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Health, Life and Disability Insurance

Laughter is by definition healthy.

—Doris Lessing (1919–)

Life is something that everyone should try at least once.

—Henry J. Tillman (dates unknown.)

The only disability in life is a bad attitude.

—Scott Hamilton (1958–)

How to Structure a Benefits Plan

Employee benefits were once called *fringe benefits*; today they are anything but *fringe*. Instead benefits are, for many employees, one of the most, if not the most, important aspect of the employment equation. How many professionals would consider accepting a job that did not offer health insurance, or that offered zero vacation and no sick leave? Some benefits are mandated by law and must be provided by an employer. These include benefit continuation (COBRA at the federal level and mini-COBRA state laws), Social Security, unemployment compensation insurance,¹ and workers' compensation. Most benefits, however, are provided at the employer's option and are part of the total compensation package designed not only to take care of the workforce, but also to attract and retain qualified staff. All staff do not have to be provided the same benefits. Employers can create eligibility criteria for certain benefits, such as by determining that only full time employees are entitled to paid vacation.

Increasingly, surveys show that intangibles, such as flexible working hours, family-friendly working conditions and even "satisfying work" and "respect in the workplace," are important factors in attracting and retaining employees long-term, especially in the nonprofit sector. In a 2008 study, "The Voice of Nonprofit Talent In 2008" by CommonGood Careers, results showed that nonprofit job seekers ranked benefits such as vacation policies and flexible work plans, such as telecommuting and a 4-day work week, as the most important non-salary benefits. These factors ranked above vision and dental insurance, tuition debt support, performance bonuses and family leave.

This trend provides both a challenge and an opportunity to nonprofit employers. On the one hand, compared to many private sector employers, resources are limited and therefore offering expensive insurance or even reduced work weeks may not be possible. On the other hand, many nonprofit

¹ Nonprofits are generally exempt from FUTA (unemployment insurance at the federal level).

workplaces are entrepreneurial and less-formal places to work that are able to be flexible in work hours and job arrangements and for the right candidate, offer job satisfaction that is unparalleled in the for-profit sector. And more and more, as competition for talented staff is on the rise, nonprofits are offering benefits in the form of insurance plans that rival their for-profit counterparts.

The key is in understanding what, beyond dollars, can motivate your employees to come to work excited every day, and, in this competitive marketplace, to stay with your organization over the long haul. Surprisingly, some of the most appreciated benefits may be the least expensive ones. So it is profitable to pay some attention to what's offered "on the fringe."

Benefits Do Not Have to be Taxing

Benefits have a dollar value; and here is the good news. Because of the special tax status that many benefits enjoy, certain benefits can be worth more to your employees than they cost you to provide. For example, a health insurance plan for an employee may cost you \$3,000 per year. Because the employee pays no taxes on that \$3,000 health benefit, for the employee it is like earning \$4,166 (assuming a 28 percent tax bracket). Put another way, the employee would have to earn about \$347 per month before taxes in order to spend \$250 per month on health insurance. If the organization is eligible to get group rates, the employee should be able to get much better coverage with that \$250 than he or she could get as an individual in the marketplace.

Also, compensation can be set aside, pre-tax, and used by employees for health care costs. These "flexible spending accounts" (often referred to as "FSAs") are prevalent in the for-profit world and are increasingly available in the nonprofit world as well. Flexible spending accounts are set up through legal documents referred to as "cafeteria plans." An FSA allows an employee to set aside a portion of his or her paycheck for qualified expenses, most commonly medical expenses, but other expenses, such as dependent care, can also qualify. The tax benefit to the employee is that the money that is deducted from the participating employee's paycheck is not subject to payroll taxes. Many diverse types of expenditures qualify for the pre-tax spending, from co-payments to contact solution, to daycare fees, diapers and even gym fees. FSAs are most usually offered in conjunction with a traditional health insurance plan.

Here's to Your Health

The United States is one of the few developed countries in the world that does not have a national health care system. Nonetheless for years the U.S. system delivered health care that was the envy of the world. But there was a catch — you only got top quality care if you could pay for it or had insurance to pay for it. Today, with insurance companies seeking to reduce costs, with patient loads skyrocketing, and with many public and nonprofit hospitals disappearing, many believe that the U.S. health-care system is in crisis. For most citizens, this means that their employer will provide the health care coverage and decide what benefits will be offered and at what price. In other words, having a job is the health-care plan, and nonprofit employers who do not offer a plan may find themselves at a big disadvantage in terms of attracting and retaining an educated and well-qualified workforce.

TRENDS IN HEALTH INSURANCE

While statistics change from year to year, it seems that each year brings increases in the cost of health insurance, even for those nonprofits that are participating in group plans with other nonprofits. To soften the blow for employees, employers need to educate employees that health care is a benefit that the employer subsidizes. Technology can help an employer control costs, but it can only help, it is not a cure. Here are some things every nonprofit should consider to help manage the costs of rising health insurance:

- ✓ *Take a second look at the structure of your program and the benefits provided by your nonprofit.*
In a soft job market, a growing percentage of employers opt to pass on health care premium increases to their employees. In many cases, this decision reflects the then current economic conditions, as employees are less likely to complain because of a soft job market. In a tight job market, the reverse is true as employers are willing to absorb health insurance premium increases in order to attract and retain workers. Many nonprofits try to absorb some or all of their employees' health insurance deductibles or provide generous benefits for dependents, as a way of making up for the fact that their employee's base salaries are lower than they might be in the for-profit workplace. Many nonprofits are reluctant to reduce these benefits by requiring staff to bear more of the burden of their insurance deductibles even when it would make economic sense to do so. Though you may not want to make any changes in your program, it is important to consider the economic cost of your nonprofit's health insurance plans.
- ✓ *Harness technology to reduce administrative costs.*
Efficiency and cost management are the prime goals behind the efforts of many organizations to move their benefits administrative paperwork online. Documents such as personnel policies, summary plan descriptions, directions on "how to submit a claim" and links to insurance companies' claims forms can be uploaded onto a nonprofit's own website in a secure area for staff. Using interactive online tools reduces errors, cuts paperwork, speeds transactions, and frees up a nonprofit's human resources personnel to focus on other matters.
- ✓ *Work with employees to manage their own health-care costs.*
Partnerships between employers and employees hold great promise for managing health care costs over the long run. Some of the things an employer can do is to facilitate the review of health care options via an online program, provide access to online educational materials about health risks, and take steps to make certain that employees understand the coverage and services available under their health plan. Doing so will enable employees to make better decisions about their health care. Also, simple training for all staff on workplace safety can reduce a nonprofit's claims. The Nonprofit Risk Management Center offers an on-line workplace safety tutorial on its website.[for online version link to: <http://nonprofitrisk.org/tools/workplace-safety/tutorials.shtml>]
- ✓ *Consider Consumer Driven Health Care.*
Consumer driven health care (CDHC) refers to health insurance plans that allow members to use personal Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products to pay routine health care expenses directly, while a high-deductible health insurance policy protects them from catastrophic medical expenses. High-deductible policies cost less, but the employee pays routine medical claims using a pre-funded spending account. If the balance on this account runs out, the user then pays claims just like under a regular deductible. Users keep any unused balance or "rollover" at the end of the year to increase future balances, or to invest for future expenses. This system of health care is referred to as "consumer driven health care" because routine claims are paid using a consumer-controlled account versus a fixed health insurance benefit. That gives patients greater control over their own health budgets.
- ✓ *Health Savings Accounts.* A Health Savings Account (HSA) is available to employees who are enrolled in a High Deductible Health Plan (HDHP). The funds are contributed to the account by the employee tax-free. Unlike a Flexible spending account (FSA), funds roll over and accumulate year over year if not spent. HSAs are owned by the employee, unlike Health Reimbursement Arrangements (HRA) that are also alternate tax-deductible source of funds paired with HDHPs but are owned by the employer. Funds deposited into an HAS may be used to pay for qualified medical expenses at any time without federal tax liability. Withdrawals for non-medical expenses

are treated in a manner similar to withdrawals from an IRA account with penalties if taken pre-retirement.

- ✓ *Health Reimbursement Accounts:* In Health Reimbursement Accounts, the employer reimburses employees for medical expenses (copays, coinsurance, deductibles and services) agreed to by the employer which are not covered by the company's selected standard insurance plan (any health insurance plan, not only [high-deductible plans](#)). These arrangements are described in IRS Section 105. The employer is not required to prepay into a fund for reimbursements, instead, the employer reimburses employee claims as they occur. Reimbursements of qualified claims are tax-deductible for the employer.

- ✓ *Choose a provider that offers a disease management program.*
The vast majority of paid medical claims are for only a small fraction of the workforce, primarily those people having chronic conditions, such as asthma, diabetes and cardiovascular disease. One way for employers to lower health-related costs for both direct care and the more expensive indirect losses, is to offer a disease management program. A disease management program, typically sponsored and run by a health maintenance organization (known as an HMO) or preferred provider organization (known as a PPO), provides educational programs, nurse support and intervention, and health monitoring and information systems.

- ✓ *Carefully evaluate carve outs as a cost-saving approach.*
When an employer purchases a portion of its health care plan from a specialty vendor, it is called a *carve out*. Many employers have chosen this route in response to rising health care costs. Some of the most popular carve outs are coverage for mental health and substance abuse, oncology services, pharmaceutical drugs, and vision care. Still, some critics think that carve outs that are closely related to other health benefits may “give the illusion of saving costs when, in fact, they may be contributing to rising costs in other health areas.” They recommend that generally carve outs be limited to health benefits, such as eye care, that are less related to other health issues. Also, employers should be aware that carve outs can create more paperwork and add to administrative costs.

- ✓ *Consider a defined contribution plan.*
Identified, defined contribution health plans are widely viewed as one of many available tools in the fight to control an organization's health care costs. A defined contribution plan allows your employees to select a desired level of coverage and pay the difference for additional benefits.

- ✓ *Take another look at absenteeism.* Managing absenteeism should be a top concern for most employers, yet it is estimated that as many as two-thirds of all employers do not even know what their absentee rate is. Many organizations wrongly assume that traditional health and wellness issues are the root cause of absenteeism. However, often employees are not motivated to come to work simply because they do not see how the job they are doing helps accomplish the nonprofit's mission. If absenteeism is a problem, re-examine the nonprofit's performance appraisal process. Are supervisors providing feedback regularly? Do employees know that being dependable in their attendance is a minimum requirement of keeping their job? Have employees whose absence from the workplace is a problem been counseled that their job is at risk?

- ✓ *Consider employee wants and needs when designing or revisiting your program.*
Many employers are surprised to learn that employees value certain benefits more than others. One step to gauge the value of a benefit is to review its actual use. If only five percent of your employees are taking advantage of a benefit, it may not be worth offering. A second step is to survey employees about how they value various benefits. It is also worthwhile to give employees a breakdown, on an annual basis, of what their benefits are worth. Include the employer's share of health, life and disability insurance, pension contributions, and vacation.

Traditional Indemnity Plans

This was like your father's Oldsmobile. Mostly they are not built this well anymore. Although they tended to focus on acute rather than preventive care, when you got sick you went to a doctor that you picked and the insurance company paid the bill, usually after some deductible.

A deductible is a fixed amount of medical expenses an employee pays before the insurance plan reimburses any more expenses. The deductible can range from \$100 to \$1,000 a year, or higher. Co-insurance is a percentage of medical expenses the employee pays, with the plan paying the remaining portion. A typical co-insurance amount is 20 percent, with the plan paying 80 percent of approved medical expenses.

- According to the U.S. Small Business Administration, the following are the most common types of insurance arrangements (indemnity plans) providing health care to groups of employees.
- A basic health insurance plan, covering hospitalization, surgery and physicians' care in the hospital.
- A major medical insurance plan, usually supplementing a basic plan by reimbursing charges not paid by that plan.
- A comprehensive plan, covering both hospital and medical care with one common deductible and co-insurance feature.

Health Maintenance Organizations (HMOs)

Health maintenance organizations provide health care for their members through a network of hospitals and physicians. Comprehensive benefits typically include preventive care, such as physical examinations, well-baby care and immunizations, and smoking cessation and weight control programs.

The main characteristics of HMOs are as follows:

- The choice of primary care providers is limited to one physician within a network; however, there is frequently a wide choice for the primary care physician.
- There is no coverage outside the HMO network of hospitals and physicians.
- Costs are lower, due to limited choice. Physicians are encouraged to keep patients healthy; accordingly, they often are paid on a per capita basis, regardless of how much care the patient needs.

The employer prepays HMO premiums on a fixed, per employee basis. Employees do not have to apply for reimbursement of charges, but they may have small co-payments for medical services.

Preferred Provider Organizations (PPOs)

Preferred provider organizations fall between the conventional insurance and health maintenance organizations, and are offered by conventional insurance underwriters. A PPO is a network of physicians and/or hospitals that contracts with a health insurer or employer to provide health care to employees at predetermined discounted rates. They offer a broad choice of health care providers. Although there is no requirement for employees to use the PPO providers, there are strong financial reasons to do so.

- Because of the broader choice of providers, PPOs are more expensive than HMOs.
- PPOs may have less comprehensive benefits than HMOs, but the benefits usually can meet almost any need.
- PPO providers usually collect payments directly from insurers.

Funding Alternatives

How a nonprofit funds its health insurance plan is really a function of how much the employer wants to

and is able to spend on this benefit. There are a number of options.

- Employer pays all.
- Employer pays a percentage.
- Employer pays for employee; employee pays for family.

It is unusual to find a nonprofit employer today who pays the total cost of a health benefit for an employee and his or her family. One reason is the cost, but another is that it is intrinsically unfair; an employee who happens to have a family receives an extra benefit.

In fact, it is becoming increasingly common to ask employees to help pay for some percentage of their own insurance cost. The rising cost of health insurance in recent years has meant that smaller organizations simply cannot keep pace as health benefits consume an ever-greater portion of their salary budgets.

How to Evaluate a Health Insurance Program

With the proliferation of different types of plans, there has come a need for a method to evaluate the various plans and figure out which is best for your organization and employees. It may be possible, if your organization is large enough or if you can join a group plan, to offer your employees several choices. This is ideal; it allows the employees to tailor their insurance benefits to their particular needs.

On the other hand, if you can offer your employees just one plan, chances are very high that it will be some form of managed care, either a PPO or an HMO, as they are usually the least expensive. But managed care plans vary dramatically in terms of what they offer at what price. One way to examine different plans is to use a series of questions that fall into the three Cs: cost, coverage and customer satisfaction.

Here are some questions to ask about the plans you are examining.

Cost

No health insurance plan will cover every expense. To get a true idea of what your costs will be under each plan, you need to look at how much your employees will pay for their premium and other costs.

- Are there deductibles your employees must pay before the insurance begins to help cover their costs?
- After employees have met their deductible, what part of their costs are paid by the plan?
- Does this amount vary by the type of service, doctor, or health facility used?
- Must employees make copayments for certain services, such as doctor visits?
- If employees use doctors outside a plan's network, how much more will they pay to get care?
- If a plan does not cover certain services or care that employees think they will need, how much will they have to pay?
- Are there any limits to how much employees must pay in the event they face a major illness?
- Is there a limit on how much the plan will pay for care in a year or over a lifetime?

Coverage

In choosing a plan, your nonprofit should try to determine what is most important to your employees. All plans have tradeoffs. Ask your employees:

- How comprehensive do you want coverage of health care services to be?
- How do you feel about limits on choices of doctors or hospitals?
- How do you feel about a primary care doctor referring you to specialists for additional care?

- How convenient does care need to be?
- How important is out-of-pocket cost of services?
- Now, from the perspective of your nonprofit, ask:
 - How much is the organization willing to spend on premiums and other health care costs?
 - How much of the costs are the nonprofit's employees willing or able to share?
 - Look at the services offered by each plan. What services are limited or not covered?
 - Is there a good match between what is provided and what your employees value or need?
 - Is there access to special equipment or medicines?
 - Which hospitals are included? Are these considered the top hospitals in the area? What if special care is required at a special institution?
 - Prescription drugs are becoming increasingly important in medical care, and costs for some medications can be very high. Does the plan cover prescriptions? Is there copay?

Find out what types of care or services the plan will not pay for, usually called exclusions. For example, most plans exclude treatments that are experimental. Yet for some patients such treatment may be the only hope. Ask how the plan decides what is or is not experimental. Find out what a participant can do if he or she disagrees with a plan's decision on medical care or coverage.

Customer Satisfaction (Quality of Care)

Quality is hard to measure, but more and more information is becoming available. Many managed care plans are regulated by federal and state agencies. Indemnity plans are regulated by state insurance commissions. Check with your state's department of health or insurance commission for more information on the plans you are interested in. You can also find out if the managed care plan you are interested in has been accredited, meaning that it meets certain standards of independent organizations. Some states require accreditation if plans serve special groups, such as people in Medicaid. Some employers will only contract with plans that are accredited. There is a list of national accrediting organizations in the Resource section of this book.

Another approach is to ask the managed health care plan providers how they ensure good medical care. Does the provider review the qualifications of doctors before adding them to the plan? Providers are supposed to review the care that is given by their doctors and hospitals. How does the provider review its own services, and has it made changes to correct problems? How does the provider resolve member complaints?

Some managed care plans survey members about their health care experiences. Ask the provider for a report of the survey results. Some providers and independent organizations are also beginning to produce *report cards*. These reports often include satisfaction survey results and other information on quality, such as whether preventive health care is provided or there is follow up on test results. Report cards may also include information on how many members stay in or leave the plan, how many of the doctors are board certified, or how long the wait is for an appointment. Remember, report cards can only give you an idea of how a plan works and may not give a full picture of a plan's quality. Ask providers if their activities have been documented in report cards developed by outside groups (business or consumer organizations).

You can also ask to talk to current members of the plan to gauge your employees' reaction to the plan's service. Ask how they feel about their experiences, such as waiting times for appointments, the helpfulness of medical staff, the services offered, and the care received. Where will you go for care? Are these places near where you work or live? How does the plan handle care when you are away from home? What doctors, hospitals, and other medical providers are part of the plan? Are there enough of the kinds of doctors you want to see? Do you need to choose a primary care doctor? If you want to see a specialist, can

you refer yourself or must your primary care doctor refer you? Do you need approval from the plan before going into the hospital or getting specialty care?

Continuation of Benefits Under COBRA

No employer is required by law to provide insurance to its employees. Once it is offered, however, the Consolidated Omnibus Budget Reconciliation Act of 1985 requires that employers with 20 or more employees notify employees of their right to continue their health insurance coverage at his or her own expense if they are separated from employment or their hours are reduced so that they are no longer eligible for benefits. Such events are called "qualifying events" and trigger the employer's obligation to provide a "COBRA Notice" to employees. Sample notices are generally available from the insurance carrier. One of the most common mistakes employers make in connection with health care is to fail to provide appropriate notice to an employee who is impacted by a qualifying event. The end result is that the employer ends up paying health care costs that otherwise the employee or insurance carrier would have paid. It is critical to include COBRA on your checklist of 'things to do' whenever an employee is terminated or resigns or has his or her hours reduced. Employees also need to know that if they are impacted by a qualifying event, any of their dependents are also impacted. The employer's notice needs to highlight this fact, as well as give employees a roadmap they can follow to elect to continue their benefits and notify the insurance carrier of their election.

COBRA gives employees who would otherwise lose their group health coverage due to certain *qualifying events*, the right to continue participating in their employer's plan for a certain period at the group rate. (Your nonprofit may be covered under COBRA even if you have fewer than 20 employees. For example, if you are part of a group insurance program involving other nonprofits, the total covered employees may be the number that determines whether COBRA applies.)

The federal COBRA law only involves group health insurance, not other types of insurance, such as life or disability. Sometimes, however, state insurance laws include separate continuation coverage provisions on those types of insurance, as well as health insurance. Other state laws (*mini-COBRA*s) establish a lower threshold (number of employees) for applicability.

Who Is a Qualified Beneficiary?

To be eligible for COBRA coverage, a qualified beneficiary must be enrolled in the employer's group health plan on the day before the qualifying event. A qualified beneficiary can be:

- a covered employee: a current or former employee (including self-employed persons, independent contractors, retirees and other non-traditional employees) covered under a group health plan.
- a spouse of a covered employee.
- a dependent child of a covered employee.
- a child born to, or placed for adoption with, the covered employee during a period of COBRA coverage.

What Is a Qualifying Event?

For a covered employee, a qualifying event can be:

- voluntary or involuntary termination of employment (except if fired for gross misconduct).
- reduction in hours of employment.
- filing of a bankruptcy proceeding by the employer (retirees and certain dependents only).
- For a spouse or dependent child, a qualifying event can be:

- a covered employee's termination of employment (except if fired for gross misconduct) or reduction in hours of employment.
- a covered employee's death.
- a spouse's divorce or legal separation from a covered employee.
- a covered employee's entitlement to Medicare (that is, the employee is actually covered under Medicare not just eligible for Medicare coverage).
- a dependent child's loss of dependent status under the plan (usually due to age).
- an employer's filing of a bankruptcy proceeding (retirees and certain dependents only).
- An employee placed on a medical leave of absence is not covered under COBRA.

Notice of COBRA Rights

Once plan coverage begins for an individual, that person and his or her spouse, if any, must be initially notified of their COBRA rights.

If a qualifying event occurs, more notices are required. In cases of termination or reduction in hours of employment, death, Medicare entitlement or bankruptcy, the employer has 30 days to notify the plan administrator. Generally, this 30-day period begins on the date of either the qualifying event or loss of coverage, whichever is later.

Once notified of the qualifying event, the plan administrator has 14 days to notify the qualified beneficiaries of their right to elect continuation coverage. If the employer and plan administrator are one and the same, the total notice period is 44 days.

In cases of certain disabilities, divorce, legal separation or loss of dependent-child status, the qualified beneficiary has 60 days to provide notice to the plan administrator.

Election Period

Qualified beneficiaries are given a certain length of time (the election period) to elect continuation coverage. This period lasts for at least 60 days, and may begin on different dates, depending on when coverage would otherwise be lost and when notices are given. Once an individual elects COBRA coverage, he or she has up to 45 days to pay the first premium.

In some cases, an employer may cancel or suspend the health insurance until continuation coverage is elected and paid for; at that time, the coverage is reinstated retroactively.

Duration of Coverage

Continuation coverage can last for up to 18 months for a termination or reduction in hours of employment; up to 29 months for certain disabled qualified beneficiaries; or up to 36 months for divorce or legal separation, the covered employee's death or Medicare entitlement, or cessation of dependent status. Under special rules that apply in bankruptcy proceedings, continuation coverage may last for life. Also, a special *multiple qualifying event* rule may extend the 18-month period to 36 months. (For example, if a termination of employment is followed by a divorce while the qualified beneficiaries are still on COBRA coverage.)

Otherwise, once the maximum period is reached, an employer is no longer obligated to offer continuation coverage. However, plans that allow for an individual conversion option must provide information on that option before the end of the COBRA coverage period.

The maximum coverage periods may be terminated early, if the qualified beneficiary fails to pay the premium on time, becomes covered under another group health plan (subject to pre-existing condition exclusions or limitations) after he or she elects COBRA coverage, or becomes entitled to Medicare after he or she elects COBRA coverage. The maximum period may also end if the employer terminates all of

its group health plans.

Premiums

Once coverage is elected, qualified beneficiaries may be required to pay a premium for this continuation coverage. The premium can be as much as 102 percent (or 150 percent for additional disability coverage) of the cost of coverage to the plan for *similarly situated individuals*. This cost includes both the employer and employee share of the premium. Generally, there is a 30-day grace period for premium payment; after that, coverage can be terminated.

LIFE INSURANCE

The two basic types of life insurance are permanent or *whole life* insurance and *term life* insurance. The type of insurance that is offered by most employers is term life. This form of insurance pays a specified amount upon the death of the insured in exchange for payment of a premium. The advantage of providing a life insurance benefit is that life insurance is fairly inexpensive. A few hundred dollars per insured per year can offer several hundreds of thousands of dollars of protection. Many employers provide insurance for one year's salary, or for a fixed amount between \$10,000 and \$100,000. The downside is that your employees can never fully appreciate this benefit (though their dependents or loved ones might).

Group life insurance programs can be structured in any number of ways. For example, a program offering coverage to nonprofits and their employees might offer:

- ✓ *Guaranteed enrollment*
Guaranteed enrollment means there are no underwriting requirements for employers that meet the insurer's threshold and other participation requirements (e.g., two or more employees, maximum benefit amounts apply).
- ✓ *Option to Upgrade*
Each employee may upgrade benefits on an individual basis. Depending on the size of the nonprofit, an employee may apply for additional group coverage or a stand alone individual policy. Note: underwriting is generally required for individual coverage.
- ✓ *Group Billing*
The nonprofit receives a single bill for the group's coverages.

DISABILITY INSURANCE

Disability insurance provides an employee security by providing an income should they become sick or injured and unable to work. It helps protect against family financial catastrophe by giving the employee an income to meet daily expenses. Unfortunately, many nonprofits neglect this category of insurance benefit, assuming that it is too costly or too difficult to obtain. In fact, it is not necessarily costly, and there are many providers.

Even though most people do not think about the possibility of a disability, every two seconds someone experiences a disabling injury, according to a report by the National Safety Council. One in three workers will lose their ability to work due to a disability lasting 90 days or longer sometime before age 65. Ability to earn income is an employee's most valuable asset.

Long-Term Disability Insurance

Long-term disability insurance is intended to provide insured employees with a source of income in the

event they become disabled and are unable to work for an extended period. It will supplement Social Security to equal as much as 60 percent of the employee's salary. An LTD policy may provide benefits up to age 65, or normal retirement age or when a person becomes eligible for Social Security and pension.

Short-Term Disability Insurance

Short-term disability plans can be designed to stand alone or as a complement to an employer's sick leave program. Some of the advantages of STD insurance include: available first-day coverage for accidents, flexible benefit percentages, choice of benefit periods: between 3 and 104 weeks, and choice of occupational, non-occupational, or 24-hour coverage. The main advantage of STD insurance is that coverage can begin very soon after injury or disability occurs. This is most beneficial to lower-income employees and those with little or no accumulated sick leave.

Short-term disability insurance comes in two major forms: A variety of employer-paid and government-sponsored programs, generally cost-free to the recipient, cover certain categories of workers.

Private policies (paid for by individuals) protect income when there are no applicable employer or government programs or when those programs do not adequately meet income needs.

You can find a list of disability insurance providers on the Internet at www.hiaa.org. Click on the Marketplace link. Note: this Web site is hosted by the Health Insurance Association of America. It has much helpful information but is the trade group of the health insurance companies. Scrutinize the information accordingly.