



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 associated with the individual or entity, unless otherwise approved by the requestor.]

Issued: August 30, 2017

Posted: September 7, 2017

[Name and address redacted]

Re: OIG Advisory Opinion No. 17-05

Dear [Name redacted]:

We are writing in response to your request for an advisory opinion regarding a retail pharmacy chain's proposal to allow Federal health care program beneficiaries to participate in a paid membership program that includes discounts on certain prescriptions and clinic services (the "Proposed Arrangement"). Specifically, you have inquired whether the Proposed Arrangement would constitute grounds for the imposition of sanctions under the civil monetary penalty provision prohibiting inducements to beneficiaries, section 1128A(a)(5) of the Social Security Act (the "Act"), or under the exclusion authority at section 1128(b)(7) of the Act, or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, the Federal anti-kickback statute.

You have certified that all of the information provided in your request, including all supplemental submissions, is true and correct and constitutes a complete description of the relevant facts and agreements among the parties.

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that: (i) the Proposed Arrangement would not constitute

grounds for the imposition of civil monetary penalties under section 1128A(a)(5) of the Act; and (ii) although the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute if the requisite intent to induce or reward referrals of Federal health care program business were present, the Office of Inspector General (“OIG”) would not impose administrative sanctions on [name redacted] under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement. This opinion is limited to the Proposed Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request for an advisory opinion or supplemental submissions.

This opinion may not be relied on by any persons other than [name redacted], the requestor 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

[Name redacted] (“Requestor”) owns and operates [name redacted] and [name redacted] retail pharmacies.¹ In addition to retail pharmacy items and services, select [name redacted] stores offer [name redacted] (“Clinic”) services.²

Requestor’s wholly owned subsidiary, [name redacted] (“Program Operator”), currently offers certain benefits to customers who satisfy eligibility criteria and pay an annual fee to join Requestor’s [name redacted] (the “Benefit Program”).³ The Benefit Program currently prohibits the enrollment of Federal health care program beneficiaries.⁴ Under the Proposed Arrangement, Requestor would modify the Benefit Program’s eligibility

¹ The retail pharmacies are owned either directly by Requestor or indirectly by Requestor’s wholly owned subsidiary.

² Requestor’s wholly owned subsidiary contracts with independent professional practices to furnish the Clinic services Requestor offers in its retail locations. We have not been asked to opine on, and we express no opinion regarding, the arrangement(s) between the independent professional practices and Requestor’s wholly owned subsidiary.

³ Requestor certified that, although the Program Operator would operate the Benefit Program, Requestor markets the Benefit Program as an offering of its retail pharmacies. In other words, to the average consumer it appears that Requestor, not Program Operator, offers and operates the Benefit Program.

⁴ We have not been asked to opine on, and we express no opinion regarding, the currently existing Benefit Program or its eligibility restrictions.

criteria to permit Federal health care program beneficiaries to enroll. As a result, under the Proposed Arrangement, any person over the age of 18, including Federal health care program beneficiaries, who pays an annual fee (“Members”) could enroll in the Benefit Program.

Under the Proposed Arrangement, Members would have access to three categories of benefits through the Benefit Program. First, Members would have access to discounts on Requestor’s pharmacies’ retail prices for specific items for which Members pay entirely out-of-pocket (*i.e.*, items for which the Member pays the entire price charged and for which no insurer, including any Federal health care program, would be billed). The Benefit Program offers the following items to Members at a discount: generic drugs, other prescription drugs listed on the Benefit Program’s formulary, pet prescriptions, nebulizer devices and related supplies, blood glucose testing meters and related supplies, and immunizations.⁵ Second, Members would have access to a 10 percent discount on any Clinic service when the Member pays for the service entirely out-of-pocket. The discounted services available to Members at Requestor’s Clinics would include physicals, immunizations, and health screenings and testing, such as lipid panel testing. Third, Members could earn a 10 percent credit toward future eligible retail purchases when they purchase certain Requestor-branded products and in-store photo-finishing.⁶ To activate the credit, Members must present the Benefit Program’s card during the transaction. Requestor certified that Members could not redeem earned credits to purchase prescriptions, immunizations, Clinic services, alcohol, gift cards, postage stamps, pre-paid cards, milk products, or tobacco products.⁷ Requestor further certified that Members could not redeem earned credits for retail pharmacy or Clinic cost-sharing amounts.

⁵ If a Member’s health or prescription plan covers an item that the Member would like to purchase through the Benefit Program, the Member would relinquish his or her health or prescription plan’s coverage for that particular purchase and, instead, pay for the item out-of-pocket.

⁶ Requestor-branded products include certain over-the-counter medications. Some Medicare and Medicaid managed care plans provide their enrollees with pre-loaded debit cards that enable their enrollees to purchase qualifying over-the-counter products using the plan-provided debit card. As a result, it is possible that certain Members may use a pre-loaded debit card, furnished by their Medicare or Medicaid managed care plan, to purchase over-the-counter products on which they earn a 10 percent credit toward future purchases.

⁷ Members could not redeem the earned credit to purchase prescriptions, immunizations, or Clinic services, regardless of whether such items or services are reimbursed by insurance, including any Federal health care program, or paid for by the Member entirely out-of-pocket.

The Benefit Program would include a guaranteed savings feature, under which a Member would be eligible for a store credit equal to the difference between the membership fee and the Member's total savings over the course of a year if the Member has not achieved total savings over the one-year membership equal to or greater than the annual membership fee.⁸

Prospective Members would enroll in the Benefit Program in one of two ways: (i) online, through Requestor's website, or (ii) in person, at Requestor's participating retail pharmacies. The only requirements for Benefit Program enrollment under the Proposed Arrangement would be: (i) the payment of an annual membership fee,⁹ (ii) that the prospective Member enrolling in the Benefit Program is over 18 years of age, and (iii) that the prospective Member provide certain personal information, including name, date of birth, address, and phone number. Prospective Members would not be required to furnish information regarding their insurance coverage or lack thereof; any Federal health care program beneficiary, any individual with health coverage from another third-party payor, and any uninsured individual could enroll in the Benefit Program, without restrictions.

As stated above, to access the Benefit Program's discounts on certain items, such as prescription drugs, and Clinic services, a Member must pay for such items and services entirely out-of-pocket. Requestor certified that neither its retail pharmacies nor its Clinics would bill, or submit a claim to, any Federal health care program or other third-party payor for any items or services purchased at a discount through the Benefit Program.¹⁰ In addition, Requestor certified that the Benefit Program's terms and conditions would require Members to be entirely financially responsible for any items or services purchased through the Benefit Program.¹¹ Finally, Requestor certified that

⁸ Requestor certified that it plans to eliminate the guaranteed savings feature from the Benefit Program by the end of 2017.

⁹ The membership fee differs for individual memberships as compared to family memberships. Family enrollment would include the individual enrolling as well as his or her immediate family, as defined by Requestor.

¹⁰ We express no opinion regarding whether the Proposed Arrangement would comply with the requirement set forth at 42 C.F.R. § 423.120(c)(3), which states that a Medicare Part D sponsor must require its network pharmacies to submit claims to the Medicare Part D sponsor or its intermediary whenever a Medicare Part D beneficiary presents a card, as described in 42 C.F.R. § 423.120(c)(1), or such card is on file at the pharmacy, unless the Medicare Part D beneficiary expressly requests that a particular claim not be submitted.

¹¹ The Benefit Program's terms and conditions would specify that Members are entirely responsible for all charges for discounted items or services they purchase through the

Members would not earn any additional credit, bonus, discount, rebate, or other reward for filling new or transferred prescriptions at Requestor’s retail pharmacy or receiving services at the Clinics.

II. LEGAL ANALYSIS

A. Law

The anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible “kickback” transaction. For purposes of the 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 was to obtain money for the referral of services or to induce further referrals. See, 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), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of \$25,000, imprisonment up to five years, or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. Where a party commits an act described in section 1128B(b) of the Act, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party under section 1128A(a)(7) of the Act. The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.

Section 1128A(a)(5) of the Act (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 (including Medicaid) beneficiary that the benefactor knows or should know is likely to influence the

Benefit Program and that the Benefit Program cannot be used in conjunction with any form of insurance or health plan coverage. The terms and conditions allow for Medicare beneficiaries’ submission of claims for drugs purchased while in the coverage gap. Such claims would count toward a Medicare Part D beneficiary’s true out-of-pocket (“TrOOP”) cost calculation.

beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or a State health care program (including Medicaid). The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs. Section 1128A(i)(6) of the Act defines "remuneration" for the purposes of the Beneficiary Inducements CMP as including "transfers of items or services for free or for other than fair market value."

Section 1128A(i)(6)(G) of the Act excludes from the definition of "remuneration" under the Beneficiary Inducements CMP certain retailer rewards programs that meet specified criteria. This provision excepts the following from the definition of "remuneration":

The offer or transfer of items or services for free or less than fair market value by a person if— (i) the items or services consist of coupons, rebates, or other rewards from a retailer; (ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and (iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII or a State health care program (as defined in section 1128(h)).

In December 2016, the OIG issued a final rule (the "2016 Final Rule") in which we interpreted this exception and codified it into regulation at 42 C.F.R. § 1003.110. 81 Fed. Reg. 88,368 (Dec. 7, 2016). In the preamble to the 2016 Final Rule, we explained that we interpreted "coupons" as "something authorizing a discount on merchandise or services," "rebates" as "a return on part of a payment," and "other rewards" to include rewards such as gasoline discounts, frequent flyer miles, and items purchased in a retailer's store. We also indicated that health care items or services can be "other rewards." *Id.* at 88,399–400.

B. Analysis

Under the Proposed Arrangement, Members would have access to discounted items and services, including prescription drugs and Clinic services, and also could earn rewards, in the form of credits, when they purchase certain merchandise and in-store photo-finishing services. The Proposed Arrangement would implicate both the anti-kickback statute and the Beneficiary Inducements CMP, because the discounted items and services and earned credits could induce a beneficiary to select Requestor as his or her supplier for federally reimbursable items or services. However, the Proposed Arrangement would satisfy the requirements of the exception to the definition of remuneration related to retailer rewards for the purposes of the Beneficiary Inducement CMP and, for the combination of the reasons described below, also would pose a low risk of fraud and abuse under the anti-kickback statute.

1. The Beneficiary Inducements CMP

The Benefit Program would offer Members rewards in the form of discounts, earned credits, and guaranteed savings. However, retailer rewards are excepted from the definition of “remuneration” under the Beneficiary Inducements CMP if: (i) the rewards consist of coupons, rebates, or other rewards from a retailer; (ii) the rewards are offered or transferred on equal terms available to the general public, regardless of health insurance status; and (iii) the offer or transfer of the rewards is not tied to the provision of other items or services reimbursed in whole or in part by the Medicare program or a State health care program.

The Proposed Arrangement would meet all of these criteria, and therefore would satisfy the retailer reward exception.

First, Requestor is a retailer because it owns and operates retail pharmacies that sell items, including prescription drugs, non-prescription drugs, and a variety of other merchandise, directly to the public. In addition, the Benefit Program’s discounts consist of a coupon and the Benefit Program’s credits and guaranteed savings consist of rebates. As stated above, the OIG has interpreted a coupon as “something authorizing a discount on merchandise or services” and, therefore, the Benefit Program’s discount on certain items and services would be the equivalent of a coupon. The earned credit would constitute a “rebate,” which the OIG has interpreted as “a return on part of a payment.” The guaranteed savings feature also would constitute a “rebate,” as it is a return on part of a Member’s membership fee payment under certain circumstances.¹² Thus, the Benefit Program’s rewards consist of coupons, rebates, or other rewards from a retailer, as required by the first prong of the statutory and regulatory retailer reward exception.

Second, under the Proposed Arrangement, the Benefit Program’s eligibility criteria would be modified to allow Federal health care program beneficiaries to enroll, meaning that membership would be offered on equal terms to all customers over the age of 18 at Requestor’s retail pharmacies and on Requestor’s website. While the discounts and credits would be available only to Members, any member of the general public, regardless of health insurance status or plan, could pay the Benefit Program’s annual fee, thereby accessing the benefits available on equal terms to all Members. As a consequence, the Proposed Arrangement satisfies the second prong of the statutory and regulatory retailer reward exception.

Third, the offer or transfer of the rewards under the Proposed Arrangement would not be tied to the provision of other items or services reimbursed in whole or in part by the Medicare program or a State health care program.

¹² The elimination of the Benefit Program’s guaranteed savings feature would not affect our analysis or conclusion.

With respect to the discounted items and services available through the Benefit Program, Requestor certified that neither its retail pharmacies nor its Clinics would submit a bill or claim to Medicare, any State health care program, or any other third-party payor for any items or services purchased at a discount through the Benefit Program.

In addition, the Benefit Program's terms and conditions would specify that Members are entirely responsible for all charges for discounted items or services they purchase through the Benefit Program, and that the Benefit Program cannot be used in conjunction with any form of insurance or health plan coverage. We recognize that Requestor lacks an enforcement mechanism to prevent Members whose insurance or health plan covers a particular item or service that the Benefit Program also offers at a discount from submitting a claim for reimbursement for items or services purchased at a discount. Despite the lack of a mechanism to enforce the condition prohibiting the use of the Benefit Program in conjunction with other insurance or health plan coverage, we believe that Federal health care program beneficiaries would be unlikely to submit a claim for reimbursement for an item or service purchased at a discount through the Benefit Program. In particular, a rational economic actor would choose to purchase items or services through the Benefit Program only if such items and services cost less than they would cost if purchased with Federal health care program coverage.¹³ To the extent that an item or service costs less through the Benefit Program than through Federal health care program coverage, the submission of a claim for reimbursement would result in no reimbursement to the beneficiary.¹⁴ As a consequence, we believe that, in most circumstances, it is unlikely that a Member would submit a claim for reimbursement for items or services purchased at a discount through the Benefit Program, because in most, if not all, cases, the Member would receive no reimbursement from the applicable insurer or plan.

Although Members who are Medicare beneficiaries could purchase discounted prescription drugs when they are in their Medicare Part D plans' coverage gaps and then submit claims for those drugs to their Medicare Part D plans to count toward their TrOOP

¹³ For example, if a Medicare Part D plan covered Drug A but required a \$10 copayment, and the Benefit Plan offered Drug A for \$15, a rational economic actor would be likely to purchase Drug A using his or her Medicare Part D coverage and pay a \$10 copayment rather than purchase it for \$15 through the Benefit Program.

¹⁴ For example, if a Medicare Part D beneficiary submitted a claim for Drug B (the receipt from Requestor's pharmacy indicating the cost to the beneficiary was \$10), and the beneficiary's copayment responsibility for Drug B was \$15, the Medicare Part D plan would provide no reimbursement to the beneficiary.

cost calculations, those Members would be solely responsible for the entire cost of those drugs during the coverage gap.¹⁵

With respect to the credits available through the Benefit Program, Requestor has structured the Benefit Program so that Members could accumulate and redeem credits in a manner that does not differentiate between (i) items and services that, in certain limited circumstances, might be paid for by Federal health care programs and (ii) items and services that are not federally reimbursable.¹⁶ While the Benefit Program would define limited products and services on which Members could earn and redeem rewards, the vast majority of products and services for which a Member could earn and redeem credits are not federally reimbursable, and Members would accumulate and redeem credits in a manner that does not differentiate, or give preference to, items and services that may be paid for by Federal health care programs. As a consequence, neither earning nor redeeming the credit is tied to the provision of other federally reimbursable items or services. If a Member could only earn or redeem, or could preferentially accumulate or

¹⁵ We acknowledge that sufficient spending during the coverage gap will result in a beneficiary reaching the catastrophic coverage portion of the Medicare Part D benefit, at which point the Medicare program may resume payment for most of the costs of the beneficiary's drugs. However, reaching the catastrophic coverage threshold would occur as a function of the Medicare Part D benefit structure, and this feature of the Benefit Program does not result in the type of problematic conduct that section 1128A(a)(5) is intended to address.

¹⁶ As noted above, Members could earn credits only on Requestor-branded products and in-store photo-finishing. Requestor-branded products do not include prescription drugs, but do include certain over-the-counter products. While, in most circumstances, Federal health care programs do not pay for over-the-counter products, certain Medicare and Medicaid managed care plans offer their enrollees pre-loaded debit cards, which enrollees may use to purchase eligible over-the-counter products. As a consequence, Members may earn credits on items paid for by a Federal health care program in certain limited circumstances.

Under the Proposed Arrangement, Members could redeem credits only on certain items, and could not redeem credits on prescriptions, immunizations, or Clinic services, regardless of whether such items or services are reimbursed by insurance, including Federal health care programs, or purchased by the Member entirely out-of-pocket. However, Members could redeem credits on over-the-counter medications, which, as stated above, may be paid for with pre-loaded debit cards furnished by a Member's Medicare or Medicaid managed care plan.

use, credits based on the purchase of federally reimbursable items and services, we would reach a different conclusion.¹⁷

For the reasons stated above, we conclude that neither the Benefit Program's discounts nor credits would be tied to the provision of other items or services reimbursed in whole or in part by the Medicare program or a State health care program.

2. The Anti-kickback Statute

Although the Proposed Arrangement would meet an exception to the definition of "remuneration" under the Beneficiary Inducements CMP, no parallel exception exists under the anti-kickback statute. However, for the following reasons, and in combination with the factors set forth above, we conclude that the Proposed Arrangement would pose a minimal risk of fraud and abuse under the anti-kickback statute and, therefore, in an exercise of our discretion, we would not impose administrative sanctions on Requestor in connection with the Proposed Arrangement.

First, the Proposed Arrangement does not include any features to specifically steer beneficiaries to Requestor's retail pharmacies or Clinics to purchase federally reimbursable items or services. Requestor's retail stores offer a broad range of inventory, including groceries and toiletries. The Benefit Program would not require Members to purchase prescription drugs, immunizations, Clinic services, or any other health care-related items or services from Requestor, and Members could earn credits through the Benefit Program without purchasing such items or services. In addition, Requestor would not offer Members any direct incentive to transfer their prescriptions to, or fill them at, Requestor's retail pharmacies, or to receive services at Requestor's Clinics; Members would not earn any credit, bonus, discount, rebate, or other reward for such actions. The Proposed Arrangement simply would allow Federal health care program beneficiaries access to the Benefit Program's discounts and rebates.

Second, the Proposed Arrangement would be unlikely to result in overutilization or otherwise increase costs to Federal health care programs. For example, any Member filling a prescription at Requestor's retail pharmacy already would have obtained a

¹⁷ Although the Proposed Arrangement would satisfy the retailer reward exception's requirement that the offer or transfer of the rewards not be tied to the provision of other items or services reimbursed in whole or in part by the Medicare program or a State health care program, this requirement does not necessitate the structure contemplated by the Proposed Arrangement. In particular, as we explained in the preamble to the 2016 Final Rule, a credit or points could be earned on prescription copayment, for example, provided that the reward (how it is earned or redeemed) does not treat federally reimbursable items and services in a manner that is different from that in which nonreimbursable items and services are treated.

written order for the prescription from his or her physician or other licensed prescriber and, regardless, Requestor's retail pharmacies would not submit a claim to a Federal health care program for any prescription drug purchased through the Benefit Program. In addition, the Proposed Arrangement would not involve a waiver or reduction in any cost-sharing amounts otherwise incurred by a Federal health care program beneficiary. Finally, except in very limited circumstances, Members would earn credits, and could redeem credits, only on items that would not be paid for by Federal health care programs.

For the foregoing reasons, we conclude that the Proposed Arrangement would meet the retailer reward exception to the definition of remuneration under the Beneficiary Inducements CMP and would not constitute grounds for the imposition of administrative sanctions under the Beneficiary Inducements CMP. In addition, we conclude that the Proposed Arrangement would pose a minimal risk of fraud and abuse under the anti-kickback statute and, thus, we would not impose administrative sanctions on Requestor under the anti-kickback statute in connection with the Proposed Arrangement.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that: (i) the Proposed Arrangement would not constitute grounds for the imposition of civil monetary penalties under section 1128A(a)(5) of the Act; and (ii) although the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute if the requisite intent to induce or reward referrals of Federal health care program business were present, the OIG would not impose administrative sanctions on [name redacted] under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to [name redacted], the requestor of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.
- This advisory opinion may not be introduced into evidence by a person or entity other than [name redacted] to prove that the person or entity did not violate the provisions of sections 1128, 1128A, or 1128B of the Act or any other law.
- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is expressed or implied 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 specific arrangement described in this letter and has no applicability to other arrangements, even those which appear similar in nature or scope.
- No opinion is expressed herein regarding the liability of any party 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 [name redacted] 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 [name redacted] 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,

/Gregory E. Demske/

Gregory E. Demske
Chief Counsel to the Inspector General