SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health Care Committee

BILL: SB 642

INTRODUCER: Senator Miller

SUBJECT: Lead Poisoning Prevention Screening and Education

DATE: January 23, 2006 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Favorable**
2.			JU	
3.			HA	
4.			WM	
5.				
6.				

I. Summary:

Senate Bill 642 creates the "Lead Poisoning Prevention Screening and Education Act." The bill expands the Department of Health's (DOH) health education responsibilities for prevention and identification of lead poisoning by establishing a multifaceted, statewide educational program designed to increase public awareness of the hazards of childhood lead poisoning, primarily as a result of exposure to lead-based paints in older buildings. The bill creates a collaborative public information initiative sponsored by the Governor, the Secretary of Health, and private industry representatives to produce and distribute public service announcements and other materials that contain culturally and linguistically appropriate information.

The bill establishes a statewide screening program for early identification of persons at risk of lead poisoning, including requirements for screening in Florida's Medicaid program. The bill requires the development of guidelines for medical followup on children identified with elevated blood-lead levels, and a surveillance system for geographic areas with the highest prevalence of children with elevated blood-lead levels.

This bill creates seven unnumbered sections of law.

II. Present Situation:

Childhood Lead Poisoning

The Federal Centers for Disease Control and Prevention (CDC) have termed excessive absorption of lead as "one of the most common pediatric health problems in the U.S. today and it

is entirely preventable."[1] Approximately 434,000 U.S. children age 1-5 years have blood-lead levels greater than the CDC recommended level of 10 micrograms of lead per deciliter (ug/dL) of blood.

Lead poisoning can affect nearly every system in the body. Because lead poisoning often occurs with no obvious symptoms, it frequently goes unrecognized. Lead poisoning can result in learning disabilities, behavioral problems, delayed congenital development, interference with metabolizing calcium, reduced heme syntheses (or the body's ability to manufacture red blood cells), reduced kidney function, and damage to the central nervous system and, at very high levels, seizures, coma, and even death. The damage to the central nervous system is not reversible. The extent to which these effects will be present in a child depends on a number of factors, including the duration and intensity of exposure. These factors are still being studied to determine long-term effects of exposure on children.

Most U.S. children today who have lead poisoning, or who are at high-risk for lead poisoning, are impoverished and live in older, deteriorating housing. Children whose nutritional status is compromised are at an even greater risk. According to the Government Accountability Office (GAO), the majority (over 60%) of children with elevated blood-lead levels (≥10µg/dL) were Medicaid eligible.[2] Currently, less than half (43%) of Medicaid-eligible children ever receive a blood lead screening test.

The main source of lead exposure among U.S. children is lead-based paint and lead-contaminated dust found in deteriorating buildings. Lead-based paints were banned from use in housing in 1978; however, approximately 24 million housing units in the U.S. still contain deteriorated leaded paint and elevated levels of lead-contaminated house dust. More than 4 million of these dwellings are homes to one or more young children.

Children are at particular risk for lead exposure due to their regular hand-to-mouth activity during daily play where lead-based paint is peeling or flaking. The dust from this deteriorating paint is easily ingested and is a significant source of exposure. According to the Children's Environmental Health Network, children 9 months of age to 2-l/2 years of age are at the greatest risk of lead poisoning.[3] They have greater hand-to-mouth activity; their brains are more sensitive to the toxic effects of lead; and they absorb a greater percentage of the lead that is ingested.

In recent years, however, other sources of lead poisoning in children have been identified. With an increasing number of refugees and other immigrants entering the United States, a corresponding increase has been seen in non-paint lead exposure (e.g., lead has been found in some homeopathic remedies, candies, and pottery and other dishes used in food storage, preparation and serving). As a result, federal lead poisoning prevention activities have expanded beyond just leaded paint exposure. For example, recently the U.S. Food and Drug Administration

[1] *Preventing Lead Poisoning in Young Children*, Office of the Director, National Center for Environmental Health and Injury Control, 1991.
[2] *Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children*. GAO/HEHS-99-18.
[3] http://www.cehn.org/cehn/leadpoisoning.html

(FDA) developed new guidelines for lead levels in candies, primarily imported from Mexico or other Latin American countries, to reduce childhood lead exposure.[4]

The Centers for Disease Control and Prevention believes that with a continued concerted effort, especially in the area of primary prevention, lead poisoning will be virtually eliminated by 2010, and the nation's health objective to "eliminate blood lead levels in children," as presented in the U.S. Department of Health and Human Services' "Healthy People 2010" (objective no. 8-11) will be achieved.

To accomplish this goal, the CDC recommends that federal and state program efforts need to increase focus in the area of housing-based primary prevention policy development and provide the necessary data to policy makers that will assure their support of those policies. Housing-based primary prevention policy will assure lead-safe housing is available for families with young children beyond 2010.

After 2010, program efforts will continue to focus on blood-lead surveillance, however, other surveillance activities that reveal changes in housing risk status and non-paint exposure sources will likely be added.

Florida's Childhood Lead Poisoning Prevention Program (CLPPP)

According to DOH, lead poisoning became a notifiable disease in Florida in 1992, and in 1993, the department began collecting and entering laboratory-based surveillance data into the state database at the Division of Environmental Health in Tallahassee. Program staff maintains laboratory data and blood-lead-level results, and accompanying information is entered, checked for quality, and merged to a main database.

The Florida Childhood Lead Poisoning Prevention Program (CLPPP) was established in 1992 with a grant from CDC. From 1990 to 2005, CDC has appropriated funds to state and local health departments to support childhood lead poisoning prevention programs. During FY 2005, CDC allocated nearly $30 million to state and city health departments.

In July 2003, the Florida CLPPP became a centralized, statewide lead poisoning prevention program and absorbed three previously independent CDC-funded lead programs in Miami-Dade, Pinellas, and Duval counties. The CLPPP currently operates within the department's Bureau of Community Environmental Health. The state CLPPP receives an estimated $1 million dollars from the CDC each year and distributes the majority of these funds to the Miami-Dade, Pinellas, and Duval county health departments, which continue to operate comprehensive childhood lead programs. A small amount of funding is also distributed to Broward, Hillsborough, Orange, Palm Beach, and Polk counties. Like Miami-Dade, Pinellas, and Duval, these five counties also have a number of older housing units and a large population of at-risk children.

In Florida, this CDC funding supports 14 full-time and seven part-time DOH staff. These employees coordinate and assist with educating the public, improving the blood-lead screening

[4] "Lead in Candy Likely To Be Consumed Frequently by Small Children: Recommended Maximum Level and Enforcement Policy," Draft Guidance. U.S. Food and Drug Administration. December 2005.

rates, educating health care providers, and providing comprehensive case management. Staff also develops partnerships to coordinate primary prevention activities. Funds are also used for travel and to purchase and distribute outreach materials.

The program distributes literature regarding the prevention of childhood lead poisoning and stresses the importance of screening and follow-up of at-risk children. This literature is published in English, Spanish, Vietnamese, and Creole. The literature is distributed via the state CLPPP, county health departments, private providers, and community organizations. Both the state and county level CLPPPs sponsor public service announcements related to preventing childhood lead exposure. The programs work closely with partners such as the Agency for Health Care Administration (AHCA) in this effort.

Although the CDC has funded CLPPP to maintain a statewide lead-screening database containing blood-lead screening records dating back to 1993, it has informed the program that funding for screening services will not be provided after June 30, 2006. Some funding should be available for outreach activities beyond this date, but it is unlikely that any CDC funding for the CLPPP program will continue after 2010. The department reports that they expect a substantial cut in the total amount of the grant in the next grant cycles.

Medicaid and Childhood Lead Poisoning

Children enrolled in the Medicaid program are required by federal law to be tested for lead exposure, and they represent the largest population screened. As part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program [currently known in Florida as Child Health Check-Up (CHCUP)], federal regulations require that all Medicaid-eligible children receive a screening blood-lead test at 12 months of age, at 24 months of age, and between the ages of 36 and 72 months, if they have not been previously screened for lead poisoning.

Medicaid screening for lead exposure is a two-step process. First, a capillary specimen (fingerstick) is taken. If the fingerstick blood-lead test result is equal to or greater than 10 micrograms per deciliter, a second test using a venous (blood drawn through the vein) blood sample must be conducted to verify the result. If a child is found to have blood-lead levels equal to or greater than 10 micrograms per deciliter using a venous blood sample, providers are advised to use their medical discretion with reference to current CDC guidelines covering patient management and treatment, including follow-up blood tests and initiating investigation as to the source of lead, where indicated.

Medicaid has a Lead Poisoning Prevention Flyer (English with reverse side in Spanish) that is sent out with the monthly CHCUP letters to eligible children nine months to five years of age to increase the awareness of families/caregivers of the importance of screening blood-lead testing. The flyer/poster has also been produced in Creole. In addition, Medicaid has developed two public service announcements identifying the importance of blood-lead testing.

Screening Guideline

Florida developed a statewide Screening Guideline (updated in 2001) with grant monies from the CDC, DOH, CLPPP and its advisory council, supporting the screening of children in at-risk groups. The document includes the AHCA requirement that all Medicaid eligible children receive a blood-lead test at age 12 months and age 24 months or between the ages of 36 and 72 months if they have not been previously screened for lead poisoning. The Screening Guideline provides a case management structure of services and interventions, updated in 2003 to meet the most current CDC recommendations. County CLPPPs collaborate with local partners to identify and ensure that children in high-risk groups are screened. They also assist private providers and DOH's Children's Medical Services Program to provide care and treatment to children with elevated blood-lead levels.

Since lead poisoning became a reportable disease in 1992, more than 7,000 children in Florida have been identified with a confirmed case of lead poisoning [a venous blood-lead level equal to or greater than 10 micrograms per deciliter (ug/dL)]. Many other children are exposed to lead, but are not screened. Confirmed venous draws are counted as cases, but many children with elevated unconfirmed capillary (finger stick) tests do not receive their appropriate follow-up venous draw. Blood-lead results submitted by laboratories do not always contain complete and consistent identifying information important for thorough public health surveillance.

III. Effect of Proposed Changes:

Section 1. Provides a popular name for this act - the "Lead Poisoning Prevention Screening and Education Act."

Section 2. Provides legislative findings, including: nearly 300,000 children in the U.S. may have elevated levels of lead in their blood; high blood-lead levels may result in impairment of the ability to think, concentrate, and learn; a significant source of lead poisoning is from lead-based paints used in older residences; childhood lead poisoning can be prevented through education; knowledge of lead-based paint hazards, their control, mitigation, abatement, and risk avoidance is not sufficiently widespread; most children at risk for lead poisoning are not tested for elevated blood-lead levels; and testing for elevated blood-lead levels can result in the mitigation or prevention of its harmful effects.

Section 3. Provides definitions as used in this act, including: affected property (a residential dwelling with lead-based paint hazards); dust-lead hazard; elevated blood-lead level; lead-based paint; lead-based paint hazard; owner (used in the context of property ownership); paint-lead hazard; person at risk; Secretary (Secretary of DOH or a designee); and tenant.

Section 4. Establishes the lead poisoning prevention educational program to meet the educational needs of tenants, property owners, health care providers, early childhood educators, care providers,[5] and realtors; requires the Governor, in conjunction with the Secretary of Health and involvement of private organizations, to sponsor a series of public service announcements

[5] The term "care providers" is not defined in the bill. It is not clear if this reference may be intended to be "child care providers."

about the nature of lead-based paint hazards, the importance of prevention standards, and the nature of this act; requires the development of culturally and linguistically appropriate information pamphlets by January 1, 2007, regarding childhood lead poisoning, the importance of screening, prevention of lead poisoning, treatment of lead poisoning, and the requirements of this act; requires this information to be distributed to parents or legal guardians of children six years of age or younger through property owners, health care providers, and owners or operators of child care facilities and kindergarten classes.

Section 5. Requires the Secretary of Health to establish a program for early identification of persons under six years of age at risk of having elevated blood-lead levels; requires screening for children at age 12 months and 24 months, or between the ages of 36 months and 72 months if they have not previously been screened; requires the Secretary to promulgate rules for screening these individuals and guidelines for the medical followup on children found to have elevated blood-lead levels; identifies persons that should receive priority screening, including Medicaid children, children under the age of six years showing delayed cognitive development, at-risk persons living in the same residence as a person identified as having an elevated blood-lead level, at-risk persons in a geographic area with significant numbers of persons identified with elevated blood-lead levels, and at-risk persons residing in (or having resided in the last three years) a building that has been subject to enforcement for violations of lead poisoning prevention standards; requires the Secretary to maintain surveillance records of all screenings by geographic area and owner to determine the location of areas at risk; and requires that all cases or probable cases of lead poisoning found in the course of screening be reported to the affected individual, to his or her parent or legal guardian if the individual is a minor, and to the Secretary.

Section 6. Provides an appropriation to the Department of Health of $308,000 in recurring general revenue funds and $1 million to the Administrative Trust Fund in FY 2006-07 for the financing of this program.

Section 7. Specifies that Sections 4, 5, and 6 of this act shall take effect only upon the Department of Health receiving federal lead-poisoning prevention funds of $1 million or greater.

Section 8. Provides an effective date of July 1, 2006.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private industry organizations, including those involved in real estate, insurance, mortgage banking, and pediatrics, would be solicited by DOH in the development and coordination of a statewide, multifaceted, ongoing educational program. Property owners, health care providers, and childcare facility owners or operators would be responsible for distributing information pamphlets regarding childhood lead poisoning, testing, prevention, and treatment. The exact cost is indeterminate at this time

C. Government Sector Impact:

This bill does not provide an adequate appropriation for implementation.

The DOH's program to administer this bill would consist of 3 Environmental Specialist III positions, 1 Data Manager, 1 Administrative Support Specialist, and 1 Outreach Coordinator, blood lead screening, case management, literature publication, and database implementation for a total cost of $798,802. Of this, CDC grant monies are anticipated to fund the cost of the 3 Environmental Specialist III positions, 1 Data Manager, 1 Administrative Support Specialist, and the operating capital outlay and expenses associated with these positions for a total of $322,536. Therefore, the full amount needed to implement the activities detailed in this bill for year one equals $476,286.

The determination of this dollar amount is based on the current structure of the childhood lead poisoning prevention program and the estimation of the number of uninsured children at high-risk for lead poisoning who would require the department to provide screening and medical management services under this bill.

It is difficult to accurately estimate the number of uninsured children at high risk for lead poisoning who are not currently being tested by DOH through either the program funded by the CDC grant, or by County Health Departments (CHDs) and other DOH community health partners. The basis for the cost estimate for the total number of uninsured children in need of blood lead level testing was derived from the following data:

- According to the Children's Defense Fund, 16.6 percent of children under 19 years of age were uninsured in 2002;
- Children are normally screened at the age of 1 and 2 years;

- The Florida CHARTS[6] estimates the population of 1 and 2-year-olds in the state to be 625,000;
- About 15 percent of all housing units in Florida were built before 1959; and
- If we assume 15 percent of all uninsured one and two year-old children live in pre-1959 housing, at high risk for lead poisoning, DOH will be responsible for testing 15,600 children (625,000 x 16.6% x 15%) at the cost of $20/ test each year.

Costs for direct medical follow-up services, including education and environmental health investigations for uninsured children was derived from the following data:

- DOH estimates .0399% of the 15,000 screened children will have elevated blood lead levels (EBLLs) (N=63) per year. (Estimates based on percentage of total screened with EBLLs in 2003.)
- Estimated case management cost per child = $480 (Breakdown: Home visit = $80, El = $300; Follow-up blood tests (average 5 per child @ $20) = $100 (est. based on average of state Medicaid reimbursement rates in U.S.) $480 x 63 children = $30,240 per year.

The DOH estimates 1 Epidemiologist, 1 Screening Program Coordinator, 1 Evaluation Specialist, 1 Data Manager, 1 Administrative Support Specialist, and 1 Outreach Coordinator will be needed to coordinate screening, physician outreach and primary prevention activities as required by this bill. All positions are highly competitive and difficult to fill. The cost of these positions was determined based on current wages of other comparable positions within the DOH and the private sector.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[6] Florida Community Health Assessment Resource Tool Set – www.floridacharts.com

VIII. Summary of Amendments:

None.