Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 626 (Smallwood-Cuevas) – As Amended May 5, 2025

SENATE VOTE: 38-0

SUBJECT: Perinatal health screenings and treatment.

SUMMARY: Revises an existing requirement on health plans and insurers relating to maternal mental health (MMH) screenings to require case management and care coordination and guidelines and standards appropriate to the provider's license, training, and scope of practice, as specified. Encourages health plans and insurers to provide coverage for at least one medication approved by the United States Food and Drug Administration (FDA) for perinatal mental health (PMH) and for at least one FDA-approved digital therapeutic for perinatal mental health. Specifically, **this bill**:

1) Revises the name of the MMH program to "perinatal mental health program" that requires PMH screening during the pregnancy and during the postpartum period and perinatal periods in accordance with applicable clinical guidelines or standards appropriate to the provider's license, training, and scope of practices.

2) Requires guidelines and standards pursuant to 1) above to be guidelines adopted by the American College of Obstetricians and Gynecologist (ACOG), unless those guidelines do not align with the provider's scope of practices. If not, permits the guidelines or standards to include, but not be limited to, guidelines or standards adopted by other recognized professional bodies. Indicates this does not expand or alter a licensed provider's existing scope of practice.

3) Requires health plans and insurers to provide case management and care coordination during the perinatal period, annually report to the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) on the utilization and outcomes of case management services; and, publicly post the information reported to DMHC and CDI on the plan's or insurer's website.

4) Encourages health plans and insurers as part of their PMH programs to provide coverage for medication approved by the FDA for PMH and FDA-approved digital therapeutics for perinatal mental health.

5) Prohibits this bill from being construed to limit access to additional treatment options for PMH.

6) Requires a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose, and treat the patient for a PMH condition in accordance with applicable clinical guidelines or standards appropriate to the provider's license, training, and scope of practice.

7) Requires guidelines and standards pursuant to 6) above to be guidelines adopted by ACOG, unless those guidelines do not align with the provider's scope of practices. If not, permits the

guidelines or standards to include, but not be limited to, guidelines or standards adopted by other recognized professional bodies. States that this bill does not expand or alter a licensed provider's existing scope of practice.

8) Specifies that 7) above does not do any of the following:

   a) Require a health care practitioner to act outside the standard of care as defined by their relevant licensing board;

   b) Require adherence to specific clinical guidelines if those guidelines are inconsistent with the practitioner's standard of care or scope of practice;

   c) Limit the authority of a licensing board to determine whether a practitioner has met the standard of care in disciplinary proceedings; or,

   d) Prevent a licensed midwife from referring a patient to a physician in accordance with existing law when a condition exceeds their scope of practice.

9) Defines "perinatal mental health" to mean a mental health condition that occurs during pregnancy, the postpartum period, or the perinatal period and includes, but is not limited to, postpartum or perinatal depression.

EXISTING LAW:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Services Plan Act of 1975 and CDI to regulate health and other insurers; and the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low-income individuals are eligible for medical coverage. [Health and Safety Code (HSC) § 1340 *et seq*., Insurance Code (INS) § 106 *et seq*., and Welfare and Institutions Code (WIC) § 14000 *et seq*.]

2) Requires a health plan, including a Medi-Cal managed care plan, or insurer to develop a MMH program designed to promote quality and cost-effective outcomes. Requires the program to consist of at least one MMH screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider. [HSC § 1367.625 and INS § 10123.867]

3) Requires the MMH program to be developed consistent with sound clinical principles and processes, and include quality measures to encourage screening, diagnosis, treatment, and referral. Requires the MMH program guidelines and criteria to be provided to relevant medical providers, including all contracting obstetric providers. As part of a MMH program the health plan or insurer is encouraged to improve screening, treatment, and referral to MMH services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and, educate enrollees about the program. [HSC § 1367.625 and INS § 10123.867]

4) Defines contracting obstetric provider to mean an individual who is certified or licensed pursuant law, as specified, or an initiative act, as specified, and who is contracted with the

health plan or insurer to provide services under the contract or policy. [HSC § 1367.625 and INS § 10123.867]

5) Defines MMH as a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression. [HSC § 1367.625 and INS § 10123.867]

6) Requires a licensed health care practitioner who provides prenatal, postpartum, or interpregnancy care for a patient to ensure that the mother is offered screening or is appropriately screened for MMH conditions, except when providing emergency services. Defines "health care practitioner" as a physician, naturopathic doctor, nurse practitioner, physician assistant, nurse midwife, or a licensed midwife. [HSC § 123640]

7) Authorizes a licensed midwife to attend cases of normal pregnancy and childbirth, as defined, and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. [Business and Professions Code 2507]

FISCAL EFFECT: According to the Senate Appropriations Committee, DMHC indicates minor and absorbable costs for state administration. Unknown potential costs for CDI for state administration (Insurance Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, perinatal mental health conditions, including depression and anxiety, are the most common complications of pregnancy and a leading cause of maternal mortality. In California, one in three birthing people are affected, yet 85% go untreated. These conditions cost the state $2.4 billion annually and increase the risk of chronic mental health issues, suicide, Sudden Infant Death Syndrome, preterm birth, impaired parent-child bonding, adverse childhood experiences, and developmental delays in children. Black, Indigenous, and people of color communities are disproportionately impacted. The author states that this bill addresses this urgent need by ensuring equitable, comprehensive mental health care for all birthing people. This bill aligns with state and federal efforts to reduce maternal mortality, including initiatives from the Administration, DHCS, California Department of Public Health, and the California Surgeon General's office. The author notes that this bill strengthens existing law by specifying screening timelines per ACOG guidelines, addressing coverage of FDA-approved treatments for perinatal mental health, and requiring insurers and health plans to report screening rates for accountability. The author concludes that this bill will increase access to timely mental health care, reduce societal costs, and improve long-term outcomes, particularly in marginalized communities.

2) **BACKGROUND**.

   a) **Prevalence of PMH illnesses**. According to the National Institute of Health, perinatal mental illness is a significant complication of pregnancy and the postpartum period. These disorders include depression, anxiety disorders, and postpartum psychosis, which usually manifests as bipolar disorder. Postpartum blues are a common but lesser manifestation of postpartum affective disturbance. Perinatal psychiatric disorders impair a person's function and are associated with suboptimal development of offspring. Risk factors include past history of depression, anxiety, or bipolar disorder, as well

psychosocial factors, such as ongoing conflict with the partner, poor social support, and ongoing stressful life events. Early symptoms of depression, anxiety, and mania can be detected through screening in pregnancy and the postpartum period. Early detection and effective management of perinatal psychiatric disorders are critical for the welfare of parents' and their offspring.

A 2025 study published in Frontiers in Global Women's Health, "*Addressing inequalities in the identification and management of perinatal mental health difficulties: The perspectives of minoritised women, healthcare practitioners and the voluntary sector*," notes that PMH difficulties affect approximately one in five birthing women. If not identified and managed appropriately, these PMH difficulties can carry impacts across generations, affecting mental health and relationship outcomes. There are known inequalities in identification and management across the healthcare pathway. Rates are likely higher in low- and middle-income countries and, within high-income countries, vulnerability is greatest amongst minoritised groups, including women from ethnic minority backgrounds. Rates of PMH difficulties in trans- and non-binary birthing people are unknown, although initial evidence suggested there may be increased vulnerability.

Lack of clarity and consistency in referral pathways (such as different pathways, practices, tools, and services on offer across different geographical areas) was also described as a barrier. Health care providers surveyed for the study noted that while they are well placed to build relationships and create safe environments that enable women to disclose their mental health difficulties, lack of clarity about referral pathways and available services acts as a block to those women accessing treatment or specialist support.

b) Consequences of untreated PMH conditions. According to a 2025 Fact Sheet from the Maternal Mental Health Leadership Alliance, individuals with untreated PMH conditions during pregnancy are more likely to have poor prenatal care; use substances such as alcohol, tobacco, or drugs, and experience physical, emotional, or sexual abuse. Infants born to those with untreated PMH conditions are at higher risk for preterm birth, small for gestational size, and low birth weight. Untreated PMH conditions in the parent can also increase the risk for impaired parent-child interactions, behavioral, cognitive, and emotional delays in the child, as well as adverse childhood experiences. Parents who are depressed or anxious are more likely to make more trips to the emergency department or doctor's office, find it challenging to manage their child's chronic health conditions, and not adhere to guidance for safe infant sleep and car seat usage.

c) ACOG recommendations. ACOG specifically recommends screening for depression, anxiety, and bipolar disorder during the perinatal period. For depression and anxiety, screening is recommended at the initial prenatal visit, later in pregnancy, and at postpartum visits. For bipolar disorder, screening is recommended at both prenatal and postpartum visits. ACOG provides guidelines on the use of psychiatric medications during pregnancy and lactation, balancing the risks of medication exposure against the potential harm of untreated mental illness for the birthing person and fetus. Upon diagnosis of perinatal depression, anxiety, obsessive compulsive disorder or post-traumatic stress disorder, ACOG recommends that the patient be referred for psychotherapy (regardless of severity). Pharmacotherapy paired with psychotherapy is recommended for patients with moderate or severe symptoms, or for patients who used

these medications before pregnancy. For pregnant patients who would benefit from pharmacotherapy, selective serotonin reuptake inhibitors (SSRIs) are recommended as the first-line of treatment, which should be paired with psychotherapy.

d) California Health Benefits Review Program analysis. As introduced, this bill required health plans and insurers to provide coverage for at least one medication approved by the U.S. Food and Drug Administration (FDA) for perinatal mental health and for at least one FDA-approved digital therapeutic for perinatal mental health. The CHBRP reports key findings included:

i) Assumptions. CHBRP has defined perinatal period as the period including pregnancy plus 12 months after the end of pregnancy. CHBRP has assumed a broad interpretation of digital therapeutics being "approved by the FDA" to include devices classified as either FDA-cleared or FDA-approved.

ii) PMH conditions can include depression, postpartum psychosis, anxiety disorders, bipolar disorder posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD).

iii) PMH treatment. Currently, there is one medication with FDA approval and one digital therapeutic with FDA approval for PMH conditions. Both are indicated specifically for postpartum depression.

(1) In 2023, the FDA approved zuranolone (Zurzuvae), an oral medication used to treat postpartum depression. A two-week course of Zuranolone cost is $15,902.

(2) MamaLift Plus, an FDA-cleared device that is a digital therapeutic, is an 8-week app-based program for patients aged 22 and older with mild-to-moderate postpartum depression. A prescription is required to access the platform, which includes self-paced "therapy sessions," exercises, meditations, and the option of requesting a "therapist consultant" when needed. FDA-cleared means a new medical device has been shown to be a substantial equivalent to devices that are already legally marketed for the same use. The eight-week course of treatment is $650.

The May 5, 2025 amendments to this bill deleted the medication coverage requirements, and the bill now encourages coverage of the treatments discussed above.

3) SUPPORT. Black Women for Wellness, Maternal Mental Health NOW, Policy Center for Maternal Mental Health, and Postpartum Support International, California Chapter are the sponsors of this bill and state that this bill will make significant strides in improving access to mental health care for birthing families, particularly those from marginalized communities. The sponsors conclude that by expanding coverage and ensuring accountability, this bill will help reduce health disparities, save lives, and ultimately lead to healthier, more supported families across the state.

The American College of Obstetricians and Gynecologists (ACOG) supports this bill and notes that it takes an important step by updating terminology from "maternal mental health" to "perinatal mental health," better reflecting the full spectrum of mental health needs from pregnancy through the postpartum period. Most notably, this bill requires that screenings,

diagnoses, and treatments be guided by clinical standards, including those established by ACOG, ensuring that care is grounded in the most current, evidence-based practices. ACOG notes that by relying on clinical guidelines rather than codifying specific practices in statute, this bill allows the standard of care to evolve with advances in science and medicine. ACOG concludes that this flexibility is critical to improving outcomes and expanding access to effective mental health services for pregnant and postpartum individuals.

4) **SUPPORT IF AMENDED**. The Medical Board of California (MBC) has a support if amended position on this bill and states that all Board licensees are required to follow the standard of care, consistent with their scope of practice. Relevant clinical guidelines may help inform the standard of care, but they do not necessarily determine the standard of care for a particular patient/client. Relatedly, the ACOG clinical practice guidelines for the treatment and management of mental health conditions during pregnancy and the postpartum period include an important disclaimer that includes, in relevant part, the following: "This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. This information does not represent ACOG clinical guidance. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications, toolkits and other resources regularly; however, this information may not reflect the most recent evidence."

   MBC notes that when the Board pursues discipline against a licensee, the standard of care related to the circumstances in question is determined by one or more qualified experts with relevant education, training, and experience. MBC argues that the proposed amendments to Health and Safety Code section 123640 could unintentionally lower the quality-of-care provided to patients/clients if the health care provider relies upon guidelines that are inconsistent with the standard of care. Furthermore, if such a provider acts in accordance with this section as currently drafted, the Board may be unable to take disciplinary action against them (e.g., for negligence or incompetence). The MBC requests that this bill be amended to simply and clearly state that health care providers should treat their patients/clients according to the applicable standard of care that is consistent with the provider's scope of practice, or that they shall refer the patient/client to a licensed provider authorized to screen, diagnose, and treat them for a perinatal mental health condition.

5) **PREVIOUS LEGISLATION**.

   a) AB 1936 (Cervantes), Chapter 815, Statutes of 2024, requires a health plan or insurer's existing MMH program to include at least one MMH screening during pregnancy, and at least one additional screening during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the treating provider's judgement.

   b) AB 904 (Calderon and Cervantes), Chapter 349, Statutes of 2023, requires health plans and insurers to develop a maternal and infant health equity program to address racial disparities through the use of doulas.

c) SB 1207 (Portantino), Chapter 618, Statutes of 2022, requires health plan and insurer MMH programs to include quality measures to encourage screening, diagnosis, treatment and referral, requires program guidelines and criteria to be provided to providers; and requires education of enrollees and insureds about the plan's or insurer's program.

d) AB 1477 (Cervantes), Chapter 535, Statues of 2021, requires a health care practitioner who provides interpregnancy care to ensure that a mother is offered screening or is appropriately screened for MMH conditions. Expands the definition of "MMH condition" to include a condition that occurs during interpregnancy care.

e) AB 2193 (Maienschein), Chapter 755, Statutes of 2018, requires health plans and insurers to develop, consistent with sound clinical principles and processes, a MMH program, as specified. Requires a health care practitioner who provides prenatal or postpartum care for a patient, to offer to screen or appropriately screen a mother for MMH conditions.

6) AMENDMENTS. As currently drafted, this bill requires PMH **screening** during the pregnancy and during the postpartum period and perinatal periods to be done in accordance with "applicable clinical guidelines" or "standards appropriate to the provider's license, training, and scope of practice." However, medically required standards of care for **treatment** are not necessarily always compatible with "clinical guidelines," and the Medical Board of California has requested amendments to clearly state that health care providers should treat their patients/clients according to the applicable standard of care. The Committee may wish to amend this bill to more clearly differentiate between clinical guidelines for use in screenings, and standard of care requirements for treatment.

REGISTERED SUPPORT / OPPOSITION:

Support

Black Women for Wellness Action Project (co-sponsor)
Maternal Mental Health Now (co-sponsor)
Policy Center for Maternal Mental Health (co-sponsor)
Postpartum Support International, California Chapter (co-sponsor)
American Academy of Pediatrics, California
American Association of University Women - California
American College of Obstetricians & Gynecologists - District IX
Asian Americans Advancing Justice-southern California
Be Mom Aware
California Access Coalition
California Association for Nurse Practitioners
California Behavioral Health Association
California Catholic Conference
California Chapter of Postpartum Support International
California Life Sciences Association
California Medical Association (CMA)
California Nurse Midwives Association (CNMA)
California Perinatal Wellness Alliance (CPWA)
California WIC Association
California's Perinatal Hub. Inc.
Claris Health

County of Fresno
Curio Digital Therapeutics
Diversity Uplifts, INC.
Ethical Family Building
Everychild Foundation
First 5 Alameda County
First 5 California
First 5 LA
Fresno County Board of Supervisors
Hispanas Organized for Political Equality (HOPE)
LA Best Babies Network
March of Dimes
National Council of Jewish Women Los Angeles
Postpartum Health Alliance
Return to Zero: H.O.P.E.
Sacramento Maternal Mental Health Collaborative (SMMHC)
The Children's Partnership
The Crow
Western Center on Law & Poverty
One individual

Opposition

None on file

Analysis Prepared by: Lara Flynn / HEALTH / (916) 319-2097