



SPONSOR: Sen. Paradee & Rep. Bush  
Sens. Cloutier, Delcollo, Ennis, Hansen, Poore, Sokola,  
Sturgeon, Townsend; Reps. Baumbach, Brady,  
Dorsey Walker, Heffernan, Kowalko, Seigfried

DELAWARE STATE SENATE  
150th GENERAL ASSEMBLY

SENATE BILL NO. 35

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATED TO HEALTH INSURANCE CONTRACTS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

1 Section 1. Amend § 3361, Title 18 of the Delaware Code by making deletions as shown by strike through and  
2 insertions as shown by underline as follows:

3 § 3361. Limitations on preexisting condition limitations for minor children.

4 ~~(a) No individual health insurance policy, contract or certificate that is delivered or issued for delivery in this State~~  
5 ~~by any health insurer, health service corporation or managed care organization which provides for hospital or medical~~  
6 ~~expenses shall deny coverage to a child under the age of 19 because of a preexisting condition.~~

7 ~~(b) Each policy shall be either guaranteed issue, without exclusion for preexisting conditions, or offered during an~~  
8 ~~open enrollment period the first month of every calendar year. [Repealed.]~~

9 Section 2. Amend § 3368, Title 18 of the Delaware Code by making deletions as shown by strike through and  
10 insertions as shown by underline as follows:

11 § 3368. No lifetime or annual limits [For application of this section, see 79 Del. Laws, c. 99, § 19]

12 (c) The term "essential health benefits" as used in this section means essential health benefits under § 1302(b) of  
13 the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(b)], as the law and its implementing regulations were in  
14 effect on January 1, 2018; Delaware law law; and applicable ~~federal and~~ state regulations.

15 Section 3. Amend § 3530, Title 18 of the Delaware Code by making deletions as shown by strike through and  
16 insertions as shown by underline as follows:

17 § 3530. Limitations on preexisting condition limitations for minor children.

18 ~~(a) No group or blanket health insurance policy, contract or certificate that is delivered or issued for delivery in~~  
19 ~~this State by any health insurer, health service corporation or managed care organization which provides for hospital or~~  
20 ~~medical expenses shall deny coverage to a child under the age of 19 because of a preexisting condition.~~

21 ~~(b) Each policy shall be either guaranteed issue, without exclusion for preexisting conditions, or offered during an~~  
22 ~~open enrollment period the first month of every calendar year. [Repealed.]~~

23 Section 4. Amend § 3571I, Title 18 of the Delaware Code by making deletions as shown by strike through and  
24 insertions as shown by underline as follows:

25 § 3571I. No lifetime or annual limits [For application of this section, see 79 Del. Laws, c. 9, § 19]

26 (c) The term "essential health benefits" as used in this section means essential health benefits under § 1302(b) of  
27 the Patient Protection and Affordable Care Act [42 U.S.C. § 18022(b)], as the law and its implementing regulations were in  
28 effect on January 1, 2018; ~~Delaware law~~ law; and applicable ~~federal and~~ state regulations.

29 Section 5. Amend Section 3571J, Title 18 of the Delaware Code by making deletions as shown by strike through  
30 and insertions as shown by underline as follows:

31 § 3571J. Guaranteed availability of coverage [For application of this section, see 79 Del. Laws, c. 99, § 19]

32 (b) *Enrollment periods.* — A health insurer may restrict enrollment in health insurance coverage to open or special  
33 enrollment periods.

34 (1)a. *Open enrollment periods in the group market.* — A health insurer in the group market must permit an  
35 employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of  
36 health insurance coverage offered in the small group market, a health insurer may decline to offer coverage to a plan  
37 sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation  
38 ~~rules, as defined in 45 C.F.R. § 147.106(b)(3), pursuant to rules under~~ rules under applicable state law and, in the case of a  
39 qualified health plan offered in the Small Business Health Options Program (SHOP), as permitted by 45 C.F.R. §  
40 156.285(c). ~~With respect to coverage in the small group market, and in the large group market if such coverage is~~  
41 ~~offered in a SHOP in this State, coverage shall become effective consistent with the dates described in 45 C.F.R. §~~  
42 ~~155.725(h).~~ For purposes of this paragraph (b)(1) of this section:

43 1. "Employer contribution rule" means a requirement relating to the minimum level or amount of  
44 employer contribution toward the premium for enrollment of participants and beneficiaries.

45 2. "Group participation rule" means a requirement relating to the minimum number of participants or  
46 beneficiaries that must be enrolled in relation to a specific percentage or number of eligible individuals or  
47 employees of an employer.

48 b. With respect to coverage in the small group market, and in the large group market if such coverage is  
49 offered in a SHOP in the State, coverage for a group enrollment received from a qualified employer at the time of  
50 an initial group enrollment or renewal becomes effective as follows:

51 1. Between the first and fifteenth day of any month, the health insurer or SHOP must ensure a  
52 coverage effective date of the first day of the following month unless the employer opts for a later effective  
53 date within a quarter for which small group market rates are available.

54 2. Between the sixteenth and last day of any month, the health insurer or SHOP must ensure a  
55 coverage effective date of the first day of the second following month unless the employer opts for a later  
56 effective date within a quarter for which small group market rates are available.

57 (2) *Special enrollment periods.* — A health insurer in the group market shall establish special enrollment periods  
58 for qualifying events as defined under § 603 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1163],  
59 as amended. Enrollees ~~shall~~ must be provided 30 calendar days after the date of the qualifying event to elect coverage, with  
60 such coverage becoming effective consistent with the dates described in ~~45 C.F.R. § 155.420(b).~~ 45 C.F.R. § 155.420(b),  
61 as in effect on January 1, 2018. These special enrollment periods are in addition to any other special enrollment periods that  
62 are required under federal and state law.

63 Section 6. Amend § 3571L, Title 18 of the Delaware Code by making deletions as shown by strike through and  
64 insertions as shown by underline as follows:

65 § 3571L. Nondiscrimination in health care [For application of this section, see 79 Del. Laws, c. 99, § 19]

66 (b) *Individuals.* — The provisions of § 1557 of the Patient Protection and Affordable Care Act (relating to  
67 nondiscrimination) [~~42 U.S.C. § 18116~~] shall [42 U.S.C. § 18116], as the law and its implementing regulations were in  
68 effect on January 1, 2018, apply with respect to a group health plan or health insurer offering group health insurance  
69 coverage.

70 Section 7. Amend § 3571M, Title 18 of the Delaware Code by making deletions as shown by strike through and  
71 insertions as shown by underline as follows:

72 § 3571M. Comprehensive health insurance coverage [For application of this section, see 79 Del. Laws, c. 99, § 19]

73 (a) *Coverage for essential health benefits package.* — A health insurer that offers health insurance coverage in the  
74 small group market shall ensure that such coverage includes the essential health benefits package in conformity with § 1302  
75 of the Patient Protection and Affordable Care Act [~~42 U.S.C. § 18022~~] [42 U.S.C. § 18022], as the law and its  
76 implementing regulations were in effect on January 1, 2018, and state law. The Commissioner shall issue a regulation  
77 setting forth what constitutes "essential health benefits" for purposes of this section.

78 (b) *Cost-sharing under group health plans.* — A group health plan shall ensure that any annual cost-sharing  
79 imposed under the plan does not exceed the limitations provided for under § 1302(c)(1) and (2) of the Patient Protection

80 and Affordable Care Act [~~42 U.S.C. § 18022(e)(1) and (2)~~] [42 U.S.C. § 18022(c)(1) and (2)], as the law and its  
81 implementing regulations were in effect on January 1, 2018, and state law.

82 (c) *Child-only plans.* — If a health insurer offers health insurance coverage in any level of coverage specified  
83 under § 1302(d) of the Patient Protection and Affordable Care Act [~~42 U.S.C. § 18022(d)~~] [42 U.S.C. § 18022(d)], as the  
84 law and its implementing regulations were in effect on January 1, 2018, or state law, the health insurer shall also offer such  
85 coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of the plan year, ~~have~~  
86 not attained the age of ~~are under the age of~~ 21.

87 (d) *Dental only.* — This section shall not apply to a plan described in § 1311(d)(2)(B)(ii) of the Patient Protection  
88 and Affordable Care Act [~~42 U.S.C. § 18031(d)(2)(B)(ii)~~]. [42 U.S.C. § 18031(d)(2)(B)(ii)], as the law and its  
89 implementing regulations were in effect on January 1, 2018.

90 Section 8. Amend § 3571P, Title 18 of the Delaware Code by making deletions as shown by strike through and  
91 insertions as shown by underline as follows:

92 § 3571P. Rating factors [For application of this section, see 79 Del. Laws, c. 99, § 19]

93 (a) In establishing rates for health insurance coverage offered in the small group market, ~~health insurers shall~~  
94 ~~comply with the rating requirements established under the Patient Protection and Affordable Care Act [P.L. 111-148] and~~  
95 ~~45 C.F.R. § 147.102. The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act~~  
96 ~~[Chapter 101 of Title 29], that are consistent with Chapter 25 of this title and set forth more specifically the rating standards~~  
97 ~~and requirements for health insurers operating within this State. the rate may vary with respect to the particular plan or~~  
98 coverage involved only by determining the following:

99 (1) Whether the plan or coverage covers an individual or family.

100 (2) Rating area, as established in accordance with subsection (d) of this section.

101 (3) Age, except that the rate may not vary by more than 3 to 1 for like individuals of different age who are age  
102 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the  
103 uniform age rating curve under subsection (e) of this section. For purposes of identifying the appropriate age  
104 adjustment under this paragraph (a)(3) of this section and the age band under subsection (e) of this section applicable to  
105 a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

106 (4) Subject to § 3571N of this title, tobacco use, except that such rate may not vary by more than 1.5 to 1 and  
107 may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes  
108 of this paragraph (a)(4) of this section, tobacco use means use of tobacco on average 4 or more times per week within

109 no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious  
110 or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

111 (b) The rate established under this section must not vary with respect to the particular plan or coverage involved by  
112 any other factor not described in subsection (a) of this section.

113 (c) A health insurer must consider the claims experience of all enrollees in all health plans, other than  
114 grandfathered health plans, offered by such insurer in the small group market in this State, including those enrollees who do  
115 not enroll in such plans through the state health exchange, to be members of a single risk pool. A health insurer must charge  
116 the same premium rate without regard to whether the plan is offered through the state health exchange or whether the plan  
117 is offered directly from the health insurer or through an agent.

118 (d) In establishing rates, all health insurers offering health plans in the small group market shall use a single rating  
119 area that applies to the entire State.

120 (e) The following uniform age bands apply for rating purposes under paragraph (a)(3) of this section:

121 (1) Child age bands.

122 a. A single age band for individuals age 0 through 14.

123 b. One-year age bands for individuals age 15 through 20.

124 (2) Adult age bands. One-year age bands for individuals age 21 through 63.

125 (3) Older adult age bands. A single age band for individuals age 64 and older.

126 (f) Application of variations based on age or tobacco use. With respect to family coverage under health insurance  
127 coverage, the rating variations permitted under paragraphs (a)(3) and (a)(4) of this section must be applied based on the  
128 portion of the premium attributable to each family member covered under the coverage.

129 (1) The total premium for family coverage must be determined by summing the premiums for each individual  
130 family member. With respect to family members under age 21, the premiums for no more than the 3 oldest covered  
131 children must be taken into account in determining the total family premium.

132 (2) If the State does not permit any rating variation for the factors described in paragraphs (a)(3) and (a)(4) of  
133 this section, as determined by the Insurance Commissioner by regulation, the State may require that premiums for  
134 family coverage be determined by using uniform family tiers and the corresponding multipliers established by the  
135 State. If the State does not establish uniform family tiers and the corresponding multipliers, the per-member-rating  
136 methodology under paragraph (f)(1) of this section applies in this State.

137           (3)a. In the case of the small group market, the total premium charged to a group health plan is determined by  
138 summing the premiums of covered participants and beneficiaries in accordance with paragraph (f)(1) or (f)(2) of this  
139 section, as applicable.

140           b. Subject to paragraph (f)(3)c. of this section, nothing in this section prevents the State from requiring  
141 health insurers to offer to a group health plan, or a health insurer from voluntarily offering to a group health plan,  
142 premiums that are based on average enrollee premium amounts, if the total group premium established at the time  
143 of applicable enrollment at the beginning of the plan year is the same total amount derived under paragraph (f)(1)  
144 or (f)(2) of this section, as applicable.

145           c. A health insurer that, in connection with a group health plan in the small group market, offers  
146 premiums that are based on average enrollee premium amounts under paragraph (f)(3)b. of this section must:

147                   1. Ensure an average enrollee premium amount calculated based on applicable enrollment of  
148 participants and beneficiaries at the beginning of the plan year that does not vary during the plan year.

149                   2. Unless the State establishes and, if applicable, CMS approves an alternate rating methodology,  
150 calculate an average enrollee premium amount for covered individuals age 21 and older, and calculate an  
151 average enrollee premium amount for covered individuals under age 21. The premium for a given family  
152 composition is determined by summing the average enrollee premium amount applicable to each family  
153 member covered under the plan, taking into account no more than 3 covered children under age 21.

154                   3. Under applicable State law, ensure that the average enrollee premium amount calculated for any  
155 individual covered under the plan does not include any rating variation for tobacco use permitted under  
156 paragraph (a)(4) of this section. The rating variation for tobacco use permitted under paragraph (a)(4) of this  
157 section is determined based on the premium rate that would be applied on a per-member basis with respect to  
158 an individual who uses tobacco and then included in the premium charged for that individual.

159                   4. To the extent permitted by applicable state law and, in the case of coverage offered through a  
160 federally-facilitated SHOP, as permitted by 45 C.F.R. § 156.285(a)(4), apply this paragraph (f)(3)c. of this  
161 section uniformly among group health plans enrolling in that product, giving those group health plans the  
162 option to pay premiums based on average enrollee premium amounts.

163           (g) The Commissioner may adopt regulations, in accordance with the Administrative Procedures Act [Chapter 101  
164 of Title 29], that are consistent with Chapter 25 of this title and set forth more specifically the rating standards and  
165 requirements for health insurers operating within this State.

166 Section 9. Amend § 3606, Title 18 of the Delaware Code by making deletions as shown by strike through and  
167 insertions as shown by underline as follows:

168 § 3606. Preexisting conditions [For application of this section, see 79 Del. Laws, c. 99, § 19]

169 (a) Notwithstanding § 3306 of this title, a policy or contract must not deny, exclude, or limit benefits for a covered  
170 individual for losses due to a preexisting condition, if an insurer or health service corporation elects to use a simplified  
171 application form, with or without a question as to the applicant's health at the time of the application, but without any  
172 questions concerning the insured's health history or medical treatment history, the policy must cover any loss from any  
173 preexisting condition, and the policy or contract shall ~~must~~ not include wording that would permit a defense based upon  
174 preexisting conditions.

175 Section 10. Amend § 3607, Title 18 of the Delaware Code by making deletions as shown by strike through and  
176 insertions as shown by underline as follows:

177 § 3607. Guaranteed availability of coverage [For application of this section, see 79 Del. Laws, c. 99, § 19]

178 (b) *Enrollment periods.* — A carrier may restrict enrollment in health insurance coverage to open or special  
179 enrollment periods.

180 (1) *Open enrollment periods in the individual market.* — A carrier in the individual market must permit an  
181 individual to purchase health insurance coverage during ~~the initial and annual open enrollment periods described in 45~~  
182 ~~C.F.R. § 155.410(b) and (c), with such coverage becoming effective consistent with the dates described in 45 C.F.R. §~~  
183 ~~155.410(e) and (f).~~ an annual open enrollment period. For benefit years beginning on or after January 1, 2018, the  
184 annual open enrollment period begins on November 1 and extends through December 15 of the calendar year  
185 preceding the benefit year. A carrier must ensure that coverage is effective January 1 for enrollments received by the  
186 carrier on or before December 15 of the calendar year preceding the benefit year.

187 (2) *Special enrollment periods.* — A carrier in the individual market shall establish special enrollment periods  
188 for qualifying events as defined under § 603 of the Employee Retirement Income Security Act of 1974, as amended [29  
189 USC § 1163]. Enrollees ~~shall~~ must be provided 30 calendar days after the date of the qualifying event to elect  
190 coverage, with such coverage becoming effective consistent with the dates described in ~~45 C.F.R. § 155.420(b).~~ 45  
191 C.F.R. § 155.420(b), as in effect on January 1, 2018. These special enrollment periods are in addition to any other  
192 special enrollment periods that are required under federal and state law.

193 Section 11. Amend § 3609, Title 18 of the Delaware Code by making deletions as shown by strike through and  
194 insertions as shown by underline as follows:

195 § 3609. Nondiscrimination in health care [For application of this section, see 79 Del. Laws, c. 99, § 19]

196 (b) *Individuals.* — The provisions of § 1557 of the Patient Protection and Affordable Care Act (relating to  
197 nondiscrimination) ~~[42 U.S.C. § 18116]~~ shall [42 U.S.C. § 18116], as the law and its implementing regulations were in  
198 effect on January 1, 2018, apply with respect to a health insurer offering individual health insurance coverage.

199 Section 12. Amend § 3610, Title 18 of the Delaware Code by making deletions as shown by strike through and  
200 insertions as shown by underline as follows:

201 § 3610. Comprehensive health insurance coverage [For application of this section, see 79 Del. Laws, c. 99, § 19]

202 (a) *Coverage for essential health benefits package.* — A health insurer that offers health insurance coverage in the  
203 individual market shall ensure that such coverage includes the essential health benefits package in conformity with § 1302  
204 of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022]~~ [42 U.S.C. § 18022], as the law and its  
205 implementing regulations were in effect on January 1, 2018, and state law. The Commissioner shall issue a regulation  
206 setting forth what constitutes "essential health benefits" for purposes of this section.

207 (b) *Cost-sharing under individual health insurance policies.* — An individual health insurance policy shall ensure  
208 that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under § 1302(c)(1) of the  
209 Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022(c)(1)]~~ [42 U.S.C. § 18022(c)(1)], as the law and its  
210 implementing regulations were in effect on January 1, 2018, and state law.

211 (c) *Child-only plans.* — If a health insurer offers health insurance coverage in any level of coverage specified  
212 under § 1302(d) of the Patient Protection and Affordable Care Act ~~[42 U.S.C. § 18022(d)]~~ [42 U.S.C. § 18022(d)], as the  
213 law and its implementing regulations were in effect on January 1, 2018, or state law, the health insurer shall also offer such  
214 coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of the plan year, ~~have~~  
215 ~~not attained the age of~~ are under age 21.

216 (d) *Dental only.* — This section ~~shall~~ does not apply to a plan described in § 1311(d)(2)(B)(ii) of the Patient  
217 Protection and Affordable Care Act ~~[42 U.S.C. § 18031(d)(2)(B)(ii)]~~ [42 U.S.C. § 18031(d)(2)(B)(ii)], as the law and its  
218 implementing regulations were in effect on January 1, 2018.

219 Section 13. Amend Section 3613, Title 18 of the Delaware Code by making deletions as shown by strike through  
220 and insertions as shown by underline as follows:

221 § 3613. Rating factors [For application of this section, see 79 Del. Laws, c. 99, § 19]

222 (a) In establishing rates for health insurance coverage offered in the individual market, health insurers shall  
223 ~~comply with the rating requirements established under the Patient Protection and Affordable Care Act [P.L. 111-148] and~~  
224 ~~45 C.F.R. § 147.102. The Commissioner shall adopt regulations, in accordance with the Administrative Procedures Act~~  
225 ~~[Chapter 101 of Title 29], that are consistent with Chapter 25 of this title and set forth more specifically the rating standards~~



226 and requirements for health insurers operating within this State. the rate may vary with respect to the particular plan or  
227 coverage involved only by determining the following:

228 (1) Whether the plan or coverage covers an individual or family.

229 (2) Rating area, as established in accordance with subsection (d) of this section.

230 (3) Age, except that the rate may not vary by more than 3 to 1 for like individuals of different age who are age  
231 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the  
232 uniform age rating curve under subsection (e) of this section. For purposes of identifying the appropriate age  
233 adjustment under this paragraph (a)(3) of this section and the age band under subsection (e) of this section applicable to  
234 a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

235 (4) Subject to § 3611 of this title, tobacco use, except that such rate may not vary by more than 1.5 to 1 and  
236 may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes  
237 of this paragraph (a)(4) of this section, tobacco use means use of tobacco on average 4 or more times per week within  
238 no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious  
239 or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

240 (b) The rate established under this section must not vary with respect to the particular plan or coverage involved by  
241 any other factor not described in subsection (a) of this section.

242 (c) A health insurer must consider the claims experience of all enrollees in all health plans, other than  
243 grandfathered health plans, offered by such insurer in individual market in this State, including those enrollees who do not  
244 enroll in such plans through the state health exchange, to be members of a single risk pool. A health insurer must charge the  
245 same premium rate without regard to whether the plan is offered through the state health exchange or whether the plan is  
246 offered directly from the health insurer or through an agent.

247 (d) In establishing rates, all health insurers offering health plans in the individual market shall use a single rating  
248 area that applies to the entire State.

249 (e) The following uniform age bands apply for rating purposes under paragraph (a)(3) of this section:

250 (1) Child age bands.

251 a. A single age band for individuals age 0 through 14.

252 b. One-year age bands for individuals age 15 through 20.

253 (2) Adult age bands. One-year age bands for individuals age 21 through 63.

254 (3) Older adult age bands. A single age band for individuals age 64 and older.

255           (f) Application of variations based on age or tobacco use. With respect to family coverage under health insurance  
256 coverage, the rating variations permitted under paragraphs (a)(3) and (a)(4) of this section must be applied based on the  
257 portion of the premium attributable to each family member covered under the coverage.

258           (1) The total premium for family coverage must be determined by summing the premiums for each individual  
259 family member. With respect to family members under age 21, the premiums for no more than the 3 oldest covered  
260 children must be taken into account in determining the total family premium.

261           (2) If the State does not permit any rating variation for the factors described in paragraphs (a)(3) and (a)(4) of  
262 this section, as determined by the Insurance Commissioner by regulation, the State may require that premiums for  
263 family coverage be determined by using uniform family tiers and the corresponding multipliers established by the  
264 State. If the State does not establish uniform family tiers and the corresponding multipliers, the per-member-rating  
265 methodology under paragraph (f)(1) of this section applies in this State.

266           (g) The Commissioner may adopt regulations, in accordance with the Administrative Procedures Act [Chapter 101  
267 of Title 29], that are consistent with Chapter 25 of this title and set forth more specifically the rating standards and  
268 requirements for health insurers operating within this State.

#### SYNOPSIS

This Act revises Delaware Insurance Code provisions related to the individual and group health insurance markets to directly incorporate into Delaware law the Patient Protection and Affordable Care Act's consumer protections related to the following:

- (1) The prohibition of preexisting condition provisions.
- (2) Guaranteed issue and availability of coverage.
- (3) Permissible rating factors.

This Act also ties references in Delaware law to the Patient Protection and Affordable Care Act to that law as it was in effect on January 1, 2018. This ensures the ACA's core consumer protection provisions will remain in place during the uncertainty surrounding the ACA in light of recent court challenges.

Finally, this Act makes technical corrections to conform existing law to the standards of the Delaware Legislative Drafting Manual.

Author: Senator Pardee