M ore than 50 years ago, H. Jack Geiger, MD, and community organizer John Hatch built a community health center in the Mississippi Delta with funding from the Office of Economic Opportunity, a federal program established by President Lyndon B. Johnson in 1964 to advance the social and economic goals of the “Great Society.” Recognizing that medications would not cure the health problems arising from poor access to nutritious foods, Geiger wrote prescriptions for healthy foods, which he stocked in the pharmacy, as medicine. And Hatch engaged Mississippi Delta residents to start community food co-ops.

Fast-forward to 2020. As the United States struggles with exorbitant health care costs and lagging health indicators, the federal government has been undermining the lesson that Geiger and Hatch learned about moving “upstream” on health. Since December 2018, the US Department of Agriculture (USDA) has changed the eligibility rules and subsidies of the Supplemental Food and Nutrition Program (SNAP), dropping more than 500,000 children ineligible for free school lunches.

Regulatory Changes
SNAP is a safety net program that addresses food insecurity, defined by the USDA as “a household-level economic and social condition of limited or uncertain access to adequate food.” To be eligible, households must be at or below 130% of the poverty level—currently $27,700 a year for a family of 3.

In December 2018, immediately after failing to secure stricter work requirements for SNAP recipients through the 2018 Farm Bill, the USDA proposed regulations to remove states’ latitude in waiving the limitation of 3 of every 36 months that able-bodied adults without dependents can be eligible for SNAP benefits (unless an area’s unemployment rate exceeds 7%). On December 4, 2019, the Trump administration finalized the new rule, set to take effect on April 1, 2020, which specifies 6% as the minimum unemployment rate for an area to receive a waiver. As of 2019, any able-bodied, nonpregnant adult without dependents younger than 18 years at home is required to spend at least 80 hours a month working, participating in a work training program, or participating in a combination of both. Because two-thirds of SNAP recipients are children, older individuals, and people with disabilities, they are exempt from the work requirement. But for the remaining third, hindering circumstances such as family caregiving, lack of transportation or child care, unsteady job availability, and low skill level are not considered.

In July 2019, the USDA proposed another rule change to SNAP, estimated to save $1.9 billion a year: elimination of “categorical eligibility.” The categorical eligibility for SNAP was established under the Food and Nutrition Act of 2008 to automatically qualify some households receiving benefits under the Temporary Assistance for Needy Families program (Title VI of the Social Security Act) for the SNAP subsidies. Eliminating it is expected to end benefits to about 3.1 million of the 45 million SNAP enrollees. Furthermore, if a household qualifies for SNAP, its children are automatically eligible for the National School Lunch and Breakfast programs. Estimates of the number of children who would lose eligibility range from 40,000 (a revised USDA estimate) to more than 500,000 (Urban Institute).

The third SNAP rule change, proposed on October 3, 2019, would alter the calculation of heating and cooling expenses in determining a household’s income level and monthly benefit amount; it would require that all states use a standard utility allowance that is 80% of the national low-income utility costs. As a result, 19% of SNAP recipients would see their benefits reduced; 16% would see an increase; and 8000 families would become ineligible.

Finally, the Trump administration’s alteration of the “public charge” rule would jeopardize the chances of immigrants who use SNAP (as well as other public programs) from obtaining legal resident status. Consequently, an estimated 130,000 immigrants could withdraw from or forgo
SNAP benefits. The final rule has not yet been enacted because of court action.

Although those supporting these policy changes argue that fraud and abuse are rampant in the program, a 2018 analysis of SNAP “mispayments” found that the error rate was 6.3%; most were related to caseworker oversights rather than fraud or abuse.

Why Food Insecurity Matters
According to the Brookings Institute, 1 in 5 families with children experience food insecurity; 85% are headed by an adult who works. Food insecurity is associated with increases in the prevalence and severity of such chronic diseases as obesity, diabetes, and heart disease. Children are particularly at risk of physical and mental health problems, as well as reduced school performance. People without food security also are more likely to find medications, prescriptive diets, and medical visits too costly, thus jeopardizing their health even more. Food insecurity results in an estimated $77.5 billion in additional health care costs.

SNAP—shown to reduce food insecurity by about 30%—kept almost 3 million people out of poverty in 2018. SNAP also reduces health care costs, improves physical and mental health, and reduces mortality rates. In a statement on the second set of rule changes, Kathleen Noonan, JD, chief executive officer for the Camden Coalition of Healthcare Providers, SNAP is a “critical health intervention” for the Camden Coalition’s clients and for people who “face systematic barriers that exacerbate food insecurity, including unstable housing, unreliable transportation, and inconsistent employment.”

Efforts to Address Food Insecurity
The Food Research and Action Center, a nonprofit organization that works to eliminate poverty-related hunger and malnutrition in the United States, is advocating 2 bills that would either increase the amount of monthly SNAP benefits (HR 1368, Closing the Meal Gap Act of 2019) or eliminate the 3-month time limit on able-bodied adults (HR 2809, Improving Access to Nutrition Act of 2019). However, even if these bills pass the House of Representatives, they are unlikely to receive the Senate’s support.

For now, local and state initiatives will likely be needed. One example of a local solution is the Stockton Economic Empowerment Demonstration in Stockton, California, which provides 125 people who have an average monthly income of $1800 with $500 cash for 18 months. About 40% of the participants are employed full-time (sometimes more than 40 hours a week) or part-time; 20% are disabled; 11% are caregivers; and 11% are looking for work. Preliminary data show that participants are spending 38% of the pre-paid debit cards on food, 25% on home goods and clothing, and 11% on utilities.

Another local initiative, the Rush Surplus Project, is a program at Rush University Medical Center and Health System in Chicago. Jennifer Grenier, DNP, RN, director of Inpatient Rehabilitation, Nicole Wynn, MSN, RN, assistant unit director, and Robyn Golden, MA, LCSW, director of the Center for Health and Social Care Integration, are working with the Greater Chicago Food Depository to deliver bags of nonperishable foods to discharged patients assessed for food insecurity. When they realized that some of their own Rush employees experienced food insecurity, they partnered with Cook County/Chicago Top Box Foods, a food subsidy program that delivers fresh food to Rush employees monthly, and they now contribute surplus food to other food bank programs in the area. Referring to their patient-focused program as “Food Is Medicine,” they are walking in the footsteps of Geiger and Hatcher.

Although these programs are important, they will be unable to address the food insecurity affecting more than 1 in 10 US residents. Despite low unemployment levels, the rate of food insecurity across US counties ranges from 3% to 36%. The proposed changes to SNAP may save a relatively modest amount of money in the name of reducing the low rate of abuse and fraud, but they will do so at the cost of higher health care spending and increased human suffering.

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