



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:** April 14, 2026

**Posted:** April 17, 2026

[Address block redacted]

### **Re: OIG Advisory Opinion No. 26-07 (Favorable)**

Dear [redacted]:

The Office of Inspector General (“OIG”) is writing in response to your request for an advisory opinion on behalf of [redacted] and its Medicare Advantage (“MA”) subsidiaries that offer Employer Group Waiver Plans (“EGWPs”) (collectively, “Requestor”), regarding its proposal to share a percentage of its savings with certain groups to which it provides coverage, in the circumstances specified below (the “Proposed Arrangement”). Specifically, you have inquired whether the Proposed Arrangement, if undertaken, would constitute grounds for the imposition of sanctions under the exclusion authority at section 1128(b)(7) of the Social Security Act (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”).

Requestor has 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 Requestor provided. We have not undertaken an independent investigation of the certified facts and information presented to us by Requestor. This advisory opinion is limited to the relevant facts presented to us by Requestor in connection with the Proposed Arrangement. If material facts have not been disclosed or have been misrepresented, or change, then this advisory 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, although the Proposed Arrangement, if undertaken, would generate—if the requisite intent were present—prohibited remuneration under the Federal anti-kickback statute, OIG would not impose administrative sanctions on Requestor in connection with the Proposed Arrangement 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.

This advisory opinion may not be relied on by any person<sup>1</sup> other than Requestor, has no applicability to any arrangements other than the Proposed Arrangement, and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

## **I. FACTUAL BACKGROUND**

### **A. Background**

Requestor, through various subsidiaries, contracts with the Centers for Medicare & Medicaid Services (“CMS”) to offer MA plans, MA-Prescription Drug (“MA-PD”) plans, and MA/MA-PD EGWPs. Requestor provides health insurance coverage and administrative services to group health plans, consistent with 42 C.F.R. § 422.106(d)(6), such as employers, trusts, and union groups (each, a “Group,” and collectively, “Groups”).

MA organizations that offer plans in the individual market<sup>2</sup> and MA organizations that offer EGWPs have certain similarities. They both: (i) contract with CMS to provide their enrollees the basic benefits available to enrollees under Medicare Parts A and B and may also provide supplemental benefits that go beyond what enrollees would have received under Parts A and B; (ii) may offer enrollees prescription drug benefits under Medicare Part D; and (iii) receive a capitated, per-member, per-month payment from CMS. However, there are certain differences between MA organizations offering plans in the individual market and MA organizations offering EGWPs that are relevant to this advisory opinion, detailed directly below.

First, unlike MA organizations offering plans in the individual market, MA organizations offering EGWPs do not submit bids to CMS.<sup>3</sup> Instead, CMS granted a waiver from MA bidding requirements for EGWPs beginning with contract year 2017, and an EGWP’s capitated amount is based on the average bids and benchmarks in the individual MA market, across all plans at the county level.<sup>4</sup>

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<sup>1</sup> We use “person” herein to include persons, as referenced in the Federal anti-kickback statute, as well as individuals and entities, as referenced in the exclusion authority at section 1128(b)(7) of the Act.

<sup>2</sup> A plan offered in the “individual market” means a plan offered and marketed by an MA organization directly to eligible Medicare enrollees.

<sup>3</sup> An MA organization offering plans in the individual market submits a bid that should represent the MA organization’s anticipated cost of providing basic benefits to a Medicare enrollee in that payment area with an average risk profile. See generally, section 1854(a)(6) of the Act. CMS then compares that bid to an annually calculated benchmark amount. See section 1853 of the Act.

<sup>4</sup> CMS has continued the waiver each year since it was initially issued for 2017. See CMS, Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and

Second, while MA organizations offering MA plans in the individual market are subject to uniform premium requirements for members enrolled in the same plan, Requestor certified that MA organizations offering EGWPs, such as Requestor, may negotiate with Groups with respect to, among other details, the scope of benefits and any additional premium amounts to be paid by the Group or its enrollees. MA organizations offering EGWPs may—but are not required to—charge a Group an additional premium for each enrollee enrolled in the EGWP, which the Group may pay or may collect, in whole or in part, from its enrollees.

Finally, as described in 42 C.F.R. § 422.266, MA organizations offering MA plans in the individual market must use a “rebate” (equal to a percentage of the amount by which an MA organization’s bid is lower than the benchmark), if any, in the form of: (i) payment for supplemental benefits (which can include reductions in cost sharing compared to Medicare fee-for-service cost sharing); (ii) a reduction in the enrollee’s Medicare Part B premium; or (iii) a reduction in the enrollee’s premium that is attributable to prescription drug coverage.<sup>5</sup> Responding to a statement that CMS made in the Advance Notice of Methodological Changes for CY 2022 MA Capitation Rates and Part C and Part D Payment Policies that “the limits in [42 C.F.R.] § 422.266 on how the MA rebate may be used have not been waived and therefore continue to apply for EGWPs,” Requestor certified that it asked CMS to clarify whether MA organizations offering EGWPs may use any funds that qualify as a rebate under CMS’s definition to make “gainshare” payments to Groups.<sup>6</sup> In response, CMS explained that MA organizations offering EGWPs receive a monthly payment for each enrollee that consists of two components, a base county payment rate and a rebate (as described above), which are added together and multiplied by the enrollee’s risk score to produce a single payment amount; these two components are not subsequently broken out. CMS further explained that, because these components are combined and not broken out, MA organizations offering EGWPs are unable to identify the amount of their total payment that is a rebate payment. Therefore, CMS has, since 2017, waived the requirement for MA organizations to inform CMS how the EGWPs will

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Medicare Advantage and Part D Payment Policies and Final Call Letter (Apr. 4, 2016), at 27-44, <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>, through CMS, Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Apr. 7, 2025), at 58-60, <https://www.cms.gov/files/document/2026-announcement.pdf>. Advance Notice of Methodological Changes and Rate Announcements for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies for each year are available at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents>.

<sup>5</sup> 42 C.F.R. § 422.266(b).

<sup>6</sup> See CMS, Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Jan. 15, 2021), at 52–53 <https://www.cms.gov/files/document/2022-announcement.pdf> (the “CY 2022 Announcement”).

distribute amounts paid as rebates among the options at 42 C.F.R. § 422.266(b). CMS also has waived the requirement that MA organizations offering EGWPs rebate to their enrollees a specific percentage of the overall payment from CMS. Accordingly, under CMS guidance, an MA organization offering an EGWP could choose not to rebate any portion of its overall payment from CMS to its enrollees. CMS also explained, however, that if an MA organization offering an EGWP chose to rebate a portion of its payment, then “any amounts that an MA EGWP rebates to enrollees must be provided in a form and manner that is consistent with [42 C.F.R.] § 422.266(b).”<sup>7</sup> In other words, an MA organization offering an EGWP is not required to issue any rebate, but if it does issue a rebate, then the EGWP must provide those rebates in a form consistent with the options at 42 C.F.R. § 422.266(b). In addition, Requestor cites to CMS’s statement that: “[CMS does] not regard the regulation at [42 C.F.R.] § 422.266, which governs the use of beneficiary rebates, as restricting how the EGWP can use the entire payment it receives from CMS, particularly its own gain/loss margin.”<sup>8</sup>

## **B. The Proposed Arrangement**

Under the Proposed Arrangement, Requestor would give Groups the opportunity to share in a percentage of Requestor’s savings (the “Gainshare Payment”). First, Requestor would enter into agreements with Groups to provide coverage to each Group’s enrollees for the basic benefits under Medicare Parts A and B and, if applicable, prescription drug coverage under Medicare Part D through an MA-PD plan, plus any supplemental benefits that Requestor and each Group may negotiate. Requestor and each Group also would negotiate whether Requestor would charge any additional amount as a premium.<sup>9</sup>

Then, as part of the Proposed Arrangement, Requestor and a Group would include conditions in their contract that would govern when a Group would be eligible to share a percentage of Requestor’s savings, if any, as a Gainshare Payment. The Gainshare Payment would be based on a negotiated “medical expense ratio” (“Negotiated MER”).<sup>10</sup> Requestor certified that the Negotiated MER would be calculated by dividing certain expenses incurred by Requestor by certain revenues Requestor received. Requestor and a Group also would negotiate a particular target Negotiated MER percentage for the Group and the terms for receiving the Gainshare

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<sup>7</sup> Id.

<sup>8</sup> Id.

<sup>9</sup> Requestor certified that any additional premium charged would encompass all benefits (*i.e.*, there would be a single additional premium that applies to the basic MA benefit, the basic Part D benefit, and any additional benefits offered as part of the plan, as applicable).

<sup>10</sup> The regulations governing calculation of the medical loss ratio for purposes of the MA program are set forth at 42 C.F.R. Part 422, subpart X. The calculation of the Negotiated MER for purposes of the Proposed Arrangement would be defined and negotiated by the parties and would not necessarily be the same as the medical loss ratio calculated pursuant to 42 C.F.R. § 422.2420. Similarly, the Negotiated MER would not be used to calculate any remittance owed to CMS pursuant to section 1847(e)(4) of the Act and 42 C.F.R. § 422.2470.

Payment, such as a minimum enrollment during the applicable plan year (usually calculated as a straight average of annual plan year membership and the Group maintains a minimum of 90 percent of members enrolled at the time of quoting) and any applicable renewal requirement to receive the Gainshare Payment (e.g., that the Group renews the EGWP contract for the following year to receive the Gainshare Payment from the prior year). If the final calculated Negotiated MER for the Group is below the negotiated target, Requestor would pay the Group an amount representing the negotiated percentage of the savings below the target (i.e., the Gainshare Payment) typically in the third quarter of the following year.<sup>11</sup> The amount of the Gainshare Payment could exceed any additional premium amount paid by the Group and could be paid to Groups that do not pay an additional premium to Requestor.<sup>12</sup>

Requestor certified that each Group would be contractually required to use any Gainshare Payment to benefit enrollees. For example, a Group could use a Gainshare Payment to fund enhanced or additional benefits offered by Requestor or another insurer or entity (e.g., where the plan does not include a Part D benefit, the Group could use the Gainshare Payment to help fund a Part D benefit through premiums with another plan or self-funded claims coverage), or for other group health benefit-related expenses (e.g., group health plan administrative expenses, such as benefits personnel costs, or other group health benefits that are not covered by a plan, such as wellness or retiree support programs). Requestor also noted that Groups with which it would enter into the Proposed Arrangement may be subject to the Employee Retirement Income Security Act<sup>13</sup> (“ERISA”) and State laws that impose fiduciary requirements. Any Group subject to ERISA, State law, or both could be subject to legal requirements that could impact how the Group uses the Gainshare Payment.

## II. LEGAL ANALYSIS

### A. Law

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

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<sup>11</sup> If the final calculated Negotiated MER for the Group is above the negotiated target, Requestor would not owe a payment to the Group (i.e., no Gainshare Payment would be earned because the savings target was not met).

<sup>12</sup> Requestor certified that plan premiums are priced competitively in the marketplace and are based on the actuarially predicted performance of the Group, such that a Gainshare Payment is not expected to be paid (i.e., if the plan performs as actuarially predicted, there should be no Gainshare Payment for a Group). However, Requestor certified that the Gainshare Payment would enable Groups to obtain some share of the savings if enrollees’ health care costs are lower than predicted.

<sup>13</sup> See 29 U.S.C. § 1001 et seq.

reimbursable under a Federal health care program.<sup>14</sup> 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.<sup>15</sup> 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.<sup>16</sup> 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, OIG may initiate administrative proceedings to impose civil monetary penalties on such person under section 1128A(a)(7) of the Act. OIG also may initiate administrative proceedings to exclude such person from Federal health care programs under section 1128(b)(7) of the Act.

## **B. Analysis**

The Proposed Arrangement would implicate the Federal anti-kickback statute because Requestor, an organization that offers EGWPs,<sup>17</sup> would offer remuneration to a Group in the form of sharing a percentage of its savings that could induce the Group to refer its enrollees to Requestor so that Requestor, via its EGWP, would arrange for the furnishing of items or services that are reimbursable by a Federal health care program. No safe harbor would apply. However, for the following reasons, we believe the risk of fraud and abuse presented by the Proposed Arrangement is sufficiently low under the Federal anti-kickback statute for OIG to issue a favorable advisory opinion.<sup>18</sup>

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<sup>14</sup> Section 1128B(b) of the Act.

<sup>15</sup> Id.

<sup>16</sup> 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).

<sup>17</sup> We recognize that Requestor contracts with CMS to offer various types of plans, including EGWPs that offer Part D coverage and EGWPs that do not. The differences do not impact the analysis, and therefore we do not refer separately to the different types of EGWPs.

<sup>18</sup> As we note in section IV below, this advisory opinion is limited to the Federal anti-kickback statute. We express no opinion herein regarding the application of any other Federal, State, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Proposed Arrangement.

We typically consider a number of factors to determine whether a Proposed Arrangement would pose a sufficiently low risk under the Federal anti-kickback statute, including, but not limited to, whether the Proposed Arrangement would be likely to result in: increased costs to Federal health care programs, overutilization, steering, or an adverse impact on competition. Here, while some of these factors could exist, in our assessment, the Proposed Arrangement would not cause or heighten these factors.

For example, increased costs to Federal health care programs could result if the costs associated with EGWPs are higher than costs associated with Medicare fee-for-service. However, in that example, the potential for increased costs would result from program design, not the Proposed Arrangement. Further, any potential payment from Requestor to a Group—or calculations used to arrive at such payment—under the Proposed Arrangement would not impact the amounts CMS pays to Requestor for its EGWP plans.

We recognize that the Proposed Arrangement presents a risk of steering, which also could adversely impact competition. Specifically, under the Proposed Arrangement, Groups would be given the opportunity to receive an incentive—the Gainshare Payment—to choose a particular plan that would arrange for federally reimbursable items and services for its enrollees. However, the Gainshare Payment is not guaranteed; Requestor certified that if the plan performs as actuarially predicted, there would be no Gainshare Payment for a Group. Requestor further certified that if a Group receives a Gainshare Payment due to its enrollees' health care costs being lower than predicted, the Group would be contractually required to use any Gainshare Payment to benefit enrollees. MA organizations that contract with CMS to offer EGWPs are permitted certain flexibilities that can impact a Group's decision regarding whether to contract with that MA organization, such as what supplemental benefits might be offered and the total cost of the plan for the Group and its enrollees (e.g., additional premium amounts).<sup>19</sup> The offer and receipt of a potential Gainshare Payment, as described by Requestor, would be an element of negotiation between the parties and would be used for the benefit of enrollees.

We note, however, if CMS program rules governing EGWPs' operation or payment were to materially change such that the potential payments contemplated under the Proposed Arrangement were no longer permissible, this opinion could be subject to modification or termination in accordance with 42 C.F.R. § 1008.45.

### **III. CONCLUSION**

Based on the relevant facts certified in your request for an advisory opinion and supplemental submissions, we conclude that, although the Proposed Arrangement, if undertaken, would generate—if the requisite intent were present—prohibited remuneration under the Federal anti-kickback statute, OIG would not impose administrative sanctions on Requestor in connection

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<sup>19</sup> We note that CMS's statement in the CY 2022 Announcement that it does not regard "the regulation at [42 C.F.R.] § 422.266, which governs the use of beneficiary rebates, as restricting how the EGWP can use the entire payment it receives from CMS, particularly its own gain/loss margin" does not expressly permit Gainshare Payments as part of the program; it simply states that 42 C.F.R. § 422.266 does not apply to the portion of a payment not issued as a rebate.

with the Proposed Arrangement 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.

#### **IV. LIMITATIONS**

The limitations applicable to this advisory opinion include the following:

- This advisory opinion is limited in scope to the Proposed Arrangement. This advisory opinion has no applicability to any other arrangements, including, without limitation, any that may have been disclosed or referenced in your request for an advisory opinion or supplemental submissions.
- This advisory opinion is issued only to Requestor. 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 Requestor 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.
- 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 advisory opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

OIG will not proceed against Requestor 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. 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, OIG will not proceed against Requestor 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 OIG.

Sincerely,

/Susan E. Gillin/

Susan E. Gillin  
Assistant Inspector General for Legal Affairs