State of New York
Office of the Attorney General
Division of Social Justice

HEALTH CARE BUREAU

Real Solutions for New Yorkers: 2013

Prepared by
The Health Care Bureau

Lisa Landau
Bureau Chief

March 2014

OFFICE OF THE NEW YORK STATE ATTORNEY GENERAL
SOCIAL JUSTICE DIVISION
HEALTH CARE BUREAU STAFF

Bureau Chief
Lisa Landau

Helpline Advocates
Chris D'Ippolito, Helpline Manager
Jacquelyn Heffner
Jennifer Longergan
Peter Panych
John Rice
Erin Signer

HCB Staff/Helpline Intake
Alex Bockstein
Bela Changrani
Fazia Khan
Margaret Lubitz
Peter Mark Nelson

Assistant Attorneys General
Dorothea Caldwell-Brown
Brant Campbell
Elizabeth R. Chesler
Carol Hunt
Michael Reisman

Health Care Helpline
Phone: 1-800-428-9071

New York Office
Mailing address: 120 Broadway, 26th Floor, New York, NY 10271-0334

Albany Office
Mailing address: The Capitol, Albany, NY 12224-0341

This report was prepared by Elizabeth Chesler, Assistant Attorney General, Health Care Bureau, with the invaluable assistance of Bela Changrani, Legal Assistant.

This report briefly describes the work of the Attorney General's Health Care Bureau ("HCB") in the period of January 1, 2013 through December 31, 2013. For further information about the HCB, including press releases on our most recent work, consumer information materials, and reports, please visit http://www.ag.ny.gov/bureau/health-care-bureau.

THE HEALTH CARE BUREAU

The Health Care Bureau is housed within the Social Justice Division[1] in the New York State Office of the Attorney General. The Health Care Bureau's principal mandate is to protect and advocate for the rights of health care consumers statewide through:

○ **Operation of the Health Care Bureau Helpline**. This toll-free telephone hotline (800-428-9071) provides assistance to New Yorkers by providing helpful information and referrals, investigating individual complaints, and mediating resolutions to help protect consumers' rights that relate to health care.

○ **Investigations and enforcement actions.** The HCB conducts investigations and litigation against health plans, health care providers, and other individuals and entities that engage in fraudulent, misleading, deceptive or illegal practices in the health care market.

○ **Consumer education.** Through outreach and dissemination of information and materials, the HCB seeks to inform New Yorkers about their rights under state and federal health, insurance and consumer protection laws.

○ **Legislation and policy initiatives.** The HCB promotes legislative and policy initiatives to enhance the rights and well-being of consumers and their ability to access high-quality and affordable health care in New York State.

THE HEALTH CARE BUREAU'S HELPLINE

The HCB's Helpline is the Attorney General's front line for consumers to raise, and for HCB advocates to resolve, complaints regarding health care.

Between January 1, 2013 and December 31, 2013, the Health Care Bureau's Helpline handled 5,788 cases. Of these cases, HCB Helpline staff investigated and resolved 3,221 consumer complaints and provided another 2,567 consumers with requested information or referred them to an appropriate agency to handle the inquiry. The complaints handled by the Helpline highlight the challenges faced by New York health care consumers, and the resulting data helps to identify trends and systemic problems in New York's health care system that then may form the basis of investigation and enforcement actions. Such investigations and enforcement actions are undertaken with the objective of protecting consumers' health care rights by providing affirmative, systemic relief to solve the problem

[1] In addition to Health Care, the Social Justice Division includes the following bureaus: Civil Rights, Labor, Environmental Protection, Charities, and Tobacco Compliance, each of which enforce the relevant laws to protect consumers in New York.

and by obtaining appropriate monetary refunds (known as "restitution") for affected consumers.

HEALTH CARE BUREAU DATA - INDINGS: January 1, 2013 - December 31, 2013

A review of the Health Care Bureau's complaint data over this one-year period shows the following:

- The greatest single issue that prompts New Yorkers to contact the HCB Helpline (31% of all handled, non-referred complaints) is "provider billing." The majority of these complaints (56.6%) relate to improper provider billing practices, such as the improper balance billing of patients and providers' failure to submit claims to insurance companies.

- The other most common issues prompting New Yorkers to contact the HCB Helpline include: claims processing and payment problems, such as "health plan error" (19%); health plans' denials of care or coverage, such as denials based on the treatment not being "medically necessary" (14.9%); wrongful practices (12%); problems obtaining and keeping health insurance coverage (9%); and problems accessing prescription medications (7.6%).

- Many consumers who call the Helpline are confused about their benefits, the rules to follow to secure coverage for care, doctor or hospital charges, appeal rights, or where to get help with some other aspect of health care. While not all consumer complaints and inquiries can be resolved by the HCB Helpline in the consumer's favor (*e.g.*, where the consumer is frustrated with a valid denial of care, a legitimate bill, or the inherent imperfections of the health care system), the HCB Helpline plays a crucial role as a source of reliable and objective information for health care consumers.

In a one-year period between January 1, 2013 and December 31, 2013, the HCB Helpline secured $4 million in restitution for consumers across New York State, and helped many New York individuals and families obtain medically necessary care that was previously being denied.

CONSUMER COMPLAINTS AND HEALTH CARE BUREAU ENFORCEMENT ACTIONS:

What follows is a more detailed description of issues raised by consumers, and specific and notable examples of resolutions achieved by the Helpline advocates as well as by Health Care Bureau enforcement actions.

(1) Provider billing practices

A significant number of complaints — 31% — raised issues relating to provider billing practices. Although state regulations and many participating provider health insurance contracts *prohibit* providers from balance-billing consumers, some providers nonetheless improperly bill consumers and subject them to collection actions. Typical complaints related to provider billing include:

- That consumers are being billed by an out-of-network provider who participated in the consumer's care — often to the surprise of the consumer who either received services in the emergency room by an out-of-network provider, or in the context of a planned hospital procedure, did not know that the provider was part of the medical team providing services (e.g., out-of-network anesthesiologists or radiologists providing care at an in-network hospital).

- That the provider failed to submit the claim to the insurance company.

- That consumers are being improperly "balance-billed" by in-network providers who have agreed to accept the contracted payment from the insurance company and not bill the patient for any remaining balance.

Helpline Resolutions

- **Surprise Bill for Out-of-Network Physician Assistant:** A consumer underwent an outpatient biopsy procedure at a hospital after ensuring that both the hospital and the surgeon were in-network with her HMO. During the procedure, and while the consumer was unconscious, the medical team brought a physician assistant ("PA") to assist. The provider submitted a claim to the HMO for the PA's services, but the HMO denied the claim and requested that the provider submit additional information. Instead of resubmitting the claim with the requested information, the provider instead improperly billed the consumer over $2,000. With the advocate's assistance, the provider agreed that the consumer was not responsible for those charges, issued a zero balance statement, and handled the claim directly with the HMO.

- **Surprise Bill by Out-of-Network Laboratory:** A consumer contacted the Helpline for assistance after receiving a laboratory bill for approximately $300. The consumer had an appointment with her in-network physician, who ordered blood work and, without discussing it with her, sent the blood work to a laboratory that did not participate in her health insurance plan. The plan denied the claim, and the consumer could not afford to pay this unexpected bill. The advocate reached out to the plan and argued that the consumer should be held harmless, and that the charges should be handled between the laboratory and provider. The plan reversed its decision and paid the claim.

- **Billing for Services Not Provided:** A consumer called the Helpline after he and his insurance company were billed for a surgery that was never performed. The consumer had gone to the hospital for hernia surgery, but the surgery was cancelled at the last minute because the doctors felt it was unsafe given the consumer's medical condition when he presented for surgery. Notwithstanding the clear cancellation, the provider submitted claims to the consumer's insurance company as if the entire procedure had been performed. The consumer contacted the Helpline after he could not get answers from his provider regarding these charges. The HCB advocate contacted the provider and succeeded in having the provider acknowledge there was a billing error and adjust the claim. Moreover, the provider agreed to review all suspended surgeries for the previous ten months to ensure they were processed correctly.

(2) Claims processing and payment problems

Nearly 19% of all HCB consumer complaints arose from mistakes made by health plans in preparing, processing, or paying claims. Nearly 42% of these complaints involved errors by the health plans, including failure to process or pay the claims, paying the incorrect amount, or making errors regarding deductibles and/or copayments. Common complaints relating to health plans' claims and payment processes include:

- That health plans did not process claims at all or did not process them in a timely manner.

- That health plans were not clear about out-of-network coverage/reimbursement such that consumers did not understand their out-of-pocket liability for seeing an out-of-network provider.

Helpline Resolutions

- **Inaccurate Information Regarding Out-Of-Network Benefits:** A consumer contacted the Helpline with a complaint regarding her plan's coverage for breast reconstruction surgery following a mastectomy. The consumer had called her insurance company to better understand her out-of-network benefits, including whether her claims for seeing out-of-network providers would be paid at a percentage of the usual and customary rate ("UCR"), or at a percentage of the Medicare rate. The consumer knew that that the latter — a percentage of the Medicare rate — would result in lower reimbursement by the plan to her provider and that she would face greater out-of-pocket costs. The plan's representative repeatedly told the consumer that her claims would be paid based on the UCR. Relying on this representation, the consumer underwent breast reconstruction surgery by the out-of-network providers of her choice. However, contrary to its representation, the plan processed the claim at the lesser Medicare-based rate, leaving the consumer with a balance that was tens of thousands of dollars over what she expected to pay. The plan refused to reprocess the claims and honor its employee's representations to the consumer. With the assistance of the HCB advocate, the plan acknowledged that its representative gave the consumer inaccurate information about her financial liability for out-of-network benefits and agreed to reprocess the claims as a percentage of UCR.

- **Undue Delay in Processing Claims:** A consumer contacted the Helpline for assistance with obtaining reimbursement for her cancer treatments. The consumer submitted claims for cancer treatment to her health plan, and the plan responded by requesting unrelated medical records. A representative for the health plan acknowledged that those records were irrelevant to her claims related to cancer treatment and outlined the documents that the plan would need to process her claim. After several months, the consumer's claims for cancer treatment had still not been processed. She contacted the HCB, and with the advocate's assistance, the plan investigated this consumer's claim. The very next day, the plan advised the advocate that the consumer's claims would be paid and she would soon receive a check for over $5,000.

(3) Denials of care or coverage

Approximately 15% of all HCB consumer complaints involved health plan denials of care or coverage for care. In most of the cases brought to the HCB's attention, the health plan denied the claim asserting that the care was not "medically necessary" (50.3%) or was not a covered benefit (26.3%). In approximately 18% of these complaints, the denials were due to errors by the health plans, including such administrative errors as improperly processing codes, incorrectly denying claims as being untimely filed, and incorrectly denying claims for failure to obtain a necessary referral or preauthorization (when such referrals and preauthorizations were obtained). Many complaints related to improper denials of mental health benefits.

Helpline Resolutions

- **Improper Denial of Air Ambulance Services Based on Medical Necessity Grounds**: A consumer requested assistance with his health plan's denial of coverage for air ambulance transport services provided to his teenage son. The consumer's son experienced a serious fall, and first responders called for an air ambulance to take him to a hospital for care. The health plan nonetheless denied the claim on the grounds that air transport was not medically necessary. The HCB advocate filed a written inquiry with the health plan, including requesting copies of the medical criteria relied upon in reaching the decision that air transport was not medically necessary. With the advocate's assistance, the denial was overturned and the air transport claim for over $10,000 was paid by the plan.

- **Coverage Denial of Breast Reconstructive Surgery:** A consumer who underwent a mastectomy after being diagnosed with aggressive breast cancer called the Helpline because her insurance plan would not pay for her initial breast reconstruction surgery and would not authorize the necessary second stage reconstructive surgery. Prior to undergoing the mastectomy, the plan gave the consumer the name of three participating doctors in her area that they claimed could perform the reconstructive work. However, when the consumer contacted the three doctors, they all denied being able to perform the procedure, and one even denied participating in the plan. The consumer appealed for authorization to be treated with the out-of-network surgeon she had selected and who was willing to accept the participating physician rate. The plan refused to cover the claim for the initial surgery or provide the necessary authorization for the second surgery. Once the consumer contacted the HCB for assistance, the advocate filed an urgent inquiry with the plan. With the HCB advocate's assistance, the plan agreed to cover the initial surgery charges of approximately $25,000 and authorized the second surgery at the participating provider rate.

- **Coverage Denial of Substance Abuse Treatment:** A woman contacted the Helpline on behalf of her son, who was seeking treatment for substance abuse. He had tried, unsuccessfully, treatment through outpatient rehabilitation services, and was now in need of treatment at a residential facility. However, his health insurance plan denied the request for pre-approval of inpatient substance abuse treatment on the grounds that it was not medically necessary. The consumer and his family contacted the HCB Helpline for assistance with their appeal. With the advocate's assistance, an appeal

and supporting documents were submitted that established the medical necessity of inpatient treatment based on the plan's criteria. The health plan reversed its initial denial, and the consumer was able to receive treatment at an inpatient facility.

(4) Wrongful practices

Some 12% of consumer complaints brought to the attention of the Helpline were due to wrongful business practices or inadequate provision of services. Half of the consumer complaints (50%) related to wrongful business practices, such as false advertising, inaccurate representations by providers about insurance coverage, and predatory lending/health care financing. Another 47% of the consumer complaints related to the quality of care received from health care providers.

Enforcement Actions[2]

- **High-Pressure Tactics In Health Credit Card Sales:** In June 2013, GE Capital Retail Bank (GE) and CareCredit LLC, its subsidiary, signed an Assurance of Discontinuance[3] ("AOD") that requires significant new protections for consumers who use CareCredit, a health care credit card that could carry an interest rate of over 26%. The HCB received many complaints related to the use of CareCredit, including that consumers felt rushed or pressured into financing expensive treatment plans through CareCredit, that providers were not informing them of the basic terms of the card (such as the 26.99% interest rate), that they were charged for care they had not yet received, and that they did not even understand they were signing up for a credit card. The AOD with CareCredit requires a "cooling-off" period to give consumers an opportunity to consider the card's terms and the treatment plan, a limit to what the provider can charge in advance, and transparency requirements to make consumers aware of high interest rates if the charge is not paid off at the end of the promotional period. In addition to imposing reforms that will ensure consumers are able to make fully informed decisions before taking on medical debt, the AOD sets forth an appeals process that may result in refunds or credits of up to $2 million to approximately 2,300 consumers whose complaints to GE or CareCredit were initially rejected.

- **Scam Promising to Find Living Kidney Donors:** Michael T. Goldstein, the founder, owner and Chief Executive Officer of Nephrologica, was falsely promising that his company could find living kidney donors for a fee. Nephrologica was paid by consumers to find kidney donors, but it never provided those consumers with donors. Further, to lend his company credibility, he posted fake testimonials promoting his services. He also offered financial rewards to potential kidney donors in violation of state and federal law. Goldstein and Nephrologica signed an AOD requiring them to provide complete refunds to victims, shutting down Nephrologica,

[2] "Enforcement Action" refers to action — including investigation, litigation, and resolution — taken by Health Care Bureau assistant attorneys general to address a violation of law.

[3] An Assurance of Discontinuance is a settlement document that the Attorney General may accept in exchange for "discontinuing" an ongoing investigation instead of filing a civil lawsuit in any case for which a person or entity has engaged in acts or practices that are in violation of the law.

and imposing a six-year prohibition on Goldstein conducting or operating any business in New York that provides direct services, including assistance in locating kidney donors, to persons with health conditions.

Helpline Resolution

- **Inaccurate Provider Representations About Insurance Coverage:** A consumer contacted the Helpline because she paid approximately $10,000 for a variety of diagnostic tests to be performed by an out-of-network provider as part of a comprehensive medical exam. The consumer paid the full amount up-front based on the provider's representations that all or most of the charges would be covered by her insurance plan. However, when the consumer received her Explanation of Benefits, she saw that the plan had largely denied the claims, and she would be responsible for nearly the entire $10,000. With the advocate's assistance, she was able to obtain a partial refund from the provider.

(5) Getting and keeping coverage

Nine percent of consumer complaints to the Helpline involved problems consumers experienced in obtaining or in keeping health care coverage. Almost a quarter of these complaints (24%) were due to employer error, while approximately 17% were due to errors by the health plan. In many instances, consumers complained of employers terminating coverage without informing employees, neglecting to pay premiums (even when employees have paid their share), or refusing to allow employees to continue coverage as required by state and federal law.

Helpline Resolutions

- **Employer Refusal to Recognize Spouse as Dependent:** A consumer contacted the Helpline with an urgent request after finding out that her employer was about to terminate her husband's coverage as a dependent under her plan. While she provided her employer with their marriage certificate, the employer requested additional documentation that could establish proof of marriage, none of which she was able to provide. The employer terminated the husband's coverage because it felt inadequate proof of marriage was submitted. The advocate reached out to the employer to discuss what other proof of marriage the employee could provide to satisfy them that she was legally married. With the advocate's assistance, the consumer was able to reach an agreement with the employer, and her husband's coverage was reinstated.

- **Plan's Failure to Extend Coverage Through Age 29:** A consumer contacted the Helpline on behalf of his daughter, who was seeking assistance with a coverage dispute regarding admittance to an out-of-state substance abuse residential treatment facility. The health plan terminated the daughter's coverage when she turned 26, but did not notify the policyholder until approximately four months later and never sent the required notification that the daughter could remain covered through age 29 pursuant to New York State law. Through the HCB's intervention, the plan reinstated the daughter, approved payment for services rendered by the treatment facility, and reimbursed the family for their out-of-pocket expenses.

- **Plan Failure to Process Premium Payments:** A consumer contacted the Helpline because his health insurance company would not acknowledge that he had paid his quarterly premium for his individual health plan and had terminated his coverage. This consumer timely paid his quarterly premium online, but later received a notice that his premium payment was past due and that his coverage was terminated. He tried contacting the health insurance company several times to establish proof of payment and to confirm his continuing coverage, but was unsuccessful. The advocate was able to determine that the consumer's payment was not credited because of the insurance company's technical problems, as well as well as a failure of communication between different departments within the insurance company. The insurer confirmed the consumer was covered under the plan and that he (along with all other erroneously terminated individuals) were reinstated without a break in coverage.

Enforcement Actions

- **New York Age 29 Law**: The HCB conducted an investigation into Emblem's compliance with New York's Age 29 Law, which requires health insurers to offer continuation health coverage to dependents of plan members until the dependents turn 30 years old. The investigation showed that Emblem failed to send statutorily required letters to more than 8,000 Emblem members between 2010 and 2012. Of these members, almost 1,000 were not even notified that they had been terminated from coverage. Emblem subsequently denied approximately 175 claims of 105 members who did not receive proper Age 29 notification, totaling more than $90,000 of unreimbursed medical treatment. In January 2014, we executed an AOD with Emblem, in which it agreed to: (i) send letters to affected members offering to reinstate coverage; (ii) re-process and pay all unpaid claims (anticipated to be in the range of $90,000) of members who did not receive proper Age 29 notification and, as a result, had claims denied due to lack of coverage; (iii) submit to monitoring and an independent audit; and (iv) pay $100,000 in penalties.

(6) Access to prescription drugs

7.6% of HCB consumer complaints concerned accessing prescription medications. These complaints included problems with the formularies and various difficulties associated with high-cost specialty drugs, including mandatory mail-order requirements and denials of preauthorization. Such complaints include:

- Denial of coverage or higher copayments for prescribed drugs that are not on the insurance plan's formulary or which are on a higher tier (and therefore have a higher copayment); assistance is often provided in obtaining pre-authorizations for the medications or with filing appeals of adverse determinations.

- Health plans increasingly requiring that "specialty" medications be obtained through mail-order pharmacies instead of retail pharmacies, which poses considerable difficulties for individuals who frequently travel, have privacy concerns, do not have a secure place to receive the package when not home, or do not live in a place with reliable, timely mail service.

HCB Action

- In response to dozens of complaints relating to mail-order and non-retail pharmacy requirements in health plans, the OAG sent letters to 15 New York-based health insurance plans in June 2013 urging them to change their policies to permit certain members to purchase specialty drug prescriptions at retail pharmacies instead of through mandatory mail-order services. The letters urged the 15 companies to adopt "Specialty Prescription Drug Fulfillment Hardship Exception Criteria" similar to the policy that the OAG negotiated earlier in the year with Empire BlueCross BlueShield. The OAG has since worked with the plans to develop hardship criteria that allow consumers to access needed medications without delays and undue privacy and security concerns. As of the end of 2013, seven insurance companies adopted a hardship exception policy allowing certain members to obtain their drugs at their neighborhood pharmacy.

Helpline Resolutions

- **Mail-Order Pharmacy Requirement for Specialty Drugs:** A consumer contacted the Helpline for assistance addressing the difficulties he experienced as a result of his health insurance plan requiring that he obtain his HIV medications through mail order. The consumer frequently travels, has no doorman in his building, and has experienced delays receiving his medication from the mail-order pharmacy. As a result, the consumer was greatly inconvenienced by being forced to wait at home for his medication to be delivered, and when he was away or experienced delays in delivery, he went days without taking his medication, placing his health in serious risk. He appealed the mail order requirement, but the plan denied his appeal. With the advocate's assistance, he was able to obtain a hardship exception that allowed him to obtain 3-month supplies of his medications through the mail-order pharmacy, rather than the 1-month previously permitted, and further allowed him to obtain 1-month supplies through his local pharmacy.

- **Pre-Authorization Requirements:** A consumer called the Helpline because her health plan was denying her generic cholesterol drug, and she was in immediate need of the medication. The advocate contacted the plan and was able to determine that the drug was denied because the prior authorization had expired. With the advocate's intervention, immediate authorization was obtained and, going forward, the plan will not require any further authorizations since this was a maintenance medication.

- **Denial of "Experimental" Chemotherapy Drugs:** The Helpline received an urgent call from a nurse who worked at a hospital that was treating a patient with a rare form of cancer. The patient's insurance plan denied coverage of a new chemotherapy drug that was being used to treat the patient on the grounds that the drug was experimental and not approved for this type of cancer. The hospital appealed and provided documents detailing the efficacy of this treatment. The appeal was denied by the health plan that same day with a boilerplate denial letter. The advocate filed an inquiry with the plan, and succeeded in having the Medical Director review the documentation submitted by the provider. The plan then reversed its denial and approved coverage of the drug.

(7) Compliance with the Affordable Care Act's consumer protection provisions

The HCB Helpline has also received complaints from consumers who are concerned that their health plans are not implementing the protections afforded to consumers under the Affordable Care Act, such as mandatory coverage of certain preventive care services at no cost to the consumer. This entitles consumers to free preventive services and screenings, including blood pressure and cholesterol tests, mammograms, colonoscopies, and vaccines.

Helpline Resolutions

- **Coverage for Preventive Colonoscopies Without Patient Cost-Sharing:** A consumer contacted the HCB Helpline because she received a routine colonoscopy due to her family history of colon cancer, but her plan covered the colonoscopy as a diagnostic procedure, and therefore she was assessed cost sharing. The health plan said the doctor did not correctly code the claim as a preventive procedure, and therefore the plan considered it diagnostic. The HCB advocate explained that a routine colonoscopy is still preventive in nature even if the patient has a family history of colon cancer. Therefore, cost-sharing remains inappropriate. In addition to resolving this individual complaint, the Health Care Bureau further succeeded in having the plan recognize that preventive screenings required for this high risk population must be covered without cost-sharing. The plan changed its coding configurations accordingly so it will pay these claims without cost-sharing.

- **Provider Improperly Collecting Co-payments for Preventive Services:** A consumer contacted the HCB Helpline after her provider charged a co-payment upfront for a scheduled preventive service, and then reimbursed her after learning that the consumer was covered by a plan subject to the Affordable Care Act. A HCB advocate advised the provider that charging patients co-payments defeats the intent of the ACA, even if the patient is later reimbursed. The provider ultimately agreed to modify its operations. It no longer collects co-payments from patients, and it only bills patients upon learning that they do in fact have cost-sharing obligations.

- **Plan Providing Incorrect Information Regarding Coverage of Breast Pumps:** A consumer contacted the HCB's Helpline after receiving a bill from a durable medical equipment ("DME") supplier. A plan representative told the consumer that the plan would cover breast pumps under the ACA and to call the DME supplier. The plan, however, later denied the claim because the consumer's plan was a grandfathered plan not covered by the ACA. After further investigation, the plan was able to identify the call where the consumer was erroneously advised. Due to the incorrect information that was given to her, the plan reprocessed her claim and paid it in full.

Conclusion

The Health Care Bureau's Helpline is an invaluable resource for health care consumers in New York State. As these examples demonstrate, our advocates ensure that consumers understand their rights within the health care system and work to protect those

rights across the broad range of issues highlighted in this report. Additionally, the Health Care Bureau analyzes these complaints to identify systemic health care problems, and then takes appropriate affirmative steps to address these systemic problems, including initiating investigations of fraudulent practices, bringing enforcement actions, and advocating for legislation that can further protect consumers' rights.