

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-04)
Private Sector Options for Financing Long-Term Care
(Reference Committee K)
(December 2004)

EXECUTIVE SUMMARY

With the number of older Americans expected to reach 70 million by 2030, increased life expectancy, and the rising costs of nursing home and home health care, there will likely be an increased demand for institutional long-term care that will overwhelm publicly financed programs such as Medicare and Medicaid, and will leave millions of Americans unprepared for both the heavy financial and non-financial burdens of long-term care services.

Council on Medical Service Report 5 (I-04) describes private sector options for financing long-term care. In 2003, the average cost of nursing home care was \$57,000 annually. Many Americans are unaware that nearly one of every two individuals age 65 or older is likely to spend at least some time in a nursing home, and the cost of one year of this care could entirely deplete personal savings. Currently, publicly financed programs shoulder more than half of the expenditures for long-term care services. Assistance with activities of daily living over a long period of time is not covered by Medicare, a misperception that many Americans share. Although Medicaid does cover some of these services for eligible individuals, it is facing significant financial constraints.

Private sector options include long-term care insurance, Health Savings Accounts (HSAs), and other approaches such as reverse mortgages, the conversion of life insurance policies, and life care communities. Long-term care insurance, the primary private sector product designed specifically to address long-term care needs is increasingly available. This option is proving to relieve some of the pressure on public programs, as are other private financing options.

In its report, the Council recommends that the AMA strongly encourage the American public to become better informed about their possible future need for long-term care services, including the importance of preparation through early saving, investing, and the option to purchase long-term care insurance. The Council also recommends that the AMA reaffirm its policy to apply tax treatment to long-term care insurance as it applied to health insurance, to encourage individual ownership of long-term care policies. In addition, the Council recommends that the AMA support legislative proposals that provide targeted tax incentives to encourage individuals to save and invest for their long-term care needs; encourage the insurance industry to develop innovative programs and insurance products that will cover the provision of services; and encourage the American public to consider HSAs as a supplemental mechanism to save for the future provision of long-term care services.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - I-04
(December 2004)

Subject: Private Sector Options for Financing Long-Term Care

Presented by: William H. Beeson, MD, Chair

Referred to: Reference Committee K
(John S. McIntyre, MD, Chair)

1 It is likely that one of the biggest health care challenges facing America in the 21st Century will be
2 the aging of “baby boomers” – those born between 1946 and 1964. By 2030, it is estimated that
3 the number of Americans age 65 and older will reach nearly 70 million, and a large proportion of
4 this group may eventually need long-term care. With the aging of the baby boom generation,
5 increasing life expectancy, and the rising costs of nursing home and home health care, there will
6 likely be an increased demand for institutional long-term care that will overwhelm publicly
7 financed programs such as Medicare and Medicaid, and will leave millions of Americans
8 unprepared for both the heavy financial and non-financial burdens of providing long-term care for
9 themselves or family members.

10
11 This report focuses on private sector options for financing long-term care, including long-term care
12 insurance, health savings accounts, and other possible approaches such as reverse mortgages, the
13 conversion of life insurance policies, and life care communities. In addition, recent federal
14 proposals to encourage private sector long-term care coverage are highlighted.

15 BACKGROUND

16
17
18 Only a small portion of “long-term care” can be considered health care services. Health insurance
19 plans generally do not pay for long-term care services. Long-term care typically refers to the broad
20 range of personal assistance services that allow people who have limited function, either due to a
21 disability or chronic condition, to carry out activities of daily living (ADLs). Those seeking long-
22 term care often have difficulty performing everyday routines such as eating, bathing, and dressing.
23 In some cases the disability may be significant enough to require ongoing nursing care, such as
24 ventilator use. These services are usually provided at home or in institutional settings such as
25 nursing or residential care facilities (Congressional Research Service, 2004).

26
27 Aside from home care, nursing homes traditionally have served as the primary setting for long-term
28 care. A 2003 study commissioned by GE Financial’s Long Term Care Insurance division
29 evaluated the cost of nursing home care for a person suffering from Parkinson’s or Alzheimer’s
30 disease. The survey showed that the national annual average cost of a year in a nursing home was
31 \$57,700. The range across the country varied from \$35,900 a year in Louisiana, to \$105,500 in
32 New York City, to \$166,700 in Alaska (National Underwriter, 2003).

33
34 According to the Centers for Medicare and Medicaid Services, during 2004, about seven million
35 men and women over the age of 65 will need long-term care. By 2020, it has been estimated that
36 12 million older Americans will need long-term care. People who reach age 65 will likely have a
37 48.6% chance of entering a nursing home (Lewin, 1997); however, this percentage includes those

1 who stay for a relatively short period of time to recuperate from a surgery or illness. About 10% of
2 the people who enter a nursing home will stay there five years or more.

3
4 Many people are unaware that they will need to prepare for their own long-term needs. According
5 to a 2001 AARP study, even though 60% of study respondents over the age of 45 claimed that they
6 were very familiar with long-term care services, only 15% were able to gauge the actual cost of
7 care within a 20% margin (American Demographics, 2002).

8
9 A person preparing for possible future long-term care needs has several options. Although one
10 alternative is to “self-insure” by setting aside personal savings and assets, most seniors are not well
11 prepared to pay for their long-term care needs. In 2000, for instance, only about 7% of seniors had
12 income in excess of \$50,000 (about the cost of a year's stay in a nursing home). In 1997, more than
13 half of nursing home residents were poor enough to qualify for Medicaid coverage (Congressional
14 Budget Office 2004).

15
16 Nevertheless, meeting the future demand for long-term care with government programs will be
17 difficult. Medicaid is the largest source of public funding for long-term care. Currently, Medicaid
18 faces significant challenges including struggling state budgets, a limited supply of beds, and a
19 dwindling workforce. In 2003, two-thirds of states cut Medicaid benefits, increased co-payments,
20 and restricted eligibility or removed people from coverage because of increasing costs and
21 decreasing revenues (Congressional Budget Office, 2004).

22
23 Furthermore, the federal government increasingly has encouraged states to control the supply of
24 beds with certificate of need programs. As a result, nursing homes have responded to limits to their
25 funding by relocating healthier long-term care recipients to community based programs, while the
26 most frail and infirm patients remain in nursing facilities. With shortages of nurses and nurses’
27 aides, the long-term care industry is facing a considerable scarcity in supply and an ever increasing
28 demand for care. These factors will continue to restrict supply and fuel increases in the price of
29 long-term care (Center for Long-Term Care Financing, 2003).

30
31 In addition, changes in family structure, such as smaller and more geographically dispersed
32 families, can limit the pool of potential informal care providers. People without informal care
33 givers often are forced to leave their homes and seek institutional care, further increasing demand
34 for institutional care.

35 36 CURRENT STATUS OF LONG-TERM CARE FINANCING

37
38 Long-term care services are currently financed through a patchwork system of public programs,
39 private insurance and individual financing. According to the Centers for Medicare and Medicaid
40 Services (CMS), of national spending on long term care in 2002, Medicaid spending accounted for
41 43%, out of pocket spending accounted for 24%, Medicare accounted for 17%, private insurance
42 (including other types of health care insurance policies) accounted for 11%, and other types of
43 public and private financing accounted for 5% (Kaiser Family Foundation, 2004). In other words,
44 when combined, more than half (60%) of expenditures on long-term care services were covered by
45 the Medicare and Medicaid programs.

46
47 Medicare – the federal health insurance program for people over the age of 65 – provides only
48 short-term skilled nursing home care following hospitalizations, and limits its coverage at home to

1 those who need skilled nursing care and rehabilitative therapy. Long-term care services primarily
2 assist people with ADLs such as dressing and bathing. Such care, often called “custodial care,” is
3 not covered by Medicare, although some Medicare Advantage plans may offer limited skilled
4 nursing facility (SNF) and home care coverage if the care is medically necessary.

5
6 Medicaid – the means tested entitlement program – covers long-term care services for eligible
7 individuals in both institutional settings (e.g., nursing homes and intermediate care facilities), and
8 homes and other community-based settings (e.g., adult day care facilities, for example). Only
9 nursing home care and home health care for people who would otherwise qualify for institutional
10 care are mandatory benefits under Medicaid.

11
12 Eligibility and services covered vary from state to state. Most often, eligibility is based on income
13 and personal resources. In general, beneficiaries are required to deplete their savings, or “spend
14 down,” to a certain income and asset level before Medicaid will pay for services. If the individual
15 is married, the spouse is expected to contribute toward nursing home care if monthly income is
16 above a certain level. Council on Medical Service Report 1 (I-02) previously addressed Medicaid
17 spend-down eligibility criteria.

18 19 PRIVATE SECTOR OPTIONS FOR FINANCING LONG-TERM CARE

20 21 Long-Term Care Insurance

22
23 Long-term care insurance (LTCI) describes a wide variety of private contracts between insurance
24 companies and policyholders. In 1989, LTCI was offered to 3% of full-time employees in private
25 industry with 100 or more employees; by 2003, 19% of full-time workers in private industry were
26 offered this benefit (Department of Labor, 2004). Despite the increased availability, fewer than
27 10% of Americans age 65 and older have purchased LTCI, and pre-retiree penetration rates are
28 even lower (Office of Personnel Management, 2004). Nevertheless, LTCI is proving to relieve
29 some of the pressure on public programs. In 1995, private insurance paid \$700 million or 0.8%
30 long-term care services for seniors. It is estimated that LTCI will cover \$6 billion or 4% of long-
31 term care services in 2004 (Congressional Budget Office, 2004).

32
33 For the individual, the primary benefit of LTCI is that it minimizes the use of personal savings to
34 pay for long-term care needs. LTCI provides protection of retirement savings, reduces financial
35 hardships for spouse and other family members, and promotes greater financial independence.
36 From a societal perspective, the primary appeal of private LTCI coverage is that it may fund a
37 substantial portion of the long-term care needs for many Americans. Furthermore, widespread
38 LTCI coverage has the potential to shift a substantial share of the funding responsibility from the
39 government to the individual.

40
41 In 2002, the Department of Health and Human Services (HHS) conducted a study to better
42 understand how having a private LTCI policy affects the use of Medicare financed home health,
43 skilled nursing, and hospital inpatient services. Not surprisingly, one of the key findings was that
44 individuals who are receiving LTCI payments are less likely to access Medicare financed home
45 health aide services, and among those who do use services, both the volume and the expenditure
46 level are lower than that for non-privately insured individuals.

47

1 The range of settings for LTCI policies includes nursing homes, adult day care centers, assisted
2 living, and formal and informal home care. For example, a “Facility Only” policy covers care that
3 is received in a licensed setting and does not cover assisted living, or home care. Coverage under a
4 facility only policy is typically triggered by an acute medical condition that eventually requires
5 skilled nursing care in a SNF. In contrast, a policy with “Integrated Home Care,” covers care
6 received in an unlicensed setting, such in a home. Coverage under this type of policy pays for care
7 that is provided by home health aides, nurses, social services, physical therapists, and other
8 sources.

9
10 Several policy provisions can affect LTCI premiums, including daily dollar maximum, duration of
11 policy, and waiting period. There may be a daily dollar maximum or a range of daily maximum
12 coverage from which a policyholder can choose when selecting a policy. Some maximums are
13 designed to cover most, if not all relevant expenses, while lower limits mean that the policyholder
14 will pay the difference between the SNF or long-term care facility charges and the limits of the
15 policy. Higher maximums result in higher premiums. Similarly, the tradeoff for purchasing a
16 longer duration policy is a higher premium. Duration periods typically range from one year to five
17 years, but can be selected for an unlimited number of years. In addition, the waiting or elimination
18 period may affect the premium rate as well. The waiting period, or time before the policy is used,
19 acts as a deductible to cover long-term care situations (i.e. the longer the waiting or elimination
20 period, the lower the cost of the premium).

21
22 In addition to these policy options, there are other factors which affect the premium such as pre-
23 existing conditions and prior hospitalizations. Other key policy provisions and options include, but
24 are not limited to, guaranteed renewability, waiver of premium, premium refund provisions, and
25 non-forfeiture of benefits.

26
27 LTCI eligibility is typically based on age, health, and affordability. Many financial planners
28 recommend that individuals age 50 or over, with more than \$200,000 but less than \$2 million in
29 assets, buy LTCI. The National Association of Insurance Commissioners (NAIC), in its model
30 regulation for LTCI, suggests that consumers should be discouraged from buying a policy if the
31 premiums account for more than 7% of income or if the purchaser does not have at least \$35,000 in
32 financial assets. The United States Health Council suggests that individuals only consider buying a
33 policy if assets are worth at least \$75,000 (excluding the value of the home and car), and annual
34 retirement income is at least \$35,000.

35
36 LTCI premiums can be expensive, especially for older individuals. In 2002, the national average
37 for a typical premium for a 50-year-old person for a policy that covers a \$150 daily benefit, four
38 years of coverage, with a 90-day deductible, and an inflation protection feature cost, was \$1,134
39 annually. This same policy for a 65-year-old was about \$2,346 annually, while the cost for a
40 person aged 79 was \$7,572 annually, or nearly 6 times the cost of a premium for a 50 year-old
41 (Health Insurance Association of America, 2004).

42
43 The variation in premiums underscores the importance of planning ahead, especially for certain
44 groups. To illustrate this point, consider the long-term care needs of women. Women represent
45 nearly three quarters (72%) of nursing home residents 65 years and older, and two-thirds of home
46 health care users (General Accounting Office, 2001).

47

1 Nevertheless, LTCI is not for everyone. For example, a person with limited assets planning to
2 purchase LTCI before age 50 may face other important financial considerations (e.g. college
3 tuition, retirement savings) that may take priority over the purchase of LTCI. In addition, because
4 of the extraordinary length of time that is likely to elapse before the buyer will actually need long-
5 term care, changes in the market could mean that a policy purchased today could fail to provide
6 access to newly emerging service options (Kaiser Family Foundation, 2003).

7 8 Health Savings Accounts

9
10 As described in Council on Medical Service Report 6 (A-04), Health Savings Accounts (HSAs) are
11 individually funded, interest bearing accounts that permit saving for medical and retiree health
12 expenses on a tax-free basis. To open an HSA, an individual must be under 65 and have a high-
13 deductible health plan (an insurance policy with a deductible of at least \$1,000 for an individual
14 and \$2,000 for a family). The investment earnings accrue interest on a tax-free basis, and are
15 similar to Individual Retirement Accounts (IRAs) in that they can be transferred if the individual
16 changes jobs. Ownership of an HSA can be transferred to a spouse upon the death of a beneficiary.

17
18 According to guidance issued by the Department of Treasury, qualified long-term care expenses
19 that can be paid for using HSAs include necessary diagnostic, preventive, therapeutic, curing,
20 treating, mitigating, and rehabilitative services, and maintenance and personal care services that are
21 required by a chronically ill individual, and provided pursuant to a plan of care prescribed by a
22 “licensed health care practitioner.” Upon evaluation, an individual unable to perform at least two
23 ADLs without substantial assistance from another individual for at least 90 days, due to a loss of
24 functional capacity, is defined as “chronically ill.” In addition, if a person requires substantial
25 supervision to be protected from threats to health and safety due to severe cognitive impairment, an
26 HSA can be used for payment (Department of Treasury, 2004).

27
28 An account beneficiary may pay LTCI premiums with distributions from an HSA. It is important
29 to note that the amount of distribution for qualified medical expenses may be limited to the annual
30 adjusted amounts that are age-dependent (e.g. age 40 or under - \$250, age 41 – 70 between \$470
31 and \$2,210, and age 71 or older \$3,310). Thus, although HSA distributions to pay or reimburse tax
32 qualified LTCI premiums meet the definition of qualified medical expenses, the exclusion from
33 gross income is limited to the adjusted amounts.

34
35 HSAs also can be used to pay for nursing home care and nursing services, which include
36 maintenance and personal care services. These services typically include those associated with
37 caring for the patient’s condition, such as giving medication or changing dressings, as well as
38 bathing and grooming the patient. These services can be provided at home or in another care
39 facility. In addition, HSAs may be used to pay for capital expenses to make reasonable
40 modifications to a home to accommodate a disabled medical condition.

41 42 Reverse Mortgages/Estate Recovery

43
44 A home is the principal financial asset for many older Americans. A reverse mortgage, or home-
45 equity conversion, is a means to pay the homeowner a fixed sum each month. The amount of
46 money is dependent on age at the time the loan is applied for, the equity of the home, type of loan,
47 and current interest rates. Eligibility is based on the age of the borrower (usually 60 or older) and
48 the type of residence (i.e., single-family homes, including condominiums, but not co-operatives).

1 A feature called “life tenure” can be added so that what is owed does not exceed the value of the
2 home when it is sold.

3
4 The benefit of a reverse mortgage loan is that it helps an older person “age in place” while
5 receiving the care that is needed. However, many Americans strongly value their ability to provide
6 an inheritance for their heirs, and the option of a reverse mortgage may have a limited appeal if
7 financing long-term care needs is a consideration.

8
9 Payments under a reverse mortgage can take several forms; some are simple lines of credit, while
10 others are fixed-term agreements that provide a series of monthly payments. Although money from
11 a reverse mortgage is tax-free, it counts toward income for determining Medicaid eligibility or
12 other state assistance programs.

13
14 When a person receiving a home equity loan either sells the home, no longer permanently lives in
15 the home, or dies, that person or his or her estate has to repay the amount received from the reverse
16 mortgage. In addition, any interest and other fees are due. Any remaining equity belongs to the
17 individual or their heirs.

18
19 The Home Equity Conversion Mortgage Program (HECM) is a program in which federally insured
20 reverse mortgages are backed by the Federal Housing Administration (FHA). The FHA insures
21 HECM loans to protect lenders against loss if amounts withdrawn exceed equity when the property
22 is sold. Reverse mortgages that are not backed by the federal government may be more expensive,
23 but often have the flexibility of providing larger loan amounts.

24
25 According to the National Reverse Mortgage Lenders Association, the volume of HECM reverse
26 mortgages nationwide in the five-month period from October 2003 through February 2004 (12,848
27 loans) was 112% higher than the level during the five-month period ending February 2003 (6,061
28 loans). HECM reverse mortgage volume in February 2004 alone (4,148 loans) set a new monthly
29 record, and was 273% higher than the level in February 2003 (1,113 loans).

30

1 Conversion of Life Insurance Policies

2
3 Many life insurance policies offer, at an extra cost, an “accelerated death benefit” rider. Under
4 such riders, a portion of a beneficiary’s life insurance benefit -- usually no more than 80% of the
5 face value of the policy -- can be paid to the beneficiary under certain circumstances, such as when
6 long term care is needed, rather than to the individual’s beneficiary at death. Most riders stipulate
7 this benefit for persons who have a terminal prognosis of 6 months to a year.
8

9 Continuing Care Retirement Community

10
11 A Continuing Care Retirement Community (CCRC), also known as a Life Care Community, is a
12 setting which charges a substantial entrance fee (typically from \$15,000 to over \$200,000), which
13 may or may not be refundable, as well as ongoing monthly fees (usually \$1000 or more). A CCRC
14 provides a range of care from assisted living services to nursing home care without extra payments.
15 It may charge additional daily fees for home health care beyond what is paid for by Medicare.
16 Outside of the requirements for housing and nursing home care, each community is unique in what
17 it offers.
18

19 FEDERAL PROPOSALS

20
21 In its 2005 budget, the Bush Administration proposed to provide \$21.4 billion over ten years to
22 make premium payments of LTCI fully deductible. The proposed “above the line” federal tax
23 deduction would allow taxpayers to deduct LTCI policy premiums from their taxable income,
24 regardless of whether they itemize on their tax return. The budget also would provide for an
25 additional personal exemption for caregivers of family members in need of long-term care.
26

27 Similar to the Bush Administration’s proposal, Representative Nancy Johnson (R-CT) has
28 introduced legislation that would provide tax deductions for purchasing LTCI and tax credits to
29 help offset the cost of providing care to a family member at home (H.R. 2096). Supporters of these
30 types of tax subsidies argue that promoting the purchase of LCTI earlier in life will both protect
31 consumers against financial losses and ultimately save the federal government money by reducing
32 Medicaid outlays. Opponents argue that the structure for tax deductions provides little or no
33 assistance to most low- and middle-income families, while disproportionately assisting high-
34 income individuals who already would have been inclined to buy LCTI.
35

36 AMA POLICY

37
38 The AMA recognizes the importance of developing individual financing methods to cover long
39 term care expenses and Policies H-280.991 and H-165.985 (AMA Policy Database) address this
40 issue extensively. Of particular relevance, Policy H-280.991[9] encourages the creation of tax
41 incentives to allow individuals to deduct the cost of long-term care coverage from income tax and
42 encourages employers to offer long-term care policies as part of employee benefit packages.
43 Policy H-165.985[9] promotes the development of improved methods of financing long-term care
44 expense through a combination of private and public resources, including encouragement of
45 privately pre-funded long-term care financing to the extent that personal income permits, assurance
46 of access to needed services when personal resources are inadequate to finance needed care, and
47 promotion of family care giving. More recently, Policy H-165.871 advocates that any tax

1 treatment applied to health insurance for the purpose of encouraging individual ownership, also
2 apply to LTCI.

3
4 DISCUSSION

5
6 The Council on Medical Service believes that as Americans age, early awareness of the possible
7 need for long-term care and its potential costs is critical to helping individuals adequately prepare
8 for the future. According to AARP, among people 45 and older, the majority are unaware of the
9 actual costs of long term care services. In 2003, the national average cost of nursing home care in a
10 semi-private room was \$57,000 annually, and costs are expected to increase. By 2030, the cost of a
11 semi-private room in a nursing home is expected to increase to \$190,600 per year, or more than
12 triple the current amount (Kaiser Family Foundation, 2004).

13
14 Medicare and Medicaid currently shoulder more than half of expenditures for long-term care
15 services. These government programs are facing considerable financial challenges as the number
16 of older Americans is expected to reach 70 million by 2030. Assistance with ADLs over a long
17 period of time is not covered by Medicare. Although Medicaid is the only government program
18 that currently covers some of these services, it is facing significant financial constraints, is
19 chronically under-funded, and requires individuals to meet strict eligibility criteria, including
20 “spend-down” requirements.

21
22 As a result, the Council believes that the AMA should encourage Americans to become better
23 informed about their potential need for long-term care and its associated costs. As discussed, LTCI
24 protects retirement savings, reduces financial hardships for family and friends, and promotes
25 financial independence. Although the number of employers offering LTCI has grown, only 19% of
26 employers currently offer this benefit. Consistent with AMA policy H-280.991[9], therefore, the
27 Council believes that the AMA should support legislative proposals that provide tax incentives to
28 purchase LTCI.

29
30 The Council also believes that the insurance industry should be encouraged to continue to develop
31 innovative programs and insurance products that anticipate long term care needs. For example,
32 James Rice of the Governance Institute has suggested the possibility of blended annuities, which
33 could combine classic insurance policies including annuities, LTCI, disability insurance, managed
34 care health insurance, and life insurance. Although this type of product has not yet been offered in
35 the market, it is an example of an innovative idea that may be more appealing to younger
36 Americans as a means of better preparing for the possible need for long-term care.

37
38 The Council also believes that HSAs should be advocated as a supplementary solution to financing
39 long-term care. The Council recognizes that HSAs are only a partial solution, because individuals
40 may not be able to save the amount needed to completely finance long-term care. Nonetheless, the
41 tax-free use of HSAs to cover the costs of LTCI premiums and long term care services is an option
42 that should be promoted further.

43
44 RECOMMENDATIONS

45
46 The Council on Medical Services recommends that the following be adopted and the reminder of
47 the report be filed:
48

- 1 1. That the American Medical Association (AMA) encourage the American public to become
2 better informed about the possible future need for long-term care services, including the
3 importance of early preparation through saving, investing, and the option to purchase long-
4 term care insurance. (Directive to Take Action)
5
- 6 2. That the AMA reaffirm Policy H-165-871[2] which advocates that any tax treatment
7 applied to health insurance for the purpose of encouraging individual ownership also apply
8 to long-term care insurance. (Reaffirm HOD Policy)
9
- 10 3. That the AMA support legislative proposals that provide targeted tax incentives that
11 encourage individuals and families to save, invest and insure for their future long-term care
12 needs. (Directive to Take Action)
13
- 14 4. That the AMA encourage the insurance industry to continue to develop innovative
15 programs and insurance products to cover the provision of long-term care services.
16 (Directive to Take Action)
17
- 18 5. That the AMA encourage the American public to consider using health savings accounts as
19 a supplemental savings mechanism to cover the future provision of long-term care services.
20 (Directive to Take Action)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Advocate private section options for financing long-term care, and support relevant legislative proposals at estimated total cost of \$1,535.