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: Ways and Means Committee

BILL:	CS/SB 642
INTRODUCER:	Judiciary Committee and Senator Miller
SUBJECT:	Lead Poisoning Prevention Screening and Education Act
DATE:	April 24, 2006 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Favorable**
2.	Luczynski	Maclure	JU	**Fav/CS**
3.	Fabricant	Peters	HA	**Favorable**
4.	Riti	Coburn	WM	**Favorable**
5.				
6.				

I. Summary:

This bill 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 because 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.

The bill includes an appropriation to implement the screening program. Implementing the education component of the bill is contingent on DOH receiving a federal lead poisoning prevention grant. A revised DOH fiscal estimate is equal to the appropriation in the bill.

This bill creates unnumbered sections of the Florida Statutes.

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 United States today, and it is entirely preventable."[1] Approximately 310,000 U.S. children aged one to five have blood-lead levels greater than the CDC recommended level of 10 micrograms of lead per deciliter (ug/dL) of blood.[2]

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 cognitive 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 (75%) of children with elevated blood-lead levels (≥10µg/dL) were Medicaid eligible.[3] Currently, less than half (43%) of Medicaid-eligible children ever receive a blood-lead screening test.[4]

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

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[1] Nat'l Ctr. for Envtl. Health, Centers for Disease Control & Prevention, *Preventing Lead Poisoning in Young Children*, 1991, http://www.cdc.gov/nceh/lead/publications/books/plpyc/chapter1.htm.
[2] Nat'l Ctr. for Envtl. Health, Centers for Disease Control & Prevention, *General Lead Information: Questions and Answers*, *at* http://www.cdc.gov/nceh/lead/faq/about.htm (last visited Mar. 1, 2006).
[3] U.S. General Accounting Office, Report to the Ranking Minority Member, Comm. on Gov't Reform, House of Representatives 3, GAO/HEHS-99-18, *Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children,* http://www.gao.gov/archive/1999/he99018.pdf.
[4] Childhood Lead Poisoning Prevention Program, Dep't of Health & Human Services, Funding Opportunity Description: CDC-RFA-EH06-602, *at* http://www.cdc.gov/od/pgo/funding/EH06-602.htm (last visited Mar. 2, 2006).

risk of lead poisoning[5]; 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 (FDA) developed new guidelines for lead levels in candies, primarily imported from Mexico or other Latin American countries, to reduce childhood lead exposure.[6]

The Centers for Disease Control and Prevention (CDC) 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 policymakers 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 the Department of Health (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 provided 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.

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[5] Bureau of Cmty. Envtl. Health, Fla. Dep't of Health, *Keeping Your Children Safe from Lead Poisoning*, http://www.doh.state.fl.us/Environment/newsroom/brochures/pdfs/LeadBrochureeng.pdf (last visited Mar. 6, 2006).

[6] Center for Food Safety & Applied Nutrition, U.S. Food & Drug Admin., *Lead in Candy Likely To Be Consumed Frequently by Small Children: Recommended Maximum Level and Enforcement Policy* (2005), *at* http://www.cfsan.fda.gov/~dms/pbguid2.html (last visited Mar. 2, 2006).

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 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 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.

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 (the primary version is printed in English with reverse side in Spanish, and one other version is produced in Creole) 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. 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 an 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:

The bill establishes a multifaceted, statewide educational program designed to increase public awareness of the hazards of childhood lead poisoning, primarily because of exposure to lead-based paints in older buildings. 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 follow-up 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.

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 (a quantity of lead in whole venous blood that exceeds 10 micrograms per deciliter); lead-based paint; lead-based paint hazard; owner (used in the context of property ownership); paint-lead hazard; person at risk; Secretary (Secretary of the Department of Health (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,[7] 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 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 who 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 for implementing Section 5 (providing for the statewide screening program for early identification of persons at risk of lead poisoning) of this act.

[7] 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."

Section 7. Specifies that Section 4 (providing for a lead poisoning prevention educational program) of this act shall take effect only if the requirements in that section are consistent with the requirements of any federal childhood lead-poisoning-prevention grant awarded to DOH and if federal funds awarded with any such grant are permitted to be used to implement the requirements in that section.
Section 8. Provides an effective date of July 1, 2006, except to the extent of the contingencies specified for certain provisions in section 7.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private industries, including those involved in real estate, insurance, mortgage banking, and pediatrics, would be solicited by the Department of Health (DOH or department) in the development and coordination of a statewide, multifaceted, on-going 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:

DOH revised the fiscal impact to $308,000, equal to the appropriation in the bill.

Estimated Expenditures	1st Year	2nd Year (Annual/Recurr.)
Salaries		(3% Increase for 2nd year salaries)
1 Blood Lead Screening Coordinator @ $41,691.94	$56,284	$57,973
Other Personal Services	$0	$0
Expense		
Standard DOH professional package With limited travel @ $13,733 first year	$13,733	$10,390
Human Resources Services	$393	$393
Screening costs@ $20/screening (n=10,639)	$212,780	$212,780
Case management of 35 cases.	$16,800	$17,304
Screening database development/maintenance	$6,110	$10,000
Operating Capital Outlay		
Standard DOH prof. pkg.@$1,900 first year only	$1,900	$0
Total Estimated Expenditures	$308,000	$308,840

These figures represent the costs associated with the implementation of Section 5. The implementation of Section 4 of this bill is contingent on its consistency with the requirements of any federal grant the DOH receives.

The DOH's proposal to administer the screening and medical management program would consist of a Blood Lead Screening Coordinator, blood lead screening, case management, and database implementation for a total cost of $308,000. The determination of this dollar amount is based on 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 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 a study by the American Academy of Pediatrics in July 2005 (http://www.aap.org/advocacy/washing/elections/mfs_fl.pdf), 16.1% of children under 19 years of age were uninsured in 2005;
- Children are normally screened at the age of 1 and 2 years;
- The Florida CHARTS estimates the population of 1 and 2-year-olds in the state to be 440,519;
- About 15% of all housing units in Florida were built before 1959; and
- If we assume 15% 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 an estimated 10,639 children at the cost of $20/ test each year.

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

- DOH estimates .33% of the 10,639 screened children will have elevated blood lead levels (EBLLs) (N=35; 0.33% * 10,639) per year. (Estimates based on percentage of total screened with EBLLs in 2004.)
- 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.) $480x 35 children = $16,800 per year.

The DOH estimates a Blood Lead Screening Coordinator will be needed to coordinate screening, surveillance, and physician outreach activities as required by Section 5 of this bill. This position is highly competitive and difficult to fill. The cost of this position is determined based on current wages of other comparable positions within the DOH and the private sector funded at the base rate + 10%.

VI. Technical Deficiencies:

Section 3 of the bill defines "elevated blood-lead level" as a quantity of lead in whole venous blood that "exceeds 10 micrograms per deciliter." This appears to be a technical error as Florida defines childhood lead poisoning as blood-lead levels of "10 micrograms per deciliter or greater."[8] The specification of "10 micrograms per deciliter or greater" is the wording used in the remainder of the bill.

VII. Related Issues:

None.

[8] *Id*.

VIII. Summary of Amendments:

None.