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BEFORE THE STATE OF NEVADA

GOVERNMENT EMPLOYEE-MANAGEMENT RELATIONS BOARD

INTERNATIONAL ASSOCIATION OF FIREFIGHTERS LOCAL NO. 731, Complainant/Cross-Respondent, vs. CITY OF SPARKS, Respondent/Cross-Complainant.	Case No. 2025-001 **UPDATED JOINT STATUS REPORT**

COMES NOW Complainant/Cross-Respondent International Association of Firefighters Local No. 731 (Local 731) and Respondent/Cross-Complainant City of Sparks (City), by and through their respective counsel of record, to submit their Updated Joint Status Report.

I. PROCEDURAL HISTORY

On July 3, 2025, the Government Employee-Management Relations Board (Board) ordered that the above captioned matter be stayed pending the issuance of the arbitrator's award and decision on Local 731's Grievance 24-002 (Group Health Grievance). The Board further ordered the Parties to file a Joint Status Report by September 30, 2025 or sooner should the arbitrator's

award and decision be received prior to September 30. Following receipt of the Parties' Joint Status Report on September 30, 2025, the Board Commissioner directed the parties to file an updated report with a copy of the award and decision attached once issued by the arbitrator.

II. STATUS OF ARBITRATOR AWARD AND DECISION

The Parties received the attached award and decision from the arbitrator on October 6, 2025, ruling "[n]o violation of the Collective Bargaining Agreement has been proved. The grievance is DENIED." Exhibit A (Op. & Award at 36).

Respectfully submitted this 8th day of October, 2025.

WESLEY K. DUNCAN
Sparks City Attorney

By: /s/ Jessica L. Coberly

Jessica L. Coberly
Acting Chief Assistant City Attorney
Attorney for Respondent/Cross-Complainant

Respectfully submitted this 8th day of October, 2025.

REESE RING VELTO, PLLC

By: /s/ Alex Velto
Alex Velto
Attorney for Complainant/Cross-Respondent

CERTIFICATE OF SERVICE

I hereby certify that on 8th day of October, 2025, I have mailed in portable document format as required by NAC 288.070(d)(3), a true and correct copy of the **JOINT STATUS REPORT** on the following persons set forth below by email:

Nevada Government Employee-Relations Board
emrb@business.nv.gov

Alex Velto, Esq.
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Paul Cotsonis, Esq.
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DATED this 8th day of October, 2025.

/s/ Nancy Ortiz
Nancy Ortiz

EXHIBIT A

ARBITRATOR'S OPINION & AWARD

IN THE MATTER OF THE ARBITRATION BEFORE ARBITRATOR CHARLENE MACMILLAN

INTERNATIONAL ASSOCIATION
OF FIREFIGHTERS LOCAL NO. 731
Union

and

CITY OF SPARKS
Employer

Health Plan Changes — Section 3, Article A

FMCS No.: 251031-00825
Grievance No.: 24-002

Date Issued: October 6, 2025

APPEARANCES

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PRELIMINARY MATTERS

This contract interpretation case arises pursuant to a Collective Bargaining Agreement to which the International Association of Firefighters Local No. 731 and the City of Sparks, Nevada are parties. It resolves a dispute over alleged unilateral changes to benefits affecting the bargaining unit.

An evidentiary hearing was held on May 28 & 29, and June 30, 2025, during which both parties had opportunities to present argument and evidence, examine and cross-examine witnesses and make rebuttals. All testimony was given under oath. The record was closed for evidence at the conclusion of the hearing, and the evidence admitted as of that date formed the basis for all factual findings contained in this Award.

The parties filed closing briefs on August 25, 2025, by agreement.

The Statement of the Issue

The parties did not agree on a statement of the issue, and authorized the Arbitrator to determine its final formulation.

The Union offers that the statement of the issues is: "1. Whether the City violated CBA §3.A by implementing plan-document changes that modified benefits without GHCC approval and City Council ratification. 2. Even if all document changes do not need to go before the GHCC, whether the City violated CBA §3.A by changing any benefits without GHCC approval and City Council ratification. 3. Whether the grievance is timely and arbitrable. 4. What the appropriate remedy should be".[1]

[1] *Brief* at 7. At hearing, the Union stated the issues as follows: "Whether the City violated the Collective Bargaining Agreement Section 3(A) when it implemented a change to the health Plan Document and benefits without abiding by the process outlined in the Collective Bargaining Agreement requiring it to get approval from the Group Health Care Committee for those changes"; and "Whether the City violated NRS 288.150 when it failed to negotiate changes to the insurance plan with the Union through the Group Health Care Committee." With regard to the latter, at hearing the parties explained they believed this was an acceptable framing of the issues, because they mutually viewed obligations under the CBA as deriving from the Statute (Tr. 3-13:6-18:23), but each altered their positions at closing. The City standard: "ultimately this Grievance is not about a failure to bargain such that NRS 288 is implicated, Local 731 is simply arguing that the City is not following the contract that resulted from that bargaining—a contract issue, not a statutory one" (*Brief* at 69); and the Union proffered the revised issue statement cited above. As its closing arguments were consistent with its revised statement, the Union is deemed to have amended its pleadings. Violation of NRS 288 is therefore not a matter under consideration in this Decision.

The Employer frames the issues as: "A. Is the grievance timely? B. If it is determined the grievance is timely, does the applicable CBA Section 3, Article A(3) require that the Group Health Care Committee (GHCC) vote on all changes to the City of Sparks health Plan Document or solely require the GHCC to vote on changes to benefits in the City of Sparks health Plan Document; C. Regardless, did the City intentionally change the benefits in the Plan Document to the detriment of any member without a GHCC vote; and, D. If so, what is the appropriate remedy?

Based on the parties' submissions, the record, and the Collective Bargaining Agreement, the issues to be decided are:

1. *Is the grievance arbitrable?*
2. *If yes, did the City violate the Collective Bargaining Agreement by implementing changes to employee benefits on January 1, 2024, without a vote of the Group Health Care Committee and ratification by the City Council?*
3. *If yes, what is an appropriate remedy?*

The parties were advised that, in the event the grievance is deemed inarbitrable, its merits would not be addressed absent their joint, express request. No such request was made.[2]

Whether the Grievance Is Arbitrable

The grievance alleges the City of Sparks ("the City") violated Articles A2b and A3 of the parties' Collective Bargaining Agreement by "implement[ing] changes to the healthcare plan that were not voted on by majority consent from the GHCC, causing harm...and denial of healthcare treatment previously provided by the plan" (U1). The Group Health Care Committee (GHCC or "the Committee") is a labor-management committee whose purpose is to address matters related to the City's health benefits plan.

[2] In its closing arguments, while holding that the grievance should be denied as untimely, the City noted that it "seeks the Arbitrator's review of the substance of the Grievance regardless" (*Brief* at 2). Findings on the arbitrability of the matter were reached prior to receipt of the parties' closing briefs.

The City moved to have the grievance dismissed as inarbitrable on grounds that the grievance was untimely filed. The International Association of Firefighters Local No. 731 ("the Union") argued this challenge was barred under Nevada law because the City first announced its intention to move for dismissal on the morning of the hearing. NRS 38.231(2) provides: "An arbitrator may decide a request for summary disposition of a claim or particular issue...Upon request of one party to the arbitral proceeding if that party gives notice to all other parties to the proceeding, and the other parties have a reasonable opportunity to respond." While the City may not have given prior notice of its intent to challenge arbitrability, in labor arbitration, a challenge on the arbitrability of a matter is often not deemed ripe for adjudication until it is brought before an arbitrator. Even so, with respect to NRS 38.231(2), the Union was allowed "reasonable opportunity to respond" before this Decision was made, and did so competently, at hearing and in its closing arguments (Tr. 1-13:8-17:18, *Brief* at 4, 7-9).

The City asserted the Union came into possession of the information leading to the grievance on April 8, 2024, but filed the grievance on May 9, 2024, three days after the contractual deadline. The Union contends it did not have actual knowledge of the violation until May 7, 2024, and that the violation is ongoing.

The Collective Bargaining Agreement between the parties establishes the following parameters for initiating the grievance procedure:

> 2. Definition of "Working Day": For the purpose of this Article, a working day shall be defined as a normal Monday through Friday workday, holidays excluded.
> 3. Time Frames: Grievances not filed within the required time frames will be forfeited...The City and Firefighters may agree in writing to extend any time requirements of this Article.
> 4. Procedure:
>
> a. STEP 1 - The employee concerned must within twenty (20) working days from the day [the] employee is grieved, file a written grievance with the Fire Chief or designee. (Article L)

The provisions defining the filing deadline, and the penalty for failing to meet it, are clear and unambiguous and may therefore be enforced as written. However, the conditions precedent to initiation of the filing require interpretation.

When Did the Grievance Occur?

The City's motion was denied because the arguments presented by both parties demonstrated there were material questions of fact as to the appropriate point at which the filing timeline should be fixed.

The action being grieved is "the implementation of changes to the healthcare plan that were not voted on by majority consent from the GHCC, causing harm..." (U1). As the parties' Agreement provides that the timeline for filing a grievance begins "the day [the] employee is grieved", that day is the effectual ground zero of the grievance process. In the common parlance, an individual is aggrieved when his rights are adversely affected.[3] The rights at issue here relate to the benefits due to bargaining unit employees under the health benefits plan.

The terminology used in the parties' Agreement does not explicitly require knowledge of the adverse effect. However, to the extent it is possible employees' rights may be adversely affected without their, or their Union's[4], knowledge, the language must be deemed to require it. This is due to the simple fact that it is impossible to contest an action or condition of which one is unaware.[5]

By both parties' accounts, the alleged benefit would have taken effect on January 1, 2024. Strictly speaking, this would be the date employees' rights were allegedly adversely affected. However, prior to the date and following, the City explicitly communicated its expectation that the existing plan would be administered, unchanged, by the new administrator, and the GHCC ostensibly addressed those benefit changes it wished to implement (C1, C19:1460, C19:1514-5, C21:1580, C21, U5, U39). As a result, at the time the change in third-party administrator took effect, it likely was not obvious to the Union that a potential violation had occurred. The record indicates, however, that the Union was aware of the issues giving rise to the grievance well in advance of the date it was filed.

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[3] ref. Garner, *Black's Law Dictionary* 83 (11th Ed. 2004)

[4] While the Collective Bargaining Agreement refers to "the employee", it is recognized that this is a class action matter that affects more than a single employee, and that the Union stands in proxy.

[5] "When the running of a limitations period commences with 'the alleged incident,' 'cause,' or 'event,' these terms may require interpretation, because the date a party knew or should have known of a contract violation will be different from the date a grievable action occurred..." Indeed, "some arbitrators...hold that time limits on filing run only from the time the Grievant knew or should have known of a claim." (*Fairweather's Practice and Procedure in Labor Arbitration*, Schoonhoven, 4th Ed., pp. 126, 129).

When Did The Union Become Aware of a Grievable Event?

The record establishes that the Union was in possession of the document which formed the basis for its determination that the Collective Bargaining Agreement had been violated by April 8, 2024 (Testimony of Darren Jackson ("Jackson"), Firefighter and GHCC representative for the Union, at Tr. 2/186:11-187:11). Though it claimed to have been misled by the fact that the document was identified as a draft, the first page of the document plainly stated it was effective January 1, 2024. The Union took note of this fact during its review (C24, U39). More importantly, it was established on the record that by April 10th, 2024 the Union had sufficient understanding of the issues it had identified that it was able to assess potential impacts to its members and determine a grievance was warranted.

On April 10 and April 16, 2024, Jackson made three phone calls to the president of the Sparks Police Protective Association (SPPA) Detective Nick Slider ("Slider"). During those calls, Jackson informed Slider the Union intended to file a grievance "relating to the City's 2024 Health Plan Document and the change in the City's Third-party administrator", based on their findings after reviewing the draft health Plan Document. Jackson wanted to know whether SPPA would be interested in joining the grievance (Slider Testimony (Uncontroverted), C35, C43). The record suggests the Union may also have sought OE3's participation, though the timing of such efforts is unclear (Testimonies of Ralph Handel ("Handel"), OE3 Business Representative; Jackson, C33).

These facts demonstrate the Union was sufficiently informed of the basis for its grievance as early as April 10th, 2024. By the terms of the Collective Bargaining Agreement, the grievance should have been filed no later than May 8th. The Union informed the City on May 7th of its intention to file a grievance (U10), but did not do so until May 9th (U1). Therefore, even granting the most favorable timeline possible, the grievance was filed at least one day after the contractual deadline. Based on the plain language of the Collective Bargaining Agreement, it should be forfeit.

Whether the Matter Constitutes an Ongoing Violation

The Agreement prescribes forfeiture where a grievance is not filed within twenty days of the employee being grieved. Given that the issues here involve the provision of health benefits, it may be anticipated that employees in the bargaining unit may become aware of impacts at various times. For this reason, the Union's designation of the grievance as an ongoing violation warrants examination.

An ongoing, or continuing, violation is one in which the condition being challenged occurs, or may reasonably be expected to occur, repeatedly. It is distinct from a violation that occurs only once, but whose effects are perpetuated; with a continuing violation, it is the alleged violation itself that perpetuates. Rather than revive the timeline for filing a grievance arising from a one-time event, the alleged improper action spawns separate violations, each with its own timeline for filing.[6] A union may reasonably invoke this anticipated 'continuing violation', not to circumvent the contractual time limits, but to avert a potential slew of similar or identical grievances. While the continuing violation must be applied with circumspection, this efficiency of dispute management is one of its advantages.

It is not solely a matter of economy, however. The continuing violation is an anomaly, an exception to the parties' mutual obligation to adhere to the contractual time limits. It is allowed for the purpose of preserving the otherwise legitimate rights of access to the grievance procedure for those who become aggrieved by, or who become aware of, the alleged violation at some later time, since the misinterpretation or misapplication of the contract may be imposed upon multiple employees and/or at varying intervals. Arbitrators recognize the premise must be narrowly applied so as to avoid the indiscriminate nullification of the contractual time limits, and will critically assess whether an exception is warranted.

[6] For example, an incorrect application of the contract with regard to payment of wage premiums can be an ongoing violation if there is reason to believe the same incorrect interpretation will be applied to each eligible employee, in each eligible circumstance (this would not apply to one-off situations or mere mistakes; the circumstances must be pervasive to some degree). Each such occurrence would constitute a new grievable event with its own filing timeline because the premiums have not been paid as required by the CBA. In deference to established grievance timelines, remedies in such cases are limited to the date the grievance was filed, since no timely grievance was filed on the prior violations. Compare this with the 'classic' example of a non-continuing violation: lost paychecks resulting from an alleged improper discharge are not considered to be a continuing violation because the ongoing loss of wages is merely an effect of the discharge (the alleged improper action) and not additional potential violations. An untimely filing of the grievance appealing the discharge could not be cured by characterizing the discharge as a continuing violation.

Here, the nature of the claims makes the grievance susceptible of a continuing violation. While the implementation of the new Plan Document was a discrete action, and was not timely challenged, it is inextricably linked to the claim of resulting harm to Union members. The Union has in the course of the dispute cited impacts to its members such as inability to access treatment and out-of-pocket costs due to denial of coverage (see for example, C23, U12, U14). Having deemed the grievance an ongoing violation, it reasonably follows that the Union would consider those situations, and any others that might subsequently arise, to be covered by the grievance.

The City argues that concerns arising from difficulty in using benefits are more appropriately resolved via the Plan's appeals process. However, the grievance alleges violation of the parties' Agreement resulting in provision of unbargained benefits, not breach of the health plan as an isolated concern. Whether the plan was changed in breach of the Collective Bargaining Agreement, and whether that caused harm to any employee, are issues to be resolved on the merits. As to the question of arbitrability, the matter reasonably attains to the standard of a continuing violation, since each alleged change in benefits could be grounds for a separate grievance when applied to a covered employee. On that basis, the grievance must be deemed arbitrable.[7]

[7] A finding that a matter constitutes a continuing violation is not a finding that a violation occurred. It merely recognizes that the timeline for grieving an alleged violation may reasonably be activated at various intervals.

BACKGROUND AND FACTUAL FINDINGS ON THE MERITS

In 1991, the City and the Union were parties to a factfinding which granted the City's proposal "to establish a joint committee which would be empowered to review costs and benefits provided under the City's group health programs, with the objective of maximizing benefits while keeping costs to a reasonable level". The Factfinder noted that: "although each individual union participating in the joint committee gives up its individual autonomy, the unions as a group will have three of five votes on the committee. It must therefore be presumed that the interests of employees will be fairly and adequately represented" (U23).

The Group Health Care Committee (GHCC, "the Committee") thus established included two other unions with which the City has collective bargaining agreements, Sparks Police Protective Association (SPPA) and Operating Engineers (OE3). All three unions were made equal parties and voting members of the Committee. The contractual provision regarding the GHCC, which has remained largely unchanged since its inception, appears in each of the unions' Collective Bargaining Agreements. It provides:

> **SECTION 3 Article A - GROUP HEALTH AND LIFE INSURANCE**
> 2. b. The City shall maintain an equal or better standard of group health insurance coverage unless change is agreed to as provided in Paragraph 3 of this Article.
> 3. Group Health Care Committee: The purpose of this Committee is to discuss cost containment measures and to recommend to the City Council any benefit changes to the City's self-insured group health and life insurance plan.
> The Committee shall be comprised of one (1) voting members and one (1) alternate member from each of the following recognized bargaining units:
> • Operating Engineers (OE3)
> • Sparks Police Protective Association (SPPA)
> • International Association of Firefighters (IAFF)
> ...
> The voting member of each recognized bargaining unit shall have the authority to bind said bargaining unit to any modification in benefits recommended to the City Council subject to ratification of at least two (2) of the voting members (OE3, SPPA, IAFF). Any two (2) of the listed three (3) bargaining units can bind the remaining bargaining units to changes to the City's self-insured group health and life insurance plans. Any modification in benefits agreed to by the City Council on recommendation of the committee shall be binding upon each represented and non-represented group. (C5, U2, U3)

As a self-insured entity, the City uses a third-party administrator to manage its health benefits program. It was understood within the Committee that the City had the sole right to select its third-party administrator, and to enter into contracts to effect such changes. It was also understood that a change in third-party administrator would not, in itself, affect the benefits provided, because changes to benefits were the particular purview of the GHCC.

The Medical and Dental Benefits Plan Document & Summary Plan Description ("the Plan Document") sets forth the benefits City employees are entitled to receive and dictates how the plan must be administered. In the years since its inception, the GHCC has routinely addressed substantive benefit changes and updates to the Plan Document necessary to effectuate those changes (City Exhs 10, 11, 13, 16, 18 & 46; Union Exhs 24-34).

For most of the Committee's existence, updates to the Plan Document were made by the third-party administrator. That changed in or around 2016 when the City changed began contracting with Hometown Health (HTH), which placed responsibility for managing the Plan Document back in the hands of the City (C11, C12, C23:1704; U27, U38). This resulted in changes to the Plan Document format and language. Those changes were not reviewed or voted on by the GHCC (Jackson Testimony, C2, C9, C13, C14, C15, U28). During this transition, the GHCC continued to discuss and take action on proposed changes to benefits (C13, C14, C15, U28).

In October 2017, the Committee voted on added pre-certification requirements for out-of-state hospitalization and out-patient surgery, specifying the point at which pre-certification must occur for those benefits (U30-32). These changes were included in a larger packet of benefit changes under consideration by the GHCC.[8]

[8] There is insufficient information on the record to determine whether the pre-certification changes approved by the Committee were advanced to the Council for ratification.

The City Selects a New Third-Party Administrator

At a meeting of the GHCC on September 21, 2023, the City announced its intention to change its third-party administrator upon expiration of its contract with HTH. Committee Chair Jill Valdez ("Valdez") stated,

> So, what the TPA choice does not affect or does not change is number one benefit levels. The benefit levels are established in the Group Health Plan Document which is voted on by this Committee and ratified by City Council... (C19:1460)

In response to questions regarding time for Committee review before the Council vote, Valdez explained, "the TPA selection is not something that comes to a vote here. It goes to Council. It's not a change in benefit levels. The [] role of this Committee is to make Plan Document design changes...regardless of which TPA we're using, they have to apply the Group Health Plan Document" (C19:1514-5).

The City Council voted on September 25th, 2023 to approve a three-year contract with UMR as its third-party administrator. As the new third-party administrator, UMR would assume responsibility for management of the Plan Document, including making any needed updates to its content, using its own standard template (C23:1705, 1759; U38). In preparation for the transition, the City began "going through specific benefits with UMR...just to ensure that all of the claims are processed as they should be processed based on the intention of the plan language" (C21:1624).

The Committee Discusses Plan Changes

At the next meeting of the GHCC on December 7, 2023, Valdez made the following statements regarding the transition to the new third-party administrator:

> We've had some questions about the Plan Document and the UMR format. As you know, each time you do a new implementation, the Plan Document normally is updated by the new third-party administrator so that it reflects all the information, the contact information, etc., from the new third-party administrator. We will have that for January 1st...
> The – putting the new information in the new format does not change any of the benefits that only the Group Health Committee can change. (C21: 1579-80).

The Committee discussed some differences in benefits that would be available through UMR, including access to most hospitals in the state rather than a single hospital system, and an expanded provider network.

Valdez later addressed questions regarding physical therapy benefits:

> So, the Medical Benefit Summary is not meant to override the detail – the meat, if you will, of the plan...In the beginning of the Eligible Medical Expense over –section, it generally talks about the need for services to be approved by a physician or other appropriate provider, that they must be medically necessary...Physical therapy specifically is listed...
> ...It does talk about excluding things that are not medically necessary or not physician prescribed. So, medical necessity is something that we see throughout the Plan Document. It's – it's common. It's – the utilization is supposed to look for medical necessity...So, services for a member who's not under the regular care of a physician; so, they're going to seek services that haven't been – you know, recommended, approved, certified by a physician, is an exclusion.
> ...
> Does physical therapy require pre-certification? The answer to that is no, not as the plan is written...
> Is there a maximum visit of physical therapy in the plan? No, that is not – there is no cap on the number of physical therapy visits per year.
> ...because of the number of questions that we've gotten on this topic, I wanted to be as thorough as possible, going over places in the document where it talks about things that are relevant to how this should be looked at and will be looked it by UMR. (C21:1616-9)

Acting City Manager and GHCC Committee member Chris Crawforth ("Crawforth") added, "This is not something new. This is just something that was supposed to be occurring over the last seven years, because that's what our plan says, but it wasn't happening...it wasn't supposed to be happening that way where you just show up and it gets paid for". No committee member disputed these statements from Valdez or Crawforth (C21:1620). The Plan Document as it existed under HTH included the medical necessity requirement for treatments such as physical therapy, but did not specify a limit on the number of visits that would be covered (Testimonies of Rachel Arulanantham ("Arulanantham"), SPPA GHCC voting member; Ralph Handel ("Handel"), OE3 Business Representative; Dion Louthan ("Louthan"), City Manager; Jackson; Slider; Jarod Stewart ("Stewart"), Firefighter/Operator and Union Grievance Committee Lead; C2, C23, U16, U38).

Another agenda item address by the Committee in this December 2023 meeting was the City's presentation of "some clarifying language that we're making you aware of, but there are also items that we need your vote on specifically because they are call outs or changes to potential benefits on the Plan Document." (C21:1623):

> We're changing the format of the Group Health Plan Document. That does not mean that any benefit levels change...
> Where we're looking for your input and/or clarification, it's with the specific benefit questions that we did not feel comfortable giving an interpretation for unless we talked to you about it first because, again, the primary role of the Group Health Care Committee is to look at the benefits and try to contain costs, but also to make changes and recommendations as necessary.
> Specifically, there are six – or five to six items that you'll be voting on...these are coming up because they're silent in the plan or a specific language is not exactly clarified, so we want to clarify. But again, we need your input before we can make that recommendation.
> Here is the list. We've got the usual and customary language. Extended care facility, hospice care, emergency room, Telehealth and Teledoc. (C21:1623-5)

The Committee voted unanimously, with "possible recommendation to City Council", to update the Plan Document to remove "usual and customary claims" language; to place a cap on extended care "with extension based on medical necessity and prior authorization"; for "clarifying language regarding in-home respite care up to eight hours per week for members under Hospice care"; and against clarifying language to exclude out-of-network Telehealth services. Voting on removal of language guaranteeing payment for emergency room visits at 100% and clarifying language for behavioral health and dermatology services through TeleDoc was tabled to allow time for discussion with union membership.[9] No voting member of the Committee moved for a vote on the anticipated changes to the formatting or other strictly typographical aspects of the Plan Document (C21:1646-1655, U37). Arulanantham requested that a discussion on whether the physical therapy benefit was properly reflected in the Plan Document be added to the agenda for the next meeting, to ensure consistency with state law.

The contract between the City and UMR was executed on April 30, 2024, with an effective date of January 1, 2024 (C22).

[9] It is not clear from the record whether or when these issues were brought back to the Committee.

The Union Identifies Other Changes

On April 4, 2024, the City responded to a public records request from Union member Darren Partyka ("Partyka") which sought, among other items, the healthcare plan documents for 2022, 2023 and 2024. After twenty-five physical therapy sessions, Partyka had been denied additional treatment on the basis of medical necessity (Jackson Testimony). In its response to Partyka's public records request, the City noted, "the UMR Plan Document is a draft and it may need to be extended or delayed due to review of UMR specifications on dissemination" (U5, U11). The document contained redline changes to the healthy lifestyle benefit, making the eligible age 6 instead of age 7, removing a 26-visit cap, adding a $150 benefit limit, and correcting a related typo. These changes had previously been voted on by the GHCC (C1, U5, U39).

Partyka shared the UMR Plan Document with the Union on or around April 8, 2024. Chris Hartwig ("Hartwig"), Firefighter and voting member of the Committee on behalf of the Union, identified numerous differences between it and its predecessor which he believed were, or could constitute, substantive changes to the benefits received by Union members, categorizing the issues as "direct changes", language changes for which "a change in benefits can be interpreted", and changes "in which wording and formatting has changed significantly" (U21, U39).

The Union had discussed these concerns with SPPA president Slider, who directed Arulanantham to canvass their membership to learn whether any members were "experiencing difficulty obtaining medical benefits…No members reported any concerns with receiving medical benefits generally or physical therapy specifically" (Testimonies of Arulanantham, Slider, E35, E36). Though SPPA was invited to join the grievance, it chose not to do so. OE3 representatives also learned of the impending grievance, but its officers declined to participate, ostensibly because it had received no concerns from its membership (Handel Testimony).

The Union and the City met on May 7th to discuss the issues the Union had raised. During that meeting, the City informed the Union the document it had received was the Document in effect. The Union filed the grievance two days later, identifying the matter as an ongoing violation.

The City contacted UMR on May 23rd and outlined 47 "differences that appear to create a decrease in benefits". The City noted further that, "There are other items in the 2024 Plan that simply use different language than the 2022 Plan which could potentially constitute decreases in benefits", but that it only included in the letter those it had positively identified as decreases. The City shared this communication with the Union. After consulting with UMR, the City proposed changes to the language in the Plan Document "to ensure the benefits from the 2022 Plan are reflected in the 2024 Plan" (C26, U9).

The Committee Addresses Concerns with the Third-Party Administrator Change

The GHCC held a workshop on June 5, 2024 during which the Committee addressed specific concerns raised by each of the unions, including IAFF's list of issues it had categorized as direct changes, language changes, and changes in wording and formatting.

In the course of these discussions, UMR's representative to the City acknowledged that folic acid screening for women was excluded from the current plan, but had been expressly provided for in the prior document (1758). Among other issues addressed was a change in out-of-network coverage for ambulance service from 60% to 80%, which the City explained had been made to ensure regulatory compliance; and the Union's concern that the Plan Document listed 60 more exclusions than the previous document. All other items raised by the Union were determined not to constitute a change in the benefits received by employees. Hartwig noted, however, "the point is, is that it's changed and we didn't vote on it. Right? And there's a possibility here for a member to have to deal with those costs, at least temporarily…why not bring the [inaudible] to the group health plan or the committee and just say these are language differences, uh, there's no change in benefits, but [inaudible] vote on it?" (C23:1795-6, 1805-6; U38).

Hartwig introduced a motion to add to the next meeting's agenda further discussion of changes the Union believed had been made to benefits. The City invited all three unions to identify any differences they believed constituted a change in benefits, which the City would then review with UMR and determine whether clarification or a vote of the GHCC was needed (C23:1810, 1815-6; U38).

Partyka made public comment, in his private capacity, regarding "physical therapy, medical necessity, and maintenance therapy". He attested to physical pain, "emotional stress", and financial burden he experienced due to treatments not being covered by the health plan (C23:1692-4). In addressing concerns related to physical therapy, the City stated:

> It's being continuously worked on. Um, we are looking for solutions. Um, and I also want to clarify that the intention was never to change any benefits. Um, as we know, we talk about benefit changes coming to the committee. The intention here was not to change a benefit at all.
> During the implementation process with UMR, however, we do have to identify administrative processes. I believe in the discussion of how should we administer the PT, um, medical necessity review. The question was asked, when do we initiate the medical necessity review? Do we do it at 8 visits, 12 visits, 14 visits? What is it? Um, standard practice can be anywhere from 8 to 12. The city elected to choose 25 as a review spot for medical necessity. Not to say this is a cap, this is where we are going to review medical necessity...
> UMR needed a threshold for the medical review in order to administer that benefit...We do realize in all of these discussions that this could be argued to be a change and the staff is working with the attorney's office on alternative options. (C23:1712-3, U38)

Hartwig explained one of the Union's concerns was that using UMR's Plan Document template would necessarily result in changes to the language, which "may be what makes it possible for UMR to deny our claims" (C23:1761, U38). In a related discussion regarding maintenance therapy, which the City explained was excluded in the HTH and UMR plan documents, Hartwig reiterated his concern that the language used in the UMR plan would "make it easier for a service to be viewed as a maintenance therapy and therefore denied" (C23:1792, U38).

The City explained there was "no cap" on visits for therapy, and that additional treatment would be provided if a physician determined they were medically necessary (C23:1771). It conceded the medical necessity review was "something that we should probably, you know, get in front of the committee and have them vote ..." (C23:1785-6, U38). The group agreed to place the issue on the agenda for the next Committee meeting. Hartwig stated:

> ...I'm just looking to agendize a vote...to remove the medical necessity review off of physical therapy [inaudible]. The reason is, is we have a lot of members that go to physical therapy to avoid a million-dollar surgery on their back or people that go to physical therapy to not have [inaudible] surgery, which are all big dollar things that are going to cost our plan more money down the

> road...But we can't do that, because there is a cap placed for visits that -- or there is a -- not cap, but there's a [inaudible] there for medical necessity, now it needs to get reviewed. And I hate to say it, but it's going to inevitably be denied if we go to maintenance therapy, right?
>
> ...
>
> What I am motioning to put on as an action item for the next agenda, for the next meeting, is we have a change that required medical necessity at 25 visits, that was a change in our medical benefits that we sussed out earlier and it wasn't there on the previous contract. I am motioning to undo that change that we didn't vote on ... (C23:1847-8; U38)

The City disagreed with Hartwig's characterization, reiterating its prior assertions that the benefit had not changed, but had been "poorly administered" under HTH. It asserted this situation did not "create a benefit. So the benefits remain the same..." (C23:1854-8; U38).

The City Responds to the Grievance

The grievance was denied at Step 1 on June 12th, and was advanced to Step 2. The parties agreed to extend timelines for the City's response to allow for a thorough review of the concerns raised. By letter dated June 24, the City Attorney's Office (CAO)[10] provided a detailed response to 59 of those concerns, which it "determined did not demonstrate differences between the 2024 and 2022 plans" (C25, U12). For a meeting of the parties scheduled to occur the following day, City Attorney Wes Duncan ("Duncan") stated that the City planned to share "differences brought to our attention and the language we will be requesting UMR to add so the 2022 and 2024 plans mirror one another" (U18). During that meeting, the Union provided markups to the City's June 24th letter, identifying areas where it believed there was new, added, or more restrictive language; comments made by the City it believed not to be true; and seeking definitions for some terms used (C27, C29).

The City provided responses to 25 other issues raised by the Union, including its markups to the June 24th letter, on July 31, 2024. On August 1st, the City requested the deadline for its Step 2 response be extended to October 10th. The Union granted this extension, on the condition that the parties would continue their efforts to reach resolution (C28).

[10] Generally, references to the CAO mean Assistant City Attorney Jessica Coberly, who was the City's lead in responding to the grievance, and its advocate for these proceedings.

The GHCC Votes on Medical Necessity Review

On September 19, 2024, and the CAO made a presentation to the GHCC "concerning which Group Health Care Plan Document the City is currently operating under and additional redline changes by the City Attorney's office to ensure the same benefits are maintained". It explained:

> ...the IAFF brought, um, over 136, uh, different issues that they -- they thought could be potential differences in plan benefits. Um, we have only made 21 changes...13 changes are language changes that make it clear the plan benefits are the same...But because it's clearer if we add the old plan language in that those benefits are the same, we added those changes.
> And then there were seven changes where we want to ensure plan benefits remain the same, meaning there's potential that the language, um, wouldn't have been administered the same, so we made, um, those changes. Something important to note, that it gets its own slide. Um, at this time no prior claims have been identified as impacted by these redline changes...And if so, they would be reprocessed because they are covered by the plan...(C4:485-8)

The CAO discussed in detail the concerns it had addressed and explained its reasoning on each. One of the redline changes the City had made to the Plan Document was additional wording to include coverage of folic acid for women (C3:439). It also presented a number of reports, including on emergency room claims that had been paid at 80%, and the frequency of denial for continued physical therapy based on medical necessity.

The Committee discussed, and called for a vote on, the timing of the medical necessity review. Hartwig announced he had "been advised not to vote on this item...731 is close to a resolution with our grievance and part of that is potentially amending the Plan Document on some items..." (C4:532). SPPA'S Arulanantham moved to approve medical necessity review after 25 visits for physical therapy. SPPA had determined, based on its communications with its members, that "conducting a medical necessity review after the 25th visit for any therapy was not perceived as an issue by the SPPA" (Testimonies of Arulanantham, Slider, E35, E36). OE3's Ihnat seconded, having deemed the review to be "reasonable". Ihnat had not received any "official complaints" from that union's members, and believed any questions that had been raised had been resolved (Testimonies of Handel, Ihnat, E34). The measure was approved (C4:532), but the issue was not subsequently presented to the City Council for ratification.

The City Denies the Grievance

On October 3, 2024, the CAO issued a third letter to the Union addressing 28 other concerns it had raised, plus a number of "changes in administration, not in benefits" the City had identified (C30). The letter concluded:

> At this point, I have reviewed all potential issues with the UMR Plan documents raised by the Union pursuant to Grievance 24-002 (Step 2 response due 10/10). As discussed in my presentation to the GHCC on September 19, I suggested 21 edits to the UMR Health Plan and 2 edits to the UMR Dental Plan to clarify that the benefits remain the same after reviewing 160+ potential issues/clarifications raised by the Union. The GHCC also voted to confirm the 25-visit checkpoint for medical necessity in the UMR Health Plan that was not previously stated in the Hometown Health Plan. (C30)

The Union replied that it was "continuing to find issues", and provided an example of one such issue, to which the City promptly responded (C44, U12). The City received no other questions, issues or requests for clarification from the Union (Testimonies of Hartwig, Jackson, C8, U8).

On October 10, 2024, the City denied the grievance, asserting it had "ensured that the UMR Plan Document accurately reflects the benefits included in the prior HTH Plan Document". It held that the Union's argument that the GHCC must vote on any and all changes to the plan documents was inconsistent with the language of the Collective Bargaining Agreement. Regarding the issue of medical review after 25 therapy visits, the City averred: "While this was not a change in benefits but a change in administration, out of an abundance of caution, this was brought to GHCC for a vote" (C8, U8).

The Parties Proceed to Arbitration

The matter remained unresolved, and the parties proceeded to arbitration. There, the Union held that the City's implementation of the current Plan Document constituted a change in the established structure and practice related to benefit changes, and provided documentary evidence and witness testimony to support its argument in this regard. The Union also enlisted the assistance of industry expert Troy Smith ("Smith") to perform an independent comparison of the HTH and UMR Plan Documents and determine whether the current Document contained substantive changes to the benefits provided.

The City moved to exclude the testimony of this expert witness on grounds that it received just one day's notice of his appearance, and that it was therefore prejudiced because it had insufficient time for review and preparation of a response to the evidence he would provide. The City also challenged the methodology of the review, the content of the report produced by the witness, and his qualifications to give expert testimony. The motion was not granted, because the parties would have opportunities to establish any necessary foundation and to rebut proffered evidence on cross-examination. Further, the City would have had additional time to secure and prepare its own expert witness, since an additional day of hearing was being planned. The City ultimately chose not to call an expert witness.

Smith testified to and provided evidence of his more than 30 years of experience in the healthcare industry, his qualifications, and his expertise working with self-insured entities in benefit plan design and administration (Tr. 1/209:1-211:4, U20). The report of his findings was admitted to the record. Making reference to NRS 689A.540, NRS 689C.075, NRS 689A.220, NRS 689A.230, and NRS 686C, Smith defined benefits as "the healthcare services, treatments, or financial reimbursements provided under a health insurance policy" (U19).

The document Smith reviewed for purposes of his analysis was the version of the Plan Document the Union had obtained through Partyka's public records request, and had used for its own initial review and identification of issues (Tr. 1/211:5-20, U5). Smith's report presented a side-by-side comparison of the essential benefits listed in the current and prior Plan Documents, and identified a total of 8 potential disparities. Those disparities included a decrease in benefits related to out-of-pocket maximums and hospice care; increase in benefits related to "Teladoc/ Telehealth"[11], preventive care, maternity care, contraception, and ambulance services; and new language not necessarily constituting a change in acupuncture and medical necessity for ambulance services. All other benefits reviewed were deemed not to have been changed, including durable equipment, emergency room, home health care, and vision benefits. Under cross-examination, Smith conceded that out-of-pocket maximums, acupuncture, maternity and preventive care, hospice care, and "Teladoc/Telehealth" benefits had not in fact been changed.

[11] Noted in quotes because the record indicates Smith may have improperly combined the two benefits.

Smith was also unaware that changes related to ambulance services, vision, and the healthy lifestyle benefit, had previously been addressed at the GHCC (Tr. 1/234:7-237:7, 238:1-240:18, 240:20-241:11, 242:1-243:14, 243:21-244:18, 251:11-252:7, 252:9-254:4, 254:7-256:17, 257:15-258:8, 258:13-259:13).

Regarding the medical necessity review, Smith affirmed medical necessity was required for all services offered under both plan documents, and that if an individual demonstrated medical necessity for further treatment, the current Plan Document does provide that entitlement (Tr. 1/240:10-18, 257:15-22). He confirmed that even under the prior Plan Document, confirmation of medical necessity would have been required "at some point" (Tr. 1/265:24-266:3). On the question of whether medical necessity was a benefit, Smith seemed to equivocate. He initially stated that an individual denied further treatment on the basis of medical necessity would "perceive" it as a change in benefits as compared with the services they received under the prior third-party administrator (Tr. 1/259:21-260:12), but later asserted the review would constitute a decrease in benefits (Tr. 1/263:15-264:10).

In closing, the Union argued the City had imposed benefit changes "without GHCC action and City Council ratification", in violation of Article 3A of the Collective Bargaining Agreement. It asserted that, "The appropriate remedy is a status quo reset: restore the pre-change plan terms, reprocess affected claims, make members whole with interest, cease and desist from further unilateral changes... fees and costs based on the City's refusal to correct admitted decreases" (*Brief* at 2-3).

The City indicated its willingness to adopt the definition of benefits developed by the Union's industry expert, but held fast to its position that the GHCC "votes on changes to benefits, not clarifying language changes". It contended there is no merit to the Union's allegations, and that the language of the Agreement, and the parties' bargaining history, support its interpretation. The City further noted that no other union member of the GHCC agrees that benefits have decreased, and asserted that its "transition in Plan Document formats caused no harm to Local 731 members" (*Brief* at 2, 17).

OPINION

The Union generally argues that the City violated both the Collective Bargaining Agreement and established past practice by improperly implementing changes to the benefits plan without the required participation of the GHCC and the City Council. The appeal to past practice is based on the proposition that the GHCC has always voted on even minute changes to the Plan Document, including grammatical and typographical edits, and that the City contravened this practice when it changed language in the Plan Document without a vote of the Committee.

Whether a Past Practice Exists

In support of this argument, the Union pointed to its Exhibit 29, which it claimed demonstrates that the Committee "approved even micro-edits (e.g., inserting a space before "APPO Directory"), deleted phrases...and struck or moved language..." (*Brief* at 13). However, the record revealed these edits were made to effect significant changes to benefits, or the manner in which they would be administered, pursuant to an agenda item approved by the Committee. The amendments being made on that occasion included changes to definitions which the City intended to send to the unions via email. The exhibit does not show that those definition changes were put to a vote. By contrast, the exhibit also includes a list of changes to health-related payments and services being considered by the Committee, which had been identified as being "for possible action", i.e., voting (Jackson Testimony). None was solely typographical (pp. 1, 6, 21). The exhibit thus demonstrates the Committee did review language changes, but that they were treated differently than were substantive changes to benefits, in that the latter were specifically identified as requiring a vote of the Committee.

A similar agenda item, listed as "benefit plan document updates", appears in Union's Exhibit 30. It followed discussions regarding certain "benefit design changes", for which the City presented "supporting language". These changes included adjustments to deductibles and elimination or addition of certain benefits. This agenda item was set for voting. A reference to "typos" appears to have been directly related to language providing for "legislated benefits and clarification for covered benefits", and not as a standalone item for Committee action.

The Union argued further that "even mandatory legal changes" were voted on by the Committee, suggesting that even changes the Committee had no power to deny were brought to a vote. It should be noted that the Collective Bargaining Agreement does not exclude legislated benefits from the GHCC's purview. The legislative items brought to the Committee were substantive additions or changes to the existing "healthcare services, treatments, or financial reimbursements". It was therefore appropriate for the City to bring those items to the Committee, and its vote on those changes was wholly appropriate under the terms of the Agreement.

While there is evidence the Committee discussed changes to the language of the plan document, that evidence does not demonstrate there was a binding past practice. The existence of a past practice may be validated if it is shown the parties possessed a shared understanding of the nature and terms of the practice asserted, but there is no evidence of such mutuality.[12]

In the first instance, the record revealed the City did not share the Union's understanding that the Committee routinely voted on inconsequential edits to the Plan Document. During the meeting of the Committee on December 7, 2023, the City explicitly distinguished between "clarifying language that we're making you aware of" and "items that we need your vote on specifically because they are call outs or changes to potential benefits on the Plan Document." (C21:1623). By this statement, the City clearly communicated its position that clarifying language was not a matter for approval by the Committee, but that changes to benefits were. Had clarifying language and typos been considered voting items as a matter of practice, the City would have had no reason to make this distinction. The perspective of the Union's cohort on the Committee is an equally important point of consideration, since it is the GHCC, and not the Union alone, which must be party to the alleged past practice. The City's statement was made before the full Committee and in the course of its normal and legitimate functioning. If voting on strictly editorial or grammatical changes was the known and accepted practice, the Union, or any of its counterparts, could be expected to lodge an objection to the City's characterization of these agenda items. There is no evidence they did.

[12] Ref. *Past Practice and Administration of Bargaining Agreements* by Mittenthal, R.

In addition, at hearing, OE3 provided evidence that it does not interpret the CBA as requiring the GHCC to vote on all changes to the Plan Document, and specifically not on changes to wording or format (Handel, E33). Consistent with this, and particularly relevant to the circumstances present in this matter, the record contains no suggestion that any Committee member or participant expected to vote on editorial changes that were made concurrent with the previous third-party administrator transition in 2015, when the City began contracting with HTH. The Union acknowledged no such voting occurred (Jackson Testimony, C2, C9, C13, C14, C15, U28).

On balance, the claim that the Committee has exercised jurisdiction on every jot and tittle of the Plan Document is not well-evidenced. The record shows instead that responsibility for making edits to the Document has passed between the City and its third-party administrator, and never was vested to the Committee.[13] The record further demonstrates the Committee routinely reviewed changes to the language of Plan Document, but that its focus was on substantive changes to healthcare services, treatments or payments when it came to voting (see, for eg., U24, 24-26; U25, 1, 20-22; U26 3-4).[14] The fact that typos were included in the editorial changes necessary to implement some change to a benefit does not elevate them to equal status.

While the City routinely apprised the Committee of the exact language that would accompany benefit changes, this is not tantamount to proof that overseeing typographical changes was the practiced role of the Committee. This course of dealing was a good faith discharge of the contractual obligations of the GHCC. Collective bargaining operates on a foundational principle of good faith, and in this context such action is valuable in fully satisfying the requirements of the Agreement.

[13] The parties have no doubt engaged in multiple contract negotiations in the years since the GHCC language was drafted, yet there is no indication the Union ever sought to amend the Agreement to establish the Committee as steward of the Plan Document. This creates both a presumption of acceptance, and establishes that the parties have acted on a mutual understanding that the GHCC votes, not on minor typographical edits, but on actual benefit changes.

[14] The Union noted that the City provided no witness who had first-hand experience of the GHCC's operation, but the record contains agendas, notes, recordings and, in many cases, transcriptions, of a number of meetings spanning approximately ten years. As the Committee meetings are conducted under open meeting law, agendas are set with deliberation and minutes are recorded. It is therefore not necessary to rely on witness testimony in order to obtain a reliable representation of the Committee's functioning over the years.

As the entitlements provided by the plan are contained and communicated in the Plan Document, it is appropriate that a showing of proper performance in matters touching the Committee's actions be made. "Arbitrators use the doctrine of good faith as an interpretive tool to define ambiguous contractual language in a way that prevents an employer or union from evading the spirit of the bargain or willfully rendering an imperfect performance..." (T. St. Antoine, *The Common Law of the Workplace*, 82 (2nd Ed., 2005). Discussion and review of accompanying changes to the content of the Plan Document supports this goal.

What the Collective Bargaining Agreement Provides

Ultimately, past practice is not determinative in answering this dispute because the operative language is clear and efficacious in itself. The Agreement sets forth the roles, rules, and restrictions of the GHCC, and of its members. It provides:

> The City shall maintain an equal or better standard of group health insurance coverage unless change is agreed to as provided in Paragraph 3 of this Article.
> The purpose of this Committee is to discuss cost containment measures and to recommend to the City Council any benefit changes to the City's self-insured group health and life insurance plan.
> ...
> Any two (2) of the listed three (3) bargaining units can bind the remaining bargaining units to changes to the City's self-insured group health and life insurance plans. Any modification in benefits agreed to by the City Council on recommendation of the committee shall be binding upon each represented and non-represented group.

The parties jointly understand that the overarching purpose and function of the Group Health Care Committee are to "discuss cost containment measures and to recommend to the City Council any benefit changes to the City's self-insured group health and life insurance plan". Given the City's willingness to adopt the definition put forward by the Union's industry expert, throughout this Opinion, a benefit will be defined to include any healthcare service, treatment, or financial reimbursement provided under the City's group health plan. In this vein, the Agreement is rendered:

> The purpose of this Committee is to discuss cost containment measures and to recommend to the City Council any [*healthcare service, treatment, or financial reimbursement*] changes to the City's self-insured group health and life insurance plan.

The Collective Bargaining Agreement thus empowers the GHCC to discuss cost-saving measures related to healthcare services, treatments or reimbursements, and to recommend to the City Council changes to the health plan.

Regarding the Plan Document

The specific services, treatments and reimbursements provided by the plan are outlined in the Plan Document, which is relied upon by the City's third-party administrator, and the GHCC, in performing their respective roles. While the health plan is contained in the Plan Document, it must be noticed that the Collective Bargaining Agreement makes no reference to the Document itself, and does not specify any particular role for the GHCC with respect to its editing. Consequently, if the Committee voted to change a benefit, but the City, or UMR, failed to update the Plan Document to reflect the change, that failure would not constitute a violation of the Collective Bargaining Agreement, because the language acts upon the benefits offered by the plan, not upon the Plan Document. Similarly, a change to the Document which does not constitute a change to benefits or to the plan design would not violate the Agreement.

Regarding the Structure of the GHCC

The structure of the GHCC facilitates the right and ability of each member union to ensure their individual interests are "fairly and adequately represented", as contemplated by the 1991 factfinding determination prescribing its establishment (U23). The Collective Bargaining Agreement stipulates that the IAFF, the OE3, and the SPPA all have equal authority in determining what changes may be implemented. The language of the Collective Bargaining Agreement makes clear that the GHCC's legitimate function consists in the triumvirate action of all three member unions. It offers no mechanism by which any one union may have preeminence, or may overturn a determination reached by a vote of the Committee.

Regarding the Powers of the GHCC

While the unions have the power, collectively, to determine what benefit changes may be advanced for the Council's consideration, the Agreement does not provide that the Council is obligated to implement any measure recommended by the Committee. However, where the Council ratifies a majority vote of the Committee, the Agreement stipulates that all three unions are bound by the change, even if the Committee vote was not unanimous. The corollary is that a measure that passes the Committee, but which does not receive the Council's approval, is not binding on the unions; it is an incomplete performance, in that it fails to give effect to action taken by the Committee.

Applying the accepted definition of the word 'benefit', the City may be deemed to have violated the terms of the Collective Bargaining Agreement if it is shown to have altered any healthcare service, treatment, or reimbursement provided by the plan without a majority concurrence of the GHCC, or if it fails to present to the City Council those amendments in which it has concurred.

Whether the City Violated the Collective Bargaining Agreement

The Union maintains the City's actions related to the implementation of the Plan Document constituted violation of the Collective Bargaining Agreement due to resulting changes in benefits which were not approved by the GHCC and ratified by the City Council. It points to the City's May 23, 2024 email to UMR as evidence of the City's acknowledgement that benefits provided under the plan had decreased.[15]

[15] While the parties primarily make reference to decreases in benefits, reasonable arguments may be lodged to the effect that even an increase in benefits must adhere to the contractual procedure, since they obviously constitute a change. This perspective must be balanced, however, with the stipulation that the City "maintain an equal or better standard of group health insurance coverage unless change is agreed to" by the GHCC and ratified by Council. This clause identifying an increase in benefits as an exception to the procedural requirement means the City may implement such increases independent of the Committee-Council review. That said, increases in one benefit often increases costs in other areas, require a decrease in other benefits, or both. The weighing and balancing of needs, interests and costs necessitated in these circumstances lies within the purview of the GHCC. As testified to by Stewart, "It's the Union's job to question these things and to sift through them, which is why we have a GHCC with Union reps in there on health care to evaluate these things and when there is an agreement to disagree there's a vote and majority rules" (Tr. 3/67:11-16). Each of the member unions must be allowed to bring to bear on all such decisions the voice of their memberships. For this reason, while the City is arguably not obligated to seek GHCC approval for improved benefits, it is more consistent with the complete terms of the CBA, and with good faith bargaining, that it do so.

Considered within its proper context, that communication was not an admission to changes in benefits. It was part of the City's initial inquiries intended to learn whether the benefits reflected in the new Plan Document had in fact changed as the Union alleged. As previously noted, UMR had assumed maintenance of the plan as part of its contracted service, and had utilized its own template for the Plan Document. This resulted in descriptions of plan benefits that differed from that contained in the prior Plan Document. In its email, the City informed UMR it had identified differences in the Document that "appear to be a decrease in benefits". It went on to identify those potential decreases as "issues" it wished to address, not as anticipated or accepted changes to the plan. Further, after receiving UMR's analysis and response to the issues, the City provided "language changes to ensure the benefits from the 2022 Plan are reflected in the 2024 Plan" (U9). There has been no assertion, or evidence, to the effect that the City's proffered language changes accomplished anything other than this stated goal.

The City would eventually review, analyze, consult on, and discuss with the Union, each of the more than 100 purported changes it identified. The Union finds these responses to be generally unsatisfactory. It maintains the City did in fact change health benefits, and that it did so in violation of the parties' Collective Bargaining Agreement, a claim the City denies.

Whether Benefits Were Improperly Changed

It is not necessary within the scope of these proceedings to reach an independent determination as to whether individual benefits have been altered, because the issues to be decided here turn on whether there has been a violation of the Collective Bargaining Agreement, not the Plan Document. That said, the Union is not bound to rely solely on the City's own assertions. The trail of the dispute is replete with input from other, well-informed sources on the specific issues the Union has raised.

The third-party administrator, whose role and expertise are concerned with administering the plan, was invited to provide input from the inception of the dispute. The administrator identified only one difference in the benefits provided during the June, 5, 2024 workshop: coverage for folic acid, with was later rectified.

Along the way, each area of concern raised by the Union was discussed at various Committee meetings beginning in or about December 2023, as well as during the workshop. These discussions occurred in the presence, and with the participation, of the full Committee. As reflected in the record, along with Local 731, the other two member unions were consistent, active and competent participants on the Committee. The unions' representatives provided input, raised challenges, brought questions and concerns to the fore, and were deliberative when taking action on issues under consideration. There is no indication the Committee operated under sway of the City in general, or with regard to the issues raised by the Union. Yet, even in this context, no other Committee member determined benefits had been changed in violation of the Collective Bargaining Agreement. This is particularly salient in light of the fact that OE3 and SPPA had made efforts to determine whether any of their members had experienced any adverse impacts following the implementation of the Plan Document, and reported no concerns.

Latterly, and quite compellingly, the Union's own expert identified only a handful of potential changes of any kind. Applying his considerable expertise, Smith documented only 8 potential issues, far fewer than did the Union. The majority of these were ultimately shown not to have been changes to benefits, and the remainder, namely changes to the emergency room and Teledoc benefits, had been addressed by the Committee in December 2023, before the current Plan Document took effect. Voting on those changes was tabled by agreement of the Committee, though it is unclear whether or when they were revisited. In any event, the parties had initiated their agreed-upon procedure for addressing changes to those particular benefits. If they remain unresolved, their resolution properly resides with the Committee, and does not pass to this arbitration.

In light of the input provided by those most knowledgeable about the benefit entitlements, the meaning of the language contained in the Plan Document, and its impact on the members of all three unions represented on the Committee, there is no reason to conclude plan benefits were improperly changed, or resulted in harm as the grievance alleges.

With regard to impacts to its own members, though the Union properly invoked the continuing violation doctrine in its grievance filing, it has identified no individual or systemic loss of right or privilege. There is evidence employees throughout the City experienced difficulties related to claims management following the installation of the new third-party administrator. On June 5, 2024, the City reported that, between October 2023 and June 4, 2024, there were a total of 72 complaints or requests for support, and that, as of the date of that meeting, only 4 were yet to be resolved. The City explained at that time that the majority of the complaints had to do with missing benefit cards, while the next largest category was "claims that have been questioned" (C23:1709, U38). It was not shown that those issues remained at the time of hearing. The single exception is Partyka's case, in which he reportedly was denied access to further physical therapy due to the imposition of a medical necessity review for those services.

The Medical Necessity Review

The parties are at odds as to whether the imposition of a review for medical necessity for some treatments constitutes a change in the benefits provided. The Union contends this added requirement "redefine[s] what the plan covers and how members qualify to receive it" (*Brief* at 15). Citing Partyka's inability to receive further physical therapy under the plan, the Union held that this "utilization gate" "reduced access and raised costs" (*Brief* at 19). The City denies it changed the benefit provided, and defends the review as imperative to the third-party administrator's ability to enforce the requirements of the health plan.

It has been established on the record that medical necessity, including for physical therapy, was an express requirement in the previous Plan Document as well as the Document currently at issue, but for which no enforcement mechanism had been specified (Testimonies of Arulanantham, Handel, Louthan, Jackson, Slider, Stewart, C2, C21:1616-9, C21:1620, C23, U16, U38). The critical change is thus not the requirement for medical necessity, but the manner in which it is administered.

The Union rejects this characterization on the basis that the review ultimately affects employees' ability to continue accessing the benefit, and this is so. A finding that therapy is no longer medically necessary could be expected to result in denial of further coverage: Prior to 2024, employees were able to continue receiving the benefit without limitation; thereafter, they would encounter a restriction after twenty-five treatments, a situation no doubt experienced as a glaring departure from previous conditions, and as a reduced benefit. But this was manifestly a difference in administration, and not a difference in benefits.

The medical necessity review consists of an administrative analysis to determine whether additional medical treatments and services are warranted. It is a health plan feature intended to ensure compliance with the plan by precluding coverage for treatments, services or payments that are not medically necessary.[16] To this point, Smith offered the following testimony:

> **Q** For medical benefits, acupuncture, why did you highlight in yellow the in-network language?
>
> **A** I highlighted the yellow because it was a difference between the two that explicitly stated medical necessity next to the benefit, No. 1.
> No. 2, medical necessity after 25 visits is excessively rich in comparison to the industry, and No. 3, I just was drawing attention that it was a silent area under acupuncture under the SPD for Hometown Health SPD, it is typical for a third-party administrator and care management company to apply medical necessity during the visits. Typically in this example you'll allow several visits to occur, after they get excessive in that 25 in this category or it could be 10, you'll investigate and have a medical director get involved and review the chart to determine whether additional services are medically necessary.
>
> **Q** Was the Hometown Health Plan silent as to when there was a medical necessity review?
>
> **A** That's correct.
>
> **Q** However, there was a change in the UMR plan to obligate a medical necessity review after 25 visits; is that correct?
>
> **A** It's explicitly spelled out, yes. (Tr. 1/217:14-218:16)

The medical necessity review does not deny access to a benefit provided under the health plan, but ensures the benefit is provided in conformance with it.

[16] It is akin to a coordination of benefits function, which is intended to avoid overpayments. With coordination of benefits, covered individuals do not lose access to benefit entitlements, but the amount paid might be limited to the extent alternative coverage is appropriate. Similarly, with a medical necessity review, individuals retain access to all provided health-related services, treatments and payments, but only to the extent they are medically necessary.

The medical necessity review is not a benefit, because it is not itself a healthcare service, treatment or payment, and the decision to ensure its enforcement does not constitute a change in the benefits provided. The Union's cohorts on the GHCC share this view. SPPA's Arulanantham testified that she did not see it as "a loss or change of benefit" (Tr. 3/179:17-24), and OE representative Handel stated that he did not think it was a change in benefits (Tr. 3/217:10-16).

Based on the record, the GHCC was discussing questions regarding the physical therapy benefit and medical necessity for such treatments before the current Plan Document came into effect. In the course of those discussions, the City communicated its understanding that medical necessity was always applicable to the physical therapy benefit, and that the benefit needed to be managed to this parameter. Neither the Union nor its counterparts seemed opposed to the City's assertions at that time. Related discussions continued following the filing of the grievance, and culminated in the vote setting a review for medical necessity after twenty-five visits.

Because the medical necessity review is not a benefit, and did not change the benefits provided by the plan, it was not necessary to obtain GHCC approval or Council ratification for its implementation. There is, however, some limited precedent for the City's consultation with the Committee regarding the timing of the review. In October 2017, the Committee discussed, and voted on added pre-certification requirements for out-of-state hospitalization and out-patient surgery (U30-32). As neither the pre-certification nor medical necessity review constituted a change in benefits, the fact that the Committee voted on these issues is notable. But its precedential value cannot be applied beyond this activity because it is not clear from the record whether the pre-certification changes approved by the Committee in 2017 were advanced to Council for ratification. That said, as those changes likely did not modify the benefits themselves, Council ratification would not have been contractually necessary. The same is true here. Consequently, while the involvement of the GHCC was a good faith and reasonable action given the potential impact of the review, the City's failure to take the matter to Council did not violate the Collective Bargaining Agreement.

The Union has advocated for rescission of the medical necessity review on the basis that there had been a "change that required medical necessity at 25 visits, that was a change in our medical benefits..." (C23:1847-8; U38) that needed to be corrected. There is no dispute the medical necessity review had been conducted in Partyka's case prior to the Committee's vote approving its conduct after the specified number of visits. However, setting aside the fact that the review did not change benefit entitlements, to the extent the vote occurred after the change was implemented, it currently stands as a matter upon which the Committee has acted. Any conceivable breach has been thereby mended. The Committee's action cannot be overturned on the basis of this grievance, particularly since there is no evidence suggesting the Committee might have arrived at different conclusions had the timing been different. Even if the medical necessity review could be deemed to constitute a change in benefits, any attempt to turn back the proverbial clock at this point would serve only to embroil the parties in a pro forma mimicry of the contractual procedure in a matter upon which the majority has already spoken.

As communicated during the meetings of the GHCC, the Union believes there is value in allowing its members to receive the physical therapy benefit without having to prove an ongoing medical need for such treatment. The desirability of this type of maintenance therapy is certainly understandable, but it is simply not provided for under the health plan. It is only allowable by a majority vote of the GHCC, and the GHCC has voted to enforce the medical necessity requirement. The Union opted to abstain from the vote, but that choice does not delegitimize its outcome. Neither does the Union's dissent. The Collective Bargaining Agreement explicitly authorizes the GHCC the make changes to the benefit plan as a body. That power is not vested in Local 731, or any of its counterparts, individually. Each of the unions holds equal authority, and each is bound by a majority vote of the Committee; unanimity is not required. The Committee's vote in September 2024 was a legitimate exercise of its powers, and the decision of the voting members was informed by their engagement with their stakeholders and with the rest of the Committee. It cannot be set aside here.

DECISION

The ultimate objective at arbitration is to restore to aggrieved parties the contractual rights and privileges they would have enjoyed but for a proven breach of agreement. No such violation of the parties' Collective Bargaining Agreement has been proved.

The parties to this dispute are the City and the Union, and these proceedings derive from the Collective Bargaining Agreement between those entities. The Agreement entrusts authority and oversight of all changes to benefits to the three members of the GHCC, equally. It provides no mechanism by which determinations made by the Committee may be reviewed by arbitration to which only one of the Committee members is party.

The record established that the City and the GHCC routinely reviewed substantive changes to the health plan as well as changes to the Plan Document that did not affect the benefits provided. However, no binding past practice with regard to voting on typographical changes was established. Such discussions were a reasonable, good faith discharge of the work of the Committee, but were not shown to be recognized issues upon which the Committee voted as a matter of course. Moreover, the relevant Collective Bargaining Agreement language provides that the GHCC's jurisdiction rests with the healthcare plan itself, not the Plan Document. Though the one is contained in the other, the two are distinguishable, and the parties' bargaining history demonstrates they have operated within this framework for many years. Further to this, the Union's request that the City be required to revert to the prior Plan Document is not a viable option, because the Plan Document has been revised to reflect a number of benefit changes approved by the Committee in the legitimate exercise of its authority prior to and throughout the course of this dispute.

The essential question at issue in this matter is not whether the City violated the Collective Bargaining Agreement by making changes to the Plan Document, but whether it did so by improperly making changes to the benefits articulated therein.

Within the context of this dispute, the definition of a benefit, as proffered by the Union's industry expert and accepted by the City, is any healthcare service, treatment or reimbursement provided by the City's group health plan. The evidence on the record, particularly as articulated by UMR, the Union's own industry expert, and GHCC member unions OE3 and SPPA, established no benefits were improperly changed by unilateral action of the City. This determination by a majority of the Committee members that no improper change had been made is sufficient to compel a finding that there was no breach of the Collective Bargaining Agreement.

In addition, the question of medical necessity, particularly as it relates to physical therapy, was being addressed in meetings of the Committee prior to the implementation of the current Plan Document, and months before the grievance was filed. As medical necessity was a pre-existing feature of the plan, the City did not err when it directed the incoming third-party administrator to enforce it. Neither its enforcement, nor the number of visits at which it would be conducted, constitutes a change in the benefit covered individuals are entitled to receive. As such, the Committee's vote was not contractually required.[17]

As the evidence on the record did not support a finding that benefits provided under the City's group health plan were improperly changed, or that members of the Union were contractually harmed as a result, the grievance must be denied.

[17] Had the medical necessity review constituted a change in benefits, the City would be ordered to obtain Council ratification, since failure to do so where a benefit has changed would constitute incomplete performance. This not being the case, Council ratification will not be ordered.

AWARD

1. The Collective Bargaining Agreement authorizes the Group Healthcare Committee to make changes to benefits provided under the City's healthcare plan by majority vote of its members and ratification by the City Council.

2. Based on the record of these proceedings, including the attestations of the two member unions with which Local 731 shares this authority, no benefits provided by the healthcare plan were improperly changed following the implementation of the current Plan Document.

3. The medical necessity review did not change the benefit entitlements provided by the healthcare plan. Consequently, GHCC approval and Council ratification were not required for its implementation.

4. No violation of the Collective Bargaining Agreement has been proved. The grievance is DENIED.

5. In accordance with Section 1, Article L(5) of the Collective Bargaining Agreement, the findings contained in this Award are final, and are binding on all parties concerned.

6. In accordance with Section 1, Article L(5) of the Collective Bargaining Agreement, all costs of the Arbitrator's services will be borne equally by the parties.

Dated this 6th day of October, 2025

Charlene MacMillan, Arbitrator