

**LEAD-BASED PAINT POISONING:  
FEDERAL RESPONSES**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON HOUSING AND TRANSPORTATION  
OF THE  
COMMITTEE ON  
BANKING, HOUSING, AND URBAN AFFAIRS  
UNITED STATES SENATE  
ONE HUNDRED SEVENTH CONGRESS  
SECOND SESSION  
ON  
AN OVERVIEW OF WHAT FIVE FEDERAL AGENCIES—HUD, EPA, DOJ,  
CMS, AND CDC—ARE CURRENTLY DOING TO HELP MAKE HOUSING  
LEAD-SAFE FOR CHILDREN

—————  
JUNE 5, 2002  
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## **LEAD-BASED PAINT POISONING: FEDERAL RESPONSES**

**WEDNESDAY, JUNE 5, 2002**

U.S. SENATE,  
COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS,  
SUBCOMMITTEE ON HOUSING AND TRANSPORTATION,  
*Washington, DC.*

The Subcommittee met at 2:45 p.m. in room SD-538 of the Dirksen Senate Office Building, Senator Jack Reed (Chairman of the Subcommittee) presiding.

### **OPENING STATEMENT OF SENATOR JACK REED**

Senator REED. The hearing will come to order.

Good afternoon. Let me welcome everyone to today's hearing on Federal responses to lead-based paint poisoning. I hope to bring greater attention to this terrible problem in our Nation's housing and its effects particularly on children. It is a follow-up to the Senate Housing Subcommittee hearing held last year regarding State and local responses to lead-based paint poisoning.

Over a decade ago, the U.S. Department of Health and Human Services announced a strategic plan for the elimination of childhood lead poisoning because it recognized the detrimental, long-lasting effects on children from exposure to lead. The efforts to achieve this long-established goal of eliminating lead poisoning by the year 2010 has stalled and may, in fact, be moving in the opposite direction.

Not only are Federal laws not being enforced, such as the requirement that all Medicaid eligible children be screened for lead, but it also appears that there is currently no coordinated action to eliminate childhood lead poisoning.

The previous Administration created a Task Force on Children's Environmental Health and Safety Risks. This task force was cochaired by the Secretary of the U.S. Department of Health and Human Services and the Administrator of the Environmental Protection Agency, and developed a set of recommendations to eliminate childhood lead poisoning in the United States as a major public health problem by the year 2010.

Specifically, this comprehensive Government-wide strategy called for making 2.3 million homes where children under the age of 6 live lead-safe by controlling lead-paint hazards. It also called for public education programs, strict enforcement of lead-paint regulations, as well as encouraging early interventions for at-risk children.

With only 8 years to go until we are to have eliminated childhood lead poisoning, it is estimated that nearly one million preschool children living in the United States continue to have blood-lead levels high enough to impair their ability to think, concentrate, and learn.

Unfortunately, except for the most severely poisoned children, there is no medical treatment for this disease. And even then, treatment may only reduce the level of lead present in the body, not reverse the harm already caused. The only effective treatment is preventing exposure, which occurs as a result of deteriorating paint in our Nation's housing stock.

The Department of Housing and Urban Development estimated in its latest national survey that lead still remains in about 39 million dwelling units, or 40 percent of all U.S. housing.

Federal efforts to reduce the hazards of lead-based paint poisoning began 31 years ago, with the enactment of the Lead-Based Paint Poisoning Prevention Act. This Act required the Secretary of HUD to establish and implement procedures to eliminate lead hazards from public housing.

In 1992, Title X of the Housing and Community Development Act authorized major changes in Federal law on the control of lead-based paint hazards and the reduction of lead exposure. Title X defined hazard in such a way that it included deteriorating lead-paint, and the lead-contaminated dust and soil that the lead-paint generates. It also mandated the creation of an infrastructure that would help correct lead-paint hazards in all of our Nation's housing. In particular, Title X required coordinated action between several Federal agencies regarding lead poisoning, including the Department of Housing and Urban Development, the Environmental Protection Agency, and the Centers for Disease Control and Prevention.

While we have made progress in dramatically reducing the number of children with elevated blood levels, significant barriers and obstacles to the elimination of this environmental health hazard remain. It raises significant questions which we will address in this hearing, significant questions that need to be addressed. Specifically: Why are we still only evaluating 20 percent of Medicaid eligible children, and why we are not coordinating better?

I would hope as we go forward with this hearing to develop all of these issues. We are fortunate to have a distinguished panel. But before I introduce the panel, let me introduce my colleague, the Ranking Member, Senator Allard.

#### **COMMENTS OF SENATOR WAYNE ALLARD**

Senator ALLARD. Mr. Chairman, I have a short statement of only about 30 pages.

[Laughter.]

I have one page, actually. I was trying to get your attention, Mr. Chairman.

[Laughter.]

Senator REED. You have my attention.

Senator ALLARD. I told you I had 30 pages.

Senator REED. Knowing of your concise and focused comments, I trusted you did not.

Senator ALLARD. Very good. I ask unanimous consent that my statement be made a part of the record. I just have a one-page statement. I will just make it a part of the record.

Senator REED. Without objection, it shall be a part of the record. Now let me introduce the panel.

Dave Jacobs is the Director of the Office of Healthy Homes and Lead Hazard Control. Before that he was Deputy Director of the National Center for Lead-Safe Housing, from 1992 to 1995. He has received a number of awards for his work on lead hazard reduction.

Mr. Thomas L. Sansonetti is the Assistant Attorney General in charge of the Environment and Natural Resources Division at the Department of Justice. Prior to arriving at the DOJ, Mr. Sansonetti was a partner in the Cheyenne office of Holland & Hart, where he specialized in natural resource and environmental law.

Mr. Adam Sharp is the Associate Assistant Administrator, Office of Prevention, Pesticides and Toxic Substances at the Environmental Protection Agency. Prior to that, he worked at the American Farm Bureau Federation on its governmental relations and regulatory affairs staff. He also served as a Director at the federation for the last 2 years of his tenure there.

Mr. Ruben King-Shaw is Deputy Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services. Prior to assuming this responsibility, he was the Secretary of the Florida Agency for Health Care Administration.

Mr. Dick Jackson is the Director of the National Center for Environmental Health, one of the centers within the Centers for Disease Control and Prevention. He is a pediatrician who has spent the past 25 years working to improve the health of children. He has also served as a State health official and as Chairman of the American Academy of Pediatrics Committee on Environmental Health.

Before you begin, I would like to thank each of you for your written testimony, which has been shared with the Members of the Subcommittee. And I would ask that you stick to our 5-minute time limit, if you would. And you may in fact make your statements in whole part of the record.

Thank you, and let's begin with Mr. Jacobs.

**STATEMENT OF DAVID E. JACOBS, Ph.D.  
DIRECTOR, OFFICE OF HEALTHY HOMES  
AND LEAD HAZARD CONTROL**

**U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT**

Mr. JACOBS. Thank you, Mr. Chairman, Senator Allard, for the opportunity to appear before you today to discuss HUD's activities in the area of childhood lead poisoning prevention.

My message today is simply this—the Nation has, in fact, made enormous progress. However, much more remains to be done. And the science and the practical program experience that we have accumulated shows that we know how to do it.

Over the past decade, the number of houses with lead-paint hazards has declined at an astonishing rate—from 64 million houses in 1990 to 38 million—as you just noted. That is an enormous decline and it is the best proof yet that what we are doing is actually working.

Yet, the challenge of eliminating hazards before children are poisoned remains quite large. And if we fail to finish the job, hundreds of thousands of children will be unnecessarily poisoned in the coming decade. That must not be permitted to happen.

The Administration is committed to eliminating childhood lead poisoning by the year 2010, and I am pleased to tell you that the Administration has continued the Executive Order that established the President's Task Force on Children's Environmental Health and Safety Risks, which produced the 10-year plan to eliminate the disease.

I am also pleased to report that HUD Secretary Mel Martinez has made this a priority of his administration, and it shows. We are creating thousands of lead-safe houses each year, more than ever before. We have trained over 28,000 housing rehab and maintenance workers in lead-safe work practices over the past year alone.

With Congressional support, we have increased HUD's lead hazard control budget by 10 percent for 2002, and the President's budget proposal for 2003 increases it by another 15 percent, which will enable even more houses to be made lead-safe.

Housing receiving Government assistance, according to our new national survey, has been made about as safe as the middle- and upper-income housing—that is, low-risk housing—evidence that our lead-paint regulation for Federally-assisted housing works.

We believe that regulation also provides an important model for the rest of the Nation because it takes action before a child is poisoned, not just after the child is already poisoned. And it proves that if we put our mind to it, we can, in fact, make our houses safe for children across the entire country.

I want to briefly highlight several key ingredients to what we think is the solution—local know-how and capacity, enforcement, proof of what works, and the importance of partnerships among the Federal agencies. And I want to close with HUD's new initiative to leverage private-sector resources, something we call Operation LEAP.

First, our grant program is the main vehicle in the country for dealing with the houses with the greatest hazards. These are low-income, dilapidated, privately-owned houses that usually receive no other form of Government assistance.

Today, the HUD program is active in over 200 jurisdictions. In 1990, only one or two jurisdictions had much in the way of a significant program that actually fixed low-income, privately-owned houses.

It will come as no news to Senator Reed that Rhode Island is, in fact, one of our best performers in this area. But there are hundreds of other jurisdictions now across the country that have the know-how to get the job done, and that is as a direct result of the HUD grant program.

Second, on enforcement of the disclosure rule to ensure that parents get the information they need to protect their children, we have had what I would describe as a truly wonderful relationship with the Department of Justice, with local law enforcement, health and housing agencies, and with EPA to target our enforcement actions to the most egregious cases. In fact, the Secretary has



increased our staffing at HUD to further expand our enforcement activities.

*Proof.* How do we actually know that any of this really works? We have conducted the Nation's largest study of modern lead hazard control techniques. And I could not resist showing you one scientific slide, at least.

[Slide.]

This slide basically shows that in approximately 2,700 housing units that we studied, dust-lead levels, which are the main predictor of children's blood-lead levels, have declined and stayed low, even though all lead-paint has not been removed. So this is clear evidence that, in fact, what we do works. We also, I might add, measured children's blood-lead levels who lived in those units, and that declined by 26 percent in one year.

Coordinating with other agencies makes our work more focused and productive. For example, in Manchester, Connecticut, I know that Senator Reed mentioned Medicaid. In that community, children who have high blood leads are automatically referred to the HUD lead grant program to make sure that their housing units are lead-safe.

In Chicago, when the Centers for Disease Control conducts its high-intensity targeted screening program that Dr. Jackson will discuss later, HUD's lead-paint grantee was there to make sure that the units were safe.

HUD and EPA have worked together to target regulations so that we use abatement contractors only for the highest-risk houses, not for routine housing rehab and maintenance work. But we do make sure that rehab and maintenance workers do get the training they need to get their jobs done safely.

Housing programs not covered by Title X, such as the Department of Energy's Weatherization Program, and States administering low-income housing tax credits that are used for rehabilitation, can use that training curriculum or the workers that we have already trained so that they do not have to reinvent the wheel. In fact, in California, Wisconsin, and elsewhere, many of our grantees combine weatherization work with lead hazard control work to get the job done and stretch the dollars.

And finally, we believe increasing private-sector involvement is a critical part of the solution. Within the next 2 to 3 weeks, HUD will be releasing a notice for funding availability for Operation LEAP, which stands for Lead Elimination Action Program.

Grants will be awarded to entities that can leverage private-sector investment, and so we hope that banks, hardware stores, community groups, landlords, and others will respond favorably to help solve this problem.

In conclusion, let me recognize Senator Reed for his truly outstanding leadership on this issue. Your resolve and commitment have been a tremendous help to America's children over the years. So thank you.

Senator REED. Thank you, Mr. Jacobs.  
Mr. Sansonetti.

**STATEMENT OF THOMAS L. SANSONETTI  
ASSISTANT ATTORNEY GENERAL  
ENVIRONMENT AND NATURAL RESOURCES DIVISION  
U.S. DEPARTMENT OF JUSTICE**

Mr. SANSONETTI. Chairman Reed, Senator Allard, I am pleased to be here today, along with my colleagues on the panel, to discuss what the Department of Justice is doing to protect America's most important resource, its children, from lead-based paint poisoning.

In my testimony today, I will focus primarily on the Department's enforcement efforts in connection with the initiative developed by our colleagues and clients at HUD and EPA. This initiative is providing tangible improvements in the lives of some of our most disadvantaged children. Of course, I would be happy to answer any questions that the Subcommittee may have.

Mr. Jacobs has pointed out, lead poisoning is a significant health risk for young children and lead poisoning is especially acute among low-income and minority children living in older housing.

This public health problem was the genesis of the Federal Residential Lead-Based Paint Hazard Reduction Act, which requires the sellers, owners, and managers of residential buildings built before 1978 to warn prospective buyers and tenants about the likely presence of lead-based paint and lead in dust or soil on the property. It also requires landlords to give tenants an EPA pamphlet about how to minimize the dangers to children, and directs them to document their compliance with the law by keeping tenants' signatures on file using a standard disclosure form.

In regard to the enforcement initiative, this Act is no different, frankly, than any other law in that it requires strong and fair enforcement to ensure that legal goals become practical realities. It is also important that law-abiding landlords and management companies have a level economic playing field on which to compete, and that those who fail to comply with the law know they will be penalized. Accordingly, HUD embarked on a civil enforcement initiative to ensure compliance with the Act's requirements after its effective date in 1996. It focused its enforcement actions on four major cities—Los Angeles, Chicago, New York, and the District of Columbia—and proceeded by targeting large management companies responsible for buildings which were covered by the Act and had multiple incidents of lead-poisoned children. EPA also has a lead coordinator in each of its 10 regions responsible for lead-paint enforcement.

This simple but effective strategy helped the agencies quickly identify those who were responsible for some of the biggest lead-paint related problems. Now based on this footwork, HUD and the EPA began filing a series of administrative enforcement actions against violators of the Act, and then also referring cases to the Department of Justice for judicial enforcement actions.

The hard-working people at HUD, EPA, and the U.S. Attorneys' offices have made this initiative a success. I think they have done a remarkable job in developing investigative strategies and putting in the many hours that it takes to turn a good plan into great results. One of the things that Senator Reed asked me to address was how DOJ can interact more efficiently with other agencies to eliminate lead-based paint poisoning in children, and I am happy

to tell you that we are already working very well with them to achieve this important goal.

The State attorneys general and the State and local lead poisoning enforcement agencies are also essential players in this enforcement effort. In fact, our cases get started when we receive reports of elevated blood levels of lead from a local health department. So thanks to their efforts, I have some major success stories to talk about, both civilly and criminally.

We have pursued several cases judicially here in the District and across the country. One big success story came last October when DOJ, HUD, and EPA announced settlements in cases against three landlords in Chicago for failure to warn their tenants that their homes may contain lead-based paint hazards. These companies controlled nearly 10,000 apartments, and they agreed to test for and cleanup any lead-based paint found in their properties, and pay \$90,000 in penalties. One of the companies also agreed to pay \$100,000 to Chicago's Health Department as part of a child health improvement project, and the other two agreed to give \$77,000 to a community-based health center to provide free blood testing for children living in Chicago and South Chicago.

We have simultaneously announced settlements in four administrative cases against landlords in New York and Los Angeles that own and manage approximately 6,500 units.

In criminal prosecutions, what started out as a civil enforcement initiative has also produced the first-ever criminal lead-paint prosecutions in the last year. The first involved David Nuyen, a Washington-area landlord who owned and managed 15 low-income rental properties in the District of Columbia and Maryland. HUD contacted Nuyen in September of 1998 as part of our enforcement initiative. His response was to present the Agency with falsified, forged, and back-dated lead-paint forms that made it appear that he had given tenants the required hazard warnings when he had not, even though he had previously received notices of violation that his apartments had dangerous levels of lead. He was convicted in July of last year, sentenced to 2 years in prison, and a \$50,000 fine.

Another similar prosecution culminated in March in New Hampshire, a gentleman named James Aneckstein sentenced in Federal district court, 15 months of incarceration, \$40,000 criminal fine. He also failed to notify his tenants of the presence of lead-paint. But in this case, one of the tenants, a 2-year-old girl named Sunday Abek, died of that lead poisoning.

In conclusion, tragic deaths such as Sunday Abek's are completely preventable. We are proud to be working with our partners at HUD, EPA, the U.S. Attorney's offices, the FBI, and State and local enforcement agencies, to bring them into this initiative to protect America's kids, especially those disadvantaged ones who are at the greatest risk.

And I am pleased to tell the Senator that yesterday, we lodged another consent decree against a Chicago landlord who had failed to notify his tenants of lead-paint in his units.

So with your continued support, we believe that we can move a long way toward eliminating lead poisoning, and I look forward to

working together with the Subcommittee on this important issue, and to answering any questions that you may have.

Senator REED. Thank you, Mr. Sansonetti.

Mr. Sharp.

**STATEMENT OF ADAM SHARP  
ASSOCIATE ASSISTANT ADMINISTRATOR  
OFFICE OF PREVENTION, PESTICIDES, AND  
TOXIC SUBSTANCES  
U.S. ENVIRONMENTAL PROTECTION AGENCY**

Mr. SHARP. Thank you, Senator.

Mr. Chairman, my name is Adam Sharp. I am the new Associate Assistant Administrator at the Office of Prevention, Pesticides, and Toxic Substances.

Thank you for the invitation to appear before you today. It is my privilege to be here today with our partners to discuss our joint efforts to prevent lead-based paint poisonings of our Nation's children. I am going to quickly summarize my testimony and ask that my full testimony be entered into the record.

Senator REED. Without objection.

Mr. SHARP. Thank you.

In the almost 10 years since Title X was enacted, EPA, together with HUD, HHS, and Justice, as well as our State partners, have made significant progress in eliminating childhood lead poisoning. While we still have a significant challenge, particularly with minority children and children living in low-income housing, EPA is very proud of how the Federal agencies and our State and private-sector partners have coordinated their efforts.

For example, the Federal Government has phased out lead in gasoline, reduced lead in drinking water, reduced lead in industrial lead pollutants, and banned or limited lead used in many consumer products, including paint. States and municipalities have set up programs to identify and treat lead-poisoned children and to rehabilitate deteriorating housing. Parents, too, have greatly helped to reduce lead exposures to their children by cleaning and maintaining homes, having their children's blood-lead levels checked, and also promoting proper nutrition.

As you can tell from the individuals at the table today, combating lead is a multifaceted and coordinated approach. EPA, as well as other agencies here today, have a variety of activities underway. Let me provide an update on those activities at the Environmental Protection Agency.

EPA's primary goal is to prevent children from being poisoned and avoiding the consequences associated with it. The basic program includes a national regulatory infrastructure involving our State and local partners, developing outreach and education programs aimed at those most at risk, educating and assisting those who can help address the problem, and focusing on how our children can be better protected.

In the area of regulations, EPA, together with HUD, have been very busy. Let me turn to a few of the highlights.

First, in 1996, EPA and HUD jointly promulgated a rule to ensure that lead-based paint information is disclosed during real estate sales and rentals, specifically for those houses built before

1978. This rule ensures that the homebuyer or renter has a right to available hazard information and a right to lead inspection if desired.

Second, also, in 1996, EPA promulgated a rule covering the professionals who work in the lead inspection and abatement profession. It also ensures that a well-trained cadre of lead inspectors, risk assessors, and abatement personnel are available. This same rule also allows EPA to authorize States, Tribes and Territories to develop and administer training and certification programs. At present, 36 States, Puerto Rico, two Tribes, and the District of Columbia are assisted by Federal grants, are authorized to carry out this program, and EPA is working with others.

Third, in 1998, EPA promulgated another rule to ensure that all owners and tenants of pre-1978 housing be given basic information about lead poisoning prevention prior to renovations that may disturb lead-based paint.

Fourth, in 2001, EPA promulgated another rule to define the specific levels of lead in dust and soil that are most likely to pose a health threat to children. These scientific standards help to determine when and how to clean up lead dust, lead-paint, and lead soil problems.

Let me now turn to education and outreach.

Education outreach is also a very important component of our lead program. We work as much as possible with our customers and our stakeholders in several areas, including the development of regulations, assisting regulated parties in complying with regulations, informing citizens of their rights under these rules, informing the public about lead-based paint hazards, and providing guidance on how to reduce risks. Our partners at HUD and CDC partially fund these activities and provide technical support.

Some of these outreach efforts include the bilingual 1-800 National Lead Information Center. This is a national clearinghouse to educate workers and the public about lead hazards and abatement precautions. The development of materials such as brochures and sample real estate disclosure forms needed to comply with regulatory requirements. The creation and distribution of education materials and national lead awareness campaigns for parents, homeowners, renters, medical professionals, renovation contractors, and do-it-yourselfers.

EPA also has done important work in scientific capacity. For example, EPA had conducted numerous studies to define the levels of exposure that should be regarded as hazardous to children and identify work practices that successfully reduce lead-based paint risks. EPA's goal is to better understand lead exposures, ensure that testing is done appropriately, and reduce the costs associated with eliminating exposure.

Even though we have accomplished a great deal of things, there is still more to be done. Let me now turn to a few other regulatory activities.

EPA anticipates completing the regulatory program mandated by Title X over the next few years. So what are the next steps? Our renovation and remodeling activities will address how to safely remove lead-based paint and debris during remodeling activities.

We anticipate that this proposed rule will be ready for publication in 2003.

EPA has already developed a model training course and other materials for renovation contractors and homeowners, which is intended to provide them with recommended methods to minimize lead hazards.

Further, of lead-based paint abatement activities on bridges and structures, we expect to publish a proposed rule in 2004.

The Agency also expects to finalize regulations on management and disposal of lead-based paint debris by the end of this year.

Thank you for the opportunity to discuss some of EPA's contributions to prevent lead-based paint poisonings, just a part of our successful collaboration on this issue. Again, I want to thank you for your support and assure you that this Administration is looking forward to working with this Subcommittee to achieve our goal of eliminating childhood lead poisonings by 2010.

Thank you.

Senator REED. Thank you, Mr. Sharp.

Mr. King-Shaw.

**STATEMENT OF RUBEN KING-SHAW, JR.  
DEPUTY ADMINISTRATOR AND CHIEF OPERATING OFFICER  
CENTERS FOR MEDICARE & MEDICAID SERVICES**

Mr. KING-SHAW. Thank you very much, Chairman Reed, and to the Subcommittee, I, too, would like to offer a verbal summary and submit my written testimony for the record.

Senator REED. Without objection.

Mr. KING-SHAW. It is a pleasure for me to be here to share with you and the Subcommittee and others what CMS is doing on this important issue of lead-based paint poisoning in children.

As the providers of Medicaid programs with a partnership with the State, this is quite an important effort for CMS. This issue affects low-income children, particularly in underserved ethnic communities in older housing. As such, it is a part of our overall effort to eradicate all health care disparities through our programs.

As you are committed, Chairman Reed, our Secretary, Tommy Thompson, Administrator Scully, myself, and all of us at CMS have a true and long-standing commitment to the preservation of health and the protection of health in children all across America. We work toward that goal through our Medicaid program directly, but we also coordinate with my colleagues at other Federal agencies and community-based organizations that are active on this issue.

The Medicaid program itself has very specific benefits and coverage regarding the screening and detection and treatment for lead-based paint poisoning in Medicaid-eligible children. Briefly, Medicaid-eligible children must be tested at 1 and 2 years of age as part of the Medicaid benefit. And again, if there is no record of a test for children between the ages of 2 and 6 years, that that test must also be provided for untested children in that age group.

Specifically, the Medicaid program pays for the testing, the diagnosis, the treatment, the case management services, and a one-time environmental investigation of the primary residence when a child's test reveals elevated blood levels for lead.

In 1999, you are aware, I am sure, of a GAO report that identified some challenges and some issues with the Medicaid program in providing this benefit. And since then, we have done some things to address some of the issues presented in that report. I will just share a few of them with you in the time that I have remaining.

Lead screening is a part of a comprehensive program known to many of you, Medicaid's Early and Periodic Screening Diagnosis and Treatment Program, or EPSDT. The EPSDT reporting system is generated by the States. It is rolled up as a statewide report and then given to us at CMS. Some time ago, as a result of some of these struggles, we added a line item that gives us specific indication of States' compliance with the lead screening program, and we monitor that rather closely.

We have also communicated directly to the States on two separate occasions urging them to share information on best practices along these lines, and also informing and reminding them of the responsibilities of State Medicaid agencies to administer the Medicaid benefit effectively and to adhere to the current policy of universal screening.

We have joined hands with a community-based organization, the Alliance to End Childhood Lead Poisoning, to do a couple of important things.

One, we have developed an education tool that is used throughout the country to encourage States and local entities, as well as providers on the importance of this issue. And together, we have written a guide, an important guide entitled, *Track, Monitor and Respond: Three Keys to Better Lead Screening for Children in Medicaid*. We believe these are positive differences that we are making in outreach and compliance nationally.

We also have engaged a contractor to conduct site visits around the country, including Providence, Rhode Island, as you know, Mr. Chairman, Baltimore, Maryland, Chicago, Illinois, the State of Iowa, and Oakland and Alameda County, California, to try to find the best ways to make sure that our programs are well communicated and in full compliance.

We, too, collaborate on the Federal level, including being an active part of the President's Task Force on Environmental Health Risks and Safety Risks to Children, and we hope to build better relationships with the colleagues around this table. And we have begun to do great work with our colleagues here as well.

We remain committed to the current policy until and unless we receive guidance from our colleagues over at the Centers for Disease Control that would warrant a change. The Secretary is awaiting those recommendations; you will hear more about that work, perhaps, from my colleague at the CDC.

But in the meantime, our challenges remain in the compliance area and we can talk about some of the things we can do there. And we remain committed to making sure that, to the best of our ability, we communicate with our provider partners and States to administer the current policy effectively for the better protection of all children in this country.

Again, I want to thank you for the opportunity to share these comments with you. I look forward to a good discussion and to providing vital information to you in the period that follows.

We remain committed to serving all children in America through the Medicaid program as defined by law and statute.

Thank you.

Senator REED. Thank you, Mr. King-Shaw.

Dr. Jackson.

**STATEMENT OF  
RICHARD J. JACKSON, M.D., M.P.H., DIRECTOR  
NATIONAL CENTER FOR ENVIRONMENTAL HEALTH  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Dr. JACKSON. Thank you, Senator. And thank you very much for the important leadership that you have provided on this issue of childhood lead poisoning. Many of the comments, even in my oral testimony, have already been made and I am going to summarize my comments for you and ask that the written document be placed in the record.

Senator REED. All of the statements will be made part of the record. In addition, Senator Stabenow wished that her statement be part of the record, too.

Dr. Jackson.

Dr. JACKSON. Thank you very much. The five major points I want to make are.

First, just the clinical, medical importance of lead.

Second, the importance of good data. If you want to make decisions, you have to have good data.

Third, the importance of primary prevention, not having lead in the child's environment.

Fourth, will be the importance of partnerships. This is too big and too hard to do alone by any one Agency or any one group.

Fifth, some new tools to really grapple with this issue of childhood lead poisoning in the pocket that is left.

When I was a medical student in New Jersey, I did a rotation in New York at Mt. Sinai. The first day on the pediatric ward, they took me around and there were 25 little kids running around, as hyperactive as could be. This is the early 1970's. They were receiving kelation. They had blood-lead levels in the 50, 60, 70 range. They were receiving very expensive, in-hospital, drug therapy for the treatment of their lead poisoning. And I said to the senior physician, this is terrible. He said, wait till you see this. And he took me into a back room and there was a child with a swollen brain, convulsing, who ultimately died of lead poisoning.

The city of New York alone had 10 kids a year that would die of lead poisoning in the late 1960's. This was a desperate problem. And most of us in the country had blood-lead levels in the range of about 20—two zero.

We have had, and thanks to the partners at this table, EPA, particularly with lead coming out of gasoline, FDA, EPA with paint issues, Consumer Product Safety Commission, and the rest.

This is probably, what I am showing to you here, the environmental health success story of the last half century. This is actual measurement of lead in the bodies of Americans. And I will ask to have this put over on the side.

[Slide.]



But it is a graph of blood leads dropping from an average of 16 in 1974, to a blood lead of, on average, two right now. It is lower than was thought to be feasible on the face of the earth.

The good news is we are not seeing the same extensive level of poisoning in our population. The bad news is we have between a half-million and 750,000 children who are left. They are the most difficult children to reach. They are in the poorest houses in the poorest neighborhoods. Sitting back and waiting for them to show up in clinic is not going to be an adequate approach to dealing with this residual population with lead poisoning.

My second major point—oh, I want to make one quick other point about that blood lead.

Our current definition of elevated blood lead is a blood lead of 10. There is a fair amount of scientific information and pressure to reconsider that level and to reduce it. We have asked the Advisory Committee on Childhood Lead Poisoning to pull all the relevant scientific data to have the experts come in and speak to that. That is an advisory committee to the Secretary and they will make formal recommendations as to what a proper definition would be.

The second issue of good data, and I give you an example here of just how powerful this is in making decisions. But it also means that we have to have data from local communities. We have to know where the hot spots for lead poisoning are, higher in this area, lower in that area. You cannot make a good decision about where to either start or stop screening without good data. The guidelines that we put out in 1997—these are screening young children for lead poisoning guidelines for State and local health officials—essentially, we do not want to stick needles in children.

So the guidance here is when you find out that you have done enough testing and there is not a problem, you can stop doing lead testing in parts of the communities that do not have a problem. And that is the guidance that we have offered.

The third quick point is just primary prevention is critical. Sitting back and trying to figure out which houses to clean up by looking at poisoned children is not adequate. We need to go after the houses, clean up the houses. In Minnesota, they are now identifying homes where poor women become pregnant, and do the clean up much earlier rather than waiting for a child to appear lead-poisoned, and then going in and retrospectively trying to undo it.

The fourth quick point—partnerships are the only way to do this. This Federal strategy that was put together by all these agencies has to occur. This is not going to be done by medical groups alone. It is not going to be done by housing alone, EPA or anyone else alone. They all have to work together. This is much too complicated or difficult for any single, isolated Agency to do and that national leadership is important.

We, CDC, are funding 43 States and 17 local health departments for intensive lead programs.

And last, new methods—this is actually a very old method—the new method is we are calling it HITS—High-Intensity Targeted Screening. We did it late last year in two inner-city areas in Chicago where we put teams together, public health nurses, housing specialists, other community people. We actually put them out into

the community, going house to house, finding the kids, doing the lead screening, looking at the paint in those houses.

Sadly, what we are finding is two-thirds of the children in those homes, in those high-risk homes, have never been screened for lead. One-third of the children, when we do a lead screening, have elevated blood leads.

And so, the point I want to make here is that we are dealing with the hardest and most difficult. The tradition a lot of times in dealing with public health problems is we push the levels down, down, down, like the tuberculosis and others, and we figure, oh, we are almost done, and we lose the attention on that issue. And that is exactly the wrong time to stop. That is when you really have to push harder because it is a harder group to deal with.

Thank you so much for your attention and your leadership on this, Senator.

Senator REED. Thank you, Dr. Jackson.

We have been joined by my colleague, Senator Corzine. Senator, do you have an opening statement, or comments?

#### COMMENTS OF SENATOR JON S. CORZINE

Senator CORZINE. I do, Mr. Chairman, but I will submit it for the record. The discussion you were having with the panel, and I thank them for their participation and thoughtful presentations.

This is a really go-to issue, in my opinion, one that, as the last panelist just remarked, we are down to the really tough parts, but it makes a huge, huge difference in the lives of an important segment of our population.

I think about a number of our urban communities in Newark, which I have extensive comments on. Estimates are that 9 out of every 10 houses in the city of Newark are tainted. We have worse numbers in Camden. The communities that are most desperately in need in almost all areas show up as the hot spots with regard to lead-based poisoning of kids.

Then we are concerned about how poorly children do in school. And we are not looking at how the holistic approach of dealing with these various problems are. So, I think you are doing God's work here by making sure that this issue is raised to a national debate that we stay fixed on it and pushing forward with it.

Thank you.

Senator REED. Thank you very much, Senator Corzine. And your full statement will be made part of the record.

Let me begin the questioning, and I will take some time and then recognize my colleague, Senator Corzine.

In response to Dr. Jackson's comments about the fact that they have been looking and finding in low-income neighborhoods children who have not yet been screened and the overall level of screening is about 20 percent.

I think, Mr. King-Shaw, you were anticipating my question. I was quite honestly startled a few months ago when the Administration was talking about giving the States the option to screen or not to screen without any type of data. In fact, all the data suggests that we are not doing enough screening. Could you just try to indicate what prompted that? I know it has been reversed by

Secretary Thompson, but what was the force or the emphasis that was leading to even that type of discussion?

Mr. KING-SHAW. First, let me say that there had never been a decision at CMS or HCFA, prior to our changing the name, to make a change in that policy.

We were receiving requests from States—Utah, Alaska, among them—to do something different than what is our current policy, to develop ways of targeting those resources into the high-risk areas. And so, the discussion was generated by an interest that came to us from States and clinical communities around the country, who asked us to consider doing screening in different ways. This conversation, then, began in responding to them. We clearly did not make any specific attempts to change the policy by rule. In fact, in all of the discussions we were having with States and clinical communities, we were very clear about the fact that we were waiting for the Secretary's advisory commission over at CDC to give us some guidance.

If there were going to be any changes, they would have to be generated from the advisory panel based on the evidence, research, and some type of data assessment indicating that potential existed to do anything different than what we were doing today.

But absence of that recommendation, until there is a recommendation, there is no effort on the part of CMS to change the policy. What you heard was a conversation; CMS responding to people interested in doing something different than our current policy. And the States generated that discussion as part of the waiver or State plan amendment request process.

Senator REED. Well, we seem to agree that that was a very bad idea. There is a good idea—in fact, it is the law—that 100 percent of Medicaid children should be screened. We are only screening approximately 20 percent. So let me ask what your Agency is going to do to ensure that 100 percent of children are screened, as required by the law?

Mr. KING-SHAW. Some of what I have already shared is a direct communication effort to remind not just the State agencies, but also provider groups and community-based organizations of the importance of doing this.

And so, the outreach, the education is about not only the clinical importance of this, but also the mandate as part of the Medicaid benefit and the policy for universal screening.

Now part of what is limiting our ability to achieve full compliance here is that we currently have very few powers to enforce this kind of provision, and the enforcement powers we do have are rather Draconian.

One option would be to withhold Medicaid funds from the State's Medicaid program. That is a very severe measure to take because it would not be segmented from most of the other Medicaid benefits. We are talking about cutting off large States from Medicaid funding in its entirety for child care services. And I do not know whether people would like to see that happen as an enforcement measure.

The other option that we are trying is working with States to improve their reporting and analysis in both the fee-for-service Medicaid environment and the managed-care Medicaid environment.

Our reporting is largely based on claim status. When a claim is paid for a lead screen, then we pick that up in our claim system. In cases where we contract with a managed care organization, we do not receive that claim information, but rather encounter data. So that we are relying on data that comes in from the States, which may not be as accurate because, in part, managed care organizations often struggle to get the information out of their provider network and to forward it over to us.

Moreover, a significant number of children get screened in local health departments, which, for a variety of reasons, may not bill us at all for the service. And when that happens, we do not receive good, reliable information on States' screening performance and what they are finding out from that screening performance.

But we are working on data collection. We are working directly with States, provider organizations, community-based organizations, and our regional offices to try to do a better job at achieving full compliance.

Senator REED. Let me ask one additional question before I move on to the other panelists. In your description of the managed care arrangement, my presumption would be that part of their contract is to screen Medicaid children 100 percent. Would that be a correct assumption?

Mr. KING-SHAW. Actually, our information shows that approximately 42 percent of contracts between managed care organizations and the State have specific language on lead screening.

Now there is another body of contracts that address the EPSDT program in general and this is a part of that program. So, therefore, by extension, it is addressed.

So our best information would be that virtually all of the contacts have some provision, either direct or indirect, that would call for this kind of screening.

States do take the primary responsibility in monitoring and in compliance with the Medicaid contract; they have teams and State agencies that do that. Our regional offices get involved in looking at that data. So the contract between the State and the managed care organization does give us some contractual relationship that we can monitor and drive compliance.

Senator REED. Not only monitor. Enforce. If you are paying Federal dollars to a managed care company that is not performing the services that you contracted for, I suspect you could enforce it. But let me move on.

If you could recommend to this Subcommittee specific enforcement powers that you think would be appropriate, short of the Draconian enforcement of denying Medicaid payments, we would appreciate that very much. In fact, I would ask you to do that.

Mr. KING-SHAW. Now? Here?

Senator REED. No, at your convenience. Promptly, but not here.

Mr. KING-SHAW. I would be pleased to do so. Thank you, Senator.

Senator REED. Thank you.

Let me ask Mr. Sharp. The EPA has been charged over many years to develop regulations. And you have indicated in your testimony that you are beginning that process. At least 10 years ago, EPA was asked to create a rule with respect to remodeling and

renovation. A lot—or some, at least—of the problems encountered are a result of remodeling and renovation.

We were in Maine in field hearings with Senator Collins. Where a young woman had talked about how she bought the house of her dreams, an old Victorian, and she had two young children. And in the process of renovation, poisoned her children. So it is a real problem. Can you update us now on the process of those regulations?

Mr. SHARP. Yes. Actually, I outlined four other regulations of course in my testimony that we have been working on and completed. We have three more, this being one of those.

We are on target to publish that rule next year. There is a number of things, of course, we have been working through. And we have completed a lot of the preliminary work on getting this rule done. Technical studies have determined the scope of the problem. It was one of the first major undertakings that we had to do and have completed those.

Guidance and training courses, identifying best practices is another portion that we have been working through, and then prerenovation materials and education of consumers. Materials like these, *Reducing Lead Hazards When Remodeling Your Home*. This is dated 1997. There is a number of materials like this that already are out there, and I want to make sure that that is a good, clear point.

There are a number of things that we have been doing even before this rule comes out to address this issue, particularly with the remodeling concerns that you have outlined. So there are a number of things that we are trying to do.

We are also trying to work with our State partners to identify those particular areas as well, where you may have more concern, and we have talked about that a lot, where there may be specific communities of people who are more at risk than others. We have been trying to work with our State partners. I mentioned that we have about 35 States now that we are working with, three Tribes, Puerto Rico, and the District of Columbia, to achieve that.

So, we are on target with the remodeling and renovation rule of getting it out next year. We are also going to be meeting with a number of stakeholders, our States and others, through the later part of this summer and the fall, to also further develop and make sure that we have all the right types of programs in place for this rule. Of course, the bottom line for putting out a new rule is that it needs to be effective. It needs to be a rule that is going to have compliance. People need to be able to look at this and comply with it, be able to understand it. It needs to be flexible. It needs to be innovative.

We need to make sure that people in that last portion of the graph are the people that this works for.

You can put out a rule and if it doesn't have the right components in it, it can sit there. And what we want to do is we want to make sure that we have something that is compliable, that people can look at and work with and make sure that it does have a benefit at the end. So that is what we are shooting for. We think we are on a good track, and with your help and guidance, we are going to have that out next year.

Senator REED. Well, I would urge you to follow through because it is important to get the rules out and then we can evaluate them, you can evaluate them and make changes. But we have been in this limbo for 10 years now with these rules required and not being promulgated.

Let me ask another question, Mr. Sharp, and that is from Mr. Sansonetti's testimony about indicting and convicting people for failing to disclose the lead presence in rental apartments.

A survey conducted by HUD in 1998 suggests that very few renters have ever been informed of the presence of lead. And there are some egregious cases in which we have taken legal action. But what are you doing to ensure that this rule, not through judicial enforcement, but administratively, is being obeyed?

Mr. SHARP. EPA, in coordination between our office, the OPPTS office and our OWECA office, our enforcement office. This has been something that we have been working, as the gentleman referred to, of identifying cases in areas. And, of course, you do need to have these types of activities take place. You need to have enforcement activities in place, and enforcement activities taken as well, to make sure that people are complying.

So, in that arena, we are trying to step up those approaches. We are trying to work closer with our OWECA office to make sure that they have a good understanding of these programs. Not only the four different pieces we put out within the last 10 years, but also the three more that we are going to be putting out in the next 2 years. So, I can also look to get you some more information on that question as well in writing at a later date here.

Senator REED. Thank you, Mr. Sharp.

Mr. Sansonetti, let me follow-up on just a couple of points.

First of all, procedurally, who makes the decision for a criminal action or for a civil/legal action? Is it the Federal attorney locally, or is it coordinated through your office here in Washington?

Mr. SANSONETTI. The U.S. Attorney's Offices often have the lead in these cases. We at the ENRD—Environment and Natural Resources Division—coordinate with the U.S. Attorney's Offices. We have meetings with them on a fairly regular basis to actually discuss the entire spectrum of criminal enforcement.

Even just recently, last month, I was down in South Carolina at our National Advocacy Center, where they had representatives from each of the U.S. Attorney's Offices. We go through the entire panoply of criminal enforcement cases in the area of environment and then we provide the U.S. Attorney's Offices with the training materials to take back to their shops to help make these decisions.

Senator REED. Have you coordinated with CDC or HUD to identify those areas where this is a great problem?

Mr. SANSONETTI. Yes.

Senator REED. And have you made in those Federal districts the Federal attorneys aware and emphasis or at least suggest it, that they vigorously prosecute?

Mr. SANSONETTI. The answer is yes. As you noted from, actually, everyone's testimony today, these things really well up from the initial investigations that go on by the people at HUD, the EPA, CDC people, and the like.

They do it, as I mentioned, in various and sundry ways. But one of the ways is to keep track of where sick kids are showing up. Who has the elevated blood level? Where have there been problems? Are they concentrated in a particular building, a particular area, or buildings owned by the same management company?

From those investigations, the referrals come to our shop if, indeed, the violators have not literally cleaned up their act and made sure that the tenants are getting the pamphlets that they are supposed to get. So it is coordinated.

Senator REED. I just want to be clear, Mr. Sansonetti. You seem to be describing a process where, if the information comes from the field to you, you will take action.

Mr. SANSONETTI. Right.

Senator REED. My question is, have you looked across the map, if you will, based upon the data of CDC and others, and said, this area is really epidemic with lead poisoning, and suggested that the Federal attorneys take vigorous action?

Mr. SANSONETTI. The coordination actually has come—it is not just us to take a look at that. It is one that we take with EPA and HUD. And that is the core of why the initiative to date has indeed centered on Los Angeles, Chicago, the District of Columbia, and New York.

Senator REED. Just a final question. You have suggested and you have indicated some serious questions which the Justice Department has brought. Have you initiated any cases in the last year and a half? Or are these cases that are a legacy from the previous administration?

Mr. SANSONETTI. The two cases that I mentioned, the Nuyen case was prosecuted I believe in 2001. The sentencing was just earlier this year. Let me make sure. The other one, I believe, was March. The Aneckstein case, I believe, was March.

[Pause.]

Yes, it culminated this March in New Hampshire, yes.

Senator REED. Thank you very much. Let me ask one question of Dr. Jackson, and then ask Mr. Jacobs a question. And then yield to my very patient colleague, Senator Corzine.

You indicated, Dr. Jackson, that one of the problems is data collection and reliable data collection.

CDC provides grants to States to establish childhood blood level surveillance systems—CBLs. Can you describe how successful that has been? Are the States actively collecting? Is it consistent? Is it reliable data? And what more do we have to do to make sure that the data is reliable and consistent across the country?

Dr. JACKSON. One is there is a lot of interest in the whole issue of environmental health tracking. Maybe you have even heard of the Pew Commission report. Senator Clinton held a hearing a while back on this issue of tracking, how we link what is going on in the environment to what is going on actually in people.

There is a genuine problem in the health arena that the data collection systems for tuberculosis, for cancer, for this and that, are completely inconsistent. It is a Tower of Babel over here. It is worse than that. Actually, if you start burrowing into one of our programs, like the lead program, we have had inconsistency in software and other kinds of computer collection systems.

The States have the ultimate authority to require reporting, to demand that the laboratories report, to demand that the counties and the doctors report. That is not an authority that resides with the Federal Government. The way we get that is through our grants process, we then require them to report.

The State where I worked and had my most experience was California. I was involved in putting the law in place in the early 1980's, and foolishly, pushed for a law that required all blood leads over 25 to be reported to the State. It was a real mistake because what we really wanted to know was where lead is not a problem, where the kids have low levels, where did they have medium- and high-levels?

We need all the lead levels being reported. A lab-based system is the way to go. They need to be consistent across all the States. They need to be linked into GIS systems, where one can actually go to a map and connect it to tax board data with other economic and social and census data. And by the way, this is being worked on right now actively. So you can begin to stack it up and figure out, this is a hot spot. We are in the process of doing this.

Then when you get positive reports, say, okay, we will put a HITS team into this community—the nurse, the community organizer, and other people go house-to-house and do that kind of aggressive work in those areas. So, we are on track. It is not as good as it should be, and we are working hard to make it better.

Senator REED. Do you have the resources to make it better?

Dr. JACKSON. Right now, the program is at about \$42 million. It sounds like a lot of money when you are really after 50 million children and about the 600,000 that are over a blood-lead level of 10. Most of that money actually goes to the State and local programs. We withhold some for training and computer and other kinds of stuff. But most of it goes to the States.

That is important because it is the management at the State and local level—the person that knows the housing people, the enforcement people, and the rest. They are the ones that are doing the real work. Lead is a local problem. We need to support them. But the real action is going to happen at a really local level.

Senator REED. Thank you, Dr. Jackson.

Mr. Jacobs, let me ask you perhaps not a summary, but a perspective. How can we better coordinate? HUD is generally regarded as the lead Agency because it is a housing-based problem. What can we do better at the Federal level to coordinate from your perspective? And where should additional resources that are necessary be applied?

Mr. JACOBS. Lead is one of those issues that is not within any specific jurisdiction among the different agencies here.

And in that respect, one of the satisfying things that I have seen in my tenure with the Federal Government has been an increasing ability to recognize each Agency's expertise, while at the same time bringing their resources to bear.

I chair the working group in the Federal task force, the President's Task Force on Children's Environmental Health and Safety Risks. We look at things such as low-income housing tax credits, or weatherization programs, and how to bring those existing programs to bear.



I think we can do better. The Federal Government is a many-headed beast. But clearly, the major need is to acquire the resources that are needed to deal with the housing stock that has lead-based paint hazards. That is the major expense and that is where the resources need to be focused.

Senator REED. Thank you, Mr. Jacobs.

Let me recognize Senator Corzine, who has been most patient. Thank you, Senator.

Senator CORZINE. Thank you, Mr. Chairman.

Let me ask Dr. Jackson. If the science took up to a point where we thought that the blood level of five, as opposed to 10, micrograms, was the standard, how much would the population of those be registering relative to what I am hearing, 700,000, 800,000?

Dr. JACKSON. Senator, I apologize for not being able to answer that, and I will get back to you on it. The question about acceptable levels below 10, the toxicity of lead, there is no safe level of lead. The number 10 was picked partly because that was as good as our laboratories were for running a lot of specimens at that time. The levels and values became relatively unstable below that. It was something that the programs could understand. It was in many ways like a speed limit. You pick a number that people can understand.

But the less lead, the better. I will be happy to get back to you with an estimate on what a cut-off of five would generate in terms of numbers of millions of people.

Senator CORZINE. Do we have any preliminary understanding of what the implications of five might be?

Dr. JACKSON. What the neuro-toxicologists and other specialists in toxicology assert is actually that, when you get these high levels, you have saturated the brain to such a degree, that you do not see as big a change at the higher lead levels as you do at the lower lead levels. In other words, not a little bit is doing a fair amount of harm. And that is why they are pushing so hard to reexamine what is the safe threshold.

From a practical standpoint—I will be very direct—I do not want to see the attention pulled away from the children who absolutely need it most in these high-risk areas by going after, at least from a programmatic standpoint, these much lower lead levels.

We really think we have to start with the highest-risk kids, the kids at 20, 30, and 40, and push the program hardest in that direction, and then we can move to these lower levels. So, I am just a little worried that if the definition of an elevated level greatly increases it, and now we have a vast middle class that is chasing after it and we lose the attention on the kids that need it most.

Senator CORZINE. It sounds like a conundrum that I hope we do not have to face. I would hope that we would be committed to finding out and dealing with these hot spots in a more serious, disciplined way.

Mr. Jacobs, if I have read the statutes right—I should honestly say, if my staff has—

[Laughter.]

The Lead-Based Paint Poisoning Prevention Act, which I think we instituted in 1992, established procedures to eliminate lead-based paint hazards in all public housing.

I apologize if you spoke to this in your opening testimony. But can you give us, or give me, your view on whether we have solved this problem in public housing, to your knowledge, with regard to Section 8 housing, have we addressed this?

Mr. JACOBS. In 1992, Congress authorized HUD to review its current regulations across all of our housing programs, not just public housing, but other assisted housing, to enable the implementation of modern forms of lead hazard control. That changed the way in which we had approached it in the past.

We implemented that rule. There was a lengthy transition period to enable all of our program recipients to get up to speed. The Deputy Secretary ended that transition period last January and that rule is now in effect across the country.

The data that we have from our housing survey show, surprisingly, I might add, that 17 percent of Federally-assisted housing has lead-paint hazards. In upper- and middle-income housing, the prevalence rate is 18 percent. The prevalence rate in low-income, unassisted housing is 41 percent. And those are the houses that we target with the HUD grant program. Most of those houses receive no other form of assistance.

So the Federally-assisted housing rules appear to work. We have evaluated them over time. They are based on the real-world experience of the HUD lead hazard control grantees across the country.

It took us a while to get there. Frankly, in the mid-1980's, it was not known, for example, that lead in settled dust was an important pathway of exposure. And until that was made clear through scientific research, we did not impose dust testing at the end of Federally-assisted rehab or maintenance work or housing finance.

That requirement is now in place. And that is why I said earlier that we believe the Federal rule provides important lessons to the Nation as EPA moves to develop regulations to apply to rehabilitation activities in privately-owned housing.

But we have done that and the evidence that we have to date is that it appears to be working well. It was a substantial undertaking. We ended up training 28,000 maintenance and rehab workers in the last year alone, to enable local communities to get up to speed so that they could comply with the rule. But compliance is a reality at this point.

Senator CORZINE. Section 8 vouchers, those housing units need to be approved with respect to lead-paint poisoning before the vouchers are allowed to be used in those circumstances? Is that correct?

Mr. JACOBS. That is correct. The new regulation requires a visual examination and then if the deteriorated paint is above a certain de minimus level, we require the paint to be repaired and then dust testing at the end of the job to make sure that the unit is safe for children to occupy. In fact, the Department pays for that dust testing so that it does not fall to the private landlord to absorb that additional cost.

Senator REED. Mr. Jacobs, do you have an estimate of either how long or how much resources are going to be necessary to deal with

that 41 percent? And what kind of timeline society should have an expectation that that should be dealt with?

Mr. JACOBS. In the 10-year plan that was published by the President's task force last year, we did estimate the resources, the expenditures, I should say, that are needed to eliminate lead-based paint poisoning from our Nation's housing stock.

That document showed that it would take a total expenditure, not necessarily a Federal expenditure, but a total expenditure of \$230 million a year for the next 10 years. That takes into account ongoing housing demolition, ongoing housing rehab, and the effect of the regulation for Federally-assisted housing.

That is why Operation LEAP is so important, because we think that that will help bridge the gap between the current Federal appropriation and where we need to be in terms of total expenditures to make our housing stock lead-safe.

That figure is based on interim controls, which means a method of making housing safe and then requiring management of lead in an ongoing way.

Abatement, which is a more permanent corrective measure, is more costly. In that report, we estimated what the costs would be for abatement of low-income housing, which would be \$2.1 billion per year for 10 years.

Senator CORZINE. We are actually getting a different number, at least kicked out of my reading of that report, although, whatever the number, \$2.1 or the \$10 billion that I actually have here, what is the amount that has been asked for in the budget for 2003, with regard to lead-based paint hazard control?

Mr. JACOBS. The President's request this year is \$126 million, which is an increase from \$110 million the previous year. If you go back to 1998, 1997, the figure was set at \$60 million. So, basically, the appropriation figure has doubled in the last few years.

The capacity is built. And I have to tell you, one of the hardest decisions I make each year is to look at the grant applications that we receive each year. Most of them demonstrate need, have a good program in place, and have the capacity to handle the resources. We have to choose a fraction of them to actually receive the funds that are necessary.

Senator CORZINE. And what, in fact, happens to the ones that are not?

Mr. JACOBS. They apply the following year. We encourage them to apply, and we try and make the wisest, most targeted use of the grant dollars that have been appropriated to us.

Senator CORZINE. This is one of those things where sometimes we wonder, or at least have to question our priorities, because sometimes—and this is not personal—when those elements are left out, we end up paying for it in a whole series of other venues because of the kind of implications that the lead-based poisoning can bring to bear on our children and families and health. I appreciate very much your response.

Senator REED. Thank you very much, Senator Corzine. I have a few more questions, and if you have additional questions, I will recognize you.

Mr. Jacobs, just a follow-up to Senator Corzine's line of questioning. You mentioned the regulations that are promulgated with

respect to the 1992 Act. I understand that the HUD Single-Family Mortgage Insurance Program was the only program not updated in those regulations. Is there any particular reason for that?

Mr. JACOBS. That is correct. There are regulations for that program that have been in place for 15 or 20 years that require visual assessment and correction of deteriorated paint and clean up, no clearance testing.

I should note that Multifamily Mortgage Insurance is covered by that regulation. A subpart of that rule remains reserved for the Single-Family Mortgage Insurance Program. But beyond that, I need to get back to you with a more complete answer.

There are some significant concerns about costs, the impact on homeownership, and the impact on other secondary mortgage institutions such as Fannie Mae and Freddie Mac.

Senator REED. Is there a significant incident of lead exposure and contamination in those particular units?

Mr. JACOBS. Well, of course, FHA finances low-income housing, for the most part. And certainly, in low-income housing, we know that the prevalence of lead-based paint hazards is higher. And the likelihood of lead paint in the older housing stock is certainly greater. So, clearly, there is a potential threat there that needs to be examined and looked at.

Senator REED. Thank you.

Dr. Jackson, you indicated in your testimony that there is between 500,000 and 750,000 children with elevated blood-lead levels. How many of these children can the CDC, together with States, effectively track today with the level of resources you have? Are we close or are we just getting a mere fraction in terms of monitoring, testing, and giving you the information?

Dr. JACKSON. The last time we did the calculation for kids over 10, the number came in at about 850,000. But that was in 1990. Our guess right now is that we are in the 500,000 to 700,000 range.

We are really going through a real transition with this program where we are—at one point, we wanted to fund every single State and every locality and we spread the money very, very thinly. That is not going to work.

There are hot spots and we are pulling back and we are going after the areas and using the money that we have as effectively as possible, and will use them in the cities and urban areas with the oldest housing, with the record of kids, and with good, solid management. Putting it into a place that does not want to invest its own State or local money, is not going to take authority and responsibility for the program and have a coalition of housing and enforcement people. It is not worth doing.

And so, honestly, our approach is, here is what we have and we are going to apply it in the most effective way possible, rather than—I have not really thought about it from the way you have asked the question, Senator. I am sorry.

Senator REED. But, essentially, your first constraint is the resources.

Dr. JACKSON. We do the best we can with the resources we have.

Senator REED. In that respect or regard, too, your HITS program, which is an innovative way to target, given your resources, how broadly can you expand this program, or how quickly?

Dr. JACKSON. I will be honest, HITS is expensive, in the sense that it requires people.

The good news is you get community engagement, and you have residual interest. The one in Chicago got a lot of media and political interest. And so, the community became invested in this. It had a lot of secondary benefits.

The other benefit is, if you are in that house looking at that child, you might be able to check an immunization record. You could look at some cockroach or asthma or other kinds of problems at the same time.

So looking very, very narrowly at lead in this population, I think what we are really coming to, and it is what Mr. Jacobs deals with a lot, is a healthy homes approach, where lead is part of a larger strategy for the homes of the poor.

Senator REED. But I think what you suggest, this is an old public health model, where a public health nurse walks in the door and checks for everything.

Dr. JACKSON. It absolutely is an old model. If you talk to the public health nurses of 30 years ago, they say it worked great. But it is not cheap.

Mr. JACOBS. If I might add.

Senator REED. Mr. Jacobs, please.

Mr. JACOBS. One of the things that our rule requires is actually a data match between lists of poisoned children that are held by local health departments and lists of subsidized housing that HUD grant recipients maintain. And so, one of the major changes in my view that needs to occur is that we should, in addition to tracking children, track houses.

In all too many cases, there are, "repeat offenders" where the same house will be responsible for multiple poisonings. And in fact, that is how we launched our enforcement initiative. We took a look at the cities that had the highest numbers of dilapidated, pre-1940 rental stock, and combined that with some CDC data, and came up with where we should go.

Senator REED. You have anticipated a question I had, and I think Mr. Sansonetti might comment also. If the child is poisoned and then he or she is treated, and then the next family moves in and that child is poisoned, and the next, that seems to me a pretty good indication that action should be taken. Is that a principle that you are following in the Justice Department, Mr. Sansonetti?

Mr. SANSONETTI. It certainly is. Our job, of course, is to be the backstop to people like investigators at EPA and HUD. And it is when they come upon violators that choose to go ahead and be obstinate and being unwilling to do what needs to be done, that they then come to us and say, well, maybe the person wants to answer to a Federal judge rather than do the right thing. But as far as deciding when you do something civilly or criminally, obviously, if it is a repeat offender, if you have a death involved—the magnitude and the number of the case is going to help decide whether we put it into the civil or into the criminal bailiwick.

Two other things I would actually follow-up on in regard to some of the questions you have asked today, is the fact that publicity about what we are talking about today is absolutely key.

One of the reasons that, frankly, as an Assistant Attorney General, I was anxious to come to participate today, was because this is one of the initiatives that I am pushing.

Now, admittedly, I had only been there about 155 days. But the fact is that this is stuff that we can put into my speeches to the different groups, real estate conventions, as part of their continuing education as a real estate entity, that they realize that this is one of the things that they have to make sure happens.

They could potentially be held responsible for themselves, if they are the owners of some of these buildings, we are going to start to get the word out.

We have 4,500 active cases going right now across the board in the ENRD.

It is no accident that I have taken cases like that Nuyen case here in Maryland, and the Aneckstein case for our key publicity roles. We now actually have a person in our office of public affairs assigned to my division to help get the kind of publicity out so that we can leverage a conviction like the Nuyen case, and the one up in New Hampshire.

So maybe it was just one conviction in a particular site. But if we trumpet it out, as we have in those cases, and it ends up in *The Wall Street Journal*, as well as the local paper, then we are getting more bang for our buck because more people are saying, whoa, I did not realize that I could go to jail for 2 years.

Pay that kind of fine? Maybe we had better make sure that our darned pamphlets have been distributed and signed off on.

So the fact that you are having this hearing today is one of the things that attracted me, because this is the kind of publicity that we need on this topic.

Senator REED. One final general question. A lot of the regulatory apparatus is based upon disclosure of lead risks and hazards by the landlord. Sometimes that prompts landlords to know as little as they can about their property since they are held only, I believe, to the standard of what they know about the property, which raises a real problem. I wonder if that approach is denying us effectively reaching children where landlords will deliberately not test their property, or not want to know about what is going on. Your experience, Mr. Jacobs? Anyone on the panel can comment.

Mr. JACOBS. You are referring to a potential chilling effect for disclosure.

Senator REED. Right.

Mr. JACOBS. That it is better not to know than to know.

Senator REED. Is that a real issue out there or this is just something hypothetical that we can dismiss?

Mr. JACOBS. I guess I would answer it this way. By looking at what has happened in our project-based Section 8 inventory, which is privately-owned, but subsidized.

In that program, we required risk assessment and an inspection and then made a voluntary program available to owners to participate if they wished. Now if they wanted to put their heads in the sand and not participate, we did not require them to use our pro-

gram to obtain free lead-paint inspections. But most of them have, in fact, come in and tried to determine where their hazards are and how to best correct them.

It is more advantageous for a property owner to know exactly where their lead-paint hazards are so that they can minimize both their liability exposure and their ongoing maintenance and rehab activity so that they are property targeted. If they do not know, then, of course, the liability would increase.

But you are correct. The existing disclosure rule does not require an inspection and in most cases that I am aware of, we know that, in fact, people generally check the I-Don't-Know box. And in that sense, the real information that a parent needs—where is the paint? Where are the hazards?—is not provided.

Senator REED. Let me just raise one final question because a vote has been called, apparently, and I will conclude the hearing. But we have heard today that the vast majority of exposure to lead is in the home. Medicaid allows States to cover the cost of one-time environmental assessments of the home. However, I understand that Medicaid will not pay for testing the dust, soil, or water as part of this assessment. I was, in my early days, when I became familiar with this problem, shocked to learn that it is not just the home, it is outside in the soil, particularly in low-income neighborhoods. And yet, those areas are not tested. Might you comment, Mr. King-Shaw?

Mr. KING-SHAW. Yes, and that is a problem. We are limited by the fact that we are bound to reimburse testing for human specimens only, by Medicaid rule, by policy, by limitation. For us to test anything more than that would require a change in our authority, which is not present today.

Senator REED. Thank you for the response.

Let me thank all of you for your testimony today and thank my colleagues, Senator Allard and Senator Corzine, for participating. We appreciate certainly your time and the effort you have put into this hearing this afternoon.

It is apparent from today's testimony, we have a great task before us. We need to find the will and the resources to eradicate lead hazards that affect hundreds of thousands of children, perhaps even millions. We also need to make more Americans aware of the dangers of lead poisoning.

At the same time, though, we have heard about how much progress we have made on this issue and what Federal officials are doing to continue this progress.

That is good news, and I look forward to continuing to work with you. I would ask, if you have any additional statements, to please submit them. And also, if there are additional questions, we will provide them to you and ask for your response no later than next Monday—10 days from today.

Thank you very much for your testimony.

The hearing is adjourned.

[Whereupon, at 4:05 p.m., the hearing was adjourned.]

[Prepared statements and response to written questions supplied for the record follow:]

**PREPARED STATEMENT OF SENATOR JACK REED**

This hearing is one in a series I hope to have to bring greater attention to the terrible problem of lead poisoning in our Nation's housing and its effects on children. The hearing is a follow-up to the Senate Housing Subcommittee hearing held last year regarding State and local responses to lead-based paint poisoning.

Over a decade ago, the U.S. Department of Health and Human Services announced a strategic plan for the elimination of childhood lead poisoning because it recognized the detrimental, long-lasting effects on children from exposure to lead. The efforts to achieve the long-established goal of eliminating lead poisoning by the year 2010 has stalled and may in fact be moving in the opposite direction.

Not only are Federal laws not being enforced, such as the requirement that all Medicaid eligible children be screened for lead, it also appears that there is currently no coordinated action to eliminate childhood lead poisoning.

The previous Administration created a Task Force on Children's Environmental Health and Safety Risks. This task force was cochaired by the Secretary of the Department of Health and Human Services and the Administrator of the EPA and developed a set of recommendations to eliminate childhood lead poisoning in the United States as a major public health problem by the year 2010.

Specifically, this comprehensive Government-wide strategy called for making 2.3 million homes where children under the age of six live lead-safe by controlling lead-paint hazards. It also called for public education programs, strict enforcement of lead-paint regulations as well as encouraging early interventions for at-risk children.

With only 8 years to go until we are to have eliminated childhood lead poisoning, it is estimated that nearly one million preschool children living in the United States continue to have blood-lead levels high enough to impair their ability to think, concentrate and learn.

Unfortunately, except for the most severely poisoned children, there is no medical treatment for this disease. The only effective treatment is preventing exposure.

The Department of Housing and Urban Development estimated in its latest national survey that lead still remains in about 39 million dwelling units or 40 percent of all U.S. housing.

Federal efforts to reduce the hazards of lead-based paint poisoning began 31 years ago with the enactment of the Lead Paint Poisoning Prevention Act. This Act required the Secretary of HUD to establish and implement procedures to eliminate lead-hazards from public housing.

In 1992, Title X of the Housing and Community Development Act authorized major changes in Federal law in the control of lead-based paint hazards and the reduction of lead exposure.

Title X defined "hazard" in such a way that it included deteriorating lead-paint, and the lead contaminated dust and soil that the lead-paint generates. It also mandated the creation of an infrastructure that would help correct lead-paint hazards in all of our Nation's housing.

In particular, Title X required coordinated action between several Federal agencies regarding lead poisoning, including the Department of Housing and Urban Development (HUD), the Environmental Protection Agency (EPA) and the Centers for Disease Control and Prevention (CDC).

While we have made progress in dramatically reducing the number of children with elevated blood levels, significant barriers and obstacles to the elimination of this environmental health hazard remain.

- Why are only 20 percent of children enrolled in Medicaid being screened for lead poisoning, when Federal law requires that all children be tested?
- If a child tests positive for high levels of lead in their blood, why aren't their homes being reported and screened for lead?
- Why hasn't the Environmental Protection Agency promulgated regulations on the safe renovation and remodeling of housing containing lead-based paint?
- How many new cases has the Department of Justice filed against landlords who are violating laws designed to protect tenants from lead poisoning?
- Why is HUD's single family mortgage insurance program the only program not to be updated in HUD's new lead-paint regulations for assisted housing?

We expect today's hearing to provide some of the answers to these questions. We will get an overview of what a number of Federal agencies—HUD, EPA, CDC, DOJ, and CMS—are currently doing to help make housing lead-safe for children; how well these agencies are coordinating with one another; and what additional tools each agency needs to achieve the national goal of eliminating lead poisoning by 2010.



This hearing is only the second in a series of Senate Housing Subcommittee hearings on lead-based paint-poisoning. It is my hope that these hearings will help shine a light on this terrible problem, energize the Federal Government into playing a greater role, and improve local, State and Federal partnerships to eliminate lead-based paint-poisoning by 2010.

Federal taxpayers and low-income children and families are paying the price for these deficiencies in terms of added costs for special education and the long-term health and developmental problems in lead exposed children.

More needs to be done. No child should have to live with the consequences of this preventable disease.

#### **Senator Jack Reed's Efforts to End Lead Poisoning**

Senator Reed has worked in Congress to increase funding to combat lead poisoning and to ensure that children are screened for lead in their blood before entering kindergarten. Senator Reed secured a 25 percent increase in 2001, and a 10 percent increase in 2002 in the Department of Housing and Urban Development (HUD) budget to remove lead-based paint, educate families about the dangers of lead, help cities comply with new Federal lead-safety regulations, test low-income housing units for the presence of lead and train inspectors and workers to identify lead contamination in housing.

He has sponsored legislation to require all children covered under Federal health programs to be screened and treated for lead poisoning. Reed's provision was included in the Children's Health Act of 2000, which was signed into law in October 2000. It also authorizes the Centers for Disease Control & Prevention to issue recommendations to ensure uniform reporting requirements for blood-lead levels at State laboratories and to improve data collection on the number of children screened for lead poisoning annually.

He introduced legislation to give the Federal Government the authority to sue the lead-paint industry to recover costs related to the lead poisoning of children and the removal of lead-paint from homes.

In October, 1999, Mrs. Tipper Gore, the national spokeswoman for the Campaign for a Lead-Safe America, dedicated a lead-safety center in the Elmwood section of Providence, Rhode Island in recognition of Senator Reed's national leadership to protect children from the dangers of lead poisoning.

The Reed Center, which is run by the Greater Elmwood Neighborhood Services (GENS) and the Health Education Leadership for Providence (HELP), is for those families who are dealing with the legacy of lead. Through counseling and treatment, the Center had helped more than over 500 families cope with the effects of lead poisoning since October 1998.

For the past 3 years Senator Reed has successfully sponsored a resolution designating a week in October as "National Childhood Lead-Poisoning Prevention Week,"

Senator Reed has also held Senate hearings in Rhode Island and Maine with Senator Susan Collins (R-ME) to highlight the important successful approaches being undertaken by State organizations, such as the Greater Elmwood Neighborhood Services (GENS), the Health and Education Leadership for Providence (HELP) and the Childhood Lead Action Project.

On discovering that the Rhode Island Housing Authority was not implementing Federal regulations regarding the elimination of lead-hazards in Federally subsidized housing (Section 8 Housing), Senator Reed secured an agreement between the Federal Government and the Housing Authority to ensure greater oversight and coordination of the Housing Authorities efforts.

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#### **PREPARED STATEMENT OF SENATOR WAYNE ALLARD**

I would like to thank Chairman Reed for holding this hearing on the hazards of lead-based paint. Childhood lead poisoning is the most common environmental disease of young children. It affects nearly every system in the body and even low levels of contamination can cause debilitating damage to children, impairing intelligence, muscle control, hearing, and emotional development.

The lead-paint in older housing and contaminated dust and soil it generates is the most common source of lead exposure for children. In the United States today, nearly one million children ages 1 to 5 have elevated blood-lead levels.

According to HUD's National Survey of Lead and Allergens in Housing, an estimated 40 percent of all homes have lead-based paint somewhere in the building, whether it be on the inside or outside of the structure. Twenty-six percent of all homes have significant lead-based paint hazards, and of the 16.4 million homes with

one or more children under the age of 6, 27 percent have significant lead-based paint hazards.

All of this is the bad news, but the good news is that lead poisoning is preventable and that is why we are convening here today. I look forward to hearing about what each of the five Federal agencies is doing to help in this prevention effort.

I thank the Chairman for holding this hearing and giving us the opportunity to learn more about the issue, what is currently being done, and what more can be done with regard to lead-based paint hazards.

Thank you, Mr. Chairman.

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#### PREPARED STATEMENT OF SENATOR JON S. CORZINE

Mr. Chairman, I want to commend you for holding this important follow-up hearing on the Federal responses to lead-based paint poisoning. This is an issue of great concern to me and to my State, which is struggling to find the resources it needs to fund lead-paint abatement programs and ensure access to early detection of childhood lead poisoning.

This is a public health problem of enormous consequence for our cities, States, and our Nation. At least one million children nationwide are victims of lead poisoning. These children have reduced IQ, hearing, growth, behavioral problems, and impaired nerve function. Many of them suffer from severe brain damage.

It is estimated that as many as two million homes in New Jersey that were built before 1978 contain toxic lead. Nine out of every 10 houses in the city of Newark are tainted with the poison. Some estimates show that up to 50 percent of Newark's children may be affected by lead poisoning. Because screening efforts have been slow, only 4,000 children in the city have been identified as having elevated blood-lead levels. As a rule, these children come from low-income minority households.

While lead-based paint poisoning is a very local problem, it is also a Federal problem. States and localities are unable to bear the costs of lead abatement, which amount to about \$15,000 per unit. Funding for the Federal Lead-Based Paint Program must be dramatically increased if we are to adequately remove the paint that continues to plague millions of low-income homes in this country.

Despite the fact that 80 percent of children with elevated blood-lead levels receive Medicaid assistance, a 1999 GAO report found that only 20 percent of children receiving Medicaid benefits had been screened for lead poisoning. This is a national disgrace. In 1989, Congress required that all children receiving Medicaid be screened for blood-lead levels, however, enforcement of this law has been minimal. I am deeply troubled by recent comments made by CMS staff that this Administration finds the Medicaid childhood lead screening requirement overly burdensome and costly for States. Unfortunately, the learning disabilities and public health costs associated with lead poisoning are much greater.

We must not only ensure that children are screened early, but also that they are screened through age 6. The Centers for Medicare and Medicaid currently only requires that children be screened through age 2, despite the fact that lead poisoning poses a clear danger to children up to age 6. Additionally, children participating in the Head Start Program should be screened for lead poisoning. While children who participate in the Head Start Program are screened for many developmental disorders, they are not screened for the blood-lead levels that so often cause these disabilities. Mr. Chairman, I know you have introduced legislation, which I have cosponsored, to make screenings available through the Head Start Program. I hope to see passage of this bill in the near future.

The public health and societal costs of this problem are enormous. This Administration must affirm its commitment to enforcing lead disclosure laws, Medicaid screening laws, and lead abatement programs. I am pleased that the President has made ending lead-based paint poisoning in the next 10 years a priority and I look forward to working with the Administration toward that end.

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#### PREPARED STATEMENT OF SENATOR DEBBIE STABENOW

Mr. Chairman, thank you for calling this second hearing on lead-based paint poisoning. This is an incredibly important topic and I am glad that today we are examining the Federal Government's role in eliminating this problem.

Lead-based paint poisoning remains a serious problem for too many children. And, we in Congress have an obligation to increase our efforts to combat this problem. Lead-based paint poisoning can be abated and even eliminated if we are willing to

pay the price and implement the necessary measures. This is precisely why I was happy to join the Chairman and several other colleagues last month in writing to Senate appropriators, urging them to provide \$200 million for the Department of Housing and Urban Development's lead safety grant program and for \$110 million for the Primary Prevention Initiative.

I worry a great deal about lead-based paint poisoning because I know it is a serious problem for many children, but it is particularly a problem in my home State of Michigan. Indeed, according to the Alliance to End Childhood Lead Poisoning, Detroit ranks third in number of cases of children identified as having severe lead poisoning. And last year, the *Detroit News* reported that children in several Detroit neighborhoods had lead levels that were 10 times the national average. This is truly outrageous and disturbing.

The Federal Government's responsibility in regard to this problem is clear and I want us to do more. To help address this problem back in Michigan, I am already working to obtain critical Federal funding for the CLEARCorps program in Detroit and in Grand Rapids.

As the Chairman knows, CLEARCorps is an innovative nation-wide network of public-private partnerships that has a proven record of offering cost-effective methods of fighting childhood lead poisoning.

Mr. Chairman, I look forward to hearing from our witnesses today and, again, I thank you for your leadership on this. The day when no child is at risk for lead-based poisoning is conceivable and I want to work with you so that we make that day happen sooner rather than later.

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**PREPARED STATEMENT OF DAVID E. JACOBS, Ph.D.**

DIRECTOR, OFFICE OF HEALTHY HOMES AND LEAD HAZARD CONTROL  
U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

JUNE 5, 2002

Thank you for the opportunity to discuss HUD's activities in the area of childhood lead poisoning prevention. The evidence shows that while the Nation has made much progress, much remains to be done to meet the goal of eliminating the disease by 2010.

I am the Director of the HUD Office of Healthy Homes and Lead Hazard Control. Before joining HUD 6 years ago, I was Deputy Director of the National Center for Lead-Safe Housing and a scientist on the faculty at the Georgia Institute of Technology, where I conducted research on residential lead hazard detection and control. I am also a board-certified industrial hygienist.

HUD Secretary Mel Martinez has made childhood lead poisoning prevention one of the priorities of his administration. As a result of this commitment, we have trained over 28,000 housing rehab and maintenance workers and others in the past year alone in lead-safe work practices. We have increased HUD's lead hazard control budget by 10 percent for fiscal year 2002 and the President's budget proposal for fiscal year 2003 increases it further still, from \$110 million to \$126 million. The Secretary has also increased our Office's staffing to improve our grant delivery, enforcement, public education, and research efforts.

The most current nationwide estimates from the Centers for Disease Control and Prevention (CDC) show that 890,000 children had blood-lead levels above the CDC level of concern during the time of the survey (1991-1994). That study also showed that 21 percent of African-American children living in older housing where lead-based paint is most prevalent were poisoned, compared to 4.4 percent for the general population. In December of 2000, the CDC provided more recent data showing that while some counties had prevalence rates as high as 27 percent, the average blood-lead level in young children declined by 25 percent from 1996-1999 to 1.9 micrograms per deciliter, suggesting our efforts to make U.S. housing lead-safe are successful.

The reason for this success is that the Nation took action. Lead exposures from food canning, gasoline, and new paint were eliminated. Lead in air emissions, occupational exposures and water all were controlled and older housing with lead-paint is continually being rehabilitated, abated, or demolished. Studies of the numerous, but often subtle, harmful effects of lead were completed and a consensus emerged. All of these actions have caused average blood-lead levels to decline by over 80 percent since the 1980's, an achievement that ranks as one the Nation's most successful public health stories.

Nevertheless, the evidence is clear that the major high dose source for most children today is existing lead-based paint in older housing and the contaminated dust and soil it generates. More must be done to prevent hundreds of thousands of additional children from being poisoned in the decades to come. HUD's new survey of lead-based paint in housing shows that the estimated number of homes with lead-paint declined from 64 million in 1990 to 38 million in 2000. Of the 38 million units with lead-paint, 25 million have lead hazards. Of those 25 million, 5.6 million house children under the age of 6, 1.6 million of those units house low-income families with children under 6, the population most at-risk of elevated blood-lead levels. Forty-one percent of low-income housing has lead-paint hazards, compared to 18 percent of middle- and upper-income housing. HUD expects to repeat the survey of housing with lead hazards in 2004, which will help better determine long-term trends of lead hazard reduction.

Importantly, Government-supported housing, which is almost all low-income housing, has a prevalence rate of 17 percent, about the same as the middle- and upper-income housing. Therefore, from a lead-safety perspective, Government-supported housing is also the safest housing, the strongest indication yet that the Federal standards are effective. The data also show that the problem is most severe in privately-owned low-income housing that is or will be occupied by families with young children. These are precisely the houses that are targeted by HUD's Lead Hazard Control Grant Program.

HUD has worked closely with other Federal agencies to protect children from lead poisoning. We must work more closely with other agencies to match families with young children and houses that have been made lead-safe through our various programs. We should find ways to get this information to families who need it most, such as Medicaid-eligible families. One option could be to make more information about HUD lead hazard control programs available to State Medicaid agencies through Centers for Medicare & Medicaid Services (CMS), CDC, and other components of the Department of Health and Human Services (HHS). When CDC conducted its High Intensity Targeted Screening effort in Chicago recently, HUD was there to provide resources needed to eliminate lead-based paint hazards for children who had not been previously identified as being at risk.

After a transition period, HUD's new lead-based paint regulation for Federally-assisted housing is now in effect across the country. Federally-assisted housing now includes modern, more effective, and scientifically proven hazard identification and control methods to ensure that it is safe for children. This regulation brings lead hazard control procedures into routine housing finance, maintenance, and rehab systems and therefore represents a change from the way the Nation approached the problem in the past, which was largely reactive and inadequate. In short, we take action *before* a child is poisoned, instead of only acting after the damage has been done. HUD's procedures for Federally-assisted housing provide a template for promoting lead safety in other housing with lead-paint hazards. Furthermore, the capacity we have built to implement lead-safe work practices among painters, remodelers, renovators and maintenance personnel can be used more broadly, because many contractors often work in both assisted and nonassisted housing.

In addition to all this, we have:

- Developed a 10-year strategy to eliminate childhood lead-paint poisoning, which was published by the President's Task Force (this marked the first time that Federal agencies developed a coordinated approach and documented the resources needed).
- Linked lead safety to other children's health hazards that may be caused by underlying housing conditions through HUD's Healthy Homes Initiative.
- Created an effective lead hazard control grant program to eliminate lead-based paint hazards in privately-owned low-income dwellings where hazards are greatest. Today, HUD's program is active in over 200 jurisdictions across the country.
- Together with State and local law enforcement, health and housing departments, the Department of Justice and EPA, enforced the lead-based paint disclosure regulation (so far, we have brought cases that have resulted in compliance and lead-paint abatement in over 158,000 high-risk dwelling units, as well as two criminal convictions against landlords who failed to comply).
- Conducted the Nation's largest study of modern lead hazard control techniques to determine the effectiveness of the HUD grant program (the results show that children who live in units where hazards have been eliminated have a 25 percent lower blood-lead level and their homes have a sustained 50–88 percent decline in dust-lead levels).
- Conducted research to reduce the cost and increase the effectiveness of hazard identification and control technologies.

- Completed the inspection and risk assessment of tens of thousands of units receiving HUD Section 8 project-based subsidies.
- Paid for clearance testing in public housing and in HUD-funded rehab programs covered by HUD's lead-safe housing rule.
- Performed public education and outreach services through private sector organizations such as Sears.
- Has been recognized by the Office of Management and Budget as an "effective" program.
- Published technical guidelines, in the form of a 500 page compendium of best practices that is regarded by practitioners in the field as state of the art and widely referenced in Federal, State, and local regulations.

Another opportunity for collaboration is between HUD and the Environmental Protection Agency (EPA). HUD and EPA have worked together to target our regulations so that abatement contractors are used for the most dangerous jobs, not routine housing rehab, and so that housing rehab workers get the training they need to do their jobs safely. For example, EPA developed a curriculum for lead-safe renovation work practices, which HUD adopted for use in assisted housing programs.

HUD and HHS already collaborate on the National Health and Nutrition Examination Survey (NHANES), where HHS pays for analysis of children's blood-lead samples and HUD pays for analysis of dust-lead samples in children's homes. It is possible that this partnership could be expanded to permit NHANES to characterize the extent of lead hazards in the Nation's housing.

HUD has also coordinated with the Department of Energy's weatherization programs. Weatherization measures are intended to make homes more energy efficient and may include window replacement, door repair, and restoration of deteriorated walls. Unfortunately, such measures may also involve disturbing lead-based paint. If contaminated dust and paint chips are not properly controlled and cleaned up, weatherization may inadvertently increase children's exposures. When weatherization is performed as suggested in such weatherization programs, it can eliminate lead-based paint hazards—a win-win opportunity. Many HUD grantees leverage lead hazard control and rehab funding with DOE weatherization funding. For example, replacement of windows is both a key weatherization practice and an effective lead hazard control method. While Title X of the 1992 Housing and Community Development Act does not cover DOE weatherization programs, we believe weatherization work practices must be consistent with lead-safe work practices to ensure children are protected in homes undergoing weatherization.

I would like to close by discussing the Secretary's new effort to increase the involvement of the private sector in lead poisoning prevention. HUD will soon release a Notice of Funding Availability for Operation LEAP (Lead Elimination Action Program). Grants will be awarded to entities that can demonstrate they can leverage additional funding and resources for local lead hazard control programs. Congress appropriated \$6.5 million for this new effort for fiscal year 2002. We are hopeful the private sector will respond to this opportunity to help solve this problem.

Finally, let me recognize Senator Jack Reed for his resolve and commitment to this important issue.

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**PREPARED STATEMENT OF THOMAS L. SANSONETTI**

ASSISTANT ATTORNEY GENERAL  
 ENVIRONMENT AND NATURAL RESOURCES DIVISION  
 U.S. DEPARTMENT OF JUSTICE

JUNE 5, 2002

Chairman Sarbanes, Senator Reed, and Members of the Subcommittee, I am pleased to be here today, along with my colleagues on this panel. I would particularly like to thank Senator Reed for his invitation to discuss what the Environment and Natural Resources Division of the Department of Justice is doing to make housing in America lead-safe. This hearing provides a wonderful opportunity to educate the public about the Federal Government's efforts to protect America's most important resource, its children, from the evil of lead-based paint poisoning.

In my testimony today, I will focus primarily on the U.S. Department of Justice's enforcement efforts in connection with the Residential Lead-Based Paint Hazard Reduction Act. I will give some background on the genesis of the Act and the enforcement initiative developed by our colleagues and clients at the Department of Housing and Urban Development (HUD) and the U.S. Environmental Protection Agency (EPA), talk about our role in that initiative, and briefly discuss a few success stories from the last year in both the civil and the criminal enforcement context. I will also touch upon the work of my Division in reaching out to the U.S. Attorneys Offices and State and local enforcement agencies to help them to be more effective in their lead-paint enforcement efforts. I would also be happy to answer any questions that the Subcommittee may have about our efforts in this important area.

**The Federal Residential Lead-Based Paint Hazard Reduction Act of 1992**

Lead poisoning is a significant health risk for young children—it can impair a child's central nervous system, kidneys, and bone marrow and, at high levels, can cause coma, convulsions, and death. Of course, ingesting lead is not good for anyone, but children under 6 years of age are at the greatest risk of lead poisoning. This is true for two reasons. First, humans are very vulnerable to the effects of lead during these formative years, when lead in the bloodstream interferes with and retards normal development. Second, as any parent knows, small children will put almost anything in their mouths, including paint chips, dust and soil containing lead, regardless of how many times you tell them not to do it. In fact, lead-contaminated dust generated from deteriorated lead-based paint in housing is the single largest source of lead poisoning. Lead poisoning is especially acute among low-income and minority children living in older housing.

This public health problem was the genesis of the Federal Residential Lead-Based Paint Hazard Reduction Act, 42 U.S.C. § 4852d, which requires the sellers, owners, and managers of residential buildings built before 1978 (the year that lead was banned from residential paint) to warn prospective buyers and tenants about the likely (and known, if any) presence of lead-based paint and lead in dust or soil on the property. It also requires landlords to give tenants an EPA pamphlet about how to minimize the dangers to children, and directs them to document their compliance with the law by keeping tenants' signatures on file, using a standard disclosure form. Regulations implementing the statute are located at 24 C.F.R. part 35 and 40 C.F.R. § 745.100 et seq.

With regard to civil enforcement actions, the Act authorizes EPA and HUD to assess an administrative civil penalty in the maximum amount of \$10,000 for each violation. (For violations occurring after January 31, 1997, this amount has been adjusted to \$11,000 per violation under the Civil Monetary Penalty Inflation Adjustment Rule.) Although the Act provides no authority for judicial civil penalties, it does authorize injunctive relief for violations of the Act.

With regard to criminal enforcement, the Act states that failure to comply with the notification requirements is a prohibited act under the Toxic Substance Control Act (TSCA) Section 309 (15 U.S.C. § 2689). The criminal enforcement provision of TSCA, in turn, provides for a criminal fine up to \$25,000 for each day of violation and/or a term of imprisonment up to 1 year. 15 U.S.C. § 2615(b). As modified under the Alternative Fines Act, the maximum criminal fine for this Class A Misdemeanor is \$100,000 for an individual, 18 U.S.C. § 3571(b)(5) and \$200,000 for an organization, 18 U.S.C. § 3571(c)(5), per count, or the greater of twice the gross gain or loss. 18 U.S.C. § 3571(d).

#### **Lead-Based Paint Enforcement Initiative**

Strong and fair enforcement of the law is necessary to ensure that legal goals become practical realities. It is also important that law-abiding businesses have a level economic playing field on which to compete, and that those who fail to comply with the law know they will be penalized. In the case of the Lead Hazard Reduction Act, the Department of Housing and Urban Development embarked on a civil enforcement initiative to ensure compliance with the Act's requirements after its effective date in 1996. HUD focused its enforcement actions on four major cities—Los Angeles, Chicago, New York, and the District of Columbia—and proceeded by targeting large management companies responsible for buildings which were covered by the Act and had multiple incidents of lead-poisoned children. Among other investigative methods, it contacted local health departments and asked them to provide the Department with a list of addresses of properties where children had been poisoned. It then zeroed in on sites where multiple lead-poisoned children appear in a single building or a single owner or management company is associated with multiple poisoned children in several buildings. EPA also has a lead coordinator in each of its 10 regions responsible for Lead Hazard Reduction Act enforcement.

This simple but effective strategy helped the agencies quickly identify those companies and individuals who were responsible for some of the biggest lead-paint related problems. The agencies could then focus their investigative resources on cases that would give the biggest bang for the buck, both in terms of the number of housing units at issue and in terms of getting the word out about the need to comply with the law. Based on this footwork, HUD and EPA began filing a series of administrative enforcement actions against violators of the Act.

Before I go on to talk about our role in this initiative, I would like to credit my colleagues and the hard-working people at HUD and EPA that have made this initiative such a success. They have done a remarkable job in developing investigative strategies and putting in the many hours it takes to turn a good plan into great results. One of the things Senator Reed asked me to address was how DOJ can interact more efficiently with other agencies to eliminate lead-based paint poisoning in children, and I am happy to tell you that we are already working very well with them to achieve this important goal. Thanks to their efforts, and also the efforts of the good people in the U.S. Attorneys Offices, the Federal Bureau of Investigation, and the State and local agencies responsible for this issue, I have some major success stories to tell you on the judicial front.

#### **The Department of Justice's Role in the Initiative**

##### *Civil Judicial Enforcement*

And the judicial front is where we at DOJ come in. One way of thinking of our role in this initiative is that we provide a backstop and a big stick to the agencies. For example, when HUD has confronted a violator, but the violator is choosing to be obstinate and unwilling to do what needs to be done to make amends for the

violations, HUD has the option of telling that person that it will refer the case to us and he can then answer to a Federal judge instead.

Also, some cases call out for more than just administrative enforcement for a variety of reasons, for example magnitude and seriousness of violations, the type of relief that the agencies want to obtain from the violators, or the need to get the word out to a broader audience about the problem and the need to comply with the law. In these cases, the agencies come to us and ask us to pursue actions in court.

We have pursued several cases judicially, beginning with the first ones that the Division and HUD filed here in the District in 1999. These first actions filed in the U.S. District Court for the District of Columbia included four settlements totaling more than \$1 million worth of lead-paint abatement in close to 4,000 dwelling units, and \$259,000 in fines and other commitments.

Our most recent success came last October, when the DOJ, HUD, and EPA announced settlements in cases against three landlords in Chicago for failure to warn their tenants that their homes may contain lead-based paint hazards. The three companies in question controlled nearly 10,000 apartments in Chicago and Cincinnati, and they agreed to test for and cleanup any lead-based paint found in their properties, and have also paid \$90,000 in penalties. One of the companies also agreed to pay \$100,000 to Chicago's Health Department as part of a child health improvement project, and the other two agreed to give \$77,000 to a community-based health center to provide free blood-lead testing for children living in Chicago and South Chicago. These settlements will not only get these companies back into compliance with the law, but will also provide benefits to the community that would not otherwise have been available.

At the same time, HUD also announced settlements in four administrative cases against landlords in New York City and Los Angeles that own and manage approximately 6,500 units. The landlords in the administrative cases agreed to pay \$61,000 in penalties and to test for lead-based paint in their properties and cleanup any lead-based paint that is found.

Taken together, these and the many other judicial and administrative actions that we have brought demonstrate that this enforcement strategy is working—we are getting thousands of units cleaned up and the word is getting out to management companies and landlords across the country that we are serious about making sure they comply with the disclosure requirements. And we have more civil cases in the pipeline across the country, from California to Senator Jack Reed's home State of Rhode Island.

Another group that I want to be sure to credit is the U.S. Attorneys Offices. To leverage our resources and enhance our effectiveness, the Division has forged partnerships with U.S. Attorneys' Offices around the Nation and provided them with materials and training so they can be more effective in bringing their own lead-paint cases. They now carry out much of the enforcement of the lead rules, which encompasses working with HUD and EPA to investigate violations, conducting file inspections to determine compliance with the law, and leading the negotiations with violators. In addition to the training and materials we provide them, the Division's role in cases where the USAO is providing the lead is to assist in drafting the settlement document, developing the scope of injunctive relief, and determining an appropriate penalty. In doing so, we help to maintain a consistent and fair remedial approach to lead disclosure cases nationwide.

We also work with State Attorneys General and other State and the local officials across the Nation to increase cooperation among local, State, and Federal lead poisoning enforcement agencies. The State and local people are essential players in this enforcement effort—in fact, our cases often get started when we receive reports of elevated blood levels of lead from a local health department. Working with the States also gives us the advantage of being able to use State and local laws, such as Maryland's, which may be more protective than Federal law.

#### *Criminal Prosecutions*

The U.S. Attorneys Offices and the State and local enforcement agencies deserve credit in the criminal as well as the civil enforcement context. There have been some especially egregious cases which have warranted criminal prosecutions. The U.S. Attorneys Offices in Maryland and New Hampshire, working with the Justice Department's Environmental Crimes Section, have brought the first two criminal cases. Their good work has been aided by special agents with HUD's Office of the Inspector General, the EPA—Criminal Investigations Division, and the FBI, and by others at HUD and EPA. In fact, the Division will be presenting them with certificates of commendation later this month.

Consider, for example, the case of David D. Nuyen, a Washington-area landlord, who owned and managed 15 low-income rental properties in the District of Colum-



bia and Maryland. HUD's Office of General Counsel contacted Nuyen in September 1998 as part of the civil enforcement initiative because his name appeared on a list of landlords with the most housing code violations and a list of landlords with multiple cases of lead-poisoned children. When first contacted, Nuyen did not have any of the required lead-paint disclosure forms, but 2 months later, he presented the Agency with lead-paint forms.

The problem with the forms that he presented to HUD was that they were falsified, forged, and backdated. They made it appear that Nuyen had given tenants the required hazard warnings when in fact he hadn't, even in those instances where he had previously received notices of violation from the District of Columbia that an apartment was found to have dangerous levels of lead. Moreover, Nuyen was familiar with the requirements of the law because he had attended classes on the Lead-Based Paint Hazard Reduction Act in 1997 and 1998 as part of his continuing education requirement for being a licensed real estate broker.

Nuyen's criminal conduct did not stop with the submission of false records to HUD. For example, during the course of the criminal investigation, Nuyen lied at a meeting with civil enforcement officials from HUD and the Department of Justice, he lied to Federal agents, he made his tenants sign affidavits under the penalties of perjury falsely saying that they had received the lead-paint disclosure forms, and he provided false testimony to a Federal Grand Jury on two separate occasions.

Nuyen's outrageous behavior made his case an appropriate one for the first criminal prosecution involving the Lead Hazard Reduction Act. His conviction last July in Greenbelt, Maryland, for obstruction of justice, false statements, and the Lead Hazard Reduction Act, earned him a 2-year prison sentence and a \$50,000 criminal fine. Under the terms of a plea agreement, Nuyen's sentence also required him to provide all tenants with new notices about lead-paint assessments performed by an independent contractor approved by the Government.

Another criminal case, *United States v. James T. Aneckstein and JTA Real Estate Brokerage and Property Management, Inc.* (D-NH), culminated in March in New Hampshire. This prosecution began with the tragic death 2 years ago of Sunday Abek, a 2-year-old girl who died of lead poisoning while residing in a rental apartment managed by Aneckstein, the owner of JTA Real Estate Brokerage and Property Management, Inc. ("JTA"). Shortly after the City of Manchester Health Department and New Hampshire Department of Health and Human Services announced that Sunday's fatal lead poisoning was most likely caused by exposure to lead-paint in the apartment in Manchester, New Hampshire, EPA officials visited JTA's office to determine whether Aneckstein and JTA had complied with the Lead Hazard Reduction Act. Aneckstein presented EPA with forged, backdated, and otherwise falsified lead-paint disclosure forms that falsely certified that Sunday's mother and other tenants in her building had been given the required lead-paint warnings. Aneckstein forged the tenants' signatures by reproducing the tenant's real signatures from their leases and transposing them onto the lead forms in an attempt to conceal his violations of the lead hazard disclosure requirements. Aneckstein signed an affidavit falsely swearing that all of the documents he provided to EPA were true and accurate. When the same information was sought by a Federal grand jury, Aneckstein and JTA again submitted false, forged, and backdated documents.

In March of this year, Aneckstein was sentenced in Federal district court in Concord, New Hampshire, to 15 months incarceration and a \$40,000 criminal fine. Again, prosecutors required Aneckstein and his company, as part of a plea agreement, to perform a lead assessment, properly notify tenants, and take other remedial measures.

The conduct of Nuyen and Aneckstein was particularly serious because it involved deliberate attempts to disobey the law. Both engaged in numerous, well-planned, and repetitive violations. Both engaged in affirmative acts to obstruct regulators and grand juries in an effort to cover-up their underlying failure to provide the lead hazard warnings required by the Lead Hazard Reduction Act. Both substantially undermined the investigative and prosecutorial process. My message to the James T. Anecksteins and the David D. Nuyens of the world is that landlords and property managers have an obligation to inform tenants of lead-paint. Deliberately failing to notify tenants of lead hazards, especially in those instances where actual hazards are known, and lying to agencies entrusted with protecting public health and safety, are serious crimes. The Department of Justice is committed to working with our partners at HUD and EPA to fully investigate and prosecute such violations.

### **Conclusion**

Childhood lead poisoning is a completely preventable threat to children. I believe that most of the real estate and housing community are law-abiding citizens who want to do the right thing, and the civil and criminal enforcement actions taken to

date have helped to educate them so that we can have better compliance with the law and lead-safe housing for our children. We are proud to be working with our partners at HUD, EPA, and State and local enforcement agencies on this effort, and look forward to bringing more successful actions to protect America's kids, especially those disadvantaged ones who are at greatest risk. With your continued support, we believe that we can move a long way toward eliminating lead poisoning.

I look forward to working with the Subcommittee on this important issue and will be happy to answer any questions that you may have.

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**PREPARED STATEMENT OF ADAM SHARP**

ASSOCIATE ASSISTANT ADMINISTRATOR  
OFFICE OF PREVENTION, PESTICIDES, AND TOXIC SUBSTANCES  
U.S. ENVIRONMENTAL PROTECTION AGENCY

JUNE 5, 2002

**Introduction**

Good afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for the invitation to appear before you today. It is my privilege to represent the U.S. Environmental Protection Agency (EPA) and to discuss the Agency's efforts to prevent lead-based paint poisoning of our Nation's children.

**Background**

In the almost 10 years since the Residential Lead-Based Paint Hazard Reduction Act of 1992 (Title X) was enacted, the U.S. Environmental Protection Agency, together with the U.S. Departments of Housing and Urban Development (HUD), Health and Human Services (HHS), and Justice, as well as our State partners, has made significant progress in eliminating childhood lead poisoning. In fact, inter-agency coordination within the Federal Government had started even earlier, dating to the 1980's, and now continues with a Presidential task force to ensure effective collaboration. How much progress have we made? In 1978, there were nearly three to four million children with elevated blood-lead levels in the United States. In the 1990's, that number had dropped to 890,000 kids, and it continues to decline. While we still have a significant challenge, particularly with minority children and children living in low-income housing, EPA is very proud of how the Federal agencies and our State and private sector partners have coordinated their efforts with the public to better protect our children.

The Federal Government has phased out lead in gasoline, reduced lead in drinking water, reduced lead in industrial air pollution, and banned or limited lead used in consumer products, including toys, mini-blinds, food cans, glazed china and ceramic wear, crystal, and residential paint. States and municipalities have set up programs to identify and treat lead-poisoned children and to rehabilitate deteriorated housing. Parents, too, have greatly helped to reduce lead exposures to their children by cleaning and maintaining homes, having their children's blood-lead levels checked, and promoting proper nutrition.

**Current Activities**

Many of the remaining cases of elevated blood-lead levels in children are caused by leaded paint and related sources in older housing. EPA has an active, multi-pronged program to combat this problem. EPA's primary goal is to prevent children from being poisoned and avoiding the consequences associated with it. The program includes creating a national regulatory infrastructure, developing outreach and education programs aimed at those most at risk, and educating those who can help address the problem. The program also conducts technical studies to determine the overall risk of exposure and how our children can be better protected.

*Regulations*

- On March 6, 1996, EPA, together with HUD, promulgated the Residential Lead-based Paint Real Estate Disclosure Rule (Toxic Substance Control Act (TSCA) § 1018). This rule mandates lead-based paint disclosure requirements for all sales and rentals of pre-1978 housing, thus ensuring that homebuyers and renters are made aware of lead-based paint hazards before deciding on a dwelling, and, in the case of homebuyers, guarantees the right to a lead inspection before purchase.
- On August 28, 1996, EPA promulgated a rule covering Training and Certification for Lead-Based Paint Professionals in Target Housing and Child-Occupied Facilities (TSCA § 402(a)). This rule ensures that a well-trained cadre of lead inspec-

tors, risk assessors, and abatement personnel is available. In addition, this rule allows EPA to authorize individual States, Tribes, and Territories to develop and administer training and certification programs, thus extending the reach of these efforts. At present, 36 States, Puerto Rico, two Tribes, and the District of Columbia, assisted by Federal grants, are authorized to carry out this program, with EPA retaining direct authority in the remaining areas.

- On June 1, 1998, EPA promulgated the Pre-Renovation Education Rule (TSCA §406(b)). This rule implements a very simple concept: All owners/tenants of pre-1978 housing (about 15 million housing units) should be given basic information about lead poisoning prevention before paint-disturbing renovations are started. EPA is continuing to work closely with advocacy groups and the regulated community to ensure that this rule is effective and not overly burdensome.
- On January 5, 2001, EPA promulgated a rule on the Identification of Hazardous Levels of Lead in Dust and Soil (TSCA §403). This rule defines certain locations and conditions of lead-based paint, and specific levels of lead in dust and soil that are most likely to pose a health threat to children. These standards effect disclosure provisions, the need to use trained, certified lead workers, and control and abatement requirements for Federally-owned and Federally-assisted housing.

#### *Outreach and Education*

EPA conducts extensive outreach with potentially affected parties in the development of regulations, to assist regulated parties in complying with regulations, to inform citizens of their rights under these rules and to inform the public about the nature of lead-based paint hazards and provide guidance on how to reduce risks. Our partners at HUD and HHS' Centers for Disease Control and Prevention (CDC) partially fund these activities and provide technical support. This outreach includes:

- A bilingual National Lead Information Center (1-800-424-LEAD). The Center operates a national hotline handling over 60,000 contacts per year, distributes 1.6 million documents annually and operates a national clearinghouse where best practices are shared.
- Development of materials, such as brochures and sample real estate disclosure forms, needed to comply with regulatory requirements.
- Creation and distribution of educational materials and national lead awareness campaigns for parents, homeowners and renters, medical professionals, renovation contractors and "do-it-yourselfers," and others. This includes the award-winning, bilingual "Get the Lead Out" campaign to increase the awareness of lead-paint hazards.
- Partnership programs with nonprofit groups and other Government agencies to conduct lead awareness/education activities, particularly targeted to minority and urban populations often most at risk.
- Cooperative programs with retail stores to distribute EPA materials where painting or renovation supplies are sold.

#### *Technical Studies*

EPA has conducted numerous studies to define the levels of exposure that should be regarded as hazardous to children and identify work practices that successfully reduce lead-based paint risks. EPA's goal is to better understand lead exposures, ensure that testing is done appropriately and reduce the cost associated with eliminating exposure. EPA's technical program includes:

- Technical studies, including risk assessments to support regulatory decisions.
- Reports on lead testing and methodologies.
- Management of a national lead laboratory accreditation program.

Even though we have accomplished a great deal, there is still more to be done. The EPA is looking for better technologies to make lead hazard control work more affordable. For example, the Agency is working with HUD on spot test kits for lead detection. As EPA Administrator Christine Todd Whitman has stated, the Agency must base its decisions on sound science. To that end, EPA is now engaged with HUD in peer review of the new spot test kit work. We are also working with the National Association of Realtors, the National Multihousing Council, and others to reassess and streamline our prerenovation education requirements.

#### **New Regulatory Activities**

EPA anticipates completing the regulatory program mandated by Title X over the next few years. Our renovation and remodeling activities, which include new rule-making, will address how to safely remove lead-based paint and debris during remodeling activities. The Agency has completed the Small Business Advocacy Review panel process and plans additional consultation with States and the business com-

munity this Autumn. We anticipate that a proposed rule will be ready for publication in 2003.

In the meantime, EPA has developed a model training course for renovation contractors, which is intended to provide them with recommended methods to minimize lead hazards. The Agency is also developing an outreach campaign to expand acceptance and use of the model course. The goal is to promote lead-safe work practices among all home remodelers, both professionals and “do-it-yourselfers,” and to ensure proper training.

EPA anticipates publishing a proposed rule addressing lead-based paint activities on bridges and structures in 2004. We are looking closely at guidance for containing paint debris developed by the Society for Protective Coatings (formerly the Steel Structures Painting Council—SSPC), an association for users and suppliers of industrial protective coatings and related products and services. SSPC’s guidance is increasingly being relied on by public and private entities engaged in deleading activities, and is referenced in State regulations governing these activities.

In addition, because of the impact the regulation could have on small communities, EPA is conducting outreach in several States through the Small Communities Outreach Project for Environmental Issues, under a cooperative agreement with the National Association of Schools of Public Affairs and Administration. This initiative is a community-based approach to engaging elected officials and local government staff at the early stage of regulatory development.

EPA expects to finalize regulations on management and disposal of lead-based paint debris by the end of 2002. The Agency proposed the rule in 1998 to address concerns expressed by HUD, HHS, some States, advocacy groups and the regulated community that the costs of testing, management, and disposal of lead-paint debris can be a significant obstacle to abatement financing. EPA’s Office of Solid Waste is completing a rule that allows this debris, including chips, dust, and sludge, to be disposed of in construction and demolition landfills. This will result in significantly lower waste management and disposal costs. EPA is also now working to introduce common-sense controls for on-site storage of lead-based paint debris prior to disposal.

### **Conclusion**

Thank you for the opportunity to discuss some of EPA’s contributions to prevent lead-based paint poisoning, just a part of our successful Federal collaboration on this issue. Again, I want to thank you for your support and assure you that this Administration is looking forward to working with the Subcommittee to achieve our goal to eliminate childhood lead poisoning by 2010. I would be pleased to answer your questions.

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**PREPARED STATEMENT OF RUBEN-SHAW, JR.**  
DEPUTY ADMINISTRATOR AND CHIEF OPERATING OFFICER  
CENTERS FOR MEDICARE & MEDICAID SERVICES

JUNE 5, 2002

Chairman Reed, Senator Allard, distinguished Subcommittee Members, thank you for inviting me to this hearing today to discuss the Centers for Medicare & Medicaid Services’ (CMS) efforts to address lead-based poisoning in children. Specifically, I would like to discuss CMS’ role in providing screening and treatment for at-risk children. Despite dramatic reductions in blood-lead levels over the past 20 years, lead poisoning continues to be a significant health risk for young children, particularly those from low-income families or who live in older housing. I know that you, Chairman Reed, have a keen interest in this issue, and we recognize and appreciate your efforts and the work of this Subcommittee.

Although lead poisoning is a preventable condition, it remains a health concern for America’s children. Administrator Scully and I share your concern regarding the very real dangers posed by lead poisoning, and I want to emphasize CMS’ commitment to protecting the health and well-being of America’s children. We are committed to following Secretary Thompson’s lead on prevention efforts and to working with our sister agencies at the Department of Health and Human Services, especially CDC, to eradicate this health concern. To this end, we are engaged in a number of efforts to address lead poisoning in children, which I will detail for you today.

### **CMS’ Role in Preventing Lead Poisoning**

The fight to eradicate poisoning from lead-based paint and dust is a collaborative effort, and CMS works closely with other HHS agencies, such as the Centers for Dis-

ease Control and Prevention (CDC), as well as the Environmental Protection Agency (EPA), the Department of Housing and Urban Development (HUD), the Department of Justice (DOJ), and other community-based organizations. Medicaid plays a distinct role in addressing lead poisoning by providing funding for four important services: Screening, treatment, investigation, and case management for eligible Medicaid beneficiaries.

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit specifically requires that all Medicaid-eligible children receive a screening blood-lead test at 1 and 2 years of age, as recommended by the CDC. Also, any child over age 2 up to age 6 for whom no record of a test exists must receive a screening blood-lead test. In addition to paying for the screening tests, Medicaid pays for any additional diagnostic and/or treatment services required for a child with elevated blood-lead levels. This includes any case management services necessary to ensure that the child and family are directed to the appropriate agencies and resources they may need, such as the local health department and housing agencies, medical care, and facilities. Once a child is diagnosed as having an elevated blood-lead level, Medicaid also will pay for a one-time investigation. During this investigation, a health professional visits a child's home (or primary residence) and inspects the area to determine the source of lead. We believe that Medicaid has contributed to the dramatic decline in blood-lead levels over the last two decades, however, we are continuing to make improvements in data collection and education with our State partners, as well as health care providers.

#### **CMS' Collaborative Efforts and Improvement Strategy**

As you may know, the General Accounting Office (GAO) released a report in January 1999 that detailed problems in the Federal response to children at risk for elevated blood levels. This report provided a roadmap for improvement, and following its publication, CMS entered into a number of activities to improve our services and commitment to helping at-risk children. For example, in 1999, we began efforts to improve the way we collect data on screening tests by adding a line item to the annual EPSDT report that States submit to us. This line item indicates the number of children under the age of 6 that received a screening blood-lead test. We began collecting this data in April 2000 for fiscal year 1999. However, the reporting of tests and test results always presents a challenge for the Agency. We only gather information on the tests we help to fund. Some tests provided by local health departments through health fairs and other venues are not generally billed to Medicaid. When no Medicaid claim for the test exists, accounting for these tests for the purpose of our annual EPSDT report is made more difficult. We have continued to encourage State Medicaid agencies to participate in data sharing activities so that the local health department and the Medicaid Agency are both aware if a test has been performed on a Medicaid-eligible child. Moreover, our Regional Offices work with State and local agencies to help coordinate and support grassroots efforts to educate providers on the importance of blood-lead screening, reporting, and data collection.

Also in 1999 in response to the GAO report, we sent a letter to all State Medicaid directors that detailed the findings of the report and reiterated the responsibilities of each State Medicaid program under the Federal Medicaid screening policy. This letter also encouraged States to develop model interagency agreements to share best practices information among the agencies in their State governments. That way, States can better assess the areas and children that lead may affect, and how to prevent and detect lead poisoning.

Building on these efforts, we also have entered into a Cooperative Agreement with the Alliance to End Childhood Lead Poisoning, awarding them \$250,000 to develop an educational tool to be used by regional, State, and local Medicaid offices, and other entities who work closely with health care providers and managed care plans involved in screening children. The tool is intended to improve awareness of and compliance with the CMS policies on childhood lead poisoning prevention. Our collaborative effort resulted in the development of a guide entitled, *Track, Monitor and Respond: Three Keys to Better Lead Screening for Children in Medicaid*, which was disseminated to State Medicaid Agencies and is available on the Alliance website. This guide is intended to be an educational document that States can use to reach out to their providers in order to resolve some of the difficulties in the provision of the blood-lead screening tests.

In addition to our work with the Alliance, we have awarded a contract for approximately \$750,000 to Abt Associates to develop a study titled, *Moving Toward Elimination of Lead in High-Risk Children*. The purpose of this study is twofold: To improve screening among low-income children by assessing the impact and effectiveness of current screening criteria in reaching high-risk, low-income children

(with a particular emphasis on Medicaid-eligible children); and to identify State and local innovations for the elimination of lead hazards facing low-income children. The study is ongoing and will identify and analyze current screening policies and practices for low-income children to determine the extent to which Medicaid and other high-risk children are being screened and whether programs are achieving successful results. The project will include site visits to five locations to provide an in-depth picture of the screening and prevention/remediation activities in five areas—Providence, Rhode Island; Baltimore, Maryland; Chicago, Illinois; the State of Iowa; and Oakland/Alameda County, California. We expect a final report by Fall 2002. We plan to share this report with State Medicaid agencies to assist them in developing the types of processes and practices that will result in more high-risk Medicaid-eligible children receiving the lead screening test to which they are entitled. We believe that the study will show that if local housing and health departments and State Medicaid agencies work together, a child's chances of being screened for lead poisoning and being able to live in lead-safe housing greatly improve.

Just as local and State agencies need to cooperate, Federal agencies must work together, too. We collaborate with many other Federal agencies on the President's Task Force on Environmental Health Risks and Safety Risks to Children. In February 2000, the Task Force published "Eliminating Childhood Lead Poisoning: A Federal Strategy Targeting Lead Paint Hazards." The report presents a program for eliminating childhood lead poisoning by 2010 based on coordinating the efforts of various Federal agencies, including HUD, EPA, CDC, and CMS to improve early intervention and follow-up services for at-risk children and to remove lead hazards from homes. We look forward to working with our partner agencies and departments and the States to address the full array of issues surrounding the elimination of childhood lead poisoning.

As we strive to develop a number of strategies to better protect America's at-risk children, we remain committed to our current policy addressing the very real threat posed by lead hazards. Moreover, while we work to ensure that at-risk children, particularly those who are Medicaid-eligible, receive early intervention and treatment for lead poisoning, we will continue to rely on the expertise of the CDC for policy recommendations on lead screening.

### **Conclusion**

National health surveys conducted periodically by the CDC have shown a marked decline in the prevalence of elevated blood-lead levels in children, primarily due to regulatory bans on lead in gasoline and paint. However, lead poisoning still presents a serious developmental health risk for many American children, including those from low-income families or who reside in older housing that may contain lead-based paint. Under the Secretary's leadership, Administrator Scully and I remain committed to helping eradicate this preventable health condition. Although our particular role in the fight to eliminate lead poisoning in children lies in reimbursing for secondary preventive services such as lead screening and any additional diagnostic and treatment services required by those Medicaid-eligible children with lead poisoning, we here at CMS are dedicated to working with State Medicaid Agencies, local organizations and our sister agencies and other Federal departments to develop innovative strategies to combat lead poisoning in the 21st Century. I want to thank the Subcommittee for your interest in this important health problem that affects primarily underserved children, and I would again like to thank Chairman Reed for his leadership regarding this issue. I look forward to answering your questions.

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### **PREPARED STATEMENT OF RICHARD J. JACKSON, M.D., M.P.H.**

DIRECTOR, NATIONAL CENTER FOR ENVIRONMENTAL HEALTH  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

JUNE 5, 2002

Good afternoon. I am Dr. Richard Jackson, Director of the National Center for Environmental Health (NCEH), of the Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. I would like to thank Senator Reed and the Senate Banking Subcommittee on Housing and Transportation for inviting me here today. It has been an honor for me to take part in the collaboration between CDC, CMS, HUD, EPA, and DOJ that has formed around this

effort. I am pleased to be here to discuss CDC's Childhood Lead Poisoning Prevention Program.

In 1991, the U.S. Department of Health and Human Services (DHHS) called for a society-wide effort to eliminate childhood lead poisoning in 20 years, and 11 years later, we remain committed to this goal. The elimination of this preventable disease will be one of the major public health accomplishments of this century.

It is clear that lead can do great harm, especially to young children. A child's exposure to lead can produce serious health consequences, including a variety of neurologic and behavioral disturbances, as well as delayed development. Over the past 25 years, we have been successful in reducing our children's blood-lead levels nationwide. The CDC's analysis of children's blood-lead levels as part of the National Health and Nutrition Examination Survey (NHANES II) conducted between 1976 and 1980 revealed that 88 percent of American children between the ages of 1 and 5 had elevated blood-lead levels (EBLL) ( $\geq 10\mu\text{g/dL}$ ). Further, CDC analyses were instrumental in revealing that decreasing lead in gasoline resulted in parallel declines in blood-lead levels. This information contributed to the subsequent U.S. Environmental Protection Agency (EPA) decision to remove lead from gasoline. This decision, along with the removal of lead from paint and other sources, has resulted in a dramatic decline in the amount of lead in the blood of all Americans. According to CDC's NHANES data from 1991–1994, the proportion of children age 1–5 years with elevated blood-lead levels had fallen from 88 percent to 4.4 percent.

Through this work, CDC has recognized that having good measures of the actual exposure of the American public to lead was going to be critical to achieving our goals. NHANES has allowed us to focus on identifying children who are at higher risk for lead poisoning. Children who have been found to be at higher risk include children from low-income families who live in older deteriorated housing; many are minority children. CDC data also indicate that there are currently an estimated 890,000 American children under the age of 6 who have elevated blood-lead levels.

I will now turn to describing the activities of CDC's Childhood Lead Poisoning Prevention Program. This program was authorized under Section 317A of the Public Health Service Act as amended in 1988. The program was reauthorized in 1992 as part of the Preventive Health Amendments Act, and in 1998, reauthorization was extended to 2002. The program received its first appropriation in 1990, and is currently funded at \$41 million for fiscal year 2002. With these funds, CDC provides guidance, technical support, and resources to 43 States and 17 local health departments for childhood lead poisoning prevention and surveillance efforts. These CDC supported programs include three main components which I will describe in detail, in addition to other elements. The main components are: (1) Primary Prevention; (2) Effective Screening and Surveillance; and (3) Public and Professional Health Education and Communication.

### **Primary Prevention**

CDC supports innovative approaches to identifying children at risk for lead exposure and ensuring their housing is lead-safe before they are exposed to lead. In addition, CDC supports the development, improvement, and oversight of policies and strategies to bring about primary prevention within all funded programs. For example, Maryland law mandates a paint maintenance standard-of-care for all rental units built before 1950, with third-party inspection prior to each rental turnover. Over half of the Maryland's 159,000 pre-1950 rental units have registered with the Maryland Lead Rental Registry. Over 75,000 third-party inspections to certify that pre-1950 rental units meet the lead standard-of-care have been conducted and reported to the State. Tenants can now call to check if a property has been registered and inspected before they rent. Through its cooperative agreement with Maryland, CDC provides expertise and funding to assist the State with this innovative approach.

### **Effective Screening**

CDC provides national guidance for the prevention of childhood lead poisoning, including *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials*. This document provides general guidelines about the roles and responsibilities of child health-care providers in preventing childhood lead poisoning, screening and follow-up testing, clinical management, chelation therapy, and family education about EBLL's. For example, as recommended by CDC guidance, North Carolina has a statewide screening plan that targets 1- and 2-year-olds and other high-risk populations, especially Medicaid and Women, Infants, and Children (WIC) program recipients. Since the targeted screening plan was adopted in October 1998, the annual screening rate among all 1- and 2-year-olds in the State has increased from 25 percent (53,390 tested in 1998) to 35 percent (81,988 tested

in 2001). Essential to this effort have been promotional efforts by the State Medicaid Agency and a statewide WIC screening initiative targeting children who have never been tested.

However, a U.S. General Accounting Office (GAO) report from February 1998 entitled, "Medicaid: Elevated Blood Lead Levels in Children," suggests that many States are not screening children at risk for lead exposure. CDC recognizes this challenge, and the new screening guidance addresses the issue of reaching children enrolled in Medicaid and other health care programs.

One way CDC is addressing this issue is by providing technical assistance to funded States for developing and enhancing the States' Childhood Blood Lead Surveillance (CBLs) system. The inclusion of State data in CDC's CBLs database provides a national picture of childhood blood-lead levels. Establishing childhood lead surveillance systems at the State levels allows the use of surveillance data to estimate the extent of EBLL's among children, assess the follow-up of these children, and help allocate resources for lead poisoning prevention activities within each specific State. Minnesota's Department of Health (MDH), for example, maintains an extensive blood-lead surveillance system for monitoring trends in blood-lead testing and BLL's in children. MDH matches lead surveillance data with Medicaid data to analyze screening trends and determine the percentage of Medicaid children screened with EBLL's. Through this analysis, MDH has been able to determine that in Minnesota 72 percent of children with EBLL's were enrolled in Medicaid. In addition, Medicaid-enrolled kids had nearly twice the rate of EBLL's than kids not enrolled in Medicaid (9.8 percent vs. 5.0 percent).

CDC provides screening and case management guidelines to all CDC funded programs. Working in conjunction with CDC, all funded programs develop, implement, and evaluate their activities to assure that children receive the best care possible. For example, Rhode Island uses the KIDSNET system, an automated tracking and follow-up tool, that links pediatric public health programs to each other and to health care providers. KIDSNET provides contextual information about the number of children who should be screened to determine screening rates and provides data which enables the State to evaluate the quality of screening and follow-up at the provider level.

#### **Public and Professional Health Education and Health Communication**

CDC conveys the negative health effects of elevated blood-lead levels to a child and the importance of screening through public outreach and professional education. CDC supports and provides oversight to funded programs to target audiences such as parents, doctors, nurses, public health professionals, and rental property owners. Information is dispersed through TV and radio announcements, educational pamphlets, training courses, and policy briefings. Salt Lake Valley (UT) Health Department's Lead Free Kids program has identified realtors and landlords as a target audience. The goals of the project include providing unaware landlords and realtors with information on disclosure regulation requirements and raising tenant awareness of lead-based paint hazards. Some of the outreach components include direct mailing of a lead disclosure brochure to area realtors, pre-1978 multifamily property owners and members of the Utah Apartment Association (UAA), and submitting articles in the realtor and apartment owners' trade journals.

CDC's activities in these areas have evolved over time, and one of the lessons that we have learned is that in order to meet our goal, we must pay attention to changes in our environment and adopt new approaches. In 2001, CDC developed the High-Intensity Targeted Screening (HITS) approach for improving the Nation's ability to target and screen children for lead poisoning and prevent exposure to lead. The goals of HITS are to identify children missed by routine screening; improve surveillance and estimate the burden of lead poisoning in a specific locale; evaluate current screening plans; develop partnerships; and increase local capacity. HITS teams, which are made up of the staffers from local childhood lead poisoning prevention programs and community members, assisted by CDC, visit homes in high-risk communities to screen children for lead. When children are found to have EBLL's, the families are offered appropriate medical treatment and a home lead evaluation. Local programs will use HITS data to improve lead screening plans, better direct resources, increase technical capacity, and monitor progress toward lead poisoning elimination. The HITS approach requires partnerships to be developed between community members and multiple Federal, State, and local agencies resulting in a more comprehensive approach to eliminating childhood lead poisoning at the local level.

In November 2001, the first HITS project in two inner-city communities in Chicago was completed. Preliminary analyses indicate that 67 percent of the children had never been previously tested, and approximately 30 percent of the children who



were tested had EBLL's. Data analysis is ongoing. CDC plans to implement HITS in additional communities over the next several years in order to improve the Nation's ability to target and screen children for lead poisoning and prevent exposure to lead.

Just as we have emphasized the importance of collaborative activities at the State and local level to develop a successful statewide screening plan, we have redoubled our efforts to collaborate with other Federal agencies to make the goal of eliminating childhood lead poisoning a reality. Since 1990, there has been a Federal partnership to focus our efforts toward this goal, with the DHHS (particularly CMS), EPA, and U.S. Department of Housing and Urban Development (HUD) taking leadership roles.

CDC and its grantees work very closely with HUD and HUD's grantees to ensure the prevention of childhood lead poisoning. The close coordination maximizes the resources of each organization without duplicating services. Each grant program draws upon its unique expertise and service delivery networks. CDC grantees have expertise in technical issues related to screening and blood-lead testing, as well as programmatic expertise in following up on the needs of high-risk children. HUD grantees have expertise in lead-based paint and lead dust hazard identification and in the physical interventions needed to make homes lead-safe.

HUD grantees concentrate their primary prevention activities in neighborhoods where children are at risk for lead poisoning. Data from CDC and its grantees are essential for HUD grantees to appropriately target their primary prevention efforts. Furthermore, HUD grantees work closely with CDC grantees to reduce lead hazards in housing where children are identified as lead-poisoned. This serves the goal of secondary prevention, as well as the goal of preventing additional children from being lead-poisoned. CDC also funds 35 States to track the problem of adult lead exposure through the Adult Blood Lead Epidemiology and Surveillance (ABLES) program. This program helps prevent lead exposures in children whose parents are exposed to lead at work and who may inadvertently bring contaminated clothing into the home. Together, CDC and HUD can identify and intervene with both at-risk children and at-risk home environments, moving us closer to eliminating childhood lead poisoning by 2010.

In closing, I would like to emphasize that we will continue to face challenges in the elimination of childhood lead poisoning prevention, but CDC and our partners in this effort have learned many lessons over the past decade that have prepared us well. In any public effort such as this, one of the biggest challenges we face is to keep resources and attention focused on a problem over time. It is important to remember that no child in this country should be adversely impacted by environmental exposure to lead. The improvement in quality of life for the children freed from the threat of possible damage caused by exposure to lead cannot be overstated. Our children, the most important resource for the future, deserve our every effort. We have come a long way in making children lead-free, and I appreciate your interest and support in continuing to make this vision a reality.

That concludes my written statement. At this time, I would be happy to answer your questions.

**RESPONSE TO WRITTEN QUESTIONS OF SENATOR REED  
FROM DAVID E. JACOBS**

**Q.1a.** What is HUD doing to make sure its new lead-safety regulations are being followed or enforced?

**A.1a.** HUD has prepared several tools and training activities to ensure that the new HUD lead-safety regulation is being followed in each program area. HUD implemented a transition assistance period that lasted from September 15, 2000 until January 10, 2002 to enable local jurisdictions to build the necessary capacity to comply with the rule. Now that the transition period has ended, HUD is ensuring that its routine program monitoring includes an evaluation of compliance with the new regulation in its housing maintenance, rehabilitation, and other subsidy programs covered by the regulation. In addition, HUD staff in the Office of Healthy Homes and Lead Hazard Control will be combining compliance checks for both the lead-paint disclosure regulation and the new HUD lead-safety regulation in selected geographic areas where lead hazards are most prevalent. Increased staff are now on board to handle this increased workload.

**Q.1b.** Why is HUD's Single-Family Mortgage Insurance Program the only program not to be updated in HUD's new lead-paint regulations for assisted housing? Is there a significant incidence of lead exposure and contamination in these units?

**A.1b.** HUD's Single-Family Mortgage Insurance Program currently requires that properties have a visual inspection, paint repair if lead is present, post repair clean-up, and disclosure to the buyer. An analysis completed in the late 1990's estimated that the imposition of the new assisted housing lead-paint regulations would cost an estimated \$93 million annually, costs that could be passed on to the homebuyer and have the effect of diminishing new homeownership opportunities. HUD does not have data on the specific incidence of lead-paint hazards in homes served by the Single-Family Mortgage Insurance Program.

**Q.2a.** How much funding would Congress have to provide you with in order to fund all of the applications you have received?

**A.2a.** For fiscal year 2001, the Office of Healthy Homes and Lead Hazard Control received 181 applications totaling \$290 million. Each applicant was limited to requesting no more than \$3 million each. Congress appropriated \$100 million for fiscal year 2001, \$110 million for fiscal year 2002, and the President's budget request for fiscal year 2003 is \$126 million.

**Q.2b.** Have requests for such assistance increased as a result of the promulgation of new HUD lead-based paint regulations (September 15, 2000)?

**A.2b.** There does not appear to be a large increase in requests for assistance as a result of the new HUD lead-based paint regulations.

**Q.3a.** What tools are needed to encourage the practice (of leveraging lead hazard control and rehabilitation funding with the Department of Energy's weatherization funding)?

**A.3a.** A better system of identifying those lead hazard control practices that promote energy efficiency and vice versa is needed to enable an improved estimate of the benefits of such leveraging. Window replacement is perhaps the most common work activity that accomplishes both improved energy efficiency and lead hazard control simultaneously, but there are undoubtedly other opportunities as well.

**Q.3b.** What tools are needed to make weatherization work practices consistent with lead-safe work practices to ensure that our children are protected in homes undergoing weatherization?

**A.3b.** A uniform training curriculum is needed to ensure weatherization workers receive consistent messages in DOE-sponsored training courses. This could be achieved by adapting EPA's lead-safe remodeling and renovation work practices course to weatherization, in much the same way that HUD adapted this course for use in assisted housing. Clearance testing should also be made an eligible weatherization expense for those jobs that disturb lead-based paint above de minimis levels.

**Q.4.** How many (Project-Based Section 8) owners have actually used this program (of free lead-paint inspections/risk assessments)? What percentage of the total inventory do these owners make up?

**A.4.** There are approximately 11,000 properties built before 1978 in the Project-Based Section 8 inventory. To date, 3,131 properties have enrolled in the HUD program providing free lead-based paint risk assessments and lead inspections. This constitutes approximately 29 percent of the inventory. In addition, HUD is aware that some owners have contracted for their own lead-based paint inspections, either voluntarily or as a result of local lead-based paint enforcement activities. Recently, HUD sent to each owner a letter and certification form to document each property's lead-safety status. The compliance deadline for completing risk assessments for the project-based units built between 1960 and 1977 (which constitutes about 9,000 of the 11,000 properties covered by the regulation) is September 15, 2003.

**Q.5.** How many HUD cases have been referred to DOJ in the last year and a half? What is the status of those cases?

**A.5.** In the past year and a half, HUD has pursued 15 cases with the Department of Justice, four of which have been formally referred to DOJ. Ten other cases have been completed with DOJ since 1998. HUD is also currently investigating dozens of other cases administratively. These cases are in various stages of investigation and negotiation. HUD and DOJ expect to continue to announce resolution of cases of noncompliance as consent decrees or other legal actions are completed.

**Q.6.** Do you believe that visual inspection, lead-safe work practices and clearance testing offer the potential to expand lead-safety on a broad enough scale to make U.S. housing lead-safe?

**A.6.** Yes, this strategy is likely to be effective for most housing with low risk and adequate cash flow to support good maintenance practices. HUD has developed a short web-based training course for visual assessment to help meet this need. Together with EPA, we have also developed several maintenance courses to teach lead-safe

work practices. But for unassisted low-income housing where cash flow and maintenance is inadequate and where deteriorated paint is extensive, other strategies are needed. Risk assessments and/or inspections will enable a more targeted approach so that lead-based paint hazards are correctly identified and controlled at minimum cost. Most deteriorated paint, even in older housing, is not, in fact, lead-based paint and therefore does not need to be addressed in order to make a property lead-safe. A visual assessment alone cannot determine the presence of lead in paint, or dust-, or soil-lead hazards.

For example, the high-risk housing treated under HUD's Lead Hazard Control Grant Program is always given a risk assessment and/or inspection to ensure that a targeted approach is used. Properties that have consistently high rates of deferred maintenance will need to be abated; other properties can be assessed visually, with follow-up lead-safe work practices and with clearance testing completed. The degree of hazard control should reflect the degree and extent of hazard. In the worst cases, demolition may be the best option.

**Q.7.** What do you believe your Agency can do to help stop houses from poisoning more than one child?

**A.7.** HUD's new lead-safe housing regulation requires that houses with lead-poisoned children and lead-based paint hazards must be made lead-safe before the unit can qualify for continued subsidy, even if the lead-poisoned child has been relocated to another unit. In addition, HUD program recipients and local health departments are required to compare lists of subsidized housing units with lists of lead-poisoned children on a quarterly basis. If there is a match, then HUD's lead hazard control requirements apply to that unit as a condition of continued subsidy. Also, some of HUD's lead hazard control grantees, such as Milwaukee, use HUD funds to leverage substantial private-sector investment in properties where children have been poisoned if the owner agrees to act quickly to eliminate the hazards.

The State of Rhode Island, which has received substantial funding from HUD for lead hazard control, recently passed a new State law that increases an owner's responsibility in houses that have poisoned more than one child. Finally, in last year's appropriation, Congress created an earmark to the National Center for Lead-Safe Housing to develop a database of lead-based paint activities. Through that organization, HUD is working with several cities to pilot-test a database that could include information on houses that have poisoned more than one child, after resolution of issues regarding confidentiality of medical records.

**Q.8.** What does your Agency believe might be appropriate statutory changes to make the Federal disclosure law regarding lead more meaningful?

**A.8.** HUD does not currently have subpoena authority under Title X of the 1992 Housing and Community Development Act to enforce the Federal disclosure regulation. Because the disclosure regulation is a joint HUD/EPA regulation, HUD has relied on EPA's subpoena authority under the Toxic Substances Control Act. While the collaboration between the two agencies has worked well, the lack of HUD

subpoena authority creates unnecessary administrative obstacles. HUD currently has subpoena authority to investigate other statutory requirements, such as the Real Estate Settlement Procedures Act (RESPA).

Also, HUD does not have statutory authority to delegate to local jurisdictions the environmental review function for the Healthy Homes and Lead Hazard Control programs. Environmental reviews are required under the National Environmental Policy Act. Local jurisdictions are best able to make the most informed assessments. Other HUD programs, such as the Community Development Block Grant (CDBG) and Housing Opportunities for People With AIDS (HOPWA), currently have statutory authority to delegate the environmental review function to local jurisdictions.

**Q.9.** What does your Agency think about this strategy (of moving beyond screening children’s blood-lead levels to actually screening high-risk housing to identify hazards before a child’s health is harmed)? What about the idea of developing registries of hazardous properties?

**A.9.** HUD supports the strategy of screening high-risk housing, which is at the heart of HUD’s lead-safe housing regulation. Several HUD lead hazard control grantees maintain lead-safe housing registries as a way of informing the public on where lead-safe housing is located (see answer to question 7 above). HUD does not currently have the statutory authority to create a national registry of hazardous properties.

**Q.10.** Does your Agency believe that lead-based paint and dust hazards in housing are the overwhelming cause of childhood lead poisoning in the United States? If not, what other causes should the Congress be looking at?

**A.10.** Lead-based paint hazards and the contaminated dust and soil it generates are clearly the major cause of childhood lead poisoning in the United States today. The President’s Task Force Report references the available scientific evidence on this question.

**Q.11.** Does your Agency support the goal of stopping children from being poisoned in the first place? If so, how is your Agency planning to achieve this goal?

**A.11.** Yes, HUD supports the goal of stopping children from being poisoned in the first place. We are planning to achieve that goal by creating lead-safe housing that children are either born into or in which they are expected to reside in the future. HUD’s Lead Hazard Control Grant Program, leveraged private sector funding and resources through Operation LEAP (Lead Elimination Action Program), HUD’s lead-safe housing regulation for Federally-assisted housing, enforcement of both that regulation and the lead disclosure regulation, public education, research, training, and coordination with other Federal, State, and local governments are the principal vehicles through which we expect to achieve the goal.

**RESPONSE TO WRITTEN QUESTIONS OF SENATOR CARPER  
FROM DAVID E. JACOBS**

**Q.1.** Both HUD and EPA have repeatedly endorsed a “lead-safe” standard for lead hazard remediation, rather than “lead-free.”

These findings seem definitive and are based on good science, yet the issue continues to get attention. What is HUD's position on "lead-safe" versus "lead-free?"

**A.1.** The two standards are not mutually exclusive; there are circumstances where one or the other is most sensible. Each standard is capable of eliminating excessive lead exposure and protecting children. A "lead-safe" standard means that while a property may have lead-based paint, it has no lead-based paint *hazards*; in other words, the mere presence of lead-based paint does not in itself constitute an immediate hazard. In order for the "lead-safe" standard to be effective, the lead-based paint must be monitored and managed over time to ensure that it remains in a nonhazardous condition. Also, any activities that disturb the lead-based paint, such as renovation, remodeling, repainting, or maintenance, must be performed using lead-safe work practices and clearance testing to ensure cleanup has been adequately performed. Several studies, including HUD's study of its Lead Hazard Control Grant Program, have shown that this approach is effective in reducing both dust-lead levels and blood-lead levels in resident children.

A "lead-free" standard may also be appropriate in cases where the lead-based paint will not be properly managed, where "gut" rehabilitation will eliminate all surfaces coated with old paint, or where only a few surfaces in a given housing unit are coated with lead-paint. In these circumstances, it may make more sense to simply remove lead-based paint, rather than pay for the on-going management and maintenance of surfaces coated with lead-paint. Since the lead-based paint is removed, no on-going maintenance or management is needed, because there is no potential for exposure to hazards. Furthermore, there is no additional disclosure or regulatory burden for properties that are free of lead-based paint.

Under both standards, removal of either deteriorated or intact lead-based paint above de minimis levels should be performed using lead-safe work practices, followed by specialized cleaning and clearance testing. HUD and several local jurisdictions have banned the use of certain methods of paint removal, such as open flame burning, abrasive blasting, large scale dry scraping, and other methods known to produce high levels of contaminated dust and/or fumes.

**Q.2.** As I understand it, HUD's Lead Hazard Control Grants are awarded to cities on a competitive basis. Would it be a more effective use of Federal dollars to provide grants based upon the severity of lead poisoning, say targeting the top twenty cities with the most severe and widespread lead hazards?

**A.2.** Need, as documented by lead poisoning prevalence, is already a key factor used in making awards. The result is that HUD's grants are, in fact, targeted to local jurisdictions with the greatest problem. However, awarding grants based solely on need would have the unintended consequence of providing resources to some cities that lack the will or capacity to use them well. In fact, building capacity in numerous jurisdictions has enabled the program to address lead-based paint hazards in many more units than those it finances directly. Also, data from HUD's National Survey of Lead and Allergens in Housing show that urbanization is not a key fac-

tor in the prevalence of lead-based paint hazards, so restricting awards to larger cities ignores the need in other areas. In cities with populations above 2 million, 29 percent of the houses have lead-based paint hazards; in small cities, 23 percent have hazards; and in rural areas, 31 percent have hazards. None of these differences are statistically significant. To deny assistance to children simply because they do not reside in the largest cities raises issues of fairness and equity. HUD has considered whether the maximum amount requested by a jurisdiction should be equal or should be related to some combination of the number of poisoned children within a given jurisdiction and its capacity. The latter would increase the complexity of the program. This past year, HUD has implemented a new grant renewal system that streamlines the application process for high-performing grantees, which are in areas of highest need as a further way of targeting resources. HUD will make a final decision regarding the maximum grant amount when the fiscal year 2003 Notice of Funding Availability is released.

**RESPONSE TO WRITTEN QUESTIONS OF SENATOR REED  
FROM THOMAS L. SANSONETTI**

**Q.1.** How many lead cases do you currently have pending? Could you provide data on the number of cases referred by each Agency and the date these cases were referred? How many of these cases have DOJ chosen to prosecute?

**A.1.** We have 15 lead-paint related matters pending. Of the 15 matters that are pending, 14 have been or are being jointly developed by Environmental Protection Agency (EPA) and Housing and Urban Development (HUD). The remaining matter is being developed by HUD, with anticipated participation by EPA at the appropriate time. We cannot meaningfully identify when each of these matters was referred because our initial involvement in these matters typically arose out of informal contacts with our Division over the course of time; formal referrals have then been submitted by the EPA and HUD following the informal contacts. We have not rejected any formal referrals.

**Q.2.** What statutory changes do you believe could be made to Federal disclosure law regarding lead-based paint and lead-based hazards that could make it more meaningful?

**A.2.** Although the disclosure law provides for administrative penalties, it does not provide for judicial penalties. The addition of such penalties would strengthen enforcement of the law. Also the law currently excludes zero-bedroom housing from the disclosure requirements. Our experience has been that this excludes coverage for a significant portion of housing stock (that is studio apartments) in which poor children live and which contains lead-paint. Inclusion of such units in the disclosure law would better protect such children from the risk of lead poisoning.

**Q.3.** What plans does DOJ have to begin working more closely with other agencies such as HUD and EPA to help keep children from being poisoned by lead-based paint in housing?

**A.3.** As we testified at the June 5, 2002 hearing before the Subcommittee, we have already developed close working relationships

with both HUD and the EPA and these relationships have resulted in a number of successful enforcement cases over the last 4 years. We look forward to continuing to work with them and also improving our outreach and training with the local U.S. Attorneys' Offices to protect children across the United States from lead poisoning.

**Q.4.** While abatement is essential in high-risk properties, in which cash flow is insufficient to support maintenance, most leaded properties can be made lead-safe through other strategies. Research and experience over the past decade has demonstrated the importance of visual inspection for peeling paint; lead-safe work practices to control, contain, and clean up lead dust in painting and remodeling projects; and clearance testing to ensure that lead-dust hazards are not left behind. Do you believe that visual inspection, lead-safe work practices and clearance testing offer the potential to expand lead-safety to a broad enough scale to make U.S. housing lead-safe?

**A.4.** We support the goal of preventing lead poisoning by making housing lead-safe, but respectfully defer to the expertise of our client agencies on how this can best be accomplished.

**Q.5.** While consistent data are not widely available, it is clear that in the majority of cases lead hazards are not corrected even after a child is identified as lead-poisoned. The same hazardous house often poisons multiple children as new families move in (that is, a Syracuse, New York, newspaper identified 47 houses that had poisoned multiple children in just 18 months). Even when health departments succeed in ordering repairs, in many States there is no oversight, no requirement for lead-safe work practices, and no clearance testing. While no house should poison a child, it is simply unconscionable that any house should poison a second, third, and fourth child. What do you believe your Agency can do to help stop houses from poisoning more than one child?

**A.5.** One significant way that the ENRD can help stop multiple children from being poisoned by the same property is by continuing to consider evidence of such a problem as a factor in enforcement decisions, that is in the decision of whether to pursue a matter criminally rather than (or in addition to) civilly, how much of a criminal fine or civil penalty to seek, and what other relief may be appropriate.

**Q.6.** What does your Agency believe might be appropriate statutory changes to make the Federal disclosure law regarding lead more meaningful?

**A.6.** See response to question 2.

**Q.7.** Many advocates and some health departments are convinced that ending childhood lead poisoning will require moving beyond screening children's blood-lead levels to actually screening high-risk housing to identify hazards before a child's health is harmed. What does your Agency think about this strategy? What about the idea of developing registries of hazardous properties?

**A.7.** We support the strategy of screening high-risk housing, and are already using it as an effective tool for identifying appropriate targets, for enforcement action. Depending on the information it



contained, a registry of hazardous properties might assist us in targeting our enforcement efforts to where they would have the most impact.

**Q.8.** Does your Agency believe that lead-based paint and dust hazards in housing are the overwhelming cause of childhood lead poisoning in the United States? If not, what other causes should the Congress be looking at?

**A.8.** Based on information that we have received from those agencies that have expertise in this area, we believe that lead-based paint and dust hazards are the major cause of childhood lead poisoning in the United States.

**Q.9.** As a result of our hearing last November on lead poisoning, it was clear that primary prevention is a very important part of eliminating childhood lead poisoning. First of all, does your Agency support the goal of stopping children from being poisoned in the first place? If so, how is your Agency planning to achieve this goal?

**A.9.** Yes, we support the goal of stopping children from being poisoned in the first place. Working in concert with our clients at HUD and EPA and State and local health agencies, we plan to achieve this goal by deterring violations of the lead-paint laws through continued vigorous enforcement of those laws and by seeking broad abatement that covers entire building inventories, not just an individual unit where disclosure wasn't made.

**RESPONSE TO WRITTEN QUESTION OF SENATOR CARPER  
FROM THOMAS L. SANSONETTI**

**Q.1.** I understand that a student at Brown University performed a study that showed that 204 identifiable landlords owned the housing units which more than 2,600 cases of elevated blood-lead levels were reported over the last 9 years in Rhode Island. This suggests that a small group of landlords are responsible for a disproportionate amount of the lead exposures. As you enforce lead disclosure laws, are you also coordinating with State or local departments of health so as to better target your enforcement?

**A.1.** Yes. As we testified in greater detail at the June 5, 2002 hearing before the Subcommittee, State and local departments of health have been invaluable partners in our enforcement efforts.

**RESPONSE TO WRITTEN QUESTIONS OF SENATOR REED  
FROM ADAM SHARP**

**Q.1.** Several years ago it became clear that clearance dust testing is a simple procedure that can be easily learned in one day. As a result, EPA developed a one-day training course for Sampling Technicians and HUD regs allow State certified sampling technicians to perform clearance testing after paint repair and remodeling projects. If the science makes clear the paramount dangers of lead-contaminated dust, why has EPA decided not to encourage expanded dust testing and expanding capacity for dust testing?

**A.1.** EPA does encourage expanded dust testing and increasing the number of individuals qualified to perform dust sampling. This policy was articulated to our State and Tribal colleagues in a letter

dated August 17, 2000 (Attachment). The Agency stated that sampling technicians should play a principal role in conducting dust testing following nonabatement activities where lead-based paint is disturbed. In addition, the Agency encouraged the use of sampling technicians in other settings such as presale home inspections, unit turnovers, or at the request of homeowners. The letter also emphasizes that while EPA does not currently regulate nonabatement activities that disturb lead-based paint, the Agency does recommend dust testing (by a trained risk assessor, inspector, or Sampling Technician) following these activities. The Agency also encouraged States and Tribes to do the following:

- Allow Sampling Technicians to conduct nonabatement clearance testing according to Housing and Urban Development's (HUD) requirements.
- Permit trained and/or certified sampling technicians to perform sampling to identify lead contaminated dust.
- Encourage accredited training programs to offer this course.
- Develop a plan for upcoming legislative sessions that would address the incorporation of the Sampling Technician discipline in their authorizing legislation.
- Communicate regulatory policy regarding the use of sampling technicians to their accredited trainers and certified firms.

In addition to these outreach activities, EPA will continue to emphasize the role of the sampling technician as we move forward with developing our renovation and remodeling program.

**Q.2.** Most Americans still view peeling paint in older housing as merely an eyesore and do not understand the significant danger of lead-contaminated dust. In January 2001, EPA finalized national standards for dangerous levels of lead in deteriorated lead-based paint, lead in dust, and lead in soil. What has EPA done to publicize these standards and highlight these dangers?

**A.2.** The Agency understands that to be effective, we must communicate the Agency's new lead hazard standards to the public. When the rule was released, the Agency launched its 403 Rule Communication Plan, which consisted of the following:

- Press Release distribution and announcement on EPA's website.
- Release and distribution of a 403 Rule Fact Sheet through EPA's toll-free nationwide hotline and website.
- Notification of all other Federal agencies, and State and tribal governments.
- Incorporation of the Hazard Standards in EPA's Protect Your Family disclosure brochure, the most widely distributed document (more than 500,000/yr.) in our program.
- Education to EPA's hotline staff on the Hazard Standards to better prepare them for public inquiries.

Since the Rule was published, the Agency has been incorporating the standards into all of our public education materials. The first document that we revised was "Protect Your Family From Lead," the Agency's main lead hazard pamphlet. This is the pamphlet required by law to be provided to buyers and lessors of all residential property built before 1978. The Agency also requires that the pam-

phlet be distributed before most renovations in residential property built before 1978. The EPA has incorporated the standards into our lead certification exams and will be formally updating our model training courses.

**Q.3.** Many researchers are convinced that EPA's standard for lead-contaminated dust of 40 micrograms per square foot is much too high. Has EPA analyzed any of those researchers' data yet?

**A.3.** Yes, the Agency continues to monitor the state of the science regarding environmental lead and its impact on children's health. In establishing the 40 micrograms per square foot dust standard, the Agency considered both the relationship between dust-lead and children's blood-lead levels and the health impacts associated with blood-lead levels. When we determined our standard, we considered the 10 ug/dl benchmark for elevated blood-lead levels currently defined by the Centers for Disease Control and Prevention. As far as the relationship between environmental lead and blood-lead, the Agency considered all of the studies of this relationship and continues to believe that the approach taken and the models used are the best currently available.

**Q.4a.** In 1998, HUD funded a survey conducted through the Bureau of the Census which showed poor compliance with the Residential Lead-Based Paint Real Estate Disclosure Rule, which mandates disclosure requirements for all sales and rentals of pre-1978 housing. Thirty-six percent of survey respondents were uncertain whether they had received the required information when they bought or rented housing. What have you done to ensure that both buyers and renters are receiving the appropriate information as required by the Rule?

**A.4a.** To ensure widespread knowledge of the Rule requirements, EPA, in the development of the Rule, worked closely with HUD, realtors, real estate associations, property management companies, and landlord associations to publicize requirements through newsletters, meetings, pamphlets, public service announcements, and billboards. For example, EPA has:

- Worked with industry to include information on the Disclosure Rule requirements in the real estate training that real estate brokers need to complete as part of their licences requirements.
- Undertaken mail-out campaigns to licenced real estate operators to make them aware of the Rule.
- Attended national real estate meetings to train people.
- Developed lead-paint websites to provide information on rules and EPA regulations.

**Q.4b.** What additional ideas do you have to help protect families who are renting or buying housing and ensure that owners of housing are complying with this requirement?

**A.4b.** EPA has discussed several options, including expanding efforts to work with the real estate community through a sustained partnership. For families, the process of homebuying is complex, and lead is only one of many issues a family might consider when deciding where to live. For families in poor urban areas, where lead risks are greatest, competing interests (acute safety concerns) are even more pressing. In addition, in a tight housing market, many

may feel that any apartment that they find will be good enough. That makes EPA's role in ensuring that lead issues are appropriately disclosed and considered even more challenging. We are considering multiple ways to meet this challenge, such as working with the real estate community to ensure that the information is disclosed in a way that will be most meaningful to the recipient, working with other parts of the housing industry (home inspectors, etc.) to encourage them to broadly distribute and reinforce this information, and working with organizations involved in low-income housing to address lead issues in a holistic fashion.

**Q.5.** What has been EPA's lead poisoning prevention funding over the past 5 years? Is this amount of funding sufficient for EPA to be an active participant in eliminating lead poisoning by 2010?

**A.5.** Over the past 5 years, EPA has committed more than \$169 million to its lead poisoning prevention program. More than \$80 million of these funds have been distributed to States, Tribes, and U.S. Territories to assist them in establishing and administering their own lead poisoning prevention programs. This level of funding is sufficient to ensure that we are an active participant in the Federal Government's efforts to eliminating lead poisoning.

**Q.6.** Your testimony talks about the 1996 Rule covering training and certification for lead-based paint professionals. How many people have been trained since the Rule was passed? Are there enough trained professionals to meet the need? What efforts has EPA been engaged in to increase participation beyond the 35 States who have obtained training grants and what tools might be needed to help achieve this goal?

**A.6.** In 1996, EPA issued a regulation to establish a nationwide network of trained and certified lead professionals. Since then, we have authorized 34 States, three Tribes, Puerto Rico, and the District of Columbia to administer and enforce this program. EPA is running the program in all nonauthorized States and Tribal lands.

EPA estimates that to date there have been more than 20,000 individuals certified by either EPA or our authorized State partners to identify and abate lead hazards. We believe that on a national basis, there are a sufficient number of certified individuals. Admittedly, in certain regions of the country, there are fewer certified contractors than we would like to see. For our part, EPA is constantly refining and updating our certification and accreditation systems to make them more responsive to the needs of the regulated community. For example, within a year, individuals seeking certification will have the ability to pay online via credit card and submit their application forms online.

With respect to the number of authorized programs, EPA is pleased with the fact that we have authorized as many States and Tribes as we have. The Agency has always believed that this program is best administered at the local level. We continue to encourage unauthorized States and Tribes to develop programs, and we provide technical and financial assistance to any State or Tribe that wishes to seek authorization. At the same time, we recognize that financial considerations often determine whether a State or Tribe seeks authorization. We will continue to solicit input from

the States and Tribes so that future regulatory elements of the program create incentives to State and Tribal authorization. EPA is more than capable of administering and enforcing this program in the States and Tribes that have chosen not seek authorization.

**Q.7.** Your testimony states that parents have greatly helped to reduce lead exposure to their children by cleaning and maintaining homes. Do you have any specific data highlighting the positive effects of these efforts?

**A.7.** Results from studies of educational interventions and cleaning by residents show that there is evidence that cleaning by residents can reduce lead levels. In an East St. Louis, Illinois study, 50 percent declines in dust-lead levels were reported in the 44 percent of the homes where the family reported that cleaning had been done according to instruction. In a study in Boston, Massachusetts, a 36 percent decline in blood-lead levels and a 38 percent decline in window sill lead levels were reported for a control group that received an outreach visit, cleaning instructions, and a free sample of cleaning solutions. In this study, floor and window well levels were essentially unchanged. In a study in Rochester, New York, 30–60 percent declines in most surfaces were reported following cleaning, but blood-lead levels did not decrease. Blood-lead levels decreased by 15 percent in a Milwaukee, Wisconsin study of educational interventions that included a demonstration of clean up and maintenance measures by outreach workers. Additional information on the effectiveness of lead interventions and abatement in residential housing can be found in the EPA report, “Review of Studies Addressing Lead Abatement Effectiveness: Updated Edition” (EPA 747-B-98-001, December 1998). This report is available through the Internet at the URL: <http://www.epa.gov/lead/finalreport.pdf>

There has been a decline in children’s blood-lead levels from 1976 to 1999 that coincides with efforts by the Federal Government and other parties to reduce exposure to lead and to increase the public’s awareness of the dangers of lead. Specifically, the geometric mean blood-lead level for children aged 1–5 years was 18.0 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ) in 1976 based on data collected in the National Human Health and Exposure Study II (NHANES II). By 1980, the geometric mean level for this group of children had declined to 9.3  $\mu\text{g}/\text{dL}$ , again based on data from NHANES II. The trend of declining geometric means continued in the late 1980’s and in the 1990’s. The geometric mean blood-lead level for children aged 1–5 years was 3.6  $\mu\text{g}/\text{dL}$  for the period 1988 to 1991, as reported from NHANES III Phase 1. For the period 1991 to 1994, the geometric mean for this group of children was 2.7  $\mu\text{g}/\text{dL}$  from NHANES III Phase 2. NHANES 1999, which was based on a smaller size sample than previous NHANES studies, estimated the geometric mean to be 2.0  $\mu\text{g}/\text{dL}$ . In addition, when the 1999 NHANES geometric mean was published, CDC published statistics based on data from 19 States with blood surveillance programs. These statistics showed that the proportion of children less than 6 years old with elevated blood-lead levels declined in the period from 1996 to 1999 in this group of States.

**Q.8.** Your testimony discusses the National Lead Awareness Campaign. Please describe the program and its positive effects. What is the current status of the program?

**A.8.** The EPA's National Lead Awareness Program has five components. They are:

- Targeting high-risk communities.
- Having material available in languages other than English.
- Working extensively and cooperatively with other Federal partners such as CDC, HUD, USDA, and the Administration of Children and Families (HHS).
- Funding community-based organizations to provide education at the grass roots level.
- Developing culturally-sensitive materials particularly for Native Americans.

The program has taken several steps to ensure a positive impact on the populations most at-risk. Two years ago, EPA launched the "Runs Better Unleaded" campaign featuring posters, mass transit, billboard, and movie theater advertising, and radio public service announcements. The campaign, designed to raise awareness, received an award from the International Association of Business Communicators, and has been replicated in several cities and States.

Over the past 2 years, EPA has developed a WIC (Women, Infants, and Children Program) Nutritionist Educational Campaign. The initiative is more focused than previous efforts because it targets WIC's seven million clients and the staff they rely on for nutritional and general health information. The materials were created in cooperation with the CDC and USDA/WIC staff at the national, State, and local levels. The materials are designed to help the nutritionists get out the message of testing children and their homes for lead, and to highlight the lead poisoning/nutrition connection. The cornerstone of this effort, EPA's "Fight Lead Poisoning With a Healthy Diet" brochure, provides not only prevention and detection messages, but also WIC-approved recipes. A Spanish-language version is currently being printed. EPA also developed a Media Outreach Kit, an adaptable guide for State and local health, housing, and environmental programs to assist them in working with the press to get information out about lead poisoning prevention. Updates to this guide are available in CD-ROM format and on EPA's website.

Currently EPA is developing an outreach initiative with the Head Start program to provide educational materials and empower this high-risk population. Specifically, we will share information with Head Start educators and the children's parents on the health hazards of lead-based paint, lead's deleterious developmental effects, and how to avoid these problems.

**Q.9a.** Your testimony talks about cooperative programs with retail stores to distribute materials, and partnership programs with non-profits and other agencies. Do you believe that these efforts are enough to spread the word about the dangers of peeling paint and paint dust?

**A.9a.** EPA has partnered with several organizations to provide outreach and education to the public on the dangers of lead-based paint hazards. However, EPA believes that its lead outreach activities should be continuous and has planned several future efforts. In particular, our planned Renovation and Remodeling Outreach Campaign will spread the messages of lead-safe work practices and training possibilities directly to contractors who do the work, non-profits who support the various industries that work with lead, and the owners of homes who would benefit from lead-safe housing. A sustained, multifaceted, multimedia approach is key to not only getting the public aware of lead issues, but also to get them to take action to prevent lead poisoning.

**Q.9b.** The Task Force recommended an expansion of these efforts, what have you done to increase outreach?

**A.9b.** EPA has been involved in several outreach efforts, as well as having many planned for the future including: (1) participating in the "National Lead Poisoning Prevention Week." This includes partnering with Centers for Disease Control and Prevention, Department of Housing and Urban Development, and the District of Columbia Health Department; (2) working with the Department of Agriculture's Women, Infants, and Children (WIC) Program to develop and distribute fact sheets and the document "Fight Lead Poisoning With a Healthy Diet," which links nutrition and lead prevention; (3) partnering with the Centers for Disease Control and Prevention, Department of Housing and Urban Development, and the Agency for Disease Registry and Toxic Substances to cosponsor a national lead health education conference with representatives from Federal, State, and Tribal governments; (4) working with a national community-based volunteer organization, Hope For Kids, to educate parents in several cities across the United States on lead poisoning prevention; (5) working with the Department of Justice's Weed and Seed Program, a national community organization that focuses on keeping juveniles out of the justice system, to educate parents and community members on lead poisoning prevention; (6) providing a grant for the development and distribution of Spanish-language public service announcements; and (7) establishing Tribal lead outreach campaigns and blood-lead screening of Tribal children.

**Q.9c.** How much money has been spent on this effort?

**A.9c.** EPA has committed nearly \$4 million to this effort.

**Q.9d.** What additional ideas does EPA have that might help increase public awareness of lead-based paint hazards in the home?

**A.9d.** General awareness messages of the past have been successful, but more can be done to target the most at-risk populations, often low-income, minority children living in older urban housing. Whether it is to motivate a parent to get their child tested, a property owner to get his rental property inspected, or a contractor to take proper health-protection steps, EPA is always looking for the best way to approach those most in need of our information. We are providing more resources electronically through EPA's website and the National Lead Information Center. However, EPA realizes that the most vulnerable communities may not have Internet ac-

cess, and to that end, we continue to produce hard copies of our educational materials. EPA also plans to continue its partnerships with nonprofit organizations that serve those populations. Through these partners, we learn more about our audiences and adjust our efforts accordingly.

“Do-it-yourselfers,” homeowners that perform renovations in their own properties, are a group that may damage not only their own health, but also the health of any children and families that live in their properties. Due to the potential for increased lead exposure, we are discussing an educational outreach plan to promote lead-safe activities by these owners.

**Q.10.** How many cases have been referred to DOJ in the last year and a half? What is the status of those cases?

**A.10.** During the last year and a half, EPA has referred a dozen cases to the U.S. Department of Justice for civil judicial enforcement: Six for injunctive relief for Section 1018 (Lead Disclosure Rule) violations, and six for judicial enforcement subpoenas under the Toxic Substances Control Act (TSCA). Eleven of these cases have been resolved in the United States’ favor. The three biggest injunctive relief settlements required inspections, risk assessments and remediation of the lead-based paint hazards for 13,000 dwelling units in Chicago and Cincinnati. One TSCA subpoena case is currently pending in the U.S. District Court for Rhode Island. In addition, EPA has also issued more than 50 civil administrative complaints with proposed monetary penalties over this time period. In one administrative settlement, a property management firm agreed to conduct inspections, risk assessments, and lead-based paint hazard remediation in 132,000 dwelling units nationwide.

**Q.11.** While abatement is essential in high-risk properties, in which cash flow is insufficient to support maintenance, most leaded properties can be made lead-safe through other strategies. Research and experience over the past decade has demonstrated the importance of visual inspection for peeling paint; lead-safe work practices to control, contain, and clean up lead dust in painting and remodeling projects; and clearance testing to ensure that lead dust hazards are not left behind. Do you believe that visual inspection, lead-safe work practices, and clearance testing offer the potential to expand lead-safety to a broad enough scale to make U.S. housing lead-safe?

**A.11.** This approach has the potential to expand lead-safety to make many more homes lead-safe. Visual inspection and the prompt lead-safe repair of deteriorated lead-based paint can reduce the number of homes in this country with existing paint lead hazards.

Pursuant to the direction of Title X, the EPA is developing a program to introduce lead-safe work practices in the renovation and remodeling industry. Through education and outreach and regulation, the Agency hopes to increase the use of these practices during renovations in homes with lead-based paint to prevent the introduction of new hazards. This program can also be used to reduce existing paint lead hazards in homes that are unlikely to be abated.



Clearance testing is still the best indicator to ensure that dust-lead hazards do not remain after an abatement or renovation event. EPA is evaluating a range of regulatory and technical alternatives to make dust clearance testing even more affordable and widely available.

**Q.12.** While consistent data are not widely available, it is clear that in the majority of cases lead hazards are not corrected even after a child is identified as lead-poisoned. The same hazardous house often poisons multiple children as new families move in (that is, a Syracuse, New York, newspaper identified 47 houses that has poisoned multiple children in just 18 months). Even when health departments succeed in ordering repairs, in many States there is no oversight, no requirement for lead-safe work practices and no clearance testing. While no house should poison a child, it is simply unconscionable that any house should poison a second, third, and fourth child. What do you believe your Agency can do to help stop houses from poisoning more than one child?

**A.12.** Once a house has been determined to be the cause of a child's lead poisoning, the hazards should be addressed to ensure that the house does not poison other children. EPA regulations clearly state that when work is done to eliminate lead hazards due to the presence of a lead-poisoned child, the work must be done following EPA abatement regulations, including requirements for lead-safe work practices and clearance testing. The EPA has authority over such actions in all nonauthorized States and Tribes. In authorized States and Tribal lands, equally protective State or Tribal regulations would apply.

However, EPA itself has no general authority to order abatements, or to ensure that abatements ordered by State health departments are actually carried out. EPA authority begins once an abatement activity begins. Therefore, while EPA can ensure that abatement, when performed, is performed correctly, we cannot force abatements to be performed in the first place.

EPA is able to encourage abatement and other lead hazard control activities as part of settling administrative and judicial enforcement cases for violations of the Lead Disclosure Rule requirements. EPA enforcement settlements have resulted in over 150,000 housing units becoming lead-safe, as defined under the HUD guidelines. EPA intends to continue to encourage landlords and property managers to review their compliance with the Lead Disclosure Rule and to conduct lead abatement activities in settling enforcement actions to address lead-paint hazards. Also, settlements have included projects aimed at reducing the future risk of harm from lead-based paint. For example, violators have funded clinical blood-lead testing of children and pregnant women at risk for lead-paint poison, and funded a seminar on the Lead Disclosure Rule requirements for real estate agents and brokers.

In individual, extreme cases, EPA has authority under the Resource Conservation and Recovery Act (RCRA) to address imminent and substantial endangerment arising from lead-based paint. Under RCRA, Section 7003, EPA can order property owners to take immediate action to minimize lead exposure to tenants, including removing lead-based paint and paint wastes, if EPA has deter-

mined that the tenants may be in imminent and substantial danger of lead poisoning.

**Q.13.** What does your Agency believe might be appropriate statutory changes to make the Federal disclosure law regarding lead more meaningful?

**A.13.** EPA does not believe that any statutory changes to Section 1018 are needed. Our continuing enforcement actions coupled with our outreach efforts are accomplishing the goal of informing the public so that they can take appropriate actions.

**Q.14.** Many advocates and some health departments are convinced that ending childhood lead poisoning will require moving beyond screening children's blood-lead levels to actually screening high-risk housing to identify hazards before a child's health is harmed. What does your Agency think about this strategy? What about the idea of developing registries of hazardous properties?

**A.14.** One key benefit of EPA's lead hazard standards is to enable exactly what you are suggesting—to screen housing for hazards before children are poisoned. These protective, health-based standards provide a criterion to identify this high-risk housing. Our real estate disclosure regulations also support this strategy by providing prospective tenants and buyers the opportunity to uncover hazards or potential hazards before moving into a dwelling.

EPA has not analyzed how such a registry program would work. Nevertheless, EPA is considering establishing a program to encourage landlords to maintain their buildings in a lead-safe manner, and then to recognize and publicize their efforts. We believe this approach may have a better chance of accomplishing our goal, because we can highlight lead-safe properties for the consumer, and we hope to also have landlords formally agree to long-term maintenance of their buildings in order to participate.

**Q.15.** Does your Agency believe that lead-based paint and dust hazards in housing are the overwhelming cause of childhood lead poisoning in the United States? If not, what other causes should Congress be looking at?

**A.15.** Yes, the Agency continues to believe that lead-based paint and dust hazards in housing are the primary sources of lead exposure for most children. Certainly, multiple other sources of lead exist (folk remedies, consumer goods, etc.) and may be responsible for individual cases of lead poisoning, but housing-related sources are by far the predominant cause of lead poisoning in the United States today.

**Q.16.** As a result of our hearing last November on lead poisoning, it was clear that primary prevention is an extremely important part of eliminating childhood lead poisoning. First of all, does your Agency support the goal of stopping children from being poisoned in the first place? If so, how is your Agency planning to achieve this goal?

**A.16.** Yes, EPA, for years, has unequivocally supported the goal of primary prevention. We plan to achieve this goal via many routes. Our regulatory program is designed to provide criteria for identifying lead hazards to give consumers the knowledge and tools to

address lead hazards before their children are poisoned, and to have qualified people available to identify and fix lead hazards. Our public education program is designed to reach people most at risk, at points in their life where they can most easily take action to prevent lead poisoning, rather than simply providing information after the damage has been done. One key goal of our technical program is to lower the cost of lead hazard assessment and repair activities, to encourage more people to use these services. We hope that we are already seeing the fruits of our labors by the continuing decline in the numbers of lead-poisoned children.

ATTACHMENT

August 17, 2000

Frank Greene  
CT Dept. of Public Health  
410 Capitol Ave., MD#LED  
P.O. Box 340308  
Hartford, CT 06134-0308

Dear State and Tribal Colleagues,

The purpose of this letter is to discuss EPA's policy with regards to the introduction and use of the lead Sampling Technician curriculum both now and in the future.

In the 1999 VA-HUD Appropriations Conference Report the Agency was afforded funding for the development of a relevant one-day Sampling Technician training course to make lead dust testing more available and affordable. In addition, the conferees encouraged the Agency to advocate the recognition of this discipline.

EPA has completed the development of this course titled "Lead Sampling Technician Training Course." The course teaches students how to conduct a visual assessment for deteriorated paint, collect samples for lead dust, and interpret sample results. The course includes five hours of training and can be presented in approximately seven hours when factoring in lunch and breaks. The majority of class time is devoted to teaching the skills needed to collect and interpret dust samples.

EPA Technicians will play a principal role conducting dust sampling for the purposes of clearance testing following non-abatement activities which disturb or repair lead-based paint. In addition, the Agency expects that Sampling Technicians may perform lead dust sampling in other settings such as pre-sale home inspections, unit turnovers, or at the request of homeowners.

EPA is likely, in the upcoming Renovation and Remodeling proposed rule, to introduce standards for conducting non-abatement clearance sampling, as well as training and certification requirements for the Sampling Technician discipline. The proposed rule will likely recommend, and may in some cases require, clearance testing by either a certified Risk Assessor, Inspector, or Sampling Technician following renovation activities. EPA plans to adopt this training course as a model for the new discipline. At this time, EPA does not expect any prerequisite experience or educational requirements for individuals wishing to become certified as a Sampling Technician.

Currently, EPA does not regulate clearance activities associated with non-abatement activities which disturb lead-based paint. However, EPA does recommend clearance examinations following non-abatement activities by a trained and/or certified individual (either Risk Assessors, Inspectors, or Sampling Technicians). EPA will promote the training and use of individuals having successfully completed this course in States and Tribes where EPA is implementing the 402 program. We recognize that the ability of Sampling Technicians to perform dust sampling may be affected by your State's or Tribe's requirements. Therefore, we recommend that training programs and Sampling Technicians consult with appropriate State or Tribal regulatory authorities prior to providing Sampling Technician training or conducting sampling in any given State or Tribe.

A new HUD rule on lead-based paint poisoning prevention in pre-1978 federally-owned and assisted housing (24 CFR part 35, subparts B-R) becomes effective September 15, 2000. HUD anticipates that clearance testing, prescribed by this regulation, will be required in about 300,000 units in its first year. Where permitted by State and Tribal requirements, HUD's rule allows trained Sampling Technicians (called "Clearance Technicians" in the HUD rule) to conduct non-abatement clearance examinations with certain restrictions. The Sampling Technician must be trained by a training program accredited by EPA or an EPA-authorized State or Tribal program to provide inspection or risk assessment training, and work under the supervision of a certified Risk Assessor or Inspector. Examples of non-abatement activities in housing covered by its rule include:

- interim control activities,
- rehabilitation that disturbs painted surfaces, and
- maintenance activities required under HUD's regulation to address lead hazards.

Where permitted by State and Tribal requirements, HUD's rule also allows Sampling Technicians certified by EPA or an EPA-authorized State or Tribal program to conduct clearance testing, without the approval of a certified Risk Assessor or Inspector, after non-abatement activities in housing covered by its rule. However, HUD does not permit a certified Sampling Technician to use random sampling of dwelling units or common areas in multifamily properties unless the clearance examination is approved and the report signed by a certified Risk Assessor or Inspector.

*Note: Sampling Technicians are not permitted to conduct clearance after abatement activities; only certified Risk Assessors or Inspectors can perform such post-abatement testing in accordance with EPA's 402 regulations.*

EPA encourages your State or Tribe to consider the following: 1) Allowing Sampling Technicians to conduct non-abatement clearance testing in accordance with HUD's requirements, 2) Permitting trained and/or certified Sampling Technicians to perform sampling to identify lead contaminated dust, 3) Encouraging your accredited training programs to offer this course, 4) Developing a plan for upcoming legislative sessions which would address the incorporation of

the Sampling Technician discipline, as well as the upcoming Renovation and Remodeling rulemaking, in your authorizing legislation, and 5) Communicating your State's or Tribe's regulatory policy regarding the use of Sampling Technicians to your accredited trainers and certified firms (attached are sample letters EPA is sending federal trainers and firms explaining Agency policy regarding the application of the Sampling Technician discipline in Federally administered States and Tribes). Such action is important and necessary to increase the supply of individuals qualified to conduct non-abatement clearance testing and support HUD's requirements.

The new training course is available on EPA's OPPT lead home page ([www.epa.gov/lead](http://www.epa.gov/lead)). A courtesy copy of the course will be forwarded to you under a separate cover. Additional printed copies will be available after September 1, 2000 thru the National Lead Information Center (NLIC) at 1-800-424-LEAD. You should also be aware that HUD will be offering workshops for accredited risk assessment training providers this summer so that they can train Sampling Technicians during the coming year. Information on HUD's rule and the training provider workshops is available on HUD's lead home page ([www.hud.gov/lea](http://www.hud.gov/lea)). Please feel free to contact me at 202-260-1866 if you have questions.

Sincerely,

[Original Signed]

Linda Vlier Moos, Associate Director  
National Program Chemicals Division

Enclosures

**RESPONSE TO WRITTEN QUESTIONS OF SENATOR REED  
FROM RUBEN KING-SHAW, JR.**

**Q.1.** States like Alaska have long argued they should be excused from universal screening because they believe they have low lead concentrations. Have these States presented any data, either in terms of their housing stock or screening rates for Medicaid-eligible children that would substantiate their position?

**A.1.** The States of Alaska and Utah have both submitted material that they suggest supports discontinuing universal lead screening for all Medicaid eligible children in their State. This material was submitted in 1998 and CMS (then HCFA) was not in a position at that time to consider allowing States to discontinue universal screening. However, we reviewed the information from both the States and informed them of our conclusions as follows:

We reviewed the study and data submitted by Alaska and concluded that it was insufficient to be used to allow the State to discontinue universal screening based on several drawbacks of their study. For example, while the study was well-designed, there was a very low response rate from a particular group (urban respondents) and this made data comparisons difficult. Another limitation was that the State tested children between the ages of 1 and 6 but did not include children under the age of one from the study. We believe the State should have attempted to obtain data on this age group, either by looking at Medicaid claims or pediatrician records, since the State felt performing the venipuncture on these young children was too difficult.

The State of Utah submitted a study from Salt Lake County that was performed by offering blood-lead tests to families enrolled in the WIC Program. The study data was collected from seven WIC clinics dispersed throughout Salt Lake County. In this instance we felt the study was too limited to be able to make a statewide recommendation.

**Q.2a.** The 1999 GAO report on the lead poisoning prevention efforts at Federal health care programs pointed out several deficiencies, including the fact that only 20 percent of Medicaid-eligible children are currently screened for lead poisoning. In your testimony, you noted that CMS sent letters to all State Medicaid directors detailing the findings of the GAO report and reiterating their responsibilities with regard to lead screening. Has CMS taken any other definitive action to address these problems?

**A.2a.** CMS has continued to work on the lead screening issue since the GAO report. In April 2000, CMS, the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and the Administration for Children and Families (ACF) cosigned a letter to State Medicaid Directors, CDC grantees, Head Start programs, and numerous other ACF and HRSA contacts transmitting our October 1999 State Medicaid Director letter and information on CMS' strategy for assuring that States comply with our lead screening policy. We also encouraged States to work together at the State and local level as we were doing at the Federal level.

CMS currently participates on the CDC's Advisory Committee for Childhood Lead Poisoning Prevention as an ex-officio Member of

the Committee. CMS has been extensively involved in the Committee's work and deliberations related to lead screening of Medicaid children and other aspects related to lead poisoning of Medicaid children. In December 2000, the Committee published "Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk." Currently the Committee is developing a report to Secretary Thompson recommending ways that State Medicaid agencies can target lead screening to those Medicaid children at highest risk for lead poisoning.

CMS also participates with many other Federal agencies on the President's Task Force on Environmental Health Risks and Safety Risks to Children. In February 2000, the Task Force published "Eliminating Childhood Lead Poisoning: A Federal Strategy Targeting Lead Paint Hazards." The report presents a program for eliminating childhood lead poisoning by 2010 based on coordinating the efforts of various Federal agencies including the Department of Housing and Urban Development (HUD), the Environmental Protection Agency (EPA), CDC, and CMS. The report identified the efforts and activities undertaken by CMS since the publication of the 1999 GAO study on lead poisoning to improve the screening, diagnosis, and treatment of Medicaid children with lead poisoning. The report also highlighted the work of an interdepartmental work group consisting of CMS, CDC, HRSA, and other DHHS agencies to improve access and the provision of these services.

CMS will continue to play a major role in Federal activities designed to reduce and eliminate lead poisoning of young children in this country. CMS' particular focus is in covering the secondary and tertiary preventive services needed by Medicaid children (for example, screening, diagnosis, and treatment services). Probably the most effective strategy we can employ is to encourage our State Medicaid agencies/partners to work together with their local health, housing, and environmental agencies toward the common goal of eliminating lead poisoning.

We have awarded two contracts that we believe will assist in improving screening rates. The contract with the Alliance to End Childhood Lead Poisoning resulted in an outreach and educational document for States to assist them in dealing with providers and managed care organizations. The final document from the Alliance contract published in August 2001, *Track, Monitor and Respond: Three Keys to Better Lead Screening for Children in Medicaid*, is intended to be an educational document that States can use in their outreach to their providers in order to resolve some of the difficulties in the provision of the blood-lead screening tests. The second contract with Abt Associates is expected to produce a final report providing us with good information and key elements for screening the highest risk children. The Abt Associates final report will also shed more light on how State Medicaid agencies are successfully working with other State and local agencies to address this problem. We intend to share this information with State Medicaid agencies.

We continue to encourage State Medicaid agencies to participate in data sharing activities so that the health department and the Medicaid Agency know which Medicaid eligible children have been



tested and which have not. We do know that many States are beginning to work on these data sharing agreements.

**Q.2b.** If not, what tools or authority does CMS need to help it remedy these deficiencies and ensure that Federal law is being followed?

**A.2b.** We continue to work with the States and other Federal agencies such as CDC on this issue and believe that this is the best way to continue addressing the problems. We hope to distribute the final report from the Abt contract to all States to provide them with information on what has worked, or has not worked, in other States. We believe sharing information is one of the best ways to encourage States to continue to focus on this important issue.

While our only enforcement tool against States is to take a compliance action that could result in the withholding of Federal Financial Participation (FFP), we do not believe withholding money from the entire program is a practical or effective approach to the problem. Additionally, the compliance process is a lengthy ordeal that can take years to complete. CMS has never withheld monies from a State as a result of a compliance action.

**Q.2c.** In addition, what additional enforcement powers may be helpful to CMS to ensure that managed care companies that are not performing screening comply with their contract requirements?

**A.2c.** The States monitor managed care organization (MCO) performance through their contracts, and the MCO's report lead screenings to the State, which then includes them in the State's report to us.

Interestingly, in the managed care arena there is more accountability than in fee-for-service because the State has the ability to hold the MCO accountable through the contract, whereas in FFS it is very difficult to hold all providers accountable. An increasing number of States are incorporating into their contracts with MCO's specific language and requirements pertaining to lead screening. A 1999 study found that 42 percent of Medicaid MCO's contracts had specific lead-screening requirements. More recently, George Washington University developed under contract with the CDC sample purchasing specifications for use by States in their contracts with Medicaid MCO's. Sample specifications for lead poisoning prevention were developed in this process. A number of States also require their Medicaid managed care contractors to report lead screening as part of their Health Plan Employer Data and Information Set (HPEDIS) performance measures.

**Q.3.** As we heard during testimony, the cause of the vast majority of lead poisoning in the United States is the home environment. For this reason, Medicaid allows States to cover the cost of a one-time environmental assessment of the home. However, Medicaid will not pay for testing of the dust, soil, or water at the house as part of this assessment. Could you please explain to the Committee the rationale behind Medicaid's policy? Would CMS support changing this policy so that Medicaid could pay for the testing of dust and other samples in the homes of lead-poisoned children?

**A.3.** The role of Medicaid is to reimburse for the delivery of *medical services* directly to eligible individuals. Using Medicaid funds to do

other environmental remediation is beyond the bounds of Medicaid and would not be an appropriate use of these funds. Extending coverage under Medicaid to other environmental interventions such as testing of environmental substances would have tremendous implications for State and Federal Medicaid budgets. Therefore, we would not support a change in this policy.

One factor that impacts this decision is that under the Medicaid program, laboratory tests must be performed in CLIA certified laboratories. CLIA certified laboratories are only certified to perform testing on *human* specimens. This requirement is stated in the statutory language in the Public Health Act, as well as CMS' regulations. Testing of environmental specimens is not performed in CLIA certified labs. Therefore, we cannot pay for these types of laboratory tests under the current law.

Even if it were possible to pay for environmental testing for lead under another coverage category, it would be extremely difficult to limit this coverage to only lead, absent specific legislative authority. There are many other diseases and conditions that are affected by environmental conditions in the home, for example, asthma. We, as well as States, would be put under pressure to then begin reimbursing for these other types of environmental interventions such as air filters or special bedding.

Housing agencies, as well as homeowners and landlords need to be responsible for their dwellings. Medicaid funds should be used for medical services to screen, diagnose, and treat lead-poisoned children. Our other partners in this area, such as HUD, and State and local governments, are better situated to address the housing issue.

**Q.4.** In your written testimony, you discuss a cooperative agreement between CMS and the Alliance to End Childhood Lead Poisoning to develop an educational guide to improve awareness of and compliance with CMS' policies. It is my understanding that the original \$250,000 agreement was funded by the previous Administration. When the Alliance submitted a proposal to extend this valuable outreach program an additional 18-months, CMS denied the request, despite report language in the fiscal year 2002 Labor-HHS-Education Appropriations bill encouraging CMS to support outreach and education. What was the reason for CMS' turnaround in supporting this cooperative agreement with the Alliance? What is CMS currently doing to support outreach and education as encouraged in the fiscal year 2002 Appropriations bill?

**A.4.** When the Alliance's unsolicited proposal was received in 2000, the Senate and House Appropriations Report recommended that CMS take appropriate steps to ensure that screening rates among children enrolled in Medicaid substantially increase. At that time, CMS had some discretionary funds available for this type of project. Therefore, we funded the Alliance \$250,000 for the education and outreach project and also awarded a contract to Abt Associates for approximately \$750,000 for an additional study on lead screening activities. At the time the Alliance requested additional funding, CMS was unable to accommodate this request due to the lack of additional discretionary funds. This funding situation has not changed.

**Q.5a.** You also describe in your testimony a study your Agency has commissioned to improve the lead screening of low-income children by assessing the impact and effectiveness of current screening criteria in reaching high-risk, low-income children. While I applaud the Agency for its continued work to ensure that screening criteria are appropriately targeting those children at greatest risk of lead exposure, I am concerned that this might mean the bigger picture is being missed. Could you please describe for the Subcommittee what *specific* steps or actions CMS is taking to ensure that all States are meeting the blood-lead screening requirement under the EPSDT benefit for Medicaid-eligible children?

**A.5a.** The latest data that we have from our CMS-416 EPSDT report indicates that nationally about 60 percent of Medicaid children under 21 are receiving all of the age-appropriate medical screening services. Unfortunately, the data on lead screening reported on the CMS-416 since fiscal year 1999 continues to be problematic. However, CMS is actively involved in collaborating and working with our State partners to improve compliance through conferences, meetings, technical assistance sessions, and work groups and dissemination of materials including “State best practices” produced with Federal funds. We feel that we will be more successful through these collaborative activities rather than taking punitive action against the States.

We also believe the two contracts we have undertaken, with the Alliance to End Childhood Lead Poisoning and Abt Associates, will assist us in improving screening rates. The Alliance contract has provided an outreach and educational document to States to assist them in dealing with the providers and managed care organizations. We also expect the final product from the Abt contract to provide us with some good information of successful programs States have implemented to improve their screening rates.

**Q.5b.** What is CMS doing to encourage States to take creative approaches to lead poisoning prevention and detection, such as my home State of Rhode Island, which received a waiver to use Medicaid funds to pay for window replacements in homes where lead-poisoned children reside?

**A.5b.** We encourage States to be innovative in their approach to the lead screening issue. We believe the Abt study will highlight some of these innovations and we will share that information with all the State Medicaid agencies. In the case of Rhode Island, the State already had an approved statewide, comprehensive section 1115 demonstration to expand Medicaid eligibility within a managed care delivery system. The amendment to include the window replacement was in the context of the larger demonstration project but targeted to expand the effectiveness of an ongoing State effort using lead centers. Through the comprehensive demonstration the State is able to achieve the savings necessary to make the lead amendment budget neutral. Achieving such budget neutrality absent a comprehensive demonstration would be very difficult. However, CMS is willing to review any innovative State proposals using this approach.

**Q.5c.** What can be done to change the perception among health care providers that lead poisoning screening is not necessary and important?

**A.5c.** I do not think the issue is one of perception of importance but rather of risk of exposure based on one's professional judgment. The final document from our Alliance to End Childhood Lead Poisoning contract, *Track, Monitor and Respond: Three Keys to Better Lead Screening for Children in Medicaid*, was intended to be an educational document that States could use in their outreach to their providers in order to resolve some of the difficulties in the provision of the blood-lead screening tests.

We hope that the final Abt Associates product will also shed more light on how State Medicaid agencies are successfully working with other State and local agencies to screen the highest risk children, including provider groups and managed care organizations. National provider organizations could also be encouraged to remind their members about the importance of lead screening.

**Q.6.** While abatement is essential in high-risk properties, in which cash flow is insufficient to support maintenance, most leaded properties can be made lead-safe through other strategies. Research and experience over the past decade has demonstrated the importance of visual inspection for peeling paint; lead-safe work practices to control, contain, and clean up lead dust in painting and remodeling projects; and clearance testing to ensure that lead dust hazards are not left behind. Do you believe that visual inspection, lead-safe work practices, and clearance testing offer the potential to expand lead-safety to a broad enough scale to make U.S. housing lead-safe?

**A.6.** The Federal Medicaid program makes funding available for a one-time investigation to determine the source of lead. We believe this inspection is an important first step to making many houses lead-safe. However, the other issues raised here, lead-safe work practices and clearance testing, are beyond the purview of the Medicaid program. Other Federal agencies such as CDC, HUD, and EPA are better suited to addressing the importance of these practices.

**Q.7.** While consistent data are not widely available, it is clear that in the majority of cases, lead hazards are not corrected even after a child is identified as lead-poisoned. The same hazardous house often poisons multiple children as new families move in (that is, a Syracuse, New York, newspaper identified 47 houses that had poisoned multiple children in just 18 months). Even when health departments succeed in ordering repairs, in many States there is no oversight, no requirement for lead-safe work practices, and no clearance testing. While no house should poison a child, it is simply unconscionable that any house should poison a second, third, and fourth child. What do you believe your Agency can do to help stop houses from poisoning more than one child?

**A.7.** The role of Medicaid is to reimburse for the delivery of medical services directly to eligible individuals. Using Medicaid funds to do lead abatement or any other environmental remediation is beyond the bounds of Medicaid and would not be an appropriate use of these funds. Extending coverage under Medicaid to lead abatement

and other environmental interventions would have tremendous implications for State and Federal Medicaid budgets. However, as stated earlier, Medicaid does reimburse for a one-time investigation to determine the source of lead. This includes the time and activities of a health professional to visit the home of a Medicaid eligible child with an elevated blood-lead level to help determine the source of lead poisoning.

Housing agencies, as well as homeowners and landlords need to be responsible for their dwellings. Medicaid funds should be used for medical services to screen, diagnose, and treat lead-poisoned children. Our other partners in this area, such as HUD, and State and local governments, are better situated to address the housing issue.

**Q.8.** What does your Agency believe might be appropriate statutory changes to make the Federal disclosure law regarding lead more meaningful?

**A.8.** The Federal Medicaid program has no authority to enforce nor interpret the Federal disclosure law. We believe this question is more appropriately directed to the HUD.

**Q.9.** Many advocates and some health departments are convinced that ending childhood lead poisoning will require moving beyond screening children's blood-lead levels to actually screening high-risk housing to identify hazards before a child's health is harmed. What does your Agency think about this strategy? What about the idea of developing registries of hazardous properties?

**A.9.** We believe that CDC and State and local governments have indeed compiled a great deal of data regarding hazardous housing. CDC would be a better source of identifying what gaps remain.

**Q.10.** Does your Agency believe that lead-based paint and dust hazards in housing are the overwhelming cause of childhood lead poisoning in the United States? If not, what other causes should the Congress be looking at?

**A.10.** CMS relies on the CDC for its information and recommendations on lead screening. We believe CDC along with HUD and EPA may have additional ideas on what, if any, other hazards that Congress could address.

**Q.11.** As a result of our hearing last November on lead poisoning, it was clear that primary prevention is an extremely important part of eliminating this childhood lead poisoning. First of all, does your Agency support the goal of stopping children from being poisoned in the first place? If so, how is your Agency planning to achieve this goal?

**A.11.** CMS does support the goal of preventing children from being poisoned by lead in their environment. However, due to the statutory requirements of our program that direct our funding be used for medical purposes, we are unable to focus our resources on this type of prevention. We are focused, however, on the early detection of children who have been exposed to lead and providing any additional medical services they need.

**RESPONSE TO WRITTEN QUESTION OF SENATOR CARPER  
FROM RUBEN KING-SHAW, JR.**

**Q.1.** The Administration recently reiterated its commitment to screening the blood-lead levels of children under age 6 enrolled in Medicaid. How will you ensure that States comply with this requirement?

**A.1.** CMS is committed to continuing our work with States and our Federal partners to ensure that children at highest risk are screened for lead poisoning. We continue to reiterate to State Medicaid agencies the importance of working with other State and local agencies to ensure that children are screened and that the data is reported. We will continue to require States to report their lead screening data on the CMS-416 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) form and monitor States continued progress in this area.

We also intend to publish the final report prepared by our contractor, Abt Associates, that is looking at innovative State and local models for the elimination of lead hazards facing low-income children, as well as assessing the impact and effectiveness of current screening criteria in reaching high-risk, low-income children. We believe this document will be useful to State Medicaid agencies in focusing their resources effectively to address this problem.

**RESPONSE TO WRITTEN QUESTIONS OF SENATOR REED  
FROM RICHARD J. JACKSON, M.D., M.P.H.**

**Q.1.** In your testimony you talk about the CDC's analysis of children's blood-lead levels as part of the National Health and Nutrition Examination Survey (NHANES) between 1976 and 1980, and again between 1991 and 1994. Are there any more recent NHANES data available on children's blood-lead levels, and if not why?

**A.1.** There are more data that have not been released yet because they are still being analyzed. We hope the data will be ready sometime this summer and we will be happy to get it to you as soon as it is ready.

**Q.2a.** Last spring, I, along with several of my colleagues in the Senate, wrote to Secretary Thompson to urge the CDC to initiate a review of the current blood-lead level (BLL) standard of 10 micrograms per deciliter to determine whether the national standard needs to be lowered. Last fall, this Subcommittee heard about research at the Children's Hospital Medical Center in Cincinnati indicating that children exposed to lead at levels currently considered "safe" scored substantially lower on intelligence tests and may be suffering other adverse health effects from exposure to lead. What is the status of the CDC's review of the current blood-lead level standard and when can we expect a report on the outcome of this important review?

**A.2a.** CDC has requested that the National Advisory Committee on Childhood Lead Poisoning Prevention (NACCLPP) study the health effects of blood-lead levels less than 10 µg/dL (that is, IQ, academic performance/achievement, behavior, attentiveness/reaction time, hearing threshold, growth, renal function, etc.) among young children. To support this activity, CDC is funding an exhaustive search of the literature on this topic. The information will be culled, and

the most relevant literature will be provided to the ACCLPP "Less Than 10" Work Group. This Subcommittee of the ACCLPP will review and assess the information to determine whether the national standard should be lowered. The contract stipulates that a literature review synopsis will be delivered to the "Less Than 10" Work Group by May 2003. The work group will consider this information and report back to CDC on its findings.

**Q.2b.** If the blood level standard was changed to five micrograms per deciliter, how many more people would be estimated to have elevated blood levels?

**A.2b.** Approximately 3 million based on the 1988 to 1994 NHANES data. Again, these data will be updated this summer and we will provide a revised estimate when the data are available.

**Q.3a.** The GAO, in its 1999 report on the lead poisoning prevention efforts of Federal health care programs, cited the lack of reliable data collection as a significant barrier to targeting appropriate services to at risk children. As you highlight in your testimony, CDC provides grants to States to establish Childhood Blood Lead Surveillance (CBLIS) systems. At present, how many States have active CBLIS systems that are collecting screening and elevated blood-lead levels (EBLL) data and reporting that data to agencies such as CDC and CMS?

**A.3a.** All 43 States and 17 local health departments that receive funds from CDC for childhood lead poisoning prevention programs collect and submit screening and elevated blood-lead level data to CDC. Some States, however, do not have laws that require that all blood-lead levels be reported. CDC is working with those programs to ensure that all blood-lead levels are reported in their States. CDC has urged State and local childhood lead-poisoning prevention programs to work with their State Medicaid offices to link data so we will know what percentage of Medicaid enrolled children have been screened for lead poisoning.

**Q.3b.** What kind of oversight or monitoring does CDC conduct to ensure that States are maximizing their efforts to develop and implement these systems?

**A.3b.** The CDC lead staff are assigned to work with specific States to assess individual childhood lead poisoning prevention program's surveillance systems. CDC offers ongoing technical assistance to help programs improve their surveillance and use of data. CDC is also enhancing its website to highlight model programs so that others can learn from the successes. CDC has created work groups with State representatives to address different surveillance issues. The work groups recommendations will be shared with all lead programs. A childhood lead surveillance meeting will be held in September 2002 to provide a forum for discussion of priority surveillance topics.

**Q.4.** I understand that the Childhood Lead Poisoning Prevention Program's authorization expires this year. As a Member of the Senate Health, Education, Labor, and Pensions Committee, I would be interested in working with your office to ensure that this critical program is reauthorized. What recommendations would you offer to help guide the reauthorization of this important program?

**A.4.** [CDC staff discussed with the Reed staff to resolve this question . . . authorization was extended by the Children’s Health Act until 2005.] CDC would be happy to work with you in the future to ensure the best reauthorization of the Childhood Lead Poisoning Prevention Program.

**Q.5a.** Primary prevention means making housing lead-safe, focusing attention and resources on the “vector of disease.” However, many health departments are stuck in the rut of educating parents about hand washing, nutrition, and wet mopping, while science shows that it is not within parents’ power to protect their children if they live in a highly contaminated home. Thus, what is your Agency doing to help deal with the vector of disease and help make our housing stock lead-safe?

**A.5a.** CDC is providing supplemental funding specifically targeting primary prevention in urban areas of highest need. For example, health departments have prenatal clinic and some have programs that target new mothers at high-risk for many health problems. By identifying these pregnant women and new mothers, the health department can go to their homes and collect dust samples and offer counseling about lead poisoning. If the dust samples are found to have lead, then more intensive environmental investigations can be conducted and remediation, if appropriate, may occur. This “primary prevention” approach can prevent young, high-risk children from becoming lead-poisoned. CDC encourages its programs to apply for HUD grants to fund remediation. CDC will require programs in 2003 to begin to develop primary prevention programs such as those described above.

**Q.5b.** What more can it do within existing law? Do current laws need to be amended to help better deal with primary prevention?

**A.5b.** Primary prevention, as defined by CDC, is allowed under the existing law. However, primary prevention activities will be both time and resource intensive, considering these activities will be most effective when conducted as a complement to the existing lead screening and case management activities, which are critical elements in our national elimination strategy.

**Q.6a.** What has CDC done to raise the sights of its grantees above screening and case management (reacting to poisoned children) and parent education?

**A.6a.** The CDC has required grantees with the heaviest estimated burden to include primary prevention activities in their programs. These grantees have implemented the following primary prevention activities:

- California has implemented a lead-related construction accreditation and certification program that provides individuals who are certified to conduct residential lead inspections and risk assessments.
- Ohio’s Childhood Lead Poisoning Prevention Program collaborates with the Help Me Grow—Home Nursing Program. Nurses in the Home Nursing Program visit the homes of newborn children and conduct a lead-risk assessment in the home. If risk factors are identified, an environmentalist will follow-up with an environmental inspection.



- New York State is examining the five highest risk counties' Medicaid/Social Service Activities and local agencies housing policies to find ways to revise policies and leverage existing funding to reduce the number of lead-contaminated dwellings for low-income families. New York City's program conducts special inspections of one and two family homes when a parent/guardian files a complaint because the landlord has not repaired peeling paint. As a result of these inspections, Commissioner's Orders to Abate can be issued and enforced.
- The Houston CLPPP staff is working on a plan to work with ClearCorps to receive referrals for homes that require hazard reduction.
- In Pennsylvania, the Commonwealth participates in and encourages participation in the "Lead-Safe Initiative" which brings together representatives of housing, environmental, social agencies, and others who focus on providing services to children and families in crisis and in adoptive and foster care. In Philadelphia, the city partners with community-based and other Government organizations to visit the homes of expectant and new mothers living in areas at high-risk for lead poisoning. These visits include an assessment of the home including dust-wipe sampling, as well as education and cleaning supplies for the mothers.

In 2003, all childhood lead poisoning prevention programs will need to address primary prevention.

**Q.6b.** How is CDC helping to keep new children from living in the same unsafe housing?

**A.6b.** CDC has developed a patient tracking and surveillance system for childhood lead poisoning. Health departments that use this software collect information on where a child lives, which allows the health department to identify addresses where multiple children/families have been found to have elevated blood-lead levels. CDC encourages its grantees to work with local housing officials to remediate the homes of children with elevated blood-lead levels.

**Q.7.** In your testimony you talked about the need for lead level reporting across all States that would help determine "hot spots." You went on to say that this type of data was being collected right now. Could you provide additional details about this effort including its time line for development and what types of information the system will eventually provide?

**A.7.** CDC is currently receiving blood-lead data for children from all the childhood lead poisoning prevention programs. CDC's new funding strategy for childhood lead poisoning prevention programs will include performance measures. One of the new performance measures will be a requirement that States require that *all* blood-lead levels be reported to the State health department in a timely manner.

**Q.8.** While abatement is essential in high-risk properties, in which cash flow is insufficient to support maintenance, most leaded properties can be made lead-safe through other strategies. Research and experience over the past decade has demonstrated the importance of visual inspection for peeling paint; lead-safe work practices to control, contain, and clean up lead dust in painting and remod-

eling projects; and clearance testing to ensure that lead dust hazards are not left behind. Do you believe that visual inspection, lead-safe work practices and clearance testing offer the potential to expand lead-safety to a broad enough scale to make U.S. housing lead-safe?

**A.8.** Yes, recent studies conducted for the Department of Housing and Urban Development (HUD) indicate that lead hazards can be controlled with visual inspection, lead-safe work practices, and clearance testing can expand lead-safety on a broad scale.

**Q.9.** While consistent data are not widely available, it is clear that in the majority of cases lead hazards are not corrected even after a child is identified as lead-poisoned. The same hazardous house often poisons multiple children as new families move in (that is, a Syracuse, New York, newspaper identified 47 houses that had poisoned multiple children in just 18 months). Even when health departments succeed in ordering repairs, in many States there is no oversight, no requirement for lead-safe work practices and no clearance testing. While no house should poison a child, it is simply unconscionable that any house should poison a second, third, and fourth child. What do you believe your Agency can do to help stop houses from poisoning more than one child?

**A.9.** It is essential for States to be able to identify lead hazards and ensure clean-up. With CDC funding, States have the capacity to identify the houses where more than one child has been poisoned. Health departments should then use this information to work with local housing authorities to assist with remediation and enforcement if landlords do not remediate.

**Q.10.** What does your Agency believe might be appropriate statutory changes to make the Federal disclosure law regarding lead more meaningful?

**A.10.** CDC believes that increasing community awareness particularly among renters and homeowners about the hazards of lead and how lead poisoning can be prevented is important.

**Q.11.** Many advocates and some health departments are convinced that ending childhood lead poisoning will require moving beyond screening children's blood-lead levels to actually screening high-risk housing to identify hazards before a child's health is harmed. What does your Agency think about this strategy? What about the idea of developing registries of hazardous properties?

**A.11.** CDC completely supports the strategy to move toward screening high-risk housing to identify hazards before a child's health is harmed. Nevertheless, CDC believes that an important component of the lead elimination strategy is screening for children with elevated blood-lead levels and offering medical and environmental interventions when appropriate. Registries of homes with hazards, as well as lead-safe homes should be a part of a comprehensive primary prevention strategy.

**Q.12.** Does your Agency believe that lead-based paint and dust hazards in housing are the overwhelming cause of childhood lead poisoning in the United States? If not, what other causes should Congress be looking at?

**A.12.** Lead-based house paint contaminates dust and soil and these sources are the most common high dose source of lead exposure for young children in this Nation. While there are other sources of lead exposure for young children, such as certain folk remedies, cultural cosmetics, and water, CDC believes that addressing leaded house paint will make a huge impact on protecting our Nation's children from the life-long affects on their health. Elimination will require identifying all potential sources of exposure for a child and making the environment lead-safe.

**Q.13a.** As a result of our hearing last November on lead poisoning, it was clear that primary prevention is an extremely important part of eliminating childhood lead poisoning. First of all, does your Agency support the goal of stopping children from being poisoned in the first place?

**A.13a.** CDC has been emphasizing the importance of preventing children from ever becoming lead-poisoned, since the publication of its 1991 document, *Preventing Lead Poisoning in Young Children*. CDC support of primary prevention is stressed in its 2002 document, *Managing Elevated Blood Lead Levels Among Young Children*.

**Q.13b.** If so, how is your Agency planning to achieve this goal?

**A.13b.** The CDC has already required grantees with the heaviest estimated burden, California, Illinois, Ohio, Pennsylvania, and Texas, to address primary prevention, but in 2003 all programs will be required to address primary prevention. Funding will help childhood lead poisoning prevention programs introduce more primary prevention activities. CDC will facilitate networking among programs, so grantees can learn from each others experiences. CDC will enhance its website to provide more information on existing and past primary prevention activities. As we increase primary prevention activities, we must remember that screening and case management must remain strong and effective. Primary prevention, screening and case management are critical to achieve our 2010 elimination goal.