THIS MODIFICATION AGREEMENT made as of the 1st day of April, 1994

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, AS REPRESENTED BY THE MINISTER OF HEALTH

(herein called the "Minister")

OF THE FIRST PART

AND:

INSURANCE CORPORATION OF BRITISH COLUMBIA, a corporation continued pursuant to the Insurance Corporation Act, R.S.B.C. 1979, Chapter 201, and having a head office at 151 West Esplanade, in the City of North Vancouver, Province of British Columbia

(herein called the "Corporation")

OF THE SECOND PART

WHEREAS:

A. The Medical Service Commission which is under the jurisdiction of the Minister has entered into an agreement with the British Columbia Medical Association as of December 21, 1993.

B. Section 4.9 of that agreement provides in part that the Minister will ensure that any charges for MSP beneficiaries involved in motor vehicle accidents are billed to the Corporation.

C. The parties have agreed to amend the agreement between the Minister and the Corporation dated January 21, 1988 (herein called the "Agreement"), a copy of which is attached as Attachment "A" to this modification agreement.

D. The Corporation and the Minister have agreed that the Corporation will amend the mode of payment for MSP accounts for medical practitioners services arising from a motor vehicle accident on an as incurred basis in accordance with the provisions set out in Attachment "B" attached to this modification agreement.

NOW THEREFORE in consideration of the terms and conditions herein contained:

1. The parties hereby mutually agree to delete and replace section 5 and Schedule "B" of the Agreement with the following:

   "5. The Corporation will pay MSP accounts for medical practitioners services arising from a motor vehicle accident on an as incurred basis in accordance with the provisions set out in Schedule "B" attached to and forming part of this agreement."

2. The parties hereto acknowledge and agree that all of the provisions and covenants of the Agreement shall continue in full force and effect save and except where they are expressly modified by this Indenture.

3. This Indenture shall enure to the benefit of and be binding upon the parties hereto and their respective heirs, executors, administrators, successors and assigns.

IN WITNESS WHEREOF the parties have hereunto set their hands as of the date set out below.

Minister of Health or a duly authorized
representative on behalf of HER MAJESTY
THE QUEEN IN RIGHT OF THE PROVINCE OF
BRITISH COLUMBIA

Authorized Signatory

OCTOBER 13, 1994
Date

The Corporate seal of INSURANCE CORPORATION
OF BRITISH COLUMBIA was hereunto affixed in
the presence of:

W.K. McCourt, President and
Chief Executive Officer

C/S

Linda K. Robertson, Corporate Secretary and
General Counsel

October 27/94
Date

CERTIFICATION CLAUSE

This is to certify that the property and/or services ordered/purchased hereby are for the use of and are being purchased by the Insurance Corporation of British Columbia with Crown funds, and are therefore not subject to the Goods and Services tax.

W. K. McCourt, President and
Chief Executive Officer

ATTACHMENT "A" TO MODIFICATION AGREEMENT

THIS AGREEMENT IS DATED FOR REFERENCE THE 21ST DAY OF JANUARY, 1988

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, AS REPRESENTED BY THE MINISTER OF HEALTH

(herein called the "Minister")

OF THE FIRST PART

AND:

INSURANCE CORPORATION OF BRITISH COLUMBIA, a corporation established pursuant to the Insurance Corporation Act, R.S.B.C. 1979, Chapter 201, and having a head office at 151 West Esplanade, in the City of North Vancouver, Province of British Columbia;

(herein called the "Corporation")

OF THE SECOND PART

WHEREAS:

A. The Corporation makes payments to the Minister with respect to the costs of health related services provided to claimants by the Minister, and arising from injuries caused by motor vehicle accidents; and,

B. The parties desire to enter into an Agreement in order to simplify administrative procedures, reduce administrative costs, and create greater certainty with respect to payments from the Corporation to the Minister.

NOW THEREFORE in consideration of the terms and conditions herein contained, the parties agree as follows:

1.0 DEFINITIONS

1.1 "Accident Benefit Claim" means those medical payments which the Corporation is required to pay under Part 7 of the Insurance (Motor Vehicle) Act Regulations.

1.2 "Bodily Injury Claim" means a claim involving bodily injury where the Corporation is liable to make payment to a claimant under Part 6 of the Insurance (Motor Vehicle) Act Regulations.

1.3 "Claimant" means a person entitled to medical benefits or indemnity pursuant to the Hospital Insurance Act or Medical Service Act or Health Emergency Act, and pursuant to the Insurance (Motor Vehicle) Act.

1.4 "Closed With Amount" means a payment has been made by the Corporation to a Claimant for a Bodily Injury Claim or Accident Benefit Claim.

1.5 "Fiscal Year" means April 1st to March 31st of the following year.

1.6 "Inpatient Services" means those inpatient hospital services provided to Claimants who remain in hospital overnight, and includes day care surgical services.

1.7 "Limitation Period" means, for a Bodily Injury Claim, the period set out in section 76 of the Insurance (Motor Vehicle) Act Regulations.

1.8 "Minister" means the Minister of Health, the Deputy Minister of Health, any person designated by either of them to act for or on their respective behalf with respect of the provisions of this Agreement, and for this Agreement, the Minister shall be deemed to act on behalf of the Medical Services Commission and the Emergency Health Services Commission.

1.9 "Outpatient Service" means those outpatient hospital services provided by hospital emergency and outpatient departments to Claimants leaving hospital the same day, but does not include day care surgical services.

1.10 "Per diem rate" means the daily rate, as set out in Schedule A, payable by the Corporation to the Minister for any hospital in the Province.

2.0 TERM

2.1 Notwithstanding the date of execution and delivery of this Agreement, the term of this Agreement (the "Term") will be deemed to have commenced on April 1, 1987, and will end on ninety (90) days written notice by either party according to paragraph 10.

2.2 All payments made by the Corporation to the Minister prior to the date of execution of this Agreement shall be deemed to have satisfied the payment obligations of the Corporation and shall not be governed by this Agreement.

3.0 SETTLEMENT PAYMENTS FOR INPATIENT SERVICES

3.1 Subject to the provisions of this section, the Corporation shall pay to the Minister the cost of past and future Inpatient Services for Bodily Injury Claims according to the percentage of liability established by the Corporation for each Bodily Injury Claim at the rate, and in the manner, set out in Schedule A.

3.2 The Corporation shall not be required to make any payment to the Minister where the Limitation Period has expired for a Bodily Injury Claim by a Claimant against the Corporation.

3.3 The Corporation is not required to make any payment to the Minister in excess of the insurance coverage limits available to the Claimant under the Insurance (Motor Vehicle) Act and an applicable Owner's Certificate of Insurance issued pursuant to the Insurance (Motor Vehicle) Act.

3.4 Where the Corporation is required to make payment under section 20 of the Insurance (Motor Vehicle) Act to a Claimant, the Corporation will pay the Minister in the same manner as described in paragraph 3.1, notwithstanding that the Claimant is in breach of his insurance policy.

3.5 The Minister shall be reimbursed for Inpatient Services at the per diem rate set out in Schedule A, or, if the services were rendered prior to the commencement of this Agreement, at the per diem rate in effect for the hospital at the time the hospital services were rendered.

4.0 SETTLEMENT PAYMENTS FOR OUTPATIENT SERVICES

4.1 After each month during the Term, the Corporation shall pay to the Minister, with respect to the cost of Outpatient Services, one and one-half (1.5%) percent of the amount paid for Inpatient Services for that month, as set out in section 3 of this Agreement. The Minister shall advise the Corporation of the amount to be paid under this paragraph.

5.0 SETTLEMENT PAYMENTS FOR MEDICAL PRACTITIONER SERVICES

5.1 After each month during the Term, the Corporation shall pay to the Minister the cost of services rendered by medical practitioners under the Medical Services Plan, at the rates set out in Schedule B for each Bodily Injury Claim Closed With Amount by the Corporation.

5.2 The Corporation will notify the Minister after each month of the number of Bodily Injury Claims Closed With Amount during that month.

5.3 The amount set out in Schedule B will be adjusted by the parties in accordance with the percentage of any increase or decrease in the payment schedule for medical practitioners under the Medical Services Plan.

6.0 SETTLEMENT PAYMENTS FOR AMBULANCE SERVICES

6.1 After each month during the Term for each Bodily Injury Claim Closed with Amount for which an ambulance was required, the Corporation shall pay to the Minister the cost of ambulance services for Claimants at the rate set out in Schedule C, less the basic ambulance user fee in effect at the date of the motor vehicle accident.

6.2 An adjustment to the amounts paid by the Corporation under paragraph 6.1 shall be made following each Fiscal Year in accordance with the actual average cost per trip, as and when calculated by the Minister, for the preceeding Fiscal Year.

6.3 The total number of ambulance trips paid by the Corporation for Accident Benefit Claims will be determined by dividing the basic ambulance user fee in effect at the date of the motor vehicle accident into the monthly Accident Benefit Claims expense of the Corporation for ambulance user fees.

6.4 The number of ambulance trips for Bodily Injury Claims payable by the Corporation to the Minister will be determined by taking the ratio of Bodily Injury Claims Closed With Amount to Accident Benefit Claims Closed With Amount, using a 12-month moving average, and multiplying it by the total number of ambulance trips, calculated under paragraph 6.3.

7.0 SETTLEMENT PAYMENTS FOR CHIROPRACTIC, MASSAGE, AND PHYSIOTHERAPY

7.1 After each month during the Term, the Corporation shall reimburse the Minister for the cost of chiropractic, massage, and physiotherapy treatments which were paid by the Minister and approved by the Corporation as Bodily Injury Claims. In the case of Accident Benefit Claims, the Corporation shall reimburse the Minister for those treatments which exceed the coverage available to the Claimant under the Medical Services Plan.

7.2 The Minister shall notify the Corporation each month of the number of chiropractic, massage and physiotherapy treatments given to Claimants for the previous month.

8.0 PAYMENT DISCHARGES OBLIGATION

8.1 Payment by the Corporation under sections 3, 4, 5, 6, and 7 of this Agreement discharges the Corporation's obligations to the Minister for the cost of any hospital, ambulance or medical services arising out of any Bodily Injury Claims which have been closed or settled pursuant to the terms of this Agreement.

8.2 Nothing in this Agreement shall apply to any cause of action other than a cause of action arising out of the ownership, use, or operation of a motor vehicle or a trailer which was, on the date that the cause of action arose, licensed for operation in British Columbia and then only to the extent that the loss or damage giving rise to the cause of action is insured against by the Corporation, except where the Corporation is responsible for payment pursuant to section 20 of the Insurance (Motor Vehicle) Act.

9.0 AUDIT

9.1 Subject to any confidentiality provisions of any statute, the Corporation and the Minister will exchange documents and working papers necessary to verify the relevant data required for this Agreement.

10.0 TERMINATION

10.1 In the event of any termination, then subject to paragraph 8.1, which will survive the termination of this Agreement, the Minister may exercise any rights of subrogation as though this Agreement had not been in effect.

10.2 Any rights and obligations of the Minister and the Corporation under this Agreement in existence at the date of any termination may be enforced and shall be discharged as though there had been no termination, and in particular and without restricting the generality of the foregoing, paragraph 9.1 continues to apply.

11.0 NOTICES

11.1 Any notice, payment, or any material that either party may be required or desire to give or deliver to the other will be deemed validly given or delivered to and received by the addressee, if transferred electronically on the date of such transfer, or if delivered personally, on the date of such personal delivery or, in the event of a postal disruption, on the date actually received by the addressee or, if mailed, on the fifth (5th) business day after mailing in British Columbia by prepaid-post addressed, if to the Minister, to:

Deputy Minister
Ministry of Health
1515 Blanshard Street
Victoria, British Columbia
V8W 3C8

and, if to the Corporation, to:

Vice-President - Claims
Insurance Corporation of British Columbia
151 West Esplanade
North Vancouver, British Columbia
V7M 3H9

11.2 For the purposes of paragraph 11.1, either party may, from time to time, advise the other by notice in writing of any change of address of the party giving such notice.

12.0 VALIDITY AND INTERPRETATION

12.1 All agreements and covenants contained herein are severable, and in the event that any of them shall be held to be illegal, unenforceable or invalid by any competent court, this Agreement shall be interpreted as if such illegal, unenforceable or invalid agreement or undertaking was not contained herein.

12.2 This Agreement shall be governed by the laws of the Province of British Columbia.

12.3 Wherever the singular or masculine is used in this Agreement, it will be construed as if the plural or feminine or neuter, as the case may be, has been used where the context or the parties hereto so require.

12.4 The schedules to this Agreement shall form an integral part of this Agreement.

13.0 ENTIRETY

13.1 This Agreement and attached schedules constitute the entire agreement between the parties, and no understandings or agreements, oral or otherwise, exist between the parties except as expressly set out in this Agreement.

14.0 WAIVER

14.1 No provision of this Agreement and no breach by either party of any such provision will be deemed to have been waived unless such waiver is in writing and signed by the parties hereto.

14.2 The written waiver by the parties of any breach of any provision of this Agreement by a party shall not be deemed a waiver of such provision for any subsequent breach of the same or any other provision of this Agreement.

15.0 AMENDMENTS

15.1 Notwithstanding any other provision of the Agreement, the parties may, at any time by mutual agreement in writing and signed by the parties hereto, amend this Agreement.

16.0 TRANSFER OF AGREEMENT

16.1 Neither party hereto may assign or transfer any of its rights or obligations under this Agreement without the prior written consent of the other party first having been obtained.

17.0 SUCCESSORS AND ASSIGNS

17.1 This Agreement shall enure to the benefit of and be binding upon the parties hereto, and their respective successors and permitted assigns.

IN WITNESS WHEREOF the parties hereto have executed this Agreement on the day and year first above written.

SIGNED BY the Minister of Health or a duly authorized representative on behalf of HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA

M.A. Moffatt
Witness

MINISTER OF HEALTH
or representative

The Corporate Seal of the INSURANCE CORPORATION OF BRITISH COLUMBIA was hereunto affixed by its duly authorized officers.

J.W. BARDUA
Vice-President - Claims

C/S

H.G. REID
Vice-President, General Counsel and Secretary

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2. The "per diem rate" payable by the Corporation, for the purpose of this Agreement, is defined as the average of hospital per diem rates as determined by the Minister. As per Schedule A Attachment 1, the Corporation will continue to be responsible for payment of a 35% surcharge for Inpatient Services and Outpatient Services. The per diem rate payable by the Corporation, inclusive of the 35% surcharge, will be:

Fiscal year 1987 - 1988	
Acute Care Hospitals	$540.00
Rehabilitation Care Hospitals	$353.70
Extended Care Hospitals	$137.70

The per diem rates in subsequent fiscal years will be adjusted in accordance with the per diem rates established by the Minister for those years.

SCHEDULE B

SETTLEMENT PAYMENTS FOR MEDICAL PRACTITIONER SERVICES

Fiscal year	1985 - 1986 base year	$ 197.90
	1986 - 1987 (+2%)	$ 201.86
	1987 - 1988	$ 201.86

SCHEDULE C

SETTLEMENT PAYMENTS FOR AMBULANCE SERVICES

Fiscal year	1985 - 1986	$ 230.18
	1986 - 1987	$ 312.00

The rate in subsequent fiscal years will be established by the Minister.

ATTACHMENT "B" TO MODIFICATION AGREEMENT

SCHEDULE "B" TO AGREEMENT

ICBC will pay MSP accounts for medical practitioner services arising from a motor vehicle accident on an as incurred basis. ICBC will pay ICBC claims in accordance with ICBC business rules as follows:

1. The Corporation will pay on an as incurred basis medical practitioner fees for services under the current MSP schedule on all qualified accounts where the date of loss for the claim occurs on or after April 1, 1994. All accounts for claims which have a date of loss prior to April 1, 1994 will be paid as follows:

   (a) such accounts will continue to be paid at the rate of $246.30 for each Bodily Injury Exposure Closed with Amount by the Corporation;

   (b) the Corporation will notify the Minister after each month of the number of Bodily Injury Exposures Closed with Amount during that month.

2. A qualified account shall mean an account for a medical practitioner services arising out of a motor vehicle accident for which a valid claim has been opened with the Corporation and for which a valid customer claim number exists. Arising from a motor vehicle accident means that the medical practitioners dominant purpose for rendering service is directly related to injuries or damage suffered as a result of a motor vehicle accident.

   Each account must:

   (a) be coded "MVA";
   (b) reference a specific practitioner number;
   (c) contain the appropriate injury coding.

3. The Corporation will pay for medical practitioner service fees, in accordance with the provisions of this schedule, incurred as an Accident Benefit Claim or as a Bodily Injury Claim.

4. The right of Minister to recover payment of a qualified account shall not exceed the rights of the claimant. In other words limitation periods, policy limits and other factors which limit a claimant's right to compensation from the Corporation will impose the same limitations on the right of the Minister to claim reimbursement from the Corporation.

   Further, the Corporation will not be liable for the payment of any account where the claimant has not formally made a service request and opened a claim file with the Corporation.

5. The Corporation shall make payment of qualified accounts to the Minister in the following manner. Medical Services Plan (MSP) will process and pay all accounts received by medical practitioners in accordance with MSP normal editing and adjudication procedures. MSP will then identify those which are qualified accounts which meet the requirements of paragraph 2 above and forward these accounts to the Corporation.

   The Corporation will then review each submission and determine whether or not in fact it meets the requirements of a qualified account. If the submission does meet the requirements of a qualified account, then the Corporation shall pay that account within 60 days of receipt of that account. If the submission does not, in the opinion of the Corporation, meet the requirements of a qualified account then that account will be returned to MSP within 90 days of receipt of that account.

6. Medical practitioners shall not be entitled to or permitted to direct bill the Corporation. The Ministry will ensure that it does not in any manner enter into an agreement to allow such direct billing.

7. On Bodily Injury Claims the Corporation will pay for medical practitioner services from the date of loss to the date of settlement, judgment or other final disposition of the file. In Bodily Injury Claims where there has been settlement or judgment, the Corporation will not make payment for medical practitioner services incurred after that settlement or judgment even though the injured party may still be using medical practitioner services after the settlement.

8. For Accident Benefit Claims the Corporation will pay for medical practitioner services from the date of loss to closure of the Accident Benefit Claim file in one of the following ways:

   (a) obtaining a release or settlement at the same time as the Bodily Injury Claim is released or settled;

   (b) obtaining a separate release or settlement or judgment of the Accident Benefit Claim; or

   (c) two years after the last payment has been made on the Accident Benefit Claim file.

9. The Corporation will require an identifiable audit trail to ensure that each payment in fact arises as a result of a motor vehicle accident. The Corporation and MSP shall enter into an agreement in a form mutually acceptable to the parties to establish procedures to provide the Corporation with such an audit trail.

10. The Corporation will pay at the medical practitioners fee for services under the MSP "Schedule Then In Effect" on the date on which the service is rendered. Provided that when there is an increase in the MSP schedule rate during the term of the agreement, the Corporation will pay the new rate effective the date of the MSP system update of the new rates. The old rate will be deemed to be the MSP "Schedule Then In Effect" for the purposes of this agreement until the effective date of the new MSP rate.

    MSP will keep the Corporation fully advised of any future increases in the plan including retroactivity so that the Corporation may adjust its reserves and plan its rates accordingly.

11. The Corporation and MSP shall enter into an agreement in a form mutually acceptable to the parties to protect the confidentiality of Personal Health Numbers provided by the Minister to the Corporation.

MOTOR VEHICLE ACCIDENT RELATED HEALTH COSTS AGREEMENT

This Agreement is dated for reference the 1st day of January, 2004.

BETWEEN:

HER MAJESTY THE QUEEN in Right of the Province of British Columbia, as represented by the Ministry of Health Services, 1515 Blanshard Street, Victoria, BC V8W 3C8

(the "Ministry")

AND:

INSURANCE CORPORATION OF BRITISH COLUMBIA
151 West Esplanade, North Vancouver, BC V7M 3H9

("ICBC")

WHEREAS:

A. ICBC makes payments to the Ministry for the costs of health related services arising from injuries caused by motor vehicle accidents pursuant to an agreement made between the parties dated for reference January 21, 1988 and modified by a modification agreement made as of April 1, 1994 (collectively, the "Previous Agreement"); and

B. The parties want to enter into a new agreement in replacement of the Previous Agreement in order to simplify administrative procedures, to establish a Liaison Committee, and to create greater certainty as to their respective rights and obligations.

NOW THEREFORE in consideration of the terms and conditions contained in this Agreement, the parties agree as follows:

1. Definitions

1.1 "**Accident Benefit Claim**" means a claim for medical payments that ICBC is required to pay under Part 7 of the *Revised Regulation (1984) Under the Insurance (Motor Vehicle) Act* (the "Regulation"), as the same may be revised from time to time.

1.2 "**Ambulance Services**" means emergency pre-hospital treatment and any transport of a Claimant or an Insured required as a direct result of a motor vehicle accident.

1.3 "**Bodily Injury Claim**" means a claim where ICBC is liable to make payment to a Claimant under Part 6 of the Regulation.

1.4 "**Claimant**" means a person with a Bodily Injury Claim.

1.5 "**Inpatient Services**" means inpatient hospital services provided to a Claimant who remains in hospital overnight, and includes daycare surgical services.

1.6 "**Insured**" means a person with an Accident Benefit Claim.

1.7 "**Limitation Period**" means in the case of a Bodily Injury Claim, 2 years from the date of the motor vehicle accident with respect to which the Bodily Injury Claim was made or, in the case of an Accident Benefit Claim, the later of the date of the motor vehicle accident with respect to which the Accident Benefit Claim was made or the date the last medical payment was paid under Part 7 of the Regulation with respect to such motor vehicle accident.

1.8 "**Medical Practitioner**" means a person lawfully entitled to practice medicine under the *Medical Practitioners Act.*

1.9 "**Ministry**" means the Deputy Minister of Health Services or any person designated by him or her to act for or on his or her behalf with respect to the provisions of this Agreement, and for this Agreement. For this Agreement, the Deputy Minister shall also be deemed to act on behalf of the Medical Services Commission and the Emergency Health Services Commission.

1.10 "**Outpatient Services**" means those outpatient hospital services provided by hospital emergency and outpatient departments to Claimants leaving the hospital the same day as they are admitted, but does not include day care surgical services.

1.11 "**Per Diem Rate**" means the Inpatient Services rates in Schedule "A". Inpatient Services rates are calculated by taking a weighted average of hospital standard ward rates in effect as at the date the Inpatient Services are rendered and the number of motor vehicle related hospital days from the Ministry's preceding fiscal year and adding a 35% surcharge. The "hospital standard ward rates" are those set by the Interprovincial Health Insurance Agreements Coordinating Committee established under the Canada Health Act.

1.12 "**Qualified Account**" means an account:

(a) for which a valid Accident Benefit Claim or Bodily Injury Claim shall have been opened with ICBC, for which a valid customer claim number exists, and, in the case of an Accident Benefit Claim, for which an insured has not been held to be in breach under the provisions of the *Insurance (Motor Vehicle) Act* or the *Revised Regulation (1984) under the Insurance (Motor Vehicle) Act*, as the same may be amended from time to time, or under any replacement legislation,

(b) for which the Medical Practitioner's dominant purpose for rendering service is directly related to injuries suffered as a result of a motor vehicle accident,

(c) that includes the following information:

(i) coded "MVA" to indicate motor vehicle accident,

(ii) a Medical Services Plan specific Medical Practitioner billing number,

(iii) the appropriate diagnostic/injury coding,

(iv) a valid Personal Health Number,

(v) not be coded "WCB" to indicate Workers Compensation Board, and

(vi) when available, an account should contain a valid ICBC claim number;

(d) that has not received a refusal code as identified in Schedule **B**; and

(e) that has not been closed as a result of a release, settlement or judgment being obtained or as a result of the expiry of the Limitation Period.

2. Term

2.1 The term of this Agreement (the "Term") is January 1, 2004, and will end on 90 days written notice by either party to the other.

2.2 This Agreement will apply to payments which are made on or after January 1, 2004 for services rendered as a result of motor vehicle accidents.

3. **Inpatient Services**

3.1 Subject to the provisions of this section and pursuant to the Per Diem Rate set out in Schedule "A", ICBC agrees to reimburse the Ministry for the cost of Inpatient Services for Bodily Injury Claims that arise:

(a) within the Limitation Period; or

(b) within 30 days from the resolution of a Bodily Injury Claim by settlement or final judgment of a court of competent jurisdiction; or

(c) from Inpatient Services rendered after a resolution as set out in subparagraph (b) where the settlement or final judgment contemplated that future services may be required,

and in case pro rated according to the percentage of liability and percentage of contributory negligence established by ICBC for each Bodily Injury Claim, provided that:

(d) coverage limits for the Bodily Injury Claim are available under Part 6 of the Regulation,

(e) where ICBC is required to make payment under section 21 of the *Insurance (Motor Vehicle) Act* to a Claimant, ICBC will pay the Ministry in the same manner as described in paragraph 3.1 notwithstanding that the insured as that term is defined in Part 6 of the *Insurance (Motor Vehicle) Act* is in breach of their insurance policy;

(f) the cost relates to Qualified Account; and

(g) ICBC will have no liability to pay until such time as ICBC has determined that the claimant was not liable for the motor vehicle accident and a payment on the claim file has actually been made.

3.2 Where Inpatient Services are rendered which qualify for payment under paragraph 3.1, ICBC agrees to pay the Ministry for Inpatient Services for Bodily Injury Claims within 30 days of ICBC notifying the Ministry of such services being rendered. ICBC will notify the Ministry of Inpatient Services being rendered for Bodily Injury Claims as soon as is reasonably practicable after it becomes aware of such services being rendered for a Bodily Injury Claim.

3.3 Where coverage limits under Part 6 of the Regulation are not available with respect to a Bodily Injury Claim or have been exceeded, ICBC will provide the Ministry with notice of such Bodily Injury Claims, identified by BC Hospital Case number and the Claimant's name. The Ministry will refund to ICBC within a reasonable time any amounts paid by ICBC with respect to such Bodily Injury Claims to the extent that such payments exceed the available coverage limits, or, if the parties agree, offset the amount of any refund against future payments.

4. Outpatient Services

4.1 ICBC agrees to pay to the Ministry for Outpatient Services 1.8% of the amount paid by ICBC to the Ministry for Inpatient Services each month.

4.2 The Ministry will invoice ICBC for Outpatient Services on a monthly basis and ICBC agrees to pay the Ministry within 30 days of receipt of an invoice for Outpatient Services from the Ministry.

5. Ambulance Services

5.1 ICBC agrees to:

(a) reimburse the Ministry the basic ambulance rate pursuant to the Health Emergency Act/Health Emergency Regulation for Claimants and Insureds with Qualified Accounts, and

(b) contribute to the fair and reasonable cost of Ambulance Services for Claimants by paying the Ministry $596.00 for each Bodily Injury Claim pro rated to the percentage of liability and percentage of contributory negligence established by ICBC, less the basic ambulance rate in effect at the date of the motor vehicle accident paid pursuant to paragraph 5.1(a).

5.2 ICBC agrees to pay the Ministry on a bi-weekly basis for Ambulance Services for invoiced amounts payable in accordance with paragraph 5.1. Within 180 days of the Ministry's fiscal year end, ICBC and the Ministry will reconcile the accuracy of the Ambulance Services invoices received by the Ministry in that fiscal year, and ICBC will pay to the Ministry the amount of any underpayment or the Ministry will repay to ICBC any overpayment, as the case may be, within 30 days of the reconciliation being completed to the satisfaction of both parties. For greater certainty, invoices do not have to be received by the Ministry in the same fiscal year in which services were rendered in order to be subject to this provision. Any invoices received by the Ministry in a fiscal year following the one in which the services were rendered will be included in the reconciliation for the fiscal year in which the invoices were received.

6. Medical Practitioners

6.1 Subject to paragraph 6.2, ICBC agrees to pay Medical Practitioner service fees to the Ministry where the Medical Practitioner service fees are:

(a) for services covered by and rendered in accordance with the Medical Service Commission ("MSC") Payment Schedule in effect on the date on which the services are rendered,

(b) incurred as an Accident Benefit Claim, which arises directly as a result of a motor vehicle accident, and

(c) with respect to a Accident Benefit Claim Qualified Account.

6.2 ICBC's liability to pay Medical Practitioner service fees under paragraph 6.1 is at the rates set out in the MSC Payment Schedule in effect as of March 31, 2004 (the "Current Schedule"). In the event that a new MSP Payment Schedule (the "New Schedule") comes into effect which increases fees payable under the Current Schedule, ICBC will be liable to pay the difference between the fee set out in the New Schedule and what it has actually paid under the Current Schedule, only if:

(a) the fee increase has been agreed to by the Ministry and the BCMA and is incorporated into the MSC system update,

(b) the British Columbia Utilities Commission ("BCUC") approves basic insurance rates which include recovery of the amount of such difference and then only to the extent of and subject to the terms and conditions of that approval by the BCUC. ICBC will have the sole discretion to determine when an application for approval of basic insurance rates will be made. ICBC will not be obligated to include in a pending application to approve basic rates the amount referred to in subparagraph (a) where ICBC receives notice of the New Schedule less than 90 days in advance of such rate application, but ICBC's liability as set out herein will be deferred to the next following basic insurance rate application. For greater certainty, ICBC's receipt of a notice under this paragraph does not obligate ICBC to make immediate application for basic insurance rates;

In the event of second or subsequent increases to Medical Practitioner service fees during the term of this Agreement, the provisions of this paragraph will apply, amended as necessary to provide that the "Current Schedule" is the schedule in effect immediately prior to the second or subsequent increase and that "New Schedule" is the schedule setting out the second or subsequent increase as the case may be.

6.3 Without in any way limiting the generality of paragraph 6.2, ICBC's liability to pay Medical Practitioner service fee increases retroactively is limited to a period of up to, but not greater than, 9 months in circumstances notwithstanding that a contract between the Ministry and the BCMA requires the Ministry to pay the BCMA retroactively for a period of 9 months or greater. The Ministry recognizes the impact that changes to Medical Practitioner fees have on ICBC, and is agreeing to this limitation to enable ICBC to effectively assess the impact on reserves and rate setting. ICBC agrees that the Ministry may apply retroactive fee increases permitted under this Agreement on a claim-by-claim or lump sum basis. In

the case of a lump sum retroactive payment, the Ministry agrees to provide ICBC with the necessary data to assist ICBC in its reconciliation.

6.4 The Ministry or its service provider will use the TELEPLAN electronic claims billing system or its successor system to process all Qualified Accounts on behalf of ICBC.

6.5 The Ministry or its service provider will process and pay all Medical Services Plan fee for service claims received from Medical Practitioners in accordance with the Medical Services Plan's normal editing and adjudication procedures. The Ministry or its service provider will then identify those Medical Services Plan claims identified as motor vehicle accident related and electronically forward those Medical Services Plan claims to ICBC on a bi-weekly basis. ICBC will then review each Medical Services Plan claim to determine whether it is a Qualified Account and will pay Medical Services Plan claims for Qualified Accounts within 60 days of receipt of the Medical Service Plan claims from the Ministry. If, in the sole opinion of ICBC, the Medical Services Plan claim is not a Qualified Account, then such Medical Services Plan claim will be returned unpaid to the Ministry within 90 days of receipt of that claim.

6.6 ICBC agrees to pay for Medical Practitioner services only from the date of loss to the date on which the following occurs with respect to an Accident Benefit Claim file:

(a) a release, settlement, or judgment is obtained, or

(b) 2 years has elapsed since the last payment has been made by ICBC on the Accident Benefit Claim.

6.7 The ability of the Ministry to recover payment of a Qualified Account from ICBC will not exceed the rights of the Claimant or the Insured, as applicable.

6.8 The Ministry and ICBC will not permit Medical Practitioners to bill ICBC directly for services covered by the Medical Services Plan.

6.9 Ministry agrees to provide ICBC with the following notifications:

(a) 90 days written notice prior to expiry of any contract or contracts that the Ministry has entered into with the BC Medical Association ("BCMA");

(b) as soon as practicable, inform ICBC to the status of contract negotiations with BCMA including any offers which may have a financial impact on ICBC; and

(c) on a best efforts basis, advise ICBC within 30 days of any changes to Medical Practitioner fees or changes to the services covered by the Medical Services Plan so that ICBC can assess the impact of those changes on reserves and premiums.

7. ICBC Payment

7.1 ICBC will not be liable to pay the Ministry for Inpatient Services, Outpatient Services, Ambulance Services, or Medical Practitioners except as set out in this Agreement.

7.2 Without limiting any other provision in this Agreement, the Ministry's right to receive any payments under this Agreement shall not exceed the rights of the Insured or the Claimant, and the Ministry specifically acknowledges and agrees that limitation periods, policy limits and other factors which limit an Insured's or a Claimant's right to payment or compensation from ICBC will apply to the Ministry's right to payment from ICBC and ICBC's liability to make such payments.

8. Confidentiality

8.1 ICBC and the Minister will comply with all confidentiality and privacy policies of ICBC and legislation of the Province of British Columbia (as amended by the Province of British Columbia from time to time), including but not limited to, the *Freedom of Information and Protection of Privacy Act*, R.S.B.C. 1996, Chapter 165 ("FOIPPA") and including all obligations for the protection of personal information which are imposed on a public body under FOIPPA.

8.2 The Ministry acknowledges that ICBC is subject to the obligations to provide information to the British Columbia Utilities Commission set out under the *Insurance Corporation Act* ("ICA") and the *Utilities Commission Act* ("UCA"). The Ministry will comply with any requirement, order, direction or decision of the BCUC with respect to document disclosure.

9. Notices

9.1 All notices and communications required or permitted under this Agreement must be in writing and sent by mail or courier to the appropriate party at its address on the first page of this Agreement and to the attention of the person noted below, or such other address as a party may give notice of in writing. Any such notice will be deemed to be given to and received by the addressee on the date of delivery in the case of delivery by courier or, in the case of mailing, on the fifth business day after the date mailed.

ICBC:
Attention Manager, Bodily Injury Support and Technical Services Department

Ministry:
Attention Executive Director, Finance and Decision Support

10. Liaison Committee

10.1 ICBC and the Ministry agree to establish a liaison committee (the "Liaison Committee") to:

(a) foster knowledgeable and meaningful exchange of information between the parties, including actual or anticipated policy changes;

(b) review this Agreement as and when necessary, but at least once every two years, to determine and recommend any necessary amendments to ensure continuing administrative efficiency and accurate reflection of the parties' rights and obligations;

(c) supplement the timely notification from the Ministry to ICBC of changes to rates as provided for by this Agreement; and

(d) review and recommend proposed changes to rates paid under this Agreement and to establish a mechanism to implement any agreed changes to rates where not otherwise dealt with under this Agreement, provided that no such changes are effective unless and until the parties agree to the changes by amending this Agreement in writing.

10.2 ICBC and the Ministry will agree on the membership of the Liaison Committee, its terms of reference, work product and timelines by way of a separate Letter Agreement. The parties agree that the Liaison Committee will have the authority to establish working committees to assist the Liaison Committee.

11. Rates and Audit Trail

11.1 The Ministry will ensure that any rate it charges to ICBC is the same or less than the rate the Ministry charges to any other automobile insurers that carry on business in British Columbia.

11.2 The Ministry will provide ICBC with an identifiable audit trail to ensure that each account arises solely as a result of a motor vehicle accident.

11.3 Subject to FOIPPA, ICBC and the Ministry will exchange information, documents and working papers necessary to verify the relevant data required for this Agreement. Such information, documents and working papers include, but are not limited to, the manner in which fees are established or changed and the manner in which covered services for Medical Practitioners are changed.

12. Dispute Resolution

12.1 Any new issue, matter of general concern or dispute arising from this Agreement will be first directed to the designated representatives listed below for resolution and if not then resolved within 30 days, it will be a matter of consultation and resolution between Deputy Minister, Ministry of Health Services and the ICBC President & CEO in such manner as they see fit. The designated representatives are:

For the Ministry:	Deputy Minister
For ICBC:	Vice President, Claims

13. Termination

13.1 Either party may terminate this Agreement upon 90 days written notice to the other party.

14. Federal Goods and Services Tax

14.1 ICBC certifies that the products and services supplied by the Ministry under this Agreement are for the use of ICBC and are being acquired by ICBC with Crown funds, and are therefore not subject to the Federal Goods and Services Tax.

15. Interpretation

15.1 In this Agreement, unless expressly provided or the context otherwise requires, words importing the masculine gender include the feminine and neuter gender and vice versa, and words in the singular include the plural and vice versa.

15.2 This Agreement shall be governed by the interpreted in accordance with the laws of the Province of British Columbia.

15.3 The invalidity of any particular provision of this Agreement shall not affect any other provision and the Agreement shall be read as if such invalid provision were omitted.

15.4 This Agreement constitutes the entire agreement between the parties. It can be amended only by a written agreement signed by both parties. There are no representations or agreements now existing that are not contained in this Agreement.

15.5 The headings in this Agreement have been included for convenience of reference only, do not form part of this Agreement, and are not intended to interpret, define or limit the scope or meaning of this Agreement or any of its provisions.

15.6 This Agreement shall enure to the benefit of and be binding upon the parties and their successors and permitted assigns.

15.7 Time is of the essence of this Agreement in all respects.

Signed by the parties as of the date set out at the beginning of this Agreement.

INSURANCE CORPORATION OF BRITISH COLUMBIA:
Per:

_____
Paul Taylor
President and Chief Executive Officer

HER MAJESTY THE QUEEN in right of the Province of British Columbia as represented by the **Ministry of Health Services**:
Per:

_____
Name:
Title:

SCHEDULE "A"

Inpatient Services

	Weighted Average Standard Ward Rate	35% Surcharge	Per Diem Rate
Acute Care – to June 30, 2004	$997.	$349.	$1,346.
Acute Care – July1, 2004 forward	$1,054.	$369	$1,423.
Rehabilitation Care – to June 30, 2004	$1,414.	$495.	$1,909.
Rehabilitation Care – July 1, 2004 forward	$1,516.	$531	$2,047.
Extended Care – to June 30, 2004	$210.	$74.	$284.
Extended Care – July 1, 2004 forward	$217	$76	$293.
Surgical Day Care – to June 30, 2004	$540.	$540.	$540.
Surgical Day Care – July 1, 2004 forward	$400	$140	$540.

Formula:

The Number of Hospital days stay multiplied by the applicable Per Diem rate.

SCHEDULE "B"

Refusal Codes

Code	MSP Message
001*	Invalid MVA - No Injury Claim
002	PHN Invalid for ICBC Number
003*	Invalid MVA - WCB Claim
004*	Breach of ICBC Coverage
005*	Services Exceed ICBC Limit
006	Payment. Suspended - Contact Claimant
007*	Service Date After Settlement
008	Invalid Service for MVA
009	MVA prior to April 1, 1994
010	Service date before accident date
020*	(No message to MSP)

FINAL
OCTOBER 1, 1993

MASTER AGREEMENT

THIS AGREEMENT made the 21 day of Dec ~~October~~, 1993.

BETWEEN:

GOVERNMENT OF THE PROVINCE OF BRITISH COLUMBIA

(the "Government")

AND:

MEDICAL SERVICES COMMISSION

(the "Commission")

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the "BCMA")

WHEREAS:

A. THE parties wish to enter into an agreement for the purpose of establishing an ongoing relationship as provided for in this Agreement.

B. THE parties wish to work as partners in the health care system to achieve certain objectives including the following:

1. To maintain and enhance the principles of Medicare.

2. To ensure a stable long term relationship between the Government and the BCMA;

3. To ensure the delivery of medically required services to residents of the Province in an efficient, high quality and effective manner;

4. To ensure that physicians are appropriately compensated for providing services covered by the Medical Services Plan, or under other alternative payment arrangements which are funded through the Alternative Payments Branch;

5. To ensure that the medical care system will continue to function well;

6. To contribute to the achievement of a mix and distribution of physicians based upon British Columbia's needs.

NOW THEREFORE the parties agree as follows:

1. DEFINITIONS

In this Agreement:

(a) "Act" means the *Medical & Health Care Services Act.*

(b) "Advisory Committees" means committees established under the *Act* which shall include advisory committees established by the Commission as required by this Agreement.

(c) "Alternative Payments Branch" means the branch of the Commission responsible for promoting and funding non-fee-for-service payment arrangements with physicians and institutions;

(d) "Available Amount" means the amount of funding allocated by the MSC for the payment of fee-for-service physician services provided in a specified fiscal year established under Section 20 of the *Act* inclusive of the Northern and Isolation Allowance ("NIA") and any adjustments which may be specified within a Working Agreement or the Master Agreement;

(e) "Base" means unless otherwise specified in a Working Agreement, the available amount from the immediately preceding fiscal year;

(f) "Benefit Plans" means programs established by the Commission pursuant to Section 21(6) of the *Act*;

(g) "Commission or MSC" means the Medical Services Commission established under the *Act* and includes reference to the Tripartite Commission.

(h) "Consult" means meaningfully seeking advice, and an exchange of views or concerns prior to the making of a decision or the finalization of a policy initiative as the context may require, and "Consultation" has a similar meaning;

(i) "Critical Care" means care provided by a Medical Practitioner enrolled under Section 12 of the *Act* on behalf of a person;

(i) whose condition is immediately threatening to life or limb, or

(ii) who presents unconscious, or

(iii) who, as a result of an emergency condition, requires immediate admission to an intensive care unit (or equivalent), and includes the medical care given in the intensive care unit, or

(iv) who has been involuntarily admitted under the *Mental Health Act*.

(j) "Differential Billing" means the difference that can be billed in accordance with regulation 5(c) made under the *Act*;

(k) "Fiscal Year" means the period commencing April 1st and concluding March 31st;

(l) "Government" means Her Majesty the Queen in right of the Province of British Columbia;

(m) "Guide to Fees" means the BCMA Guide to Fees or the Relative Value Fee Guide.

(n) "Insured Medical Services" means medical services which are benefits under the *Act*;

(o) "Medical Services" means medical services performed by a medical practitioner;

(p) "Minister" means the Minister of Health and Minister responsible for Seniors and includes the Deputy Minister or a person designated to act on the Minister's behalf;

(q) "Ministry of Health" means the Ministry of Health of the Government of British Columbia, including the Minister of Health where the context may require:

(r) "MSC Total Claims Cost or Total Claims Cost" means the actual paid value of all fee-for-service insured medical services provided by medical practitioners within B. C. during a specified fiscal year, inclusive of any NIA payment but exclusive of any interest payments related to the late payment of claims or as otherwise made under the terms of this Master Agreement or the Working Agreement;

(s) "Payment Schedule" means a payment schedule established under Section 21 of the *Act*;

(t) "**Population**" means the total number of residents of the Province as measured by B. C. Statistics Division of the Ministry of Finance and Corporate Relations, using the spanned average method as of April of any specified Fiscal Year. The spanned average method is based on the weighted average of the Provincial population over five points in time throughout the Fiscal Year (April 1, July 1, October 1, January 1 and April 1 of the next Fiscal Year.). The weights assigned are one eighth for the beginning and end points in a Fiscal Year and one quarter for the middle three points.

(u) "**Proration**" means a temporary reduction in the payment for a service or services below the fees listed in the Payment Schedule;

(v) "**Regulations**" means regulations made under the *Act*.

(w) "**Reserve Account**" means the fund established in Article 8 of this Agreement.

(x) "**Tariff Committee**" means the BCMA Economics Committee as described in the Constitution and By-Laws of the Association in effect on the date of execution of this Agreement;

(y) "**Utilization**" means changes to the MSC Total Claims Cost not attributable to adjustments to the Payment Schedule.

(z) "**Working Agreement**" means the Agreement(s) established from time to time between the parties for the purpose of determining overall (gross) fee changes for the payment schedule, sessional payment rates and for determining administrative policies and Benefit Plans and/or other programs the parties mutually agree upon;

(aa) Words used in this Agreement that are defined in the *Act* or *Regulations* have the same meaning as in the *Act* or *Regulations* unless otherwise defined in this Agreement or any Working Agreement.

2. APPLICATION AND REPRESENTATION

2.1 This Agreement applies to those physicians resident within the Province who practise medicine on a fee-for-service or a sessional basis and, except where otherwise stated, who participate in the Plan, whether paid directly by the Commission or through an agency or institution funded in whole or in part by the Government or the Commission.

2.2 The Government and the Commission hereby grant to the BCMA the sole and exclusive right to represent physicians who practice medicine on a fee-for-service or sessional basis and who participate in the Plan.

2.3 The Commission undertakes to include within its Alternate Payments Branch contracts with institutions a clause requiring the institution to advise physicians of their right to be represented by the BCMA and to negotiate in good faith when establishing contracts with physicians. The Commission further undertakes that institutions using an alternative payment mode for physicians will recognize the status of the BCMA to represent physicians who request the assistance of the BCMA in negotiating contracts with those institutions.

3. COOPERATION AND CONSULTATION

3.1 While the primary responsibility of the Commission is, as described in Section 2(2) of the *Act*, to facilitate reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan, it is understood and agreed that the primary and paramount responsibility of physicians is to advise and treat their patients and to otherwise discharge their responsibilities. The BCMA agrees that it will work with the Commission to cooperate and assist in the provision of high quality medical services.

3.2 It is acknowledged and agreed that the partnership envisaged by this Agreement requires ongoing dialogue and consultation on matters of significance to the provision of medical care, including policy, whether such care is funded directly or indirectly by the Commission or by Government.

3.3 In particular, the BCMA shall be consulted prior to the adoption of policy initiatives by the Minister or the Commission which would affect the provision of medical care by physicians under the Plan, including the direct impact of the policy of regionalization.

3.4 The BCMA agrees to participate with representatives of the Minister, the Commission, the College of Physicians and Surgeons and University of British Columbia Faculty of Medicine in a review from time to time of the distribution and mix of physicians in the Province.

3.5 The Commission will Consult with the BCMA in order to assist the Commission in determining the policies and circumstances under which physicians' methods of remuneration may be converted to a different payment mode.

4. SHARING OF INFORMATION

4.1 The parties acknowledge and agree that the sharing of relevant information and data in a timely way is critically important to the achievement of the objectives established in this Agreement, and to the administration of the *Act*.

4.2 Each party agrees to share relevant information which is requested to be shared by the other party. Relevant historical and predictive data prepared by any party will be fully shared.

4.3 In order to foster and encourage mutual cooperation, the parties shall consult on ways and means to improve the timely collection and analysis of information and data and the method by which the data can be effectively and meaningfully communicated to each other. This process of consultation shall continue on an ongoing and regular basis.

4.4 The Commission shall provide aggregate information on Commission Total Claims Cost on a monthly basis, and detailed information on a schedule and format agreed between the parties in order for the BCMA to assist the Commission in the administration of the *Act*, any Working Agreement and this Agreement.

5. CONFIDENTIALITY

5.1 It is understood and agreed that the open sharing of information, statistics, advice and points of view exchanged in consultation requires a degree of confidentiality.

5.2 It is understood and agreed that certain information exchanged between the BCMA and the Commission will be confidential information under Section 43 of the *Act*. The BCMA will comply with the required statutory confidentiality.

5.3 Certain information which contains the identification of physicians or Beneficiaries may be provided to the Advisory Committees of the Commission and to the BCMA for the purposes of the administration of the *Act*.

6. ADMINISTRATION

6.1 In addition to consultation on policy issues, it is acknowledged that administrative systems and processes which help to ensure that quality health care is maintained are desirable and appropriate, and should be developed in a cooperative way.

6.2 Similarly, systems and processes for predicting required funding and for planning medical care resources and expenditures are desirable and appropriate, and will be developed by the Commission as an integral part of consultation.

6.3 It is acknowledged and agreed that there exists a common interest in ensuring that medical accounts are processed and paid promptly. To facilitate adjudication of a particular medical account or an audit of a particular physician's services the Commission may require copies of specific clinical records. The Commission may determine the routine data and format and transmission protocols required for processing a routine medical account. The routine data presently required is outlined in the Appendix to this Agreement.

6.4 Should a need to review the routine data requirements, formats and/or transmission protocols arise, part of the review must consider the efficacy of the modification and the cost to the physicians of implementing such a change. Attempts will be made to conclude an agreement on costs, if any, and for the compensation of same.

6.5 When the Commission must make unilateral modifications to the routine data requirements, submission formats, or transmission protocols the net average cost of implementing these modification shall be jointly determined and appropriate compensation including retroactivity, if any, provided.

6.6 If no satisfactory agreement concerning Clauses 6.4 and 6.5 can be achieved after one year the dispute will become a matter for arbitration pursuant to the *Commercial Arbitration Act*.

6.7 On behalf of Beneficiaries, the Commission will promptly pay in accordance with the Payment Schedule, medical accounts submitted by physicians for the provision of services covered by the Plan, subject to Sections 22(2), 19(2), and 21(3) of the *Act* and further subject to the provisions of this Agreement, and any Working Agreement.

6.8 If any Beneficiary shall incur a private liability with respect to a Differential Billing, the Commission shall pay to the physician only the amount set by the Commission.

6.9 Normally the Commission makes general remittances for fee for service claims on a regular cycle which is at least semi-monthly. If the Commission is unable to make a general remittance within five working days of the end of a payment cycle an advance against accounts payable will be paid by the Commission, but this will be limited to the physician's average regular cycle payment, measured over the previous 12 months or over the length of time the Physician has participated in the Plan, whichever is the lesser period of time.

6.10 Consideration may also be given on an individual basis at the discretion of the Commission to physicians requesting an advance because they are encountering temporary difficulty submitting their medical accounts or having those accounts processed by the Commission.

6.11 Such advances will be applied against subsequent remittances to the physicians until the advance is fully repaid. Interest at the same rate and under the same conditions specified in Clause 6.12 shall apply.

6.12 Interest at the rate specified in the Regulations passed pursuant to the *Financial Administration Act*, shall apply and be paid by the Commission on Medical Accounts outstanding 60 days after receipt by the Commission, except for Medical Accounts referred to the Reference Committee.

6.13 When the Commission accepts the recommendation of the Reference Committee to pay a Medical Account as submitted by a physician, the Commission shall pay interest pursuant to the *Financial Administration Act* on the account outstanding 60 days after the date of receipt by the Commission. Where the Reference Committee recommends a revision of a medical account, or payment as offered by the Commission, no interest shall be payable until the expiry of 60 days from the date that a recommendation by the Reference Committee is received by the Commission.

6.14 Where a physician has rendered a Benefit to a Resident of the Province possessing or eligible for an MSP identity card, in circumstances requiring Critical Care, the Commission agrees not to later reject medical accounts submitted for such services on the ground that the person was not a Beneficiary. Disputes with respect to the application of the definition of critical care may be referred to the Reference Committee.

7. MEDICAL SERVICES COMMISSION

7.1 The parties agree to work cooperatively to establish the Medical Services Commission as created by Section 2.1 of the *Act*.

7.2 The following process will be established for the purpose of appointing the members to the Commission, and will be completed within sixty days of approval and ratification of this Agreement under Clause 21.1 of this Agreement.

(a) The Minister will advise the BCMA of the three individuals who will be recommended to the Lieutenant Governor in Council for appointment under the *Act* as representatives of the Government.

(b) The BCMA will advise the Minister of the three individuals it wishes to have appointed as representatives of the BCMA. The Minister will recommend to the Lieutenant Governor in Council the appointment of those three individuals under the *Act*.

(c) The Minister and the BCMA will Consult as to the names of three individuals who will be appointed under the *Act* as representatives of Beneficiaries. The Minister and the BCMA must agree on a joint recommendation of the three

individuals who will be recommended to the Lieutenant Governor in Council for appointment.

(d) It is agreed that in order to ensure appropriate continuity, the terms of initial appointment for the members of the Commission will be for 1, 2, and 3 years for each category of Commissioner, so that one Commissioner from each sector shall be appointed for a one-year term, one Commissioner from each sector shall be appointed for a two year term, and one Commissioner from each sector shall be appointed for a three year term. A Commissioner may be reappointed. Any reappointment and all subsequent appointments shall be for a term of three years.

(e) Upon the expiry of the term of any member of the Commission or, in the event of death, disability, incapacity, or resignation during the term of appointment, the above-described process will be utilized to the extent necessary to replace such member or members.

7.3 It is acknowledged that Section 2.3 of the *Act* requires that the Lieutenant Governor in Council must designate a member of the Commission appointed by the Government as the Chair of the Commission. The Minister will consult with the BCMA prior to the appointment or reappointment of the Chair of the Commission.

7.4 Both parties agree that it is in the best interests of all parties and in the public interest for the Commission to exercise its full legal authority in an independent manner under the management of the members of the Commission.

7.5 The Chair of the Commission shall not execute or initiate matters or changes not previously authorized or agreed to by the Commission in the period between meetings of the Commission.

7.6 The Ministry and the BCMA each retain the right to remove any member of the Commission appointed as its representative and Government will cooperate with the BCMA by passing any necessary Order-In-Council.

7.7 It is understood that an alternate Commissioner may be appointed to serve in the absence of a Commissioner as permitted by Section 23 of the *Interpretation Act*.

8 DETERMINATION OF BUDGET

8.1 It is acknowledged and understood that the Legislature has the right and responsibility to determine the amount allocated to the Commission for the purpose of establishing the Available Amount(s) under Section 20 of the *Act*.

8.2 Notwithstanding Clause 8.1, the parties agree to consult with respect to the amount allocated to the Commission for increases in utilization in accordance with the following procedures:

(a) The BCMA will be entitled to participate as members of an Advisory Committee appointed by the Commission under Section 4(1)(o) of the *Act* as provided in Clause 11.3 of this Agreement, to make recommendations to the Commission with respect to any request which the Commission will make to the Government for changes in the amount allocated to the Commission in the following fiscal year, taking into account predicted changes in the level of utilization.

(b) The Minister will meet with the BCMA prior to the end of July of each year to discuss the considerations which will be taken into account in formulating the recommendations of the Ministry with respect to changes in the level of utilization for the following fiscal year.

8.3 The BCMA shall be afforded the opportunity to consult with the Minister of Health prior to the MSC budget request being transmitted to Treasury Board.

8.4 The MSC budget request with respect to fees and utilization as they impact on the MSC Total Claims Cost, shall be a matter for the public record.

8.5 The Minister shall advise the MSC and the BCMA of the process by which, in the Minister's opinion, any variation of the Commission's request occurred during the budgetary process.

8.6 The Minister shall advise the BCMA and the Commission no later than April 15 of any fiscal year of the amount intended to be tabled in the Legislature for the establishment of the Available Amount. Should that amount be less than the amount requested by the Commission, the parties will immediately meet to define their respective responsibilities for the difference between the amount requested by the Commission and the amount identified by the Minister. If an agreement is reached by the parties, the agreement will be reduced to writing.

8.7 It the parties are in dispute as to which of the parties should be responsible for an amount or proportion of the differences between the Commission's budgetary request and the proposed Available Amount, either the BCMA or the Government may, by notice in writing given at any time after 15 working days after the Commission's publication of the proposed Available Amount, elect to have the disputed responsibilities assigned as between Government, the Commission and physicians by an independent adjudicator whose decision will be final and binding upon the parties.

8.8 The Commission must publish the Available Amount no later than 15 days following the approval of health estimates by the Legislature. Should the Available Amount be at variance with the amount the Minister disclosed pursuant to Article 8.6 of this Agreement, the parties will immediately meet to define their respective responsibilities for the difference between the amount requested by the Commission and the Available Amount. If an agreement is reached by the parties, the agreement will be reduced to writing.

8.9 If the parties are in dispute as to which of the parties should be responsible for an amount or proportion of the difference between the Commission's budgetary request

and the Available Amount published, either the BCMA or the Government may, by notice in writing given at any time after 15 working days after the Commission's publication of the Available Amount, elect to have the disputed responsibilities assigned as between Government, the Commission, and physicians by an independent adjudicator whose decision will be final and binding upon the parties.

8.10 The adjudicator will be appointed within 7 days of the notice in writing being given by the BCMA or the Government, and shall commence hearing the dispute within 20 days of his or her appointment.

8.11 If the parties cannot agree on an adjudicator within 7 days, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint one, and the person so appointed will adjudicate the dispute in accordance with this Agreement.

8.12 The adjudicator shall determine what proportion of the difference between the budgetary request made by the Commission related to MSC Total Claims Cost and the Commission's published Available Amount should be the responsibility of the parties to this Agreement by criteria such as the following:

(a) such factors as population growth, ageing, technology, access, morbidity trends, disease, public expectations, shifts in payment modalities and Government policies and initiatives;

(b) the effectiveness of such utilization management initiatives as protocols and clinical guidelines, public education, physician education, audits, delisting, information enhancement, physician supply management, deletion of ineligible immigrants, third party responsibilities, and other effective management practises; and

(c) such other factors and considerations as the Adjudicator considers relevant and appropriate.

8.13 It is agreed that resulting from this Clause, no proration of physician's fees for medical services rendered will take place prior to the adjudicator reaching a decision provided that the decision is published prior to July 30th. It is further agreed that the adjudicator will have no jurisdiction to cause a retroactive proration.

8.14 The adjudicator shall publish his or her decision within 21 days of completing the hearing process and shall take all necessary steps to endeavour to publish the decision prior to July 30th.

8.15 Clauses 8.6 to 8.14 inclusive of this Agreement shall be effective as of April 1, 1997. Clauses 8.2 to 8.5 of this Agreement shall be effective as of April 1, 1996.

8.16 In the event of a disaster, province-wide epidemic or other catastrophic event as determined by the Commission, the Commission will make a recommendation for additional funds from Government to cover the costs of additional medical services required due to the catastrophic event and will make this recommendation public. The Government with respond to the recommendation within 30 days.

8.17 The Reserve Account established in the Working Agreement will be continued during the term of this Agreement to allow funds to be carried across fiscal years to alleviate any amount to be prorated during the life of any Working Agreement. Subject to Clause 8.20 and as may be agreed in any Working Agreement, nothing in this Agreement will require new funds to be added to the Reserve Account.

8.18 The Reserve Account established in a Working Agreement will be administered by the Government.

8.19 The Reserve Account established in a Working Agreement may not be accessed without the written consent of the BCMA.

8.20 In the event that MSC Total Claims Cost is less than the Available Amount(s) as set by the Commission in any fiscal year, the difference will be placed in the Reserve Account, subject to the terms of any Working Agreement.

8.21 Subject to the provisions of this Article and Article 10 of this Agreement and of any Working Agreement, in the event that actual spending is exceeding, or is forecast to exceed the Available Amount(s) as set by the Commission, the Commission will exercise its authority under Section 19 of the *Act*.

8.22 A joint process for reviewing and monitoring amounts to be transferred from the Available Amount to the Alternative Payments Branch budget shall be established. The agreement of the BCMA must be obtained with respect to the amount of funds to be transferred to or from the Available Amount to or from the Alternative Payments Branch. No funds will be transferred to the Alternative Payments Branch until the amount is agreed upon or arbitrated under the *Commercial Arbitration Act*. However, nothing in this Clause will preclude the transfer of services prior to settlement of the amount of funds to be transferred.

8.23 It is agreed that in establishing the Available Amount(s) for 1997/98 it will be no less than the 1996/97 Available Amount.

9. WORKING AGREEMENT

9.1 No later than April 15th in the fiscal year of the expiry of a Working Agreement, the Government's negotiator(s) and the BCMA will meet to negotiate a new Working Agreement.

9.2 If the Government negotiator(s) and the BCMA are unable to agree on the terms of a new Working Agreement by May 31, the parties shall seek the assistance of a conciliator.

9.3 If the Government negotiator(s) and the BCMA are unable to agree on the selection of the conciliator, they will request that the Chief Justice of the British Columbia Supreme Court appoint the conciliator.

9.4 The conciliator shall meet with the Government negotiator(s) and the BCMA and attempt to assist them in concluding the terms of a new Working Agreement.

9.5 If the Government negotiator(s) and the BCMA, with the assistance of the conciliator, have not been able to reach agreement on a new Working Agreement by the end of June, the matter will be referred to a mediator. If the Government negotiator(s) and the BCMA are unable to agree on the selection of the mediator, they will request that the Chief Justice of the British Columbia Supreme Court appoint the mediator.

9.6 The mediator shall meet with the Government negotiators and the BCMA negotiators and attempt to assist them in concluding the terms of a new Working Agreement.

9.7 The parties will meet to review the mediator's recommendations no later than September 15th. If the parties have not reached agreement by September 30th, the dispute will be referred to the Commission, which shall decide the terms of the Working Agreement remaining in dispute.

9.8 The decision of the Commission is final and binding on the parties.

10. MONITORING AND MANAGING THE AVAILABLE AMOUNT

10.1 It is understood and agreed that the decisions and actions of Government and its agencies have an effect upon utilization of the Medical Services Plan, for which physicians should not be responsible under Part 4 of the *Act*. In the event that the Government implements new medical programs which directly affect the cost of insured medical services, these costs will be borne by the Government. With respect to "New Directions", as outlined in the document entitled New Directions for a Healthy British Columbia published by the Government in February, 1993, the cost of any initiatives proposed by Government, a regional health board or a community health council that result in increased medical utilization above the Available Amount will be approved in advance by the Ministry. The costs will not be the responsibility of the physicians in B. C.

10.2 Government will arrange for the reimbursement by the appropriate Agency, other Ministry, or Crown Corporation of the Total Claims Cost, and neither the Commission nor physicians will have responsibility under the *Act* for the costs of such services. In particular, the Total Claims Cost for such services shall not form any part of the measurement of the Total Claims Cost against the Available Amount managed by the Commission, which would affect decisions taken pursuant to Clauses 10.5, 10.6 and 10.7.

10.3 Upon the ratification of this Agreement, the Commission and the BCMA will forthwith design and agree upon methods of tracking those issues contemplated in any Working Agreement or in Clauses 10.1 and 10.2 of this Agreement, such as:

(a) services required by the policies of other Government agencies;

(b) services required by policies or programs initiated by Government. For example, closure of hospital beds, screening programs, new hospitals or clinics, the introduction of new technology, or the expansion of access to existing technology, and the impact of regionalization or other Government initiatives.

10.4 The Commission will track Total Claims Cost against the Available Amount at the conclusion of each month and will make a forecast concerning the adequacy of the Available Amount. The results will be immediately forwarded to the BCMA. The Commission will give the BCMA written notice when the Commission's projections indicate that the Available Amount will be exceeded immediately such a projection is made by the Commission. The notice will include the specific date on which the Available Amount is projected to be exceeded.

10.5 If the Commission concludes on the basis of a reasonable forecast that the Total Claims Cost for a fiscal year is likely to exceed the Available Amount, the Chair of the Commission shall immediately call a meeting of the Commission and prior to that meeting the Commission will forthwith consult with the BCMA and the Ministry on the matter. Immediately following the Commission meeting, the Commission will report to the Minister and the BCMA:

(a) the fact of the forecast that the Available Amount may be exceeded;

(b) the apparent reasons for the forecast overrun of the Available Amount; and

(c) in consultation with the BCMA, the Commission's suggestions for preventing the overrun of the Available Amount.

10.6 Prior to any suggestions which the Commission might present pursuant to Clause 10.5 (c), the Commission will be obliged to consider the use of the Reserve Account to alleviate any overrun of the Available Amount, subject to Clause 8.17 of this Agreement. The Commission and Government will be bound by any request related to Article 10 which the BCMA makes with respect to the use of the Reserve Account.

10.7 (a) A decision to initiate proration in order to meet the Available Amount in any year requires a decision of a majority of the Commission, and will not be a decision taken by the Chair. Proration will not be applied to payments for services already rendered.

(b) No proration decision will be taken until the use of the Reserve Account has been pursued.

10.8 (a) Within any fiscal year, in the event that Total Claims Costs are less than the Available Amount, and no proration has occurred for that fiscal year, the difference will be placed in the Reserve Account identified in Clause 8.15 of this Agreement, subject to any specific conditions which may be contained in any Working Agreement.

(b) Should proration have occurred, the difference will be immediately returned to those affected physicians, by the reversal of the proration, to the extent of the difference, or the amount of proration, whichever is the lesser, and any remainder will be placed in the Reserve Account.

10.9 (a) Reconciliation of the MSC Total Claims Cost with the Available Amount shall take place and be concluded by October 31st of the following fiscal year. In the event the reconciliation identifies that the Available Amount was still exceeded after the implementation of all measures contemplated by this Article 10, the amount of the excess will be recovered by, and in order of priority, use of the Reserve Account, and where the Reserve Account is insufficient to recover the amount of the excess, the Commission will determine the mechanisms, which may include proration, for recovering the remaining difference.

(b) In the event the reconciliation identifies that the MSC Total Claims Cost was less than the Available Amount after the implementation of all measures contemplated by this Article 10, and no proration had occurred, the difference will be placed in the Reserve Account, subject to any specific provisions which may be contained in any Working Agreement. Should proration have occurred, the difference will be immediately returned to those affected physicians, by the reversal of the proration, to the extent of the difference or the amount of proration, whichever is the lesser, and any remainder will be placed in the Reserve Account.

10.10 (a) It is agreed and understood that the Commission has a responsibility to manage Total Claims Cost to stay within the Available Amount.

(b) The parties further agree that the Commission must exercise this responsibility through the use of all reasonable methods within their jurisdiction, subject to the specific provisions of any Working Agreement, and this Agreement. An integral part of that management process will be the development of protocols and billing guidelines. The BCMA will participate in the development of those protocols and guidelines and the medical profession will make every effort to adhere to such protocols and guidelines once implemented.

(c) It is agreed and understood that insured benefits are medically required services which fall within defined, approved protocols and practice guidelines and those medically required services where no protocols or practice guidelines exist.

10.11 In recognition of the need for all parties to this Agreement to be satisfied that the Commission continues to be effective in managing the Available Amount, the Chair of the Commission, the Deputy Minister of Health, and the Chief Executive Officer of the British Columbia Medical Association will meet at regular three monthly intervals in order to assess the management process. The parties will report the results of these meetings to the Minister, the Commission, and the Board of Directors of the BCMA on a timely basis.

11. ADVISORY COMMITTEES

11.1 Reference Committee

(a) The current Reference Committee of the BCMA shall be considered to be an advisory committee to the Commission under Section 4(1)(o) of the *Act*.

(b) The Commission shall inform physicians of their opportunity to refer to the Reference Committee matters relating to medical accounts submitted by the physician where:

i. there is a continuing disagreement between the physician and the Commission which exceeds sixty days from the date the physician first raises a written enquiry to the Commission with respect to an account or accounts; or

ii. there is a continuing dispute with the physician over payment for services or procedures which exceeds sixty days from the date the physician first raises a written enquiry to the Commission for which no fee has been established and approved by the Commission.

(c) The Reference Committee shall promptly review all matters referred to it and shall forward its report or recommendations to the Commission and the BCMA within one month of its meeting.

(d) The Reference Committee shall meet to review matters referred to it at least three times per calendar year and the period between successive meetings is not to exceed six months. A report or recommendation by the Reference Committee is not binding on the Commission. However, the Commission will endeavour to follow the recommendations of the Reference Committee.

(e) The approved costs of the Reference Committee will be shared equally by the BCMA and the Commission.

11.2 Patterns of Practice Committee

(a) The current Patterns of Practice Committee of the BCMA shall continue as an advisory committee to the Commission under Section 4(1)(o) of the *Act*.

(b) The Commission has a right and responsibility to refer to the BCMA and to expect consideration of information concerning a physician who has exhibited abnormal billing patterns or a fee item or items in the Payment Schedule the billing of which produces abnormal or unexpected payments to physicians. The BCMA agrees to promptly investigate the matters referred and to convey the results of the BCMA's investigation to the Commission.

(c) The BCMA also has a right and responsibility to examine and investigate available information concerning abnormal or unexpected patterns of practice and to advise the Commission as to the action that the BCMA deems proper and to expect consideration thereof by the Commission.

(d) It is understood and agreed that where either party has referred a matter to the Patterns of Practice Committee, the Committee will investigate and report to both parties within a reasonable period of time from the date of referral, and will endeavour to develop and forward its recommendations, if any, within six months.

(e) The Commission agrees to promptly consider these recommendations and communicate its response to the Patterns of Practice Committee within six months. A report or recommendation by the Patterns of Practice Committee is not binding on the Commission.

(f) The approved costs of the Patterns of Practice Committee will be shared equally by the Commission and the BCMA.

(g) It is agreed that the Patterns of Practice Committee shall continue its function and work during any period when no Working Agreement exists.

11.3 Utilization Committee

(a) A Utilization Committee shall be created which shall be an advisory committee to the Commission under Section 4(1)(o) of the *Act* as provided in Clause 8.2(a) of this Agreement.

(b) The Utilization Committee shall consist of equal numbers of representatives of the BCMA and the Ministry, and will be jointly chaired. The membership may be expanded to include lay representation on agreement of the parties.

(c) The objective of the Utilization Committee will be to measure and evaluate the changing levels of utilization of medical services, and where appropriate for complete understanding, drug and hospital services.

(d) The Commission shall refer to the Utilization Committee issues which may affect utilization, the cost of services and means to affect utilization of medical services. Examples include physical resources, alternative payment mechanisms, physician supply, protocols and guidelines, determination of services, public education, agency billing and the use of technology.

(e) The Utilization Committee shall promptly review all matters referred to it and shall forward its report and recommendations to the Commission and the BCMA within one month of its meeting.

(f) The Utilization Committee shall meet to review matters referred to it at least three times per calendar year and the period between successive meetings is not to exceed six months. A report or recommendation to the Commission is not binding on the Commission.

(g) The approved costs of the Utilization Committee meetings shall be shared equally by the BCMA and the Commission.

12. AUDIT AND INSPECTION COMMITTEE

12.1 The Commission has the right and responsibility to audit claims for payment by practitioners and the patterns of practice or billing of physicians as part of a random review or in response to service verification irregularities. The BCMA will support and participate in the Commission's audit program. This audit program will be funded by the Commission.

12.2 An Audit and Inspection Committee shall be created and delegated the powers of the Commission under Section 31(1) to (11) of the *Act* to audit and inspect medical practitioners and shall consist of representatives of the BCMA, College of Physicians and Surgeons, the public and the Commission.

12.3 The Committee's responsibilities may include random audits and inspections referred to the Committee by the Commission or any Physician peer review committee, including the Patterns of Practice Committee.

12.4 The Patterns of Practice Committee will be notified prior to initiation of an audit or review of the pattern of practice or billing of a practitioner under Section 31(2) of the *Act*.

12.5 Inspectors are to be appointed from a list maintained by the Committee and proposed jointly by the BCMA and the College of Physicians and Surgeons.

12.6 Notice of review and inspection must be provided to the medical practitioner(s) in question. Except in extraordinary circumstances which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.

12.7 Inspection guidelines are to be clearly laid out and communicated to the medical practitioner(s) prior to inspection. The Committee will meet forthwith after execution of this Agreement to develop inspection guidelines which provide an assurance of due process and the maintenance of confidentiality of a patient's medical records and history.

12.8 The confidential nature of medical records will be protected. The identity of patients shall be protected except to the extent necessary for verification or as evidence for a hearing.

12.9 Prior to any decision being made by the Commission resulting from a referral of the Committee, it is understood that the physician shall be entitled to be heard by the Commission, is entitled to have legal counsel present, and may have one or more colleagues present to comment on the practice of the physician.

12.10 Prior to a hearing before the Commission, the Committee will communicate in writing to the Physicians its concerns and provide copies of all relevant documents to the Physicians at least 21 days prior to the hearing.

12.11 The approved costs of the Audit and Inspection Committee shall be funded by the Commission.

13. REVISION AND MAINTENANCE OF GUIDE TO FEES

13.1 Upon ratification of a Working Agreement, the amount of funds to be made available for revisions to the Payment Schedule will be allocated by the BCMA to fee items in the Guide to Fees in accordance with the Working Agreement.

13.2 Subject to Article 13 of this Agreement and except where otherwise specially and mutually agreed, revisions to the Guide to Fees allocating amounts of money made available under a negotiated Working Agreement will be effective April 1 of the appropriate year during the term of the Agreement.

13.3 When the Tariff Committee of the BCMA has prepared recommendations for a revision of the Guide to Fees for consideration by the Board of Directors of the BCMA, prior to transmission of its recommendations to the Board of Directors the Tariff Committee will:

(a) inform the Commission of the recommendation; and

(b) consult with the Commission to identify any comments or concerns the Commission may have respecting such recommendations in order that the Tariff Committee have the Commission's comments or concerns before them at the time of finally recommending a revision of the Guide to Fees to the Board of Directors.

13.4 The BCMA and the Commission agree to follow the Consultation process with respect to particular payment items which either party feels need to be jointly addressed.

13.5 Either party may make representation to the other where a particular new item or modification of existing items is felt appropriate. Where a mutually agreeable solution cannot be found with respect to a particular item or items within 12 months after written notification by the chief executive officer of one party to the chief executive officer of the other party, either party may refer the arguments concerning a particular fee to a joint review panel.

13.6 The composition of the joint review panel shall be two Physicians appointed by the BCMA and two Physicians appointed by the Commission and a lay chair acceptable to both parties. The Chair shall be chosen by the Commission from a roster of 3 mutually acceptable names established at the beginning of each fiscal year. The Physicians appointed shall be chosen so as to avoid direct conflict of interest.

13.7 The joint review panel must render a majority recommendation within 3 months of receiving a request.

13.8 Recommendations of the joint review panel will be given equal priority with other revisions to the Guide to Fees in each year during the term of a Working Agreement.

13.9 The Commission agrees that should it introduce any redefinition of insured medical services it will provide at least 30 days' notice to all Physicians enrolled in the Medical Services Plan.

14. APPROVAL OF PAYMENT SCHEDULE

14.1 The Commission shall adopt as part of its Payment Schedule additions to, deletions from or other modifications of the BCMA Guide to Fees or the Relative Value Fee Guide when implemented, provided that:

(a) the Commission agrees such modifications are consistent with the requirements of the *Act* or *Regulations;*

(b) the Commission agrees that the services covered by a given fee item are medically necessary;

(c) the Commission agrees to the estimated projected net cost effect on the MSC Total Claims Cost which would result from adding, deleting, or modifying fee items in the payment schedule;

(d) the Commission agrees that implementation of recommendations of the joint review panel or through consultation have been given appropriate consideration along with other revisions to the payment schedule.

14.2 Addition, deletion, or modification of an individual item or items of the Guide to Fees shall not be given effect in the Payment Schedule until it has been agreed to by both parties.

14.3 For the purpose of calculation of the estimated effect in MSC Total Claims Cost of changes in a fee item or items of the Guide to Fees and the Payment Schedule, the most current usage data as prepared by the Commission will be used, adjusted as appropriate for trends in usage when trends can be established or predicted.

14.4 It is understood as agreed that no addition to, deletion from or modification of the Payment Schedule or of any item or items therein under or resulting from any provision of this Agreement shall have effect without prior agreement and approval in writing of the Commission.

15. PHYSICIAN BENEFIT PLANS

15.1 It is understood and agreed that where this Agreement permits or requires the BCMA to administer a benefit program, the responsibilities of the BCMA include the verification that public funds have been properly used for the purposes intended, including such audit and inspection procedures as may be necessary and required.

15.2 The BCMA acknowledges and accepts its responsibility to administer the physician Benefit Plans available to all physicians who have not made an election under Section 13 of the *Act* or who are not subject to an order made under Section 14(2)(b) of the *Act*, and acknowledges and accepts its responsibility to provide the same standard of administration to both members and non-members of the BCMA.

15.3 It is understood and agreed that the BCMA may charge physicians who are not members of the BCMA an administrative fee when non-members apply for a negotiated benefit to which they are entitled. It is further understood and agreed that non-members will not be charged administrative fees which exceed the equivalent of dues and levies charged to BCMA members in the calendar year in which the non-member applies for a benefit or benefits.

15.4 It is understood and agreed that the Benefit Plans described below will continue to be funded by the Commission during the term of this Agreement at the funding levels established on the effective date of this Agreement. It is further agreed that changed funding for any Benefit Plan is an appropriate topic for monetary negotiations pursuant to Article 9 of this Agreement. Where changed funding is negotiated for any Benefit Program, the new level of funding which results is the level of funding to be continued for the balance of the remaining term of this Agreement, unless new levels of funding are negotiated and agreed upon. Funding at the last negotiated levels for these benefit plans will continue during the term of this Agreement, notwithstanding the expiry of any Working Agreement.

15.5 Continuing Medical Education Program

(a) Government agrees, subject to Clause 15.4 of this Agreement, to continue to fund this Program at the level determined under any Working Agreement and in accordance with the arrangements established under that Agreement. The annual funding for this Program will be deposited with the BCMA on May 1st of each year. Any monies earned from the investment of this funding shall be added to the fund and be additional to the negotiated amounts established in any Working Agreement.

(b) It is agreed that a committee, known as the Continuing Medical Education Trust Fund Committee, providing for equal numbers of representatives of the Association and the Commission, co-chaired by representatives of the Commission and the Association, will oversee the management, funding and financial administration of the Program. It is further agreed that a joint committee known as the Continuing Medical Education Fund Advisory Committee, consisting of four Physicians appointed by each party, will oversee and recommend to the Parties the rules for qualification and eligibility for Physician participation in the Program.

(c) It is agreed that this Program permits physicians to claim entitlement over a period of at least two years. Accordingly, unclaimed funds in any fiscal year will remain in the Program for funding accrued entitlements.

(d) The approved Committee and administration costs of this benefit will be paid from the funds provided under Clause 15.5(a) of this Agreement.

15.6 **Physicians' Disability Insurance Program**

(a) The Government agrees, subject to Clause 15.4 of this Agreement, to continue to fund this Program at the level determined under any Working Agreement and in accordance with the arrangements established under that Agreement.

(b) It is agreed that a Committee known as the Physician Disability Insurance Trustee Committee, providing for equal numbers of representatives of the BCMA and the Commission co-chaired by representatives of the Association and the Commission, will oversee the management, funding and financial administration of the program.

(c) The approved Committee and administration costs of this benefit will be paid from the funds provided under Clause 15.6(a) of this Agreement.

15.7 **CMPA Dues Rebate Program**

(a) Government agrees, subject to Clause 15.4 of this Agreement, to continue to fund this Program at the level determined under any Working Agreement, and in accordance with the arrangements established under that Agreement. The annual funding for this Program will be deposited with BCMA on May 1st of each year. Any monies earned from the investment of the funding shall be attached to this fund and be additional to the negotiated amounts established in any Working Agreement.

(b) It is agreed that this Program will be administered by the BCMA, in accordance with Clauses 15.1, 15.2, 15.3 and 15.4 of this Agreement.

(c) The approved Committee and administration costs of this benefit will be paid from the funds provided under Clause 15(7)(a) of this Agreement.

16. NORTHERN AND ISOLATION PROGRAM (NIA/NITA)

(a) The Commission is committed to developing and maintaining incentives for practice in northern and isolated communities. In this regard, the Northern/Isolation Allowance and Northern/Isolation Travel Assistance Programs will be continued.

(b) It is agreed that a committee, known as the Northern and Isolation Committee, providing for equal numbers of representatives of the BCMA and the Commission, co-chaired by representatives of the Commission and the BCMA, will be established under Section 4(1)(o) of the *Act* and will oversee the management, funding and financial administration of the Northern and Isolation programs.

(c) Approved Committee expenses for the Northern and Isolation Committee will be shared equally by the BCMA and the Commission.

17. VOLUNTARY AND COMPULSORY NON-PARTICIPANTS

17.1 Any physician may elect to be a voluntary non-participant under the Plan pursuant to Section 13 of the *Act* and by so doing gives up any physician Benefits covered under this Agreement. B.C. Residents who are eligible Beneficiaries under the Plan may remain or become patients of such a voluntary non-participating physician without loss of their right to reimbursement in accordance with the *Act* or *Regulations*.

17.2 The Commission will be responsible for the direct payment of non-participating physicians accounts only where that physician has rendered emergency services in circumstances where the medical condition or state of mental incompetence of the Beneficiary prevents the physician from properly informing the patient of the physician's non-participation, and from obtaining the Beneficiary's informed consent.

17.3 Where the Commission has, for cause, made an order under Section 14 of the *Act* declaring that a physician's services are not Insured Services, that physician is no longer entitled to Physician Benefits under this Agreement.

18. AMENDMENTS

18.1 This Agreement or any of the terms of this Agreement may be amended at any time with the mutual written consent of the parties.

18.2 No amendment or modification to this Agreement will become effective unless the same will have been reduced to writing and duly executed by the parties hereto.

19. DISPUTE RESOLUTION

19.1 Any dispute with respect to the interpretation, application or alleged breach of the Master Agreement or of any Working Agreement will be resolved pursuant to the *Commercial Arbitration Act*.

19.2 Should the parties be unable to agree on the selection of an Arbitrator within 7 days after notice is served by any party seeking the appointment of an Arbitrator, the Supreme Court of British Columbia will be asked to appoint the Arbitrator under the provisions of Section 17 of the *Commercial Arbitration Act*.

20. TERMINATION

20.1 This agreement comes into force on the date first written above and, on midnight March 31, 2000 this Agreement will expire.

20.2 The parties acknowledge the mutual benefit of a continuing agreement. In this regard the parties agree to meet within six months prior to the expiry of this Agreement to commence discussions and make every reasonable effort to conclude a renewal of this Agreement prior to its expiry.

21. MISCELLANEOUS

21.1 This Agreement is subject to the approval of the Lieutenant Governor in Council and ratification by the membership and Board of Directors of the BCMA. In the absence of such approval and ratification this Agreement is of no force or effect.

21.2 This Agreement will be governed by, and construed in accordance with, the laws of the Province of British Columbia.

21.3 This Agreement will be construed in accordance with the *Act*. In the event that the *Act* is amended, rendering any part of the Master Agreement or a Working Agreement to be invalid or unenforceable, the balance of those Agreements will be deemed to be severed and to remain in full force and effect.

21.4 In the event that an amendment to the *Act* causes a part of the Master Agreement or a Working Agreement to be invalid or unenforceable, the parties will negotiate new provisions which, to the extent legally possible, will carry out the original intent of those provisions which are invalid or unenforceable. Should the parties be unable to agree, then the difference shall be referred to arbitration pursuant to the *Commercial Arbitration Act*.

24.5 The Government agrees to take all necessary steps to ensure that the terms of this Master Agreement and a Working Agreement are implemented by the Commission.

21.6 The headings appearing in this Agreement have been inserted for reference and as a matter of convenience and in no way define, limit or enlarge the scope of any provision of this Agreement.

21.7 The Appendix to this Agreement is an integral part of this Agreement as if set out at length in the body of this Agreement.

DATED AT VICTORIA, British Columbia, this 21 day of DECEMBER, 1993.

SIGNED ON BEHALF OF THE GOVERNMENT OF THE PROVINCE OF BRITISH COLUMBIA)

Paul Ramsey)

THE COMMON SEAL of THE BRITISH COLUMBIA MEDICAL ASSOCIATION was hereunto affixed in the presence of:)

C/S

SIGNED ON BEHALF OF THE MEDICAL SERVICES COMMISSION)

Chair

APPENDIX

For the purposes of Clause 6.3 of this Agreement, "routine data" means:

patient personal health number
patient name
month and year of birth -- required for newborns, optional for others
location of services(s)
time, where appropriate
appropriate diagnostic code
diagnosis of chief complaint
payment schedule code of service(s) rendered
whether motor vehicle accident related
appropriate fee
practitioner number, specialty code and payee number of physician who rendered the service
claim number
referred "to" and/or referred "by" practitioner number
"pre-authorization of coverage" number, where applicable