118TH CONGRESS
2D SESSION

S. 5633

To establish Medicare flex fund accounts and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 19 (legislative day, DECEMBER 16), 2024

Mr. SCOTT of Florida introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To establish Medicare flex fund accounts and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Flex Fund Accounts and Flexible Benefits Act of 2024''.

SEC. 2. MEDICARE FLEX FUND ACCOUNTS.

(a) IN GENERAL.—Part VIII of subchapter F of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 530A. MEDICARE FLEX FUND ACCOUNTS.

"(a) IN GENERAL.—A Medicare flex fund account shall be exempt from taxation under this subtitle. Notwithstanding the preceding sentence, the Medicare flex fund account shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable organizations).

"(b) MEDICARE FLEX FUND ACCOUNT.—For purposes of this section:

"(1) IN GENERAL.—The term 'Medicare flex fund account' means a trust created or organized in the United States as a Medicare flex fund account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

"(A) Except in the case of a rollover contribution described in subsection (c)(2), section 220(f)(5), or section 223(f)(5) or a contribution described in section 138A(1), no contribution will be accepted—

"(i) unless it is in cash,

"(ii) unless the account beneficiary is an eligible individual for the taxable year in which the contribution is made, and

"(iii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—

"(I) the dollar amount in effect under section 223(b)(2)(A), plus

"(II) in the case of an individual who has attained age 55 before the close of the calendar year, the dollar amount in effect under section 223(b)(3)(B).

"(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(C) No part of the trust assets will be invested in life insurance contracts.

"(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(E) The interest of an individual in the balance in his account is nonforfeitable.

''(2) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'qualified medical expenses' shall have the meaning given such term under section 223(d)(2) (determined without regard to subparagraph (B) thereof).

''(B) EXCEPTION FOR MEDIGAP PREMIUMS.—Such term shall not include any premium for a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

''(3) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means, with respect to any taxable year, any individual entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B or D of such title, including individuals covered under a Medicare Advantage plan, on the last day of such taxable year.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(f)(3) (relating to time when contributions made).

''(B) Section 408(g) (relating to community property laws).

''(C) Section 408(h) (relating to custodial accounts).

''(D) Paragraphs (2) and (4) of section 408(e).

''(c) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Any amount distributed out of a Medicare flex fund account shall be subject to tax in the same extent and in the same manner as distributions from a health savings account under section 223(f), except that—

''(A) amounts described in paragraph (2) thereof shall be includible in gross income in the manner provided under section 72 (after taking into account rules similar to the rules of section 408(d)(2)),

''(B) for purposes of paragraph (3)(B) thereof a rollover contribution described in paragraph (2) shall not be considered an excess contribution, and

''(C) paragraph (4) thereof shall not apply.

''(2) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—An amount distributed from a Medicare flex fund account shall not be includible in gross income if such amount is paid or distributed from a Medicare flex fund account to the account beneficiary to the extent the amount received is paid into a Medicare flex fund account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a Medicare flex fund account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a Medicare flex fund account which was not includible in the individual's gross income because of the application of this paragraph.

''(d) REPORTS.—The Secretary may require the trustee of a Medicare flex fund account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, the return of excess contributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.''.

(b) GOVERNMENT CONTRIBUTIONS.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 138 the following new section:

''SEC. 138A. CERTAIN CONTRIBUTIONS TO MEDICARE FLEX FUND ACCOUNTS.

''Gross income shall not include any payment to the Medicare flex fund account (as defined in section 530A) of an individual by—

''(1) the Secretary of Health and Human Services, or

''(2) the administrator of a Medicare Advantage plan.''.

(c) CONTRIBUTIONS FROM OTHER SAVINGS VEHICLES.—

(1) HEALTH SAVINGS ACCOUNTS.—Section 223(f)(5) of the Internal Revenue Code of 1986 is amended by inserting ''or a Medicare flex fund account (as defined in section 530A)'' after ''paid into a health savings account''.

(2) ARCHER MSAS.—Section 220(f)(5) of such Code is amended by striking ''or a health savings account (as defined in section 223(d))'' and inserting '', a health savings account (as defined in section 223(d)), or a Medicare flex fund account (as defined in section 530A)''.

(3) IRA DISTRIBUTIONS.—Section 408(d) of such Code is amended by adding at the end the following new paragraph:

''(10) DISTRIBUTION FOR MEDICARE FLEX FUND ACCOUNT FUNDING.—

''(A) IN GENERAL.—In the case of an individual who is an eligible individual (as defined in section 530A(b)(3)) and who elects the application of this paragraph for a taxable year, gross income of the individual for the taxable year does not include a qualified Medicare FFA funding distribution to the extent such distribution is otherwise includible in gross income.

''(B) QUALIFIED MEDICARE FFA FUNDING DISTRIBUTION.—For purposes of this paragraph, the term 'qualified Medicare FFA funding distribution' means a distribution from an individual retirement plan (other than a plan described in subsection (k) or (p)) of the employee to the extent that such distribution is contributed to the Medicare flex fund account (as defined in section 530A) of the individual in a direct trustee-to-trustee transfer.

''(C) LIMITATION.—

''(i) IN GENERAL.—The amount excluded from gross income by subparagraph (A) shall not exceed the annual limitation under section 530A(b)(1)(A)(iii).

''(ii) ONE-TIME TRANSFER.—An individual may make an election under subparagraph (A) only for one qualified Medicare FFA funding distribution during the lifetime of the individual. Such an election, once made, shall be irrevocable.

''(D) APPLICATION OF SECTION 72.—Rules similar to the rules of paragraph (9)(E) shall apply for purposes of this paragraph.''.

(d) EXCESS CONTRIBUTIONS.—

(1) IN GENERAL.—Section 4973(a) of such Code is amended by striking ''or'' at the end of paragraph (5), by inserting ''or'' at the end of paragraph (6), and by inserting after paragraph (6) the following new paragraph:

''(7) a Medicare flex fund account (within the meaning of section 530A),''.

(2) EXCESS CONTRIBUTIONS.—Section 4973 of such Code is amended by adding at the end the following new subsection:

''(i) EXCESS CONTRIBUTIONS TO MEDICARE FLEX FUND ACCOUNTS.—

''(1) IN GENERAL.—In the case of a Medicare flex fund account, the term 'excess contributions' means the sum of—

''(A) the amount by which the amount contributed for the taxable year to such accounts exceeds the contribution limitation determined under section 530A(b)(1)(A)(iii), and

''(B) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

''(i) the distributions out of the accounts for the taxable year which were not used exclusively to pay the qualified med-

ical expenses (as determined under section 223(f)(2)) of the account beneficiary,

"(ii) the excess of—

"(I) the distributions out of the accounts for such taxable year which were used exclusively to pay the qualified medical expenses (as determined under section 223(f)(1)) of the account beneficiary, over

"(II) the amount which would be taxable by reason of section 530A(c)(1)(A) if such amounts were described in section 223(f)(2) with respect to such distributions, and

"(iii) the excess (if any) of the maximum amount which may be contributed to the accounts for the taxable year over the amount contributed to the accounts for the taxable year.

"(2) SPECIAL RULES.—For purposes of paragraph (1), the following contributions shall not be taken into account:

"(A) Any contribution which is distributed out of the Medicare flex fund account in a distribution if—

"(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

"(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

"(B) Any rollover contribution described in section 220(f)(5), 223(f)(5), or 530A(c)(2).".

(e) APPLICATION OF PROHIBITED TRANSACTION RULES.—

(1) IN GENERAL.—Section 4975(e)(1) of the Internal Revenue Code of 1986 is amended by striking "or" at the end of subparagraph (F), by redesignating subparagraph (G) as subparagraph (H), and by inserting after subparagraph (F) the following new subparagraph:

"(G) a Medicare flex fund account described in section 530A, or".

(2) SPECIAL RULE.—Section 4975(c) of such Code is amended by adding at the end the following new paragraph:

"(8) SPECIAL RULE FOR MEDICARE FLEX FUND ACCOUNTS.—An individual for whose benefit a Medi-

care flex fund account (within the meaning of section 530A) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a Medicare flex fund account by reason of the application of section 530A(b)(4)(D) to such account.''.

(f) OTHER CONFORMING AMENDMENTS.—

(1) Section 35(g)(3) of the Internal Revenue Code of 1986 is amended by striking ''or from a health savings account (as defined in section 223(d))'' and inserting '', from a health savings account (as defined in section 223(d)), or from a Medicare flex fund account (as defined in section 530A(b))''.

(2) Section 848(e)(1)(B) of such Code is amended by striking ''and'' at the end of clause (iv), by striking the period at the end of clause (v) and inserting '', and'', and by adding at the end the following new clause:

> ''(vi) any contract which is a Medicare flex fund account (as defined in section 530A(b)).''.

(3) Section 877A(e)(2) of such Code is amended by inserting ''a Medicare flex fund account (as defined in section 530A(b)),'' after ''a health savings account (as defined in section 223)''.

(4) Section 6693(a)(2) of such Code is amended by striking ''and'' at the end of subparagraph (E), by striking the period at the end of subparagraph (F) and inserting '', and'', and by inserting after subparagraph (G) the following new subparagraph:

''(G) section 530A(d) (relating to Medicare flex fund accounts).''.

(5) Section 1027(g)(4) of the Consumer Financial Protection Act of 2010 (12 U.S.C. 5517(g)(4)) is amended by striking ''or 530'' and inserting ''530, or 530A''.

(g) CLERICAL AMENDMENTS.—

(1) The table of sections for part VIII of subchapter F of chapter 1 of such Code is amended by adding at the end the following new item:

''Sec. 530A. Medicare flex fund accounts.''.

(2) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 138 the following new item:

''Sec. 138A. Certain contributions to Medicare flex fund accounts.''.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning on or after January 1, 2026.

SEC. 3. MEDICARE FLEX FUND ACCOUNTS UNDER MEDICARE ADVANTAGE.

(a) REQUIREMENT FOR MEDICARE FLEX FUND ACCOUNTS.—

(1) MA PLAN REQUIREMENT TO ESTABLISH MEDICARE FLEX FUND ACCOUNT ON BEHALF OF AN ENROLLEE.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(k) MA PLAN REQUIREMENT TO ESTABLISH MEDICARE FFA ON BEHALF OF AN ENROLLEE.—

''(1) IN GENERAL.—Notwithstanding any other provision of law and subject to paragraph (4), any MA plan offered under this part (other than an MSA plan) shall establish a Medicare flex fund account (as defined in section 530A of the Internal Revenue Code of 1986 and referred to in this subsection as a 'Medicare FFA') on behalf of an enrollee in the plan.

''(2) REBATES.—In the case of a plan that is required to provide a monthly rebate to an enrollee under section 1854(b)(1)(C), the MA plan may pro-

vide part or all of such rebate through depositing money into the enrollee's Medicare FFA.

"(3) INCENTIVE PAYMENTS.—

"(A) IN GENERAL.—Notwithstanding section 1851(h)(4)(A) or any other provision of this part and subject to subparagraph (B), MA plans may deposit money into an enrollee's Medicare FFA as a result of the enrollee completing educational or training programs, programs for chronic disease management, programs that promote wellness and health, or other programs as determined by the Secretary.

"(B) RULES.—In making the deposits described in subparagraph (A), the following rules shall apply:

"(i) No payment shall be made to an MA organization under this part as a result of such deposits.

"(ii) In submitting bid information required under section 1854, the MA organization offering the MA plan shall not take into account such deposits.

"(iii) The MA plan may not charge a premium or otherwise increase a premium

under section 1854 as a result of such deposits.

''(4) INITIAL PAYMENT FLOOR.—

''(A) IN GENERAL.—Subject to subparagraph (B), for the first 3 years a Medicare FFA is established pursuant to paragraph (1) with respect to an enrollee, each MA plan shall deposit no less than $400 each year into the enrollee's Medicare FFA.

''(B) REBATES AND INCENTIVE PAYMENTS.—The rebates described in paragraph (2) and incentive payments described in paragraph (3) shall count towards the required minimum deposit amount described in subparagraph (A).

''(5) PROHIBITION ON SPENDING MEDICARE FFAS ON MEDIGAP PREMIUMS.—An enrollee may not spend any amount in a Medicare FFA on a premium for a medicare supplemental policy under section 1882.

''(6) WAIVER OF MEDICARE FFA REQUIREMENT FOR CERTAIN PLANS.—

''(A) IN GENERAL.—The Secretary may waive the requirement described in paragraph (1) for—

"(i) a specialized MA plan for special needs individuals;

"(ii) an employer sponsored MA plan described in section 1857(i)(2); and

"(iii) an MA plan in which an enrollee in such plan already has a Medicare FFA if the study required by section 3(b) of the Medicare Flex Fund Accounts and Flexible Benefits Act of 2024 concludes that it is feasible to permit Medicare beneficiaries enrolled in an MA plan to select their preferred Medicare FFA band under the plan.

"(B) ENROLLEE CHOICE.—Notwithstanding subparagraph (A), an MA plan described in such subparagraph shall establish a Medicare FFA if an enrollee in such plan elects to have a Medicare FFA established on behalf of the enrollee.

"(7) EDUCATION.—The Secretary shall include information regarding Medicare FFAs in relevant education materials, including—

"(A) the notice required under section 1804(a) (commonly referred to as the Medicare & You handbook);

''(B) any site-of-service transparency information made available to the public under section 1834(t);

''(C) any information provided to individuals regarding coverage options under section 1851(d); and

''(D) in consultation with the Secretary of the Treasury, additional general beneficiary educational material regarding this title and this part.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plan years beginning on or after January 1, 2026.

(b) HHS STUDY AND REPORT ON BENEFICIARIES CHOOSING THEIR PREFERRED BANK FOR MEDICARE FFAS.—

(1) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study on the feasibility of permitting Medicare beneficiaries enrolled in a Medicare Advantage plan under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to select their preferred Medicare flex fund account (as described in section 1851(k) of such Act (42 U.S.C. 1395w–21(k))) bank under the

plan. Such study shall include an analysis of any administrative actions that the Secretary may take in order to permit such beneficiaries to make such selection.

(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with—

(A) a description of any administrative actions described in paragraph (1) that the Secretary has taken, or plans to take; and

(B) recommendations for such legislation as the Secretary determines appropriate.

(c) HHS STUDY AND REPORT ON BENEFICIARIES CHOOSING THEIR PREFERRED SUPPLEMENTAL HEALTH BENEFITS.—

(1) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary''), shall conduct a study on the feasibility of permitting Medicare beneficiaries enrolled in a Medicare Advantage plan under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to select their preferred supplemental health benefits under such plan and have the savings from unused benefits deposited into the Medicare

flex fund account (as described in section 1851(k) of such Act (42 U.S.C. 1395w–21(k))) of the enrollee. Such study shall include an analysis of any administrative actions that the Secretary may take in order to permit such beneficiaries to make such selection.

(2) CONSULTATION.—In carrying out the study under paragraph (1), the Secretary shall conduct public meetings and consult with Medicare Advantage plans, actuaries, and health think tanks.

(3) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with—

(A) a description of any administrative actions described in paragraph (1) that the Secretary has taken, or plans to take; and

(B) recommendations for such legislation as the Secretary determines appropriate.

SEC. 4. MEDICARE FLEX FUND ACCOUNTS UNDER OTHER MEDICARE PROGRAMS.

(a) CMI MODEL.—Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following new clause:

''(xxviii) Permitting individuals participating in a model conducted under this

section to have a Medicare flex fund account created by section 530A of the Internal Revenue Code of 1986.''.

(b) INCENTIVE PROGRAMS.—The Secretary of Health and Human Services may include a Medicare flex fund account created by section 530A of the Internal Revenue Code of 1986 as a component in any Medicare shared savings program or other Medicare incentive based program established after the date of enactment of this section.

SEC. 5. SITE OF SERVICE PRICE TRANSPARENCY UPDATE.

(a) PRICE TRANSPARENCY WEBSITE UPDATE.—Section 1834(t)(1) of the Social Security Act (42 U.S.C. 1395m(t)(1)) is amended—

(1) in subparagraph (A), by striking ''and'' at the end;

(2) in subparagraph (B), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(C) the hospital outpatient departments and ambulatory surgical centers nearest to a specific zip code entered on the website;

''(D) whether payments for items and services furnished will be made under the payment system under section 1833(t) or under section 1833(i); and

''(E) if available, the quality rating of each hospital outpatient department and surgical center.''.

(b) PRICE TRANSPARENCY WEBSITE ADVISORY GROUP.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services (referred to in this subsection as the ''Administrator'') shall establish a Medicare Price Transparency Website Advisory Group (referred to in the subsection as the ''Advisory Group'').

(2) MEMBERS.—The Advisory Group shall be composed of the following individuals or the designees of those individuals:

(A) The Administrator.

(B) The Chair of the Medicare Payment Advisory Commission.

(C) Two representatives from each of the following sectors to be selected by the Administrator:

(i) Medical.

(ii) Technology.

(iii) Think tanks with a background in health economics.

(D) Four individuals from non-profit organizations that represent seniors.

(E) Any other individual the Administrator determines appropriate.

(3) NO COMPENSATION FOR MEMBERS.—A member of the Advisory Group shall serve without compensation in addition to any compensation received for the service of the member as an officer or employee of the United States, if applicable.

(4) DUTIES.—

(A) IN GENERAL.—The Advisory Group shall review the website described in section 1834(t) of the Social Security Act (42 U.S.C. 1395(t)) (referred to in this subsection as the ''website'') and provide recommendations to the Secretary of Health and Human Services (referred to in the subsection as the ''Secretary'') on ways the website could be changed to increase its usability and allow users of the website to better understand the cost and quality for services offered by hospital outpatient departments and ambulatory surgical centers covered by the Medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.) in

order for users of the website to be better informed regarding their medical choices.

(B) REPORT.—Not later than 180 days after the first meeting of the Advisory Group, the Advisory Group shall submit a report to the Secretary detailing its recommendations.

(5) WEBSITE UPDATE.—Not later than 1 year after receiving the report required by paragraph (4)(B), the Secretary shall update the website considering the recommendations contained in such report.

SEC. 6. VOLUNTARY PATIENT DRIVEN BENEFIT FLEXIBILITY.

(a) DIRECT PRIMARY CARE PAYMENT ADVISORY GROUP.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services (referred to in this subsection as the ''Administrator'') shall establish a Direct Primary Care Payment Advisory Group (referred to in the subsection as the ''Advisory Group'').

(2) MEMBERS.—The Advisory Group shall be composed of the following individuals or the designees of those individuals:

(A) The Administrator.

(B) The Chair of the Medicare Payment Advisory Commission.

(C) Two primary care physicians with experience in direct primary care.

(D) Two specialist physicians who provide primary care services to patients with chronic diseases with experience in direct primary care.

(E) Two representatives of Medicare Advantage plans.

(F) Two health actuaries.

(G) Two representatives of think tanks with a health policy background.

(H) Any other individual the Administrator determines appropriate.

(3) NO COMPENSATION FOR MEMBERS.—A member of the Advisory Group shall serve without compensation in addition to any compensation received for the service of the member as an officer or employee of the United States, if applicable.

(4) DUTIES.—

(A) IN GENERAL.—The Advisory Group shall determine—

(i) a definition of primary care benefits provided under Medicare Advantage plans; and

(ii) how best to calculate the amount Medicare Advantage plans would save if patients, including patients that have chronic conditions and for whom primary care is provided by a specialist physician, were to contract with providers of primary care on their own without using health insurance.

(B) REPORT.—Not later than 180 days after the first meeting of the Advisory Group, the Advisory Group shall submit a report to the Secretary of Health and Humans Services detailing its recommendations.

(b) MA PLANS.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended—

(1) in subparagraph (A), by inserting ''and the patient flexibility and bundled payment requirements described in subparagraph (C)'' after ''under section 1854(f)(1)(A))''; and

(2) by adding at the end the following new subparagraph:

"(C) DIRECT PRIMARY CARE AND FLEXIBILITY PAYMENTS.—

"(i) DIRECT PRIMARY CARE PAYMENTS.—

"(I) IN GENERAL.—Beginning with plan years beginning on or after January 1, 2027, each Medicare Advantage plan shall allow enrollees to elect to receive a direct primary care benefit payment, described in subclause (II), in lieu of receiving coverage of primary care benefits (as defined by the Secretary taking into account the recommendations of the Direct Primary Care Payment Advisory Group established under section 6(a) of the Medicare Flex Fund Accounts and Flexible Benefits Act of 2024) under the Medicare Advantage plan.

"(II) DIRECT PRIMARY CARE BENEFIT PAYMENT.—The direct primary care benefit payment for an enrollee shall be—

"(aa) equal to the amount of the average per capita savings to

the Medicare Advantage plan by not providing coverage of primary care benefits under such plan to such enrollee (as determined by the Secretary taking into account the recommendations of the Direct Primary Care Payment Advisory Group established under section 6(a) of the Medicare Flex Fund Accounts and Flexible Benefits Act of 2024); and

''(bb) deposited into the Medicare flex fund account (as defined in section 530A of the Internal Revenue Code of 1986 and referred to in this subparagraph as a 'Medicare FFA') of such enrollee.

''(III) ELECTION.—

''(aa) IN GENERAL.—Subject to item (bb), during the period beginning on January 1 and ending on March 31 of each plan year, an enrollee may elect to re-

ceive the direct primary care benefit payment for that year.

"(bb) OTHER REQUIREMENTS.—

"(AA) FREQUENCY OF CHANGE.—If an enrollee makes the election described in item (aa), the enrollee may elect to stop receiving the direct primary care benefit payment and begin to receive primary care benefits under the Medicare Advantage plan for the remainder of that calendar year.

"(BB) CARRY OVER OF ELECTION.—If an enrollee makes the election described in item (aa), the enrollee shall continue to receive the direct primary care benefit payment until the enrollee elects to receive primary care benefits under the Medicare Advantage plan for

the year during the period described in such item, the enrollee makes the election described in subitem (AA), or the enrollee changes Medicare Advantage plans.

"(CC) CHANGING OF MEDICARE ADVANTAGE PLANS.—If an enrollee changes Medicare Advantage plans as described in subitem (BB), the enrollee may elect to receive the direct primary care benefit payment or to receive primary care benefits under the Medicare Advantage plan for the remainder of the year.

"(ii) FLEXIBILITY PAYMENTS FOR SHOPPABLE SERVICES.—

"(I) IN GENERAL.—Beginning with plan years beginning on or after January 1, 2027, each Medicare Advantage plan shall allow enrollees to receive a payment from such plan that

meets the requirements of subclause (II) and allows enrollees to receive treatment from a pre-approved alternate provider.

"(II) PAYMENT.—The payment described in subclause (I) shall—

"(aa) be the same amount that would have been paid to an in-network provider and include any processing costs; and

"(bb) be deposited in the Medicare FFA of the enrollee once a contract has been signed by the enrollee, the Medicare Advantage plan, and the alternative provider to provide treatment to the member.

"(III) ALTERNATIVE PROVIDERS.—

"(aa) MENU OF OPTIONS.—Each Medicare Advantage plan may develop a list of pre-approved alternate providers and information regarding the price, treatment outcomes, and cus-

tomer experience of each pre-approved alternate provider for certain treatments, procedures, and episodes of care. If a Medicare Advantage plan chooses to develop such list, the Medicare Advantage plan shall provide such list to an enrollee upon the request of such enrollee.

''(bb) PROVIDING THE MENU TO THE ENROLLEE.—Each Medicare Advantage plan shall provide the list described in item (aa) before the enrollee requests such list if it could result in the enrollee receiving treatment for a lesser price.

''(cc) NO COST FOR BEING ON ALTERNATIVE TREATMENT LOCATION LIST.—No Medicare Advantage plan shall charge a provider for being on a list described in item (aa).

''(IV) DEFINITION OF PRE-APPROVED ALTERNATE PROVIDER.—For

the purposes of this clause, the term 'pre-approved alternate provider' means a provider of services or a supplier—

"(aa) located in the United States or a territory of the United States;

"(bb) licensed by the State or territory in which the provider furnishes services;

"(cc) willing to provide services on a cash basis; and

"(dd) that has received the review described in subclause (V).

"(V) REVIEW OF SERVICES.—Before an enrollee has received treatment by a pre-approved alternative provider, the Medicare Advantage plan shall review any contracts or documents relating to the treatment provided by such provider to ensure that—

"(aa) any enrollee who elects to receive treatment by the provider will receive appropriate

health quality and the desired treatment outcome; and

"(bb) to protect the enrollee from hidden fees or surprise bills, the cost of the service quoted by the pre-approved alternative provider will be the total price paid by the enrollee.

"(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to limit any responsibility of a Medicare Advantage plan under this part, to reduce the actuarial value of such a plan, or to change any network adequacy requirement.".

(c) PRESCRIPTION DRUG COVERAGE.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

"(p) PHARMACEUTICAL SAVINGS.—

"(1) IN GENERAL.—In the case of a covered part D drug on the formulary of a prescription drug plan or an MA–PD plan, the plan shall, if requested by an enrollee of such plan, provide such enrollee with a payment described in paragraph (2) in lieu

of the plan paying for such covered part D drug under the plan.

''(2) PAYMENT.—The payment described in paragraph (1) shall be an amount equal to the amount the prescription drug plan or MA–PD plan would reimburse a preferred pharmacy for such covered part D drug plus any fees that would be paid to such plan (or a subsidiary of such plan) by the manufacturer of such covered part D drug.''.

(d) RULE FOR PATIENT DRIVEN BENEFIT FLEXIBILITY SPENDING REGARDING DEDUCTIBLES AND OUT-OF-POCKET SPENDING.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

''(j) RULE FOR PATIENT DRIVEN BENEFIT FLEXIBILITY SPENDING REGARDING DEDUCTIBLES AND OUT-OF-POCKET SPENDING.—Any amount spent by an enrollee from payments made by an MA plan under section 1852(a)(1)(C) or 1860D–4(p) shall not count towards any deductible or maximum limitation on out-of-pocket expenses applicable to such MA plan.''.

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