Balance billing is a common practice that occurs when a medically insured patient receives treatment from an out-of-network healthcare provider, either intentionally or inadvertently, and subsequently is billed the difference between the insurance company’s reimbursement rate and the amount charged by the provider. Not bound by contractual, in-network rate agreements with insurers, out-of-network providers are permitted to bill patients the remaining balance for services rendered after deductibles, copayments and coinsurance obligations have been paid. In most cases, the amount charged by a provider and the insurer’s reimbursement rate are significantly different, resulting in a confusing and/or financially distressful medical bill that must be settled or resolved by the patient.

As healthcare costs in the United States continue to climb, often forcing consumers to pay higher premiums and deductibles for care, balance billing has become a controversial and confounding policy issue involving insurers, healthcare providers, consumer advocate organizations and regulators at both the state and federal levels. Balance billing most frequently occurs after patients unintentionally receive care outside their insurance network, either during emergencies or other situations when options to choose providers are restricted.

This SLC Regional Resource provides an overview of balance billing practices and actions that Southern states have taken or considered to address the prevalence of surprise medical bills. Several states in the region have passed legislation to protect patients from balance billing in specified situations, but the scope of legislation is limited due to federal restrictions.