TPD and trauma: both or either?

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Overview

Trauma or critical illness benefits came into existence in the early 1980s and, ever since, advisers and other professional advisers have asked the question, ‘Should clients have total and permanent disability (TPD) benefits or trauma benefits, or both’?

The answer to this question has always been the same — clients who are able to obtain both, should be advised to have both. The only question that should be asked is, ‘How much, in dollar terms of each benefit, should each client be recommended to take up’? That is determined by the discovery and the affordability discussions and the needs analysis.

For advisers who do question or challenge the ‘both benefits’ rule of thumb (citing doubt about the need for both) this article is designed to present the logic, in a detailed fashion, that may represent new thinking — depending on how the advisers were trained and mentored. The bottom line for this advice — under client best interests — is that recommendations are definitely needed for both.

Learning objectives

After reading this article, you should be able to:

- Explain supporting recommendations that include the benefits of having both TPD and trauma cover
- employ easy-to-understand explanations of TPD and trauma benefits to clients
- analyse the needs analysis for both benefits to cater to combined affordability
- apply accurate, meaningful and compliant statement of advice content in relation to TPD and trauma cover.

Why would this uncertainty arise?

It's somewhat of a mystery as to how these two disparate life insurance benefit types have come to be seen by some in the industry as similar, or as substitutes for each other. Of course, there are plenty of advisers who would not put together a recommendation on a client's protection package without including both benefit types.

For those who still have some doubt about the value of both total and permanent disability (TPD) and trauma, there are a series of basic principles for every client, which are a good start in triggering more in-depth thinking on the need for both.

Firstly though, there is a need to clarify that the two benefits have really only two things in common:

- They both pay a lump sum at claim
- They both pay a 'living' claimant

Death benefits via 'term life' are simply not enough. Many clients with term life in their super fund have a vague perception that they 'have insurance and are okay'. It is the adviser's role to delve deeper to uncover the true risks and needs. These clients have a major gap in their portfolio — they must be deceased to claim. This is where the other lump sum benefits come into play.

Just how different are the benefits?

It is the five principles underlying each benefit that are the key to appreciating how one benefit alone is not sufficient, and two combined in a set of recommendations for insurance within the portfolio will always meet clients' best interests safely. These five principles can be summarised as follows:

1. Trauma is in no way contingent upon either time off work or inability to work — TPD requires an inability to work for a claim to be met.

2. Trauma can pay a claim immediately (subject to the time taken to obtain the medical certification) — TPD can only consider then pay a claim after a minimum of three continuous months from the date last worked, with many policies in force requiring a minimum of six months off work.

3. Trauma is contingent on the insured suffering one of a list of clearly defined 'events' — TPD has no requirement for the absence from work to be for anything other than an illness or injury (as opposed to unemployment).

4. Trauma is a higher dollar cost per dollar return: as it is much more likely to pay a claim — TPD is (sometimes) much less expensive dollar-for-dollar, reflecting the level of disability required for it to pay out.

5. Trauma is regarded, therefore, as likely to have a lower sum insured for immediate medical, financial and care costs — TPD was always designed to provide a large capital sum to allow for a long-term income replacement, living adaptations and a medical/care costs budget.

A brief acknowledgement of the nuances

Anyone used to working with these benefits will be aware that there are some exceptions to the factual application of the above principles. The following points, therefore, acknowledge such infrequent exceptions. The remainder of the article is premised on accepting that the above guiding principles cover the majority of client situations and so are indeed representative of the 'mainstream'.

Matching the above numbered points, here are some 'exceptions':

1. (a) Some trauma payments are contingent upon the insured reaching a certain level of deterioration in order to be paid. These definitional drivers are unrelated to any ability to work, but relate to physical capacity. So a client who suffers a stroke, for instance, may need to have a defined level of neurological deficit post-stroke to be paid; they may at the same time be able to work.

   (b) Some TPD definitions include clauses enabling a payment upon a few defined events (e.g. loss of sight) and so they do not require the inability to work or the cessation of work, to pay out. The claims for these rare events are, as a percentage of TPD claims, very few.

2. Most of the commonly claimed trauma events are eligible for a benefit payment as soon as the diagnosis fitting the event definition is final and the relevant medical certification is submitted to the insurer.

   Refer to 1(a), however, in which it is recognised that if a certain minimum level of physical effect has to be measured after an insured event has occurred, then it may be that the trauma claim is not paid simply on diagnosis of the condition. Some examples are multiple sclerosis and Parkinson's disease. Hence the immediacy of a trauma benefit payment is not assured, depending on the progression of the condition before the insured notifies the adviser and/or the insurer of their potential claim.

3. With certain insurers, as well as on certain legacy or current benefit options, a trauma claim may be triggered **not** by a specific diagnosis matching an event definition, but rather by a 'catch-all' event that requires a physical inability to fulfil some of the activities of daily living, regardless of the diagnostic cause.

4. TPD's comparative-to-trauma cost per $1,000 of benefit will differ depending on whether the TPD definition chosen/recommended/costed for the advice document is the 'own' or similar occupation definition; colloquially known as the 'any occupation' definition, or the actual 'own occupation' (being performed at the time of the disablement) definition which is somewhat more expensive than the former.

   Another TPD option chosen by advisers is the 'home duties' definition, where a client is an at-home non-income earner. This often has a similar premium cost to the 'any occupation' definition, or is even incorporated into the 'any occupation' definition.

5. The exception would be where trauma is used within small and medium-sized enterprise (SME) business succession planning recommendations around considerations such as buy/sell, key person and/or debt protection; for all or any of which large sums insured may be necessary and equal to those for the TPD benefits.

A closer look at both benefits

The need to have clear explanations for clients is fulfilled by having simple answers and lists of reasons ready. This is because clients often struggle with the concept of benefit types being 'bundled'. Describing the straightforward premise that 'If you haven't died, then your path beyond a crisis can go in so many unknown directions that a 'package' of benefits has been developed to cater for these different paths', is a good start.

Consider

A simple analogy to draw is why would a consumer choose the expense of optional anti-lock braking system (ABS) brakes on a new car and not also choose optional 'all-round' airbags, as the airbags are the final safety net if the ABS fails to avoid the collision.

Clients also may ask the same question, but more likely expressed as, 'Why do I need to have both of these'? Thus, for advisers who are already committed to advising on both for all eligible clients, this article will provide some useful explanations in plain English for use in those client conversations.

What do the benefits do and how do they work?

TPD

TPD will cater for being ill or injured (but not dead) — just like trauma. TPD provides a benefit as long as the insured is both totally and permanently disabled (by the applicable definition), when at the same time an income protection (IP) benefit would be payable for insureds who are income earners.

Thus, TPD may be used to provide funding for:

- capital items such as debt reduction
- in some cases, a sinking fund to secure the children's education plans — not necessary if the household income was going to be the sole source of that education, and this level of income is fully funded after the TPD
- sundry important items such as medical expenses and other amounts incurred (perhaps by changes necessary to clients' physical circumstances) — these can be substantial
- for an income earner, a capital sum to produce a top-up-to-IP replacement income — this may not be necessary if a mortgage debt has been removed
- for a non-income earner, a capital sum to produce an income for paying carers to look after dependants and/or the household, and/or to care for the insured

- a capital sum to provide funds for retirement — if they cannot work, then there is no way to contribute to superannuation (or calculate the fourth principle listed earlier in the article to yield through to an age beyond normal retirement)
- SME business succession-related needs.

However, TPD is not sufficient on its own, as the insured:

- may not qualify for total and permanent disablement — if they are not totally disabled or they are not permanently disabled (a claim may not be payable at all at the three or six-month stage or even thereafter)
- has a three or six-month gap to fund (even if they qualify) and this gap may be even longer allowing for medical assessment, which can be quite challenging and time-consuming from the insurer's end
- may be suffering from an illness or injury that does not result in any long-term effects (or no effects at all) on their income earning capacity, meaning that TPD will not pay a benefit at all for that condition. IP could, but may not, if the insured is not off work for the relevant waiting period on their IP (or at all).

Therefore, TPD is vital to protect against the financial risks around:

- clients these days rarely having surplus income/savings — hence IP (remembering it is taxable as income) is never going to fully supplement the income loss to the household cash flow
- spouses performing home duties being unable to use/purchase IP, so TPD is their only available solution regarding disablement cover
- being unable to fund for retirement. It can provide a lump sum to invest for retirement funds; for when the IP claim ceases at 65. (It is assumed that advisers always recommend an IP benefit period to age 65 in the client's best interests, unless their occupation or existing insurance dictates another strategy.)

Contrary to popular rumour and assertion, with many insurers, total TPD benefit payments would be greater than total trauma insurance benefit payments. This is partly due to so many of the population having TPD in superannuation, but no advice on trauma cover.

Trauma

As mentioned, trauma claims are not contingent on the client being disabled, so they may be, and often are, paid when neither income protection nor TPD are payable. Also, as trauma is available to certain demographic groups who cannot have income protection or TPD (such as those with uninsurable occupations), it plays a very important gap-filling role.

There is no doubt that in the event of, say, a non-fatal heart attack, with the sufferer off work and in hospital with an unpredictable prognosis:

› no term life benefit is yet payable

› no TPD benefit is yet payable because not only is the prognosis in doubt, but the three- or six-month waiting period is still a long way off

› there may be no work involved in the equation (i.e. the insured was not earning an income that needs to be replaced; but the family often need to hire services to fill the gap in physical contribution to the household).

Thus a trauma benefit may be used to:

› replace the income of a partner who chooses to take time off work to care for the claiming partner

› seek out the best treatment possible for the condition suffered

› relieve the sufferer of financial worry which could hinder recovery — pay debts and cover medical bills.

The above three are the most common needs discussed with clients.

Also, if affordability and the client's 'wish-list' warrant, it can:

› provide funds for early retirement (after a 'scare')

› be used to source personal care and avoid being a burden to family and friends — for single clients

› provide income if the client cannot or does not want to work; it can constitute an alternative avenue for topping up income protection beyond the 75%

› provide a choice for the insured to have a break from work.

Finally, trauma fulfils SME business succession-related needs.

However, trauma is not sufficient on its own, for the following reasons:

› The insured may suffer a non-eligible event. As a very powerful argument, many claims on life insurance benefits are triggered by mental illnesses and musculoskeletal conditions. Mental illnesses will not be met with a trauma claim, as they are not a specified event under any trauma policy. Most musculoskeletal conditions will not meet any of the definitions under trauma either.

› The insured may suffer an eligible event but not yet (or never) satisfy the level of symptomatology/sequelae required for a trauma payout.

Consider

Following are some specific examples of sicknesses or injuries which could lead to the insured being eligible for a TPD benefit, but which are not or may not be covered under a trauma benefit contract (some insurers include one or two of these as events):

- central nervous system — chronic brain syndrome
- emotional disorders — psychoses and neuroses
- mental disorders — depression, anxiety, bipolar and schizophrenic disorders
- cardiovascular disorders — coronary artery disease (not requiring surgery), hypertension, congenital heart disorders, peripheral vascular disorders, cardiac arrest
- musculoskeletal disorders — osteoarthritis, rheumatoid arthritis, chronic overuse syndrome (repetitive strain injury)
- ear and eye disorders — labyrinthitis and retinal detachment
- gastrointestinal disorders — ulcerative colitis
- endocrine disorders — some forms of diabetes
- respiratory disorders — pulmonary fibrosis, emphysema, cystic fibrosis.

Most significantly, key sudden, critical, life-changing events are covered and the majority of trauma claims are for cancer and cardiac events.

The needs analysis and affordability

For the purposes of this section, the calculations that feed SME business succession-related needs for trauma and TPD are not addressed, as there is direct and easily identifiable data that generates these SME recommendations. The focus is on the more challenging personal protection arena.

A post-crisis scenario will differ greatly in terms of its effects on the family if the insured is alive rather than deceased, and this is where these two lump sum benefits come into play.

If the client knew what would befall them in the future, they could insure for that event alone and the relevant specifics. Unfortunately, no such foresight exists. So, any and all contingencies need to be assessed and addressed in the advice process, then balanced for affordability.

How advisers balance the sums insured for each of the lump sum ‘living’ benefit solutions will depend on a clear understanding of how each benefit contributes when it becomes payable. Many examples of the potential ‘spend’ are described above.

There are some basic rules of thumb to guide advisers:

› TPD is the long-term safety net.

› Trauma is most often the early financial 'hero', contributing especially to the emotional support package, which is known to make a difference to early physical recovery outcomes

› In many cases, IP will provide most of the income replacement after the waiting period if the client is in fact not able to work (non-earning partners excepted).

Combining these rules of thumb with the fifth principle listed earlier in the article — that is, trauma is regarded as likely to have a lower sum insured and TPD was always designed to provide a large capital sum — brings an adviser to the most common outcome. Hence, it is 'normal' to see trauma of $500,000 or less, with TPD of $1,500,000 or more, for instance.

Case study

The value of choice

An adviser in the Australian Capital Territory reported to the author a few years ago on the interesting outcome from an unfortunate spate of breast cancer claims for which he had assisted his clients.

Five women had trauma (as well as IP and TPD) cover. At the time, each trauma claim was paid, he recommended, in line with the basis of his original advice, that they hold onto the funds until they determined if any particular treatment would be recommended that may warrant new expensive drugs (many are not on the Pharmaceutical Benefits Scheme yet) or even overseas treatment. For instance, the emerging range of cancer-fighting immunotherapeutic options include some that are not yet available in Australia.

In the original advice, the removal of debt was not a specific basis for their sums insured, because of the balancing of cost as mentioned above. This adviser's calculations for recommendations are based on the partner taking time off plus a 'good' allowance for medical-related expenses (this varies according to the client's overall financial position).

Yet, despite this original thinking and despite his cautionary advice to these clients at the time of the trauma payment, every one of those clients chose to place the funds into their mortgages, saying that gave them the most relief from their current worries. This is human nature at work.

What is significant about this is:

› they had funds and, therefore, a choice

› the funds could have been drawn back from the mortgage if they needed to pay for medical expenses

- the partner's income was not so vital, because the mortgage did not demand any repayments, or imposed a lower repayment load on the family's cash flow
- the IP then kicked in, in each case, with the timing dependent on their waiting period and whether they had a specified illness benefit.

So, nothing is hard and fast in terms of the 'spend' post-trauma claim, but having choices is critical.

The best-practice bottom line

Many working Australians have TPD in their superannuation funds and, unless they have opted out of this arrangement, they are at least engaged with the concept.

That should make it easier to recommend TPD and, with responsibly-minded clients, it should also be straightforward to have a logical conversation about whether (and by how much) they need to top up their existing TPD, or replace it.

When it comes to trauma and the obvious challenge of the cost of a robust amount of this benefit in a portfolio, clients sometimes cannot be convinced to take this up at substantial levels. However, bearing in mind the imperative to address clients' best interests, there is no doubt that if a licensee were to be developing a 'house view' on TPD and trauma, it would not be to choose one over the other per se. Rather, it would ideally be to mandate that any recommendations always include at least a token amount of trauma; say, $25,000.

Why is a 'token' amount justifiable? Several reasons come to mind:

- In so many cases of cancer or cardiac events — the most common causes of claim as stated — the provision of a diagnostic proof is easy and quick. This means the IP waiting period is supplemented, or where there is no IP on a non-earner, there is some relief overall that just would not otherwise be there at all.
- Where the inevitable complaint could arise — the 'Why did I not have any of this trauma'? issue — there is less basis for the complaint. The benefit recommendation was made, accepted and has paid a minimum amount. However, at least it paid and the records show an unwillingness to purchase more.
- Where a 'token' amount is in place, the engagement in trauma is established and at review, the concept of increasing this is so much more approachable.
- If not, even when a token amount is recommended, this is not full advice in the client's best interests.

In fact, if TPD is not recommended but trauma is, this also does not constitute full advice. The only one of the five benefit types available to clients (some clients cannot qualify for IP, as they do not work or work part-time — this is a given) that is acceptable to disregard is business expenses, if it does not apply.

Conclusion

There is no either/or when it comes to TPD and trauma, if full advice is the intention. Even if a client has preconceptions and instructs a scoping out of one of these benefits, it is nevertheless necessary to provide the advice that they are then free to ignore, rather than scoping a benefit out altogether such that it appears to be optional from a best practice protection perspective.

Many unfortunate claimants claim on both. Advisers need to be sure that those who would qualify have been offered such protection, even if it is then their decision whether to implement it.