FISCAL IMPACT REPORT

SPONSOR	House Consumer and Public Affairs Committee	**LAST UPDATED**	02/21/2025
		ORIGINAL DATE	02/17/2025
SHORT TITLE	Congenital Heart Disease Tests for Infants	**BILL NUMBER**	CS/House Bill 76/HCPACS
		ANALYST	Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT* **
(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Medicaid	**No fiscal impact**	**Up to $3,718.0**	**Up to $3,718.0**	**Up to $7,436.0**	Recurring	General Fund
Medicaid	**No fiscal impact**	**Up to $13,182.0**	**Up to $13,182.0**	**Up to $26,364.0**	Recurring	Federal Funds
Total	**No fiscal impact**	**Up to $16,900.0**	**Up to $16,900.0**	**Up to $33,800.0**	Recurring	General Fund

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect the most recent analysis of this legislation
** Amounts quoted refer to initial estimates for the original bill; there has not been time to determine what the cost for this slightly scaled-down bill would be.

Sources of Information

LFC Files

Agency Analysis Received From
Health Care Authority (HCA)
University of New Mexico Health Sciences Center (UNM-HSC)
Department of Health (DOH)
Note: these agencies responded with respect to the original bill; only UNM-HSC has had time to revise its response to evaluate the committee substitute version of the bill.

SUMMARY

Synopsis of HCPAC Substitute for House Bill 76

The House Consumer and Public Affairs Committee substitute for House Bill 76 (HB76) adds electrocardiography (EKG) and echocardiography (echo), an ultrasound of the heart, to the list of conditions included in Section 24-1-6 NMSA 1978 for which newborn infants are to be screened by birth hospitals and institutions. House Bill 76 adds language to require the use of an echo or EKG with any of the following risk factors:

- Family history of congenital heart disease or history of heart operations in early life,
- Biological parent report of unexplained seizures or syncope,
- Biological parent report of chest pain or shortness of breath with exercise,
- Family relationship with someone who has died of heart disease or sudden death before age 50,
- Sudden infant death syndrome,

- First-degree relative with history of implantation of a defibrillator at less than 50 years of age,
- First-degree relative with cardiomyopathy or Marfan or Loeys-Dietz syndrome,
- First-degree relative with heritable pulmonary arterial hypertension

DOH would be tasked with devising a questionnaire regarding these problems/diseases, to be administered by birth hospitals or newborn nursery attending physicians, who would, on the basis of the answers, determine if further evaluation was needed. Birth hospitals without the facilities to do the necessary tests would need to refer for those tests to be done after the child is discharged.

In addition, the bill would require the Department of Health to consider recommendations of the New Mexico Pediatric Society (NMPS), the American Society of Echocardiography, and the American Academy of Pediatrics (AAP) in adding other conditions to be screened for. The NMPS is the New Mexico subunit of the AAP.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns if enacted, or June 20, 2025.

FISCAL IMPLICATIONS

The major cost associated with adoption of this legislation would be for echocardiograms and EKGs. The average cost of an echo is $1,500; EKGs' average cost is $500. With the revised criteria for testing contained in the committee substitute, it is unclear how many infants would need additional testing; this would be determined by individual health care providers based on their best knowledge of the risks of critical congenital heart disease based on family history.

If both an echocardiogram and EKG were required to be done on all newborns with a family history, and if 53 percent of all infants had a family history of heart disease, of the 20,951 New Mexico births in 2023, a minimum of 11,104 would require screening, at a cost of $22 million. According to a 2022 LFC evaluation of the Medicaid network, about 77 percent of births in New Mexico in 2021 were covered by Medicaid, resulting in a cost for screening that proportion of newborns of $16.9 million. With current matching, the share of the Medicaid cost that would be borne by the state is 22 percent, or $3.7 million. It is likely that considerably fewer than 53 percent of infants would meet the revised criteria, so the costs in the table above will need to be revised down when DOH, the University of New Mexico Health Sciences Center (UNM-HSC), and HCA have an opportunity to review the revised criteria.

Private insurers and their customers would also face additional birthing costs, but some cases of critical congenital heart disease might be detected before they were acutely dangerous, potentially saving costs.

UNM-HSC states:

> Feedback from New Mexico's pediatric cardiology community indicates strong opposition to both the original and substitute bills. They also note that the American Academy of Pediatrics and the American College of Cardiology have voiced opposition to both versions of this legislation.

SIGNIFICANT ISSUES

The list of required newborn screenings began with phenylketonuria and was expanded to include many other congenital metabolic diseases by legislation passed in 2005 and 2010. Oximetry was added in 2014 to screen for congenital heart and lung diseases.

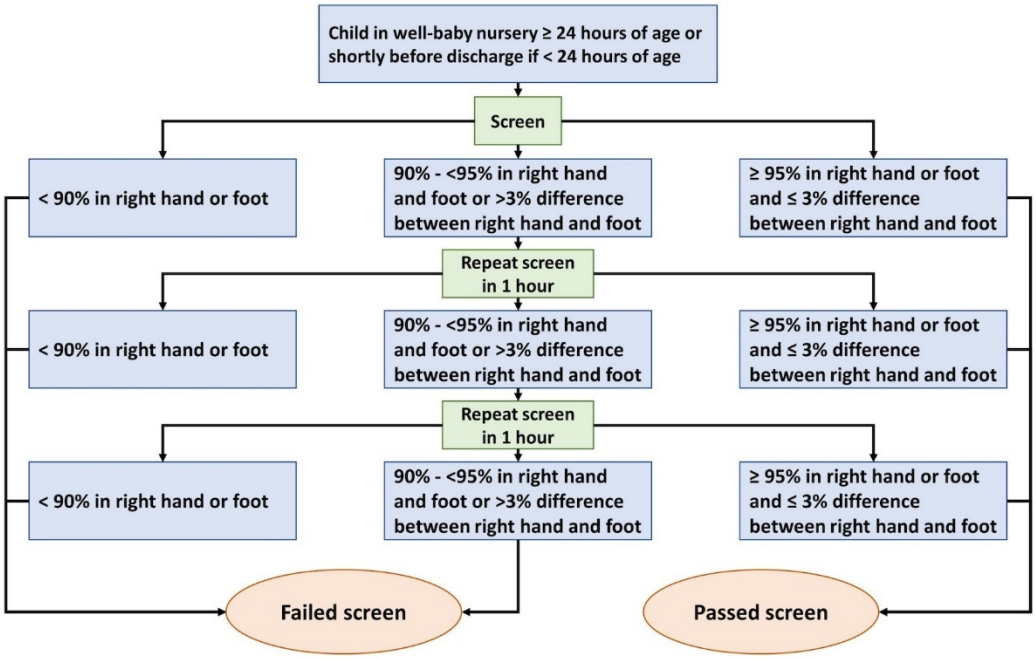
In a comprehensive article about risk for congenital heart disease from Cincinnati Children's Hospital,[1] researchers delineate the increased risk for congenital heart disease for a newborn whose parents or siblings have congenital heart disease:

> In the general population, about 1 percent of all children are born with congenital heart disease. However, the risk increases when either parent has congenital heart disease (CHD), or when another sibling was born with CHD.
>
> Consider the following statistics:
>
> - If you have had one child with congenital heart disease, the chance that another child will be born with CHD ranges from 1.5 percent to 5 percent, depending on the type of CHD in the first child.
> - If you have had two children with CHD, then the risk increases to 5 percent to 10 percent to have another child with CHD.
> - If the mother has CHD, the risk for a child to be born with CHD ranges from 2.5 percent to 18 percent, with an average risk of 6.7 percent.
> - If the father has CHD, the risk for a child to be born with CHD ranges from 1.5 percent to 3 percent.
> - Congenital heart defects involving obstructions to blood flow in the left side of the heart have a higher rate of reoccurrence than other heart defects.
> - If another child is born with CHD, it can be a different type of defect than seen in the first child.

In a January 2025 policy statement, the Centers for Disease Control and Prevention (CDC) recommend oximetry (determination of the blood oxygen content) for all newborns prior to hospital discharge,[2] indicating that use of this technique would detect some 98 percent of critical congenital heart disease and result in saving about 120 deaths per year in the United States due to CHD. The CDC algorithm for this procedure follows:

[1] https://www.cincinnatichildrens.org/health/c/factors-chd#:~:text=Family%20History%20and%20CHD&text=If%20you%20have%20had%20one,CHD%20in%20the%20first%20child

[2] https://www.cdc.gov/heart-defects/hcp/screening/index.html



Where the child fails the screen, CDC recommends an echocardiogram. Neither CDC nor the American Academy of Pediatrics (see https://www.aap.org/en/patient-care/congenital-heart-defects/newborn-screening-for-critical-congenital-heart-defect-cchd/) recommend an EKG, and neither recommend screening other than oximetry for infants whose family history indicates adult-onset heart disease.

The Department of Health points out that no specialty society recommends a broad application of these more expensive and time-consuming tests of cardiac function and structure to all of those even in the smaller, revised list of conditions for which the questionnaire might be positive.

The University of New Mexico-Health Sciences Center (UNM-HSC) initially estimated a large proportion of births where family history would necessitate EKG and an echo before or shortly after hospital discharge: Both UNM HSC and DOH agreed that the initial criteria for requiring an EKG and echo were too broad and would have resulted in high costs and delay in discharge for many infants who would not have been likely to benefit from the added tests. Neither DOH nor UNM HSC has had an opportunity to comment on the revised criteria.

While the original bill required hospitals to do both echocardiogram and EKG on all infants who met the inclusive criteria specified, the current substitute requires that a questionnaire be evaluated by a health care provider who would then decide if one or both of these additional tests would be warranted. Oximetry, on the other hand, is required on all infants, and as noted above, would be likely to discover all but two percent of critical congenital heart disease.

In 2014, the state law on newborn screening added a requirement for oximetry testing for all newborns; and 2010 HB201, which amended 2004 HB479. Both bills added to the tests required to be done on all newborns in the state.

LAC/rl/hg