

Expanded Palliative Care Services

An Opportunity for Employers and Insurers

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The Case for Expanded Palliative Care Services

People with advanced chronic illness who are within a few years of the end of life can benefit greatly from “palliative care” services. These are services aimed at reducing symptoms and suffering rather than curing or treating illness. Making these services more available to people who need them is an opportunity to reduce suffering, honor patient and family preferences for care, and at the same time improve care quality, patient and family satisfaction, and overall cost-effectiveness.

The first part of this paper describes the problem and options available. It includes an [illustrative story on page four](#), continued on page seven. The second part describes [palliative care in more detail, beginning on page six](#). The third part, [beginning on page eleven](#), gives a specific description of how health care payers could expand access to good palliative care

Several factors create a compelling case for expanding access to palliative care services. The public is gradually becoming aware that suffering at the end of life could be greatly reduced. Demographic trends show an expanding aging population and therefore a growing population with advancing chronic disease. Health care costs continue to rise and are concentrated in the last year of life.

The Minnesota Palliative Care Partnership urges all parties to examine the possibilities and initiate efforts to improve the availability of and payment for expanded palliative care services as soon as possible.

THE PROBLEM

Today’s situation is unacceptable

Referring to a report by *Last Acts*, a coalition of end-of-life organizations, a reporter for the *Philadelphia Inquirer* describes the current reality. “[People] want to die at home, but most don’t. They want to die free of pain, but many don’t....Terminally ill and dying [people] receive only mediocre care at the end of life.”

These conclusions, echoed by many personal and professional stories, follow years of clinical experience, polling and research. The majority of people, 75% to 80%, want to die at home, while fewer than 25% actually do. (*Institute of Medicine, Last Acts, Gallop*) People frequently suffer in pain, isolation, and the discomfort of unwanted medical treatments while they face the psychological and spiritual crisis of approaching death. Even when they have made written requests to limit or avoid invasive, aggressive care, their wishes are too often overridden or missed by the health care system.

In 2003, the Institute of Medicine, in its *Priority Areas for National Action: Transforming Health Care Quality*, named twenty key areas where health care quality could and should be improved and called on the nation to take action. Three of those areas relate to end of life care: pain control in advanced cancer; end of life care in general; and care for the frail elderly. In describing what is needed for people with advanced organ system failure and the end of life, the IOM group states, “...Implementing good care for this population requires learning how to

... plan ahead, and how to provide good care for very sick people in their homes and nursing homes.”

In 1999, the national Medicare Payment Advisory Commission found that “the gap between ideal care and the care now given...is wider in end of life care than in probably any other area of medicine,” and “the present situation is unacceptable.”

Problems will grow rapidly

Eighty percent of deaths in America occur in people over age 65. This population segment will grow 14% to 15% by 2011. At that time, baby-boomers begin to turn 65, further accelerating the growth in the numbers of older people. With an older population comes a higher prevalence of advanced, ultimately fatal, chronic illness. If end of life care is widely unacceptable today, a growing number of patients and their families will experience that inadequacy.

Costs are concentrated and exploding

Expenses for patients in the last year of life are one fourth to one third of the total Medicare budget. Approximately half of those expenses are spent in the last month of life. This pattern results from disease crises that now result in hospitalization – a procedure-focused, regimented environment that contributes to the unacceptability of today’s end of life experiences.

All the factors that drive health care costs up – aging, technology, economic incentives, new techniques, and new drugs – are exacerbated at the end of life. This is why there is such a concentration of costs at life’s end.

Obstacles to better end of life care

Technical, financial, cultural, and personal factors combine with lack of knowledge of end of life alternatives to create formidable obstacles to better end of life care.

The chief obstacles are these:

- There is very little insurance coverage for better models of end of life care (except for hospice coverage – still not widely understood [see page six.](#))
- There is extensive insurance coverage for today’s more common, aggressive care at the end of life.
- Very few people pay for additional services for end of life care without insurance coverage.
- Life expectancy is difficult to predict, particularly for certain diagnoses such as chronic heart failure, resulting in an inevitable lack of clarity about when “end of life” begins.
- There are large geographic variations in the availability of programs with expanded services at the end of life.
- The main existing insurance benefit for end of life care, the Medicare hospice benefit, requires patients, in effect, to choose between continuing their current

- treatment or accepting hospice care, often with too little understanding of the benefits of each. Patients resist foregoing the medical care they are used to receiving.
- The multiplicity of payment and care sources make it particularly difficult for nursing home residents to obtain better care at the end of their lives.

A STORY TO ILLUSTRATE

Consider this story:

Stuart is eighty-four years old with chronic obstructive pulmonary disease (COPD). His discomfort with breathing is increasing steadily. He uses an oxygen tank that he must take with him everywhere, yet is finding that his symptoms are no longer relieved as they once were. He is becoming quite anxious as his breathing difficulties increase, and his anxiety only makes matters worse. He is married with two adult children who live locally. He is a retired machinist with very modest income.

Stuart has never been told that COPD is a terminal disease and that already his treatment is mostly able only to manage his symptoms and slow the course of the disease's progression. His doctor is reluctant to talk with Stuart about the eventual course of his disease because of the waxing and waning course of this particular illness. He will most likely experience many exacerbations from which he might recover in the short term, but one of which will lead to his death. She resists sending him to a hospice program since a hospice would require her to give Stuart a six-month prognosis. This is a difficult prediction for a patient with COPD. It is even harder for her to discuss the possibility directly with Stuart and his family knowing that her prediction may be inaccurate. Since she can never really know which exacerbation he will recover from and which will eventually take his life, she is afraid that talking about dying might cause Stuart to "give up," both on himself and on her.

Stuart's children refuse to even think about their father dying, while Stuart's wife, Betty, is becoming more and more afraid, but never says a word. Stuart is sinking into despair, wondering if his life has had meaning, longing for the things he used to be able to do, and discouraged about his prospects for the time he has left.

For the third time in six months, Stuart wakes up one night gasping for air and is rushed to the hospital by ambulance. The ER physician talks with the children and Stuart's own physician. Betty is too upset to tell the ER staff that she and Stuart are ambivalent about aggressive treatment. Stuart and Betty are told

that unless they intubate him and place him on a respirator (breathing machine) he will die. Struggling to draw every breath, and with no other options offered to them, they agree to the respirator.

Stuart continues to decline from the virus infection that led to this crisis and becomes dependent on the respirator. He can no longer talk, is sedated to make it easier for the respirator to breathe for him, and becomes confused in the ICU where night and day run together. He is uncomfortable as he is repositioned every two hours, and he is restrained so he won't pull out the tubes and access lines in his confusion.

Betty and the children are often at his bedside. Betty sleeps in a chair or couch in the ICU family room. She is stoic in his presence, but cries often when she is alone. Ten days pass. His children can't continue to miss work and eventually have to abandon their vigil. They do see him every couple of days at the hospital. Betty becomes quite ill and goes home to sleep just one night in her own bed. That night, Stuart's heart stops. The code team arrives and performs cardiopulmonary resuscitation (CPR), compressing his chest and shocking his heart, but to no avail. He dies alone, confused and sedated without family or friends at his side.

His total hospital bill for these eleven days is \$35,000 and for the last six months of his life, \$45,000.

The blending of culture, our health care systems and insurance structures set the stage for the suffering of Stuart and his family. His adult children won't talk about his approaching end; he doesn't like to think about it; so he makes no plans. His doctor doesn't talk about his dying.

His doctor has at least heard of "hospice" – the only form of end of life care for which a specific insurance benefit yet exists. But the barriers of prognostic uncertainty and a medical culture of aggressive treatment combine to close the door to a hospice referral.

Stuart's wife experiences the all-too-common health consequences of unsupported caregiving, and she may have substantial health care costs of her own. Stuart's despair leaves him in a deepening crisis of meaning, and the reality of the ICU leaves him dying in pain, isolation confusion and fear.

All the costs of his hospitalization in the intensive care unit are covered by his insurances. He could not have afforded counseling out of his pocket, and he wasn't inclined to seek it anyway. Betty would never seek help for herself, except when she got physically ill and called her own doctor.

Stuart's experience was NOT inevitable. But until public knowledge, patient expectations, and insurance coverages change dramatically, it will be the most common story of our families, our loved ones, and ourselves.

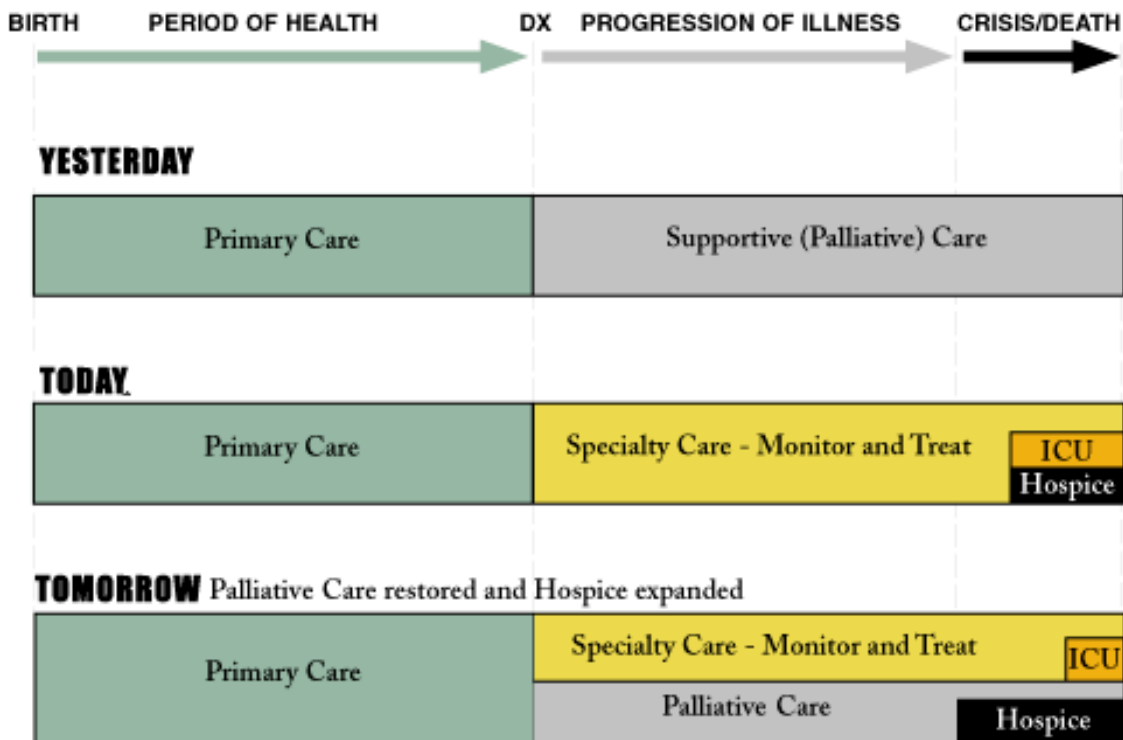
WHAT IS PALLIATIVE CARE?

The continuum of care

Most modern U.S. medical care is oriented to diagnosing, treating, or monitoring disease and injury. Increasingly, it is also oriented to preventing disease and injury. This monitoring and treating mode can extend all the way from diagnosis of a progressive illness to death and frequently does. Often people die as the health care system tries to intervene to “rescue” them from the natural course of their advanced disease or serious injury.

As little as one century ago, medical care consisted primarily of easing the pain and suffering of advanced illness, of supporting the patient and his or her family emotionally and spiritually. Death occurred at home with family and community support. With twentieth century treatment advances, the continuum changed (see diagram below.)

The Continuum of Care



Hospice care – one form of palliative care

In 1983 in the U.S., the hospice benefit became part of the federal Medicare insurance program for people over age 65. Hospice care is based on a comfort care model developed in Britain and other parts of Europe, one that recreates much of what was the norm in earlier times. In other words, it is care focused on relieving pain and other symptoms, on emotional and spiritual support, and on acknowledging that dying is a natural part of life.

“Hospice care” in the U.S. has also come narrowly to mean that which is offered under the insurance specifications enacted in 1983. It then refers to supportive services available only when a physician has certified that a patient has less than six months to live. It requires the patient to agree to have all his or her insurance benefits turned over to the hospice provider, leaving no coverage for “curative” traditional care unless it is unrelated to the terminal illness. Hospice palliative care includes the services of an interdisciplinary team of physicians, nurses, social workers, chaplains, and volunteers. Hospice benefits are frequently included in private health insurance as well and are nearly always modeled after the federal benefit.

Because of the six month prognosis requirement for the Medicare benefit and because Medicare reimbursement precludes coverage of aggressive therapies, “hospice” has acquired an unfortunate association with “giving up.”

Hospice is a subset of the broader notion of palliative care. Palliative care may occur throughout the continuum of care (see diagram), and end of life expanded palliative care services could begin well before the expected death. This paper examines the need and value of paying for expanded palliative care services earlier in the course of illness than hospice care.

Elements of palliative care

Palliative care is the kind of care that can reverse the unacceptability of today’s typical experience at end of life as well as relieve suffering that occurs before the immediate end of life period. Expanded palliative care can reach more people than hospice care can.

Palliative care that supplements (rather than replaces) regular curative medical care is an approach to care using an interdisciplinary team to provide services that ease suffering on physical, emotional, and spiritual levels.

Expanded palliative care services:

- Focus on managing pain and other distressing symptoms.
- Include support for planning – designing advance directives (instructions to physicians regarding care at the point that the patient can no longer speak for him- or herself), and designating health care power of attorney (someone who can make decisions when the patient cannot.)
- Are interdisciplinary, including nursing, social work, chaplaincy and medicine.
- Support the patient’s family, as the patient defines it, and other caregivers
- Address emotional and spiritual suffering as well as clinical symptoms

- Provide professionals skilled in talking about end of life options when physicians do not have the time or are uncomfortable doing so.
- Address grief and bereavement issues.

For a more detailed description of expanded palliative care services, [see Appendix A](#).

Expanded palliative care services as we are describing them here may or may not be followed by hospice services for a particular patient as that patient's condition progresses, depending upon the choice of the patient and his or her family.

THE STORY REVISITED

Here is Stuart's story, rewritten, as it might be if he had been insured for, received early palliative care services, and had then chosen to follow with hospice services:

When Stuart's COPD reaches an advanced stage, his physician discusses the terminal nature of the disease and the different palliative care options. His medical care by this point is, by definition, "palliative," because it only relieves his symptoms without rendering a cure. There are, however, additional palliative care services available, services that supplement his palliative medical care.

She tells him she would not be surprised if Stuart's disease were to become fatal within two years. Stuart is not surprised since she has been honest throughout the course of his illness that treatment will not cure him but rather will relieve his symptoms and slow the illness' course. She explains that the expanded palliative care services will help him and his family manage his disease. Since he has insurance to pay for this new kind of service, which he could not afford otherwise, Stuart agrees to try these services.

A nurse schedules an appointment with Stuart and Betty in their home. At later visits she will include their children as well. She learns how Stuart and Betty are feeling about this diagnosis and what plans they have for the future. They have never thought about planning. She tells them briefly what possibilities are available, what to expect as the disease worsens, and possible outcomes, including the possibility of a respirator. On a later visit, she brings along a chaplain whom Stuart and Betty immediately like.

The nurse then introduces the idea of an Advance Directive that will outline Stuart's preferences for when his disease gets worse. It will also identify a "surrogate decision maker" to help direct Stuart's care if he becomes unable to do so himself. Stuart and Betty complete the form and review it with their children. Stuart wants to die when the time comes at their cabin with Betty near him, so he can see the lake he has always loved from his bed. When he is no longer able to breathe on his own with oxygen, he wants to avoid forced breathing

by machines. He does not, however, want to feel anxious, short of breath or in pain, if possible.

Stuart and Betty are relieved after these first few visits and go on with their lives, doing the things they enjoy as best Stuart can. They have confidence that they will have someone to call if Stuart's doctor doesn't have time to answer all their questions. Their palliative care nurse checks in with them once a month by telephone.

The chaplain visits with them to talk about their questions and fears. He finds out their faith beliefs and learns that they have had no church affiliation for decades. He is able to get them to talk about what gives their lives meaning - their children, their volunteer work, their grandchildren and new great granddaughter, Betty's garden and Stuart's puttering around fixing things and working in his garage workshop. A social worker helps Stuart figure out how he can continue these activities and helps him understand and accept his feelings of loss as he his abilities decline.

Stuart's physician is pleased that he is remaining active and seems to have a positive attitude. These improve his physical health somewhat. Betty has a hard time talking about Stuart's death, and asks for a private visit with the chaplain to talk about her deep fear of losing Stuart. She wants Stuart to have what he wants, but she is scared. One time, her children come with her, and it turns out that their avoidance of the topic masks their own deep fears. As they open up about these, Betty does not feel so alone.

As the palliative care nurse sees Stuart's condition worsening, she discusses his case with his physician and subsequently suggests hospice care. Stuart could continue receiving the same expanded palliative care services, but she wonders if, given his preferences, he might not be better off now with the more intense and readily available services of the hospice team. Stuart chooses to enter hospice, and his doctor, knowing of his wishes, is comfortable in certifying him to do so. He elects to stay within the same hospice provider organization that provided his expanded palliative care, so his palliative care team is able to stay in contact with him and Betty from time to time. He continues to live at home with Betty and now has a nurse visit him nearly every day.

Stuart has a few episodes of breathing difficulties, as his doctor has said he might. The nurse has left an anti-anxiety medication that Betty gives him as she talks to the nurse on the phone. He relaxes and his breathing returns to more regular. One night, Stuart wakes up desperately gasping for air. Betty calls the hospice nurse's number and calls their children. This episode seems very serious, and the anti-anxiety medication is not helping much. Their nurse arrives in a half an hour and begins administering other medications to relax and soothe Stuart and relieve his symptoms.

Together, Stuart and Betty and their children go to the family cabin an hour away. They rearrange the furniture so Stuart and Betty's bed is by the window. They take Stuart to the lakeside in a wheelchair to watch the sunset. The chaplain learns of their situation and visits.

To his surprise, Stuart is grateful for the prayers of the chaplain. Betty often takes the chaplain aside to talk about what she is experiencing at this stage of her grief. The nurse tells her and their children what to expect and what they will see. Stuart lives just fifteen more hours, but he is able to see the sun rise over the lake, say goodbye and express his love to his family. Betty is holding Stuart's hand as he breathes out for the last time and the chaplain stands beside her.

Stuart's total bill for the last six months of his life is only \$28,000, including all the palliative care visits, hospice daily payments, and his doctor visits. Much of it is for his medications.

In this second scenario, Stuart's medical expenses in the last six months are \$17,000 less than they were in the first scenario – a savings of nearly 40%.

Had he not elected hospice, he could have continued with his palliative care team until his death. (His coverage for palliative care may have had a dollar limit, though.) Because the family, with the support of the palliative care team, had discussed Stuart's options and preferences, they would likely have made all the arrangements to go to their cabin at the end. Depending on availability, members of the care team might have been available by telephone and may have been with them for part of the time. It is more likely, though, that patients like Stuart, having developed both knowledge and trust through their expanded palliative care experiences and clarity about their preferences, will elect hospice care as the care option that best meets their wishes.

WHAT WOULD A PALLIATIVE CARE INSURANCE BENEFIT LOOK LIKE?

The Minnesota Palliative Care Partnership proposes that payers include some coverage or payment for expanded palliative care services, whether in person, at home, over the telephone, as follows:

- Palliative care services to be available during at least the anticipated last two years of life – to be assessed by the physician or other health care professional primarily treating the patient. One suggested standard is a “No” response to the question, “Would you be surprised if the patient were to die within two years, given the usual course of his or her illness?”
- Care to be available at the same time as other treatment plans, no matter how aggressive.
- A lifetime maximum payment may be established. A maximum payment of \$4,000, adjusted for inflation, will cover palliative care services for most, up to the point of their eligibility for hospice.
- Patient to be able to consult a palliative care team member by telephone seven days a week, twenty-four hours a day, 365 days a year.
- Benefit available initially to the under age 65 population.
- Benefit covered only if provided by a licensed hospice organization or closely affiliated organization, to ensure comprehensive palliative care capabilities.

We estimate the cost of the services for this population, not taking account of any offsetting savings even though savings are very likely to occur, to be \$0.086 per member per month. We further estimate that a \$4,000 lifetime maximum would fully meet the needs of at least 80% of eligible patients (*based on an analysis of age-specific, disease-specific mortality rates and average costs of services in 2003. For further information, please contact the Minnesota Palliative Care Partnership.*)

Because, based on research to date, we anticipate significant offsetting savings, more than an average of \$4,000 per case, the Minnesota Partnership believes this benefit could be offered with no premium or reserve increases and still be cost-neutral or cost-saving for the payer.

WHY A PALLIATIVE CARE INSURANCE BENEFIT?

Palliative care is the right, most humane thing to do and represents best practice

The example of Stuart illustrates many of the “whys.” The experiences surrounding death of a loved one can leave others either devastated or positively enriched. These, in turn, affect their health. Not everyone will choose palliative care, but for those who do, a far better experience – physically, emotionally, and spiritually – is available. Stuart’s loneliness was alleviated. He did not suffer from physical symptoms, so his family did not have to watch him suffer. He and

his family had support to talk about their fears, concerns, and preferences. His death was gentle, in a setting he loved surrounded by people he loved.

Palliative care meets all five Guiding Principles for End of Life Care set out by the Minnesota Commission on End of Life Care in its final report in 2001. This Commission was co-sponsored by the State Department of Health and the Minnesota Palliative Care Partnership, then known as the Minnesota Partnership to Improve End of Life Care. A broad representation of parties interested in these issues reached consensus on [essential principles for best practice in end of life care in Minnesota](#).

Costs can and generally are lowered substantially

Early demonstration projects provide strong initial evidence of the cost savings potential. Demonstration projects in Montana, Michigan, Washington, California (both within the Veterans Administration and the private market) Louisiana, South Carolina, and New York have reported early analyses that show major costs savings, even when expanded palliative care is provided concurrent with more traditional aggressive care. (See “*Financial Implications of Promoting Excellence in End of Life Care*” October, 2002, www.pursuingexcellence.org) Early results from two demonstration projects in fact show that the total cost of care drops by 35% to 45% when expanded palliative care is added to the more aggressive therapies even though the more aggressive therapies continue.

A program near Albany, New York experimented with expanded palliative care paid for per diem by a partner HMO program. In the first six months, they showed that inpatient days were lowered by 83%, Emergency Department visits reduced by 48%, and total costs lowered by 11% even after the per diem payments to the palliative care provider. These comparisons were against an earlier equal length period of time for the same patients and achieved these results even though the patients’ diseases were presumably LESS severe in the earlier period.

A study released in June 2003 by the National Hospice and Palliative Care Organization showed that palliative care, in the form of hospice care, saved state Medicaid programs (care for the poor) approximately \$7,000 for every hospice-eligible beneficiary. Early palliative care, such as would be covered under the payment for expanded palliative care services, would in all likelihood increase the use of hospice care in total, as it did in the example of Stuart. Expanded palliative care services reduce costs on their own and by improving awareness and use of the hospice option.

How are costs lowered?

The majority of the savings come from reduced hospitalization, especially for unanticipated crises, and in particular, from avoiding terminal hospitalizations. Terminal hospitalizations are likely to include futile and intensive care. When a patient’s wishes are known and honored, with the support of a palliative care or hospice team, this concentrated, highly costly, highly invasive care simply does not occur unless the patient wishes to have it. Over three fourths of patients do not want it.

Palliative care involves the patient’s family and significant others. When they are educated and informed about what to expect, they are less likely to insist on futile care when it would violate the patient’s preferences. Expanded palliative care offers 24-hour telephone contact,

and therefore the family has somewhere to call for help in assessing what to do in the event of a crisis. Stuart's wife had a number other than 911 to call.

Cost reduction does depend on the choices patients make. It is never the intention of palliative care to block access to other valuable care. But even for patients who want to receive the most aggressive care available until death, having family members trained to handle some events at home and having backup nursing support available to them still reduce the use of hospitals and other more costly resources.

With palliative care, the percentage of people who die at home more closely matches the percentage who says that is what they want. Compared to today's 20% to 25% who die at home, among patients receiving expanded palliative care services or hospice services, 60 to 75% die at home, a number in line with what surveys report people say they want.

Other savings -- more indirect but important -- come for employers in the form of reduced loss of work time and productivity for family members. In 2002, *Last Acts* noted the need for further study of this question. Anecdotal evidence suggests that expanded palliative care services allow an employee with a dying family member to have more confidence about when they can safely be at work. These services also reduce the stress on the employee and therefore may reduce employee illnesses and absenteeism. Likewise, expanded palliative care services provide grief support before and after the death and so help employee family members regain their productivity. These changes lower costs for employers.

Quality of care is improved

Reduction of suffering is both a process and outcome quality measure. Palliative care's central objective is to reduce suffering of all sorts, and survey findings from some of the demonstration projects cited earlier show that it is successful in achieving this outcome.

In good end of life care, death is an expected outcome, not a failure. While quality measures in acute and early chronic disease care have often focused on mortality and morbidity, quality at the end of life must focus on the experience of the patient and family. Quality at the end of life means the care achieves what patients and families prefer – usually not to be alone at death, to be free of suffering, and to be respected as an individual whose values are heard and acted upon.

In 2001, the Institute of Medicine published *Crossing the Quality Chasm: A New Health System for the 21st Century*. In it, the IOM set forth six principles to guide all health care. It called for care to be:

- Safe
- Timely
- Effective
- Equitable
- Efficient
- Patient-centered

Palliative care, and especially expanded palliative care services at the end of life as we are proposing, consistently meets all six of these standards.

An article in *Critical Care Medicine* [31(9):2255-2262. 9/03] identifies seven end of life care domains as they pertain to intensive care units, not where one usually thinks of palliative care. Expanded palliative care will, in fact, tend to reduce the use of intensive care units altogether. The article identifies quality indicators for each of the following domains:

- Patient and family centered decision making
- Communication within the team and with patients and families
- Continuity of care
- Emotional and practical support for patients and families
- Symptom management and comfort care
- Spiritual support for patients and families
- As necessary, emotional and organizational support of ICU clinicians

These domains are precisely where palliative care excels. In fact, these domains describe most of palliative care. It is palliative care that will improve quality even in these settings.

On measures of patient, family and provider satisfaction, results consistently show much higher levels of satisfaction and reports of better experiences with palliative care than with traditional aggressive care alone. Satisfaction measures are also an important outcome measure of quality.

SUMMARY

Payment for expanded palliative care offers a rare opportunity to “win/win” across multiple dimensions.

- Palliative care in the last year or two of life is recognized nationally as an important and needed care innovation.
- A benefit that pays for expanded palliative care services improves early access to humane, interdisciplinary care.
- At the same time, palliative care can produce savings. It appears to be reasonable to consider an expanded palliative care benefit to be cost-neutral.
- Palliative care services improve the satisfaction and experience of all involved.

Accordingly, the Minnesota Palliative Care Partnership urges those who pay for health care to begin innovations to expand access to and payment for expanded palliative care services as soon as possible.

APPENDIX A

Expanded Palliative Care Services:

INCLUDE:

- Palliative care nurse care
- Palliative care social worker care
- Chaplain care
- May include pharmacist consultations
- Visits in person, at home, on the telephone, or in other settings
- Telephone availability of contact 24 hours, 7 days, 365 days per year

DO NOT INCLUDE:

- Any care, services, or equipment covered by other benefits under the same insurance plan, for example:
 - durable medical equipment
 - home care services
 - hospice services
- The costs of medications covered by a pharmacy care benefit under the same insurance plan
- Respite care
- Companion or homemaker services (as a rule)
- Skilled nursing facility services or custodial residential services
- Any services provided by a family member or friend or other individuals who are residents in the patient's place of residence
- Services beyond the lifetime maximum benefit of \$4,000 (if elected by the payer.)