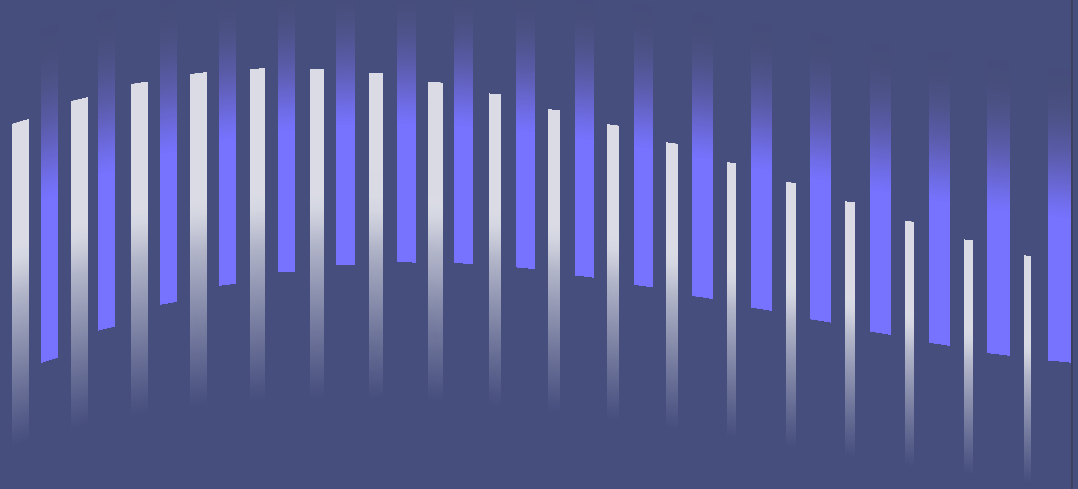
scyne ADVISORY

WorkCover Tasmania

Scheme Review to 30 June 2023

November 2023



Disclaimer

This report is not intended to be read or used by anyone other than WorkCover Tasmania.

We prepared this report solely for WorkCover Tasmania's use and benefit in accordance with and for the purpose set out in our contract with WorkCover Tasmania, dated 30 September 2019, and the corresponding extension in the deed of variation dated 6 June 2023. In doing so, we acted exclusively for WorkCover Tasmania and considered no-one else's interests.

Our engagement did not constitute an audit, review or assurance engagement in accordance with Pronouncements or Standards issued by the Australian Auditing and Assurance Standards Board, and accordingly no such assurance will be provided in this report.

We accept no responsibility, duty or liability:

- to anyone other than WorkCover Tasmania in connection with this report; and
- to WorkCover Tasmania for the consequences of using or relying on it for a purpose other than that referred to above.

We make no representation concerning the appropriateness of this report for anyone other than WorkCover Tasmania. If anyone other than WorkCover Tasmania chooses to use or rely on it, they do so at their own risk.

This disclaimer applies:

- to the maximum extent permitted by law and, without limitation, to liability arising in negligence or under statute; and
- even if we consent to anyone other than WorkCover Tasmania receiving or using this report.

WorkCover Tasmania Board

WorkSafe Tasmania
30 Gordons Hill Road, Rosny Park
Tasmania 7018

Cc: Mr Damian Davidson
WorkSafe Tasmania

November 2023

Please find enclosed our report covering our review of the operation and performance of the Tasmanian workers' compensation scheme for the period to 30 June 2023.

The key findings of our review are set out in the Executive Summary of this report.

Subsequent to preparing this report, we have been informed by WorkSafe Tasmania of an understatement of covered wages submitted by one self-insurer in respect of the 2023/24 financial year. We have reviewed whether this would alter our advice and we are of the opinion that the results and conclusions outlined in this report remain appropriate and importantly do not impact the licensed insurer or Tasmanian State Service segments.

We look forward to discussing this report with you.

Yours sincerely,

Andrew Smith
Fellow of the Institute of
Actuaries of Australia

Vansh Desai
Fellow of the Institute of
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Insights

Scheme Sustainability

- Growth in wages has outpaced growth in ultimate cost. As such, discounted ultimate cost has decreased from 1.62% of earned wages for the 2021/22 accident year to 1.53% for the 2022/23 accident year.
- The long-term trend of decreasing claim frequencies (driven by the licensed insurer sector) has stabilised in the past year. We estimate claim frequency for the 2022/23 accident year to be 0.47 claims per million dollars of wages, which is in line with 2021/22 and is also our forecast for the 2023/24 accident year.
- Licensed insurer claims continue to cost less on average (around $25,800), whereas self-insurer and TSS claims continue to cost more on average (around $47,700 and $56,000, respectively). An average claim size of $32,900 is expected for accident years 2022/23 and 2023/24 – this is 1% lower than 2021/22.
- Experience for mental health-related claims has been a key driver of emerging trends in the Scheme. The proportion of claims that are mental health-related has risen from 6% (2012/13) to 12% (2022/23). Payment volumes for non-mental health claimants have been relatively stable in recent years, whereas mental health-related claimants' share of payments has grown from 13% in 2012/13 to 33% in 2022/23.

Licensed Insurers

- Wages covered by licensed insurers grew by 4.4% in real terms to $12.7 billion for the 2022/23 accident year. Preliminary figures suggest that wages covered will grow an additional 4.8% in real terms, to be $13.3 billion in 2023/24.
- Claim frequency has stabilised at 0.47 claims per million dollars of wages.
- The discounted ultimate cost of the 2022/23 accident year is projected to be 1.22% of earned wages, which is in line with that projected for 2021/22.
- Profitability continues to appear to be healthy, with a profit margin of 26% projected for accident year 2022/23 – this is slightly higher than 2021/22 (24%).

Self-Insurers

- Wages covered by self-insurers grew by 2.5% in real terms to $492 million for the 2022/23 accident year. Preliminary figures suggest that wages covered will grow an additional 2.6% in real terms, to be $505 million in 2023/24.
- The decreasing trend in claim frequency has continued into 2022/23, with a decrease in claim frequency per million dollars of wages from 0.36 for accident year 2021/22 to 0.30 for accident year 2022/23.
- Discounted ultimate cost as a proportion of earned wages has averaged 1.54% for 2012/13 to 2021/22, with 1.37% projected for the 2022/23 accident year.

Tasmanian State Service

- Wages covered by the TSS grew by 6.9% in real terms to $3.5 billion for the 2022/23 accident year. Preliminary figures suggest that wages covered will grow an additional 5.1% in real terms, to be $3.7 billion in 2023/24.
- Claim frequency remains in line with historic experience, at 0.49 claims per million dollars of wages for the 2022/23 accident year.
- 10% growth in earned wages has driven a decrease in discounted ultimate cost from 3.06% of earned wages for 2021/22 to 2.70% for 2022/23.
- 26% of claims for accident year 2022/23 are mental health-related, with recent increases driven by emergency service and frontline healthcare workers.
- Weekly payments for non-mental health-related TSS claimants has been stable, whereas weekly payments to mental health-related TSS claimants has doubled from $15 million in 2020/21 to $32 million in 2022/23.

Part I: Executive Summary

1. Introduction and Background

Scyne Advisory ("Scyne") – formerly known as PricewaterhouseCoopers Consulting (Australia) – has been engaged by the WorkCover Tasmania Board to review the operation and performance of the Tasmanian workers' compensation scheme ("the Scheme") to 30 June 2023. The Executive Summary of this report discusses our key findings.

This work has been performed under our contract with WorkCover Tasmania, dated 30 September 2019, and the corresponding extension in the deed of variation dated 6 June 2023.

Unless otherwise stated, all amounts are quoted in 30 June 2023 values throughout this report. In addition, payment figures are typically presented on a financial year basis, which means that payments in any financial year will relate to a mix of accident years.

2. Features of Scheme Experience

The key features of the experience that has emerged 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 grew by 5% in real terms, from $15.9 billion in 2021/22 to $16.7 billion in 2022/23. The growth was driven by licensed insurers and the TSS. Preliminary figures suggest that wages covered will grow an additional 5% in real terms, to be $17.5 billion in 2023/24.

Claim Numbers and Frequency

Experience by accident year has been as follows:

- The ultimate number of claims for the 2022/23 accident year is projected to be 7,795.
  - This is 5% higher than the projected ultimate for the 2021/22 accident year, with the growth having been driven by licensed insurers and the TSS.
  - The projected ultimate for 2022/23 implies a claim frequency of 0.47 claims per million dollars of wages, which is in line with the 2021/22 accident year.
- Our forecast of the ultimate number of claims for the 2023/24 accident year is 8,151.
  - This is 5% higher than the projected ultimate for 2022/23, and is in line with forecasted growth in earned wages.
  - The forecasted ultimate for 2023/24 implies a claim frequency of 0.47 claims per million dollars of wages, which is in line with the 2022/23 accident year.

Experience by report year has been as follows:

- 7,739 claims were reported to the Scheme in 2022/23, which is 3% higher than 2021/22.
- We project that 8,139 claims will be reported to the Scheme in 2023/24, which is 5% higher than 2022/23.

Claim Payments and Average Claim Size

Comparing the 2022/23 financial year to 2021/22, Scheme payments grew by 12% in real terms from $217.2 million to $242.6 million. This increase has been partly driven by a rebound in lump sum payments, after falling to its lowest level in a decade in 2021/22. There has also been a step-up in weekly payments in the last two financial years, with this largely relating to TSS claims (in particular, mental health-related claims in the TSS).

For the Scheme overall, the average claim size for the 2022/23 accident year is projected to be $32,900 – this is 1% lower in real terms than our projection for 2021/22. The selected average claim size for new accidents is also $32,900.

Licensed insurer claims tend to cost less on average (assumed to be $25,800 for new accidents), whereas self-insurer and TSS claims tend to cost more on average (assumed to be $47,700 and $56,000 respectively for new accidents). There has been an 8% increase in our TSS average claim size selection for new accidents, on account of increased selections for the weekly and lump sum components of average claim size.

Weekly Benefits

Experience relating to weekly benefits has been as follows:

- 69% of claims for the 2022/23 accident year are projected to be lost time claims, which is consistent with experience for 2021/22. We are forecasting consistent experience for 2023/24 as well.
- Weekly actives grew by 2% to 11,507 in the 2022/23 financial year, and is forecast to grow by 5% to 12,132 in 2023/24. This is predominantly driven by the TSS (8% per annum growth across both years).
- There was $97.5 million of weekly payments in 2022/23, which was 7% higher than 2021/22 in real terms. We have forecasted $98.9 million of weekly payments in 2023/24, which would be 1% higher than 2022/23.
- The weekly Payment per Active Claim (PPAC) for 2022/23 was around $8,500, which was 4% higher in real terms than 2021/22. TSS continues to have the highest weekly PPAC of the three sectors, whereas licensed insurers have the lowest. The weekly PPAC projected for 2023/24 is around $8,200 – this is 4% lower in real terms than 2022/23.

Lump Sums

Experience relating to lump sum benefits has been as follows:

- We forecast that 477 claims will receive their first lump sum in the 2023/24 financial year, which is in line with the majority of experience since 2016/17. We estimate an ultimate number of 508 lump sum claims for the 2022/23 accident year and forecast an ultimate number of 525 lump sum claims for the 2023/24 accident year.
- Lump sum category utilisation continues to be relatively stable. Around 75% of lump sum utilisation has been in respect of redemptions, with most of the remaining utilisation being in respect of permanent impairment payments.
- There was a rebound in lump sum payment volumes to $68.3 million in the 2022/23 financial year, after falling in 2021/22 to their lowest level in a decade. We have forecasted $69.1 million of lump sum payments in 2023/24, which would be 1% higher than 2022/23 in real terms.
- The average lump sum claim size per claim that receives a lump sum is projected to be $154,100 for the 2022/23 accident year, which is 2% lower in real terms than 2021/22. The selected lump sum average claim size for new accidents is $156,800.

Medical and Related Payments

Experience relating to medical and related payments has been as follows:

- There was $56.2 million of medical payments in the 2022/23 financial year, which was 7% higher than 2021/22 in real terms. We have forecasted $57.3 million of medical payments in 2023/24, which would be 2% higher than 2022/23.
- The medical component of average claim size is projected to be $7,300 for the 2022/23 accident year, which is 1% higher in real terms than 2021/22. The selected medical average claim size for new accidents is $7,400.

Legal and Investigation Payments

Experience relating to legal and investigation payments has been as follows:

- There was $20.6 million of payments in the 2022/23 financial year for legal and investigation costs, which was 15% higher than 2021/22 in real terms. We have forecasted $19.8 million of payments in 2023/24 for legal and investigation costs, which would be 4% higher than 2022/23.
- The legal/investigation average claim size is projected to be $2,500 for the 2022/23 accident year, which is 0.3% lower in real terms than 2021/22. The selected legal/investigation average claim size for new accidents is $2,600.

Ultimate Cost by Accident Year

The undiscounted ultimate cost of accident year 2022/23 is projected to be $272.6 million, with the 8% increase relative to our projection for 2021/22 being driven by the 12% increase for licensed insurers. The undiscounted ultimate cost for the new accident year (2023/24) is forecasted to be $295.7 million, which is 9% higher in real terms than our forecast for the new accident year at the previous review. The movement for licensed insurers and self-insurers was driven by the movement in ultimate claim numbers, whereas the increase for the TSS was driven by increases in average claim size for future TSS accidents.

The discounted ultimate cost of accident year 2022/23 is projected to be 1.53% of earned wages, which is lower than the 1.62% projected for 2021/22. Upward revisions in our TSS ultimate cost estimates for recent accident years have been driven by increased estimates for weekly and lump sum. We forecast discounted ultimate cost for the new accident year (2023/24) to be 1.52% of earned wages, as compared to 1.53% for the new accident year at the previous review.

Mental Health Claims

The proportion of reported claims that are mental health-related has approximately doubled over the past decade across all three sectors, with mental health-related claims representing 12% of claims reported to date for accident year 2022/23. The proportion of claims that are mental health-related continues to be the highest for the TSS (26% for 2022/23), with recent increases driven by emergency service and frontline healthcare workers.

Payment volumes for non-mental health claimants have been relatively stable in recent years, whereas payments to mental health-related claimants has grown such that their share of Scheme payments has increased from 13% for 2012/13 to 33% for 2022/23. In particular, TSS payments for mental health-related claims have quadrupled in the past decade, which has increased these claims' share of TSS payments from 36% in 2012/13 to 67% in 2022/23.

We remain of the view that there are opportunities to develop and apply interventions that may be effective in managing the incidence and cost of mental health-related claims.

Silicosis Claims

There continues to be ongoing concern across Australia regarding an increase in the prevalence of silicosis due to prior exposure to silica dust. Claims that have arisen from silicosis are included like all other claims in our analysis however no explicit adjustments for silicosis claims have been made due to lack of claims experience.

18 silicosis claims have been reported to date, in respect of 15 distinct employees. The 18 reported claims are attributable to 10 distinct employers, and the average age at injury is 40 years old. Of the 14 claims that are accepted, three relate to accident year 1997 and prior, one is in respect of the 2011 accident year, and the remaining ten claims pertain to accident years 2018 to 2023.

Payments to date and outstanding case estimates for silicosis claims are around $2.63 million and $2.24 million, respectively. ANZSIC06 division C (Manufacturing) represents 13 of the 18 reported claims, as well as around 70% of both payments to date and outstanding case estimates. Two claims relate to division B (Mining) and one claim each has emerged from divisions D (Electricity, Gas, Water and Waste Services), E (Construction) and F (Wholesale Trade).

COVID-19

As at 19 May 2023, there were 141 reported claims caused by either contracting COVID-19 or having a mental health condition due to COVID-19, of which 61% were from the TSS. These 141 claims are estimated to have an ultimate cost of

$8.5 million, of which $4.7 million has already been paid (with the majority being weekly payments). We continue to not make any explicit adjustments for COVID-19 in our projections, due to COVID-19's relatively small impact to date and an expectation that it will continue to be of minimal impact going forward.

Licensed Insurer Experience

Experience relating to licensed insurers has been as follows:

- The number of policies written in 2022/23 was 19,474 – this is 2.6% higher than 2021/22. We have forecasted a further 2.6% increase to 19,975 for 2023/24.
- Earned premiums are estimated to be $278.2 million for accident year 2022/23, which is 11.5% higher than 2021/22. We have forecasted an 11.2% increase to $309.4 million for 2023/24, with the increase being driven by the growth that has been forecast for earned wages.
- The achieved premium rate for 2022/23 is projected to be 2.24%, as compared to 2.16% for 2021/22. We have forecasted an achieved premium rate of 2.29% for 2023/24.
- The projected profit margin of 26% for 2022/23 is slightly higher than 24% for 2021/22, with the increase driven by a decrease in the projected loss ratio. Recent improvements in licensed insurer profitability have likely been driven by increases in achieved premium rates, even though suggested rates have been decreasing since 2020/21.
- The sum of licensed insurer case estimates and IBN(E)R reserves (as sourced from the End of Financial Year Reconciliations) is 40% 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 outstanding claims liability central estimate determined by self-insurers is $17.4 million, which is 8% lower than our central estimate of $18.9 million. We note that self-insurers may also hold risk margins in addition to their central estimate. In aggregate, self-insurer bank guarantees are 1.4 times our actuarial central estimate (with the latter including an illustrative 10% allowance for claims handling expenses). Therefore, as a whole, self-insurers appear to be adequately reserved and have an appropriate level of bank guarantees.

Nominal Insurer Experience

Experience relating to the Nominal Insurer has been as follows:

- 60 claims were reported to the Nominal Insurer between 2002/03 and 2022/23. An average of 4.8 claims per annum were reported between 2002/03 and 2012/13, but this has fallen to an average of 0.7 claims per annum since 2013/14.
- An average of $441,000 of Nominal Insurer claim payments is made 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 around $97,000 (this is much higher than the rest of the Scheme).
- The Nominal Insurer has, on average, incurred $68,000 of administration expenses per annum. This translates to an average of $27,000 of administration expenses per claim reported, and an average ratio of 15% between administration expenses and claim payments.

Tribunal Matters

Experience relating to matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal ("Tribunal") has been as follows:

- 952 claims had their first matter referred to the Tribunal in 2022/23, which is 1% higher than 2021/22. The proportion of claims (with at least one dispute) that relate to the TSS has increased from 20% in 2017/18 to 30% in 2022/23, whereas licensed insurers and self-insurers have fallen from 73% to 66% and 7% to 4%, respectively.

Three-quarters of claims lodge one matter, 14% two matters, 9% three matters, and 3% lodge for four or more matters.

- Dispute of liability under Section 81A continues to be the most common dispute type. Section 42 referrals and settlement approvals are most likely to be the second (or later) dispute category that is referred for a claim. There appears to have been a step up in the past two years, in respect to the number of Section 71 disputes (these are disputes relating to compensation for permanent impairment).
- The overall disputation rate continues to remain between 10% and 13%, with it being 12% for 2022/23. The relativity between the Section 81A disputation rate and the overall rate continues to be relatively stable. Disputation rates for 2022/23 were 11% for licensed insurers, 17% for the TSS and 23% for self-insurers. The self-insurer disputation rate continues to be around double that of licensed insurer disputation rates, while the gap of TSS being above licensed insurer disputation rates has widened in recent years.
- The number of finalisations has grown by an average of 1.4% per annum between 2013/14 and 2022/23. There were 1,257 finalisations in 2022/23, which is 2.1% higher than 2021/22. The average delay between referral and finalisation reached a decade-low in 2021/22 (82 days), but has since increased to 102 days for 2023/24, which is in line with historical levels. Settlement approvals and disputes of liability under Section 81A continue to have the shortest average delays (seven days and 21 days, respectively).
- 15 matters have been adjourned between 2018/19 and 2023/24, with one matter being adjourned in 2021/22 and no matters being adjourned in 2022/23.

3. Reliance and Limitations

This Executive Summary should be read in conjunction with the full report, and the reliance and limitations described therein.

Part II: Scheme Report Card

	2021/22 Actual (A)	2022/23 Expected[2] (E)	2022/23 Actual (A)	2022/23 A – E	2023/24 Projected[2]
Earned Wages[1]					
Licensed Insurers	11,540.9	12,166.3	12,432.2	266.0	13,525.9
Self-Insurers	456.1	507.2	481.2	-26.0	509.1
Tasmanian State Service	3,115.6	3,475.4	3,427.4	-48.0	3,737.9
Scheme	**15,112.7**	**16,148.9**	**16,340.9**	**192.0**	**17,772.9**
Number of Claims Reported					
All Claims					
Licensed Insurers	5,670	5,652	5,912	260	6,194
Self-Insurers	181	188	154	-34	155
Tasmanian State Service	1,644	1,724	1,673	-51	1,791
Scheme	**7,495**	**7,565**	**7,739**	**174**	**8,139**
Total Claim Payments ($m)					
Licensed Insurers	126.2	145.1	144.3	-0.9	151.2
Self-Insurers	7.3	8.6	8.4	-0.2	7.8
Tasmanian State Service	73.4	78.8	85.4	6.5	90.7
Scheme	**206.9**	**232.6**	**238.0**	**5.4**	**249.7**
Weekly Benefits					
Lost Time Claims Reported					
Licensed Insurers	3,896	3,850	4,023	173	4,271
Self-Insurers	131	138	103	-35	108
Tasmanian State Service	1,196	1,141	1,079	-62	1,179
Scheme	**5,223**	**5,129**	**5,205**	**76**	**5,558**
Weekly Benefit Payments ($m)					
Licensed Insurers	44.9	45.5	48.1	2.6	49.7
Self-Insurers	2.7	3.1	3.0	-0.1	2.8
Tasmanian State Service	39.7	41.4	44.7	3.4	48.3
Scheme	**87.3**	**90.0**	**95.8**	**5.8**	**100.8**

	2021/22 Actual (A)	2022/23 Expected[2] (E)	2022/23 Actual (A)	2022/23 A – E	2023/24 Projected[2]
Lump Sum Benefits					
Lump Sum Claims					
Licensed Insurers	329	357	365	8	370
Self-Insurers	13	18	22	4	17
Tasmanian State Service	77	75	87	12	90
Scheme	**419**	**450**	**474**	**24**	**477**
Lump Sum Benefit Payments ($m)					
Licensed Insurers	34.7	50.9	44.5	-6.4	47.2
Self-Insurers	1.9	2.4	2.0	-0.4	2.3
Tasmanian State Service	15.7	17.6	20.2	2.6	20.9
Scheme	**52.3**	**70.9**	**66.7**	**-4.2**	**70.4**
Medical & Related Benefit ($m)					
Licensed Insurers	34.0	35.7	37.0	1.3	39.7
Self-Insurers	2.0	2.2	2.4	0.2	1.9
Tasmanian State Service	14.2	15.6	15.9	0.2	16.8
Scheme	**50.2**	**53.5**	**55.3**	**1.8**	**58.4**
Legal & Investigation ($m)					
Licensed Insurers	12.6	13.1	14.7	1.6	14.6
Self-Insurers	0.8	0.8	1.0	0.1	0.8
Tasmanian State Service	3.8	4.3	4.6	0.3	4.8
Scheme	**17.1**	**18.2**	**20.2**	**2.0**	**20.2**
Insurer Earned Premium Rate[1]	**2.16%**		**2.24%**		

Note: all wages and payments figures are shown in original values in the above table. However, in the rest of this report, amounts are generally expressed in 30 June 2023 values

1. Adjusted for the movement from estimated initial to final.
2. Specific allowance for Section 87 legislative changes was not included in the projection of expected payments for either 2022/23 or 2023/24, although this is expected to be small in total.

Part III: Contents

1. Introduction and Background

1.1. Purpose

Scyne Advisory ("Scyne") – formerly known as PricewaterhouseCoopers Consulting (Australia) – has been engaged by the WorkCover Tasmania Board to review the operation and performance of the Tasmanian workers' compensation Scheme ("the Scheme") to 30 June 2023.

This work has been performed under our contract with WorkCover Tasmania, dated 30 September 2019, and the corresponding extension in the deed of variation dated 6 June 2023.

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

The previous report ("Previous Scheme Review Report") relates to the Scheme review to 30 June 2022, with the report being dated October 2022. This is the eighth time we have undertaken this review.

Our most recent review of suggested industry premium rates ("the Previous Pricing Review") was in respect of the 2023/24 year and was based on data to 31 December 2022. Our findings are documented in the report *"Suggested Industry Premium Rates for 2023/24"*, dated March 2023.

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 benefits (including rehabilitation);
  - Legal and investigation costs; and
  - Lump sums (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 2023 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.

In completing our review and preparing projections, we have given regard to the legislative reforms outlined in Appendix D. In particular, since our previous Scheme review, the 2022 amendments to Sections 27 and 87 of Tasmania's *Workers Rehabilitation and Compensation Act 1988* (the Act) came into effect from 1 March 2023. The changes made were as follows:

- 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.
- Section 87: 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. We performed a costing of the impact of the change to Section 87, in our report titled *'Section 87 Costing'* (dated 21 June 2022). Our costing estimated the impact of the change would be a reduction of 0.04% to claims costs (i.e. risk premium) as a proportion of wages. Given the low materiality of the expected impact and that the change would have only impacted one-third of the most recent accident year, we have not made any explicit adjustment in our analysis for the impact of the change to Section 87.

1.3. Data Used

We have prepared this report using claim and policy data to 30 June 2023, extracted from the WorkSafe Information Management System (WIMS) during the month of August 2023. We have also used claims with disputes data, extracted as at 29 August 2023, and Nominal Insurer data, extracted as at 16 August 2023. WIMS has been operational since 1 July 2012 and replaced WorkSafe's previous data management system.

Since the Scheme Review to 30 June 2018, we have identified licensed insurer claims with large outstanding case estimates (greater than $2 million) and used these claims' common law case estimate in our lump sum modelling. In each case, WorkSafe has confirmed each claim's case estimate (both in aggregate and for common law) with the relevant insurer. As detailed in Section 6.4, at this review, WorkSafe was unable to obtain confirmation on the common law case estimate of one large claim. In the absence of any information, we have not adopted any explicit allowance for this claim's common law estimate.

Where case estimate amounts are quoted in this report in aggregate 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 figures provided for the Reconciliations, are considered more reliable overall. As mentioned above, in the limited instances where we have used case estimates for individual claims, in particular for the licensed insurer claims, WorkSafe has confirmed the case estimates with the relevant insurers.

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 that 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 half-yearly 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 2023/24 accident year. These estimates are referred to throughout this report as "projections." These costs are built up from 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 on our approach can be found in Section 14.3.

1.5. Structure of the Report

Our Review is set out 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 benefits;
- Section 8 – provides further detail in relation to legal and investigation benefits;
- Section 9 – summarises the projected ultimate claims cost for each accident year;
- Section 10 – presents information in relation to 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 relation to 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 relation to the Nominal Insurer, including the number of claims reported, claims costs, and administration 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 supporting the report deal with the data, detailed methodology, and Scheme background. They also provide further details in relation to our analysis of Scheme experience.

2. Covered Wages

This section summarises wages covered by the Scheme.

Key Points

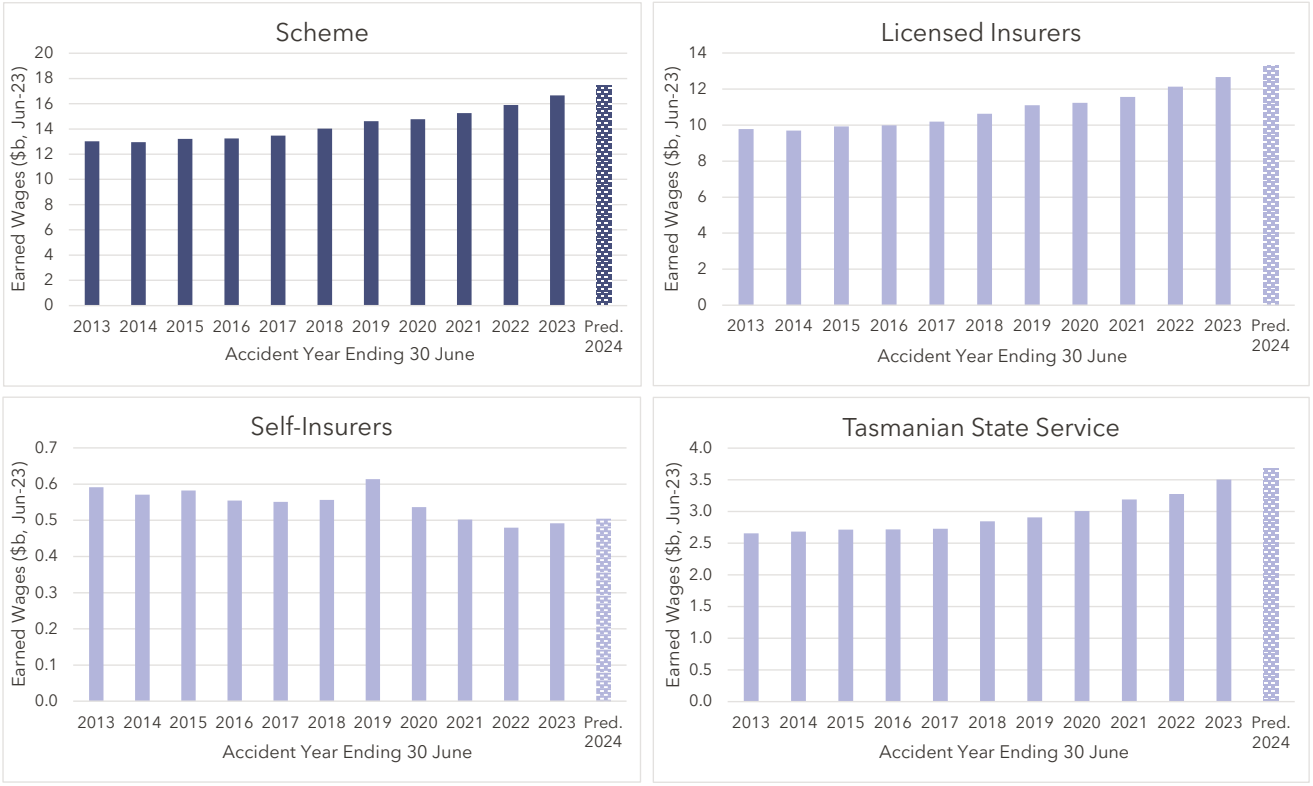
Wages covered by the Scheme grew by 5% in real terms, from $15.9 billion in 2021/22 to $16.7 billion in 2022/23. The growth was driven by licensed insurers and the TSS. Preliminary figures suggest that wages covered will grow an additional 5% in real terms, to be $17.5 billion in 2023/24.

2.1. Earned Wages

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 2.1.1 shows earned wages by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. All figures shown are in 30 June 2023 values, so that real growth in earned wages can be assessed. The wages shown for accident years 2021/22 to 2023/24 include an allowance for expected development, as wages are often revised from initial estimates to actual figures once finalised. In particular, we note there is considerable uncertainty in forecasting results for the incomplete 2023/24 year. Further details with respect to our analysis and projection of wages can be found in Appendix L.

Figure 2.1.1: Earned Wages, by Accident Year ($ billion, in 30 June 2023 values)



Source data can be found in Appendix E.1.

Comparing the 2022/23 accident year to 2021/22, earned wages grew by 4.9% in real terms from $15.9 billion to $16.7 billion. This was driven by licensed insurers (+$0.53b; +4.4%) and the TSS (+$0.23b; +6.9%), whereas growth was softer for self-insurers (+$0.01b; +2.5%).

Preliminary figures suggest that earned wages will grow by 4.8% in real terms, to be $17.5 billion in 2023/24. Again, this is expected to be driven by growth for licensed insurers and the TSS.

3. Claim Numbers and Frequency

This section summarises the claim number and frequency experience for the Scheme.

Key Points

For the 2022/23 accident year, we estimate an ultimate number of 7,795 claims. This implies a claim frequency of 0.47 claims per million dollars of wages for 2022/23, which is in line with the 2021/22 accident year.

For the 2023/24 accident year, we are forecasting an ultimate number of 8,151 claims. This implies a claim frequency of 0.47 claims per million dollars of wages for 2023/24, which is in line with the 2022/23 accident year.

7,739 claims were reported to the Scheme in 2022/23, which is 3% higher than 2021/22. We project that 8,139 claims will be reported to the Scheme in 2023/24, which is 5% higher than 2022/23.

3.1. Estimated Ultimate Claim Numbers – All Claims

Key Points

The ultimate number of claims for the 2022/23 accident year is projected to be 7,795. This is 5% higher than the projected ultimate for the 2021/22 accident year, with the growth having been driven by licensed insurers and the TSS.

Our forecast of the ultimate number of claims for the 2023/24 accident year is 8,151 claims, which is 5% higher than the projected ultimate for 2022/23. This is in line with the forecasted growth in earned wages.

Figure 3.1.1 shows estimated ultimate claim numbers by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also included a forecast of the number of claims that may emerge in respect of the 2023/24 accident year. Figure 3.1.1 also displays the ultimate claim number estimates at our previous review of the Scheme.

Figure 3.1.1: Ultimate Claim Numbers, by Accident Year (All Claims)

Source data can be found in Appendix E.2.

The ultimate number of claims in the Scheme for the 2022/23 accident year is projected to be 7,795. This is 5% (+357) higher than the projected ultimate for the 2021/22 accident year. Experience by sector has been as follows:

- for **licensed insurers**, the ultimate number of claims for 2022/23 is projected to be 5,944 – this is 5% (+302) higher than the projected ultimate for 2021/22, with the proportional increase being slightly higher than growth in earned wages;
- for **self-insurers**, the ultimate number of claims for 2022/23 is projected to be 149 – this is 15% (-25) lower than the projected ultimate for 2021/22, and was driven by large reductions for a handful of self-insurers; and
- for the **TSS**, the ultimate number of claims for 2022/23 is projected to be 1,702 – this is 5% (+80) higher than the projected ultimate for 2021/22, with the proportional increase being lower than growth in earned wages.

Our forecast of the ultimate number of claims for the 2023/24 accident year is 8,151 claims, which is 5% (+356) higher than the projected ultimate for 2022/23. The proportional increase in claims forecasted for each sector is in line with the quantum of growth predicted for the sector's earned wages.

3.2. Claim Frequency – All Claims

Key Points

Scheme claim frequency for the 2022/23 accident year is projected to be 0.47 claims per million dollars of wages. This is in line with the Scheme claim frequency for the 2021/22 accident year.

Our forecast of Scheme claim frequency for 2023/24 is 0.47 claims per million dollars of wages.

Figure 3.2.1 shows ultimate claim frequency by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also included the forecast of claim frequency for the 2023/24 accident year. Ultimate claim frequency has been calculated by dividing the projected ultimate number of claims by earned wages (in 30 June 2023 values).

Figure 3.2.1: Ultimate Claim Frequency, by Accident Year (All Claims)

Source data can be found in Appendix E.3.

Scheme claim frequency for the 2022/23 accident year is projected to be 0.47 claims per million dollars of wages. This is in line with the Scheme claim frequency for the 2021/22 accident year. Experience by sector has been as follows:

- **licensed insurer** claim frequency (per million dollars of wages) has increased slightly from 0.46 for 2021/22 to 0.47 for 2022/23 – this appears to be a stabilisation in claim frequency, given decreases in previous years;
- **self-insurer** claim frequency (per million dollars of wages) has decreased from 0.36 for 2021/22 to 0.30 for 2022/23 – this is a continuation of the decreases observed in previous years; and
- **TSS** claim frequency (per million dollars of wages) has decreased slightly from 0.50 for 2021/22 to 0.49 for 2022/23 – this is in line with historic experience.

Our forecast of Scheme claim frequency for the 2023/24 accident year is 0.47 claims per million dollars of wages. This assumes that claim frequency for each sector will be similar between 2022/23 and 2023/24.

3.3. Implications for Reported Claim Numbers

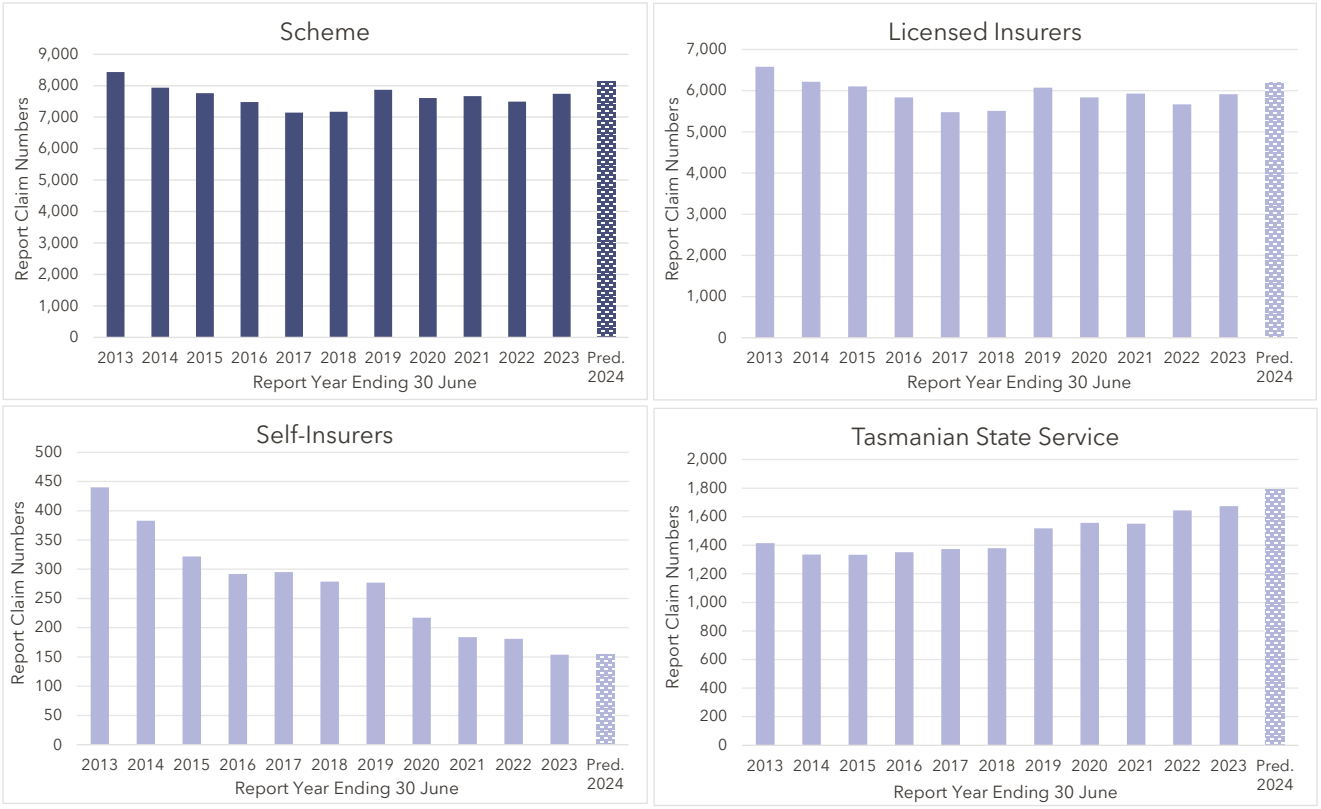
Key Points

7,739 claims were reported to the Scheme in 2022/23, which is 3% higher than 2021/22.

We project that 8,139 claims will be reported to the Scheme in 2023/24, which is 5% higher than 2022/23.

Figure 3.3.1 shows the historical number of claims reported in each financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also included our projection of the number of claims that will be reported in 2023/24. We note that Figure 3.3.1 has been presented on a report year basis, as opposed to the accident year basis used for Figure 3.1.1 and Figure 3.2.1.

Figure 3.3.1: Claim Numbers, by Report Year (All Claims)



Source data can be found in Appendix E.4.

The number of claims reported to the Scheme in 2022/23 was 7,739. This is 3% (+244) higher than the number of claims reported to the Scheme in 2021/22. Experience by sector has been as follows:

- for **licensed insurers**, 5,912 claims were reported in 2022/23, which is 4% (+242) higher than 2021/22;
- for **self-insurers**, 154 claims were reported in 2022/23, which is 15% (-27) lower than 2021/22 – this was driven by a lower-than-expected number of claims being reported in respect of the 2022/23 accident year; and
- for the **TSS**, 1,673 claims were reported in 2022/23, which is 2% (+29) higher than 2021/22.

Our projection of the number of claims to be reported to the Scheme in 2023/24 is 8,139 claims, which is 5% (+400) higher than the number of claims reported in 2022/23. This increase is expected to be driven by licensed insurers and the TSS.

4. Claim Payments and Other Items of Note

This section describes our findings with respect to trends in claim payments and average claim costs in the Scheme. We also document our assumptions regarding average claim size and payment patterns. This section relies on our analysis and assumptions for each payment type, which has been detailed in Sections 5 to 8.

We also document recent items of note, including the impact of the COVID-19 pandemic on the Scheme as well as Scheme experience for mental health claims.

Key Points

Scheme payments grew by 12% in real terms from $217.2 million (2021/22) to $242.6 million (2022/23), with the increase driven by a rebound in lump sum payments as well as continued growth in TSS weekly payments. We project that there will be $245.1 million of Scheme payments in 2023/24.

The selected average claim size for new accidents is $32,900 (in 30 June 2023 values), which is 1% higher in real terms than what was selected at the previous review. Licensed insurer claims ($25,800) tend to cost less on average than self-insurer ($47,700) and TSS ($56,000) claims.

The proportion of claims that are mental health-related has doubled over the past decade across all three sectors, with mental health-related claims representing 12% of claims reported to date for accident year 2022/23. The proportion remains to be the highest for the TSS (26% for 2022/23), with recent increases driven by emergency service and frontline healthcare workers. Payments to mental health-related claimants have grown, including a quadrupling for the TSS in the past decade. We remain of the view that there are opportunities to develop and apply interventions that may be effective in managing the incidence and cost of mental health-related claims.

18 silicosis claims have been reported to date, in respect of 15 distinct employees and 10 distinct employers. Payments to date and outstanding case estimates are $2.63 million and $2.24 million – of which, 76% and 98% (respectively) relate to claims for accident years 2018 to 2023. ANZSIC06 division C represents 13 of the 18 reported claims, and around 70% of both payments to date and outstanding case estimates. The remaining claims are spread across divisions B, D, E and F.

As at 19 May 2023, there were 141 reported claims caused by either contracting COVID-19 or having a mental health condition due to COVID-19, of which 61% were from the TSS. These 141 claims are estimated to have an ultimate cost of $8.5 million, of which $4.7 million has already been paid (with the majority being weekly payments). We continue to not make any explicit adjustments for COVID-19 in our projections, due to COVID-19's relatively small impact to date and an expectation that it will continue to be of minimal impact going forward.

4.1. Claim Payments in Total

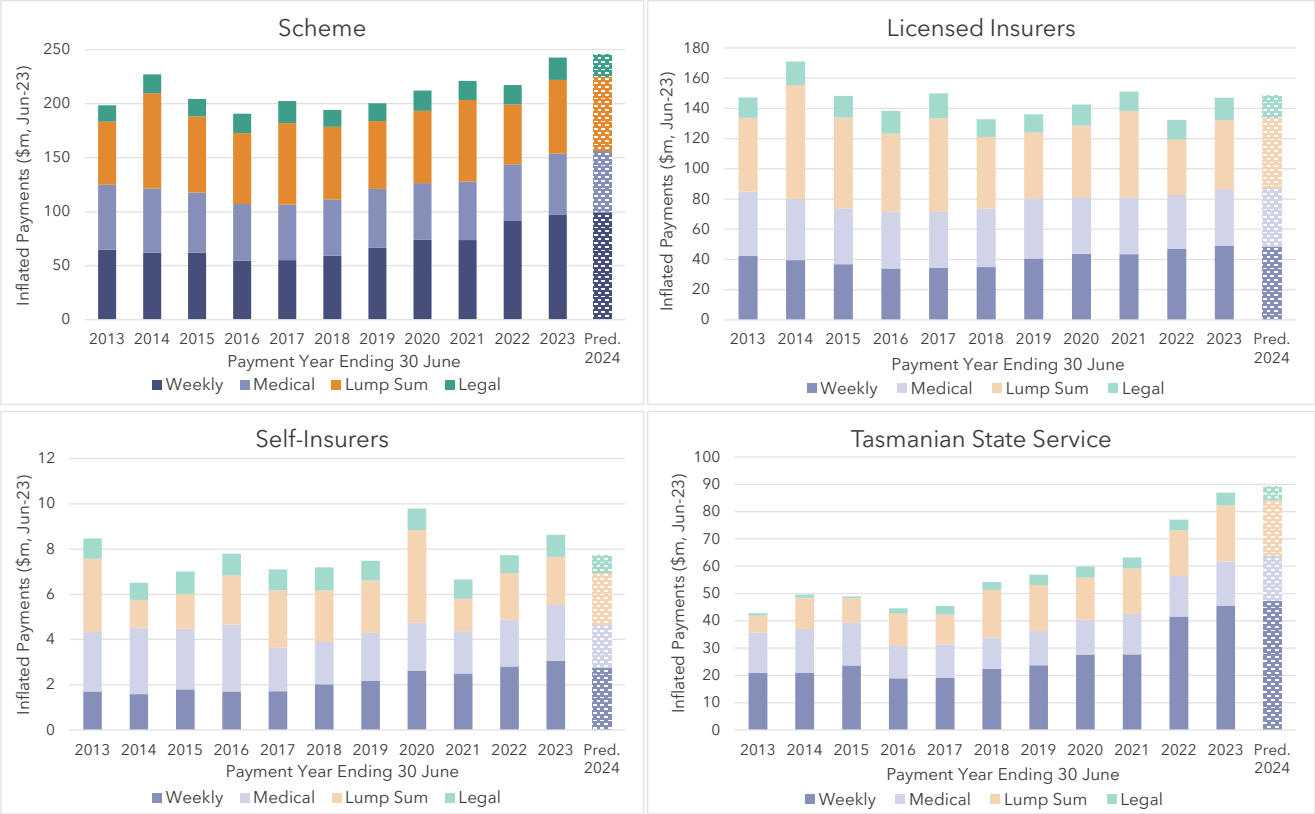
Key Points

Comparing the 2022/23 payment year to 2021/22, Scheme payments grew by 12% in real terms from $217.2 million to $242.6 million. This increase has been partly driven by a rebound in lump sum payments, after falling to its lowest level in a decade in 2021/22. There has also been a step-up in weekly payments in the last two financial years, with this largely relating to TSS claims.

We project that there will be $245.1 million of Scheme payments in financial year 2023/24, which would be 1% higher than 2022/23 in real terms.

Figure 4.1.1 shows total payments by payment type and financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also included a forecast of the quantum of payments that will be made in 2023/24. Given that Figure 4.1.1 is constructed on a payment year basis, payments in any year will relate to a mix of accident years. All amounts shown are in 30 June 2023 values, so that real growth in payments can be assessed.

Figure 4.1.1: Claim Payments, by Financial Year ($ million, in 30 June 2023 values)



Source data can be found in Appendix E.7.

Comparing the 2022/23 payment year to 2021/22, Scheme payments grew by 12% in real terms from $217.2 million to $242.6 million. Experience by sector has been as follows:

- for **licensed insurers**, payments grew by 11% in real terms from $132.4 million to $147.1 million – this was driven by a rebound in lump sum payments;
- for **self-insurers**, payments grew by 12% in real terms from $7.7 million to $8.6 million – this was driven by the increases observed for medical and legal payments; and
- for the **TSS**, payments grew by 13% in real terms from $77.0 million to $86.9 million – this was driven by the increases observed for weekly and lump sum payments.

There has been a notable step-up in weekly payments in the last two financial years, with this being driven by TSS experience. In 2021/22, lump sum payments reached its lowest level in a decade, with this being attributable to the decrease for licensed insurers. Lump sum payments have rebounded in 2022/23, to be more in line with historical levels.

We project that there will be $245.1 million of Scheme payments in financial year 2023/24. In real terms, this is 1% higher than 2022/23 and this proportional increase is consistent across the different payment types.

4.2. Selected Average Claim Size

Key Points

For the Scheme overall, the average claim size for the 2022/23 accident year is projected to be $32,900. This is 1% lower in real terms than our projection for the 2021/22 accident year. The selected average claim size for new accidents is $32,900 (in 30 June 2023 values), which is 1% higher in real terms than what was selected at the previous review.

Licensed insurer claims tend to cost less on average (assumed to be $25,800 for new accidents), whereas self-insurer and TSS claims tend to cost more on average (assumed to be $47,700 and $56,000 respectively for new accidents). The 8% increase in average claim size selection for the TSS has been driven by higher selections for weekly and lump sum.

Figure 4.2.1 shows our selected average claim sizes by payment type and accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. The average claim sizes shown include both payments already made and our projection of future payments (with the process for determining the latter being discussed further in Sections 5 to 8). Average claim sizes have been calculated by dividing by the ultimate number of claims projected for the relevant accident year. All average claim size amounts shown are in 30 June 2023 values, so that real growth in average claim sizes can be assessed.

Figure 4.2.1: Adopted Average Claim Sizes, by Accident Year ($, in 30 June 2023 values)

Source data can be found in Appendix E.8.

For the Scheme overall, the average claim size for the 2022/23 accident year is projected to be approximately $32,900. This is 1% lower in real terms than our projection for the 2021/22 accident year, and has been driven by a 2% decrease for the weekly average claim size. Experience by sector has been as follows:

- for **licensed insurers**, the average claim size for 2022/23 is projected to be around $26,000 – this is 3% higher in real terms than 2021/22 and has been driven by 6% and 3% increases for weekly and medical, respectively;
- for **self-insurers**, the average claim size for 2022/23 is projected to be around $45,200 – this is 12% lower in real terms than 2021/22 and has been driven by 15% and 14% decreases for weekly and lump sum, respectively; and

- for the **TSS**, the average claim size for 2022/23 is projected to be around $55,600 – this is 5% lower in real terms than 2021/22 and has been driven by 7% and 3% decreases for weekly and lump sum, respectively.

For the Scheme overall, the selected average claim size for the new accident year 2023/24 is around $32,900 (in 30 June 2023 values), which is 1% higher in real terms than what was selected for the new accident year (2022/23) at the previous review. The selected average claim sizes for each sector are as follows:

- for **licensed insurers**, we have selected an average size of around $25,800 for new accidents, which is 1% lower in real terms than the selection at the previous review – this has been driven by a 5% decrease in our selection for lump sum, such that it is more in line with emerging experience;
- for **self-insurers**, we have selected an average size of around $47,700 for new accidents, which is 3% lower in real terms than the selection at the previous review – this has been driven by a 9% decrease in our selection for lump sum, such that it is more in line with emerging experience; and
- for the **TSS**, we have selected an average size of around $56,000 for new accidents, which is 8% higher in real terms than the selection at the previous review – this has been driven by 9% and 13% increases in our selections for weekly and lump sum (respectively), such that they are more in line with emerging experience.

Table 4.2.2 summarises our average claim size selections for new accidents, at the previous and current review. Figures have been split out by sector and payment type, and are shown in 30 June 2023 values.

Table 4.2.2: Adopted Average Claim Sizes for New Accidents ($, in 30 June 2023 values)

Payment Type	Previous Review ($, Jun-23)	Current Review ($, Jun-23)	Change (%)
Licensed Insurers			
Weekly	8,254	8,146	-1%
Medical	6,458	6,502	1%
Lump Sum	9,157	8,740	-5%
Legal	2,358	2,458	4%
Total	**26,227**	**25,846**	**-1%**
Self-Insurers			
Weekly	18,098	18,213	1%
Medical	12,006	11,829	-1%
Lump Sum	14,470	13,236	-9%
Legal	4,361	4,402	1%
Total	**48,936**	**47,680**	**-3%**
Tasmanian State Service			
Weekly	26,373	28,789	9%
Medical	10,048	9,945	-1%
Lump Sum	12,874	14,516	13%
Legal	2,702	2,796	4%
Total	**51,997**	**56,046**	**8%**

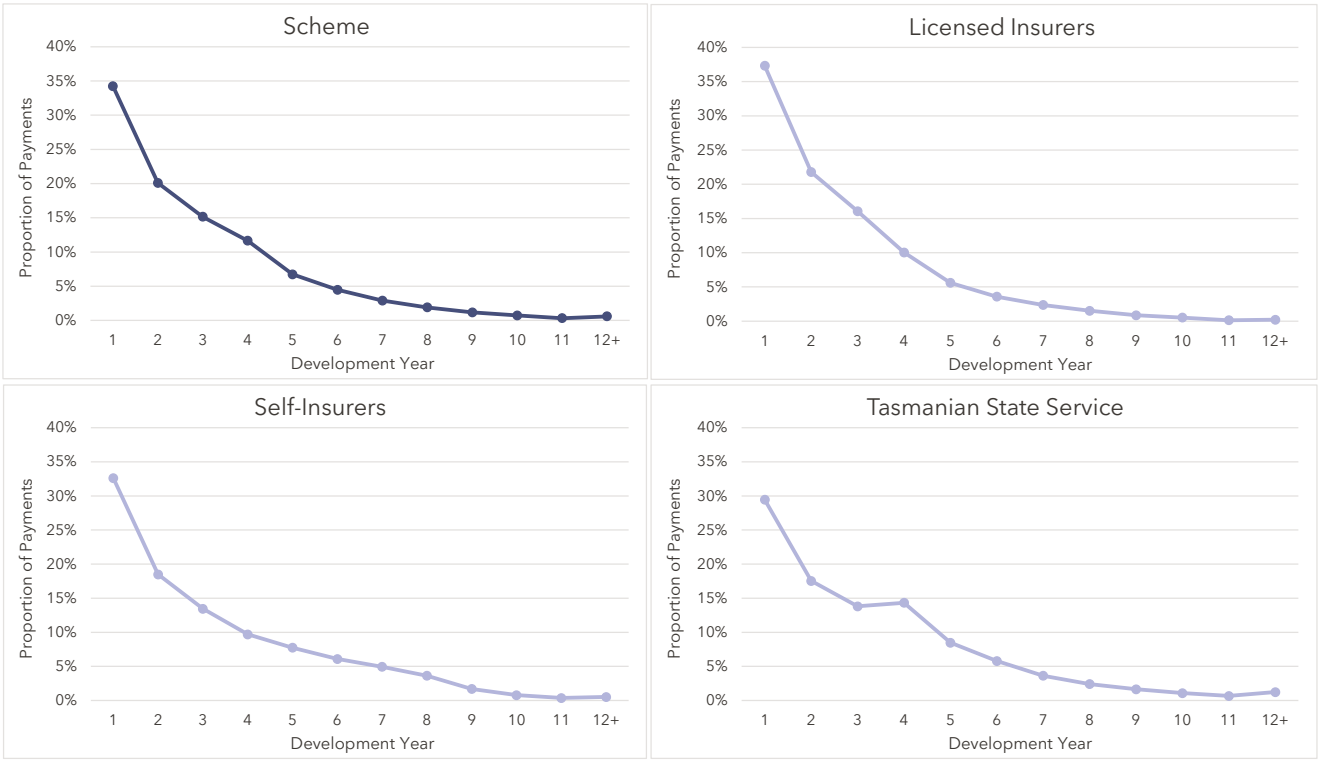
4.3. Payment Pattern

Our modelling approach is based on assumptions that are split out by development period and, hence, implies a certain payment pattern. While each payment type is modelled separately analysis, the implied payment patterns for new accidents that are presented below are for all payment types combined.

Key Points

The payment pattern for the Scheme overall is relatively front-loaded, and implies a weighted average payment term of 2.2 years. The weighted average payment term for licensed insurers (1.9 years) is shorter than that for self-insurers (2.5 years) and the TSS (2.6 years).

Figure 4.3.1: Implied Payment Pattern for New Accidents



Source data can be found in Appendix E.9.

The majority of payments tend to be made within the first few years after accident, with around 92% of payments typically being made within the first six years after accident. The payment pattern for the Scheme overall implies a weighted average payment term of 2.2 years (from the date of the accident). Note that this is not the time to first payment, but rather the weighted average time from accident for all payments.

The payment pattern for self-insurers and the TSS is slightly slower than that for licensed insurers. This is reflected in the weighted average payment term for licensed insurers (1.9 years) being shorter than that for self-insurers (2.5 years) and the TSS (2.6 years).

4.4. Mental Health Claims

Key Points

The proportion of reported claims that are mental health-related has approximately doubled over the past decade across all three sectors, with mental health-related claims representing 12% of claims reported to date for accident year 2022/23. The proportion of claims that are mental health-related continues to be the highest for the TSS (26% for 2022/23), with recent increases driven by emergency service and frontline healthcare workers.

Payments volumes for non-mental health claimants have been relatively stable in recent years, whereas payments to mental health-related claimants has grown such that their share of Scheme payments has grown from 13% for 2012/13 to 33% for 2022/23. In particular, TSS payments for mental health-related claims have quadrupled in the past decade, which has increased these claims' share of TSS payments from 36% in 2012/13 to 67% in 2022/23.

We remain of the view that there are opportunities to develop and apply interventions that may be effective in managing the incidence and cost of mental health-related claims.

4.4.1. Mental Health Claim Numbers

Figure 4.4.1 shows the number of claims reported to date by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. The claim report numbers have been split out into mental health (MH) related claims and non-mental health (non-MH) related claims.

Figure 4.4.1 shows that the proportion of reported claims that are mental health-related has approximately doubled over the past decade. This strong growth in the proportion of claims that are mental health-related is a trend that has been observed in other Australian states and territories.

For the Scheme overall, 9% of claims reported for accident years 2018/19 to 2020/21 were mental health-related. This has increased to 11% for 2021/22 and 12% for 2022/23 (based on claim report experience to date). Experience by sector has been as follows:

Licensed Insurers

- Mental health-related claims represent 8% of licensed insurer claims reported to date for accident year 2022/23. This compares to 4% for accident year 2012/13 and 6% for accident year 2017/18.
- The proportion of claims that are mental health-related has consistently been lower for licensed insurers than self-insurers and the TSS, especially compared to the latter.

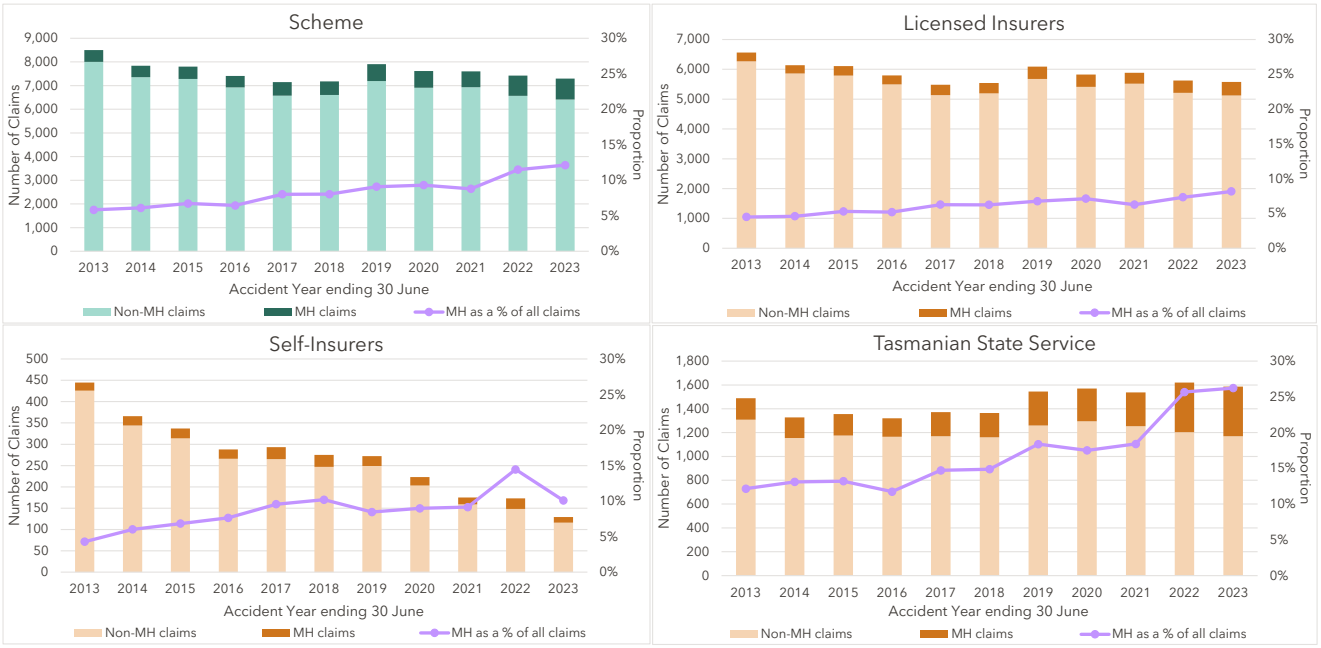
Self-Insurers

- Mental health-related claims represent 10% of self-insurer claims reported to date for accident year 2022/23. This is more in line with recent years, after peaking at 14% for accident year 2021/22.

Tasmanian State Service

- Mental health-related claims represent 26% of TSS claims reported to date for accident year 2022/23. While this is consistent with 2021/22, this is a noteworthy increase from 18% (observed for accident years 2018/19 to 2020/21).
- The proportion of claims that are mental health-related has consistently been higher for the TSS than licensed insurers and self-insurers, with the gap having widened in recent years. The October 2018 amendments (detailed further in Appendix D8) introduced presumptive provisions for post-traumatic stress disorder (PTSD) claims in the TSS. This may have contributed to faster growth in the number of mental health-related claims in the TSS, as compared to licensed insurers and self-insurers.

Figure 4.4.1: Claims Reported to Date by Accident Year, Split out into Mental Health (MH) and Non-MH Claims

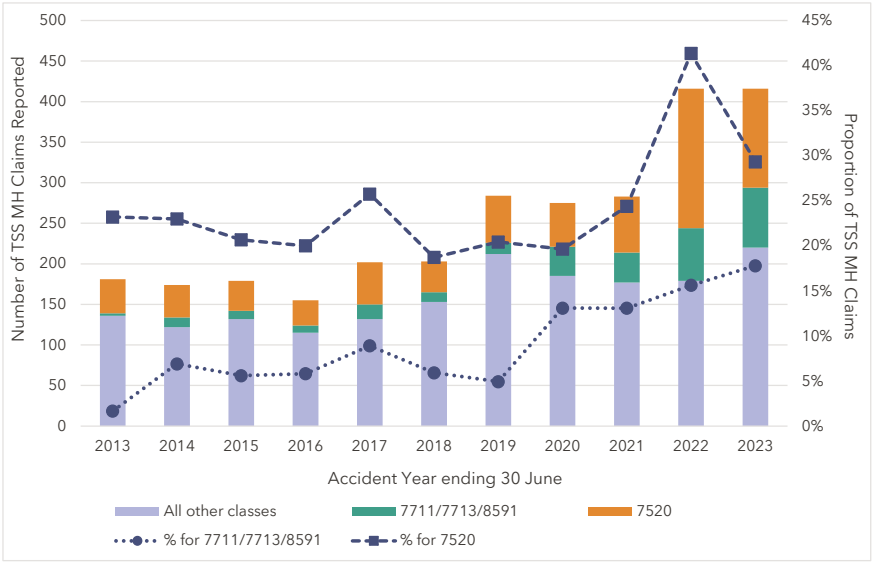


Source data can be found in Appendix E.5.

Figure 4.4.2 shows increases in the proportion of mental health-related TSS claims that relate to certain ANZSIC06 classes, in particular:

- **Classes 7711, 7713 and 8591 ('Police Services', 'Fire Protection and Other Emergency Services' and 'Ambulance Services', respectively)** – For most of the past decade, these three emergency service-related classes have collectively represented 5 to 7% of mental health-related TSS claims. However, this has increased to 13% for accident years 2019/20 and 2020/21, and increased further to 16% for 2021/22 and 18% for 2022/23.
- **Class 7520 ('State Government Administration')** – For most of the past decade, 20 to 25% of mental health-related TSS claims have related to class 7520. This rose to 41% for accident year 2021/22, before dropping back to 29% for 2022/23. We understand from previous discussions with WorkSafe that some Department of Health coverages have previously been incorrectly categorised to class 7520. We also understand that many of the employees under these incorrectly classified coverages were frontline healthcare workers, some of whom worked in hospitals.

Figure 4.4.2: Mental Health (MH) Claims Reported in the TSS, by Accident Year and ANZSIC06 Class

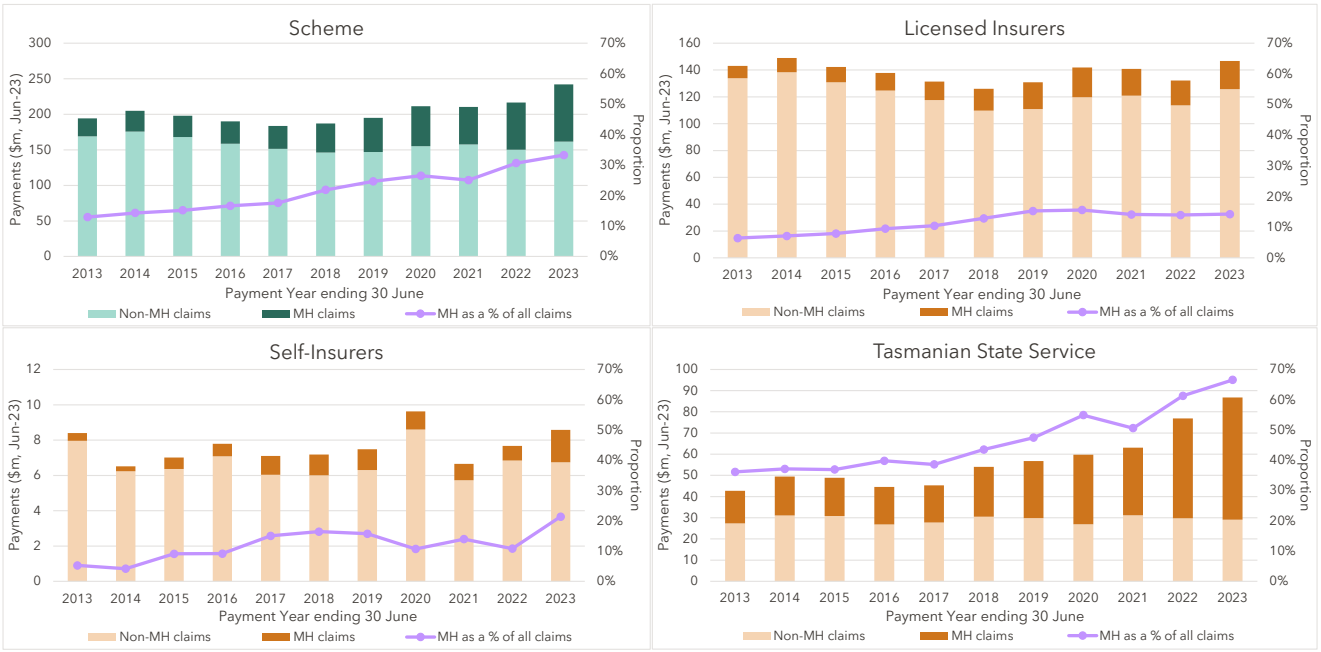


Source data can be found in Appendix E.5.

4.4.2. Mental Health Claim Payments

Figure 4.4.3 shows total payments by financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. Payments have been split out into payments for mental health (MH) related claims and payments for non-mental health (non-MH) related claims. All payment amounts shown are in 30 June 2023 values.

Figure 4.4.3: Payments ($ million, in 30 June 2023 values), Split out into Mental Health (MH) and Non-MH Claims



Source data can be found in Appendix E.6.

Figure 4.4.3 shows that the proportion of payments that are for mental health-related claims has more than doubled over the past decade. This growth has been stronger than the increases that have been observed for the proportion of reported claims that are mental health-related.

For the Scheme overall, payments to non-mental health-related claimants have been relatively stable in recent years, whereas payments to mental health-related claimants has grown. This has meant that the proportion of payments that pertain to mental health-related claims has increased from 25-27% (for 2018/19 to 2020/21) to 31% (2021/22) and to 33% (2022/23). Experience by sector has been as follows:

Licensed Insurers

- The proportion of licensed insurer payments that pertain to mental health-related claims has remained stable at 14%, in financial years 2020/21 to 2022/23. Nevertheless, this is higher than the first half of the past decade (e.g. 6% for 2012/13 and 10% for 2016/17).
- In 2022/23, licensed insurers (14%) became the sector with the lowest proportion of payments that are for mental health-related claims (as compared to 21% for self-insurers and 67% for the TSS).

Self-Insurers

- From 2012/13 to 2015/16, 9% of self-insurer payments were in respect of mental health-related claims. This increased to 14% for 2016/17 to 2021/22, and has risen further to 21% for 2022/23.

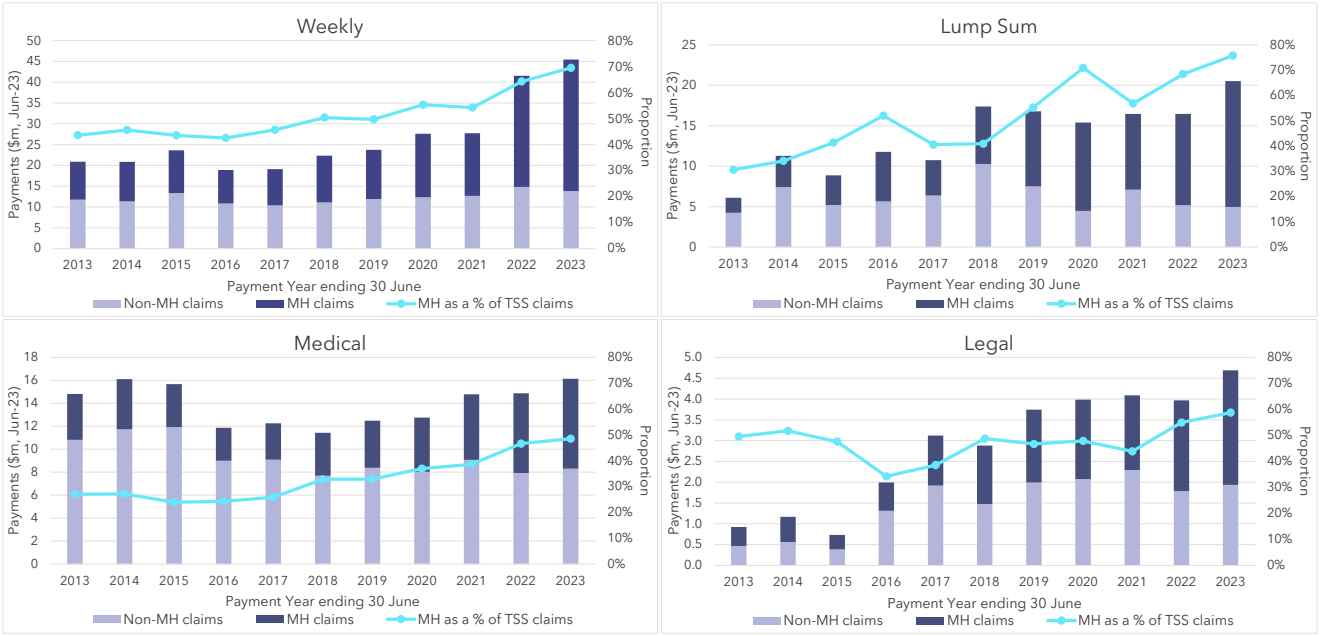
Tasmanian State Service

- From 2012/13 to 2016/17, 38% of TSS payments were in respect of mental health-related claims. This has then consistently increased year-on-year from 46% (2017/18 and 2018/19), to 53% (2019/20 and 2020/21), to 61% (2021/22), and to 67% (2022/23).
- This has been due to payments to non-mental health-related claimants remaining relatively flat, whereas payments to mental health-related claimants has nearly quadrupled in the past decade (this corresponds to an average growth rate of 13% per annum).
- The proportion of payments that pertain to mental health-related claims has consistently been higher for the TSS than licensed insurers and self-insurers, with the gap having widened over time.

We note that it is not surprising to see that the growth rate in mental health-related claim payments has outstripped the growth rate in the number of mental health-related claims reported. This is because mental health-related claims tend to be more costly, given that they are often of a longer duration than physical injury claims and also have a greater propensity to receive lump sum benefits.

In order to examine the TSS in greater detail, Figure 4.4.4 shows TSS payments by financial year and payment type. Just like Figure 4.4.3, payments have been split out into payments for mental health (MH) related claims and payments for non-mental health (non-MH) related claims. All payment amounts shown are in 30 June 2023 values.

Figure 4.4.4: TSS Payments ($ million, in 30 June 2023 values), Split Out into Mental Health (MH) and Non-MH claims



Source data can be found in Appendix E.6.

Figure 4.4.4 shows that the proportion of TSS payments that pertains to mental health-related claims has increased across all payment types. Experience by payment type has been as follows:

Weekly

- The proportion of weekly TSS payments that pertain to mental health-related claims was relatively stable (~45%) from 2012/13 to 2016/17. It has since increased, especially in the past two years (from 54% for 2020/21 to 64% for 2021/22 to 70% for 2022/23).
- The large increase in the past two years has been due to weekly payments for non-mental health-related claimants remaining relatively flat, whereas weekly payments to mental health-related claimants has increased from $15 million in 2020/21 to $27 million in 2021/22 to $32 million in 2022/23.

Lump Sum

- From 2012/13 to 2017/18, 41% of lump sum TSS payments were in respect of mental health-related claims. This increased to 63% for 2018/19 to 2021/22, and has risen further to 76% for 2022/23.
- Lump sum is the payment type with the greatest proportion of payments pertaining to mental health-related claims. This is not surprising given the higher propensity for mental health-related claims to receive a lump sum benefit.

Medical

- The proportion of medical TSS payments that pertain to mental health-related claims was relatively stable (~25%) from 2012/13 to 2016/17. This has then increased to 33% (2017/18 and 2018/19), to 38% (2019/20 and 2020/21), and to 48% (2021/22 and 2022/23).

Legal

- The proportion of legal TSS payments that pertain to mental health-related claims was relatively stable (~47%) from 2017/18 to 2020/21. It has since increased to 55% for 2021/22 and 59% for 2022/23.

Given that there is a lag between accident and payment, it is likely that the step-up in accident years 2021/22 and 2022/23 for the proportion of TSS claims that are mental health-related, will continue to flow through into payment experience for upcoming financial years.

We recognise the work that has been done over the last four years by WorkSafe, in monitoring the changing injury mix of claims and the agency and occupation mix of mental health-related claims. We remain of the view that there are opportunities to develop and apply interventions that may be effective in managing the incidence and cost of mental health-related claims.

4.5. Silicosis Claims

Key Points

18 silicosis claims have been reported to date, in respect of 15 distinct employees. The 18 reported claims are attributable to 10 distinct employers, and the average age at injury is 40 years old.

Of the 14 claims that are accepted, three relate to accident year 1997 and prior, one is in respect of the 2011 accident year, and the remaining ten claims pertain to accident years 2018 to 2023.

Payments to date and outstanding case estimates for silicosis claims are around $2.63 million and $2.24 million, respectively – of which, 76% and 98% (respectively) relate to claims for accident years 2018 to 2023.

ANZSIC06 division C represents 13 of the 18 reported claims, as well as 70% of both payments to date and outstanding case estimates. Two claims relate to division B and one claim each has emerged from divisions D, E and F.

There continues to be ongoing concern across Australia regarding an increase in the prevalence of silicosis due to prior exposure to silica dust. Claims that have arisen from silicosis are included like all other claims in our analysis, however no explicit adjustments for silicosis claims have been made due to lack of claims experience.

In total, there are 18 known silicosis claims that have been reported to date in Tasmania. These 18 claims appear to relate to 15 distinct employees, given that three employees have each lodged two claims. In each of these three cases, one claim is in respect of one employer's coverage and one claim is in respect of another employer's coverage. The 18 reported claims are attributable to 10 distinct employers, and the average age at injury is 40 years old.

14 of the claims are accepted, with two of the rejected claims being one of the claims reported by two of the employees that lodged two claims. Of the 14 accepted claims, three relate to accident year 1997 and prior, one is in respect of the 2011 accident year, and the remaining ten claims pertain to accident years 2018 to 2023.

Payments to date for silicosis claims are around $2.63 million (in nominal values) – of which, three-quarters ($1.99 million) relates to claims for accident years 2018 to 2023. 39% of payments to date has been in respect of lump sum

benefits, 32% for weekly, 22% for legal/investigation and 7% for medical. There is also $2.24 million of outstanding case estimates on these claims – of which, 98% relates to the claims for accident years 2018 to 2023.

ANZSIC06 division C (Manufacturing) represents 13 of the 18 reported claims, as well as 68% of payments to date and 71% of outstanding case estimates. Two claims relate to division B (Mining) and one claim each has emerged from divisions D (Electricity, Gas, Water and Waste Services), E (Construction) and F (Wholesale Trade). A $0.62 million case estimate for one of the division B claims represents the majority of the $0.66m worth of outstanding case estimates for claims that are not from division B.

4.6. COVID-19

Key Points

As at the 19th of May 2023, there were 141 reported claims caused by either contracting COVID-19 or having a mental health condition due to COVID-19, of which 31 were reported in 2022/23. 74% of the claims have been due to contracting COVID-19, with the remaining 26% being mental health-related. 61% of the 141 reported claims were from the TSS.

These 141 claims are estimated to have an ultimate cost of $8.5 million, which translates to an average cost of $60,000 per claim. $4.7 million has already been paid, with the majority of this being weekly payments and most of the remainder pertaining to medical payments.

We continue to not make any explicit adjustments for COVID-19 in our projections, due to COVID-19's relatively small impact to date and an expectation that it will continue to be of minimal impact going forward.

As at the 19th of May 2023, there have been 141 reported worker injury claims caused by either contracting COVID-19 or having a mental health condition due to COVID-19 in Tasmania, with 31 of these claims being reported in 2022/23. Not included in these 141 claims are 36 claims that relate to one of the following: injury while working from home (23); severe reaction to COVID-19 vaccination (9); and testing/exposure/isolation due to COVID-19 (4).

The majority (74%; 105) of the 141 claims reported that their claim was due to contracting COVID-19, with the remaining 36 claims relating to mental health conditions related to COVID-19. 61% (86) of claims were from the TSS, with the remaining 55 from licensed insurers and self-insurers. The most common industry for COVID-19 claims has been hospital (41%) and the most common occupation has been midwifery and nursing professional (30%).

The majority of the COVID-19 related claims have an accident date in early April 2020, with most of these claims being TSS claims that were reported within four months of the injury occurring. When COVID-19 restrictions were eased in early 2022, there was another burst of COVID-19 related claims, with most of these being from licensed insurers and self-insurers.

WorkSafe's estimate of the ultimate cost of these 141 claims is $8.5 million, which translates to an average cost of around $60,000 per claim. $4.7 million has already been paid – of which, 73% relates to weekly payments and most of the remainder pertains to medical payments. To date, 72% of reported claims have not exceeded 30 days of lost time, with 55% of the claims that have exceeded 30 days being claims due to contracting COVID-19.

Overall, the impact of COVID-19 related claims on the Scheme has been small. Given the soft COVID-19 related claims experience relative to overall Scheme experience, our projections **do not** include any explicit adjustment for the impact of COVID-19 (both in the past and the future).

5. Weekly Benefits

This section describes our 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 claim frequency for the 2022/23 accident year is projected to be 0.32 claims per million dollars of wages. The forecasted frequency for 2023/24 is 0.32 as well.

69% of claims for the 2022/23 accident year are projected to be lost time claims, which is consistent with experience for 2021/22. 69% of claims being lost time claims is forecasted for 2023/24 as well.

Weekly actives grew by 2% to 11,507 in the 2022/23 financial year, and is forecast to grow by 5% to 12,132 in 2023/24. This is predominantly driven by the TSS (8% per annum growth across both years).

There was $97.5 million of weekly payments in the 2022/23 financial year, which was 7% higher than 2021/22 in real terms. We have forecasted $98.9 million of weekly payments in 2023/24, which would be 1% higher than 2022/23.

The weekly Payment per Active Claim (PPAC) for the 2022/23 financial year was around $8,500, which was 4% higher in real terms than 2021/22. TSS continues to have the highest weekly PPAC of the three sectors, whereas licensed insurers have the lowest. The weekly PPAC projected for 2023/24 is around $8,200 – this is 4% lower in real terms than 2022/23.

5.1. Claim Frequency – Lost Time Claims

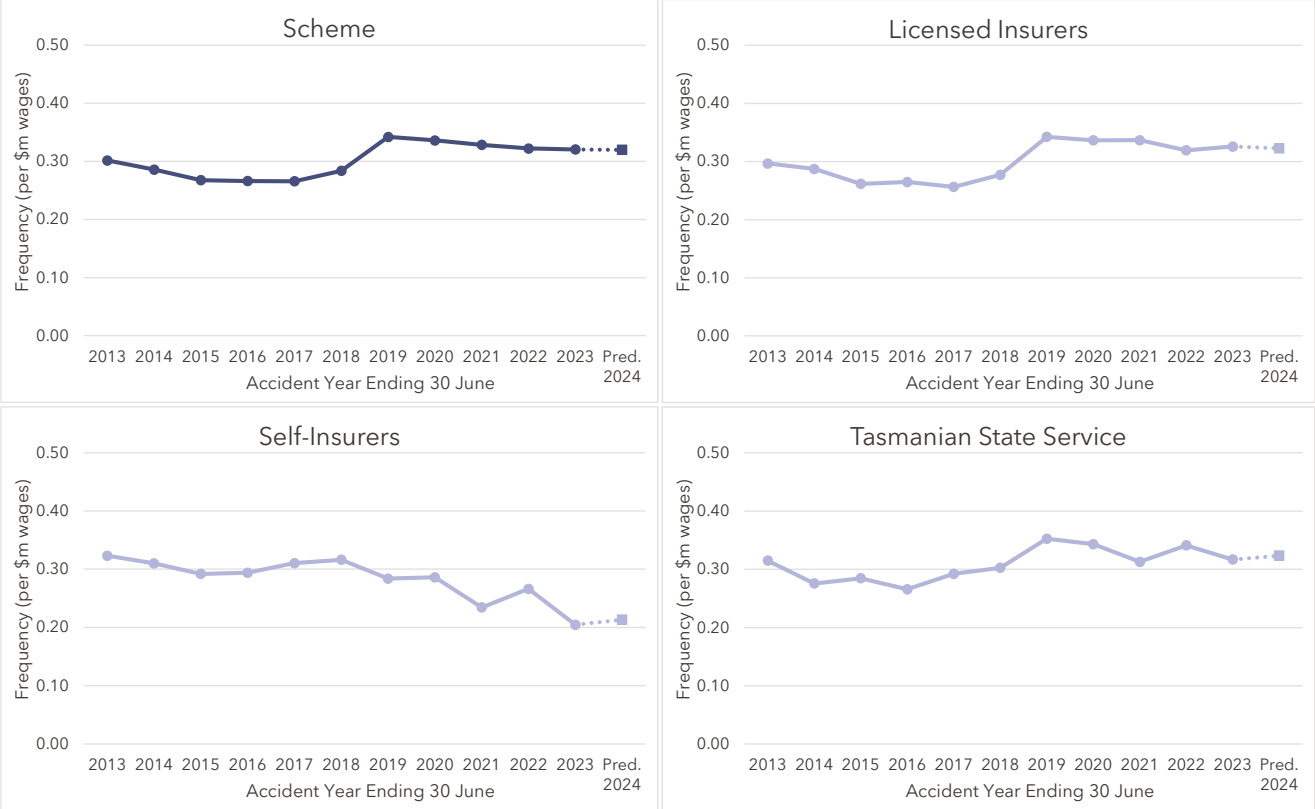
Key Points

Scheme lost time claim frequency for the 2022/23 accident year is projected to be 0.32 claims per million dollars of wages. This is in line with the Scheme lost time claim frequency for the 2021/22 accident year.

Our forecast of Scheme lost time claim frequency for 2023/24 is 0.32 claims per million dollars of wages.

In order to understand the trends in the number of claimants receiving weekly benefit payments, we have estimated the ultimate number of lost time claims and divided this by earned wages (in 30 June 2023 values) to derive ultimate lost time claim frequency. Figure 5.1.1 shows ultimate lost time claim frequency by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also including a forecast for the 2023/24 accident year.

Figure 5.1.1: Ultimate Claim Frequency, by Accident Year (Lost Time Claims)



Source data can be found in Appendix E.10.

Scheme lost time claim frequency for the 2022/23 accident year is projected to be 0.32 claims per million dollars of wages. This is in line with the Scheme lost time claim frequency for the 2021/22 accident year. Experience by sector has been as follows:

- **licensed insurer** lost time claim frequency (per million dollars of wages) has increased slightly from 0.32 for 2021/22 to 0.37 for 2022/23 – this is closer to the frequency of 0.34 observed for 2018/19 to 2020/21;
- **self-insurer** lost time claim frequency (per million dollars of wages) has decreased from 0.27 for 2021/22 to 0.20 for 2022/23 – this has been driven by the drop in all claim frequency for self-insurers; and
- **TSS** lost time claim frequency (per million dollars of wages) has decreased from 0.34 for 2021/22 to 0.32 for 2022/23, but remains in line with historic experience.

Our forecast of Scheme lost time claim frequency for the 2023/24 accident year is 0.32 claims per million dollars of wages. This assumes that, for each sector, the ratio between lost time claims and all claims for the 2023/24 accident year will be similar to the past few accident years.

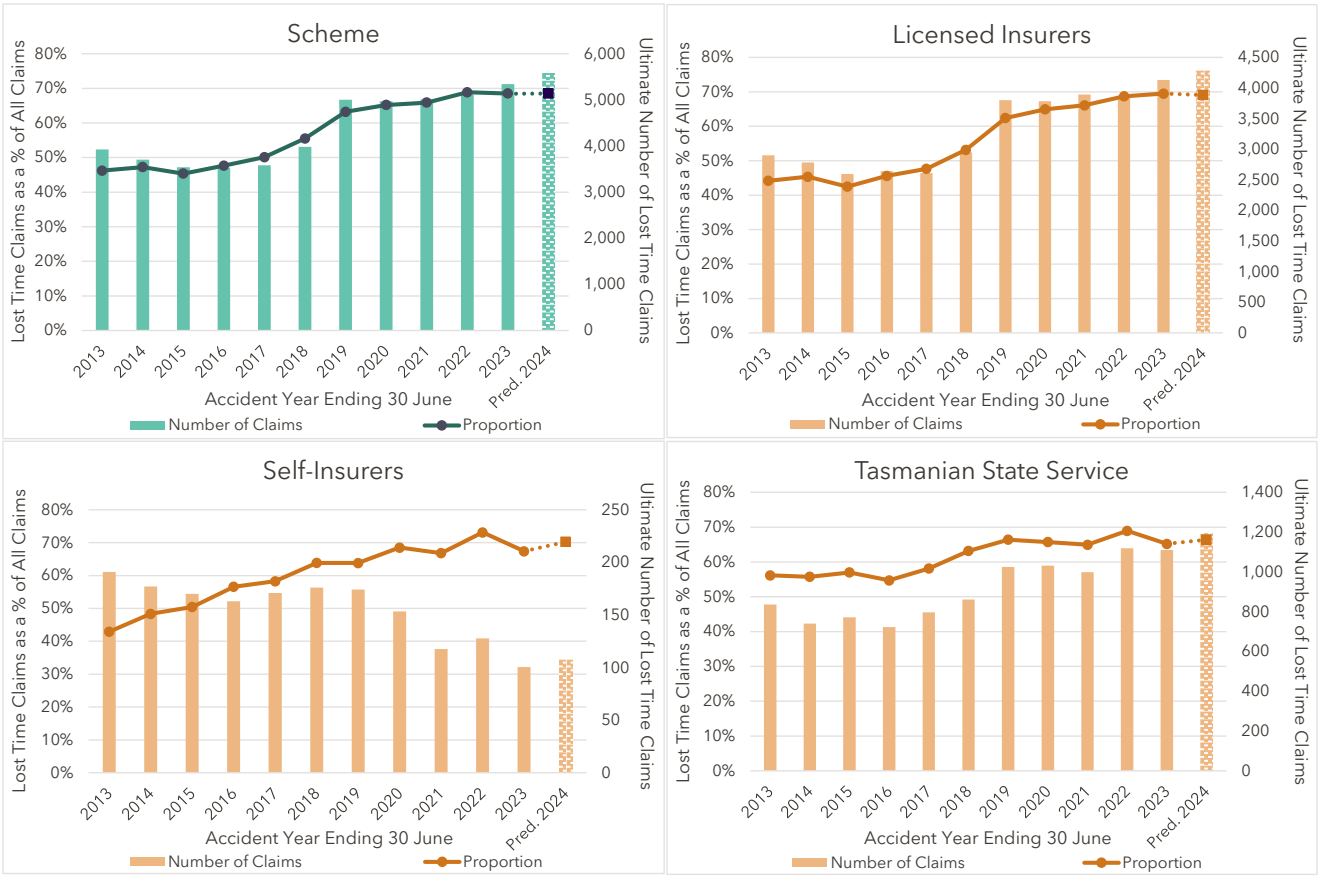
5.2. Lost Time Claim Proportions

Key Points

The proportion of Scheme claims that are lost time claims is projected to be 69% for the 2022/23 accident year, and is line with 2021/22. We forecast that 69% of claims for the 2023/24 accident year will be lost time claims.

Figure 5.2.1 shows our estimate of the ultimate number of lost time claims by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also included our forecast of the ultimate number of lost time claims that may emerge in respect of the 2023/24 accident year. Figure 5.2.1 also displays the proportion of all claims that are lost time claims.

Figure 5.2.1: Lost Time Claims, by Accident Year



Source data can be found in Appendix E.11.

The proportion of Scheme claims that are lost time claims is projected to be 69% for the 2022/23 accident year, and is line with the 2021/22 accident year. Experience by sector has been as follows:

- the proportion of **licensed insurer** claims that are lost time claims is 69% for both the 2021/22 and 2022/23 accident years – this is the highest of any year in the past decade;
- the proportion of **self-insurer** claims that are lost time claims decreased from 73% for 2021/22 to 67% for 2022/23 – the proportion for 2022/23 is in line with accident years 2019/20 and 2020/21; and
- the proportion of **TSS** claims that are lost time claims decreased from 69% for 2021/22 to 65% for 2022/23 – the proportion for 2022/23 is in line with accident years 2018/19 and 2020/21.

Our forecast for the 2023/24 accident year is that 69% of Scheme claims will be lost time claims. This assumes that, for each sector, the ratio between lost time claims and all claims for the 2023/24 accident year will be similar to the past few accident years.

5.3. Weekly Active Claim Numbers

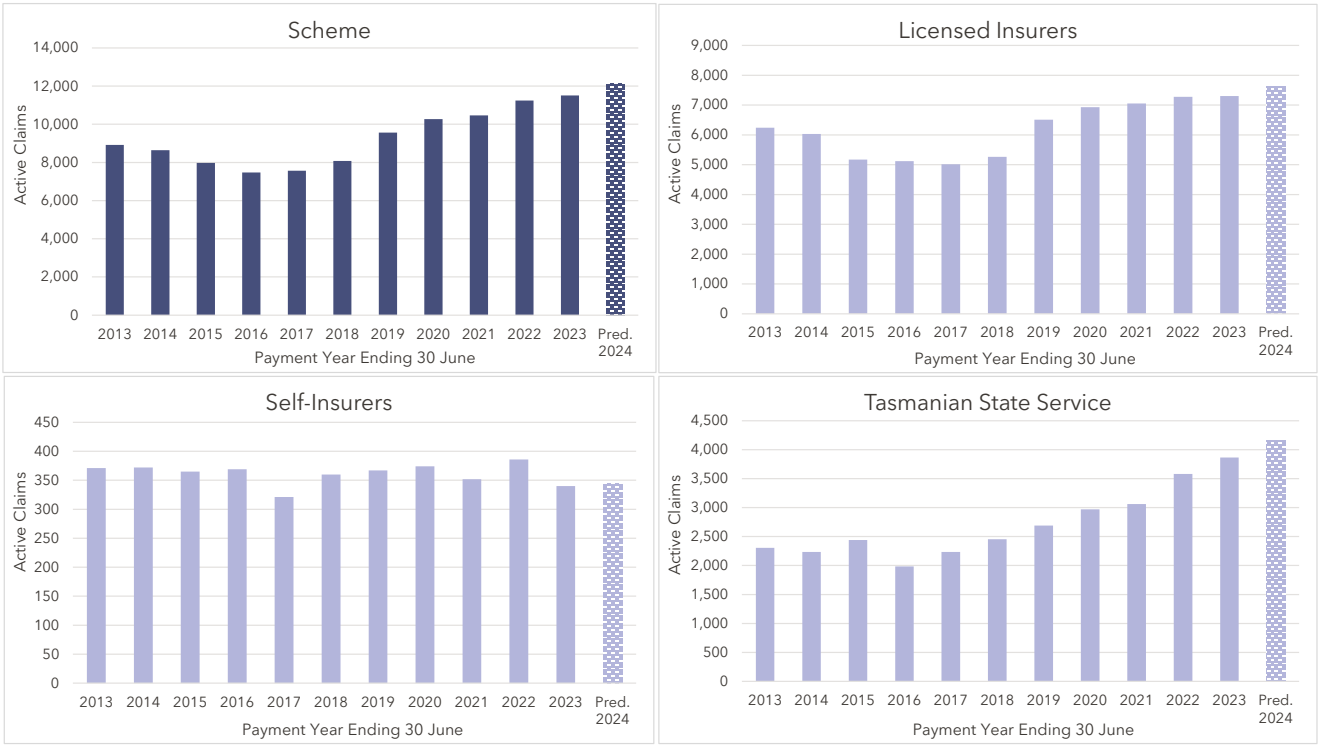
Key Points

The number of weekly actives in the Scheme overall in 2022/23 was 11,507. This is 2% higher than 2021/22, and was driven by an 8% increase in the number of weekly actives in the TSS. Our projection of the number of weekly actives for 2023/24 is 12,131. This is 5% higher than 2022/23, and is expected to be driven by increases for the TSS (+8%) and licensed insurers (+4%).

As further explained in Appendix B3, we use a Payments per Active Claim ("PPAC") model to estimate the ultimate cost of weekly benefits. 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 in the relevant period). This assumes weekly payments in any period are correlated to the number of claims receiving weekly benefits in that particular period.

Figure 5.3.1 shows the number of weekly active claims in each financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. Given that weekly active claim numbers are modelled at a quarterly granularity, the number of weekly actives shown 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, they would count as three weekly active claims for that year).

Figure 5.3.1: Number of Weekly Active Claims, by Financial Year



Source data can be found in Appendix E.39.

The number of weekly actives in the Scheme overall in 2022/23 was 11,507. This is 2% (+263) higher than the number of weekly actives in the Scheme in 2021/22. Experience by sector has been as follows:

- for **licensed insurers**, there were 7,301 weekly actives in 2022/23, which is 0.4% (+26) higher than 2021/22;
- for **self-insurers**, there were 340 weekly actives in 2022/23, which is 12% (-46) lower than 2021/22; and
- for the **TSS**, there were 3,866 weekly actives in 2022/23, which is 8% (+283) higher than 2021/22.

Our projection of the number of weekly actives in the Scheme overall in 2023/24 is 12,131. This is 5% (+624) higher than the number of weekly actives in 2022/23, and is expected to be driven by the TSS (+8%) and licensed insurers (+4%).

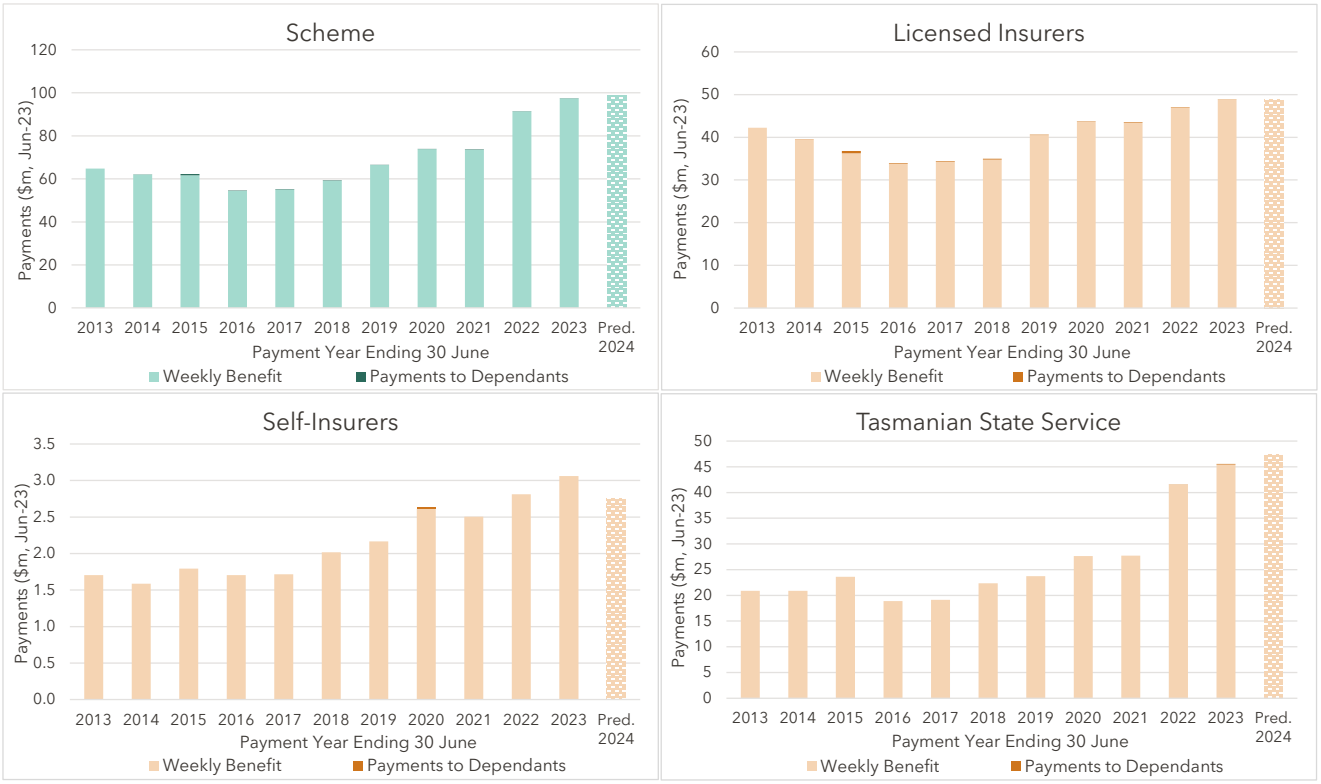
5.4. Weekly Benefits Paid in Each Year

Key Points

Weekly payments grew by 7% in real terms from $91.5 million for 2021/22 to $97.5 million for 2022/23. The step-up in the last two years has been driven by TSS experience (in particular, mental health-related claims). We project that there will be $98.9 million of weekly payments in 2023/24, which would be 1% higher than 2022/23 in real terms.

Figure 5.4.1 shows weekly payments by financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. Payments to dependants are shown separately, albeit they make up a small proportion of weekly payments. All amounts shown are in 30 June 2023 values, so that real growth in payments can be assessed.

Figure 5.4.1: Weekly Benefit Payments, by Financial Year ($ million, in 30 June 2023 values)



Source data can be found in Appendix E.12.

Comparing the 2022/23 payment year to 2021/22, weekly payments for the Scheme overall grew by 7% in real terms from $91.5 million to $97.5 million. Experience by sector has been as follows:

- for **licensed insurers**, weekly payments grew by 4% in real terms from $47.1 million to $48.9 million;
- for **self-insurers**, weekly payments grew by 9% in real terms from $2.8 million to $3.1 million; and
- for the **TSS**, weekly payments grew by 10% in real terms from $41.6 million to $45.6 million.

There has been a notable step-up in weekly payments in the last two financial years, with this being driven by TSS experience. As discussed in Section 4.4.2, whilst weekly payments in the TSS for non-mental health-related claimants have remained relatively flat, weekly payments to mental health-related claimants in the TSS has increased from $15.0 million in 2020/21 to $26.7 million in 2021/22 to $31.6 million in 2022/23. A portion of the increase in TSS weekly payments between 2020/21 and 2021/22 was also due to the clearance of a $2 million backlog.

For the Scheme overall, we project that there will be $98.9 million of weekly payments in financial year 2023/24. In real terms, this is 1% higher than 2022/23. The projected increase is driven by the 4% increase forecasted for the TSS, but is partially offset by the 10% decrease forecasted for self-insurers.

5.5. Weekly Payments per Active Claim (PPACs)

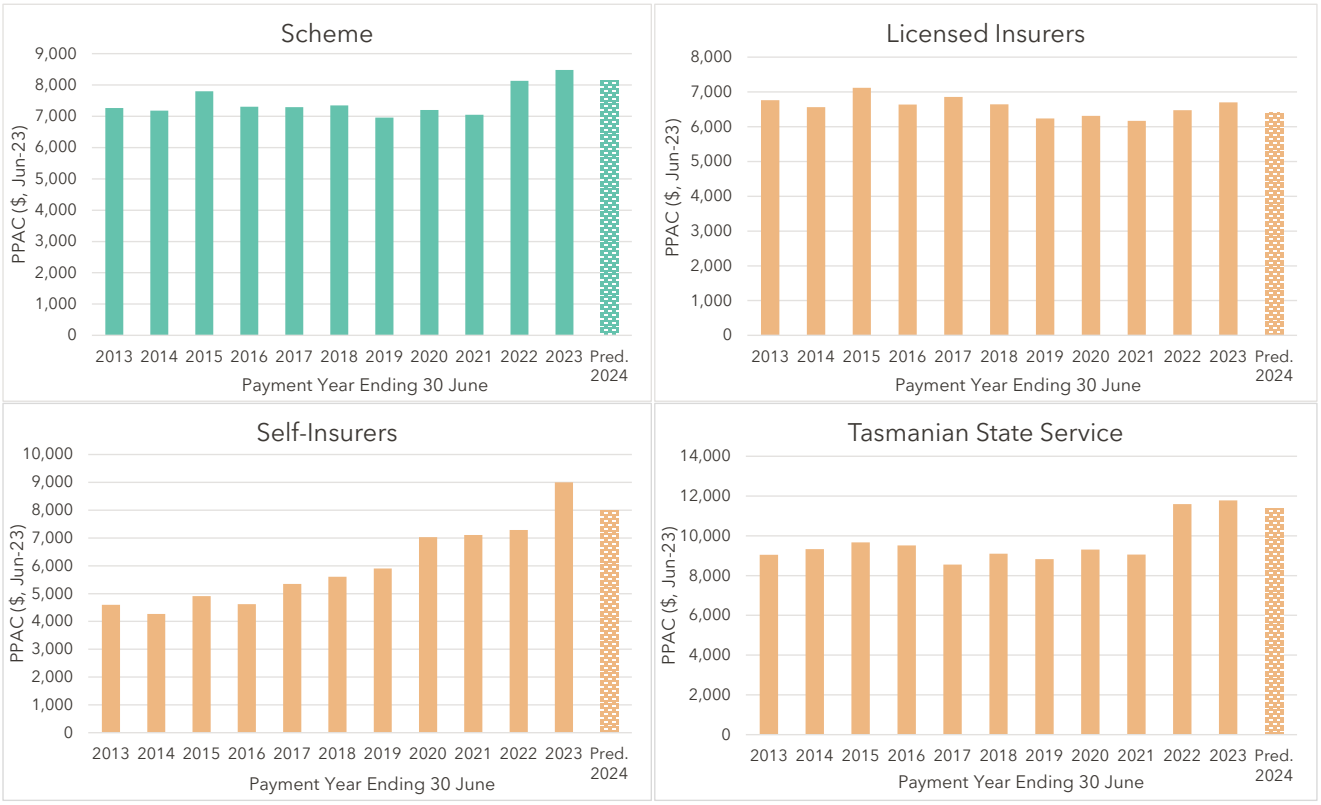
Key Points

The weekly PPAC for 2022/23 was around $8,500, which was 4% higher in real terms than 2021/22. TSS continues to have the highest weekly PPACs ($11,800 in 2022/23) of the three sectors, whereas licensed insurers have the lowest ($6,700 in 2022/23).

Based on our projections of weekly payments and actives for 2023/24, the implied weekly PPAC projected for 2023/24 is around $8,200, which is 4% lower in real terms than 2022/23.

Figure 5.5.1 shows weekly 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 weekly PPAC for 2023/24 that is implied by our projections of weekly payments and weekly actives for this financial year. All PPACs are shown in 30 June 2023 values, so that real growth in PPACs can be assessed.

Figure 5.5.1: Weekly PPACs, by Financial Year ($, in 30 June 2023 values)



Source data can be found in Appendix E.13.

For the Scheme overall, the weekly PPAC for the 2022/23 financial year was around $8,500. This is 4% higher in real terms than the weekly PPAC for 2021/22. Experience by sector was as follows:

- for **licensed insurers**, the weekly PPAC for 2022/23 was around $6,700, which was 4% higher than 2021/22;
- for **self-insurers**, the weekly PPAC for 2022/23 was approximately $9,000, which was 24% higher than 2021/22 – it should be noted that the weekly PPACs for self-insurers are based on denominators (i.e. weekly actives) of less than 400 for each financial year; and
- for the **TSS**, the weekly PPAC for 2022/23 was around $11,800, which was 2% higher than 2021/22.

Based on our projections of weekly payments and actives for the 2023/24 financial year, the implied weekly PPAC projected for the Scheme overall in 2023/24 is around $8,200, which is 4% lower in real terms than the weekly PPAC for 2022/23.

6. Lump Sums

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

Key Points

We forecast that 477 claims will receive their first lump sum in the 2023/24 financial year, which is in line with the majority of experience since 2016/17. We estimate an ultimate number of 508 lump sum claims for the 2022/23 accident year and forecast an ultimate number of 525 lump sum claims for the 2023/24 accident year.

Lump sum category utilisation continues to be relatively stable. Around 75% of lump sum utilisation has been in respect of redemptions, with the majority of the remaining utilisation being in respect of permanent impairment payments.

There was a rebound in lump sum payment volumes to $68.3 million in the 2022/23 financial year, after falling in 2021/22 to their lowest level in a decade. We have forecasted $69.1 million of lump sum payments in 2023/24, which is 1% higher than 2022/23 in real terms.

The average lump sum claim size per claim that receives a lump sum is projected to be $154,100 for the 2022/23 accident year, which is 2% lower in real terms than 2021/22. The selected lump sum average claim size for new accidents is $156,800 – this is 2% lower in real terms than what was selected at the previous review.

6.1. Estimated Ultimate Claim Numbers – Lump Sum Claims

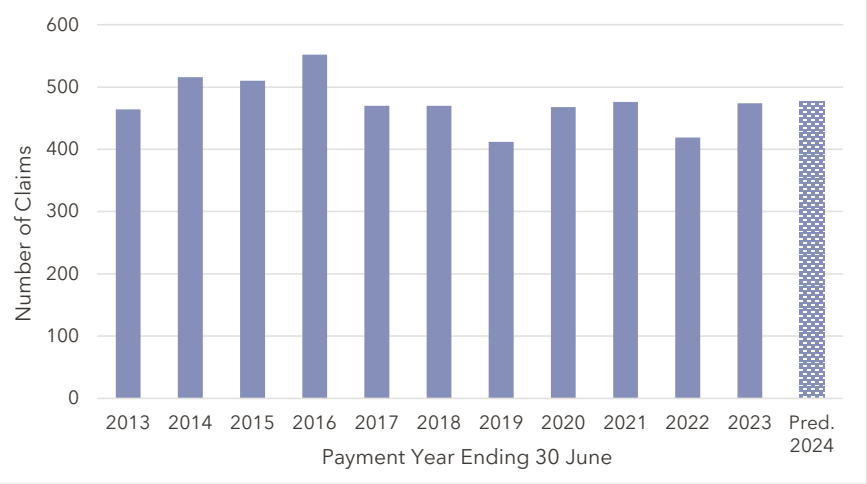
Key Points

Since 2016/17, around 470 claims have received their first lump sum each year, except for lower experience in 2018/19 and 2021/22. Our forecast is that 477 claims will receive their first lump sum in the 2023/24 financial year.

The ultimate number of lump sum claims in the Scheme for the 2022/23 accident year is projected to be 508, which is 7% higher than the projected ultimate for 2021/22. Our forecast for the 2023/24 accident year is 525 claims, which is 3% higher than our projection for 2022/23.

Figure 6.1.1 shows the number of claims in the Scheme overall 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 6.1.1: Number of Claims Receiving First Lump Sum, by Financial Year

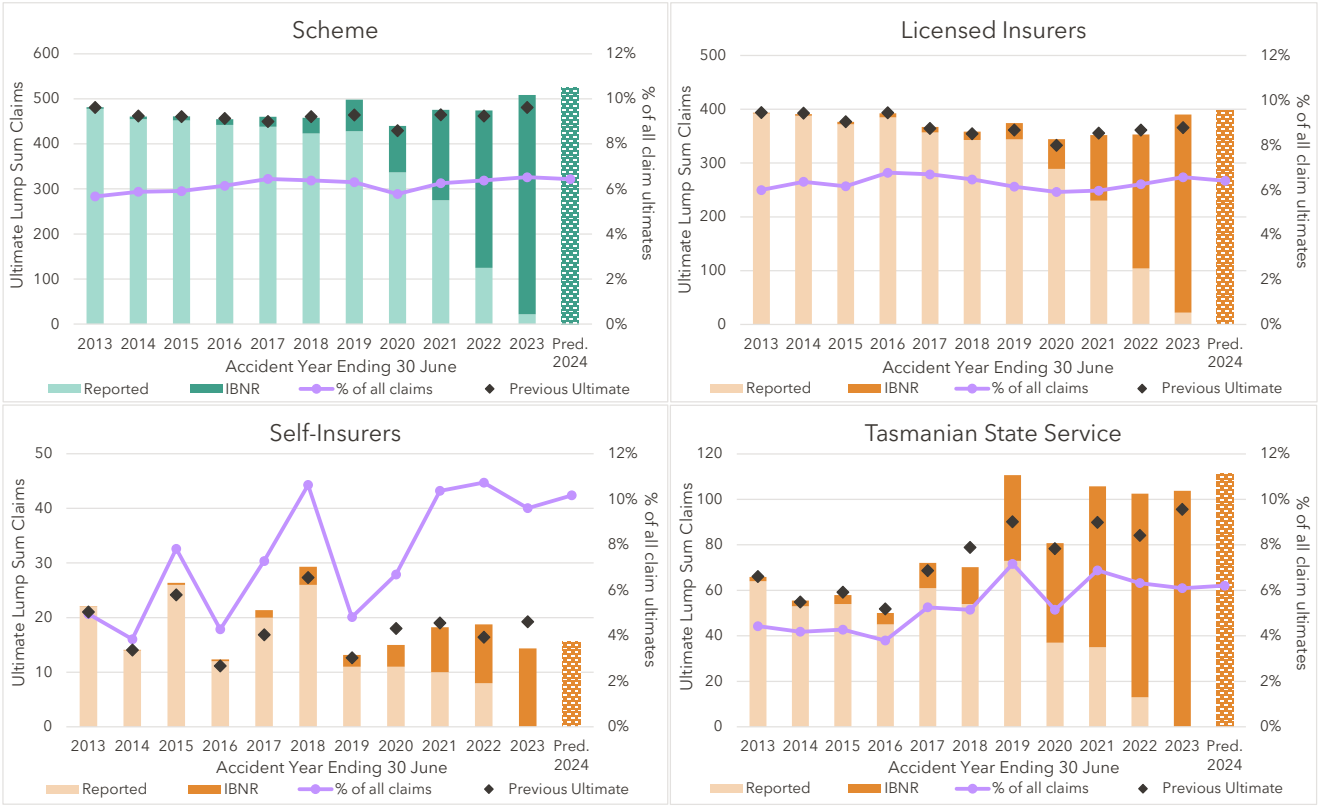


Source data can be found in Appendix E.14.

Since 2016/17, around 470 claims per annum have received their first lump sum, with the exception of 2018/19 and 2021/22 which both had lower experience (412 and 419 claims, respectively). Our forecast is that 477 claims will receive their first lump sum in the 2023/24 financial year.

Figure 6.1.2 shows estimated ultimate lump sum claim numbers by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. This includes a forecast of the number of lump sum claims that may emerge in respect of the 2023/24 accident year. We have also shown our estimates of lump sum claim ultimates as proportions of our all claim ultimate estimates. Figure 6.1.2 also displays our estimates of lump sum claim ultimates at the previous review of the Scheme.

Figure 6.1.2: Ultimate Claim Numbers, by Accident Year (Lump Sum Claims)



Source data can be found in Appendix E.15.

The ultimate number of lump sum claims in the Scheme for the 2022/23 accident year is projected to be 508. This is 7% (+34) higher than the projected ultimate for the 2021/22 accident year. Experience by sector has been as follows:

- for **licensed insurers**, the ultimate number of lump sum claims for 2022/23 is projected to be 390 – this is 11% (+37) higher than the projected ultimate for 2021/22, with this proportional increase being higher than the 5% growth projected for the all claim ultimate;
- for **self-insurers**, the ultimate number of lump sum claims for 2022/23 is projected to be 14 – this is 23% (-4) lower than the projected ultimate for 2021/22, and was driven by the 15% decrease projected for the all claim ultimate; and
- for the **TSS**, the ultimate number of lump sum claims for 2022/23 is projected to be 104 – this is 1% (+1) higher than the projected ultimate for 2021/22, with this proportional increase being lower than the 5% growth projected for the all claim ultimate.

Our forecast of the ultimate number of lump sum claims for the 2023/24 accident year is 525 claims, which is 3% (+16) higher than the projected lump sum claim ultimate for 2022/23. All three sectors are projected to have a higher lump sum claim ultimate in accident year 2023/24, as compared to 2022/23.

6.2. Lump Sum Experience by Payment Category

Key Points

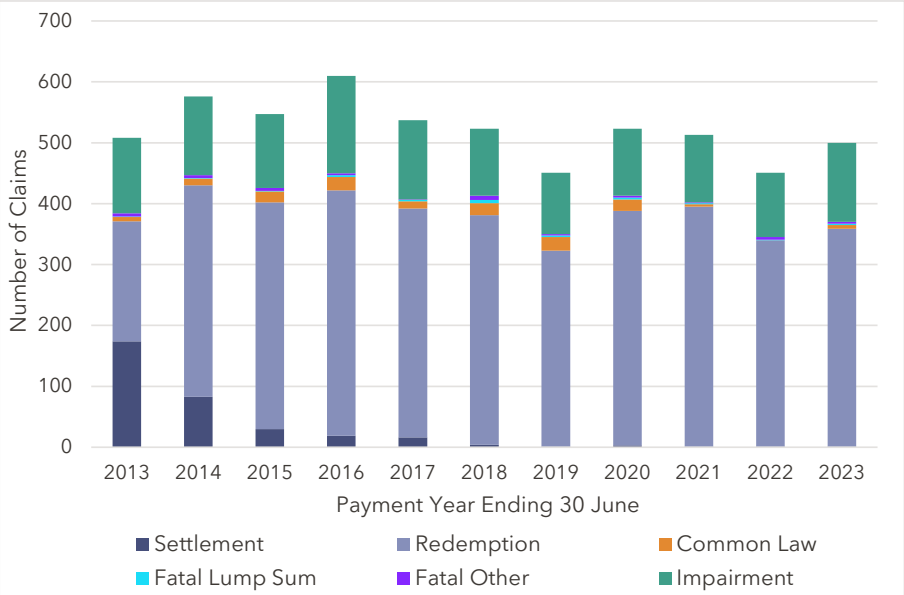
The number of settlements reduced markedly between 2012/13 and 2017/18, with this mainly being replaced by growth in the number of redemptions. In recent years, around 75% of lump sum utilisation has been in respect of redemptions, with the majority of the remaining utilisation being in respect of permanent impairment payments.

Figure 6.2.1 shows the number of claims in the Scheme overall that received their first payment for each lump sum category, by financial year. Unlike Figure 6.1.1 in Section 6.1, if a claimant receives payments for more than one lump sum category, they will be counted more than once in Figure 6.2.1. However, any claimant that receives more than one payment for any lump sum category will only be counted once for that lump sum category.

We note that claims receiving an impairment benefit can later, if entitled, pursue common law or redeem their remaining statutory benefits. In other instances, the common law benefit and redemption may be included in the impairment benefit, and thus be recorded as utilising only one lump sum category (impairment).

We emphasise that Figure 6.2.1 is the only instance in this report, where lump sums have been counted in this manner. In the rest of this report (as well as our modelling), any claim that receives at least one lump sum payment is counted as one lump sum claim, regardless of how many lump sum categories are utilised and regardless of how many lump sum payments are made to the claimant.

Figure 6.2.1: Number of Claims Receiving First Payment for Each Lump Sum Category, by Financial Year



Source data can be found in Appendix E.16.

We observe the following:

- In the first half of the past decade, the number of settlements has reduced markedly, with this mainly being replaced by growth in the number of redemptions. This has resulted in three-quarters of lump sum utilisation in the past five years being for redemptions, whereas settlements have represented less than 1% of utilisation over that period.
- The number of impairment lump sums has been relatively stable, with 20 to 25% of lump sum utilisation over this period being in respect of permanent impairment payments.
- Common law payments represented 4% of lump sum utilisation in 2017/18 to 2019/20, but this has decreased to 1% for 2020/21 to 2022/23.
- Fatal payments continue to represent 1% of lump sum utilisation.

6.3. Lump Sums Paid in Each Year

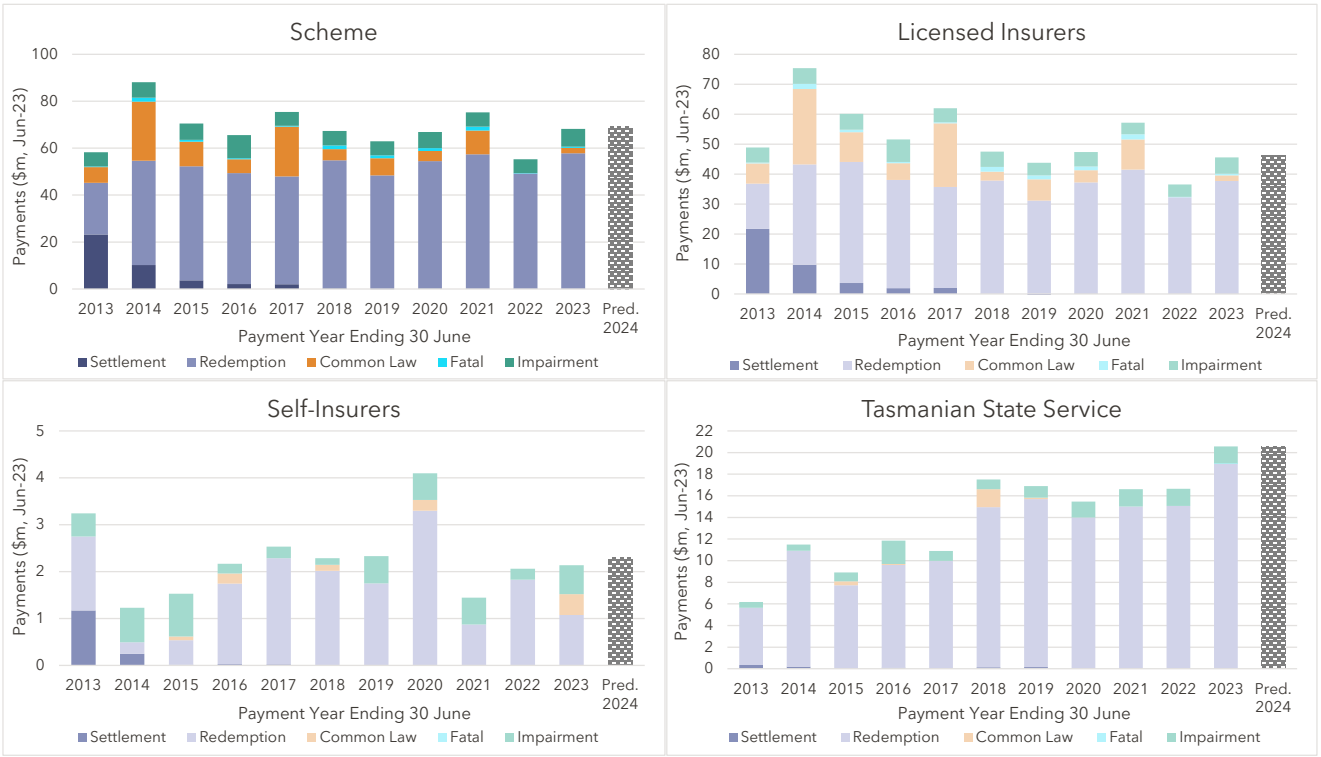
Key Points

Lump sum payments grew by 23% in real terms from $55.3 million for 2021/22 to $68.3 million for 2022/23. This appears to be a rebound in lump sum payment volumes, after falling in 2021/22 to their lowest level in a decade. We note that the increase in the past year for the TSS is almost entirely attributable to mental health claims.

We project that there will be $69.1 million of lump sum payments in 2023/24, which would be 1% higher than 2022/23 in real terms. This includes an expectation that TSS lump sum payments will stabilise.

Figure 6.3.1 shows lump sum payments by financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. Payments have been split out into the lump sum payment categories that were shown in Section 6.2. We have also included a forecast of the quantum of lump sum payments that will be made in 2023/24, however we are not able to break down this forecast into lump sum payment categories. All amounts shown are in 30 June 2023 values, so that real growth in payments can be assessed.

Figure 6.3.1: Lump Sum Payments, by Financial Year ($ million, in 30 June 2023 values)



Source data can be found in Appendix E.17.

Comparing the 2022/23 payment year to 2021/22, lump sum payments for the Scheme overall grew by 23% in real terms from $55.3 million to $68.3 million. However, we note that this is essentially a rebound in lump sum payment volumes, after lump sum payments fell in 2021/22 to their lowest level in a decade. Experience by sector is as follows:

- for **licensed insurers**, lump sum payments grew by 25% in real terms from $36.6 million in 2021/22 to $45.6 million in 2022/23 – this rebound in lump sum payment volumes has brought 2022/23 closer to historic experience, albeit still less than 2020/21;
- for **self-insurers**, lump sum payments grew by 4% in real terms from $2.06 million in 2021/22 to $2.14 million in 2022/23 – this remains in line with historic experience, notwithstanding lower than the outlier 2019/20 year; and
- for the **TSS**, lump sum payments grew by 24% in real terms from $16.6 million in 2021/22 to $20.6 million in 2022/23 – this is the highest level of lump sum payments in the TSS over the past decade.

As discussed in Section 4.4.2, lump sum payments in the TSS for non-mental health-related claimants was relatively flat from 2021/22 to 2022/23. Instead, the increase observed for TSS lump sum payments was due to mental health-related claimants, for whom lump sum payments increased from $11.3 million in 2021/22 to $15.5 million in 2022/23.

For the Scheme overall, we project that there will be $69.1 million of lump sum payments in financial year 2023/24. In real terms, this is 1% higher than 2022/23. This includes an expectation that TSS lump sum payments will stabilise – that is, projected TSS lump sum payments for 2023/24 ($20.5 million) is expected to be in line with 2022/23.

We also note that our projection of lump sum payments for future financial years (such as 2023/24) includes an explicit allowance for the emergence of payments, in respect of the common law case estimate of large licensed insurer claims. Large claims are defined as those claims with an overall case estimate of $2 million or more. Our projections of future lump sum payments also include an explicit IBNR allowance that recognises the possibility that additional large licensed insurer claims may emerge in respect of more recent accident years (specifically, 2021/22 and later).

6.4. Lump Sum Payments per Lump Sum Claim Incurred

Key Points

For the Scheme overall, the lump sum average claim size for the 2022/23 accident year is projected to be $154,100. This is 2% lower in real terms than our projection for the 2021/22 accident year. The selected lump sum average claim size for new accidents is $156,800, which is 2% lower in real terms than what was selected at the previous review.

The average lump sum cost per claim that receives at least one lump sum benefit is much higher for the TSS than for licensed insurers and self-insurers. However, the average lump sum cost based on all claims is similar between self-insurers and the TSS, because lump sum claims a proportion of all claims is larger for the former than the latter.

As further explained in Appendix B2, we use a Payments per Claim Incurred ("PPCI") model to estimate the ultimate cost of lump sum benefits. 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.

As mentioned in Section 6.3, we also include a separate allowance for common law payments made to licensed insurer claims that have an overall case estimate of $2 million or more. At this review, there were five such claims across three insurers, with the overall case estimates of these five claims totalling around $24 million. Of this $24 million, there was $3.2 million of known case estimates for common law.

Figure 6.4.1 shows our selected lump sum average claim sizes by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS 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 2023 values, so that real growth in PPCIs can be assessed.

We note that Figure 6.4.1 reflects our explicit allowance for common law costs of large licensed insurer claims, both reported and IBNR.

Figure 6.4.1: Lump Sum PPCIs, by Accident Year ($000, in 30 June 2023 values)

Source data can be found in Appendix E.18.

For the Scheme overall, the lump sum average claim size for the 2022/23 accident year is projected to be approximately $154,100 (noting that payments to date represents only 1% of this). This is 2% lower in real terms than our projection for the 2021/22 accident year, and has been driven by the 3% decrease in the lump sum average claim size for licensed insurers. Experience by sector has been as follows:

- for **licensed insurers**, the lump sum average claim size for 2022/23 is projected to be approximately $134,800 – this is 3% lower in real terms than 2021/22;
- for **self-insurers**, the lump sum average claim size for 2022/23 is projected to be approximately $124,900 – this is 4% lower in real terms than 2021/22; and
- for the **TSS**, the lump sum average claim size for 2022/23 is projected to be approximately $230,800 – this is 0.1% higher in real terms than 2021/22.

For the Scheme overall, the selected lump sum average claim size for the new accident year 2023/24 is around $156,800 (in 30 June 2023 values), which is 2% lower in real terms than what was selected for the new accident year (2022/23) at the previous review. The selected lump sum average claim sizes for each sector are as follows:

- for **licensed insurers**, we have selected an average size of around $136,300 for new accidents, which is 4% lower in real terms than the selection at the previous review;
- for **self-insurers**, we have selected an average size of around $130,200 for new accidents, which is 9% lower in real terms than the selection at the previous review; and
- for the **TSS**, we have selected an average size of around $233,900 for new accidents, which is 0.2% lower in real terms than the selection at the previous review.

This shows the average cost of lump sum payments per claim that receives at least one lump sum benefit is much higher for the TSS than for licensed insurers and self-insurers. Table 6.4.2, however, shows that average lump sum costs based on all claims (i.e. regardless of whether they receive lump sum benefits or not) is relatively similar between self-insurers and the TSS. This is because the self-insurer sector is the one with lump sum claims representing the largest proportion of all claims, as was shown in Figure 6.1.2.

Table 6.4.2: Adopted Lump Sum Average Claim Sizes (ACS) for New Accidents ($, in 30 June 2023 values)

	ACS based on lump sum claims only			ACS based on all claims		
	Previous Review	Current Review	Change	Previous Review	Current Review	Change
Licensed Insurers	141,742	136,299	-3.8%	9,157	8,740	-4.6%
Self-Insurers	143,182	130,157	-9.1%	14,470	13,236	-8.5%
Tasmanian State Service	234,316	233,921	-0.2%	12,874	14,516	+12.8%
Scheme	**160,206**	**156,843**	**-2.1%**	**10,142**	**10,097**	**-0.4%**

Table 6.4.2 shows that the real growth in lump sum average claim size assumptions between the previous and current review is similar, regardless of whether average costs are calculate based on lump sum claims only or all claims. The main exception to this is the TSS – for which the all-claims average cost has increased by 12.8%, as opposed to a 0.2% decrease for the average cost based on lump sum claims only. This is due to an increase (from 5.5% to 6.2%) to our assumption regarding the proportion of TSS claims for new accidents that will also be a lump sum claim.

7. Medical and Related Payments

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

Key Points

There was $56.2 million of medical payments in the 2022/23 financial year, which was 7% higher than 2021/22 in real terms. We have forecasted $57.3 million of medical payments in 2023/24, which would be 2% higher than 2022/23.

The medical component of average claim size is projected to be $7,300 for the 2022/23 accident year, which is 1% higher in real terms than 2021/22. The selected medical average claim size for new accidents is $7,400 – this is 1% lower in real terms than what was selected at the previous review.

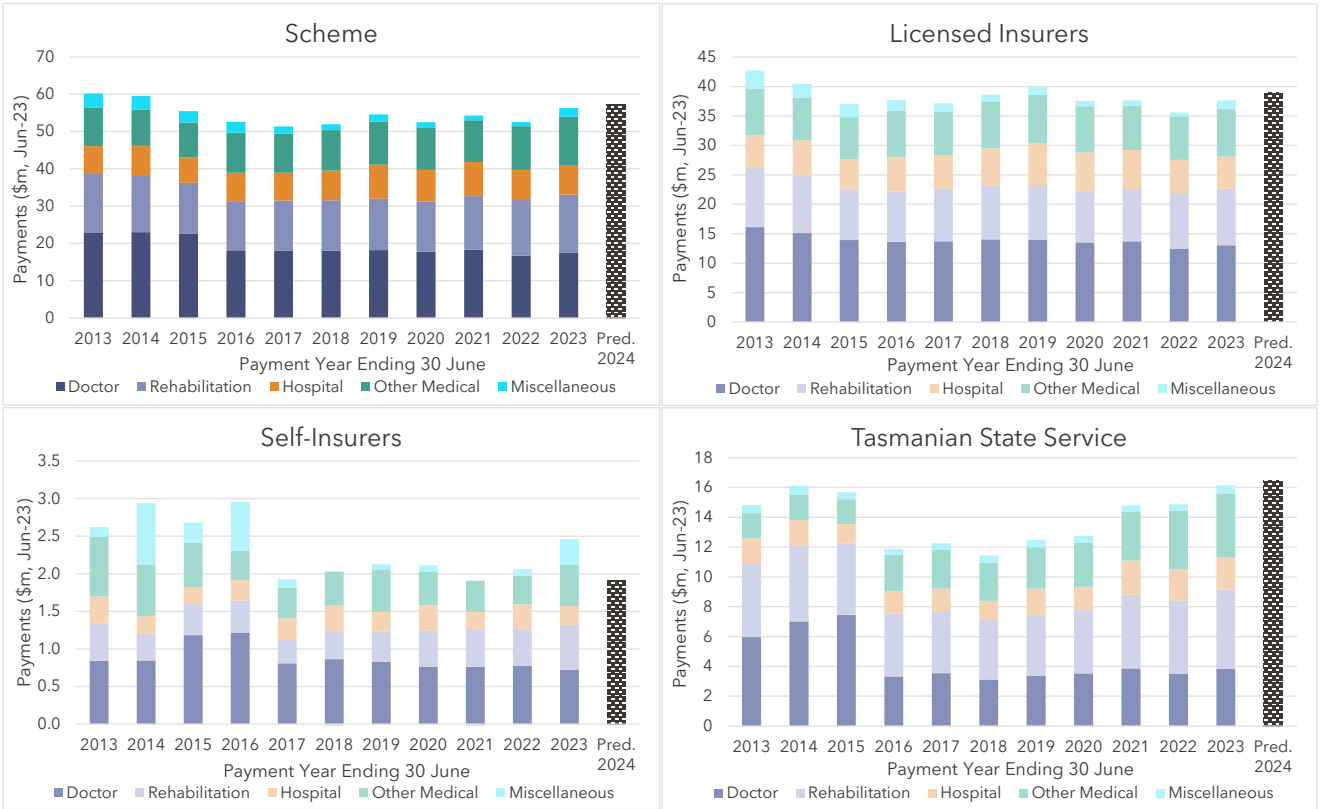
7.1. Medical and Related Benefits Paid in Each Year

Key Points

Payments for medical and related benefits grew by 7% in real terms from $52.5 million for 2021/22 to $56.2 million for 2022/23. We project that there will be $57.3 million of medical and related payments in 2023/24, which would be 2% higher than 2022/23 in real terms.

Figure 7.1.1 shows medical and related payments by financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. Payments have been split out into five payment categories (doctor, rehabilitation, hospital, other medical, and miscellaneous). We have also included a forecast of the quantum of medical and related payments that will be made in 2023/24, however we are not able to break down this forecast into payment categories. All amounts shown are in 30 June 2023 values, so that real growth in payments can be assessed.

Figure 7.1.1: Medical and Related Payments, by Financial Year ($ million, in 30 June 2023 values)



Source data can be found in Appendix E.19.

Comparing the 2022/23 payment year to 2021/22, medical and related payments for the Scheme overall grew by 7% in real terms from $52.5 million to $56.2 million. Experience by sector was as follows:

- for **licensed insurers**, payments grew by 6% in real terms from $35.6 million in 2021/22 to $37.6 million in 2022/23;
- for **self-insurers**, payments grew by 20% in real terms from $2.1 million in 2021/22 to $2.5 million in 2022/23; and
- for the **TSS**, payments grew by 9% in real terms from $14.9 million in 2021/22 to $16.1 million in 2022/23.

For the Scheme overall, we project that there will be $57.3 million of medical and related payments in financial year 2023/24. In real terms, this is 2% higher than 2022/23. The projected increase is driven by the 3% increase forecasted for licensed insurers, but is partially offset by the decrease forecasted for self-insurers.

7.2. Medical and Related Payments per Claim Incurred

Key Points

For the Scheme overall, the medical average claim size for the 2022/23 accident year is projected to be $7,300. This is 1% higher in real terms than our projection for the 2021/22 accident year. The selected medical average claim size for new accidents is $7,400, which is 1% lower in real terms than what was selected at the previous review.

As further explained in Appendix B2, we use a Payments per Claim Incurred ("PPCI") model to estimate the ultimate cost of medical and related benefits. The PPCI approach projects medical and related payments as a function of the ultimate number of claims for the relevant accident period. This assumes medical and related payments in any period are correlated to the ultimate number of claims.

Figure 7.2.1 shows our selected medical average claim sizes by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS 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 medical and related benefits by the ultimate number of claims projected for the relevant accident year. All PPCIs shown are in 30 June 2023 values, so that real growth in PPCIs can be assessed.

Figure 7.2.1: Medical PPCIs, by Accident Year ($, in 30 June 2023 values)

Source data can be found in Appendix E.20.

For the Scheme overall, the medical average claim size for the 2022/23 accident year is projected to be approximately $7,300 (noting that payments to date represents 39% of this). This is 1% higher in real terms than our projection for the 2021/22 accident year, and has been driven by the 3% increase in the medical average claim size for licensed insurers. Experience by sector has been as follows:

- for **licensed insurers**, the medical average claim size for 2022/23 is projected to be approximately $6,400 – this is 3% higher in real terms than 2021/22;
- for **self-insurers**, the medical average claim size for 2022/23 is projected to be approximately $11,400 – this is 5% lower in real terms than 2021/22; and
- for the **TSS**, the medical average claim size for 2022/23 is projected to be approximately $9,800 – this is 1% lower in real terms than 2021/22.

For the Scheme overall, the selected medical average claim size for the new accident year 2023/24 is around $7,400 (in 30 June 2023 values), which is 1% lower in real terms than what was selected for the new accident year (2022/23) at the previous review. The selected medical average claim sizes for each sector are as follows:

- for **licensed insurers**, we have selected an average size of around $6,500 for new accidents, which is 1% higher in real terms than the selection at the previous review;
- for **self-insurers**, we have selected an average size of around $11,800 for new accidents, which is 1% lower in real terms than the selection at the previous review; and
- for the **TSS**, we have selected an average size of around $9,900 for new accidents, which is 1% lower in real terms than the selection at the previous review.

8. Legal and Investigation Payments

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

Key Points

There was $20.6 million of payments in the 2022/23 financial year for legal and investigation costs, which was 15% higher than 2021/22 in real terms. We have forecasted $19.8 million of payments in 2023/24 for legal and investigation costs, which would be 4% higher than 2022/23.

The legal/investigation average claim size is projected to be $2,500 for the 2022/23 accident year, which is 0.3% lower in real terms than 2021/22. The selected legal/investigation average claim size for new accidents is $2,600 – this is 3% higher in real terms than what was selected at the previous review.

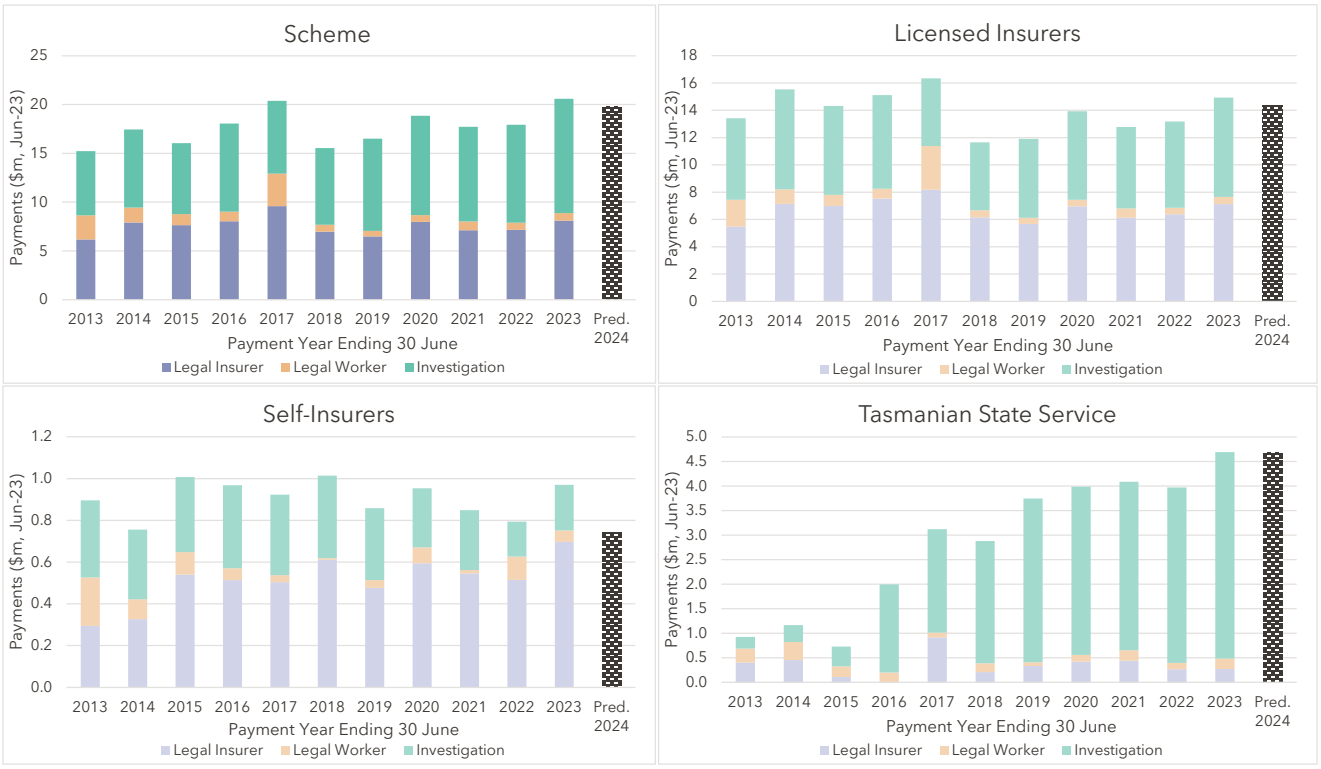
8.1. Legal and Investigation Costs Paid in Each Year

Key Points

Payments for legal and investigation costs grew by 15% in real terms from $17.9 million for 2021/22 to $20.6 million for 2022/23, with the increase being driven by the legal insurer and investigation payment categories. We forecast $19.8 million of payments in 2023/24 for legal and investigation costs, which would be 4% higher than 2022/23 in real terms.

Figure 8.1.1 shows payments for legal and investigation costs by financial year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. Payments have been split out into three payment categories (legal insurer, legal worker, and investigation). We have also included a forecast of the quantum of legal/investigation payments that will be made in 2023/24, however we are not able to break down this forecast into payment categories. All amounts shown are in 30 June 2023 values, so that real growth in payments can be assessed.

Figure 8.1.1: Legal and Investigation Payments, by Financial Year ($ million, in 30 June 2023 values)



Source data can be found in Appendix E.21.

Comparing the 2022/23 payment year to 2021/22, legal and investigation payments for the Scheme overall grew by 15% in real terms from $17.9 million to $20.6 million. This was driven by 13% and 17% increases for the legal insurer and investigation payment categories, respectively. We understand that, in recent years, costs associated with the Director of Public Prosecutions (DPP) has increasingly been directly coded to individual claims, which may be contributing to the growth in legal and investigation payments.

Experience by sector has been as follows:

- for **licensed insurers**, payments grew by 13% in real terms from $13.2 million in 2021/22 to $14.9 million in 2022/23 – this was driven by 12% and 16% increases for the legal insurer and investigation payment categories, respectively;
- for **self-insurers**, payments grew by 22% in real terms from $0.8 million in 2021/22 to $1.0 million in 2022/23 – this was driven by higher payments for the legal insurer and investigation payment categories; and
- for the **TSS**, payments grew by 18% in real terms from $4.0 million in 2021/22 to $4.7 million in 2022/23 – this was driven by the 19% increase in payments for investigation costs.

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. Further to this, year-to-year movements in the quantum of legal and investigation payments in the TSS have been mostly driven by experience for investigation-related payments.

For the Scheme overall, we project that there will be $19.8 million of payments in financial year 2023/24 for legal and investigation costs. In real terms, this is 4% lower than 2022/23. The projected decrease is driven by the 4% decrease forecasted for licensed insurers.

8.2. Legal and Investigation Payments per Claim Incurred

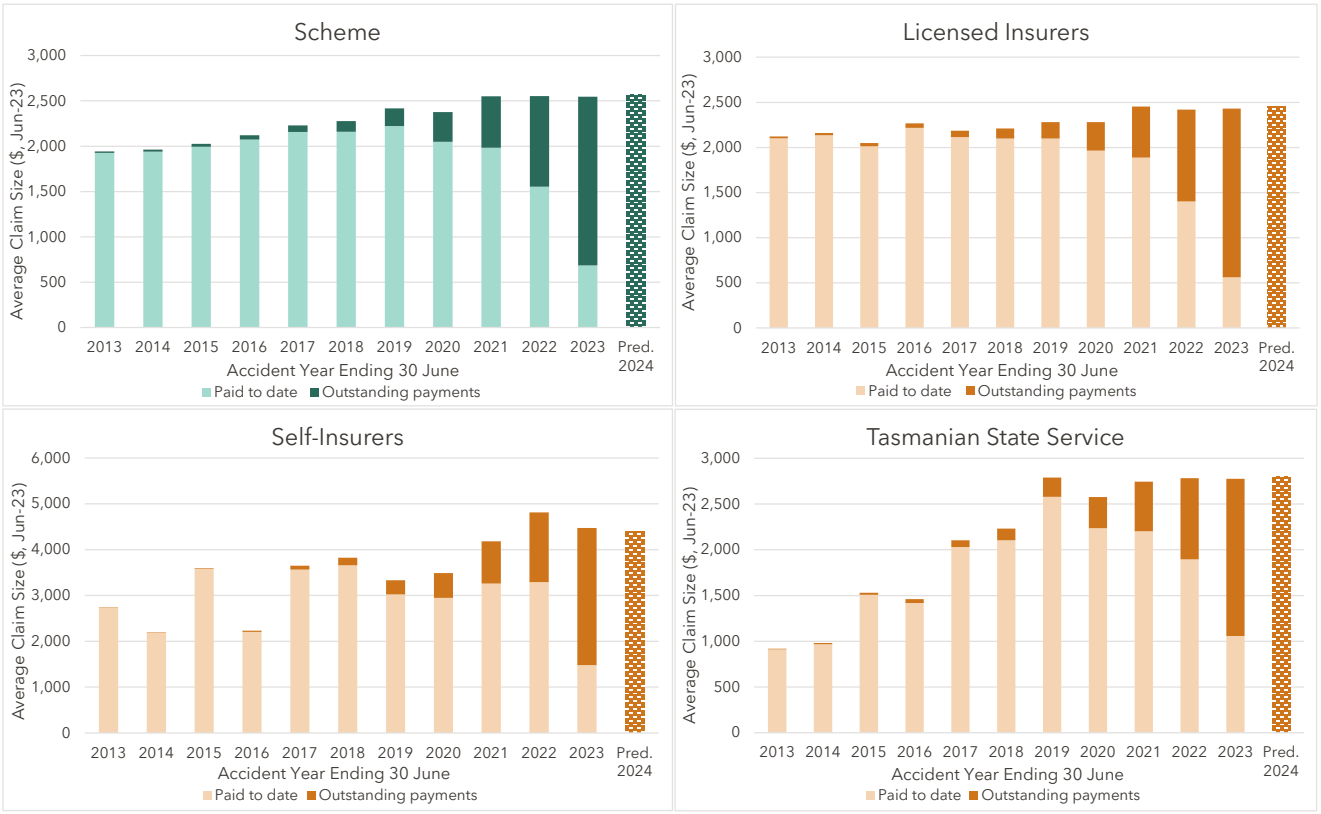
Key Points

For the Scheme overall, the legal/investigation average claim size for the 2022/23 accident year is projected to be $2,500. This is 0.3% lower in real terms than our projection for the 2021/22 accident year. The selected legal/investigation average claim size for new accidents is $2,600, which is 3% higher in real terms than what was selected at the previous review.

As further explained in Appendix B2, we use a Payments per Claim Incurred ("PPCI") model to estimate the ultimate cost of payments for legal and investigation costs. The PPCI approach projects payments for legal and investigation costs, as a function of the ultimate number of claims for the relevant accident period. This assumes payments in any period for legal and investigation costs are correlated to the ultimate number of claims.

Figure 8.2.1 shows our selected legal/investigation average claim sizes by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS 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 legal and investigation payments by the ultimate number of claims projected for the relevant accident year. All PPCIs shown are in 30 June 2023 values, so that real growth in PPCIs can be assessed.

Figure 8.2.1: Legal/Investigation PPCIs, by Accident Year ($, in 30 June 2023 values)



Source data can be found in Appendix E.22.

For the Scheme overall, the legal/investigation average claim size for the 2022/23 accident year is projected to be approximately $2,500 (noting that payments to date represents 27% of this). This is 0.3% lower in real terms than our projection for the 2021/22 accident year. Experience by sector has been as follows:

- for **licensed insurers**, the legal/investigation average claim size for 2022/23 is projected to be approximately $2,400 – this is 0.5% higher in real terms than 2021/22;
- for **self-insurers**, the legal/investigation average claim size for 2022/23 is projected to be approximately $4,500 – this is 7% lower in real terms than 2021/22; and
- for the **TSS**, the legal/investigation average claim size for 2022/23 is projected to be approximately $2,800 – this is 0.2% lower in real terms than 2021/22.

For the Scheme overall, the selected legal/investigation average claim size for the new accident year 2023/24 is around $2,600 (in 30 June 2023 values), which is 3% higher in real terms than what was selected for the new accident year (2022/23) at the previous review. The selected legal/investigation average claim sizes for each sector are as follows:

- for **licensed insurers**, we have selected an average size of around $2,500 for new accidents, which is 4% higher in real terms than the selection at the previous review;
- for **self-insurers**, we have selected an average size of around $4,400 for new accidents, which is 1% higher in real terms than the selection at the previous review; and
- for the **TSS**, we have selected an average size of around $2,800 for new accidents, which is 4% higher in real terms than the selection at the previous review.

9. Ultimate Cost by Accident Year

Based on payments to date and our estimates of outstanding payments, we have derived estimates of projected ultimate claims cost for each accident year. This section summarises these results.

Key Points

The undiscounted ultimate cost of accident year 2022/23 is projected to be $272.6 million, which is 8% higher than our projection for 2021/22. The undiscounted ultimate cost for the new accident year (2023/24) is forecasted to be $295.7 million, which is 9% higher in real terms than our forecast for the new accident year (2022/23) at the previous review.

The discounted ultimate cost of accident year 2022/23 is projected to be 1.53% of earned wages, which is lower than the 1.62% projected for 2021/22. Upward revisions in our TSS ultimate cost estimates for recent accident years have been driven by increased estimates for weekly and lump sum. We forecast discounted ultimate cost for the new accident year (2023/24) to be 1.52% of earned wages, as compared to 1.53% for the new accident year at the previous review.

9.1. Ultimate Cost

Key Points

The undiscounted ultimate cost of accident year 2022/23 is projected to be $272.6 million, with the $19.4 million (+8%) increase relative to our projection for 2021/22 being driven by the $18.1 million (+12%) increase for licensed insurers.

The undiscounted ultimate cost for the new accident year (2023/24) is forecasted to be $295.7 million, which is 9% higher in real terms than our forecast for the new accident year at the previous review. The movement for licensed insurers and self-insurers was driven by the movement in ultimate claim numbers, whereas the increase for the TSS was driven by increases in our average claim size selections for future TSS accidents.

Table 9.1.1 shows our central estimate of gross ultimate costs by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also included the forecast for the 2023/24 accident year. The ultimate costs shown are inflated to the date of each underlying payment. We have shown both undiscounted and discounted results, with the latter discounted back to the middle of the respective accident year (so that a more like-for-like comparison with earned wages for that accident year can be considered in Section 9.2).

Table 9.1.1: Estimated Ultimate Claims Costs, by Accident Year Ending 30 June ($ million)

Year	Infl. Undisc.				Infl. Disc.			
	LI	SI	TSS	Total	LI	SI	TSS	Total
2013	103.5	8.2	40.9	**152.5**	98.7	7.5	37.8	**144.0**
2014	110.0	5.4	35.3	**150.7**	103.6	5.0	31.9	**140.5**
2015	102.0	8.7	42.8	**153.5**	97.6	8.1	40.1	**145.9**
2016	115.8	3.8	38.7	**158.3**	111.6	3.6	36.2	**151.4**
2017	113.8	6.8	47.8	**168.4**	109.2	6.4	44.7	**160.3**
2018	126.1	9.2	47.0	**182.3**	120.2	8.6	44.0	**172.8**
2019	138.2	6.5	76.7	**221.3**	132.9	6.2	71.9	**211.0**
2020	132.9	8.2	82.2	**223.3**	130.2	8.0	79.5	**217.7**
2021	141.4	8.8	83.3	**233.5**	140.4	8.7	82.0	**231.0**
2022	145.0	9.3	99.0	**253.2**	141.2	8.9	95.2	**245.3**
2023	163.0	7.3	102.3	**272.6**	151.6	6.6	92.5	**250.7**
Pred. 2024	174.9	8.1	112.6	**295.7**	161.8	7.4	101.2	**270.4**

Note: "LI" refers to licensed insurers, "SI" refers to self-insurers, "TSS" refers to the Tasmanian State Service and "Total" refers to the Scheme overall. Also, "Infl. Undisc." means inflated and undiscounted, whereas "Infl. Disc." means inflated and discounted.

For the Scheme overall, the undiscounted ultimate cost of the 2022/23 accident year is projected to be $272.6 million. This is $19.4 million (+8%) higher than our projection for the 2021/22 accident year, and has been driven by the $18.1 million increase for licensed insurers. Experience by sector has been as follows:

- for **licensed insurers**, the undiscounted ultimate cost of the 2022/23 accident year is projected to be $163.0 million, which is $18.1 million (+12%) higher than 2021/22 – the increase in ultimate cost has been similar across the different payment types (ranges from +10% for legal/investigation costs to +15% for weekly benefits) and has been partly driven by the ultimate number of licensed insurer claims for 2022/23 being 5% higher than that for 2021/22;

- for **self-insurers**, the undiscounted ultimate cost of the 2022/23 accident year is projected to be $7.3 million, which is $2.0 million (-21%) lower than 2021/22 – the decrease is mainly driven by the ultimate number of self-insurer claims for 2022/23 being 15% lower than that projected for 2021/22; and

- for the **TSS**, the undiscounted ultimate cost of the 2022/23 accident year is projected to be $102.3 million, which is $3.3 million (+3%) higher than 2021/22 – the increase has been driven by $1.3 million (+5%) and $1.2 million (+7%) increases for lump sum and medical benefits, respectively.

For the Scheme overall, the undiscounted ultimate cost for the new accident year 2023/24 is forecasted to be $295.7 million, which is 9% higher in real terms than what was forecasted for the new accident year (2022/23) at the previous review. Forecasts for each sector are as follows:

- for **licensed insurers**, we have forecasted an undiscounted ultimate cost of $174.9 million for the accident year 2023/24, which is 9% higher in real terms than what was forecasted for 2022/23 at the previous review – this has been driven by our forecast of the ultimate number of licensed insurer claims for 2023/24 being 9% higher than our forecast at the previous review for 2022/23;

- for **self-insurers**, we have forecasted an undiscounted ultimate cost of $8.1 million for the accident year 2023/24, which is 21% lower in real terms than what was forecasted for 2022/23 at the previous review – this has been driven by our forecast of the ultimate number of self-insurer claims for 2023/24 being 20% lower than our forecast at the previous review for 2022/23; and

- for the **TSS**, we have forecasted an undiscounted ultimate cost of $112.6 million for the accident year 2023/24, which is 13% higher in real terms than what was forecasted for 2022/23 at the previous review – this has been driven by the selected TSS average claim size for 2023/24 being 8% higher in real terms than our selection at the previous review for 2022/23.

9.2. Ultimate Cost as a Percentage of Wages

Key Points

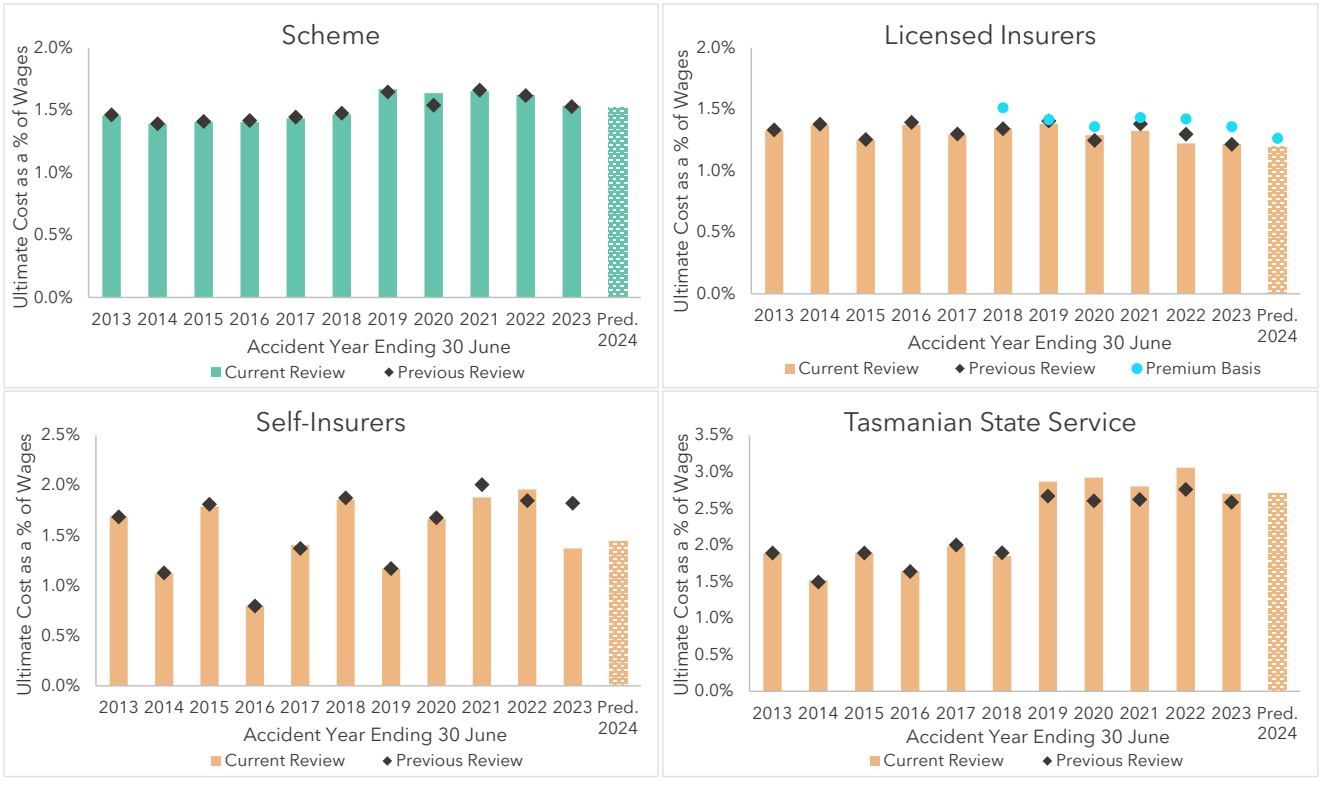
The discounted ultimate cost of accident year 2022/23 is projected to be 1.53% of earned wages, which is lower than the 1.62% projected for 2021/22.

TSS ultimate costs for accident years 2018/19 to 2021/22 have increased by 7 to 12% compared to the previous review, with this being driven by increases for weekly and lump sum. The downward revision in self-insurer ultimate cost for 2022/23 has been driven by a 22% decrease in the projection of ultimate claim numbers.

The discounted ultimate cost for the new accident year (2023/24) is forecasted to be 1.52% of earned wages, which is slightly lower than the 1.53% projected for the new accident year at the previous review. The reduced forecast for self-insurers is due to the reduced forecast for claim frequency, whereas the increased forecast for the TSS has been driven by the increased forecast for ultimate cost.

Figure 9.2.1 shows ultimate cost as a percentage of wages by accident year for the Scheme overall, as well as for licensed insurers, self-insurers and the TSS individually. We have also included the forecast for the 2023/24 accident year. Ultimate cost as a percentage of wages has been calculated by dividing the discounted ultimate claims costs (as per the right-hand side of Table 9.1.1) for each accident year by ultimate earned wages (in nominal values, i.e. not adjusted to be in 30 June 2023 values) for the respective accident year. In the absence of any legislative or behavioural changes, we would expect Figure 9.2.1 to show a relatively flat trend ultimate claim costs would move in line with wage inflation and workforce growth.

Figure 9.2.1: Estimated Ultimate Claims Costs (Discounted) as a Percentage of Earned Wages



Source data can be found in Appendix E.23.

For the Scheme overall, the discounted ultimate cost of the 2022/23 accident year is projected to be 1.53% of earned wages, which is lower than the 1.62% projected for the 2021/22 accident year. The decrease can be broken down into a 2% increase in discounted ultimate cost (numerator) versus an 8% increase in earned wages (denominator). Experience by sector has been as follows:

- for **licensed insurers**, the discounted ultimate cost of the 2022/23 accident year is projected to be 1.22% of earned wages, which is in line with that projected for 2021/22;
- for **self-insurers**, the discounted ultimate cost of the 2022/23 accident year is projected to be 1.37% of earned wages, which is lower than the 1.96% projected for 2021/22 – the decrease can be broken down into a 26% decrease in discounted ultimate cost versus a 5% increase in earned wages; and
- for the **TSS**, the discounted ultimate cost of the 2022/23 accident year is projected to be 2.70% of earned wages, which is lower than the 3.06% projected for 2021/22 – the decrease can be broken down into a 3% decrease in discounted ultimate cost versus a 10% increase in earned wages.

Figure 9.2.1 shows that the TSS has been sector with the largest movements in ultimate cost estimates between the previous and current review. In particular, the TSS ultimate costs for accident years 2018/19 to 2021/22 have increased by 7 to 12% compared to the previous review, with this being driven by increases for weekly and lump sum. The noteworthy decrease for self-insurers for 2022/23 was driven by ultimate claims being 22% lower than that forecasted at the previous review. Figure 9.2.1 also shows that the ultimate costs that have emerged for licensed insurers in recent years have been lower than that implied by our previous reviews of suggested industry premium rates, albeit this gap has narrowed in the past few years.

For the Scheme overall, the discounted ultimate cost of the new accident year 2023/24 is forecasted to be 1.52% of earned wages, which is slightly lower than the 1.53% forecasted for the new accident year (2022/23) at the previous review. Forecasts for each sector are as follows:

- for **licensed insurers**, the discounted ultimate cost of the accident year 2023/24 is forecasted to be 1.20%, which is slightly lower than the 1.22% forecasted for 2022/23 at the previous review;
- for **self-insurers**, the discounted ultimate cost of the accident year 2023/24 is forecasted to be 1.44%, which is higher than the 1.82% forecasted for 2022/23 at the previous review – this is due to the ultimate cost forecast being 20% lower, on account of a lower claim frequency being forecasted; and
- for the **TSS**, the discounted ultimate cost of the accident year 2023/24 is forecasted to be 2.71%, which is higher than the 2.58% forecasted for 2022/23 at the previous review – the increase can be broken down into the discounted ultimate cost forecast being 13% higher versus the earned wages forecast being 8% higher.

10. Licensed Insurer Experience

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

Key Points

The number of written policies in 2022/23 was 19,474 – this is 2.6% higher than 2021/22. We have forecasted a further 2.6% increase to 19,975 for 2023/24.

Earned premiums are estimated to be $278.2 million for 2022/23, which is 11.5% higher than 2021/22. We have forecasted an 11.2% increase to $309.4 million for 2023/24, with the increase being driven by growth in earned wages.

The achieved premium rate for 2022/23 is projected to be 2.24%, as compared to 2.16% for 2021/22. We have forecasted an achieved premium rate of 2.29% for 2023/24.

The projected profit margin of 26% for 2022/23 is slightly higher than 24% for 2021/22, with the increase driven by a decrease in the projected loss ratio. Recent improvements in licensed insurer profitability have likely been driven by increases in achieved premium rates, even though suggested rates have been decreasing since 2020/21.

The sum of licensed insurer case estimates and IBN(E)R reserves (as sourced from the End of Financial Year Reconciliations) is 40% higher than our central estimate of the outstanding claims liability. Therefore, as a whole, licensed insurers appear to be adequately reserved.

10.1. Number of Policies Written

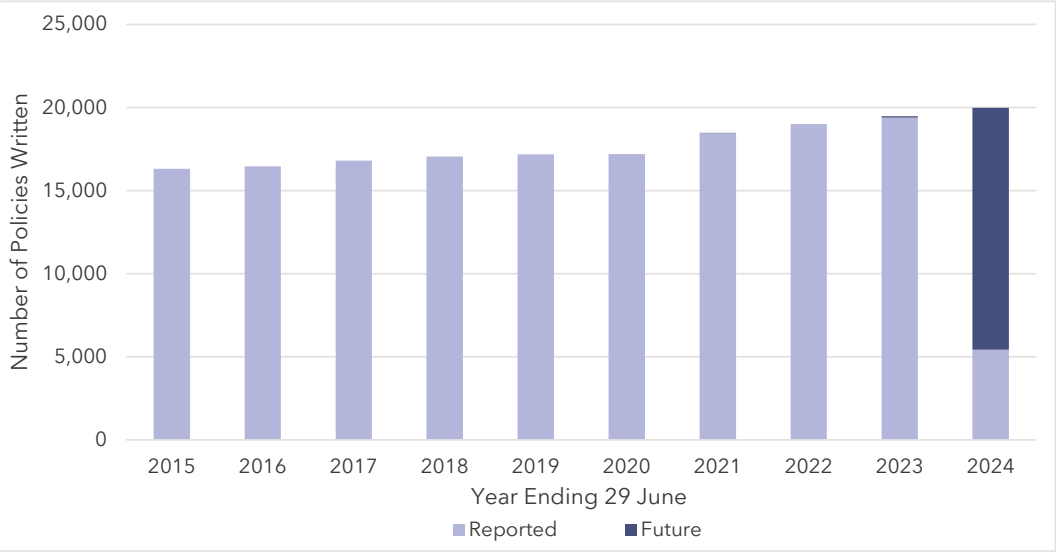
Key Points

Between 2014/15 and 2019/20, the number of policies written grew by an average of 1% per annum. The number of policies written in 2020/21 was 7.3% higher than 2019/20, with this being driven by one insurer writing more policies as short-term policies in early 2020/21 in response to the underwriting uncertainties associated with COVID-19.

The number of written policies increased by 2.6% from 2021/22 (18,985) to 2022/23 (19,474). We have forecasted a further 2.6% increase, such that the projected number of written policies for 2023/24 is 19,975.

Figure 10.1.1 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 10.1.1 shows policy counts, and this differs to the number of employers covered.

Figure 10.1.1: Number of Policies Written by Licensed Insurers, by Year Ending 29 June



Source data can be found in Appendix E.24.

Between 2014/15 and 2019/20, the year-on-year growth rate in the number of policies written ranged between 0.1% and 2.0%. The number of policies written in 2020/21 was 7.3% higher than 2019/20 – however, this was driven by one insurer responded 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 2.6% in the past year – from 18,985 in 2021/22 to 19,474 in 2022/23. This is comparable to the 2.9% increase from 2020/21 to 2021/22. The projected number of written policies for 2023/24 is 19,975 – this is 2.6% higher than that of 2022/23. We note that there is considerable uncertainty in projecting the number of policies written for the incomplete 2023/24 year.

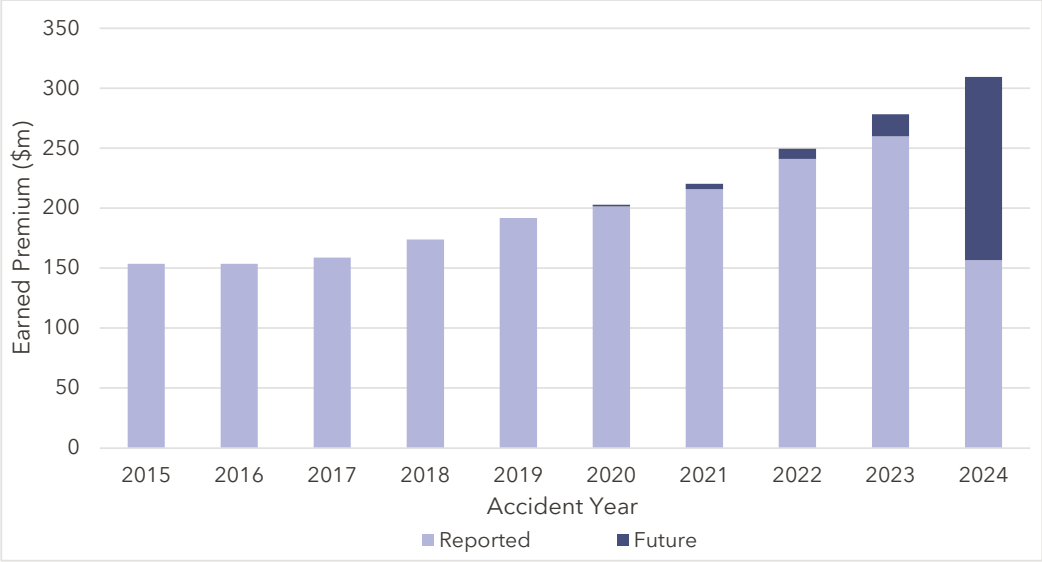
10.2. Earned Premiums

Key Points

Earned premiums are estimated to be $278.2 million for 2022/23, which is 11.5% higher than 2021/22. Our forecast of earned premiums for 2023/24 is $309.4 million, which would be 11.2% higher than 2022/23. This 11.2% increase is driven by our forecast of 8.8% growth in earned wages (in nominal values).

Figure 10.2.1 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 2023 values.

Figure 10.2.1: Earned Premiums for Licensed Insurers, by Accident Year ($ million)



Source data can be found in Appendix E.24.

Earned premiums for accident year 2022/23 are estimated to be $278.2 million, which is $28.7 million (+11.5%) higher than our estimate for 2021/22. We forecast $309.4 million of earned premiums for accident year 2023/24, which would be $31.2 million (+11.2%) higher than our estimate for 2022/23. Our forecast of earned premiums for 2023/24 is based on our forecasts of:

- earned wages (in nominal values), which we have forecast to grow by 8.8% between 2022/23 ($12.4 billion) and 2023/24 ($13.5 billion);
- achieved earned premium rates, which we have forecast to increase from 2.24% in 2022/23 to 2.29% in 2023/24 (as will be discussed in Section 10.3.1).

10.3. Premium Rates

Key Points

Between 2019/20 and 2022/23, achieved premium rates have increased year-on-year by increments of around 0.08 percentage points. We forecast an achieved premium rate of 2.29% for 2023/24, which would be 0.05 percentage points higher than 2021/22 (2.24%).

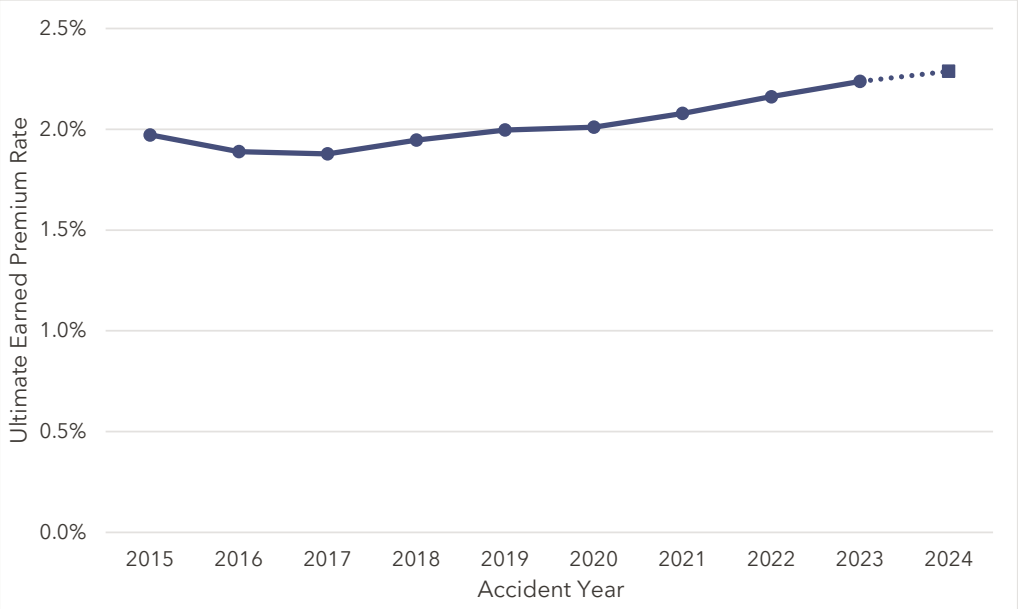
The risk premium rate suggested at this review for the 2023/24 accident year (1.20%) is lower than the rate suggested at the Previous Pricing Review for the 2023/24 underwriting year (1.24%). This has been driven by an update in forecasted wages. The lower suggested risk premium rate has resulted in a lower overall suggested premium rate too.

Our forecast of earned premiums to be collected by licensed insurers for accident year 2023/24 implies a forecast of 2.29% for the average premium rate achieved. If this were to occur, we expect insurers would realise margins that are larger than that assumed in our suggested pricing basis.

10.3.1. Achieved Premium Rates

Figure 10.3.1 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 2023 values. We note that Figure 10.3.1 shows ultimate premium rates, i.e. it allows for our projection of remaining future development in earned premiums and wages.

Figure 10.3.1: Achieved Earned Premium Rates for Licensed Insurers, by Accident Year



Source data can be found in Appendix E.25.

For 2014/15 and 2019/20, achieved premium rates have ranged between 1.88% and 2.01%. However, between 2019/20 and 2022/23, achieved premium rates have increased year-on-year by increments of around 0.08%.

The achieved premium rate for accident year 2022/23 is projected to be 2.24%, which is 0.08 percentage points higher than our projection for 2021/22 (2.16%). We forecast an achieved premium rate of 2.29% for accident year 2023/24, which would be 0.05 percentage points higher than our projection for 2021/22.

We note that our projections of ultimate achieved premium rates is subject to uncertainty about the extent of remaining development, especially for accident years 2022/23 and 2023/24 which are both particularly underdeveloped.

10.3.2. Implications of Scheme Review Results for Suggested Premium Rates

Table 10.3.2 shows key results relating to suggested industry premium rates for 2023/24.

The "Pricing Review" column of Table 10.3.2 relates to forecasts of written figures for the 2023/24 underwriting year, as per what was provided in the Previous Pricing Review. The Previous Pricing Review was based on data to 31 December 2022, and the findings of this review was documented in our report *"Suggested Industry Premium Rates for 2023/24"*, dated March 2023.

The "Scheme Review" column of Table 10.3.2 shows our forecasts of earned figures for the 2023/24 accident year, with this being based on data to 30 June 2023. The $161.8 million forecast for the risk premium pool is equivalent to our forecast of 2023/24 accident year's discounted ultimate cost, which was shown in Section 9.1. 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 10.3.2: Suggested Premium Rates for 2023/24

Premium Rate Component	Pricing Review (Written)	Scheme Review (Earned)
Risk Premium Pool ($ million)	159.6	161.8
Expense Loading ($ million)	53.8	54.6
Insurer Margin ($ million)	31.9	32.3
Total Premium Pool ($ million)	**245.4**	**248.7**
Wages ($ million)	12,920	13,526
Average Risk Premium Rate (as a % of wages)	**1.24%**	**1.20%**
Average Premium Rate (as a % of wages)	**1.90%**	**1.84%**

The risk premium rate suggested at this review for the 2023/24 accident year (1.20%) is lower than the rate suggested at the Previous Pricing Review for the 2023/24 underwriting year (1.24%). This has been driven by an update in our forecast of wages. The lower suggested risk premium rate has resulted in a lower overall suggested premium rate too.

We are forecasting $309.4 million of earned premiums to be collected by licensed insurers for accident year 2023/24. If this were to occur, the average premium rate achieved would be 2.29% of wages, as has been shown in Section 10.3.1, and insurers would realise margins that are larger than that assumed in our suggested pricing basis. Insurers may wish to consider experience and results outlined in this report to inform the setting of premium rates.

10.4. Profitability

Key Points

Since 2016/17, there appears to have been year-on-year improvements in licensed insurer profitability. The projected profit margin of 26% for 2022/23 is slightly higher than 2021/22. The increase is due to the projected loss ratio falling from 57% to 54%, whereas the expense ratio has remained flat at 20%. We note that profitability results are particularly uncertain for recent accident years, given the relatively small proportion of ultimate costs that has been paid to date.

Recent improvements in licensed insurer profitability have likely been driven by increases in achieved premium rates. In particular, suggested rates have been decreasing since 2020/21 whereas ultimate rates achieved by insurers have continued to increase year-on-year.

Table 10.4.1 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 2022/23) and may change as experience develops. Also, loss and expense ratios (and, by extension, profit margins) will vary between individual licensed insurers.

Table 10.4.1: Licensed Insurer Profitability, by Accident Year Ending 30 June

Accident Year	Ultimate Claims Cost[1] ($m)	Expenses[2] ($m)	Earned Premium[3] ($m)	Loss Ratio (%)	Expense Ratio (%)	Profit Margin (%)
2015	93.8	33.1	153.5	61%	22%	17%
2016	108.4	33.8	153.5	71%	22%	7%
2017	105.6	36.8	158.8	66%	23%	10%
2018	118.7	41.2	173.9	68%	24%	8%
2019	132.9	41.9	191.8	69%	22%	9%
2020	130.2	43.2	202.9	64%	21%	15%
2021	140.4	45.8	220.1	64%	21%	15%
2022	141.2	49.0	249.5	57%	20%	24%
2023	151.6	54.8	278.2	54%	20%	26%

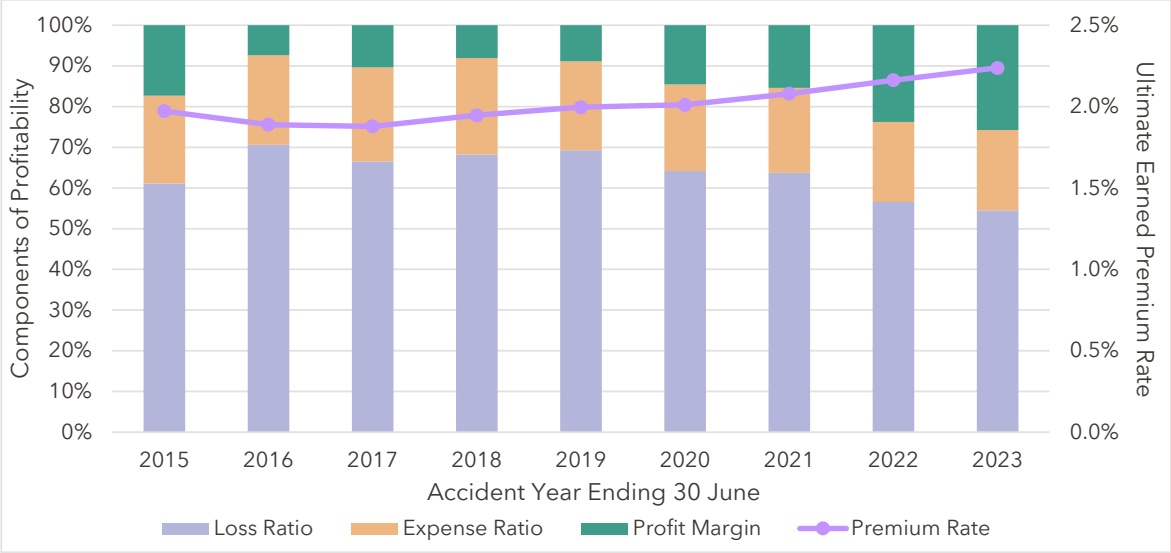
1 Inflated to the date of each underlying payment and discounted back to the middle of the respective accident year.

2 Based on actual expenses for the respective financial year, as reported by insurers in the End of Financial Year Reconciliations.

3 Projected ultimates in nominal values, as per what has been shown in Section 10.2.

Figure 10.4.2 shows the results from Table 10.4.1 in a graphical form. We have also shown the achieved earned premium rates that were discussed in Section 10.3.1.

Figure 10.4.2: Licensed Insurer Profitability, by Accident Year Ending 30 June



Source data can be found in Appendix E.26.

Since 2016/17, there appears to have been year-on-year improvements in licensed insurer profitability. In particular, there were notable step changes between 2018/19 and 2019/20 (profit margin increased from 9% to 15%) and between 2020/21 and 2021/22 (increased from 15% to 24%). The projected profit margin of 26% for 2022/23 is slightly higher than 2021/22. The increase is due to the projected loss ratio falling from 57% for 2021/22 to 54% for 2022/23, whereas the expense ratio has remained flat at 20%. 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 (26% for 2022/23, 53% for 2021/22 and 72% for 2020/21).

Recent improvements in licensed insurer profitability have likely been driven by increases in achieved premium rates. In particular, suggested rates have been decreasing since 2020/21 whereas ultimate rates achieved by insurers have continued to increase year-on-year. This resulted in ultimate achieved rates converging with suggested rates in 2021/22 and since then, the gap of ultimate achieved rates being above suggested rates has widened.

10.5. Outstanding Claims Liability

Key Points

The sum of licensed insurer case estimates and IBN(E)R reserves (as sourced from the End of Financial Year Reconciliations) is $373.6 million, which is $106.4 million (+40%) higher than our central estimate of $267.2 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, as a whole, licensed insurers appear to be adequately reserved.

The central estimate of outstanding claims liability as at 30 June 2023 is calculated by discounting our estimates of future claim payments to 30 June 2023. Table 10.5.1 compares our central estimate of outstanding claims liability for licensed insurers, with insurer case estimates and IBN(E)R reserves (as sourced from the End of Financial Year Reconciliations).

Table 10.5.1: Estimated Gross Outstanding Claims Liability for Licensed Insurers

	Scyne Central Estimate[1] ($m)	Insurer Estimates ($m)	Difference between Insurer and Scyne Estimates ($m)	Ratio between Insurer and Scyne Estimates (%)
Case Estimates		263.8		
IBNR/IBNER		109.8		
Total	**267.2**	**373.6**	**+106.4**	**140%**

[1] Inflated and discounted to 30 June 2023

Our central estimate of the outstanding claims liability for licensed insurers is $267.2 million, as at 30 June 2023.

Licensed insurer case estimates are $263.8 million as at 30 June 2023. In addition, licensed insurers have reported they held reserves of $109.8 million at 30 June 2023 in respect of IBN(E)R. As such, the implied central estimate determined by licensed insurers is $373.6 million, which is $106.4 million (+40%) higher than our central estimate of $267.2 million. This compares to a difference of 22% as at 30 June 2022, based on the results of the previous review. We note that licensed insurers are also required by APRA to hold a risk margin in addition to their central estimate.

As a whole, licensed insurers appear to be adequately reserved. We note that the above analysis of reserve adequacy is performed at an aggregate level for the licensed insurer sector. The adequacy of each individual licensed insurer's reserves will vary depending on the licensed insurer's own reserving practices.

11. Self-Insurer Information

This section presents a comparison of our estimates to self-insurer case estimates and IBN(E)R reserves, plus a comparison of our estimates to bank guarantees held.

Key Points

As a whole, self-insurers appear to be adequately reserved and have an appropriate level of bank guarantees.

The outstanding claims liability central estimate determined by self-insurers is $17.4 million, which is $1.5 million (-8%) lower than our central estimate of $18.9 million. We note that self-insurers may also hold risk margins in addition to their central estimate.

In aggregate, self-insurer bank guarantees are 1.4 times our actuarial central estimate (with the latter including an illustrative 10% allowance for claims handling expenses).

11.1. Outstanding Claims Liability

The central estimate of outstanding claims liability as at 30 June 2023 is calculated by discounting our estimates of future claim payments to 30 June 2023. Table 11.1.1 compares our central estimate of the outstanding claims liability for self-insurers, with self-insurer case estimates and IBN(E)R reserves (as sourced from the End of Financial Year Reconciliations).

Table 11.1.1: Estimated Gross Outstanding Claims Liability for Self-Insurers

	Scyne Central Estimate[1] ($m)	Insurer Estimates ($m)	Difference between Insurer and Scyne Estimates ($m)	Ratio between Insurer and Scyne Estimates (%)
Case Estimates		8.3		
IBNR/IBNER		9.1		
Total	**18.9**	**17.4**	**-1.5**	**92%**

[1] Inflated and discounted to 30 June 2023

Our central estimate of the outstanding claims liability for self-insurers is $18.9 million, as at 30 June 2023.

Self-insurer case estimates are $8.3 million as at 30 June 2023. In addition, self-insurers have reported they held reserves of $9.1 million at 30 June 2023 in respect of IBN(E)R. As such, the implied central estimate determined by self-insurers is $17.4 million, which is $1.5 million (-8%) lower than our central estimate of $18.9 million. Self-insurers may also hold risk margins in addition to their central estimate.

The self-insurer central estimates are slightly lower than our estimate, albeit a smaller difference than that observed at the previous review ($5.5 million, 27%). However, we note there is considerable uncertainty that surrounds the estimates of future costs, in particular for lump sums, and that the level of bank guarantees is higher than our central estimate (as will be discussed in Section 11.2).

We note that the above analysis of reserve adequacy 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 self-insurer's own reserving practices.

11.2. Self-Insurer Bank Guarantees

Table 11.2.1 compares our outstanding claims liability estimate for the self-insured sector against the bank guarantees which self-insurers are required to hold. Forestry Tasmania is exempt from this requirement, but for the purposes of this assessment, we have calculated the bank guarantee that Forestry Tasmania would have otherwise been required to hold, using the formula specified by the Board (i.e. equal to 150% of the self-insurer's assessment of it's outstanding claims liability central estimate).

Table 11.2.1: Comparison of Self-Insurer Outstanding Claims Liability with Bank Guarantees

	$m
Estimated gross outstanding claims liability for self-insurers	18.9
plus allowance for claims handling expenses (10%)	1.9
Total actuarial estimate	**20.8**
Total bank guarantee (including calculation for Forestry Tasmania)	**29.2**
Ratio between total bank guarantee and total actuarial estimate	**140%**

The comparison shows that in aggregate, self-insurer bank guarantees are 1.4 times the actuarial central estimate (with the latter including an illustrative 10% allowance for claims handling expenses).

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

12. Nominal Insurer Experience

This section presents experience relating to the Nominal Insurer for workers' compensation in Tasmania. The Nominal Insurer is the body established under workers' compensation legislation to act as the insurer, in the event an insurer becomes insolvent, an employer has not taken out insurance, or other certain circumstances. Note that this analysis excludes the claims that arose from the failure of the HIH Insurance, which have subsequently been the subject of a portfolio transfer to IAG.

Key Points

60 claims were reported to the Nominal Insurer between 2002/03 and 2022/23. An average of 4.8 claims per annum were reported between 2002/03 and 2012/13, but this has fallen to an average of 0.7 claims per annum since 2013/14.

An average of $441,000 of Nominal Insurer claim payments is made 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 around $97,000 (this is much higher than the rest of the Scheme).

The Nominal Insurer has, on average, incurred $68,000 of administration expenses per annum. This translates to an average of $27,000 of administration expenses per claim reported, and an average ratio of 15% between administration expenses and claim payments.

12.1. Number of Claims Reported

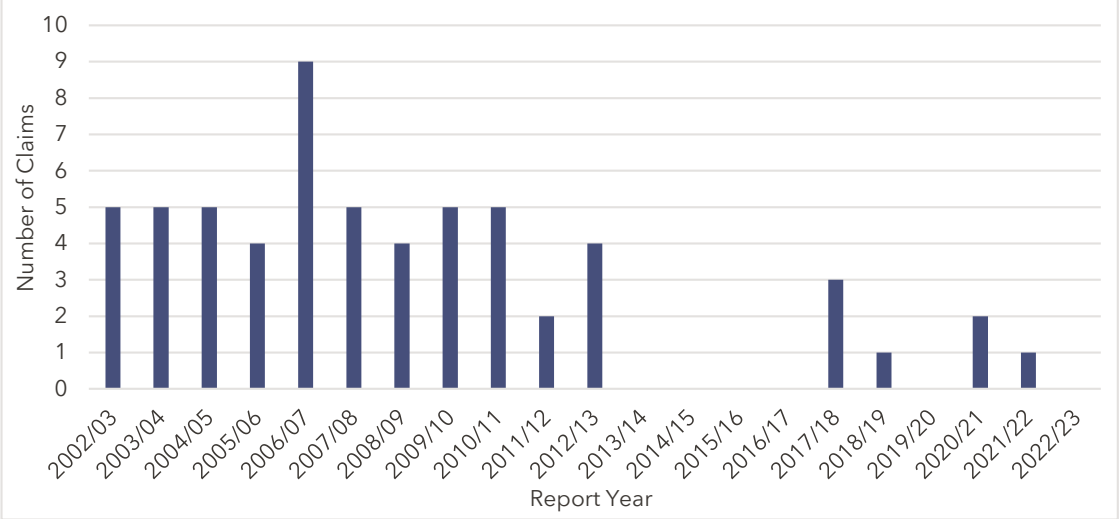
Since 2013/14, claims reported to the Nominal Insurer have not been captured in the WorkSafe Information Management System (WIMS). We have been advised separately of the Nominal Insurer claims that are not recorded in WIMS. To date, we have been informed of 38 claims that are not captured in WIMS, which can be split out as follows:

- 26 claims do not have a recorded report date (of which, 20 pertain to accident year 2002/03 or later);
- 5 claims were reported in 2012/13 or prior; and
- 7 claims were reported in 2013/14 or later (including one claim that does not have a recorded accident date, as the claim form for this claim was incomplete).

We have been unable to include claims without a report or accident date in Figure 12.1.1 and Figure 12.1.2 (respectively), given that these charts are presented on report year and accident year bases (respectively).

Figure 12.1.1 shows the total number of claims reported to the Nominal Insurer for each report year.

Figure 12.1.1: Number of Claims Reported to the Nominal Insurer, by Report Year

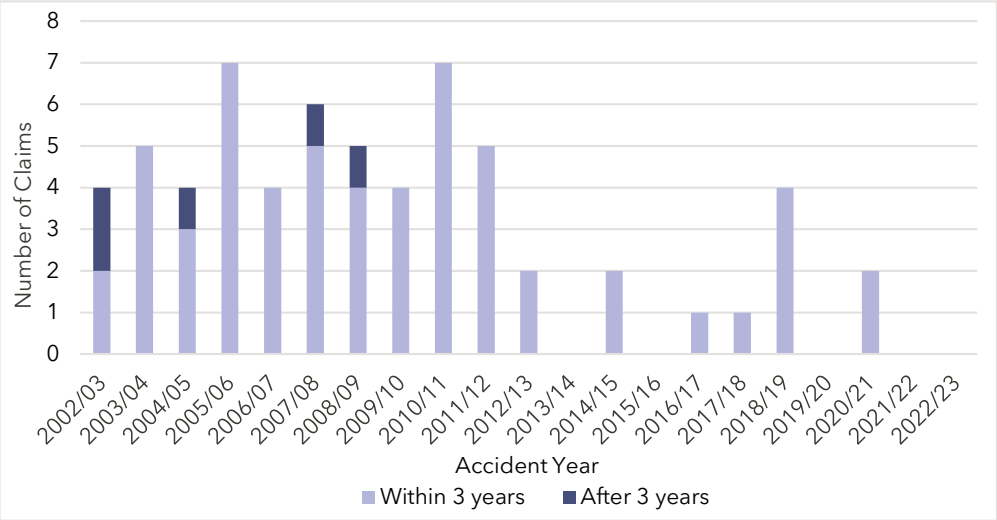


Source data can be found in Appendix E.27.

60 claims have been reported to the Nominal Insurer, in report years 2002/03 to 2022/23. This is less than 0.1% of the number of claims reported to licensed insurers over the same period. An average of 4.8 claims per annum were reported between 2002/03 and 2012/13, but this has reduced to an average of 0.7 claims per annum since 2013/14.

Figure 12.1.2 shows the total number of claims reported to the Nominal Insurer for each accident year. We have split out claims into those reported within three years of the accident and those reported more than three years after the accident.

Figure 12.1.2: Number of Claims Reported to the Nominal Insurer, by Accident Year



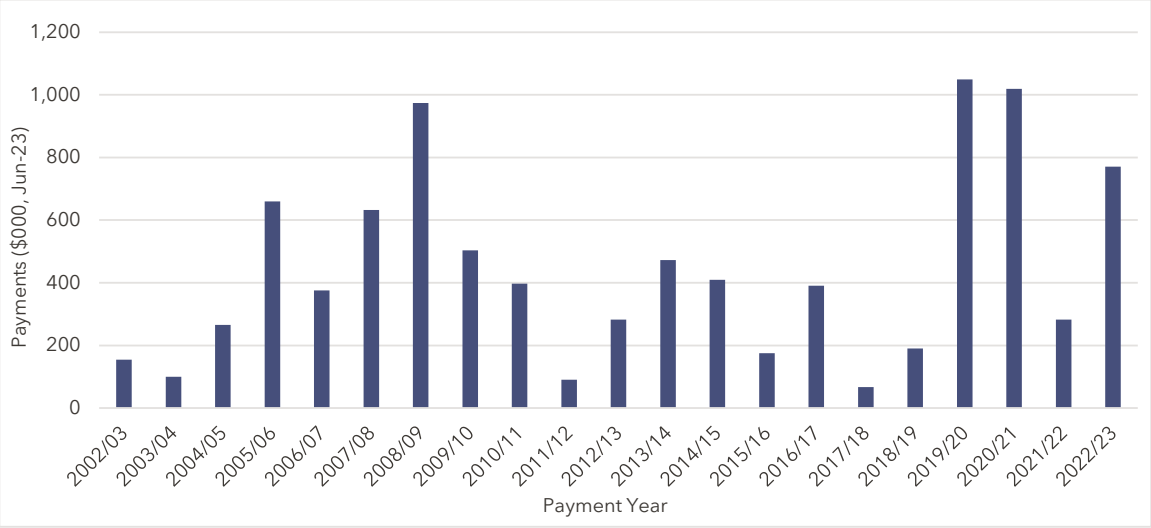
Source data can be found in Appendix E.28.

The majority of claims are reported within three years of accident. Given this, it is not surprising to see a lower level of claims for more recent accident years, similar to that observed for more recent report years in Figure 12.1.1.

12.2. Cost of Claims

Figure 12.2.1 shows Nominal Insurer claim payments by financial year, with the amounts shown being in 30 June 2023 values.

Figure 12.2.1: Payments for Nominal Insurer Claims, by Payment Year ($ thousands, in 30 June 2023 values)



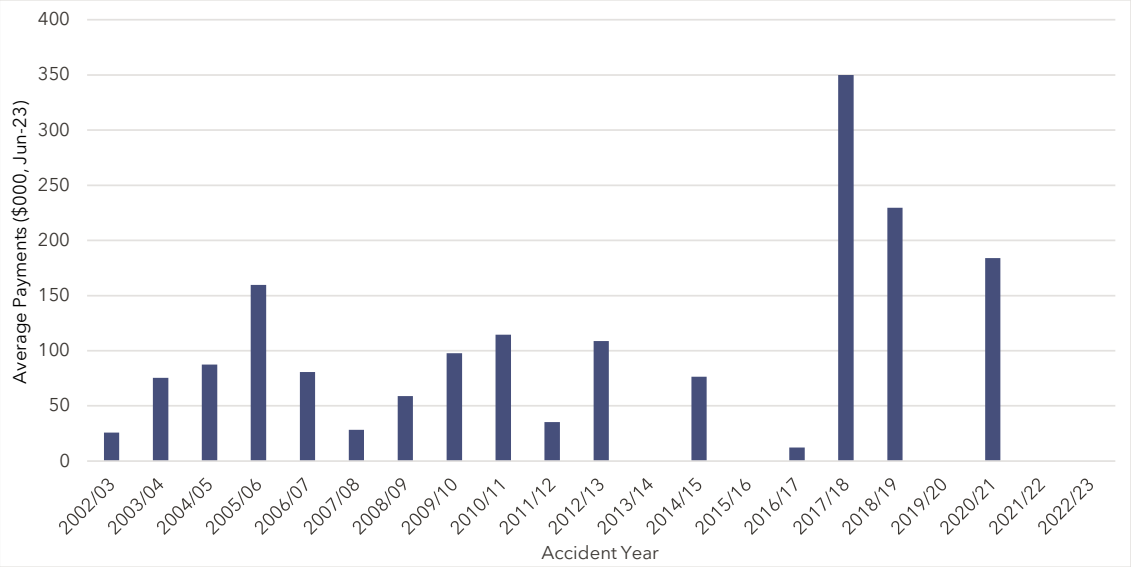
Source data can be found in Appendix E.29.

There has been $9.3 million (in 30 June 2023 values) worth of Nominal Insurer claim payments made between 2002/03 and 2022/23. This translates to an average of around $441,000 of Nominal Insurer claim payments per financial year. However, there has been volatility in year-to-year experience, with payments ranging from approximately $67,000 for 2017/18 to $1.05 million for 2019/20. The relatively high payment volumes for recent financial years have been driven by the following:

- 2019/20: A negotiated settlement lump sum payment of around $479,000 (in nominal values);
- 2020/21: A negotiated settlement lump sum payment of around $512,000 (in nominal values); and
- 2022/23: Negotiated settlement lump sum payments of around $273,000 and $157,000 (both in nominal values), for two separate claims.

Figure 12.2.2 shows average payments for Nominal Insurer claims by accident year, with the amounts shown being in 30 June 2023 values. Average payments have been calculated for each accident year, by dividing payments to date for the respective accident year by the number of claims reported to date for that accident year.

Figure 12.2.2: Average Payments for Nominal Insurer Claims, by Accident Year ($ thousands, in 30 June 2023 values)



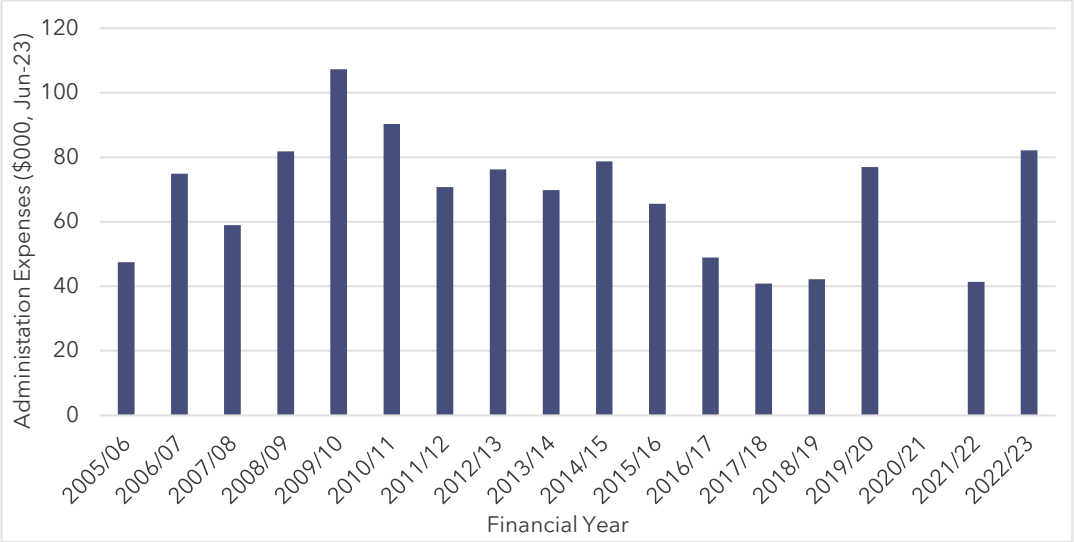
Source data can be found in Appendix E.30.

The average quantum of payments made for Nominal Insurer claims that relate to accident years 2002/03 to 2022/23 is around $97,000 (in 30 June 2023 values). This is three times the average claim size of $32,900 that we have assumed for new accidents in the rest of the Scheme. We note that average payments for Nominal Insurer claims can be volatile, often due to the impact of occasional large claims (such as those receiving negotiated settlement lump sum payments).

12.3. Administration Expenses

Figure 12.3.1 shows administration costs for the Nominal Insurer by financial year, with the amounts shown being in 30 June 2023 values. The figures have been sourced from the End of Financial Year Reconciliations. WorkSafe have been unable to provide a figure for 2020/21, due to temporary operational limitations that meant administration expenses were not recorded for that financial year.

Figure 12.3.1: Administration Costs for the Nominal Insurer, by Financial Year ($ thousands, in 30 June 2023 values)



Source data can be found in Table 12.3.2.

The Nominal Insurer has incurred $1.15 million (in 30 June 2023 values) worth of administration expenses since 2005/06. Excluding 2020/21, this translates to an average of around $68,000 of administration expenses per annum.

Figure 12.3.1 shows the administration expenses per claim reported and as a percentage of claim payments over the years since 2005/06.

Table 12.3.2: Administration Costs per Claims Reported/Payments, by Financial Year (in 30 June 2023 values)

Financial Year	Administration Expenses	Claims Reported	Claim Payments	Expenses per Claim Reported	Ratio of Expenses to Claim Payments
2005/06	47,478	4	659,292	11,869	7%
2006/07	74,842	9	375,900	8,316	20%
2007/08	58,945	5	632,269	11,789	9%
2008/09	81,799	4	973,633	20,450	8%
2009/10	107,228	5	503,910	21,446	21%
2010/11	90,347	5	397,539	18,069	23%
2011/12	70,739	2	91,011	35,370	78%
2012/13	76,247	4	282,371	19,062	27%
2013/14	69,755	0	472,291	n/a	15%
2014/15	78,670	0	409,308	n/a	19%
2015/16	65,544	0	174,754	n/a	38%
2016/17	48,951	0	390,325	n/a	13%
2017/18	40,796	3	67,390	13,599	61%
2018/19	42,225	1	190,121	42,225	22%
2019/20	76,999	0	1,049,176	n/a	7%
2020/21	n/a	2	1,018,895	n/a	n/a
2021/22	41,353	1	282,527	41,353	15%
2022/23	82,092	0	770,721	n/a	11%
Unknown	*n/a*	*26*	*n/a*	*n/a*	*n/a*
Average (excl. 2020/21)	**67,883**	**2.5**	**454,267**	**26,837**	**15%**

As per Section 12.1, 26 claims do not have a recorded report date and, hence, are categorised as unknown. However, the payments associated with these claims have been assigned to the relevant financial year.

Administration expenses per claim reported has averaged around $27,000 (in 30 June 2023 values), whereas the ratio of administration expenses to claim payments has averaged 15%. This is higher than the level of claims handling expenses we would expect to see for a licensed insurer, but is not unexpected given the very low number of claims managed by the Nominal Insurer. We also note that some administration costs incurred by the Nominal Insurer would be fixed costs – that is, would remain the same irrespective of the number of claims managed or the amount of claim payments made.

13. Tribunal Matters

This section examines matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal ("Tribunal"). The Tribunal was formerly known as the Workers Rehabilitation and Compensation Tribunal. The Tribunal is a statutory independent Tribunal created under the *Tasmanian Civil and Administrative Tribunal Act 2021*, with primary responsibility to determine all disputes relating to workers compensation in Tasmania under the *Workers Rehabilitation and Compensation Act 1988*.

Key Points

952 claims had their first matter referred to the Tribunal in 2022/23, which is 1% higher than the 939 for 2021/22. The proportion of claims (with at least one dispute) that relate to the TSS has increased from 20% in 2017/18 to 30% in 2022/23, whereas licensed insurers and self-insurers have fallen from 73% to 66% and 7% to 4%, respectively. Three-quarters of claims lodge one matter, 14% two matters, 9% three matters, and 3% lodge for four or more matters.

Dispute of liability under Section 81A continues to be the most common dispute type. Section 42 referrals and settlement approvals are most likely to be the second (or later) dispute category that is referred for a claim. There appears to have been a step up in the past two years, in respect to the number of Section 71 disputes (these are disputes relating to compensation for permanent impairment).

The overall disputation rate continues to remain between 10% and 13%, with it being 12% for 2022/23. The relativity between the Section 81A disputation rate and the overall rate continues to be relatively stable. Disputation rates for 2022/23 were 11% for licensed insurers, 17% for the TSS and 23% for self-insurers. The self-insurer disputation rate continues to be around double that of licensed insurer disputation rates, while the gap of TSS being above licensed insurer disputation rates has widened in recent years.

The number of finalisations has grown by an average of 1.4% per annum between 2013/14 and 2022/23. There were 1,257 finalisations in 2022/23, which is 2.1% higher than 2021/22. The average delay between referral and finalisation reached a decade-low in 2021/22 (82 days), but has since increased to 102 days for 2023/24, which is in line with historical levels. Settlement approvals and disputes of liability under Section 81A continue to have the shortest average delays (seven days and 21 days, respectively).

15 matters have been adjourned between 2018/19 and 2023/24, with one matter being adjourned in 2021/22 and no matters being adjourned in 2022/23.

13.1. Data Supplied

Our analysis of Tribunal matters has been based on the 'claims with disputes' data, extracted as at 29 August 2023.

Each Tribunal matter is linked to the relevant claim, with a claim able to have more than one matter associated with it. Some matters have more than one dispute associated with the matter. For example, a matter can include a dispute regarding compensation for permanent impairment, as well as a dispute regarding medical/rehabilitation services.

Besides this reason, a matter may have more than one record in the 'claims with disputes' data, because:

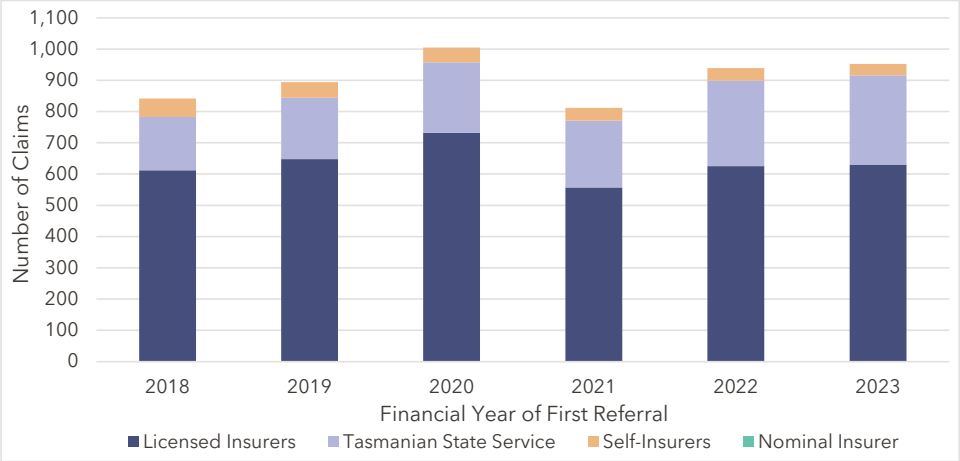
- an Application for Costs under Section 59 was sought when the matter was lodged (we have not counted Applications for Costs in our counts of disputes); and/or
- the matter was adjourned *sine die* i.e. adjourned prior to a decision being reached and without a future hearing date set (where this is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

Some of the following analysis is based on the number of distinct matters, whereas other portions of our analysis have been based on the number of distinct claims that have at least one dispute.

13.2. Number of Claims with Disputes

Figure 13.2.1 shows, for each sector, the number of claims with at least one dispute. Each claim has been allocated to a 'financial year of first referral', which is the year in which the claimant's earliest matter was referred to the Tribunal.

Figure 13.2.1: Number of Claims with Disputes, by Financial Year of First Referral



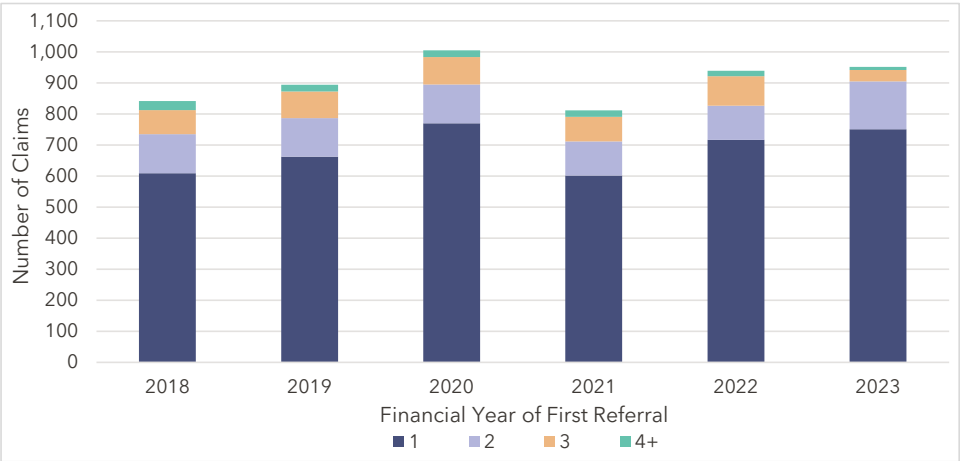
Source data can be found in Appendix E.31.

952 claims had their first matter referred to the Tribunal in 2022/23, which is 1% higher than 2021/22. There has been year-to-year volatility, with an average of 898 claims per annum first referred between 2017/18 and 2021/22.

Even though most claims with at least one dispute are licensed insurer claims, this proportion has been reducing in recent years (from 73% in 2017/18 to 66% in 2022/23). Similarly, over the same period, self-insurers have reduced their share of claims with a referral, from 7% to 4%. On the other hand, year-on-year increases for TSS claims with at least one dispute have resulted in the TSS' share increasing from 20% to 30%.

Figure 13.2.2 shows the number of matters referred to date for each claim with at least one dispute. Again, we have presented this by financial year of first referral, i.e. the year in which the claim's earliest matter was referred to the Tribunal. Claims that have had four or more matters referred to date have been grouped together as "4+".

Figure 13.2.2: Number of Matters Referred to Date per Claim, by Financial Year or First Referral



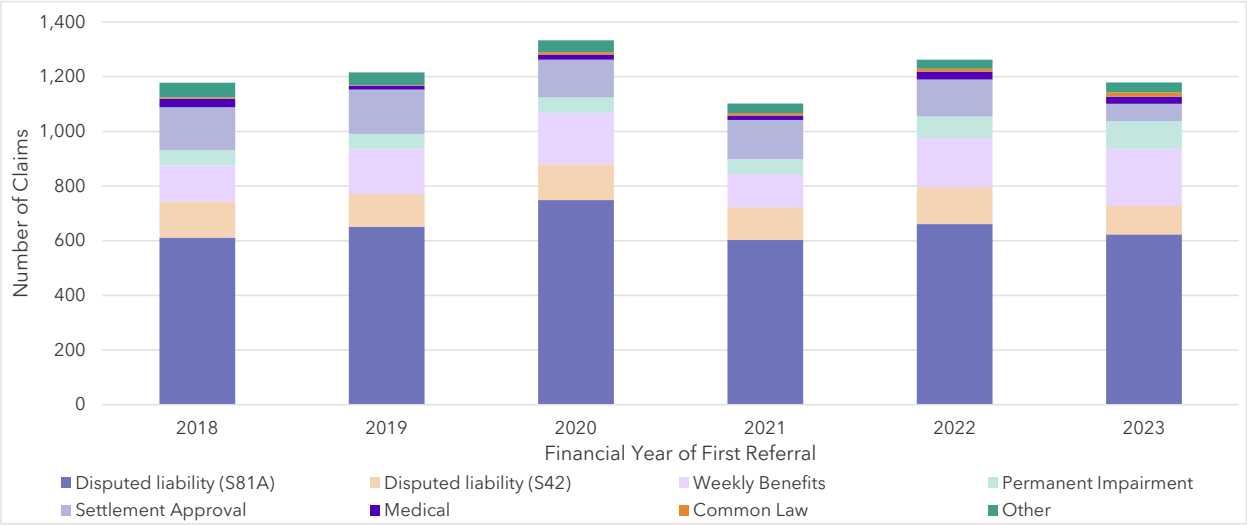
Source data can be found in Appendix E.32.

Of the claims first referred between 2017/18 and 2020/21, 74% have lodged one matter, 14% two matters, 9% three matters, and 3% have lodged four or more matters. To date, 79% of claims first referred in 2022/23 have lodged only one matter, but this proportion is expected to reduce as these claims have more time to refer additional matters.

13.3. Number of Disputes

Figure 13.3.1 shows, for each dispute category, the number of distinct claims that have lodged one or more disputes in respect of that dispute category. As such, claims that have lodged disputes for two or more distinct categories are counted more than once. We have presented Figure 13.3.1 by financial year of first referral, i.e. the year in which the claim's earliest matter was referred to the Tribunal.

Figure 13.3.1: Number of Distinct Claims for each Dispute Category, by Financial Year of First Referral



Source data can be found in Appendix E.33.

Experience for the more common dispute categories has been as follows:

- 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. This continues to be the most common dispute category. Of the claims first referred in 2022/23, 623 have already lodged at least one Section 81A dispute.

- Section 42 referrals: Any party (whether it be the worker, employer or insurer) may refer a claim to the Tribunal under Section 42, as long as there is a dispute about some aspect of the claim. All parties to a Section 42 referral must participate in a conciliation process, whereas this is not compulsory for Section 81A referrals. Section 42 is often the second (or later) dispute category that is referred for a claim. At the previous review, 93 claims first referred in 2021/22 had a dispute under Section 42 – at the current review, this is now 135 claims.

- Disputes relating to weekly benefits: Most 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, whereas Section 86(4) is only available to workers. Of the claims first referred in 2022/23, 210 have already lodged at least one dispute relating to weekly benefits.

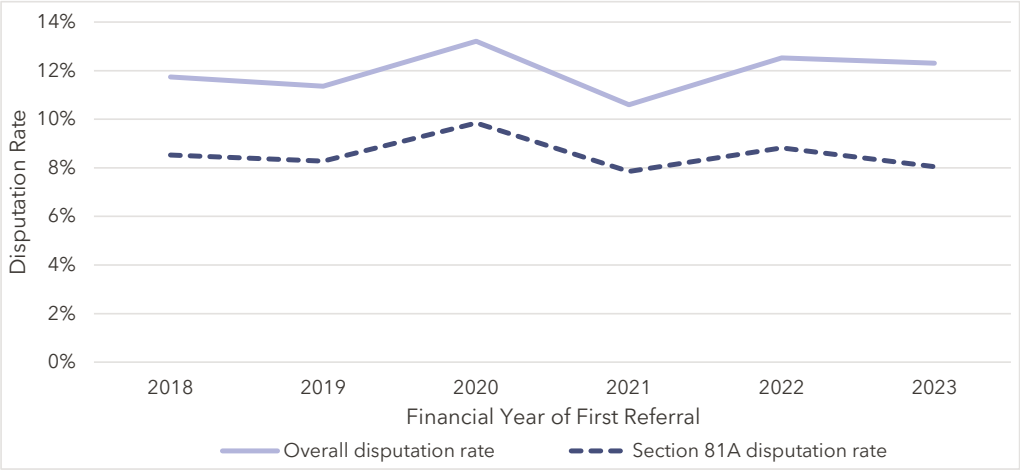
- Disputes relating to compensation for permanent impairment (Section 71): The number of claims with a Section 71 dispute was stable at around 55 claims per annum, for 2017/18 to 2020/21. This increased to 79 claims for the 2021/22 year and has increased further to 100 claims being referred to date for the 2022/23 year.

- Settlement approval: More than 99% of referrals relating to settlement approval are made under Section 132A(4). Referrals are made under Section 132A(4) to seek the Tribunal's approval for a proposed agreement to settle. Settlement approval referrals are often the second (or later) dispute category that is referred for a claim. At the previous review, 61 claims first referred in 2021/22 had already lodged a referral for settlement approval – at the current review, this is now 136 claims.

13.4. Disputation Rates

Figure 13.4.1 shows disputation rates, by financial year of first referral. The overall disputation rate has been calculated by dividing the number of claims with at least one dispute by the number of new claims reported to the Scheme in that financial year. The Section 81A disputation rate has been calculated using the same denominator, but the numerator is the number of claims with at least one Section 81A dispute.

Figure 13.4.1: Disputation Rates, by Financial Year of First Referral

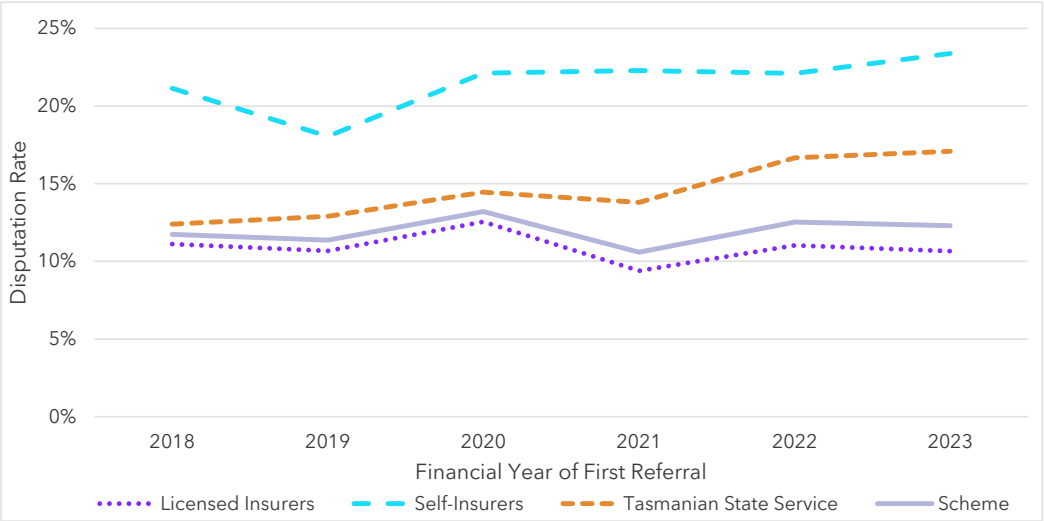


Source data can be found in Appendix E.34.

The overall disputation rate continues to remain between 10% and 13%, with it being 12% for 2022/23. The relativity between Section 81A disputation rate and overall rate has been relatively stable, with the former being 8% for 2022/23.

Figure 13.4.2 shows the overall disputation rate for each sector, by financial year of first referral.

Figure 13.4.2: Disputation Rates, by Sector and Financial Year of First Referral



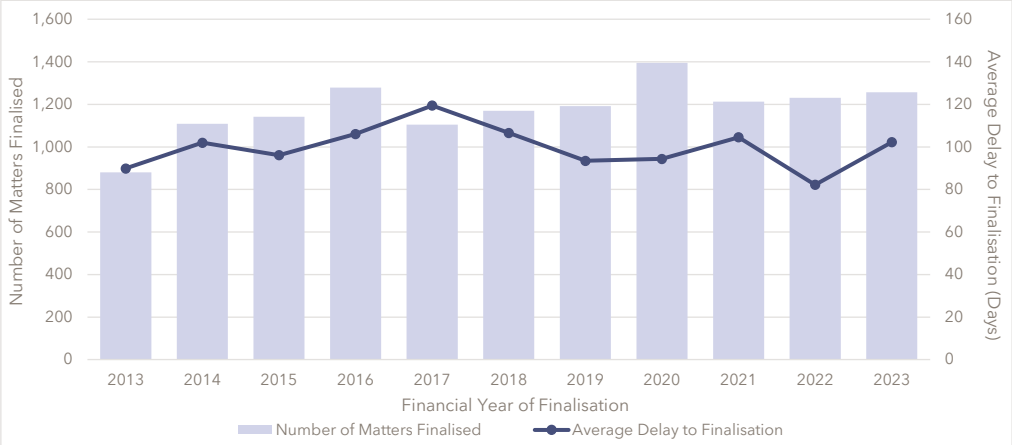
Source data can be found in Appendix E.34.

The disputation rate for the licensed insurer sector continues to remain between 9% and 13%, with it being 11% for 2022/23. Given that most Scheme claims are for the licensed insurer sector, disputation rates for the Scheme overall are driven by licensed insurer disputation experience. The self-insurer disputation rate was 23% for 2022/23, and it continues to be around double that of licensed insurer disputation rates. On the other hand, the gap between licensed insurer and TSS disputation rates has widened in recent years, with the latter being 17% for 2022/23.

13.5. Finalisations

Figure 13.5.1 shows the number of matters finalised at the Tribunal in each financial year, and the average delay between referral and finalisation for these claims.

Figure 13.5.1: Number of Matters Finalised and Average Delay to Finalisation, by Financial Year of Finalisation



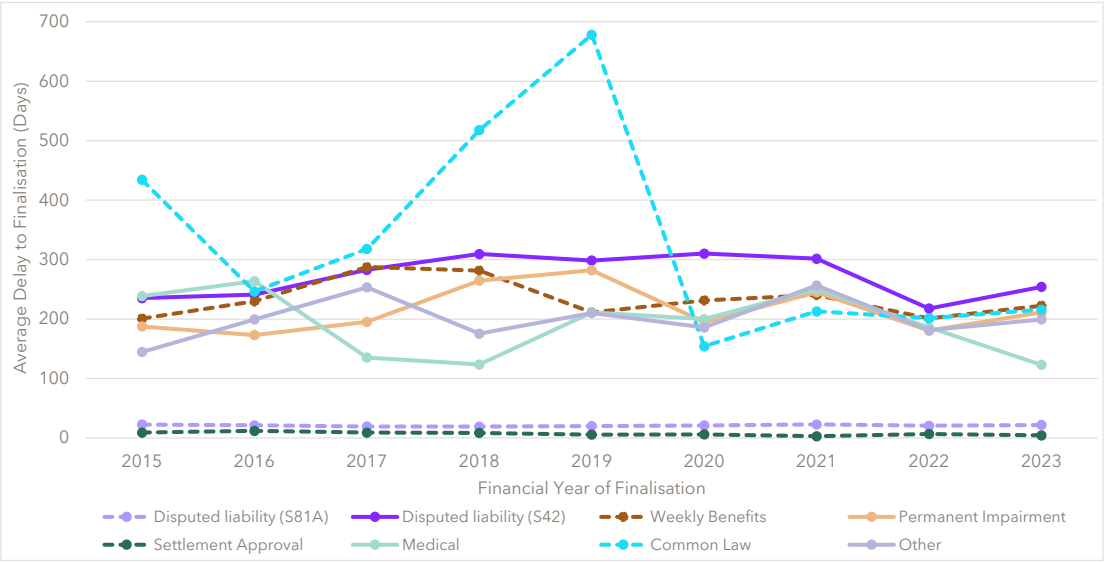
Source data can be found in Appendix E.35.

The number of finalisations has grown by an average of 1.4% per annum between 2013/14 and 2022/23. The main deviations from this were increases of 12% and 17% for 2015/16 and 2019/20, respectively. However, this was followed by similarly sized decreases in the following year (-14% for 2016/17 and -13% for 2020/21). There were 1,257 finalisations in 2022/23, which is 2.1% higher than the 1,231 finalisations in 2021/22.

The average delay between referral and finalisation grew from 61 days for 2012/13 to 119 days for 2016/17. It then improved over the next three years, reaching 94 days in 2019/20. The average delay of 82 days for 2021/22 was the lowest in the past decade. It has since increased to 102 days for 2023/24, which is in line with historical levels.

Figure 13.5.2 shows the average delay between referral and finalisation, by dispute category. The average delay for each dispute category has been calculated based on matters that finalised in the relevant year and have at least one dispute that belongs to the relevant category.

Figure 13.5.2: Average Delay to Finalisation, by Dispute Category and Financial Year of Finalisation



Source data can be found in Appendix E.36.

Experience for the more common dispute categories, over the period shown in Figure 13.5.2, has been as follows:

- Referrals relating to settlement approval have historically been the quickest to be finalised by the Tribunal, with an average delay of seven days.
- Disputes of liability under Section 81A continues to have the second shortest average delay (around 21 days).
- The remaining dispute categories have much longer delays between referral and finalisation:
  - 211 days (i.e. 6.9 months) for disputes under Section 71 in relation to compensation for permanent impairment;
  - 233 days (i.e. 7.7 months) for disputes relating to weekly benefits; and
  - 271 days (i.e. 8.9 months) for Section 42 referrals, for which a conciliation process is compulsory.

An average of seven matters that include a common law dispute are finalised each year. Therefore, it is not unexpected to observe volatility in average delay experience for this dispute category.

We note that the time taken to resolve a matter at the Tribunal reflects several factors, including the availability of medical and specialist appointments and the speed with which expert reports are provided.

13.6. Adjournments

Matters can be adjourned *sine die* at the Tribunal, i.e. adjourned prior to a decision being reached and without a future hearing date set.

An average of around 100 matters per annum were adjourned from 2011/12 to 2014/15. This then decreased to averages of 57 matters per annum for 2015/16 to 2017/18 and five matters per annum for 2018/19 to 2020/21. One matter was adjourned in 2021/22 and no matters were adjourned in 2022/23.

The average delay between referral and adjournment was 95 days (i.e. 3.1 months), for matters adjourned between 2011/12 and 2014/15. This then increased to 129 days (i.e. 4.2 months) for 2015/16 to 2017/18. The average delay for the 15 matters that have been adjourned since 2018/19 is 311 days. However, this has been distorted by a matter that was referred in 2011/12 but adjourned in 2020/21. When this matter is removed, the average delay since 2018/19 reduces to 97 days (i.e. 3.2 months).

14. Actuarial Assumptions

This section includes a statement of our compliance with relevant actuarial standards, and also describes the approach and economic assumptions used for this review. The results presented in this report are subject to a number of limitations, reliance and assumptions, as outlined in this section.

14.1. Compliance with Professional Standards

The advice 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 our analysis of experience in the Tasmanian workers' compensation scheme, we have broadly followed the same approach that was used at the previous review. This involved examination of both claim frequency and average claim size (by benefit type).

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

14.3.1. Benefit Types

For our analysis, benefit types were grouped as follows:

- weekly benefits, including death benefits made as periodic payments to dependents;
- medical and related benefits – includes 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, which include common law, settlements, redemptions, impairment lump sums and death benefits.

14.3.2. Valuation Methodology

For the purpose of our analysis, all data has been grouped into accident half-years, i.e. the half-year in which the injury which gave rise to the claim occurred. Development of this data is then analysed and projected by development half-year (which is a measure of the number of half-years that have elapsed since the accident half-year), and development quarter for weekly active claims. For example, development half-year zero represents the half-year period in which the injury occurred, whereas development half-year one is the half-year that ends six months after the end of the accident half year.

In conducting our analysis, we have used the following actuarial projection methods:

- **Claim numbers** have been projected using the Chain Ladder Method.
  - All claims: we use the Chain Ladder Method to estimate the number of claims relating to accidents that occurred prior to 30 June 2023 but are yet to be reported ("Incurred But Not Reported" or IBNR claims). The estimated ultimate number of claims (that is, 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. We have used estimates of ultimate inflation-adjusted wages earned in each accident period, as our exposure measure. Further details on the calculation of ultimate inflation-adjusted wages can be found in Appendix L.
  - Lost time claims: we separately analyse the number of lost time claims (i.e. those claims which receive weekly benefits) using the Chain Ladder Method. We also analyse the frequency of lost time claims relative to total ultimate claims.
  - Weekly active claims: we separately analyse the number of weekly active claims by quarter (i.e. those claims which receive at least one weekly payment within the quarter). Our modelling of weekly active claims requires continuance rate assumptions, which relate to the ratio between 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: we separately examine the number of lump sum claims, using an approach that blends results from the Chain Ladder Method with the estimated ultimate number of lump sum claims using an exposure-based calculation (i.e. assuming that the number of claims is proportional to earned wages). The blending is done using a Bornheutter-Ferguson (BF) approach that considers the emergence pattern implied by the development factors in the Chain Ladder Method. The ultimate number of lump sum claims derived from the BF approach was then divided by total ultimate claims, to produce a measure of lump sum utilisation.
- **Average claim sizes** have been projected using both the Payments per Claim Incurred ("PPCI") and Payments per Active Claim ("PPAC") methods.
  - 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 more detailed description of these methods can be found in Appendix B.

14.3.3. Inflation and Discounting

All past payments, wages and premiums information have been converted to 30 June 2023 values using the Average Weekly Earnings (AWE) index for Tasmania for All Persons Full Time Ordinary Time Earnings.

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.

For the purpose of 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;
- Normal/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 2023) payments. The projected payments are then combined with our assumptions regarding future normal/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 2023, when estimating the outstanding claims liability as at 30 June 2023; 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

For the purpose of 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 may be an appropriate starting point in determining such discount rates."

Discount rates have been set with reference to the market prices of Commonwealth Government bonds. Since the previous review, the yields available on Commonwealth Government bonds have increased across most durations (especially in relation to 2023/24), but have slightly decreased for some medium-term durations.

Where we have discounted payments to the middle of the respective accident year (e.g. for analysis of ultimate costs), we have relied on yields available on Commonwealth government bonds, as at the middle of the accident year.

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 assumptions of 3.75% p.a. until 30 June 2024 and 3.50% p.a. thereafter.

- 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 review.

14.4.3. Economic Growth

As part of Tasmania's 2023-24 State Budget (handed down in May 2023), the Department of Treasury and Finance provided updated economic forecasts. In particular, it projected that Tasmania's gross state product would grow by 2% in real terms, during 2023/24.

We have used preliminary data for 2023/24 to help project ultimate earned wages for 2023/24. The implied real growth in ultimate earned wages between 2022/23 and 2023/24 for all sectors of the Scheme is higher than the 2% economic growth forecast:

- for **licensed insurers**, growth is projected to be 4.8% (as compared to 5.0% and 4.4% for the preceding two years);
- for **self-insurers**, growth is projected to be 2.6% (which is in line with 2.5% for the preceding year); and
- for the **TSS**, growth is projected to be 5.1% (as compared to 6.1%, 2.7% and 6.9% for the preceding three 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

We have relied on the accuracy and completeness of all data and other information (qualitative, quantitative, written and oral) provided to us by WorkSafe Tasmania for the purposes of this report. We have not independently verified or audited the data, but we have reviewed it for general reasonableness and consistency (e.g. internal consistency and consistency with data provided for previous reviews). It should be noted that if any data or other information is inaccurate or incomplete, we should be advised so that our advice can be revised, if warranted.

14.5.2. Uncertainty

The estimates of future claim costs are intended to be central estimates and, as such, are based on assumptions selected without deliberate bias towards either over-estimation or under-estimation. Please note, however, that it is not possible to put a value on future claim costs with certainty. In particular, outcomes are dependent on future events, including legislative, social and economic factors. Although we have prepared estimates in conformity with what we believe to be the likely future experience, actual experience could vary considerably from our estimates. Deviations are normal and are to be expected.

We have generally assumed that the run-off of claims and payments will occur in a similar pattern to that observed previously. We have not anticipated any extraordinary changes to the legal, social or economic environment (or to the interpretation of policy language) that might affect the cost, frequency or future reporting of claims.

In our judgement, we have employed techniques and assumptions that are appropriate, and the conclusions presented herein are reasonable, given the information currently available. However, it should be recognised that future claims and payments emergence will likely deviate, perhaps materially, from our estimates.

14.5.3. Distribution and Use

This report is being provided for the use of the WorkCover Tasmania 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 WorkCover Tasmania Board for the purpose for which it is intended. This report should be considered as a whole.

We understand that WorkSafe Tasmania 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 Scyne to the third party.

Scyne 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.

Part IV: Appendices

Appendix A Data

A1. Approach to Use of Data

A1.1 Data Supplied

This is the tenth 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 to 30 June 2023, and extracted during the month of August 2023.

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;
- 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 2022/23 – this report includes data for each insurer/self-insurer (as well as for the TSS) 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 29 August 2023), which includes information regarding matters referred to the Personal Compensation Stream of the Tasmanian Civil and Administrative Tribunal; and
- Date relating to Nominal Insurer claims that are not recorded in WIMS (this was extracted as at 16 August 2023).

In addition to the data reports listed above, we have also had the benefit of a number of discussions with WorkSafe Tasmania.

A1.2 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:

- assigned coverages a Policy Renewal Year (PRY) 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).

A1.3 Data Reconciliation

In preparing this review, we have relied on information provided by WorkSafe, in relation to the interpretation of the data. We have not independently verified or audited the data, but we have reviewed it for general reasonableness and consistency (e.g. internal consistency and consistency with data provided for previous reviews).

As such, we have outlined below some of the key consistency checks that we have performed.

Internal Consistency Check of Payments for the 2022/23 Financial Year

We cross-checked the various data sources for internal consistency in the following areas:

- Claim payments in the claim transaction file against the End of Year Reconciliations
- Case estimates as at the end of each financial year in the case estimate file against the "outstanding claims reserve data" file
- Claim numbers and payments by benefit type against the data supplied for the previous reports
- Earned premiums by underwriting year against the End of Year Reconciliations
- Earned wages against the figures shown in the previous reports.

We have compared payments figures for 2022/23 in the claim payment transaction file with payments figures reported by insurers in the End of Financial Year Reconciliation for 2022/23. Table A.1 shows the results of this reconciliation.

Table A.1: Reconciliation of Payments for the 2022/23 Financial Year

Sector	Claim Payment Transaction File ($m)	End of Financial Year Reconciliation ($m)	Difference ($m)	Difference (%)
Licensed Insurers	144.256	143.671	0.584	0.4%
Self-Insurers	8.429	8.529	-0.100	-1.2%
Tasmanian State Service	85.362	85.363	-0.001	-0.001%
Total	**238.046**	**237.563**	**0.483**	**0.2%**

Payments from WIMS (which is provided in the claim payment transaction file) reconciles closely to payments figures included in the End of Financial Year Reconciliation. This is the case for all three sectors, as well as in aggregate.

Internal Consistency Check of Case Estimates as at 30 June 2023

We have compared case estimate figures in the case estimate file with case estimate figures reported by insurers in the End of Financial Year Reconciliation for 2022/23. Table A.2 shows the results of this reconciliation.

Table A.2: Reconciliation of Case Estimates as at 30 June 2023

Sector	Case Estimate File ($m)	End of Financial Year Reconciliation ($m)	Difference ($m)	Difference (%)
Licensed Insurers	266.035	263.813	2.222	0.8%
Self-Insurers	11.813	8.341	3.472	29.4%
Tasmanian State Service	162.315	158.972	3.343	2.1%
Total	**440.163**	**431.126**	**9.037**	**2.1%**

For licensed insurers and the TSS, case estimates from WIMS (which is provided in the case estimate file) reconciles closely to case estimate figures included in the End of Financial Year Reconciliation. In relation to self-insurers, we have been informed that a bug in the software used by self-insurers to report case estimates to WorkSafe is resulting in overstated case estimate figures flowing into WIMS. This explains why self-insurer case estimates from WIMS are 29% higher than that in the End of Financial Year Reconciliation. We note that our review does not make any usage of self-insurer case estimate information in the case estimate file from WIMS.

Internal Consistency Check of Earned Premiums, for Financial Years 2018/19 to 2022/23

We have compared earned premium figures derived from the WIMS data extracts, with earned premium figures reported by insurers in the End of Financial Year Reconciliations for 2018/19 to 2022/23. Table A.3 shows the results of this reconciliation.

Table A.3: Reconciliation of Earned Premiums, for Financial Years 2018/19 to 2022/23

Financial Year	WIMS Data Extracts ($m)	End of Financial Year Reconciliation ($m)	Difference ($m)	Difference (%)
2018/19	194.946	185.279	9.666	5.2%
2019/20	200.091	200.033	0.059	0.03%
2020/21	214.625	209.587	5.037	2.4%
2021/22	239.742	251.331	-11.589	-4.6%
2022/23	260.437	276.742	-16.305	-5.9%
Total	**1,109.840**	**1,122.972**	**-13.132**	**-1.2%**

Overall, for financial years 2018/19 to 2022/23, earned premiums calculated based on WIMS data extracts are 1.2% lower than what has been reported by insurers in the End of Financial Year Reconciliations.

Part of the difference between WIMS and the Reconciliation file for any given year will be due to premium adjustments being received after the end of the policy year. We note that differences for individual financial years may offset with

each other, to produce a total difference that is closer to nil. Differences between WIMS and the Reconciliation files have not been resolved, and we have relied on the information provided in the WIMS extracts.

It is possible that the data from WIMS may not be fully accurate in representing the premiums actually written (and earned) by each insurer. In order for WorkSafe to maintain an accurate view of the Tasmanian workers' compensation scheme, WIMS should be an accurate reflection of insurer operations. We emphasise the reliance of our findings and recommendations on the accuracy and integrity of the data provided to us.

A1.4 Data Segmentation

We separately analyse data for licensed insurers, self-insurers and the TSS. Employers can move from 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.

A1.5 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.

A1.6 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.

A1.7 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.

A1.8 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.

A2. Detailed File Specifications

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

A2.1 Individual Claim Header File

We received an individual claim listing 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
- 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.

A2.2 Claim Payment Transaction File

We received an individual claim payment transaction file 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").

A2.3 Case Estimate File

We received an individual case estimate file showing amounts outstanding as at 9 August 2023. The file includes the following variables:

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

A2.4 Individual Policy Header File

We received an individual policy listing 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")

A2.5 Coverage File

We received an individual premium file 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").

A2.6 End of Financial Year Reconciliation

The End of Financial Year Reconciliation includes data for each insurer/self-insurer (as well as for the TSS) 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).

A2.7 'Claims with disputes' data

We received a file 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").

Appendix B Valuation Approaches Used

B1. 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.

B2. Payments per Claim Incurred Method

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

For medical and legal/investigation benefits, total claim numbers is used as the claims exposure, whereas lump sum claim numbers is used for lump sum benefits.

B3. Payments per Active Claim Method

The Payments per Active Claim (PPAC) 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 half-year 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 half-year and development quarter. Dividing these payments by the active claim numbers generate patterns of average Payments per Active Claim, for each accident half-year 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.

Appendix C Scheme Coverage

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

C1. 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 2023, there were six licensed insurers and nine self-insurers in Tasmania.

C1.1 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.

C1.2 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.

C2. 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.

C2.1 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 these 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.

C2.2 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.

C2.3 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.

C2.4 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.

C2.5 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 actually goes all the way to a determination 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.

C3. 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 week's 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.

Appendix D Legislative Reforms

This section summarises the various legislative reforms that have had an impact on the Tasmanian workers' compensation scheme. The reader should referred 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.

D1. 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.

D2. 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.

D3. 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.

D4. 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.

D5. 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 D.1 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.).

D6. 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.

D7. January 2018 Amendments

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

- 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 Act 1991* (Cth). This ensured 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.

D8. 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.

D9. 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.

D10. 2023 Amendments

Amendments to Sections 27 and 87 of 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 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.

D11. Proposed Amendments

We are not aware of any proposed amendments.

D12. Other Changes Impacting the Scheme

There have been several other changes that have impacted Scheme experience:

- 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.

Appendix E Graph Data

Appendix F Claim Numbers – Licensed Insurers

F1. All Claims
F2. Above Excess Claims
F3. Active Claims
F4. Lost Time Claims
F5. Lump Sum Claims

Appendix G Claim Numbers – Self-Insurers

G1. All Claims
G2. Active Claims
G3. Lost Time Claims
G4. Lump Sum Claims

Appendix H Claim Numbers – TSS

H1. All Claims
H2. Active Claims
H3. Lost Time Claims
H4. Lump Sum Claims

Appendix I Payments – Licensed Insurers

Appendix J Payments – Self-Insurers

J1. Weekly Payments
J2. Medical Payments
J3. Lump Sum Payments
J4. Legal Payments
J5. All Payments

Appendix K Payments – TSS

K1. Weekly Payments
K2. Medical Payments
K3. Lump Sum Payments
K4. Legal Payments
K5. All Payments

Appendix L Wages and Premiums

L1. Wages for Licensed Insurers

Wages recorded in the coverage file can develop over time, due to reporting delays and changes in the initial estimates. To track the development of wages, we have tabulated written wages by renewal quarter (RQ) and delay quarter (DQ). We use the Chain Ladder Ratio Method to produce estimates of ultimate written wages, as shown in the most right-hand side column of Table L.1.

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

RQ	DQ0	DQ1	DQ2	DQ3	DQ4	DQ5	DQ6	DQ7
Sep-19	5,195,019,711	5,835,923,854	5,862,455,603	5,862,580,802	5,863,410,352	5,865,697,996	5,865,697,996	5,865,697,996
Dec-19	1,179,364,084	1,553,062,944	1,554,102,629	1,555,112,361	1,559,875,138	1,559,915,322	1,559,915,322	1,559,915,322
Mar-20	1,169,534,011	1,451,475,194	1,453,684,789	1,454,353,942	1,454,422,593	1,454,422,593	1,454,422,593	1,454,422,593
Jun-20	1,038,854,270	1,248,367,313	1,259,378,657	1,259,885,700	1,260,285,700	1,260,285,700	1,260,285,700	1,260,285,700
Sep-20	5,159,577,857	5,914,498,181	5,940,317,646	5,982,094,342	5,990,841,823	5,991,305,120	5,991,365,782	5,991,413,558
Dec-20	1,541,740,906	1,998,965,797	2,008,079,248	2,009,858,128	2,011,513,274	2,011,688,403	2,014,305,823	2,014,305,823
Mar-21	1,197,472,195	1,542,321,433	1,543,307,875	1,545,615,704	1,545,985,304	1,546,128,460	1,546,128,460	1,546,128,460
Jun-21	1,191,031,569	1,391,390,837	1,396,549,319	1,396,929,319	1,397,125,318	1,397,185,318	1,397,185,318	1,397,185,318
Sep-21	6,006,870,204	6,644,354,881	6,648,524,067	6,649,565,453	6,663,232,037	6,667,097,684	6,668,264,148	6,668,344,658
Dec-21	1,603,166,033	1,980,677,582	1,991,622,534	1,991,622,534	1,993,058,971	1,993,118,971	1,993,118,971	1,993,126,977
Mar-22	1,311,311,399	1,735,091,651	1,739,251,579	1,739,251,579	1,739,271,579	1,739,271,579	1,739,477,164	1,739,484,152
Jun-22	1,207,596,605	1,406,649,453	1,410,011,138	1,410,118,139	1,410,265,380	1,410,571,315	1,410,738,048	1,410,743,715
Sep-22	6,175,899,949	7,041,527,665	7,061,140,278	7,068,478,508	7,075,427,048	7,076,961,953	7,077,798,464	7,077,826,895
Dec-22	1,711,102,922	2,118,975,586	2,127,512,389	2,143,987,239	2,146,094,846	2,146,560,409	2,146,814,136	2,146,822,760
Mar-23	1,424,277,117	1,780,824,425	1,786,252,703	1,788,459,945	1,790,218,058	1,790,606,419	1,790,818,072	1,790,825,265
Jun-23	1,388,258,911	1,661,906,005	1,666,971,798	1,669,031,646	1,670,672,358	1,671,034,784	1,671,232,304	1,671,239,017
Sep-23	6,784,248,839	7,656,893,296	7,680,232,904	7,689,723,238	7,697,282,481	7,698,952,288	7,699,862,320	7,699,893,249
Dec-23	1,880,746,958	2,387,449,015	2,394,726,396	2,397,685,519	2,400,042,520	2,400,563,172	2,400,846,924	2,400,856,568
Mar-24	1,530,002,256	1,969,326,183	1,975,329,049	1,977,769,929	1,979,714,140	1,980,143,609	1,980,377,666	1,980,385,621
Jun-24	1,463,121,799	1,737,624,518	1,742,921,115	1,745,074,813	1,746,790,277	1,747,169,216	1,747,375,735	1,747,382,754

Table L.2 shows reported to date written wages (in nominal values) for licensed insurers by underwriting year, as well as our estimates of ultimate written wages (in nominal values – "uninfl." – and 30 June 2023 values – "infl.").

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

Underwriting Year	Reported ($m, uninfl.)	Ultimate ($m, uninfl.)	Ultimate ($m, infl.)
2013/14	7,592.67	7,592.67	9,754.02
2014/15	7,846.51	7,846.51	9,916.84
2015/16	8,312.11	8,312.11	10,143.47
2016/17	8,565.54	8,565.54	10,290.77
2017/18	9,033.29	9,033.29	10,680.33
2018/19	9,757.17	9,757.17	11,175.97
2019/20	10,138.88	10,138.88	11,191.38
2020/21	10,832.70	10,832.70	11,769.28
2021/22	11,809.35	11,811.70	12,290.43
2022/23	12,655.59	12,686.71	12,838.96

Written wage estimates have been transformed into earned wage estimates, based on the earning pattern implied by policies written to date. Table L.3 shows reported to date earned wages (in nominal values) for licensed insurers by accident year, as well as our estimates of ultimate earned wages (in nominal values – "uninfl." – and 30 June 2023 values – "infl.").

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

Accident Year	Reported ($m, uninfl.)	Ultimate ($m, uninfl.)	Ultimate ($m, infl.)
2013/14	7,555.39	7,555.39	9,690.85
2014/15	7,780.45	7,780.45	9,924.00
2015/16	8,123.88	8,123.88	9,981.03
2016/17	8,455.04	8,455.04	10,187.13
2017/18	8,931.31	8,931.31	10,630.56
2018/19	9,605.20	9,605.20	11,096.55
2019/20	10,090.73	10,090.73	11,236.95
2020/21	10,589.45	10,589.45	11,559.45
2021/22	11,537.07	11,540.93	12,134.44
2022/23	12,408.80	12,432.25	12,666.96
2023/24	9,271.07	13,525.89	13,279.19

Preliminary figures suggest that earned wages for licensed insurers will grow by 4.8% in real terms, from $12.7 billion for accident year 2022/23 to $13.3 billion for accident year 2023/24.

L2. Wages for Self-Insurers and the TSS

Table L.4 shows reported to date earned wages (in nominal values) for self-insurers by accident year, as well as our estimates of ultimate earned wages (in nominal values – "uninfl." – and 30 June 2023 values – "infl.").

Table L.4: Reported to Date and Ultimate Earned Wages for Self-Insurers, by Accident Year

Accident Year	Reported ($m, uninfl.)	Ultimate ($m, uninfl.)	Ultimate ($m, infl.)
2013/14	446.72	446.72	570.90
2014/15	455.27	455.27	582.69
2015/16	450.95	450.95	554.51
2016/17	457.04	457.04	550.94
2017/18	465.96	465.96	556.55
2018/19	529.89	529.89	613.94
2019/20	479.47	479.47	536.35
2020/21	460.71	460.71	502.00
2021/22	456.13	456.13	479.74
2022/23	481.22	481.22	491.86
2023/24	503.90	509.15	504.53

Preliminary figures suggest that earned wages for self-insurers will grow by 2.6% in real terms, from $492 million for accident year 2022/23 to $505 million for accident year 2023/24.

Table L.5 shows reported to date earned wages (in nominal values) for the TSS by accident year, as well as our estimates of ultimate earned wages (in nominal values – "uninfl." – and 30 June 2023 values – "infl.").

Table L.5: Reported to Date and Ultimate Earned Wages for the TSS, by Accident Year

Accident Year	Reported ($m, uninfl.)	Ultimate ($m, uninfl.)	Ultimate ($m, infl.)
2013/14	2,100.33	2,100.33	2,684.41
2014/15	2,119.52	2,119.52	2,712.71
2015/16	2,209.00	2,209.00	2,716.15
2016/17	2,262.82	2,262.82	2,727.84
2017/18	2,381.20	2,381.20	2,846.87
2018/19	2,510.35	2,510.35	2,908.78
2019/20	2,723.37	2,723.37	3,006.58
2020/21	2,927.88	2,927.88	3,190.27
2021/22	3,115.64	3,115.64	3,277.21
2022/23	3,427.41	3,427.41	3,503.48
2023/24	3,591.48	3,737.91	3,681.42

Preliminary figures suggest that earned wages for the TSS will grow by 5.1% in real terms, from $3.5 billion for accident year 2022/23 to $3.7 billion for accident year 2023/24.

L3. Conventional Policy Premiums for Licensed Insurers

Premiums recorded in the coverage file develop over time, due to reporting delays and adjustment premiums. To track the development of premiums, we have tabulated written premiums by renewal quarter (RQ) and delay quarter (DQ). We use the Chain Ladder Ratio Method to produce estimates of ultimate written premiums for conventional (i.e. non-burning cost) policies, as shown in the most right hand side column of Table L.6.

Table L.6: Licensed Insurer Written Premiums (in Nominal Values), by Renewal Quarter (RQ) and Delay Quarter (DQ)

RQ	DQ0	DQ1	DQ2	DQ3	DQ4	DQ5	DQ6	DQ7
Sep-19	83,362,928	92,590,092	92,698,136	92,704,830	92,731,600	92,820,179	92,820,179	92,820,179
Dec-19	25,653,959	32,201,281	32,218,345	32,242,013	32,257,765	32,258,215	32,258,215	32,258,215
Mar-20	15,353,613	21,492,336	21,529,167	21,533,491	21,540,620	21,540,620	21,540,620	21,540,620
Jun-20	21,738,786	27,701,868	27,866,286	27,887,343	27,898,053	27,898,053	27,898,053	27,898,053
Sep-20	86,369,528	97,797,321	98,000,705	98,090,741	98,159,994	98,169,883	98,170,793	98,173,685
Dec-20	33,315,950	40,604,997	40,855,954	40,919,027	40,966,038	40,969,189	40,980,706	40,980,706
Mar-21	17,640,145	24,844,653	24,880,411	24,953,698	24,957,283	24,958,500	24,958,500	24,958,500
Jun-21	25,057,091	31,161,225	31,312,024	31,314,760	31,317,111	31,317,468	31,317,468	31,317,468
Sep-21	103,400,825	116,263,851	116,337,550	116,388,660	116,690,626	116,848,926	116,916,481	116,918,820
Dec-21	36,664,723	43,965,763	44,282,682	44,282,682	44,398,355	44,401,271	44,401,271	44,401,684
Mar-22	21,179,267	29,394,140	29,459,788	29,459,788	29,459,881	29,459,881	29,463,944	29,464,217
Jun-22	30,889,056	36,411,366	36,464,096	36,480,063	36,481,625	36,498,110	36,503,143	36,503,482
Sep-22	112,889,897	127,430,860	127,991,298	128,198,691	128,286,359	128,344,328	128,362,027	128,363,220
Dec-22	40,749,237	49,527,911	49,753,121	49,798,685	49,832,740	49,855,258	49,862,133	49,862,596
Mar-23	24,009,226	32,496,798	32,601,665	32,631,522	32,653,837	32,668,593	32,673,098	32,673,401
Jun-23	32,413,755	40,055,835	40,185,096	40,221,898	40,249,404	40,267,591	40,273,144	40,273,518
Sep-23	124,243,091	139,711,054	140,161,904	140,290,266	140,386,203	140,449,640	140,469,008	140,470,313
Dec-23	45,167,728	55,193,473	55,371,584	55,422,294	55,460,194	55,485,255	55,492,907	55,493,422
Mar-24	25,452,739	35,428,446	35,542,774	35,575,325	35,599,653	35,615,739	35,620,651	35,620,982
Jun-24	35,607,893	44,003,044	44,145,042	44,185,471	44,215,687	44,235,667	44,241,767	44,242,178

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