Court File No. 98-CV-141369 CP00

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N :

DIANNA LOUISE PARSONS, MICHAEL HERBERT CRUICKSHANKS, DAVID TULL, MARTIN HENRY GRIFFEN, ANNA KARDISH, ELSIE KOTYK, Executrix of the Estate of Harry Kotyk, deceased and ELSIE KOTYK, personally

Plaintiffs

and

THE CANADIAN RED CROSS SOCIETY, HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO and THE ATTORNEY GENERAL OF CANADA

Defendants

and

HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF ALBERTA
HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF SASKATCHEWAN,
HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF MANITOBA,
HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF NEW BRUNSWICK
HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF PRINCE EDWARD ISLAND,
HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF NOVA SCOTIA
HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF NEWFOUNDLAND,
THE GOVERNMENT OF THE NORTHWEST TERRITORIES,
THE GOVERNMENT OF NUNAVUT and THE GOVERNMENT OF THE YUKON TERRITORY

Intervenors

Proceeding under the Class Proceedings Act, 1992

Court File No. 98-CV-146405

B E T W E E N:

JAMES KREPPNER, BARRY ISAAC, NORMAN LANDRY, as Executor of the Estate of the late SERGE LANDRY, PETER FELSING, DONALD MILLIGAN, ALLAN GRUHLKE, JIM LOVE and PAULINE FOURNIER as Executrix of the Estate of the late PIERRE FOURNIER

Plaintiffs

and

THE CANADIAN RED CROSS SOCIETY, THE ATTORNEY GENERAL OF CANADA and HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO

Defendants

and

HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF ALBERTA, HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF SASKATCHEWAN, HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF MANITOBA,
HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF NEW BRUNSWICK, HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF PRINCE EDWARD ISLAND HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF NOVA SCOTIA
HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF NEWFOUNDLAND,
THE GOVERNMENT OF THE NORTHWEST TERRITORIES,
THE GOVERNMENT OF NUNAVUT AND THE GOVERNMENT OF THE YUKON TERRITORY

Intervenors

Proceeding under the Class Proceedings Act, 1992

No. C965349
Vancouver Registry

In the Supreme Court of British Columbia

Between:

Anita Endean, as representative plaintiff

Plaintiff

and:

**The Canadian Red Cross Society
Her Majesty the Queen in Right of the Province of
British Columbia, and The Attorney General of Canada**

Defendants

and:

**Prince George Regional Hospital, Dr. William Galliford, Dr.
Robert Hart Dykes, Dr. Peter Houghton, Dr. John Doe,
Her Majesty the Queen in Right of Canada, and
Her Majesty the Queen in Right of the Province of British Columbia**

Third Parties

Proceeding under the Class Proceedings Act, R.S.B.C. 1996, C. 50

CANADA
PROVINCE OF QUÉBEC
DISTRICT OF MONTRÉAL

NO : 500-06-000016-960

SUPERIOR COURT
Class action

DOMINIQUE HONHON

Plaintiff

-vs-

THE ATTORNEY GENERAL OF CANADA
THE ATTORNEY GENERAL OF QUÉBEC
THE CANADIAN RED CROSS SOCIETY

Defendants

-and-

MICHEL SAVONITTO, in the capacity of the Joint Committee member for the province of Québec

PETITIONER

-and-

FONDS D'AIDE AUX RECOURS COLLECTIFS

-and-

LE CURATEUR PUBLIC DU QUÉBEC

Mis-en-cause

CANADA
PROVINCE OF QUÉBEC
DISTRICT OF MONTRÉAL

NO : 500-06-000068-987

SUPERIOR COURT
Class action

DAVID PAGE

Plaintiff

-vs-

THE ATTORNEY GENERAL OF CANADA
THE ATTORNEY GENERAL OF QUÉBEC
THE CANADIAN RED CROSS SOCIETY

Defendants

-and-

FONDS D'AIDE AUX RECOURS COLLECTIFS

-and-

LE CURATEUR PUBLIC DU QUÉBEC

Mis-en-cause

AFFIDAVIT OF PETER GORHAM
(Sworn January 29, 2016)

I, Peter Gorham, of the Town of Whitby, in the Province of Ontario, MAKE OATH AND SAY AS FOLLOWS:

1. I am a fellow of both the Canadian Institute of Actuaries and the Society of Actuaries, which is the professional association for actuaries in the United States of America. I attained my designation as Associate, Society of Actuaries, in 1977 and attained both fellowships as an actuary in 1980.

2. I am an experienced actuary having spent my professional career providing pension benefits and actuarial consulting services to numerous clients across Canada. I also teach pension courses at the Humber College Centre for Employee Benefits. As such, I have knowledge of matters to which I hereinafter depose.

3. In 1976, I graduated from the University of Toronto with a Bachelor of Sciences in Actuarial and Computer Sciences.

4. I began my actuarial career with Crown Life Insurance Company, where I worked as a pension administrator and an actuarial assistant specializing in pensions and group insurance. I began working at MLH + A Inc. (now Aon Hewitt) in 1978 as an Associate Actuary, serving clients in the area of pension and employee benefits.

5. I continued working at MLH + A Inc. until 1998 becoming a partner in that firm in 1989. I joined Morneau Sobeco (now Morneau Shepell) as a partner in 1998. Morneau Shepell is a firm with over 2,500 employees throughout Canada and the United States. Morneau Shepell

provides integrated human resource services to a wide range of clients. The firm has very large and active practice groups in the fields of asset management, benefits, compensation, disability management and employee assistance programs, which provide actuarial and other services pertaining to pensions, employee benefits and compensation plans. My practice focuses on the design, financing, administration and governance of pension and benefit plans. This includes costing and valuations of pension plan benefits and advice, as well as valuations of pension and benefits obligations for funding and accounting purposes.

6. I retired from Morneau Shepell in June 2011 and commenced working for JDM Actuarial Expert Services Inc as president and actuary. I continue to provide consulting services as a contractor to Morneau Shepell and it is in that capacity that I provide expert witness services in this matter.

7. I have been a member and served as a director of numerous pension-related councils and committees. For example, from 1988 to 1994, I sat on the Pension Review Council, an advisory group of the largest pension and legal firms in Canada. I was a founding director of the Multi-Employer Benefit Plan Council of Canada from 1992 to 1993. I recently completed an appointment as the lead member of the Capital Accumulation Plans Fees Disclosure Industry Working Group that was constituted to provide advice to the Joint Forum of Financial Market Regulators.

8. I have provided evidence as an expert witness in the Superior Court of Ontario for a class action related to alleged excessive credit card interest charges of a major Canadian financial institution. In addition, I have provided expert evidence for the assessment of investment based damages payable on administered funds held by the Federal Government

over an 85 year period, a class action against a number of pay-day loan companies, two constitutional challenges to the Ontario Workplace and Safety Insurance Board regarding benefit entitlement for disabled seniors, and on matters related to the valuation of pensions for family law purposes, life estates valuations, the present value of future income and care costs, as well as other actuarial areas. In testifying, I have appeared before various Courts in Ontario, British Columbia and Alberta, the Ontario Employment Standards Tribunal, the Ontario Workplace Safety and Insurance Tribunal and the Canadian Institute of Actuaries Disciplinary Tribunal. I have also testified before the High Court of Justice in Trinidad and Tobago and the Supreme Court of Bermuda.

9. My *curriculum vitae* is attached as Appendix E to my Report.

10. Morneau Shepell was retained by Canada to prepare an actuarial valuation of the 1986-1990 Settlement Fund for use in the sufficiency review of that fund as of 31 December, 2013. I previously had been engaged by Canada to prepare similar reports assessing the financial sufficiency of the Settlement Fund as at 31 December, 2004, December 31, 2007 and December 31, 2010.

11. For the 2013 valuation we worked cooperatively with Eckler to develop the joint selection of actuarial methods and assumptions. The intent was to use the same assumptions in our respective valuations provided that did not result in compromising our professional integrity or result in using assumptions that we believed were inappropriate for the purpose. The two firms co-operated with the analysis of the data, including data we received from the administrator, developed a common set of assumptions utilized by both firms and shared our respective findings. The differences between the reports were immaterial. Those Reports concluded that

the Fund was sufficient as at December 31, 2013.

12. The current Morneau Shepell retainer in respect of the potential allocation of that actuarial surplus of the 1986-1990 Hepatitis C Compensation Fund as of December 31, 2013 required that we analyze the cost of the benefit enhancements proposed by the class and the sources of the current unallocated surplus.

13. Attached hereto and marked as Exhibit A to this my affidavit is a copy of my Report dated January 29, 2016.

14. Attached hereto and marked as Exhibit B to this my affidavit is a copy of the Administrator's data which I relied upon in formulating the conclusions I reached in paragraph 50 of my report, Exhibit A.

I make this affidavit in response to the plaintiffs' material prepared in support of the fund sufficiency motion.

SWORN before me at the City of Toronto, in the Province of Ontario, this 29th day of January, 2016.

A Commissioner for taking affidavits within the Province of Ontario

PETER GORHAM

This is Exhibit "A" referred to in the
affidavit of Peter Gorham
sworn before me at Toronto, ON
this 29th day of January, 2016

A Commissioner for taking affidavits
within the Province of Ontario

MORNEAU SHEPELL

ACTUARIAL REPORT ON PROPOSED ALLOCATION OF THE ACTUARIALLY UNALLOCATED FUNDS AS OF 31 DECEMBER 2013

Prepared by:
Peter Gorham, F.C.I.A., F.S.A.
Morneau Shepell
895 Don Mills Rd., Suite 700
Toronto, ON M3C 1W3

Prepared 29 January 2016

Table of Contents

A. Purpose 1
B. Executive Summary 2
C. Treatment Implications for the Claimants 5
D. Treatment for Claimants at Level 2 7
E. Comparison of 1999 Cohort and 2013 Cohort 12
F. Federal and Provincial Government Contributions 17
G. Attribution Of Excess Assets 20
H. Summary of Cost of Proposed Changes 22
I. First Claim Deadline 25
J. Increase Fixed Payments by 10% 28
K. Family Member Payments 31
L. Eliminate Deduction of Collateral Benefits for Loss of Income and Loss of Support Claims 33
M. Compensation for Diminished Pension Savings 42
N. Increase Loss of Services from 20 to 22 Hours per Week 45
O. Increase Maximum Payable for Cost of Care from $50,000 to $60,000 (1999 dollars) 47
P. Out-of-Pocket Expenses - $200 Allowance for Accompanying Family Members 49
Q. Increase Cap on Funeral Expenses from $5,000 to $10,000 (1999 dollars) 52
R. Administrative Expenses 54
S. Buffer Against Catastrophic Events 55
T. Certification 56
Appendix A Loss of Guidance, Care & Companionship in Canada 57
Appendix B Compensation Schedule for HVC Infected Persons 59
Appendix C Average Funeral Expense in Canada 60
Appendix D Documents Provided 64
Appendix E Curriculum Vitae of Peter Gorham, F.C.I.A., F.S.A. 68
Appendix F Form 53 – Acknowledgement of Expert's Duty 69

A. PURPOSE

1. I am president and actuary with JDM Actuarial Expert Services Inc and I am contracted as a consulting actuary with Morneau Shepell. I regularly provide actuarial consulting services as well as actuarial expert testimony. I am a fellow of the Canadian Institute of Actuaries and of the Society of Actuaries. I received my Actuarial Fellowship in 1980 and have provided pension, benefits and actuarial consulting services for approximately 38 years. A copy of my curriculum vitae is attached as Appendix E.

2. I understand and acknowledge that as an expert, I have a duty to provide evidence in this proceeding as follows:

   a. to provide opinion evidence that is fair, objective and non-partisan;

   b. to provide opinion evidence that is related only to matters that are within my area of expertise; and

   c. to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

3. I acknowledge that the duty referred to above prevails over any obligation that I may owe to any party by whom or on whose behalf I am engaged. A copy of Ontario Form 53 acknowledging those duties is attached as Appendix F.

4. This report has been prepared in order to provide an actuarial analysis of the proposed increases to compensation payments under the 1986 – 1990 Hepatitis C Settlement Agreement made as of 15 June 1999 (the "**Agreement**" or "**Settlement Agreement**") as set out in the Notice of Application filed by the British Columbia Joint Committee Member dated 16 October 2015 and to provide the expected cost should the proposals be implemented.

5. This report is supplemental to the **2013 Morneau Shepell Sufficiency Report**[1].

6. The intended users of this report are the courts having jurisdiction over the matter, Health Canada, the Department of Justice of the Government of Canada and the Joint Committee. The law may require this report to be provided to other parties who are not intended users. The report may not be provided to anyone who is not an intended user except as may be required by law. The findings herein may not be used or relied upon by any party other than an intended user without the prior written consent of Morneau Shepell.

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[1] Actuarial Report Assessing the Financial Sufficiency of the 1986-1990 Hepatitis C Trust Fund as at 31 December 2013, prepared by Péter Gorham and dated 8 April 2015

B. EXECUTIVE SUMMARY

7. With the introduction of new drugs for treatment of the Hepatitis C virus ("**HCV**"), most claimants under the Agreement are eligible for treatment that is much easier to endure than with past drugs and has a very high success rate of 90% to 95% for curing most infected persons (an exception is those who are co-infected with HIV where the cure rate is just over 80%). Even so, there are some HCV genotypes for which these new drugs are contraindicated and where a regimen including interferon and/or ribavirin is still the indicated treatment. Based on the 2013 Report of the Medical Model Working Group (the "**MMWG**"), fewer than 10% of the claimants are in that category.

8. We understand that there are additional new drugs in the approval pipeline that are expected to work effectively with very high rates of success for all genotypes[2]. Once those drugs are approved, we can expect that all claimants (other than those at level 1, who are already cured, and some of those at level 6 for whom we understand treatment is not effective) will be eligible for treatment.

9. We can therefore expect that within the next few years, about 90% to 95% of the claimants will be cured of HCV with about 5% to 10% remaining infected.

TREATMENT FOR CLAIMANTS AT LEVEL 2

10. An issue was identified in the **Eckler Costing Report**[3] whereby the Settlement Agreement provides that claimants at level 2 who meet certain conditions for treatment will qualify for the $30,000 (1999 dollars) lump sum payment that is paid at disease level 3. In addition, they would also qualify for a $1,000 (1999 dollars) payment for each month that they remain on treatment. We understand that the Joint Committee instructed Eckler to assume that all claimants at level 2 would qualify for those payments. Eckler restated the excess assets identified in the **2013 Eckler Sufficiency Report**[4] to provide for those potential payments and thereby reduced the excess assets by $29,421,000 - from $236 million to $206 million.

11. To qualify for the lump sum and monthly payments, the medication these claimants receive must include ribavirin, interferon or any other drug with serious side effects. We understand that under the current drug regimens, only about 60% of claimants at level 2 would require ribavirin and only then if they were prescribed Holkira Pak. We also understand that there is an alternate

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2 Affidavit of Dr. Samuel S. Lee, sworn 26 January 2016, paragraph 25.

3 Actuarial Report to the Joint Committee – Proposed Allocation of the 2013 Sufficiency Assessment Actuarially Unallocated Assets prepared by Richard Border and Wendy Harrison and attached to affidavit #5 of Richard Border.

4 Actuarial Report to the Joint Committee Assessing the Financial Sufficiency of the 1986-1990 Hepatitis C Trust as at December 31, 2013, prepared by Richard Border and Wendy Harrison date 11 March 2015.

treatment (Harvoni) that does not require ribavirin and that Harvoni is the drug currently prescribed in the vast majority of treatment situations[5].

12. We understand that there is a question as to whether it is appropriate to make such payments to a claimant at level 2 by reason only of taking the new treatment (Holkira Pak in combination with ribavirin). We suggest that the situation be reviewed to determine whether the court approved protocol regarding these payments should be revised.

13. If these payments are made to all level 2 claimants who could receive Holkira Pak with ribavirin, we estimate the present value of all such lump sums[6] would be about $21.6 million.

14. It is our opinion that even if these payments are made to claimants at level 2, the liabilities that were set aside as part of the 2013 Morneau Shepell Sufficiency Report are sufficient to provide for these additional lump sum payments and that there is no need to adjust the liabilities and restate the excess assets.

FEDERAL PROVINCIAL AND TERRITORIAL GOVERNMENT CONTRIBUTIONS

15. The federal government made a cash contribution to the 1986-1990 Hepatitis C Trust Fund (the "**Fund**" or "**Compensation Fund**") that was invested and has been used to pay 8/11^{ths} of all benefit payments and expenses. The provincial and territorial governments (the "**PT Governments**") pay 3/11^{ths} of all benefit payments and expenses as they fall due. The present value of the federal and PT Governments contributions totalled about $1.1 billion in 1999.

16. In addition to those contribution obligations, the federal and the PT Governments have exempted the Fund from all income taxes and the claimants from income taxes on any benefit they receive. We have estimated that the present value as of 31 December 2013 of past taxes foregone plus expected future taxes to be foregone is about $555 million.

17. We also reviewed the development of the excess assets and determined that had the federal government not made an up-front contribution, but instead had contributed on the if-and-when basis used by the PT Governments, the Fund would have a deficit of about $348 million as of 31 December 2013. With the actual position being an excess of $256 million, the Fund currently has about $604 million of assets more than it would have had in the absence of prefunding.

18. If the PT Governments had prefunded their contributions like the federal government did, the Fund would have about $224 million more assets as of 31 December 2013 than it actually has.

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5 Affidavit of Dr. Samuel S. Lee, sworn 26 January 2016, paragraph 23.

6 The 2013 sufficiency review already includes a provision for the $1,000 per month payment, but did not include any provision for the $30,000 lump sum payment.

COST OF PROPOSED CHANGES

19. We have estimated the cost of the proposed changes, together with additional administrative expenses and a buffer against catastrophic events, to be about $228 million. That is greater than the $205 million cost shown in the Eckler Costing Report. Most of that difference is because we believe that there is a risk that claiming patterns may change and result in larger future benefits than were assumed by Eckler.

20. As part of our review, we have identified some possible issues with the proposed changes.

    a. The 10% increase to the fixed payments will result in different top-up amounts being paid to claimants in similar situations simply due to the year in which the original payment was made. As an example, for claimants at level 3, if the original lump sum of $60,000 (1999 dollars) was paid in 2001, the top-up amount in 2016 will be $6,250 and if the original lump sum amount was paid in 2013, the top-up amount in 2016 would be $8,002.

    b. A similar situation exists for Family Member top-ups where the amount payable will vary solely due to the year in which the original payment was made.

    c. Eliminating the deduction of collateral benefits from Loss of Income and Loss of Support will result in payments that exceed the actual loss. In our opinion, paying a loss of income or support benefit that exceeds the actual loss is not actuarially sound. If the amount exceeding full compensation is appropriate to pay, it should be paid in some other form, not as compensation for a loss of income.

    d. If the Loss of Income benefit exceeds the lost income, and the claimant is receiving disability income benefits from an insurance company, some of the insurance companies may reduce the benefit they pay by some or all of the Loss of Income benefit.

    e. We believe it is likely that there are many claimants who would like a family member to accompany them to their appointments but who have not done so in the past due to the need to take time off work. In our opinion, the proposal to compensate a family member with $200 when they accompany an infected person to a medical appointment may result in a significant increase in the number of out-of-pocket claims compared with the past experience. We believe that in the past, many out-of-pocket expenses have not been claimed due to their small amount and so the data seriously understates number of medical visits actually taken by the claimants.

C. TREATMENT IMPLICATIONS FOR THE CLAIMANTS

21. Virtually all alive class members (excluding those at level 1 who are already cured and some of those at level 6 for whom the drugs will not help) are eligible to receive treatment. The MMWG assumptions about treatment result in about 85% of the claimants at levels 2 to 5 being cured of the disease by 2019. We utilised those assumptions in the 2013 Morneau Shepell Sufficiency Report.

22. Of the almost 3,750 claimants alive at levels 1 to 5 at the end of 2013, about 3,200 will be cured and about 550 will remain infected. There are a further 130 claimants at level 6 who are assumed to either not qualify for treatment or who are not cured.

23. Based on the MMWG treatment assumptions, of the 550 at levels 1 to 5 who are not cured, about 350 are because they do not meet the current treatment protocols (and therefore do not receive treatment) and about 200 are because the treatment is not effective.

24. There are certain genotypes of HCV for which the current drugs are either not very effective or are contraindicated. Some claimants may still need to take interferon. In the Affidavit of Dr. Samuel S. Lee, sworn 26 January 2016 (the "**Lee Affidavit**", paragraph 25) he advised that there are a number of new drugs in the approval pipeline, in addition to one approved in January 2016, that will be able to treat all genotypes and have a cure rate in excess of 90%. We have assumed that these new drugs will be priced competitively or even below the current drugs in order to obtain an appropriate percentage of the market. (Holkira Pak is about $64,000 for 12 weeks and Harvoni is about $77,000 for 12 weeks[7]. Sofosbuvir (which is used for some of the genotypes) is in the same price range).

25. The 2013 Morneau Shepell Sufficiency Review included a liability of about $160 million for the costs of the approximately 89% of claimants for whom treatment is assumed to be medically indicated. Some of the cost will be paid by private insurance and some (especially for those over 65) by provincial health plans. The balance of about $160 million is assumed to be paid by the Fund.

26. Applying the MMWG treatment assumptions will leave about 11% of the claimants at levels 2 to 5 untreated. Our understanding (Lee Affidavit paragraph 25) is that those claimants will likely be eligible medically for treatment when the new drugs are approved within a very short time. While the liabilities set aside in 2013 did not contemplate these claimants being treated, the reduction in future claims is expected to be more than enough to pay for their treatment without having to touch any of the surplus.

27. So we can consider that in the next few years, almost every claimant who wants treatment will receive it at no personal cost. Once all claimants have been treated, we estimate that between about 5% to 10% will be left with HCV because they did not get cured by the available treatment.

---

7 Prices quoted by Shoppers Drug Mart – see also paragraph 47.

28. The 2013 Morneau Shepell Sufficiency Review contemplated a small percentage (15% at levels 1 to 5) of the class would remain infected after 2018. That percent should be smaller after the new drugs are available in 2016. Most of the funds remaining after paying for treatment will be needed:

    a. To provide for the approximately 5% to 10% of non-cured claimants;

    b. Continue to pay for Loss of Support and Loss of Services to dependants of those who died prior to this drug breakthrough;

    c. Provide ongoing Loss of Income to some claimants who, even though cured, are still unable to return to work. Even though the HCV is cured, there are some situations where disablement may continue (affidavit of Dr. Vince Bain, sworn 11 March 2015, pages 15 to 17). In addition to those who remain unable to return to work, there is a risk that some claimants will be unemployed even though they are not disabled. Some of those may be due to having lost or been unable to learn new skills require for their job due to the length of their disability. Others may have the skills but lack the motivation to return to work.

    d. We expect many, if not virtually all, loss of service claims payable to the infected persons will continue, because people may have come to rely on that compensation to meet household expenses and it could cause hardship to have it cease. All of the dependants who are receiving Loss of Services as a result of an infected person's death will continue to receive it, since curing the disease will have no effect on those claims.

29. The cost of treatment for all the alive class members eligible based on the MMWG assumptions, was recognised in the 2013 sufficiency review. The total cost to the Fund was projected to be almost $160 million (including a provision for adverse deviations of $50 million)[8]. That cost is an increase of about $95 million from what the future costs for treatment would have been if the new drugs had not been developed[9].

30. Offsetting the cost increase for treatment by the new drugs is the reduction in future compensation payments of a little over $200 million because most of the claimants will be cured[10].

31. As a result, the actuarially unallocated funds increased by $105 million as a net effect of the new drug treatments (the expected reduction of $200 million in future compensation minus the $95 million increase in cost of treatment between the prior and current treatment costs).

32. Based on the MMWG assumption that all claimants who are eligible will receive treatment by the end of 2018, of the almost 3,750 claimants who are alive at levels 1 to 5, there will be about 550 who remain infected (some of whom may be cured by the new drugs expected in 2016) and about 3,200 who are cured.

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8 2013 Morneau Shepell Sufficiency Report, Table 169a and 169b

9 2013 Morneau Shepell Sufficiency Report, Table 191 and paragraph 195.p

10 2013 Morneau Shepell Sufficiency Report, Table 191 and paragraphs 195.m and 195.q

D. TREATMENT FOR CLAIMANTS AT LEVEL 2

33. The Settlement Agreement provides that the $30,000 (1999 dollars) lump sum payment at Level 3 will be paid to any claimant who meets the protocol for Compensable HCV Drug Therapy.

> *"4.01 Fixed Payments*
>
> *"(1) Each Approved HCV Infected Person will be paid the amounts set out below as compensation for damages:*
>
> ...
>
> (c) *"unless waived pursuant to the provisions of Section 4.01(3), the amount of $30,000 upon delivering to the Administrator evidence demonstrating that he or she has (i) developed fibrous tissue in the portal areas of the liver with fibrous bands extending out from the portal area but without any bridging to other portal tracts or to central veins (i.e., non-bridging fibrous) or* ***(ii) received Compensable HCV Drug Therapy or (iii) has met or meets a protocol for Compensable HCV Drug Therapy notwithstanding that such treatment was not recommended or, if recommended, has been declined;"*** [emphasis added].
>
> Compensable HCV Drug Therapy is defined as:
>
> *"'**Compensable HCV Drug Therapy**' means interferon or ribavirin, used alone or in combination, or any other treatment that has a propensity to cause adverse side effects and that has been approved by the Courts for compensation."*

34. We understand that the Joint Committee instructed Eckler to assume that all claimants at level 2 would qualify for those payments. The Eckler Costing Report quantifies that as an increase in the liabilities reported for the 2013 Sufficiency Review of $29,421,000. It also results in an equal reduction in the excess assets - from $236 million to $206 million.

35. In addition, the Settlement Agreement provides for a $1,000 (1999 dollars) per month while a claimant is receiving Compensable HCV Drug Therapy. The possibility of payment has already been recognised in the 2013 sufficiency liabilities.

DISCUSSION

36. We understand there is an issue as to whether a claimant at level 2 would qualify for the $30,000 lump sum and $,1000 per month payments simply by receiving treatment. However, even if we assume that any level 2 claimant who receives Compensable HCV Drug therapy will receive these payments, only some of the claimants at level 2 could actually qualify for it.

37. We understand that the DAA drug treatments (specifically Harvoni and Holkira Pak) do not get used in combination with interferon, but some infected persons taking Holkira Pak should use it in combination with ribavirin. While these new drugs have some side effects, "there is no medical

reason to suggest that any patient would undergo a hardship in following either Holkira PAK or Harvoni treatment regimens" (Lee Affidavit paragraph 24), which we interpret to be no "adverse side effects". That means the only way a claimant taking one of the DAA treatments would qualify as receiving Compensable HCV Drug Therapy is if the drug is taken in combination with interferon and/or ribavirin.

38. In discussions with Dr. Lee (Lee Affidavit, paragraph 23), we were informed that the most common and likely drug that would be prescribed for a patient would be Harvoni. Harvoni does not require a combination with ribavirin (or interferon).

39. We understand that there are some new drugs that are in the process of approval, and one that received approval in January 2016, that will improve treatment outcomes for some of the genotypes that currently do not have over 90% cure rates with the current drugs and for the genotypes where interferon and ribavirin remains the recommended treatment. These new drugs will not require usage in combination with either ribavirin or interferon and so are unlikely to meet the definition of compensable HCV Drug Therapy. In order to compete against the current drugs, we have assumed that these new drugs will be priced competitively or below the cost of Harvoni and Holkira Pak.

40. We note that most of the drugs taken in the past did include interferon and/or ribavirin and so would have met the definition of Compensable HCV Drug Therapy.

41. After reviewing the data received from the administrator about drug therapy, no claimant at level 2 appears to have received drug treatment in the past. (The data does not indicate whether any claimant at level 2 met the conditions for Compensable HCV Drug Therapy and declined treatment, thus receiving the lump sum payment).

42. Dr. Lee advised us that should a patient at level 2 specifically request treatment with Holkira Pak, he would expect that most specialists would prescribe it regardless of what the specialist would normally have prescribed. Further, he advised that there is no appreciable disadvantage in treatment effectiveness from prescribing Holkira Pak (Lee Affidavit, paragraph 24). The main difference is in the cost (Holkira Pak is about $13,000 cheaper for a 12-week treatment) and the number of pills required to be taken daily (1 for Harvoni and 4 or 6 for Holkira Pak[11]).

43. In our opinion, unless there are specific requests from patients, there is little reason to expect more than a few claimants at level 2 to receive drugs that qualify as Compensable HCV Drug Treatment.

44. To date, this potential lump sum payment has not been an issue. We assume that is either because:

    a. it was not permitted under standard operating procedures except in specific cases, or

---

[11] Holkira Pak is taken as 3 pills in the morning and one in the evening. If ribavirin is used, it is taken twice per day. (www.Abbvie.ca)

b. no one realized that they could get the $30,000 just by requesting a recommendation for the treatment, even though it was never taken.

45. We believe that this issue should be addressed and clarification provided as to whether these payments are appropriate to make under the Agreement. Otherwise, there is a risk that claimants at level 2 may request and receive treatment fully paid for by the Fund and that claimant will not only have a better than 90% chance of being cured, but will also receive $30,000 (1999 dollars) plus $1,000 (1999 dollars) per month while taking the drug[12].

46. There is no medical reason to suggest that a claimant at level 2 would undergo a hardship in taking either Harvoni or Holkira Pak (Lee Affidavit, paragraph 24). We have therefore determined that there is no need to adjust the liabilities from the 2013 Morneau Shepell Sufficiency Report to recognise that there may be some lump sums paid. Assuming that the conditions to qualify for Compensable HCV Drug Therapy are clarified to exclude most or all uses of Holkira Pak and Harvoni, we expect that there will be at most only a few claimants at level 2 who might qualify for the lump sum.

47. However, to provide for the possibility that these lump sums will be payable, we have estimated their present value.

a. Based on the genotypes typical in Canada (affidavit of Dr. Vince Bain sworn 11 March 2015), we estimate that about 50% of level 2 claimants could take Holkira Pak with ribavirin and so qualify for the lump sum[13]. That drug costs approximately $64,000[14].

b. In addition, these level 2 claimants would receive the lump sum which in 2013 dollars is $40,373.

c. They would also receive the monthly drug treatment benefit, but that was included in the 2013 Sufficiency liabilities, so it should not be recognised again here.

d. The total cost (prior to recognising any portion payable by private health insurance or provincial government drug plans) would therefore average about $105,000 per claimant.

e. We estimate that a further 10% of level 2 claimants would require treatment using other drugs that include ribavirin or interferon at a cost of about $80,000 plus a lump sum for a total cost of about $120,000.

f. So a total of about 60% of level 2 claimants could potentially qualify to receive the lump sum payment. The average cost of treatment plus the lump sum is a little less than $108,000.

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12 Requires that treatment is Holkira Pak in combination with ribavirin.

13 They could also receive Harvoni and would thereby not qualify for the lump sum. We understand Haroni is currently prescribed in most situations where there is a choice (Lee Affidavit paragraph 23).

14 In November 2015, we were quoted a price of $64,400 by Shoppers Drug Mart in Ontario for a 12 week supply of Holkira Pak. Prices may vary by store and by province. We assume that the average price will not be materially different. We understand that Abbvie, the manufacturer of Holkira Pak, has a program to supply ribavirin at no cost to patients who require it. (www.pacifichepc.org/hepctip/ribavirin/). For this report, we assumed that the cost of a 12-week treatment would be the average cost for all claimants (there are some treatment protocols that require only 8-weeks and others that require 24 weeks).

48. In the 2013 Morneau Shepell Sufficiency Report, we made an assumption that all claimants who had not previously cleared the virus would receive treatment in accordance with the MMWG model during the period 2013 to 2018. That includes all claimants at level 2. We assumed (including provision for adverse deviations) that the cost of treatment would be $110,000 prior to recognising any amounts payable by private or government plans. That $110,000 assumption does not include an allowance for the possibility of paying the level 3 lump sum. The average cost of treatment plus the lump sum (paragraph 47.f) of about $108,000 is a little less than the assumption of treatment costs ($110,000) made in the 2013 sufficiency review.

49. If the 60% of level 2 claimants do receive the lump sum payments, the total of all lump sums would be about $30.3 million, of which $8.7 million has already been recognised in the 2013 Morneau Shepell Sufficiency Report for level 2 claimants who are expected to advance to level 3. So the total additional amount that would be payable is about $21.6 million.

50. This potential cost is not recognised in our 2013 best estimate sufficiency liabilities but is covered by the 2013 sufficiency liabilities including provision for adverse deviations. Consequently, it is our opinion that any lump sum payment has already been adequately recognised in the provision for adverse deviations liabilities and no adjustment to the result presented in the 2013 Morneau Shepell Sufficiency Report is required to recognise the possibility that this lump sum amount might become payable.

51. Should these lump sums be payable, the effect of making no adjustment to the liabilities is to reduce the provision for adverse deviations that was included in the 2013 Sufficiency Report. That will be partly offset by an increase in the provision for adverse deviations because of the assumption we made about the $1,000 (1999 dollars) per month payable while receiving drug therapy. In the 2013 sufficiency review, we had assumed that all claimants receiving treatment of any type would qualify for that payment. In our opinion, that will not be the case for most treatments received after 2013. An inspection of the drug claims paid since 2012 shows that many claimants do not receive the monthly payment. In our opinion, reflecting this change will increase the provision for adverse deviations in our 2013 Sufficiency Report by about $8 million.

52. There is one other event of note subsequent to our 2013 sufficiency review. In January 2016, the federal government announced plans to join the provincial governments for the purpose of establishing a bulk purchasing group for publicly-funded prescription drugs. Shortly after that, the Canadian Life and Health Insurance Association requested a seat at the table as representative of those privately-funding drugs[15]. Assuming that comes to fruition, we expect the cost of prescription drugs will decrease from the levels seen in 2015 (and from the levels used in this report and the 2013 sufficiency review) through the purchasing power of all the players in the funding of prescription drugs.

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15 "Private insurers want in on national bulk-buying deal for drugs", by Jennifer Patterson, Benefits Canada, 20 January 2016, [http://www.benefitscanada.com/uncategorized/private-insurers-want-in-on-bulk-buying-deal-for-drugs-76109]

53. Consequently, in our opinion, there is no need to restate the sufficiency liabilities and so the excess assets in the Fund are the $256,594,000 shown in the 2013 Morneau Shepell Sufficiency Report.

E. COMPARISON OF 1999 COHORT AND 2013 COHORT

54. We undertook an analysis of the 1986 to 1990 claimant cohort in an effort to to reconcile the 1999 estimated class composition with the 2013 estimate.

55. The original transfused class was estimated to be 8,180 – 8,104 of whom were alive at January 1999 and 76 who were deceased as a result of HCV[16]. As of 31 December 2013, there are 3,924 transfused class members who have filed a claim and been approved plus an expected 254 yet to be approved[17]. That gives a total of 4,178 expected transfused claimants – a little more than 50% of the 1999 estimated class size.

56. We have restricted our analysis to the transfused cohort. While the original haemophiliac cohort was larger than those who have filed a claim or are expected to file a claim (1,645 in 1999 vs 1,385 in 2013), the difference in size is much smaller than for the transfused cohort. Throughout the history of the Agreement, we understand that the number and identification of the likely haemophiliac cohort was reasonably well known by class counsel and subsequently by the Joint Committee.

57. All of those people infected with HCV in the class period would have started their progress through the disease stages on the date of infection. By applying the transition probabilities developed by the Medical Model Working Group (the "**MMWG**") to this homogenous population of infected persons, we can determine the expected distribution of the cohort in 2013. That distribution can be compared to the actual distribution of the claimants in 2013.

PROCESS

Transfused Patients Infected with HCV 1986 to 1990

58. We started with the estimate of transfused patients who were infected with HCV from transfusion during the class period of 1986 to 1990. In Dr. Remis' Report dated 22 June 1998 (the "**1998 Remis Report**"), that number was reported as 15,700 (page 13). In the report prepared by the Canadian Association for the Study of the Liver Working Group on Hepatitis C Prognosis dated 6 April 1999 (the "**CASL Report**"), that number is reported as 15,707 (Table 2). In the actuarial report prepared by Eckler and dated 9 July 1999 (the "**1999 Eckler Report**"), the total number of infections during the class period is assumed to be 15,707.

59. The 15,707 persons infected through transfusion are not all potential claimants, as any such person who died prior to 1999 from causes other than HCV does not qualify for compensation under the Agreement. However, that number of infected people formed the base for the estimate

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16 Actuarial report prepared by Eckler and dated 9 July 1999, pages 7-8.

17 2013 Morneau Shepell Sufficiency Report, Table 146a

of the original transfused cohort in 1999 and it has been used as the basis for our projections herein.

60. We assumed that these 15,707 people were infected over the period 1986 to 1990 based on the number of transfusions in each year contained in the 1998 Remis Report.

Table 60 – HCV Infections by Year

Year	HCV Infections from Transfusion
1986	4,501
1987	3,882
1988	3,425
1989	3,047
1990	852
Total	**15,707**

Disease Transition Rates

61. We assumed that the transition rates developed by the MMWG in their 2013 Report applied in each year from 1986 to 2013. We believe that this is likely the most accurate set of progression rates that apply to the class since they involve the greatest amount of data and represent the most recent refinement of the MMWG in the estimation of disease progression rates. Those rates were developed from the information of all claimants under the Agreement, including those who are alive in 2013 and all those who died prior to 2013. It reflects the various progression rates from slow to fast as well as the various comorbidity factors that are present in some claimants.

62. We note that each update to the progression rates produced by the MMWG have involved refinements to the prior reported rates. While some of the refinements were significant changes to the specific rate, the totality of the transition rate refinements had only a modest effect on the time from infection to cirrhosis and decompensation. While the amount of time spent at each disease stage has changed from 1999 to 2013, the total time from infection to cirrhosis (Level 5) has remained reasonably similar at 36 to 41 years.

Spontaneous Viral Clearance ("SVC")

63. We assumed that the rate of spontaneous viral clearance during the six-months post-infection was 20%, the same rate utilised as of 1999 in the 1999 Eckler Report. Dr. Lee advised that from his experience, the rate of SVC among the transfused class would be at least 25% (Lee Affidavit paragraph 38).

64. The transition rates recognise that SVC continues to occur, possibly long after infection. Consequently, if the initial rate of SVC is 20% within the first 6 to 12 months of infection, the ultimate rate will be larger, as infected individuals continue to experience SVC. For example, if we

assume a 20% SVC at the time of infection between 1986 and 1990, and then project that cohort using the MMWG transition assumptions, by 1999 the total rate of SVC has become about 33%.

Post-Transfusion Excess Mortality

65. We assumed that the excess mortality as a result of the reason for the transfusion was the same as assumed in the CASL Report. That assumption for excess post-transfusion mortality was applied for the first ten years post transfusion, at which point it was assumed to have been reduced to zero. That resulted in an assumption that 8,104 transfused infected persons were alive in 1999. The CASL Report assumed an additional 76 transfused infected persons had died prior to 1999 as a result of HCV for a total estimated class size of 8,180.

Treatment

66. Our model allowed for treatment based on the assumptions in the 2007 MMWG Report. We determined that the treatment assumptions in the 2013 MMWG Report were not appropriate as they anticipated the new DAA drug regimens available beginning in 2013. In the CASL Report, we noted that the assumption used for treatment prior to 1999 was nil. For 1999 and beyond, the assumption used by the MMWG was similar each year but with the percentage of successful treatments gradually increasing. In our opinion, the 2007 treatment assumptions are a reasonable proxy for the average effect of treatment set out in the CASL Report through to the 2010 MMWG Report.

RESULTS OF PROJECTIONS

67. By combining the assumption for excess post-transfusion mortality and the disease transition rates, we projected the distribution of the 15,707 infected people to 1999. That produced 8,104 alive infected persons as of 1 January 1999 distributed by disease stage as shown in Table 67. Adding in the 76 deceased class members gives a total assumed class of 8,180 in 1999.

Table 67 – Infected Transfused Patients Surviving to 1999

Level	Assumed Cohort in 1986 - 1990	Projected to 1999	Assumed Cohort in 1999*
1	3,141	2,697	1,621
2	12,566	2,924	2,271
3	-	2,035	2,739
4	-	326	790
5	-	107	544
6	-	15	140
Total Alive	15,707	8,104	8,104
Deceased - HCV	-	76	76
Excess HCV Mortality	-	-	-
Died after 1998 - non HCV	-	-	-
Died before 1999 – non HCV	-	7,527	7,527
Total Deceased	0	7,603	7,603
Total	15,707	15,707	15,707

* *The numbers shown for the Assumed Cohort in 1999 are taken from the 1999 Eckler Report and do not add to the totals shown due to rounding.*

68. Table 67 shows that the assumed distribution of the cohort in 1999 was significantly more advanced in the disease than would be predicted by the disease transition rates. Such overstatement would serve to add a significant provision for adverse deviations to the initial liabilities of the Agreement and increase the likelihood that the assets would prove more than sufficient to pay all compensation as it falls due.

69. We can continue our projection of the 15,707 infected persons from 1999 to 2013. Since the 7,603 persons who are assumed to have died due to post-transfusion causes are not part of the class, we have not included them in Table 69 and thereafter. The total number of infected persons that form our cohort is 8,180.

Table 69 – Infected Transfused Patients Surviving to 2013

Level	Original Cohort projected to 1999	Original Cohort projected to 2013	Actual Cohort 2013
1	2,697	2,925	542
2	2,924	874	1,055
3	2,035	1,327	954
4	326	584	186
5	107	575	168
6	15	192	93
Total Alive	8,104	6,477	2,998
Deceased - HCV	76	338	715
Excess HCV Mortality	-	450	
Died After 1998 - non HCV	-	915	465
Total Deceased	76	1,703	1,180
Total	8,180	8,180	4,178

70. In Table 69, we can see that if there were 8,180 persons originally infected during the class period who survived to 1999 or who died prior to 1999 from HCV, then by 2013 we would expect there to be 6,477 alive infected persons and 1,703 deceased.

71. We can compare the projection of the original assumed cohort with the actual 2013 cohort.

    a. In total, there are 4,178 claimants compared with an expected 8,180.

    b. There are 2,998 alive claimants compared with 6,477 who would be expected to have survived out of the original 1999 assumed cohort.

    c. There are 1,180 deceased claimants compared with 1,703 who would be expected to have died out of the original 1999 assumed cohort.

72. In our opinion, the actual class is likely much smaller than the original 1999 estimate of 8,180. However, we have not yet reached a stage in our analysis where we can quantify that difference.

F. FEDERAL AND PROVINCIAL GOVERNMENT CONTRIBUTIONS

73. The contributions from the federal, provincial and territorial governments (the "**FPT Governments**") have been made up of the direct cash contributions plus foregone tax revenue. The amount of foregone tax revenue was estimated in 1999 by Jacob Levi of Eckler to be $357 million (1999 Eckler Report, page 55). That calculation looked only at the foregone taxes on investment income of the Compensation Fund. Implicitly, it assumed that the contributions of the FPT Governments to the Fund and the payments of benefits to claimants would be non-taxable.

74. We have therefore estimated the amount of income tax foregone by the FPT Governments from

    a. investment income of the Fund; and

    b. payments of compensation to the claimants.

75. In performing these calculations, we made some rough assumptions in order to simplify the calculations involved. For purposes of tax on investment income, we assumed:

    a. the Fund would have been taxed as a personal trust based on a federal tax rate of 19% and a provincial tax rate of 16.8%[18];

    b. past investment income would be the same as was actually earned and future investment income would be at the rates used in the 2013 Sufficiency Review for the provision for adverse deviations assumptions (3.65% on invested assets, inclusive of future inflation) and compensation payments of the fund would be the same as shown in the 2013 Morneau Shepell Sufficiency Report in section 10.

    c. the tax payable by the trust for each year would be based on the investment income of the fund in that year reduced by the amounts paid to claimants[19] in the year and reduced by the expenses of the fund;

    d. investment income attributable to the Real Return Bonds would be taxable as ordinary income in the year accrued, regardless of when it is paid;

    e. since Real Return Bonds are expected to generally be held to maturity, any capital gains and losses on them will net out to zero over the life of the fund and no tax would be paid on these capital gains and losses;

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18 The 16.8% rate is the top tax rate applicable in British Columbia. A reduction of $10,400 was made to recognise the gradual tax structure of British Columbia. It may be that if the trust were taxable, it would be taxed in a different province and at a different rate.

19 For purposes of the trust fund taxes, only the portion of the benefits paid from the fund were included – the PT Government portion was not included as income and was not deducted for purposes of the trust fund's taxes.

f. approximately 20% of the fund's investment income would be in the form of capital gains and dividends, which attract a different treatment for tax than ordinary income. To recognise the tax-preferred status of capital gains and dividends, 9% of the total investment income could be treated as non-taxable and 91% taxable as ordinary income[20];

g. for simplification purposes, any capital gains are assumed to be taxed as they arise whether realised or unrealised;

h. payments to claimants and all expenses of the Fund would be deductible from income in each year, with any amount that exceeds the investment income eligible to carry forward to a future year;

i. there would be no flow-through of taxation (e.g. dividends and capital gains) to individuals; and

j. any taxes that might have been paid would have been refunded to the Compensation Fund by an additional contribution from the governments, as contemplated in the Agreement, so that the total assets of the Fund would remain unchanged as a result of taxation.

76. In calculating the income taxes of claimants, we assumed:

a. payments of pecuniary damages from the Compensation Fund would be taxed as ordinary income;

b. payments of non-pecuniary damages and reimbursement of expenses would not be taxed;

c. loss of income, loss of services and loss of support are pecuniary damages and therefore are taxable and all other compensation is non-pecuniary and therefore non-taxable;

d. the average individual income tax rate that would apply to pecuniary damages would be 20.5% for federal taxes and 8.0% for provincial taxes[21]; and

e. there would be no deduction made against the Compensation Fund payment (or if there is a deduction, it would have been available to the individual under the current regime where these payments are actually non-taxable).

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20 Only half of capital gains are taxable with the balance non-taxable. The effective tax rate that applies on dividends is about 72% of the tax rate that applies on ordinary income. We assumed 16% of the investment income is from capital gains, so 8% is non-taxable and 8% is taxable at the ordinary tax rate. We assumed 4% of the investment income is from dividends, which is equivalent to about 1% non-taxable and about 3% taxable at the ordinary tax rate. So in total, 9% of all investment income would not be taxed and the rest would be taxable at ordinary tax rates.

21 For this, we assumed that half of the claimants would have taxable income of about $30,000 on average and half would have taxable income of about $70,000 on average. The tax rates used are the average of the marginal rates applicable at those income levels (with the Ontario rate used as a proxy for provincial taxes).

77. Based on these assumptions, the total present value as of 31 December 2013 for past and future income taxes is estimated to be approximately:

Table 77 – Estimated Present Value of Foregone Income Taxes as at 31 December 2013

	Amount of Tax (in 000s)
Tax on Investment Income	
Federal Taxes	$ 226,942
Provincial Taxes	131,011
Total tax on investment income	357,953
Tax Paid by Claimants	
Federal Taxes	141,592
Provincial Taxes	55,255
Total tax on compensation payments	196,847
Total Income Tax	
Federal Taxes	368,534
Provincial Taxes	186,266
Total income taxes	$ 554,800

78. As of December 2013, we estimate that approximately $555 million of income taxes that would normally be payable by a settlement have and will be foregone by the FPT Governments. This is in addition to their respective contributions to the Compensation Fund for the payment of benefits and expenses.

79. The present value of the estimated foregone income taxes as of 1999 is about $336 million. That is similar to the $357 million estimated by Eckler in the 1999 Eckler Report. The total contribution of the federal and PT Governments is therefore approximately the 1.1 billion cash contributions plus the $0.34 billion of foregone income taxes for a total of $1.44 billion.

G. ATTRIBUTION OF EXCESS ASSETS

80. The 2013 Morneau Shepell Sufficiency Report identified $256,594,000 of excess assets (the 2013 Eckler Sufficiency Report identified the excess assets as $236,341,000). Excess assets are also referred to as Actuarially Unallocated Assets.

81. The existence of these excess assets is entirely due to the pre-funding of the Compensation Fund by the federal government. Had the federal government not prefunded their contribution obligation, the Fund would have been insufficient as of 31 December 2013.

82. In the absence of pre-funding, we assumed that the federal government would have contributed funds as and when compensation payments are made – in the same way that the provincial and territorial governments do. The unpaid contribution obligation would grow with interest calculated at the yield on Government of Canada 91-day Treasury Bills.

83. We have calculated the financial position of the Compensation Fund as of 31 December 2013 based on an assumption that neither the federal nor PT Governments pre-funded their contributions.

Table 83 – Financial Position if No Pre-Funding by Canada (in '000s)

	Best Estimate		*Provision for Adverse Deviations*	
	2013	***2010***	***2013***	***2010***
Assets	$ 585,718	$ 678,644	$ 585,718	$ 678,644
Liabilities				
▪ Transfused	387,114	412,012	491,612	528,404
▪ Haemophiliacs	223,969	242,240	264,471	284,150
▪ HIV Program	950	1,100	970	1,100
▪ Fees & Expenses	53,455	34,091	55,552	34,658
Total Fund Liabilities	665,488	689,443	812,605	848,312
Fund Surplus (Deficit)	**$(79,770)**	**$(10,799)**	**(226,887)**	**(169,668)**
Additional buffer against catastrophic events			121,000	-
Excess (Shortfall) in Assets			**$ (347,887)**	**$ (169,668)**

84. If there had been no pre-funding by Canada, we estimate that the Compensation Fund would have been insufficient as of 31 December 2013 by about $348 million. There were actually excess assets of about $256 million, meaning that the pre-funding by Canada has put the Compensation Fund in a $604 million better position than if no prefunding had occurred.

85. Similarly, we calculated the financial position of the Compensation Fund assuming that the PT Governments had pre-funded their obligation along with Canada.

Table 85 – Financial Position if PT Governments had Pre-Funded their Obligation (in '000s)

	Best Estimate		*Provision for Adverse Deviations*	
	2013	*2010*	*2013*	*2010*
Assets	$ 1,413,547	$ 1,360,403	$ 1,413,547	$ 1,360,403
Liabilities				
▪ Transfused	387,114	412,012	491,612	528,404
▪ Haemophiliacs	223,969	242,240	264,471	284,150
▪ HIV Program	950	1,100	970	1,100
▪ Fees & Expenses	53,455	34,091	55,552	34,658
Total Fund Liabilities	665,488	689,443	812,605	848,312
Fund Surplus (Deficit)	**$748,059**	**$670,960**	**600,942**	**512,091**
Additional buffer against catastrophic events			121,000	-
Excess (Shortfall) in Assets			**$ 479,942**	**$ 512,091**

86. Had the PT Governments pre-funded their contribution obligation along with Canada, the Compensation Fund would have excess assets of about $480 million as of 31 December 2013 – about $224 million greater than actually exists.

87. In our opinion, the excess assets are entirely due to the agreement by Canada to pre-fund the federal contribution obligation.

H. SUMMARY OF COST OF PROPOSED CHANGES

88. The estimated costs of the Joint Committee's proposals are presented in the following tables. Detailed information and discussion about each proposal is in the sections that follow.

89. We have continued to utilise the assumptions from the 2013 Morneau Shepell Sufficiency Report. For this report, we used the assumptions including a provision for adverse deviations.

90. Because of the nature of the proposals, we had to make some additional assumptions regarding the amounts and the claimants who would receive any increase in the benefits. These assumptions are set out in the sections that follow describing each proposed change.

91. For the most part, we adopted assumptions and methodologies that are consistent with those used by Eckler in the Eckler Costing Report. In a few situations, we believe that different assumptions are warranted to capture the full extent of the top-up payments to be made. In most situations, the impact on the cost is likely not material – for example, future payments for loss of services was determined by Eckler to be $21,014,000 and by us $24,108,000.

92. However, there are a few proposals where the difference in assumption or methodology has a material effect on the cost of the proposed change. For example, the future payments for cost of care was determined by Eckler to be $505,000 and by us to be $2,563,000. The expected cost for the change to out-of-pocket expenses was determined by Eckler to be $1,957,000 and by us to be $8,370,000.

93. In all situations where we utilised different assumptions or methodologies it was to recognise the risk of a possible change in behaviour of claimants as a result of the proposed changes. As an example, for the cost of care assumptions, we believe that claimants who incurred expenses close to but not over the current $50,000 (1999 dollars) maximum did so because they could not afford to pay for services out of their own pocket, even though such services were required. In the future, we expect even though they have never exceeded the current maximum, they will utilise the additional services afforded by the increase in maximum to $60,000 (1999 dollars).

94. We show two tables of costs for the proposed changes. Table 94a is based on there being no interest or indexing for retroactive payments between the date of the original payment and the date of the top-up payment. That is consistent with the Joint Committee proposals. In other words, if a claimant had incurred a loss of services payment of $14,288 in 2005 (the maximum payable in that year based on 20 hours per week) the top-up would be $1,428.80 in 2016. No interest or index adjustment to adjust the amount from 2005 to payment in 2016 would be made. Table 94b provides for indexing all past payments to the date the top-up is paid. (For our costings, that adjustment was applied up to December 2013 to be consistent with the date of the sufficiency review.)

Table 94a- Summary of Costs for Proposed Changes to HCV Settlement Agreement – No Interest on Retroactive Payments ('000s)

		Transfused Cohort			Haemophiliac Cohort				
Description	Number of Claimants Affected	Retro-active Cost	Future Cost	Total Cost	Retro-active Cost	Future Cost	Total Cost	Total Cost	Eckler Total Cost
First Claim Deadline	-	$ -	$ 28,605	$ 28,605	$ -	$ 3,794	$ 3,794	$ 32,399	$ 32,399
Increase Fixed Payments by 10%	5,453	29,153	7,635	36,788	11,259	2,830	14,089	50,877	51,266
Family Member Payments	2,487	9,069	7,456	16,525	2,212	3,857	6,069	22,594	22,162
Loss of Income/Support - eliminate deduction of collateral benefits	297	6,392	7,003	13,395	11,747	10,952	22,699	36,094	27,539
Compensate for Diminished Pension Savings	294	5,502	3,747	9,249	4,800	3,655	8,454	17,703	19,787
Loss of Services - Compensate for up to 22 Hours per Week	718	8,950	14,665	23,615	4,326	9,443	13,769	37,384	34,561
Cost of Care - increase maximum to $60,000 (1999 dollars)	13	114	1,641	1,755	7	922	929	2,684	627
Out-of-Pocket Expenses - $200 for accompanying Family Member	2,231	-	5,940	5,940	-	2,430	2,430	8,370	1,957
Funeral Expenses - increase maximum to $10,000 (1999 dollars)	375	710	661	1,371	371	283	654	2,025	2,050
Administrative Expenses	-	-	609	609	-	300	300	909	909
Buffer (15%)	-	-	11,694	11,694	-	5,770	5,770	17,464	12,167
Total Cost of Proposed Changes	**5,453**	**$59,890**	**$89,656**	**$149,546**	**$34,722**	**$44,235**	**$78,957**	**$228,503**	**$205,424**

Table 94b - Summary of Costs for Proposed Changes to HCV Settlement Agreement - Retroactive Payments indexed to 2013 ('000s)

		Transfused Cohort			Haemophiliac Cohort				
Description	Number of Claimants Affected	Retro-active Cost	Future Cost	Total Cost	Retro-active Cost	Future Cost	Total Cost	Total Cost	Eckler Total Cost
First Claim Deadline	-	$ -	$ 28,605	$ 28,605	$ -	$ 3,794	$ 3,794	$ 32,399	$ 32,399
Increase Fixed Payments by 10%	5,453	35,171	7,635	42,806	14,622	2,830	17,452	60,258	51,266
Family Member Payments	2,487	10,642	7,456	18,098	2,596	3,857	6,453	24,551	22,162
Loss of Income/Support - eliminate deduction of collateral benefits	297	7,172	7,004	14,175	13,479	10,952	24,430	38,606	27,539
Compensate for Diminished Pension Savings	294	6,188	3,747	9,935	5,294	3,655	8,948	18,883	19,787
Loss of Services - Compensate for up to 22 Hours per Week	718	10,121	14,665	24,786	4,909	9,443	14,352	39,138	34,561
Cost of Care - increase maximum to $60,000 (1999 dollars)	13	122	1,641	1,763	8	922	929	2,692	627
Out-of-Pocket Expenses - $200 for accompanying Family Member*	2,231	-	5,940	5,940	-	2,430	2,430	8,370	1,957
Funeral Expenses - increase maximum to $10,000 (1999 dollars)	375	820	661	1,481	430	283	713	2,195	2,050
Administrative Expenses*	-	-	609	609	-	300	300	909	909
Buffer (15%)	-	-	11,694	11,694	-	5,770	5,770	17,464	12,167
Total Cost of Proposed Changes	**5,453**	**$ 70,237**	**$ 89,656**	**$159,893**	**$ 41,337**	**$ 44,235**	**$ 85,571**	**$245,464**	**$205,424**

* Out-of-Pocket expenses and Administrative expenses have no retroactive element and are not affected by indexing.

I. FIRST CLAIM DEADLINE

95. The Agreement provided that the first claim deadline would be 30 June 2010, after which claims would be accepted in only specified situations ("late claims").

96. The Agreement provisions related to filing a late claim were clarified in two court approved protocols that became effective May 2012. In summary, those protocols provide that a class member may submit a claim if they:

    a. first learned of their infection within the three years prior to first advising the administrator of their claim; or

    b. do so within one year of attaining the age of majority; or

    c. are a secondarily infected person and they file a claim within three years of the date the primarily infected person first filed their claim; or

    d. are the personal representative and are seeking to file a claim within three years of the infected person's death; or

    e. are a dependant or family member and are seeking to file a claim within three years of the infected person's death; or

    f. the claim was initially advanced under the Pre-1986/Post-1990 Hepatitis C Settlement prior to 30 June 2010.

97. There are other conditions that a person must meet in order for a claim to be accepted by the administrator, such as completing the application within a specified time period. A claim that is accepted in accordance with one of the late claim protocols will still go through the approval process and may be approved or denied in accordance with the Agreement terms and administrative procedures.

98. The Joint Committee proposes that a third late claim protocol be approved to permit claims to be accepted by the administrator from a person who:

    a. did not receive timely notice of the deadline until after it had passed; or

    b. did receive notice of the deadline prior to it passing but did not have sufficient time to file a claim; or

    c. failed to meet the first claim deadline due to matters considered to be beyond their control.

DISCUSSION

99. If adopted, the proposal will likely result in a number of new claimants being approved for compensation. The actual number will depend on the approval rate. It appears that there would be a two-step process:

    a. first, the referee or court would determine whether the person meets the conditions of the late claims protocol so that the administrator may accept the claim;

    b. second, the normal approval processes would be followed as for every other claim submitted with the claim either accepted or denied.

100. The historical approval rate can be utilised to estimate the percent of these late claims that are likely to get approved in the second step of the process. Recent claims approval rates have been about 50% for transfused claimants and about 67% for haemophiliac claimants. We do not have any data to assist in selecting an assumption for the percent of claims that may be approved for acceptance under the first step.

101. We have reviewed the assumptions that were used in the Eckler Costing Report and the Eckler 2013 Sufficiency Report and we agree that they are reasonable assumptions for the purpose at hand. The key assumptions are:

    a. the rate for accepting a late claim will be about 80%;

    b. 50% of the accepted claims will be approved for transfused people and 70% for haemophiliacs, with the balance denied;

    c. this gives a total acceptance rate (steps 1 and 2 combined) of 40% for transfused people and 55% for haemophiliacs;

    d. based on the enquiries received to December 2013 by the administrator and projections of future applications, there will likely be about 295 transfused and 18 haemophiliac requests for filing a claim under this protocol if it is adopted;

    e. the disease and age distribution of the approved claimants will be the same as the current claimant cohort, with the exception that the new claimants approved will not include any who died prior to 1999.

102. In total, those assumptions produce 118 new transfused claims and 10 new haemophiliac claims.

CALCULATION OF COST FOR FIRST CLAIM DEADLINE

103. We have estimated the cost should the court approved protocol be adopted by:

a. ***Retroactive Cost***: Any retroactive compensation is included in the future cost. This is consistent with the methods and assumptions used for the 2013 Sufficiency Review by both Eckler and Morneau Shepell.

b. ***Future Cost***: We have accepted the Eckler calculation of this amount since our assumptions are the same.

104. The costs for the proposed late claims protocol are:

Table 104 – Costs for Late Claims Protocol ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Modification of First Claim deadline	$ 0	$ 28,605	$ 0	$ 3,794	$ 32,399

J. INCREASE FIXED PAYMENTS BY 10%

105. Currently, there are lump sum compensation amounts payable at most of the disease levels. The amounts are cumulative, so a person who is approved as a claimant at level 6 would receive the amounts for each of levels 1 through 6 for a cumulative total of $225,000 (1999 dollars) which is $302,799 in 2014 dollars.

106. The following lump sum amounts are in 1999 dollars:

Table 106 – Lump Sum Payments

Level	Lump Sum	Cumulative Amount
1	$ 10,000	$ 10,000
2	20,000	30,000
3	30,000	60,000
4	-	60,000
5	65,000	125,000
6	100,000	225,000

107. There are some other lump sum amounts under the Agreement.

a. A haemophiliac infected claimant who was also infected with HIV may elect to receive $50,000 (1999 dollars) in full satisfaction of all claims under the Agreement. This payment is likely of interest only to those haemophiliac claimants at level 1 and possibly some claimants at level 2.

b. Where an infected person died prior to 1999, the estate may claim either a lump sum of $120,000 (1999 dollars) in full satisfaction of all claims under the Agreement, or a lump sum of $50,000 (1999 dollars) in respect of all pre-death losses with family members and dependants eligible to claim additional losses.

c. Where a haemophiliac infected person who was also infected with HIV died prior to 1999, the estate may claim a lump sum of $72,000 (1999 dollars) in full satisfaction of all claims under the Agreement. This option does not require evidence about the cause of the HCV infection.

108. The Joint Committee proposes to increase these lump sum payments by 10%. The increase in respect of past payments will not be adjusted from the year of original payment to the date of payment for either interest or by the pension index.

DISCUSSION

109. The proposal will result in a lump sum amount equal to 10% of the actual lump sum paid to each infected person and estate with no adjustment for interest or the pension index. As a result,

claimants at the same level will receive different dollar amounts depending on the year they received the original lump sum amount.

110. For example, consider a level 3 claimant who received $60,000 (1999 dollars) upon approval as a claimant. For such a claimant who was approved in 2001, their original payment was $62,502.70, so the 10% increase would pay $6,250.27 in 2016. For a level 3 claimant approved in 2013, the original lump sum amount was $80,021.95, so the 10% increase would pay $8,002.20 in 2016.

111. If paying amounts that differ based on the year of the original payment is considered to be inappropriate, two of the possible alternatives are to pay the 10% increase based on:

    a. the 1999 dollar amounts with no interest or pension index adjustment to the date of payment; and

    b. the 1999 dollar amounts indexed to the date of payment of the top-up.

112. Under both alternatives, all claimants who are at the same level today, and all deceased claimants at that level when they died, will receive the same lump sum increase. The alternative (b) amounts shown in Table 112 are based on amounts payable in 2016.

Table 112 – Alternative Increases for Fixed Payments

Level	Alternative (a)	Alternative (b)
1	$ 1,000	$ 1,386
2	3,000	4,159
3	6,000	8,318
4	6,000	8,318
5	12,500	17,330
6	22,500	31,194
Haemophiliac $50,0000	5,000	6,932
Pre-1999 Death $120,000	12,000	16,637
Pre-1999 Death $50,000	5,000	6,932
Haemophiliac Pre-1999 Death $72,000	7,200	9,982

113. If Alternative (a) is adopted, consideration should be given for the amounts to be paid to future approved claimants. Would it be:

    a. the unindexed 10% amount as shown in the table (which will complicate the administration and explanation of the payment amounts in the future); or

    b. 10% of the 1999-dollar amount plus indexing to the year of payment (similar to Alternative (b)).

114. If Alternative (b) is adopted, there should be no issues due to differences in the amounts paid to claimants in different years.

CALCULATION OF COST FOR FIXED PAYMENTS

115. We have estimated the cost for the fixed payments by:

    a. ***Retroactive Cost***: The retroactive compensation for the fixed payments as proposed is equal to 10% of all lump sum amounts paid in the past. For the alternatives set out above, we totaled the number of lump sum payments made at each level and multiplied each total by the retroactive amounts payable as shown in Table 112.

    b. ***Future Cost***: The liability from the 2013 Morneau Shepell Sufficiency review for each of the lump sum payments was increased by 10%.

116. The costs for the proposed increase and the two options discussed are:

Table 116 – Costs for 10% Increase to Fixed Payments ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Proposal	$29,153	$7,635	$11,259	$2,830	$50,877
Alternative (a)	26,135	7,635	10,866	2,830	47,466
Alternative (b)	35,171	7,635	14,622	2,830	60,258

K. FAMILY MEMBER PAYMENTS

117. Currently, family members of a deceased infected claimant may claim a lump sum amount as compensation for loss of guidance, care and companionship. The amounts vary based on the relationship of the individual to the infected claimant – from $500 (1999 dollars) for a grandchild or grandparent to $25,000 (1999 dollars) for a spouse.

118. The Joint Committee is proposing that the amounts payable to children over age 21 and to parents be increased from $5,000 (1999 dollars) to $10,000 (1999 dollars).

DISCUSSION

119. A comparison of the lump sum amounts by province and territory for loss of guidance, care and companionship is attached as Appendix A. Neither of these increases will result in a payment that exceeds the maximum values shown in Appendix A for children or parents.

120. This proposal, if approved, will result in top-up payments for retroactive amounts that differ based on the year the original amount was paid – with larger payments going to those whose original benefit was paid more recently.

121. As with the Lump Sum amounts discussed above, two of the possible alternatives would be to make the payment in 1999 dollars with no adjustment for interest or pension index (for a top-up payment of $5,000), or to pay a flat amount that includes indexing to the date of payment of the top-up (for a top-up payment of $6,932 if paid in 2016).

122. The discussion comparing past and future payments in paragraphs 113 and 114 also applies to these payments.

CALCULATION OF COST FOR FAMILY MEMBER PAYMENTS

123. We have estimated the cost for the Family member payments by:

    a. ***Retroactive Cost***: The retroactive compensation for lump sum payments as proposed is equal to 100% of all family member amounts paid to parents and children over age 21 in the past. For the alternatives set out above, we totaled the number of these family member payments made and multiplied each total by the retroactive amounts payable.

    b. ***Future Cost***: The total amount paid in the past to children over 21 and to parents is 30.3% of all family member payments. We assumed that ratio would continue into the future in the absence of this proposal and determined the cost to be equal to 30.3% of the liability from the 2013 Sufficiency review.

124. The costs for the proposed increase and the two options discussed are:

Table 124 – Costs for 10% Increase to Family Member Payments ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Proposal	$9,069	$7,456	$2,212	$3,857	$22,594
Alternative (a)	7,838	7,456	1,912	3,857	21,063
Alternative (b)	10,642	7,456	2,596	3,857	24,551

L. ELIMINATE DEDUCTION OF COLLATERAL BENEFITS FOR LOSS OF INCOME AND LOSS OF SUPPORT CLAIMS

125. Currently, when a claimant suffers a loss of income as a result of their HCV infection, compensation equal to the loss in net income is paid. The focus is on the amount of net income so that after payment of the Loss of Income benefit ("**LOI**"), the claimant will be returned to approximately the same financial position after tax that they would have been in were it not for the disability. LOI is recalculated each year to take into account any changes in the claimant's financial situation. LOI is paid each year of loss until the claimant attains age 65 or the loss ends.

126. In the calculation of the amount of LOI payable, a deduction is made for any amounts the claimant receives in the year of the lost income, after tax, for the sum of:

    a. Canada Pension Plan and/or Quebec Pension Plan ("**C/QPP**") disability income[22]; plus

    b. Employment Insurance benefits; plus

    c. disability insurance (for example, from an employer long-term disability income plan); plus

    d. benefits from the HIV Extraordinary Access Plan ("**EAP**"), the HIV Multi-Provincial and Territorial Assistance Program ("**MPTAP**") and Nova Scotia HIV Assistance Program (collectively, the "**HIV Payments**").

127. Currently, following the death of an infected claimant, any surviving dependants may receive 70% of the lost income amount as a Loss of Support ("**LOS**"). That is payable for the dependants' life but not beyond the date the infected claimant would have attained age 65.

128. In the calculation of the amount of LOS payable, a deduction is made for any amounts the dependant receives in the year of the lost income, after tax, for the sum of:

    a. Canada Pension Plan and/or Quebec Pension Plan ("**C/QPP**") survivor benefits (including amounts for dependants)[23]; plus

    b. survivor HIV Payments.

129. The Joint Committee proposes to remove the deduction of these collateral benefits and thereby increase the amount of benefit payable for both past and future losses. Past losses will not be adjusted from the year of loss to the date of payment for either interest or by the pension index.

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22 The Notice of Application only references CPP in the section "Part 1: Orders Sought". Both Heather Rumble Peterson's affidavit and Richard Border's affidavit include QPP in their discussions and cost estimates. We have included both CPP and QPP in our discussion and cost estimates.

23 The Notice of Application references CPP disability payments in the section "Part 1: Orders Sought". There are no disability payments under the C/QPP after a person's death. We have recognised both CPP and QPP *survivor* benefits in our discussion and cost estimates.

DISCUSSION

130. Net income is defined to be the gross earned income of the claimant reduced by income taxes, C/QPP contributions and Employment Insurance premiums. Other payroll deductions (such as pension contributions and union dues) are ignored in calculating net income, so the net income amount likely will exceed what the claimant actually received after all deductions[24]. (Earned income is from working. Investment income and other forms of income that would not be affected by disability are not included in the loss of income calculation.)

131. The LOI amount is equal to 100% of the difference in pre-disability net income and the post-disability net income[25]. Effectively, the calculation is:

    a. Pre-disability Net Income (average over the best three consecutive years of total earned income less specified deductions); reduced by

    b. The difference between

        (i) the sum of the following amounts received in the year for which compensation is payable:

            (1) Earned income; plus

            (2) C/QPP disability benefits; plus

            (3) Employment Insurance benefits; plus

            (4) Disability income; plus

            (5) HIV Payments; and

        (ii) the ordinary payroll deductions that would apply to these amounts – essentially the income tax payable, C/QPP contributions, and EI contributions.

132. The Joint Committee's proposal would alter the LOI calculation set out above to remove items b(i)(2) through b(i)(5) (the "**Collateral Benefits**"). A similar change would apply for LOS benefits.

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24 Ignoring these other payroll deductions does not necessarily mean that the claimant is being overcompensated. For example, the calculation of net income ignores any employee contributions for pension and health insurance benefits. But those contributions help to pay for benefits that provide value to the employee, so it would be reasonable to assume that by incurring a loss of income, the claimant also incurs a loss of those other benefits. By ignoring the deductions of employee contributions, the loss of those benefits is partially compensated (the partial compensation is for the portion paid for by the employee contributions).

25 Originally, LOI compensation was 70% of the loss and the pre-disability income amount was limited to $75,000, but those limitations were removed, subject to court approval for any pre-disability income amount exceeding $300,000 (1999 dollars).

EFFECT OF REMOVING COLLATERAL BENEFITS ON LOI COMPENSATION

133. For most or all claimants who are in receipt of Collateral Benefits, removing the deduction of those Collateral Benefits will result in payment of significantly more than the actual loss in income. There is one possible exception: any amount of collateral benefit that was also payable during the period used to determine pre-disability income (see below at paragraph 138).

134. Table 134 provides examples of the current and proposed provisions. Line 5, pre-disability net income, is the amount used for the LOI calculation. For scenarios 1 to 3, total income after tax and pre-disability net income are the same. For Scenarios 4 and 5, they differ.

    a. Scenarios 1 and 2 are claimants with no Collateral Benefits. Their LOI amount is the same under the current and proposed calculations. In both situations, they receive 100% replacement of their pre-disability total income after tax.

    b. Scenario 3 is a claimant with Collateral Benefits but no HIV Payments. This is representative of most of the claimants who have Collateral Benefits. For the current calculation, they receive 100% of their pre-disability total income after tax[26]. For the proposed calculation, they receive more than 100% of their total income after tax.

    c. Scenario 4 is a claimant with Collateral Benefits, all of which are HIV Payments. Under the current calculations, the LOI benefit replaces 100% of the "pre-disability net income", but since that net income excludes (by definition) the HIV Payments, the actual replacement of pre-disability total income after tax is less than 100%. The proposed calculation provides for a replacement of 100% of pre-disability total income after tax. In 2013, there was one claimant in this situation.

    d. Scenario 5 is a claimant with Collateral Benefits, only some of which are HIV Payments. Under the current calculations, the LOI benefit replaces 100% of the "pre-disability net income", but since that net income excludes (by definition) the HIV Payments, the actual replacement of pre-disability total income after tax is less than 100%. The proposed calculation provides for a replacement of more than 100% of pre-disability total income after tax due to the effect of not deducting the non-HIV Collateral Benefits. *If the non-HIV Collateral Benefits are deducted but the HIV Payments are not deducted, the replacement ratio based on the total income after tax would be 100%.* In 2013, there were two claimants in this situation.

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[26] However, if any of their Collateral Benefits had been payable prior to disability, their income replacement would be less than 100%. We believe such a situation would be rare or non-existent.

Table 134 – Loss of Income Calculations – Current and Proposed

Line	Description	Calculation	Scenario 1	2	3	4	5
Pre Disability Amounts							
1	Earned Income		$ 59,000	$ 59,000	$ 59,000	$ 59,000	$ 59,000
2	HIV Payments		-	-	-	43,926	43,926
3	Income Tax Deduction		12,254	12,254	12,254	12,254	12,254
4	Pre-Disability Income after Tax	(1) + (2) - (3)	46,746	46,746	46,746	90,672	90,672
5	Pre-Disability Net Income	(1) - (3)	46,746	46,746	46,746	46,746	46,746
Post Disability Amounts							
6	Earned Income		-	12,000	12,000	-	-
7	HIV Payments		-	-	-	43,800	43,800
8	Other Collateral Benefits		-	-	28,437	-	28,437
9	Income Tax Deduction		-	646	4,458	-	1,457
10	Net Income prior to LOI Payment	(6)+(7)+(8)-(9)	-	11,354	35,979	43,800	70,780
Current Benefit							
11	Current LOI	(5) - (10)	46,746	35,393	10,768	2,946	-
12	Total Income After Tax - Current	(10) + (11)	46,746	46,746	46,746	46,746	70,780
13	Percent of Pre-Disability Income after Tax - **Current**	(12) ÷ (4)	100%	100%	100%	52%	78%
Proposed Benefit							
14	Proposed LOI	(5) – [(6) - (9)]	46,746	35,393	39,205	46,746	48,204
15	Total Income After Tax - Proposed	(10) + (14)	46,746	46,746	75,183	90,546	118,983
16	Percent of Pre-Disability Income after Tax - **Proposed**	(15) ÷ (4)	100%	100%	161%	100%	131%

135. Table 135 summarises the LOI claims for 2011 to 2013. It shows that virtually all claimants with Collateral Benefits would receive a "replacement" of more than 100% of their loss if Collateral Benefits are no longer deducted.

Table 135 – Effect of no Deduction for Collateral Benefits on LOI

	2011	2012	2013
Claimants with a LOI payment	112	121	113
Claimants with 100% loss of earned income	57	66	62
Claimants with partial loss of earned income	55	55	51
Claimants with Collateral Benefits	46	44	42
If no deduction for Collateral Benefits:			
- number of claimants with LOI in excess of loss	46	44	42
- average percent of lost net income that is "replaced"	131.8%	129.9%	128.3%
- maximum percent of lost net income that is "replaced"	185.1%	167.6%	165.8%

136. From an actuarial perspective, paying an amount that exceeds an actual financial loss is not appropriate. Most insured disability plans include a provision that limits post-disability income from all sources to no more than 85% of pre-disability income. That limit provides an incentive for the disabled person to return to work when first able to do so. It also recognises that expenses generally are lower when one does not work.

137. Any amount paid that exceeds the income loss is not compensation for a loss of income. If there is a valid reason for paying more than 100% of the loss, in our opinion, it should not be included with the LOI benefit but be provided elsewhere under the Agreement.

138. There is a situation where the current provisions are likely to produce a replacement of less than 100% of the income the claimant was receiving prior to disability. This can be sub categorised as:

    a. Where a claimant was in receipt of HIV Payments prior to the onset of disability and loss of income, the LOI benefit will be less than the loss of net income by an amount equal to the HIV payments (see examples 4 and 5 in Table 134). This happens because the pre-disability income does not include the HIV payments but the reduction from the Loss of Income amount does include the HIV Payments.

       We believe that it is likely all recipients of HIV Payments were in receipt of them prior to their disability. From 2011 to 2013, there are only three claimants receiving Loss of Income along with HIV Payments. However, if we assume that all co-infected haemophiliacs were in receipt of HIV Payments, we find that there were 13 other coinfected claimants who have received a loss of income benefit in the past and who have since died[27].

    b. Where a claimant was in receipt of C/QPP disability income, EI benefits and/or other disability income during the years that are used for calculating the pre-disability income amounts, the LOI benefit will be less than the loss of net income by an amount equal to those payments.

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27 Overall, there are 535 coinfected haemophiliac claimants of whom 357 had died as at Dec 31, 2013. Of those 357 deceased claimants, 13 had received LOI benefits. Of the 178 alive coinfected haemophiliacs, 3 are currently receiving LOI benefits.

We believe that the likelihood of this situation arising is extremely small, since it would require an ongoing disability for other than HCV at the same time as the person was earning an income, followed by a separate loss of income due to HCV.

139. From our analysis, it is clear that removing the offset for the Collateral Benefits other than for HIV payments and for any disability income that was in receipt during the pre-disability income averaging period, will result in paying more than 100% of the lost income.

EFFECT OF PAYING MORE THAN 100% OF LOST INCOME

140. Almost all long-term disability income insurance ("**LTD**") provided through an employer health and welfare plan contain a provision that provides for a reduction in the LTD benefit should the person's total income from all sources exceed a percentage of their pre-disability income. Normally that all-source maximum is 85% of the pre-disability income[28].

141. We have reviewed the standard policy terms of the major insurers and in our opinion, it is not clear whether the LOI payments from the Compensation Fund would be considered as part of the all-source maximum calculation. If the LOI benefit is used as part of the all-source maximum, the LTD payment to the individual will be reduced by part or all of the LOI payment.

EFFECT OF PROPOSED CHANGES ON LOSS OF SUPPORT

142. The Loss of Support ("**LOS**") payments are subject to the same effects as discussed above for LOI, except that LOS was designed to provide compensation equal to 70% of the income lost as a result of death due to HCV. Standard practice in personal injury cases is for the difference between 100% and about 70% replacement to represent the approximate deemed value of personal consumption – that is the portion of income that would have been spent by the infected claimant on him or herself and so it would not be considered a loss to the surviving dependants[29].

143. For purposes of whether LOS compensation exceeds the actual loss, we would therefor use the benchmark of 70% of the pre-disability income. In all other respects, the comments regarding LOI apply to LOS payments.

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28 LTD benefits can be either taxable or non-taxable, depending on whether the employee or employer paid the premiums. The all-source maximum is usually expressed as a percent of the gross income if the LTD benefits are taxable and as a percent of the net income if the LTD benefits are non-taxable.

In addition, the term "all-source maximum" is somewhat misleading, since any disability income from an individual LTD policy is ignored for purposes of the maximum.

These two distinctions in this footnote have no or immaterial effect on this issue.

29 Assessment of Personal Injury Damages, fifth edition, Christopher Bruce, Kelly Rathje, Laura Weir, LexisNexis Canada Inc, June 2011, pages 64 to 73 and 293 to 315.

144. Table 144 summarises the LOS claims for 2011 to 2013. It shows that virtually all claimants with Collateral Benefits would receive a "replacement" of more than 70% for loss of support if Collateral Benefits are no longer deducted.

Table 144 – Effect of no Deduction for Collateral Benefits on LOS[30]

	2011	2012	2013
Claimants with a LOS payment	80	65	60
Claimants with 70% loss of support	16	9	9
Claimants with partial loss of support	64	56	51
Claimants with Collateral Benefits	64	56	51
If no deduction for Collateral Benefits			
- number of claimants with support in excess of loss	64	56	51
- average percent of lost support that is "replaced"	89.5%	87.5%	85.7%
- maximum percent of lost support that is "replaced"	115.5%	110.8%	110.2%

145. As with the LOI compensation, from an actuarial perspective, paying an amount that exceeds an actual financial loss is not appropriate. In the case of LOS, the actual loss is deemed to be 70% of the infected claimant's after tax income prior to death.

CALCULATION OF COST FOR CHANGES TO LOI AND LOS

146. In calculating the cost of the proposed changes to LOI and LOS, we utilized the following assumptions and methods:

a. ***Retroactive Benefits - LOI***: Based on the detailed summary of LOI payments for 2011 to 2013 provided by the Joint Committee, we determined that the actual LOI payments for those three years would have been approximately 11.8% greater had there been no deduction for Collateral Benefits. We assumed that percentage would apply to all prior years and applied it to the actual LOI payments made since 1999.

We reviewed the data for deceased co-infected haemophiliacs who we assumed were all in receipt of HIV Payments. (There have been 13 such claimants). We assumed that there would be a retroactive payment made to these co-infected haemophiliac's estates to compensate for the past deduction but that the value of such a payment would not be recognised in the 11.8% factor referenced above. In our calculation we assumed that the HIV Payments would have been $30,000 per annum for each year while the claimant was alive. That assumption ignores

30 The percentages in Table 144 are all calculated in relation to the infected person's total earned income. So a percent of 89.5% is the portion of the total earned income that is replaced by LOS and that exceeds the 70% level for full compensation of the loss of support.

the indexing of the HIV Payments that began at various times between 2001 and 2007. We determined that ignoring indexing would not materially affect the total cost.

b. ***Future Benefits - LOI***: We performed the same analysis as above, but with pre-disability income capped at $200,000 to remove the effect of the very high earners that we assume are unlikely to affect future claims. The resulting increase in benefits was 14.8% and we assumed that the average benefit for LOI in the future would be 14.8% greater than we had assumed for our 2013 Sufficiency Report – giving an average benefit of $49,365 for transfused claimants and $60,845 for haemophiliacs. No adjustment for future HIV Payments is considered necessary.

c. ***Retroactive Benefits - LOS***: Based on the detailed summary of LOS payments for 2011 to 2013 provided by the Joint Committee, we determined that the actual LOS payments for those three years would have been approximately 16.3% greater had there been no deduction for Collateral Benefits[31]. We assumed that percentage would apply to all prior years and applied it to the actual LOS payments made since 1999.

   We reviewed the data for 31 deceased co-infected haemophiliacs (this is the 13 identified above plus 18 who died prior to 2009). We assumed that where a LOS benefit was paid, the spouse would have been in receipt of a survivor HIV Payment for the first five years following the infected claimant's death. We assumed that there would be a retroactive payment made to these dependants to compensate for the past deduction but where the value of such payment is not recognised in the 16.3% factor above. In our calculation we assumed that the spousal HIV Payments would have been $20,000 per annum for each year and ignored the effect of indexing on the actual benefit. We determined that ignoring indexing would not materially affect the total cost.

d. ***Future Benefits - LOS***: We applied the same 16.3% percentage for future payments – giving an average benefit of $39,540 for transfused claimants and $41,870 for haemophiliacs.

147. As part of the costings, we separately determined the cost if only the HIV Payments are removed as an offset. In other respects, the analysis was the same as described in paragraph 146. The resulting increase in benefits is 0.9% for both retroactive and future payments, plus an additional amount in respect of past HIV Payments.

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31 Eckler determined an increase of 11.5% based on a total of $741,156 of Collateral Benefits paid in 2011 to 2013 (Eckler Costing Report, page 17, table at paragraph 46). Morneau Shepell determined that Collateral Benefits totaled $1,054,794 during those three years, producing a proposed increase in LOS payments of 16.3%.

148. The costs of the changes for the LOI benefit are:

Table 148 – Cost of Changes to Loss of Income Payments ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Remove offset for Collateral Benefits other than HIV Payments	$4,548	$4,135	$3,968	$4,034	$16,685
Remove offset for HIV Payments only	0	0	2,709	1,195	3,904
Remove offset for all Collateral Benefits	$4,548	$4,135	$6,677	$5,229	$20,589

149. The costs of the changes for the LOS benefit are:

Table 149 – Cost of Changes to Loss of Support Payments ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Remove offset for Collateral Benefits other than HIV Payments	$1,843	$2,868	$3,010	$5,253	$12,974
Remove offset for HIV Payments only	0	0	2,061	470	2,531
Remove offset for all Collateral Benefits	$1,843	$2,868	$5,071	$5,723	$15,505

M. COMPENSATION FOR DIMINISHED PENSION SAVINGS

150. When a claimant suffers a loss of income, they may also lose pension and other benefits provided by their employer. The Loss of Income benefit includes the value of the employee contribution paid for pension benefits but does not include the value of the employer contribution for pensions. So it is only the employer portion of pension cost that should be considered here.

151. The Joint Committee proposes to compensate all claimants for a loss of pension by an amount equal to 10% of the gross amount of income lost, with the lost income amount capped at $200,000 (indexed from 2014 for the future only). Past losses will not be adjusted from the year of loss to the date of payment for either interest or by the pension index.

DISCUSSION

152. Not all employers provide a retirement savings plan, and for those that do, the contribution rates and benefits can vary significantly. Employer contributions can typically range from a low of about 2.5% of earnings to as much as 20% of earnings. In our opinion, the average employer contribution is likely in the range of 7% to 10% of earnings[32].

153. There are few statistics regarding how many employers offer a retirement savings plan. A frequently cited statistic is that about 35% to 40% of employees (many of whom are public sector) are members of an employer sponsored pension plan. However, that statistic only looks at *registered* pension plans (both trusteed plans and those funded through an insurance contract) and ignores all the employer sponsored group RRSPs. There is little to no information about the prevalence of such group RRSPs. In a study "Portrait du marché de la retraite au Québec" conducted in 2010 by the Régie des rentes du Quebec, it is reported that 38% of Quebec workers are covered by a workplace pension plan and an additional 15% of workers are covered by a group RRSP or other type of retirement plan (Table 7 on page 49)[33]. Assuming that Quebec employer-provided pension coverage is similar to the rest of Canada, that suggests that slightly more than 50% of workers are members of a workplace retirement savings plan.

154. In addition to loss of pension, a claimant who has a loss of income may also have a loss of their Canada Pension Plan or Quebec Pension Plan benefit.

155. A claimant who receives a C/QPP disability income will not lose any C/QPP pension benefit, as periods of C/QPP disability are treated in a manner that is similar to deeming contributions continue. A claimant who has a partial loss of income and whose post-disability gross income is greater than the maximum pensionable earnings under the C/QPP ($51,100 for 2013) will not suffer a loss of C/QPP pension, since they would still be contributing the maximum amount to the

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32 Public sector employers typically will contribute more to a retirement plan than a private sector employer. The average private sector employer contribution is likely in the range of 5% to 7% of earnings.

33 Those percentages are after removing workers who are covered by more than one type of plan.

C/QPP. Approximately one third of claimants in receipt of a loss of income benefit between 2011 and 2013 are either in receipt of a C/QPP disability income or have post-disability earnings sufficient to remain fully eligible for C/QPP pension accruals.

156. The rate of contribution to the C/QPP is 9.90% of earnings between $3,500 and the maximum pensionable earnings for the year. Contributions are split equally between employer and employee. The determination of the loss of income benefits does not provide compensation for the C/QPP contributions previously paid by an employee, so if it is found to be appropriate to compensate claimants for the loss of C/QPP pension, it would be based on both employer and employee contributions - 9.90% of earnings up to the maximum.

157. In paragraphs 52 and 53 of the Eckler Costing Report, it is stated that the range of pension plans provided varies widely between employers. The administrative complexity of identifying whether a claimant was a participant in a pension plan and how much the employer contributions were, is likely too great to be effectively employed for the Compensation Fund. We agree. (In most cases, a claimant's membership in a workplace pension can be determined from the income tax return with the exception of participation in a group RRSP. The amount of lost pension and its value are much harder to determine.)

158. We can estimate what the average amount of lost pension is for all claimants who have a loss of income. About 50% of claimants will have lost an employer pension worth on average about 8.5% of gross lost earnings and about 2/3rds of claimants will have lost their C/QPP worth 9.90% of gross lost earnings, to a maximum of about $4,700 (in 2013 dollars). If we ignore the cap on the C/QPP loss, that gives an average loss of about 10.9% of gross lost earnings[34].

159. The Joint Committee has recommended compensation be paid equal to 10% of gross lost earnings. For the approximately 1/3rd of claimants who (a)did not have a workplace retirement savings plan, (b) have pre-disability income of less than the maximum C/QPP earnings and (c) are not in receipt of C/QPP disability income, 10% compensation will be almost exactly their loss. For the other 2/3rds of claimants, it will likely overcompensate or undercompensate.

CALCULATION OF COST FOR LOSS OF PENSION

160. The retroactive compensation for loss of pension is proposed to be determined with reference to the gross loss of earnings – that is pre-disability gross earnings less post-disability gross earnings. The data provided for 2011 to 2013 contains information sufficient to do the calculation of cost, but the data for years prior to 2011 does not have sufficient data so, for purposes of determining the cost, we translated the 10% of lost gross earnings into a percent of actual LOI benefit paid.

161. We have estimated the cost for the loss of lost pension by:

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34 The average would be slightly less if the cap on C/QPP losses was recognised.

a. ***Retroactive Cost***: The LOI data from 2011 to 2013 was reviewed and the total amount of compensation based on 10% of the difference between pre-disability gross income (capped at $200,000[35]) and post-disability gross income was calculated. That gave an average cost equal to 11.7% of the LOI benefit paid. That 11.7% was then applied to the actual LOI payment for each of the past years to estimate the retroactive liability.

b. ***Future Cost***: That same 11.7% was applied to the LOI liability from the 2013 Morneau Shepell Sufficiency Review to estimate the future cost.

162. The costs of the changes for lost pension are:

Table 162 – Cost of Changes for Loss of Pension Benefits ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Cost for loss of pension benefits	$ 5,502	$ 3,747	$ 4,800	$ 3,655	$ 17,703

35 The $200,000 was applied without adjustment in each year of past loss.

N. INCREASE LOSS OF SERVICES FROM 20 TO 22 HOURS PER WEEK

163. A claimant who is unable to perform household chores is eligible for compensation of up to 20 hours per week at a rate of $12.00 (1999 dollars) per hour. That produces an annual maximum payment of $12,480 (1999 dollars).

164. The Joint Committee proposes that the number of hours for which compensation is payable be increased by 10% to 22 hours per week. That would result in a maximum annual compensation of $13,728 (1999 dollars). Amounts for past losses will not be adjusted from the year of loss to the date of payment for either interest or by the pension index.

DISCUSSION

165. A review of past claims shows that there are some claimants who report a reduction in the hours they work around the home as a result of disability of less than 20 hours and many who report the reduction as more than 20.

Table 165 - Claimants with Loss of Services in 2013

Hours Claimed	Number
Less than 20 hours	34
20 to 21 hours	30
22 to 29 hours	154
30 to 39 hours	106
40 to 49 hours	80
50 to 99 hours	138
100 or more hours	19
Total	561

166. ***Table 166- Average Weekly Hours for Loss of Services***

	2011	2012	2013
Number of claimants	603	597	561
Average weekly hours pre-disability	47.3	47.3	47.5
Average weekly hours post-disability	4.9	4.9	4.8
Average weekly hours claimed	42.4	42.4	42.7
Average weekly hours paid	19.4	19.5	19.5
Percent of all services lost	89.6%	89.6%	89.9%

167. We note that there is a huge variation in the number of hours reported as being spent performing services around the home prior to disability. The hours spent pre-disability as well as post-

disability are self reported. It is likely that the number of pre-disability hours is somewhat subjective.

168. From an actuarial perspective, providing compensation for a loss that is not capable of independent verification is poor practice. In such a situation, it is better to provide compensation based on a loss that reflects average behaviours, such as is done under the Agreement.

CALCULATION OF COST FOR LOSS OF SERVICES

169. The data provided for 2011 to 2013 contains information sufficient to calculate the cost for the change to the Loss of Services benefit, but the data for years prior to 2011 does not have sufficient information.

170. We have estimated the cost for Loss of Services by:

    a. ***Retroactive Cost***: The data from 2011 to 2013 was reviewed and the number of additional hours that would be payable was determined. Claimants with 20 or less hours of loss claimed will receive no retroactive amount. Claimants with 22 or more hours claimed will receive an amount equal to 2 additional hours of loss per week – a 10% increase. We applied the $12.00 hourly rate (1999 dollars), including indexing to the year of the loss, to determine the additional payment for that year. That gave an average cost equal to 8.75% of the Loss of Services benefit previously paid for those three years. That 8.75% was then applied to the actual Loss of Services payments for each of the past years to estimate the retroactive liability.

    b. ***Future Cost***: We assumed that most of the claimants who reported between 20 and 22 hours of loss may update their reported loss to at least 22 hours for the future. That differs from Eckler's assumption that implicitly assumed there would be no change in reporting of lost hours. While that leaves a few claimants with less than 20 hours of loss, we assumed that all future loss of services would be paid at the maximum of 22 hours per week – a 10% increase (compared to the assumption used by Eckler of an 8.9% increase). That 10% was applied to the Loss of Services liability from the 2013 Morneau Shepell Sufficiency Review to estimate the future cost.

171. The costs of the changes for loss of services are:

Table 171 – Cost of Changes for Loss of Services ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Cost for increase in Loss of Services	$ 8,950	$ 14,665	$ 4,326	$ 9,443	$ 37,384

O. INCREASE MAXIMUM PAYABLE FOR COST OF CARE FROM $50,000 TO $60,000 (1999 DOLLARS)

172. The Agreement provides infected claimants at Level 6 (decompensation, cancer, etc.) who require home care support reimbursement of any reasonable costs incurred that are not covered by a public or private health plan up to a maximum of $50,000 (1999 dollars) per year.

173. The Joint Committee proposes that the annual maximum reimbursement for Cost of Care be increased to $60,000 (1999 dollars). Past amounts will not be adjusted from the year of expense to the date of payment for either interest or by the pension index.

DISCUSSION

174. The Joint Committee provided an extract from the Administrator's data showing all Cost of Care claims that exceeded the maximum. There are a total of 9 claimants whose costs exceeded the maximum out of 321 claimants who have received a cost of care benefit at any time since 1999.

175. Separately, we examined all past claims (which do not indicate the amount of actual costs incurred, just the amount reimbursed). We found that a significant number of claimants had a reimbursement that was slightly less than the maximum available.

176. In our opinion, it is likely that there are a number of claimants who are unable to afford to pay for care and so they restrict the care received so that the total will be eligible for reimbursement and they will not be out of pocket. Since 1999, there have been 36 claims from 13 claimants where the total amount claimed is within 5% of the maximum.

Table 176 – Large Cost of Care Claims 2011 to 2013

	2011	2012	2013
Number of claims	59	50	41
$50,000 indexed to year	$ 63,710	$ 65,520	$ 66,673
Claims exceeding 90% of maximum	8	10	6
Average amount of claims that exceed 90% of maximum	$ 62,927	$ 65,112	$ 63,095
Claims exceeding 95% of maximum	6	8	3
Average amount of claims that exceed 95% of maximum	$ 64,092	$ 66,088	$ 64,870

177. In our opinion, it is likely that claimants who require significant amounts of care but are not able to afford it, will increase the amount of care they incur in the future to stop just short of the new maximum.

CALCULATION OF COST FOR COST OF CARE

178. We have estimated the cost for Cost of Care by:

a. ***Retroactive Cost***: The data file listing all claims where the cost incurred exceeded the amount reimbursed was reviewed and the additional amount based on the $60,000 (1999 dollars) maximum was assumed to be payable. No interest adjustment was made for the time from the date the cost was incurred to the payment date of the additional amount.

b. ***Future Cost***: We assumed that all claimants whose costs exceeded $47,000 (1999 dollars) for a year will increase the amount of care that they purchase in the future by the $10,000 (1999 dollars) increase in the maximum. For those who incurred an amount that exceeded the maximum, we assumed that they would incur at least $60,000 (1999 dollars) in the future. Had the increased maximum been in place for 2011 to 2013, those assumptions would have increased the average amount of compensation by about 5.1%. We applied that 5.1% to the liabilities from the 2013 Morneau Shepell Sufficiency Review to estimate the future cost.

179. The costs of the changes for cost of care are:

Table 179 – Cost of Changes for Cost of Care ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Cost for increase in Cost of Care	$ 114	$ 1,641	$ 7	$ 922	$ 2,684

P. OUT-OF-POCKET EXPENSES - $200 ALLOWANCE FOR ACCOMPANYING FAMILY MEMBERS

180. Currently, the Agreement provides reimbursement for any out-of-pocket expenses

    a. incurred by an infected person;

    b. where those expenses are not recoverable from an insurance plan; and

    c. that were incurred in conjunction with attending medical appointments related to their HCV infection or establishing a claim under the Agreement.

    This includes amounts for travel, hotels, meals, telephone and similar items.

181. The Joint Committee proposes that there be an additional amount of a flat $200 (indexed from 2014) payable in respect of a family member (as defined in the Agreement) where that family member accompanies the infected claimant to a medical appointment connected with the claimant's HCV infection. This would only apply to such visits that occur after court approval is granted.

DISCUSSION

182. The reason given in Heather Rumble Peterson's affidavit for this payment is to provide compensation for the family member's loss of vacation, sick days or wages.

183. We note that there is no similar provision currently or proposed to compensate infected persons for a similar loss of vacation, sick pay or wages. There does not appear to be compensation payable currently or proposed for any out-of-pocket expenses incurred by an accompanying person. And there does not appear to be any requirement that the accompanying person must actually have taken a day off work to qualify for this payment.

184. If this proposal is introduced, it is our opinion that there is a risk it may lead to an increase in the number of accompanying family members from what would have happened in the absence of such compensation.

185. We estimate that $200 of non-taxable income for one day of time is equivalent to an annual wage of about $65,000 to $70,000. (If the time required exceeds one day, then the annualized equivalent will be proportionately reduced, since the proposal is for a flat amount per visit, not a per diem.)

186. In addition, we believe that currently there are a large number of infected claimants who do not bother filing an out-of-pocket claim because the amount is minimal and it is not worth the effort of completing the required forms. If they are eligible for a $200 payment for an accompanying person, we believe that the number of out-of-pocket claims will increase from the past level. Since the amount of these claims is assumed to be minimal in the absence of the $200 payment, it

is only the number of claims that would lead to a material increase in compensation. The effect of the additional out-of-pocket expenses would be expected to be small.

187. From 1999 to 2013, there have been a total of 7,412 claims paid for out-of-pocket expenses. That is less than 2 claims per infected claimant over the entire 15 years. Of those claims, 187 (2.5%) were for less than $20 and 73 (1%) were for less than $10. In our opinion, few claimants from large metropolitan centres have filed an out-of-pocket claim, since such claimants are likely to have only minimal expenses.

188. We also note that the proposal references $200 "per visit". We have interpreted that term the same way Eckler did as meaning "per trip". It is possible that a claimant could have multiple appointments with different (or even the same) service provider within one trip. It is also possible that an infected person might require a stay away from home for an extended period of time in order to receive treatment. We recommend that the term "visit" be clearly defined. To be consistent with the costings, it should be one $200 payment per trip from home. Allowing for larger amounts for extended trips could likely be accommodated without a material difference in total cost, as we expect such trips to be relatively few. However, if the amount is payable per appointment, there is a risk that the total cost could be significantly greater than we have estimated.

CALCULATION OF COST FOR OUT-OF-POCKET EXPENSES

189. We have estimated the cost for Out-of-Pocket Expenses by:

    a. ***Retroactive Cost***: There is no retroactive payment proposed, so the cost is nil.

    b. ***Future Cost***: We have made three distinct assumptions to recognise the additional cost of this payment in respect of family members.

        (i) We assumed that 90% of all claimants who seek treatment with the new drug therapies will be accompanied by a family member and that such treatment will require 5 medical appointments up to the point of evaluation of successful treatment. This increases the average expense assumed in the 2013 Morneau Shepell Sufficiency Review from $2,400 to $4,800 for transfused claimants and from $10,000 to $11,800 for haemophiliacs, with the total expenses assumed payable coincident with treatment.

        (ii) In addition, we assumed that the average number of medical visits after successful treatment for which an out-of-pocket claim is submitted will double (from 1.4 to 2.8 for transfused and from 3.1 to 6.2 for haemophiliacs) with 90% of claimants assumed to be accompanied by a family member.

        (iii) For all claimants who do not clear the virus, we assumed that the percentage of claimants who have an expense each year will double from 8% assumed in the 2013

sufficiency review to 16% and that the average claim amount will increase from $1,800 to $2,200 for transfused claimants and from $2,600 to $3,000 for haemophiliacs.

190. The costs of the changes for out-of-pocket expenses are:

Table 190 – Cost of Changes for Out-of-Pocket Expenses ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Cost for increase in Out-of-Pocket expenses	$ -	$ 5,940	$ -	$ 2,430	$ 8,370

Q. INCREASE CAP ON FUNERAL EXPENSES FROM $5,000 TO $10,000 (1999 DOLLARS)

191. Currently, the Agreement will provide reimbursement for any uninsured funeral expenses, less the Canada or Quebec Pension Plan death benefit, up to a maximum reimbursement of $5,000 (1999 dollars).

192. The Joint Committee proposes increasing the maximum amount reimbursed from $5,000 to $10,000 (1999 dollars). Past amounts will not be adjusted from the year of the expense to the date of payment for either interest or by the pension index.

DISCUSSION

193. There have been 823 claims for funeral expenses since 1999 of which 375 were limited by the maximum reimbursement. The average amount of funeral costs that exceeded the maximum is $3,730. Total funeral costs ranged from a low of $470 to a high of $44,156.

194. A search of the internet found normal funeral costs in Canada are reported to range from about $5,000 to about $8,000 for a cremation and from about $7,000 to about $12,000 for a burial. The average appears to be about $7,000 for cremation and $10,000 for burial. (See Appendix C).

195. The Last Post Fund is operated by Veterans Affairs Canada and provides funds for veterans who do not have the means for a dignified funeral. Their definition of a dignified funeral as well as the costs the fund pays is contained in Appendix C. The maximum the Last Post Fund would cover in 2009 for a dignified funeral totals about $10,000. An evaluation team found that there were a number of expenses that were not covered by the fund but which were suggested could be considered as part of a dignified funeral. Those additional items average a total cost of $785.

196. If we take the Last Post Fund maximum amount and include the average cost of the additional items, the total in 2013 dollars is $11,500 ($8,545 in 1999 dollars). That should cover the average cost of either a dignified cremation or a burial in Canada.

197. If we look at the average cost per veteran whose funeral is covered by the Last Post Fund, it was reported as $4,368 in 2007 – about $4,800 when indexed to 2013 ($3,570 in 1999 dollars).

198. The Joint Committee's proposed maximum for funeral expenses is $10,000 (1999 dollars) which is $13,458 in 2013 dollars.

199. We have analysed the past claims assuming that the funeral expenses less the death benefit under the C/QPP are reimbursed up to the proposed amount.

Table 199 – Funeral Expenses

	Actual Dollars	1999 Dollars
Total funeral claims	823	823
Average total funeral expense	$ 7,677	$ 6,724
Average claim - Funeral expense reduced by C/QPP death benefit	$ 5,917	$ 5,167
Average reimbursement	$ 4,218	$ 3,689
Number of claims that exceed $5,000 (1999 dollars)	375	375
Average total claim that exceeds $5,000 (1999 dollars)	$ 9,347	$ 8,144
Number of claims that exceed $10,000 (1999 dollars)	73	109
Average total claim that exceeds $10,000 (1999 dollars)	$15,918	$12,250

CALCULATION OF COST FOR FUNERAL EXPENSES

200. We have estimated the cost for Funeral Expenses by:

a. ***Retroactive Cost***: The data provided contained sufficient information to determine the amount of all retroactive payments for adjusting the maximum amount from $5,000 to $10,000 (1999 dollars). The past cost is the actual expenses submitted reduced by the C/QPP death benefit received, with a maximum of $10,000 (1999 dollars) and minus the original reimbursement amount.

b. ***Future Cost***: We determined that the retroactive cost was an average increase of 30.9% over the average past reimbursement. While there may be a tendency for the cost of future funerals to increase from what was claimed in the past if this proposal is implemented, we believe that any such increase will not be material and we have ignored it. This assumption increases the assumed average reimbursement for funeral expenses from the $4,300 (1999 dollars) used in the 2013 Morneau Shepell Sufficiency Review to $5,630 (1999 dollars).

201. The costs of the changes for Uninsured Funeral Expenses are:

Table 201 – Cost of Changes for Uninsured Funeral Expenses ('000s)

	Transfuseds		Haemophiliacs		
	Retroactive Cost	Future Cost	Retroactive Cost	Future Cost	Total Cost
Cost for Uninsured Funeral Expenses	$ 710	$ 661	$ 371	$ 283	$ 2,025

R. ADMINISTRATIVE EXPENSES

202. The administrator provided estimates of the expense to administer the proposed changes. These are set out in Heather Rumble Peterson's affidavit #13 at Exhibit E and summarised in the Eckler Costing Report (page 11). We have utilised these costs as provided and offer no opinion as to their reasonableness.

Table 202 - Summary of Administrative Cost for Proposed Changes

Description	Cost
First claim deadline	$ 51,000
Increase fixed payments by 10%	126,000
Family member payments	287,000
Loss of Income/Support - eliminate deduction of Collateral Benefits	143,000
Compensate for diminished pension savings	-
Loss of Services - Compensate for up to 22 Hours per Week	196,000
Cost of Care - increase maximum to $60,000 (1999 dollars)	2,000
Out-of-Pocket Expenses - $200 for accompanying family member	-
Funeral Expenses - increase maximum to $10,000 (1999 dollars)	43,000
Additional expense associated with administration of estates	61,000
Total administrative cost	**$ 909,000**

S. BUFFER AGAINST CATASTROPHIC EVENTS

203. In the Morneau Shepell Sufficiency Report, we discussed the provision for adverse deviations that was utilised in determining the liabilities of the Agreement and introduced a buffer against catastrophic events (pages 48-49).

204. Actuarial valuations require the use of assumptions about the future. Those assumptions may prove, with the benefit of hindsight, to have under-estimated or over-estimated the occurrence of the specific contingency. Normally, there will be a mixture of gains and losses and the final outcome will be reasonably close to the actuarial estimates.

205. Including a provision for adverse deviations produces liabilities larger than the amount that would have a 50% chance of being sufficient and a 50% chance of being insufficient. This provides greater assurance that the fund will have sufficient assets to meet all payments most of the time.

206. The provision for adverse deviations does not provide a full guarantee. Events could occur that were outside the expected scope of possibilities when the assumptions were first made. When considering whether assets are sufficient enough that a portion of them could be repurposed, it is prudent to include a buffer in addition to the provision for adverse deviations. We have utilised a 15% buffer.

207. The buffer is only applied against the liability for future payments since the retroactive payments are reasonably well known and are unlikely to deviate materially from the cost calculated herein.

208. Eckler have taken a different approach to this and performed calculations to estimate the amount of additional capital that should be set aside to provide for a possibility of a catastrophic event occurring. The additional required capital determined by Eckler for the proposed changes is less than our 15% additional buffer. The Eckler total required capital is somewhat greater than 15%, but is not materially different in quantum from our total buffer.

209. Based on a total future cost for the proposed changes of $116 million, the 15% buffer against catastrophic events is $17,464,000.

T. CERTIFICATION

210. I hereby certify that:

a. In my opinion, the data used is sufficient and reliable for the purposes of this report;

b. In my opinion, the actuarial methods are appropriate for the purpose of this report;

c. In my opinion, the assumptions used are, in aggregate, appropriate for the purpose of this report;

d. There may be contingencies other than those considered in the preparation of this report that could have a positive or negative impact on the amounts presented herein;

e. The calculations were prepared in accordance with the Canadian Institute of Actuaries' Standards of Practice;

f. This report has been prepared and my opinions given in accordance with accepted actuarial practice in Canada;

g. There are no subsequent events other than those discussed in this report that I am aware of that would have an impact on the results presented herein; and

h. This report conforms to my duty to:

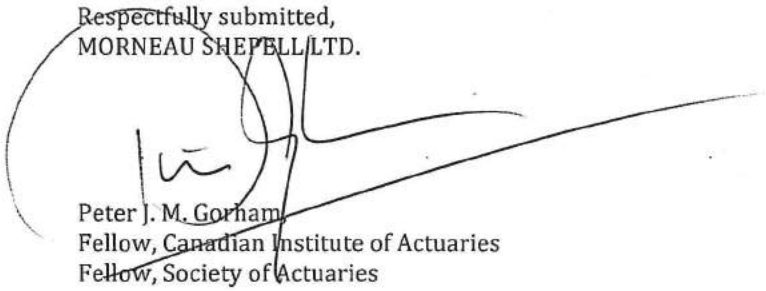
(i) provide opinion evidence that is fair, objective and non-partisan and related only to matters that are within my area of expertise;

(ii) if called upon to give oral or written testimony, I will give that testimony in a fair, objective manner and without advocacy for either party; and

(iii) assist the court and provide such additional assistance as the court may reasonably require to determine the matter at issue.

211. I am available to answer any questions or to provide additional information regarding this report.

Respectfully submitted,
MORNEAU SHEPELL LTD.



Peter J. M. Gorham
Fellow, Canadian Institute of Actuaries
Fellow, Society of Actuaries

APPENDIX A LOSS OF GUIDANCE, CARE & COMPANIONSHIP IN CANADA

Loss of Guidance, Care and Companionship 2000

Comparison of Canadian Legislation and Common Law

Jurisdiction	Applicable Legislation	Spouses	Parents	Children	Siblings	Grandparents	Grandchildren	Specific Comments/Notes
Manitoba	Section 3(4) of the Fatal Accidents Act	10,000	10,000	10,000	2,500	10,000	10,000	Discretion of the courts; cap of $100,000 initially indexed to inflation which would be about $270,000 (in 2000), inflation adjustment no longer carrried out; the Act also declared that a claim for loss of guidance, care and companionship does not survive, in case of death, to the benefit of the claimant's estate
Ontario	Section 61(2) of the Family Law Act	30,000 - 50,000	25,000 - 40,000	25,000 - 30,000	7,500 - 10,000	Not in Document		Discretion of the courts; generous and not conventional awards
Nova Scotia	Section 5(2) of the Fatal Injuries Act	20,000	2,500 - 25,000	20000	N/A	Not in Document		Discretion of the courts
New Brunswick	Section 3(4) of the Fatal Accidents Act	N/A	30,000*	N/A	N/A	N/A	N/A	Discretion of the courts; consistency; 15,000 for grief and 15,000 for companionship
Prince Edward Island	Section 3(c) of the Fatal Accidents Act		Not Addressed			Not in Document		Discretion of the courts; extensive range of allowed claimants
Alberta	Section 8(1) of the Fatal Accidents Act	43,000	43,000*	27,000	N/A	N/A	N/A	Set by legislation and may be adjusted periodically by regulation; spouse or "cohabitant" in agreement with definition; restricts the definition of eligible children to being minors or between the ages of 18 and 26 and not living with a cohabitant at the time of the parent's death
British Columbia	No discrete legislation in Family Compensation Act			Not in Document				Non-pecuniary losses often restated as pecuniary losses to allow for recovery and this is accepetable under the Act
Newfoundland	No discrete legislation in Fatal Accidents Act		10000		N/A	Not in Document		Non-pecuniary losses often restated as pecuniary losses to allow for recovery and this is accepetable under the Act
Saskatchewan	No discrete legislation in Fatal Accidents Act	Not in Document		<1,000 - 25,000	N/A	Not in Document		Non-pecuniary losses often restated as pecuniary losses to allow for recovery and this is accepetable under the Act
Northwest Territories and Nunavut	No discrete legislation in Fatal Accidents Act			Not in Document				Non-pecuniary losses often restated as pecuniary losses to allow for recovery and this is accepetable under the Act
Yukon	No discrete legislation in Fatal Accidents Act			Not in Document				Non-pecuniary losses often restated as pecuniary losses to allow for recovery and this is accepetable under the Act
Quebec	Not in Document							

Key and General Comments/Notes:
N/A means not an eligible claimant.
Definitions of spouses, parents, children and siblings vary among provinces/territories.
**These amounts are for the parent or parents, to be split equally where the action is brought for the benefit of both persons.*

Source: Assessment of Damages under the Fatal Accidents Act for the Loss of Guidance, Care and Companionship (Report #105) by the Manitoba Law Reform Commission dated October 2000

Loss of Guidance, Care and Companionship 2014

Comparison of Canadian Legislation and Common Law

Jurisdiction	Applicable Legislation	Spouses	Parents	Children	Siblings	Grandparents	Grandchildren	Specific Comments/Notes
Manitoba	Section 3.1 of the Fatal Accidents Act	36,930	36,930	36,930	12,310	12,310	12,310	Set by legislation; indexed with inflation; appears to use exact numbers from 2012 source but mistakenly not adjusting for inflation since then
Ontario	Section 61 of the Family Law Act	7,500 - 100,000 with 50,000 avg	11,250 - 125,000 with 59,000 avg	3,000 - 50,000 with 31,000 avg	21,000	Not in Document	9,000	Discretion of the courts; grandchild - 9,000
Nova Scotia	Section 5 of the Fatal Injuries Act	65,000	No recent case law	4,000 - 40,000 with 26,000 avg	N/A	No recent case law	4,000 - 40,000 with 26,000 avg	Discretion of the courts; granddaughter - 4,000
New Brunswick	Section 3 of the Fatal Accidents Act	N/A	25,000	N/A	N/A	25,000	N/A	Discretion of the courts; assuming classification mistake of eligible claimant of compensation in source
Prince Edward Island	Section 6 of the Fatal Accidents Act		No case law		N/A	Not in Document		Discretion of the courts
Alberta	Section 8 of the Fatal Accidents Act	82,000	82,000*	49,000	N/A	N/A	N/A	Set by legislation and may be adjusted periodically by regulation; applicable since 2002
British Columbia	No discrete legislation in Family Compensation Act			Not in Document/Not Addressed				No discrete legislation; non-pecuniary losses often restated as pecuniary losses to allow for recovery and this is accepetable under the Act
Newfoundland	Section 6 of the Fatal Accidents Act		No case law		N/A	No case law		Discretion of the courts
Saskatchewan	Section 4.1 of the Fatal Accidents Act	60,000	30,000	30,000	N/A	N/A	N/A	Set by legislation
Northwest Territories and Nunavut	No discrete legislation in Fatal Accidents Act			Not in Document/Not Addressed				No discrete legislation; non-pecuniary losses often restated as pecuniary losses to allow for recovery and this is accepetable under the Act
Yukon	No discrete legislation in Fatal Accidents Act			Not in Document/Not Addressed				No discrete legislation; non-pecuniary losses often restated as pecuniary losses to allow for recovery and this is accepetable under the Act
Quebec	Solatium Doloris under Civil Code articles 1053 and 1056	5,000 - 150,000 with 54,000 avg	6,250 - 125,000 with 43,000 avg	2,000 - 125,000 with 32,000 avg	13,000	6,000	3,400	Discretion of the courts; no set list of eligible claimants; grandparent - 6,000; grandchild - 3,400; aunts - 2,000
Canada	Section 6 of the Marine Liability Act	75,000	No case law	25,000 - 75,000 with 37,000 avg	15,000	Not in Document		Discretion of the courts

Key and General Comments/Notes:

means the amounts are not generalized and only representative of a few cases.

N/A means not an eligible claimant.

Definitions of spouses, parents, children and siblings vary among provinces/territories.

**These amounts are for the parent or parents, to be split equally where the action is brought for the benefit of both persons.*

According to the Bank of Canada's website, the Consumer Price Index for January 2014 is 123.1 over 2002 dollars.

Source: Proposed Amendments to the Fatal Accidents Act Discussion Paper by the Government of Yukon Department of Justice dated February 2014

APPENDIX B COMPENSATION SCHEDULE FOR HVC INFECTED PERSONS

DISEASE LEVEL	MEDICAL CONDITIONS CAUSED BY HCV	COMPENSATION (indicates 2013 proposed amounts)[36]					
		Fixed Payments As Compensation for Pain	Loss of Income or Compensation for Loss of Home	Additional Payment If You Take Compensable	Reimbursement For Uninsured Treatment And	Reimbursement For Out-of-Pocket Expenses	Reimbursement For Care Costs
6	You are considered a Level 6 claimant if: 1. you receive a liver transplant; or 2. you develop: a) decompensation of the liver; b) hepatocellular cancer; c) B-cell lymphoma; d) symptomatic mixed cryoglobulinemia; e) glomerulonephritis requiring dialysis; f) renal failure	You will receive $100,000 at this level. ($110,000)	Yes	Yes, $1,000 per month of completed therapy.	Yes	Yes	Yes, up to $50,000 per year. ($60,000)
5	You are considered a Level 5 claimant if you develop: (a) cirrhosis (fibrous bands in the liver extending or bridging from portal area to portal area with the development of nodules and regeneration); (b) unresponsive porphyria cutanea tarda which is causing significant disfigurement and disability; (c) unresponsive thrombocytopenia (low platelets) which is associated with purpura or other spontaneous bleeding, or which results in excessive bleeding following trauma or a platelet count below $30x10^9$; or (d) glomerulonephritis not requiring dialysis.	You will receive $65,000 at this level. ($71,500)	Yes	Yes, $1,000 per month of completed therapy.	Yes	Yes	Not applicable
4	You are a Level 4 claimant if: you develop bridging fibrosis (i.e. fibrous tissue in the portal areas of the liver with fibrous bands bridging to other portal areas or to central veins but without nodular formation or nodular regeneration).	There is no fixed payment at this level.	Yes	Yes, $1,000 per month of completed therapy	Yes	Yes	Not applicable
3	You are considered a Level 3 claimant if: 1. you develop non-bridging fibrosis (i.e. fibrous tissue in the portal areas of the liver with fibrous bands extending out from the portal area but without any bridging to other portal tracts or central veins); or 2. you receive Compensable HCV Drug Therapy (i.e. interferon or ribavarin); or 3. you have met a protocol for Compensable HCV Drug Therapy even though you have not taken the therapy.	OPTION 1: You will receive $30,000 at this level. ($33,000)	OPTION 2: If you waive the $30,000 payment, you may claim loss of income or compensation for loss of services in the home if HCV has caused you to be at least 80% disabled.	$1,000 per month of completed therapy	Yes	Yes	Not applicable
2	You are considered a Level 2 claimant if: you test positive on a polymerase chain reaction (PCR) test demonstrating that HCV is present in your blood.	You will receive $20,000 at this level. ($22,000)	Not applicable	Not applicable	Yes	Yes	Not applicable
1	You are considered a Level 1 claimant if: your blood test demonstrates that the HCV antibody is present in your blood,	You will receive $10,000 at this level. ($11,000)	Not applicable	Not applicable	Yes	Yes	Not applicable

36 All amounts shown are in 1999 dollars and subject to annual adjustments for inflation. The adjustment for 2013 is 1.345774. So an amount of $10,000 in 1999 dollars would be $13,457.74 if paid in 2013.

37 Fixed payments are cumulative—for example, a Level 3 claimant choosing Option 1 will receive (in 1999 dollars) Level 1- $10,000 plus Level 2 $20,0000 plus Level 3 - $30,000, for a total of $60,000.

38 You may elect one or the other. Loss of Income is only available to claimants under age 65.

APPENDIX C AVERAGE FUNERAL EXPENSE IN CANADA

FROM MONEYSENSE MAGAZINE

www.moneysense.ca/spend/how-to-plan-a-funeral/

212. Funerals range from basic to lavish, with price tags to match. In Ontario, the average cost of funeral home services comes to approximately $4,100, plus another $2,200 for a casket or container. But this does not cover extras such as flowers, clergy, a burial plot or death notices.

FROM THE HALIFAX CHRONICAL HERALD

thechronicleherald.ca/business/133001-it-costs-a-lot-to-die-in-nova-scotia-survey-says

213. A 2012 article references survey data from Everest, a funeral service company in Texas that had recently surveyed funeral homes across Canada to determine average costs by location. We were unable to locate a copy of the survey results online. In the article, the following average costs are provided by province:

Province	Traditional	Cremation
BC	$ -	$ 1,917
Alberta	10,387	-
Saskatchewan	-	2,401
Ontario	10,091	-
New Brunswick	-	2,322
Nova Scotia	10,495	2,250
PEI	9,117	-
Halifax	11,152	-
Canada	**9,790**	**-**

214. We believe that the above costs for cremation are for the basic required services only whereas the traditional costs are for all normal services. For example, the cremation costs appear to not include a visitation at the funeral home but the traditional costs do include it.

BASIC FUNERALS AND CREMATION CHOICES INC.

basicfunerals.ca/your-options/funeral/traditional-cremation-pricing/

215. We include this company as it provides online pricing and appears to position itself to be at the low end of the pricing range.

216. This company provides online pricing of $4,680 plus taxes for a basic funeral with cremation. For a traditional funeral with burial, the cost is $5,235 plus taxes, but the cost of a cemetery plot, marker and perpetual care is extra. The included services meet the definition of dignified funeral set out below, with the exception of a Canadian Flag and possibly no viewing room. The company presently only operates within Ontario.

LAST POST FUND

217. The following is excerpted from Evaluation of the Funeral and Burial Program – January 2009 prepared for the Audit and Evaluation Committee of Veterans Affairs Canada[39]. The program is operated by the Last Post Fund ("LPF").

Table 3 - Summary of Benefits Payable

Item	Maximum reimbursement amount*
Funeral Services This includes the following: • Normal preparation of the remains for viewing • A casket, if the remains are to be buried • A rental casket, if the remains are to be cremated • The use of a viewing room and a chapel • The use of a hearse and up to two vehicles for mourners and pallbearers • The attendance at the place of burial or cremation by funeral home officials • Local transportation of the remains from the place where the death occurred to the nearest funeral home and from there to the nearest place of burial, up to a maximum of 16 km for each stage (in the case of cremation, an additional transportation from the funeral home to the place of cremation)	$3,600 for one funeral director $4,100 when two funeral directors are required
Cremation Urn	$350
Cost to cremate the body	Paid at cost (approx $675 on average)
Last Sickness	$75
Regional Transportation Regional transportation is reimbursed up to a maximum amount, but only if the service of two funeral directors is required.	$500
Special Preparation of the Body (If required)	$210
Grave liner	570
Grave plot The rate is called "lowest cost earth burial" and is set by the LPF Branches in the various provinces after consulting with one or more cemeteries. The plot is located in a section of the cemetery designated for Veterans, or in a section of a cemetery designated as a "Field of Honour", or a plot that would ensure a dignified funeral.	Rate set by LPF **
Opening and Closing of Grave	At cost **
Grave Marker& Installation Rate is negotiated with local suppliers	Negotiated rate **
Perpetual Care of Grave	At cost **

* Detailed numbers, if not in the VBRs, were taken from policy submissions and the LPF database
** These four items are approximately $2,000, on average.

39 www.veterans.gc.ca/eng/about-us/reports/departmental-audit-evaluation/2009-01-evaluation-funeral-burial

Unmet Client Needs

The evaluation team conducted a case file review of 39 approved applications made after the funeral and burial. The file review revealed that there were frequently items that were listed as a funeral expense, but were not eligible expenses under the Funeral and Burial Program. Specifically, 77% of applicants claimed obituaries as an expense (average amount $318); 46% claimed an honourarium for clergy (average amount $225); and 44% claimed amounts for flowers (average amount $240). Interviews with LPF and Funeral Directors supported these findings; that is, in the view of applicants, obituaries, clergy, and flowers are often items associated with a dignified burial.

Dignified Funeral

The components for funeral and burial assistance, as outlined in the VBRs, include the following:

- *a casket made of solid wood or wood veneer with a swelled or tiered top, a satin or high gloss exterior finish, an eggshell satin lining and extension bar handles;*
- *a cremation urn;*
- *preparation of the body for viewing;*
- *a viewing of the body for two days;*
- *a Canadian flag to cover the casket while it is on public view;*
- *appropriate clothing;*
- *clergy services;*
- *a grave marker;*
- *a plot in a cemetery;*
- *perpetual care of grave.*

The items listed above provide the Department's de facto definition of a dignified burial, as these are the specific items which will either be provided (Type I) or reimbursed (Type II).

Funeral industry experts agreed that the items listed above constitute a dignified burial, but there are other definitions of a dignified burial. According to funeral industry representatives, the dignity is not in the components of the funeral, but rather the manner in which the family wishes to memorialize their loved one. One funeral industry representative stated that "funerals are about a community's care, compassion, respect and most importantly spiritual beliefs. A funeral allows the family to face the reality of death and provides a climate to mourn, share sorrows and celebrate the achievements of loved ones in a dignified manner."

Society's views on funerals are changing. For example, the funeral directors interviewed noted that some families choose not to have a religious service for the deceased. Many families place more emphasis on the luncheon than the visitation. Often, families employ a funeral celebrant, who helps plan the celebration of the person's life. There is also a trend toward "green funerals" which may include a shroud, biodegradable caskets, and environmentally friendly embalming fluids.

Although the definition of a dignified funeral is based on individual beliefs, the consensus among key informants interviewed was that a dignified funeral for a Veteran should be more elaborate than a social services funeral. There should be a grave marker and perpetual care of the grave in order to ensure that the grave site is maintained and thus the memory of the sacrifices of the Veteran would be recognized for generations to come.

Inflation Effect on Costs

Certain items in the FBP are reimbursed at cost, such as cost of cremation and perpetual care. Other items, such as Funeral Director Services and caskets, have maximum allowable limits. The limits have not increased since 2001. Although the FBP is successful in providing financial assistance, the rates at which the Department reimburses either the funeral directors (Type I) or the applicants (Type II) are not keeping pace with inflationary changes. VAC reimburses $3,600 for the services of a Funeral Director and a casket. A recent survey provided to the Department from the Funeral Services Association of Canada indicated that the average retail cost of the funeral director service fee and a casket is $5,892. This is supported by statistics in the LPF database, where the average retail costs for the same services claimed in approved Type II cases was $5,337.

Program Costs

The table below itemizes the costs paid to the recipients and/or to the funeral and burial service providers.

Table 7 - Program Costs

Disbursements	2002	2003	2004	2005	2006	2007
Burials	$1,497,557	$1,402,808	$1,212,048	$1,190,085	$1,296,822	$1,132,274
Grave Markers	$513,788	$599,719	$532,956	$576,523	$526,343	$480,104
Transportation	$61,114	$51,908	$41,391	$35,817	$37,975	$35,438
Funeral Director Services	$8,132,780	$7,423,670	$6,694,344	$6,176,138	$6,321,480	$5,571,874
Cremation	$673,900	$648,662	$595,323	$611,419	$668,999	$640,611
Last Illness	$10,605	$11,108	$8,482	$8,271	$8,452	$6,976
Total Program Costs	$10,889,744	$10,137,875	$9,084,544	$8,598,253	$8,860,071	$7,867,277
Average program cost per Approved Case	n/a	$3,817	$3,709	$3,887	$4,258	$4,368

Source: Consolidated Auditor's Reports of the Last Post Fund Corporation

Program costs include all monies paid out for approved cases to applicants to cover the categories of expenses listed in Table 7. It is unlikely that savings can be had in this area.

The cost forecasts indicate the amount expended per year will remain between $8 million and $9 million up to 2010-11.

With the exception of 2004, the average program cost per approved application is increasing steadily. This is due to the increase in costs for items reimbursed at cost; such as burial, grave markers and cremation. The costs for funeral director fees have remained steady due to the set maximum amount of $3,600.

APPENDIX D DOCUMENTS PROVIDED

218. We were provided with the following documents that we utilized in the preparation of this report. We also utilized other documents as listed in the 2013 Morneau Shepell Sufficiency Report.

a. Notice of Motion submitted by the Joint Committee dated 16 October 2015;

b. Notice of Application together with Appendices A and B submitted by the British Columbia Joint Committee Member dated 16 October 2016 (the "**Notice of Application**")

c. Affidavit #13 of Heather Rumble Peterson sworn 16 October 2015, together with Exhibits A through F;

d. Affidavit #5 of Richard Border sworn 14 October 2015 together with Exhibit A (the "**Eckler Costing Report**");

e. Affidavit #1 of Alan Melamund sworn 15 October 2015;

f. Affidavit #1 of Arnaud Sauve-Dagenais, sworn 15 October 2015;

g. Affidavit #1 of Chya Mogerman sworn 16 October 2015;

h. Affidavit #1 of Shelly Woodrich sworn 15 October 2015;

i. Actuarial Report to the Joint Committee Assessing the Financial Sufficiency of the 1986-1990 Hepatitis C Trust as at December 31, 2013 prepared by Richard Border and Wendy Harrison and dated 11 March 2015 (the "**2013 Eckler Sufficiency Report**");

j. Motion Record of the Joint Committee regarding the financial sufficiency of the HCV Trust Fund dated 16 March 2015;

k. Affidavit of Dr. Vince Bain sworn 11 March 2015;

l. A series of data files in excel format prepared by the administrator was provided to us by Eckler along with a document detailing the calculation of a loss of income benefit;

m. A data file prepared by the administrator listing the claims for uninsured medications that involved any of the drugs Telepravir, Boceprevir, Simeprevir, Sofosbuvir, Harvoni & Holkira Pak up to 15 October 2015;

n. Affidavit #1 of Dr. Samuel S. Lee, sworn 26 January 2016 (the "**Lee Affidavit**");

o. Estimating the Number of Blood Transfusion Recipients Infected by Hepatitis C Virus in Canada, 1960-85 and 1990-92 by Dr. Robert S. Remis dated 22 Jun 1998 (the "**1998 Remis Report**");

p. Epidemiology of Transfusion-Associated Hepatitis C Virus Infection in British Columbia, 1955-1986 by Dr. Robert S. Remis dated 2 September 1998;

q. Estimating the Number of Potential Beneficiaries of the Canadian HCV Class Action Settlement for Persons Infected by Transfusions Received from January 1986 to July 1990 by Dr. Robert S. Remis dated 6 July 1999 (the "**1999 Remis Report**");

r. Estimating the Number of Persons Infected by Hepatits C Virus Through Blood Transfusion in Canada from 1986-90: An Update Incorporating Results from the Testing of Retained Specimens, by Dr. Robert S. Remis dated 16 May 2002;

s. Transfusion Related Hepatitis C in Canada: 1986 to Mid 1990 Occurrence and Natural History, a report to LCDC by Stephen A Marion, Murray Krahn, Jutta Preiksaitis, Robert Hogg, Morris Sherman and Robert Remis, revised 15 January 1998;

t. Estimating the Prognosis of Hepatitis C Patients Infected by Transfusion in Canada between 1986 and 1990 by the Canadian Association for the Study of the Liver Working Group on Hepatitis C Prognosis, together with a transmittal letter from Dr. Samuel S. Lee dated 6 April 1999, (the "**CASL Report**");

u. Letter from Dr. Murray Krahn to J. J. Camp dated 16 June 1999 clarifying and commenting on items in the CASL Report;

v. Actuarial Report on 1986-90 Hepatitis C Settlement by Jacob Levi, Murray Segal and Francois Vachon dated 9 July 1999 (the "**1999 Eckler Report**");

w. Letter from J. Levi to Mr. Harvey T. Strosberg dated 26 July 1999 providing a breakdown of the assets, liabilities and expenses along with some other items between each of the three class actions, as well as the inflation adjusted upper limit for non-pecuniary damages;

x. Letter from Mr. Murray A. Segal to Mr. H. T. Strosberg dated 30 July 1999 providing examples of Loss of Support calculations and the potential financial consequences of a claimant possibly being unable to purchase individual life insurance;

y. Letter from Mr. Murray A. Segal to Mr. H. T. Strosberg dated 3 August 1999 providing details about the Canada Pension Plan disability and pension benefits;

z. Letter from Mr. Murray A. Segal to Mr. H. T. Strosberg dated 3 August 1999 providing details about how the Loss of Income calculations are affected by the initial limits on lost income;

aa. Letter from J. Levi to Mr. J. J. Camp dated 13 October 1999 providing a correction to the asset values presented in the 1999 Eckler Report;

bb. Letter from J. Levi to Mr. Harvey T. Strosberg dated 1 November 1999 providing additional calculations to those contained in the 1999 Eckler Report;

cc. Affidavit of Dr. Frank Anderson sworn 8 July 1999;

dd. Report of Frank Anderson to the Joint Committee of the 1986-1990 Hepatitis C Settlement Agreement, dated July 2005;

ee. Affidavit number 3 of Dr. Frank Anderson, sworn 6 October 2010;

ff. Hepatitis C Class Action Settlement 1986-1990 Year 15 Report of the Joint Committee for the Period Ending December 31, 2014 dated 24 July 2015. In addition, we referenced the various annual reports of the Joint Committee from years 1 to 14 which had previously been provided to us or were obtained by us from the administrator's web site (www.HepC86-90.ca).

219. In addition, we utilized a number of documents that are in our files from previous consultations and sufficiency review work:

a. Reasons for Decision of the Ontario Superior Court of Justice in the matters of Parsons et al v. Canadian Red Cross Society et al and of Kreppner et al v. Canadian Red Cross Society et al by Winkler J dated 22 September 1999;

b. Judgment of the Ontario Superior Court of Justice in the matters of Parsons et al v. Canadian Red Cross Society et al and of Kreppner et al v. Canadian Red Cross Society et al by Winkler J dated 22 October 1999;

c. 1986 – 1990 Hepatitis C Settlement: Settlement Agreement and Funding Agreement made as of 15 June 1999, including Schedules A through E (the "**Agreement**" or "**Settlement Agreement**";

d. Court Approved Protocol: Recent HCV Diagnosis Exception to the 2010 First Claims Deadline dated May 2012;

e. Court Approved Protocol: Issuance of Initial Claims Packages after the June 30, 2010 First Claim Deadline dated May 2012;

f. Estimating the Prognosis of Canadians infected with the Hepatitis C Virus through the Blood Supply, 1986-1990, fifth revision by Wendong Chen, Qilong Yi, William Wong and Murray Krahn dated September 2014;

g. Estimating the Prognosis of Canadians infected with the Hepatitis C Virus through the Blood Supply, 1986-1990, fourth revision by Hla-Hla Thein, Qilong Yi, and Murray Krahn dated April 2011;

h. Estimating the Prognosis of Canadians infected with the Hepatitis C Virus through the Blood Supply, 1986-1990, third revision by Murray Krahn, Hla-Hla Thein and Qilong Yi dated January 2008; and

i. Estimating the Prognosis of Canadians infected with the Hepatitis C Virus through the Blood Supply, 1986-1990, second revision by Murray Krahn, Peter Wang, Qilong Yi, Linda Scully, Morris Sherman and Jenny Heathcote dated May 2005.

220. In addition to the above documents, we obtained the following documents from the Internet:

a. "Portrait du marché de la retraite au Québec" published March 2010 by the Régie des rentes du Quebec, [http://www.rrq.gouv.qc.ca/en/services/publications/etudes/retraite/Pages/portrait_marche_retraite_qc.aspx];

b. Compensation Programs for Individuals with HIV or Hepatitis C, published by the Canadian Hemophilia Society on 14 November 2014 [http://www.hemophilia.ca/en/hcv-hiv/hepatitis-c-and-hiv-compensation/];

c. How to Plan a Funeral, by Peter Shawn Taylor, published in MoneySense Magazine, 15 April 2011 [www.moneysense.ca/spend/how-to-plan-a-funeral/];

d. It Costs a Lot to Die in Nova Scotia Survey Says, an article by John Demont in the Halifax Chronical Herald, 5 September 2012 [thechronicleherald.ca/business/133001-it-costs-a-lot-to-die-in-nova-scotia-survey-says]

e. Evaluation of the Funeral and Burial Program – January 2009 prepared for the Audit and Evaluation Committee of Veterans Affairs Canada, dated 3 December 2014 [www.veterans.gc.ca/eng/about-us/reports/departmental-audit-evaluation/2009-01-evaluation-funeral-burial];

f. Assessment of Damages Under the Fatal Accidents Act for the Loss of Guidance, Care and Companionship, a report for the Manitoba Law Reform Commission prepared by Prof. Philip Osborne dated October 2000, [http://www.manitobalawreform.ca/pubs/pdf/archives/105-full_report.pdf];

g. Review of Damage Amounts under Section 8 of the Fatal Accidents Act by the Government of Alberta Justice and Solicitor General dated May 2012, [https://www.justice.alberta.ca/programs_services/law/Documents/FAA-Discussion-Paper-May-2012.pdf];

h. Proposed Amendments to the Fatal Accidents Act Discussion Paper by the Government of Yukon Department of Justice dated February 2014, [www.justice.gov.yk.ca/pdf/Discussion_Paper_-_Proposed_Amendments_to_the_Fatal_Accidents_Act.pdf];

APPENDIX E CURRICULUM VITAE OF PETER GORHAM, F.C.I.A., F.S.A.

Position & Responsibilities

Peter is President and Actuary of JDM Actuarial Expert Services Inc. (JDM Actuarial). He provides pension and actuarial consulting advice, expert testimony, retirement planning and governance services.

Areas of Specialization

Peter has provided expert advice and testimony to the legal profession since 1987. His experience includes determining:

- certification of criminal rates of interest,
- lost benefits for wrongful dismissal,
- the present value of future income and future care costs,
- valuation of life estates,
- present value of future trust plan benefits and present value of past funds under various possible investment scenarios,
- present value of future contingent events,
- family law pension valuations.

He has provided expert testimony to the Ontario Superior Court of Justice, the Supreme Court of British Columbia, Court of Queen's Bench of Alberta, the Ontario Unified Family Court, the High Court of Justice of Trinidad and Tobago, the Supreme Court of Bermuda, Ontario Employment Standards Tribunal, Ontario Workplace Safety and Insurance Tribunal and the Canadian Institute of Actuaries Disciplinary Tribunal.

Within the pension and actuarial consulting practice, Peter's main areas of expertise include the design, financing, administration and governance of pension and benefit plans. His strengths lie in providing innovative and workable solutions that address a client's needs. He is effective in communicating actuarial concepts in simple and understandable terms.

Peter is an experienced public speaker and an author of numerous articles related to pensions and benefits.

Background

Peter is an actuary, receiving his fellowship in 1980. He attended the University of Toronto, graduating with a B.Sc. in Actuarial and Computer Sciences. Prior to joining JDM Actuarial, Peter spent 13 years as a partner at Morneau Shepell, and prior to that, 20 years with Aon Consulting, (formerly MLH + A inc), serving clients in the area of pension and employee benefits.

Professional & Other Affiliations

Fellow of the Canadian Institute of Actuaries
Fellow of the Society of Actuaries
Faculty, Humber College PPAC program
Past-President, Rotary Club of Whitby Sunrise

APPENDIX F FORM 53 – ACKNOWLEDGEMENT OF EXPERT'S DUTY

FORM 53

Courts of Justice Act

ACKNOWLEDGMENT OF EXPERT'S DUTY

(General heading)

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Peter Gorham *(name)*. I live at Town of Whitby *(city)*, in the Province *(province/state)* of Ontario *(name of province/state)*.

2. I have been engaged by or on behalf of the Department of Justice of Canada *(name of party/parties)* to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date 29 January 2016

Signature

NOTE: This form must be attached to any report signed by the expert and provided for the purposes of subrule 53.03(1) or (2) of the *Rules of Civil Procedure*.

RCP-E 53

(November 1, 2008)

This is Exhibit "B" referred to in the
affidavit of Peter Gorham
sworn before me at Toronto, ON
this 29th day of January, 2016

William Knight

A Commissioner for taking affidavits
within the Province of Ontario

Claim ID	Disease Level	Claim Type	Age	Gender	Prov	Therapy Type	Total Cost of Drugs	Total Reimbursed by Province and/or Insurance	Amount Reimbursed by Hep C Fund	Insurance Plan
6	3	Hemo	62	M	MB	Boceprevir + Peginterferon/Ribavirin & Harvoni	$ 11,458.25	$ 4,299.85	$ 7,158.40	Assure Health
7	4	Hemo	70	M	MB	Harvoni	$ 77,064.99	$ -	$ 77,064.99	None
8	3	Hemo	65	M	MB	Boceprevir + Peginterferon/Ribavirin & Harvoni	$ 6,156.67	$ 5,142.13	$ 1,014.54	GreenShield & Provincial Plan
47	5	Tran	86	M	ON	Galexos, Sovaldi & Ibavyr	$ 109,768.96	$ -	$ 109,768.96	None
100	5	Tran	59	F	NB	Harvoni	$ 154,122.78	$ -	$ 154,122.78	None
159	3	Tran	29	F	NS	Galexos & Sovaldi	$ 109,657.92	$ -	$ 109,657.92	None
180	3	Tran	33	M	NS	Sovaldi & Ribavirin	$ 1,039.71	$ -	$ 1,039.71	Unknown
189	5	Tran	61	F	NS	Galexos & Sovaldi	$ 104,714.44	$ -	$ 104,714.44	None
219	3	Tran	49	F	NS	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
492	6	Tran	57	M	AB	Galexos & Sovaldi	$ 143,414.53	$ -	$ 143,414.53	None
512	3	Tran	52	M	AB	Galexos, Sovaldi & Pegasys	$ 139,406.79	$ -	$ 139,406.79	None
525	3	Tran	62	F	AB	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
586	5	Hemo	51	M	AB	Harvoni	$ 96,481.44	$ -	$ 96,481.44	None
623	3	Hemo	59	M	QC	Harvoni + Ibavyr	$ 163,108.56	$ -	$ 163,108.56	None
684	3	Tran	43	F	AB	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
740	3	Hemo	34	M	ON	Galexos & Sovaldi	$ 116,023.50	$ -	$ 116,023.50	None
777	5	Hemo	61	F	QC	Sovaldi & Ribavirin	$ 33,952.10	$ 27,725.87	$ 6,226.23	Brunet
827	5	Hemo	60	M	QC	Sovaldi & Ribavirin	$ -	$ -	$ -	Manulife

837	3	Tran	53	M	NS	Harvoni	$ 77,084.49	$ -	$ 77,084.49	None
869	5	Tran	26	F	QC	Telaprevir + Peginterferon/Ribavirin	$ 16,703.40	$ 15,953.40	$ 750.00	Private Insurance Plan
1068	3	Tran	56	F	NS	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1129	5	Hemo	58	M	ON	Boceprevir + Peginterferon/Ribavirin	$ 43,970.64	$ 36,278.11	$ 7,692.53	Private Insurance Plan
1241	3	Hemo	66	F	ON	Harvoni	$ 81,323.73	$ -	$ 81,323.73	None
1307	3	Tran	71	M	QC	Harvoni	$ 78,390.00	$ -	$ 78,390.00	None
1319	3	Tran	65	F	AB	Galexos & Sovaldi	$ 107,561.01	$ -	$ 107,561.01	None
1326	4	Tran	77	M	ON	Galexos, Sovaldi & Ibavyr	$ 111,307.53	$ -	$ 111,307.53	None
1386	3	Hemo	53	M	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1401	3	Tran	57	F	AB	Galexos & Sovaldi	$ 107,561.01	$ -	$ 107,561.01	None
1543	3	Tran	19	M	BC	Harvoni	$ 49,157.80	$ -	$ 49,157.80	None
1886	4	Hemo	36	M	QC	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1914	3	Hemo	42	F	QC	Sovaldi & Ibavyr	$ 63,567.15	$ -	$ 63,567.15	None
2142	3	Tran	57	F	SK	Harvoni	$ 140,041.38	$ 111,956.76	$ 28,084.62	ESI Canada
2290	3	Hemo	43	M	ON	Harvoni	$ 84,834.00	$ -	$ 84,834.00	None
2304	5	Hemo	40	M	ON	Galexos & Sovaldi	$ 111,144.23	$ -	$ 111,144.23	None
2381	5	Hemo	52	M	ON	Harvoni	$ 144,791.94	$ -	$ 144,791.94	None
2458	3	Tran	31	M	NS	Harvoni	$ 77,084.49	$ -	$ 77,084.49	None
2628	3	Hemo	35	M	ON	Harvoni	$ 154,123.96	$ -	$ 154,123.96	None
2790	3	Tran	29	F	ON	Harvoni	$ 77,084.94	$ -	$ 77,084.94	None
2802	4	Hemo	68	M	ON	Harvoni	$ 76,496.26	$ -	$ 76,496.26	None
2853	5	Hemo	60	F	ON	Harvoni	$ 77,061.98	$ -	$ 77,061.98	None
2892	5	Tran	40	M	MB	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
2957	5	Hemo	45	F	QC	Galexos & Sovaldi & Harvoni	$ 188,511.24	$ 65,121.79	$ 123,389.45	SunLife
3108	6	Hemo	68	M	ON	Galexos & Sovaldi	$ 108,373.15	$ -	$ 108,373.15	None
3113	6	Hemo	46	M	SK	Sovaldi	$ 135,718.14	$ -	$ 135,718.14	None
3135	3	Hemo	56	M	AB	Harvoni	$ 77,085.96	$ 60,060.72	$ 17,025.24	Assure Health
3235	3	Tran	26	F	ON	Harvoni	$ 49,915.47	$ 44,922.85	$ 4,992.62	Assure Health

3730	6	Hemo	50	M	ON	Galexos & Sovaldi	$ 106,260.27	$ -	$ 106,260.27	None
3818	5	Hemo	35	M	ON	Harvoni	$ 153,781.51	$ 152,320.55	$ 1,460.96	Manulife
3883	5	Hemo	54	M	AB	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
3901	3	Tran	20	M	ON	Harvoni	$ 25,481.71	$ -	$ 25,481.71	None
3928	3	Tran	26	F	AB	Telaprevir + Peginterferon/Ribavirin	$ 9,735.41	$ 8,401.94	$ 1,333.47	Private Insurance Plan
3957	3	Hemo	43	M	AB	Galexos & Sovaldi	$ 107,561.01	$ -	$ 107,561.01	None
4301	3	Tran	26	M	BC	Telaprevir + Peginterferon/Ribavirin	$ 46,665.20	$ 1,397.65	$ 45,267.55	BC Pharmacare
4337	5	Tran	25	M	AB	Harvoni + Ribavirin	$ -	$ -	$ -	Unknown
4537	3	Hemo	39	M	NB	Sovaldi & Pegasys	$ 80,060.22	$ -	$ 80,060.22	None
5279	6	Tran	55	M	ON	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
5722	3	Hemo	43	M	ON	Harvoni	$ 75,745.97	$ 60,060.77	$ 15,685.20	Assure Health
5861	3	Hemo	55	M	QC	Galexos, Sovaldi & Ibavyr	$ -	$ -	$ -	Unknown
6256	4	Tran	52	F	ON	Boceprevir + Peginterferon/Ribavirin	$ 69,184.18	$ 67,200.16	$ 1,984.02	Private Insurance Plan
6991	3	Tran	49	F	NL	Harvoni	$ 77,085.99	$ -	$ 77,085.99	None
7039	6	Hemo	33	M	NT	Harvoni	$ 73,736.66	$ -	$ 73,736.66	None
7233	6	Tran	70	F	BC	Sovaldi	$ 7,575.45	$ 6,406.89	$ 1,168.56	BC Pharmacare
7717	5	Tran	55	F	ON	Harvoni	$ 77,085.96	$ 61,656.78	$ 15,429.18	Express Scripts
7839	6	Tran	50	F	ON	Boceprevir + Peginterferon/Ribavirin & Holkira Pak	$ 84,772.28	$ -	$ 84,772.28	None
7932	5	Hemo	52	M	ON	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
8046	3	Tran	29	M	AB	Sovaldi & Pegasys	$ 71,827.15	$ -	$ 71,827.15	None
8099	3	Tran	57	F	QC	Sovaldi + Ibavyr	$ 134,028.00	$ 5,983.92	$ 128,044.08	Private Insurance Plan
8114	3	Tran	28	F	ON	Galexos & Sovaldi	$ 105,594.21	$ -	$ 105,594.21	None
8211	3	Tran	20	M	MB	Galexos & Sovaldi	$ 109,461.27	$ -	$ 109,461.27	None
8232	5	Tran	60	F	AB	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
9331	3	Tran	88	M	AB	Harvoni	$ 71,356.35	$ -	$ 71,356.35	None

9337	4	Tran	67	M	AB	Telaprevir + Peginterferon/Ribavirin	$ 50,415.12	$ 45,374.67	$ 5,040.45	Private Insurance Plan
9770	5	Tran	52	F	AB	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
10100	3	Hemo	51	F	QC	Telaprevir + Peginterferon/Ribavirin	$ 15,134.30	$ 14,457.67	$ 676.63	SSQ Group Financier
10151	4	Tran	64	F	QC	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
10362	3	Tran	59	F	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
10679	3	Tran	56	F	AB	Harvoni	$ 69,346.89	$ -	$ 69,346.89	None
10690	3	Tran	52	F	NS	Harvoni	$ 72,395.97	$ -	$ 72,395.97	None
10774	3	Tran	50	M	AB	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
10926	3	Tran	41	F	AB	Holkira Pak	$ 61,198.71	$ 14,084.31	$ 47,114.40	Private Insurance Plan
11163	4	Tran	60	F	ON	Sovaldi & Pegasys	$ 68,369.54	$ -	$ 68,369.54	None
11543	5	Hemo	38	M	ON	Galexos & Sovaldi & Harvoni	$ 189,961.71	$ -	$ 189,961.71	None
12054	6	Tran	81	M	ON	Sovaldi & Pegasys	$ -	$ -	$ -	Unknown
12123	5	Tran	46	M	ON	Boceprevir + Peginterferon/Ribavirin	$ 545.53	$ -	$ 545.53	Private Insurance Plan
12130	5	Tran	35	M	SK	Harvoni	$ 70,650.00	$ -	$ 70,650.00	None
12806	4	Tran	60	F	QC	Holkira Pak	$ 27,820.98	$ 26,802.98	$ 1,018.00	Private Insurance Plan
12955	3	Hemo	41	F	QC	Harvoni	$ 18,201.30	$ 17,195.30	$ 1,006.00	Private Insurance Plan
13071	3	Tran	66	M	ON	Telaprevir + Peginterferon/Ribavirin	$ 65,907.18	$ -	$ 65,907.18	None
13569	3	Hemo	41	M	ON	Harvoni	$ 77,061.98	$ -	$ 77,061.98	None
13825	3	Hemo	49	F	NS	Harvoni	$ 25,694.83	$ 24,970.93	$ 723.90	Private Insurance Plan
14491	3	Tran	31	F	BC	Harvoni	$ 50,218.85	$ -	$ 50,218.85	None
14574	4	Hemo	52	M	PE	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown

14679	5	Tran	59	F	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
15484	3	Tran	55	M	SK	Harvoni	$ 44,829.16	$ -	$ 44,829.16	None
15908	5	Tran	51	M	ON	Harvoni	$ 148,720.00	$ -	$ 148,720.00	None
15933	5	Tran	51	F	ON	Sovaldi & Pegasys	$ 68,906.93	$ -	$ 68,906.93	None
16652	5	Tran	65	M	ON	Harvoni	$ 77,284.95	$ -	$ 77,284.95	None
17006	3	Tran	43	M	NS	Sovaldi + Ibavyr	$ 66,412.26	$ -	$ 66,412.26	None
17040	3	Tran	54	M	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
17133	6	Hemo	68	M	AB	Sovaldi & Ribavirin	$ -	$ -	$ -	Unknown
17750	3	Tran	29	M	ON	Faldaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
18091	5	Tran	43	M	ON	Galexos & Sovaldi	$ 108,373.19	$ -	$ 108,373.19	None
18138	5	Tran	70	M	AB	Telaprevir + Peginterferon/Ribavirin	$ 50,120.54	$ 49,870.54	$ 250.00	Private Insurance Plan
18143	4	Tran	26	M	ON	Galexos & Sovaldi	$ 108,373.15	$ -	$ 108,373.15	None
18427	5	Tran	63	M	AB	Boceprevir + Peginterferon/Ribavirin & Harvoni	$ 194,567.14	$ -	$ 194,567.14	None
18495	5	Tran	57	M	QC	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
18599	5	Hemo	56	M	ON	Boceprevir + Peginterferon/Ribavirin & Galexos + Sovaldi	$ 108,749.57	$ -	$ 108,749.57	None
18612	3	Tran	32	M	ON	Harvoni	$ 92,034.00	$ -	$ 92,034.00	None
19062	3	Tran	27	F	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
19082	5	Hemo	36	M	ON	Galexos	$ 15,430.51	$ 15,430.51	$ -	Private Insurance Plan
19229	4	Tran	48	M	QC	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
19258	3	Tran	57	M	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown

19400	3	Tran	57	F	ON	Boceprevir + Peginterferon/Ribavirin	$ 63,415.82	$ 3,964.98	$ 59,450.84	Private Insurance Plan
19529	3	Tran	51	F	ON	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
19623	3	Tran	41	F	AB	Holkira Pak	$ 63,740.19	$ -	$ 63,740.19	None
19767	5	Tran	54	M	NS	Telaprevir + Peginterferon/Ribavirin & Harvoni	$ 154,169.28	$ -	$ 154,169.28	None
19771	4	Tran	59	F	AB	Faldaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
19819	3	Tran	57	F	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
19968	3	Hemo	51	M	QC	Boceprevir + Peginterferon/Ribavirin	$ 22,963.46	$ 21,068.45	$ 1,895.01	Private Insurance Plan
20476	5	Tran	52	F	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
20517	6	Tran	58	F	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
20578	3	Tran	28	M	SK	Telaprevir + Peginterferon/Ribavirin	$ 43,950.30	$ 43,510.81	$ 439.49	Private Insurance Plan
20773	5	Tran	63	M	ON	Telaprevir + Peginterferon/Ribavirin & Harvoni	$ 194,215.13	$ -	$ 194,215.13	None
1000074	3	Tran	23	F	ON	Harvoni	$ 84,857.99	$ -	$ 84,857.99	None
1000123	5	Tran	50	F	ON	Harvoni	$ 77,085.99	$ 61,668.81	$ 15,417.18	Private Insurance Plan
1000137	3	Tran	28	M	ON	Harvoni	$ 77,061.98	$ -	$ 77,061.98	None
1000207	3	Tran	44	M	ON	Harvoni	$ 77,082.63	$ 65,520.24	$ 11,562.39	Private Insurance Plan
1000219	3	Tran	48	M	NS	Telaprevir + Peginterferon/Ribavirin	$ 58,266.73	$ 42,633.55	$ 15,633.18	Private Insurance Plan
1000225	5	Tran	63	F	ON	Galexos & Sovaldi	$ 119,323.50	$ -	$ 119,323.50	None
1000271	6	Tran	64	F	ON	Sovaldi & Ribavirin	$ 64,853.83	$ -	$ 64,853.83	None
1000288	3	Tran	63	M	ON	Galexos & Sovaldi	$ 108,373.15	$ -	$ 108,373.15	None
1000381	5	Tran	61	F	MB	Sovaldi + Ibavyr	$ 138,093.06	$ -	$ 138,093.06	None

1000507	3	Tran	59	F	ON	Galexos & Sovaldi	$ 105,772.17	$ -	$ 105,772.17	None
1000512	3	Tran	59	M	ON	Harvoni	$ 77,061.98	$ -	$ 77,061.98	None
1000574	3	Tran	56	F	ON	Harvoni	$ 25,481.71	$ -	$ 25,481.71	None
1000656	3	Tran	64	F	ON	ABT 450 ABT 267 ABT 333 + Ribavirin	$ -	$ -	$ -	Unknown
1000680	3	Tran	51	M	ON	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1000718	3	Tran	44	M	ON	Telaprevir + Peginterferon/Ribavirin	$ 52,025.27	$ 41,620.21	$ 10,405.06	Private Insurance Plan
1000754	3	Tran	61	F	ON	Galexos, Sovaldi & Ibavyr	$ 111,067.11	$ -	$ 111,067.11	None
1000789	5	Tran	45	F	ON	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1000824	3	Tran	45	M	SK	Boceprevir + Peginterferon/Ribavirin	$ 40,868.21	$ 38,896.51	$ 1,971.70	SK Prescription Drug Plan + Private Insurance Plan
1000837	6	Tran	65	M	On	Telaprevir + Peginterferon/Ribavirin	$ 49,413.42	$ 28,360.64	$ 21,052.78	Private Insurance Plan
1000850	5	Tran	86	M	ON	Sovaldi + Ibavyr	$ 90,376.75	$ -	$ 90,376.75	None
1000910	3	Tran	73	M	AB	Harvoni	$ 72,361.08	$ -	$ 72,361.08	None
1100008	5	Hemo	48	M	ON	Harvoni	$ 77,082.57	$ 69,363.48	$ 7,719.09	Private Insurance Plan
1100009	4	Hemo	58	M	ON	Telaprevir + Peginterferon/Ribavirin	$ 63,099.70	$ -	$ 63,099.70	None
1100010	5	Hemo	61	F	ON	Harvoni	$ 79,995.99	$ -	$ 79,995.99	None
1100016	6	Hemo	77	M	ON	Harvoni	$ 76,447.00	$ -	$ 76,447.00	None
1100028	3	Hemo	55	M	ON	Galexos & Sovaldi	$ 108,373.19	$ -	$ 108,373.19	None
1100039	6	Hemo	64	M	NS	Sovaldi + Ibavyr	$ 133,309.13	$ -	$ 133,309.13	None
1100044	6	Hemo	55	M	NS	Harvoni	$ 77,084.64	$ -	$ 77,084.64	None
1100045	4	Hemo	30	M	NS	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1100048	4	Hemo	62	M	NB	Boceprevir + Peginterferon/Ribavirin	$ 8,421.19	$ 7,621.24	$ 799.95	Great West
1100054	4	Hemo	45	M	PE	Harvoni + Ibavyr	$ 20,549.25	$ 17,642.42	$ 2,906.83	Private Insurance Plan
1100065	3	Hemo	69	M	AB	Sovaldi & Pegasys	$ 65,851.16	$ 46,086.75	$ 19,764.41	Private Insurance Plan

1100077	4	Hemo	51	M	AB	Galexos & Sovaldi	$ 107,561.01	$ -	$ 107,561.01	None
1100079	3	Hemo	62	M	AB	Harvoni	$ 72,361.08	$ -	$ 72,361.08	None
1100082	4	Hemo	67	M	BC	Sovaldi & Ribavirin	$ 66,521.13	$ -	$ 66,521.13	None
1100106	6	Hemo	76	M	QC	Boceprevir + Peginterferon/Ribavirin	$ 11,091.16	$ 10,856.81	$ 234.35	RAMQ
1100149	3	Hemo	43	M	QC	Harvoni	$ 85,855.68	$ 68,684.54	$ 17,171.14	Private Insurance Plan
1100163	6	Hemo	57	M	ON	Harvoni	$ 19,023.24	$ 16,023.24	$ 3,000.00	Private Insurance Plan
1100175	3	Hemo	57	M	BC	Harvoni	$ 73,736.68	$ -	$ 73,736.68	None
1100193	3	Hemo	49	M	BC	Galexos & Sovaldi	$ 51,053.54	$ 8,761.04	$ 42,292.50	Private Insurance Plan
1100215	3	Hemo	38	M	MB	Harvoni	$ 25,735.85	$ -	$ 25,735.85	None
1100224	6	Hemo	53	M	SK	Harvoni	$ 134,487.48	$ -	$ 134,487.48	None
1100226	4	Hemo	64	M	ON	Boceprevir + Harvoni	$ 133,313.51	$ 5,172.96	$ 128,140.55	Private Insurance Plan
1100246	6	Hemo	58	M	ON	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1100268	3	Hemo	40	M	On	Harvoni	$ 77,062.08	$ -	$ 77,062.08	None
1100276	5	Hemo	39	M	QC	Galexos & Sovaldi	$ 101,423.88	$ -	$ 101,423.88	None
1100301	4	Hemo	51	M	ON	Harvoni	$ 77,061.98	$ -	$ 77,061.98	None
1100328	5	Hemo	50	M	On	Harvoni + Ibavyr	$ 81,332.59	$ 79,983.72	$ 1,348.87	Private Insurance Plan
1100351	5	Hemo	47	M	NS	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1100398	3	Hemo	54	M	ON	Telaprevir + Peginterferon/Ribavirin	$ 30,192.51	$ 28,755.23	$ 1,437.28	Private Insurance Plan
1100409	5	Hemo	56	F	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1100417	6	Hemo	62	F	ON	Harvoni	$ 52,551.98	$ -	$ 52,551.98	None
1100455	3	Hemo	49	M	ON	Telaprevir + Peginterferon/Ribavirin	$ 67,761.41	$ 67,431.41	$ 330.00	Private Insurance Plan
1100460	3	Hemo	47	M	AB	Galexos & Sovaldi	$ 107,112.88	$ -	$ 107,112.88	None
1100478	5	Hemo	60	M	NB	Harvoni & Holkira Pak	$ 139,106.61	$ 1,566.27	$ 137,540.34	Private Insurance Plan

1100495	3	Hemo	37	M	ON	Harvoni	$ 77,061.39	$ -	$ 77,061.39	None
1100498	6	Hemo	48	M	AB	Galexos, Sovaldi & Pegasys	$ 102,790.37	$ -	$ 102,790.37	None
1100504	3	Hemo	51	M	NB	Boceprevir + Peginterferon/Ribavirin	$ 83,217.74	$ -	$ 33,217.74	None
1100506	3	Hemo	76	M	ON	Sovaldi + Ibavyr	$ 67,048.12	$ -	$ 67,048.12	None
1100554	4	Hemo	63	F	ON	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1100565	6	Hemo	44	M	BC	Harvoni + Ibavyr	$ 163,975.56	$ -	$ 163,975.56	None
1100581	5	Hemo	65	M	ON	Galexos & Sovaldi	$ 102,899.40	$ -	$ 102,899.40	None
1100584	3	Hemo	56	M	NL	Sovaldi & Pegasys	$ -	$ -	$ -	Unknown
1100591	3	Hemo	33	M	BC	Harvoni	$ 74,853.39	$ -	$ 74,853.39	None
1100595	3	Hemo	44	M	ON	Harvoni	$ 72,361.08	$ -	$ 72,361.08	None
1100605	5	Hemo	50	M	AB	Telaprevir + Peginterferon/Ribavirin	$ 8,296.85	$ 6,473.14	$ 1,823.71	BC Pharmacare
1100611	3	Hemo	47	M	ON	Galexos, Sovaldi & Ribavirin	$ 111,980.51	$ -	$ 111,980.51	None
1100637	6	Hemo	64	M	NB	Harvoni + Ibavyr	$ 158,771.76	$ -	$ 158,771.76	None
1100656	6	Hemo	48	M	NB	Galexos & Sovaldi	$ 109,609.51	$ -	$ 109,609.51	None
1100665	3	Hemo	38	M	ON	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1100739	4	Hemo	56	M	QC	Harvoni + Ibavyr	$ 82,741.83	$ -	$ 82,741.83	None
1100762	4	Hemo	57	M	QC	Sovaldi + Ribavirin	$ -	$ -	$ -	Unknown
1100772	4	Hemo	51	M	ON	Galexos & Sovaldi	$ 208,844.70	$ -	$ 208,844.70	None
1100780	3	Hemo	67	F	ON	Sovaldi & Ibavyr	$ 68,475.14	$ -	$ 68,475.14	None
1100781	3	Hemo	40	M	BC	Telaprevir + Peginterferon/Ribavirin	$ 20,526.06	$ 12,967.12	$ 7,558.94	Private Insurance Plan
1100787	6	Hemo	62	M	NB	Galexos, Sovaldi & Pegasys	$ 114,224.19	$ -	$ 114,224.19	None
1100806	5	Hemo	60	M	ON	Harvoni + Ibavyr	$ 90,445.47	$ 5,878.62	$ 84,566.85	Private Insurance Plan
1100826	3	Hemo	29	M	ON	Boceprevir + Peginterferon/Ribavirin	$ 23,354.14	$ -	$ 23,354.14	None
1100835	3	Hemo	44	M	NB	Sovaldi + Ibavyr	$ 134,295.34	$ -	$ 134,295.34	None
1100843	3	Hemo	38	M	SK	Harvoni	$ 77,061.98	$ -	$ 77,061.98	None

1100850	5	Hemo	62	M	BC	Harvoni	$ 147,483.61	$ -	$ 147,483.61	None
1100865	3	Hemo	59	M	BC	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1100866	5	Hemo	50	M	AB	Telaprevir + Peginterferon/Ribavirin	$ 22,100.64	$ 21,506.56	$ 594.08	Private Insurance Plan
1200003	3	Hemo	44	F	QC	Harvoni	$ 51,737.46	$ -	$ 51,737.46	None
1200076	3	Tran	81	M	QC	Harvoni	$ 78,390.00	$ -	$ 78,390.00	None
1200114	3	Tran	50	F	QC	Galexos & Sovaldi	$ 107,194.47	$ -	$ 107,194.47	None
1200142	5	Hemo	45	F	QC	Telaprevir + Peginterferon/Ribavirin	$ 10,303.30	$ 9,383.26	$ 920.04	Private Insurance Plan
1200172	4	Tran	59	F	QC	Holkira Pak + Ibavyr	$ 68,328.87	$ -	$ 68,328.87	None
1200177	6	Hemo	58	F	QC	Boceprevir + Peginterferon/Ribavirin	$ 35,931.60	$ 34,978.91	$ 952.69	RAMQ
1200192	5	Tran	58	M	QC	Harvoni	$ 152,806.50	$ -	$ 152,806.50	None
1200204	4	Tran	73	M	QC	Harvoni	$ 26,130.00	$ 25,600.00	$ 530.00	Private Insurance Plan
1200225	5	Tran	63	M	QC	Sovaldi + Ribavirin	$ -	$ -	$ -	Unknown
1200241	5	Tran	61	M	QC	Galexos & Sovaldi	$ 107,194.47	$ -	$ 107,194.47	None
1200311	3	Tran	71	M	QC	Sovaldi + Ibavyr	$ 83,219.75	$ -	$ 83,219.75	None
1200374	3	Tran	32	F	QC	Galexos & Sovaldi	$ 60,479.99	$ 60,249.11	$ 230.88	Private Insurance Plan
1200382	6	Tran	27	F	QC	Harvoni	$ 11,905.85	$ 11,812.34	$ 93.51	Private Insurance Plan
1300095	3	Tran	60	F	BC	Holikira Pak	$ 61,198.71	$ -	$ 61,198.71	None
1300137	4	Tran	32	M	BC	Telaprevir + Peginterferon/Ribavirin	$ 9,700.52	$ 8,825.83	$ 874.69	BC Pharmacare
1300162	5	Tran	78	M	BC	Galexos & Sovaldi	$ 103,834.25	$ -	$ 103,834.25	None
1300166	3	Tran	66	F	BC	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1300235	6	Tran	46	F	BC	Harvoni	$ 79,740.00	$ -	$ 79,740.00	None
1300310	3	Tran	71	M	BC	Sovaldi + Ibavyr	$ 133,746.08	$ -	$ 133,746.08	None
1300403	5	Tran	58	F	BC	Harvoni	$ 8,385.00	$ 7,010.60	$ 1,374.40	Private Insurance Plan

1300503	3	Tran	54	M	ON	Boceprevir + Peginterferon/Ribavirin	$ 44,042.03	$ 35,597.85	$ 8,444.18	Private Insurance Plan
1300598	4	Tran	59	F	BC	Boceprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1300626	3	Tran	72	F	BC	Galexos & Sovaldi	$ 105,287.52	$ -	$ 105,287.52	None
1300704	4	Tran	66	M	BC	Boceprevir + Peginterferon/Ribavirin	$ 26,927.81	$ 3,645.25	$ 23,282.56	Private Insurance Plan
1300769	3	Tran	57	M	BC	Sovaldi + Ribavirin	$ 52,650.88	$ 51,650.88	$ 1,000.00	Private Insurance Plan
1400134	6	Tran	66	M	ON	Galexos & Sovaldi	$ 105,810.98	$ -	$ 105,810.98	None
1400217	5	Tran	62	M	MB	Galexos & Sovaldi	$ 101,852.43	$ -	$ 101,852.43	None
1400269	6	Tran	59	M	ON	Sovaldi & Pegasys	$ 96,743.68	$ -	$ 96,743.68	None
1400545	5	Tran	74	M	ON	Harvoni	$ 77,061.98	$ -	$ 77,061.98	None
1400765	4	Hemo	52	M	NS	Telaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1400841	3	Tran	68	F	QC	Harvoni	$ 78,390.00	$ -	$ 78,390.00	None
1400905	5	Tran	77	F	ON	Galexos & Sovaldi	$ 108,373.15	$ -	$ 108,373.15	None
1400937	5	Tran	69	M	BC	Harvoni	$ 73,736.64	$ -	$ 73,736.64	None
1401184	3	Tran	58	M	ON	Boceprevir + Peginterferon/Ribavirin	$ 29,045.23	$ 14,522.60	$ 14,522.63	Private Insurance Plan
1401397	5	Tran	65	M	ON	Galexos & Sovaldi	$ 99,943.74	$ -	$ 99,943.74	None
1401466	3	Tran	49	M	NS	Harvoni	$ 11,690.87	$ 11,098.74	$ 592.13	Private Insurance Plan
1401517	5	Tran	69	M	ON	Telaprevir + Peginterferon/Ribavirin & Galexos + Sovaldi & Ribavirin	$ 116,023.50	$ -	$ 116,023.50	None
1401600	6	Tran	46	F	AB	Galexos, Sovaldi & Ibavyr	$ 109,574.70	$ -	$ 109,574.70	None
1401619	5	Tran	73	M	ON	Sovaldi + Ibavyr	$ 157,308.36	$ -	$ 157,308.36	None
1401641	3	Tran	31	M	BC	Galexos & Sovaldi	$ 103,765.66	$ -	$ 103,765.66	None
1401651	5	Tran	67	F	QC	Harvoni	$ 99,597.82	$ 25,270.18	$ 74,327.64	Private Insurance Plan
1401768	5	Tran	59	F	BC	Harvoni	$ 73,736.64	$ -	$ 73,736.64	None
1402031	3	Tran	63	M	ON	Harvoni	$ 76,016.97	$ -	$ 76,016.97	None
1402151	3	Tran	68	M	ON	Rotpmavor & Ribavirin	$ -	$ -	$ -	Unknown

1402180	3	Tran	59	F	AB	Galexos & Sovaldi	$ 107,897.90	$ 15,389.65	$ 92,508.25	Private Insurance Plan
1402193	3	Tran	22	M	AB	Galexos & Sovaldi	$ 107,561.01	$ -	$ 107,561.01	None
1402355	3	Tran	52	F	ON	Harvoni	$ 18,354.43	$ 17,354.50	$ 999.93	Private Insurance Plan
1402408	3	Tran	29	F	ON	Faldaprevir + Peginterferon/Ribavirin	$ -	$ -	$ -	Unknown
1402494	6	Tran	53	F	QC	Galexos & Sovaldi & Ribavirin	$ 236,100.74	$ -	$ 236,100.74	None
1402495	4	Tran	57	M	ON	Boceprevir + Peginterferon/Ribavirin & Galexos + Sovaldi	$ 180,683.20	$ -	$ 180,683.20	None
1402528	3	Tran	45	M	ON	Harvoni	$ 74,660.04	$ -	$ 74,660.04	None
1402565	3	Tran	60	M	QC	Sovaldi & Pegasys	$ 10,449.60	$ 9,567.05	$ 882.55	Private Insurance Plan
1402594	3	Tran	51	M	QC	Galexos & Sovaldi	$ 93,980.04	$ 93,814.72	$ 165.32	Private Insurance Plan
1402677	3	Hemo	68	M	QC	Sovaldi + Ribavirin	$ -	$ -	$ -	Unknown
1402735	3	Tran	31	M	AB	Harvoni	$ 48,240.99	$ -	$ 48,240.99	None
1500088	5	Tran	65	F	BC	Harvoni	$ 153,474.93	$ -	$ 153,474.93	None
1500123	5	Tran	74	F	BC	Sovaldi & Ribavirin	$ 64,107.12	$ -	$ 64,107.12	None
1500157	4	Tran	56	F	BC	Galexos & Sovaldi	$ 105,287.52	$ -	$ 105,287.52	None
1500172	3	Tran	44	M	BC	Telaprevir + Peginterferon/Ribavirin	$ 1,153.83	$ 923.15	$ 230.68	Private Insurance Plan
Total Claims (265)							**$ 17,397,606.01**	**$ 2,201,790.42**	**$ 15,195,815.59**	

Duration of Treatment (Months)	Drug Therapy Claimed	Drug Therapy Reimbursed by Hep C Fund	Successful Response to Therapy	Claims for benefits subsequent to Treatment?	Type of Subsequent Costs	Total Reimbursed by Hep C Fund for Subsequent Costs
3	Yes	$ 4,001.10	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	Yes	Other meds	$ 223.56
3	No	$ -	Unknown	No	N/A	$ -
6	No	$ -	Unknown	Yes	Travelling Expense	$ 2,822.11
3	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Other Meds	$ 902.25
3	Yes	$ 4,037.31	Unknown	No	N/A	$ -
6	No	$ -	Unknown	Yes	Other Meds	$ 5,021.53
6	Yes	$ 8,074.62	Unknown	Yes	Mileage	$ 627.15
6	Yes	$ 8,074.62	Unknown	No	N/A	$ -
5	No	$ -	Unknown	Yes	Other Meds & Travelling Expenses	$ 7,332.96
6	Yes	$ 8,219.52	Unknown	Yes	Travelling Expense	$ 1,332.77
9	Yes	$ 11,344.68	Yes	Yes	Other meds, mileage, parking & meals	$ 5,856.08
3	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 8,219.52	Unknown	Yes	Other Meds & Travelling Expenses	$ 2,967.53
4	Yes	$ 5,383.08	Unknown	No	N/A	$ -

3	No	$ -	Unknown	Yes	Travelling Expenses	$ 1,578.51
7	Yes	$ 9,335.90	No	Yes	Mileage, Meals, Parking	$ 1,286.75
7	Yes	$ 9,335.90	Unknown	Yes	Mileage	$ 5,300.05
12	Yes	$ 14,803.51	Unknown	Yes	Other Meds & Mileage	$ 2,479.31
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Mileage	$ 45.60
3	Yes	$ 4,109.76	Unknown	No	N/A	$ -
12	Yes	$ 16,149.24	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Other Meds	$ 911.85
2	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 8,002.20	Yes	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
5	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
5	No	$ -	Unknown	Yes	Travelling Expenses	$ 1,194.76
3	No	$ -	Unknown	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Other Meds	$ 1,911.90
3	No	$ -	Unknown	No	N/A	$ -
9	Yes	$ 12,003.30	No	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
6	No	$ -	Unknown	Yes	Other Meds + Travelling Expense	$ 2,465.33
3	No	$ -	Unknown	No	N/A	$ -
2	No	$ -	Unknown	No	N/A	$ -

3	No	$ -	Unknown	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -
4	Yes	$ 5,334.80	No	Yes	Mileage & parking	$ 319.20
1	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 8,074.62	Unknown	Yes	Mileage	$ 360.23
3	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 8,002.20	Yes	No	N/A	$ -
3	Yes	$ 4,109.76	Unknown	No	N/A	$ -
3	Yes	$ 4,109.76	Unknown	Yes	Mileage & Parking	$ 31.91
6	Yes	$ 7,863.90	Unknown	Yes	Mileage	$ 439.59
3	No	$ -	Unknown	No	N/A	$ -
4	Yes	$ 5,455.53	Unknown	No	N/A	$ -
12	Yes	$ 15,866.10	Unknown	Yes	Bus fare, other medications, form completion	$ 1,076.62
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	Yes	Other Meds	$ 399.10
3	No	$ -	Unknown	No	N/A	$ -
13	Yes	$ 17,495.01	Unknown	Yes	Other Meds	$ 16,217.26
5	Yes	$ 6,668.50	No	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	No	N/A	$ -
6	Yes	$ 8,219.52	Unknown	Yes	Travelling Expenses	$ 376.38
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Mileage, Meals & Parking	$ 1,818.82
12	Yes	$ 16,149.24	Unknown	Yes	Mileage & Parking	$ 5,325.94
3	No	$ -	Unknown	No	N/A	$ -

6	Yes	$ 8,002.20	Yes	No	N/A	$ -
6	Yes	$ 8,002.20	No	No	N/A	$ -
6	Yes	$ 8,002.20	Unknown	Yes	Other Medications, Mileage, Meals, Parking	$ 4,061.92
11	Yes	$ 14,670.70	Unknown	Yes	Taxi's & Other Meds	$ 1,739.37
12	Yes	$ 16,004.40	Yes	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Travelling Expenses	$ 112.26
9	Yes	$ 12,039.51	Yes	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	Yes	Mileage, Meals & Parking	$ 1,167.13
3	Yes	$ 4,109.76	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	Yes	Other Meds	$ 33.35
11	Yes	$ 14,532.40	Unknown	Yes	Other meds, mileage, parking, meals, blood tests	$ 8,788.64
3	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	No	N/A	$ -
12	Yes	$ 15,866.10	Unknown	Yes	Mileage, meals, hotels, other medications	$ 15,374.89
3	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	No	N/A	$ -
2	No	$ -	Unknown	Yes	Traveling Expenses	$ 403.60
2	Yes	$ 2,667.40	Unknown	Yes	Mileage & meals	$ 1,347.88

12	Yes	$ 16,004.40	No	Yes	Other meds, mileage, parking, & meals	$ 1,755.13
2	No	$ -	Unknown	Yes	Traveling Expenses	$ 78.90
6	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	Yes	Traveling Expenses	$ 488.80
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 2,678.77
11	Yes	$ 14,532.40	No	No	N/A	$ -
6	Yes	$ 8,074.62	Unknown	Yes	Travel Expenses & Other Meds	$ 21,058.60
6	Yes	$ 8,002.20	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Travel Expenses	$ 1,365.63
6	Yes	$ 8,074.62	Unknown	Yes	Other meds, mileage, parking	$ 175.04
3	No	$ -	Unknown	No	N/A	$ -
12	Yes	$ 16,149.24	Unknown	No	N/A	$ -
12	Yes	$ 15,866.10	Yes	Yes	Mileage & Parking	$ 1,854.25
15	Yes	$ 20,259.00	Unknown	Yes	Traveling Expenses	$ 271.20
3	No	$ -	Unknown	No	N/A	$ -
12	Yes	$ 16,004.40	Unknown	Yes	Other Meds, Mileage & Parking	$ 1,973.08
3	No	$ -	Unknown	Yes	Travel Expenses	$ 1,240.86
7	Yes	$ 9,174.55	Unknown	Yes	Mileage, meals & parking	$ 4,455.95
18	Yes	$ 24,368.76	No	Yes	Mileage	$ 600.00

3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 816.95
1	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	Yes	Mileage, meals & parking	$ 405.43
6	Yes	$ 8,002.20	Unknown	Yes	Mileage, Meals, Parking	$ 1,916.98
6	Yes	$ 7,863.90	Yes	Yes	Mileage, hotels, other medications	$ 1,809.85
3	Yes	$ 4,109.76	Unknown	No	N/A	$ -
1	Yes	$ 1,333.70	No	No	N/A	$ -
7	Yes	$ 9,335.90	Yes	Yes	Mileage, Parking, Other Medications	$ 235.09
7	Yes	$ 9,420.39	Yes	Yes	Other Meds, mileage, meals	$ 9,770.21
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 1,081.30
13	Yes	$ 17,338.10	No	Yes	Other medications, massage, physiotherapy	$ 38,113.24
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 8,219.52	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 810.76
13	Yes	$ 17,315.05	Unknown	No	N/A	$ -
11	Yes	$ 14,670.70	Yes	Yes	Mileage & Parking	$ 144.45
1	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	No	N/A	$ -

3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Yes	Yes	Travel Expenses	$ 684.25
7	Yes	$ 9,335.90	No	Yes	Meals, mileage, parking, other medications	$ 9,098.01
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 240.75
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 1,640.65
3	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -
7	Yes	$ 9,589.44	Unknown	No	N/A	$ -
1	Yes	$ 1,310.65	No	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,109.76	Unknown	No	N/A	$ -
2	Yes	$ 2,691.54	Unknown	No	N/A	$ -
6	Yes	$ 7,863.90	Unknown	Yes	Other medications, mileage, parking	$ 311.32
6	Yes	$ 7,863.90	Yes	No	N/A	$ -
2	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 7,863.90	Unknown	Yes	Other medications, mileage, meals, parking	$ 1,835.60
3	No	$ -	Unknown	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -

3	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	No	N/A	$ -
12	Yes	$ 16,076.82	Unknown	Yes	Mileage, parking, meals, other medications	$ 309.73
3	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 7,863.90	Unknown	Yes	Other meds, mileage & meals	$ 1,652.57
6	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	Yes	Travel Expenses	$ 619.84
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
11	Yes	$ 14,731.05	No	Yes	Other Meds, Mileage, Parking	$ 382.63
3	Yes	$ 4,037.31	Unknown	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -
11	Yes	$ 14,670.70	Unknown	No	N/A	$ -
3	Yes	$ 4,109.76	Unknown	Yes	Traveling Expenses	$ 239.50
3	Yes	$ 4,037.31	Unknown	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,109.76	Unknown	Yes	Travel Expenses	$ 86.12
6	Yes	$ 8,002.20	Unknown	Yes	Parking	$ 22.50
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 126.50
12	Yes	$ 16,004.40	Unknown	Yes	Mileage	$ 570.00
7	Yes	$ 9,589.44	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -

6	No	$ -	Unknown	Yes	Traveling Expenses	$ 395.08
12	Yes	$ 16,149.24	Unknown	No	N/A	$ -
12	Yes	$ 16,004.40	Unknown	Yes	Other medications	$ 6.62
2	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 138.60
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 828.89
12	Yes	$ 8,002.20	Unknown	Yes	Mileage, parking, meals, other medications	$ 10,661.44
3	No	$ -	Unknown	No	N/A	$ -
10	Yes	$ 12,039.51	Unknown	Yes	Mileage , Parking, Meals, Hotel, Other Meds	$ 10,782.95
6	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	Yes	Traveling Expenses	$ 966.31
1	Yes	$ 1,369.92	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
11	Yes	$ 14,670.70	Unknown	Yes	Other Medications	$ 43.78
3	No	$ -	Unknown	Yes	Travel Expenses	$ 1,371.14
6	Yes	$ 8,002.20	Unknown	Yes	Other meds, mileage & parking	$ 3,550.35
3	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 8,219.52	Unknown	No	N/A	$ -
1	No	$ -	Unknown	No	N/A	$ -

6	Yes	$ 8,002.20	Unknown	No	N/A	$ -
6	Yes	$ 8,074.64	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
11	Yes	$ 14,670.70	Yes	Yes	Other medications	$ 492.90
3	Yes	$ 4,109.76	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
4	Yes	$ 5,479.68	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 2,618.00
2	Yes	$ 2,667.40	Unknown	Yes	Other meds, mileage & parking	$ 2,244.21
3	No	$ -	Unknown	Yes	Traveling Expenses	$ 30.02
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
7	Yes	$ 9,335.90	Unknown	Yes	Mileage	$ 73.46
3	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	No	N/A	$ -
9	Yes	$ 12,039.51	No	Yes	Other Meds, mileage, parking	$ 405.20
6	Yes	$ 8,219.52	Unknown	Yes	Travel Expenses	$ 402.00
6	Yes	$ 8,219.52	Unknown	Yes	Traveling Expenses	$ 2,911.26
3	No	$ -	Unknown	Yes	Travel Expenses	$ 1,318.28
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 8,074.62	Unknown	No	N/A	$ -

3	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	No	N/A	$ -
1	No	$ -	Unknown	No	N/A	$ -
6	Yes	$ 8,002.20	Unknown	Yes	Other Meds, mileage, parking & meals	$ 2,101.46
6	Yes	$ 2,691.54	Unknown	No	N/A	$ -
11	Yes	$ 14,670.70	No	Yes	Mileage, parking, meals	$ 1,666.42
3	No	$ -	Unknown	No	N/A	$ -
3	Yes	$ 4,037.31	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Travel Expenses	$ 357.59
3	Yes	$ 4,037.31	Unknown	Yes	Other Meds + Travelling Expense	$ 350.52
2	No	$ -	Unknown	No	N/A	$ -
6	No	$ -	Unknown	No	N/A	$ -
3	No	$ -	Unknown	Yes	Other Meds	$ 157.00
3	No	$ -	Unknown	No	N/A	$ -
4	Yes	$ 5,334.80	Unknown	No	N/A	$ -
		$ 1,137,125.40				**$ 289,825.87**