AMA Summary of Select Provisions and Implementation Dates in Public Law 119–21, the "One Big Beautiful Bill Act"

Introduction

On July 4, 2025, President Trump signed into law Public Law 119–21 (commonly known as the "One Big Beautiful Bill Act" or the "OBBBA"). The law includes many provisions that were of interest to the American Medical Association (AMA). This document summarizes select provisions and any relevant implementation dates that were included in the final version of the law. The provisions are organized by subject matter, and any citations are to OBBBA unless otherwise specified.

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I. Medicaid and the Children's Health Insurance Program (CHIP)

- **Moratorium on implementing regulations that would streamline eligibility and enrollment for Medicaid, CHIP, and the Medicare Savings Program (MSP) (Sections 71101 and 71102).**
  - These sections impose a 10-year moratorium on two regulations (Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment and Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes) promulgated by the Biden Administration that are intended to streamline enrollment in Medicaid, CHIP, and the MSP. As a result, fewer individuals are expected to enroll in or maintain enrollment in Medicaid, CHIP, and the MSP.
  - The moratorium begins on the date of enactment (July 4, 2025) and ends on September 30, 2034.
- **Require states to conduct quarterly screenings comparing enrollee names against names in Social Security Death Master File (DMF) (Section 71104).**
  - Requires states to conduct quarterly checks of the DMF to ensure deceased individuals are not enrolled in the program.
  - The changes made by section 71104 take effect on January 1, 2027.
- **Require states to conduct more frequent eligibility checks, including quarterly screenings comparing names of medical providers against names in the Social Security DMF (Section 71105).**

    - Currently, providers are screened upon enrollment. This provision significantly expands provider screening and may lead to erroneous exclusion of participating providers, as the DMF sometimes lists people as dead who are in fact alive (average rate of 5,500 names per month).
    - The changes made by Section 71105 take effect on January 1, 2028.
- **Payment reduction related to certain erroneous excess payments under Medicaid (Section 71106).**
    - Under current law, the Department of Health and Human Resources (HHS) is allowed to waive the limitation that states may not get a federal match for erroneous payments in excess of 0.03% of all payments made under their Medicaid program if the state acts in good faith to limit erroneous payments. Section 71106 of OBBBA will largely eliminate HHS's authority to waive the limitation, shifting more of the risk of erroneous excess payments to the states. States could respond by imposing more pre-payment requirements on providers (e.g., additional documentation or provider authorization).
    - The changes made by Section 71106 take effect on October 1, 2029.
- **Biannual eligibility redeterminations for expansion enrollees (Section 71107).**
    - This section requires states to redetermine the eligibility of individuals enrolled in Medicaid through the Affordable Care Act (ACA) expansion pathway once every six months (compared to once every 12 months under current law).
    - Requirement takes effect on January 1, 2027.
- **Alien Medicaid eligibility (Section 71109).**
    - Narrows the definition of which lawful immigrants may be covered by Medicaid or CHIP. Restricts the definition of qualified immigrants for purposes of Medicaid or CHIP eligibility to lawful permanent residents, certain Cuban and Haitian immigrants, citizens of the Freely Associated States (COFA migrants) lawfully residing in the U.S., and lawfully residing children and pregnant adults in states that cover them under the Immigrant Children's Health Improvement Act (section 1903(v)(4) of the Social Security Act (42 U.S.C. 1396b(v)(4)).
    - Federal payment for Medicaid coverage of immigrants who are not lawfully present has long been prohibited (except for treatment of emergency medical conditions).
    - Takes effect on October 1, 2026.
- **FMAP for emergency Medicaid (Section 71110).**
    - Provides that the traditional FMAP (and not the enhanced 90 percent federal match for the Medicaid expansion) will apply to emergency Medicaid services provided to immigrants who are not otherwise eligible for Medicaid, regardless of whether they would otherwise qualify for an expansion program.
    - Takes effect on October 1, 2026.
- **Shortening retroactive coverage (Section 71112).**
    - Under current law, states are required to retroactively cover individuals for up to three months before the month in which they apply for Medicaid if they meet eligibility requirements in those months. OBBBA changes this to two months of retroactive coverage for non-expansion enrollees and one month of retroactive coverage for expansion enrollees.
    - Also limits CHIP retroactive coverage to a maximum of two months for all enrollees. While the three months of retroactive coverage is not required for CHIP plans, many states currently provide three months of retroactive coverage.
    - Takes effect on January 1, 2027.
- **No federal payments to prohibited entities that provide abortions (Section 71113).**
    - Temporarily prohibits federal Medicaid funding for *any* services provided by certain prohibited entities that provide abortion services (note that federal funding has long been prohibited for abortion). The scope of the prohibition is narrow (although the precise scope will depend on how the Centers for Medicare & Medicaid Services (CMS)

implements/interprets the statute) and is understood to be targeting Planned Parenthood, which has sued the administration over this provision.
    - This provision is temporary and only applies for one year: July 4, 2025, to July 3, 2026.
- **Provider taxes and state-directed payments (Sections 71115, 71116, and 71117).**
    - Effective July 4, 2025, eliminates the statutory safe harbor for all states with respect to new provider taxes. Without the safe harbor, which applied to taxes that did not exceed 6.0 percent of net patient revenue, it will be more difficult for states to receive approval for provider tax arrangements that help finance state Medicaid programs.
    - For expansion states only, phases down the permissible rate of existing provider taxes (excluding taxes on nursing facilities and intermediate care facilities) from 6.0 percent of net patient revenue to 3.5 percent by 0.5 percentage points per year. The phase-down begins October 1, 2027, and the reduction will be fully phased-in on October 1, 2031. Note that whether and when a state will have to reduce its tax rate to comply with the new threshold depends on the state's existing tax rate.
    - Limits the rate of state-directed payments (SDPs) (payments to providers made through contractual arrangements with managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans) to 100 percent of Medicare rates for expansion states and 110 percent for non-expansion states.
        - Takes effect on July 4, 2025.
        - Certain existing SDPs are grandfathered in but, beginning January 1, 2028, must be phased down by 10 percentage points per year until they reach the new allowed rates.
    - Prohibits provider tax arrangements that are designed to primarily burden Medicaid providers and services instead of non-Medicaid providers and services. Multiple states have existing provider tax arrangements that mostly fall on Medicaid providers, who are then reimbursed through increased Medicaid payments. Takes effect on July 4, 2025, but is subject to a "transition period" of up to three years, at the discretion of the Secretary of HHS.
        - CMS has proposed a rule ("Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole") that substantially overlaps with this provision.
    - None of the provider tax or state directed payment changes apply to the territories.
- **Section 1115 Medicaid demonstration waiver budget neutrality (Section 71118).**
    - Current policy and practice already requires that Section 1115 Medicaid waivers be "budget neutral" to the federal government, but the methodology for determining budget neutrality is not specified in statute, giving states and CMS flexibility in finding that a waiver would be budget neutral (typically by comparing per enrollee spending with and without the waiver). Section 71118 mandates that budget neutrality be determined by the chief actuary of CMS (not the CMS Administrator or Secretary of HHS) using a methodology that looks at total federal expenditures with and without the waiver.
    - The new budget neutrality methodology takes effect on January 1, 2027.
- **Medicaid community engagement requirement for certain individuals (i.e., work requirements) (Section 71119).**
    - Requires states to implement work requirements as a condition of Medicaid eligibility for beneficiaries who are enrolled in Medicaid through the expansion pathway or who are part of the expansion population but are enrolled through a different pathway (such as in Georgia and Wisconsin where Medicaid is available to individuals with household incomes up to 100 percent of the federal poverty level).
    - An individual can satisfy the work requirement for a month in any of the following ways:
        - Engage in 80 hours of work, community service, or work program participation (or some combination thereof).
        - By being enrolled in an educational program at least half-time (40 hours/month).
        - Have a monthly income of at least $580.

        - For seasonal workers only, have an average monthly income over the preceding 6 months that is not less than $580.
    - For new applicants subject to the work requirement, they must show that they have satisfied the work requirement for one to three (at state discretion) consecutive months immediately preceding the month in which they are applying for Medicaid.
    - For existing enrollees, they must satisfy the work requirement for at least one month during each period between eligibility redetermination (for expansion enrollees this will be every six months). However, states have flexibility to (1) require individuals to satisfy the requirement for months during that period; and (2) require more frequent verification of work requirement satisfaction. For example, a state could require that the work requirement be satisfied every month and could verify satisfaction every month.
    - There are several exceptions to the work requirement. Some are mandatory (states must grant exceptions for individuals who meet these criteria), others are at state option. Exceptions include:
        - Younger than 19 or older than 64 (mandatory).
        - Enrolled in Medicare (mandatory).
        - Eligible for Medicaid under a mandatory category (mandatory).
        - Was an inmate of a public institution within the last 3 months (mandatory).
        - Is a "specified excluded individual" (mandatory):
            - Former foster kids
            - Native Americans
            - Caregivers of a dependent child under 14 years old or a disabled individual
            - Veterans with disabilities rated as total under 38 U.S.C. 1155
            - People who are medically frail or otherwise have special medical needs, as defined by the Secretary of HHS, but including:
                - Blind/disabled (as defined for purposes of the Supplemental Security Income (SSI) program)
                - Substance use disorder
                - Physical, intellectual, or developmental disability that significantly impairs ability to perform 1 or more activities of daily living
                - Serious or complex medical condition (not defined)
            - Complying with work requirements under TANF or SNAP programs
            - Participating in drug or alcohol rehabilitation program
            - Inmate of a public institution
            - Pregnant or entitled to postpartum Medicaid coverage under 60-day or 1-year continuous eligibility options
        - Received inpatient services at a hospital, nursing facility, or intermediate care facility, or outpatient services relating to those services (state option).
        - Lives in an area where (1) an emergency or disaster declaration is in effect, or (2) unemployment is above a specified threshold (state option).
        - Needed to travel to receive, or to take a dependent child to receive, medical services for a serious or complex medical condition (state option).
    - States must try to use available data to determine compliance, if possible. If a state finds that an individual is not in compliance with the work requirement:
        - The state must give the individual notice and a 30-day opportunity period to demonstrate that they are in compliance with the work requirement or should not be subject to the work requirement.
        - For enrollees, states must continue to provide Medicaid coverage during the 30-day opportunity period. If the individual cannot show compliance or that they are not subject to the requirement, the state must disenroll the individual no later than the end of the month following the end of the 30-day opportunity period.

- Impact on premium tax credit eligibility: Any individual who would have been eligible for Medicaid for a month but for the individual's failure to satisfy a work requirement is not eligible to receive a premium tax credit for an ACA marketplace plan for that month.
- States may NOT receive a waiver for the work requirement mandate.
- State grants: $200M included for grants to states to implement work requirements or conduct eligibility determinations. $100M is split evenly between 50 states and DC, the other $100M is divided among the states based on the relative size of their Medicaid population.
- Implementation dates:
  - HHS rulemaking: Interim final rule required no later than June 1, 2026.
  - In general, states must implement work requirements no later than January 1, 2027.
  - States have the option to implement earlier.
  - The Secretary of HHS may grant an exemption to states that make good faith efforts to implement but cannot meet the requirement in time. HHS can delay the implementation date to no later than January 1, 2029, and may terminate an exemption early if HHS finds the state is not acting in good faith or fails to report progress.

- **Modifying cost sharing requirements for certain expansion individuals (Section 71120).**
  - Requires states to impose cost sharing of up to $35 per service on expansion adults with incomes between 100 percent and 138 percent of the federal poverty line. Exempts certain services including primary care services, pregnancy-related services, family planning services and supplies, emergency services, hospice services, mental health services, and substance use disorder services, vaccines recommended by the CDC (and vaccine administration), as well as services provided by FQHCs, behavioral health clinics, and rural health clinics.
  - Law expressly permits providers to reduce or waive application of cost sharing.
  - Takes effect October 1, 2028.
- **NOT INCLUDED in the final version of OBBBA:**
  - Federal Medical Assistance Percentage (FMAP) cuts, per capita caps, or block grants.
  - Penalties for states that use state funds to cover undocumented immigrants.
  - Prohibition on coverage of gender transition procedures under Medicaid.
  - Delay to pending Medicaid Disproportionate Share Hospital (DSH) cuts. $8,000,000,000 in cuts per year are scheduled to take effect starting October 1, 2025. The House version included a DSH extension to October 1, 2028, but it was dropped in the Senate. Congress typically extends the cuts before they can take effect, usually in year-end spending bills.

II. Affordable Care Act Marketplaces

- **Permitting Premium Tax Credit Only for Certain Individuals & Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility Due to Alien Status (Section 71301).**
  - On or after January 1, 2027, only eligible immigrants will be able to receive premium tax credits. Eligible immigrants are those that are lawfully present and are either admitted for permanent residence (ex. green card), granted status as a Cuban and/or Haitian entrant, or are here via a Compact of Free Association per 8 U.S.C. 7 1612(b)(2)(G) (ex. Marshall Islands, Palau, Micronesia). Would exclude lawfully present immigrants such as refugees, asylees, and Temporary Protected Status (TPS) recipients.
- **Disallowing Premium Tax Credit During Periods of Medicaid Ineligibility Due to Alien Status (Section 71302).**

    - After December 31, 2025, lawfully present immigrants with incomes below 100 percent of the federal poverty line who are not eligible for Medicaid due to their immigration status will no longer be eligible for premium tax credits.
- **Pre-enrollment verification of premium tax credit eligibility (Section 71303).**
    - Requires that individuals verify income, immigration status, health coverage status, family size, and other relevant information before they can receive premium tax credits or cost sharing reductions. This effectively ends auto-renewals for subsidized enrollees.
    - Applies to plan years beginning on or after January 1, 2028.
- **No Premium Tax Credits for individuals who enroll during special enrollment periods not related to qualifying life events (Section 71304).**
    - Prohibits Premium Tax Credits for individuals who enroll in marketplace plans during the continuous special enrollment period for individuals with incomes below 150 percent of the federal poverty line or any other special enrollment periods that are not related to events or changes in circumstances specified by the Secretary of HHS.
    - Applies to plan years beginning on or after January 1, 2026.
- **Removes limits on recapture of excess premium tax credits regardless of income (Section 71305).**
    - Removes the cap in current law on the amount of excess Premium Tax Credits that an individual is required to repay if they receive a premium tax credit that is more than what they are ultimately found to be eligible for.
    - Applies to plan years beginning on or after January 1, 2026.
- **NOT INCLUDED in the final version of OBBBA:**
    - Cost sharing reduction payments.
    - Prohibitions on gender affirming care through ACA plans.
    - Extension of enhanced Premium Tax Credits (set to expire on December 31, 2025).
- **Not included in OBBBA, but included in finalized rule.** On June 20, 2025, CMS issued a final rule, the "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Final Rule." The final rule includes several significant policies that were included in the House-passed version of OBBBA (not the final version), including:
    - Shortening the annual Open Enrollment Period (all OEPs must end by December 31, and federally operated exchanges will end their open enrollment periods on December 15).
    - Excluding Deferred Action for Childhood Arrivals (DACA) recipients from enrolling in health plans through the exchanges or receiving premium tax credits or cost sharing reductions.
    - Prohibiting Premium Tax Credits for individuals who failed to "file and reconcile" for a prior year (sunsets at the end of 2026).
    - Ending Special Enrollment Period for individuals with income < 150 percent of federal poverty line.
    - Prohibiting sex-trait modification procedures as an Essential Health Benefit in marketplace plans.
    - Modifying Premium Adjustment Percentage (PAP) methodology and Actuarial Value requirements.

III. Student Loans

- **Establishment Of Loan Limits For Graduate And Professional Students And Parent Borrowers; Termination Of Graduate And Professional Plus Loans (Section 81001).**
    - Graduate and professional students cannot receive a Federal Direct PLUS Loan for any period of instruction beginning on or after July 1, 2026.
    - The maximum annual amount of Federal Direct Unsubsidized Stafford loans beginning July 1, 2026:

        - Graduate student $20,500 a year
        - Professional student $50,000 a year
    - The maximum total amount of Federal Direct Unsubsidized Stafford loans, in addition to the amount borrowed for undergraduate education, that can be borrowed beginning July 1, 2026:
        - Graduate student = $100,000
        - Professional student = $200,000, minus the amount borrowed for any graduate education
    - The maximum amount of overall loans that a student may borrow, not including parental loans or loans under section 428B, is $257,500 beginning on July 1, 2026.
    - Parents can borrow an annual maximum of $20,000 and a total of $65,000 in Federal Direct PLUS loans on behalf of a dependent student beginning on July 1, 2026.
    - The amount of loans a student that is not full-time can borrow will be reduced in direct proportion to the degree to which the student is enrolled in courses.
    - An institution of higher education, at their own discretion, can limit the total amount of loans made for a program of study for students and parents if that limit is applied consistently to all students enrolled in that program of study beginning on July 1, 2026.
    - Students are grandfathered into current rules surrounding PLUS loans if their program of study ends before June 30, 2026, or if they have already enrolled in and received loans and have the lesser of three academic years or the difference between the program length and the length of study remaining as of June 30, 2026.
- **Loan Repayment (Section 82001).**
    - Before July 1, 2028, every borrower who has loans that are in repayment status or on administrative forbearance via an income contingent repayment plan must choose to continue to repay their loans per the Repayment Assistance Plan, the income based repayment plan under 493C, or any other repayment plan authorized under 455(d)(1).
        - On or before July 1, 2028, these borrowers must begin repayment in accordance with their chosen plan.
        - If a borrower fails to choose a repayment plan the borrower will be assigned to either the Repayment Assistance Plan or the income based repayment plan under 493C and begin repayment by July 1, 2028.
    - Borrowers who took out a loan prior to July 1, 2026, can continue to utilize the existing repayment plans (e.g., standard, graduated repayment, and extended repayment). Before June 30, 2028, individuals may still choose to use the income contingent repayment plan if they have not received a loan on or after July 1, 2026, and if they are not a borrower of a Federal Direct PLUS loan made on behalf of a dependent student. This portion also notes that the income-based repayment plan will not be available to an excepted Consolidated Loan received before July 1, 2026. Beginning July 1, 2026, these borrowers may also choose to repay their loans per the Repayment Assistance Plan, except for excepted loans.
    - Loans made on or after July 1, 2026, will be restricted to being repaid via only two repayment plans, this includes Federal Direct Consolidated Loans:
        - The Standard Plan: A fixed monthly repayment amount repaid over a fixed period based on the total outstanding principal of all the loans borrowed on or after July 1, 2026, at the time the borrower enters repayment. If a borrower does not choose or properly recertify a repayment plan the Standard Plan will be chosen on behalf of the borrower.
            - <$25,000 = 10 years
            - $25,001 - $50,000 = 15 years
            - $50,001 -$100,000 = 20 years
            - More than $100,000 = 25 years
        - The income-based Repayment Assistance Plan (RAP): These loans will be forgiven after 360 monthly qualifying payments and payments will be based on

the adjusted gross income of the borrower. A borrower must recertify their income each year. If a borrower makes an on-time applicable payment and that payment does not pay the total amount of interest owed for the month, interest will not accrue and if the outstanding principal is not reduced by at least $50 then the outstanding principal will be reduced by the lesser of $50 or the amount paid by the borrower for the month minus the amount of that payment that was applied to the principal balance. The minimum payment under this plan will be $10 a month.
        - <$10,000 = $120
        - $10,001 - $20,000 = 1 percent
        - $20,001 - $30,000 = 2 percent
        - $30,001 - $40,000 = 3 percent
        - $40,001 - $50,000 = 4 percent
        - $50,001 - $60,000 = 5 percent
        - $60,001 - $70,000 = 6 percent
        - $70,001 - $80,000 = 7 percent
        - $80,001 - $90,000 = 8 percent
        - $90,001 - $100,000 = 9 percent
        - $100,001 or more = 10 percent
    - Borrowers may switch between the Standard Plan and the RAP at any time. On or after July 1, 2026, a borrower will be required to repay an excepted loan (Federal Direct PLUS Loan or Federal Direct Consolidated Loan), including borrowers who had excepted loans before this date, under the Standard Plan.
- **Deferment; Forbearance (Section 82002).**
    - Removes the ability for borrowers to defer their loans based on unemployment or economic hardship for loans made on or after July 1, 2027.
    - Loans issued on or after July 1, 2027, are only eligible for forbearance for nine months out of a 24-month period.
- **Loan Rehabilitation (Section 82003).**
    - Allows FEEL, Direct, and Perkins Loans to be rehabilitated twice instead of once beginning July 1, 2027, with a minimum monthly payment of $10.
- **Public Service Loan Forgiveness (Section 82004).**
    - Adds in the Repayment Assistance Plan as a repayment plan that can be used for PSLF while acknowledging that the existing income-based repayment plans will be sunset and will no longer be an eligible repayment plan after that time.
- **Federal Pell Grant Exclusion Relating to Other Grant Aid (Section 83004).**
    - Beginning July 1, 2026, a student will not be eligible for a Federal Pell Grant for any period that they receive grant aid from non-federal sources if that aid equals or exceeds the cost of attendance.
- **Ineligibility Based on Low Earning Outcomes (Section 84001).**
    - Beginning July 1, 2026, if a program is low earning, meaning:
        - individuals with only a high school diploma earn more (per the median) than an individual with an undergraduate degree
        - individuals with only an undergraduate degree earn more (per the median) than individuals with a graduate or professional degree

      Then students who want to enroll in that program will not be able to take federal student loans for that program.
- **Delay of Rule Relating to Borrower Defense to Repayment (Section 85001).**
    - 87 Fed Reg 65904 will not be effective (delayed implementation) until July 1, 2035, and borrower defenses will revert to regulations that were in place on July 1, 2020.
- **Delay of Rule Relating to Closed School Discharges (Section 85002).**

    - 87 Fed Reg 65904 will not be effective (delayed implementation) until July 1, 2035, as related to closed school discharges and the original language of the Federal Regulations will be in effect.
- **Exclusion for Employer Payments of Student Loans (Section 70412).**
    - For payments made after December 31, 2025, the amount of money that may be excluded from the gross income of an individual for educational assistance will be increased in accordance with a cost-of-living adjustment.
- **Certain Postsecondary Credentialing Expenses Treated as Qualified Higher Education Expenses for Purposes of 529 Accounts (Section 70414).**
    - Qualified postsecondary credentialing expenses now includes tuition, fees, books, supplies, and equipment required for the enrollment or attendance of a designated beneficiary in a recognized postsecondary credential program, or any other expense incurred in connection with enrollment in or attendance at a recognized postsecondary credential program if such expense would, if incurred in connection with enrollment or attendance at an eligible educational institution, fees for testing if such testing is required to obtain or maintain a recognized postsecondary credential, and fees for continuing education if such education is required to maintain a recognized postsecondary credential.
- **Extension and Modification of Exclusion from Gross Income of Student Loans Discharged on Account of Death or Disability (Section 70119).**
    - Permanently extends the exclusion from a taxpayer's income any income resulting from the discharge of student debt on account of death or total disability of the student. This provision also adds a requirement that the taxpayer provide a work-eligible Social Security number to claim such an exclusion. This provision applies to discharges after December 31, 2025.

IV. Medicare Physician Payment

- **Temporary Payment Increase Under the Medicare Physician Fee Schedule to Account for Exceptional Circumstances (Sec. 71202).**
    - Provides a one-year 2.5 percent increase to the Medicare Physician Fee Schedule for services furnished on or after January 1, 2026, and before January 1, 2027.
    - This increase would apply on top of the statutory 0.75 percent update for qualifying APM participants and 0.25 percent update for all other physicians under current law.
    - Implementation date: January 1, 2026.

V. Supplemental Nutrition Assistance Program (SNAP)

- **Re-evaluation of thrifty food plan (Section 10101).**
    - Limits Secretary of Agriculture's discretion in determining "thrifty food plan" (which is the basis for SNAP benefit amounts), including by freezing the current thrifty food plan (last updated in 2021) until October 1, 2027, and requiring that future updates to the thrifty food plan be cost neutral. The Congressional Budget Office (CBO) estimates this will reduce federal SNAP spending by $37 billion over 10 years.
    - Takes effect on July 4, 2025, but unclear how quickly states will be able to implement.
- **Modifications to SNAP work requirements for able-bodied adults (Section 10102).**
    - Narrows exceptions to SNAP work requirements, including by: applying the requirements to individuals ages 18-65 (previously18-55); limiting exception for parents or other caretakers of dependent children to children under 14 years old; and ending the exception for former foster children under age 24.
    - Narrows the Secretary of Agriculture's discretion to waive requirements in an area based on an area not having a sufficient number of jobs—waivers only permitted in areas where unemployment is over 10 percent or, in "noncontiguous States" (Hawaii

and Alaska), in areas where unemployment is at least1.5 times the national unemployment rate.
    - CBO estimates these changes will reduce federal spending by $68.6 billion over 10 years.
    - Takes effect July 4, 2025, but "noncontiguous States" (again, HI/AK) may receive an exemption from the Secretary of Agriculture through December 31, 2028.
- **Availability of standard utility allowances based on receipt of energy assistance (Section 10103).**
    - Limits automatic qualification for standard utility allowance (a proxy for actual household utility costs for purposes of determining SNAP eligibility) to households receiving of Low-Income Home Energy Assistance Program (LIHEAP) benefits that include an elderly or disabled member; limits ability of households w/o elderly or disabled members to exclude energy assistance from household income or treat assistance payments as expenses for purposes of SNAP eligibility.
    - CBO estimates this section will reduce federal spending by $5.94 billion over 10 years.
    - Takes effect July 4, 2025, but unclear how quickly states will be able to implement.
- **Restrictions on internet expenses (Section 10104).**
    - Excludes internet costs from determining "excess shelter deduction" for purposes of determining SNAP eligibility. CBO estimates this will save $10.09 billion over 10 years.
    - Takes effect July 4, 2025, but unclear how quickly states will be able to implement.
- **Matching funds requirements (Section 10105).**
    - Requires states to pay a state share of SNAP costs if their payment error rate is at least 6%, with the state share equaling 5%, 10%, or 15%, depending on the state's payment error rate (with states with a higher error rate paying a higher state share). CBO estimates this will reduce federal spending by $40 billion over 10 years.
    - Effective dates:
        - For states with payment error rates below a certain threshold (13.33%), October 1, 2027.
        - For states with payment error rates above a certain threshold, October 1, 2028, or October 1, 2029, depending on state's payment error rate in FY 2026.
- **Administrative cost sharing (Section 10106).**
    - Reduces the federal share of SNAP administrative costs from 50% to 25%, effective October 1, 2026.
    - CBO estimates this will reduce federal spending by $24.66 billion over 10 years.
- **National education and obesity prevention grant program (Section 10107).**
    - Eliminates annual funding for National Education and Obesity Prevention Grant Program (funded at $538 million in 2025) after FY 2025. CBO estimates this will reduce federal spending by $5.47 billion over 10 years.
    - Effective immediately—no funding provided after FY 2025.
- **Alien SNAP eligibility (Section 10108).**
    - Limits SNAP eligibility for immigrants to those who are lawfully present and are either admitted for permanent residence (ex. green card), granted status as a Cuban and/or Haitian entrant, or are here via a Compact of Free Association per 8 U.S.C. 7 1612(b)(2)(G) (e.g., Marshall Islands, Palau, Micronesia). A household that includes a member who is an immigrant that is not eligible for SNAP may still receive SNAP benefits, but the excluded individual's income is still considered for purposes of determining eligibility. CBO estimates this will reduce federal spending by $1.9 billion over 10 years.
    - Effective immediately, July 4, 2025.

VI. Other Issues

- **Enhancement of Department of Defense Resources for Improving the Quality of Life for Military Personnel (Section 20001).**
  - FY 2025 to remain available until September 30, 2029, $2,000,000,000 for the Defense Health Program.
- **Rural health transformation program (Section 71401).**
  - Appropriates $50,000,000,000 over five years (FY 2026-FY 2030) to provide allotments to states to make payments to rural health care providers and for other specified purposes. 50 percent of the funds will be divided equally between the 50 states (DC and the territories not eligible), and the remaining 50 percent will be distributed according to a methodology to be developed by the Secretary of HHS. No matching funds required. States required to submit a plan for how they will use funding to improve rural health.
  - States must apply for allotments not later than December 31, 2025.
- **Fees Relating to Applications for Adjustment of Status (Section 100013).**
  - For Fiscal Year 2025 the fee for adjustment of status will be the greater of $1,500 or an amount as the Attorney General establishes by rule. The fees will be updated each year in accordance with inflation.