

## RESEARCH BRIEF

## SNAP work requirements increase mental health care use

Lindsay Allen PhD, MA<sup>1</sup>  | Diana Henry BA<sup>2</sup> | Alicia Atwood PhD, MPH<sup>3</sup>

<sup>1</sup>Department of Emergency Medicine,  
Feinberg School of Medicine, Northwestern  
University, Chicago, Illinois, USA

<sup>2</sup>Vassar College, Poughkeepsie, New  
York, USA

<sup>3</sup>Department of Economics, Vassar College,  
Poughkeepsie, New York, USA

**Correspondence**

Lindsay Allen, Buehler Center for Health  
Economics and Policy, Feinberg School of  
Medicine, Northwestern University, Evanston,  
Illinois, USA.

Email: [lindsay.allen@northwestern.edu](mailto:lindsay.allen@northwestern.edu)

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[Correction added on 12 January 2023,  
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**Abstract**

**Objective:** We measured the impact of Supplemental Nutrition Assistance Program (SNAP) work requirements on mental health care use.

**Data Sources and Study Setting:** We used 2015–2018 West Virginia Medicaid and SNAP data.

**Study Design:** Nine counties were exposed to SNAP work requirements. Using an event study framework, we assessed how this changed the probability and number of visits for depression and anxiety in the treatment versus the control group.

**Data Collection/Extraction Methods:** The sample included individuals aged 18–49, enrolled in both SNAP and Medicaid at the start of the study. Dually eligible individuals were excluded.

**Principal Findings:** At baseline, the probability of having a mood disorder visit was 6.1% among women and 5.3% among men, rising by 0.9 percentage points (SE 0.4, relative change +14.1%) among women and 0.7 percentage points (SE 0.3, relative change +13.0%) among men after exposure to work requirements. The probability of having an anxiety visit rose by 1.0 (SE 0.4) percentage points among women, a 17.8% relative increase over the baseline of 5.8%. Among men, the likelihood of having an anxiety visit increased by 1.0 percentage points (SE 0.5), a relative change of 24.3% over a baseline probability of 5.0%, though this effect occurred much more gradually compared to women.

**Conclusions:** Exposure to SNAP work requirements was associated with increases in health care use for mood disorders and anxiety among enrollees. The policy's effect differed between men and women.

**KEYWORDS**

anxiety, depression, food insecurity, Medicaid, policy

**What is known in this topic**

- Food insecurity is associated with poor mental health care outcomes.
- The Supplemental Nutritional Assistant Program (SNAP) improves food security for its enrollees, but recent work requirement policies have made it more difficult to qualify for the program, which may in turn worsen mental health.
- The impact of SNAP work requirements on mental health care use has not been empirically evaluated.

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**What this study adds**

- SNAP work requirements increased the use of mental health care services for depression and anxiety among enrollees.
- The timing of these effects differed between men and women.

**1 | INTRODUCTION**

The Supplemental Nutrition Assistance Program (SNAP) provides benefits to low-income individuals and families to reduce hunger and improve wellbeing.<sup>1</sup> In 2015, 20.8 million families participated in SNAP, the largest nutrition assistance program in the United States.<sup>2</sup> Recently, work requirement policies have made it more difficult to access SNAP benefits, which may have important health consequences – especially those related to mental wellbeing.

Work requirement policies limit the time able-bodied adults without dependents (ABAWDS) can receive SNAP benefits, unless they work or participate in training activities.<sup>3</sup> They are intended to incentivize work rather than reliance on public benefits; however, their effects on employment outcomes are modest at best, rendering work requirements a “de facto time” limit for jobless enrollees.<sup>4-6</sup>

Food insecurity—a lack of consistent access to food for all household members—is associated with poor mental health outcomes, including higher rates of depression and anxiety.<sup>1,7-11</sup> Beyond the biological link between inadequate nutrition and mental health, feelings of alienation, worry, guilt, irritability, and shame from being food insecure also have a negative psychological impact.<sup>11-13</sup> Women are especially vulnerable to these adverse effects because they are over-represented among low-income groups and are often responsible for household caretaking and food preparation.<sup>7,8,10,14,15</sup>

Despite the well-documented relationship between food security and mental health, and the number of people affected by increasingly stringent work requirements, no study has examined the impact of SNAP work requirements policies on enrollee mental health. Our study fills this gap, leveraging a natural experiment in West Virginia (WV), which rolled back work requirement exemptions in a subset of its counties. We used Medicaid claims data in an event study framework to assess whether health care visits for depression and anxiety changed after the treated counties were exposed to SNAP work requirements.

**2 | METHODS**

In WV, SNAP work requirement policies mandate that ABAWDS aged 18–49 must engage in work or education training activities for 20 h per week to receive benefits.<sup>16</sup> Individuals cannot receive benefits for more than three months in three years if they are unemployed and do not have an exemption.<sup>17</sup> A person can be individually exempted from the work requirement for several reasons, including if a doctor

declares them mentally or physically unfit for work or if they receive disability benefits.<sup>18</sup>

Beyond individual exemptions, state SNAP agencies can request waivers to eliminate the three-month limit in areas with an unemployment rate above 10% or a “lack of sufficient jobs.”<sup>17</sup> Prior to 2016, all WV counties had a work requirement waiver in place. In January 2016, a pilot program eliminated waivers for nine WV counties,<sup>19</sup> which comprised our treatment group. Enrollees were given time to identify exemptions or establish compliance, so treatment group benefits were first at risk in May 2016. The remaining 46 counties comprised our control group.

Our study period was from October 2015 to September 2018, ahead of when WV rolled out work requirements to additional counties in October 2018. We used complete Medicaid claims data linked to SNAP participation records, which allowed us to observe mental health care use for enrollees, as well as age, race, and sex information. Our sample included a balanced panel of non-dually eligible individuals 18–49 (i.e., the age group targeted by the policy) enrolled in both SNAP and Medicaid during 2015. Linking SNAP and Medicaid enrollment files in 2015 allowed us to identify those individuals who qualified and were enrolled in both programs before the SNAP waiver expiration was announced. We required continuous Medicaid enrollment throughout the study period and excluded those who aged into or out of the work requirements age group during the study period.

We employed an event study to examine whether exposure to SNAP work requirements (via waiver elimination) affected mental health care use. The model took the form:

$$Y_{icmy} = \alpha + \sum_{k=0}^{24} \beta_k (\text{Waiver Drop}_c * k) + \sum_{k=-2}^{-7} \theta_k (\text{Waiver Drop}_c * k) + \lambda X_{icmy} + \nu_{cmy} + \delta_c + \gamma_{my} + \varepsilon_{icmy}$$

$Y_{icmy}$  is a mental health outcome for individual  $i$  in county  $c$  in month  $m$  and year  $y$ . Our key independent variables were dichotomous indicators measuring time relative to the month SNAP benefits were first at risk in an individual's county of residence. The coefficients  $\theta_k$  and  $\beta_k$ , where  $k$  represents the number of months elapsed since the benefits were first at risk, on these variables measure the covariate-adjusted relationship between work requirement exposure and the dependent variable. The  $\beta_k$  coefficient represents the effect of the waiver removal on mental health care use; it is identified by comparing individual outcomes in treatment counties to those in control counties after benefits were first at risk. The identifying assumption is that outcomes for treated counties would have evolved similarly to

non-treated counties in the absence of the waiver elimination. The  $\theta_k$  coefficients test this assumption as they compare outcomes in the treated and control counties before any waiver removal occurred. The month prior to the elimination of the work requirement ( $k = -1$ ) is the omitted category, normalizing the estimates of  $\theta_k$  and  $\beta_k$  to zero in that month. The model also controlled for individual-level characteristics ( $\lambda X_{icmy}$ , age, race/ethnicity), unemployment rate in an individual's county of residence ( $v_{cmy}$ ), month-year fixed effects ( $\gamma_{my}$ ), and county fixed effects ( $\delta_c$ ). Standard errors were clustered at the county level.

Our primary outcome was mental health care use, measured as (1) having a mental health care visit during the month and (2) the number of health care visits that month. We separately examine visits for mood disorders (including depression) and anxiety disorders, both of which have been linked to food insecurity. Because men and women are differentially impacted by food insecurity, we stratified the sample by sex.<sup>20-22</sup> We also examined the impact of the policy on SNAP enrollment, directly. We aggregated individual data to the county level and ran the same event study using a county's monthly SNAP enrollment as the outcome. We ran a placebo analysis and several robustness checks, described in Appendix S1.

A limitation of our study is that we do not observe household composition in our data, and therefore cannot restrict our analysis to individuals without dependents (i.e., those targeted by the policy). Because some who were exempted from the policy are therefore included in our analysis, our results will be biased toward the null. A second limitation is that we are unable to observe individuals who may have found gainful employment due to the work requirement, subsequently disenrolling from Medicaid. These individuals might have improved mental health due to the work requirement, biasing our results away from the null. Because the WV work requirement did not increase employment, we believe this limitation is unlikely to impact our results.<sup>23</sup>

### 3 | RESULTS

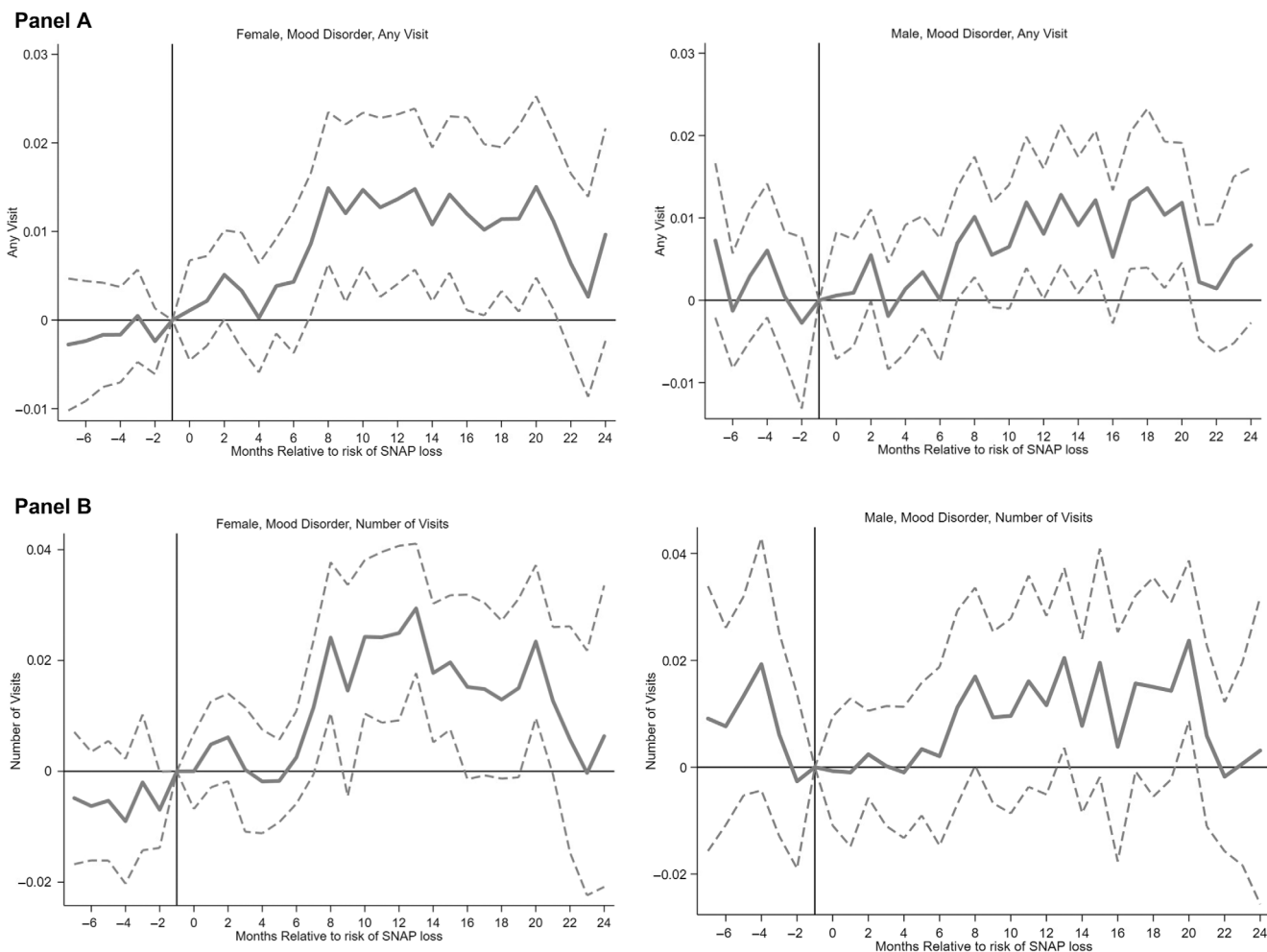
Our sample included 65,157 Medicaid enrollees. As shown in Table 1, pre-period unemployment was lower in the treated counties, which aligns with how they were chosen for the pilot program (i.e., the state selected counties with greater perceived economic opportunity). Those in treated counties were less likely to have mental health office visits, which were rare across the sample; women were more likely to have mental health care visits compared to men.

The event studies in Figure 1 present the  $\beta_k$  coefficients from our models. They represent the adjusted difference in the relationship between the policy and outcomes across the treatment and control groups each month. There were no significant differential trends between the groups before the work requirement waivers were rolled back, lending support for the parallel trends assumption. About seven months after benefits were at risk, we observed that work requirements increased the probability that women had a mood disorder visit by 0.87 ( $p < 0.05$ ) percentage points, a 14.1% increase over their baseline mean (see Appendix S1 for coefficients and standard errors).

TABLE 1 Characteristics of non-elderly adults with SNAP and Medicaid in West Virginia, 2016

|   | All enrollees      |                 | Female enrollees   |                 | Male enrollees   |                 |
|---|--------------------|-----------------|--------------------|-----------------|------------------|-----------------|
|   | Treatment (SD)     | Control (SD)    | Treatment (SD)     | Control (SD)    | Treatment (SD)   | Control (SD)    |
| Female (%)  | 70.60*** (45.56)   | 68.07 (46.62)   | 100 (0)            | 100 (0)         | 0 (0)            | 0 (0)           |
| Age (mean)  | 32.87*** (8.35)    | 33.42 (8.50)    | 32.38*** (8.30)    | 32.88 (8.49)    | 34.06*** (9.34)  | 34.57 (8.43)    |
| White (%)   | 93.04*** (25.45)   | 97.43 (15.81)   | 92.83*** (25.80)   | 97.31 (16.17)   | 93.54*** (24.58) | 97.68 (15.04)   |
| Black or African American (%)                         | 6.96*** (25.45)    | 2.57 (15.82)    | 7.17*** (25.80)    | 2.69 (16.17)    | 6.46*** (24.758) | 2.32 (15.04)    |
| County unemployment rate                              | 5.06*** (0.86)     | 7.80 (2.27)     | 5.05*** (0.87)     | 7.76 (2.26)     | 5.10*** (0.84)   | 7.89 (2.31)     |
| Mood disorder office visit in month (%)               | 0.0590* (0.2356)   | 0.0636 (0.2440) | 0.0614* (0.2401)   | 0.0674 (0.2508) | 0.0531 (0.2243)  | 0.0553 (0.2285) |
| Number of mood disorder office visits in month (Mean) | 0.0894 (0.5305)    | 0.0833 (0.3947) | 0.0930 (0.5226)    | 0.0879 (0.3991) | 0.0807 (0.5489)  | 0.0733 (0.3852) |
| Anxiety office visit (%)                              | 0.0557*** (0.2293) | 0.0625 (0.2421) | 0.0580*** (0.2338) | 0.0660 (0.2482) | 0.0502 (0.2184)  | 0.0553 (0.2285) |
| Number of anxiety office visits (mean)                | 0.0829 (0.4830)    | 0.0788 (0.3789) | 0.0869 (0.4935)    | 0.0828 (0.3884) | 0.0731 (0.4567)  | 0.0703 (0.3576) |
| Observations (N)                                      | 21,071             | 44,086          | 14,877             | 30,010          | 6194             | 14,076          |

Note: The observation period, April 2016, is the month prior to the month during which SNAP benefits were first at risk. Stars reflect statistical difference using t-tests between treatment and control groups at \*\*\* $p < 0.001$ , \*\* $p < 0.01$ , and \* $p < 0.05$  levels. Additional digits are added to cells in which rounding would make the values appear to be the same.



**FIGURE 1** Impact of exposure to SNAP work requirements on probability and number of mood disorder care visits, by sex. Event studies depict the regression-adjusted difference in outcomes between the treatment and control groups in each month.

The impact was sustained for most of the study period. We observed a similar trend among men.

Panel B shows that work requirements increased mood disorder health care use by 0.02 ( $p < 0.01$ ) visits per person about eight months after the policy was introduced, a relative increase of 25.9%. The number of mood disorder visits by men also increased after the policy, but rarely rose to the level of statistical significance.

Figure 2 documents that work requirements increased the probability of an anxiety visit for women by 1.0 percentage points in month eight, a 17.8% increase over the mean (Panel A, see Appendix B1 for coefficients). The policy also increased the probability of an anxiety visit among men, though this effect occurred more gradually compared to women. In Panel B, we documented that work requirements increased anxiety visits by 0.01 visits (12.3%,  $p < 0.01$ ) among women beginning in month seven. We found a similar effect among men beginning in month 13, with an increase of 0.2 visits (29.7%,  $p < 0.01$ ).

Though monthly changes in SNAP enrollment were the same among treatment and control counties prior to the waiver removal (results shown in Appendix C1), we found that SNAP enrollment

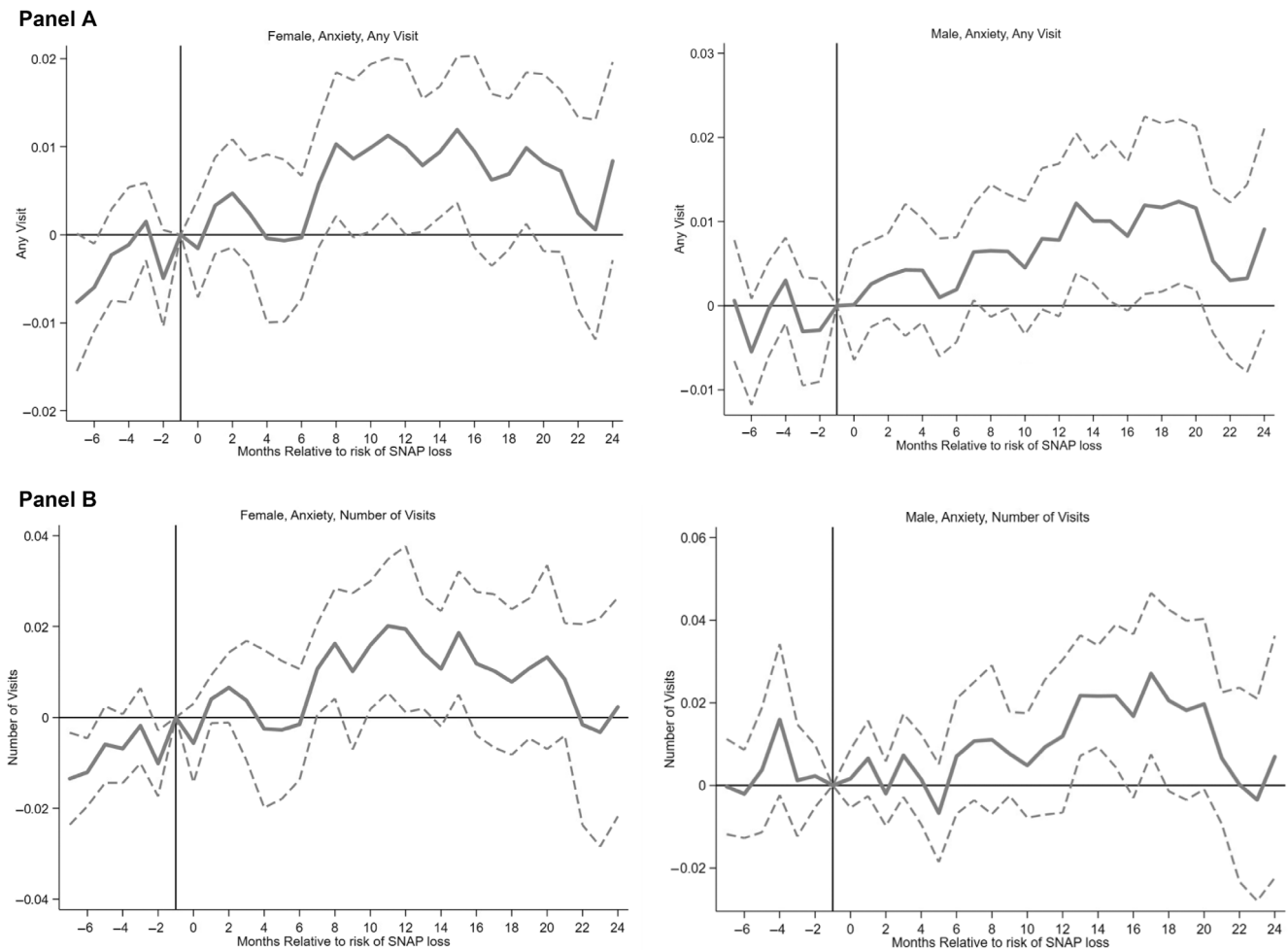
dropped off markedly ( $p < 0.01$ ) in treatment counties but not in control counties about nine months after benefits were at risk.

The results from our placebo analysis and robustness checks are available in Appendix S1. We did not find evidence of an impact on mental health for those aged 50+, who were not subject to the policy, and our main results were robust across the other analyses.

## 4 | DISCUSSION

We leveraged a natural experiment in which SNAP work requirement waivers were eliminated in nine WV counties. Work requirements increased the probability that women engaged in a mental health care visit, as well as the number of mental health care visits each month. In men, we detected an increase in the probability of having a mood disorder visit, no change in the number of mood disorders visits, and increases in the probability and number of anxiety visits, those these changes occurred much later compared to women.

Our results could be explained by several mechanisms. First, the threat or reality of losing SNAP benefits may worsen psychological



**FIGURE 2** Impact of exposure to SNAP work requirements on probability and number of anxiety care visits, by sex. Event studies depict the regression-adjusted difference in outcomes between the treatment and control groups in each month.

distress among participants with previously undiagnosed mood disorders. While this study is among the first to directly test the impact of work requirements on mental health care use, established literature has linked food insecurity with poorer mental health outcomes.<sup>1,7,9,11,14,15,24</sup>

Second, work requirement policies could prompt people with previously undiagnosed or undertreated conditions to visit a doctor to secure an exemption from the work requirements. Approximately one-third of people with major depression do not seek treatment, and only one in ten people with the disorder receive adequate treatment.<sup>25</sup> Among the 4 million adult Medicaid enrollees who had a major depressive episode in 2018, about 30% were untreated.<sup>26</sup> In this case, increased mental health care use might be socially desirable.

A third explanation is that enrollees try to “game” the policy by pursuing a false mental health disorder diagnosis to qualify for an exemption. We believe this is unlikely because prior work has found little evidence that ABAWDs respond to work requirements by claiming disability.<sup>27</sup>

We found that women were impacted much earlier by work requirements compared to men, in line with a host of studies that

have documented an association between food insecurity and poorer mental health outcomes among women.<sup>1,7–11</sup> Overrepresented in SNAP programs, women play a larger role in managing family feeding, which in turn may make them more vulnerable to consequences of food insecurity.<sup>14,28,29</sup> Additionally, the policy strictly defines “dependents” as someone under 18 or someone who is incapacitated. Many women still bear the primary caregiving burden for someone not meeting these definitions.<sup>30</sup> Half of non-working women have reported that childcare/family obligations contributed to their employment decision.<sup>31</sup> Women are also more likely than men to have part-time work, limiting their eligibility for a policy exemption.<sup>31</sup>

The impact of work requirements on outcomes did not occur immediately after benefits were at risk. The delay could be attributable to SNAP recertification processes, required every six months. This process is time intensive and must occur within a certain interval for SNAP to continue without interruption.<sup>32</sup> Additionally, if an individual does not meet the work requirements, they are sent multiple letters asking for verification before removal from the program. There is evidence that both enrollees and case managers can be confused by the requirements and this, in turn, may impact participation in



programs.<sup>33,34</sup> Gray et al. found that SNAP disenrollment in Virginia did not occur until the end of recertification periods for ABAWDs not satisfying the program's work requirements.<sup>35</sup>

We documented that limiting access to SNAP through work requirements has impacts beyond nutrition and can possibly harm mental health. Our study adds to a growing body of recent evidence that SNAP work requirements do not result in large employment gains, but do reduce SNAP participation, especially among vulnerable groups such as those with no income, the unhoused, and those living in rural areas.<sup>6,35,36</sup> Policy makers and future research should seek to better understand these tradeoffs when considering the net impact of SNAP work requirement policies on an already-marginalized population.

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## ORCID

Lindsay Allen  <https://orcid.org/0000-0003-1723-9248>

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#### SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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