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Policy Studies

Offsetting the Effects of Medical Expenses on Older Adults' Household Food Budgets: An Analysis of the Standard Medical Expense Deduction

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Abstract

The Supplemental Nutrition Assistance Program (SNAP) provides critical nutrition assistance to over 40 million Americans each month. Low-income older adults (60 and older) and disabled participants experience additional budgetary constraints because of high out-of-pocket medical expenses. In recent years, some states have adopted a "Standard Medical Expense Deduction" (SMED) for senior and disabled beneficiaries, making it easier to report medical expenses in the SNAP application process. We conduct a descriptive national analysis that shows increases in benefit levels and reporting of medical expenses for states that have implemented SMED. We then present descriptive findings from Medicare claims data among a sample of low-income older adults in need of food assistance in Georgia. Average medical expenses among this sample approach $200 per month, whereas those for persons diagnosed with multiple chronic conditions exceed $300 per month. Policy implications of this analysis include the need for more states to consider adoption of SMED or alternative estimating approaches, leading to increases in benefit levels for the neediest beneficiaries and decreases in administrative burden among state agencies. We present two possible policy approaches states might take to receive approval for these changes from U.S. Department of Agriculture.

Keywords: Nutrition and feeding issues, Poverty, Public policy, Social services

The Supplemental Nutrition Assistance Program (SNAP), the nation's largest antihunger program, provides food assistance to over 40 million low-income Americans each month (United States Department of Agriculture, 2015). SNAP benefits are intended to fill the gap between what households can afford to spend on food and the cost of food using the "Thrifty Food Plan" (Carlson, Lino, Juan, Hanson, & Basiotis, 2007) (the "Thrifty Food Plan" is used as a guide for the basis of maximum food stamp allocation, representing what the U.S. Department of Agriculture [USDA] says is "a representative healthful and minimal cost meal plan that shows how a nutritious diet may be achieved with limited resources"). Thus, benefits are inversely related to households' incomes. Older adults and disabled individuals often have higher medical expenditures than the general population, which reduces the funds they have available for food (Bhargava, Lee, Jain, Johnson, & Brown, 2012; Lee, 2013). Accordingly, SNAP allows them to deduct out-of-pocket medical expenses that exceed $35 from their reported income (United States Department of Agriculture, 2012; U.S. Regulation 7 CFR § 273.9(d)(3)(i-x)). Reporting medical expenses can make a significant

difference in the SNAP benefit amount an eligible senior or disabled person receives.

Among SNAP participants, older adults (the USDA defines a "senior" as an adult aged 60 years and older) and disabled individuals have historically had much lower rates of participation relative to the average eligible individual (United States Department of Agriculture, 2002). Although this low participation rate has several causes, the relatively low benefits many would receive is an important factor in reducing the incentive to apply (Gabor, Williams, Bellamy, & Hardison, 2002). Even among those who do receive SNAP, many receive less than they could under program rules because they fail to claim the medical deduction (Jones, 2014). In order for an individual to receive the medical expense deduction, states commonly require them to provide proof of their out-of-pocket expenditures. This introduces another barrier, or additional transaction cost, for new applicants and for recipients seeking recertification of their eligibility (Super, 2004). A barrier such as this may be especially cumbersome or inconvenient for a senior or disabled person that is homebound or has limited access to transportation. Traditionally, the burden of proof has been on the client to demonstrate each dollar of out-of-pocket expenditures. In turn, state agencies must spend administrative hours confirming these expenses, which can be costly.

In recent years, the USDA has allowed states to adopt a "Standard" Medical Expense Deduction (SMED), which allows senior and disabled SNAP beneficiaries to claim the deduction by verifying that they have at least $35 in monthly out-of-pocket medical expenses. This policy option allows states to choose a specified amount, which serves as SMED. Instead of having to verify every single expense, senior and disabled individuals must prove they have at least $35 in out-of-pocket medical expenses. For example, a state with $185 SMED would provide this deduction for an individual with $160 in medical expenses as long as they can prove that they spend $35 per month.

In order for a state to implement SMED, it must first receive a waiver from the USDA of the usual program rules. USDA will not grant such waivers unless the state meets its criteria for "cost neutrality." Cost neutrality means the state must demonstrate that there will not be an increase in the cost of total SNAP benefits allocated in that state if SMED is adopted. An alternative approach that the Food and Nutrition Act provides is to estimate senior and disabled persons' medical costs based on the costs that are typical for those with their diagnoses. This "estimate" approach does not require a waiver or any benefit reductions and targets the additional SNAP benefits on those most in need because the allowed medical deduction is based on the average out-of-pocket medical expenses incurred for specific diagnoses (e.g., diabetes, cancer, or heart disease).

Congress authorized the estimate approach in the 1990 Farm Bill. The "estimate" approach has not yet been used but has important advantages over cost neutrality waivers. Although USDA does not object to increasing participation among those already eligible under federal rules, it does require states to offset any benefit increases resulting from a SMED waiver. Because households with actual expenses higher than the standard are allowed to claim them, senior and disabled recipients using the standard are likely to be receiving just such a benefit increase. To further explain, using the estimate approach rather than the more common cost neutrality approach would not require states to offset costs of SMED by exhibiting cost neutrality to receive the waiver.

To date, 18 states have adopted the standard medical expense deduction. Most states made the policy change in 2008 or later. States have the autonomy to decide for themselves the amount of their standard medical expense deduction. Thus, there is wide variation in SMED amounts, ranging from $75 to $207. States do not have to base this deduction amount on what the average patient or beneficiary spends, and can choose the number solely as a function of meeting cost neutrality (Jones, 2014; Figure 1).

All the 18 states that have been approved to use SMED have achieved cost neutrality by making small across-the-board cuts in other aspects of the SNAP benefit calculation formula. Thus far, states have chosen to decrease their Standard Utility Allowance to achieve cost neutrality, giving participating households less credit for the impact of utility costs on their ability to purchase food (personal email correspondence with state SNAP directors, March 23, 2015). These offsets, although small, may have the effect of shifting benefits away from even poorer households. Although 18 states to date have adopted SMED, no state yet knows how to best develop, implement, and evaluate the Standard Medical Expense Deduction. In August of 2014, the Center for Budget and Policy Priorities published a report highlighting the use of SMED and the potential that this particular policy option has for directly impacting senior and disabled SNAP beneficiaries. Among states that have implemented the deduction, it was found that benefit amounts among senior and disabled individuals using the deduction increased between $7 and $53. Other than this report, there has been no research on the use of SMED and the potential effects on benefit receipt or program enrollment. This study provides an overview of SMED and medical deduction estimate policy options for state SNAP programs and takes a systematic approach in explaining the options available for states that are considering adoption of SMED. This study explores the association between the adoption of the deduction and client outcomes and how data on actual medical expenditures among the target population might be used to create an evidence-based approach to deciding on the appropriate dollar amount for the medical deduction. This study's approach is to use a combination of national and state-specific data to examine the effect SMED has had in states adopting the deduction and then to study levels of need and health status as reflected in actual health expenditures among the target population. In particular, we used health claims data to forecast need in the state of Georgia as an example of constructing an evidence-based deduction

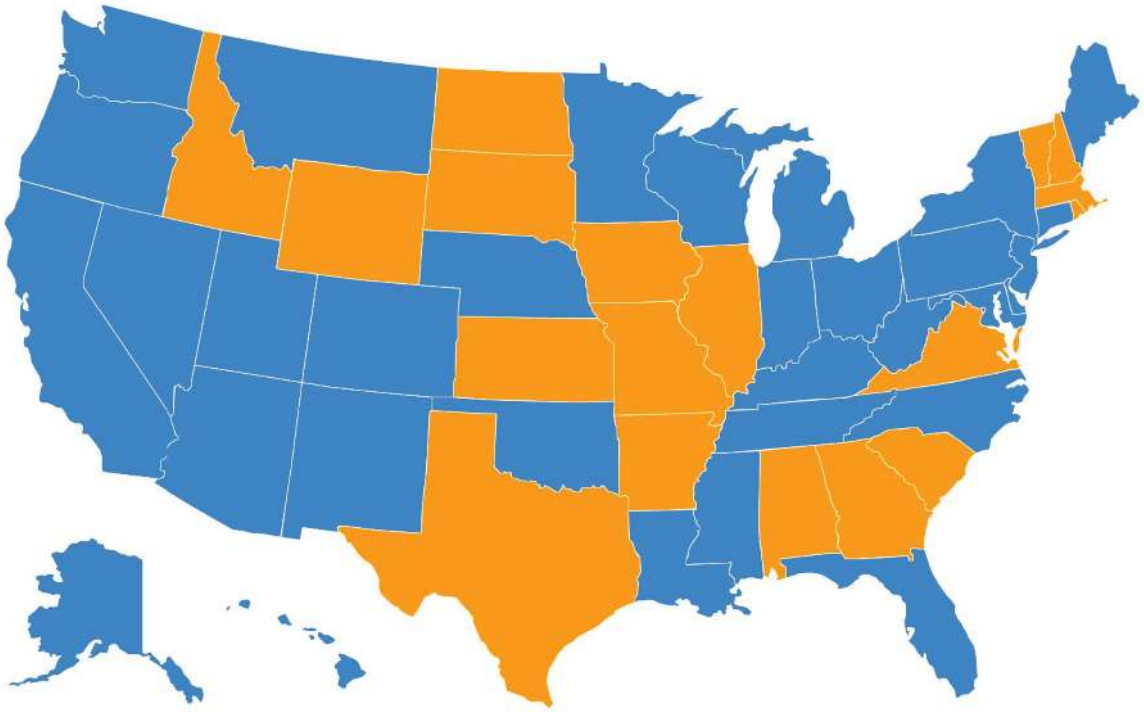

Figure 1. Map of Standard Medical Expense Deduction Implementation, 2015 (United States Department of Agriculture, 2013). Implementation map as of October 2015. Lighter states indicate the presence of a Standard Medical Expense Deduction; darker states indicate that the state does not have the standard deduction. Eighteen states have adopted the deduction, including Georgia and South Carolina, which were both approved in 2015. Data are from the U.S. Department of Agriculture State Policy Options Report.

for senior and disabled SNAP participants because using health status and actual health expenditure data (rather than reported expenditures) could be an important policy tool in understanding the food assistance needs of this population, in deciding the appropriate amount for a SMED, and in making defensible estimates of the medical costs of recipients with various common conditions.

Study Data, Methods, and Limitations

Data

For the purposes of these analyses, we used two separate data sets. We used national Supplemental Nutrition Assistance Program Quality Control (SNAP-QC) data to first examine the effect of SMED implementation on client outcomes including benefit amount received, likelihood of reporting medical expenditures, and total expenditures reported (Supplemental Nutrition Assistance Program Quality Control Data, 2005–2012). Second, we used Medicare claims data of low-income older Georgia residents in need of food assistance to examine the actual medical expenditures of SNAP participants and program eligible nonparticipants, specifically focusing on their expenditures and health status (Lee, Johnson, Brown, & Nord, 2011).

National-level analyses were done using the data from the SNAP-QC Database and compared outcomes for senior beneficiaries in states with and without SMED. The USDA defines a "senior" SNAP beneficiary as one who is 60 years of age and older, and low income as being at 130% of the Federal Poverty Line (FPL) and below. This is the definition we used in constructing the sample for low-income seniors in the SNAP-QC database. State-level analyses were conducted using data from the Georgia Advanced Performance Outcomes Measures Project 6 (GA Advanced POMP6; 2008–2009) and the Centers for Medicare and Medicaid Services (CMS) to estimate annual out-of-pocket medical expenditures of low-income older adults in Georgia. The GA Advanced POMP6 sample was limited to those aged 65 years and older, which is the eligibility age for Medicare. The same threshold for low income, 130% FPL, was used in both data sets. Georgia is well suited for this type of analysis because it is one of the poorest states in the United States, with a large SNAP caseload. There have also been administrative challenges that have prevented eligible SNAP participants from applying for and receiving benefits to which they are entitled, especially in the senior population.

National Data: SNAP-QC Data, 2005–2013

Required by federal law, the SNAP-QC Database compiles detailed demographic, economic, and SNAP-specific case information for a nationally representative sample of approximately 50,000 SNAP "households." A SNAP household is defined as an individual receiving SNAP or a group of individuals who, together, are certified for SNAP receipt. The SNAP-QC data are collected over the course of each fiscal year. On a monthly basis, a random sample of

SNAP cases in each state is selected for review. Because of the probability sampling method, these data are well suited for studying the characteristics of SNAP recipients and for estimating the effect of policy or implementation changes in the SNAP program for recipients.

We used the SNAP-QC data from 2005 through 2013, which we pooled for cross-sectional analysis, to compare benefit amounts, amount of medical expenditures reported, and probability of using the medical deductions among senior and disabled SNAP recipients in states that have adopted SMED (n = 18 as of October 2015) to states that have not adopted the deduction. Each state's Standard Medical Expense Deduction year of implementation was used to divide the sample into two groups: states with SMED and without SMED.

Georgia-Specific Data: GA Advanced POMP6–CMS Data, 2008

The GA Advanced POMP6 is a collaborative study between the University of Georgia and the Georgia Department of Human Services, Division of Aging Services, and was originally designed to assess the cross-sectional and longitudinal impact of Older Americans Act Nutrition Program (OAANP) participation on food security and nutritional health in older Georgia residents. Approximately 5,500 community-dwelling, active and new OAANP participants and wait-listed individuals in Georgia completed self-administered mail surveys between 2008 and 2009 (Lee, 2013; Lee, Johnson, & Brown, 2011). Due to the expanded scope of the project, the GA Advanced POMP6 further acquired the CMS administrative health claims data for its participants. The GA Advanced POMP6 provides mostly self-reported or subjective data on sociodemographic and economic characteristics, food security, SNAP and OAANP participation status, and health status (Lee, 2013). The CMS administrative health claims data provide objective measures of Medicare and out-of-pocket expenditures, use of different types of healthcare services, and health status. Also, the CMS data provide information on annual beneficiary responsibility toward payment for different types of medical services used by each beneficiary.

The merged GA Advanced POMP6 and the CMS data set is the first of its kind and only available statewide data set to provide key variables needed for this study in a substantially large number of low-income, minority, and noninstitutionalized older adults who have been difficult to recruit and are understudied. These data provide an exceptional opportunity to compare actual annual out-of-pocket medical expenses in a statewide sample of low-income older adults by their health status, SNAP eligibility, and SNAP participation status. For the purposes of this study, the 2008 CMS and baseline data from the longitudinal study sample of the GA Advanced POMP6 were used. The sample includes 636 older adults who were eligible for SNAP benefits based on the reported household income and household size. The study sample was divided into SNAP-eligible nonparticipants and SNAP participants.

Methods

First, descriptive analysis using the national, representative SNAP-QC data was conducted to compare outcomes of interest in SMED states and non-SMED states over the observation period. We restricted our analysis to low-income older individuals who would be eligible for the medical expense deduction under SNAP policy guidelines. We examined several key variables of interest, comparing SMED to non-SMED states: benefit levels in dollar amounts, the percentage of SNAP recipients receiving the minimum SNAP benefit, the percentage of recipients reporting any medical expenditures, and the dollar amount of medical expenditures reported among recipients who claimed the deduction.

Second, descriptive analysis using the GA Advanced POMP6–CMS data was conducted to compare key characteristics between SNAP-eligible nonparticipants and SNAP participants including sociodemographic and economic characteristics, food insecurity, chronic conditions, and health status. We also compared monthly out-of-pocket expenditures of the study sample by the type and number of chronic conditions between SNAP-eligible nonparticipants and SNAP participants and tested the differences using Wilcoxon rank-sum test.

Total annual Medicare-related out-of-pocket expenditures were derived by summing the payments made by each beneficiary for use of inpatient, outpatient, and physician services; skilled nursing facilities; durable medical equipment; and prescription drugs between January 1, 2008 and December 31, 2008. Total expenditures were then averaged over the 12-month period to get approximate monthly out-of-pocket expenditures. The out-of-pocket expenditures include all coinsurance and deductible amounts but exclude any premiums that the beneficiary was financially responsible for during the year. Many, although not all, Medicare beneficiaries with incomes low enough to qualify for SNAP should have these premiums paid by Medicaid.

Results

The national analysis comparing SMED to non-SMED states shows significant differences in several variables of interest for SNAP beneficiaries. The SNAP-QC data show a significant difference in the average monthly SNAP benefit dollar amount received by senior SNAP beneficiaries in SMED states (mean = \$126.46, SD = \$99.39) compared to non-SMED states (mean = \$108.34, SD = \$102.61, $p < .001$). In addition, the mean percentage of senior SNAP beneficiaries receiving the minimum SNAP benefit is significantly lower in SMED states. On average, the percentage of senior beneficiaries receiving the minimum SNAP benefit is significantly higher in non-SMED states than the

percentage of beneficiaries receiving the minimum benefit in SMED states (17% vs 13%, respectively, $p < .001$). This means that these senior beneficiaries are receiving, on average, more in benefits than comparable beneficiaries in states that have not adopted this standard deduction. This also suggests that some significant number of senior and disabled SNAP recipients who should qualify for a medical deduction are getting the very minimum possible benefit (and thus have a great deal to gain from policies making the deduction more accessible).

Comparing means also showed a difference in the average monthly medical expenditures reported among SNAP beneficiaries in SMED states: On average, the out-of-pocket medical expenditures reported in SMED states is \$38.51 (*SD* = \$149.05), compared to \$21.07 (*SD* = \$104.48, $p < .001$) in states without the simplified deduction. These dollar amounts are among all SNAP households with an older adult. When the analysis is limited to households with an older adult that reported any medical expenses, we find that individuals in SMED states (mean = \$185.22, *SD* = \$283.16) receive a medical deduction amount that is approximately \$40 ($p < .001$) higher than non-SMED states (mean = 146.99, *SD* = \$240.18). We also observe differences in the percentage of households reporting any medical expenses—SMED states have a 6% higher rate (21% vs 15%, respectively, $p < .001$) of reporting of medical expenses among eligible households, relative to non-SMED states. On average, these descriptive statistics show significant differences in mean values for SNAP beneficiaries in SMED states versus non-SMED states (Table 1).

Next, Georgia-specific data allow us to examine the characteristics of SNAP-eligible older adults who would be affected by SMED policy. SNAP-eligible nonparticipants were less likely than eligible participants to report food insecurity. Both SNAP-eligible participants and nonparticipants are at high risk of incurring medical expenses; more than two thirds of older adults in both groups have more than three chronic conditions, which are associated with high monthly health expenses.

Dual enrollment in Medicaid and Medicare was significantly higher among SNAP-eligible participants than SNAP-eligible nonparticipants—92% for participants and 39% for eligible nonparticipants qualify for both programs (Table 2).

Based on data from the GA Advanced POMP6–CMS data, total monthly Medicare-related out-of-pocket expenses of SNAP-eligible participants and nonparticipants aged 65 and older were calculated. On average, SNAP-eligible nonparticipants incurred higher out-of-pocket medical expenses than SNAP participants. Mean monthly out-of-pocket medical expenditures of SNAP-eligible nonparticipants and SNAP participants were \$202.40 and \$163.62, respectively. These differences, however, were not statistically significant. For each chronic condition, including diabetes, heart disease, chronic obstructive pulmonary disease (COPD), depression, and cancer, we found that SNAP-eligible nonparticipants tend to spend more out-of-pocket than comparable SNAP participants. However, out-of-pocket spending of only those with diabetes is significantly different.

It is also important to note the distribution of health care spending for all beneficiaries as the number of chronic

Table 1. Comparison of SMED and Non-SMED States

Variables of interest	SMED states		Non-SMED states	
	Mean	*SD*	Mean	*SD*
SNAP benefit (\$ per month)	126.46**	99.39	108.34	102.61
Minimum benefit received (proportion of households)	0.13**	0.33	0.17	0.38
Medical expenses reported (\$ per month)	38.51**	149.05	21.07	104.48
Medical deduction (\$, if medical expenses > 0)	185.22**	283.16	146.99	240.18
Eligible household reporting expenses (proportion of households)	0.21**	0.41	0.15	0.36
Total deductions (\$ per month)	542.08**	352.41	425.52	282.48
Family size	1.25	0.68	1.29	0.74
Rent/mortgage payment (\$ per month)	267.68	238.96	254.34	236
Age (years)	70.18	9.11	69.74	9.3
Less than high school education	0.37	0.48	0.4	0.49
High school	0.37	0.48	0.34	0.47
Post high school	0.07	0.26	0.06	0.24
College	0.05	0.22	0.04	0.19
Male	0.32	0.47	0.3	0.46
% of FPL	86.75	35.20	84.1	29.53
N	7,570		64,843	

Note: FPL = Federal Poverty Level; SMED = Standard Medical Expense Deduction. Difference-in-means tests were estimated for medical expenses reported, medical deduction, percentage of eligible households reporting, total deductions, minimum benefit received, and food stamp benefit. Data are from National SNAP Quality Control Database from 2005 through 2013.

**$p < .001$.

Table 2. Characteristics of the Study Sample: The GA Advanced POMP6–CMS, 2008 (*N* = 636)

Variables of interest	All beneficiaries	SNAP-eligible nonparticipants	SNAP-eligible participants
	Mean ± *SD* or %	Mean ± *SD* or %	Mean ± *SD* or %
Food insecure (%)	52.04	45.41	67.72
Age (years)	76.88 ± 7.72	77.61 ± 7.98	75.15 ± 6.80
65–74 (%)	42.14	39.15	49.21
75–84 (%)	38.84	39.15	38.10
85 and older (%)	19.03	21.70	12.70
Female (%)	70.91	68.23	77.25
Race (%)			
Black and others	35.69	29.31	50.79
Living alone	55.50	49.44	69.84
Income less than 20 k (%)	77.20	70.25	93.65
Education (%)			
Less than high school	54.56	48.55	68.78
Fair/poor self-reported health (%)	75.47	72.71	82.01
Chronic conditions (%)			
Diabetes	43.90	41.61	48.15
Heart disease	62.42	61.97	63.49
COPD	31.45	29.98	34.92
Depression	28.93	28.64	29.63
Cancer	9.28	10.74	5.82
Number of chronic conditions	4.14 ± 2.44	4.13 ± 2.46	4.15 ± 2.38
0	7.39	7.83	6.35
1 or 2	20.44	20.13	21.16
3–5	42.92	43.40	41.80
6 or more	29.25	28.64	30.69
Household size	1.66 ± 1.0	1.76 ± 1.03	1.45 ± 0.87
Dual enrollment (%)	54.72	39.15	91.53
N	636	447	189

Note: CMS = Centers for Medicare and Medicaid Services; COPD = chronic obstructive pulmonary disease; GA Advanced POMP6 = Georgia Advanced Performance Outcomes Measures Project 6; SNAP = Supplemental Nutrition Assistance Program.

conditions increases. For individuals with three or more chronic conditions, monthly average out-of-pocket expenditures are well over $100. For individuals with six or more chronic conditions, monthly out-of-pocket expenditures approach $346.

There is a trend for low-income, eligible nonparticipants to have higher out-of-pocket expenditures in each disease category relative to SNAP participants, although these costs are only significantly higher for those with diabetes (as shown in Table 3).

Discussion

The national analysis shows differences among states with SMED and without, and highlights the potential this policy change has in impacting senior and disabled SNAP beneficiaries. First, the percentage of beneficiaries receiving the minimum benefit is lower in SMED states. When senior and disabled individuals report their medical expenses, many are eligible for more in benefit amounts than they would be if they do not report their expenses. We also see a difference in the actual benefit levels among the senior sample in SMED states. Both benefit-level variables are larger in states where the deduction has been adopted. The standard medical deduction should allow eligible SNAP beneficiaries to report their expenses more easily and when medical expenses are reported and verified, SNAP agencies will be able to calculate accurate household net incomes to determine appropriate benefit levels.

The increase in benefit levels for eligible senior and disabled individuals could be associated with the increase in the probability of reporting medical expenditures. When a state adopts SMED, the senior or disabled SNAP client only has to report $35 in medical expenses. Once they reach this amount in reporting, they have met the requirement and can receive SMED for that state. In states without SMED, beneficiaries must report every single dollar in out-of-pocket medical expenses or forego the deduction for those expenses. This can be a significant barrier for beneficiaries because of the time and record-keeping required to document each expense. States with the standard deduction have, on average, 40% more eligible beneficiaries reporting their medical expenditures than states without the deduction.

Table 3. Monthly Out-of-Pocket Expenditures Among Low-Income Older Georgia Residents: The GA Advanced POMP6–CMS, 2008 (*N* = 636)

Variables of interest	All beneficiaries		SNAP-eligible nonparticipants		SNAP-eligible participants		
	Mean ($)	*SD* ($)	Mean ($)	*SD* ($)	Mean ($)	*SD* ($)	*p* values[a]
Overall	190.88	288.80	202.40	309.79	163.62	230.20	.4361
Diabetes	258.34	363.59	292.33	401.23	188.87	259.28	.0292
Heart disease	251.04	330.71	270.98	363.66	204.99	232.73	.5971
COPD	260.83	307.66	282.29	337.30	217.26	232.66	.3364
Depression	284.94	369.46	290.50	381.43	272.24	343.50	.9988
Cancer	341.85	444.62	368.30	483.90	226.41	167.48	.9379
Number of chronic conditions							
0	16.22	24.12	14.90	20.20	20.05	33.91	.9212
1 or 2	73.95	128.36	80.35	142.54	59.54	88.45	.3403
3–5	171.17	217.90	176.43	225.46	158.27	198.90	.8684
6 or more	345.66	403.52	378.85	439.05	272.40	301.73	.1652
n	636		447		189		

Note: CMS = Centers for Medicare and Medicaid Services; COPD = chronic obstructive pulmonary disease; GA Advanced POMP6 = Georgia Advanced Performance Outcomes Measures Project 6; SNAP = Supplemental Nutrition Assistance Program.
[a]*p* values are based on Wilcoxon Rank-Sum (Mann–Whitney) test comparing monthly out-of-pocket expenditure of SNAP-eligible nonparticipants and SNAP participants.

These SMED states also have higher average medical expenses reported. Average medical deductions received among individuals reporting any medical expenses are approximately $185 in states that have implemented the standardized deduction. This figure is compared to $147 in average medical deductions among those reporting any expenditure in states without the standard deduction. Benefit levels and reported medical expenses are higher in states that have adopted the standard deduction.

Potential benefits of SMED are not limited to SNAP beneficiaries. State agencies could also benefit from adoption of a standard deduction. Although the responsibility of reporting medical expenses falls on the client, the task of confirming expenses can impose administrative burdens on SNAP state agencies. Implementing this standard deduction could decrease administrative costs in processing medical expense deductions because SNAP beneficiaries do not have to report each expenditure; they only have to prove that they have met the minimum out-of-pocket expense of $35. The reduction in administrative burden for SNAP agencies and their employees could result in administrative cost-savings for states that have adopted SMED.

Perhaps the greatest potential of SMED is illustrated by the state-level analysis. The Georgia-specific data demonstrate a deep level of need among SNAP-eligible older adults. This sample of participants and nonparticipants are low-income and SNAP eligible. From these data, we observe the majority of individuals in the sample have monthly medical expenses that average approximately $190 per month. Many of these individuals are diagnosed with chronic conditions that require consistent health care utilization, which results in high medical expenses every month.

For the most common conditions, such as diabetes, COPD, heart disease, and cancer, medical expenses add up to approximately $300 per month. Many of the individuals in that sample are eligible for SNAP but are not participating. The budget constraint created by high out-of-pocket medical expenses increases the need for these individuals to participate in the program.

This is a descriptive analysis, yet limitations are important to consider. First, the GA Advanced POMP6–CMS data do not include Medicaid expenditures and we do not know whether Medicaid pays for some of a person's medical expenditures that are left after Medicare payments. This means we could be overestimating out-of-pocket expenses for some of the individuals that are "dual enrolled" in both Medicare and Medicaid in the sample. We do, however, have information on what percentage of the sample is dual recipient of both programs (55%), which allows us to determine if expenditures are significantly different between the dual enrolled sample and those receiving only Medicare benefits. In comparing out-of-pocket expenses between those who are dual enrolled and those who are not, we did not find a statistically significant difference between their expenditures.

We are not estimating predictive models for this study, but using a descriptive approach. The next step in subsequent research is to use these national- and state-level data to estimate predictive models, assessing the impact of SMED policy change on outcomes of interest including benefit levels and reporting of medical expenditures for SNAP beneficiaries.

Based on our analyses and assistance in calculating the impact of SMED, the state of Georgia was approved for

implementation of the deduction, which began on October 1, 2015. The outcomes for senior and disabled SNAP beneficiaries analyzed in this study lead to a policy recommendation of adopting the Standard Medical Expense Deduction or condition-based estimates in the state of Georgia and other states across the country.

Conclusion

Based on our analysis, we recommend states that have not yet simplified the medical deduction to consider implementation of SMED or condition-based estimates. We find significant differences in beneficiaries' benefit levels and their likelihood of reporting their medical expenses. We also introduce two different options that states have for receiving approval for implementation of SMED: the cost neutrality approach and the "estimate" approach.

The needs of the sample studied in the GA Advanced POMP6 and CMS data are not unique to Georgia. Older adults and disabled individuals have historically had very low participation rates in SNAP relative to other groups. These individuals are also, on average, in poorer health and have high out-of-pocket medical expenses. Understanding the health status and health expenses of this population is critical to policy design and implementation aimed at assisting vulnerable older adults and disabled individuals meet their basic needs, especially nutrition.

Policy implications of these findings have several layers. First, if SMED is associated with increases in benefit levels and the use of the medical deduction, households are benefitting by receiving additional nutritional assistance that they are entitled to through SNAP. Implementation of SMED or condition-based estimates of the medical expense deduction could decrease the transaction costs associated with applying for the program, especially if individuals receiving the minimum benefit (currently $16 per month) find that they are eligible for much more in benefit amounts. This could ultimately increase participation rates among a population that has been consistently difficult to enroll in the program. Second, SNAP beneficiaries could increase their benefit levels and decrease the burden of reporting individual medical expenditures, instead opting to take the SMED (beneficiaries with high amounts of medical expenditures, exceeding the standard amount adopted, are still able to report actual expenditures rather than take the standard if they so choose). Implementation of either option for improving the deduction could also serve to decrease administrative burdens for state agencies and administrators.

It is worth noting that each of the chronic conditions that are often diagnosed in senior and disabled individuals is exponentially more complicated when a person does not have adequate nutrition. Nutrition policy aiming to increase access to food and food security among this population should focus on streamlining application and verification processes for those eligible for the program. Policy options at the state level, such as SMED, should be implemented when possible to achieve program goals and objectives, especially for the most vulnerable populations.

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