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THE 2014 FARM BILL AND SNAP: IMPROVING THE DIETS OF LOW-INCOME AMERICANS?

Mathew Swinburne*

Diet-related illnesses present a public health challenge often disproportionately borne by people of color, and results in significant human and economic costs. Evidence that approximately 35 percent of American adults and 17 percent of its youth are obese serves as a starting point for consideration of these health issues.[1] This obesity epidemic results in approximately $147 billion in annual medical costs, almost 10 percent of all U.S. medical spending.[2] Unfortunately, there are racial health disparities within this epidemic. While 33.4 percent of white adult Americans are obese, 47.8 percent of their black and 42 percent of their Hispanic counterparts are obese.[3] Coronary heart disease (CHD), a diet-related illness, kills 370,000 Americans annually and costs the United States approximately $108.9 billion each year.[4] Again, there are unsettling racial disparities in the CHD affected population with black Americans dying at a much higher rate than white Americans.[5] Diabetes, yet another diet-related illness, affects 29.1 million Americans[6] and costs our nation $245 billion in

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[1] Cynthia L. Ogden et al., *Prevalence of Childhood and Adult Obesity in the United States, 2011-2012*, 311 JAMA 806, 810–11 Tables 3 & 4 (2014), http://jama.jamanetwork.com/article.aspx?articleid=1832542.

[2] Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer and Service Specific Estimates*, 28 HEALTH AFF. 822, 822 (2009), http://content.healthaffairs.org/content/28/5/w822.full.html.

[3] Ogden, *supra* note 1, at 811 Table 4.

[4] *Heart Disease Fact Sheet*, CTR. DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_disease.htm (last updated Feb. 19, 2015).

[5] *See* Cathleen D. Gillespie et al., *Coronary Heart Disease and Stroke Deaths—United States, 2009*, *in* 62 MORBIDITY & MORTALITY WKLY. REP. 157, 158 (2013), http://www.cdc.gov/mmwr/pdf/other/su6203.pdf (indicating that age adjusted death rates from coronary heart disease were 20 percent higher in black Americans); *see also* Monika M. Safford et al., *Association of Race and Sex with Risk of Incident Acute Coronary Heart Disease Events*, 308 JAMA 1768, 1772 (2012), http://jama.jamanetwork.com/article.aspx?articleid=1389611 (finding that black men and women had twice the age standardized rate of fatal coronary heart disease).

[6] CTR. FOR DISEASE CONTROL AND PREVENTION, NATIONAL DIABETES STATISTICS REPORT 1 (2014), http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf.

annual direct and indirect medical costs.[7] However, black and Hispanic Americans are almost twice as likely to be diagnosed with this illness.[8]

Despite these disturbing figures, one study indicates that only 10 percent of Americans have a "good diet" based on Healthy Eating Index (HEI) scores,[9] a measure created by the United States Department of Agriculture (USDA) to evaluate an individual's adherence to national dietary guidelines.[10] In another survey, 38 percent of Americans reported consuming fruits less than once a day and 23 percent reported consuming vegetables less than once a day.[11] Recent studies show that 14.3 percent of U.S. households are food insecure, indicating that their access to sufficient food is limited by a lack of money and other resources.[12] Racial disparities are also present with food insecurity, particularly in black and Hispanic households that are more than twice as likely to experience food insecurity than their white counterparts.[13]

Unfortunately, we live in a society where eating a healthful diet can be challenging largely because of the food system we have created. A *food system* is a system "comprised of all the processes involved in getting food from farm to table to disposal, including producing, processing, distributing, preparing, marketing, accessing,

[7] *Id.* at 8.
[8] *See id.* at 2 (noting that while 7.6% of people age 20 and older diagnosed with Diabetes from 2010 to 2012 were white, 13.2% and 12.8% of the people were black and Hispanic respectively).
[9] P. Peter Basiotis et al., *The Healthy Eating Index 1999-2000: Charting Dietary Patterns of Americans*, *in* 16 FAM. ECON. & NUTRITION REV. 39, 41 (2004), http://www.cnpp.usda.gov/sites/default/files/archived_projects/FENRV16N1.pdf.
[10] *Healthy Eating Index*, U.S. DEP'T OF AGRIC., http://www.cnpp.usda.gov/healthyeatingindex (last visited Sept. 26, 2015).
[11] CTR. FOR DISEASE CONTROL AND PREVENTION, STATE INDICATOR REPORT ON FRUITS AND VEGETABLES 8 Table 1 (2013), http://www.cdc.gov/nutrition/downloads/state-indicator-report-fruits-vegetables-2013.pdf.
[12] ALISHA COLEMAN-JENSEN ET AL., U.S. DEP'T OF AGRIC., HOUSEHOLD FOOD SECURITY IN THE UNITED STATES IN 2013, 4–8 (2014), http://www.ers.usda.gov/media/1565415/err173.pdf.
[13] *See id.* at 13 Table 2 (indicating that 10.6 percent of white households experienced food insecurity compared to 26.1 percent of black and 23.7 percent Hispanic households).

consuming, and disposing."[14] From a production standpoint, we incentivize corn and soybeans, the primary ingredients in processed foods, by providing federal subsidies and crop insurance, while depriving farmers who grow fruits and vegetables of equivalent support.[15] These policies are reflected in the fact that only 2 percent of our cropland is used to grow fruits and vegetables,[16] while corn and soybeans account for more than 50 percent.[17] Physical access to healthy food can also be a challenge. The USDA estimates that 23.5 million Americans live in *food deserts*, which are low-income communities "without ready access to fresh, healthy, and affordable food."[18] Production incentives and food deserts are just a sample of the challenges in our current national food system,[19] within which it is more expensive to eat a healthy diet than an unhealthy one.[20] And when fiscal barriers to a healthy diet are erected, they create the potential to broaden the racial disparities in diet-related illnesses. This danger looms largely because of the simple fact that Hispanic Americans are approximately two and a half times more likely and black Americans almost three times more likely than their white counterparts to live below the poverty line.[21]

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[14] Roni A. Neff et al., *Food Systems and Public Health Disparities*, 4 J. HUNGER & ENVTL. NUTRITION 282, 283 (2009).

[15] *Id.* at 288; *see also* UNION OF CONCERNED SCIENTISTS, ENSURING THE HARVEST: CROP INSURANCE AND CREDIT FOR A HEALTH FARM AND FOOD FUTURE 1 (2012), http://www.ucsusa.org/sites/default/files/legacy/assets/documents/food_and_agriculture/Ensuring-the-Harvest_summary.pdf (discussing the federal support provided to commodities and the lack of equivalent support for fruit and vegetable farmers).

[16] UNION OF CONCERNED SCIENTISTS, *supra* note 15, at 2.

[17] U. S. DEP'T OF AGRIC., FARMS AND FARMLAND: NUMBER, ACREAGE, OWNERSHIP, AND USE 2 (2014) http://www.agcensus.usda.gov/Publications/2012/Online_Resources/Highlights/Farms_and_Farmland/Highlights_Farms_and_Farmland.pdf.

[18] U. S. Dep't of Agric., *Food Deserts*, AGRIC. MARKETING SERVICES, http://apps.ams.usda.gov/fooddeserts/fooddeserts.aspx (last visited Oct. 22, 2015).

[19] *See* Neff, *supra* note 14, at 283–284 (discussing elements in our food system that serve as obstacles to a healthier diet).

[20] *See* Mayuree Rao et al., *Do Healthier Foods and Diet Patterns Cost More than Less Healthy Options? A Systematic Review and Meta-analysis*, 3 BRIT. MED. J. OPEN 1, 15 (2013), http://bmjopen.bmj.com/content/3/12/e004277.full.pdf (finding that on average it cost $1.50 more per day to eat healthy).

[21] *See* CARMEN DE NAVAS-WALT & BERNADETTE D. PROCTOR, U. S. CENSUS BUREAU, INCOME AND POVERTY IN THE UNITED STATES: 2013 13 Table 3 (2014), http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf (indicating that in 2013, 9.6 percent of white Americans lived below the

Given the inherent complexity of our national food system, in which the federal government is a major player, there are several changes that could help Americans eat healthier diets. The Supplemental Nutrition Assistance Program (SNAP) is a federal program that has the potential to affect the direction of our food system. SNAP, formerly known as food stamps, provides approximately 46.5 million low-income Americans with funds to purchase food.[22] This article evaluates recent changes made to the SNAP program by the 2014 Farm Bill in an effort to adjust our food system and facilitate healthier diets for low-income Americans. Specifically, this piece analyzes (1) how the revised vendor standards will affect the food environment and whether this change will lead to improved diets, and (2) the Food Insecurity Nutrition Incentive (FINI) Program's ability to increase both produce consumption and potential partnerships generated by the Hospital Readmission Reduction Program.

I. SNAP OVERVIEW

A. Background

SNAP has roots in World War II with the creation of the first national food stamp program in 1939,[23] an experimental model linking poor Americans with surplus agriculture goods. The original system required participants to purchase orange stamps that could be used for any type of food.[24] For every dollar of orange stamps purchased, the participant received fifty cents of blue stamps that could only be used to purchase designated surplus agricultural goods.[25] The program was successful and at its peak had approximately 4 million participants; however, it was cancelled in 1943 because of the country's improved

poverty level while 23.2 percent of Hispanic and 27.2 of black Americans lived below the poverty level).

[22] *Supplemental Nutrition Assistance Program Participation and Costs*, U. S. DEP'T OF AGRIC., http://www.fns.usda.gov/sites/default/files/pd/SNAPsummary.pdf (last visited Sept. 4, 2015) [hereinafter *SNAP Participation and Costs*].

[23] *The History of SNAP*, SNAP TO HEALTH, http://www.snaptohealth.org/snap/the-history-of-snap/ (last visited Nov. 20, 2015).

[24] *Id.*

[25] *Id.*

economic conditions.[26] Twenty-one years later Congress passed the Food Stamp Act of 1964 "to provide for improved levels of nutrition among low income households."[27] Over the next fifty years the Food Stamp program underwent considerable changes, including a new name in 2008—the Supplemental Nutrition Assistance Program (SNAP).[28]

Today SNAP is the nation's largest nutrition assistance program for low-income Americans and it is an economic powerhouse. In 2014, approximately 46.5 million Americans participated in this program, which cost the federal government approximately 74 billion dollars.[29] For additional perspective, SNAP is the largest expenditure in the Farm Bill, and for fiscal year 2014 to fiscal year 2018, 391 billion dollars are budgeted for its support.[30] This represents 80 percent of the 2014 Farm Bill's budget.[31]

According to the USDA, whites represent the largest group of SNAP beneficiaries at 40.2 percent, and black Americans represent 25.7 percent.[32] This appears to indicate that white Americans rely on the SNAP program significantly more than their black counterparts; however, this is misleading. According to the Census Bureau's most recent numbers, 62.1 percent of Americans self-identified as white.[33] In comparison, 13.2 percent of Americans identified as black.[34] So while white Americans outnumber black Americans at a rate of 5 to 1 in the general population, they outnumber black Americans less than 2

[26] *A Short History of SNAP*, U. S. DEP'T OF AGRIC. (Nov. 20, 2014), http://www.fns.usda.gov/snap/short-history-snap [hereinafter SNAP History].
[27] Food Stamp Act of 1964, Pub. L. No. 88-525, § 1, 78 Stat. 703, 703 (1964).
[28] *See* SNAP History, *supra* note 26 (discussing the transformation of the Food Stamp Program into the current SNAP program).
[29] *See Snap Participation and Costs*, *supra* note 22.
[30] JIM MONKE, CONG. RESEARCH SERV., R42484, BUDGET ISSUES THAT SHAPED THE 2014 FARM BILL 1 (2014), http://nationalaglawcenter.org/wp-content/uploads/assets/crs/R42484.pdf.
[31] *Id.*
[32] KELSEY FARSON GRAY, U.S. DEP'T OF AGRIC., CHARACTERISTICS OF SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM HOUSEHOLDS: FISCAL YEAR 2013 57 Table A.21 (2014), http://www.fns.usda.gov/sites/default/files/ops/Characteristics2013.pdf.
[33] *State & County QuickFacts: USA*, U.S. CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/00000.html (last visited Aug. 31, 2015).
[34] *Id.*

to 1 in the SNAP beneficiary population. This demonstrates that a higher percentage of black Americans receive SNAP benefits, and serves as an indicator of the racial economic disparities in this country. But at the same time it reveals that SNAP has the potential to address some of the racial disparities in diet-related illness. However, before we can examine how the economic clout of this program and the recent changes made by the 2014 Farm Bill can be leveraged to improve the diets of low-income Americans, we must consider how SNAP currently functions. The following sections examine basic aspects of the federal/state partnership required to administer the program, participant eligibility requirements, and vendor participation requirements.

B. Federal/State Partnership

SNAP provides eligible low-income households with a monthly allotment of nutrition benefits to purchase food.[35] These benefits are distributed on an Electronic Benefits Transfer (EBT) card which functions like a debit card.[36] To administer this program the USDA's Food and Nutrition Service partners with state welfare agencies.[37] The federal government provides 100 percent of the benefits funding[38] and has established baseline requirements for numerous aspects of the SNAP program, including household eligibility requirements, benefit calculations, and vendor

[35] *See* 7 U.S.C. § 2012(b) (2006) (defining allotment as the "total value of benefits a household is authorized to receive during each month."); *see also* 7 U.S.C. § 2012(d) (2006) (defining benefit as the "value of supplemental nutrition assistance provided to a household"); 7 U.S.C. § 2017(a) (2006) (describing how the value of a household's SNAP benefit is calculated).

[36] *See* 7 U.S.C. § 2016 (2006) (requiring the use of EBT cards). EBT is available in all 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. *General Electronic Benefit Transfer (EBT) Information*, U. S. DEP'T OF AGRIC. (Sep. 24, 2015), http://www.fns.usda.gov/ebt/general-electronic-benefit-transfer-ebt-information.

[37] *See* 7 C.F.R. § 271.3(a) (2015) (delegating federal administration of the SNAP program to the Food and Nutrition Service); *see also* 7 C.F.R. § 271.4(a) (2015) (delegating specific local administrative functions to the states).

[38] RANDY ALISON AUSSENBERG, CONG. RESEARCH SERV., R42505, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP): A PRIMER ON ELIGIBILITY AND BENEFITS 14 (2014), https://www.fas.org/sgp/crs/misc/R42505.pdf.

requirements.[39] Each state is responsible for the administration of SNAP benefits within its jurisdiction, which includes, but is not limited to, certification of eligible households, issuance of benefits, developing and maintaining complaint procedures, training, and specific record keeping and reporting functions.[40] To help minimize the economic burden of administering SNAP, the federal government also provides for 50 percent of the states' administrative costs.[41]

C. SNAP Eligibility

It is important to understand who is eligible for SNAP benefits because these individuals—the poor—represent some of the most nutritionally vulnerable. In fact, the SNAP eligibility regulations state that "[p]articipation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet."[42] There are two ways to qualify for SNAP: (1) meeting the "traditional" eligibility requirements; or (2) automatic or "categorical" eligibility based on eligibility for other specific low-income assistance programs.[43]

1. Traditional

Traditional eligibility looks at a household's citizenship and wealth. The citizenship element requires beneficiaries to be U.S. citizens or a member of specifically delineated group.[44] To ensure that SNAP resources target the neediest households, traditional financial eligibility requirements look at three factors: a household's gross income, net income, and resources.[45] The process for calculating the

[39] *See* 7 U.S.C. § 2014 (2006) (providing beneficiary eligibility requirements); 7 U.S.C. § 2017 (2006) (providing benefit calculation procedures); 7 U.S.C. § 2018 (2006) (establishing eligibility requirements for food vendors to participate in the SNAP program).
[40] 7 C.F.R. § 271.4 (2015).
[41] 7 C.F.R. § 277.4(b) (2015).
[42] 7 C.F.R. § 273.9(a) (2015).
[43] GENE FALK & RANDY ALISON AUSSENBERG, CONG. RESEARCH SERV., R42054, THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP): CATEGORICAL ELIGIBILITY 1 (2014), https://www.fas.org/sgp/crs/misc/R42054.pdf.
[44] *See* 7 C.F.R. § 273.4 (2015) (listing all of the citizenship or alien status requirements for the SNAP program).
[45] *See* 7 C.F.R. § 273.9 (2015) (providing income guidelines); *see also* 7 C.F.R. § 273.8 (2015) (providing resource guidelines).

income and asset limits is very complex and, therefore, this article covers only the basic steps to demonstrate that the SNAP program targets the most economically vulnerable.

First, traditional eligibility requires that households in the contiguous 48 states and the District of Columbia have a gross monthly income below 130 percent of the federal poverty level for the 48 contiguous states and the District of Columbia.[46] However, in Hawaii and Alaska the gross income restriction is limited to 130 percent of the federal poverty level in each respective state.[47] This creates a higher income threshold for these states to account for the higher cost of living in their jurisdictions. Second, traditional eligibility requires that households in the contiguous 48 states and the District of Columbia have a net income below 100 percent of the federal poverty guidelines[48] after specific income exclusions and deductions are taken into account.[49] For perspective, the 2015 federal poverty level for a family of four is $24,250.[50] Households that contain an elderly or disabled member need only meet SNAP's net income eligibility, a concession to the increased economic costs of caring for these individuals.[51] Third, traditional eligibility places a resource cap on SNAP participants. To receive SNAP benefits, federal regulations set a household asset limit at $2,000.[52] However, households with disabled members over 60 years of age are allowed up to $3,000 in assets.[53] There is also an extensive list of exemptions that include assets such as the home and surrounding property, household items, and vehicles utilized for specific purposes, e.g., a vehicle used to generate income for the household.[54]

[46] 7 C.F.R. § 273.9 (a)(1)(i).
[47] 7 C.F.R. § 273.9(a)(1)(ii)-(iii).
[48] 7 C.F.R. § 273.9(a)(2)(i).
[49] *See* 7 C.F.R. § 273.9(c) (listing the extensive series of income exclusions); *see also* 7 C.F.R. § 273.9(d) (providing the list of income deductions for the SNAP income eligibility calculation).
[50] Annual Update of the HHS Poverty Guidelines, 80 Fed. Reg. 3236, 3237 (Jan. 22, 2015).
[51] 7 C.F.R. § 273.9(a) (2015).
[52] 7 C.F.R. § 273.8(b) (2015).
[53] *Id.*
[54] *See* 7 C.F.R. § 273.8(e) (2015) (delineating the list of assets excluded from a household resource calculation).

2. Categorical

Categorical eligibility eliminates the requirements listed above for households that have already met financial eligibility rules for another specified low-income program.[55] This is intended to eliminate redundant administrative steps, facilitate beneficiary entry to SNAP, and improve coordination among low-income assistance programs.[56] The low-income assistance programs that can automatically qualify a household for SNAP include Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and state-financed General Assistance (GA) programs.[57] Again, the categorical exemption highlights that SNAP beneficiaries are among the most vulnerable to food insecurity, relying on a variety of federal and state programs to make ends meet.

D. Vendor Requirements

With 46.5 million Americans spending approximately $70 billion dollars in SNAP benefits during 2014,[58] food retailers are eager to participate in this program. In fiscal year (FY) 2014, over 261,000 stores across 25 categories vied for SNAP customers.[59] However, to access this large pool of customers, retailers must qualify for the program by meeting several federal standards.[60] These standards include an evaluation of a store's food offerings and the business's integrity.[61]

[55] *See* 7 C.F.R. § 273.8(a) (2015) (stating that households that are eligible for assistance programs under § 273.2(j)(2) or § 273.2(j)(4) do not have to meet the asset requirements of the section); *see also* 7 C.F.R. § 273.9(a) (2015) (stating that households that are eligible for assistance programs under § 273.2(j)(2) or § 273.2(j)(4) do not have to meet the asset requirements of the section).
[56] H.R. REP. No. 99-271, pt. 1, at 142 (1985).
[57] GENE FALK & RANDY ALISON AUSSENBERG, *supra* note 43, at 2.
[58] *SNAP Participation and Costs*, *supra* note 22.
[59] U. S. DEP'T OF AGRIC., SNAP RETAILER MANAGEMENT 2014 ANNUAL REPORT 7 (2015), http://www.fns.usda.gov/sites/default/files/snap/2014-SNAP-Retailer-Management-Annual-Report.pdf [hereinafter SNAP RETAILER MANAGEMENT REPORT].
[60] *See* 7 C.F.R § 278.1 (2015) (describing retailer requirements and the retailer application process).
[61] *See* 7 C.F.R. § 278.1(b)(1)(i) (providing vendor stocking requirements); *see also* 7 C.F.R. § 278.1(k)(3) (outlining business integrity standard).

II. THE 2014 FARM BILL AND THE NEW SNAP VENDOR STANDARDS

A. Farm Bill History

The Farm Bill has its roots in Franklin Delano Roosevelt's New Deal. In 1933, the Agriculture Adjustment Act (AAA) was passed in an effort to help America's struggling farms during the great depression.[62] During this time there was a massive agricultural surplus that had drastically driven down the price of staple crops and products.[63] The AAA provided subsidies for U.S. farmers to stop production of seven basic agricultural commodities: wheat, cotton, corn, hogs, rice, tobacco, and milk.[64] The hope was that this measure would decrease the supply of these goods and as a result drive up staple crop prices.[65]

Today, the Farm Bill has become an omnibus piece of legislation with a massive budget.[66] The bill is reauthorized every 5-7 years and typically addresses a wide range of issues including commodity programs, conservation, rural development, crop insurance, and nutrition.[67] Most important for this article, the Farm Bill's nutrition title deals with the reauthorization of the SNAP

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[62] Kathleen Masterson, *The Farm Bill: From Charitable Start to Prime Budget Target*, NATIONAL PUBLIC RADIO (Sept. 26, 2011), http://www.npr.org/sections/thesalt/2011/09/26/140802243/the-farm-bill-from-charitable-start-to-prime-budget-target (discussing the history of the Farm Bill).

[63] *Id.*

[64] *See* Agricultural Adjustment Act of 1933, Pub. L. No. 73-10, § 8, 48 Stat. 31, 34 (1993) (providing the Secretary of Agriculture with the authority to reduce acreage or production of basic agricultural commodities through agreements or other voluntary means); *see also id.* § 11 at 38 (defining basic agricultural commodities as wheat, cotton, corn, hogs, rice, tobacco, and milk).

[65] *See id.* § 2 at 32 (stating that it is the policy of Congress "to establish and maintain such balance between the production and consumption of agricultural commodities, and such marketing conditions therefor, as will reestablish prices to farmers at a level that will give agricultural commodities a purchasing power with respect to articles that farmers buy. . . .").

[66] RENEE JOHNSON & JIM MONKE, CONG. RESEARCH SERV., RS22131, WHAT IS THE FARM BILL? 1 (2014), https://www.fas.org/sgp/crs/misc/RS22131.pdf; *see also* the Agriculture Act of 2014, Pub. L. No. 113-79, 128 Stat. 649 (2014) (containing ten titles addressing a broad range of topics).

[67] *See* Agriculture Act of 2014, *supra* note 66.

program and changes to its administration.[68] The most recent Farm Bill, the Agriculture Act of 2014, reauthorized the SNAP program for 391 billion dollars over the next five years.[69] It also made two important changes to SNAP that have the potential to improve food security and healthy food access for low-income Americans. The first change is a modification of vendor requirements, which will require SNAP vendors to carry additional healthy options.[70] The second change creates the Food Insecurity Nutrition Incentive (FINI) program, which will support a series of incentive programs, aimed at increasing fruit and vegetable consumption among SNAP beneficiaries.[71] But what are the implications of these changes and how can they be made more effective?

B. New Vendor Standards

Vendors must meet specific standards to participate in the SNAP program. One of these standards requires that (1) vendors sell certain varieties of foods in each of the four staple categories, or (2) 50 percent of the store's retail sales must come from the sale of eligible staple foods.[72] The eligible staple food categories include (1) poultry, meat, and fish; (2) bread and cereal; (3) vegetables and fruits; and (4) dairy products.[73] Prior to the 2014 Farm Bill, vendors were required to carry at least three varieties in each of the staple food categories and had to provide perishable options in at least two of the food categories.[74] Now, SNAP vendors must carry at least seven varieties in each of the staple food categories and provide perishable options in

[68] *Id.* §§ 4001-4033.
[69] MONKE, *supra* note 30.
[70] Agriculture Act of 2014, § 4002(a) (amending 7 U.S.C. § 212(p)(1)(A) to require retail stores to carry at least 7 varieties in each staple food category and perishable foods in at least 3 of the categories).
[71] *Id.* § 4208 at 826.
[72] 7 C.F.R. § 278.1(b)(1)(i) (2015).
[73] 7 C.F.R § 271.2 (2015).
[74] *See* Food Stamp Program: Revision to the Retail Food Store Definition and Program Authorization Guidance, 66 Fed. Reg. 2795, 2799 (Jan. 12, 2001) (creating the requirement that vendors have at least three varieties of food items in each staple food category and the requirement that perishable foods are available in at least two categories).

at least three of the categories.[75] This change to the vendor standard has two intended outcomes: (1) decrease SNAP fraud by making it harder for unscrupulous vendors to enter the system, and (2) increase access to healthy food options.[76]

C. New Vendor Standard = Healthier Diets?

To evaluate whether the new vendor standard will result in healthier diets, it is necessary to determine if it indeed increases access to healthy food and to assess the response of SNAP beneficiaries to any potential increases. There are 25 categories of vendors approved to accept SNAP benefits.[77] The change in vendor stocking requirements will have little effect on large food retailers like supermarkets, super stores, and grocers because these stores already carry a wide variety of the four staple food categories and likely have more than 50 percent of their sales from these items. However, the new stocking standard will affect smaller retailers like convenience stores and combination grocery/other (CGO) retailers, which do not stock a variety of healthy foods.[78] CGOs include independent drug stores, dollar stores, and general stores.[79]

By requiring convenience stores and CGOs to stock additional healthy options, what is the potential effect on healthy food access? Convenience stores and CGOs represented the largest group of SNAP

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[75] 7 U.S.C. § 2012(o)(1)(A) (2006). SNAP benefits can only be used at "retail food stores which have been approved for participation in the supplemental nutrition assistance program." 7 U.S.C. § 2013(a) (2006).

[76] Laura Tiehen, *2014 Farm Act Maintains SNAP Eligibility Guidelines and Funds New Initiatives* (July 7, 2014), U. S. DEP'T OF AGRIC., http://www.ers.usda.gov/amber-waves/2014-july/2014-farm-act-maintains-snap-eligibility-guidelines-and-funds-new-initiatives.aspx#.Vb2CfvlViko; *see also* House Committee on Agriculture, Joint Explanatory Statement of the Committee of Conference 1011, http://docs.house.gov/billsthisweek/20140127/CRPT-113hrpt-HR2642-SOM.pdf (stating that change "reduces fraud at retail stores by requiring a more rigorous standard for stores to become eligible to process SNAP benefits").

[77] SNAP RETAILER MANAGEMENT REPORT, *supra* note 59, at 7.

[78] Mary E. Kennelly et al., *Strengthening Vendor Standards in the Supplemental Nutrition at Assistance Program: Are Healthier Foods within Reach*?, 16 J. HEALTH CARE L. & POL'Y 141, 159 (2013).

[79] MICHELE VER PLOEG ET AL., U.S. DEP'T OF AGRIC., ACCESS TO AFFORDABLE AND NUTRITIOUS FOOD: MEASURING AND UNDERSTANDING FOOD DESERTS AND THEIR CONSEQUENCES 62 Table 5.1 (2009), http://www.ers.usda.gov/media/242675/ap036_1_.pdf.

vendors in 2014 with 174,025, which accounted for 66 percent of authorized SNAP vendors.[80] However, they represented only a small portion of SNAP sales at 11.79 percent,[81] but even this small percentage equates to $8.2 billion in sales.[82]

In theory, this change to the vendor stocking standard could potentially increase healthy food access at 174,025 stores, many of which are located in underserved food deserts.[83] But if SNAP vendors choose to leave the program as a result of the new standard, it will undercut the attempt to increase availability. Many vendors will have to deal with additional costs related to obtaining and stocking the newly required items, which include the expense of the items themselves, time required to secure the items, and durable equipment/refrigeration needed to store perishable goods.[84] There are programs currently in place that help small storeowners transition to healthier food selections. For example, the Food Trust organization runs the Healthy Corner Store Initiative.[85] Services provided include healthy food marketing materials, training for store employees on healthy food retailing, connections with food distribution channels to help ensure affordability, and assistance with infrastructure changes such as new shelving and refrigeration.[86] Hopefully, programs like the Healthy Corner Store Initiative will help limit any SNAP vendor attrition due to the new stocking requirement.

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[80] SNAP RETAILER MANAGEMENT REPORT, *supra* note 59, at 7.
[81] *Id.*
[82] *Id.*
[83] *See, e.g.*, Nadine Budd et al., *B'More Healthy: Retail Rewards-Design of Multi-Level Communication and Pricing Intervention to Improve the Food Environment in Baltimore City*, 15 BMC PUB. HEALTH 283, 284 (2015), http://www.biomedcentral.com/content/pdf/s12889-015-1616-6.pdf (describing the food environment of low-income predominately black neighborhoods in Baltimore City as "replete with small convenience-type food stores and nearly devoid of supermarkets").
[84] *See* Kennelly, *supra* note 78, at 165–67 (describing the effects a stricter stocking standard would have on small SNAP retailers—specifically addressing inventory and durable expenses).
[85] THE FOOD TRUST, HEALTHY CORNER STORE INITIATIVE: PHILADELPHIA 2013–2014 (2014), http://thefoodtrust.org/uploads/media_items/corner-store-year-3-report.original.pdf; THE FOOD TRUST, HEALTHY CORNER STORE INITIATIVE 3 (2014), http://thefoodtrust.org/uploads/media_items/healthy-corner-store-overview.original.pdf [hereinafter FOOD TRUST, INITIATIVE].
[86] *See* FOOD TRUST, INITIATIVE, *supra* note 85, at 6–7 (describing the Healthy Corner Store Initiative model).

While access to healthy options is surely a necessary element to their increased consumption, it is not a guarantee. SNAP benefits can be spent on almost any food item;[87] therefore, the purchase does not need to be a healthy item or one of the designated staple foods that vendors are required to carry under the new standard. As a result of the freedom given SNAP beneficiaries, it is important to understand how they use convenience stores and CGOs: these smaller retailers are not used as a primary source for groceries. One study reveals that a mere 0.3 percent of SNAP beneficiaries utilize conveniences stores as their primary source of food.[88] SNAP beneficiaries, like other Americans, conduct the majority of their grocery shopping at supermarkets, with 89.6 percent reporting supermarkets as their primary shopping location.[89] These figures are supported by the fact that 81 percent of SNAP sales are made at supermarkets or superstores,[90] and beneficiaries use convenience stores and CGOs for supplementary purchases.[91]

Although there is no information breaking down SNAP purchases by food type at these locations, there are several insightful studies examining how individuals in low-income communities use convenience stores. Unfortunately, what they reveal is unsettling. Studies of youth shopping patterns reveal that the most popular purchases are energy-dense and nutrient-poor options including chips, candy, and sugar-sweetened beverages.[92] Among adults, the patterns are similar: unhealthy items are purchased most often.[93] This evidence

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[87] *See* 7 C.F.R. § 271.2 (2015) (defining SNAP eligible food as "any food or food product intended for human consumption except alcoholic beverages, tobacco, and hot foods and hot food products prepared for immediate consumption. . .").

[88] JAMES C. OHLS ET AL., MATHEMATIC POL'Y RES., FOOD STAMP PARTICIPANTS' ACCESS TO FOOD RETAILERS 32 Table III.1 (1999), http://www.fns.usda.gov/sites/default/files/retailer.pdf.

[89] *Id.*

[90] SNAP RETAILER MANAGEMENT REPORT, *supra* note 59, at 7.

[91] OHLS, *supra* note 88.

[92] *See, e.g.*, Kelley E. Borradaile et al., *Snacking in Children: The Role of the Urban Corner Stores*, 124 PEDIATRICS 1293, 1294 (2009) (finding that chips, candy, and artificially flavored fruit drinks counted for 33.5%, 21.3%, and 45.7% respectively of all corner store purchases).

[93] *See, e.g.*, Kamila Kiszko et al., *Corner Store Purchases in a Low-Income Urban Community in NYC*, J. COMMUNITY HEALTH Table 3 (2015) (finding that the most

indicates that shopping behaviors need to be changed ─otherwise the new SNAP stocking requirement will simply result in healthy items sitting on the shelf.

Another aspect of low-income (and by extension, SNAP beneficiary) shopping behavior also needs to be examined. Low-income shoppers are acutely price-sensitive in their food shopping because of limited resources.[94] Based on this restriction, these shoppers make complex calculations that address the need to maximize access to sale items from several stores, minimize transportation costs, extend the number of meals per dollar spent, and limit food waste.[95] Price becomes a barrier to healthy purchases when placed in the context of this complex decision process,[96] and food items such as fresh fruits and vegetables are often cut from the shopping list in order to stay on budget.[97] This reality is reflected in the observation of one SNAP beneficiary study: "[p]rice is their primary consideration. Nutrition, while a concern, often takes a distant second place."[98] The tension between price-sensitivity and healthy food is exacerbated when dealing with small retailers who cannot offer nutritious items at the same low prices as supermarkets because they lack economies of scale and appropriate distribution networks.[99] If

common purchases included soda, sugar sweetened beverages, cookies, cakes, candy, and ice cream).

[94] *See* Drew A. Zachary et al., *A Framework for Understanding Grocery Purchasing in a Low-Income Urban Environment*, 23 QUALITATIVE HEALTH RESEARCH 665, 669–73 (2013) (explaining that shoppers "meet their households' needs [by making] cost-effective purchases. . . .[essentially they] form and apply decision strategies based on their available resources, past experiences, and qualities of the physical environment.").

[95] *Id.*

[96] *Id.* at 676 (stating that "limited resources can make it difficult to buy healthy foods while still buying enough food for the household").

[97] Adam Drewnowski & Petra Eichelsdoerfer, *Can Low-Income Americans Afford a Healthy Diet?*, 44 NUTRITION TODAY 246, 246 (2010).

[98] KATHRYN EDIN ET AL., U.S. DEP'T OF ARGIC., SNAP FOOD SECURITY IN-DEPTH INTERVIEW STUDY 42 (2013), http://www.fns.usda.gov/sites/default/files/SNAPFoodSec.pdf.

[99] *See e.g.* MINNEAPOLIS DEP'T OF HEALTH AND FAMILY SUPPORT, MINNEAPOLIS HEALTHY CORNER STORE PROGRAM 7-8 (2012), http://www.health.state.mn.us/divs/oshii/docs/Mpls_Healthy_Corner_Store.pdf (explaining that many convenience stores cannot obtain affordable produce from wholesale suppliers because their orders are too small and as a result shop owners purchase produce from other larger retailers, supermarkets or superstores, to stock

SNAP beneficiaries perceive healthy food items as expensive luxuries at supermarket prices, how will they react to even higher convenience store prices? These higher prices serve as a deterrent to SNAP beneficiaries and limit the effectiveness of the vendor standard as an intervention to improve the diets of low-income Americans.

As a result of these dynamics, simply requiring healthier food availability may not improve the diets of SNAP beneficiaries. Additional intervention is required to ensure the success of the vendor standard and address current shopping behaviors. Prior to the passage of the new vendor standard, several studies examined the impact of interventions to improve the healthy food selection at convenience stores. The observed interventions have included consumer education, healthy food marketing, storeowner and employee training, structure changes to the retail environment, and price incentives.[100] These studies reveal that such interventions have a positive effect on healthy food availability,[101] but the results are mixed when observing the effect on healthy food purchases.[102] The competing outcomes of these

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their shelves); *see also* Rebecca A. Krukowski et al., *Neighborhood Impact on Healthy Food Availability and Pricing in Food Stores*, 35 J. COMMUNITY HEALTH 315, 319 (2010), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071013/pdf/nihms281823.pdf (finding that larger stores provide more favorable pricing than smaller stores in relation to healthy foods).

[100] *See* Joel Gittelsohn et al., *Interventions in Small Food Stores to Change the Food Environment, Improve Diet, and Reduce Risk of Chronic Disease*, CTR. FOR DISEASE CONTROL AND PREVENTION (2012), http://www.cdc.gov/pcd/issues/2012/11_0015.htm (providing a review of intervention studies from around the world).

[101] *See id*. (indicating that healthy food availability increased in all of the trials); s*ee also* Erica Cavanaugh et al., *Changes in Food and Beverage Environments After an Urban Corner Store Intervention*, 65 PREVENTATIVE MED. 7, 11 (2014) (finding that intervention improved the availability of healthy options at participating convenience stores).

[102] *Compare* Guadalupe X. Ayala et al., *Efficacy of a Store-Based Environmental Change Intervention Compared with a Delayed Treatment Control Condition on Store Customers' Intake of Fruits and Vegetables*, 16 PUB. HEALTH NUTRITION 1953, 1956–60 (2013) (concluding that environmental interventions which included employee trainings, structural changes to the store, and food marketing campaigns led to moderate increase in fruit and vegetable consumption) and Joel Gittelsohn et al., *An Urban Food Store Intervention Positively Impacts Food-Related Psychosocial Variables and Food Behaviors*, 37 HEALTH EDUC. & BEHAVIOR 390, 398 (2010) (finding that corner store interventions positively impacted the purchase of healthier food options), *with* Hannah G. Lawman et al., *Changes in Quantity,*

studies underscore the complexity of behavioral change. However, the studies that indicate no behavioral change did not include specific interventions targeted at reducing the price of healthier options,[103] and given the price sensitivity of low-income food shoppers, this is a critical element. This aspect of intervention could take an array of forms such as coupons or vouchers issued to the consumers or cash incentives provided to store owners for the purchase of healthy foods.[104] Yet, for sustained success in maintaining a competitive price point on healthy options, improved food distribution channels are necessary. Because of their smaller size many convenience stores cannot establish affordable distribution contracts for healthy items, so they self-supply by purchasing these items at larger stores, e.g., supermarkets, and reselling them at a mark-up.[105] Additional research on effects of improved food distribution channels would be useful in developing sustained price-reduction interventions.

Overall, it appears that the new vendor standard is a small step towards improving the diets of SNAP beneficiaries, and additional interventions by public and private partners at all geographic levels—national, state and local—are required to ensure its effectiveness.

III. THE CREATION OF THE FOOD INSECURITY NUTRITION INCENTIVE PROGRAM

Spending, and Nutritional Characteristics of Adult, Adolescent and Child Urban Corner Store Purchases After an Environmental Intervention, 74 PREVENTATIVE MED. 81, 83–84 (2015) (finding there were no significant changes in the energy content or nutrient characteristics of purchases after environmental interventions that included stocking additional healthy options, employee trainings, marketing campaigns, and the provision of additional shelving and refrigeration), *and* Michelle R. Lent et al., *A Randomized Controlled Study of a Healthy Corner Store Initiative on the Purchases of Urban, Low-Income Youth*, 22 OBESITY 2494, 2496–98 (2014) (concluding that there was no significant change in the energy or nutritional content of youth purchases after an intervention that included student nutritional education, a marketing campaign, store owner trainings, and increased healthy items availability).

[103] *See* Lent, *supra* note 102, at 2496 (indicating intervention strategies do not include a price-reduction element and focus solely on student nutritional education, a marketing campaign, store owner trainings, and increased healthy items availability); *see also* Lawman, *supra* note 102, at 83 (listing the components of the HSCI basic and advanced interventions, none of which included price reduction).

[104] *See* Gittelsohn, *supra* note 100 (providing a review of price-reduction interventions utilized in convenience store studies).

[105] *See* Kennelly, *supra* note 78, at 165–66 (describing the process of self-supplying).

A. Overview and Mechanics of the FINI Program

In addition to the new vendor standard, the Agriculture Act of 2014 also created the Food Insecurity Nutrition Incentive (FINI) program.[106] FINI is a grant program designed to encourage fruit and vegetable purchases by SNAP beneficiaries through a financial incentive at the point of purchase.[107] Congress authorized $100 million dollars for the FINI program over five years: $35 million in FY 2014 and 2015, $20 million in FY 2016, $20 Million in FY 2017, and $25 million in FY 2018.[108] These grants are provided to programs run by eligible entities with SNAP incentive programs. Eligible entities include, but are not limited to, non-profit organizations, agricultural cooperatives, community health organizations, community-supported agriculture (CSA) programs, farmers' markets, and state, local, or tribal agencies.[109] To qualify for the grant program, projects must: (1) obtain the support of the state agency that administers the SNAP program, (2) provide point of purchase incentives aimed at increasing the purchase of fruit and vegetables by SNAP beneficiaries, (3) agree to participate in an independent evaluation of the project's effectiveness, (4) ensure the same terms and conditions on sales made to SNAP beneficiaries and non-beneficiaries, and (5) include effective and efficient use of benefit redemption technology.[110]

There are three FINI grant categories based on the size and scope of the project: FINI Pilot Projects (FPP), FINI Projects (FP), and FINI Large Scale Projects (FLSP).[111] FPP grants target new programs that are in the early stages of development and are small in scale.[112] These grants are limited to a maximum of $100,000 over a one year performance period. [113] The FP grants are aimed at mid-sized projects

[106] The Agriculture Act of 2014, Pub. L. No. 113-79, § 4208, 128 Stat. 652, 826–28 (2014).
[107] 7 U.S.C. § 7517(b)(2)(A)(II) (2006).
[108] 7 U.S.C. § 7517(c)(2) (20006).
[109] 7 U.S.C. § 7517(a)(1)(2006).
[110] 7 U.S.C. § 7517(b)(2)(A) (2006).
[111] U.S. DEP'T. AGRIC., FOOD INSECURITY NUTRITION INCENTIVE (FINI) GRANT PROGRAM 6-10 (2014), http://nifa.usda.gov/sites/default/files/rfa/1415_FINI.pdf [hereinafter FINI].
[112] *Id*. at 7.
[113] *Id.* at 6.

that have advanced past the pilot stage and focus on incentives at the local or state level.[114] These grants are limited to $500,000 over a four-year performance period.[115] Finally, FLSP grants target the largest programs that focus on multi-county, statewide, or regional incentive projects.[116] These grants are for at least $500,000 with a maximum performance period of four years.[117] In awarding these grants, priority is given to projects that maximize the share of grant funds used as a direct incentive, use direct-to-consumer marketing, have a proven track record, provide local or regional produce, and locate in underserved communities.[118] All of these grants are intended to supplement other efforts; therefore, these grants can only provide for up to fifty percent of a program's cost.[119] However, the non-federal share of funding can be provided in cash or in-kind donations, e.g., facilities, equipment, or services.[120]

Earlier in 2015, the USDA announced the first round of FINI grant awards to 31 organizations for a total of $31.5 million in support.[121] These grants support a diverse array of programs. For example, Heritage Ranch, Inc., in Hawaii received $100,000 under a FPP grant to establish a new incentive program called Buy One Fresh/Get One Local.[122] For every dollar a SNAP beneficiary spends on fruits and vegetables, Heritage Ranch will provide them with coupons of equal value that can be used for fresh local produce at participating farmers' markets, grocers, and CSAs.[123] On the other end of the spectrum, the Fair Food Network received almost $5.2 million dollars to expand their successful Double Up Food Bucks program.[124] This expansion will incorporate retail grocery stores in addition to the farmers' markets it has traditionally served, a change

[114] *Id.* at 8.
[115] *Id.* at 7.
[116] *Id.* at 9.
[117] *Id.*
[118] 7 U.S.C. § 7517(b)(2)(B) (2006).
[119] 7 U.S.C. § 7517(b)(1)(B) (2006).
[120] 7 U.S.C. § 7517(b)(1)(C) (2006).
[121] *USDA Awards $31 Million in Grants to Help SNAP Participants Afford Healthy Foods*, NAT'L INST. OF FOOD AND AGRIC. (Mar. 31, 2015), http://nifa.usda.gov/resource/usda-awards-31-million-grants-help-snap-participants-afford-healthy-foods [hereinafter *USDA Awards $31 Million*].
[122] *Id.*
[123] *Id.*
[124] *Id.*

that will help ensure that incentives are provided year-round.[125] Also, in the process, the Fair Food Network plans to transition their existing token-based incentive program to an electronic-based incentive.[126] While these 31 projects represent an impressive congregation of resources, they do not encompass the complete universe of SNAP incentive programs. There are many excellent programs operating without the aid of this federal revenue stream.[127]

B. Proven Track Record

The FINI grant program includes two structural characteristics that serve to effectively improve the diets of some of America's most vulnerable people: (1) it confronts the issue of SNAP beneficiary price sensitivity by providing extra funds for fruits and vegetables, and (2) the grants prioritize programs in underserved areas, e.g., food deserts.[128] Growing data supports the effectiveness of this dynamic. The Food Conservation and Energy Act of 2008 authorized the USDA to create pilot programs to explore the use of SNAP produce incentives.[129] This authorization resulted in the Healthy Incentive Pilot (HIP), which was a year-long program in Hampden County, Massachusetts, a community suffering from an array of diet-related illnesses.[130] HIP provided participating SNAP households with a 30-cent incentive on their EBT card for every dollar of fruits and vegetables they purchased.[131] This incentive was credited to the EBT card and could be used for the purchase of any SNAP eligible food

[125] *Id.*
[126] *Id.*
[127] *See e.g.*, *Maryland Market Money*, MD. FARMERS MARKET ASSOC., http://www.marylandfma.org/programs/maryland-market-money/ (last visited Oct. 9, 2016) (describing the Maryland Market Money program that provides up to a $10 match for SNAP benefits used to purchase fruits and vegetables at 23 farmers' markets in Maryland).
[128] *See* FINI, *supra* note 111, at 6 (prioritizing grant applications with projects located in underserved communities).
[129] Food Conservation and Energy Act of 2008, Pub. L. No. 110-246, § 4141, 122 Stat. 1651, 1879-81 (codified at 7 U.S.C. §2026(k)).
[130] *See* SUSAN BARTLETT ET AL., U. S. DEP'T OF AGRIC., EVALUATION OF THE HEALTHY INCENTIVES PILOT (HIP) 1 (2014), http://www.fns.usda.gov/sites/default/files/HIP-Final.pdf (providing an overview of the Healthy Incentive Pilot investigation).
[131] *Id.*

item; use of the incentive was not limited to fruits and vegetables.[132] Evaluation of the HIP project revealed a 26 percent increase in the daily consumption of fruits and vegetables.[133] While this increase is significant, by volume it was approximately a one quarter cup increase.[134] Non-HIP participants were eating less than one cup of targeted fruits and vegetables per day,[135] while the USDA recommends consuming approximately five cups per day.[136] This discrepancy highlights how much work needs to be done to improve the diets of SNAP beneficiaries.

Other studies have revealed similar successes. Examination of the Philly Food Bucks program revealed that the SNAP incentive program increased SNAP purchases at participating Philadelphia farmers' markets by 300 percent during the first two years of the program.[137] The study also showed that the largest farmers' market experienced an impressive 5-fold increase in sales.[138] The Philly Food Bucks' incentives were distributed two ways: (1) community organizations that worked with SNAP eligible populations distributed two dollar coupons to encourage attendance at farmers' markets and (2) participating farmers' markets distributed two dollar coupons for every five dollars spent.[139] These coupons could only be spent on fruits and vegetables at these markets, unlike the HIP incentive, which was not limited to fruits and vegetables.[140] This study is particularly hopeful because the structure of the incentive system ensures that the incentive will not be used for unhealthy options, and farmers' markets

[132] *Id.*
[133] *Id.* at 4.
[134] *Id.*
[135] *Id.*
[136] *See How Many Vegetables are Needed Daily or Weekly?*, U. S. DEP'T OF AGRIC., http://fnsweb01.edc.usda.gov/printpages/MyPlateFoodGroups/Vegetables/food-groups.vegetables-amount.pdf (recommending between 2.5 and 3 cups of vegetables daily for adults); *see also How Much Fruit Is Needed Daily?*, U. S. DEP'T OF AGRIC., http://fnsweb01.edc.usda.gov/food-groups/fruits-amount.pdf (recommending between 1.5 and 2 cups of fruit daily for adults).
[137] Candace R. Young et al., *Improving Fruit and Vegetable Consumption Among Low-Income Customers at Farmers Markets: Philly Food Bucks*, 10 PREVENTING CHRONIC DISEASE 4 (2013), http://www.cdc.gov/pcd/issues/2013/pdf/12_0356.pdf.
[138] *Id.*
[139] *Id*. at 2.
[140] *Id*.

by definition have a much healthier selection of foods than other food outlets.

In addition to official studies, several SNAP incentive programs have reported important success. The Fair Food Network operates the Double Up Bucks program in Michigan and parts of Northern Ohio.[141] This program provides a dollar match for SNAP benefits spent on produce at participating farmers' markets and pilot grocery retailers; this match can only be used to purchase locally grown produce.[142] The Fair Food Network reports that the program was pivotal in increasing SNAP beneficiary utilization of farmers' markets. In 2009 program participants spent $21,554 in SNAP benefits and distributed $9,548 in coupons.[143] Four years later, in 2013, SNAP sales had grown to $811,876 with an additional $739,118 distributed in incentives.[144] The Fair Food Network also reports that "93% of participating SNAP users at farmers markets' report eating more fruits and vegetables, including more varieties."[145] This impressive work highlights the dramatic effect a successful incentive program can have on a local food system and the diets of SNAP beneficiaries.

C. Interventions to Increase the Effectiveness of FINI Sponsored Programs

While SNAP incentive programs have proved successful in the past, there is an important intervention that can improve their effectiveness. A survey of first round FINI grantees reveals that while some may include traditional grocery stores, the majority of the projects involve farmers' markets.[146] This is a natural development given the program's focus on underserved areas[147] and the use of local

[141] *See* FAIR FOOD NETWORK, DOUBLE UP FOOD BUCKS 5, http://www.fairfoodnetwork.org/sites/default/files/FFN_DoubleUpFoodBucks_5YearReport.pdf (reporting that the programs operate at over 150 "sites across Michigan and 2 in Toledo, Ohio including 106 markets, 2 food-share programs, 2 mobile food trucks, 3 full-service grocery stores, and a network of farm stands").
[142] *Id.* at 5.
[143] *Id.* at 5.
[144] *Id.*
[145] *Id.* at 8.
[146] *USDA Awards $31 Million*, *supra* note 121.
[147] *See* 7 U.S.C. §7517(b)(2)(B) (2012) (prioritizing grant awards to projects located in underserved areas).

produce.[148] However, farmers' markets present their own challenges in the struggle to effectively improve the diets of SNAP users.

1. Attracting SNAP Beneficiaries to Farmers' Markets

The first challenge is to draw SNAP users to the farmers' markets. As discussed earlier, supermarkets and super stores are the preferred shopping locations for SNAP users, accounting for 81% of sales.[149] In comparison, farmers' markets and direct market farmers accounted for approximately $18.8 million in SNAP sales which equates to 0.03 percent of the total sales.[150] This data tracks with studies that find farmers' market customers tend to be "[w]hite, middle-aged, middle to upper class, and well-educated."[151] However, the role of farmers' markets and direct market farmers is growing. Between FY 2010 and FY 2014 the number of SNAP authorized farmers' markets and direct marketing farmers grew from 1,611 to 5,175,[152] a 211 percent increase over 5 years.[153] In addition, during the same period SNAP redemption at these vendors grew 150 percent, from approximately $7.5 million to approximately $18.8 million.[154]

2. Utilization of the Hospital Readmission Reduction Program

Despite the growth in SNAP utilization of farmers' markets, ensuring the use of these vendors is a critical challenge for FINI grantees. While FINI emphasizes use of direct to consumer marketing, there is an opportunity to expand outreach through the development of critical partnerships with health care providers. In addition to the natural connection between diet and health, the Affordable Care Act (ACA) provides a financial motivation for certain

[148] *See id.* (prioritizing grant awards to projects utilizing local or regional produce).
[149] SNAP RETAILER MANAGEMENT 2014 REPORT, *supra* note 59, at 6.
[150] *Id. at 7.*
[151] *See* Darcy Freedman et al., *Assessing Readiness for Establishing a Farmers' Market at a Community Health Center*, 37 J. CMTY. HEALTH 80, 81 (2012), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3208118/ (citing Eastwood DB et al., *Location and Other Market Attributes Affecting Farmers' Market Patronage: the Case of Tennessee*, 30 J. FOOD DISTRIBUTION RES. 63–72 (1999) and R. Govindasamy et al., *Farmers' Market: Consumer Trends, Preferences, and Characteristics*, 4 J. EXTENSION 1 (2002)).
[152] SNAP RETAILER MANAGEMENT REPORT, *supra* note 59, at 11.
[153] *Id.*
[154] *Id.*

health care providers to partner with FINI through the creation of the Hospital Readmission Reduction Program (HRRP).

a. Overview of the HRRP

In 2011, there were approximately 3.3 million hospital readmissions within 30 days of discharge in the United States.[155] These readmissions contributed $41.3 billion in total hospital costs.[156] Medicare patients comprised the largest share of these readmissions at approximately 1.8 million (55.9 percent). For additional perspective, one in five Medicare patients are readmitted within 30 days.[157] Medicare patients also accounted for the largest readmission cost at approximately $24 billion.[158] These are costs that are borne by the American taxpayer since Medicare is a publicly funded program.

In an attempt to decrease the massive costs associated with the readmission of Medicare patients and to improve the quality of patient care, the Hospital Readmission Reduction Program (HRRP) was passed as part of the ACA.[159] The HRRP creates financial penalties for excessive readmissions of Medicare patients with specific medical conditions.[160] The HRRP applies to most acute care hospitals, however, there are several categories of hospitals that are exempt from this program including psychiatric, rehabilitation, long term care, children's, cancer, critical access hospitals,[161] and all hospitals in

[155] ANIKA L. HINES ET AL., HEALTH CARE COSTS AND UTILIZATION PROJECT, CONDITIONS WITH THE LARGEST NUMBER OF ADULT HOSPITAL READMISSIONS BY PAYER 2 (2014), http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf.
[156] *Id.*
[157] Stephen F. Jencks et al., *Rehospitalizations Among Patients in the Medicare Fee-for-Service Program*, 360 NEW ENG. J. MED. 1418, 1420 (2009), http://www.nejm.org/doi/pdf/10.1056/NEJMsa0803563.
[158] HINES, *supra* note 155, at 2 Table 1.
[159] Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 3025, 124 Stat. 119, 408-413 (Mar. 30, 2010) (codified as amended at 42 U.S.C. § 1395ww(q)).
[160] *Id.*
[161] *See* 42 U.S.C. § 1395ww(q)(5)(C) (2006) (defining applicable hospitals as those paid under 42 U.S.C. § 1395ww(d) or 42 U.S.C. § 1395f(b)(3)); *see also* 42 U.S.C. 1395ww(d) (2006) (defining a hospital as a hospital located in one of the fifty states or the District of Columbia except for certain facilities, e.g., psychiatric hospitals, rehabilitation hospitals, hospitals whose inpatients are predominantly under the age of 18, and hospitals where the average length of inpatient stay is great than 25 days).

Maryland.[162] The Secretary of Health and Human Services has the authority to identify the specific conditions that will serve as the metrics for excessive readmissions,[163] but the Secretary's selections must be either high volume or high expenditure procedures or conditions.[164] Currently the HHRP monitors readmissions for six conditions: (1) acute myocardial infarction (AMI), (2) heart failure (HF), (3) pneumonia (PN),[165] (4) acute exacerbation of chronic obstructive pulmonary disease (COPD), (5) total hip arthroplasty (THA), and (6) total knee arthroplasty (TKA).[166] The Center for Medicare and Medicaid Services (CMS) has also announced that in FY 2017 it will add coronary artery bypass graft surgery to the list of applicable conditions.[167] Readmission for these qualifying conditions is only counted against a hospital if it occurs within thirty days of the

[162] *See* 42 U.S.C. § 1395ww(q)(2)(B)(ii) (2006) (allowing the Secretary to exempt hospitals that are paid under 42 U.S.C. §1395(b)(3)); s*ee also* 42 U.S.C. § 1395ww(b)(3) (2006) (describing the authority to continue special payment agreements based on demonstration projects); *Maryland All Payer Model,* CTR. FOR MEDICARE AND MEDICAID SERVICES, http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/ (indicating that Maryland is the only state with all-payer system of hospital finance created subject to section 1814(b) of the Social Security Act which is codified at 42 U.S.C. § 1395(b)).

[163] *See* 42 U.S.C. § 1395ww(q)(5)(A) (2006) (defining applicable condition as "a condition or procedure selected by the Secretary" that, among other measures, are high volume and/or high expenditure).

[164] *Id.*

[165] *See* Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and FY 2012 Rates, 76 Fed. Reg. 51476, 51665–66 (Aug. 11, 2011) (discussing and adopting Acute Myocardial Infarction, Heart Failure, and Pneumonia as the three initial conditions monitored by the HRRP) [hereinafter Medicare 12].

[166] *See* Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates, 78 Fed. Reg. 50496, 50659-63 (Aug. 19, 2013) (to be codified at 42 C.F.R. pt 412) (discussing and adopting Chronic Obstructive Pulmonary Disorder as an applicable condition for the HRRP).

[167] *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates, 79 Fed. Reg. 49854, 50025 (Aug. 22, 2014) (announcing that CMS will include coronary artery bypass graft surgery as an applicable condition for the HRRP).

initial discharge.[168] However, both readmission to the original hospital or other acute care facility can be counted against a facility.[169]

The penalty for excessive readmissions is a reduction in Medicare payments to the offending hospitals.[170] To determine if a hospital has experienced excessive readmission, CMS has established a complex calculation methodology that measures a hospital's performance against the national average to establish an excessive readmission ratio.[171] These calculations make risk adjustments for certain factors including relevant demographic characteristic, comorbidities, and patient frailty.[172] This risk adjustment is intended to level the playing field "by taking into account that some hospitals' patients are sicker than others on admission and therefore have a higher risk of readmission."[173] This excessive readmission ratio is the basis for a hospital's penalty or readmission payment adjustment, and the higher the readmission ratio the greater the penalty.[174] HRRP then penalizes facilities by reducing their Medicare payments for all admissions not just readmissions.[175]

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[168] *See* Medicare 12, 78 Fed. Reg. at 51670 (finalizing the thirty-day readmission window for the HRRP).

[169] *See* 42 U.S.C. § 1395ww(q)(5)(E) (2006) (explaining that "'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge").

[170] *See* 42 C.F.R. § 412.150 (2015) (describing the purpose of the HRRP as a program, "under which payments to applicable hospitals are reduced in order to account for certain excess readmissions").

[171] *See* 42 C.F.R. §§ 412.152, 412.154 (2015) (outlining the process for calculating excessive readmissions and a hospital's penalty for such readmissions); *see also* CRISTINA BOCCUTI & GISELLE CASILLAS, AIMING FOR FEWER HOSPITAL U-TURNS: THE MEDICARE HOSPITAL READMISSION REDUCTION PROGRAM 2-3 (2015), *available at* http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/ (providing a clear description of the HRRP calculations).

[172] *See* Medicare 12, 78 Fed. Reg. at 51670 (discussing the variables considered when risk adjusting the excess readmission ratio with specific mention of patient demographic factors, patient co-existing medical conditions, and indicators of patient frailty).

[173] *Id.*

[174] *See supra* note 171 and accompanying text.

[175] *Id.*

To understand the scope of this financial incentive, it is important to note that CMS estimates that it has issued or will issue the following total penalties for excessive readmissions: (1) $290 million in FY 2013, (2) $227 million in FY 2014, and (3) $428 million in FY 2015. [176] Also, in the latest round of readmission penalties, 2,610 hospitals were fined.[177]

b. Connecting HRRP and the SNAP Program

Where does the SNAP program fit into this scenario? First, there is considerable potential overlap between the SNAP program and the Medicare patients at issue in the HRRP. According to a recent study, 9 percent of SNAP beneficiaries in 2013 were 60 years or older.[178] That year SNAP provided benefits to 47.6 million people,[179] so if we do the math, approximately 4.3 million individuals 60 years of age or older received SNAP that year. While this age range does not directly match the population of Medicare patients, which has a general eligibility age of 65,[180] it suggests that there could be millions of Medicare patients on SNAP or eligible for SNAP.

Second, the applicable conditions for the HRRP—AMI, HF, PN, COPD, THA, and TKA—were chosen in part because there are specific interventions that hospitals can take to reduce readmissions.[181] Identified interventions include improved post-discharge care, pre-discharge planning, home-based follow-up, and patient education.[182] Helping patients consume a healthy diet can be an integral part of these interventions. For example, poor adherence to a low sodium diet is associated with increased readmissions and mortality among heart

[176] BOCCUTI & CASILLAS, *supra* note 171.
[177] Jordan Rau, *Medicare Fines 2,610 Hospitals in Third Round of Readmission Penalties*, KAISER HEALTH NEWS (Oct. 2, 2014), http://khn.org/news/medicare-readmissions-penalties-2015/.
[178] KELSEY FARSON GRAY, U. S. DEP'T OF AGRIC., CHARACTERISTICS OF SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM HOUSEHOLDS: FISCAL YEAR 2013 (SUMMARY) (2014), http://www.fns.usda.gov/sites/default/files/ops/Characteristics2013-Summary.pdf.
[179] *Id.*
[180] 42 U.S.C. § 1395c (2006).
[181] *See* Medicare 12, 78 Fed. Reg. at 51660 (discussing how hospitals can work with their communities to reduce readmissions and the success of specific interventions in the prevention of readmission).
[182] *Id.*

failure patients.[183] This is especially relevant to the HRRP's mission because heart failure results in the greatest number of Medicare readmissions.[184] Increased financial access to fruits and vegetables delivered by the FINI incentive programs could make adherence to a low sodium diet easier for Medicare patients.

While not as direct as its link to heart failure, a healthy diet can impact hip and knee arthroplasty—HRRP monitored conditions. Obesity increases the need for these procedures by placing physical stress on the joints and tissues, as well as through chemical changes in the body that increase cartilage inflammation and degradation.[185] It also increases intraoperative complications during surgery, including higher blood transfusion needs and difficulty identifying anatomy that can lead to iatrogenic damage or misalignment of the prosthesis.[186] And finally, obesity can increase post-operative complications including dislocation[187] and infection.[188] Again, by connecting patients with FINI programs, hospitals can facilitate their patients' consumption of a nutritious diet, with a healthy body weight as an end goal. This in turn could affect the success of THA and TKA procedures, which is critical because by 2030, the number of hip arthroplasty cases is expected to exceed 500,000 per year and the demand for knee arthroplasty is expected to approach 3.5 million.[189]

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[183] *See e.g.*, Toni Kuehneman et al., *Demonstrating the Impact of Nutrition Intervention in a Heart Failure Program*, 102 J. AM. DIETETIC ASS'N, 1790, 1790–94 (2002) (discussing the importance of diet modification in patients with heart failure and the effectiveness of registered dieticians in improving patient adherence to low sodium diet); *see also* Misook L. Chung et al., *Patients Differ in their Ability to Self-Monitor Adherence to Low-Sodium Diet Versus Medication*, 14 J. CARDIAC FAILURE 114, 114 (2008), http://www.sciencedirect.com/science/article/pii/S1071916407010871#.

[184] HINES, *supra* note 155, at 3 Table 2 (noting that readmission rates among Medicare beneficiaries were 7.3 for heart failure).

[185] Bryan D. Springer et al., *Obesity and Total Joint Arthroplasty: A Literature Based Review*, 28 J. Arthroplasty, 714, 714 (2013), http://www.sciencedirect.com/science/article/pii/S0883540313001745#.

[186] Saif Salih & Paul Sutton, *Obesity, Knee Osteoarthritis and Knee Arthroplasty*, 5 BMC SPORTS SCI., MED., & REHABILITATION 25, 27 (2013), http://www.biomedcentral.com/2052-1847/5/25.

[187] *See* Springer, *supra* note 185, at 717 (discussing the increased dislocation rate in obese and morbidly obese patients).

[188] *Id.* at 716 (discussing a series of studies linking obesity to increased infection rates following arthroplasty surgery).

[189] *Id.* at 714.

It is important to note that there are racial disparities within HRRP's applicable conditions. Black Americans are twice as likely as white Americans to experience heart failure,[190] and, as mentioned earlier, black Americans die of coronary heart disease at a much higher rate than white Americans.[191] Also, while 33.4 percent of white adult Americans are obese, 47.8 percent of their black and 42 percent of their Hispanic counterparts are obese,[192] which can affect THA and TKA procedures. This reveals that the HRRP has the potential to advance racial health-equity.

c. Using Nutritional Interventions to Promote Health

Recognizing the importance of nutrition in patient recovery, some hospitals have already taken important steps to ensure that their elderly patients have a healthy diet. For example Eskenazy Health, in Indiana, has partnered with Meals on Wheels to provide free meals to patients over 60 years of age following their discharge from the hospital.[193] The program helps ensure that the patients are following their doctor's advice by tailoring meals to the patients' nutritional needs.[194] Also, the practice of prescribing and providing for nutritious food to all patients is a growing hospital practice, which has taken several different forms. At the Boston Medical Center, the Preventive Food Pantry links low-income patients with nutritious food.[195] Primary care providers refer their patients with special nutritional needs to the Pantry by writing "prescription[s] for supplemental foods that best promote physical health, prevent future illness and facilitate recovery."[196] At the University of Vermont Medical Center and the

[190] *See* Hossein Bahrami et al., *Differences in the Incidence of Congestive Heart Failure by Ethnicity*, 168 ARCHIVES OF INTERNAL MED. 2138, 2142 (2008), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3038918/pdf/nihms268893.pdf (noting that incidence rates were 4.6 and 2.4 in 1000 persons-years, among blacks and whites respectively).
[191] *See supra* note 5 and accompanying text.
[192] Ogden, *supra* note 1, at 811 Table 4.
[193] Shari Rudavsky, *Free Food for Seniors Aims to Reduce Hospital Readmissions*, INDYSTAR (Dec. 17, 2014), http://www.indystar.com/story/life/diet-fitness/2014/12/17/free-food-seniors-aims-reduce-hospital-readmissions/20559633/.
[194] *Id.*
[195] *About the Preventive Food Pantry,* Nutrition Resource Center, BOS. MED. CTR., http://www.bmc.org/nutritionresourcecenter/foodpantry.htm.
[196] *Id.*

Central Vermont Medical Center, patients are prescribed Health Care Shares, which are free CSA shares from a local farm run by the Vermont Youth Conservation Corps.[197] And the Lankenau Medical Center has partnered with the Philadelphia Department of Health and the Food Trust to create an innovative nutrition program.[198] Lankenau's initiative provides overweight patients with type 2 diabetes with a prescription for Philly Food Bucks, which can be redeemed for fruits and vegetables at the Food Trust farmers' markets.[199]

While these programs are important interventions, FINI-sponsored incentive projects provides another useful resource that can easily be integrated into the existing program structure of a hospital. Although individual organizational structures vary, most hospitals have a social services or social work department that connects patients with community resources to help address their basic needs.[200] Some social work departments are already connecting their patients with SNAP by helping them enroll in the program.[201] However, FINI grantees and other SNAP incentive programs should connect with their local hospitals' social work departments to ensure that information regarding their program is shared with patients. This simple outreach can expand a FINI project's advocate base, and

[197] *The Health Care Share*, VERMONT YOUTH CONSERVATION CORE, http://www.farmatvycc.org/#!health-care-share/cr43 (last visited Nov. 14, 2015); *see also* Kathryn Flagg, *Vermont Hospitals Prescribe Farm-Fresh Food*, SEVEN DAYS (July 23, 2014), http://www.sevendaysvt.com/vermont/vermont-hospitals-prescribe-farm-fresh-food/Content?oid=2405335 (describing the fruit and vegetable prescription program).

[198] Ayana Jones, *Community Health Partnership Promotes Wellness*, PHILA. TRIB. (July 21, 2015), http://www.phillytrib.com/news/health/community-health-partnership-promotes-wellness/article_1014d849-857b-5f54-9801-d46598312103.html.

[199] *Id.*

[200] *See, e.g.*, *Social Work*, ROCHESTER REG'L HEALTH, http://www.rochestergeneral.org/centers-and-services/social-work/ (stating that the "Social Work Services team can provide a convenient link to community resources and services that can help you cope with the medical, financial and emotional issues you may face during or after your hospital stay. These might include securing coverage for prescription medications; accessing appropriate food, clothing or transportation; or finding help with efforts to stop smoking or other medically advised challenge").

[201] *See, e.g.*, *MGH & Community Resources*, MASS. GEN. HOSP. PATIENT CARE SERV., http://www.mghpcs.org/socialservice/resources/Community_Resources.asp.

hospital social workers are uniquely situated to educate vulnerable SNAP beneficiaries about the importance of these programs. This outreach-multiplier has the potential to bring additional SNAP participants to farmers' markets to better leverage the FINI funds.

With the clear connection between diet and readmission for conditions monitored by HRRP, SNAP and the FINI program provide hospitals with another resource to improve patient outcomes and avoid readmission penalties. However, there is potential for wider benefit if hospitals look beyond their Medicare patients and link all of their SNAP-eligible patients with local FINI grantees and other SNAP incentive programs.

CONCLUSION

With an economic force of 74 billion dollars a year,[202] SNAP has the potential to influence our food system and make healthy eating a reality for low-income Americans. Also, given the economic disparities that exist in America, SNAP is an intervention that can be leveraged against the racial health disparities in diet-related illnesses. The 2014 Farm Bill and its changes to SNAP attempt to hone the program's focus on healthy food choices. However, these changes are first steps on a challenging path. Without additional efforts by government and the private sector, these changes will fall short of their intended outcome. The revised vendor standards will increase the amount of healthy food options at small convenience stores, but unless a wide range of interventions occurs, there is the real possibility that these small retailers will have healthy food rotting on their shelves.

Likewise, the FINI grant program works to make produce more affordable, yet it relies heavily on farmers' markets, which SNAP recipients do not currently utilize with much frequency. FINI grant recipients must address this reality to ensure the success and growth of their programs. Local hospitals, with innate role as community caregivers, and the economic incentive provided by HRRP are natural partners. By utilizing a hospital's social work department, a FINI grantee can attract new SNAP beneficiaries to its program and hospitals can provide patients with a valuable resource to improve their diet and health while taking a positive step to prevent excessive

[202] *SNAP Participation and Costs*, *supra* note 22.

readmissions. Although the new vendor standard and FINI require additional interventions, they are important catalysts in the evolution of our food system. Ignoring the public health challenge of creating a system that makes healthy food a real option for all Americans will only perpetuate the diet-related illness epidemic and its racial disparities.