Court File No. 98-CV-141369 CP00

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

DIANNA LOUISE PARSONS, deceased
by her Estate Administrator, William John Forsyth,
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

C A N A D A

PROVINCE OF QUÉBEC

DISTRICT OF MONTRÉAL

SUPERIOR COURT

Class action

NO : 500-06-000016-960

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

C A N A D A

PROVINCE OF QUÉBEC

DISTRICT OF MONTRÉAL

SUPERIOR COURT

Class action

NO : 500-06-000068-987

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

FACTUM/SUBMISSIONS/WRITTEN ARGUMENT OF THE JOINT COMMITTEE
(FUND SUFFICIENCY 2013 - ALLOCATION APPLICATIONS)

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PART I - OVERVIEW

1. Sixteen years ago, the Courts approved a hard choice made by the representative plaintiffs on behalf of class members and family class members. In the face of a lot of unknown variables about the Hepatitis C Virus ("**HCV**") as a chronic progressive disease and about how many persons were infected with HCV through the blood supply between 1986 and 1990, class members and family class members accepted the risk of whether the capped settlement funds paid by the federal, provincial and territorial governments (the "**FPT Governments**") in exchange for full and final releases from all class members and family class members would be enough to pay a compromised schedule of benefits. At that time, the chance that there would be unallocated assets in the trust was only hypothetical. But the forbearance of class members, skilled management of risk, and some luck made the hypothetical a reality and made this application possible.

2. The Joint Committee requests that the Courts exercise their unfettered discretion to allocate actuarially unallocated money and assets (the "**Excess Capital**"), held by the Trustee of the 1986-1990 Hepatitis C Settlement Agreement (the "**Settlement Agreement**") as at December 31, 2013, for the benefit of class members and family class members by approving nine recommendations aimed at ameliorating some of the compromises class members and family class members made. The Joint Committee also seeks an order that the competing application by the Attorney General of Canada ("Canada"), requesting that the Excess Capital be paid to it, be dismissed.

3. These applications pertaining to Excess Capital are before the Courts because at the time of the approval of the Settlement Agreement, the Courts recognized that the scheduled benefits provided to class members and family class members under the Transfused HCV Plan and the Hemophiliac HCV Plan (the "**Plans**") were not ideal as they were based on making them "fit" within the maximum global amount the FPT Governments were prepared to pay, were subject to various caps and holdbacks, and subject to fluctuation such that they were not guaranteed. The Courts further recognized that because the FPT Governments' financial liability was capped under the settlement, class members solely bore the risk that the Trust to be established would be financially insufficient to provide even the scheduled benefits. In the circumstances, the Courts were not prepared to approve the Settlement Agreement "as is", as it mandated any surplus to revert to the FPT Governments after the settlement had been fully administered. In the interest

of fairness, the Courts required the Settlement Agreement to be amended to permit class members and family class members to share in any surplus that might arise in the future.

4. Following a further round of negotiations, the parties presented consent orders to the Ontario and British Columbia Courts, which approved the Settlement Agreement, subject to various amendments, including a provision which conferred on the Courts "unfettered discretion" to order, from time to time, at the request of the Joint Committee or any party, that all or any portion of the money or other assets that are held by the Trustee and are "actuarially unallocated" be allocated for the benefit of class members and/or family class members, allocated in any manner that may reasonably be expected to benefit class members and/or family class members even though the allocation does not provide for monetary relief to individual class members and/or family class members, paid in whole or in part to the FPT Governments or one of them considering the source of money or other assets comprising the Trust Fund, and/or or retained in whole or in part within the Trust Fund (the "**Allocation Provisions**").

5. The unfettered discretion conferred upon the Courts in the Allocation Provisions is only subject to two limitations: (1) reasonableness in all of the circumstances; and (2) geographic equality, in that there shall be no discrimination based upon where the class member received blood or where they reside. While ten factors the Courts may consider in exercising their unfettered discretion are included in the Allocation Provisions, the parties' negotiated language specifically provides that the Courts "may consider, but are not bound to consider" those factors. The Courts of Ontario and British Columbia approved the consent orders and identical provisions were incorporated into a Schedule F to the Settlement Agreement approved by the Superior Court of Québec.

6. Following the triennial financial sufficiency review triggered on December 31, 2013, the Courts issued consent orders and a judgment declaring that, as of December 31, 2013, the trust assets exceeded the liabilities by an amount between $236,341,000, calculated by the Joint Committee's actuaries, and $256,594,000, calculated by Canada's actuaries.

7. However, those amounts did not account for potential reclassification of class members and their consequent eligibility for fixed payment compensation set out in the Plans where they meet the court-approved protocol for treatment. This results in an increase in liabilities of

$29,421,000, which the Joint Committee submits ought to reduce its estimate of the actuarially unallocated money and assets as of December 31, 2013 from $236,341,000 to $206,920,000. This position is consistent with the Joint Committee's fiscally conservative stance through the history of the Settlement Agreement and is taken to ensure that the risks to which class members are exposed are appropriately managed. While Canada's actuaries' calculation of this liability is not materially different, they do not agree that a restatement is actuarially required.

8. The nine recommendations made by the Joint Committee to allocate Excess Capital for the benefit of class members and family class members are aimed at addressing certain shortfalls and compromises in compensation available to them under the existing Plans. Similar to the circumstances at the time of the original settlement approval hearings, the benefits recommended by the Joint Committee are limited by the funds available, so not all shortcomings in compensation to class members and family class members can be financially addressed at this time. The Joint Committee's recommendations represent further compromises.

9. The Joint Committee's recommended allocations are reasonable in all the circumstances and respect geographic equality. Moreover, all of the optional factors the Courts may consider in exercising their unfettered discretion fully support the recommended allocations, all of which will be paid solely from the Excess Capital so that the PT Governments, who fund their liabilities on a monthly "pay as you go" basis, will not be called upon to fund them in any way.

10. Canada's application must fail, largely because it is not grounded in fact. Canada ignores the risks assumed and successfully managed by class members and family class members and asserts entitlement to Excess Capital because it pre-funded its maximum liability and because improvements in treatment of HCV mean that surviving class members have a much greater chance of being free of the virus today than they have had in the 26-30 years they have lived with the virus.

11. While Canada pre-funded its maximum liability, the evidence, including from Canada's own actuaries, demonstrates that the Excess Capital exists because of the risk class members and family class members assumed in investing the pre-funded liability, absent which there would be a $348 million deficit. The investment strategy undertaken by class members and family class members through the Joint Committee, acting on the advice of professional advisors, was accomplished at considerable cost to them. It would be manifestly unreasonable

and unfair to reward Canada with any portion of the Excess Capital, when class members and family class members not only bore all risks, but also bore all of the costs to achieve this positive result.

12. Nor is the so-called "cure" a panacea. Many class members have died of HCV. Those who have survived have lived with permanent degradation of their livers, physically debilitating treatment, the social stigma of having Hepatitis C, the fear of infecting loved ones, the fear of still being at increased risk of developing liver cancer, and the fear of dying. Painfully.

13. The compromises necessary to reach this settlement resulted in class members and family class members enduring sixteen years of compromised benefits under the Plans, which the Joint Committee's recommendations seek to somewhat ameliorate with the funds available at this time. Tragically, for many class members and family class members, it is too late. The Joint Committee requests that its applications be granted and that the Courts do so expeditiously and uniformly, so that sick and aging class members and family class members will receive some of the additional compensation that they justly deserve.

PART II - THE FACTS

A. The Underlying Litigation

14. Between 1996 and 1998, class actions were commenced in each of British Columbia, Québec and Ontario seeking damages for personal injury and wrongful death on behalf of transfused persons and persons with hemophilia who received blood or certain blood products in Canada between January 1, 1986 and July 1, 1990 and were infected with HCV. The Ontario actions included claims for persons wherever located who were not included in the British Columbia and Québec actions and claims in respect of certain Family members of infected persons.[1]

15. The defendants in the various actions included the Canadian Red Cross Society and The Attorney General of Canada and, in their respective province, Her Majesty the Queen in Right of the Province of British Columbia, le Gouvernement du Québec, or Her Majesty the Queen in

[1] Affidavit #13 of Heather Rumble Peterson, sworn October 16, 2015 [Peterson Affidavit #13] Joint Record [**JR**] Vol. 2, Tab 12, para 2, pp. 349-350.

Right of Ontario. The provinces and territories not originally named as defendants in the Ontario transfused action were given notice in September 1997 of an intended transfused action and they ultimately became intervenors in the Ontario actions, making the class actions, when viewed collectively, national in scope.[2]

16. Following certification the parties entered into settlement discussions.

B. The Settlement Agreement

17. The Settlement Agreement is the culmination of over 18 months of intense negotiations, provisional court approvals, and further negotiations that led to consent Approval Orders that amended the Settlement Agreement that the Courts ultimately approved. While the Settlement Agreement was influenced by a variety of complex considerations, including anticipated class size, disease modeling, and damages,[3] four key issues truly divided the parties and formed the cornerstone of the agreement. As discussed below, these issues were: (1) how much funding the FPT Governments would provide; (2) who would bear the risk of a funding insufficiency; (3) how would class members and family class members be compensated; and, (4) what would happen to any surplus if it should arise?

i. Negotiations Leading to the Settlement Agreement

18. From the very beginning of negotiations, negotiators on behalf of the FPT Governments ("**FPT Counsel**") were adamant that the FPT Governments' funding liability had to be capped. This was initially made clear in the first face-to-face settlement discussions on February 6, 1998. During the course of those preliminary discussions, government representatives explained that they could not make commitments for future governments; a single final sum had to be agreed upon at the time of settlement.[4]

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[2] Peterson Affidavit #13, JR Vol. 2, Tab 12, para 3, p. 350.

[3] Affidavit of Heather Rumble Peterson, sworn November 23, 1999 [**November 1999 Peterson Affidavit**], JR Vol. 13, Tab 34, para. 48, p. 4287.

[4] Affidavit of Asvini Krishnamoorthy, sworn January 29, 2016 [**Krishnamoorthy Affidavit**], JR Vol. 9, Tab 28, Exhibit O, Affidavit of J.J. Camp, sworn July 12, 1999 [**Camp Affidavit**] para. 48, p. 3412 and Exhibit "O" Letter from Camp, pp. 3507-3513.

19. Shortly thereafter, on March 27, 1998, the FPT Governments publically announced that they were prepared to offer up to $1.1 billion to settle with 1986-1990 Hepatitis C claimants.[5] FPT Counsel repeatedly confirmed during the course of negotiations that the $1.1 billion figure was the absolute ceiling – a ceiling which could not be exceeded, but which could be lowered.[6]

20. The FPT Governments' cap on the settlement amount stalled the negotiations. As a result of diametrically different views of the disease profile of the class, the negotiators on behalf of the class ("**Class Counsel**") and FPT Counsel could not agree on the costing of different settlement proposals.[7] FPT Counsel viewed the settlement proposals made by Class Counsel as too costly.[8] In particular, the FPT Counsel were unprepared to accept the loss of income, loss of support and future care costs compensation sought by Class Counsel.[9]

21. As a result, Class Counsel became increasingly convinced that the only way to achieve an acceptable level of compensation was for the class members and family class members to bear the risk of fund insufficiency. Otherwise, the FPT Governments would continue to insist on a significant buffer between the projected actuarial cost of the compensation promised and the $1.1 billion ceiling, thereby substantially reducing the level of compensation paid to class members and family class members.[10]

22. On November 2, 1998, the parties overcame this hurdle when FPT Counsel agreed to negotiate on the basis that the FPT Governments would agree to a settlement amount of $1.1 billion, and the class would bear the risk of fund insufficiency.[11] Following this breakthrough, the parties were able to reach a Framework Agreement on December 18, 1998.[12]

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[5] Camp Affidavit, JR Vol. 9, Tab 28, para. 54, pp. 3413-3414.

[6] Camp Affidavit, JR Vol. 9, Tab 28, para. 65, pp. 3418-3419; November 1999 Peterson Affidavit, JR Vol. 13, Tab 34, para. 31, pp. 4280-4281.

[7] Camp Affidavit, JR Vol. 9, Tab 28, paras. 89, pp. 3427, 93-95, pp. 3428, 98, p. 3430, 99-100, pp. 3430-3431,104, p. 3432,106, p. 3433; November 1999 Peterson Affidavit, JR Vol. 13, Tab 34, paras. 61-62, p. 4292.

[8] Camp Affidavit, JR Vol. 9, Tab 28, paras. 69, p. 3420 79, p. 3423, 82, p. 3424, and Exhibit "OO" Letter from Camp, pp. 3625-3636.

[9] Camp Affidavit, JR Vol. 9, Tab 28, para. 106, p. 3433.

[10] Camp Affidavit, JR Vol. 9, Tab 28, para. 105, p. 3432.

[11] Camp Affidavit, JR Vol. 9, Tab 28, para. 109, p. 3434 and Exhibit "EEE" Letter from Camp, pp. 3706-3707.

[12] Camp Affidavit, JR Vol. 9, Tab 28, paras. 110-114, pp. 3434-3435.

23. The Framework Agreement reflected the staged approach to compensation desired by Class Counsel, where compensation was based on the severity of a class member's medical condition and the progression of the disease, as well as compensation for loss of income, loss of support and future cost of care. In order to ensure the sufficiency of the $1.1 billion, restrictions and holdbacks and other compromises on scheduled compensation were established. The Framework Agreement contemplated that holdbacks and restrictions could be reduced or removed if a surplus developed.[13]

24. After the parties agreed on the Framework Agreement, additional issues arose as the parties formalized the agreement. One particularly contentious issue was the amount of interest that would be paid on the settlement funds. The Framework Agreement contemplated that the FPT Governments would notionally invest the settlement funds and guarantee interest on them at a rate equivalent to long-term Government of Canada Bonds.[14] This was later sought to be changed by the FPT Governments to the lower Treasury Bill Rate.[15] The issue was resolved by the Federal Government agreeing to pay to a trustee 8/11ths of the settlement amount ($846,327,527 plus interest) upon settlement approval, who would invest the money based on investment recommendations (which would exceed the Treasury Bill Rate).[16] The interest gains would then be applied to the settlement amount.[17] The PT Governments could pay their respective shares on a pay as you go basis with interest attributed at the Treasury Bill Rate. Subsequently the FPT Governments agreed that the interest earned on the settlement fund would be tax free.[18]

25. The Settlement Agreement was finally concluded in June, 1999, and then required court approval in Ontario, British Columbia, and Québec, the three provinces where class proceedings had been certified.[19]

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[13] November 1999 Peterson Affidavit, JR Vol. 13, Tab 34, Exhibit "P" Letter from Strosberg, pp. 4611-4620.

[14] Camp Affidavit, JR Vol. 9, Tab 28, para. 119(a), pp. 3437-3438.

[15] Camp Affidavit, JR Vol. 9, Tab 28, para. 119(a), pp. 3437-3438 and Exhibit "KKK" Letter from Whitehall, pp. 3750-3752.

[16] Camp Affidavit, JR Vol. 9, Tab 28, para. 119(a) , pp. 3437-3438 and Exhibit "LLL" Letter from Strosberg, pp. 3753-3756.

[17] November 1999 Peterson Affidavit, JR Vol. 13, Tab 34, para. 78, pp. 4297-4298.

[18] November 1999 Peterson Affidavit, JR Vol. 13, Tab 34, para. 84(b), p. 4301.

[19] Camp Affidavit, JR Vol. 9, Tab 28, para. 121, p. 3439.

ii. The Settlement Approval Process

26. In reasons for decision dated September 22, 1999, Justice Winkler (as he then was) of the Ontario Superior Court of Justice provisionally approved the settlement, but identified three areas of concern and afforded Class Counsel and the FPT Governments an opportunity to address those concerns with changes to the settlement.[20]

27. The area of concern relevant to the issues under consideration was the provision at section 12.03(3) of the Settlement Agreement, which mandated that any surplus assets in the Trust revert to the FPT Governments following termination of the Settlement Agreement. At the time, it was not known whether there would ever be a surplus. Indeed, a deficit of more than $58.5 million was projected if the settlement benefits and other liabilities were paid in the absence of the holdbacks and restrictions on class member compensation (discussed at paragraphs 77 to 81 below), which Justice Winkler characterized as "significant".[21]

28. Justice Winkler went on to consider whether it was appropriate for any surplus to revert entirely to the defendants in the context of this particular settlement given that the amount of compensatory benefits assigned to class members and family class members at different levels was not ideal, but rather "largely influenced by the total of the monies available for allocation"[22] and that class members bore the risk of insufficiency.[23] He concluded it was not appropriate.

> The court is asked to approve the settlement even though the benefits are subject to fluctuation and regardless that the defendants are not required to make up any shortfall should the Fund prove deficient. This is so notwithstanding that the benefit levels are not perfect. It is therefore in keeping with the nature of the settlement and in the interests of consistency and fairness that some portion of a surplus may be applied to benefit class members.[24]

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[20] *Parsons v. Canadian Red Cross Society*, [1999] O.J. No. 3572 (S.C.J.)[***Parsons***], JR Vol. 22, Tab 51, at paras. 129, 132, p. 7633.

[21] *Parsons*, JR Vol. 22, Tab 51, para. 59, p. 7618, para. 107, p. 7628, para. 114, p. 7630, para. 131, p. 7633.

[22] *Parsons*, JR Vol. 22, Tab 51, para. 104, p. 7628.

[23] Affidavit of R. Douglas Elliott, sworn July 12, 1999 **[Elliott Affidavit]**, JR Vol. 12, Tab 32, para. 202, pp. 4148-4149.

[24] *Parsons*, JR Vol. 22, Tab 51, para. 122, p. 7631.

29. In Justice Winkler's view, the requirement that a potential surplus in the Trust could go to the benefit of the class, instead of the FPT Governments, was not a material change to the agreement:

> The changes to the settlement required to obtain the approval of this court are not material in nature when viewed from the perspective of the defendants… The change required in respect of the surplus provision resolves the anomaly of tying up any surplus for the entire 80 year period of the administration of the settlement. In any event, given the projected $58,000,000 deficit, the question of a surplus is highly conjectural.[25]

30. Justice Smith of the British Columbia Supreme Court concurred with Justice Winkler that these modifications were required. Concerning the compensation payable to class members under the settlement he said:

> However, this is not a situation where the parties have negotiated the global settlement amount by estimating its constituent parts, as is the usual case in litigation. Here, the global amount was predetermined, and the benefits payable had to be made to fit within it. As well, it is a term of the settlement that the claimants bear the risk of insufficiency of the fund.[26]

iii. The Allocation Provisions

31. Initially, the FPT Governments were not prepared to accept the change to the reversion of any surplus funds required by Justice Winkler. FPT Counsel took the position that the modification was "material", and that if Class Counsel did not agree to jointly go back to Justice Winkler to request that the change be abandoned, the FPT Governments would argue that there had been no court approval of the Settlement Agreement. Class Counsel refused to go back to Justice Winkler to request the change, and the FPT Governments ultimately relented.[27]

32. Together, Class Counsel, FPT Counsel, and the intervenors that had participated in the settlement approval motion drafted consent orders to address the Courts' concerns, which specifically amended the Settlement Agreement as follows:[28]

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[25] *Parsons*, JR Vol. 22, Tab 51, para. 131, p. 7633.

[26] *Endean v. Canadian Red Cross Society*, [1999] B.C.J. No. 2180 (S.C.) [***Endean***], JR Vol. 22, Tab 53, at para. 8, p. 7677, para. 22, pp. 7679-7680.

[27] November 1999 Peterson Affidavit, JR Vol. 13, Tab 34, para. 93, pp. 4307-4308.

[28] November 1999 Peterson Affidavit, JR Vol. 13, Tab 34, para. 96, p. 4309.

> 9. THIS COURT ORDERS AND ADJUDGES that the Agreement, annexed hereto as Schedule 1, and the Funding Agreement, annexed hereto as Schedule 2, both made as of June 15, 1999 are fair, reasonable, adequate, and in the best interests of the Ontario Class members and the Ontario Family Class members in the Ontario Class Actions and **this good faith settlement of the Ontario Class Actions is hereby approved on the terms set out in the Agreement and the Funding Agreement, both of which form part of and are incorporated by reference into this judgment, subject to the following modifications, namely:**
>
> ...
>
> (b) in their unfettered discretion, the Courts may order, from time to time, at the request of any Party or the Joint Committee, that all or any portion of the money and other assets that are held by the Trustee pursuant to the Agreement and are actuarially unallocated be:
>
> (i) allocated for the benefit of the Class Members and/or the Family Class Members in the Class Actions;
>
> (ii) allocated in any manner that may reasonably be expected to benefit Class Members and/or the Family Class Members even though the allocation does not provide for monetary relief to individual Class Members and/or Family Class Members;
>
> (iii) paid, in whole or in part, to the FPT Governments or some or one of them considering the source of the money and other assets which comprise the Trust Fund; and/or
>
> (iv) retained, in whole or in part, within the Trust Fund;
>
> in such manner as the Courts in their unfettered discretion determine is reasonable in all of the circumstances provided that in distribution there shall be no discrimination based upon where the Class Member received Blood or based upon where the Class Member resides;[29]
>
> [Emphasis added]

33. Justice Winkler approved and signed the consent Ontario Approval Order a month after his decision was released, on October 22, 1999.

34. A substantially similar consent Approval Order was signed by the Supreme Court of British Columbia on October 28, 1999. It sets out the Allocation Provisions at paragraph 5(b).[30]

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[29] Ontario Approval Order, JR Vol. 22, Tab 52, para. 9(b), pp. 7648-7649.

[30] BC Approval Order, JR Vol. 22, Tab 54, para. 5(b), pp. 7697-7698.

35. A substantially similar Approval Order was issued by the Superior Court of Québec on November 19, 1999, through the addition of Schedule F Modification Number 1 to its prior Approval Order dated September 21, 1999.

iv. The Optional Factors for Consideration

36. The consent Approval Orders in Ontario and British Columbia and Schedule F to the Settlement Agreement in Québec (the "**Approval Orders**") set out ten factors the Courts could consider, but were not bound to consider, in exercising their unfettered discretion (the "**Optional Factors for Consideration**"). The Ontario Approval Order reads:

> (c) in exercising their unfettered discretion under subparagraph 9(b) [5(b) in the BC Approval Order and Schedule F, para 1 p.2 in Québec], the Courts may consider, but are not bound to consider, among other things, the following:
>
> (i) the number of Class Members and Family Class Members;
>
> (ii) the experience of the Trust Fund;
>
> (iii) the fact that the benefits provided under the Plans do not reflect the tort model;
>
> (iv) section 26(10) of the Act [section 34(5) of the British Columbia Class Proceedings Act, 1036 of the Civil Code of Québec of Procedure];
>
> (v) whether the integrity of the Agreement will be maintained and the benefits particularized in the Plans ensured;
>
> (vi) whether the progress of the disease is significantly different than the medical model used in the Eckler actuarial report [31] ...;
>
> (vii) the fact that the Class Members and Family Class Members bear the risk of insufficiency of the Trust Fund;
>
> (viii) the fact that the FPT Governments' contributions under the Agreement are capped;
>
> *(ix)* the source of the money and other assets which comprise the Trust Fund; and
>
> *(x)* any other facts the Courts consider material.
>
> [Added]

[31] Krishnamoorthy Affidavit, JR Vol. 8, Tab 28, Exhibit K 1999 Eckler Actuarial Report, pp. 2945-2948.

v. Key Features of the Settlement Agreement as Amended

37. For the purposes of these allocation applications, the key terms of the Settlement Agreement, as amended by the Approval Orders, are as follows:

(a) the FPT Governments agreed to contribute up to a maximum of $1.118 billion to a Trust Fund that would be administered on behalf of class members and family class members, with the Federal Government paying 8/11ths of this amount upon approval of the settlement by the Courts of Ontario, British Columbia. and Québec and with the PT Governments paying 3/11ths of this amount on a "pay as you go" basis;[32]

(b) the FPT Governments are relieved of all obligations other than to provide the funding promised, even if the amounts are insufficient to make all of the payments contemplated by the Settlement Agreement;[33]

(c) class members who did not opt-out of the actions released the FPT Governments (and others) from all claims they had or may thereafter have;[34]

(d) scheduled benefits payable to class members and family class members are set out in the Plans, but were subject to certain holdbacks and restrictions in order to ensure fund sufficiency;

(e) at the request of a Party or the Joint Committee, the Courts can order that a surplus in the Trust Fund be allocated to the benefit of class members and family class members, repaid to the FPT Governments, or continue to be held in the Trust Fund;[35] and

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[32] Funding Agreement, Schedule "D" to the Settlement Agreement [**Funding Agreement**], JR Vol. 21, Tab 49D, s. 2.01, p. 7457, Article 4, pp. 7459-7460.

[33] Settlement Agreement, JR Vol. 21, Tab 49, s. 1.10, p. 7320, s. 4.01, p. 7322; Funding Agreement, JR Vol. 21, Tab 49D, s. 3.03, p. 7458, s. 4.05, p. 7460.

[34] Settlement Agreement, JR Vol. 21, Tab 49, s. 1.01, pp. 7314-7319; Ontario Approval Order, JR, Vol. 22, Tab 52, para. 30, p. 7663, paras. 33-35, pp. 7662, 7664-7665; BC Approval Order, JR Vol. 22, Tab 54, paras. 29-31, pp. 7709-7711; Québec Schedule F, JR Vol. 22, Tab 57, para. 1 p.1) p. 7755**.**

[35] Ontario Approval Order, JR Vol. 22, Tab 52, para. 9(b), pp. 7648-7649; BC Approval Order, JR Vol. 22, Tab 54, para. 5(b), p. 7697-7698; Québec Schedule F, JR Vol. 22, Tab 57, para. 1 p.1) p. 7755.

(f) subject to the Allocation Provisions, at the termination of the settlement, any remaining monies revert to the FPT Governments.[36]

vi. Scheduled Benefits Payable Under the Plans

38. The scheduled benefits provided to class members and family class members under the settlement are restricted to those set out in the Plans. A summary of those benefits is set out below and in the chart appended hereto at Schedule C. All amounts payable under the Plans are expressed in 1999 dollars. Those amounts are inclusive of prejudgment interest or other amounts and do not accrue interest, except as specifically provided. Most payments are indexed annually by the Canadian Pension Index as provided.[37] Amounts expressed in 1999 dollars can be converted to their approximate 2014 dollar equivalent by multiplying them by 1.35.[38]

Fixed Payments for Pain and Suffering

39. Compensation for general damages is based on the severity of a class member's medical condition, using a six level scale. The fixed payment grid set out in the Plans is based on pre-determined disease states, which track the most commonly utilized method of staging fibrosis caused by HCV infection:

(a) F0 – no fibrosis (disease levels 1 and 2 in the Plans);

(b) F1 – minimal fibrotic changes which do not extend beyond the portal areas (included in disease level 3 in the Plans);

(c) F2 – fibrotic changes to portal areas with short extensions (included in disease level 3 in the Plans);

(d) F3 – fibrotic changes to the liver known as bridging fibrosis (corresponds to disease level 4 in the Plans); and

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[36] Ontario Approval Order, JR Vol. 22, Tab 52, para. 38; p. 7667; BC Approval Order, JR Vol. 22, Tab 54, para. 34, p. 7712.

[37] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.09, p. 7368, s. 7.02, p. 7372, s. 7.03(2), pp. 7372-7373; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.09, p. 7415, s. 7.02, p. 7420, s. 7.03(2), pp. 7420-7421.

[38] Affidavit #4 of Peter Gorham, sworn April 8, 2015 [**Gorham Affidavit #4**], JR Vol. 20, Tab 48, Exhibit B, para. 224, p. 7257.

(e) F4 – cirrhosis – fibrotic changes which have become cirrhotic (corresponds to disease level 5 in the Plans).[39]

40. A fixed payment, ranging from $10,000 at disease level 1 to $100,000 at disease level 6, is payable based on disease level at the time of initial claim approval with eligibility for further fixed payments if health deteriorates and the medical criteria for the next level are met.

41. Fixed payments are cumulative. The maximum amount of fixed payments payable to a class member under the Plans is $225,000.[40] As of January 1999, the maximum amount recoverable for general damages under the trilogy of cases in the Supreme Court of Canada was $260,500.[41]

42. The Plans initially imposed a restriction or holdback on a portion of the disease level 2 payment.[42] This restriction was subsequently lifted as described in paragraph 78 below.

Loss of Income

43. Class members at disease level 4 or higher who are disabled from working at their employment in whole or in part and class members at disease level 3 who are 80% disabled from performing their usual employment and elect to forego the $30,000 fixed payment at that disease level may claim loss of income.

44. Loss of income is calculated net of all income other than earned income and paid net of income tax and all collateral benefits received by the class members. It ceases when the class member reaches age 65.[43]

45. The Plans initially imposed two restrictions or holdbacks on loss of income claims: claims are calculated on pre-claim gross earned income to a maximum of $75,000; and, only

[39] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 19-23, pp. 6833-6834, paras. 27-28, p. 6835.

[40] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.01 pp. 7360-7363; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.01, pp. 7407-7409.

[41] Elliott Affidavit, JR Vol. 12, Tab 32, para. 174, p. 4140.

[42] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.01(1),(b), p. 7361; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.01(1),(b), p. 7407.

[43] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.02, pp. 7363-7366; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.02, pp. 7409-7412.

70% of the annual loss of net income calculated was payable initially.[44] These restrictions were subsequently lifted or varied by the Courts as described in paragraphs 79 to 80 below.

Loss of Services in the Home

46. Class members at disease level 4 or higher who normally performed household duties in the home (and class members at disease level 3 who make the election discussed above) may claim for loss of services in the home at a rate of $12 per hour to a maximum of $240/week, equivalent to 20 hours per week. Loss of income and loss of services in the home are alternative benefits, a class member cannot claim both in respect of the same time period.[45]

Cost of Care

47. A class member at disease level 6 who incurs care costs due to HCV that are not recoverable under any public or private health care plan is entitled to be reimbursed those costs to a maximum of $50,000 per calendar year.[46]

Compensable HCV Drug Therapy

48. A class member at disease level 3 or higher who takes Compensable HCV Drug Therapy is entitled to be paid $1,000 for each completed month of therapy.[47] Compensable HCV Drug Therapy is defined as: interferon or ribavarin, alone or in combination, or any other treatment that has a propensity to cause adverse side effects that has been approved by the Courts for compensation.[48]

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[44] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.02, pp. 7363-7366; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.02, pp. 7409-7412.

[45] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.03, p. 7366; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.03, pp. 7412-7413.

[46] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.04, p. 7367; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.04, pp. 7413-7414.

[47] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.05, p. 7367; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.05, p. 7414.

[48] Transfused Plan, JR Vol. 21, Tab 49A, s. 1.01, p. 7348; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 1.01, p. 7394.

Uninsured Treatment and Medication Cost

49. Class members at any disease level may claim reimbursement for uninsured treatment and medication costs due to their HCV infection.[49]

Out-of-Pocket Expenses

50. Class members at any disease level may claim reimbursement for uninsured out-of-pocket expenses attributable to their HCV infection based on rates contained in the *Financial Administration Act* regulations.[50]

$50,000 Election for Co-Infected Hemophiliacs

51. Hemophiliac class members who are co-infected with HIV may elect to be paid $50,000 in full satisfaction of all claims, past, present or future, including potential claims by their dependents or other Family members.[51]

Compensation where class member died *before* January 1, 1999

52. For class members who died prior to January 1, 1999, the Plans provide that their death must have been caused by HCV for any benefits to become payable to their estate, dependants and family members. Where this condition is satisfied, the Plans provide these options:

> (a) the estate may claim an all inclusive sum of $50,000 in respect of pre-death losses, plus up to $5,000 for reimbursement of uninsured funeral expenses. The dependants may claim post-death loss of services in the home or loss of support (described below). Family class members may claim loss of guidance, care and companionship payments in accordance with the family class member payments (described below);[52]

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[49] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.06, p. 7367; Hemophiliac Plan, JR Vol. 21, Tab 49B, s.4.06, p. 7414.

[50] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.07, p. 7368; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.07, pp. 7414-7415.

[51] Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.08(2), p. 7415.

[52] Transfused Plan, JR Vol. 21, Tab 49A, s. 5.01(1), p. 7369; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 5.01(1), p. 7416.

(b) alternatively, the estate, dependants and the family class members may agree to collectively claim an all inclusive lump sum of $120,000, plus up to $5,000 for reimbursement of uninsured funeral expenses in full satisfaction of all their claims;[53] or

(c) alternatively, in the case of hemophiliac class members who were co-infected with HIV, their estate, dependents and other family class members may collectively claim $72,000 in full satisfaction of all their claims without proof of death due to HCV.[54]

Compensation where class member died *after* January 1, 1999

53. The estate of a class member who dies after January 1, 1999 may claim any benefits the deceased class member would have been entitled to claim while alive which had not already been paid out. If the death was caused by his/her HCV infection, his/her dependants may claim post-death loss of services in the home or loss of support and family class members may claim loss of guidance, care and companionship payments in accordance with the family class member fixed payments.[55]

Family class member fixed payments

54. Approved family members of a class member whose death was caused by his/her HCV infection are entitled to fixed payments for loss of guidance, care and companionship (unless they chose one of the joint payment options described above), ranging from $500 for a grandchild to $25,000 for a Spouse.[56]

Loss of support

55. Approved dependants of a class member whose death was caused by his/her HCV infection who were living with the class member at the time of death are entitled to claim loss of support calculated in the same manner as the loss of income less a 30% discount to offset that portion of income the wage earner would have expended on his/herself while alive. As with

[53] Transfused Plan, JR Vol. 21, Tab 49A, s. 5.01(2), p. 7369; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 5.01(2), p. 7416.

[54] Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 5.01(4), pp. 7416-7417.

[55] Transfused Plan, JR Vol. 21, Tab 49A, s. 5.02(1), pp. 7369-7370; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 5.02(1), p. 7417.

[56] Transfused Plan, JR Vol. 21, Tab 49A, s. 6.02, p. 7371; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 6.02, pp. 7418-7419.

a loss of income claim, a loss of support claim ceases upon the date of what would have been the class member's 65th birthday, at which time the dependant may switch to a claim for loss of services in the home.[57]

Dependant's Loss of Services Claim

56. A dependant living with a class member at the time of the class member's death caused by HCV infection may claim for loss of the class member's services in the home as an alternative to a loss of support claim. A loss of services claim is payable until the earlier of the death of the dependant or the statistical lifetime of the deceased class member calculated without regard to his/her HCV infection.[58]

C. Compromises in Scheduled Benefits

57. In order to make compensation fit within the global settlement amount available, several benefits that would otherwise be available under the tort model and civil law compensation principles had to be compromised. The compromised benefits include:

(a) cost of care:

(i) compensation for skilled care or family provided care to the class member is compensable only for disease level 6 instead of based on proof of need;

(ii) the amount paid for cost of care is capped;

(iii) loss of the class member's services in the home are only compensated at disease level 4 or higher (unless the class member foregoes the disease level 3 fixed payment)) and only as an alternative to loss of income or loss of support. Compensation is limited to a scheduled hourly rate capped at 20 hours per week, regardless of the actual circumstances of the class member; and

[57] Transfused Plan, JR Vol. 21, Tab 49A, s. 6.01, p. 7370; Hemophiliac Plan, JR Vol. 21, Tab 49B, s.6.01, p. 7418.

[58] Transfused Plan, JR Vol. 21, Tab 49A, s. 6.01(2),(3), p. 7370; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 6.01(2),(3), p. 7418.

(iv) class members are required to exhaust their private or public health insurance or drug plans before the Plans will pay for the costs of drugs.

(b) non-pecuniary damages: end stage liver disease, B-cell lymphoma, renal failure, symptomatic mixed cryoglobulinemia, glomeronephritis requiring dialysis and hepatocellular cancer are completely disabling, life threatening and potentially life ending but the total non-pecuniary damages paid are less than the rough upper limit under the trilogy;

(c) loss of income and loss of support:

(i) deduction of collateral benefits from loss of income and loss of support awards and deduction of income tax from loss of income awards;

(ii) no compensation for pension losses or lost employment benefits; and

(iii) no income loss is paid below disease level 4 regardless of disability (unless the class member foregoes the disease level 3 fixed payment) or after age 65.

(d) wrongful death and derivative awards:

(i) payments to family class members are only after the death of a class member caused by HCV and are less than statutory amounts prescribed in some jurisdictions or awards that could be attained in other jurisdictions;

(ii) special damages: funeral expenses are capped at $5,000 regardless of the actual expense; and

(iii) the estates of persons who died before 1999 are limited to a lump sum payment regardless of the advancement of their disease or the extent of the pecuniary losses at the time of death.

58. The legal principles applicable to the compromises in scheduled benefits are addressed at paragraphs 237 to 280.

D. Other Facts Relevant to The Optional Factors for Consideration

i. The Number of Class members and Family Class members

59. At the time of the settlement approval in 1999, cohort size was acknowledged to be a major issue with major limitations on how well it could be assessed based on the available data and medical knowledge. Assumptions were made based on the best estimates available which had wide confidence intervals. The actuarial treatment of the issue was stated to be conservative because of the risk to the class members and family class members if it was wrong by a significant magnitude.[59]

60. The Courts acknowledged that the conservatism in the Eckler approach was appropriate in the circumstances, even though the conservatism meant that the benefits were less generous than they could have been had less conservative assumptions been used.[60]

61. As of December 31, 2013, there were 5,283 HCV infected class members who had been approved or who had submitted applications and were assumed to be approved. Of those: 1,585 have already died (959 due to HCV); 240 of the alive persons have already developed cirrhosis and 121 of the deceased persons have progressed to cirrhosis by the time of death; and, 137 of the alive persons have already progressed to disease level 6. Of the deceased persons, 467 had progressed to disease level 6 by the time of death.[61]

62. There were also 390 "in progress" claims as of September 30, 2015, comprised of 265 infected persons and 125 Family members, including 207 primarily infected transfused persons, 29 primarily infected hemophiliac persons and 29 secondarily infected persons. Of the infected in progress claimants, 23 had died before January 1, 1999, and 87 died after January 1, 1999, leaving 155 alive in September 2015.[62]

63. In addition to the approved and "in progress" claims as at September 30, 2015, the Administrator had received 246 late claim requests after the June 30, 2010 First Claim Deadline

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[59] *Parsons*, JR Vol. 22, Tab 51, paras. 108-111, pp. 7629-7630; Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, paras. 61-66, pp. 2010-2011.

[60] *Parsons*, JR Vol. 22, Tab 51, paras. 108-114, pp. 7629-7630; *Endean*, JR Vol. 22, Tab 53, paras. 20-22, pp. 7679.

[61] Border Affidavit #4, JR Vol. 19, Tab 45, Exhibit A, paras. 100-112, pp. 6765-6767 and Appendix A pp. 6801-6802; Gorham Affidavit #4, JR Vol. 20, Tab 48, Exhibit B, Tables 146a and 146b, pp. 7229-7230.

[62] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 23, p. 356.

from persons who do not meet the exceptions to the deadline listed in the Plans and the court-approved protocols. Over the last 3 years this averages approximately 2 such claim requests per month. The late claims situation is discussed at paragraphs 138 to 146 below.

64. Cohort size remains an unsettled issue. Over time, and with the advent and passing of the First Claim Deadline, the number of class members who will come forward and claim have become better understood. Canada's actuary compares the number of people who have come forward with what was projected and concludes the actual class is likely much smaller than what was assumed, although he concedes "we have not yet reached a stage in our analysis where we can quantify the difference."[63]

65. The number of class members who have not yet been diagnosed is still unknown. Canada's witness, Dr. Lee estimates that one quarter to one third of those at the cirrhotic stage are as yet undiagnosed.[64] He acknowledged in response to written interrogatories that there is no peer reviewed literature to assist with this issue.[65] The Joint Committee's witness, Dr. Bain, points out that to make an estimate one needs to know the total who may be infected and that simply is not known.[66] Class members who are not diagnosed are not affected by the First Claim Deadline; they are entitled to make a claim within than three years of diagnosis.

66. Dr. Lee, for Canada, says that: "… a considerable percentage of patients who have previously had a transfusion cannot recall its occurrence with certainty when asked about blood transfusions during their intake examination." He goes on to describe that the traumatic events that can lead to blood transfusion can also create fragmented memories of the nature of the treatment (ie: transfusion). He also describes how he and his clinic staff will direct persons who have had HCV and who have transfusions to the Settlement Agreement. The majority of such persons were not aware of the Settlement Agreement prior to these discussions. This continues today, more than five years after the first claims filing deadline.[67]

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[63] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 67-72, pp. 2318-2320.

[64] Affidavit #1 of Dr. Samuel S. Lee, sworn January 26, 2016 [**Lee Affidavit #1**], JR Vol. 6, Tab 27, para. 59, p. 2426.

[65] Affidavit #2 of Dr. Samuel S. Lee, sworn April 20, 2016 [**Lee Affidavit #2**], JR Vol. 11, Tab 30, Exhibit B, para. 11, p. 4073.

[66] Bain Affidavit #2, JR Vol. 5, Tab 20, para. 6, pp. 2020-2021.

[67] Lee Affidavit #1, JR Vol. 6, Tab 27, paras. 44-46, pp. 2420-2421.

67. Ultimate cohort size remains an unknown quantity and so some measure of the risk continues, albeit on a significantly reduced scale. It is dealt with in the actuarial analysis by an estimate of future claimants, a quantified liability for those claimants, and a required capital reserve. If the number is wrong, the financial impact is $5.3 million for every 25 additional persons.[68]

ii. The Experience of the Trust Fund

68. In keeping with the "hands off" bargain it struck, Canada has had nothing to do with the investments of the Trust Fund.[69]

69. To properly implement, settle and manage the Trust Fund and the investment of its assets, a structure was required, which included development of Terms of Appointment of a Trustee, Investment Manager and Investment Consultant as well as Investment Guidelines and administrative procedures.[70]

70. Class members and family class members have borne all of the costs attributable to the Trust Fund and the investment and management of its assets over the course of the 14 years to the December 31, 2013 valuation date, and will continue to do so.[71] These costs include: $232,411 directly related to establishing the Trust Fund structure and guidelines; $4,121,200 in direct investment costs; a significant portion of the costs of the administration payment structure and the general actuarial and investment advice totalling $847,488; a portion of the audit and fund sufficiency review costs of $4,666,818; and, a portion of the general administration and administrative oversight costs of $39,189,281 which pertain to the Trust Fund and investment of assets.[72]

71. Canada's actuary confirms that had the Trust Fund been invested at the Treasury Bill Rates that the PT Governments' shares have been notionally held, even with fewer

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[68] Affidavit #4 of Richard Border, re-sworn May 9, 2016, [**Border Affidavit #4**], JR Vol. 19, Tab 45, Exhibit A, paras. 100-113, pp. 6765-6767, paras. 245-246, pp. 6793-6794.

[69] Settlement Agreement, JR Vol. 21, Tab 49, s. 1.10, p. 7320, s. 4.03, pp. 7322-7323; Funding Agreement, JR Vol. 21, Tab 49D, s. 4.05, p. 7460.

[70] Peterson Affidavit #15, JR Vol. 5, Tab 18, para. 3, p. 1843.

[71] Peterson Affidavit #15, JR Vol. 5, Tab 18, para. 11, p. 1845.

[72] Peterson Affidavit #15, JR Vol. 5, Tab 18, paras. 4-7, pp. 1843-1844, and Exhibit B, pp. 1856-1866, Exhibit C, pp. 1867-1889, Exhibit D, pp. 1890-1931, Exhibit E, pp. 1932-1934.

class members there would have been an actuarial shortfall of $348 million as at December 31, 2013.[73]

iii. Disease Progression and Disease Distribution

72. At the time the Settlement Agreement was negotiated, nothing was known about disease progression in the unique cohort of persons who were infected with HCV through blood transfusion between 1986 and 1990 or who are hemophiliacs who received blood products between 1986 and 1990 and who are infected with HCV. The original medical model was based on literature and medical evidence which was not specific to such persons.[74]

73. Over the years, it was possible to begin blending the literature with data from the class members and eventually the medical model became based on the class members.[75] This did not result in an even reduction in risk over time. The changing actuarial results as impacted by changes in the medical model over time demonstrate this:[76]

(a) from settlement approval to 2001, the actuarial results deteriorated by $84 million (the liabilities increased) due to changes in the medical model combined with other experience gains or losses;

(b) from 2001 to 2004, the actuarial results improved by $5 million due to changes in the medical model combined with other experience gains or losses;

(c) from 2004 to 2007 the actuarial results deteriorated by $44 million due to changes in the medical model;

(d) from 2007 to 2010, the actuarial results deteriorated by $62 million due to changes in the medical model; and

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[73] Affidavit #5 of Peter Gorham, made January 29, 2016 [**Gorham Affidavit #5**], JR Vol. 6, Tab 26, Exhibit B, paras. 83-87, pp. 2324-2325.

[74] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, para. 62, p. 2010; Affidavit #4 of Dr. Murray Krahn, re-sworn May 4, 2016 [**Krahn Affidavit #4**], JR Vol. 20, Tab 47, Exhibit A, paras. 3, 8-9, pp. 6948 and 6953-6954.

[75] Krahn Affidavit #4, JR Vol. 20, Tab 47, Exhibit A, paras. 3-18.

[76] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, para. 60, pp. 2008-2009.

(e) from 2010 to 2013 the actuarial results improved by $305 million partially offset by $146 million in treatment costs due to changes in the medical model.

74. The single most important factor accounting for the significant improvement in actuarial results is the advances made in antiviral therapy discussed further below.

E. Financial Sufficiency

75. Several features were built into the Settlement Agreement to manage the risk of financial insufficiency including: compromises from the tort model discussed more fully at paragraphs 237 to 280 below; triennial financial sufficiency reviews; restrictions or holdbacks on some benefits with jurisdiction to vary or remove them if financial sufficiency permitted; and, jurisdiction for the Courts to alter the scheduled compensation if financial insufficiency was realized or anticipated.[77] At the time of the approval of the Settlement Agreement, there was no guarantee that the Trust would be sufficient to meet all of the claims and/or make all of the payments provided under the Plans.[78]

76. As shown by the snapshot of sufficiency review results in the chart below over the five triennial sufficiency reviews since approval of the settlement, the swings in the gains and losses of the various items that affect both assets and liabilities have been both wide and varied and starkly demonstrate the significant risks that the class members and family class members assumed and that have been successfully managed on their behalf.[79]

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[77] Settlement Agreement, JR Vol. 21, Tab 49, s. 10.01(1)(i), pp. 7327-7328.

[78] Krishnamoorthy Affidavit, JR Vol. 8, Tab 28, Exhibit K, 1999 Eckler Report, pp. 42-43 and 57, pp. 2984-2985 and 2999.

[79] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, para. 60, pp. 2008-2009.

Sources of Gains and Losses ($ millions)					
	2001	**2004**	**2007**	**2010**	**2013**
Investment gains	0	132	24	62	22
Discount rate change	**-18**	**-99**	**-12**	**-92**	0
Cohort update	222	329	148	**-42**	17
Medical model update	**-84**[80]	5[80]	**-44**	**-62**	305
Experience gains / losses			**-34**	15	14
Other assumption and method changes	**-78**	**-127**	19	**-38**	2
New Drug Cost					**-146**
Remove aggregate model simplifying assumptions/implicit margins				64	
Initial stage distribution changes			**-89**	75	
Excess HCV mortality below level 6 recognised				**-92**	
Increase Loss of Income cap			**-27**		
Lift holdbacks and caps		**-145**			
Remove opt-outs	10				
Delay in unknowns coming forward	46	4			

i. Restrictions on Payments under the Plans Varied/Removed

77. Because of the successful investment results, the three reviewable restrictions or holdbacks on payments placed in the Plans in the first instance to help address the risk of insufficient funds have been dealt with over time.

[80] For the 2001 and 2004 sufficiency reviews, the line items medical model update and other experience gains or losses were aggregated. Experience gains or losses include items such as actual loss of income being different to that assumed, actual deaths being different to that assumed, etc.

78. In or about July 2002, the Courts addressed the first restriction – the $5,000 holdback from the $20,000 fixed amount payable at disease level 2 and ordered that the restriction be deleted, the payment that was heldback be paid, and future claims at disease level 2 be paid the full $20,000 fixed payment available at that level.[81]

79. In 2004, the Courts addressed the 70% restriction on the amount of loss of income or loss of support payable and ordered that the restriction be deleted, the incremental amount be paid out, and future claims be processed and paid without this restriction.[82]

80. Also in 2004, the Courts addressed the $75,000 upper limit on gross earned income which could be used to calculate loss of income or loss of support payments and ordered that the upper limit be increased to $300,000 for calculation purposes, the incremental amount owed be paid out, and future income and support claims be processed and paid in accordance with the $300,000 gross earned income upper limit.[83]

81. The Courts again reassessed this upper limit on gross earned income used to calculate loss of income or loss of support in 2008 ordered the amendment of the section, effectively raising the gross earned income upper limit to $2.3 million, subject to a requirement to acquire pre-approval of the payment from the Court with jurisdiction where the gross earned income used in the calculation exceeded $300,000.[84] In total, the Courts have approved the past and future loss of income claims of four class members under the amended section since 2008.[85] The

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[81] Transfused Plan, s. 4.01(1)(b), JR Vol. 21, Tab 49A, p. 7361; Hemophiliac Plan, s .4.01(1)(b), JR Vol. 21, Tab 49B, p. 7407; Peterson Affidavit #13, para. 68, JR Vol. 2, Tab 12, pp. 370-371; Orders from July 2002, JR Vol. 23, Tabs 62-64, pp. 7782-7783, 7794, 7798; Orders from July 2002 regarding the $5,000 holdback: Order of the Superior Court of Ontario, JR Vol. 23, Tab 62, p. 7779; Order of the Superior Court of Québec, JR Vol.23, Tab 63, p. 7785; Order of the Supreme Court of British Columbia, JR Vol. 23, Tab 64, p. 7796.

[82] Transfused Plan, JR Vol. 21, Tab 49A, ss. 4.02, pp. 7363-7366, ss. 6.01(1), p. 7370; Hemophiliac Plan, JR Vol. 21, Tab 49(B), ss. 4.02, pp. 7409-7412, ss. 6.01(1), p. 7418; Peterson Affidavit #13, para. 69, JR Vol. 2, Tab 12, p. 371; Orders from 2004: Order of the Superior Court of Ontario, JR Vol. 23, Tab 68, p. 7864; Order of the Superior Court of Québec, JR Vol.23, Tab 69, p. 7869; Order of the Supreme Court of British Columbia, JR Vol. 23, Tab 70, p. 7876.

[83] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.02(2)(b)(i), p. 7364; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.02(2)(b)(i), pp. 7410-7411; Peterson Affidavit #13, para. 69, JR Vol. 2, Tab 12, p. 371; Orders from 2004: Order of the Superior Court of Ontario, JR Vol. 23, Tab 68, p. 7864; Order of the Superior Court of Québec, JR Vol. 23, Tab 69, p. 7869; Order of the Supreme Court of British Columbia, JR Vol. 23, Tab 70, p. 7876.

[84] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.02(2)(b)(i), p. 7364; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.02(2)(b)(i), pp. 7410-7411; Peterson Affidavit #13, para. 70, JR Vol. 2, Tab 12, p. 371; Orders from 2008: Order of the Superior Court of Ontario, JR Vol. 23, Tab 71, p. 7879; Order of the Superior Court of Québec, JR Vol. 23, Tab 72, p. 7884; Order of the Supreme Court of British Columbia, JR Vol. 23, Tab 73, p. 7892.

[85] Of the four such claims approved: one class member reached the age of 65 and has since died; one class member is now over 65 years old; one class member, whose 65th birthday is in 2024, received an income loss payment in 2014 of

Courts have not been asked to revisit this remaining restriction on loss of income or loss of support in place since 2008.

82. Eckler has advised the Joint Committee that, while it is statistically unlikely that another very large loss of income claim will be submitted, the impact of even one such claim is significant to the sufficiency analysis of the Trust.[86] In order to ensure the integrity of the Trust, the Joint Committee recommends that the restriction on maximum gross earned income that may be used to calculate income loss or support loss remain in place at this time.[87] The Federal Government concurs with this recommendation.[88]

ii. December 31, 2013 Sufficiency Review

83. In the summer of 2015, each of the Courts made an order in respect of sufficiency of the Trust (the "**Sufficiency Orders**") as follows:

> That the assets of the Trust exceed the liabilities and therefore the Trust Fund is financially sufficient as at December 31, 2013 pursuant to section 10.01(1)(i) of the January 1, 1986 to July 1, 1990 Hepatitis C Settlement Agreement.[89]

84. Subsequent to the making of the Sufficiency Orders in the preparation for these allocation hearings, the Joint Committee identified a sufficiency liability which was not reflected in the financial position of the Trust in respect of those class members at disease level 2 who transition to disease level 3 and become entitled to the $30,000 fixed payment associated with

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$1.5 million; and one class member, whose 65th birthday is in 2034, received an income loss payment in 2014 of $340,000. Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 71, pp. 371-372.

[86] Affidavit #5 of Richard Border, re-sworn May 9, 2016 [**Border Affidavit #5**], Vol. 2, Tab 13A, Exhibit A, Appendix A, para. 44, JR p. 473.

[87] Peterson Affidavit #13, JR Vol. 2, Tab12, para. 73, p. 372.

[88] Federal Government Applications: Notice of Motion of the Attorney General of Canada and Response to the Notice of Motion on the Joint Committee (Ontario), JR Vol. 1, Tab 2, para. 3, p. 44; Notice of Application and Response of the Attorney General of Canada to the Notice of Application of the Joint Committee (British Columbia), JR Vol. 1, Tab 6, para.3, p. 158; Motion from the Attorney General of Canada for the Allocation of Actuarially Unallocated Assets (Québec), JR Vol.1, Tab 10, p. 306 (4th conclusion sought).

[89] 2013 Financial Sufficiency Orders: Order of the Superior Court of Ontario made July 10, 2015, JR Vol. 23, Tab 81, p. 8006; Order of the Superior Court of Québec made on July 16, 2015, JR Vol. 23, Tab 82, p. 8012; Order of the Supreme Court of British Columbia, made July 23, 2015, JR Vol. 23, Tab 83, p. 8016.

level 3, not based upon disease progression (fibrosis) accounted for in the medical model, but rather based upon the provision in the Plans concerning Compensable HCV Drug Therapy.[90]

85. Because the medical model provides for a transition from disease level 2 to disease level 3 based solely upon disease progression and because the actuarial models are built on the medical model disease progressions, the liability for this portion of the class who transitions to disease level 3 on a different basis is not addressed in the sufficiency analysis.[91]

86. Section 4.01(1)(c) of the Plans provide for a $30,000 fixed payment to class members at disease level 3 in any one of three ways follows:

> …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;

87. A protocol developed by the Joint Committee in consultation with medical experts, and approved by the Courts, provides instruction to the Administrator in respect of evidence acceptable for the various disease level approvals including for disease level 3.[92]

88. The court-approved protocol provides three ways that Compensable HCV Drug Therapy can satisfy the disease level 3 criteria: by having undergone Compensable HCV Drug Therapy; by meeting a protocol for Compensable HCV Drug Therapy based on medical criteria (including a positive fibroscan or elevated ALTs); or, by having an HCV medical specialist certify that the person met or meets a protocol for Compensable HCV Drug Therapy consistent with the CASL Consensus Guidelines for the Management of Hepatitis C. In the case of these last two criteria, it is not necessary that the person undergo the treatment or even that the treatment be

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[90] Peterson Affidavit #15, JR Vol. 5, Tab 18, para. 12, pp. 1845-1846.

[91] Peterson Affidavit #15, JR Vol. 5, Tab 18, para. 13, p. 1846.

[92] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.01(1),(2), pp. 7360-7362; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.01(1),(2), pp. 7407-7408; Peterson Affidavit #15, JR Vol. 5, Tab 18, paras. 17-21, pp. 1847-1848, Exhibit F, pp. 1935-1942, Exhibit G, pp. 1943-1950, Exhibit H, pp. 1951-1968.

recommended; it is simply enough that the criteria is met. This is consistent with the terms of the Settlement Agreement.[93]

89. The forms completed by a physician in support of a disease level 3 classification make clear that Compensable HCV Drug Therapy means "treatment with interferon alone and/or ribavirin alone or in combination with each other or with other drugs".[94]

90. Since the introduction of direct-acting antiviral agents ("**DAA**") drugs, which can be taken without ribavirin or interferon in many cases, some claimants have taken treatment that includes ribavirin or interferon and satisfy the first branch of the protocol. Some claimants have satisfied the second branch of the protocol with medical test results. And, some claimants have been approved at disease level 3 where there is no specific evidence that they were prescribed interferon or ribavirin, but where their specialist has certified that they met the specified protocol for Compensable HCV Drug Therapy satisfying the third branch of the protocol.[95]

91. Canada's actuary questions whether disease level 2 class members who are approved for treatment with DAA drugs will or should be paid the disease level 3 payment since those drugs do not necessarily include ribavirin or interferon.[96] Since the appropriateness of this payment has been raised, the Joint Committee has instructed the Administrator to refrain from approving class members for disease level 3 based upon meeting a protocol for Compensable HCV Drug Therapy, except in the situation where interferon or ribavirin are part of the treatment until this issue is resolved.[97]

92. Morneau Shepell opines that, based on the genotypes of the disease typical in Canada, up to 60% of disease level 2 claimants could qualify for lump sum payments based on Compensable HCV Drug Therapy with ribavirin or interferon amounting to an additional liability of $21,600,000 not included in their best estimate sufficiency liabilities previously

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[93] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.01(1)(c) , p. 361; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.01(1)(c), p. 7407; Peterson Affidavit #15, JR Vol. 5, Tab 18, paras. 17-21, pp. 1847-1848.

[94] Peterson Affidavit #15, JR Vol. 5, Tab 18, Exhibit G, pp. 1943-1950.

[95] Peterson Affidavit #15, JR Vol. 5, Tab 18, para. 22, pp. 1848-1849 and Exhibit J, pp. 1986-1987, Exhibit K, pp. 1988-1990.

[96] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 12-14, p. 2307, paras. 44-45, pp. 2312-2313.

[97] Peterson Affidavit #15, JR Vol. 5, Tab 18, para. 15, pp. 1846-1847.

calculated. However, Mr. Gorham concludes no adjustment is required to recognize this liability because any lump sum payment relating to this provision has already been adequately recognized in the provision for adverse deviation and although the provision for adverse deviation will be reduced, he says that is partly offset by a change in the assumption concerning monthly compensation payments during Compensable HCV Drug Therapy after 2013.[98]

93. The Joint Committee asked its actuaries to identify the cost of the advancement from disease level 2 to disease level 3 based upon the protocol for Compensable HCV Drug Therapy on a conservative basis, ie: all disease level 2 claimants (who are not accounted for in the medical model) advance to disease level 3 in this manner. The financial consequences of this progression are approximately $29,421,000,[99] hence the Joint Committee's request for the downward restatement of the amount available to be allocated.

F. Impact of Hepatitis C on Class Members and Family Class Members

94. In order to fully appreciate the impact of HCV infection on class members, it is important to have a basic understanding of what HCV is, what HCV infection can lead to, and past and current treatments.

i. An Overview of HCV, its Effects and Treatments

95. Hepatitis means inflammation of the liver. In 75% of infected persons, HCV causes chronic, progressive and ultimately life threatening disease if left untreated or, in some cases, even if successfully treated. Until very recently, the treatment often lasted a year or longer and caused brutal side effects, with cure rates as low as 5 - 10%.[100]

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[98] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 14, p.2307, para. 26, p. 2309.

[99] Border Affidavit #5, JR Vol. 2, Tab 13A, Exhibit A, paras. 8-9, pp. 462-463.

[100] Affidavit #1 of Dr. Vince Bain, affirmed March 11, 2015 [**Bain Affidavit #1**], JR Vol. 19, Tab 46, para. 9, p. 6831, paras. 15-16, pp. 6832-6833, para. 20, p. 6833, paras. 26-29, p. 6835, paras. 33-37, pp. 6838-6839, para. 41, p. 6840, para. 50, pp. 6842-6843, paras. 55-57, pp. 6844-6845; Affidavit #2 of Dr. Vince Bain, affirmed March 31, 2016 [**Bain Affidavit #2**], JR Vol. 5, Tab 20, paras. 5-6, pp. 2016-2018.

96. HCV takes the form of six different genotypes. Certain genotypes respond less well to a given treatment than others. The virus may mutate during viral replication and possibly as a result of treatment. Mutation, in turn, may cause the virus to become resistant to treatment.[101]

97. Approximately 25% of all persons infected clear the HCV spontaneously within approximately one year of infection. Those persons will still test positive for the antibody but they will not test positive on a Polymerase Chain Reaction ("**PCR**") test, nor will they experience any progressive liver disease due to HCV.[102] Spontaneous clearance after one year post infection is rare.[103]

98. Persons who do not clear the virus after the acute stage of the illness, within approximately six months of infection, have chronic HCV. In chronic HCV, inflammation causes progressive scarring (fibrosis) and death (necrosis) of liver cells.[104]

99. Fibrosis appears in various patterns in HCV patients, and these patterns are referred to as stages. The higher the stage, the more marked the pattern of fibrosis in the liver. When the fibrosis advances enough it disrupts the liver's architecture so as to interfere with its functioning. The most commonly utilized method of staging fibrosis utilizes four stages, which co-relate to the disease levels used in the Plans, as discussed above at paragraph 39.

100. Cirrhotic patients have livers which are either compensated or decompensated. Where there are enough viable liver cells to maintain liver function, notwithstanding the cirrhotic pattern, the person has compensated cirrhosis.[105]

101. Decompensated cirrhosis, also referred to as decompensation of the liver, is included at disease level 6 in the Plans.[106] It occurs when the liver is no longer able to perform one or more of its essential functions. It is diagnosed by the presence of one or more conditions which are life

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[101] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 9-11, p. 6831.

[102] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 14-15, pp. 6832-6833.

[103] Bain Affidavit #2, JR Vol. 5, Tab 20, para. 6, p. 2057.

[104] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 16-17, p. 6833.

[105] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 26, p. 6835.

[106] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.01(1)(e), p. 7362; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.01(1)(e), p. 7408.

threatening without a transplant. This is also referred to as liver failure or end stage liver disease.[107]

102. Conditions which define liver failure include gastrointestinal haemorrhaging, ascites (fluid build up in the abdomen), and inadequate excretion of bilirubin by the liver causing jaundice or failure to remove the usual toxins absorbed from the bowel. This latter condition can affect brain cells causing drowsiness, confusion and possibly coma, known as hepatic encephalopathy. Persons with liver failure also experience protein malnutrition causing bruising, bleeding and muscle wasting. Other organ failure may occur with progressive disease most commonly involving the lungs and kidneys.[108]

103. Patients who progress to cirrhosis with or without decompensation may develop hepatocellular cancer. This is a primary form of liver cancer secondary to viral infection or cirrhosis.[109] Hepatocellular cancer is included in disease level 6 in the Plans.[110]

104. Many patients are asymptomatic prior to developing cirrhosis or hepatocellular cancer but others suffer serious symptoms. Pre-cirrhotic symptoms include: fatigue, weight loss, upper right abdominal discomfort, mood disturbance, poor concentration, anxiety and depression. Of those symptoms, fatigue is the most common. Patients typically describe the fatigue as a feeling of exhaustion and lack of energy.[111]

105. Some patients with HCV suffer from conditions which are related to their infection with HCV, conditions which they are more vulnerable to developing as a result of infection with HCV or conditions which HCV exacerbates. Such conditions are considered co-morbidities and they include: hepatocellular cancer; pain; mental illnesses such as depression and anxiety; diabetes (higher incidence in HCV population); mixed cryoglobulinemia (inflammation in blood vessels); erythema multiform, erythema nodosum, lichen planus and other skin conditions;

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[107] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 27-28, p. 6835.

[108] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 28, p. 6835.

[109] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 29, p. 6835.

[110] Transfused Plan, JR Vol. 21, Tab 49, s. 4.01(1)(e), p. 7362; Hemophiliac Plan, JR Vol. 21, Tab 49, s. 4.01(1)(e), p. 7408.

[111] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 24-25, pp. 6834-6835; Bain Affidavit # 2, JR Vol. 5, Tab 20, paras. 9-10, pp. 2018-2019.

glomerulonephritis (inflammation in the kidneys and in some instances kidney failure); thyroid diseases; polyarteritis (inflammation of small blood vessels); porphyria cutanea tarda (painful blisters on exposed skin areas); thrombocytopenia (low platelets); uveitis, Mooren corneal ulcers; Sjogren's syndrome (lack of production of tears and saliva); and B-cell lymphoma (cancer of the lymph glands).[112]

106. Treatment of HCV is called antiviral therapy. The goal of antiviral therapy is a sustained viral response ("**SVR**") which means the virus drops below detectable levels on PCR blood testing and stays below detectable levels for 12 weeks after antiviral treatment. If SVR is attained, inflammation stops and so will further scarring and death of liver cells except in advanced cirrhosis where the extent of scarring is so great that the liver proceeds to liver failure notwithstanding the cessation of inflammation. Reversal of fibrosis is also possible. The precise threshold for the various outcomes is not well understood.[113]

107. The major forms of antiviral therapy in the history of HCV treatment have been as follows:

(a) interferon monotherapy which consisted of injections of interferon;

(b) combination interferon and ribavirin therapy, which progressed to delivery of the interferon in a long-acting, pegylated form, still injected, and ribavirin pills, known as pegylated interferon and ribavirin combination therapy; and

(c) DAA.[114]

108. Both interferon and ribavirin can cause significant side effects, which has motivated research and development into DAAs some of which are effective without interferon and/or ribavirin. The first generation of DAAs were approved for treatment in 2011. They were prescribed with pegylated interferon and ribavirin. Although they had increased SVR rates

[112] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 30, pp. 6836-6837.

[113] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 33-34, p. 6838.

[114] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 35, pp. 6838-6839.

compared to interferon and ribavirin alone, they also had severe side effects and many associated drug interactions and they are rarely prescribed in Canada anymore.[115]

109. The next DAAs approved for use in Canada in 2013 were also prescribed with pegylated interferon and ribavirin or ribavirin alone, depending on the genotype of the HCV infected person. Their use has been limited by the DAA drugs approved for use in 2014 and 2015 which are interferon free combinations.[116]

110. The 2014 and 2015 DAA drugs were a combination of DAA drugs marketed as Harvoni and a combination of DAA drugs marketed as the Holkira Pak, which may be combined with ribavirin in some persons.[117]

111. With some exceptions, Harvoni and Holkira Pak are effective in persons who have not been previously treated and in those treated previously who did not respond. Harvoni and Holkira Pak are expected to achieve SVR in over 90% of cases, with the exception of categories of patients such as genotype 3 patients with cirrhosis. Harvoni and Holkira Pak are also the primary treatments for persons co-infected with HCV and HIV.[118]

112. Dr. Lee's evidence (led by Canada) that the current DAA treatment is associated with no discernible side effects[119] is disputed. The DAA drugs approved in 2011 had very serious side effects which hampered completion of the treatment for some people and were life threatening for some people. The 2014 approved DAA drugs, Holkira Pak and Harvoni, are associated with side effects including fatigue, headaches, insomnia, nausea, diarrhea, pruritus and asthenia. In some cases ribavirin must be taken with Holkira Pak. Ribarvirin can cause significant side effects.[120]

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[115] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 36-37, p. 6839.

[116] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 38, p. 6839.

[117] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 38-40, pp. 6839-6840.

[118] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 41, p. 6840.

[119] Lee Affidavit #1, JR Vol. 6, Tab 27, para. 22, p. 2410.

[120] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 51, p. 6843; Bain Affidavit #2, JR Vol. 5, Tab 20, para. 6, pp. 2017-2018.

113. Antiviral therapy treatment durations and contraindications have decreased but the cost of treatment has increased. Treatment duration currently ranges from 8 weeks to 24 weeks depending on genotype, disease progression and whether the person has been treated before. The cost starts at approximately $50,000 for 8 weeks to $76,000 for 12 weeks. If ribavirin is added, the additional cost is approximately $3,800-$4,400 for 12 weeks.[121]

114. The 2013 medical model takes into account DAA drugs approved up to and including 2014. The treatment efficacy rates were adopted in the actuarial models of both Eckler and Morneau Shepell.[122]

115. It is only latterly that the medical model changes, driven by the higher efficacy treatment rates, have allowed the class members and family class members a relief from the risk they have borne since 1999.[123] Offsetting against the financial upside from the DAA therapy efficacy rates is the cost of the treatment which is actuarially estimated to be $146 million as of December 31, 2013 as well as provisions for adverse deviation built into the liabilities due to the uncertainty of the efficacy of the new treatments.[124]

116. The development of DAA therapies has, over the last three years, made becoming HCV-free possible for a large proportion of the class members who are still living with the disease. However, this does not guarantee a return to good health. The class members' livers have been damaged over a course of some 30 years of chronic and progressive viral infection. According to Dr. Bain, post-SVR health status is complicated by the difficulty of comparing pre-infection health with post-cure health after up to 30 years of infection and because of the combination of medical, psychological, socio-economic and age factors that play into recovery from such a long

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[121] Bain Affidavit #1, JR Vol. 19, Tab 46, paras. 42-45, pp. 6840-6841.

[122] Affidavit #4 of Peter Gorham, made April 8, 2015 [**Gorham Affidavit #4]**, JR Vol. 20, Tab 48, Exhibit B, Table D 4a, p. 7292; Krahn Affidavit #4, JR Vol. 20, Tab 47, Exhibit A, Table 13.1, pp. 7025-7026; Affidavit #5 of Dr. Murray Krahn, re-sworn May 4, 2016 [**Krahn Affidavit #5**], JR Vol. 5, Tab 21, para. 7, pp. 2057-2058; Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, paras. 14-16, p. 2000.

[123] Dr. Lee criticizes the December 31, 2010 medical model (the 4th model) for not taking into account DAA drugs but he acknowledges on written interrogatories that he did not review the 4th model report (or the 5th model report) in detail and he acknowledges that the first DAA drugs were approved in August 2011 (after the 4th medical model was completed). He acknowledges that the DAA drugs approved at the time the December 31, 2013 medical model was completed are taken into account in that model: Lee Affidavit #1, JR Vol. 6, Tab 27, para. 58, pp. 2425-2426; Lee Affidavit #2, JR Vol. 11, Tab 30, Exhibit B, paras. 3-5, 8, p. 4071.

[124] Border Affidavit #4, JR Vol. 19, Tab 45, Exhibit A, para. 81, p. 6761, para. 202, pp. 6785-6786, paras. 208-210, pp. 6786-6787.

illness. Some HCV symptoms, such as debilitating fatigue and some of the long list of co-morbidities survive the "cure". While some persons will regain functionality and some will return to jobs outside the home or services around the home, others will not depending on their level of liver function before treatment and other factors.[125]

117. Cured or not, class members have an elevated risk of hepatocellular cancer and are vulnerable to a subsequent liver insult. Those who had progressed to liver failure at the time of treatment continue in a life threatened situation unless they have a liver transplant.[126] As Dr. Lee observes:[127]

> Risk factors for a poor prognosis remain a concern despite the advent of DAA therapies. The liver is a major human organ and can suffer insult from agents other than viral hepatitis. Alcohol consumption, auto-immune conditions, obesity, gender and age all can influence the extent and progression of harm suffered by a liver infected with HCV. DAA therapies cannot eliminate these risk factors but they have reduced substantially the treatment burden formerly faced by patients taking a PR regimen.

118. After SVR, prior infection with HCV can still be a material contributor to death in those who: had liver failure at the time SVR is achieved and a liver transplant does not occur or is not successful; have a subsequent insult to the liver such as another hepatitis infection, an autoimmune disease, or alcoholism; or, develop hepatocellular cancer.[128]

119. Notwithstanding the higher efficacy of the DAA drugs assumed in the 2013 medical model, of the class members alive as of August 31, 2013, the medical model predicts that by 2070:[129]

(a) 19.9% have already developed or will develop cirrhosis;

(b) 12.1% have already developed or will develop decompensated cirrhosis;

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[125] Bain Affidavit #1, JR Vol. 9, Tab 46, paras. 52-57, pp. 6843-6845.

[126] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 52-57, pp. 6843-6845.

[127] Lee Affidavit #1, JR Vol. 6, Tab 27, para. 9, p. 2404.

[128] Bain Affidavit #1, JR Vol. 19, Tab 46, para. 57, pp. 6845.

[129] Dr. Lee criticizes the cumulative transition rates 4th medical model (December 31, 2010). When asked on written interrogatories about the cumulative transition rates in the 5th medical model (December 31, 2013) on which this allocation application is based, he replied that his criticisms only concern the 4th model. Lee Affidavit #2, JR Vol. 11, Tab 30, Exhibit B, para. 10, p. 4073.

(c) 4.3% have already developed or will develop hepatocellular; and

(d) 14.7% have already experienced or will experience liver-related mortality.[130]

120. The cure has come too late for many class members and even those who have been cured could have ravaged livers and associated health consequences. The glimpse into the lived experiences of class members and family class members in their written submission powerfully describe the nature and effect of their personal disease progression.

ii. Class Member Consultations

121. While the Joint Committee members frequently receive telephone inquiries and other communications from class members, public consultation meetings with the class members and family class members have not been held since the settlement was implemented.[131] In view of the pending allocation hearings, the Joint Committee undertook to explore the damages class members and their families suffered as a result of their HCV infection and to ascertain whether the various scheduled benefits available under the Plans adequately compensated them.[132]

122. In the spring of 2015, a posting was developed for the website www.hepc8690.ca to publicize information pertaining to financial sufficiency.[133] And, in August 2015, a notice concerning the financial sufficiency review, allocation hearings and consultations sessions was distributed by email and direct mail to approved class members and family class members and in progress and late claimants.[134]

123. In advance of the consultation sessions with the class members and family class members, the Joint Committee held preliminary meetings and discussions with the Administrator to review all benefits and the problems class members and family class members

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[130] Krahn Affidavit #4, JR Vol. 20, Tab 47, Exhibit A, Tables 13.1 and 13.2, pp. 7025-7027.

[131] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 31, p. 358.

[132] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 26, p. 357 and Exhibit B Administrators website homepage, pp. 393-395.

[133] Peterson Affidavit #13, JR Vol. 2, Tab 12, paras. 27-28, p. 357 and Exhibit C, pp. 397-400.

[134] Peterson Affidavit # 13, JR Vol. 2, Tab 12, paras. 29-30, pp. 357-358, and Exhibit C Notice to Class, pp. 397-400; Affidavit #1 of Arnaud Sauvé-Dagenais sworn on October 15, 2015 [**Dagenais Affidavit #1**], JR Vol. 4, Tab 17, para. 3, p. 1568 and Exhibit ASD-1, pp. 1574-1582.

had already expressed to them over the years.[135] From the outset of the administration, the Joint Committee had also developed a list of areas within the Plans that it believed were compromised from tort principles during the negotiations in order to create a schedule of benefits that fit within the settlement amount then available. The Joint Committee added to that list various suggestions made from time to time by class members and family class members about perceived shortfalls or inequities in the benefits available under the Plans.[136] Another important source of information for the Joint Committee was a review of the appeals taken from the Administrator's decisions under the Plans.[137]

124. With the help of the Administrator and other interested groups, such as the Canadian Hemophilia Society, the Joint Committee identified locations near or where numerous class members reside. In August and September 2015, the Joint Committee held seven consultation sessions across the country.[138] The consultation sessions in Vancouver, Toronto and Montreal were also webcast live over the internet, thus providing the opportunity for persons across the country unable to attend in person to attend and to ask questions and make comments electronically while the sessions were taking place. This proved to be a successful way of obtaining feedback from class members and family class members and to more fully inform them about the Plans, their administration and the allocation hearings. The Joint Committee received many emails as a direct result of these webcasts.[139]

125. Those attending the consultation sessions gave detailed descriptions of daily life with HCV infection or as a family member of an HCV infected person. They gave concrete examples of areas where the compensation received was inadequate, nonexistent or too limited in time or scope.[140]

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[135] Peterson Affidavit #13, JR Vol. 2, Tab 12, paras. 37-38, p. 360.

[136] Peterson Affidavit #13 JR Vol. 2, Tab 12, para. 41, p. 361.

[137] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 42, p. 362.

[138] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 31, p. 358.

[139] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 33, p. 359.

[140] Affidavit #1 of Chya Mogerman, sworn on October 16, 2015 [**Mogerman Affidavit #1**], JR Vol. 2, Tab 14, para. 13, pp. 578-520; Affidavit #1 of Alan Melamud, sworn on October 15, 2015 [**Melamud Affidavit #1**], JR Vol. 3, Tab 15, para. 10, pp. 780-785, para. 14, pp. 785-786; Dagenais Affidavit # 1, JR Vol. 4, Tab 17, para. 9, pp. 1568-1570, para. 11, pp. 1570-1572.

iii. The Written Submissions Received from Class Members and Family Class Members

126. Class members and family class members were invited to provide written submissions to the Joint Committee for consideration and presentation to the Courts. They were also invited to communicate with the Joint Committee by telephone if they wished to do so. Each office received many telephone calls, heard many life stories, answered many questions, encouraged callers to send written submissions and received many submissions which were then circulated among the Joint Committee members.[141] Some of these communications pertained to issues unique to the person's own file and benefits, but most told a bit of their story, explained how benefits did or did not address their needs and expressed their views on how additional monies should be allocated.[142]

127. As of April 16, 2016, more than 740 submissions received from and on behalf of class members and family class members were filed for use on these allocation hearings. Written submissions received from the Canadian Hemophilia Society, Action Hepatitis Canada and the Manitoba Public Guardian and Trustee were also filed.[143] Since that date, the Joint Committee has continued to receive additional written submissions, which will be filed for use on the allocation hearings.

128. Throughout the consultation process, the Joint Committee cautioned class members and family class members that it would not be able to recommend all of the suggestions and invited additional written submissions if class members and family class members did not agree with the Joint Committee's recommendations and/or wished to request to appear at the allocation hearings.[144]

129. From the written submissions received, telephone calls and consultation sessions, the Joint Committee formed the strong impression that class members and family class members

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[141] Peterson Affidavit # 13, JR Vol. 2, Tab 12, paras. 34-35, p. 359; Dagenais Affidavit #1, JR Vol. 4, Tab 17, paras. 3-4, p. 1568; Mogerman Affidavit #1, JR Vol. 2, Tab 14, para. 8, p. 517; Affidavit #1 of Shelley Woodrich, affirmed on October 16, 2015 [**Woodrich Affidavit #1**], JR Vol. 4, Tab 16, paras. 12-13, p. 1349.

[142] Peterson Affidavit # 13, JR Vol. 2 Tab 12, para. 34, p. 359.

[143] Dagenais Affidavit #1, JR Vol. 4, Tab 17, Exhibit ASD-2, pp. 1583-1838; Mogerman Affidavit #1, JR Vol. 2, Tab 14, Exhibit A, pp. 534-716, Exhibit B p. 718, Exhibit C, pp. 720-774; Melamud Affidavit #1, JR Vol. 3, Tab 15, Exhibit A, pp. 791-1286; Woodrich Affidavit #1, JR Vol. 4, Tab 16, Exhibit A, pp. 1352-1564.

[144] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 36, p. 359-360.

continue to suffer damages for which they have not been adequately compensated notwithstanding the scheduled compensation received to date under the Plans.

iv. Developing and Narrowing the List of Shortfalls in Compensation

130. Based on the information gathered from all these sources, a list of possible recommendations emerged over time and formed the basis of the Joint Committee's working sessions on these allocation issues. A comprehensive list of twenty-eight (28) issues was considered for possible recommendation for the benefit of class members and family class members.[145] Even that list did not capture all of the issues raised that could have been added.

131. Representatives of the Joint Committee met with its actuary Eckler to articulate possible associated benefits and ask them to calculate their itemized values.[146] The Administrator was also requested to estimate the cost of administering several of the recommendations.[147]

132. Once the Joint Committee received Eckler's input on the itemized values of the potential recommendations and it became apparent not all considered benefits could be accommodated within the Excess Capital, the following factors went into deciding which benefits to recommend:[148]

(a) priority should be given to addressing those benefits most compromised in comparison to the tort model;

(b) priority should be given to class members and family class member input where possible, provided the input was consistent with the tort model;

(c) some compensation should be obtained for as many class members and family class members as possible;

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[145] Peterson Affidavit #13, JR Vol. 2, Tab 12, paras. 44-45, pp. 362-364.

[146] Peterson Affidavit #13, JR Vol. 2, Tab 12, paras. 39-40, p. 361.

[147] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 38, p. 361, paras. 51-61, pp. 366-368 and Exhibit E, Administration Cost Estimate, p. 432-435.

[148] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 63, p. 369.

(d) that issues that were identified based on the data from the Administrator which quantified a shortfall and identified that the benefit was not adequately compensating the majority as intended should be addressed;

(e) the administrative burden that the benefit would impose on class members and family class members should be considered; and

(f) the cost of administering the benefit should be considered.

133. In order to maintain the integrity of the Trust Fund for the best interests of class members and family class members, the Joint Committee worked within the following parameters regarding the attribution of the actuarially unallocated assets:

(a) allocation of Excess Capital should be limited to the lower amount identified within the range of unallocated assets (after restatement to account for progression between disease level 2 and disease level 3 not accounted for in the medical and actuarial models described in paragraphs 84 to 93); and

(b) the funding that is required for such benefits as the Courts may order should be paid from Excess Capital only and, as such, not require any contribution from the PT Governments' notional fund.[149]

134. The Joint Committee has limited its recommendations accordingly, despite the fact that the Joint Committee does not believe that its recommendations fix all of the inadequacies under the Plans or even the ones that are addressed in their entirety.[150]

v. The Joint Committee's Recommendations

135. Respecting these parameters, the Joint Committee formulated the following nine (9) recommendations.

[149] In any event, the PT Governments will reach their maximum liability in the ordinary course in 2026 and have no obligation thereafter. Border Affidavit #5, Vol. 2, Tab 23, Exhibit A, paras. 15-16, pp. 464-465.

[150] Peterson Affidavit #13 JR Vol. 2, Tab 12, para. 64, p. 369.

Recommendation concerning the First Claim Deadline

136. The Plans provide a First Claim Deadline of June 30, 2010, with limited exceptions provided for in the court approved protocols which are in place.[151]

137. As at September 30, 2015, the Administrator had received 246 late claim requests after the June 30, 2010 First Claim Deadline from persons who do not meet the exceptions to the deadline listed in the Plans and the court approved protocols that are in place.[152]

138. In 2013, before any actuarially unallocated assets were identified, the Courts were asked to approve a protocol pursuant to the Courts' inherent administrative jurisdiction which would allow class members who did not claim before June 30, 2010 (the "late claimants") to do so pursuant to a process involving an assessment of their personal circumstances justifying their delay in applying.

139. The FPT Governments opposed those applications and three separate hearings were conducted. Each Court each rendered its reasons for decision. Because there were material differences in their decisions, the requested order never took effect[153] with the result that the potential claims of these class members could not be reviewed or approved.[154]

140. The Joint Committee heard from and received written submissions from several late claimants explaining the delay in claiming. Similar information was available from those surveyed by the Administrator in advance of the earlier applications. It also received several written submissions from class members and family class members in favour of using some of

[151] Transfused Plan, JR Vol. 21, Tab 49A, s. 3.08, p. 7360; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 3.07, p. 7406.

[152] Other provisions within the Plans that provided for earlier claims deadlines in respect of certain claims that can be made under the Plans have been addressed and modified by the Courts on one or more occasion. Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 5, p. 350;

[153] Settlement Agreement, JR Vol. 21, Tab 49, s. 10.01(2), p. 7328.

[154] *Parsons v. The Canadian Red Cross Society*, 2013 ONSC 7788, JR Vol. 23, Tab 78, p. 7931; *Honhon v. The Attorney General of Canada*, 2014 QCCS 2032, JR Vol. 23, Tab 79, p. 7950 (English translation in Joint Committee's Book of Authorities; *Endean v. The Canadian Red Cross Society*, 2014 BCSC 621, JR Vol. 23, Tab 80, p. 7964.

the Excess Capital to process the late claim requests and compensate eligible class members who did not apply in time.[155]

141. Assuming not all persons who make late claim requests would be permitted by the referee to make a claim based upon the proposed protocol and assuming the historical denial rate would apply to a determination of eligibility, the actuarial assessment by Eckler of the value of the estimated claims under the late claims protocol is $32,399,000.[156] Morneau Shepell concurs with the assumptions used by Eckler in this estimation and the approximate value of these claims, although Canada continues to oppose the implementation of this recommendation.[157]

142. With an associated administrative cost estimated at $51,000, the approximate total cost of this first recommendation is $32,450,000.[158]

143. Based on the further input received through the consultation sessions and in submissions, the draft protocol provides the referee discretion to determine whether a reasonable explanation for the delay had been provided by the claimant. This was thought to be preferable to attempting to create a comprehensive list of possible reasonable explanations for their delay without the benefit of having heard them. The proposed protocol also provides for deficient claims in the same way as other protocols have recently. [159]

144. Implementing a protocol to address the claims of these class members and to provide payment of full benefits from Excess Capital to all determined to be eligible in the ordinary course is recommended by the Joint Committee. Because any benefits payable under this recommendation would be paid from Excess Capital the liabilities of the PT Governments are not affected.[160]

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[155] Dagenais Affidavit #1, Exhibit ASD-2, JR Vol. 14, Tab 17, pp, 1741, 1808.

[156] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 79, p. 374; Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, p. 471.

[157] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, pp. 2329-2331.

[158] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 79, p. 374; Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, p. 468.

[159] Peterson Affidavit #13, JR Vol. 2, paras. 77-78, Tab 12, p. 373-374 and Exhibit "F", Proposed Protocol, p. 437.

[160] Border Affidavit #5, Vol. 2, Tab 23, Exhibit A, paras. 15-16, pp. 464-465.

Recommendation concerning fixed payments

145. The cumulative fixed payments that are payable to living class members or class members who died after January 1, 1999 for non-pecuniary general damages at the various disease levels; the $50,000 and $120,000 fixed payment options in respect of class members whose death before January 1, 1999 was caused by HCV; and the $50,000 and $72,000 hemophiliac co-infected HIV options (described more fully at paragraphs 53 and 54 above) are included in this recommendation.

146. It is the Joint Committee's view based on consultations with class members and their written submissions about the nature of this chronic progressive disease, that the original compromises made on fixed payments should be addressed.

147. As such, a 10% increase in respect of all fixed payments under the Plans, as at the date the lump sum was originally paid, payable retroactively and prospectively is recommended by the Joint Committee. The actuarial valuation by Eckler of this proposal inclusive of its administration cost is $51,392,000.[161] Alternatively, Eckler has calculated that, for the same total value, these fixed payments could be increased by 8.5% (instead of 10%) and then indexed to January 1st, 2014.[162] This second approach would mean each eligible class member would receive the equivalent increase for their respective fixed payment irrespective of the date at which the original lump sum was paid.

148. According to the Administrator, as of October 15, 2016, approximately 5,320 class members including 1,650 estates as well as other in progress and/or future claimants who may later qualify could receive such allocation benefit if approved.[163]

Recommendation concerning family class member fixed payments

149. This recommendation addresses loss of guidance, care and companionship payments to some family class members. The fixed payments set out in the Plans are as follows:[164]

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[161] Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, p. 468 and para. 79, p. 484.

[162] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, paras. 31, 35, p. 2004.

[163] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 87, p. 376.

(a) $25,000 for the spouse;

(b) $15,000 for each child under the age of 21 years at the date of death of the HCV infected person;

(c) $5,000 for each child 21 years of age or older at the date of death of the HCV infected person;

(d) $5,000 for each parent and/or each sibling; and

(e) $500 for each grandparent and/or each grandchild.

150. Family class members do not receive loss of guidance, care and companionship benefits while the infected class member is alive contrary to statutory provisions in some jurisdictions.[165] At the time the Settlement Agreement was negotiated there was a great variation in legislation across the country and entitlement to and quantum of this type of award was not uniformly available. Subsequently, legislation has been put in place in some provinces fixing a quantum for various family member awards however even the newer legislation is not uniform across the country.[166]

151. During the consultation sessions held by the Joint Committee and in the written submissions received from the family class members, many family class members spoke and wrote about the quantum of these awards. The uniform view expressed, regardless of which family class member amount was received, was that the awards were parsimonious at best.[167]

152. While the Joint Committee considered recommending increases to each of these awards, because of the limits on the Excess Capital available at this time and the competing interest of other benefits sought to be addressed, its current recommendation is to increase the amount of the benefits payable to children 21 years or older and to parents which it believes are significantly out of line with the higher awards to spouses and to children under age 21 having

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[164] Transfused Plan, JR Vol. 21, Tab 49A, s. 6.02, p. 7371; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 6.02, pp. 748-749.

[165] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 88, p. 376.

[166] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 90, p. 377.

[167] Mogerman Affidavit, JR Vol. 2, Tab 14, paras. 13 (ee), (ff), p. 523, paras. 15 (v), (ww), p. 527; Melamud Affidavit, JR Vol. 3, Tab 15, paras. 10 (z), (aa), p. 784; Dagenais Affidavit #1, JR Vol. 4, Tab 17, paras. 9 j), p. 1569, para. 11 h), p. 1571.

regard to the fact that parent, child and spouse are all first degree of consanguinity/affinity Family members and having regard to the common law, the legislation and the jurisprudence pertaining to such compensation.[168]

153. As such, the Joint Committee recommends an increase of $5,000 indexed to the date the lump sum was originally paid in respect of these two awards, payable retroactively and prospectively. The actuarial valuation by Eckler of this proposal inclusive of its administration cost is $22,449,000.[169] Alternatively, Eckler has calculated that, for the same total value, the fixed payment could be increased by $4,600 (instead of $5,000) and then indexed to January 1, 2014.[170] This second approach would mean each eligible family class member would receive the equivalent lump sum increase for his/her respective family class payment.

154. Morneau Shepell recognizes that these proposed increases will not result in a payment that exceeds the maximum values payable to children or parents for loss of guidance, care and companionship under applicable law.[171]

155. According to the Administrator, as of October 15, 2015, there were approximately 1,699 Family members classified as children over age 21 and approximately 311 Family members classified as parents that may benefit from this allocation as well as in progress and/or future claimants who may later qualify.[172]

Recommendations concerning loss of income/loss of support

156. This recommendation addresses loss of income payments to class members and loss of support payments to dependants of a deceased class member whose death was due to HCV (described more fully at paragraphs 43 to 45 and 55).[173]

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[168] Peterson Affidavit #13, JR Vol. 1, Tab 12, para. 94, p. 278.

[169] Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, pp. 468, 483.

[170] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, para. 37, p. 2004.

[171] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 119, p. 2335.

[172] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 95, p. 378.

[173] Transfused Plan, JR Vol. 21, Tab 49A, s. 6.01, p. 7370; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 6.01, p. 7418.

157. The loss of income and loss of support benefits available under the Plans represent the single largest compromise from the tort model. Payment of loss of income and support under the Plans is made on a net basis after deductions are made for income tax that would have been payable and after deduction of all collateral benefits received.[174] The list of 28 issues initially considered for allocation by the Joint Committee included 10 or more issues around the loss of income/support benefits which were valued by Eckler.[175]

158. While appreciating that loss of income/support benefits are critical to those who receive them, the Joint Committee also recognizes that not all of the loss of income/support issues that have been identified can be addressed at this time as the cost is too great and there are competing interests in terms of other benefits to be addressed. Ultimately the Joint Committee focused on two of these issues.

159. **The first recommendation is to eliminate deduction of collateral benefits in calculating loss of income and loss of support**. The provisions of the Plans exclude collateral income from being included in pre-claim net income but then require that collateral benefits be deducted as post-claim net income, thus reducing the actual income loss recovered.[176]

160. The claims data demonstrates that class members have had significant amounts deducted in their income loss calculation for CPP/QPP disability, UEI/EI, sickness, accident or disability insurance, and EAP/MPTAP/Nova Scotia Compensation Plan in respect of HIV.[177]

161. This situation was specifically raised by several class members during the consultation sessions and in many of the submissions received by the Joint Committee.[178]

162. The recommendation of the Joint Committee to eliminate the deduction of collateral benefits as post-claim net income from the calculation of the annual loss of net income and loss

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[174] Elliott Affidavit, JR Vol. 12, Tab 32, para. 178, p. 4141.

[175] Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, paras. 37-56, pp. 472, paras,122-140, pp. 496-501.

[176] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.02(2), p. 7363-7304, s. 6.01(1), p. 7370; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.02(2), p. 7410, s,6.01(1), p. 7418; Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 101, p. 380.

[177] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 101, p. 380.

[178] Dagenais Affidavit #1, JR Vol. 4, Tab 17, para 9 b), Exhibit ASD-2, p. 1742; Mogerman Affidavit, JR Vol. 2, Tab 14, para. 13 (h), p. 519; Melamud Affidavit #1, JR Vol. 3, Tab 15, Exhibit A, p. 792-800.

of support is valued by Eckler at approximately $27,539,000 plus $143,000 of administrative costs for a total of $27,682,000.[179]

163. Morneau Shepell criticizes this recommendation on the basis that the non-deductibility could lead to compensation exceeding the actual lost income in many cases.[180] However, their analysis shows the opposite in circumstances where a claimant was in receipt of collateral benefits during the years used to calculate pre-claim net income the loss of income benefit will be less than the loss of income paid.[181] Moreover, they omit any consideration of the law relating to the non-deductibility of collateral benefits in the calculation of income loss as recoverable damages in tort/civil liability cases as considered and decided by the highest court of Canada. A discussion of the applicable law is set out in paragraphs 237 to 280.

164. The valuation of this recommendation by Morneau Shepell is $36,094,000[182] without administrative costs, or $8,555,000 more than Eckler's valuation.

165. Eckler has reviewed Morneau Shepell's comments on this recommendation and maintains its position on valuation while identifying two differences that could explain this discrepancy.[183]

166. **The second recommendation related to loss of income is to compensate for diminished benefits in the form of lost pension.** The second issue pertaining to the loss of income compensation that the Joint Committee focused on is the fact that the Plans do not compensate for pension loss suffered by class members as a result of their being disabled from working due to their infection with HCV.[184]

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[179] Border Affidavit #5, JR Vol. 2, Tab 13A, Exhibit A, p. 468, paras. 37-50, pp. 472-475.

[180] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 133-149, pp. 2339-2345.

[181] Gorham Affidavit#5, JR Vol.6, Tab 26, Exhibit A, para. 138, pp. 2341-2342.

[182] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, Table 94a, p. 2327.

[183] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, paras. 41-42, p. 2005

[184] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 101, p. 380.

167. Several class members and family class members highlighted this shortfall during the consultation sessions and in their written submissions addressed to the Joint Committee.[185]

168. Eckler provided information to the Joint Committee with regards to the valuation of an appropriate compensation for this proposed allocation benefit.[186] The Joint Committee did not feel it was able to recommend the full 14% in respect of pension benefits discussed by Eckler because of the limits on the funds available for allocation at this time and the competing interests of other benefits to be addressed. Because of these limitations, the Joint Committee also requested Eckler to value this allocation benefit to be calculated with a maximum of $200,000 (2014 dollars) of admissible gross income per annum.

169. The Joint Committee recommends an allocation benefit of 10% of gross loss of income, capped as indicated, payable retroactively and prospectively to establish a pension benefit at this time.[187] Eckler's total valuation for this allocation benefit is $19,787,000.[188]

170. Morneau Shepell agrees that when a claimant suffers a loss of income, he/she may also lose pension benefits.[189] Their comments on the wide variety of retirement saving plans are similar to Eckler's.[190] They also recognize that the administrative complexity of identifying each individual situation is likely too great to be effectively employed for the purpose of allocating the proposed benefit[191] thus creating an inevitable imperfect compensation.[192]

171. Morneau Shepell estimates the average amount of lost pension for claimants who have a loss of income is between 9.9% and 10.9% of gross lost earnings.[193] Its valuation of the

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[185] Mogerman Affidavit #1, JR Vol. 2, Tab 14, para. 13(b), p. 518, para. 13(c)(ii), p. 518, Exhibit A, p. 600; Melamud Affidavit #1, JR Vol. 13, Tab 15, para. 10(c), p. 781; para. 14(c), p 786.

[186] Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, paras. 51-55, p. 476.

[187] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 102, p. 381; Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, para. 56, p. 477.

[188] Border Affidavit #5, Exhibit A, JR Vol. 2, Tab 13A, p. 468 and para. 56, p. 477.

[189] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 150, 154, p. 2346.

[190] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 152-153 p. 2346.

[191] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 157, p. 2347.

[192] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. p. 2347.

[193] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 158, p. 2347.

10% allocation benefit recommended by the Joint Committee is a little less than Eckler's valuation.[194]

172. According to the Administrator, as of October 16, 2015, there are approximately 528 loss of income/support claimants that may benefit from these two recommendations pertaining to loss of income and loss of support as well as in progress and/or future claimants who may later qualify.[195]

173. The combined value of these two recommendations pertaining to loss of income and loss of support as calculated by Eckler is $47,326,000, before administration costs which are estimated at $143,000.[196]

Recommendation concerning loss of services in the home

174. This recommendation addresses loss of services payments to living class members and loss of services payments to dependants of a deceased class member whose death was due to HCV.[197] As noted at paragraph 46 claims for loss of services in the home are limited to a maximum of 20 hours per week recoverable at a rate of $12 per hour and may not be claimed in conjunction with loss of income/support.[198]

175. Many written and oral communications from class members and family class members described loss of services payments as being vital to their survival and many commented (especially at consultation sessions) that the current rate, $16.50, and number of hours are insufficient to actually replace the work.[199]

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[194] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, Table 94a, p. 2327.

[195] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 104, p. 381.

[196] Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, p. 468.

[197] Transfused Plan, JR Vol. 21, Tab 49A, s. 6.01, p. 7370; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 6.01, p. 7418

[198] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.03(2), p. 7366, s. 6.01(2), p. 7370; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.03(2), p. 7413, s. 6.01(2), p. 7418.

[199] Mogerman Affidavit #1, JR Vol. 2, Tab 14, para. 13(m), p. 520, paras. 15(h), (i), p. 525, para. 17(c), p. 529, Exhibit A, pp. 708-709; Melamud Affidavit #1, JR Vol. 3, Tab 1, para. 10(i), p. 782; Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 109, p. 382.

176. The Administrator has indicated, based on the data from the last three years, that approximately 95% of such claimants had a pre-disability level in excess of 20 hours per week and that the average pre-disability level is about 47 hours per week.[200]

177. The Joint Committee considered increases to both the number of hours reimbursed and the hourly rate of this compensation. It also considered three different scenarios for extending the duration of the payments and whether these benefits and loss of income/support should be mutually exclusive and Eckler was instructed to cost all of these options using various scenarios outlined in their report. [201]

178. In the end, because of the limits of the funds available and the competing interests of other benefits to be addressed, the Joint Committee recommends at this time an increase in the maximum number of hours compensated by 2 hours per week (for a total of 22 hours) payable retroactively and prospectively.[202]

179. Eckler's valuation of this allocation benefit is approximately $34,364,000 exclusive of the administrative costs established at $196,000.[203]

180. The additional information provided by Morneau Shepell regarding this recommendation is in line with that of the Joint Committee and the oral and written representations made on this issue by the class members and family class members.[204]

181. The valuation of this allocation benefit by Morneau Shepell at $37,384,000[205] is not significantly different from Eckler's. According to Morneau Shepell, the difference comes from

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[200] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 110, p. 382-383.

[201] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 111, p. 383 ; Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, paras. 141-145, p. 502.

[202] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 111, p. 383.

[203] Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, p. 468.

[204] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 165-168, pp. 2349-2350.

[205] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 171, p. 2350.

their assumption that "all future loss of services will be paid at the maximum of 22 hours per week", representing a 10% increase instead of the 8.9% increase used by Eckler.[206]

182. When questioned on their assumption and its corollary implicit assertion that class members who reported between 20 and 22 hours of loss would modify their reported loss to at least 22 hours in the future, Morneau Shepell acknowledged that it was not supported by any data or direct information and confirmed that "all" used in the formulation of their assumption included the claimants who previously reported less than 22 hours.[207] The administrative processes in place for these claims will limit the impact of Morneau Shepell's assumption in this regard.[208]

183. Based on information provided by the Administrator as at October 16, 2015, there are approximately 1,462 loss of services claimants that may benefit from this allocation now or in the future as the disease progresses as well as in progress and/or future claimants who may later qualify.[209]

Recommendation concerning costs of care

184. This recommendation addresses costs of care reimbursed at disease level 6. Reimbursable costs of care include only those costs that are not recoverable under any public or private health care plan or under loss of services in the home.[210]

185. When the Joint Committee reviewed the cost of care compensation with the Administrator, it learned that for approximately 10% to 15% of the eligible claimants, the current benefit did not compensate the total expenditure incurred by them for cost of care.[211] During the consultations, the Joint Committee also heard class members and family class members describe

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[206] Gorham Affidavit #5 JR Vol. 6, Tab 26, Exhibit A, para. 170b, p. 2350.

[207] Affidavit #6 of Peter Gorham, sworn April 19, 2016 **[Gorham Affidavit #6**], JR Vol. 11, Tab 29, Exhibit A, para. 25, p. 4026.

[208] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 110, p. pp. 382-383.

[209] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 113, p. 383-384.

[210] Transfused Plan, JR Vol. 21, Tab 49A, s. 4.04, p. 7367; Hemophiliac Plan, JR Vol. 21, Tab 49B, s. 4.04, pp. 7413-7414.

[211] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 115, p. 384.

this reality and explain that in some cases care is or was required at disease levels below level 6.[212]

186. The Joint Committee considered recommending that this benefit become available at a lower disease level and that the amount of this award be increased and Eckler was instructed to cost both.[213] However, because of the limits on the funds available and the competing interests of other benefits to be addressed, the recommendation of the Joint Committee at this time is to increase the maximum award for costs of care at disease level 6 by $10,000 (in 1999 dollars for a total of $60,000) payable retroactively and prospectively.[214]

187. The valuation of this recommendation by Eckler is approximately $627,000 for a total of $629,000 including $2,000 of administrative costs.[215]

188. The additional information included by Morneau Shepell in their comments regarding this recommendation supports the fact that for some claimants, the benefit received did not cover the amount of their annual cost of care expense not reimbursable by a public or private health care plan.[216]

189. Their valuation of the proposed recommendation amounts to $2,684,000 exclusive of administration costs compare to Eckler's valuation at $627,000.[217]

190. The significant difference in valuation results entirely from Morneau Shepell's assumption that "all claimants whose costs exceeded $47,000 for a year will increase the amount of care they purchase in the future by the $10,000 increase to the maximum."[218] Morneau Shepell's underlying assumption is that "it is likely that class members who require significant amounts of care but are not able to afford it, will increase the amount of care they

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[212] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 115, p. 384.

[213] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 115, p. 384; Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, paras. 63-65, p. 480, paras. 160-163, p. 505.

[214] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 116, p.384.

[215] Border Affidavit #5, Exhibit A, JR Vol. 2, Tab 13, para. 65 and table, p. 468.

[216] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 174-176, p. 2351; Gorham Affidavit #6, JR Vol. 11, Tab 29, Exhibit A, para. 27, p. 4027.

[217] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 179, p. 2352.

[218] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 178.b, p. 2352.

incur in the future to stop just short of the new maximum."[219] In response to a written interrogatory on this assumption, Morneau Shepell indicated that they had no data or direct information to support this.[220]

191. Discussing the important difference between the two actuarial valuations, Eckler confirms the sole reason is Morneau Shepell's assumption about future conduct applied versus the 1% increase for future payments calculated by Eckler on the basis of actual claims made that exceeded the current limit.[221] It is Eckler's opinion that the assumption used by Morneau Shepell is not reasonably supported by the data for actuarial purposes.[222]

192. According to the Administrator, as at October 16, 2015, there are approximately 9 cost of care claims in recent years which exceed the maximum permissible reimbursement and may benefit from this allocation as well as others in the future with ongoing costs of care claims and potential in progress and/or future claimants who may later qualify.[223]

Recommendation concerning out-of-pocket reimbursement

193. This recommendation addresses an out-of-pocket expense incurred by family class members not addressed under the Plans.

194. The Joint Committee considered various submissions made by class members and family class members concerning ways in which reimbursement for out-of-pocket expenses were inadequate. One of the things frequently mentioned was that time, vacation/sick days and/or wages were lost by family class members when they accompanied class members to required medical appointments.[224]

195. The Joint Committee recommends at this time that the benefits under the provision for out-of-pocket expenses include an amount of $200 (2014 dollars) per visit payable prospectively

[219] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 177, p. 2351.

[220] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 93, p. 2326, para. 176, p. 2351;. Gorham Affidavit #6, JR Vol. 11, Tab 29, Exhibit A, para. 26, p. 4027.

[221] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, paras. 43-46, pp. 2005-2006.

[222] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, para. 47, p. 2006.

[223] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 118, p. 384.

[224] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 120, p. 385.

in those circumstances where a family class member accompanies a class member to his/her medical appointment related to his/her HCV.[225]

196. Eckler values this recommendation at approximately $1,957,000[226] and there is no associated increase of administrative costs.[227]

197. The valuation of the same recommendation by Morneau Shepell amounts to $8,370,000.[228]

198. Morneau Shepell assumes in their calculation: that the number of accompanied visits will increase and that the number of visits claimed will increase[229] based upon their personal interpretation of the available data.[230]

199. Morneau Shepell confirmed in written interrogatories that they had no direct information or other specific data that would support their assumptions that there would be increased numbers apart from the data available to both actuaries.[231] And, Morneau Shepell agrees that such an increase in accompanied visits would include circumstances where the family class member could not previously afford to accompany the class member without an allowance but will now be able to afford to accompany the class member.[232] Mr. Gorham also admits on written interrogatories that the number of visits used in his calculation was not informed by any additional data.[233]

200. Eckler has reviewed Morneau Shepell's assumptions. They identify at least one different and reasonable explanation for the data results and opine that Morneau Shepell's belief that "many class members do not currently bother to claim as their expenses are too small to justify

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[225] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 121, p. 385.

[226]Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, paras. 66-69, p. 481.

[227] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 122 and Exhibit E, p. 433.

[228] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 190, p. 2355.

[229] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 189.b.(i),(ii),(iii), pp 2354-2355.

[230] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 186-187, pp. 2353-2354.

[231] Gorham Affidavit #6, JR Vol. 11, Tab 29, Exhibit A, para. 30.b, p. 4028.

[232] Gorham Affidavit #6, JR Vol. 11, Tab 29, Exhibit A, para. 29, p. 4028.

[233] Gorham Affidavit #6, JR Vol. 11, Tab 29, Exhibit A, para. 29, p. 4028.

the effort" is speculative.[234] And, regarding the possibility of an increased number of claims, Eckler indicates that although plausible, such an assumption is not reasonably supported by the data for actuarial purposes.[235]

201. According to the Administrator, as of October 16, 2015, there were approximately 3,022 claimants that could benefit from this allocation as well as other in progress and/or future claimants who may later qualify.[236]

Recommendation concerning funeral expenses

202. This recommendation addresses uninsured funeral expenses of up to $5,000 reimbursed under the Plans.[237]

203. Administration data shows that for 395 of the 823 claims for funeral expenses, the current maximum amount payable of $5,000 was inadequate to reimburse the incurred expenses.[238]

204. The Joint Committee considered increasing this amount and also considered recommending that the deduction required for the collateral death benefits received by claimants be removed.[239] However, because of the limits on the funds available and the competing interests of other benefits to be addressed and after reviewing the valuation and the impact of each of these scenarios to determine how to best benefit the most estates, the Joint Committee recommends a $5,000 increase to the maximum award for funeral expenses of $5,000, payable retroactively and prospectively.[240]

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[234] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, para. 52, p. 2006.

[235] Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, para. 54, p. 2007.

[236] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 123, p. 385.

[237] Transfused Plan, JR Vol. 21, Tab 49A, s. 5.01(1), p. 7369, s. 5.02(1), pp. 7369-7370; Hemophiliac Plan, JR Vol. 21, Tab 49B, ss. 5.01(1), p. 7416, s. 5.02(1), p, 7417.

[238] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 125, p. 386.

[239] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 126, p. 386.

[240] Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 126, p. 386.

205. Eckler's calculation of the value of this recommendation, exclusive of administrative costs, is $2,050,000.[241]

206. The additional information provided by Morneau Shepell regarding the normal funeral costs in Canada and other compensation plans confirms the inadequacy of the current $5,000 maximum payment and the appropriateness of the recommended increase.[242]

207. There is no significant difference in valuations for this recommendation as Morneau Shepell arrives at $2,025,000.[243]

PART III - ISSUES AND THE LAW

208. The applications by the Joint Committee and Canada to allocate unallocated assets in connection with the Financial Sufficiency review as at December 31, 2013 raise the following issues:

(a) What is the amount of Excess Capital available for allocation?

(b) Does the Court have jurisdiction to allocate assets as recommended by the Joint Committee?

(c) How should the Courts exercise their unfettered discretion to allocate the Excess Capital?

209. For the reasons discussed below, the Joint Committee submits the answers to these questions are:

(a) The Excess Capital is $206,920,000 and given that class members and family Class members bear the risk of future insufficiency, it is appropriate that the most conservative estimate be used in making any allocation.

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[241] Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, paras. 70-74, p. 468 (p. 11 of the report).

[242] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, paras. 194-197, p. 2356.

[243] Gorham Affidavit #5, JR Vol. 6, Tab 26, Exhibit A, para. 201, p. 2357.

(b) Yes, the Courts' discretion on these applications is unfettered, subject only to being reasonable in all the circumstances and geographic equality. The Joint Committee's recommendations satisfy these requirements.

(c) The Courts' unfettered discretion should be exercised to allocate all of the Excess Capital to benefit class members and family class members as recommended by the Joint Committee.

A. The Excess Capital is $206,920,000 and No Greater Amount Should be Allocated

210. As discussed at paragraphs 84 to 93, following the Courts making the Sufficiency Orders, the Joint Committee discovered what it believes to be a material issue relating to the reclassification of class members to level 3 where they meet the Court approved treatment protocol. Level 3 status triggers a fixed payment.

211. In Eckler's opinion, the liability associated with this reclassification reduces the Excess Capital available for allocation to $206,920,000.

212. While Canada contests the appropriateness of reclassification, its actuaries calculation of this liability is not materially different. Even so, Morneau Shepell does not concur with the need to restate.

213. Given that only class members bear the risk associated with an allocation of overstated Excess Capital, the Joint Committee submits that the conservative approach it advocates, which was accepted as appropriate by the Courts when the settlement was approved, dictates that the Courts should only allocate $206,920,000.

B. The Courts Have Jurisdiction to Allocate Assets as Recommended by The Joint Committee

214. As detailed above, the Ontario and British Columbia Courts were not prepared to approve the Settlement Agreement "as is". Recognizing that the scheduled benefits provided to class members and family class members in the Plans were not perfect and that class members and family class members bore the risk of financial insufficiency, those Courts required the Settlement Agreement to be amended to permit class members and family class members to share in any surplus arising prior to the settlement's termination. An express amendment was required given (1) section 12.03(3), which provides that any surplus assets are to be transferred

to the FPT Governments on the termination of the settlement; (2) section 10.01(1)(i), which only permits the Plans to be amended "due to financial insufficiency or anticipated financial insufficiency"; and (3) section 12.02, which precludes any amendment or supplement to the Settlement Agreement, absent the agreement of the FPT Governments and the Joint Committee and the Courts' approval, except as expressly provided in the Agreement. It was within this factual matrix that the parties negotiated those amendments and incorporated them into consent orders, which expressly provide that the Settlement Agreement was approved "subject to the following modifications". In Québec, Schedule F containing these terms was added to the Settlement Agreement.

215. It is trite law that Settlement Agreements and consent orders are to be treated as contracts.[244] As such, they are to be interpreted based on the language used by the parties in the context of the whole with regard to the factual matrix.[245] As the Supreme Court has said, the "overriding concern is to determine 'the intent of the parties and the scope of their understanding'.[246] The Courts must reject an interpretation that renders explicit terms ineffective.[247]

216. The Allocation Provisions make clear that upon receiving a request by the Joint Committee or a Party to allocate unallocated assets, the Courts acquire "unfettered discretion" to allocate assets in such manner as they determine to be "reasonable in all of the circumstances," subject only to one limitation: there "shall be no discrimination based on where the Class Member received Blood or based on where the Class Member resides".

217. That the parties intended the Courts' discretion on these applications to be unfettered, subject only to reasonableness and geographic equality, is further emphasized in the section that

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[244] *Neinstein v. Marrero*, [2007] O.J. No. 1595 at para. 12 (S.C.J.) [***Neinstein (ONSC)***]; *Monarch Construction Ltd. v. Buildevco Ltd.*, [1998] O.J. No. 332 (C.A.); *McCowan v. McCowan*, [1995] O.J. No. 2245 at paras. 16, 18-19 (C.A.); *Ruffudeen-Coutts v. Coutts*, [2012] O.J. No. 400 (C.A.) at paras. 62-63; *Rick v. Brandsema*, [2009] 1 S.C.R. 295, at para. 64; *Shackleton v. Shackleton*, [1999] B.C.J. No. 2653 at para. 12 (C.A.); *Markus c. Reebok Canada Inc*, 2012 QCCS 3562 at para. 21.

[245] Neinstein (ONSC), ibid. at para. 12; Sattva Capital Corp. v. Creston Moly Corp. , 2014 SCC 53 at paras. 47 and 57 [***Sattva***]; ss. 1425-1426 Civil Code of Québec; Courchesne v. Noranda Inc, 2006 QCCS 4010 at paras. 48-55; Association d'aide aux victimes des prothèses de la hanche c. Centerpulse orthopedics inc., 2005 CanLII 37469 (QC CS) at paras. 21-30.

[246] *Sattva*, *ibid*. at para. 47

[247] Geoff R. Hall, *Canadian Contractual Interpretation Law*, 3rd ed. (Markham: LexisNexis Canada, 2016) at p. 16; s. 1428 Civil Code of Québec.

follows. It expressly states that the Courts may consider "but are not bound to consider" several listed factors in the exercise of their unfettered discretion.

218. Canada argues that the Courts' jurisdiction is limited to implementing the terms of the Settlement Agreement and that any change that operates to decrease the residue that the defendants can claim after the Settlement Agreement is satisfied constitutes a "material change," which can only be made with the consent of all parties through the amending formula.[248]

219. Canada's argument must be rejected as it renders ineffective the explicit terms of the Allocation Provisions, which confer "unfettered discretion" upon the Courts in these circumstances. It also renders subparagraphs (i) and (ii) of the Allocation Provisions void. Since the Settlement Agreement strictly limits class members and family class member compensation to the scheduled benefits set out in the Plans, any allocation of surplus assets "for the benefit of Class Members and/or Family Class Members" necessarily operates to the detriment of the FPT Governments, as it decreases the residue in the settlement fund that the FPT Governments can claim after the satisfaction of the Settlement Agreement. Put another way, if the Courts' jurisdiction was restricted to simply implementing the terms, they could never confer a benefit on class members and family class members beyond that already expressly allowed under the Plans, such that those portions of the Allocation Provisions are meaningless.

220. While all of the Joint Committee's recommended allocations in favour of class members and family class members necessarily operate to decrease the residue to Canada's detriment such that they would meet Canada's definition of an impermissible "material variation", Canada seems to take issue with some of the Joint Committee's recommendations, yet not others, for reasons that are not explained.[249] For example, stroking out each of the fixed payment amounts payable to class members and family class members in sections 4.01(1), 5.01(1), and 5.01(2) of the Transfused Plan and in sections 4.01(1), 4.08(2), 5.01(1), and 5.01(4) of the Hemophiliac Plan and inserting different amounts to increase that benefit from the inception of the settlement apparently does <u>not</u> constitute an impermissible amendment/material variation even though it has the effect of reducing the residue available by almost $51.4 million. Yet, increasing a benefit by

[248] Canada's Notice of Application and Response to the Notice of Application of the Joint Committee dated January 29, 2016 **[Canada's Application Response]**, JR Vol. 1, Tab 6, paras. 32-35, p. 167.

[249] Canada's Application Response, JR Vol. 1, Tab 6, para. 38, p. 168.

stroking out deductions to be made from it, which reduces the residue by $27.7 million if collateral benefits are no longer deducted from loss of income, apparently does constitute a substantive amendment. So, too, does stroking out the First Claim Deadline in section 3.08 of the Plans, which would reduce the residue by about $32.5 million,[250] and providing a new benefit outside of the Plans, such as compensation for loss of pension.

221. It is implicit in Canada's position that (1) some unspecified terms of the Plans are more fundamental and inviolate than others, such that the Courts do not have jurisdiction to vary them; and (2) the Courts do not have jurisdiction to provide a new benefit in addition to those provided in the Plans, all of which constitute substantive amendments under Canada's interpretation.

222. But that is not what the Allocations Provisions say. The Allocation Provisions confer unfettered discretion on the Courts to allocate unallocated assets in any manner they see fit, subject only to ensuring geographic equality and reasonableness in all the circumstances. Simply put, there are no limits on what the Courts can do in conferring a benefit on class and/or family class members from assets that are unallocated. The Courts have jurisdiction to make each and every allocation requested by the Joint Committee to benefit class and/or family class members, whether it is to increase an existing scheduled benefit directly (by varying the amount stipulated) or indirectly (by reducing or eliminating what is deducted from that benefit) or creating an entirely new benefit, or otherwise. This interpretation gives "unfettered" its ordinary and grammatical meaning. Canada's interpretation fetters the Court's discretion and must be rejected.

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[250] While an application under the Allocation Provisions was not before him, on the application by BC Class Counsel to approve a late claims protocol, Chief Justice Hinkson expressed the view, in *obiter*, that it would be inappropriate to exercise the Court's discretion under the Allocation Provisions to extend the First Claim Deadline as it would amount to a fundamental alteration of the Settlement to the detriment of the FPT Governments. *Endean v. Canadian Red Cross Society*, 2014 BCSC. No. 611 at para. 27, JR Vol. 23, Tab 79.

In contrast, Justice Perell in *Parsons v. The Canadian Red Cross Society*, 2013 ONSC 7788 at para. 93, JR Vol. 23, Tab 78 expressly recognized the Courts' jurisdiction to extend the First Claim Deadline under the Court's unfettered discretion conferred under the Allocation Provisions. Chief Justice Rolland in *Honhon v. The Attorney General of Canada*, 2014 QCCS 2032 at paras. 18-19, 28, 30-31 JR Vol. 23, Tab 79 (unofficial English translation in Joint Committee's Book of Authorities), also appears to recognize the Courts' jurisdiction to have the late claims dealt with later ("pourront éventuellement être traitées") but held that it was premature to seek any distribution until the existence of unallocated assets had been established and the parties had been heard regarding their distribution, as is now the case.

223. For the reasons expressed below, the Courts should exercise their unfettered discretion to allocate benefits in favour of class members and family class members in the manner proposed by the Joint Committee.

C. The Optional Factors for Consideration Favour Allocation to Class members and Family Class members

224. The Optional Factors for Consideration set out a non-exhaustive list of factors that the Courts may consider, but are not bound to consider, in determining whether and how to allocate actuarially unallocated assets.[251] As discussed below, each of the listed factors favour the allocation of Excess Capital to class members and family class members.

225. Many of the listed factors compel consideration of the risk class members and family class members assumed. These risks included all manner of eventualities, including investment returns and inflation rates, as well as unknown quantities, including cohort size, disease progression and potentially extremely large claims for loss of income and loss of services in the home, as well as benefits which were compromised to ensure financial sufficiency and not guaranteed.

226. In addition to the specified factors, the experience of class members and family class members with HCV and with compensation under the Plans is relevant to the Courts' exercise of unfettered discretion as part of "any other facts the Courts consider material," and compels allocation to benefit class members and family class members in the manner proposed by the Joint Committee.

i. The Number of Class members and Family Class members

227. At the time of settlement, cohort size (along with disease distribution and disease progression) was a major issue with major limitations on how well it could be assessed based on the available data and medical knowledge.[252]

228. Although fewer class members have made claims to date than the conservative (highest) estimate of class size predicted at the time of settlement approval, the risk of this issue was

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[251] Ontario Approval Order, JR Vol. 22, Tab 52, para.9(c), pp. 7649-7650; BC Approval Order, JR Vol. 22, Tab 54, para. 5(c), p. 7698-7699; Québec Schedule F, JR Vol. 22, para. 2, pp. 7755-7756.

[252] *Parsons*, JR Vol.22, Tab 51, paras.108-111, pp.7629-7630.

clearly borne and realized by class members and family class members and, to a certain extent, continues.

229. Canada's actuaries, Morneau Shepell, conclude that the projections made at the time of settlement approval were "overstated" serving to increase the likelihood of a surplus. This conclusion ignores the real gaps in information available at the time of settlement approval so it does not assist in understanding the risks of financial insufficiency accepted by class members and family class members. The actuarial treatment of the issue was conservative, necessary and appropriate,[253] not an overstatement (deliberate or otherwise) intending to create a surplus 16 years down the road.

230. As noted by Justice Smith in his settlement approval reasons,[254] the conservative assumption or high estimate of class member size was a double edged sword. On the one hand, it was an appropriate measure of protection for class members and family class members to ensure benefits could be paid to all. On the other hand, because the compensation benefits to be paid to each had to fit within the settlement funds available, a conservative estimate of class members served to decrease the amount of benefits that would be paid to each. That risk was realized from the outset and, as such, has contributed to the accumulation of Excess Capital, a fact which the Courts can acknowledge by an allocation in favour of class members and family class members.

231. The continuing nature of the risk is that certain categories of class members who have not come forward will still come forward (regardless of the disposition of late claims). The medical evidence reviewed above points to a considerable group that is undiagnosed. The management of this risk continues to involve an actuarial allocation of funds to cover those projected to come forward and a recognition of the uncertainty in such an estimate acknowledged in the calculation of required capital (buffer). Since there is still a cap on the amount of funds available, class members and family class members continue to realize the downside of making such conservative allowances: less funds are available for allocation due to the allowances that must be made for future claimants.

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[253] *Parsons*, JR Vol.22, Tab 51, paras.108-113, pp.7629-7630

[254] *Endean*, JR Vol.22, Tab 23, paras.21-22, pp.7879-7680.

232. The First Claim Deadline posed a risk to the many class members whose claims were released but did not know of the existence of the Settlement Agreement in time to make a claim or were prevented by circumstances beyond their control from making a claim. Late claims do not pose a risk to any of class or family class members who have made a claim because the Trust Fund is financially sufficient to absorb the late class members.[255]

233. The fact that these various 'cohort size' risks did not result in more class members making claims than expected does not detract from the fact the risks existed, have been realized in part, and that Canada wanted no part of them and bore no part of them.

ii. The Experience of the Trust Fund

234. At settlement approval, the Trust was expected to be in a deficit position of $58,533,000 if all payments scheduled under the Plans were made without holdbacks. With the holdbacks in place, the Trust had a positive balance of $34,173,000.

235. At the time, those margins, combined with the risk as described, seemed oppressive and overwhelming. But accepting the risk and maximizing the benefits to the class members and family class members within the fixed envelope of compensation available with margins to manage the risk was the only path to have significant compensation start flowing to the class members and family class members.

236. In the five sufficiency reviews since settlement approval, the risk realization has been wide and wild. Although the risks have been managed overall such that the financial sufficiency of the Trust has gradually improved, the swings in gains and losses of the constituent elements which posed the major risks have ranged between large and enormous. The chart at paragraph 76 above demonstrates this.

iii. The Fact that the Benefits Provided Under the Plans Do not Reflect the Tort model

237. The Joint Committee's proposals reflect the concerns expressed by the Courts at the time of settlement approval. Although the Settlement Agreement as a whole was fair and reasonable

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[255] The Eckler December 31, 2013 actuarial report treats late claims as a sensitivity analysis valued at $29 million which could have been absorbed into the liabilities (and would have increased them) but on instructions did not treat them as a liability. They are included in the calculation of the allocation benefits sought by the Joint Committee at a revised value of $32.4 million: Border Affidavit #4, JR Vol. 19, Tab 45, Exhibit A, para. 253, p. 6796; Border Affidavit #5, JR Vol. 2, Tab 13, Exhibit A, paras. 34-35, p. 471.

given the circumstances, the amounts of compensation it provided and the terms of the benefits as scheduled were not optimal because compromises had to be made to fit the scheduled benefits into the fixed settlement amount envelope.[256]

238. The fundamental principle of compensation in personal injury cases is that a plaintiff should receive full and fair compensation, calculated to place him/her in the same position as he/she would have been in had the tort not been committed, insofar as this can be achieved by a monetary award.[257] The principle of *restitutio in integrum* referred to in civil law is to the same effect.

239. This principle is sought to be accomplished by awarding damages for pecuniary loss in the amount reasonably required to permit a standard of living and day to day functionality that, to the extent possible, approximates what the plaintiff would have experienced but for the wrong he was subjected to.

240. In *Andrews*, the Court set a rough upper limit of $100,000 in 1978 dollars for non-pecuniary damages, premised on the notion that the paramountcy of full compensation for pecuniary damages will have been met.[258]

241. The premise on which the rough upper limit was set demonstrates that while the heads of damages are to be assessed individually, they are also interlocking. In particular, the future needs of the plaintiff must be met through the pecuniary awards or the plaintiff will have to fall back on the non-pecuniary award to fill the gaps. It is paramount that the pecuniary losses be fully dealt with or the balance struck between restorative care awards and policy driven arbitrary non-pecuniary damages will not be achieved.[259]

242. The imbalance the Supreme Court of Canada sought to avoid is only compounded where, as here, in the case of the scheduled benefits under the Plans, the future care award, the loss of income award and the non-pecuniary damages award, fall short of full tort or civil law compensation.

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[256] *Parsons*, JR Vol. 22, Tab 51, para.58, pp. 7617-7618, paras. 82-83, pp. 7622-7624, paras. 102-104, p. 7628, paras. 108-112, pp. 7629-7630, paras. 121-122, p. 7631; *Endean*, JR Vol.22, Tab 23, paras. 21-22, pp. 7879-7680.

[257] *Andrews v. Grand & Toy Alberta Ltd*. [1978] 2 S.C.R. 229 [***Andrews***] at pp. 240-242.

[258] *Andrews, supra*, at pp. 240-241, 261-262, 265; see also *Arnold v. Teno*,[1978] 2 S.C.R. 287 at pp. 329-330 and 333-334.

[259] *Arnold v. Teno*, supra, at pp. 329-330, 333-334; *Andrews, supra* at pp. 240-241 and 261.

Fixed Payments for Non-Pecuniary Damages

243. The cumulative fixed payments under the Plans limit payment for non-pecuniary damages for a person who reaches the debilitating and life threatening conditions at disease level 6 (such as decompensated cirrhosis or hepatocellular cancer) to $303,750 (2014 dollars).[260] In comparison, in 2014, the rough upper limit on non-pecuniary damages established by the Supreme Court of Canada ranged from $350,712-$358,689.[261] The Joint Committee's proposed 8.5% increase on the 2014 indexed disease level fixed payments amounts to $329,569.

244. The input from class members at the consultation session and in their written submissions about the symptoms and effects of HCV infection and/or Compensable HCV Drug Therapy amply demonstrate that the Joint Committee's proposals of a modest increase to the fixed payments, which still leaves the top level below the trilogy rough upper limit by $20,000-$30,000, are appropriate.

Cost of Care and Loss of Services in the Home

245. Pecuniary damages, especially cost of care, must address the needs of the injured persons so that, to the extent possible, the physical or mental health of the person is sustained or improved. This is the paramount concern when assessing damages for personal injury.[262]

246. The Plans limit paying for care from professional care providers or family members to persons at disease level 6, regardless of when the need for care arose, and limit payment to $50,000 per annum in 1999 dollars. This is a marked departure from tort principles which would provide compensation for care based on the needs of the person to the level reasonably required. This departure was solely driven by financial sufficiency concerns.

247. Loss of services in the home under the Plans compensates for the loss of contribution the class member can make to the running of the household. In a tort or civil liability case, such compensation would be paid as part of cost of future care as aspects of the daily living that must be replaced for the plaintiff, either by hiring someone else or relying on a family member to

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[260] The conversion rate is 1.35: Eckler Sufficiency Report, Exhibit A, JR Vol. 19 , Tab 45A, para. 293, p. 6820; Peterson Affidavit #13, JR Vol. 2, Tab 12, para. 19, pp. 354-355.

[261] McKellar, Non Pecuniary Damages Upper Limits, Online: McKellar Structured Settlements <http://www.mckellar.com/non-pecuniary-damages-upper-limits>

[262] *Andrews*, *supra*, at pp. 240-242 and 261.

provide these valuable services. The Plans treat loss of services in the home as an alternative to loss of income payments and they are only paid in the alternative. They are paid at a capped hourly rate ($12 in 1999 dollars) for a capped number of hours per week (20). These are also marked departures from tort principles solely driven by financial sufficiency concerns.

248. As emphasized by the Supreme Court of Canada in the trilogy, full compensation on cost of care is paramount given policy choices to restrict non-pecuniary damages. The compromises made in the Plans in order to ensure financial sufficiency are not faithful to this trade-off since the Plans under- compensate cost of care and the fixed disease level payments are cumulatively less than the trilogy rough upper limit notwithstanding that disease level 6 is triggered by devastating and debilitating conditions such as end stage liver failure, B-cell lymphoma, symptomatic mixed cryoglobulinemia, glomerulonephritis requiring dialysis and renal failure.

Family Class Member Benefits and Funeral Expenses

249. In Ontario, wrongful injury claims are available to family members of an injured person under statute where a person is injured or killed by the fault or neglect of another under circumstances where the person is entitled to recover damages, or would have been entitled if not killed.[263]

250. In wrongful death cases, recovery is also governed by statute. All Canadian jurisdictions permit pecuniary losses to be recovered including funeral costs and loss of financial support to the dependants of the deceased. The legislation of all of the provinces (in the case of Québec, the Civil Code and jurisprudence developed thereunder), provides for bereavement damages, except for British Columbia.[264] None of the territorial legislation provides for bereavement damages. In British Columba, the legislation is limited to pecuniary losses, which has been interpreted to include loss of care, guidance and companionship to children of the deceased.[265]

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[263] Ontario: *Family Law Act*, RSO 1990, c F.3, s. 61

[264] Also referred to as loss of consortium, *solatium doloris*, moral compensation for grief and distress and/or loss of care, guidance and companionship. Alberta: *Fatal Accidents Act*, RSA 2000, c F-8 s. 8; Saskatchewan: *The Fatal Accidents Act*, RSS 1978, c F-11 , s. 4.1; Manitoba: *The Fatal Accidents Act*, CCSM c F50, s. 3.1; Ontario: *Family Law Act*, RSO 1990, c F.3, s. 61; Québec: Civil Code of Québec article 1457 (replacing art. 1053 and 1054.1 CCLC); New Brunswick: *Fatal Accidents Act*, SNB 2012, c 104, s. 10; Nova Scotia: *Fatal Injuries Act*, RSNS 1989, c 163, s. 5; Prince Edward Island: *Fatal Accidents Act*, RSPEI 1988, c F-5 s. 6; Newfoundland and Labrador: *Fatal Accidents Act*, RSNL 1990, c F-6 s. 6

[265] *Balmer Estate v. Hrehirchuk* (1998), 63 B.C.L.R. (3d) 288, at paras. 17-33 *St. Lawrence & Ottawa Ry. Co. v. Lett* (1885) 11 S.C.R. 422 at pp. 432-433.

The persons to whom bereavement, loss of consortium, *solatium doloris* and loss of care, guidance and companionship can be paid varies by statute. In some provinces, the amounts are scheduled in the statutes. In others, they must be proven.[266]

251. The Plans provide scheduled damages for parents, children, siblings, grandparents and grandchildren only in the case of the death of a class member caused by HCV in the scheduled amounts shown below. A review of legislation and cases from 2001-2012 demonstrates that the average awards[267] fell into the ranges shown below.[268]

	Amount under Plans (1999 dollars)	**Amount under Plans (2014 dollars)**	**Awards in case law (2014 dollars)**
Spouse	$25,000	$33,750	$36,210 to $75,000
Child under the age of 21	$15,000	$20,250	$26,000 to $45,000
Child 21 years or older	$5,000	$6,750	$26,000 to $45,000
Parent	$5,000	$6,750	$6,250 to $125,000
Sibling	$5,000	$6,750	$13,000 to $21,000
Grandparent	$500	$675	$6,000
Grandchild	$500	$675	$3,400 to $9,000

252. In addition to the legal basis for adjustment, the submissions of class members and family class members demonstrate that the burden of the disease is very heavy on family class members, notably parents, spouses and adult children, especially where the deceased's illness required family resources in support.

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[266] *Augustus v. Gosset* [1996] 3 S.C.R. 268 at paras. 26-51; see also s. 1607 and 1611 of the Québec Civil Code; Government of Alberta, Review of the Damage Amounts Under Section 8 of the *Fatal Accidents Act* May 2012: https://www.justice.alberta.ca/programs_services/law/Documents/FAA-Discussion-Paper-May-2012.pdf at pp. 5-6 and Appendix A.

[267] The awards in each jurisdiction were described as an average, or a range and an average. We provide the average for each jurisdiction where there is a range, and not the low or high end of the range, which results in a range of averages overall. See: Government of Alberta, Review of the Damage Amounts Under Section 8 of the *Fatal Accidents Act* May 2012: https://www.justice.alberta.ca/programs_services/law/Documents/FAA-Discussion-Paper-May-2012.pdf at pp. 7-8.

[268] Transfused Plan, JR vol. 21, Tab 49A, s. 6.02, p. 7371; Hemophiliac Plan, JR vol. 21, Tab 49B, s. 6.02, pp. 7418-7419.

253. Taking into account that most jurisdictions provide compensation for spouses, children and parents while others provide also for siblings, grandparents and grandchildren,[269] the Joint Committee determined that while the Plans' provisions for most family members are lower than statutory and at large damage awards in most jurisdictions, children of deceased infected persons over the age of 21 and parents of deceased persons were the awards most significantly out of line and the most compelling areas for adjustment particularly having regard to the fact that parent, child and spouse are all first degree of consanguinity/affinity family members.[270]

254. Funeral damages are recoverable in "reasonable" amounts. Unlike the Plans, no jurisdiction has a cap.[271]

Loss of Income and Loss of Support: Non-deductibility of Collateral Benefits

255. The provisions of the Plans exclude collateral income from being included in pre-claim net income, but they nevertheless require that collateral benefits be deducted as post-claim net income, thus reducing the actual income and/or support loss recoverable.[272] The deducted benefits include disability insurance, CPP/QPP, employment insurance and HIV Programs.

256. In addition to the provisions concerning collateral benefits in the income/support loss provisions of the Plans, there is a specific provision concerning collateral benefits as follows:

> 8.03 Collateral Benefits
>
> > (1) If a Class Member is or was entitled to be paid compensation under this Plan and is or was also entitled to be paid compensation under an insurance policy or other plan or claim in any way relating to or arising from the infection of a HCV Infected Person with HCV, the compensation payable under this Plan will be reduced by the amount of the

[269] CBABC Briefing Note, *Family Compensation Act*, Current to August 31, 2014, available online at: http://www.cbabc.org/CMSPages/GetFile.aspx?guid=daa1204b-37ec-40ac-afa4-a530b88ed5cb at pp. 11-12.

[270] Peterson Affidavit #13, JR Vol.1, Tab 12, para. 94, p.378.

[271] Alberta: *Fatal Accidents Act*, RSA 2000, c F-8 s. 7; Saskatchewan: *The Fatal Accidents Act*, RSS 1978, c F-11 , s. 4(2); British Columbia: *Family Compensation Act*, RSBC 1996, c.126, s. 3(9)(b); Manitoba: *The Fatal Accidents Act*, CCSM c F50, s. 3(3); Ontario: *Family Law Act*, RSO 1990, c F.3, s. 61(2); Québec: Civil Code of Québec article 1457 (replacing art. 1053 and 1054.1 CCLC); New Brunswick: *Fatal Accidents Act*, SNB 2012, c 104, s. 9; Nova Scotia: *Fatal Injuries Act*, RSNS 1989, c 163, s. 5; Prince Edward Island: *Fatal Accidents Act*, RSPEI 1988, c F-5 s. 6(3)(a); Newfoundland and Labrador: *Fatal Accidents Act*, RSNL 1990, c F-6 s. 9

[272] Transfused Plan, JR Vol.21, Tab 49A, s. 4.02(2), pp. 7363-7363, s. 6.01(1), p. 7370; Hemophiliac Plan, JR Vol.21, Tab 49B, s. 4.02(2), p. 7410, s,6.01(1), p. 7418 Peterson Affidavit #13, JR Vol.2, Tab 12, para.101, p. p.380.

> compensation that the Class Member is entitled to be paid under the insurance policy or other plan or claim.
>
> (2) Notwithstanding the provisions of Section 8.03(1), life insurance payments received by any Class Member will not be taken into account for any purposes whatsoever under this Plan.

257. The existence of provisions of this nature in the Plans is very much in keeping with the need to contain the scheduled benefits within the envelope of compensation available and in no way should detract from the fact that deductions such as these are a significant compromise from the tort principle of full and fair compensation found in the case law concerning pecuniary loss which is discussed below.

258. The case law pertaining to collateral benefits rests on the principle that recovery in tort claims for personal injury should be as complete as possible compensation for the loss suffered. The plaintiff is not entitled to double recovery.[273]

259. The leading case in Canada on the non-deductibility of income related collateral benefits in tort cases is *Cunningham*.[274] In that case, the majority (per Cory J.) held that the principle that a tort victim is entitled to compensation for his injuries but not to double compensation is subject to exception for charitable donations and insurance for which consideration has been given. The minority agreed that charitable donations are not deductible, but held that the deductibility of insurance or other benefits, in particular disability insurance, turns on whether the insurance is an indemnity contract (deductible unless it is subrogated) or non-indemnity.[275] Non-indemnity benefits which are not deductible include accident insurance, CPP benefits and company pension plan benefits. [276]

260. The majority held that while earlier cases had focussed on indemnity / non-indemnity and what "caused" the insurance to be paid to be the fulcrum for determining deductibility, the appropriate approach was to determine whether the plaintiff had paid for the benefit, and if the

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[273] *Cunningham v. Wheeler* [1994] 1 S.C.R. 359 at 396 [***Cunningham***].

[274] Ibid. In *Cunningham* the Supreme Court of Canada also confirmed its previous decision *R v. Jennings,* [1966] S.C.R. 532 that a plaintiff's damages for lost income should not be reduced by the amount of tax which would have been payable had they been earned as income. At this time, however, the Joint Committee does not seek to restore the income tax payments which have been deducted from loss of income claims.

[275] *Cunningham, supra,* minority reasons at pp. 370-373, 390.

[276] The minority in *Cunningham* cites previous cases of the Court including *Canadian Pacific v. Gill* [1973] S.C.R. 654 [***Gill***]; *Guy v. Trizec Equities Ltd.* [1979] 2 S.C.R. 756.

answer was yes, the defendant could not take credit for it. Any income replacement benefits for which the plaintiff has directly or indirectly provided consideration, such as an employment benefit where the rate of pay would have been higher but for the benefit, are not deductible.[277]

261. The majority in *Cunningham* also addressed article 1608 of the Civil Code of Québec which provides:

> Article 1608
>
> The obligation of the debtor to pay damages to the creditor is neither reduced or altered by the fact that the creditor receives a benefit from a third person, as a result of the injury he has suffered, except so far as the third person is subrogated to the rights of the creditor.

The majority characterized this provision as a "specific provision for no deductibility" "after careful consideration of the advantages and disadvantages".[278]

262. Since *Cunningham,* the Supreme Court of Canada has considered whether establishing that the plaintiff has "paid" for the insurance is central to the determination of whether a benefit is deductible in a wrongful dismissal case, *Waterman v. IBM Canada Ltd*. [279] The Court has broadened the analysis by bringing the indemnity / non-indemnity issue back in, retained the inquiry as to whether the plaintiff paid for the benefit but reduced its importance in the ultimate determination of deductibility, and added policy considerations to the analysis.[280]

263. Although *Waterman* is a wrongful dismissal case about pension retirement benefits paid during the notice period, it has been applied in one personal injury case.[281] The law in Québec has not changed in regard to the proper interpretation of article 1608: in the absence of a subrogation clause, income replacement payments received by a plaintiff from her professional organization are not deductible when the plaintiff makes a claim for income loss for the same period.[282]

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[277] *Cunningham*, supra, at pp. 400-401, 403-404, 407-408.

[278] *Cunningham,* supra, at pp. 401-403.

[279] 2013 SCC 70 [***Waterman***].

[280] *Waterman, supra,* at para. 76.

[281] *Mazucco* v. *Herer*, 2015 ONSC 7083 [***Mazucco***] at pp. 6-8.

[282] *Asgar c. Syndicat de la copropriété Lofts Saint-Urbain*, 2015 QCCS 179 at paras. 44-51.

264. The jurisprudence continues to highlight the differing views on this issue, the most contentious issues pertain to private income replacement collateral benefits. Some collateral benefits such as CPP disability insurance and EI benefits have been the subject of steadfast rules to not deduct. The collateral benefits in issue on this application include some private benefits and some benefits that are not controversial. The following paragraphs discuss the case law specific to the collateral benefits in issue on these applications.

Disability Insurance

265. As discussed, in Québec, the rule against deductibility except where subrogation exists is codified and undisturbed. The Québec non-deductibility principle supports the proposal made by the Joint Committee.

266. The common law *Waterman* considerations of indemnity / non-indemnity and whether the plaintiff paid for or contributed to the provision of the benefit cannot be squared with the Québec non-deductibility principle and are difficult to apply on a class wide basis as it would require each class member to adduce evidence of the indemnity character of the benefit and the contribution the class member made to its provision, as well as subrogation rights. However, *Waterman* also instructs that policy considerations are germane as "there is room in the analysis of the deduction issue for broader policy considerations such as the desirability of equal treatment of those in similar situations, the possibility of providing incentives for socially desirable conduct, and the need for clear rules that are easy to apply."[283]

267. In this case, the combination of the broad rule against deductibility in the Civil Code of Québec; the policy reasons promoted in *Waterman* such as treating all class members in a like manner notwithstanding the character of the benefit or whether they paid consideration for the benefit; and the need for clear rules that are easy to apply in the administration of loss of income payments all bode in favour of reversing the compromise in favour of a rule to not deduct any disability insurance.

CPP/QPP Disability Benefits

268. In general, at common law, a defendant is not entitled to deduct CPP benefits received by the plaintiff from an award of damages for loss of income because CPP benefits are similar to

[283] *Waterman*, *supra*, at para. 76.

benefits paid under a contract of indemnity insurance, and so should be excluded from consideration in assessing damages.[284] Since *Gill,*[285] and after *Waterman,*[286] Canadian appellate and trial courts have consistently found that CPP benefits are not deductible from income loss awards made in tort actions.[287] Under Québec law, QPP benefits are non-deductible in the calculation of loss of income award[288] and the same rule is applicable to CPP in the absence of subrogation.

Employment Insurance

269. Employment insurance, previously known as unemployment insurance, has long been held to not be deductible on the basis that it is a benefit of the employment contract and only paid by virtue of this contract.[289] This is the same reasoning that contributory pension benefits should not be deducted.[290] In 1980, the Québec Court of Appeal established that these benefits should not be deducted from the compensation for loss of income paid to a victim due to the absence of legal subrogation in the applicable law[291] which is still applicable and consistent with s. 1608 C.C.Q.

HIV Programs

270. EAP is an HIV program provided by the Federal Government. The Nova Scotia Compensation Plan and the MPTAP are provided by the PT Governments. They all provide compensation for persons who contracted HIV through the blood system.[292]

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[284] *Gill, supra* at p.670.

[285] *Demers v. B.R. Davidson Mining & Development Ltd.* 2012 ONCA 384 at para. 13; *Sulz v. Canada (Attorney General)* 2006 BCCA 582 at paras. 65-66; *Hayre v. Walz* [1992] B.C.J. No. 985, (CA) at p.4.

[286] *Waterman, supra* at paras. 43-46.

[287] *Mazzucco, supra* at p. 2.

[288] Fortier c. Sainte-Séraphine (Municipalité) 2003 CanLII 589 (QC CS) para. 101.

[289] *Jack Cewe v. Jorgenson* [1980] 1 SCR 812 at 818.

[290] *Guy v. Trizec Equities Ltd*., *supra* at pp.762-764.

[291] *Girardeau c. Nadeau* [1980] C.A. 258, at paras. 20-22 and 25-30.

[292] The Extraordinary Assistance Program ("**EAP**") is a Federal program that provides compensation for persons who contracted HIV through the blood system of $30,000 tax free to the earlier of four years or date of death. The Multi-Provincial Territorial Assistance Program ("**MPTAP**"). offered by all provinces and territories except Nova Scotia, provides compensation for persons who contracted HIV through the blood system in the amount of $22,000 upon acceptance (following the EAP payments) and then $30,000 tax free per annum paid for life. Spouses and children of an infected person are also entitled to survivor benefits under MPTAP. The Nova Scotia Compensation Plan is similar

271. In *Re Canadian Red Cross Society,* the Ontario Superior Court of Justice characterised the MPTAP program as "*ex gratia* financial assistance" ... "to persons directly infected with HIV through the blood system in Canada", and EAP and the Nova Scotia Compensation Plan and other collateral benefit programs as "gratuitous programs initiated by the various levels of government in an attempt to address the consequences of the blood contamination tragedy". [293]

272. A collateral benefit "problem" only arises in respect of a benefit that constitutes an excess recovery for the plaintiff's loss, and there is only a collateral benefit problem if the benefit in question is significantly connected to the defendant's breach.

273. The Settlement Agreement compensates class members infected with HCV. Although some class members are co-infected with HIV and HCV, the Settlement Agreement does not purport to compensate class members who have HIV for their HIV.[294] While the same entities were responsible for the contraction of HIV and HCV in infected persons, each was the result of distinct and independent blood contamination events.

274. In sum, HIV programs are gratuitous payments for a separate divisible injury and should not be deductible given the steadfast rules pertaining to non-deductibility of charitable gifts, non-deductibility of non-indemnity payments, and non-deductibility of payments which are not causally connected to the defendant's breach.[295]

Compensation For Diminished Pension and Employment Benefits

275. The Plans do not have any provisions for the loss of pension or other employment benefits suffered by class members as a result of their being disabled from working due to their infection with HCV.[296] This is a significant departure from tort principles.

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to MPTAP but includes additional items such as, education and drug benefits. The MPTAP and Nova Scotia plans provide that if a cure becomes available the payments shall end. Commission of Inquiry on the Blood System in Canada, Final Report, Vol. 3 (Ottawa: Public Work and Government Services Canada, 1997), at pp. 1031-1033.

[293] *Re Canadian Red Cross* Society, 2006 CanLII 22141 at paras. 17-20

[294] Section 3.03 of the Settlement Agreement established the Program to provide HIV Secondarily-Infected Persons with a lump-sum payment of $240,000. Such payments will be made out of the Trust to a maximum of 240 payments. This is not compensation to class members. Settlement Agreement, JR Vol. 21, Tab 49, s. 3.01, p.7322 and Schedule C, pp. 7438-7442

[295] *Cunningham, supra*, at p. 370 and *Waterman, supra* at paras. 15, 28-32, 39

[296] Peterson Affidavit #13, JR Vol.2, Tab 12, para.101, p.380

276. The jurisprudence provides that contributions which employers make to pension plans (including the CPP) and the lost opportunity to make one's own contributions to a pension are part of earning capacity and compensable.[297] Employment benefits are routinely valued in the future income loss component of tort recoveries.

277. The Plans do not compensate for lost pension and other employment benefits and in this manner fall short of the objective of providing full and fair pecuniary compensation. The Joint Committee recommends a conservative and practical approach to valuing these losses as 10% percent of income to an upper limit of $200,000 (2014 dollars), ie: the measure of the loss is the annual cost of the contribution to the benefit.[298] While one objection to such an across the board approach is the risk of over compensating some individuals who do not have pensions or employment benefits equalling that amount and undercompensating those who have them in greater amounts, the policy reasons in *Waterman* such as treating all class members in a like manner notwithstanding the character of the benefit or whether they paid consideration for it; and the need for clear and manageable rules in the class action context favours this simple remedy to these omitted benefits.

Subrogation

278. The Plans contain a provision concerning rights of subrogation as follows:

> 8.04 Subrogation
>
> No subrogation payment of any nature or kind will be paid, directly or indirectly, under this Plan, and without restricting the generality of this provision:
>
> (a) no FPT Government and no department of an FPT Government providing employment insurance, health care, hospital, medical and prescription services, social assistance or welfare will be paid under this Plan;
>
> (b) no municipality and no department of a municipality will be paid under this Plan;
>
> (c) no person exercising a right of subrogation will be paid under this Plan; and

[297] *Embleton v. Wiseman* (1981), [1982] 1 W.W.R. 80 B.C.C.A. at paras. 17-20; *Ouellette v Tardif*, 2000 CanLII 8519 (QC CA), paras. 65-69.

[298] Border #5, JR Vol. 2, Tab 13A, Exhibit A, paras. 52-56, pp. 476-477.

> (d) no claimant will be paid compensation if the claim is being asserted as a subrogated Claim or if the claimant will hold any money paid under this Plan in trust for any other party exercising a right of subrogation or, except as provided in Section 8.02, if a payment under this Plan will lead to a reduction in other payments for which the claimant would otherwise qualify.

279. Because this settlement was achieved in the context of national class proceedings, it was necessary to structure the Plans so as to create a pan-Canadian solution in the face of legislation and case law that was not uniform across the national front. This was necessary in respect of subrogation because of differences in the way it is applied in common and civil law.

280. As can be seen from the jurisprudence, subrogation is not the only issue that determines the treatment of collateral benefits.

281. The compromises within the Plans across the board establish deductions and restrictions that benefit the financial sufficiency of the Plans. Over the course of the 14 years of administration to the valuation date, class members and family class members in receipt of these benefits that are the subject of this recommendation have suffered the direct financial impact of scheduled benefits which are compromised from tort principles to ensure the overall good of the Trust. The original compromises treated all class members the same and so should they all share in its relief now that the class members' forbearance and prudent management of the funds in the Trust Fund have resulted in actuarially unallocated assets.

282. The class members and family class members now have many years of experience living with HCV and with compensation under the Plans. It is reasonable, given that a key structural feature of the Settlement Agreement is to pay compensation based on the progressive nature of the disease, to take advantage of their rich accumulation of information and experiences to determine whether and how to allocate the Excess Capital.

283. The input provided by the class members and family class members at the consultation sessions and in writing makes it clear that the compromises made due to financial sufficiency concerns have resulted in benefits that do not meet the test set by the Supreme Court of Canada that compensation should "dignify and accept the gravely injured person as a continuing, useful

member of the human race, to whom every assistance should be afforded with a view to his reintegration in society".[299]

iv. Return of Unclaimed Amounts

284. Section 26(10) of Ontario *Class Proceedings Act, 1992*,[300] Section 34(5) of the British Columbia *Class Proceedings Act*,[301] and Section 1036 of the Québec Civil Code of Procedure[302] (or section 597 since the New Civil Code of Procedure[303] is in force in Québec), are not directly applicable.

285. The Ontario and British Columbia provisions are part of the provisions pertaining to aggregate awards, so they are premised on the court giving judgment in an aggregate amount after a common issues trial. These sections address a situation when all claims have been exhausted and a fund remains at a pre-designated point in time. The Québec provision pertains to *cy-pres* awards where payment to class members is impracticable or inappropriate. These are not the circumstances of this application which deals with an actuarial estimate of the future claims against the actuarial estimate of the funds available to satisfy them giving rise to actuarially unallocated funds.

286. As noted above, the factors to be considered by the Courts are not mandatory but permissive. Given the inapplicability of these provisions to these circumstances they are not useful in making a determination on allocation on this application.

v. Whether the Integrity of The Settlement Agreement and Whether the Benefits Particularized in the Plans Ensured

287. The integrity of the Settlement Agreement rests upon essential ingredients of the Settlement Approvals, including the amendment brought about by the Allocation Provisions. The Joint Committee's proposal of allocating the Excess Capital to benefit class members and family class members in ways related to the benefits already provided in the Settlement Agreement and to relieve compromises that had to be made to fit within the envelope

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[299] *Thornton v. School District No. 57 (Prince George)*, [1978] 2 S.C.R. 267 at p. 276.

[300] S.O. 1992. c.6

[301] R.S.B.C. 1996, c.50

[302] *Code of Civil Procedure,* C.Q.L.R., c. C-25, Article 1036

[303] *Code of Civil Procedure,* C.Q.L.R., c. C-25.01, Article 597

of the capped liability of the FPT Governments, is eminently consistent with the integrity of the Settlement Agreement for the following reasons:

(a) the proposals adhere to the underlying philosophy[304] of the Settlement Agreement of tailoring compensation to disease level experienced by each class member over time;

(b) the question of allocation is only possible because class members and family class members have lived with, realized and successfully managed the enormous risk they assumed. Some of that risk came home, some of it was partially avoided, some of it continues, and some of it was not capable of management (ie: disease progression). That portion of the risk that could be managed was managed and the costs of managing it were paid by the class members and family class members;

(c) the proposals essentially seek to improve the scheduled benefits which were acknowledged to be fair and reasonable but "not perfect"[305] due in part to the fact that they had to be compromised to fit within the envelope of available compensation; and

(d) the proposals seek to improve upon the scheduled benefits in ways which are consistent with tort principles as they must be adapted in a class action; ie: to be consistent across the class even though the legal entitlements of the class members differ depending on their home province, and because compensation in a settlement of a class action must be fair on a class wide basis.

288. Canada takes the view that the proposals are an affront to the integrity of the Settlement Agreement because, for example, the Plans call for the deduction of employment insurance benefits from a loss of income claim. To say that the Allocation Provisions cannot be used to benefit class members by relieving them of this compromise, which is inconsistent with compensatory principles, makes no sense. The Allocation Provisions must have some meaning but Canada's objections render them meaningless, as discussed above.

289. Moreover, Canada ignores completely the remaining wording of this factor. When this factor is read in its entirely and in context, it is clear that it is aimed at ensuring that the benefits

[304] *Parsons*, JR Vol. 22, Tab 51, para. 87, p. 7625.

[305] *Parsons*, JR Vol. 22, Tab 51, para. 121, p. 7631.

provided by the Plans not be compromised and that the integrity of the settlement be maintained. So, for example, an allocation that could have the effect of impairing the availability of scheduled benefits for undiagnosed patients who could claim in the future would impact the integrity of the agreement and the entitlements to benefits that should be available thereunder.

vi. Progress of the Disease Compared to the 1999 Medical Model

290. This was an area of risk that was incapable of management. The disease is chronic and progressive in 75% of persons infected and how it manifests is a multi-variate complex phenomenon, the understanding of which has been gradual and emerging over time.

291. At the time of the approval of the Settlement Agreement there was a relative paucity of understanding of the natural history of HCV,[306] especially in regards to persons infected with it through the blood supply, significant portions of whom are hemophiliac and some of whom are co-infected with HIV.

292. Accordingly, class members and family class members bore the risk from the outset that if their disease progression was worse or different than the literature predicted for a much broader group of infected persons, the medical model would be off and they would bear any financial consequences.

293. From 1999 to the financial sufficiency review triggered at December 31, 2010, this risk had significant negative effect on the financial viability of the Trust. Its net effect during that time period was negative $101 million. In fact, its' risk profile was positive only once during that period – by a mere $5 million. Between the December 31, 2007 and December 31, 2010 financial sufficiency reviews, the risk profile deteriorated by $62 million dollars. The advent of DAA therapy very recently markedly changed the financial picture for the most recent (December 31, 2013) financial sufficiency review.[307]

294. For most of the period the Settlement Agreement has been in place, it is debatable whether the treatment was worse than the disease. Treatment with interferon monotherapy with cure rates of 5-10% or the later combination interferon and ribavirin therapy were prolonged affairs which some class members could not take and which had significant side effects.

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[306] *Parsons*, JR Vol. 22, Tab 51, paras.108-110, p .7629.

[307] Border Affidavit #6, JR Vol.5, Tab 19(A), Exhibit A, Actuarial Report para.60, p. 2008.

295. The first group of DAA drugs, with their promise of high SVR rates and low side effects, were a failure due to high rates of contraindications and much worse than expected side effects including, for some, life threatening side effects dictating cessation of treatment before the prescribed period.

296. Finally, in 2014 and 2015, DAA drugs which can be used for some, but not all, class members without interferon and/or ribavirin are at hand. They offer high cure rates. But, it is important to note that they are unproven. The risk has not been eliminated. The risks of ineffectiveness and/or unexpected side effects or triggers of co-morbidities from these drugs have not been eliminated.

297. The 2013 medical model takes into account DAA drugs approved up to and including 2014.[308] The treatment efficacy rates were adopted in the actuarial models of both Eckler and Morneau Shepell.[309]

298. The DAA drugs also bring with them a cost. The agreed upon actuarial estimate of the costs is $146 million; this increase in liability offsets the $305 million decrease in liability due to the reduction of the progression of the disease in the class members. In addition, it was necessary to incorporate a provision for adverse deviation into the liabilities due to the uncertainty of the efficacy of the new treatments.[310]

299. The class members and family class members accepted, and for some 14 years to the valuation date realized, the risk that the Settlement Agreement had to cover a chronic progressive disease with no comprehensive treatment and lousy cure rates. Nor does an SVR guarantee a return to good health. The class members' livers have been damaged over a course

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[308] Dr. Lee criticizes the December 31, 2010 medical model (the 4th model) for not taking into account DAA drugs but he acknowledges on written interrogatories that he did not review the 4th model report (or the 5th model report) in detail and he acknowledges that the first DAA drugs were approved in August 2011 (after the 4th medical model was completed). He acknowledges that the DAA drugs approved at the time the December 31, 2013 medical model was completed are taken into account in that model: Lee Affidavit #1, JR Vol.6, Tab 27, para. 58, pp. 2425-2426; Lee Affidavit #2, JR Vol. 11, Tab 30, Exhibit B, paras. 3-5, 8, p. 4071.

[309] Affidavit #4 of Peter Gorham, made April 8, 2015 [**Gorham Affidavit #4]**, JR Vol. 20, Tab 48, Exhibit B, Table D 4a, p. 7292; Krahn Affidavit #4, JR Vol. 20, Tab 47, Exhibit A, Table 13.1, pp. 7025-7026; Affidavit #5 of Dr. Murray Krahn, re-sworn May 4, 2016 [**Krahn Affidavit #5**], JR Vol. 5, Tab 21, para. 7, pp. 2057-2058; Border Affidavit #6, JR Vol. 5, Tab 19, Exhibit A, paras. 14-16, p. 2000.

[310] Border Affidavit #4, JR Vol.19, Tab 45, Exhibit A, para. 81, p. 6761, para. 202, pp. 6785-6786, paras. 208-210, pp. 6786-6787.

of some 30 years of chronic and progressive viral infection. Some HCV symptoms and co-morbidities will persist.

300. With regard to the progression of the disease, measured not in financial costs to the Trust but rather in the health of the class members, the situation is bleak. Tragically, 959 have died of HCV and, of those still living, 240 have already developed cirrhosis and a further 137 have progressed to disease level 6. And, notwithstanding the higher efficacy of the DAA drugs, significant percentages of class members alive on December 31, 2013 are still headed to cirrhosis, decompensated cirrhosis, hepatocellular cancer and/or death due to HCV by the year 2070.[311]

301. The cure has come too late for many class members and even those who have been cured could have ravaged livers and associated health consequences. The glimpse into the lived experiences of class members and family class members demonstrate that they have fully absorbed the risk of disease progression.

vii. The Fact that Class Members and Family Class Members Bear the Risk of Insufficiency of the Trust Fund

302. This factor is stark. The essential bargain was that the FPT Governments bore no risk and class members and family class members took it all. Canada and the PT Governments eschewed risk to the point where they wrote into the Settlement Agreement that they declined any opportunity or obligation to have a say in the management of the risk.[312]

303. In addition to cohort size, disease distribution, disease progression and investment returns already discussed, certain categories of compensation, such as loss of income, loss of services in the home, out of pocket expenses, uninsured medication, are quantified based on the class members' situation and evidence. At the outset, very broad assumptions had to be made about what quantum of, for example, loss of income claims at the individual and aggregate levels as well as how many would be made at what time.[313] They were refined over time based on

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[311] Krahn Affidavit #4, JR Vol. 20, Tab 47(A), Exhibit A, Medical Modeling Report, Tables 13.1, 13.2, pp. 7025-7026, 7027.

[312] Settlement Agreement, JR Vol. 21, Tab 49, s. 1.10, p. 7320, s. 4.03, pp. 7322-7323.

[313] Krishnamoorthy Affidavit, JR. Vol. 8, Tab 28, Exhibit K 1999 Eckler Actuarial Report, pp. 2960-2963, 2966-2967 and 2999; *Parsons*, JR Vol. 22, Tab 51, para. 58, pp. 7617-7618.

experience with the class members. Those fluctuations show up in the experience gains/loss line in the chart at paragraph 76.

304. The risk has been borne, realized and managed successfully by class members and family class members. There has been a significant cost paid to manage this risk and it has been paid by class members and family class members. In addition to the costs of establishing the Trust Fund and investing the funds of $4,353,611, they have paid $5,209,234 in actuarial advice, annual audits of the Trust triennial financial sufficiency costs, and legal fees as well as $39,494,353 in administration fees, including starting up the processes for the interaction between the administrator and the Trustee and general administration and other fees over 14 years to the valuation date, which relates to some degree to managing the risk, ensuring the sufficiency of the funds to pay claims under the scheduled benefits, and to creating the Excess Capital.

305. Having contractually ensured it had no downside from the risk nor any obligation to manage the risk, Canada now seeks to take advantage of the successful management of the risk borne by the class and the positive results that were achieved.

306. This factor favours the Joint Committee's recommendation.

viii. The Fact That FPT Governments' Contributions Under The Settlement Agreement are Capped

307. The FPT Governments received releases from all class members and family class members in exchange for paying or promising to pay their respective shares of up to a maximum of the settlement amount and no more under any circumstances. In the event that was not enough to provide adequate compensation to class members and family class members, they were out of luck – the FPT Governments had no further requirement to provide further funding.[314]

308. Having ensured all the risk was on class members and family class members, having not participated in any way in the creation of the Excess Capital, and having not shared in any of the expenses pertaining to running the Trust Fund or administering the Settlement Agreement, any

[314] Settlement Agreement, JR Vol. 21, Tab 49, s. 1.10, p. 7320, s. 4.03, pp. 7322-7323; Funding Agreement, JR Vol. 21, Tab 49(D), s. 4.05, p. 7460.

award of Excess Capital to Canada before addressing the compromised benefits payable to class members and family class would be a windfall.

309. Given that the Joint Committee has structured its proposals to provide that all retroactive and prospective benefits which may become payable to class members and family class members come from the Excess Capital, the PT Governments are neither required to accelerate their "pay as you go" contributions, nor to increase their payments beyond the bargained amount.

ix. Source of the Money and Other Assets which Comprise the Trust Fund

310. The source of the money and other assets which currently comprise the Trust Fund is primarily the investment returns earned by class members and family class members. The returns were earned through the strategy and skill of the investment consultants, the investment managers, the actuaries, the accountants, the Trustee, the Administrator, Class Counsel and the Joint Committee, all as overseen by the Courts, and all at the expense of class members and family class members. [315]

311. In keeping with the "hands off" bargain it struck in the Settlement Agreement, Canada has had nothing to do with the investments of the Trust Fund[316] or paid any of the direct costs of $4,353,611 in setting up the Trust Fund, development of the investment strategy and annual investment costs. Nor has Canada contributed to the set up administrative costs and ongoing actuarial and administrative costs totalling $44,703,587.

312. Indeed, had the Trust Fund been invested at the Treasury Bill Rates at which the PT Governments' shares have been notionally held, Canada's actuary calculates an actuarial shortfall of $348 million as at December 31, 2013.[317] That is to say, the $604 million difference they identify between this notional shortfall and its $256 million Excess Capital position is entirely the product of the investment strategy carried out for and funded by class members and family class members.

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[315] Border Affidavit #6, JR Vol.5, Tab 19, Exhibit A, paras. 55-59, p. 2008.

[316] Settlement Agreement, JR Vol.21, Tab 49, s. 1.10, p. 7320, s. 4.03, pp. 7322-7323; Funding Agreement, JR Vol. 21, Tab 49D, s. 4.05, p. 7460.

[317] Affidavit #5 of Peter Gorham, made January 29, 2016 [**Gorham Affidavit #5**], JR Vol. 6, Tab 26, Exhibit B, paras. 83-87, pp. 2324-2325.

313. In summary, without exception, all of the factors the Courts may consider favour granting the Joint Committee's application and denying Canada's application.

PART IV - ORDER REQUESTED

314. For the foregoing reasons, the Joint Committee request the relief set out in the following paragraphs.

315. A declaration that the Trustee of the 1986-1990 Hepatitis C Settlement Agreement (the "Settlement Agreement") holds $206,920,000 actuarially unallocated money and assets as at December 31, 2013 (the "excess capital").

316. An order that the restrictions on payments of amounts for loss of income claims in section 4.02(2)(b)(i) of the Transfused HCV Plan and section 4.02(2)(b)(i) of the Hemophiliac HCV Plan and for loss of support under section 6.01(1) of the Transfused HCV Plan and section 6.01(1) of the Hemophiliac HCV Plan, as previously varied, not be varied or removed in whole or in part at this time.

317. An order that the Court exercise its unfettered discretion to allocate the excess capital for the benefit of Class Members and Family Class Members by approving the following:

(a) the Court Approved Protocol for Late Claim Requests following the June 30, 2010 First Claim Deadline, attached as Appendix "A", to permit Class Members who missed the June 30, 2010 First Claim Deadline to apply to receive an Initial Claim Package and have his or her Claim processed in circumstances where they have satisfied a Referee that their delay was for reasons beyond their control or there is a reasonable explanation for their delay;

(b.1) a 10% increase in the fixed payments made pursuant to: section 4.01(1) of the Transfused HCV Plan; the $50,000 (1999 dollars) fixed payment made pursuant to 5.01(1) of the Transfused HCV Plan; the $120,000 (1999 dollars) fixed payment made pursuant to 5.01(2) of the Transfused HCV Plan; the fixed payments made pursuant to section 4.01 of the Hemophiliac HCV Plan; the $50,000 (1999 dollars) fixed payment made pursuant to s.4.08(2) of the Hemophiliac HCV Plan; the $50,000 (1999 dollars) fixed payment made pursuant to s. 5.01(1) of the Hemophiliac HCV Plan, the $120,000

(1999 dollars) fixed payment made pursuant to s. 5.01(2) of the Hemophiliac HCV Plan and the $72,000 (1999 dollars) fixed payment made pursuant to 5.01(4) of the Hemophiliac HCV Plan, made retroactively and prospectively;

(b.2) in the alternative to (b.1), an 8.5% increase, indexed to January 1, 2014, in the fixed payments made pursuant to: section 4.01(1) of the Transfused HCV Plan; the $50,000 (1999 dollars) fixed payment made pursuant to 5.01(1) of the Transfused HCV Plan; the $120,000 (1999 dollars) fixed payment made pursuant to 5.01(2) of the Transfused HCV Plan; the fixed payments made pursuant to section 4.01 of the Hemophiliac HCV Plan; the $50,000 (1999 dollars) fixed payment made pursuant to s.4.08(2) of the Hemophiliac HCV Plan; the $50,000 (1999 dollars) fixed payment made pursuant to s. 5.01(1) of the Hemophiliac HCV Plan; the $120,000 (1999 dollars) fixed payment made pursuant to s. 5.01(2) of the Hemophiliac HCV Plan and the $72,000 (1999 dollars) fixed payment made pursuant to 5.01(4) of the Hemophiliac HCV Plan, made retroactively and prospectively;

(c.1) an increase from $5,000 (1999 dollars) to $10,000 (1999 dollars) in the fixed payment to a Child 21 years or older at the date of death of an HCV Infected Person pursuant to section 6.02(c) of the Transfused HCV Plan and section 6.02(c) of the Hemophiliac HCV Plan, made retroactively and prospectively;

(c.2) in the alternative (c.1), an increase from $5,000 (1999 dollars) to $9,600 (1999 dollars) in the fixed payment to a Child 21 years or older at the date of death of an HCV Infected Person pursuant to section 6.02(c) of the Transfused HCV Plan and section 6.02(c) of the Hemophiliac HCV Plan, made retroactively and prospectively, indexed to January 1, 2014;

(d.1) an increase from $5,000 (1999 dollars) to $10,000 (1999 dollars) in the fixed payment to a Parent pursuant to section 6.02 (d) of the Transfused HCV Plan and section 6.02(d) of the Hemophiliac HCV Plan, made retroactively and prospectively;

(d.2) in the alternative (d.1), an increase from $5,000 (1999 dollars) to $9,600 (1999 dollars) in the fixed payment to a Parent pursuant to section 6.02 (d) of the

Transfused HCV Plan and section 6.02(d) of the Hemophiliac HCV Plan, made retroactively and prospectively, indexed to January 1, 2014;

(e) a retroactive payment of the amounts deducted for Canada Pension Plan ("CPP") disability payments, disability insurance, Employment Insurance ("UEI/EI") and Multi-Provincial and Territorial Assistance Program ("MPTAP") from loss of income and loss of support claims in sections 4.02 and 6.01(1) of the Transfused HCV Plan and sections 4.02 and 6.01(1) of the Hemophiliac HCV Plan, and discontinuing such deductions from loss of income and loss of support claims prospectively;

(f) a 10% increase on loss of income and loss of support payments made pursuant to Section 4.02 of the Transfused HCV Plan and section 4.02 of the Hemophiliac HCV Plan, subject to a cap on the income to which the increase is applied of $200,000 for years prior to 2014 and $200,000 indexed for years 2014 forward, to provide compensation for diminished pension due to disability, made retroactively and prospectively;

(g) an increase in the maximum hours on which a loss of services claim can be based pursuant to sections 4.03(2) and 6.01(2) of the Transfused HCV Plan and section 4.03(2) and 6.01(2) of the Hemophiliac HCV Plan from the equivalent of 20 hours per week to 22 hours per week, made retroactively and prospectively;

(h) an increase in the limit on cost of care compensation in section 4.04 of the Transfused HCV Plan and section 4.04 of the Hemophiliac HCV Plan from $50,000 per annum (1999 dollars) to $60,000 per annum (1999 dollars), made retroactively and prospectively;

(i) a $200 (2014 dollars) allowance payable to a Family Member (as that term is defined in section 1.01 of the Transfused HCV Plan and section 1.01 of the Hemophiliac HCV Plan) who accompanies an HCV Infected Person to a medical appointment seeking medical advice or treatment due to his or her HCV infection, in addition to the out of pocket expenses recoverable under section 4.07(a) of the Transfused HCV Plan and section 4.07(a) of the Hemophiliac HCV Plan, payable prospectively;

(j) an increase in the limit on reimbursement of funeral expenses in sections 5.01(1) and 5.02(1) of the Transfused HCV Plan and sections 5.01(1) and 5.02(1) of the Hemophiliac HCV Plan, from $5,000 (1999 dollars) to $10,000 (1999 dollars), made retroactively and prospectively; and

(k) payment of the costs associated with administering the foregoing benefits.

318. An order that all retroactive payments to be made shall be made by way of lump sum to the Class Member and/or Family Class Member or their Personal Representative as that term is defined in section 1.01 of the Transfused HCV Plan and section 1.01 of the Hemophiliac HCV Plan.

319. An Order that all allocation benefits payable to Class Members and Family Class Members shall be paid from the Invested Fund.

320. An order that the remaining excess capital shall be retained within the Trust Fund subject to any further application by the Joint Committee.

321. An order that the orders made pertaining to the preceding paragraphs shall not be effective unless and until corresponding orders are made by each of the Courts.

322. An order that Canada's application is dismissed.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 28th day of May, 2016.

Kathryn Podrebarac, Joint Committee Member

for Harvey Strosberg, Joint Committee Member

J.J. Camp, Joint Committee Member

Michel Savonitto, Joint Committee Member

SCHEDULE "A"
LIST OF AUTHORITIES

Cases

Tab	Authority
1.	*Andrews v Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229
2.	*Arnold v Teno,* [1978] 2 S.C.R. 287
3.	*Asgar c. Syndicat de la copropriété Lofts Saint-Urbain,* 2015 QCCS 179 (CanLII)
4.	*Association d'aide aux victimes des prothèses de la hanche c. Centerpulse orthopedics inc.*, 2005 CanLII 37469 (QC CS)
5.	*Augustus v Gosset,* [1996] 3 S.C.R. 268
6.	*Balmer Estate v Hrehirchuk* (1998), 63 B.C.L.R. (3d) 288 (BCSC) (QL)
7.	*Canadian Pacific Ltd. v Gill,* [1973] S.C.R. 654
8.	*Courchesne c. Noranda Inc.,* 2006 QCCS 4010 (CanLII)
9.	*Cunningham v Wheeler*, [1994] 1 S.C.R. 359
10.	*Demers v B.R. Davidson Mining & Development Ltd.,* 2012 ONCA 384 (CanLII)
11.	*Embleton v Wiseman,* [1982] 1 W.W.R. 80 (QL)
12.	*Fortier c. Sainte-Séraphine (Municipalité),* 2003 CanLII 589 (QC CS)
13.	*Girardeau c. Nadeau,* [1980] C.A. 258 (QL)
14.	*Guy v Trizec Equities Ltd.,* [1979] 2 S.C.R. 756
15.	*Hayre v Walz,* [1992] B.C.J. No. 985 (CA) (QL)
16.	*Honhon c. Canada (Procureur général),* 2014 QCCS 2032 (CanLII) (Unofficial English Translation of the decision on late claims)
17.	*Jack Cewe Ltd. v Jorgenson,* [1980] 1 S.C.R. 812
18.	*Markus c Reebok Canada Inc.,* 2012 QCCS 3562 (CanLII)
19.	*Mazzucco v Herer,* 2015 ONSC 7083 (CanLII)
20.	*McCowan v McCowan,* [1995] O.J. No. 2245 (CA) (QL)
21.	*Monarch Construction Ltd. v Buildevco Ltd*., [1998] O.J. No. 332 (CA) (QL)

Tab	Authority
22.	*Neinstein v Marrero*, [2007] O.J. No. 1595 (SCJ) (QL)
23.	*Ouellette c. Tardif*, 2000 CanLII 8519 (QC CA)
24.	*R. v Jennings*, [1966] S.C.R. 532
25.	*Re Canadian Red Cross Society*, 2006 CanLII 22141, 23 CBR (5th) 143
26.	*Rick v. Brandsema*, 2009 SCC 10, [2009] 1 S.C.R. 295
27.	*Ruffudeen-Coutts v Coutts*, [2012] O.J. No. 400 (CA) (QL)
28.	*Sattva Capital Corp v Creston Moly Corp*., 2014 SCC 53, [2014] 2 S.C.R. 633
29.	*Shackleton v Shackleton*, [1999] B.C.J. No. 2653 (CA) (QL)
30.	*St. Lawrence & Ottawa Ry. Co v Lett* (1885), 11 S.C.R. 422
31.	*Sulz v Canada (Attorney General)*, 2006 BCCA 582 (CanLII)
32.	*Thornton v School District No. 57 (Prince George) et al*, [1978] 2 S.C.R. 267
33.	*Waterman v IBM Canada Ltd.*, 2013 SCC 70, [2013] 3 S.C.R. 985

Secondary Sources

Tab	Authority
34.	CBABC Briefing Note, *Family Compensation Act*, Current to August 31, 2014, available online at: http://www.cbabc.org/CMSPages/GetFile.aspx?guid=daa1204b-37ec-40ac-afa4-a530b88ed5cb at pp. 11-12
35.	*Commission of Inquiry on the Blood System in Canada: Final Report*, Vol. 3 (Ottawa: Public Works and Government Services Canada, 1997), at pp. 1031-1033
36.	Geoff R. Hall, *Canadian Contractual Interpretation Law*, 3rd ed. (Markham: LexisNexis Canada, 2016) at pp. 16-17
37.	Government of Alberta, Review of Damage Amounts Under Section 8 of *the Fatal Accidents Act*, May 2012: https://www.justice.alberta.ca/programs_services/law/Documents/FAA-Discussion-Paper-May-2012.pdf at pp. 5-8 and Appendix A
38.	McKellar, Non Pecuniary Damages Upper Limits, Online: McKellar Structured Settlements <http://www.mckellar.com/non-pecuniary-damages-upper-limits>

Legislation

Tab	Authority
39.	*Civil Code of Québec*, C.C.Q., c. 64, Articles 1425-1432, 1457, 1607, 1608, 1611 & 1615
40.	*Class Proceedings Act*, RSBC 1996, c. 50, s. 34(5)
41.	*Class Proceedings Act*, SO 1992, c. 6, s. 26(10)
42.	*Code of Civil Procedure*, C.Q.L.R., c. C-25, Article 1036
43.	*Code of Civil Procedure*, C.Q.L.R., c. C-25.01, Article 597
44.	*Family Compensation Act*, RSBC 1996, c. 126, s. 3(9)(b)
45.	*Family Law Act*, RSO 1990 c, F.3, s. 61(1), 61(2)
46.	*Fatal Accidents Act*, RSPEI 1988, c. F-5, s. 6, 6(3)(a)
47.	*Fatal Accidents Act*, RSNL 1990, c. F-6, s. 6, 9
48.	*Fatal Accidents Act*, RSA 2000, c. F-8, s. 7, 8
49.	*Fatal Accidents Act*, SNB 2012, c. 104, s. 9, 10
50.	*Fatal Injuries Act*, RSNS 1989, c. 163, s. 5
51.	*The Fatal Accidents Act*, RSS 1978, c. F-11, s. 4(2), 4.1
52.	*The Fatal Accidents Act*, CCSM c. F50, s. 3(3), 3.1

SCHEDULE "B"
RELEVANT STATUTES

Ontario

Class Proceedings Act, 1992, S.O. 1992, c. 6

26 (10) Any part of an award for division among individual class members that remains unclaimed or otherwise undistributed after a time set by the court shall be returned to the party against whom the award was made, without further order of the court. 1992, c. 6, s. 26 (10).

British Columbia

Class Proceedings Act, RSBC 1996, c. 50

34(5) If any part of an award that, under section 32 (1), is to be divided among individual class or subclass members remains unclaimed or otherwise undistributed after a time set by the court, the court may order that that part of the award

(a) be applied against the cost of the class proceeding,

(b) be forfeited to the government, or

(c) be returned to the party against whom the award was made.

Quebec

Civil Code of Quebec, C.C.Q., c. 64

1036. The court disposes of the balance in the manner it determines, taking particular account of the interest of the members, after giving the parties and any other person it designates an opportunity to be heard.

DISEASE-BASED COMPENSATION SCHEDULE FOR HCV INFECTED PERSONS

DISEASE LEVEL	MEDICAL CONDITIONS CAUSED BY HCV	COMPENSATION					
		FIXED PAYMENTS AS COMPENSATION FOR PAIN AND SUFFERING*	LOSS OF INCOME OR COMPENSATION FOR LOSS OF HOME SERVICES (CLAIM ONE OR THE OTHER)	ADDITIONAL PAYMENT IF YOU TAKE COMPENSABLE HCV DRUG THERAPY	REIMBURSEMENT FOR UNINSURED TREATMENT AND MEDICATION COSTS	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; or f) renal failure.	**You will receive $100,000** at this level.**	**Yes**	**Yes, $1,000 per month of completed therapy.**	**Yes**	**Yes**	**Yes, up to $50,000** per year.**
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.**	**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 2 If you waive the $30,000** payment at this level, 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.**	**Yes**	**$1,000 per month of completed therapy**	**Yes**	**Yes**	**Not applicable**
		OPTION 1 You will receive $30,000 at this level.**	**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.**	**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.**	**Not applicable**	**Not applicable**	**Yes**	**Yes**	**Not applicable**

*Fixed payments are cumulative—for example, a Level 3 claimant choosing Option 1 will receive Level 1- $10,000** plus Level 2 - $20,0000** plus Level 3 - $30,000**, for a total of $60,000**.
**Amounts shown are in 1999 dollars and subject to annual CPI adjustment.