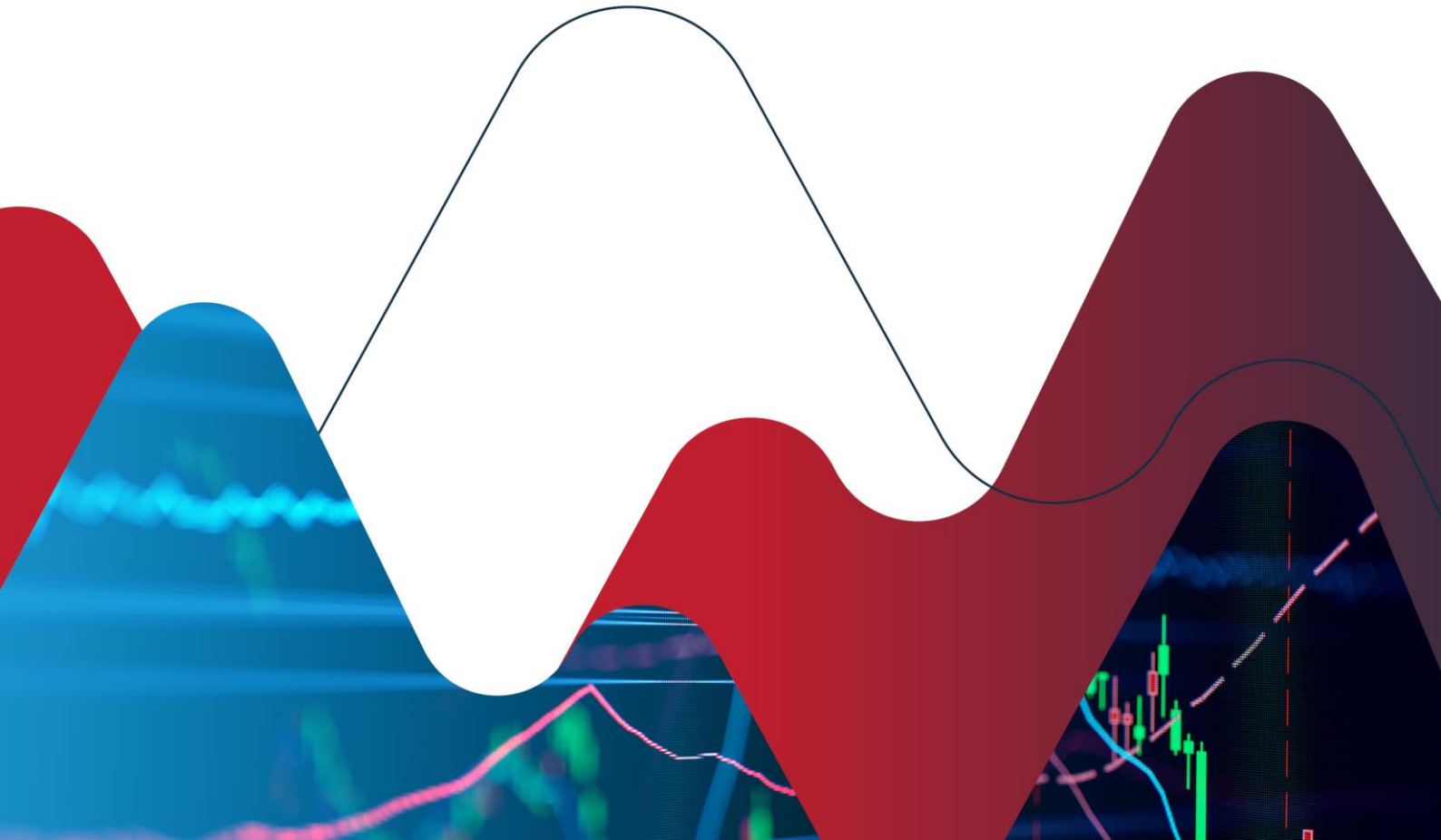
Australian Government
Australian Government Actuary

Actuarial Investigation into the Costs of Military Compensation

30 June 2023



Contents

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 2023 under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA). Together these two schemes are known as the Military Compensation Scheme (MCS).

1.1.2 The MCS provides support and compensation to ADF personnel who sustain physical or psychological impairment or incapacity that is related to their defence service. This support ranges across income replacement for those who are unable to maintain full-time employment, coverage for medical, rehabilitation and related costs, financial compensation for permanent impairment, and benefits payable to dependents upon death.

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

1.1.4 The reported cashflows and liabilities have been divided between the run-off of the obligations under the DRCA and liabilities arising under the MRCA for claims attributable to service occurring on or after 1 July 2004 where relevant.

1.1.5 In response to the Royal Commission into Defence and Veteran Suicide, DVA are currently undergoing consultation in relation to potential legislative reforms related to existing compensation schemes including the MRCA and DRCA. As the reforms have not been finalised or legislated at the date of this report, we have not incorporated any potential impacts as a result of future legislative change in our modelling. However, we note that future outcomes could vary significantly from the results presented in this report should legislation be changed in the future.

1.1.6 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 2023 for all outstanding claims under the DRCA, including those which have not yet been reported, and outstanding claims under the MRCA where the service giving rise to the claim predates the valuation date, again including those that have not yet been reported;
- the projected outstanding claims liability under the DRCA and MRCA for the 10 years following the valuation date, including the allowance for claims which are expected to occur over that period;
- the estimated cash flow for benefit payments over the same period; and

- the annual notional premium required to fully fund the estimated claims liability arising from service undertaken during 2023–24.

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.

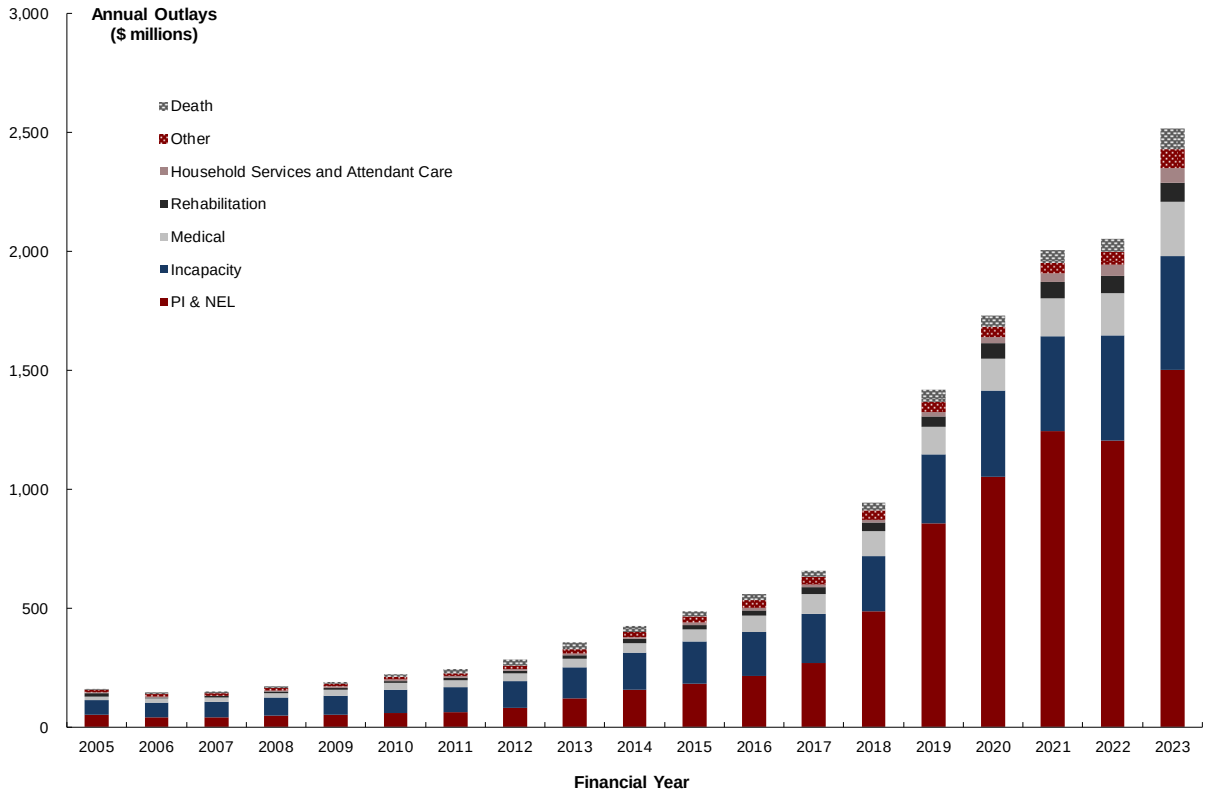
1.2.3 This report has been prepared for the purpose of advising Government of the nature and quantum of its liabilities in respect of compensation for military personnel injured in the course of service. This report also forms the basis for our advice to DVA on reporting for financial statement purposes 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).

1.2.4 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 by benefit type to 30 June 2023. Please note the incapacity expenditure included in this graph is from the transactional payments data set and does not include any repayments or offsets made in the year. The repayments are small in the context of MCS expenditure and are discussed further in Chapter 8 of the report.

Figure 1.1: Recent payment experience - DRCA and MRCA combined



1.3.2 Growth in total expenditure has been rapid since Veteran Centric Reform in 2018. The stabilisation in outlays observed in 2022 was a result of processing constraints rather than a genuine stabilisation in the underlying experience. DVA received additional funding for staffing increases in 2023 which resulted in a significant increase in the number of initial liability (IL) claims completed with a subsequent flow on impact to benefit payments. It is important to note here that although financial year 2023 saw an increase in the level of benefit payments, the level of IL completion significantly increased in the second half of the 2023 calendar year. As there can be a delay between IL completion and when any subsequent benefit claims are made, the full impact of the IL claims clearance will not be seen in the expenditure experience until the following financial years.

1.3.3 Permanent impairment (PI) payments have increased substantially over the last decade and may have been impacted by ADF operational activity, transitional issues associated with the introduction of MRCA, and the introduction of Veteran Centric Reform. Although expenditure growth in recent years had slowed, as mentioned above, this has largely been driven by processing limitations within DVA rather than an actual slowing of experience.

1.3.4 Payments have also grown in other benefit categories, most notably medical benefits and household services in the latest year. Total medical expenditure increased by approximately 28 per cent over the year to 2023, increasing from $176.6m in 2022 to $226.1m in 2023. The increase in medical expenditure has been driven by a significant increase in the number of claimants, in particular those with access to the MRCA Gold Card. MRCA Gold Cards provide veterans with coverage for all medical expenses for life, including private hospital costs and travel for treatment expenses, irrespective of whether treatment is for a liability accepted injury. As such, the long-term costs associated with Gold Cards are significant. We have also seen significant increases in household services and attendant care expenditure over recent years. Since 2019, expenditure growth has averaged 45 per cent, year on year to 2023, driven by increasing numbers of new claimants and lower numbers of veterans ceasing use of benefits.

1.3.5 The following tables compare actual payments over the last year with the amounts projected in the 2022 valuation. In total, actual payments were 7.7 per cent higher than those projected. The largest difference, in dollar terms, was for permanent impairment where outlays were $96.2m higher than projected. This was a result of similar-to-expected processing of PI claims over the 2022-23 year but substantially higher than expected average claim sizes.

Table 1.1: Comparison of actual and projected payments for 2022–23

Category	Projected $m	Actual $m	Difference $m	*% Difference*
Incapacity	438.9	459.3[1]	20.4	4.6%
PI and NEL	1,405.8	1,502.0	96.2	6.8%
Medical	217.2	226.1	8.9	4.1%
Rehabilitation	73.2	79.0	5.8	8.0%
Death	65.2	90.0	24.8	38.0%
Other	118.5	141.5	23.0	19.4%
Total	**2,318.8**	**2,498.0**	**179.1**	**7.7%**

1.3.6 Additional comparisons by claim numbers and average size for benefit categories are included in the Appendix.

1.3.7 Between calendar years 2020 and 2022, the level of IL claim[2] lodgements for DRCA and MRCA remained relatively stable after a period of rapid growth between 2017 and 2019. However, the most recent calendar year has again seen significant growth in the number of new IL claims lodged. This is especially concerning for DRCA, a scheme which has been closed for almost 20 years.

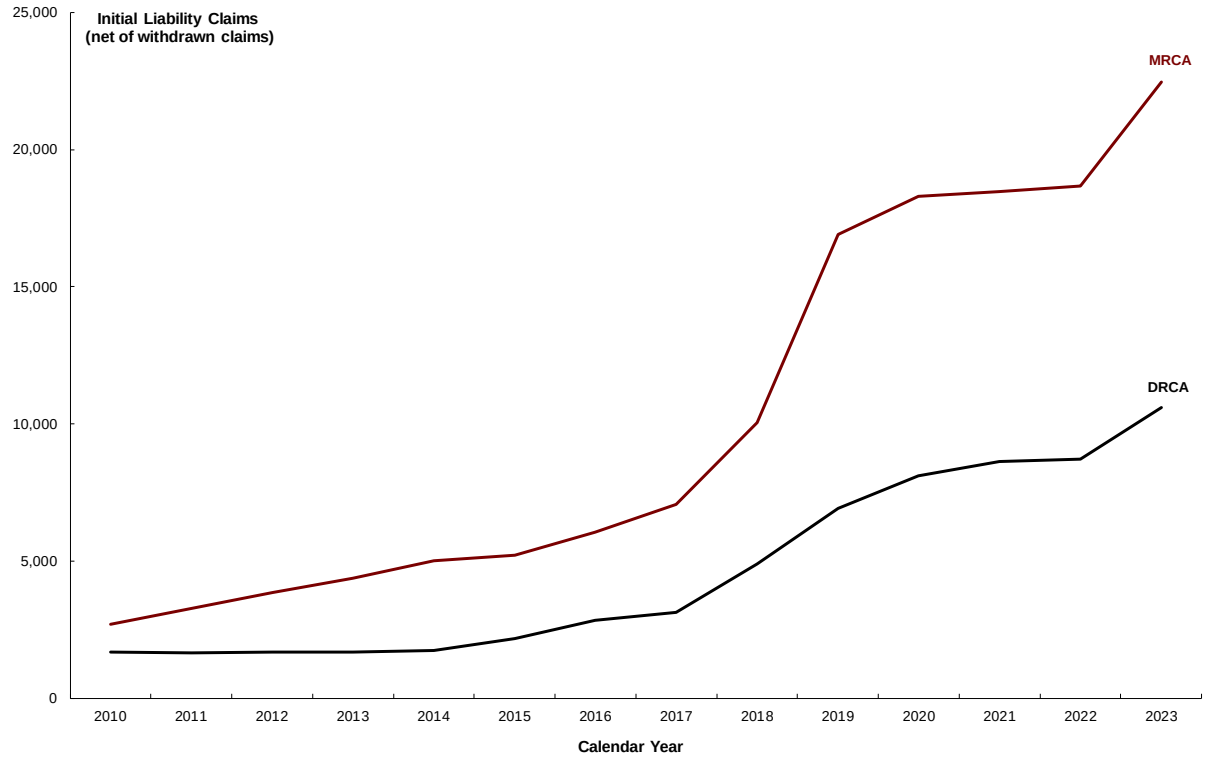
1.3.8 An IL claim can consist of one or more underlying conditions. The number of conditions lodged per claim has increased over time. Net of withdrawn claims, the average number of lodged conditions per person has increased from approximately 3.4 in the 2017 calendar year to 5.0 in the 2023 calendar year for MRCA. Similar experience is also seen in DRCA, where the average number of conditions lodged per person has increased from 2.4 to 4.0 over the same period despite the scheme being closed to injuries sustained beyond 30 June 2004. The proportion of new claimants has also declined over time with approximately 34 per cent of claimants for MRCA and 38 per cent of claimants for DRCA being new to the schemes who lodged claims in calendar year 2023. This is not unexpected as a scheme matures over time but the relatively high proportion of new entrants for DRCA, a 'closed' scheme, is atypical. The experience in our data shows that there is still a significant number of veterans claiming with DVA for the first time, at a minimum of 19 years post their injury date.

1.3.9 Figure 1.2 below shows the number of IL lodgements for DRCA and MRCA by calendar year. These lodgements are summarised to the person level by calendar year and are net of any withdrawn claims. For example, should a veteran lodge 2 claims in a calendar year, they are only counted once.

[1] Incapacity payments are from DVA's general ledger. These include offsets and repayments which are allowed for in our projected cashflows.

[2] 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.

Figure 1.2: Initial Liability Claims (net of withdrawn claims) - DRCA and MRCA



1.3.10 DVA increased processing capacity in the 2023 year, resulting in a noticeable increase to the rate of IL completion and benefit payments in the second half of the 2023 calendar year. 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.

1.3.11 At the date of this report, 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. DVA has provided us with their Demand Driven Funding Model (DDFM) which projects expected administrative personnel levels over the medium term. Currently, the DDFM remains our best source of information for the Department's expected processing capacity and has been considered when projecting our short term cashflows. However, it is important to note that there is considerable uncertainty around the timing of when the claims on hand will be cleared as this is subject to a number of factors including ongoing Departmental funding, training of ongoing staff, staff retention, and the level of incoming new claims, some of which are outside of DVA's control.

1.4 Valuation Results

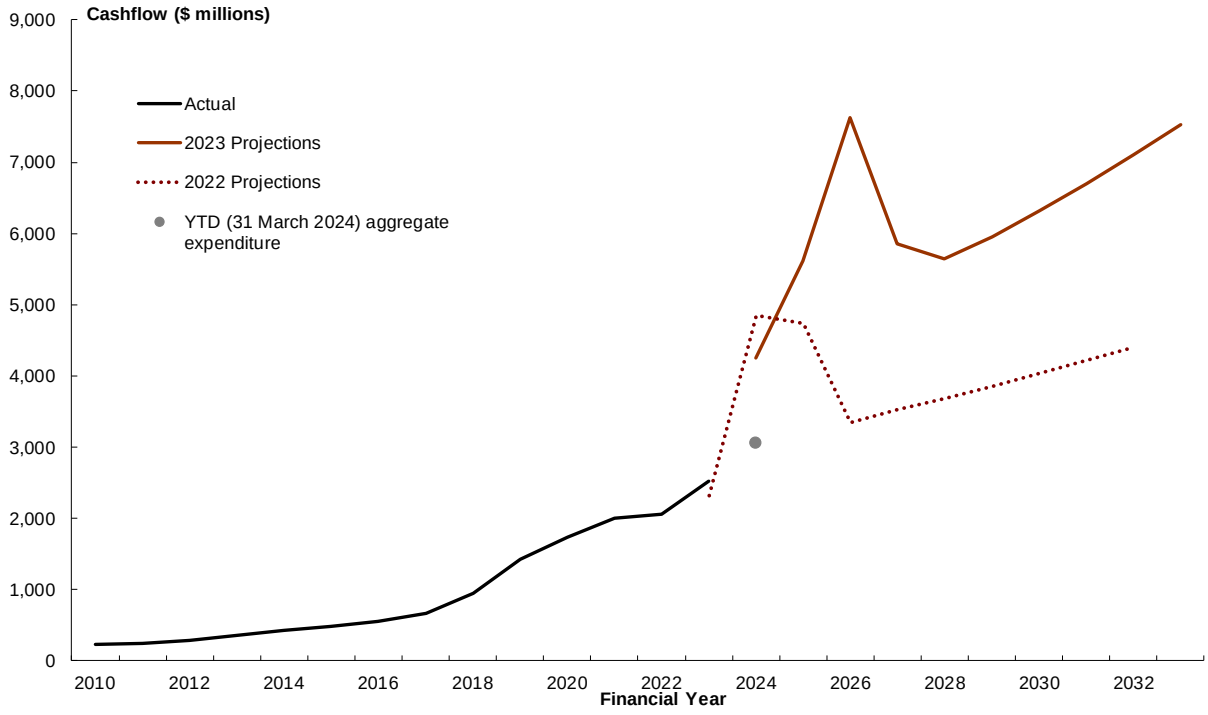
SUMMARY

The liability for the MCS as at 30 June 2023 is $64,764.9 million. This is significantly higher than what was projected at the previous valuation of $44,823.6 million. The almost $20 billion increase was largely driven by:

- an increase in the level of expected future initial liability claims which has a flow-on impact to expected future benefit payments;
- an increase to the level of expected future MRCA PI claims and the average size of these claims which has led to an increase of approximately $6.6 billion;
- an increase to the expected number of Gold Card recipients under MRCA medical benefits and increased average size of benefit usage at advanced ages which has led to an increase of almost $7 billion; and
- an increase to the assumptions adopted for incapacity benefits as a result of model changes which has led to an increase of approximately $3.3 billion.

1.4.1 Figure 1.3 below shows the projected cashflows aggregated across all categories from the 2023 valuation compared to cashflows projected at the 2022 valuation. We have also included the year-to-date aggregate 2023–24 outlays to 31 March 2024 (9 months of expenditure) from the general ledger data.

Figure 1.3: Cashflow projection for DRCA and MRCA



1.4.2 The projected cashflows are significantly higher than those projected at the last valuation, driven by increases across most benefit types. The largest increases were across MRCA

medical, permanent impairment, and incapacity benefits. We have also attempted to factor in the speed of claims processing based on DVA's DDFM model. This has resulted in a stepped increase in outlays over the 2025–26 and 2026–27 financial years, in line with processing expectations for initial liability claims and permanent impairment claims. This eventually subsides as processing is expected to keep pace with the level of lodged claims going forward.

1.4.3 Table 1.2 below shows the 30 June 2023 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 2023

Benefit Type	Current Valuation ($ million)	Previous Valuation ($ million)	Difference ($million)
Permanent Impairment	21,385.8	14,370.9	7,014.9
Incapacity	12,768.6	9,453.5	3,315.1
Medical	22,084.2	15,250.0	6,834.2
Rehabilitation	1,401.7	640.2	761.5
HSAC	5,336.0	4,038.1	1,297.9
Other	1,313.6	638.0	675.6
Death	475.0	433.0	42.1
Total	**64,764.9**	**44,823.6**	**19,941.3**

1.4.4 In the latest calendar year, the number of initial liability lodgements have substantially increased for both DRCA and MRCA. Discussions with DVA point to a number of possible reasons for this, including increased awareness of DVA benefits through greater media exposure, engagement with the veteran community on potential legislative reform, and Department communications around the clearance of the current claims backlog which may encourage veterans to lodge new claims. It is difficult to ascertain whether the current level of lodgements will continue into the future. The possible drivers of experience could be temporary or result in a genuine shift in future experience. In our projection this year, we have assumed that the current level of initial liability lodgements will continue and over the long term, claims processing levels will keep pace with this new level. 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.

1.4.5 Table 1.3 shows the estimates of the key cost indicators broken down by Service Arm.

Table 1.3: Valuation results

Overall Cost Estimates Shown by Service			
Service	**Outstanding Claims Liability $m**	**Notional Premium $m (% salaries[3])**	**Projected Cashflows $m**
Current Report	at 30 June 2023	for 2023–24	for 2023–24
Army	45,274.6	4,324.4	3,022.0
Navy	10,411.8	943.2	659.1
RAAF	9,078.5	807.4	564.2
Total	**64,764.9**	**6,075.0 (86.4%)**	**4,245.0**
Previous Report	**at 30 June 2022**	**for 2022–23**	**for 2022–23**
Expected (30/6/2023)	*44,823.6*	*3,529.5*	*4,845.0*
Total	**41,607.0**	**3,427.7 (51.5%)**	**2,318.9**

1.4.6 The outstanding claims liability as at 30 June 2023 represents the estimated present value of future claim payments to be made in respect of injuries sustained prior to 30 June 2023. The split of liabilities between the DRCA and MRCA is detailed in section 18.

1.4.7 The notional premium represents the estimated cost of compensation for claims arising from service rendered during 2023–24. It is the amount which, if paid over the course of the 2023–24 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 2023–24 financial year for claims attributable to any service prior to and including 2023–24. The final rows show the comparable figures from the previous valuation, that is, the expected figures as at 30 June 2023 and the reported results as at 30 June 2022. The changes to modelling approach and assumptions have resulted in a 44 per cent increase to the expected liability and 72 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 $44,824m by 30 June 2023. The current liability is $64,764.9m. This is almost $20 billion higher than expected and has been driven by increases across almost all benefit types, with the largest dollar increases in MRCA medical benefits, permanent impairment benefits, and incapacity benefits.

1.5.2 At the last valuation, we applied significant modelling changes to MRCA medical to distinguish between White Card and Gold Card holders in the medical benefits population, driven by the increasing proportion of Gold Card holders and additional data which enabled the analysis. The growth in the number of Gold Card holders has increased rapidly in recent months, with almost 2,000 new Gold Cards issued in the 6 months to 31 December 2023. In light of this new experience, we increased our expected number of future Gold Card holders. As veterans become eligible for the Gold Card on reaching 60 or more impairment points under permanent impairment, we have also leveraged new permanent impairment conditions data to estimate the proportion of veterans likely to reach this threshold in the existing DVA population. This

3 Estimate of salaries and allowances for 2023-24 provided by the Department of Defence.

increased our selected future proportion of Gold Card holders and has contributed almost $3 billion to the increase in medical liabilities.

1.5.3 As MRCA only commenced on 1 July 2004, the veteran population accessing benefits under MRCA is still relatively young. As such, the expenditure data we receive only includes veterans aged up to their mid-70s, with very few veterans beyond this age. DVA was able to provide us with additional analysis this year on the older cohort of veterans under the VEA and the average expenditure on Gold Cards for this group at advanced ages. We have considered this analysis in setting the average annual cost of Gold Cards at ages beyond 75, noting there are some differences between the VEA cohorts and the MRCA cohort. As medical benefits are accessible till death, the increase to the average size at older ages has resulted in an increase of almost $2 billion to the medical liability. The MRCA medical liability increased overall from an expected liability of $15,189 million as at 30 June 2023 to $21,992 million at this year's valuation, an overall increase of almost $7 billion. Further details are provided in Section 10 of the report.

1.5.4 One of the largest sources of uncertainty in the last few years has been the level of initial liability claims lodged with DVA and the subsequent flow on impact into benefit payments. Past experience in the scheme shows a strong trend in claimants with accepted initial liability claims eventually moving on to a benefit claim. Although the number of claim lodgements was relatively stable between calendar years 2020 and 2022, the latest year saw a significant increase in the level of IL lodgements for both DRCA and MRCA. At this year's valuation, we have developed an additional model to project future IL claim lodgements, completions, and acceptances. Future lodgements are expected to remain at the heightened levels seen in the most recent year which has a flow on impact to all benefit types (due to IL claims being the precursor to all other benefit claims).

1.5.5 We have seen in the historic experience that there is a strong correlation between accepted IL claims and PI claim lodgements. We have revised our modelling of MRCA PI benefits this year by utilising the new IL claims projection model and developing assumptions related to the transition of accepted IL claims to accepted PI claims. This has resulted in a significant increase to the projected number of future PI claims. We have also seen the increasing trend in PI average claim size continue in the latest experience, likely driven by high levels of medically separated veterans and claims with increased numbers of conditions. The update to PI modelling has allowed for more nuanced average size assumptions which now vary with the time since an accident has occurred. The size assumptions were set based on the latest MRCA PI experience, with superimposed inflation added for the first 4 years of the projection 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 $11,346 million to $17,970 million, an increase of approximately $6.6 billion.

1.5.6 Incapacity benefits were separated into a projection for short-term (recipients on benefits for less than a year) and long-term incapacity (recipients on benefits for longer than a year) at the previous valuation. We have removed this binary distinction and instead modelled duration as a continuous variable from when a veteran commences incapacity benefits. This approach takes into account the discontinuity in remaining on incapacity after 22 fortnights of benefit payments, corresponding with the reduction in incapacity benefit after 45 weeks. We have retained the age groups used in the previous model and developed average size assumptions based on duration on payment and age at entry. This has resulted in a significant change in the projected liability. Experience over the year has also been higher than expected for both new claimants and average size of payments. The future expected claimants are expected to increase with the increasing level of IL lodgements seen in the latest calendar year. Combined,

the impact of these changes has resulted in a liability of $12,769 million for incapacity benefits, an increase of approximately $3.3 billion from the expected liability as at 30 June 2023 from the previous valuation.

1.5.7 Interpreting experience in a rapidly changing environment poses significant challenges. It is important to note that the estimates given in this report are actuarial central estimates. This means, in broad terms, that the estimates are just as likely to be too high as too low. However, the true liability cannot be known with certainty and the range of factors which might impact on future claim numbers and sizes means that estimates presented here are subject to considerable uncertainty.

1.5.8 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.

1.5.9 With the recent growth in experience and changes in claims behaviour, there remains a question as to what proportion of veterans will ultimately seek support from DVA and what the average cost of those benefits will be. The current data available to the AGA does not allow us to accurately form this view. Additional information from Defence and DVA detailing the demographics of the veteran and serving population, including date of and reason for separation, and injuries sustained during service could assist in forming a view.

2 Background

2.1 The Military Compensation Scheme

2.1.1 Compensation for military personnel injured in the course of their duties is provided under 4 separate pieces of legislation:

- the *Military Rehabilitation and Compensation Act 2004* (MRCA);
- the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA);
- the *Veterans' Entitlements Act 1986* (VEA); and
- the *Defence Act 1903*.

2.1.2 MRCA provides rehabilitation and compensation coverage for service with the Australian Defence Force on or after 1 July 2004.

2.1.3 DRCA provides similar rehabilitation and compensation to that provided under the MRCA, but only covers:

- injuries and diseases that arose from peacetime and peacekeeping service up to and including 30 June 2004; and
- operational service between 7 April 1994 and 30 June 2004.

2.1.4 Operational service prior to 7 April 1994 (which includes World War II, the Korean War and the Vietnam War) is not covered by DRCA. Operational service on or after 7 April 1994 gives rise to 'dual eligibility', that is, the option of applying for benefits under either or both the VEA and DRCA. This could be expected to affect the comparability of DRCA and MRCA experience.

2.1.5 This report covers liabilities arising from payments under the MRCA and the DRCA only.

2.1.6 The MRCA included some differences in benefits relative to the DRCA. The most significant differences in terms of their impact on costs were:

- the introduction of a loading on incapacity payments to compensate for the loss of non-salary elements of ADF remuneration packages;
- removal of the offset against incapacity payments for the member's superannuation contributions;
- the use of health care cards for medical treatment; and
- changes to the assessment process and payment options for permanent impairment claims. Under the MRCA, permanent impairment benefits can be taken as a periodic benefit or be converted to a lump sum using age-based factors.

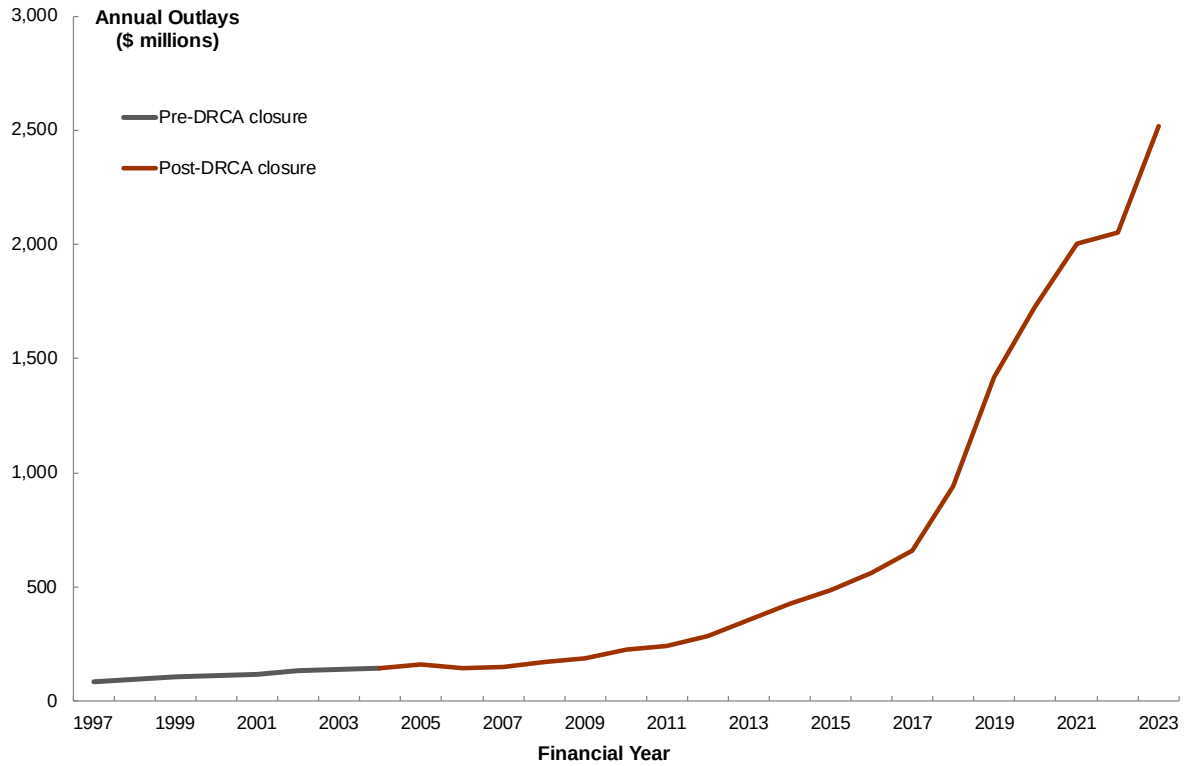
2.1.7 It should be noted that, in actuarial terms, MRCA is far from fully mature with experience limited to a maximum of 19 and a half years after the injury date. This compares with payment obligations that may continue for 60 or more years after the date of injury.

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

2.2 Trends in Expenditure

2.2.1 Figure 2.1 shows total outlays of the MCS since 1996–97. Prior to 2004, expenditure had grown at a steady but moderate pace, averaging around 5 per cent per annum. The introduction of MRCA from 1 July 2004 led to a significant disruption in expenditure. Although early experience was relatively stable, with some growth between 2005 and 2010, experience from 2011 accelerated at a much higher rate than had been seen previously in the scheme. From 2011 to 2023, outlays increased at a rate of approximately 21 per cent per annum with the largest single increase of 50 per cent occurring between 2018 and 2019. Growth in expenditure slowed considerably between 2021 and 2022, however this was driven by limitations in processing capacity which resulted in backlogs of both initial liability claims and claims for permanent impairment benefits (rather than an actual stabilisation of experience). Over the last year, DVA had increased their processing capacity to administer the significant backlog of claims. This increased expenditure in the latest financial year, with outlays across DRCA and MRCA totalling approximately $2.5bn, a 23 per cent increase 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 2024, DVA released an exposure draft for legislation reform to harmonise the existing three Acts (the DRCA, VEA, and MRCA) into one single Act from 1 July 2026. This announcement 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 is in place. There is significant uncertainty surrounding both the short term and long term impacts of this legislation on scheme costs. As discussed previously, at the time of writing, legislation has yet to pass Parliament and as such, any anticipated changes resulting from legislative change have not been incorporated into any projections discussed in this report.

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 2023;
- 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 2023–24.

2.3.2 Liabilities are split between run-off liabilities under the DRCA and liabilities under the MRCA and we have projected the liabilities and cashflows under each Act. Note that some expenditure related claims made under the DRCA will be met under MRCA appropriations due to the arrangements applying to health care cards. Specifically, clients with an accepted claim under both schemes will be issued with a MRCA health care card and all expenditure arising

from use of the card will be MRCA expenditure. Going forward, this could be expected to reduce DRCA liabilities, with a compensating increase in MRCA liabilities.

2.3.3 This report does not consider liabilities arising from common law actions against the Department of Defence. Any awards made as a result of these actions will be funded by the Department of Defence outside the MCS.

2.3.4 This report has been prepared for the purpose of advising Government of the nature and quantum of its liabilities in respect of compensation for military personnel injured in the course of duty. It is also intended to comply with the requirements of the Actuaries Institute's Professional Standard 302 (PS302), which deals with actuarial reports and advice on general insurance technical liabilities, where appropriate.

2.3.5 This report also forms the basis for our separate advice to DVA on reporting for financial statement purposes for the year following the valuation date. For that advice, adjustments are made to the results presented here to allow for the use of a discount rate which is considered to comply with the relevant Australian Accounting Standard (AASB 137).

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.

3 The Military Compensation Environment

3.1 Operational Environment

3.1.1 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.

3.1.2 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.

3.1.3 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.

3.1.4 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.

3.1.5 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.

3.1.6 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.

3.1.7 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.

3.1.8 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.

3.1.9 More recently, we have been informed of higher numbers of medically discharged veterans by DVA Data and Insights. Figures provided by DVA show a significant increase in the number of medically discharged veterans from 2020 onwards compared to previous years. Experience to 2022 suggests that this trend could continue into the future. Medically discharged veterans are more likely to have higher numbers and severity of injuries than other separating ADF personnel and could have led to some of the experience changes seen in the most recent MRCA permanent impairment data. This is discussed further in section 10 of the report.

3.2 Administrative Environment

3.2.1 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.

3.2.2 More recently, there have been significant changes in the approach taken by Defence and DVA to manage claims. For example, DVA now has advisers on base to assist personnel in making claims. 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.

3.2.3 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.

3.2.4 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.

4 Data Used for the Valuation

4.1 Data Sources

4.1.1 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.

4.1.2 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.

4.1.3 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.

4.1.4 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.

4.1.5 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 2023 is a combination of extracts from legacy systems and ISH.

4.2 Data Provided

4.2.1 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 2023. The payments data for the 2022-23 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 2023 into the analysis for all heads of damage.

4.2.2 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.

4.2.3 In addition to the unit record payments and claims data, DVA also provided the following datasets:

- De-identified data for MRCA medical card holders which provide the issue date and type of medical treatment card held by the veteran;

- Unit record MRCA pharmaceutical data which allowed for the separation of pharmaceutical expenditure between Gold and White card holders. To the extent possible, this was verified again aggregate pharmaceutical data provided by DVA. Although some discrepancies exist when the two data sources are compared on a quarterly basis due to timing differences in the aggregate data, overall payments across calendar years 2021 to 2023 matched within 1 per cent;
- Periodic incapacity data which provided the fortnightly payment rate and incapacity start and end dates. To the extent possible, this was reconciled against the transactional incapacity payments data received and was found to be broadly consistent;
- Incapacity repayments which included repayments relating to superannuation offsets, overpayments etc.;
- PI conditions data which provided some high level attribution of impairment points to associated body regions; and
- Dependent data which included the dependent's year of birth. This was used in modelling future expected payments for dependents receiving MRCA education supplements. When linked to the education supplements payment data, we were able to match approximately 99 per cent of recipients to their year of birth.

4.2.4 DVA also provided aggregate payment data up to the third quarter of 2023–24. 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.

4.2.5 In September 2023, the DVA Data and Insights team made an adjustment to how initial liability claims lodged under multiple Acts would appear in the claims data set. This change removed claims which were subsequently withdrawn from the Act/s it was not considered under. For example, if a claim was lodged under both DRCA and MRCA and allocated to MRCA but was subsequently withdrawn, the lodged and withdrawn claim would only show under the MRCA and would be removed from the DRCA. As such, the number of completed and withdrawn claims differ between the datasets received this year and the prior year. This does not have a material impact on our analysis.

4.2.6 DVA use an internal model named the Demand Driven Funding Model (DDFM) to project future processing capacity and efficiency. As DVA are currently in the process of completing a significant number of open claims, there is considerable uncertainty around when finalisation and subsequent payments will be made. A key factor in determining the level of clearance and payments in the near future is the number of processing staff employed and their efficiency in claim completion. DDFM projects the expected level of claims lodged and cleared based on past experience and discussions with DVA's Client Benefits Division. Currently the model is used by DVA for Budget estimates and policy costings. At this valuation, DDFM remains our best source of information with regards to processing capacity over the medium term and thus, has been considered when shaping our expected claimant and cashflow projections, particularly over the first two years of the projection. Please note, AGA cannot independently verify the results of the DDFM as we do not have access to the relevant data sources nor the underlying model.

4.2.7 The DVA Data and Insights team provided us with additional analysis conducted on the cost of Gold Cards covering all veterans and dependents. This analysis included data related to Gold Card holders under both the VEA and MRCA and thus included information related to expenditure for veterans at older ages. As MRCA is a relatively younger cohort, we currently do not have visibility of expenditure patterns at older ages in the data we receive. When setting assumptions for expected expenditure at older ages for MRCA Gold Card holders, we have

considered DVA's analysis, particularly for veterans aged 75 and older. AGA cannot independently verify the results of this analysis and have relied on the internal checks conducted by DVA to ensure the results are accurate. How this analysis has been used is further discussed in Section 10.

4.2.8 At this valuation we have also remapped a small number of payments to better reflect the nature of support offered and to enhance modelling consistency. These include moving payments related to aids and appliances to the Rehabilitation benefit category, moving supplements including the energy supplement from a number of benefit categories into one consolidated group within the Other benefit category, and grouping death related payments such as funeral benefits into the Death benefit category.

4.2.9 The unit record data for DRCA provided payments which covered the period from 2005 to 31 December 2023 for incapacity payments and from 2001 to 31 December 2023 for non-incapacity benefits. We have relied primarily on unit record data over the most recent calendar years to 31 December 2023 to set assumptions in the DRCA valuation.

4.2.10 The unit record data for MRCA provided payments for the period from 1 July 2004 when the MRCA scheme began to 31 December 2023. 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.

4.2.11 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.

4.3 Data Quality

4.3.1 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.

4.3.2 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 4.1: DRCA data – reconciliation of payments

2022–23 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	113.7	139.8	139.5	100
Permanent Impairment	181.0	181.5	181.5	100
Medical	8.8	8.8	8.7	99
Rehabilitation	13.1	13.2	12.8	97
HSAC	28.7	28.8	28.7	100
Other	5.8	5.7	4.3	75
Death	63.5	63.5	63.5	100
Total	**414.5**	**441.3**	**439.0**	**99**

4.3.3 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.

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

Table 4.2: MRCA data - reconciliation of payments made in the last three financial years

2022–23 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	345.6	339.5	338.6	100
Permanent Impairment	1,341.7	1,320.6	1,320.4	100
Medical	218.0	215.4	215.4	100
Rehabilitation	65.4	65.8	64.2	97
HSAC	35.9	36.0	35.9	100
Other	71.3	71.2	69.4	98
Death	26.4	26.5	26.2	99
Total	**2,104.2**	**2,075.1**	**2,070.1**	**100**

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

5 Valuation Approach

5.1 Projection Models and Exposure

5.1.1 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.

5.1.2 All projection models use year of accident exposure based on the number of serving members within that year. Although this is a broad exposure measure, it is currently the only data available to AGA. Should injury or separations data become available to AGA in future, these could assist in refining our exposure measure and selected model assumptions.

5.1.3 In March 2022, the Government announced an increase to the Defence workforce, increasing the permanent ADF to approximately 80,000 by 2040. In light of this, we have increased our expected ADF personnel from 2024 onwards to linearly increase to an exposure of around 80,000 by 2040. We have increased the expected number of reservists proportionately. Although this increase does not impact on the liability, it does impact on the 10 years of future projected cashflows presented in this report.

5.2 Initial Liability Experience and Projection

5.2.1 Processing constraints have remained an issue at DVA over the last few years, resulting in a backlog of lodged initial liability (IL) claims under both DRCA and MRCA. Over the last year, DVA have expanded their processing capacity to clear the existing number of outstanding claims and to keep pace with the level of claims being lodged. However, there remains a number of open claims awaiting completion under both DRCA and MRCA as at 31 December 2023.

5.2.2 Figure 5.1 and Figure 5.2 below show the level of lodged and completed IL claims under DRCA and MRCA to the end of calendar year 2023. Please note that the claims in the figures below have been counted as unique individuals with lodged or completed claims within the calendar year e.g. if a veteran has lodged multiple IL injuries within the year, they are only counted once in that year. 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 5.1: DRCA Lodged and Completed Initial Liability Claims

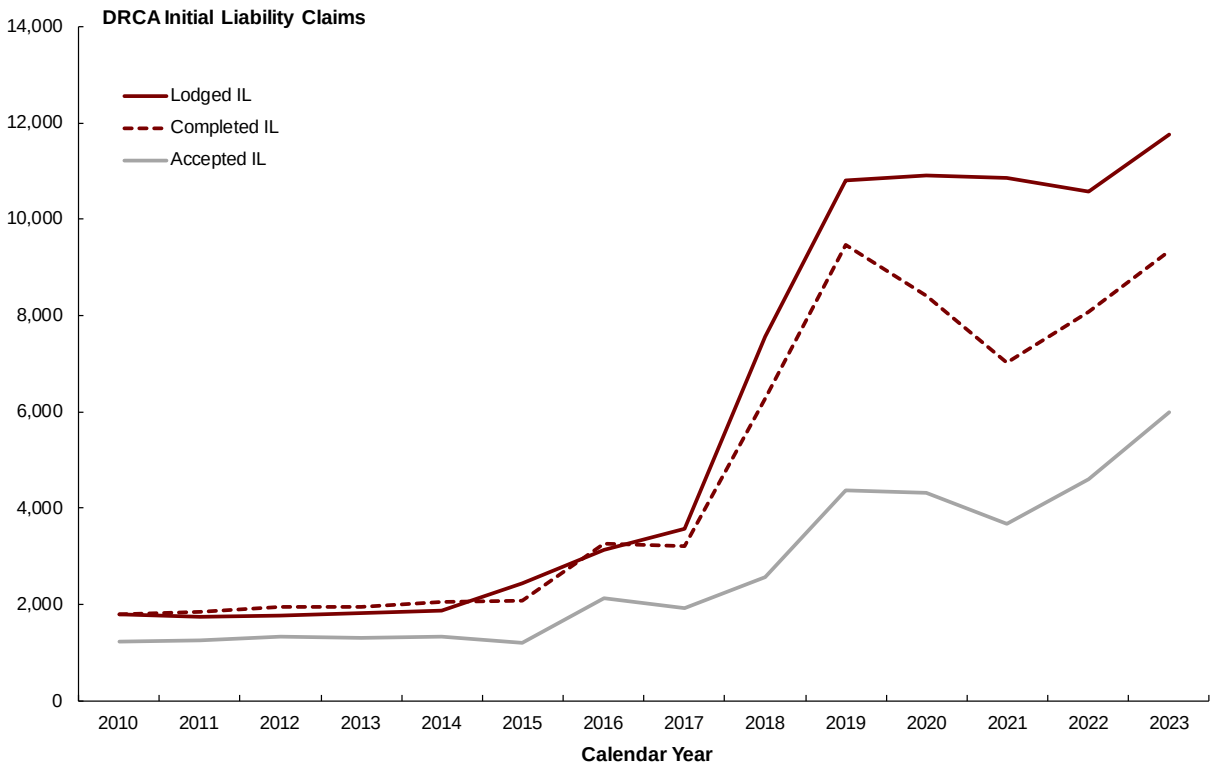
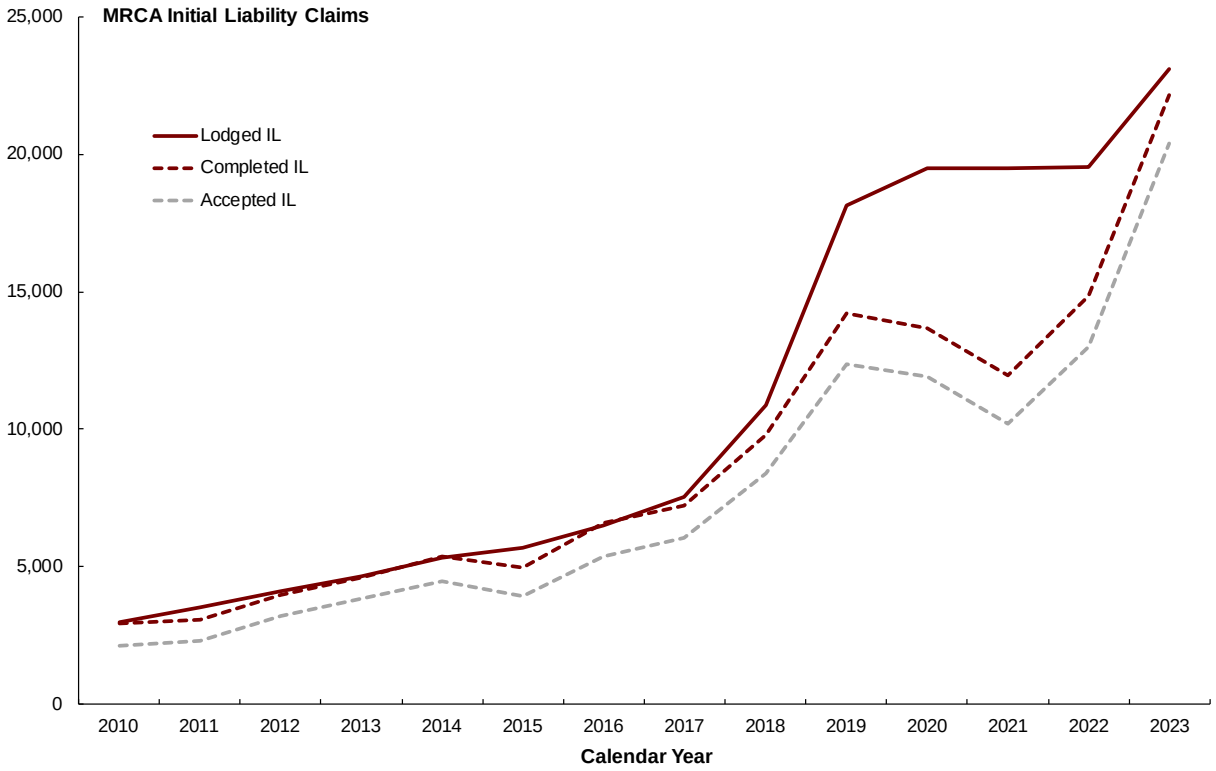


Figure 5.2: MRCA Lodged and Completed Initial Liability Claims



5.2.3 The level of completed claims in the last calendar year has been significantly higher than previous years, most noticeably for MRCA. However, there still remains a substantial number of open claims.

5.2.4 Figures 5.3 and 5.4 below show the number of completed and withdrawn claims by the calendar year of lodgement. The graphs below differ from Figures 5.1 and 5.2 above as they are on a lodgement year basis, rather than calendar year basis. For example, in Figures 5.1 and 5.2, the number of completed IL claims for 2023 represents the total number of completed claims in that year, regardless of when they were lodged. In Figures 5.3 and 5.4, the completed IL claims for 2023 represents the number of completed IL claims that were lodged in 2023 only, regardless of when they were completed.

Figure 5.3: DRCA Lodged and Completed Initial Liability Claims by Lodgement Year

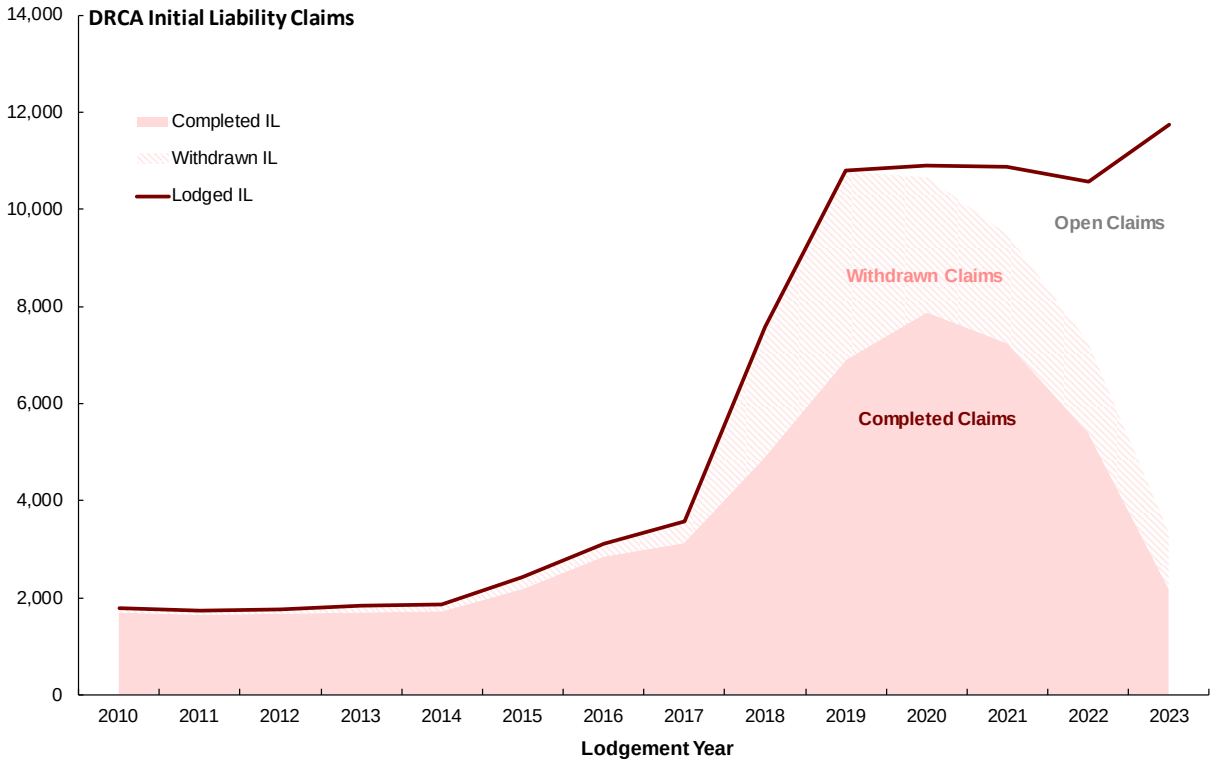
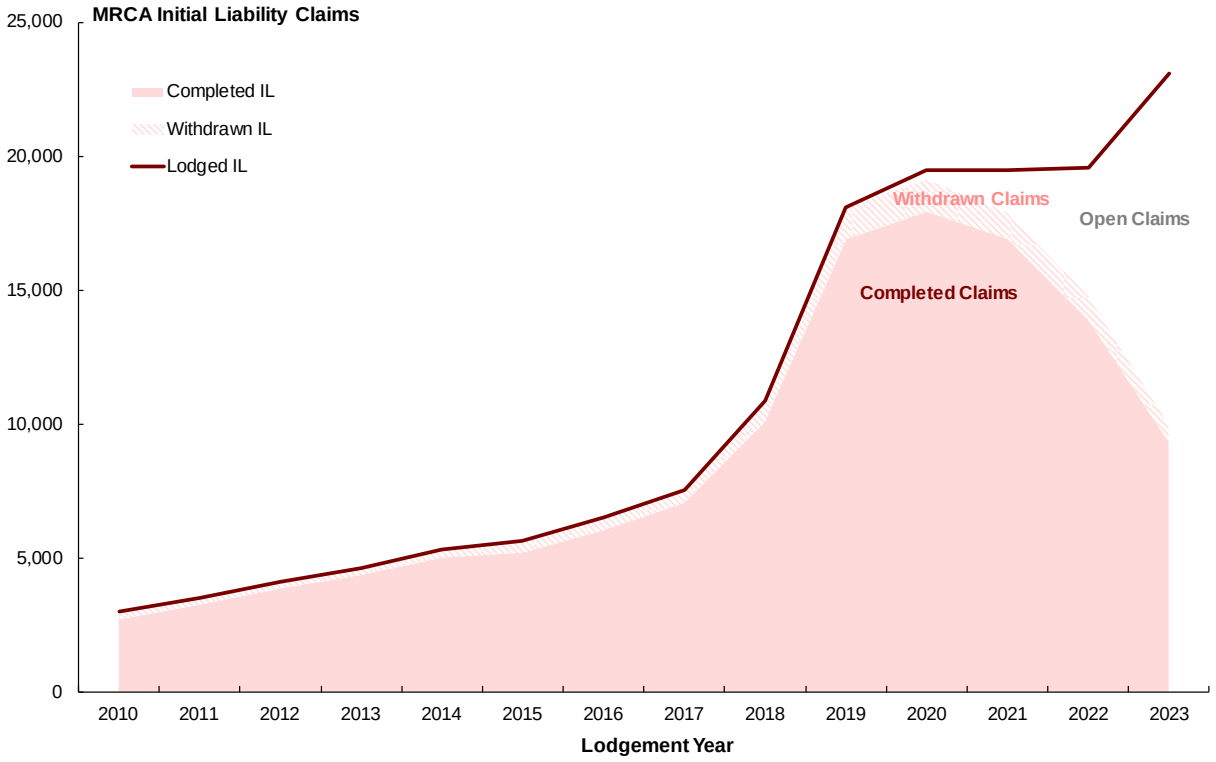


Figure 5.4: MRCA Lodged and Completed Initial Liability Claims by Lodgement Year



5.2.5 For both DRCA and MRCA, almost all claims lodged in 2020 and prior have been completed at the end of 2023. For the 2021 lodgement year, 87 per cent and 92 per cent of claims for DRCA and MRCA respectively have been completed or withdrawn. The majority of current outstanding claims are from the 2022 and 2023 lodgement years.

5.2.6 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.

5.2.7 At this valuation, we have explicitly modelled future expected IL claims for MRCA. 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. The following section discusses the methodology used and the resulting projections of the IL analysis. How this analysis is used by each of the benefit models will differ and further details are provided under each benefit section.

5.2.8 For MRCA, lodged IL claims are summarised by accident year and lodgement year at the person level for each lodgement year. 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. If a person lodges multiple ILs in the same lodgement year, only one IL 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.

5.2.9 A withdrawal rate is also 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 per cent.

5.2.10 A chain ladder model is used to project future IL lodgements for accident years 2007 and prior. For accident years after 2007, claim frequencies are used to project future lodged IL claims. The selected claim frequencies are primarily based on experience in the most recent year.

5.2.11 Figure 5.5 shows the number of lodged ILs as at 31 December 2023 and projected IL claims by accident year. Figure 5.6 shows the actual and expected IL lodgements by calendar year.

Figure 5.5: MRCA Actual and Projected Lodged ILs by Accident Year

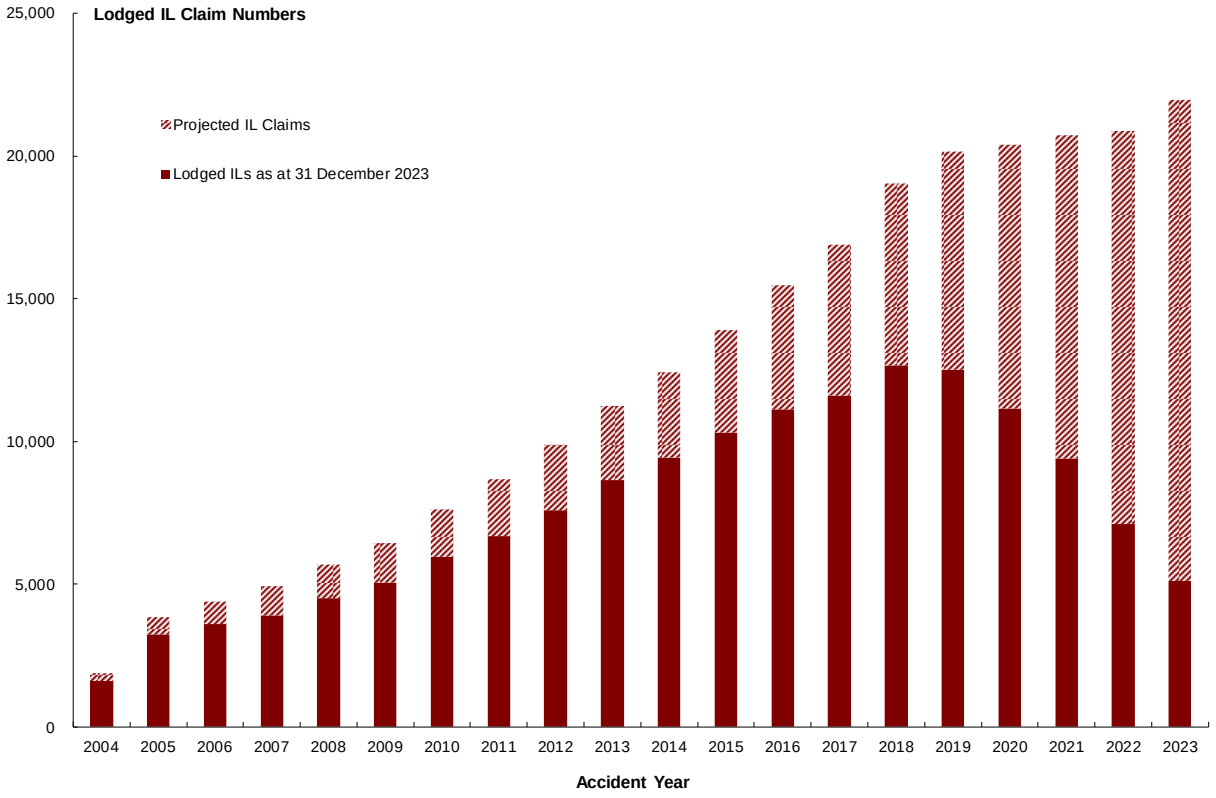
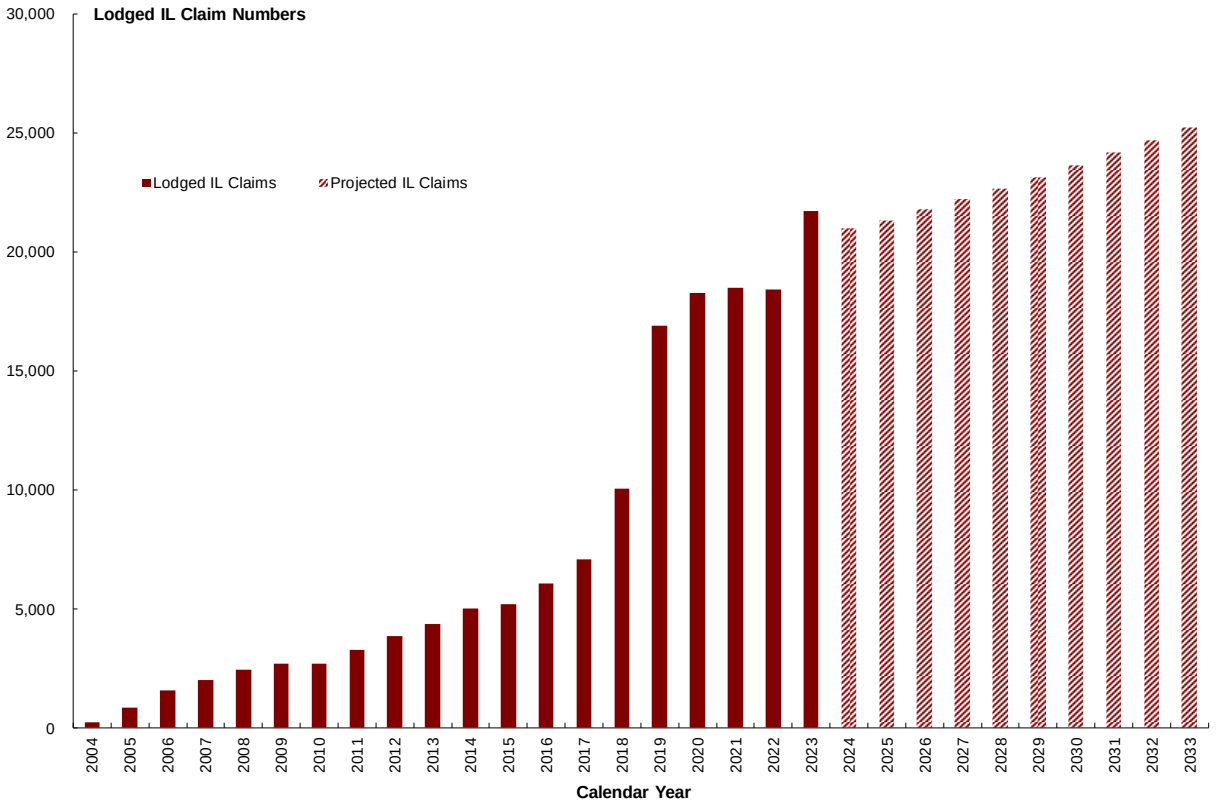


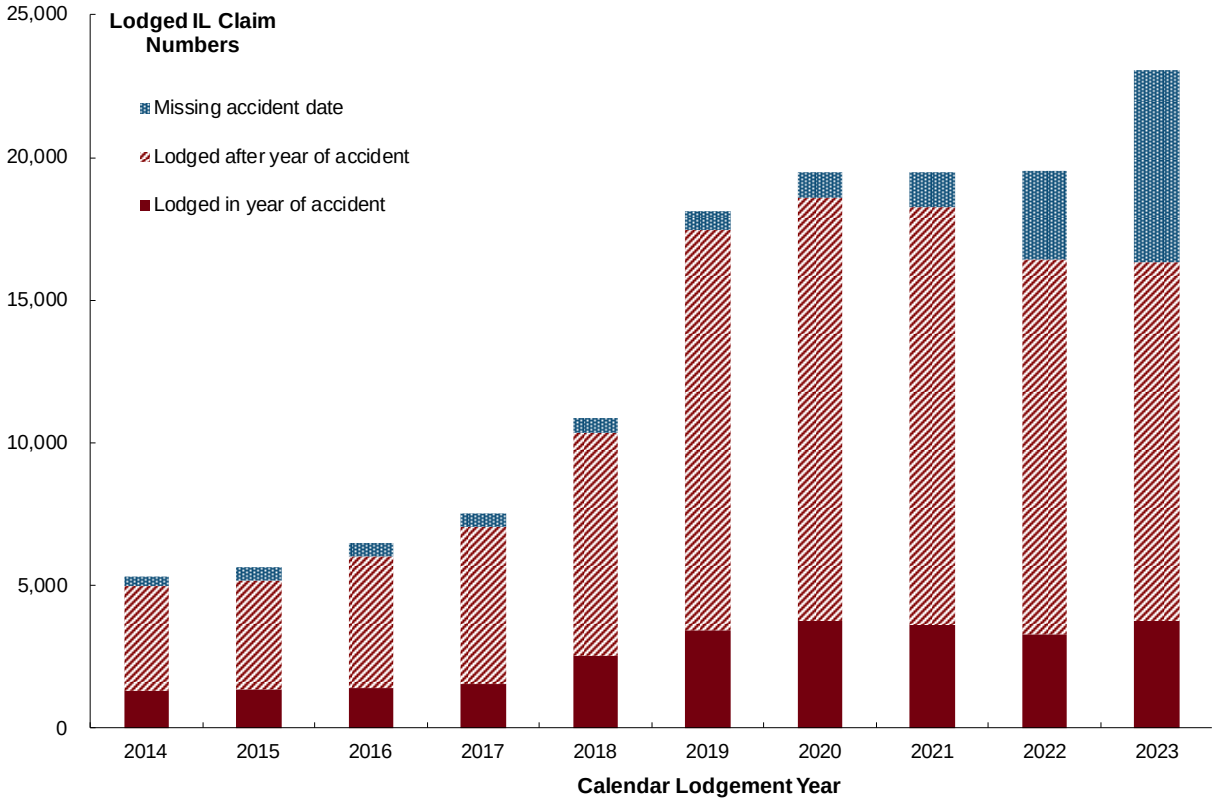
Figure 5.6: MRCA Actual and Projected Lodged ILs by Lodgement Year



5.2.12 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 2005. For example, an IL 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 lodgements will be lower for earlier years of accident than later accident years.

5.2.13 Accident years 2018 to 2022, after the implementation of Veteran Centric Reform, all have similar patterns, thus resulting in similar projected ultimate IL claims. Figure 5.7 shows the number of ILs 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 has been completed). The 2023 calendar year saw an increase in the number of lodged IL claims. As at 31 December 2023, a large number of these claims did not have any associated injury dates. The number of IL claims lodged in 2023 in respect of accidents that occurred in 2023 is already almost as high as for prior years, even before the claims with missing injury dates are taken into account i.e. the 2023 accident year appears significantly higher than prior years at this early stage of development.

Figure 5.7: MRCA Lodged ILs by Lodgement Year



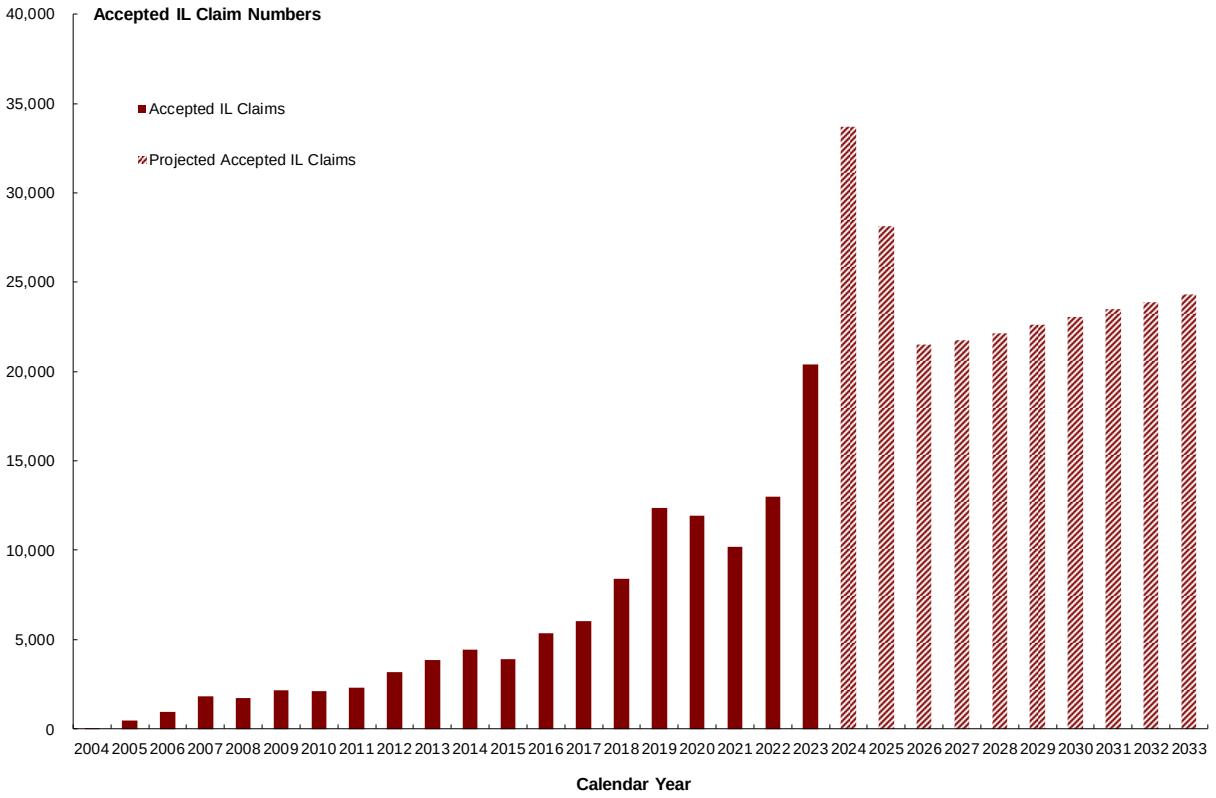
5.2.14 An average injury year was imputed for claims with missing dates based on the prior year experience. The resulting figures show a significantly higher number of lodgements with an average accident year of 2023. The ultimate projected lodgements are also higher for this year to reflect the heightened experience seen to date.

5.2.15 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. As DVA has increased processing capacity, we have adjusted expected completion rates for the first two projection years to reflect this increase. The adjustment has been made with reference to DVA's Demand Driven Funding Model (DDFM) which projects future administrative processing capacity. This is currently our best source of information with regards to the timing of claims processing.

5.2.16 Acceptance rates are then applied to the completed claims to arrive at the number of projected accepted IL claims. Acceptance rates have been relatively stable since Veteran Centric Reform, averaging 95 to 96 per cent. We have selected future acceptance rates of 94 to 97 per cent, varying by delay from the time of accident.

5.2.17 Figure 5.8 below shows the projected number of accepted IL claims by calendar year.

Figure 5.8: MRCA Actual and Projected Accepted ILs by Calendar Year



5.2.18 We anticipate a significant increase in the number of accepted IL claims over the 2024 and 2025 calendar years as current open claims are completed before returning to levels which are commensurate with the level of lodgements seen in the latest calendar year.

5.3 Economic Assumptions

5.3.1 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.

5.3.2 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.

5.3.3 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 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 recent coronavirus pandemic on access to services and type of services offered.

5.3.4 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.

5.3.5 In setting inflation assumptions, we have had regard to any statutory guidelines on indexation, tempered by the observed experience. The main area where this tempering occurs is in relation to permanent impairment.

5.3.6 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 period from calendar years 2006 to 2023, the annual rate of growth has been approximately 8 per cent. 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. Since 2019, the rate of growth has slowed, with the most recent period exhibiting an annual rate of growth of approximately 4.6 per cent. As such, we have retained the inflation rate assumption of 5 per cent adopted at the last valuation for DRCA PI.

5.3.7 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 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. We have incorporated additional superimposed inflation of 2 per cent over the next four financial years to account for this increasing trend. A period of four years was selected to coincide with the anticipated clearance of the current open IL and PI claims before nominal inflation reduces to be in line with price inflation.

5.3.8 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 2026 onwards, expected long term wage growth of 3.7 per cent is adopted.

5.3.9 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.

5.3.10 The following table summarises the combined nominal rate of inflation (that is, normal inflation plus superimposed inflation) used for the current valuation and the previous valuation. The rates shown are the long-term assumptions.

Table 5.1: Rates of inflation

Category	2023 Valuation	2022 Valuation
Incapacity payments	3.7%	3.7%
PI and NEL (DRCA)	5.0%	5.0%
PI (MRCA)	2.5%	2.5%
Medical	3.7%	3.7%
Rehabilitation (DRCA)	3.7%	3.7%
Rehabilitation (MRCA)	3.7%	3.7%
Death (DRCA)	3.7%	3.7%
Death (MRCA)	2.5%	2.5%
Household Services & Attendant Care	3.7%	3.7%
Other – Medico-Legal	3.7%	3.7%
Other – Supplements	2.5%	n/a
Other – Education & Training Scheme	2.5%	2.5%

5.3.11 The estimation process involves projecting the future claim payments allowing for normal inflation and superimposed inflation as described above. To calculate the liability, the payments are then discounted to a present value. This discounting recognises the time-value of money and enables the realistic assessment of long-term financial arrangements such as the MCS.

5.3.12 The Australian Accounting Standard (AASB 137) which would apply for financial reporting purposes specifies that the discount rate used in preparing estimates of claim liabilities should be a pre-tax rate that reflects current market assessments of the time value of money and the risks specific to the liability. In an arrangement such as the MCS, this might be interpreted as the return on Commonwealth securities of appropriate durations and, for financial statement purposes, we use a yield curve derived from the yields on Commonwealth securities as at the relevant 30 June for discounting purposes.

5.3.13 Such an approach can lead to major changes in the estimate of the liability due solely to changes in interest rates. For the full actuarial review that we are reporting on here, we regard a stable interest rate assumption to be preferable as it allows other changes in experience, which are more important from a policy perspective, to be observed. We have retained the 5 per cent long term interest rate for discounting cashflows used at the previous valuation. The 5 per cent long term interest rate is consistent with the rate used to discount other long term Commonwealth liabilities, in particular, the cost of military superannuation benefits. This is based on long term expectations of 2.50 per cent CPI growth, 1.20 per cent productivity growth, and 1.25 per cent population growth.

5.3.14 Note that an additional letter of advice will be provided to DVA for financial statement purposes. This letter will include the result of the roll forward process which provides the liability as at 30 June 2024 and will discount cashflows using a yield curve derived from Commonwealth securities as described in 5.3.12.

5.4 Administrative Expenses

5.4.1 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.

5.5 Risk Margins and Risk Assessment

5.5.1 The estimates provided in this report represent our best estimates of the liability and projected cashflows. That is, it is intended to be equally likely that they are too low as that they are too high. We have not calculated a risk margin (prudential margin).

5.5.2 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.

5.5.3 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.

5.5.4 To help illustrate the uncertainty, we have included some sensitivity and scenario analysis around key assumptions in section 19. The analysis focuses on the largest benefit types, the key assumptions which contribute to the liability result, and areas of significant uncertainty.

5.6 Reinsurance and Non-Reinsurance Recoveries

5.6.1 DVA has no reinsurance contracts in place relating to MCS liabilities. As such, provisions have not been made for expected reinsurance recoveries.

5.6.2 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.

6 DRCA Permanent Impairment and Non-Economic Loss

6.1 Modelling Approach

6.1.1 Under DRCA, lump sum payments are made where a service person suffers a permanent impairment. In most cases, a further lump sum payment is made to compensate for non-economic loss. Due to the strong correlation between the two payments, we model the combined payment.

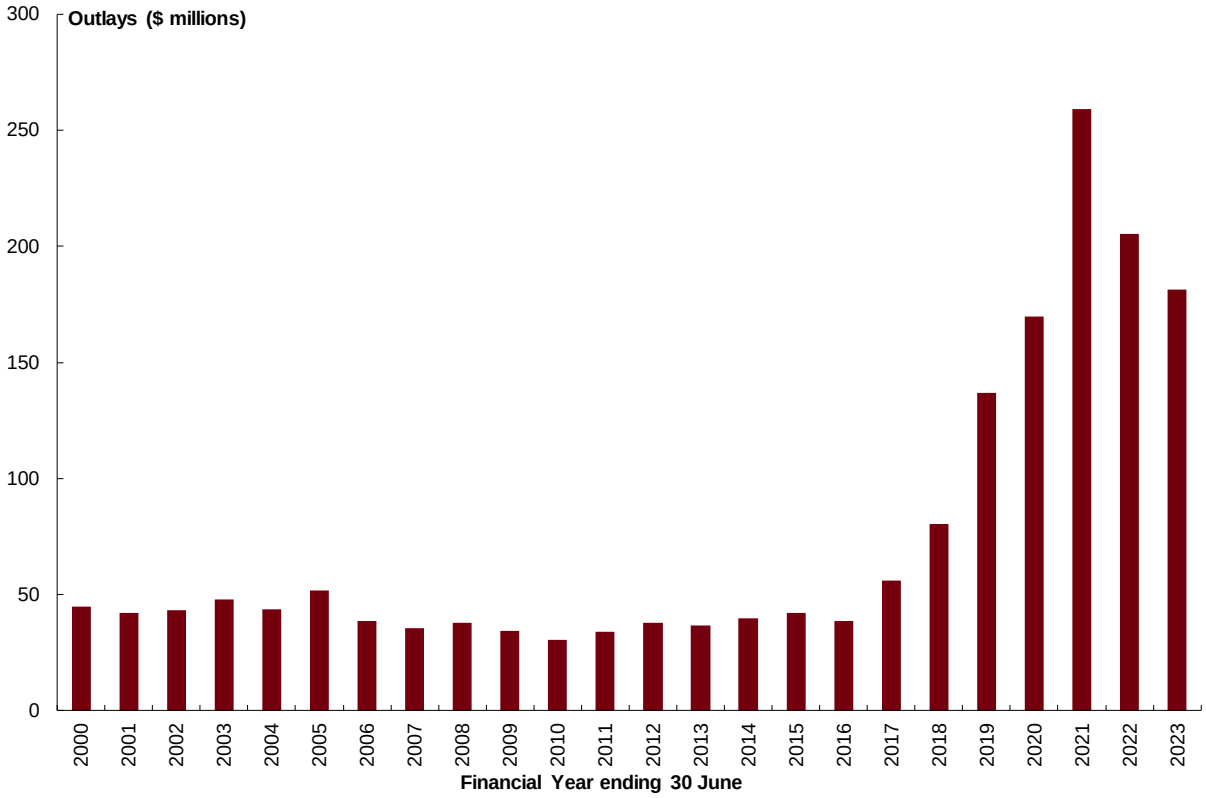
6.1.2 The modelling approach taken with DRCA payments was to look at the number of claims by development year per unit of exposure. An average size is then applied to estimate the quantum of permanent impairment payments arising in each year, with an allowance for superimposed inflation to increase the average size over time.

6.1.3 For the current valuation, we have continued to make allowance for the current level of open claims, both in initial liability and permanent impairment. We have adopted the same approach as last year, namely a 'top down' approach which considers the rate of IL lodgements and applies various conversion factors to estimate the number of PI claims that would have been paid in the absence of claims processing constraints. The actual experience is then compared with the theoretical number of PI claims, and a scaling factor is applied to the actual claims curve. The scaled claims curve is used to project the future rate of PI claims. An additional allowance has been included to explicitly account for the existing backlogs of open claims in IL and PI.

6.2 Recent Experience and Valuation Assumptions

6.2.1 Figure 6.1 shows the expenditure on permanent impairment (including non-economic loss payments for DRCA) over the last two decades.

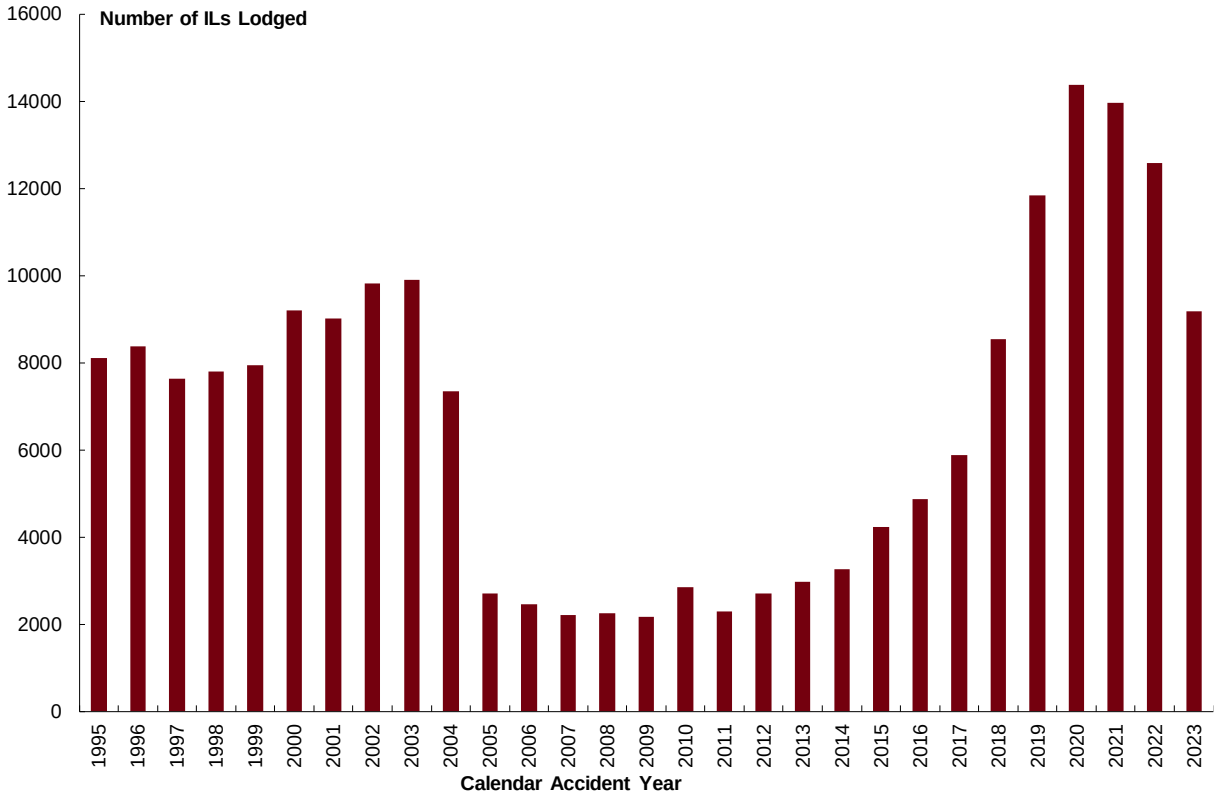
Figure 6.1: Expenditure on DRCA permanent impairment payments



6.2.2 Despite the closure of DRCA for injuries occurring after 1 July 2004, expenditure has significantly increased year-on-year since 2017, with the highest expenditure seen to date in 2021. While expenditure since 2021 has decreased, this is not representative of underlying experience as payments have been impacted by processing constraints in both DRCA IL and PI.

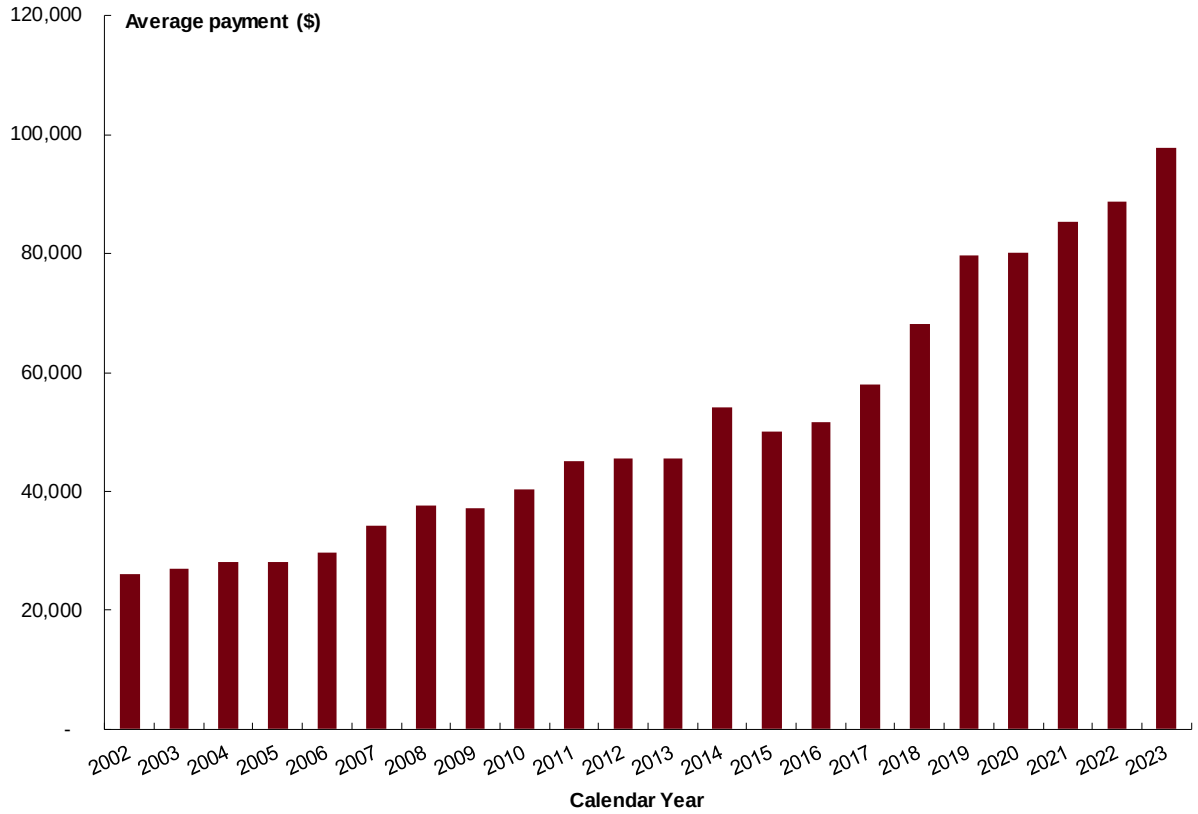
6.2.3 Figure 6.2 shows the number of DRCA IL claims summarised by accident year (noting that recent accident years will have substantial numbers of new ILs reported in the future). Despite the closure of the scheme in 2004, a substantial (and growing) number of claims have accident/effective dates after 2004. More IL claims have been lodged for the 2019 to 2022 accident years than were lodged for pre-2004 accident years, when the scheme was open. This is due to the nature of the injuries being claimed against the DRCA scheme, with many being late onset injuries such as spondylosis, hearing loss or mental injury claims, where there is no single event that caused the injury/illness. In these cases, the accident/effective date assigned is usually the date of first onset of the condition or the date treatment was first received. This poses significant challenges to our modelling, as we cannot link claims back to a particular period of exposure. For the 2024 valuation, we intend to explore modelling alternatives that more explicitly deals with late onset claims.

Figure 6.2: Number of DRCA IL claims by year of accident



6.2.4 The impact of the increasing numbers of claims is magnified by the substantial increase in the size of payments made in respect of these claims, as shown in Figure 6.3. 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).

Figure 6.3: Average size of DRCA permanent impairment payments



6.2.5 The average size of PI lump sums has increased at an annual rate averaging around 8 per cent per annum since 2006. There have been some years where the increase has been substantially more than this, notably 2018, 2019 and 2023 at 18 per cent, 17 per cent and 10 per cent respectively.

6.2.6 We adopt an average claim size which covers both permanent impairment and non-economic loss payments. We have adopted a size of $97,000, based on the experience in the 2023 calendar year. The adopted average size is 6 per cent higher than the 2022 valuation assumption of $91,350 (inflated with expected inflation of 5 per annum to 2023 values), reflecting the more recent experience.

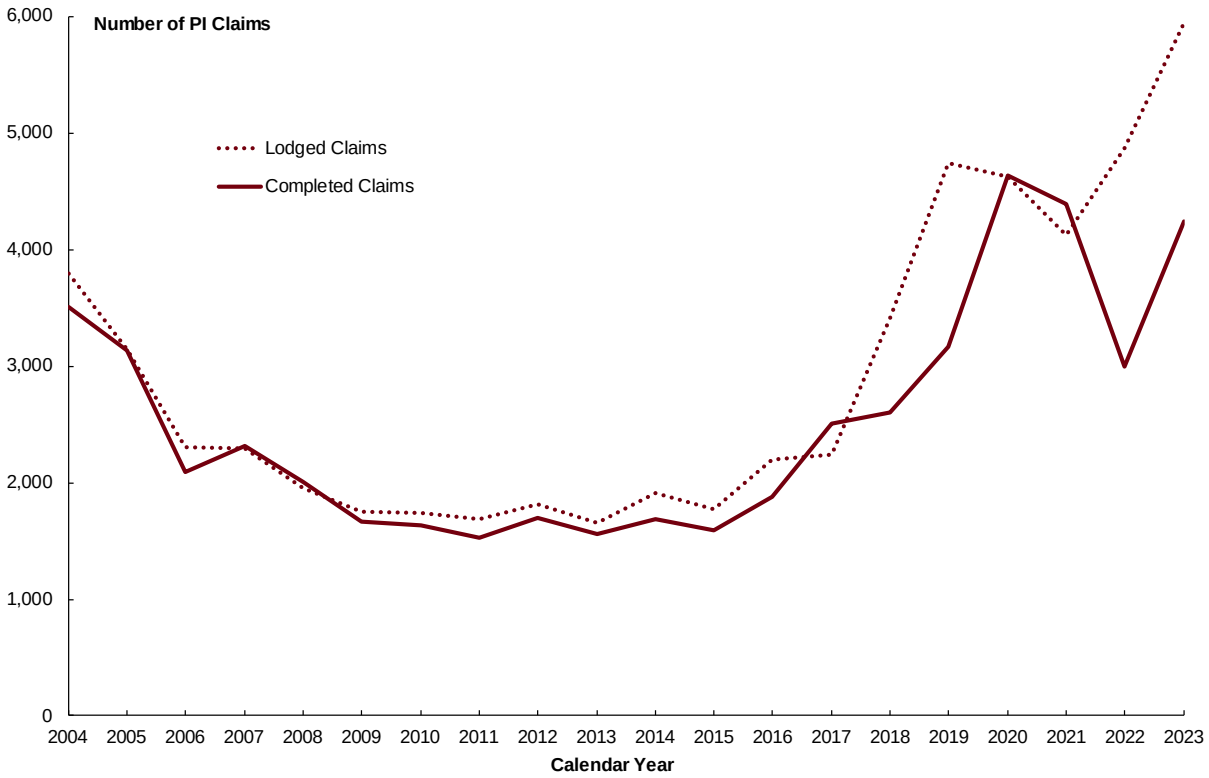
6.2.7 While, in theory, these payments are indexed in line with the price inflation, in practice, the average payment has increased by more than double this index over the last 15 years. As such, we have retained the 2022 assumption that average claims will increase by 5 per cent per annum in the long term (comprised of 2.5 per cent per annum for price inflation and 2.5 per cent per annum for superimposed inflation).

6.2.8 The constraints in both initial liability and permanent impairment processing persist and continue to distort the observed payment experience to date. There remain a large number of open DRCA IL claims which have accumulated due to ongoing limitations in processing capacity.

6.2.9 Figure 6.4 below shows the level of lodged and completed PI claims by calendar year. PI claims lodged have increased over the past 12 months, likely a direct result of the increase in IL claims completed during this time. The number of PI claims completed increased in 2023, following the decline seen in 2022, likely reflecting the increased resourcing. However, the

number of completed PI claims still remains well below PI lodgements. The number of open PI claims has continued to grow since the previous valuation and will likely increase over the next 1 to 2 years as open claims are completed.

Figure 6.4: Lodged and Completed PI Claims



6.2.10 For the current valuation, we have retained our methodology to allow for the current number of open claims and processing constraints, both in IL and PI. The adjustment consists of two explicit components:

- The first component is an allowance for the existing open claims in IL and PI i.e. the number of claims that have already been lodged but have not yet been paid. This component is calculated by considering the number of additional claims outstanding at 31 December 2023 and applying various conversion factors to estimate the number of PI payments that will arise as a result of IL claims that have been lodged but not yet processed and also PI claims that have been lodged but not yet processed.
- A second adjustment is required to account for the impact of current claims processing constraints on the observed experience in setting the assumed future claim rates and projecting future claimant numbers i.e. the recent experience used to set assumptions is too low relative to what we would expect had normal processing capacity been available. This adjustment is calculated by considering the rate of IL lodgements and applying various conversion rates to estimate the number of PI claims that would have been paid in the absence of claims processing constraints. The actual paid experience is then scaled up to the theoretical number of permanent impairment payments, which is then used to project the future rate of PI claims.

6.2.11 To estimate the quantum of the first component of the adjustment, the number of claims awaiting processing and conversion assumptions are required. Based on data to

31 December 2023, there are around 10,000 claimants with IL claims awaiting processing, and 4,000 claimants with PI claims awaiting processing.

6.2.12 Assumptions are required for:

1. IL lodgement withdrawal rates, to estimate IL lodgement net of withdrawals;
2. IL lodgement net of withdrawals to IL acceptance;
3. IL acceptance to PI lodgement;
4. PI lodgement withdrawal rates;
5. PI lodgement net of withdrawals to PI acceptance.

6.2.13 Figure 6.5 below sets out the withdrawal rates for DRCA IL and DRCA PI claims. The solid lines indicate the actual withdrawal rates. For the three most recent years, there is a clear drop in actual withdrawal rates due to insufficient time having passed for the claims to have been withdrawn. For these years, we assume an ultimate withdrawal rate of 25 per cent for IL and 8 per cent for PI (shown as dashed lines). These assumed ultimate withdrawal rates are based on withdrawal rates for more recent years where the lodgements have largely been completed and thus fully mature.

Figure 6.5: DRCA withdrawal rates

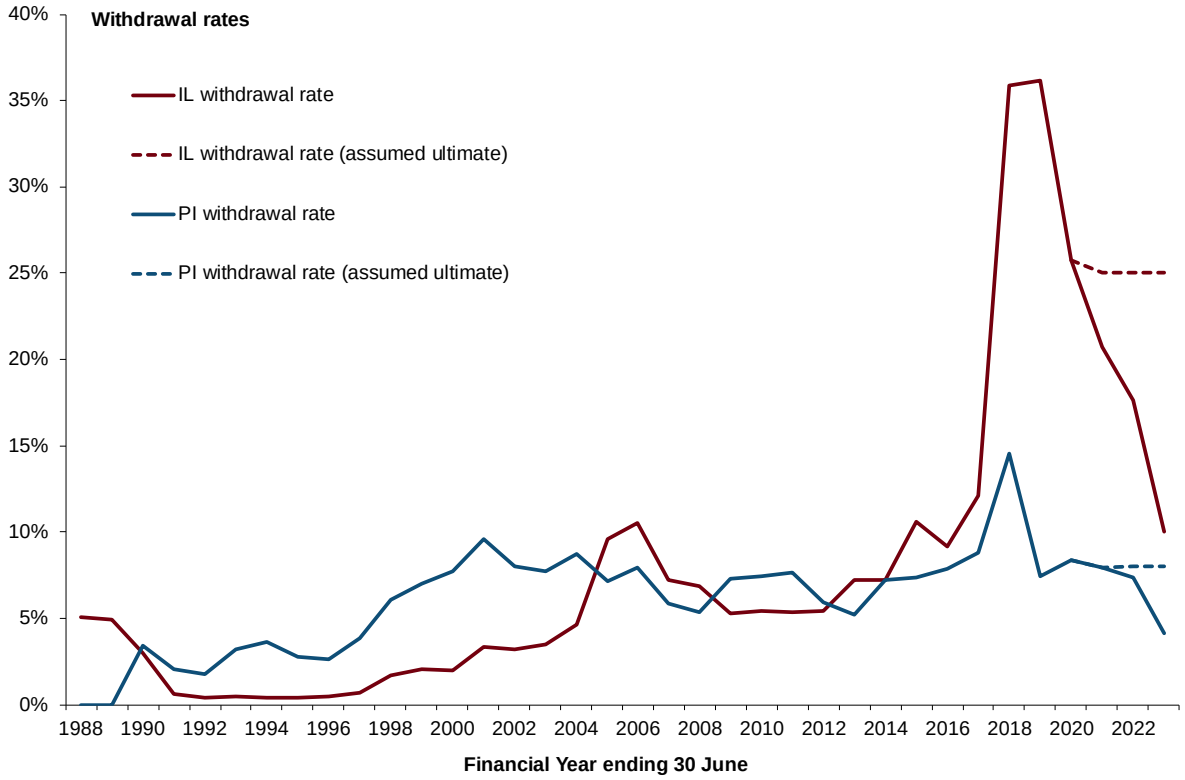
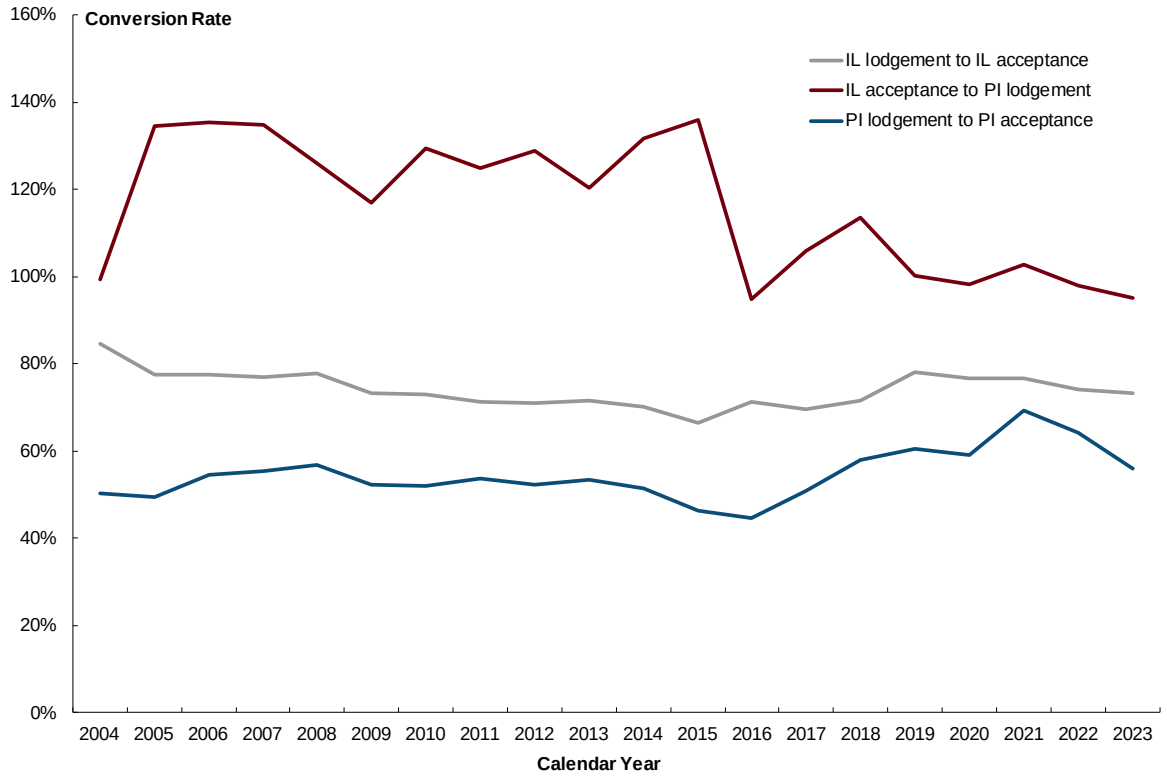


Figure 6.6 below sets out the conversion rates for DRCA IL and DRCA PI.

Figure 6.6: DRCA conversion rates



6.2.14 The acceptance rates for IL claims have been relatively steady in recent years, albeit declining slightly over the last 5 years. For the purpose of the adjustment, acceptance rates of 73 per cent for DRCA have been adopted when calculating the accepted number of IL claims in the absence of any processing constraints.

6.2.15 We have assumed a conversion rate from accepted IL to lodged PI of 100 per cent. 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, particularly since 2016.

6.2.16 PI acceptance rates have declined since 2021. To reflect this we have adopted the acceptance rate of the most recent year, resulting in an assumed PI acceptance rate of 56 per cent.

6.2.17 Based on the number of IL and PI claims outstanding as at 31 December 2023 compared with expected levels of claims on hand, and the assumed conversion rates above, we have added an additional 4,500 DRCA PI claims to the claimant projection to account for the current IL and PI open claims.

6.2.18 The second component of the adjustment accounts for the impact of current processing constraints on the observed experience in setting the assumed future claim rates. The observed claims curve based on paid claims is being supressed by current limitations to processing capacity and is not representative of expected future claim rates.

6.2.19 We start with the rate of IL claims over the past year and apply the assumed conversion rates to calculate the theoretical rate of PI payments over this same period. This implies a scale up factor of 51 per cent to be applied to the observed claims curve, which can be decomposed

into 22 per cent due to processing constraints in PI and 29 per cent due to processing constraints in IL.

6.2.20 We have estimated future claim reports based on this scaled up claims curve i.e. use the most recent year only. Figures 5.1 and 6.4 show the number of IL claims lodged and PI claims lodged have surged in 2023, while the number of completed PI claims increased in 2023 relative to the low level of 2022. By adopting the latest year, we reflect the heightened level of IL lodgements, as well as the increased level of claims processing in 2023. Relying on the latest year also capitalises on a rate of PI claims processing that is closer to potential rates in the absence of any processing constraints. Further, the gap between IL lodgements and PI claims completed is relatively lower in the latest year. This consequently reduces the adjustment, thereby reducing the level of reliance on it. This is preferable as the adjustment introduces an inherent uncertainty due to the assumptions required to derive it.

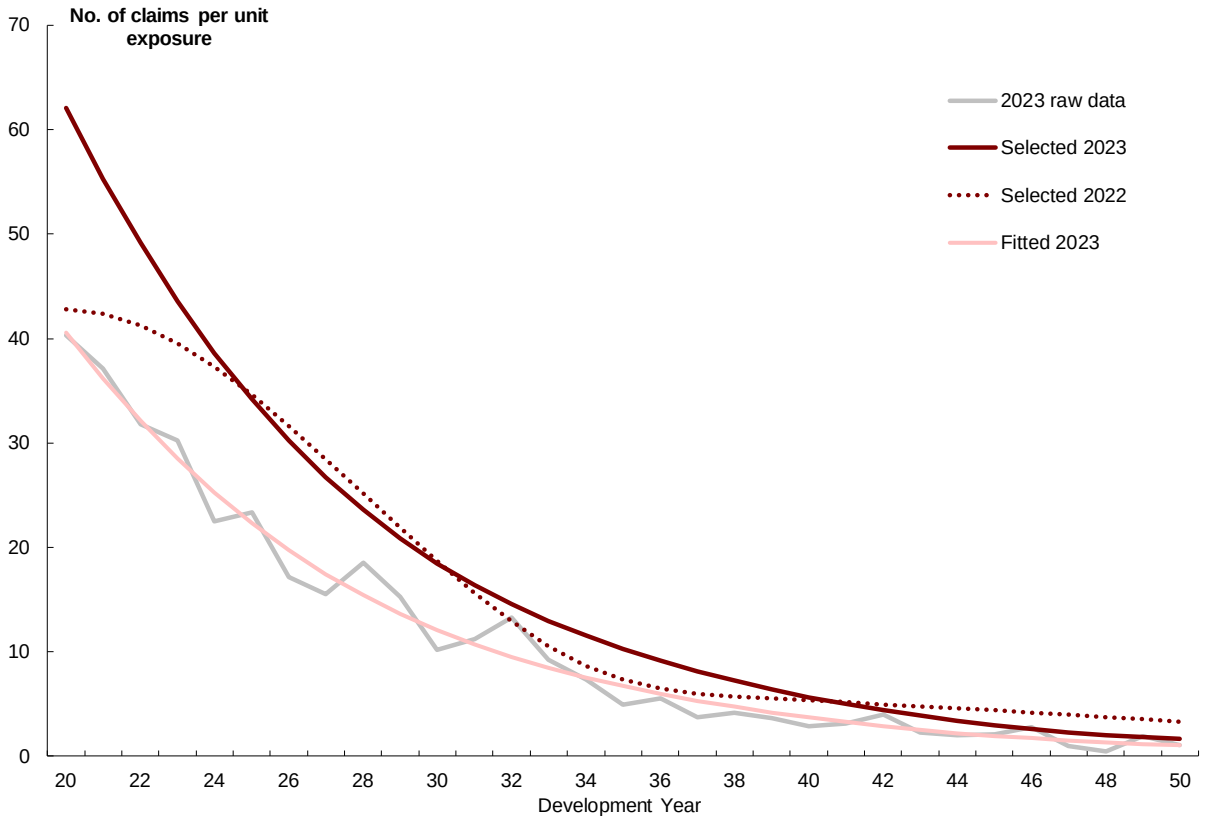
6.2.21 Figure 6.7 compares the number of claims per unit of exposure over the most recent calendar year with the assumptions adopted for the current valuation and the 2022 valuation.

6.2.22 This year we have relied upon accident dates from the PI claims data on top of the accident dates from the IL data to derive the durations between accident and claim lodgement. In the past, we primarily relied on the IL data due to accident dates being scant in the PI data. For PI claims completed in more recent years however, the accident date field has become more complete and thus could be relied on when calculating durations.

6.2.23 As mentioned in 6.2.3 above, there are a substantial number of claims that have accident/effective dates after 2004. Previously, we have allocated these claims to the claimant's most recent accident prior to 2004, if available. This assumes claims with post-2004 accident/effective dates can be related to an accident prior to scheme closure. An implication of this approach is that post-2004 claims may be allocated to older accidents that are not relevant to the claim. This results in a material number of claims being allocated to longer delays. This year, we have also investigated the shape of the claims curve using claims with accidents prior to 2004 only. This results in a claims curve with fewer claims in the tail.

6.2.24 Figure 6.7 below shows the selected curve. It places an equal weighting on a claims curve where post-2004 accidents are allocated an older existing injury, and a claims curve using pre-2004 accidents only.

Figure 6.7: Number of Claims per Unit Exposure

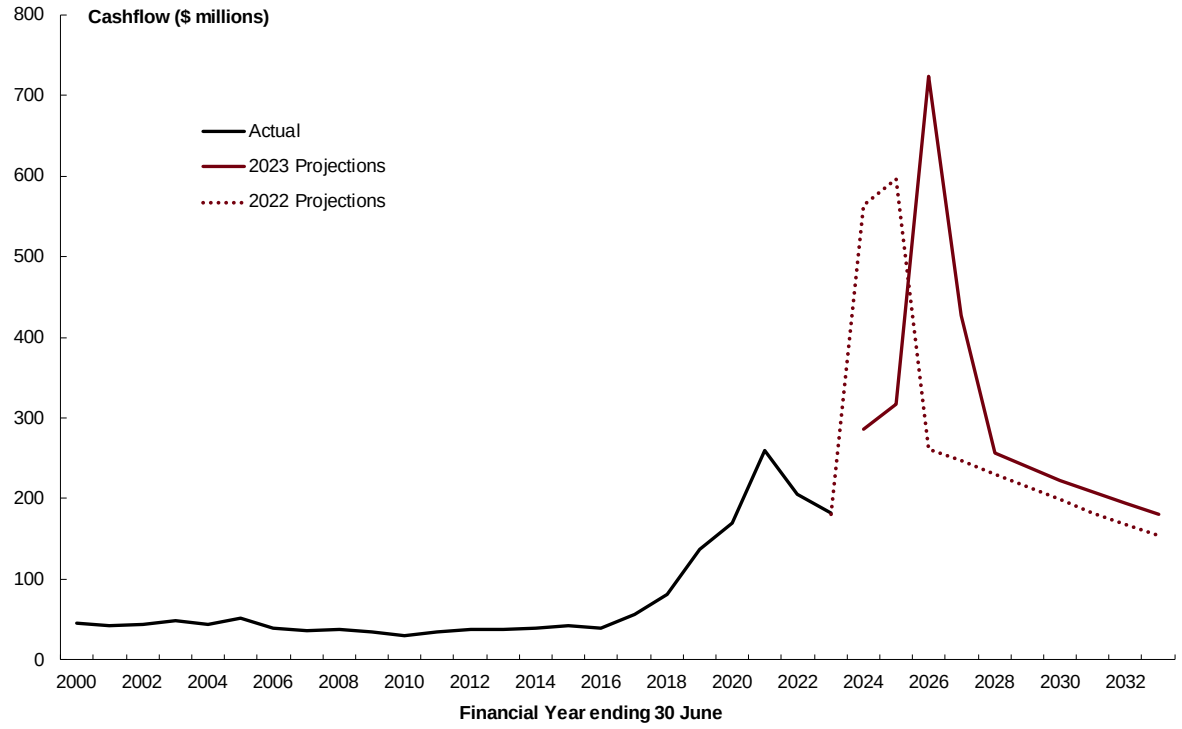


6.2.25 A timing adjustment has been applied to the cashflow projection to reflect current and projected staffing levels within DVA. The adjustment factors applied have been based on DVA's DDFM projections of staffing levels over the short to medium term. This is currently our best source of information regarding future departmental staffing objectives and funding.

6.2.26 It is not possible for us to independently forecast staffing levels within DVA, and as such we have relied on internal modelling and guidance provided by the department. Specifically, we assume claim payments will continue to be supressed in the 2024 financial year before the impact of recruitment initiatives becomes apparent from 2025 onwards. We expect heightened levels of processing over the 2026 and 2027 financial years in order to clear existing backlogs, which will result in a significant increase in claims paid in these years. Should actual recruitment or retention rates differ to those assumed in DVA's internal modelling, then the timing adjustments applied to the projected cashflows will not eventuate.

6.2.27 Figure 6.8 below shows the historic and projected cashflows for DRCA permanent impairment payments resulting from these assumptions.

Figure 6.8: Historic and projected DRCA permanent impairment payments



6.3 Liability Estimate

6.3.1 Table 9.1 shows the outstanding liability at 30 June 2023 in respect of permanent impairment and non-economic loss claim payments broken down by year of accident. The total estimated liability for DRCA claims is $3,416.3m. The 2022 valuation projected that the DRCA liability as at 30 June 2023 would be $3,025.5m.

Table 6.1: Outstanding claims liability for permanent impairment and non-economic loss claims by year of accident

Year of accident – year ending 30 June	Liability (inflated and discounted) ($'m)
1979 and before	215.5
1980 – 1984	178.7
1985 – 1989	312.7
1990 – 1994	533.4
1995 – 1999	819.9
2000 – 2004	1.356.2
Total	**3,416.3**
Expected at 30/06/2023	*3,025.5*
Total (30/06/2022)	**3,057.9**

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

Table 6.2: Reconciliation of liability for permanent impairment payments

	$m
Liability estimate at 30/06/22 (previous report)	3,057.9
Assumed Interest	148.4
Projected Payments	(180.8)
Notional Premium	0.0
Projected liability as at 30 June 2023 (previous valuation)	3,025.5
Experience effects and assumption changes	
Difference between actual and projected payments	(24.7)
Change in claim numbers	216.5
Change due to average size	199.0
Current Estimate	**3,416.3**

7 MRCA Permanent Impairment

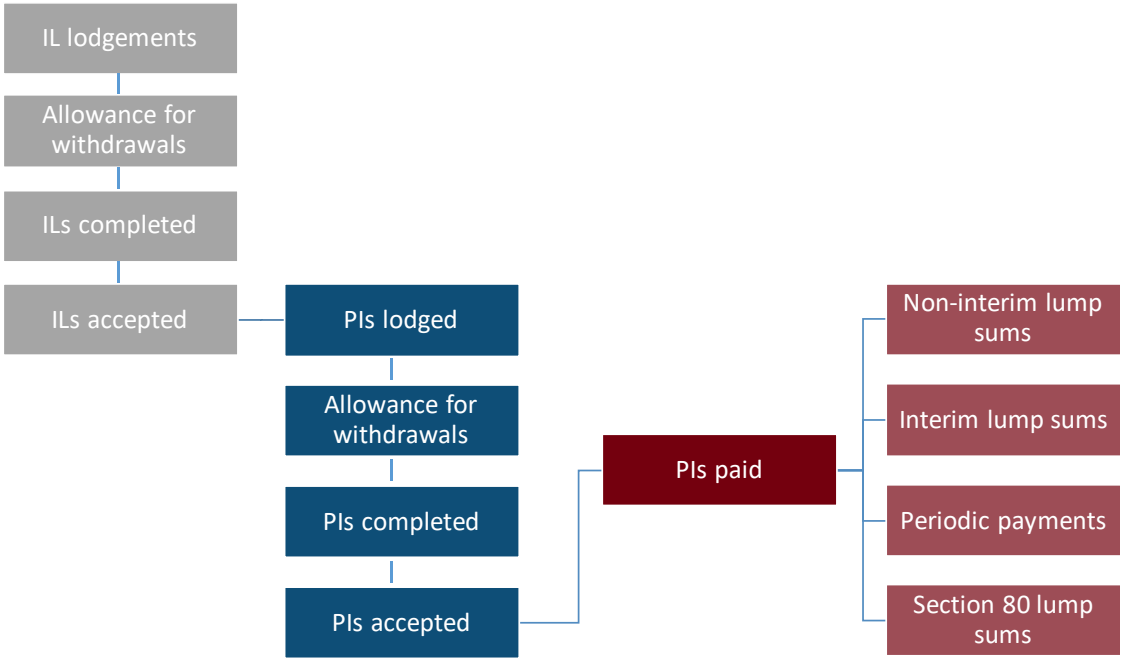
7.1 Modelling Approach

7.1.1 We have updated our modelling approach for MRCA permanent impairment (PI) benefits at this valuation. As discussed in Section 5.2, we have developed a model that projects future numbers of accepted ILs by accident year. As accepted ILs are a lead indicator of the number of PIs expected to be lodged, we have built a model that converts accepted ILs to expected numbers of PI lodgements. Our model then projects the numbers of PI lodgements that will be completed, accepted and ultimately paid.

7.1.2 Under MRCA, the default entitlement in 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 (the split between interim and non-interim lump sums represents a change in our modelling approach this year). We have then assumed that a proportion of all PI claimants will also have Section 80 payments.

7.1.3 Our modelling approach is summarised schematically below.

Figure 7.1: PI Model Approach



7.1.4 Note that the way we have counted PI claims and the way we have calculated the average size attached to those claims in this valuation differs from the 2022 valuation. Previously, our valuation relied on the PI claims data only. We assumed that a PI payment was made if there was an increase in the number of impairment points awarded in the year, and the average claim size adopted was based on assumed whole person impairment/service type/age distributions also derived from the PI claims file. For this valuation, we have used the claims file to track PI claims through from lodgement to acceptance, and then have used the transactional level payment data to count actual PI payments and the average size of those payments. Due to this change in approach, figures included in this year's valuation may not be directly comparable to the 2022 valuation.

7.1.5 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.

7.1.6 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.

7.1.7 A key uncertainty in determining the level of claims for PI 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.

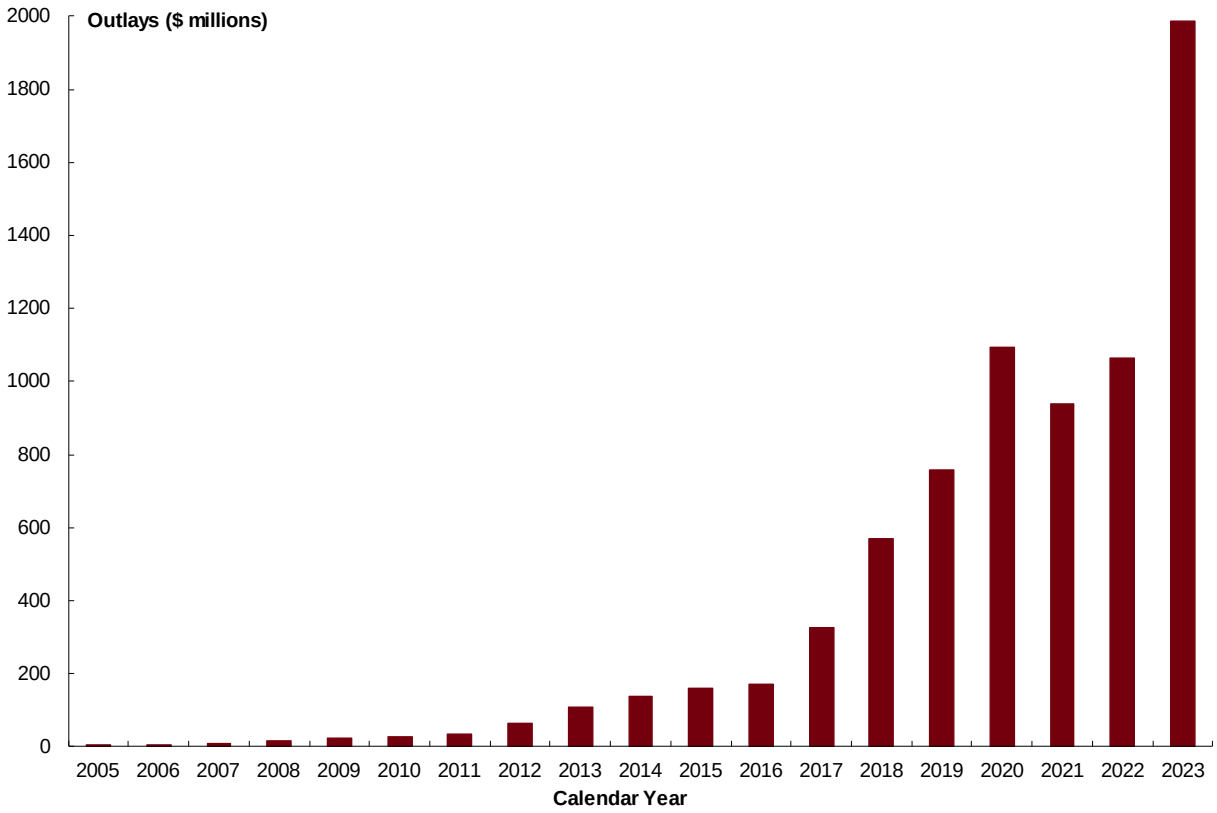
7.1.8 Claims also arise from the existing population of veterans who may have separated from Defence a number of years ago and where the severity of injuries has increased over time. Improved access to DVA services and greater awareness of benefits might be influencing the propensity of these veterans to make a claim and potentially claiming earlier than they otherwise would have. Information regarding discharges and the likely total veteran population may be useful in helping to narrow the exposure for claimants from the existing veteran population who might make a PI claim in future and provide an upper limit to the number of potential claimants likely to emerge over time from this cohort.

7.1.9 As with DRCA PI, we have incorporated a timing adjustment to account for the current MRCA IL and PI open claims.

7.2 Recent Experience

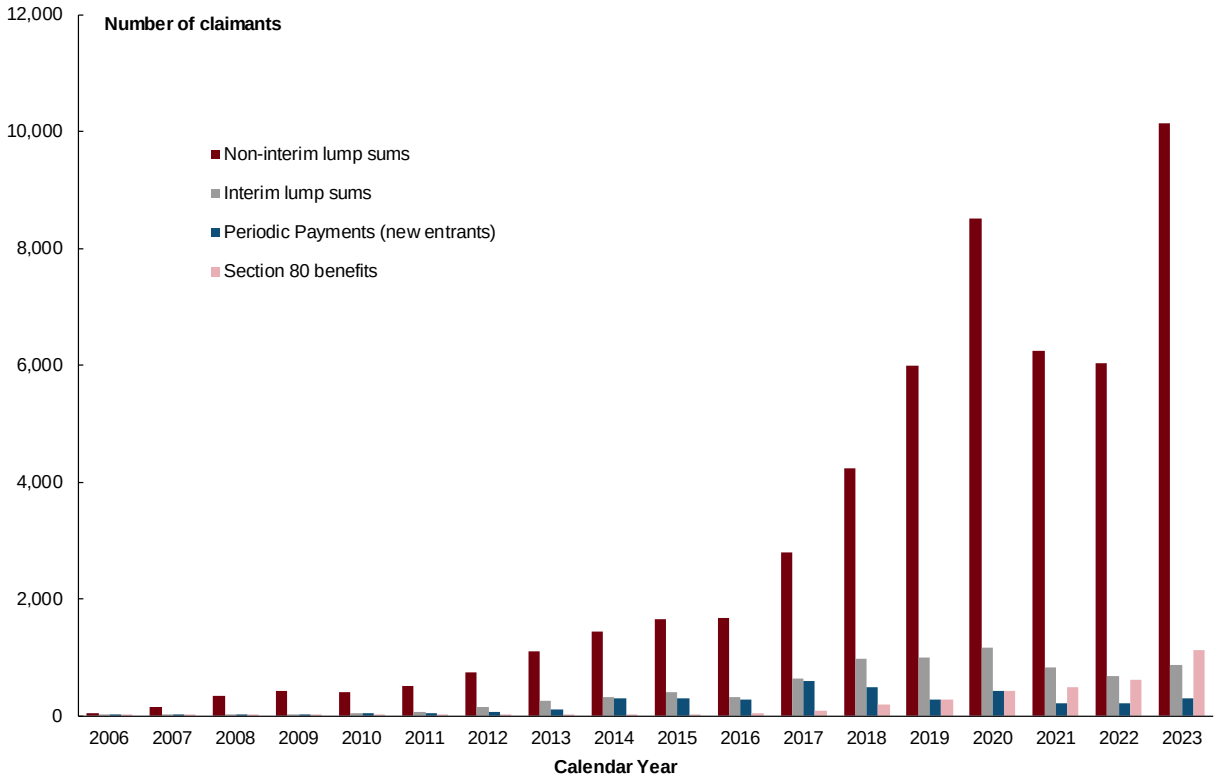
7.2.1 Figure 7.2 shows expenditure on permanent impairment payments since the inception of MRCA (noting these are payments in each calendar year rather than financial year). There were virtually no payments in the first two years of operation of the scheme and for the following 5 years outlays increased only slowly. Nonetheless, 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, payments almost doubled and were just under $2 billion.

Figure 7.2: Expenditure on permanent impairment benefits



7.2.2 The significant increases in PI payments have been driven by both an increase in claimant numbers and an increase in the average payment amount. Figure 7.3 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 after the processing-impacted years of 2021 and 2022. Claimants electing to receive periodic payments make up only around 3 per cent of lump sum recipients. We can also see that, while still a relatively small number, the number of claimants in receipt of Section 80 benefits have increased substantially over the last five years or so.

Figure 7.3: Number of MRCA claimants by type of payment

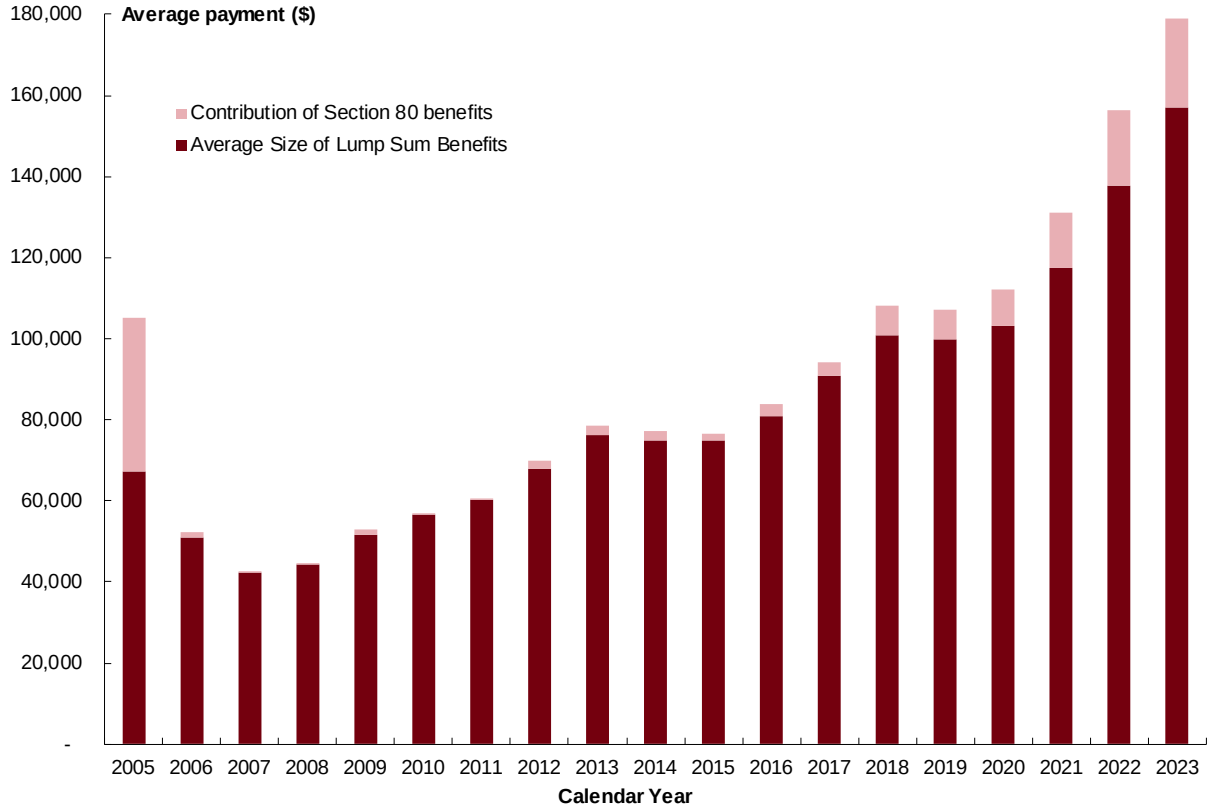


7.2.3 Figure 7.4 shows the average lump sum payment (in original dollars) for those electing to receive either an interim or non-interim lump sum. The contribution to the average claim size of Section 80 benefits is shown separately (claimants receiving periodic payments and the amounts associated with those payments are not included). Note the average payment for 2005 looks unusual due to small numbers (the average only includes 5 lump sums).

7.2.4 Indexation applied to MRCA lump sum benefits from 1 July 2023 was high at 7.8 per cent (compared with our previous valuation assumption of 2.5 per cent per annum). Nevertheless, the average claim size for 2023 (excluding Section 80 benefits) has increased by significantly more than inflation (by 14 per cent, including the indexation change). This followed substantial increases in both 2021 (14 per cent) and 2022 (17 per cent).

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

Figure 7.4: Average lump sum payment (actual values)

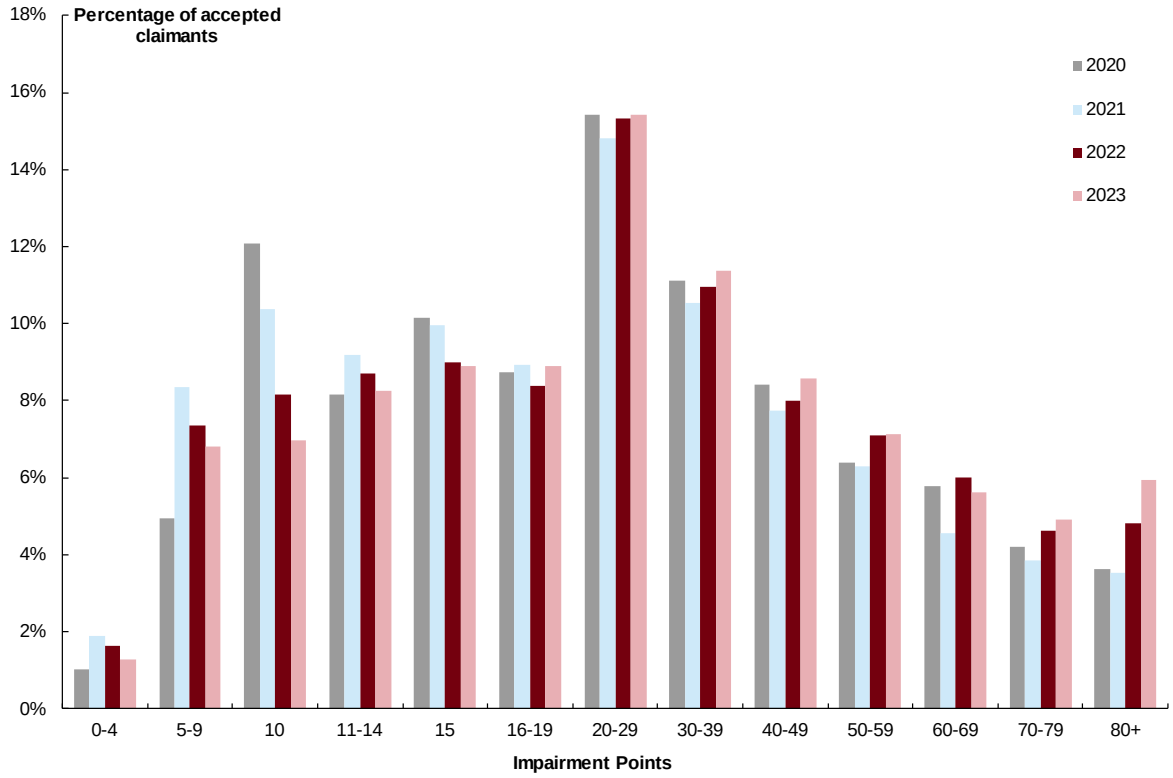


7.2.6 There are several factors which may be driving this increase in average claim size, including policy and cultural changes within the organisation, or an increase in the level of injuries sustained by claimants while at Defence. Analysis conducted by DVA shows the number of medically separated veterans has increased. This group is more likely to be severely impaired and tend to have much higher payment amounts. This group is also more likely to be prioritised for claims processing, which may be distorting the observed experience over the past few years where processing delays have been significant. The reason for the increase in the number of medically separated veterans is unknown, and there remains uncertainty as to whether current levels will continue into the future.

7.2.7 We are also aware that the 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 open claims have been cleared and processing capacity is commensurate with lodgements.

7.2.8 We have looked at the distributions of individual impairment points awarded to those in receipt of permanent impairment benefits. Figure 7.5 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 7.5: Distribution of claim severity over the last four years



7.2.9 Over the past four years, there has been a shift in the distribution of impairment points towards higher levels of impairment, consistent with the increase in the observed average size. Substantially fewer claimants have been awarded 10 points or less, and substantially more claimants have been awarded more than 70 points with a large increase in the proportion awarded more than 80 points.

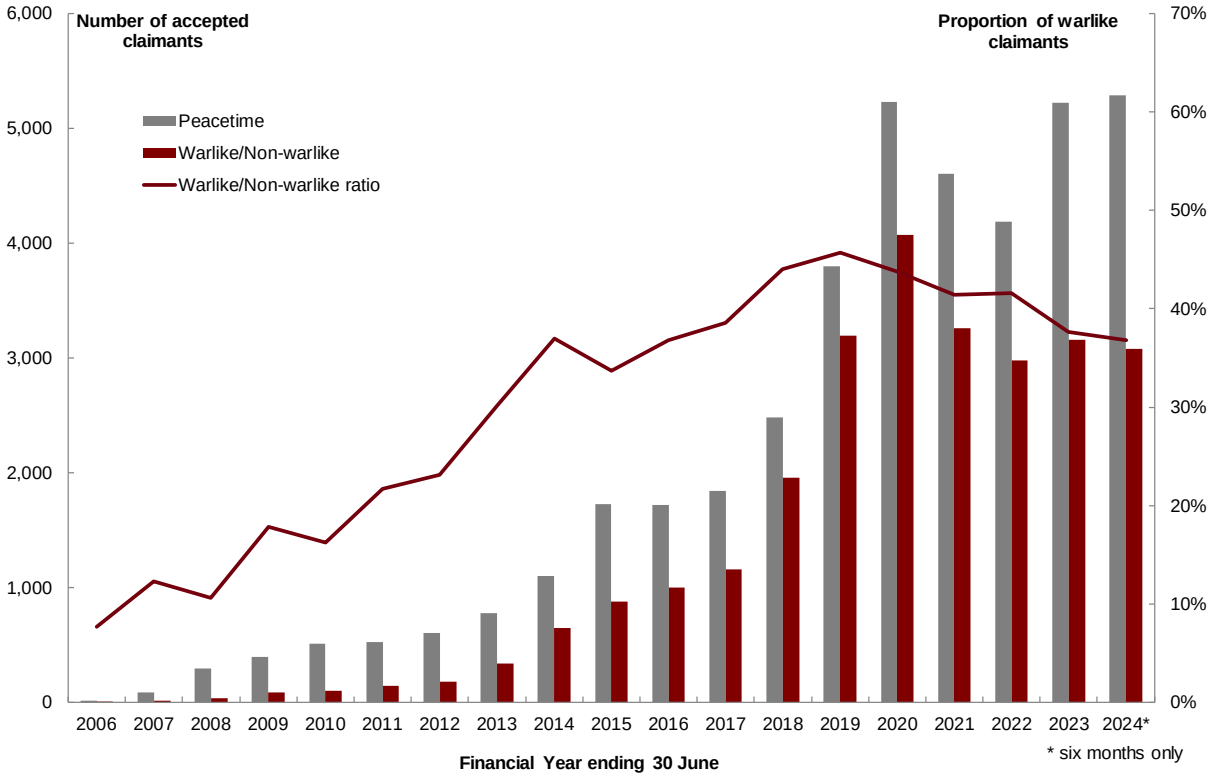
7.2.10 One-fifth of claimants in 2020 had 50 or more (incremental) impairment points awarded compared to one-quarter in 2023. Achieving an assessment of at least 50 impairment points brings with it a number of benefits; notably potential access to the Gold Card (which covers all health care costs, not just those related to the compensable injury), 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.

7.2.11 As mentioned in Section 7.1, veterans can receive an additional lump-sum payment under MRCA if they are severely impaired and have dependents. This additional Section 80 payment is available to veterans who have been assessed at 80 or more impairment points and are entitled to compensation for a permanent impairment. The additional payment is payable for each eligible young person that depends on the veteran for economic support at the assessment date. The increase in the number of veterans assessed at 80 or more impairment points has increased the number of Section 80 payments.

7.2.12 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 7.6 shows the number of recipients by nature of service over time. While the number of both warlike and peacetime claims has grown substantially over the period since 2011, growth has been greater for claims associated with warlike service; the proportion of warlike claims has

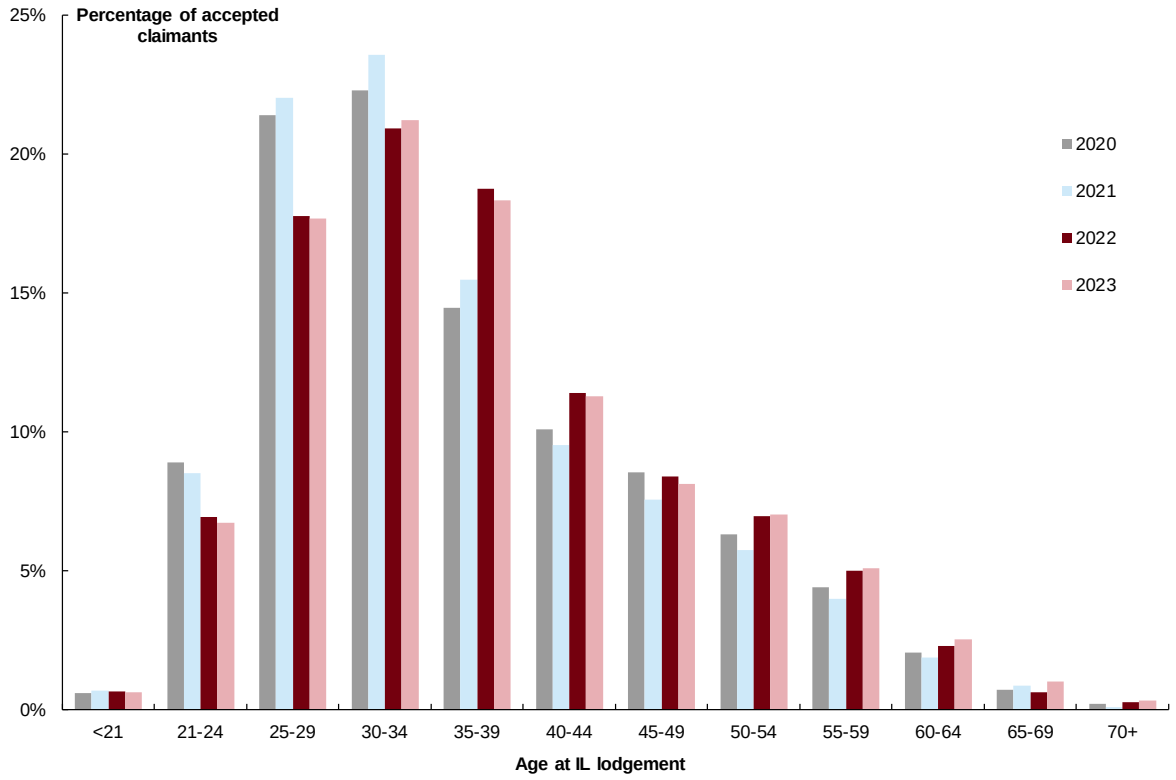
steadily increased since the inception of MRCA. More recently however, the proportion of warlike claims appears to have reduced a little from the peak in 2018-19. Note that in most cases it is not possible to unambiguously identify whether a claim is related to warlike or peacetime service. We have assumed warlike service if a claimant sustains injuries during both wartime and peacetime service.

Figure 7.6: Number of recipients by nature of service



7.2.13 We have also looked at the age distribution of claimants who have an accepted PI claim in the last four years. Figure 7.7 shows the number of claimants in each age band (being their age at time of lodgement). The age of claimants at the time of IL lodgement has increased by around 1.5 years over the period shown; there were substantially more claimants aged 35 to 44 years at IL lodgement and less claimants aged 21 to 34 years.

Figure 7.7: Age distribution chart



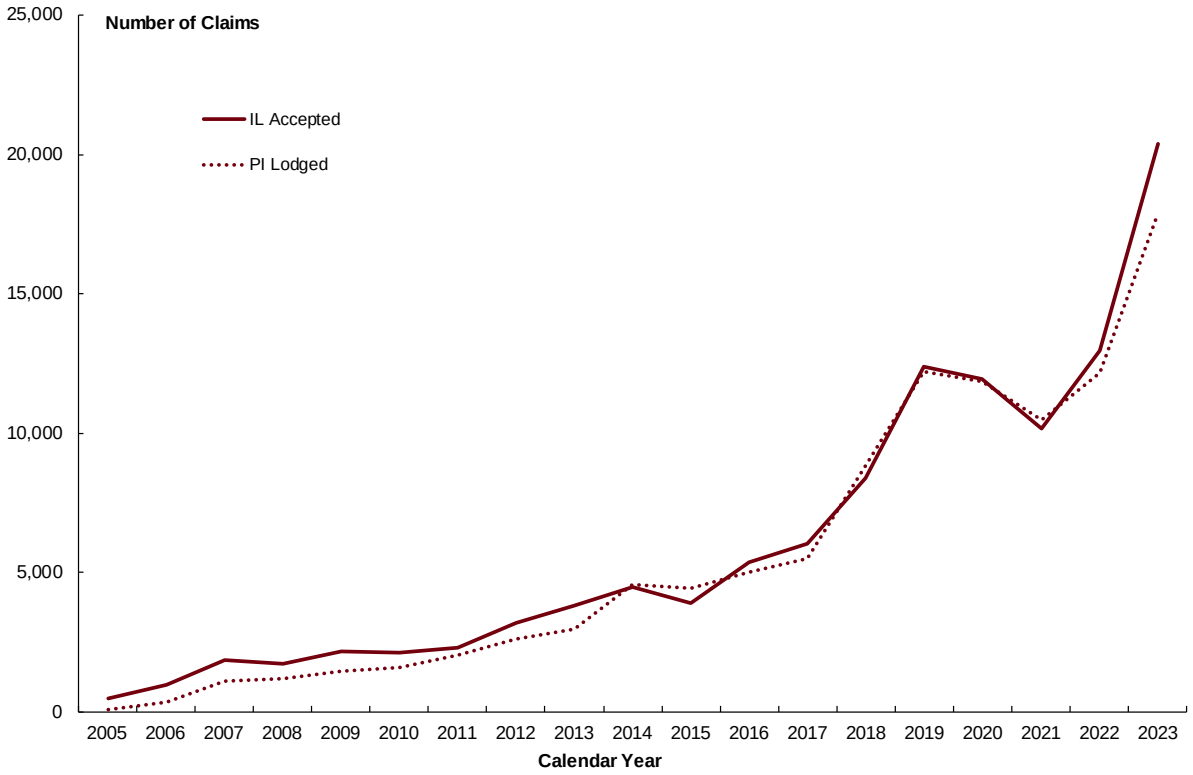
7.2.14 In our previous valuation, our average claim size assumptions were set based on assumptions around the mix of warlike and peacetime service-related claims (with allowance for this to change over time), the severity distribution for each type of claim, and the age distribution of claimants. For this valuation, we have changed our approach and 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.

7.3 Valuation Assumptions – Numbers of PI Claims

7.3.1 The high numbers of open claims in both IL and PI persist and continue to distort the observed experience. While there have been inroads made into processing, 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.

7.3.2 Figure 7.8 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 12 months, a direct result of the increase in IL claims accepted during this time.

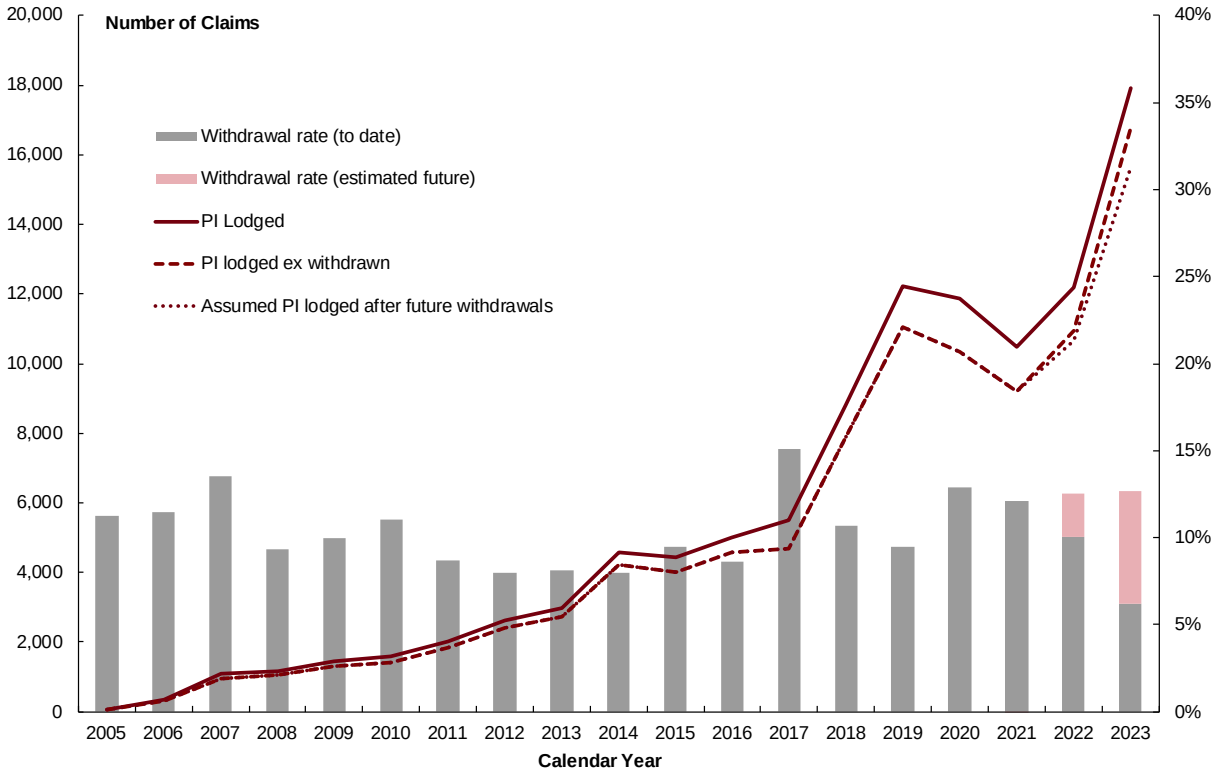
Figure 7.8: IL Claims Accepted and PI Claims Lodged, by calendar year



7.3.3 We note that due to the way MRCA claims are assessed, we cannot readily link the transition of IL claims into PI claims. Under the MRCA scheme, claims are assessed on a whole person basis, rather than individual injury assessments as for DRCA. As such, where a veteran has multiple injuries and multiple claims, it is not possible to determine which of the injuries led to a specific PI claim.

7.3.4 Figure 7.9 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 12 per cent of PI claims lodged in 2022 and 2023 will ultimately be withdrawn, similar to levels for 2020 and 2021.

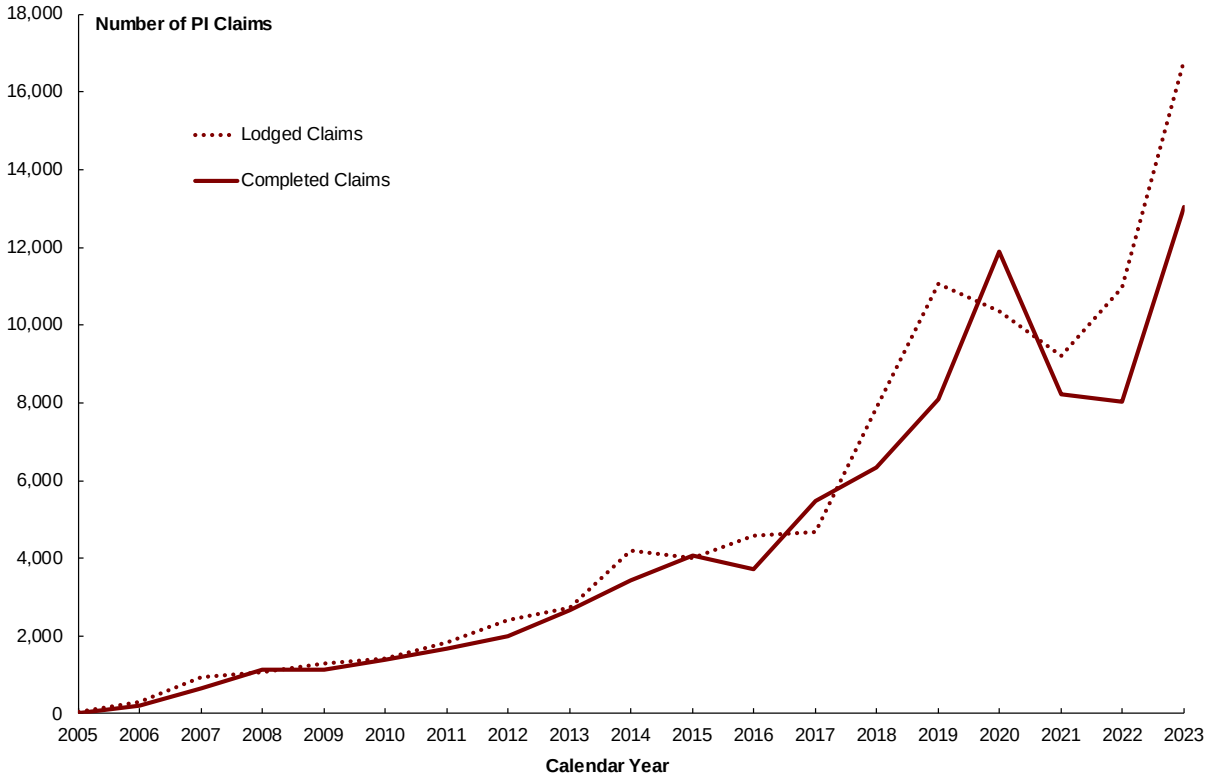
Figure 7.9: PI Claims Lodged including and excluding withdrawn claims, by calendar year



7.3.5 The combination of our assumptions around the conversion rate from IL accepted to PI lodged and our assumed ultimate PI withdrawal rate, results in around 85 per cent of ILs accepted resulting in a non-withdrawn PI lodgement.

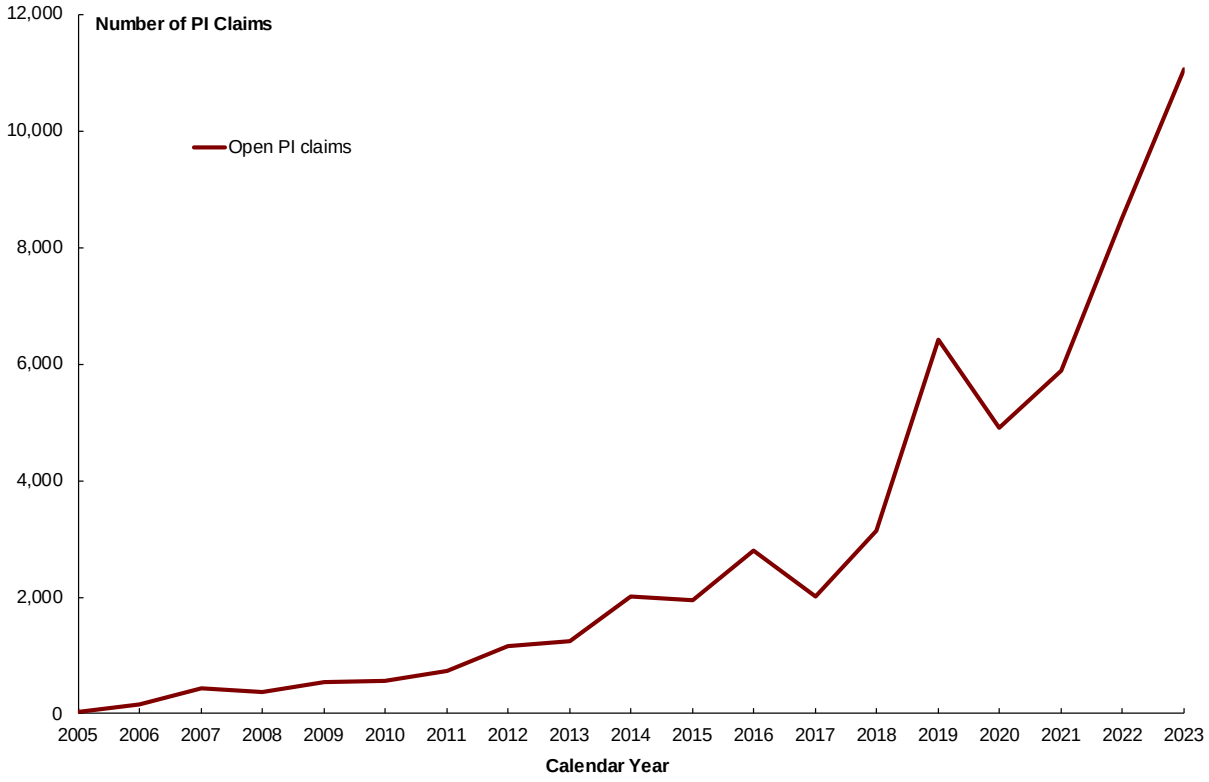
7.3.6 Figure 7.10 below shows the number of PI claims lodged (after withdrawals) and completed by calendar year. While the PI claims lodged in the last 12 months have increased dramatically, the number of PI claims completed has not kept pace with lodgements.

Figure 7.10: Lodged (after withdrawals) and Completed PI Claims



7.3.7 As a result of the significant gap between PI lodgements and PI completions in the last three years, the number of open PI claims has grown dramatically as shown in Figure 7.11. The number of open PI claims has continued to grow since the previous valuation; last year there were around 8,500 open PI claims as at 31 December and there are now over 11,000 as at 31 December 2023.

Figure 7.11: Open PI Claims

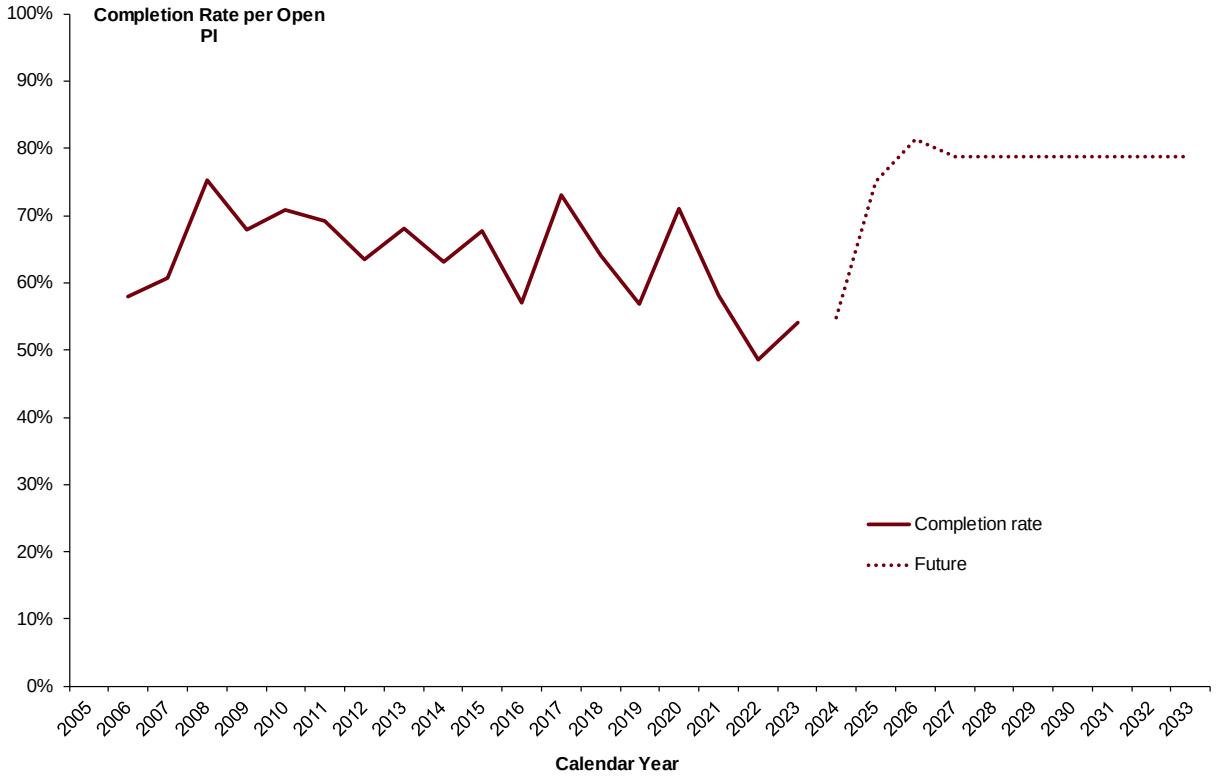


7.3.8 With the new model we have developed for this valuation, the number of future PI lodgements are directly linked to the number of ILs accepted, which are in turn directly linked to ILs completed. As discussed in Section 5, our model projects IL completions per open IL, therefore directly incorporating an allowance for the current open IL claims and the anticipated completion of these claims over 2024-25. As such, we expect a further influx of PI lodgements in the next two years as the ILs are processed and accepted.

7.3.9 PI completions are then projected per open PI claim. This approach directly incorporates allowance for the current open PI claims, the expected influx in new PI lodgements in the next year, and the completion of current open claims over the next two years.

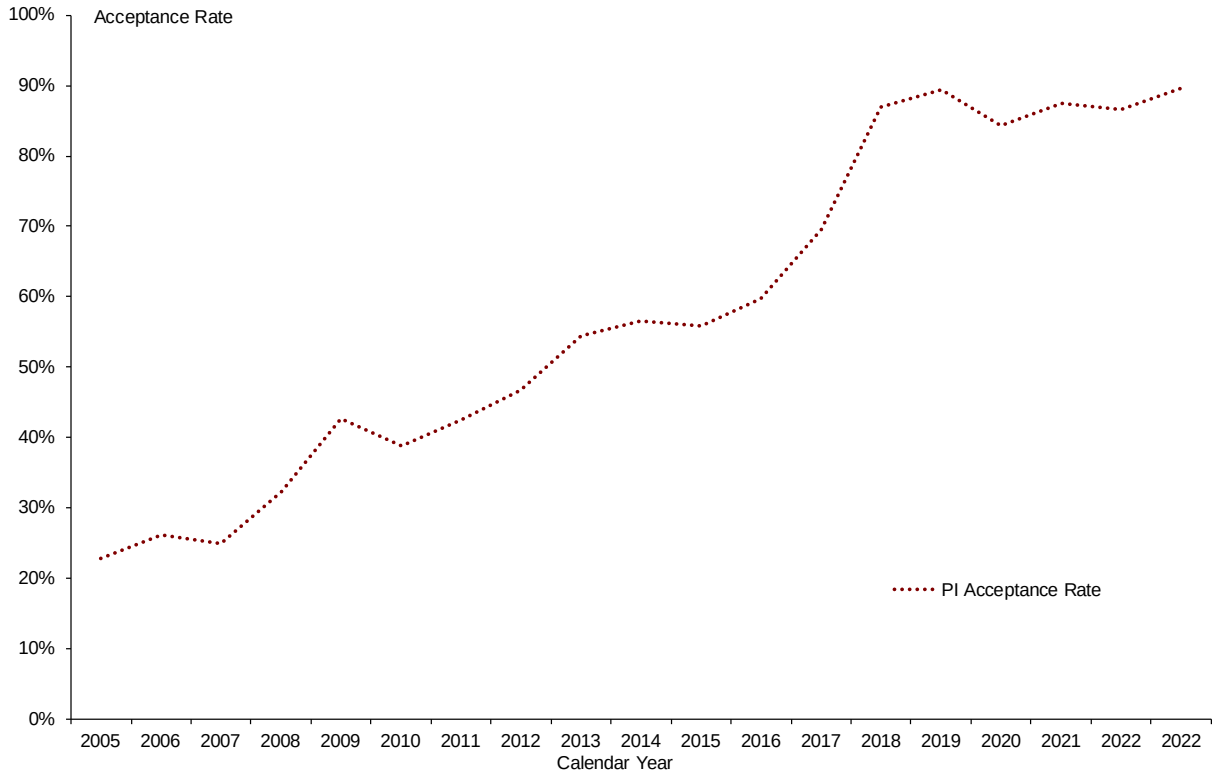
7.3.10 Figure 7.12 shows the completion rates per open claim. While the completion rates have varied a little over time, the completion rate was particularly low in 2022 (due to processing constraints). The completion rate was higher in 2023 but remains well below historical levels. We have projected a completion rate for 2024 that is similar to 2023, before increasing significantly in 2025 and 2026 (to 75 per cent and 81 per cent respectively) as we understand resources will be directed to processing permanent impairment claims in those years. We have assumed a longer-term completion rate of 79 per cent which is higher than the historical level of around 65 per cent. This longer-term assumption assumes that a higher level of resourcing is maintained into the future, enabling a "float" of open claims equal to around one quarter or a year's lodgements.

Figure 7.12: PI completion rates



7.3.11 Figure 7.13 below shows the acceptance rates for PI claims since 2004. Acceptance rates have been stable (and high) at an average of 87 per cent since 2018, coinciding with Veteran Centric Reform. We have assumed a permanent impairment acceptance rate consistent with this experience.

Figure 7.13: PI Acceptance Rates



7.3.12 Figure 7.14 shows, by accident year, the number of accepted PIs as at 31 December 2023 and our projected future accepted PIs. Figure 7.15 shows the same information summarised by acceptance year (including allowance for new accidents). The large number of accepted PIs projected in the next three years reflects the planned processing of current open IL and PI claims.

Figure 7.14: MRCA Actual and Projected Accepted PIs by Accident Year

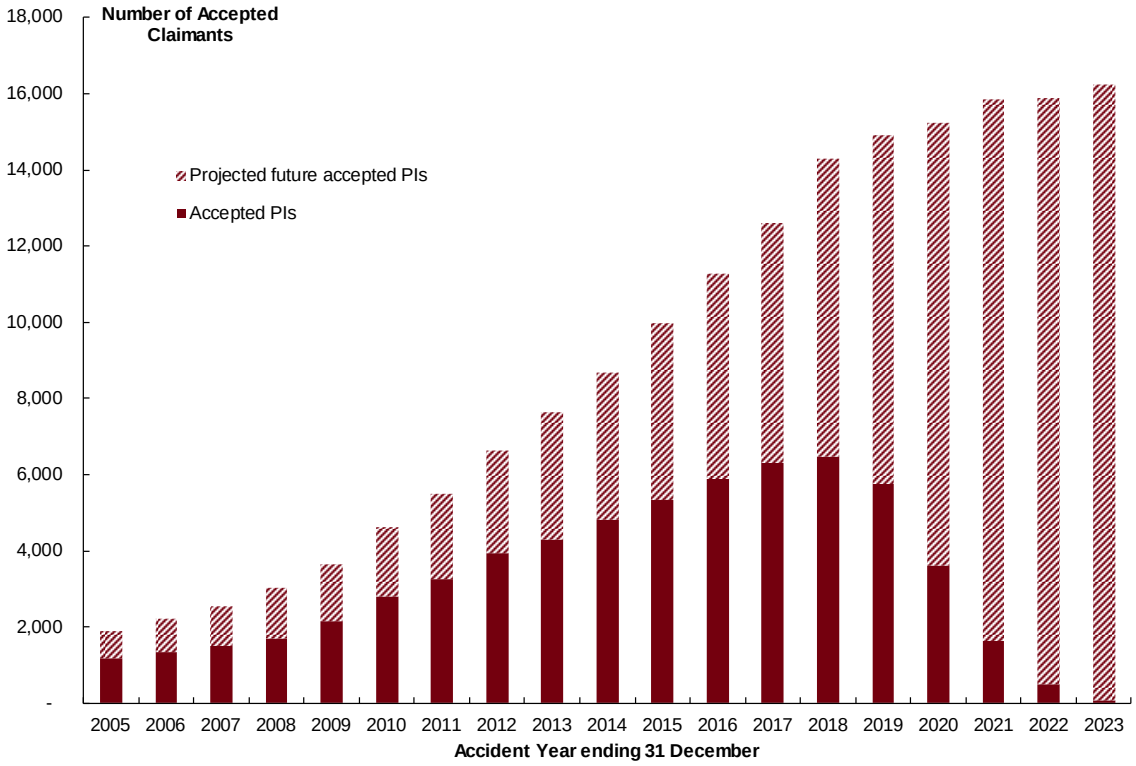
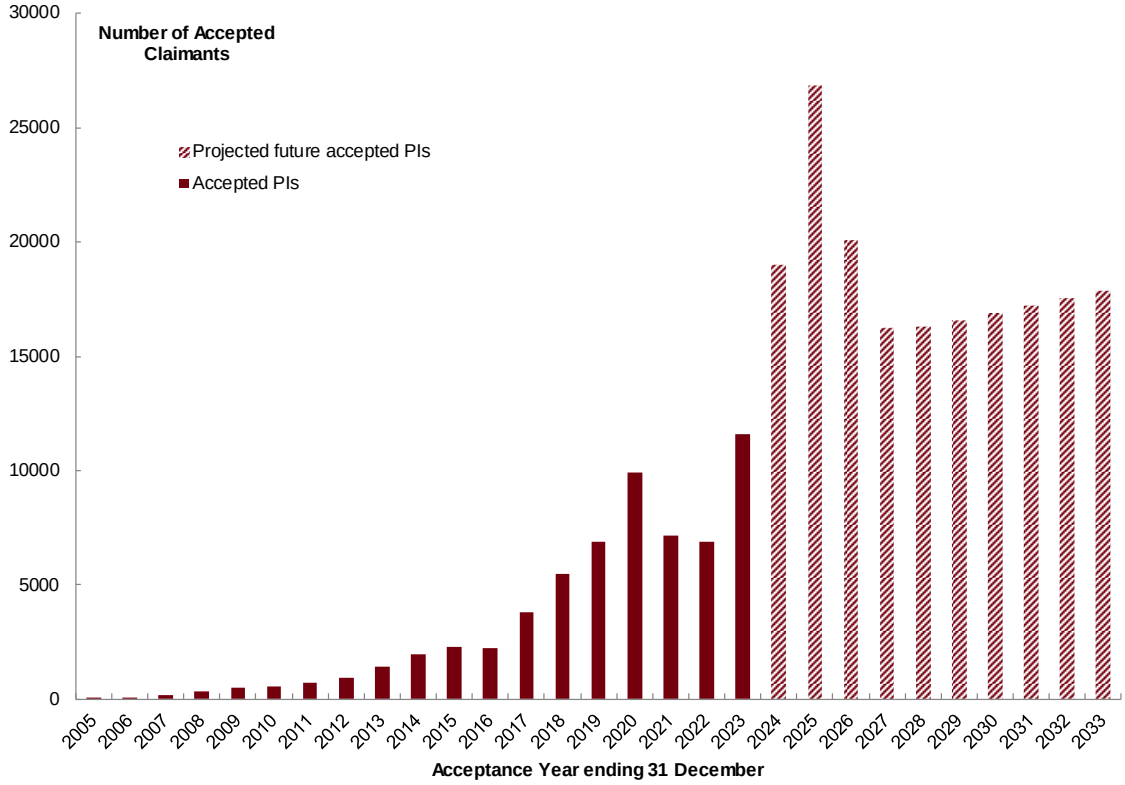


Figure 7.15: MRCA Actual and Projected Accepted PIs by Acceptance Year



7.3.13 While it is not straightforward to directly compare our ultimate number of claims adopted this year to those used in the 2022 valuation (due to the changes in approach and definitions), we

have increased our adopted numbers of claims considerably in response to the emerging experience. This is primarily due to the substantial increase in new ILs lodged in the last year that are expected to flow through to substantially more PI claims, and an expectation that this higher level of IL lodgements will be maintained into the future.

7.4 Valuation Assumptions – Average Claim Size

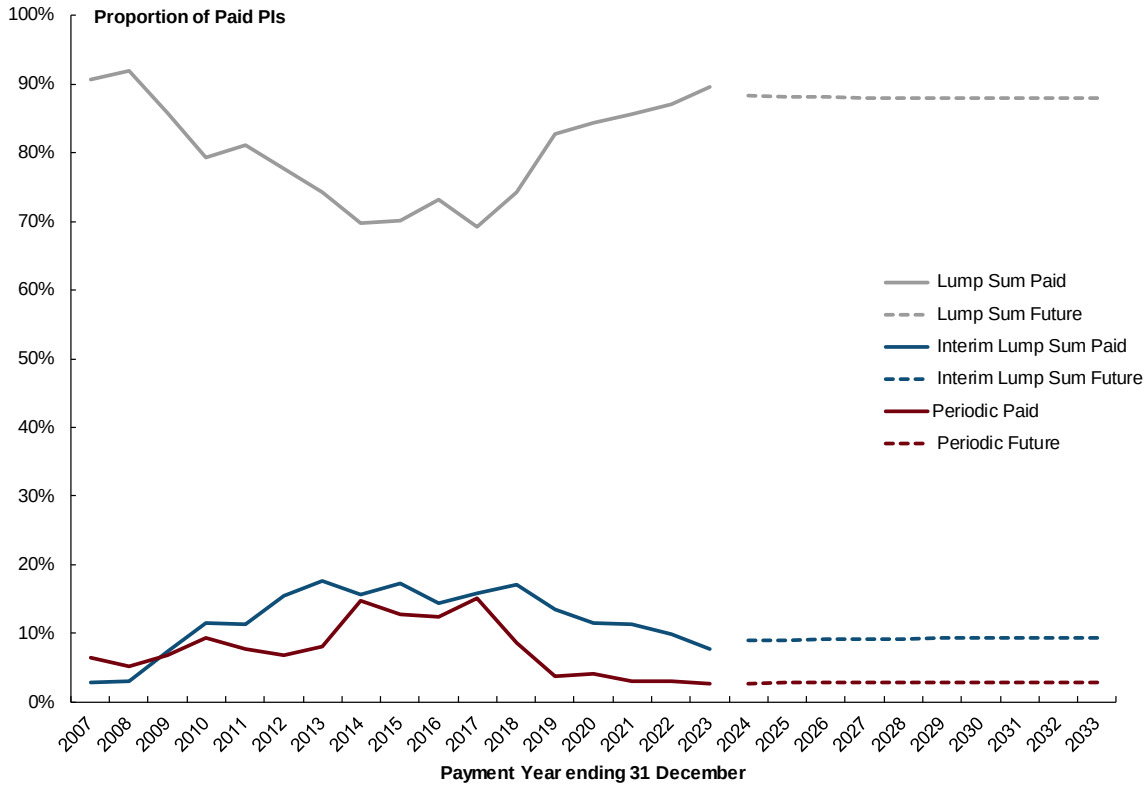
7.4.1 Our overall adopted average claims size is comprised of the following assumptions:

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

7.4.2 For each of the assumptions, we have adopted assumptions that vary by delay since accident. The average claim size tends to be lower at early delays (as those with less complex injuries are able to be finalised more quickly), increasing with delay since accident, before reducing again at later delays (as claimants at these later delays will include those receiving a “top up” or additional lump sum if their condition has deteriorated i.e. some lump sum payments at later durations are only partial lump sums).

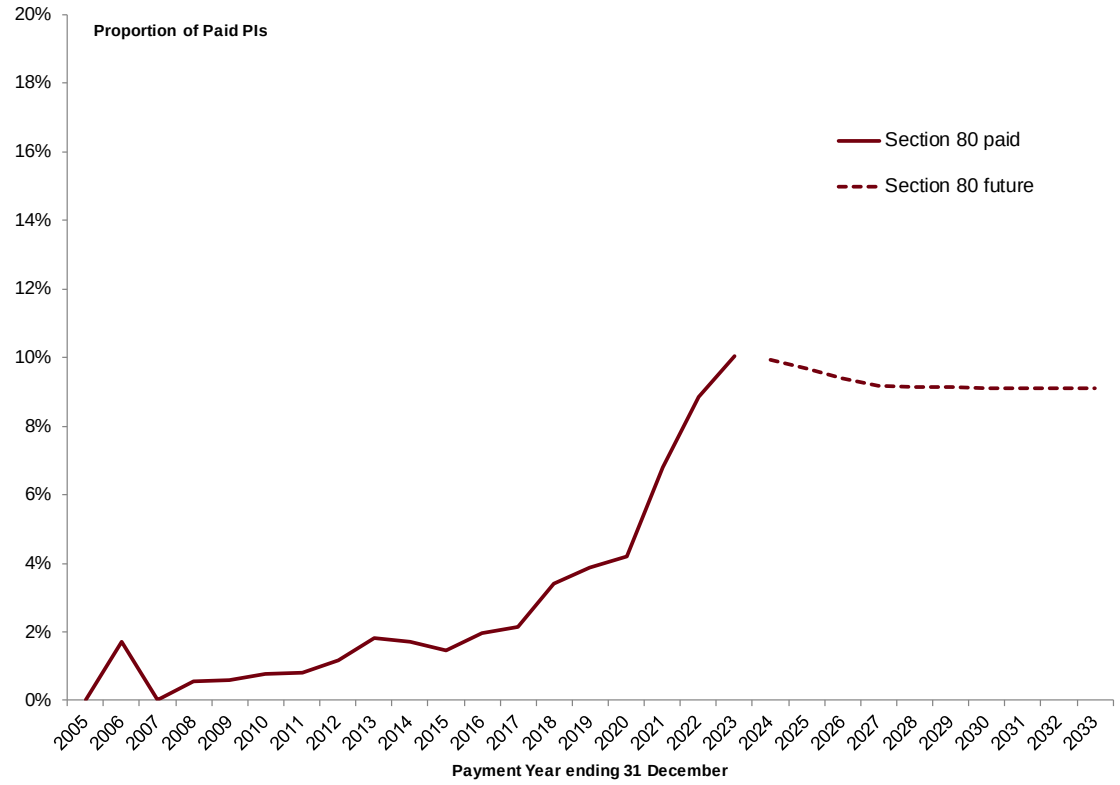
7.4.3 Figure 7.16 shows the historical and projected mix of payments by type of PI. The proportion of PIs paid as non-interim lump sums has increased over the last five years while the numbers electing to choose a periodic payment has reduced with only 3 per cent of claimant electing this payment type. The number of interim lump sums has also reduced which may be impacted by processing delays; if claimants have to wait longer for their PI to be assessed, then there is a higher likelihood that the injury would have stabilised before assessment. We have assumed the mix of PI payments by payment type will be similar to the most recent experience.

Figure 7.16: Mix of PIs by Type of Payment



7.4.4 Figure 7.17 shows the historical and projected loadings assumed for the number of claimants in receipt of a Section 80 benefit. We have assumed that around 9 per cent of future PI claimants will be eligible for a Section 80 benefit. This assumes that there is no further deterioration in the proportion of claimants exceeding the 80 whole person impairment point threshold.

Figure 7.17: Proportion of PI Claimants in receipt of a Section 80 Benefit

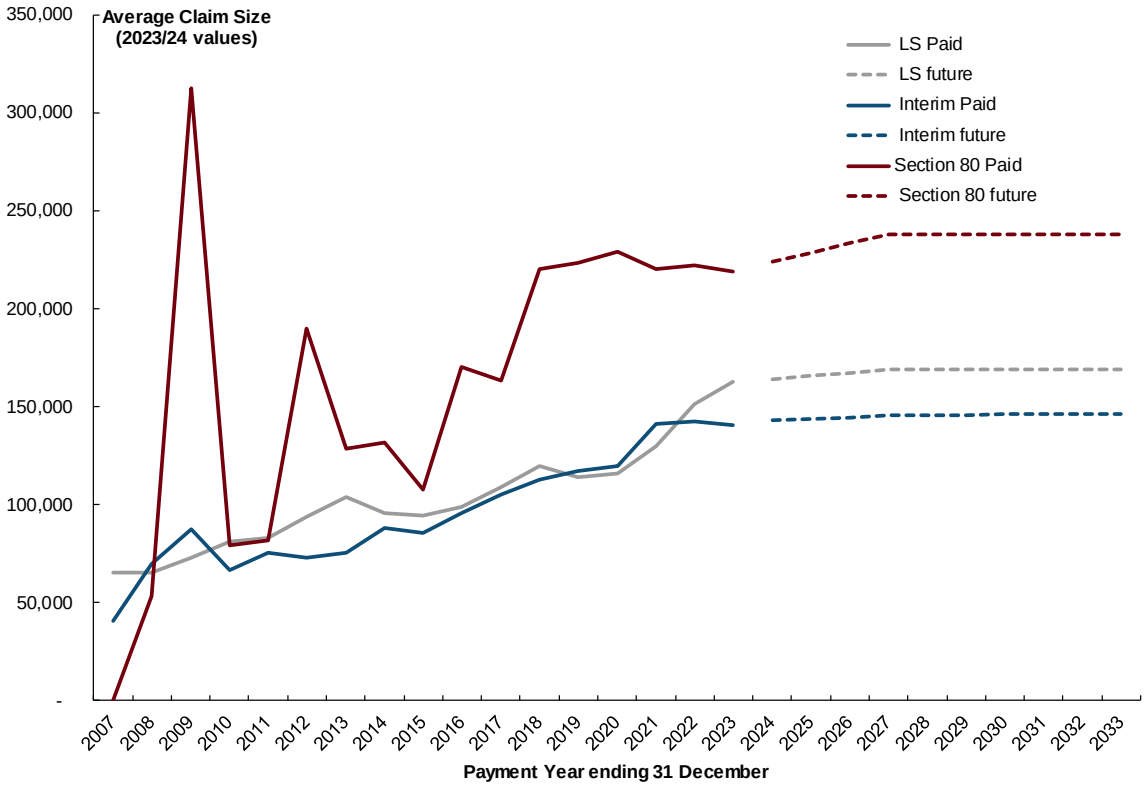


7.4.5 Figure 7.18 shows the historical and projected average claim sizes for each of the PI payment types. The average size for periodic benefits is not shown as we use an annuity method to value these payments as discussed below. All amounts shown include any arrears payments and are in 2023 calendar year values i.e. past payments have been inflated to current values, and future amounts do not yet have indexation added. We have however included superimposed inflation in the adopted average claim sizes of 2 per cent per annum over the next four years. This superimposed inflation allowance is included in the projected average claim sizes shown and is discussed further in section 7.5 below.

7.4.6 We have adopted average claim sizes for each PI payment type for 2024 based on the experience in the most recent 1 to 2 years.

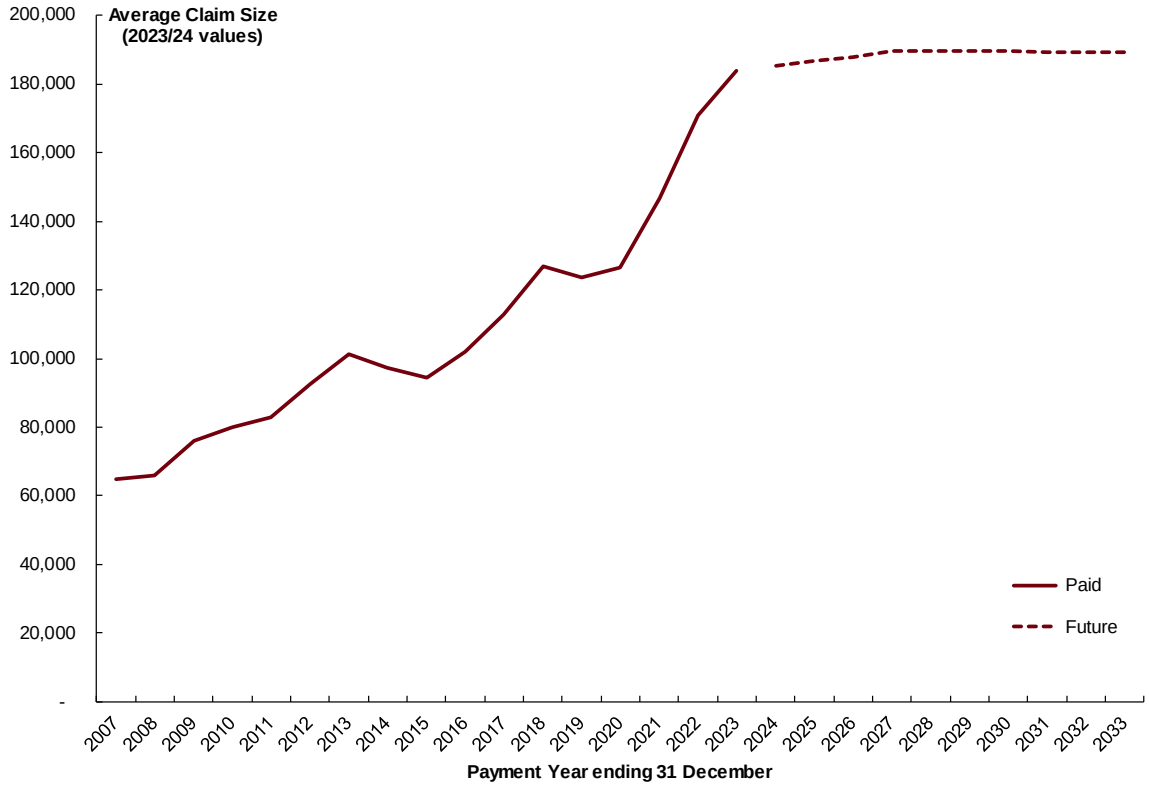
7.4.7 The selected average claim size for Section 80 payments represents an average of two dependants per claimant.

Figure 7.18: Average size of PIs by Payment Type



7.4.8 Combining the above assumptions on the mix of claims by type and the selected average claim sizes results in an overall average claim size as shown in Figure 7.19. 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.

Figure 7.19: Overall average PI claim size



7.4.9 For periodic payments, we have applied an annuity method to those currently in receipt of a periodic payment. The claimants are valued individually, using their actual fortnightly PI payment amount and current age to project future payments. Allowance is made for future claimants to receive periodic payments, with the average payment amount and adopted average age derived from the recent experience of those currently in receipt of a periodic payment.

7.5 Valuation Assumptions – Inflation assumptions

7.5.1 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 2022 valuation.

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

- the very high levels of superimposed inflation observed over the history of the scheme, which warrants inclusion of some superimposed inflation.

- the historical drivers of superimposed inflation may not continue into the future. DVA postulates that recent superimposed inflation may be driven by increasing numbers of medically discharged veterans who are presenting with higher injury severity. There is also the possibility that processing constraints have resulted in higher numbers of conditions being considered in a PI claim, which is highly correlated with the resulting benefit

payment. Further, the proportion of PI claims with warlike service is expected to reduce in the future which may act to reduce future average claim size. Average whole person impairment scores have also increased over time, however there is a natural upper limit on impairment levels.

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

7.5.3 On balance, we have adopted 2 per cent per annum superimposed inflation for the next four years for this valuation. A period of four years was selected to coincide with the anticipated clearance of the IL and PI open claims, before nominal inflation reduces to be in line with price inflation. This is an increase from the 0 per cent assumption adopted for the 2022 valuation.

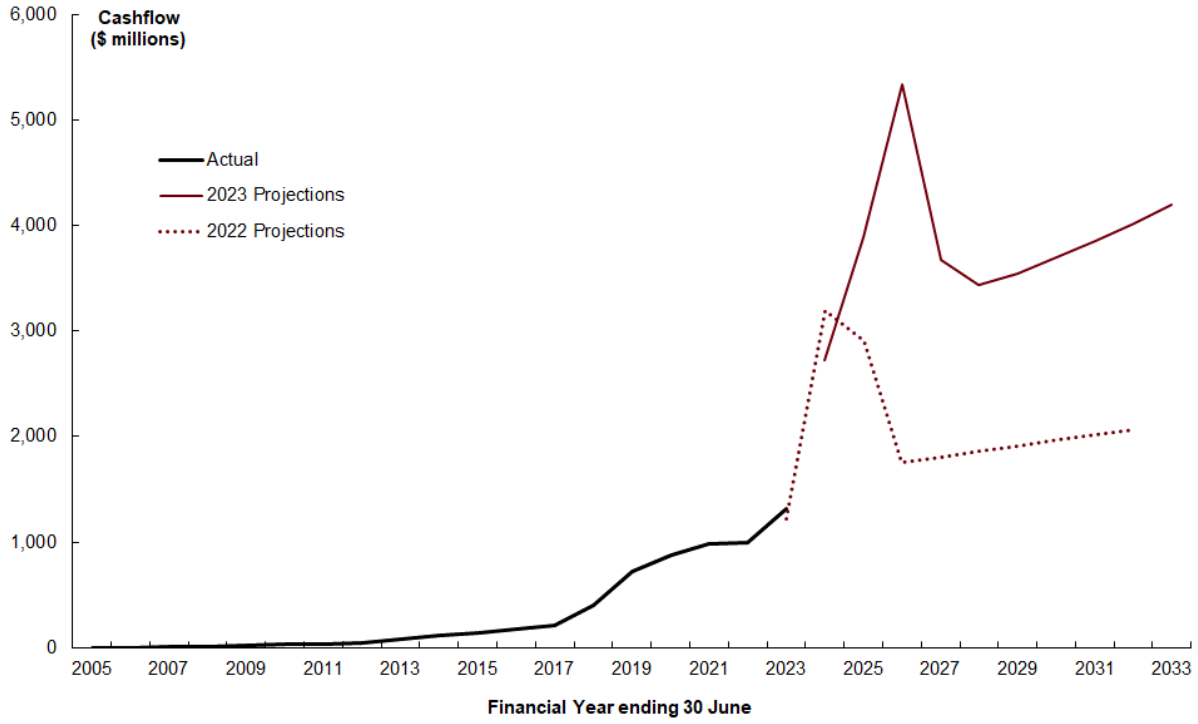
7.5.4 We have applied the superimposed inflation to projected average claim sizes for non-interim lump sums, interim lump sums and Section 80 payments. The inclusion of superimposed inflation in Section 80 payments can be thought of as an allowance for increasing proportions of claimants being assessed as above 80 impairment points.

7.6 Cashflows

7.6.1 Figure 7.20 shows the historical and projected cashflows for MRCA permanent impairment payments generated by these assumptions. We note that the level of future cashflows will be influenced by the level of processing capacity available and the level of future claims experience. As with DRCA PI, a timing adjustment has been applied to the cashflow projection to reflect current and projected staffing levels within DVA. These adjustments assume increased processing capacity will eventuate and are based on DVA's internal DDFM.

7.6.2 It is not possible for us to independently forecast staffing levels within DVA, and as such we have relied on internal modelling and guidance provided by the department. Specifically, we have been advised that the recruitment activities undertaken in the last year or so are expected to result in the completion of current open IL claims in the 2023-24 and 2024-25 years. A focus will remain on IL processing until open claims are cleared, and then attention will turn to focus on processing PI claims. The number of open PI claims is expected to increase with the influx of lodged PI claims as the IL claims are cleared, before open PI claims are cleared over the 2024-25 and 2025-26 years. As such, we expect heightened levels of payments over the 2024–25 and 2025–26 years before payments return to expected baseline levels. Should the expected clearance of either the open IL or PI claims not eventuate, then the timing adjustments applied to the projected cashflows will not eventuate.

Figure 7.20: Historic and projected MRCA permanent impairment payments



7.7 Liability Estimate

7.7.1 Table 7.1 shows the outstanding liability at 30 June 2023 in respect of permanent impairment claim payments broken down by year of accident.

Table 7.1: Outstanding claims liability for permanent impairment claims by year of accident

Year of accident – year ending 30 June	Liability ($'m)
2005	94.2
2006	103.9
2007	123.9
2008	153.8
2009	183.6
2010	216.2
2011	280.5
2012	364.9
2013	472.8
2014	593.6
2015	727.0
2016	892.8
2017	1,077.7
2018	1,342.6
2019	1,646.1
2020	2,004.9
2021	2,411.4
2022	2,620.0
2023	2,659.9
Total	**17,969.5**
Expected at 30/06/2023	*11,345.5*
Total at 30/06/2022 (taken from previous report)	**10,618.5**

7.7.2 The 2022 review projected that the MRCA liability as at 30 June 2023 would be $11,345.5m. The current estimate is $17,696.5m. Table 7.2 reconciles the liability estimate for PI payments with the corresponding estimate at the previous valuation. We note that due to the changes made in approach at this valuation that the reconciliation should be viewed as indicative rather than precise.

Table 7.2: Reconciliation of liability for permanent impairment payments

	$m
Liability estimate at 30/06/22 (previous report)	**10,618.5**
Assumed Interest	535.7
Projected Payments	(1,224.9)
Notional Premium	1,416.2
Projected liability as at 30 June 2023 (previous valuation)	**11,345.5**
Experience effects and assumption changes	
Additional open claims compared with expected	60
Increase in claim numbers	2,090
Higher indexation at 1/7/23 than allowed for	680
Superimposed inflation in 2022/23	1,600
Revision to average claim size assumption	1,220
Allowance for future superimposed inflation	860
Change in periodic payment valuation	110
Current Estimate	**17,969.5**

7.7.3 The main items that have driven the increase in the liability are:

- $60 million addition due to fewer PI claims being paid in the year to 30 June 2023 compared with expected;
- $2,090 million addition due to higher adopted claim numbers. As discussed in Section 7.3.13, this is primarily due to the substantial increase in new ILs lodged in the last year;
- $680 million due to a higher rate of indexation in the year of 7.8 per cent compared with the 2.5 per cent allowance in our 2022 valuation;
- $1,600 million increase due to superimposed inflation in 2022-23 of around 12 per cent compared with zero allowance in our 2022 valuation;
- $1,220 million increase due to further revisions in our adopted average claim size. With the benefit of hindsight, our view now is that our previous average claim size assumption was too low and current levels are likely to persist into the future;
- $860 million increase to allow for superimposed inflation of 2 per cent per annum over the next four years;
- $110 million increase in the annuity valuation of periodic payments. This reflects both an increase in the fortnightly periodic payment plus allowance for higher numbers of future recipients of periodic benefits.

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 a service-related condition. Payments are made fortnightly and are paid at a level related to the recipient's salary prior to injury. Incapacity payments are initially payable at a replacement rate of 100 per cent of pre-injury earnings. After 45 weeks on incapacity payment, the replacement rate decreases to between 75 and 100 per cent, depending on the number of hours worked each week. Veterans fully incapacitated from work receive 75 per cent of pre-injury earnings. Actual employment earnings and any Commonwealth superannuation (including both pension and lump sum) payments received by the veteran are offset against incapacity benefits. Incapacity benefits cease at Age Pension age in most cases.

8.1.2 Veterans must provide current medical evidence and employment information when required to remain on incapacity payments. Incapacity recipients may also be expected to participate in a rehabilitation program designed to increase their capacity for suitable employment. Rehabilitation programs may involve both vocational and non-vocational assistance, including a period of facilitated job search assistance for veterans assessed as having the potential to return to work. The success of these rehabilitation programs will impact the duration which veterans remain on incapacity benefits. The modelling of rehabilitation benefits is discussed further in Chapters 11 and 12.

8.1.3 Veterans eligible under the MRCA with significant restrictions to their capacity to work are eligible for the Special Rate Disability Pension (SRDP) which is an alternative form of compensation. Veterans that have been assessed at 50 or more impairment points and are unable to undertake paid work for more than 10 hours per week and where rehabilitation is unlikely to be effective are offered a choice between receiving incapacity payments or receiving SRDP. SRDP payments are tax-free and continue indefinitely past retirement age, provided the recipient continues to maintain a whole person impairment score of 50 or more and are unable to undertake remunerative work of 10 hours or more per week. The offsetting arrangements that apply to SRDP (including full or partial offset of any permanent impairment or Commonwealth superannuation payments) may mean that the SRDP amount payable is less than that available under incapacity. Veterans must seek financial advice before commencing SRDP payments, and reimbursement is available from the costs incurred in obtaining this advice.

8.2 Modelling Approach

8.2.1 A new 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 2023, where the age distribution, duration in receipt of benefits and rates of payment are known) as well as future new episodes (which may relate to prior or future injuries). The continuance rates and fortnightly payment amounts are assumed to vary by the

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

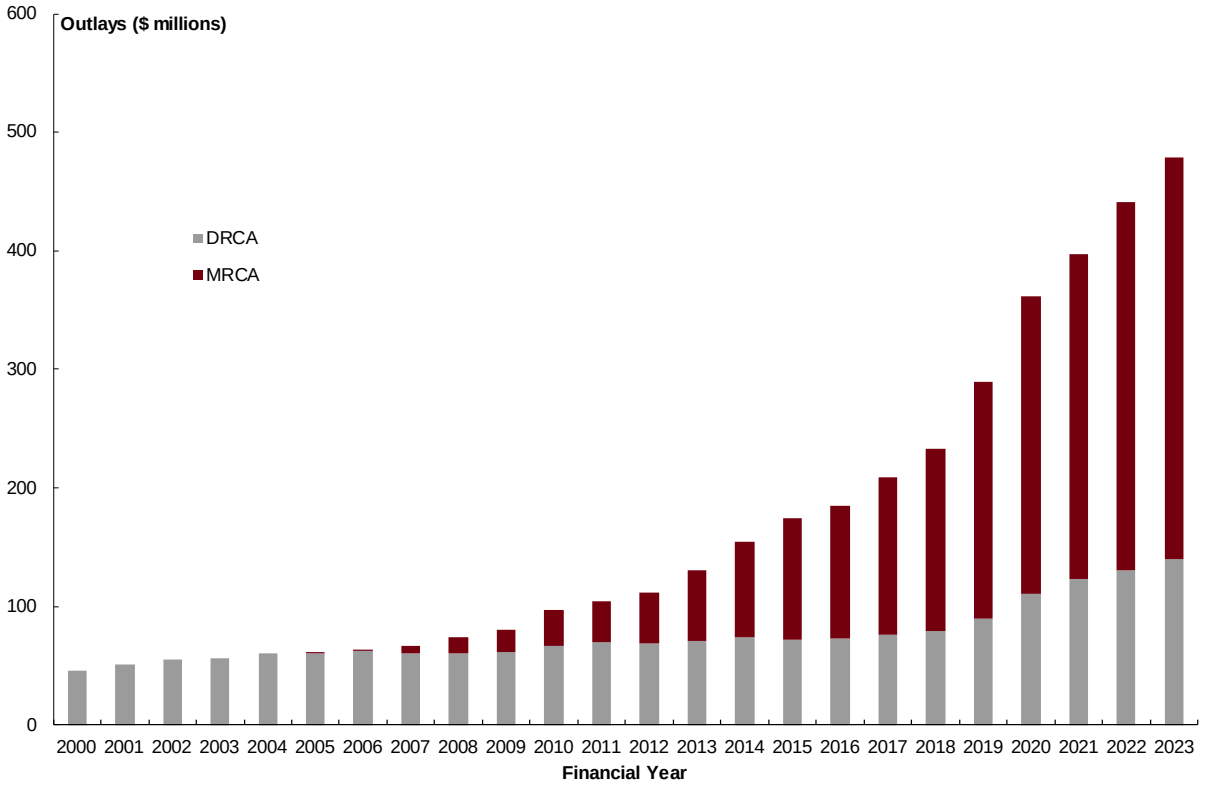
8.2.2 At previous valuations, we made a distinction between payments made in the first 12 months of an incapacity episode (referred to as short-term payments) and payments made after a recipient has been in receipt of incapacity payments for more than 12 months (referred to as long-term payments). For this valuation, we have removed this distinction between short-term and long-term recipients and have instead considered episode duration as a continuous variable. This approach still recognises the impact of duration on both continuance rates and fortnightly payment rates but allows for a more nuanced approach in assumption setting.

8.2.3 In 2023, we received additional incapacity periods data. This data was extracted from ISH and shows the incapacity payment rate applicable in each period. For this valuation, we have revised our methodology to utilise the incapacity periods data to a greater extent. This has removed the need to define episodes based on business rules, particularly in relation to the allocation of lump sum arrears payments to fortnightly periods and number of periods without a payment required to deem an episode as completed. We have also taken a longitudinal approach to assumption setting, considering the experience of different cohorts of incapacity recipients over time. While the new methodology allows for greater granularity in assumption setting, particularly when looking at the impact of duration on continuance probabilities and fortnightly payment rates, it does mean that the assumptions adopted in this year's valuation are not directly comparable with those used in last year's valuation model.

8.3 Recent Experience

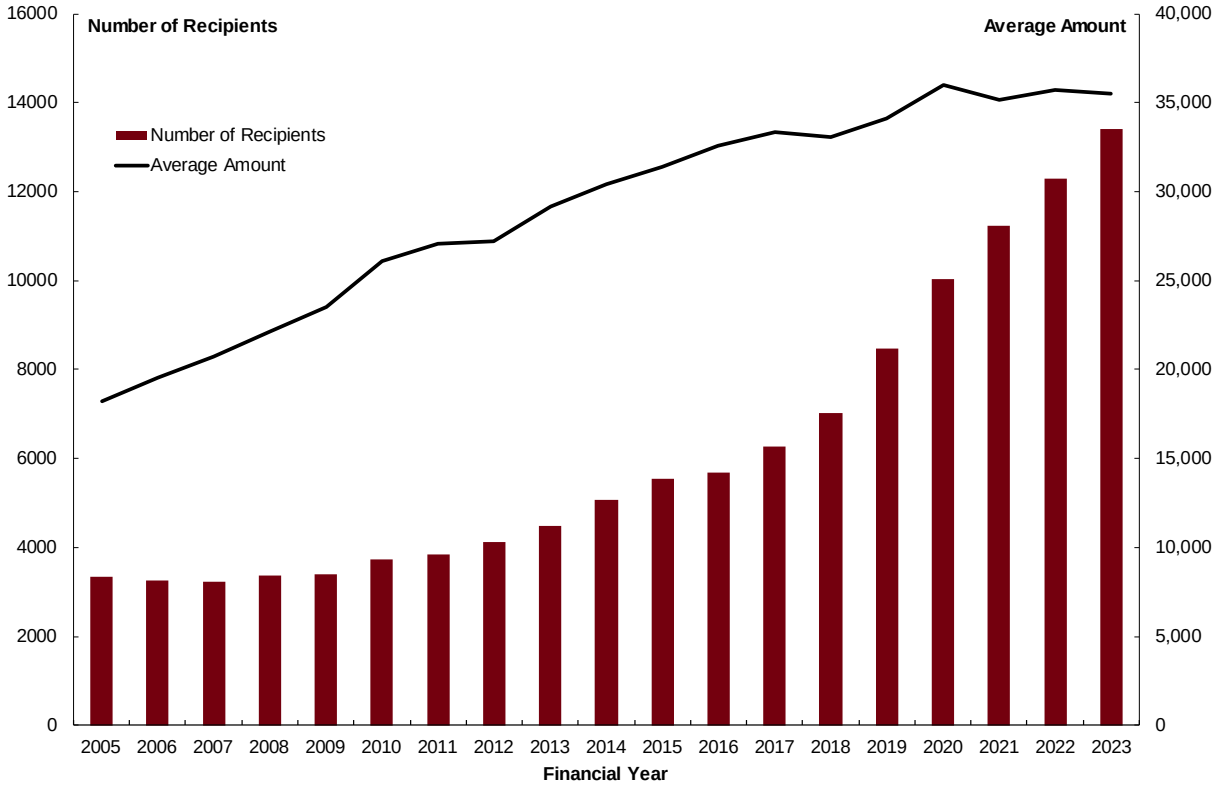
8.3.1 Figure 8.1 shows the expenditure on incapacity payments since 2001. The payments to 2011 reflect a period of relatively slow growth; DRCA outlays remained stable and the MRCA scheme, which was introduced from 1 July 2004, was beginning to increase. From 2012 to 2018, there has been a strong upward trend in expenditure, mainly driven by growth in outlays paid under MRCA. From 2019, outlays increased significantly for both MRCA and DRCA, 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: Total expenditure on incapacity payments



8.3.2 Figure 8.2 shows that early experience to 2011 was characterised by relatively stable recipient numbers but increasing average payment size. Between 2012 and 2017, we saw both increasing claimant numbers and increasing average payments. From 2017, there has been significant growth in the number of claimants which has continued in the most recent year. Average payments have exhibited stability since 2020. Note that the average amount represents the average annual payments made during the financial year. Given that not all incapacity recipients will be paid for the full year, the average amounts shown here will be less than that implied by the average fortnightly payment rates discussed later in this section.

Figure 8.2: Number of incapacity recipients and average annual payments



8.4 Valuation Assumptions

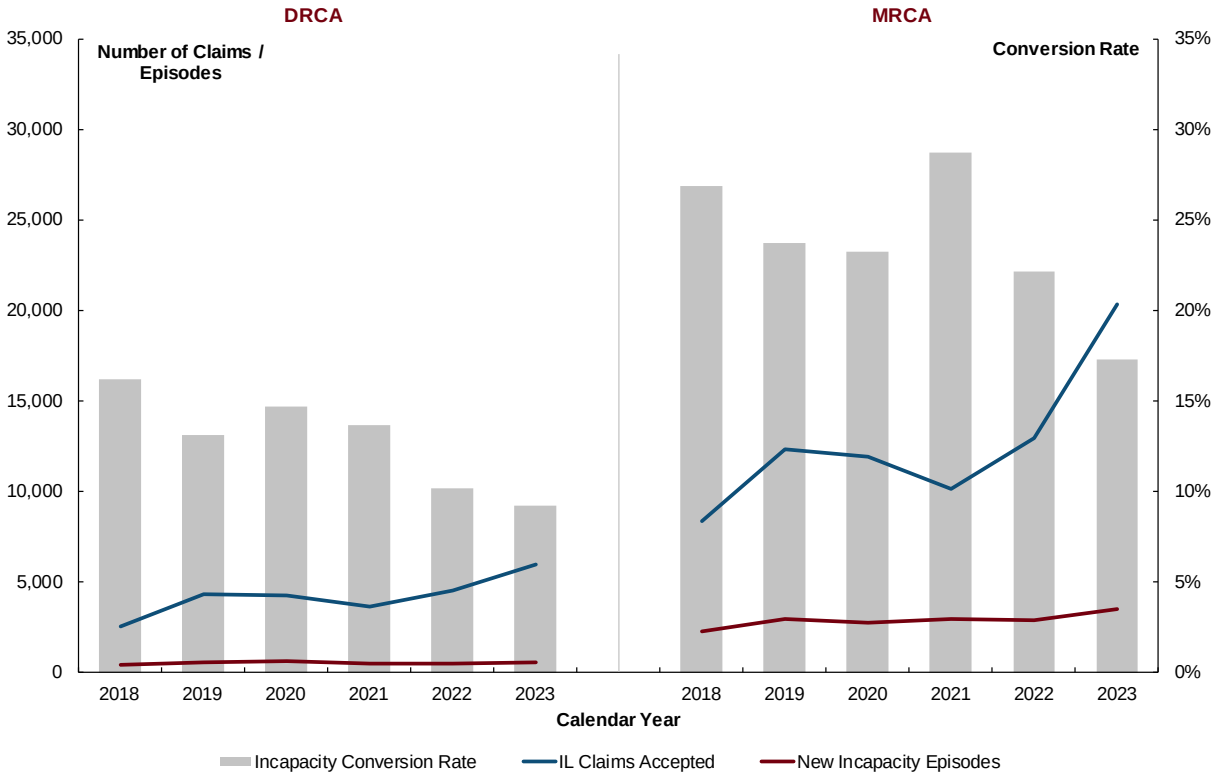
8.4.1 Broadly speaking, the incapacity model requires three main assumptions:

- 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 each incapacity recipient 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 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 8.3 below shows the number of IL claims accepted and new incapacity recipients since 2018 for both DRCA and MRCA. While there appears to be a relationship between the number of IL claims accepted and new incapacity episodes in a period, the conversion rate is relatively low (in comparison to permanent impairment for example) and the correlation is not particularly strong. This is not necessarily surprising as not all conditions compensable under permanent impairment are expected to result in reduced capacity to work and a loss of income. Moreover, a veteran can only have a single open incapacity claim at a given time but may lodge multiple permanent impairment claims in any given year.

Figure 8.3: Conversion between number of IL claims accepted and new incapacity episodes



8.4.3 In the most recent financial year, 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. This could be due to prioritisation of IL claims in previous periods leading to a somewhat biased pool of outstanding IL claims waiting to be processed. We have assumed that the recent lower conversion rate between IL claims accepted and new incapacity episodes is a temporary phenomenon and the new episode projection assumes that the transition rate will return to historical levels once the open claims have been cleared.

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

Figure 8.4: DRCA incapacity commencements by development year

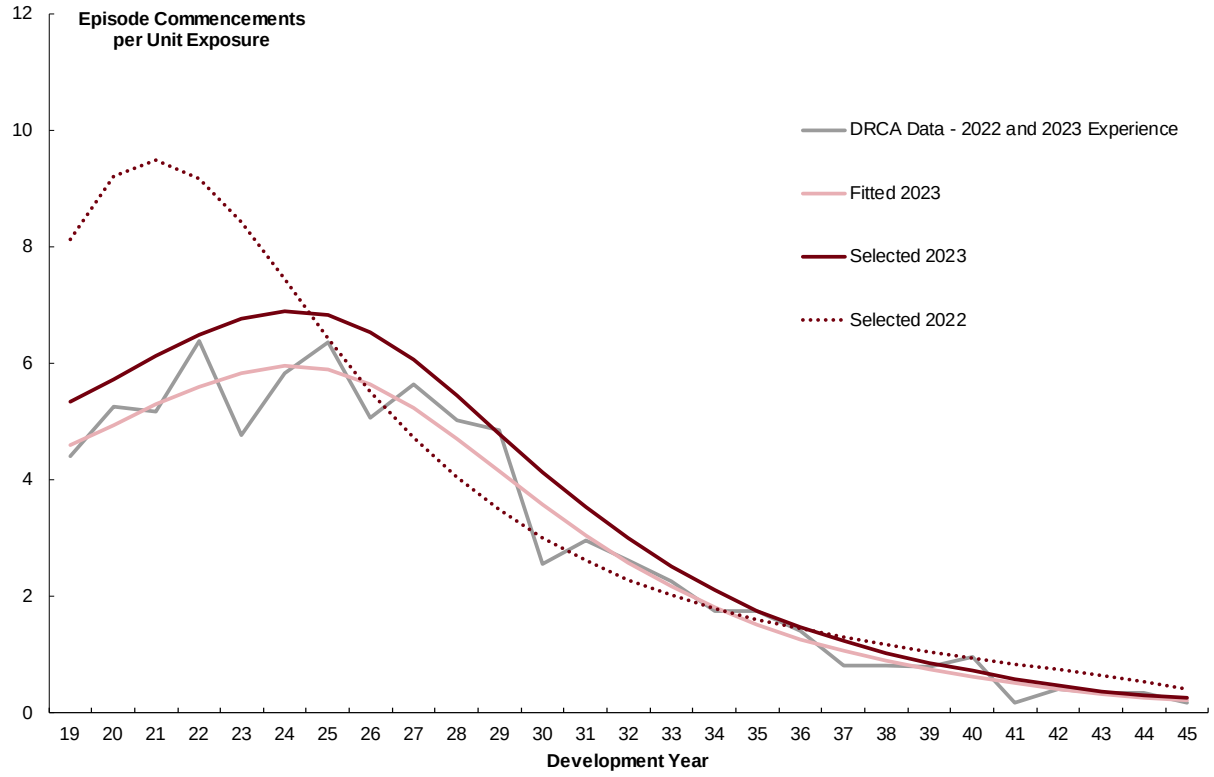
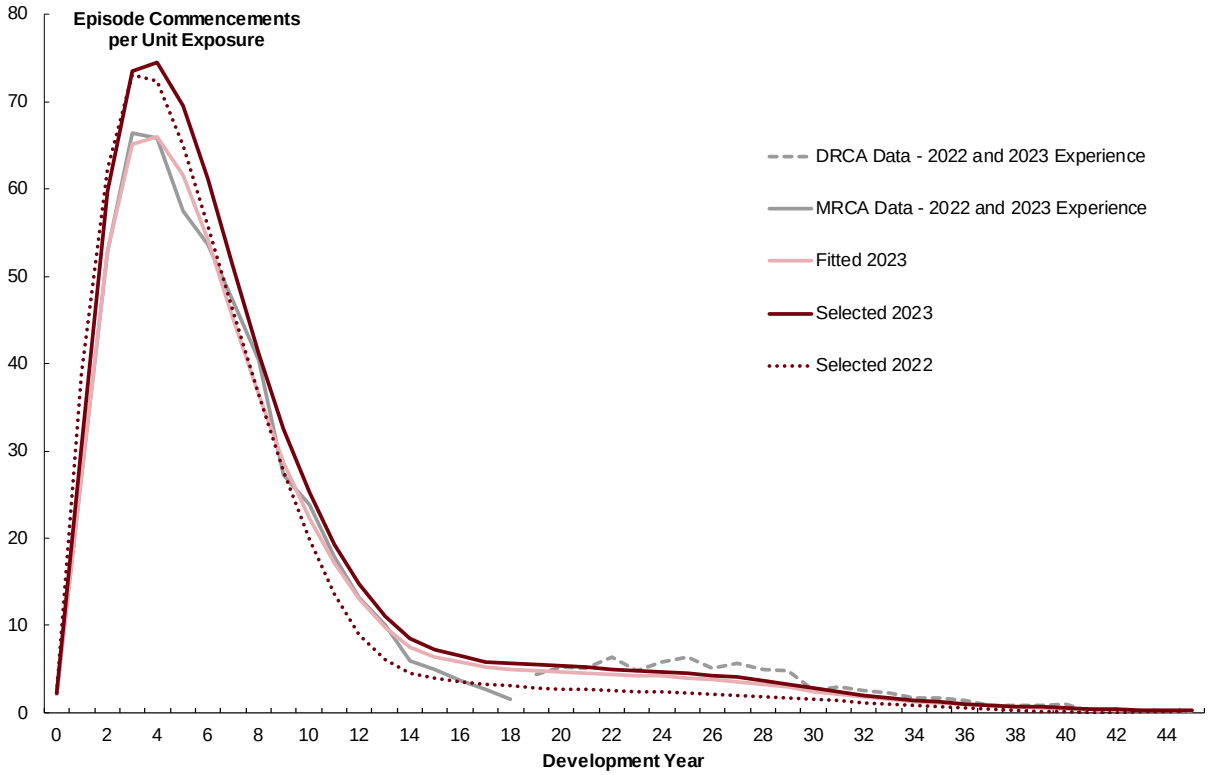


Figure 8.5: MRCA incapacity commencements by development year



8.4.5 As with last year, we have included two adjustments to the new entrant projection. The first adjustment is to apply a proportional increase to the rates of commencement per unit exposure, to account for the impact of processing constraints on incapacity new entrants. The adjustment recognises that the level of IL completions and thus incapacity new entrants were incommensurate with the level of IL lodgements over the period used to calculate the commencement rates. The proportional increase has been determined by applying IL acceptance and incapacity conversion rates to the level of IL lodgements, compared with actual incapacity commencements. For this valuation, the proportional increases are 16 per cent and 13 per cent for DRCA and MRCA respectively. These adjustments have been applied to the fitted curves, resulting in the selected curves shown in Figures 8.4 and 8.5 above.

8.4.6 The second adjustment is an allowance to account for the high level of open IL claims which are expected to drive a heightened number of accepted IL claims over the short-term, and the flow on impact this will have on incapacity benefits. Figure 8.6 and Figure 8.7 show the projected number of incapacity new entrants relative to the IL projections set out in Chapter 5, for DRCA and MRCA respectively. The DRCA IL projection is broadly based on expected claims processing rates in DVA's DDFM.

Figure 8.6: Projected IL claims accepted and new incapacity episodes – DRCA

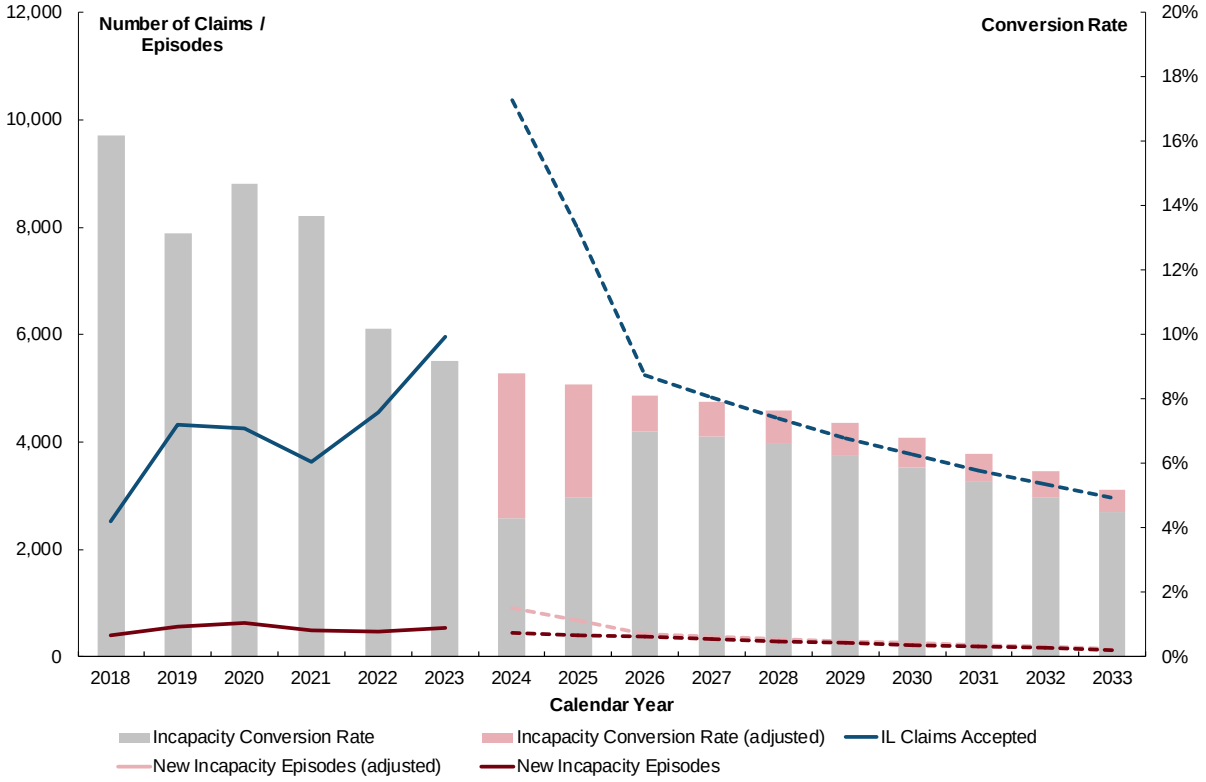
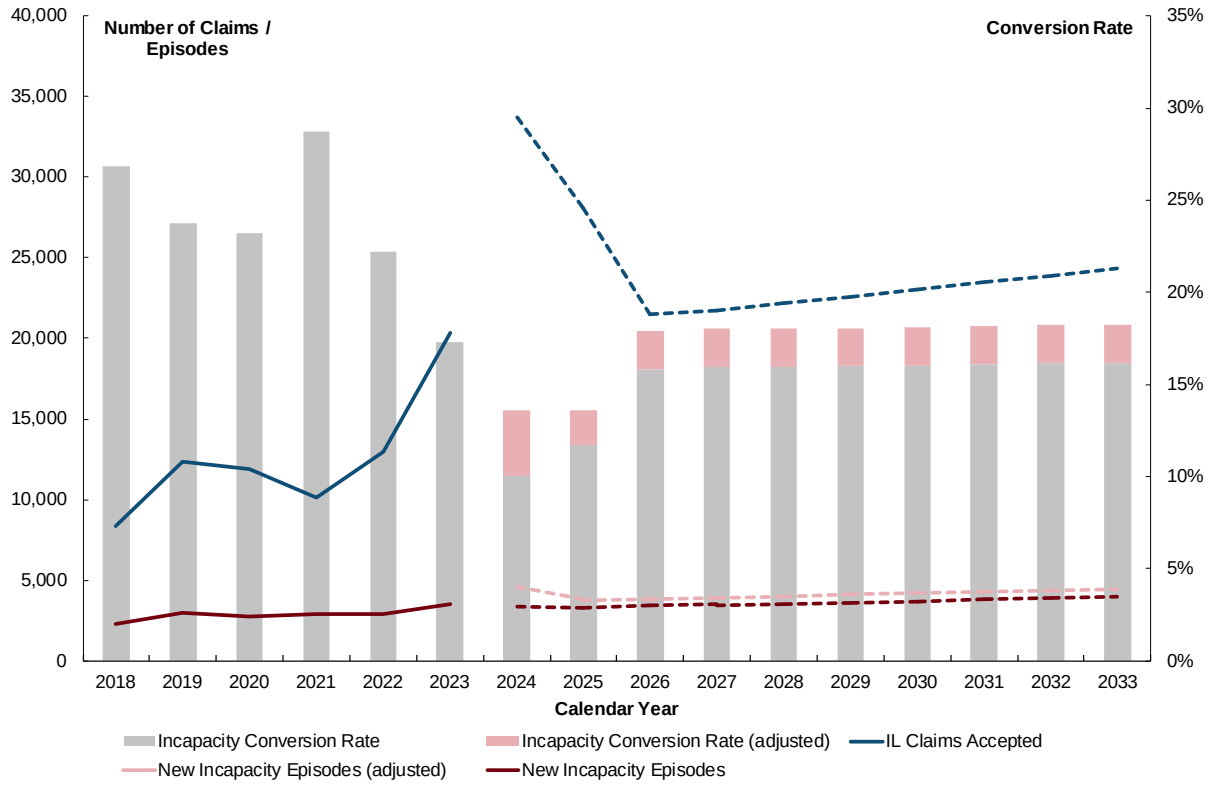


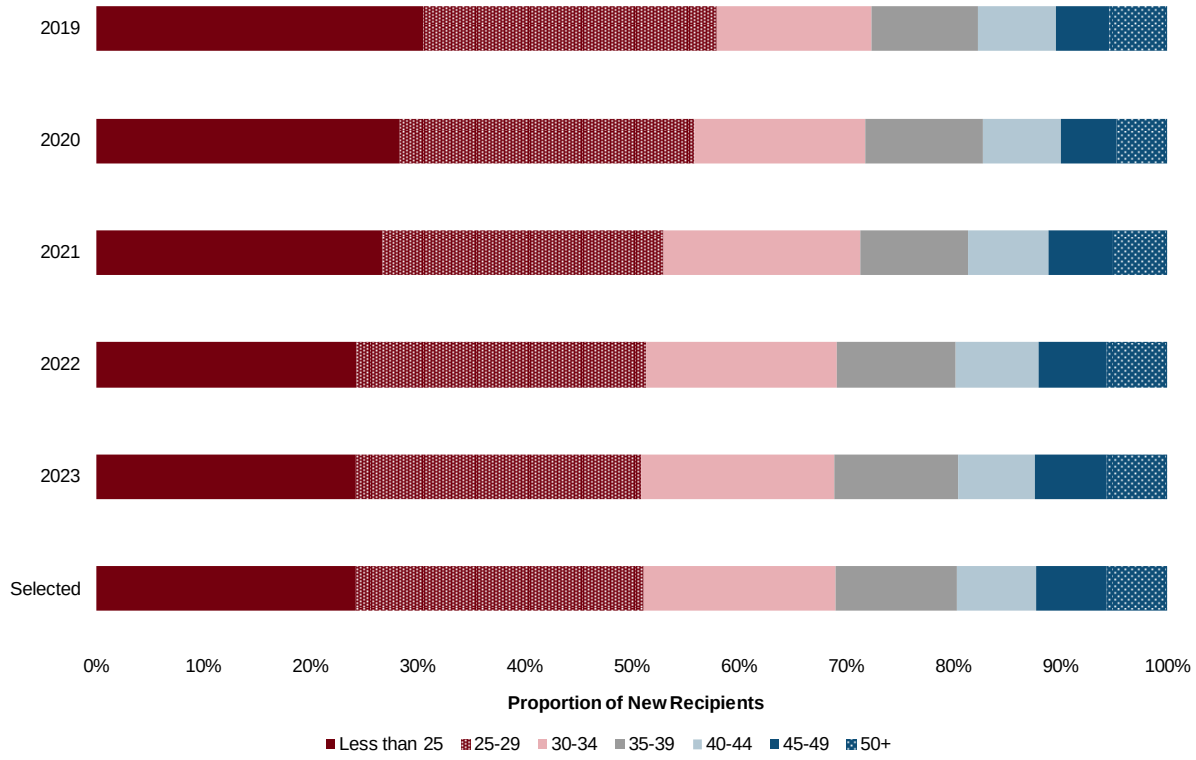
Figure 8.7: Projected IL claims accepted and new incapacity episodes – MRCA



8.4.7 DRCA new incapacity commencement numbers are expected to decline relative to DRCA ILs 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 conversion rate between IL and incapacity is expected to remain suppressed over the next two years (in line with the conversion rate observed over the first 6 months of the 2024 financial year) while the current pool of outstanding IL claims is processed, and then revert to historical levels thereafter.

8.4.8 Having projected future episode commencements, we need to assign an age distribution to the population of new entrants. Figure 8.8 shows the age at injury distribution of recipients commencing an incapacity episode for the past five calendar years, along with the selected distribution which is based on experience from the previous two calendar years. 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



8.4.9 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.

8.4.10 In setting the continuance rate assumptions, we have adopted a longer-term view and used data from the previous five calendar years rather than applying full weighting to the more recent experience. While the two most recent years of experience have demonstrated a lower proportion of recipients remaining on benefit, this period was characterised by historically low unemployment rates which may not persist over the long term. The latest forecasts from the Reserve Bank of Australia suggest that the unemployment rate is expected to increase from current levels of 3.9 per cent to 4.6 per cent from mid-2025 onwards[4].

8.4.11 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.

[4] RBA (2024) Statement on Monetary Policy – May 2024. https://www.rba.gov.au/publications/smp/2024/may/outlook.html#3-5-detailed-forecast-information

Figure 8.9: Incapacity survival curves – less than 35 years old at episode commencement

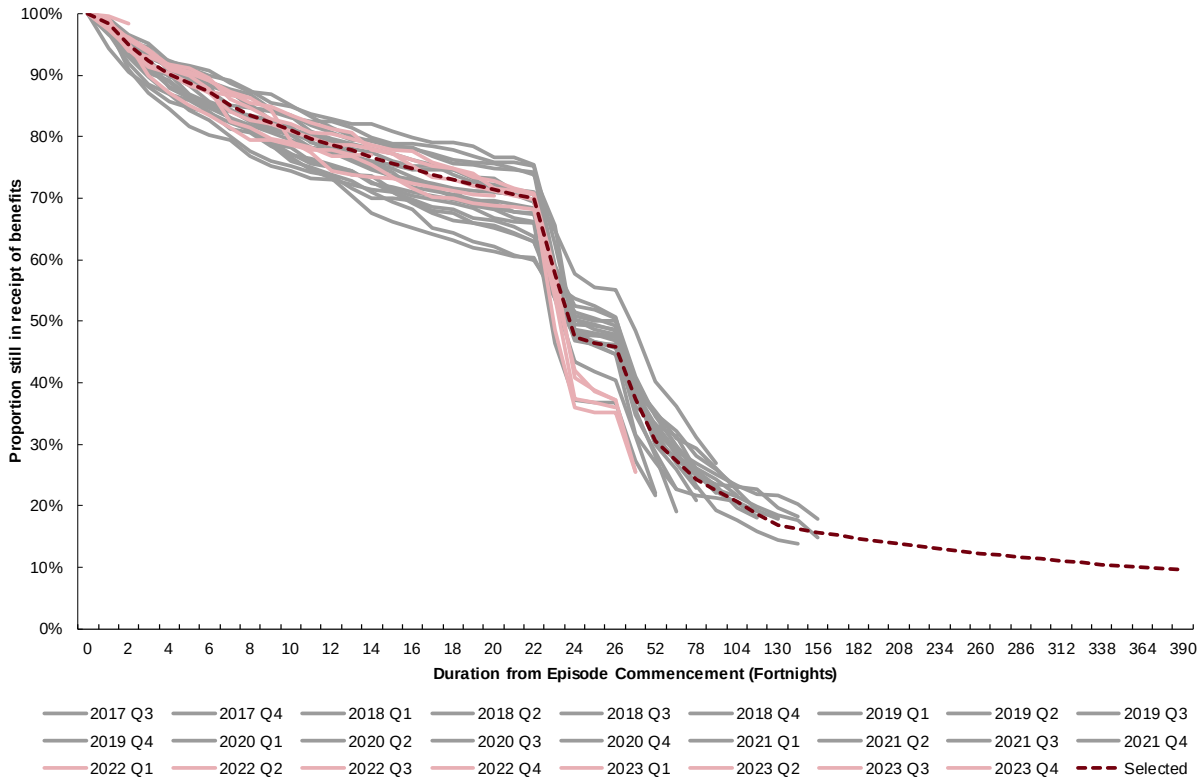


Figure 8.10: Incapacity survival curves – 35 to 49 years old at episode commencement

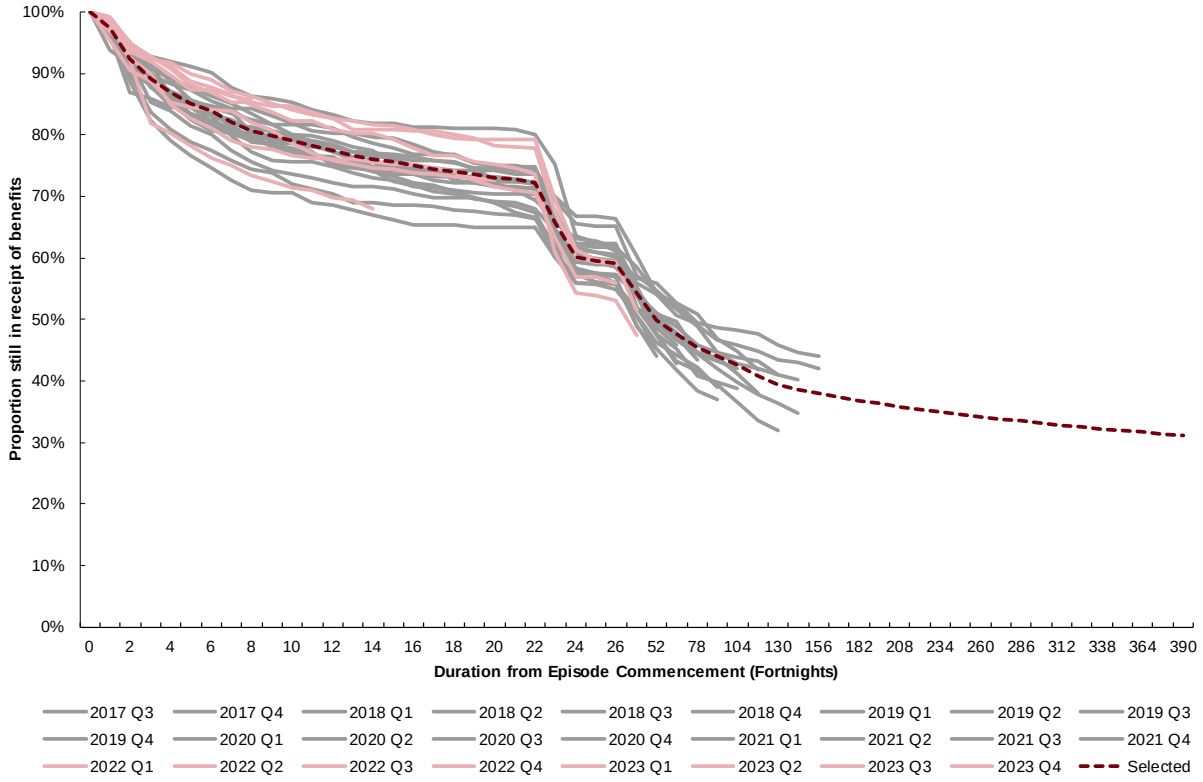
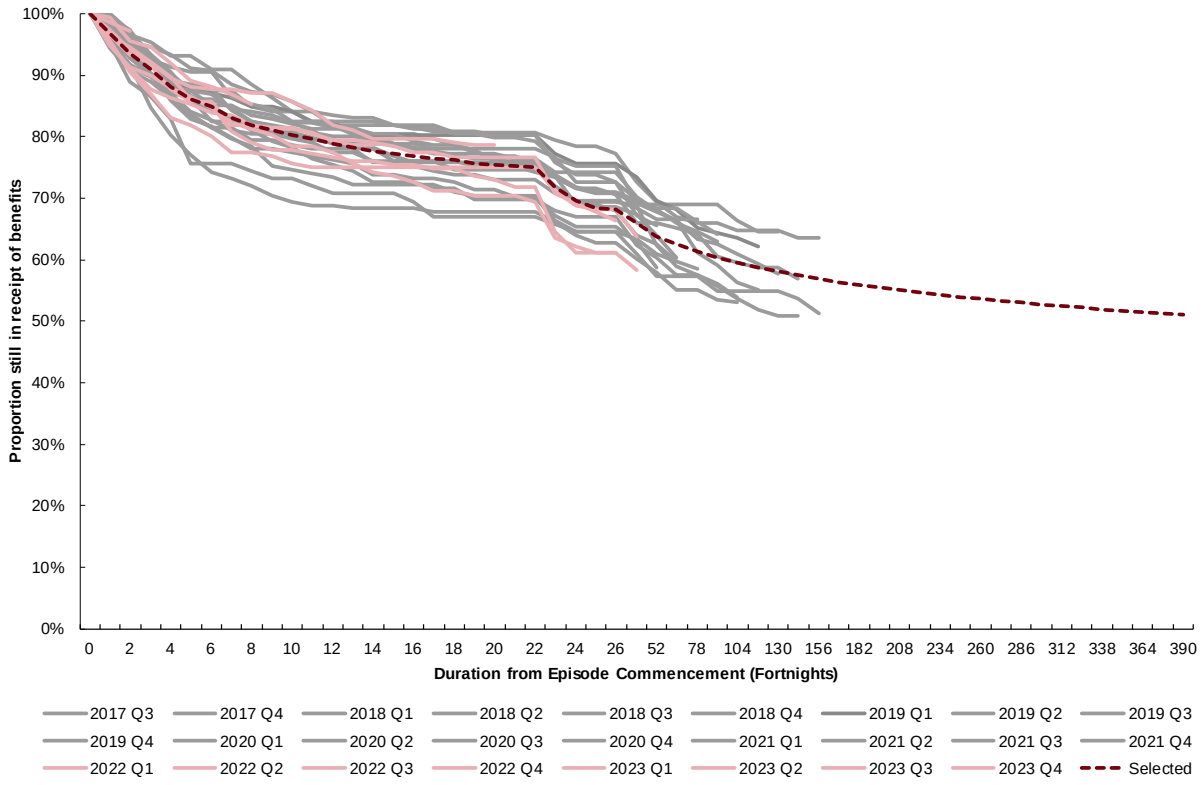


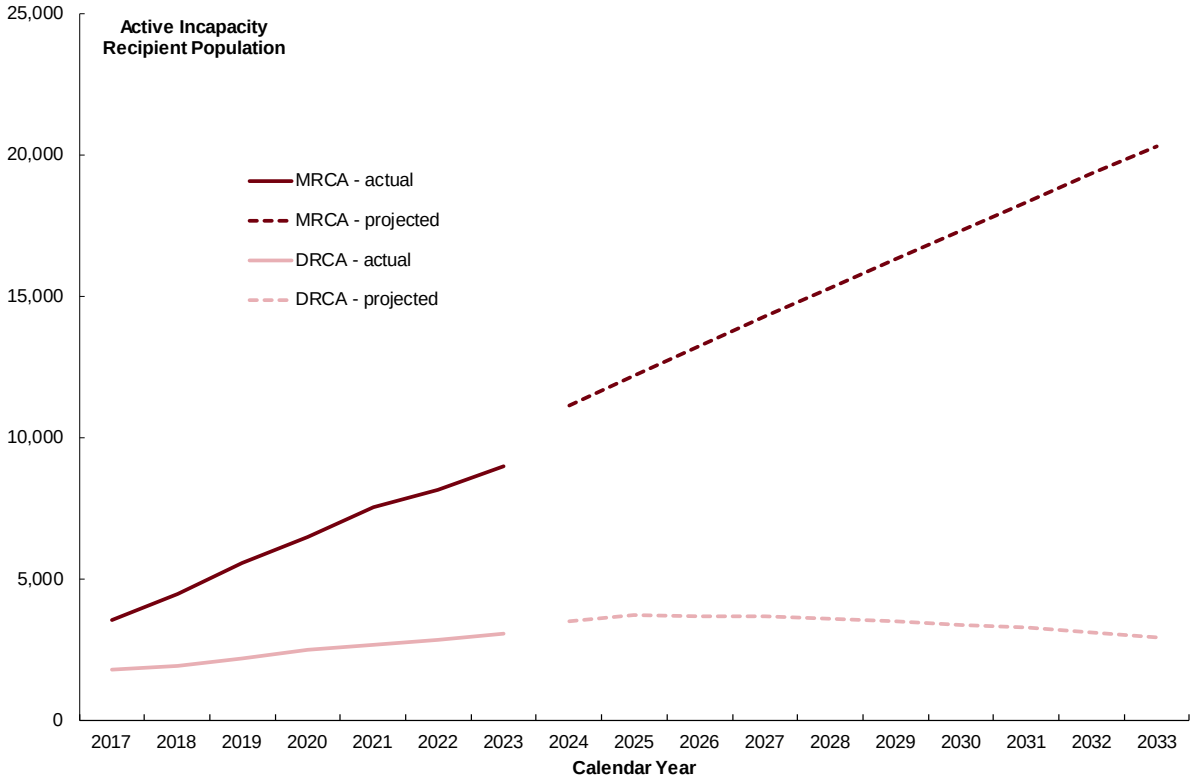
Figure 8.11: Incapacity survival curves – greater than 49 years old at episode commencement



8.4.12 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 have the lowest continuance probabilities while those aged 50 and older have the highest continuance probabilities. This could be driven by a number of factors correlated with age such as injury severity, levels of pre-injury income, employment prospects post injury and the effectiveness of rehabilitation programs. The experience of individual episode commencement quarter cohorts can be volatile, reflecting the uncertainty inherent in the continuance probability assumptions.

8.4.13 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.

Figure 8.12: Incapacity recipient population projection



8.4.14 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. It is important to note that 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.

8.4.15 The following three figures show the payment experience for each age cohort since 2018, along with the selected fortnightly payment rates. Note that historical payment rates have been inflated to 2024 dollars in line with the indexation of ADF salaries.

Figure 8.13: Incapacity payment rates – less than 35 years old at episode commencement

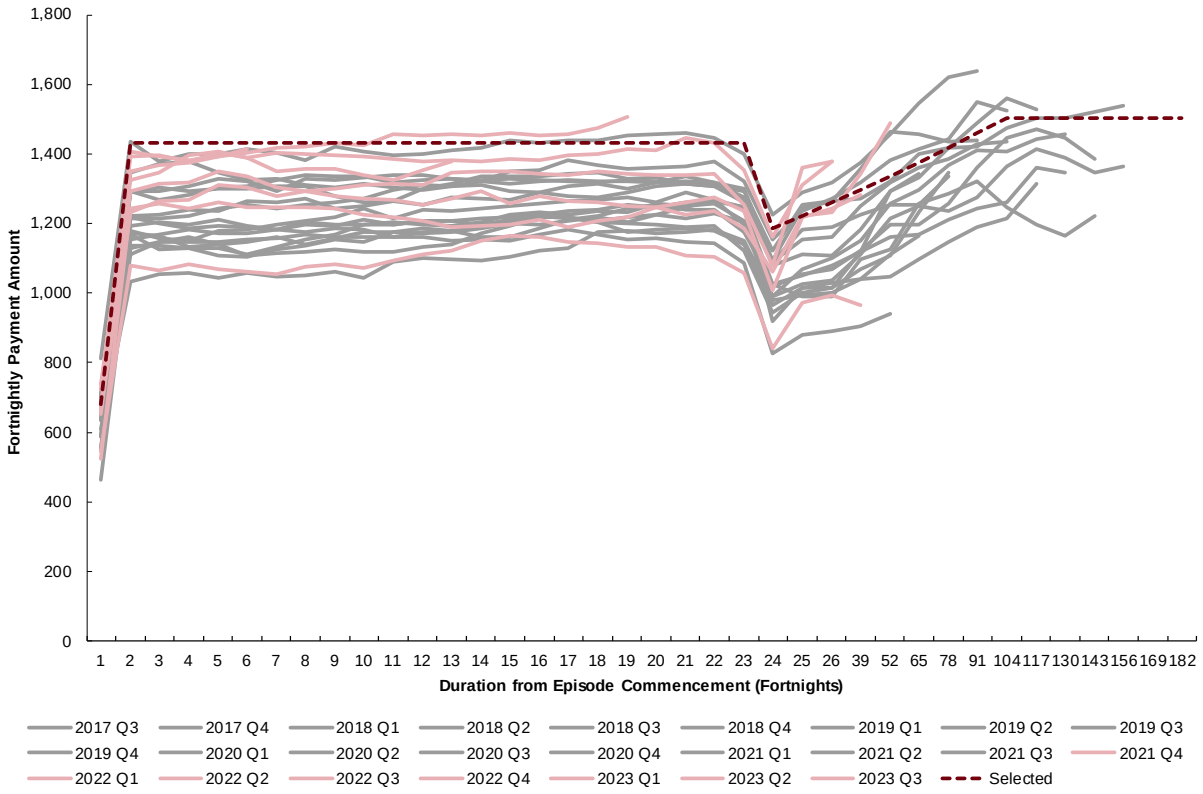


Figure 8.14: Incapacity payment rates – 35 to 49 years old at episode commencement

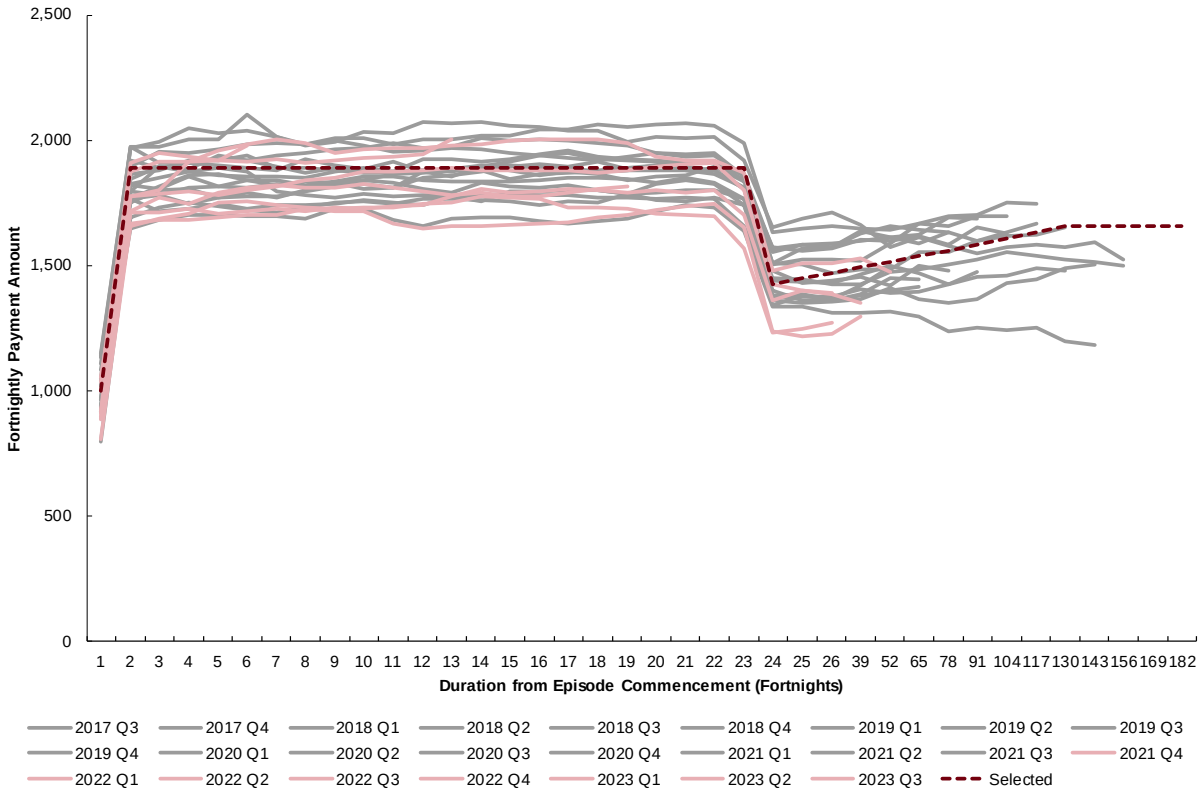
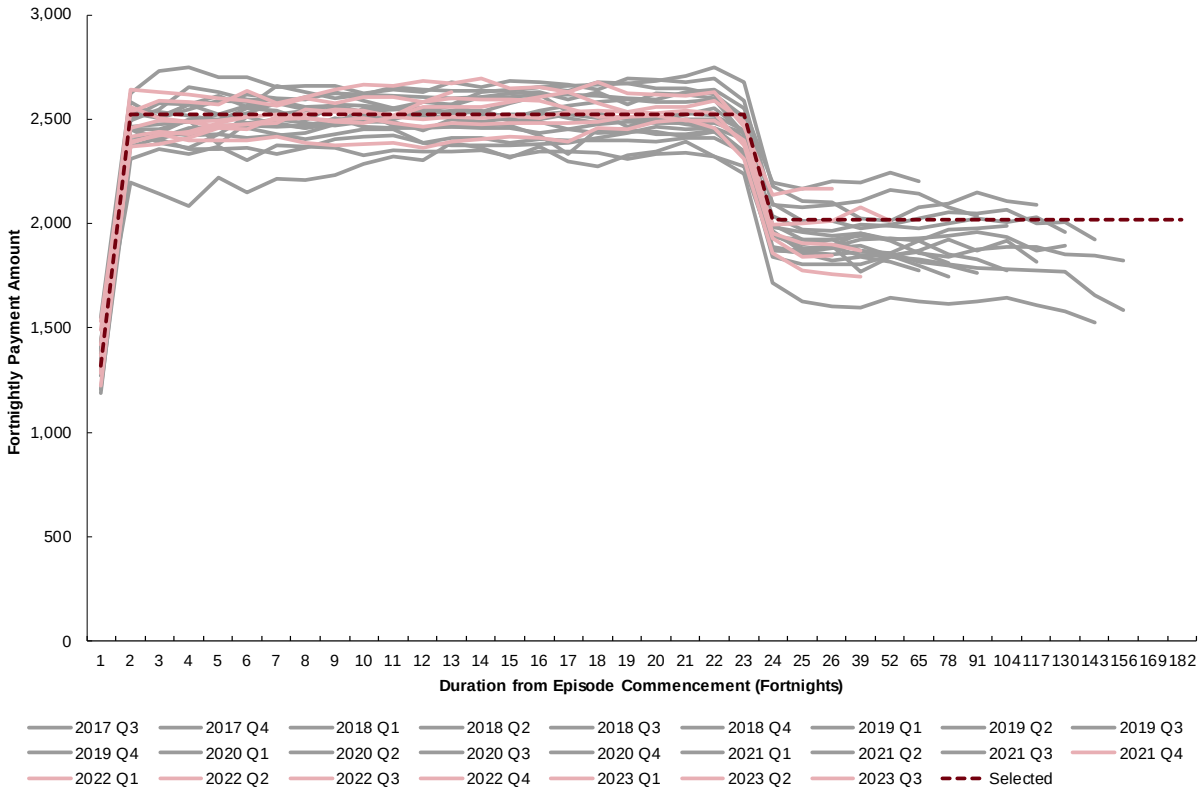


Figure 8.15: Incapacity payment rates – greater than 49 years old at episode commencement



8.4.16 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.

8.4.17 Interestingly, for those aged less than 50 years old at commencement, and particularly those aged less than 35, we see that average fortnightly payment rates tend to increase over time. There are two likely reasons for this. The first being that capacity to work may deteriorate over time, leading to reduced employment income to be offset. The second is that there is an interaction effect between the amount paid and the propensity to continue receiving fortnightly payments, which would lead to an increasingly biased pool of recipients with higher payment rates over time. To account for this phenomenon, we have allowed the assumed average fortnightly payment rates to increase over time in line with the observed experience. For those aged 49 and older at episode commencement, there is no similar increase observed with duration.

8.4.18 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 increase over time in line with the pattern assumed for new episodes. These payment rates are assumed to increase annually in line with the wage inflation rates set out in Chapter 5. Specifically, 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, and expected long term wage growth of 3.7 per cent thereafter.

8.4.19 As previously mentioned, former members with a high level of disability may elect to receive SRDP in lieu of incapacity payments. There also exists a small number of DRCA incapacity recipients that have lifetime entitlements to incapacity payments. These former members are a grand parented group in the legislation whereby they can remain on incapacity payments beyond the retirement age.

8.4.20 We have modelled the DRCA lifetime entitlement (currently 31 recipients) and MRCA SRDP (currently 94 recipients) populations using an annuity model. We have made an allowance for future SRDP entrants to emerge, assuming that 0.8 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.

8.4.21 We have assumed that existing recipients will continue to receive their current payment rate. New SRDP entrants are expected to receive an average fortnightly payment rate of $860 per fortnight. Veterans must seek financial advice before commencing SRDP payments, and reimbursement is available from the costs incurred in obtaining this advice. We have assumed that approximately 6.9 per cent of eligible recipients that receive financial advice will elect to receive SRDP payments and that the average cost of financial advice is $2,750.

8.5 Projected Cashflows and Liability Estimate

8.5.1 Combining these assumptions yields the projection of cashflows shown in Figure 8.16 and Figure 8.17 for DRCA and MRCA respectively. The projections from the previous year's valuation are included for comparison. The projected payments are gross of any repayments made as a result of superannuation offsets or other debt recoveries.

Figure 8.16: Historic and Projected Incapacity Payments – DRCA

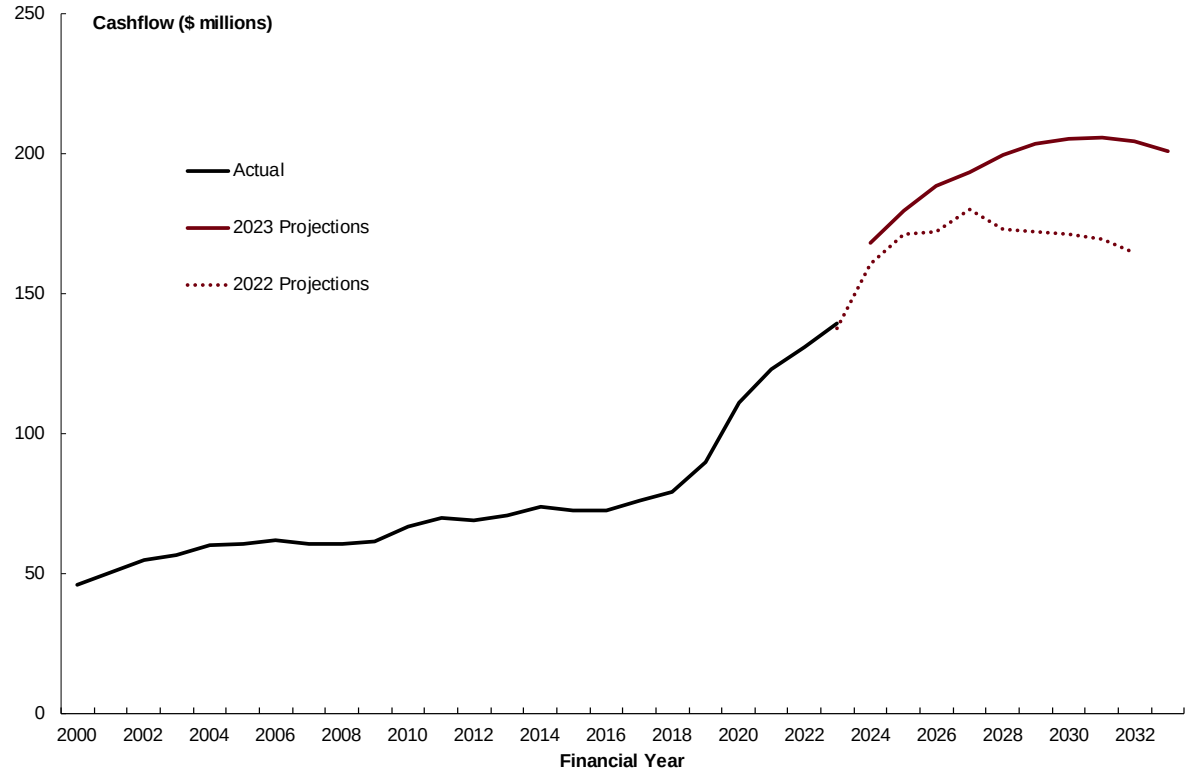
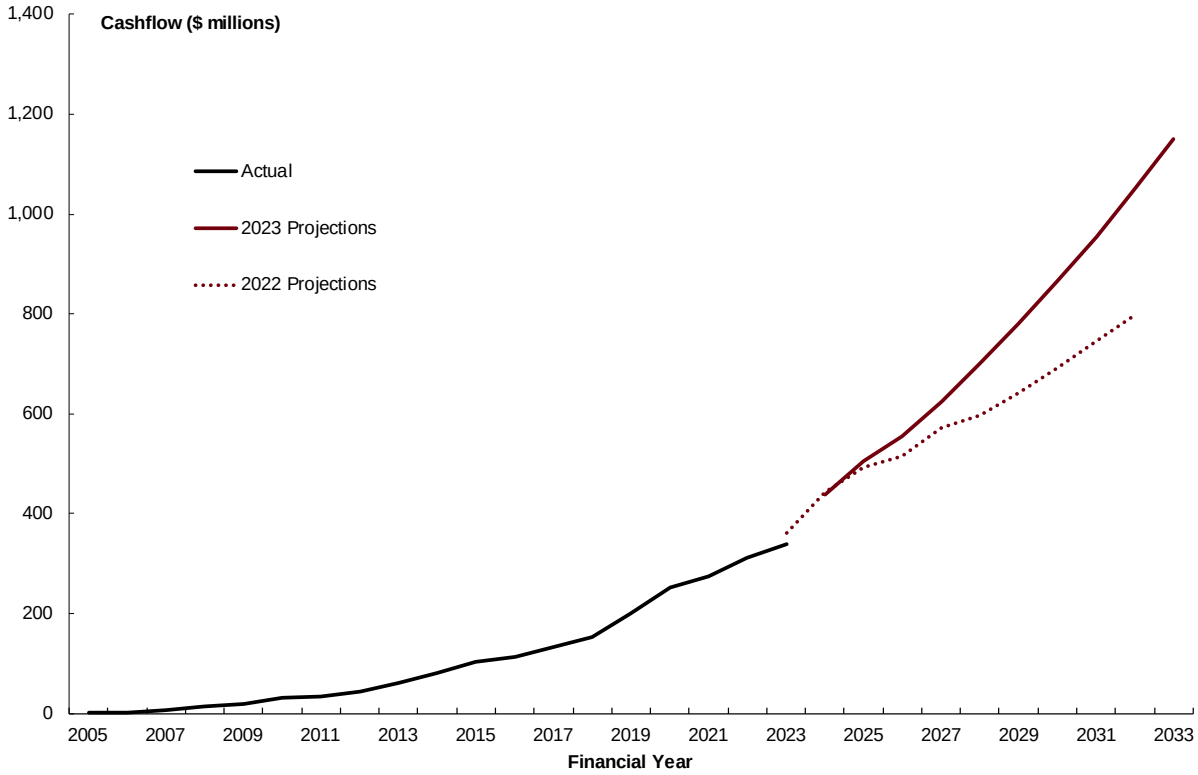


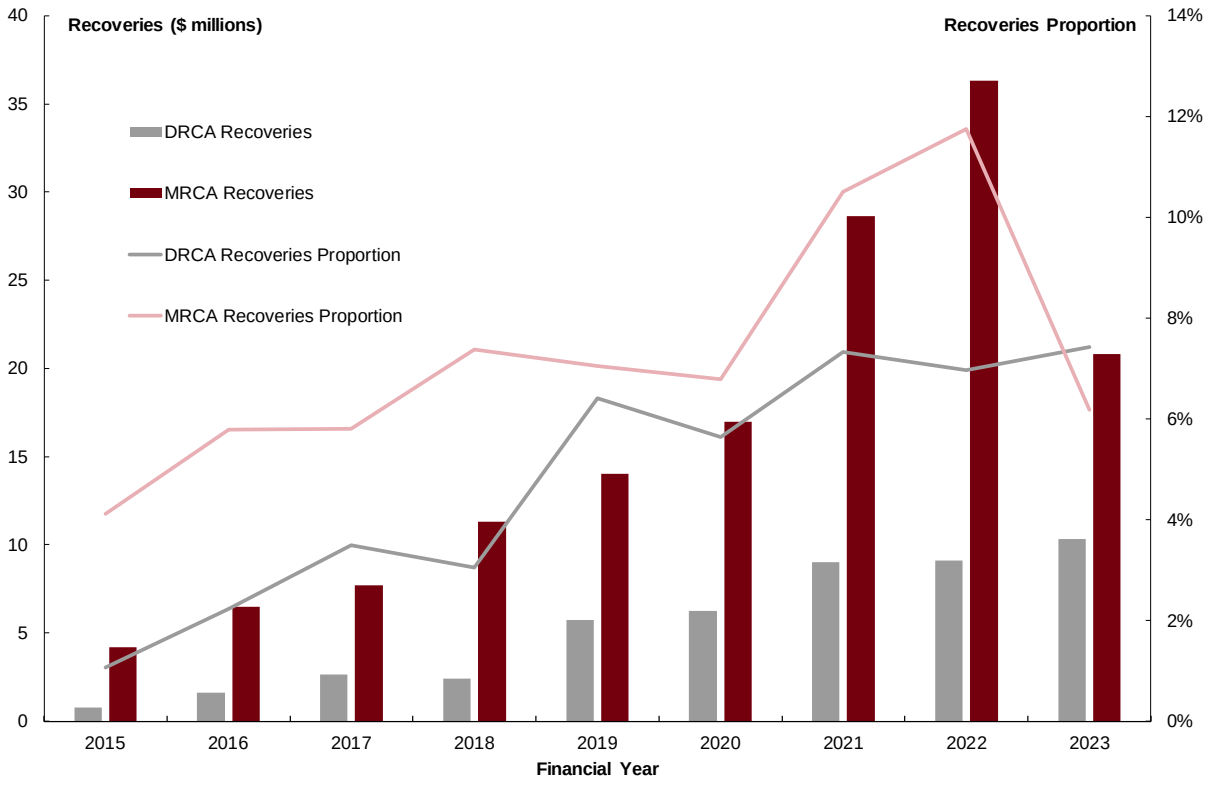
Figure 8.17: Historic and Projected Incapacity Payments – MRCA



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

8.5.3 Historically, these receivable repayments have not been included in our unit record data. Instead, we have relied on the aggregate general ledger figures to determine the level of recoveries made in a period. Where previously all repayments had been allocated to a DRCA nominal, in 2024 DVA updated their systems to correctly record MRCA incapacity recoveries under a new MRCA nominal in the aggregate data. We have also received unit record incapacity repayments data that contains the repayment date and amount received by the Department. Figure 8.18 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 for both DRCA and MRCA.

Figure 8.18: Incapacity Debt Recoveries



8.5.4 Table 8.1 shows the current estimate of the liability broken down by year of accident together with the liability estimated in the 2022 valuation. The estimated liability values gross of recoveries have also been included, to satisfy the requirements of PS302. In the 2022

valuation, we projected a liability as at 30 June 2023 of $9,453.5m. The revised estimate of the liability is $12,768.6m, which is $3,315.1m higher than projected. Table 8.2 provides a reconciliation between the liability estimate as at 30 June 2022 and the current estimate at 30 June 2023.

Table 8.1: Outstanding claims liability as at 30 June 2023

	Liability ($m)		
Year of accident	**DRCA**	**MRCA**	**Total**
1989 and before	150.8		150.8
1990 – 1994	326.0		326.0
1995 – 1999	806.7		806.7
2000 – 2004	862.0		862.0
2005 – 2009		1,056.5	1,056.5
2010 – 2014		2,367.7	2,367.7
2015 – 2019		3,602.2	3,602.2
2020 – 2023		3,596.6	3,596.6
Total	**2,145.5**	**10,623.1**	**12,768.6**
Total (gross of recoveries)	2,307.0	11,422.7	13,729.7
Expected at 30/06/2023	*1,615.2*	*7,838.2*	*9,453.5*

Table 8.2: Reconciliation of liability estimates for incapacity payments

	DRCA	MRCA
Liability estimate as at 30 June 2022 (previous valuation)	**1,613.8**	**7,279.3**
Assumed interest	78.8	368.7
Notional premium	-	551.8
Projected payments	(77.4)	(361.6)
Liability estimate as at 30 June 2023 (previous valuation)	**1,615.2**	**7,838.2**
Experience effects and assumption changes		
change due to experience	(35.5)	(142.0)
change due to new model	295.3	1,100.0
change due to new entrant projection	(40.2)	949.6
change due to continuance probabilities	30.2	202.6
change due to payment rates	64.3	1,301.3
change due to inflation assumption	2.2	12.8
change due to recoveries assumption	213.9	(793.8)
change due to inclusion of SRDP	-	154.3
Current liability estimate	**2,145.5**	**10,623.1**

9 DRCA Medical Costs

9.1 Benefit Overview

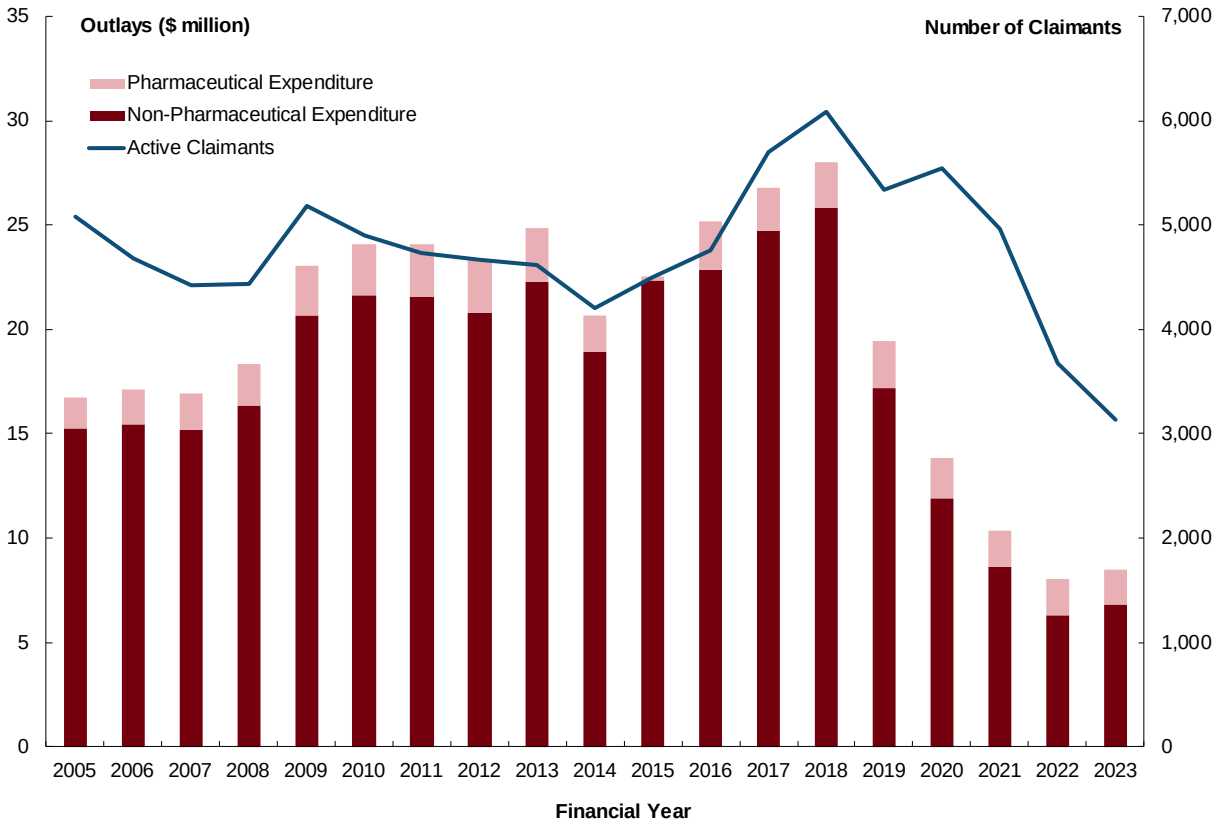
9.1.1 Veterans are entitled to a range of health care benefits for the treatment of service-related conditions under the DRCA. This can include general practitioner and specialist services; allied health services such as podiatry and physiotherapy; dental care, optical and hearing aids; treatment at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

9.1.2 DRCA medical experience is now being perceptibly affected by the introduction of health care cards for DRCA claimants and the hierarchy which exists in relation to these cards. Specifically, where a client has been issued with a health card and has entitlements under both DRCA and MRCA, any medical expenditure will be recorded under MRCA and the individual will not appear as an active DRCA claimant. This has no effect on the earlier cohorts since they will have completed their service well before the transition to MRCA. For later cohorts, however, there are significant numbers of claimants with an entitlement under both schemes and the sharp reduction observed for the more recent cohorts may reflect the fact that such claimants are being classified as MRCA recipients. We have not attempted to model this transition between schemes and this will lead to some outlays which we project as occurring under DRCA actually being made under MRCA.

9.2 Recent Experience and Valuation Assumptions

9.2.1 Figure 9.1 shows the annual expenditure on DRCA medical and pharmaceutical payments along with the number of active claimants since 2005. It can be seen that, after a period of growth, annual expenditure stabilised at around $25m in 2010. This stability in experience was disrupted by the introduction of health care cards for DRCA claimants in 2013 and the associated transition of medical expenses to MRCA for those with claims under both Acts. There was an immediate decline in DRCA outlays in 2014, however outlays increased over the next 4 years, reaching the highest point of $28m in 2018. The effect of the policy change appears to materialise thereafter, with outlays declining since, reaching its lowest of $8m in the 2022 financial year. Outlays increased marginally in the most recent financial year, driven by an increase in the average annual cost per active claimant.

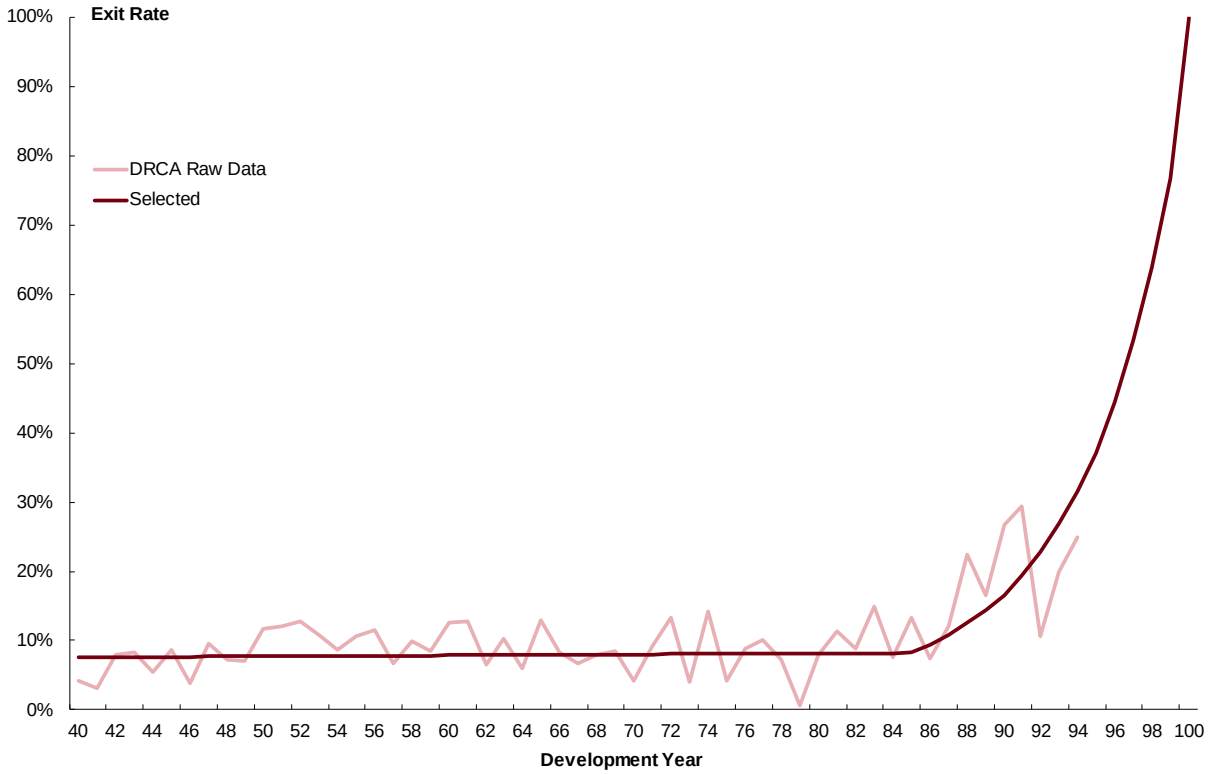
Figure 9.1: Expenditure on DRCA medical payments and number of active claimants



9.2.2 To project the number of active claimants, we apply an exit rate to the current claimant population. An average size is then applied to the active claimant population in each year to estimate expected future payments. As in previous years, we have not included those receiving only pharmaceutical benefits in the claimant population, but instead applied a loading to projected non-pharmaceutical cashflows in line with the historical relationship between the two components of expenditure. For the current review, a loading of 25 per cent has been applied. This is consistent with actual experience over the past two calendar years and is unchanged from the 2022 valuation.

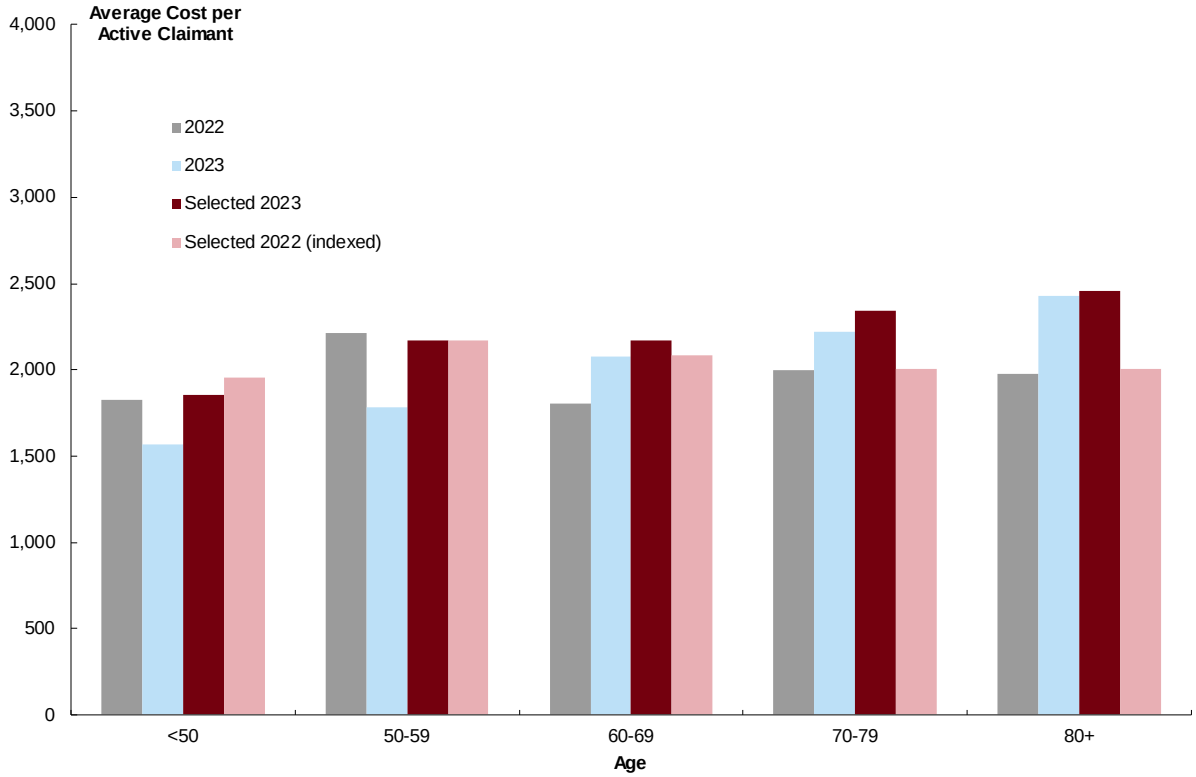
9.2.3 For this valuation, we derived age-based exit rates from the DRCA medical experience. Figure 9.2 shows the raw data and the fitted age-based exit rates. In fitting the exit rates, a longer period of ten years has been used to avoid placing undue weight on the recent marked decline in active DRCA medical claimants.

Figure 9.2: Assumed exit rates for active DRCA medical claimants



9.2.4 Future cashflows are then calculated by multiplying the resulting projections of active claimants by the average cost per active claimant. Figure 9.3 shows the average cost per active claimant over the last two calendar years and the selected assumption, together with the assumption adopted in 2022. A large irregular claim of over $1m has been excluded from the 2023 experience and accounted for through a loading applied in the selected average size. The assumed average sizes are higher than that selected at the 2022 valuation, particularly at older ages, reflecting the most recent experience. 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.

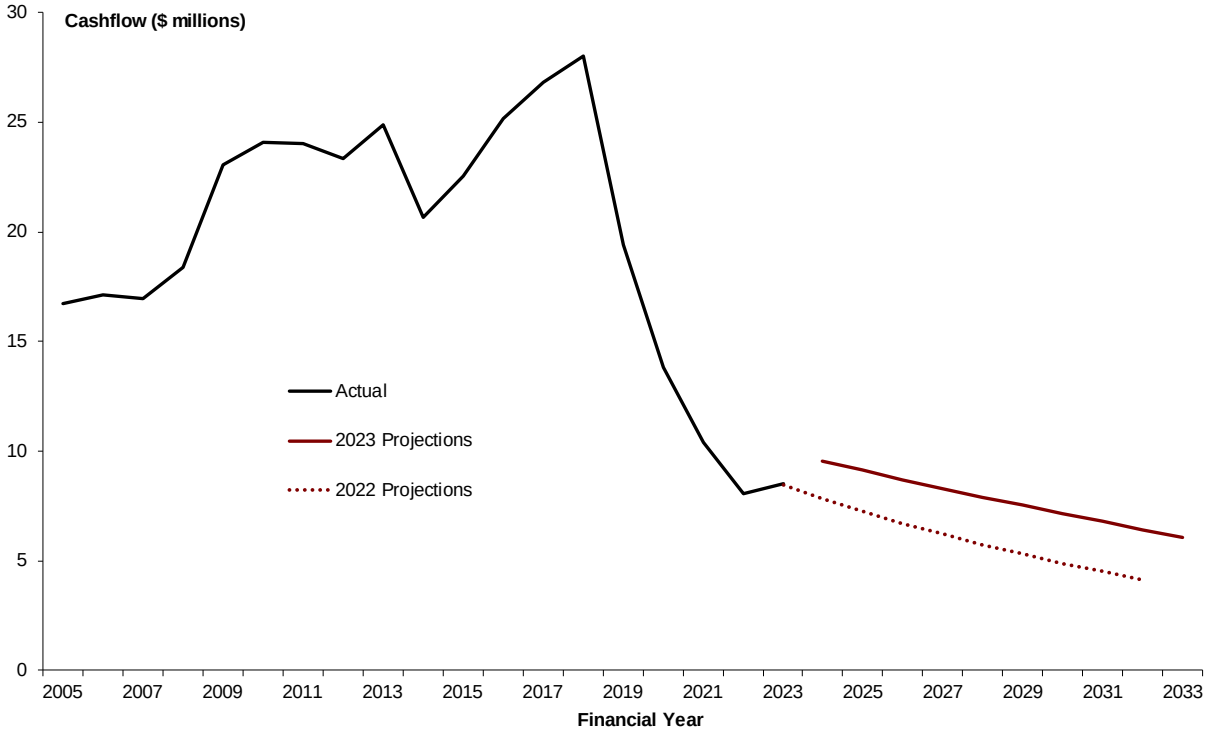
Figure 9.3: Average annual costs per active claimant by age



9.3 Projected Cashflows and Liability Estimate

9.3.1 Figure 9.4 shows the historical and projected cashflows for DRCA medical claims. The increase in projected cashflows compared with the previous review reflects the increased average size and lower assumed exit rates adopted for the current valuation. Aggregate expenditure data to 31 March 2023 shows total outlays of $7.0m in the 9 months to date, suggesting a full year expenditure of around $9-10m for 2023–24. In light of this, our cashflow projections do not look unreasonable.

Figure 9.4: Historic and projected DRCA medical payments



9.3.2 Table 9.1 shows the estimate of the DRCA medical liability broken down by year of accident. The projected liability as at 30 June 2023 in the 2022 valuation for DRCA medical claims was $61.0m. The liability at the 2023 valuation is $92.6m, which is $31.6m higher than expected, reflecting the increase in projected cashflows seen in Figure 9.4. The difference between these two figures is reconciled in Table 9.1 below.

Table 9.1: Outstanding claims liability for medical costs by year of accident

Year of accident – year ending 30 June	Liability (inflated and discounted) ($'m)
1979 and before	19.5
1980 – 1984	6.5
1985 – 1989	9.2
1990 – 1994	16.7
1995 – 1999	23.2
2000 – 2004	17.4
Total	**92.6**
Expected at 30/06/2023	*61.0*

Table 9.2: Reconciliation of liability for DRCA Medical cost

	$m
Liability estimate as at 30 June 2022 (previous valuation)	**66.3**
Assumed Interest	3.1
Projected Payments	(8.5)
Notional Premium	-
Projected liability as at 30 June 2023 (previous valuation)	**61.0**
Experience effects and assumption changes	
difference between actual and projected payments	(0.0)
change due to experience	6.9
change in average cost	16.5
change in exit rates	8.3
Current Estimate	**92.6**

10 MRCA Medical Costs

10.1 Modelling Approach

10.1.1 A broad range of health care benefits are available to eligible veterans and eligible dependants under the MRCA. These include general practitioner services; medical specialist services such as pathology and radiology; allied health services such as podiatry and physiotherapy; dental care, optical and hearing aids; public and private hospital; subsidised pharmaceuticals; and medical aids and appliances[5].

10.1.2 Veterans entitled to medical benefits under MRCA are issued with one of two types of medical treatment cards. The White Card provides veterans with entitlement to medical treatment, including subsidised pharmaceuticals, for accepted service-related conditions, as well as all mental health conditions (for veterans with continuous full-time service or certain reserve service). The Gold Card provides veterans with entitlement to clinically required treatment for all medical conditions, regardless of whether the condition is related to defence service. Veterans may also receive reimbursements for medical expenses privately incurred.

10.1.3 Veterans may receive a Gold Card if they:

- have impairment points of at least 60 from service-related conditions;
- have impairment points of at least 50 from service-related conditions and are eligible for the Special Rate Disability Pension;
- have impairment points of at least 30 from service-related conditions and receive a Service Pension; or
- are aged 70 years or over with qualifying service.

A wholly dependent partner, eligible young person or other dependent who is eligible for compensation in respect of a veteran's death under MRCA may also receive a Gold Card.

10.1.4 Historically, we have modelled the costs associated with both Gold Cards and White Cards together, using an overall average size and usage probability assumption. This approach was originally adopted as the number of veterans with a MRCA Gold Card was small, and there was limited experience to derive separate assumptions for Gold Card holders and White Card holders. Over the past few years however, the number of MRCA veterans with Gold Cards has increased substantially, largely driven by the increase in the number of veterans reaching 60 impairment points as a result of the experience observed in PI.

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

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

10.1.6 This led us to revise our methodology for modelling future payments under MRCA medical for the 2022 valuation. The new model projects medical claimants and models the transition from White Card status to Gold Card status over time. These assumed transition rates vary by duration from first medical payment and have been selected based on an assumed ultimate Gold Card proportion. Separate average size and utilisation rate assumptions by card type are used to reflect differences in usage patterns between the two cohorts. We have again received this card holder data for the 2023 valuation and have continued to explicitly model both White Card and Gold Card holders in the valuation.

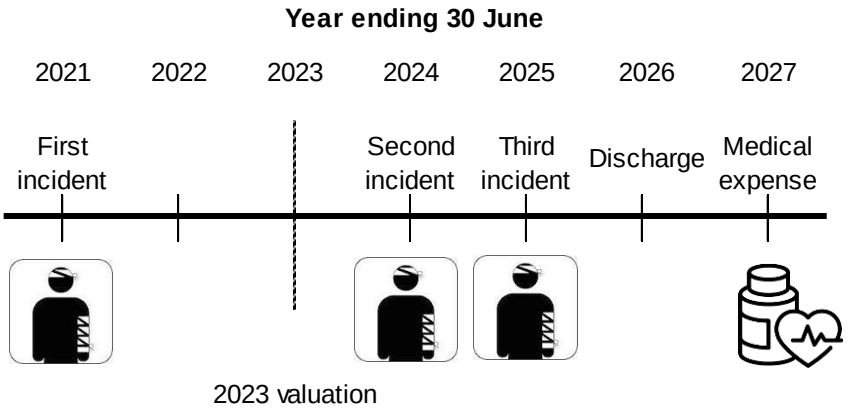
10.1.7 We have continued the use of the first year of accident for determining development year. However, most MRCA claimants have multiple claims spanning a range of accident years. Furthermore, expenditure is incurred through the use of health care cards and the data does not record the particular condition to which a service relates. For those with Gold Cards, all medical expenditure is covered, not just that related to compensable conditions. This means there is considerable ambiguity about the proportion of expenditure that should be treated as part of the liability at the valuation date.

10.1.8 Serving ADF personnel are entitled to medical treatment provided by ADF health services. Thus, DVA typically only becomes involved in providing medical services at the time an individual is discharged. An exception applies for reservists whose health care costs related to a compensable injury will be covered by DVA. For non-reservists, however, the existence of a medical expenditure transaction indicates that the individual concerned has been discharged. Given this feature, it is reasonable to conclude that all future costs in relation to medical services for non-reservists have been accrued at the time the first transaction arises. Thus, any future projected expenditure for claimants who have had any medical transactions in the past can be treated as fully accrued. That is, all future expenditure arising from these claimants forms part of the liability as at 30 June 2023. This is not necessarily true for reservists, but the assumptions we have adopted are intended to allow for this.

10.1.9 For those who have had medical expenditure in the past (and, hence, can be assumed to have been discharged from the ADF), we have used utilisation rates to project the proportion of claimants that will incur expenditure in future years. We allow for mortality to gradually reduce this population over time.

10.1.10 There is 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. It is possible that these people have been discharged from service. However, it is also possible that they are still serving members of the ADF. For this latter group, future expenditure may relate to incidents that occurred before the valuation date but there is the potential for expenditure to arise from future incidents that occur after the valuation date. Figure 10.1 illustrates a hypothetical scenario of this type.

Figure 10.1: Illustrative Scenario



10.1.11 In this example, one of the three incidents which will give rise to future medical expenditure has occurred before the valuation date, but the other two occur in the future. Conceptually, only that portion of expenditure that relates to the first incident should be treated as a liability for the current valuation. In estimating the liability, therefore, we need to treat the population that have not yet given rise to medical expenditure differently from those who have already incurred expenditure.

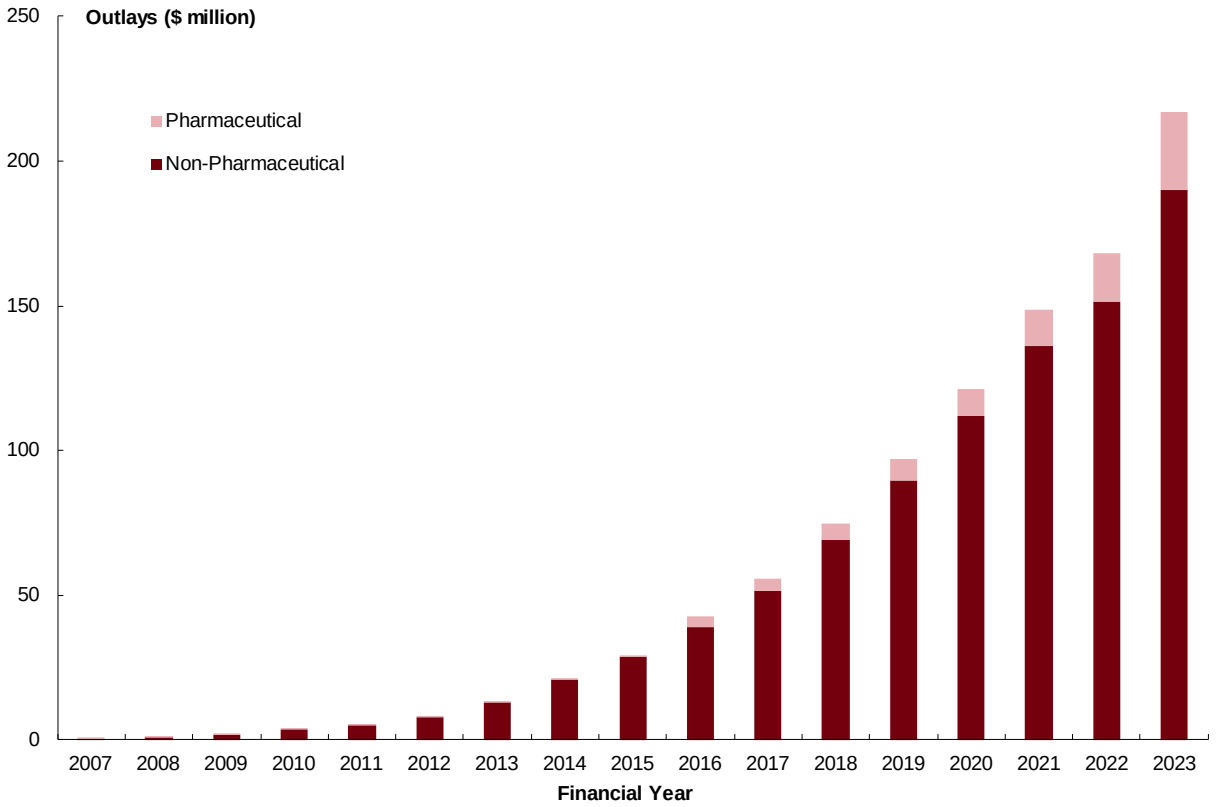
10.1.12 For the population who have not incurred medical expenditure (and whose ADF status is therefore unknown), we have used claim rates based on development year from date of earliest accident to project the number of claimants we might expect to see in future who have an earliest accident year prior to the valuation date. Based on experience to date, we would expect most claimants to have multiple claims. This is particularly the case for those with a long period between the earliest incident and first medical expenditure. To determine the proportion of future expenditure that should be treated as accrued at the valuation date and included in the liability, we have used information on the historical distribution of accepted conditions conditional upon the period of time between the earliest accident year and the year in which expenditure is first incurred. In the scenario illustrated in Figure 10.1 above, one of the three incidents occurs prior to the valuation date and, hence, we would treat one third of the expenditure as having accrued as at 2023, while the remaining expenditure for this individual would form part of the notional premium for future years.

10.1.13 Note also that we have not made any explicit allowance for the provisions in MRCA that entitle all veterans who have rendered warlike service on or after 1 July 2004 to a gold card at age 70. Given the current information available, this is impossible to model since we would need to know the potentially eligible population and the proportion who would not already have a health care card prior to reaching age 70. Costs for this group might also be expected to be somewhat lower, since by definition they would not be existing MRCA claimants. The first of this group might be expected to qualify in around ten years, but significant numbers are unlikely for another thirty years or so. This is a practical example of how access to improved information on the veteran population could improve the estimate of the projected cashflows.

10.2 Recent Experience

10.2.1 Figure 10.2 shows MRCA expenditure with the outlays for pharmaceutical benefits separately identified. Outlays grew very slowly over the early years of operation of the scheme but have increased rapidly over the last few years with an increase of 29 per cent in the latest financial year.

Figure 10.2: Expenditure on MRCA Medical



10.2.2 Figure 10.3 shows the MRCA non-pharmaceutical expenditure separated by card type. Payments have been allocated based on the claimant's card status within the year. Gold Cards originally contributed a relatively small proportion to overall MRCA Medical outlays. Since 2013 however, expenditure arising from Gold Cards has exhibited substantial growth, reaching 67 per cent of MRCA non-pharmaceutical medical outlays in the 2023 financial year. Figure 10.4 provides further insights into the experience over this period. The proportion of medical claimants with a Gold Card increased gradually from 2010 to 2017, with growth accelerating from 2017 onwards. In the most recent financial year, around 37 per cent of claimants accessing medical benefits had a Gold Card.

Figure 10.3: Expenditure on MRCA Medical by Card Type

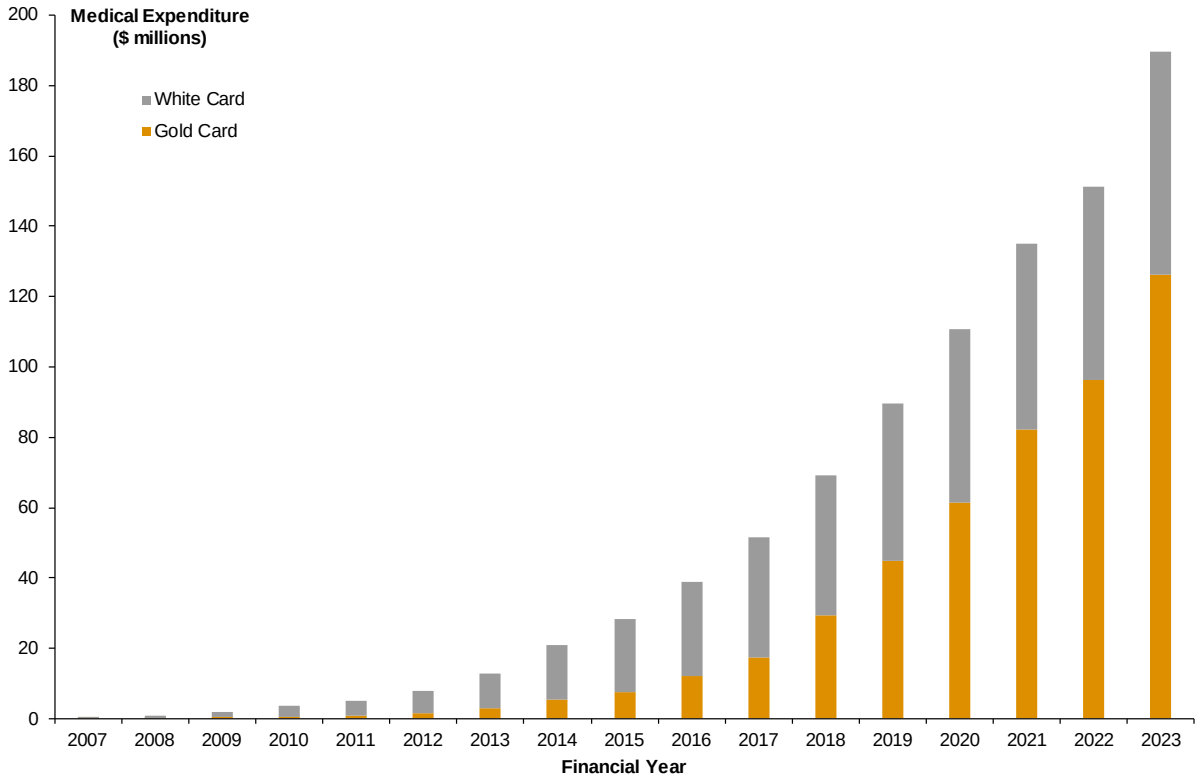
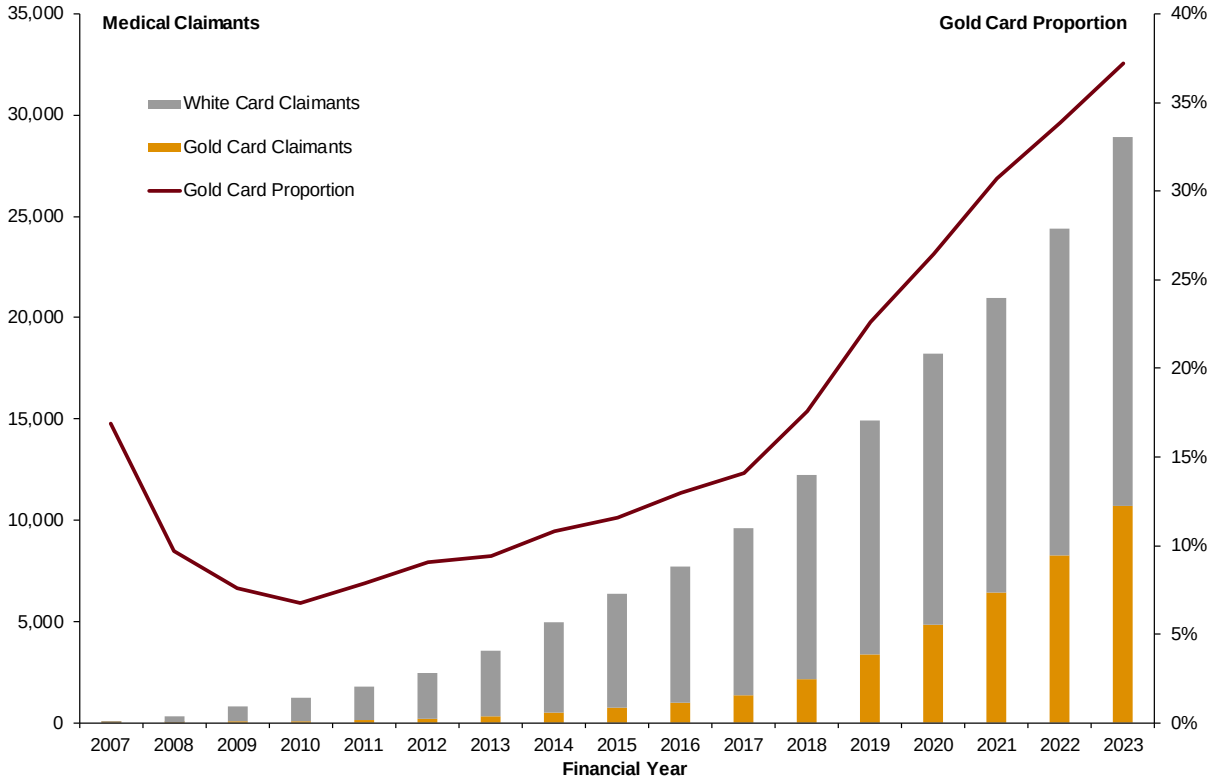


Figure 10.4: MRCA Medical Claimants by Card Type



10.3 Valuation Assumptions

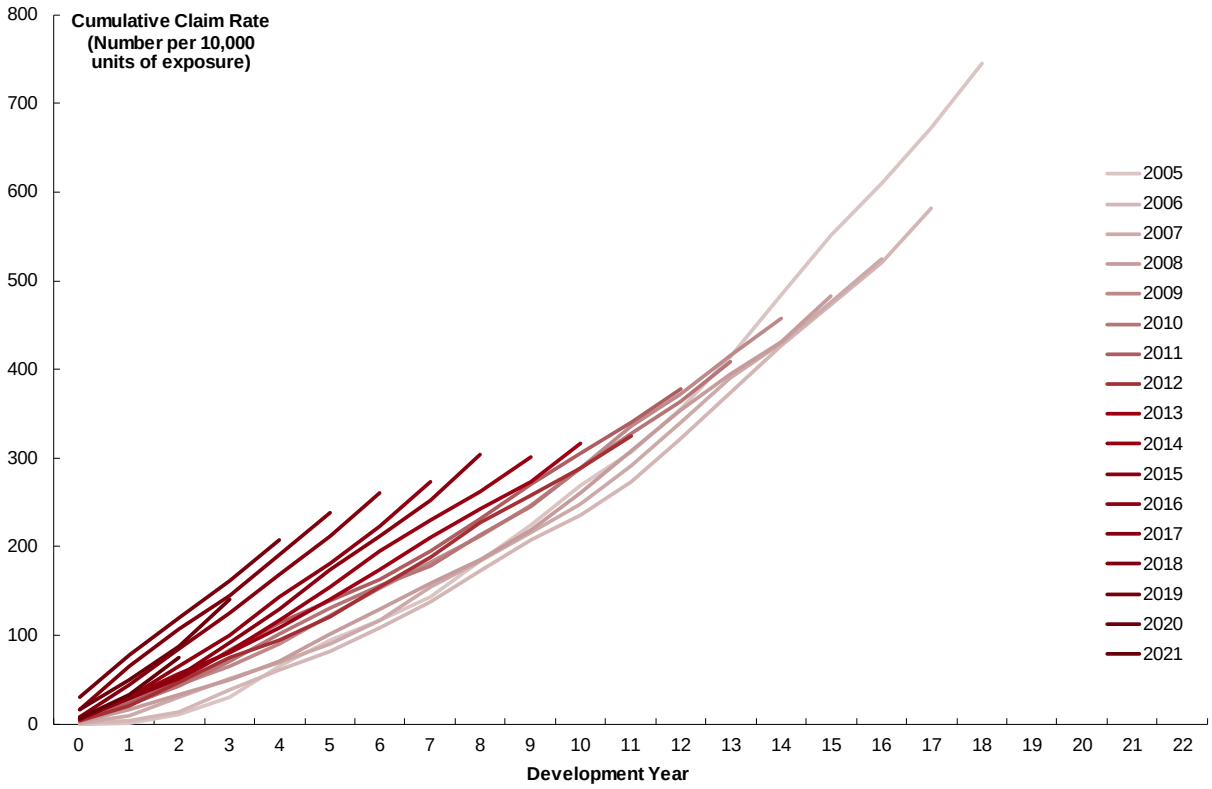
10.3.1 The MRCA medical model requires five main assumptions:

- the new medical entrant projection (including a projection of the proportion of future cashflows that have been accrued at the valuation date);
- gold card issuance rates (to model the transition to Gold Card status over time);
- utilisation rates (to calculate the number of medical claimants accessing benefits in each future period);
- average expenditure per active claimant; and
- pharmaceutical loading.

Combining the existing medical claimant population, the projection of future medical entrants, the Gold Card issuance rates and the utilisation rates yields a projection of active medical claimants in each period. The average expenditure per active claimant and the pharmaceutical loading is then applied to calculate the expected medical costs incurred in each future period. Each model component will be discussed in turn.

10.3.2 A chain ladder method has been adopted to project future medical entrants. Figure 10.5 shows the relationship between earliest accident year and the year in which medical expenditure is first incurred. The pattern of claims emerging has changed substantially since the commencement of MRCA. For the more recent accident years, there has been an increase in the number of new claimants emerging only a few years after their first injury. At the same time however, older accident years also have new claimants emerging many years after the first injury. Of note is the 2005 year, the earliest accident year for MRCA, which is still exhibiting an upwards trend rather than any stabilisation, as claimants are still emerging.

Figure 10.5: Cumulative claim rate by lag between earliest accident year and first expenditure



10.3.3 For this valuation, we have selected five sets of development factors, separating the accident years into distinct periods from the first accident year, the early accident years to 2012, the accident years prior to Veteran Centric Reform and the post 2017 accident years. Our selected development factors attempt to account for potential changes to the pattern of emergence over time. For example, a veteran injured in 2023 is expected to approach DVA much sooner than someone injured in the earliest years of the scheme. The projected claimant numbers for a subset of accident years are shown in Figure 10.6 and the projected ultimate claimant number for all accident years are shown in Figure 10.7. We have projected new entrants in the 2024 financial year by considering the number of new entrants to 31 December 2023 and projected figures from a secondary model of the delay from first IL lodged to first medical expenditure. We have then applied the selected development factors thereafter.

10.3.4 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 the development factors with more certainty. Our limited access to exposure data also hinders any further analysis that can be conducted on potential claimant emergence patterns. While we have access to the number of serving members in each accident year from publicly available information, we currently do not have access to data relating to dates of separation or reason for separation. Such information could be used to support the new entrant projection and elucidate the underlying exposure to some extent, for example by considering the delay from separation to first medical expenditure or the separation type (in particular medically discharged members).

Figure 10.6: Projected cumulative claim rate by lag between earliest accident year and first expenditure for selected accident years

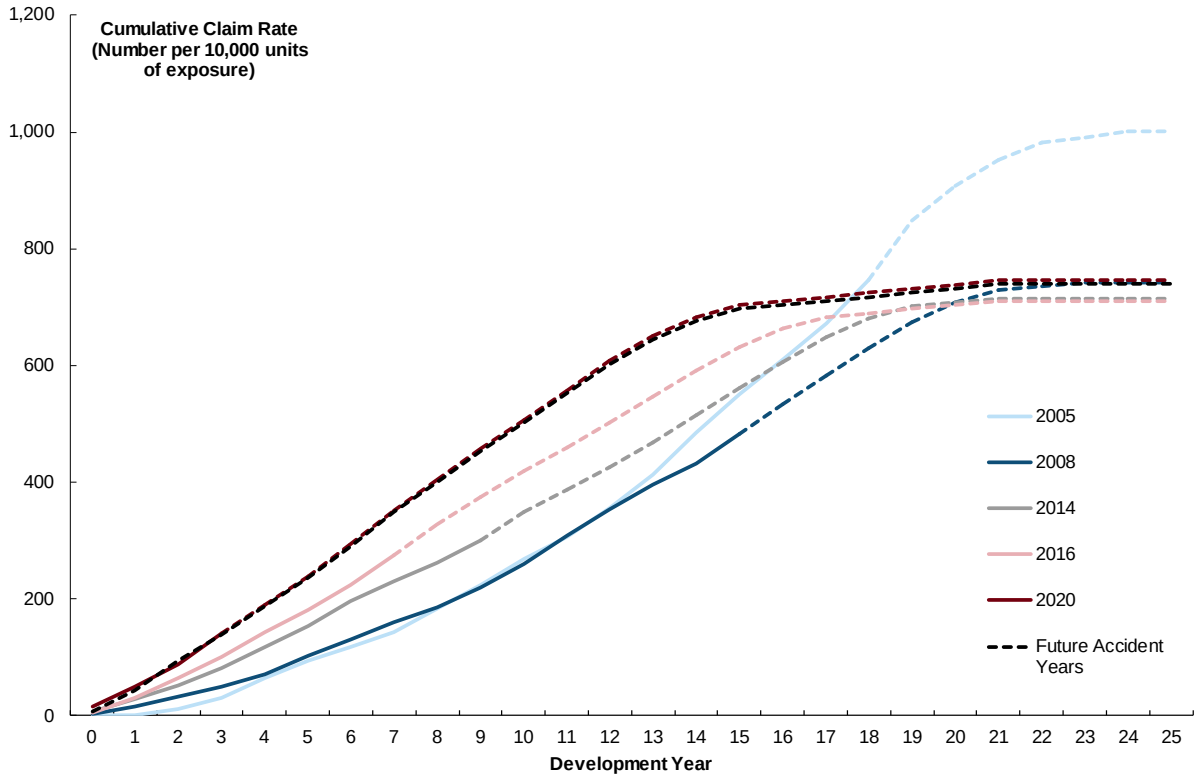
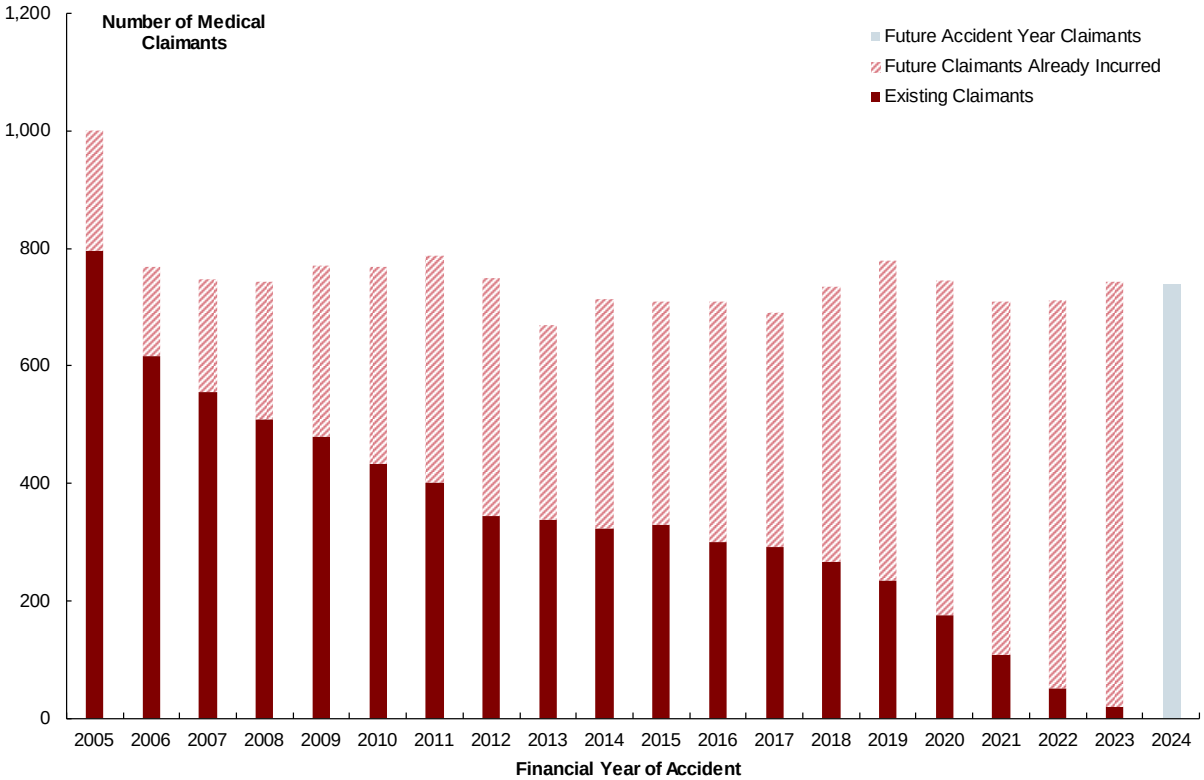
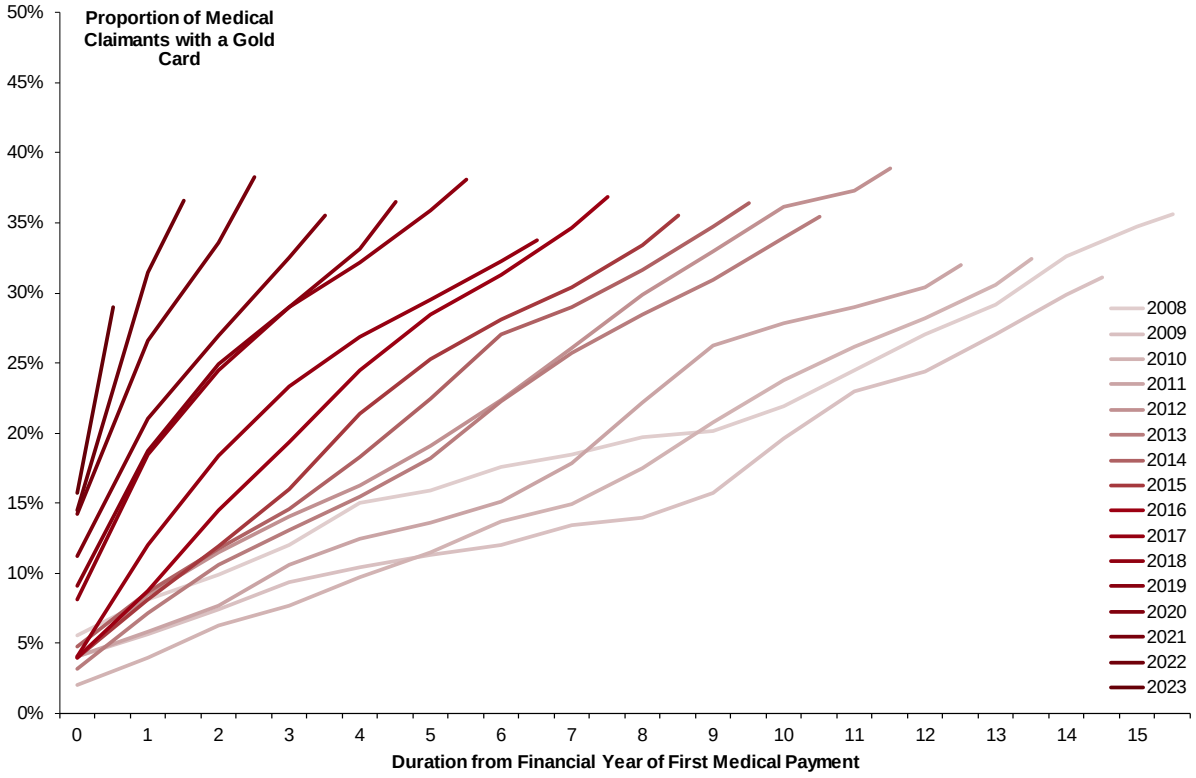


Figure 10.7: Projected ultimate claim rates by first accident years



10.3.5 Once we have projected the medical claimant population, we then model rates of Gold Card issuance over time. The majority of Gold Cards are issued as a result of the veteran reaching 60 impairment points, or 50 impairment points if the veteran has SRDP eligibility. As such, it may take medical claimants several years to accumulate the level of impairment points required. Figure 10.8 shows the historical rates of Gold Card issuance by duration from first medical payment by cohort. Note that cohorts here are defined by financial year of first medical payment. The pattern of issuance has changed considerably over the period presented. Older cohorts displayed low issuance rates initially, but have exhibited significantly higher issuance rates at later durations. Conversely, more recent cohorts are seeing higher issuance rates at earlier durations. This likely reflects policy changes within DVA as well as the growth observed in PI claims over recent years.

Figure 10.8: Proportion of MRCA Medical Claimants with a Gold Card by Duration from Financial Year of First Medical Payment

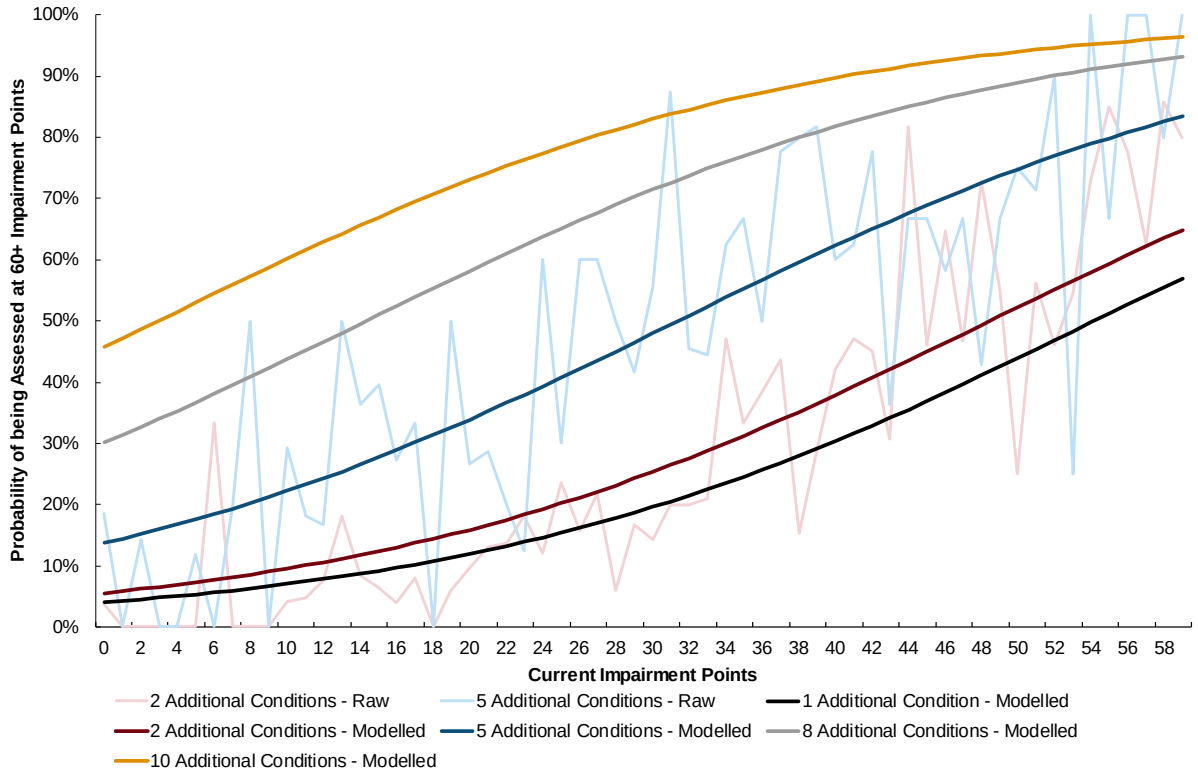


10.3.6 We have selected an ultimate proportion of medical claimants that will receive a Gold Card, and adjusted the duration specific issuance probabilities such that each cohort will converge to the assumed ultimate proportion over time. At the previous valuation, we assumed that 40 per cent of claimants will eventually receive a Gold Card. In the 2023 financial year, the number of Gold Cards issued was around 2,600, almost 40 per cent higher than expected. In the 6 months to 31 December 2023, there has been a further 2,000 medical claimants with a Gold Card issued. This change in the experience is likely being driven by the large volume of PI claims that have been accepted over the past 18 months, and the resulting increase to whole person impairment points because of PI claims assessments.

10.3.7 For this valuation, we conducted some additional analysis to quantify the potential impact the currently outstanding IL and PI claims may have on the whole person impairment ratings of existing medical claimants. In early 2024, we received additional MRCA PI conditions data from DVA which describes the relative contribution of each accepted IL condition to the PI

impairment point assessment. This allowed us to examine the relationship between the number of conditions assessed and resulting changes to impairment point scores. Specifically, we utilised a generalised linear model to model the probability of being assessed as having 60 or more impairment points (which would grant Gold Card eligibility), based on a veteran's current level of impairment as well as the number of outstanding PI claims and IL conditions waiting to be finalised, using experience data from the previous two years. Figure 10.9 shows the raw data for veterans with 2 and 5 additional conditions assessed in a PI claim and modelled probabilities for veterans with a wider range of additional conditions assessed.

Figure 10.9: Probability of being assessed at 60 or more impairment points



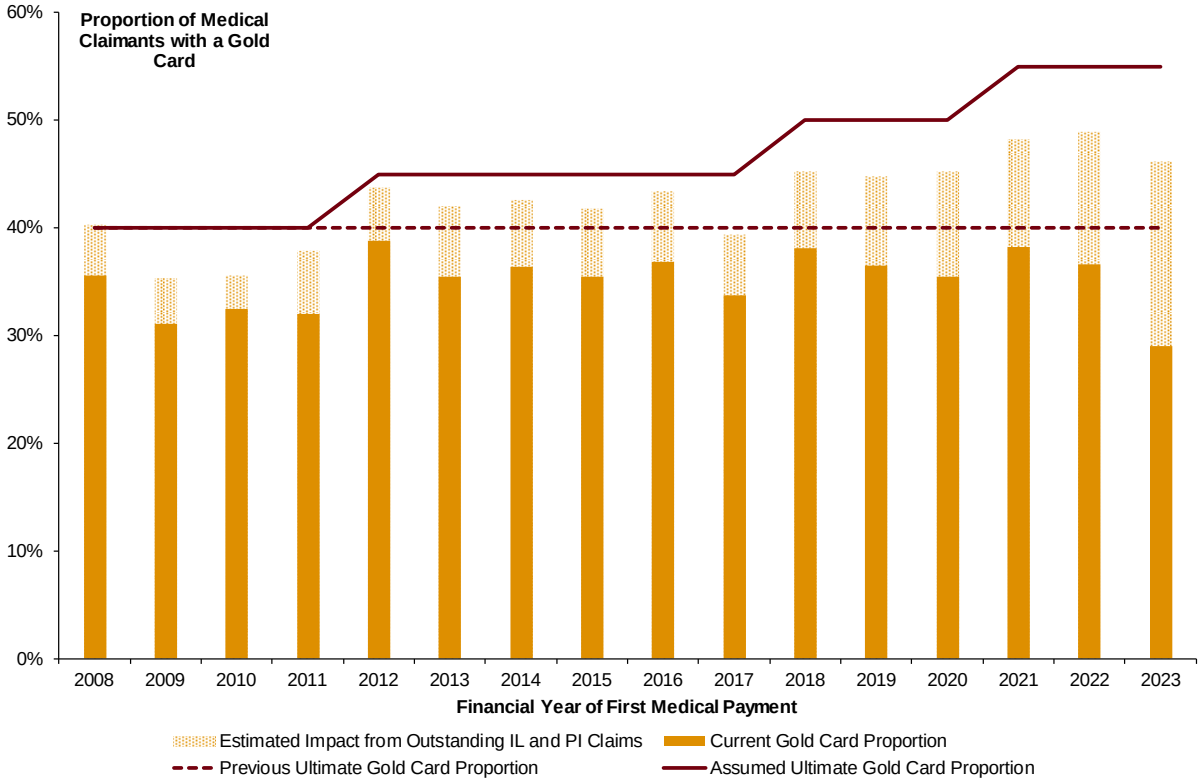
10.3.8 Although the raw data shows volatility in experience, the resulting fitted probabilities are broadly in line with expectations. That is, higher probabilities are expected of reaching 60 or more impairment points with higher numbers of outstanding IL and/or PI conditions and these probabilities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

10.3.9 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 85 per cent). This yields an estimate of the number of medical claimants expected to reach 60 or more impairment points and thus receive a Gold Card as a result of their lodged IL conditions to date as shown in Figure 10.10 below. It can be seen that the proportion of medical claimants with a Gold Card is likely to increase after all outstanding claims have been processed and may exceed the previous assumption of 40 per cent for most of the cohorts.

10.3.10 This, combined with the higher than expected number of Gold Cards issued over the past 12 months, has led us to increase our assumed ultimate Gold Card proportions. The adopted proportions are set out in Figure 10.10 and start at 40 per cent for the 2005 to 2011 first

payment year cohorts and increase to 55 per cent for the most recent cohorts. This increase is substantial and reflects the higher than expected increase in Gold Card claimants in the most recent year and the expected impact of finalising outstanding IL and PI claims. We note the substantial uncertainty inherent in setting an ultimate assumption in the face of evolving experience. It may be some time until the experience is stable enough to provide more certainty in the assumed ultimate Gold Card proportions and we will continue to review this assumption as experience emerges.

Figure 10.10: Proportion of Medical Claimants with a Gold Card by Financial Year of First Medical Payment



10.3.11 Once the future claimant population by card status has been projected, a utilisation rate, an average expenditure per active claimant and a pharmaceutical loading is applied to estimate the future cost of medical benefits. The utilisation rates by duration and financial year of first medical payment cohort for White Card holders are shown in Figure 10.11. Utilisation rates for White Cards begin at 100 per cent by definition. Utilisation rates for White Cards are volatile and ultimate utilisation rates vary across cohorts. For existing claimants, the current experience has been interpolated using an average of the most recent two years of utilisation rates. The experience of claimants from the two most recent cohorts has been interpolated and applied for future claimants. Actual and projected utilisation rates for a sample of cohorts is shown Figure 10.12 along with the selected utilisation rates for future new medical claimants.

Figure 10.11: White Card Utilisation by Duration from Financial Year of First Medical Payment

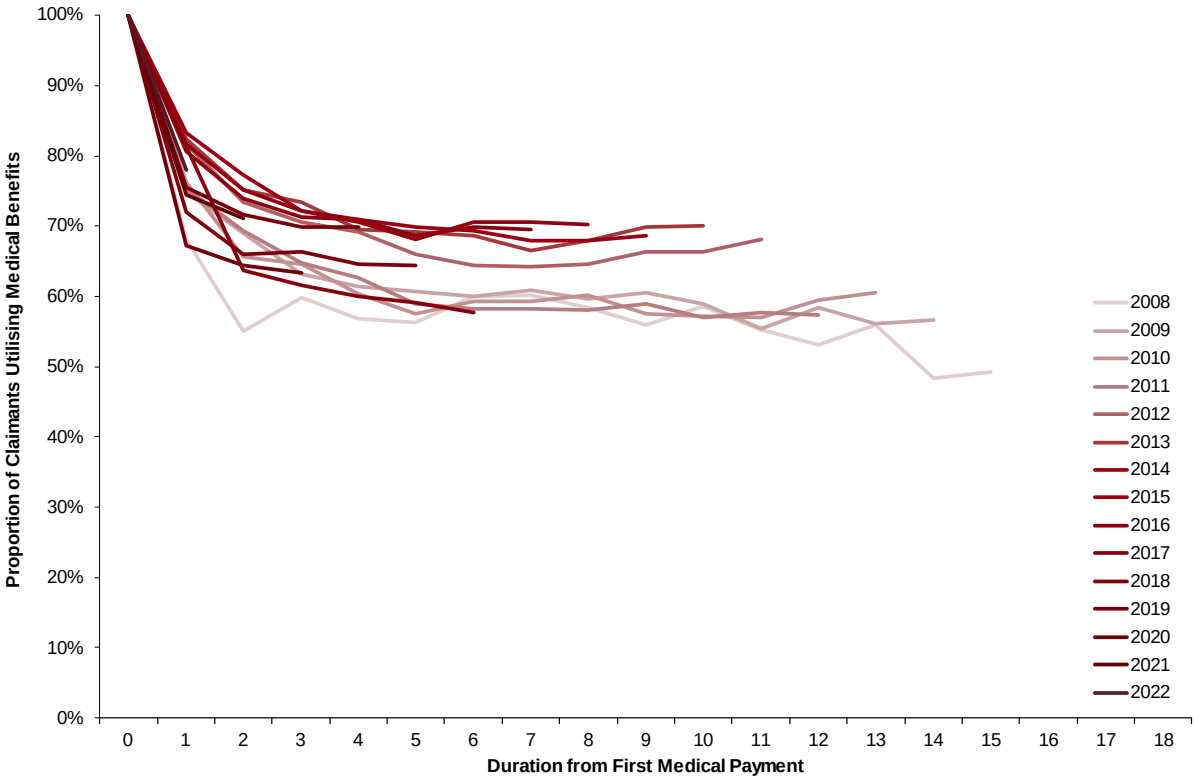
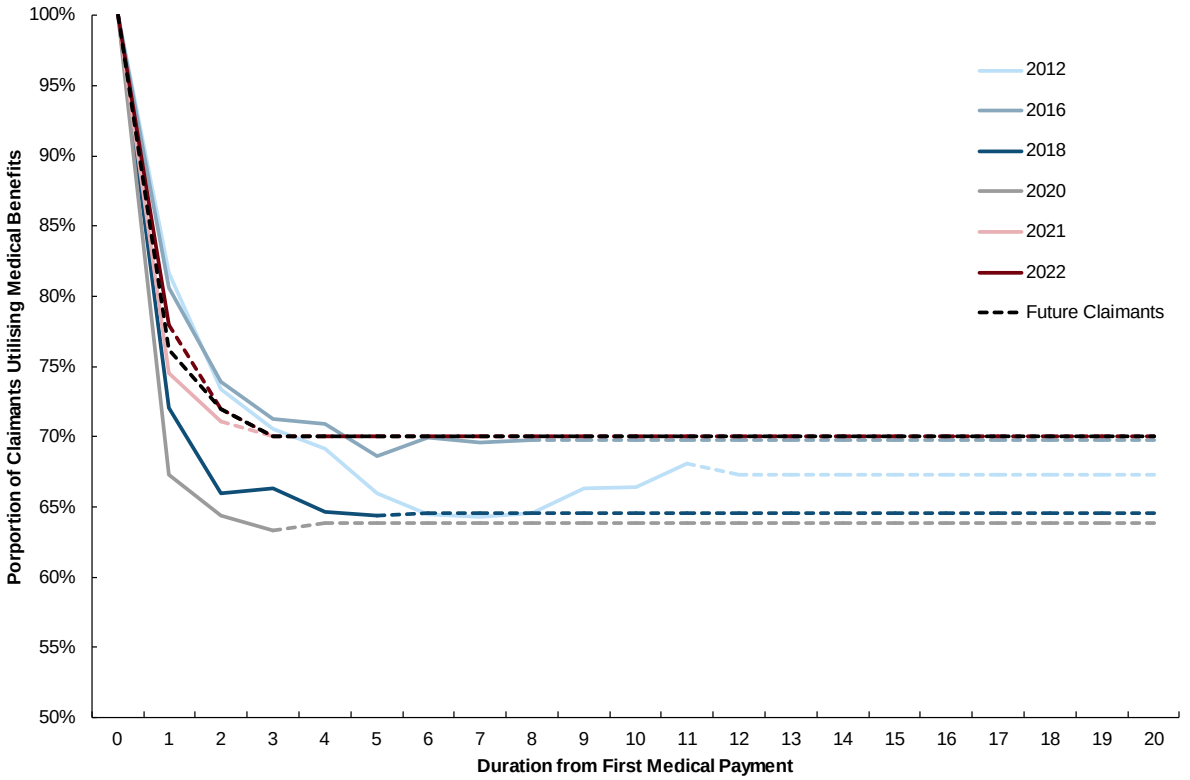


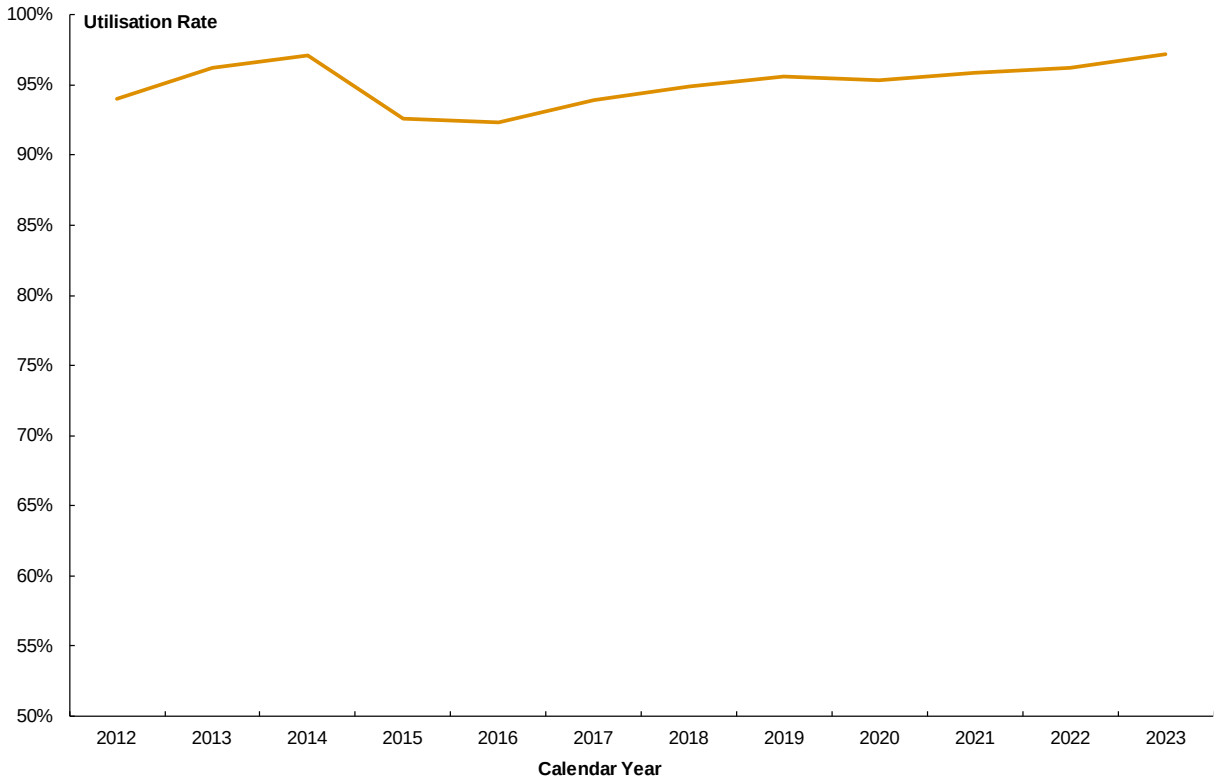
Figure 10.12: Projected White Card Utilisation by Duration from First Medical Payment



10.3.12 Figure 10.13 below shows historical Gold Card utilisation rates by calendar year. Utilisation rates are significantly higher for claimants with a Gold Card, again reflecting the expanded

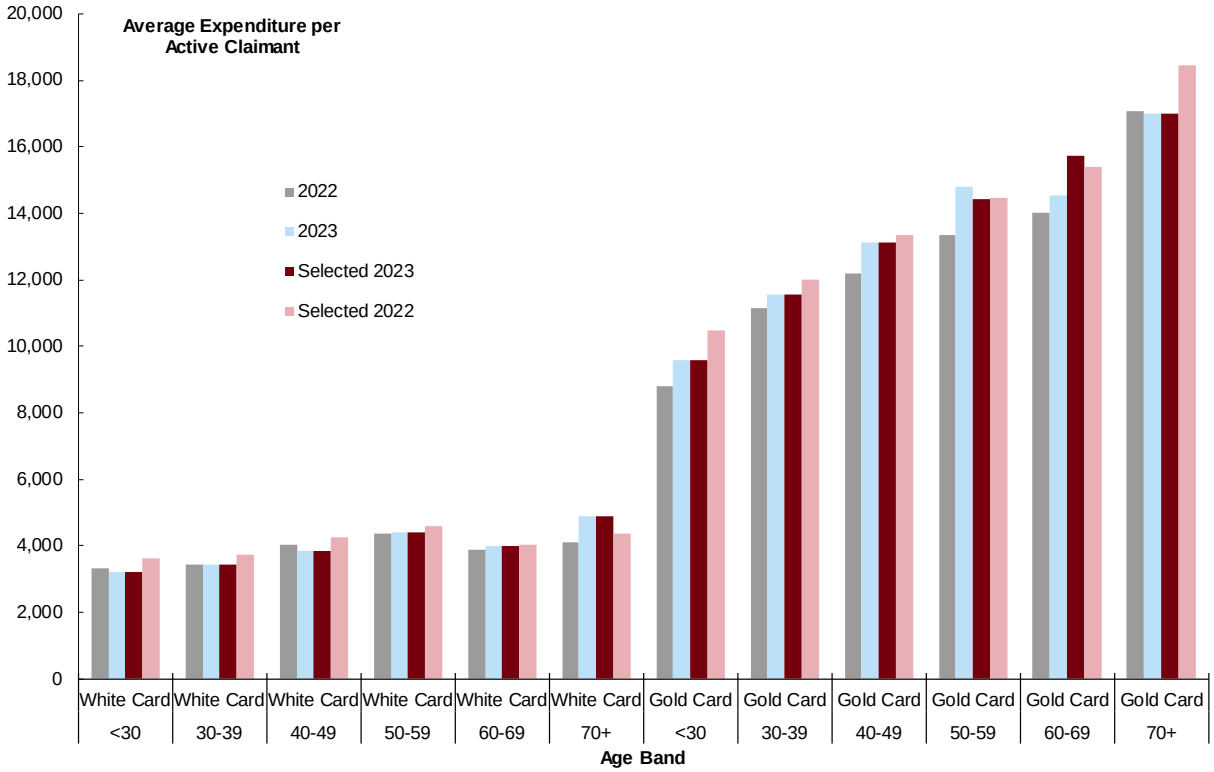
range of benefits provided under a Gold Card as well as the higher levels of impairment implied through having a Gold Card. Gold Card utilisation rates have been relatively stable over time, increasing slightly in the most recent year. We have selected a Gold Card utilisation rate of 97 per cent, compared with 96 per cent at the previous valuation.

Figure 10.13: Gold Card Utilisation Rate by Calendar Year



10.3.13 The average expenditure per active claimant, that is the average annual expenditure for claimants utilising medical benefits, is assumed to vary by card type and age band. Figure 10.14 shows the average expenditure observed for MRCA over the last two calendar years. The average expenditure is substantially higher for Gold Cards across all ages, reflecting the fact that all medical expenditure is covered as well as the higher levels of impairment required for eligibility. The average expenditure has increased slightly for most age bands over the most recent calendar year. The assumed amounts are based on the most recent experience, and 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.

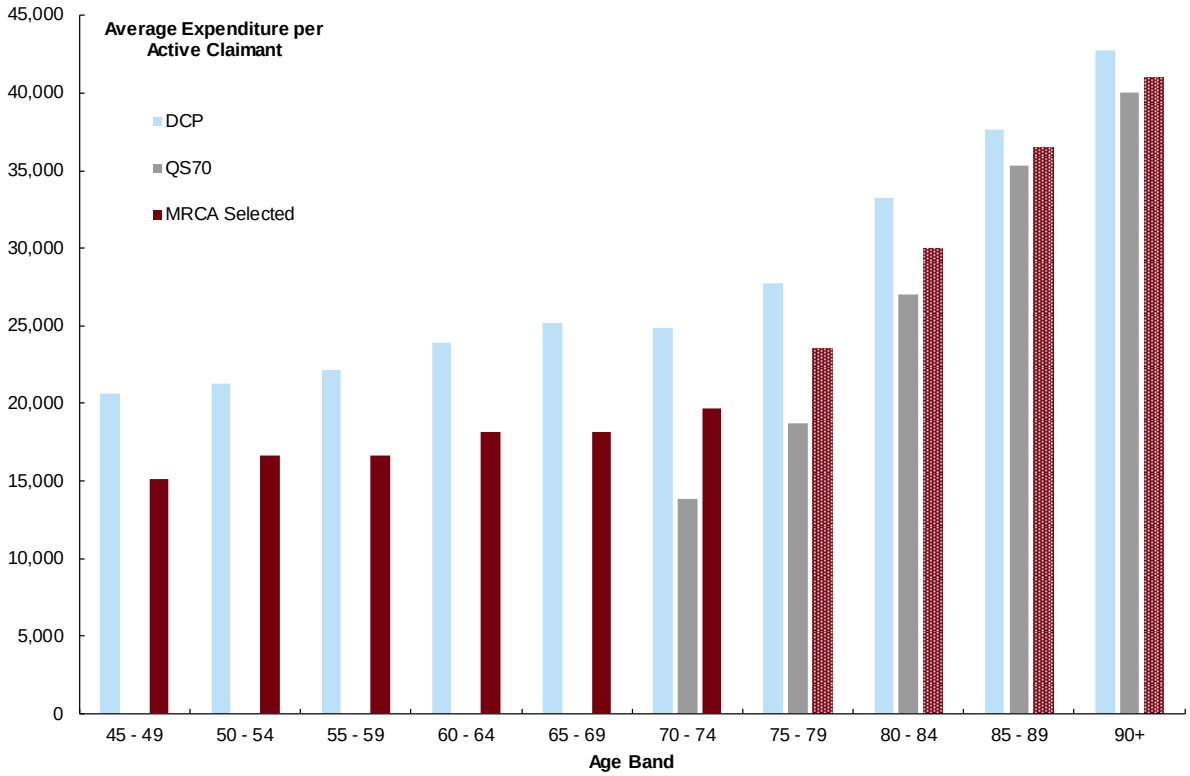
Figure 10.14: Average expenditure per active claimant



10.3.14 As MRCA commenced in 2004, there is very little experience currently available for those aged over 70. At the previous valuation, we adopted a constant expenditure assumption for ages 70 and over for both White Card and Gold Card claimants in the absence of any information suggesting otherwise. For this valuation, we received some additional analysis from the DVA Data and Insights Branch on the VEA Gold Card experience which we have no visibility on in the valuation data we receive. Figure 10.15 shows the average expenditure per active claimant for VEA veterans aged 70 and over with qualifying service (QS70) and those receiving Disability Compensation Payments (DCP), compared with the adopted Gold Card average expenditure. Note that the analysis provided by DVA was performed using data from the 2022 financial year, so values have been indexed by one year. Note also that the DCP and QS70 figures include pharmaceuticals, so the selected MRCA average expenditure figures include a loading for pharmaceuticals. Also note that payments related to Rehabilitation Aids and Appliances have been removed from the QS70 and DCP average sizes as these benefits are modelled separately as described in Chapter 12.

10.3.15 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 may also receive a VEA Gold Card, which implies that the Veteran hasn't received a Gold Card by other means. It is possible that the DCP Gold Card cohort may have higher levels of impairment compared with the MRCA cohort due to the requirement to have war service and high incapacity. It is also plausible that the QS70 cohort may have lower levels of impairment compared with the MRCA cohort as they have not met eligible criteria for a Gold Card by any other means.

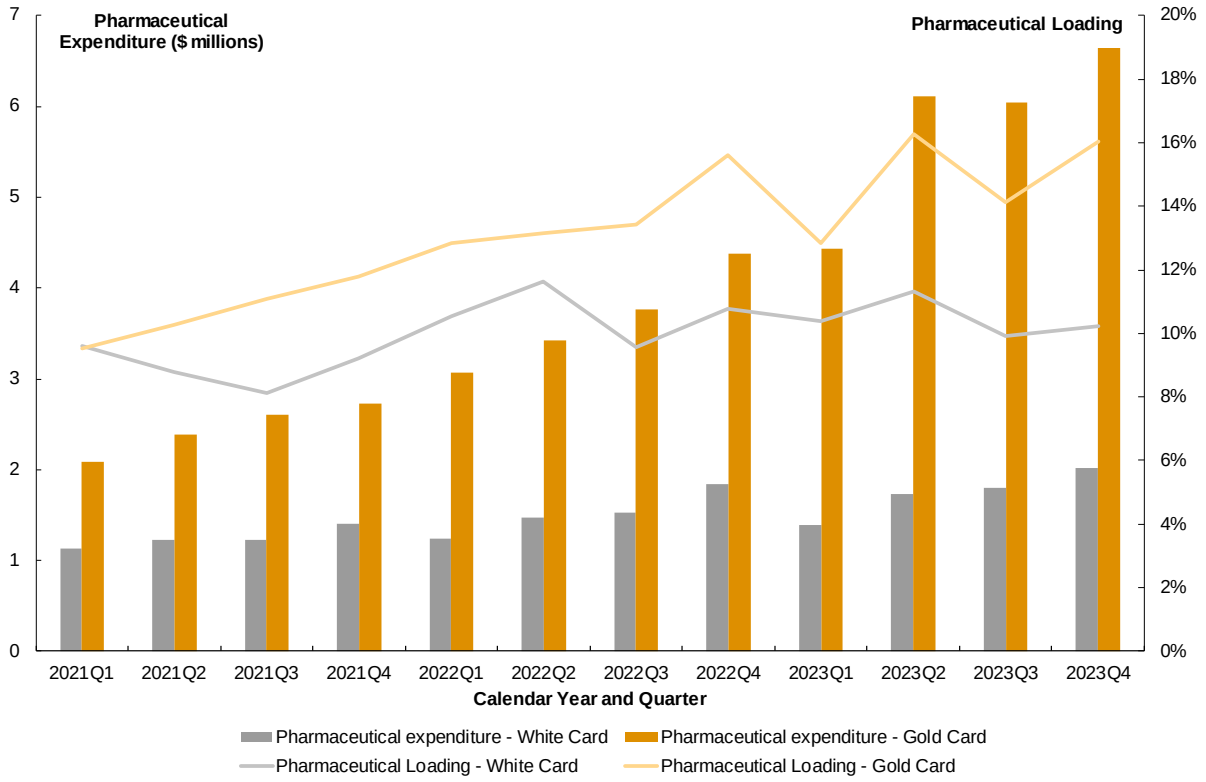
Figure 10.15: VEA DCP and QS70 average Gold Card expenditure per active claimant



10.3.16 The average expenditure for both DCP and QS70 Gold Card claimants increases substantially after age 75. The DCP average expenditure per active claimant is significantly higher than the MRCA experience observed to date from 45 to 75. However, while the QS70 experience is lower than the MRCA experience at ages 70 to 74, the DCP and QS70 average expenditure converge at older ages. This could suggest that age-related medical costs are driving the higher Gold Card average expenditure at older ages, rather than the levels of impairment. For this valuation, we have assumed that MRCA average expenditure per active Gold Card claimant will increase after age 75 in a similar fashion to that observed for the DCP and QS70 cohort, reaching around $41,000 per year after age 90. For those aged 80 and over with a White Card, where experience is currently not available, we have continued to assume that average expenditure will be consistent with the 70 to 79 age group as only treatment for service-related conditions is covered. We will continue to monitor this assumption as more experience emerges or if new information comes to light.

10.3.17 As with DRCA, 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 this valuation, we received unit record pharmaceutical transactions data for the first time. In previous valuations, we relied on aggregate pharmaceutical payments from DVA's general ledger to determine a loading to apply to all medical payments. This new data allowed us to analyse the pharmaceutical experience for White Card and Gold Card holders separately. Figure 10.16 shows the pharmaceutical expenditure and loading by card type. The majority of pharmaceutical expenditure is coming from Gold Card holders and the loading is higher for Gold Card holders. We have adopted a loading of 15.5 per cent and 10.5 per cent for Gold Cards and White Cards respectively; this represents a loading of around 14 per cent of total medical expenditure which compares with 12 per cent adopted at the previous valuation.

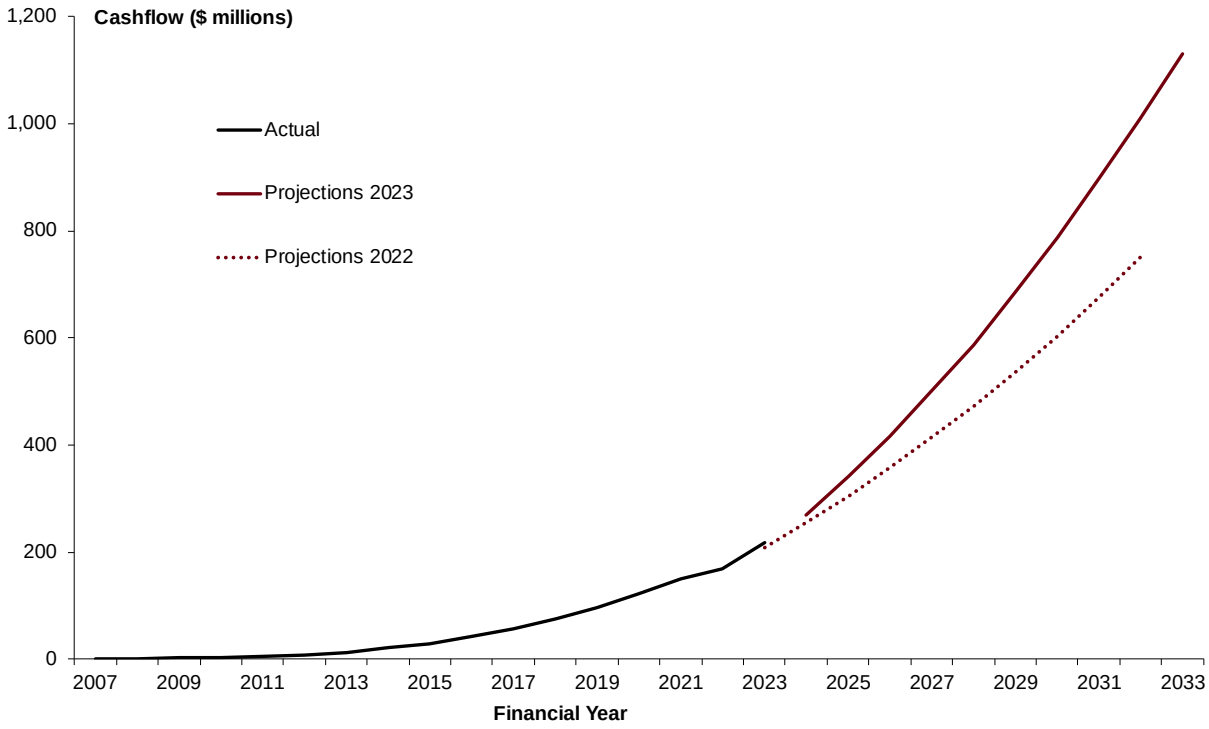
Figure 10.16: Pharmaceutical Expenditure and Loading by Card Type



10.4 Projected Cashflows and Liability Estimate

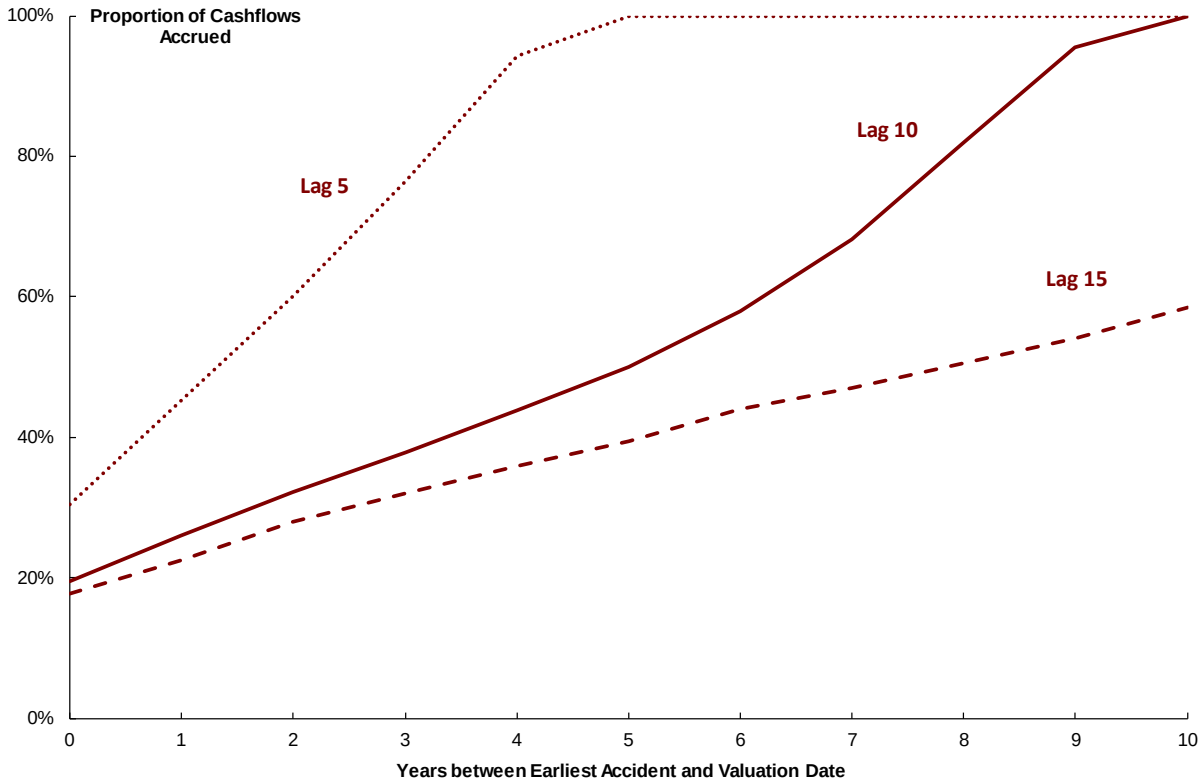
10.4.1 Applying the utilisation rates, average expenditure and pharmaceutical loading to the projected medical claimant population gives an estimate of total future medical expenditure as shown in Figure 10.17.

Figure 10.17: Historical and projected cashflows for MRCA medical



10.4.2 Some of these cashflows will relate to incidents that occur after the valuation date. In order to arrive at an estimate of the incurred expense, we have examined how accident dates are spread over the period between the earliest accident year and the year in which expenditure is first accrued. Figure 10.18 shows the proportion of accepted conditions with an accident prior to a given date within this period for three different lag periods. For example, for a claimant with an earliest accident year of 2018 and a 10 year lag until medical expenditure is incurred, the proportion of expenditure that is assumed to be accrued as at the valuation date of 30 June 2023 can be found by looking at the Lag 10 curve where the x-axis value is 5, that is, 50 per cent. These proportions converge to 100 per cent by the time of first medical payment as we assume that an individual has discharged at the point at which expenditure first occurs, all future expenditure is assumed to be accrued from that time.

Figure 10.18: Distribution of claims



10.4.3 While it is unlikely that each condition would contribute equally to a veteran's future medical expenditure, there is a strong positive correlation between the number of conditions and whole person impairment levels and this likely translates into a positive relationship between additional claimed conditions and future medical expenditure. As a simplifying assumption, we have used the proportions shown in Figure 10.18 to split projected expenditure between amounts accrued at the valuation date and amounts expected to be accrued in future accident years. Given the high level of uncertainty around the estimates of medical costs, we do not believe that this simplifying assumption is unreasonable.

10.4.4 Table 10.1 shows the estimate of the MRCA liability to meet medical costs broken down by earliest year of accident. As noted in the previous section, there is now some MRCA liability related to accident years prior to 1 July 2004 and some of the liability shown against later accident years will arise from those with DRCA claims and a MRCA treatment card.

Table 10.1: Outstanding claims liability for MRCA medical costs by year of earliest accident

Year of accident – year ending 30 June	Liability ($'m)
2004 and before	143.7
2005 – 2009	7,123.6
2010 – 2014	6,211.8
2015 – 2019	5,613.0
2020	933.0
2021	797.9
2022	663.9
2023	504.9
Total	**21,991.6**
Expected at 30/06/2023	*15,189.0*

10.4.5 The estimated liability at 30 June 2023 is $21,991.6m. The projected liability in the 2022 valuation for 30 June 2023 was $15,189.0m. Table 10.2 below shows the reconciliation of liability results for MRCA from last year to this year.

Table 10.2: Reconciliation of liability for MRCA medical costs

	$m
Liability estimate as at 30 June 2022 (previous valuation)	**13,627.2**
Assumed Interest	702.6
Projected Payments	(208.7)
Notional Premium	1,068.0
Liability estimate as at 30 June 2023 (previous valuation)	**15,189.0**
Experience effects and assumption changes	
difference between actual and projected payments	(8.4)
change due to experience	287.7
change due to new entrant projection	1,284.9
change due to gold card issuance probabilities	2,828.4
change due to utilisation rates	223.8
change due to pharmaceutical loading	474.9
change due to average size	1,711.2
Current Estimate	**21,991.6**

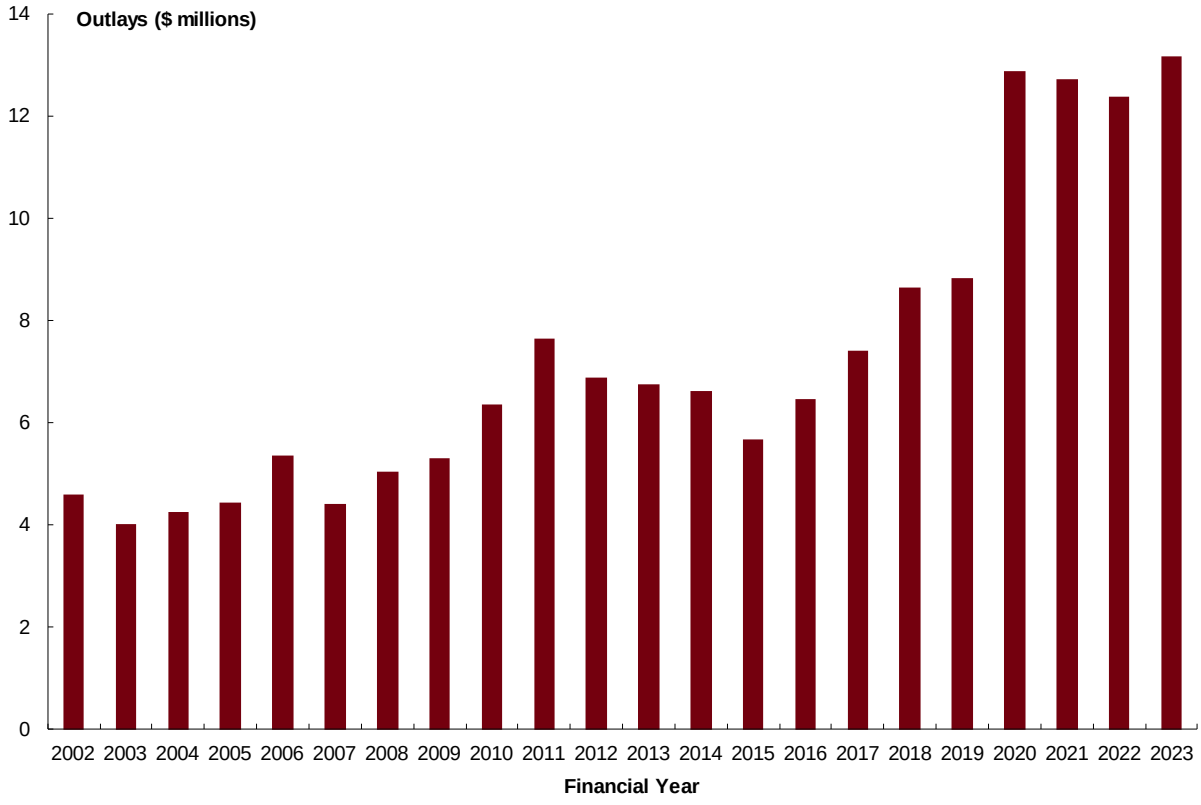
11 DRCA Rehabilitation

11.1 Recent Experience

11.1.1 The main objective of rehabilitation expenditure is to return the veteran to work. This tends to primarily be through socialisation and retraining with some expenditure also related to minimising claimants' functional impairments, for example through the provision of aids and appliances. DVA clients receiving incapacity payments are required to participate in the rehabilitation program. DRCA claimants, due to their higher average age, will tend to have reduced prospects for a return to the labour force. At the same time, the degree of functional impairment is likely to increase with advancing age.

11.1.2 Figure 11.1 shows the expenditure on rehabilitation for DRCA since 2002. The relative importance of the two objectives in DVA's approach to rehabilitation is therefore likely to influence DRCA outlays in this area. For example, DVA advised that the period of rapid growth between 2007 and 2011 was the result of an increased focus on rehabilitation for all veterans, not just those with a prospect of returning to work. Subsequently, rehabilitation efforts became more focussed on return to work programs and, given the older age profile of DRCA claimants, this is likely to have explained the decline until 2015. Payments increased dramatically in 2020 and have since remained at similar levels, with a slight increase in the most recent financial year.

Figure 11.1: Expenditure on DRCA rehabilitation



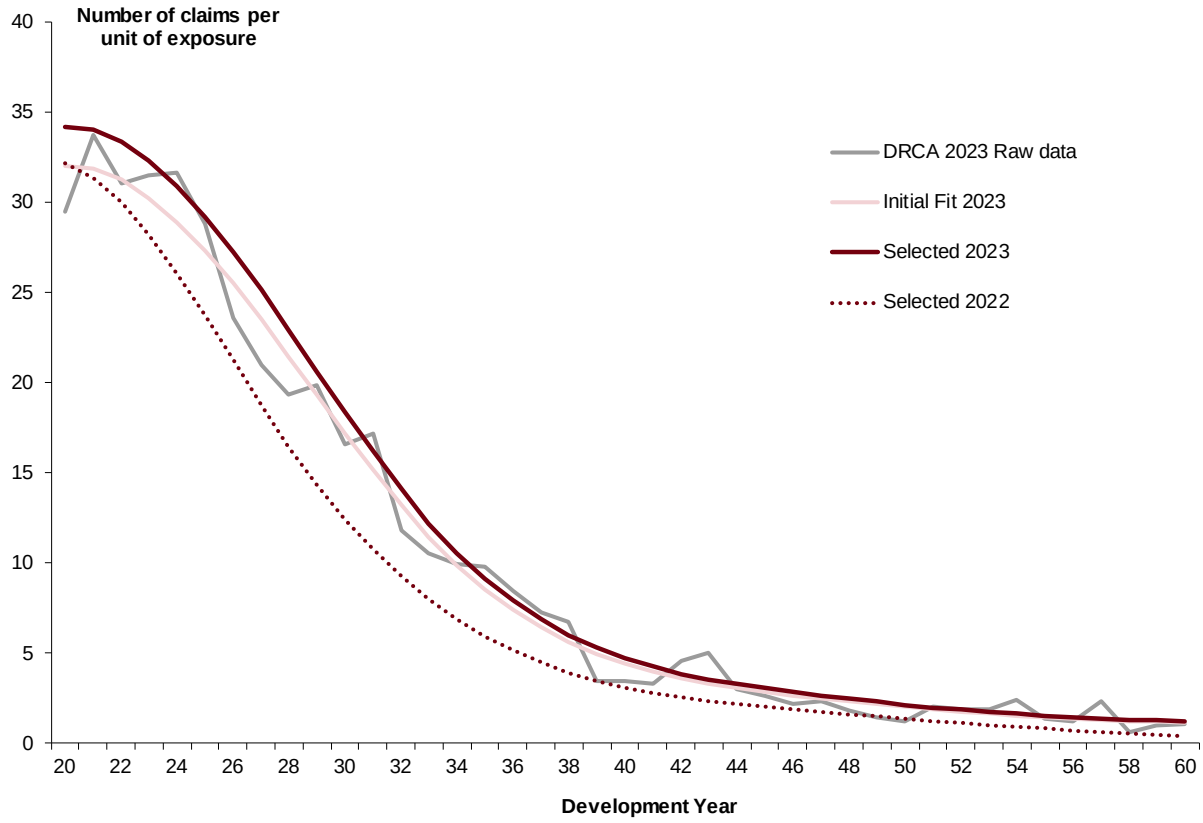
11.1.3 In recent years, claimants who were studying were able to retain 100 per cent of their incapacity benefit past the initial 45 week period. DVA staff advised that this led to increasing numbers of claimants remaining on rehabilitation programs than they had seen historically and could have contributed to the high levels of expenditure seen in recent years. This scheme has since closed.

11.2 Valuation Assumptions

11.2.1 Our modelling approach involves fitting a cubic spline to the pattern of claims per unit exposure by development year observed over the last two years, and then applying an assumption on average amounts paid per claim.

11.2.2 Figure 11.2 compares the number of claims per unit of exposure over the most recent calendar year with the assumptions adopted for the current valuation and the 2022 valuation. The claim rates per unit of exposure are higher compared with the selected assumption from last year's valuation. This reflects the additional payment nominals added to DRCA rehab for this valuation. As with last year, we have made an allowance for the potential impact of the high level of open IL claims on rehabilitation benefits. To account for potential impacts of processing delays on the most recent experience, we included a proportional increase of 7 per cent to the number of claims per unit of exposure, based on the level of lodgements and historical conversion rates between initial liability and rehabilitation payments.

Figure 11.2: Number of claimants per unit of exposure – DRCA rehabilitation

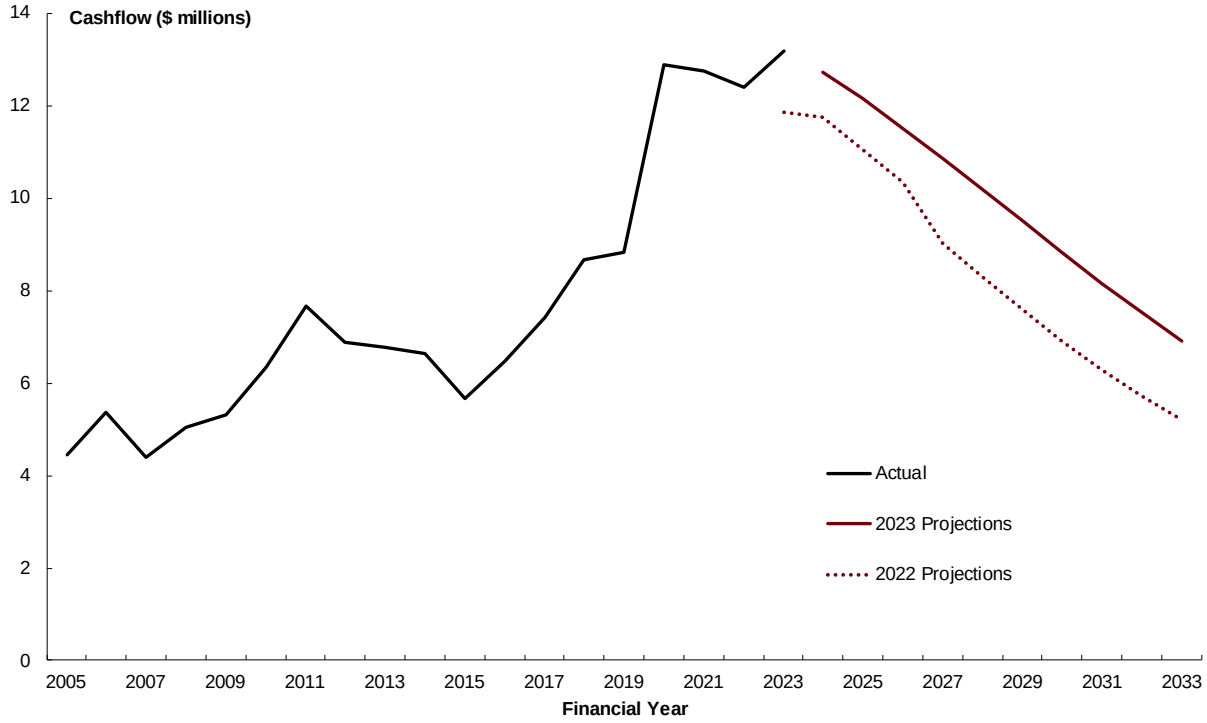


11.2.3 The average cost per claimant was selected to be $4,370, based on experience over the most recent year. We have assumed that the average cost per claimant will increase by 3.7 per cent per annum in future. This is somewhat higher than the inflation seen over the past few

years but we regard it as a reasonable assumption going forward given that costs are expected to be driven in large part by wages.

11.2.4 The resulting projected cashflows are shown in Figure 11.3, together with the historic cashflows and the projections from the 2022 valuation.

Figure 11.3: Historic and projected DRCA rehabilitation payments



11.3 Liability Estimate

11.3.1 Table 11.1 shows the estimate of the liability for DRCA rehabilitation costs broken down by year of accident.

Table 11.1: Outstanding claims liability for rehabilitation costs by year of accident

Year of accident (year ending 30 June)	Liability (inflated and discounted) ($'m)
1979 and before	7.2
1980 – 1984	6.6
1985 – 1989	10.5
1990 – 1994	17.7
1995 – 1999	27.6
2000 – 2004	41.4
Total	111.0
Expected at 30/06/2023	89.5
Total (30/06/2022)	**96.8**

11.3.2 The 2022 valuation projected a liability of $89.5m as at 30 June 2023. The current estimate is $111.0m, which is $21.5m higher than expected, reflecting the change in the nominal mapping and the update to assumptions. Table 11.2 reconciles the current liability estimate with the earlier figure.

Table 11.2: Reconciliation of liability for rehabilitation costs

	$m
Liability estimate at 30/06/22 (previous report)	**96.8**
Assumed Interest	4.5
Projected Payments	(11.8)
Notional Premium	0.0
Projected liability as at 30 June 2023 (previous valuation)	**89.5**
Experience effects and Assumption changes	
difference between actual and projected payments	(1.3)
change due to nominal mapping	20.0
change due to claimant projection	17.9
change due to average cost	(15.1)
Current Estimate	**111.0**

12 MRCA Rehabilitation

12.1 Benefit Overview

12.1.1 For this valuation, we have separated MRCA rehabilitation benefits into two categories which we refer to as rehabilitation programs and aids and appliances.

12.1.2 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. 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.

12.1.3 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.

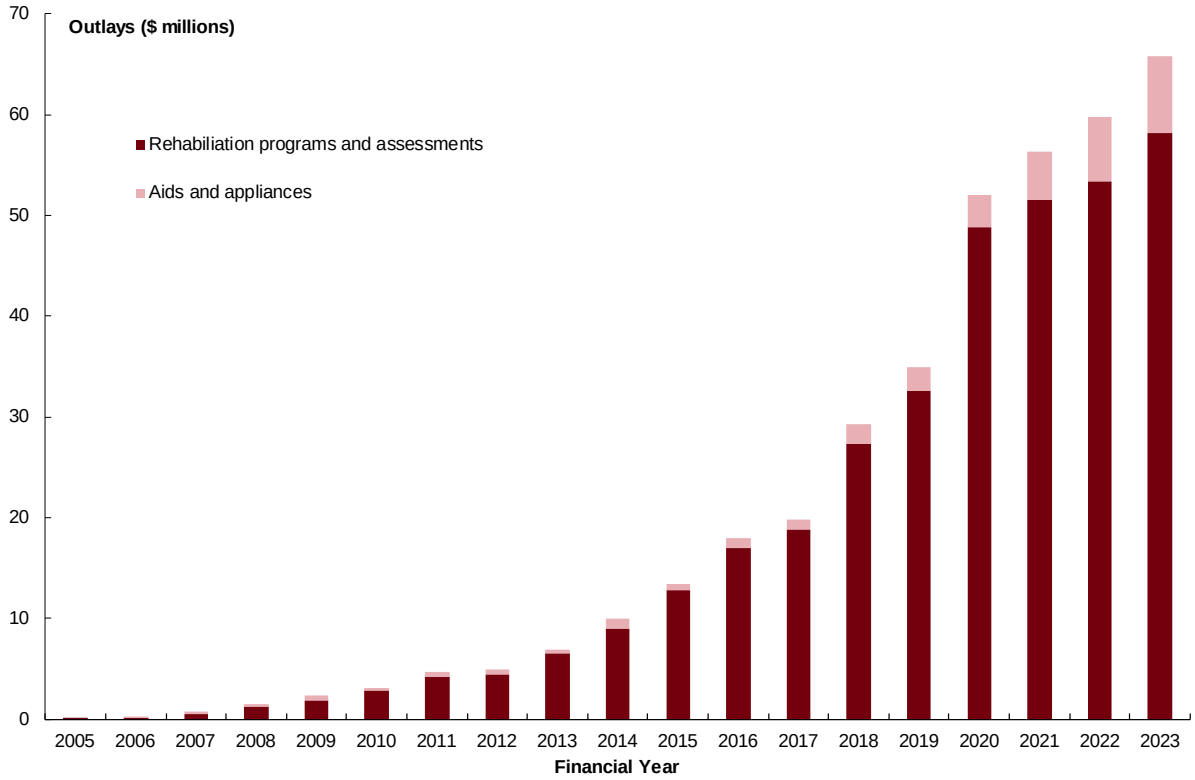
12.1.4 The second category consists of payments made under the Rehabilitation Appliances Program (RAP). The RAP provides aids, equipment and modifications to help veterans to live safely and independently. The aids, equipment and modifications available can be classified into the following broad categories: speech, hearing, cognition and vision devices; feeding appliances; personal hygiene products; diabetes products; assistance dogs; respiratory home therapy devices; beds, chairs and other supports; lifting and mobility devices; orthoses and prostheses; palliative care appliances; home modifications and vehicle modifications. Veterans are eligible for RAP if they have an assessed clinical need and either a Gold Card or a White Card and the equipment is for an accepted condition. As such, the RAP benefits can be considered as an extension to the MRCA medical benefits.

12.2 Recent Experience and Valuation Assumptions

12.2.1 Figure 12.1 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. This has continued in the most recent financial year, with outlays increasing by 10 per cent.

Figure 12.1: Expenditure on MRCA rehabilitation



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

12.2.3 A chain ladder method has been adopted to project future rehabilitation entrants. Figures 12.2 and 12.3 show the relationship between average accident year and the year in which rehabilitation expenditure is first incurred, for rehabilitation programs and aids and appliances respectively. The pattern of claims emerging has changed substantially since the commencement of MRCA and in particular since the introduction of Veteran Centric Reform. Successive accident years are experiencing higher numbers of new entrants, particularly in the initial development years. However, the few most recent accident years do appear to be emerging at similar levels, suggesting that the pattern of claims emerging may be beginning to stabilise.

Figure 12.2: Cumulative claimant numbers – Rehabilitation programs

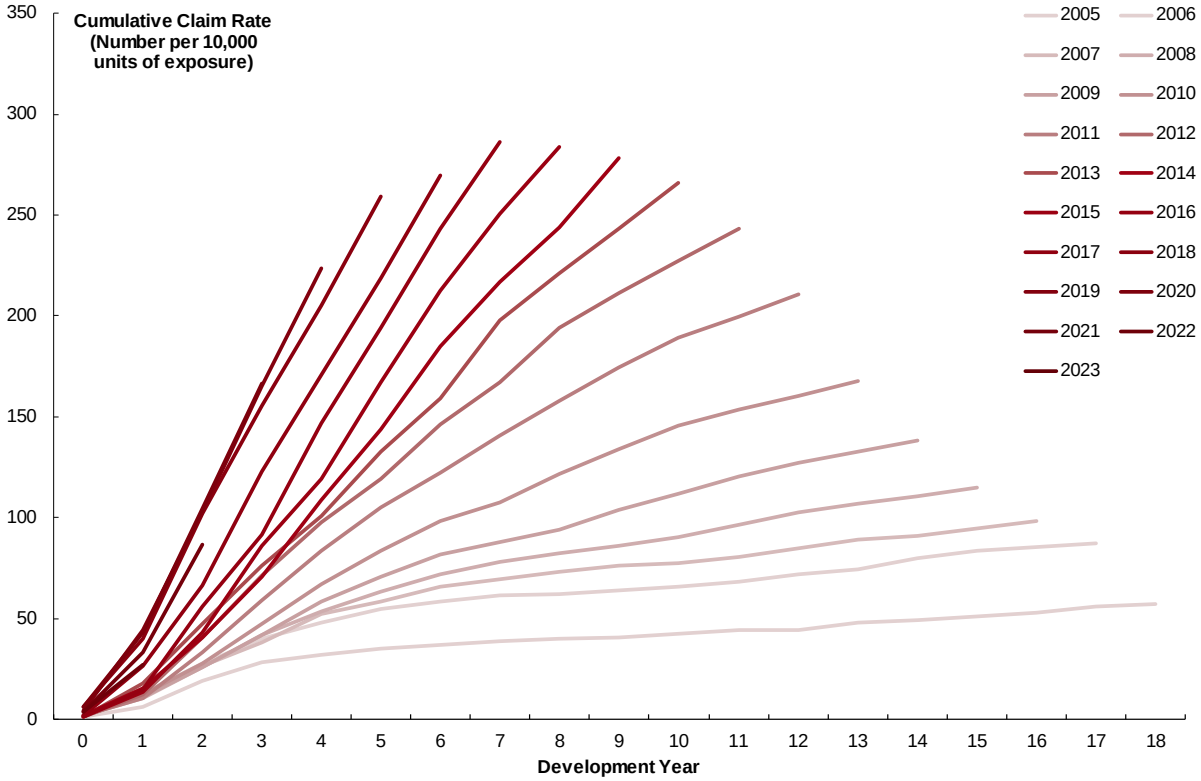
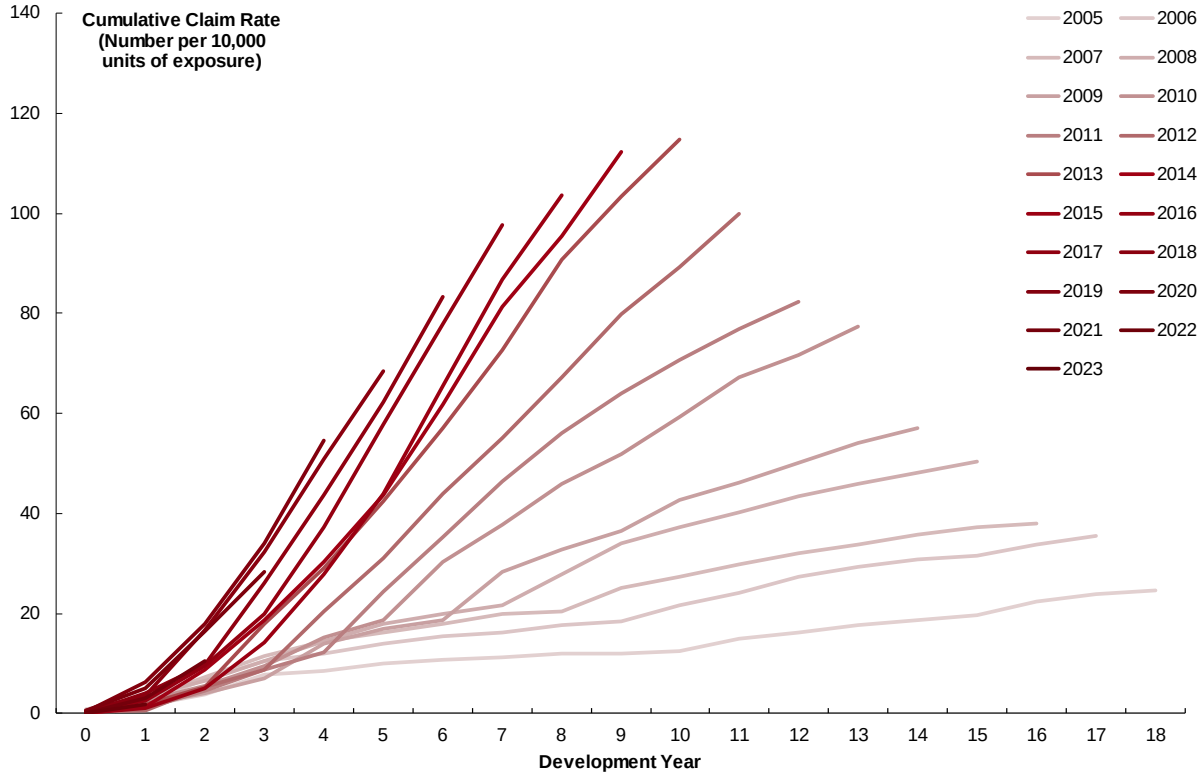


Figure 12.3: Cumulative claimant numbers – Aids and Appliances



12.2.4 We have selected separate development factors for the initial accident years to 2012 and the accident years from 2013 onwards to account for these changes in the pattern of reporting.

We have also made adjustments to the recent accident years to acknowledge the impact processing constraints and subsequent backlog clearance have had on the development of these accident years. Figures 12.4 and 12.5 show the projected cumulative claimant numbers for a subset of accident years, for rehabilitation programs and aids and appliances respectively.

Figure 12.4: Projected cumulative claimant numbers – Rehabilitation Programs

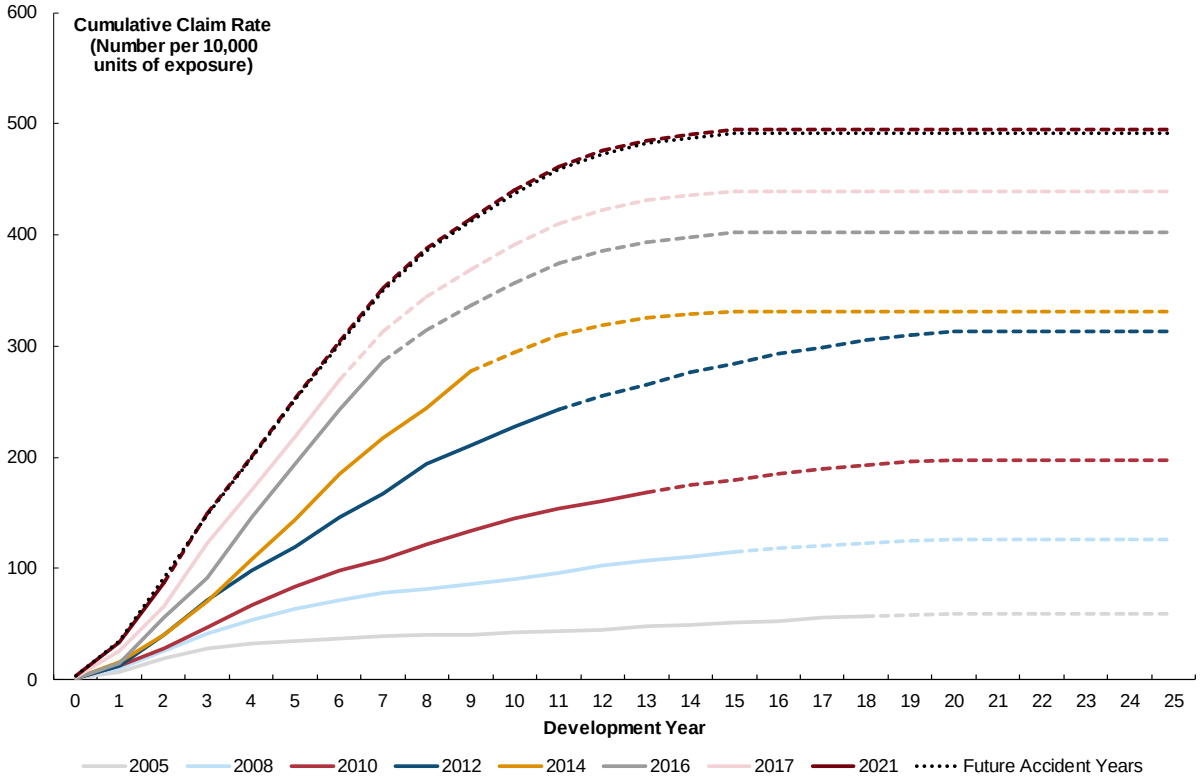
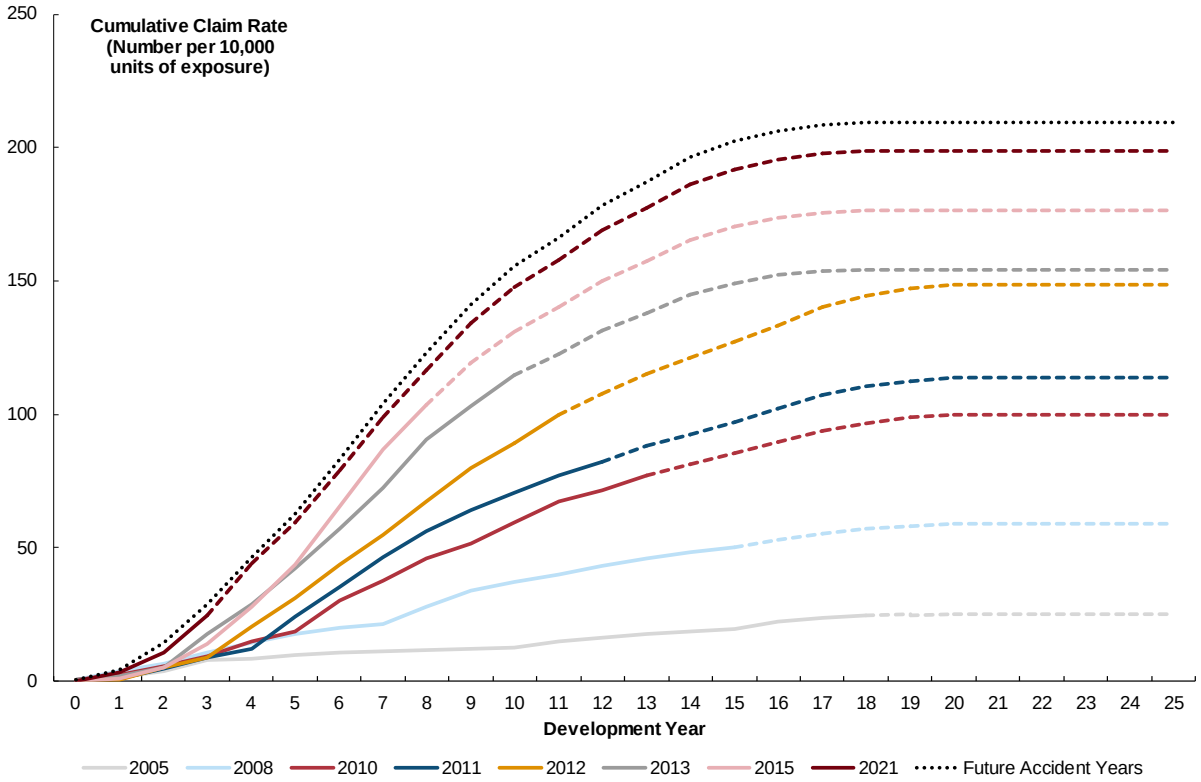


Figure 12.5: Projected cumulative claimant numbers – Aids and Appliances



12.2.5 Once we have projected the cumulative claimant numbers, we then need to project the number of claimants receiving benefits in each future period. Figures 12.6 and 12.7 show the utilisation rates by duration from first rehabilitation payment for each entry year cohort, for rehabilitation programs and aids and appliances respectively. The utilisation rates start at 100 per cent by definition and decrease significantly in the first and second year after entry. For rehabilitation programs the utilisation rates appear to gradually decline over time. For aids and appliances however, after the initial decline, utilisation tends to remain stable over time, suggesting that veterans continue to utilise aids and appliances benefits year on year. Notably, for older first entry cohorts, utilisation of aids and appliances benefits decreased initially but has since increased which suggests that claimants have recommenced the Rehabilitation Appliances Program after a period of not utilising these benefits.

Figure 12.6: Utilisation Rate by Duration from First Payment – Rehabilitation Programs

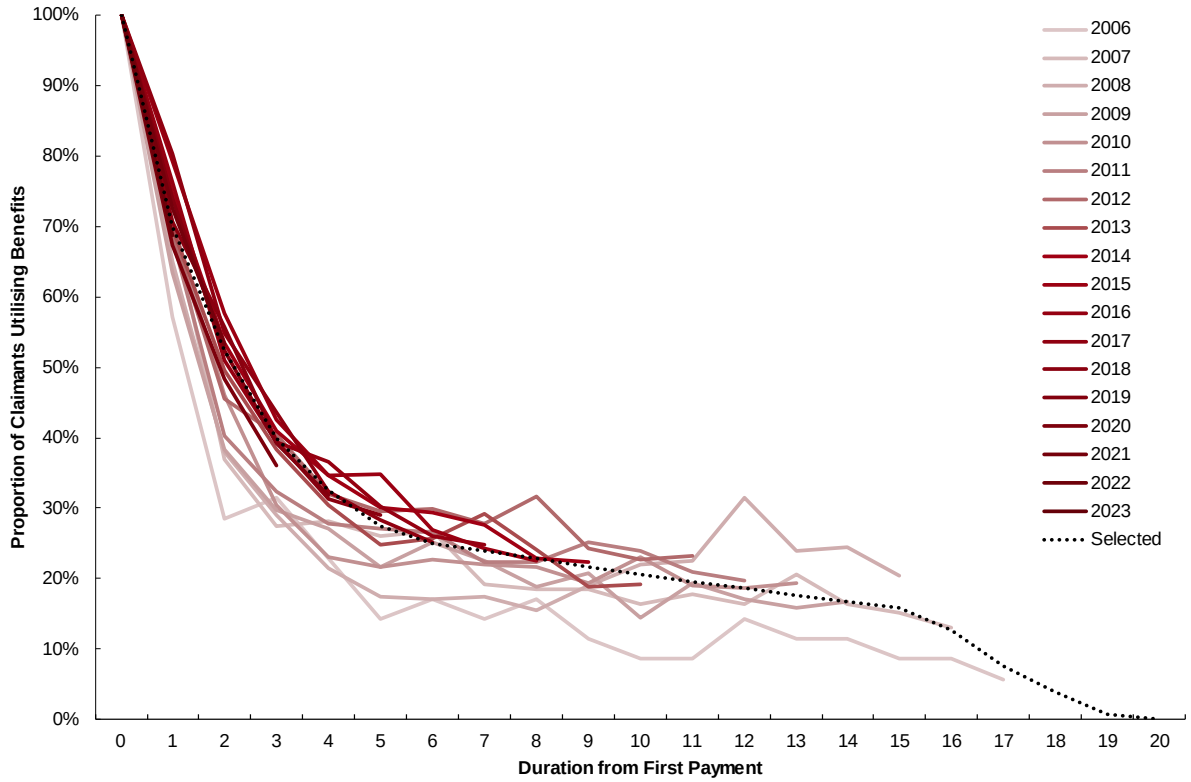
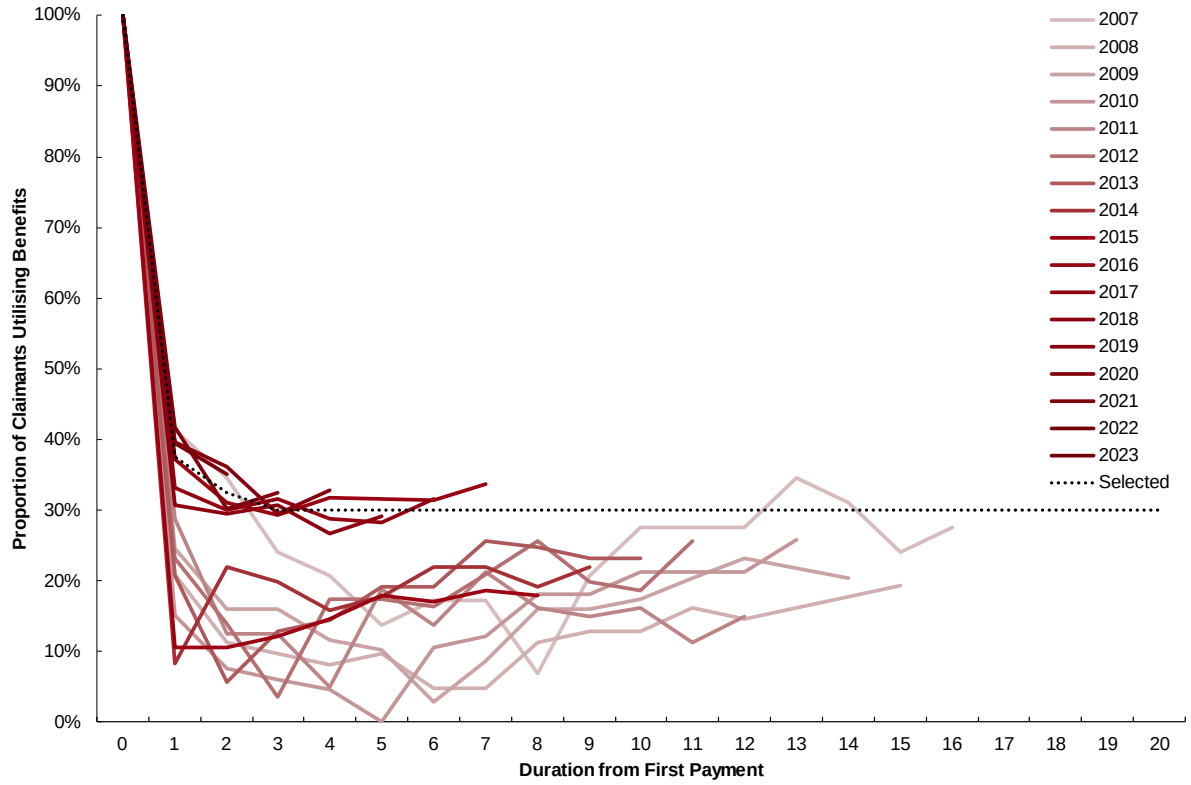


Figure 12.7: Utilisation Rate by Duration from First Payment – Aids and Appliances

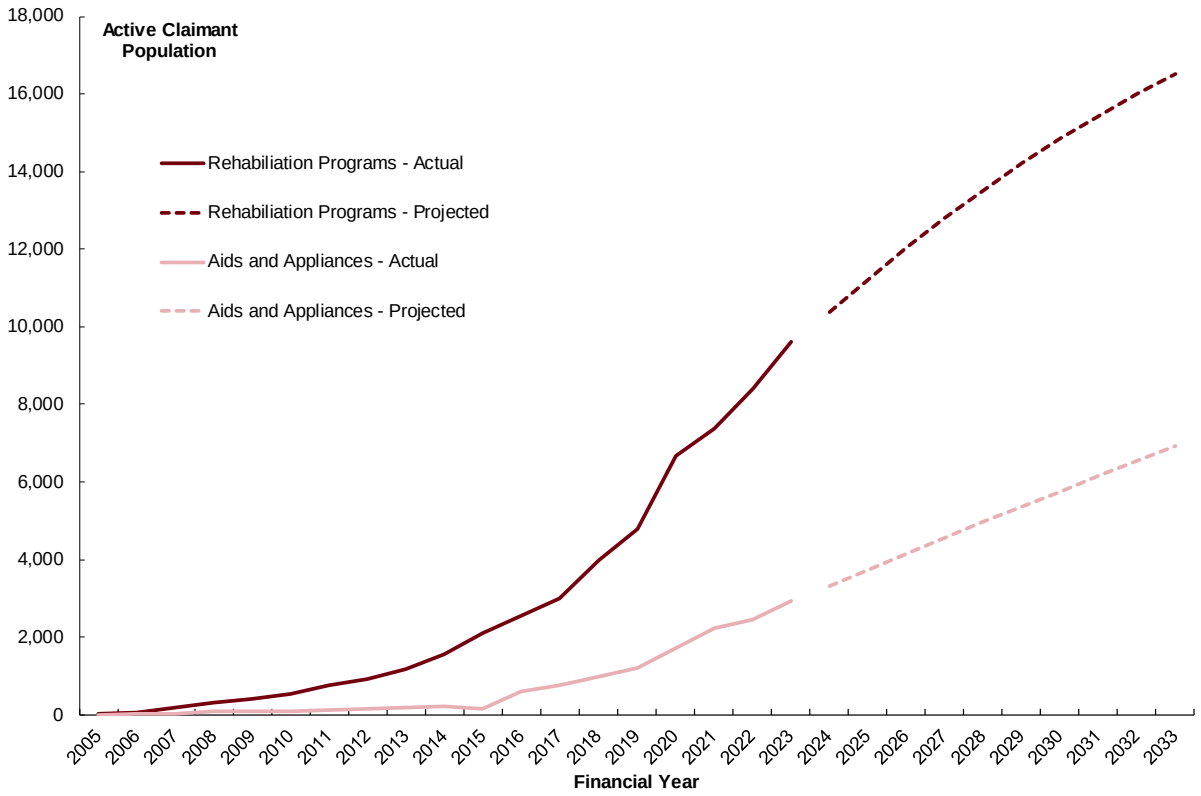


12.2.6 For rehabilitation programs, we have assumed that utilisation declines over time and ceases after 20 years from the first payment. This reflects the nature of rehabilitation programs which

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

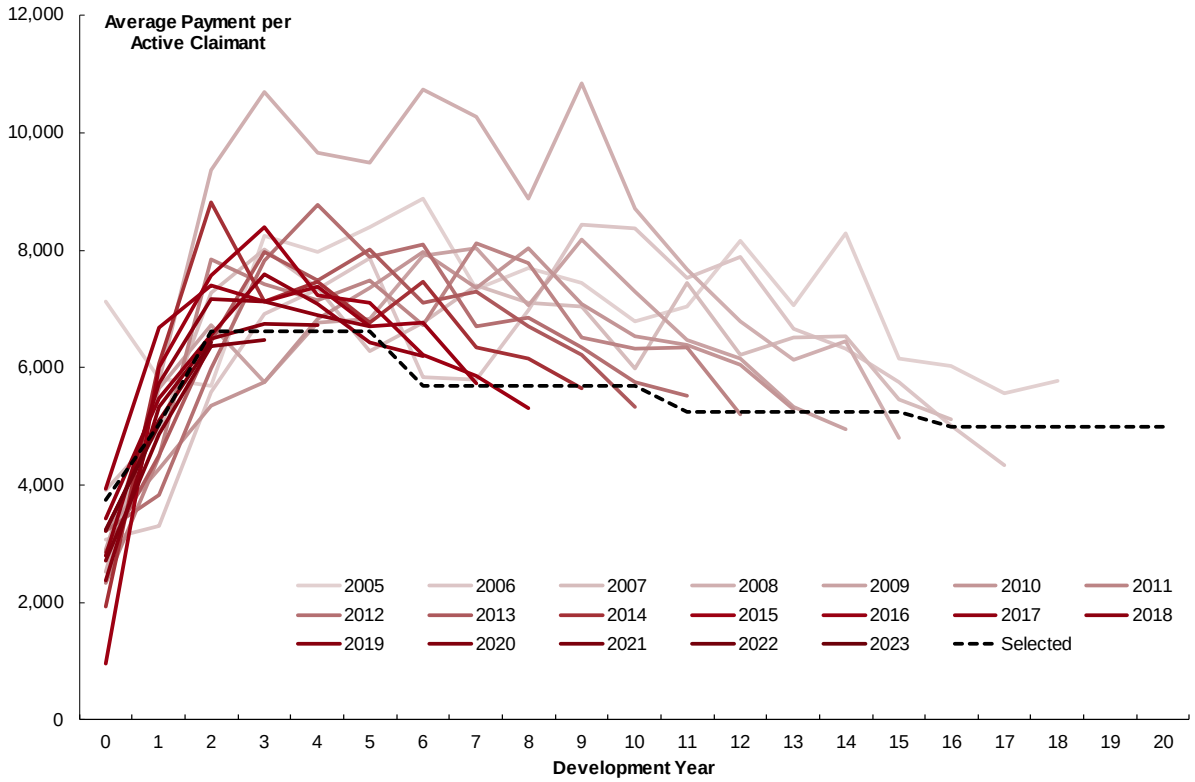
12.2.7 Combining the new entrant projection and the assumed utilisation rates results in a projection of the active claimant population for both rehabilitation programs and aids and appliances, shown in Figure 12.8 below. Our adopted assumptions suggest that the active claimant population will continue to grow over time as new entrants enter rehabilitation programs and the appliances program, and existing recipients continue to utilise benefits.

Figure 12.8: Active Claimant Projection



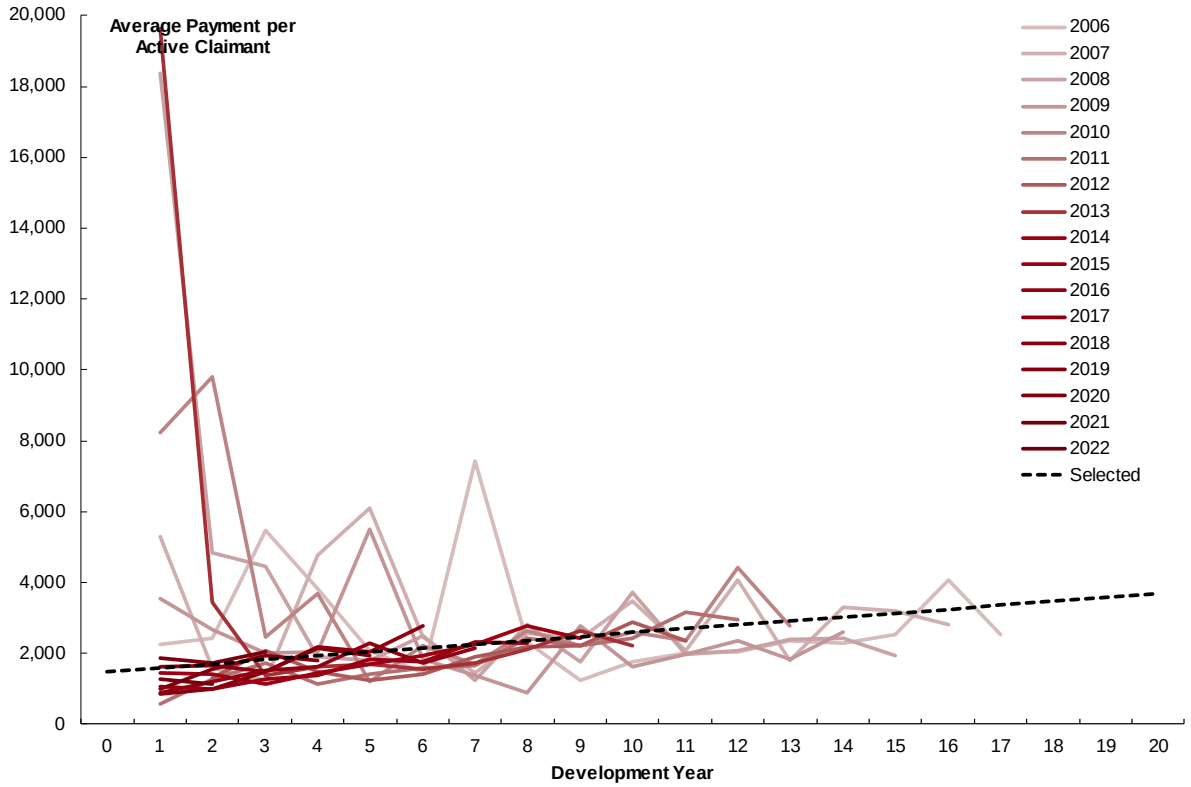
12.2.8 The final assumptions required relate to the average payment per active claimant. Figure 12.9 below shows the average payment amounts for each accident year for rehabilitation programs, along with the selected assumption. Note that payments have been indexed to 2023 dollars. Average payment amounts appear to be highest in the first five years after injury and then decrease over time. We have thus allowed the selected assumption to vary by development year to recognise the impact of temporal proximity from injury on expected payment amounts. 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 programs had taken place where reassessment of individual veteran needs was conducted and service contracts with new suppliers had been established. As such, recent experience may be more indicative of future experience.

Figure 12.9: Average Payment per Active Claimant – Rehabilitation Programs



12.2.9 Figure 12.10 below shows similar information for aids and appliances. Note that average payment amounts where the number of active claimants is less than five have been removed from the chart. We have allowed the selected average payment amounts to increase over time in line with the observed experience and the adopted assumption is based on the previous two years. We have assumed that the average payment per active claimant remains constant after development year 20 in the absence of information otherwise. We have assumed that the average cost per claimant will increase by 3.7 per cent per annum in future.

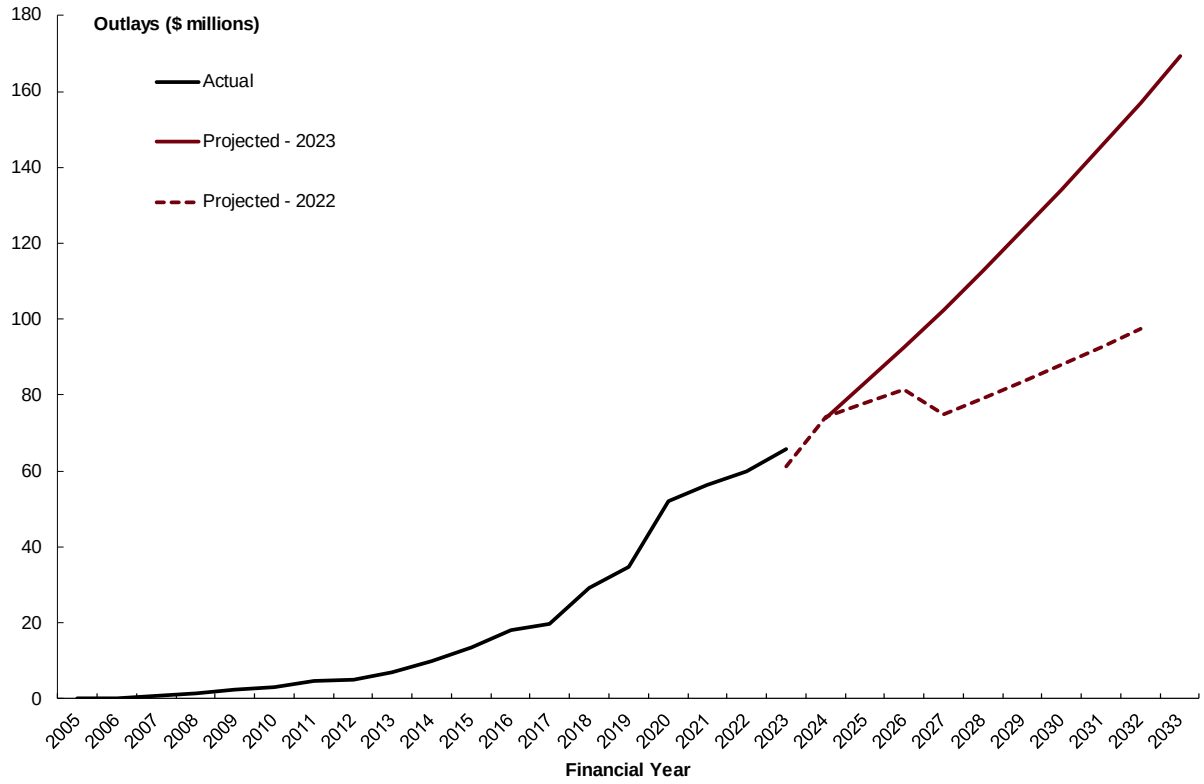
Figure 12.10: Average Payment per Active Claimant – Aids and Appliances



12.3 Projected Payments and Liability Estimate

12.3.1 Figure 12.11 shows the historical and projected cashflows for MRCA rehabilitation, together with the projections from the 2022 valuation.

Figure 12.11: Historic and projected MRCA rehabilitation payments



12.3.2 Table 12.1 shows the estimate of the liability for MRCA rehabilitation costs broken down by accident year. The 2022 valuation projected a liability of $550.7m as at 30 June 2023. The liability at 30 June 2023 is $1,290.7m; this is $740.0m higher than projected last year. Table 12.2 reconciles the current liability estimate with the 2022 valuation.

Table 12.1: Outstanding claims liability for rehabilitation costs by year of accident

Year of accident – year ending 30 June	Liability (inflated and discounted) ($'m)
2005 – 2009	55.6
2010 – 2014	243.9
2015 – 2019	491.3
2020	127.0
2021	124.9
2022	124.7
2023	123.4
Total	**1,290.7**
Expected at 30/06/2022	*550.7*

Table 12.2: Reconciliation of liability for MRCA rehabilitation costs

	$m
Liability estimate as at 30 June 2022 (previous valuation)	522.2
Assumed Interest	26.2
Projected Payments	(61.3)
Notional Premium	63.6
Projected liability as at 30 June 2023 (previous valuation)	550.7
Experience effects and Assumption changes	
difference between actual and projected payments	(4.5)
change due to nominal mapping	95.2
change due to claimant projection	963.6
change due to average cost	(314.4)
Current Estimate	**1,290.7**

13 DRCA Household Services and Attendant Care

13.1 Benefit Overview

13.1.1 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 cleaning, shopping, laundry, ironing, lawn mowing, gardening, and meal preparation.

13.1.2 Attendant care (AC) offers personal care services to meet essential and ongoing needs for individuals affected by service-related conditions. This care includes activities such as bathing, toileting, grooming, dressing, and feeding. Attendant care may be provided on a short-term basis, such as during recovery from surgery, or on a long-term basis for those with chronic health conditions.

13.2 Modelling Approach

13.2.1 Historically, Household Services and Attendant Care (HSAC) benefits were included under the 'Other 2' category in Other, which combined various smaller benefit types. This year's report introduces separate chapters for HSAC benefits. Expenditure related to HSAC has increased significantly over the last few years, with the latest calendar year showing total expenditure exceeding $31 million across both benefit types under the DRCA. For HS, the increase has been driven by increased numbers of new entrants and fewer veterans ceasing the use of benefits.

13.2.2 We have separately modelled the number of new claimants and the probability of remaining on benefit for existing and new claimants for household services. New claimants are projected using a claims curve derived from recent experience. Once the number of claimants is established, their ages are determined based on an age distribution, and they are combined with the existing cohort of claimants. Following this, their future utilisation rates and annual average costs are projected. This projection is then overlaid with mortality to derive the liability for the benefit. The approach we have used for modelling household services is similar to the methodology used from the previous valuation.

13.2.3 In the previous valuation, AC was accounted for by a loading factor applied to the HS payments. However, AC costs under DRCA continues to account for a large proportion of the total HSAC payments, representing approximately 27 per cent of expenditure in the most recent calendar year. This year, we have adopted a separate model to project AC benefits.

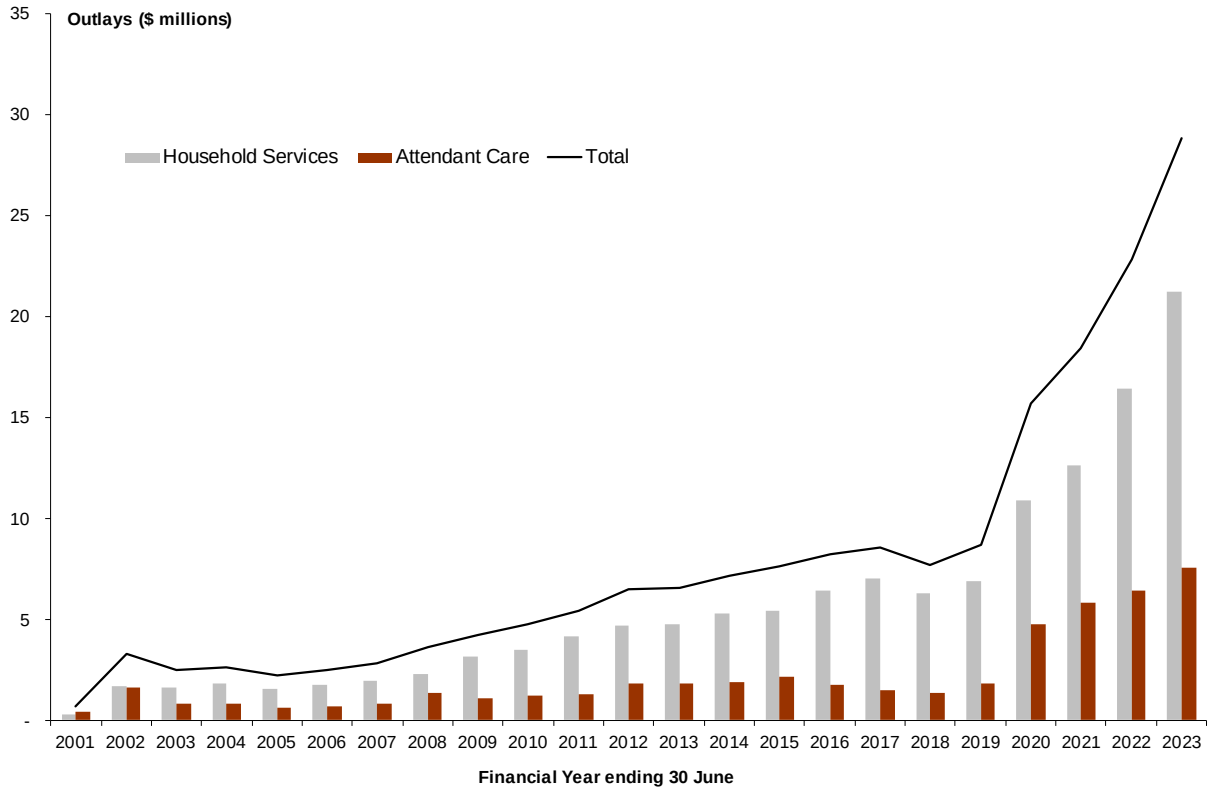
13.2.4 The main challenge in separately modelling AC arises from the relatively small number of claimants. Over the last three years, there have been approximately 200 claimants accessing benefits in each calendar year, with small numbers of new entrants each year. In 2023, there were only 86 new claimants using AC benefits. The small numbers of new entrants provides a challenge in constructing a robust claims curve. As such, we have modelled new entrants for HSAC combined and HS alone, taking the difference to be those allocated as new AC claimants. Once new claimants have been projected, AC-specific utilisation rates and average annual costs are adopted to project future expenditure. This process is similar to that used for HS.

13.2.5 A provision for the current level of open IL claims was also included in our modelling by adjusting the claims curve of new entrants in line with the expected clearance of DRCA IL claims. The new claimant numbers for the next two years were calculated based on the projected number of IL claims accepted and a conversion rate between accepted IL claims to new household services claimants.

13.3 Recent Experience and Valuation Assumptions

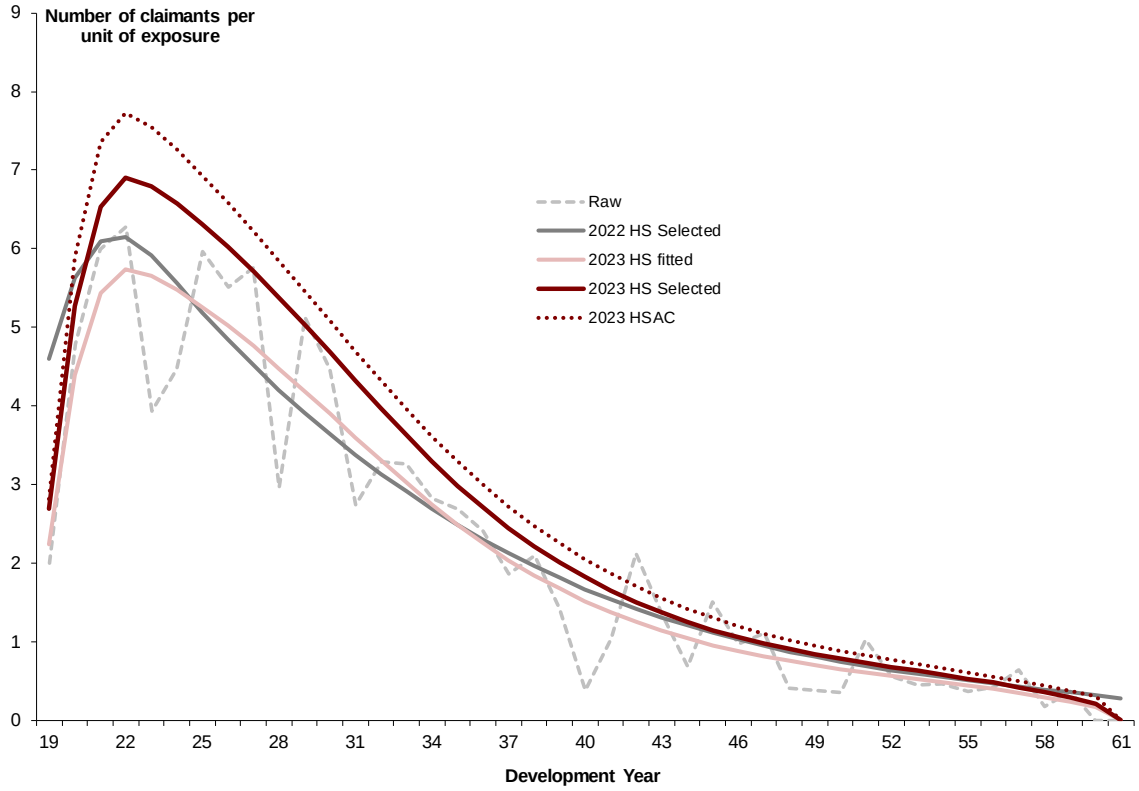
13.3.1 Figure 13.1 shows the expenditure since 2001, split between HS and AC. In total, DRCA HSAC expenditure shows a gradual increase from 2006 to 2017, before expenditure stabilised for three years. Since 2020, there has been significant year on year growth in total expenditure, largely driven by the higher number of new claimants and claimants remaining on benefits for longer. Notably, the expenditure on HS has increased at a more rapid pace in recent years than AC. This may have been driven by DVA policy changes in 2019 where household services benefits were brought into the needs assessment process and the maximum reassessment period was extended to 5 years.

Figure 13.1: Expenditure on DRCA payments by category



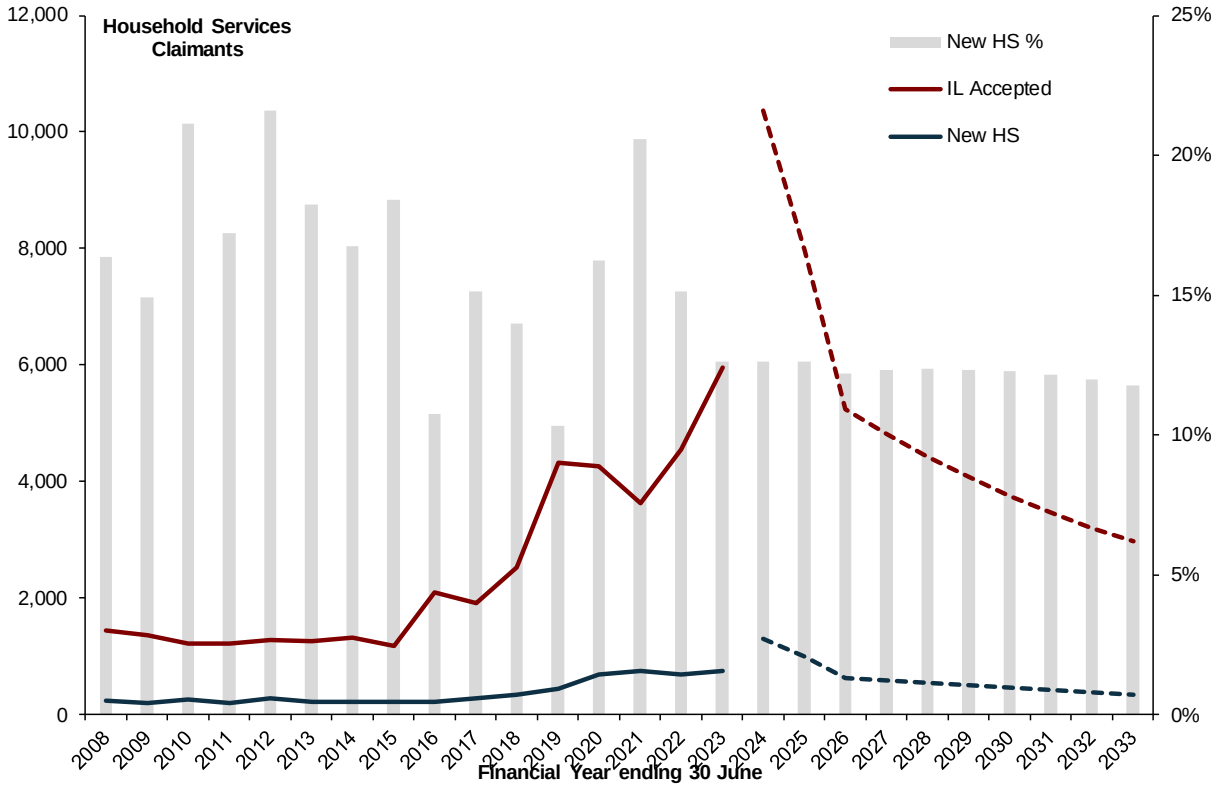
13.3.2 Figure 13.2 below shows the raw data on the numbers of new claims per unit of exposure for HS, the selected long term assumption and the selected assumption for HSAC. We have set our long term assumption in line with experience over the 2023 calendar year, including a loading to account for claimants with invalid or missing year of accident data. The selected long term curve is higher than that selected at the last valuation, reflecting the increased number of new entrants in the latest year. We have also included the assumptions we have selected for HSAC combined, which was used to derive the number of new entrants for AC.

Figure 13.2: Number of new claimants per unit of exposure – household service (DRCA)



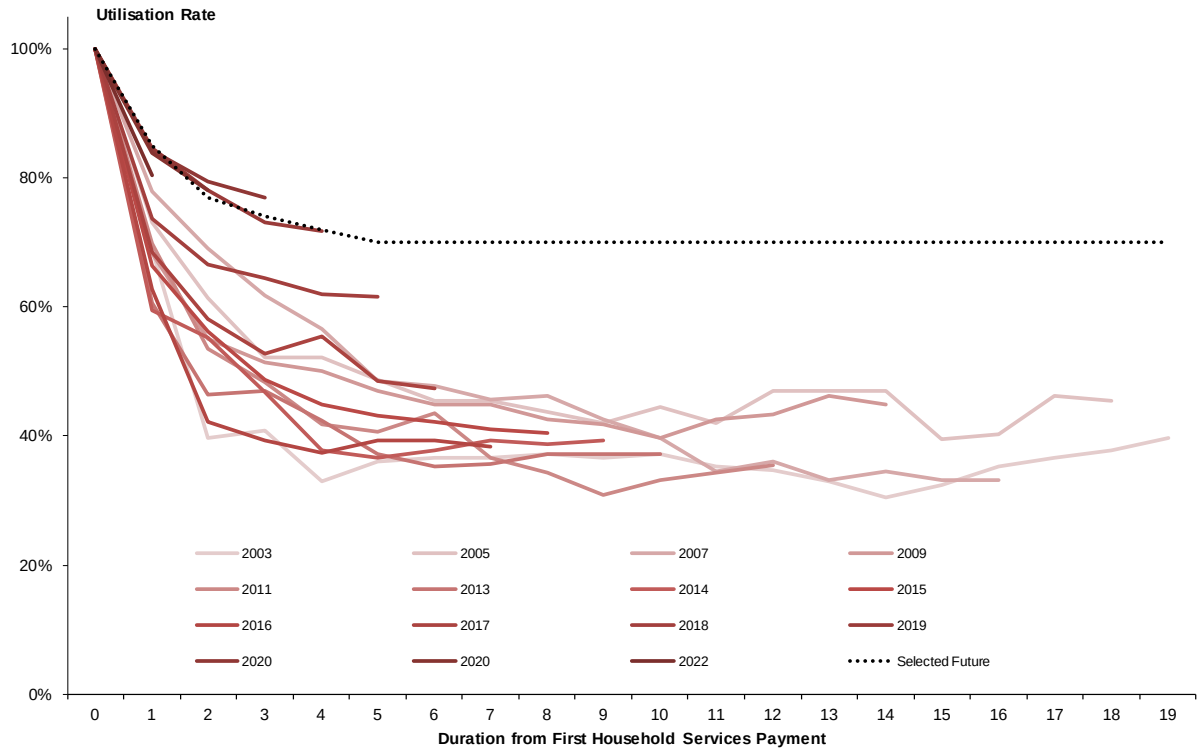
13.3.3 Figure 13.3 below shows the number of accepted IL claims and new household services claimants over time, as well as the conversion rate between the two. We have also included the projected level of accepted IL claims based on the DRCA IL projection, which is broadly based on expected claims processing rates in the DDFM. This shows that the number of accepted IL claims will increase as processing capacity increases to clear the current open IL claims, resulting in an increase in the number of new claimants in the short term. We have selected a conversion rate of 13 per cent based on recent experience which translates to an increase of approximately 900 new claimants over the base projection over the next two years. The timing of when these additional claimants start to access the scheme is broadly in line with the DRCA IL projections. We have also assumed that the number of new claimants will revert to the selected long term assumption after two years.

Figure 13.3: Number of IL Accepted, household services claimants and conversion rate (DRCA)



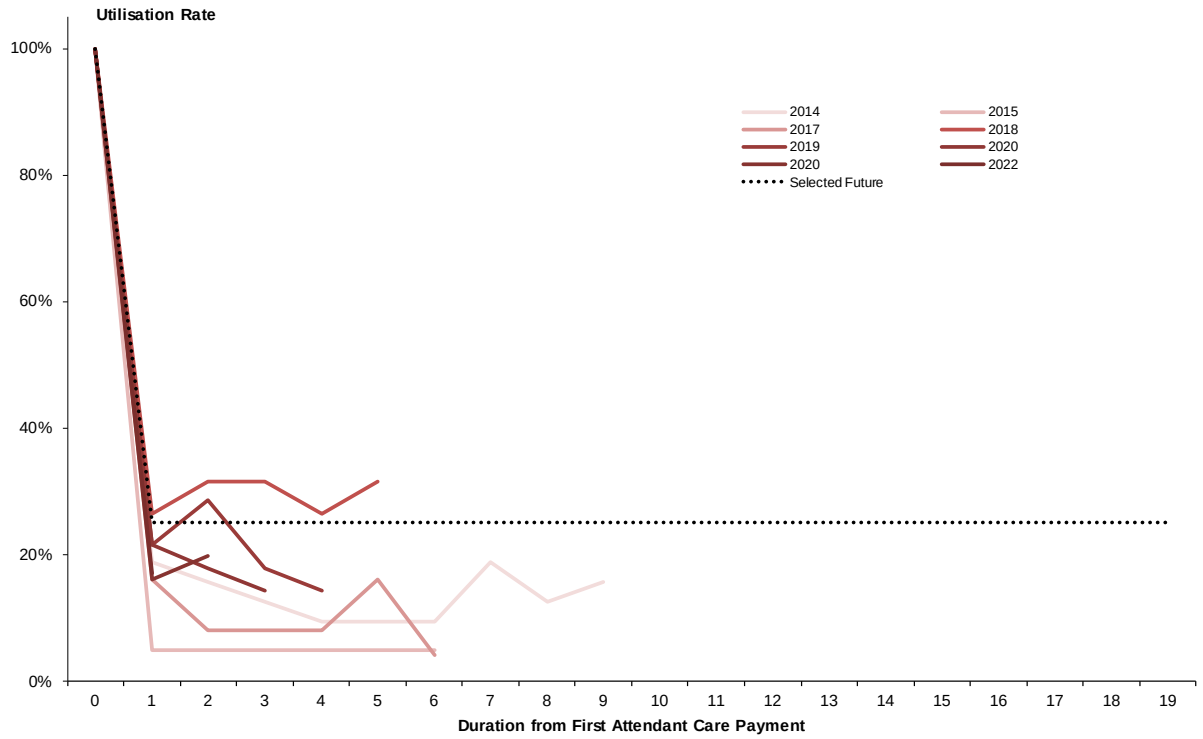
13.3.4 The historic utilisation rates by duration and first payment year for HS benefits are shown in Figure 13.4 below with the selected utilisation assumption. The selected utilisation rates begin at 100 per cent by definition and decrease to 85 per cent at duration 1 for new entrants. This means that if 100 new claimants accessed benefits for the first time in 2024, we would anticipate 85 to continue accessing benefits one year later, in 2025. Utilisation rates have shown an increasing trend in recent payment years, particularly since the introduction of Veteran Centric Reform and the 2019 policy changes. However, it is also important to note that there is limited experience from recent years and there remains uncertainty in how utilisation experience might emerge over the long term. At this valuation, for new claimants we have set a long term utilisation rate assumption of 70 per cent which is reached by duration 5. This reflects trends seen in the more recent experience. All claimants remaining after 5 years of usage will only exit from HS benefits as a result of mortality.

Figure 13.4: Household services utilisation rates



13.3.5 Figure 13.5 shows the utilisation rates for AC. The graph shows a steep decline in utilisation after the first year of payment. It is also important to note that there is limited experience for new claimants from recent years and the data is highly volatile due to the small number of claimants. There remains uncertainty in how utilisation experience might emerge over the long term. At this valuation, for new claimants we have set a long-term utilisation rate assumption of 25 per cent which is reached by duration 1. That is, we assume 25 per cent of the new claimants in each year will continue receiving benefits after the first year, with future exists driven by mortality only.

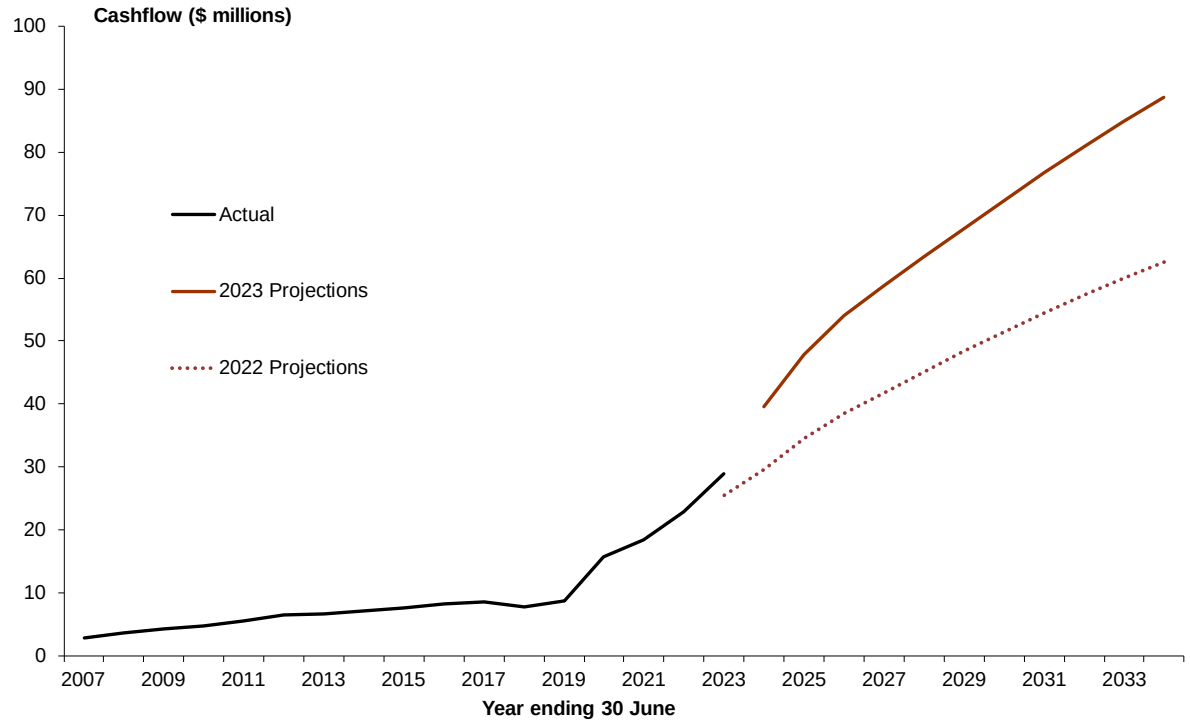
Figure 13.5: Attendant Care utilisation rates



13.3.6 As with the previous valuation, we have set the average size assumption for HS based on the experience for claimants not in their first year of payment to ensure only claimants with a full year of benefit usage are included. This year, we have also removed claimants with annual expenditure exceeding the statutory limit in the average cost calculation. This prevents the average size assumption from being skewed by a small number of claimants with very high annual expenditure. These very large claimants are then accounted for using a loading factor. The average cost of HS was set at $5,175, and the loading for the very large claimants was set at 14 per cent, based on the most recent calendar year of experience. The average cost for AC was set at $65,800. For new claimants in HS and AC, we assume entry occurs in the middle of the year, thus only half of the selected average size is applied in the first year.

13.3.7 Figure 13.6 below shows actual outlays over the last decade together with projected cashflows for the next 10 years. The significant increase in the projected cashflows is driven by the continued increase in claimants accessing household services.

Figure 13.6: Historical and projected HSAC payments



13.4 Liability Estimate

13.4.1 Table 13.1 shows the estimate of the liability in relation to HSAC payments broken down by year of accident. The expected liability as at 30 June 2023 from the 2022 valuation was $1,093.5m. The liability at this valuation is $1,508.3m, an increase of $415m driven by changes in the assumption for new entrants and utilisation rates.

Table 13.1: Outstanding claims liability for HSAC payments by year of accident

Year of accident – year ending 30 June	Liability (inflated and discounted) ($'m)
1979 and before	98.8
1980 – 1984	88.1
1985 – 1989	173.4
1990 – 1994	283.4
1995 – 1999	404.0
2000 – 2004	460.5
Total	**1,508.3**
Expected at 30/06/2023	*1,093.5*
Total (30/06/2022)	**1,017.8**

13.4.2 Table 16.2 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 13.2: Reconciliation of liability for HSAC payments

	$m
Liability estimate at 30/06/22 (previous report)	1,017.8
Assumed Interest	50.3
Projected Payments	25.5
Notional Premium	0.0
Projected liability as at 30 June 2023 (previous valuation)	**1,093.5**
Experience effects and Assumption changes	
difference between actual and projected payments	(3.4)
change in experience	88.0
change in age distribution	14.4
change in new entrants	57.4
change in utilisation	124.1
change in average size and AC gross up factor	46.1
change in modelling methodology for AC	88.0
Current Estimate	**1,508.3**

14 MRCA Household Services and Attendant Care

14.1 Modelling Approach

14.1.1 As with DRCA, MRCA household services and attendant care (HSAC) benefits form their own benefit category at this year's valuation. Experience in MRCA HSAC has been similar to that under DRCA, with significant year on year growth in expenditure since 2019. Household services expenditure, in particular, has grown at a rate of over 50 per cent year on year over the last 5 calendar years. Combined with attendant care, expenditure reached over $40 million in calendar year 2023.

14.1.2 For household services (HS), we have separately modelled the number of new claimants and the probability of remaining on benefit for existing and new claimants. New claimants are projected using a claims curve derived from recent experience. Once the number of claimants is established, their ages are determined based on an age distribution, and they are combined with the existing cohort of claimants. Following this, their future utilisation rates and average costs are projected. This projection is then overlaid with mortality to derive the liability for the benefit. This methodology used remains unchanged from the previous valuation.

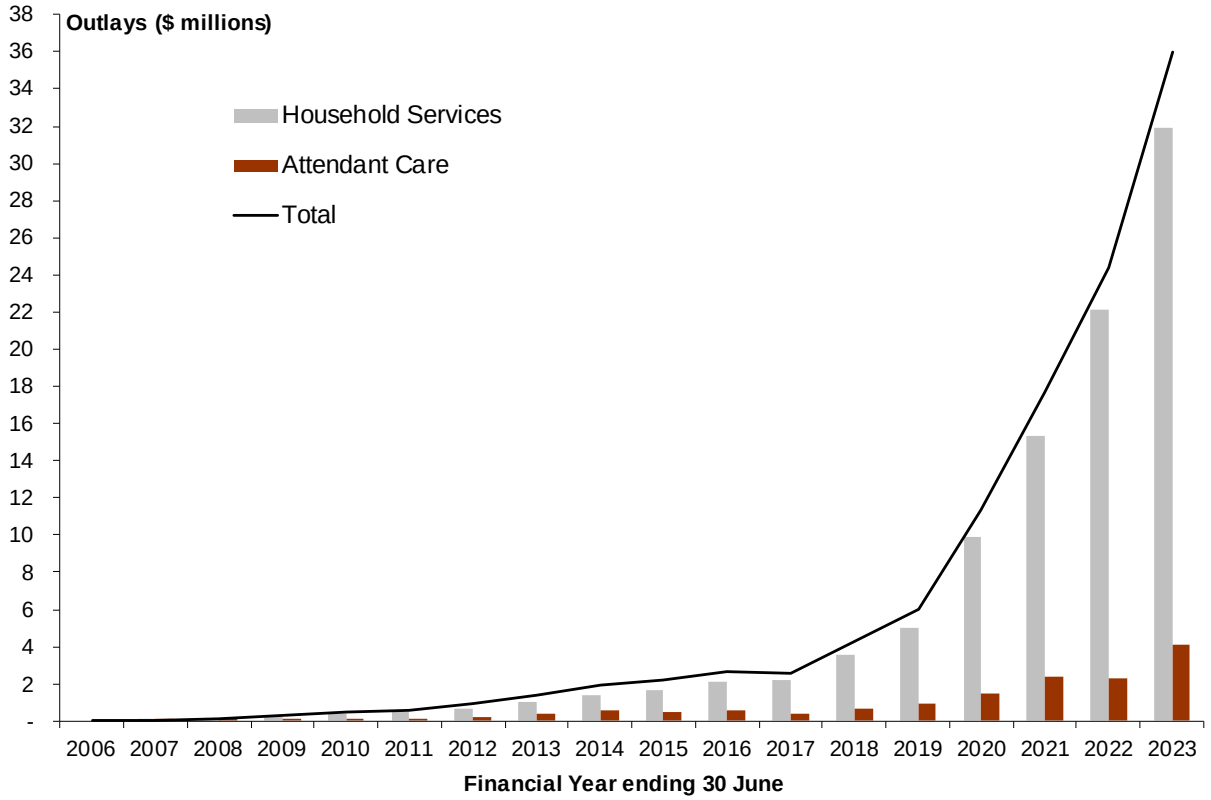
14.1.3 A provision for the current number of open IL claims was also included in our modelling by adjusting the claims curve of new entrants in line with the expected clearance of MRCA IL claims as shown in Chapter 5 of the report. The new claimant numbers for the next two years were calculated based on the projected number of IL claims accepted and a conversion rate between accepted IL claims to new household services claimants.

14.1.4 Attendant care expenditure under MRCA is relatively small and accounts for approximately 10 per cent of all expenditure under HSAC. At this valuation, we have not modelled AC separately. We have accounted for AC costs through the use of a loading factor applied to projected HS cashflows.

14.2 Recent Experience and Valuation Assumptions

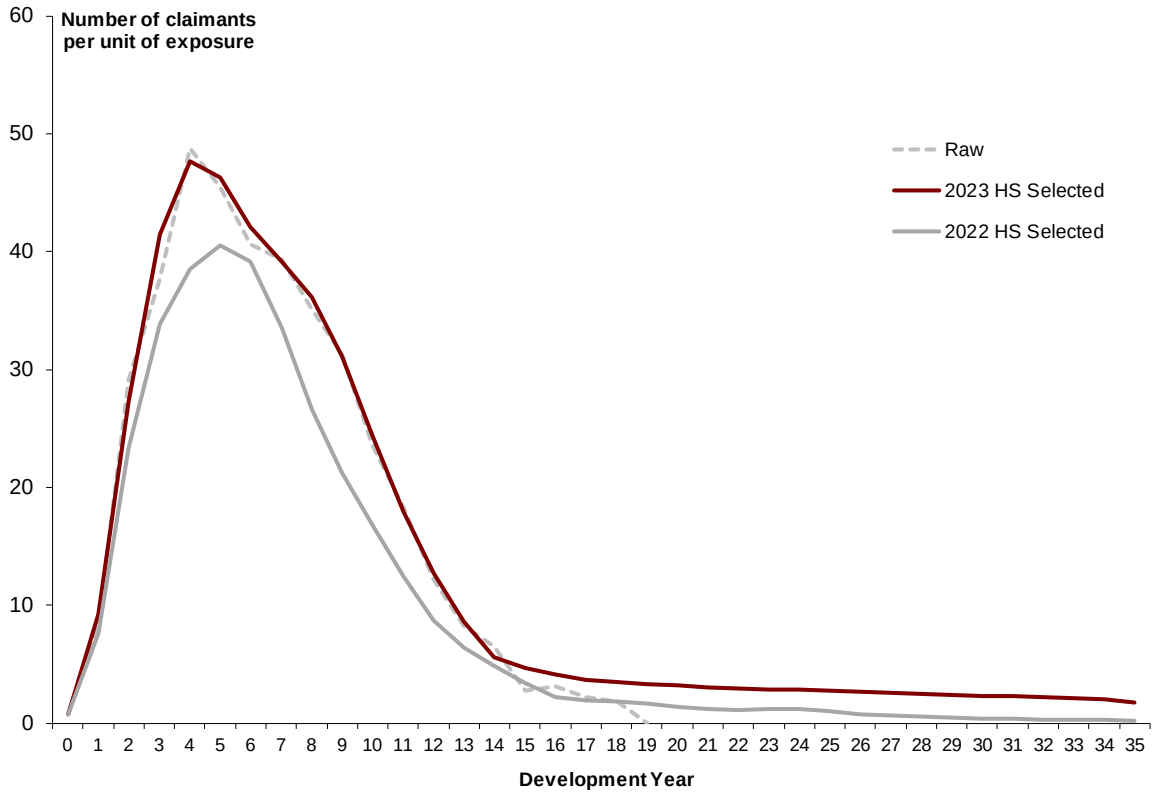
Figure 14.1 shows annual expenditure since 2006, split between HS and AC. MRCA HSAC expenditure was low in the early years of the scheme, before gradually increasing until 2017. Since 2017, growth in expenditure has been substantial, driven by expenditure in household services. As with DRCA, the increase since 2017 has been driven by significant numbers of new claimants, particularly since 2020, likely driven by Veteran Centric Reform and the 2019 policy changes.

Figure 14.1: Expenditure on MRCA payments by category



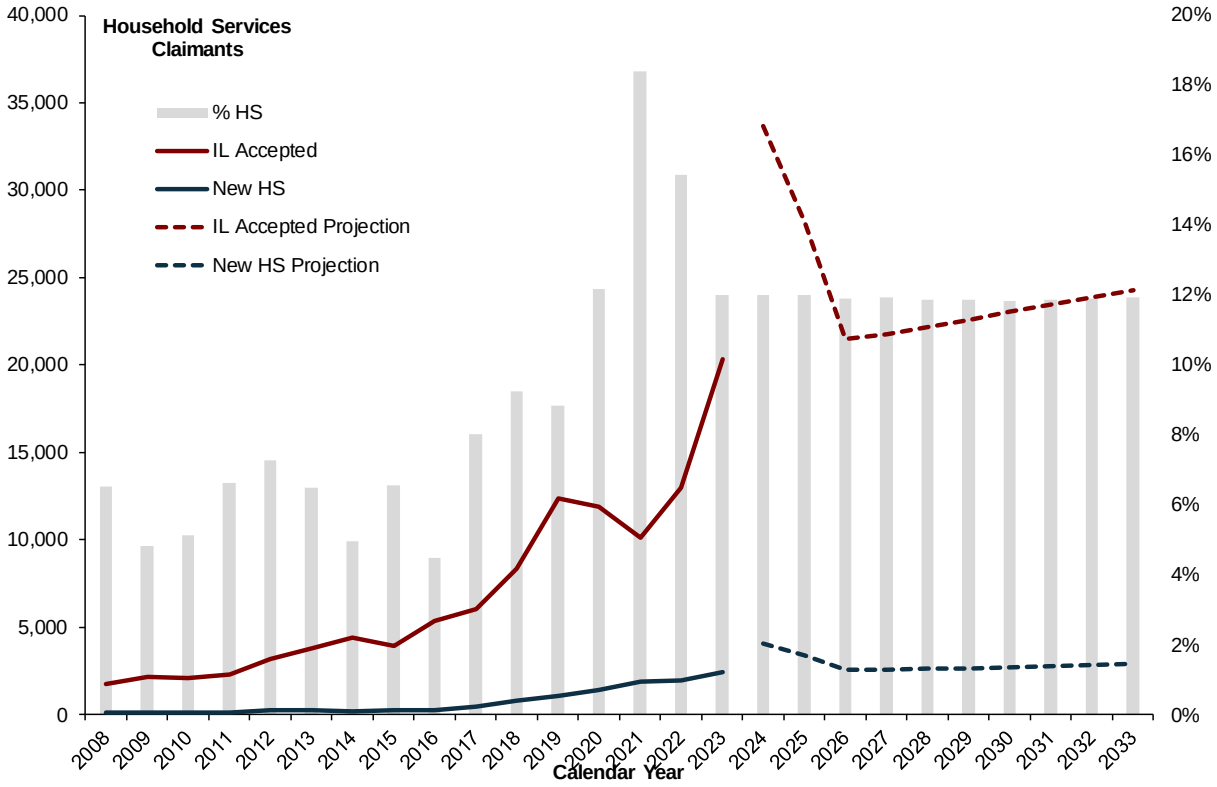
14.2.2 Figure 14.2 below shows the raw data on the numbers of new claims per unit of exposure for HS and the current and previous year selected assumptions. We have set our assumptions for the current valuation in line with experience over the 2023 calendar year. We have observed a higher number of new claimants in the most recent calendar year, consistent with the higher number of IL claims processed and accepted this year.

Figure 14.2: Number of new claimants per unit of exposure – household service (MRCA)



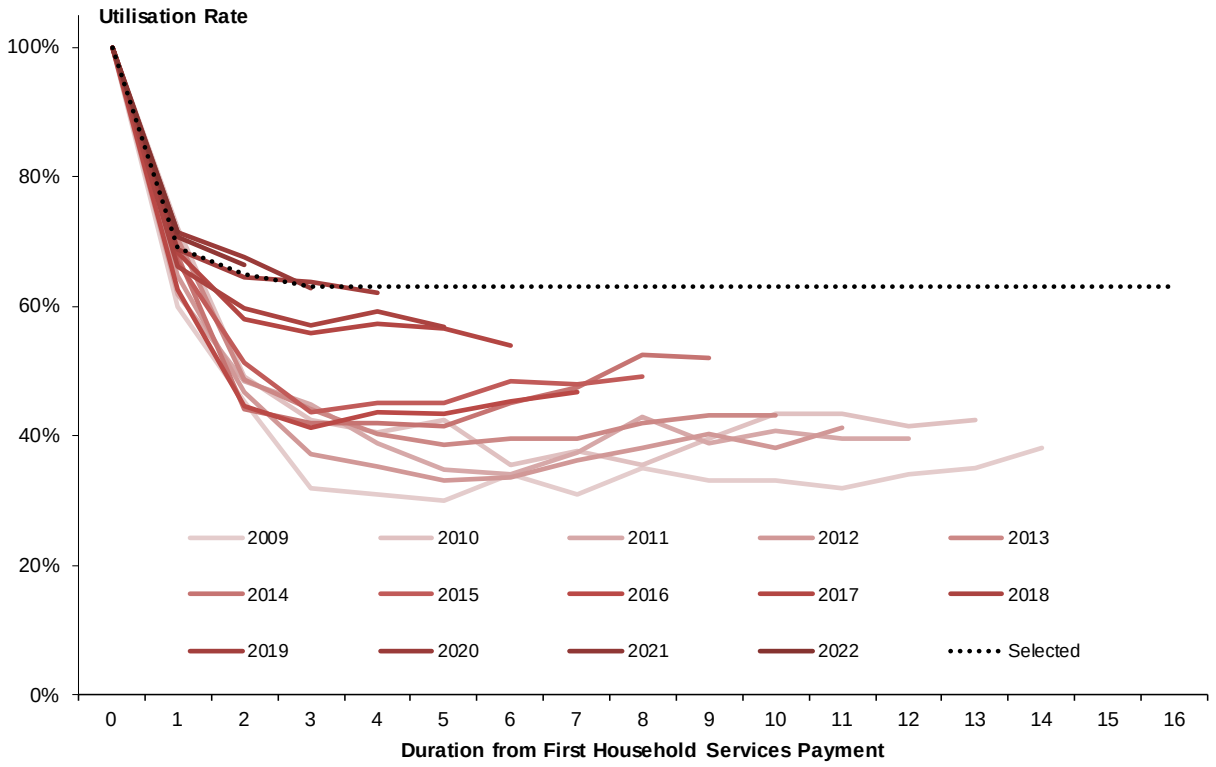
14.2.3 Figure 14.3 below shows the number of accepted IL claims and new household services claimants over time, as well as the conversion rate between the two. We have also included the projected level of accepted IL claims based on the MRCA IL projection, which is broadly based on expected claims processing rates in the DDFM. This shows that the number of accepted IL claims will increase as processing capacity increases to clear existing open claims, resulting in an increase in the number of new claimants in the short term. We have selected a conversion rate of 12 per cent for the next two years based on the most recent two calendar years of experience, which translates to an increase of approximately 2,400 new claimants over the base projection. The timing of when these additional claimants start to access the scheme is broadly in line with the MRCA IL projections. We have also assumed that the number of new claimants will revert to the selected long term assumptions after two years.

Figure 14.3: Number of IL Accepted, household services claimants and conversion rate (MRCA)



14.2.4 The historic utilisation rates by duration and first payment year for household services benefits are shown in Figure 14.4, along with the selected rates. The selected utilisation rates begin at 100 per cent by definition and decrease to 69 per cent at duration 1. That is, if 100 new claimants accessed benefits for the first time in 2024, we would anticipate 69 to continue accessing benefits one year later, in 2025. Utilisation rates show 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 for more recent years and there remains uncertainty in how utilisation experience might emerge over the long term. In light of recent experience, for new claimants we have set a long term utilisation rate assumption of 63 per cent which is reached by duration 3. That is, all claimants remaining after 3 years will only exit from household services benefits as a result of mortality.

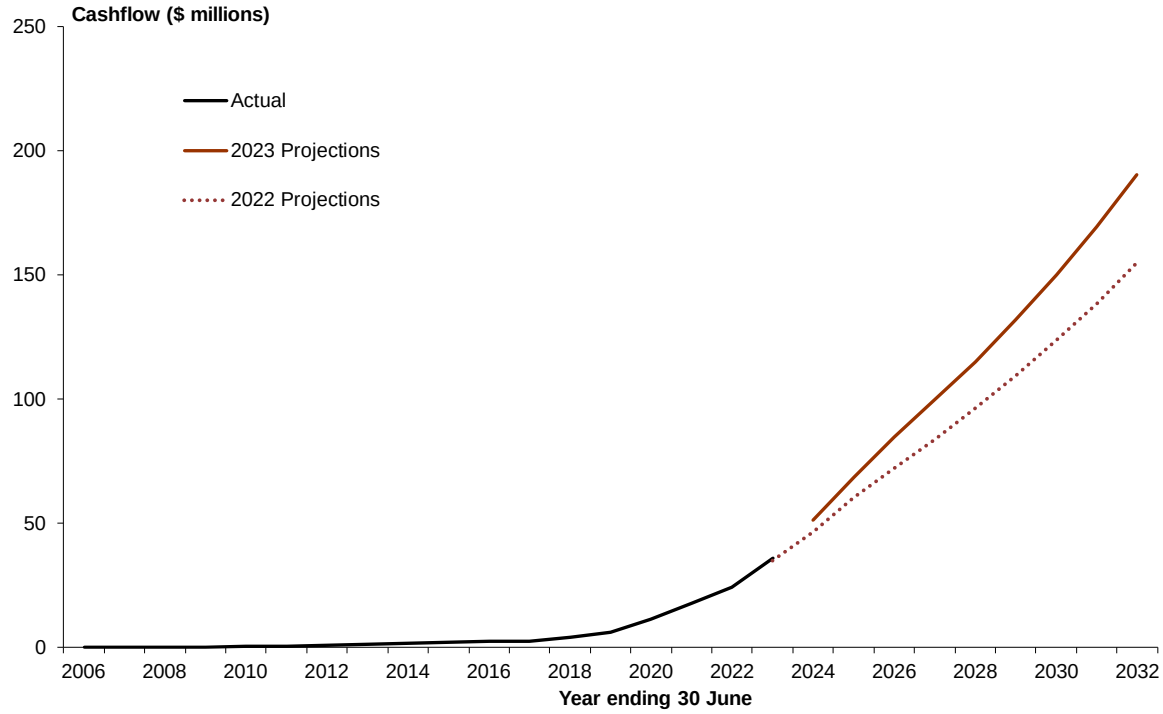
Figure 14.4: Household services utilisation rates



14.2.5 As with the previous valuation, we have set the average size assumption for HS based on the experience for claimants not in their first year of payment to ensure only claimants with a full year of benefit usage are included. This year, we have also removed claimants with annual expenditure exceeding the statutory limit in the average cost calculation. This prevents the average size assumption from being skewed by a small number of claimants with very high annual expenditure. These very large claimants are then accounted for using a loading factor. The average cost of household services benefits was set at $5,500, and the loading for the very large claimants was set at 2.5 per cent, based on the most recent calendar year of experience. For new claimants, we assume entry occurs in the middle of the year, thus 50 per cent of the selected average size is applied in the first year.

14.2.6 Figure 14.5 shows actual outlays over the last decade together with projected cashflows for the next 10 years. The significant increase in the projected cashflows is driven by the increase in expected claimants.

Figure 14.5: Historical and projected HSAC payments



14.3 Liability Estimate

14.3.1 Table 14.1 shows the estimate of the liability in relation to HSAC payments broken down by year of accident. The expected liability as at 30 June 2023 from the 2022 valuation was $2,944.5m. The liability at this valuation is $3,827.7m, an increase of $883m driven by higher numbers of expected claimants and higher adopted average size of benefits.

Table 14.1: Outstanding claims liability for HSAC payments by year of accident

Year of accident – year ending 30 June	Liability (inflated and discounted) ($'m)
2005 - 2009	220.05
2010	80.41
2011	110.83
2012	143.67
2013	176.72
2014	204.38
2015	249.88
2016	284.95
2017	312.31
2018	325.15
2019	342.58
2020	341.57
2021	352.84
2022	348.84
2023	333.54
Total	**3,827.7**
Expected at 30/06/2023	*2,944.5*
Total (30/06/2022)	**2,622.2**

14.3.2 Table 16.2 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 14.2: Reconciliation of liability for HSAC payments

	$m
Liability estimate at 30/06/22 (previous report)	2,622.2
Assumed Interest	137.4
Projected Payments	(35.0)
Notional Premium	220.0
Projected liability as at 30 June 2023 (previous valuation)	**2,944.5**
Experience effects and Assumption changes	
difference between actual and projected payments	(1.0)
change in experience	192.0
change in age distribution	(133.3)
change in future claimants assumption	606.1
change in utilisation assumption	163.0
change in average size	56.3
Current Estimate	**3,827.7**

15 DRCA Other Benefits

15.1 Benefit Overview

15.1.1 Historically, the residual category of 'other payments' covered transactions in respect of costs of household services, attendant care, legal costs, medical examinations, travel, funeral expenses and damage to property. These were divided into two categories termed 'Other 1', which included expenditure covering medical examinations and legal services undertaken as part of the claim process, and 'Other 2' which covered all other payment types including household services and attendant care. The growing expenditure under household services and attendant care in recent years has warranted separating out these two benefits into their own category, discussed in Chapters 13 and 14. For DRCA, the remaining category of Other now covers only medical examinations, legal services, and supplement payments which were moved into this category this year.

15.1.2 As discussed in Chapter 5, a number of transactions were remapped this year into benefit categories which better reflect the nature of the payment. Funeral expenses which were previously included in Other were reallocated to Death benefits, alterations expenses such as home modifications were moved to the Rehabilitation category, whilst supplement payments which were previously included across a number of different benefit categories have been consolidated into Other.

15.1.3 A detailed summary by payment nominal movements is included in the Appendix.

15.2 Modelling Approach

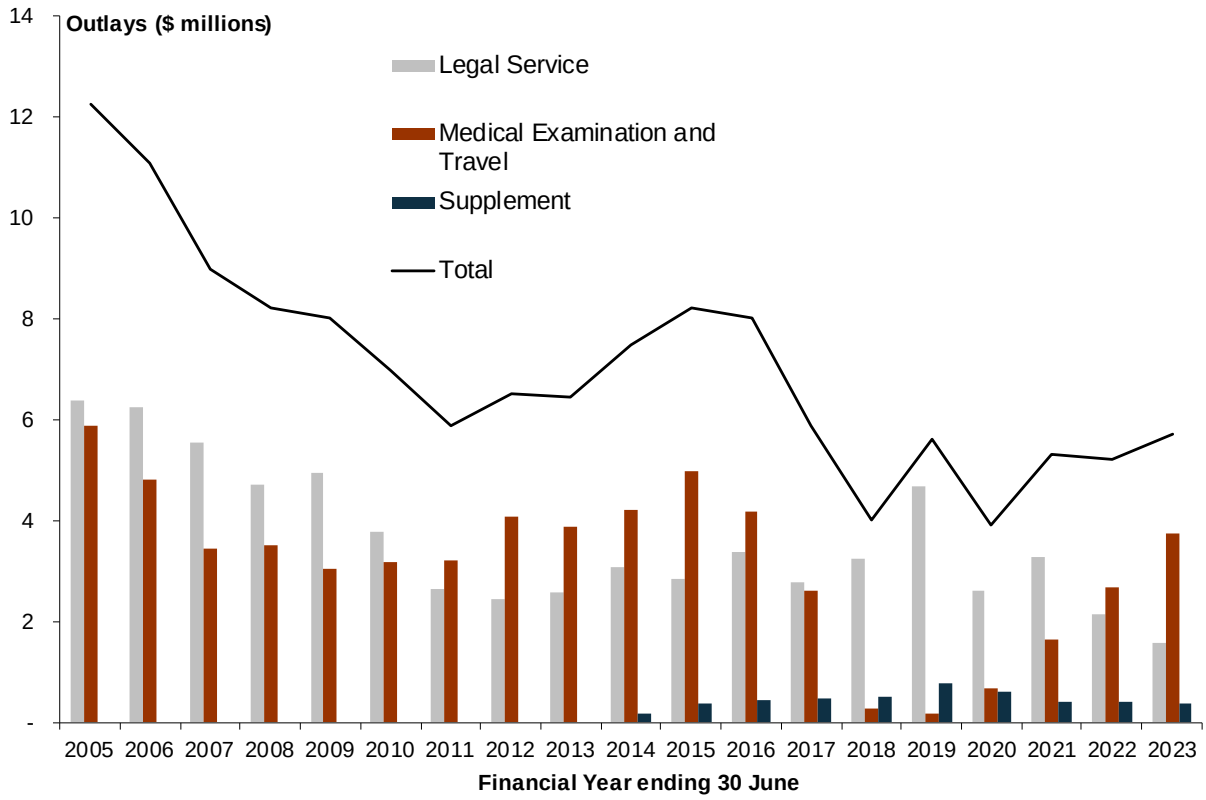
15.2.1 The modelling approach for Other expenditure has been split between medical examinations and legal expenses. For each type of payment, we have modelled the number of claims per unit exposure and applied an average cost to the resulting estimate of future claim numbers.

15.2.2 Supplement payments under DRCA are relatively small and account for approximately 6 per cent of all expenditure under Other in the latest calendar year. At this valuation, we have not modelled supplements separately. We have accounted for supplement payments through the use of a loading factor applied to the projected cashflows for medical examinations and legal expenses.

15.3 Recent Experience and Valuation Assumptions

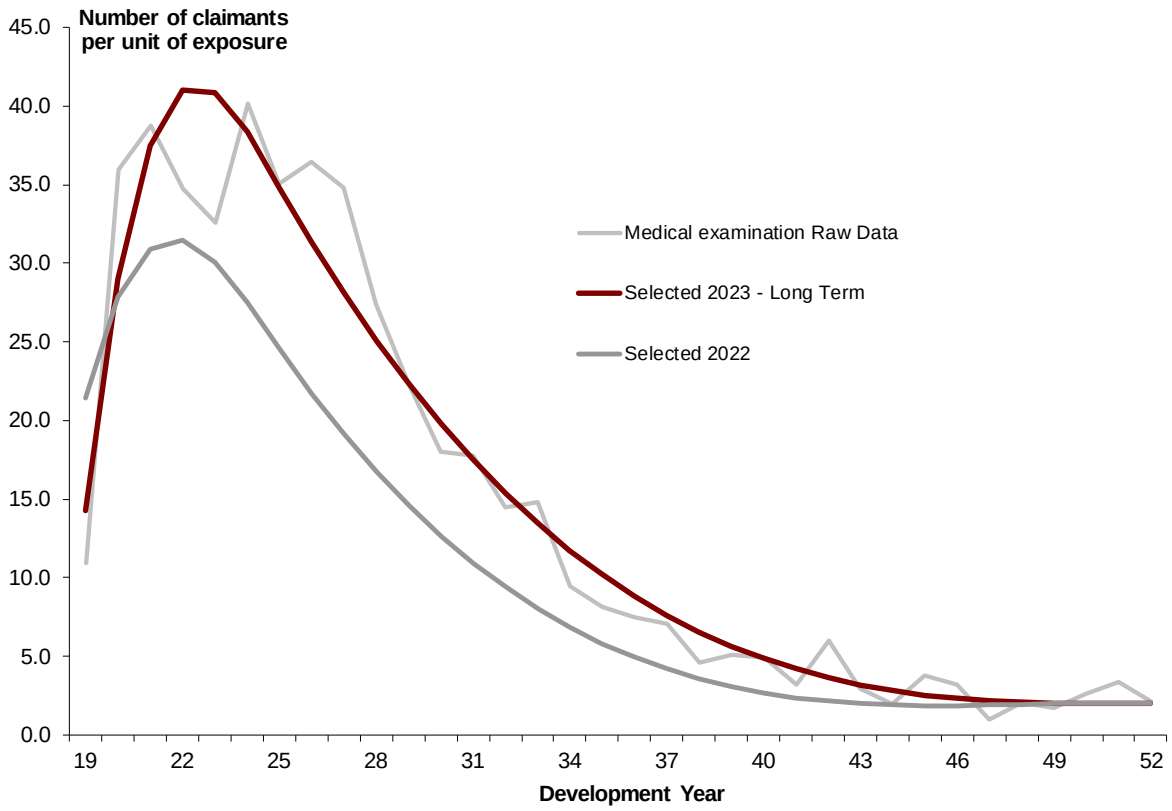
15.3.1 Figure 15.1 shows the expenditure on other payments since 2005, split between legal fees, medical exams and supplement payments. DRCA legal expenses started relatively high and exhibited some decline before fluctuating between 2012 to 2021. Over the last two years, legal expenses have shown a decreasing trend, with expenditure in 2023, the lowest it has been over the last 20 years. Although expenses have been decreasing in recent years, clearance of existing open IL claims is likely to result in increased expenditure over the short. Medical examination expenses also started at a relatively high level and experienced a series of fluctuations. The increasing trend observed in recent years is consistent with the influx of claims for initial liability and then permanent impairment, both of which generally involve medical examinations. Supplement payments have remained relatively stable over the period.

Figure 15.1: Expenditure on other payments by category (DRCA data)



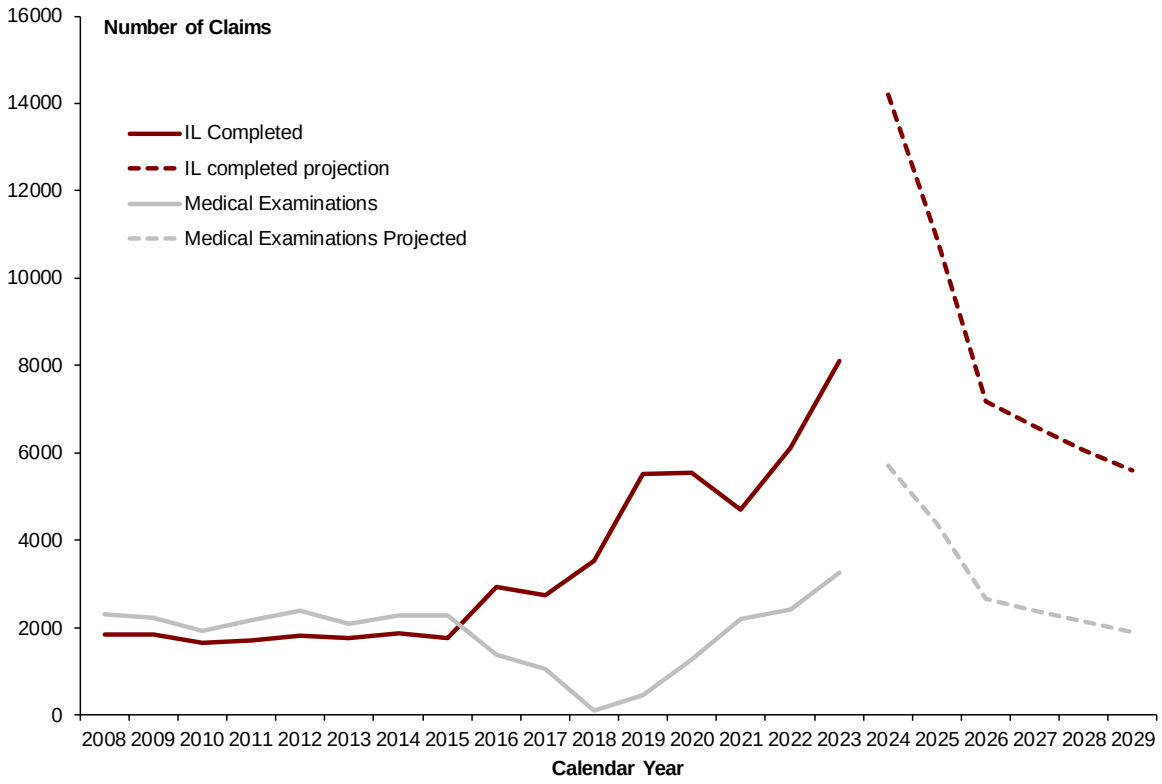
15.3.2 Figure 15.2 shows the raw data on the numbers of claim per unit of exposure for medical examinations and the selected assumptions based on the most recent calendar year of experience.

Figure 15.2: Number of claimants per unit of exposure – medical examinations (DRCA)



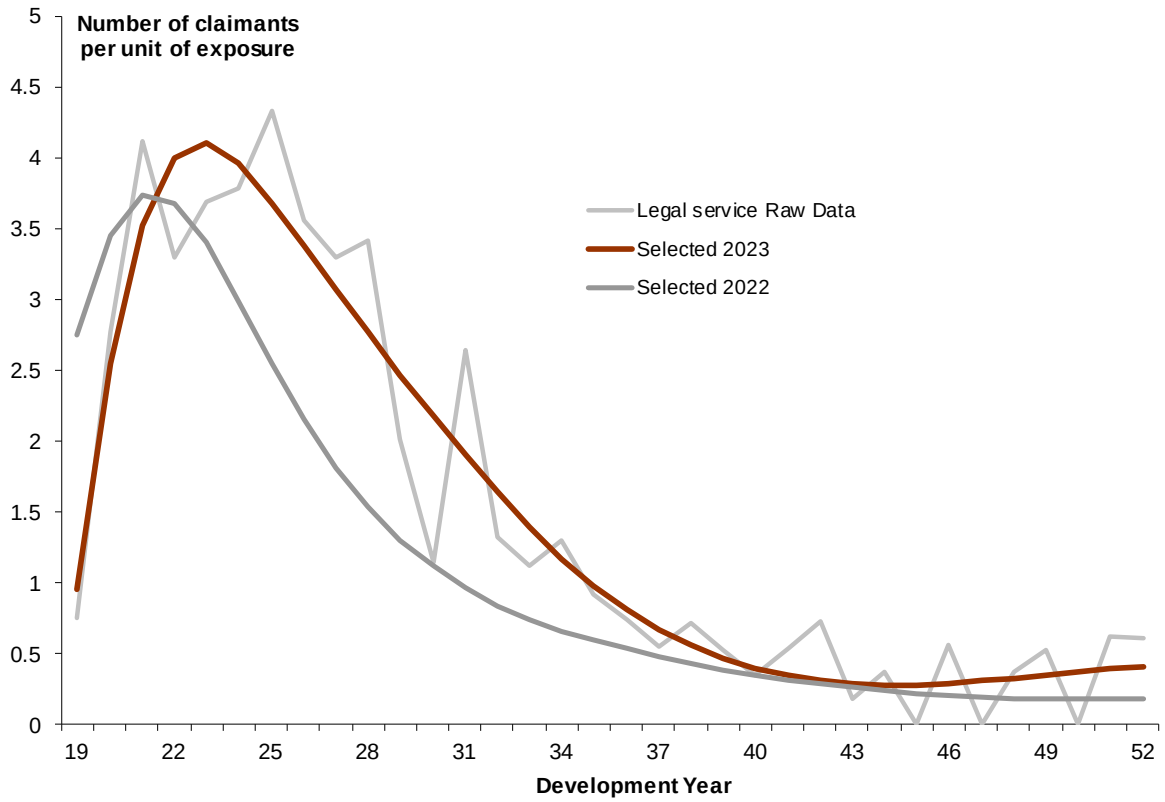
15.3.3 Figure 15.3 shows the trend in the number of IL claims and medical examinations from 2009. It is challenging to analyse the relationship between IL lodgements, IL completions, and claims for DRCA medical examinations as reimbursement for exams can occur prior to when a claim is finalised and the need for exams will vary between claims. To estimate the number of claims over the next two years, we applied a corresponding increase to the base level of expected medical claims as that in IL completions. This broadly assumes that the expected increase in IL completions over the next two years will correspond with an associated increase in medical examinations as part of the assessment process.

Figure 15.3: Number of IL Completed and Medical Examinations – Actual and Projection



15.3.4 Figure 15.4 shows the raw data on the numbers of claim per unit of exposure for legal expenses and the selected assumptions based on the most recent calendar year of experience.

Figure 15.4: Number of claimants per unit of exposure – legal expenses (DRCA)

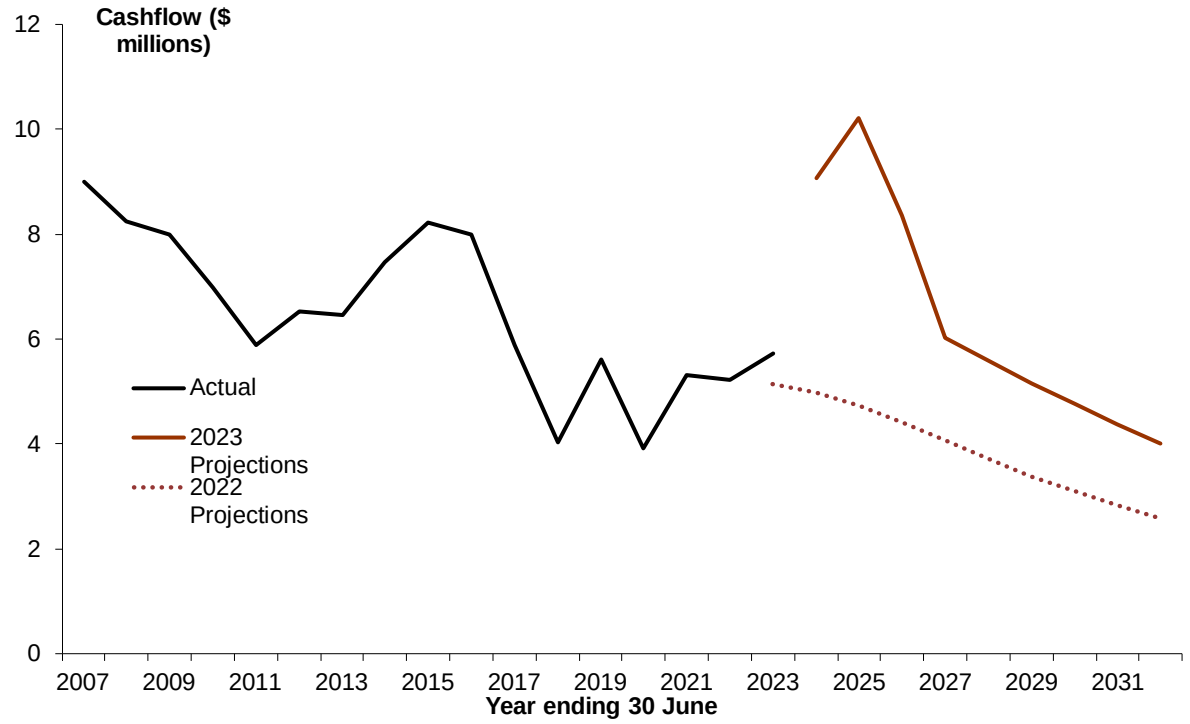


15.3.5 The adopted average sizes are $1,450 per claim for medical examinations and $5,275 for legal expenses. This compares to the respective assumptions of $1,348 and $6,507, inflated from the 2022 valuation. The selected average sizes in this valuation have been set with reference to the most recent calendar year of experience.

15.3.6 We have adopted a loading factor of 6 per cent to account for supplement payments, based on the experience in the most recent year. This is applied to the combined medical examination and legal expenses projections.

15.3.7 Figure 15.5 shows actual outlays over the last decade together with projected cashflows for the next 10 years. The 2023 projected cashflows are different to those projected at the 2022 valuation, reflecting changes to both the number of expected future claims and the average size of benefits. The 2023 projection also includes a loading for supplement payments which were not included in last year's Other category.

Figure 15.5: Historical and projected other payments



15.4 Liability Estimate

15.4.1 Table 15.1 shows the estimate of the liability in relation to other payments broken down by year of accident. The liability as at 30 June 2023 is $67.9m. This compares to an expected projected liability of $47.7m from the 2022 valuation and is primarily driven by the changes in the new claimant assumption.

Table 15.1: Outstanding claims liability for DRCA other payments by year of accident

Year of accident – year ending 30 June	Liability (inflated and discounted) ($'m)
1979 and before	5.3
1980- 1984	3.9
1985- 1989	6.1
1990- 1994	10.5
1995- 1999	16.7
2000- 2004	25.4
Total	**67.9**
Expected at 30/06/2023	*47.7*
Total (30/06/2022)	**41.0**

15.4.2 Table 15.2 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 15.2: Reconciliation of liability for other payments

	$m
Liability estimate at 30/06/22 (previous report)	41.0
Assumed Interest	1.9
Projected Payments	4.8
Notional Premium	0.0
Projected liability as at 30 June 2023 (previous valuation)	47.7
Experience effects and Assumption changes	
difference between actual and projected payments	(0.6)
change in claimants	17.3
change in average size	(0.5)
addition of supplement payments	4.0
Current Estimate	**67.9**

16 MRCA Other Benefits

16.1 Benefit Overview

16.1.1 As with DRCA Other, the remaining category of MRCA Other now covers only medical examinations, legal services, education payments, supplements payments which were moved into this category this year, and smaller ancillary benefits.

16.1.2 A number of reallocations were also made to MRCA Other payments. Veterans' supplements and pharmaceutical allowances which were previously included in PI, and energy supplements which were previously included across a number of different benefit categories have been consolidated with the clean energy payments into a 'Supplements' category in Other. Death related expenses such as financial advice payments paid to partners or dependents following the death of the veteran and funeral expenses were reallocated to the Death category, while aids and appliances and motor alterations were reallocated to the Rehabilitation category. A summary of payment nominal movements is included in the Appendix.

16.1.3 Education payments refer to the expenses paid to eligible dependents of ex-service personnel who meet certain criteria. These include eligibility for the Special Rate Disability pension; or impairment resulting in 80 or more impairment points; or had a service-related death. At last year's valuation, MRCA education scheme payments paid to dependents of members with accepted service-related death were reallocated to the Death category. These payments are payable to 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. At this year's valuation, we have reallocated these payments back to Other and combined them with the non-death related education payments for dependents, into a new Education and Training Scheme (ETS) subcategory.

16.1.4 This year we received additional dependent data which provided the dependent's year of birth from DVA, as discussed in Section 4. This data was incorporated into our modelling approach to allow for more nuanced, age-based projections for likely future benefit usage.

16.2 Modelling Approach

16.2.1 For medical examinations, we modelled claimants per unit exposure based on MRCA experience for the development years for which data is available. For the later development years, we used an average of pre-closure and current DRCA experience adjusted to take account of the fact that recent DRCA experience may not be representative of future MRCA experience. A cubic spline was then fitted to the adjusted data.

16.2.2 For ETS payments, as with last year's valuation, we have aligned the expected number of new claimants with projected PI claimant numbers. This year, we utilised DVA's additional dependent data to derive an age distribution for new entrants and a probability distribution of claimants remaining in the scheme. This differs to the assumed average duration of usage adopted in last year's valuation in the absence of any dependent age data.

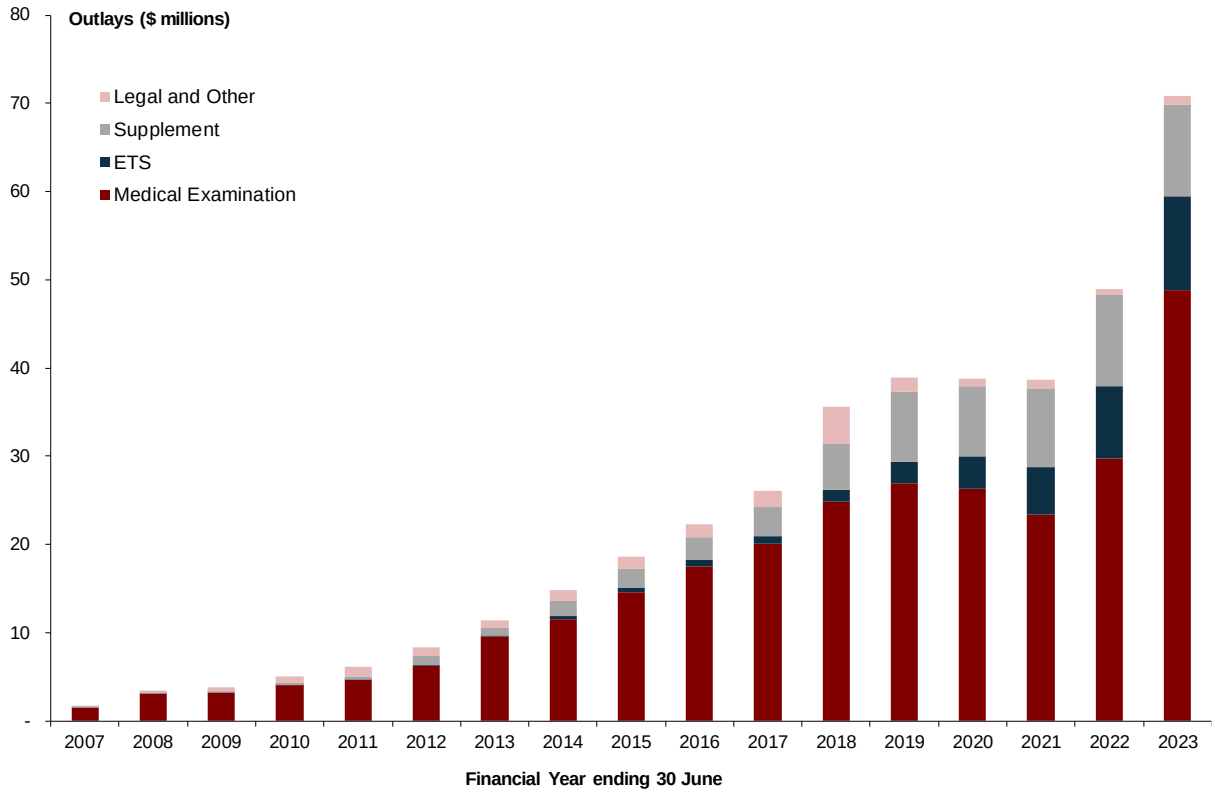
16.2.3 Energy supplements, veterans' supplements and pharmaceutical allowances are modelled together as 'Supplements' to recognise the nature that these are ongoing, small periodic payments. Energy payments are not indexed, and veteran's supplements are indexed with price inflation every year.

16.2.4 MRCA supplement payments are modelled using a Payments per Claim Incurred model. Ultimate claimant numbers are projected using a chain ladder method, and average size per development year is selected based on the most recent experience. We have also considered the nature of supplement payments being ongoing and decayed the selected average size for future development years only by mortality. Multiplying the average size per development year by the projected ultimate claimant numbers yields a projection of future supplement payments.

16.3 Recent Experience and Valuation Assumptions

16.3.1 Figure 16.1 shows the expenditure on other payments by each subcategory since 2007. Medical examination expenses have shown a significant increase in 2023, reflecting both the increase seen in IL claims being completed and new claims lodged. ETS payments have steadily increased 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 7) is likely a driver of the increase in ETS claimant numbers. Supplement payments have been relatively stable over recent years. Lastly, legal expenses and other miscellaneous payments remain low, exhibiting minor fluctuations across more recent years.

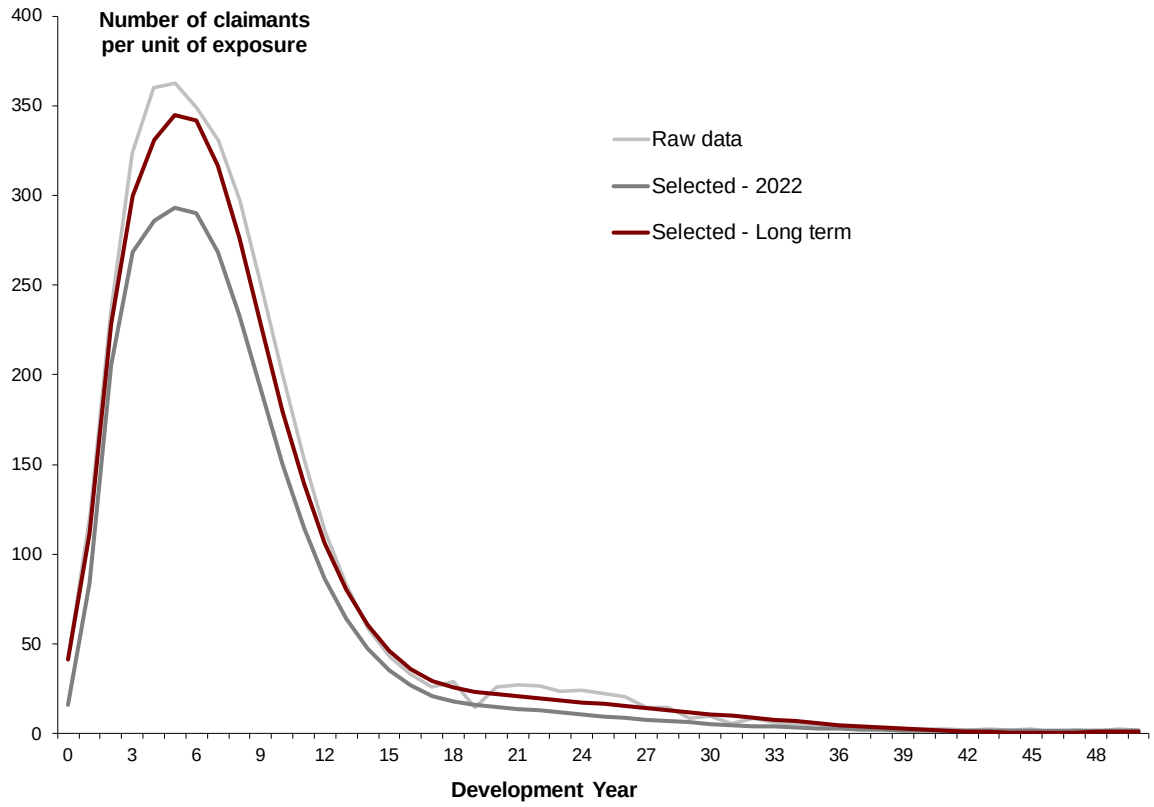
Figure 16.1: Expenditure on other payments by category (MRCA data)



16.3.2 Figure 16.2 shows assumptions adopted for MRCA medical examinations on numbers of claimants per unit of exposure against the raw data from which these assumptions were derived. In the most recent year, there has been a large increase in the number of claimants for MRCA medical exams, mainly driven by an increase in the processing capacity to complete the current open IL claims. We expected this heightened level of claimants to be sustained for

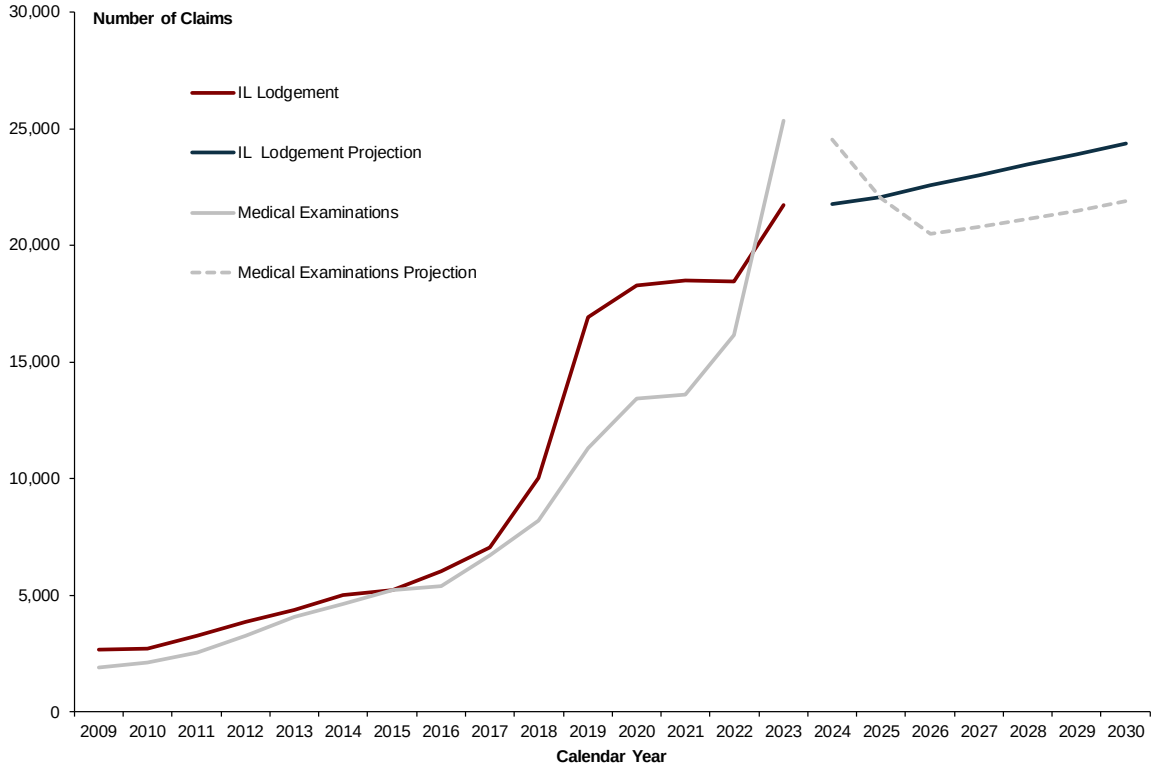
the current and next financial year but have reduced our future projection to be in line with the level of expected IL lodgements. This is reflected in the lower long-term assumption shown.

Figure 16.2: Number of claimants per unit of exposure – medical examinations



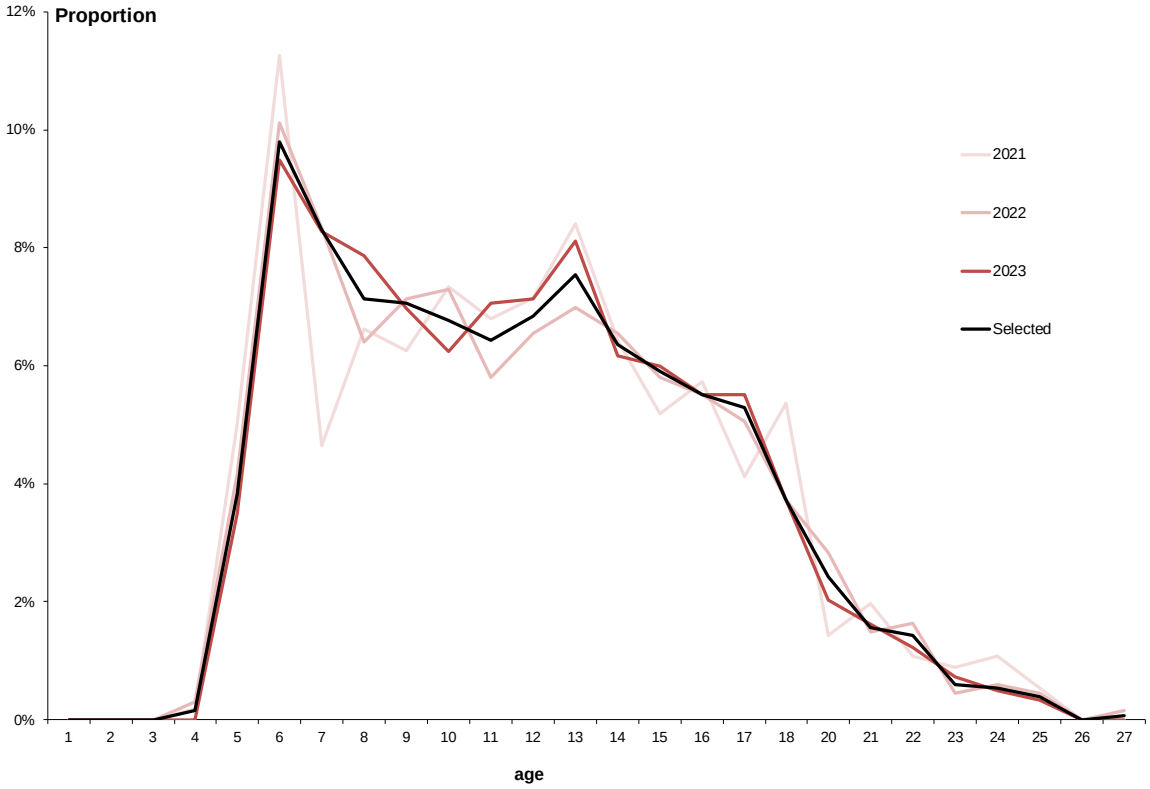
16.3.3 Figure 16.3 shows the trend in the number of IL lodgements and medical examinations from 2009. From 2009 to 2018, the number medical examinations have been approximately 90 per cent of IL lodgements. Since 2019, medical examinations claims have not kept pace with the level of IL lodgements, likely as a result of processing constraints. However, in recent years, this appears to have reversed, with the number of medical exams exceeding the level of IL lodgements. DVA have confirmed that reimbursement for medical exam fees can occur prior to the completion of an IL claim thus the increase in the level of medical exam reimbursements could reflect the increase in processing capacity where open claims have now been allocated to DVA delegates and claim support officers. Using the historical number of IL lodgements from 2019 to 2023 and a 90 per cent conversion assumption between lodgements and medical examinations, we calculated the difference between the expected and actual medical examinations as the number of open medical exam claims. This results in approximately 9,000 additional medical examinations to be cleared in the next two financial years. We expect medical examination claims to reach 24,500 and 22,000 in the next two calendar years, before reverting back to the long-term assumption of 90 per cent of IL lodgements.

Figure 16.3: Number of IL Lodged, IL Completed and Medical Examinations – actual and projection



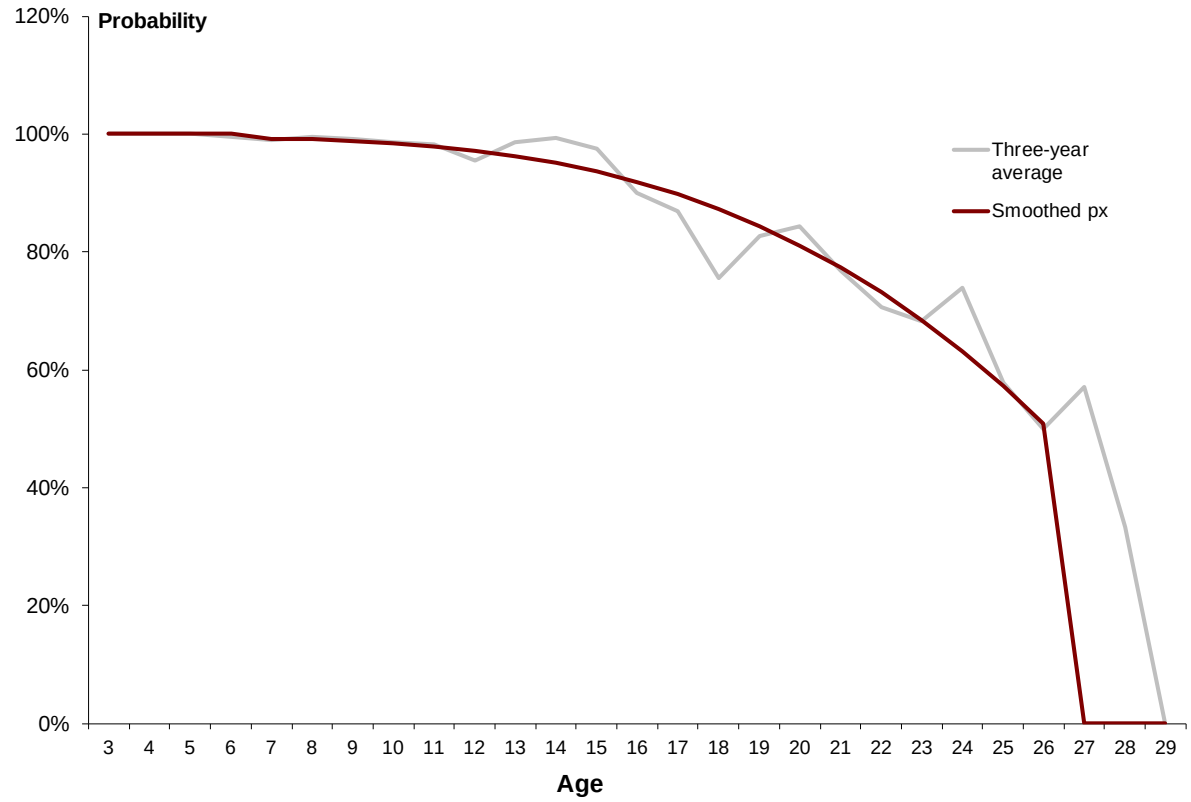
16.3.4 Figure 16.4 below shows the age distribution for the most recent three calendar years and the adopted age distribution for new ETS claimants. The chart shows a sharp peak at age 5, indicating a high proportion of new claimants in the younger age group, which broadly declines with increasing age. Notable peaks can also be observed at ages that correspond to the start of primary, secondary and tertiary education, where dependents might require support for costs associated with their studies.

Figure 16.4: Age distribution for ETS new claimants



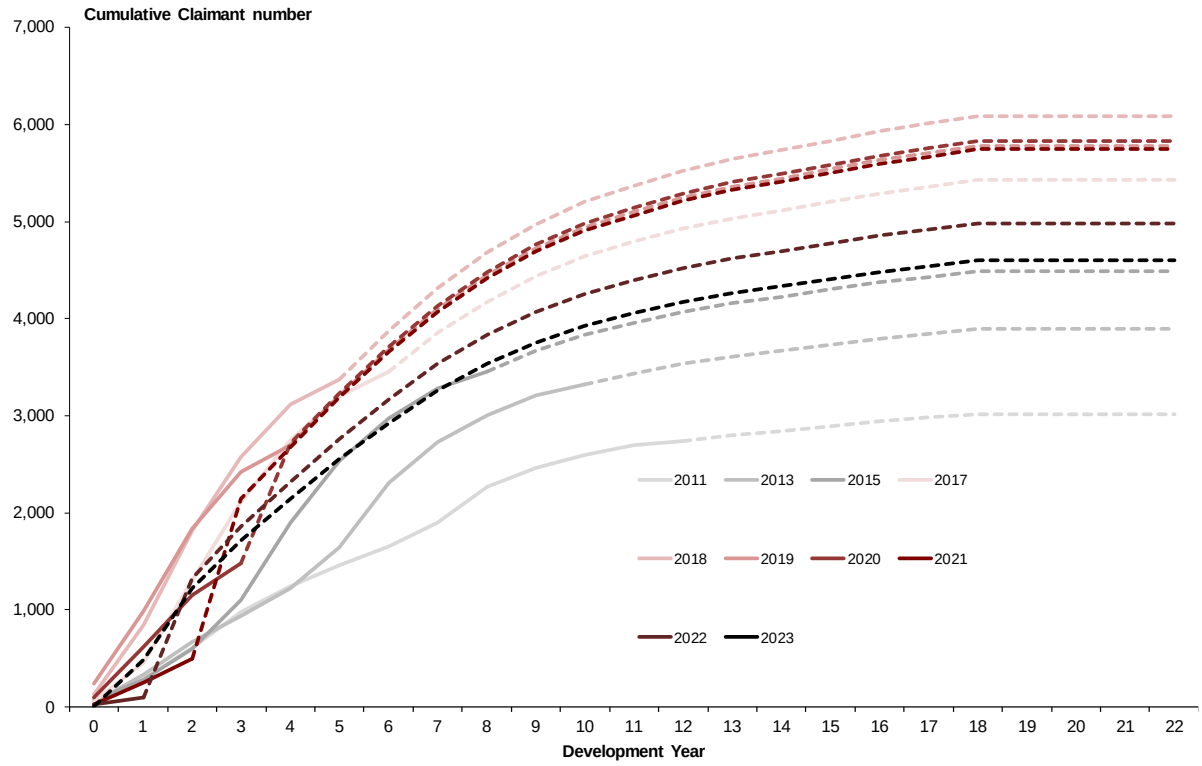
16.3.5 Figure 16.5 below shows the three-year average and the selected assumption on the probability that a dependent remains in the scheme for another year. For example, the probability at age 18 of remaining on benefits is 82 per cent from the figure below indicating that if 100 claimants aged 18 accessed benefits in 2024, we would anticipate 82 of them to continue accessing benefits one year later when they are 19. We have truncated the distribution at age 27 to align with the age eligibility criteria for ETS payments, noting that there are very small numbers of recipients receiving benefits beyond this age. We do not believe this has a material impact on the valuation.

Figure 16.5: Probability of remaining in the ETS



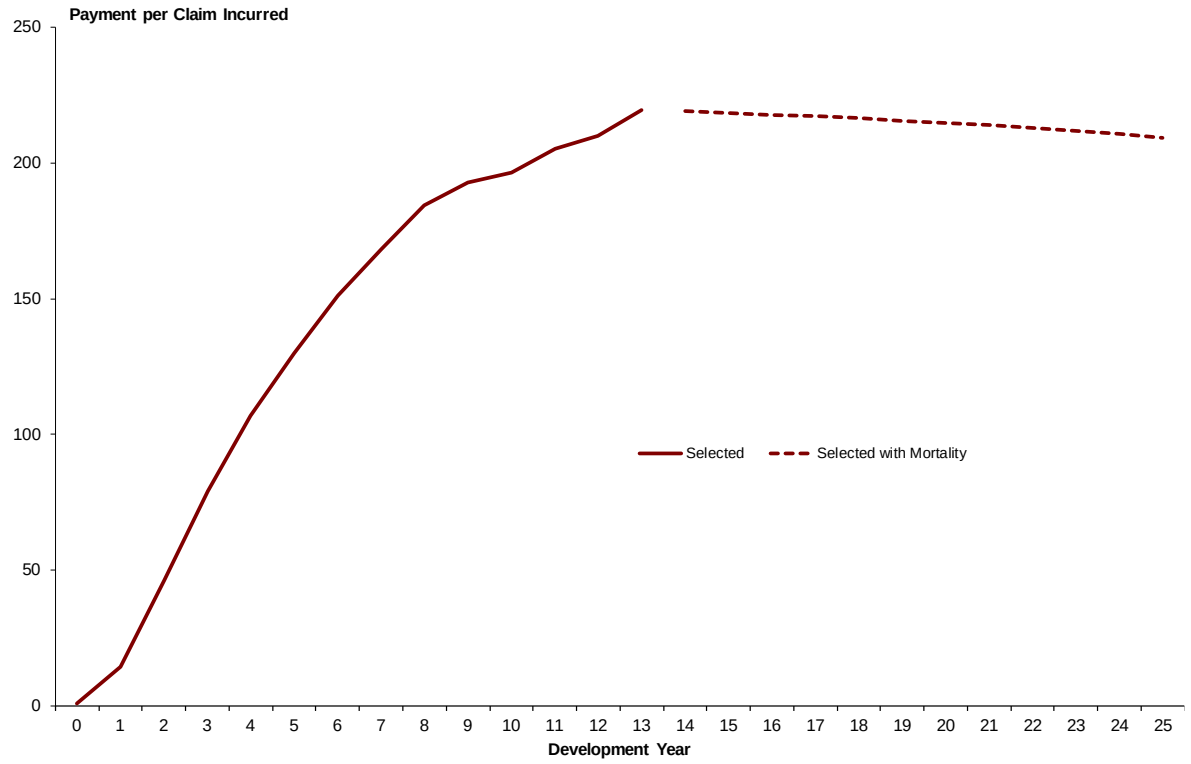
16.3.6 Figure 16.6 below shows the projected cumulative claimant numbers for a subset of accident years for supplement payments. A chain ladder model was used to project future new claimants. Development factors were selected based on experience over the last four years. Additional adjustments were made to some of the early development periods for the most recent accident years to account for the impact of processing constraints.

Figure 16.6: Projected cumulative claimant number



16.3.7 Figure 16.7 below shows the payment per ultimate claim incurred for MRCA supplement payments, selected based on the average of the most recent four years. Initially, there is a significant increase in payment as new claimants enter and begin to access the benefit for the first time, driving the curve upwards. This slows over time and reaches its peak at around development year 13, at which point it is overlaid with mortality to project the future payments per claim. These payment amounts are then multiplied by the corresponding projected ultimate number of claimants to derive the future payments for each accident year and development year.

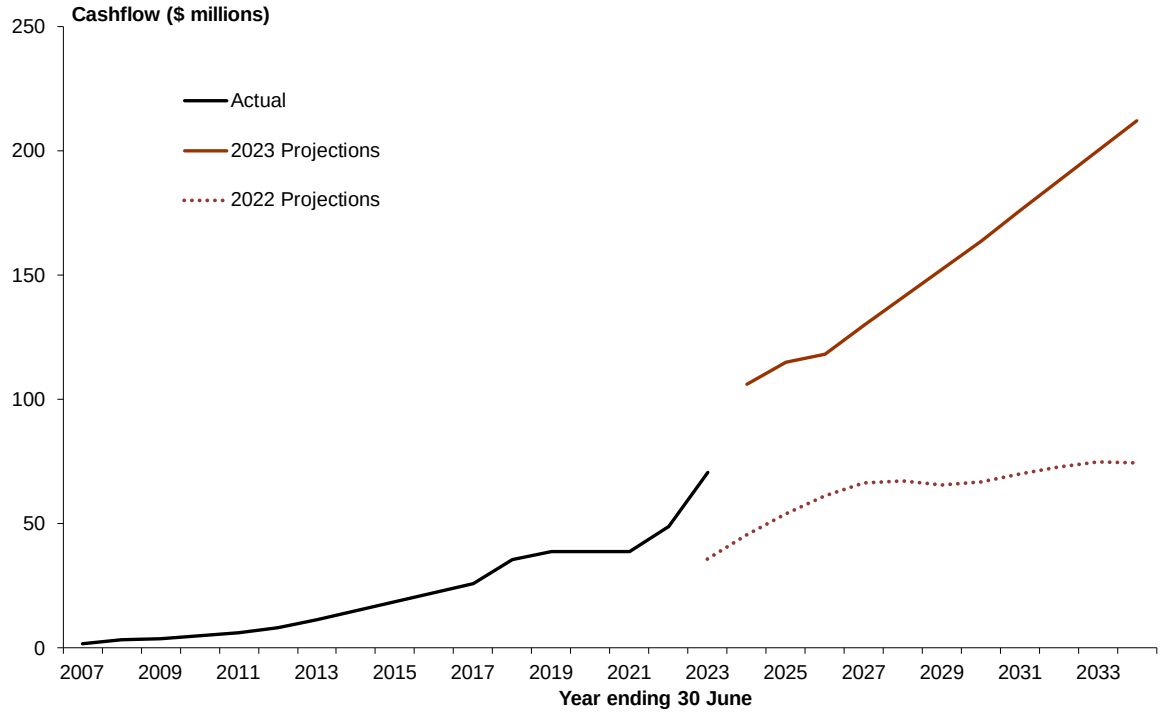
Figure 16.7: Payment per Claim incurred – MRCA Supplements



16.3.8 Based on more recent experience, we have increased the average cost for medical examinations to $2,850 from $2,297 per claimant selected at the previous valuation, inflated to 2023 dollars. The average cost assumption for education payments has also been increased to $4,275 from $3,484, the selected value from the previous valuation, inflated to 2023 dollars. The large increase is partially due to an update in the calculation where we have set the average size assumption for education payments based on the experience for claimants not in their first year of payment to ensure only claimants with a full year of benefit usage are included. A loading factor of 1.3 per cent has been applied to the medical examination payments to account for legal fees and 0.14 per cent to all Other payments to account for the remaining miscellaneous payments.

16.3.9 When these components are combined, we can estimate the total projected payments for future years and compare them against the historical experience as shown in Figure 16.8. The 2023 projected cashflows are different to those projected at the 2022 valuation, reflecting changes to both the number of expected future claims and the average size of benefits. The 2023 projection also includes a projection for supplement payments which were not included in last year's Other category.

Figure 16.8: Historical and projected other payments



16.4 Liability Estimate

16.4.1 Table 16.1 shows the estimate of the liability in relation to other payments broken down by year of accident. The liability as at 30 June 2023 is $1,245.7m. This compares to a projected liability of $351.2m from the 2022 valuation and is driven by increases across both expected ETS benefits and medical exam fees. The projection this year also includes supplements which were previously included across a number of other benefit types.

Table 16.1: Outstanding claims liability for MRCA other payments by year of accident

Year of accident – year ending 30 June	Liability (inflated and discounted) ($'m)
2005 – 2009	77.4
2010	28.1
2011	36.9
2012	44.2
2013	53.1
2014	59.5
2015	68.4
2016	77.5
2017	87.2
2018	99.5
2019	105.8
2020	119.0
2021	128.9
2022	130.3
2023	129.7
Total	**1,245.7**
Expected at 30/06/2023	*351.2*
Total (30/06/2022)	**325.7**

16.4.2 Table 16.2 reconciles the liability estimate with the corresponding estimate at the previous valuation.

Table 16.2: Reconciliation of liability for other payments

	$m
Liability estimate at 30/06/22 (previous report)	325.7
Assumed Interest	18.2
Projected Payments	(35.9)
Notional Premium	43.2
Projected liability as at 30 June 2023 (previous valuation)	**351.2**
Experience effects and Assumption changes	
difference between actual and projected payments	(23.9)
change in claimants	258.2
change in average size	134.4
change in ETS duration assumption	162.3
additional supplements model	363.43
Current Estimate	**1,245.7**

17 Death Benefits

17.1 Modelling Approach and Assumptions

17.1.1 Death benefits are the smallest liability among the various heads of damage and the number of deaths can be highly variable from year to year. The assumptions made therefore involve a more significant degree of judgement relative to the other components of the liability.

17.1.2 Under DRCA, lump sum benefits are payable to surviving spouses on death due to work related causes. In addition, fortnightly benefits are payable to dependent children until they reach the age of 21. Under MRCA, a lump sum death benefit is payable on death where the deceased had suffered impairment as a result of service assessed at 80 or more impairment points, and an additional benefit is payable to a dependent spouse where the death occurred in service. The lump sum death benefit is broadly equivalent to the VEA widow's pension and can be taken as a periodic payment or a lump sum. A further lump sum benefit is payable in respect of each dependent child as well as an additional lump sum where the death has been accepted as having been related to ADF service.

17.1.3 The DRCA maximum lump sum death benefit payable as at 1 July 2023 was $617,131, while the maximum MRCA lump sum benefit was $1,085,230 with the actual amount payable dependent upon the age of the widow or widower and whether or not the death is accepted as having been related to ADF service.

17.1.4 Apart from deaths due to long latency diseases, such as asbestos related illnesses, the main compensable cause of death is likely to be accidental. Lump sum benefits payable on death would also generally be expected to be paid within a relatively short time after the death. Thus, in most cases, the lag between the time of the injury causing death and the payment of benefits will be relatively short.

17.1.5 From September 2017, the smoking policy was amended to allow claims for smoking-related illnesses if they satisfy certain criteria under the DRCA scheme. Further to this, policy changes were made in November 2018 to lower the level of evidence required in relation to asbestos exposure for veterans who served on certain RAN ships from 1940 to 2003. In addition, changes to straight through processing for mental health conditions related to operational service could mean posthumous mental health diagnoses become easier to determine for suicide cases. Anecdotal evidence from the DVA policy area suggests that the broader suite of services provided by Service Coordination within DVA could have been proactively seeking out potential death payment claimants. All these factors could have led to the sustained high levels of death payments seen in recent years.

17.1.6 For MRCA, almost all death benefits paid to date have been paid within two years of the date of death, with over 50 per cent of the benefits being paid in the year of death and almost 40 per cent being paid in the following year. This might be expected to change in future as the scope for lagged claims increases with the ageing of the scheme. At this stage, however, we have not made any allowance for the emergence of lagged death claims under MRCA. This does not mean that such claims will not arise in future, but at present we have no basis for making a judgement about the quantum of any liability. In particular, the DRCA experience with asbestos related diseases might not be expected to be a good guide to future MRCA outcomes.

17.1.7 For DRCA, however, typically around 30 per cent of death benefits paid in a given financial year are for deaths occurring more than two years prior to the end of the financial year and it is reasonable to model payments rather than deaths. This pattern of lags between deaths and payment has been reasonably consistent over the last 3 years and needs to be allowed for in the valuation since the amount of the death benefit entitlement will depend upon the year of death rather than the year of payment.

17.1.8 At this year's valuation, we have reallocated death-related MRCA education scheme payments back to Other into a consolidated education payments category. Death related expenses such as funeral expenses, financial advice and Defence Act additional death benefit, which were previously included in 'Other 2', were reallocated to Death benefits.

17.1.9 Table 15.1 shows the number of death benefits paid in each of the last 20 calendar years under DRCA and MRCA. Similar to last year, only the calendar year of death was provided in our data.

Table 17.1: Number of death benefits in recent calendar years

Calendar Year	DRCA Deaths	MRCA Deaths
2004	15	0
2005	10	7
2006	5	4
2007	15	9
2008	19	2
2009	24	5
2010	16	12
2011	31	14
2012	43	10
2013	53	8
2014	25	10
2015	34	8
2016	33	11
2017	34	15
2018	38	28
2019	60	22
2020	64	14
2021	42	30
2022	91	28
2023	81	34

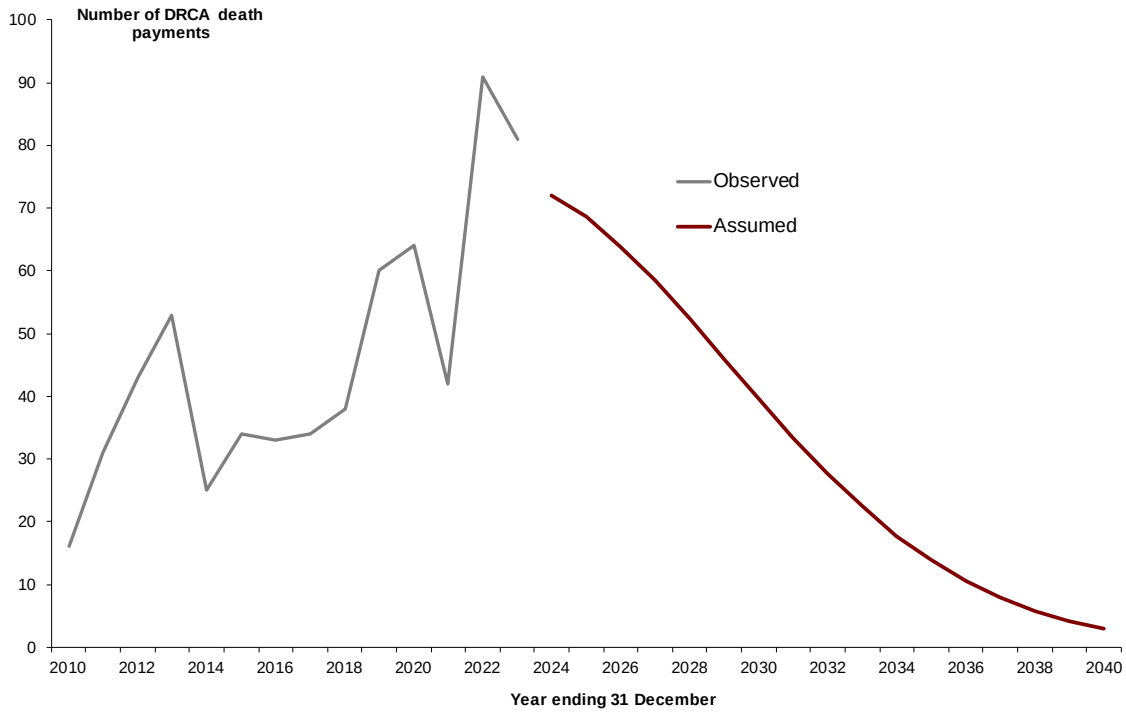
17.1.10 DRCA death benefit claims did not decline as expected following the closure of the scheme in 2004 but rather trended upwards. It seems likely that most of these claims have arisen from long latency diseases such as those related to asbestos exposure. The future trajectory of these claims is quite uncertain. However, other information on claim patterns for asbestos related diseases suggests that such death 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.

17.1.11 At this valuation, DVA was unable to provide further information related to cause of death for DRCA or MRCA. As such, further analysis could not be conducted at this valuation to ascertain the drivers of the high numbers of death claims seen in recent years across both Acts. There remains great uncertainty in the absence of this information as to whether these heightened levels will continue into the future.

17.1.12 Figure 17.1 shows the run-off in claims assumed in 2023 against recent experience. We have seen a sustained high level of death payments over the last two years for DRCA. It is likely that recent policy changes, such as the change in service-related smoking take-up and mental health claims, could have had an impact on the level of claims arising.

Figure 17.1: Observed and assumed number of DRCA death payments from long latency diseases



17.1.13 We have assumed that these payments relate to deaths occurring up to 3 years prior to the year of payment. All the benefits are assumed to be paid at the higher rate which came into effect from 1 July 2009. In practice, a small number of claims relate to still earlier years and would be paid at the lower rates; this was the case for 7 of the 81 claims in 2023. In view of the other uncertainties, we do not consider that this assumption gives rise to any material error.

17.1.14 In light of the most recent experience in MRCA death payments, we have increased the expected number of deaths over the next year to be 60. The number of death payments in the 6 months to 31 December 2023 is 25, compared to our previous assumption of 25 for the whole year. The 2023-24 aggregate expenditure data to 31 March 2024 shows $35 million in death payments, suggesting full year expenditure could reach $47 million. This compares to $26 million in financial year 2022-23. Death experience can be extremely volatile and over the long term, we have adopted an assumption of 30 deaths per year for MRCA, based on experience in the last 3 calendar years.

17.1.15 We have assumed that 55 per cent of MRCA death benefits will be paid as a lump sum payment. This is derived from the most recent two years of experience.

17.1.16 The age distribution assumed for surviving dependants affects how long periodic payments made to a spouse or children are assumed to continue. Table 17.2 shows the age distribution adopted in the 2023 valuation for surviving spouses together with the latest observed data.

Table 17.2: Observed and assumed age distribution for surviving spouses

Age Group	Observed	2023 Assumption	2022 Assumption
Less than 25	6%	5%	5%
25–29	16%	15%	15%
30–34	14%	15%	15%
35–39	17%	15%	20%
40–44	13%	15%	15%
45–49	9%	10%	10%
50–54	11%	10%	10%
55–59	9%	10%	5%
60 or more	3%	3%	5%

17.1.17 The assumed age distribution of children is shown in Table 17.3 below. The assumptions are identical to those adopted at the 2022 valuation which are also included in the table.

Table 17.3: Observed and assumed age distribution for dependent children

Age Group	Observed	2023 Assumption	2022 Assumption
Less than 5	26%	25%	25%
5–9	28%	30%	30%
10–14	24%	22%	22%
15–19	19%	20%	20%
20 or more	3%	3%	3%

17.1.18 For DRCA, we have assumed an average of 0.1 new children per death paid, based on the most recent four calendar years of data. This figure has shown a decreasing trend in recent years, reflecting the aging DRCA cohort and a decline in the number of eligible dependent children.

17.1.19 For MRCA, the average number of children per surviving spouse was 1.4; the same as the assumption adopted in 2022. Children's pensions are assumed to cease at age 21, while spouse pensioners are assumed to experience mortality in line with the most recent Australian Life Tables (ALT 2015–17).

17.1.20 For DRCA, we have assumed a take up rate of 85 per cent for funeral expenses and 20 per cent for financial advice reimbursements. The average size of funeral expenses and financial advice reimbursement are assumed to be 50 per cent and 65 per cent of the statutory limit, respectively. For MRCA funeral expenses, we have assumed a 70 per cent take up rate and 70 per cent average amount reimbursed.

17.1.21 Benefits are assumed to increase in the future in line with the relevant statutory provisions. For DRCA, this means that we are allowing for indexation of the lump sum benefit, which constitutes the bulk of the liability, in line with general wage growth. Indexation of any periodic payment for children is also in line with general wage growth. For MRCA, all benefits are indexed in line with price inflation. Financial advice and funeral benefit expenses are also indexed in line with price inflation.

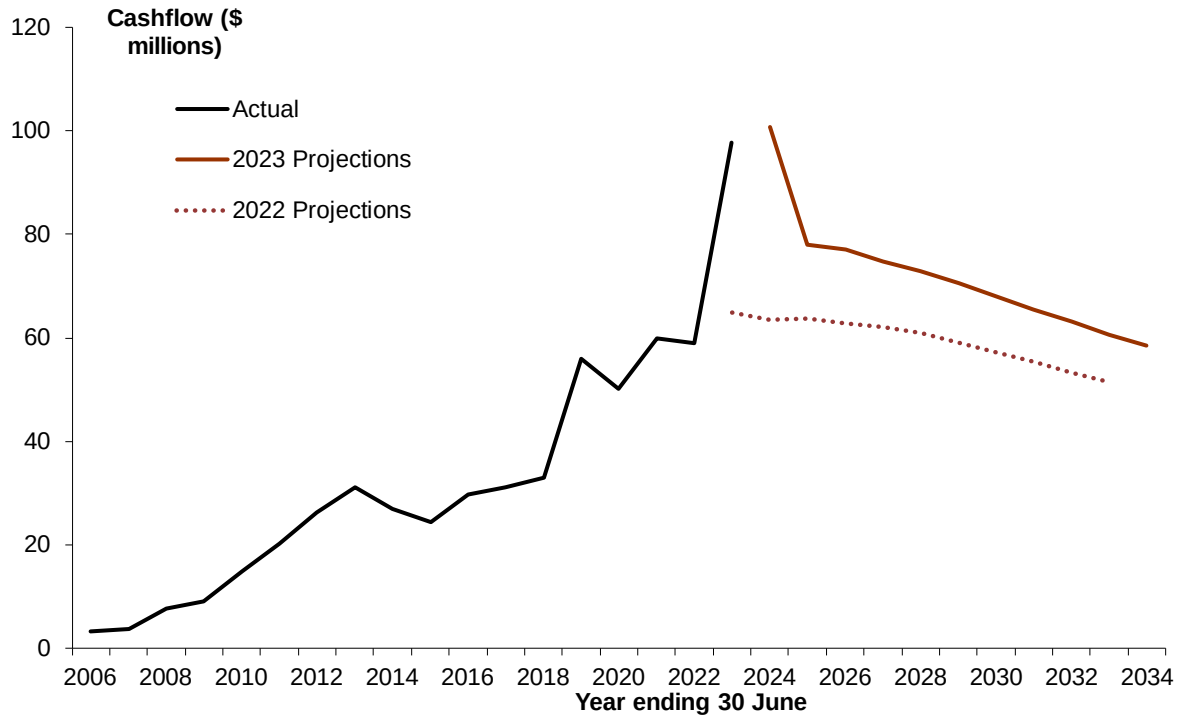
17.2 Liability Estimate

17.2.1 The liability estimate for death benefits amounts to $475.0m. The bulk of the liability relates to DRCA claims and the estimate is extremely sensitive to the assumed number of DRCA death payments. It is important to note that death benefits are extremely volatile and the degree of uncertainty around this assumption cannot be overstated.

17.2.2 The projected cashflows have increased significantly this year, driven by higher claimant assumptions adopted for both DRCA and MRCA.

17.2.3 Figure 15.2 below shows the projected cashflows for both schemes combined.

Figure 17.2: Projected cashflows – DRCA and MRCA death benefits



17.2.4 At the previous valuation, we were projecting a total liability of $433.0m as at 30 June 2023, which is lower than the 2023 valuation result of $475.0m. The increase has been driven by the higher number of expected future deaths for both DRCA and MRCA. The projection this year also includes death related benefits which were included in Others benefit at the previous valuation.

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

18.1 Summary of Outstanding Claims Liability

18.1.1 Table 18.1 shows the overall outstanding claims liability split between benefit types as at 30 June 2023.

Table 18.1: Outstanding claims liability as at 30 June 2023

Payment Type	Liability (inflated and discounted)	
Permanent Impairment[6]	21,385.8	33%
Incapacity	12,768.6	20%
Medical Expenses	22,084.2	34%
Rehabilitation Costs	1,401.7	2%
Benefits Payable on Death[7]	475.0	1%
Household Services and Attendant Care	5,336.0	8%
Other[8]	1,313.6	2%
Total	**64,764.9**	**100%**

18.1.2 Table 18.2 shows the outstanding claims liability as at 30 June 2023 by payment type and service arm.

6 Includes non-economic loss payments.

7 Includes lump sums and fortnightly payments to dependent children.

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

Table 18.2: Outstanding claims liability as at 30 June 2023

	Liability (Inflated and Discounted) $'m			
Payment Type	**Army**	**Navy**	**RAAF**	**Total**
PI and NEL	16,247.8	2,707.3	2,430.7	21,385.8
Incapacity	8,457.0	2,408.9	1,902.7	12,768.6
Medical Expenses	15,104.3	3,621.1	3,358.8	22,084.2
Rehabilitation Costs	951.0	257.3	193.4	1,401.7
Death Benefits	186.2	166.5	122.4	475.0
Household Services and Attendant Care	3,505.5	1,023.0	807.4	5,336.0
Other	822.8	227.7	263.2	1,313.6
Total	**45,274.6**	**10,411.8**	**9,078.5**	**64,764.9**

18.1.3 Table 18.3 shows the outstanding claims liability for 2023, and projected for 10 years, split between DRCA and MRCA claims. The proportion of MRCA claim related liabilities are projected to increase from about 88 per cent of the total as at the valuation date to almost 96 per cent by the end of the projection period.

Table 18.3: Outstanding claims liability split between DRCA and MRCA

As at 30 June	DRCA ($m)	MRCA ($m)	Total ($m)
2023	7,694.3	57,070.5	64,764.9
2024	7,498.3	62,379.7	69,878.0
2025	7,245.0	66,985.9	74,231.0
2026	6,553.1	70,563.7	77,116.8
2027	6,128.5	76,203.6	82,332.1
2028	5,851.2	82,481.8	88,333.1
2029	5,574.7	89,063.9	94,638.6
2030	5,300.2	95,932.5	101,232.7
2031	5,027.9	103,080.2	108,108.0
2032	4,758.6	110,527.6	115,286.2

18.1.4 Table 19.3 reconciles the overall liability estimate given in our 2022 report with the current estimate of the outstanding claims liability. In total, the various adjustments made to assumptions have increased the liability by approximately $20bn compared with that projected in the 2022 valuation.

Table 18.4: Reconciliation of overall liability estimate

	$m
Liability estimate at 30/06/22 (previous report)	**41,607.0**
Assumed Interest	2,107.7
Projected Payments	(2,318.9)
Notional Premium	3,427.7
Projected liability as at 30 June 2023 (previous valuation)	44,823.6
Experience effects and assumption changes	
difference between actual and projected payments	(199.4)
Increase in MRCA PI claims numbers	2,089.8
Increase in MRCA PI size (incl superimposed inflation)	4,363.8
Increase in DRCA PI claimant projection and average size	415.5
Incapacity model change	1,549.6
Incapacity assumption changes	1,943.0
MRCA Medical change in expected new entrants	1,284.9
MRCA Medical change in future Gold Card recipients assumption	2,828.4
MRCA Medical change in average size (incl pharmaceutical costs) assumption	2,186.1
Increase in MRCA Rehab claimant projection	965.7
DRCA HSAC model and assumption updates	418.1
MRCA HSAC change in assumptions	884.1
MRCA Other model and assumption changes	554.9
Other adjustments	656.7
Current Estimate	**64,764.9**

18.2 Summary of Projected Cashflows

18.2.1 This section combines the projected cashflows for incapacity and non-incapacity payments for the following decade allowing for future injuries. Table 18.5 shows the projected cashflows in respect of injuries sustained before the valuation date under the DRCA, while Table 18.6 shows the cashflows arising from injuries sustained before the valuation date under the MRCA. Table 18.7 shows the projected cashflows for those injuries occurring after 30 June 2023. Note that all figures are in nominal dollars, that is, they have not been discounted to 2023 dollars.

Table 18.5: Projected payments for DRCA claims as at 30 June 2023

	Payments (future dollars) $'m							
Year ending 30 June	**PI and NEL**	**Incapacity**	**Medical Expenses**	**Rehab**	**Death**	**HSAC**	**Other[9]**	**All[10]**
2024	285.6	156.5	9.5	12.7	53.7	39.6	9.1	566.8
2025	317.0	167.2	9.1	12.1	49.5	47.9	10.2	613.0
2026	723.6	175.3	8.7	11.5	47.2	54.1	8.3	1,028.8
2027	426.6	180.1	8.3	10.9	43.5	58.8	6.0	734.2
2028	256.5	185.6	7.9	10.2	40.5	63.4	5.6	569.6
2029	239.0	189.3	7.5	9.5	36.9	67.9	5.2	555.3
2030	222.9	190.8	7.1	8.8	33.0	72.4	4.8	539.9
2031	207.9	191.4	6.8	8.2	29.0	76.8	4.4	524.4
2032	193.9	190.2	6.4	7.5	25.0	81.0	4.0	508.1
2033	180.9	186.9	6.1	6.9	21.2	84.9	3.7	490.6

Table 18.6: Projected payments for MRCA claims incurred as at 30 June 2023

	Payments (future dollars) $'m							
Year ending 30 June	**PI**	**Incapacity**	**Medical Expenses**	**Rehab**	**Death**	**HSAC**	**Other**	**All**
2024	2,689.7	407.6	267.3	73.9	26.3	51.3	105.1	3,621.2
2025	3,417.7	465.4	335.2	81.7	6.3	68.5	110.7	4,485.6
2026	4,479.9	501.1	398.5	87.3	6.3	83.9	107.3	5,664.2
2027	2,237.4	543.7	462.8	90.8	6.2	96.4	108.8	3,545.9
2028	1,533.0	581.0	522.3	92.8	6.0	108.0	106.8	2,949.9
2029	1,230.9	611.5	584.6	93.3	5.9	119.2	102.9	2,748.3
2030	1,017.1	636.5	642.6	93.7	5.9	129.8	97.6	2,623.3
2031	858.7	658.0	702.8	92.8	5.8	139.8	91.7	2,549.6
2032	727.8	676.0	756.8	91.2	5.7	149.2	85.6	2,492.3
2033	613.4	690.6	812.9	89.3	5.6	158.1	79.9	2,449.6

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

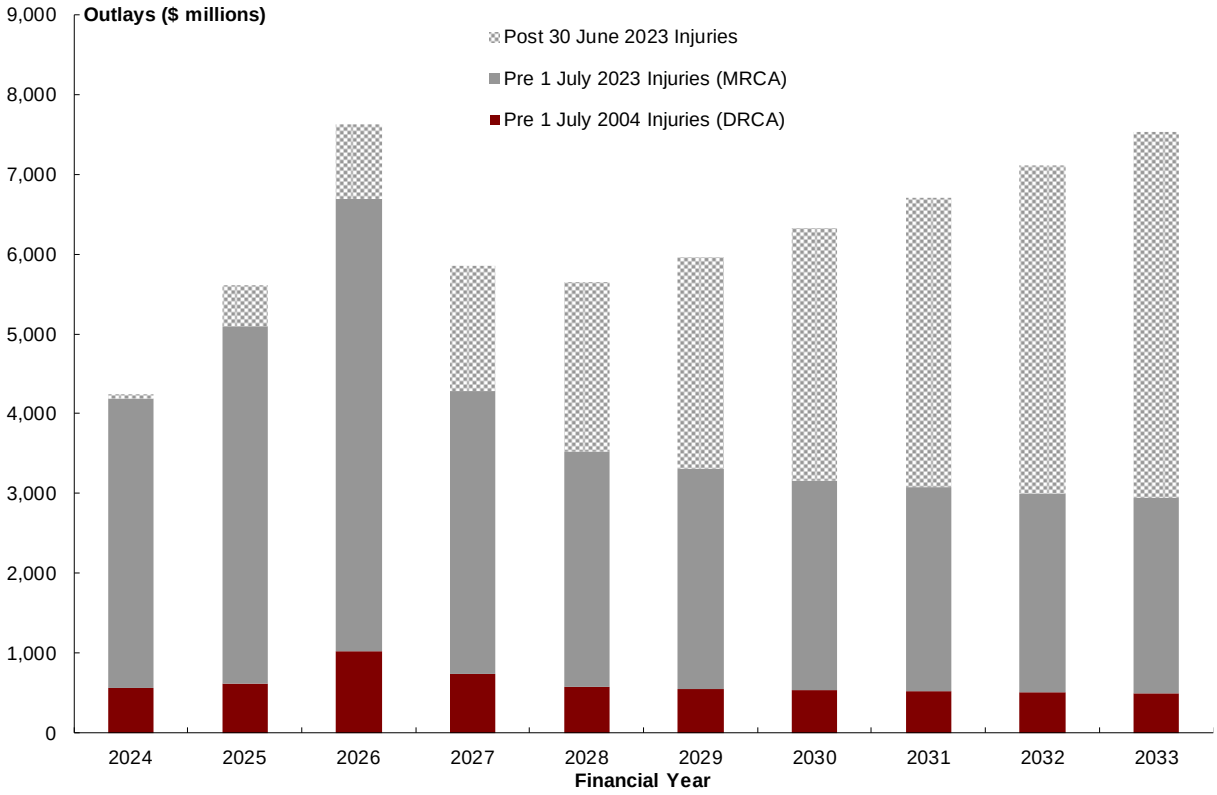
10 Excludes incapacity payments.

Table 18.7: Projected payments for MRCA claims incurred after 30 June 2023

	PI	Incapacity	Medical Expenses	Rehab	Death	HSAC	Other	All
	34.3	0.1	1.0	0.1	20.8	0.0	1.0	57.3
	472.9	4.1	5.8	1.3	22.3	0.2	4.4	510.9
	858.1	16.5	16.9	5.4	23.6	1.1	10.9	932.5
	1,434.1	40.5	35.8	11.7	25.0	3.3	21.3	1,571.7
	1,902.3	76.2	62.9	19.9	26.4	7.0	34.4	2,129.2
	2,315.6	123.2	98.2	29.9	27.8	12.7	49.6	2,657.0
	2,679.3	180.7	141.1	40.5	29.2	20.2	66.4	3,157.5
	2,990.6	247.8	191.5	52.7	30.7	29.7	84.1	3,627.1
	3,290.5	323.6	248.6	65.8	32.3	41.3	102.2	4,104.3
	3,583.7	407.5	312.0	79.9	33.8	55.1	120.2	4,592.2

18.2.2 Figure 18.1 shows this information graphically.

Figure 18.1: Projected payments



18.2.3 Table 18.8 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 2023 dollars.

Table 18.8: Projected payments split between DRCA and MRCA injuries

Year ending 30 June	Total	
	DRCA ($'m)	MRCA ($'m)
2024	566.8	3,678.5
2025	613.0	4,996.5
2026	1,028.8	6,596.7
2027	734.2	5,117.7
2028	569.6	5,079.1
2029	555.3	5,405.2
2030	539.9	5,780.8
2031	524.4	6,176.7
2032	508.1	6,596.7
2033	490.6	7,041.7

18.3 Estimated Notional Premium

18.3.1 The notional premium is an estimate of the lifetime compensation cost of work related injuries occurring during 2023–24. 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 2023–24 if experience unfolded in line with the valuation assumptions. The notional premium for 2023–24 relates entirely to MRCA claims. It is important to note the distinction between the notional premium for 2023–24 and the actual claim payments which will be made during 2023–24.

18.3.2 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 2023–24.

18.3.3 The estimate of the notional premium is calculated as the present value of the cashflows arising from the 2023–24 accident year adjusted for half a year's interest to give the amount that would need to be paid over the course of 2023–24.

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

18.3.5 Table 18.9 sets out the estimates of the notional premium, broken down by Service Arm, and by payment type. The notional premium for 2023–24 is $6,075.0m.

Table 18.9: 2023–24 notional premium by service and payment type

Payment Type	ARMY ($'m)	NAVY ($'m)	RAAF ($'m)	Total ($'m)
Permanent Impairment	2,045.1	340.8	305.9	2,691.8
Incapacity	627.8	178.8	141.2	947.8
Medical	1,249.3	299.5	277.8	1,826.6
Rehabilitation	84.6	22.9	17.2	124.6
Death	19.9	17.8	13.1	50.7
HSAC	199.2	58.1	45.9	303.1
Other	81.6	22.6	26.1	130.3
Total	**4,324.4**	**943.2**	**807.4**	**6,075.0**

18.3.6 Table 18.10 shows the overall notional premium estimates, expressed as percentages of the total military salary expenditure expected to be paid during 2023–24. Salary estimates for this review were provided by Defence.

Table 18.10: 2023–24 notional premium by service (percentage of salary)

	ARMY	NAVY	RAAF	Total
Notional Premium ($ m)	4,324.4	943.2	807.4	6,075.0
Forecast salaries 2023–24 ($m)	3,226.6	1,965.5	1,840.2	7,032.3
Notional Premium (%)	134.0%	48.0%	43.9%	86.4%

18.3.7 Defence advised overall estimated salaries of approximately $7.0bn for 2023–24. This was around $375m higher than the salary roll for 2022–23, an increase of 5.6 per cent. The notional premium has increased by around 72 per cent and this has resulted in an increase in the premium expressed as a percentage of salary of approximately 35 percentage points compared to last year's valuation. Most of the premium is attributable to the Army, which accounts for over 70 per cent of the total premium.

19 Scenario Analysis

19.1 Background

19.1.1 As discussed throughout the report, there remains great uncertainty in estimating the MCS liability. The very long term over which these liabilities will be paid out makes the results very sensitive to relatively small changes in assumptions. Interpreting experience in a rapidly changing environment also poses significant challenges. We have included a range of sensitivity tests and scenarios to show the impact of changes in key modelling assumptions and the impact of wider scheme experience changes. Please note that the sensitivities and scenarios included in this section are a subset of possible outcomes and are not intended to be an exhaustive list of all possible future outcomes. The results are not intended to represent lower and upper bounds to all possible future outcomes.

19.1.2 As noted in section 5.2, the choice of the interest rate used to discount future cashflows to determine the present value of liability has a major impact on the results. This is the result of the very long time period over which payments are projected combined with the relatively high rates of payment inflation.

19.1.3 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 2023 DVA financial statements, therefore, we discounted the cashflows generated by the 2022 model using a yield curve for Commonwealth securities as at 30 June 2023. We have recalculated the liability based on the cashflows from the current valuation using that same yield curve.

19.1.4 One of the key uncertainties at this valuation is the level of future initial liability claims. Although the level of lodged IL claims remained relatively stable over the 2020 to 2022 calendar years, the latest year saw a significant increase across both DRCA and MRCA. As the level of future expected IL claims has an impact on a number of the major benefits, we have included scenarios to show the liability if IL lodgement levels were to return to those seen in previous periods or continue to escalate beyond current levels.

19.1.5 In selecting scenarios for analysis, we have focused on the largest benefit categories, focusing particularly on assumptions where experience has been changing or volatile. We have focused our scenario tests around MRCA PI, incapacity, MRCA medical, and MRCA household services 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.

19.2 Results

Discount Rate Scenario

19.2.1 The following table shows the liabilities as at 30 June 2023 by head of damage and Act using the yield curve adopted for the 2022–23 financial statements.

Table 19.1: Estimated liability using 2023 yield curve

Payment Type	DRCA ($'m)	MRCA ($'m)	Total ($'m)
Permanent Impairment	3,615	18,672	22,287
Incapacity	2,288	11,575	13,863
Medical	99	25,082	25,180
Rehabilitation	118	1,396	1,513
HSAC	1,662	4,325	5,987
Other	72	1,334	1,405
Death	369	132	501
Total	**8,221**	**62,515**	**70,736**

19.2.2 The total liability increases by almost $6bn when the 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.

19.2.3 Cashflows are not affected by the choice of discount rate but the notional premium is. Using the yield curve, the calculated notional premium increases by $763m to approximately $6.8bn, approximately 97 per cent of estimated ADF salaries for 2023-24.

Initial Liability Scenarios

19.2.4 As discussed in the report, the most recent year of experience saw a significant increase to the level of lodged DRCA and MRCA IL claims. For our valuation, we have adopted the most recent experience (i.e. the 2023 calendar year) as our assumption for future levels of IL lodgements.

19.2.5 We have spoken to DVA policy areas around the potential drivers of this experience which suggests possible reasons such as greater awareness through the Royal Commission into Defence and Veteran Suicide, media coverage/word of mouth on the clearance of the DVA claims backlog, "on base" activities informing veterans of their entitlements, organisation of advocacy groups (such as the RSL) to assist veterans with making claims, all of which may encourage veterans to lodge new or further claims. Some of these impacts may be temporary and lodgements could return to previous levels or they may persist or accelerate further.

19.2.6 We have performed two scenarios around lodgement experience for MRCA, noting these are not exhaustive of all possible outcomes nor are they intended to represent a floor or ceiling in outcomes:

- a return to previous lodgement levels i.e. that lodgements in 2024 will be 15% lower than in 2023 (a similar level as for the 2020 to 2022 years), and that this lower level will be maintained in future years; and
- a further increase in lodgement levels, namely a 15% increase in 2024, and that this higher level will be maintained in future years.

Table 19.2: MRCA liability under modelled initial liability scenarios[11]

Scenario	Description	MRCA Liability ($'m)	Change in Liability ($m)	% Change
Base		57,070.5		
1	IL lodgements return to levels seen in CY2020 to CY2022 (i.e. 15% lower than adopted)	52,431.2	(4,639.3)	(8%)
2	IL lodgements increase by 15% on levels seen in CY2023 (i.e. 15% higher than adopted)	61,739.9	4,669.3	8%

Permanent Impairment Scenarios

19.2.7 The main driver of the liability increase in MRCA permanent impairment at this year's valuation has been the increase in average size. We have provided scenarios to illustrate the impact on the liability should components of the average size be different to those selected. Note that for these scenarios, we have only tested the sensitivity of changes in the size of those receiving interim or non-interim lump sums; the average size of Section 80 benefits and the amounts received in periodic benefits is assumed unchanged.

19.2.8 Our adopted rate of superimposed inflation included in the valuation result is for four years of superimposed inflation at a rate of 2.0 per cent per annum. We have provided scenarios where there is no superimposed inflation, and also where superimposed inflation is 2.5 per cent per annum for all future years.

19.2.9 In recent years, conversion between accepted IL claims and PI lodgements have also been high and directly impacts the number of expected future PI claims. We have also included a sensitivity test on the conversion rate between IL and PI.

19.2.10 The results are included in Table 19.3 below.

[11] Note that for MRCA models where there are existing claimants such as medical and household services, only the IBNR component of the liability has been adjusted for the scenario analysis.

Table 19.3: MRCA Permanent impairment liabilities under modelled scenarios

Scenario	Description	MRCA PI Liability ($'m)	Change in Liability ($m)	% Change
Base		17,969.5		
1	Average size lump sums higher by 10%	19,383.3	1,413.8	7.9%
2	Average size of lump sums lower by 10%	16,555.7	(1,413.8)	(7.9%)
3	Average size in the tail is higher (payments made 15 years after the accident date are 20% higher)	18,552.7	583.2	3.2%
4	Average size in the tail is lower (payments made 15 years after the accident date are 20% lower)	17,464.6	(504.9)	-2.8%
5	Higher superimposed inflation (2.5% for all future years)	18,964.7	995.2	5.5%
6	No superimposed inflation	17,112.1	(857.4)	(4.8%)
7	Higher conversion rate from IL (5% more ILs convert to PIs)	18,744.8	775.3	4.3%
8	Lower conversion rate from IL (5% fewer ILs convert to PIs)	17,194.3	(775.3)	(4.3%)

19.2.11 Table 19.4 below shows the sensitivity test results for DRCA PI. We have tested the two key assumptions of average size and expected claim numbers.

19.2.12 Note that an increase / decrease to the expected claimants does not correspond to an equivalent increase / decrease to the liability. This is because the change in expected future claimants will not impact the current cohort of open claims. As such, not all future claims will be impacted, only those that have yet to be reported.

Table 19.4: DRCA Permanent impairment liabilities – sensitivity test results

Scenario	Description	DRCA PI Liability ($'m)	Change in Liability ($m)	% Change
Base		3,416.3		
1	Average size higher by 10%	3,757.9	341.6	10.0%
2	Average size lower by 10%	3,074.7	(341.6)	(10.0%)
3	Higher number of expected claimants by 10%	3,714.0	297.6	8.7%
4	Lower number of expected claimants by 10%	3,119.3	(297.6)	(8.7%)

Incapacity Scenarios

19.2.13 The main drivers for the incapacity liability are continuance rates and average size assumptions. We have provided sensitivity tests and scenarios to illustrate the impact on the liability should these drivers be different to what was assumed. We have also included results should the conversion rate from IL differ to what was adopted. Table 19.5 below shows the resulting liability impact.

Table 19.5: Incapacity liability scenario and sensitivity test results

Scenario	Description	Incapacity Liability ($'m)	Change in Liability ($m)	% Change
Base		12,768.6		
1	Average size is 10% higher	14,045.4	1,276.9	10.0%
2	Average size is 10% lower	11,491.7	(1,276.9)	(10.0%)
3	Continuance rates are based on more recent experience (2022 and 2023 data)	11,460.3	(1,308.3)	(10.2%)
4	Continuance rates are higher than expected (10 per cent decrease to exits)	13,694.7	926.1	7.3%
5	Conversion from IL is higher - DRCA: 10% conversion in 2024, decreasing to 6% by 2033 - MRCA: 17% conversion in 2024 and 2025, 20% thereafter	13,969.7	1,201.1	9.4%
6	Conversion from IL is lower - DRCA: 5% conversion in 2024, 6% in 2025, 8% in 2026, decreasing to 5% by 2033 - MRCA: 14% conversion in 2024 and 2025, 16% thereafter	12,072.0	(696.6)	(5.5%)

MRCA Medical Scenarios

19.2.14 Table 19.6 below contains the results for the sensitivity analysis on the MRCA medical liability. This includes sensitivity tests on the key assumptions of claimant numbers, utilisation of benefits, and average size of benefits.

Table 19.6: MRCA Medical liability sensitivity analysis

Sensitivity	Description	MRCA Medical Liability ($'m)	Change in Liability ($m)	% Change
Base	-	21,992		
1	Utilisation rates (white card) increase by 10%	22,305	313	1.4%
2	Utilisation rates (white card) decrease by 10%	21,674	(318)	(1.4%)
3	Average size increases by 10%	24,191	2,199	10.0%
4	Average size decreases by 10%	19,792	(2,199)	(10.0%)
5	Claimant projection increases by 10%	22,917	926	4.2%
6	Claimant projection decreases by 10%	20,995	(996)	(4.5%)

19.2.15 One of the key drivers of the increase to the MRCA medical liability at this valuation has been the increase in the projected number of claimants who will eventually obtain a Gold Card. There has been rapid growth in the number of claimants receiving Gold Cards in recent years and there remains great uncertainty around the level to which this will continue going forward. We have included scenarios where the ultimate proportion of Gold Card recipients and higher

or lower than what was adopted. We have also included scenarios around the use of heavier mortality rates and the liability accrual assumption. The results are shown in Table 19.7 below.

Table 19.7: MRCA Medical liability under modelled scenarios

Scenario	Description	MRCA Medical Liability ($m)	Change in Liability ($m)	% Change
Base	-	21,992		
1	All cashflows arising from claimants with at least one injury before the valuation date are fully accrued	28,776	6,785	30.9%
2	Defence Superannuation invalidity mortality	19,381	(2,611)	(11.9%)
3	Ultimate Gold Card proportion lower than adopted - Pre 2012 entry years: 40% - 2012 onwards: 45%	19,880	(2,111)	(9.6%)
4	Ultimate Gold Card proportion lower than adopted - Pre 2012 entry years: 40% - 2012 to 2017 entry years: 45% - 2018 onwards: 50%	21,066	(925)	(4.2%)
5	Ultimate Gold Card Proportion higher than adopted - Pre 2012 entry years: 45% - 2012 to 2017 entry years: 50% - 2018 to 2020 entry years: 55% - 2021 onwards: 60%	23,459	1,467	6.7%
6	Ultimate Gold Card Proportion higher than adopted - Pre 2012 entry years: 45% - 2012 to 2017 entry years: 50% - 2018 to 2020 entry years: 60% - 2021 onwards: 65%	24,643	2,652	12.1%

19.2.16 The estimate of the MRCA medical liability was based on assumptions around how the future cashflows can be attributed to incidents arising before and after the valuation date. If we treated all cashflows arising from those known or assumed to have at least one incident before the valuation date as contributing to the accrued liability as in Scenario 1, the MRCA medical liability would increase by $6.8bn to $28.8bn.

Household Services Scenarios

19.2.17 There has been significant growth in the usage of household benefits under MRCA, particularly since 2019 when benefits were moved to the needs assessment process after IL claims acceptance. We have seen increasing numbers of new claimants, as well as high proportions of claimants continuing usage of benefits over long periods. There remains considerable uncertainty as to whether these trends will continue indefinitely. We have provided results for sensitivity tests on the key assumptions of the modelling in Table 19.8 and scenarios around future utilisation rates and conversion rates from IL in Table 19.9.

Table 19.8: MRCA HSAC liability sensitivity and scenario analysis

Sensitivity	Description	MRCA HSAC Liability ($'m)	Change in Liability ($m)	% Change
Base	-	3,828		
1	Average size is 10% higher	4,210	383	10%
2	Average size is 10% lower	3,445	(383)	(10%)
3	New claimants are 10% higher	4,096	269	7%
4	New claimants are 10% lower	3,566	(262)	(7%)
5	Usage is 10% higher	4,087	259	7%
6	Usage is 10% lower	3,569	(259)	(7%)

Table 19.9: MRCA HSAC liability under modelled scenarios

Scenario	Description	MRCA HSAC Liability ($'m)	Change in Liability ($m)	% Change
Base	-	3,828		
1	Utilisation rate flattens at a higher long term rate of 68%	4,068	241	6%
2	Utilisation rate further reduces to a long term rate of 58%	3,579	(248)	(6%)
3	Defence Superannuation invalidity mortality is used	3,498	(330)	(9%)
4	Conversion rate from initial liability for the next two years (backlog clearance) is lower than expected	3,641	(187)	(5%)
5	Conversion rate from initial liability for the next two years (backlog clearance) is higher than expected	4,017	189	5%
6	Superimposed inflation of 1.3% (5% nominal inflation)	5,193	1,365	36%

20 Compliance with Professional Actuarial Standards

20.1.1 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 2024 for financial statement purposes will be provided to DVA in July of 2024. This report, in conjunction with the financial statements letter provided to DVA in July, has been produced to comply with the requirements of PS302.

20.1.2 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.

20.1.3 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

27 June 2024