SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2021-2022 Regular Session

AB 2326 (Reyes)
Version: May 2, 2022
Hearing Date: June 14, 2022
Fiscal: Yes
Urgency: No
AM

SUBJECT

Lead poisoning prevention: laboratory reporting

DIGEST

This bill replaces the threshold blood lead level (BLL) that initiates certain reporting requirements for health care providers and laboratories with the most recent federal Centers for Disease Control and Prevention reference level for an elevated BLL. The bill also requires a laboratory that performs a BLL analysis to report additional information, as provided, and specifies additional circumstances under which confidential information may be disclosed with respect to BLLs.

EXECUTIVE SUMMARY

According to the author and sponsor of the bill, current state law prevents or delays appropriate and timely case management for children and adults with elevated BLLs due to incomplete reporting requirements for laboratories, lack of authority for the State Department of Public Health (DPH) to share data, and that current state law is not aligned with the recently updated elevated BLL threshold under federal standards, which is currently 3.5 micrograms/deciliter. This bill replaces the threshold BLL for certain reporting requirements to align with the current recent federal Centers for Disease Control and Prevention reference level. The bill also requires laboratories to report additional information and authorizes additional purposes for which DPH may share confidential data received from the laboratories.

The bill is sponsored by the Environmental Working Group and supported by various organizations. There is no known opposition. The bill passed the Senate Health Committee on a vote of 9 to 0.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Requires a laboratory that performs a blood lead analysis on a specimen of human blood drawn in California to report specified information to DPH for each analysis on every person tested, including the person's birth date if the analyzing laboratory has that information, or if not, the persons age, and, the person's address, including the ZIP Code, if the analyzing laboratory has that information, or if not, a telephone number by which the person may be contacted. (Health & Saf. Code §124130(a).)

2) Requires the information reported to be kept confidential except for the purpose of surveillance, case management, investigation, environmental assessment, environmental remediation, or abatement with the local health department, environmental health agency, as authorized, or building departments.
    a) Authorizes the information to be shared with the Department of Health Care Services (DHCS) for the purposes of determining whether children enrolled in the Medi-Cal program are being screened for lead poisoning and receiving appropriate related services.
    b) Authorizes DHCS to further disclose to the enrollee's managed care plan, who may further disclose the information to the enrollee's health care provider.
    c) Authorizes DHCS to use, disclose and maintain the confidentiality of information in accordance with the federal Health Insurance Portability and Accountability Act of 1996 and other laws applicable to DHCS. (*Id*. (g).)

3) Requires the information required in 1) above to be submitted within three working days of the analysis if the result of a blood lead analysis has a BLL equal to or greater than 10 micrograms per deciliter, and, if less than that value, to be submitted within 30 calendar days. (*Id*. (e).)

This bill:

1) Requires the reporting of additional information, as specified, by a laboratory that performs a blood lead analysis on a specimen of human blood drawn in California, including:
    a) birth date and telephone number of the tested person;
    b) the telephone number of the provider along with the National Provider Identifier (NPI) of the provider that ordered the analysis;
    c) the Clinical Laboratory Improvement Amendments (CLIA) number and NPI of the analyzing laboratory;
    d) the person's Medi-Cal client identification (CIN) or, for other health plans, the name of the health plan and the medical plan identification number;

e) the person's sex, race, ethnicity, pregnancy status, and sexual orientation if available;
f) the name, address, telephone number, and CLIA number of the referring laboratory, if any; and
g) the testing methodology used for blood lead analysis specified as point of care, inductively coupled plasma mass spectrometry, graphite furnace atomic spectroscopy, or other.

2) Changes the blood lead analysis BLL value for timing of making reporting requirements to the most recent federal Centers for Disease Control and Prevention (CDC) reference level for an elevated BLL.

3) Provides additional authority to DPH to share confidential date for the following purposes or persons:
   a) to the individual to whom the information pertains;
   b) with the prior written voluntary consent of the individual to whom the information pertains;
   c) when required by state or federal law;
   d) when compelled by an order of the court or an administrative hearing officer, if a protective order that prohibits any further disclosure is secured prior to disclosure;
   e) for the purpose of case management and health care providers treating patients with elevated BLLs or receiving case management services, or a federal, state, or local governmental agency; and
   f) for research, as defined in federal regulations, as may be amended, if the request for information is approved by the Committee for the Protection of Human Subjects for the California Health and Human Services Agency, the requesting entity provides documentation to the department that demonstrates, to the department's satisfaction, that the entity has established the procedures and ability to maintain the confidentiality of the information, and the requesting entity has agreed, in writing, to maintain the confidentiality of the information.

COMMENTS

1. Stated need for the bill

The author writes:

> In 2018, 7,141 children in California were found to have elevated blood lead levels. It is incredibly concerning that thousands of children were suffering from lead poisoning but it's especially concerning because we know that lead poisoning does not impact all children equally. Children living in poverty, children enrolled in Medicaid, children living in older housing, and children of color are found to have

higher levels of lead exposure. We need a more robust public health system to prevent these exposures from harming our children.

AB 2326 will align California's lab reporting requirements with federal Blood Lead Level standards to reduce time delays in patients receiving follow-up care. It would also require laboratories to report additional information when performing blood lead analysis as well as require the Department of Public Health to share management information with health care providers so that more children receive appropriate intervention for missed tests and elevated blood lead levels.

2. Background

California established a Childhood Lead Poisoning Prevention Program within DPH (CLLP) in 1986. (Health & Saf. § 124125, et seq.). The CLPP is largely supported by fees assessed and collected annually from lead polluters (e.g., paint and petroleum industries as historical polluters, and industrial air emitters). The CLPP carries out prevention activities including outreach, education, and surveillance, promotes lead screening for children at risk for lead exposure, and provides case management and follow-up for children with elevated BLLs. Existing law requires laboratories that perform BLL analysis to report specified information to DPH.

Under existing law, if the BLLC is equal to or greater than 10 micrograms/deciliter the information must be submitted within three working days, if it is less than that level it is to be submitted within 30 calendar days. (Health & Saf. § 124130(e).) All information required to be reported by a laboratory is confidential. (*Id*. (g).) However, existing law authorizes DPH to share the information for specified purposes, including for surveillance, case management, coordination of care, investigation, environmental assessment, environmental remediation, or abatement with the local health department, authorized environmental health agency, or building department. (*Id*.) Existing law also allows the data to be shared with the State Department of Health Care Services for the purpose of determining whether children enrolled in Medi-Cal are being screened for lead poisoning and receiving appropriate related services.

In 2020, the California State Auditor released an audit titled *Childhood Lead Levels – Millions of Children in Medi-Cal Have Not Received Required Testing for Lead Poisoning* based on an assessment of the CCLP and administration of lead tests to children in Medi-Cal.[1] The audit found, among other things, that DPH has not taken steps to advocate for changing a state law that currently makes it optional for laboratories to report certain contact information with test results for children tested for elevated lead levels. It also found that state law does not require the use of a unique identifier, which

[1] Cal. State Auditor, *Childhood Lead Levels – Millions of Children in Medi-Cal Have Not Received Required Testing for Lead Poisoning* (Jan. 2020), available at https://www.auditor.ca.gov/pdfs/reports/2019-105.pdf.

would allow DPH to effectively match lead tests with existing cases of lead poisoning. The audit concluded that missing information has contributed to DPH's backlog of unprocessed test results and hindered its ability to contact families and monitor lead poisoning cases and recommended the Legislature amend the law to require laboratories to report contact information and unique identifiers.[2]

The author argues that current state law results in the prevention or delay of children and adults with elevated blood lead levels receiving appropriate and timely case management in three ways: 1) incomplete reporting requirements for laboratories; 2) lack of necessary authority to share data; and 3) lack of alignment with recently updated elevated BLL threshold federal standards (now 3.5 micrograms/deciliter). The bill addresses these issues in several ways. It aligns California's laboratory reporting requirements with federal BLL standards to reduce time delays in patients receiving follow-up care. The bill incorporates by reference the CDC BLL reference value rather than by a set value to ensure that if the CDC changes the reference value again no delays will occur in providing timely case management. The bill authorizes DPH to disclose case management information, collaborate with health care providers, and share data with federal, state, or local agencies and researchers. The author argues this will improve the ability of families to receive timely and appropriate access to case management services and better serve children. The author also notes that data sharing with federal agencies is often a requirement for federal grant eligibility.

Lastly, the bill requires laboratories to report additional information, if available, when performing a BLL analysis. This aspect of the bill implements the State Auditor's recommendation regarding contact information and a unique identifier. The author and sponsor of the bill note that these changes will provide DPH with the information necessary to match screening data to individual patient information, reduce delays in patients receiving care management, and improve surveillance data. This will advance the identification of disparities in health and healthcare, as well as support the design and evaluation of intervention programs to effectively target and eliminate disparities. As pointed out by a coalition of supporters of the bill:

> All children can be exposed to lead, but the Department of Public Health states that the vast majority -- 88 percent -- of California's lead-poisoned kids are enrolled in Medi-Cal, the state's health care plan for low-income families. Low-income kids are more apt to be lead-poisoned because they are more likely to live in older housing with lead paint or nearby a general airport with lead emissions. Low-income children are also more likely to be malnourished, which causes them to absorb lead faster. If not stopped, a child's ongoing exposure to lead will continue to harm their nervous system, and cause damage that can last a lifetime.

[2] *Id.* at 3.

3. Statements in support

A coalition of various organizations, including the sponsor, write in support:

> Because lead exposure happens silently, and disproportionately affects low-income kids, state and federal regulations require all Medi-Cal toddlers to receive blood lead tests when they are one and two years old. Unfortunately, many of these children are not tested. A 2019 state audit of state data found that an estimated 70 percent of the state's 12 and 24-month old children who are enrolled in Medi-Cal do not receive blood lead screenings each year in accordance with federal and state recommendations.
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> The state audit also recommended that various statutory changes occur to help the Department of Public Health manage the State's Childhood Lead Poisoning Prevention Program. For example, the audit advocated for changing a state law "that currently makes it optional for laboratories to report certain contact information with test results for children tested for elevated lead levels. This state law does not require the use of a unique identifier that would allow CDPH to effectively match lead tests with existing cases of lead poisoning. The fact that this information is missing from lead tests has contributed to CDPH's backlog of unprocessed test results and impeded its ability to contact families and monitor lead poisoning cases."
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> In addition to the above concern, other statutory shortcomings inhibit the provision of services to lead-exposed children. The department does not have the authority to disclose information related to a patient's lead poisoning and care management plan to the child's health provider. Nor can the department share surveillance data with federal, state, and local agencies. Such surveillance data provides researchers information needed to address root causes of lead poisoning and exposure in children.
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> Assembly Bill 2326 will resolve these gaps in current law by requiring laboratories to use a unique identifier for lead tests and to report demographic information; by authorizing CDPH to share case data with providers and public agencies; and by aligning the state's blood lead reference value with the value set by the Centers for Disease Control.

SUPPORT

Environmental Working Group (sponsor)
Breast Cancer Prevention Partners
California Coalition of California Welfare Rights Organizations
California Nurses for Environmental Health and Justice
Center for Environmental Health

Children Now
Children's Environmental Health Network
Clean Water Action
Coalition for Economic Survival
Development of Court Skills Elite
Families Advocating for Chemical and Toxics Safety
Friends Committee on Legislation of California
Jonas Philanthropies
Nontoxic Neighborhoods
Planning and Conservation League
Western Center on Law and Poverty

OPPOSITION

None known

RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation:

AB 2422 (Grayson, 2020) would have, among other things, added to the information that a laboratory is required to report to DPH when it performs a blood lead analysis test to include the Medi-Cal identification number, or other equivalent medical identification number of the person tested. AB 2422 died in the Assembly Health Committee.

AB 2278 (Quirk, 2020) would have required an analyzing laboratory that performs a blood lead analysis to also report to DPH the person's telephone number in addition to the person's address and ZIP code if the analyzing laboratory has that information, and the Medi-Cal identification number and medical plan identification number, if available, and would also have required the existing "within 30 calendar day" timeframe for an analyzing laboratory to report less to DPH a blood lead test of less than 10 µg/dL begins from the date of the analysis. AB 2278 died in the Assembly Health Committee.

PRIOR VOTES:

Senate Health Committee (Ayes 9, Noes 0)
Assembly Floor (Ayes 73, Noes 0)
Assembly Appropriations Committee (Ayes 15, Noes 0)
Assembly Health Committee (Ayes 14, Noes 0)

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