IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Halvorson v. Medical Services Commission of British Columbia,* 2014 BCSC 448

Date: 20140318
Docket: C985385
Registry: Vancouver

Between:

James Peter Halvorson, as representative plaintiff

Plaintiff

And

Medical Services Commission of British Columbia, Her Majesty the Queen in Right of British Columbia and the Minister of Health, represented by the Attorney General of British Columbia

Defendants

Brought under the ***Class Proceedings Act***, R.S.B.C. 1996, c. 50

Before: The Honourable Madam Justice Adair

Reasons for Judgment

Counsel for the Plaintiff:	Arthur Grant and Sandy Kovacs
Counsel for the Defendants:	Gareth Morley, Tamara Saunders and Christina Drake
Place and Date of Hearing:	Vancouver, B.C. April 22-24, 2013
Place and Date of Judgment:	Vancouver, B.C. March 18, 2014

Introduction

[1] This class proceeding involves claims by fee-for-service medical doctors for payment for medical services the doctors say they rendered to certain patients who, at the time, were B.C. residents. Dr. James Halvorson is a medical doctor practicing in B.C. and he is the representative plaintiff. The class members (with some exclusions) are all medical practitioners who were enrolled under the ***Medical and Health Care Services Act***, S.B.C. 1992, c. 76, as amended, at any time during the period from July 23, 1992 to April 30, 1996 (the "Material Period").

[2] Dr. Halvorson asserts that, during the Material Period, he and the other class members provided medical services to B.C. residents enrolled with B.C.'s Medical Services Plan. In the pleadings, Dr. Halvorson describes these individuals as "beneficiaries." Dr. Halvorson says that he and the other class members are entitled to payment for providing medical services to these individuals, but that he and the class members have been refused payment because the defendants wrongfully cancelled the enrollment under the Medical Services Plan of the individuals treated. He asserts that, although the defendants were wrongfully refusing to pay him and

the other class members for medical services rendered, they were receiving a full cash contribution for health care from the Government of Canada. Dr. Halvorson alleges that, in order to receive the full cash contribution, the defendants represented to the Government of Canada that the Medical Services Plan satisfied the criteria in s. 7 of the ***Canada Health Act***, R.S.C. 1985, c. C-6, but, during the Material Period, the defendants violated sections 9, 10 and 12 of the ***Canada Health Act*** (concerning comprehensiveness, universality and accessibility, respectively).

[3] Dr. Halvorson and the other class members say that, as a result of the defendants' refusal to pay them for the medical services rendered, the class members have been unjustly deprived and the defendants have been unjustly enriched. Dr. Halvorson and the other class members also say that the defendants breached their statutory obligations to pay them for medical services rendered. Dr. Halvorson and the other class members seek a variety of remedies, including damages for breach of statute and compensation for unjust enrichment.

[4] The certification order was pronounced on July 12, 2012 (see 2012 BCSC 1110), and the common issues certified were:

> Did the Medical Services Commission have the legal authority during the period July 23, 1992 to April 30, 1996 to de-enrol beneficiaries who were British Columbia residents for non-payment of Medical Services Plan premiums:
>
> a. under the ***Medical and Health Care Services Act***, S.B.C. 1992, c. 76, as amended, and/or;
>
> b. under s. 8.02 of the ***Medical Services Act Regulations***, B.C. Reg. 144/68, as amended?

[5] Dr. Halvorson now seeks a final determination, by way of summary trial, of the certified common issues. The parties agree (as I do) that the issues can be determined on a summary trial.

[6] The resolution of the certified common issues involves matters of statutory interpretation. There is little dispute concerning the facts relevant to the common issues. There is little dispute about the legal principles that apply to matters of

statutory interpretation. However, there is a serious dispute concerning the result that should flow from the application of those principles.

[7] Mr. Grant, on behalf of Dr. Halvorson and the other class members, says that the application of the principles of statutory interpretation to the provisions in issue (s. 8(2) of the ***Medical and Health Care Services Act*** and s. 8.02 of the ***Medical Services Act Regulations***) should lead to the conclusion that the Medical Services Commission had no legal authority during the Material Period to cancel the enrollment of beneficiaries for non-payment of MSP premiums. Therefore, in Mr. Grant's submission, the answers to both of the common issues must be no.

[8] On the other hand, Mr. Morley, for the defendants, says that application of those principles to the provisions in issue makes it clear that the drafters intended to give the Commission precisely the legal authority that Dr. Halvorson and class members say it did not have. Therefore, in Mr. Morley's submission, the answers to both of the common issues must be yes.

[9] I will first set out the background, which is straightforward and consists almost entirely of a chronological outline of various pieces of legislation relating to medicare, beginning in the late 1960s and continuing through to the late 1990s. I will then summarize the basic legal principles applicable to statutory interpretation, and follow with my analysis and conclusions concerning each of the common issues. Finally, I will briefly discuss two procedural issues that arose during the hearing. The first concerns the admissibility of the affidavit no. 3 of Andrea Gordon, filed on behalf of the plaintiff on April 18, 2013. The second concerns changes (in the form of an addition) proposed by Mr. Grant to the certified common issues.

Background

(a) The Medical Services Plan is established in 1968 under the *Medical Services Act Regulations*

[10] Prior to 1967, there was no formal, comprehensive government-run medical insurance plan in B.C.

[11] In 1966, the Federal Government enacted the ***Medical Care Act***, S.C. 1966-67, c. 64. This was the original federal statute that provided for cost-sharing for provincial medicare programs, and provided for annual financial assistance to each province in respect of the cost of insured services pursuant to a medical care insurance plan.

[12] The ***Medical Care Act*** set out specific criteria to be met by each province as a condition for such assistance. The criteria included reasonable compensation for insured services furnished by medical practitioners under a plan that does not "impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons" (see s. 4(1)(b)). Other criteria that (pursuant to s. 4(1)) had to be met by a province's insurance plan in order for the province to receive federal money, included that:

> (c) the number of insurable residents of the province who are entitled under the plan to insured services is not less than 90% of the total number of insurable residents of the province, except that in applying this paragraph for the purpose of determining whether the plan satisfies the criteria set forth in this subsection throughout the third and each subsequent year after the year commencing on the contribution commencement day, there shall be substituted for the expression "90%" in this paragraph the expression "95%";

[13] In March 1967, in response to the ***Medical Care Act***, B.C. enacted the ***Medical Services Act***, S.B.C. 1967, c. 24.

[14] Section 10 of the ***Medical Services Act*** provided, in relevant part:

> 10. The Lieutenant-Governor in Council may by regulation establish a voluntary medical services plan for the Province, and may make regulations whereunder
>
> . . .
>
> (c) the Commission is empowered to fix premium rates;
>
> . . .
>
> (e) assessment and approval of all individual accounts for insured services and the amounts to be paid in respect thereof on a basis that provides for reasonable compensation for insured services provided by the plan and that does not impede or preclude either directly or

> indirectly, whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons is provided for; . . .
>
> . . .
>
> and which will in all respects qualify and enable the Province to receive payment of contributions by Canada towards the cost of medical services.

[15] There can be little doubt that (as stated in the closing words of s. 10) one of the objects of the ***Medical Services Act*** was to establish a plan that would qualify and enable B.C. to receive payment from the federal government towards the cost of medical services: see ***Mia v. Medical Services Commission of British Columbia***, 1985 CanLII 148, (*sub nom* ***Re Mia and Medical Services Commission of British Columbia***) 17 D.L.R. (4th) 385 (B.C.S.C.) at p. 389.

[16] In due course, the ***Medical Services Act Regulations***, B.C. Reg. 144/68 (the "***Regulations***") were passed. Among other things, they created the statutory health insurance plan known as the Medical Services Plan (the "MSP") and established the Medical Services Commission (the "Commission") to manage the MSP.

[17] Division 2 of the ***Regulations*** set out a number of defined terms, including the following:

> 2.01 In these regulations, unless the context otherwise requires,
>
> . . .
>
> "insured person" means a resident of the Province who is entitled to insured services and insured under the plan of these regulations, and who is not in default in payment of premiums;
>
> "insured services" means services covered by the Plan rendered by a medical practitioner that are medically required . . . ;
>
> . . .
>
> "medical practitioner" means a person lawfully entitled to practise medicine in the Province or similarly lawfully entitled to practise medicine in any other jurisdiction where the service is rendered;
>
> . . .
>
> "Plan" means the over-all Medical Services Plan of British Columbia established and prescribed by these regulations;
>
> . . .
>
> "subscriber" means an insured person who

> (a) has his ordinary residence in the Province;
>
> (b) has applied to a carrier under the Plan for coverage for himself or for himself and his dependents and has been accepted by the carrier as a subscriber;
>
> (c) is not in default in the payment of any premium; and
>
> (d) has not misrepresented any material fact.

[18] Various powers and functions of the Commission were set out in Division 3 of the ***Regulations***. This included the power to fix premium rates (s. 3.09). It also included the power to assess and approve all individual accounts for insured services under the MSP and to determine the amounts to be paid in accordance with a tariff of fees approved by the Commission on a basis that provided for reasonable compensation for insured services rendered by medical practitioners and that "does not impede or preclude, either directly or indirectly . . . , reasonable access to insured services by insured persons" (s. 3.12).

[19] Division 4 provided for the establishment of the MSP, and in particular stated:

> 4.01 There is established for the Province an over-all Medical Services Plan which shall be administered and operated on a non-profit basis in accordance with these regulations by and under the supervision of the Commission.
>
> 4.02 Subject to section 4.03 and section 4.04, the Plan shall provide for any resident of the Province, who applies therefor and pays the premium fixed by the Commission, and for his dependants, payment for all insured services.

[20] Division 8 dealt with premiums under the Plan. Section 8.01 provided that:

> 8.01 The premiums payable by subscribers for the Plan shall be those fixed by the Commission, and the Commission may fix different premiums for different subscribers with different numbers of dependents.

[21] Section 8.02 of the ***Regulations*** addressed the consequences of default of payment of premium for coverage, and provided:

> 8.02 Coverage of a person as an insured person ceases upon the premium for that coverage being fifteen days in default, but where the default occurs and the said person, within thirty days after the date upon which the premiums became in default, pays the required premium, the said person

> shall be reinstated as an insured person under the Plan and coverage shall thereupon continue without interruption.

[22] Within about a month of the ***Regulations*** being enacted, s. 8.02 was amended by B.C. Reg. 195/68. The amended version read as follows (underlining shows the amendment):

> 8.02 Subject to s. 8.03, coverage of a person as an insured person ceases upon the premium for that coverage being fifteen days in default unless the Commission decides otherwise, but where the default occurs and the said person, within thirty days after the date upon which the premiums became in default, pays the required premium, the said person shall be reinstated as an insured person under the Plan and coverage shall thereupon continue without interruption.

[23] Thus, by the amendment, the Commission was given a discretion. There is an issue concerning the object of the discretion. Was it only in respect of the period of default? Or was it in respect of the consequences of default?

[24] There are three examples where the Commission exercised its discretion.

[25] On November 18, 1975, during an ongoing mail strike, the Commission recorded a "minute" deeming and deciding that the period of coverage of a person as an insured person "shall not cease" during the mail strike. The minute provided that:

> THEREFORE:
>
> The Commission by this Minute deems, and has decided that the coverage of a person as an insured person shall not cease during the period of the current mail strike, (and for a reasonable period not in excess of two months without further Minute following the date of cessation of the mail strike to provide for notices to be mailed and premiums received,) by reason of failure to pay (or have paid on their behalf) the premium payable, and shall not be deemed to be in default, and hence shall continue as an insured person and therefore entitled to have benefits paid for an insured service where the premium has been paid for the person, and recorded in the Plan system, to a month three months or less prior to the date that the insured service is rendered, and payment may be made under the Plan and the Regulations for that service.

[26] On February 16, 1976, by a further "minute," the Commission extended the three-month period set out in the November 18 minute, in the following terms:

> THEREFORE this Minute amends the Minute of the 18th of November 1975 and extends the determination therein made, in respect of default, to April 30, 1976 but that date may be amended by further simple Minute to a future date or indefinitely following any subsequent discussions with the Minister.

[27] Finally, on April 26, 1976, and again by "minute," the Commission extended the determination made in the November 18, 1975 minute (which was due to end on April 30, 1976) indefinitely, in the following terms:

> THEREFORE the Minute of 16th of February, 1976 is amended by striking out all the words following the word "default" in the last paragraph of that Minute and inserting the words "indefinitely, subject to reconsideration and possible modification if changes are approved in premium collection policy or other determination of the Minister".

[28] No subsequent minute reconsiders the decision in the April 26, 1976 minute.

[29] Mr. Grant points out that the ***Medical Services Act*** was enacted and the ***Regulations*** made against the statutory backdrop of s. 4(1)(c) of the ***Medical Care Act***, whereby the number of insurable residents entitled under the MSP to insured services was set at not less than 90% of insurable residents in the province (with that percentage rising to 95% after three years from the date of the first contribution) in order to qualify to receive payment by the Federal Government towards the cost of medical services. However, in 1984, the ***Medical Care Act*** was repealed and the ***Canada Health Act*** came into force. It required that, to satisfy the criterion of universality, the MSP must entitle 100% of the insured persons of the province to the insured health services provided for by the plan, on uniform terms and conditions.

(b) The *Canada Health Act* comes into force on April 1, 1984

[30] On April 1, 1984, the ***Canada Health Act***, S.C. 1984, c. 6, came into force. It repealed the ***Medical Care Act***.

[31] The ***Canada Health Act*** is described as:

> An Act relating to cash contributions by Canada in respect of insured health services provided under provincial health care insurance plans and amounts payable by Canada in respect of extended health care services . . . .

[32] It contains a preamble, which states in part:

> WHEREAS the Parliament of Canada recognizes:
>
> . . .
>
> —that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

[33] Section 2 of the ***Canada Health Act*** contains a number of definitions, including the following:

> "health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;
>
> . . .
>
> "insured health services" means . . . , physician services. . . provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;
>
> "insured person" means, in relation to a province, a resident of the province other than
>
> > (a) a member of the Canadian Forces,
> >
> > (b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein [Repealed, 2012, c. 19, s. 377],
> >
> > (c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or
> >
> > (d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;
>
> "medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;
>
> . . .
>
> "physician services" means any medically required services rendered by medical practitioners;
>
> "resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

[34] Sections 3 and 4 describe the "Primary objective of Canadian health care policy" and the "Purpose of this Act," respectively, as follows:

> 3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.
>
> 4. The purpose of this Act is to establish criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law.

[35] "Program criteria" are described in s. 7:

> 7. In order that a province may qualify for a full cash contribution . . . for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:
>
> (a) public administration;
>
> (b) comprehensiveness;
>
> (c) universality;
>
> (d) portability; and
>
> (e) accessibility.

[36] Sections 8 through 12 provide greater detail concerning the "Program criteria." For purposes of the issues before me, the important provisions are those concerning comprehensiveness, universality and accessibility (sections 9, 10 and 12), with universality and accessibility being particularly key:

> 9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.
>
> 10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.
>
> . . .
>
> 12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

> (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;
>
> (b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
>
> (c) must provide for reasonable compensation for all insured health services rendered by medical practitioners . . . ;
>
> . . .

(c) The *Medical and Health Care Services Act* (in force July 24, 1992)

[37] In 1992, the ***Medical Services Act*** was repealed. It was replaced by the ***Medical and Health Care Services Act***, S.B.C. 1992, c. 76, which was proclaimed in force on July 24, 1992. The Material Period begins the day before: July 23, 1992. On that day, the only possible source of authority to "de-enrol beneficiaries" was s. 8.02 of the ***Regulations***.

[38] Section 1 of the ***Medical and Health Care Services Act*** set out a number of defined terms.

[39] A "beneficiary" was defined to mean:

> a resident who is enrolled in accordance with section 6, and includes that resident's spouse or child who is a resident and has been enrolled under section 6;

[40] The common issues are framed using the term "beneficiaries," and the term is also used in the Third Amended Notice of Civil Claim filed November 25, 2011. However, there is not an exact correspondence between the statutory definition and how the term is used in the pleadings.

[41] The "commission" was defined as "the Medical Services Commission continued under section 2 . . . ."

[42] "Enroll," in respect of a beneficiary, was defined to mean "enrollment under section 6." The term "de-enrol" (or any variant of it) is not found anywhere in the

legislation. Rather, the term used is "cancel the enrollment of": see, e.g., s. 6(7) and s. 8(2). I will treat the terms "de-enrol" and "cancel the enrollment of" as synonymous.

[43] A "premium" was defined as "an amount prescribed under section 7."

[44] A "resident" was defined to mean:

> a person who
>
> (a) is a citizen of Canada or is lawfully admitted to Canada for permanent residence,
>
> (b) makes his or her home in British Columbia, and
>
> (c) is physically present in British Columbia at least 6 months in a calendar year,
>
> and includes a person who is deemed under the regulations to be a resident but does not include a tourist or visitor to British Columbia.

[45] Section 4 set out the responsibilities and powers of the Commission, and provided, among other things, the following:

> 4. (1) The commission may
>
> (a) administer this Act on a non-profit basis,
>
> (b) receive premiums that are payable by beneficiaries,
>
> . . .
>
> (f) investigate and determine whether a person is a resident and, for this purpose, require the person to provide the commission with evidence, satisfactory to the commission, that residency has been established;
>
> . . .
>
> (i) determine for the purposes of this Act whether a person meets the requirements established in the regulations for premium assistance,
>
> . . .
>
> (q) enter into arrangements and make payment for the costs of rendering benefits that will be provided on a fee for service or other basis,
>
> . . .
>
> (t) exercise other powers or functions that are authorized by the regulations or the minister.

> (2) The commission must not act under subsection (1) in a manner that does not satisfy the criteria described in section 7 of the *Canada Health Act* (Canada).

[46] On behalf of the class members, Mr. Grant argues that the criteria described in s. 7 of the ***Canada Health Act*** (including universality, comprehensiveness and accessibility) were incorporated by reference in s. 4(2) of the ***Medical and Health Care Services Act***, and he cites ***B.C.G.E.U. v. British Columbia (Minister of Health Services)***, 2007 BCCA 379 ("***BCGEU***"), at paras. 39-47 in support. Accordingly, Mr. Grant argues that the criteria of universality, comprehensiveness and accessibility should be understood as being incorporated into s. 4(2)'s mandatory direction to the Commission – that it must not act under subsection (1) in a manner that does not satisfy the criteria described in s. 7 of the ***Canada Health Act*** – and as providing further context in which to understand the purpose and object of the ***Medical and Health Care Services Act***. Moreover, in Mr. Grant's submission, s. 4(2) of the ***Medical and Health Care Services Act*** should be construed as saying that the Commission must not administer the ***Act*** (including exercising its powers under s. 8(2)) in a manner that does not satisfy the criteria described in s. 7 of the ***Canada Health Act***.

[47] On behalf of the defendants, Mr. Morley acknowledges that ***BCGEU*** is the leading case on incorporation of the ***Canada Health Act*** into the ***Medical and Health Care Services Act*** (then the ***Medicare Protection Act***, R.S.B.C. 1996, c. 286). However, Mr. Morley argues that the effect of material incorporated by reference depends on how it is used in the enactment in which it is incorporated, and the result of the incorporation by reference of the ***Canada Health Act*** is much more limited than what Mr. Grant asserts.

[48] Section 6 of the ***Medical and Health Care Services Act*** dealt with the eligibility and enrollment of beneficiaries, and provided:

> 6. (1) A resident who wishes to be enrolled as a beneficiary on his or her own behalf, or on behalf of his or her spouse or children, must apply to the commission in the manner required by the commission.

> (2) The commission must, after determining that the applicant, the spouse of the applicant and each of the applicant's children named in the application are residents, enroll as beneficiaries those covered by the application who are residents, effective not more than 3 months after receipt of the application.
>
> (3) The commission may, at the time of enrollment under subsection (2), or at any other time, enroll as a beneficiary a spouse or a child of a beneficiary after the commission determines that the spouse or child is a resident.
>
> (4) An enrollment under subsection (2) or (3) may be made effective on a date preceding the date of application for enrollment.
>
> (5) A beneficiary enrolled under subsection (2) or (3) must pay to the commission the applicable premiums.
>
> (6) Every person who was an insured person under the former Act immediately before this Act came into force is a beneficiary under this Act until he or she ceases to be a beneficiary in accordance with this Act or the regulations.
>
> (7) The commission may cancel the enrollment of a beneficiary if the commission determines that the beneficiary no longer is a resident.
>
> (8) If a person paid premiums for a period after which cancellation of that person's enrollment as a beneficiary took effect, the commission must, if practicable, refund the amount of those premiums to the person who paid them.

[49] Under s. 7, concerning premiums, the ***Act*** provided:

> 7. (1) The Lieutenant Governor in Council may prescribe premium rates for beneficiaries.
>
> (2) The rates may be different for different categories of beneficiaries, as defined in the regulations, and the regulations may provide that, in respect of a category of beneficiaries as defined in the regulations, no premiums are payable.
>
> (3) A premium that has not been paid during any period in which a beneficiary has been enrolled may be recovered by the commission as a debt owing to the commission.

[50] Section 8 concerned "Payments for benefits and cancellation or extension of enrollment," and provided that:

> 8. (1) A beneficiary is, subject to sections 9(1), 10, 13 and 14, entitled to have payment made for a benefit that he or she has received, in accordance with amounts in a payment schedule, less any applicable patient visit charge.

> (2) The commission may cancel the enrollment of a beneficiary who has failed to pay premiums
>
> (a) within the time required by the commission, or
>
> (b) within any extension of time that may be given by the commission.
>
> (3) An extension under subsection (2)(b) may be given after the time under subsection (2)(a) has expired.
>
> (4) A beneficiary whose enrollment is cancelled under subsection (2) may, with the consent of the commission, be reinstated on payment of the arrears owing at the time of the reinstatement.
>
> (5) A beneficiary who is reinstated is entitled to have payment made for benefits that he or she has received during the period that the beneficiary's enrollment was cancelled.

[51] The resolution of the first common issue requires me to interpret s. 8(2). The defendants say that this section gives the Commission the legal authority, in the period from July 24, 1992 to April 30, 1996, to cancel the enrollment of – or "de-enrol" – beneficiaries who were B.C. residents for non-payment of premiums. On the other hand, the class members say that, properly construed and particularly in the context of the later amendments to the ***Medical and Health Care Services Act***, the section does not give the Commission that authority.

[52] Section 12 concerns the enrollment of medical and health care practitioners. Section 12(3) provides that:

> (3) A practitioner who renders benefits to a beneficiary is, if this Act and the regulations made under it are complied with, eligible to be paid for his or her services in accordance with the appropriate payment schedule, less any applicable patient visit charge or reduction made under section 19(2).

(d) Amendments to the *Medical and Health Care Services Act* – the *Medicare Protection Act*

[53] In 1995, the Legislature amended the ***Medical and Health Care Services Act*** by the ***Medical and Health Care Services (Amendment) Act***, S.B.C. 1995, c. 52, effective September 30, 1995 (the "***Amendment Act***").

[54] The ***Amendment Act*** repealed the title of the ***Medical and Health Care Services Act***, and replaced it with the title the ***Medicare Protection Act***. This is the current title of the statute.

[55] The ***Amendment Act*** also added the following preamble:

> WHEREAS the people and government of British Columbia believe that medicare is one of the defining features of Canadian nationhood and are committed to its preservation for future generations;
>
> WHEREAS the people and government of British Columbia wish to confirm and entrench universality, comprehensiveness, accessibility, portability, and public administration as the guiding principles of the health care system of British Columbia and are committed to the preservation of these principles in perpetuity;
>
> WHEREAS the people and government of British Columbia recognize a responsibility for the judicious use of medical services in order to maintain a fiscally sustainable health care system for future generations;
>
> AND WHEREAS the people in government of British Columbia believe it to be fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay;

[56] In ***BCGEU***, Madam Justice Rowles (at para. 40) described this as

> a strongly-worded preamble which reflects the intention of the legislature in enacting health care legislation for British Columbia, specifically, the principles upon which the Medical Services Plan is to operate. The preamble states that "the people and government of British Columbia wish to confirm and entrench universality, comprehensiveness, accessibility, portability and public administration as the guiding principles of the health care system of British Columbia and are committed to the preservation of these principles in perpetuity".

She continued, at para. 41:

> [41] Section 7 of the ***Canada Health Act*** sets out the five principles in the context of a province qualifying for federal funding. The ***Medicare Protection Act*** has adopted those principles not simply as a means to receive federal funding but as the guiding principles for administering health care in the Province. The use of the words "confirm and entrench" in relation to the five principles leaves no room for ambiguity.

[57] Moreover, the ***Amendment Act*** (s. 3) added a "Purpose" provision, as s. 1.1, which stated:

> 1.1. The purpose of this Act is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay.

[58] May 1, 1996 is the effective date of a Ministerial Directive directing the Commission to cease cancelling the enrollment as a beneficiary of a B.C. resident who has failed to pay premiums. After May 1, 1996, unpaid premiums were then enforced by other means. May 1, 1996 therefore marks the end of the period relevant to the certified common issues.

[59] January 1, 1998 is the effective date of sections 1-4 of the ***Medicare Protection Amendment Act, 1997***, S.B.C. 1997, c. 26, which repeals and replaces s. 9 of the ***Medicare Protection Act*** (formerly s. 8 of the ***Medical and Health Care Services Act***). January 1, 1998 is also the effective date of the ***Medical and Health Care Services Regulation***, B.C. Reg. 426/97, which repeals and replaces the ***Regulations***.

[60] Thus, as of January 1, 1998, both s. 8(2) of the ***Medical and Health Care Services Act*** and s. 8.02 of the ***Regulations*** had been repealed.

Discussion and analysis

[61] I will first set out the basic principles applicable to questions of statutory interpretation. Then I will address the arguments in respect of the proper interpretation of s. 8(2) of the ***Medical and Health Care Services Act***. This provision covers all but one day (July 23, 1992) of the period in issue. I will then address the issues concerning the interpretation of s. 8.02 of the ***Regulation***.

(a) Statutory Interpretation: Basic Principles

[62] In ***Rizzo & Rizzo Shoes Ltd. (Re)***, [1998] 1 S.C.R. 27, one of the leading cases on statutory interpretation, Mr. Justice Iacobucci said, at para. 21:

> 21 Although much has been written about the interpretation of legislation . . . , Elmer Driedger in *Construction of Statutes* (2nd ed. 1983) best encapsulates the approach upon which I prefer to rely. He recognizes that

> statutory interpretation cannot be founded on the wording of the legislation alone. At p. 87 he states:
>
> > Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.

See also ***Bell ExpressVu Partnership Limited v. Rex***, 2002 SCC 42, [2002] 2 S.C.R. 559, at para. 26; ***Alberta Union of Provincial Employees v. Lethbridge Community College***, 2004 SCC 28, [2004] 1 S.C.R. 727, at para. 25; and ***Canada (Information Commissioner) v. Canada (Minister of National Defence)***, 2011 SCC 25, [2011] 2 S.C.R. 306, at para. 27.

[63] Context in the construction of statutory language is invaluable. The modern approach to statutory interpretation recognizes that statutory interpretation cannot be founded on the wording of the provision alone, and that the words of the particular provision must be considered in light of the legislation as a whole. See ***Lethbridge Community College***, at para. 26.

[64] Thus, the interpretation of a statutory provision must be made according to a textual, contextual and purposive analysis to find a meaning that is harmonious with the legislation as a whole. When the words of a provision are precise and unequivocal, the ordinary meaning of the words plays a dominant role in the interpretive process. On the other hand, where the words can support more than one reasonable meaning, the ordinary meaning of the words plays a lesser role. The relative effects of ordinary meaning, context and purpose on the interpretive process may vary, but in all cases the court must seek to read the provisions of an Act as a harmonious whole. See ***Canada Trustco Mortgage Co. v. Canada***, 2005 SCC 54, [2005] 2 S.C.R. 601, at para. 10.

[65] In ***Novak v. Bond***, [1999] 1 S.C.R. 808, McLachlin J. (as she then was) described the approach to statutory interpretation in these terms, at para. 63:

> The cardinal principle of statutory interpretation is that a legislative provision should be construed in a way that best furthers its objects: see *Rizzo & Rizzo Shoes Ltd. (Re)*, [1998] 1 S.C.R. 27, at paras. 21-22, *per* Iacobucci J.,

> and *Interpretation Act*, R.S.B.C. 1996, c. 238, s. 8. Subsidiary rules of statutory interpretation provide that each part of an enactment must be given meaning, and that statutes must be construed in such a way that absurdities are avoided: see *Rizzo Shoes*, *supra*, at para. 27, *per* Iacobucci J.

[66] The provisions of the ***Interpretation Act***, R.S.B.C. 1996, c. 238 are also a very important source of guidance. For example, s. 8 provides that:

> Every enactment must be construed as being remedial, and must be given such fair, large and liberal construction and interpretation as best ensures the attainment of its objects.

[67] In considering the object and purpose of an Act, a preamble can be a valuable tool. Section 9 of the ***Interpretation Act*** provides that: "The title and preamble of an enactment are part of it and are intended to assist in explaining its meaning and object." On the other hand, as Mr. Justice LaForest observed in ***McVey (Re); McVey v. United States of America***, [1992] 3 S.C.R. 475, at p. 525: "it would seem odd if general words in a preamble were to be given more weight than the specific provisions that deal with the matter." See also ***Yin v. Lewin***, 2006 ABQB 402, aff'd (*sub nom* ***Poira v. Kirby***) 2007 ABCA 406, at paras. 31-32.

[68] Sections 36 and 37 of the ***Interpretation Act*** provide guidance where enactments have been repealed and replaced. For example, regarding whether inferences should be drawn from the repeal or amendment of legislation, s. 37 provides:

> **No implications from repeal, amendment, etc.**
>
> 37 (1) The repeal of all or part of an enactment, or the repeal of an enactment and the substitution for it of another enactment, or the amendment of an enactment must not be construed to be or to involve either a declaration that the enactment was or was considered by the Legislature or other body or person who enacted it to have been previously in force, or a declaration about the previous state of the law.
>
> (2) The amendment of an enactment must not be construed to be or to involve a declaration that the law under the enactment prior to the amendment was or was considered by the Legislature or other body or person who enacted it to have been different from the law under the enactment as amended.
>
> (3) An amendment, consolidation, re-enactment or revision of an enactment must not be construed to be or to involve an adoption of the

> construction that has by judicial decision or otherwise been placed on the language used in the enactment or on similar language.

[69] Mr. Grant and Mr. Morley disagree on which aspects of the modern approach to statutory interpretation should be given the most weight in answering the common issues. Mr. Grant emphasizes the scheme and purpose of the legislation as driving the proper construction of the provisions in issue, and argues that, after identification of the scheme and purpose, the task is then to identify the interpretation of the specific provision that best furthers the scheme and purpose. On the other hand, Mr. Morley emphasizes the textual analysis.

[70] However, as is clear from the cases referred to above, the words of the provisions in issue "are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention" of the Legislature.

(b) Did s. 8(2) of the *Medical and Health Care Services Act* (as amended) give the Commission legal authority to de-enrol beneficiaries?

[71] For convenience, I again set out s. 8(2) of the ***Medical and Health Care Services Act***:

> The commission may cancel the enrollment of a beneficiary who has failed to pay premiums
>
> (a) within the time required by the commission, or
>
> (b) within any extension of time that may be given by the commission.

[72] The textual analysis of s. 8(2) is straightforward.

[73] The section provides that the "commission" (i.e., the Commission, one of the defendants in this case) "may cancel the enrollment of a beneficiary who has failed to pay premiums." The word "may" indicates that the Commission is being given a legal authority and connotes a measure of discretion: see the definition of "may" in s. 29 of the ***Interpretation Act***, and ***Canada (Attorney General) v. Mavi***, 2011 SCC 30, [2011] 2 S.C.R. 504, at para. 54. In the light of the definitions of

"beneficiary" and "resident" under s. 1 of the ***Act***, all beneficiaries were by definition B.C. residents, and the authority under s. 8(2) could therefore be exercised with respect to B.C. residents. The only basis for authority under s. 8(2) to cancel the enrollment of a beneficiary is with respect to someone who has failed to pay premiums. It follows, on the basis of the textual analysis, that the Commission has the legal authority to de-enrol beneficiaries who (by definition) were B.C. residents for non-payment of MSP premiums.

[74] However, while the textual analysis can be straightforward, it does not necessarily represent the last word, as ***Rizzo & Rizzo*** itself illustrates.

[75] Mr. Grant acknowledges that, at first blush, s. 8 (and specifically s. 8(2)) of the ***Medical and Health Care Services Act*** would appear to give the Commission the authority to de-enrol (i.e., cancel the enrollment of) beneficiaries for non-payment of premiums, given what s. 8(2) expressly states.

[76] However, in Mr. Grant's submission, s. 8(2) must be construed in the context of the object and purpose of the ***Act*** and of the other provisions of the ***Act***. These include s. 4(2), which incorporates the ***Canada Health Act*** by reference. In that context, the Commission's powers under s. 8(2) are more limited and do not provide the Commission with the legal authority to cancel the enrollment of beneficiaries for non-payment of premiums.

[77] In Mr. Grant's submission, the Legislature has assisted in the interpretive exercise by the amendments in the ***Amendment Act***, which Mr. Grant says clarified and defined exactly what the object of the legislation always was. Mr. Grant submits that the fact that the ***Amendment Act*** came three years after the original enactment of the ***Medical and Health Care Services Act*** should not be taken to have changed its object or purpose. Rather the amendments should be understood as confirming and entrenching the legislative objects and reinforcing the legislature's original aims. He relies on s. 37(2) of the ***Interpretation Act*** in that regard.

[78] Mr. Grant argues (based on s. 3 of the ***Amendment Act***, which added the purpose provision as s. 1.1 of the ***Act***) that the purpose of the ***Act*** has been legislatively defined as being "to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not on an individual's ability to pay."

[79] In Mr. Grant's submission, the change in the name (to the ***Medicare Protection Act***) brought about by the ***Amendment Act*** was "arguably one of the most ardent statements about how this legislature was intending to defend public medicare." Mr. Grant describes the preamble in the ***Amendment Act*** as "nothing less than a passionate embrace of the core principles of the Canadian medicare system." In Mr. Grant's submission, by the amendments in the ***Amendment Act***, the legislature made it clear that it intended the legislation "to be a ringing endorsement" of the principles of universality, comprehensiveness and accessibility.

[80] Mr. Grant argues that, even before the ***Amendment Act***, and certainly after, s. 8(2) must be interpreted in the context of s. 4(2), which provided that the Commission "must not act" under s. 4(1) "in a manner that does not satisfy the criteria described" in s. 7 of the ***Canada Health Act***. Indeed, Mr. Grant argues that the Commission's power under s. 8(2) is itself circumscribed and limited by s. 4(2).

[81] In Mr. Grant's submission, any interpretation of s. 8(2) that would allow the Commission to de-enroll a beneficiary for non-payment of premiums would fly in the face of the purpose and object of the ***Medical and Health Care Services Act*** (as amended by the ***Amendment Act***) and the requirements of s. 4(2). Mr. Grant argues that such an interpretation would produce an absurdity, namely: that while (based on what Mr. Grant says is the proper construction of s. 4(2)) the Commission is not entitled to do anything that would be inconsistent with the principles of universality, comprehensiveness and accessibility, it could deny to a beneficiary the ability to obtain publicly funded medical services, all because he or she had not paid his or her premiums. In Mr. Grant's submission, such an interpretation would run counter to the accepted modern principle of statutory interpretation because it is

incompatible with what, in Mr. Grant's submission, is the purpose and object of the ***Act***.

[82] Mr. Grant addresses the question of how, against the background he has described, s. 8(2) of the ***Medical and Health Care Services Act*** can be given meaning, and be reconciled with what, in his submission, is the purpose and object of that ***Act***.

[83] Mr. Grant submits first that s. 8(2) should be interpreted as applicable only where the Commission determined that the beneficiary was no longer a B.C. resident and that this was the reason for non-payment of premiums. In Mr. Grant's submission, based on such an interpretation of s. 8(2), the Commission would not be violating the criteria of universality, accessibility and comprehensiveness (something that, in Mr. Grant's submission, the Commission was legally prohibited from doing, based on his interpretation of s. 4(2) of the ***Act***) and would be ensuring that 100% of B.C. residents were able to access publicly funded health care solely on the basis of need, and not the ability to pay.

[84] In Mr. Grant's submission, such a construction of s. 8(2) would be the "large and liberal" interpretation that is consistent with the purpose of the ***Act*** and with the preamble and title of the ***Act*** added by the ***Amendment Act***. Moreover, in Mr. Grant's submission, this interpretation would be consistent with the "mandate" of s. 4(2) of the ***Act***.

[85] In the alternative, Mr. Grant argues that s. 8(2) of the ***Act*** could be interpreted so that it would be applied to cancel enrollment of a beneficiary only if the criteria of the ***Canada Health Act*** could be complied with. In Mr. Grant's submission, under this interpretation of s. 8(2), the Commission would not exercise its powers under the section until such time as the ***Canada Health Act*** criteria were amended by Parliament in a way that would allow the Commission to exercise its powers without violating those criteria.

[86] In Mr. Grant's submission, under either of his proposed interpretations of s. 8(2), the Commission's authority would be: (a) limited by the purpose and object of the ***Medical and Health Care Services Act*** (as amended by the ***Amendment Act***); (b) consistent with a remedial interpretation of the legislation; and (c) consistent with the requirements of s. 4(2).

[87] However, in my view, Mr. Grant's attempt in this way to give meaning to s. 8(2) (other than what, at first blush, appears to be the obvious meaning) must fail.

[88] With respect to Mr. Grant's first suggested construction, it is inconsistent with the definition of "beneficiary" in s. 1 of the ***Act***. A non-resident, by definition, cannot be a beneficiary. There would be no need to provide the Commission with the power to cancel the enrollment of someone who is, by definition, not a beneficiary. Moreover, s. 6(7) of the ***Act*** provides the Commission with separate, express authority to cancel the enrollment of a beneficiary if the Commission determined the individual is no longer a resident. Mr. Grant's proposed construction of s. 8(2) – to deal with non-residents – renders the section redundant. Finally, if (as Mr. Grant proposes), s. 8(2) should be read as applying to non-residents, it is incompatible with sections 8(4) and (5), which permit the Commission to reinstate a beneficiary (who, by definition, must be a resident). These subsections are part of the context in which s. 8(2) is to be interpreted.

[89] With respect to Mr. Grant's alternative interpretation, Mr. Grant cited no example or precedent where a court concluded a legislature expressly created an authority with the intention that the authority would not be exercised except in the event of unanticipated changes in legislation of a different level of government. Mr. Grant's attempt in this way to give meaning to s. 8(2) is too far-fetched to be either reasonable or persuasive.

[90] In oral submissions, Mr. Grant referred to s. 4(2) of the ***Act*** as the centrepiece of the purpose and object of the legislation. Indeed, an important implication of his argument about the proper construction of s. 8(2) is that providing the Commission with a discretion to cancel the enrollment of a beneficiary for non-payment of

premiums was fundamentally inconsistent with the ***Canada Health Act*** criteria of universality and accessibility, and therefore (based on the "mandate" in s. 4(2)) contrary to the scheme and purpose of the ***Medical and Health Care Services Act***. Mr. Grant submits that, when the ***Act*** was enacted in 1992, the Legislature underscored its intention that the ***Act*** be a "ringing endorsement" of the principles of universality, comprehensiveness and accessibility incorporated in s. 4(2) by "mandating that the Commission do nothing in administering the Act that would not satisfy the criteria as described by the *Canada Health Act*."

[91] But s. 4(2) does not in fact state that the Commission do nothing in administering the ***Act*** that would not satisfy the criteria as described by the ***Canada Health Act***. Rather, it states that "The commission must not act under subsection (1) in a manner that does not satisfy the criteria described in section 7 of the *Canada Health Act* (Canada)" [underlining added]. Mr. Grant's interpretation of s. 4(2) treats the underlined words as superfluous and meaningless. It requires that the acts described in s. 4(1) be stretched far beyond what would be justified, given the descriptions and in the context of the ***Act*** as a whole, to include specific powers set out in another Part of the ***Act***. It ignores the context in which those specific powers of the Commission (such as those under s. 8) are found.

[92] Placed in its actual context, the limitation described in s. 4(2) applies (as the subsection says) to what is described in s. 4(1). If the Legislature had intended a more general limitation on the manner in which the Commission was permitted to act – one going beyond the scope of s. 4(1) – it would have been a simple matter to draft one. But this was not done. ***BCGEU*** does not assist Mr. Grant to expand the reach of s. 4(2) to s. 8(2) because the powers that were in issue in ***BCGEU*** were powers the Commission had under s. 4(1) (then s. 5(1) of the ***Medicare Protection Act***).

[93] Of course, after September 30, 1995, the ***Medicare Protection Act*** included the "strongly-worded preamble," expressly confirming and entrenching universality, comprehensiveness and accessibility as guiding principles, and committing to the

preservation of these principles "in perpetuity." The preamble expresses the belief that it is "fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay." The express purpose provision stated that the purpose of the ***Act*** "is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay."

[94] As the ***Interpretation Act*** provides, the title and preamble of an enactment are intended to assist in explaining the enactment's meaning and object. An express purpose provision cannot be safely ignored.

[95] In Mr. Grant's submission, the amendments made in 1995 should not be taken to have changed the object or purpose of the ***Medical and Health Care Services Act***. Rather, they can and should be employed as tools in the interpretation of the ***Act*** from the time it was first enacted. They should be understood as simply affirming and supporting (in addition to expressly stating) what was previously the implicit object and purpose of the ***Act***.

[96] However, even if the amendments should be understood as simply making explicit what was previously the implicit object and purpose of the ***Act***, in my opinion, it would not advance Mr. Grant's position concerning the proper construction of s. 8(2), applying the modern approach to statutory interpretation.

[97] Both the preamble and the purpose provision added by the ***Amendment Act*** mention as goals a system where access to medical care can be solely based on need and not on an individual's ability to pay, and the maintenance of a fiscally sustainable health care system. There can be little doubt that these were objects of the ***Medical and Health Care Services Act*** in 1992, even though they were not expressed in the same way as in the ***Amendment Act***.

[98] However (as Mr. Morley points out in his submissions), the goals are potentially in tension with one another. In interpreting the provisions of the ***Act***, it

would not be proper to focus only on words supporting the object of a system where access to medical care can be solely based on need and not on ability to pay, and ignore the words concerning fiscal sustainability. To do so would be to ignore part of the context in which the words appear. Instead, the modern approach requires that words of an Act be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act and the intention of the legislature.

[99] When the ***Medical and Health Care Services Act*** was enacted in 1992, the Legislature addressed the "fiscally sustainable" aspect by requiring the payment by a beneficiary of "the applicable premiums": see s. 6(5) of the ***Act***. Under s. 7, premium rates prescribed might be different for different categories of beneficiaries, and "regulations may provide that . . . no premiums are payable." Such provisions, which acknowledge the goals of fiscal sustainability and accessibility based on need rather than ability to pay, are part of the context in which s. 8(2) must be interpreted. Funding alternatives other than the payment of premiums were, no doubt, available. But payment of premiums was the choice made at the time to promote fiscal sustainability. If premiums are a part of a fiscally sustainable system, there must be some way to ensure payment when an individual is able but not willing to pay. This is what s. 8(2) is designed to facilitate.

[100] My role is to interpret what the words in the ***Act*** mean, based on the accepted principles applicable to statutory interpretation and looking at the words actually chosen by the Legislature. In my opinion, giving the Commission the discretion to cancel the enrollment of a beneficiary who has failed to pay premiums, as provided for in s. 8(2), supports the goal of a fiscally sustainable health care system and is neither incompatible nor inconsistent with the goal of a system where access to medical care can be solely based on need and not on an individual's ability to pay. Such an interpretation of s. 8(2) is in harmony with the scheme and object of the ***Act***, as made explicit by the amendments in the ***Amendment Act***. It does not offend either the principle of universality or the principle of accessibility.

[101] Since the ***Medical and Health Care Services Act*** was not in force on July 23, 1992, it could not provide the Commission with the legal authority to do anything on that date.

[102] Accordingly, I conclude that the question, Did the Commission have the legal authority under the ***Medical and Health Care Services Act***, as amended, during the Material Period to de-enrol beneficiaries who were B.C. residents for non-payment of MSP premiums?, should be answered Yes, except for July 23, 1992.

(c) Did s. 8.02 of the *Regulations* give the Commission legal authority to de-enrol beneficiaries?

[103] Again for convenience, I set out s. 8.02 of the ***Regulations***, as amended:

> 8.02 Subject to s. 8.03, coverage of a person as an insured person ceases upon the premium for that coverage being fifteen days in default unless the Commission decides otherwise, but where the default occurs and the said person, within thirty days after the date upon which the premiums became in default, pays the required premium, the said person shall be reinstated as an insured person under the Plan and coverage shall thereupon continue without interruption.

[104] The ***Regulations*** were not repealed when the ***Medical Services Act*** (under which they had been made) was repealed and replaced by the ***Medical and Health Care Services Act*** in 1992. In addition, since the ***Regulations*** were made under the ***Medical Services Act***, they use terminology (e.g., “insured person,” “insured services”) used under that ***Act***.

[105] On the question whether the ***Regulations*** remained in force after July 23, 1992 (until they were repealed in January 1998), the ***Interpretation Act*** provides:

> **Repeal and replacement**
>
> 36 (1) If an enactment (the "former enactment") is repealed and another enactment (the "new enactment") is substituted for it,
>
> . . .
>
> (e) all regulations made under the former enactment remain in force and are deemed to have been made under the new enactment, in so far as they are not inconsistent with the new enactment, until they are repealed or others are made in their place,

[106] Thus, pursuant to s. 36(1)(e) of the ***Interpretation Act***, s. 8.02 of the ***Regulations*** remained in force after the enactment of the ***Medical and Health Care Services Act*** in so far as it was not inconsistent with that ***Act***.

[107] Mr. Grant argues that s. 8.02 of the ***Regulation*** is inconsistent with both the ***Act*** generally (in the light of s. 4(2)), and with s. 8(2) in particular. In Mr. Grant's submission, for that reason, effective July 24, 1992, the Commission had no legal authority to de-enrol beneficiaries for non-payment of MSP premiums relying on s. 8.02.

[108] On the other hand, Mr. Morley argues that there is no inconsistency. Therefore, in Mr. Morley's submission, s. 8.02 of the ***Regulations*** remained in force until the ***Regulations*** were repealed in 1998, and they provided another basis (an alternative to s. 8(2) of the ***Medical and Health Care Services Act***) for the authority of the Commission to de-enroll – i.e., cancel the enrollment of – beneficiaries for non-payment of MSP premiums.

[109] In support of his position that s. 8.02 of the ***Regulations*** is inconsistent with the ***Medical and Health Care Services Act***, Mr. Grant argues that s. 8.02 provides for a mandatory cessation of coverage (in oral submissions, Mr. Grant described the approach in s. 8.02 as "shoot first and ask questions later"), whereas s. 8(2) of the ***Act*** provides the Commission with a discretion. In Mr. Grant's submission, the mandatory cessation of "coverage" of an "insured person" and the discretionary de-enrollment of a "beneficiary" is not the only conflict between s. 8.02 of the ***Regulations*** and s. 8(2) of the ***Act***, but it is the most stark.

[110] I do not agree that s. 8.02 is mandatory in the sense that the Commission had no discretion. Rather the structure of the drafting in s. 8.02 (describing a particular result unless the decision maker decides otherwise) is seen in many cases where, without a doubt, the decision maker is being given a discretion. The ***Supreme Court Civil Rules*** have many examples. For instance, Rule 14-1(9) provides that "costs of a proceeding must be awarded to the successful party unless the court otherwise orders."

[111] However, what does the discretion under s. 8.02 relate to?

[112] Mr. Grant argues that, to the extent the Commission had any discretion, the discretion was narrow and related only to the period of time. Thus, the Commission had the discretion to extend the period before which "coverage of a person as an insured person ceases" to something more than fifteen days in default; in other words, to fix a deadline that was more than fifteen days. This is something the Commission in fact did, by the minutes in 1975 and 1976, referred to above. But, in Mr. Grant's submission, the Commission did not have the discretion to decide coverage would not cease at all where there was a default.

[113] In support of the submission that the Commission's discretion under s. 8.02 was limited in a way that renders s. 8.02 inconsistent with s. 8(2) of the ***Act***, Mr. Grant points to the definition of "insured person" under the ***Regulations*** [underlining added]:

> "insured person" means a resident of the Province who is entitled to insured services and insured under the plan of these regulations, and who is not in default in payment of premiums;

[114] Thus, under the ***Regulations***, an "insured person" is defined in terms of someone who is not in default in payment of premiums. The definition of "beneficiary" under the ***Act*** does not do this.

[115] I agree with Mr. Grant that, properly construed, the Commission's discretion under s. 8.02 is narrow.

[116] Since, under the ***Regulations***, a person in default of payment of premiums could not be an "insured person," the Commission's discretion under s. 8.02 necessarily was limited to fixing a deadline, after which coverage ceases. The Commission had no discretion with respect to the consequences of missing the deadline. That was spelled out in s. 8.02: "coverage . . . ceases."

[117] This is not the approach under s. 8(2) of the ***Act***. Cancellation of enrollment of a beneficiary does not necessarily follow from the fact that the beneficiary has

failed either to pay premiums within the time required by the Commission or within any extension of time that may be given by the Commission. The Commission is given a discretion with respect to time, and, more importantly, the Commission is clearly given a discretion concerning the consequences of a failure to pay: the Commission may cancel the enrollment. That was not the case under s. 8.02 of the ***Regulation***.

[118] In that light, I conclude that s. 8.02 of the ***Regulation*** is inconsistent with s. 8(2) of the ***Act***. The result, based on s. 36(1)(e) of the ***Interpretation Act***, is that s. 8.02 of the ***Regulation*** is effectively repealed by s. 8(2) of the ***Medical and Health Care Services Act***.

[119] Because I have concluded that s. 8.02 of the ***Regulation*** is inconsistent with s. 8(2) of the ***Act***, and therefore s. 8.02 was effectively repealed as of July 24, 1992, I do not intend to address the arguments relating to s. 8.02 based on s. 4(2) of the ***Act***.

[120] What was the situation on July 23, 1992? In my opinion, reading s. 8.02 in context, and harmoniously with the scheme and object of the ***Medical Services Act*** and the ***Regulations***, the Commission had the legal authority under s. 8.02 to de-enrol beneficiaries (or "insured persons") who were B.C. residents for non-payment of MSP premiums.

(d) Procedural Issues

[121] As I mentioned in the Introduction, there are two procedural issues that I will address briefly.

[122] The first concerns Ms. Gordon's affidavit no. 3 (apart from Exhibit "C"). Ms. Gordon is a legal administrative assistant in the office of plaintiff's counsel. The purpose of her affidavit is to put copies of documents (attached as exhibits) before the court. Mr. Morley objected to the admissibility of the affidavit on several grounds: that it was filed late; that it was not proper reply or rebuttal evidence; and

that the documents attached are not admissible to prove the truth of statements made in them, rendering the affidavit irrelevant.

[123] Ms. Gordon's affidavit no. 3 was apparently filed to respond to some of the submissions (referring to ***Canada Health Act*** Reports) made in the defendants' written submissions filed on April 16, 2013. In the plaintiff's written reply, Mr. Grant suggested that the defendants referred to these Reports as "somehow being conclusive proof" of certain facts, while he submitted that these Reports were irrelevant and proof of nothing. Certainly, on a summary trial (and absent agreement), the contents of the Reports would not be admissible to prove the truth of the statements made in the Reports, much less "conclusive proof" of such statements. In any event, Mr. Morley was not tendering them or referring to them for that purpose.

[124] I am sustaining Mr. Morley's objection to Ms. Gordon's affidavit no. 3. The exhibits (other than Exhibit C) attached to the affidavit are not admissible to prove the truth of the facts stated in them and are not relevant to any other matter in issue on the summary trial. In addition to the affidavit not being proper reply, the affidavit is irrelevant.

[125] The second issue concerns amendments Mr. Grant proposed during the hearing to the relief requested in the plaintiff's notice of application filed March 18, 2013. In oral submissions, Mr. Grant indicated that, if the court concluded the Commission had authority under s. 8(2) of the ***Medical and Health Care Services Act*** to de-enrol beneficiaries, then he was seeking a declaration about how that authority must be exercised. Mr. Morley objected.

[126] I am sustaining Mr. Morley's objection.

[127] Although there are a number of problems with Mr. Grant's request, the main one is that, in my view, the request was an attempt to add a new common issue for determination by the court. However, no such issue has been certified as a common issue in this case. The certified common issues were the product of negotiation,

resulting in a consent certification order. The court has not (yet) heard argument about whether any other issue – in particular, the issue Mr. Grant was proposing be determined as part of the summary trial – could or should be certified as a common issue in this case.

Summary and Disposition

[128] The first question I was required to answer is:

> Did the Medical Services Commission have the legal authority during the period July 23, 1992 to April 30, 1996 to de-enrol beneficiaries who were British Columbia residents for non-payment of Medical Services Plan premiums:
>
> (a) under the ***Medical and Health Care Services Act***, S.B.C. 1992, c. 76, as amended?

[129] I answer that question No on July 23, 1992, and Yes during the period from July 24, 1992 to April 30, 1996, inclusive.

[130] The second question I was required to answer is:

> Did the Medical Services Commission have the legal authority during the period July 23, 1992 to April 30, 1996 to de-enrol beneficiaries who were British Columbia residents for non-payment of Medical Services Plan premiums:
>
> (b) under s. 8.02 of the ***Medical Services Act Regulations***, B.C. Reg. 144/68, as amended?

[131] I answer that question Yes on July 23, 1992 and No during the period from July 24, 1992 to April 30, 1996, inclusive.

[132] Declaratory orders will go accordingly.

[133] Counsel have leave to make submissions on costs, provided they make arrangements within 30 days of the date of this judgment to do so.

"Adair J."