April 2, 2019

Certification Policy Branch
SNAP Program Development Division
Food and Nutrition Service, USDA
3101 Park Center Drive
Alexandria, VA 22302

Re: RIN 0584-AE57 Supplemental Nutrition Assistance Program: Requirements and Services for Able-Bodied Adults Without Dependents (ABAWDs) Proposed Rule; submitted electronically via http://www.regulations.gov

Dear Sir or Madam;

Trinity Health appreciates the opportunity to provide comments to the United States Department of Agriculture Food and Nutrition Service's above-referenced notice of proposed rulemaking. We are deeply concerned that the proposed rule would negatively impact access to necessary food and nutrition assistance while doing little to support access to programs that promote self-sufficiency. We are also concerned these changes would result in hundreds of thousands of individuals losing Supplemental Nutrition Assistance Program (SNAP) benefits--this will lead to greater food insecurity and more people in need. Access to food and proper nutrition is a major factor in determining health outcomes, and the proposed rule will adversely affect the health of those who stand to lose SNAP coverage. **We urge you to withdraw or modify the rule so that it protects access to necessary food and nutrition programs and adheres to the bipartisan policies implemented in the recently passed 2018 Farm Bill.**

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 94 hospitals as well as 109 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns $1.1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 133,000 colleagues, including more than 7,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 23 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models (APMs).

As informed by Catholic Social Teaching, Trinity Health is committed to advancing policies that support the integral development of individuals. **We believe that access to food is a fundamental human right and basic need and support identifying effective policies to ensure adequate**

food, nutrition and economic stability for all individuals and families. We support policies that provide greater support for individuals and families so that they can learn the skills necessary to contribute to the well-being of their families and communities. Unfortunately, as written, the proposed regulation provides barriers to food assistance while providing little to no additional support for those who would now be required to participate in education and training programs in order to continue to receive food assistance.

Food Insecurity Increases Suffering and Health Care Costs

Our health care providers report regularly the undue suffering and illness experienced by patients and their families when there is food insecurity. This witnessed experience is supported by an extensive body of research, which reveals a consistent and strong correlation between food insecurity and poor health outcomes across the life cycle. Food insecurity among children is linked to increased risks of poor diets, the development of chronic health conditions including asthma and anemia, cognitive and behavioral problems, anxiety and depression, and poorer general health. Food insecurity among working-age adults is associated with poorer diet quality; multiple chronic conditions, including hypertension, coronary heart disease, diabetes, and kidney disease; and poorer general and mental health. And among seniors, food insecurity is linked to poorer diets, chronic conditions such as diabetes and anemia, worse general health, depression, more limitations in daily activities, and decreased quality of life.[1] Though to a lesser degree than with food insecurity, research suggests that marginal food security, defined by at least one reported indication of stress related to having insufficient food (but not as many indications as those considered food insecure), is also linked with adverse health outcomes among young children and caregivers.[2]

Canadian researchers, for example, using linked survey and administrative data on 67,000 working-age adults in Ontario province, show that public health care expenditures are substantially higher for food-insecure people, even after adjusting for other socioeconomic and demographic characteristics that might affect either food security or costs. The findings are particularly compelling because the study occurred in the context of Canada's universal health care system, alleviating concerns that the observed differences are due to differences in access to health insurance. The researchers found that individuals in households with moderate food insecurity are a third more likely to use health care services — and expenses among these health care users are a third higher — than those in food-secure households. As food insecurity increases, so do health care costs. Individuals in households with the most severe food insecurity are 71 percent more likely to use health care services, and the expenses of these health care users are 76 percent higher than those in food-secure households.[3]

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[1] For summaries of the extensive research on the health consequences of food insecurity, see Barbara A. Laraia, "Food Insecurity and Chronic Disease," Advances in Nutrition: An International Review Journal, 4(2):203-212, 2013, http://advances.nutrition.org/content/4/2/203.full; Alisha Coleman-Jensen, William McFall, and Mark Nord, "Food Insecurity in Households with Children," EIB-113. U.S. Department of Agriculture, Economic Research Service, May 2013, https://www.ers.usda.gov/webdocs/publications/43763/37672_eib-113.pdf?v=41424; and Craig Gundersen and James P. Ziliak, "Food Insecurity and Health Outcomes," Health Affairs, 34(11):1830-1839, 2015, http://gattonweb.uky.edu/Faculty/Ziliak/GZ_HealthAffairs_34(11)_2015.pdf.
[2] John T. Cook *et al*., "Are Food Insecurity's Health Impacts Underestimated in the U.S. Population? Marginal Food Security Also Predicts Adverse Health Outcomes in Young U.S. Children and Mothers,' *Advances in Nutrition: An International Review Journal*, 4(1):51-61, 2013, http://advances.nutrition.org/content/4/1/51.long.
[3] Valerie Tarasuk *et al*., "Association Between Household Food Insecurity and Annual Health Care Costs," *Canadian Medical Association Journal*, 187(14):E429-E436, October 6, 2015, http://www.cmaj.ca/content/187/14/E429.

Researchers in the United States, using national survey data to capture out-of-pocket expenses and insurance payments for two years after a household experiences food insecurity, found similar results. On average, after adjusting for a range of socioeconomic and demographic characteristics expected to affect food security and spending on health care (both out-of-pocket and paid by insurance, including Medicare and Medicaid), people in food-insecure households spend roughly 45 percent more on medical costs in a year ($6,100) than people in food-secure households ($4,200). Annual health care costs are $4,400 higher among those with diabetes, $2,200 higher among those with hypertension, and $5,100 higher among those with heart disease.[4]

Food insecurity is also associated with greater use of health care services. Adults in food-insecure households are about 50 percent more likely to visit an emergency room and be admitted to a hospital—and remain hospitalized about 50 percent longer—than adults in food-secure households. Food-insecure seniors are more likely to utilize health care services, including office visits, overnight stays in a hospital, and emergency rooms, than food-secure seniors.[5]

Trinity Health is a Committed Partner in Addressing Food Insecurity and Improving Nutrition in the Communities We Serve

Trinity Health recognizes the importance of access to healthy foods and the impact it has on the health of individuals, families, and communities. In 2016, Trinity Health launched the Transforming Communities Initiative (TCI) to advance community partnerships that focus on improving the health and well-being in communities. TCI is an innovative funding model and technical assistance initiative supporting eight communities using policy, system, and environmental (PSE) change strategies to prevent tobacco use and childhood obesity, as well as address social determinants of health.

The TCI childhood obesity prevention and reduction efforts have impacted nearly 260,000 youth in the 8 selected communities and resulted in:

- Increased collaboration with schools to improve food and beverage choices and increasing physical activity
- Creation of economic opportunity through food system development through partnerships with local communities
- Community assessment and action planning focused on improving public school policy and environment
- Nutrition and physical activity policy and practice assessments
- Engagement of local school and district staff at multiple sites
- Focus on cross-site coordinated work to promote school wellness
- Development of policy and environmental changes in early childcare settings as well as community food access

[4] Seth A. Berkowitz, Sanjay Basu, James B. Meigs, and Hillary K. Seligman, "Food Insecurity and Health Care Expenditures in the United States, 2011-2013," *Health Services Research*, June 13, 2017, http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12730/full.

[5] Seth Berkowitz, Hilary K. Seligman, and Sanjay Basu, "Impact of Food Insecurity and SNAP Participation on Healthcare Utilization and Expenditures," University of Kentucky Center for Poverty Research Discussion Paper Series, DP2017-02, 2017, http://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1105&context=ukcpr_papers; and Vibha Bhargava and Jung Sun Lee, "Food Insecurity and Health Care Utilization Among Older Adults in the United States," *Journal of Nutrition in Gerontology and Geriatrics*, 35(3):177-192, 2016, http://www.tandfonline.com/doi/abs/10.1080/21551197.2016.1200334.

Trinity Health is also partnering with others in the city of Hartford, Connecticut to address that community's challenges in accessing healthy food. The Health Hartford Hub (HHH) project is a collaborative effort to address Hartford's food desert and positively impact the health of Hartford residents, especially those living in the city's North End/Promise Zone neighborhoods. The HHH project is proposed to be located on four acres in north Hartford and will be anchored by a ground floor full service supermarket, a second floor restaurant/café, and adjacent parking. A planned mixed-use development on a separate parcel across an existing street will include a multi-story building with ground floor, retail space, and approximately 24 units of mixed-income housing above. Retail space of the mixed-use building is anticipated to include other health promoting services, such as a health clinic, a community teaching kitchen, and/or wellness center, and may include other complementary retail tenants. Trinity Health provided a $1.5 million letter of interest to support the project's development in 2018.

In addition, our Holy Cross Hospital in Fort Lauderdale has played an instrumental role in assisting private parochial schools with enrolling, implementing, and sustaining participation in The National School Lunch Program - a federally assisted meal program. School participation in this program opened access to portion controlled-nutritious school breakfast and lunches to thousands of eligible and hungry children. The impact on the individual family household's budget was also positively impacted by their child's enrollment in this free/reduced rate meal program. The hospital also partners with the local parks and recreation centers, libraries, and housing authority sites to provide access to the Summer Food Service Program, federally funded under the U.S. Department of Agriculture (USDA) and, in Florida, administered by the Florida Department of Agriculture and Consumer Services to provide access to more than 164,000 meals during the summer months to children out of school and lacking access to nutritious meals. Some students report that these are the only meals they receive during the summer months. Year round efforts to increase access to fresh fruits and vegetables is a priority in the Broward Community, especially those areas identified as food deserts. A food collaborative made up of governmental and non-governmental agencies provides year-round delivers fresh produce to 25 neighborhood sites and a mobile school pantry provides five Title I schools with a monthly farmers market so that families have access to fresh fruits and vegetables in existing food deserts.

SNAP Fills a Critical Need in Our Communities

Our commitment to advancing access to healthy food is strong and evidenced by the TCI program and examples of the Healthy Hartford Hub project and the efforts by Holy Cross Hospital as described above. Trinity Health also connects patients to organizations like Catholic Charities across the country to provide critical services, such as food, to those in need. The SNAP program is crucial to ensuring that individuals in need have access to adequate food. If implemented, the proposed rule would impact an estimated 1.2 million SNAP participants, 88 percent of whom have a household income at or below 50 percent of the poverty level and one-third of whom have an average monthly household income of $557.2[6].

[6] Cunnyngham, Karen, "Proposed Changes to the Supplemental Nutrition Assistance Program: Waivers to Work-Related Time Limits," Mathematica Policy Research, March 2019.

Modification of ABAWD Waiver Policy

Federal law limits the amount of time an able-bodied adult without dependents (ABAWD) can receive SNAP benefits, unless the individual meets certain work requirements. States' ability to request waivers for this time limit in areas with high unemployment and lack of sufficient jobs is crucial to continuing to ensure low-income individuals and families have access to proper nutrition.

On the request of a state SNAP agency, the law also gives the Department of Agriculture the authority to temporarily waive the time limit in areas that have an unemployment rate of over 10 percent or lack sufficient jobs. The law also provides state agencies with a limited number of exemptions that can be used by states to extend SNAP eligibility for ABAWDs subject to the time limit. Any efforts to modify or limit waivers for ABAWDs must include careful consideration of individuals who have fallen on hard times and are struggling to find a way out of poverty. We recommend prioritization of communities designated as having a “lack of sufficient jobs” for inclusion in other federal and state economic improvement and business development zone designations. This coordination in programs would encourage gainful employment among ABAWDs through leveraging private investment in order to develop new jobs and economic opportunities in underserved/high unemployment communities. Furthermore, procurement policies could be improved to give preferential status to employers in low employment communities.

Proposed elimination of LSA standard and creation of 7% unemployment floor for waivers

Current law allows ABAWDs between the ages of 18-49 to receive SNAP for a limited amount of time unless they meet work requirements which show they are working or participating in a qualifying education and training activity of for at least 80 hours per month. States are able to request waivers from these time limits by showing they fall within specific categories that illustrate high rates of unemployment. Included in these categories are if a state has a designation as a Labor Surplus Area (LSA) by the Department of Labor (DoL) or have a recent 24-month average unemployment rate 20 percent above the national average for the same 24-month period. Among other changes, the proposed rule would eliminate the ability for states to receive waivers if they are an LSA and would decrease the floor from 20 percent to 7 percent employment in the 24-month category.

Efforts to strengthen waiver requirements SNAP recipients must take in to account economic challenges faced by ABAWDs. If the proposed rule is implemented, an estimated 89 percent of ABAWDs would live in areas ineligible for a waiver. If an even higher unemployment floor of 10 percent were implemented, about 98 percent of people would live in areas unable to meet the waiver requirements.[7] This would mean more than 755,000 individuals would lose SNAP benefits over three years if they are unable to find work or enroll in a state approved employment and training program.

The USDA should work towards fully implementing reforms included in the Agriculture Improvement Act of 2018 to strengthen state education and training programs and provide more meaningful and effective means for assisting individuals in preparing for and finding dignified work. States should be encouraged to coordinate economic and community development in such a way to prioritize employment access and training for low-income communities. In addition, states should be incentivized to develop policies that link social services and private employers hiring practices through entities like social enterprises, transitional hiring partnerships, and case management in order

[7] Supplemental Nutrition Assistance Program: Requirements for Able-Bodied Adults Without Dependents, 84 Fed. Reg. 980, 992 [proposed section 273.24(f)(ii)].

to encourage employment and job retention for ABAWDs as they work to overcome barriers to employment.

States should also be encouraged to support SNAP case management for ABAWDs as they are engaged in a job training program, supportive social enterprise employment, or as they transition back into the workforce with a private employer. The USDA and states should also place greater priority in providing access to transportation and continued use of flexible waivers in places were employment and education and training initiatives require long-distance transportation.

Proposed restrictions on States combining groups in sub-state areas

Current regulation provides flexibility to states to define the areas covered by ABAWD waivers and allows states to combine data to group two or more sub-state areas, such as counties, together when calculating an unemployment rate representative. This flexibility has allowed states to tailor waiver requests to meet the economic and transportation realities of a given region. The proposed rule would restrict this flexibility by requiring states only combine data from individual areas that are collectively considered to be a Labor Market Area by the DoL.

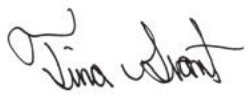
The proposed change will prohibit states from being able to adequately respond to various changing transportation and labor needs in a specific area or region. While jobs may exist in a given regional labor market, they may be impossible to attain in their local community, or there may be a lack of basic support systems such as reliable transportation. USDA should re-evaluate this proposed change and special consideration should be given to barriers that keep specific populations—such as those with a history of incarceration or substance abuse—from attaining existing jobs in communities. In addition, States should be able to consider accessibility of regional public transportation, the types of industries experiencing employment growth, and whether local educational attainment would give their population access to those opportunities.

Conclusion

The proposed rule would result in fewer people receiving SNAP benefits and more individuals will lack access to adequate sources of nutrition—which is inconsistent with the values Trinity Health holds around human dignity. The link between food insecurity and poorer health and increased health expenditures is now well-documented—this rule is not only inhumane and shortsighted, but is inconsistent with the goals of improving overall health in our country and lowering the cost of care.

Trinity Health appreciates the opportunity to comment on this proposed rule. If you have questions on our comments, please feel free to contact me at granttw@trinity-health.org or 734-343-1375.

Sincerely,



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