SENATE THIRD READING
SB 626 (Smallwood-Cuevas and Cervantes)
As Amended August 20, 2026
Majority vote

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.

Major Provisions

COMMENTS

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.

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.

The American College of Obstetricians and Gynecologists (*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 are recommended as the first-line of treatment, which should be paired with psychotherapy.

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 FDA for perinatal mental health and for at least one FDA-approved digital therapeutic for perinatal mental health. The CHBRP reports key findings included:

1) *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.

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

3) *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.

    a) 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.

    b) 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.

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.

Arguments in 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.

Arguments in Opposition
The California Association of Health Plans and the Association of California Life and Health Insurance Companies note, in opposition to 16 health insurance mandate bills, including this bill, that large employers, unions, small businesses, and hard-working families value their ability to shop for the right health plan – at the right price – that best fits their needs. Benefit mandates

impose a one-size-fits-all approach to medical care and benefit design without consideration for consumer choice.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, California Department of Insurance estimates costs of $6,000 in fiscal year (FY) 2025-26, $32,000 in FY 2026-27, and $15,000 in FY 2027-28 and ongoing for state administration (Insurance Fund). The Department of Managed Health Care anticipates minor and absorbable costs. CalPERS does not anticipate costs associated with this bill. Costs to the Department of Health Care Services, if any, are likely negligible.

VOTES

SENATE FLOOR: 38-0-2
YES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Jones, Laird, Limón, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener
ABS, ABST OR NV: Hurtado, Reyes

ASM HEALTH: 16-0-0
YES: Bonta, Chen, Addis, Aguiar-Curry, Caloza, Carrillo, Flora, Mark González, Krell, Patel, Patterson, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins, Stefani

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Arambula, Calderon, Caloza, Dixon, Elhawary, Fong, Mark González, Hart, Pacheco, Pellerin, Jeff Gonzalez, Solache, Ta, Tangipa

ASSEMBLY FLOOR: 74-0-5
YES: Addis, Aguiar-Curry, Ahrens, Alanis, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Chen, Connolly, Davies, DeMaio, Dixon, Ellis, Flora, Fong, Gabriel, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Tangipa, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
ABS, ABST OR NV: Alvarez, Berman, Elhawary, Gallagher, Valencia

UPDATED

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