Office of the New York State Attorney General Letitia James

HEALTH CARE BUREAU 2025

Real Solutions for New Yorkers

Each year, the Office of the New York State Attorney General Letitia James (OAG) helps thousands of New Yorkers navigate the health care system. Through its Health Care Bureau's (HCB) health care helpline staffed by a dedicated team of advocates, OAG works with New Yorkers to resolve disputes with their insurance companies, correct overbilling, and obtain medically necessary health care and medication. The complaints received by the helpline often lead to larger investigations, enforcement actions, and policy initiatives by OAG.

In 2025, OAG secured $1.53 million for health care costs in restitution and savings on behalf of New Yorkers. This report covers health care concerns New Yorkers faced in 2025, including existing and new health care issues.

For further information about the HCB, please visit ag.ny.gov/about/about-office/social-justice-division#healthcare

2025 at a glance

The Health Care Bureau's helpline makes it easy for New Yorkers to communicate their health care concerns to the Office of the New York State Attorney General (OAG). Serving as OAG's front line for health care, the helpline's team of advocates takes New Yorkers' complaints for review and resolution.

In 2025, New Yorkers filed 4,890 complaints with the helpline, requesting assistance or information about health care, and submitting other inquiries. Helpline staff handled these as follows:

» evaluated and directly handled 3,279 complaints at the advocate level

» assessed the remaining 1611 complaints, then provided the callers with information or referred them to agencies best equipped to handle the inquiries

These complaints highlight the challenges New Yorkers face and help OAG identify systemic problems in New York's health care system. In addition, these complaints often lead to further investigation and enforcement actions against health plans, providers, and other entities in the health care market.

During 2025, OAG secured $1.53 million for New Yorkers in restitution and savings. The OAG recovered and saved these funds by:

» correcting erroneous medical billing

» reversing wrongfully rejected and correcting inaccurately processed health insurance claims

» correcting companies' wrongful business practices

In addition, through the helpline, OAG helped New Yorkers obtain medically necessary care and prescriptions where health plans had denied coverage. Helpline staff also assisted consumers get back coverage when their health plans had incorrectly terminated coverage.

The main issues for which New Yorkers call the helpline are:

» incorrect billing

» health plan errors

» uncertainty about benefits

» rules to follow to obtain coverage

» appeal rights

» referral information to other agencies that deal with health care issues outside OAG's scope

While its staff cannot resolve all complaints and inquiries in consumers' favor, the helpline plays a crucial role as a source of reliable information and accessible assistance for New Yorkers.

Helpline callers' most common complaints

Complaints to the helpline fall into six general categories: provider billing, wrongful practices, claims processing, health plan denials, insurance coverage, and prescription drugs. Most of these complaints concern incorrect provider billing and wrongful practices or improper claims processing.

In 2025, most complaints to the helpline were about incorrect medical billing, including by private physician practices and hospitals. These issues typically include the following situations:

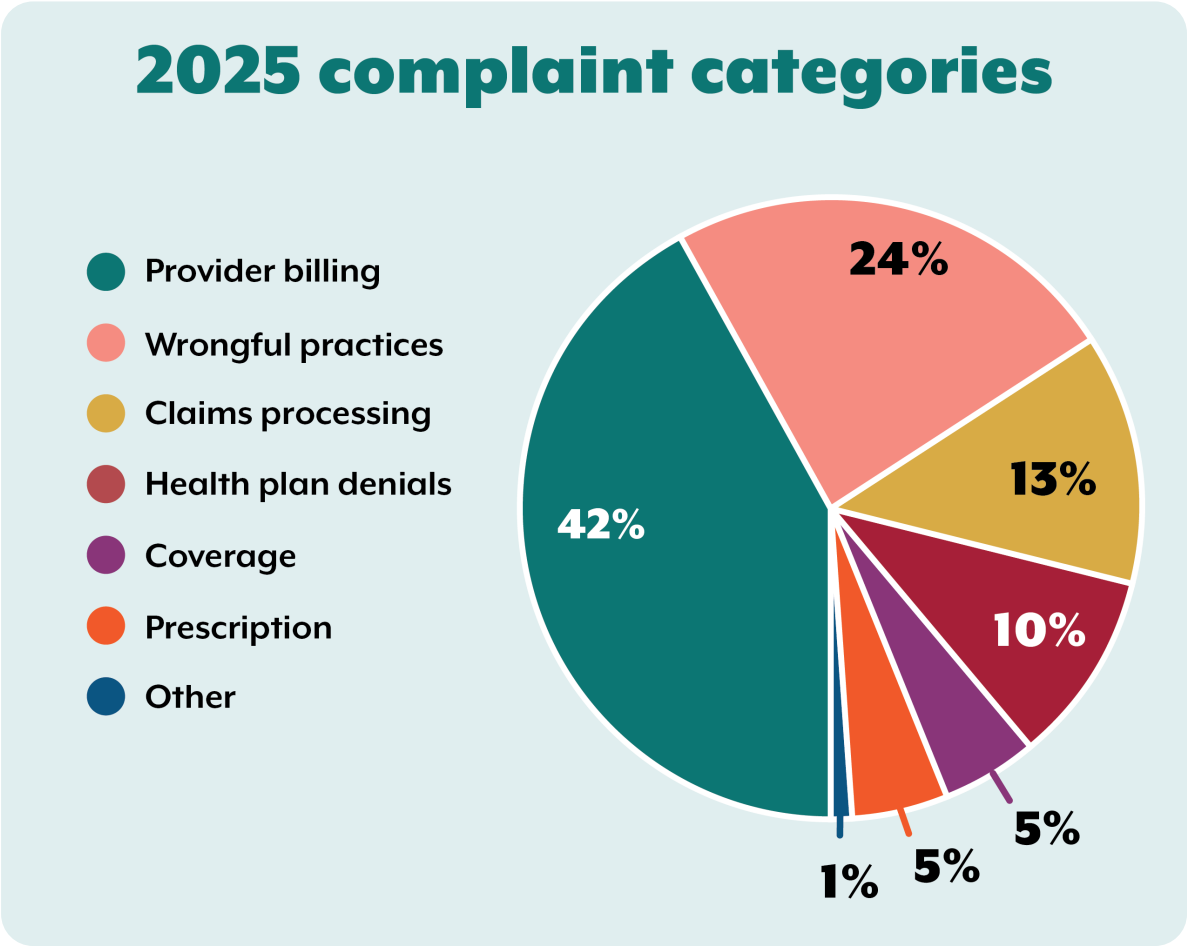
» a provider fails to submit or incorrectly submits a claim to an insurance company

» there is duplicate billing

» a patient is incorrectly balance billed

Balance billing occurs when a provider bills a patient for the difference between the amount the provider is charging and the amount the patient's health plan has paid. When a provider is in the patient's network, the provider is not allowed to balance bill the patient, except for coinsurance, copayment, and deductible: The provider agrees to accept the insurance plan's payment as payment in full. A provider who is not in the health plan's network, however, is allowed to balance-bill.

Incorrect billing has been the number-one issue raised by New Yorkers to the helpline since 2011. The following graph shows the breakdown of complaints for 2025.



How OAG has helped New Yorkers

Highlights: Helpline resolutions and OAG enforcement resolutions and actions

Here are further details on the most common issues prompting calls to the helpline, and how OAG helped resolve them in specific cases.

Provider billing practices

Erroneous provider bills are unfortunately not uncommon, can be costly, and can even lead to referrals to collection agencies or legal judgments. In 2025, 42 percent of complaints concerned provider billing practices. The following are some of the complaints the helpline received and resolved in this category:

Reducing a surprise bill for $12,183 to $150 in copayments. A former New York state resident who still had in-state residence went to an out-of-network hospital for emergency surgery and follow-up care. Her insurance paid part of the bill and indicated she owed only $150. The hospital balance-billed her for $12,183. She contacted the helpline. An OAG advocate negotiated with the insurance company, the insurer's network-pricing company, and the hospital. The parties agreed to charge the consumer only her in-network cost share. The consumer had to pay only $150.

Getting a refund for an unauthorized urgent-care charge. When a consumer visited an urgent care center, Medicare was supposed to cover the visit, but the consumer's wife paid a $30 copay by debit card. One month later, the couple discovered that the urgent care provider had taken out $1,233 from their checking account. They had almost no money left to live on. The wife stated that she was told to sign an electronic signature pad four times and could not read what she was signing. The couple did not receive any notice and did not agree to keep their card on file or have their card charged automatically. Medicare rejected the claim because it was missing information from the provider. The couple contacted the helpline. An OAG advocate requested the provider to immediately refund the money, remove the consumer's debit-card information from their system, and provide an itemized bill for any remaining balance after Medicare processed the claim. The urgent care center quickly did everything that OAG had requested.

Clearing up bills for unnecessary tests caused by a possible patient mix-up. A consumer had routine blood and urine testing before a vasectomy. He received a bill for $1,307. When he disputed the charges, the provider told him the tests were extensive and expensive because he had tested positive for E. coli. The consumer believed that the provider had confused him with another patient. He contacted the helpline. An OAG advocate asked the provider to review and waive the bill. The consumer's records showed that his tests had not detected E. coli, but the provider had written a jumbled sentence that mixed up two unrelated sentences. The provider agreed that the consumer should not have been tested for E. coil and canceled the charges.

Resolving a $6,443 bill for out-of-network anesthesiology at an in-network surgery facility. A consumer had shoulder surgery at a facility that was in her insurance plan's network. The attending anesthesiologist was not in her network. The consumer was billed for $6,443. She had never been told that her surgery at an in-network facility might include out-of-network doctors. She filed a complaint with the helpline, and an OAG advocate looked for a resolution to the problem. The consumer ultimately did not have to pay anything beyond her normal-in-network cost sharing. Not only did the insurance plan pay the additional amount that was billed to the consumer, but they charged her nothing for the date of the surgery. The consumer owed $0 on the account.

Straightening out a name error on a provider's claims. A consumer's insurance company repeatedly rejected a bill he submitted for his daughter's treatment. No matter how many times he submitted the bill, the denials kept coming. The consumer contacted the helpline. When an OAG advocate contacted the provider, the provider said that the insurance company had claimed the daughter was not on the plan. The advocate discovered that the provider had reversed the patient's name on the claims. The advocate resolved the situation and the consumer owed $0 on the account.

Stopping inappropriate facility fees for telehealth appointments. A consumer complained for their minor child, who had had five telehealth appointments with a psychologist. The provider sent the consumer a bill for $2,020, which included facility fees, even though the appointments had all been on the provider's online platform. The explanation of benefits showed the consumer owed only a $15 copayment for each date of service. An OAG advocate was told that the issue was caused by an incorrect billing code. The provider said that the problem was being fixed but continued to send incorrect bills. The advocate stopped the continuous billing. The provider admitted that the patient would not have to pay for the bills.

Canceling an inaccurate bill caused by a coding error. A consumer was billed for lab services that were part of his annual physical. His insurance company should have covered the physical and the lab services, which were preventive care. After trying to resolve the issue on his own, the consumer contacted the helpline. An OAG advocate contacted the provider and found that the lab work had been coded incorrectly. The billing department adjusted the account. The insurance company covered 100 percent of the charges for the wellness visit.

Clearing up a $5,017 bill caused by a bad estimate. Before having a planned cesarean section, a consumer paid the part of the bill that she was responsible for. Her patient responsibility was based on an estimate from the hospital performing the surgery. After the C-section, the consumer started receiving large bills for herself and her new baby. She had been told to dispute the bills if they totaled more than $400. Unable to resolve the issue on her own, she filed a complaint with the helpline. An OAG advocate contacted the hospital and found that the hospital had incorrectly estimated the costs. The hospital had accidentally left out the patient's plan's coinsurance. The hospital honored the original estimate and adjusted the labor and delivery balances to $0.

CityMd provides refunds, cancels debt, and pays a $95,000 penalty for wrongful COVID-19 billing. Many consumers complained to OAG that CityMD had billed them for COVID-19 testing. The OAG investigated the situation and found that CityMD had billed thousands of patients for testing between 2020 and 2022. CityMD sent the bills as late as two years after doing the tests. This billing violated state and federal laws that prohibited out-of-pocket charges for medically necessary testing during the COVID-19 public health emergency. Some patients had even received threats of debt collection. The OAG's investigation led to an agreement that returned nearly $6.9 million in refunds for more than 215,000 patients, and more than $7 million in debts cancellation for more than 87,000 patients. CityMD also agreed to comply with billing laws and pay $95,000 in penalties. It could pay $5,000 for each future violation.

Fidelis Care refunds consumers and cancels debt for COVID-19 testing and HIV screening that should have been free. Between 2021 and 2023, Fidelis Care incorrectly billed more than 18,000 consumers for more than 38,000 visits related to COVID-19 testing, and more than 2,100 consumers for more than 2,800 HIV screenings. The OAG investigated consumers' complaints about the incorrect billing and reached an agreement with Fidelis. Fidelis reprocessed tens of thousands of claims and paid more than $2.8 million plus interest to providers. Fidelis also canceled improper bills and refunded consumers. In addition, it updated its internal systems to prevent future errors and paid a $175,000 penalty to New York state. The company is prohibited from charging patients for these HIV screenings and from trying to collect improper charges related to COVID-19.

Wrongful practices

These complaints include improper refund processes, improper collection activity, and general inefficiencies. In 2025, about 24 percent of all helpline complaints involved a wrongful practice, which is an overall increase of five percent since 2024.

Reducing a $10,429 ambulance bill to $100. A consumer's son had to be moved from one hospital to another because of complications related to an emergency surgical procedure. He had to be transported twice by ambulance. The consumer's insurance company mistakenly stated that the consumer would not have to pay for the transport. The insurance plan's error left the consumer with a bill for $10,429. An OAG advocate investigated whether an in-network ambulance company could have been used. The advocate found that the nearest company was an hour away from the hospital, while the closest company – 10 minutes away – was out of network. The advocate requested an exception based on the risk of delaying care for the patient's situation. The insurance plan agreed not to hold the consumer responsible for both ambulance transports, and billed only $100 for copayments.

Obtaining financial assistance that was wrongfully denied to an eligible patient. A consumer had to visit the emergency room. She had no insurance at the time and was told that she could apply for financial assistance when she received the bill. She submitted her financial-assistance application when she received her bill for $6,556. The hospital claimed they did not receive it, so she sent the application again. The hospital refused to consider the application until the consumer provided proof that she had active health insurance. She tried to explain that she had no insurance and could not provide this proof. Instead, she offered to pay $100 per month toward the bill, but the hospital refused. She filed a complaint with the helpline. An OAG advocate explained to the provider that, under the Hospital Financial Assistance Law, consumers without insurance are still eligible for financial assistance. The advocate asked the hospital to process the consumer's application. The hospital reconsidered the consumer's application, approved her for a 90-percent discount, and billed her for only $355.

Dental provider failed to honor discounted price advertised after dentures were made. An 89-year-old consumer tried to use a provider's $399 coupon to order basic denture arches. She went to a location that the provider had advertised as participating in the coupon. She showed the provider the coupon and made it clear that she only wanted the basic dentures that were covered by the coupon. She bought four basic denture arches, assuming that each would cost $399, for a total of $1,596. She received a bill for $3,876. The provider had charged $969 per arch. They had not honored the $399 coupon, even though on their website they had stated the location was participating in the coupon. An OAG advocate took a screen capture of the advertisement, showing that the location was participating in the $399 coupon. The advocate sent the screen capture to the provider and requested a discount for the consumer. The provider responded in less than 48 hours, stating that the coupon code had been applied. The consumer received a refund of $2,280.

Securing a refund for wrongfully collected payment. A consumer checked in for her scheduled surgery with an in-network provider. She had gotten prior authorization and was supposed to pay $75. But the front desk attendant insisted on full payment, telling the consumer she would receive a refund after the insurance plan paid the provider. The consumer had fasted in preparation for the surgery, was in pain, and did not want to reschedule the procedure. She let her husband use his credit card to pay the full charge of about $5,500. After her surgery, the consumer asked the helpline to help her recover her husband's money. An OAG advocate contacted the consumer's health plan and asked whether its network providers were allowed to demand payment up front for scheduled, preauthorized surgery. The health plan confirmed that the providers were not allowed to bill for covered services. The consumer quickly received a refund. The OAG demanded the facility to train and educate its employees on the proper requirements for billing patients up front.

Getting an MRI for a cancer patient whose online account was incorrectly closed. A consumer was diagnosed with lymphoma and her specialist ordered an MRI. Her test was rejected. The consumer found that her online account with the insurance plan had been closed in error. She asked insurance representatives many times to reopen the account without success. An OAG advocate contacted the insurance plan. The company immediately responded that it would troubleshoot the problem. The consumer's account was restored and the test was scheduled.

Westchester Medical Center must reform policies and procedures to improve access to mental health services. The OAG investigated serious failures in emergency mental health care at three Hudson Valley hospitals. The OAG found that Westchester County Health Care Corporation and HealthAlliance Inc. (WMCHealth) had violated the federal emergency Medical Treatment and Labor Act (EMTALA) and New York health regulations. WMCHealth agreed to pay $400,000 in penalties and improve patients' access to mental health services. In addition, WMCHealth agreed to restore and maintain inpatient psychiatric beds closed during the COVID-19 pandemic and avoid closing reopened beds for three years. WMCHealth agreed to overhaul emergency-room screening, documentation, discharge-planning, and restraint policies. WMCHealth must also improve coordination with families and community providers, and implement new oversight, training, and compliance reporting. This agreement expands consumers' access to safer, more compassionate psychiatric treatment in the Hudson Valley. It is the nation's first agreement of its kind that involves an attorney general enforcing EMTALA for inadequate care for mental health crises.

Claim-processing and payment problems

These issues included health plan errors, such as a plan's failure to pay claims, processing errors, payment of incorrect amounts, and deductible or copayment errors. In 2025, 13 percent of all helpline complaints were related to claim processing or payment errors, a slight rise from the year prior.

Zeroing out a $700 bill for preventive breast-cancer screening. A consumer was incorrectly charged out-of-pocket costs for a breast ultrasound. The consumer continued to be charged, even though she had appealed to her insurance plan to overturn a denial, plus a letter from her provider supporting the ultrasound for necessary cancer screening. An OAG advocate contacted the insurance plan. The plan reprocessed the claim, charged the consumer $0 for cost sharing, and sent her a refund.

Saving more than a quarter million dollars for a disabled Social Security recipient. A disabled woman was awarded retroactive Medicare coverage as part of her disability benefits. The private health insurance plan that had covered her was supposed to cancel all payment on medical claims she had already paid since June 2023 (for Medicare Part A) and August 2024 (for Medicare Part B). The consumer tried to resolve the matter on her own without success. The bills had been sent to a collection agency and debt collectors had been chasing her nonstop. An OAG advocate sent the insurance plan a verification letter from the Social Security Administration (SSA), which the plan initially refused to honor. The advocate continued to press the plan for a resolution. The plan eventually agreed to reprocess and pay all claims. The consumer's costs for the affected service dates decreased from $262,466 to $1,297.

Clearing up incorrect coding for preventive care. A consumer was billed three years in a row by his provider for his annual wellness exam. He was charged $905, even though he should have been charged nothing. An OAG advocate found that the provider had been incorrectly using diagnostic codes for knee pain, rather than the correct codes for preventive care. The advocate asked the provider to review and reprocess the claims. The consumer's $905 bill was canceled.

Getting a $10,629 reimbursement for prepaid gender-affirming care. A consumer paid in advance for a surgical procedure and submitted a claim to their insurance plan. The consumer believed the surgical provider was in their network, but received only partial reimbursement. They contacted the helpline for assistance. An OAG advocate explained to the insurance plan that the consumer believed that the provider was in their network, and that the explanation of benefits seemed to support this belief. The insurance plan responded that it had processed the claim as out-of-network because the provider's group record was not listed as a network provider. The plan reprocessed the claim and paid the consumer $10,629, which included $9,000 in reimbursements to the provider.

Health plan denials of coverage for care

Denials of coverage most often occur when an insurance company decides that recommended care is not medically necessary, even though a physician determined that the care is needed. These complaints often represent some of the most important and challenging issues the helpline handles. In 2025, approximately 10 percent of all helpline complaints involved health plan denials of coverage, one percent higher than in 2024.

Getting approval for a lifesaving double-lung transplant after insurance denied coverage. An OAG advocate helped get essential coverage for a lifesaving procedure for a consumer in a life-or-death situation. The consumer, who had Stage 4 lung cancer and pulmonary fibrosis, was told by his doctors that he could expect to live for only one to three years. A hospital approved him for a clinical trial involving a double-lung transplant. His insurance plan would not authorize the procedure. To provide preauthorization, the plan required the consumer to show that he was cancer free for five years. Given only a short time left to live, the consumer could not meet the plan's criteria. His wife contacted the helpline. An OAG advocate contacted the insurance plan, pointing out several flaws in its decision-making procedure. For one thing, the insurance company had failed to consider whether the patient would die without a transplant, which it was required to do. In addition, the company responded that it had not known that the transplant request was for a clinical trial. The plan then approved the consumer's request for coverage.

Negotiating a difficult situation to save a consumer $6,450 for a home birth. An insurance company refused in-network coverage for a consumer's home birth. The consumer had tried unsuccessfully to find an in-network midwife before the child's birth. The insurance company confirmed that there were no covered providers in the area. An OAG advocate requested an exception for the consumer since they had no in-network options. The consumer was unfortunately in a self-funded plan, which would not normally cover the exception. The advocate continued to negotiate with the plan's sales team. The plan agreed to a one-time exception that saved the consumer $6,450.

Saving a consumer charged $15,000 for being in an accident that never happened. A consumer received a $15,000 MRI bill that his insurance plan refused to cover. The plan had denied coverage because it believed the service was related to an earlier accident. The consumer confirmed that his symptoms were not related to any accidents. The MRI was instead for chronic neck pain with an unknown cause. The provider had coded the service with a general code for cervical neck pain, not for accident-related services. An OAG advocate worked with the plan to clear up the error. The plan reprocessed the claim to make full payments to the provider and leave the consumer owing $0.

Disputing denied coverage for a preauthorized $33,708 surgery. A consumer's child needed complex foot surgery. The family found a qualified surgeon who contracted with their insurance plan, but operated only in an out-of-network facility. Before the procedure, the consumer made a special request for insurance coverage for the surgery at the specific facility. The insurance plan approved the coverage. The consumer's child then had the preapproved surgery, but the plan denied coverage afterward. An OAG advocate argued to the insurance company that the consumer had relied on the plan's initial authorization and should not be charged. The advocate requested several times that the company honor the authorization. The insurance company finally agreed to cover the services. The consumer owed $0.

Resolving an unfair $79,721 surprise bill for mental health care. A consumer asked her insurance plan to help her find in-network providers of residential mental health treatment for her son. The plan's directory did not list any in-network residential providers. The plan offered two in-network providers, but one was not a good fit and the other did not treat the patient's condition. The consumer found an out-of-network residential facility that agreed to treat her son. He was admitted to the facility. At first, the plan reimbursed the consumer at the out-of-network rate. But then the plan claimed that it had overpaid the charges and billed the consumer. An OAG advocate raised concerns about whether the plan was satisfying state adequacy requirements (ability to deliver promised benefits) and federal No Surprises Act requirements. The advocate further questioned the plan about the following items: its reimbursement-rate changes, inadequate network, directory inaccuracies, unhelpful or inaccurate responses to the consumer's request for -in-network options, inaccuracies in its records of the child's previous treatment, and potential violations of earlier settlement agreements with OAG. The health plan finally agreed to reprocess the covered dates of service at the cost-sharing rate for in-network service, plus interest.

Getting fertility claims reprocessed to save a consumer $9,041. A consumer receiving in-vitro fertility (IVF) treatment understood that her plan would cover three egg retrievals and three embryo transfers. She had already exhausted the three cycles before having the third egg retrieval. An OAG advocate asked the plan to review the consumer's situation and consider additional coverage. During the review, the plan found a separate item that had been incorrectly denied. The claim was reprocessed and the plan paid $9,041 that it had originally billed the consumer.

Obtaining and keeping coverage

In 2025, five percent of helpline complaints were about obtaining and keeping coverage. Of these, 30 percent were due to health plan error and 13 percent were caused by employer error.

Recovering premiums a consumer paid for a fake plan. A consumer shopped for health insurance on the internet because she believed she qualified for Medicaid. She clicked on a link that claimed to offer New York state health insurance plans. She talked to an "insurance broker" who told her that she did not qualify for Medicaid and offered a plan that he said would meet her needs. The consumer paid $4,287 in premiums for one year of coverage. She tried to use the "plan" at a pharmacy and found that it did not cover prescriptions. She then learned that she actually qualified for Medicaid and tried to cancel the "plan" and get a refund. She tried many times to cancel over the phone, and her call was either put on hold for hours and finally disconnected, or she was told that she could not cancel. The consumer also tried unsuccessfully to cancel by email. An OAG advocate was able to cancel the plan and secure a refund for the entire $4,287.

Getting a consumer retroactive coverage for a $4,971 bill. A consumer was a covered dependent under his mother's plan. When his mother ended her membership to enroll in another plan, the consumer contacted the first insurer to ask if he could pay to keep his coverage. He said he did not hear back from the insurer and was removed from the plan. He enrolled in another plan with the same insurer, but had a one-month gap in coverage in between plans. He received a $4,971 bill from his provider during that gap. An OAG advocate contacted the insurance company and explained that the consumer had tried to keep his membership active, but had not received a response to his questions. The insurance plan gave the consumer retroactive coverage for the gap month and paid the entire $4,971 bill.

Securing $1,500 for a consumer whose plan ignored her cancellation request. A consumer was paying for extra dental coverage. When her insurance refused to cover an emergency bone graft, she called the plan to cancel her membership. The insurer canceled her coverage but continued to bill her for two more months. Six months after the cancellation, the insurer re-enrolled the consumer without her knowledge. An OAG advocate asked the insurance plan to cancel the membership, stop billing the consumer, and review the denied claim for an emergency bone graft. The plan paid the claim and the dentist refunded the consumer $1,500 she had already paid.

Access to prescription drugs

These complaints included issues with formularies (lists of covered prescription drugs), problems with mail-order drugs (including delays and non-deliveries), and denials of preauthorization for high-cost specialty drugs. In 2025, these complaints represented about five percent of all cases handled by the helpline.

Winning approval for a brand-name drug that plan dropped from its formulary. A consumer's minor child had been taking a brand-name drug for more than four years. The consumer's insurance plan then dropped the drug when it updated its formulary. The plan told the consumer that her child would have to try all generic forms of the drug before the insurance would consider covering the brand-name drug. The consumer was afraid that her child might suffer bad side effects from the generic drugs. She contacted the helpline. An OAG advocate informed the insurer that the Food & Drug Administration (FDA) had only recently approved the generic drug and had not approved it for pediatric use. The insurer quickly approved coverage for the brand name drug's use.

Helping a consumer regain approval for the weight-loss drug he needed. A consumer received his insurance plan's approval for coverage of a GLP-1 weight-loss drug. At the time, the consumer was unable to get the approved medication because of a national shortage. The FDA had temporarily approved another drug to replace the approved medication during the shortage. When the FDA's temporary approval ended, the consumer requested his insurance plan to once again approve coverage for the original drug. The plan denied his application for coverage and explained that he was participating in a weight-loss program that the plan had not approved. The consumer switched to a program that the plan recommended, but was denied drug coverage because his body mass index (BMI) was too low. He contacted the helpline. An OAG advocate requested the plan to overturn its denial, noting that it had previously approved coverage of the medication. The advocate added that the consumer had tried to comply with the plan's requirements by joining an approved weight-loss program. In addition, the advocate explained, the consumer had lowered his BMI by using the medication that he could no longer get because the FDA no longer approved it. The insurance plan then covered the approved drug.

Reminding a plan of its promise to cover a drug for gender-affirming care. An insurer denied coverage for an adult patient's testosterone prescription. The denial letter claimed that the plan did not cover the medication for a diagnosis of gender dysphoria. An OAG advocate visited the plan's website and found coverage and policy documents that stated that the plan would cover the medication for gender dysphoria if the patient met certain criteria for medical necessity. The advocate asked the plan to consider whether it had made an error in denying the claim, and asked the plan to clarify which criteria had not been met. The insurer approved the claim without explaining why it had been denied.

About OAG's Health Care Bureau

The Health Care Bureau (HCB) is part of the Social Justice Division in the Office of the New York State Attorney General. HCB's principal mandate is to protect and advocate for the rights of health care consumers statewide through:

Health care helpline. Our helpline serves as a direct line between consumers and OAG. The helpline is staffed by intake specialists and advocates trained to assist New York health care consumers to protect consumers' rights in the health care system. Assistance ranges from providing helpful information and referrals to investigating individual complaints and mediating of disputes.

You can receive helpline assistance by:

Submitting a complaint online

ag.ny.gov/file-complaint/health-care

Calling HCB's toll-free helpline

1-800-428-9071

Investigations and enforcement actions. HCB investigates and litigates against, health plans, health care providers, and other individuals and business entities that engage in fraudulent, misleading, deceptive, or illegal practices in the health care market. HCB also works on tobacco compliance and enforcement, including monitoring compliance with, and enforcement of, the Tobacco Master Settlement Agreement.

Consumer education. Through outreach and dissemination of information andmaterials, HCB keeps New Yorkers informed of their rights under state and federal health and consumer-protection laws.

Legislation and policy initiatives. HCB promotes legislative and policy initiatives to enhance consumer rights, well-being, and ability to access high-quality and affordable health care in New York state.

Conclusion

We at HCB, through our team of knowledgeable and dedicated advocates, attorneys, and support staff, remained active in 2025, working to protect the rights of health care consumers in New York and helping consumers navigate the complicated system of health care.

We encourage New Yorkers to contact the helpline if they need help with sorting out confusing medical bills, insurance claim denials, or fraudulent practices. Our advocates work to resolve consumers' problems when possible. If we find no error or violation, we help consumers understand the health care system. We value consumer complaints, which lead to many of OAG's investigations in the health care realm.

We thank the individuals who brought important matters to our attention in 2025. We look forward in 2026 to bringing our skills and energy to champion the rights of consumers and enforce the laws and regulations governing the health care industry to ensure that health care consumers can access quality, affordable care in New York state.