State of New York
Office of the Attorney General
Health Care Bureau

Getting the Lead Out: Are New York's Managed Care Plans Complying with the State's Childhood Lead Screening Law?

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Health Care Bureau

The Health Care Bureau (HCB) is part of the Division of Public Advocacy in the Office of the New York State Attorney General. The HCB's principal mandate is to protect and advocate for the rights of health care consumers statewide, through:

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EXECUTIVE SUMMARY

The toxic legacy of lead paint continues to affect New York's children. In order to control lead poisoning, New York law requires health maintenance organizations, health care providers and certain health facilities to ensure that all children are screened, or referred for screening, for lead poisoning at the ages of 1 and 2. Yet, several Medicaid and Child Health Plus managed care plans in New York have consistently failed to adhere to the lead screening mandate. Additionally, the average statewide rate of compliance with the statute, as measured by the percentage of children in each plan screened for lead poisoning by age 2, has actually declined over the past three years among Medicaid plans and has remained stagnant for Child Health Plus plans. Medicaid and Child Health Plus plans, which are the focus of this inquiry, serve the population at greatest risk of exposure to lead in the home.

In this report, the Attorney General reviews the public policy behind the lead screening requirement and presents a Managed Care Childhood Lead Screening Compliance Profile, based upon health plan data reported to and published by the New York State Department of Health. The profile shows the plans that consistently screened for lead at a rate significantly below the statewide average, the plans that consistently performed significantly above average, and the plans that consistently performed at or near the average. Simultaneous with the release of this report, the Attorney General has written to the health plans to request that they provide specific information about their compliance with the state's lead screening mandate.

CHILDHOOD LEAD POISONING

Exposure: How and Who

Children are most commonly exposed to lead in the home through lead-based paint.[1] Although the sale and manufacture of lead-based paint was banned by Congress in 1978 (lead-based paint in subsidized housing was banned in 1970), many older homes still contain lead-based paint.[2] When disturbed, either through chipping, wear or renovations, lead is released into a child's environment through lead paint chips or dust containing lead.[3]

The Centers for Disease Control and Prevention (CDC) estimates that 2.2% of children in the United States under 5 years of age, or approximately 434,000 children, currently have lead poisoning, which is defined as levels of lead in their blood that exceed the acceptable threshold of 10 micrograms per deciliter (μg/dL) set by the CDC. [4] Elevated blood lead levels are disproportionately higher in low-income minority urban populations living in older, poorly-maintained housing: 5.4% of children in urban centers, 8% of low-income children and 11.2% of African-American children have lead levels in their blood that exceed the acceptable CDC threshold.[5] The greatest percentage of lead-poisoned children, 21.9%, occurs among African-American children living in pre-1946 housing.[6]

These disparities are particularly pronounced in New York. 95% of lead-poisoned children in New York City in 2001 were African-American, Hispanic or Asian.[7] African-American children make up 29% of the New York City population under 18, but represent 42% of the children with elevated blood lead levels.[8] Caucasian children constitute 23% of New York City children, but comprise just 5% of children with elevated blood lead levels. [9]

In Monroe County, which includes the City of Rochester, 90% of children referred to the County Department of Health between 1995 and 1999 for environmental lead management in the home due to high blood lead levels were children of families on public assistance.[10] (All children found to have elevated blood lead levels over 20 μg/dL are referred to county health departments for environmental lead management in the home.) Additionally, 95% of lead-poisoned children in Monroe County were from the City of Rochester,[11] which correlated statistically with more poverty, greater prevalence of poor housing conditions and older housing stock.[12]

Health Effects of Lead Poisoning

Lead-poisoned children can experience a variety of deleterious physical, mental, behavioral and social effects that can last well into adulthood, depending on the severity of the poisoning and the point at which it is detected and treated. Because lead directly affects the neuro-cognitive system, the most prevalent effects of lead poisoning at moderate blood lead levels (10-25 μg/dL) can be impaired mental capacity, learning disabilities, behavioral problems, growth delays and hearing loss.[13]

Lead poisoning has been directly tied to a decline in IQ scores of 2.5 to 3.0 points for every incremental increase of 10 μg/dL of lead in the blood (or 0.25 to 0.30 IQ points per 1 μg/dL).[14] Although the CDC considers a child with a blood lead level at or above 10 μg/dL to be lead-poisoned for regulatory purposes,[15] recent research suggests that impaired intelligence resulting in reduced IQ scores is found even at levels below 10 μg/dL.[16] Indeed, one researcher found that the neurological damage caused by an increase of blood lead level from 0 to 10 μg/dL results in an average IQ drop of 7.4 points, which is nearly three times the

estimated IQ deficits for the same incremental increases over the CDC "safe" level of 10 μg/dL.[17]

When blood lead levels remain elevated for a prolonged period of time in young children, brain damage and IQ loss can become permanent and irreversible. At higher blood lead levels (over 25 μg/dL), lead poisoning can cause anemia, kidney malfunction, osteoporosis, hypertension (high blood pressure) and, in some severe cases, encephalopathy (disruption of normal brain functioning).[18]

While the health effects of lead poisoning on children and the trauma to their families are certainly of paramount concern, the economic costs to society, including medical care, rehabilitative care and remedial education, are also significant. Nationally, the annual cost of disease related to childhood lead poisoning is estimated at $43.4 billion.[19]

Based on a national cost estimate methodology,[20] direct medical care costs resulting from lead poisoning in New York State comprise a significant portion of lead-related costs, amounting to an estimated $3 million annually.[21] Since many lead-poisoned children receive health care through Medicaid or Child Health Plus (CHP), these health care costs are borne largely by the state's taxpayers.

Researchers at the University of Rochester estimated that 20% of children nationwide with blood lead levels over 25 μg/dL require special education for three years to address neurological impairment.[22] In New York State, special education costs for such children, including remedial reading, psychological testing and other specialized care, total an estimated $7.7 million.[23] These services are generally provided by local school districts, which rely on local school taxes. The outlay can be significant for already fiscally strained urban school districts, where the problem is most pronounced.

Lead Screening

Importance of Early Detection

Younger children are most vulnerable to neurological damage from lead poisoning because their nervous systems are in a critical stage of development in which brain cells are still making important neurobiological connections.[24] Additionally, their body weight results in a greater proportional absorption of lead in the blood.[25] Because pre-school children do not typically exhibit any overt symptoms of lead poisoning, reading, attention, behavioral and motor coordination impairments may not become obvious until they attend school.[26] For this reason, many states, including New York, require children to be tested for lead during their pre-school years.[27]

Early detection of lead poisoning through routine screening allows treatment to begin before more severe and irreversible damage is done. Treatment involves eliminating further exposure to lead in the home and removing lead from the body.[28] At low blood lead levels, lead poisoning can be treated with dietary modifications and nutritional counseling. For example, a child's diet can be supplemented with foods high in iron and calcium, two minerals that help cleanse the body of lead. At higher levels of lead poisoning, a child may need to undergo chelation therapy, i.e., the use of oral or intravenous drugs that bind with the lead and allow it to pass through the urine.[29]

Lead Screening in New York State

In 1992, New York State enacted a comprehensive lead screening law that states:

> Every physician or other authorized practitioner who provides medical care to children or pregnant women, shall screen children or refer them for screening for elevated blood lead levels at the intervals and using the methods specified in such

> regulations. Every licensed, registered or approved health care facility serving children including but not limited to hospitals, clinics and health maintenance organizations, shall ensure, by providing screenings or by referring for screenings, that their patients receive screening for lead at the intervals and using the methods specified in such regulations.[30]

As noted above, early detection of lead allows treatment to begin before more severe and irreversible damage is done. Therefore, New York State Department of Health (NYSDOH) regulations require screening of all children for elevated blood lead levels at age 1 and 2, preferably as part of routine well-child care visits.[31] If a child's blood lead level exceeds the CDC threshold, steps must be taken to address the child's condition and, if necessary, abate the lead contamination in the home.[32]

Medicaid and CHP managed care plans, as well as commercial managed care plans, are required to submit statistics to NYSDOH documenting the number of children screened each year by the plan for lead poisoning by age 2 compared with the total number of children age 2 or younger enrolled in the plan.[33] Lead screening statistics for each plan are reported as a rate, for example, the percentage of enrolled children who were screened for lead poisoning by age 2. Statewide averages for lead screening are also calculated each year to determine which plans are performing significantly below, significantly above or near average for each year.[34] The Attorney General's Health Care Bureau has relied on these reports to evaluate plan compliance with the lead screening mandate.[35]

Based on figures from the NYSDOH Managed Care Plan Performance Reports from 2000 to 2002, the Health Care Bureau has developed a Managed Care Childhood Lead Screening Compliance Profile that shows: (i) the plans that consistently screened for lead at a rate significantly below the statewide averages; (ii) those plans that consistently performed

significantly above the statewide averages; and (iii) those that consistently performed at or near the statewide averages.[36] (See Appendix A.)

The Compliance Profile demonstrates that overall average lead screening rates have declined for Medicaid plans and remained stagnant for CHP plans for the past three years. Among Medicaid plans, average screening rates were 76% in 2000 and 2001, and then declined to 74% in 2002. Similarly, average CHP plan screening rates were 68% in 2000, 70% in 2001, and then declined to 68% in 2002.[37]

Several health plans have consistently reported lead screening rates significantly above the statewide averages; namely, Buffalo Community Health (Medicaid and CHP), Community Premier Plus (Medicaid and CHP), Excellus-Rochester (Medicaid), MetroPlus (Medicaid and CHP), New York-Presbyterian CHP (Medicaid and CHP), Preferred Care (Medicaid) and Suffolk Health Plan (Medicaid). (See Table 1 below.)

Table 1

❖ TOP PERFORMERS (2000 - 2002) ❖						
Plan	**2002**		**2001**		**2000**	
STATEWIDE AVERAGE	**Med. 74**	**CHP 68**	**Med. 76**	**CHP 70**	**Med. 76**	**CHP 68**
Buffalo Community Health (Med. & CHP)	**88**	**81**	**88**	**84**	**83**	**82**
Community Premier Plus (Medicaid & CHP)	**86**	**83**	**86**	**79**	**86**	**80**
Excellus-Rochester (Medicaid)	**80**		**88**		**88**	
Metro Plus (Medicaid & CHP)	**86**	**85**	**88**	**80**	**86**	**83**
NY Presbyterian CHP (Medicaid)	**82**		**86**		**82**	
Preferred Care (Medicaid)	**81**		**80**		**83**	
Suffolk Health Plan (Medicaid)	**86**		**90**		**87**	

At the other end of the spectrum, some plans have regularly performed significantly below average; namely, ABC Health Plan (Medicaid), BSNENY-Health Now (Medicaid), Community Blue (Medicaid), Community Choice (Medicaid), Empire BC and BS (CHP), Health First (CHP), HIP (Medicaid and CHP), United HealthCare (Medicaid), Vytra Health Plans (Medicaid) and WellCare (Medicaid and CHP). (See Table 2 below).

Table 2

❖ LOW PERFORMERS (2000 - 2002) ❖

Plan	2002		2001		2000	
STATEWIDE AVERAGE	**Med. 74**	**CHP 68**	**Med. 76**	**CHP 70**	**Med. 76**	**CHP 68**
ABC Health Plan (Medicaid)	62		63		72	
BSNENY (HealthNow) (Medicaid)	65		58		N/A	
Community Blue (Medicaid)	68		70		74	
Community Choice (Medicaid)	64		63		66	
Empire (BC & BS) (CHP)*		65 *		65		60
Health First (CHP)		62		55		60
HIP (Medicaid & CHP)*	67	65 *	66	63	72	63
United HealthCare (Medicaid)**	63 **					
UHC - NYC (Medicaid)	**		39		63	
UHC - Upstate NY (Medicaid)	**		46		79	
Vytra Health Plans (Medicaid)	62		55		60	
WellCare (Medicaid & CHP)	56	47	61	62	58	59

* Although Empire and HIP's CHP lead screening rates were only slightly below average in 2002, they rated significantly below average in the two prior years.
**United HealthCare-New York City and United HealthCare-Upstate merged into one entity, United HealthCare of New York, and began reporting as such in 2002.

The expansion of health care coverage to high-risk populations through Medicaid and CHP managed care plans, which promote early detection of illness and preventive medicine, presents an increased opportunity to screen for lead poisoning at an early age. Indeed, among Medicaid managed care plans in New York, the rate of well-child visits (rated as more than five before 15 months), at which lead screening should take place,

has risen over the past three years from 55% to 72% - a dramatic 30% increase.[38] In contrast, Medicaid lead screening rates have actually declined from 76% to 74% during that same period. This may indicate that the plans are not taking advantage of the increased opportunity to screen for lead at well-child visits, even though NYSDOH regulations state that it is "preferable" that lead screening occur during these visits.

The patchwork of compliance with the lead screening mandate suggests that many high-risk children are at an unnecessary risk of lead poisoning because they are not being screened and treated at an early age. Additionally, the wide disparity of screening rates among plans within the same region creates a situation in which the chances of a child being screened for lead early are dependent upon the plan in which the family chose to enroll. For example, both MetroPlus and WellCare include New York City in their service areas, yet MetroPlus reported some of the highest lead screening rates, while WellCare demonstrated among the lowest.[39] This dangerous inequity leaves a child's health to the luck of the draw.

The Attorney General's Inquiry

The Attorney General's office has previously addressed the issue of childhood lead poisoning in a variety of contexts.[40] This report demonstrates that average statewide lead screening rates have dropped over the past three years among New York's Medicaid managed care plans and have remained stagnant for Child Health Plus plans. Furthermore, a number of plans have consistently reported lead screening rates significantly below the statewide average, thus placing children at greater risk that lead poisoning may not be detected until significant, and possibly permanent, harm has been done.

Consequently, with release of this report, the Attorney General's Health Care Bureau has sent letters to each of the managed care plans to request that they provide specific information about their compliance with the state's lead screening mandate. This inquiry is designed not only to determine whether there is non-compliance with the state mandate, but also to identify specific strategies that the consistently high-performing plans employ to promote effective lead screening efforts.

MANAGED CARE CHILDHOOD LEAD SCREENING COMPLIANCE PROFILE
(MEDICAID AND CHILD HEALTH PLUS PLANS • 2000 - 2002)

Plan	2002		2001		2000	
STATEWIDE AVERAGE	Med. 74	CHP 68	Med. 76	CHP 70	Med. 76	CHP 68
ABC Health Plan	62↓	N/A	63↓	N/A	72	N/A
Affinity	79↑	66	78	72	N/A	N/A
AmeriChoice	77	N/A	67↓	N/A	65↓	N/A
BSNENY (Health Now)	65↓	65	58↓	69	N/A	70
Buffalo Community Health	88↑	81↑	88↑	84↑	83↑	82↑
Care Plus Health Plan	73	67	80	67	79	77
CDPHP	71	69	68↓	64	67↓	62
CenterCare	70	72	82↑	74	75	70
Community Blue	68↓	70	70↓	69	74	70
Community Choice	64↓	71	63↓	81↑	66↓	70
Community Premier Plus	86↑	83↑	86↑	79↑	86↑	80↑
Empire (BCBS)	N/A	65	N/A	65↓	N/A	60↓
Excellus-Rochester (Blue Choice Option)	80↑	66	88↑	69	88↑	58↓
Fidelis Care New York	78	69	77	73	79	70
Health Plus	76	71	89↑	79↑	79	66
Health First	68↓	62↓	73	55↓	76	60↓
Health Source/HHP	79↑	79↑	70↓	74	73	N/A
HIP	67↓	65	66↓	63↓	72	63↓
IHA/MediSource (Buffalo)	76	N/A	62↓	N/A	70↓	N/A
MetroPlus	86↑	85↑	88↑	80↑	86↑	83↑
Neighborhood Health Providers	76	70	76	68	82↑	73↑
New York Presbyterian CHP	82↑	87↑	86↑	68	82↑	78↑
Partners in Health	76	N/A	85↑	N/A	69↓	N/A
Preferred Care	81↑	N/A	80	N/A	83↑	N/A
Suffolk Health Plan	86↑	68	90↑	89↑	87↑	81↑
Total Care	78	70	79	76	76	77
United Health Care of New York	63↓*	62↓*				
• UHC - NYC	N/A	N/A	39↓	73	63↓	48↓
• UHC - Upstate	N/A	N/A	46↓	71	79	72
Vytra Health Plans	62↓	N/A	55↓	N/A	60↓	N/A
WellCare	56↓	47↓	61↓	62↓	58↓	59↓

↓ Significantly below average.

↑ Significantly above average.

* United Health Care-New York City and United Health Care-Upstate merged into one entity, United Health Care of New York, and began reporting as such in 2002.

ENDNOTES

1. *Second National Report on Human Exposure to Environmental Chemicals*, CDC, January 31, 2003.

Children can also be exposed to lead through exposure to lead-contaminated soil or dust inside or outside the home.

2. CDC, "Surveillance for Elevated Blood Lead Levels Among Children - United States, 1997-2001", *Morbidity and Mortality Weekly Report*, Vol. 52, No. SS-10. See also, Lanphear, Bruce P., MD, MPH, "Community Characteristics Associated with Elevated Blood Lead Levels in Children," *Pediatrics*, Vol. 101, No. 2, February 1998.

3. Levy, Barry S., MD, MPH, "Protecting Children From Lead Poisoning and Building Healthy Communities," *American Journal of Public Health*, Vol. 89, No. 6, June 1999.

4. CDC, "Surveillance for Elevated Blood Lead Levels Among Children - United States, 1997-2001", *Morbidity and Mortality Weekly Report*, Vol. 52, SS-10, September 12, 2003.

Blood lead levels are measured in micrograms per deciliter, or μg/dL. Each increment of 1 μg/dL translated into one millionth of a gram of lead in one tenth of a liter of fluid. The CDC considers a blood lead level below 10 μg/dL to be safe.

Lead screening and lead abatement has been successful at decreasing the rate at which children are exposed to and poisoned by lead. In the past quarter century, mean blood lead levels of U.S. children fell 80%, and the overall number of U.S. children with elevated blood lead levels dropped by 90%, primarily due to the elimination of lead from gasoline, lead paint products and metal food containers. [Levy, Barry, MD, MPH et al., "Protecting Children from Lead Poisoning and Building Healthy Communities," *American Journal of Public Health*, Vol. 89, No. 6, June, 1999] In New York State, the rate of lead-poisoned children declined to 5.8% in 1999, a 36% decrease over the previous four years. And New York City experienced a 51% decrease from 1996-2000. [*Protecting Our Children From Lead: The Success of New York's Efforts to Prevent Childhood Lead Poisoning*, New York State Department of Health, 2001.]

5. CDC, "Update: Blood Lead Levels - United States, 1991-1994 ," *Morbidity and Mortality Weekly Repor*t, Vol. 46, No. 7, February 21, 1997.

The same ethnic and income delineations provided in this report are not available in the more recent CDC publication provided in the previous endnote.

6. *Ibid.*

7. New York City Department of Health and Mental Hygiene, "Preventing Lead Poisoning in New York City," *Annual Report*, 2001.

8. *Ibid*.

9. *Ibid.*

10. "Lead Poisoning Among Young Children in Monroe County: A Needs Assessment, Projection, Model and Next Steps," May 2002. Prepared for the Monroe County Department of Health by CGR, Inc. (accessed at www.Monroecounty.gov).

11. Lanphear, Bruce P., MD, MPH, et al., "Community Characteristics Associated with Elevated Blood Lead Levels in Children," *Pediatrics*, Vol. 101, No. 2, February 1998.

12. *Ibid.*

13. Lanphear, Bruce P., MD, MPH, "The Paradox of Lead Poisoning Prevention," *Science*, 281 (5383): 1617; Weitzman, Michael, MD, "Childhood Lead Poisoning and Managed Care," *Journal of Public Health Management and Practice*, Vol. 4, No. 1, January 1998.

14. Lanphear, Bruce P., MD, MPH et al., "Lead Contaminated House Dust and Urban Children's Blood Lead Levels," *American Journal of Public Health*, Vol. 86, No. 10, October 1996.

15. Prior to 1970, the acceptable blood lead level set by the CDC was 70 μg/dL, a level at which serious, irreversible damage, and even death, can occur. As a result of medical research on the health effects of lead poisoning in the ensuing decades, the CDC successively lowered the acceptable blood lead level to 40 μg/dL in 1970, 30 μg/dL in 1975, 25 μg/dL in 1985 and the current level of 10 μg/dL in 1991.

16. Lanphear, Bruce P. et al., "Intellectual Impairment in Children with Blood Concentrations Below 10 μg per Deciliter," *New England Journal of Medicine*, Vol. 348: 1527-1526, No. 16, 2003. See also, EPA, "America's Children and the Environment: Measures of Contaminants, Body Burdens, and Illness," 2003.

This has sparked a debate at the CDC over the possible need to review the scientific data and yet again lower the acceptable level, this time to 5 μg/dL. In the meantime, the Rochester Lead Coalition has spearheaded the "strive for five" campaign to keep blood lead levels below 5 μg/dL, while stating that no level of lead poisoning should be considered fully safe.

17. *Ibid.*

18. CDC, "Second National Report on Human Exposure to Environmental Chemicals," (January 31, 2003). See also CDC, 2003, *Morbidity and Mortality Weekly Update*, Vol. 52, No. SS-10.

19. Landrigan, P.J., et al. (2002) "Environmental Pollutants and Disease in American Children: Estimates of Morbidity, Mortality and Costs for Lead Poisoning, Asthma, Cancer and Developmental Disabilities," *Environmental Health Perspectives*, 110(7) 721-728.

20. *Ibid*. See also Grosse, Scott D., (2002), "Economic Gains Resulting From the Reduction in Childrens' Exposure to Lead in the United States," *Environmental Health Perspectives*, 110(6), 563-569.

21. Korfmacher, Katrine Smith, Ph.D., University of Rochester, Environmental Health Sciences Center, "Long-Term Costs of Lead Poisoning: How Much Can New York Save by Stopping Lead?" citing to Schwartz, Joel, "Societal Benefits of Reducing Lead Exposure," *Environmental Research*, 66: 105-124 (accessed at www.leadfreerochester.org).

22. *Ibid.*

23. *Ibid.*

24. CDC, "Surveillance for Elevated Blood Lead Levels Among Children - United States, 1997-2001," *Morbidity and Mortality Weekly Report*, Vol. 52, No. SS-10, 2003. See also, EPA, "America's Children and the Environment," 2003; and Landrigan, Philip, et al., "Environment Pollutants and Disease in American Children," *Environmental Health Perspectives*, July 2002, Vol. 110, No. 7.

25. *Ibid.*

26. Weitzman, Michael, MD, "Childhood Lead Poisoning and Managed Care," *Journal of Public Health Management and Practice,* January, 1998, Vol. 4, No. 1

NYSDOH regulations require licensed child care providers, nursery schools and pre-schools to obtain a certificate of lead screening for each enrolled child between the age of 1 and 6. However, the child cannot be excluded from such care and schooling due to a lack of a certificate of lead screening. In such instances, the provider or school must provide the parent with information on lead poisoning and refer the parent to the child's primary care provider to obtain a blood lead test. Because many children do not enroll in such care prior to the age of 2, and early detection and treatment are so crucial, universal screening by health care providers, health maintenance organizations and other health care facilities is mandated by age 2. [Title 10, NYCRR, Part 67, Subpart 67-1.4]

27. Pursuant to 10 NYCRR 67-1.3, the two accepted methods for lead screening are the fingerstick and venous (venipuncture) blood tests; the former being quicker, cheaper and less invasive, and the latter being more expensive and invasive, but more accurate. The fingerstick test is less accurate because it can result in more false positives, i.e. a detection of lead poisoning when no poisoning exists. Thus, a positive fingerstick test is followed by a venous test to verify the results. But neither test will generally miss the presence of lead poisoning with a false negative.

28. Merck Manual of Medical Information (Second Home Edition), Mark H. Beers, MD, Editor-in-Chief (2003).

29. *Ibid*.

30. New York State Public Health Law §1373-c

31. Title 10, NYCRR, Part 67, Subpart 67-1.2(a)

32. Title 10 NYCRR Part 67, Subparts 67-1 and 67-2.

When a child tests at a moderate level of lead poisoning (10-19 µg/dL), the physician must provide risk reduction education and nutritional counseling (certain dietary deficiencies can lead a child's body to absorb more lead). When a blood lead level exceeds 20 µg/dL, diagnostic evaluation and medical treatment, if necessary, must be conducted and the case must be reported to the New York State Department of Health ("NYSDOH") or the local health departments and the child's home must be inspected for lead contamination. If the home is found to be contaminated, certain lead abatement steps must be taken to significantly reduce or completely eliminate the risk to children of any further exposure to lead.

33. New York State Department of Health Quality Assurance Reporting Requirements ("QARR"). State Medicaid and CHP contracts also require QARR reporting.

34. It should be noted that neither the statute nor the regulations measure compliance in relation to the statewide averages, but rather require universal screening by age 2. The statewide averages are simply a measure of a plan's performance in relation to its competitors.

35. Although NYSDOH regulations specify that screening should take place at or around the ages of 1 and 2, NYSDOH Managed Care Plan Performed Reports report only the percentage of 2 year-olds that had a blood test for lead.

36. Statistics for each year were reported in the following year's report - e.g., 2002 numbers were reported in the 2003 report.

37. Lead screening rates among Medicaid managed care plans increased from 64% in 1994 to 70% in 1998. [Managed Care Plan Performance Reports, 1994 and 1998, New York State Department of Health] Screening rates among all payers for children born between 1994 and 1997 under age 2 remained steady at approximately 62%. [Protecting our Children From Lead: The Success of New York's Efforts to Prevent Childhood Lead Poisoning, New York State Department of Health, 2001]

38. Managed Care Plan Performance Reports, 1998-2002.

39. WellCare's low numbers date back over a decade to the first NYSDOH Managed Care Performance Report in 1994, in which WellCare reported a 46% lead screening rate - 18% below the statewide average of 64% for that year.

40. Attorney General Spitzer led a multi-state effort that ultimately resulted in paint manufacturers agreeing in 2003 to place warning labels on all paint products explaining the risks of disturbing and preparing lead-contaminated surfaces.

In 2003, the Attorney General filed an *amicus curiae* brief in the case of New York City Coalition to End Lead Poisoning v. Vallone, 100 N.Y.2d 337 (2003), arguing successfully that the City Council did not properly consider the environmental impact of New York City Local Law 38 - a weak lead abatement law which lead advocates opposed - during its review and passage, in violation of the State Environmental Quality Review Act ("SEQRA").