S-0852.2

SENATE BILL 5803

State of Washington 54th Legislature 1995 Regular Session

By Senators Quigley and Moyer

Read first time 02/07/95. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to patient care; amending RCW 48.43.170 and 43.72.310; adding a new section to chapter 43.72 RCW; adding a new section to chapter 70.43 RCW; adding new chapters to Title 70 RCW; adding a new chapter to Title 48 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** LEGISLATIVE FINDINGS. (1) The legislature finds that the pace of health care reforms initiated by both the public and private sectors can result in unforeseen consequences in the delivery system unless safeguards are put in place. These undesired consequences can include negative effects on the quality of patient care, reducing the options open to patients to receive the kind of care they desire, regulation that decreases the competition in the delivery system, concentration in the marketplace the effect of which is to achieve market power in relation to consumers and to disrupt established and historically useful relationships in the delivery system.

(2) Preserving the best of what already exists in the delivery system, while providing for sufficient flexibility so the system can

evolve into a more cost-effective one, requires careful balancing among competing objectives.

NEW SECTION. **Sec. 2.** QUALIFICATIONS DISCLOSURE. (1) All health care payers subject to the jurisdiction of the state of Washington must disclose to their enrollees the qualifications and training of the types of practitioners who provide services under their plans and programs.

(2) The health services commission shall adopt by rule the contents of such disclosure and shall contain, at a minimum, the length and source of formal training of the practitioner, including posttraining experience.

NEW SECTION. **Sec. 3.** SUPERVISION OF PHYSICIANS BY NONPHYSICIANS. (1) For purposes of this section, the following definitions apply:

(a) "Physician" means those persons licensed pursuant to chapters 18.57 and 18.71 RCW.

(b) "Supervision" means having the right to tell physicians how to practice medicine because of the nature of the relationship with the physician or by contract irrespective of whether the right is exercised or whether the right is obtained indirectly by, for example, refusing to pay the physician for care delivered because of a disagreement regarding its medical necessity or quality.

(2) No entity supervising physicians may impose on a physician adverse consequences of any kind because of referring patients for care to facilities or practitioners other than those approved by the supervising entity where the physician in good faith believes that there is a substantial patient care justification for doing so and that the care was otherwise unavailable.

(3) No entity supervising physicians shall interfere directly or indirectly with the physicians selecting the malpractice carrier of their choice.

(4) No public or private health care payer subject to the jurisdiction of the state of Washington shall propose, issue, sign, or renew a provider agreement or enrollee service agreement that contains a clause whose effect, in any way, is to disclaim liability for the care delivered or not delivered to an enrollee because of a decision of the payer as to whether the care was a covered service, medically necessary, economically provided, medically appropriate or similar

consideration. Similarly, no clause shall attempt to shift liability for harm caused by such payer decisions to providers and/or enrollees by claiming that the decision as to whether care should be delivered, as opposed to paid for, is between the provider and patient alone as if the fact of whether or not care is paid for played little or no role in a patient's decision to obtain care. Nothing in this subsection shall be inferred to result in liability to anyone for a payer's payment decisions that are consistent with the language of the applicable service agreement or consistent with the cost-effective delivery of health care. The intent of this section is only to prevent payers from shifting their liability for payment decisions to providers and/or enrollees.

(5) In the case of hospitals supervising physicians, hospitals may not take any disciplinary action of any kind against such a physician regarding quality of care or utilization review unless the physician was afforded the same procedural rights as physicians not supervised by the hospital under the hospital's medical staff bylaws. This protection extends to clinical performance standards, economic performance standards whether formally stated or not, and terminations or limitations relating to clinical or economic performance.

(6) All physicians shall be protected from reprisals for making reports regarding the practices and standards of supervising entities subject to the jurisdiction of the state of Washington to federal or state government authorities to the same extent as government employees are protected for reporting to the state auditor under chapter 42.40 RCW. This protection shall extend to reprisals of any kind initiated by a plan against a reporting provider.

(7) No payer, subject to the jurisdiction of the state of Washington, may take any adverse action against a provider for criticizing the practices or standards of the payer on the grounds of quality and necessity of care to the enrollees of a plan or the person or entity paying the premiums of the enrollees.

(8) Nothing in this section shall apply to entities who supervise physicians that are in full compliance with chapter 18.100 RCW or equivalent provisions relating to the corporate practice of medicine.

NEW SECTION. **Sec. 4.** A new section is added to chapter 43.72 RCW to read as follows:

The health services commission, after consultation with the insurance commissioner shall adopt rules establishing the sufficiency of the number of practitioners under contract with a health care plan to meet the needs of the health care plan's enrollees. For purposes of this section, the rules adopted shall apply also to medicaid, the department of labor and industries, or any other private or public payer subject to the jurisdiction of the state of Washington.

Sec. 5. RCW 48.43.170 and 1993 c 492 s 431 are each amended to read as follows:

(1) Balancing the need for health care reform and the need to protect health care providers, as a class and as individual providers, from improper exclusion presents a problem that can be satisfied with the creation of a process to ensure fair consideration of the inclusion of health care providers in managed care systems operated by certified health plans. It is therefore the intent of the legislature that the health services commission in developing rules in accordance with this section and the attorney general in monitoring the level of competition in the various geographic markets, balance the need for cost-effective and quality delivery of health services with the need for inclusion of both individual health care providers and categories of health care providers in managed care programs developed by certified health plans.

(2) All licensed health care providers licensed by the state, irrespective of the type or kind of practice, should be afforded the opportunity for inclusion in certified health plans consistent with the goals of health care reform.

The health services commission shall adopt rules requiring certified health plans to publish general criteria for the plan's selection or termination of health care providers. Such rules shall not require the disclosure of criteria deemed by the plan to be of a proprietary or competitive nature that would hurt the plan's ability to compete or to manage health services. Disclosure of criteria is proprietary or anticompetitive if revealing the criteria would have the tendency to cause health care providers to alter their practice pattern in a manner that would harm efforts to contain health care costs and is proprietary if revealing the criteria would cause the plan's competitors to obtain valuable business information.

If a certified health plan uses unpublished criteria to judge the quality and cost-effectiveness of a health care provider's practice

under any specific program within the plan, the plan may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that his or her practice fails to meet and is given a reasonable opportunity to conform to such criteria.

(3)(a) Whenever a determination is made under (b) of this subsection that a plan's share of the market reaches a point where the plan's exclusion of health care providers from a program of the plan would result in the substantial inability of providers to continue their practice thereby unreasonably restricting consumer access to needed health services, the certified health plan must allow all providers within the affected market to participate in the programs of the certified health plan. All such providers must meet the published criteria and requirements of the programs.

(b) The attorney general with the assistance of the insurance commissioner shall periodically analyze the market power of certified health plans to determine when the market share of any program of a certified health plan reaches a point where the plan's exclusion of health service providers from a program of the plan would result in the substantial inability of providers to continue their practice thereby unreasonably restricting consumer access to needed health services. In analyzing the market power of a certified health plan, the attorney general shall consider:

(i) The ease with which providers may obtain contracts with other plans;

(ii) The amount of the private pay and government employer business that is controlled by the certified health plan taking into account the selling of its provider network to self-insured employer plans;

(iii) The difficulty in establishing new competing plans in the relevant geographic market; and

(iv) The sufficiency of the number or type of providers under contract with the plan available to meet the needs of plan enrollees.

Notwithstanding the provisions of this subsection, if the certified health plan demonstrates to the satisfaction of the attorney general and the health services commission that health service utilization data and similar information shows that the inclusion of additional health service providers would substantially lessen the plan's ability to control health care costs and that the plan's procedures for selection

of providers are not improperly exclusive of providers, the plan need not include additional providers within the plan's program.

(4) The health services commission shall adopt rules for the resolution of disputes between providers and certified health plans or other health care plan or payer subject to the jurisdiction of the state of Washington. This shall include the adoption of a rule establishing a uniform credentialing and recredentialing system for health care practitioners providing services to a health care plan, including disputes regarding the decision of a plan not to include the services of a provider.

(5) Nothing contained in this section shall be construed to require a plan to allow or continue the participation of a provider if the plan is a federally qualified health maintenance organization and the participation of the provider or providers would prevent the health maintenance organization from operating as a health maintenance organization in accordance with 42 U.S.C. Sec. 300e.

Sec. 6. RCW 43.72.310 and 1993 c 492 s 448 are each amended to read as follows:

(1) A certified health plan, health care facility, health care provider, or other person involved in the development, delivery, or marketing of health care or certified health plans may request, in writing, that the commission obtain an informal opinion from the attorney general as to whether particular conduct is authorized by chapter 492, Laws of 1993. The attorney general shall issue such opinion within thirty days of receipt of a written request for an opinion or within thirty days of receipt of any additional information requested by the attorney general necessary for rendering an opinion unless extended by the attorney general for good cause shown. If the attorney general concludes that such conduct is not authorized by chapter 492, Laws of 1993, the person or organization making the request may petition the commission for review and approval of such conduct in accordance with subsection (3) of this section.

(2) After obtaining the written opinion of the attorney general and consistent with such opinion, the health services commission:

(a) May authorize conduct by a certified health plan, health care facility, health care provider, or any other person that could tend to lessen competition in the relevant market upon a strong showing that

the conduct is likely to achieve the policy goals of chapter 492, Laws of 1993 and a more competitive alternative is impractical;

(b) Shall adopt rules governing conduct among providers, health care facilities, and certified health plans including rules governing provider and facility contracts with certified health plans, rules governing the use of "most favored nation" clauses and exclusive dealing clauses in such contracts, and rules providing that certified health plans in rural areas contract with a sufficient number and type of health care providers and facilities to ensure consumer access to local health care services;

(c) Shall adopt rules permitting health care providers within the service area of a plan to collectively negotiate the terms and conditions of contracts with a certified health plan or other health care plan subject to state jurisdiction including the ability of providers to meet and communicate for the purposes of these negotiations; and

(d) Shall adopt rules governing cooperative activities among health care facilities and providers.

(3) A certified health plan, health care facility, health care provider, or any other person involved in the development, delivery, and marketing of health services or certified health plans may file a written petition with the commission requesting approval of conduct that could tend to lessen competition in the relevant market. Such petition shall be filed in a form and manner prescribed by rule of the commission.

The commission shall issue a written decision approving or denying a petition filed under this section within ninety days of receipt of a properly completed written petition unless extended by the commission for good cause shown. The decision shall set forth findings as to benefits and disadvantages and conclusions as to whether the benefits outweigh the disadvantages.

(4) In authorizing conduct and adopting rules of conduct under this section, the commission with the advice of the attorney general, shall consider the benefits of such conduct in furthering the goals of health care reform including but not limited to:

(a) Enhancement of the quality of health services to consumers;

(b) Gains in cost efficiency of health services;

(c) Improvements in utilization of health services and equipment;

(d) Avoidance of duplication of health services resources; or

(e) And as to (b) and (c) of this subsection: (i) Facilitates the exchange of information relating to performance expectations; (ii) simplifies the negotiation of delivery arrangements and relationships; and (iii) reduces the transactions costs on the part of certified health plans and providers in negotiating more cost-effective delivery arrangements.

These benefits must outweigh disadvantages including and not limited to:

(i) Reduced competition among certified health plans, health care providers, or health care facilities;

(ii) Adverse impact on quality, availability, or price of health care services to consumers; or

(iii) The availability of arrangements less restrictive to competition that achieve the same benefits.

(5) Conduct authorized by the commission shall be deemed taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(6) With the assistance of the attorney general's office, the commission shall actively supervise any conduct authorized under this section to determine whether such conduct or rules permitting certain conduct should be continued and whether a more competitive alternative is practical. The commission shall periodically review petitioned conduct through, at least, annual progress reports from petitioners, annual or more frequent reviews by the commission that evaluate whether the conduct is consistent with the petition, and whether the benefits continue to outweigh any disadvantages. If the commission determines that the likely benefits of any conduct approved through rule, petition, or otherwise by the commission no longer outweigh the disadvantages attributable to potential reduction in competition, the commission shall order a modification or discontinuance of such conduct. Conduct ordered discontinued by the commission shall no longer be deemed to be taken pursuant to state statute and in the furtherance of the public purposes of the state of Washington.

(7) Nothing contained in chapter 492, Laws of 1993 is intended to in any way limit the ability of rural hospital districts to enter into cooperative agreements and contracts pursuant to RCW 70.44.450 and chapter 39.34 RCW.

NEW SECTION. **Sec. 7.** DEFINITIONS. For purposes of this chapter, unless the context clearly indicates otherwise, the following words have the following meanings:

(1) "Utilization review program" means a system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a health care payer and includes nonprovider programs that contract with health care payers. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review. However, the term does not include the internal programs of health care providers regulated pursuant to Title 18 or 70 RCW or networks of providers owned, operated, and controlled by such providers when performing utilization review functions for the health services they deliver under health care service contracts with payers.

(2) "Managed care plan" means a health care payer subject to the jurisdiction of the state of Washington that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(a) Arrangements with providers selected by the health care plan to furnish health care services;

(b) Organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution; or

(c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the managed care plan.

(3) "Commissioner" means the insurance commissioner.

NEW SECTION. **Sec. 8.** CERTIFICATION REQUIRED. No person shall operate a managed care plan or utilization review program subject to the jurisdiction of the state of Washington unless it has been certified by the commissioner in compliance with this chapter.

NEW SECTION. **Sec. 9.** CERTIFICATION PROCESS--MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS. (1) The commissioner shall establish a process for certification, recertification, and decertification of managed care plans meeting the requirements of section 10 of this act and of utilization review programs meeting the requirements of section 11 of this act. No managed care plan or utilization review program

shall be decertified unless it has first had an adjudicatory hearing consistent with chapter 34.05 RCW.

(2) The commissioner shall establish procedures for the periodic review and recertification of qualified managed care plans and qualified utilization review programs.

(3)(a) If, upon application, the commissioner finds that a national accreditation body establishes a requirement or requirements for accreditation of a managed care plan or utilization review program that are substantially equivalent to requirements established under sections 10 and 11 of this act, the commissioner shall treat a managed care plan or utilization review program thus accredited as meeting the requirements of sections 10 and 11 of this act.

(b) National accreditation bodies may apply directly to the commissioner for such a finding. Denials of such a finding shall be subject to an adjudicatory hearing pursuant to chapter 34.05 RCW.

NEW SECTION. **Sec. 10.** REQUIREMENTS FOR CERTIFICATION--MANAGED CARE PLANS. A managed care plan shall be certified by the commissioner if it meets the following requirements:

(1) Prospective enrollees in managed care plans must be provided information as to the terms and conditions of the plan so that they can make informed decisions about enrolling. All written plan descriptions must be in a readable and understandable format, consistent with standards developed for supplemental insurance coverage under Title XVIII of the social security act. This format must be standardized so that customers can compare the attributes of the plans. Specific items that must be included are:

(a) Coverage provisions, benefits, and any exclusions by category of service, provider, and if applicable, by specific service;

(b) Any and all prior authorization or other review requirements including preauthorization review, concurrent review, postservice review, postpayment review, and any procedures that may lead the patient to be denied coverage for or not be provided a particular service;

(c) Financial arrangements or contractual provisions with hospitals, review companies, providers of health care services that would limit the services offered, restrict referral or treatment options, or negatively affect the providers' fiduciary responsibility

to their patients, including but not limited to financial incentives not to provide medical or other services;

(d) Explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment for coinsurance or other noncovered or out-of-plan services;

(e) Loss ratios for the previous three years of the plan identified by program; and

(f) Enrollee satisfaction statistics, including percent reenrollment and reasons for leaving plan and program.

(2) Plans must demonstrate that they have adequate access to providers, so that all covered health care services will be provided in a timely fashion as defined in rule by the health services commission. This requirement cannot be waived and must be met in all areas where the plan has enrollees, including rural areas.

(3) All plans shall be required to establish a mechanism, with defined rights, under which providers participating in the plan provide input into the plan's medical policy including coverage of new technology and procedures, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

(4) All plans shall have a practitioner-credentialing process that includes the following characteristics:

(a) The process shall begin upon application of a provider to the plan for inclusion.

(b) Each application shall be reviewed by a credentialing committee with appropriate representation of the applicant's clinical specialty.

(c) Credentialing shall be based on objective standards of quality with input from physicians credentialed in the plan and such standards shall be available to applicants and enrollees. When economic considerations are part of the decision, objective criteria must be used and must be available to applicants, participating physicians, and enrollees. Any economic profiling of physicians must be adjusted to recognize case mix, severity of illness, age of patients, and other features of a physician's practice that may account for higher or lower than expected costs. Profiles must be made available to those so profiled.

(d) All decisions shall be made on the record, and the applicant shall be provided with all reasons used if the application is denied or the contract not renewed.

(e) Plans shall not be allowed to include clauses in physician or other provider contracts that allow for the plan to terminate the contract "without cause."

(f) There shall be a due process appeal from all adverse decisions consistent with RCW 48.43.170(4) and rules adopted thereunder. A plan may also use the appeals set forth in the health care quality improvement act of 1986, 42 U.S.C. Sec. 11101-11152.

(g) The same standards and procedures used for an application for credentials shall also be used in those cases where the plan seeks to reduce or withdraw such credentials. Prior to initiation of a proceeding leading to termination of a contract for cause, the physician shall be provided notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by the provider’s regulatory authority or other government agency that effectively impairs the physician’s ability to provide services within the state of Washington.

NEW SECTION. **Sec. 11.** REQUIREMENTS FOR CERTIFICATION--UTILIZATION REVIEW PROGRAMS. A utilization review program shall be certified by the commissioner if it meets the following requirements:

(1) All programs must have a medical director responsible for all clinical decisions by the plan and provide assurances that the medical review or utilization practices they use, and the medical review or utilization practices of payers or reviewers with whom they contract, comply with the requirements of subsection (2) of this section.

(2) Medical review or utilization practices shall comply with the following:

(a) Screening criteria, weighing elements, and computer algorithms utilized in the review process and their method of development, must be released to providers and the public;

(b) Such criteria must be based on sound scientific principles and developed in cooperation with practitioners;

(c) Any person who recommends denial of coverage or payment, or determines that a service should not be provided, based on medical necessity standards, must permit that decision to be reviewed by another practitioner of the same medical specialty within forty-eight hours of that decision, the latter’s decision to prevail over the former if inconsistent;

(d) Each claimant, or provider upon assignment of a claimant, who has had a claim denied as not medically necessary must be provided an opportunity for a due process appeal to a medical consultant or peer review group not involved in the organization that performed the initial review;

(e) Any individual making a negative judgment or recommendation about the necessity or appropriateness of services or the site of service must be a physician licensed to practice medicine in this state;

(f) Upon request, practitioners and patients will be provided the names and credentials of all individuals conducting medical necessity or appropriateness review;

(g) Prior authorization is not required for emergency care, and patient or practitioner requests for prior authorization of a nonemergency service must be answered within two business days, and qualified personnel must be available for same-day telephone responses to inquiries about medical necessity, including certification of continued length of stay;

(h) Plans must ensure that enrollees, in plans where prior authorization is a condition to coverage of a service, are required to sign medical information release consent forms upon enrollment for use where services requiring prior authorization are recommended or proposed by their physician;

(i) When prior approval for a service or other covered item is obtained, it shall be considered approval for all purposes, and the service shall be considered to be covered unless there was fraud or incorrect information provided at the time such prior approval was obtained;

(j) No payer subject to the jurisdiction of the state of Washington shall retroactively disapprove a procedure or site of a procedure as medically necessary after having previously approved or failed to object to the procedure or site of procedure.

NEW SECTION. **Sec. 12.** PATIENT AND PROVIDER MANAGED CARE OPT-OUT PROVISION. Notwithstanding any other provision of law, no health care plan shall prohibit directly or indirectly its enrollees from freely contracting to obtain or provide, respectively, any health care services outside the health care plan on any terms or conditions they choose.

NEW SECTION. **Sec. 13.** PLAN COMPETITION. Any entity functioning as a joint purchaser of health care plan services for more than one purchaser shall offer all health care plans doing business in its catchment area that are regulated pursuant to Title 48 RCW.

NEW SECTION. **Sec. 14.** PROVIDER INCLUSION IN LARGE HEALTH CARE PLANS. Any health care plan with a market penetration as defined in this section of thirty percent or more shall permit any provider to contract to provide services thereunder that agrees to comply with the provider contract and possesses the credentials otherwise required of that kind of provider by the health care plan. For purposes of this section, market penetration for health care plans shall be measured by gross premium revenues or number of enrollees, whichever measure produces the higher penetration. Health care markets shall be the counties of the state of Washington. However, the attorney general may identify additional local markets that are part of counties or are on both sides of a county border where that will lead to a more accurate assessment of a payer's market penetration for these purposes.

NEW SECTION. **Sec. 15.** PLAIN PLAN LANGUAGE. The health services commission shall adopt rules implementing a plain language requirement in the services agreements of all health care payers subject to the jurisdiction of the state of Washington. The commission shall identify the responsible enforcement agency for each type of payer. For purposes of this section the plain language requirement means payers adopting style of prose in drafting their service agreements that, to the maximum extent consistent with precision of expression, is understandable to a person with an average comprehension of the relevant language.

NEW SECTION. **Sec. 16.** CHOICE REQUIREMENTS FOR POINT-OF-SERVICE PLANS. (1) Notwithstanding any other provision of law, nothing shall prohibit a health care payer subject to the jurisdiction of the state of Washington from offering to all eligible enrollees the opportunity to enroll for coverage that permits the enrollee to obtain coverage from nonparticipating providers a point-of-service plan as that term is customarily understood.

(2) As to health maintenance organizations or certified health plans, licensed pursuant to chapters 48.43 and 48.46 RCW, respectively,

the commissioner shall apply the terms of RCW 48.44.030 to the services provided by nonparticipating providers under a point-of-service plan.

(3) All payers subject to the state of Washington shall advise prospective enrollees in their marketing information and all enrollees in some conspicuous manner as to the availability of a point-of-service plan from the payer in connection with the coverage they are considering purchasing or have purchased.

NEW SECTION. **Sec. 17.** LEGISLATIVE FINDINGS. In addition to the findings in section 1 of this act, the legislature finds that:

(1) Health care is a personal and intimate relationship between patients and providers of health care services. There are contending points of view as to appropriate therapeutic approaches, medically safe sites for care, and appropriate training of health care practitioners.

(2) Hospitals are under considerable pressure to fill beds and are turning to giving clinical privileges to nonphysicians. However, physicians are being asked to risk antitrust and malpractice exposure by being involved with the credentialing, supervision, peer review, and backup of nonphysicians with whom they have no voluntary relationship.

(3) This chapter seeks to ensure the patient's freedom of choice consistent with the freedom of various practitioners to compete for patients and the freedom of practitioners to be free from being unfairly exposed to liability because of needing to intervene in care that was managed by another type of practitioner.

(4) This chapter also seeks to guarantee the freedom of hospitals and health care payers to engage in the provision or payment of care only that they believe is safe and cost-effective.

(5) The purpose of this chapter is for the state to regulate competition in this area by mandating that more information be made available in the marketplace in a way that creates real therapeutic choices for patients and also places some, but not all, of the responsibility for those choices on the patient making them.

NEW SECTION. **Sec. 18.** BACKUP RELATIONSHIPS AMONG PRACTITIONERS. Practitioners who must render care to patients with whom they have no care agreement or no backup relationship with the patient's practitioner and are not members of such practitioner's hospital staff will have any malpractice action brought against them arising out of such care adjudicated by a new standard of care imposing liability only

where there is intentional or reckless disregard of the standard of care in the community proven by clear and convincing evidence. The secretary of health may exempt by rule from this subsection unforeseeable health care rendered to persons in different geographic localities from their place of residence.

NEW SECTION. **Sec. 19.** HOSPITAL OBLIGATIONS TO GRANT STAFF MEMBERSHIP AND ADMITTING PRIVILEGES. (1) Hospitals shall not combine practitioners of different licensure into the same hospital staffs without the consent of such practitioners. However, the medical staff shall contain practitioners licensed pursuant to chapters 18.32, 18.57, and 18.71 RCW, but shall not contain other practitioners except on such terms and conditions as the medical staff, as so constituted, by a two-thirds vote accepts.

(2) Subject to subsection (1) of this section, hospitals may create as many staffs as they choose.

(3) No hospital shall require practitioners of another licensure staff to comment on the application, credentials, or conduct of practitioners outside of their staff.

(4) A hospital may require physicians to provide emergency care to patients of practitioners not on the medical staff, but such care will be judged in malpractice actions under the standard contained in section 18 of this act.

NEW SECTION. **Sec. 20.** A new section is added to chapter 70.43 RCW to read as follows:

Nothing contained in this chapter shall be construed to require anything inconsistent with sections 17 through 19 of this act.

NEW SECTION. **Sec. 21.** CAPTIONS. Captions as used in this act constitute no part of the law.

NEW SECTION. **Sec. 22.** CODIFICATION. (1) Sections 1 through 3 of this act shall constitute a new chapter in Title 70 RCW.

(2) Sections 7 through 16 of this act shall constitute a new chapter in Title 48 RCW.

(3) Sections 17 through 19 of this act shall constitute a new chapter in Title 70 RCW.

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