Lehigh County Pennsylvania

OFFICE OF THE CONTROLLER
Mark Pinsley, MBA — COUNTY CONTROLLER
Nanton John, CIA,CFE — DEPUTY CONTROLLER

TO: Final Report Distribution

FROM: Mark Pinsley, County Controller

DATE: September 9, 2025

RE: 2021 Medical Claim Payment Audit – Follow-up

The Controller's office has completed a follow-up to the recommendations presented in the 2021 Medical Claim Payment Audit report (#22-16), issued October 21, 2022. Our report, number 25-24, is attached. We wish to thank the Director of Administration and the Human Resources department for their cooperation and support.

Current status of recommendations:

- Of the 15 total recommendations presented in the 2021 Medical Claim Payment Audit (12 findings), it appears that 3 have been implemented, 2 partially implemented, and 10 have not been implemented.
- Varying degrees of residual risk remains for 13 of the 15 total recommendations. See Follow-up to Prior Audit Recommendations beginning on page 6.

Attachment

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COUNTY OF LEHIGH, PENNSYLVANIA

2021 MEDICAL CLAIM PAYMENT AUDIT – FOLLOW-UP

REPORT NO. 25-24

COUNTY OF LEHIGH, PENNSYLVANIA
2021 MEDICAL CLAIM PAYMENT AUDIT – FOLLOW-UP

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COUNTY OF LEHIGH, PENNSYLVANIA
2021 MEDICAL CLAIM PAYMENT AUDIT – FOLLOW-UP

Background

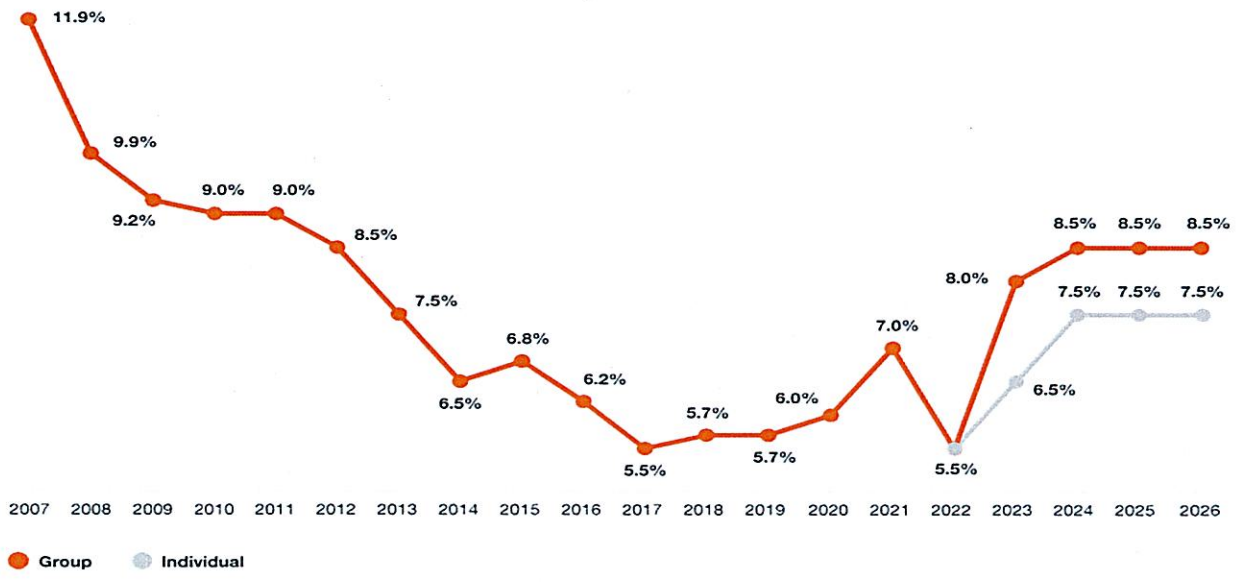
Significant Items Noted in the 2021 Medical Claim Payment Audit Report (#22-16):

- An external medical claim audit identified $63k in agreed recoveries (some having been identified by Highmark and reimbursed), $81k in disputed recoveries for sampled and out-of-sample claims, and $143k of additional recovery potential.
- The evaluation of potential savings from competitive medical pricing through a referenced-based structure (e.g., mark-up from Medicare negotiated rates) should be periodically assessed to realize the potential savings of $4M as noted during the County's 2022 medical plan renewal process.
- If referenced-based pricing is not pursued, the Administration should require the payment of outpatient and inpatient hospital rates to be the lower of the Highmark negotiated rates or the hospital cash rates.
- Ownership and controls over the validation of contractual obligations, compliance and payment accuracy should be strengthened.
- Recovered $106k of erroneously billed stop-loss claims.
- Identified and recovered $44k of overpaid commissions.

Medical costs continue to rise year-over year. According to PricewaterhouseCooprs (PwC), "Medical cost trend is once again hovering at rates reminiscent of 15 years ago. The US healthcare system is heading into another year of powerful inflationary forces exerting pressure with few deflationary forces in sight"*.
The graph presentend below by PwC provides their calculated medical cost trends over the past 19 years, and their projection for 2026. Based on their projection, medical costs are expected to rise another 8.5% in 2026.

PwC medical cost trends, 2007-2026

PwC projects medical cost trend to be 8.5% for Group and 7.5% for Individual in 2026, in line with 8.5% and 7.5% in 2025

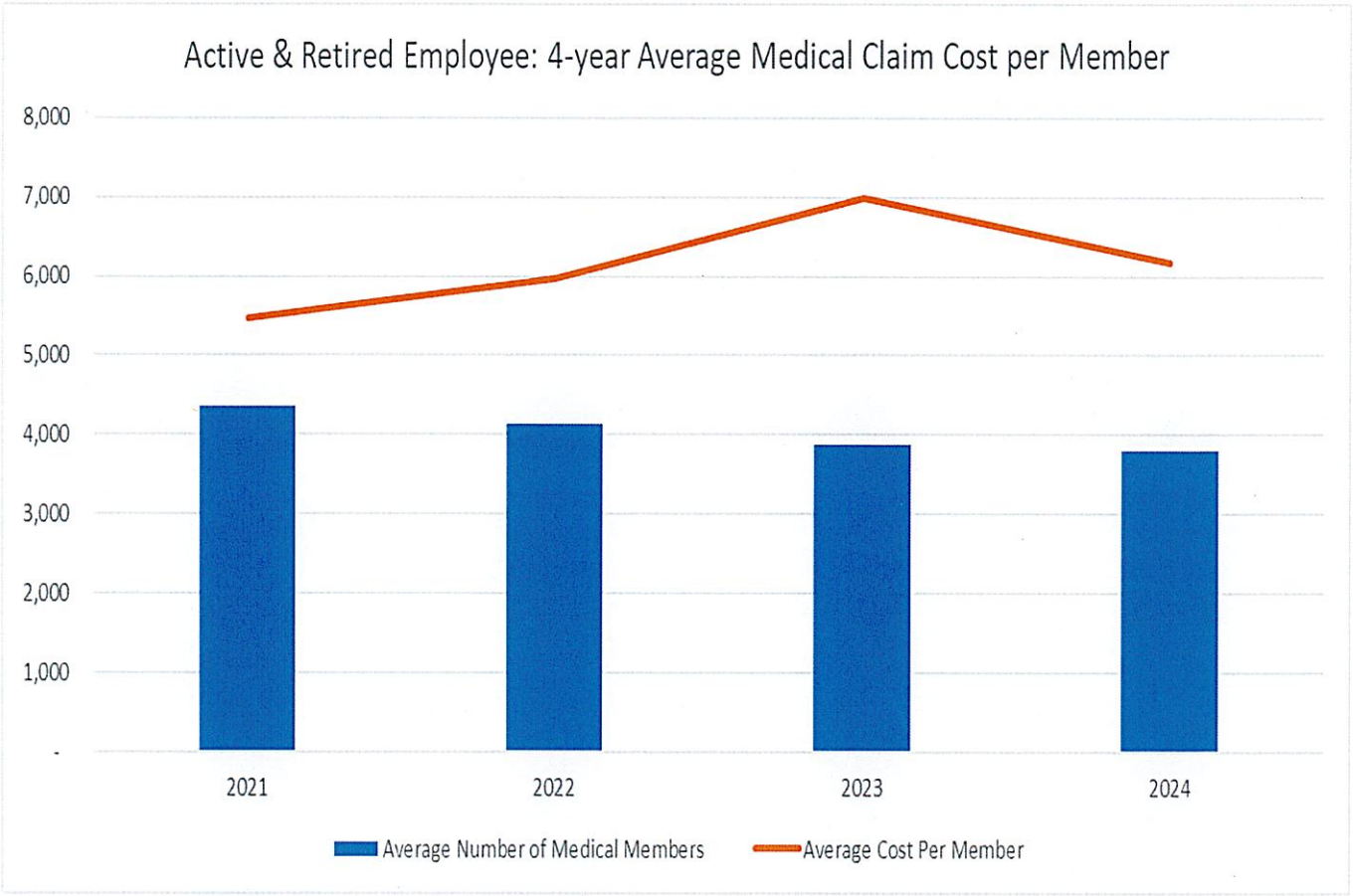


Source: PwC analysis

* = Source: https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

Background - Continued

As for the County of Lehigh, when comparing 2021 paid medical health care plan costs to 2024, the total dollar amount has remained relatively unchanged. However, the average number of medical members has decreased by 13% (a reduction of 557 members), while the average cost per member has increased by 13% (an increase of $702 per medical member). The impact of the increased average cost is approximately $2.7M.



Overall, when compared to PwC's medical cost trends, the Administration and Broker have done well in minimizing the continued increasing costs of medical coverage between 2021 through 2024 for its employees and retirees. As one of the County's largest employment expenditures ($23.5M in 2024), and the continuous trend of increased medical costs, we believe our report recommendations can provide options for enhanced oversight, transparency, and the potential of reduced costs for the County.

Background - Continued

Below is a timeline of key dates pertaining to our report and applicable health care vendors:

October 2022
- Issued 2021 Medical Claim Payment Audit Report containing 12 Findings and 15 Recommendations (Report #22-16)

January 2023
- Controller's Office requested a 3-month follow-up from the Administration regarding the implementation of the 14 recommendations noted in the 2021 Medical Claim Payment audit report. No response was received.

April 2023
- Board of Commissioners approve the renewal of McGriff as the Broker of Record to Represent Lehigh County with its Employee Health Insurance Administator or Provider (Resolution 2023-15). Period: 3/1/2023 through 2/28/2026

November 2023
- Board of Commissioners approve the renewal of Highmark for the Medical Portion of the Health Care Plan for Lehigh County Active Employees, Qualifies Sposuses, and Dependents for calendar years 2024, 2025 and 2026

September 2025
- Issuance of this report: 2021 Medical Claim Payment Audit Follow-up Report with current statuses of the 15 Recommendations (Report #25-24)

February 2026
- McGriff's Employee Health Administrator Broker Contract with the County Expires 2/28/2026

December 2026
- Highmark's Employee Medical Portion of the Health Care Plan Contract expires 12/31/2026

COUNTY OF LEHIGH, PENNSYLVANIA
2021 MEDICAL CLAIM PAYMENT AUDIT – FOLLOW-UP

Current Status of Recommendations

Finding	Recommendation Summary	Implemented	Partially Implemented	Not Implemented
1	Pursuit of third-party medical claim specialist identified agreed recoveries, disputed findings. and informational findings. Periodic paid claim audit by medical claim specialist			✓ ✓
2	The County should require that all future audit data requests from Highmark contain NPI codes at the individual claim level to better understand cost savings achieved through Highmark for specific hospitals procedures. Pursuit of alternative employee medical coverage without eroding employee coverage – e.g. referenced-based pricing models. Negotiate outpatient and inpatient hospital rates with Highmark to be the lower of negotiated rates or cash price.		✓	✓ ✓
3	Administration should fully understand all aspects of Highmark's contractual obligations prior to invoiced payments.			✓
4	Administration should actively manage stop-loss premiums and loss payments, especially when transistioning between insurance carriers.		✓	
5	Administration should validate compliance with the Producer of Record Letter prior to the payment of Broker invoices.	✓		
6	Administration should continually monitor the value derived from Highmark's Value-Based Program.			✓
7	Administration should continually monitor Highmark's administration of the College Tuition program.	✓		
8	Administration should instruct McGriff Insurance to actively pursue opportunities to reduce the percentage fee for recoveries/savings, or pursue a direct relationship with a third-party.			✓
9	Administration should work with McGriff Insurance to identify alternative stop-loss options/markets in balancing the mitigation of risk to price.	✓		
10	The County should have the ability to review the handling of claims referred to Highmark's SIU and their associated outcomes.			✓
11	Administration should work to allow greater transparency of claims data for audit purposes.			✓
12	Administration should consider the inclusion of a requirement within our agreement twith McGriff Insurance to disclose, on a timely basis, any and all monetary and non-monetary compensation, incentives and awards pertaining to County plans under agreement.			✓

Lehigh County Pennsylvania

OFFICE OF THE CONTROLLER

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2021 Medical Claim Payment Audit – Follow-up

The Office of the Controller conducts audits of Lehigh County's entities, programs, and contractors to provide the residents of the County, the Board of Commissioners, the County's Administration and management, unbiased and relevant information to use in promoting accountability, transparency, and stewardship for the improvement of government operations.

Objective:
The objective of the follow-up is to validate/confirm the actions taken by the Administration to address the noted findings.

Scope
With continued pressure to meet budgetary constraints, the Controller's office performed a follow-up on the recommendations presented in the 2021 Medical Claim Payment Audit (issued October 21, 2022 – report #22-16) to determine their current statuses.

Methodology
Our follow-up review included interviews, tests of records, and other auditing procedures as we considered necessary in the circumstances. Transactions, processes, and situations reviewed were not limited by the audit period.

Conclusion
We conclude that 3 of the 15 recommendations have been implemented; 2 have been partially implemented, and 10 have not been implemented. Of the 15 recommendations, various levels of residual risks exist for 13 of the recommendations. See Follow-up to Prior Audit Recommendations – page 6-13.

Mark Pinsley

MARK PINSLEY
County Controller

Allentown, Pennsylvania
September 9, 2025

Final Distribution:
Phillips Armstrong, County Executive
Board of Commissioners
Keisha McCollin-Bulluck, Chief Human Resource Officer
Timothy Reeves, Chief Fiscal Officer

Follow-up to Prior Audit Recommendations

This section describes actions taken by the Administration on the recommendations presented in our 2021 Medical Claim Payment Audit report. The conditions and recommendations herein are those of the original audit, followed by the current status and residual risks.

1. Paid Claims Audit

Condition: The County of Lehigh's Controller's Office contracted with John Graham Incorporated to perform a paid claim audit for the year 2021. Please see attachment A for the issued audit report which includes an executive summary, an overview of the audit process, agreed findings, disputed findings, and informational findings.

Recommendations: Based on the paid claim audit findings, we recommend that the Office of Administration should pursue the following:

Agreed Recoveries:

- All agreed recoveries ($63k) should be verified as received from Highmark. This includes the reimbursement of $27k due to Highmark missing the timeframe submission to Medicare.

Disputed Findings:

- Review the intent of the Medicare Part B deductible under our Signature 65 plan and ensure alignment with our agreement/contract with Highmark. Gain understanding why some deductibles were agreed recoveries and the remaining are not.
- Highmark should be notified to recover claims on retroactive terminations ($35k – sampled and out-of-sample balances), and future contracts should include their proactive pursuit of amounts paid on claims from retroactive terminations.
- Confirm eligibility for identified newborn grandchildren coverage ($41k). If eligibility cannot be confirmed, and coverage is not included in our plan, recovery should be pursued.
- Review with Highmark the various other identified disputed findings: paying in excess of plan limit (routine examinations, nutritional counseling, maintenance care), and coverage of cochlear implants and other hearing devices.

Informational Findings:

- Evaluation of adding provisions for Medicare estimation to provide financial incentives for members to enroll in Medicare, reducing claim costs.
- Evaluation of family members with over $1M of paid drug treatment without clinical review by Highmark.
- Review the plan's intention regarding multiple co-pays per day.
- Evaluate and align the limit on skilled nursing facility coverage between 100 days and the contract year.
- Gain a greater understanding of the Quality Blue charges, their related benefits, and confirm adherence with program criteria prior to payment.

In addition, we recommend that the Office of Administration periodically request a paid claim audit with a comprehensive claims audit scope. This type of audit, by a medical claim specialist, will provide the County assurance that our medical claim insurer is processing and adjudicating our claims in compliance with our contract/agreement.

Current Status:

1. Administration is unaware whether the recoveries from Highmark were received or disputed and information findings pursued. - *Not Implemented*
2. No independent review of paid medical claims has been conducted since the release of the audit report (2022). – *Not Implemented*

Residual Risk:

- Agreed recoveries were not reimbursed to the County. In addition, it appears that potential recoveries identified as Disputed and Informational findings were not pursued.
- No independent validation of compliance with the County's contract with Highmark.
- County paying for Highmark's erroneously processing of medical claims

2. Competitive Pricing

Condition: In 2021, the County had a contract with Highmark to process and pay County employee and retiree medical claims. The County established this relationship to take advantage of Highmark's negotiated rates with health networks, hospitals, doctor offices, and third-party healthcare claims processing vendors to reduce related costs to the County.

Over the last several years there have been laws/regulations passed designed to provide increased transparency to buyers of healthcare:

- Transparency in Coverage Final Rule - aimed at insurers and plans;
- Hospital Price Transparency Final Rule - aimed at hospitals;
- Consolidated Appropriations Act of 2021 (CAA) - impacts plans, insurers, providers and plan service providers;
- No Surprises Act - governs many disputes arising from emergency care and non-network care at network hospitals and emergency rooms and dictates the behavior of providers, facilities, and payers/plans.

One of the provisions within the CAA mandates hospitals to provide clear, accessible pricing information to assist consumers to shop and compare prices across hospitals. Hospitals are supposed to provide public access to all their contract pricing and other pricing they make available to consumers. However, not all hospitals in our local area are completely compliant with this Act.

We were able to obtain 'cash pricing' also known as 'self-pay' pricing which is the price that a consumer without insurance would pay from some of our local hospitals. This information was not available for every medical procedure the County paid for in 2021; however, using pricing data from area hospitals and our paid claims data, we compared available procedure code pricing to listed 'cash-pricing' and Medicare costs. An exact savings of cash pricing could not be determined because, although requested, the 2021 claims file received from Highmark did not contain the National Provider Identifier (NPI) code. The NPI is a unique identification number that will allow reviewers to understand what hospital performed a specific procedure. However, based on the pricing data available in comparison to averaged paid procedure costs, we identified instances where the County is paying more than hospital posted cash prices, and considerably more than Medicare costs. This level of savings is consistent with a quote received by a third-party that provided referenced-based pricing during the County's 2022 Medical Renewal process at a $4M reduction in comparison to 2021 costs.

Recommendation #1

The County should require that all future audit data requests from Highmark contain NPI codes at the individual claim level to better understand cost savings achieved through Highmark for specific hospitals procedures.

Recommendation #2

With the continued accessibility to pricing data, the Office of Administration should better understand the value derived from our relationship with Highmark. Additional evaluation of alternative solutions should be pursued without eroding employee coverage. The Controller believes that all prices should be based on a mark-up from Medicare cost/rate (as the reference) rather than an insurance carrier's negotiated rates with individual hospitals and service providers.

Recommendation #3

If the County does not pursue a reference-based pricing option, it should consider requiring the payment of outpatient and inpatient hospital rates to be the lower of Highmark's negotiated rates or the hospital's cash rates.

Current Status:

1. Administration stated that the inclusion of the NPI codes in data requests will be considered during the next employee healthcare Request for Proposal (during 2026). - *Not Implemented*
2. Administration was informed by Broker (McGriff), only one local company contracted with a referenced-based medical provider, and is no longer with them. Administration noted the implementation of Flex Blue in 2024 with Lehigh Valley Health Network which has reduced costs. – *Partially Implemented.*

   Testing revealed that although the dollar amount of paid medical claims remained relatively unchanged, the average number of medical members decreased by 13% (-557) from 2021 to 2024, increasing the average cost per member by 13% ($702) - A $2.7M impact.
3. Administration stated that the negotiation of outpatient and inpatient rates with Highmark to be lower of negotiated rates or cash price will be considered during the next employee healthcare Request for Proposal (during 2026). - *Not Implemented.*

Residual Risk:

- Reliance on Broker to identify alternative employee medical coverage.
- Risk that the Broker may not have the best interest of the County when identifying alternative medical coverage
- County paying higher than cash price for outpatient and inpatient hospital services.
- Inability to determine cost savings achieved though negotiated rates without NPI codes.

3. Administration of Medical Claim Payments

Condition: In 2021, the County incurred approximately $28M in medical claims and associated costs. Based on our review, we noted instances of unfamiliarity of costs and processing of inaccurate payments which gives the appearance that there is a lack of understanding, and ownership/monitoring of the contractual obligations and value derived from our relationship with Highmark.

Recommendation: The Office of Administration should fully understand all aspects of Highmark's contractual obligations for our medical plan and validate them to ensure compliance prior to payment. This will reduce waste of County resources and provide greater assurance of plan effectiveness.

Current Status:
Administration stated that the responsibility was assumed by Human Resources Director and Benefit/Training Specialist
Based on follow-up with Human Resource personnel, there still remains aspects of Highmark's billed services that are unknown when invoices are approved for payment.– *Not Implemented*

Residual Risk:

- Overpaying of invoices for uncontracted or unknown services.
- No evaluation of whether benefits of ancillary programs outweigh the associated costs.

4. Stop-Loss Claims Erroneously Billed ($106k)

Condition: Based on our inquiry of reconciled stop-loss premium and loss payments between the carrier (Highmark Life Insurance Company), McGriff Insurance and analysis of paid invoices, we were informed that Highmark Life Insurance Company erroneously billed the County approximately $106k for claims covered under the previous insurance carrier. Once identified, a credit was applied to the 3/29/2022 Highmark medical claim invoice.

Recommendation: The Office of Administration should actively manage stop-loss premiums and loss payments to ensure compliance with the policy. Special attention is required when transitioning from one insurance carrier to another.

Current Status:
Administration stated that the responsibility for reconciling the stop-loss premium and loss payments/recoveries were assumed by the Human Resources Director.
Based on follow-up with Human Resource personnel, only stop-loss premium payments are processed and approved by Human Resources. Losses are not monitored for potential recovery. – *Partially Implemented*

Residual Risk:

- Not identifying or pursuing recovering amounts owed on loss payments
- Relying on a third-party for the recovery of loss payments
- No independent audit/review performed on third-party administration of stop-loss payments/refunds to ensure the accuracy of transactions during the transition to new stop-loss carrier.

5. Overpayment of Commissions ($44k)

Condition: In the Controller's 2019 audit of Highmark's Prescription Drug Costs, issued in 2021, it was noted that McGriff Insurance was a representative for Highmark and not the County. Based on this finding, the County Executive issued a Producer of Record Letter notifying Highmark that commission payments (previously paid by Highmark to McGriff Insurance) would cease 3/1/2021.
Based on testing, we confirmed that Highmark continued to invoice the County for commissions throughout 2021, and the County overpaid $44,123.40. After bringing this to Highmark's attention, we confirmed that a credit was applied to the County's 9/30/2022 invoice for the overpayment.

Recommendation: The Office of Administration should validate compliance with the Producer of Record Letter prior to the payment of invoices.

Current Status:
Auditor confirmed that administrative fees are excluded, and commission reductions are applied when invoices are paid by the Office of Fiscal Affairs. - *Implemented*

Residual Risk:
Little to none.

6. Paid Value-Based Reimbursements ($168k)

Condition: In 2021, the County was invoiced and paid $167,935.93 for Value-Based Reimbursements to Highmark. We have, on multiple occasions, reached-out to Highmark, copying McGriff Insurance and the Office of Administration, to gain an understanding of the program and determine the savings the County achieved in 2021 for the amount paid. To date, no response has been received.

Recommendation: The County should discontinue the payment of the Value-Based Reimbursement program and request a full refund of all prior paid amounts until benefits can be justified. Oversight of derived value from this payment should be continually monitored by the Office of Administration.

Current Status:
Administration and Human Recourses are unaware of the benefit derived from Highmark's Value-Based Program that was in-place during 2021. Informed by Human Resources that the County is no longer using the program (contract change). – *Not Implemented.*

Residual Risk:
- Overpaying of invoices for uncontracted or unknown services.
- No evaluation of whether benefits of ancillary programs outweigh the associated costs.

7. College Tuition Program ($29k)

Condition: In 2021, the Office of Administration opted to participate in a College Tuition program through our agreement with Highmark. Each month a fee was charged based on the number of plan participants. For 2021, the County was invoiced and paid $28,806. Based on our inquiry, Highmark admitted that they failed to establish the County's College Tuition program with Sage Benefits (the administrator). We have noted that the County continues to pay the College Tuition fees in 2022, but have not received any confirmation that Highmark has established our program with Sage Benefits.

Recommendation: The County should discontinue the payment of the College Tuition program and request a full refund of all prior paid amounts until benefits can be justified. Oversight of the Administration of the College Tuition program should be continually monitored by the Office of Administration.

Current Status:
Administration stated that the responsibility to monitor the implementation and communication of the College Tuition program was assumed by the Human Resources Director.
Informed by Human Resources personnel, that after the audit brought to the attention of the Administration and Highmark that the program had not been established for the employees, Highmark initiated the program via SAGE and it has been communicated to the employees. Payments are monitored by Human Resources. SAGE Member communication validated by auditor. - *Implemented.*

Residual Risk:
Little to none.

8. Recovery and Savings Percentage paid to Highmark

Condition: Amendment 3 to the Master Health Service Agreement with Highmark indicates that the County should pay a 35% fee for recoveries and savings identified by Highmark (e.g. subrogation, audits, etc.) or their third-party vendors (Cotiviti & Optum). When asked whether the recovery fee percentage was comparable to the market, McGriff Insurance indicated that they have seen other carriers in the 30% range, and mentioned other means in which similar fees have been reduced.

Recommendation: Based on our contractual agreement, management should instruct McGriff Insurance to actively pursue opportunities to reduce the percentage fee for recoveries/savings. We are unclear as to the contractual relationships between Highmark and their third-parties (Cotiviti & Optum) with regards to fees and commissions. If recovery and savings fees cannot be reduced, consideration should be given to the use of a third party contracted directly by the County of Lehigh for the identification of recoveries and savings.

Current Status:
Administration stated that the recovery fee percentage will be considered during the next employee healthcare Request for Proposal (during 2026). – *Not Implemented*

Residual Risk:
- Excessive recoveries/savings payments to Highmark.
- Risk that the Broker may not have the best interest of the County when negotiating recovery/savings percentages with Highmark.

9. Stop-Loss Coverage Options

Condition: The County retains stop-loss coverage for individual claims that exceed $350k in a policy year. Based on past loss experience, premiums for the County's stop-loss policy have increased significantly year-over-year: 2019: $123k, or 27% increase; 2020: $62k or 11% increase; 2021: $454k or 71% increase*. (*Excludes one-time $263k credit to sign a policy with Highmark Insurance Group). McGriff Insurance indicated that due to the County's past loss experience, fewer stop-loss carriers are interested in quoting our coverage.

Recommendation: The Office of Administration should work with McGriff Insurance to identify other stop-loss options/markets (e.g., risk pools) in balancing the mitigation of risk to price.

Current Status:
The Administration has modified the stop-loss threshold and has transitioned the program twice since the release of the audit report. – *Implemented*

When moving away from Highmark Life Insurance Company in 2024, Highmark began charging a carve-out fee of $3 per contract (i.e. participating employee) per month.
Since 2021, the number of contracts has reduced by 18% (335), and annualized premium and carve-out costs based on beginning enrollments has increased 59% ($685k), In addition, the County has assumed additional risk by increasing the stop-loss threshold from $350k to $400k.

Residual Risk:
- Continual rise in medical costs
- Uncertainty of large employee medical claims/management costs
- Higher the loss ratio (recovering more than paying in premiums), the higher of premiums will rise.
- Risk of limiting insurable options based on high loss ratios

10. Highmark Special Investigative Unit (SIU) Referred Claims

Condition: Highmark's SIU pursues, among other responsibilities, instances of potential provider and member fraud. Several requests were made to Highmark to provide a list of County claims referred to their Special Investigative Unit in 2021, and the specific actions taken from their review. To date, no response has been received.

Recommendation: As the Sponsor of our agreement with Highmark, the County should have the ability to review the handling of claims referred to Highmark's SIU and their associated outcomes. This requirement should be put into all future contracts, and monitored periodically.

Current Status:
Administration stated that the review of associated SIU claims will be considered during the next employee healthcare Request for Proposal (during 2026). – *Not Implemented*

Residual Risk:
- No awareness of Highmark's pursuit of fraudulent activities that impact County members.
- Lack of member awareness of possible fraudulent activities could result in increased costs to the County's self-insured plan

11. Contract Language with Highmark is not Transparent and Restricts Access to Data

Condition: The Highmark contract is not transparent to the public, controller, or anyone outside of the Office of Administration or the Office of Human Resources. Reduced transparency allows Highmark to capture additional savings which could have offset the cost of the health care plan and ultimately, the taxpayer.
Based on our review, there were a number of contract transparency issues which included:
- Contract language prevents the disclosure of detailed claim data, excluding personal health information, to other parties for cost comparisons on a routine basis to ensure competitiveness and lowest cost borne to taxpayers.
- Highmark only allows an audit of the most recent contract year, and must be completed no later than 11-months. In addition, only 200 paid claims may be audited annually without incurring addition costs.

- The terms and conditions language in the contract are confidential and prevent the disclosure of claim spending details to ensure competitiveness
- Contracts, price lists, data reports, techniques, and actual costs are being deemed proprietary information and are not permitted to be shared with anyone without prior written consent from Highmark.
- Any audit to be completed, must be discussed with and approved by Highmark before an audit is allowed to proceed.
- Highmark and the plan sponsor (County of Lehigh Administration) must agree on the scope of the audit, before an audit is allowed to commence.

Recommendation: Management should review the contract requirements and change the language to allow greater transparency to the county controller and to the public to ensure the taxpayers are paying the lowest costs for the County of Lehigh health care plan.

Current Status:
Administration stated that the language to allow greater transparency of claim data/information will be considered during the next employee healthcare Request for Proposal (during 2026). – *Not Implemented*

Residual Risk:
- Limitations to claims data for audit purposes.

12. Contract Language with McGriff Insurance does not Require Other Compensation Disclosure

Condition: The Broker Services Agreement with McGriff Insurance indicates the potential receipt of other compensation from insurers, trade organizations, or business partners, but does not require them to disclose the receipt of the compensation.

Recommendation: Agreements for services funded by taxpayer dollars should be transparent and require full disclosure of any compensation/gifts received to avoid the appearance of a conflict of interest. Management should consider the inclusion of a requirement within our agreement to disclose, on a timely basis, any and all monetary and non-monetary compensation, incentives and awards pertaining to County plans under agreement.

Current Status:
Administration stated that the language to require timely disclosure of monetary and non-monetary compensation will be considered during next health broker contract renewal (during 2025). – *Not Implemented*
Based on review, it appears that the language that was included in the County's contract with McGriff covering 2021 pertaining to the exclusion of McGriff's receipt of monetary or non-monetary awards against their compensation, was excluded from the contract renewal (3/1/2023 to 2/28/2026).
No language was noted in the contract renewal requiring immediate disclosure by McGriff for the receipt of monetary and non-monetary compensation, incentives and awards pertaining to County plans under agreement.

Residual Risk:
- Risk that the Broker may not have the best interest of the County pertaining to disclosing monetary and/or non-monetary compensation.