Memorial Sloan Kettering Cancer Center

Calculating the Average Amount Generally Billed

An individual who is eligible for the financial assistance program will never be charged more than 45 percent of the total hospital charges for medically necessary care. That includes both inpatient and outpatient care. Forty-five percent is the average rate at which Medicare fee for service and insurance companies reimburse Memorial Sloan Kettering.

To reach that 45 percent rule, we use the "look back" method. We add up all of the claims paid to us in a 12-month period by Medicare fee for service and insurance companies. We divide that amount by the full total of the charges for those claims. The number we get is called the amount generally billed, or AGB for short. The claims we review are those that have been paid within that 12-month period, not services that were provided in that time. If a claim has not been finalized by the last day of the 12-month period, we don't count that claim in the total. Claims are only counted when they are paid.

When calculating the AGB percentage, we include the full amount allowed by an insurance company. That means the amount the company pays plus the amount the patient pays. A patient's responsibilities may include co-payments, co-insurance, and deductibles. In terms of what amount we count for the patient's payment, it doesn't matter whether the full charge for the service was actually paid. We also don't take into account whether a discount was applied to the patient's bill.

We come up with a different AGB for doctors charges, but we use the same look back method. An individual who is eligible for the financial assistance program will never be charged more than 44 percent of the total doctors charges.