House of Representatives

General Assembly

File No. 365

January Session, 2007

House Bill No. 6723

House of Representatives, April 5, 2007

The Committee on Public Health reported through REP. SAYERS, P. of the 60th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING THE PREVENTION OF CHILDHOOD LEAD POISONING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-111a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The **[**Commissioner**]** Department of Public Health shall be the lead state agency for lead poisoning prevention in this state. The Commissioner of Public Health shall (1) identify the state and local agencies in this state with responsibilities related to lead poisoning prevention, and (2) schedule a meeting of such state agencies and representative local agencies at least once annually in order to coordinate lead poisoning prevention efforts in this state.

(b) Within available appropriations, the commissioner shall establish a lead poisoning prevention program **[**. Such program shall**]** to provide screening, diagnosis, consultation, inspection and treatment services, including, but not limited to, the prevention and elimination

14 of lead poisoning through research, abatement, education and
15 epidemiological and clinical activities. Such program shall include, but
16 not be limited to, the screening services provided pursuant to section 2
17 of this act.

18 [(b)] (c) Within available appropriations, the [Commissioner of
19 Public Health] commissioner may contract with individuals, groups or
20 agencies for the provision of necessary services and enter into
21 assistance agreements with municipalities, cities, boroughs or district
22 departments of health or special service districts for the development
23 and implementation of comprehensive lead poisoning prevention
24 programs consistent with the provisions of sections 19a-110 to 19a-
25 111c, inclusive.

26 Sec. 2. (NEW) (*Effective October 1, 2007*) (a) Each primary care
27 provider giving pediatric care to a child six years of age or under in
28 this state shall take or cause to be taken a blood sample from each such
29 child for the purpose of conducting blood lead screening in accordance
30 with this section. Each primary care provider shall also arrange for
31 lead risk assessments in accordance with subsection (b) of this section.
32 The requirements of this section shall not apply to any child whose
33 parent or guardian objects to a blood test as being in conflict with the
34 parent or guardian's religious tenets and practices. For the purposes of
35 this section, a "child six years of age or under" means a child (1) six
36 years of age or under, or (2) whose chronological age is over six years
37 but who is developmentally delayed or has a loss of cognitive skill for
38 no identified reason.

39 (b) (1) Lead screening shall be conducted at least annually for each
40 child age nine months to thirty-six months inclusive. Additional
41 screening shall be conducted as clinically indicated as determined by
42 the primary care provider. For purposes of this section, clinically
43 indicated screening shall include, but not be limited to, screening for a
44 child who:

45 (A) Has never been screened for blood lead, in which case the child
46 shall be immediately screened regardless of other risk factors; or

47 (B) Has a clinical record or exhibits symptoms indicative of elevated
48 blood lead levels, which symptoms may include, but not be limited to,
49 neurological symptoms, hyperactivity, behavioral disorders,
50 abdominal pain or developmental delays.

51 (2) In addition to such screening, a risk assessment shall be
52 conducted at least annually for each child age thirty-seven months to
53 seventy-two months inclusive. Such risk assessment shall comply with
54 standards established by the Commissioner of Public Health, and shall
55 include, but not be limited to, questions to determine whether the
56 child:

57 (A) Is exhibiting a habit of eating nonfood substances;

58 (B) Has a prior confirmed venous blood lead level equal to or
59 greater than ten micrograms per deciliter; or

60 (C) Resides in a residence constructed before 1978 that has
61 undergone major renovations that may increase the risk of lead
62 exposure.

63 Sec. 3. Section 19a-110 of the general statutes is repealed and the
64 following is substituted in lieu thereof (*Effective October 1, 2007*):

65 (a) **[**Each institution licensed under the provisions of sections 19a-
66 490 to 19a-503, inclusive, and each private clinical laboratory licensed
67 under section 19a-30 shall, within**]** Not later than forty-eight hours **[**of
68 receipt of knowledge thereof,**]** after receiving or completing a report of
69 a person found to have a level of lead in the blood equal to or greater
70 than ten micrograms per deciliter of blood or any other abnormal body
71 burden of lead, each institution licensed under sections 19a-490 to 19a-
72 503, inclusive, and each clinical laboratory licensed under section 19a-
73 30 shall report to (1) the Commissioner of Public Health, and to the
74 director of health of the town, city or borough in which the person
75 resides: **[**(1)**]** (A) The name, full residence address, date of birth,
76 gender, race and ethnicity of each person found to have a level of lead
77 in the blood equal to or greater than ten micrograms per deciliter of

78 blood or any other abnormal body burden of lead; [(2)] (B) the name,
79 address and telephone number of the health care provider who
80 ordered the test; [(3)] (C) the sample collection date, analysis date, type
81 and blood lead analysis result; and [(4)] (D) such other information as
82 the commissioner may require, and (2) the health care provider who
83 ordered the test, the results of the test. With respect to a child six years
84 of age or under, as defined in section 2 of this act, not later than
85 seventy-two hours after the provider receives such results, the
86 provider shall make reasonable efforts to notify the parent or guardian
87 of the child of the blood lead analysis results. Any institution or
88 laboratory making an accurate report in good faith shall not be liable
89 for the act of disclosing said report to the commissioner or to the
90 director of health. The commissioner, after consultation with the Chief
91 Information Officer of the Department of Information Technology,
92 shall determine the method and format of transmission of data
93 contained in said report.

94 (b) Each institution or laboratory that conducts lead testing
95 pursuant to subsection (a) of this section shall, at least monthly, submit
96 to the Commissioner of Public Health a comprehensive report that
97 includes: (1) The name, full residence address, date of birth, gender,
98 race and ethnicity of each person tested pursuant to subsection (a) of
99 this section regardless of the level of lead in the blood; (2) the name,
100 address and telephone number of the health care provider who
101 ordered the test; (3) the sample collection date, analysis date, type and
102 blood lead analysis result; (4) laboratory identifiers; and (5) such other
103 information as the commissioner may require. Any institution or
104 laboratory making an accurate report in good faith shall not be liable
105 for the act of disclosing said report to the commissioner. The
106 commissioner, after consultation with the Chief Information Officer,
107 shall determine the method and format of transmission of data
108 contained in said report.

109 (c) Whenever an institutional laboratory or private clinical
110 laboratory conducting blood lead tests pursuant to this section refers a
111 blood lead sample to another laboratory for analysis, the laboratories

112 may agree on which laboratory will report in compliance with
113 subsections (a) and (b) of this section, but both laboratories shall be
114 accountable to insure that reports are made. The referring laboratory
115 shall insure that the requisition slip includes all of the information that
116 is required in subsections (a) and (b) of this section and that this
117 information is transmitted with the blood specimen to the laboratory
118 performing the analysis.

119 (d) The director of health of the town, city or borough shall provide
120 or cause to be provided, to the parent or guardian of a child reported,
121 pursuant to subsection (a) of this section, with information describing
122 the dangers of lead poisoning, precautions to reduce the risk of lead
123 poisoning, information about potential eligibility for services for
124 children from birth to three years of age pursuant to sections 17a-248
125 to 17a-248g, inclusive, and laws and regulations concerning lead
126 abatement. Said information shall be developed by the Department of
127 Public Health and provided to each local and district director of health.
128 Such director shall conduct an on-site inspection of the source of the
129 lead causing a confirmed venous blood lead level equal to or greater
130 than ten micrograms per deciliter and take further action pursuant to
131 section 19a-111, as amended by this act, if the on-site inspection does
132 not identify the source of the lead exposure.

133 Sec. 4. Section 19a-111 of the general statutes is repealed and the
134 following is substituted in lieu thereof (*Effective October 1, 2007*):

135 Upon receipt of each report of confirmed venous blood lead level
136 equal to or greater than twenty micrograms per deciliter of blood, or
137 after an on-site inspection conducted pursuant to section 19a-110, as
138 amended by this act, fails to identify the source of lead exposure, the
139 local director of health shall make or cause to be made an
140 epidemiological investigation of the source of the lead causing the
141 increased lead level or abnormal body burden and shall order action to
142 be taken by the appropriate person or persons responsible for the
143 condition or conditions which brought about such lead poisoning as
144 may be necessary to prevent further exposure of persons to such

145 poisoning. In the case of any residential unit where such action will not
146 result in removal of the hazard within a reasonable time, the local
147 director of health shall utilize such community resources as are
148 available to effect relocation of any family occupying such unit. The
149 local director of health may permit occupancy in said residential unit
150 during abatement if, in his judgment, occupancy would not threaten
151 the health and well-being of the occupants. The local director of health
152 shall, within thirty days of the conclusion of his investigation, report to
153 the Commissioner of Public Health the result of such investigation and
154 the action taken to insure against further lead poisoning from the same
155 source, including any measures taken to effect relocation of families.
156 Such report shall include information relevant to the identification and
157 location of the source of lead poisoning and such other information as
158 the commissioner may require pursuant to regulations adopted in
159 accordance with **[**the provisions of**]** chapter 54. The commissioner shall
160 maintain comprehensive records of all reports submitted pursuant to
161 this section and section 19a-110, as amended by this act. Such records
162 shall be geographically indexed in order to determine the location of
163 areas of relatively high incidence of lead poisoning. The commissioner
164 shall prepare a quarterly summary of such records which he shall keep
165 on file and release upon request. The commissioner shall establish, in
166 conjunction with recognized professional medical groups, guidelines
167 consistent with the National Centers for Disease Control for
168 assessment of the risk of lead poisoning, screening for lead poisoning
169 and treatment and follow-up care of individuals including children
170 with lead poisoning, women who are pregnant and women who are
171 planning pregnancy. Nothing in this section shall be construed to
172 prohibit a local building official from requiring abatement of sources of
173 lead.

174 Sec. 5. (NEW) (*Effective October 1, 2007*) Each individual health
175 insurance policy providing coverage of the type specified in
176 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
177 statutes delivered, issued for delivery, amended, renewed or
178 continued in this state on or after October 1, 2007, shall provide
179 coverage for blood lead screening and risk assessments ordered by a

180 primary care provider pursuant to section 2 of this act.

181 Sec. 6. Subsection (b) of section 38a-535 of the general statutes is
182 repealed and the following is substituted in lieu thereof (*Effective*
183 *October 1, 2007*):

184 (b) **[**Every**]** Each group health insurance policy providing coverage
185 of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of
186 section 38a-469 delivered, issued for delivery or renewed on or after
187 October 1, 1989, or continued as defined in section 38a-531, on or after
188 October 1, 1990, shall provide benefits for preventive pediatric care for
189 any child covered by the policy or contract at approximately the
190 following age intervals: Every two months from birth to six months of
191 age, every three months from nine to eighteen months of age and
192 annually from two through six years of age. Any such policy may
193 provide that services rendered during a periodic review shall be
194 covered to the extent that such services are provided by or under the
195 supervision of a single physician during the course of one visit. Each
196 such policy shall also provide coverage for blood lead screening and
197 risk assessments ordered by a primary care provider pursuant to
198 section 2 of this act. Such benefits shall be subject to any policy
199 provisions which apply to other services covered by such policy.

200 Sec. 7. (NEW) (*Effective October 1, 2007*) Not later than January 1,
201 2008, the Commissioner of Public Health shall review the data
202 collected by the Department of Public Health regarding lead poisoning
203 to determine if it is recorded in a format that is compatible with the
204 information reported by institutions and laboratories pursuant to
205 section 19a-110 of the general statutes, as amended by this act. If the
206 commissioner finds that such data should be reported in a different
207 manner, the commissioner shall adopt regulations, in accordance with
208 chapter 54 of the general statutes, to establish the manner for reporting
209 such data.

This act shall take effect as follows and shall amend the following sections:

Section 1	*October 1, 2007*	19a-111a
Sec. 2	*October 1, 2007*	New section
Sec. 3	*October 1, 2007*	19a-110
Sec. 4	*October 1, 2007*	19a-111
Sec. 5	*October 1, 2007*	New section
Sec. 6	*October 1, 2007*	38a-535(b)
Sec. 7	*October 1, 2007*	New section

KID *Joint Favorable C/R* PH

PH *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 $	FY 09 $
Public Health, Dept.	GF - Cost	1,404,538	1,082,889
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	See Below	See Below
Department of Mental Retardation	GF - Cost	Potential	Potential
Social Services, Dept.	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 08 $	FY 09 $
All Municipalities	STATE MANDATE - Cost	552,100	1,104,200
Various Municipalities	Cost	Indeterminate	Indeterminate

Explanation

Department of Public Health (DPH)

The Department of Public Health will incur an FY 08 cost of $1,404,500 to institute comprehensive screening of children for lead poisoning and meet other duties in the bill. Fringe benefits costs of $123,413 will also be incurred.[1]

This funding will support the salaries of 9 positions within the State

[1] The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The estimated first year fringe benefit rate for a new employee as a percentage of average salary is 25.8%, effective July 1, 2006. The first year fringe benefit costs for new positions do not include pension costs. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System (SERS). The SERS 2006-07 fringe benefit rate is 34.4%, which when combined with the non pension fringe benefit rate totals 60.2%.

Laboratory and 6 positions within the department's Lead Poisoning Prevention and Control Program, as well as the costs of laboratory supplies, associated other expenses and one-time equipment costs.

It should be noted that while the bill establishes the mandatory testing program as of 10/1/07, this cost estimate is based upon a 1/1/08 implementation date in recognition of the length of time needed by the DPH to acquire and put into operation needed laboratory equipment, as well as train staff.

The FY 09 cost associated with the department's implementation of the bill will be $1,082,900, reflecting full year salaries and annualized laboratory costs. Fringe benefits costs of $461,310 will also be incurred.

Should no appropriation be included within the enacted FY 08-09 Biennial Budget for purposes of the bill, the requirement that associated costs be accommodated within available appropriations will likely result in one of four outcomes: (1) DPH will proceed, and require a deficiency appropriation; (2) DPH will delay the implementation of the bill pending the approval of additional appropriations in future fiscal years; (3) DPH will shift resources from other department priorities, thereby impacting existing departmental programs; or (4) DPH will not implement the comprehensive lead screening program.

Local Health Authorities

Local health authorities will experience costs to the extent that they conduct additional on-site investigations of sources of lead and epidemiological investigations. This results from lowering from 20 to 10 micrograms the per deciliter blood lead level that prompts investigation and the expansion of the number of children identified having blood lead levels of 20 micrograms per deciliter or greater.

On an annualized basis it is estimated that 1,465 more investigations will be conducted. Estimated aggregate statewide costs of approximately $1.1 million will be incurred by local health authorities,

based upon an average cost of $1,400 per case for 413 children requiring epidemiological investigations, and $500 per case for 1,052 children requiring less intensive on-site inspections. Assuming an implementation date of 1/1/08, FY 08 costs of approximately $550,000 would be incurred.

Actual costs would vary by community based upon the incidence of children with elevated blood lead levels.

Department of Social Services (DSS)

This bill requires group health insurance policies as well as the HUSKY A and B programs to provide coverage for blood lead screening for children annually between 6 months and 36 months of age.

Under current practice, the Commissioner of Public Health waives laboratory testing charges for blood lead level tests provided to children who are enrolled in the Medicaid and HUSKY programs. If the Commissioner were to initiate billing for these services, it would result in an added cost to these Department of Social Services' programs of $480,000 annually. This estimate assumes that these programs would pay for 30,000 screens annually, at a cost of $16 per screen. If billing were to occur, these costs would be partially reimbursed by the federal government at a rate of 50% for the HUSKY A program and 65% for the HUSKY B program, for a total of $245,500 in federal matching funds.

Department of Mental Retardation

Section 3 of the bill requires local health directors to provide information to parents of children with elevated blood lead levels concerning the child's potential eligibility for the Birth-to-Three program. To the extent that this results in additional evaluations and increased enrollment in the program, an additional cost may result to the Department of Mental Retardation (as this is an entitlement program). Although the bill does not change eligibility for Birth-to-

Three services, the provision may result in identifying eligible children earlier than may have otherwise occurred. The average annual net cost per child is $7,300.

State and Local Heath Insurance Plans

The bill mandates that health insurance policies cover lead screening and risk assessments ordered by a child's primary care providers. This provision is anticipated to increase costs for the state and certain municipal health insurance plans that cannot be determined at this time. Such cost would be mitigated by the savings associated with future health problems prevented by the early detection of elevated lead levels.

Summary

Should provisions in this bill mitigate the incidence of lead poisoning in children or reduce the severity of such poisoning, future indeterminate savings in the areas of educational and health services may result.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis
HB 6723

AN ACT CONCERNING THE PREVENTION OF CHILDHOOD LEAD POISONING.

SUMMARY:

Within available appropriations, this bill mandates additional components in the Department of Public Health's (DPH) lead-poisoning prevention program. It creates a timetable and reporting requirements for testing babies and toddlers and continuing risk assessments for pre-schoolers and kindergartners.

The bill requires local health officials to conduct more in-depth investigations to locate the source of lead causing a child's lead poisoning.

EFFECTIVE DATE: October 1, 2007

§§ 2, 3 & 4 — SCREENING AND RISK ASSESSMENTS

Blood Testing

The bill requires primary care providers to take blood samples that measure lead levels in all their patients (1) age 6 and under and (2) older children with developmental delays or who have lost cognitive skills for no identified reason. Children whose parents object to blood tests on religious grounds are exempt.

The bill requires testing at least annually for children between nine and 36 months of age. Primary care providers must also order testing for other youngsters when they determine it is clinically indicated. Among others, they must test children who:

1. have never been tested or

2. have a clinical record or exhibit symptoms consistent with elevated lead levels, such as neurological symptoms, hyperactivity, behavioral disorders, abdominal pain, or developmental delays.

Risk Assessments

Primary care providers must also arrange for annual lead risk assessments for patients ages 37 to 72 months. The DPH commissioner must set standards including questions to determine whether the child:

1. has a habit of eating nonfood substances,

2. has had a prior confirmed venous blood level of at least 10 micrograms/deciliter of blood, or

3. lives in a building built before 1978 that has undergone major renovations that may increase the risk of lead exposure.

§§ 5 & 6 — Insurance Coverage

The bill requires individual and group health insurance policies to cover lead screening and risk assessments ordered by a child's primary care provider. This requirement applies to Connecticut policies delivered, issued for delivery, amended, renewed, or continued on or after October 1, 2007.

§ 3 — REPORTING ELEVATED BLOOD LEVELS

Health Care Providers

By law, health care institutions and clinical laboratories must notify the DPH commissioner and appropriate local health official within 48 hours of receiving or completing a report on a person with a lead level of 10 or more micrograms per deciliter of blood or other abnormal bodily lead level. The bill requires them also to report the results within 48 hours to the health care provider who ordered the test.

Parents or Guardians

The bill requires the health care provider to make reasonable efforts

to notify parents or guardians of the test result for a child under age six who is subject to the bill's mandatory lead screening provision described above. The provider must do this not later than 72 hours after learning the test results.

It also requires the local health director to give parents information about their potential eligibility for the state's Birth to Three program, which provides services to families with children with disabilities age three and under. They must already give them information about lead poisoning dangers and lead abatement laws and regulations.

§§ 3 & 4 — HEALTH DEPARTMENT INSPECTIONS & INVESTIGATIONS

The bill requires the local or district health director to conduct an on-site inspection of the source of lead causing every confirmed blood lead level of 10 or more micrograms per deciliter. If the source cannot be identified, the director must conduct, or arrange for someone else to conduct, an epidemiological investigation. This involves an inspection conducted by a lead inspector to detect lead-based paint and an evaluation of other sources such as dust, soil, pottery, gasoline, toys, or occupational exposures. It may also include isotopic analysis of lead-containing items.

Currently, the epidemiological investigation is required for lead levels of 20 micrograms per deciliter or above.

§ 1 — COORDINATING LEAD-POISONING PREVENTION EFFORTS

The bill makes DPH the lead agency for lead-poisoning prevention in the state. The commissioner must identify the state and local agencies with responsibilities related to lead poisoning and schedule a meeting with them at least once a year to coordinate their efforts statewide.

§ 17 — DATA COLLECTION

The bill requires the public health commissioner, by January 1, 2008, to review the lead-poisoning data DPH collects and determine if its

format is compatible with reports from institutional and private clinical labs performing lead testing. The commissioner must adopt regulations if it is determined that the department should report its data differently.

COMMITTEE ACTION

Select Committee on Children

Joint Favorable Change of Reference
Yea 10 Nay 0 (03/06/2007)

Public Health Committee

Joint Favorable
Yea 21 Nay 6 (03/21/2007)