Date of Hearing: April 12, 2016

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2782 (Bloom) – As Amended March 30, 2016

SUBJECT: Healthy California Fund.

SUMMARY: Imposes a health promotion fee of $0.02 per fluid ounce on bottled sugar sweetened beverages (SSBs) and concentrates. Establishes the Healthy California Fund (Fund) and allocates moneys from the Fund to various state departments for purposes of reducing the incidence and impact of diabetes, obesity, and dental disease in California. Authorizes the Board of Equalization (BOE) to administer and collect the fee and deposit all fees, penalties, and interest collected into the Fund. Specifically, **this bill**:

1) Imposes a health impact fee on bottled SSBs and concentrates in the state using the following formula:

    a) Two cents ($0.02) per fluid ounce on bottled sweetened beverages; and,

    b) Two cents ($0.02) per fluid ounce of sweetened beverages produced from concentrate, based on the largest volume resulting from the concentrate's use according to any manufacturer's instructions.

2) Establishes the Fund within the State Treasury. Requires the Fund to support culturally and linguistically appropriate programs to improve access to healthy and affordable foods and beverages, reduce access to calorie-dense and nutrient-poor foods, encourage physical activity, and raise awareness of the importance of nutrition and physical activity in the prevention of obesity, diabetes, and dental disease. Specifies the allocation of funds, by percentage, to various entities as follows:

    a) Fifty-one percent to the Department of Public Health (DPH), to be divided, as specified, among the following activities:

        i) A regular grant program to all county and city health departments, or their nonprofit designees, seeking to invest in obesity, diabetes, and dental disease prevention activities;

        ii) A competitive grant program to nonprofit organizations and community based organizations seeking to invest in obesity, diabetes, and dental disease prevention activities. Requires a percentage of these funds to be used for the following:

            (1) To support nonprofit organizations working statewide, including those that provide capacity building and technical assistance services; and,

            (2) For statewide priority population leadership networks, including African American, Hispanic, American Indian and Alaska Native, Asian American, Native Hawaiian and Pacific Islander and low socioeconomic status populations.

iii) A competitive grant program for licensed clinics to invest in obesity, diabetes, and dental disease prevention and treatment activities, and to support programs that use education, and other public health approaches that raise awareness about the importance of nutrition and physical activity;

iv) Statewide advertising and media campaigns, including social media initiatives, to change social and cultural norms around risk factors for chronic diseases, including diet and physical activity, and dental disease prevention;

v) Dental health programs through the DPH Oral Health Program; and,

vi) Administration, independent evaluation, and disease surveillance.

b) Twenty-five percent to the Department of Education (CDE), to be divided among the following activities:

i) Competitive grant programs for school districts for educational, environmental, policy, and other public health approaches that promote physical activity, improved nutrition and ensure access to clean drinking water throughout the school day. Permits these funds to be used for school recreational facility improvements and improving quality of school meals; and,

ii) The CDE Farm to School Program.

c) Twenty percent to the Office of Farm to Fork in the Department of Food and Agriculture (DFA), to support consumer incentive programs and to administer a competitive grant program to aid community food producers; and,

d) Four percent of funds to the Department of Health Care Services (DHCS) for the Expanded Access to Primary Care, Rural Health Services Development, Seasonal Agricultural Migratory Workers, and Indian Health programs. Requires the funds to be used to support clinic-based obesity and diabetes prevention and related disease management.

3) Requires target populations to be the focus of the campaign implemented pursuant to this bill, and all moneys in the fund to be allocated with no less than 60% priority given to communities located in zip codes with the highest 30 percentile of type II diabetes, as reported by the California Health Interview Survey (CHIS). Specifies the following target populations:

a) African American, Hispanic, American Indian and Alaska Native, Asian American, Native Hawaiian, and Pacific Islander;

b) Low socioeconomic status populations;

c) Zip codes with the top 30th percentile of rates of type II diabetes;

d) Communities identified as dentally underserved or with high rates of dental disease; and,

e) At-risk populations, as determined by CHIS and other data sources.

4) Requires that DPH funding for local government activities be focused and primarily expended on programs directly serving African American, Hispanic, American Indian and Alaska Native, Asian American, Native Hawaiian, and Pacific Islander communities and where consumption of bottled sugar-sweetened beverages is the highest, in neighborhoods with schools with a high concentration of students who qualify for supplemental and concentration grants, and in neighborhoods with a demonstrated need for services, including a high concentration of Medi-Cal eligible residents.

5) Requires DPH to develop a funding formula to provide a minimum base level to all county and city health departments with the additional amount weighted to reflect the number of residents in each jurisdiction living below 150% of the federal poverty level. Makes funding dependent on each local health department submitting an approved implementation plan and maintaining a community coalition to support the objectives of the funding. Requires at least one third of each jurisdiction's funds be subgranted to community partners selected through a competitive process with a priority and focus on directly serving African American, Hispanic, American Indian and Alaska Native, Asian American, Native Hawaiian, and Pacific Islander communities.

6) Limits administrative expenses to 3% of funds allocated to DPH, DHCS, CDE, and DFA.

7) Requires that moneys in the Fund be expended only for purposes specified and to supplement existing levels of service. Prohibits moneys in the Fund from supplanting current federal, state, or local funding for existing levels of service.

8) Authorizes the State Public Health Officer, the Secretary of DFA, the Director of DHCS, and the Superintendent of Public Instruction to coordinate to make rules and regulations to implement the Fund allocation.

9) Requires the State Auditor to conduct periodic audits, starting no later than 24 months after the bill's effective date, to ensure annual allocation to individual programs is awarded in a timely fashion consistent with the requirements of this bill.

10) Creates the 13-member Healthy California Fund Oversight Committee (Committee) to advise DPH, CDE, DFA, and DHCS with respect to policy development, integration, and evaluation of the state and local programs funded under this bill, and requires the Committee to develop a master plan for the future implementation of diabetes, obesity, and dental disease prevention programs. Requires the Committee to submit to the Legislature an annual report detailing the number and scope of programs enabled by the Fund, the amount of Fund moneys spent and unspent and recommendations, if any for policy changes.

11) Requires, by July 1, 2017, and annually thereafter, DPH, DHCS, CDE, and DFA to prepare a program budget for the following year including anticipated revenues and costs of implementing the program, a recommended funding level to operate the program, and the amount of fees collected by the state.

12) Creates the Healthy California Fund Administration Account for the purpose of reimbursing DPH, DHCS, CDE, and DFA for administrative and implementation costs of the program.

13) Requires the BOE to administer and collect the fees under the Fee Collection Procedures Law. Allows the BOE to adopt regulations and prescribe reporting requirements necessary to implement the fee, including information regarding the total amount of bottled SSB and concentrate sold, and the amount of fee due. Limits BOE's administrative expenses to 3%.

14) Requires distributors subject to the fee to register with BOE.

15) Requires fee payers to file with BOE a return on or before the last day of the calendar month following the calendar quarter, together with a remittance for the amount of fee due for that period.

16) Provides several definitions including , but not limited to, the following:

    a) A "sugar-sweetened beverage" means a nonalcoholic beverage, carbonated or not, that contains added caloric sweetener; and,

    b) Specifies that SSBs do not include:

        i) Beverages sold to the U.S. government and American Indian tribal governments;

        ii) Certain transactions where beverages are sold by one distributor to another;

        iii) Beverages sweetened with noncaloric sweeteners;

        iv) Beverages sweetened with 100% natural fruit or vegetable juice;

        v) Beverages in which milk (including plant based milk-substitutes) is the primary or first-listed ingredient;

        vi) Beverages with fewer than five grams of added sugar or other caloric sweeteners per 12 ounces;

        vii) Coffee or tea without added caloric sweetener;

        viii) Infant formula;

        ix) Beverages for medical use; and,

        x) Water without any caloric sweetener.

17) Makes various findings and declarations regarding the negative impact of sugar on human health.

EXISTING LAW:

1) Establishes DPH to protect and improve the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention.

2) Establishes restrictions on the sale of certain beverages in schools by placing restrictions on the types of beverages allowed to be sold in elementary, middle, and junior high schools and high schools.

3) Establishes the BOE to collect California state sales and use tax, as well as fuel, alcohol, and tobacco taxes and fees that provide revenue for state government and essential funding for counties, cities, and special districts.

4) Imposes sales tax on the retail sale of tangible personal property. Imposes use tax on the storage, use, or other consumption of tangible personal property from any retailer. Requires the sale or use tax to be computed on the retailer's gross receipts or sales price, respectively, unless the law provides a specific exemption or exclusion. Provides an exemption for the sale of, and the storage, use, or other consumption of, food products for human consumption including, in part, all fruit juices, vegetable juices, and other beverages, including bottled water, but not to include carbonated beverages.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, California is facing a diabetes and obesity epidemic, yet spends less than any other state on prevention. There are approximately 2.5 million Californians, about 9% of the state's population, living with diabetes today. An estimated 13 million Californians, about 46% of the state's population, have pre-diabetes and up to 70% of these individuals will go on to develop type 2 diabetes in their lifetime. From 1980 to 2010, the national obesity rate more than doubled among adults and tripled among children. These rates are even higher in low-income communities and communities of color and unless current trends are reversed, one out of every three Americans will have diabetes.

The author states that soda and other sugary drinks are the number one source of added sugar in the American diet, and are linked to increased risk of diabetes, heart and liver disease, stroke, obesity, and tooth decay. This bill will create a dedicated revenue source to address the harmful effects of overconsumption of SSBs. The revenues from the fee will go to diabetes prevention programs, as well as oral health programs, programs to increase access to clean drinking water in schools, and physical education programs. This bill will not only help improve public health outcomes, but will also save taxpayers billions of dollars every year on healthcare costs in the long run.

2) OBESITY, DIABETES, AND OTHER CHRONIC DISEASES. According to the Centers for Disease Control and Prevention, more than one-third of U.S. adults are obese, and approximately 12.5 million children and adolescents ages two to 19 years are obese. Research indicates a tripling in the youth obesity rate over the past three decades. While this increase has stabilized between the years 2005 and 2010, in 2010, 38% of public school children were overweight and obese. Overweight youth face increased risks for many serious detrimental health conditions that do not commonly occur during childhood, including high cholesterol and type 2 diabetes. Additionally, more than 80% of obese adolescents remain obese as adults. Obese children and teenagers also remain at greater risk for developing serious chronic diseases including type 2 diabetes, heart disease, high blood pressure, cancer

and other health conditions including asthma, sleep apnea, and psychosocial effects such as decreased self-esteem. In one large study, 61% of overweight five to 10 year-olds already had at least one risk factor for heart disease, and 26% had two or more risk factors. An overweight adolescent has a 70% chance of being overweight or obese as an adult.

According to the September 2014 "Burden of Diabetes in California" report by DPH, over 2.3 million California adults report having been diagnosed with diabetes, representing one out of every 12 adult Californians. The vast majority of diabetes cases in California are type 2, representing 1.9 million adults. The prevalence increases with age—one out of every six adult Californians aged 65 and above have type 2 diabetes—and is higher among ethnic/racial minorities and Californians with low education attainment and/or family income. Compared with non-Hispanic whites, Hispanics and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from their disease. Diabetes is the seventh leading cause of death in California, and determined to be the underlying cause of death in almost 8,000 people each year. As diabetes is a contributing factor to many deaths from heart disease and stroke, diabetes may be under-represented as a contributing cause of death.

3) **THE ECONOMIC BURDEN.** The last decade has witnessed a 32% rise in diabetes prevalence, affecting some 3.9 million people and costing upwards of $24 billion per year. Overall health care spending on obesity continues to significantly burden the nation, however, and the most recent research data available estimate obesity-related health care costs at nearly $150 billion annually. According to the National Conference on State Legislatures, taxpayers fund about half of these costs, at approximately $60 billion, through Medicare and Medicaid. Recent research indicates that if obesity rates are reduced by as little as 5%, health care savings could exceed $29 billion. Childhood obesity also poses a national security challenge, as obesity has become one of the most common disqualifiers for military service; affecting 25% of those who apply to serve.

   The medical costs and associated costs of diabetes jumped to $245 billion in 2012, meaning that the diabetes toll on the economy has increased by more than 40% since 2007, according to a recent report from the American Diabetes Association. The 2007 figures were $116 billion for diabetes and the indirect costs (disability, work loss, premature mortality) were $58 billion. According to the California Diabetes Program, total health care and related costs for the treatment of diabetes in California are about $24.5 billion each year. Direct medical costs (e.g., hospitalizations, medical care, treatment, supplies) account for about $18.7 billion, with the other $5.8 billion including indirect costs such as disability payments, time lost from work, and premature death. The average annual treatment cost per case for diagnosed diabetes in the U.S. was nearly $10,000 in 2007. The economic burden of diabetes and prediabetes on the average person is estimated to be over $700 for every man, woman, and child — representing a hidden 'tax' paid by all through higher insurance premiums[1].

4) **CAUSE, CORRELATION, AND RISK.** It is very difficult to scientifically prove a direct causal relationship between diet and disease in humans. In laboratory animal studies, a single variable can be changed while all others are held constant to determine a direct cause-

[1] March 2012 fact sheet. California Diabetes Program, Diabetes Information Resource Center. www.caldiabetes.org

and-effect relationship. It is nearly impossible to exert the same level of control in human dietary studies. However, while it may be impossible to completely eliminate alternate hypotheses, a causal relationship between the intake of added sugar and obesity is supported by strong epidemiological evidence. A meta-analysis published in the *American Journal of Clinical Nutrition* looked at 30 studies of sugary drink consumption published from 1966 to 2005 and found that sugary drink consumption was associated with weight gain and obesity. Another study concluded that sugary drinks are likely to account for at least 20% of the weight gained by Americans between 1977 and 2007. Numerous studies indicate that higher consumption of sugary drinks is associated with higher risk of weight gain and also with higher risk of developing type 2 diabetes.

5) **EFFORTS TO REDUCE CALORIE CONSUMPTION**. Along with increasing physical activity and providing nutritious food, reducing calories from all sources is a necessary component to reduce obesity and associated chronic health conditions. Research shows that people generally underestimate the number of calories in the foods they consume. A recent study asking participants to estimate the caloric content of nine restaurant entrées found that 90% underestimated the caloric content of less healthy items by an average of more than 600 calories. Controlling the intake of added sugars represents an important component of lifestyle management for weight control and maintenance. A recent report by the Institute of Medicine identified sugary drinks as the single largest contributor of calories and added sugars to the U.S. diet. The "2010 Dietary Guidelines for Americans," published every five years jointly by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture, admonished individuals to reduce consumption of SSBs, recommended that adult Americans should eat a maximum of 10% of their daily calories from added sugars. In March 2015, the World Health Organization's (WHO) new "Guideline: Sugars Intake for Adults and Children" recommends reduced intake of sugar throughout the life course. In both adults and children, the intake of sugar should be reduced to less than 10% of total energy intake. For a person who consumes 2,000 calories per day that means intake of added sugars should be limited to less than 30 grams (or two tablespoons). WHO found that a further reduction to below 5% of total energy intake would provide additional health benefits.

6) **POLICY INTERVENTIONS AND UNHEALTHY PRODUCTS.** Mounting evidence suggests that effectively curbing the obesity epidemic and reversing the upward trend will require comprehensive approaches across sectors involving public and private stakeholders at the local, state, and federal level. Many believe that the comprehensive approach must be similar to policy efforts previously employed to improve motor vehicle safety or curb usage of alcohol or tobacco. After passage of the California Tobacco Tax and Health Promotion Act of 1988 (Proposition 99), the state created the California Tobacco Control Program (CTCP), implemented a variety of grassroots efforts to educate consumers about the harmful effects of tobacco use, and passed several anti-tobacco laws, such as local and statewide policies to limit smoking in public places, prohibit the incidence of tobacco sales to minors, and restrictions on tobacco advertising; all designed to address smoking prevalence. California's early efforts have shaped best practices for comprehensive tobacco control efforts throughout the nation and the world. According to CTCP, these efforts have so far saved more than one million lives and over $86 billion in health care costs. While tobacco use continues to be pervasive and costly, California has been successful at significantly curbing the burden of tobacco use on California families, our health care system and our economy.

Since the early 1980s, a growing number of economists have examined the impact of the price of alcoholic beverages on alcohol consumption. Studies investigating such a relationship found that alcohol prices were one factor influencing alcohol consumption among youth and young adults. Other studies determined that increases in the total price of alcohol can reduce drinking and driving and its consequences among all age groups; lower the frequency of diseases, injuries, and deaths related to alcohol use and abuse; and, reduce alcohol-related violence and other crime. A large body of research supports the view that increases in the monetary prices of alcoholic beverages, which can be achieved by raising federal, state, and local alcohol taxes, significantly reduce alcohol consumption[2].

7) **POTENTIAL EFFECT OF SSB FEE.** Over the past decade, states and localities have begun to consider taxing SSBs in order to generate revenue, reduce consumption of unhealthy beverages, and promote public health. According to a 2009 issue brief by the Robert Wood Johnson Foundation, emerging studies suggest that small taxes on SSBs are unlikely to affect obesity rates, but they can generate revenue that states can invest in improving public health. In addition, while there is only limited research on the impact of taxes on SSB consumption rates and related weight outcomes, existing research on the impact of prices on food-purchasing behaviors in general suggest that substantive taxes on SSBs could significantly affect consumption patterns and thereby have an impact on overweight and obesity rates.

   In October 2013, Mexican President Enrique Peña Nieto approved a one peso (about $0.07) tax per liter of SSB, which national health experts saw as one antidote to Mexico's alarming diabetes rates. The measure took effect January 1, 2014. A year later, preliminary data suggest consumption rates are falling, though it's too early to say precisely how much. Mexico's National Institute of Public Health earliest results suggest that in the first three months of 2014, purchases of sugary drinks dropped by 10% from the same period in 2013. Meanwhile purchases of untaxed drinks, like 100% fruit juice and milk, went up 7%, and purchases of bottled water went up 13%.

8) **RECENT LOCAL EFFORTS.** In November 2014, Berkeley, California became the first city in the nation to adopt a soda tax after 30 other cities and states around the country failed. Its Measure D levied a penny-per-ounce tax on sugar-sweetened drinks. Its revenues were not dedicated to any particular purpose, therefore needing only a simple majority vote to pass. It won the support of 75% of voters. In the first 11 months of implementation Berkeley's soda tax has generated $1.5 million. In the same election, a similar measure in San Francisco failed. San Francisco's Proposition E would have levied $0.02 per-ounce tax, and it needed two-thirds of the votes to pass because it would have directed revenue to physical education and nutrition programs for children. Proposition E failed to secure two-thirds support, and only received a simple majority, 55%, of votes. In November 2016 a new San Francisco penny-per-once soda tax initiative will be on the ballot. It will require a simple majority for passage.

9) **SUPPORT.** The American Heart Association, cosponsor of this bill, states that SSBs have a direct link to obesity and diabetes, as well as many other diseases and are the largest source of daily calories for adolescents in the U.S. Moreover, SSB consumption is highest among

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[2] Chaloupka FJ, Grossman M, and Saffer H. 2002. *The Effects of Price on Alcohol Consumption and Alcohol-Related Problems* Alcohol Res Health. 2002;26(1):22-34.

groups that have the highest risk of type 2 diabetes. If nothing is done, it is predicted that 50% of Latino and African American children born since the year 2000 will develop type 2 diabetes during their lifetime. This bill will enable the state to invest in communities disproportionately burdened by diseases related to the consumption of SSBs. The American Diabetes Association (ADA), a cosponsor of this bill, argues that this bill can play an important role in preventing diabetes by deterring consumption of SSBs and appropriating monies from the health impact fee for educational and health purposes in communities hardest hit by the disease. The ADA states that diabetes costs $37.1 billion annually in California alone and argues that California cannot afford to wait to address this growing epidemic. The Latino Coalition for a Healthy California argues that the investment in communities of color made possible by the fee on SSBs, which will raise over $2 billion, will comprehensively address the root causes of poor health outcomes in these communities. The American Academy of Pediatrics, California supports this bill because it will bring awareness of the hazardous effects of SSBs, provide dedicated resources to impacted communities, and reduce SSB consumption.

10) **OPPOSITION.** Californians for Food and Beverage Choice (CFB) argues that this tax does not just impact soda, it also would place a misguided tax on juice drinks, sports drinks, iced teas, and enhanced waters and result in higher prices on hundreds of products sold at convenience and grocery stores and restaurants. These increased prices will especially impact middle- and lower-income Californians. CFB argues that obesity and diabetes are complex health issues so it is unfair and inaccurate to portray SSBs as the main culprit. While obesity and diabetes are serious concerns, consumption of SSBs has steadily declined over the past decade while the rates of obesity and diabetes have increased. The California Restaurant Association argues that this bill is an overreach of government. Singling out and increasing costs on one specific product is a misguided tactic and will likely force higher costs on all drinks. Placing higher taxes on beverages or food will not singularly make people healthier. PepsiCo states that data from the U.S. Department of Agriculture show that over the last 40 years calorie intake from "added fat" and "refined grains" have risen while calories from products with "added sugar" have been flat, with total calories from the former two sources each being larger than calories from added sugar. Pepsi also argues that this bill endangers good jobs in California.

11) **RELATED LEGISLATION.** AB 2696 (Beth Gaines) requires DPH to submit a report to the Legislature on or before January 1, 2018, that includes a summary and compilation of recommendations on diabetes prevention and management.

12) **PREVIOUS LEGISLATION.**

a) AB 1357 (Bloom) of 2015 was largely similar to this bill. AB 1357 failed passage in the Assembly Health Committee.

b) AB 572 (Beth Gaines) would have required DPH to create a detailed diabetes action plan for the state, and to report the results of the plan to the Legislature biennially. Requirements include the development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan and a proposed budget for each action step, as well as policy recommendations for the prevention and treatment of diabetes. AB 572 was held on the Suspense File in the Senate Appropriations Committee.

c) SB 203 (Monning) of 2015 would have established the Sugar-Sweetened Beverages Safety Warning Act, to be administered by DPH, and required a safety warning on all sealed SSB containers. Would have required the warning label to be posted in a place that is easily visible at the point-of-purchase of an establishment where a beverage container is not filled by the consumer. SB 203 failed passage in the Senate Health Committee.

d) SCR 34 (Monning) of 2015 proclaimed the month of September 2015, and each year thereafter, as Childhood Obesity Awareness Month, and expressed the Legislature's support of various programs that work to reduce obesity among children.

e) SR 47 (Hall) of 2015 proclaimed November 2016 as Diabetes Awareness Month, and expressed the Senate's support of aggressive early detection and treatment of diabetes.

f) SB 1000 (Monning) of 2014 was largely similar to SB 203. SB 1000 failed passage in the Assembly Health Committee.

g) SB 622 (Monning) of 2013 would have imposed $0.01 per fluid ounce tax on bottled SSBs and concentrates. SB 622 was held on the Suspense File in the Senate Appropriations Committee.

h) AB 669 (Monning) of 2011 was similar to SB 622. AB 669 was held in the Assembly Revenue and Taxation Committee.

i) AB 2100 (Coto) of 2010 would have imposed a $0.01 per teaspoon of added sweetener tax on SSBs and concentrates. AB 2100 was held in the Assembly Revenue and Taxation Committee.

j) SB 1210 (Florez) of 2010, a similar measure to AB 2100, was placed on the former Senate Revenue and Taxation Committee's Suspense File.

k) SB 1520 (Ortiz) of 2002 would have imposed an excise tax upon every distributor, manufacturer, or wholesale dealer at a rate of $2 per gallon of soft drink syrup or simple syrup, $0.21 per gallon of bottled soft drinks, and $0.21 per gallon of soft drink produced from powder. The soda tax provisions were removed from the April 29, 2002, version of the bill.

l) AB 105 (Moore) of 1983 would have imposed an excise tax on the distribution of nonalcoholic carbonated beverages, except carbonated water and carbonated fruit juice, at the rate of $0.07 per gallon. The provisions of that bill also included an excise tax on the distribution of nonalcoholic carbonated beverage syrup at the rate of $0.50 per gallon of liquid syrup. AB 105 also died in the Assembly Revenue and Taxation Committee.

13) TECHNICAL AMENDMENTS.

a) On page 12, line 36, insert the word "media" before "campaign" to clarify what campaign this refers to.

b) On page 13, it appears that lines 8 and 9 should be deleted as they are duplicative of language already included in this paragraph on page 12, line 39.

c) Three technical amendments are recommended related to section 104895.57 of this bill, as follows:

i) In order to clarify the definition of "program" as used in section 104895.57 beginning on page 19, line 11 of the bill, the following should be inserted on page 20 after line 10: "(d) For purposes of this section, "program" shall mean all of the activities paid for by the Fund."

ii) In section 104895.57 beginning on page 19, line 11, as drafted, this bill requires DPH, DHCS, CDE and DFA to prepare an annual program budget, including the amount of fees that have been paid to BOE. The bill should add BOE to that list of departments which will coordinate to provide the necessary information for preparing the annual budget.

iii) Paragraph (c) of section 104895.57 beginning on page 20, line 1, states that DPH, DHCS, DFA, and CDE "shall deposit all moneys submitted for reimbursement by the program into the Healthy California Fund Administration Account . . ." The bill should clarify the meaning of this provision or delete it.

14) DOUBLE REFERRAL. This bill has been double-referred. Should this bill pass out of this committee, it will be referred to the Assembly Revenue and Tax Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

American Diabetes Association (cosponsor)
American Heart Association (cosponsor)
California Black Health Network (cosponsor)
California Dental Association (cosponsor)
California Primary Care Association (cosponsor)
Latino Coalition for a Healthy California (cosponsor)
Public Health Institute (cosponsor)
Roots of Change (cosponsor)
100 Black Men of Sacramento
ACT for Women and Girls
AFSMC District Council 36
Agriculture and Land-Based Training Association
Alchemist CDC
Alliance for Rural Community Health
AltaMed Health Services Corporation
American Academy of Pediatrics
American Federation of State, County and Municipal Employees, (AFL-CIO)
Asian Pacific Islander Obesity Prevention Alliance
California Academy of Physician Assistants
California Chronic Care Coalition

California Food Policy Advocates
California Immigrant Policy Center
California Latinas for Reproductive Justice
California Pan-Ethnic Health Network
California Rural Legal Assistance Foundation
California School-Based Health Alliance
California School Nurses Association
Cambodian Family Community Center
Children Now
Community Clinic Association of Los Angeles County
Community Clinic Consortium
Community Health Partnership
Community Water Center
County Health Executives Association of California
Cultiva La Salud
Dignity Health
Ecology Center
Families in Good Health
Farmers Guild
Having our Say!
Health and Life Organization, Inc.
Health Trust
Kheir Center
Long Beach Fresh
Los Angeles Trust for Children's Health
Mathiesen Memorial Health Clinic
Mountain Valleys Health Centers
National Hmong American Farmers
North Coast Clinics Network
North East Medical Services
Orange County Food Access
PDI Surgery Center
Pico Union Project
Sacramento Native American Health Center, Inc.
San Ysidro Health Center
SEIU California
Sonoma County Board of Supervisors
Sonoma County Indian Health Project
South Asian Network
Southeast Asia Resource Action Center
Street Level Health Project
Tiburcio Vasquez Health Center
UFCW Western States Council
United Nurses Association of California
Vision y Compromiso

Opposition

California Restaurant Association

California Teamsters Public Affairs Council
Californians for Food and Beverage Choice
PepsiCo

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