

Local Food Prices, SNAP Purchasing Power, and Child Health*

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Abstract:

The Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) is one of the most important elements of the social safety net. Unlike most other safety net programs, SNAP varies little across states and over time, which creates challenges for quasi-experimental evaluation. Notably, SNAP benefits are fixed across 48 states; but local food prices vary, leading to geographic variation in the *real* value – or purchasing power – of SNAP benefits. In this study, we provide the first estimates that leverage variation in SNAP purchasing power across markets to examine effects of SNAP on child health. We link panel data on regional food prices to National Health Interview Survey data and use a fixed effects framework to estimate the relationship between local purchasing power of SNAP and children’s health and health care utilization. We find that lower SNAP purchasing power leads to lower utilization of preventive health care and more days of school missed due to illness. We find no effect on reported health status.

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1 Introduction

The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp program) is the largest food assistance program and one of the largest safety net programs in the United States.¹ SNAP plays a crucial role in reducing poverty for children in the U.S., with only the EITC (combined with the Child Tax Credit) raising more children above poverty (Fox 2017). Eligibility for the program is universal in that it depends only on a family's income and assets; in 2015, 1 in 7 Americans received SNAP benefits (Ziliak 2015).

SNAP's primary goals are to improve food security among low-income households, reduce hunger, and increase access to a healthful diet.² The extant literature demonstrates that the program succeeds in reducing food insecurity among recipient households (see, e.g., Yen et al. 2008; Nord and Golla 2009; Mykerezi and Mills 2010; Ratcliffe, McKernan, and Zhang 2011; Shaefer and Gutierrez 2011; Schmidt, Shore-Sheppard, and Watson 2016 and the recent review by Hoynes and Schanzenbach 2016). Nonetheless, rates of food insecurity among SNAP households remain quite high, raising the question of whether SNAP benefits are adequate to meet the nutritional needs of recipients (Coleman-Jensen et al. 2012). Indeed, evidence regarding how SNAP benefits impact recipients' nutrition is more mixed (see, e.g., Yen 2010; Gregory et al. 2013; Bronchetti, Christensen, and Hansen 2017b).

Our study provides unique and highly policy-relevant evidence on the impact of variation in the generosity of SNAP benefit levels on child health. Estimating the causal relationship

¹ SNAP benefits paid in 2016 amounted to more than 66 billion dollars. The program has also grown dramatically in the years since 1996 welfare reform, with benefits paid out almost tripling in real terms over the years in this study (1999-2010).

² See, for example, the most recently amended authorizing legislation, the Food and Nutrition Act of 2008, available at <https://fns-prod.azureedge.net/sites/default/files/snap/Food-And-Nutrition-Act-2008.pdf>.

between SNAP and health is difficult because SNAP benefits and eligibility rules are legislated at the federal level and do not vary across states, leaving few opportunities for quasi-experimental analysis. One set of quasi-experimental studies analyzes the rollout of the food stamp program across counties in the 1960s and 1970s and finds that food stamps leads to significant improvements in birth outcomes (Currie and Moretti 2008; Almond, Hoynes, and Schanzenbach 2011) and access to food stamps in early childhood leads to significant improvements in adult health (Hoynes, Schanzenbach, and Almond 2016). A second set of studies uses recent state changes in application procedures (e.g. allowing online applications, whether there is a finger printing requirement) as instruments for SNAP participation (Schmeiser 2012),³ though these state policies had relatively small effects on participation (Ziliak 2015). A third approach is taken by East (2016), who uses variation in eligibility for SNAP generated by welfare reform legislation in the 1990s, and finds that SNAP in early childhood leads to improvements in health status at ages 6-16. None of these studies, however, is able to shed light on how changes to legislated SNAP benefit levels might impact health outcomes.

Our approach leverages plausibly exogenous geographic variation in the *real value of SNAP benefits* to identify the effects of variation in SNAP generosity on health for a sample of children in SNAP households. Importantly, the SNAP benefit formula is fixed across 48 states (benefits are higher in Alaska and Hawaii) even though the price of food varies significantly across the country (Todd et al. 2010; Todd, Leibtag, and Penberthy 2011).⁴ Across the continental U.S.,

³ Gregory and Deb (2015) use the Medical Expenditure Panel Survey and state policy variables and find that SNAP participants have fewer sick days and fewer doctor's visits, but more checkup visits.

⁴ Studying data from the Quarterly Food at Home Price Database (QFAHPD), Todd et al. (2011) find that regional food prices vary from 70 to 90 percent of the national average at the low end to 120 to 140 percent at the high end.

maximum benefits vary only with family size; in 2018 a family of three is eligible for a maximum benefit of \$504/month regardless of the local cost of living. Though SNAP benefits are implicitly adjusted for variation in the cost of living through allowed deductions (e.g., for housing, and child care) in the calculation of net income, the limited available evidence indicates these adjustments are not sufficient to equalize *real* benefits, particularly in high cost areas (Breen et al. 2011). Gundersen, Kreider, and Pepper (2011) and the Institute of Medicine (2013) propose this as an area for future research.

Higher SNAP purchasing power may impact children's health through three possible channels. A *direct* (nutrition) effect occurs if higher SNAP purchasing power leads to increases in the quality or quantity of food. Higher SNAP purchasing power, by freeing up resources more generally, may also impact health *indirectly*, facilitating households to increase consumption of other inputs into the health production function, like health care. Finally, if additional SNAP purchasing power leads to reductions in stress and "bandwidth poverty" (Bertrand et al 2004, Mullainathan and Shafir 2013), it may result in better compliance with activities such as getting children to school and to the doctor for annual exams.

Linking nationally representative data from the 1999-2010 National Health Interview Surveys (NHIS) to information on regional food prices from the Quarterly Food-at-home Price Database (QFAHPD), we study the effect of variation in SNAP purchasing power on children's health care utilization and health. Our measure of SNAP purchasing power compares the maximum SNAP benefit to the regional cost of the Thrifty Food Plan (TFP), a nutrition plan constructed by the USDA to represent a nutritious diet at minimal cost and the basis for maximum legislated SNAP benefits (i.e., maximum benefits are set to the TFP national average

cost). The QFAHPD includes information on food prices that allows us to construct an estimated TFP price for each of 30 designated “market group” geographic areas across the U.S. We relate child health care utilization and health outcomes to SNAP purchasing power (i.e., the ratio of the national SNAP maximum benefit to the market group-level TFP price faced by a household) in a fixed effects framework that controls for a number of individual-level and region characteristics (including non-food prices in the area) and state policy variables. Identification comes from differences across the 30 market groups in trends in the price of the TFP.

Our study contributes to the growing body of evidence on the SNAP program and its effects in a few key ways. First, we provide new evidence on the relationship between SNAP benefit generosity and the health and wellbeing of the SNAP population. Our findings consistently indicate that children in market groups with lower purchasing power of SNAP utilize less preventive/ambulatory health care. We find that a 10 percent increase in SNAP purchasing power raises the likelihood a child has an annual checkup by 6.3 percentage points (8.1 percent) and the likelihood of *any* doctor’s visit by 3.1 percentage points (3.4 percent). While lower real SNAP benefits do not result in significant declines in reported health status, we document significant detrimental impacts on some health indicators, like the number of school days missed due to illness, as well as on children’s food security. Summary indices corroborate the existence of effects on health care utilization, but not health outcomes generally. We confirm that these effects are not driven by relationships between geographic variation in food prices and SNAP participation or health insurance coverage, nor are they present in placebo samples of children of college educated mothers (who have low rates of SNAP participation) and noncitizen children (who are ineligible for SNAP).

A second contribution is methodological, in that our approach highlights a new identification strategy for estimating effects of proposed changes in SNAP generosity on other outcomes of interest. To our knowledge, ours is the first study to utilize variation in the real value of SNAP as a source of identification.⁵ Future research could leverage geographic variation in SNAP purchasing to examine SNAP's impacts on nutrition, food consumption and other spending patterns, birth outcomes, and adult health.⁶

We interpret our estimates as reflecting the impacts of variation in SNAP purchasing power, rather than simply the effects of variation in local food prices.⁷ Variation in real SNAP generosity may affect households differently than variation in prices to the extent that local earnings adjust to account for higher local prices (Roback 1982; Albouy 2008; Moretti 2013), while SNAP benefits do not. Indeed, we demonstrate that SNAP purchasing power does not significantly impact our key health outcomes or food insecurity for samples that are ineligible for SNAP or have very low SNAP utilization (e.g., non-citizen children, children in families with a college educated mother). Additionally, while our main models include controls for regional prices of other goods (such as housing, energy, transportation, etc.), our results are robust to the inclusion of these factors, suggesting that we are not simply capturing the broader effects of living in a more or less expensive market.

More broadly, our findings point to sizeable, beneficial impacts of SNAP (and of increasing

⁵ In related work, Gregory and Coleman-Jensen (2013) study the direct relationship between local food prices and food insecurity for a sample of SNAP households. The authors find that SNAP participants in high-priced areas are 15-20 percent more likely to be food insecure than those in low-priced areas.

⁶ Bronchetti, Christensen, and Hansen (2017b) link National Household Food Acquisition and Purchase Survey (FoodAPS) data on SNAP recipients' diets to local data on the cost of the TFP to study the effects of variation in SNAP purchasing power on nutrition among the SNAP population.

⁷ Throughout, our models include market area and time fixed effects and controls for local housing costs (HUD fair market rent), other non-food prices, and local labor market conditions.

the generosity of SNAP benefits) for children's health care utilization, food security, and some measures of their health, benefits which should be weighed carefully against the cost savings of any proposed cuts to the SNAP program. These results also shed light on the expected impact of adjusting benefit levels to account for geographic variation in food prices across market groups. Such adjustments would likely reduce disparities in preventive/ambulatory care, school absenteeism, and food security among low-income children, but may not lead to contemporaneous changes in other health outcomes.

The paper proceeds as follows. The next section describes our multiple sources of data on regional food prices, child health, food security, and SNAP participation, and Section 3 lays out our empirical approach. Section 4 presents our main results regarding the impact of SNAP purchasing power on children's health care utilization and health, Section 5 explores mechanisms and several robustness checks, and Section 6 concludes.

2 Data

In this study, we combine three sets of data to estimate the effect of SNAP on children's health. Below we describe the data on the price of the TFP, the National Health Interview Survey, and the state and county control variables. Additionally, we supplement our main analysis with administrative data on SNAP caseloads and household-level data on food insecurity from the December Current Population Survey (CPS).

2.1 Regional Cost of the Thrifty Food Plan (TFP)

The Thrifty Food Plan (TFP) is a food plan constructed by the USDA, specifying foods and

amounts that represent a nutritious diet at a minimal cost. The TFP is used as the basis for legislated maximum SNAP benefit levels. In 2016, the U.S. average weekly TFP cost was \$146.90 for a family of four with two adults and two children (ages 6-8 and 9-11).⁸

To assign food prices to our sample of households in the NHIS, we construct data on the regional price of the TFP using the Quarterly Food-at-Home Price Database (QFAHPD) (Todd et al. 2010) for the years from 1999 through 2010. The QFAHPD, created by the USDA's Economic Research Service, uses Nielsen scanner data to compute quarterly estimates of the price of 52 food categories (e.g. three categories of fruit: fresh or frozen fruit, canned fruit, fruit juices; nine categories of vegetables, etc.) for 35 regional market groups. The 35 market groups covered in the QFAHPD include 26 metropolitan areas and 9 nonmetropolitan areas, though for 1999-2001 only 4 nonmetropolitan areas are captured.⁹ Each market group consists of a combination of counties. We map the 52 QFAHPD food categories to the 29 TFP food categories to create a single price estimate for the TFP for each market group and year during the full 1999-2010 period covered by the QFAHPD, following the methods in Gregory and Coleman-Jensen (2013).^{10, 11}

To map the QFAHPD food group prices to the TFP food group prices in the market basket,

⁸ See <https://www.cnpp.usda.gov/sites/default/files/CostofFoodNov2016.pdf>. (Accessed 1/28/17)

⁹ In 1999-2001, the QFAHPD identified one nonmetropolitan area for each of the 4 census regions (east, central, south and west). In 2002 and later, they expanded to include nonmetropolitan areas in each of the 9 census divisions: New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain and Pacific. For comparability we use the four nonmetropolitan areas throughout. Appendix figure 1 shows these market groups.

¹⁰ We come very close to reproducing their estimates. As in this earlier work, we can cleanly link the QFAHPD categories to 23 of the 29 TFP categories without duplication or overlap of QFAHPD prices. The remaining six TFP categories contain foods that are accounted for in other parts of the QFAHPD TFP basket. For details on the construction of the TFP itself, see Carlson et al. (2007).

¹¹ There are two versions of the QFAHPD: QFAHPD-1, which provides price data on 52 food groups for 1999-2006, and QFAHPD-2, which includes prices for 54 food groups for 2004-2010. We bridge the two series by estimating the average ratio of QFAHPD-1 to QFAHPD-2 for years 2004 through 2006 for each market group. We then divide the price data for 1999-2003 (i.e. the years with information on only 52 food groups) by this ratio to put everything in consistent units.

we use an expenditure-weighted average of the prices for the QFAHPD foods, where the weights are the expenditure shares for the QFAHPD foods within each TFP category (most TFP food categories consist of multiple QFAHPD food groups). We construct *national* expenditure shares by averaging the shares across all market groups. To avoid confounding regional variation in food prices with regional variation in consumption of different food categories, we apply these *national* expenditure shares to each market group's prices when constructing the market group-level cost of the TFP.^{12, 13} We use the 2006 specification of the TFP, which features food categories that are relatively closely aligned with the food categories in the QFAHPD data (Carlson et al. 2007).

We assign each household in the NHIS to a market group-level TFP price based on the county of residence and the year of interview. When estimating the relationship between the real value of SNAP benefits and health, we measure the purchasing power of SNAP using the ratio of the maximum SNAP benefit to the TFP price faced by the household. Our main regression models use the natural log of this ratio as the key independent variable for ease of interpretation; however, results are qualitatively very similar when the level of the ratio is employed instead.¹⁴

¹² We have also constructed measures of TFP cost using total national expenditure shares (as opposed to averaging the weights across market groups) and obtain very similar estimates of the TFP and effect sizes.

¹³ An example (borrowed from Gregory and Coleman-Jensen (2013)) is illustrative. The TFP food category "whole fruit" consists of two QFAHPD food groups: "fresh/frozen fruit" and "canned fruit." In Hartford (market group 1) in the first quarter of 2002, expenditures on fresh/frozen fruit were \$35.7 million, and expenditures on canned fruit were \$5.8 million. This yields expenditure weights for whole fruit (in Hartford in quarter 1 2002) of 0.86 and 0.13, respectively. We then average these expenditure shares across *all market groups* to generate the national expenditure shares (for each item and period). In 2002, these national expenditure weights are 0.84 and 0.16 for fresh fruit and canned fruit, respectively. We apply these shares to the first-quarter 2002 prices of fresh/frozen and canned fruit in the Hartford market group (\$0.218 and \$0.244 per 100 grams, respectively) to compute a price for whole fruit in Hartford for the first quarter of 2002 ($0.84 \times \$0.218 + 0.16 \times \$0.244 = \$0.222$ per 100 grams).

¹⁴ These results are available upon request.

Figure 1 illustrates the variation across regions and over time in the real value of SNAP, equal to the maximum SNAP benefit for a family of 4 divided by the regional cost of the TFP.¹⁵ Panel A displays the value of this ratio in 1999, Panel B shows its value in 2008, and Panel C shows its value in 2010. In each case, a darker shading represents a higher SNAP/TFP ratio, or greater SNAP purchasing power. In lower-cost areas the SNAP benefit covers up to 80 percent of the cost of the TFP, while in higher cost areas (e.g., the west and northeast) this ratio falls to less than 65 percent. Note that since the statutory TFP is constructed using a national average, some areas are, by definition, likely to have SNAP benefits that exceed the cost of the TFP. However, our purchasing power measure (maximum SNAP benefit/price of TFP) is less than 1 for all market groups. One reason for this is that the regional TFP prices from the QFAHPD are based on average prices paid for each food category by all consumers, whereas the statutory TFP price is based on prices paid by low-income persons. If low-income households are shopping at different stores, or buying on sale or buying cheaper (e.g., store) brands, then the TFP price we estimate using the QFAHPD will consistently be too high.

Our identification strategy relies not on the exact level of the TFP price (or SNAP purchasing power), but on differences across markets in trends in SNAP purchasing power. Using the QFAHPD we can compare prices paid by all households (which we use to construct the regional cost of the TFP) to the prices paid by low income households (who would more closely track prices paid by SNAP households). Figure 2 demonstrates a strong, positive correlation between the market area price paid by low-income households and the market area all-household price, for a variety of food categories suggesting that the all-households price tracks well the low-

¹⁵ An interactive version of this figure is available online at http://garretchristensen.shinyapps.io/Food_Price_Maps.

income household price.¹⁶ In Appendix Figure 2, we compare our estimated TFP price to a lowest-cost TFP price measure, by market area, which we construct using only the lowest-cost QFAHPD food category within each TFP category (similar to how the statutory TFP price is calculated). Reassuringly, we find a strong correlation (0.98) between our index and this lowest-cost alternate measure across market areas.

Figure 1 also demonstrates noticeable *changes* in SNAP purchasing power within regions over the 1999 – 2010 period. The changes in 2010 reflect, in part, the effect of the stimulus package (ARRA), which raised the maximum SNAP benefit in the second half of 2009 and throughout 2010. Appendix Figures 3a and 3b present trends in the TFP price and SNAP purchasing power, respectively, for each of the market group areas. Appendix Figure 3a shows that the TFP price varies significantly across areas – prices are higher in places such as San Francisco and Metro New York but with different trend paths.¹⁷ The same is true for SNAP purchasing power, though the effect of the increase in benefits due to the ARRA is common to all areas.¹⁸

Given that food stamp recipients are not limited to purchasing the TFP basket, why do we use it? Ultimately, we are looking for a standardized index across places and over time that allows us to trace out variation in food prices that are relevant for the low-income population.

¹⁶ The low-income sample is from households below 185 percent of the federal poverty line in Nielsen HomeScan data. See Appendix C of Todd et al. (2010) for details. The plotted data come from Tables C1-C5. Todd et al. conclude “When the markets are ranked by the price index in each food group, we consistently see the most expensive markets as determined by the full sample also appearing as the most expensive markets in the low-income sample, and the same pattern holds for the least expensive markets as well.”

¹⁷ Prices may vary across areas due to differences in costs of labor or rent. DellaVigna and Gentzkow (2017) find evidence of uniform pricing across the U.S. at large food chains. Stoebel and Vavra (2017) find that prices across stores vary with housing prices, suggesting more evidence of local variation. They show that the differences across areas are not due to changes in store or product quality. Less is known about geographic price variation across smaller stores.

¹⁸ In robustness tests presented below, we examine the sensitivity to dropping 2009 and 2010. The ARRA increased the maximum SNAP benefit by 13.6 percent (Hoynes and Schanzenbach 2016).

Our investigations (Figure 2, Appendix Figure 2) indicate that the different price series are very highly correlated across place. In the end, we view the TFP as appealing because it is the index used by USDA in setting benefits. Furthermore, by using the price of a set basket we remove the influence of any (endogenous) changes in food choices that recipients make in the face of higher prices.

2.2 National Health Interview Survey (NHIS) Data on SNAP Children

We use restricted-access micro data from the National Health Interview Survey (NHIS) for the years 1999-2010 to examine effects on child health and health care utilization.¹⁹ The NHIS surveys approximately 35,000 households per year. By gaining restricted-use access to this data we can observe the county of residence for each household in the survey. This allows us to link respondents to regional area food prices and access detailed information on children’s health and the characteristics of their parents and households for a large and representative national sample. From each household with children, the survey selects one child at random (the “sample child”) and collects more extensive and detailed information on this child’s health and health care utilization. Several of the outcomes we study are only available in these Sample Child files, while others (e.g., parent-reported health status) are available for all NHIS respondents in the Person-level file.

Our primary sample includes children ages 17 and under who are citizens of the United States. We impose the citizenship restriction because the post-welfare reform era witnessed

¹⁹ State and county identifiers are masked in the public use NHIS data. Researchers interested in accessing the restricted geocode data should contact Peter Meyer at rdca@cdc.gov.

dramatic changes to rules regarding non-citizens' eligibility for many social safety net programs, including SNAP. (We analyze noncitizen children as a placebo group below.) We conduct our main analyses on the sample of children in households who report having received SNAP benefits in at least one of the past 12 months. For the years from 1999 through 2010, there are 44,627 such children; 18,299 of them are also interviewed as Sample Children. While the advantage of limiting our analysis to the SNAP recipients is clear (this is the group most affected by SNAP), non-random selection into SNAP participation would call into question a causal interpretation of our estimates. In Section 4.1, we analyze the impact of SNAP purchasing power on SNAP participation at the county level and document no significant relationship between the real value of SNAP benefits and the per-capita SNAP caseload.²⁰ As a robustness check in Section 5, we also test the sensitivity of our results using an alternative sample with a high likelihood of being on SNAP—children living with low-educated, unmarried parent(s).

Families with limited resources may respond to lower SNAP purchasing power by reducing consumption of other goods that impact health, like ambulatory or preventive health care. Additionally, lower SNAP purchasing power could lead to increases in stress and bandwidth poverty, resulting in lower compliance with preventive care. Our primary measures of health care utilization are indicators for whether the child has had a check-up in the past 12 months and whether the child has had *any* doctor's visit in the past 12 months. According to guidelines from the American Academy of Pediatrics (AAP), children should have 6-7 preventive visits before age 1, 3 visits per year as 1-year olds, 2 visits as 2-year olds, and at least one visit per

²⁰ We also document no significant relationship between SNAP purchasing power and the likelihood of SNAP participation at the individual level, among Sample Children in the NHIS (see Appendix Table 3).

year for ages 3 through 17. We also analyze the relationship between SNAP purchasing power and whether (the parent reports that) a child has delayed or forgone care due to cost in the past 12 months. Finally, we study whether the child has visited the ER in the past year; if lower SNAP purchasing power reduces the use of preventive/ambulatory care, we might also see increased utilization of ER care.

We also analyze the effects of SNAP purchasing power on several direct measures of child health that might respond to reduced nutrition, or to reduced consumption of other inputs in the health production function (e.g., health care). Parental respondents report the child's health status on a 5-point scale (excellent, very good, good, fair, and poor); we use this measure to construct an indicator for whether the child is in excellent or very good health. As measures of contemporaneous health, we also study whether the child was hospitalized over the past 12 months, the number of school days missed due to illness in the past 12 months (for the sub-sample of school aged children), and an indicator for whether the child missed 5 or more days of school due to illness. School attendance might also respond due to the stress and bandwidth poverty channel. In addition, we estimate the relationship between SNAP purchasing power and two longer-term health outcomes that may be affected by reduced nutrition or to food insecurity: an indicator for obesity based on height and weight data (for the subsample of children ages 12-17), and whether the child has emotional problems (defined for the universe of children ages 4 and older).

In addition, we test both of these groups of outcomes (preventive health care utilization,

health outcomes) using summary index methods as in Kling, Liebman, and Katz (2007).²¹

Table 1 displays summary statistics for SNAP recipient children and for the entire population of children. As expected, SNAP children are likely to be poor, live in single-parent households (only a third live with both parents), and are disproportionately likely to be black or Hispanic. Because such a high fraction (72 percent) of SNAP children receive Medicaid, the rate of uninsurance among this sample is low, at about 7 percent. Health care utilization and health outcomes are somewhat similar for SNAP citizen children compared to the general population of children in the U.S. Nearly one-quarter of SNAP children went without a check-up in the past year, but 90 percent had at least some sort of doctor's visit during that time, and more than 5 percent report having delayed or gone without care due to its cost. However, ER utilization is high, at over 30 percent, compared to 21 percent among the entire population. In terms of health itself, SNAP children have similar health status, but miss more school days (5, on average, but one-third of SNAP children missed 5 or more in the past year), and more commonly have emotional problems (46 percent of SNAP children 4 or older compared to 27 percent in the general population).

2.3 State and County Control Variables

We include several variables to control for regional policies and prices that might affect child health and be correlated with local food prices. First, we control for local labor market

²¹ We create summary indices by subtracting the mean and dividing by the standard deviation of each variable, then averaging across variables within items in the index. Typically, the mean and standard deviation of a control group are used, but lacking that, we use the full sample. Note that the sample in these regressions is limited to those with full data from all included measures. For the health outcomes index this implies school age children only. Anderson (2008) explains similar indices clearly, and Hoynes, Schanzenbach, and Almond (2016) use the technique when evaluating long-run impacts of SNAP.

conditions with the county unemployment rate (and in some robustness tests we also control for log employment and average earnings by 1-digit sector using the Quarterly Census of Employment and Wages). Second, we include a summary index of state-level SNAP policies developed by Ganong and Liebman (2018), which incorporates measures for simplified reporting, recertification lengths, interview format (e.g. in person or not), call centers, online applications, Supplemental Security Income Combined Application Project, vehicle exemptions for asset requirement, and broad-based categorical eligibility. Third, we control for other state policies including the minimum wage, state EITC, TANF maximum benefit guarantee amounts, and Medicaid/State Children’s Health Insurance Program (CHIP) income eligibility limits. Finally, we control for prices of other goods by including HUD’s fair market rent (measured by county as the “40th percentile of gross rents for typical, non-substandard rental units occupied by recent movers in a local housing market”²²) and regional Consumer Price Indices (CPIs) for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other goods and services). These regional CPI prices are available for 26 metro areas; for the remaining areas, the CPI is calculated within each of the four census regions and for four county population sizes (<50,000, 50,000-1.5 million, >1.5 million).

2.4 Supplemental Data on SNAP Caseloads and Food Insecurity

We investigate the relationship between SNAP purchasing power and SNAP participation in Section 4.1, using administrative data on county-level SNAP caseloads from the U.S. Department of Agriculture (USDA), for the years from 1999 through 2010. We match each

²² More specifically, HUD estimates FMRs for 530 metropolitan areas and 2,045 nonmetropolitan county FMR areas.

county-year observation to that year’s TFP price for the market group to which the county belongs.

To further probe mechanisms whereby variation in regional food prices may impact child health, we supplement our main analysis by studying the relationship between SNAP purchasing power and food insecurity.²³ For this analysis we use data from the December Current Population Survey Food Security Supplement (CPS-FSS) for the years from 2001-2010.²⁴ We identify a sample of 37,277 citizen children, ages 0 to 17, who live in households that report receiving SNAP, and link them to market group TFP prices according to location of residence.²⁵

3 Empirical Methods

We estimate the causal impact of variation in the real value of SNAP benefits on measures of child health and health care utilization for children in households who report receiving SNAP benefits during the past 12 months. Throughout, our regressions take the following form:

$$(1) \quad y_{irt} = \alpha + \beta \ln \left(\frac{SNAPMAX_t}{TFP_{rt}} \right) + X_{irt}\theta + Z_{rt}\gamma + \delta_t + \lambda_r + \varepsilon_{irt}$$

where y_{irt} is the health outcome of individual i who resides in region r (market group) in time t .

The key independent variable is the natural log of the ratio of maximum SNAP benefits for a

²³ Food insecurity is a household-level measure of well-being, defined as being unable to obtain, or uncertain of obtaining, an adequate quantity and quality of food due to money or resources. Very-low food insecurity is defined as food insecurity that includes disrupted or restricted dietary patterns. Prior to 2006, very-low food insecurity was labeled “food insecurity with hunger”.

²⁴ The December food security supplement was not collected in 1999 and 2000.

²⁵ The public-use food security supplement files reports geographic information on all states, 217 counties, 69 primary metropolitan statistical areas, 173 metropolitan statistical areas (MSA), 40 combined statistical areas (CSA), and 278 core-based statistical areas (CBSA) during our period of analysis. In order to assign CPS observations to a market group, we first identify states that include a single market group and assign all observations in that state to the corresponding market group. Continuing with the next most general geography (CSA), we repeat this process at increasingly more detailed geographies levels to the county identifiers. After this step, we then assign observations living in a non-metropolitan area to the rural market group based on their state of residence (for states with rural areas in a single market group). We match 83.7 percent of CPS observations to a market group using this iterative process.

family of four (which vary by year, but is constant across regions) to the TFP price in region r in year t . The vector X_{irt} contains a set of controls for the child's characteristics, including his/her age (and its square), race, Hispanic ethnicity, family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. The unemployment and state policy variables described in Section 2.3 are included in Z_{rt} , as are a set of regional CPIs in non-food, non-housing consumption categories. All models also include a full set of fixed effects for the year (δ_t) and market group (λ_r). In all models, the standard errors are corrected for clustering at the market group level.

One important question is how much variation in the cost of food remains after controlling for the prices of other goods. Appendix Table 1 shows an R^2 of 0.82 when regressing our main food price measure on other prices indexes, and R^2 of 0.97 after adding fixed effects. Appendix Figure 4 plots the residuals, which exhibit a fair amount of idiosyncratic variation. What causes these residuals (and leads to our plausibly exogenous variation) is by definition difficult to explain but could be related to local wages and demand conditions, which grocery/outlet chains are in a market, or local supply shocks.²⁶

Identification in this model comes from variation in trends in the price of the Thrifty Food Plan across market groups. As we discussed in Section 2.1 (see Figure 1), there is substantial variation across geographic areas in the purchasing power of SNAP benefits. More importantly for our identification strategy, these regional differences change over time, with some areas

²⁶ It is similarly difficult to fully explain regional prices for other commodities such as gasoline in California. See for example Borenstein, Bushnell, and Lewis (2004) and Borenstein (2015).

experiencing larger increases in SNAP purchasing power from 1999 to 2010, and others experiencing smaller increases (e.g., purchasing power in some southern metropolitan areas increased nearly 17 percent, but only about 4.5 percent in urban New York).²⁷

4 Results

4.1 SNAP Participation

We begin by analyzing the effects of SNAP purchasing power on the SNAP caseload. If variation in the real value of SNAP leads to changes in SNAP participation, then selection may bias our estimates of the effect of SNAP purchasing power on child health.

Using data from USDA, we construct a county panel for annual SNAP caseloads covering 1999-2010. We estimate equation (1) where the dependent variable is SNAP caseloads divided by county population. Table 2 displays the results of five different specifications of the model. Each includes year and market group fixed effects, as well as the natural log of the ratio of maximum SNAP benefits to the market group TFP price. In the second column we add a control for the county unemployment rate, which is a significant determinant of SNAP caseloads (Bitler and Hoynes 2016) and possibly correlated with regional prices. In column 3 we add controls for state policy variables, including for SNAP, EITC, minimum wages, TANF generosity, and Medicaid. In column 4 we add controls for regional prices, including the county HUD fair market rent and regional CPIs for goods other than food. In column 5, we extend the specification by

²⁷ SNAP benefits in 2010 and 6 months of 2009 include increased benefits provided through the American Recovery and Reinvestment Act (ARRA). ARRA benefits amounted to \$62, or about a 13.6 percent increase above the base 2009 levels. Changes in SNAP purchasing power ranged from a decrease of 5.8 percent in San Francisco to 4.3 percent increase in metropolitan areas in Arkansas and Oklahoma over the 1999-2008 period.

including a market group linear time trend.

When only year and market group fixed effects are included, the estimated coefficient on SNAP purchasing power is positive and significant, consistent with the SNAP caseload per capita rising when the purchasing power of SNAP increases. However, once we add county unemployment rate, in column (2), the coefficient drops substantially in magnitude and is no longer statistically different from zero. The addition of the state policy controls (column 3) and the regional prices (column 4) does not change the coefficient significantly. Adding market group-specific linear time trends (column 5) leads to little change in the estimated coefficient on SNAP purchasing power.

In Appendix Table 2, we show that these results are robust to the addition of further controls for local economic conditions, including aggregate and sector-specific employment and wages from the QCEW. Appendix Table 3 presents the results of analogous regressions at the individual level, wherein we estimate the relationship between SNAP purchasing power and the likelihood of SNAP participation among children ages 0-17 in the Sample Child Files of the NHIS, 1999-2010. Similar to the caseload analysis described below, the individual-level results also document no evidence of a significant relationship between SNAP purchasing power and SNAP participation. Taking all of this evidence together, we conclude that there is no significant relationship between the real value of SNAP and SNAP participation, and thus we interpret our main results free of concerns about selection.

4.2 SNAP Purchasing Power and Health Care Utilization

The primary goal of our study is to analyze the impacts of variation in the purchasing power of SNAP benefits on outcomes related to child health. We begin by examining evidence for

measures of health care utilization, recognizing that families facing higher food prices may respond to the lower real value of their SNAP benefits by reducing out-of-pocket spending on other goods, including health care.

We present the results of this analysis in Table 3. Our primary measure of health care utilization is an indicator for whether the child has had a check-up in the past 12 months (column 1), which is observed only for children in the Sample Child file. We also examine indicators for whether the child has had any doctor's visit in the past 12 months (column 2), and whether a child has visited an ER in the past 12 months (column 3). Whether a child has delayed or forgone care is reported in the Person file of the NHIS so is observed for all NHIS children under age 18; we report this estimate in column 4. The model includes fixed effects for market group, year, individual controls, and regional controls for unemployment rate, non-food prices, and state safety net policies (similar to column 4 of Table 2).²⁸ The key independent variable, representing SNAP purchasing power, is $\ln(\text{SNAPMAX}/\text{TFP})$.

Among SNAP-recipient children, we find that increased purchasing power of SNAP significantly raises the likelihood a child has had a checkup in the past 12 months. A ten percent increase in the ratio (SNAPMAX/TFP) leads to a 6.3 percentage point (or 8.1 percent) increase in the likelihood of a checkup. We also document a smaller, but significant impact of increased SNAP purchasing power on the probability a child has had *any* doctor's visit over the past 12 months. A ten percent increase in the purchasing power of SNAP raises the likelihood of any doctor's visit by 3.1 percentage points, or 3.4 percent.

²⁸ Individual-level controls include the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship.

The results in columns 3 and 4 indicate that SNAP purchasing power has no statistically significant effect on whether children have visited the ER in the past 12 months, or are reported to have delayed or forgone care due to cost. However, the coefficients are negative, suggesting a protective effect of SNAP.

4.3 SNAP Purchasing Power and Health Outcomes

Table 4 presents evidence on the extent to which variation in SNAP purchasing power affects child health outcomes. The regression specifications include the same set of controls as in Table 3. Note that several of the outcomes are defined only for sub-samples of children, leading to different numbers of observations across the columns of Table 4. Specifically, obesity is measured only for children ages 12 through 17,²⁹ emotional problems are identified for children ages 4 and older, and the number of school days missed is recorded only for children age 5 and older who are in school. Parent-reported health status and hospitalization in the past 12 months are reported for all children, but the other health outcomes are only provided for children in the Sample Child file.

We find no statistically significant relationship between SNAP purchasing power and an indicator for the child's (parent-reported) health status being excellent or very good, nor the likelihood of having been hospitalized in the past year. However, we document a strong negative and robust relationship between the real value of SNAP and the number of school days children missed due to illness. For SNAP recipient children, a ten percent increase in SNAP

²⁹ The indicator for obesity is based on BMI calculations, which are affected by some outlying height and weight measurements. We trim the top and bottom of the BMI distribution to exclude the top and bottom percentile. In addition, height and weight information was only collected for children ages 12 and older in years 2008 through 2010. We therefore limit the sample to children ages 12-17.

purchasing power is associated with a decrease in missed school days of just over 1 day (or a 22 percent decrease relative to the mean of approximately 5 days missed).

The evidence in Table 4 indicates that SNAP purchasing power does not significantly impact obesity or the propensity to have emotional problems, although we note that these are longer term health problems that often develop over time and should be less likely to respond contemporaneously to higher area food prices. It is possible that these outcomes would be likely to respond only after a longer, cumulative period of food insecurity, poor nutrition, or reduced health care.

4.4 Summary Index Tests

To address concerns of multiple hypothesis testing, we conduct a collective test of these health care utilization and health outcomes by constructing summary index estimates as in Kling, Liebman, and Katz (2007). We normalize and combine the outcomes into a health care utilization index and a health index, changing signs when necessary so that all positive outcomes mean more health care utilization or better health outcomes. The index for health care utilization includes the variables for checkups, any doctor visits, delay seeking health care, and ER visit. The summary index for health outcomes includes health status, hospitalization, emotional problems, and school days missed.

Results are shown in Table 5. We find that a 10% increase in SNAP purchasing power leads to a statistically significant 0.09 standard deviation increase in health care utilization. We find positive but not significant effects on SNAP children's health; a 10% increase in SNAP purchasing power leads to a statistically insignificant 0.03 standard deviation increase of the health measure.

Broadly, we interpret our results (in Tables 3 and 5) as suggesting that children in households facing lower SNAP purchasing power receive less preventive and ambulatory care. Our findings for health outcomes (Tables 4 and 5) suggest that variation in the real value of SNAP may lead to changes in school attendance but has no overall impact on children's contemporaneous health. A weakness of measuring health using the number of school days missed due to illness is that it may depend on the parent's evaluation of the child's health; however, parent-reported child health status, which is also a subjective measure, does not appear to respond to variation in the real value of SNAP. On the other hand, the number of missed school days is perhaps the only health outcome we analyze that might be expected to respond contemporaneously to reduced nutrition or limited use of preventive/ambulatory health care.

5 Mechanisms and Robustness Checks

5.1 Mechanisms

We outlined three possible mechanisms for effects of SNAP purchasing power on child health care utilization and health including: direct (nutrition) effects, indirect (other goods) effects, and stress/bandwidth effects.

One test for the direct channel is to examine impacts of SNAP purchasing power on food insecurity. Children in families facing higher SNAP purchasing power may be able to consume more (or higher quality) food which may then lead to a reduction in food insecurity. Because the NHIS did not provide information on food security or nutritional intake in the years of data we analyze, we turn to data from the December food security supplement to the CPS to

estimate the impact of SNAP purchasing power on food insecurity among SNAP-recipient children.

We display these results in Table 6.³⁰ We find that a higher real value of SNAP benefits is associated with an improvement in children's food security: A 10 percent increase in SNAP purchasing power reduces the likelihood a child is food insecure by 6.4 percentage points (a 21.8 percent decrease relative to the mean). These results are qualitatively quite similar to those in Gregory and Coleman-Jensen (2013), which used fewer years of the same data and a different estimation strategy. They are also robust to the inclusion of additional controls for local economic conditions like employment and wages (see Appendix Table 4). The result for very low food security (column 2) is not statistically significant; however, we note that very low food security is a rare outcome even for SNAP children (only 4 percent of the children in our sample are very food insecure while almost 30 percent are food insecure). In particular, very low food security implies not only that households are uncertain of obtaining an adequate quantity and quality of food due to money or resources, but that they also restrict or disrupt food intake because of lack of resources. It is perhaps not surprising, then, that this more extreme outcome is not significantly responsive to marginal variation in area food prices.

Overall, these results are suggestive that the direct effect may be part of the mechanism for our findings. In addition, they confirm a well-studied and robust finding that higher SNAP generosity leads to a reduction in food insecurity (see review of the evidence in Hoynes and Schanzenbach 2016). This is important as it provides validation for our research design.

³⁰ The regression specifications include the same set of controls as in Tables 3 and 4 except because we cannot identify counties in the CPS, we do not control for local CPI for nonfood nor the HUD fair market rent data which are measured at the county level.

In Table 7 we investigate whether the impacts of SNAP on health care utilization and health could be explained by a relationship between SNAP purchasing power and health insurance coverage. Such a relationship would be unexpected for this sample, given that SNAP recipient children are all likely to be income-eligible for Medicaid or CHIP. Returning to our sample of NHIS children, we estimate equation (1), where the dependent variable is now an indicator for whether the child is uninsured. Reassuringly, for both children in the Sample Child file and all NHIS children, we find no statistically significant effect of SNAP purchasing power on the likelihood a child has no health insurance. Additionally, Appendix Table 5 shows no relationship between SNAP purchasing power and child participation in other food and nutrition programs.

Two of our most robust findings – that higher SNAP purchasing power leads to reductions in school absences and increases in compliance with well child checkups – are consistent with the stress and bandwidth channel. We are limited in our ability to test more directly for this channel, though the NHIS does include mental health variables for the sample adult. These include questions related to how often the respondent felt sad, worthless, nervous, hopeless, etc. We analyzed these variables for sample adults who were mothers of the children in our sample and found small and statistically insignificant effects though the signs of the coefficients are consistent with protective effects of SNAP purchasing power on these measures of mental health (see Appendix Table 6).

5.2 SNAP Purchasing Power versus Local Prices

A natural check of our main results is to estimate our models for health care utilization and health outcomes on a placebo sample of children that should not be affected by SNAP. We present results for two groups: noncitizen children (who are not eligible for SNAP) and children

living with mothers who have a college education or higher (who have low levels of SNAP participation).³¹ If our main results reflect impacts of SNAP on children’s health, rather than simply impacts of local food prices, we would expect SNAP purchasing power to have no significant impact on these placebo samples.

These results are presented in Table 8. Panel A presents estimates for the college educated sample, and Panel B presents estimates for noncitizen children. SNAP participation rates are low among these samples, at 2 percent for children living with college educated mothers, and 14 percent for non-citizen children.³² Estimated coefficients for our key outcomes (i.e., had check-up, had any doctor’s visit, and number of school days missed) are small and statistically insignificant; in fact only one of the 20 coefficients presented in the table is (marginally) statistically significant (for the presence of an emotional problem in the noncitizen children sample). These findings are also reflected in estimates on the summary indexes (see Appendix Table 7) where we find small and statistically insignificant coefficients for both noncitizen children and children with college educated mothers. Appendix Table 8 shows there is no impact of SNAP purchasing power on child food insecurity in these placebo samples.

Finally, we also explore the sensitivity of our findings to whether we control for non-food regional CPI price controls (such as housing, energy, transportation, et cetera). As shown in Appendix Table 9, our results are robust to the inclusion of these factors, suggesting that we

³¹ An alternative placebo group could be based on family income (since SNAP eligibility requires income below 130 percent of poverty). This is potentially problematic, however, as the NHIS exhibits high levels of income non-response (weighted item nonresponse rates to an exact amount question on annual total family income were around 30 percent during our study period; see Pleis et al., 2007). As with our main sample, this placebo sample is limited to children ages 0 through 17 who are citizens of the U.S.

³² Note that mixed status households are common, consisting of some family members that are citizens and some that are not. SNAP is a household benefit so an ineligible child could live in a household with some eligible family members and thus “participate” in SNAP (that is be in a household with SNAP benefits).

are not simply capturing the broader effects of living in a more or less expensive market.³³

5.3 Robustness Checks

As shown in Appendix Figure 3b, our measure of SNAP purchasing power exhibits a large increase across all geographic areas following the ARRA temporary benefit increase (Appendix Figure 3b). In Appendix Tables 10 and 11 we test the sensitivity of these results to excluding the years of ARRA expansions (2009 and 2010). The relationships are less precisely estimated but are similar in magnitude, indicating a beneficial effect of SNAP purchasing power on healthcare utilization among SNAP children (Appendix Table 10) and health care outcomes (Appendix Table 11).

Table 9 displays the results of a series of additional robustness checks to our main findings regarding the impacts of SNAP purchasing power on health care utilization and health. In panel A, we re-estimate the models including a lead term that uses the $t+1$ market group TFP price. This lead specification provides a test for the validity of our fixed effects design. If we find significant effects of future SNAP purchasing power (while controlling for current purchasing power) we might be concerned that we are capturing the effects of some other trend in the regions. That is, we estimate:

$$(2) \quad y_{irt} = \alpha + \beta_1 \ln\left(\frac{SNAPMAX_t}{TFP_{rt}}\right) + \beta_2 \ln\left(\frac{SNAPMAX_{t+1}}{TFP_{r,t+1}}\right) X_{irt} \theta + Z_{rt} \gamma + \delta_t + \lambda_r + \varepsilon_{irt}$$

Only in one of the ten specifications is the lead of SNAP purchasing power significant. Importantly, our results for the contemporaneous effect of SNAP purchasing power are largely unchanged: The magnitudes of the estimated coefficients for “had checkup” and “school days

³³ In results not shown here, we estimated models where we dropped the non-food regional CPI price controls and the state SNAP and other policy controls, and find very similar results.

missed” are quite similar to those in Tables 3 and 4. One exception is that the estimated impact of current-period SNAP purchasing power on whether a child had any doctor’s visit in the past 12 months is a third as large and is no longer statistically significant.

The second panel of Table 9 contains results from a model that includes a set of market group linear time trends. This approach places serious demands on the data in that identification now must come from departures in market groups’ TFP prices from their trends (assumed to be linear). The main estimates for health care utilization (had checkup, had any doctor’s visit) are qualitatively similar to those in Table 3, but they are smaller in magnitude and no longer statistically significant. The estimated impact of SNAP purchasing power on missed school days, however, remains nearly identical in magnitude and significance to that in Table 4.

Finally, to address concerns that inclusion in our main sample of SNAP recipients may be endogenous to SNAP purchasing power, we estimate the impacts of variation in SNAP purchasing power on health care utilization and health for an alternative high intent-to-treat sample. In particular, we identify a sample of children living with unmarried parent(s) with less than a college education.³⁴ The results (in panel C of Table 9 along with the index models in column 3 of Appendix Table 7) show qualitatively similar findings to our main results. Again, the estimated impacts on the likelihood of a checkup and on the number of missed school days are quite similar in magnitude to those for our main sample (although the p-value on the coefficient for missed school days rises to 0.141). The estimated relationship between SNAP purchasing power and having had *any* doctor’s visit is smaller and no longer statistically

³⁴ Even though this is a high-ITT group, observable characteristics show that it is more advantaged, on average, than the SNAP population.

significant. Interestingly, we document a negative effect of increased SNAP purchasing power on ER utilization for this somewhat higher-income sample: a 10 percent increase in the ratio (SNAPMAX/TFP) reduces the likelihood of an ER visit by 4.8 percentage points.³⁵

6 Discussion and Conclusion

In this paper we provide some of the first direct evidence on how variation in the purchasing power of SNAP benefits affects children's health care utilization and health outcomes. We find evidence consistent with families adjusting to lower SNAP purchasing power by reducing utilization of preventive/ambulatory medical care. In particular, we document that a 10 percent increase in SNAP purchasing power increases the likelihood a child had a check-up in the past year by 8.1 percent and increases the likelihood that children had *any* doctor's visit in the past 12 months by 3.4 percent.

We do not find much evidence that lower SNAP purchasing power causes detrimental impacts on health status, the likelihood of a hospitalization, or other measures of physical (e.g., obesity) and mental health (e.g., child has emotional problems). One exception is that children with reduced SNAP purchasing power miss significantly more days of school due to illness (22 percent more, relative to a baseline mean of 5 missed days, when SNAP purchasing power is reduced by 10 percent). We also find that lower purchasing power of SNAP benefits results in a greater likelihood of food insecurity.

One possible explanation for our finding stronger effects on utilization than on health itself

³⁵ We also tested models with additional family control variables including income, parental health status, and an indicator for insurance coverage. As these may change endogenously with SNAP purchasing power, we omit them from our main specifications. The results are generally similar, however; see Appendix Tables 12 and 13.

is that most of the health measures we consider are more chronic and cumulative in nature (e.g., obesity). However, we also find no evidence of a relationship between SNAP purchasing power and caregiver-reported health status, an outcome which could be less likely to suffer from the same problem. A second possible interpretation of our findings is that while lower SNAP purchasing power causes reduced health care utilization among children and negatively affects food security, neither translates into substantial detrimental impacts on children's health status.

We also note that our measure of variation in the price of food is constructed using 30 market groups that perhaps mask variation in urban and rural customers who are in fact paying different prices, thus masking why certain SNAP recipients are able to buy relatively inexpensive food and stay relatively healthy. In related work, Bronchetti and Christensen (2017) use food prices measured at a much finer geographic level from the National Household Food Acquisition and Purchase Survey (FoodAPS) and demonstrate that whether SNAP benefits are sufficient to buy the TFP depends largely on whether recipients are able to identify and travel to the lowest-cost store in their area. Relating health and other outcomes to SNAP purchasing power using finer geographic variation may be a fruitful research area in the future.

Finally, our results speak to whether adjusting benefit levels to account for geographic variation in food prices across market groups would help improve child health and wellbeing. We conclude that such adjustment would reduce disparities in child healthcare utilization and school absenteeism in low-income households, but may not lead to significant changes in contemporaneous health status.

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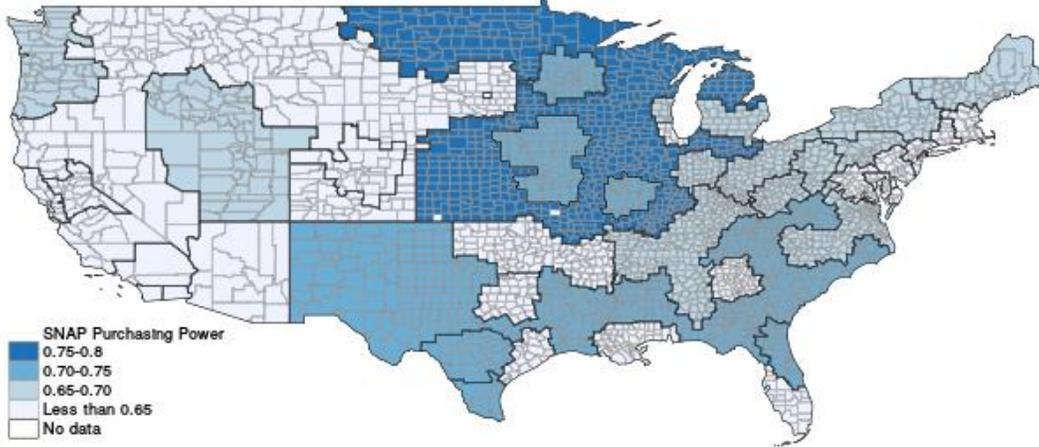
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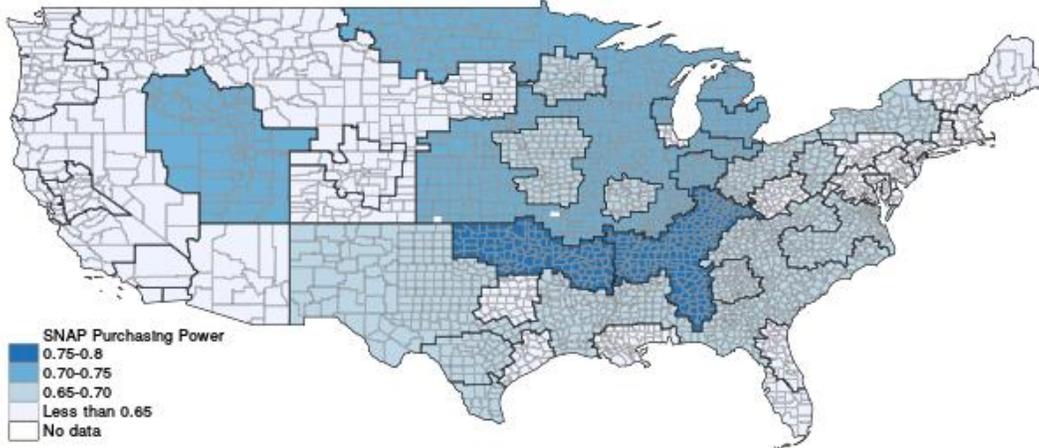
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Figure 1: Purchasing Power of SNAP by Market Group

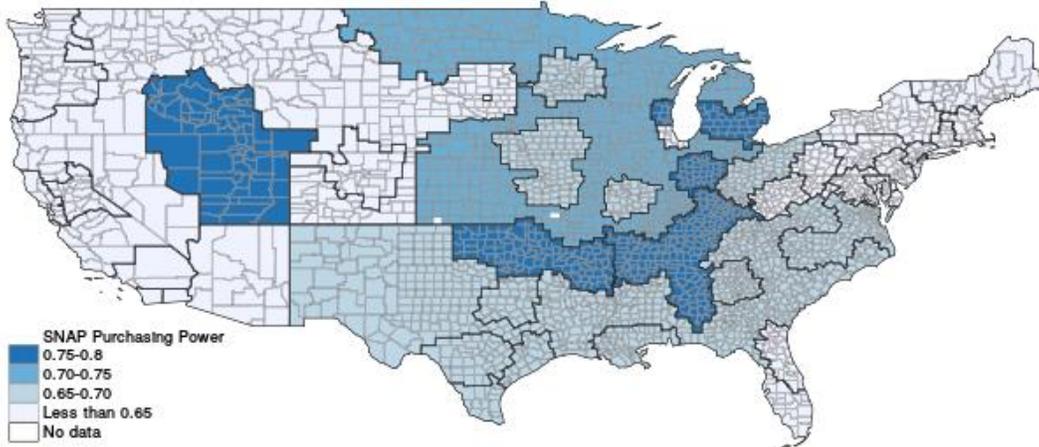
Panel A: 1999



Panel B: 2008



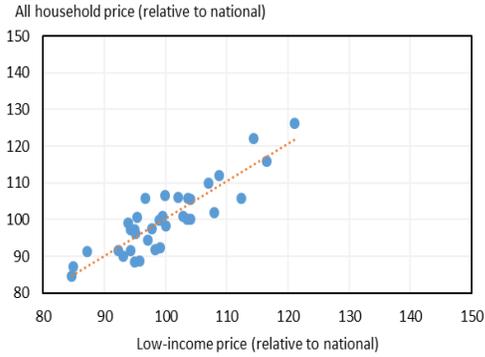
Panel C: 2010



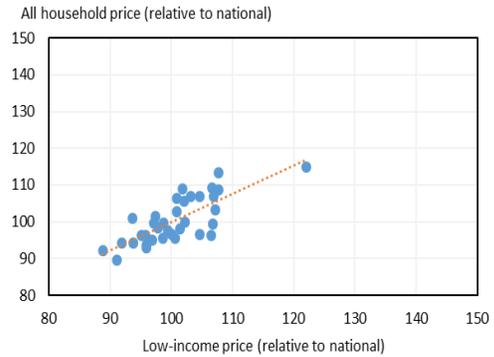
Notes: Maps plot $SNAPMAX/TFP$ for each of the 30 market groups identified consistently in the Quarterly Food at Home Price Database (QFAHPD).

Figure 2: Comparison of Prices Across Market Groups
Full Sample vs. Low-income Sample

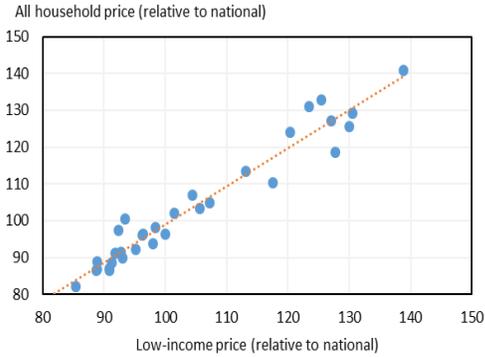
Canned Fruit



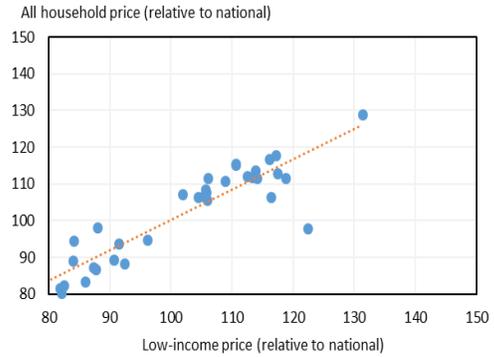
Packaged Whole Grains



Eggs



Low-Fat Milk



Carbonated Beverages

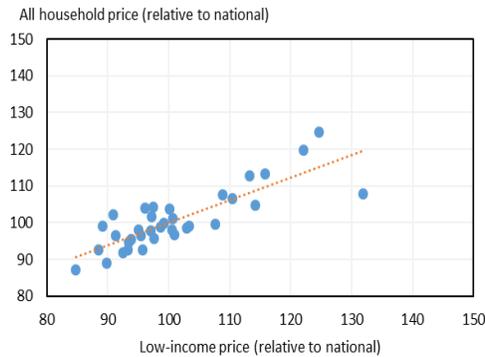


Table 1
Summary Statistics for Children in NHIS

<i>Child/Household Characteristics</i>	SNAP	All	<i>Health Care Utilization</i>	SNAP	All
	Citizen Children	Children		Sample Children	Sample Children
TFP price	203 (14.36)	205 (14.18)	Any check-up (12m)	0.77 (0.42)	0.74 (0.44)
Max SNAP benefit	143 (11.57)	141 (10.17)	Any doctor's visit (12m)	0.90 (0.30)	0.88 (0.32)
Income to poverty ratio	0.90 (0.74)	3.06 (2.24)	Any ER visit (12m)	0.32 (0.47)	0.21 (0.41)
Child's age	7.50 (5.09)	8.5 (5.19)	Delay/forgo care (12m)	0.06 (0.23)	0.05 (0.22)
Child is male	0.51 (0.50)	0.51 (0.50)	<i>Health Outcomes</i>		
Child is black	0.34 (0.47)	0.16 (0.36)	Health status exc. or v. good	0.71 (0.45)	0.70 (0.46)
Child is Hispanic	0.26 (0.44)	0.19 (0.40)	Hospitalized overnight (12m)	0.09 (0.28)	0.08 (0.26)
Mother is present	0.94 (0.24)	0.95 (0.23)	School days missed, illness (12m)	4.96 (9.36)	3.53 (6.43)
Father is present	0.39 (0.49)	0.75 (0.43)	5+ school days missed (12m)	0.33 (0.47)	0.25 (0.43)
Both parents	0.36 (0.48)	0.71 (0.45)	Obese	0.20 (0.40)	0.13 (0.34)
Child receives Medicaid	0.72 (0.45)	0.21 (0.41)	Emotional problem	0.46 (0.76)	0.27 (0.59)
Child has no health insurance	0.07 (0.25)	0.10 (0.30)			
Number of observations	44,627	296,779	Number of observations	18,299	139,268

Notes: Tables contains estimates of means of US citizen children in household receiving SNAP, weighted to account for complex survey design. Standard errors in parentheses. Left panel are children from the person-file dataset (i.e. all children in household, separately for SNAP and all households) while right panel shows only children from sample child file (i.e. one child per household.)

Table 2
Effect of SNAP Purchasing Power on Per-Capita SNAP Caseload

<i>Dependent Variable = SNAP Caseload / County Population</i>	(1)	(2)	(3)	(4)	(5)
log(SNAPMax/TFP _t)	0.091** (0.036)	0.024 (0.089)	0.003 (0.088)	-0.004 (0.079)	0.010 (0.085)
Mean of dep. var.	0.111	0.111	0.111	0.111	0.111
Effect of a 10% increase in SNAP purchasing power	0.009	0.002	0.000	0.000	0.001
As a % of mean of dep. var.	7.8%	2.1%	0.3%	-0.3%	0.9%
N	37,277	37,277	37,277	37,177	37,177
R ²	0.299	0.497	0.514	0.539	0.544
Fixed effect for year, market group	Yes	Yes	Yes	Yes	Yes
County UR	No	Yes	Yes	Yes	Yes
State SNAP and other policy controls	No	No	Yes	Yes	Yes
Regional price controls	No	No	No	Yes	Yes
Linear time trend	No	No	No	No	Yes

Notes: Data consists of county by year panel for 1999-2010. Results are weighted using county population. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include fixed effects for market group and year. Columns (2)-(5) add controls for the county unemployment rate; an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/SCHIP income eligibility limits, and TANF generosity; controls for HUD's fair market rent and regional CPIs for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other goods and services); and a market group-specific linear time trend.

Table 3
Effects of Variation in SNAP Purchasing Power on Children's Health Care Utilization
Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2010

	Children in Sample Child File			All Children
	(1)	(2)	(3)	(4)
	Had a checkup past 12m	Doctor's visit past 12m	Any ER visit past 12m	Delay or forgo care past 12m
log(SNAPMAX/TFP)	0.656*** (0.225)	0.323** (0.147)	-0.178 (0.215)	-0.089 (0.092)
Mean of dep. var.	0.77	0.901	0.315	0.051
Effect of 10% increase in SNAP purchasing power	0.063	0.031	-0.017	-0.009
As a % of mean of dep. var.	8.1%	3.4%	-5.4%	-16.6%
N	18,169	18,108	18,217	44,626
R ²	0.077	0.038	0.046	0.022

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. All regressions also include controls for local economic and policy variables: the county unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, TANF generosity, as well as controls for HUD's fair market rent, and regional CPIs for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other goods and services). Finally, all models include year and market group fixed effects. Outcomes in columns 1-3 are observed only for children in the Sample Child files.

Table 4
Effects of Variation in SNAP Purchasing Power on Children's Health Outcomes
Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2010

	Children in Sample Child File				All NHIS Children 0-17	
	(1)	(2)	(3)	(4)	(5)	(6)
	School days missed due to illness	5 or more school days missed	Obese	Emotional problem	Health status excellent or very good	Hospitalized overnight past 12m
log(SNAPMAX/TFP)	-11.43** (5.374)	-0.148 (0.272)	-0.24 (0.374)	0.055 (0.468)	-0.121 (0.199)	0.020 (0.065)
Mean of dep. var.	4.955	0.332	0.199	0.464	0.700	0.075
Effect of 10% increase in SNAP purch. power	-1.090	-0.014	-0.023	0.005	-0.012	0.002
As a % of mean of dep. var.	-22.0%	-4.2%	-11.5%	1.1%	-1.6%	2.6%
N	11420	11420	4471	10779	44,627	44,620
R ²	0.033	0.041	0.035	0.055	0.032	0.150

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include the same controls as in Table 3. Outcomes in columns 1-4 are observed only for children in the Sample Child files. Missed school days is defined only for children ages 5 and older who attend school; information on obesity is consistently available for children ages 12-17, trimmed to exclude the top and bottom percentile of the BMI distribution; and emotional problem defined for the universe of children ages 4 and older.

Table 5
 Summary Index Estimates
Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2010

	(1)	(2)
	Index for health care utilization	Index for health outcomes
log(SNAPMax/TFP)	0.919*** (0.298)	0.311 (0.354)
Mean of dep. var.	-0.003	0.032
Effect of 10% increase in SNAP purchasing power	0.088	0.030
N	18,023	9,514
R ²	0.043	0.036

Notes: Table features coefficients from mean effects estimates for health care utilization variable (checkups, any doctor visits, delay seeking health care, and any ER visit) or for health outcome variables (school days missed, emotional problem, health status, and any hospitalization). Variables are standard normalized and averaged so coefficient represents standard deviation units. All observations are from the Sample Child file.

Table 6
 Effects of SNAP Purchasing Power on Food Insecurity
Sample: SNAP Recipient U.S. Citizen Children in the December CPS, 2001-2010

	(1) Child is food insecure	(2) Child is very food insecure
log(SNAPMax/TFP _t)	-0.670* (0.330)	0.0856 (0.107)
Mean of dep. var.	0.293	0.041
Effect of 10% increase in SNAP purchasing power	-0.064	-0.008
As a % of mean of dep. var.	-21.8%	-19.5%
N	29,324	29,324
R ²	0.033	0.021

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. All regressions also include controls for local economic and policy variables: the state unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, and TANF generosity. Finally, all models include year and market group fixed effects.

Table 7
 Effects of SNAP Purchasing Power on Health Insurance Coverage
Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2010

	Children in Sample Child File	All NHIS Children 0-17
	(1)	(2)
	No Insurance	No Insurance
log(SNAPMax/TFP _t)	-0.136 (0.146)	-0.071 (0.136)
Mean of dep. var.	0.068	0.067
Effect of 10% increase in SNAP purchasing power	-0.013	-0.007
As a % of mean of dep. var.	-19.0%	-10.1%
N	18,259	44,540
R ²	0.036	0.033

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. All regressions also include controls for local economic and policy variables: the county unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, TANF generosity, as well as controls for HUD's fair market rent, and regional CPIs for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other) goods and services. Finally, all models include year and market group fixed effects.

Table 8
Effects of SNAP Purchasing Power on Health Care Utilization and Health: Robustness Checks
Placebo Samples

	<i>Health Care Utilization</i>				<i>Health</i>					
	Children in Sample Child File		All Children		Children in Sample Child File			All Children		
<i>PANEL A: CHILDREN OF COLLEGE-EDUCATED MOTHERS</i> (SNAP Participation Rate: 2 percent)										
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(5)	(6)
	Had checkup	Doctor's visit	Any ER visit	Delay or forgo care	School days missed	5+ school days missed	Obese	Emotiona problem	Health status exc or v good	Hosp. overnight
log(SNAPMax/TFP _t)	0.201 (0.184)	0.211 (0.131)	-0.162 (0.130)	-0.0162 (0.0370)	-0.565 (1.949)	-0.179 (0.151)	0.0725 (0.123)	0.199 (0.216)	-0.081 (0.082)	-0.033 (0.049)
Mean of dep. var.	0.815	0.935	0.165	0.025	3.022	0.215	0.078	0.203	0.926	0.064
Effect of 10% increase in SNAP PP	0.019	0.020	-0.015	-0.002	-0.054	-0.017	0.007	-0.027	-0.008	-0.003
As a % of mean of dep. var.	2.3%	2.1%	-9.1%	-6.2%	-1.8%	-8.0%	8.8%	-13.1%	-0.8%	-4.7%
N	28,695	28,647	28,779	57,313	19,155	19,155	8,770	17,427	28,886	28,881
R ²	0.079	0.027	0.016	0.014	0.020	0.018	0.047	0.032	0.023	0.214
<i>PANEL B: NONCITIZEN CHILDREN</i> (SNAP Participation Rate: 14 percent)										
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(5)	(6)
	Had checkup	Doctor's visit	Any ER visit	Delay or forgo care	School days missed	5+ school days missed	Obese	Emotiona problem	Health status exc or v good	Hosp. overnight
log(SNAPMax/TFP _t)	0.143 (0.429)	0.204 (0.363)	0.403 (0.281)	0.112 (0.193)	-0.700 (3.567)	-0.245 (0.192)	0.185 (0.236)	-0.630* (0.314)	-0.310 (0.251)	0.0284 (0.064)
Mean of dep. var.	0.516	0.673	0.129	0.088	2.137	0.131	0.116	0.126	0.755	0.020
Effect of 10% increase in SNAP PP	0.014	0.020	0.038	0.011	-0.067	-0.023	0.018	-0.060	-0.030	0.003
As a % of mean of dep. var.	2.7%	3.0%	29.5%	12.5%	-3.1%	-17.6%	15.5%	-47.6%	-4.0%	15.0%
N	5,440	5,421	5,458	12,358	4,809	4,809	2,490	4,163	12,372	12,368
R ²	0.161	0.124	0.034	0.035	0.022	0.028	0.089	0.029	0.077	0.025

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. Insurance coverage not included as control in columns 1 and 5. All regressions also include controls for local economic and policy variables: the county unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, TANF generosity and Medicaid/CHIP income eligibility limits, as well as controls for HUD's fair market rent, and regional CPIs for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other goods and services). Finally, all models include year and market group fixed effects. Health care utilization outcomes, columns 1-3, and health outcomes, columns 1-4 are observed only for children in the Sample Child files. Panel A contains results for children ages 0 through 17 in families with mother who has a college degree. Panel B displays results for children ages 0 through 17 who are not US citizens.

Table 9
Effects of SNAP Purchasing Power on Health Care Utilization and Health: Robustness Checks
Sample: SNAP-Recipient U.S. Citizen Children, 1999-2010

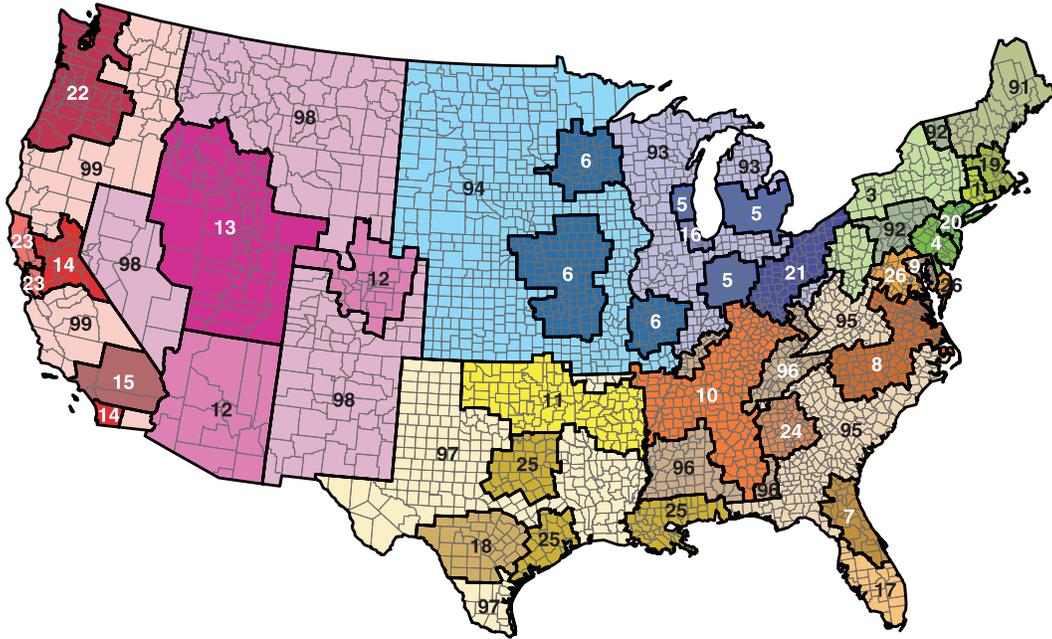
Robustness Check	A. Health Care Utilization				B. Health Outcomes					
	Children in Sample Child File			All Children	Children in Sample Child File				All Children	
	(1) Had checkup	(2) Doctor's visit	(3) Any ER visit	(4) Delay or forgo care	(1) School days missed	(2) 5+ school days missed	(3) Obese	(4) Emotional problem	(5) Health status exc or v good	(6) Hosp. overnight
A. Include lead term using future TFP price										
log(SNAPMax/TFP _t)	0.517*	0.111	0.011	0.040	-13.48**	-0.161	-0.273	0.003	-0.065	0.043
	(0.278)	(0.161)	(0.308)	(0.089)	(5.90)	(0.327)	(0.535)	(0.774)	(0.305)	(0.060)
log(SNAPMax/TFP _{t+1})	0.194	0.260	-0.386	-0.185*	-4.756	-0.303	0.0717	0.266	-0.155	-0.076
	(0.247)	(0.192)	(0.238)	(0.097)	(4.02)	(0.295)	(0.473)	(0.792)	(0.316)	(0.089)
Mean of dep. var.	0.764	0.900	0.312	0.054	4.981	0.333	0.201	0.459	0.697	0.075
Effect of 10% increase in SNAP PP	0.049	0.011	0.001	0.004	-1.284	-0.015	-0.026	0.000	-0.006	0.004
As a % of mean of dep. var.	6.5%	1.2%	0.3%	7.1%	-25.8%	-4.6%	-13.0%	0.1%	-0.9%	5.5%
B. Include market group-level linear time trends										
log(SNAPMax/TFP _t)	0.268	0.148	0.0724	-0.0316	-12.53*	-0.018	-0.351	-0.098	-0.228	0.0775
	(0.272)	(0.196)	(0.315)	(0.116)	(6.82)	(0.289)	(0.433)	(0.671)	(0.248)	(0.064)
Mean of dep. var.	0.770	0.901	0.315	0.051	4.955	0.332	0.199	0.464	0.70	0.07
Effect of 10% increase in SNAP PP	0.026	0.014	0.007	-0.003	-1.194	-0.002	-0.034	-0.009	-0.02	0.01
As a % of mean of dep. var.	3.3%	1.6%	2.2%	-5.9%	-24.1%	-0.5%	-16.8%	-2.0%	-3.1%	9.9%
C. Alternate Sample: Children of Low-Educated, Unmarried Parents										
log(SNAPMax/TFP _t)	0.640**	0.100	-0.505**	0.013	-11.68	-0.011	0.210	-0.305	0.058	-0.047
	(0.255)	(0.161)	(0.184)	(0.086)	(7.93)	(0.194)	(0.344)	(0.427)	(0.195)	(0.053)
Mean of dep. var.	0.726	0.867	0.279	0.057	4.323	0.305	0.181	0.396	0.705	0.062
Effect of 10% increase in SNAP PP	0.061	0.010	-0.048	0.001	-1.113	-0.001	0.020	-0.029	0.006	-0.005
As a % of mean of dep. var.	8.4%	1.1%	-17.3%	2.1%	-25.7%	-0.3%	11.0%	-7.3%	0.8%	-7.2%

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. Insurance coverage not included as control in columns 1 and 5. All regressions also include controls for local economic and policy variables: the county unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, TANF generosity, and Medicaid/CHIP income eligibility limits, as well as controls for HUD's fair market rent, and regional CPIs for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other). Finally, all models include year and market group fixed effects. Outcomes in Panel A, columns 1-3, and outcomes on Panel B, columns 1-4 are observed only for children in the Sample Child files.

Appendix

Appendix Figure 1. Reprinted from Todd et al. (2010). (Government document not subject to copyright.)

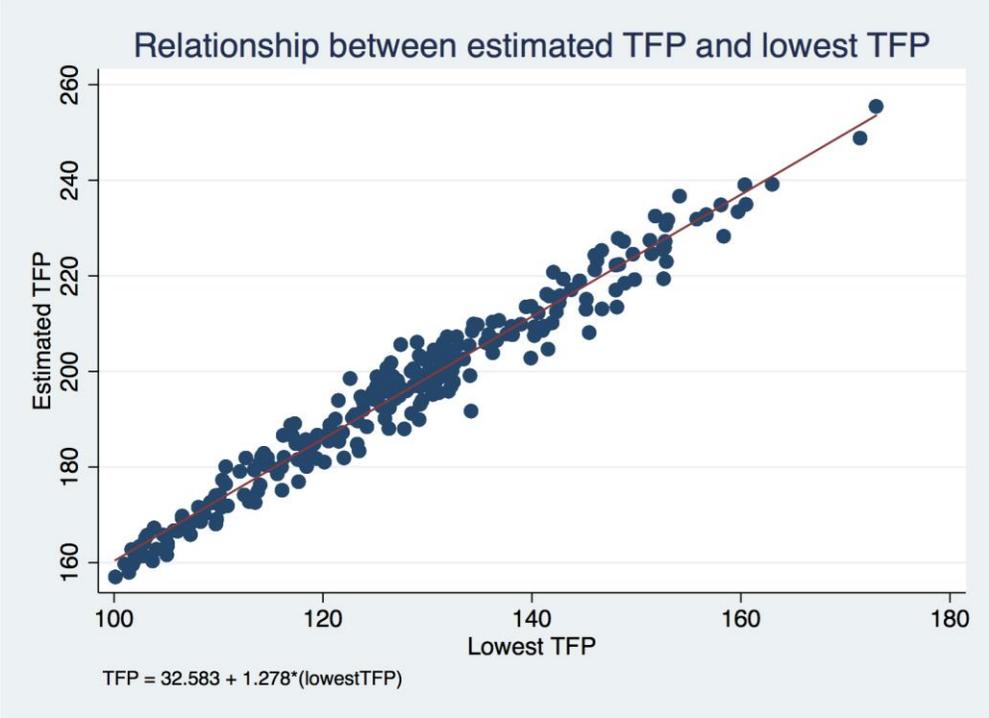
Figure 1
 Quarterly Food-at-Home Price Database Market Groups, 2002-06



Notes: For 1999-2001, markets 91 and 92 are combined as market 81; markets 93 and 94 are combined as market 82; markets 95, 96, and 97 are combined as market 83; and markets 98 and 99 are combined as market 84.

- | | | | |
|----|------------------|----|-----------------------------|
| 1 | Hartford | 19 | Boston |
| 2 | Urban NY | 20 | Other NY |
| 3 | Western NY/PA | 21 | Metro Ohio |
| 4 | Philadelphia | 22 | North Pacific |
| 5 | Metro Midwest 1 | 23 | San Francisco |
| 6 | Metro Midwest 2 | 24 | Atlanta |
| 7 | North Florida | 25 | Metro South 4 |
| 8 | Metro South 1 | 26 | Washington, DC |
| 9 | Baltimore | 91 | Nonmetro New England |
| 10 | Metro South 2 | 92 | Nonmetro Middle Atlantic |
| 11 | Metro South 3 | 93 | Nonmetro East North Central |
| 12 | Metro Mountain | 94 | Nonmetro West North Central |
| 13 | Salt Lake City | 95 | Nonmetro South Atlantic |
| 14 | Metro California | 96 | Nonmetro East South Central |
| 15 | Los Angeles | 97 | Nonmetro West South Central |
| 16 | Chicago | 98 | Nonmetro Mountain |
| 17 | South Florida | 99 | Nonmetro Pacific |
| 18 | San Antonio | | |

Appendix Figure 2: Comparison of Main TFP Measure to Lowest-Cost Category Measure

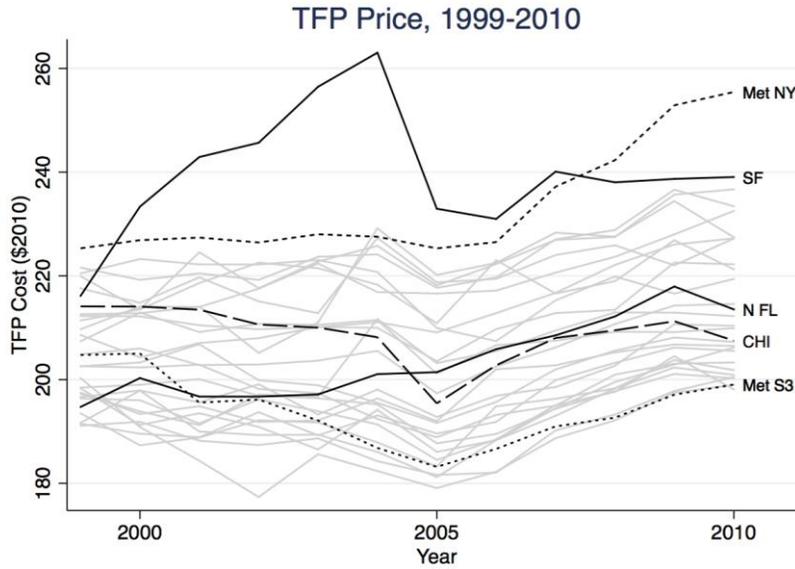


Notes: Authors' tabulations of QFAHPD. This plots the estimated TFP used in our study (y axis) against the TFP price one would obtain from only purchasing food in the lowest cost QFAHPD categories within each TFP category (x axis).

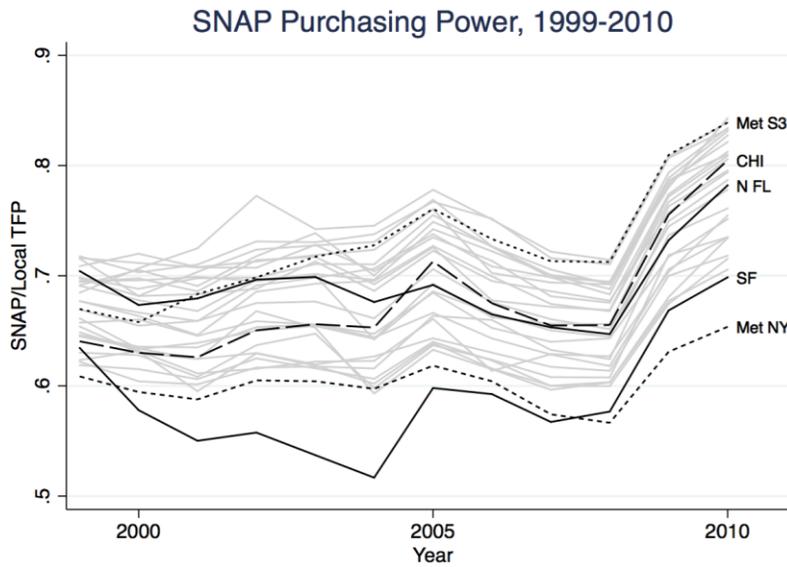
Appendix Figure 3

Variation across Market Group Areas, 1999-2010

(a) Real TFP Cost 1999-2010

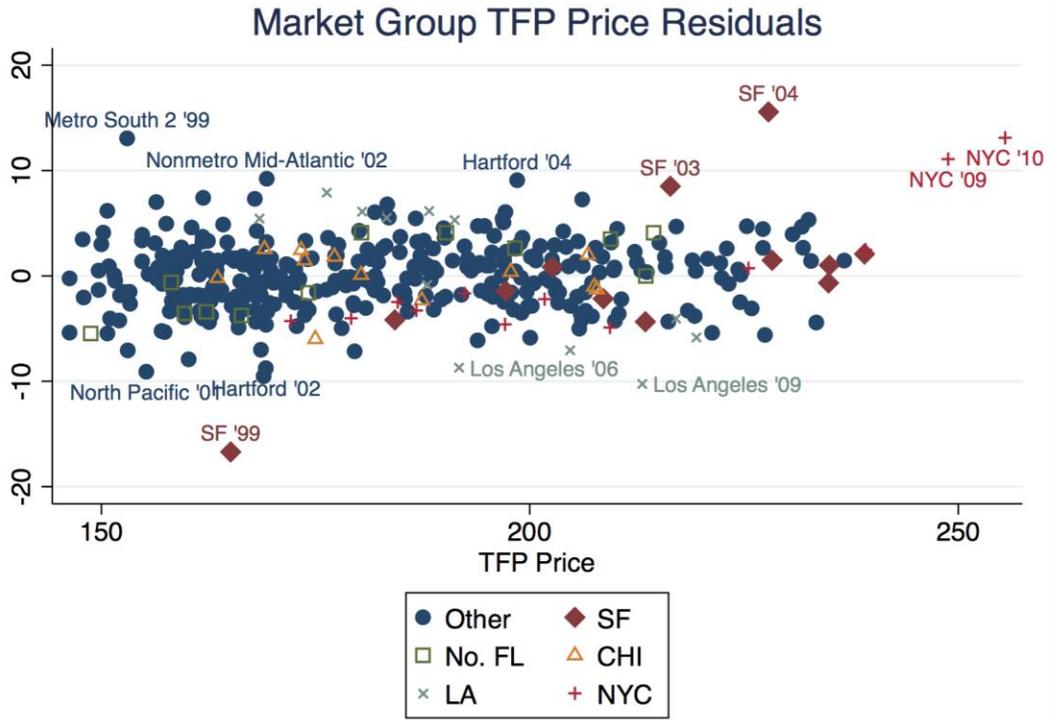


(b) SNAP Purchasing Power



Notes: Figure shows (a) the TFP in constant 2010 dollars and (b) the ratio of maximum SNAP benefits to market group TFP. Highlighted regions are those with the largest increase over the period (North Florida, New York, San Francisco) and the largest decrease (Chicago, Metro South: Little Rock, Metro Oklahoma).

Appendix Figure 4



Notes: Figure shows residuals from regression of market group TFP price on other price measures and including market group and year fixed effects.

Appendix Table 1
Relationship between Food (TFP) Price and Other Prices

VARIABLES	(1) TFP Price	(2) TFP Price	(3) TFP Price
CPI Apparel	0.235*** (0.08)	0.079 (0.08)	0.107 (0.08)
CPI Commodities	0.026 (0.20)	0.968*** (0.31)	0.904*** (0.31)
CPI Education	1.963*** (0.11)	-0.055 (0.14)	-0.075 (0.14)
CPI Housing	2.032*** (0.15)	0.687** (0.28)	0.562* (0.30)
CPI Medical	-0.046 (0.06)	-0.031 (0.05)	-0.026 (0.05)
CPI Other G&S	0.286*** (0.04)	0.053 (0.05)	0.061 (0.05)
CPI Recreation	0.418*** (0.13)	0.059 (0.11)	0.090 (0.11)
CPI Services	-2.205*** (0.22)	-0.526 (0.35)	-0.496 (0.36)
CPI Transportation	0.406*** (0.11)	-0.641*** (0.20)	-0.603*** (0.20)
State Unemployment			-0.490 (0.36)
Fair Market Rent			0.012** (0.00)
Observations	393	393	393
R ²	0.822	0.974	0.974
Marketgroup FE	No	Yes	Yes
Year FE	No	Yes	Yes

Notes: Table shows regression of main price level measure (TFP by marketgroup and year) on other price controls and fixed effects. Standard errors in brackets; *** p<0.01, ** p<0.05, * p<0.1.

Appendix Table 2
 Effect of SNAP Purchasing Power on SNAP Participation, County-Level Analysis
 Including additional controls for local economic conditions

<i>Dependent Variable = SNAP Caseload / County Population</i>	Table 2 (Col 1)	Table 2 (Col 2)	Robustness to adding controls from QCEW	
log(SNAPMax/TFP _t)	0.091** (0.036)	0.024 (0.089)	0.008 (0.078)	-0.030 (0.086)
Observations	37,277	37,277	37,177	37,177
R ²	0.299	0.497	0.54	0.542
Mean	0.111	0.111	0.111	0.111
Effect of a 10% increase in SNAP purchasing power	0.9%	0.2%	0.1%	-0.3%
As a % of mean of dep. var.	7.8%	2.1%	0.6%	-2.6%
Fixed effect for year, market group	Yes	Yes	Yes	Yes
County UR	No	Yes	Yes	Yes
Aggregate employment and wages (QCEW)	No	No	Yes	No
Sector employment and wages (QCEW)	No	No	No	Yes
State SNAP and other policy controls	No	No	No	No
Regional price controls	No	No	No	No
Linear time trend	No	No	No	No

Notes: Data consists of county by year panel for 1999-2010. Results are weighted using county population. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include fixed effects for market group and year. Columns (2) adds a control for the county unemployment rate; Column (3) includes controls for aggregate employment and wage, while Column (4) instead adds controls for sector-specific employment and wages.

Appendix Table 3
 Effect of SNAP Purchasing Power on SNAP Participation Among Children in the NHIS
 (Sample: Children Ages 0-17 in the Sample Child Files of the NHIS, 1999-2010)

<i>Dependent Variable = Child Received SNAP (Past 12 Mos.)</i>	(1)	(2)	(3)	(4)	(5)
log(SNAPMax/TFP _t)	-0.027 (0.117)	-0.127 (0.140)	-0.104 (0.062)	-0.098 (0.060)	-0.088 (0.061)
Observations	139,227	139,143	134,736	134,140	134,140
R ²	0.025	0.036	0.231	0.232	0.233
Mean	0.150	0.150	0.148	0.148	0.148
Effect of a 10% increase in SNAP purchasing power	-0.003 -1.7%	-0.012 -8.1%	-0.010 -6.7%	-0.009 -6.3%	-0.008 -5.7%
Fixed effect for year, market group	Yes	Yes	Yes	Yes	Yes
County UR	No	Yes	Yes	Yes	Yes
State SNAP and other policy controls	No	No	Yes	Yes	Yes
Regional price controls	No	No	No	Yes	Yes
Linear time trend	No	No	No	No	Yes

Notes: Individual-level data on all children included in the NHIS Sample Child files, 1999-2010. Results are from weighted OLS regression; Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include fixed effects for market group and year. Column (2) adds a control for the unemployment rate in the child's county. Column (3) adds controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/SCHIP income eligibility limits, and TANF generosity. Column (4) also includes controls for HUD's fair market rent, and regional CPIs for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other goods and services). Column (5) adds a market group-specific linear time trend.

Appendix Table 4
 Effects of SNAP Purchasing Power on Food Insecurity
Including additional controls for local economic conditions
 Sample: SNAP Recipient U.S. Citizen Children in the December CPS, 2001-2010

	(1)	(2)	(3)	(4)
	Child is food insecure	Child is food insecure	Child is very food insecure	Child is very food insecure
log(SNAPMax/TFP _t)	-0.704** [0.317]	-0.542 [0.421]	0.0921 [0.111]	0.0410 [0.160]
Mean of dep. var.	0.301	0.301	0.0339	0.0339
Effect of 10% increase in SNAP purchasing power	-0.064	-0.067	-0.009	-0.004
As a % of mean of dep. var.	-21.3%	-22.3%	-26.5%	-11.8%
N	29,324	29,324	29,324	29,324
R ²	0.033	0.036	0.021	0.022
Employment and wage controls (QCEW)	Aggregate	Sector	Aggregate	Sector

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. All regressions also include controls for local economic and policy variables: the state unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, and TANF generosity. Finally, all models include year and market group fixed effects.

Appendix Table 5
 Effects of SNAP Purchasing Power on Other Program Participation
 Sample: SNAP Recipient U.S. Citizen Children in the December CPS, 2001-2010

	(1) [Ages 0-5] WIC	(2) [Ages 5-17] School Breakfast	(3) [Ages 5-17] School Lunch
log(SNAPMax/TFP _i)	0.199 (0.493)	0.295 (0.566)	0.360 (0.332)
Mean of dep. var.	0.597	0.719	0.878
Effect of 10% increase in SNAP purchasing power	0.019	0.028	0.034
As a % of mean of dep. var.	3.2%	3.9%	3.9%
N	9,713	19,171	19,244
R ²	0.096	0.082	0.058

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. All regressions also include controls for local economic and policy variables: the state unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, and TANF generosity. Finally, all models include year and market group fixed effects.

Appendix Table 6
 Effects of SNAP Purchasing Power on Mothers' Mental Health
Sample: Mothers of SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2010

	(1) Feel Sad	(2) Feel Worthless	(3) Feel Nervous	(4) Feel Restless	(5) Feel Hopeless	(6) Feel Everything Is an Effort	(7) K6 Index
log(SNAPMax/TFP _{<i>t</i>})	-0.048 (0.109)	-0.053 (0.0604)	-0.073 (0.129)	0.037 (0.140)	-0.062 (0.131)	-0.007 (0.144)	-0.811 (2.798)
Mean of dep. var.	0.077	0.046	0.101	0.124	0.059	0.134	4.169
Effect of 10% increase in SNAP purchasing power	-0.005	-0.005	-0.007	0.004	-0.006	-0.001	-0.077
As a % of mean of dep. var.	-6.5%	-11.0%	-6.9%	2.8%	-10.0%	-0.4%	-1.9%
N	16,448	16,430	16,450	16,443	16,440	16,418	16,381
R ²	0.029	0.024	0.040	0.036	0.026	0.031	0.074

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. Sample is mothers of U.S. Citizen Children in households who receive SNAP, from the Sample Adult files. Dependent variables in columns (1)-(6) are indicators for the mother reporting that they feel this way either some, most, or all of the time during the past 30 days (and is 0 if they feel this way a little or not at all); dependent variable in column (7) is the K6 index, which is a weighted sum of the responses to the questions used for columns (1) through (6); see Kessler (2003). All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. All regressions also include controls for local economic and policy variables: the state unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, and TANF generosity. Finally, all models include year and market group fixed effects.

Appendix Table 7
 Summary Index Estimates, Placebo and Alternative Treatment Groups

A. Health Care Utilization			
	(1)	(2)	(3)
	Placebo Samples		
SAMPLE	Children of College Educated Mothers	Noncitizen Children	Citizen Low-Education Unmarried
log(SNAPMax/TFPYRM)	0.213 (0.271)	-0.189 (0.442)	0.793*** (0.264)
Mean of dep. var.	-0.008	0.013	-0.002
Effect of 10% increase in SNAP purchasing power	0.020	-0.018	0.076
N	28,538	5,402	17,651
R ²	0.05	0.13	0.05
B. Health Outcomes			
	(1)	(2)	(3)
	Placebo Samples		
SAMPLE	Children of College Educated Mothers	Noncitizen Children	Citizen Low-Education Unmarried
log(SNAPMax/TFPYRM)	-0.016 (0.207)	-0.027 (0.436)	0.650 (0.457)
Mean of dep. var.	-0.047	0.020	0.033
Effect of 10% increase in SNAP purchasing power	-0.001	-0.003	0.062
N	15,863	3,941	9,869
R ²	0.03	0.05	0.03
Mean SNAP participation rate	0.02	0.14	0.41

Notes: Table features coefficients from mean effects estimates for health care utilization variable (checkups, any doctor visits, delay seeking health care, and any ER visit) or for health outcome variables (school days missed, emotional problem, health status, and any hospitalization). Variables are standard normalized and averaged, so coefficient represents standard deviation units. All observations are from the Sample Child file. The sample varies by column.

Appendix Table 8
Effects of SNAP Purchasing Power on Food Insecurity
Placebo Samples

	<u>Placebo Samples</u>	
	<u>Children of College Educated Mothers</u>	<u>Non-citizen Children</u>
log(SNAPMax/TFP _{<i>t</i>})	0.049 (0.058)	-0.168 (0.317)
Mean of dep. var.	0.028	0.177
Effect of 10% increase in SNAP PP	0.005	-0.016
As a % of mean of dep. var.	16.8%	-9.0%
N	62,164	8,415
R ²	0.051	0.093

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. All regressions also include controls for local economic and policy variables: the state unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, and TANF generosity. Panel A displays results for the sample of citizen children with family income between 300 and 450 percent of the federal poverty line, and Panel B shows results for the sample of non-citizen children. Finally, all models include year and market group fixed effects.

Appendix Table 9
 Effects of Variation in SNAP Purchasing Power on Children's Health Care Utilization and Health, without CPI Controls
 Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2010

	<i>Health Care Utilization</i>				<i>Health</i>				
	Children in Sample Child File			All Children	Children in Sample Child File			All Children	
	(1) Had checkup	(2) Doctor's visit	(3) Any ER visit	(4) Delay or forgo care	(1) School days missed	(2) Obese	(3) Emotional problem	(5) Health status exc or v good	(6) Hosp. overnight
log(SNAPMax/TFP _{<i>i</i>})	0.616** (0.224)	0.284* (0.148)	-0.221 (0.209)	-0.071 (0.087)	-12.91** (5.362)	-0.329 (0.346)	-0.007 (0.449)	-0.127 (0.197)	0.024 (0.062)
Mean of dep. var.	0.770	0.901	0.315	0.051	4.956	0.199	0.463	0.700	0.075
Effect of 10% increase in SNAP PP	0.059	0.027	-0.021	-0.007	-1.230	-0.031	-0.001	-0.012	0.002
As a % of mean of dep. var.	7.6%	3.0%	-6.7%	-13.2%	-24.8%	-15.7%	-0.1%	-1.7%	3.1%
N	18,211	18,150	18,259	44,724	11,438	4,478	10,785	44,725	44,718
R ²	0.076	0.036	0.045	0.021	0.032	0.033	0.054	0.031	0.149

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. Regressions include controls for local economic and policy variables: the county unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, TANF generosity, but do not include controls for HUD's fair market rent, and regional CPIs for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other goods and services). Finally, all models include year and market group fixed effects. Outcomes in columns 1-3 are observed only for children in the Sample Child files.

Appendix Table 10
 Effects of Variation in SNAP Purchasing Power on Children's Health Care Utilization
Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2008

	Children in Sample Child File			All Children
	(1) Had a checkup past 12m	(2) Doctor's visit past 12m	(3) Any ER visit past 12m	(4) Delay or forgo care past 12m
log(SNAPMAX/TFP)	0.396* (0.215)	0.268 (0.165)	-0.211 (0.256)	-0.089 (0.111)
Mean of dep. var.	0.756	0.897	0.314	0.055
Effect of 10% increase in SNAP purchasing power	0.038	0.026	-0.020	-0.009
As a % of mean of dep. var.	5.0%	2.8%	-6.4%	-15.5%
N	13,929	13,880	14,034	34,348
R ²	0.085	0.040	0.050	0.026

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include controls for the child's age (and its square), whether the child is black or Hispanic, the child's family size, indicators for the presence of the mother (and/or father) in the household, and interactions between indicators for the mother's (father's) presence and the mother's (father's) education, marital status, age, and citizenship. All regressions also include controls for local economic and policy variables: the county unemployment rate, an index of state SNAP policies (Ganong and Liebman, 2015), the state minimum wage, EITC, and Medicaid/CHIP income eligibility limits, TANF generosity, as well as controls for HUD's fair market rent, and regional CPIs for non-food, non-housing categories (apparel, commodities, education, medical, recreation, services, transportation and other goods and services). Finally, all models include year and market group fixed effects. Outcomes in columns 1-3 are observed only for children in the Sample Child files.

Appendix Table 11
 Effects of Variation in SNAP Purchasing Power on Children's Health Outcomes
 Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2008

	Children in Sample Child File				All NHIS Children 0-17	
	(1)	(2)	(3)	(4)	(5)	(6)
	School days missed due to illness	5 or more school days missed	Obese	Emotional problem	Health status excellent or very good	Hospitalized overnight past 12m
log(SNAPMAX/TFP)	-10.46* (5.954)	-0.363 (0.310)	-0.121 (0.494)	0.421 (0.603)	-0.310 (0.250)	-0.0928 (0.121)
Mean of dep. var.	5.004	0.335	0.202	0.463	0.696	0.075
Effect of 10% increase in SNAP purch power	-0.996	-0.035	-0.012	0.040	-0.030	-0.009
As a % of mean of dep. var.	-19.9%	-10.3%	-5.7%	8.7%	-4.3%	-11.8%
N	8,721	8,721	3,370	7,778	14,036	14,029
R ²	0.039	0.044	0.041	0.055	0.034	0.162

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include the same controls as in Table 3. Outcomes in columns 1-4 are observed only for children in the Sample Child files. Missed school days is defined only for children ages 5 and older who attend school; information on obesity is consistently available for children ages 12-17, trimmed to exclude the top and bottom percentile of the BMI distribution; and emotional problem defined for the universe of children ages 4 and older.

Appendix Table 12
 Effects of Variation in SNAP Purchasing Power on Children's Health Care Utilization
Adding controls for income, parental insurance and health status
 Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2010

	Children in Sample Child File			All Children
	(1)	(2)	(3)	(4)
	Had a checkup past 12m	Doctor's visit past 12m	Any ER visit past 12m	Delay or forgo care past 12m
log(SNAPMAX/TFP)	0.648*** (0.223)	0.301** (0.146)	-0.230 (0.207)	-0.084 (0.085)
Mean of dep. var.	0.770	0.901	0.315	0.051
Effect of 10% increase in SNAP purchasing power	0.062	0.029	-0.022	-0.008
As a % of mean of dep. var.	8.1%	3.2%	-7.0%	-15.7%
N	18,126	18,065	18,171	44,504
R ²	0.087	0.052	0.063	0.097

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include the same controls as in Table 3 of paper but also add controls for family income, whether child has health insurance coverage, and child's health status (1-5). Finally, all models include year and market group fixed effects. Outcomes in columns 1, 2, and 4 are observed only for children in the Sample Child files.

Appendix Table 13
 Effects of Variation in SNAP Purchasing Power on Children's Health Outcomes
Adding controls for income, parental insurance and health status
 Sample: SNAP Recipient U.S. Citizen Children in the NHIS, 1999-2010

					All NHIS Children 0-17	
	(1)	(2)	(3)	(4)	(5)	(6)
	School days missed due to illness	5 or more school days missed	Obese	Emotional problem	Health status excellent or very good	Hospitalized overnight past 12m
log(SNAPMAX/TFP)	-12.16** (5.57)	-0.179 (0.257)	-0.338 (0.380)	-0.008 (0.436)	-0.140 (0.196)	0.021 (0.065)
Mean of dep. var.	4.96	0.332	0.199	0.463	0.700	0.075
Effect of 10% increase in SNAP purch power	-1.16	-0.017	-0.032	-0.001	-0.013	0.002
As a % of mean of dep. var.	-23.4%	-5.1%	-16.1%	-0.2%	-1.9%	2.7%
N	11420	11420	4471	10779	44,627	44,620
R2	0.033	0.041	0.035	0.055	0.034	0.150

Notes: Results from weighted OLS regressions. Standard errors in parentheses are corrected for clustering at the market group level; *** p<0.01, ** p<0.05, * p<0.1. All regressions include the same controls as in Table 4 of paper but also add controls for family income, whether child has health insurance coverage, and child's health status (1-5) when health status is not the outcome of interest. Outcomes in columns (3)-(6) are observed only for children in the Sample Child files.. Outcomes in columns (3)-(6) are observed only for children in the Sample Child files. Missed school days is defined only for children ages 5 and older who attend school; information on obesity is consistently available for children ages 12-17, trimmed to exclude the top and bottom percentile of the BMI distribution; and emotional problem defined for the universe of children ages 4 and older.