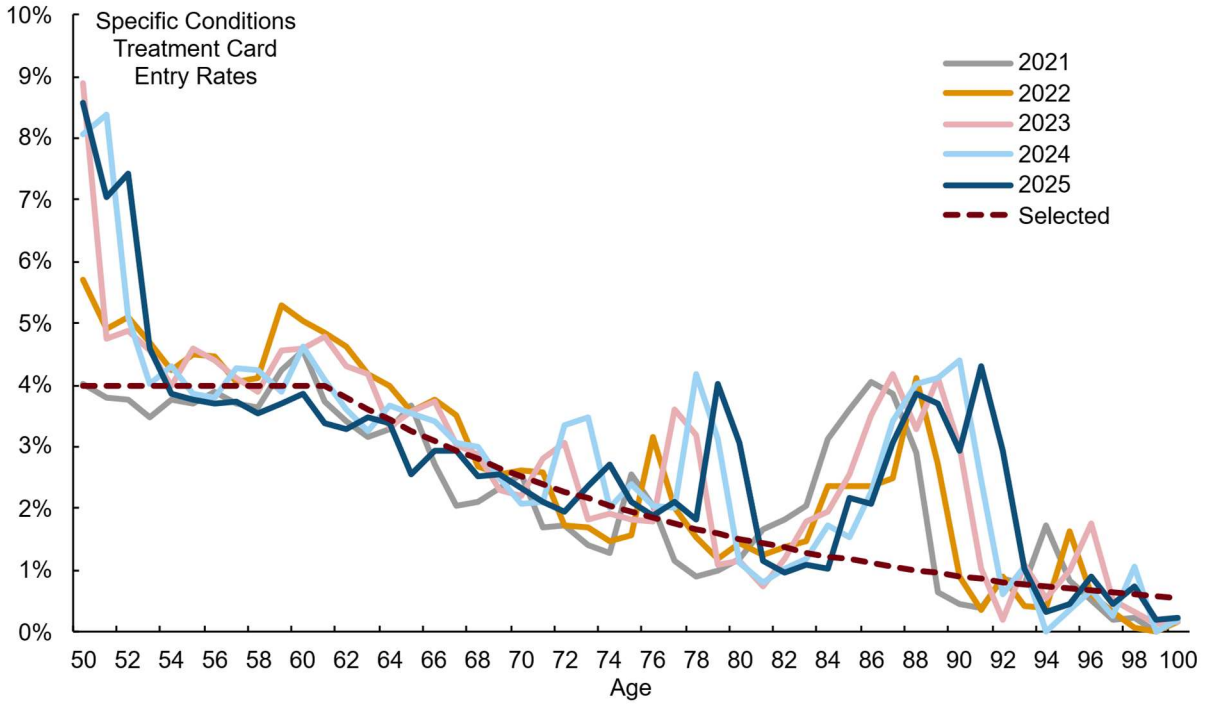
9.8.3 Similar to the VEA All Conditions Treatment Card projection, we have projected existing VEA Specific Conditions Treatment Card holders as well as veterans expected to receive a VEA Specific Conditions Treatment Card in the future under the current legislation. For existing Specific Conditions Treatment Card holders, we have derived age-based continuance rates to project the decline of this population over time, as shown in Figure 9.36 below.

Figure 9.36: Actual and Selected VEA Specific Conditions Treatment Card Continuance Rates



9.8.4 To estimate the number of future VEA Specific Conditions Treatment Card entrants in future years, we have used the VPM VEA population and assumed age-based entry rates calculated based on data since 2021. The actual and selected entry rates are shown in Figure 9.37.

Figure 9.37: Actual and Selected VEA Specific Conditions Treatment Card Entry Rates



9.8.5 Figure 9.38 shows the actual and projected number of veterans receiving a VEA Specific Conditions Treatment Card under the current VEA legislation. Figure 9.39 summaries the actual and projected VEA Specific Conditions Treatment Card population over time.

Figure 9.38: Actual and Projected New VEA Specific Conditions Treatment Card Holders

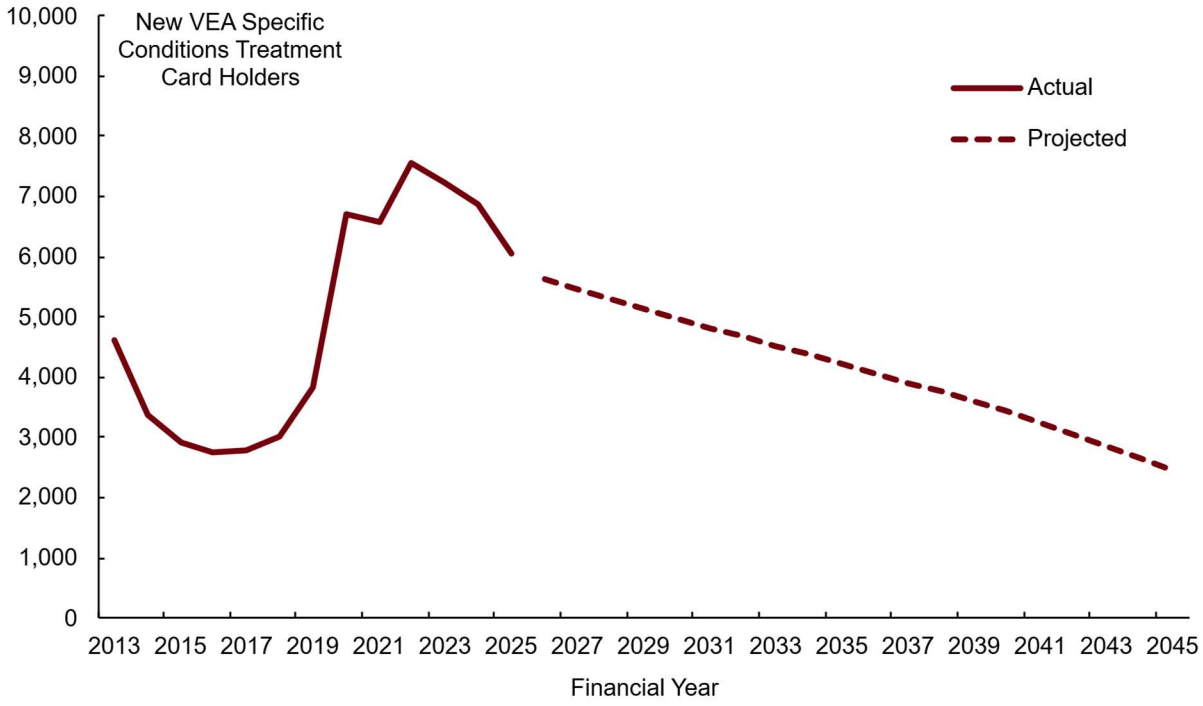
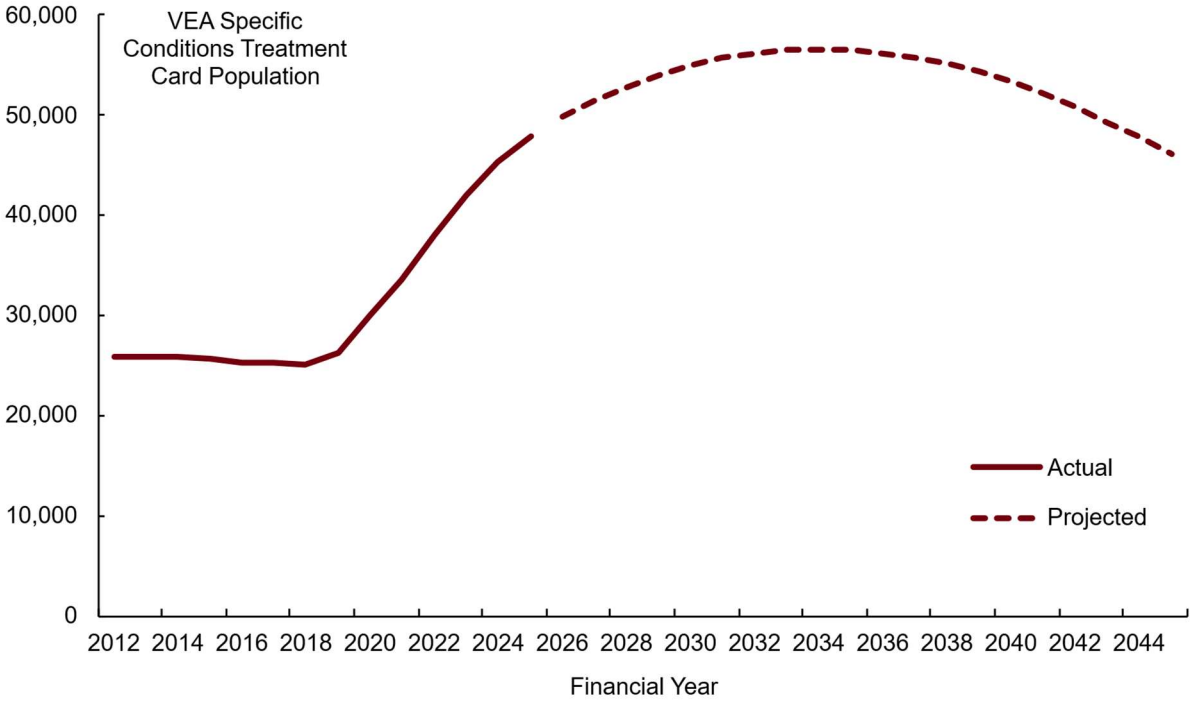
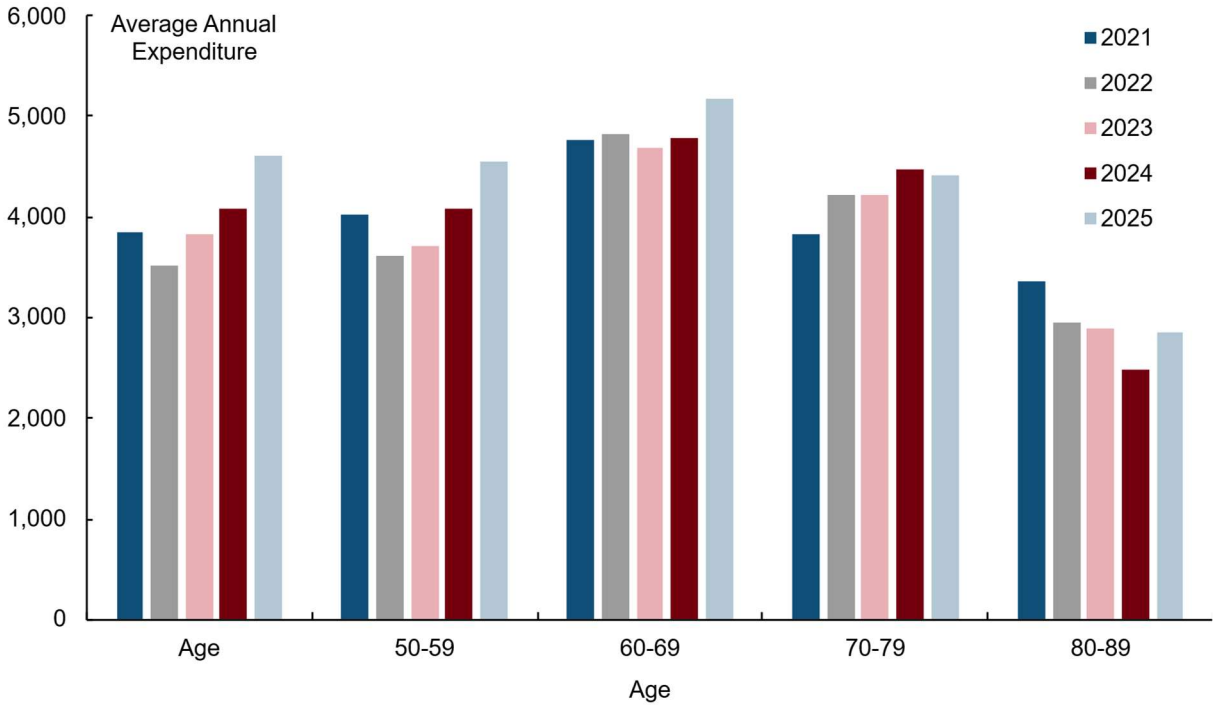


Figure 9.39: Actual and Projected VEA Specific Conditions Treatment Card Population



9.8.6 The next assumption required is the average annual expenditure per cardholder. Figure 9.40 below shows the average expenditure per VEA Specific Conditions Treatment Card cardholder since 2021. We have selected average costs based on the most recent financial year.

Figure 9.40: Average Annual Expenditure per VEA Specific Conditions Treatment Card Holder



9.8.7 Combining these assumptions yields a projection of future VEA Specific Conditions Treatment Card expenditure. However, not all these costs are to be accrued under the MRCA as a result of the VETS Act. Veterans projected to receive a VEA Specific Conditions Treatment Card in the future will now receive a MRCA Specific Conditions Treatment Card. For veterans currently with a VEA Specific Conditions Treatment Card, their card will only be reclassified to MRCA if they lodge a MRCA claim that gets accepted. Table 9.2 shows the estimated present value of future costs in respect of each Specific Conditions Treatment Card group described above, as well as the assumed proportion of these costs expected to be reclassified under MRCA. There is significant uncertainty inherent in these assumptions.

Table 9.2: Present Value of Future Specific Conditions Treatment Card Costs and Proportion to be Accrued under MRCA

	Present Value of Future Medical Costs ($m)	Assumed Proportion Accrued	MRCA Liability ($m)
Veterans with a VEA Specific Conditions Treatment Card	1,903.8	19%	369.7
Veterans projected to receive a VEA Specific Conditions Treatment Card in the future under VEA	4,154.7	100%	4,154.7
Total	6,058.5	75%	4,524.4

9.9 Impact of the VETS Act – Travel for Treatment Reimbursements

9.9.1 From 1 July 2026, all treatment-related travel reimbursement claims will be paid under MRCA.

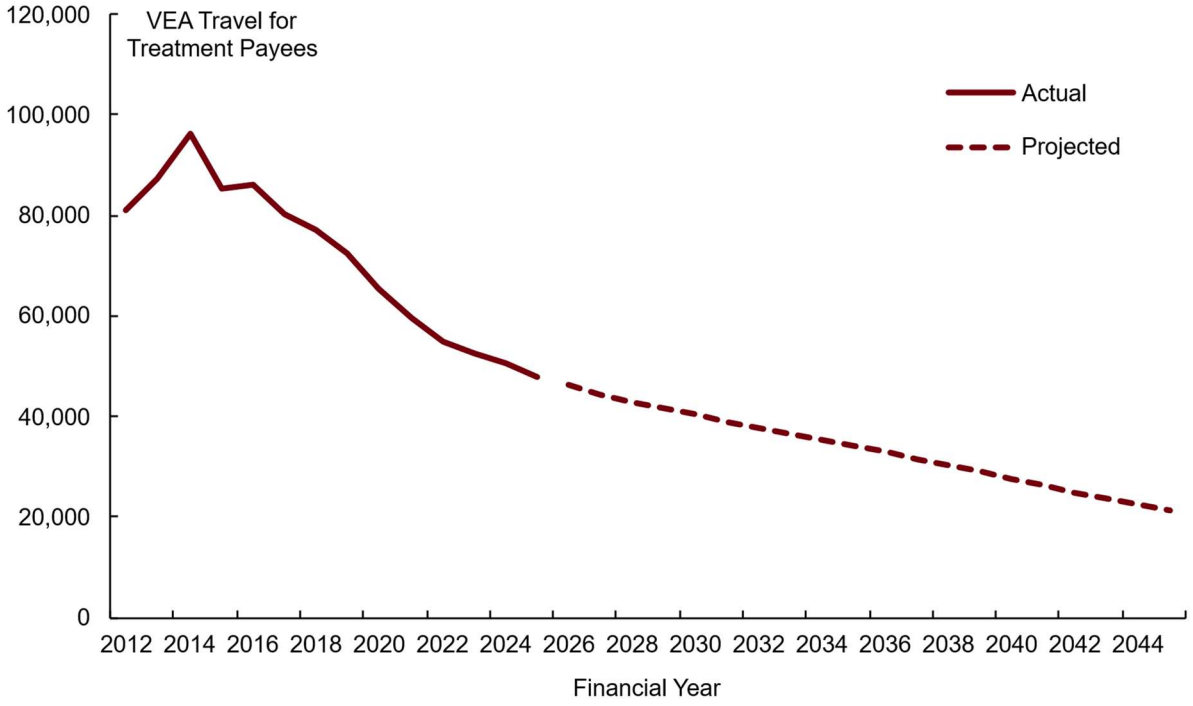
9.9.2 Although travel for treatment is available under all three Acts, the eligibility criteria and level of entitlement differs across Acts:

- Under the MRCA and DRCA, there is a 50 kilometre round-trip minimum distance for private vehicle travel; this is being removed under the legislation reform. There is no minimum distance requirement for private vehicle travel under the VEA.
- Under the VEA, private travel is currently reimbursed at a rate of $0.44 per kilometre. From 1 July 2026, private travel will be reimbursed at the higher (MRCA and DRCA) rate of $0.68 per kilometre. Accommodation and meal allowances will also be at the MRCA rates.

9.9.3 We have focused on the VEA travel for treatment expenditure. We have not considered the impact on veterans with MRCA and DRCA eligibility as we expect the changes for these groups is likely to be small. We have also not considered the changes to accommodation and meal allowances.

9.9.4 To quantify the treatment-related travel costs that will now be paid under the MRCA from 1 July 2026, we have modelled travel costs incurred by All Conditions Treatment Card and Specific Conditions Treatment Card holders separately. We have leveraged the VEA All Conditions Treatment Card and Specific Conditions Treatment Card projections described above and applied a utilisation rate assumption to estimate the number of VEA card holders claiming travel reimbursements in each future year. These utilisation rates are 51 per cent and 8 per cent for All Conditions Treatment Cards and Specific Conditions Treatment Cards respectively. Figure 9.41 shows the actual and projected number of VEA card holders claiming travel for treatment reimbursement based on these assumptions.

Figure 9.41: Actual and Projected VEA Travel for Treatment Reimbursement Payees



9.9.5 We have also assumed average rates of reimbursement that vary by card type. These average sizes are $2,150 and $1,350 for All Conditions Treatment Cards and Specific Conditions Treatment Cards respectively.

9.9.6 From 1 July 2026, VEA veterans will have private travel reimbursed at the MRCA rate, which is higher than the current VEA rate. To account for this, we have applied a 5.7 per cent increase to the assumed average annual treatment-related travel reimbursement rates. This reflects the increase to the per kilometre rate as well as an assumption around the proportion of travel for treatment expenditure that relates to private vehicle reimbursement. This proportion was estimated by DVA.

9.9.7 The estimated liability for travel-related reimbursement claims in respect of VEA veterans that will be paid out under the MRCA as a result of the VETS Act is $1,639 million as at 30 June 2025.

9.10 Liability Estimate

9.10.1 Table 9.3 shows the estimate of the MRCA liability for medical costs broken down by year of accident. The projected liability in the 2024 valuation for 30 June 2025 was $38,714.5m. The revised estimate of the liability at 30 June 2025 before the VETS Act is $50,217.4m. The liability at 30 June 2025 after the VETS Act is $67,128.8m. Table 9.4 below provides a reconciliation of this movement.

Table 9.3: Outstanding Claims Liability for Medical Costs

	Liability ($m)		
Year of Accident	**DRCA**	**MRCA**	**Total**
1979 and before	24.0	-	24.0
1980 – 1984	9.3	-	9.3
1985 – 1989	15.8	-	15.8
1990 – 1994	25.4	-	25.4
1995 – 1999	36.1	-	36.1
2000 – 2004	26.3	-	26.3
2005 – 2009	-	3,511.2	3,511.2
2010 – 2014	-	8,087.0	8,087.0
2015 – 2019	-	15,090.8	15,090.8
2020 – 2024	-	19,403.9	19,403.9
2025	-	3,987.6	3,987.6
Total (before VETS Act)	**136.8**	**50,080.5**	**50,217.4**
VETS Act Impact – DRCA Veterans	*(47.4)*	*440.1*	*392.7*
VETS Act Impact – VEA All Conditions Treatment Cards	-	*10,355.3*	*10,355.3*
VETS Act Impact – VEA Specific Conditions Treatment Cards	-	*4,524.4*	*4,524.4*
VETS Act Impact – Travel for Treatment	-	*1,639.0*	*1,639.0*
Total (after VETS Act)	**89.4**	**67,039.4**	**67,128.8**

Table 9.4: Reconciliation of the Liability for Medical Costs

	DRCA	MRCA	Total
Liability estimate as at 30 June 2024 (previous valuation)	113.0	34,395.3	34,508.3
Assumed Interest	5.4	1,779.8	1,785.2
Projected Payments	(11.6)	(450.3)	(461.9)
Notional Premium	-	2,882.8	2,882.8
Liability estimate as at 30 June 2025 (previous valuation)	106.9	38,607.7	38,714.5
Experience effects and assumption changes			
Difference between actual and projected payments	1.1	24.6	25.7
Change due to experience	8.3	(414.8)	(406.5)
Change due to claimant projection	15.6	3,171.4	3,187.0
Change due to All Conditions Treatment Card proportions	-	4,704.1	4,704.1
Change due to utilisation rates	-	(324.5)	(324.5)
Change due to average cost per active claimant	5.1	775.0	780.0
Change due to medicinal cannabis superimposed inflation	-	(987.6)	(987.6)
Change due to public hospital loading	-	2,850.3	2,850.3
Change due to community nursing	-	1,674.4	1,674.4
Liability at 30 June 2025 (before VETS Act)	**136.8**	**50,080.5**	**50,217.4**
Change due to VETS Act – DRCA Veterans	(47.4)	440.1	392.7
Change due to VETS Act – VEA All Conditions Treatment Cards	-	10,355.3	10,355.3
Change due to VETS Act – VEA Specific Conditions Treatment Cards	-	4,524.4	4,524.4
Change due to VETS Act – VEA Travel for Treatment	-	1,639.0	1,639.0
Liability at 30 June 2025 (after VETS Act)	**89.4**	**67,039.4**	**67,128.8**

10 Rehabilitation

10.1 Benefit Overview

10.1.1 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.

10.1.2 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.

10.1.3 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.

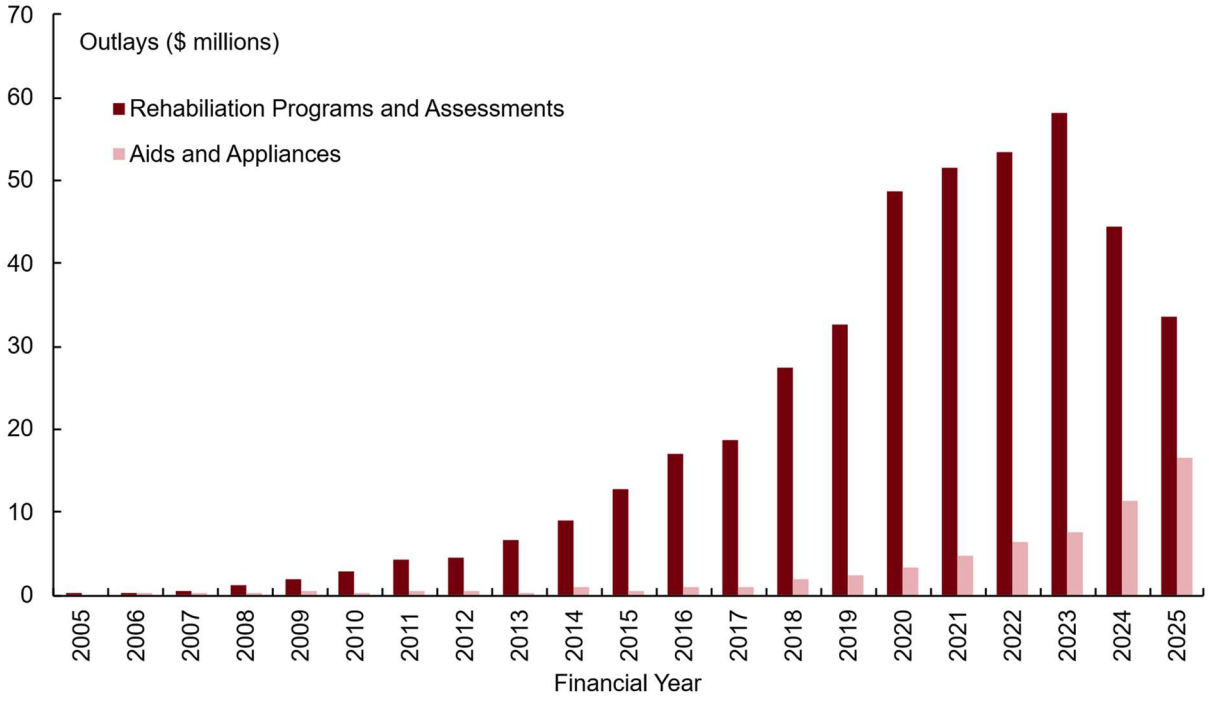
10.1.4 The second category consists of payments made under the Rehabilitation Appliances Program. The Rehabilitation Appliances Program provides aids, equipment and modifications to help veterans to live safely and independently. The aids, equipment and modifications available can be classified into 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 the Rehabilitation Appliances Program if they have an assessed clinical need and either an All Conditions Treatment Card, or a Specific Conditions Treatment Card and the equipment is for an accepted condition. As such, aids and appliances can be considered as an extension to the MRCA medical benefits.

10.2 Recent Experience

10.2.1 Figure 10.1 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. Expenditure on aids and appliances, while the smaller of the two components, is growing rapidly, and is projected to continue to increase as a proportion of all rehabilitation expenditure.

Figure 10.1: Expenditure on MRCA Rehabilitation

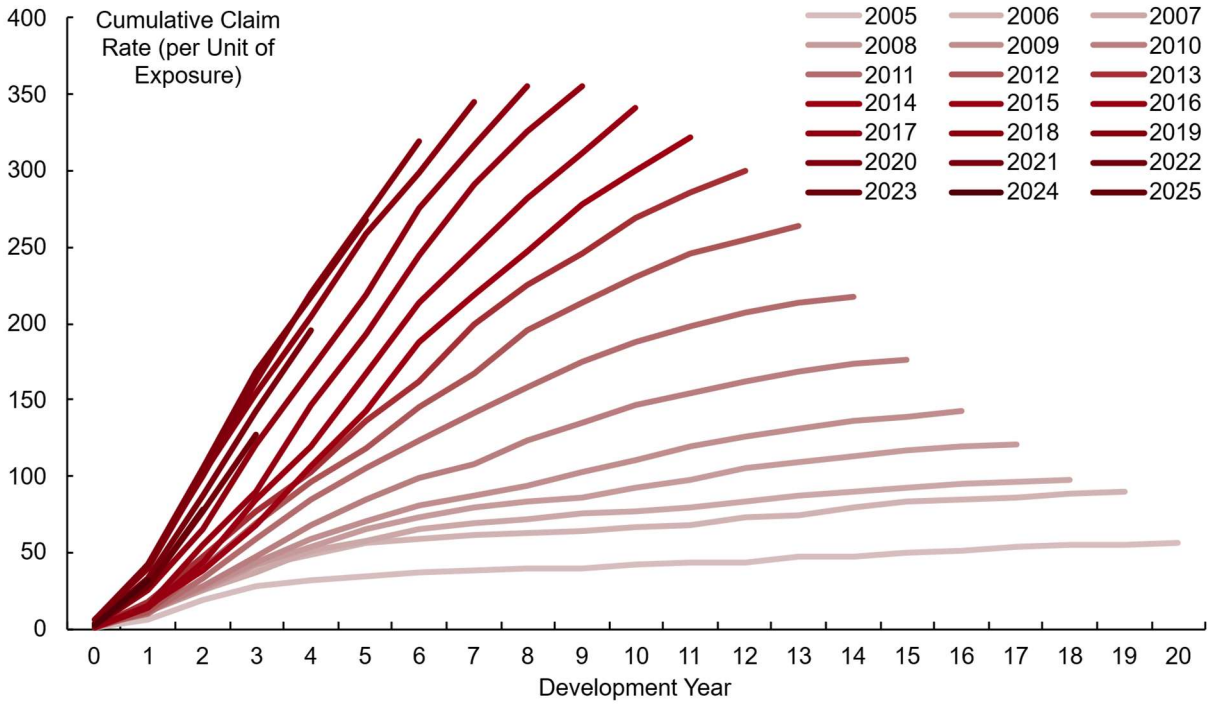


10.3 Valuation Assumptions – Rehabilitation Programs and Assessments

10.3.1 Future expenditure on MRCA rehabilitation programs and assessments is modelled using a Payments per Active Claimant model. New claimants are projected using a chain ladder model and utilisation rates are applied to determine the number of active claimants in each future period. Combining the projection of the active claimant population with an average expenditure per active claimant assumption yields a projection of future rehabilitation outlays.

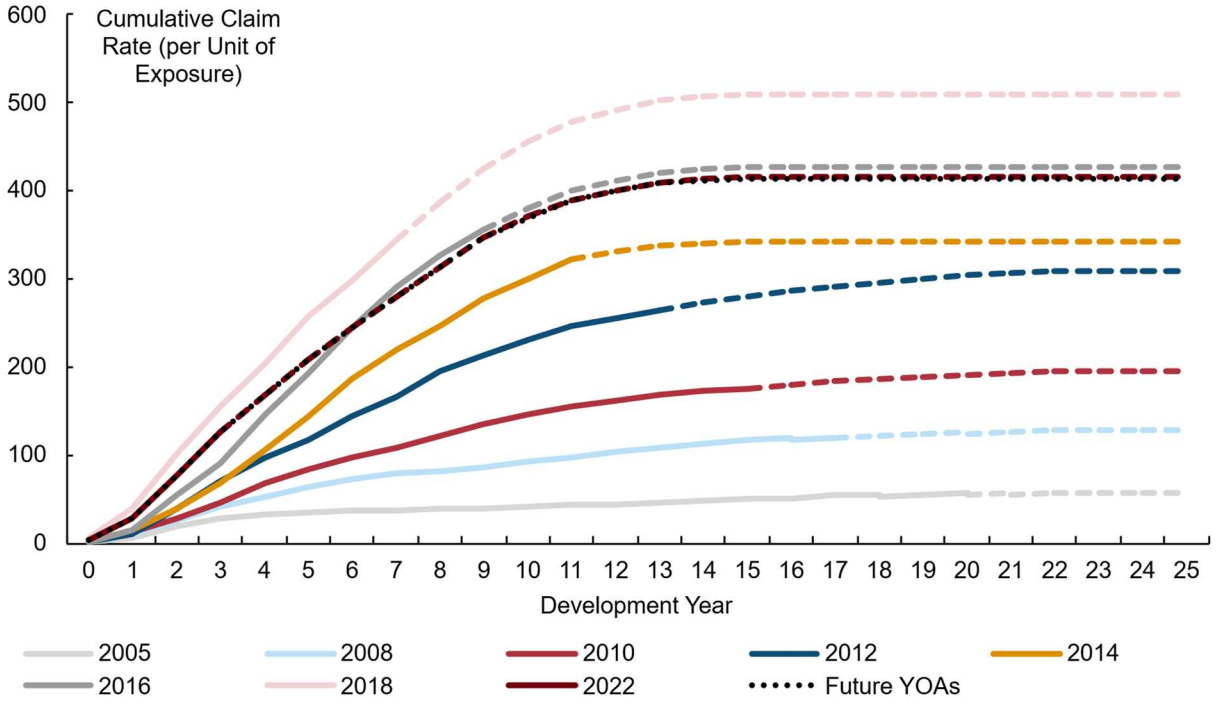
10.3.2 A chain ladder method has been adopted to project future rehabilitation entrants. Figure 10.2 shows the relationship between average accident year and the year in which rehabilitation expenditure is first incurred. The pattern of claims emerging has changed substantially since the commencement 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 emerging claims may be beginning to stabilise.

Figure 10.2: Cumulative Claimant Numbers – Rehabilitation Programs



10.3.3 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. Figure 10.3 shows the projected cumulative claimant numbers for a subset of accident years.

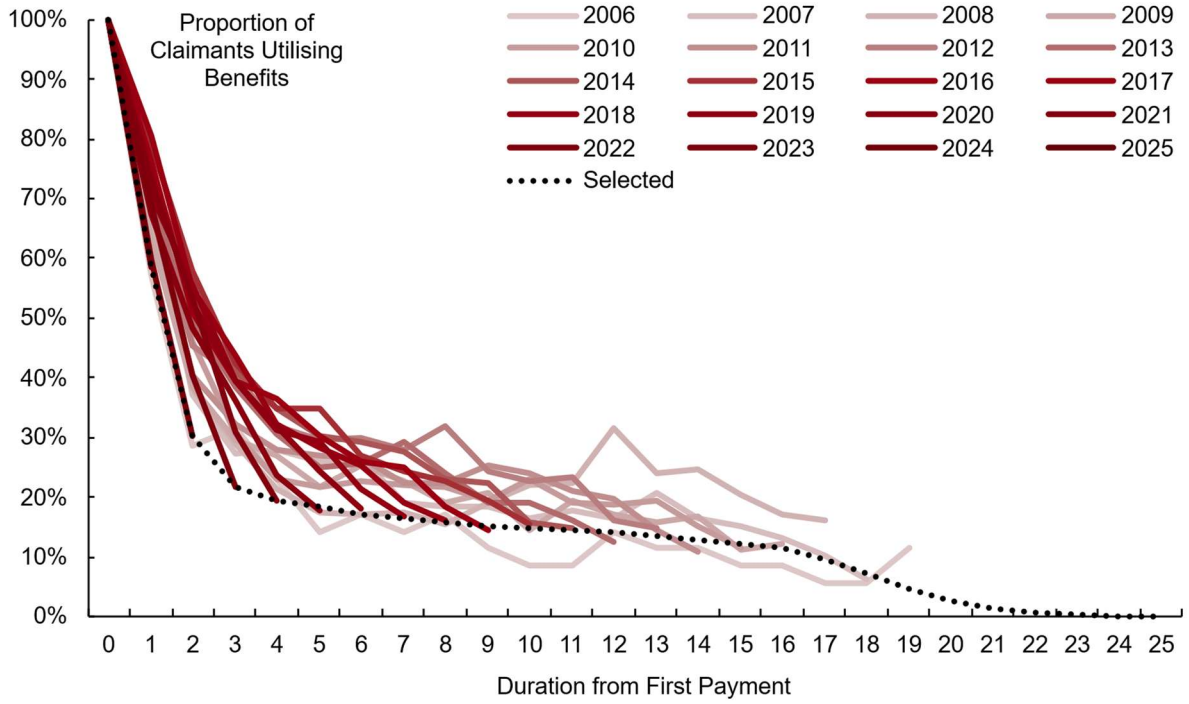
Figure 10.3: Projected Cumulative Claimant Numbers – Rehabilitation Programs



10.3.4 Once we have projected the cumulative claimant numbers, we then need to project the number of claimants receiving benefits in each future period. Figure 10.4 shows the utilisation rates by duration from first rehabilitation payment for each entry year cohort for rehabilitation programs.

The utilisation rates start at 100 per cent by definition and decrease significantly in the first and second year after entry. Utilisation rates have declined significantly over the last two years, and the adopted assumption has been updated to reflect the lower patterns of utilisation following the 2024 program review. No additional allowances have been made for further reductions in utilisation as the program review is now complete.

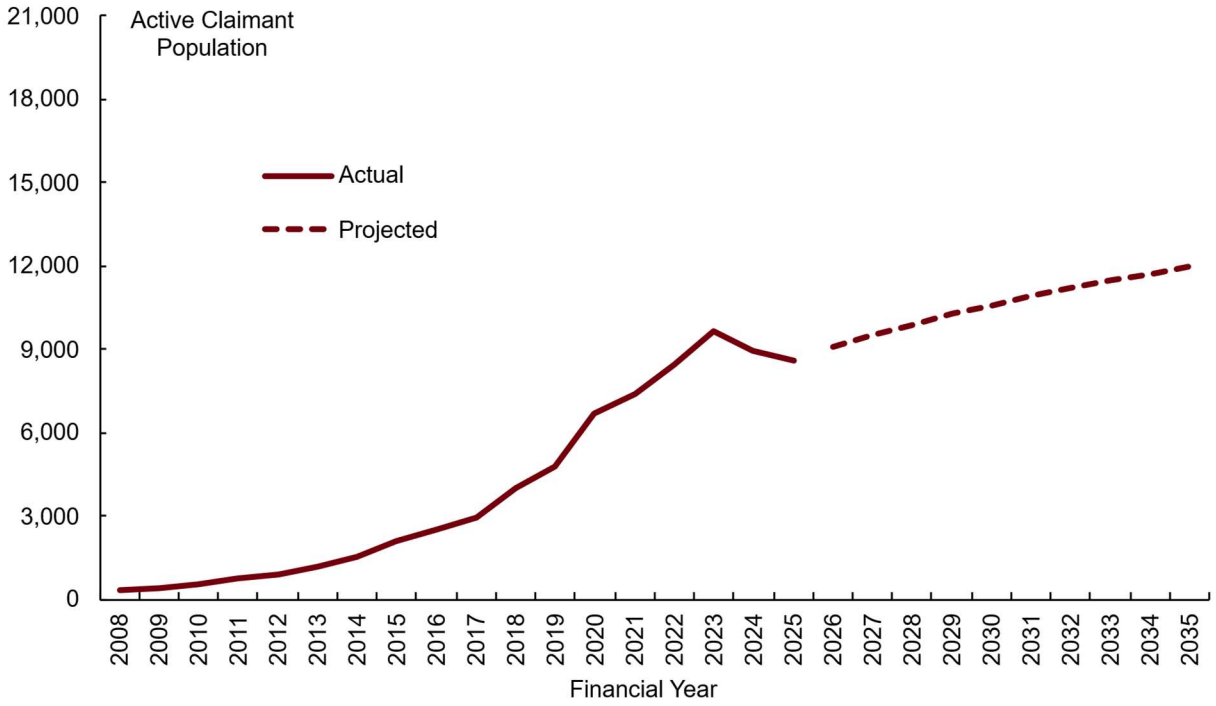
Figure 10.4: Utilisation Rate by Duration from First Payment – Rehabilitation Programs



10.3.5 The assumed utilisation rates decline over time and cease after 25 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.

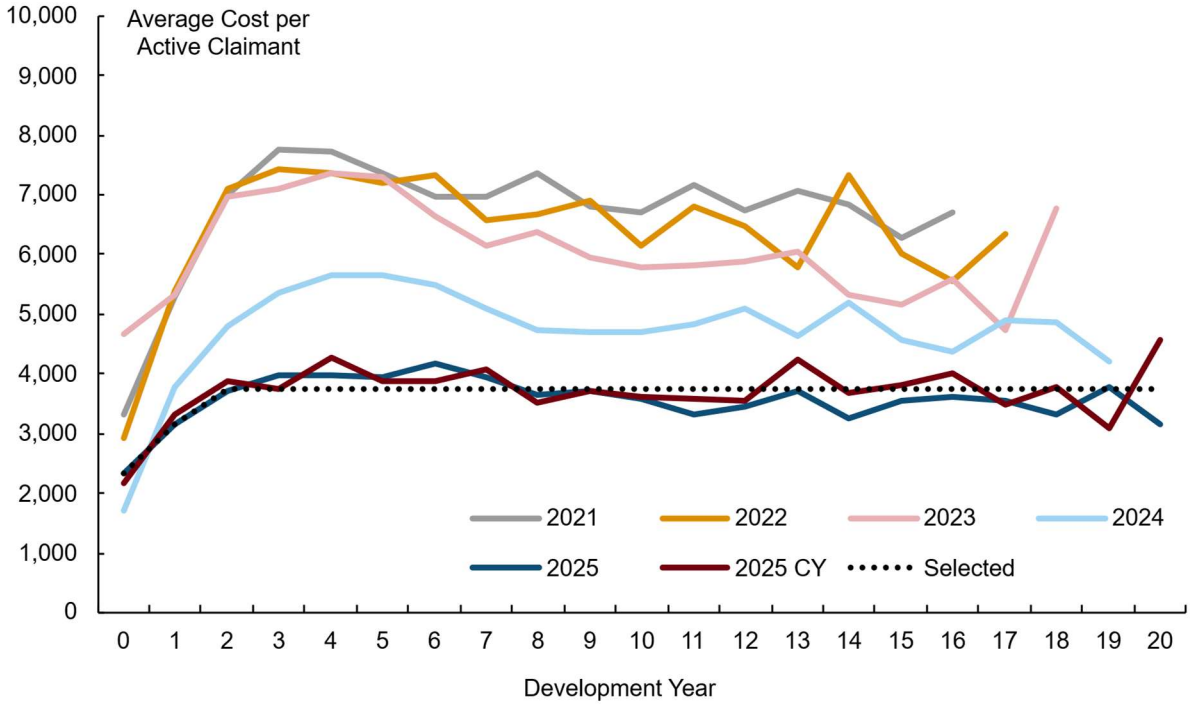
10.3.6 Combining the new entrant projection and the assumed utilisation rates results in a projection of the active claimant population for both rehabilitation programs, shown in Figure 10.5 below.

Figure 10.5: MRCA Rehabilitation Programs and Assessments Active Claimant Projection



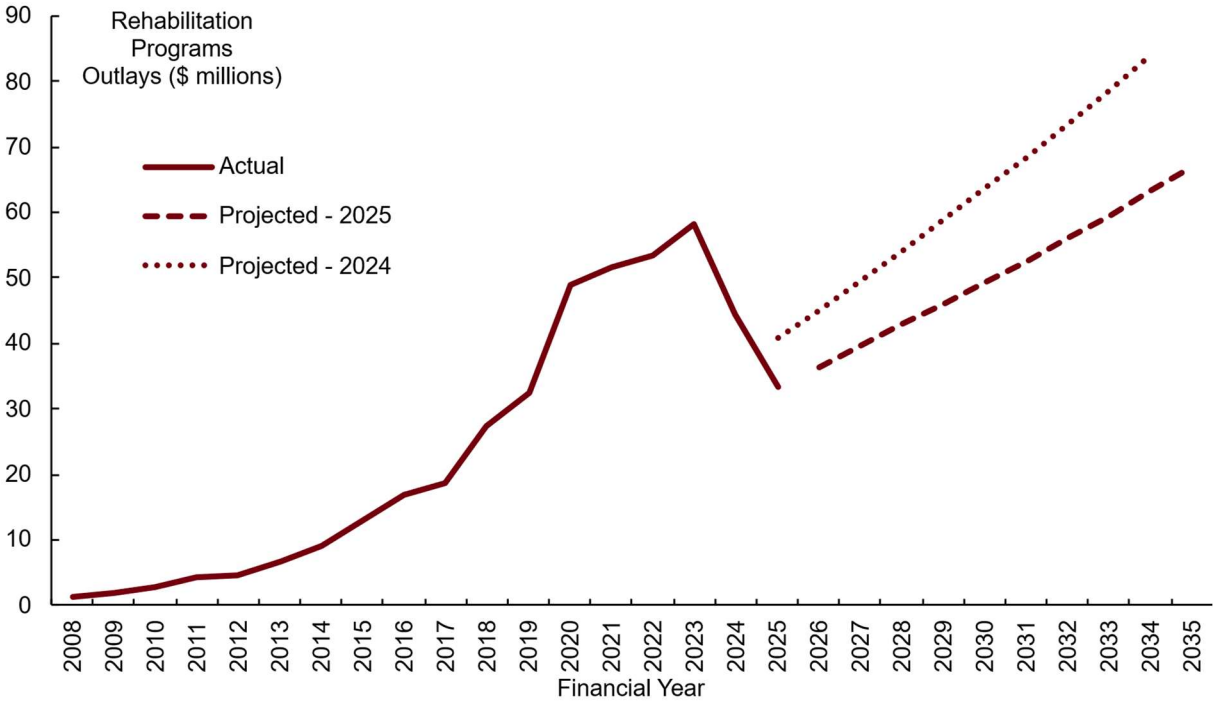
10.3.7 The final assumptions required relate to the average payment per active claimant. Figure 10.6 below shows the average payment amounts for the past five financial years as well as the most recent calendar year for rehabilitation programs, along with the selected assumption. Note that payments have been indexed to 2025 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. We have assumed that the average cost per claimant will increase by 3.7 per cent per annum in future.

Figure 10.6: Average Payment per Active Claimant – Rehabilitation Programs



10.3.8 Figure 10.7 shows the historical and projected cashflows for MRCA rehabilitation programs, together with the projections from the 2024 valuation.

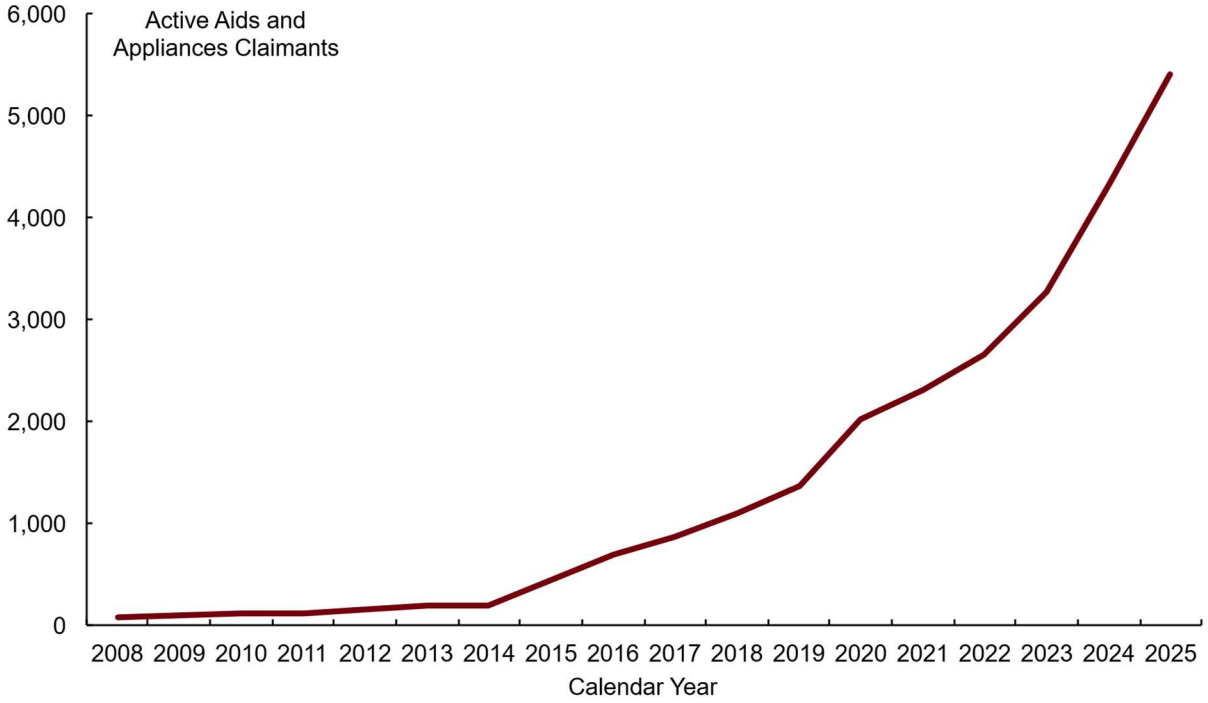
Figure 10.7: Historic and Projected MRCA Rehabilitation Payments



10.4 Valuation Assumptions – Aids and Appliances

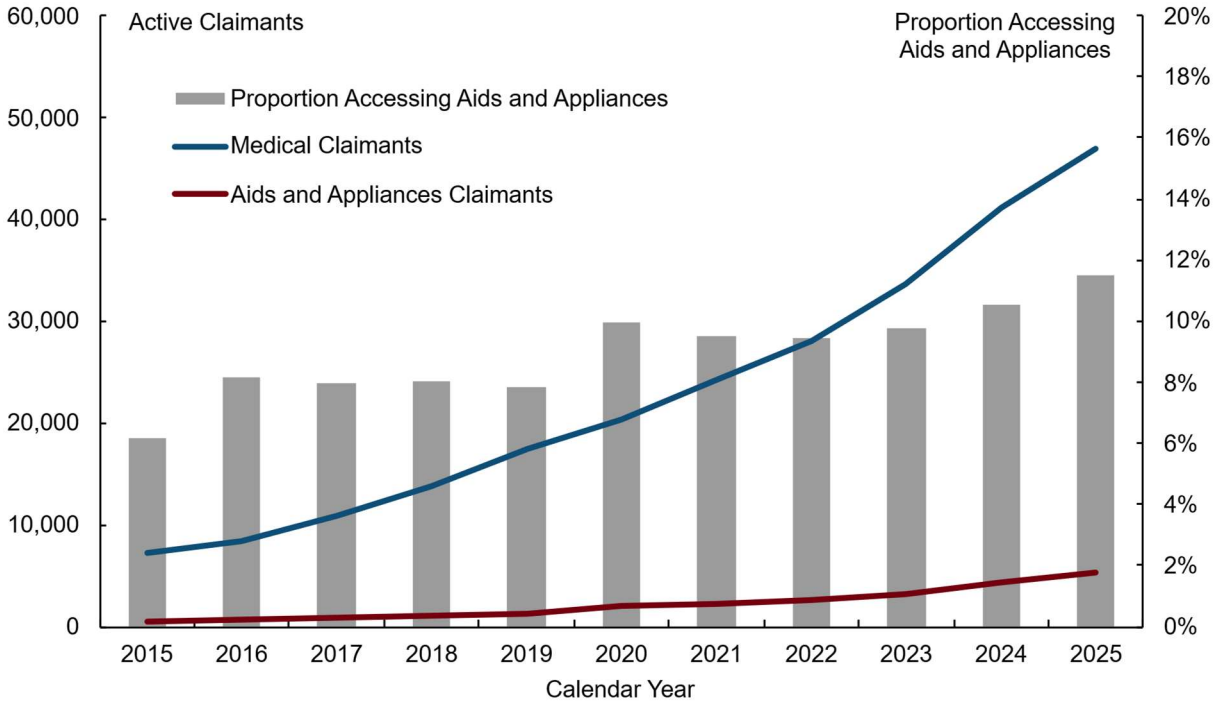
10.4.1 MRCA aids and appliances have previously been modelled using a Payments per Active Claimant approach. However, the number of clients accessing aids and appliances has been increasing rapidly, as shown in Figure 10.8.

Figure 10.8: Number of Active Aids and Appliances Clients



10.4.2 Further investigations revealed that this growth has been largely driven by an increase in the number of clients with a MRCA All Conditions Treatment Card. Veterans are eligible for aids and appliances if they have an assessed clinical need and hold either an All Conditions Treatment Card, or a Specific Conditions Treatment Card where the equipment is for an accepted condition. Around 20 per cent of active medical claimants with an All Conditions Treatment Card accessed aids and appliances in 2025, compared with 2 per cent of active medical claimants with a Specific Conditions Treatment Card. Figure 10.9 shows the number and proportion of medical claimants using aids and appliances.

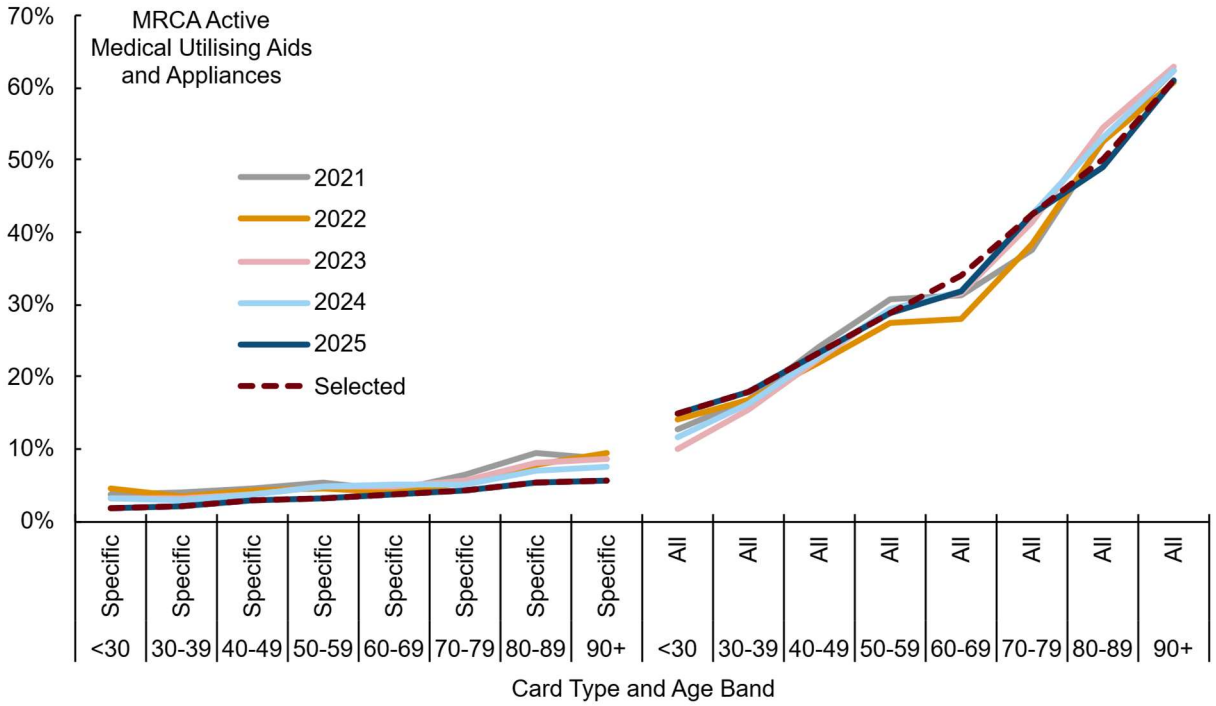
Figure 10.9: Active Medical and Aids and Appliances Claimants



10.4.3 As the MRCA All Conditions Treatment Card population is expected to continue to grow rapidly over the coming years, aids and appliances costs are also likely to increase significantly. For this valuation, we have revised the modelling methodology for aids and appliances by explicitly linking the projections to the MRCA medical active claimant projections described in Section 9. This modelling change acknowledges the correlation between All Conditions Treatment Card eligibility and aids and appliances utilisation while ensuring that the flow on impacts on aids and appliances from the projected growth in All Conditions Treatment Card numbers is adequately captured in the projections.

10.4.4 To project the number of veterans accessing aids and appliances, we have assumed probabilities (referred to as aids and appliances utilisation rates) that an active medical claimant will access aids and appliances each year; these probabilities are assumed to vary by age and card type. Figure 10.10 below shows the actual and assumed aids and appliances utilisation rates since 2021. For ages above 70, where there is very limited MRCA experience given the younger age profile of the cohort, VEA experience has been used.

Figure 10.10: Actual and Assumed Aids and Appliances Utilisation Rates

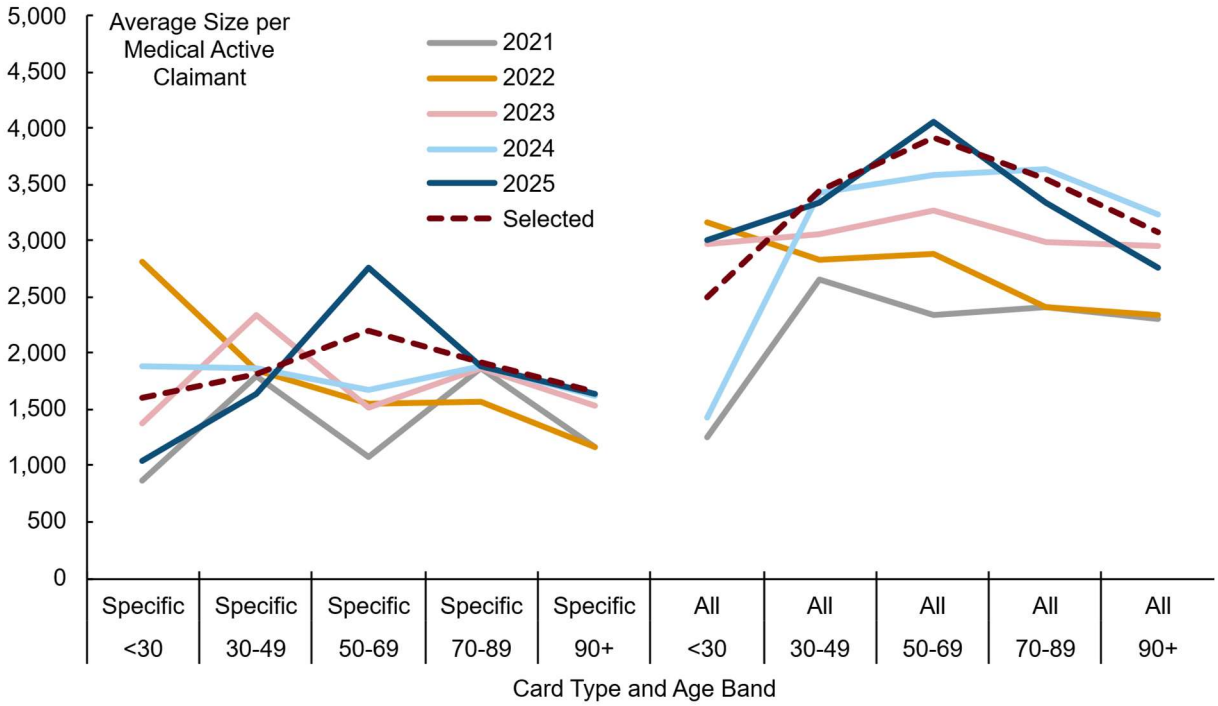


10.4.5 The proportion of active medical clients accessing aids and appliances benefits is significantly higher for veterans with All Conditions Treatment Card eligibility. The utilisation rates increase considerably with age in the VEA data, to the point where the majority of active medical claimants are utilising aids and appliances beyond age 80. Utilisation rates have exhibited relative stability over time, likely due to ongoing costs associated with aids and appliances, such as replacement costs, maintenance and repairs.

10.4.6 The next assumption we have considered is the average cost per veteran accessing aids and appliances benefits. For the previous valuation, we relied only on the MRCA aids and appliances experience and assumed the average cost of aids and appliances increased with duration up to 20 years, beyond which the average cost was assumed to stabilise.

10.4.7 For this valuation, we have also considered the average cost of aids and appliances from the VEA veteran cohort. This analysis indicated an increase in costs at older ages for veterans with an All Conditions Treatment Card. This has led us to assume average costs per client that vary by age. Figure 10.11 shows the average costs per client accessing aids and appliances since 2021. Costs broadly increase with age, except at the oldest age band, where costs decline slightly. RAP is available to veterans in residential aged care where a facility is unable to provide the item, which may explain the slight drop in average costs, along with functional decline due to old age reducing the need for certain aids and appliances. Average costs are more volatile from year to year compared with utilisation, likely driven by the mix of large one-off home modifications compared with ongoing aids and appliances costs. Given this volatility, we have grouped the data into wider age bands and assumed an average based on experience from the last two years.

Figure 10.11: Average Aids and Appliances Cost per Active Medical Claimant



10.4.8 Combining the aids and appliances utilisation rates and the MRCA medical active claimant projection yields projected numbers of active aids and appliances claimants over time, shown in Figure 10.12. Applying the average cost per active medical claimant accessing aids and appliances then results in a projection of aids and appliances costs, as shown in Figure 10.13. These projections are significantly higher than the previous projections, due to the anticipated increase in the number of MRCA All Conditions Treatment Cards over time and the assumption that aids and appliances usage and costs will increase markedly with age, as observed in the VEA veteran cohort.

Figure 10.12: MRCA Aids and Appliances Active Claimant Projection

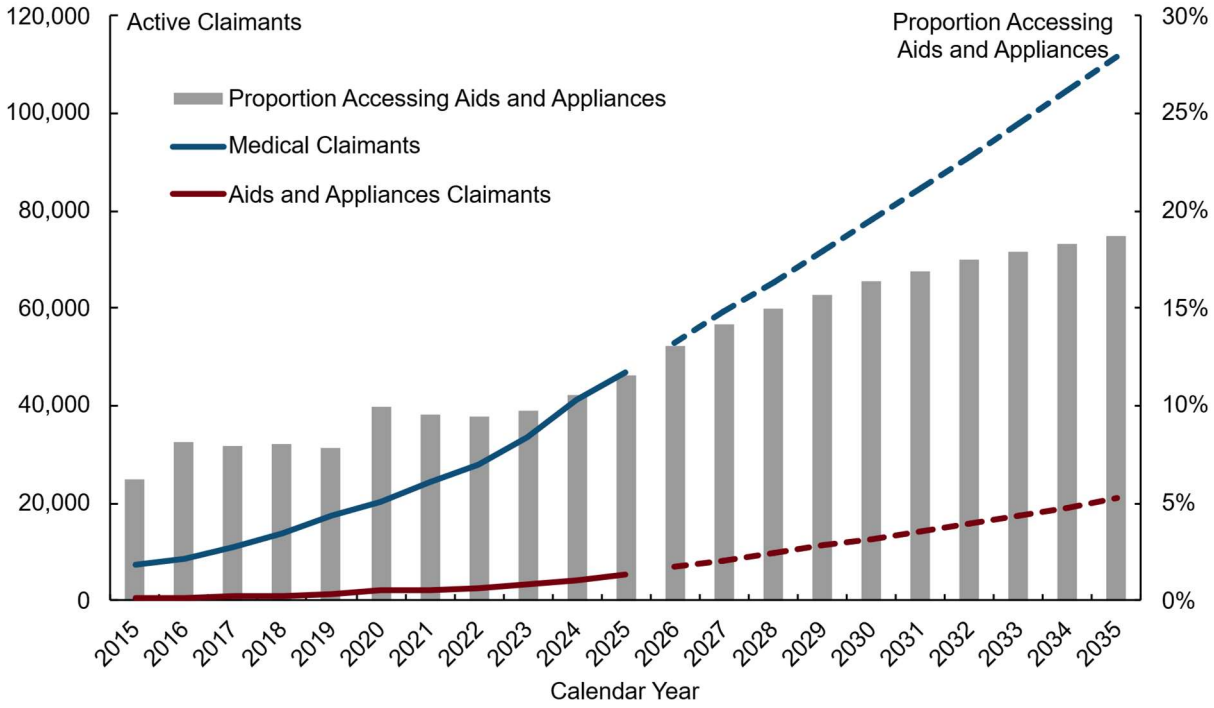
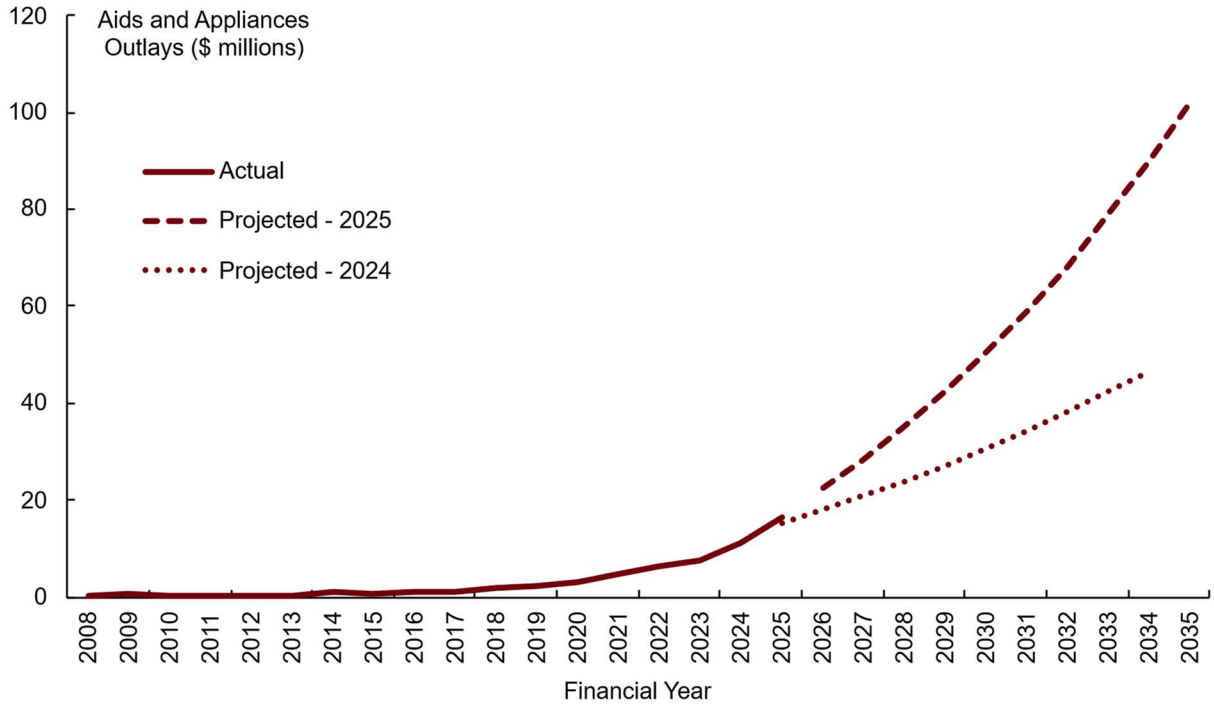


Figure 10.13: Actual and Projected MRCA Aids and Appliances Outlays

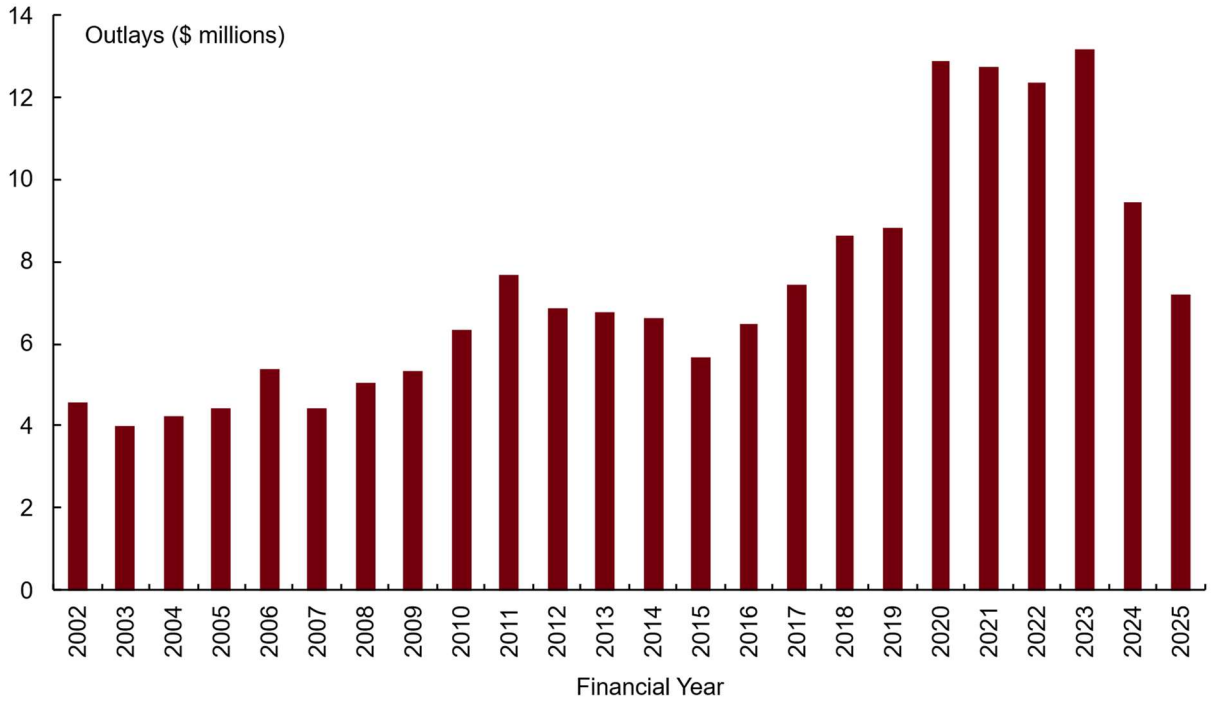


10.5 Impact of the VETS Act – DRCA Rehabilitation

10.5.1 From 1 July 2026, the DRCA will close to new rehabilitation claims and veterans currently on a rehabilitation program under the DRCA will have their services transitioned across to the MRCA as a result of the VETS Act.

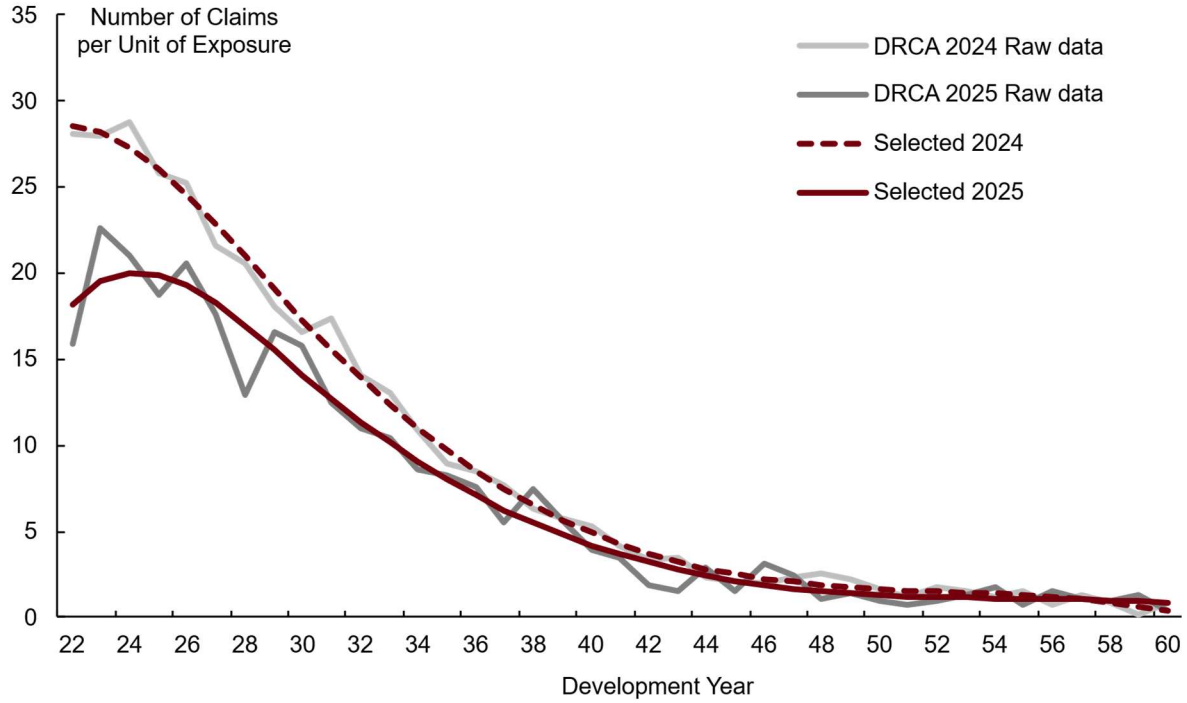
10.5.2 Figure 10.14 shows the expenditure on DRCA rehabilitation since 2002. DVA advised that the period of rapid growth between 2007 and 2011 was the result of an increased focus on rehabilitation for all veterans, not just those with a prospect of returning to work. Subsequently, rehabilitation efforts 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, before 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. 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 instead of incremental approvals which were used previously. This has resulted in a significant reduction in expenditure in the last two financial years.

Figure 10.14: Expenditure on DRCA Rehabilitation



10.5.3 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. Figure 10.15 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 2024 valuation. The claim rates per unit of exposure are lower compared with the selected assumption from last year's valuation.

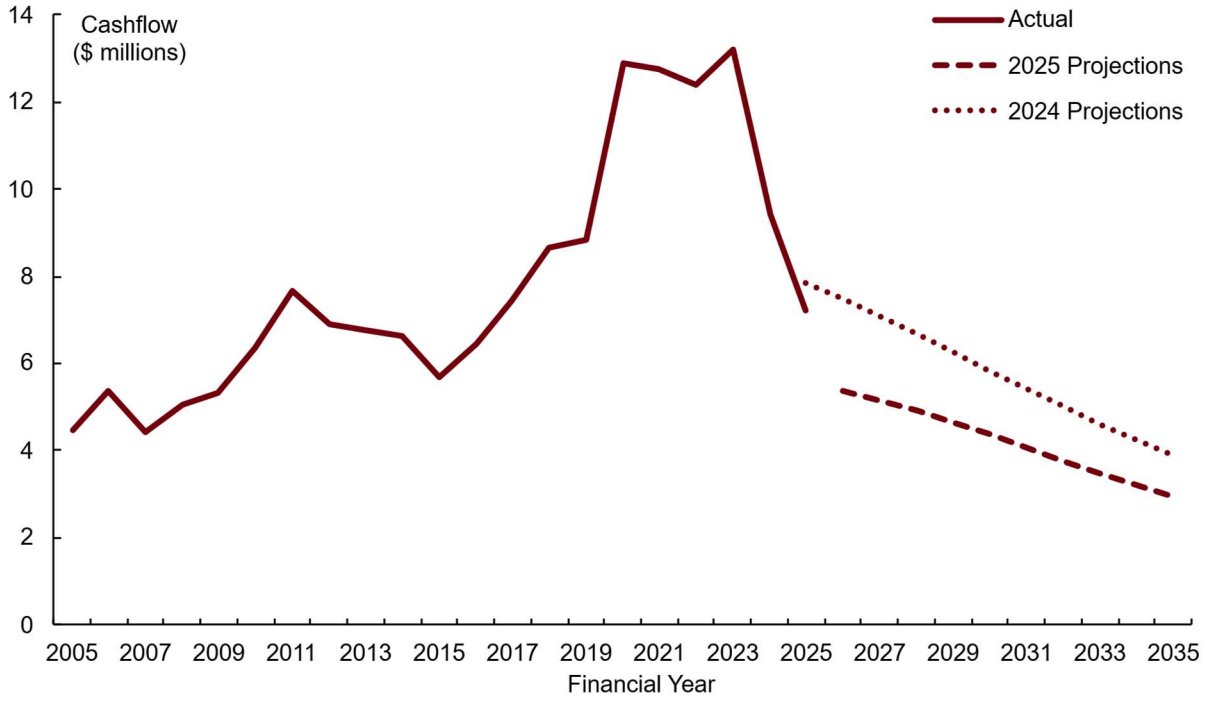
Figure 10.15: Number of DRCA Rehabilitation Claimants per unit of Exposure



10.5.4 The average cost per claimant was selected to be $3,000, 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.

10.5.5 The resulting projected cashflows are shown in Figure 10.16, together with the actual cashflows and the projections from the 2024 valuation, before consideration of the VETS Act impact.

Figure 10.16: Actual and Projected DRCA Rehabilitation payments



10.6 Impact of the VETS Act – VEA Aids and Appliances

10.6.1 Currently, eligibility and entitlements for aids, appliances and modifications vary across VEA, DRCA and MRCA. From 1 July 2026, all aids, appliances and modifications claims and entitlements will be considered under the MRCA.

10.6.2 Existing veterans will not be required to transition immediately. They may either continue receiving supports under current arrangements or elect to access those supports under the MRCA from 1 July 2026. We have assumed that all veterans will elect to have aids and appliances assessed under the MRCA.

10.6.3 The costs of aids and appliances for VEA All Conditions Treatment Cards and Specific Conditions Treatment Cards were modelled in Sections 9.7 and 9.8. We have assumed that 2.8 per cent of future medical costs relate to aids and appliances for All Conditions Treatment Cards, and 1.8 per cent for Specific Conditions Treatment Cards, based on the contribution of aids and appliances costs to the assumed average expenditure per active claimant amounts. This results in an estimated liability for aids and appliances claims in respect of VEA veterans that will be paid out under the MRCA from 1 July 2026 as a result of the VETS Act of $2,313.4m as at 30 June 2025.

10.7 Liability Estimate

10.7.1 Table 10.1 shows the estimate of the liability for rehabilitation costs broken down by accident year. The 2024 valuation projected a liability of $1,379.5m as at 30 June 2025. The liability at 30 June 2025 is $2,963.5m before the VETS Act; this is $1,599.2m higher than projected last year. The liability after the VETS Act is 5,276.9m as at 30 June 2025. Table 10.2 reconciles the current liability estimate with the 2024 valuation.

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

Year of accident	DRCA	MRCA	Total
1979 and before	2.5	-	2.5
1980 – 1984	2.5	-	2.5
1985 – 1989	4.4	-	4.4
1990 – 1994	7.7	-	7.7
1995 – 1999	11.9	-	11.9
2000 – 2004	17.6	-	17.6
2005 – 2009	-	187.3	187.3
2010 – 2014	-	460.5	460.5
2015 – 2019	-	891.9	891.9
2020 – 2024	-	1,143.4	1,143.4
2025	-	233.7	233.7
Total (before VETS Act)	**46.7**	**2,916.8**	**2,963.5**
VETS Act Impact – DRCA Veterans	*(41.5)*	*41.5*	-
VETS Act Impact – VEA Veterans	-	*2,313.4*	*2,313.4*
Total (after VETS Act)	**5.2**	**5,271.6**	**5,276.9**

Table 10.2: Reconciliation of Liability for Rehabilitation Costs

	DRCA	MRCA Rehabilitation Programs	MRCA Aid and Appliances	Total
Liability estimate as at 30 June 2024 (previous valuation)	66.7	504.5	702.1	1,273.2
Assumed Interest	3.1	25.6	36.0	64.7
Projected Payments	(7.8)	54.1	51.2	97.5
Notional Premium	0.0	(40.7)	15.3	(25.5)
Projected liability as at 30 June 2025 (previous valuation)	61.9	543.5	774.0	1,379.5
Experience effects and assumption changes:				
Difference between actual and projected payments	(1.6)	7.3	(1.3)	4.3
Change due to active claimant projection	(10.5)	(102.5)	1,874.3	1,761.3
Change due to average cost	(3.1)	8.8	(187.3)	(181.6)
Liability at 30 June 2025 (before VETS Act)	**46.7**	**457.1**	**2,459.7**	**2,963.5**
Change due to VETS Act – DRCA veterans	(41.5)	41.5		-
Change due to VETS Act – VEA veterans	-	2,313.4		2,313.4
Liability at 30 June 2025 (after VETS Act)	**5.2**	**5,271.6**		**5,276.9**

11 Household Services and Attendant Care

11.1 Benefit Overview

11.1.1 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.

11.1.2 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 AC clients have sustained injuries that are classified as catastrophic injuries. These recipients require a higher level of care than other AC clients, and usually on a long-term basis.

11.1.3 DVA can reimburse the veteran or pay the service provider directly for approved services up to a statutory maximum weekly amount. If the services are being provided under the DRCA, the maximum amount is currently $588.55 per week. If the services are being provided under the MRCA the maximum rate is currently $611.46 per week. Note that this maximum amount is applicable to both household and attendant care services. For catastrophically injured veterans, these maximum rates can be waived, and the veteran is reimbursed for all approved services. Household services are also subject to an hourly maximum rate which is currently $79.90 per hour.

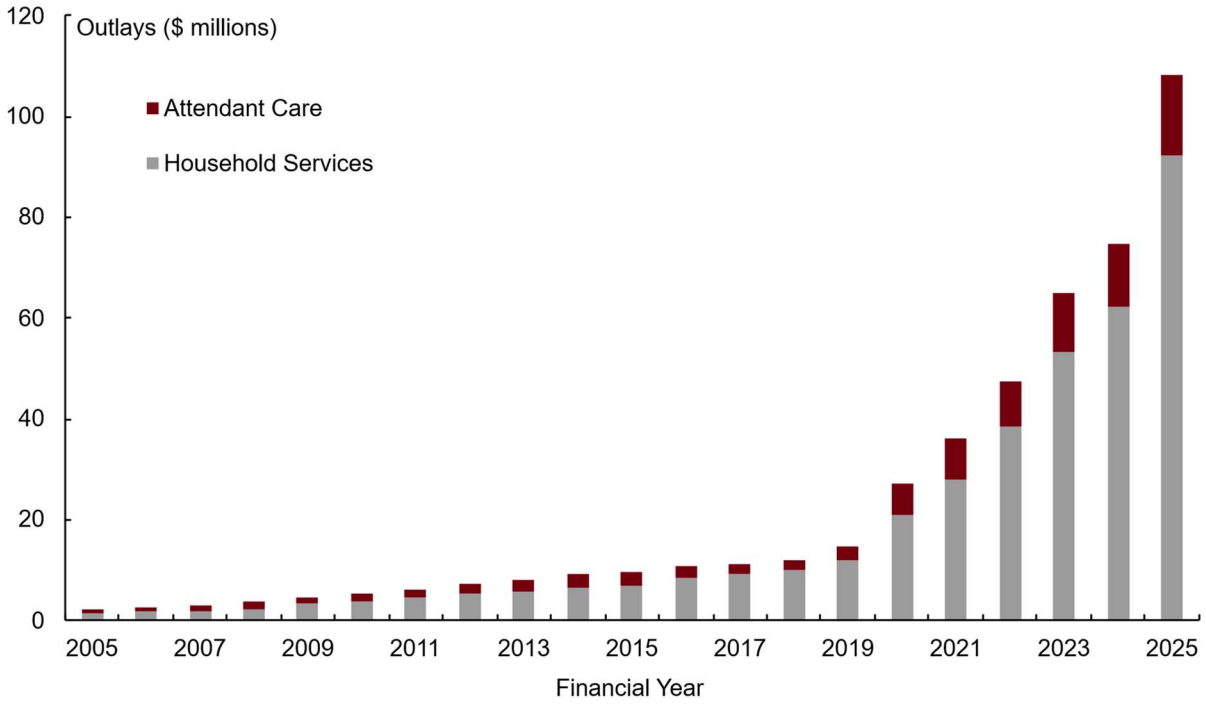
11.1.4 From 1 July 2026, access to household services and attendant care under the MRCA will be expanded to all veterans where an accepted service-related condition results in a need for these services. Veterans receiving household services and attendant care under the DRCA will have their services transferred to the MRCA and be eligible for the higher maximum weekly rate available under the MRCA. Veterans with eligibility under the VEA, including those that are currently accessing the Veterans' Home Care program (VHC), will be able to access household services and attendant care under the MRCA for the first time. Access to services provided via the VHC may also continue for veterans with current eligibility. These changes are discussed in more detail in the following sections. Veterans already receiving services under the MRCA will not be affected by these changes.

11.2 Recent Experience

11.2.1 Figure 11.1 shows the expenditure since 2005, split by benefit type. Overall expenditure on HSAC increased gradually between 2005 and 2019. From 2020 onwards, there has been significant year on year growth in total expenditure, reflecting an increase in the number of new claimants and rising costs per client. This growth may have been due to policy changes introduced in 2019 where HS payments were incorporated into the needs assessment process and the maximum reassessment period was extended to five years. AC expenditure has

increased by almost six-fold over this period, due to growth in new clients deemed catastrophically injured and increased expenditure per client. Total HSAC outlays increased by approximately 45 per cent in the 2025 financial year.

Figure 11.1: Expenditure on HSAC Payments by Benefit



11.3 Modelling Approach

11.3.1 The HSAC model projects future benefit outlays by separately modelling new entrants and the ongoing utilisation of benefits by existing clients. New HSAC clients are projected using a claims curve derived from recent experience. Future utilisation and average annual costs are then applied to both existing and new clients to estimate expenditure over time.

11.3.2 The HSAC model relies on three main assumptions:

- New client projection (a projection of people commencing HSAC benefits in each future year, including their age and accident year);
- Utilisation rates (which determine the probability clients remain in receipt of services in each future year); and
- Average annual cost per client (to calculate the expected costs for each HSAC client in each future year).

Combining the existing HSAC client population, the projection of new 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 below.

11.4 Valuation Assumptions – Active Claimant Projection

11.4.1 Figures 11.2 and 11.3 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.

Figure 11.2: New DRCA Household Services Clients by Development Year

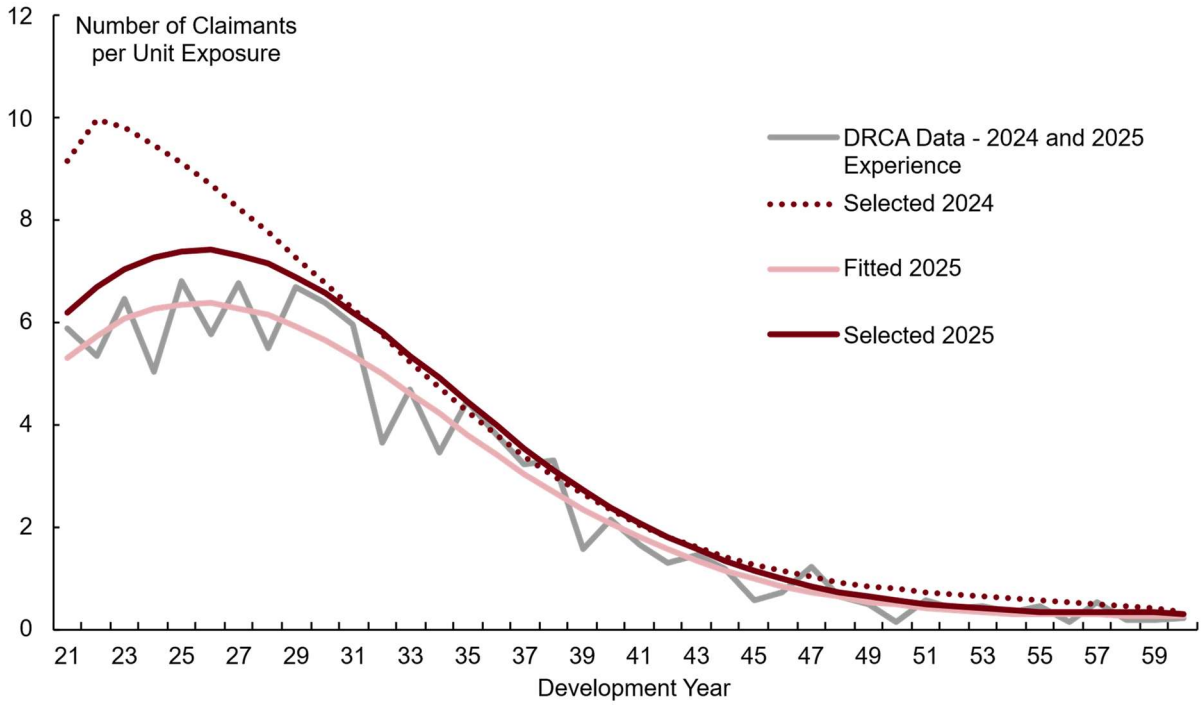
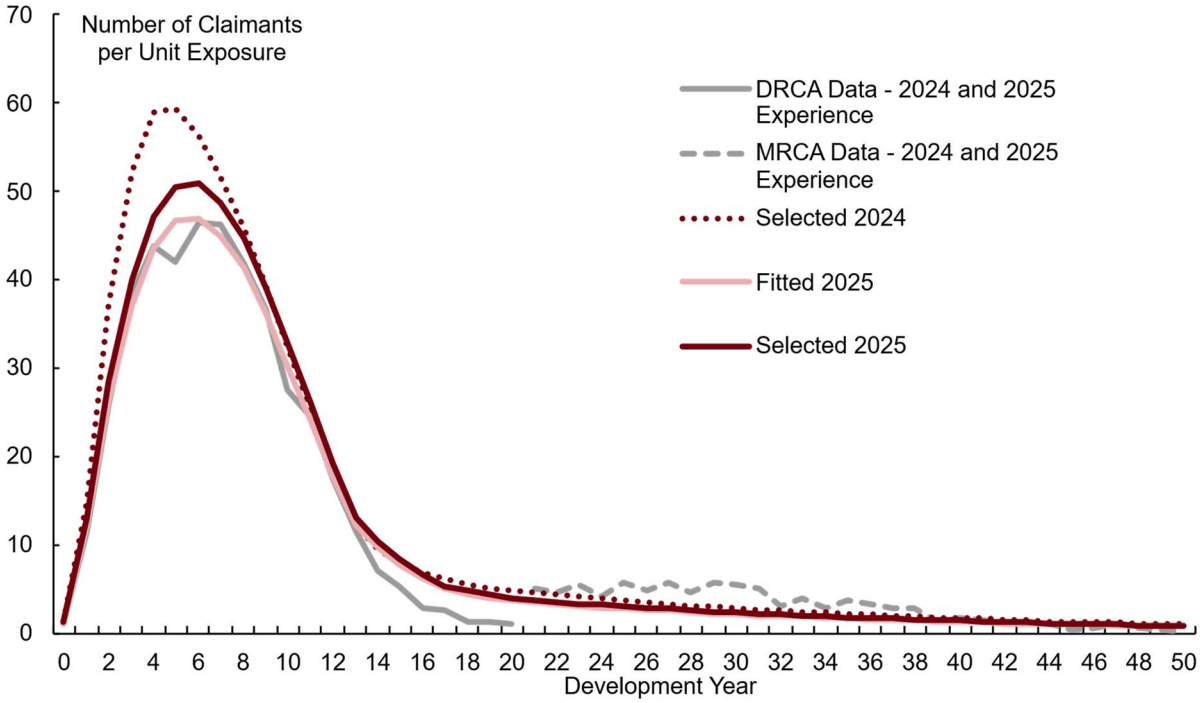


Figure 11.3: New MRCA Household Services Clients by Development Year



11.4.2 Lower numbers of new entrants were observed for both DRCA and MRCA in the 2025 calendar year. Discussions with the HS program area indicated that processing capacity is currently insufficient relative to demand. To account for these constraints, proportional increases of 16 per cent and 8 per cent have been applied to the DRCA and MRCA new HS claimant rates respectively. These adjustments result in the selected curves shown in Figures 11.2 and 11.3. The resulting projections of new HS recipients are shown in Figures 11.4 and 11.5, along with the conversion rate from IL claims accepted.

Figure 11.4: New Household Services Clients – DRCA

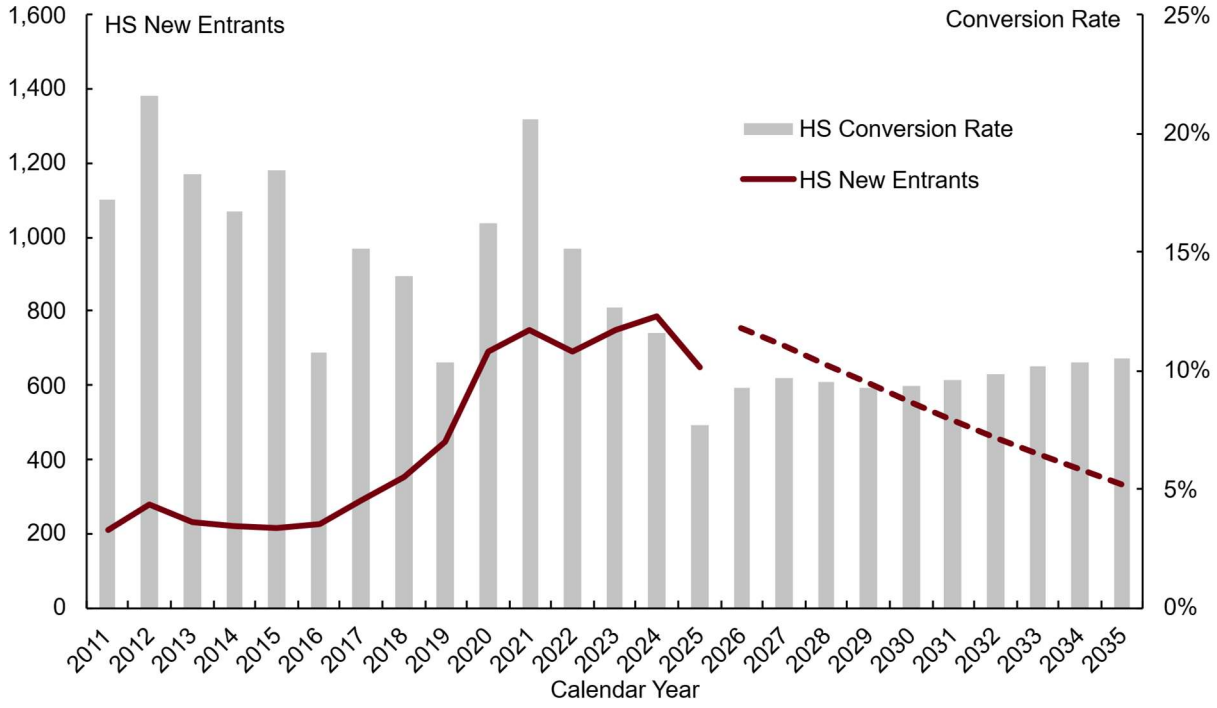
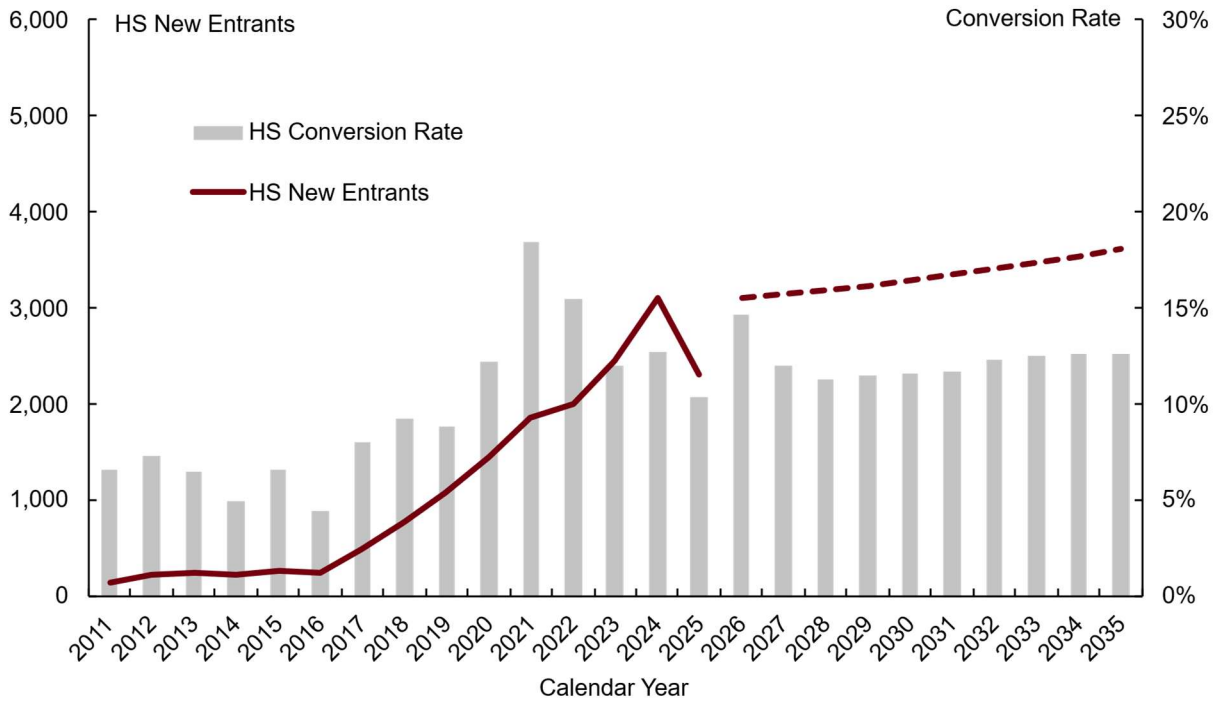
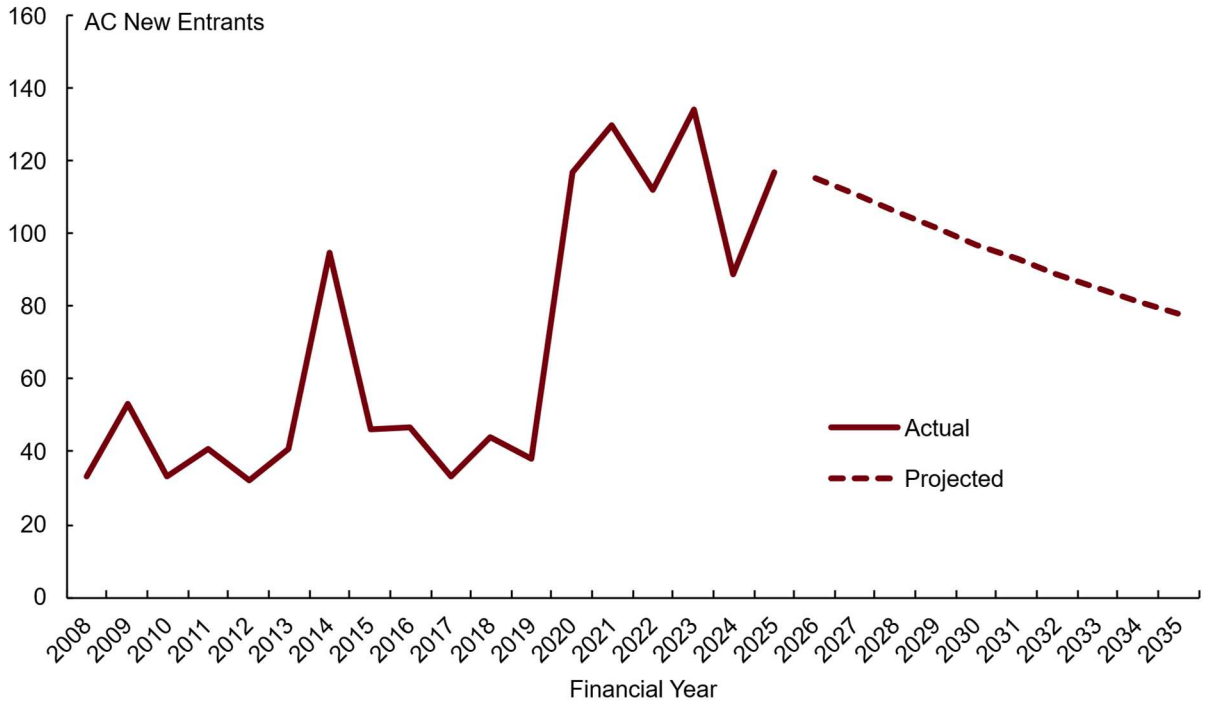


Figure 11.5: New Household Services Clients – MRCA



11.4.3 AC new entrants have been projected as a proportion of HS new entrants. The main challenge in modelling AC arises from the small number of claimants. Figure 11.6 shows the past and projected new AC clients for 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 high for these projections as client numbers are small.

Figure 11.6: New Attendant Care Clients



11.4.4 Figures 11.7 and 11.8 show the age at injury distribution of new HS clients for the past six calendar years, and the selected distribution which is based on experience from the most recent calendar year, 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. By separating the DRCA and MRCA claimants, we account for the differences in the patterns of age at injury between the two populations. The AC assumption is the same as for HS.

Figure 11.7: Age at Injury Distribution for New Household Services Clients – DRCA

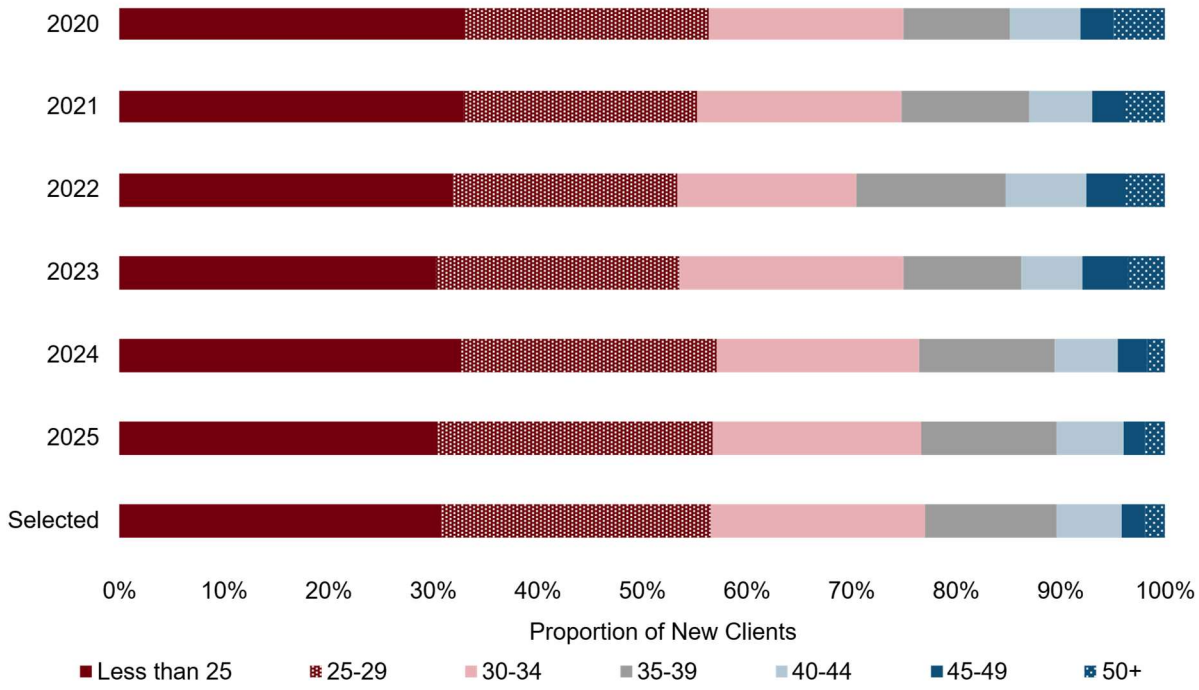
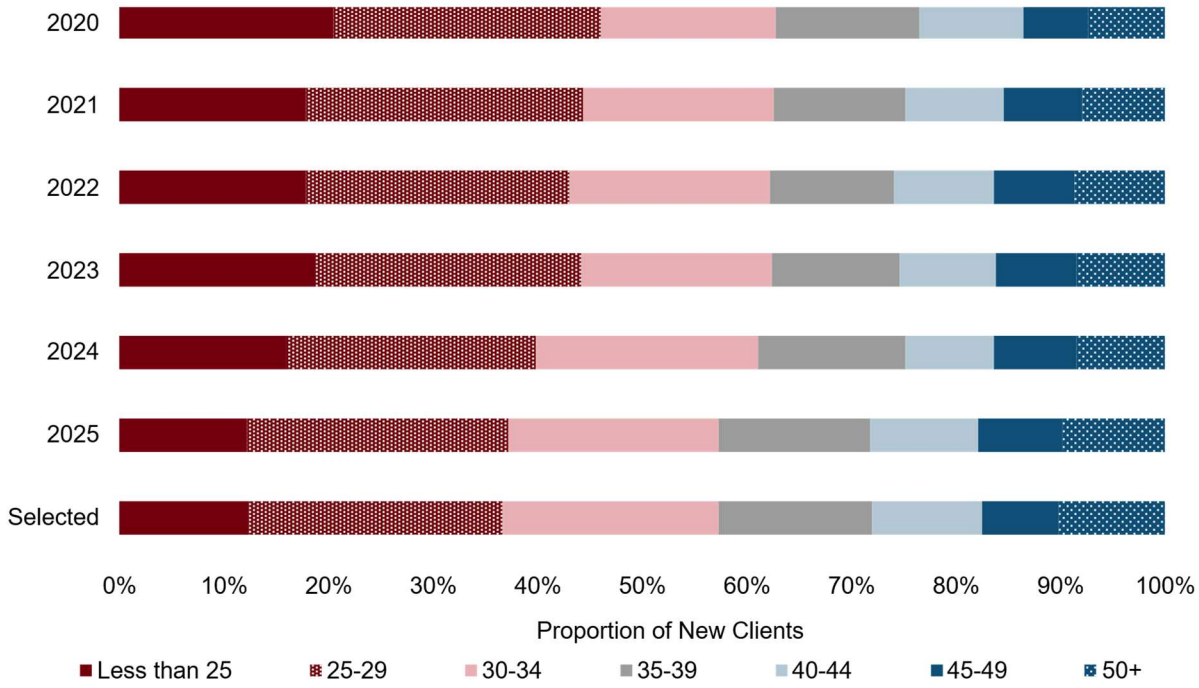


Figure 11.8: Age at Injury Distribution for New Household Services Clients – MRCA



11.4.5 The historic utilisation rates by duration and first payment year for HS benefits under DRCA and MRCA are shown in Figure 11.9 and Figure 11.10 respectively, with the selected utilisation assumptions. Utilisation rates have exhibited 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. We have set a long-term utilisation rate assumption at 70 per cent and 62 per cent for DRCA and

MRCA respectively. These reflect trends seen in the more recent experience. All claimants remaining after 5 years of usage will only cease receiving HS benefits as a result of mortality.

Figure 11.9: Household Services Utilisation Rates – DRCA

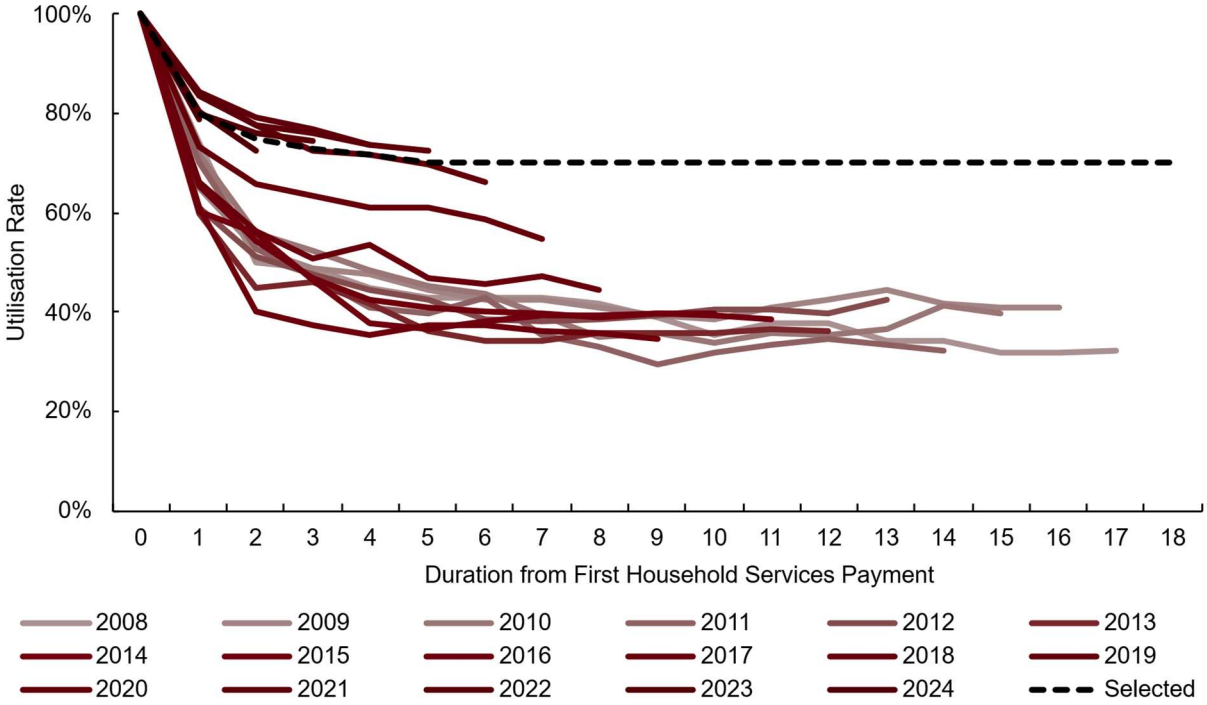
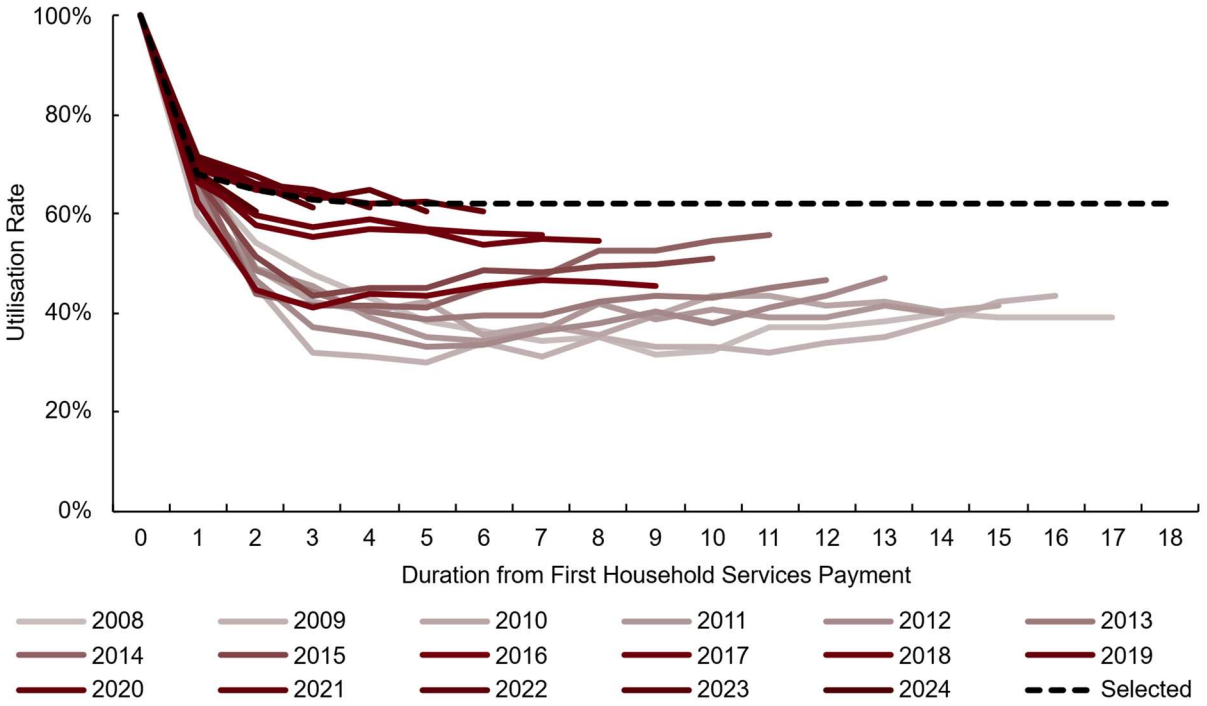


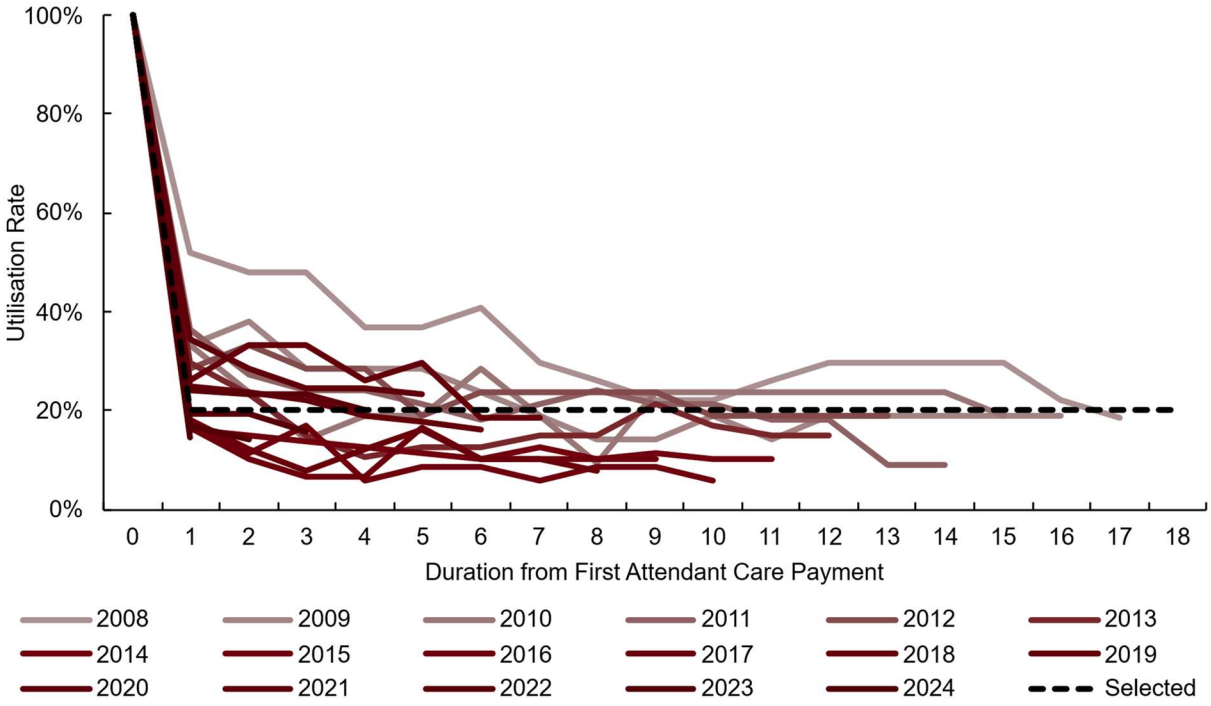
Figure 11.10: Household Services Utilisation Rates – MRCA



11.4.6 Figure 11.11 shows the utilisation rates for AC for both DRCA and MRCA. The data have been grouped together as the AC client numbers are small. The graph shows a decline in utilisation after the first year of payment. The data is volatile due to the small number of claimants. At this valuation, we have retained 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.

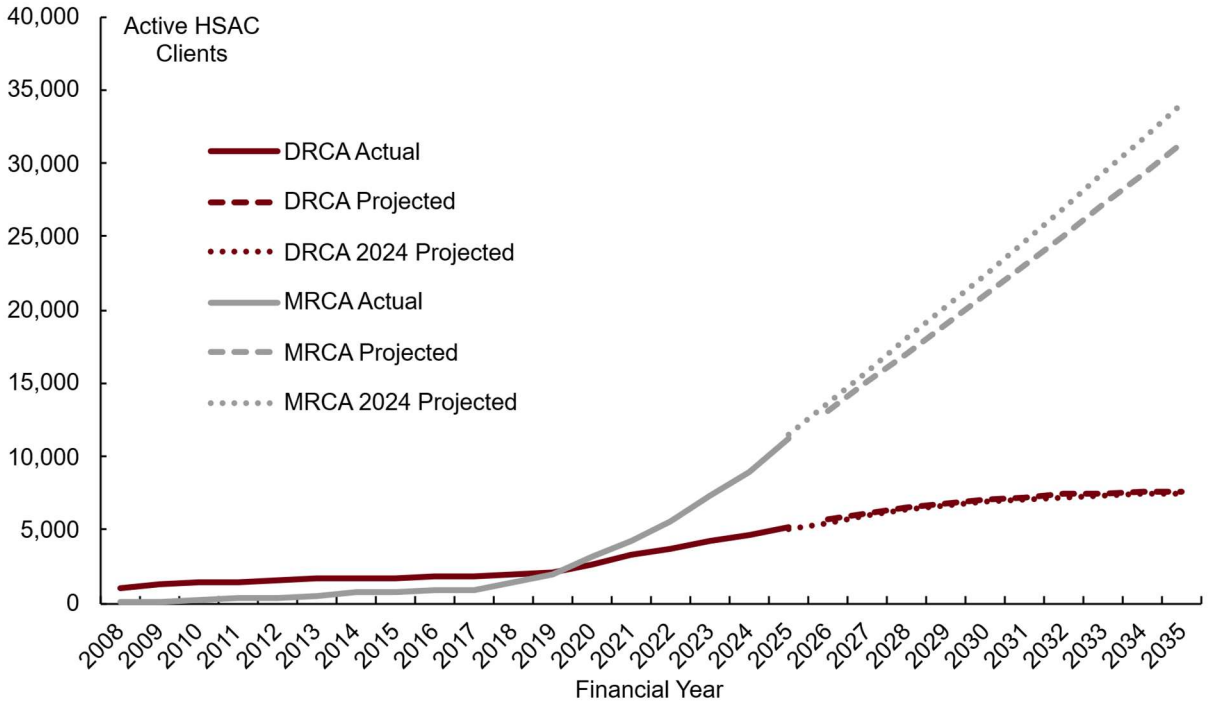
Figure 11.11: Attendant Care Utilisation Rates



11.4.7 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.

11.4.8 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 11.12.

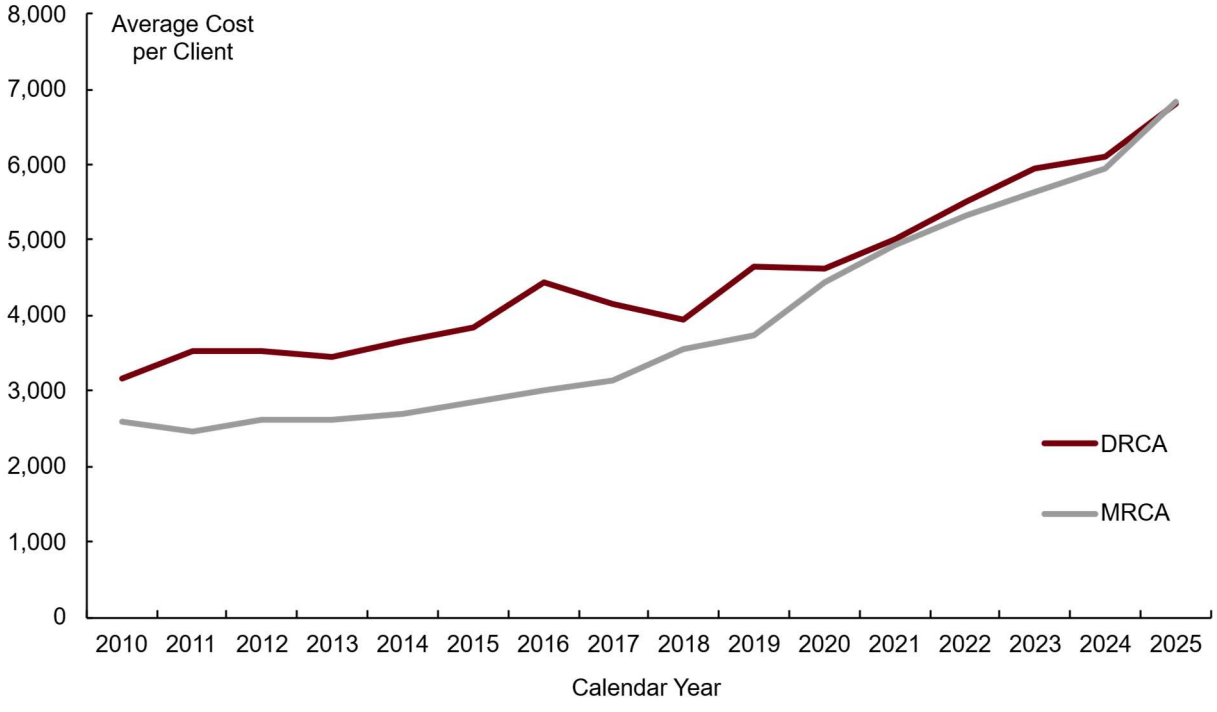
Figure 11.12: Household Services and Attendant Care Client Population Projection



11.5 Valuation Assumptions – Average Cost per Active Claimant

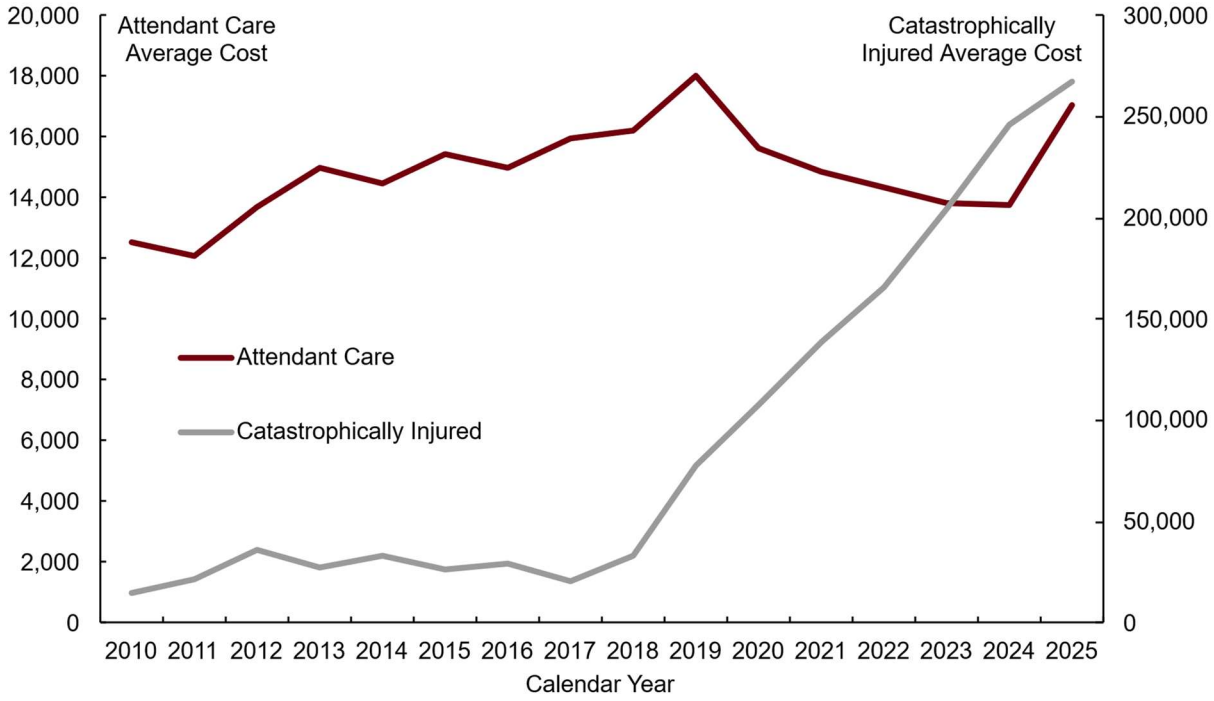
11.5.1 The average annual cost per HS client is shown in Figure 11.13. Since 2020, the average cost under DRCA and MRCA have been very similar. Accordingly, we have assumed an average annual cost of $6,800 for both DRCA and MRCA.

Figure 11.13: Average Annual Cost for Household Services Clients



11.5.2 Figure 11.14 shows the average annual cost for AC clients. We have assumed an average size of $17,000 for AC clients who are not catastrophically injured, and $270,000 for catastrophically injured clients.

Figure 11.14: Average Annual Cost for Attendant Care Clients

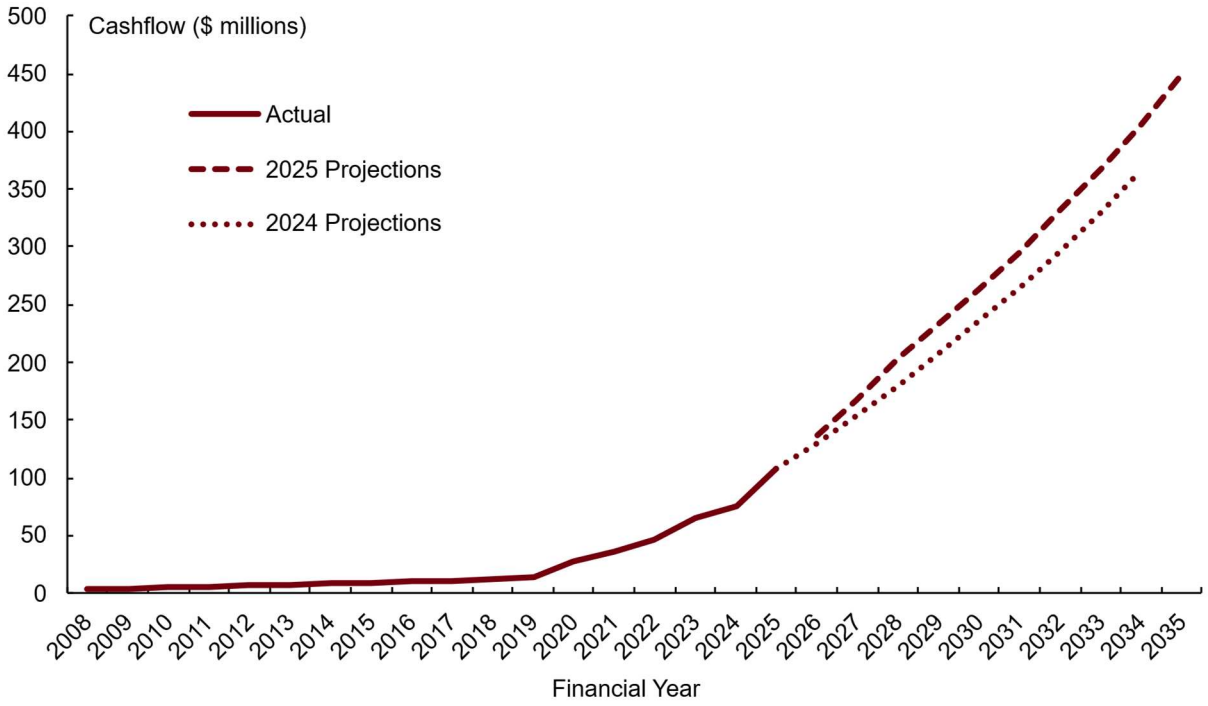


11.5.3 Average costs have been increasing significantly and consistently above inflation. Based on discussions with the Household Services program area, we understand that provider behaviour may be contributing to this experience. For HS and AC, we have assumed this higher rate of inflation will continue over the short term, adopting superimposed inflation assumptions of 5 per cent above the assumed level of wage inflation for three years. For catastrophically injured clients, where superimposed inflation is more likely reflecting the increasing levels of care needed over time, we have assumed that the average annual cost will increase by 5 per cent above the assumed level of wage inflation indefinitely.

11.5.4 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.

11.5.5 Figure 13.15 below shows actual outlays together with projected cashflows over the next 10 years for both DRCA and MRCA, before allowing for the impact of the VETS Act.

Figure 11.15: Historical and Projected HSAC Payments



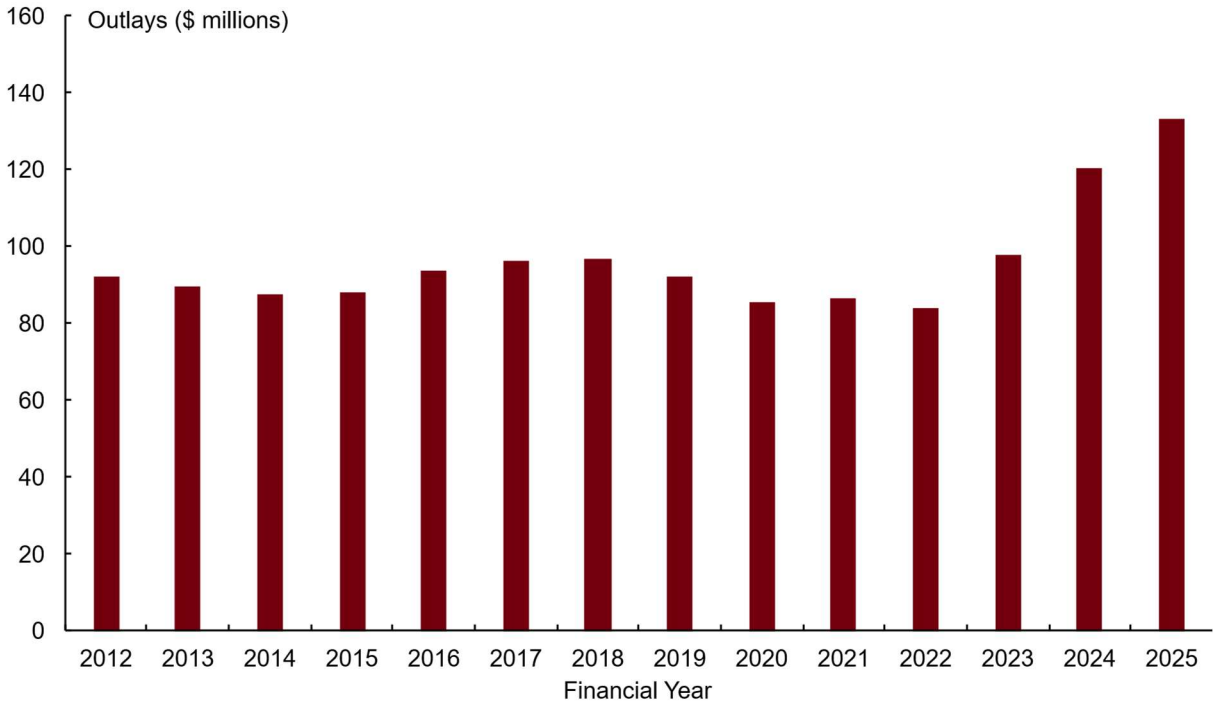
11.6 Impact of the VETS Act – DRCA Veterans

11.6.1 Veterans receiving Household Services and Attendant Care under the DRCA will have their services transferred to the MRCA and be eligible for the higher maximum weekly rate available under the MRCA. The current maximum weekly rate available under MRCA is $611.46 per week, compared with $588.55 per week under the DRCA. The increase to the maximum weekly rate would only impact veterans who are close to the current maximum under DRCA. This is a very small group of veterans and would have an immaterial impact on the MRCA liability. As such, we have not explicitly factored in the higher maximum rate for current DRCA veterans. We have assumed these service transfer to MRCA from 1 July 2026.

11.7 Impact of the VETS Act – VEA Veterans

11.7.1 Veterans with eligibility under the VEA can access the Veterans' Home Care (VHC) program. VHC provides in-home care and support services, including domestic assistance, personal care, home and garden maintenance, in-home and residential respite care and social assistance services. VHC is subject to weekly and yearly total hour caps, and most services are subject to a small co-payment. Figure 11.16 below sets out the VEA Home Care outlays since 2012.

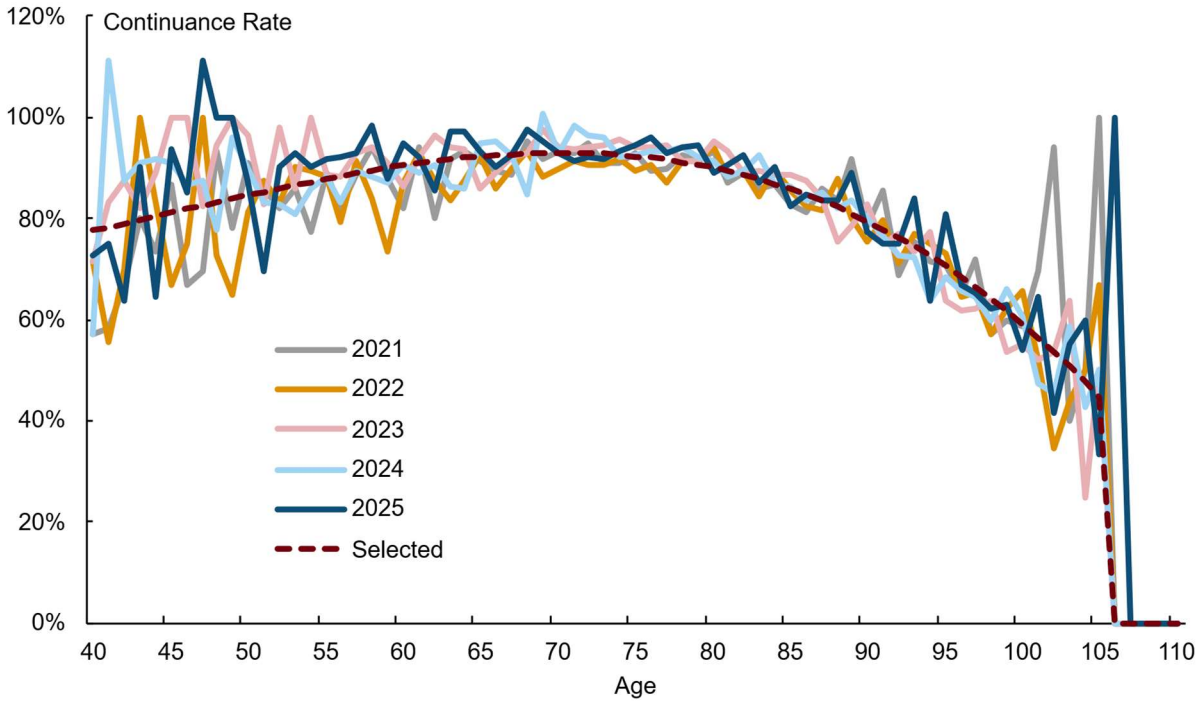
Figure 11.16: VEA Home Care Outlays



11.7.2 From 1 July 2026, veterans with eligibility under the VEA, including those currently accessing VHC, will be able to access household services and attendant care under the MRCA. This is expected to result in an increase in the level of services available for most veterans, noting, however, that some services available under VHC, such as respite care, are not available under MRCA HSAC. Access to services provided under VHC can continue for veterans with existing eligibility.

11.7.3 To quantify the potential impact on the MRCA liability arising from newly eligible VEA veterans, we have first considered the existing cohort of VEA veterans accessing VHC services. We have assumed a staged transition of veterans to HS over three years, due to capacity limitations within the program area. However, we have assumed that all existing VHC recipients will ultimately transition, given the higher level of services available under the MRCA. Specifically, we have assumed a quarter of the existing VHC population will transition in the 2027 financial year, a further half in the 2028 financial year and the remaining quarter in the 2029 financial year. We have excluded veterans accessing respite services only, those with access to HSAC through DRCA eligibility, those with All Conditions Treatment Card eligibility due to the qualifying service criteria only, and war widows. We have also removed a small number of people under the age of 40 who we assume are dependents. We have assumed that this group will receive household services subject to age-based continuance rates derived from data since 2021, as shown in Figure 11.17 below.

Figure 11.17: Actual and Assumed VHC Continuance Rates



11.7.4 We have also considered veterans with injuries related to VEA service that are not currently accessing VHC under VEA but would have otherwise accessed VHC in the future. These veterans will be eligible for MRCA Household Services from 1 July 2026. To estimate this population, we have assumed claim rates based on recent new entrant experience and the VPM VEA veteran population projections. The actual and assumed new entrant rates since 2021 are presented in Figure 11.18 below. The resulting new entrant projection and the VHC recipient population are summarised in Figures 11.19 and 11.20 respectively.

Figure 11.18: Actual and Assumed VHC New Entrant Rates

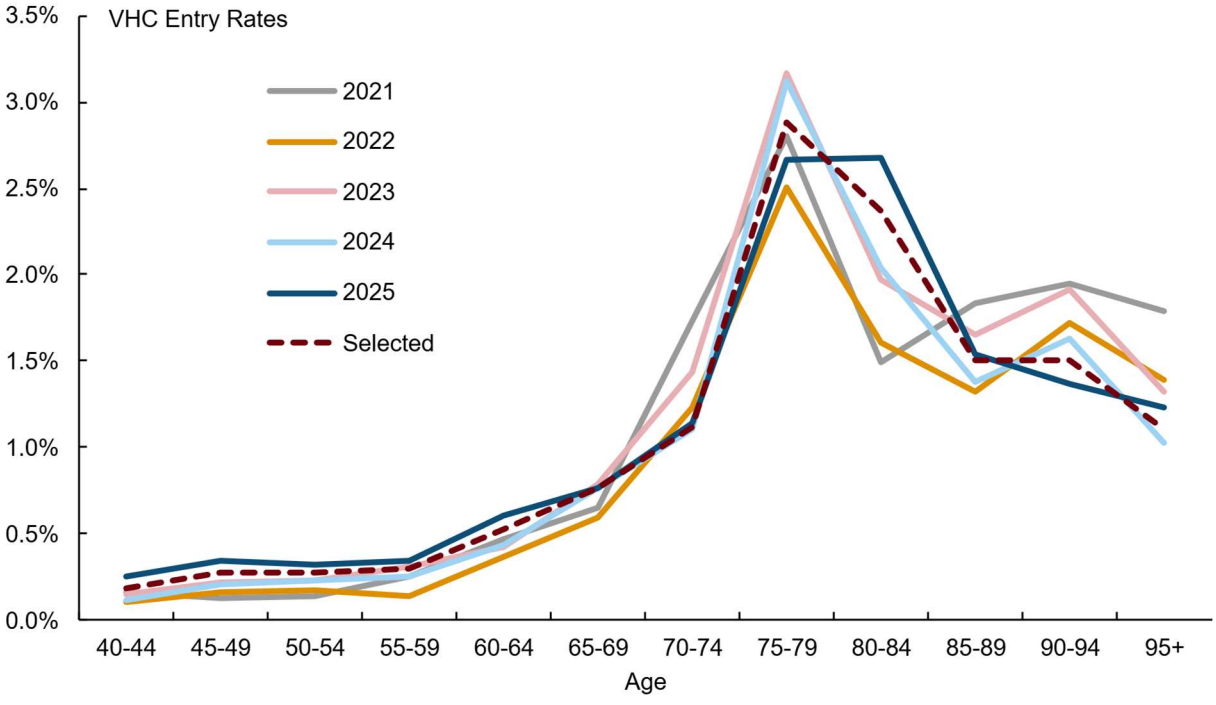


Figure 11.19: Actual and Projected VHC New Entrants

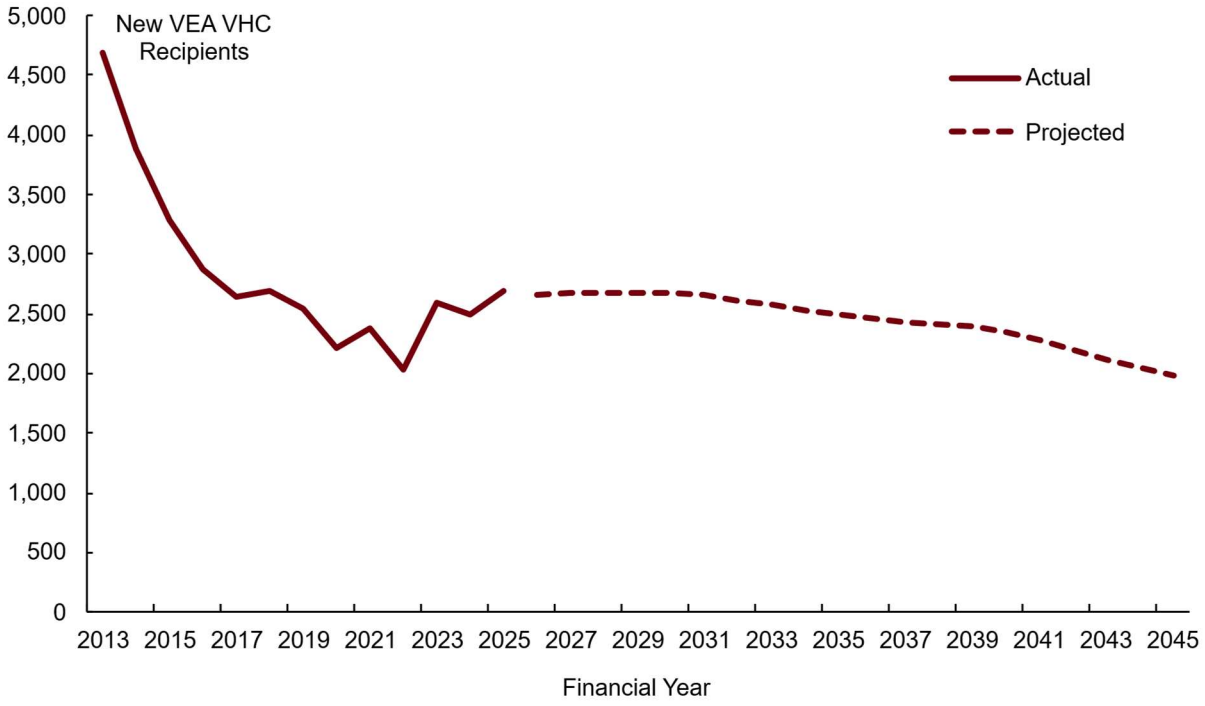
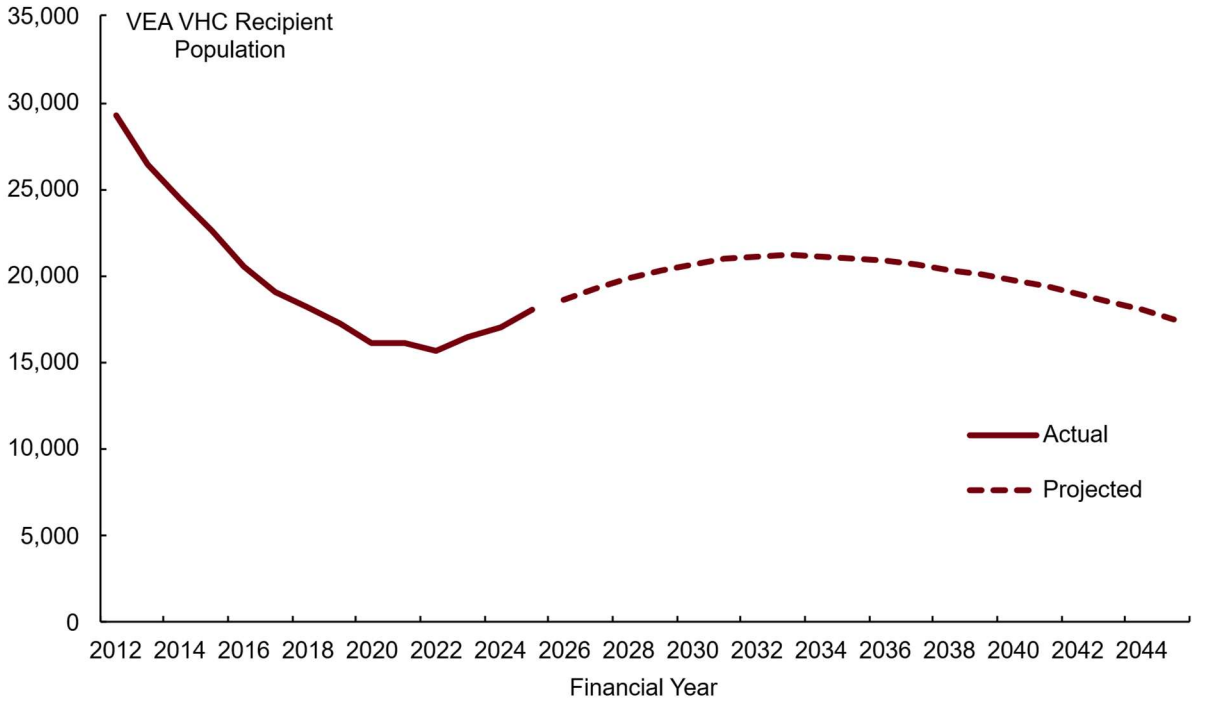


Figure 11.20: Actual and Projected VHC Recipient Population



11.7.5 We have assumed that VHC recipients will access a level of services that is similar to current MRCA and DRCA veterans on average, and that costs will increase in line with wage inflation over time.

11.7.6 These projections result in an additional liability of $3,143.9m added to the MRCA liability as at 30 June 2025 due to the VETS Act. There is considerable uncertainty inherent in this estimate. The current VHC scheme is targeted at an older group of veterans and services are

intended to be similar to those offered under Home Care through the Aged Care system. As such, behaviour in this group of veterans might be significantly different to that observed in the MRCA and DRCA cohorts.

11.8 Liability Estimate

11.8.1 Table 11.1 shows the estimate of the liability in relation to HSAC payments, broken down by year of accident. The expected liability as at 30 June 2025 from the 2024 valuation was $6,636.1 m. The liability at this valuation is $8,122.7m before the VETS Act, an increase of $1,486.6m driven largely by higher average costs and the allowance for further superimposed inflation. The liability after the VETS Act impact, which sees VEA Home Care costs transition to MRCA, is $11,266.6m. Table 11.2 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 11.1: Outstanding Claims Liability for HSAC Payments by Year of Accident

	Liability ($m)		
Year of accident	**DRCA**	**MRCA**	**Total**
1979 and before	60.6	-	60.6
1980 – 1984	64.0	-	64.0
1985 – 1989	184.0	-	184.0
1990 – 1994	308.1	-	308.1
1995 – 1999	527.0	-	527.0
2000 – 2004	678.3	-	678.3
2005 – 2009	-	308.8	308.8
2010 – 2014	-	944.2	944.2
2015 – 2019	-	2,109.0	2,109.0
2020 – 2024	-	2,464.4	2,464.4
2025	-	474.3	474.3
Total (before VETS Act)	**1,821.9**	**6,300.7**	**8,122.7**
VETS Act Impact – DRCA Veterans	*(1,775.8)*	*1,775.8*	-
VETS Act Impact – VEA Veterans	-	*3,143.9*	*3,143.9*
Total (after VETS Act)	**46.2**	**11,220.5**	**11,266.6**

Table 11.2: Reconciliation of Liability for HSAC Payments

	DRCA	MRCA	Total
Liability estimate at 30 June 2024 (previous report)	1,568.0	5,068.1	6,636.1
Assumed Interest	77.4	263.2	340.5
Projected Payments	(41.2)	(66.1)	(107.3)
Notional Premium	0.0	460.8	460.8
Projected liability at 30 June 2025 (previous valuation)	*1,604.2*	*5,725.9*	*7,330.2*
Experience effects and Assumption changes:			
Difference between actual and projected payments	(1.3)	0.4	(0.9)
Change due to experience	(72.8)	(106.0)	(178.8)
Change due to active claimant projection	5.2	(455.6)	(450.4)
Change due to average cost assumptions	134.8	473.5	608.3
Change due to superimposed inflation	151.9	662.5	814.3
Liability at 30 June 2025 (before VETS Act)	***1,821.9***	***6,300.7***	***8,122.7***
Change due to VETS Act	(1,775.8)	*3,143.9*	*3,143.9*
Liability at 30 June 2025 (after the VETS Act)	**46.2**	**11,220.5**	**11,266.6**

12 Other Benefits

12.1 Benefit Overview

12.1.1 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.

12.1.2 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 per cent 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 prior to implementation of the VETS Act.)

12.1.3 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 Specific Conditions Treatment Card or All Conditions Treatment 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.

12.1.4 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.

12.2 Modelling Approach

12.2.1 For medical examinations, medico-legal reports and legal expenditure, there have been some changes in the usage of the various payment sub-categories over the years, and so 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.

12.2.2 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.

12.2.3 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.

12.2.4 Supplement payments under DRCA are relatively small. As for the previous valuation, we have applied a loading to the projected cashflows for medical examinations and legal expenses to allow for supplement payments.

12.3 Recent Payment Experience

12.3.1 Figure 12.1 shows for MRCA the expenditure on other payments for each of the three subcategories modelled since 2011. Figure 12.2 shows the same for DRCA (noting there are no education payments under DRCA).

Figure 12.1: Expenditure on Other Payments by Category (MRCA)

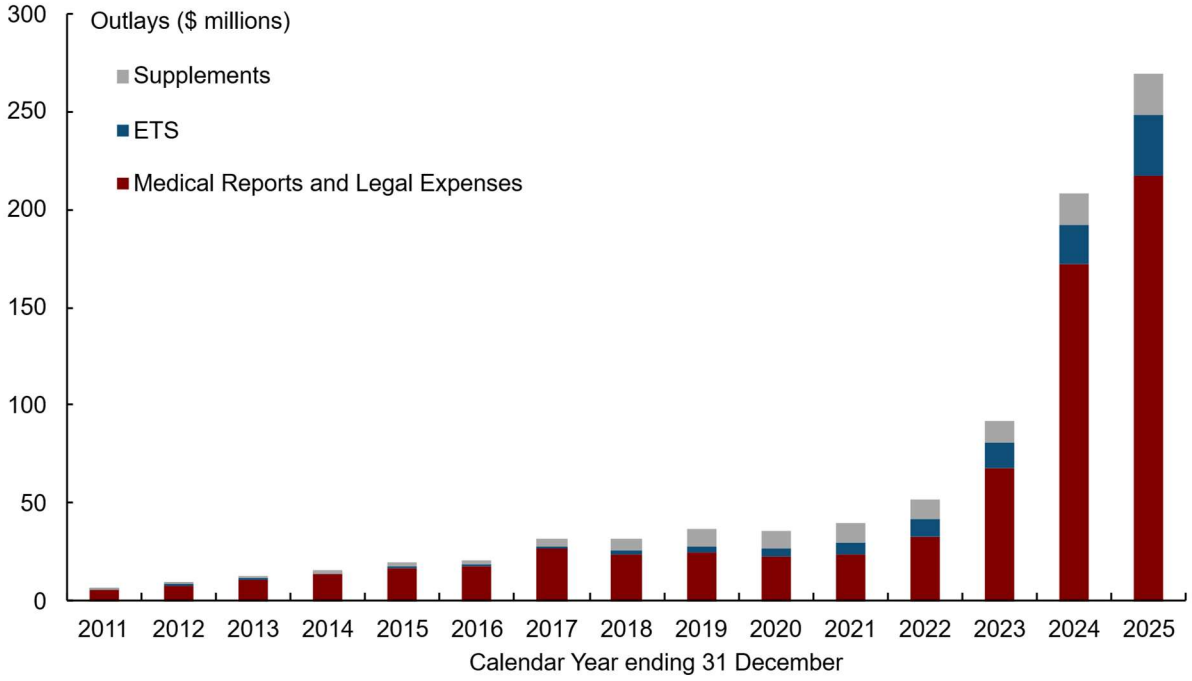
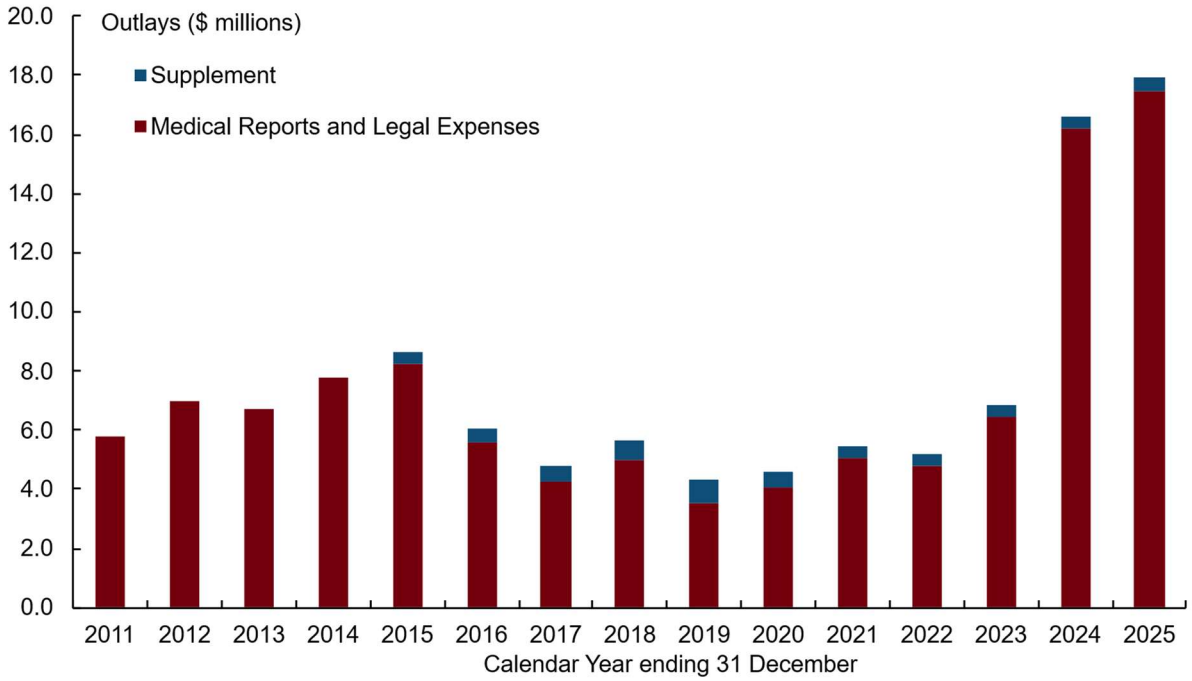


Figure 12.2: Expenditure on Other Payments by Category (DRCA)



12.3.2 For both MRCA and DRCA, there was a substantial increase in payments made for medical reports and legal expenditure in 2024, with a further increase in 2025. 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.

12.3.3 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.

12.3.4 MRCA supplement payments, while again a small component, have also increased substantially in recent years. 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 two years. DRCA supplement payments were similar to 2023 and 2024 levels.

12.4 Valuation Assumptions - Medical Reports and Legal Expenses

12.4.1 Figure 12.3 shows for MRCA, over the last six 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 12.4 shows the same information for DRCA.

12.4.2 A large part of the increase in expenditure for medical reports/legal expenses in 2024 was due to growth in the number of claimants receiving such a service. In 2025, the number of claimants in receipt of such a service was similar to 2024 levels. The growth in the number of payments outstripped the number of claimants between 2020 and 2024, however the number of payments in 2025 was substantially less than in 2024 i.e. the number of services per claimant has reduced considerably. This may be due to DVA initiatives aimed at reducing the number of medical reports each veteran needs to attend.

12.4.3 For DRCA, the number of claimants and the number of payments have both reduced in 2025, with the average number of services per claimant stable over the last five years at just over 1.5 services per person.

Figure 12.3: Number of Claimants and Number of Payments (MRCA)

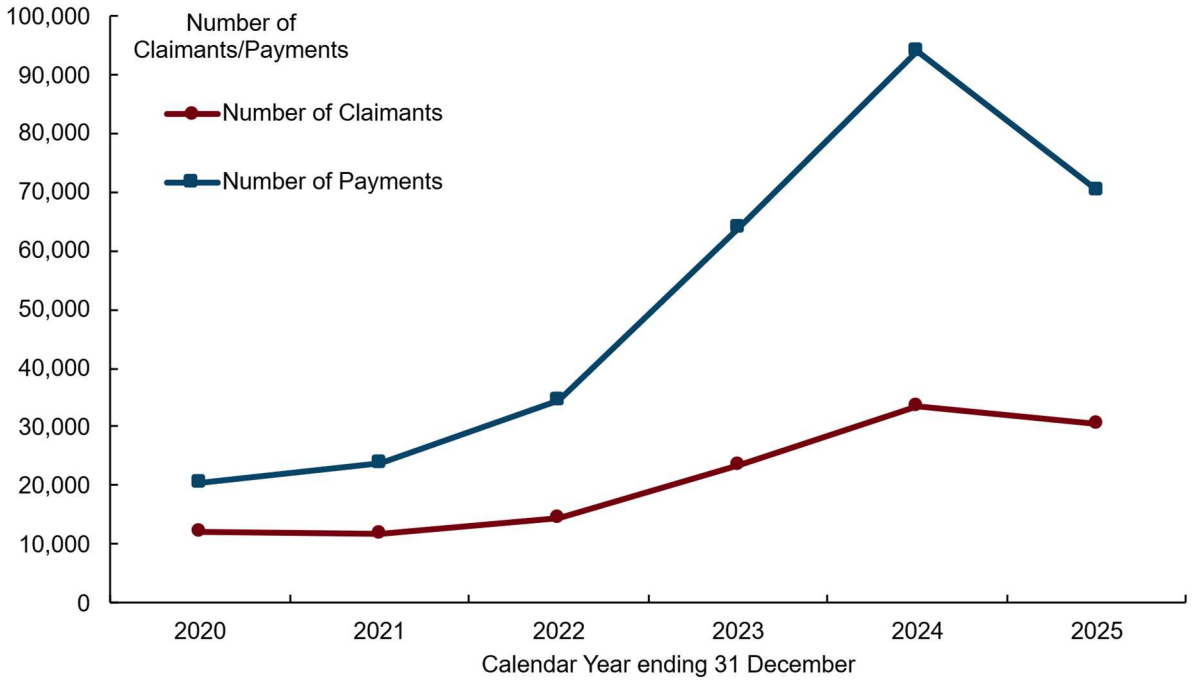
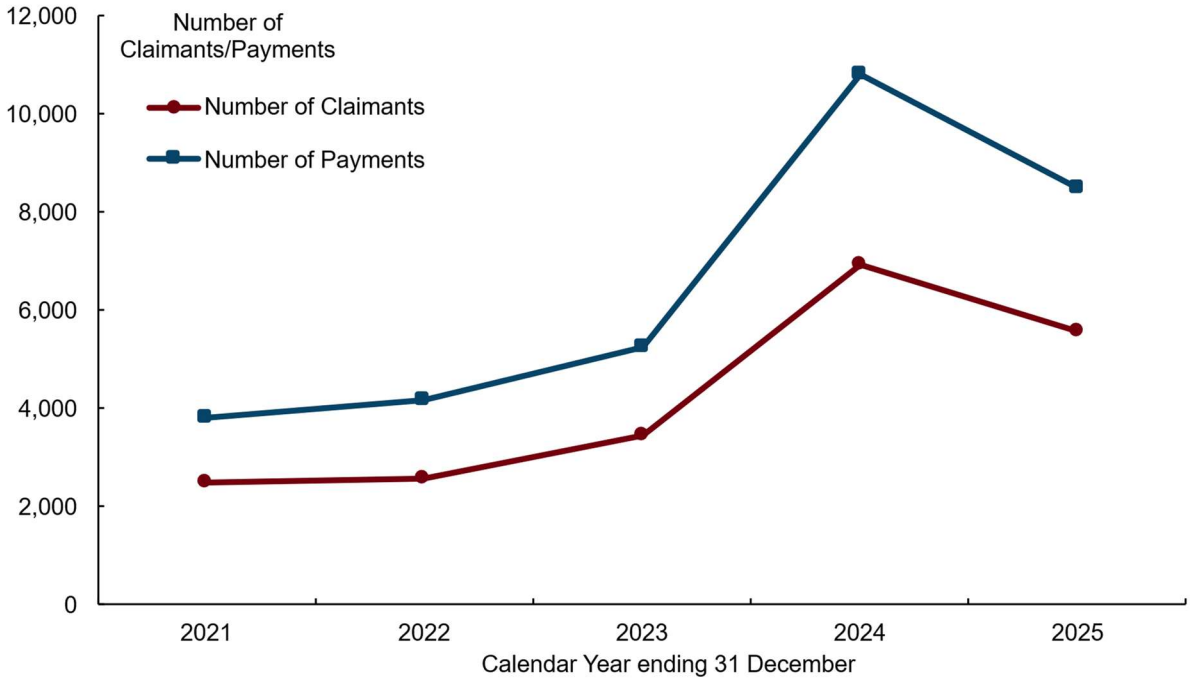


Figure 12.4: Number of Claimants and Number of Payments (DRCA)



12.4.4 Figure 12.5 shows for MRCA, over the last six years, the average amount of expenditure on medical reports/legal expenses both per claimant and per payment while Figure 12.6 shows the same information for DRCA.

12.4.5 In 2025, the average payment per claimant and the average per payment were both substantially higher than in 2024 for both MRCA and DRCA. For MRCA, the average amount per claimant increased by around $2,000 (39 per cent) while the average amount per payment

was $1,300 (70 per cent) higher. For DRCA, the average payment per claimant in 2025 was around $780 (34 per cent) higher than in 2024 while the average amount per payment was $550 (37 per cent) higher. This compares to our inflation allowance included in the previous valuation of 3.7 per cent.

12.4.6 We have adopted an average cost per claimant equal to the average paid in 2025 i.e. $7,100 per claimant for MRCA (an increase of 34 per cent on our previous assumption) and $3,100 per claimant for DRCA (an increase of 31 per cent on our previous assumption).

Figure 12.5: Average Payment Per Claimant (MRCA, $)

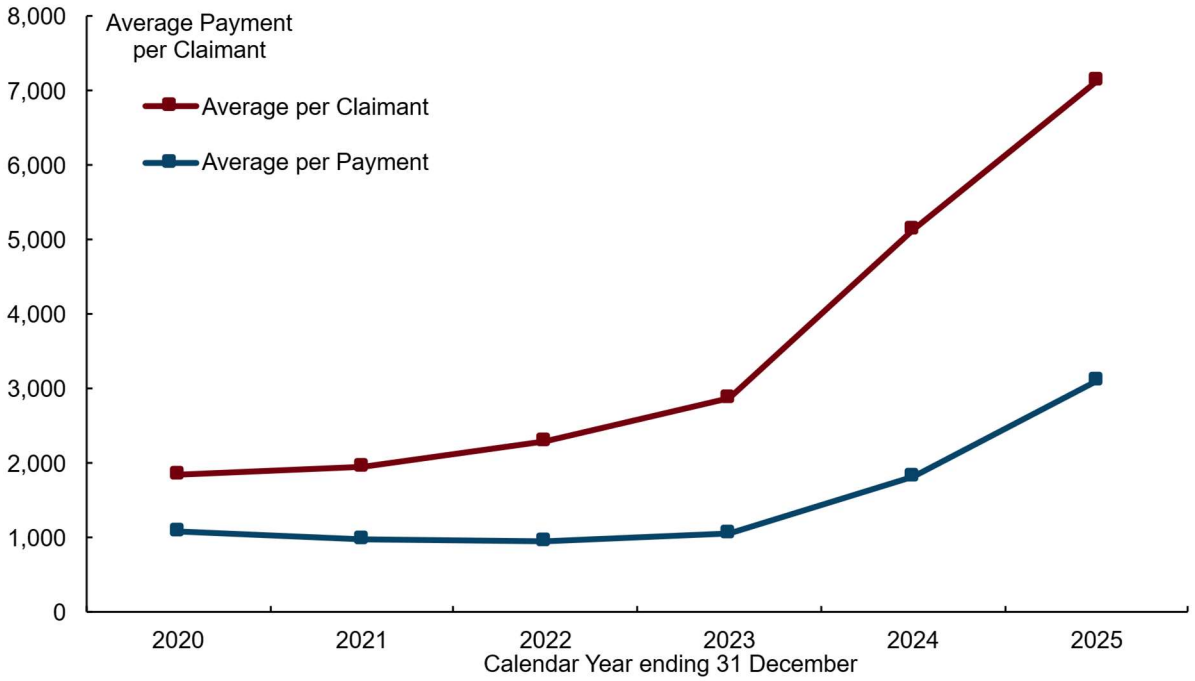
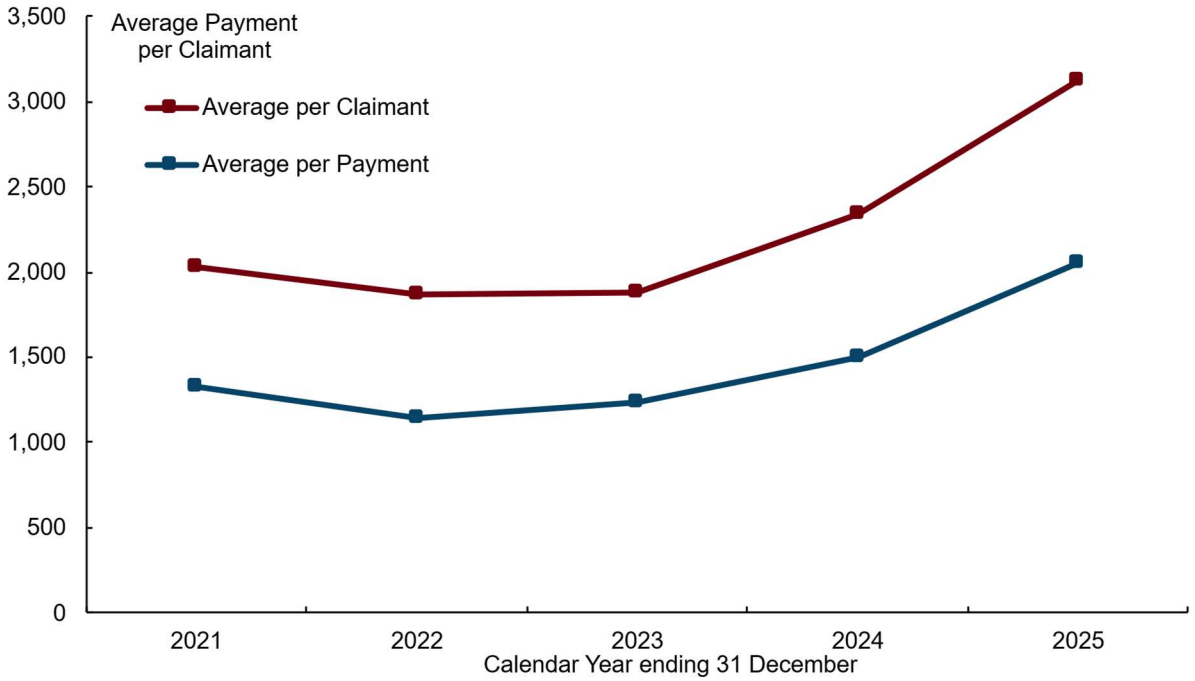


Figure 12.6: Average Payment Per Claimant (DRCA, $)



12.4.7 Figure 12.7 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 12.8 shows the same information for DRCA.

12.4.8 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 12.7: Number of IL Completed and Medical Examinations (MRCA)

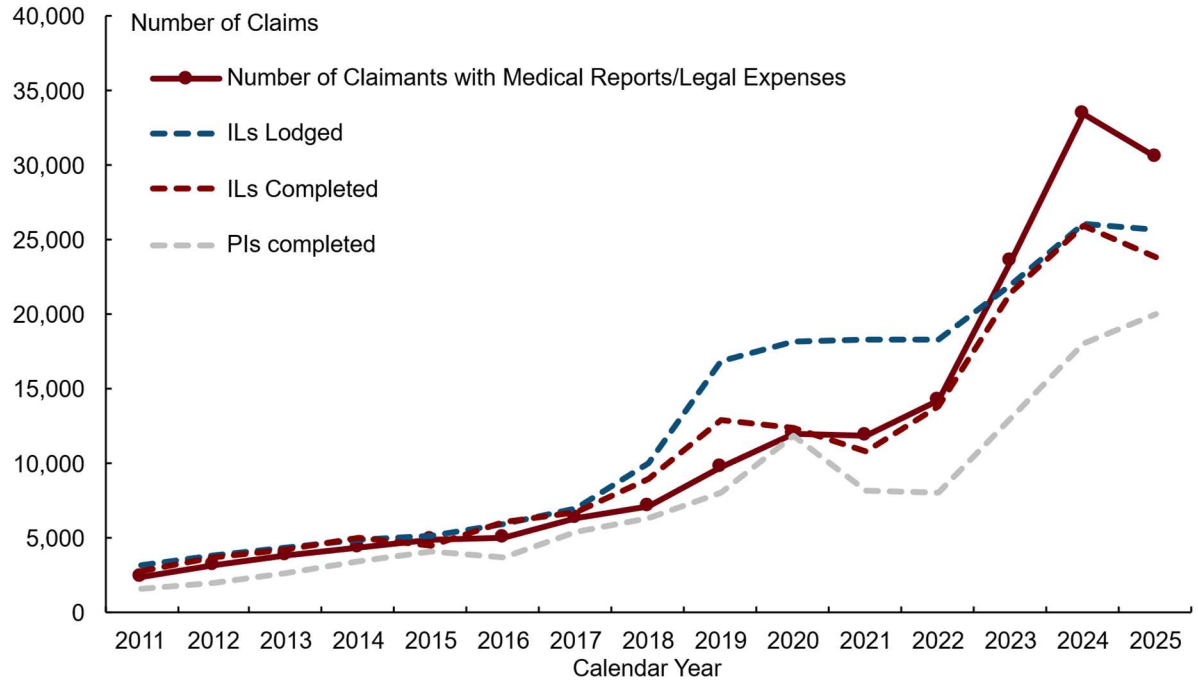
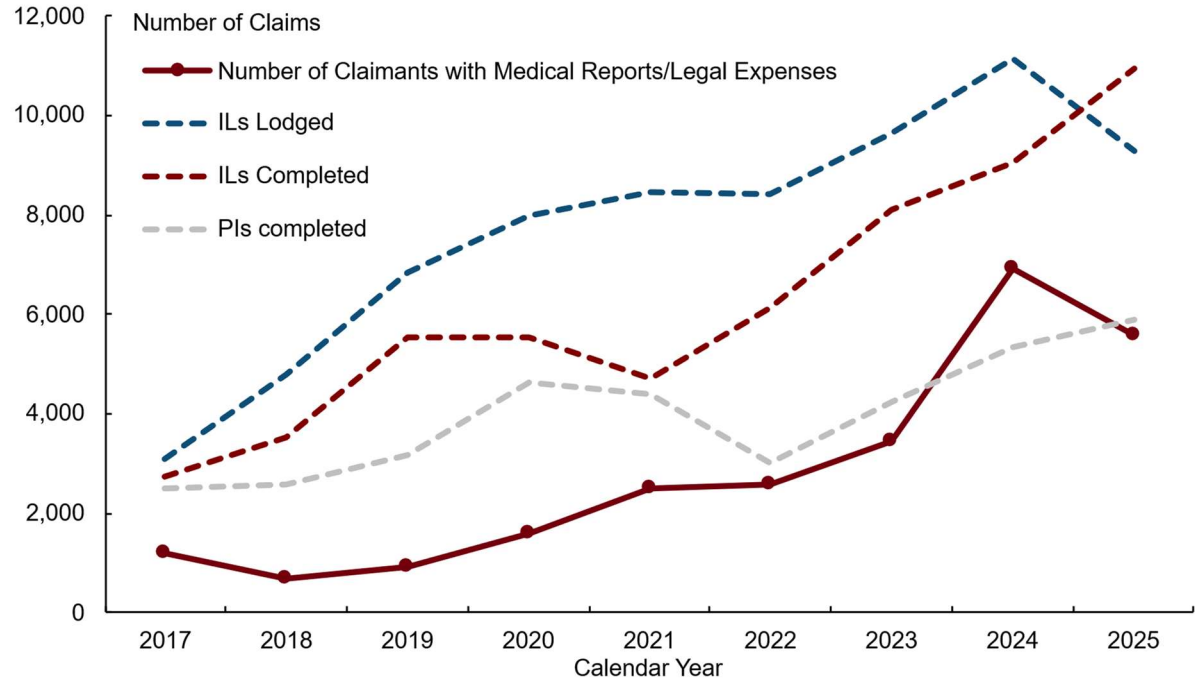


Figure 12.8: Number of IL Completed and Medical Examinations (DRCA)



12.4.9 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 12.9 and 12.10 show the historical and adopted proportions for MRCA and DRCA respectively. We have adopted proportions for each scheme that are equal to the 2025 experience. These proportions have reduced in 2025 and could reduce further 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 continue to monitor this metric in future valuations.

Figure 12.9: Number of Claimants per Completed IL Claim and Completed PI Claim (MRCA)

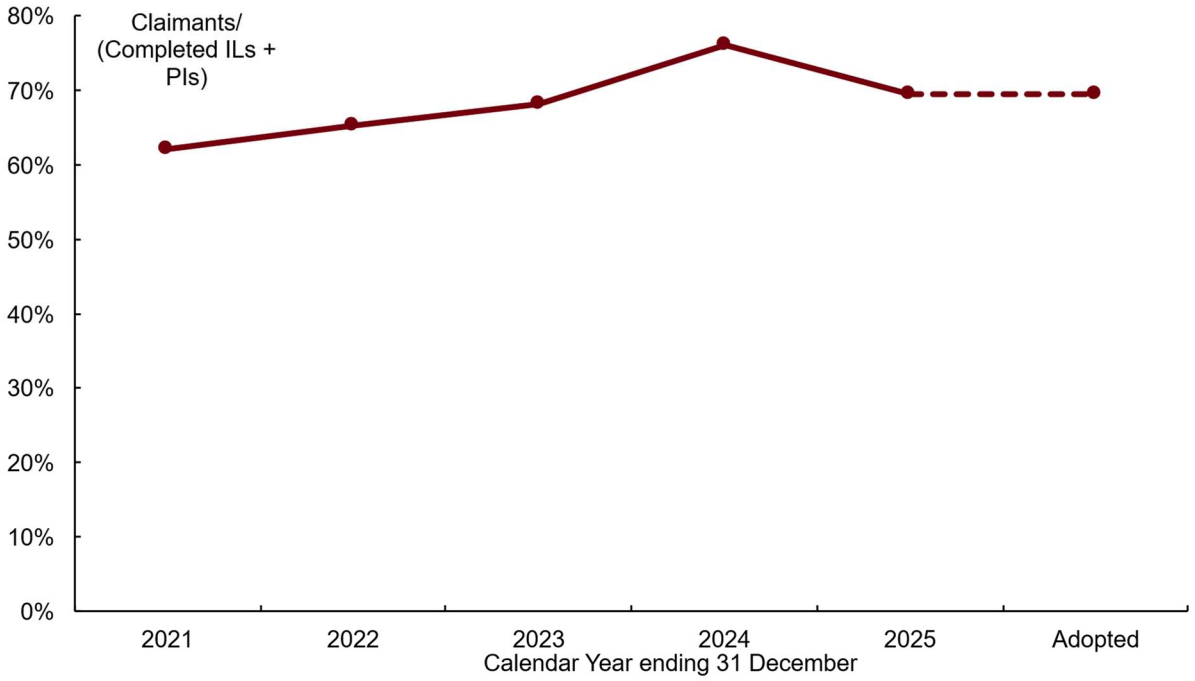
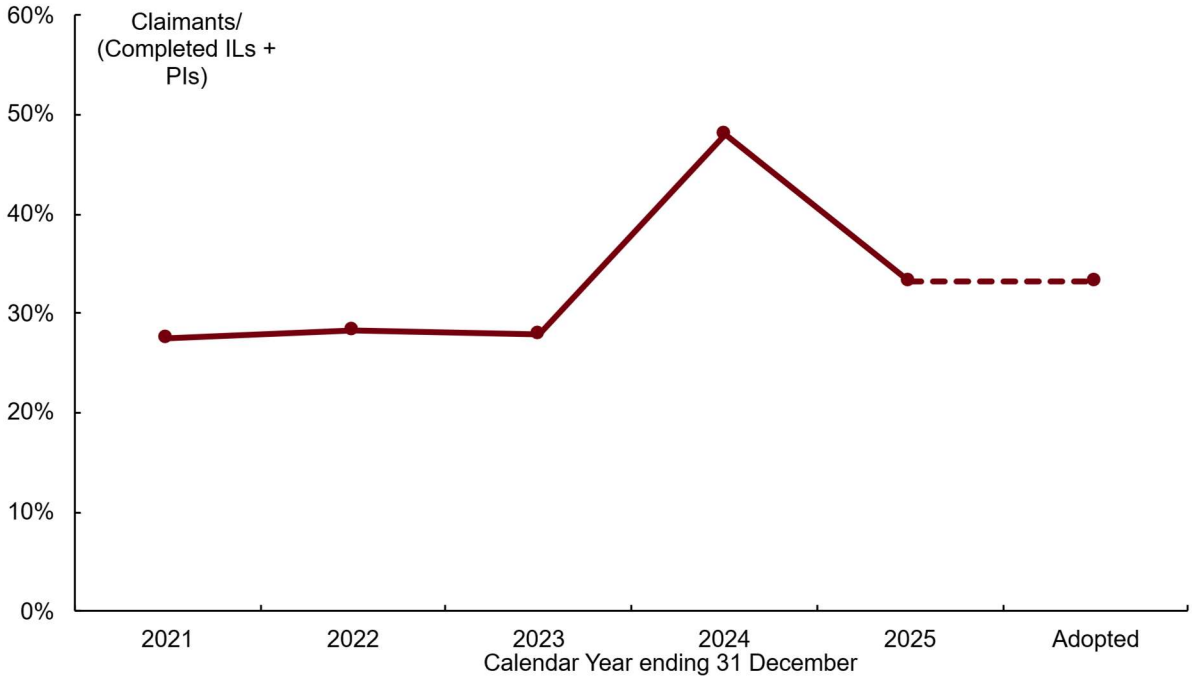


Figure 12.10: Number of Claimants per Completed IL Claim and Completed PI Claim (DRCA)



12.4.10 Figures 12.11 and 12.12 shows the actual and projected number of claimants in receipt of medical reports or legal expenses for each of MRCA and DRCA. We have also shown our projected numbers from the previous valuation. The projected numbers for MRCA are

reasonably close to our previous projection while for DRCA the numbers are substantially lower.

Figure 12.11: Actual and Projected Number of Claimants (MRCA)

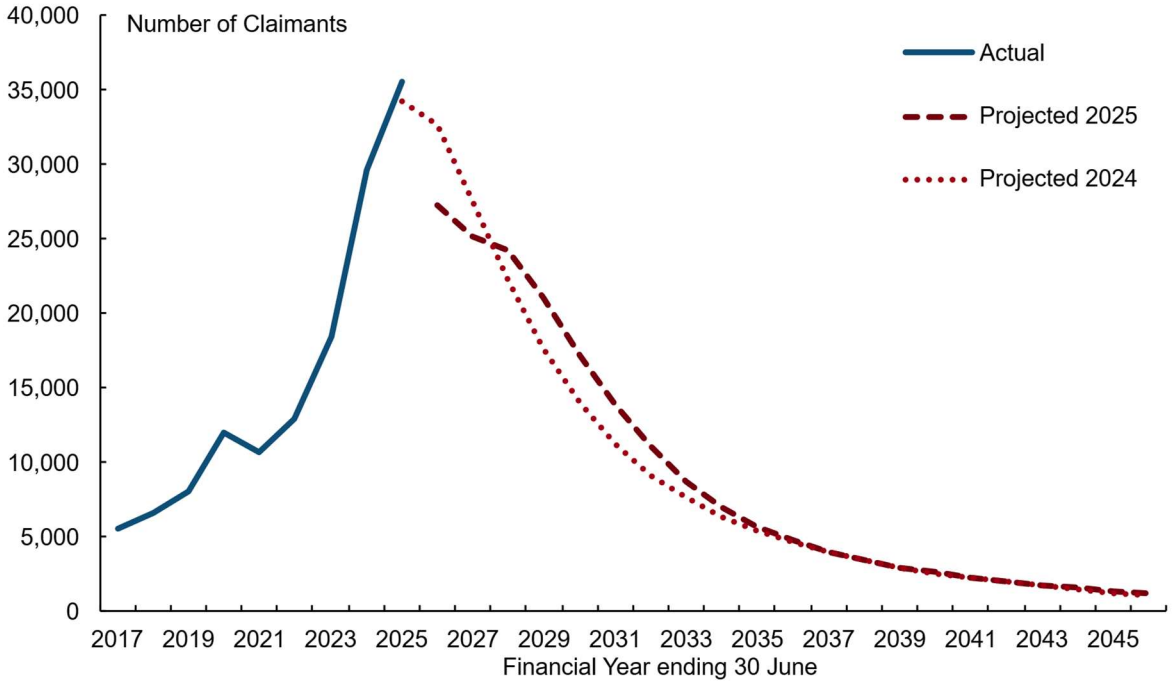
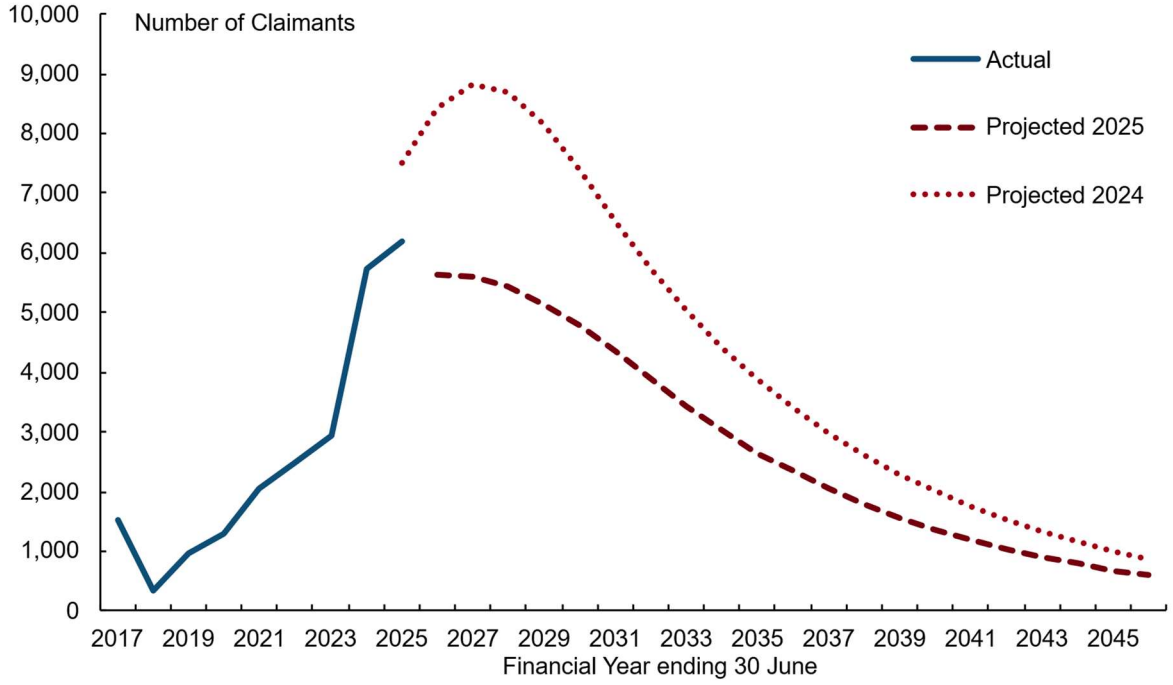


Figure 12.12: Actual and Projected Number of Claimants (DRCA)



12.5 Valuation Assumptions - ETS Payments

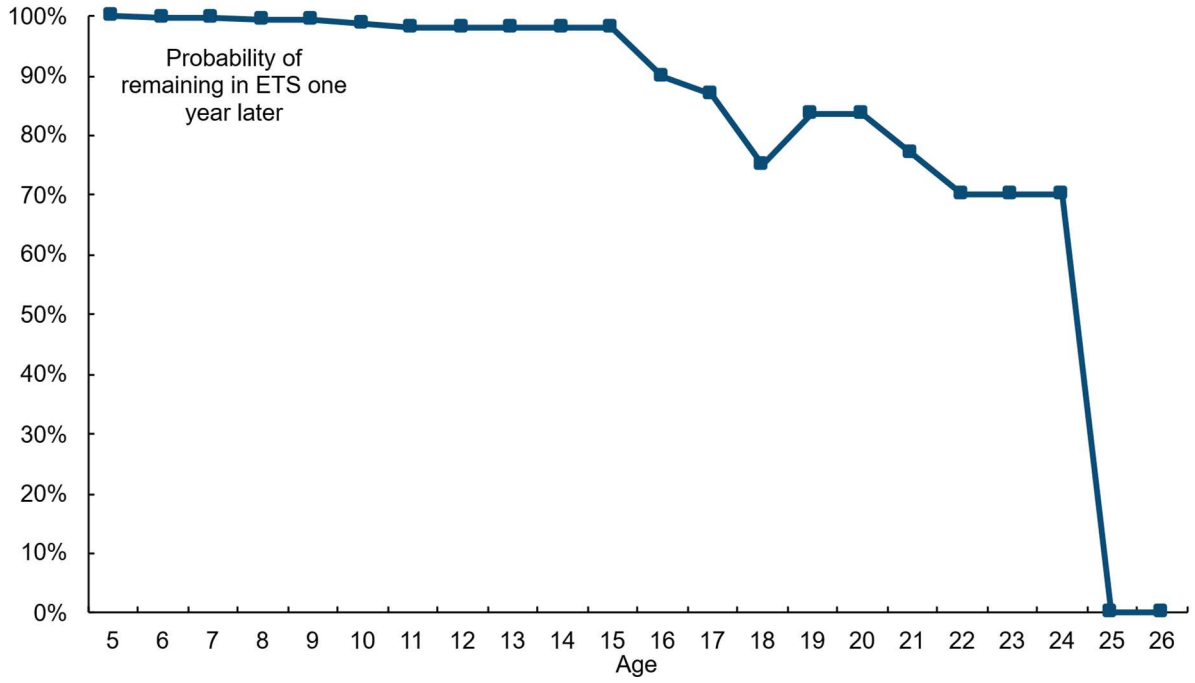
12.5.1 Table 12.1 shows the number of recipients of ETS payments in both the 2025 and 2024 financial years and their estimated age (noting we are only supplied with their year of birth). There were almost 1,200 more recipients of ETS payment in 2025 compared with the previous year, a 28 per cent increase. This is unsurprising given the large number of veterans who exceeded 80 WPI for the first time in 2025.

Table 12.1: MRCA ETS recipients

Age	Number of Recipients in FY2025	Number of Recipients in FY2024	Difference
5 and under	128	203	-75
6-7	570	452	118
8-9	753	586	167
10-11	777	641	136
12-13	808	615	193
14-15	818	629	189
16-17	731	545	186
18-19	459	294	165
20-21	258	206	52
22-23	138	95	43
24+	68	51	17
Total	**5,508**	**4,317**	1,191

12.5.2 We have assumed that these recipients will cease receiving ETS payments in accordance with recent experience as shown in Figure 12.13. 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 15). These assumptions are unchanged since our previous valuation.

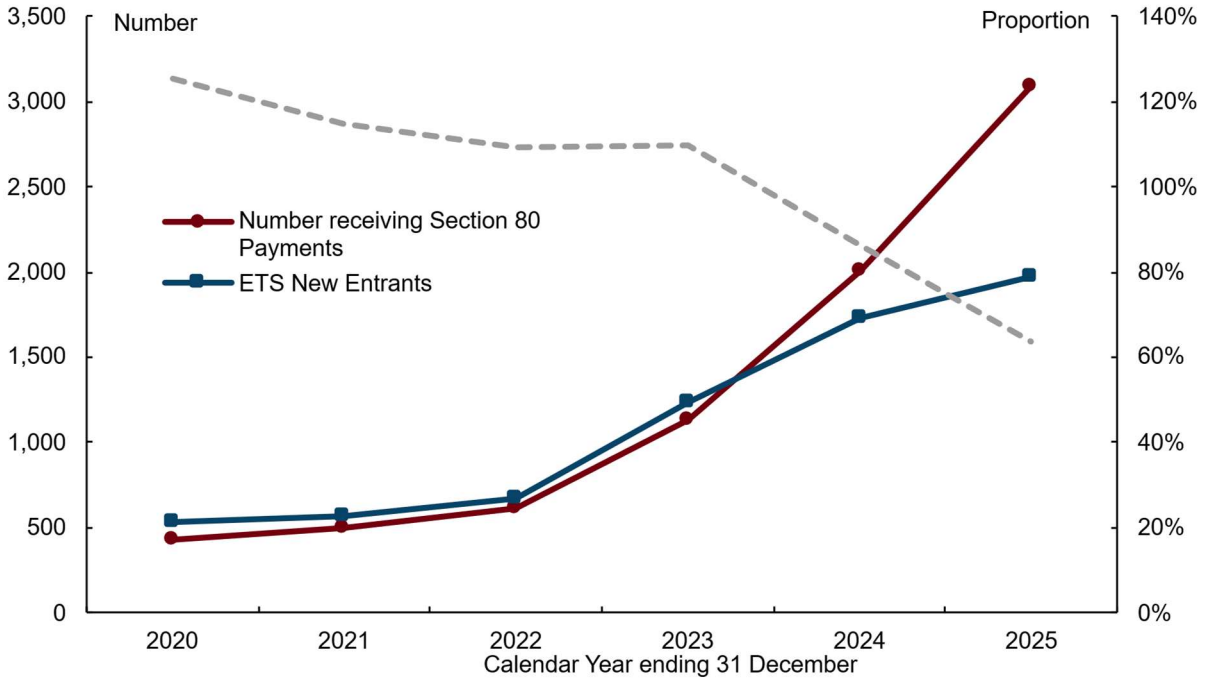
Figure 12.13: Probability of Remaining in the ETS from one Age to the next



12.5.3 Figure 12.14 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.

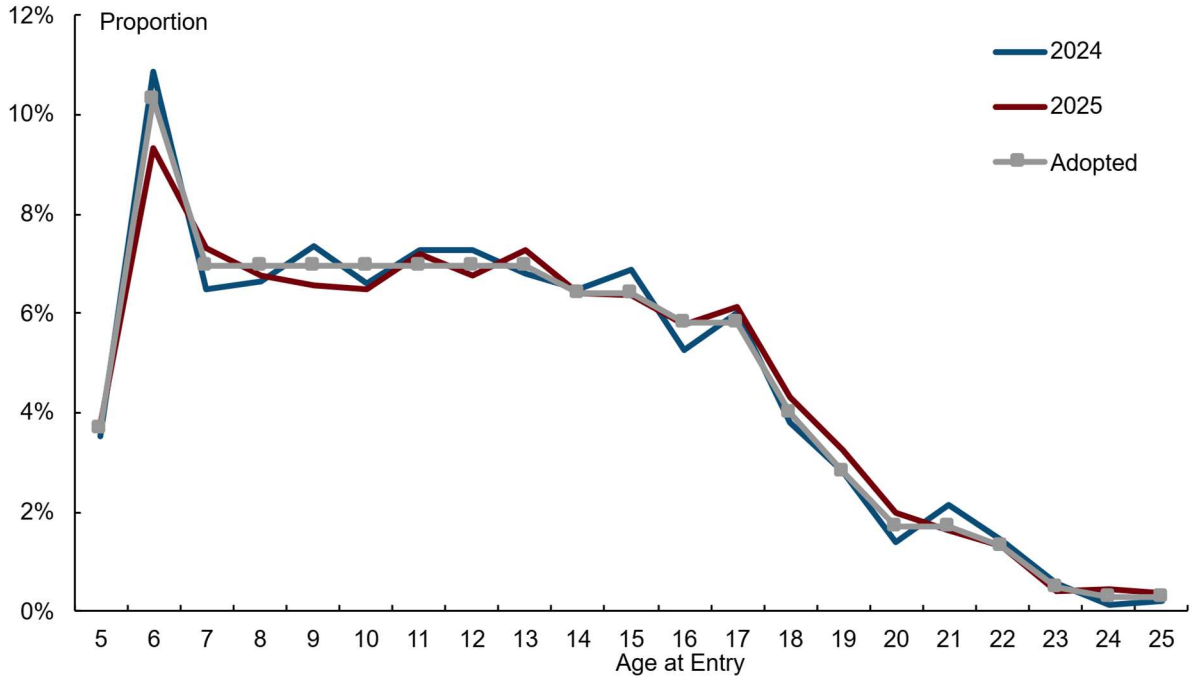
12.5.4 Over the last three years, both the number of claimants receiving Section 80 benefits and the number of ETS new entrants have increased substantially, although the number of ETS new entrants has not kept pace with the number of claimants receiving Section 80 benefits in 2024 and 2025; the number of ETS new entrants has fallen from about 110 per cent to 64 per cent of the number claimants receiving Section 80 benefits over the last two years. We are unsure why this proportion has fallen; it may be because those receiving Section 80 benefits in 2024 and 2025 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 75 per cent of claimants receiving Section 80 payments i.e. the average of the two most recent years.

Figure 12.14: ETS new entrants per new claimants exceeding 80 WPI points



12.5.5 We have assumed an age distribution for new entrants that is consistent with recent experience as shown in Figure 12.15. The age distribution of new entrants has been largely unchanged over the last ten years, with an average age at entry of just over 12 years old.

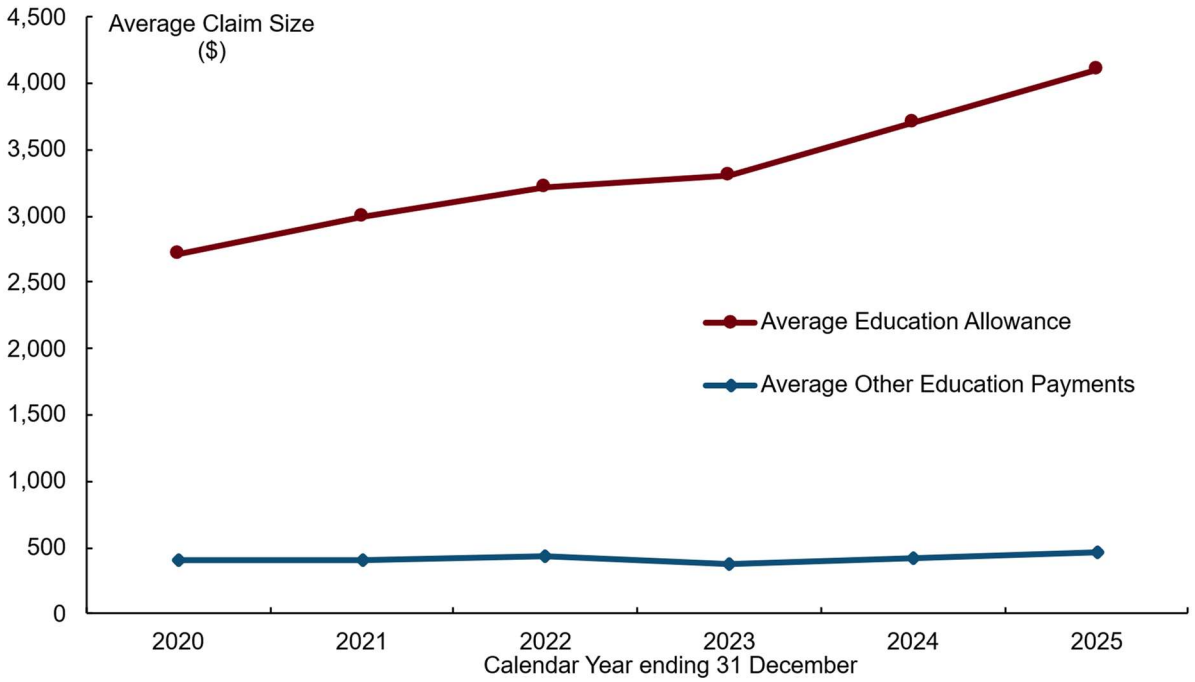
Figure 12.15: ETS new entrants assumed Age at Entry



12.5.6 Figure 12.16 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 $450 per ETS claimant per annum. We have adopted an average size for other education payments of $460 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.

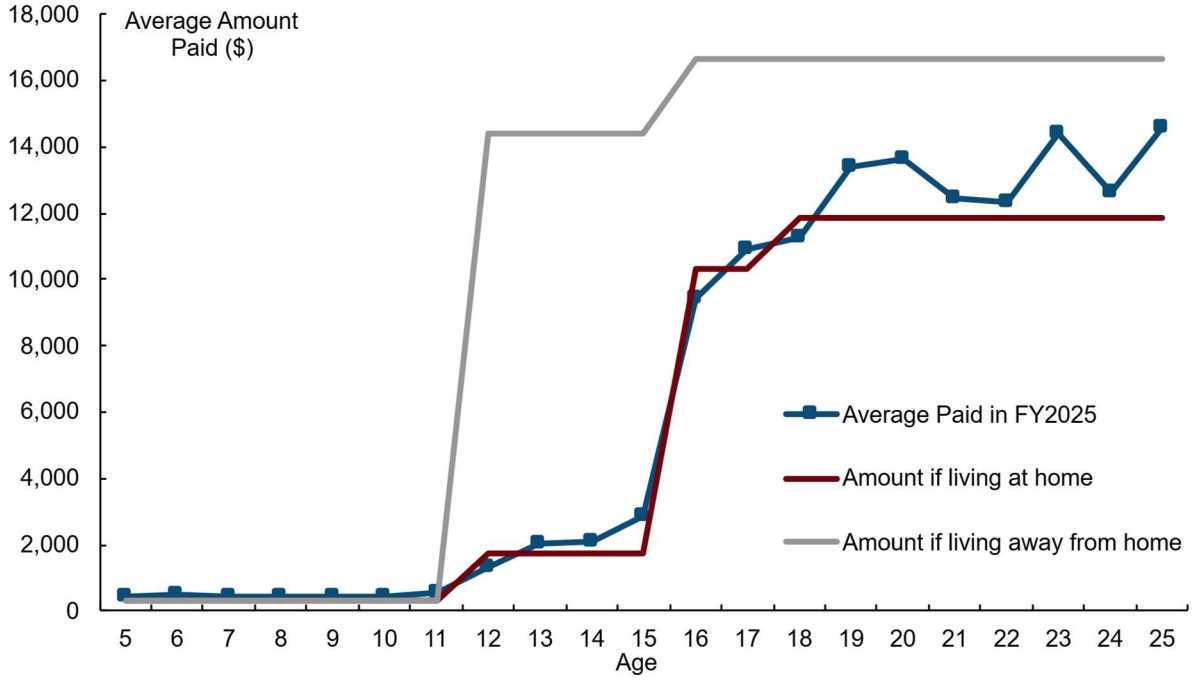
Figure 12.16: Average ETS Amounts Paid per ETS Recipient



12.5.7 Figure 12.17 shows the average education allowance paid in the 2025 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 2025 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.

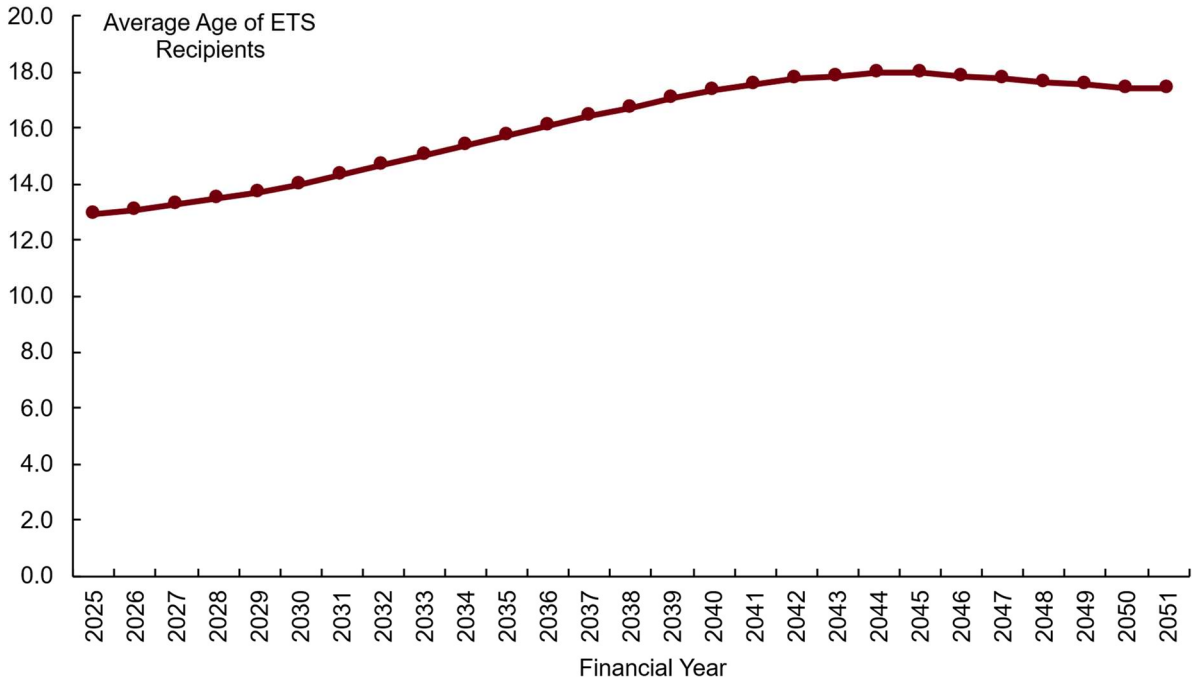
12.5.8 The graph also indicates that very few children are living away from home prior to age 19 (the amount paid is close to the living at home amounts), with the benefits increasing from age 19 as a higher proportion of children move out of home and qualify for the higher benefit.

Figure 12.17: Average Education Allowances and Other Education Payments



12.5.9 We have adopted average claim sizes for each age that are consistent with the average amounts paid in 2025. 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 12.1), the assumed ages of new entrants (Figure 12.15), and the assumed decrement rates (Figure 12.13). The overall average age implied by these assumptions is shown in Figure 12.18.

Figure 12.18: Projected Average Age of ETS Recipients



12.5.10 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.

12.6 Valuation Assumptions – Supplements

12.6.1 Table 12.2 shows the number of recipients of either the MRCA veteran supplement or energy supplement in the 2025 financial year and their estimated age (noting we are only supplied with their year of birth).

Table 12.2: MRCA Supplement recipients

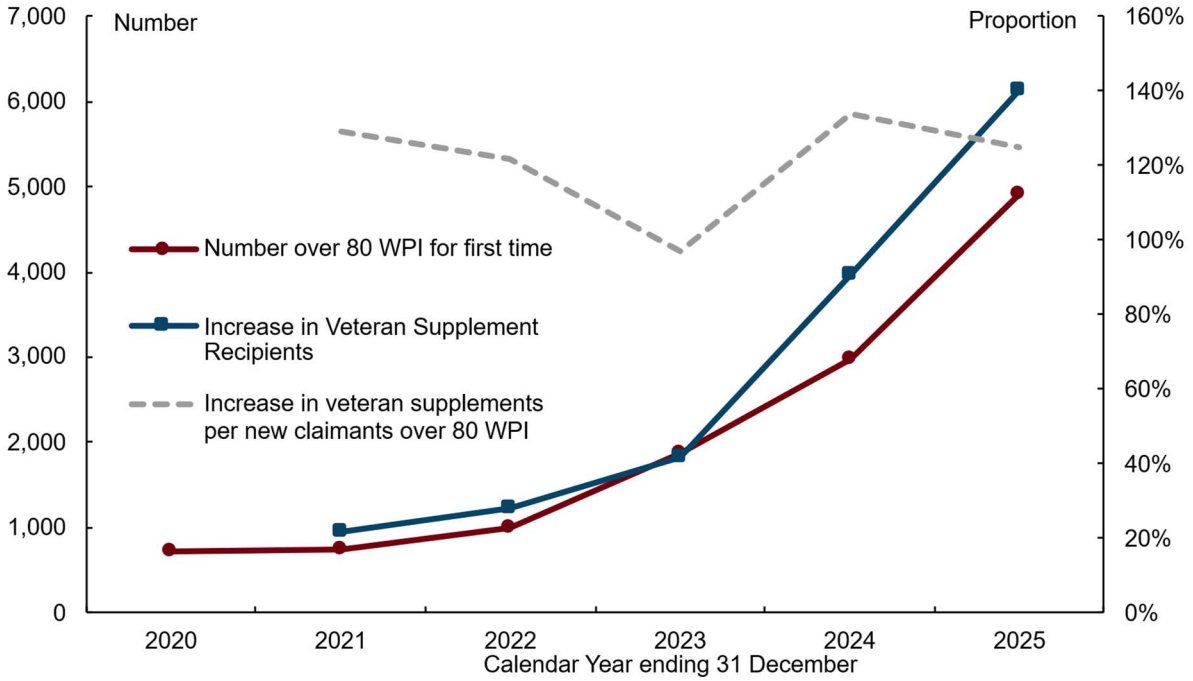
Age in FY2025	Veteran Supplement	Energy Supplement
25 and under	211	1,122
26-30	1,725	5,566
31-35	4,047	9,149
36-40	5,124	9,544
41-45	4,378	7,638
46-50	2,784	5,057
51-55	2,376	4,458
56-60	1,797	3,488
61-65	1,481	2,485
66-70	527	1,246
71+	167	633
Total	**24,617**	**50,386**

12.6.2 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".

12.6.3 Figure 12.19 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.

12.6.4 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 Specific Conditions Treatment Card or All Conditions Treatment 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 125 per cent of those exceeding 80 WPI points for the first time.

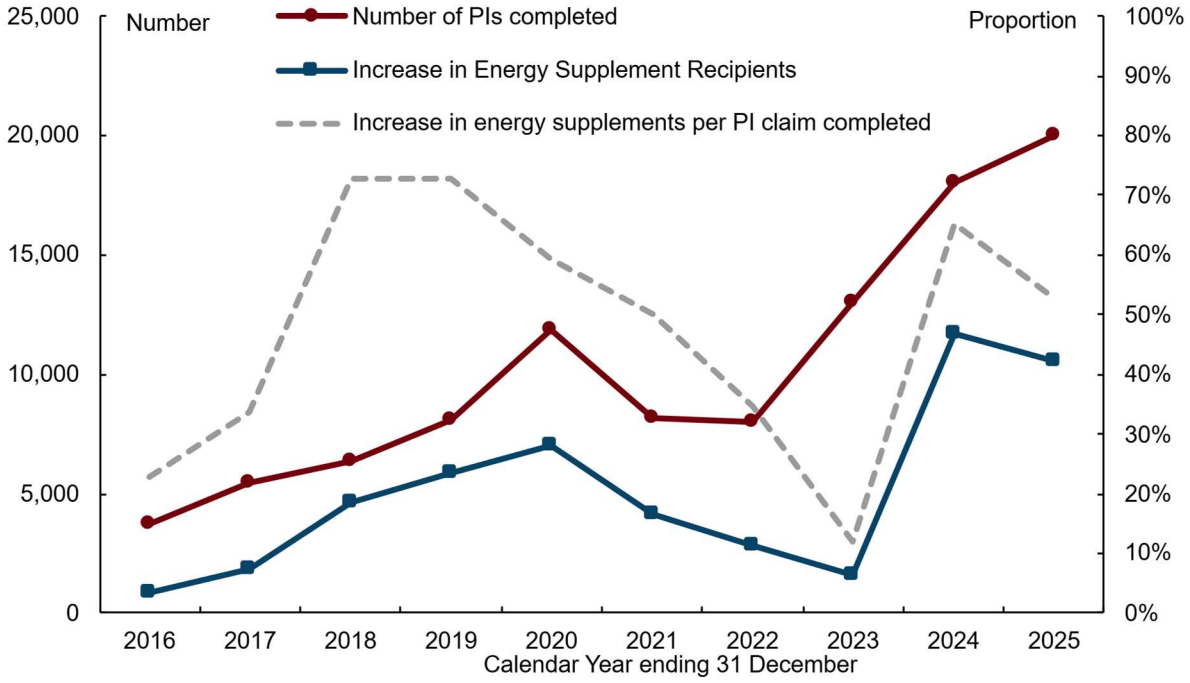
Figure 12.19: Increase in veteran supplement recipients per new claimants exceeding 80 WPI points



12.6.5 Figure 12.20 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.

12.6.6 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 50 per cent of PI completions in FY2026, consistent with the 2025 experience. 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).

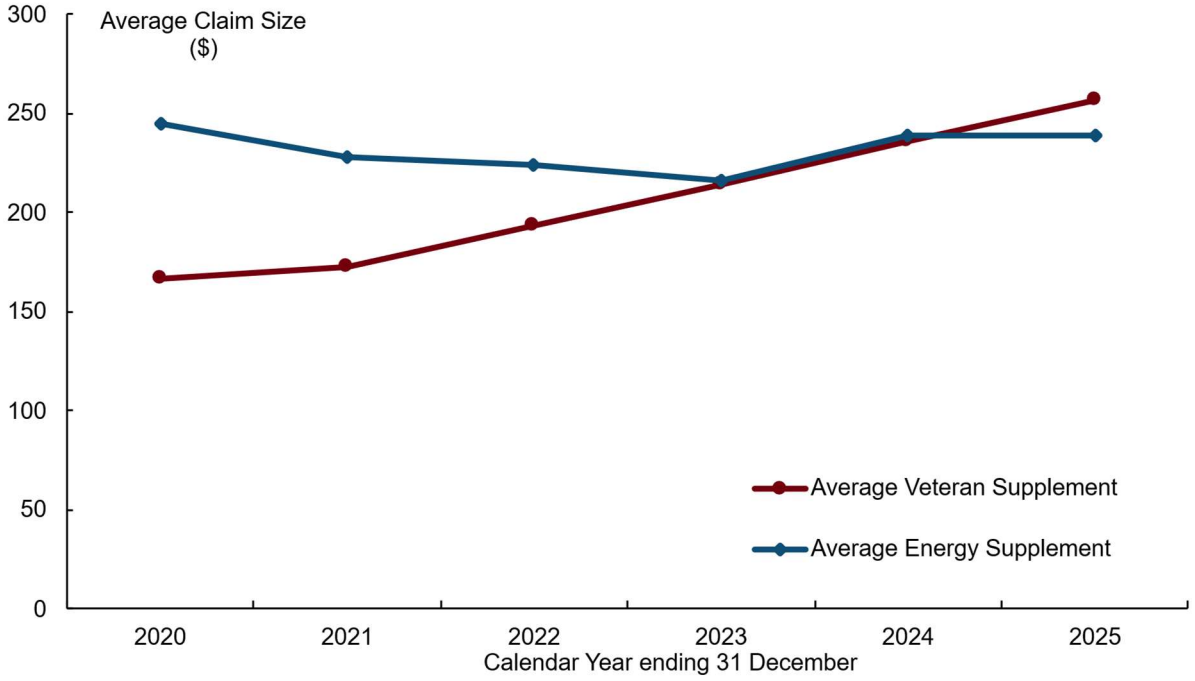
Figure 12.20: Increase in energy supplement recipients per PI claim completed



12.6.7 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.

12.6.8 Figure 12.21 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 $253 for the veteran supplement (assumed to increase in line with price inflation of 2.5 per cent per annum) and $230 for the energy supplement (with no future indexation).

Figure 12.21: Average Supplements per Annum



12.6.9 For DRCA, we have adopted a loading factor of 2.5 per cent to account for supplement payments, based on the experience in the most recent year. This is slightly lower than the 2.7 per cent adopted in our previous valuation.

12.7 Impact of the VETS Act – ETS benefits

12.7.1 Under the VETS Act, access to the MRCAETS will be extended to eligible dependants of DRCA and VEA veterans. We have included allowance for DRCA child dependents who become eligible because their parent's death is accepted to be service-related or their parent has received more than 80 impairment points under MRCA PI. We have allowed for the same cohorts of VEA child dependents (i.e. parent's death is accepted to be service-related or their parent has received more than 80 impairment points under MRCA PI), as well as the transfer to MRCA of VEA dependants currently eligible under the Veterans' Children Education Scheme (VCES).

12.7.2 For the numbers of child dependants expected as a result of service-related deaths, we have relied on the projected numbers from the DRCA and VEA death projection models (after allowance for the VETS Act). For the child dependants expected as a result of veterans with over 80 impairment points, we have relied on the projected numbers of severely injured veterans from the DRCA and VEA permanent impairment models (after allowance for the VETS Act).

12.7.3 For each of these groups, we assume ETS benefits are paid until they turn 25 years of age. For dependants currently receiving benefits under VCES, their age is known. For the remaining groups, we assume a single average age for new entrants of 15, the same as allowed for in the DRCA death child dependant valuation.

1.1.1 We have adopted the MRCA average claim sizes used in the MRCA ETS valuation. These MRCA sizes vary with the different stages of a dependant's life as per the legislated MRCA benefits.

1.1.2 The resulting liability at 30 June 2025 is $509 million in respect of DRCA members and $541 million in respect of VEA members.

12.8 Impact of the VETS Act – Medical Reports and Legal Expenses

12.8.1 Additional costs associated with medical reports and legal expenses will be incurred from 1 July 2026 in relation to current and future VEA veterans who will now be claiming under the MRCA.

12.8.2 To estimate the number of VEA veterans incurring such costs, we have used the projection of veterans who are expected to apply for a new DCP or review of their existing DCP. Under the MRCA, this group may incur additional medical reimbursement costs as they lodge claims. For the average size assumption, we have adopted the same average size as adopted for MRCA medical costs, indexed with wage inflation.

12.8.3 The resulting liability at 30 June 2025 is approximately $425 million.

12.9 Liability Estimate

12.9.1 Table 12.3 shows the estimate of the liability in relation to other payments, with each component shown separately.

12.9.2 Before the impact of the VETS Act, the liability for MRCA at 30 June 2025 is $3.1 billion, compared with a projected liability of $2.8 billion from the 2024 valuation. The liability for DRCA at 30 June 2025 is $180 million, compared with a projected liability of $209 million from the 2024 valuation.

12.9.3 After the impact of the VETS Act, the MRCA liability increases by $1.6 billion to $4.8 billion at 30 June 2025. We understand that all medical reports and legal costs in respect of DRCA members incurred after 1 July 2026 will become liabilities of MRCA at 30 June 2025 i.e. the DRCA liability after the impact of the VETS Act is in respect of payments in the year ending 30 June 2026 only.

Table 12.3: Outstanding Claims Liability for Other Payments

Component	MRCA Liability ($ m)	DRCA Liability ($ m)
Medical reports and legal expenses	1,294.6	175.7
ETS	1,094.3	n/a
Supplements	732.0	4.5
Total before VETS Act	**3,120.9**	**180.2**
Expected at 30 June 2025 before VETS Act	*2,834.9*	*208.5*
VETS Act Impact – Transfer from DRCA	162.3	(162.3)
VETS Act Impact – ETS payments	1,050.1	0.0
VETS Act Impact – Medical reports and legal expenses	426.0	0.0
Total after VETS Act	**4,759.2**	**17.9**
Total at 30 June 2024	*2,523.3*	*216.3*

12.9.4 Table 12.4 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 12.4: Reconciliation of Liability for Other Payments

	MRCA $m	DRCA $m
Liability estimate at 30 June 2024 (previous report)	2,523.3	216.3
Assumed Interest	120.7	10.6
Projected Payments	(219.6)	(18.1)
Notional Premium	410.5	0.0
Projected liability as at 30 June 2025 (previous valuation)	2,834.9	208.5
Experience effects and Assumption changes		
Number of medical reports and legal expenses	(174.2)	(89.6)
Average size of medical reports legal expenses	370.6	61.8
Number of ETS recipients	(154.9)	0.0
Average size of ETS payments	130.6	0.0
Number of supplement recipients	88.5	(0.6)
Average size of supplements	25.3	0.0
Liability at 30 June 2025 (before VETS Act)	**3,120.9**	**180.2**
Change due to VETS Act	1,638.3	(162.3)
Liability at 30 June 2025 (after VETS Act)	**4,759.2**	**17.9**

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

- A reduction of $264 million across both MRCA and DRCA due to lower assumed future numbers of claimants receiving medical reports and legal expenses;

- An increase of $433 million across both MRCA and DRCA due to higher average claim size assumptions for medical reports and legal expenses, reflecting the much higher than expected experience in the last year;

- A reduction of $155 million in MRCA due to a lower number of assumed ETS recipients. This is a combination of both lower-than-expected numbers entering the ETS scheme in 2025 and projected lower future numbers;

- An increase of $131 million in MRCA due to higher average ETS payments. The available benefits increased by substantially more than CPI over the last year, particularly for older secondary school children;

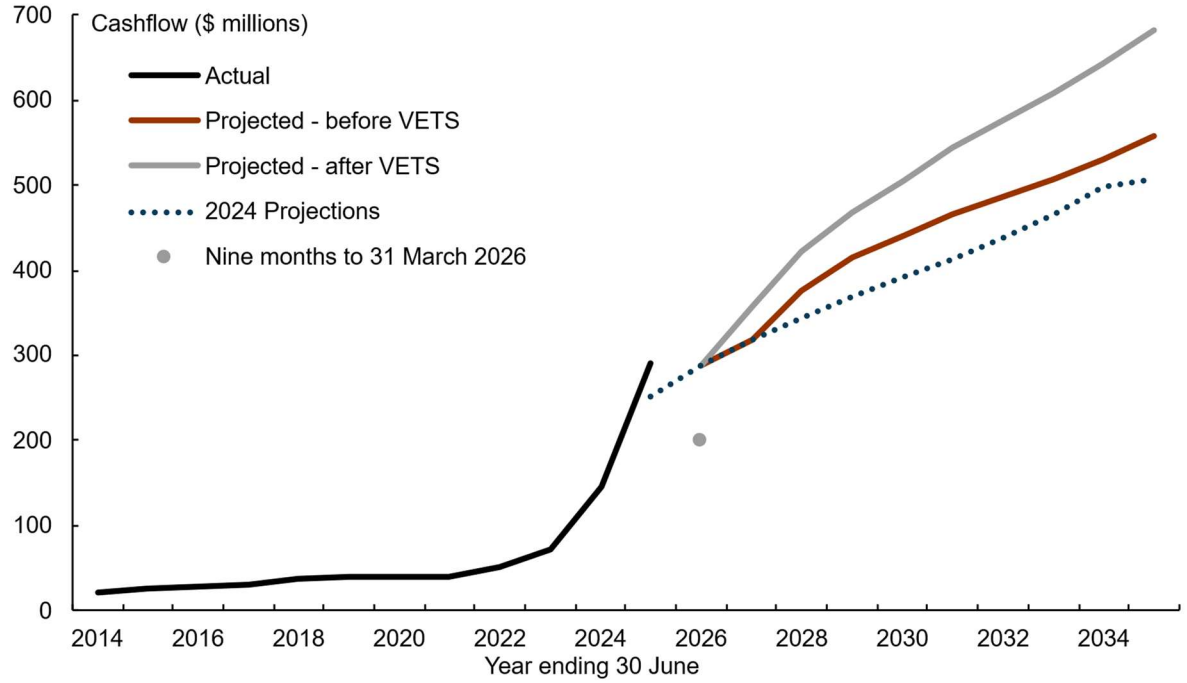
- An increase of $114 million in MRCA supplements, due to both increases in the number of recipients and the average size of supplements;

- An increase of $1.6 billion in the MRCA liabilities and a reduction of $162 million in the DRCA liabilities due to the impact of the VETS Act.

12.10 Cashflows

12.10.1 Figure 12.22 shows actual outlays since 2014 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 2026. Our projection, before the impact of the VETS Act, is higher than that adopted in our previous valuation, and the VETS Act further increases the projected payments. Actual payments in the first nine months of 2026 are 69 per cent of our full year projection for 2026 i.e. the latest experience is consistent with our short-term projection.

Figure 12.22: Historical and Projected Other Payments



13 Death Benefits

13.1 Benefit Overview

13.1.1 The number of deaths can be highly variable from year to year and the assumptions made therefore involve a more significant degree of judgement relative to the other components of the liability.

13.1.2 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 2025-26 being $664,265. 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 $73,336 (2025-26 deaths) and to each dependent child in the amount of $107,792 (2025-26 deaths);
- Fortnightly benefits are payable to dependent children until they reach the age of 16, or 25 if in full time education (currently $182.68 per fortnight);
- Dependents are also entitled to claim death-related expenses for funeral expenses and financial advice. These are subject to maximum amounts of $14,990 and $2,122 respectively (for 2025-26 deaths).

13.1.3 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 $600.40 per week (including 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 is payable to those aged 40 or under and is $185,289 for 2025-26 deaths);
- A further lump sum benefit payable in respect of each dependent child, regardless of whether the death was service-related ($111,173 for 2025-26 deaths);
- Fortnightly benefits are payable to dependent children until they reach the age of 16, or 25 if in full time education (currently $184.90 per week);
- 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 $3,279 (for 2025-26 deaths).

13.1.4 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.

13.1.5 From September 2017, the smoking policy was amended to allow claims for smoking-related illnesses if they satisfy certain criteria under the DRCA scheme. Policy changes were also 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 benefit claimants. All these factors could have led to higher levels of death payments seen in recent years.

13.2 DRCA Approach and Assumptions

13.2.1 This section discusses our estimate of the liability for DRCA death benefits prior to the introduction of the VETS Act.

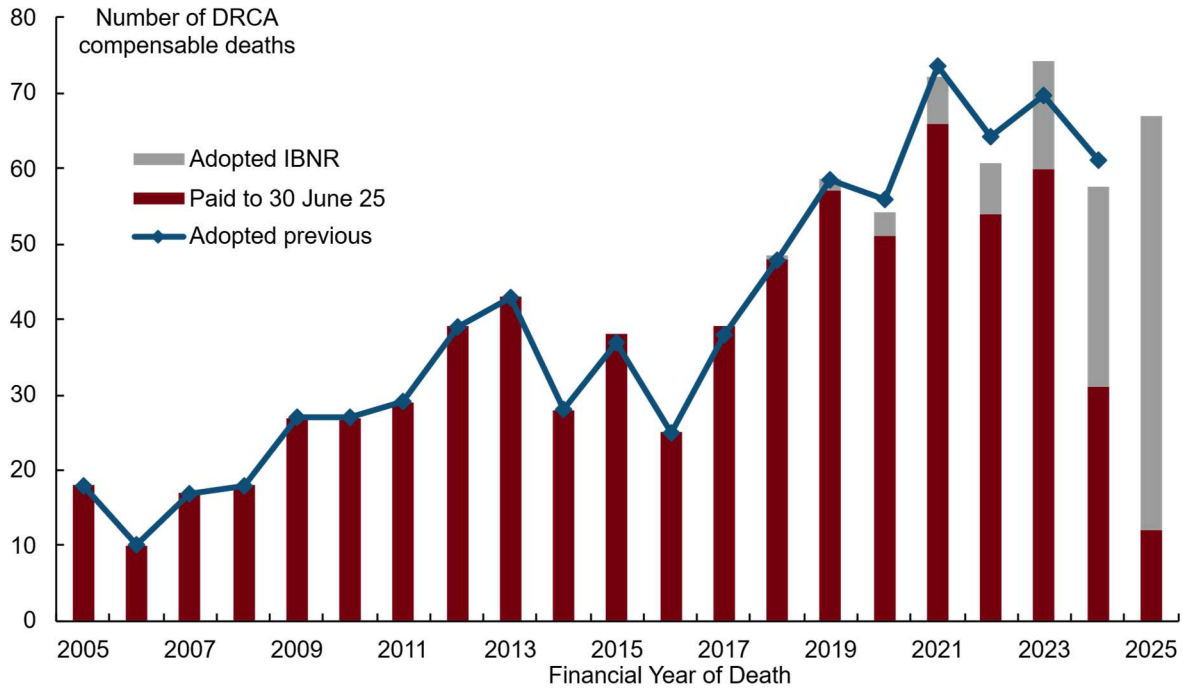
13.2.2 For this valuation we have allowed for future payments on service-related deaths that have occurred but have not yet been paid (IBNR) and future deaths expected to be service related. We have followed the same approach to forming our assumptions as for the previous valuation i.e. sub-divided the 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.

13.2.3 As for the previous valuation, we have estimated the number of IBNR claims at 30 June 2025 using a simple chain ladder model on a development triangle of the number of deaths. One small variation this year is that we have constructed the development triangles by financial year of occurrence and duration until financial year of payment. Previously we were only supplied with calendar year of death, not financial year. In modelling death benefits, the use of financial year better aligns with the indexation of benefits which occurs on 1 July of each year.

13.2.4 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 2025 (not 30 June 2025). The two approaches give consistent results.

13.2.5 Figure 15.1 shows the ultimate numbers we have adopted at this valuation compared with the previous valuation. The ultimate numbers adopted this year are similar to those adopted previously. We have allowed for 114 IBNR death claims at 30 June 2025.

Figure 13.1: Adopted DRCA Compensable Death Claims (deaths prior to 30 June 2025)

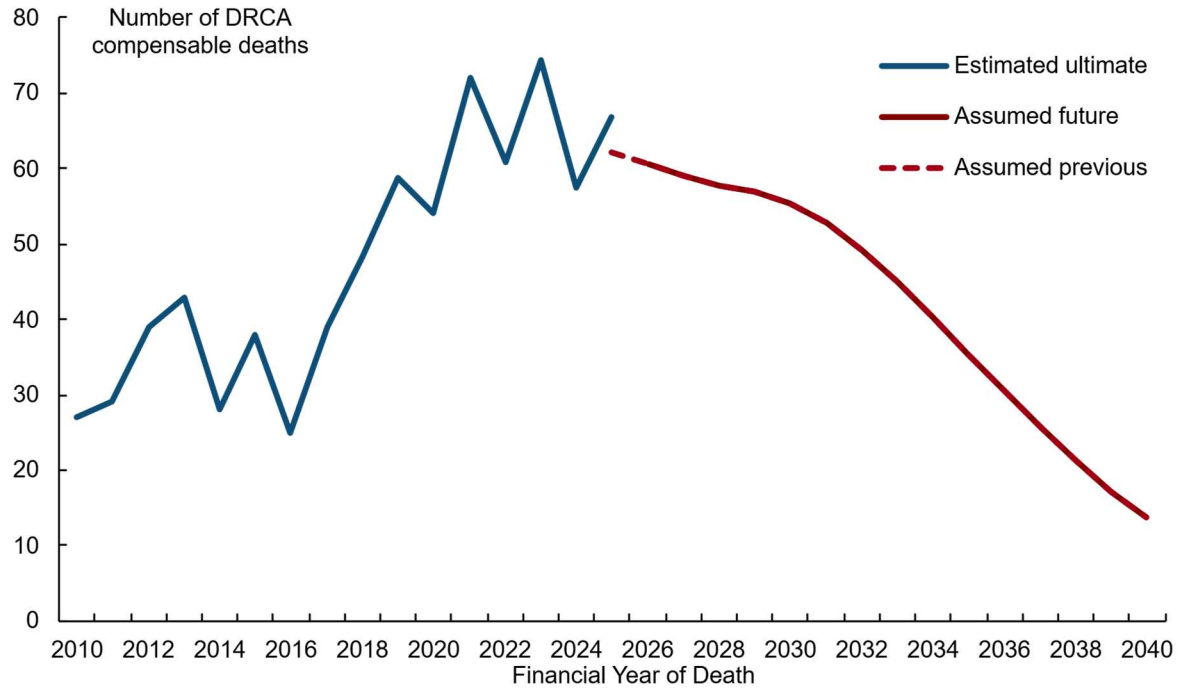


13.2.6 It is likely that recent policy changes (such as the change in coverage of service-related smoking and mental health claims), combined with Veteran Centric Reform, could have contributed to the increase in the number of compensable death claims seen between 2017 and 2019. The number of compensable deaths under DRCA since 2019 is estimated to have been reasonably stable at between 54 to 74 deaths each year.

13.2.7 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.

13.2.8 Figure 15.2 shows our estimated ultimate number of pre-30 June 2025 compensable death claims and our assumed run-off. Given that the experience in 2025 was similar to that adopted in our previous valuation, we have not changed our assumed future run-off. 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. There is a high degree of judgment involved in selecting these assumptions and we provide sensitivities around these assumptions in section 17.

Figure 13.2: Assumed Future Number of DRCA Compensable Death Claims



13.2.9 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 there will be 0.12 child dependents per death (up slightly from 0.10 assumed at our previous review). 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 80 per cent of death claims will have funeral expenses paid at 55 per cent of the maximum (down from 95 per cent receiving this benefit at 60 per cent of the maximum assumed in our previous review). For financial assistance, we have assumed 20 per cent of dependants will seek financial assistance and will claim the full amount (unchanged from our previous assumptions). These assumptions are consistent with recent experience.

13.2.10 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 15 per cent of lump sums will be paid in the year of death, 45 per cent in the year following death, 20 per cent in the year after that, 10 per cent in the year after that, and 10 per cent in the fourth year after the death occurs.

13.2.11 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 prior to 30 June 2025. There were 42 children in receipt of dependent benefits at 30 June 2025. The future number of new entrants are assumed to be the same as the number receiving a lump sum benefit (i.e. 0.12 times the number of compensable deaths).

13.2.12 The fortnightly benefit valued is $182.68 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).

13.2.13 For existing recipients, the dependent's year of birth is supplied and the approximate age at 30 June 2025 is calculated as 2025 less year of birth. The average age of new entrants is assumed to be 15 years. This reflects the average age of new dependents over the last five years (a small increase from 14 years assumed at the previous valuation). 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.

13.2.14 Table 15.2 shows a summary of the components making up the DRCA death benefits liability valuation at 30 June 2025, prior to the introduction of the VETS Act.

Table 13.1: DRCA Death Benefits Liability at 30 June 2025 – Before VETS Act

Component	Estimated Liability ($m)
Dependent lump sum	435.1
Additional lump sum - spouse	48.0
Additional lump sum - children	8.5
Period benefits - existing children	3.0
Period benefits - new children	7.5
Funeral benefits	4.1
Financial assistance	0.3
Total Liability	**506.4**

13.2.15 The DRCA death benefits liability at 30 June 2024 was $521.4 million, projected to reduce to $489.7 million by 30 June 2025 (prior to the impact of the VETS Act). The total liability at this valuation, prior to the impact of the VETS Act, of $506.4 million is 3 per cent higher than projected. This is primarily due to fewer death benefits being paid in 2024-25 compared with expected i.e. while our assumed ultimate numbers of deaths are largely unchanged, there are more unpaid death claims than anticipated at our previous review.

13.3 MRCA Approach and Assumptions – Deaths occurring prior to 30 June 2025

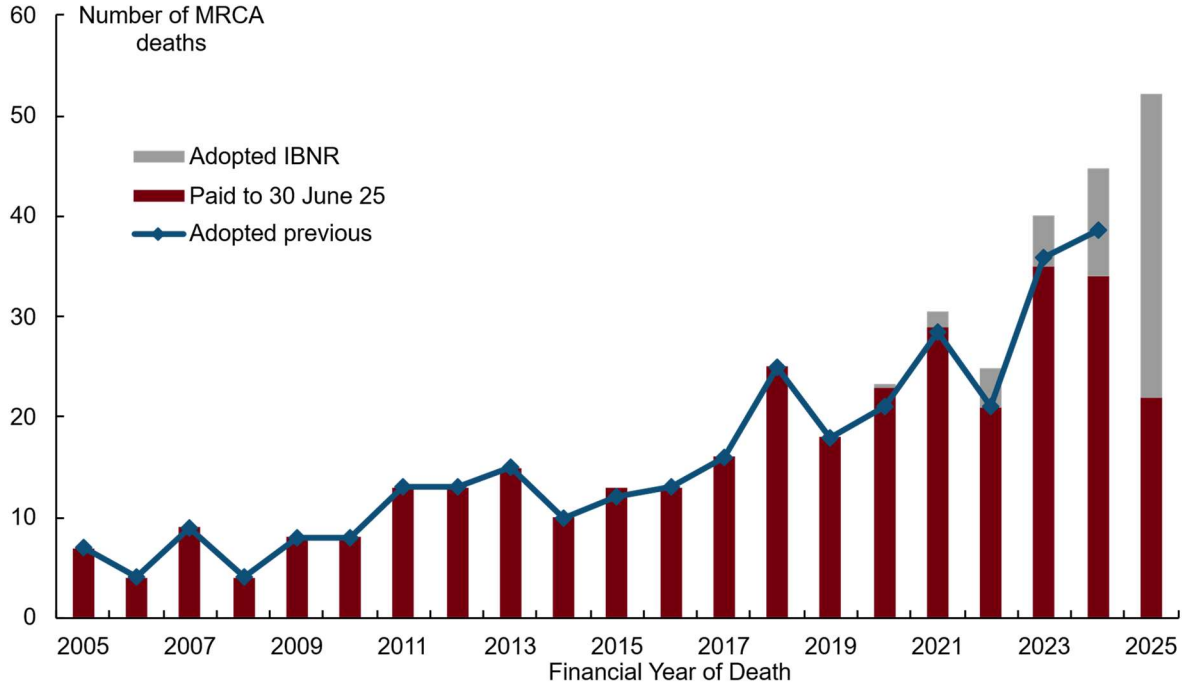
13.3.1 This section documents our liability estimate for MRCA deaths that occurred prior to 30 June 2025 but had not yet been paid at that date (IBNR) and prior to the introduction of the VETS Act.

13.3.2 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.

13.3.3 Figure 15.3 shows the ultimate numbers we have adopted at this valuation compared with the previous valuation. Our adopted ultimate numbers this year are higher than the previous

assumptions for 2020 and later years. The number of death claims paid so far for the 2025 year, at 22, is particularly high (the 2024 year at the same stage of development had 15 death claims paid). We have allowed for 52 IBNR death claims at 30 June 2025.

Figure 13.3: Adopted MRCA Death Claims (deaths prior to 30 June 2025)



13.3.4 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. Further, we would expect the number of MRCA death claims to increase as the scheme matures and veterans covered by the MRCA legislation age.

13.3.5 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, effectively assuming that the lump sum conversion is cost-neutral compared with electing to receive periodic benefits. We note that the lump sum commutation factors have increased by around 1-3 per cent since our previous review (they are reviewed every five years when the AGA's Life Tables are released). While in practice we understand that the supplements are not commuted if a lump sum election is made, for simplicity, we have allowed for the supplements to be commuted. 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 42.4 years, up slightly from 41.5 years assumed previously);
- 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 42.4 years, receiving around 92 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 60 per cent of death claims will have funeral expenses paid at 100 per cent of the maximum (up from 50 per cent receiving the benefit at 70 per cent of the maximum assumed previously). For financial assistance, we have assumed 25 per cent of dependants will seek financial assistance and will claim the full amount (up from 20 per cent seeking financial assistance previously). These assumptions are consistent with the recent experience;
- 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).

13.3.6 For this valuation, we have included an allowance for the costs associated with access to the All Conditions Treatment Card for the dependent partner. Wholly dependent partners eligible for death benefits are entitled to receive an All Conditions Treatment Card which covers all clinically necessary treatment for medical conditions. We have assumed an average cost of medical benefits that varies by age, based on the recent experience of war widows with All Conditions Treatment Card entitlements under the VEA. The average cost adopted ranges from $10,000 for dependent partners aged under 50 years to $35,000 for those aged 90 and above.

13.3.7 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, 5 per cent in the year after that, and 5 per cent in the fourth year after the death occurs.

13.3.8 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 prior to 30 June 2025. There were 144 spouses in receipt of dependent benefits at 30 June 2025. The weekly benefit value is $600.40 (including supplements), 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 2025 is calculated as 2025 less year of birth. This is used as the input to mortality decrements, with mortality rates taken from the Australian Life Tables 2020-22.

13.3.9 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 372 children in receipt of dependent benefits at 30 June 2025. 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 weekly benefit value is $184.90, 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 2025 is calculated as 2025 less year of birth. The average age of new entrants is assumed to be 11 years, lower than 15 years assumed for DRCA (noting the average age of DRCA members is older than MRCA members). Benefits are assumed to cease at age 25.

13.3.10 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 2025, prior to the introduction of the VETS Act.

Table 13.2: MRCA Death Benefits Liability for Deaths Occurring Prior to 30 June 2025 – Before VETS Act

Component	Estimated Liability ($m)
Dependent lump sum	40.2
Additional lump sum - spouse	6.0
Additional lump sum - children	7.2
Period benefits - existing spouses	81.3
Period benefits - existing children	32.3
Periodic benefits – new All Conditions Treatment Cards	26.4
Period benefits - new children	7.7
Funeral benefits	0.4
Financial assistance	0.0
Total Liability	**201.6**

13.3.11 The MRCA death benefits liability at 30 June 2024 was $127.9 million, projected to be $124.4 million by 30 June 2025. The total liability assumed at this valuation of $201.6 million is 62% higher than projected. This is primarily due to higher assumed numbers of IBNR claims and the inclusion of an allowance for widow All Conditions Treatment Cards.

13.4 MRCA Approach and Assumptions – Deaths occurring after 30 June 2025

13.4.1 Death compensation under MRCA is provided to dependent partners for veterans with SRDP eligibility or whole person impairments points greater than 80 (“80 WPI”), irrespective of whether the member’s death is service-related. Dependents are entitled to the same benefits as outlined in paragraph 15.1.3, with the additional death benefit only payable in the event that the death is service-related.

13.4.2 For the number of future such deaths we have adopted the following approach:

- Our starting point is the MRCA population at 31 December 2025 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 15,400 people at 31 December 2025, with a known age distribution;
- Estimate the MRCA population at 30 June 2025 who have 80 WPI/SRDP eligibility by deducting from the 31 December 2025 population the estimated number who first met the 80 WPI/SRDP criteria between 1 July 2025 and 31 December 2025. We have estimated the number of such people by taking the number who received a Section 80 payment in the six month period an applying the historical ratio of the (number who first exceeded 80 WPI)/(number who received a Section 80 payment). Over the last six years, 64 per cent of people exceeding 80 WPI for the first time received a Section 80 payment. This gives an estimated population of around 13,000 people with 80 WPI/SRDP eligibility at 30 June 2025. We have assumed the age distribution of this population is the same as our 31 December 2025 population;
- Estimate the expected number of people who will become eligible for the death compensation benefit after 30 June 2025 (in respect of injuries/conditions acquired prior to

the valuation date). We have estimated the number expected to exceed 80 WPI by utilising our projection of the number of people expected to receive a Section 80 payment (see Section 5) and applying the same ratio of the (number who first exceeded 80 WPI)/(number who received a Section 80 payment) as used above. We have then included allowance for the number eligible for SRDP using the same ratio as in our existing population (15 per cent). This gives a future number of people expected to become eligible for death compensation of around 43,200. We have assumed the age distribution of these people are the same as our 31 December 2025 population;

- 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 32,500 people expected to be paid death compensation benefits in respect of injuries/conditions acquired prior to 30 June 2025.

13.4.3 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 in accordance with CPI as per the legislated indexation.

13.4.4 We have also included an allowance for the costs associated with access to the All Conditions Treatment Card for the dependent partner. 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 that varies by age, as for the MRCA pre-30 June 2025 deaths. In our previous valuation, we assumed that the average cost of medical benefits was the same for all ages and was $18,150 (in 2025 values). Our adopted average medical cost is substantially higher this year at $28,900. This increase is due to a number of factors including higher average medical costs that have emerged during the year, an allowance for data maturity issues related to public hospital costs, an allowance for community nursing costs that were previously omitted from the valuation data received, and an allowance for aids and appliances that were previously included in the valuation of rehabilitation benefits.

13.4.5 The provision for death compensation benefits and associated All Conditions Treatment Card costs at 30 June 2025 is approximately $14.3 billion, with around $6.7 billion of death compensation benefits and around $7.6 billion for the associated All Conditions Treatment Cards.

13.4.6 The liability estimate of $14.3 billion is an increase of $3.9 billion above the 30 June 2025 liability estimate projected at the previous valuation. This is primarily due to two factors: 1) higher numbers of veterans exceeding 80 WPI points in 2025 and our assumption that future numbers exceeding 80 WPI points will be higher than previously, and 2) the higher average

medical cost associated with dependent partners who access an All Conditions Treatment Card.

13.5 Impact of the VETS Act – DRCA Veterans

13.5.1 From 1 July 2026, claims for service-related deaths currently assessed under the DRCA will be assessed under the MRCA. For future DRCA dependants, the main differences between the death benefits currently available under DRCA and the benefits available under MRCA are the lump sum amounts available to spouses and the entitlement to an All Conditions Treatment Card under MRCA. The current DRCA amount is around $665,000 regardless of age, whereas the converted MRCA lump sum amounts vary by age and are currently around $850,000 for a widow aged 40 and around $460,000 for a widow aged 70. The MRCA amounts are less than the DRCA amounts once the widow is aged 55 or older. Given the older age of the DRCA cohort, most widows will receive a lower lump sum under MRCA compared with DRCA. This is only partially offset by the higher additional death benefit available to DRCA dependents compared with MRCA dependents.

13.5.2 To cost the change to DRCA benefits, we used our DRCA assumptions for the number of dependent spouses, number of dependent children and age of the children and have assumed the MRCA death benefit amounts would apply from 1 July 2026. To estimate the additional costs of All Conditions Treatment Card entitlements for spouses of DRCA veterans, we adopted the assumptions used for MRCA (as discussed above). We assumed all DRCA dependants will opt to receive the age-based lump sum under MRCA.

13.5.3 The total DRCA liability for service-related deaths at this valuation, after allowance for the impact of the VETS Act, is $706.6 million, an increase of $200.2 million. While the dependent lump sums are lower under the new MRCA, the liability is higher due to the higher additional death benefits and All Conditions Treatment Cards granted to DRCA widows.

13.5.4 In addition to the liability for service-related deaths, DRCA members who lodge initial liability claims under the new MRCA after 1 July 2026 will be entitled to death compensation benefits if they are assessed to have a WPI of more than 80 points or are ever SRDP eligible. In Section 6.9 we estimated the number of DRCA veterans who would be eligible for Section 80 benefits, both on a “business as usual” basis and the addition of further veterans who may be eligible by virtue of submitting to a MRCA whole person impairment assessment on implementation of the VETS Act. Based on the older ages of the DRCA cohort, we estimate that these veterans represent around 26 per cent of all veterans who exceed 80 whole person impairment points (lower than 64 per cent assumed for younger MRCA veterans). We have assumed that these 7,100 veterans will be eligible for death compensation benefits.

13.5.5 As for MRCA death compensation benefits, we have assumed partnering rates at age of death, and again with the older cohort, the overall implied partnering rate is 54 per cent (compared with 60 per cent for MRCA). This results in around 3,800 people expected to be paid death compensation benefits in respect of DRCA injuries/conditions acquired prior to 30 June 2025.

13.5.6 We have assumed that this population will receive all of the usual MRCA death benefits other than the additional death benefit (which is only paid for service-related deaths). We have also included an allowance for the costs associated with access to the All Conditions Treatment Card for the dependent partner using the same assumptions as for MRCA.

13.5.7 The provision for death compensation benefits and associated All Conditions Treatment Card costs at 30 June 2025 is approximately $1.7 billion.

13.6 Impact of the VETS Act - VEA Veterans

13.6.1 For VEA dependants, those claiming for a service-related death will be entitled to death liability benefits under the MRCA. In addition, VEA dependants of veterans who have a made a MRCA claim under the amended MRCA and have over 80 WPI points will be eligible for death compensation benefits. For future VEA dependants, we have used the new entrant model used for the projection of dependant MRCA All Conditions Treatment Cards for the number and average age of dependants in each year i.e. we have a projection of the number of new dependent partners in each future year.

13.6.2 Of these projected dependants, a proportion is likely to claim under the MRCA for service-related death. Under the MRCA, accepted service-related death claims will provide access to an age-based lump sum conversion of the fortnightly pension, an additional lump sum death benefit, as well as access to a higher limit for funeral benefits (around $15,000 compared to $3,000 under the VEA) and financial advice benefits. In setting the assumption for the likely proportion of dependant partners who may claim under MRCA, we have used the same 20 per cent assumption that was adopted by DVA in their internal costing of the VETS Act. The proportion has been selected by DVA based on judgement as there is currently no historic data available to inform this assumption.

13.6.3 We have also assumed a proportion of these dependants will have dependant children. In setting the assumption, we have relied on the DRCA experience and adopted the DRCA assumptions of approximately 0.12 dependants per veteran and an average age of 15. For these child dependants, a fixed lump sum amount is assumed to be paid along with a fortnightly benefit until age 25.

13.6.4 Using these assumptions, the liability under MRCA for service-related deaths for the VEA veteran cohort, including associated All Conditions Treatment Cards, is expected to be around $1.8 billion as at 30 June 2025.

13.6.5 In addition to the liability for service-related deaths, VEA members who lodge initial liability claims under the new MRCA after 1 July 2026 will be entitled to death compensation benefits if they are assessed to have a WPI of more than 80 points or are ever SRDP eligible. Our approach to assessing the number of such veterans differs a little to the approach used for DRCA as we have utilised the same projection of dependant partners mentioned above. We have assumed that only a portion of these dependant partners will be eligible for death compensation benefits as the veteran would been to be assessed as over 80 WPI points to access death compensation (but only 60 WPI points for an All Conditions Treatment Card). We have assumed 22 per cent of those with more than 60 WPI points will have more than 80 WPI points. In addition, current VEA members will need to lodge a MRCA claim to be eligible – we have assumed 22 per cent of all future dependant partners arising from VEA members who have already claimed under VEA will also lodge a MRCA claim. This results in an estimate of 2,150 dependent partners expected to be paid death compensation benefits in respect of VEA injuries/conditions acquired prior to 30 June 2025.

13.6.6 We have assumed that this population will receive all of the usual MRCA death benefits other than the additional death benefit (which is only paid for service-related deaths). We have also included an allowance for the costs associated with access to the All Conditions Treatment Card.

13.6.7 The provision for death compensation benefits and associated All Conditions Treatment Card costs at 30 June 2025 is approximately $870 million.

13.7 Liability Estimate

13.7.1 Table 15.6 summarises the death benefits liability at 30 June 2025 under each of the Acts, both before and after the impact of the VETS Act.

Table 13.3: Death Benefits Liability at 30 June 2025

Component	Estimated Liability before VETS Act ($m)	Estimated Liability after VETS Act ($m)	Impact of VETS Act ($m)
DRCA service-related deaths	506.4	706.6	200.2
DRCA non-service-related deaths	0.0	1,650.1	1,650.1
MRCA deaths occurring prior to 30 June 2025	201.6	201.6	0.0
MRCA deaths occurring after 30 June 2025	14,342.7	14,342.7	0.0
VEA service-related deaths	0.0	1,831.5	1,831.5
VEA non-service-related deaths	0.0	867.6	867.6
Total Liability	**15,050.7**	**19,600.2**	**4,549.4**

13.7.2 The liability estimate for death benefits amounts to $15.1 billion prior to the introduction of the VETS Act and increases to $19.6 billion after the VETS Act. The liability is dominated by the 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.

13.7.3 The bulk of the liability is a MRCA liability at 30 June 2025, with only $53.5 million remaining in DRCA, being the liability in relation to the expected payments in the 2025/26 financial year.

13.7.4 Table 13.4 reconciles the liability estimate with the corresponding estimate at the previous valuation.

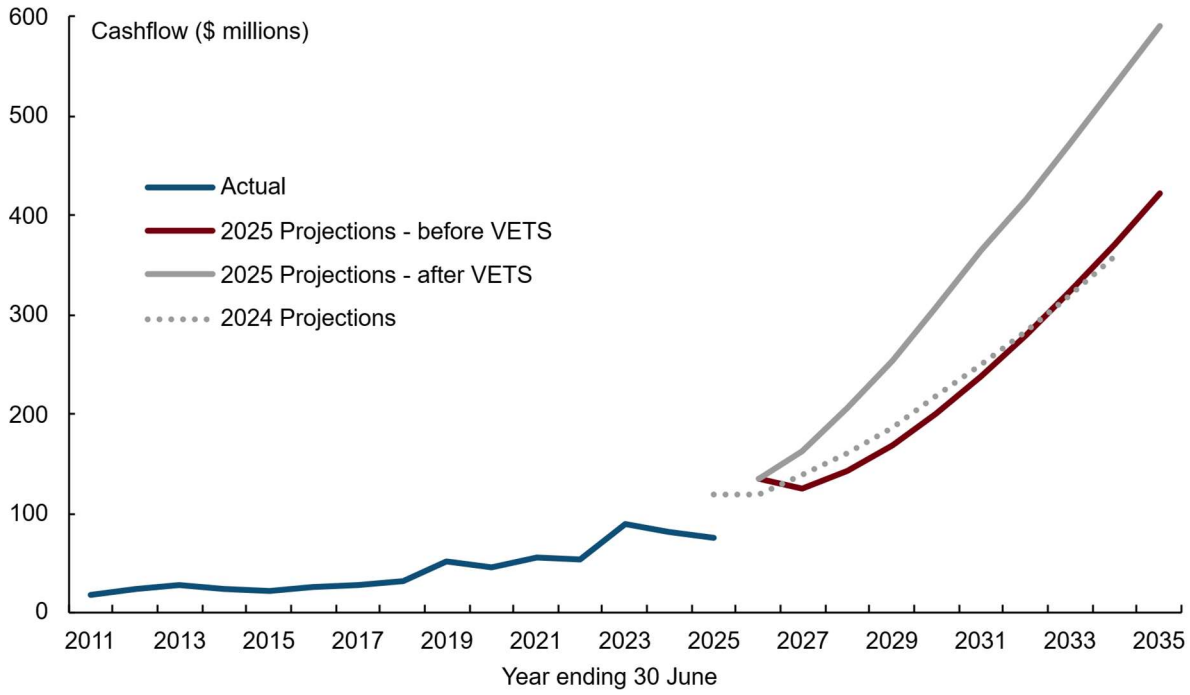
Table 13.4: Reconciliation of Liability for Death Benefits

	$m
Liability estimate at 30 June 2024 (previous report)	9,726.7
Assumed Interest	483.7
Projected Payments	(105.7)
Notional Premium	991.1
Projected liability as at 30 June 2025 (previous valuation)	**11,095.8**
Experience effects and assumption changes	
Change in DRCA service-related deaths	16.8
Change in MRCA service-related deaths	77.3
MRCA deaths after 30 June 2025 – change in death benefit	340.5
MRCA deaths after 30 June 2025 – change in **All Conditions Treatment Card** size	2,074.5
MRCA deaths after 30 June 2025 – change in number over 80WPI/SRDP eligible	1,680.7
MRCA deaths after 30 June 2025 – other	(234.9)
Liability estimate at 30 June 2025 (before VETS Act)	**15,050.7**
Change due to VETS Act	4,549.4
Liability estimate at 30 June 2025	19,600.2

13.8 Cashflows

13.8.1 Figure 13.4 below shows the projected cashflows for all death benefits combined. We have shown the projected cashflows both before and after the impact of the VETS Act.

Figure 13.4: Projected Cashflows – Death Benefits



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

14.1 Summary of Outstanding Claims Liability

14.1.1 Table 14.1 shows the overall outstanding claims liability split between benefit types as at 30 June 2025 including impact of the VETS Act.

Table 14.1: Outstanding Claims Liability as at 30 June 2025

Payment Type	Liability ($m) (inflated and discounted)	
Permanent Impairment[9]	42,116.9	25%
Incapacity	15,771.4	10%
Medical Expenses	67,128.8	40%
Rehabilitation Costs	5,276.9	3%
Benefits Payable on Death[10]	19,600.2	12%
Household Services and Attendant Care	11,266.6	7%
Other[11]	4,777.1	3%
Total	**165,937.9**	**100%**

14.1.2 Table 14.2 shows the outstanding claims liability as at 30 June 2025 by payment type and service arm. Please note that the estimated proportional split by service arm is based on payments made under the DRCA and MRCA only.

9 Includes non-economic loss payments.

10 Includes lump sums and fortnightly payments to dependent children.

11 Legal costs, general services/medical examinations, MRCA education supports, supplements, surveillance, and damage to property.

Table 14.2: Outstanding Claims Liability as at 30 June 2025

	Liability (Inflated and Discounted) $ m			
Payment Type	**Army**	**Navy**	**RAAF**	**Total**
PI and NEL	31,867.7	5,306.9	4,942.3	42,116.9
Incapacity	10,175.1	3,104.9	2,491.4	15,771.4
Medical Expenses	43,508.7	11,863.4	11,756.6	67,128.8
Rehabilitation Costs	3,373.0	1,036.1	867.8	5,276.9
Death Benefits	9,330.4	5,762.4	4,507.4	19,600.2
Household Services and Attendant Care	7,079.3	2,269.4	1,917.9	11,266.6
Other	2,822.7	1,057.9	896.5	4,777.1
Total	**108,157.0**	**30,401.0**	**27,379.9**	**165,937.9**

14.1.3 Table 14.3 shows the outstanding claims liability for 2025, and projected for 10 years, split between DRCA and MRCA claims. The proportion of MRCA liabilities is expected to increase significantly following implementation of the VETS Act on 1 July 2026.

Table 14.3: Outstanding Claims Liability Split between DRCA and MRCA

As at 30 June	DRCA ($m)	MRCA ($m)	Total ($m)
2025	2,390.7	163,547.2	165,937.9
2026	1,571.1	178,285.7	179,856.8
2027	1,015.1	191,933.6	192,948.7
2028	521.7	205,427.6	205,949.3
2029	222.4	219,070.4	219,292.8
2030	100.4	233,300.2	233,400.6
2031	67.3	248,481.9	248,549.2
2032	59.2	264,550.5	264,609.7
2033	55.4	281,588.8	281,644.2
2034	51.9	299,593.7	299,645.6

14.2 Summary of Projected Cashflows

14.2.1 This section combines the projected cashflows for incapacity and non-incapacity payments for the following decade allowing for future injuries. Table 14.5 shows the projected cashflows in respect of injuries sustained before the valuation date under the DRCA, while Table 14.6 shows the cashflows arising from injuries sustained before the valuation date under the MRCA. Table 14.7 shows the projected cashflows for those injuries occurring after 30 June 2025. Note that all figures are in nominal dollars, that is, they have not been discounted to 2025 dollars.

Table 14.4: Projected Payments for DRCA Claims as at 30 June 2025

	Payments (future dollars) $ m							
Year ending 30 June	**PI and NEL**	**Incapacity**	**Medical Expenses**	**Rehab**	**Death**	**HSAC**	**Other[12]**	**All[13]**
2026	616.9	162.9	10.9	5.4	54.8	47.3	18.3	916.5
2027	611.7	0.0	7.5	0.0	0.0	0.0	0.0	619.3
2028	522.9	0.0	8.1	0.0	0.0	0.0	0.0	531.0
2029	309.8	0.0	7.7	0.0	0.0	0.0	0.0	317.6
2030	122.6	0.0	7.4	0.0	0.0	0.0	0.0	130.0
2031	30.1	0.0	7.0	0.0	0.0	0.0	0.0	37.2
2032	4.4	0.0	6.7	0.0	0.0	0.0	0.0	11.2
2033	0.2	0.0	6.4	0.0	0.0	0.0	0.0	6.6
2034	0.0	0.0	6.1	0.0	0.0	0.0	0.0	6.1
2035	0.0	0.0	5.8	0.0	0.0	0.0	0.0	5.8

Table 14.5: Projected Payments for MRCA Claims Incurred as at 30 June 2025

	Payments (future dollars) $ m							
Year ending 30 June	**PI**	**Incapacity**	**Medical Expenses**	**Rehab**	**Death**	**HSAC**	**Other**	**All**
2026	4,351.8	505.5	591.4	58.9	77.3	89.0	255.9	5,929.7
2027	5,161.2	809.2	1,022.2	216.7	167.9	207.3	322.5	7,907.0
2028	5,391.8	912.5	1,264.7	225.0	214.9	291.9	344.9	8,645.7
2029	5,218.1	966.3	1,503.4	232.8	265.9	363.1	348.2	8,897.8
2030	4,713.7	1,018.1	1,741.1	240.4	322.6	408.5	344.8	8,789.2
2031	3,953.4	1,062.6	1,975.5	247.6	379.4	441.0	344.4	8,404.0
2032	3,389.2	1,097.0	2,205.0	254.6	427.3	474.2	342.4	8,189.8
2033	2,876.9	1,121.3	2,429.0	261.0	475.2	503.3	342.4	8,009.1
2034	2,450.6	1,136.2	2,646.6	266.9	521.6	530.2	344.9	7,897.0
2035	2,103.3	1,140.4	2,858.7	272.5	566.6	558.1	348.8	7,848.3

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

13 Excludes incapacity payments.

Table 14.6: Projected Payments for MRCA Claims Incurred After 30 June 2025

	Payments (future dollars) $ m							
Year ending 30 June	**PI**	**Incapacity**	**Medical Expenses**	**Rehab**	**Death**	**HSAC**	**Other**	**All**
2026	32.2	0.2	1.5	0.1	2.6	0.0	13.8	50.4
2027	386.1	5.4	7.4	0.9	5.3	0.4	39.1	444.7
2028	1,036.8	19.5	21.1	3.2	7.7	2.1	80.8	1,171.2
2029	1,852.0	43.7	45.5	6.7	11.8	5.2	124.4	2,089.3
2030	2,601.1	78.4	82.9	11.1	18.8	10.4	165.0	2,967.7
2031	3,304.7	123.7	135.2	16.4	28.8	17.6	204.2	3,830.6
2032	3,955.8	179.9	204.0	22.7	42.6	28.5	238.5	4,672.0
2033	4,544.3	246.8	290.8	30.3	60.4	42.4	269.3	5,484.4
2034	5,119.1	324.6	397.0	39.2	82.0	58.8	302.6	6,323.3
2035	5,661.6	413.0	523.8	49.4	107.8	80.4	338.0	7,174.0

14.2.2 Table 14.8 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 2025 dollars.

Table 14.7: Projected Payments Split between DRCA and MRCA Injuries

Year ending 30 June	**Total**	
	DRCA ($ m)	MRCA ($ m)
2026	916.5	5,980.1
2027	619.3	8,351.7
2028	531.0	9,816.9
2029	317.6	10,987.0
2030	130.0	11,756.8
2031	37.2	12,234.6
2032	11.2	12,861.8
2033	6.6	13,493.4
2034	6.1	14,220.3
2035	5.8	15,022.3

14.3 Estimated Notional Premium

14.3.1 The notional premium is an estimate of the lifetime compensation cost of work related injuries occurring during 2025–26. 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 2025–26 if experience unfolded in line with the valuation assumptions. The notional premium for 2025–26 relates entirely to MRCA claims. It is

important to note the distinction between the notional premium for 2025–26 and the actual claim payments which will be made during 2025–26.

14.3.2 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 2025–26.

14.3.3 The estimate of the notional premium is calculated as the present value of the cashflows arising from the 2025–26 accident year adjusted for half a year's interest to give the amount that would need to be paid over the course of 2025–26.

14.3.4 Administration costs have not been included for this review, as they are considered outside the scope of the review itself.

14.3.5 Table 14.9 sets out the estimates of the notional premium, broken down by Service Arm, and by payment type. The notional premium for 2025–26 is $12,383.1m.

Table 14.8: 2025–26 Notional Premium by Service and Payment Type

Payment Type	ARMY ($ m)	NAVY ($ m)	RAAF ($ m)	Total ($ m)
Permanent Impairment	3,370.0	561.2	522.6	4,453.8
Incapacity	692.2	211.2	169.5	1,072.9
Medical	2,642.1	720.4	713.9	4,076.4
Rehabilitation	151.6	46.6	39.0	237.2
Death	724.0	447.1	349.8	1,520.9
HSAC	323.4	103.7	87.6	514.8
Other	299.7	112.3	95.2	507.1
Total	**8,960.1**	**1,798.9**	**1,624.1**	**12,383.1**

14.3.6 Table 14.10 shows the overall notional premium estimates, expressed as percentages of the total military salary expenditure expected to be paid during 2025–26. Salary estimates for this review were provided by Defence.

Table 14.9: 2024–25 Notional Premium by Service (Percentage of Salary)

	ARMY	NAVY	RAAF	Total
Notional Premium ($ m)	8,960.1	1,798.9	1,624.1	12,383.1
Forecast salaries 2025–26 ($m)	3,659.7	2,259.6	2,195.6	8,115.0
Notional Premium (%)	244.8%	79.6%	74.0%	152.6%

14.3.7 Defence advised overall estimated salaries of approximately $8.1bn for 2025–26. This was around $668m higher than the salary roll for 2024–25, an increase of 9 per cent. The notional premium has increased by around 29 per cent and this has resulted in an increase in the premium expressed as a percentage of salary of approximately 23 percentage points compared to last year's valuation. Most of the premium is attributable to the Army, which accounts for over 72 per cent of the total premium.

15 Scenario Analysis

15.1 Background

15.1.1 As discussed throughout the report, there remains significant 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.

15.1.2 The results of the valuation are based on experience to 31 December 2025 and reflect the experience of the scheme up to that point. The valuation does not explicitly include any adjustment for new policy measures introduced during the Mid-Year Economic and Fiscal Outlook (MYEFO) 2025-26 and the Federal Budget (Budget) 2026-27. As such, we have included a range of sensitivity tests and scenarios to show the impact of changes in key modelling assumptions as well as the potential impact of policy 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.

15.1.3 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 2025 DVA financial statements, therefore, we discounted the cashflows generated by the 2024 model using a yield curve for Commonwealth securities as at 30 June 2025. We have recalculated the liability based on the cashflows from the current valuation using that same yield curve.

15.1.4 In selecting scenarios for analysis, we have focused on the largest benefit categories, particularly on assumptions where experience has been changing or volatile, and where the VETS Act is expected to have the greatest impact. 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.

15.1.5 Note that in this section when we refer to the “MRCA cohort”, “DRCA cohort” or “VEA cohort”, we are referring to the group of claimants who would have claimed under those Acts in the absence of the harmonisation legislation.

15.2 Results

Discount Rate Scenario

15.2.1 The following table shows the liabilities as at 30 June 2025 by head of damage and Act using the yield curve adopted for the 2024–25 financial statements.

Table 15.1: Estimated Liability Using 2025 Yield Curve

Payment Type	DRCA ($ m)	MRCA ($ m)	Total ($ m)
Permanent Impairment	2,082	42,046	44,128
Incapacity	160	16,237	16,397
Medical	93	66,217	66,310
Rehabilitation	5	5,301	5,306
HSAC	46	11,245	11,292
Other	18	4,959	4,977
Death	54	19,114	19,168
Total	**2,459**	**165,119**	**167,579**

15.2.2 The total liability increases by over $1.5bn when the June 2025 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.

15.2.3 Cashflows are not affected by the choice of discount rate but the notional premium is. Using the June 2025 yield curve, the calculated notional premium increases to around $12.3bn, or approximately 152 per cent of estimated ADF salaries for 2025-26.

Permanent Impairment Scenarios

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

- modest changes in lodgement levels for the MRCA cohort i.e. that lodgements in 2026 will be 10 per cent lower or higher than our central estimate assumption, and that these levels will be maintained in future years;
- larger changes in lodgement levels for the MRCA cohort i.e. that lodgements in 2026 will be 20 per cent lower or higher than assumed, and that these levels will be maintained in future years;
- modest 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) for the MRCA cohort. We have shown the impact on the liability of both a 10 per cent reduction in the average claim size and a 10 per cent increase;
- larger changes in the average size of interim and non-interim lump sums for the MRCA cohort, namely the impact on the liability of both a 20 per cent reduction in the average claim size and a 20 per cent increase;
- changes in the proportion of MRCA cohort 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 from 17.2 per cent in 2025 to 18.9 per cent in 2028 before reducing again to 16.8 per cent in 2030. We have shown the impact on the liability if the proportion returns to 2024 levels (12.5 per cent) in 2026, or if the proportion increases to 20.0 per cent in 2026, and then remains at that level;
- scenarios around the number of impairment points awarded. We have allowed for the impact on PI lump sums of both a 2 point decrease and a 2 point increase in whole person

impairment points (as well as the flow on effect to Section 80 benefits). We have also allowed for a scenario where fewer PI claims and lower impairment points are awarded. This has been extended into a scenario where we have assumed some behavioural change such that those who are close to the 60 and 80 point WPI thresholds to access certain other benefits do not have a reduction in WPI points.

- changes in our superimposed inflation allowance for the MRCA cohort. Our adopted rate of superimposed inflation included in the valuation result is 5.0 per cent for 2026, and 2.0 per cent for 2027 and 2028. We have provided scenarios where there is no superimposed inflation, and also where superimposed inflation is the same as the base scenario but with 2.0 per cent per annum for all years beyond 2028 (instead of 0 per cent);
- changes in the number of MRCA PI claims arising from the DRCA and VEA cohorts post implementation of the VETS Act i.e. that PI claims will be 10 per cent lower or higher than assumed;
- changes in the average size of MRCA PI claims arising from the DRCA and VEA cohorts post implementation of the VETS Act i.e. that the average size of PI claims from this cohort will be 10 per cent lower or higher than assumed.

15.2.5 Given its relatively small magnitude, we have not provided any scenarios in respect of the estimated $2 billion of permanent impairment liabilities for “in flight” DRCA PI claims (that remains DRCA liabilities post- implementation of the VETS Act).

Table 15.2: MRCA Permanent Impairment Liabilities Under Modelled Scenarios

Scenario	Description	MRCA PI Liability ($ b)	Change in Liability ($b)	% Change
Base		40.1		
Impacts on MRCA cohort				
1	IL lodgements reduce by 10%	38.5	-1.6	-4%
2	IL lodgements increase by 10%	41.7	1.6	4%
3	IL lodgements reduce by 20%	36.9	-3.2	-8%
4	IL lodgements increase by 20%	43.3	3.2	8%
5	Average size of lump sums is 10% lower	37.9	-2.2	-5%
6	Average size of lump sums is 10% higher	42.3	2.2	5%
7	Average size of lump sums is 20% lower	35.8	-4.3	-11%
8	Average size of lump sums is 20% higher	44.4	4.3	11%
9	Lower proportion receiving Section 80 benefits	38.8	-1.3	-3%
10	Higher proportion receiving Section 80 benefits	40.7	0.6	1%
11	2 fewer WPI points are awarded	38.2	-1.9	-5%
12	2 more WPI points are awarded	41.2	1.1	3%
13	Reduction in PI numbers and WPI	36.7	-3.4	-8%
14	Reduction in PI numbers and WPI with behavioural change	37.5	-2.6	-7%
15	No superimposed inflation	38.4	-1.7	-4%
16	Higher superimposed inflation	41.3	1.2	3%
Impacts on DRCA and VEA cohorts				
17	MRCA PI claims reduce by 10%	39.0	-1.1	-3%
18	MRCA PI claims increase by 10%	41.2	1.1	3%
19	MRCA PI average size reduces by 10%	39.0	-1.1	-3%
20	MRCA PI average size increases by 10%	41.2	1.1	3%

Incapacity Scenarios

15.2.6 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 sensitivity analysis on the VEA cohort. Table 15.3 below shows the resulting liability impact.

Table 15.3: Incapacity Liability Scenario and Sensitivity Test Results

Scenario	Description	Incapacity Liability ($ b)	Change in Liability ($b)	% Change
Impacts on MRCA and DRCA cohorts				
Base		14.5		
1	Average payment rates are 10% higher	15.9	1.4	10.0%
2	Average payment rates are 10% lower	13.0	(1.4)	(10.0%)
3	Exit rates are 10% higher	13.6	(0.9)	(6.1%)
4	Exit rates are 10% lower	15.4	1.0	6.8%
5	New entrant numbers are 10% higher	15.3	0.8	5.8%
6	New entrant numbers are 10% lower	13.6	(0.8)	(5.8%)
Impacts on VEA cohort				
Base		0.8		
1	VEA veterans are more likely to access Incapacity (age-based take-up rates are 10% higher)	1.2	0.4	55.0%
2	VEA veterans are less likely to access Incapacity (age-based take-up rates are 10% lower)	0.4	(0.4)	(51.5%)

Medical Scenarios

15.2.7 Table 15.4 below contains the results for the sensitivity and scenario analysis on the medical liability, testing the key assumptions used in the valuation.

- Scenarios 1 to 8 test the sensitivity of the liability to changes in the assumed average annual size of benefit cost and new entrant numbers.
- As treatment cards remain with a veteran for life, we have also included a scenario (scenario 9) with alternate mortality assumptions to assess the impact on the liability. The Defence Superannuation invalidity mortality rates are heavier than the assumed population mortality adopted in the valuation result.
- 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 an All Conditions Treatment Card. There has been rapid growth in the number of claimants receiving All Conditions Treatment 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 All Conditions Treatment Card recipients is higher or lower than what was adopted in scenarios 10 to 13.
- For MRCA PI, additional scenarios were conducted for higher and lower impairment points awarded. This has a flow on impact into medical benefits due to the eligibility criteria for the All Conditions treatment card. Scenarios 14 and 15 show these impacts.

15.2.8 The estimated impact on MRCA medical benefits from the introduction of the VETS Act is approximately $16.5b, of which $14.9b is related to VEA veterans. There is significant uncertainty around the proportion of current and future VEA claimants who might be eligible for a MRCA All Conditions Treatment Card from 1 July 2026. We have included additional scenarios to show the impact on the liability should this proportion differ to the assumptions adopted in the valuation.

- Scenarios 1 and 2 consider the impact of current VEA treatment card holders being more or less likely to lodge MRCA claims and gain MRCA eligibility from 1 July 2026. From that date, all new claims for compensation will be assessed under the MRCA. VEA card holders may gain eligibility for MRCA treatment cards due to the legislated hierarchy for cost allocation, whereby VEA treatment cards are superseded by MRCA treatment cards. These scenarios exhibit a 13 per cent increase, or 11 per cent decrease to the MRCA liability.
- Scenarios 3 and 4 consider the impact should future new entrants (that is, veterans who would have received a VEA treatment card in the future under the VEA legislation, but will instead claim under the MRCA) be higher or lower that modelled.
- Similar to Scenario 9, Scenario 5 applies heavier mortality assumptions to the expected VEA cohort. This results in a reduction of $2.6b to the liability.

Table 15.4: MRCA Medical Liability Sensitivity and Scenario Analysis

Sensitivity/ Scenario	Description	MRCA Medical Liability ($b)	Change in Liability ($b)	% Change
Impacts on MRCA cohort				
Base		50.1		
1	Average cost is 8% higher	54.1	4.0	8.0%
2	Average cost is 8% lower	46.1	(4.0)	(8.0%)
3	Average cost is 10% higher	55.1	5.0	10.0%
4	Average cost is 10% lower	45.1	(5.0)	(10.0%)
5	Average cost is 20% higher	60.0	10.0	20.0%
6	Average cost is 20% lower	40.1	(10.0)	(20.0%)
7	New entrant numbers are 10% higher	52.2	2.1	4.2%
8	New entrant numbers are 10% lower	48.0	(2.1)	(4.2%)
9	Defence Superannuation invalidity mortality applied	43.1	(7.0)	(13.9%)
10	Ultimate All Conditions Treatment Card proportion is 10% lower than adopted ultimate	45.2	(4.9)	(9.8%)
11	Ultimate All Conditions Treatment Card proportion is 10% higher than adopted ultimate	55.0	4.9	9.8%
12	Ultimate All Conditions Treatment Card proportion is 20% lower than adopted ultimate	40.6	(9.5)	(18.9%)
13	Ultimate All Conditions Treatment Card proportion is 20% higher than adopted ultimate	59.9	9.8	19.7%
14	MRCA Veterans receive 2 additional impairment points	50.5	0.4	0.8%
15	MRCA Veterans receive 2 less impairment points	49.2	(0.9)	(1.7%)
Impacts on VEA cohort				
Base		14.9		
1	Higher proportion of VEA clients gain MRCA eligibility (10% increase to MRCA claim rates)	16.8	1.9	13%
2	Lower proportion of VEA clients gain MRCA eligibility (10% decrease to MRCA claim rates)	13.2	(1.7)	(11%)
3	New entrant numbers are 10% higher	16.0	1.1	7%
4	New entrant numbers are 10% lower	13.8	(1.1)	(7%)
5	Defence Superannuation invalidity mortality applied	12.3	(2.6)	(17%)

Household Services Scenarios

15.2.9 There has been significant growth in the usage of household services benefits, particularly since 2019 when benefits were moved to the needs assessment process after IL claim 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 15.5.

15.2.10 The introduction of the VETS Act will also enable current and future VEA veterans to access household services benefits under the MRCA if they meet the eligibility criteria. We have included scenarios related to two of the key assumptions in the modelling i.e. the level of expected claimants and the average size of expenditure.

Table 15.5: HSAC Liability Sensitivity and Scenario Analysis

Sensitivity/ Scenario	Description	HSAC Liability ($ m)	Change in Liability ($m)	% Change
Impacts on MRCA and DRCA cohorts				
Base		8,123		
1	Average cost is 10% higher	8,935	812	10%
2	Average cost is 10% lower	7,310	(812)	(10%)
3	New claimants are 10% higher	8,582	459	5.7%
4	New claimants are 10% lower	7,652	(471)	(5.8%)
5	New claimants are 20% higher	9,029	906	11.2%
6	New claimants are 20% lower	7,155	(968)	(11.9%)
7	Utilisation rate is 10% higher	8,645	522	6.4%
8	Utilisation rate is 10% lower	7,640	(483)	(5.9%)
9	Defence Superannuation invalidity mortality rates	7,238	(885)	(10.9%)
10	Superimposed inflation of 5% for 3 years, 1.3% thereafter	10,286	2,164	26.6%
Impacts on VEA cohort				
Base		3,144		
1	50% of current VHC recipients take up MRCA HS (instead of 100%)	2,887	(257)	(8.2%)
2	VHC new entrants are 10% higher	3,407	263	8.4%
3	VHC new entrants are 10% lower	2,881	(263)	(8.4%)
4	Average cost is 10% higher	3,458	314	10.0%
5	Average cost is 10% lower	2,830	(314)	(10.0%)
6	Current VHC average size is applied	1,684	(1,460)	(46.4%)

MRCA Death Benefits Scenarios

15.2.11 For liability in respect of MRCA members who are expected to receive an auto-grant death compensation benefit due to being assessed as over 80 WPI 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 All Conditions Treatment 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.

15.2.12 We have included the following scenarios:

- the impact of IL lodgements being either 10 per cent lower or 10 per cent higher than our central estimate;
- the impact of IL lodgements being either 20 per cent lower or 20 per cent higher than our central estimate;
- consistent with the MRCA Permanent Impairment scenarios, we have included scenarios where the proportion of claimants receiving Section 80 benefits was either lower or higher than our central estimate (i.e. if the proportion receiving Section 80 benefits remains unchanged from the 2024 levels of 12.5 per cent, or if the proportion increases to 20.0 per cent).
- consistent with the MRCA Permanent Impairment scenarios, we have included scenarios where the WPI points awarded were either lower or higher than our central estimate, thus resulting in fewer/more claimants exceeding 80 impairment points and thus meeting the eligibility criteria for the death benefit.
- Our central estimate 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.
- Our central estimate assumed that widows who received an All Conditions Treatment Card following the death of their spouse would receive on average $28,900 per annum in medical benefits, with the amount varying based on the age of the widow. We have tested the impact of assuming a 10 per cent lower annual cost or a 10 per cent higher annual cost.
- Our central estimate 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.

- changes in the number of DRCA and VEA members qualifying for death compensation benefits post implementation of the VETS Act i.e. that the number of death compensation claims from this cohort will be 10 per cent lower or higher than assumed.

Table 15.6: MRCA Death Benefit Liabilities Under Modelled Scenarios

Scenario	Description	MRCA Death Benefit Liability ($ b)	Change in Liability ($b)	% Change
Base		19.5		
Impacts on MRCA cohort				
1	IL lodgements reduce by 10%	18.9	-0.6	-3%
2	IL lodgements increase by 10%	20.2	0.6	3%
3	IL lodgements reduce by 20%	18.3	-1.2	-6%
4	IL lodgements increase by 20%	20.8	1.2	7%
5	Lower proportion receiving Section 80 benefits	16.6	-3.0	-14%
6	Higher proportion receiving Section 80 benefits	20.9	1.3	8%
7	2 fewer WPI points are awarded	17.5	-2.1	-10%
8	2 more WPI points are awarded	20.2	0.7	4%
9	Reduction in PI numbers and WPI	17.2	-2.3	-11%
10	Reduction in PI numbers and WPI with behavioural change	18.5	-1.0	-6%
11	Lower proportion of partnered members	18.1	-1.4	-8%
12	Higher proportion of partnered members	21.0	1.4	8%
13	Lower cost of widow All Conditions Treatment Cards	18.8	-0.8	-4%
14	Higher cost of widow All Conditions Treatment Cards	20.3	0.8	4%
15	Mortality in accordance with ALT2020-22	15.9	-3.6	-18%
Impacts on DRCA and VEA cohorts				
16	MRCA death compensation claims reduce by 10%	19.1	-0.4	-3%
17	MRCA death compensation claims increase by 10%	20.0	0.4	2%

16 Compliance with Professional Actuarial Standards

16.1.1 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.

16.1.2 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.

16.1.3 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.



Jane Miao, FIAA
Actuary

26 June 2026