KPMG

Scheme Review to 30 June 2025

WorkCover Tasmania

20 November 2025

WorkCover Tasmania Board

WorkSafe Tasmania
30 Gordons Hill Road, Rosny Park
Tasmania, 7018

Cc. Mr Damian Davidson, Ms Alison Allen
WorkSafe Tasmania

20 November 2025

Scheme Review to 30 June 2025

We are pleased to enclose our report in respect of our review of the operation and performance of the Tasmanian workers' compensation scheme for the period to 30 June 2025.

If you have any questions with respect to this report, please feel free to contact us.

Yours sincerely

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Insights

Scheme Sustainability

- Scheme payments have increased by 19.3% in comparison to 2023/24 financial year. This is driven by an increase across all payment types except for legal. Weekly payments increased by 25.1% and lump sum payments by 54.6%. A 25.9% increase to medical payments was observed, which was partially offset by a 21.9% reduction to legal payments due to the re-classification of independent medical reviews from being a legal benefit to being a medical benefit.
- Claims frequency has decreased in the 2024/25 accident year at 0.40 claims per million dollars of wages, which has been maintained as the forecast for the 2025/26 financial year.
- The average claim size for the Scheme is $48,611 for the 2024/25 accident year, which is an increase of 8.0% (in real terms) compared to projections for the 2023/24 accident year. The average claim size for the new accident year is $48,663, which is an increase of 12.7% (in real terms) compared to the average claim size of new accidents from the previous scheme review.
- Growth in the ultimate cost has outpaced growth in the wages. This is reflected in a higher discounted ultimate cost as a percentage of earned wages of 2.02% in the 2024/25 accident year, up from 1.96% for the 2023/24 accident year. For the 2025/26 accident year, this is estimated to be 2.10% of earned wages, an increase of 17.2% higher than the rate at the Previous Scheme Review.
- Experience for mental health-related claims has been a key driver of the emerging trends. The proportion of mental health-related claims has risen to 14.7% of the total reported claims to the Scheme for the 2024/25 accident year.

Licensed Insurers

- Earned wages increased by 1.0% (in real terms) to $15.2 billion in the 2024/25 financial year. The real growth forecast is 1.4% such that the earned wages for 2025/26 is expected to be $15.4 billion.
- Total claim payments have increased by 15.0% which is driven by medical (+29.2%), and weekly payments (+18.0%). However, it should be noted that there was a re-classification of independent medical reviews from being a legal benefit to being a medical benefit due to the introduction of NIDS v8.1.
- Claim frequency has decreased to 0.39 claims per million dollars of wages in 2024/25 from 0.42 in 2023/24.
- The average claim size is $36,300 for the 2024/25 accident year, which is 10.5% higher than the assumption adopted at the Previous Scheme Review.
- The discounted ultimate cost is 1.48% of the earned wages for the 2024/25 accident year, which is 8.8% higher than assumed at the Previous Scheme Review.
- The expected profit margin is 16% for the 2024/25 and 2023/24 financial years due to unfavourable claims experience, which has reduced the expected profit margin from 21% at the Previous Scheme Review.

Self-Insurers

- Earned wages decreased by 5.3% (in real terms) to $569 million in the 2024/25 financial year. The real growth forecast is broadly stable, such that the earned wages for 2025/26 is expected to be $557 million.
- Total claim payments have decreased by 6.1% which is driven by legal payments (-20.8%), and medical (-15.8%).
- Claim frequency has decreased to 0.30 claims per million dollars of wages in 2024/25 from 0.33 in 2023/24.
- The average claim size is $67,615 for the 2024/25 accident year, which is 4.4% higher than the assumption adopted at the Previous Scheme Review.
- The discounted ultimate cost is 2.17% of the earned wages for the 2024/25 accident year, which is remains broadly consistent with the level assumed at the Previous Scheme Review.

Tasmanian State Service

- Earned wages increased by 3.3% (in real terms) to $4.2 billion in the 2024/25 financial year. The real growth forecast is expected to be broadly stable, such that the earned wages for 2025/26 is expected to be $4.1 billion.
- Total claim payments have increased by 28.5% which is driven by lump sum payments (+54.6%), and medical (+25.1%). However, it should be noted that there was a re-classification of independent medical reviews from being a legal benefit to being a medical benefit due to the introduction of NIDS v8.1.
- Claim frequency has slightly increased to 0.45 claims per million dollars of wages in 2024/25 from 0.44 in 2023/24.
- The average claim size is $86,533 for the 2024/25 accident year, which is 11.0% higher than the assumption adopted at the Previous Scheme Review.
- The discounted ultimate cost is 3.99% of the earned wages for the 2024/25 accident year, which is 18.3% higher than assumed at the Previous Scheme Review.
- The mental health-related claims represent 28.7% of all TSS claims reported in 2024/25.

Executive summary

1. Introduction and Background

KPMG has been engaged by the WorkCover Tasmania Board ('Board') to review the operation and performance of the Tasmanian workers' compensation Scheme ('the Scheme') to 30 June 2025. This section summarises the key findings.

The following work has been performed under our contract with WorkCover Tasmania, dated 8 November 2024.

Unless otherwise stated, all amounts are quoted in 30 June 2025 ('Jun-25') values throughout this report. Additionally, the payment figures are typically shown on a financial year basis, and payments in any financial year may relate to a number of accident years.

2. Features of Scheme Experience

The key features of experience emerging over the past year for licensed insurers, self-insurers and the Tasmanian State Service ("TSS") are discussed below.

Covered Wages

Wages covered by the Scheme increased by 1.3% (in real terms), from $19.7 billion in 2023/24 to $19.9 billion in 2024/25.

- Licensed insurers wages increased by 1.0%;
- Self-insurer wages decreased by 5.3%; and
- TSS wages increased by 3.3%.

Earned wages are projected to increase by 3.9% (in real terms) to $20.7 billion in 2025/26.

Claim Numbers and Frequency

The experience by accident year is discussed below:

- The ultimate number of claims for the 2024/25 accident year is projected to be 8,035.
  - This is 2.6% lower than the projected ultimate number of claims for the 2023/24 accident year. For licensed insurers and self-insurers, there is a projected reduction of 4.6% and 11.9% respectively. For TSS there is a projected increase of 5.7% which is partly driven by unfavourable experience observed in reported claim volumes over the year.
  - The projected ultimate for 2024/25 implies a claim frequency of 0.40 claims per $1 million dollars of wages, and this is in line with the 2023/24 accident year.
- Our projection of the ultimate number of claims for the 2025/26 accident year is 8,321.
  - This is 3.6% higher than the projected ultimate number of claims for 2024/25, and is in line with projected growth in earned wages.
  - The projected ultimate for 2025/26 implies a claim frequency of 0.40 claims per million dollars of wages, which is in line with the 2024/25 accident year.

The experience by report year is discussed below:

- 8,085 claims were reported to the Scheme in 2024/25, which is 2.1% lower than 2023/24.
- 8,300 claims have been projected to be reported to the Scheme in 2025/26, which is 2.7% higher than 2024/25.

Claim Payments and Average Claim Size

In comparison to the 2023/24 financial year, Scheme payments increased by 19.3% (in real terms) from $317.8 million to $379.2 million, primarily driven by increases in lump sum payments (+$26.1 million) and weekly payments (+$23.2 million) across most insurer sectors. At the current review, $361.9 million of Scheme payments are projected for the 2025/26 payment year.

The average claim size for the overall Scheme is projected to be $48,611 for the 2024/25 accident year, which is an 8.0% increase (in real terms) compared to the projection for the 2023/24 accident year. The projected average claim

size for the 2025/26 accident year is selected to be $48,663 (in real terms), which is a 12.7% increase (in real terms) compared to selection for the new accident year made at the Previous Scheme Review (i.e., 2024/25 accident year).

Licensed insurer claims tend to cost less than self-insurers and TSS claims, with average claims size assumptions for new accidents being $36,256, $67,618 and $86,533 for licensed insurers, self-insurers and TSS respectively. There have been notable increases in the average claim size for new accidents across the industry, increasing by 8.2%, 3.0% and 3.5% respectively for licensed insurers, self-insurers and TSS respectively. The increases result from increased assumptions for all payment types, in particular from the weekly, medical and lump sum payment types.

Weekly Benefits

The claims experience of weekly benefits is discussed below:

- 74.6% of all claims for the 2024/25 accident year are projected to be lost time claims, which is an increase compared to the experience for 2023/24 (69.5%). For the 2025/26 accident year, 73.7% of all claims are projected to be lost time claims.
- $149.4 million of weekly payments were made in the 2024/25 financial year, which is an 18.4% increase (in real terms) compared to 2023/24. The higher payments are driven by a higher number of claims receiving weekly benefits (referred to as 'weekly actives'). Weekly payments for 2025/26 are projected to be $146.6 million.
- The volume of weekly actives[1] increased by 8.3% to 14,311 claims in the 2024/25 financial year, with higher numbers observed across licensed insurers, self-insurers and TSS. This increase is driven by higher lost time claim reports over the year and claimants remaining on benefit for longer. For 2025/26, the volume of weekly actives are projected to increase by 4.0% to 14,878 underpinned by growth projected in all three sectors (10.9% for self-insurers, 4.8% for licensed insurers and 1.9% for the TSS).
- The weekly Payment per Active Claim ('PPAC')[2] for 2024/25 was $10,441, which is 9.4% higher (in real terms) than 2023/24. TSS continues to have the highest weekly PPAC of the three sectors given longer claim durations and a higher mix of mental health claims which typically take longer to settle (resulting in higher costs). Meanwhile, licensed insurers have the lowest PPAC. The weekly PPAC projected for 2025/26 is $9,854, which is 5.6% lower (in real terms) than 2024/25.

Lump Sums

The claims experience relating to lump sum benefits is discussed below:

- 599 claims received a lump sum for the first time in 2024/25. This is a 11% increase on first-time lump sum claims in 2023/24. 577 claims are projected to receive their first lump sum in the 2025/26 financial year. This is a 3.7% reduction compared to the claims projected for 2024/25. The projections reflect the underlying trend in mental health-related claims with an increasing prevalence mental health-related claims and their higher likelihood to claim a lump sum. On this basis, we estimate an ultimate number of 619 lump sum claims for the 2024/25 accident year and project an ultimate number of 631 lump sum claims for the 2025/26 accident year.

- The redemption utilisation for lump sum benefits has increased to 77% in the 2024/25 financial year compared to 76% in 2023/24. Most of the remaining utilisation is in relation to permanent impairment payments.

- There was a large uplift in lump sum payments to $123.9 million in the 2024/25 financial year (26.7% higher than 2023/24), which is driven by surges in the lump sum claim payments from TSS (+54.4%). An increase in the number of lump sum payments has primarily driven this increase, with the average claim size per claim contributing to a lesser extent (see below). Lump sum payments are projected to be $110.9 million for the 2025/26 accident year, which is 10.5% lower than 2024/25 (in real terms). The surge in lump sum utilisation over the year can be attributed strongly to the 2022 accident year, and there are signs that this may be due to a potential claims clean-up to clear processing volumes.

- The average claim size per lump sum claim[3], on a payment year basis, for the overall Scheme has increased by 14% (in real terms) from $180,450 in 2023/24 to $206,225 in 2024/25. The average lump sum claim size on an accident year basis is projected to be $194,000 for the 2024/25 accident year, which is 5.8% higher (in real terms)

[1] The number of weekly actives in a year is the sum of the quarterly weekly actives. Hence, a claim is counted four times if they were active in all four quarters of the year.

[2] The PPAC method refers to the average payment per quarter per active claim.

[3] Average claim size per lump sum claim on a payment year basis is calculated by dividing total lump sum payments paid in the year by the number of claims that have received a lump sum payment for the first time in the year

compared to 2023/24. The selected lump sum average claim size for new accidents is $190,248, which is 3.8% higher (in real terms) than the selection made at the Previous Scheme Review.

Medical and Related Payments

The claims experience relating to medical and related payments is discussed below:

- $86.6 million of medical payments were made in the 2024/25 financial year, which was a 26.0% increase compared to 2023/24 (in real terms). This is also driven by the re-classification of independent medical review payments from the legal benefit type to the medical benefit type at the current review. $88.4 million of medical payments are projected in 2025/26, which is a 2.2% increase compared to 2024/25.

- The average claim size of the medical payments is projected to be $11,445 for the 2024/25 accident year, which is an 13.4% increase (in real terms) compared to 2023/24. The selected average claim size for the medical component related to new accidents is $11,836, which is a 34.5% increase (in real terms) compared to the selection made at the Previous Scheme Review.

Legal and Investigation Payments

The claims experience relating to legal and investigation payments is discussed below:

- $20.1 million of payments for legal and investigation costs in the 2024/25 financial year, which was a 21.8% reduction compared to 2022/23 (in real terms). As discussed above, this is driven by the re-classification of independent medical review payments at the current review. $15.9 million of payments for legal and investigation costs are projected in 2025/26, which is a 21.0% decrease compared to 2024/25.

- The average claim size for legal and investigation costs is projected to be $2,007 for the 2024/25 accident year, which is a 21.7% decrease (in real terms) compared to 2023/24. The selected average claim size related to new accidents is $1,808, which is a 46.1% reduction (in real terms) compared to the selection made at the Previous Scheme Review. The significant reduction in the average claim size selection is driven by the re-classification of legal payments to medical at the current review.

Ultimate Cost by Accident Year

The inflated and undiscounted ultimate cost of the 2024/25 accident year is projected to be $423.8 million which is an increase of $38.4 million (+10.0%) relative to our projection for 2023/24. This is driven by a 14.2% increase for the TSS, and a 7.8% increase for licensed insurers. The inflated and undiscounted ultimate cost for the new 2025/26 accident year is projected to be $457.6 million, which is 15.1% higher (in real terms) than the projection for the new accident year at the Previous Scheme Review. The increased projections for all insurer sectors reflects the greater proportion of claims either accessing lump sums or remaining on benefits for longer.

The inflated and discounted ultimate cost of the 2024/25 accident year is projected to be 1.96% of earned wages, which is higher than the 1.94% projected for 2023/24. The discounted ultimate cost for the new 2025/26 accident year is projected to be 2.02% of earned wages, which is higher than the 1.79% projected for the new accident year at the Previous Scheme Review.

Mental Health Claims

The proportion of reported claims that are mental health-related have increased for licenses insurers and TSS, but have decreased for self-insurers. Mental health-related claims represent 14.7% of claims reported to date for accident year 2024/25, compared to 13.1% in the 2023/24 accident year. Most insurer sectors have seen increases in mental health claims as a proportion of total claims in the 2024/25 accident year. Mental health-related claimants have grown such that their share of Scheme claim numbers has increased from an average of 10.9% of claims reported for the 2019/20 to 2023/24 accident years to 14.7% for 2024/25.

The proportion of claims that are mental health-related continues to be the highest for the TSS (28.7% for 2024/25), with increases continuing to be driven by the education sector and emergency service workers. This represents an increase of 11.9% in the number of reported mental health-related claims from 2023/24. In particular, 15.7% of the mental health claims reported are post-traumatic stress disorder (PTSD) claims. TSS payments for mental health-related claims have increased close to three-fold since 2019/20, which has increased these claims' share of TSS payments to 69.9% in 2024/25.

There are opportunities to develop and apply interventions that may effectively manage the incidence and cost of mental health-related claims.

Silicosis Claims

In recent years, there has been increased awareness across the country in terms of increasing exposures of workers to silica dust, particularly through the manufacturing and use of engineered stone. At the current review, claims that have arisen from silicosis exposure are included in the analysis and would only impact the suggested premium rates as far as the historical experience suggests that it is warranted. A ban on the manufacturing and installing of engineered stone came into effect on 1 July 2024 and it is expected that the ban should greatly minimise the impacts of engineered stone silicosis in future years.

There have been 23 silicosis claims reported to date (compared to 19 reported at the Previous Scheme Review) with respect to 21 distinct claimants. These claimants have an average age at injury of 41 years old. There are 17 accepted claims, of which 12 claims pertain to the 2019-2025 accident years. Payments to date for the accepted claims are $3.63 million with the corresponding outstanding case estimates being $1.00 million. ANZSIC06 division C (Manufacturing) represents 16 of the 23 reported claims, as well as around 79% of payments to date.

Licensed Insurer Experience

The experience relating to licensed insurers is discussed below:

- The estimated total number of policies written in 2024/25 is 20,450, which is 3.7% higher than 2023/24. We have projected a further 2.3% increase to 20,924 for 2025/26.
- Earned premiums are estimated to be $333.6 million for the 2024/25 accident year, which is 9.9% higher than 2023/24. The earned premiums are projected to increase by 5.4% to $351.6 million for 2025/26, with the increase being driven by the expected growth in earned wages.
- The achieved premium rate for 2024/25 is projected to be 2.30%, as compared to 2.21% for 2023/24. Should insurers continue to charge written premiums at a similar rate as in 2024/25, we project an achieved earned premium rate of 2.28% for 2025/26.
- The projected profit margin remains strong at 16% for 2024/25 and 2023/24.
- The sum of licensed insurer case estimates and IBN(E)R reserves is 4% higher than our central estimate of the outstanding claims liability. Therefore, as a whole, licensed insurers appear to be adequately reserved.

Self-Insurer Information

The central estimate of the outstanding claims liability determined by self-insurers is $21.3 million, $8.2 million lower than the calculated central estimate of $29.5 million. In addition, we note that self-insurers may hold risk margins in addition to the central estimate.

Overall, self-insurer bank guarantees are slightly higher than the calculated actuarial central estimate (with the latter including an illustrative 10% allowance for claims handling expenses).

Nominal Insurer Experience

The experience relating to the Nominal Insurer is discussed below:

- 62 claims were reported to the Nominal Insurer between 2002/03 and 2024/25. An average of 4.7 claims p.a. were reported between 2002/03 and 2013/14, but this has fallen to an average of 0.8 claims p.a. since 2014/15.
- An average of $472,368 of Nominal Insurer claim payments were made in each financial year, noting that there is volatility in year-to-year payments experience. The average quantum of payments made for Nominal Insurer claims is $101,220. The Nominal Insurer has, on average, incurred $76,806 of administration expenses p.a. This is equivalent to an average of $33,394 of administration expenses per claim reported, and representing a ratio of 17% of claim payments.

Tribunal Matters

The experience relating to matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal (“Tribunal”) is discussed below:

- 1,115 claims had their first matter referred to the Tribunal in 2024/25, which is 3% lower than the 1,145 claims in 2023/24. The proportion of claims (with at least one dispute) that relate to the TSS has decreased from 28% in 2023/24 to 26% in 2024/25. The majority of claims referred continue to lodge only one matter (83%).

- Dispute of liability under Section 81A continues to be the most common dispute type. Disputes for weekly benefits and Section 71 (permanent impairment) are the next most common dispute types.

- The overall disputation rate of 13.5% in 2024/25 has fallen from its highest rate of 14.5% in 2023/24. Disputation rates for 2024/25 were 12.2% for licensed insurers, 24.5% for self-insurers, and 17.0% for the TSS.

- There have been 1,501 dispute finalisations in 2024/25, which is a 4.0% reduction on the matters finalised in 2023/24. The average delay between referral and finalisation of 120 days, which has increased from the longer-term averages of 103 days since 2014/15.

- Since 2018/19, only 17 matters have been adjourned; with no matters adjourned since 2022/23.

3. Reliance and Limitations

The report should be read in its entirety. Individual section of the report, including the Executive Summary, could be misleading if considered in isolation. In particular, the opinions expressed in the report are based on a number of assumptions and qualifications which are set out in more detail in the report.

Scheme Report Card

	2023/24 Actual (A)	2024/25 Expected (E)	2024/25 Actual (A)	2024/25 A – E	2025/26 Projected
Earned Wages[1] ($m)					
Licensed Insurers	13,766.8	14,794.0	14,511.3	-282.7	15,829.9
Self-Insurers	548.0	551.3	542.4	-8.9	578.3
Tasmanian State Service	3,691.2	3,912.8	3,982.6	69.8	4,298.9
Scheme	18,006.0	19,258.1	19,036.3	-221.8	20,707.0
Number of Claims Reported					
All Claims					
Licensed Insurers	6,335	6,375	6,031	-344	6,239
Self-Insurers	200	190	177	-13	173
Tasmanian State Service	1,720	1,778	1,877	99	1,887
Scheme	8,255	8,343	8,085	-258	8,300
Total Claim Payments ($m)					
Licensed Insurers	173.2	186.9	209.1	22.2	218.6
Self-Insurers	11.2	11.2	11.0	-0.2	10.8
Tasmanian State Service	113.6	114.5	153.2	38.7	138.9
Scheme	298.0	312.6	373.3	60.7	368.3
Weekly Benefits					
Lost Time Claims Reported					
Licensed Insurers	4,446	4,518	4,351	-167	4,625.1
Self-Insurers	147	138	138	0	131.2
Tasmanian State Service	1,145	1,176	1,407	231	1,404.0
Scheme	5,738	5,832	5,896	64	6,160.3
Weekly Benefit Payments ($m)					
Licensed Insurers	58.0	64.5	71.8	7.3	75.5
Self-Insurers	3.5	3.8	3.6	-0.2	4.0
Tasmanian State Service	56.9	59.0	71.6	12.6	69.7
Scheme	118.4	127.2	147.0	19.8	149.2

Lump Sum Benefits					
Lump Sum Claims					
Licensed Insurers	403	444	439	-5	431
Self-Insurers	25	19	21	2	22
Tasmanian State Service	112	106	139	33	124
Scheme	540	570	599	29	577
Lump Sum Benefit Payments ($m)					
Licensed Insurers	54.6	57.3	63.7	6.4	67.4
Self-Insurers	3.2	3.3	3.6	0.3	3.2
Tasmanian State Service	33.5	31.0	54.4	23.4	42.2
Scheme	91.3	91.6	121.7	30.1	112.9
Medical & Related Payments ($m)					
Licensed Insurers[2]	43.5	52.2	59.0	6.8	63.0
Self-Insurers[2]	3.0	3.2	2.7	-0.5	2.5
Tasmanian State Service[3]	17.7	18.6	20.9	2.3	24.6
Scheme	64.2	73.9	82.6	8.6	90.0
Legal & Investigation Payments ($m)					
Licensed Insurers[2]	17.1	13.0	14.6	1.5	12.7
Self-Insurers[2]	1.4	0.9	1.1	0.2	1.1
Tasmanian State Service[3]	5.5	5.9	6.3	0.4	2.4
Scheme	24.1	19.9	22.0	2.2	16.2
Insurer Earned Premium Rate[1]	2.21%		2.30%		

Note: all payments are shown in nominal values in the Scheme Report Card above. However, payments are typically quoted in current (30 June 2025) values in the remainder of this report unless otherwise stated.

[1] Adjusted for the movement from estimated initial to ultimate final.

[2] 2024/25 Expected payments have been adjusted from the Scyne 30 June 2024 Scheme Review to allow for the implementation NIDS v8.1 in January 2025, whereby independent medical reviews have been re-categorised from the medical benefit type to the legal & investigations benefit type. The adjustment has only been performed for the Licensed and Self-insurers and allows for comparison of Actual and Expected payment on a consistent basis.

[3] The implementation of NIDS v8.1 was delayed past 30 June 2025. No adjustments for independent medical reviews have occurred. Therefore, the basis of TSS' Actual and Expected payments comparison is different to the Licensed and Self-insurers Actual and Expected payments comparison.

Contents

KPMG

Part I: Scheme Review

1. Introduction and Background

1.1. Purpose

KPMG has been engaged by the WorkCover Tasmania Board ('Board') to review the operation and performance of the Tasmanian workers' compensation Scheme ('the Scheme') to 30 June 2025.

This work has been performed under our contract with WorkCover Tasmania, dated 8 November 2024.

WorkSafe Tasmania ('WorkSafe') is the organisation that administers workers' compensation and work health and safety in Tasmania and helps the Board fulfil its statutory functions.

The previous report ("Previous Scheme Review") relates to the Scheme review to 30 June 2024, dated October 2024, and which was prepared by Scyne Advisory. This is the first time KPMG has undertaken this review.

Our most recent review of suggested industry premium rates ("Previous Pricing Review") was in respect of the 2025/26 year and was based on data to 31 December 2024. Our findings are documented in the report "Suggested Industry Premium Rates for 2025/26", dated 6 May 2025.

1.2. Scope of the Investigation

Our Scheme review includes analysis of key aspects of Scheme performance for licensed insurers, self-insurers and the Tasmanian State Service ("TSS"), with consideration being given to:

- Wages covered;
- Trends in claims numbers (in total and for weekly active claims, lost time and lump sum claims);
- Claim payments by type of payment, which has been grouped as follows:
  - Weekly benefits (including dependant benefits);
  - Medical and related payments (including rehabilitation);
  - Legal and investigation payments; and
  - Lump sum benefits (including common law, settlements, redemptions, impairment lump sums and death benefits);
- Estimated levels of insurer profitability (including assessment of the adequacy of case estimates);
- Estimated levels of adequacy of self-insurer bank guarantees;
- Analysis of Nominal Insurer experience; and
- Analysis of disputation levels, based on matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal (formerly known as the Workers Rehabilitation and Compensation Tribunal).

Unless otherwise stated, all amounts are quoted in 30 June 2025 ('Jun-25') values throughout this report. Conversely, as noted in the report card, wages and payments figures in the report card are shown in original values.

Appendix C sets out a summary of the coverage provided by the Tasmanian workers' compensation scheme and the available benefits.

Appendix D sets out the various legislative changes that have impacted the Scheme. Appendix D also includes commentary on a number of non-legislative changes that have impacted Scheme experience.

1.3. Data Used

We have prepared this report using claim and policy data to 30 June 2025, extracted from the WorkSafe Information Management System (WIMS) during the month of August 2025. We have also used claims with disputes data and Nominal Insurer data, both extracted as at 8 August 2025. WIMS has been operational since 1 July 2012 and replaced WorkSafe's previous data management system.

We have identified licensed insurer claims with large outstanding case estimates (greater than $2 million) and used the case estimates from these claims to model a separate allowance of large lump sum claims.

Where case estimate amounts are quoted in this report in aggregated at a sector level or in total, we have generally taken these amounts from the End of Financial Year Reconciliations. Case estimates at a single point of time, as summarised by insurers in the Reconciliations, are considered more reliable overall. As mentioned above, there have been limited instances where we have used case estimates for individual claims.

We have taken earned premium data from the WIMS extracts, as the figures in the End of Financial Year Reconciliations are not of a sufficient level of granularity.

Details of the data supplied by WorkSafe and the reconciliations we have performed are included in Appendix A.

1.4. Approach

We receive claim number, claim payment, premium and wages data from WorkSafe. Our approach to analysing Scheme experience is as follows:

- We sub-divide the data into accident periods and development periods, and calculate historical claim frequencies (in the case of claim numbers) and average claim sizes (in the case of claim payments). Analysis has been performed using a quarterly level of granularity and grouped into financial years ending 30 June, unless otherwise stated.
- We form estimates of future costs for past accident years and for the cost of the upcoming 2025/26 accident year. These estimates are referred to throughout this report as “projections”. These costs rely on a number of actuarial assumptions for claim frequency and average claim size. Such assumptions are referred to in this report as our ‘adopted’ or ‘selected’ assumptions. We also compare our adopted assumptions to those adopted at the previous Scheme review (as documented in the Previous Scheme Review report).

Further detail regarding our approach can be found in Section 14.3.

1.5. Structure of the Report

Our review is outlined in the following report sections:

- Section 2 – examines the wages covered by the Scheme;
- Section 3 – summarises claim number and claim frequency experience;
- Section 4 – describes our findings with respect to trends in claim payments and average claim costs in the Scheme;
- Section 5 – provides further detail in relation to weekly benefits;
- Section 6 – provides further detail in relation to lump sum benefits;
- Section 7 – provides further detail in relation to medical and related payments;
- Section 8 – provides further detail in relation to legal and investigation payments;
- Section 9 – summarises the projected ultimate claims cost for each accident year;
- Section 10 – presents information in respect of licensed insurers, including number of policies written, earned premiums, premium rates, assessment of past levels of profitability, and a comparison of our estimates to licensed insurer case estimates and IBN(E)R reserves;
- Section 11 – presents information in respect of self-insurers, including comparisons of our estimates to self-insurer case estimates and IBN(E)R reserves, as well as bank guarantees;
- Section 12 – presents information in respect of the Nominal Insurer, including the number of claims reported, claims costs, and administrative expenses;
- Section 13 – examines matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal; and
- Section 14 – includes a statement of our compliance with relevant actuarial standards and describes the approach and economic assumptions used for this review. This section also includes the reliance and limitations to which this report is subject.

The Appendices provides information in relation to data (Appendix A), valuation methodology (Appendix B), and Scheme background (Appendix C). They also provide further details in relation to our analysis of Scheme experience (Appendices D to L).

2. Covered Wages

This section presents the wages covered by the Scheme. Throughout this report, references to covered wages relates to earned wages unless specified otherwise.

Key Points

Earned wages covered by the Scheme increased by 1.3% (in real terms), from $19.7 billion in 2023/24 to $19.9 billion in 2024/25. The growth was driven by increases to the earned wages of licensed insurers and TSS.

Earned wages are projected to increase by 0.9% (in real terms) to $20.1 billion in 2025/26.

Earned wages is used as a measure of 'exposure' in our analysis and hence, is used to 'normalise' claim numbers such that claim frequencies can be compared on a like-for-like basis from year to year.

Figure 2.1 shows earned wages by accident year for the Scheme overall, as well as for licensed insurers, self-insurers, and the TSS individually. All figures are shown in 30 June 2025 dollar values so that real growth in earned wages can be assessed. The wages shown for accident years 2023/24 to 2025/26 include an allowance for expected development, as wages are often revised from initial estimates to actual figures once finalised. We note there is considerable uncertainty in projecting results for the incomplete 2025/26 year. Further details regarding our analysis and projection of wages can be found in Appendix L.

Figure 2.1: Earned Wages, by Accident Year ($b, Jun-25 values)

Earned wages grew by 1.3% in real terms (over and above inflation) from $19.7 billion in the 2023/24 accident year to $19.9 billion in the 2024/25 accident year. The earned wages growth observed in the licensed insurer category was 1.0% and TSS was 3.3%. For self-insurers, earned wages experienced a reduction of 5.3% (with earned wages remaining at $0.6 billion) due to the withdrawal of a self-insurer in the previous year.

Real earned wage growth is expected to be 0.9% over 2025/26, increasing from $19.9 billion to $20.1 billion. Growth from licensed insurers is expected to be 1.4%, meanwhile TSS and self-insurer earned wage growth is expected to remain broadly stable.

3. Claims Numbers and Frequency

This section presents a summary of the claim number and claim frequency experience for the Scheme.

Key Points

For the 2024/25 accident year, the ultimate number of claims is estimated to be 8,035. This is an implied claim frequency of 0.40 claims per million dollars of wages for 2024/25 and lower than the assumption adopted in the 2023/24 accident year.

For the 2025/26 accident year, the ultimate number of claims is projected to be 8,321. This is an implied claim frequency of 0.40 claims per million dollars of wages for 2025/26 and is in line with the assumption adopted in the 2024/25 accident year.

8,085 claims were reported to the Scheme in 2024/25, which is 2.1% lower than 2023/24. 8,300 claims are projected to be reported to the Scheme in 2025/26, which is 2.7% higher than the 2024/25 year.

3.1. Estimated Ultimate Claim Numbers – All Claims

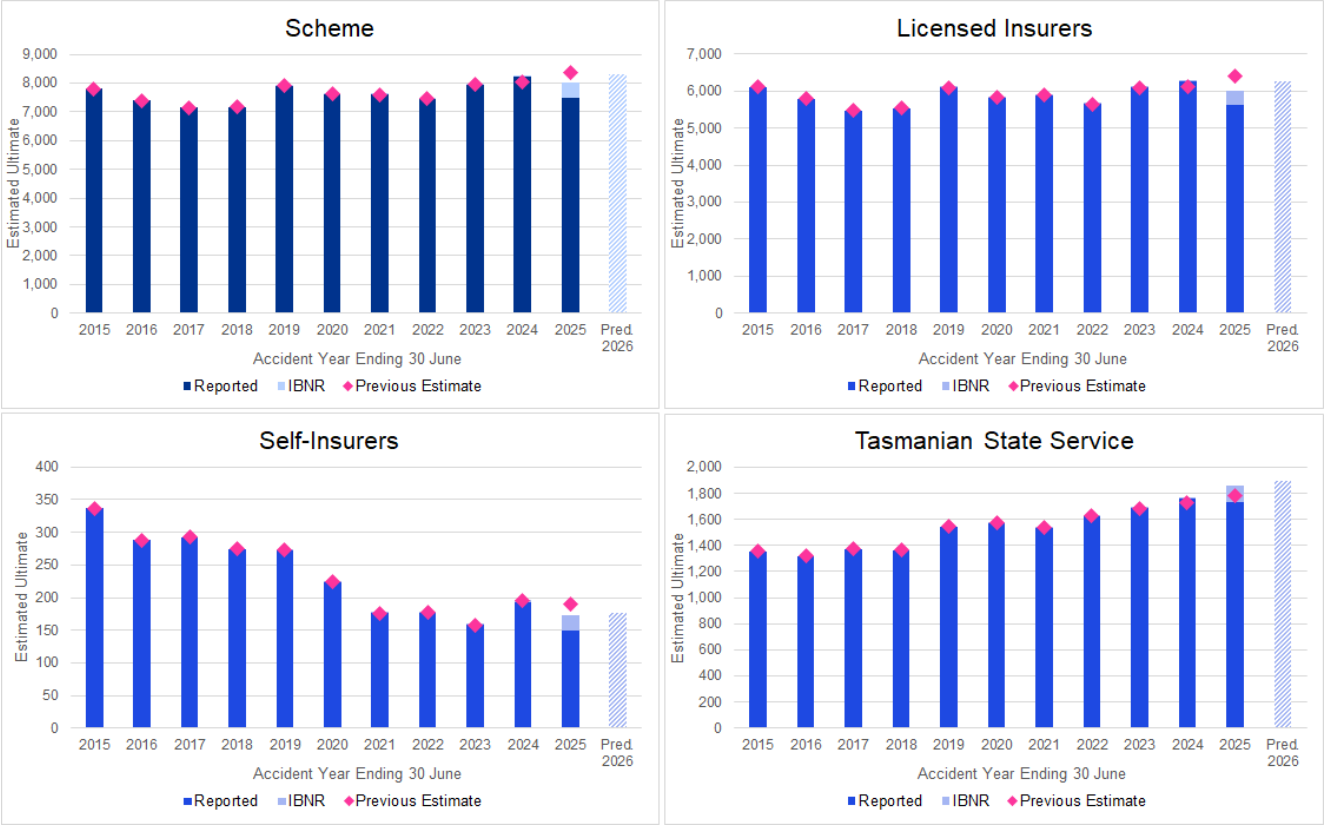
Key Points

For the 2024/25 accident year, the ultimate number of claims is estimated to be 8,035.

For the 2025/26 accident year, the ultimate number of claims is projected to be 8,321.

The estimates of the ultimate number of claims by accident year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 3.1. A projection of the number of claims expected to emerge in the 2025/26 accident year is also included. The estimates of the ultimate number of claims at the Previous Scheme Review are also shown.

Figure 3.1: Ultimate Claim Numbers, by Accident Year (All Claims)



Source data can be found in Appendix E.

The ultimate number of claims for the overall Scheme in the 2024/25 accident year is projected to be 8,035. This is 2.6% lower than the ultimate projected for the 2023/24 accident year. The experience by sector is discussed below:

- **Licensed insurers**: the ultimate number of claims for 2024/25 is projected to be 6,000, which is 4.6% lower than the projected ultimate for 2023/24. This is lower than the projection of 6,401 claims at the Previous Scheme Review, for the 2024/25 year (i.e. a reduction of 6.3%);
- **Self-insurers**: the ultimate number of claims for 2024/25 is projected to be 173, which is 11.9% lower than the projected ultimate for 2023/24, which is driven by a particular self-insurer opting to obtain insurance from a licensed insurer from May 2024. This is lower than the projection of 190 claims at the Previous Scheme Review for the 2024/25 year (i.e. a reduction of 9.0%). This was similarly driven by favourable development emerging from the reduction in self-insurer pool size in the preceding year; and
- **TSS**: the ultimate number of claims for 2024/25 is projected to be 1,861, which is 5.7% higher than the projected ultimate for 2023/24. This is higher than the projection of 1,783 claims at the Previous Scheme Review for the 2024/25 year (i.e. an increase of 4.4%). These estimates have increased following unfavourable experience observed in reported claim volumes over the year.

Projection for the 2025/26 accident year

The projection of the ultimate number of claims for the 2025/26 accident year is 8,321 claims, which is 3.6% higher than the projected ultimate for 2024/25. The growth is driven by growth in earned wages. Claim frequency per million dollars of wages (as discussed in Section 3.2) is projected to remain at levels consistent with recent accident years.

3.2. Claim Frequency – All Claims

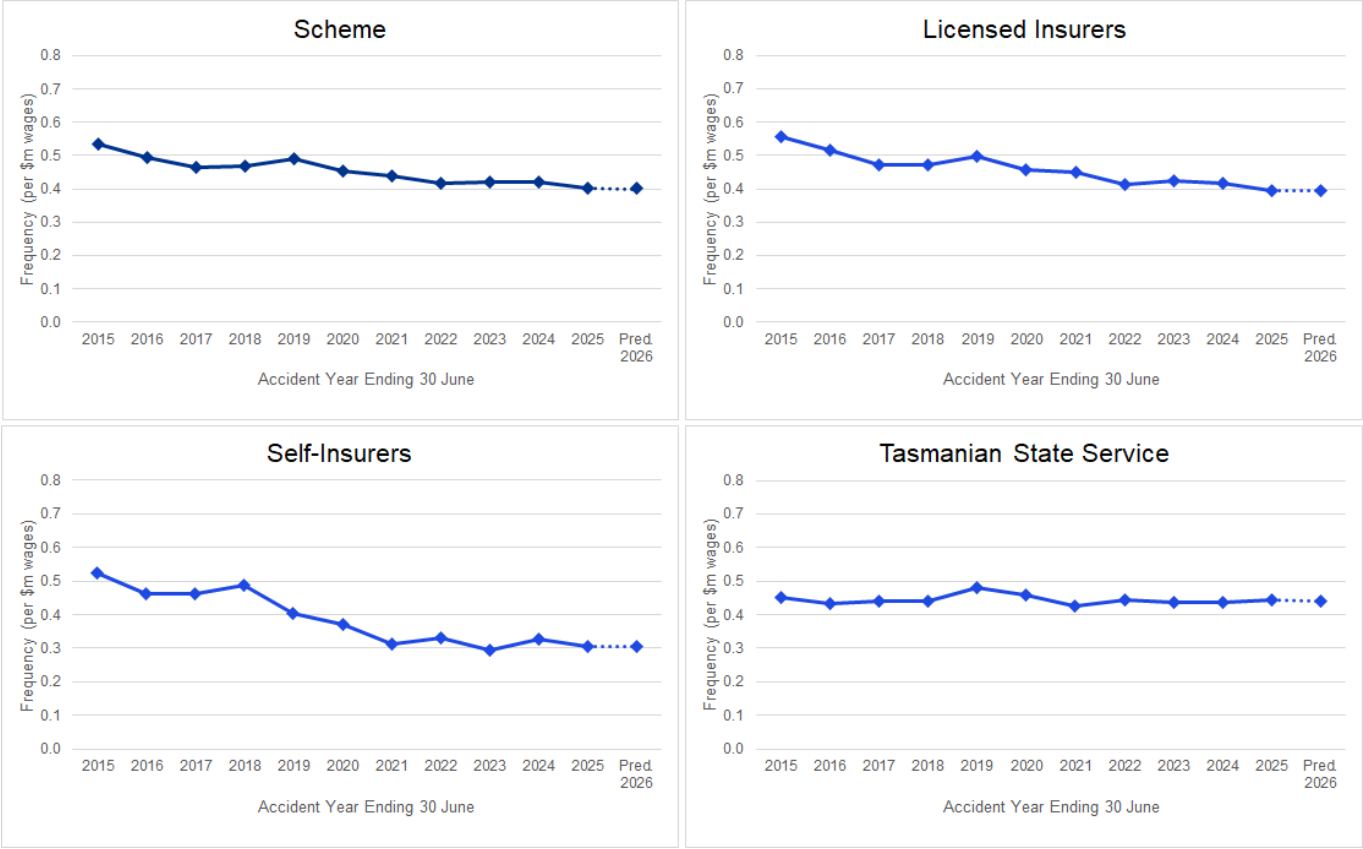
Key Points

For the 2024/25 accident year, the ultimate claim frequency is estimated to be 0.40 claims per million dollars of wages, which is lower than the assumption of 0.42 claims adopted in the 2023/24 accident year.

For the 2025/26 accident year, the ultimate claim frequency is projected to be 0.40 claims per million dollars of wages, which is in line with the assumption for the 2024/25 accident year.

The ultimate claim frequency by accident year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 3.2. A projection of the claim frequency for the 2024/25 accident year is also included. The ultimate claim frequency is calculated by dividing the projected ultimate number claims by the earned wages (in 30 June 2025 dollar values).

Figure 3.2: Ultimate Claim Frequency, by Accident Year (All Claims)



Source data can be found in Appendix E.

The ultimate claim frequency for the overall Scheme in the 2024/25 accident year is projected to be 0.40 claims per million dollars of wages. This is 3.8% lower than the claim frequency projected for the 2023/24 accident year. The experience by sector is discussed below:

- **Licensed insurers**: the claim frequency for 2024/25 is 0.39 claims per million dollars of wages, which is lower than the claim frequency of 0.42 for 2023/24. This is lower than the claim frequencies observed in recent years due to favourable experience observed in claims reported over the year;
- **Self-insurers**: the claim frequency for 2024/25 is 0.30 claims per million dollars of wages, which is lower than the claim frequency of 0.33 for 2023/24. This is broadly aligned to the claim frequencies observed in the last four years; and
- **TSS**: the claim frequency for 2024/25 is 0.45 per million of dollar wages, which is broadly in line with the claim frequency for 2023/24 and historical claim frequency experience.

Projection for the 2025/26 accident year

The claim frequencies have been relatively stable year-on-year. The projection of the claim frequency of the overall Scheme for the 2025/26 accident year is 0.40 claims per million dollars of wages. This is broadly in line with the ultimate claim frequency for the 2024/25 accident year.

3.3. Implications for Reported Claim Numbers

Key Points

8,085 claims were reported to the Scheme in 2024/25, which is 2.1% lower than 2023/24.

8,300 claims have been projected to be reported to the Scheme in 2025/26, which is 2.7% higher than 2024/25.

The historical number of claims reported by accident year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 3.3. A projection of the number of claims to be reported in the 2025/26 accident year is also included. The figure below has been presented on a report year basis, as opposed to the accident year basis used for Figure 3.1 and Figure 3.2.

Figure 3.3: Claim Numbers, by Report Year (All Claims)

Source data can be found in Appendix E.

The number of claims reported to the overall Scheme in 2024/25 was 8,085. This is 2.1% lower than the number of claims reported to the Scheme in 2023/24. The experience by sector is discussed below:

- **Licensed insurers**: 6,031 claims were reported in 2024/25, which is 4.8% lower than 2023/24;
- **Self-insurers**: 177 claims were reported in 2024/25, which is 11.5% lower than 2023/24. This is driven by a lower number of self-insurers reporting claims in the most recent accident year; and
- **TSS**: 1,877 claims were reported in 2024/25, which is 9.1% higher than 2023/24.

Projection for the 2025/26 accident year

The number of claims to be reported to the overall Scheme in 2025/26 is projected to be 8,300 claims. This is 2.7% higher than the number of claims reported in 2024/25. The expected increase is driven primarily by the projected growth in exposure from licensed insurers.

4. Claim Payments and Other Items of Note

This section presents the findings with respect to the trends in the claim payments and the average claim costs in the Scheme. The assumptions related to the average claim size and payment patterns are documented in this section. This section relies on the analysis and assumptions for each payment type, as detailed in Section 5 to Section 8.

Recent items of note, including the impact of the silicosis claims and the Scheme experience for mental health-related claims, are documented in this section.

Key Points

$379.2 million in Scheme payments were made in the 2024/25 payment year, which are 19.3% higher (in real terms) compared to 2023/24. The increase is driven by medical and lump sum payments to the TSS as well as medical and weekly payments to licensed insurers. $361.9 million of Scheme payments are projected for the 2025/26 financial year.

The average claim size for new accidents in the 2025/26 accident year is selected to be $48,663 (in 30 June 2025 dollar values) which is broadly in line (0.1% higher) with the average claim size of $48,610 projected for the 2024/25 accident year. Compared to the Previous Scheme Review, the average claim sizes for the 2024/25 accident year have increased (in real terms) across all insurer segments: by 11% for licensed insurers, 5% for self-insurers, and 13% for the TSS.

The payment pattern for the overall Scheme is front-loaded with an implied weighted average payment term of 2.6 years.

Mental health-related claims represent 15% of the total claims reported to date for the 2024/25 accident year, an increase compared to the 13% in 2023/24. This experience continues to be driven by the TSS and, in particular, frontline healthcare and emergency service workers. 38% of the payments for the overall Scheme in 2024/25 were for mental health-related claims, compared to 35% in 2023/24.

23 silicosis claims have been reported to date, with 17 of these accepted, 5 rejected and 1 pending. Payments to date for the accepted claims are $3.63 million with the corresponding case estimates being $1.00 million. Of these 23 claims, 7 remain open as at 30 June 2025.

4.1. Claim Payments in total

Key Points

$379.2 million in Scheme payments were made in the 2024/25 payment year, which is 19.3% higher (in real terms) compared to 2023/24. This increase is driven by medical and lump sum payments to the TSS as well as medical and weekly payments to licensed insurers.

$361.9 million of Scheme payments are projected for the 2025/26 financial year.

The total payments by payment type and financial year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 4.1. A projection of the quantum of payments that are to be made in 2025/26 are also included. The figure below is constructed on a payment year basis, with the payments in any year relating to a mix of accident years. All figures are in 30 June 2025 dollar values to ensure the real growth in payments can be assessed.

Figure 4.1: Claim Payments, by Financial Year ($m, Jun-25 values)

Source data can be found in Appendix E.

The payments for the overall Scheme increased by 19.3% (in real terms) from $317.8 million in 2023/24 to $379.2 million in 2024/25. The experience by sector is discussed below:

- **Licensed insurers**: payments increased by 15.0% (in real terms) from $184.8 million to $212.4 million. The higher payments were observed in most categories, with the exception of legal payments;
- **Self-insurers**: payments decreased by 6.1% (in real terms) from $11.9 million to $11.2 million. The lower payments were observed in most categories, with the exception of lump sum payments; and
- **TSS**: payments increased by 28.5% (in real terms) from $121.1 million to $155.6 million. The higher payments were observed in all categories, with the exception of legal payments.

There has been a notable increase in the lump sum payments ($26.1 million higher than 2023/24, in real terms) which has been driven by licensed insurers and the TSS, where an increase in lump sum utilisation was observed.

The primary driver of the higher weekly payments is an increase in the lost time claim reports over the year as well as the higher number of weekly active claims due to claimants remaining on benefit for a longer period, particularly given shifts in the claims mix towards mental health claims which typically incur longer return-to-work rates.

Medical payments have also increased at due to the introduction of NIDS v8.1, whereby independent medical reviews have been re-categorised from the legal & investigations benefit type to the medical benefit type from 1 January 2025 and onwards. As a result of this, legal payments have reduced by similar a quantum.

Projection for the 2025/26 financial year

The payments for the overall Scheme in 2025/26 are projected to be $361.9 million. In real terms, this is reduction of 4.6% compared to 2024/25. This is driven by:

- 1.9% decrease in weekly payments;
- 10.2% decrease in lump sum payments; and
- 20.7% decrease in legal payments.

This is partially offset by an increase of 2.5% in medical payments.

Despite an increase in lump sum payments in the 2024/25 financial year, a significant number of these claims were attached to the 2021/22 accident year, which suggests a clean-up of claims rather than sustained levels of claims reporting. These factors have been considered when determining the future projections.

4.2. Selected Average Claim Size

Key Points

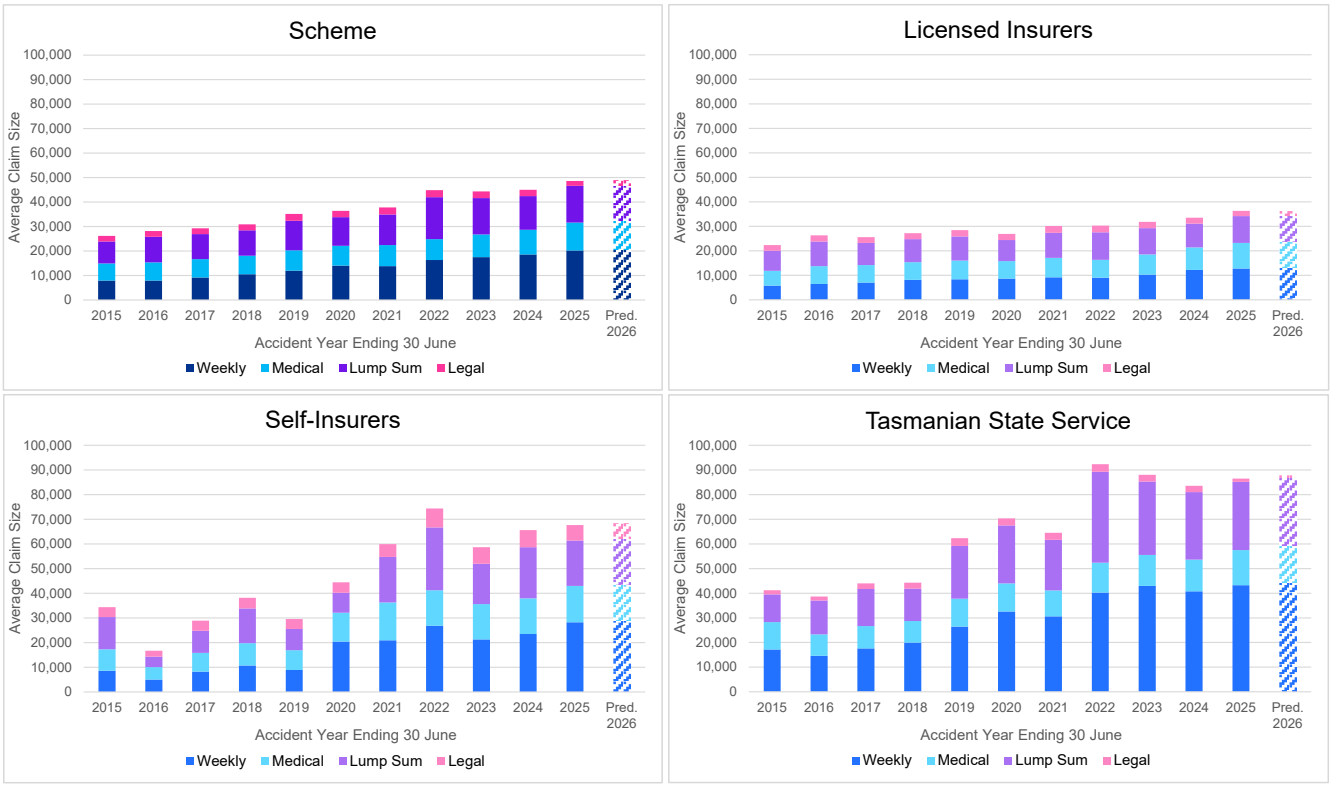
The average claim size for the overall Scheme is projected to be $48,611 for the 2024/25 accident year, which is an 8.0% increase (in real terms) compared to the projection for the 2023/24 accident year. This is also 13% higher than the average claim size for the 2024/25 accident year projected at the Previous Scheme Review.

The projected average claim size for accident year 2025/26 is selected to be $48,663 (in real terms) which is broadly in line with the average claim size of $48,611 projected for the 2024/25 accident year.

Across each insurer segment, the movements have been outlined as being stable for licensed insurers, 0.8% increase for self-insurers, and 1.5% increase for the TSS. These have been driven by the deteriorating experience of weekly payments across all insurer segments, as well as deteriorating experience of medical payments for licensed insurers and TSS, which are offset by lower expected legal payments due to the re-classification of independent medical review payments from legal benefits to medical benefits.

The average claims size selections by payment type and accident year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 4.2. The average claim sizes include both the payments already made and the projected future payments (the process for determining the future payments is detailed in Section 5 to Section 8). The average claim sizes are calculated by dividing the projected ultimate number of claims for the relevant accident years. All figures are in 30 June 2025 dollar values to ensure the real growth in payments can be assessed.

Figure 4.2: Adopted Average Claim Size, by Accident Year ($, Jun-25 values)



Source data can be found in Appendix E.

The average claim size for the overall Scheme is projected to be $48,611 for the 2024/25 accident year. This is a 8.0% increase (in real terms) compared to the projection for the 2023/24 accident year and has been driven by increases to the average claim sizes across all sectors. The experience by sector is discussed below:

- **Licensed insurers**: the average claim size is projected to be $36,256 for 2024/25. This is a 8.2% increase (in real terms) compared to 2023/24 and is driven by increases across all payment types, with the exception of legal payments;

- **Self-insurers**: the average claim size is projected to be $67,618 for 2024/25. This is a 3.0% increase (in real terms) compared to 2023/24 and is driven by increases in the medical and weekly payment average claim sizes; and

- **TSS**: the average claim size is projected to be $86,533 for 2024/25. This is a 3.5% increase (in real terms) compared to 2023/24 and is driven by increases across all payment types, with the exception of legal payments.

There is evidence of growth in the average claim size for licensed insurers in the more recent accident years. Similarly, the average claim size for TSS is projected to be higher for the more recent accident years, particularly for 2022 and onwards. The growth in average claim size coincides with the growth in the prevalence of mental health-related claims for these insurer sectors. The average claim size, by accident year, for self-insurers is relatively more volatile due to the smaller size of the sector.

Projection for the 2025/26 accident year

The trends observed above are reflected in the average claim sizes selected for the new accident year. For the overall Scheme, the average claim size selected for the 2025/26 accident year is $48,663 (in 30 June 2025 dollar values). This is a 12.7% increase (in real terms) compared to the selection for the new 2024/25 accident year at the previous year. The decrease in the average claim size selection is driven by the deteriorating payments experience and the continued increase to proportion of mental health claims (which typically attach higher costs) observed in the claims mix. The average claim size selections for each sector are discussed below:

- **Licensed insurers**: the average claim size selected for new accidents is $36,256, which is 10.5% higher (in real terms) compared to the selection made for the new 2024/25 accident year at the Previous Scheme Review;

- **Self-insurers**: the average claim size selected for new accidents is $68,178, which is 5.3% higher (in real terms) compared to the selection made for the new 2024/25 accident year at the Previous Scheme Review; and

- **TSS**: the average claim size selected for new accidents is $87,829, which is 12.6% higher (in real terms) compared to the selection made for the new 2024/25 accident year at the Previous Scheme Review.

The average claim size selections by payment type, compared to the Previous Scheme Review is shown in Table 4.1. The average claim size for each payment type, for all insurer sectors has increased, to varying degrees. As noted above, the average claim sizes are shown to be the projected ultimate costs divided by the projected ultimate claims for 2025/26. The increases of the average claim sizes shown below reflect the increases in the underlying cost but also reflect the increases in the projected utilisation of payment types by claimants.

Changes in the selections made for each payment type are discussed in the respective sections of the report.

Table 4.1: Adopted Average Claim Sizes for New Accidents in 2025/26 ($, Jun-25 values)

Payment Type	Previous Review	Current Review	Change (%)
Licensed Insurers			
Weekly	10,894	13,175	21%
Medical	7,812	10,800	38%
Lump Sum	10,919	10,331	-5%
Legal	3,191	1,950	-39%
Total	**32,816**	**36,256**	**10%**
Self-Insurers			
Weekly	23,938	29,099	22%
Medical	15,775	14,607	-7%
Lump Sum	17,562	18,472	5%
Legal	7,533	6,000	-20%
Total	**64,809**	**68,178**	**5%**
Tasmanian State Service			
Weekly	39,757	44,328	11%
Medical	11,430	15,000	31%
Lump Sum	23,222	27,551	19%
Legal	3,610	950	-74%
Total	**78,020**	**87,829**	**13%**

4.3. Payment Pattern

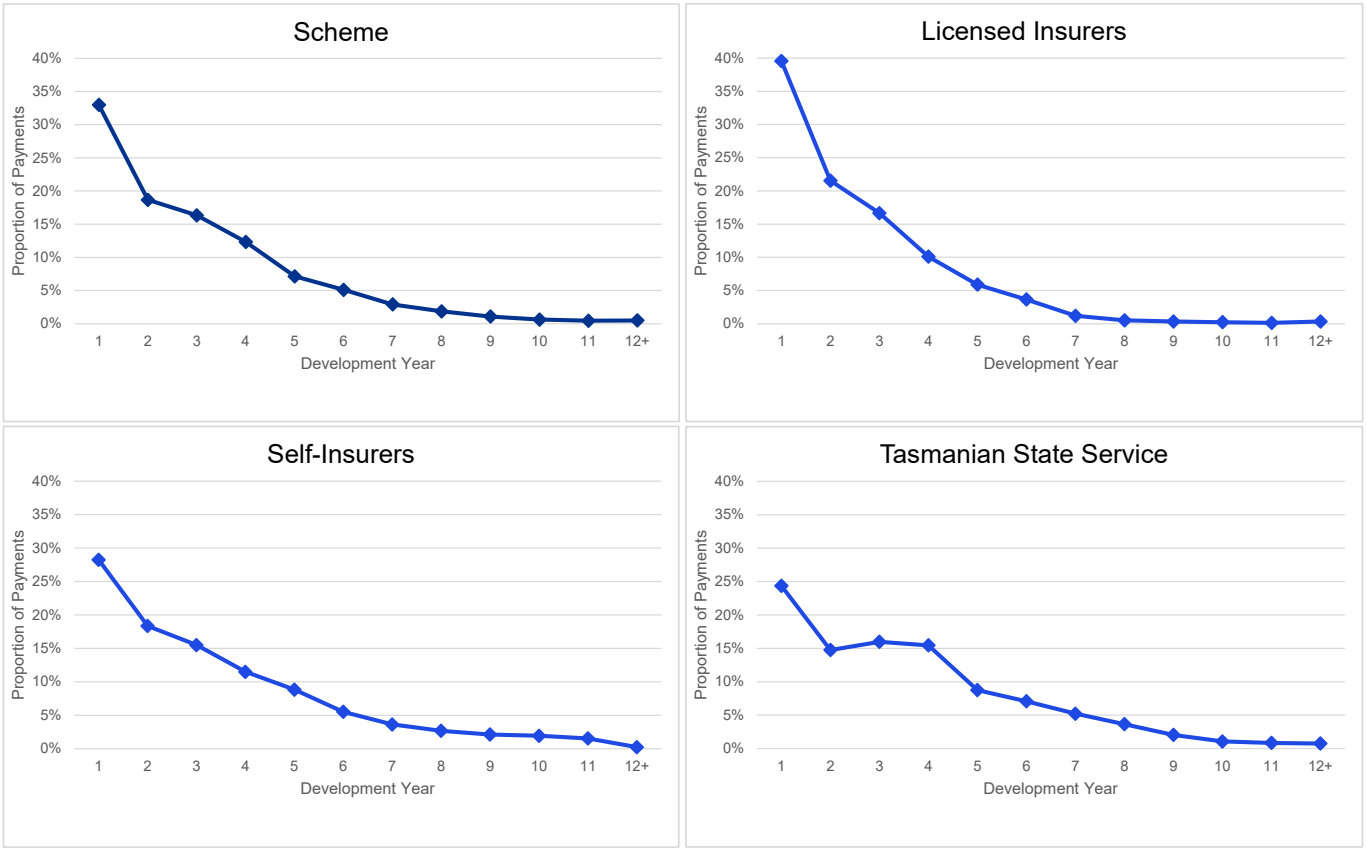
The modelling approach is based on assumptions that are split out by development period, implying a certain payment pattern. While each payment type is modelled separately, the implied payment patterns for new accidents presented below combine all payment types.

Key Points

The payment pattern for the overall Scheme is front-loaded with an implied weighted average payment term of 2.6 years.

The weighted average payment term for licensed insurers (2.1 years) is shorter than that for self-insurers (3.0 years) and the TSS (3.3 years).

Figure 4.3: Implied Payment Pattern for New Accidents



Source data can be found in Appendix E.

The majority of payments are made within the first few years following the accident, with 92.6% of the payments being made within the first six years following the accident. The payment pattern for the overall Scheme implies a weighted average payment term of 2.6 years from the date of the accident. The weighted average payment term represents the weighted average time from accident for all payments to occur, rather than the time to the first payment.

The payment pattern for self-insurers and the TSS are slower than that of the licensed insurers. This is reflected in the weighted average payment term for the licensed insurers of 2.1 years being shorter than that for self-insurers (3.0 years) and the TSS (3.3 years). The TSS payment pattern reflects the timing of large lump sum payments which, on average, are observed to occur 4.8 years after the accident date.

4.4. Mental Health Claims

Key Points

Over the last decade, the proportion of mental health-related claims have increased across most sectors, with the exception of self-insurers. These claims account for 14.7% of the total reported claims to the overall Scheme in the 2024/25 accident year, compared to 13.1% in 2023/24.

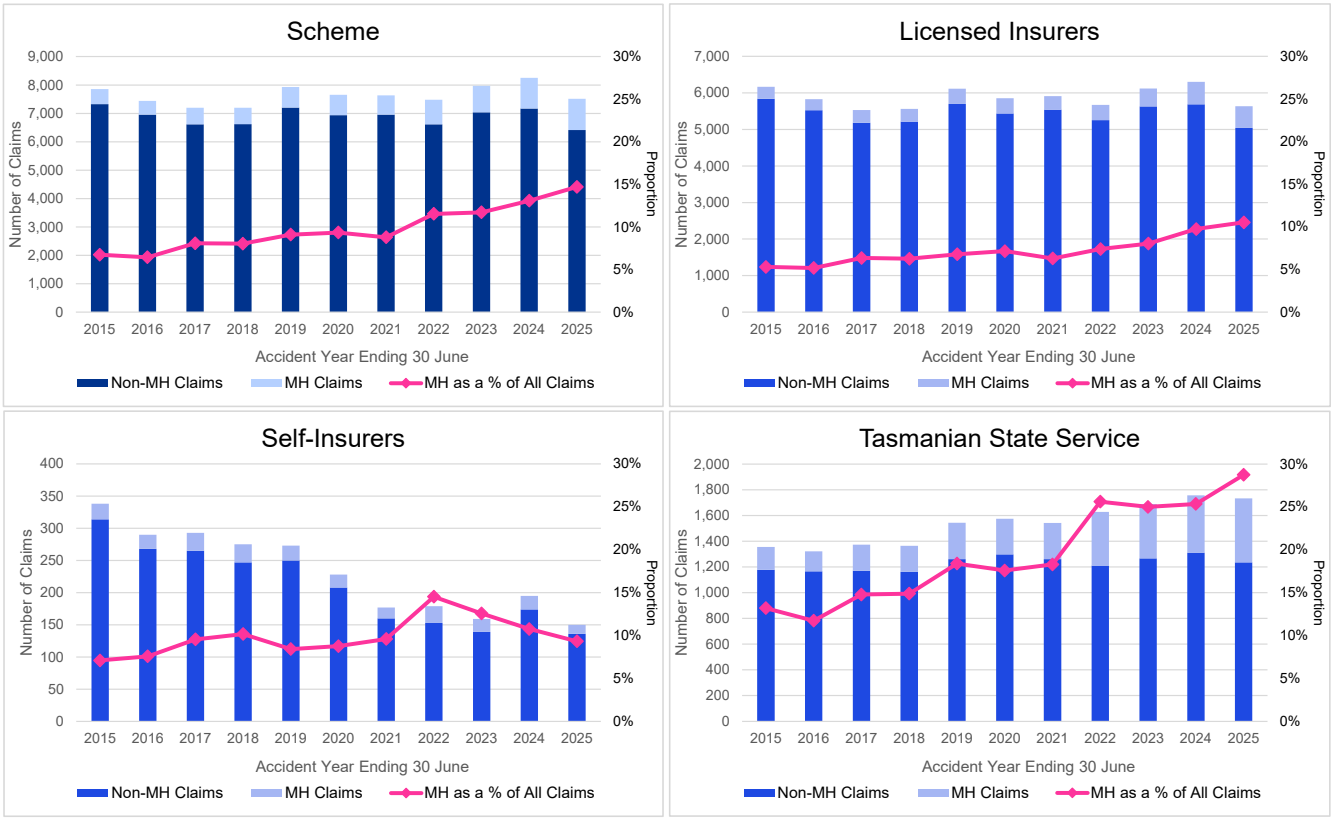
The TSS continue to have the highest proportion of mental health-related claims with the claims representing 28.7% for the 2024/25 accident year. The increase is driven by frontline healthcare and emergency service workers. 8% of the mental health-related claims reported in 2024/25 are post-traumatic stress disorder (PTSD) claims.

The mental health-related claimants represent 38% of the total Scheme payments in the 2024/25 financial year. This is the highest proportion record, an increase from the previous high of 35% in 2023/24. Within the TSS, the mental health-related payments represent 70% of the payments made over the same period.

4.4.1. Mental Health Claim Numbers

The number of claims reported to date by accident period for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 4.4. The reported number of claims are separated into mental health-related claims and non-mental health-related claims. Throughout this report, references to mental health-related claims are in relation to claims with a primary mental health injury. A primary mental health injury is defined by the injury codes outlined in Appendix A.1.9.

Figure 4.4: Claims Reported to Date by Accident Year, Split by Mental Health (MH) and Non-MH Claims



The proportion of reported claims that are mental health-related have increased over the last decade. The strong increase in the proportion of mental health-related claims is a trend that has been observed across other Australian states and territories.

For the overall Scheme, 10.9% of claims reported for the 2019/20 to 2023/24 accident years were mental health-related. This proportion has increased to 14.7% for 2024/25, based on the experience of claims reported to date. The TSS continues to have the highest proportion of mental health-related claims compared to licensed insurers and self-insurers. The experience by sector is discussed below:

- **Licensed insurers**: mental health-related claims represent 10.5% of licensed insurer claims reported to date for the 2024/25 accident year. This is compared to the 9.7% for the 2023/24 accident year. Although there has been a 3.4% reduction in the number of reported mental health-related claims over the year, the proportion of mental health-related claims has increased due to a greater reduction in the number of total reported claims. Compared to the 2020/21 accident year, the number of yearly mental health-related claims have increased by 59.4%;

- **Self-insurers**: mental health-related claims represent 9.3% of self-insurer claims reported to date for the 2024/25 accident year. This is compared to the 10.8% for the 2023/24 accident year. There was a 33.3% reduction in the number of reported mental health-related claims over the year. Compared to the 2020/21 accident year, the number of yearly mental health-related claims have decreased by 17.6%; and

- **TSS**: mental health-related claims represent 28.7% of TSS claims reported to date for the 2024/25 accident year. This is compared to the 25.3% for the 2023/24 accident year, which relates to an 11.9% increase in the number of reported mental health-related claims over the year. 15.7% of the mental health-related claims reported in 2024/25 are PTSD claims. Since the 2020/21 accident year, there has been a notable increase in the number of mental health-related claim that also reflects the increase in the number of PTSD. Compared to the 2020/21 accident year, the number of yearly mental health-related claims have increased by 76.6%. The October 2018

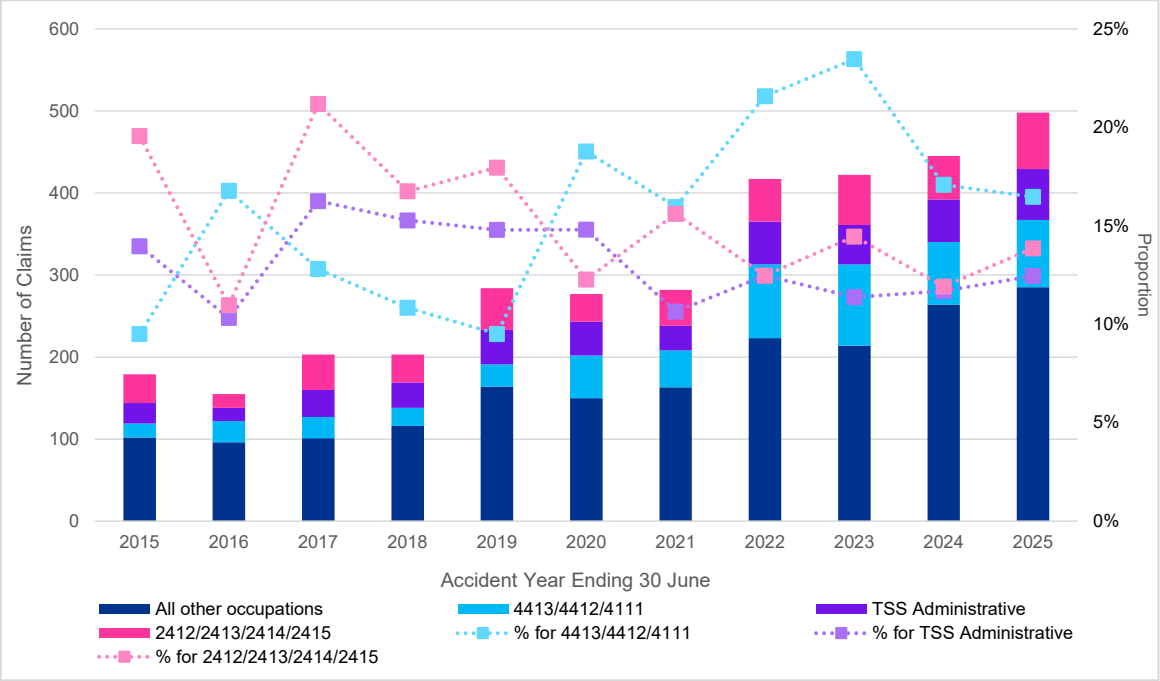
amendments (detailed in Appendix D.8) introduced presumptive provisions for PTSD claims in the TSS, which required the agency to accept PTSD claims as being work-related unless prove otherwise.

The increases in the proportion of mental health-related TSS claims that relate to certain ANZSCO occupations are shown in Figure 4.5. In particular:

- **Occupation groups 4413, 4412 and 4111 ('Police Services', 'Fire Protection and Other Emergency Services' and 'Ambulance Services', respectively)**: These emergency service-related classes collectively represent 9% to 23% of the mental health-related TSS claims over the majority of the last decade. The percentage of claims from these classes appear to be increasing over the past 5 years, with an average of 19% each year.
- **Administrative workers**: The proportion of claims in the TSS relating to administrative occupations has been reducing slightly over time. Between the 2015 and 2020 accident years, the average proportion of claims from this occupation group was 14%, and this has reduced to approximately 11% over the 2021-2025 accident years.
- **Occupation groups 2412, 2413, 2414, 2415 ('Primary School Teachers', 'Middle School Teachers', 'Secondary School Teachers', 'Special Education Teachers')**: The proportion of claims in the TSS relating to education-related classes collectively has been reducing over time. Between the 2015 and 2019 accident years, the average proportion of claims from this occupation group was 17%, and this has reduced to 13% over the 2020-2025 accident years.

It should be noted that despite the changes in proportions between the occupation groups, each of the occupations have experienced an increase in the number of claims reported over the last decade.

Figure 4.5: Mental Health (MH) Claims Reported in the TSS, by Accident Year and ANZSIC06 Class

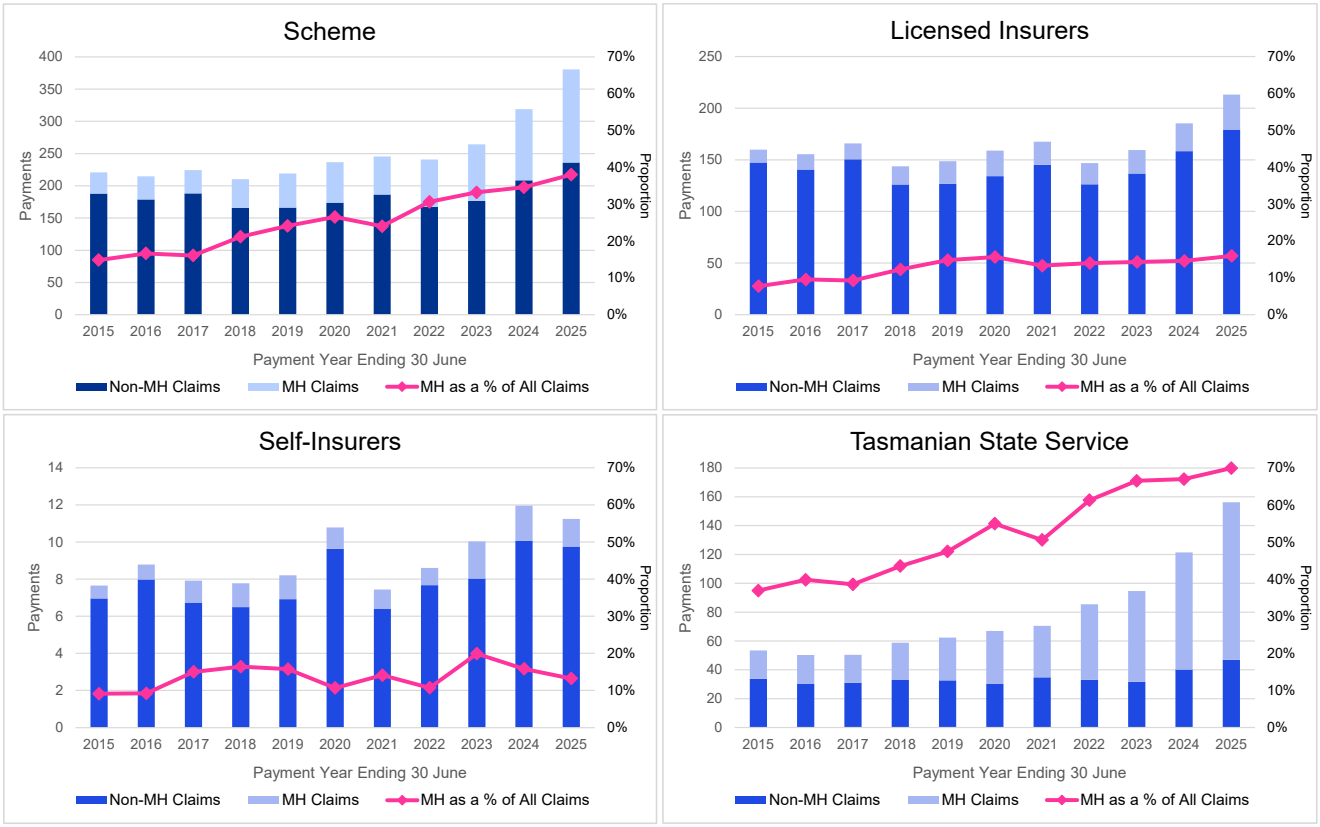


Source data can be found in Appendix E.

4.4.2. Mental Health Claim Payments

The total payments by financial year for the overall Scheme, licensed insurers, self-insurers and the TSS are shown in Figure 4.6. The payments have been separated into payments for mental health-related claims and payments for non-mental health-related claims. All figures are in 30 June 2025 dollar values.

Figure 4.6: Payments by Payment Year, Split by Mental Health (MH) and Non-MH Claims ($m, Jun-25 values)



Source data can be found in Appendix E.

The proportion of payments that are for mental health-related claims has also increased over the last decade. Over the last five years, the average proportion of claims for the overall Scheme that are mental health-related is 12.0%, whilst the proportion of payments for the overall Scheme that are mental health-related is higher at 32.7% over the same period. In general, mental health-related claims tend to be more expensive, as they often receive benefits of a longer duration than physical injury claims and have a greater propensity to receive lump sum benefits.

The proportion of mental health-related payments has continued to increase in 2024/25 however experience indicates higher payments are related to both mental health-related and non-mental health-related claims. The above analysis only classifies a mental health-related claim based on the primary injury. Broader industry trends have seen an increased focus on secondary mental health injuries as a result of a physical injury, leading to further deterioration in the claims experience.

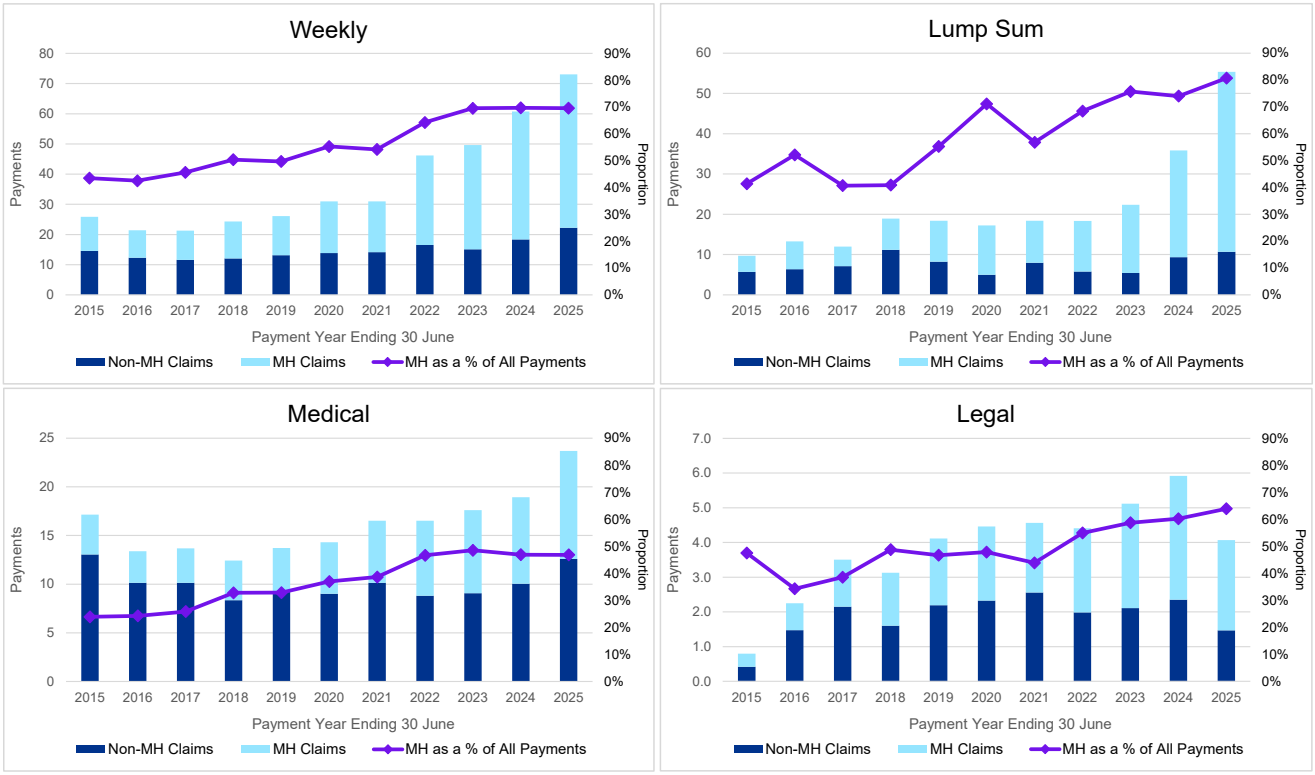
The proportion of payments related to mental health-related claims, at the sector level, has consistently been higher for the TSS than licensed insurers and self-insurers. The experience by sector is discussed below:

- **Licensed insurers**: the proportion of mental health-related payments has increased to 15.9% for 2024/25 compared to 14.6% in 2023/24;
- **Self-insurers**: the proportion of mental health-related payments has decreased to 13.2% for 2024/25 compared to 15.8% in 2023/24; and
- **TSS**: the proportion of mental health-related payments has increased to 69.9% for 2024/25 compared to 67.0% in 2023/24. $24 million of payments over the 2024/25 year for TSS mental health-related claimants are attributed to PTSD claimants, which has increased close to three-fold since 2019-20. Weekly payments represent 46% of these payments.

4.4.3. TSS Mental Health Claims

The TSS payments by financial year and payment type are shown in Figure 4.7. Similar to Figure 4.6, payments are separated into payments for mental health-related claims and payments for non-mental health-related claims. All figures are in 30 June 2025 dollar values.

Figure 4.7: TSS Payments by Payment Year, Split by Mental Health (MH) and Non-MH Claims ($m, Jun-25 values)



Source data can be found in Appendix E.

The proportion of TSS payments remain at elevated levels in the 2024/25 payment year. The experience by payment type is discussed below:

- **Weekly payments**: the proportion of mental health-related payments were 55.3% in 2019/20. It has since increased to 69.6% in 2024/25;
- **Lump sum payments**: the proportion of mental health-related payments were 71.1% in 2019/20. It has since increased to 80.7% in 2024/25. Lump sum payments have the greatest proportion of mental health-related payments. This is expected due to the higher propensity for mental health-related claims to receive a lump sum benefit.
- **Medical payments**: the proportion of mental health-related payments were 37.0% in 2019/20. It has since increased to 46.8% in 2024/25; and
- **Legal payments**: the proportion of mental health-related payments were 47.9% in 2019/20. It has since increased to 63.9% in 2024/25.

Given the delay between the accident occurring and the payment, it is likely that the increase in the proportion of mental health-related TSS claims for the 2021/22 and 2023/24 accident years will continue to flow through into payment experience for upcoming financial years.

WorkSafe Tasmania has conducted work over the last five years related to monitoring the changing injury mix of claims and the agency and occupation mix of mental health-related claims. WorkSafe Tasmania currently have a program of work underway to collect secondary injury data which is expected to provide further insights into the Scheme's experience.

There are opportunities to develop and apply interventions that may effectively manage the incidence and cost of mental health-related claims.

4.5. Silicosis Claims

Key Points

23 silicosis claims reported to date, with 17 accepted claims, 5 rejected claims and 1 pending claim. There have been 21 distinct claimants.

The claimants have an average age at injury of 41 years old. Of the 17 accepted claims, 12 claims relate to the 2019-2025 accident years.

Payments to date for the accepted claims are $3.63 million with the corresponding outstanding case estimates being $1.00 million.

In recent years, there has been increased awareness and apprehension across the country in terms of increasing exposures of workers to silica dust, particularly through the manufacturing and use of engineered stone. At the current review, claims that have arisen from silicosis exposure are included in the analysis and would only impact the suggested premium rates as far as the historical experience suggests that it is warranted. A ban on the manufacturing and installing of engineered stone came into effect on 1 July 2024 and it is expected that the ban should greatly minimise the impacts of engineered stone silicosis in future years.

There have been 23 known silicosis claims that have been reported to date in Tasmania. These claims relate to 21 distinct claimants, as 3 claimants have each lodged two claims against two insurers, of which one of them was rejected for each claimant. The 23 reported claims are attributable to 13 distinct employers, with the average age at injury being 41 years old.

Of the accepted claims, three relate to 1997 and prior accident years; four relate to 1998 to 2017 accident years, and the remaining sixteen claims are related to the 2018 to 2024 accident years. Of the five rejected claims, 3 of the claims were reported by three claimants of the claimants that lodged two claims against two separate employers.

The payments made to date for silicosis claims are $3.63 million (in nominal terms), including $2.96 million related to claims for the 2018 to 2025 accident years. 47% of payments to date have been in respect of lump sum benefits, 28% in respect of weekly payments, 18% in respect of legal/investigation payments and 7% in respect of medical. $1.00 million in outstanding case estimates is provisioned for these claims, with 68% related to the claims for the 2024 to 2025 accident years.

ANZSIC06 division C (Manufacturing) represents 16 of the 23 reported claims, as well as 79% of payments to date and 55% of outstanding case estimates. 2 claims are related to division B (Mining) and 1 claim each has emerged from divisions F (Wholesale Trade), divisions D (Electricity, Gas, Water and Waste Services) and E (Construction).

5. Weekly Benefits

This section presents the key findings in relation to weekly benefits, including the number of lost time claims, continuance rates and average claim sizes.

Key Points

Scheme Lost Time Claims Frequency (by accident year)

The Scheme lost time claim[4] frequency is projected to be 0.30 claims per million dollars of wages for the 2024/25 accident year. The claim frequency is projected to be in line with recent experience at 0.30 claims per million dollars of wages for the 2025/26 accident year.

The lost time claim frequency as a proportion of all claims is projected to be 75% for the 2024/25 accident year, which is an increase compared to the projections for the 2023/24 accident year. The proportion of lost time claim frequency is projected to be 74% of all claims for the 2025/26 accident year. This is broadly in line with the recent accident year.

Scheme Weekly Actives (by financial year)

The weekly actives[5] increased by 8.3% to 14,311 claims in the 2024/25 financial year. The weekly actives are projected to increase further by 4.0% to 14,878 claims in 2025/26. An increase in the claim numbers was observed across all three insurer sectors, with self-insurers experiencing the greatest rate of growth in weekly actives over the last year and TSS experiencing the greatest growth in number of weekly actives over the last year. This increase is driven by higher lost time claim reports over the year and claimants remaining on benefit for longer due to shifts in claims mix towards mental health claims.

Scheme Weekly Average Claim Size (by financial year)

The modelled average claim size for weekly benefits is on an average payment per quarter per active claim basis. The modelled average claim size for weekly benefits was $10,441 for the 2024/25 financial year, which is 9.4% higher (in real terms) compared to 2023/24. TSS continues to have the highest claim size of the three sectors, whereas licensed insurers have the lowest. The average is projected to be $9,854 for 2025/26, which is largely in line with recent experience.

Scheme Weekly Payments (by financial year)

$149.4 million of weekly payments were made in the 2024/25 financial year, which was an 18.4% increase (in real terms) compared to 2023/24. The higher payments are driven by a higher number of weekly actives and average claim sizes over the year. $146.6 million of weekly payments are projected for 2025/26, which is a slight reduction from 2024/25, primarily driven by the TSS projection.

5.1. Claim Frequency – Lost Time Claims

Key Points

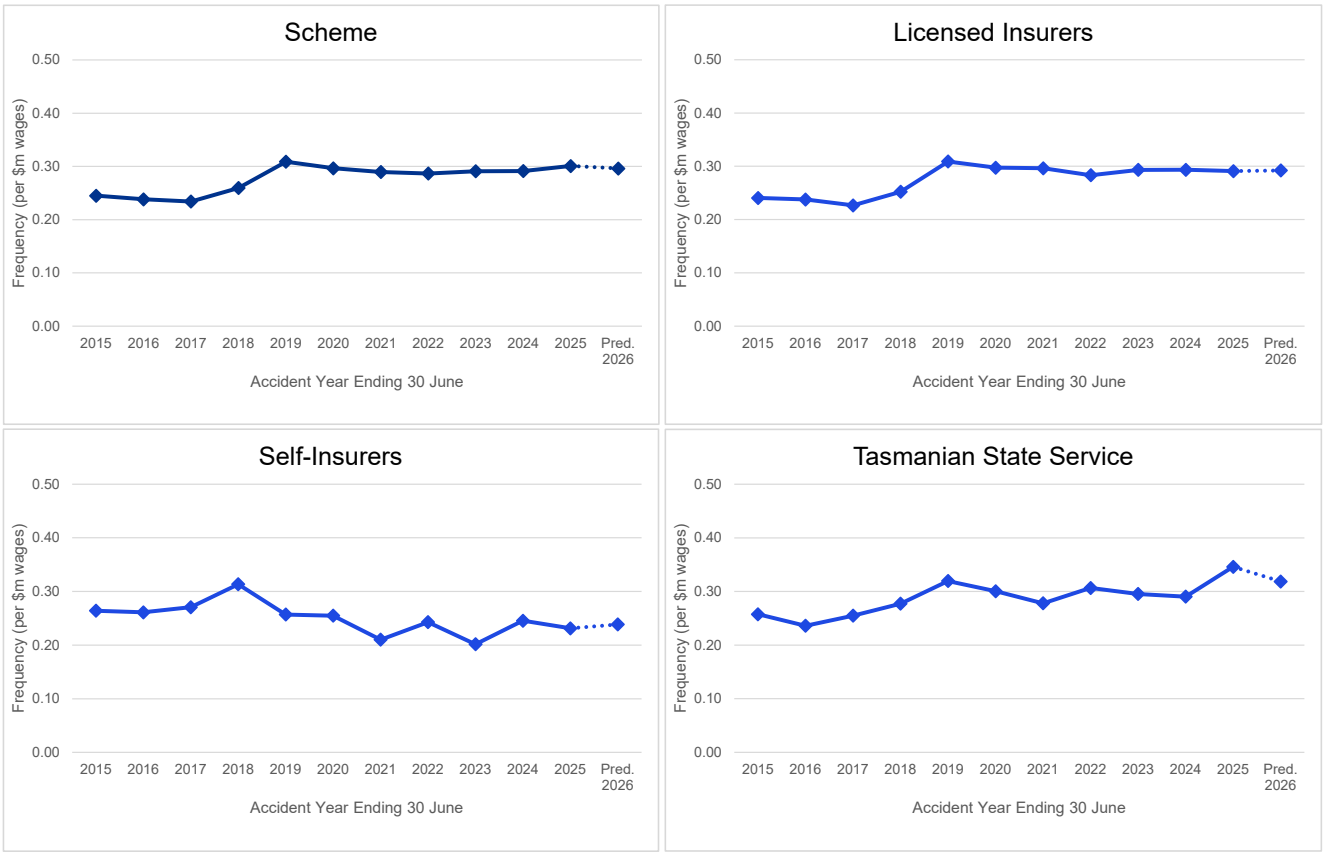
The Scheme lost time claim frequency is projected to be 0.30 claims per million dollars of wages for the 2024/25 accident year. The claim frequency is projected to be in line with recent experience at 0.30 claims per million dollars of wages for the 2025/26 accident year.

To understand the trends in the number of claimants receiving weekly benefit payments, the ultimate lost time claim frequency is calculated by deriving the estimates of the ultimate number of lost time claims and dividing them by earned wages (in 30 June 2025 dollar values). The ultimate lost time claim frequency by accident year for the overall

[4] A lost time claim is a claim that is receiving a weekly benefit.
[5] The number of weekly actives in a year is the sum of the quarterly weekly actives. Hence, a claim is counted four times if they were active in all four quarters of the year.

Scheme overall, licensed insurers, self-insurers and the TSS are shown in Figure 5.1. A projection for the 2025/26 accident year is also included.

Figure 5.1: Ultimate Lost Time Claim Frequency (per $m wages), by Accident Year



Source data can be found in Appendix E.

The Scheme lost time claim frequency is projected to be 0.30 claims per million dollars of wages for the 2024/25 accident year. This is in line with the claim frequency experience for the recent accident years. The experience by sector is discussed below:

- **Licensed insurer**: the lost time claim frequency of 0.29 (per million dollars of wages) for 2024/25 has remained consistent with 2023/24. The experience over the past seven accident years has been broadly consistent around this frequency;
- **Self-insurer**: the lost time claim frequency (per million dollars of wages) has decreased from 0.25 for 2023/24 to 0.23 for 2024/25. This is due to the relatively smaller size of this sector resulting in volatility in the frequency over the recent accident years; and
- **TSS**: the lost time claim frequency (per million dollars of wages) has increased from 0.29 for 2023/24 to 0.35 for 2024/25 and is elevated compared with historic experience. This is due to increasing volumes of total claims and strong development to date in weekly claim numbers for the most recent accident year.

Projection for the 2025/26 accident year

The overall lost time claim frequency has been relatively stable on an accident year basis for licensed insurers and self-insurers, with some volatility for TSS given the experience of the most recent accident year. The Scheme lost time claim frequency is projected to be 0.30 claims per million dollars of wages for the 2024/25 accident year. At the sector and scheme levels, the selection for the 2025/26 accident year is largely consistent with recent periods. The TSS selection for the 2025/26 accident year remains slightly lower than the 2024/25 accident year (but higher than the 2023/24 accident year) given the higher levels of uncertainty surrounding whether the elevated claim volumes observed in 2024/25 will persist.

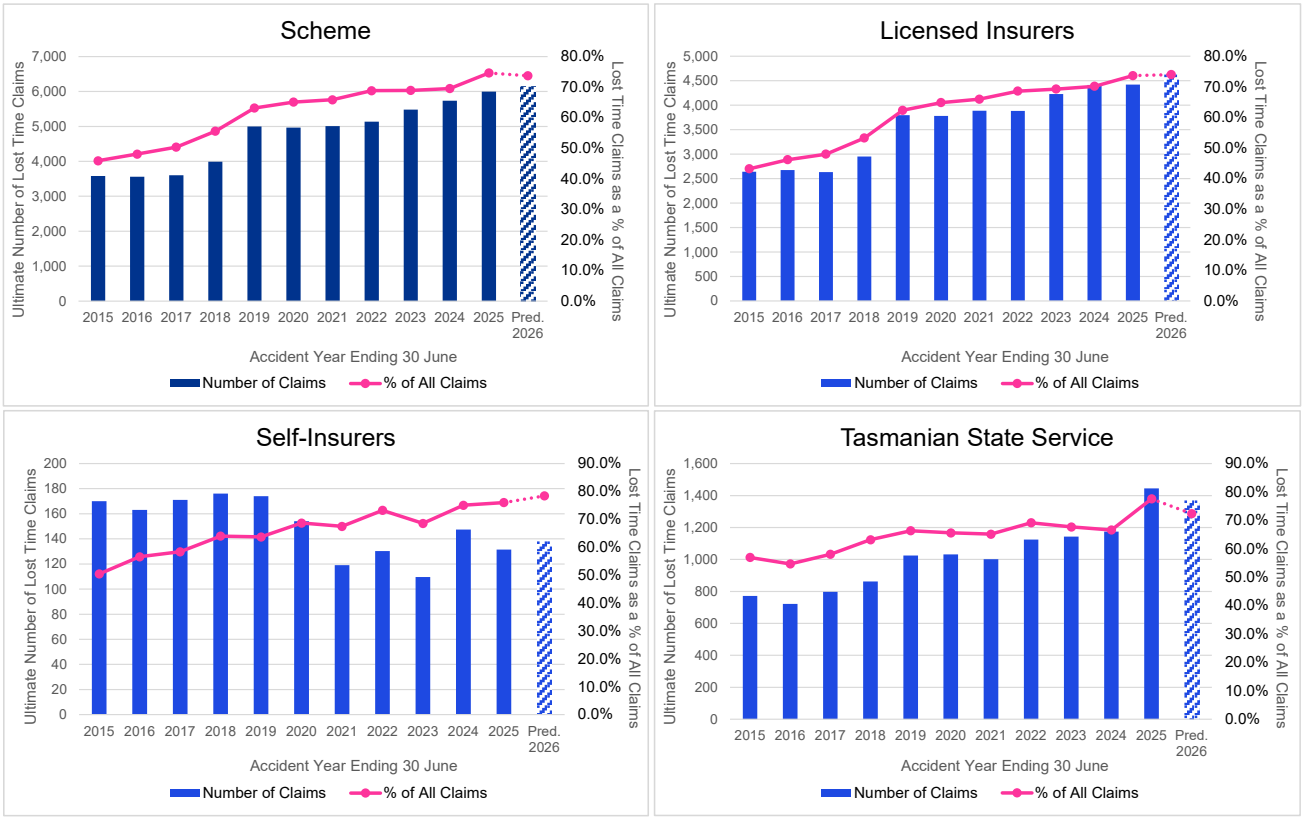
5.2. Lost Time Claim Proportions

Key Points

The lost time claim frequency as a proportion of all claims is projected to be 74.6% for the 2024/25 accident year, which is an increase compared to the projections for the 2023/24 accident year. The proportion of lost time claim frequency is projected to be 73.7% of all claims for the 2025/26 accident year. This is largely in line with recent accident periods.

The estimate of the ultimate number of lost time claims by accident year for the overall Scheme, licensed insurers, self-insurers and TSS are shown in Figure 5.2. A projection of the ultimate number of lost time claims that are expected to emerge for the 2025/26 accident year. The proportion of all claims that are lost time claims is also provided.

Figure 5.2: Lost Time Claims, by Accident Year



Source data can be found in Appendix E.

The number of claims are projected to be 5,997 claims for the 2024/25 accident year, which is 4.5% higher than the projections for the 2023/24 accident year. The proportion of Scheme claims are projected to be 74.6% for the 2024/25 accident year and 69.5% for the 2023/24 accident year. The experience by sector is discussed below:

- **Licensed insurer**: the proportion of lost time claims for licensed insurers are projected to increase from 70.2% for 2023/24 to 73.7% for 2024/25 and has generally trended upward over time;
- **Self-insurer**: the proportion of lost time claims for self-insurers are projected to increase from 75.1% for 2023/24 to 76.0% for 2024/25 and has generally trended upward over time; and
- **TSS**: the proportion of lost time claims for the TSS are projected to increase from 66.7% for 2023/24 to 77.6% for 2024/25 and has generally trended slightly upward over time, with strong levels of development observed in the most recent 2024/25 accident year.

Projection for the 2025/26 accident year

The ultimate lost time claims are projected to be 6,134 for the 2025/26 accident year, which is 2.3% higher than 2024/25. In terms of the proportion of total claim numbers these claims represent, lost time claims will be 73.7% of overall Scheme claims compared to 74.6% in 2024/25. At the sector and scheme levels, the selection for the 2025/26 accident year is largely consistent with recent periods, with some further growth expected for licensed insurers and self-insurers. However, TSS lost time claim numbers are assumed to reduce slightly given the higher levels of uncertainty the 2025/26 claims and whether the elevated volumes will be sustained into the future.

5.3. Weekly Active Claim Numbers

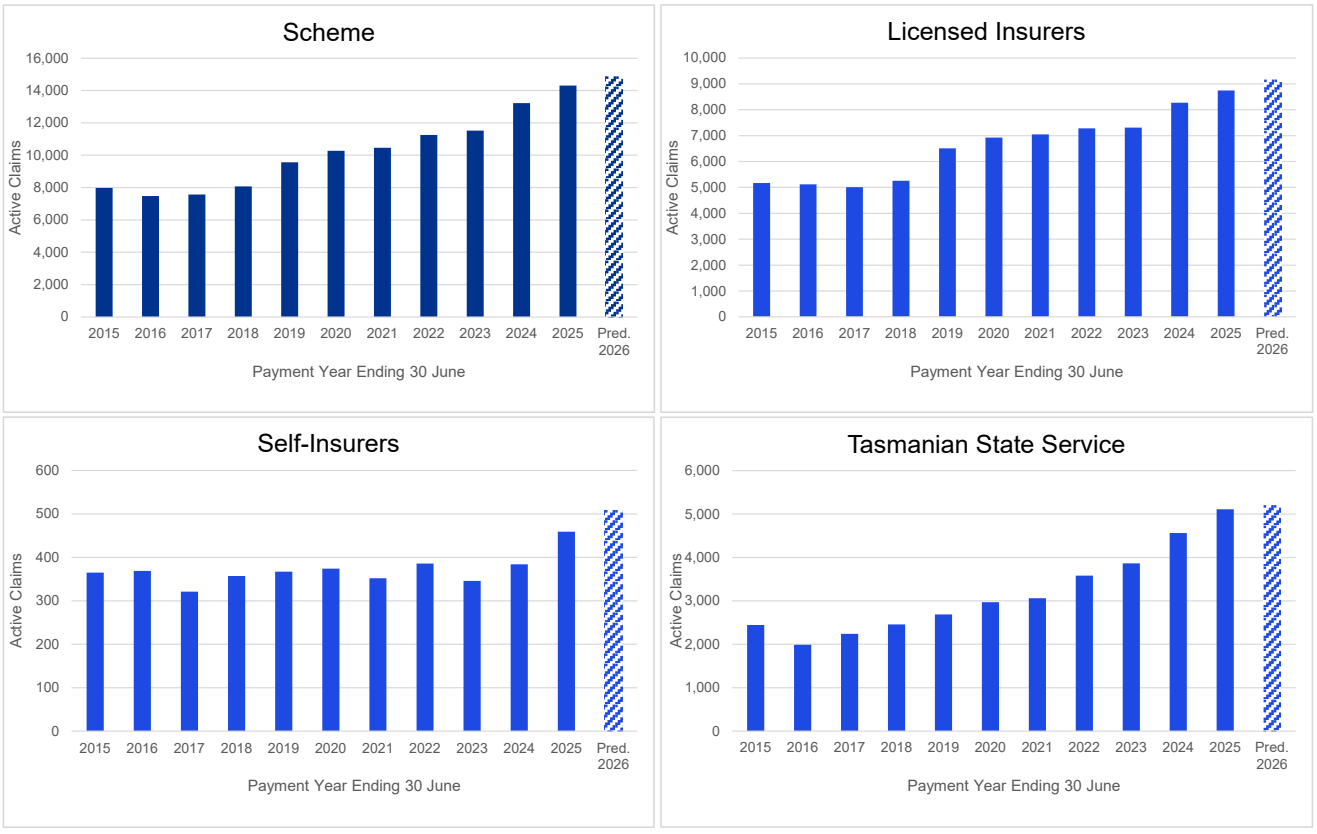
Key Points

The weekly actives increased by 8.3% to 14,311 claims in the 2024/25 financial year. The weekly actives are projected to increase by 4.0% to 14,878 claims in 2025/26. An increase in the claim numbers was observed across all three insurer sectors, with self-insurers experiencing the greatest growth in weekly actives over the last year. This increase is driven by higher lost time claim reports over the year and claimants remaining on benefit for longer.

The PPAC model is adopted to estimate the ultimate cost of weekly benefits, which is outlined further in Appendix B.3. The PPAC approach projects weekly payments as a function of the number of weekly active claims (with a claim being active if it receives one or more weekly payments within the relevant period), which assumes weekly payments in any period are correlated to the number of claims receiving weekly benefits within a particular period.

The number of weekly active claims in each financial year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 5.3. The weekly active claim numbers are modelled on a quarterly basis, the number of weekly actives for each financial year is the total number of weekly actives across the four quarters of each year (e.g. if a claimant received weekly benefits in three of the four quarters of the financial year, this would count as three weekly active claims for that year).

Figure 5.3: Number of Weekly Active Claims, by Financial Year



Source data can be found in Appendix E.

The number of weekly active claims observed in the overall Scheme in 2024/25 was 14,311. This is 8.3% higher than the number of weekly actives in the Scheme in 2023/24.

Experience by sector has been as follows:

• **Licensed insurers**: there were 8,744 weekly active claims in 2024/25 which is 5.7% higher than 2023/24 – this was partly driven by a higher number of lost time claims reported in the year as well as claims remaining on benefits for longer;

• **Self-insurers**: there were 459 weekly active claims in 2024/25, which is 19.5% higher than 2023/24 – which is largely driven by a higher number of lost time claims reported in the year as well as claims remaining on benefits for longer; and

• **TSS**: there were 5,108 weekly active claims in 2024/25, which is 11.9% higher than 2024/25. This is mainly driven by a higher number of lost time claims reported in the year but also claims remaining on benefits for longer to a lesser extent.

The observed trend of claims remaining on benefits for an increasing amount of time across all insurer sectors is due to a shift in claims mix towards mental health claims in recent years, which typically have lower return-to-work rates.

Projection for the 2025/26 financial year

The increasing trend for weekly active claims has continued over the year, which can be attributed to a higher number of lost time claims and longer claim durations and is expected to continue into the following year. The projected number of weekly active claims in the overall Scheme for the 2025/26 accident year is 14,878. This is 4.0% higher than the number of weekly active claims for the 2024/25 accident year. For licensed insurers, self-insurers and TSS, the projected 2025/26 weekly active claims are 4.8%, 10.9% and 1.9% higher respectively than the 2024/25 accident year.

5.4. Weekly Payments per Active Claim

Key Points

The weekly PPAC for 2024/25 was observed to be $10,441, 9.4% higher (in real terms) than 2023/24. TSS remains as the sector with the highest weekly PPAC of $14,249 in 2024/25) of the three sectors, whereas licensed insurers remain the lowest, with a PPAC of $8,344 in 2024/25).

The projections of weekly payments and active claims result in an implied weekly PPAC for 2025/26 of $9,854, which is 5.6% lower (in real terms) than 2024/25.

The modelled average claim size for weekly benefits is defined as the average payment per quarter per active claim. Figure 5.4 shows PPACs by financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also presented the PPAC for 2025/26 resulting from our projections of weekly payments and weekly active claims. All PPACs are shown in 30 June 2025 dollar values, so that real growth in PPACs can be assessed.

Figure 5.4: Weekly PPACs, by Financial Year ($, Jun-25 values)

Source data can be found in Appendix E.

The PPAC on the overall scheme level was $10,441 for the 2024/25 financial year, which was 9.4% higher in real terms than the PPAC for 2023/24. The experience by sector is discussed below:

• **Licensed insurer**, the PPAC for 2023/24 emerged at $8,344, which remained 11.6% higher than 2023/24 – PPAC values have been increasing since the 2020/21 accident year;

• **Self-insurers:** the PPAC for 2023/24 emerged at $8,014, which was an 18.3% reduction compared to 2023/24 – PPAC values increased significantly in 2022/23 but have reduced to historical levels over the 2024/25 financial year; and

• **TSS**: the PPAC for 2023/24 emerged at $14,249, which remained 7.3% higher than 2023/24 – PPAC values have increased significantly in 2021/22, with steady increases observed since then.

Projection for the 2025/26 financial year

Recent experience has been considered in the assumption setting process of the projections for the 2025/26 financial year, with the PPAC estimated to be $9,854, which is 5.6% lower in real terms compared to the PPAC for 2024/25. This reduction is primarily driven by the TSS, where a longer-term average was adopted given the relative stability observed in historical years.

5.5. Weekly Benefit Paid in Each Year

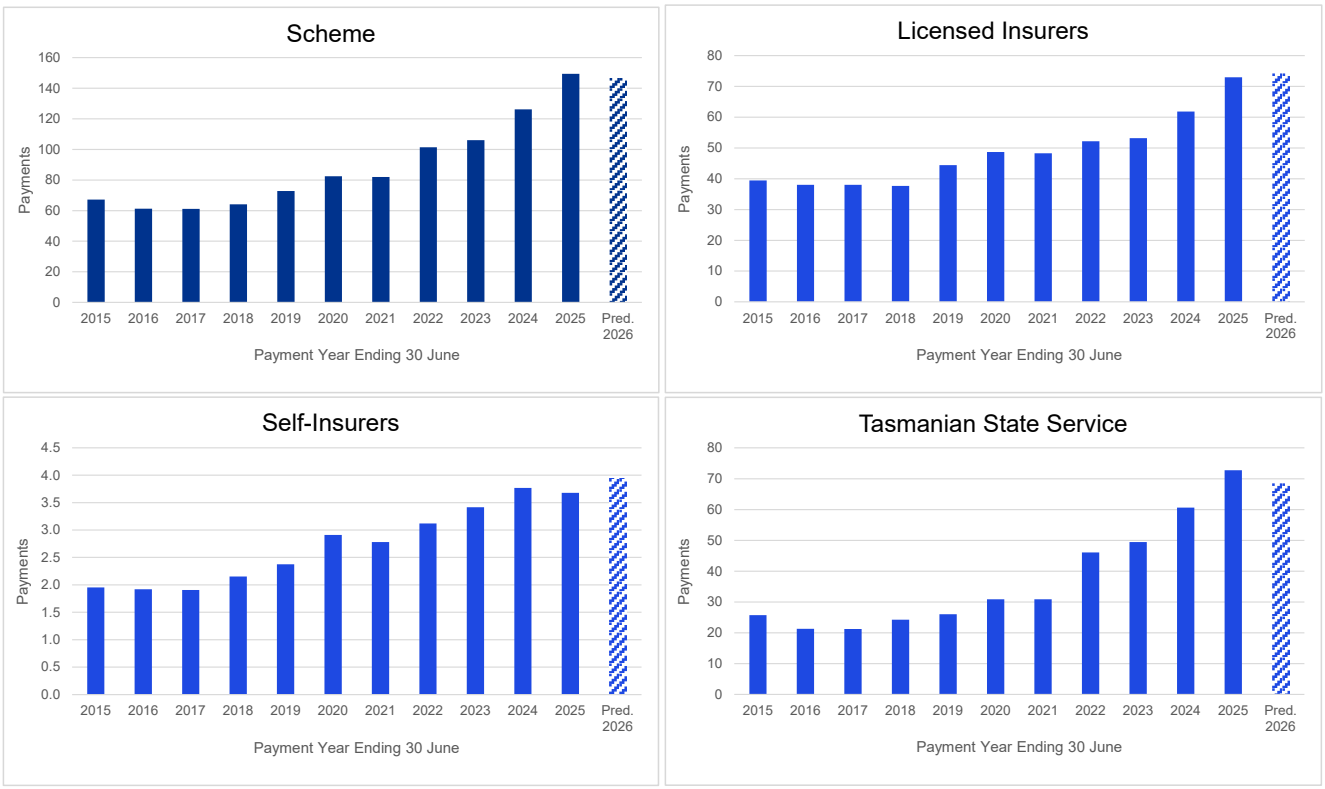
Key Points

The payments associated with weekly benefits grew by 18.4% in real terms from $126.2 million for the 2023/24 financial year to $149.4 million for financial year 2024/25. This growth in payments can be attributed to both an increasing number of active claims across all insurer segments and higher PPAC values for licensed insurers

and self-insurers. $146.6 million of weekly payments are projected to emerge in the 2025/26 financial year, which would be broadly consistent with 2024/25 in real terms.

Figure 5.5 presents the weekly payments by financial year at the overall Scheme level, as well as for each insurance sector individually. All payments shown are in 30 June 2025 dollar values, allowing for assessment of real growth in payments.

Figure 5.5: Weekly Benefit Payments, by Financial Year ($m, Jun-25 values)



Source data can be found in Appendix E.

Weekly payments for the overall Scheme increased by 18.4% in real terms from $126.2 million in the 2023/24 financial year to $149.4 million in the 2024/25 financial year. The experience by sector is discussed below:

• **Licensed insurers:** weekly payments increased by 18.0% in real terms from $61.8 million in the 2023/24 financial year to $73.0 million in the 2024/25 financial year;

• **Self-insurers**: weekly payments decreased by 2.4% in real terms from $3.8 million in the 2023/24 financial year to $3.7 million in the 2024/25 financial year; and

• **TSS**: weekly payments increased by 20.1% in real terms from $60.6 million in the 2023/24 financial year to $72.8 million in the 2024/25 financial year. The elevated payment levels were predominantly driven by the higher number of weekly actives and a higher number of lost time claims overall.

Deteriorating trends in the weekly benefit payments have continued to emerge as at 30 June 2025, with payments continuing to increase substantially, particularly for licensed insurers and TSS. Self-insurers payments have remained broadly consistent and have slightly reduced from the 2023/24 financial year levels. However, it remains too early to conclude that the trend has stabilised, with further deteriorations still expected in accordance with historic trends.

In Section 4.4.3 of this report, it was noted that deterioration of weekly payments in the TSS has been largely driven by mental health claims, where payment volumes increased from $17 million in 2021/22 to $51 million in 2024/25. By comparison, non-mental health claims experienced an increase from $14 million to $22 million in the same period.

Projection for the 2025/26 financial year

At the overall Scheme level, $146.6 million of weekly payments are projected for financial year 2025/26. In real terms, this remains broadly similar (1.9% lower) to the 2024/25 financial year. By segment, licensed insurers and self-

insurers are projected to experience a 1.7% and 6.8% growth in weekly payments respectively in the 2025/26 financial year. Meanwhile, TSS is projected to experience a 5.9% reduction in payments due to a slightly lower PPAC value.

6. Lump Sums

This section presents the key findings in relation to lump sums, including lump sum claim numbers, payments by lump sum category and average claim sizes.

Key Points

Scheme First Lump Sum Claim Numbers (by financial year)

The number of claims receiving a first lump sum has been steadily increasing since the 2021/22 financial year, with this trend continuing into 2024/25, whereby there were 599 claims that received a lump sum for the first time. This constitutes an 11% increase on first-time lump sum claims from 2023/24 and there are 577 claims projected to receive their first lump sum in the 2025/26 financial year.

Scheme Lump Sum Claim Numbers (by accident year)

The number of claims receiving a lump sum are also projected to increase on an accident year basis with higher projected ultimate claim numbers for periods post 2020/21, reflecting the increasing incidence of mental health claims and their higher propensity to claim a lump sum.

On an accident year basis, an ultimate number of 619 lump sum claims for the 2024/25 accident year is projected and an ultimate number of 631 lump sum claims for the 2025/26 accident year is projected.

Scheme Lump Sum category utilisation (by financial year)

Analysis of utilisation of each lump sum benefit category has suggested that redemption utilisation has increased slightly to 77% in the 2024/25 financial year from 76% in 2023/24. Of the remaining lump sum utilisation, 20% is in relation to permanent impairment payments with the remaining 2% being attributed to Common Law and Fatal Other payments.

Scheme Average Claim Size (by accident year)

The average lump sum claim size per claim that receives a lump sum is projected to be $194,000 for the 2023/24 accident year, which is 5.8% higher in real terms than 2023/24.

The selected lump sum average claim size for new accidents in the 2025/26 accident year is $190,248. This is 6.1% higher in real terms than what was selected at the Previous Scheme Review as the projected 2024/25 accident year claim size.

Scheme Lump Sum payments (by financial year)

Over the year, a substantial increase in lump sum payment volume was observed, from $97.8 million in the 2023/24 financial year to $123.9 million in the 2024/25 financial year. This significant growth is driven primarily by surges in the lump sum claim volumes from TSS, which saw payments increase from $35.8 million in the 2023/24 financial year to $55.4 million in the 2024/25 financial year.

We have projected $110.9 million of lump sum payments in 2025/26, which remains 10.5% lower than 2024/25 in real terms. The surge in lump sum utilisation over the year can be attributed strongly to the 2022 accident year, and there are signs that this may be due to a potential claims clean-up to clear processing volumes given the strong attachment to a particular year. This has been considered in the future projection of lump sum claims and payments.

6.1. Estimated Ultimate Lump Sum Claim Numbers

Key Points

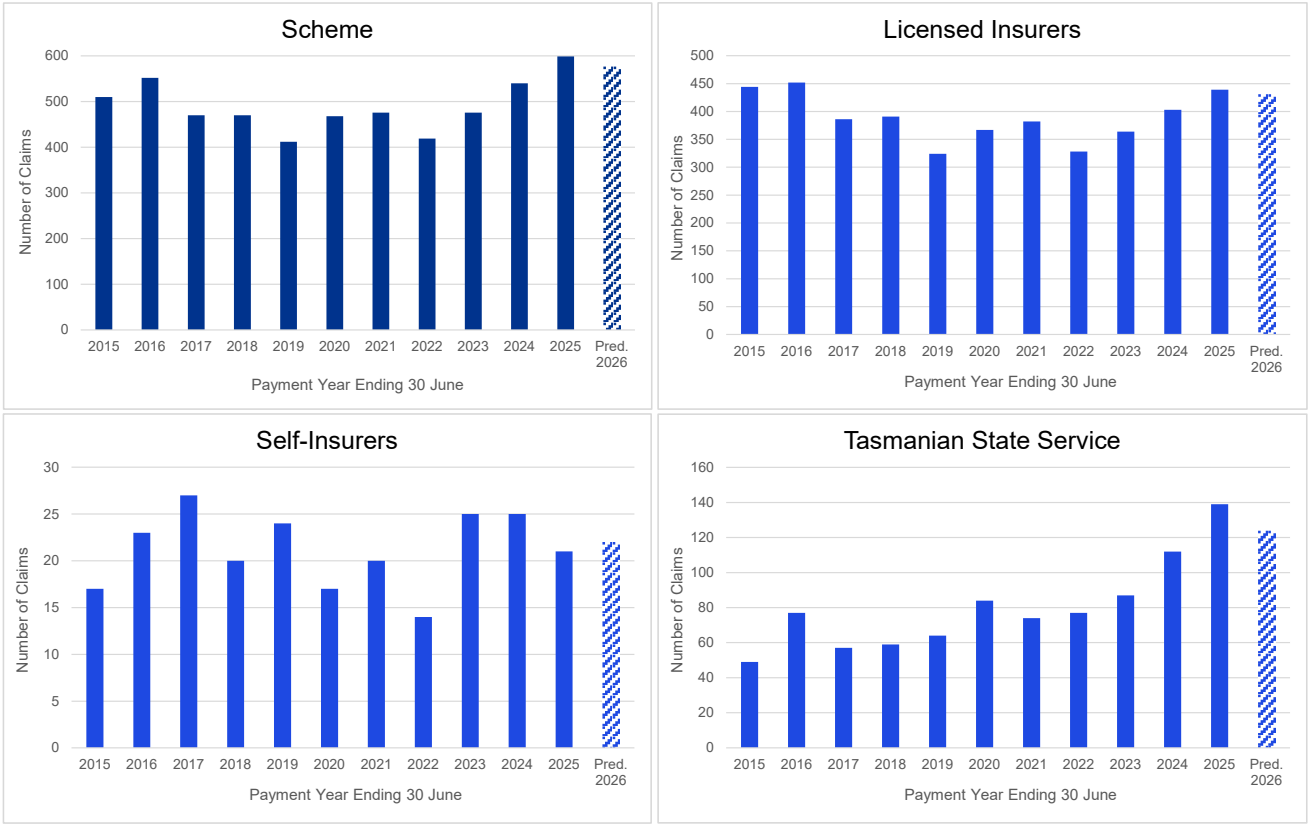
The number of claims receiving a first lump sum has been steadily increasing since the 2021/22 financial year, with this trend continuing into 2024/25, whereby there were 599 claims that received a lump sum for the first time.

This constitutes an 11% increase on first lump sum claims from 2023/24 and there are 577 claims projected to receive their first lump sum in the 2025/26 financial year.

The number of claims receiving a lump sum are also projected to increase on an accident year basis with higher projected ultimate claim numbers for periods post 2020/21, reflecting the increasing incidence of mental health claims and their higher propensity to claim a lump sum. On an accident year basis, an ultimate number of 619 lump sum claims for the 2024/25 accident year is projected and an ultimate number of 631 lump sum claims for the 2025/26 accident year is projected.

Figure 6.1 shows the number of claims at the overall Scheme level that received their first lump sum payment, by financial year. As such, any claimant that receives more than one lump sum payment is only counted once.

Figure 6.1: Number of Claims Receiving First Lump Sum, by Financial Year



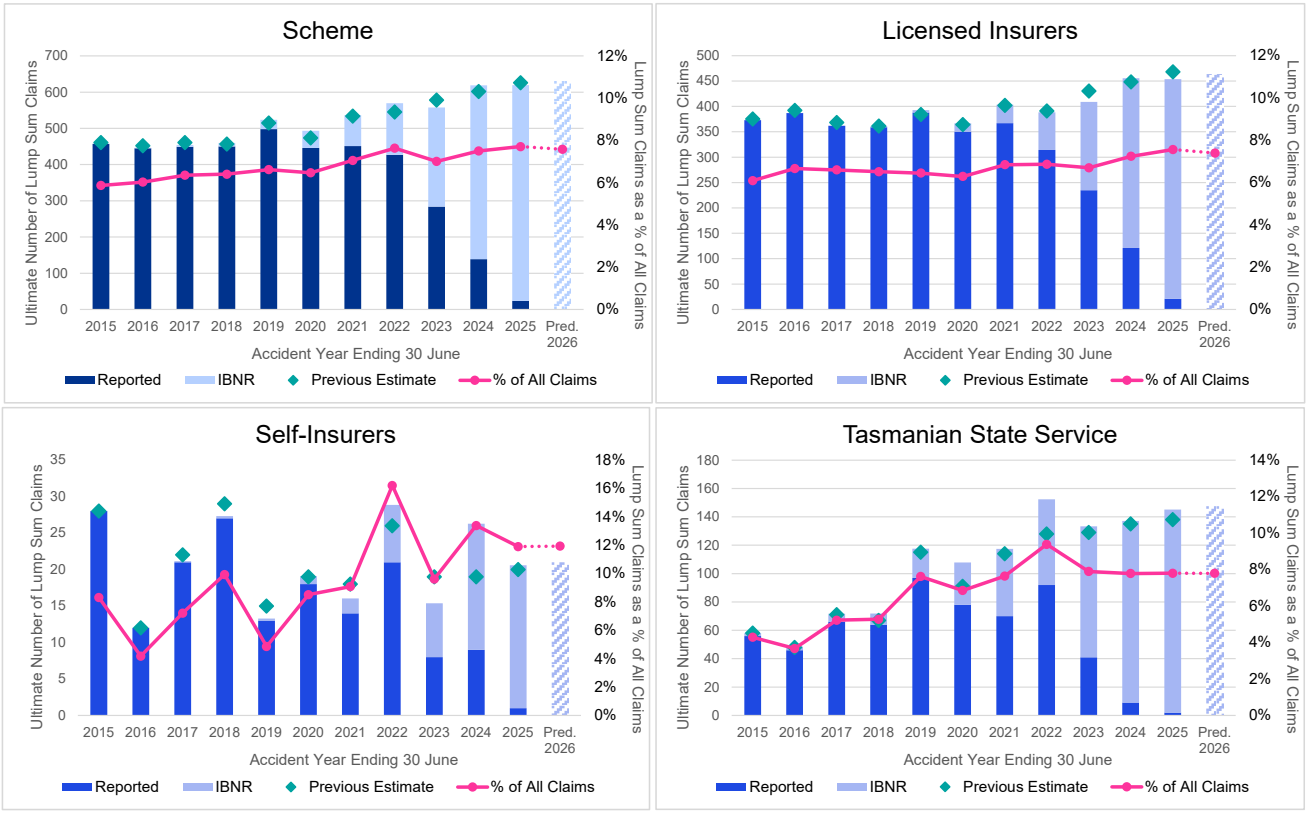
Source data can be found in Appendix E.

At the overall scheme level, the number of claims receiving a first lump sum payment has experienced strong growth over the last four years, primarily driven by the licensed insurer and TSS segments. In particular, growth in the first lump sum claim numbers for TSS in the 2024/25 financial year has been significant, with 139 claims receiving a first lump sum, compared to 112 in the preceding year. Of the 139 claims, 52 relate to the 2021/22 accident year. The high volumes attaching to one particular year may suggest that there may be some clean-up of claims alongside the deterioration observed in recent experience.

Self-insurer experience remains more volatile given the lower exposures, with a reduction in first lump sum claims in the 2024/25 financial year from 25 to 21.

Figure 6.2 shows estimated ultimate lump sum claim numbers by accident year for the overall Scheme level, as well as each insurance segment individually. This includes a projection of the number of lump sum claims that may emerge in respect of the 2025/26 accident year. We have also shown the estimated number of ultimate lump sum claims as proportions of the estimated ultimate number of total claims. Figure 6.2 also displays the estimates of lump sum claim ultimates at the Previous Scheme Review.

Figure 6.2: Ultimate Lump Sum Claim Numbers, by Accident Year



Source data can be found in Appendix E.

Ultimate lump sum claim numbers at the overall scheme level are projected to be 619 for the 2024/25 accident year, which is consistent with the number projected for the 2023/24 accident year and is 1.1% lower than the 626 claims projected from the previous scheme review. The claim numbers are projected to continue increasing on an accident year basis, reflecting the increasing incidence of mental health-related claims in recent accident periods and their higher propensity to attract a lump sum payment.

The experience by sector is discussed below:

- **Licensed insurers**: the ultimate number of lump sum claims for the 2024/25 accident year is projected to be 454. This is broadly consistent with the projected ultimate for 2023/24 and 3.1% lower than the projections for the 2024/25 year from the previous scheme review.
- **Self-insurers**: the ultimate number of lump sum claims for the 2024/25 accident year is projected to be 21. This is 21.7% lower than the projected ultimate for 2023/24 and 2.9% higher than the projections for the 2024/25 year from the previous scheme review. Volatility in self-insurer experience can be expected given the lower levels of exposure.
- **TSS**: the ultimate number of lump sum claims for the 2024/25 accident year is projected to be 145. This is 5.9% higher than the projected ultimate for 2023/24 and 5.2% higher than the projections for the 2024/25 year from the previous scheme review.

Across the licensed insurer and TSS, an increasing trend has been observed over time due to increase in proportion of mental health claims.

Projection for the 2025/26 accident year

At the overall scheme level, the ultimate number of lump sum claims for the 2024/25 accident year is 631 claims, which is 1.8% higher than the projected lump sum claim ultimate for the 2024/25 accident year. All three insurance sectors are projected to have a higher lump sum claim ultimate in accident year 2025/26 relative to 2024/25, with increases of 1.9% for licensed insurers, 2.0% for self-insurers and 1.6% for TSS. These projected figures reflect underlying trends in mental health claims.

6.2. Lump Sum Experience by Payment Category

Key Points

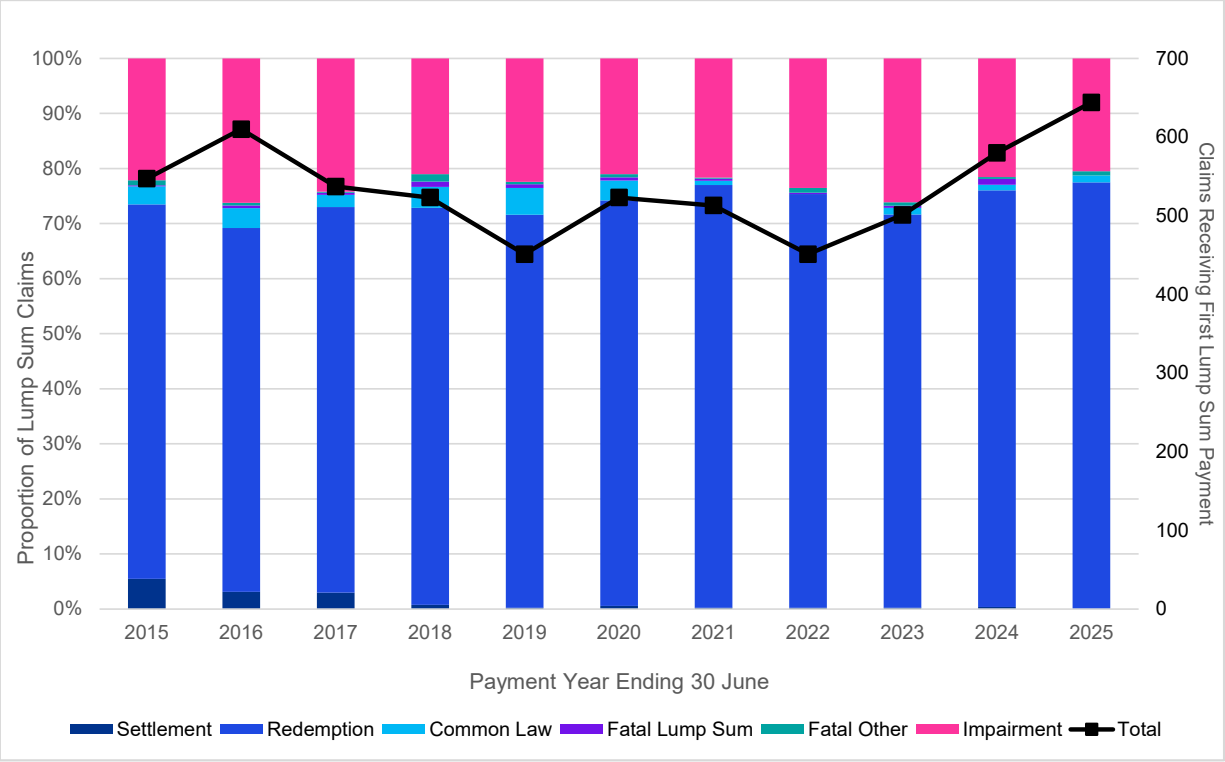
Redemptions and Impairments are the two main categories of lump sum payments, forming approximately 75% and 20% of total lump sum payments respectively. The proportion of redemption payments have increased over time, from 70% in the 2016/17 financial year to 78% in 2024/25.

The increase in lump sum payments and claim numbers over the 2024/25 financial year was primarily driven by an increase in the number of redemption payments. Whilst redemption payments were higher for all insurer sectors, the increasing trend was particularly strong for the TSS, where there was an increase of 33% in redemption payments, increasing from 101 payments in 2023/24 to 134 payments in 2024/25.

Figure 6.3[6] shows the number of claims in the overall Scheme level that received their first payment for each lump sum category, by financial year.

It should also be noted that claimants receiving an impairment benefit may still be entitled to pursue Common Law damages or redeem any remaining statutory benefits, but these entitlements may also be included in the impairment benefit in certain instances.

Figure 6.3: Proportion & Total Claims Receiving First Payment for Each Lump Sum Category, by Financial Year



Source data can be found in Appendix E.

The following observations are made based on the above graph:

• Growth in lump sum payments across the 2024/25 financial year were predominantly driven by an increase in the number of redemption payments. At the overall Scheme level, there were 499 claims that received a redemption payment in the year, the highest level observed to date. The trend of increasing redemption payments is particularly notable for the TSS, which observed a 33% increase in their redemption payments from 101 payments in 2023/24 to 134 payments in 2024/25.

[6] A lump sum claimant receiving payments under different categories is counted more than once, i.e., once in each category of payment. However, they will only be counted once for each category regardless of the number of payments they receive within each category.

• Claimants utilising the impairment benefit category have also increased over the 2024/25 financial year, from 125 to 132. This follows a period of lower utilisation of this benefit category from 2018 to 2022.

•Common law payments represented approximately 3-4% of lump sum utilisation across the 2015/16 to 2019/20 financial years. However, utilisation of Common Law has reduced in recent years, reducing to approximately 1% from FY21-FY25 on average. Despite low occurrences of Common Law claims, they typically settle at higher average costs compared to other categories given the complex legal and medical nature of these claims.

•Fatal payments continue to represent less than 1% of lump sum utilisation.

6.3. Lump Sum Payments per Lump Sum Claim Incurred

Key Points

At the overall scheme level, the average lump sum claim size per claim that receives a lump sum is projected to be $194,000 for the 2024/25 accident year, which is 5.8% higher in real terms than 2023/24. The selected lump sum average claim size for new accidents in the 2025/26 accident year is $190,248 – this is 3.8% higher in real terms than what was selected at the Previous Scheme Review as the projected 2024/25 accident year claim size.

The average lump sum cost per claim for claims that receive at least one lump sum benefit remains significantly higher for the TSS than for licensed insurers and self-insurers. A similar trend can be observed for the average lump sum cost based on all claims, with adverse emerging experience resulting in a large increase in average claim size for the TSS ($27,551), which is now clearly higher than self-insurers ($18,472) and licenser insurers ($10,331) in the 2024/25 accident year.

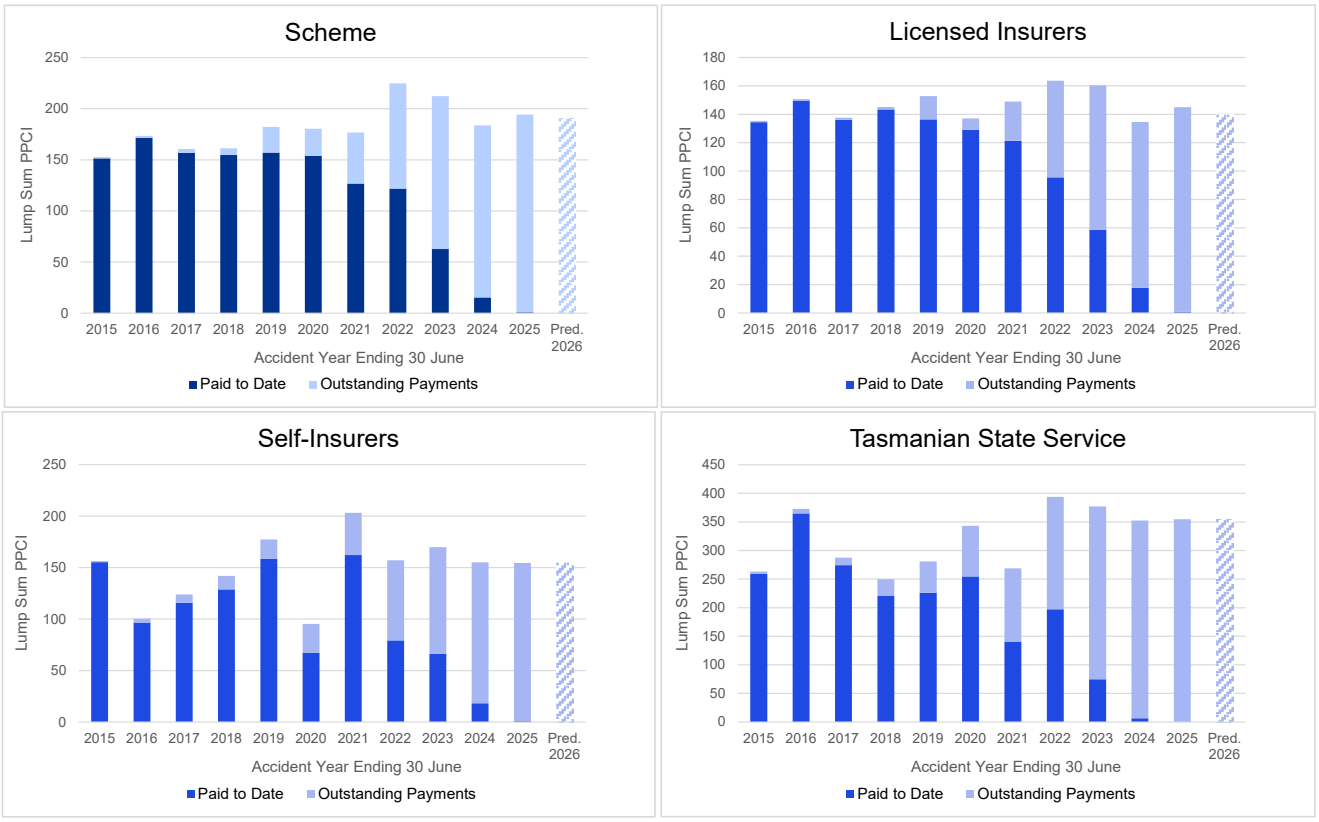
A Payments per Claim Incurred ("PPCI") model is used to estimate the ultimate cost of lump sum benefits, with further details found in Appendix B2. The PPCI approach projects lump sum benefits as a function of the ultimate number of lump sum claims for the relevant accident period. This assumes lump sum payments in any period are correlated to the ultimate number of claims that are expected to receive lump sum benefits.

Given lump sum claims can attract significant levels of payment, we have included a separate allowance for large claims, which have been defined as claims with $2 million of payments or case estimates. These lump sum claims have been separated out for licensed insurers only (given low volumes of such claims for self-insurers and TSS to form a statistically reliable estimate), with claim numbers and average claim size projected using longer-term averages. At this review, there were eight claims with a case estimate above of $2 million or higher, and nine claims where there have been lump sum payments of $2 million or higher.

Figure 6.4 shows our selected lump sum average claim sizes by accident year at the overall Scheme level, as well as for each insurance sector individually. The average claim sizes shown include both payments already made ("paid to date") and our projection of future payments ("outstanding payments"). The average claim sizes are referred to as PPCIs, given that they have been calculated by dividing the projected ultimate cost of lump sum benefits by the ultimate number of lump sum claims projected for the relevant accident year. All PPCIs shown are in 30 June 2025 dollar values, allowing for the assessment in real growth in the PPCIs.

We note that Figure 6.4 reflects our explicit allowance for large claim costs of large licensed insurer claims, both reported and IBNR.

Figure 6.4: Lump Sum PPCIs, by Accident Year ($'000, Jun-25 values)



Source data can be found in Appendix E.

At the overall Scheme level, average claim sizes for lump sum payments are projected to be $194,000 for the 2024/25 accident year, although it should be noted that payments have not yet materially emerged, comprising less than 1% of the PPCI amount for this accident year. The adopted PPCI value is 5.8% higher in real terms than our projection for the 2023/24 accident year. The experience by sector is discussed below:

• **Licensed insurers**: the average claim size for lump sums is projected to be $145,000 for the 2024/25 accident year, which is 7.7% higher in real terms than 2023/24;

• **Self-insurers**: the average claim size for lump sums is projected to be $155,000 for the 2024/25 accident year, which is consistent with 2023/24;

• **TSS:** the average claim size for lump sums is projected to be $355,000 for the 2024/25 accident year, which is 6.4% higher in real terms than 2023/24;

It is noted that on a payment year basis, the average claim size per lump sum claim for the Scheme has increased by 14% (in real terms) from $180,450 in 2023/24 to $206,225 in 2024/25.

Projection for the 2025/26 accident year

At the overall scheme level, the average lump sum claim size adopted for the future accident year 2025/26 is $190,248 in 30 June 2025 dollar values. This is 3.8% higher in real terms than what was selected for the new 2024/25 accident year at the Previous Scheme Review. The selected lump sum average claim sizes for each sector are as follows:

• **Licensed insurers**: Average lump sum claim sizes were projected to be $139,724, which is 6.4% lower in real terms with the selection for the future 2024/25 accident year at the Previous Scheme Review;

• **Self-insurers**: Average lump sum claim sizes were projected to be $154,841, which is 7.3% lower in real terms with the selection for the future 2024/25 accident year at the Previous Scheme Review;

• **TSS:** Average lump sum claim sizes were projected to be $353,668, which is 17.7% higher in real terms with the selection for the future 2024/25 accident year at the Previous Scheme Review;

The table below highlights the average cost of lump sum payments per claim that receives at least one lump sum benefit being much higher for the TSS than for licensed insurers and self-insurers.

Table 6.1: Adopted Lump Sum average Claim Sizes (ACS) for New Accidents ($, Jun-25 values)

	ACS based on lump sum claims			ACS based on all claims		
	Previous Review	Current Review	Change (%)	Previous Review	Current Review	Change (%)
Licensed Insurers	149,420	139,724	-6%	10,919	10,331	-5%
Self-Insurers	167,118	154,841	-7%	17,562	18,472	5%
Tasmanian State Service	300,418	353,668	18%	23,222	27,551	19%
Scheme	**183,246**	**190,248**	**4%**	**14,445**	**14,420**	**0%**

In the table above, the ACS based on all claims has remained broadly stable while the ACS based on lump sum claims has experienced an increase of 3.8%. The increases to the TSS ACS based on lump sum claims and all claims of 18% and 19% respectively have been largely offset by the slight reductions of the licensed insurers (which have been maintained to be in line with historical experience).

6.4. Lump Sums Paid in Each Year

Key Points

Over the year, lump sum payments has increased by 26.7%, from $97.8 million in 2023/24 to $123.9 million in 2024/25. This significant growth is driven primarily by a surge in the number of lump sum claims from TSS, thus payments increased from $35.8 million in 2023/24 to $55.4 million in 2024/25. Much of the TSS increase is attributed to mental health claims, which increased from $27 million in 2023/24 to $45 million in 2024/25, i.e., 67% increase.

We have projected $110.9m of lump sum payments in 2025/26, which remains 10.5% lower than 2024/25 in real terms. The surge in lump sum utilisation over the year can be attributed strongly to one accident year, specifically the 2021/22 accident year. This may be due to a deliberate activity to close claims.

Figure 6.5 shows lump sum payments by financial year for the overall Scheme level, as well as for each insurance sector individually. Payments have been split out into the lump sum payment categories that were shown in Section 6.2. We have also included a projection of the volume of lump sum payments that will be made in 2025/26 in aggregate. All amounts shown are in 30 June 2025 dollar values, allowing for an assessment of real growth in payments.

Figure 6.5: Lump Sum Payments, by Financial Year ($m, Jun-25 values)

Source data can be found in Appendix E.

Lump sum payments at the overall Scheme level increased significantly by 26.7% in real terms from $97.8 million in the 2023/24 financial year to $123.9 million in the 2024/25 financial year. The increasing trend emerging since 2021/22 has continued into 2024/25, with a notable increase in the most recent year with payments at the highest level in the past decade.

This experience is driven largely by the increase in lump sum claim numbers over the year in the TSS, coinciding with the continued shift in proportion towards mental health claims and also a potential clean-up of claims given the strong attachment to one particular accident year.

The experience by sector is discussed below:

- **Licensed insurers**: Lump sum payments increased by 11.0% in real terms from $58.5 million in 2023/24 to $64.9 million in 2024/25. There has been a gradual shift towards a higher proportion of mental health claims but a majority of payments made still relate to redemption payments to non-mental health claims.
- **Self-insurers**: Lump sum payments grew by 5.2% in real terms from $3.5 million in 2023/24 to $3.6 million in 2024/25. Similar to licensed insurers, there appears to be a shift towards a higher proportion of mental health claims over time, although experience has been more volatile given lower exposures in this cohort.; and
- **TSS**: Lump sum payments grew significantly by 54.4% in real terms from $35.8 million in 2023/24 to $55.4 million in 2024/25. This is the highest level of lump sum payments in the TSS over the past decade. As discussed in Section 4.4 the increase in TSS lump sum payments over the last year has been driven by mental health-related claims. In particular, there has been a 58% increase in the number of PTSD claims in 2024/25 compared to 2023/24 financial years, with these claims typically incurring high costs even amongst mental health claims due to the complexity of the condition. In total, mental health claims have contributed to 93% of the increase in lump sum payments (in real terms).

Projection for the 2025/26 financial year

At the overall Scheme level, lump sum payments are projected to be $110.9 million in financial year 2025/26, which is 10.5% lower than the 2024/25 financial year in real terms. As noted in earlier sections, the increase in 2024/25 lump sum payments have been concentrated within one accident year, indicating a deliberate activity to close claims . This leads to some uncertainty regarding whether the elevated claim payments will persist into the following year.

However, there remains potential upward pressure on lump sum payments due to the higher number of mental health-related claims reporting in the scheme and if claim volumes continue to increase according to recent years.

Historically, these claims are observed to have a higher propensity to be paid a lump sum, in particular, a redemption lump sum, compared to non-mental health claims.

The projection model splits out the modelling of large claims (with $2 million or more payments or case estimates) to allow for the incidence of larger claims and their case estimates, which would otherwise be unaccounted for (especially in more recent accident years) due to the adoption of payment-based methods and models.

7. Medical and Related Payments

This section presents the key findings in relation to medical and related payments, including payments by medical payment category and average claim sizes.

Key Points

Medical payments in the 2024/25 financial year were $86.6 million, which was a 26.0% increase compared to 2023/24 (in real terms). This was driven by unfavourable experience over the year and the re-classification of payments at the current review. $88.4 million of medical payments are projected in 2025/26, which is a 2.2% increase compared to 2024/25.

The average claim size of the medical component is projected to be $11,445 for the 2024/25 accident year, which is an 13.4% increase (in real terms) compared to 2023/24. The selected average claim size for the medical component related to new accidents in the 2025/26 accident year is $11,836, which is a 34.5% increase (in real terms) compared to the selection made at the Previous Scheme Review for the 2024/25 accident year.

7.1. Medical and Related Payments Paid in Each Year

Key Points

Medical payments in the 2024/25 financial year were $86.6 million, which was a 26.0% increase compared to 2023/24 (in real terms). This was driven by unfavourable experience over the year and the re-classification of payments at the current review. $88.4 million of medical payments are projected in 2025/26, which is a 2.2% increase compared to 2024/25.

Medical and related payments by financial year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 7.1. Payments have been split out into five payment categories (doctor, rehabilitation, hospital, other medical, and miscellaneous). A projection of the quantum of medical and related payments that are expected be made in 2025/26 are included, however this projection has not been separated into payment categories. All figures are in 30 June 2025 dollar values to ensure the real growth in payments can be assessed.

Figure 7.1: Medical and Related Payments, by Financial Year ($m, Jun-25 values)

Source data can be found in Appendix E.

In comparison to 2023/24, the medical and related payments for the overall Scheme have increased by 26% (in real terms) from $68.7 million to $86.6 million. The experience by sector is discussed below (in real terms):

- **Licensed insurers**: payments increased by 29.2%, from $46.5 million in 2023/24 to $60.2 million in 2024/25. This is driven by the other medical payments made to date due to a re-classification of payments, where independent medical reviews were previously considered under the legal payments category but are considered under the medical category for the current review following the implementation of NIDS v8.1;
- **Self-insurers**: payments decreased by 15.7%, from $3.2 million in 2023/24 to $2.7 million in 2024/25, remaining broadly consistent with longer-term average levels. Self-insurers had low levels of independent medical review payments observed to date, resulting in the absence of a significant increase similar to licensed insurers and TSS.
- **TSS**: payments increased by 25.1%, from $18.9 million in 2023/24 to $23.7 million in 2024/25. This is driven by the reclassification of independent medical review payments under the medical category, as described above.

Deterioration in real terms was observed to be limited across all insurance sectors and the growth in payments is largely attributable to the re-coding of independent medical reviews.

Projection for the 2025/26 accident year

$88.4 million of medical and related payments are projected for the overall Scheme in the 2025/26 financial year, which is a 2.2% increase compared to 2024/25 (in real terms). The projected increase is driven by increases projected across most sectors, with a projected increase of 2.8% for licensed insurers and 1.9% for the TSS. This is offset by a projected reduction of 10.4% for self-insurers. These projections have been set in accordance with experience following the NIDS v8.1 re-classification of independent medical reviews.

7.2. Medical and Related Payments per Claim Incurred

Key Points

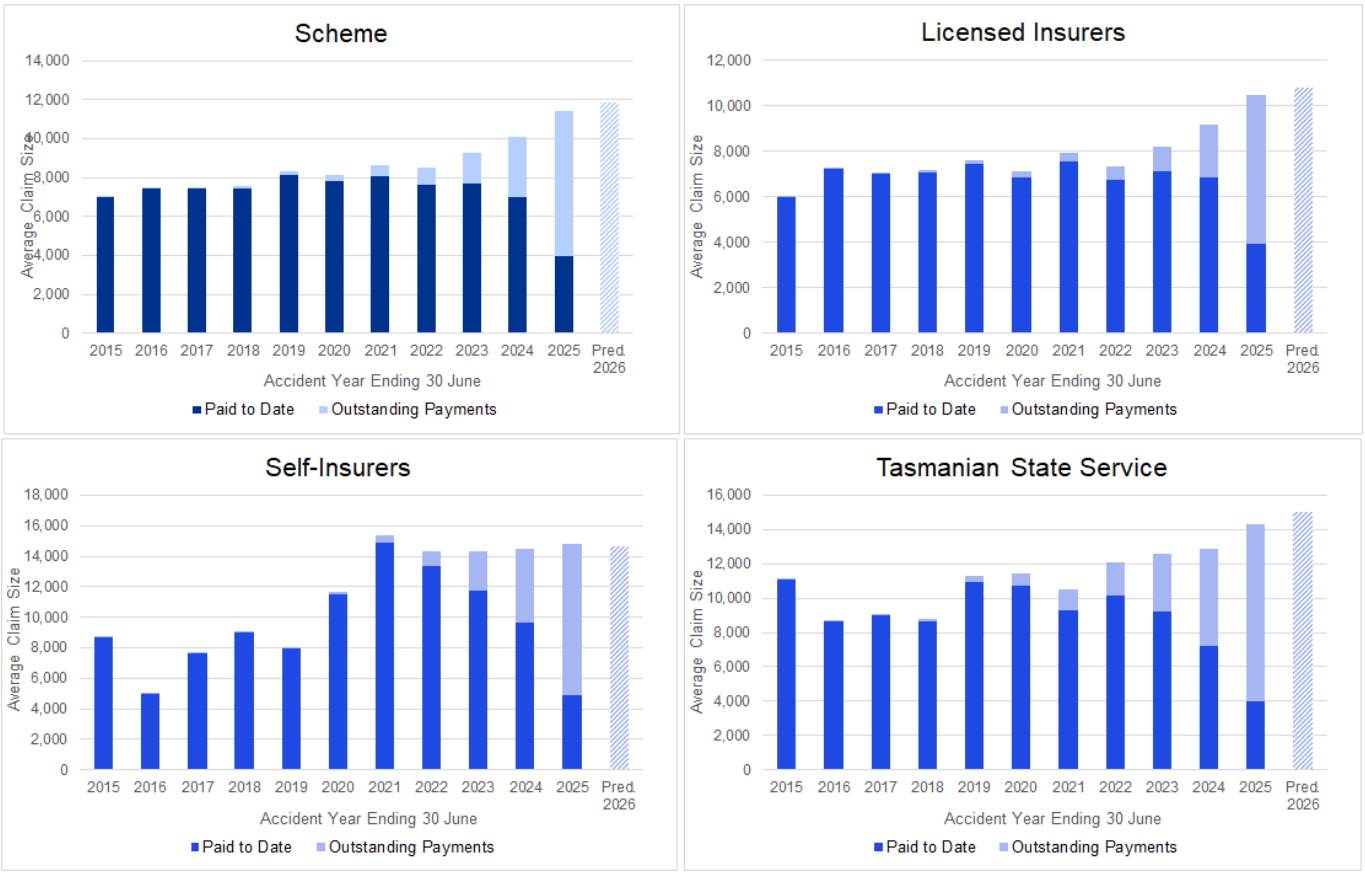
The average claim size of the medical component is projected to be $11,445 for the 2024/25 accident year, which is an 13.4% increase (in real terms) compared to 2024/25. The selected average claim size for the medical

component related to new 2025/26 accident year is $11,836, which is a 34.5% increase (in real terms) compared to the selection made at the Previous Scheme Review for the future 2024/25 accident year.

The Payments per Claim Incurred model is adopted to estimate the ultimate cost of medical and related benefits, which is outlined further in Appendix B.2. The PPCI approach projects medical and related payments as a function of the ultimate number of claims for the relevant accident period, which assumes medical and related payments in any period are correlated to the ultimate number of claims.

The selected medical average claim sizes by accident year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 7.2. The average claim sizes include both payments which have already been made ("paid to date") and the projected future payments ("outstanding payments"). The average claim sizes are referred to as PPCIs as they have been calculated by dividing the projected ultimate cost of medical and related benefits by the ultimate number of claims projected for the relevant accident year. All PPCIs are in 30 June 2025 dollar values to ensure the real growth in PPCIs can be assessed.

Figure 7.2: Medical PPCIs, by Accident Year ($, Jun-25 values)



Source data can be found in Appendix E.

The average claim size for the medical component of the overall Scheme is projected to be $11,445 (noting that payments to date represents 34.8% of this). This is an increase of 13.4% (in real terms) compared to the projection for 2023/24. The experience by sector is discussed below (in real terms):

- **Licensed insurers**: the average claim size for the medical component is projected to be $10,470 for 2024/25, which is a 14.0% increase compared to 2023/24. This increase is driven by an increase in the PPCI factor selections made in the earlier development quarters due to the reclassification of legal payments to medical, as described in Section 7.1;
- **Self-insurers**: the average claim size for the medical component is projected to be $14,782 for 2024/25, which is a 2.3% increase compared to 2023/24; and
- **TSS**: the average claim size for the medical component is projected to be $14,280 for 2024/25, which is an 11.1% increase compared to 2023/24. The increase was driven by the same factors as licensed insurers.

Projection for the 2025/26 accident year

The selected average claim size for the medical component of the new 2025/26 accident year is $11,836 (in 30 June 2025 dollar values), which is a 34.5% increase compared to the selection for the new accident year (2024/25) at the Previous Scheme Review. As discussed in Section 5.3, we have observed claimants are remaining on benefits for longer. We have also observed a corresponding increase in medical payments due to re-allocation of independent medical reviews from the legal benefit type to medical benefits following implementation of NIDS v8.1. As a result, we have increased our medical payment projections compared to the Previous Scheme Review to reflect this change. The average claim size selections for the medical component, by sector, are discussed below (in real terms):

- **Licensed insurers**: an average size of $10,800 is selected for new accidents, which is a 37.4% increase compared to the selection at the Previous Scheme Review;
- **Self-insurers**: an average size of $14,607 is selected for new accidents, which is a 7.7% decrease compared to the selection at the Previous Scheme Review; and
- **TSS**: an average size of $15,000 is selected for new accidents, which is a 31.3% increase compared to the selection at the Previous Scheme Review.

8. Legal and Investigation Payments

This section presents the key findings in relation to legal and investigation payments, including payments by category and average claim sizes.

Key Points

Legal and investigation costs in the 2024/25 financial year were $20.1 million of payments, which was a 21.8% reduction compared to 2023/24 (in real terms). This was driven by the re-classification of independent medical review payments at the current review (as discussed in Section 7). $15.9 million of payments for legal and investigation costs are projected in 2025/26, which is a 21.0% decrease compared to 2024/25.

The average claim size for legal and investigation costs is projected to be $2,007 for the 2024/25 accident year, which is a 21.7% decrease (in real terms) compared to 2023/24. The selected average claim size related to new accidents is $1,808, which is a 46.1% reduction (in real terms) compared to the selection made at the Previous Scheme Review. The significant reduction in the average claim size selection is driven by the re-classification of legal payments to medical at the current review.

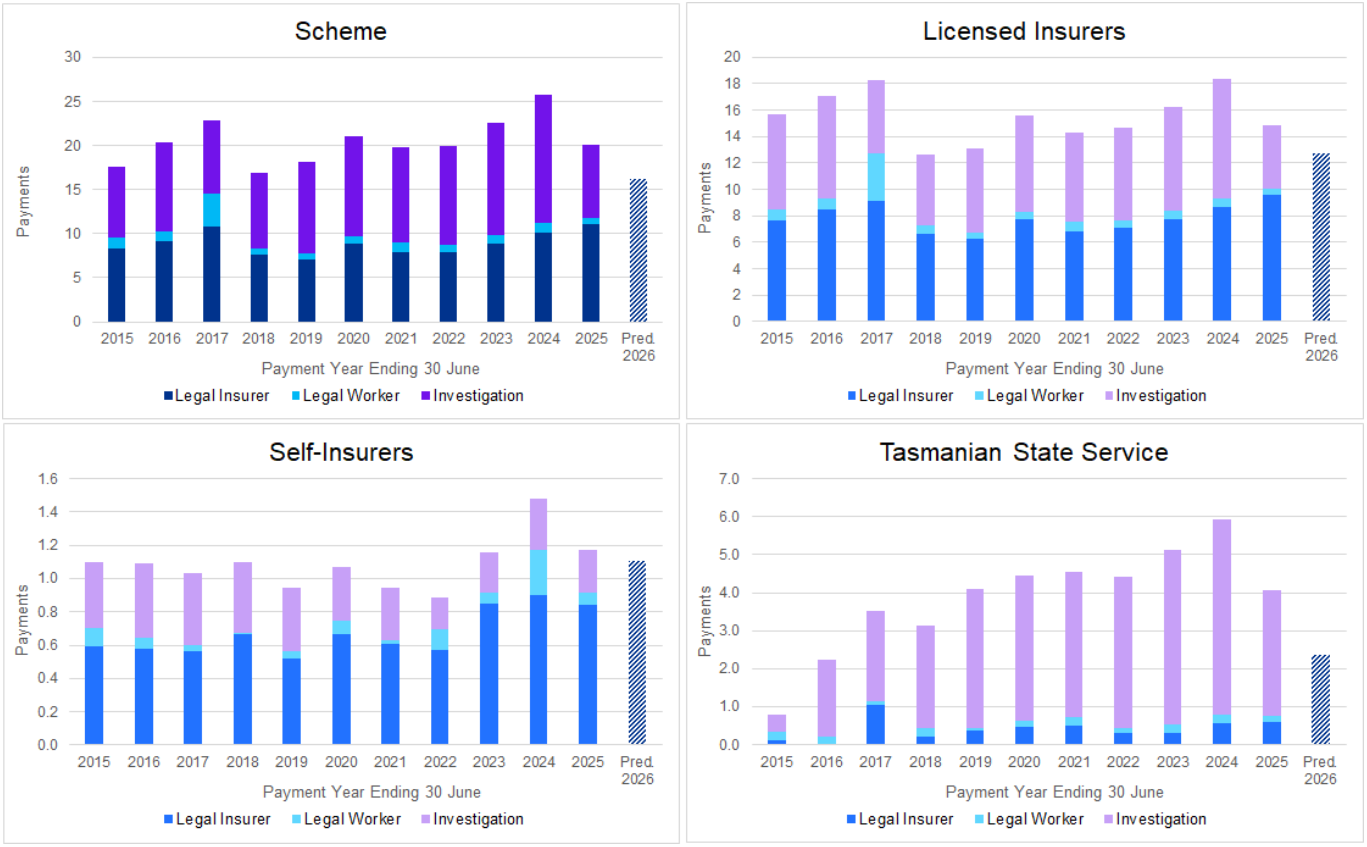
8.1. Legal and Investigation Payments Paid in Each Year

Key Points

Legal and investigation costs in the 2024/25 financial year were $20.1 million of payments, which was a 21.8% reduction compared to 2023/24 (in real terms). This was driven by the re-classification of independent medical review payments at the current review (as discussed in Section 7). $15.9 million of payments for legal and investigation costs are projected in 2025/26, which is a 21.0% decrease compared to 2024/25.

The payments for legal and investigation costs by financial year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 8.1. The payments have been separated into three payment categories (legal insurer, legal worker, and investigation). A projection of the quantum of legal and investigation payments that are expected be made in 2024/25 are included, however this projectionhas not been separated into payment categories. All figures are in 30 June 2025 dollar values to enable an assessment of the real growth in payments.

Figure 8.1: Legal and Investigation Payments, by Financial Year ($m, Jun-25 values)



Source data can be found in Appendix E.

In comparison to 2023/24, the legal and investigation payments for the overall Scheme decreased by 21.8% (in real terms) from $25.8 million to $20.1 million. This was driven by a 42.6% decrease for the legal worker payment category and a 42.1% decrease for the investigation category, which is offset by a 9.6% increase for the legal insurer category.

The experience by sector is discussed below (in real terms):

- **Licensed insurers**: payments have decreased by 18.9% from $18.4 million in 2023/24 to $14.9 million in 2024/25, with decreases observed across most payment categories, with the exception of legal insurer category;
- **Self-insurers**: payments have decreased by 20.5% from $1.5 million in 2023/24 to $1.2 million in 2024/25, with decreases observed across all payment categories, particularly the legal worker payment category; and
- **TSS**: payments have decreased by 31.3% from $5.9 million in 2023/24 to $4.1 million in 2024/25 after removing for independent medical reviews, with decreases observed across most payment categories, with the exception of legal insurer category.

In contrast to experience for licensed insurers and self-insurers, the vast majority of legal and investigation payments in the TSS are in respect of investigation costs. Reduction in payments can be largely attributed to the removal of payments relating to independent medical reviews from this category due to the introduction of NIDS v.8 (National Insurer Data Specifications), as detailed in Section 7.

Projection for the 2025/26 financial year

$15.9 million of payments for legal and investigation costs are projected for the overall Scheme in the 2025/26 financial year, which is a 21.0% decrease compared to 2024/25 (in real terms). The projected reduction is driven by projected decreases across most sectors, with a projected decrease of 42.8% for the TSS, 16.2% for licensed insurers, and 7.3% for self-insurers.

Consideration of the new levels of legal payments following the removal of independent medical reviews has been given in the setting of assumptions for modelling.

8.2. Legal and Investigation Payments per Claim Incurred

Key Points

The average claim size for legal and investigation costs is projected to be $2,007 for the 2024/25 accident year, which is a 21.7% decrease (in real terms) compared to 2023/24. The selected average claim size related to new accidents is $1,808, which is a 46.1% reduction (in real terms) compared to the selection made at the Previous Scheme Review. The significant reduction in the average claim size selection is driven by the re-classification of legal payments to medical at the current review.

The Payments per Claim Incurred model is adopted to estimate the ultimate cost of payments for legal and investigation costs, which is outlined further in Appendix B.2. The PPCI approach projects medical and related payments as a function of the ultimate number of claims for the relevant accident period, which assumes payments for legal and investigation costs in any period are correlated to the ultimate number of claims.

The selected average claim sizes for legal and investigation costs by accident year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 8.2. The average claim sizes include both payments which have already been made ("paid to date") and the projected future payments ("outstanding payments"). The average claim sizes are referred to as PPCIs as they have been calculated by dividing the projected ultimate cost of payments for legal and investigation costs by the ultimate number of claims projected for the relevant accident year. All PPCIs are in 30 June 2025 dollar values to ensure the real growth in PPCIs can be assessed.

Figure 8.2: Legal and Investigation PPCIs, by Accident Year ($, Jun-25 values)

Source data can be found in Appendix E.

The average claim size for the legal and investigation costs of the overall Scheme is projected to be $2,007 (noting that payments to date represents 25.2% of this). This is a reduction of 21.7% (in real terms) compared to the projection for 2023/24. The experience by sector is discussed below (in real terms):

- **Licensed insurers**: the average claim size for the legal and investigation costs is projected to be $2,087 for 2024/25, which is a 14.5% decrease compared to 2023/24. This decrease is driven by the reclassification of independent medical reviews from legal payments to medical, as described in Section 7.1;

- **Self-insurers**: the average claim size for the legal and investigation costs is projected to be $6,253 for 2024/25, which is a 9.8% decrease compared to 2023/24; and
- **TSS**: the average claim size for the legal and investigation costs is projected to be $1,355 for 2024/25, which is a 46.1% decrease compared to 2023/24. Similar to the factors driving the licensed insurer reduction, this decrease is driven by the reclassification of independent medical reviews from legal payments to medical payments.

Projection for the 2025/26 accident year

The selected average claim size for the medical component of the new 2025/26 accident year is $1,808 (in 30 June 2025 dollar values), which is a 46.1% reduction compared to the selection for the new accident year (2023/24) at the Previous Scheme Review. This significant reduction is driven by the reclassification of independent medical reviews were previously considered under the legal payments category but are considered under the medical category for the current review. The average claim size selections for the legal and investigation costs, by sector, are discussed below (in real terms):

- **Licensed insurers**: an average size of $1,950 is selected for new accidents, which is an 38.0% reduction compared to the selection at the Previous Scheme Review;
- **Self-insurers**: an average size of $6,000 is selected for new accidents, which is a 20.5% reduction compared to the selection at the Previous Scheme Review; and
- **TSS**: an average size of $950 is selected for new accidents, which is an 73.3% reduction compared to the selection at the Previous Scheme Review.

9. Ultimate Cost by Accident Year

The estimates of projected ultimate claims cost for each accident year are derived based on the payments to date and the estimates of outstanding payments. The following section presents a summary of the estimates of the projected ultimate claims cost.

Key Points

The inflated and undiscounted ultimate cost of accident year 2024/25 is projected to be $423.8 million which is an increase of $38.4 million (+10.0%) relative to our projection for the 2023/24 accident year, driven by the $22.4 million (+14.2%) increase for the TSS. The inflated and undiscounted ultimate cost for the new 2025/26 accident year is projected to be $457.6 million, which is 15.1% higher in real terms than the projection for the new accident year at the Previous Scheme Review.

The inflated and discounted ultimate cost of accident year 2024/25 is projected to be 2.02% of earned wages, which is higher than the 1.96% projected for 2023/24. The discounted ultimate cost for the new 2025/26 accident year is projected to be 2.10% of earned wages, which is higher than the 1.79% projected for the new accident year at the Previous Scheme Review.

As noted throughout the report, the increased projections for all insurer sectors reflects higher lost time claim volumes, claimants remaining on benefits for longer and the increasing prevalence of lump sum payments.

9.1. Ultimate Cost

Key Points

The inflated and undiscounted ultimate cost of accident year 2024/25 is projected to be $423.8 million which is an increase of $38.4 million (+10.0%) relative to our projection for 2023/24, driven by the $22.4 million (+14.2%) increase for the TSS.

The inflated and undiscounted ultimate cost for the new 2025/26 accident year is projected to be $457.6 million, which is 15.1% higher in real terms than the projection for the new accident year at the Previous Scheme Review.

The central estimate of gross ultimate costs by accident year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Table 9.1. The projection for the 2024/25 accident year is also included in the Table below. The ultimate costs are inflated to the date of each underlying payment. Both the undiscounted and discounted results are provided, with the latter discounted back to the middle of the respective accident years (to ensure a more like-for-like comparison with earned wages for that accident year can be considered in Section 9.2).

Table 9.1: Estimated Ultimate Claims Costs, by Accident Year Ending 30 June ($m)

Accident Year	Inflated & Undiscounted (IUD)				Inflated & Discounted (ID)			
	LI	*SI*	*TSS*	*Total*	*LI*	*SI*	*TSS*	*Total*
2014/15	101.5	8.9	42.9	153.3	97.1	8.3	40.3	145.7
2015/16	115.9	3.7	40.4	160.0	111.8	3.5	37.7	153.0
2016/17	110.3	6.8	49.1	166.2	106.6	6.4	46.1	159.1
2017/18	122.9	8.7	51.1	182.7	117.8	8.2	47.7	173.7
2018/19	146.8	6.8	84.7	238.3	140.2	6.5	79.2	226.0
2019/20	135.3	8.9	100.8	245.1	132.9	8.7	97.4	238.9
2020/21	159.5	9.9	93.8	263.2	158.7	9.7	92.5	261.0
2021/22	161.7	12.9	147.9	322.6	158.1	12.5	142.3	312.8
2022/23	190.7	9.4	152.5	352.6	177.4	8.6	136.2	322.2
2023/24	214.6	13.6	157.3	385.5	200.2	12.3	140.3	352.7
2024/25	231.2	12.9	179.7	423.8	214.7	11.5	158.8	385.1
2025/26 Predicted	250.4	13.8	193.4	457.6	234.8	12.5	173.1	420.4

Note: "LI" refers to licensed insurers, "SI" refers to self-insurers, "TSS" refers to the Tasmanian State Service and "Total" refers to the overall Scheme.

Undiscounted ultimate cost for the 2024/25 accident year

The undiscounted ultimate cost for the overall Scheme in the 2024/25 accident year is projected to be $ 423.8 million. This is a $38.4 million (+10.0%) increase compared to the projection for the 2023/24 accident year. The ultimate costs are increasing on an accident year basis to reflect the emerging payment and claim trends and the higher prevalence of mental health claims in more recent accident years. The experience by sector is discussed below:

- **Licensed insurers**: the undiscounted ultimate cost for the 2024/25 accident year is projected to be $231.2 million, which is a $16.7 million (+7.8%) increase compared to 2023/24. The ultimate cost for most payment categories has increased, except for legal payments. In particular, the increase is driven by medical (+13.4%) and lump sum payments (+11.9%);
- **Self-insurers**: the undiscounted ultimate cost for the 2024/25 accident year is projected to be $12.9 million, which is a $0.7 million (-5.0%) reduction compared to 2023/24. The ultimate cost for most payment categories has decreased, except for weekly payments. In particular, the reduction is driven by lump sum payments (-18.4%) and legal payments (-16.6%); and
- **TSS**: the undiscounted ultimate cost for the 2024/25 accident year is projected to be $179.7 million, which is a $22.4 million (+14.2%) increase compared to 2023/24. The ultimate cost for most payment categories has increased, except for legal payments. The increase is driven by medical (+22.2%), weekly (+17.3%) and lump sum payments (+11.0%).

Undiscounted ultimate cost for the 2025/26 accident year

The undiscounted ultimate cost for the overall Scheme in the new 2025/26 accident year is projected to be $457.6 million, which is a 15.1% increase (in real terms) compared to the projection for the new accident year (2024/25) at the Previous Scheme Review. Across all insurer sectors, the higher projections at this review compared to the Previous Scheme Review, is reflective of deterioration in costs per claim, from claimants remaining on benefits for longer and the increasing prevalence of lump sum payments, as well as growth in exposure as measured by wages. The projections by sector are discussed below (in real terms):

- **Licensed insurers**: the undiscounted ultimate cost is projected to be $250.4 million for the accident year 2025/26, which is a 15.1% increase compared to that projected for 2024/25 at the Previous Scheme Review. This has been driven by the selected licensed insurer average claim size for 2025/26 being 10.5% higher than the selection at the Previous Scheme Review for 2024/25 for reasons discussed above;
- **Self-insurers**: the undiscounted ultimate cost is projected to be $13.8 million for the accident year 2025/26, which is a 5.5% increase compared to that projected for 2024/25 at the Previous Scheme Review. This has been driven by the selected self-insurer average claim size for 2025/26 being 5.2% higher than the selection at the Previous Scheme Review for 2024/25 for reasons discussed above; and

- **TSS**: the undiscounted ultimate cost is projected to be $193.4 million for the accident year 2025/26, which is a 30.1% increase compared to that projected for 2024/25 at the Previous Scheme Review. This has been driven by the selected TSS average claim size for 2025/26 being 12.6% higher than the selection at the Previous Scheme Review for 2024/25 for reasons discussed above.

9.2. Ultimate Cost as a Percentage of Wages

Key Points

The inflated and discounted ultimate cost of accident year 2024/25 is projected to be 2.02% of earned wages, which is higher than the 1.96% projected for 2023/24. Ultimate costs for the overall Scheme for accident years 2019/20 to 2020/21 have increased by 5.3% and 5.0% (in real terms), respectively, compared to the Previous Scheme Review, whilst accident years 2021/22 to 2023/24 have increased ranging from 13.6% to 19.3%.

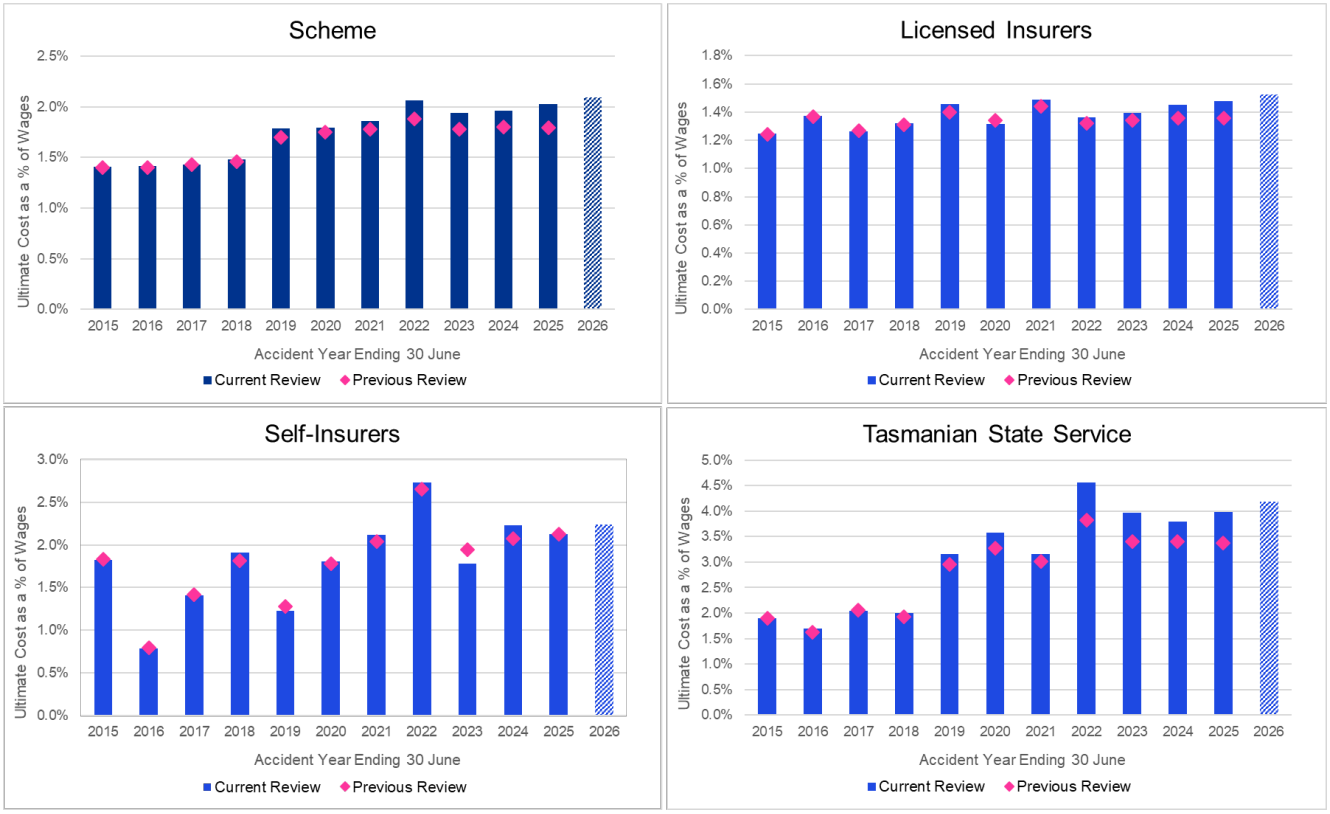
The discounted ultimate cost for the new 2025/26 accident year is projected to be 2.10% of earned wages, which is higher than the 1.79% projected for the new accident year at the Previous Scheme Review.

As noted throughout the report, the deteriorating experience across all sectors is a result of claimants remaining on benefits for longer (due to shift in mix towards mental health claims, particularly in the TSS) and the increasing prevalence of lump sum payments that subsequently emerge.

The ultimate cost as a percentage of wages by accident year for the overall Scheme, licensed insurers, self-insurers, and the TSS are shown in Figure 9.1. The projection for the 2024/25 accident year has also been included. Ultimate cost as a percentage of wages is derived by dividing the inflated and discounted ultimate claims costs (as per the 'ID' side of Table 9.1) for each accident year by the ultimate earned wages (in nominal values, i.e. not adjusted to be in 30 June 2025 dollar values) for the respective accident year. The figures from the Previous Scheme Review are on a discounted ultimate cost basis with expected wages from the Previous Scheme Review stated in nominal values.

In the absence of any underlying claim trends or legislative or behavioural changes, it is expected Figure 9.1 presents a relatively flat trend and the ultimate claim costs would move in line with wage inflation and workforce growth. The increased prevalence of mental health claims in more recent accident years as noted above is reflected in the higher ultimate claims cost by accident year, as well as our revised ultimate cost at the current review compared to the Previous Scheme Review.

Figure 9.1: Estimated Ultimate Claims Cost (Discounted) as a Percentage of Earned Wages



Source data can be found in Appendix E.

The following commentary is intended to draw out any differences by accident year and to illustrate the impact of changes in assumptions at the current review compared to the Previous Scheme Review. The figures outlined here are not on the same basis as the suggested premium rates. A comparison of the 2025/26 current implied suggested premium rates to the previous pricing review is outlined in Section 10.3.2.

Discounted ultimate cost as a percentage of wages for the 2024/25 accident year

The discounted ultimate cost for the overall Scheme in the 2024/25 accident year is projected to be 2.02% of earned wages, which is an increase compared to the 1.96% projected for 2023/24. The 3.3% increase is driven by a 9.2% increase in discounted ultimate cost (numerator), which is a relatively larger increase compared to the 5.7% increase in earned wages (denominator). The experience by sector is discussed below:

- **Licensed insurers**: the discounted ultimate cost of the 2024/25 accident year is projected to be 1.48% of earned wages, which is higher than the 1.45% projected for 2023/24. The 1.7% increase is driven by a 7.3% increase in discounted ultimate cost which is a relatively larger increase compared to the 5.4% increase in earned wages;
- **Self-insurers**: the discounted ultimate cost of the 2024/25 accident year is projected to be 2.13% of earned wages, which is lower than the 2.24% projected for 2023/24. The 4.9% reduction is driven by a 5.9% reduction in discounted ultimate cost which is a relatively larger reduction compared to the 1.0% reduction in earned wages; and
- **TSS**: the discounted ultimate cost of the 2024/25 accident year is projected to be 3.99% of earned wages, which is higher than the 3.80% projected for 2023/24. The 4.9% increase is driven by a 13.2% increase in discounted ultimate cost which is a relatively larger increase compared to the 7.9% increase in earned wages.

All sectors have observed large movements in ultimate cost estimates between the previous and current review. Ultimate costs for the overall Scheme for accident years 2019/20 to 2020/21 have decreased by 5.3% and 5.0% (in real terms), respectively, compared to the Previous Scheme Review, whilst accident years 2021/22 to 2023/24 have observed increases ranging from 13.6% to 18.1%. As noted throughout the report, the deteriorating experience across all sectors is a result of claimants remaining on benefits for longer (due to shift in mix towards mental health claims, particularly in the TSS) and the increasing prevalence of lump sum payments that subsequently emerge. These trends are more evident in the accident periods post 2020/21.

Discounted ultimate cost for new accidents as a percentage of wages for the 2025/26 accident year

The discounted ultimate cost for the new 2025/26 accident year is projected to be 2.10% of earned wages, which is higher than the 1.79% projected for the new accident year at the Previous Scheme Review. The 17.2% increase is driven by a 22.1% increase in discounted ultimate cost which is a relatively larger increase compared to the 4.0% increase in earned wages. The projections by sector are discussed below (in real terms):

- **Licensed insurers**: the discounted ultimate cost is projected to be 1.52% of earned wages, which is higher than the 1.36% projected for 2024/25 at the Previous Scheme Review. This is due to a 17.0% increase in discounted ultimate cost which is a relatively larger increase compared to the 4.2% increase in earned wages;
- **Self-insurers**: the discounted ultimate cost is projected to be 2.24% of earned wages, which is higher than the 2.13% projected for 2024/25 at the Previous Scheme Review. This is due to a 6.5% increase in discounted ultimate cost which is a relatively larger increase compared to the 1.0% increase in earned wages; and
- **TSS**: the discounted ultimate cost is projected to be 4.25% of earned wages, which is higher than the 3.37% projected for 2024/25 at the Previous Scheme Review. This is due to a 31.3% increase in discounted ultimate cost which is a relatively larger increase compared to the 4.0% increase in earned wages.

As noted throughout the report, the higher projections at the current review are reflective of the deterioration in costs per claim from claimants remaining on benefits for longer and the increasing prevalence of lump sum payments.

10. Licensed Insurer Experience

This section presents information in relation to licensed insurers, including the number of policies written, earned premiums, premium rates, profitability levels, and a comparison of the estimates to insurers' case estimates and IBN(E)R reserves.

Key Points

The estimated total number of policies written in 2024/25 is around 20,450. The projection of total number of policies written in 2025/26 is approximately 20,924 (a 2.3% increase from 2024/25).

Earned premiums are estimated to be $333.6 million for 2024/25, which is 9.9% higher than 2023/24. Our projection of earned premiums for 2025/26 is $351.6 million, which would be 5.4% higher than 2024/25. This 5.4% increase is driven by our projection of 6.0% growth in earned wages (in nominal values).

The achieved premium rate for accident year 2024/25 is projected to be 2.30%, which is 0.09 percentage points higher than our projection for 2023/24 (2.21%).

The risk premium rate suggested at this review for the 2025/26 accident year (1.37%) is slightly lower than the rate suggested at the Previous Pricing Review for the 2025/26 underwriting year (1.38%%). This has been driven by a slight reduction in the risk premium pool. The lower suggested risk premium rate has also resulted in a lower overall suggested premium rate.

Projected profitability for accident year 2024/25 is 16% which is consistent with 2023/24, due to a small reduction in the loss ratio (from 66% for 2023/24 to 64% for 2024/25), offset by a small increase in the expense ratio (from 18% in 2023/24 to 20% in 2024/25). As mentioned earlier, we stress that profitability results are particularly uncertain for recent accident years, given the relatively small proportion of projected ultimate claims costs that has been paid to date.

The sum of licensed insurers' case estimates and IBN(E)R reserves (as sourced from the End of Financial Year Reconciliations) is $412.4 million, which is $17.7 million (+4%) higher than our central estimate of $394.7 million for the outstanding claims liability.

We note that licensed insurers are also required by the Australian Prudential Regulation Authority to hold a risk margin in addition to their central estimate. Therefore the Scheme Review indicates licensed insurers, at an aggregate level, are adequately reserved.

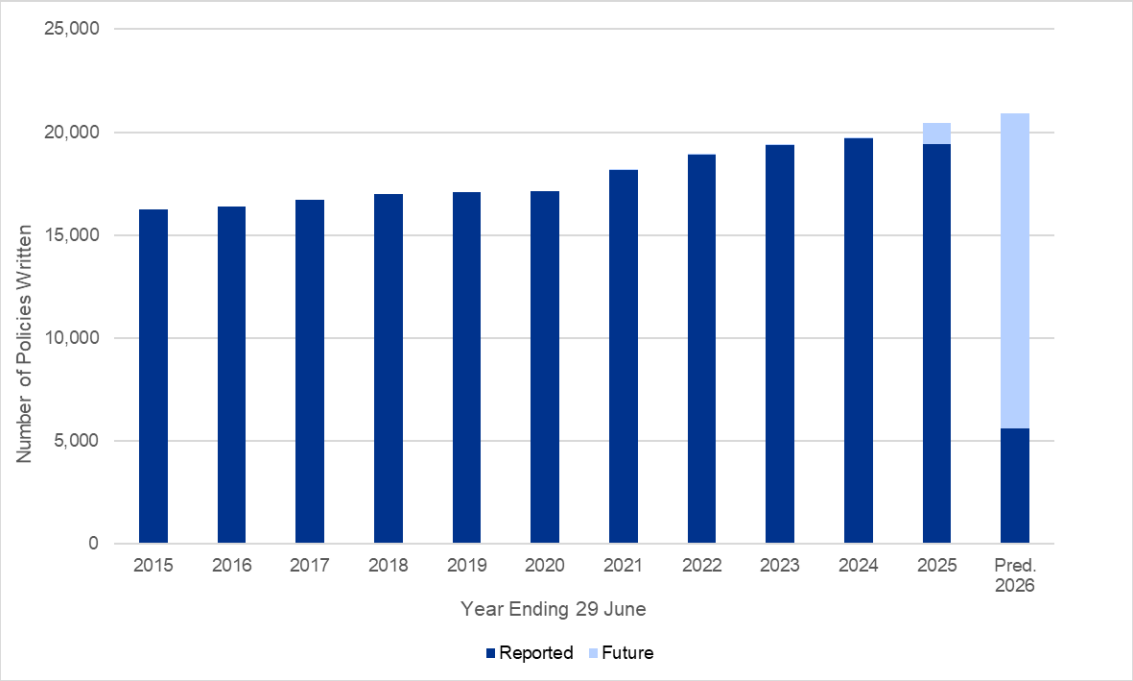
10.1. Number of Policies Written

Key Points

The estimated total number of policies written in 2024/25 is around 20,500. The projection of total number of policies written in 2025/26 is approximately 21,000 (a 2.5% increase from 2024/25).

Figure 10.1 shows the number of policies written by licensed insurers for each year ending 29 June, split by reported policies as at the data extraction date and projected future policies. We note that Figure 10.1 shows policy counts, and this differs to the number of employers covered.

Figure 10.1: Number of Policies Written by Licensed Insurers, by Year Ending 29 June



Source data can be found in Appendix E.

Between 2015/16 and 2019/20, the year-on-year growth rate in the number of policies written ranged between 0.2% and 2.0% and an average of 1.1% per annum. The number of policies written in 2020/21 was 6.1% higher than 2019/20 – however, this was driven by one insurer responding to the underwriting uncertainties associated with COVID-19, by writing more policies in early 2020/21 as short-term policies. This insurer has since reverted back to standard practice in 2021/22 and thereafter.

The estimated number of written policies has increased by 3.7% in the past year – from 19,724 in 2023/24 to 20,450 in 2024/25. The projected number of written policies for 2025/26 is 20,924 – this is 2.3% higher than that of 2024/25. We note that there is considerable uncertainty in projecting the number of policies written for the incomplete 2025/26 year.

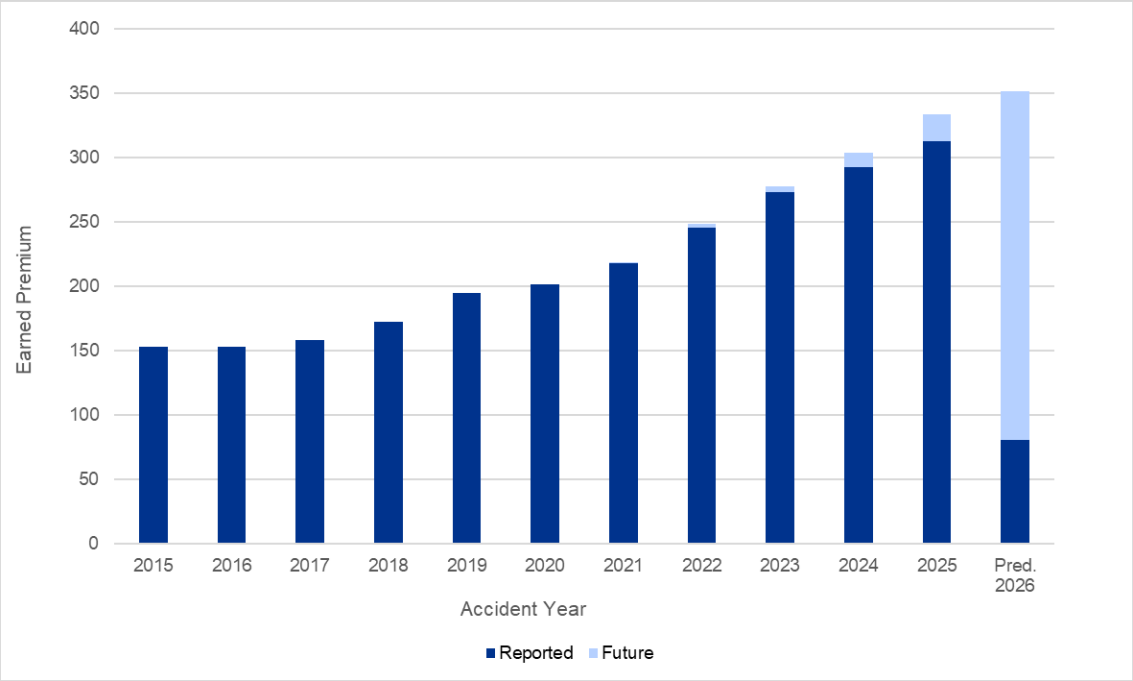
10.2. Earned Premiums

Key Points

Earned premiums are estimated to be $333.6 million for 2024/25, which is 9.9% higher than 2023/24. Our projection of earned premiums for 2025/26 is $351.6 million, which would be 5.4% higher than 2024/25. This 5.4% increase is driven by our projection of 6.0% growth in earned wages (in nominal values).

Figure 10.2 shows earned premiums for licensed insurers by accident year, split by reported premium as at the data extraction date and projected future premium receipts. Figures are expressed in nominal values, i.e. have not been adjusted to be in 30 June 2025 dollar values.

Figure 10.2: Earned Premiums for Licensed Insurers, by Accident Year ($m)



Source data can be found in Appendix E.

Earned premiums for accident year 2024/25 are estimated to be $333.6 million, which is $29.9 million (+9.9%) higher than our estimate for 2023/24. We project $351.6 million of earned premiums for accident year 2025/26, which would be $18.1 million (+5.4%) higher than our estimate for 2024/25. Our projection of earned premiums for 2024/25 is based on our estimates of:

- earned wages (in nominal values), which we have projected to grow by 6.0% between 2024/25 ($14.5 billion) and 2025/26 ($15.4 billion);
- achieved earned premium rates, which we estimate to be 2.28% in 2025/26 (as will be discussed in Section 10.3.1).

10.3. Premium Rates

Key Points

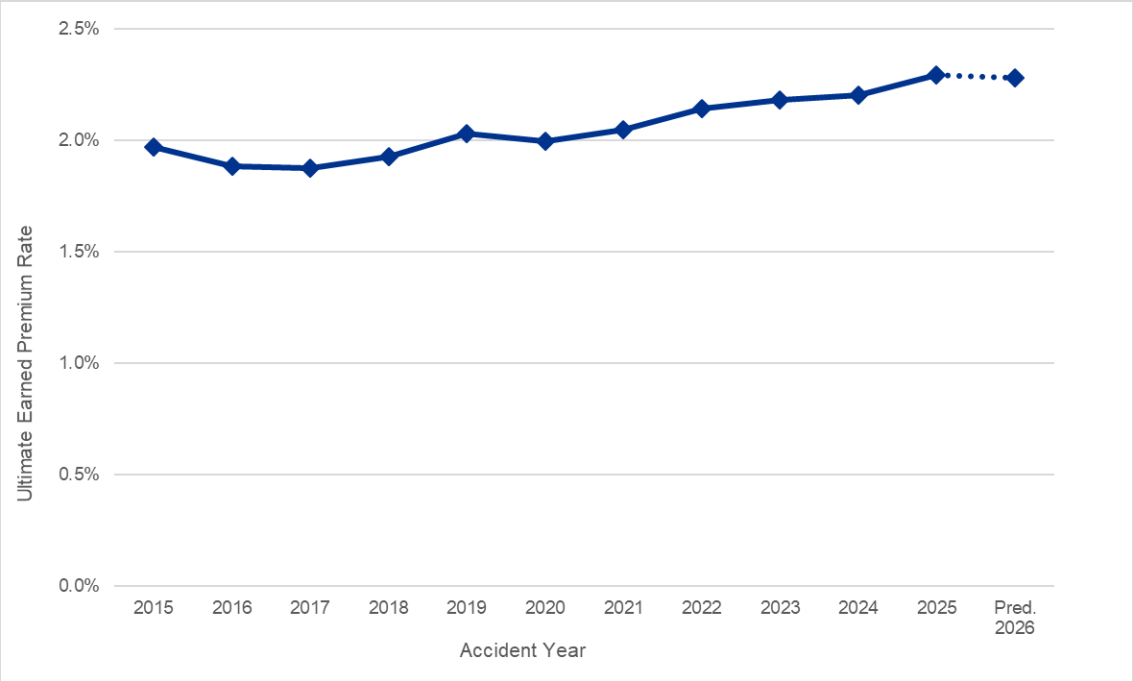
The achieved premium rate for accident year 2024/25 is projected to be 2.30%, which is 0.09 percentage points higher than our projection for 2023/24 (2.21%).

The risk premium rate suggested at this review for the 2025/26 accident year (1.37%) is slightly lower than the rate suggested at the Previous Pricing Review for the 2025/26 underwriting year (1.38%%). This has been driven by a slight reduction in the risk premium pool. The lower suggested risk premium rate has also resulted in a lower overall suggested premium rate.

10.3.1. Achieved Premium Rates

Figure 10.3 shows earned premium rates achieved by licensed insurers for each accident year. The achieved premium rates shown have been calculated by dividing earned premiums for each accident year (as per what is shown in Section 10.2) by earned wages. The earned premiums and wages figures relied on are both in nominal values, i.e. have not been adjusted to be in 30 June 2025 dollar values. We note that Figure 10.3 shows ultimate premium rates, i.e. it allows for our projection of remaining future development in earned premiums and wages.

Figure 10.3: Achieved Earned Premium Rates for Licensed Insurers, by Accident Year



Source data can be found in Appendix E.

For the period from 2014/15 to 2019/20, achieved premium rates have ranged between 1.88% and 2.03%. Between 2019/20 and 2024/25, achieved premium rates have increased year-on-year by increments of on average, 0.06 percentage points.

The achieved earned premium rate for accident year 2024/25 is projected to be 2.30%, which is 0.09 percentage points higher than our projection for 2023/24 (2.21%). Assuming insurers continue to write premiums at a rate which is broadly consistent with that observed in 2024/25, the earned premium rate for 2025/26 is estimated to be 2.28%.

We note that our projections of ultimate achieved premium rates is subject to uncertainty about the extent of remaining development, especially for accident years 2024/25 and 2025/26 which are both particularly underdeveloped.

10.3.2. Implications of Scheme Review Results for Suggested Premium Rates

Table 10.1 shows key results relating to suggested industry premium rates for 2025/26.

The “Pricing Review” column of Table 10.1 relates to projections of written figures for the 2025/26 underwriting year, as per what was provided in the Previous Pricing Review. The Previous Pricing Review was based on data to 31 December 2024, and the findings of this review was documented in our report “Suggested Industry Premium Rates for 2024/25”, dated 6 May 2025.

The “Scheme Review” column of Table 10.1 shows our forecasts of earned figures for the 2024/25 accident year, with this being based on data to 30 June 2025. The $237.2 million projection for the risk premium pool is stated on the same basis as the figures from the pricing review. Given the below summary is for illustrative purposes, we have assumed for “Scheme Review” that the ratio between risk premium, expense loading and insurer margin is consistent with “Pricing Review”.

Table 10.1: Suggested Premium Rates for 2025/26

Premium Rate Component ($m)	Pricing Review	Scheme Review
Risk premium pool	238.6	237.2
Expense Loading	70.6	70.2
Insurer margin	46.2	45.9
Total premium pool	**355.4**	**353.4**
Wages	17,258	17,258
Average risk premium (% wages)	**1.38%**	**1.37%**
Average premium rate (% wages)	**2.06%**	**2.05%**

The risk premium rate suggested at this review (1.37%) is broadly consistent with the rate suggested at the Previous Pricing Review for the 2025/26 underwriting year (1.38%). This reflects lower estimated claim numbers for 2025/26, offset by increases in adopted average claim sizes.

It should be noted that the average risk premium rate has increased from the previous Scheme review, where it was stated to be 1.30%. This increase is driven by the strengthening in ultimate costs as observed in section 9.1 and is driven by higher lost time claim volumes, claimants remaining on benefits for longer and the increasing prevalence of lump sum payments.

The lower suggested risk premium rate has also resulted in a lower overall suggested premium rate.

10.4. Profitability

Key Points

Projected profitability for accident year 2024/25 is 16% which is consistent with the 2023/24 accident year, due to a small reduction in the loss ratio (from 66% for 2023/24 to 64% for 2024/25), offset by a small increase in the expense ratio (from 18% in 2023/24 to 20% in 2024/25). As mentioned earlier, we stress that profitability results are particularly uncertain for recent accident years, given the relatively small proportion of projected ultimate claims costs that has been paid to date.

Table 10.2 shows our estimates of licensed insurer profitability for each accident year. In order to estimate profitability, we have calculated the following for each accident year:

- Loss ratio: This is calculated by dividing our estimate of discounted ultimate cost (net of employer excess for accident periods where the excess applied) for the licensed insurer sector, by earned premium for the respective accident year. Ultimate costs have been discounted to the middle of the relevant accident year.
- Expense ratio: First, we determine actual expenses (including administrative expenses, commissions and brokerage, levies and net cost of reinsurance) for all licensed insurers for each financial year, as per what has been reported by insurers in the End of Financial Year Reconciliations. This is then divided by earned premium for the respective accident year, to calculate expense ratio.

The combined ratio is the sum of the loss and expense ratios and, hence, profit margin is calculated as 100% less the combined ratio. Accordingly, a combined ratio of less (or more) than 100% indicates a profit (or loss). We note that profitability results for recent accident years are preliminary (particularly, for 2024/25) and may change as experience develops. Also, loss and expense ratios (and, by extension, profit margins) will vary between individual licensed insurers.

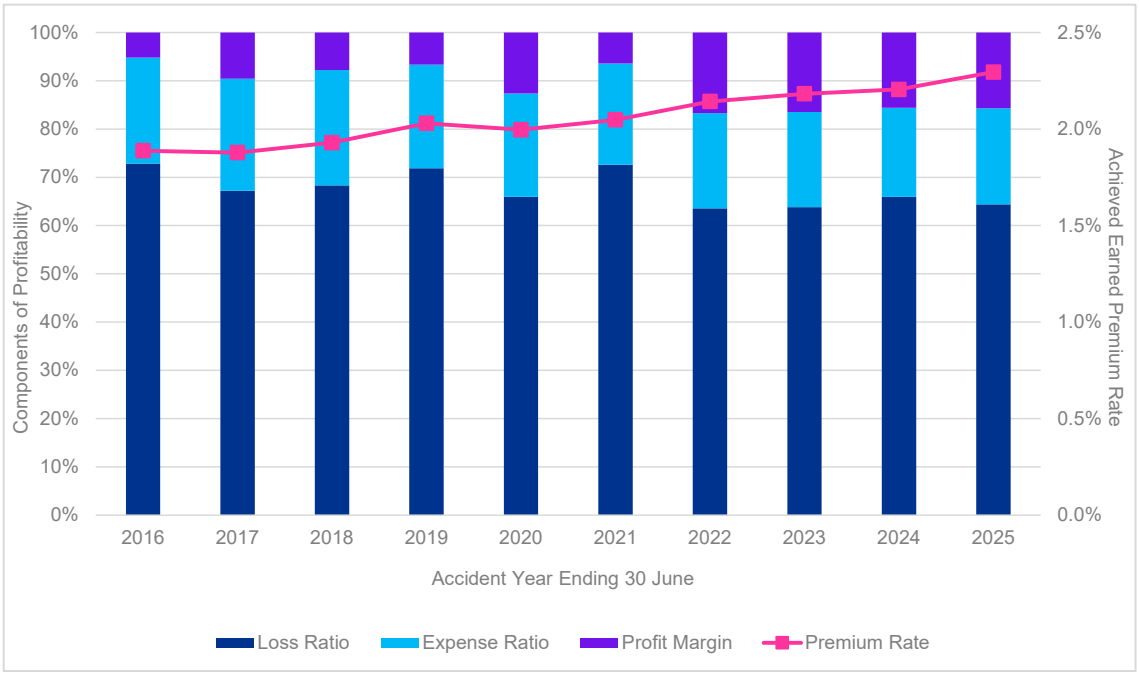
Table 10.2: Licensed Insurer Profitability, by Accident Year Ending 30 June (Jun-25 values)

Accident Year	Ultimate Claims Cost[1] ($m)	Expenses[2] ($m)	Earned Premium[3] ($m)	Loss Ratio (%)	Expense Ratio (%)	Profit Margin (%)
2016	111.8	33.8	153.5	73%	22%	5%
2017	106.6	36.8	158.6	67%	23%	10%
2018	117.8	41.2	172.4	68%	24%	8%
2019	140.2	41.9	195.1	72%	21%	7%
2020	132.9	43.2	201.6	66%	21%	13%
2021	158.7	45.8	218.6	73%	21%	6%
2022	158.1	49.0	248.7	64%	20%	17%
2023	177.4	54.8	278.0	64%	20%	16%
2024	200.2	56.2	303.6	66%	18%	16%
2025	214.7	66.4	333.6	64%	20%	16%

[1] Inflated to the date of each underlying payment and discounted back to the middle of the respective accident year..
[2] Based on actual expenses for the respective financial year, as reported by insurers in the End of Financial Year Reconciliations.
[3] Projected ultimates are in nominal values, as per what has been shown in Figure 10.2.

Figure 10.4 shows the results from Table 10.2 in a graphical form. We have also shown the achieved earned premium rates that were discussed in Section 10.3.1.

Figure 10.4: Licensed Insurer Profitability, by Accident Year Ending 30 June



Source data can be found in Appendix E.

For accident years 2015/16 to 2020/21, profit margin ranges from 5% to 13%. Since then, there was a notable step change with profit margin increasing to 17% 2021/22, and 16% in 2022/23, mainly due to a reduction in the loss ratio from around 70% to 64%. The projected profit margin of 16% in 2024/25 is consistent with the profit margin observed in the past two accident years. Projected profitability for accident year 2024/25 is consistent with 2023/24, where the loss ratio has reduced slightly, offset by a slight increase in the expense ratio.

Overall, the projected profit margin remains strong at 16% for 2024/25, and 16% 2023/24 despite the unfavourable claims experience which reduced the expected profit margin from 21% at the Previous Scheme Review.

As mentioned earlier, we stress that profitability results are particularly uncertain for recent accident years, given the relatively small proportion of projected ultimate claims costs that has been paid to date (23% for 2024/25, 51% for 2023/24 and 66% for 2022/23).

10.5. Outstanding Claims Liability

Key Points

The sum of licensed insurer case estimates and IBN(E)R reserves is $412.4 million, which is $17.7 million (+4%) higher than our central estimate of $394.7 million for the outstanding claims liability. We note that licensed insurers are also required by the Australian Prudential Regulation Authority (APRA) to hold a risk margin in addition to their central estimate.

Therefore the Scheme Review indicates that licensed insurers, at an aggregate level, are adequately reserved.

The central estimate of outstanding claims liability as at 30 June 2025 is calculated by discounting our estimates of future claim payments to 30 June 2025. Table 10.3 compares our central estimate of outstanding claims liability for licensed insurers, with insurer case estimates and IBN(E)R reserves[7].

Table 10.3: Estimated Gross Outstanding Claims Liability for Licensed Insurers

	Scheme Review Central Estimate[1] ($m)	Insurer Estimates ($m)	Difference between Insurer and Scheme Review Estimtes ($m)	Ratio between Insurer and Scheme Review Estimates (%)
Case Estimates		299.8		
IBNR/IBNER		112.6		
Self-Insurers	394.7	412.4	+17.7	104%

[1] *Inflated and discounted to 30 June 2025*

The central estimate of the outstanding claims liability for licensed insurers is $394.7 million, as at 30 June 2025.

Licensed insurer case estimates are $299.8 million as at 30 June 2025. In addition, licensed insurers have reported they held reserves of $112.6 million at 30 June 2025 in respect of IBN(E)R. As such, the implied central estimate determined by licensed insurers is $412.4 million, which is $17.7 million (+4%) higher than our central estimate of $394.7 million. We note that licensed insurers are also required by APRA to hold a risk margin in addition to their central estimate.

Based on aggregate analysis, licensed insurers appear to be adequately reserved. The adequacy of each individual licensed insurer's reserves will vary depending on the licensed insurer's own reserving practices.

[7] Insurer estimates, being case estimates and IBN(E)R reserves are sourced from the End of Financial Year Reconciliations.

11. Self-Insurer Information

This section presents a comparison of the self-insurer case estimates and IBNR / IBNER reserves. A comparison of the estimates of bank guarantees held if also provided.

Key Points

The central estimate of the outstanding claims liability determined by self-insurers is $21.3 million, $8.2 million lower than the calculated central estimate of $29.5 million. In addition, we note that self-insurers may hold risk margins on top of the central estimate.

Overall, self-insurer bank guarantees are slightly higher than the calculated central estimate which includes an allowance of 10% for claims handling expenses.

11.1. Outstanding Claims Liability

The central estimate of outstanding claims liability as at 30 June 2025 is determined using the estimated future claim payments to 30 June 2025 and discounting these payments to derive the present value. The comparison of the central estimate for self-insurers, split by case estimates and IBNR / IBNER[8] are provided in Table 11.1.

Table 11.1: Estimated Gross Outstanding Claims Liability for Self-Insurers

	Scheme Review Central Estimate[1] ($m)	Insurer Estimates ($m)	Difference between Insurer and Scheme Review Estimtes ($m)	Ratio between Insurer and Scheme Review Estimates (%)
Case Estimates		8.9		
IBNR/IBNER		12.4		
Self-Insurers	29.5	21.3	-8.2	72%

[1] *Inflated and discounted to 30 June 2025*

The central estimate of the outstanding claims liability for self-insurers is $29.5 million as at 30 June 2025.

The case estimates for self-insurers are $8.9 million as at 30 June 2025 and have reported reserves of $12.4 million in respect of IBNR / IBNER. The implied central estimate determined by the self-insurers is $21.3 million, which is $8.2 million (-28%) lower than the calculated central estimate of $29.5 million. As noted above, the self-insurers may hold risk margins in addition to the central estimate.

The self-insurer central estimates are considerably lower than the calculated estimate however we note this may be due to timing delays between the estimates being provided to WorkCover and the completion of the actuarial valuation. This may lead to limited comparability between estimates. There is also considerable uncertainty surrounding the estimates of future costs, particularly for lump sums, and the level of bank guarantees are higher than the calculated central estimate (as discussed in Section 11.2).

We note the above reserve adequacy analysis is performed at an aggregate level for the self-insured sector. The adequacy of each individual self-insurer's reserves will vary depending on the reserving practices adopted by the self-insurers.

11.2. Self-Insurer Bank Guarantees

A comparison of the estimate of the outstanding claims liability for the self-insurers against the bank guarantees which self-insurers are required to hold is provided in Table 11.2. Forestry Tasmania is exempt from the self-insurer bank guarantee requirement but, for the purposes of this assessment, the bank guarantee that Forestry Tasmania

[8] Insurer estimates, being case estimates and IBN(E)R reserves are sourced from the End of Financial Year Reconciliations.

would have otherwise been required to hold has been calculated. This calculation uses a formula specified by the Board such that the bank guarantee is equal to 150% of the self-insurer's central estimate of the outstanding claims liability.

Table 11.2: Comparison of Self-Insurer Outstanding Claims Liability with Bank Guarantees

Premium Rate Component ($m)	($m)
Estimated gross outstanding claims liability for self-insurers	29.5
plus allowance for claims handling expenses (10%)	2.9
Total actuarial estimate	**32.4**
Total bank guarantee (including calculation for Forestry Tasmania)	**32.5**
Ratio between total bank guarantee and total actuarial estimate	**100%**

In aggregate, the self-insurer bank guarantees are slightly higher than the Scheme Review's central estimate which includes an allowance of 10% for claims handling expenses.

The above assessment is calculated for the self-insurer sector as a whole. The ratio between the individual self-insurer's bank guarantee and the central estimate of the individual outstanding claims liability will vary.

12. Nominal Insurer Information

This section highlights the experience for the workers compensation Nominal Insurer in Tasmania. The Nominal Insurer is the entity established under the workers' compensation legislation to serve as the insurer in the event that: an insurer becomes insolvent, an employer has not taken out insurance, or other specified circumstances. The following analysis excludes the claims related to the collapse of HIH Insurance, which have been the subject of a portfolio transfer to IAG.

Key Points

From 2002/03 to 2024/25, there were 62 claims reported to the Nominal Insurer with a valid report date, with 1 claim notified to the Nominal Insurer during 2024/25. From the 2002/23 to 2013/14 financial years, there was an average of 4.7 claims p.a. reported to the Nominal Insurer, but this has fallen to an average of 0.8 for the 2014/15 to 2024/25 financial years. However, it should be noted that there are 15 claims observed with no reporting date and as such, has been excluded from all analysis involving reporting years.

On average, $472,368 of claim payments were made in each financial year during the 2002/03 to 2024/25 period. Significant volatility in the year-to-year payments experience is observed given the low volume of claims in the portfolio. The average claim size for the Nominal Insurer has been observed to be $101,220 over this period, which remains higher than the licensed insurers, self-insurers and the TSS.

On average, $76,806 of administration expenses were incurred in each financial year by the Nominal Insurer between 2005/06 and 2024/25. This is equivalent to an average of $33,394 in administration expenses per claim reported, and an average ratio of 17% between administration expenses and claims payments.

12.1. Number of Claims Reported

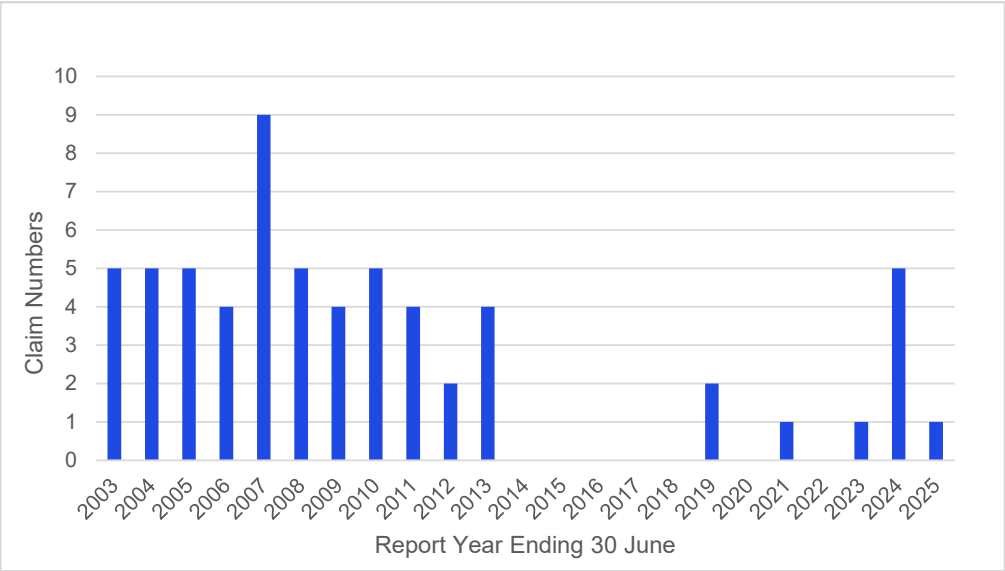
From 2013/14, the claims reported to the Nominal Insurer have not been captured in the WorkSafe Information Management System (WIMS). These have been advised separately. To date, 44 claims have been identified as not being captured in WIMS and can be split out as follows:

- **No recorded report date**: 15 claims without a recorded report date. Of these, 11 claims relate to accident year 2002/03 or later);
- **Reported in 2012/13 or prior**: 19 claims were reported in 2012/13 or earlier; and
- **Reported in 2013/14 or later**: 10 claims were reported in 2013/14 or later. Of these there is one claim that does not have a recorded accident date as the claim form remained incomplete.

Claims without a valid report and accident date have been excluded from the analysis presented in Figure 12.1 and Figure 12.2, given they are presented on a reporting year and accident year basis, respectively.

The number of claims reported to the Nominal Insurer each financial year from 2002/03 to 2024/25 are shown in Figure 12.1.

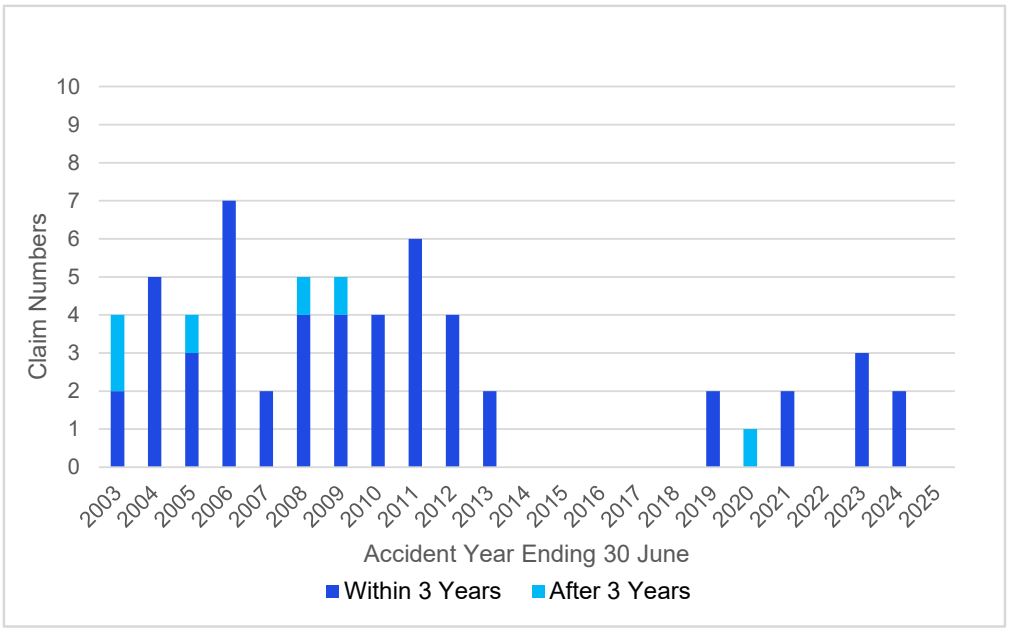
Figure 12.1: Number of Claims Reported to the Nominal Insurer, by Report Year



From 2002/03 to 2024/25, there were 62 claims reported to the Nominal Insurer with a valid report date, with 1 claim notified to the Nominal Insurer during 2024/25. Claim numbers for the Nominal Insurer are less than 0.1% of the claim numbers reported to licensed insurers over the same period. From 2002/23 to 20213/14, there was an average of 4.7 claims p.a. reported to the Nominal Insurer, but this average has fallen to 0.8 from 2014/15 to 2024/25.

The number of claims reported to the Nominal Insurer for each accident year are shown in Figure 12.2. The claims have been split into those reported within three years of the accident and those reported more than three years following the accident.

Figure 12.2: Number of Claims Reported to the Nominal Insurer, by Accident Year



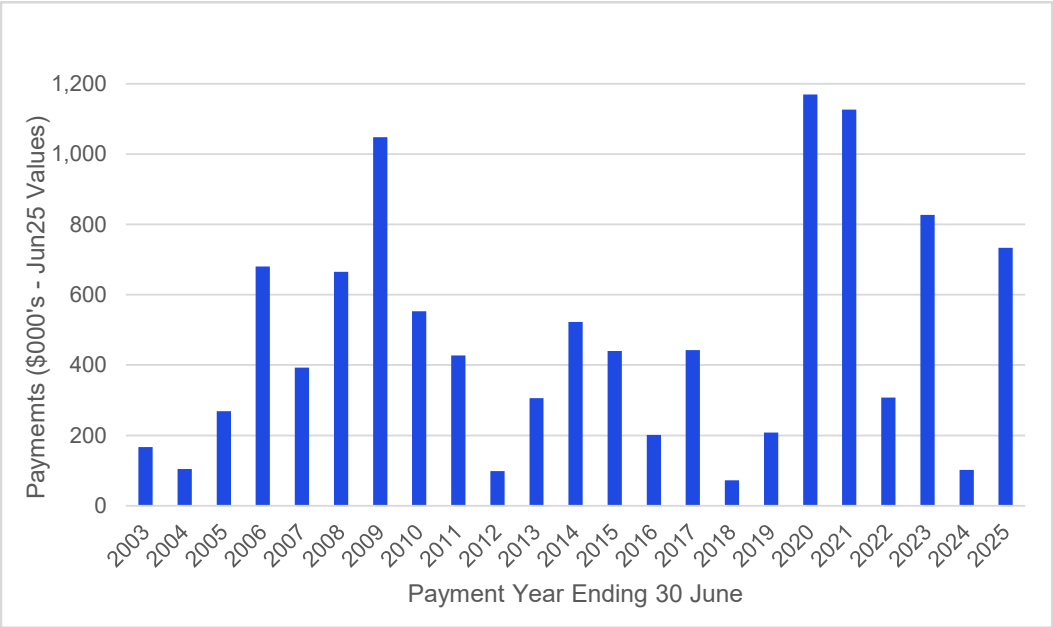
Source data can be found in Appendix E.

In general, 90% of claims have been reported within three years post-accident, and 10% of claim reports are reported after three years post-accident, as shown above. Given the low level of claims by accident year and most claims reporting within three years of the accident, it can be expected that there are also a low number of claims by report year (as observed in Figure 12.1)..

12.2. Cost of Claims

Figure 12.3 shows the Nominal Insurer claim payments (on a current value basis) by financial year.

Figure 12.3: Payments for Nominal Insurer Claims, by Payment Year ($'000, Jun-25 values)



Source data can be found in Appendix E.

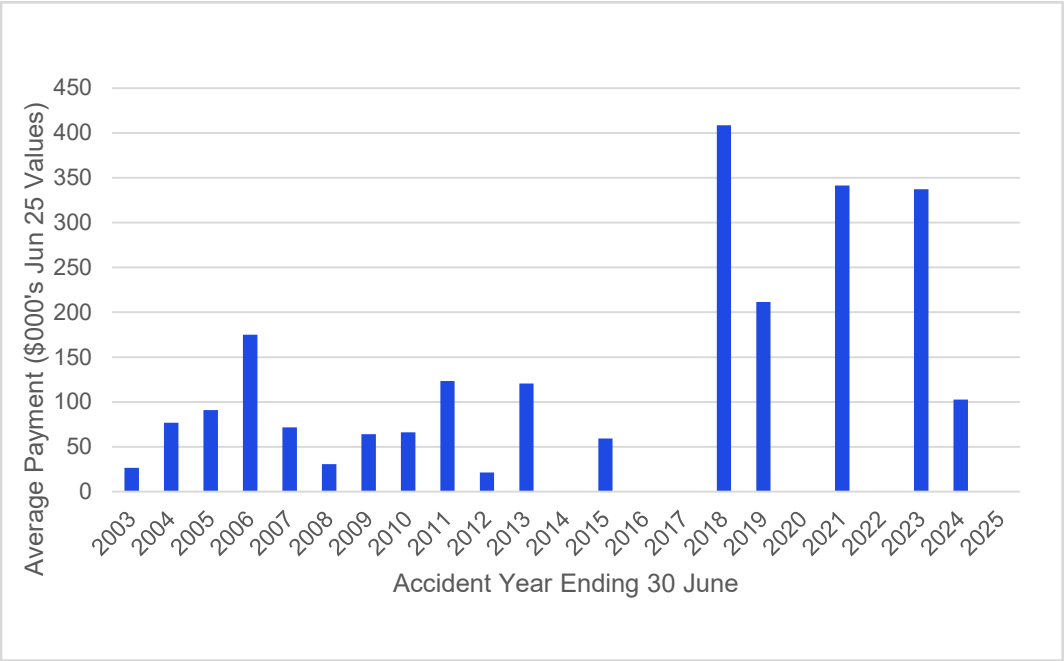
The Nominal Insurer claim payments made between 2002/03 and 2024/25 is $10.9 million (in 30 June 2025 dollar values). This is equivalent to an average of $472,368 of Nominal Insurer claim payments per financial year. There has been significant volatility in the year-to-year claim payments experience, with payments ranging from $72,594 for 2017/18 to $1,169,481 for 2019/20. The relatively high payment volumes in the recent financial years have been driven by the following:

- **2019/20**: A negotiated settlement lump sum payment of $478,674 (in nominal values);
- **2020/21**: A negotiated settlement lump sum payment of $512,000 (in nominal values);
- **2022/23**: Two negotiated settlement lump sum payments of $273,400 and $156,600 (in nominal values);
- **2024/25**: Two negotiated settlement lump sum payments of $186,115 and $50,000 (in nominal values);

For 2024/25, the Nominal Insurer has declared $59,588 in legal expense payments on claims that have been notified to as "potential" claims. These can include claims which the Nominal Insurer has not yet been ordered to pay, where the employer / insurer has taken over the payments, or the matter is yet to go to Tribunal. As such, these amounts are excluded from the Nominal Insurer claim payments in the 2024/25 year.

The average payments for Nominal Insurer claims (on a current value basis) by accident year are shown in Figure 12.4. Average payments have been calculated for each accident year as the payments to date for the accident year over the number of claims reported to date for the accident year.

Figure 12.4: Average Payments for Nominal Insurer Claims, by Accident Year ($'000, Jun-25 values)



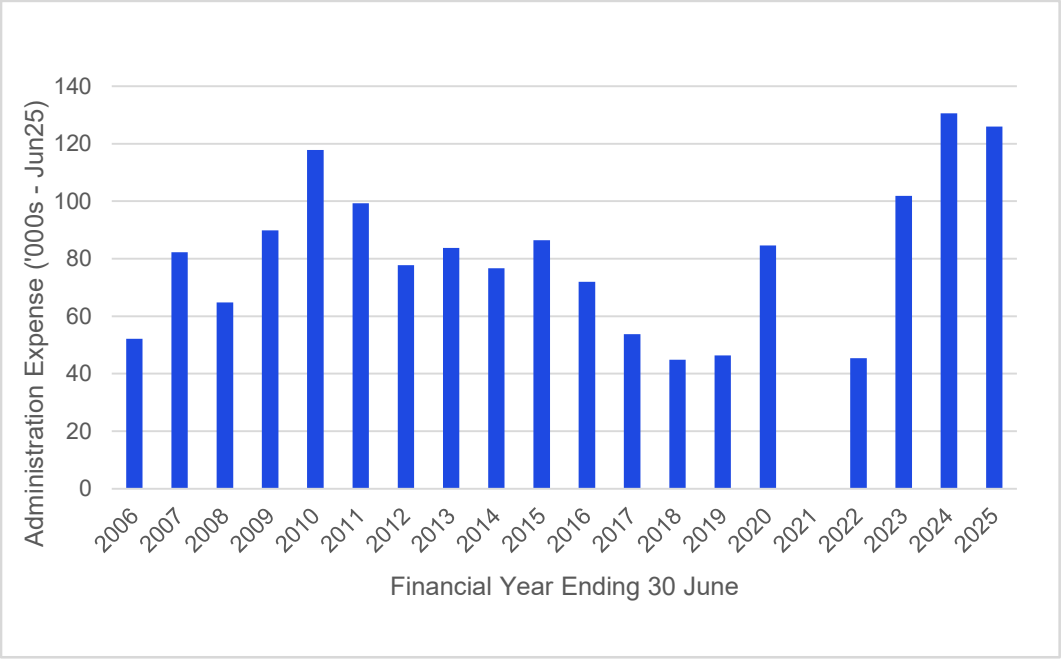
Source data can be found in Appendix E.

The average quantum of payments made for the Nominal Insurer claims that relate to accident years 2002/03 to 2024/25 is $101,220 (in 30 June 2025 dollar values). This remains higher than the average claim size of $48,663 that is assumed for the new accidents in the rest of the Scheme and also the TSS (with an adopted average claim size of $87,829 for the 2025/26 future accident year). The average payments for Nominal Insurer claims exhibit significant volatility due to the impact of occasional large claims (such as those receiving negotiated settlement lump sum payments).

12.3. Administration Expenses

The administration costs for the Nominal Insurer (on a current value basis) by financial year are shown in Figure 12.5. These figures are sourced from WorkSafe and the expenses for 2020/21 were not provided due to operational limitations.

Figure 12.5: Administration Costs for the Nominal Insurer, by Financial Year ($'000, Jun-25 values)



Source data can be found in Appendix E.

The Nominal Insurer has incurred $1.54 million (in 30 June 2025 dollar values) of administration expenses since 2005/06. Excluding, 2020/21, this is equivalent to an average of $76,806 p.a. of administration expenses.

The administration expenses per claim reported and as a percentage of the claim payments since 2005/06 are shown in Table 12.1.

Table .1: Administration Costs per Claims Reported/Payments, by Financial Year (Jun-25 values)

Financial Year	Administration Expenses	Claims Reported	Claim Payments	Expenses per Claim Reported	Ratio of Expenses to Claim Payments
2005/06	52,164	4	680,088	13,041	8%
2006/07	82,228	9	392,731	9,136	21%
2007/08	64,762	5	665,566	12,952	10%
2008/09	89,872	4	1,047,618	22,468	9%
2009/10	117,811	5	552,969	23,562	21%
2010/11	99,264	4	427,431	24,816	23%
2011/12	77,722	2	98,579	38,861	79%
2012/13	83,773	4	306,251	20,943	27%
2013/14	76,640	0	522,915	0	15%
2014/15	86,435	0	439,707	0	20%
2015/16	72,013	0	201,544	0	36%
2016/17	53,783	0	442,620	0	12%
2017/18	44,823	0	72,594	0	62%
2018/19	46,392	2	208,142	23,196	22%
2019/20	84,599	0	1,169,481	0	7%
2020/21	0	1	1,126,795	0	0%
2021/22	45,434	0	307,456	0	15%
2022/23	101,822	1	827,191	101,822	12%
2023/24	130,611	5	101,953	26,122	128%
2024/25	125,963	1	733,498	125,963	17%
Unknown	n/a	15	n/a	n/a	n/a
Total/Average	**1,536,112**	**62**	**10,325,128**	**33,394**	**17%**

As noted in Section 12.1, 15 claims do not have a recorded report date, thus they are categorised as unknown. However, the payments associated with these claims have been included in the financial year in which they occur.

The average administration expenses per claim reported is $33,394 (in 30 June 2025 dollar values) while the ratio of administration expenses to the claim payments has averaged 17%. This is higher than the typical level of claims handling expenses expected for a licensed insurer but is not unreasonable given the low number of claims managed by the Nominal Insurer. It is reasonable that the Nominal Insurer would carry proportionately a higher level of fixed expenses than a licensed insurer. These expenses remain irrespective of the number of claims managed or the amount of claim payments made.

13. Tribunal Matters

This section presents the matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal ("Tribunal"). The Tribunal was previously known as the Workers Rehabilitation and Compensation Tribunal. The Tribunal is an independent statutory Tribunal established under the *Tasmanian Civil and Administrative Tribunal Act 2021*, which has the primary responsibility to determine all disputes related to workers compensation in Tasmania under the *Workers Rehabilitation and Compensation Act 1988*.

Key Points

1,115 claims had their first matter referred to the Tribunal in 2024/25, which is 3% lower than the 1,145 claims in 2023/24. The majority of claims (83%) continue to lodge only one matter. The proportion of TSS claims with at least one dispute has decreased from 28% in 2023/24 to 26% in 2024/25, and the proportion of licensed insurers and self-insurers have slightly increased during the same period.

The most common dispute type continues to be disputes of liability under Section 81A. The next most common types of disputes are weekly benefits and Section 71 (permanent impairment) disputes.

The overall disputation rate of 13.5% in 2024/25 has fallen from its highest rate of 14.5% in 2023/24. Disputation rates for 2024/25 were 12.2% for licensed insurers, 24.5% for self-insurers, and 17.0% for the TSS.

The number of finalisations has grown by an average of 3.2% p.a. over the last decade. There have been 1,501 finalisations in 2024/25 which is reduction of 4.0% on the matters finalised in 2023/24. The average delay between the referral and finalisation of matters is 120 days, which is an increase from the longer-term average of 103 days since 2014/15. Settlement approvals and disputes of liability under Section 81A continue to have the shortest average delays.

Since 2018/19, only 17 matters have been adjourned; with no matters adjourned since 2022/23.

13.1. Data Supplied

The analysis of Tribunal matters is conducted using the "claims with disputes" data extracted as at 8 August 2025.

The Tribunal matters are linked to the relevant claims. Multiple matters and disputes can be brought against one claim. For example, a matter can include a dispute regarding compensation for permanent impairment, as well as a dispute regarding medical/rehabilitation services.

Besides the above example, a matter may have more than one record in the "claims with disputes" data due to:

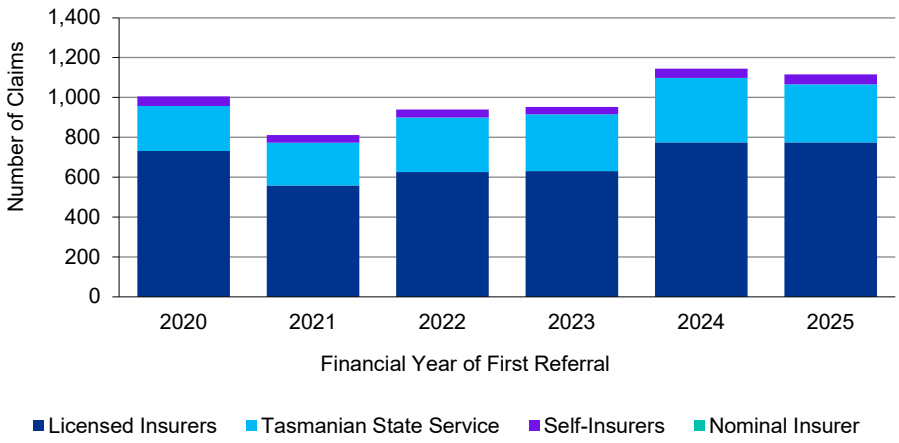
- an Application for Costs under Section 59 was sought when the matter was lodged – Applications for Costs have not been included in the counts for disputes; and/or
- an adjournment *sine die* (i.e. the matter was adjourned prior to a decision being reached and without a future hearing date being set) – in this case, the matter is only included once in the counts for disputes.

Some of the analysis below is based on the number of distinct matters, while other analysis has been based on the number of distinct claims that have at least one dispute.

13.2. Number of Claims with Disputes

The number of claims with at least one dispute, for each sector, is shown in Figure 13.1. Each claim has been allocated to a "financial year of fist referral" which is the year in which the claimant's earliest matter was referred to the Tribunal.

Figure 13.1: Number of Claims with Disputes, by Financial Year of First Referral



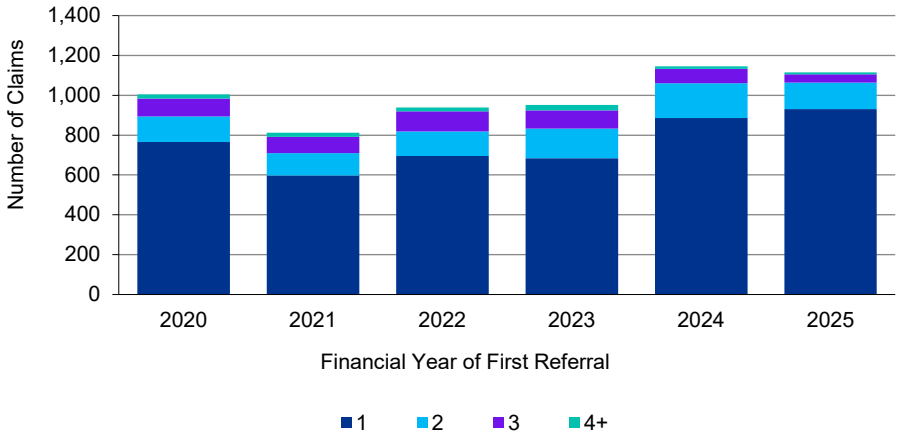
Source data can be found in Appendix E.

1,115 claims had their first matter referred to the Tribunal in 2024/25, which is 3% lower than the claims in 2023/24. There has been annual volatility in the number of matters, with an average of 971 claims p.a. being first referred between 2019/20 to 2023/24.

The insurer section with the most claims with at least one dispute are licensed insurer claims, however the proportion of these to the total matters (on a Scheme level) with a first referral in the respective financial year has generally been decreasing (from 73% in 2019/20 to 69% in 2024/25). Over the same period, the share of self-insurer claims with a referral has also reduced from 5% to 4%. Conversely, the share of TSS claims with at least one dispute has increased from 22% to 26% during the same period.

The number of matters referred to date for each claim with at least one dispute is shown in Figure 13.2. Each claim has been allocated to a "financial year of fist referral" which is the year in which the claimant's earliest matter was referred to the Tribunal. Claims that have four or more matters referred to date have been grouped under the "4+" category.

Figure 13.2: Number of Matters Referred to Date per Claim, by Financial Year of First Referral



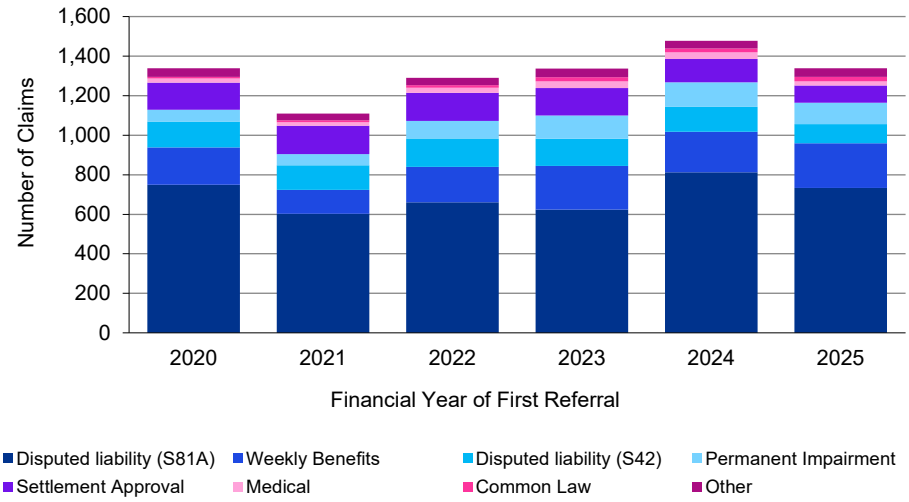
Of the claims first referred between 2019/20 and 2024/25: 76% have lodged one matter, 14% lodged two matters, 8% lodged three matters, and 2% have lodged four or more matters. As at 30 June 2025, 83% of claims first referred in 2024/25 have lodged only one matter, however this proportion is expected to reduce over time as these claims have time to refer to additional matters.

13.3. Number of Disputes

The number of distinct claims that have lodged one or more disputes in respect of each dispute category is shown in Figure 13.3. As such, claims that have lodged disputes for two or more distinct categories are counted more than

once. Each claim in the figure below has been allocated to a “financial year of fist referral” which is the year in which the claimant’s earliest matter was referred to the Tribunal.

Figure 13.3: Number of Distinct Claims for each Dispute Category, by Financial Year of First Referral



The experience for the more common dispute categories has been discussed below:

- **Dispute of liability under Section 81A**: Section 81A disputes relate to cases where the employer / insurer has referred the initial question of liability to the Tribunal. Similar to the Previous Scheme Review, this category continues to be the most common dispute category. At the current review, 733 claims of all claims first referred in 2024/25 have already lodged a Section 81A dispute.

- **Disputes relating to weekly benefits**: Most of the disputes regarding weekly benefits are referred under Section 88, with Section 86(4) being the next most common Section under which disputes about weekly benefits are referred to the Tribunal. Section 88 referrals are available to workers, employers and insurers, while Section 86(4) referrals are only available to workers. At the current review, 226 claims which were first referred in 2024/25 had already lodged one dispute related to weekly benefits.

- **Section 42 referrals**: Any party (worker, employer, or insurer) with a dispute about some aspect of their claim may refer the claim to the Tribunal under Section 42. All parties subject to a Section 42 referral must participate in a conciliation process, which is not compulsory for Section 81A referrals. Section 42 disputes are often a top dispute category that is referred for a claim. At the current review, 98 claims which were first referred in 2024/25 had a dispute under Section 42.

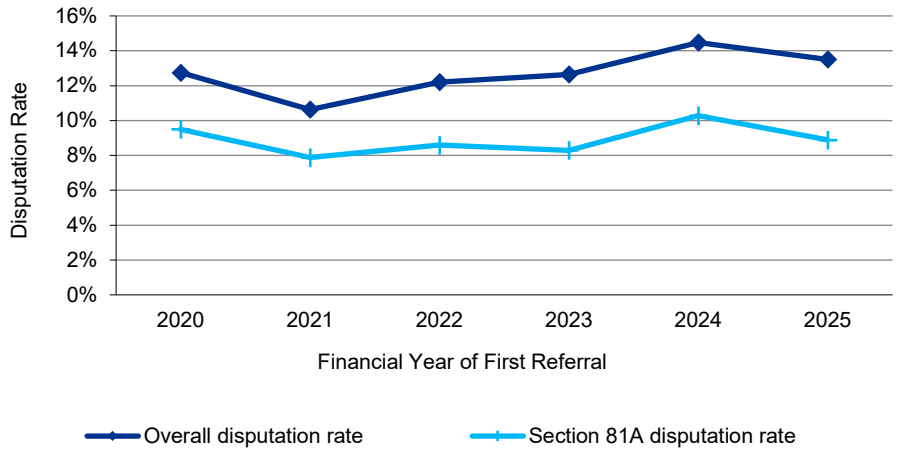
- **Disputes relating to compensation under Section 71 (permanent impairment)**: The number of claims with a section 71 dispute continues to increase in recent years. At the current review, 107 claims which were first referred in 2024/25 had a dispute under Section 71.

- **Settlement approval**: Over 99% of referrals related to settlement approvals are made under Section 132A(4). Referrals are made under Section 132A(4) to seek approval from the Tribunal for a proposed settlement agreement. At the current review, 88 claims which were first referred in 2024/25 had a settlement approval referral.

13.4. Disputation Rates

The disputation rates by financial year of first referral are shown in Figure 13.4. The overall disputation rate has been calculated as the number of claims with at least one dispute over the number of new claims reported to the Scheme in each financial year. Section 81A disputation rate has been calculated as the number of claims with at least one Section 81A dispute over the number of new claims reported to the Scheme in each financial year.

Figure 13.4: Disputation Rates, by Financial Year of First Referral

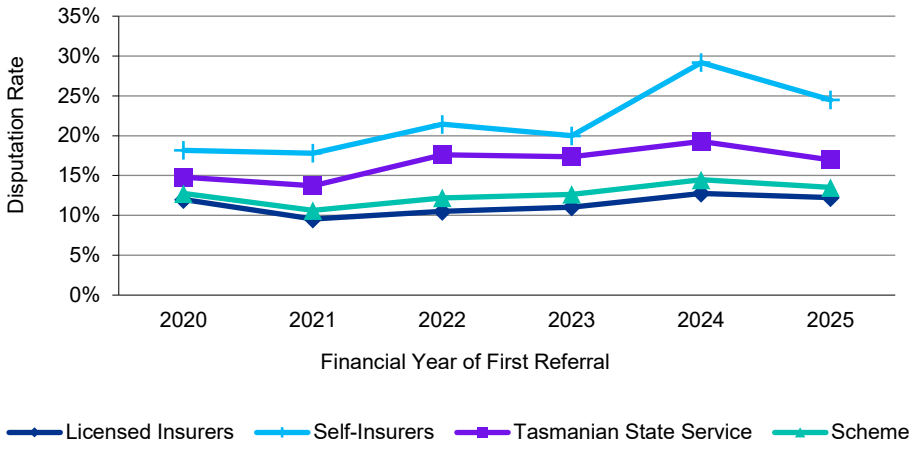


Source data can be found in Appendix E.

The overall disputation rate in 2024/25 has decreased to 13.5% from the all-time high of 14.5% in 2023/24. The relativity between Section 81A disputation rate and the overall rate has been relatively stable, with the Section 81A disputation rate being 8.9% in 2024/25.

The overall disputation rate, for each sector, by financial year of first referral are shown in Figure 13.5.

Figure 13.5: Disputation Rates, by Sector and Financial Year of First Referral



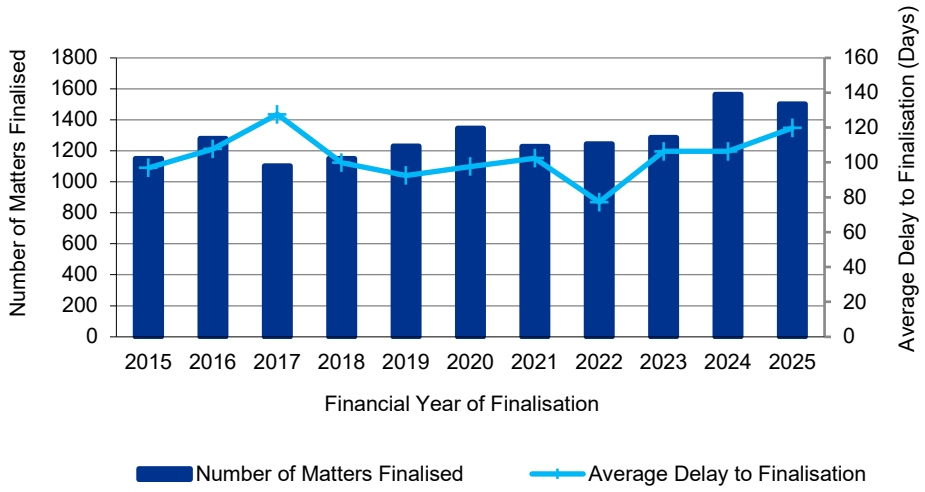
Source data can be found in Appendix E.

Most of the Scheme's claims are for the licensed insurer sector. The disputation rates for the licensed insurer sector remains between 9.5% and 12.8%, with the rate being on the higher end of the range at 12.2% in 2024/25. Both the self-insurer and TSS disputation rates have slightly decreased since their highest rate in 2023/24, with the disputation rates being 24.5% and 17.0% in 2024/25 respectively.

13.5. Finalisations

The number of matters finalised at the Tribunal in each financial year, and the average delay between referral and finalisation of these claims is shown in Figure 13.6.

Figure 13.6: Number of Matters Finalised and Average Delay to Finalisation, by Financial Year of Finalisation



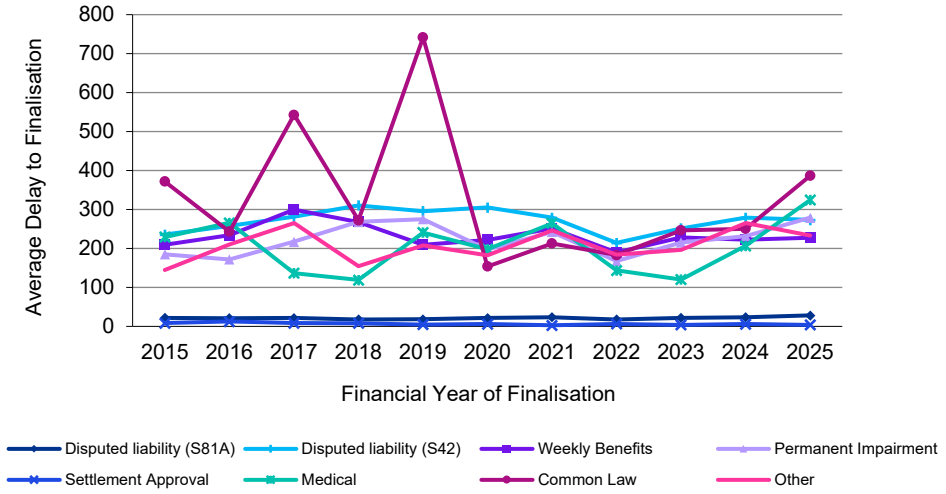
Source data can be found in Appendix E.

The number of finalisations has increased by an average of 3.2% p.a. over the last decade. There were 1,501 finalisations in 2024/25, which is a reduction of 4.0% on the matters finalised in the previous financial year.

The average delay between referral and finalisation has increased from 106 days for claims finalised in 2023/24 to 120 days for claims finalised in 2024/25.

The average delay between referral and finalisation, by dispute category, is shown in Figure 13.7. The average delay by the dispute category is calculated based on the matter that were finalised in the relevant financial year and have at least one dispute that belongs to the relevant category.

Figure 13.7: Average Delay to Finalisation, by Dispute Category and Financial Year of Finalisation



Source data can be found in Appendix E.

Experience for the common dispute categories over the period shown in Figure 13.7 is discussed below:

- **Settlement approval**: Referrals related to settlement approval have historically been the quickest to be finalised by the Tribunal, with an average delay of 7 days over the last decade;
- **Dispute of liability under Section 81A**: Section 81A disputes continue to have the second shortest average delay of 22 days over the last decade; and
- The remaining dispute categories have much longer delays between the referral and finalisation:
    - **Section 42 referrals (for which a conciliation process is compulsory)**: 271 days;
    - **Disputes relating to weekly benefits**: 233 days; and

- **Disputes relating to compensation under Section 71**: 223 days.

An average of 11 matters that include a common law dispute were finalised each year, with 28 matters finalised in 2024/25. It is not unexpected to observe volatility in average delay experience for this dispute category.

The time taken to resolve matters at the Tribunal reflect several factors, including the availability of medical and specialist appointments and the speed at which expert reports are provided.

13.6. Adjournments

Matters may be adjourned *sine die* (i.e. the matter was adjourned prior to a decision being reached and without a future hearing date being set) at the Tribunal.

An average of 117 matters p.a. were adjourned between 2011/12 to 2015/16. This has decreased to an average of 76 matters p.a. in 2015/16 to 2017/18. Since 2018/19, only 17 maters have been adjourned, with no matters adjourned since 2022/23.

The average delay between referral and adjournment was 100 days, for matters adjourned between 2011/12 and 2014/15. This increased to 127 days in the period 2015/16 to 2017/18. The average delay for the matters that have been adjourned since 2018/19 is 395 days. However, this is distorted by a matter referred in 2011/12 but adjourned in 2020/21 (claim number TS813205). With the exception of this matter, the average delay since 2018/19 reduces to 198 days.

14. Actuarial Assumptions

This section presents a statement of compliance with relevant actuarial standards and outlines the approach and economic assumptions adopted for this review. The results presented in this report are subject to a number of limitations, reliance and assumptions, as outlined in the following section.

14.1. Compliance with Professional Standards

The advice provided in this report is a Service as defined in the Code of Conduct issued by the Institute of Actuaries of Australia. The advice is intended to satisfy that Code.

The purpose of this report is to provide an overview of the performance of the Scheme and is not to advise any individual entity on the financial reporting of its workers' compensation liabilities. Accordingly, the Institute of Actuaries of Australia's Professional Standard 302 Valuation of General Insurance Claims (PS302) does not apply to this report. In the absence of any other applicable professional standard, we have used PS302 for guidance on our approach to this review, but our report is not intended to comply with all requirements of PS302.

14.2. Basis of Estimates

The estimates provided in this report in respect of future claims costs are intended to be central estimates, which means they are based on assumptions selected without deliberate bias towards either over-estimation or under-estimation.

14.3. Approach

In conducting the analysis of experience in the Tasmanian workers' compensation scheme, the approach that was used at the Previous Scheme Review has broadly been maintained. This involved the examination of both claim frequency and average claim sizes (by benefit type).

While the analysis has been performed separately for each sector, the basis of analysis is consistent (or that differences are justified) when compared across sectors and for the Scheme overall.

14.3.1. Benefit Types

In the analysis, benefit types were grouped as:

- Weekly benefits, including death benefits made as periodic payments to dependents;
- Medical and related benefits, including doctor payments, hospital payments, rehabilitation (including modifications to workplace, residence or vehicles), other medical and miscellaneous payments (e.g. funeral expenses and counselling services to dependants in the case of death of the worker, road accident rescue costs, and the cost of travel to undertake treatment);
- Legal and investigation costs; and
- Lump sums, including common law, settlements, redemptions, impairment lump sums and death benefits.

14.3.2. Valuation Methodology

For our analysis, all data has been grouped into accident quarters, i.e. the quarter in which the injury leading to the claim occurred. Development of the data is analysed and projected by development quarter, which is a measure of the number of quarters that have elapsed since the accident quarter. For example, development quarter zero represents the quarter in which the injury occurred, whereas development quarter one is the quarter that ends three months after the end of the accident quarter.

The following actuarial projection methods were utilised to perform the analysis:

- **Chain Ladder Method** is used to project the claim numbers.
  - ***All claims***: the Chain Ladder Method is used to estimate the number of claims relating to accidents that occurred prior to 30 June 2025 but are yet to be reported ("Incurred But Not Reported" or IBNR claims). The

estimated ultimate number of claims (i.e. the reported claims to date plus IBNR claims) is then expressed as a claims frequency by dividing the ultimate number of claims in each accident period by a measure of exposure. Estimates of ultimate inflation-adjusted wages earned in each accident period are used as the exposure measure. Appendix L provides further details on the calculation of ultimate inflation-adjusted wages.

- ***Lost time claims***: the number of lost time claims (i.e. those claims which receive weekly benefits) are analysed separately using the Chain Ladder Method and the frequency of lost time claims is analysed relative to the total ultimate claims.
- ***Weekly active claims***: the number of weekly active claims by quarter (i.e. those claims which receive at least one weekly payment within the quarter) are analysed separately. The modelling of weekly active claims requires continuance rate assumptions, which relate to the ratio of the number of weekly active claims in a certain quarter and the number of weekly active claims in the preceding quarter. This represents the net effect of claims ceasing to receive weekly benefits as well as claims commencing receipt of weekly benefits.
- ***Lump sum claims***: the number of lump sum claims are analysed separately using an approach that blends the results from the Chain Ladder Method with the estimated ultimate number of lump sum claims using an exposure-based calculation (i.e. assuming the number of claims is proportional to the number of all claims). The blending is conducted using a Bornheutter-Ferguson (BF) approach that considers the emergence pattern implied by the development factors in the Chain Ladder Method. A measure if lump sum utilisation is expressed as the ultimate number of lump sum claims derived from the BF approach divided by the total ultimate claims, to produce a measure of lump sum utilisation.

- Both the **Payments per Claim Incurred** and **Payments per Active Claim** methods are used to project the average claim sizes.
  - The PPCI method is used to estimate the ultimate cost of medical and related benefits, legal and investigation benefits, and lump sum benefits. For medical and legal/investigation benefits, average sizes are based on total claim numbers. For lump sum benefits, average sizes are based on lump sum claim numbers.
  - The PPAC method is used to estimate the ultimate cost of weekly benefits. PPACs have been calculated based on the number of active claims in the preceding quarter.
  - Average claim sizes were determined separately for each payment type, and varied by legislative period and development period.
  - The overall average claim size for each accident period is derived by dividing projected ultimate cost (which is the sum of payments to date and our estimate of outstanding cost) by the projected ultimate number of claims.

A detailed description of these methods is provided in Appendix B.

14.3.3. Inflation and Discounting

All past payments, wages and premiums information have been converted to 30 June 2025 dollar values using the Average Weekly Earnings (AWE) index for Tasmania for All Persons Full Time Ordinary Time Earnings (ABS AWE Table 13F series ID A85000864R).

The long-tailed nature of workers' compensation business means that it is appropriate to allow for both future inflation and the time value of money, when assessing the ultimate cost of the Scheme.

In projecting future claim costs, we have based our assessment of the various economic assumptions on the following:

- **Discount rate**: expected returns on Commonwealth government bonds over the period in which payments are made;
- **Economic inflation**: current economic forecasts for wage inflation (specifically, the AWE index); and
- **Superimposed inflation**: analysis of recent Scheme experience, together with expectations for the future (which is necessarily judgemental).

Further details regarding economic assumptions are provided in Section 14.4.

14.3.4. Projected Payments and Outstanding Claims Liability

The above projection methods produce a set of projected current dollar (i.e. 30 June 2025) payments. The projected payments are then combined with our assumptions regarding future economic and superimposed inflation to produce a set of projected cashflows in future payment year values. These future cashflows are then discounted to:

- 30 June 2025, when estimating the outstanding claims liability as at 30 June 2025; and

- the middle of the respective accident year, when determining estimates of discounted ultimate cost (that are then compared to earned wages or premiums for the same year).

14.4. Economic Assumptions

14.4.1. Discount Rate

In determining present values of future claim payments, we believe it is appropriate to follow the approach that would be used by insurers in setting outstanding claims provisions. The relevant accounting standard AASB 1023 states that the discount rates used in measuring the present value of expected future claim payments shall be "risk-free discount rates that are based on current observable, objective rates that relate to the nature, structure and term of the future obligations." AASB 1023 also states that:

- "the discount rates adopted are not intended to reflect risks inherent in the liability cash flows"; and
- "typically, government bond rates may be appropriate discount rates for the purposes of this Standard, or they maybe an appropriate starting point in determining such discount rates."

Discount rates have been set with reference to the market prices of Commonwealth Government bonds as at 30 June 2025. Since the Previous Scheme Review, the yields available on Commonwealth Government bonds have decreased across shorter durations, and increased across medium to longer term durations.

In the instances where we have assessed ultimate costs (such as in Section 9 and 10), we have discounted payments back to the middle of the respective accident year and have relied on yields available at the time. For example, all nominal payments for the 2015 financial accident year were discounted back to 31 December 2014.

14.4.2. Inflation

Two types of inflation are accounted for in the projections produced by our payment models: normal/economic inflation and superimposed inflation.

- **Normal/economic inflation**: As mentioned in Section 14.3.3, our assumptions for normal/economic inflation is based on current economic forecasts for wage inflation (specifically, the AWE index), especially given the income-related nature of weekly benefits. We have adopted an assumption of 3.50% p.a., which is an increase from the Previous Scheme Review.
- **Superimposed inflation**: Superimposed inflation refers to the tendency for average claim sizes to increase at a faster (or slower) rate than normal/economic inflation. Superimposed inflation is notoriously difficult to quantify and rarely operates in a uniform and predictable manner. It can arise from many sources, including benefit changes from judicial precedents, increased use/cost of medical services/technology, and claims from previously unknown sources. We have adopted a superimposed inflation assumption of 0.75% p.a. across all payment types. This is consistent with the Previous Scheme Review.

14.4.3. Economic Growth

As part of Tasmania's mid-year review of the 2024/25 State Budget, the Department of Treasury and Finance released updated economic projections in February 2025. In particular, it projected that Tasmania's gross state product would grow by 2% in real terms, during 2025/26.

We have adopted an economic growth rate of 2%, in determining our estimate of written wages for the 2025/26 underwriting year. This is consistent with the economic projection provided by the Department of Treasury and Finance.

We have used preliminary data for 2025/26, assumptions on salary inflation (Section 14.4.2), and the above 2% assumption for growth on written wages to help project ultimate earned wages for 2024/25. The projected growth in ultimate earned wages for 2025/26 compared to 2024/25 is as follows:

- for licensed insurers, growth is projected to be 1.4% (as compared to 2.6% for the preceding year);
- for self-insurers and TSS, growth is projected to be broadly stable, remaining consistent with previous historical years.

14.5. Reliance and Limitations

The results presented in this report are subject to a number of limitations, reliances and assumptions as outlined in the following sections.

14.5.1. Data

The report relies on the completeness and accuracy of information compiled and provided by WorkSafe Tasmania. We have not verified that the data is accurate or complete, but we have checked it for internal consistency and for consistency with information provided for previous work performed.

We note that WorkSafe is reliant on the accuracy of the data supplied to them by licensed insurers. It should also be noted that if any data or other information is inaccurate or incomplete, we should be advised so that our advice could be revised, if warranted.

14.5.2. Uncertainty

The estimates of claim costs are intended to be central estimates and are based on assumptions selected without deliberate bias towards either over-estimation or under-estimation.

14.5.3. Distribution and Use

This report is being provided for the use of the Board for the purposes stated in Section 1 of this report. It is not intended, nor necessarily suitable, for any other purpose. This report should only be relied on by the Board for the purpose for which it is intended.

We understand that WorkSafe will publish this report on their website. Permission is granted for such publication on the condition that the entire report (including appendices), rather than any excerpt, be distributed.

Third parties, including but not limited to parties who obtain this report from WorkSafe's website, should recognise that the use of this report is not a substitute for their own due diligence and should place no reliance on this report or the data contained herein which would result in the creation of any duty or liability by KPMG to the third party.

KPMG has performed the work assigned and has prepared this report in conformity with its intended utilisation by a person technically competent in the areas addressed and for the stated purposes only. Judgements about the conclusions drawn in this report should be made only after considering the report in its entirety, as the conclusions reached by a review of a Section or Sections on an isolated basis may be incorrect.

This report should be considered in its entirety.

Part II: Appendices

A. Data

A.1. Approach to Use of Data

A.1.1. Data Adjustments

Based on previous discussions with WorkSafe, we understand that there have been instances where some insurers have miscoded null values as zeros. To account for this, we adopted the following approach:

The value selected for premium is as per the following hierarchy:

- the “Actual Final Premium” data field, if neither zero nor null;
- if not possible, then the “Adjusted Amount” data field, if neither zero nor null;
- if not possible, then the “Initial Deposit” data field, if not null; and
- if not possible, then set to be zero.

The value selected for wages is as per the following hierarchy:

- the “Actual Wages” data field, if neither zero nor null;
- if not possible, then the “Estimated Wages” data field, if not null; and
- if not possible, then set to be zero.

In addition to this, we have made the following adjustments, to the premium file:

- assigning coverages an underwriting year that is based on defining financial year as the year ending 29 June (this is consistent with how insurers prepare their statutory returns);
- removing coverages with zero or negative durations, as we were advised by WorkSafe that such data records do not represent valid coverages;
- allocating wages to separate coverage financial years, for coverages longer than 12 months (we have been advised that wages have already been pro-rated by insurers, for coverages shorter than 12 months – hence, no adjustment is required for these coverages); and
- where more than one coverage record exists with the same policy ID, ANZSIC06 class and effective date, we have consolidated these records into one record (this had minimal impact on the aggregate amount of wages/premiums).

We have also made specific adjustments to the wages and premium data for the following:

- for the introduction of NIDS v8.1 which involved a re-classification of independent medical review payments from being a legal benefit to being a medical benefit from 1 January 2025. Licensed insurers and self-insurers have adopted use of this new code, while TSS have not yet done so. Workcover Tasmania have worked with TSS to identify the transactions impacted, for which we have made an adjustment to the data at the current review. We understand that this will be rectified in future data extracts.
- For two particular self-insurer lump sum claims that were incorrectly coded as medical claims.

A.1.2. Data Supplied

This is the twelfth review of the Scheme prepared using data from WorkSafe’s WIMS system. WIMS allows insurers to submit data in ‘real time’ as opposed to previous data submissions which were at consistent cut-off dates. The data we received for this review was extracted during the month of August 2025.

The claim and policy information we received was comprised of the following components:

- individual claim header file with information for each claim incurred since 30 June 1988;
- claim payment transaction file with payments made (by payment type);
- case estimate file showing the reported incurred cost, paid to date and case estimate, for each open claim;
- individual policy header file, with information for each policy written since 30 June 1988; and

- premium file (also known as coverage file), with the premium and wages information for each policy.

We also received the following reports, which were extracted/prepared outside of the WIMS environment:

- End of Financial Year Reconciliations for each financial year up to and including 2023/24 – this report includes data for each insurer/self-insurer (as well as for the Tasmanian State Service) regarding:
  - gross earned premiums and total claim payments made during the financial year;
  - expenses (which is split out into categories relating to items such as administrative expenses, commissions and brokerage, reinsurance costs, and levies); and
  - outstanding claims reserves (which includes items such as case estimates, allowances for IBNR/IBNER, recoveries, and the prudential margin).
- 'Claims with disputes' data (extracted as at 8 August 2025), which includes information regarding matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal; and
- Data relating to Nominal Insurer claims that are not recorded in WIM (extracted as at 8 August 2025).

We have supplemented the information above with a number of discussions with WorkSafe Tasmania.

A.1.3. Data Reconciliation

As part of the scheme review process, we have relied on data supplied by Workcover Tasmania. We have not independently verified or audited the data, but have performed general reasonableness checks for internal consistency. Examples of some checks performed have been detailed below.

Internal Consistency Checks for Payments and Case Estimates in the 2024/25 Financial Year

To ensure the data is internally consistent, we have conducted the following checks:

- Checked claim payments in the claim transactions file against the 'End of Year Reconciliation' files for each insurer
- Checked case estimates in the case estimates file against the 'End of Year Reconciliation' files for each insurer. It should be noted that given timing differences between the two data sources, minor variances can be expected. Our use of case estimates for the purposes of this review are limited.
- Checked reported claim numbers and payments by benefit type against prior year scheme review reports.

The table below shows a comparison of the payment figures for the 2024/25 financial year as sourced from the claim payments transaction file compared against 'End of Financial Year Reconciliation' files provided by insurers at year-end.

Table A.1: Reconciliation of Payments for the 2024/25 Financial Year

Sector	Claim Payment Transaction File ($'000s)	End of Financial Year Reconciliation ($'000s)		Difference ($'000s)	Difference (%)
Licensed Insurers	209.10	209.69	-	0.59	-0.3%
Self-Insurers	11.00	11.03	-	0.03	-0.2%
Tasmanian State Service	153.18	153.18	-	0.00	0.0%
Total	**373.28**	**373.90**	**-**	**0.62**	**-0.2%**

Payments from the claim payment transaction file (sourced from WIMS) reconciles closely to those observed by the individual insurer sectors. As a result, the overall payments over the year differs by 0.2% between the two data sources.

Internal Consistency Checks for Earned Premiums and Wages in the 2024/25 Financial Year

To ensure the data is internally consistent, we have conducted the following checks:

- Checked earned wages calculated from the coverage files against the figures shown in the Previous Scheme Review report.

- Checked earned premiums calculated from the coverage files against the End of Year Reconciliations.

Table A.2: Reconciliation of Earned Premiums, for Financials Years 2020/21 to 2024/25

Financial Year	WIMS Data Extract ($m)	End of Financial Year Reconciliation ($m)	Difference ($m)	Difference (%)
2020/21	217.43	209.59	7.8	3.7%
2021/22	245.82	251.33	- 5.5	-2.2%
2022/23	273.11	276.74	- 3.6	-1.3%
2023/24	292.59	294.06	- 1.5	-0.5%
2024/25	313.07	323.20	- 10.1	-3.1%
Total	**1,342**	**1,355**	**- 13**	**-1.0%**

Across the five financial years listed above, earned premiums calculated based on the WIMS data extract are 1.0% higher than the amounts reported by individual insurers in the 'End of Financial Year Reconciliation' files.

Potential drivers of this difference between the two data sources may include any premium adjustments that are received after the end of the policy year. Differences for each financial year can offset each other, resulting in a broadly consistent earned premium in aggregate.

It should be noted that overall differences have reduced since the previous year, and continued reliance is placed upon the WIMS data extract. It should be noted that the accuracy of the data provided remains an area of significance upon which the results of our review continue to rely on.

A.1.4. Data Segmentation

We separately analyse data for licensed insurers, self-insurers and the TSS. Employers can move from a being a policyholder of a licensed insurer to being a self-insurer (and vice versa). Wages, premiums, claims and payments are classified based on the employer's status (as a licensed insurer policyholder versus a self-insurer) at that point in time.

A.1.5. Goods and Services Tax (GST)

Data since the introduction of the GST is reported net of GST. No explicit adjustment has been made to the data to allow for the impact of GST.

A.1.6. Reinsurance and Other Recoveries

The data supplied for the purposes of our review did not appear to include details of reinsurance or other recovery arrangements or amounts. Therefore, all data and figures in this report are gross of all reinsurance and other recoveries.

A.1.7. Employer Excess Claims

The employer excess was removed for accidents occurring from 1 January 2018 onwards. Nevertheless, experience (and, hence, data) relating to accidents occurring before this date were impacted by the excess. Unless explicitly indicated otherwise, all figures in this report are inclusive of both below and above excess claims and payments.

A.1.8. Claims Processing

The contract with the previous

service provider that processed TSS claims ended in June 2015. Prior to the conclusion of this contract, the provider processed a backlog of claims that had previously not been processed. This resulted in a one-off spike in TSS claim payments during the month of June 2015. Since then, the new service provider appears to have processed payments in a timely manner, with payments exhibiting a more consistent trend.

Notably, no reimbursements to Departments were actioned in October 2023 due to the TSS' claims administrator transition to a new claims management system. These reimbursements were actioned in the proceeding months along with new requests received. We also understand that there was one Department that conducted an audit and identified reimbursement that had not been requested in previous years. These reimbursements were processed in February 2024.

A.1.9. Mental Health Injury Codes

Through this report, when referencing mental health-related claims, we specifically refer to claims with a primary mental health injury. A primary mental health injury is defined by the following injury codes:

- 702 – Post-traumatic stress disorder
- 703 – Anxiety/Stress Disorder
- 704 – Depression
- 705 – Anxiety/Depression combined
- 706 – Short term shock
- 707 – Reaction to stressors
- 718 – Other mental diseases
- 719 – Unspecified mental diseases

A.1.10. Mental Health Injury Codes

Version 8.1 of the National Insurers Data Specification (NIDS) was released on 1 July 2024, with insurer compliance being effective from 1 January 2025. This document aims to set out Workcover Tasmania's rules for collection of policy and claims data from licensed insurers and self-insurers operating within the Tasmania jurisdiction. This includes how each payment transaction is coded and mapped to benefit types and benefit descriptions.

As part of this updated version of the guidance, it was noted that independent medical reviews would be separated out into a new payment type code. Through discussions with Workcover Tasmania, we understand that this payment type code would be re-classified from being a legal benefit to being a medical benefit. We have observed adoption of the new payment type code by licensed insurers and self-insurers, but not the TSS. As such, the independent medical review transactions were separately identified and adjusted in the data as detailed in Appendix A.1.1.

A.2. Detailed File Specifications

The following sets out detailed specifications of the files supplied for this review.

A.2.1. Individual Claim Header File

We received an individual claim listing ("claims extract no narrative 08.08.25.csv") for all claims incurred since 30 June 1988. This includes the variables listed below:

- Claim number ("ClaimID", "Claim Number")
- Coverage identifier, which is used as unique identifier link to the policy file
- Accident date
- Report date, which is the date that the claim was notified to the insurer by the employer
- Lodgement date, which is the date that the claim was lodged with the employer
- Insurer code, which is used to identify the relevant insurer ("Insurer Number")
- Four-digit ANZSIC class (both ANZSIC93 and ANZSIC06)
- Type of injury ("Injury")
- Mechanism of injury ("Mechanism")
- Part of body injured ("Body Location")
- Agency of injury ("Agency")

- Claim finalised date.

A.2.2. Claim Payment Transaction File

We received an individual claim payment transaction file (“payments extract 08.08.25.csv”) for all payments made since 30 June 1989. This includes the following variables:

- Claim number (“ClaimID”, “Claim Number”)
- Insurer code (“Insurer Number”)
- Unique payment record number (“PaymentID”)
- Date of transaction
- Amount of payments by benefit type (“Payment Type Code”)
- Indicator of payments as being under or above excess (“Payment Source Type Code”)
- Number of minutes in lost time (“Time Lost in Minutes”).

A.2.3. Case Estimate File

We received an individual case estimate file (“case estimates 08.08.25.csv”) showing insurers’ estimates of amounts outstanding. The file includes the following variables:

- Claim number (“ClaimID”, “Claim Number”)
- Insurer code (“Insurer Number”, “Insurer Name”)
- Incurred claim cost (“Total Estimated Payments”)
- Payments to date (“Total Payment Amount”)
- Outstanding amount (“Outstanding Amount”)

A.2.4. Individual Policy Header File

We received an individual policy listing (“policy extract 08.08.25.csv”) for all policies written since 30 June 1988. The file includes the variables listed below:

- Policy number (“PolicyId”, “Policy Number”)
- Insurer code (“Insurer Number”, “Insurer Name”)
- Australian Business Number to which the record relates (“Employer ABN”)
- Name of employer (“Employer Name”)
- Employer postcode (“EMPLOYER ADDRESS POSTCODE”)

A.2.5. Coverage File

We received an individual premium file (“coverage extract 08.08.25.csv”) for all policies with exposure since 30 June 1988. The file includes the variables listed below:

- Policy number (“Policy Id”, “Policy Number”)
- Insurer code (“Insurer Number”, “Insurer Name”)
- Unique coverage transaction record number (“Coverage Id”, “Coverage External Reference”)
- Four-digit ANZSIC class (both ANZSIC93 and ANZSIC06)
- Start date of period of cover (“Effective Date”)
- End date of period of cover (“Expiry Date”)
- Number of workers (“Estimated Workers”/“Actual Workers”)
- Wages in dollars (“Estimated Wages”/“Actual Wages”)
- Premiums charged (“Initial Deposit”/“Adjusted Amount”/”Actual Final Premium”).

A.2.6. End of Financial Year Reconciliation

The End of Financial Year Reconciliation includes data for each insurer/self-insurer and the TSS. For self-insurers and the TSS we receive the following items:

- gross earned premiums and total claim payments made during the financial year;
- expenses (which is split out into categories relating to items such as administrative expenses, commissions and brokerage, reinsurance costs, and levies); and
- outstanding claims reserves (which includes items such as case estimates, allowances for IBNR/IBNER, recoveries, and the prudential margin).

We receive the following items:

- income statement for the financial year ended 30 June 2025 including a breakdown for insurance revenue and insurance service expense
- number of claims reported in the current year by accident year
- number of claims paid in the current year by accident year
- number of reported claims outstanding at the end of the current year by accident year
- total case estimate outstanding at the end of the current year by accident year
- liability of incurred claims at the end of the current year by accident year (undiscounted and discounted) including split by case estimate, IBNR and IBNER allowance, claims handling expenses, risk adjustments on insurance contracts issued
- asset of incurred claims at the end of the current year by accident year (undiscounted and discounted) including breakdown into reinsurance recoveries and risk adjustment on reinsurance contracts held
- earned by not yet raised premium by earned year for burning cost contracts

A.2.7. ‘Claims with Disputes’ Data

We received a file (“claims with disputes 08.08.25”) for all matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal since 1 July 2009. This file includes the variables listed below:

- Claim Number (“ClaimNumber”)
- Matter number (“MatterNumber”)
- Referral lodgement date (“Referral Lodgement”)
- Current status description (“CurrentStatusDescription”)
- Dispute code (“Code”),
- Dispute description (“Description”)
- Outcome-related information (“OutcomeDate”, “OutcomeCode” and “OutcomePerformed”)
- Referral-related information (“Referral FY”, “Referral Lodgement Month”, “Referral Lodgement Year”).

B. Valuation Approaches Used

For each of these methods, a quarterly approach has been adopted. That is, claim experience is analysed across accident quarters and payment delay quarters.

B.1. Chain Ladder Ratio Method

The Chain Ladder Ratio (CLR) method is typically used for projecting claim numbers. It looks at patterns in the development of cumulative claim numbers from one development period to the next. The selected ratios of development (the chain ladder ratios) are multiplied with the current level of cumulative claim to project future numbers.

In the case of claim numbers, we have used the CLR method to project the ultimate number of claims for each accident period. The analysis was based on cumulative number of claims to reduce the volatility in the experience.

B.2. Payments per Claim Incurred Method

The Payments per Claim Incurred method considers the average amount paid per claim incurred at intervals subsequent to the injury.

Payments (expressed in valuation date values) are summarised by accident quarter and development quarter. Dividing these summarised payments by the corresponding claims exposure generates patterns of average Payments per Claim Incurred for each accident quarter up to the latest development quarter for which data is available. An adopted Payments per Claim Incurred is determined for each development quarter. Projected payments are derived by multiplying the claims exposure by the adopted PPCI for each future development quarter.

For medical and legal/investigation benefits, total claim numbers are used for claims exposure, while lump sum claim numbers are used for lump sum benefits.

B.3. Payments per Active Claim Method

The Payments per Active Claim method is particularly useful for modelling payment types where payments are made at regular intervals (i.e. periodic payment types). It considers the average amount paid to claims on benefits (the “active” claims) during intervals subsequent to injury. We have used the PPAC method for modelling weekly benefits.

A claim is defined as active when it has received at least one weekly payment in the development quarter. The number of active claims for the weekly payment type is then tabulated by accident quarter and development quarter.

Using the active claim tabulation, the number of active claims in future periods is projected using a Continuance Rate approach. In doing so, we consider historical experience regarding the ratio of active claims in each development quarter versus the preceding quarter, and set “continuance rate” assumptions in line with observed experience for these ratios.

The main driver in the PPAC modelling methodology is the number of active claims, and in particular the number of active claims in the latest diagonal (i.e. the number of actives in the quarter of the valuation date), as the selected continuance rates assumptions are applied to the latest diagonal to project future active claims.

Payments (expressed in valuation date values) are summarised by accident quarter and development quarter. Dividing these payments by the active claim numbers generate patterns of average Payments per Active Claim, for each accident quarter up to the latest development quarter for which data is available. An adopted Payments per Active Claim is determined for each development quarter. Projected payments are derived by multiplying future active claims by the adopted PPAC for each future development quarter.

C. Scheme Coverage

This section sets out the coverage of the workers compensation scheme in Tasmania and the benefits available.

C.1. Introduction

The Tasmanian workers' compensation scheme ("Scheme") is a privately underwritten scheme, operating on a no-fault basis under the Workers Rehabilitation and Compensation Act 1988 (the "Act"). Under the Act, employers are required to take out a workers' compensation insurance policy with a licensed insurer or be granted a permit by the WorkCover Tasmania Board to self-insure these risks. A licensed insurer is one which is licensed by the Board to insure Tasmanian employers' workers' compensation liabilities. As at 30 June 2025, there were six licensed insurers and eight self-insurers in Tasmania. *In May 2024, one self-insurer surrendered their self-insurer permit.*

C.1.1. The Tasmanian State Service

Coverage under the Tasmanian State Service ("TSS") was established in 1989, to meet the cost of workers' compensation claims of employees of Tasmanian government agencies. In effect, this arrangement operates like a self-insurer.

C.1.2. The Nominal Insurer

The Nominal Insurer is the body established under the Act, to act as the insurer in the event an insurer becomes insolvent, an employer has not taken out insurance, or other certain circumstances. The Nominal Insurer is funded by a levy on premiums, and on notional premiums in the case of self-insurers. Discussion of Nominal Insurer experience is provided in Section 12 of this report.

C.2. Compensation Types

Under the Act, a worker is currently entitled to compensation in the form of:

- weekly payments;
- reimbursement for medical and other expenses;
- lump sum payments (e.g. permanent impairment, redemption);
- payments to dependants of deceased workers ("death benefits"); and
- common law damages (and associated legal costs).

For our modelling, we have grouped together permanent impairment lump sums, redemptions, common law damages, settlements, and lump sum death benefits together as 'lump sum' payments. Weekly payments to dependants have been included with the weekly compensation payments.

C.2.1. Weekly Payments

A worker who is incapacitated (either totally or partially) for work as a result of a work-related injury or disease is entitled to weekly payments. The worker is entitled to weekly payments at the highest amount of the following two options:

- the worker's ordinary time rate of pay for the employment (as set by an Award or other industrial instrument such as an Enterprise Agreement) that the worker was engaged in immediately before the incapacity began; or
- the normal weekly earnings of the worker averaged over the relevant period of employment.

For the first 26 weeks of incapacity, the worker receives weekly payments at 100% of their normal weekly earnings. After these 26 weeks, there are two reductions (or 'step-downs') in weekly payments:

- if the worker is incapacitated for more than 26 weeks, weekly payments are paid at 90% of their normal weekly earnings. However, if the worker is able to return to some form of work, but their employer is unwilling or unable to provide suitable alternative duties, then the worker will receive 95% of normal weekly earnings; and

- if the worker's incapacity exceeds 78 weeks, weekly payments are reduced to 80%. However, if the worker is able to return to some form of work, but their employer is unwilling or unable to provide suitable alternative duties, then the worker will receive 85% of normal weekly earnings.

The step-downs do not apply (that is, the worker will continue to be paid 100% of normal weekly earnings) if the worker is back at work for 50% or more of their normal weekly hours. If the worker is back at work for less than 50% of their normal weekly hours, then the step-down only applies to the difference between what they are earning for the duties they are performing and their normal weekly earnings.

The maximum period that weekly payments can be paid depends on the worker's level of whole person impairment (WPI):

- a worker with a WPI of less than 15% is entitled to weekly payments for up to nine years;
- a worker with a WPI of at least 15% but less than 20% is entitled to weekly payments for up to 12 years;
- a worker with a WPI of at least 20% but less than 30% is entitled to weekly payments for up to 20 years; and
- a worker with a WPI of 30% (or more) is entitled to weekly payments until the worker reaches the pension age.

C.2.2. Medical and Other Expenses

The Act provides for compensation to workers for the cost of all reasonable expenses the worker necessarily incurs for:

- medical services;
- hospital services;
- household services, for the proper running and maintenance of the worker's home (e.g. cleaning, laundry and gardening);
- nursing services;
- attendant services, including the constant or regular personal attendance on the worker provided by a non-family member (e.g. to shower, dress or feed the worker);
- rehabilitation services; and
- ambulance services.

Workers are also entitled to compensation of reasonable expenses for the worker to travel to any medical, hospital or rehabilitation service or to attend any medical examination organised by their employer.

The worker is only entitled to have expenses for medical or other services paid if the expense was reasonable and necessarily incurred. This will largely depend on the individual circumstances of each case.

A worker's maximum period of entitlement to compensation for medical and other expenses depends on whether the worker is or has been entitled to weekly payments of compensation or not. Where a worker is or has been entitled to weekly payments as a result of their work-related injury, their entitlement to compensation for medical and other expenses stops 52 weeks after their weekly payments are terminated. For medical only claims (that is, claims where the worker is not and has never been incapacitated for work but has claimed compensation for medical or other expenses) entitlement stops 52 weeks after the date the claim for compensation was made.

C.2.3. Lump Sum Compensation (Permanent Impairment, Redemption)

To be entitled to lump sum permanent impairment compensation, the worker must meet the appropriate WPI threshold. These are:

- for the loss of part, or all, of a finger or toe: no threshold applies;
- for any other permanent physical impairment: a threshold of 5% WPI applies;
- for permanent psychological impairment: a threshold of 10% WPI applies; and
- for industrial deafness: a threshold of 5% binaural hearing loss, suffered since 16 August 1995, applies.

Once the worker's level of WPI has been determined, the amount of lump sum compensation they are entitled to will be calculated according to formulas set out in the Act.

In certain circumstances, the worker and the employer can enter into an agreement to settle the worker's claim, in the form of a redemption. This means the worker will receive one lump sum payment (a once and for all payment)

to cover their remaining entitlements to compensation (e.g. weekly payments, medical expenses, permanent impairment). Once this occurs, the worker will not be able to make any further claims for compensation for that particular injury. There are limitations on agreements to settle, as the key focus of the Act and the Scheme is on recovery and return to work.

C.2.4. Compensation to Dependants of Deceased Workers ("Death Benefits")

Where a worker dies as a result of their work-related injury or disease, their dependants may be entitled to compensation under the Act. This may include:

- weekly payments;
- lump sum payments;
- compensation for the worker's medical expenses;
- compensation for counselling costs; and/or
- compensation for burial or cremation costs.

The amount of the lump sum and the way it is distributed depends upon the dependants of the deceased worker and their degree of dependency on the deceased worker.

C.2.5. Common Law Damages and Associated Legal Costs

Common law damages differ from statutory workers compensation benefits (e.g. weekly payments) in that:

- common law damages are fault-based: the worker must be able to prove that the injury resulted from negligence, breach of contract or breach of statutory duty by the employer (or by a person the employer is vicariously liable for); and
- common law damages can compensate for losses not covered by statutory benefits: for example, pain and suffering, loss of amenities, past and future loss of earning capacity.

The worker can only claim common law damages where the injury or disease suffered has resulted in a WPI of 20% or more. Common law claims are complex and, in addition to the threshold requirement mentioned above, there are other legal requirements that apply. There are strict time limits on starting common law proceedings. In practice, most common law damages claims are settled by agreement and executed via a common law deed. It is rare that a case is determined by a court. A common law settlement typically extinguishes all further liabilities arising from the injury, both under the Act and through common law. We note that an injured worker may also seek reimbursement for the costs of legal and other expenses incurred as a result of pursuing common law damages.

C.3. Employer Excess

The employer excess was removed for accidents occurring from 1 January 2018 onwards. Previously, employers were required to meet the costs of the first weeks' worth of weekly payments and the first $200 of medical and related expenses. The level of this excess remained fixed until its removal. There was scope within the Act for the employer to increase the period of the excess payment to 30 days or to reduce the excess to zero, subject to Board approval.

D. Legislative Reforms

This appendix summarises the various legislative reforms that have had an impact on the Tasmanian workers' compensation scheme. The reader should refer to the relevant legislation for full details of the changes. We have also included commentary on a number of other changes that have impacted the Scheme.

D.1. 1995 Amendments

The amendments introduced on 15 August 1995 brought about the following changes to benefit payments:

- step-downs in the replacement ratio for weekly benefits (prior to this, the replacement ratio was always 100%);
- introduction of the employer excess for weekly benefits (one week's worth of benefits);
- introduction of the employer excess for medical and related payments ($200);
- abolishment of the ability to redeem statutory entitlements;
- removal of coverage for journey claims; and
- tightening of conditions for stress claims.

D.2. 2001 Amendments

On 1 July 2001, the following changes were introduced:

- further reduction in the replacement ratio for weekly benefits, and replacement of the monetary cap on weekly benefits with instead a ten year time limit;
- ten year time limit for medical and related payments;
- a threshold of 30% WPI to access common law (previously, access was unrestricted);
- replacement of the Table of Maims benefits with benefits based on WPI, with a 5% threshold and an increase in the maximum benefit; and
- reinstatement of the ability to redeem statutory entitlements.

D.3. 2004 Amendments

Following the Rutherford Review into the Tasmanian workers' compensation scheme, amendments were introduced to wind back some elements of the 2001 amendments. The key change introduced on 29 June 2004 was that the replacement ratios for weekly benefits would increase, although not to the level they were following the 1995 amendments. To counter some of the cost increase associated with this change, the ten year time limit was reduced to nine years. This amendment was applied retrospectively to 1 July 2001, with insurers able to recover from the Nominal Insurer their costs for claims retrospectively impacted.

D.4. 2007 Amendments

The 2007 amendments were introduced on 31 October 2007, with the purpose of correcting a number of anomalies in the Act that were considered to result in undue harshness for some workers. The amendments included:

- making it easier to prove and assess industrial deafness claims;
- changes to the calculation of the weekly compensation benefit rate, for casual employers and employees with short employment histories;
- introduction of coverage for jockeys for race-riding work; and
- tightening of the "at work" and "in the course of work" tests for coverage of diseases.

These amendments were expected to have a minimal impact on the cost of the Scheme.

D.5. 2009 Amendments

In October 2009, the Tasmanian government passed a set of amendments to the Act. These amendments were the outcome of the so-called “Clayton reforms” which followed the release of the September 2007 Clayton report. The Clayton report was the result of an investigation into the fairness and equity of current benefits, and the comparability of Scheme benefits (both statutory and common law) and premiums with those of other Australian jurisdictions.

These amendments to the Act only applied to injuries that occurred on or after the effective date of the legislation (which was 1 July 2010).

As part of the amendments, weekly benefit step-downs and replacement ratios were modified as follows:

Table D.1: Modifications to Weekly Benefit Replacement Ratios

Duration	Pre-2009 Amendments	Post-2009 Amendments
First 13 weeks	100%	100%
14 to 26 weeks	85%	100%
27 to 78 weeks	85%	90%, or 95% if the injured worker is able to perform suitable alternative duties but the employer does not enable it
79 weeks to maximum duration	80%	80%, or 85% if the injured worker is able to perform suitable alternative duties but the employer does not enable it

In addition, the maximum period that weekly payments can be paid for was revised to be as follows:

- for WPI of less than 15%, maximum duration is nine years;
- for WPI of 15% or more but less than 20%, maximum duration is 12 years;
- for WPI of 20% or more but less than 30%, maximum duration is 20 years; and
- for WPI of 30% or more, maximum duration is to pension age.

The step downs shown in Table 19 do not apply if the worker engages in work for more than 50% of their normal weekly hours in accordance with their return-to-work or injury management plan.

Other changes that were made as part of the 2009 amendments include:

- an increase to weekly benefits for dependent children;
- an increase to the lump sum death benefit and the maximum lump sum permanent impairment benefit (both increased from 369 units to 415 units);
- reduction in the threshold (from 30% WPI to 20% WPI) to access common law;
- introduction of requirements that the Tribunal needs to be satisfied of, for claims to be settled through agreement between parties within two years of the claim being made;
- expansion of benefits for medical and related services to include household services, road accident rescue services and counselling services to the worker’s family members (in the case of the death of the worker);
- setting the maximum payment period for medical and related services to be one year following the cessation of weekly benefits, or, if not entitled to weekly benefits, one year following the date the claim is made (this can be modified at the Tribunal’s discretion); and
- to encourage early reporting, the employer has up to three days to notify its insurer of a claim. If it fails to do so, the employer is liable for the cost of weekly benefit payments from day three until the claim is reported (this is effectively an extension of the employer excess for employers who report claims late).

A number of procedural and other changes were also made to the Act (e.g. statement of Scheme goals, medical assessment procedures, injury management programs, etc.).

D.6. 2013 Amendments

In 2013, amendments to the Act established a presumption that a certain class of cancers developed by fire-fighters were taken to be work-related unless proven otherwise, thus making the process of claiming compensation less onerous for this cohort of injured workers. In 2017, this presumptive clause was further strengthened by an additional amendment, which removed requirements for volunteer fire-fighters to have attended a specified number of exposure events before the presumption would apply.

D.7. January 2018 Amendments

Amendments to remove excessive 'red tape' associated with the Scheme were introduced on 1 January 2018. In particular, the amendments included the:

- removal of the employer excess and introduction of a requirement for employers to insure the full amount of their workers' compensation liabilities; and
- removal of age restrictions for weekly benefits, with this being replaced by a link to the Social Securities Act1991 (Cth). This meant there was no gap between when a person's entitlement to weekly compensation payments ceased (on account of age) and when any entitlement to the Age Pension may have begun (this amendment applied to all workers whether their injury occurred before or after the effective date of the amendment).

A number of other procedural and general changes were also made to the Act.

D.8. October 2018 Amendments

On 31 October 2018, the Tasmanian government issued an administrative employment direction to public sector agencies, introducing presumptive provisions for post-traumatic stress disorder (PTSD) claims. Similar to the earlier introduction of fire-fighter cancer presumption, these provisions required government agencies to accept diagnosed PTSD claims as work-related unless proven otherwise.

D.9. 2019 Amendments

In September 2019, amendments were made to the Act to remove the step-down provisions relating to weekly benefit entitlements, but only for police officers.

D.10. 2023 Amendments

Amendments to Sections 27 and 87 of the Workers Rehabilitation and Compensation Act 1988 ('the Act') came into effect from 1 March 2023.

The change to Section 27 granted employees of the Bushfire Risk Unit of the Tasmanian Fire Service entitlement to the presumptive cancer clause that other Tasmanian firefighters were already entitled to.

The changes to Section 87 ('Section 87 amendments') set the cessation date for receiving weekly benefits to be:

- the pension age, if the injury occurred two years or more before the pension date; and
- two years after the date of injury, if the injury occurred less than two years before the pension age or occurred after the pension age.

The changes to Section 87 were intended to further lessen any discriminatory impact of a worker's age, whereby workers injured after their pension age were not subject to cessation of weekly benefits, whilst workers injured before pension age were subject to cessation of weekly benefits.

D.11. Proposed Amendments

We are not aware of any proposed amendments.

D.12. Other Changes Impacting the Scheme

These include:

- Tasmania's current Work Health and Safety (WHS) laws commenced on 1 January 2013. These laws mirror the provisions of the national model developed by Safe Work Australia. During 2013, WorkSafe observed a decrease in claims from medium sized employers that we understand may be attributed to these WHS changes.
- The Primary Treating Medical Practitioner role, introduced on 1 July 2010, required medical professionals to spend more time with injured workers at the initial consultation phase. This meant there was an initial one-off increase in the numbers of claims exceeding the employer medical excess. We suspect that these were from claimants with more minor injuries.
- The Tasmanian Guidelines for Assessing Permanent Impairment (Version 2) came into effect 1 April 2011, applying to all assessments conducted after this date, regardless of when the injury occurred or was reported. Version 3 of the Guidelines was issued on 1 October 2011 to incorporate AMA5 for all respiratory assessments. The impact of the Guidelines have now been reflected in the past 12 or so years of lump sum experience.

E. Graph Data

Included separately as an Excel file.

F. Claim Numbers – Licensed Insurers

Included separately as an Excel file.

F.1. All Claims

F.2. Active Claims

F.3. Lost Time Claims

F.4. Lump Sum Claims

G. Claim Numbers – Self-Insurers

Included separately as an Excel file.

G.1. All Claims

G.2. Active Claims

G.3. Lost Time Claims

G.4. Lump Sum Claims

H. Claim Numbers – TSS

Included separately as an Excel file.

H.1. All Claims

H.2. Active Claims

H.3. Lost Time Claims

H.4. Lump Sum Claims

I. Payments – Licensed Insurers

Included separately as an Excel file.

I.1. Weekly Payments

I.2. Medical Payments

I.3. Lump Sum Payments

I.4. Legal Payments

I.5. All Payments

J. Payments – Self-Insurers

Included separately as an Excel file.

J.1. Weekly Payments

J.2. Medical Payments

J.3. Lump Sum Payments

J.4. Legal Payments

J.5. All Payments

K. Payments – TSS

Included separately as an Excel file.

K.1. Weekly Payments

K.2. Medical Payments

K.3. Lump Sum Payments

K.4. Legal Payments

K.5. All Payments

L. Wages and Premiums

L.1. Wages for Licensed Insurers

Wages sourced from the coverage file are expected to develop over time due to reporting delays or changes to initial estimates. To track how wages have changed over time for each underwriting cohort, the written wages data has been triangulated by underwriting and delay quarters. A Chain Ladder model is then applied to project future movements to wages for each of the underwriting cohorts.

Table L.1 below shows our estimates for changes in written wages for the September 2021 to the June 2025 underwriting quarters. We have also included a projection of the written wages and their development for the September 2025 to June 2026 underwriting quarters.

Table L.1: Written Wages (in Current Values) for Licensed Insurers, by Underwriting Quarter (RQ) and Delay Quarter (DQ)

	Delay Qtr							
Underwriting Quarter	0	1	2	3	4	5	6	7
Sep-19	6,513	7,268	7,301	7,301	7,302	7,305	7,305	7,305
Dec-19	1,505	1,938	1,939	1,940	1,946	1,946	1,946	1,946
Mar-20	1,428	1,697	1,700	1,701	1,701	1,701	1,701	1,701
Jun-20	1,364	1,621	1,635	1,635	1,636	1,636	1,636	1,636
Sep-20	6,349	7,259	7,290	7,340	7,351	7,351	7,351	7,351
Dec-20	1,904	2,404	2,414	2,416	2,418	2,418	2,421	2,421
Mar-21	1,459	1,749	1,750	1,751	1,752	1,752	1,752	1,752
Jun-21	1,515	1,751	1,759	1,759	1,759	1,759	1,759	1,759
Sep-21	7,059	7,727	7,728	7,729	7,742	7,746	7,746	7,746
Dec-21	1,989	2,403	2,416	2,418	2,420	2,421	2,421	2,421
Mar-22	1,490	1,827	1,831	1,831	1,831	1,831	1,831	1,831
Jun-22	1,634	1,857	1,861	1,861	1,866	1,866	1,866	1,866
Sep-22	7,041	7,984	8,006	8,014	8,017	8,022	8,022	8,022
Dec-22	1,988	2,434	2,444	2,462	2,463	2,463	2,463	2,466
Mar-23	1,662	2,019	2,023	2,023	2,023	2,025	2,025	2,025
Jun-23	1,674	1,989	1,990	1,992	1,992	1,993	1,993	1,993
Sep-23	7,537	8,305	8,358	8,360	8,376	8,376	8,376	8,376
Dec-23	2,173	2,647	2,649	2,651	2,652	2,652	2,652	2,652
Mar-24	1,596	1,865	1,867	1,867	1,888	1,888	1,888	1,889
Jun-24	2,120	2,343	2,351	2,351	2,351	2,351	2,351	2,352
Sep-24	7,760	8,389	8,392	8,395	8,408	8,410	8,410	8,411
Dec-24	2,243	2,630	2,632	2,635	2,639	2,640	2,640	2,640
Mar-25	1,641	1,935	1,940	1,942	1,945	1,946	1,946	1,946
Jun-25	2,005	2,262	2,268	2,271	2,274	2,275	2,275	2,275
Sep-25	7,803	8,801	8,825	8,835	8,849	8,851	8,851	8,852
Dec-25	2,321	2,617	2,625	2,628	2,632	2,632	2,633	2,633
Mar-26	1,642	1,852	1,857	1,859	1,862	1,863	1,863	1,863
Jun-26	2,099	2,368	2,374	2,377	2,381	2,381	2,381	2,382

Table L.2 below presents written wages to date in nominal values by underwriting

Table L.2: Reported to Date and Ultimate Written Wages for Licensed Insurers, by Underwriting Year

Underwriting Financial Year	Reported (uninflated)	Ultimate (uninflated)	Ultimate (inflated)
2016	8,247.23	8,247.23	11,419.03
2017	8,588.57	8,588.57	11,680.93
2018	9,075.08	9,075.08	11,776.83
2019	9,757.70	9,757.70	12,411.47
2020	10,114.18	10,114.18	12,587.14
2021	10,980.90	10,980.90	13,295.77
2022	11,906.72	11,906.72	13,870.60
2023	13,079.83	13,079.83	14,507.79
2024	14,232.86	14,234.74	15,269.16
2025	14,605.33	14,910.75	15,273.22
2026	6,896.49	16,116.91	15,730.26

Estimates of written wage are then transformed into estimates of earned wages, based on a uniform earning on each policy. The overall earnings pattern on the portfolio level will be dependent on the seasonality of written wages, which is heavily weighted towards the September quarter of each year, given the influx of policy renewals at the start of each financial year. Table L.3 below shows reported to date earned wages in nominal values for licensed insurers by earning year. It also presents our estimates of the ultimate earned wages on uninflated (nominal) and inflated (30 June 2025) values.

Table L.3: Reported to Date and Ultimate Earned Wages for Licensed Insurers, by Accident Year

Earning Year	Reported (uninflated)	Ultimate (uninflated)	Ultimate (inflated)
2015	7,780.57	7,780.57	10,975.96
2016	8,132.48	8,132.48	11,266.73
2017	8,443.27	8,443.27	11,613.20
2018	8,935.53	8,935.53	11,706.65
2019	9,610.31	9,610.31	12,289.35
2020	10,096.93	10,096.93	12,711.90
2021	10,675.47	10,675.47	13,126.15
2022	11,607.80	11,607.80	13,704.83
2023	12,737.40	12,737.40	14,415.55
2024	13,766.12	13,766.82	15,041.95
2025	14,454.16	14,511.33	15,193.24
2026	3,744.46	15,829.85	15,410.74

Our initial projection for earned wages for licensed insurers in the 2025/26 earnings year is $15.4 billion, representing a 1.4% growth from $15.2 billion in the 2023/24 earning year.

L.2. Wages for Self-Insurers and the TSS

Table L.4 below shows reported to date earned wages in nominal values for self-insurers by earning year. It also presents our estimates of the ultimate earned wages on uninflated (nominal) and inflated (30 June 2025) values.

Table L.3: Reported to Date and Ultimate Earned Wages for Self-Insurers, by Accident Year

Earning Year	Reported (uninflated)	Ultimate (uninflated)	Ultimate (inflated)
2015	455.29	455.29	643.83
2016	450.94	450.94	624.27
2017	457.06	457.06	631.51
2018	430.45	430.45	561.60
2019	530.04	530.04	676.78
2020	479.30	479.30	604.23
2021	460.67	460.67	566.68
2022	456.16	456.16	536.53
2023	481.29	481.29	543.59
2024	548.00	548.00	600.15
2025	542.38	542.38	568.50
2026	-	578.26	556.99

Our initial projection for earned wages for self-insurers in the 2025/26 earnings year is $557.0 million, remaining broadly stable from the 2023/24 earning year (with a minor reduction in real terms).

Table L.5 below shows reported to date earned wages in nominal values for the TSS by earning year. It also presents our estimates of the ultimate earned wages on uninflated (nominal) and inflated (30 June 2025) values.

Table L.4 Reported to Date and Ultimate Earned Wages for the TSS, by Accident Year

Earning Year	Reported (uninflated)	Ultimate (uninflated)	Ultimate (inflated)
2015	2,119.59	2,119.59	2,997.27
2016	2,209.22	2,209.22	3,058.57
2017	2,262.98	2,262.98	3,126.71
2018	2,381.55	2,381.55	3,107.62
2019	2,510.70	2,510.70	3,207.33
2020	2,723.97	2,723.97	3,433.79
2021	2,928.44	2,928.44	3,602.54
2022	3,116.15	3,116.15	3,665.72
2023	3,428.07	3,428.07	3,871.23
2024	3,691.19	3,691.19	4,042.77
2025	3,982.61	3,982.61	4,174.91
2026	4,068.68	4,298.92	4,140.81

Our initial projection for earned wages for the TSS in the 2025/26 earnings year is $4.1 million, remaining stable from the 2023/24 earning year.

L.3. Conventional Policy Premiums for Licensed Insurers

Similar to the wages data, the premiums sourced from the coverage file are expected to develop over time due to reporting delays or premium adjustments. To track how premiums have changed over time for each underwriting cohort, the written premiums data has been triangulated by underwriting and delay quarters. A Chain Ladder model is then applied to project future movements to wages for each of the underwriting cohorts.

Table L.6 below shows our estimates for changes in written premiums for the September 2021 to the June 2025 underwriting quarters. We have also included a projection of the written premium and their development for the September 2025 to June 2026 underwriting quarters.

Table L.5: Licensed Insurer Written Premiums (in Current Values), by Renewal Quarter (RQ) and Delay Quarter (DQ)

	Delay Quarter							
Underwriting Quarter	0	1	2	3	4	5	6	7
Sep-19	104	115	115	115	115	115	115	115
Dec-19	33	40	40	40	40	40	40	40
Mar-20	19	26	26	26	26	26	26	26
Jun-20	27	35	35	35	35	35	35	35
Sep-20	106	120	120	120	120	120	120	120
Dec-20	41	49	49	49	50	50	50	50
Mar-21	22	28	28	28	28	28	28	28
Jun-21	31	38	38	38	38	38	38	38
Sep-21	120	133	133	133	133	133	133	133
Dec-21	44	52	53	53	53	53	53	53
Mar-22	24	32	32	32	32	32	32	32
Jun-22	37	43	43	43	43	43	43	43
Sep-22	126	141	142	142	142	142	142	142
Dec-22	44	53	53	53	53	53	53	53
Mar-23	26	34	35	35	35	35	35	35
Jun-23	38	47	47	47	47	47	47	47
Sep-23	133	150	150	150	151	151	151	151
Dec-23	51	61	61	61	61	61	61	61
Mar-24	27	33	33	33	33	33	33	33
Jun-24	41	47	47	47	47	47	47	47
Sep-24	149	162	162	162	162	162	162	162
Dec-24	51	59	59	59	59	59	59	59
Mar-25	25	32	32	32	32	32	32	32
Jun-25	40	46	46	46	46	46	46	46
Sep-25	160	184	184	185	185	185	185	185
Dec-25	56	64	65	65	65	65	65	65
Mar-26	26	30	30	31	31	31	31	31
Jun-26	43	49	50	50	50	50	50	50

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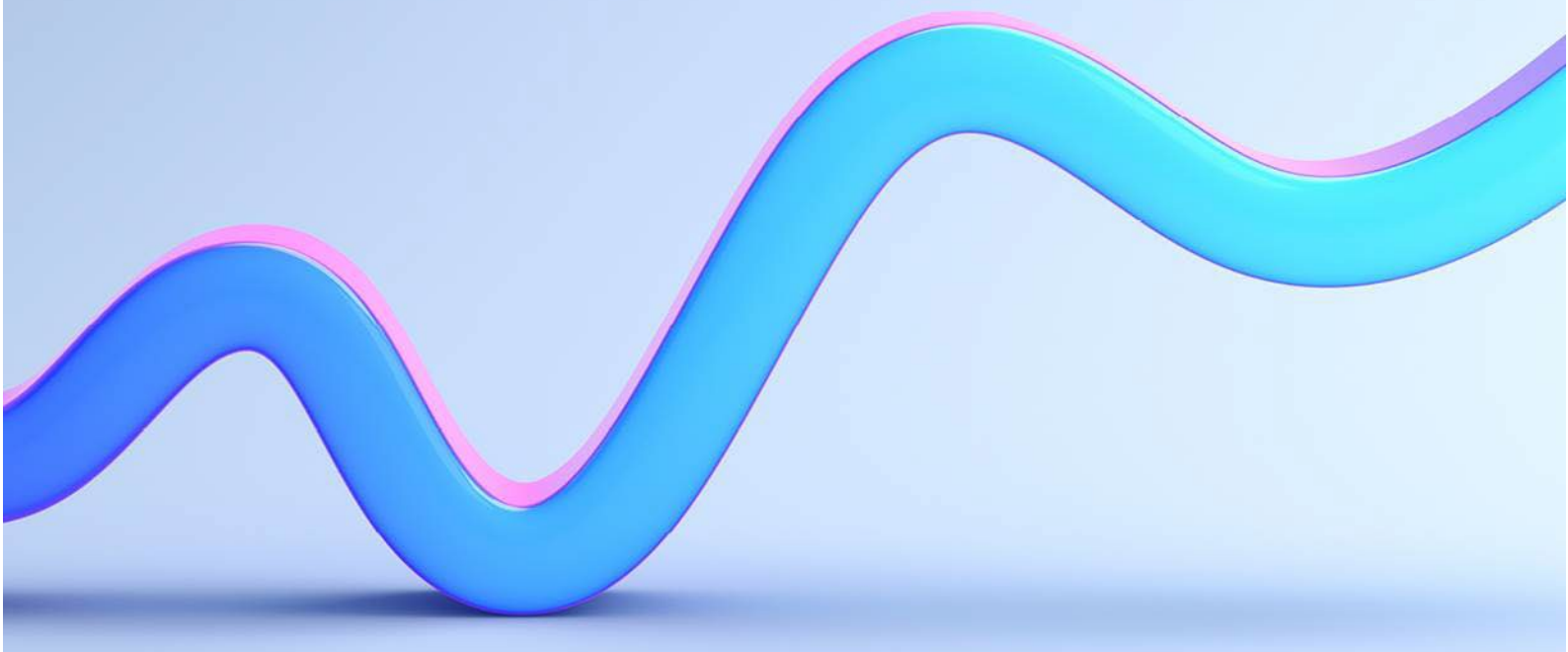

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