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Four decades have passed since the International Foundation of Employee Benefit Plans first compiled this glossary to bring together, in one volume, the diverse terminology used by those in the employee benefits field. With this updated 13th edition, the International Foundation continues its commitment to providing a practical, easy-to-use guide to benefit and compensation terms that will be a valuable resource for benefit plan trustees, administrators and other benefits stakeholders.

This new version of the glossary defines a record 4,000-plus terms. More than 700 of these terms are new. Many other terms have been revised to reflect changing public policies and the evolving interests of those in the benefits arena. Definitions for the terms in this book have been derived from current Canadian and U.S. sources covering the following:

- Compensation
- Employee benefits design, funding and administration
- Government programs, regulations and legislation
- Health care and health care cost-containment strategies
- Human resources
- Insurance
- Investments
- Labor relations
- Taxes.

Special features of this publication include:

- A 6-page section devoted to the Affordable Care Act of 2010—providing explanations of key terms and summarizing some of the most important changes that are part of this landmark health care reform package

- At the back of the book, a list of over 1,100 acronyms and abbreviations covering a wide range of benefit-related topics.
Please keep in mind that this glossary has been created to provide you with a starting point when you are seeking information on a particular employee benefits topic; it should not be viewed as a definitive source. Every effort has been made to present accurate and up-to-date information, but employee benefits is a complex and rapidly changing arena. Use this glossary as a resource, not an authority. Refer to standard texts and reference works for more details and the most current information on the terms presented. Seek professional assistance in making decisions regarding benefit planning and administration.

The International Foundation welcomes feedback for future updates of this glossary. Contact the Publications Department directly with any suggestions.
The editor extends sincere appreciation to all the dedicated employees at the International Foundation who contributed to this endeavor from the start to when it rolled off the press. Special thanks to Suzy Aschoff, Kathy Bergstrom, Barb Pamperin, Rose Plewa and Chris Vogel for their assistance identifying many of the terms that have been added to this edition of the glossary. Special thanks also to those who helped to ensure the accuracy of definitions: Kelli Kolsrud, Lois Gleason, Robbie Hartman, Sharon Olecheck, Jenny Lucey and Amanda Wilke.
habitative/habilitative services—health care that helps a person keep, learn or improve daily living skills and functioning. An example is therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

hammer clause—provision in a liability insurance policy that restricts the amount that will be paid if the insurance company recommends a case be settled, but the insured rejects this advice and chooses to litigate.

harassment—unwanted and annoying actions of one party or a group upon another, including threats and demands. The purposes may vary, including personal malice, racial prejudice, an attempt to force someone to quit a job or grant sexual favors, illegal pressure to collect a bill or merely gaining pleasure from making someone fearful or anxious. Generally, harassment is a behavior that persists over time. However, serious one-time incidents can sometimes be considered harassment.

hard assets—physical items (land, buildings, equipment) or financial instruments (cash, credit, stock). Hard assets are tangible and are usually subjected to inventory and/or custodial safeguards. See also soft assets.

hard dollars—investment term that refers to the direct payment of fees for services (including research) to a brokerage firm versus payment through trade commissions, which are referred to as soft dollars.

hardship allowance/pay—compensation for the difficulty that may be experiences when workers and their families must adjust to a new location or live in challenging/unpleasant conditions. Factors that may result in hardship pay include the climate, infrastructure, civil liberties, language and culture of the locale relative to home conditions.

hardship withdrawal—removal of money from a qualified retirement plan prior to retirement to cover a pressing financial need. For the purposes of a 401(k) plan, the IRS defines hardship as the immediate and heavy financial need of an employee, including the employee’s spouse, nonspouse, dependent and nondependent beneficiary. These needs include (1) certain medical expenses; (2) costs related to the purchase of a principal residence; (3) tuition and related educational fees and expenses; (4) payments necessary to prevent eviction from, or foreclosure on, a principal residence; (5) burial or funeral expenses and (6) certain expenses for the repair of damage to an employee’s principal residence. A withdrawal is not considered necessary if the employee has other resources available to meet the need, including assets of the employee’s spouse and minor children. The withdrawal may not exceed the amount of employee need. However, the amount required to satisfy the financial need may include amounts necessary to pay any taxes or penalties that may result from the distribution.

harmonized sales tax (HST)—consumption tax used in Canadian provinces that combines the federal goods and services tax (GST) with the regional provincial sales tax (PST).

hazardous duty pay—special compensation for employees exposed to high-risk working conditions.

health—state of physical, mental and social well-being.

health advocacy services—support offered by an employer, health plan, hospital or other entity to help patients navigate the health care arena. Examples of services include encouraging healthy behaviors, directing individuals to the best doctors and treatments, and assisting with billing and insurance coverage issues. See also “Navigators” in the Appendix A: Affordable Care Act of 2010 (ACA).

Health and Human Services Department—see U.S. Department of Health and Human Services (HHS).

health and productivity management—development, implementation and/or monitoring of strategies that improve employee health status and work output. Improvements in health may be measured by reductions in health risks, disability claims, health care costs, etc. Absenteeism, presenteeism and manufacturing output are among the factors that may be used to measure changes in productivity.

health and welfare benefit plan—see employee health and welfare benefit plan.

health and welfare fund—see employee health and welfare fund.
Health Care and Education Reconciliation Act of March 30, 2010—see the Appendix A: Affordable Care Act of 2010 (ACA).

health care coalition—organization working on any of a broad range of health care concerns such as access, costs and quality. Participants can be businesses, health care providers, third-party payers and/or consumers. Often there is government participation as well. Health care purchasing coalitions use their collective power to obtain health care products and services with significant cost savings.

health care cooperative—nonprofit, member-owned and member-operated health insurance organization that provides coverage to individuals and small businesses. Care may be through a system of health care providers or the contracting out of medical services for members. Like other cooperatives, health care cooperatives are governed by a board of directors elected by members. See also “Consumer Operated and Oriented Plan (CO-OP) program” in the Appendix A: Affordable Care Act of 2010 (ACA).

health care cost trend rate—percentage change in per capita health claim costs over time as a result of factors such as inflation, service utilization, plan design, technological developments and changes in the health status of plan participants.

Healthcare Effectiveness Data and Information Set (HEDIS)—widely used collection of 81 performance measures across five domains of health care. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS makes it possible to compare the performance of one health plan to another, as well as to regional and national benchmarks. A sampling of the measures include beta blocker treatment after a heart attack, controlling high blood pressure, breast cancer screening, antidepressant medication management, childhood and adolescent immunization, and advising smokers to quit.

Health Care Financing Administration (HCFA)—former name of the Centers for Medicare and Medicaid Services (CMS).

health care flexible spending account—fund established by an employer under IRC Section 125 that allows employees to use pretax dollars for qualified health care benefits. See also flexible spending arrangement (FSA) and medical care expense.

health care fraud—intentional deception or misrepresentation for the purpose of gaining an unauthorized medical benefit or benefit payment. Examples of health care fraud include billing for goods or services never provided, misrepresenting what and when treatment was provided, and performing medically unnecessary services. Health care fraud is almost always criminal, but the specific nature or degree of the criminal acts may vary from state to state.

health care provider—individual or organization (e.g., physician, nurse, hospital, laboratory) that provides medical services.

health care proxy—see durable power of attorney.

health care quality—degree to which health goods and services increase the likelihood of desired health outcomes and are consistent with current knowledge.

health care reform—changes in a health care delivery system, how it is structured and how it is financed. The goals of reform are typically to increase access to health care, expand health care provider options, improve the quality of care and decrease cost. See also the Appendix A: Affordable Care Act of 2010 (ACA).

health care reimbursement account—see health reimbursement arrangement (HRA).

health care spending account (HCSA)—individual employee account that reimburses the eligible medical and dental expenses of Canadian employees, their spouses and dependents. The sponsor of a HCSA program contributes a defined amount of funds into an account for each eligible plan member. These funds may be used to pay for health and dental expenses not otherwise covered by a group benefit or provincial health plan. Typical expenses include deductibles or coinsurance payments, expenses in excess of maximum coverage amounts and expenses that qualify for medical expense tax credits such as payments to medical practitioners and hospitals, transportation and travel expenses, medical equipment, eyeglasses, rehabilitative therapy and dentures. Accounts are governed by taxation rules and regulations developed by the Canada Revenue Agency (CRA).

health coach—person trained to help individuals address a specific health issue and, if need be, make behavioral changes. Health coaches work one-on-one to help individuals set goals, identify obstacles to achieving these goals, find solutions to challenges and remain motivated. Situations in which health coaches are used include diabetes management, weight loss and smoking cessation.
health consumerism—movement advocating that patients be partners with their physicians versus simply accepting whatever a doctor recommends. Such involvement requires patients to be more informed and actively participate in the health care decision process. Patients may also be encouraged to have a better understanding of their bodies and health issues so they can take preventive measures.

health exchange—see “Public health exchanges” in the Appendix A: Affordable Care Act of 2010 (ACA) and private health exchange.

health fair—event that provides basic preventive medicine services, offers medical screenings, disseminates information on disease prevention and/or encourages healthy behavior. A health fair may also be a marketing tool for medical providers.

health flexible spending account—see health care flexible spending account.

health information technology (HIT)—computer systems, hardware, software, etc., used to store, update, transmit and retrieve health care information.

Health Information Technology for Economic and Clinical Health (HITECH) Act—enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA), U.S. legislation concerning health care information technology in general (e.g., creation of a national health care infrastructure) and requirements (e.g., marketing communications, restrictions and accounting) that modify the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Provisions of HITECH include incentives to accelerate the adoption of electronic health record (EHR) systems among providers and a requirement that health care providers, health plans and others covered by HIPAA notify individuals when their health information is breached. See also Health Insurance Portability and Accountability Act of 1996 (HIPAA).

health insurance—protection against financial losses due to sickness or injury. See also accident insurance, accidental death and dismemberment (AD&D) benefit, basic medical insurance, disability insurance, hospital-surgical expense insurance, indemnity insurance, major medical insurance and medical insurance.

health insurance exchange—see “Public health exchanges” in the Appendix A: Affordable Care Act of 2010 (ACA).

health insurance marketplace—see “Public health exchanges” in the Appendix A: Affordable Care Act of 2010 (ACA) and private exchange.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)—U.S. legislation that:

- Guarantees availability and renewability of health insurance coverage for all employers regardless of claims experience or business size
- Allows employees, their spouses and dependents to enroll for coverage outside a plan’s open enrollment under special circumstances. See also special enrollment.
- Provides tax incentives for the purchase of long-term care insurance
- Establishes medical saving accounts (MSAs)
- Requires the U.S. Department of Health and Human Services to establish national standards for electronic health care transactions
- Addresses the security and privacy of health data. See also Health Information Technology for Economic and Clinical Health Act (HITECH) Act, privacy office/official and release of information (ROI).

health literacy—degree to which individuals are able to obtain, process and understand basic health information in order to make appropriate health decisions.

health maintenance organization (HMO)—medical system with member physicians, professional staff and facilities that provide a comprehensive benefits package including hospitalization and surgery. Supplemental services such as dental care, mental health care, eye care and prescription drugs may be part of the package as well. HMOs emphasize preventive care, early diagnosis and outpatient treatment. Both the insurer and provider of health care, HMOs are sponsored by governments, medical schools, hospitals, employers, labor unions, consumer groups and insurance companies. An HMO participant pays a fixed periodic fee that is set without regard to the amount or kind of services received. Service coverage is virtually 100%, with an occasional copay. A primary care physician authorizes kinds of services received. Service coverage is virtually 100%, with an occasional copay. A primary care physician authorizes and refers patients to specialists and other providers within the system. No coverage is provided outside the HMO network of providers, except for emergency treatment or when traveling outside the geographic area covered by the network. There are no claim forms to file unless a patient goes outside the network. See also dental health maintenance organization (DHMO), exclusive provider organization (EPO), group practice model HMO, hybrid HMO, IPA model HMO, network model HMO, point-of-service (POS) plan, referral management and staff model HMO.

health plan categories—see “Qualified health plans” in the Appendix A: Affordable Care Act of 2010 (ACA).

Health Plan Identifier (HPID)—standard identifier for health plans, which was required to be adopted under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).
**health promotion**—education, marketing and other endeavors that help people gain greater control over their health and the factors that impact it. See also wellness program.

**health reimbursement account**—see health reimbursement arrangement (HRA).

**health reimbursement arrangement (HRA)**—employer-sponsored and employer-funded account that permits the use of pretax dollars to pay for qualified medical expenses incurred by employees, their spouses and dependents. Qualified expenses are determined by IRC Section 213(d) and plan design. Expenses may include health insurance and long-term care insurance premiums. Money remaining in the account at year-end can be carried over and used to cover future medical costs, but the account is not portable if the employee changes employers. Contributions are not included in taxable income, and reimbursements from an HRA that are used to pay qualified medical expenses are also not taxed. HRAs are a way to encourage patients to shop wisely for health care. See also Section 213.

**health risk assessment (HRA)**—also referred to as a health risk appraisal, the process in which lifestyle behaviors and other information specific to an individual is identified and evaluated to determine the likelihood of disease, injury or death. A health risk assessment is a common element in wellness programs. Research has shown that helping people identify threats to their health facilitates behavioral change. See also wellness program.

**health savings account (HSA)**—introduced by the U.S. Congress in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, a tax-exempt trust or custodial account created by individuals or employers for those (employees, retirees, self-employed) who are covered under a high-deductible health plan. Contributions can be made by the employer or employee. Funds contributed by the account holder are deductible for federal tax purposes. Funds can be used for qualified medical expenses qualified under Section 213(d), long-term care premiums and long-term care. The account beneficiary owns the HSA, making the plan portable. Amounts not distributed may be carried over from year to year. These accounts are designed to empower employees to take more responsibility for their own health care and help employers control health care costs. An HSA can be offered under a Section 125 cafeteria plan. See also high-deductible health plan (HDHP) and medical care expenses.

**health spending account (HSA)**—self-insured private health services plan (PHSP) benefit that permits an employer to allocate funds exclusively for the purpose of health and/or dental care payments by employees residing in Canada. In some cases, the employer makes advance payments including the cost of administration and taxes on behalf of employees. With other plans, payments are made on a “pay as you go” basis. The employee receives reimbursement from the account for eligible claims. Claims, administration fees and taxes are a 100% business deduction for the employer. An HSA can be used to supplement an insured private health services plan (PHSP) or to implement a standalone plan.

**health stock ownership plan (HSOP)**—combination of an employee stock ownership plan and 401(h) account. HSOPs allow a sponsoring employer to provide retiree medical benefits for its current employees without having to accrue future liabilities, as would be required if such benefits were provided outside the qualified plan context. The IRS is presently not issuing determination letters for new plans of this type.

**health tourism**—see medical tourism.

**hearing aid coverage**—benefit plan or insurance that reimburses the insured for the purchase of a hearing aid and/or offers a discount on the amount paid by the insured for a hearing aid.

**hedge**—strategy for reducing or eliminating financial risk; for example, taking two investment positions so that one will offset the other if prices change.

**hedge fund**—aggressively managed investment portfolio that uses advanced investment strategies such as leveraged, long, short and derivative positions in an effort to “hedge out” market risk and produce returns independent of overall market performance. Each fund poses a unique set of risks and investment opportunities. Most often set up as private partnerships, hedge funds are open to a limited number of investors with very large initial minimum investments. Investors generally must keep their money in the fund for at least one year. Unlike mutual funds, hedge funds are largely unregulated. U.S. law does require the majority of investors in a hedge fund to be accredited; in other words, investors must earn a minimum amount of money annually, have a net worth of more than $1 million and have significant investment knowledge.

**heir**—person entitled by law or the terms of a will to inherit the property of another.

**high-cost excise tax**—see “Fees/Taxes” in the Appendix A: Affordable Care Act of 2010 (ACA).
highest average indexed compensation — average of the best three non-overlapping 12-month periods of indexed compensation. For this purpose, monthly compensation is indexed to increases in the average wage from the calendar year in which the compensation was paid to the year pension payments begin. Highest average indexed compensation is used to determine the highest lifetime retirement benefit that may be paid from a defined benefit pension plan in Canada.

high-deductible health plan (HDHP) — sometimes referred to as a catastrophic health insurance plan, an HDHP is a lower-cost insurance policy that features a higher annual deductible than that of a traditional health insurance policy. As the term “catastrophic” suggests, HDHPs provide affordable coverage for health events that might wreak financial havoc on a household. With an HDHP, the insured pays for nearly all medical expenses until the annual deductible amount is reached. In the U.S., participating in a qualified HDHP is a requirement for establishing a health savings account and is used in conjunction with other tax-advantaged programs such as health reimbursement arrangements. The IRC allows HDHPs to provide some preventive care benefits without the high deductible or below the minimum annual deductible. See also consumer-driven health care (CDHC), deductible, health reimbursement arrangement (HRA) and health savings account (HSA).

highly compensated employee (HCE) — term used when testing whether a benefit plan discriminates in favor of select workers. IRS definitions vary with the type of plan. For purposes of a qualified retirement plan in the U.S., an HCE is a 5% owner of the company or a person whose compensation was at least $110,000 in 2009. The income figure is indexed annually. For a cafeteria plan, an HCE is an officer, a shareholder who owns more than 5% of the voting power or value of all classes of the employer’s stock, an employee who is highly compensated based on the facts and circumstances or a spouse or dependent of a person who meets any of those criteria. For purposes of a self-insured health plan, an HCE is one of the five highest paid officers, an employee who owns (directly or indirectly) more than 10% of the value of the employer’s stock or an employee who is among the highest paid 25% of all employees (other than those who can be excluded from the plan).

high-risk pool — insurance plan to provide coverage to persons who find it difficult or impossible to purchase insurance. Drivers of motor vehicles who have had a number of accidents or tickets, or a serious infraction such as driving under the influence of alcohol, can be classified as “high-risk drivers.” Some are able to purchase “nonstandard” insurance from a private insurance company who groups these drivers and charges higher rates that those charged to drivers with good driving records. For drivers who are rejected by private insurance carriers, insurance can be purchased through their state’s “assigned risk” pool, which also has insurance premiums higher than those offered to persons with good driving records. Prior to passage of the Affordable Care Act of 2010 (ACA), many states had private, self-funded health insurance plans for persons who had a health condition that made it impossible to get health coverage in the private individual insurance market and did not have access to group insurance. The plans were subsidized by state government with premiums up to twice as much as what an individual would pay for individual coverage if he or she were healthy. Coverage was sometimes similar to that sold by private insurers, or it might have had limited coverage for certain services (e.g., mental health or maternity care).

high self-insured deductible (HSID) plan — see shared funding.

high-yield bond — see junk bond.

hiring bonus — extra money used to entice an applicant to accept a job offer. The hiring bonus is paid upon acceptance of employment.

hiring rate — beginning wage or salary typically paid when an employee is hired.

HITECH Act — see Health Information Technology for Economic and Clinical Health (HITECH) Act.

holder in due course — legal doctrine that one who purchased a check or promissory note in good faith, and with no suspicion that it might not be good, claimed by another, overdue or previously dishonored, may enforce payment in court despite any borrower defense or other reason for not paying. See also bona fide purchaser.

hold harmless clause — contract provision in which one party promises not to hold another party liable for any damage or loss, regardless of the responsibility or negligence involved.

holding company — corporation that owns the securities of another, in most cases with voting control.
**Home Buyers’ Plan (HBP)**—program introduced by the Canadian government in 1992 that allows individuals to borrow from their Registered Retirement Savings Plan (RRSP) to buy or build a home. The amount withdrawn must be repaid within 15 years.

**home country**—nation where a person was born and usually raised, regardless of his or her present country of residence and citizenship. See also base country.

**home equity**—market value of a home minus the amount still owed on the property.

**home equity conversion mortgage**—see reverse mortgage.

**home health agency (HHA)**—licensed entity providing skilled nursing care, home health aides and other therapeutic services in a patient’s home.

**home health care (HHC)**—health and social services that are provided in the homes of individuals who are disabled or ill. The services range from skilled nursing care and physical therapy to personal assistance and help with household chores.

**home infusion therapy**—provision of vital fluids and medications outside a formal health care environment, usually to reduce the inconvenience or cost of a hospital visit.

**home office**—portion of a home used for business purposes. The IRS allows a business deduction for a home office if the space is used exclusively and regularly as either (1) a principal place of business or (2) a place to meet or deal with patients, clients or customers in the normal course of business. Where there is a separate structure not attached to a home, the regular and exclusive use does not need to be a principal place of business as long as the use is in connection with the worker’s trade or business. A deduction is also allowed for space used on a regular basis for storage of items such as inventory or product samples.

**homeopathy**—treatment of disease using minute doses of natural substances that in a healthy person would produce symptoms of disease. This approach is thought to stimulate the body’s natural defenses against the symptoms of the disease. Homeopathy as a formal system of medicine is no longer practiced in the United States. However, it may be informally practiced as an alternative therapy.

**horizontal integration**—combining of two or more similar organizations to form a larger entity. Hospitals often merge into regional systems to provide greater coverage and a fuller range of clinical services. Horizontal integration, also referred to as specialty integration, makes it possible to take advantage of economies of scale and to leverage buying power with vendors. See also vertical integration.

**hospice**—health care program providing medical care, support services and comfort to terminally ill patients and their families. The support services may include emotional, spiritual, social and financial assistance. Hospice care is available in diverse settings including an independent hospice facility, a nursing home, a unit of a hospital or as professional care in a patient’s home.

**hospital**—facility that provides medical and surgical care to the sick and injured on a residential or inpatient basis. Hospital facilities are under the supervision of a staff of one or more licensed physicians and provide 24-hour nursing services by a registered nurse on duty or call. Facilities operated exclusively for the treatment of the aged, drug addiction or alcoholism may be operated as separate institutions by a hospital, but they are not considered hospitals. Hospitals are not convalescent, nursing, rest or extended care facilities.

**hospital audit**—examination of records to determine whether a patient received billed goods and services, and that the dollar amounts billed are consistent with contract agreements. A hospital audit is generally used when there is a large claim to ensure there are no billing errors.

**hospital confinement insurance**—see indemnity insurance.

**hospital income insurance**—see indemnity insurance.

**hospital indemnity insurance**—see indemnity insurance.

**hospital insurance (HI)**—fee-for-service coverage for expenses incurred as the result of a stay in a hospital.

—Part A of the U.S. government’s Medicare insurance that covers the cost of hospital charges for senior citizens and the disabled.

**hospitalist**—health care provider, usually a physician, whose practice is devoted to treating patients in a hospital setting. A hospitalist typically takes over care from a primary physician while a patient is in the hospital, keeping the primary doctor informed regarding the patient’s progress. The patient returns to the care of the primary doctor when he or she leaves the hospital.