UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

DISTRICT OF COLUMBIA, STATE OF NEW YORK, STATE OF CALIFORNIA, STATE OF CONNECTICUT, STATE OF MARYLAND, COMMONWEALTH OF MASSACHUSETTS, STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEVADA, STATE OF NEW JERSEY, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, STATE OF RHODE ISLAND, STATE OF VERMONT, COMMONWEALTH OF VIRGINIA and CITY OF NEW YORK,

Plaintiffs,

v.

U.S. DEPARTMENT OF AGRICULTURE; GEORGE ERVIN PERDUE III, in his official capacity as Secretary of the U.S. Department of Agriculture, and UNITED STATES OF AMERICA,

Defendants.

Case No. 1:20-cv-00119

DECLARATION OF HEATHER HARTLINE-GRAFTON IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

1. I am over the age of eighteen (18) years, competent to testify to the matters contained herein, and testify based on my personal knowledge and information.

2. I am the senior researcher for nutrition policy and community health at the Food Research & Action Center (FRAC). I am a Registered Dietitian and hold honors bachelors' degrees in nutritional sciences and dietetics from the University of Delaware, an M.P.H. in nutrition from the University of North Carolina, and a Dr.PH. in community health sciences from Tulane University. I joined the FRAC staff in January 2009 and have extensive experience in nutrition policy research, social determinants of health, obesity prevention, and healthy eating strategies, including through my prior work at the American Cancer Society, Mathematica Policy Research, and Tulane University. As FRAC's senior researcher for nutrition policy and community health, my work primarily focuses on obesity, dietary quality, and health outcomes among low-income and food-insecure children and families, with emphasis on how the federal

nutrition programs improve health, nutrition, and well-being. I am also actively involved in FRAC's work on screening for and addressing food insecurity in health care settings.

3. I am aware that the federal government recently issued a final rule "Supplemental Nutrition Assistance Program: Requirements for Able-Bodied Adults Without Dependents," 84 Fed. Reg. 66,782 ("the Rule"). Under prior authority, able-bodied adults without dependents (ABAWDs) may only receive three months of benefits from the Supplemental Nutrition Assistance Program (SNAP) unless they fulfill certain work requirements. However, states with areas of high unemployment or insufficient jobs may apply for waivers of this time limit. The new final Rule eliminates or restricts many of the criteria upon which states can rely when applying for a waiver of the ABAWD time limit. I have reviewed the Rule and am aware of its direct implications on the administration of the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, within the states. I understand that this lawsuit challenges the Rule.

4. FRAC is the leading national nonprofit organization working to eradicate poverty-related hunger and undernutrition in the United States. FRAC leads efforts to identify and communicate the connections among poverty, hunger, and obesity among low-income people; conducts research to document the extent of hunger, its impact, and effective solutions; seeks stronger federal, state and local public policies that will reduce hunger, undernutrition, and obesity; monitors the implementation of laws and serves as a watchdog of programs; provides coordination, training, technical assistance, and support on nutrition and anti-poverty issues to a nationwide network of advocates, service providers, food banks, program administrators and participants, and policymakers; and conducts public information campaigns to help promote changes in attitude and policies.

5. In 2018, more than 37 million people lived in food-insecure households.[1] Food insecurity is a term defined by the U.S. Department of Agriculture (USDA) that indicates that the availability of nutritionally adequate and safe food, or the ability to acquire such food, is limited or uncertain for a household.

6. Food insecurity is a health-related social need that contributes to poor physical and mental health outcomes.[2] For example, studies have found that food insecurity increases the prevalence and severity of diet-related diseases, including obesity, type-2 diabetes, heart disease, stroke, and some cancers. In addition, because of limited financial resources, individuals that are food insecure may use coping strategies to stretch budgets that are harmful for health, such as engaging in cost-related medication underuse, postponing or forgoing preventive or needed medical care, foregoing the foods needed for special medical diets, and making trade-offs between food and other basic necessities (e.g., housing, utilities, transportation).

7. Food insecurity and its related coping strategies can exacerbate existing disease and compromise health, while also contributing to increased physician visits, emergency room visits, hospitalizations, and expenditures for prescription medications.[3] As a result, food

[1] Coleman-Jensen, A., Rabbitt, M. P., Gregory, C. A., & Singh, A. (2019). Household food security in the United States in 2018. *Economic Research Report*, 270. Washington, DC: U.S. Department of Agriculture, Economic Research Service.
[2] Hartline-Grafton, H. (2017). *The Impact of Poverty, Food Insecurity, & Poor Nutrition on Health and Well-Being*. Washington, DC: Food Research & Action Center.
[3] Ibid.

insecurity is a strong predictor of increased health care costs. According to recent analyses, food insecurity contributed to $52.9 billion in excess health care costs for the nation in 2016.[4] California had the highest annual health care costs associated with food insecurity at $7.2 billion. (See Exhibit A for cost estimates by U.S. states and the District of Columbia.)

8. SNAP is the largest nutrition assistance program administered by the USDA and serves as the first line of the nation's public policy defense against hunger and undernutrition. This invaluable program has a critical role, not just in reducing food insecurity, but in improving the health of the nation, especially among the most vulnerable Americans.[5]

9. Several studies demonstrate that SNAP alleviates food insecurity, which, in turn, can improve the dietary intake and health of SNAP recipients. For instance, a study by Urban Institute researchers found that SNAP reduced the likelihood of being food insecure by approximately 31 percent and the likelihood of being very food insecure by 20 percent.[6]

10. SNAP is a critical health intervention and support for vulnerable Americans, with considerable evidence demonstrating the program's effectiveness in improving health outcomes.[7] SNAP has been particularly beneficial for SNAP recipients with diabetes. Among a sample of low-income, urban medical center patients with Type 2 diabetes, SNAP receipt was associated with a lower risk of poor glucose control among those who were food insecure. The authors of the study raised concerns that cuts to SNAP could result in "worse chronic disease control among low-income patients with diabetes."[8] Studies also have shown that hospital admissions for hypoglycemia (i.e., low blood sugar) are higher at the end of the month for low-income individuals with diabetes than high-income individuals with diabetes. [9] This suggests that low-income patients are more likely to have hypoglycemia when food and other benefits (e.g., SNAP) are most likely to be depleted, typically at the end of the month.

11. SNAP participation also has been linked to improved mental health for recipients. A national study of SNAP households found that participation in SNAP for six months was associated with a 38 percent reduction in psychological distress.[10] In a national sample of low-income adults, low food security and very low food security were both associated with higher odds of depression among SNAP participants, but the odds were not as great as those for similarly situated non-participants. These findings suggest that SNAP may have a protective effect on mental health.[11]

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[4] Berkowitz, S. A., Basu, S., Gundersen, C., & Seligman, H. K. (2019). State-level and county-level estimates of health care costs associated with food insecurity. *Preventing Chronic Disease*, 16, e90.
[5] Hartline-Grafton, H. (2017). *SNAP and Public Health: The Role of the Supplemental Nutrition Assistance Program in Improving the Health and Well-Being of Americans*. Washington, DC: Food Research & Action Center.
[6] Ratcliffe, C., McKernan, S. M., & Zhang, S. (2011). How much does the Supplemental Nutrition Assistance Program reduce food insecurity? *American Journal of Agricultural Economics*, 93(4), 1082–1098.
[7] Hartline-Grafton, H. (2017). *SNAP and Public Health: The Role of the Supplemental Nutrition Assistance Program in Improving the Health and Well-Being of Americans*. Washington, DC: Food Research & Action Center.
[8] Mayer, V. L., McDonough, K., Seligman, H., Mitra, N., & Long, J. A. (2016). Food insecurity, coping strategies and glucose control in low-income patients with diabetes. *Public Health Nutrition*, 19(6), 1103–1111.
[9] Seligman, H. K., Bolger, A. F., Guzman, D., López, A., & Bibbins-Domingo, K. (2014). Exhaustion of food budgets at month's end and hospital admissions for hypoglycemia. *Health Affairs*, 33(1), 116–123.
[10] Oddo, V.M., & Mabli, J. (2015). Association of participation in the Supplemental Nutrition Assistance Program and psychological distress. *American Journal of Public Health*, 105(6), e30-e35.
[11] Leung, C. W., Epel, E. S., Willett, W. C., Rimm, E. B., & Laraia, B. A. (2015). Household food insecurity is positively associated with depression among low-income Supplemental Nutrition Assistance Program participants and income-eligible nonparticipants. *Journal of Nutrition*, 145(3), 622–627.

12. Increased SNAP participation also reduces health care utilization and costs. For example, a national study found that "SNAP participation was associated with approximately $1400 per year per person lower subsequent health care expenditures in low-income adults."[12] The savings were even larger for SNAP participants with hypertension or coronary heart disease.

13. Many of the ABAWDs who would lose their benefits under the new waiver Rule also participate in Medicaid. SNAP participation and benefits have implications for Medicaid spending, as demonstrated in studies examining the impact of a temporary increase in SNAP benefits on health care utilization and expenditures. For instance, in a nationwide study, monthly Medicaid admission growth fell from 0.80 to 0.35 percentage points after the temporary increase in SNAP benefits, but then rose to 2.42 percentage points after the boost ended (and SNAP benefits decreased).[13] Inflation-adjusted monthly inpatient Medicaid expenditures followed a similar pattern and were associated with $26.5 billion in savings over the 55 months of the benefit increase and $6.4 billion in additional costs over the first 14 months of the SNAP benefit decrease.

14. Recent research shows that expansions of SNAP work requirements would result in rapid declines in caseloads and benefits. Researchers examined how changes in the implementation of work requirements (i.e., the absence of waivers for ABAWDs) impacted SNAP caseloads and benefits from 2013 to 2017.[14] In analyses that accounted for unemployment, poverty, and Medicaid expansions, SNAP work requirement expansions caused approximately 600,000 participants to lose SNAP benefits between 2013 and 2017. Additional estimates indicate that more than one-third of all ABAWDs lost SNAP benefits due to the adoption of work requirements. The work requirement expansions also resulted in a loss of about $2.5 billion in SNAP benefits in 2017. The authors wrote, "in light of research indicating that SNAP reduces food insecurity and is associated with improved health and lower health expenditures, our analysis suggests that work requirements could create hardships for low-income adults, including increased food insecurity and impaired health."

15. SNAP improves local economies and access to healthy food. The positive economic stimulative effects of SNAP, particularly during recessionary periods, are well documented. According to recent studies, it is estimated that $1 of SNAP benefits leads to between $1.50 and $1.80 in total economic activity during a recession.[15] Those dollars help all parts of the food system, from farmers and food producers, to store owners and clerks. Many farmers' markets receive revenue from SNAP purchases and many of those markets also participate in incentive programs that provide SNAP shoppers with bonuses for purchasing fruits and vegetables. SNAP benefits help many food retailers who operate on thin margins to remain in business, which improves food access for the whole community.

I declare under penalty of perjury that the forgoing is true and correct and of my own

[12] Berkowitz, S. A., Seligman, H. K., Rigdon, J., Meigs, J. B., & Basu, S. (2017). Supplemental Nutrition Assistance Program (SNAP) participation and health care expenditures among low-income adults. *JAMA Internal Medicine*, 177(11) 1642–1649.
[13] Sonik, R. A., Parish, S. L., & Mitra, M. (2018). Inpatient Medicaid usage and expenditure patterns after changes in Supplemental Nutrition Assistance Program benefit levels. *Preventing Chronic Disease*, 15, e12.
[14] Ku, L., Brantley, E., & Pillai, D. (2019). The effects of SNAP work requirements in reducing participation and benefits from 2013 to 2017. *American Journal of Public Health*, 109(10), 1446–1451.
[15] Canning, P., & Stacy, B. (2019). The Supplemental Nutrition Assistance Program (SNAP) and the economy: new estimates of the SNAP multiplier. *Economic Research Report*, 265. Washington, DC: U.S. Department of Agriculture, Economic Research Service. [Technical Note: See pages 6-8 and Table 1 for research by Blinder and Zandi.]

personal knowledge.

Executed on January 8, 2020 in Tomball, TX.

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