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Testimony re: SB 184
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I. Introductory Remarks:

PACT provides workers compensation benefits to most of the small and rural governmental agencies with police officers and firefighters. We recognize and value the services provided by our police officers and firefighters and readily provide coverage for their occupational diseases that occur as a result of their employment.

With regard to SB 184, since the Legislature determined as a matter of public policy that Hepatitis benefits should be extended to paid firefighters, we believe it is entirely appropriate to extend coverage to police officers who likely are exposed to HCV as much or more than firefighters. However, we do want to note the significant fiscal impact of this benefit and to restate our concerns about the conclusive presumption for workers compensation benefits.

During the 2001 Legislative Session, Hepatitis A,B and C occupational disease coverage was added for full time, paid firefighters and extended the conclusive presumption language to this benefit. SB 184 apparently would expand this to ***all*** police officers, not just full time, paid police officers. Therefore, this bill contains an even more significant fiscal impact that must be considered.

II. What do we suggest the committee do with SB 184?

Further explanation is provided below, but the committee should consider these issues and recommendations, although several are outside the scope of this particular bill:

1. Restrict SB 184 eligibility to full-time, paid police officers
2. Cost and sources for funding Hepatitis benefits whether or not expanded to police
3. Change the conclusive presumption by adopting the approach done in AB 279 of the 2001 Session which requires immediate and subsequent testing following an exposure
4. Change benefit eligibility to focus on long-term employees
5. Change PTD provisions to be the same as it is for all other occupations
6. Modify the post-employment eligibility period for heart/lung disease
7. Commission an LCB study of the lifetime costs of all police and firefighter benefits

III. Financial consequences of SB 184

Fiscal data is difficult to obtain regarding the subject of Hepatitis C (HCV), particularly when the definition includes any associated condition or disease. A Center for Disease Control

study indicated that HCV incidence rates were 1.8% for the general population out of which over 2/3 had active HCV infection.

One of the provisions of SB 184 requires base line testing. There are two outcomes to this: 1) we immediately identify cases, some of which could require immediate treatment at high costs and 2) we catch cases early enough to allow drug treatment to save lives and also reduce long term costs.

If caught early and subject to a course of drug treatments that successfully avoid a liver transplant, those treatment costs have been estimated to be about $50,000 in one Nevada case, but could range between $65,000 and $200,000 lifetime, depending upon age of start of treatment, according to a Milliman & Robertson actuarial study. Cost without treatment ranged from $100,000 to $410,000, according to the study.

Data provided by the Nevada Rural Hospital Project revealed charges for all hospitals totaling $7.566 million for in-patient only care of 18 HCV cases from the 3rd quarter of 1998 through the 2nd quarter of 2000 for 1900 patient days. This does not include any outpatient testing and treatment, liver transplants or other provider care. This comes to about $420,000 per case for the in-patient treatment only. From one large southeastern county (not in Nevada) it was reported that their 10 Hepatitis C cases were reserved at $3.5 million for an average of $350,000 each.

PACT exposure to HCV cases arises from these employee and volunteer estimates throughout small and rural communities that comprise our membership base:

Counties (14)	683 Paid Police; 332 Volunteer Police
Cities (7)	124 Paid Police; 133 Volunteer Police
TOTALS:	807 Paid Police; 465 Volunteer Police

If the ten claims incurred by the southeastern county mentioned previously are any indication of potential risk, the average cost per case will be $350,000. The Nevada hospital data would indicate that his figure should be at least $420,000 and probably near $650,000 with other worker compensation costs and benefits added. For the purpose of this fiscal analysis, $400,000 is used.

If we assume that a course of drug treatments would be the only needed medical intervention at a cost of $50,000 each to only 1.8% of the total number of employees (excluding volunteers) shown above (15 potential cases), the risk potential would be $726,300. However, by applying $400,000 to contemplate cost without treatment including potential transplants or other related diseases, such as AIDS, the risk potential rises to over $5,800,000.

The chart on page 3 summarizes the cost of risk:

	Paid Police	# Disabled @ 1.8% disability rate	Medical only costs @ $50,000	Medical only costs @ $400,000	Annual Indemnity costs @ $32,181 year	Cost for a 10 year indemnity payout period
Counties (14)	683	12.29	$ 614,700	$ 4,917,600	$ 395,633	$ 3,956,332
Cities (7)	124	2.23	$ 111,600	$ 892,800	$ 71,828	$ 718,280
TOTAL:	807	15	$ 726,300	$ 5,810,400	$ 467,461	$ 4,674,612

	Volunteer Police	# Disabled @ 1.8% disability rate	Medical only costs @ $50,000	Medical only costs @ $400,000	Annual Indemnity costs @ $24,000 year	Cost for a 10 year benefit payout period
Counties (14)	332	5.98	$ 298,800	$ 2,390,400	$ 143,424	$ 1,434,240
Cities (7)	133	2.39	$ 119,700	$ 957,600	$ 57,456	$ 574,560
TOTAL:	465	8.37	$ 418,500	$ 3,348,000	$ 200,880	$ 2,008,800

For volunteers, using the same 1.8% or 8 cases, the risk potential would be an additional cost ranging from $418,500 to $3,348,000 using the same assumptions as for paid employees regarding medical costs.

We have no ability to predict appropriate funding levels based on our own experience and have to rely on national data in order to do so. Because of the apparent 20-30 year period for manifestation of the disease, we will need to fund for this risk continuously in anticipation of the impact now and some 30 years from now. This bill also extends to diseases or conditions associated with or the result of HCV, an unknown variety of diseases for which the cost is difficult to measure.

Adding the conclusive presumption for HCV on top of that for heart/lung lifetime benefits dramatically will affect our ability to fund these risks, given the small and rural agency membership base we have. With the economic problems in rural Nevada, a large rate increase simply becomes unaffordable or results in layoffs.

There is no conclusive evidence that HCV necessarily arises from the workplace simply because someone worked in a qualifying occupation. HCV data from Federal sources indicates a significant problem emerging at the national level from non-occupational causes of HCV. There is evidence that it arises primarily from intravenous drug use, blood transfusions prior to 1992, from sharing needles, toothbrushes, razors, etc. of contaminated persons, and from mother to child during childbirth. Certainly police officers could be exposed to persons with HCV as a consequence of their work and should be covered when that happens.

It is important to the Legislature and to public sector employers to know objectively what costs will result from including coverage under the workers compensation system on a

conclusive presumption basis not only for HCV, but also for heart and lung diseases. There likely will be significant public policy implications that will arise should such a study reach the same conclusions as shown in the chart above and extrapolate them to all governmental agencies.

In workers compensation, both medical treatment plus disability payments must be provided. As seen in the chart above, using the current maximum annual indemnity rate of $32,181 and applying it to the same 15 potential Hepatitis cases involving PACT's paid police officers, the annual cost for indemnity would be $467,461 in addition to the medical costs. For volunteers, the deemed wage is $24,000. Applying that to the 8 cases yields an indemnity cost potential of $200,880 annually. If both the paid and volunteer cases resulted in a 10 year indemnity benefit payment period, the cumulative total comes to about $6,700,000.

Other Key Issues

Below is a discussion of the effect of the conclusive presumption and its application to former employees as a result of a key court decision and some issues that should be considered regarding the public policy implications.

III. Summary of Gallagher v. City of Las Vegas, City of Las Vegas v. Sorensen 114 Nev. Ad. Op. 68 (May 19, 1998)

On May 19, 1998, the Nevada Supreme Court was asked to decide whether veteran firefighters who are disabled by heart disease after they retire are entitled to occupational disease benefits under NRS 617.457 (1). This statutory provision establishes a conclusive presumption that a firefighter's heart disease arises out of and in the course of employment if certain conditions are met. Based on the history and language of the entire statute and the public policy underlying its enactment, the Supreme Court concluded that the veteran firefighters at issue, namely James Gallagher and William Sorensen, were entitled to invoke the conclusive presumption to establish their claims for benefits.

IV. Issues Raised by the Gallagher and Sorensen Decisions

A. Presumption of work relationship

The principles of workers compensation provide coverage for injuries that occur on the job to employees of the particular employer. The conclusive presumption sets aside the employment basis for workers compensation coverage by extending benefits to non-employment related diseases. PACT consistently has opposed the conclusive presumption as unconstitutional and has suggested that a rebuttable presumption or no presumption be substituted for occupational diseases as is the case for nearly all other occupations.

In the 2001 Legislative Session, AB 279 (now NRS 617.481) granted HCV coverage to nurses by requiring an immediate baseline test within 72 hours of an exposure incident and subsequent testing. If the employee tested negative on the first test, then positive on the subsequent follow-up test, then they were deemed eligible for coverage. This should be the approach for police officers and firemen as well.

The conclusive presumption that heart and lung disease would be an occupational disease for persons who have been employed for five years as police officers or firefighters was added to NRS in 1989, then expanded in 2001 to include Hepatitis for paid firefighters. SB 184 seeks to include all police officers for this benefit.

B. Eligibility intent – during and post employment

The heart and lung disease provisions require "continuous, uninterrupted and salaried occupation as a fireman or police officer in this state before the date of disablement" in order for the conclusive presumption to apply.

In *Gallagher v. City of Las Vegas* the Nevada Supreme Court ruled that the conclusive presumption applied regardless of the employment status at the time of disablement. The Court decided that "before the date of disablement" meant **at any time** prior to the disablement, **not immediately preceding** the disablement. The Court reached this latter conclusion citing a 1987 legislative amendment that was deleted in 1989 (albeit the amendment at issue related to preexisting conditions immediately preceding employment not disablement). Further, the Court cited language of the statute (NRS 617.457) and the spirit and policy behind the legislation as reasons for their decision.

Based on this case some persons who may be qualified for coverage (based on 5 years continuous employment as a police officer) may have joined other member agencies, but others may have gone to non-PACT member agencies or to the state thus transferring the risk to them. Others may have left the profession entirely but still are eligible for coverage. This is important because the courts ruled that the benefit applies to former employees and retirees. While the statute was silent, that silence was interpreted by the courts in *Gallagher* and *Sorensen* to connote eligibility for coverage under heart/lung for life.

When PACT analyzed the potential risk just for eligible former employees for heart disease costs, our actuary advised us to increase our rates by 44%. His study required looking into the demographic trends and health care cost trends going out 30 years. For retirees, since most employees take normal retirement to avoid the PERS offset for workers compensation, the cost estimate as a result of these court rulings depend upon the total number police officers and firefighters currently retired and those expected to retire in the future adjusted by the expected rate of disability. According to the PERS data on those currently receiving disability benefits, 29% of the disabilities were due to heart and lung disease (25% for police; 41% for firefighters). Suffice it to say that cost projections are substantial for known retirees. Given demographic trends, those costs will increase dramatically even without expansion of benefits.

In the 1999 Legislative Session, SB 132 attempted to limit the extension of benefits from lifetime to a formula based on 4 months for each year of service, thus entitling a 30 year employee to a manifestation period of 10 years to connect the occupational disease to employment and workers compensation coverage. That measure did not pass then. However, we expect that the significant fiscal impact of this court decision could result in the unintended consequence of the state's and local governments' inability to fund the expected benefit for deserving long-term employees. This concept should be reconsidered. Changing the eligibility and capping the time beyond employment connects delayed manifestation of occupational diseases to employment and enables more certainty in calculation of the fiscal impact of this post-employment coverage. This greater certainty better assures the ability to fund the benefits intended.

C. Uniqueness of election by claimant of permanent total disability

While the *Gallagher* decision did not address this issue, the issue must be considered as an unintended consequence of the decision. Under NRS 617.455 (7) and NRS 617.457

(7), a person who is determined to be partially disabled from heart or lung disease, or now Hepatitis, and is incapable of performing, with or without remuneration, work as a fireman or police officer, "may elect to receive the benefits provided under NRS 616C.440 for a permanent total disability."

No other categories of occupational disease or injury or other employees have the right to elect permanent total disability (PTD) when partially disabled or solely because they are unable to perform their particular occupation. In fact, such an election removes a key purpose of workers compensation to return injured workers to gainful employment within their abilities on a modified duty basis or after rehabilitation. Also, this right to elect PTD appears inconsistent with existing law that governs PTD. NRS 616A.340; NRS 616C.440. With regard to retirees, there simply is no incentive for returning to any employment. As for those who satisfied the statutory requirements for the conclusive presumption, but have gone on to other occupations subsequently, the former employee may have no incentive other than to elect permanent total disability.

As an example, a police officer, who worked for five years to meet the presumption of eligibility, leaves employment to work in construction for the balance of his working career. Shortly before his retirement, he suffers a heart, lung or Hepatitis disease and files for benefits. The governmental agency that last employed him 20 years ago may face paying for the permanent total disability he will elect since there is no reasonable likelihood that he would be able or willing to return to employment as a police officer.

As an aside, PERS benefits are available to disabled police officers and firefighters. They may apply for disability retirement, which in effect enables them to receive retirement benefits without the penalty for early retirement. However, if they elected a disability retirement and are receiving workers compensation disability benefits, PERS offsets its disability benefits. If they already are retired and receiving benefits from PERS at the time they apply for workers compensation benefits, then there is no offset. Hence, retirees may, when the disease manifests, then apply for workers compensation benefits, elect PTD, and receive both PERS full retirement plus PTD with no offset.

D. Basis for calculation of disability benefits – post retirement

The *Gallagher* decision did not determine the wage basis for calculation of any disability benefit for retirees. Hence, there remain important questions for the Legislature. Is the wage basis none for retirees, since there is no actual wage in retirement, unless there is a combining wage issue as a result of post-retirement employment? Legislative policy should clarify the wage basis if the Legislature determines to continue the benefits in accordance with the *Gallagher* decision.

E. Volunteers eligibility – during and post employment

Volunteer firemen are presumed eligible for coverage of heart, lung disease and cancer, after they have satisfied the statutory requirements. What is implied in the *Gallagher* decision is that if the conclusive presumption creates eligibility for benefits for employees forever, it also creates eligibility for volunteers who no longer volunteer. The only time limitation for volunteer firemen is found in the heart statute in which the disease onset must be before age 55. There is no time limitation for lung disease or cancer. Considering the sheer number of volunteers and the high rate of turnover even after five years of continuous service, the burden on employers to track volunteers to verify eligibility and to provide coverage in accordance with the *Gallagher* decision virtually is immeasurable.