

Legislative and Regulatory History of the WIC Program

During WIC's history, a number of legislative acts and Federal regulations have shaped the program (table 5). This chapter describes WIC's evolution by examining its legislative and regulatory history.

The 1960s and 1970s: Establishment of the WIC Program

The origins of WIC date back to the 1960s when the Nation began to recognize that many low-income Americans were suffering from malnutrition. Various studies identified hunger as a major problem in this country. Events such as the Poor Peoples' March on Washington, DC, and the CBS documentary "Hunger in America" helped publicize the problem (USDA, 1999). In 1968, a group of physicians met with officials from the U.S. Department of Health, Education, and Welfare (HEW) and USDA in Washington, DC (Leonard, 1994). The physicians described young women, often pregnant, in their clinics with various ailments caused by lack of food. Out of this meeting came a plan to build food commissaries attached to neighborhood clinics. Doctors or clinic staff would prescribe needed foods and the prescription served as a voucher that the women would take to the commissary to obtain a food package. Later that year, the first USDA commissary program was established in Atlanta, GA.²⁶ Independently, another voucher program to distribute foods in a Baltimore, MD, neighborhood was developed by Dr. David Paige of Johns Hopkins University (Leonard, 1994).

In response to the growing public concern about malnutrition among low-income mothers and children, USDA established the Commodity Supplemental Food Program (originally named the Supplemental Food Program) in 1969 (Institute of Medicine, 1996). The program provided commodities to feed low-income pregnant women, infants, and children up to age 6. It was eventually recognized, however, that the available food assistance programs, including the Food Stamp Program and the Commodity Supplemental Food Program, were not meeting the special needs of pregnant women and infants (USDA, 1999).

In December 1969, the White House Conference on Food, Nutrition and Health focused national attention and resources on the problem of malnutrition and hunger due to poverty. Among the recommendations stated in the conference report was the need for special attention to be given to the nutritional needs of low-income pregnant women and preschool children (White House Conference on Food, Nutrition and Health, 1970).

On September 26, 1972, WIC was formally authorized by an amendment to the Child Nutrition Act of 1966. The legislation (P.L. 92-433), sponsored by Senator Hubert H. Humphrey, established the Special Supplemental Food Program as a 2-year pilot program.²⁷ The legislation's writers used the earlier Johns Hopkins voucher program as a model and designed the program to be a 2-year demonstration, with the expectation that the program's benefits

²⁶ The commissary in this program was stocked with USDA commodity foods.

²⁷ In 1973, the Department chose to call it the Special Supplemental Food Program for Women, Infants, and Children (WIC program) to prevent confusion with the supplemental food program being operated as an adjunct of the Food Distribution Program (38 *Federal Register* 18447-18451). In 1994, P.L. 103-448 changed WIC's name to the Special Supplemental Nutrition Program for Women, Infants, and Children to emphasize its role as a nutrition program.

Table 5

WIC timeline

1972	Legislation created the Special Supplemental Food Program as a 2-year pilot project (Public Law (P.L.) 92-433).
1973	The program was renamed the Special Supplemental Food Program for Women, Infants, and Children (WIC), and two food packages were created—one for infants and one for children and pregnant and breastfeeding women. WIC supplemental foods included infant formula, milk, cheese, eggs, infant and adult cereals, and fruit juice.
1974	The first WIC site officially opened in Pineville, KY.
1975	Legislation established WIC as a permanent national health and nutrition program (P.L. 94-105).
1977	USDA issued regulations that established a priority system based on nutritional need to determine who shall receive program benefits first. The regulations also allowed State agencies to operate up to three types of food distribution systems (home delivery, retail purchase, and direct distribution) and added a third WIC food package (for children with special dietary needs).
1978	The Child Nutrition Amendments of 1978 (P.L. 95-627) established a national income standard for program eligibility based on the income standards prescribed for reduced-price school lunches. The standards in 1978 stated that a household's income had to be 195 percent of the Federal poverty guidelines or lower. The act also strengthened WIC's nutrition education component by requiring that nutrition education be provided to all program participants.
1980	The number of food packages increased from three to six. Dry beans and peas or peanut butter were added to the food packages for children and pregnant and breastfeeding women, and a maximum level of 6 grams of sugar per dry ounce for adult cereals was set. Wyoming became the last State to implement WIC (the District of Columbia implemented its program in 1981).
1981	The maximum income level for reduced-price lunches was lowered to 185 percent of the Federal poverty guidelines. Since the WIC income eligibility standard was tied to the National School Lunch Program's eligibility standard, the maximum income level for WIC was also lowered to 185 percent of poverty.
1987	Tennessee became the first State to implement an infant formula rebate program.
1988	The Hunger Prevention Act of 1988 (P.L. 100-435) provided grants in up to 10 States to conduct Farmers' Market Demonstration Projects.
1989	The Child Nutrition and WIC Reauthorization Act of 1989 (P.L. 101-147) required WIC agencies with retail food distribution systems to use competitive bidding to procure infant formula unless another cost-containment approach yielded equal or greater savings. The act established adjunct income eligibility for Food Stamp, Medicaid, and Aid to Families with Dependent Children (AFDC) recipients. The act also required that USDA promote breastfeeding.
1992	To encourage breastfeeding among WIC mothers, an enhanced WIC food package (food package VII) was created that added two new food items—carrots and canned tuna—along with increased amounts of juice, cheese, and beans/peas and peanut butter for women who exclusively breastfeed their infants. The WIC Farmers' Market Nutrition Act of 1992 (P.L. 102-314) established the WIC Farmers' Market Nutrition Program.
1994	The Healthy Meals for Healthy Americans Act of 1994 (P.L. 103-448) changed the name of the program to the Special Supplemental Nutrition Program for Women, Infants, and Children to emphasize its role as a nutrition program.
1997	USDA kicked off the National Breastfeeding Promotion Campaign to encourage WIC participants to begin and continue breastfeeding.
1998	The William F. Goodling Child Nutrition Reauthorization Act of 1998 (P.L. 105-336) required at certification that, except in limited circumstances, all applicants for WIC must be physically present, document their income, and present proof of residency.
1999	WIC State agencies are required to use definitions of nutritional risk from a national list established for the WIC program. States are not required to use all of the nutritional risk criteria on the list.
2004	The Child Nutrition and WIC Reauthorization Act of 2004 implemented provisions to maintain competitive pricing among WIC vendors, including peer group pricing.
2007	Interim final rule revises regulations governing the WIC food packages by adding fruits, vegetables, and whole grains; reducing the amounts of certain foods in the existing packages (e.g., juice and milk); and allowing more food substitution that accommodates different cultural eating patterns.

would be so overwhelming that it would continue as a full program (Leonard, 1994).

The legislation assigned USDA the responsibility of administering a program to provide supplemental foods to participants. Specific foods were not identified; however, supplemental foods were defined as foods containing nutrients currently lacking in the diets of populations at nutritional risk, particularly foods containing high-quality protein, iron, calcium, vitamin A, and vitamin C.²⁸ Also, no mention was made of providing nutrition education or health care referrals. The legislation, however, which grew out of concern that low-income families were not receiving good health care or proper nutrition, created a close association between the supplemental food aspect of the program and health care services by requiring that WIC eligibility depend on participants being at nutritional risk as determined by health professionals (U.S. General Accounting Office, 1979).²⁹

Because USDA took little action, the Food Research and Action Center (FRAC) filed suit against USDA, and a Federal court judge ordered USDA to issue regulations to implement the program (Leonard, 1994; 38 *Federal Register* 18447-18451). The regulations, issued in July 1973, created two food packages—one for infants and one for children and pregnant and breastfeeding women—and specified the maximum monthly quantities of each food to be made available to participants. Authorized WIC foods were infant formula, milk, cheese, eggs, infant and adult cereals, and fruit juice. Later that year, legislation (P.L. 93-150) was enacted that authorized federally recognized Indian tribes to act as their own WIC State agencies.

The first WIC site officially opened in Pineville, KY, on January 15, 1974 (USDA, 1999). By the end of the year, WIC was operating in parts of 45 States.³⁰ At this time, WIC provided supplemental foods only to pregnant and breastfeeding women, infants, and children ages 1–3.³¹ Nonbreastfeeding postpartum women and children age 4 and older were excluded.

On October 7, 1975, P.L. 94-105 established WIC as a permanent program. The legislation stated, “Congress finds that substantial numbers of pregnant women, infants, and young children are at special risk in respect to their physical and mental health by reason of poor or inadequate nutrition or health care, or both. It is, therefore, the purpose of the program authorized by this section to provide supplemental nutritious food as an adjunct to good health during such critical times of growth and development in order to prevent the occurrence of health problems.” Categorical eligibility was extended to nonbreastfeeding women (up to 6 months postpartum) and children up to their fifth birthday.³² Eligibility was limited to people determined by the program to be at nutritional risk because of inadequate nutrition and inadequate income. What constituted inadequate nutrition and inadequate income, however, was not defined. The program was designed to supplement food stamps and, as a result, participation in the Food Stamp Program did not preclude a person from participating in WIC.³³ The legislation required that the program begin in areas most in need of special supplemental food and allowed costs for nutrition education as administrative expenses.

²⁸ Nutrition research in the 1970s identified these nutrients as most likely to be lacking in the diets of low-income women, infants, and children (72 *Federal Register* 68965).

²⁹ The U.S. General Accounting Office (1979) reported that the proponents of the legislation creating WIC “envisioned that, since participants would be routinely visiting health clinics in connection with obtaining the supplemental food, they would be treated for medical conditions that otherwise would go untreated.”

³⁰ In 1980, Wyoming became the last State to enter the program (USDA, 1999).

³¹ The U.S. General Accounting Office (1979) reported that these groups were highly vulnerable because they were in critical periods of growth and development and were susceptible to a variety of potentially harmful nutritional and nutritionally related medical problems. The inclusion of pregnant women was justified primarily by the vulnerability of the developing fetus and the beneficial impact of early WIC intervention. Support and reinforcement of breastfeeding practices, along with the increased nutritional demands associated with lactation, justified the inclusion of breastfeeding women. In the case of infants and young children, the rapid and critical stages of their growth and development and the nutritional demands and health risks they impose justified their inclusion.

³² It has been suggested that Congress established the age limit at 5 years as a bridge between WIC and other child nutrition programs that begin when the child enters school (U.S. General Accounting Office, 1985).

³³ However, participation in the Commodity Supplemental Food Program disqualifies a person from participating in the WIC program.

In 1977, regulations were issued that established a priority system based on nutritional need to ensure that people most in need received program benefits first (42 *Federal Register* 43206-43220). The system specified priorities for serving categories of participants within the target population. Because of the difficulties associated with determining inadequate dietary patterns as indicators of nutritional need, it was deemed that people with clinical indicators of nutritional need (e.g., people suffering from anemia, abnormal growth patterns, or medical conditions) deserved higher priority levels than people with no clinical indicators. The regulations also allowed State agencies to operate up to three types of food distribution systems (home delivery, retail purchase, and direct distribution) and added a third WIC food package (for children with special dietary needs).³⁴

In 1978, P.L. 95-627 defined nutritional risk and established income eligibility standards linked to the income standards prescribed for free and reduced-price school meals.³⁵ The legislation required that nutrition education be provided to all program participants (or their parents/caretakers) and that not less than a sixth of administrative funds be used for nutrition education activities. The act removed any reference to specific nutrients by defining supplemental foods as “those foods containing nutrients determined by nutrition research to be lacking in the diets” of the target population, as prescribed by the Secretary of Agriculture. The Secretary (“to the degree possible”) was also to ensure that the fat, sugar, and salt content of the foods prescribed by WIC were appropriate. The act strengthened the link between WIC and the third component of its benefit package—referrals to health and other services—by requiring that WIC State agencies describe their plans to coordinate WIC operations with special counseling services, such as family planning, immunization, child abuse counseling, and alcohol and drug abuse prevention counseling.

The 1980s and 1990s: WIC Expands

The WIC program saw a number of changes in the 1980s and 1990s, during which time program caseloads nearly quadrupled. Prior to 1980, WIC provided three food packages: one for infants, one for women and children, and one for children with special dietary needs. These food packages were designed so that local WIC agencies could tailor the packages to suit the nutritional needs of the individual. In 1980, new regulations increased the number of food packages from three to six: infants 0-3 months, infants 4-11 months, children/women with special dietary needs, children 1-4 years, pregnant and breastfeeding women, and nonbreastfeeding postpartum women (45 *Federal Register* 74854-74877). The additional food packages took into account the different nutritional needs of participants and the belief that little tailoring was taking place.³⁶ Dry beans and peas or peanut butter were added to the food packages for children and pregnant and breastfeeding women to increase food variety and enhance nutrient value. The regulations also set a maximum level of 6 grams of sugar per dry ounce for adult cereals due to concerns over sugar’s contribution to tooth decay.

In 1989, P.L. 100-435 established a Farmers’ Market Coupon Demonstration Project in which 3-year grants were awarded in 10 States to create

³⁴ To receive the food package for children with special dietary needs, a physician was required to document that the child’s condition precluded the use of the conventional food package for children.

³⁵ The current guideline for free school meals is household income at or below 130 percent of the Federal poverty guidelines; households with income between 130 and 185 percent of the Federal poverty guidelines are eligible for reduced-price school meals.

³⁶ A 1979 study by the U.S. General Accounting Office (1979) concluded that nearly all WIC participants were given the maximum allowable quantities of WIC foods without any attempts to tailor the kinds and amounts of food to meet the nutritional needs of individuals.

demonstration projects designed to provide WIC participants with coupons that could be exchanged for fresh, unprepared foods at farmers' markets. Largely as a result of the success of these demonstration projects, P.L. 102-314 in 1992 permanently established the WIC Farmers' Market Nutrition Program (FMNP). Because of limited funding, the FMNP is only available in some geographical areas. Participants in the FMNP receive \$10-\$30 worth of coupons per year to be spent at approved farmers' markets (a set of vouchers can be provided to a household or to an individual.)³⁷

One of the most important legislative acts required WIC State agencies to implement cost-containment practices. In the mid-1980s, infant formula accounted for nearly 40 percent of total WIC food costs and infant formula retail prices were rising more quickly than prices for other foods. These factors led several WIC State agencies to look into cost-containment practices to reduce infant formula costs. In 1987, Tennessee became the first State with a retail food delivery system to implement a rebate system to control costs associated with infant formula. It used competitive bidding to award a contract to an infant formula manufacturer for the exclusive right to provide its product to WIC participants in the State in exchange for a rebate on the formula. The practice proved to be so successful in containing costs that P.L. 101-147 was enacted in 1989, requiring that all WIC State agencies enter into cost-containment contracts for the purchase of infant formula. Because funding for WIC is fixed by congressional appropriations, cost-containment practices allow the program to serve more participants or absorb higher food costs. Since establishment of the infant formula rebate system, rebates have increased dramatically. (For more information on the infant formula rebate program, see the section on "Infant Formula Costs," p. 51.)

While the savings from infant formula rebates allowed WIC State agencies to serve more participants, the escalation in participation increased States' administrative burden (Macro International, 1995). When infant formula rebates were first implemented, the NSA portion of the States' Federal appropriations was fixed at 20 percent of the total appropriation.³⁸ As a result, the increase in participation reduced the amount of NSA dollars per participant. To address this funding constraint, P.L. 101-147 (enacted in 1989) changed how the total Federal WIC appropriation to WIC State agencies is allocated for NSA. The new law changed the funding for NSA to a per participant basis based upon the 1987 national average NSA grant per participant (i.e., before the large-scale implementation of infant formula rebates) adjusted annually for inflation.

P.L. 101-147 also established adjunct income eligibility for Food Stamp, Medicaid, and Aid to Families with Dependent Children (AFDC) participants.³⁹ This was intended to simplify the WIC application process since, at that time, the income eligibility criteria for these other programs were lower than those for WIC.⁴⁰ This eligibility provision also had the effect of increasing the coordination between WIC and these other programs (Bartlett et al., 2000). Through the provision of onsite health services or referrals to other health care and social service providers, WIC became an important source for an array of health and social services as it "evolved from being an adjunct to maternal and child health services to becoming an

³⁷ This is the Federal share of benefits received. States may provide additional benefits.

³⁸ Federal grants to WIC State agencies are divided into food grants and nutrition services and administration (NSA) grants.

³⁹ P.L. 104-193 replaced AFDC with the Temporary Assistance for Needy Families program in 1996.

⁴⁰ Eligibility rules and practices in some States now enable people with incomes above 185 percent of poverty to enroll in Medicaid and therefore be income eligible for WIC.

important gateway program through which many low-income households entered the public health system” (Macro International, 1995).

The late 1980s also saw an increased emphasis on breastfeeding promotion and support in WIC.⁴¹ Concern about low breastfeeding rates among WIC mothers prompted Congress in 1989 to mandate \$8 million to support breastfeeding promotion activities in WIC and allow the use of administrative funds to purchase breastfeeding aids by WIC agencies as part of P.L. 101-147 (U.S. General Accounting Office, 1993). A Breastfeeding Promotion Consortium was established in 1990 to exchange ideas on how the Federal Government and private health organizations can collaboratively promote breastfeeding as the optimal form of infant feeding to WIC participants and the general public. The 1991 Act (P.L. 102-342) required that the Secretary of Agriculture establish a promotion program to promote breastfeeding as the best method of infant nutrition and to foster wider public acceptance of breastfeeding in this country. In 1992, USDA established an enhanced WIC food package for breastfeeding mothers whose infants do not receive WIC infant formula. The enhanced package added two new food items—carrots and canned tuna—along with increased amounts of juice, cheese, and beans/peas and peanut butter, to the items provided in the food package for pregnant and breastfeeding women. In 1994, P.L. 103-448 required WIC to spend at least \$21 (to be adjusted annually for inflation) for breastfeeding promotion on every pregnant and breastfeeding woman participating in the program.

As WIC expanded rapidly in the 1990s, the potential for misuse of program funds and violation of program regulations increased. Legislative and regulatory actions were enacted to strengthen the integrity of the program. For example, the 1998 William F. Goodling Child Nutrition Reauthorization Act (P.L. 105-336) required that, except in limited circumstances, applicants must be physically present at certification to document their income if they were not adjunctively income eligible based on enrollment in other programs and provide proof of residency (to prevent dual participation).⁴² P.L. 105-336 also required WIC State agencies to permanently disqualify WIC vendors convicted of trafficking food instruments (i.e., accepting food instruments for cash).

In 1999, the WIC program standardized nutritional risk criteria for determining program eligibility and assigning individual priority levels. As noted earlier, the priority system was designed to ensure that, in the event that program funds were not sufficient to serve all eligible people, WIC benefits would be provided to those most in need. Prior to April 1, 1999, each WIC State agency developed its own nutritional risk criteria subject to broad Federal parameters. As of April 1, 1999, however, WIC State agencies are required to use consistently defined nutritional risk criteria selected from a list of nearly 100 risk factors established specifically for use in the WIC program and issued by FNS (USDA, 1998).⁴³ WIC State agencies may choose to use some or all of the nutritional risk criteria on the national list.

⁴¹ Although breastfeeding was always an area of concern in the WIC program, the level of concern rose as the program grew because of the increasing number of women being served and WIC's growing share of the infant formula market (Schwartz et al., 1992).

⁴² Dual participation refers to simultaneous participation in the WIC and Commodity Supplemental Food Program as well as to participation in more than one local WIC program at the same time.

⁴³ Concerned about the variation in criteria used to determine nutritional risk eligibility among WIC State agencies, Congress directed USDA in 1989 (P.L. 101-147) to conduct a review of risk criteria (USDA 1998). In 1993, USDA awarded a grant to the Institute of Medicine (IOM) to conduct a comprehensive independent review of the nutritional risk criteria in use at that time. Following the publication of the IOM report in 1996 (Institute of Medicine, 1996), a joint National Association of WIC Directors (NAWD)/FNS workgroup called the Risk Identification and Selection Collaborative (RISC) was formed to review each of the criteria addressed by IOM. In 1998, FNS issued the list of the national nutritional risk criteria (several nutritional risk criteria have been added or modified since then).

2000 to the Present: Recent Developments

The beginning of the decade saw a rapid increase in the number of “WIC-only” stores (i.e., stores that sell only or predominantly WIC foods and serve only or predominantly WIC participants). Under the retail food delivery system used by most WIC State agencies, WIC participants exchange food vouchers (or instruments) for supplemental foods at authorized retail outlets. Although WIC participants receive their WIC foods for free, market forces discourage regular WIC vendors from taking advantage of the price insensitivity of WIC participants and charging higher prices for WIC foods. That is because regular WIC vendors serve both WIC and non-WIC customers and if a WIC vendor charges too high a price for the WIC foods, the non-WIC customers—who pay out of pocket for their food—may shop at another store, resulting in a loss of revenue for the vendor. Since WIC-only stores do not serve non-WIC customers, there is less economic incentive for them to keep prices low. As a result, the prices at WIC-only stores are generally higher than those of other WIC vendors.⁴⁴ Neuberger and Greenstein (2004) estimated that WIC-only stores in California increase WIC food costs by about \$33 million per year. Because WIC participants are not required to obtain all the foods listed on their food instrument, it is not clear to what extent WIC-only stores have higher costs because of higher prices or because WIC vouchers are more likely to be redeemed in full there.

To address concerns about the increasing number of WIC-only stores with higher food costs, the Child Nutrition and WIC Reauthorization Act of 2004 (P.L. 108-265) included several vendor cost-containment provisions. The new law required that WIC State agencies establish a vendor peer group system, distinct peer competitive price criteria, and allowable reimbursement levels for each peer group. WIC State agencies must use the competitive price criteria to evaluate the prices a vendor applicant charges for supplemental foods compared with the prices charged by other vendor applicants and authorized vendors. State agencies must establish peer groups to determine the competitive-price criteria and maximum reimbursement levels applicable to vendors; vendors are assigned to peer groups based on characteristics such as geographic location, number of cash registers, WIC sales volume, type of ownership (sole proprietorship, corporate, or partnership) and other criteria indicating that all of the vendors in a peer group would be expected to have similar prices. The law also mandated special cost-containment requirements for “above-50-percent vendors,” (i.e., vendors that derive more than 50 percent of their annual food sales revenue from WIC food instruments). P.L. 108-265 requires that WIC State agencies ensure that the prices of above-50-percent vendors do not result in higher total food costs.⁴⁵

This decade also saw major changes to WIC food packages. Prior to 2007, WIC food packages had remained largely unchanged since the 1970s, even as the WIC population became more diverse, food patterns and participants’ nutritional risks changed, and nutritional science advanced. For many years, WIC program administrators, medical and scientific communities, advocacy groups, and Congress had expressed an interest in updating the food packages. In December 2007, USDA published an interim final rule that overhauled the WIC food packages (72 *Federal Register* 68965-69032).⁴⁶

⁴⁴ There may be other reasons for the higher prices in WIC-only stores. For example, smaller WIC-only stores may be less able to take advantage of economies of scale in their purchases.

⁴⁵ P.L. 108-447 (which contained the FY 2005 appropriations for WIC) and P.L. 109-97 (which contained the FY 2006 appropriations for WIC) prohibited the authorization of new above-50-percent vendors except for stores needed to ensure participant access to program benefits or stores that had moved short distances. This prohibition was not continued in succeeding years because P.L. 108-265 required FNS certification of a State agency’s vendor cost-containment system for a State agency to authorize above-50-percent vendors. These certifications were completed by the end of FY 2006.

⁴⁶ An interim final rule has the full force and effect of a final rule, yet allows the Department to obtain feedback on the provisions while implementation goes forward.

The interim final rule's revisions largely reflect recommendations made by the Institute of Medicine (IOM) of the National Academies in its report, "WIC Food Packages: Time for a Change," with certain cost-containment and administrative modifications that ensure cost neutrality (Institute of Medicine, 2005).⁴⁷ The interim final rule revised regulations to align WIC food packages with the *Dietary Guidelines for Americans* (U.S. Department of Health and Human Services and U.S. Department of Agriculture, 2005) and with the current infant feeding guidelines set by the American Academy of Pediatrics. This alignment was aimed at promoting and supporting the establishment of successful long-term breastfeeding, providing WIC participants with a wider variety of food and WIC State agencies with greater flexibility in prescribing food packages for participants with cultural food preferences. In order to serve the greatest number of eligible applicants, the revised food packages were designed to be cost-neutral (i.e., to cost no more than the packages they replaced). Although WIC State agencies could begin to phase in the revised food packages by February 2008, none did so.⁴⁸ All WIC State agencies are required to implement the new provisions no later than October 1, 2009. (For additional details about the WIC food packages revisions, see the section on "Potential Impact of the Revised WIC Food Packages," p. 44.)

⁴⁷ For example, the IOM report recommended adding yogurt to the WIC food packages as a milk substitute for children and women and providing fruit and vegetable vouchers with a cash value of \$10 per month for women and \$8 per month for children. To maintain cost neutrality, however, the interim final rule did not include yogurt and the cash value of the fruit and vegetable vouchers was reduced to \$8 for nonbreastfeeding women and \$6 for children.

⁴⁸ New York and Delaware were the first States to begin implementing the revised food packages in January 2009.