



FOOD SECURITY
ISSUE BRIEF

WIC: Lessons Learned from COVID-19


Introduction

The Special Supplemental Nutrition Program for Women, Infants, and Children (commonly known as the WIC program) is the third largest food and nutrition assistance program in the United States. In 2020 alone, WIC served approximately 6.2 million participants a month, including almost half of all infants born in the country.¹ Covering such a large population cost the government \$4.9 billion in 2020.² Research on the program has shown that participants have lower rates of fetal death and infant mortality, higher birthweights, improved growth of children, and improved access to medical care for both the mother and child.³ Given the size and importance of this program, its effective administration requires consistent reevaluation. The COVID-19 pandemic forced the program to expand benefits and alter administration in ways that have greatly improved participants' lives and should remain in place regardless of the state of the pandemic.

WIC Overview

WIC is a federal government sponsored short-term intervention program designed to promote lifetime nutrition and health behaviors.⁴ The program serves low-income pregnant, postpartum, and breastfeeding individuals.⁵ These services are essential to promoting and maintaining the health of mothers and children across the country.

The WIC eligibility requirements include having an income at or below 185 percent of the U.S. Poverty Income Guidelines, or being enrolled in Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or Medicaid. Applicants must also be screened by professionals for 1) medically based risks such as anemia, underweight, smoking, maternal age, history of pregnancy complications, or poor pregnancy outcomes and 2) diet-based risks such as not consuming the U.S. Dietary Guidelines recommended amount of protein or iron in their diet.⁶




Administered by the Department of Agriculture (USDA), WIC provides federal grants to states (including Indian Tribal Organizations, the District of Columbia, and five territories) for supplemental food and beverages (called a nutrition prescription or the WIC food packages), and to oversee essential WIC activities. To serve the greatest population possible, states enter cost containment contracts with formula providers to obtain the best price for participants.⁷ States administer the WIC program by certifying participants, managing enrollment, tracking and distributing benefits, and working with certified retailers. Beginning in October 2020, WIC transitioned from checks or paper vouchers to using Electronic Benefit Transfer (EBT) cards to administer benefits to participants, providing a safer, easier, and more efficient mode of payment.⁸

WIC plays a critical role in improving lifetime health.⁹ The benefits of WIC are well established in scientific literature for both mothers and children. WIC has proven health benefits for participants including lower rates of preterm birth, improved food security, and improved nutrition.¹⁰ Updates to the WIC package in 2009 that increased fruits, vegetables, whole grains, and lower-fat milk, and expanded cultural food options resulted in additional positive changes to health and well-being.¹¹ There is evidence regarding the cost-effectiveness of different aspects of the WIC program. For example, when considering how WIC's programs for prenatal care impact birth outcomes, a \$1 WIC investment is estimated to save about \$2.50 in medical, educational, and worker productivity costs due to WIC's reduction in pre-term births and improved health and development.¹²

COVID-19 Changes to WIC

To meet the needs of participants during the COVID-19 pandemic, WIC made many changes to the administration of the program. With the economic hardships that came with the pandemic, many more individuals found themselves in need of assistance. However, before COVID-19, only about half of eligible families were utilizing WIC services, with one of the major barriers to access being the administrative burden.¹³ The passage of the Families First Coronavirus Response Act included \$500 million of funding to aid WIC to increase participation in the program through September 30, 2021. Other than increased funding, changes to the program focused on reducing administrative barriers to participation. The changes included waivers for in-person enrolment, remote issuance of benefits, and food package substitution waivers. Comparing February 2020 to February 2021, WIC participation increased 2.1 percent, from 6.1 million to 6.2 million. While not uniform across states, due to differences in state administrative policies, these waivers did help increase enrollment and participation, indicating their usefulness.¹⁴

The first substantial change was the allowance of physical presence waivers. The physical presence waivers permitted participants and applicants to obtain benefits without going in person, limiting unnecessary exposures to COVID-19. Traditionally, individuals must go into a WIC office to file for enrollment or re-enrollment, as one of the requirements of participation is physical presence in the state. The WIC program also deferred the in person nutritional risk assessments for participants. Nearly all WIC local agencies (99 percent) conducted certification appointments remotely (up from 12 percent prior to the pandemic) using the flexibilities under the physical presence waiver.¹⁵ Similarly, remote benefit issuance waivers allowed the USDA to grant waivers of the requirement that



participants physically come into the clinic to pick up WIC EBT cards and/or paper coupons. As participants were no longer required to enroll in person, requiring them to then go in to pick up EBT cards would have been burdensome.

Finally, the food package substitution waivers were created in response to potential supply chain shortage issues, allowing the USDA to permit appropriate substitutions of foods.¹⁶ Previously, WIC participants could only use benefits to select healthy foods from a set of products that meet nutritional requirements for mothers and young children. These waivers allowed states to expand the list of approved foods for WIC families to include a broader array of package sizes and brands. WIC also partnered with manufacturers and retailers to address disruptions to the supply chain, but sporadic shortages remain in both urban and rural settings.


These waivers have been vital to participants with regard to receiving adequate benefits. However, they currently will only be in place until 90 days after the end of the nationally declared public health emergency under section 319 of the Public Health Services Act.¹⁷ While in use, these waivers did not uniformly benefit all participants. Participation increased in 26 states and the District of Columbia, but it also decreased in 24 states, mainly due to a difference in states' administration of offline versus online benefit access.¹⁸

Issues with WIC During COVID

Since 2005, the USDA has issued detailed annual estimates of the number of individuals eligible for WIC by state, population category, and race. The USDA has compared the actual number of participants to the estimated number of eligible people to estimate a "coverage rate," representing the share of eligible individuals the program is reaching. Prior to the pandemic, the WIC coverage rate was declining.¹⁹ Moreover, the coverage rate for 2018 confirmed that many eligible low-income families were not receiving WIC benefits.²⁰ Nationwide, WIC reached only 57 percent of eligible individuals. While nearly all eligible infants participated in WIC, only 53 percent of eligible pregnant individuals participated, as did only 44 percent of eligible children ages 1 through 4. Coverage rates in 2018 also varied widely across states, ranging from 44 percent to 75 percent.²¹

Nationwide, overall WIC participation increased by 2 percent during the pandemic, between February 2020 and February 2021.²² However, the changes varied by state, ranging from a 20 percent increase to a 21 percent decrease. Nineteen states and the District of Columbia grew by more than 2 percent. The other states had smaller growth or declined. Similarly, national WIC participation among children increased by 5 percent but changes at the state level ranged from a 25 percent gain to a 22 percent decline.²³ Eighteen states plus D.C. grew by more than the nationwide figure of 5 percent; the rest had smaller growth or declined.²⁴

I. In-Person Benefit Reloading (Offline WIC) vs. Online WIC During the COVID-19 Pandemic



One reason WIC participation during COVID varied across states relates to differences in the administrative burden families face when enrolling in WIC and accessing and redeeming benefits.²⁵ Families participating in WIC receive electronic benefits transfer (EBT) debit cards, which they can use to purchase approved food and beverage products from vendors that accept WIC benefits. Nine “offline EBT” states, Arkansas, Louisiana, New Mexico, Missouri, Ohio, Pennsylvania, Utah, Texas, and Wyoming, still require WIC beneficiaries to present these cards in-person at their local WIC office every 3-4 months to reload their benefits.²⁶ In all other states, WIC EBT cards are automatically reloaded online (remotely) each month, and beneficiaries do not have to travel to WIC clinics in-person during the pandemic.


States’ reasons for sticking to offline EBT reloading vary slightly, but most center around the benefits that accompany in-person reloading, such as nutrition education, health check-ins, and the cost of switching to an online system. These benefits are largely outweighed by the burdens associated with offline systems. WIC serves a population challenged by social determinants of health,²⁷ combined with the strain of pregnancy and newborn care. Pandemic or not, EBT cards are easier and safer to reload online. In-person reloading requires mothers to travel to WIC offices, often on public transportation and with young children.²⁸ The pandemic adds risks of in-person contact, delays in mail processing and delivery, and increases socioeconomic and transportation barriers.²⁹ Requiring participants to have reliable transportation to just access their benefits goes against the goals of the WIC program. Furthermore, recertification, nutrition education, breastfeeding support, and referrals to health care providers can easily be provided online by phone or video visit, as many online states are already doing.³⁰

Most notably, offline reloading decreases WIC participation. Multiple studies have shown that offline EBT reloading limited access to benefits during the pandemic, when eligible families needed them most. Prior to the pandemic, WIC participation declined in both online and offline states; during the pandemic, however, WIC participation increased sharply in online EBT states while it continued to decline in offline EBT states.³¹ A study by the Center on Budget and Policy Priorities showed that over the first nine months of the pandemic, states with offline EBT experienced a 9.2 percent decrease in participation, relative to online EBT states.³² As of January 2021, researchers estimated that WIC participation was 14 percent lower in offline states, relative to online states.³³ This corresponds to an estimated 160,000 fewer beneficiaries in these nine states.³⁴

The challenges of the pandemic have made clear that an online program better serves WIC beneficiaries, and that even seemingly minor barriers to accessing public programs may substantially reduce participation.

II. Faster Growth in Medicaid and SNAP during the COVID-19 Pandemic Shows WIC is Missing Eligible Families

To assess how effectively WIC is reaching eligible families during the pandemic, researchers have compared participation changes in WIC to those in Medicaid, which provides access to



comprehensive health care, and in SNAP, which offers grocery benefits to help individuals and families afford food. Every pregnant or postpartum individual and child under 5 participating in Medicaid or SNAP are also “adjunctively eligible” for WIC, meaning they are considered income-eligible and do not need to separately document their income to enroll in WIC.³⁵ Therefore, examining the number of pregnant and postpartum people and children under 5 who participate in Medicaid and SNAP gives an indication of who WIC could be reaching.³⁶

Even before the pandemic, a significant share of Medicaid and SNAP participants who were income-eligible for WIC were not enrolled in the program. Pilot projects conducted in four states during 2018 and 2019 found that between 44 percent and 63 percent of WIC-eligible people enrolled in Medicaid or SNAP were not enrolled in WIC.³⁷


During the pandemic, total Medicaid enrollment increased by 16 percent in the 50 states and D.C. between February 2020 and February 2021, while WIC participation increased by only 2 percent.³⁸ Among the 50 states and D.C., Medicaid child enrollment increased by roughly 11 percent over this period while WIC child participation increased by roughly 5 percent.³⁹ WIC’s lower growth suggests that the number of young children participating in Medicaid who are eligible for WIC but missing out has risen since the pandemic started. Available SNAP data suggest that SNAP participation has also grown more rapidly than WIC during the pandemic, further highlighting WIC’s participation problems.⁴⁰ While USDA does not publish recent child participation data for SNAP, ten states do. In these ten states, SNAP participation by children of all ages increased by 10 percent during the pandemic; nationwide, WIC participation by children under 5 increased by 5 percent. If these ten states are representative, child participation nationally grew by roughly half as much in WIC as in SNAP.⁴¹ These data suggest that the number of children receiving SNAP who are eligible for WIC but not participating may have grown over the pandemic.

Policy Recommendations

I. Reaching SNAP and Medicaid Participants

In light of the long-term decline in WIC participation and the evidence that many SNAP and Medicaid participants who are eligible for WIC aren’t getting WIC benefits, efforts must be made to increase WIC participation among Medicaid and SNAP participants. WIC state and local officials should partner with their Medicaid and SNAP counterparts to compare program participation among children under 5 and pregnant or postpartum individuals.⁴² This type of analysis would allow officials to identify Medicaid and SNAP participants who are also eligible for WIC but not enrolled. It would also allow officials to implement routine referrals from Medicaid or SNAP to WIC and conduct targeted outreach to enroll eligible families in WIC.⁴³

II. Addressing Administrative Barriers



Administrative barriers significantly reduce participation in WIC. The USDA and state-level administrators of WIC must take action to address these barriers. To start, online EBT states should continue to offer remote benefit reloading and remote participant certification. WIC offices should continue to allow video or phone call appointments for eligibility checks and enrollment to ease the transportation and childcare burden of individuals seeking participation. This process could be eased further by allowing individuals to schedule appointments online, rather than only calling during business hours when many individuals are also working. Permitting submission of documents online and text or email reminders about appointments would further facilitate the enrollment process.⁴⁴

Moreover, states that mandate in person EBT reloading should transition to an online EBT reloading system. While working on this transition, states should load more benefits during every visit to limit the burden of frequent in-person visits. The cards should be programmed so that they only release one month's worth of benefits at the start of each month, to ensure that multiple months of funds are not accidentally spent all at once. Both online and offline EBT states should also consider minimizing administrative burden by: easing WIC enrollment for families enrolled in SNAP or Medicaid; streamlining data sharing between WIC administrative offices and pediatric care providers to limit unnecessary visits to WIC offices for screening already performed at doctors' offices; and making permanent the COVID-19 physical presence waivers and remote benefits waivers.⁴⁵

III. Simplifying the Shopping Experience

Another difficulty participants complain about is the actual shopping experience. The list of WIC-approved foods can be unclear or not communicated to participants, leading to inability to use benefits at the store. WIC agencies should prepare participants with more nutrition education, shopping preparation, and ongoing access to education resources to simplify the shopping experience and allow participants to get the most out of their benefits. Another innovation would be to allow individuals to scan item barcodes to determine if they are WIC-approved.⁴⁶ Some states have already begun adding more help and convenience features to aid participant shopping. In Knoxville, Tennessee, the "Call the WIC Lady SOS" campaign allows WIC participants to call or text the local WIC agency if they have a question or issues while shopping. WIC customers can text questions with pictures of the food items attached.⁴⁷ Further, as the food package substitution waivers wane, allowing participants to purchase non-WIC foods, in the event WIC-approved foods are not available, would further benefit participants.

Conclusion

The COVID-19 pandemic highlighted current issues with the WIC Program, and while band aid solutions in the form of temporary waivers aided the program, much more is needed to ensure greater participation and adequate benefits for participants. Continuing to reform the enrollment and re-enrollment process as well as increased advertisement to SNAP and Medicaid participants will help increase enrollment. Permitting online benefit reloading and making the shopping experience more transparent will help participants to optimize their benefits. As WIC has such great lifetime health and

well-being benefits for participants, expanding the program's reach will have innumerable benefits for public health.

SUPPORTERS



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