

(Effective January 1, 2027)

WAC 182-40-0200 Definitions. The following definitions and those found in chapter 41.05 RCW apply to this chapter. If a definition in this chapter conflicts with a definition in chapter 41.05 RCW, the definition in chapter 41.05 RCW prevails:

"Authority" - See RCW 41.05.011.

"Allowed amount" means the maximum portion of a billed charge a contractor will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service.

"Benchmark reimbursement" means the applicable payment standard against which a contractor's allowed amounts paid to providers and facilities are assessed for compliance measurement.

"Benchmark weight" means a numerical assignment of required resources to provide care for a specific medicare diagnosis-related group (DRG) relative to average resources across all DRGs.

"Centers for Medicare and Medicaid Services" or **"CMS"** - See WAC 182-500-0020.

"Compliance measurement" means the authority's review of contractor-submitted data for each plan year to determine compliance under this chapter.

"Contractor" means a health carrier that provides medical insurance offered to public employees and their covered dependents under chapter 41.05 RCW, or a third-party administrator contracted by the authority to provide medical coverage to public employees under chapter 41.05 RCW.

"Diagnosis-related group" or **"DRG"** - See WAC 182-550-1050.

"Hospital" means a hospital licensed under chapter 70.41 RCW and located in Washington state that receives payment for services provided to enrollees in the public employees' benefits board (PEBB) program, as defined in WAC 182-08-015, or enrollees in the school employees' benefits board (SEBB) program, as defined in WAC 182-30-020.

"Percent of medicare" means the percent of the equivalent amount of medicare or other reimbursement benchmarking as determined by the reimbursement benchmarking methodology in WAC 182-40-0600.

"Plan year" means the 12-month period beginning on January 1st of each year and ending on December 31st of the same year.

"Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" does not include amounts paid as enrollee point-of-service cost-sharing.

"Public employee" - See RCW 41.05.011.

"Ratio of costs-to-charges" or **"RCC"** - See WAC 182-550-1050.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 41.05.028. WSR 25-24-066, s 182-40-0200, filed 12/1/25, effective 1/1/27.]