

PERSPECTIVES ON **OPPORTUNITY**

Promoting Mobility Through SNAP: Toward Better Health and Employment Outcomes

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The Supplemental Nutrition Assistance Program (SNAP) is among the nation's largest safety-net programs, helping low-income households afford food, improve nutrition, and support employment. As program expenditures continue to grow, assessing SNAP from the perspective of employment and health outcomes is crucial. We analyze administrative and survey data to document trends in employment and health outcomes for adult SNAP recipients from 1996 to 2019. We find the fastest-growing groups of the adult caseload suffer from low employment levels and poor health outcomes. These results suggest that program reforms should focus on not only reducing hunger but also improving employment and nutrition.

The Supplemental Nutrition Assistance Program (or SNAP, formerly called the Food Stamp Program) provides food benefits to 40 million Americans each month at a total cost of over \$110 billion in 2022 (USDA 2023b). One of SNAP's primary goals is to reduce hunger and malnutrition by helping low-income households afford food. However, the program's purpose goes beyond simply providing resources for food. It also aims to help families escape poverty by encouraging proper nutrition and stable, gainful employment.

A growing body of research shows that SNAP's design can work against these goals by discouraging employment and contributing to poor diet (Hoynes and Schanzenbach 2012; East 2018; Andreyeva, Tripp, and Schwartz 2015; Mande and Flaherty 2023). Unlike other federal food assistance programs, SNAP has no

nutritional standards, allowing participants to purchase any food or beverage product intended for consumption, except alcohol. As a result, data show that sizable portions of SNAP dollars purchase nonnutritious foods, such as sugary beverages and ultra-processed foods, which can lead to poor health (USDA 2016).

Additionally, SNAP's work requirements have a limited scope, with the most stringent work requirements applying only to age 18–49 able-bodied adults without dependents (ABAWDs). Over the past several years, states have exploited exceptions in the law to waive these work requirements, resulting in many ABAWDs not subject to a work requirement at all. Moreover, research suggests that SNAP benefits can disincentivize work among some low-income families, reducing the prospects of upward mobility.

Although previous research has investigated SNAP's health and employment effects, we know little about trends in employment and health outcomes for adult SNAP participants over time. To document trends in SNAP participants' health and employment outcomes over the past two decades, we analyzed data from the US Department of Agriculture's (USDA) Quality Control (QC) dataset to explore changes in the composition and employment levels of the SNAP adult caseload from 1996 to 2019 and health data from the National Health Interview Survey (NHIS).

SNAP QC data compile demographic and economic information on a representative sample of SNAP households from all 50 states, collected to determine SNAP eligibility. The NHIS is a household survey conducted yearly by the Centers for Disease Control and Prevention asking respondents a variety of health- and employment-related questions, including whether anyone in the household receives SNAP. Both datasets are cross-sectional, meaning the results reflect the SNAP caseload at points in time, not necessarily the same individuals over time. For our analyses, we grouped SNAP adults by age and parent status, stemming from how SNAP policy is currently structured.¹

Our results show that adult SNAP recipients have had especially poor health and employment levels over the past two decades. We found that the average age of adults receiving SNAP has risen substantially over time and that these adults were more likely than ever to be childless. Older and childless adults displayed the lowest employment levels of all recipients consistently across years. Additionally, we documented high rates of physical and mental health issues among all groups of SNAP adults, especially when compared to other groups of US adults. Making matters worse, these health and employment challenges are affecting a greater number of low-income Americans as SNAP caseloads have grown over time. Our findings raise serious concerns about the employment and health status of SNAP adults and the program's potential contribution to these alarming statistics.

In the sections that follow, we first describe SNAP's history, including the evolution of policies related to employment and nutrition. Next, we document SNAP's caseload and expenditure growth since 1996, along with changes to the composition of the SNAP caseload by age

and parent profiles. In the third section, we review employment levels for the SNAP caseload by age and parent profiles using SNAP QC data. In the fourth section, we review health outcomes using data from the NHIS, also according to age and parent profiles. We conclude with key takeaways for policymakers as they consider SNAP reforms.

Program History

The Food Stamp Program began in the 1930s as a small effort to match excess commodities from farmers with hungry families, offering disadvantaged Americans an essential social service throughout the Great Depression. The modern-day SNAP—retitled from the Food Stamp Program in 2008—has roots in this early program but long ago shifted its purpose away from redistributing excess commodities to reducing poverty. Upon signing the Food Stamp Act of 1964, President Lyndon B. Johnson signaled this shift, saying, “As a permanent program, the food stamp plan will be one of our most valuable weapons for the war on poverty” (Johnson 1964).

Several additional legislative efforts in the following decade further transformed the program into its current form. Notably, President Richard Nixon set a goal in 1969 to end hunger in America (Nixon 1969), and Congress responded by mandating that states offer the Food Stamp Program nationwide by 1974, which began a period of exceptional program growth.

The language used in the 1964 Food Stamp Act outlined the core goals of the program, which remain in place today: “It is hereby declared to be the policy of Congress, in order to promote the general welfare . . . to safeguard the health and well-being of the Nation's population by raising levels of nutrition among low-income households.”² The program's goals were not limited to the vision of “reducing hunger and malnutrition”; they also included promoting more nutritious diets among low-income Americans and supporting domestic agriculture. In the 1977 Food Stamp Act, Congress attributed “limited purchasing power” as a factor leading “to hunger and malnutrition in the US” and authorized food stamps to “permit low-income households to obtain a

1 For example, nonparent adults age 18–49 are subject to work requirements, so for our analyses, we use the same age range.

2 Food Stamp Act of 1964, Pub. L. No. 88-525; and Food and Nutrition Act of 2008, Pub. L. No. 88-525.

more nutritious diet through normal channels of trade by increasing food purchasing power for all eligible households who apply for participation.”³

Consistent with Congress’s motivation to promote nutrition (while also supporting domestic agriculture), SNAP has always been an in-kind benefit that recipients can use only for food and beverages, making it different from other safety-net programs that offer direct cash assistance, such as cash welfare. Efforts to restrict benefit use even further—such as excluding items with no nutritional value—invited intense debate throughout the 1970s that continues today, but Congress has never restricted benefit use beyond a few goods, such as alcohol and tobacco products (NRC 2013).

Another common theme across legislative efforts over the years has involved employment. Policymakers have long debated what, if any, work expectations the program should place on recipients (NRC 2013). Proponents of work requirements argue that able-bodied Americans should work insofar as they are able, whereas opponents argue that work requirements effectively penalize the most disadvantaged Americans. In early legislation, participants had to register for work, and by 1977, certain participants were required to search for a job. Later, as part of welfare reforms in 1996, Congress required ABAWDs age 18–49 to work (USDA 2018).

This brief program history frames how researchers and policymakers tend to think about SNAP’s goals and effectiveness. Reducing hunger and food insecurity (defined as “not having access to sufficient food, or food of an adequate quality, to meet one’s basic needs”) has always been the most prominent program goal (USDA 2023a). For this reason, the USDA has tracked food insecurity rates since 1996 and has used these trends to assess SNAP’s performance. This research generally shows that SNAP reduces food insecurity in the short term. But given SNAP’s negative effects on employment and health—both necessary for upward mobility and self-sufficiency—questions remain over whether SNAP effectively reduces

food insecurity in the long run.⁴ Although the government does not routinely assess nutrition outcomes or employment, a body of research suggests that SNAP reduces employment and contributes to poor diet (Hoynes and Schanzenbach 2012; East 2018; Andreyeva, Tripp, and Schwartz 2015; Mande and Flaherty 2023).

SNAP Growth and Demographic Changes

SNAP participation and costs have grown tremendously over the past two decades. The percentage of the US population participating in SNAP increased from 7.1 percent in 1980 to 14.9 percent at its peak in 2013 after the Great Recession. Even with pre-pandemic unemployment rates at record lows, one in 10 Americans received SNAP in 2019 (Crouse 2022). Increases in the costs of the program have tracked closely with increases in participation. From 2000 to 2019, SNAP’s annual costs grew from \$23 billion to \$57 billion (in 2021 dollars) (USDA 2023b).⁵ During the pandemic, a number of measures increased SNAP spending on a per-person basis, resulting in a near doubling of costs from 2019 to 2022 (Figure 1). Given these benefit increases, the Congressional Budget Office projects that total costs will top \$110 billion annually through 2033 (CBO 2023).

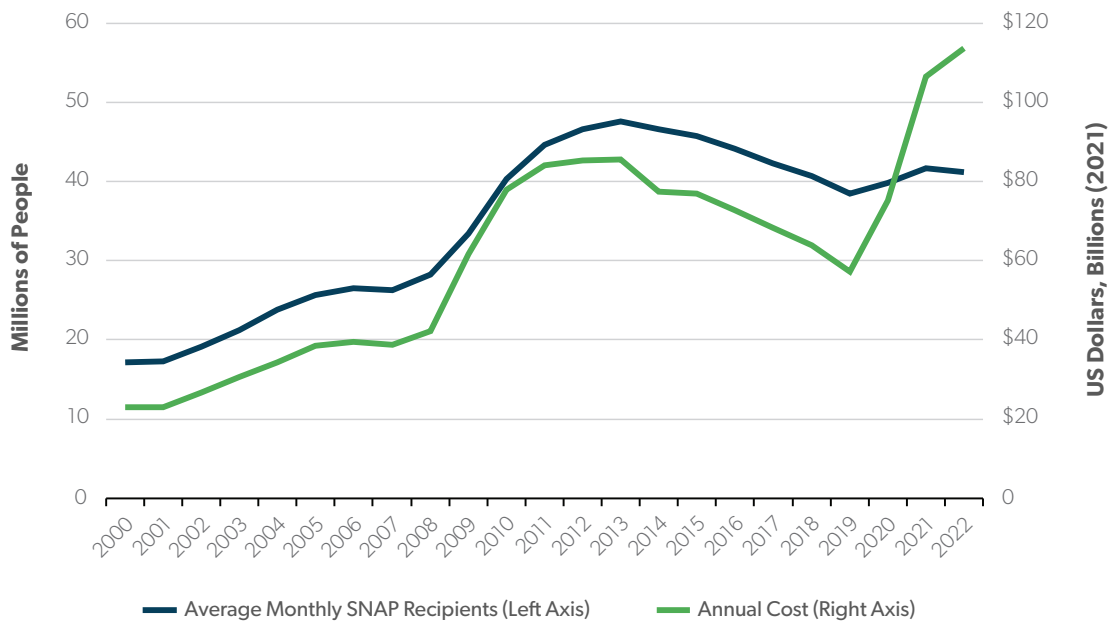
The growth of SNAP is the result of a confluence of changes to both policy and economic conditions starting in the mid-to-late 2000s (Rachidi 2021). First, changes to the program’s administration from paper coupons to electronic benefits occurred in the early 2000s, as did the reinstatement of eligibility for some immigrants. Second, the economic distress the Great Recession caused increased the number of low-income Americans eligible for SNAP. Additionally, the 2008 Farm Bill changed the program title, adding the term “nutrition” among other things and liberalizing some operational program components. Altogether, these economic and

3 Food Stamp Act of 1977, Pub. L. No. 88-525.

4 One study examined increases in SNAP benefits stemming from the 2009 American Recovery and Reinvestment Act (ARRA) and found that it decreased food insecurity by 2.2 percentage points (Nord and Prell 2011). However, another study using a different data source found that the ARRA SNAP expansions did not affect food insecurity rates for youth, nor did higher benefits result in healthier diets (Hudak, Racine, and Schulkind 2021). Yet another study using an even different data source and methodology found that SNAP participation lowered food insecurity for households after receiving six months of benefits but did not affect very low food security (i.e., a proxy for hunger) among some subgroups (USDA 2013). Moreover, it is difficult to ignore the reality that despite the exceptional growth in SNAP participation, food insecurity rates have held relatively steady over the past two decades, only fluctuating with the business cycle.

5 SNAP costs were adjusted using the Consumer Price Index for All Urban Consumers.

Figure 1. SNAP Participation and Costs, 2000–22



Note: Costs were adjusted for inflation using the Consumer Price Index for All Urban Consumers.
Source: USDA (2023b).

policy changes reduced program stigma and extended its reach.

Perhaps the most consequential effects on SNAP participation during this time, however, involved three important policy changes. First, in response to the Great Recession, the American Rescue and Recovery Act of 2009 waived the ABAWD time limit nationwide from April 2009 through September 2010, and many states continued to request waivers in subsequent years, citing a struggling economy and limited labor market prospects for recipients. However, even as the economy recovered and the labor market grew stronger, many states were slow to reinstate the ABAWD time limit, often exploiting loopholes in the law (USDA 2019).

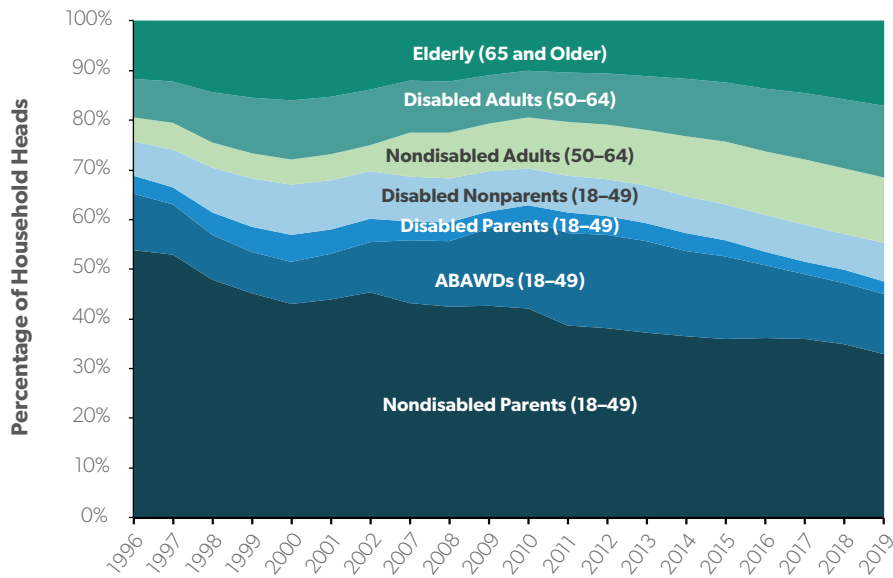
Secondly, many states eliminated SNAP’s asset test during this time, which the law allowed but states increasingly opted to do after the Great Recession (Sykes 2017). Lastly, when the pandemic hit in 2020, SNAP participation increased due to rising levels of economic hardship and pandemic-related emergency measures, such as delaying recertification requirements, issuing emergency allotments, and suspending the ABAWD work requirement. SNAP also ignored the value of over \$1 trillion in federal

pandemic stimulus checks, tax credits, and unemployment bonuses in determining claimant eligibility, further driving caseload increases (Weidinger 2023). Because the federal public health emergency remained in effect well into 2023, SNAP caseloads have remained stubbornly high, even though economic conditions have improved.

Despite SNAP’s rising caseloads over the past two decades, such growth has not been uniform across demographic groups. We used SNAP QC data to categorize SNAP household heads into mutually exclusive groups by parent status, age, and disability status. For our purposes, nondisabled individuals include those who were not receiving federal disability assistance.

As displayed in Figure 2, the composition of SNAP household heads has changed considerably over the past two decades. The average age of household heads has become substantially older, and those household heads have become much more likely to be childless, evidenced by an increasing share of adults age 50–64 and a decreasing share of parents age 18–49. In 1996, adults age 50–64 accounted for only 12.6 percent of all household heads, but by 2019, this group’s share had more than doubled, accounting for over a quarter of all SNAP household

Figure 2. SNAP Composition by Age, Disability, and Parental Status Among Household Heads, 1996–2019



Note: See SNAP QC (n.d.) for a definition of “disability.” Although the data stop identifying individuals with disability at age 59, we construct a similar measure of disability for those age 60–64. We use age 49 as a cutoff for adults because this is the upper age limit at which ABAWD work requirements apply. Percentages reflect the share of household heads, not all recipients.
Source: SNAP QC (n.d.) for individual years 1996–2019.

heads (27.6 percent). Much of the growth of this group is attributable to *nondisabled* adults age 50–64, which has nearly tripled from 5 percent of heads of households in 1996 to 13 percent in 2019.

In contrast, the group of SNAP household heads witnessing the most dramatic declines in caseload share were *nondisabled* parents age 18–49, falling from 53.5 percent in 1996 to 33 percent by 2019. Childless household heads age 18–49 fluctuated over time but remained a similar share in 2019 as in 1996. As a result, among household heads age 18–49, the share with children outnumbered those without children three to one in 1996, but by 2019, the ratio was 1.8 to one. The other groups shown in Figure 2 fluctuated over time but did not change as dramatically from 1996 to 2019.

Notably, when Congress passed the ABAWD work requirement as part of welfare reform in 1996, ABAWDs constituted 11.2 percent of SNAP household heads, whereas *nondisabled* 50-to-64-year-olds accounted for 4.9 percent. After two decades, *nondisabled* 50-to-64-year-olds now constitute a *greater* share of SNAP

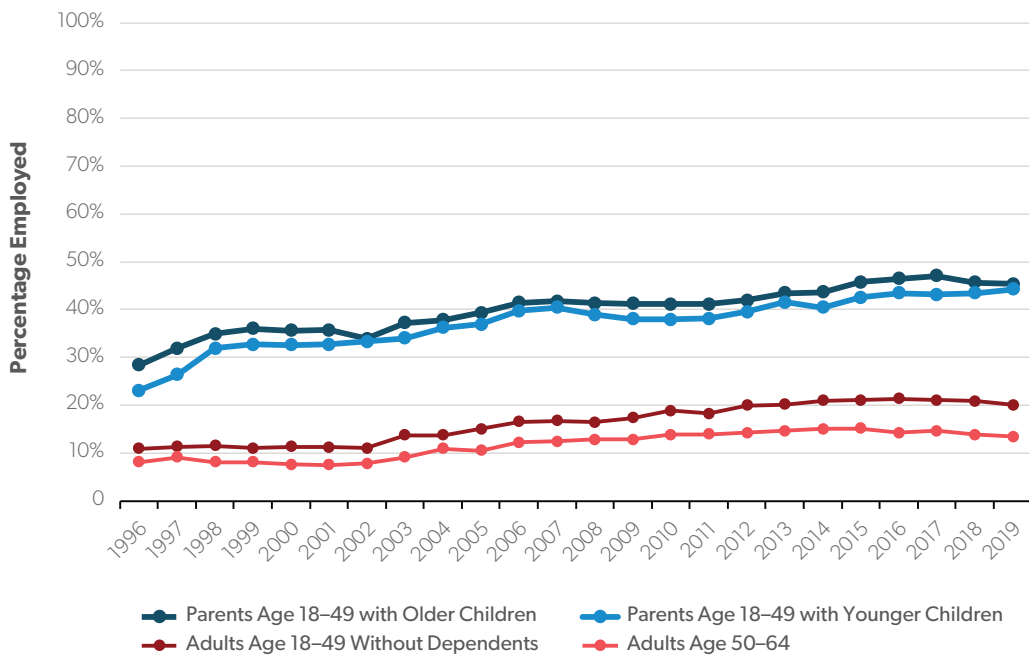
household heads than ABAWDs (13.3 and 12 percent, respectively) despite the much larger age span for ABAWDs, raising concerns over the rising reciprocity of older, *nondisabled* SNAP household heads.

In some ways, the growing share of older SNAP recipients simply reflects broader demographic trends observed throughout the entire US. As baby boomers age into retirement and fewer younger Americans have children, the country has become progressively older over time—evidenced by an increase in the median age by 3.4 years since 2000 and fertility falling below the replacement rate (Census Bureau 2022).

While these population-wide shifts likely play a role in dictating SNAP trends, they certainly are not large enough to explain such dramatic changes in the composition of the SNAP caseload. As a share of the entire poor population (according to the Official Poverty Measure), 50-to-64-year-olds have grown from 15 percent in 1997 to 22 percent in 2019. But among adults receiving SNAP, 50-to-64-year-olds grew from 14 percent to 28 percent over the same period.⁶ Policy

⁶ Authors’ calculations using the Current Population Survey. The “poor population” includes those who are below 125 of the federal poverty line.

Figure 3. Percentage of SNAP Recipients Employed by Group, 1996–2019



Note: Parents of “older” children are parents who *only* have children age 5 or above. Parents of “younger” children are those who have *any* children younger than age 5.

Source: SNAP QC (n.d.) for individual years 1996–2019.

changes—including the waiving of work requirements and asset tests—have almost certainly affected who did and did not receive SNAP benefits over the past two decades.

The analyses of caseload data show that the SNAP caseload of today does not resemble the caseload of previous decades. Around the time of welfare reform, parents with children headed the majority of SNAP households, yet today less than 40 percent fall into this category. Rising reciprocity among older and childless adults calls attention to their employment and health outcomes, along with SNAP’s contribution to their challenges.

Employment and SNAP

When examining employment levels, we maintained the same age groups as in Figure 2, but we disaggregated 18-to-49-year-old parents by the age of their children

to reflect their differing caretaking responsibilities and attachment to the labor force. We also excluded the oldest cohort of recipients (age 65 and older) from the analysis, given that many Americans of this age are retired.

As displayed in Figure 3, in the most recent years of data, slightly less than half of SNAP parents age 18–49, regardless of the children’s age, worked while receiving SNAP, a rate that has increased modestly over time.⁷ Older household heads age 50–64 (with or without dependents) experienced the lowest employment levels consistently across time, with 13 percent reporting employment while receiving SNAP in 2019, marginally higher than in 1996.⁸

Moreover, only about one in five household heads age 18–49 without dependents reported employment while receiving SNAP in 2019, also marginally better over time. Employment levels for SNAP parents have increased steadily over time. However, the gains have been small, and overall employment levels remain low.

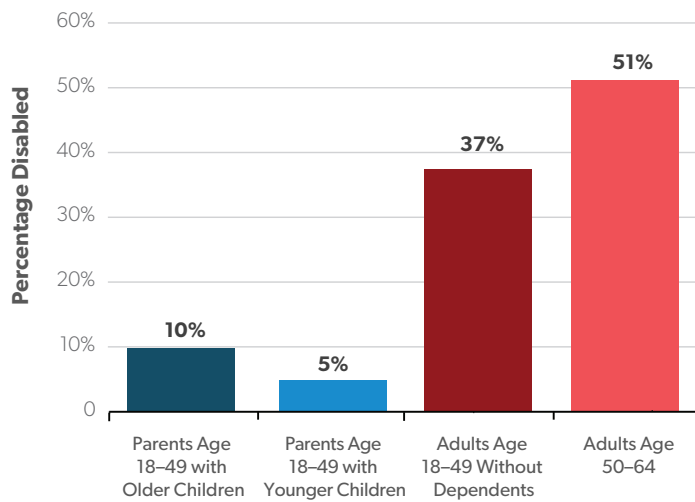
7 For definitions of “older” and “younger” children, see Appendix A.

8 In the most recent year of data, only 11.4 percent of SNAP household heads age 50–64 had a dependent in the household.

One reason for such low employment levels was due to a high incidence of disability. Undeniably, disabilities and work limitations can majorly inhibit stable and gainful employment, and SNAP receipt often goes hand in hand with disability benefits. For example, one of the nation's largest disability programs, Supplemental Security Income (SSI), makes SSI individuals living alone (or with other SSI recipients) categorically eligible for SNAP (Trenkamp and Wiseman 2007). Figure 4 shows that, among SNAP recipients, disabilities were more common among adults age 18–49 without dependents and adults age 50–64 than they were for parents, which partly explains the low employment levels observed in Figure 3.

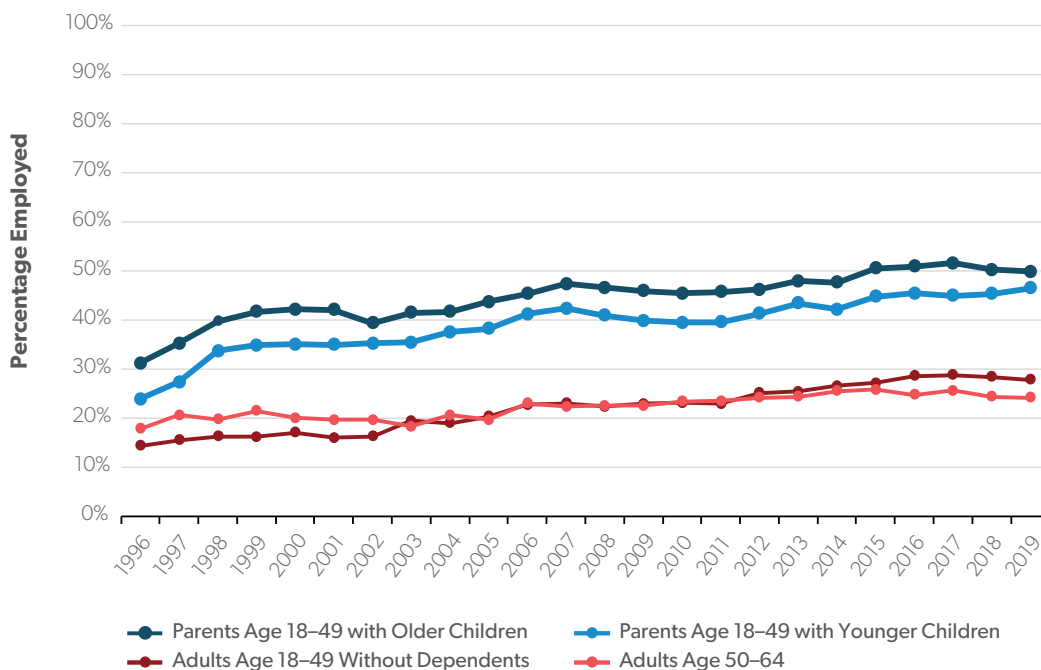
Older and childless SNAP household heads were much more likely to be disabled than younger SNAP adults with children were—and presumably less able to work. However, even when considering the employment levels for nondisabled SNAP adults, employment rates remained remarkably low. As Figure 5 shows, while employment levels have risen over time, still only about a quarter

Figure 4. Percentage of SNAP Recipients Who Receive Disability Assistance by Group



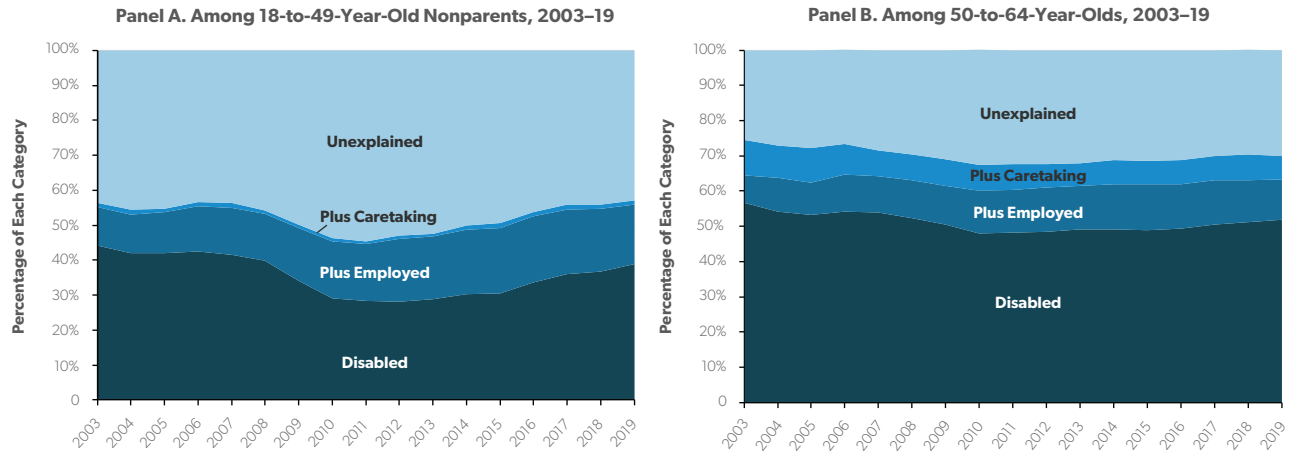
Note: The rates of disability are pooled across the most recent three years of data, 2017–19. Disability rates for each groups do not vary substantially across time. Source: SNAP QC (n.d.) for individual years 2017–19.

Figure 5. Percentage of Nondisabled SNAP Recipients Employed by Group, 1996–2019



Source: SNAP QC (n.d.) for individual years 1996–2019.

Figure 6. Percentage of SNAP Recipients Who Are Either Disabled, Employed, or Engaged in Caretaking



Note: See Appendix A for a description of calculations for each category. We begin the series in 2003 rather than 1996 because, for 50-to-64-year-olds, our method for identifying disabled 60-to-64-year-olds is not consistent with the data provided in previous years. Source: SNAP QC (n.d.) for individual years 2003–19.

of nondisabled adults age 18–49 without dependents and household heads age 50–64 worked while receiving SNAP (27.8 percent and 24.1 percent, respectively) in 2019.

Because SNAP targets low-income households (and employment offers a substantial source of income), it is unsurprising that SNAP adults generally have low levels of employment. But these data raise the question of why so many nondisabled, childless adults remain without employment, especially in years when nationwide unemployment rates were low and job opportunities were plentiful.

To gain a fuller understanding of the factors that could be contributing to low employment rates—especially among SNAP recipients age 18–49 without dependents and those age 50–64—we accounted for the share of each group that was either disabled, already employed, or had caretaking responsibilities. As Figure 6 Panels A and B show, a sizable share of household heads age 18–49 without dependents and household heads age 50–64 were not disabled, did not have caretaking responsibilities, and lacked employment.⁹ This leaves major shares of these groups’ status while receiving SNAP unexplained.

In sum, our findings suggest that the fastest-growing groups of SNAP household heads had low levels of

employment across much of the past three decades. Even after accounting for a variety of factors that might explain these low levels of employment, we found that a large share of these SNAP recipients were not working, caretaking, or disabled.

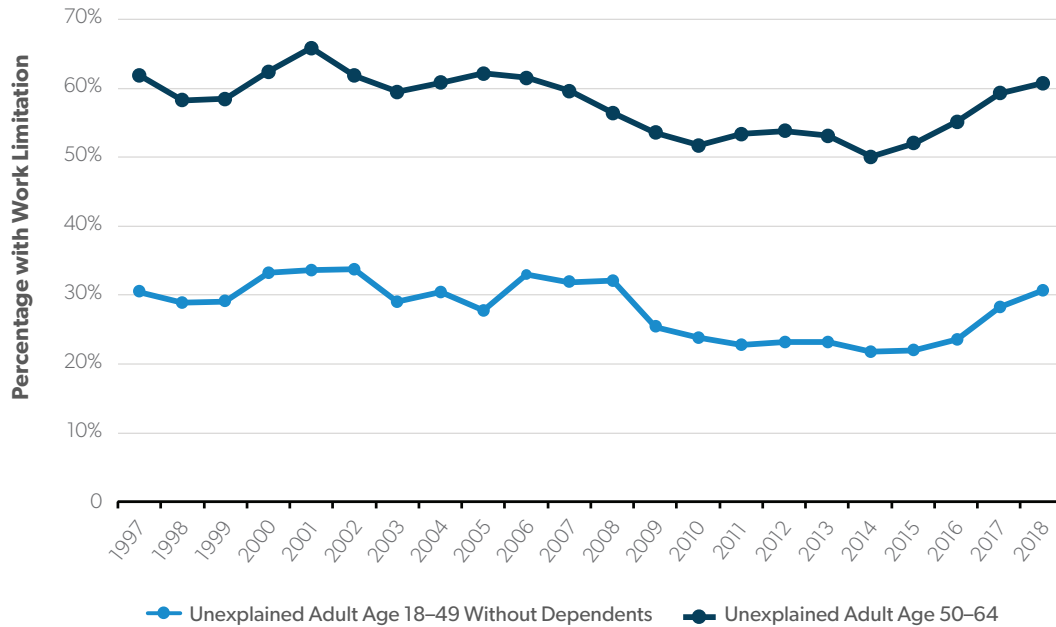
Health and SNAP

Employment and health are interdependent, but it can be difficult to disentangle cause and effect. Poor health might cause unemployment, but not working might also cause deteriorating health (Hussam et al. 2021). SNAP’s status as a nutrition benefit that provides income support offers a unique opportunity to promote both health and employment, potentially spurring a cycle of healthy living and stable employment among low-income adults. However, the health status of SNAP adults suggests that the program falls well short of promoting good health.

To analyze health outcomes among SNAP adults, we used data from the NHIS—a nationally representative health survey. We explored physical and mental health outcomes for SNAP adults based on parent and age status from 1997 to 2018. We also compared their outcomes

⁹ We used a generous definition of caretaking, to include if they had (1) a child below age 18 residing in their SNAP-defined household, (2) an elderly person age 65 or older in their household, or (3) anyone in their household who was disabled.

Figure 7. Percentage of Unexplained with Self-Reported Work Limitation, 1997–2018



Note: The unexplained are SNAP recipients who are nondisabled, not working, and have no caretaking responsibilities. A work limitation is defined as any physical, mental, or emotional problem that prevents the respondent from working or limits the kind or amount of work that the respondent is able to undertake.

Source: NHIS (n.d.) for individual years 1997–2018.

to two groups of adults not receiving SNAP: low-income non-recipients and high-income non-recipients.¹⁰

First, we explored self-reported health limitations for the “unexplained” SNAP adults identified in Figure 6. As displayed in Figure 7, a large share (between 50 and 60 percent across time) of the 50-to-64-year-old unexplained group reported a health-related work limitation, which changed only slightly over time. A smaller percentage of unexplained adults age 18–49 without dependents reported a work limitation, suggesting that something other than a health issue was driving low employment within this group. This suggests that a large share of the nonworking 50-to-64-year-old group had a health issue that limited their employment, while health issues explained a smaller share of employment problems for those age 18–49.

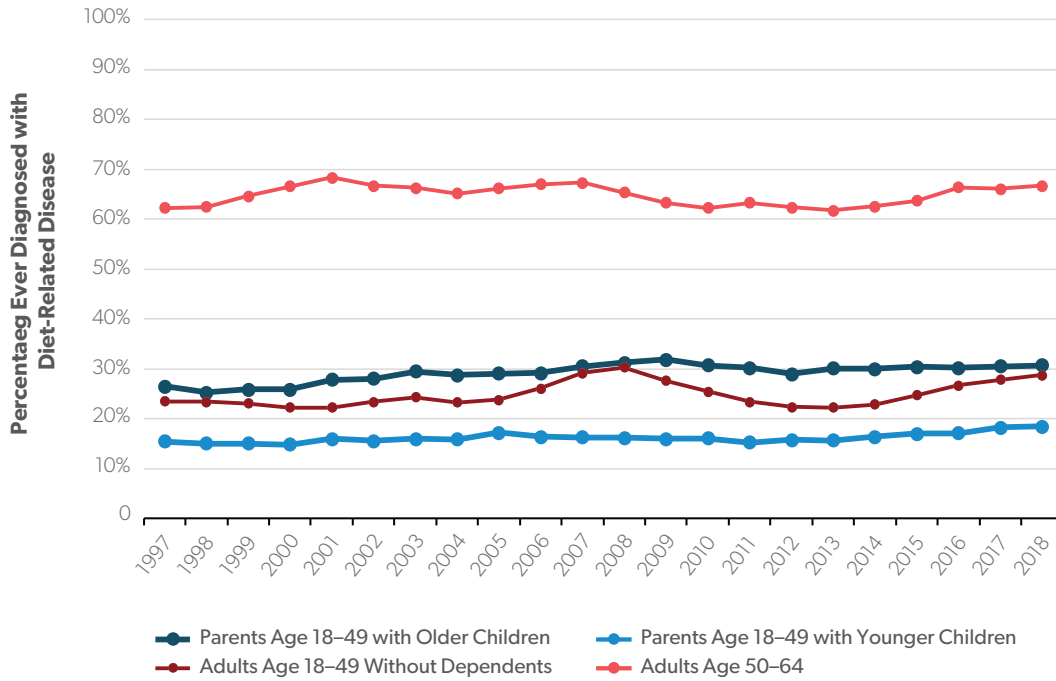
Next, we explored physical and mental health outcomes among all adults receiving SNAP to understand the health issues facing the SNAP population as a whole.

As shown in Figure 8, across age and parent profiles, SNAP adults reported high rates of ever having a diet-related disease (including diagnosed with diabetes, heart disease, stroke, or hypertension) (CDC 2022)—especially recipients age 50–64. Between 60 to 70 percent of this group reported ever having a diet-related disease over the past two decades; even among SNAP parents of young children, almost 20 percent reported ever having a diet-related disease in 2018.

Figure 9 displays how, for each age and parent profile, ever having a diet-related disease was much more common among SNAP recipients compared to low- and high-income non-recipients (non-recipients below 125 percent of the federal poverty line and non-recipients above 125 percent of the poverty line, respectively). For example, 65 percent of 50-to-64-year-old SNAP recipients reported having at least one diet-related disease, whereas only 44 percent of similarly aged high-income non-recipients and 57 percent of low-income

¹⁰ Specifically, we define “low-income non-recipients” as those who are below 125 percent of the federal poverty line but do not receive SNAP. And we define “high-income non-recipients” as those who are above 125 percent of the poverty line and do not receive SNAP.

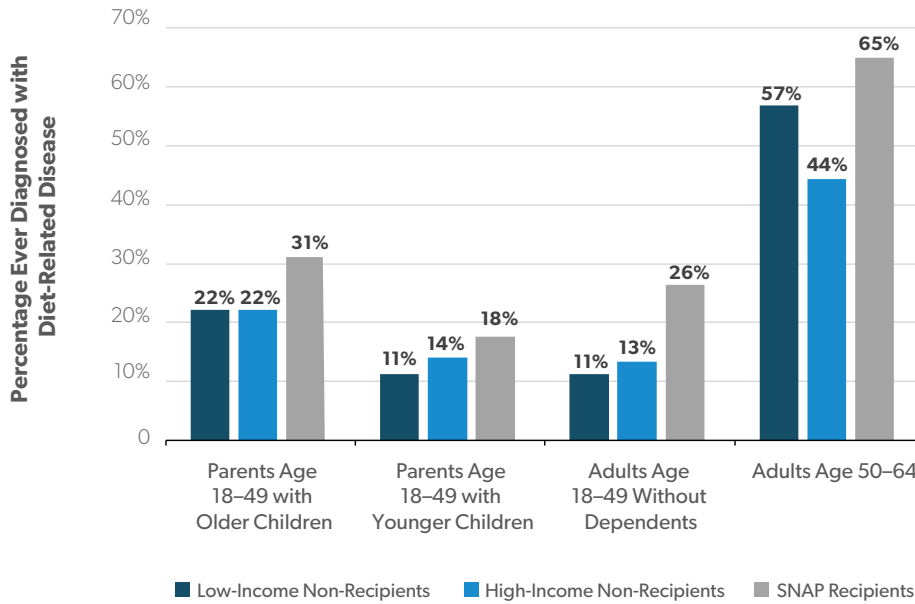
Figure 8. Percentage of SNAP Adults with Diet-Related Disease, 1997–2018



Note: Results are three-year running averages. Diet-related disease is defined as ever being diagnosed with diabetes, non-congenital heart disease, stroke, or hypertension.

Source: NHIS (n.d.) for individual years 1997–2018.

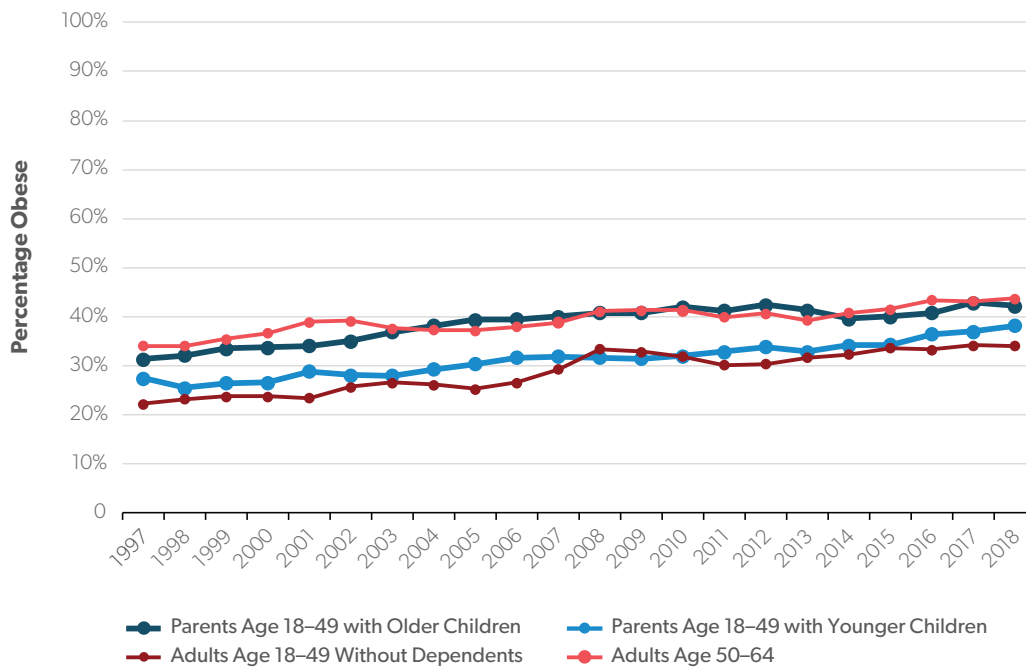
Figure 9. Diet-Related Disease by SNAP Status and Age and Parent Profiles, 2014–18



Note: Diet-related disease is defined as ever being diagnosed with diabetes, non-congenital heart disease, stroke, or hypertension. The figure reflects pooled averages of diet-related disease from 2014 to 2018. All differences between SNAP recipients and the two comparison groups are statistically significant at the 0.05 level.

Source: NHIS (n.d.) for individual years 2014–18.

Figure 10. Percentage of SNAP Recipients with Obesity, 1997–2018



Note: Results are three-year running averages. Obesity is defined as having a body mass index of 30 or greater. Source: NHIS (n.d.) for individual years 1997–2018.

non-recipients reported having a diet-related disease. That diet-related disease was much more common among SNAP recipients than other low-income adults suggests that SNAP serves a particularly unhealthy population.

We observed the same pattern for obesity rates. Like US adults broadly, rates of obesity among adults receiving SNAP have increased over the past two decades. As shown in Figure 10, among SNAP adults age 18–49 with children and SNAP adults age 50–64, obesity rates at the time of the survey increased from approximately 30 percent in the late 1990s to around 40 percent by 2018. But the group of household heads experiencing the most rapid rise in obesity has been adults age 18–49 without dependents, whose rate has grown from 22 percent to 34 percent, a 55 percent increase.

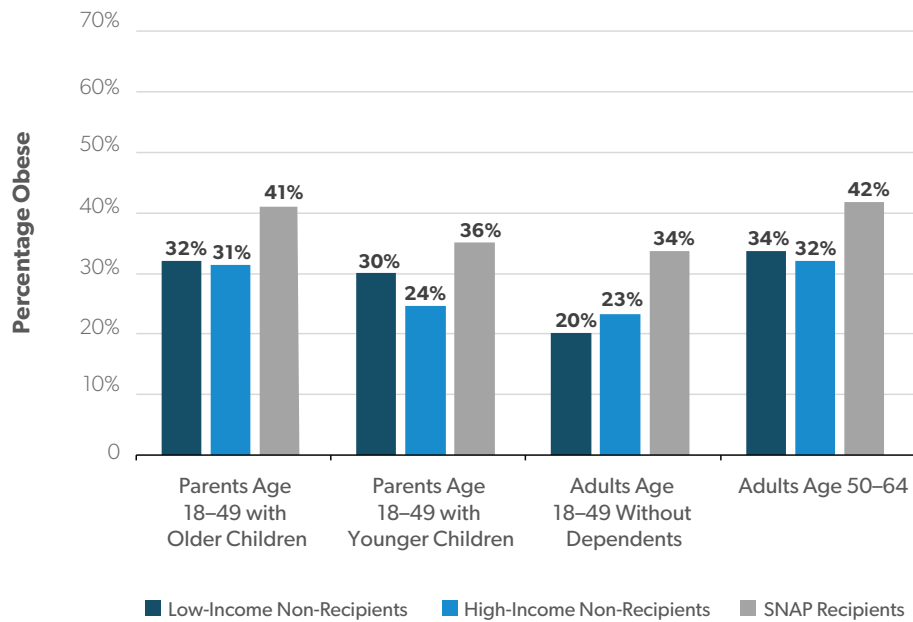
Although obesity plagues US adults of all socio-economic statuses, SNAP adults were much more likely to be obese than were low-income non-recipients and high-income non-recipients, suggesting again that there is something uniquely substandard about the health status of adults receiving SNAP. As Figure 11 displays, over one-third (34 percent) of SNAP adults age 18–49

without dependents were obese, while only 20 percent of low-income non-recipients and 23 percent of high-income non-recipients were obese.

Unsurprisingly, given SNAP recipients’ high rates of diet-related disease and obesity, a relatively large percentage of SNAP adults, especially those age 50–64, rated their health as fair or poor at the time of the survey. As Figure 12 shows, this trend improved over time for the oldest cohort of SNAP recipients, but still half reported fair or poor health by 2018. Consistent with the other health measures, SNAP adults also reported fair or poor health at higher rates than non-recipients did, as shown in Figure 13.

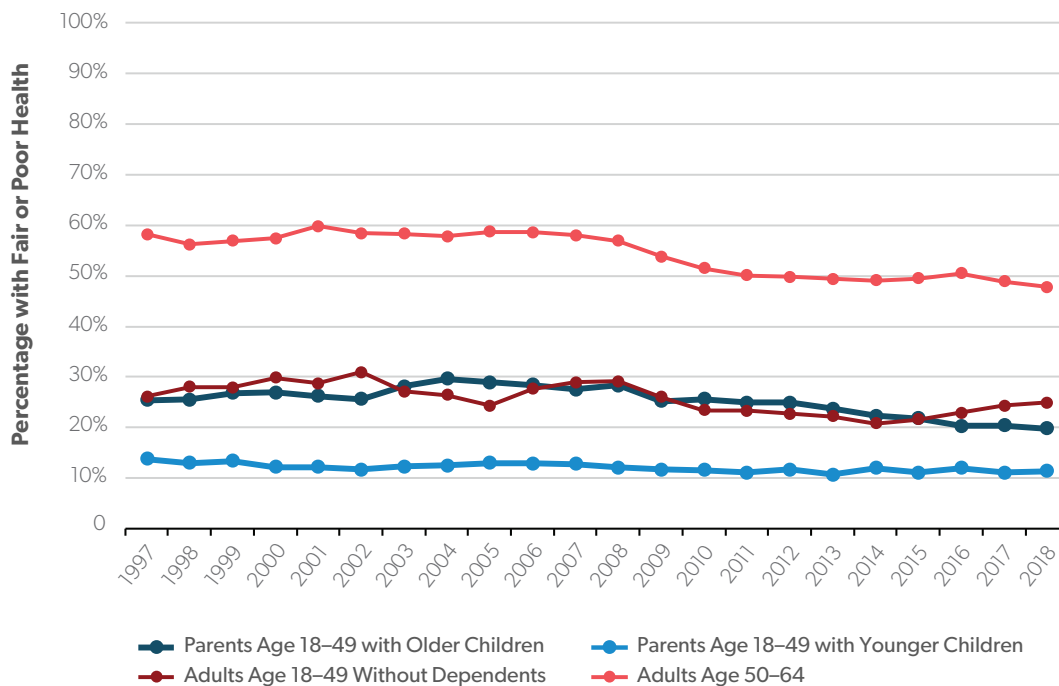
Many of the health problems facing low-income Americans—and SNAP recipients in particular—are not merely physical. Figure 14 presents the share of SNAP adults who reported feeling either “hopeless” or “worthless” in the 30 days preceding the survey. We focused on these two indicators because research has shown these to be two of the strongest predictors of severe mental health issues (Shand et al. 2015). For SNAP adults age 50–64, these mental health issues subsided slightly over time as more people in this age category joined SNAP, but still

Figure 11. Obesity by SNAP Status and Age and Parent Profiles, 2014–18



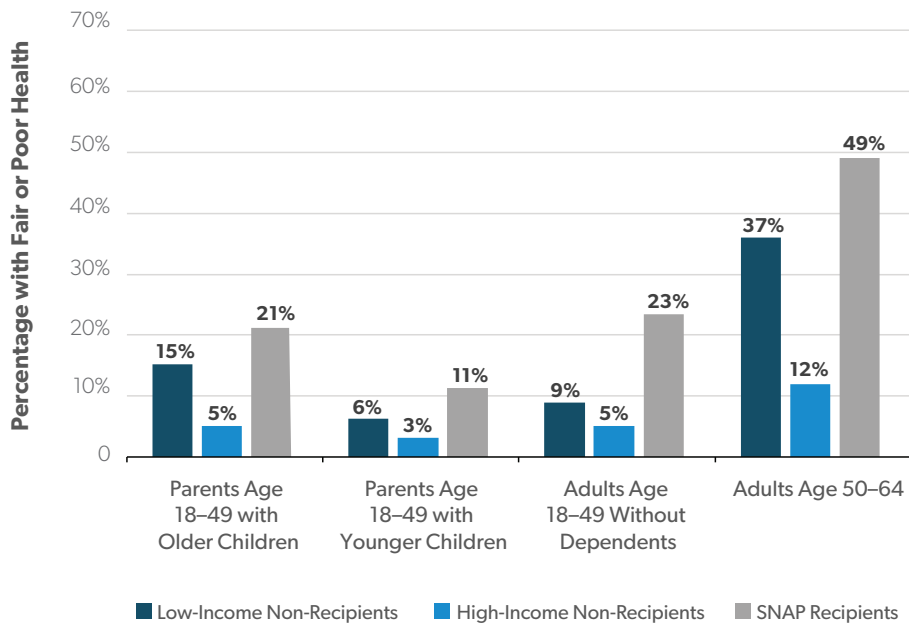
Note: Results are averages across the past five years of data (2014–18). All differences between SNAP recipients and the two comparison groups are statistically significant at the 0.05 level.
 Source: NHIS (n.d.) for individual years 2014–18.

Figure 12. Percentage of SNAP Recipients That Rate Their Health Status as Fair or Poor, 1997–2018



Note: Results are three-year running averages. Fair and poor health status are the two lowest self-assessments on a five-point Likert scale, ranging from “poor” to “excellent.”
 Source: NHIS (n.d.) for individual years 1997–2018.

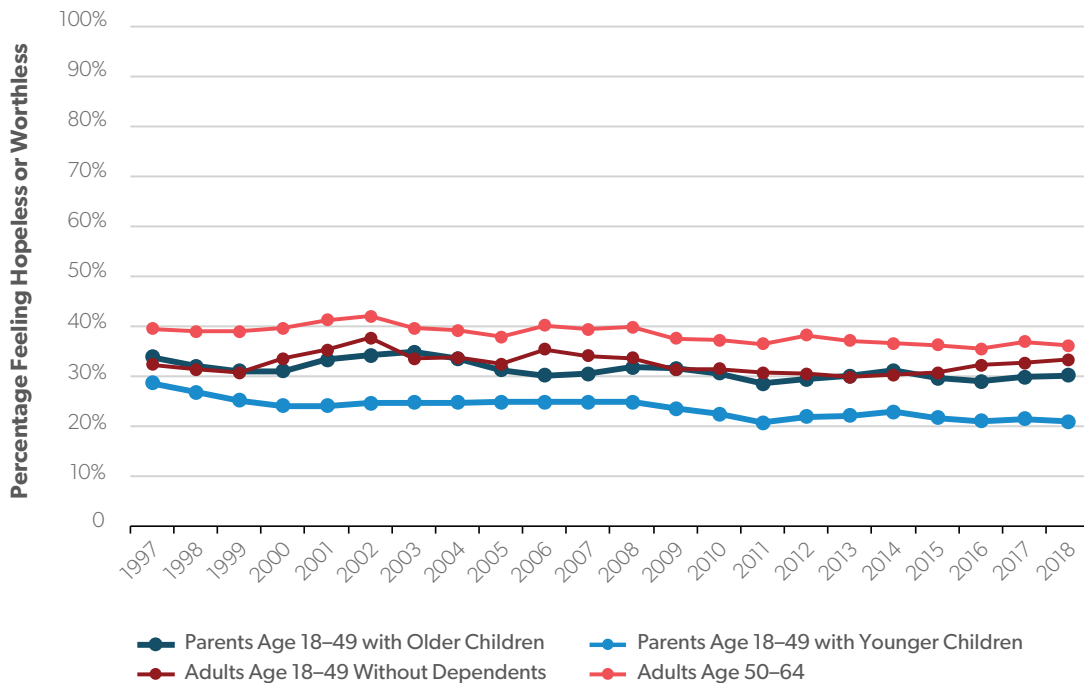
Figure 13. Fair or Poor Health Status by SNAP Status and Age and Parent Profiles, 2014–18



Note: Results are averages across the past five years of data (2014–18). All differences between SNAP recipients and the two comparison groups are statistically significant at the 0.05 level.

Source: NHIS (n.d.) for individual years 2014–18.

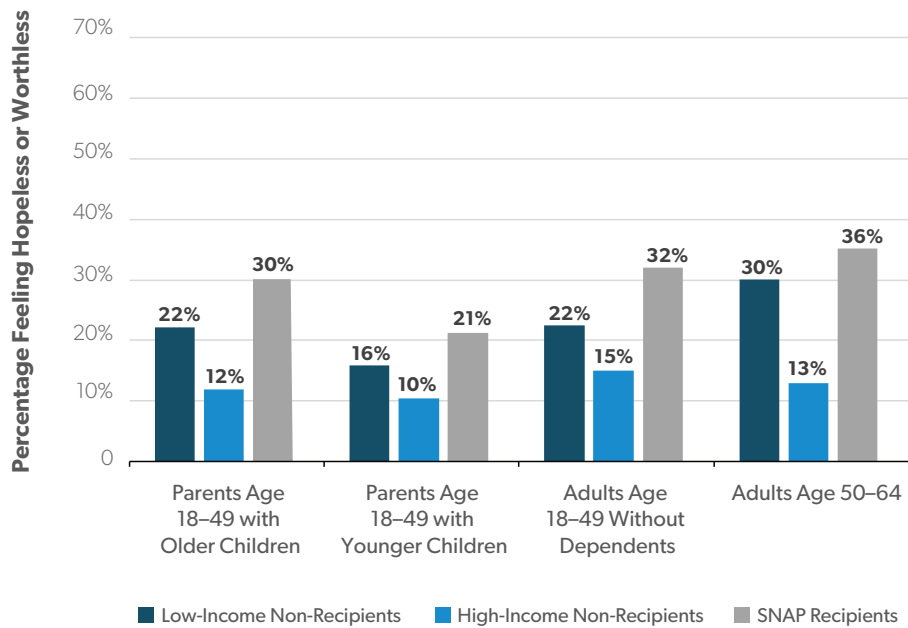
Figure 14. Percentage of SNAP Recipients Who Report Feeling Hopeless or Worthless in the Past Month, 1997–2018



Note: Results are three-year running averages.

Source: NHIS (n.d.) for individual years 1997–2018.

Figure 15. Feelings of Hopelessness or Worthlessness by SNAP Status and Age and Parent Profiles, 2014–18



Note: Results are averages across the past five years of data (2014–18). All differences between SNAP recipients and the two comparison groups are statistically significant at the 0.05 level.
 Source: NHIS (n.d.) for individual years 2014–18.

35 percent reported these feelings in 2018—a higher percentage than any other group. Like other health measures, SNAP adults reported higher rates than non-recipients did, as shown in Figure 15.

Altogether, these data show that physical and mental health problems were common among adults receiving SNAP and likely contributed to their relatively low employment levels over the past two decades. These data also raise questions about the degree to which SNAP might be exacerbating health issues among low-income adults by contributing to poor nutrition and discouraging employment. It is cause for concern that almost 70 percent of SNAP adults age 50–64 reported ever having a diet-related disease, and 40 percent reported feeling “hopeless” or “worthless” in recent years.

Whether SNAP causes poor health or attracts people with already poor health remains up for debate. However, the persistently high rates of health problems among adults receiving SNAP—along with enduring gaps between recipients and non-recipients—suggest that SNAP is falling short on leading participants toward good health and may even make matters worse by supporting non-nutritious diets for millions of disadvantaged adults.

Conclusion

SNAP is one of the nation’s largest safety-net programs, transferring more than \$100 billion per year to low-income households. Although research shows that SNAP may reduce food insecurity in the short run, our results document low employment levels and poor—and, in the case of disease and obesity rates, worsening—health status, raising questions about the program’s long-term effectiveness. Specifically, we find that two of the fastest-growing groups of SNAP recipients—50-to-64-year-olds and adults age 18–49 without dependents—face the worst health and employment outcomes.

Approximately half of household heads age 50–64 and a third of adults age 18–49 without dependents were disabled while receiving SNAP. However, even when we exclude disabled recipients from our calculations, employment levels remained low. In 2019, at a time of historically low unemployment in the US economy, only 28 percent of ABAWD household heads worked while receiving SNAP, and only 24 percent of nondisabled 50-to-64-year-olds worked. Further, we found that caretaking responsibilities played a limited

role in depressing labor force participation among these groups. We found that three in 10 SNAP household heads age 50–64 and 43 percent of those age 18–49 without dependents were not working and were neither caretaking nor disabled. In other words, their inability to work remains unexplained.

One reason we discovered for a large share of unexplained SNAP adults was poor health that did not rise to the level of disability, according to data from the NHIS. Alarming, more than two-thirds of unexplained 50-to-64-year-olds reported a health problem that limited their ability to work. However, our analyses also found that these health problems were not limited to unexplained recipients. SNAP adults consistently reported high rates of diet-related disease and obesity and viewed their health poorly. When compared to the rest of US adults—both low-income and high-income non-recipients—SNAP recipients consistently reported higher rates of physical and mental health problems.

These findings reveal a concerning picture of SNAP. One of SNAP's main goals is to improve nutrition for low-income households by giving them additional resources to afford a healthy diet. And proper nutrition is a crucial ingredient to helping people be healthy so that they can work and escape poverty. Put simply, the poor employment and health outcomes associated with SNAP adults suggest that the program is failing in both regards.

Some might argue that SNAP benefit levels are insufficient for households to afford a healthy diet, requiring that SNAP participants purchase unhealthy food because they cannot afford to eat an appropriate diet. However, little evidence exists to support this contention when properly scrutinized. Contrary to conventional wisdom, research shows that when measured properly (per nutrient or per serving, for example), healthy foods actually cost less than unhealthy foods (Carlson and Frazão 2012; Savoie-Roskos and Durward n.d.). In fact, research suggests that people who eat ultra-processed foods (common in SNAP participant diets) on average consume 500 more calories per day than those who eat diets full of unprocessed foods such as fruits and vegetables (Hall et al. 2019).

Additionally, over the long run, diets full of ultra-processed foods have substantial secondary costs, such

as high medical costs and employment disruptions due to poor health (Savoie-Roskos and Durward n.d.). Collectively, this shows that unhealthy diets like those common among SNAP participants are likely more costly in the short run and definitely more costly in the long run than are healthy diets rich in minimally processed foods.

SNAP is due for reauthorization in 2023 as part of the farm bill, and policymakers must act to address the myriad health and employment challenges facing SNAP recipients. With the proper reforms, policymakers can maintain SNAP as a vital income support while also addressing the alarmingly low employment rates and poor health outcomes of its participants. The first priority must be to place commonsense nutritional standards on SNAP, similar to those that already apply to other federal food assistance programs such as the National School Lunch Program and the Special Supplemental Nutrition Program for Women, Infants, and Children. This can start with excluding sugary beverages from the list of eligible food items for purchase with SNAP benefits. The next priority must be to strengthen existing work requirements for ABAWDs and extend the positive aspects of work requirements to other SNAP populations (Rachidi 2023).

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Appendix A. Data and Methods

For all original analyses in this report, we primarily rely on two different data sources. The first is the US Department of Agriculture’s (USDA) Supplemental Nutrition Assistance Program (SNAP) Quality Control (QC) data, an administrative dataset containing tens of thousands of observations each year. The second data source we use is the National Health Interview Survey (NHIS), which is a yearly study that has been conducted since 1963, asking a representative sample of Americans about a variety of health and employment outcomes.

In this appendix, we give a detailed account of each dataset, including any methodological decisions that we made in cleaning and preparing the data for our analyses. We then go through a series of terms that we use throughout the report, clearly articulating our definition of each term within each dataset. We begin with the NHIS.

National Health Interview Survey

The NHIS, conducted yearly by the Centers for Disease Control and Prevention, asks respondents a variety of different health- and employment-related questions. Beginning in 2019, the survey underwent a significant redesign, which makes comparability with prior years difficult. However, the survey was conducted using consistent methods from 1997 to 2018, making it an optimal source for examining yearly trends in health outcomes for various populations. The sample sizes are sufficiently large to break out by SNAP reciprocity, age, and parental status.

We extracted our sample of NHIS variables from the University of Minnesota’s Integrated Public Use Microdata Series. Our subset of variables includes a standard set of demographic and income variables, a variety of variables asking respondents about their physical and mental health status, and household-level indicators of SNAP receipt.

SNAP QC Data

As part of SNAP’s administration, the program implemented a quality control system to ensure that SNAP recipients are receiving the proper amount of benefits given their income and household size. A random sample of households is selected each year to participate in a quality control review, in which a SNAP caseworker meets face-to-face with the randomly selected household. Throughout this review, caseworkers ask recipients a variety of questions about their employment, income, household size, and participation in other government programs.

Each year, the USDA publishes anonymized data collected through this process in the form of SNAP QC data. Because these data are collected directly by the USDA and administered face-to-face, it is viewed as the authoritative data source on SNAP receipt. However, due to a variety of different coding discrepancies and survey methodologies over the past two decades, the data are difficult to compare across time.

In certain years, the administrators of SNAP QC data warn those using the data about potential coding errors or inconsistencies. On some variables, SNAP QC data recommend either against using a given variable—evidence that the variable was coded so inconsistently that it is totally unreliable—or that users take caution when using a variable. Although we never used any variable that the SNAP QC data recommend against using, we did, in some cases, use variables for which the QC data recommended caution. In each case we did so, we detailed what measures we took to ensure that our data were accurate.

We also dropped some observations from the data. Most notably, we dropped those who were deemed ineligible for SNAP as a result of the review process. These observations are households that, as a result of being reviewed, no longer qualify for SNAP and lose their SNAP benefits. After 2002, QC data administrators dropped these observations from the sample before releasing the public use data. Before 2002, there were usually only a few hundred such observations that we dropped. Additionally, we dropped households for which there was no

identifying information—such as head of household status or employment—again, resulting in a negligible number of observations dropped per year.

We now turn to our definitions of each term that we employ throughout the report, highlighting any important methodological decisions that we made and any definitional discrepancies between our two data sources.

Disability

The NHIS data have asked respondents about their disability status every year from 1997 to 2018. We define an individual as disabled if they report receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). The NHIS asked respondents four questions about whether they receive SSI or SSDI, and if they answered in the affirmative in any of those questions, then they are categorized as disabled. Conversely, we refer to any respondent who did not receive SSI or SSDI as nondisabled.

The SNAP QC data, on the other hand, define disability slightly differently. From 2012 onward, SNAP QC defines “non-elderly individuals identified as disabled using receipt of SSI or a combination of hours worked, work registration status, receipt of Social Security, veterans’ benefits, or workers’ compensation, and/or unit medical expense deduction.” For the full list of criteria used by the QC data to identify disability, refer to Appendix B in SNAP QC data’s technical documentation (Cornquist, Lauffer, and Vigil 2020).

Curiously, from 2007 to 2011, SNAP QC data documentation does not include individual-level disability identifiers, but the data files available for download include consistent measures of individual-level disability identifiers. After performing a series of checks, it appears that SNAP QC retroactively coded disability for these years just as they did from 2012 onward. From 2003 to 2006, however, the data files do not have individual-level disability information, so we reconstructed SNAP QC’s measure of disability, replicating their methods with the given information. From 1996 to 2002, SNAP measured disability in a nearly identical manner, using information from a similar combination of programs.

Importantly, SNAP QC data identify disability only among the nonelderly population—therefore excluding those age 60 and older. Because we are interested in the employment trends of those between age 50 and 64, we create individual-level disability identifiers for heads of households between age 60 and 64. If an individual between age 60 and 64 receives SSI or veterans’ benefits, then we also count them as disabled. And if an individual is age 60 or 61 and receives Social Security, then we count them as disabled. Our justification for the latter is that SNAP QC data do not uniquely identify SSDI receipt, so we assume that all Social Security recipients age 60 and 61 are receiving SSDI. Despite our relatively simple measure of disability for those age 60 to 64, our analyses show that disability rates for this group are similar to external sources of data and are consistent with disability incidence for those below 60.

However, because of methodological differences in how the QC collected data on disability before 2003, we are unable to consistently measure disability for those 60 and older before 2003. Therefore, our analyses of the unexplained (Figure 6, Panels A and B) only extend back to 2003.

With the SNAP QC data, we also define anyone not meeting any of the above criteria as “nondisabled.” Although the NHIS and SNAP QC data employ slightly different definitions of “disability,” we contend that these differences do not affect any of our conclusions. We also never use the two different definitions interchangeably—using the NHIS definition of disability when referring to health outcomes and using the QC definition of disability when referring to demographic changes or employment outcomes.

Employment and Labor Force Participation

The NHIS asks respondents about their employment status and gives them five possible responses: (1) working for pay at a job, (2) working without pay at a job, (3) with job but not at work, (4) unemployed, or (5) not in the labor force. We define anyone who responds one, two, three, or four as a part of the labor force and define anyone who responds one, two, or three as employed.

In most years, the SNAP QC data recommend caution when using their employment variables, because there are often inconsistencies between their two employment variables and between them and other income variables. Because the sample sizes in the SNAP QC data are large (and without information on whether inconsistencies were more or less likely among the employed), we took a conservative approach when navigating these potential data issues, dropping all observations for which we witnessed significant inconsistencies between these variables.

Specifically, we dropped all observations that do not have employment data. We also dropped any observation for which one employment variable indicated that the observation was employed and the other employment variable indicated that they were not employed. We did not drop any observation based on inconsistencies between employment status and income, as we were only interested in trends in employment, not income.

After dropping these observations, we define any observation as employed if they claim to be working for at least one hour per week. And we define any observation as being in the labor force if they are employed or actively looking for work.

Head of Household

When examining demographic or employment changes using the QC data, we are only interested in trends among adults. Although the share of children on SNAP has been growing over time, the scope of this report was to review the health and employment outcomes of adults on SNAP. Specifically, our focus on health and employment outcomes motivated us to narrow our focus to adults.

We conducted several tests to ensure that the heads of SNAP households were representative of all adults receiving SNAP, and our results were not sensitive to such changes.

The Unexplained

Using the SNAP QC data, we define the unexplained as an individual between age 50 and 64 who is not employed, not disabled, and not caretaking. See above for our definitions of employment and disability.

We define an individual as caretaking if they have (1) a child below age 18 residing in their SNAP-defined household, (2) an elderly person age 65 or older in their household, or (3) anyone in their household who is disabled.

We also progressively account for disability, employment, and caretaking, meaning that we first count the overall share of the given group of recipients who are disabled. Then, among those who are nondisabled, we account for the share who are employed. Then, among those who are nondisabled and unemployed, we account for the share who are caretaking. The remainder—those not disabled, unemployed, and not caretaking, are the unexplained. Therefore, the shares reflected in Figure 6 are not meant to be representative of the *overall* disability, employment, and caretaking responsibilities in each group.

We also replicated the unexplained in the NHIS data. For this, we use the NHIS definition of disability and employment. (See above.) And because the NHIS does not allow us to identify individuals who have caretaking responsibilities for elderly or disabled household members, an individual has caretaking responsibilities only if they have a child in the household under age 18.

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