

REPORT OF THE JOINT COMMITTEE
RELATING TO THE 1986 – 1990 HEPATITIS C TRUST FUND

Submitted: June 30, 2005
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INTRODUCTION

1. The Joint Committee was established by the Courts in accordance with s. 9.01 of the January 1, 1986-July 1, 1990 Hepatitis C Settlement Agreement (“Agreement”). The current members of the Joint Committee are J. J. Camp, Q.C., Bonnie Tough, Michel Savonitto and Harvey T. Strosberg, Q.C..

2. Section 10.01(i) of the Agreement requires that the Courts “assess the financial sufficiency of the” 1986-1990 Hepatitis C Trust Fund (“Fund”).

3. The Joint Committee retained Eckler Partners Ltd. (“Eckler”) to prepare an actuarial report assessing the financial sufficiency of the Fund.

4. What follows is the Joint Committee’s report to the Courts setting out the assumptions given to Eckler and the basis of those assumptions.

APPROACH TO FORMING THE ASSUMPTIONS

5. For the 1999 actuarial study, class counsel used studies, surveys and other data that was not class specific to make assumptions about the nature and quantum of class members claims under the various heads of compensation.

6. For the 2001 valuation, the Joint Committee compared the 1999 assumptions to the claims experience to December 31, 2001. Where appropriate, the 1999 assumptions were revised to reflect actual claims data to the end of 2001. In some cases there was

insufficient claims data to make an assumption, then the Joint Committee looked to other sources.

7. For this valuation, the Joint Committee compared the 2001 assumptions to the claims experience to December 31, 2004. Where appropriate, the 2001 assumptions were revised to reflect actual claims data to the end of 2004. If the Joint Committee believed that there was insufficient claims data to allow it to reach a conclusion, then it modified its conclusions accordingly.

ESTIMATE OF THE TRANSFUSED COHORT SIZE

8. The critical question is: by June 30, 2010, the date when the Transfused HCV Plan closes, how many transfused primarily infected claimants will apply and, ultimately, be approved for compensation?

9. In 1999, based upon epidemiological analyses, Class Counsel instructed Eckler to assume that the maximum transfused cohort of potential claimants was 8,180 transfused primarily infected persons including 76 persons whose death before January 1, 1999 was caused by HCV (“DB9”).

10. For the 2001 valuation, after reviewing further epidemiological analyses and the 2000 and 2001 claims volume experience, the Joint Committee instructed Eckler to assume that the maximum transfused cohort of potential claimants was 9,108 transfused primarily infected persons who were alive on January 1, 1999 plus 150 DB9s but that

only 6,500 transfused primarily infected persons who were alive on January 1, 1999 plus 150 DB9s would apply by June 30, 2010 and be approved.

11. For the 2003 update, the purpose of which was to consider the removal of the loss of income caps, the Joint Committee decided not to commission an epidemiological analysis. Instead, the Joint Committee focused on the three and one-half years of historical claims volume experience as the basis for predicting the total number of transfused primarily infected persons who would apply by June 30, 2010 and be approved. The Joint Committee then instructed Eckler to assume that 4,000 to 5,000 transfused primarily infected persons who were alive on January 1, 1999 plus 150 DB9s would apply by June 30, 2010 and be approved.

12. For this valuation, the Joint Committee decided not to commission any further epidemiological studies. The Joint Committee's fundamental assumption is that the historical claims volume experience is the most reliable indicator of how many transfused primarily infected persons will apply by June 30, 2010 and be approved.

THE CURRENT ESTIMATE OF TRANSFUSED COHORT SIZE

13. The Joint Committee's best estimate of the total number of transfused primarily infected claimants who will claim by June 30, 2010 and be approved is 4,600, including 214 DB9s, and its has instructed Eckler to make this assumption for the purposes of its valuation report.

14. The Joint Committee has also instructed Eckler to perform sensitivity analyses based on the following alternative estimates:

- (a) 4,000 transfused primarily infected persons including 214 DB9s; and
- (b) 5,200 transfused primarily infected persons including 214 DB9s.

15. The analysis leading to this conclusion follows.

PROJECTIONS BASED UPON THE APPROVED AND IN PROCESS CLAIMS

16. Each of the following charts sets out the number of approved transfused primarily infected claims, the number of transfused primarily infected claims in process at a particular date and the Joint Committee's estimate of the number of claims to be approved based on a projected denial rate.

Transfused Cohort to December 31, 2001	Transfused primarily infected claimants including DA9 and DB9
Claims approved to December 31, 2001	1,990
Claims in process to December 31, 2001	1,205
Less: denial rate applied to claims in process	(286) (22% for alive and DA9, 39% for DB9)
Estimate of the number of persons who will be approved from those who had made a claim by December 31, 2001	2,909

Transfused Cohort to September 30, 2003	Transfused primarily infected persons including DA9 and DB9
Claims approved to September 30, 2003	3,021
Claims in process to September 30, 2003	472 (16 of which are DB9)
Less: denial rate applied to claims in process	(118) 25%
Estimate of the number of persons who will be approved from those who had made a claim by September 30, 2003	3,375

Transfused Cohort to December 31, 2004	Transfused primarily infected persons including DA9 and DB9
Claims approved to December 31, 2004	3,291 (153 of which are DB9)
Claims in process to December 31, 2004	526 (83 of which are DB9)
Less: denial rate applied to claims in process	(132) 25%
Less: Health Canada Negative denials	(83)
Estimate of the number of persons who will be approved from those who had made a claim by December 31, 2004	3,602

17. It is noteworthy that the estimate of the number of persons who would be approved based upon the number who had applied by September 30, 2003 (3,375) is more than the persons actually approved on December 31, 2004 (3,291) and that at December 31, 2004, there were more in process claims (526) than there were at September 30, 2003 (472), despite a declining claims volume. Of the 526 in process claims outstanding as of December 31, 2004, 285 were initiated in 2002 or earlier and have been in process for 2 years or more. The Administrator advises that, currently, 284 of the in process claims have been archived. This probably indicates that the deficiencies in some of the claims are taking a long time to clear up or will not be cleared up.

FACTORS CONSIDERED IN CALCULATING THE DENIAL RATE

18. For this valuation, the Joint Committee applied a denial rate of 25% to calculate how many claimants would be approved from the claimants who had applied by December 31, 2004 and in its go forward projections based upon a blended hard denial rate of 25.7% calculated as described below. This is the same rate that was used for the 2003 update report.

19. If the initiating claim form has been submitted but, for various reasons, the claim has not proceeded to approval or denial, it is categorized as an “in process claim.” An in process claim may ultimately be approved, hard denied, soft denied or archived by the Administrator. In process claims are archived where the Administrator loses contact with a claimant or where the claimant has not complied with the claims process. Some of these claims are “unarchived” when the reason for archival has been resolved.

20. A hard denial occurs when the Administrator advises a claimant that the claim is denied. To December 31, 2004, the total number of hard denials of transfused primarily infected claims is 1,354. When considered against total transfused primarily infected claims made, 5171¹, the hard denial rate is 26.2%.

21. A soft denial occurs when the Administrator advises a claimant that the claim is denied pending the claimant providing evidence to overcome a particular presumption in the Settlement Agreement. Some claims are archived after the Administrator issues a soft denial because the Administrator was not able to contact the claimant after issuing the soft denial.

22. The combined denial rate for both soft denials and hard denials for transfused primarily infected claimants is approximately 31%².

23. Some denied claims eventually are approved. According to the Administrator, 25 hard denials were eventually approved because of a successful appeal to a Referee, or because new information became available. If these variables are considered, the hard denial rate becomes 25.7%. In addition, 17 soft denials eventually were approved.

24. For the 2001 valuation, the Joint Committee calculated different hard denial rates for alive/DA9 claims (22%) and for DB9 claims (39%) because DB9 claims resulted in a

¹ 3,291 approved, 526 in progress and 1,354 hard denied. The denominator does not therefore include soft denials which are pending hard denial.

² The source for this number is the Administrator's Claims Summary Report appended to this report as Appendix 1. Some of the numbers are slightly different than numbers used in the 2002 and 2003 reviews because as the claims progress these statistics are reviewed and refined over time.

much higher denial rate. These different rates were applied to determine how many claimants would be approved from the claimants who had applied by December 31, 2001 but for the go forward projections applied only the lower 22% alive and DA9 hard denial rate. However, in calculating the denial rate for this valuation (and the same was true for the 2003 update), a blended denial rate for alive, DA9 and DB9 claims has been calculated and applied because the number of DB9 claims in process after 2001 were few.

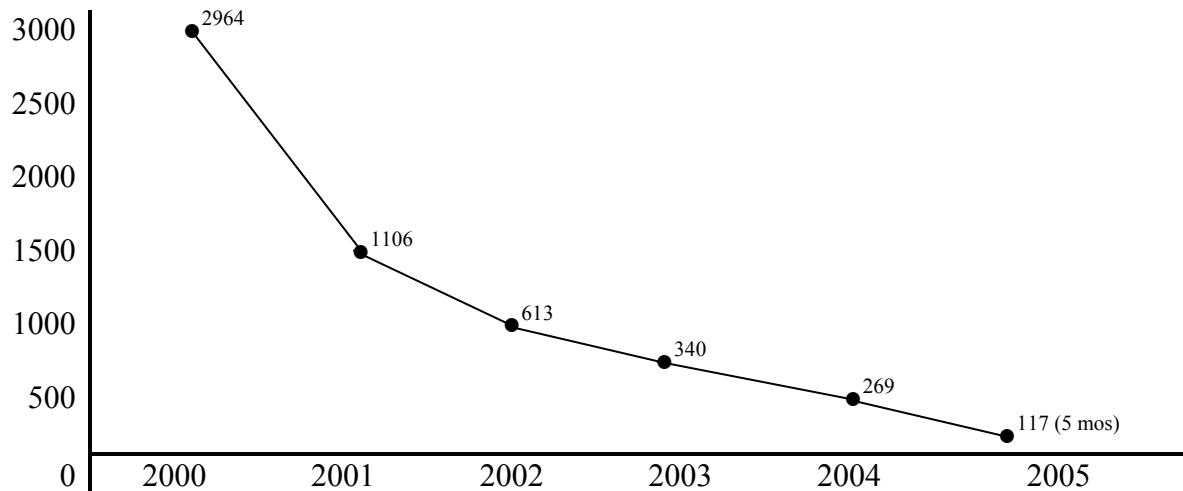
HEALTH CANADA NEGATIVE DENIALS

25. There are a category of post-approval denials called Health Canada Negative denials (“HCN” denials). A transfused primarily infected claimant who has an inconclusive traceback after six months is approved pursuant to the Transfused HCV Plan and the Court Approved Protocol on Tracebacks. But, if the ongoing Health Canada traceback subsequently produces evidence that the claimant was not infected by blood for the first time in the class period, an HCN denial occurs. The Administrator issues a “soft” denial letter which it converts to a hard denial in the event that the claimant cannot produce evidence that he or she was infected for the first time by a transfusion in the class period. Such a person receives no further compensation but he or she is not required to repay any benefits received between initial approval and HCN denial.

26. To date, 83 persons received HCN denials: 8 were categorized as DA9, and 1 was categorized DB9. Accordingly, the estimate of approved transfused primarily infected persons to December 31, 2004 (referred to as “knowns” in the Eckler valuation) has been reduced by 83 to account for the HCN denials.

PROJECTIONS THROUGH JUNE 30, 2010

27. The Joint Committee also reviewed the pace at which transfused primarily infected claims are being made. The year-by-year decline in claims volume is depicted in the following graph:



The year-by-year summaries of new claims (before approval or denial)³, and their respective percentages in comparison to the previous year are as follows:

Quarter	2000	2001	2002	2003	2004	2005
Jan – March	N/A	401	198	110	81	68
Apr – June	1,231 (May and June only)	234	172	77	65	49 (April and May)
July-Sept	1,136	256	125	76	57	N/A
Oct – Dec	597	215	118	77	66	N/A
Total	2,964	1,106 (63% drop)	613 (45% drop)	340 (43% drop)	269 (21% drop)	117 to May 31/05

28. The approximate number of new transfused claims for the first 5 months of 2005 is 117, or, an average, 23.4 per month compared to 22.4 per month for 2004. The

³ The source of this is also the Administrator's Claims Summary Report appended to this report as Appendix 1.

estimates of claims in 2005 are based on “unrefined” applications which may be recategorized when subjected to further claims processing.

29. In the following chart, the Joint Committee projects the total number of transfused primarily infected claimants who may ultimately be approved once the Transfused HCV Plan is closed in June 30, 2010, assuming a denial rate of 25% and also assuming various claims rates.

Projected claims volume based on various declines from the 2004 claims volume						
	30% decline annually	20% decline annually	10% decline annually	5% decline annually	0% decline annually	Slowing Decline from 20% - 5%
2005	188	215	242	256	269	215(20%)
2006	132	172	218	243	269	181(17%)
2007	93	138	196	231	269	155 (14%)
2008	65	110	176	219	269	138 (11%)
2009	45	88	159	208	269	127 (8%)
2010 (to June 30)	16	36	71	99	135	61(5%)
Total new claims	539	759	1,062	1,256	1,480	877
Less: denial rate 25%	(135)	(190)	(266)	(314)	(370)	(219)
Add estimated approvable claims to 31/12/2004	3,602	3,602	3,602	3,602	3,602	3,602
Total estimated claims approved to June 30, 2010	4,006	4,171	4,398	4,544	4,712	4,260

30. The Joint Committee concludes that, unless claims volumes increase or denial rates decrease between December 31, 2004 and June 30, 2010 from the historical rates, the number of approved transfused primarily infected claims will be no more than 4,700.

FACTORS WHICH COULD AFFECT THE PROJECTIONS OF THE NUMBER OF PRIMARILY INFECTED TRANSFUSED CLAIMANTS

31. In reaching its conclusions, the Joint Committee considered the following factors which could either increase claims volume or decrease denial rates.

- (a) **PERSONS WHO HAVE NOT BEEN DIAGNOSED TO DATE ARE ULTIMATELY DIAGNOSED AND APPLY PRIOR TO THE 2010 DEADLINE.** The Joint Committee has not been able to determine a method to quantify this variable. The Administrator's data is probably not a reliable indicator of the date of diagnosis because it tracks the most recent antibody or viral test date, which is not necessarily the test which produced the diagnosis. Generally, the data shows that later claims have later test dates associated with them, which is not surprising and probably of little assistance;
- (b) **DEVELOPMENTS IN SCIENCE AND/OR MEDICINE COULD IMPACT THE TYPE OF PROOF FOR TRANSFUSED CLAIMS APPROVAL AND/OR THE APPROVAL CRITERIA.** For example:
 - (i) a recent study by Castillo et al. published in the *Journal of Infectious Diseases*, 2004, vol. 189(1) deals with the relationship between HCV

infection, antibody testing, PCR serum testing and PCR biopsy testing. The article raises the possibility that a person could be negative for both HCV antibodies and HCV RNA on blood testing, but have HCV RNA in liver tissue tested on biopsy; and

- (ii) a debate in the medical literature pertaining to whether a person infected with HCV may lose antibodies to the virus over time;

(c) PROVINCIAL NOTIFICATION PROGRAMS AND PUBLIC AWARENESS

CAMPAIGNS:

- (i) although some hospitals in Ontario have in different ways attempted to communicate with people potentially infected with HCV by blood, Ontario has not carried out a coordinated, province-wide, lookback or traceback program. Matthews' 2002 affidavit, in paragraph 42, stated that the coordinator of the Hepatitis C Compensation Secretariat within the Ontario Ministry of Health could not confirm whether a co-ordinated province-wide notification program would go ahead although he did provide some details of a proposed notification program. The Joint Committee has been advised that the then proposed program has not proceeded. Given Ontario's delay, the Joint Committee concluded that it is improbable that Ontario will institute a province-wide lookback or traceback program before June 30, 2010;
- (ii) Labrador and Newfoundland does not intend to undertake a lookback notification program but has conducted a two tier public awareness campaign

through notification to the medical community and radio public service announcements. The Joint Committee does not anticipate further claims to come forward as a result of this public awareness campaign; and

- (iii) Alberta, Manitoba, Quebec, British Columbia, Prince Edward Island, Saskatchewan, New Brunswick, Nova Scotia, Northwest Territories, Yukon and Nunavut have each conducted some type of notification program and, thus, the Joint Committee does not expect any large influx of claims from these other provinces and territories as a result of a notification program;
- (d) **PERSONS WHO HAVE BEEN DIAGNOSED, HAVE NOT YET APPLIED BUT MAY APPLY PRIOR TO THE 2010 DEADLINE.** Such persons might be prompted to apply by a communications program or media coverage. Past experience with communications efforts is as follows:
 - (i) following the 2001 valuation which demonstrated that fewer claimants were coming forward than the cohort assumed in the 1999 actuarial analysis, the Joint Committee attempted to communicate with such potential claimants through Canadian physicians. In October 2003, a letter was sent to 26,920 physicians in the following categories: general physicians, family physicians and physicians who specialize in gastroenterology, hematology, infectious diseases, internal medicine (with an interest in gastroenterology), hematology and infectious diseases. The claims in the six months prior to this communication campaign averaged 25.5 per month and in the six months

following 25.3 per month. Accordingly, there was no appreciable effect on claims volumes as a result of this campaign; and

(ii) in November 2004, the federal Minister of Health announced an intention to compensate persons infected before 1986 and after 1990. The Health Minister's announcement created significant media attention around this settlement suggesting that such persons might be included in this settlement. In November and December 2004, transfused claims averaged 22.5 per month, compared with an average of 22.4 per month for the nine months prior to November. In January to May, 2005, transfused claims averaged 23.4 per month. This could represent a slight effect on claims subsequent to the announcement.

ESTIMATE OF THE HEMOPHILIAC COHORT SIZE

32. The critical question is: by June 30, 2010, the date the Hemophiliac HCV Plan closes, how many hemophiliac primarily infected claimants will apply and, ultimately, be approved for compensation?

33. In 1999, based upon estimates by medical experts, Class Counsel instructed Eckler to assume that the maximum hemophiliac cohort size was 1,645 hemophiliac primarily infected persons including 355 who were deceased prior to January 1, 1999, regardless of the cause of their death. Establishing that HCV caused death is not a requirement for co-infected hemophiliac DB9s. But, cause of death does affect the level

at which compensation may be claimed as discussed below.

34. For the 2001 valuation, based upon the original cohort estimate and after reviewing the 2000 and 2001 claims volume experience, the Joint Committee instructed Eckler to assume that 90% of the original estimated cohort or 1,481 hemophiliac primarily infected persons including DB9s would apply by June 30, 2010 and be approved.

35. For the 2003 update, the Joint Committee reviewed the 90% cohort assumption and the three and one half years of historical claims volume experience and instructed Eckler to maintain the 90% cohort assumption of 1,481 hemophiliac primarily infected claimants including DB9s.

36. For this valuation, the Joint Committee reviewed the 90% cohort assumption and checked it against the historical claims volume to estimate how many hemophiliac primarily infected persons will apply by June 30, 2010 and be approved.

THE CURRENT ESTIMATE OF HEMOPHILIAC COHORT SIZE

37. The Joint Committee instructed Eckler to assume that the total number of hemophiliac primarily infected persons who will apply by June 30, 2010 and be approved is 1,455. That is, 90% of the original estimate of the 1,290 hemophiliac primarily

infected persons alive as at January 1, 1999 plus 294 DB9 hemophiliac primarily infected persons⁴.

38. The Joint Committee has performed the following claims experience analysis to check this conclusion.

PROJECTIONS BASED UPON THE APPROVED AND IN PROCESS CLAIMS

39. The total number of hemophiliac approvals to December 31, 2004 is 1,240. There are 86 in process claims. A total of 31 claims (2.44%) have been denied.

40. Of the 1,240 approved claims, 983 are approved hemophiliac primarily infected claims for alive or DA9 claimants. If the denials continue at the same rate, 47 of the 49 in process alive or DA9 claims will be approved bringing the estimated alive or DA9 hemophiliac cohort that will be approved from those who had made a claim by December 31, 2004 to 1,030 (79.8% of the 1,290 original cohort alive estimate).

41. There are 257 approved hemophiliac DB9 claims as of December 31, 2004. The Joint Committee estimates that the 37 current in process DB9 claims will be approved. This will result in an estimated 294 hemophiliac DB9 claims that will be approved from those who had made a claim by December 31, 2004 (83% of the 355 original estimate).

⁴ The hemophiliac primarily transfused cohort is categorized further in the section of this report dealing with the Hemophiliac HCV Plan assumptions.

PROJECTIONS THROUGH JUNE 30, 2010

42. The Joint Committee projects that the total number of additional hemophiliac alive and DA9 primarily infected claims which will be made by June 30, 2010 and approved is 131, based upon 90% of the original cohort estimate.

43. The Joint Committee reviewed the pace at which hemophiliac primarily infected claims are being made. In the one year period April 2004 to March 2005, 22 new claims were made. A further 5 new claims have been made in April and May 2005.

44. If the 2004 claims volume is maintained to June 30, 2010 without any decline in year-to-year applications, 121 new claims will be made.

45. The Joint Committee concluded that no further DB9 claims will be made based upon the results of the extensive efforts to date to encourage this population to apply and the expiry of the deadlines applying to these claims (subject to the Administrator's discretion relating to approval of late claims).

FACTORS CONSIDERED IN THE PROJECTION OF THE NUMBER OF HEMOPHILIAC CLAIMANTS

46. The following steps have been taken to give notice to hemophiliacs and their families or estates in addition to the general letter writing campaign to physicians described above:

- (a) notice of the settlement was sent to 17 hemophilia treatment centres across Canada with a request that the notice be posted. Most moderate or severe hemophiliacs are treated at least once per year at these centres;
- (b) notice of the settlement was sent to hemophiliac treating physicians and nurses;
- (c) on at least two occasions, mailings, including notice of the settlement, were included in the Hemophilia Today publication which is sent to everyone on the Canadian Hemophilia Society (“CHS”) mailing list;
- (d) there have been six public meetings about the settlement organized through local hemophilia chapters as follows: Toronto; Montreal; London; Vancouver; and Hamilton;
- (e) according to Jeff Rice, the Coordinator of Regional Resources and Hepatitis C Programs for the Canadian Hemophilia Society (“CHS”), the CHS:
 - (i) published an article in Hemophilia Today in the Fall 2001 issue including an interview with Bonnie Tough discussing estate claims;
 - (ii) in February 2003, posted a notice on the CHS website explaining the March 2003 claims deadline for estates;
 - (iii) in February and March 2003, mailed a notice explaining the March 2003 claims deadline to the members of the CHS HCV/HIV Task Force, all CHS staff, CHS Chapter Presidents, hemophilia clinics and community partners;

- (f) according to Lorie Reznik, the manager of the Canadian Blood Agency the Multi-Provincial/Territorial Assistance Program (“MPTAP”) Program, the Canadian Blood Agency MPTAP Program carried out a telephone campaign to contact the survivors of DB9 hemophiliacs over 15 days in February 2003 and were able to contact 276 of 353 estates.

47. It is possible that the pre-1986 compensation programs in Quebec and Ontario may have diverted some hemophiliac applicants. Hemophiliacs who received blood products prior to 1986 are also eligible under the Quebec or Ontario Plan. Level 1 hemophiliacs can receive more compensation under the pre-1986 Ontario and Quebec programs (\$25,000 or \$24,500, respectively) than they can under the Hemophiliac HCV Plan (\$10,000 plus an inflationary increase).

THE FORMATION OF ASSUMPTIONS RELATING TO THE COMPENSATION PAYMENTS UNDER THE PLANS

48. The analysis the Joint Committee undertook on the claims data follows.

LEVEL 3 LOSS OF INCOME/SERVICES IN LIEU OF \$30,000 LUMP SUM PAYMENT – SECTION 4.01(3)

49. The Plans provide that claimants approved at level 3 (including the estates of DA9s with pre-death losses) may take a \$30,000 lump sum payment (1999 dollars) or, alternatively, if 80% or more disabled, elect to waive the \$30,000 lump sum payment and claim for any loss of income or loss of services in the home. A claimant may defer this election. That is, the claimant may defer the \$30,000 lump sum payment and wait to see

whether he or she becomes disabled and has an income/services loss before reaching level 4 when these losses would otherwise become payable. If the claimant does not become disabled before reaching level 4, he or she may then collect the \$30,000 lump sum payment.

PREVIOUS ASSUMPTIONS RELATING TO THE \$30,000 LUMP SUM WAIVER

50. For the 2001 valuation, the Joint Committee instructed Eckler to assume that 5% of primarily infected claimants who were or would be approved at level 3 would waive the \$30,000 lump sum payment and if under age 65 claim loss of income to age 65 and then loss of services for life and if age 65 or over claim loss of services for life.

THE CURRENT ASSUMPTIONS RELATING TO THE \$30,000 LUMP SUM WAIVER

51. Based upon an analysis of the claims experience to December 31, 2004, the Joint Committee instructed Eckler to assume for this valuation that 5% of claimants will elect to waive the \$30,000 lump sum as follows:

- a. 3% of primarily infected claimants who are or will be approved at level 3 will waive the \$30,000 lump sum payment and claim loss of income to age 65 and then loss of services for life;
- b. 2% of primarily infected claimants who are or will be approved at level 3 will waive the \$30,000 lump sum payment and claim loss of services for life; and
- c. level 3 loss of income/services payments will be for the same amounts, on average, as loss of income/services claims generally.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO THE \$30,000 LUMP SUM WAIVER

51. To December 31, 2004, 1,045 primarily infected claimants were approved at level 3. Of these claimants, 34 (3.3%) elected to waive the \$30,000 lump sum payment and take loss of income/services. A further 22 of these claimants deferred the election. If the 22 claimants who deferred the election take loss of income/services before attaining level 4, the overall percentage of level 3 claimants electing loss of income/services will be 5.4%. The claims breakdown follows:

Level 3	Transfused	Hemophiliac	Total	%
Level 3 \$30,000 lump sum payment	665	324	989	94.6
Elected Loss of Income/Services	23	11	34	3.3
Deferred Election of Loss of Income/Services	17	5	22	2.1
Total Approved	705	340	1045	100

52. Of the 34 level 3 claimants who waived the \$30,000 lump sum payment, 1 has not yet made a claim but presumably will do so if and when 80% disabled, 3 are over age 65 and 4 are estates of DA9s. The breakdown of the 33 loss of income/services claims follows:

	# Claiming Loss of Income	# Claiming Loss of Services	# Claiming Loss of Income and Services (different years)	Total Claiming Loss of Income/Services
Transfused	12	8	3	23
Hemophiliac	3	5	2	10
Total	15	13	5	33

LOSS OF INCOME/SERVICES—SECTIONS 4.02, 4.03

53. The Plans provide that claimants approved at level 4 or above (including the estates of DA9s with pre-death losses) are entitled to claim compensation for any loss of income or loss of services experienced in the home.

PREVIOUS ASSUMPTIONS RELATING TO LOSS OF INCOME/SERVICES

54. For the 2001 valuation, the Joint Committee instructed Eckler to assume that:
- (a) 7.5% of primarily infected claimants who were or would be approved at levels 4 and 5 would claim loss of income to age 65 and then loss of services for life and 22.5% would claim loss of services for life;
 - (b) 10% of primarily infected claimants who were or would be approved at level 6 would claim loss of income to age 65 and, then, loss of services for life and 30% would claim loss of services for life;
 - (c) the average annual loss of income claim, in 2002 dollars, for 100% disability would be \$21,100 for these transfused claimants and \$33,600 for these hemophiliac claimants;
 - (d) the average annual loss of services claim, in 2002 dollars, for 100% disability would be \$11,600 for these transfused claimants and \$12,300 for these hemophiliac claimants;
 - (e) on average, these transfused claimants will be 80% disabled and these hemophiliac claimants will be 75% disabled; and
 - (f) these claimants will become disabled, on average, 10 years after infection.

55. For the 2003 update, the loss of income assumption for a transfused claimant was \$50,000 and for a hemophiliac claimant \$60,000, both in 2002 dollars.

THE CURRENT ASSUMPTIONS RELATING TO LOSS OF INCOME/SERVICES

56. Based upon an analysis of the claims experience to December 31, 2004, the Joint Committee instructed Eckler to assume for this valuation that:

- (a) 50% of primarily infected claimants who are or will be approved at levels 4 and 5 will claim loss of income/services allocated 36% claiming loss of services for life and 14% claiming loss of income to age 65 and, then, loss of services for life;
- (b) 68% of primarily infected claimants who are or will be approved at level 6 will claim loss of income/services allocated 49% claiming loss of services for life and 19% claiming loss of income to age 65 and, then, loss of services for life;
- (c) the average annual loss of income claim, in 2005 dollars, will be \$38,000 for these transfused claimants and \$45,000 for these hemophiliac claimants; and
- (d) the average annual loss of services claim, in 2005 dollars, will be \$13,000 for these transfused claimants and \$14,000 for these hemophiliac claimants.

57. There is no direct correlation between the extent of a claimant's disability and the amount of compensation paid for these losses. The income loss calculation takes into

account the claimant's percentage of disability by deducting any income earned from working if the claimant is not totally disabled. The calculation for loss of services also takes into account the claimant's percentage of disability because the Plans limit the maximum number of compensable hours to 20 per week and the Court Approved Protocol applies presumptions of disability for loss of services claims.

58. Currently, 3 claimants who are temporarily disabled are receiving loss of income and 10 such claimants are receiving loss of services. Since the number of temporary disability claimants is small and the duration of their disability is unknown, the Joint Committee instructed Eckler to assume that all disability will be lifelong.

59. Claimants entitled to loss of income/services payments have been paid from the beginning of the year of disability to December 31, 2003. There is a recovery lag because the loss of income payments for 2004 can only be made once the claimants provide 2004 income tax information. This tax information is required by the Administrator to calculate entitlement. The loss of services claims for 2004 are currently being processed and will be paid in 2005. The Joint Committee has instructed Eckler to assume that the alive claimants who have been approved for loss of income/services will be paid to December 31, 2004 and thereafter their future claims.

60. Based on the instructions from the Joint Committee, the actuarial model developed by Eckler assumes and calculates loss of income/services for the unknown claimants and for those claimants who have been approved but have not yet reached the level entitling them to claim loss of income/services commencing when they reach level

4 or higher (and for 5% of the claimants at level 3). However, some claimants may not actually become disabled until they reach level 5 or 6. Thus, the Eckler model will have overstated their claims for loss of income/services. But, while level 4 (and for 5% of the claimants level 3) is the trigger point in the Eckler model, some claimants may become disabled before they reach level 4. In these cases once the claimant reaches level 4, he or she is entitled to claim compensation retroactive to their date of disability. These past losses are not factored into the Eckler model. The Joint Committee believes that, on balance, these two variables offset each other. For this reason, the Joint Committee instructed Eckler to make the assumption set out above.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO THE LOSS OF INCOME/SERVICES

61. To December 31, 2004, 56.7% of primarily infected claimants approved at levels 4 to 6 were paid a loss of income/services claim. At the end of 2004, a further 5 new loss of income claims (4 alive, 1 DA9) and 21 new loss of services claims (16 living, 5 DA9) were being processed. The breakdown of the loss of income/services claims is as follows (not including claims in process):

	# Claiming Loss of Income		# Claiming Loss of Services		# Claiming Loss of Income and Services (different years)		Total
	Transfused	Hemophiliac	Transfused	Hemophiliac	Transfused	Hemophiliac	
Levels 4 to 5	23	12	137	60	13	7	252/499 (50.5%)
Level 6	16	7	134	38	13	2	210/316 (66.5%)
Total	39	19	271	98	26	9	462/815 (56.7%)

Levels 4 and 5	Total Approved Claimants	Transfused Under 65	Hemophiliac Under 65	Transfused 65 and Over	Hemophiliac 65 and Over
Loss of Income Claimants	55	32	19	4	0
Loss of Services Claimants	197	75	57	61	4
Total Approved Claimants	252	107	76	65	4

Level 6	Total Approved Claimants	Transfused Under 65	Hemophiliac Under 65	Transfused 65 and Over	Hemophiliac 65 and Over
Loss of Income Claimants	38	23	8	7	0
Loss of Services Claimants	172	43	36	90	3
Total Approved Claimants	210	66	44	97	3

62. Actual claims experience to December 31, 2004, demonstrates that:
- (a) the number of loss of income/services claims at levels 4 to 6 are significantly higher than assumed for the 2001 valuation; and
 - (b) fewer claimants claimed loss of income than predicted at levels 4 to 6 than assumed for the 2001 valuation.

63. Until 2004, the Plans paid only 70% of loss of income based upon a calculation that restricted the maximum earned income to \$75,000 (1999 dollars). Any balance over these limits was accrued pending a decision by the Courts the Fund was sufficient to pay the accrued losses. Because of these limitations, the amount paid under the Plans for a loss of services claim was very close to the maximum amount paid out for average loss of income claim. Also, the claims process for loss of income claims was much more complicated than the loss of services claim application process.

64. In 2004, the restriction on earned income was increased to \$300,000. The 70% limit on payment of loss of income claims was also removed. All accrued loss of income payments triggered by eliminating the 70% payment restriction on income loss and by raising the \$75,000 limit on earned income to \$300,000 were paid for all years up to and including 2003.

65. Accordingly, loss of income claimants are now paid 100% of their net loss of income up to \$300,000. In the result, the amount paid for a loss of income claim may be much larger than the maximum amount paid for a loss of services claim. The change in the restrictions on loss of income claims may result in claimants who have in the past claimed loss of services to instead make a loss of income claim. Moreover, it is probable that new claimants entering the system will choose loss of income claims rather than loss of services.

66. The annual averages calculated below represent 100% of income loss paid to claimants up to the revised \$300,000 earned income cap.

67. By year of loss, the average loss of income claim for approved level 3 to 6 primarily infected claimants is as follows:

Year of Loss	#Transfused Loss of Income Claims	Transfused Average	#Hemophiliac Loss of Income Claims	Hemophiliac Average
1987	2	\$22,866.66	1	\$73,475.41
1988	4	\$20,615.28	2	\$66,872.13
1989	5	\$23,294.63	5	\$32,968.54
1990	14	\$19,094.99	7	\$30,754.61
1991	17	\$20,172.23	8	\$32,195.93
1992	19	\$22,689.10	9	\$32,904.28
1993	19	\$24,066.48	9	\$31,042.44
1994	22	\$28,408.72	9	\$34,243.71
1995	31	\$27,112.58	12	\$31,951.99
1996	35	\$25,309.97	15	\$28,872.89
1997	40	\$25,903.06	17	\$29,652.67
1998	44	\$27,396.54	18	\$32,026.73
1999	50	\$26,559.98	23	\$33,538.53
2000	53	\$26,905.33	23	\$35,084.56
2001	46	\$32,774.58	24	\$41,442.30
2002	48	\$33,642.85	22	\$43,265.25
2003	40	\$36,228.51	25	\$43,010.37

68. In 2005 dollars, the average loss of income claim for the year 2003 for transfused claimants was \$38,036.87 and \$45,157.25 for hemophiliac claimants.

69. By year of loss, the average loss of services claim for approved level 3 to 6 primarily infected claimants is as follows:

Year of Loss	#Transfused Loss of Services Claims	Transfused Average	#Hemophiliac Loss of Services Claims	Hemophiliac Average
1986	4	\$7,621.16	4	\$8,611.75
1987	8	\$11,011.93	5	\$12,840.77
1988	22	\$8,199.69	7	\$8,818.05
1989	32	\$10,246.84	10	\$11,507.99
1990	51	\$10,952.67	12	\$13,192.63
1991	70	\$11,312.19	15	\$12,681.13
1992	81	\$11,660.55	25	\$10,958.09
1993	93	\$11,898.10	34	\$10,893.33
1994	104	\$12,273.51	42	\$11,625.30
1995	124	\$11,690.64	57	\$11,560.23
1996	147	\$12,016.80	66	\$12,164.72
1997	179	\$11,922.28	79	\$11,662.88
1998	206	\$11,889.69	84	\$12,825.88
1999	232	\$11,106.22	88	\$12,348.70
2000	233	\$11,090.85	94	\$12,311.48
2001	213	\$11,574.87	92	\$11,884.96
2002	189	\$11,194.53	88	\$12,339.78
2003	168	\$12,024.00	80	\$12,976.15

70. In 2005 dollars, the average loss of services claim for the year 2003 for transfused claimants was \$12,624.18 and \$13,623.86 for hemophiliac claimants.

71. The claims experience shows that 46.6% of the level 3 to 6 claimants (231/495) who were paid loss of income/services, on average, received 4.7 years of payments within the 10 year period from their date of transfusion or receipt of blood products (1031 years/231 claimants).

72. The claims experience shows that level 3 to 6 claimants, on average, were each paid for 6.4 years of past loss of income/services (3153 years/495 claimants).

COSTS OF CARE—SECTION 4.04

73. The Plans provide that approved level 6 claimants (including the estates of DA9s with pre-death losses) are entitled to claim up to \$50,000 per year (in 1999 dollars) for costs of care, including services provided by family members.

PREVIOUS ASSUMPTIONS RELATING TO COSTS OF CARE

74. In 2001, there had only been 2 to 3 months of claims experience with costs of care claims. Based on the limited claims experience and the medical evidence of Dr. Anderson, the Joint Committee instructed Eckler to assume for the 2001 valuation that 25% of primarily infected claimants who were or would be approved at level 6 would make a one-time \$50,000 claim for costs of care (in 2002 dollars).

THE CURRENT ASSUMPTIONS RELATING TO COSTS OF CARE

75. Based upon an analysis of the claims experience to December 31, 2004, the Joint Committee instructed Eckler to assume for this valuation that, annually, on average, 20% of approved primarily infected level 6 claimants will be paid costs of care of \$11,000 in 2005 dollars.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO THE COSTS OF CARE

76. Overall, 45% of approved primarily infected level 6 claimants (143/316) made a costs of care claim at least once. This group is subdivided into 49% transfused claimants (120/245) and 32% hemophiliac claimants (23/71).

77. The number of costs of care claims paid in the years 2002 to 2004 compared to the number of eligible claimants in those years are as follows:

	2002	2003	2004
Transfused	47/214 (22%)	54/230 (23.5%)	45/245 (18.4%)
Hemophiliac	9/69 (13%)	7/71 (10%)	16/71 (22.4%)
All Claims	56/283 (19.8%)	61/301 (20.2%)	61/316 (19.3%)

78. The total costs of care paid to eligible claimants is as follows:

	2002	2003	2004	Total
Annual payments	\$1,910,829.73	\$1,711,989.25	\$1,131,889.91	\$4,754,708.89

79. Based on the two tables above, the average costs of care claim per claimant (which may include past losses) is as follows:

	2002	2003	2004
Average payment	\$34,121.96	\$28,065.40	\$18,555.57

80. The decline in the average costs of care per claimant from 2002 to 2004 probably means that past losses are being worked out of the system. That is, the first claim paid for costs of care is usually for more than a single year. As time progresses, costs of care claims for losses incurred other than in the current year should continue to decrease.

81. The average annual costs of care payment by the year in which costs of care were incurred is as follows:

Year	# of Claims	Average Payment	Average in 2004 Dollars
1991	1	\$687.89	\$870.16
1992	1	\$1,368.30	\$1,704.90
1993	5	\$7,677.97	\$9,397.59
1994	12	\$8,259.26	\$10,089.25
1995	19	\$9,323.97	\$11,149.39
1996	24	\$10,452.90	\$12,298.69
1997	31	\$12,297.99	\$14,240.98
1998	58	\$9,850.88	\$11,302.21
1999	66	\$10,026.72	\$11,306.15
2000	60	\$9,192.99	\$10,092.04
2001	57	\$10,047.10	\$10,754.88
2002	60	\$9,469.40	\$9,915.02
2003	56	\$10,097.85	\$10,287.75
2004	35	\$9,024.63	\$9,024.63

82. Since 1999, the average annual costs of care payment, on an incurred basis, has been between \$9,000 and \$11,000 in 2004 dollars. And, this amount has been paid to between 19 and 20 percent of approved level 6 primarily infected claimants in any given year. For these reasons, the Joint Committee instructed Eckler to assume that, annually, on average, 20% of level 6 claimants will be paid costs of care of \$11,000 in 2005 dollars.

COMPENSABLE HCV DRUG THERAPY—SECTION 4.05

83. The Plans and the Court Approved Protocol for Compensable HCV Drug Therapy provide for a payment of \$1000 per month, in 1999 dollars, for each month an approved claimant at levels 3 to 6 undergoes treatment, including DA9s who underwent treatment.

PREVIOUS ASSUMPTIONS RELATING TO COMPENSABLE HCV DRUG THERAPY

84. For the 2001 valuation, the Joint Committee instructed Eckler to assume that, on average, 65% of approved primarily infected claimants at levels 3 to 5 under the age of 65 years and 20% of approved primarily infected claimants at levels 3 to 5 over the age of 65 years would undergo Compensable HCV Drug Therapy for, on average, 9 months.

THE CURRENT ASSUMPTIONS RELATING TO COMPENSABLE HCV DRUG THERAPY

85. Based upon an analysis of the claims experience to December 31, 2004, the Joint Committee instructed Eckler to assume for this valuation that 65% of approved primarily infected claimants at level 3, stage 2 fibrosis and levels 4 to 6 will undergo Compensable HCV Drug Therapy for, on average, 11 months.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO COMPENSABLE HCV DRUG THERAPY

86. For this analysis, the Joint Committee decided to disregard differences in age and variations between disease levels 3 to 6 because it is often not possible to determine from the claims data the age or disease level of the claimant when the Compensable HCV Drug Therapy was taken and because the claims experience shows that age and disease do not predict who has or will receive treatment.

87. As at December 31, 2004, 43% of approved level 3 to 6 primarily infected claimants of all ages, including 43% (564/1311) of transfused claimants and 42% (231/549) of hemophiliac claimants, received Compensable HCV Drug Therapy payments.

88. Overall, primarily infected claimants at levels 3 to 6 have undergone, on average, 10.9 months of Compensable HCV Drug Therapy calculated as follows:

	Total # of Therapy Months	# of Claimants on Therapy	Average # of Therapy Months
Transfused	6294	564	11.2
Hemophiliac	2374	231	10.3
All Claimants	8668	795	10.9

89. The claims experience, in part, reflects past treatment received under earlier and different medical treatment regimens and repeat therapy and interferon maintenance therapy.

90. In evaluating the assumptions for Compensable HCV Drug Therapy, it should be noted that this area of compensation may dramatically increase in cost because the medical treatment regimens may change and because the Courts may approve compensation for additional or future treatments.

UNINSURED TREATMENT AND MEDICATION—SECTION 4.06

91. The Plans reimburse claimants, including the estates of DA9s with pre-death expenses, for the cost of uninsured generally accepted treatment and medication expenses incurred in the treatment or management of HCV.

PREVIOUS ASSUMPTIONS RELATING TO THE COSTS OF UNINSURED TREATMENT AND MEDICATION

92. For the 2001 valuation, the Joint Committee instructed Eckler to assume that:
- (a) 32% of all primarily infected claimants at levels 3 to 6 would be reimbursed a total of \$3,000, in 2002 dollars, for the cost of drugs for Compensable HCV Drug Therapy;
 - (b) 4% of all primarily infected claimants at levels 2 to 6 would make an initial claim of \$1,056, in 2002 dollars, for reimbursement for the other costs of uninsured medication and treatment; and
 - (c) all living primarily infected claimants at levels 2 to 6 would make future claims of \$528, in 2002 dollars, every 4 years for life.

THE CURRENT ASSUMPTIONS RELATING TO THE COSTS OF UNINSURED TREATMENT AND MEDICATION

93. Based upon an analysis of the actual claims experience to December 13, 2004, the Joint Committee instructed Eckler to assume that, annually:
- (a) 6% of transfused primarily infected claimants approved at levels 2 to 6 will claim \$4,000 in 2005 dollars; and
 - (b) 7% of hemophiliac primarily infected claimants approved at levels 2 to 6 will claim \$6,000 in 2005 dollars.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO THE COST OF UNINSURED TREATMENT AND MEDICATION

94. Uninsured treatment and medication expense claims theoretically should be limited to claimants at level 2 and higher since claimants who have not moved beyond level 1 should not require treatment for HCV. However, 1.1% of claimants at level 1 (6/536) received payment for uninsured medication and treatment and have been included in the calculations that follow.

95. Of primarily infected claimants approved at levels 2 to 6, 15.5% of transfused (396/2549) and 16.7% of hemophiliacs (140/843) sought reimbursement for uninsured medication and/or treatment expenses at least once. Overall, 16% of level 2 to 6 claimants (536/3392) made a claim for reimbursement for uninsured medication and/or treatment expenses.

96. The annual number of uninsured treatment and medication expense claims compared to the total number of primarily infected level 2 to 6 claimants in that year are as follows:

	2001	2002	2003	2004
Transfused	143/1628 (8.8%)	106/2120 (5%)	148/2400 (6.2%)	159/2549 (6.2%)
Hemophiliac	54/689 (7.9%)	38/785 (4.8%)	57/824 (6.9%)	68/843 (8.0%)
All Claims	197/2317 (8.5%)	144/2905 (5.0%)	205/3224 (6.4%)	227/3392 (6.7%)

97. The annual total of uninsured treatment and medication expense payments made to eligible claimants are as follows:

	2001	2002	2003	2004	Total
Transfused	\$223,027.00	\$127,407.88	\$435,726.24	\$545,033.17	\$820,409.45
Hemophiliac	\$75,832.83	\$95,443.44	\$281,894.49	\$367,238.69	\$1,331,194.29
All Claims	\$298,859.83	\$222,851.32	\$717,620.73	\$912,271.86	\$2,151,603.74

98. Based on the two tables above, the average annual uninsured treatment and medication expense reimbursement payment per claimant per year is as follows:

	2001	2002	2003	2004
Transfused	\$1,559.63	\$1,201.96	\$2,944.10	\$3,427.88
Hemophiliac	\$1,404.31	\$2,511.67	\$4,945.52	\$5,400.57
All Claims	\$1,517.05	\$1,547.58	\$3,500.59	\$4,018.82

99. The actual claims experience demonstrates that:

- (a) about 16% of eligible claimants have claimed reimbursement for uninsured treatment and/or medication expenses at least once;
- (b) annually, between 4.8% to 8.8% of eligible claimants sought reimbursement for uninsured treatment and/or medication expenses;
- (c) on a year-by-year basis, the percentage of eligible claimants seeking reimbursement for uninsured treatment and/or medication expenses is trending down; and
- (d) the average amount paid for reimbursement for uninsured treatment and/or medication expenses has increased in each year and for 2004, is about \$3,400 per transfused claimant and \$5,400 per hemophiliac claimant, both in 2004 dollars.

100. As the number of claimants eligible for Compensable HCV Drug Therapy increases, it is likely that the number of claimants seeking reimbursement for the costs of uninsured treatment and/or medication will also rise.

101. Several further factors may impact future costs for uninsured treatment and medication expenses. First, other diseases and/or conditions may be found to be caused by or related to HCV. If so, their treatment may be a necessary part of HCV treatment and management. Moreover, the future costs of medications for the treatment of newly diagnosed HCV related diseases and/or conditions is unknown. And, the costs of current and future treatment and/or the amounts covered by provincial and/or private drug plans cannot be predicted. The Joint Committee is concerned that the costs of reimbursing claimants for uninsured treatment and medication expenses may significantly increase in the future.

OUT-OF-POCKET EXPENSES—SECTION 4.07

102. The Plans provide for reimbursement to approved claimants at all levels, including the estates of DA9s with pre-death expenses, for uninsured out-of-pocket expenses incurred as a result of HCV infection.

PREVIOUS ASSUMPTIONS RELATING TO REIMBURSEMENT OF OUT-OF-POCKET EXPENSES

103. For the 2001 valuation, the Joint Committee instructed Eckler to assume that 25% of primarily infected claimants at all levels would initially seek reimbursement of out-of-pocket expenses averaging \$1,373 in 2002 dollars, and, in addition, 25% of alive primarily infected claimants at levels 2 to 6 would seek a further \$528 in 2002 dollars every 4 years for life.

THE CURRENT ASSUMPTIONS RELATING TO REIMBURSEMENT OF OUT-OF-POCKET EXPENSES

104. Based upon an analysis of actual claims experience to December 31, 2004, the Joint Committee instructed Eckler to assume for this valuation that, until 2012, 12% of level 1 to 6 approved primarily infected claimants will, annually, seek reimbursement of out-of-pocket expenses and that these transfused claimants will be paid \$1,500 and these hemophiliac claimants will be paid \$2,000, in 2005 dollars, annually. The Joint Committee also instructed Eckler that after 2012, the same annual percentages and dollar values will apply but only for level 2 to 6 claimants.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO OUT-OF-POCKET EXPENSES

105. The Joint Committee assumes that level 1 approved primarily infected claimants will seek reimbursement for out-of-pocket expenses on initial approval but, if claimants remain at level 1, they will not have significant ongoing out-of-pocket expenses. In the analysis that follows, the Joint Committee assumes that there will be no level 1 claims for out-of-pocket expenses after 2012 when all initial claims will have made their way through the system.

106. Overall, 32% of approved primarily infected claimants at all levels (1306/4121) made claims for reimbursement of uninsured out-of-pocket expenses at least once. The 32% breaks down to 30.7% of transfused claimants (962/3138) and 35% of hemophiliac claimants (344/983).

107. The number of claimants annually seeking reimbursement for uninsured out-of-pocket expenses compared to the number of eligible claimants is as follows:

	2001	2002	2003	2004
Transfused	438/1897 (23.1%)	264/2560 (10.3%)	341/2938 (11.6%)	282/3138 (8.9%)
Hemophiliac	182/781 (23.3%)	113/907 (12.5%)	129/960 (13.4%)	118/ 983 (12%)
All Claims	620/2678 (23.2%)	377/2467 (15.3%)	470/3898 (12.1%)	400/4121 (9.7%)

108. The annual total of out-of-pocket expenses paid to eligible claimants is as follows:

	2001	2002	2003	2004	Total PKT payments
Transfused	\$525,642.16	\$412,163.64	\$499,847.01	\$409,372.56	\$1,847,025.37
Hemophiliac	\$234,746.57	\$221,317.58	\$430,269.68	\$228,935.27	\$1,115,269.10
All Claims	\$760,388.73	\$633,481.22	\$930,116.69	\$638,307.83	\$2,962,294.47

109. Based on the two tables above, the average annual payment per claimant for reimbursement for uninsured out-of-pocket expenses is as follows:

	2001	2002	2003	2004
Transfused	\$1,200.10	\$1,561.23	\$1,465.82	\$1,451.68
Hemophiliac	\$1,289.82	\$1,958.56	\$3,335.42	\$1,940.13
All Claims	\$1,226.43	\$1,680.32	\$1,978.97	\$1,595.77

110. The actual claims experience relating to uninsured out-of-pocket expenses shows that:

- (a) about 32% of approved primarily infected claimants have sought reimbursement at least once;
- (b) between 9% to 23% of these claimants sought reimbursement in any given year;
- (c) the percentage of these claimants making claims on a year by year basis is trending down; and

- (d) overall, the average annual claim ranges between \$1,200 and \$3,300 and has generally trended up.

DEATH CLAIMS FOR PERSONS WHO DIED PRIOR TO JANUARY 1, 1999 (“DB9s”)—SECTIONS 5.01, 6.01 AND 6.02

111. The Plans provide that if death occurred prior to January 1, 1999, the claimant must prove that HCV was the cause of death, except if the deceased was a hemophiliac co-infected HIV claimant.

112. If the estate and all family members who have claims agree, they can elect to receive \$120,000 and up to \$5,000 for funeral expenses (in 1999 dollars) as settlement of all claims (the “\$120k option”). If they do not take the \$120k option, the estate can claim \$50,000 plus funeral expenses of up to \$5,000 (in 1999 dollars) (the “\$50k+ option”) and dependants can claim amounts for loss of support/services, if applicable, and family members can claim amounts for loss of guidance, care and companionship. The Hemophiliac HCV Plan contains a third option, the estate and family members of a hemophiliac DB9 co-infected with HIV can elect to receive \$72,000 (the “\$72k option”) without proof that HCV caused the death.

PREVIOUS ASSUMPTIONS RELATING TO DB9 TRANSFUSED CLAIMANTS

113. The Joint Committee instructed Eckler to assume for the 2001 valuation that:
- (a) 65% of transfused DB9 claimants who would be approved would elect the \$120k option and 35% would elect the \$50k+ option and make claims for loss of support/services and loss of guidance, care and companionship;

- (b) the average claim by estates of transfused DB9s for compensation for funeral expenses would be \$4,000 in 2002 dollars;
- (c) the average claim by family members of transfused DB9s for loss of guidance, care and companionship would be \$31,700 per family unit in 2002 dollars;
- (d) claims by dependants of transfused DB9s would be divided 12% to loss of support and 88% to loss of services;
- (e) the average loss of support claim would be \$17,300 in 2002 dollars to the deceased's age 65 and then convert to a loss of services claim for the actuarial life expectancy of the deceased (absent infection with HCV) based on the Canada Life Tables; and
- (f) the average loss of services claim would be \$13,000 in 2002 dollars for the actuarial life expectancy of the deceased (absent infection with HCV) based on the Canada Life Tables.

THE CURRENT ASSUMPTIONS RELATING TO DB9 TRANSFUSED CLAIMANTS

114. Based upon an analysis of the claims experience to December 31, 2004, the Joint Committee instructed Eckler to assume for this valuation that:

- (a) 48% of transfused DB9 claimants who will be approved will elect the \$120k option and 52% will elect the \$50k+ option and make claims for loss of support/services and loss of guidance, care and companionship;
- (b) the average claims by estates of transfused DB9s for compensation for funeral expenses will be \$4,500 in 2005 dollars;

- (c) the average claim by family members of transfused DB9s for loss of guidance, care and companionship will be \$47,000 per family unit, in 2005 dollars;
- (d) claims by dependants of transfused DB9s will be divided 19% to loss of support and 81% to loss of services;
- (e) the average loss of support claim will be \$26,600 (\$38,000 less 30%) in 2005 dollars to the deceased's age 65 and then convert to a loss of services claim for the actuarial life expectancy of the deceased (absent infection with HCV) based on the Canada Life Tables; and
- (f) the average loss of services claim will be \$13,000 in 2005 dollars for the actuarial life expectancy of the deceased (absent infection with HCV) based on the Canada Life Tables.

115. Losses have been paid for loss of support/services claims to the end of 2003. The Joint Committee has instructed Eckler to assume that the transfused DB9 claimants already approved for loss of support/services will be paid to December 31, 2004 in addition to their future claims.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO DB9 TRANSFUSED

116. To December 31, 2004, 153 transfused DB9 claims have been approved and a further 83 are in process. Of the 153 approved transfused DB9 claims, 76 elected to take the \$120k option and 77 elected the \$50k+ option (1 of which later received an HCN denial).

117. The estates of 121 transfused DB9s received reimbursements totalling \$487,663,92 for funeral expenses, an average of \$4,030 in 2004 dollars.

118. The family members of 74 transfused DB9 claimants who elected the \$50k+ option have received payments for loss of guidance, care and companionship totalling \$3,453,374.39 and averaging \$46,667 per family in 2005 dollars.

119. The dependants of 12 transfused DB9s who elected the \$50k+ option claimed loss of support as follows:

Year of loss	# of Loss of Income Claims	Average
1987	1	10,375.10
1988	1	11,262.31
1989	1	11,684.05
1990	2	21,137.91
1991	3	20,646.08
1992	3	21,442.24
1993	4	28,119.02
1994	5	25,918.71
1995	7	24,481.49
1996	6	26,511.22
1997	8	29,993.80
1998	10	33,485.34
1999	11	32,977.61
2000	11	34,337.88
2001	9	34,887.24
2002	9	35,914.26
2003	8	35,874.79

120. In 2005 dollars, the average loss of support claim for the year 2003 for transfused DB9 deaths was \$37,665.49.

121. The dependants of 59 transfused DB9s who elected the \$50k+ option claimed loss of services as follows:

Year of Loss	# of Loss of Services Claims	Average
1988	1	8,845.71
1989	4	6,797.14
1990	6	10,177.14
1991	9	10,464.76
1992	11	10,859.22
1993	16	9,921.43
1994	20	11,014.20
1995	23	11,623.45
1996	34	9,902.57
1997	46	10,233.62
1998	56	10,445.60
1999	55	11,788.14
2000	53	12,047.32
2001	55	11,960.95
2002	55	11,961.85
2003	56	11,884.78

122. In 2005 dollars, the average loss of services claim for the year 2003 for transfused DB9 deaths was \$12,478.01.

123. The claims experience shows that the average number of years of past loss of support/services paid for transfused DB9 deaths is 7.4 years (522 years/71 claimants).

124. Overall, there were 71 claims by dependants for loss of support/services from the 77 transfused DB9 claimants who elected the \$50k+ option. The expectation at the time the \$50k+ option was developed was that essentially all \$50k+ option claimants would claim loss of support/services. Accordingly, the Joint Committee instructed Eckler to assume that the other approved transfused DB9 claimants who took the \$50k+ option will make a loss of support/services claim.

PREVIOUS ASSUMPTIONS RELATING TO DB9 HEMOPHILIAC CLAIMANTS

125. The Joint Committee instructed Eckler to assume for the 2001 valuation that:
- (a) the average claim by estates of hemophiliac DB9s for funeral expenses would be \$4,000 in 2002 dollars;
 - (b) the average claim by family members of hemophiliac DB9s for loss of guidance, care and companionship would be \$44,400 per family unit, in 2002 dollars;
 - (c) claims by dependants of hemophiliac DB9s would be divided 30% to loss of support and 70% to loss of services;
 - (d) the average loss of support claim would be \$9,800 in 2002 dollars to the deceased's age 65 and then convert to a loss of services claim for the actuarial life expectancy of the deceased (absent infection with HCV and, if applicable, HIV) based on the Canada Life Tables; and
 - (e) the average loss of services claim would be \$12,300, in 2002 dollars for the actuarial life expectancy of the deceased (absent infection with HCV and, if applicable, HIV) based on the Canada Life Tables.

THE CURRENT ASSUMPTIONS RELATING TO DB9 HEMOPHILIACS

126. Based upon an analysis of the claims experience to December 31, 2004, the Joint Committee instructed Eckler to assume for this valuation that:
- (a) the average claim by estates of hemophiliac DB9s for funeral expenses will be \$4,500 in 2005 dollars;

- (b) the average claim by family members of hemophiliac DB9s for loss of guidance, care and companionship will be \$55,000 per family unit, in 2005 dollars;
- (c) claims by dependants of hemophiliac DB9s will be divided 35% to loss of support and 65% to loss of services;
- (d) the average loss of support claim will be \$31,500 (\$45,000 less 30%), in 2005 dollars, to the deceased's age 65 and then convert to a loss of services claim for the actuarial life expectancy of the deceased (absent infection with HCV and, if applicable, HIV) based on the Canada Life Tables; and
- (e) the average annual loss of services claim will be \$14,000, in 2005 dollars, for the actuarial life expectancy of the deceased (absent infection with HCV and, if applicable, HCV) based on the Canada Life Tables.

127. Losses have been paid for loss of support/services claims to the end of 2003. The Joint Committee instructed Eckler to assume that the hemophiliac DB9s claimants already approved for loss of support/services will be paid to December 31, 2004 in addition to their future claims.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO DB9 HEMOPHILIAC

128. To December 31 2004, 75 of the 142 approved hemophiliac DB9 claims where HCV caused death elected the \$50k+ option and 67 elected the \$120k+ option. The other 115 approved hemophiliac claims elected the \$72k+ option.

129. The estates of 114 of the approved hemophiliac DB9 claims where HCV caused death received, in total, \$457,123.40 as reimbursement for funeral expenses. The average payment was \$4,009 in 2004 dollars.

130. The family members of 70 DB9 (hemophiliac claimants who elected the \$50k+ option have received payments for loss of guidance, care and companionship totalling \$3,848,667 and averaging \$54,981 in 2005 dollars.

131. The dependants of 30 hemophiliac DB9s who elected the \$50k+ option claimed loss of support as follows:

Year of Loss	# of Loss of Support Claims	Average
1989	2	33,444.40
1990	2	35,074.71
1991	2	36,248.79
1992	3	44,279.36
1993	5	33,439.62
1994	3	36,713.81
1995	4	37,636.71
1996	4	37,900.23
1997	8	23,689.83
1998	9	23,653.92
1999	21	24,177.05
2000	22	25,872.67
2001	24	29,400.97
2002	28	29,565.31
2003	30	29,597.32

132. In 2005 dollars, the average loss of support claim for the year 2003 for hemophiliac DB9 deaths was \$31,074.68.

133. The dependants of 58 hemophiliac DB9s who elected the \$50k+ option claimed loss of services as follows:

Year of Loss	# of Loss of Services Claims	Average
1986	1	3,310.60
1987	2	11,386.62
1988	3	11,954.28
1989	6	11,949.37
1990	9	11,185.38
1991	19	9,361.48
1992	23	12,302.84
1993	28	11,588.34
1994	37	12,003.00
1995	42	12,173.95
1996	47	12,327.03
1997	51	12,766.94
1998	54	12,787.85
1999	42	13,145.19
2000	41	12,939.93
2001	39	13,262.18
2002	35	13,109.37
2003	32	13,605.87

134. In 2005 dollars, the average loss of services claim for the year 2003 for hemophiliac DB9 deaths was \$14,285.01.

135. The claims experience shows that the average number of years of past loss of support/services paid for hemophiliac DB9 deaths is 7.9 years (592 years/75 claimants).

136. Overall, there were 88 claims by dependants for loss of support/services from the 75 hemophiliac DB9 claimants who elected the \$50k+ option. Some dependants claimed both loss of support and loss of services, but the claims were for different years. This supports the Joint Committee's expectation that 100% of hemophiliac DB9 claimants who elected the \$50K+ option would claim for loss of support/services.

DEATHS AFTER JANUARY 1, 1999 (“DA9”)—SECTIONS 5.02, 6.01 AND 6.02

137. The Plans provide that the estate of a person infected with HCV who died after January 1, 1999 may claim all compensation that the deceased could have claimed before his or her death. In addition, if the death was caused by HCV, the estate may claim for funeral expenses, the dependants may claim for loss of support/services during the deceased’s life expectancy and the family members may claim for loss of guidance, care and companionship.

PREVIOUS ASSUMPTIONS RELATING TO DA9 CLAIMS

138. For the 2001 valuation, the Joint Committee instructed Eckler to assume that:
- (a) the average funeral expense claim would be \$4,000, in 2002 dollars;
 - (b) 30% of DA9 primarily infected deaths caused by HCV would result in claims for loss of support/services and that all such claims would be modeled as loss of services claims;
 - (c) loss of services claims would be for the maximum amount, \$12,480 in year 1999 dollars, from the date of death over the actuarial life expectancy of the deceased (absent infection with HCV or, if applicable, HIV) based on the Canada Life Tables;
 - (d) the average payment for loss of guidance, care and companionship claim to each family unit as a result of a DA9 primarily infected death caused by HCV would be \$29,000 for transfused claimants and \$20,900 for hemophiliac claimants, both in 2002 dollars.

THE CURRENT ASSUMPTIONS RELATING TO DA9 CLAIMS

139. Based upon an analysis of actual claims experience to December 31, 2004, the Joint Committee instructed Eckler to assume for this valuation that:

- (a) the average DA9 funeral expense claim will be \$4,500 in 2005 dollars;
- (b) 50% of primarily infected DA9 deaths caused by HCV will result in claims for loss of support/services;
- (c) the loss of support/services claims resulting from DA9 deaths of persons under age 65 caused by HCV will be divided 10% to loss of support and 40% to loss of services;
- (d) the loss of support/services claims resulting from DA9 deaths of persons age 65 years or over caused by HCV will all be for loss of services;
- (e) loss of support claims will all convert to loss of services claims at the deceased's age 65 and all loss of services claims will be paid for the actuarial life expectancy of the deceased (absent infection with HCV or, if applicable, HIV) based on the Canada Life Tables;
- (f) the average annual payment for loss of support resulting from a transfused DA9 death caused by HCV will be \$26,000 (\$38,000 less 30%) and \$31,500 (\$45,000 less 30%) for a hemophiliac DA9 death caused by HCV, both in 2005 dollars;
- (g) the average annual payment for loss of services resulting from a transfused DA9 death caused by HCV will be \$13,000 and \$14,000 for a hemophiliac DA9 death caused by HCV, both in 2005 dollars; and
- (h) the average payment for loss of guidance, care and companionship for each family unit for a transfused DA9 death caused by HCV will be

\$48,000 and \$44,000 for a hemophiliac DA9 death caused by HCV, both in 2005 dollars.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO DA9 CLAIMS

140. With respect to DA9 funeral expenses, the claims to December 31, 2004 are as follows:

	# of DA9 funeral expense claims	Total in 2004 Dollars	Average in 2004 Dollars
Transfused	198	\$764,749.64	\$3,862.37
Hemophiliac	46	\$212,991.76	\$4,630.25

141. Of the 275 DA9 primarily infected deaths to the end of 2003, 138 were caused by HCV. Because these losses have only been paid to the end of 2003, the 2004 deaths (27) are not included in this statistic. The 138 DA9 deaths caused by HCV gave rise to the following claims for loss of support/services:

Claim	Under age 65	Age 65 and over	All ages
Loss of Support	10/117 (8.5%)	0/158	10/275 (3.6%)
Loss of Services	40/117 (34.2%)	88/158 (55.7%)	128/275 (46.5%)
All claims	50/117 (42.7%)	88/158 (55.7%)	138/275 (50.2%)

142. Loss of support claims were made as a result of 10 DA9 primarily infected deaths (8 transfused, 2 hemophiliac) resulting in payment of a total of 22 years of loss of support, calculated as follows:

Loss of Support	# Hemophiliac Claims per year	Hemophiliac Average in 2005 Dollars	# Transfused Claims per year	Transfused Average in 2005 Dollars
2000			1	\$19,263.17
2001	1	\$21,304.88	4	\$22,682.06
2002	1	\$22,586.51	6	\$40,292.90
2003	2	\$20,175.35	7	\$37,506.31

143. Loss of services claims were made as a result of 123 DA9 primarily infected deaths (107 transfused, 16 hemophiliac) resulting in payment for a total of 400 years of loss of services, as follows:

Loss of Services	# Hemophiliac Claims per year	Hemophiliac Average in 2005 Dollars	# Transfused Claims per year	Transfused Average in 2005 Dollars
1999	3	\$10,388.55	26	\$8,000.60
2000	8	\$9,064.03	52	\$9,857.29
2001	8	\$13,161.70	74	\$10,987.81
2002	11	\$10,878.77	96	\$10,806.18
2003	15	\$11,379.64	107	\$12,532.45

144. After reviewing the claims data, the Joint Committee concluded that there were too few DA9 loss of support claims and too few hemophiliac DA9 loss of services claims to support an actuarial assumption. The Joint Committee instructed Eckler to assume that DA9 loss of support/services claims will be for the same average amounts as for loss of income/services claims generally.

145. With respect to family member claims for loss of guidance, care and companionship for DA9 primarily infected deaths caused by HCV, the average payment through 2004, adjusted to 2005 dollars, is as follows:

	# DA9 deaths caused by HCV resulting in a family member claim	Total family member claims in 2005 Dollars	Average family member claim per family unit in 2005 Dollars
Transfused	231	\$11,060,813.59	\$47,882.30
Hemophiliac	55	\$2,363,540.44	\$43,930.40

SECONDARILY INFECTED PERSONS—SECTION 3.02

146. The Plans provide that the spouse of a primarily infected person or the child of a primarily or secondarily infected person who is infected with HCV by their spouse or parent is entitled to make the same claims as a primarily infected person.

PREVIOUS ASSUMPTIONS RELATING TO SECONDARILY INFECTED PERSONS

147. For the 2001 valuation, the Joint Committee instructed Eckler to assume that 2% of transfused and 1% of hemophiliac primarily infected claims approved at levels 2 to 6 would give rise to secondarily infected claims. The Joint Committee also instructed Eckler to model these claims in the same way as primarily infected claims except to assume that the disease progress will be, on average, 7 years from the 2001 valuation date.

THE CURRENT ASSUMPTIONS RELATING TO SECONDARILY INFECTED PERSONS

148. Based upon an analysis of the claims experience, the Joint Committee instructed Eckler to assume for this valuation that 2% of transfused and 1% of hemophiliac primarily infected claims approved at levels 2 to 6 will give rise to a secondarily infected claim, 7 years from the current valuation date. The Joint Committee also instructed Eckler to continue to model these claims in the same way as primarily infected claims.

ANALYSIS OF THE CLAIMS EXPERIENCE RELATING TO SECONDARILY INFECTED PERSONS

149. As of December 31, 2004, 30 secondarily infected persons were approved as being infected by a transfused spouse and 9 by a transfused parent. There are a further 39 secondarily infected claims relating to transfused spouses or parents in process.

Applying the same denial rate (because the primarily infected person must be approved in order for the secondarily infected claim to be approved), approximately a further 29 (39 x 75%) of these in progress claims will be approved. In comparison to total approved and in process levels 2 to 6 transfused primarily infected claims, 68 secondarily infected persons reflects a 2.6% infection rate.

150. Additionally, 6 secondarily infected persons have been approved as being infected by a hemophiliac spouse. There are 4 more claims in process (3 relating to a spouse and 1 to a parent). Applying the same denial rate, a further 3 of these in progress claims will be approved. In comparison to total approved and in process level 2 to 6 hemophiliac primarily infected claims, 9 secondarily infected persons reflects a 1.1% infection rate.

151. It is possible that additional spouses and children will become secondarily infected and so the experience to date may underestimate the actual infection rate, however, the Plans set an ultimate deadline for applications by primarily infected persons of 2010 and limit the claims of secondarily infected persons to 3 years from the date of the application by the primarily infected person.

HEMOPHILIAC HCV PLAN

152. The Hemophilic HCV Plan provides a compensation scheme that is identical to the Transfused HCV Plan in most respects and in addition provides that:

- (a) an alive or DA9 claimant co-infected with HIV may elect a \$50,000 payment in satisfaction of all claims (section 4.08(2)); and
- (b) the estate of an HIV co-infected person who died before January 1, 1999 may elect a \$72,000 payment in satisfaction of all claims without proof of HCV as the cause of death (s. 5.01(4)).

ASSUMPTIONS RELATING TO THE HEMOPHILIAC HCV PLAN

153. The assumptions pertaining to hemophilic primarily infected claimants for those parts of the compensation scheme that are common to both Plans are dealt with in the earlier sections of this report.

154. Based on the 1999 assumptions, the claims experience and the current hemophilic cohort projection, the Joint Committee instructed Eckler to assume that the hemophilic cohort of 1,455 will be subdivided as follows:

	1999 Valuation Assumptions	Claims Experience to December 31, 2001	Claims Experience to December 31, 2004	Current Valuation Assumptions	# of Claimants yet to apply and be approved
Cohort assumption # Alive on January 1, 1999 and DB9s who will be approved	1645	1118 applied 881 approved	1357 applied 1240 approved	1455	215
# alive on January 1, 1999	1290	921 applied 785 approved (748 alive, 37 DA9)	1063 applied 983 approved (893 alive, 90 DA9)	1161	178 (167 alive, 11 DA9)
# alive who will be singularly infected	990	562 approved (546 alive, 16 DA9) (26 approvals are unclassified and modelled as singularly infected)	719 approved (674 alive, 45 DA9)	891	172 (162 alive, 10 DA9)
# alive who will be co-infected	300	223 approved (202 alive, 21 DA9)	264 approved (219 alive, 45 DA9)	270	6 (5 alive, 1 DA9)
# DB9	355	197 applied 95 approved	294 applied 257 approved	294	37
# DB9 who will be singularly infected	15	10 approved (3 approvals are unclassified and modelled as singularly infected)	20 approved	34	14
# DB9 who will be co-infected	340	85 approved	237 approved	260	23

155. The Joint Committee has instructed Eckler to assume that the 172 hemophiliac alive and DA9 singularly infected claimants who will be approved will claim under the on-going provisions of the Hemophiliac HCV Plan.

156. The Joint Committee has instructed Eckler to assume that the 6 hemophiliac alive and DA9 co-infected primarily infected claimants who will be approved and the 51 already approved hemophiliac alive co-infected primarily infected claimants who are level 1 or 2, will claim as follows:

- (a) 10 approved alive co-infected level 1 and 2 claimants will elect this \$50,000 option;
- (b) 41 approved alive co-infected level 1 and 2 claimants will claim under the on-going provisions of the Hemophiliac HCV Plan;
- (c) 1 alive co-infected claimant who will be approved will elect this \$50,000 option; and
- (d) 4 alive and 1 DA9 co-infected claimants who will be approved will claim under the ongoing provisions of the Hemophiliac HCV Plan.

157. The Joint Committee has instructed Eckler to assume that the 37 DB9 hemophiliac primarily infected claimants who will be approved, will claim as follows:

- (a) 12 DB9 co-infected claimants who will be approved will elect to take the \$72k option;
- (b) of the remaining 11 DB9 co-infected claimants and the 14 DB9 singularly infected claimants who will be approved, 12 will elect the \$120k option and 13 will elect the \$50k+ option and make claims for loss of support/services and loss of guidance, care and companionship.

FEES AND EXPENSES

158. The Joint Committee instructed Eckler to assume the following fees and expenses (referred to in 2004 dollars) and GST thereon will be payable by the Fund:

ACTUARIAL

- (a) \$420,000.00 for Fund assessment actuarial services in 2005 and \$50,000 for actuarial services (including both actuarial and investment services) in 2006 and 2007, with the cycle to be repeated every three years;

ACCOUNTING EXPERT TESTIMONY AND ASSISTANCE

- (b) \$60,000 per year;

ADMINISTRATION

- (c) \$2.2 million for 2005, declining thereafter 10% per annum until it reaches \$1 million and thereafter \$1 million per year;

ADVERTISING

- (d) \$2 million in 2009;

ARBITRATORS/REFEREES

- (e) \$200,000 for 2005, declining thereafter 10% per year until it reaches \$50,000 and thereafter \$50,000 per year;

AUDIT

- (f) \$80,000 per year for regular audit activities with an additional \$15,000 per year for special projects;

CANADIAN BLOOD SERVICES

- (g) \$30,000 per year until 2013;

COHORT EPIDIMIOLOGICAL MODELLING

- (h) no further expenses;

FUND COUNSEL

- (i) \$700,000 for 2005, declining thereafter 10% per year until it reaches \$100,000 and thereafter \$100,000 per year; PST at 7% on one-half of the total;

HÉMA-QUÉBEC

- (j) \$15,000 for 2005 and 2006 and \$10,000 for each year thereafter until 2013;

INDEPENDENT COUNSEL

- (k) \$100,000 per year until 2010 and \$50,000 per year thereafter;

JOINT COMMITTEE

- (l) \$750,000 for 2005, declining thereafter 10% per year until it reaches \$100,000 and thereafter \$100,000 per year; PST at 7% on one-half of the total;

MEDICAL MODELING

- (m) \$200,000 in 2005 and \$200,000 in 2008;

MONITOR

- (n) \$50,000 per year;

SOFTWARE DEVELOPMENT

- (o) \$20,000 per year;

SUFFICIENCY HEARINGS

- (p) \$1.875 million in 2005, \$625,000 in 2006, \$1.25 million in 2008 and 2011 and thereafter \$500,000 every third year.

159. Fees and expenses should be valued for a further 24 years. It is assumed that activities under the Plans and therefore attendant expenses will decrease as the cohort ages.

BREAKDOWN AND RECONCILIATION OF PAYMENTS

160. As part of the process of analyzing the claims data, the Joint Committee had the claims payment data broken down into the payments made under each provision of the Transfused Plan and the Hemophiliac Plan and reconciled those payments to the total payments made. These reconciliations were provided to Eckler and were used to analyze the data under the various compensation components. The reconciliations are appended as Appendix 2.

AGE DISTRIBUTION

161. The Joint Committee had an age distribution chart for transfused claimants and an age distribution chart for hemophiliac claimants created from the claims data. These charts were provided to Eckler and Eckler was instructed to use these distributions for their analyses. The distributions are appended as Appendix 3.

APPENDIX 1

Approved and Denied Claim Summary
as of June 6, 2005

Type of Claim	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6 (YTD)		Total	
	Approved	Denied	Approved	Denied	Approved	Denied	Approved	Denied	Approved	Denied	Approved	Denied	Approved	Denied
Primarily Infected Person														
Living	1,695	188	1,113	517	441	292	166	157	107	110	18	20	3,540	1,284
Died after January 1, 1999	97	2	145	35	150	45	124	28	82	19	14	1	612	130
Living/Died after January 1, 1999	1,792	190	1,258	552	591	337	290	185	189	129	32	21	4,152	1,414
Died before January 1, 1999	158	8	116	64	69	21	60	24	23	22	5	-	431	139
Total Primarily Infected Person	1,950	198	1,374	616	660	358	350	209	212	151	37	21	4,583	1,553
Secondarily Infected Person														
Living	5	-	10	11	14	6	9	17	4	4	-	-	42	38
Died after January 1, 1999	-	-	-	-	3	1	1	-	1	-	-	-	5	1
Living/Died after January 1, 1999	5	-	10	11	17	7	10	17	5	4	-	-	47	39
Died before January 1, 1999	-	-	-	-	-	1	-	-	-	1	-	-	-	2
Total Secondarily Infected Person	5	-	10	11	17	8	10	17	5	5	-	-	47	41
Family Member Claims	321	-	1,707	92	1,552	47	868	78	842	5	121	1	5,411	221
Total	2,276	198	3,091	719	2,229	413	1,228	304	1,059	161	158	20	10,041	1,815

POC Intake Summary
as of June 6, 2005

	PIP's	FMD's	SIP's	Total
Year 1				
TRAN	3,361	560	53	3,974
HEMO	981	306	9	1,296
	4,342	866	62	5,270
Year 2				
TRAN	900	1,175	34	2,109
HEMO	199	581	1	781
	1,099	1,756	35	2,890
Year 3				
TRAN	525	1,077	17	1,619
HEMO	88	404	1	493
	613	1,481	18	2,112
Year 4				
TRAN	311	632	16	959
HEMO	76	343	1	420
	387	975	17	1,379
Year 5				
TRAN	259	536	7	801
HEMO	22	194	1	218
	281	730	8	1,019
Year 6				
<i>As of May 6, 2005</i>				
TRAN	32	56	-	88
HEMO	3	13	2	18
	35	69	2	106
<i>For the period from May 6, 2005 to June 6, 2005</i>				
TRAN	17	55	-	72
HEMO	2	13	-	15
	19	68	-	87
<i>Year 6 Monthly Average as of June 6, 2005</i>				
TRAN	22.4	50.4	-	72.9
HEMO	2.1	11.9	0.9	14.9
	24.5	62.3	0.9	87.7
Totals for Year 6				
TRAN	49	111	-	160
HEMO	5	26	2	33
	54	137	2	193
Totals For Program To-Date				
TRAN	5,405	4,090	126	9,622
HEMO	1,371	1,855	16	3,241
TOTAL	6,776	5,945	142	12,863

APPENDIX 2

PAYMENTS TO TRANSFUSED CLAIMANTS 2000 - 2004¹

Type of Payment	1999 Amount	\$ Paid 2000	\$ Paid 2001	\$ Paid 2002	\$ Paid 2003	\$ Paid 2004	Total Paid
4.01(1)(a) Level 1	\$10,000	\$4,265,868.60	\$15,007,944.03	\$7,658,836.02	\$4,219,382.29	\$2,239,667.39	\$33,391,698.33
4.01(1)(b) Level 2 upfront ²	\$15,000 / \$20,000	\$4,722,924.40	\$19,028,436.42	\$9,552,567.15	\$7,408,575.37	\$3,736,532.18	\$44,449,035.52
4.01(1)(b) Level 2 holdback	\$5,000			\$10,589,648.52	\$69,834.28	\$18,782.96	\$10,678,265.76
4.01(1)(c) Level 3	\$30,000	\$5,088,570.16	\$17,653,645.35	\$7,788,155.74	\$5,724,631.50	\$4,288,007.68	\$40,543,010.43
4.01(1)(d) Level 5	\$65,000	\$3,829,123.46	\$13,945,858.04	\$5,439,492.24	\$3,827,324.52	\$3,291,974.10	\$30,333,772.36
4.01(1)(e) Level 6	\$100,000	\$2,539,206.75	\$10,415,129.00	\$4,827,951.90	\$4,143,542.42	\$3,826,568.42	\$25,752,398.49
4.02 Loss of Income ³	N/A	0	\$1,661,235.08	\$2,535,323.33	\$2,367,914.51	\$7,713,896.34	\$14,278,369.26

¹ Including Secondarily Infected Claimants

² Level 2 payments were \$15,000 until approximately September 2002 when the courts removed the Level 2 holdback. Thereafter payments were \$20,000. Persons who received Level 2 payments while the holdback was in place received a \$5,000 Level 2 holdback payment (plus interest) when the holdback was removed.

³ Loss of income payments have been made covering income losses to December 31, 2003. The 2004 payments will be calculated when the claimants provide their 2004 income tax information to the Administrator. Loss of income payments under this provision are for alive claimants and to the estate of HCV Infected Persons who died after January 1, 1999 (“DA9”) where the DA9 HCV Infected Person incurred loss of income prior to death. Loss of income payments to the dependants of deceased persons where the dependants have suffered a loss of income due to the death of a DA9 HCV Infected Person or the death of an HCV Infected Person who died before January 1, 1999 (“DB9”) are considered below. These payments also include some loss of income payments mistakenly made to the estates of DB9 claimants in the years 2001 and 2002. The fund is being repaid for those payments made in error.

Type of Payment	1999 Amount	\$ Paid 2000	\$ Paid 2001	\$ Paid 2002	\$ Paid 2003	\$ Paid 2004	Total Paid
4.03(2) Loss of Services ⁴	\$12/ hour to \$240/ week	0	\$4,569,600.58	\$11,563,446.58	\$4,801,569.21	\$4,375,577.28	\$25,310,193.65
4.04(a) Cost of Care	\$50,000	0	0	\$1,672,734.68	\$1,497,546.22	\$745,042.08	\$3,915,322.98
4.05 HCV Drug Therapy per month	\$1,000	\$725,195.52	\$2,570,446.68	\$1,330,371.20	\$812,355.45	\$1,277,397.10	\$6,715,765.95
4.06 Uninsured Treatment and Medication	N/A		\$223,027.00	\$127,407.88	\$437,602.13	\$555,736.79	\$1,343,773.80
4.07 Out of Pockets	N/A	0	\$525,875.81	\$414,814.29	\$506,551.00	\$415,332.57	\$1,862,573.67
4.08	\$240,000	N/A	N/A	N/A	N/A	N/A	N/A
5.01(1) DB9 Funeral	\$5,000		\$187,592.78	\$145,302.32	\$96,160.92	\$36,746.44	\$465,802.46
5.01(1) DB9 Estate	\$50,000	0	\$1,301,891.25	\$1,931,180.76	\$599,723.30	\$281,365.30	\$4,114,160.61

⁴ Loss of services payments under this provision are for alive claimants and to the estate of DA9 HCV Infected Persons where the DA9 HCV Infected Person incurred loss of services prior to death. Loss of service payments to the dependants of deceased persons where the dependants have suffered a loss of service due to the death of the HCV Infected Person (both DA9 and DB9) are considered below. Loss of services payments have been made to December 31, 2003. The 2004 payments are currently being assessed. These payments also include some loss of services payments mistakenly made to the estates of DB9 claimants in the years 2001 and 2002. The Fund is being repaid for those payments made in error.

Type of Payment	1999 Amount	\$ Paid 2000	\$ Paid 2001	\$ Paid 2002	\$ Paid 2003	\$ Paid 2004	Total Paid
5.01(2) DB9 Option	\$120,000	\$121,881.91	\$6,346,845.67	\$1,931,180.89	\$785,092.25	\$405,166.08	\$9,590,166.80
5.02(1) DA9 Funeral	\$5,000	0	\$186,418.73	\$190,782.53	\$160,284.83	\$212,109.20	\$749,595.29
6.01(1) Loss of Support ⁵	N/A	0	\$34,085.57	\$459,783.39	\$800,190.70	\$2,306,333.88	\$3,600,393.54
6.01(2) Loss of Services ⁶	\$12/hour \$240/ week	0	\$683,166.12	\$3,016,053.84	\$3,094,617.29	\$3,288,592.52	\$10,082,429.77
6.02(a) FM- Spouse	\$25,000	\$25,392.07	\$1,197,739.72	\$2,253,044.64	\$1,662,869.15	\$1,111,392.94	\$6,250,438.52
6.02(b) FM-Child < 21	\$15,000	0	\$62,490.00	\$257,490.72	\$212,629.17	\$202,583.04	\$735,103.69
6.02(c), (d), (e) FM- child >21, sibling, parent	\$5,000	\$45,705.69	\$1,291,474.88	\$2,499,805.74	\$1,755,553.66	\$1,834,503.06	\$7,427,043.03

⁵ These are loss of support payments to the dependants of DB9 or DA9 claimants who died due to HCV. Payments have been made to December 31, 2003. The 2004 payments are currently being assessed.

⁶ These are loss of services payments to the dependants of DB9 or DA9 claimants who died due to HCV. Payments have been made up to December 31, 2003. The 2004 payments are currently being assessed.

Type of Payment	1999 Amount	\$ Paid 2000	\$ Paid 2001	\$ Paid 2002	\$ Paid 2003	\$ Paid 2004	Total Paid
6.02(f), (g) FM – grandparent or grandchild	\$500	\$2,539.20	\$114,567.20	\$186,113.32	\$144,478.00	\$142,933.42	\$590,631.14

Subtotal \$ 282,180,035.05 (before subtracting ADJ and PRV)
Less 671,424.34 (ADJ and PRV)
Total \$281,508,610.71

Administrators' total \$281,664,569.80
Total 281,508,601.71
Difference \$155,959.09

PAYMENTS TO HEMOPHILIAC CLAIMANTS 2000 - 2004¹

Type of Payment	1999 Amount	\$ Paid 2000	\$ Paid 2001	\$ Paid 2002	\$ Paid 2003	\$ Paid 2004	Total Paid
4.01(1)(a) Level 1	\$10,000	\$3,666,615.63	\$4,176,467.13	\$1,436,715.57	\$556,107.06	\$303,874.47	\$10,139,779.86
4.01(1)(b) Level 2 upfront ²	\$15,000 /\$20,000	\$4,829,571.08	\$5,514,809.57	\$1,790,294.82	\$828,708.56	\$562,730.75	\$13,526,114.78
4.01(1)(b) Level 2 holdback	\$5,000	0	0	\$4,158,143.22	\$29,900.11	\$12,743.47	\$4,200,786.80
4.01(1)(c) Level 3	\$30,000	\$5,545,627.36	\$6,780,249.63	\$2,124,299.10	\$1,177,638.48	\$1,012,915.20	\$16,640,729.77
4.01(1)(d) Level 5	\$65,000	\$3,763,104.09	\$4,264,995.42	\$697,370.80	\$1,063,145.70	\$1,097,324.70	\$10,885,940.71
4.01(1)(e) Level 6	\$100,000	\$2,132,933.67	\$2,288,745.36	\$536,439.10	\$1,090,405.90	\$1,350,553.56	\$7,399,077.59
4.02 Loss of Income ³	N/A		\$1,587,170.94	\$1,138,537.40	\$680,391.75	\$4,903,033.36	\$8,309,133.45

¹ Including Secondarily Infected Claimants

² Level 2 payments were \$15,000 until approximately September 2002 when the courts ordered the holdback removed, and the payment increased to \$20,000. The Level 2 holdback (plus interest) was paid to all persons who received a Level 2 payment while the holdback was in place.

³ Loss of income payments have been made covering income losses to December 31, 2003. The 2004 payments will be calculated when the claimants provide their 2004 income tax information to the Administrator. Loss of income payments under this provision are for alive claimants and to the estate of HCV Infected Persons who died after January 1, 1999 ("DA9") where the DA9 HCV Infected Person incurred loss of income prior to death. Loss of income payments to the dependants of deceased persons where the dependants have suffered a loss of income due to the death of a DA9 HCV Infected Person or the death of an HCV Infected Person who died before January 1, 1999 ("DB9") are considered below. These payments also include some loss of income payments mistakenly made to the estates of DB9 claimants in the years 1 and . The fund is being repaid for those payments made in error.

Type of Payment	1999 Amount	\$ Paid 2000	\$ Paid 2001	\$ Paid 2002	\$ Paid 2003	\$ Paid 2004	Total Paid
4.03(2) Loss of Services ⁴	\$12/ hour to \$240/ week		\$1,655,035.09	\$4,521,167.65	\$1,881,721.66	\$2,932,183.59	\$10,990,107.99
4.04(a) Cost of Care	\$50,000			\$238,095.05	\$214,443.03	\$386,847.83	\$839,385.91
4.05 HCV Drug Therapy per month	\$1,000	\$490,573.44	\$706,143.78	\$422,714.72	\$340,207.92	\$544,722.64	\$2,504,362.50
4.06 Uninsured Treatment and Medication	N/A		\$75,832.83	\$95,443.44	\$281,894.49	\$367,238.69	\$820,409.45
4.07 Out of Pockets	N/A		\$234,746.57	\$221,317.58	\$430,269.68	\$228,935.27	\$1,115,269.10
4.08	\$240,000						
4.08(2) Alive HIV Co-Infected Option ⁵	\$50,000	0	\$1,504,986.19	\$273,583.96	\$228,930.74	\$56,273.06	\$2,063,773.95

⁴ Loss of services payments under this provision are for alive claimants and to the estate of DA9 HCV Infected Persons where the DA9 HCV Infected Person incurred loss of services prior to death. Loss of service payments to the dependants of deceased persons where the dependants have suffered a loss of service due to the death of the HCV Infected Person (both DB9 and DA9) are considered below. Loss of services payments have been made to December 31, 2003. The 2004 payments are currently being assessed. These payments also include some loss of services payments mistakenly made to the estates of DB9 claimants in the years 2001 and 2002. The Fund is being repaid for those payments made in error.

⁵ Some hemophiliacs claimants did not wish to make a co-infected election right away. Claimants approved at level 1 or 2 were paid those amounts while they considered this option. If a claimant later made this election, the claimant was paid the difference between the payments already received and the \$50,000 (indexed).

Type of Payment	1999 Amount	\$ Paid 2000	\$ Paid 2001	\$ Paid 2002	\$ Paid 2003	\$ Paid 2004	Total Paid
5.01(1) DB9 Funeral	\$5,000	0	\$211,867.25	\$111,526.98	\$61,854.28	\$50,537.98	\$435,786.49
5.01(1) DB9 Estate	\$50,000	\$101,568.26	\$1,614,345.15	\$1,287,453.84	\$599,723.30	\$393,911.42	\$3,997,001.97
5.01(2) DB9 Option	\$120,000	0	\$4,235,352.29	\$2,188,671.54	\$785,092.24	\$1,364,573.84	\$8,573,689.91
5.01(4) HIV Co- infected option	\$72,000	\$73,129.15	\$3,224,523.89	\$2,389,582.19	\$1,491,675.27	\$1,625,746.24	\$8,804,656.74
5.02(1) DA9 Funeral	\$5,000	0	\$49,494.48	\$54,905.03	\$33,378.19	\$68,515.85	\$206,293.55
6.01(1) Loss of Support ⁶	N/A		\$309,993.21	\$627,246.88	\$887,488.00	\$3,176,681.88	\$5,001,409.97
6.01(2) Loss of Services ⁷	\$12/hour \$240/ week		\$938,147.23	\$2,711,364.81	\$1,402,703.14	\$1,844,787.49	\$6,897,002.67
6.02(a) FM- Spouse	\$25,000	\$76,176.21	\$781,134.60	\$938,768.60	\$490,682.70	\$590,867.13	\$2,877,629.24

⁶ These are loss of support payments to the dependants of DB9 or DA9 claimants who died due to HCV. Payments have been made to December 31, 2003. The 2004 payments are currently being assessed.

⁷ These are loss of services payments to the dependants of DB9 or DA9 claimants who died due to HCV. Payments have been made up to December 31, 2003. The 2004 payments are currently being assessed.

Type of Payment	1999 Amount	\$ Paid 2000	\$ Paid 2001	\$ Paid 2002	\$ Paid 2003	\$ Paid 2004	Total Paid
6.02(b) FM-Child < 21	\$15,000		\$421,812.63	\$562,790.47	\$457,970.52	\$236,346.88	\$1,678,920.50
6.02(c), (d), (e) FM- child >21, sibling, parent	\$5,000	\$15,235.23	\$650,945.00	\$965,590.20	\$425,258.34	\$635,886.03	\$2,692,914.80
6.02(f), (g) FM – grandparent or grandchild	\$500	\$1,523.52	\$6,249.12	\$10,728.80	\$4,361.60	\$9,566.41	\$32,429.45

Subtotal Reconciliation \$130,632,607.15
Less 651,237.92 (ADJ and PRV)
Total Reconciliation \$129,981,369.23

Errors' o \$129,985,424.30
Total Reconciliation 129,981,369.23
Difference \$4,055.07

APPENDIX 3

**HCV TRANSFUSED AGE DISTRIBUTION FOR ALIVE
(APPROVED AND UNAPPROVED) CLAIMANTS AT TIME OF CLAIM**
(males and females, current age is defined as at June 30, 2004)

	<10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100	>100	
Approved	0	123	94	300	562	466	419	413	230	36	1	2644
Unapproved	0	15	8	52	130	89	29	21	14	4	0	362

Note: There are 9 additional alive transfused unapproved claimants who have not provided dates of birth.

**HCV HEMOPHILIAC AGE DISTRIBUTION FOR ALIVE
(APPROVED AND UNAPPROVED) CLAIMANTS AT TIME OF CLAIM**
(males and females, current age is defined as at June 30, 2004)

	<10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100	>100	
Approved		14	175	262	225	122	58	30	7	0	0	893
Unapproved	0	0	8	10	13	9	5	1	0	0	0	46