DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

[*We redact certain identifying information and certain potentially privileged, confidential, or proprietary information, unless otherwise approved by the requestor(s).*]

Issued: July 1, 2021

Posted: July 7, 2021

[Names and addresses redacted]

Re: OIG Advisory Opinion No. 21-07

Dear [Names redacted]:

The Office of Inspector General ("OIG") is writing in response to your request for an advisory opinion on behalf of [name redacted] (the "Medigap Plan"), a licensed offeror of Medicare Supplemental Health Insurance ("Medigap") policies, and [name redacted] (the "PHO"), a preferred hospital organization, regarding a proposal to incentivize the Medigap Plan policyholders to seek inpatient care from a hospital within the PHO's network (the "Proposed Arrangement"). Specifically, you have inquired whether the Proposed Arrangement, if undertaken, would constitute grounds for the imposition of sanctions under: the civil monetary penalty provision at section 1128A(a)(7) of the Social Security Act (the "Act"), as that section relates to the commission of acts described in section 1128B(b) of the Act (the "Federal anti-kickback statute"); the civil monetary penalty provision prohibiting inducements to beneficiaries, section 1128A(a)(5) of the Act (the "Beneficiary Inducements CMP"); or the exclusion authority at section 1128(b)(7) of the Act, as that section relates to the commission of acts described in the Federal anti-kickback statute and the Beneficiary Inducements CMP.

The Medigap Plan and the PHO have certified that all of the information provided in the request, including all supplemental submissions, is true and correct and constitutes a complete description of the relevant facts and agreements among the parties in connection with the Proposed Arrangement, and we have relied solely on the facts and information you provided. We have not undertaken an independent investigation of the certified facts and information presented to us by the Medigap Plan and the PHO. This opinion is limited to the relevant facts presented to us by the Medigap Plan and the PHO in connection with the Proposed Arrangement. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the relevant facts certified in your request for an advisory opinion and supplemental submissions, we conclude that: (i) although the Proposed Arrangement, if undertaken, would generate prohibited remuneration under the Federal anti-kickback statute if the requisite intent were present, the OIG would not impose administrative sanctions on the Medigap Plan or the PHO under sections 1128A(a)(7) or 1128(b)(7) of the Act, as those sections relate to the commission of acts described in the Federal anti-kickback statute; and (ii) although the Proposed Arrangement, if undertaken, would generate prohibited remuneration under the Beneficiary Inducements CMP, the OIG would not impose administrative sanctions on the Medigap Plan or the PHO in connection with the Proposed Arrangement under the Beneficiary Inducements CMP or section 1128(b)(7) of the Act, as that section relates to the commission of acts described in the Beneficiary Inducements CMP.

This opinion may not be relied on by any person[1] other than the Medigap Plan and the PHO, the requestors of this opinion, and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

A. Discount on Policyholders' Deductibles

The Medigap Plan's policies cover, among other things, the Medicare Part A deductible that may be incurred by its Medigap policyholders ("Policyholders") during an inpatient hospital stay.[2] The Medigap Plan proposes to participate in an arrangement with the PHO, which has contracts with hospitals throughout the country ("Network Hospitals").

Through the Medigap Plan's proposed arrangement with the PHO, each Network Hospital would provide a discount on the Medicare Part A inpatient deductible[3] that the Medigap Plan otherwise would cover for any Policyholder. The discount would be established in advance, pursuant to a

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[1] We use "person" herein to include persons, as referenced in the Federal anti-kickback statute and Beneficiary Inducements CMP, as well as individuals and entities, as referenced in the exclusion authority at section 1128(b)(7) of the Act.

[2] Insurers offering a Medigap policy are private insurance companies. In exchange for a premium payment, their Medigap policies provide various benefits to Medicare beneficiaries and may cover certain health care costs that Medicare Part A and Part B do not cover, like all or part of the Medicare Part A deductible. See Centers for Medicare & Medicaid Services, Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (Feb. 2020), available at https://www.medicare.gov/Pubs/pdf/02110-medicare-medigap-guide.pdf.

[3] Under the Proposed Arrangement, the discount on the Medicare Part A inpatient deductible offered by a Network Hospital to the Medigap Plan could be as high as 100 percent. While the discount offered could vary by Network Hospital, it would not vary based on the volume of Policyholder claims.

written agreement between the PHO and each of its Network Hospitals,[4] and again documented in a separate written agreement between the PHO and the Medigap Plan. The PHO certified that, under the Proposed Arrangement, each Network Hospital's discount on the Medicare Part A inpatient deductible would be applied uniformly to all Policyholders for a term of at least one year. Neither the PHO nor any Network Hospital would provide anything else of value to the Medigap Plan.

As represented by the PHO, any accredited, Medicare-certified hospital is eligible to become a Network Hospital if it: (i) meets the licensing and other requirements of applicable state law; and (ii) agrees to discount the Medicare Part A inpatient deductible costs on behalf of all licensed offerors of Medigap policies that contract with the PHO, including the Medigap Plan.

B. Policyholder Premium Credit

Under the Proposed Arrangement, the Medigap Plan would offer a $100 premium credit to each Policyholder who selects a Network Hospital for a Medicare Part A-covered inpatient stay,[5] subject to the frequency limitations described further below. The premium credit would be applied to the next premium payment due to the Medigap Plan after the Policyholder's applicable inpatient stay[6] and would be in the form of a reduction in the amount the Policyholder would owe. In nearly all circumstances, the premium credit would not be in the form of a check, deposit, or other affirmative payment from the Medigap Plan to the Policyholder.[7]

Policyholders would be eligible to receive only one $100 premium credit per Medicare Part A benefit period. A benefit period under Medicare Part A starts with the first day on which a Medicare beneficiary is furnished inpatient hospital or extended care services by a hospital or a skilled nursing facility ("SNF"), respectively, and ends after 60 consecutive days during which the beneficiary was not an inpatient of either a hospital or a SNF.[8] The Medigap Plan acknowledged

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[4] The PHO certified that there would be no financial arrangement between it and any Network Hospital. In particular, the PHO certified that the Network Hospitals would not furnish remuneration to the PHO, directly or indirectly, to be included in the PHO's network of hospitals.

[5] The Medicare Part A payment rate for inpatient services is unaffected by beneficiary cost sharing.

[6] Under the Proposed Arrangement, if a Policyholder's premium payment is less than the $100 premium credit, the Medigap Plan would apply the amount of credit needed to reduce the premium payment due to zero, and the remaining balance would be applied to the Policyholder's next premium payment.

[7] In the limited circumstances where a Policyholder has no future premium payment, e.g., the Policyholder cancels the policy, the Medigap Plan would issue a check for the remaining balance of the premium credit to the Policyholder.

[8] Section 1861(a) of the Act; see also Centers for Medicare & Medicaid Services, Medicare General Information, Eligibility, and Entitlement Manual, Ch. 3, § 10.4, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf.

that, in very rare circumstances, Policyholders could receive up to five $100 premium credits per year. Nevertheless, the Medigap Plan certified that only a small minority of Policyholders typically would undergo more than one, and an even smaller minority would undergo more than two, inpatient admissions in a single year. Therefore, the vast majority of Policyholders would receive only one $100 premium credit per year under the Proposed Arrangement.[9]

The Proposed Arrangement would not affect the liability of any Policyholder for payment obligations stemming from Medicare Part A-covered inpatient services, whether provided by a Network Hospital or any other hospital. Whether a Policyholder is admitted to a Network Hospital or a hospital that is not a Network Hospital, the Policyholder would not be responsible for paying any part of the Part A inpatient deductible, as provided for under the Medigap Plan's policies, nor would the Policyholder be subject to any financial penalty (e.g., an increased premium) for not selecting a Network Hospital for Medicare Part A-covered inpatient care.

While the Medigap Plan would not advertise the Proposed Arrangement, in whole or in part, to potential enrollees, it would provide information about the Network Hospitals and the premium credit to Policyholders upon enrollment and through periodic mailings thereafter. In all such materials, the Medigap Plan certified that it would make clear that a Policyholder's use of a hospital that is not a Network Hospital would: (i) have no effect on the Policyholder's liability for any costs covered by the Medigap Plan's policy; and (ii) not result in a financial penalty (e.g., an increased premium) to the Policyholder. The PHO certified that it would not, acting by itself or in conjunction with the Network Hospitals, advertise any aspect of the Proposed Arrangement to Policyholders or potential enrollees of the Medigap Plan.

C. The PHO's Administrative Fee

The PHO and the Medigap Plan would enter into a written agreement pursuant to which the Medigap Plan would pay the PHO a monthly administrative fee as compensation for establishing the hospital network and arranging for the Network Hospitals to discount the Medicare Part A inpatient deductible. The administrative fee would be a percentage-based fee; specifically, the PHO would receive a percentage of the aggregate savings that the Medigap Plan would realize from the Network Hospitals' discounts on Policyholders' Medicare Part A inpatient deductibles in a given month. As such, the monthly fee would vary by: (i) the number of Policyholder claims for which Network Hospitals provided a discount on the Medicare Part A inpatient deductibles; and (ii) the amount of the discount on the Medicare Part A inpatient deductibles, as established in Network Hospitals' respective written agreements with the PHO.

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[9] The Medigap Plan certified that it would not use the Proposed Arrangement, and in particular its offer of a premium credit, as a vehicle to encourage inappropriate utilization of any item or service that may be furnished to its Policyholders during an inpatient stay at a Network Hospital. Indeed, as a payor that assumes financial responsibility for certain expenses incurred by Policyholders, it generally would not be in its financial interest to do so. Moreover, the Medigap Plan represented that patients generally do not control whether they are admitted as an inpatient because this is a clinical decision.

As certified by both the Medigap Plan and the PHO, the PHO's administrative fee would be consistent with fair market value.[10] The Medigap Plan further certified that it would not pass on or otherwise shift the cost of the PHO's administrative fee to any Federal health care program.

II. LEGAL ANALYSIS

A. Law

1. Federal Anti-Kickback Statute

The Federal anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce, or in return for, the referral of an individual to a person for the furnishing of, or arranging for the furnishing of, any item or service reimbursable under a Federal health care program.[11] The statute's prohibition also extends to remuneration to induce, or in return for, the purchasing, leasing, or ordering of, or arranging for or recommending the purchasing, leasing, or ordering of, any good, facility, service, or item reimbursable by a Federal health care program.[12] For purposes of the Federal anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to induce referrals for items or services reimbursable by a Federal health care program.[13] Violation of the statute constitutes a felony punishable by a maximum fine of $100,000, imprisonment up to 10 years, or both. Conviction also will lead to exclusion from Federal health care programs, including Medicare and Medicaid. When a person commits an act described in section 1128B(b) of the Act, the OIG may initiate administrative proceedings to impose civil monetary penalties on such person under section 1128A(a)(7) of the Act. The OIG also may initiate administrative proceedings to exclude such person from Federal health care programs under section 1128(b)(7) of the Act.

Congress has developed several statutory exceptions to the Federal anti-kickback statute.[14] In addition, the U.S. Department of Health and Human Services has promulgated safe harbor regulations that specify certain practices that are not treated as an offense under the Federal anti-

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[10] We are precluded by statute from opining on whether fair market value shall be or was paid for goods, services, or property. Section 1128D(b)(3)(A) of the Act.

[11] Section 1128B(b) of the Act.

[12] Id.

[13] E.g., United States v. Nagelvoort, 856 F.3d 1117 (7th Cir. 2017); United States v. McClatchey, 217 F.3d 823 (10th Cir. 2000); United States v. Davis, 132 F.3d 1092 (5th Cir. 1998); United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir. 1985).

[14] Section 1128B(b)(3) of the Act.

kickback statute and do not serve as the basis for an exclusion.[15] However, safe harbor protection is afforded only to those arrangements that precisely meet all of the conditions set forth in the safe harbor. Compliance with a safe harbor is voluntary. Arrangements that do not comply with a safe harbor are evaluated on a case-by-case basis.

2. Civil Monetary Penalties Law

The Beneficiary Inducements CMP provides for the imposition of civil monetary penalties against any person who offers or transfers remuneration to a Medicare or State health care program beneficiary that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier for the order or receipt of any item or service for which payment may be made, in whole or in part, by Medicare or a State health care program. The OIG also may initiate administrative proceedings to exclude such person from Federal health care programs. Section 1128A(i)(6) of the Act defines "remuneration" for purposes of the Beneficiary Inducements CMP as including "transfers of items or services for free or for other than fair market value."

B. Analysis

The Proposed Arrangement would involve three distinct streams of remuneration: (i) the Network Hospitals' discounts to the Medigap Plan on Policyholders' Medicare Part A inpatient deductibles; (ii) the premium credit offered by the Medigap Plan to Policyholders; and (iii) the administrative fee paid by the Medigap Plan to the PHO. While all three streams of remuneration would implicate the Federal anti-kickback statute and one—the premium credit offered by the Medigap Plan to Policyholders—also would implicate the Beneficiary Inducements CMP, for the combination of reasons discussed below, we conclude that the Proposed Arrangement poses a sufficiently low risk of fraud and abuse under the Federal anti-kickback statute, and we would not impose administrative sanctions under the Beneficiary Inducements CMP in connection with the Proposed Arrangement.

1. Discount on Policyholders' Deductibles and the Premium Credit

a. *Federal Anti-Kickback Statute*

Both the Network Hospitals' discounts on Policyholders' Medicare Part A inpatient deductibles and the Medigap Plan's offer of a premium credit would constitute remuneration—the former to the Medigap Plan and the latter to Policyholders. Likewise, both streams of remuneration could influence the referrals of Federal health care program business. The discount on Policyholders' deductibles would be designed to induce the Medigap Plan to arrange for or recommend the provision of federally reimbursable items and services by the Network Hospitals on behalf of its Policyholders. The premium credit could influence: (i) potential enrollees to select the Medigap Plan; (ii) Policyholders to re-enroll in the Medigap Plan; and (iii) Policyholders to select a Network Hospital as their inpatient hospital provider. Accordingly, both the Network Hospitals' discounts

[15] 42 C.F.R. § 1001.952.

on Policyholders' deductibles and the Medigap Plan's offer of the premium credit implicate the Federal anti-kickback statute.

No safe harbor under the Federal anti-kickback statute would be available for either stream of remuneration. For example, the safe harbor protecting certain price reductions offered by health care providers to their contracted health plans would not apply to the Network Hospitals' discounts on the inpatient deductibles.[16] There is no written agreement between the Medigap Plan and the Network Hospitals, as would be required by the safe harbor, and each Network Hospital's price reduction would be with respect to only a specific part of its charges for Medicare-covered inpatient hospital services, i.e., the Medicare Part A inpatient deductible, not its total charges.[17] As another example, the safe harbor protecting price reductions offered to eligible managed care organizations by its contractors also would not apply because the Medigap Plan would not meet the safe harbor definition of "eligible managed care organization."[18]

However, for the combination of reasons set forth below, we find that the Network Hospitals' discounts on Policyholders' Medicare Part A inpatient deductibles and the Medigap Plan's offer of the premium credit pose a minimal risk of fraud and abuse under the Federal anti-kickback statute.

First, we believe it is unlikely that these two streams of remuneration would result in overutilization of health care items or services or pose a risk of increased costs to Federal health care programs. The Medigap Plan is an offeror of Medigap policies, with financial responsibility for all Policyholder costs that its policies may cover. Because it is generally in the Medigap Plan's financial interest to ensure appropriate utilization and costs, we believe it is unlikely that it would use either the offer of a premium credit to its Policyholders or savings realized from the Network Hospitals' discounts on the Medicare Part A inpatient deductibles[19] to promote inappropriate utilization by its Policyholders. Moreover, we believe it is unlikely the premium credit would serve as an improper inducement to Policyholders to utilize inpatient care considering: (i) that, as the Medigap Plan represented, patients generally do not control whether they are admitted as an inpatient because this is a clinical decision;[20] and (ii) the form of the premium credit (i.e., the

[16] See 42 C.F.R. § 1001.952(m).

[17] See id.

[18] See 42 C.F.R. § 1001.952(t).

[19] We further note that the Network Hospitals' discounts on Policyholders' Medicare Part A inpatient deductibles would not affect Medicare Part A payments for inpatient care. Medicare Part A payments for inpatient services are unaffected by beneficiary cost sharing.

[20] See also Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35,952, 35,962 (July 29, 1991) ("A routine waiver [of inpatient cost-sharing obligations] will not likely increase patient demand for these services, since beneficiaries cannot admit themselves, and hospital overnight stays are inherently undesirable from a patient's perspective.").

premium credit would reduce the amount the Policyholder would owe to the Medigap Plan rather than being an affirmative payment, such as a check or cash deposit into the Policyholder's bank account).

Second, the potential for patient harm that may be posed by the Network Hospitals' discounts on Policyholders' Medicare Part A inpatient deductibles and the Medigap Plan's offer of a premium credit is minimal. The Network Hospitals' discounts on the Medicare Part A inpatient deductibles would apply universally to all Policyholders and would not be limited by discriminatory eligibility criteria, such as length of stay or a Policyholder's disease state. Likewise, patient choice would not be impacted, as Policyholders could elect to receive care at a hospital that is not a Network Hospital without any increase in cost-sharing obligations or premiums by the Medigap Plan.

Third, we believe these two streams of remuneration would be unlikely to significantly impact competition. Considering first the impact on competition among insurers offering Medigap policies, we rely on the Medigap Plan's certification that it would not advertise any aspect of the Proposed Arrangement to potential enrollees. While we acknowledge the potential for the premium credit to induce Policyholders to re-enroll in a policy offered by the Medigap Plan in future policy years, we believe this risk is mitigated because Policyholders would receive the premium credit only if: (i) they required one or more inpatient stays in a policy year, which may not happen or be foreseeable; and (ii) they selected a Network Hospital for their inpatient stay(s). Considering the potential impact on competition among inpatient providers, we note that, under the Proposed Arrangement, the Medigap Plan would not limit Policyholders' choice of inpatient hospitals to the Network Hospitals. Policyholders would continue to be able to select any inpatient hospital, irrespective of whether it was a Network Hospital, without any impact on their cost-sharing obligations associated with their Part A inpatient deductible or any financial penalty (e.g., an increased premium). We further highlight the PHO's certification that it would not advertise the Proposed Arrangement, in whole or in part, and that any interested hospital is eligible to join its network provided the hospital is Medicare-certified and: (i) has met the licensing and other requirements of applicable state law; and (ii) agreed to discount the Medicare Part A inpatient deductible costs on behalf of all licensed offerors of Medigap policies that contract with the PHO.

b. *Beneficiary Inducements CMP*

Under the Proposed Arrangement, the Medigap Plan's offer of a premium credit to qualifying Policyholders also would implicate the Beneficiary Inducements CMP. In particular, the Medigap Plan's offer of the premium credit could influence a Policyholder to select a Network Hospital for federally reimbursable items and services.[21] While there is no exception to the definition of

[21] The Beneficiary Inducements CMP would not apply to the potential for the premium credit to induce potential enrollees or Policyholders to select the Medigap Plan. See, e.g., Publication of the OIG's Compliance Program Guidance for Medicare+Choice Organizations Offering Coordinated Care Plans, 64 Fed. Reg. 61,893, 61,902 (Nov. 15, 1999) ("It is our view that organizations that provide incentives to Federal health care program beneficiaries to enroll in a plan are not offering remuneration to induce the enrollees to use a particular provider, practitioner or supplier.")

"remuneration" under the Beneficiary Inducements CMP that would protect this stream of remuneration, for the reasons detailed above, we would not impose administrative sanctions under the Beneficiary Inducements CMP in connection with the Medigap Plan's offer of the premium credit to its Policyholders.

2. The PHO's Administrative Fee

The administrative fee the Medigap Plan would pay to the PHO under the Proposed Arrangement also would implicate the Federal anti-kickback statute because such payment would be in exchange for the PHO arranging for the provision of federally reimbursable inpatient services furnished by its Network Hospitals to Policyholders at a reduced rate. No safe harbor would be available to protect the administrative fee, including the personal services and management contracts and outcomes-based payment arrangements safe harbor, because the methodology for determining the PHO's compensation would be determined in a manner that directly takes into account the volume or value of business otherwise generated between the parties for which payment may be made in whole or in part under Medicare.[22]

Nevertheless, based on the totality of the facts and circumstances, we find that the Medigap Plan's payment of the administrative fee to the PHO would be sufficiently low risk under the Federal anti-kickback statute. The Medigap Plan and the PHO certified that the PHO's administrative fee would be consistent with fair market value. In addition, the Proposed Arrangement is distinguishable from certain other arrangements where compensation is determined in a manner that takes into account the volume or value of Federal health care program business because we believe there is a low risk that the methodology for calculating the administrative fee would drive overutilization of Federal health care items or services or result in increased costs to any Federal health care program. In reaching this conclusion, we rely upon the following: (i) the PHO's administrative fee, while tied to the volume or value of referrals between the Medigap Plan and the Network Hospitals, ultimately reflects a percentage of the savings realized by the Medigap Plan, not revenue generated by the Network Hospitals; (ii) it would be contrary to the Medigap Plan's financial interest, as an offeror of Medigap policies with financial responsibility for the cost of certain items and services furnished to its Policyholders, to drive overutilization of inpatient hospital services paid for by Medicare Part A; and (iii) the Medigap Plan certified that it would not pass on or otherwise shift the cost of the PHO's administrative fee to any Federal health care program. We further highlight the PHO's certification that it would not (acting by itself or in conjunction with its Network Hospitals) advertise the Proposed Arrangement, thereby limiting the potential for the PHO or the Network Hospitals to impact Policyholder referrals to the Network Hospitals and, in turn, the PHO's administrative fee.

III. CONCLUSION

Based on the relevant facts certified in your request for an advisory opinion and supplemental submissions, we conclude that: (i) although the Proposed Arrangement, if undertaken, would

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[22] See 42 C.F.R. § 1001.952(d)(1).

generate prohibited remuneration under the Federal anti-kickback statute if the requisite intent were present, the OIG would not impose administrative sanctions on the Medigap Plan or the PHO under sections 1128A(a)(7) or 1128(b)(7) of the Act, as those sections relate to the commission of acts described in the Federal anti-kickback statute; and (ii) although the Proposed Arrangement, if undertaken, would generate prohibited remuneration under the Beneficiary Inducements CMP, the OIG would not impose administrative sanctions on the Medigap Plan or the PHO in connection with the Proposed Arrangement under the Beneficiary Inducements CMP or section 1128(b)(7) of the Act, as that section relates to the commission of acts described in the Beneficiary Inducements CMP.

IV. LIMITATIONS

- This advisory opinion is limited in scope to the Arrangement and has no applicability to any other arrangements that may have been disclosed or referenced in your request for an advisory opinion or supplemental submissions.

- This advisory opinion is issued only to the Medigap Plan and the PHO. This advisory opinion has no application to, and cannot be relied upon by, any other person.

- This advisory opinion may not be introduced into evidence by a person other than the Medigap Plan or the PHO to prove that the person did not violate the provisions of sections 1128, 1128A, or 1128B of the Act or any other law.

- This advisory opinion applies only to the statutory provisions specifically addressed in the analysis above. We express no opinion herein with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Proposed Arrangement, including, without limitation, the physician self-referral law, section 1877 of the Act (or that provision's application to the Medicaid program at section 1903(s) of the Act).

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.

- This advisory opinion is limited in scope to the Proposed Arrangement and has no applicability to other arrangements, even those that appear similar in nature or scope.

- We express no opinion herein regarding the liability of any person under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against the Medigap Plan or the PHO with respect to any action that is part of the Proposed Arrangement taken in good faith reliance upon this advisory opinion, as long as all of the material facts have been fully, completely, and accurately presented, and the Proposed

Arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, to rescind, modify, or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the Medigap Plan or the PHO with respect to any action that is part of the Proposed Arrangement taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion. An advisory opinion may be rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/Robert K. DeConti/

Robert K. DeConti
Assistant Inspector General for Legal Affairs