Office of Senate Floor Analyses
(916) 651-4171

UNFINISHED BUSINESS

Bill No: SB 626
Author: Smallwood-Cuevas (D) and Cervantes (D), et al.
Amended: 8/20/26
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 4/30/25
AYES: Menjivar, Valladares, Durazo, Gonzalez, Grove, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener

SENATE APPROPRIATIONS COMMITTEE: 6-0, 5/23/25
AYES: Caballero, Seyarto, Cabaldon, Grayson, Richardson, Wahab
NO VOTE RECORDED: Dahle

SENATE FLOOR: 38-0, 6/2/25
AYES: 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
NO VOTE RECORDED: Hurtado, Reyes

ASSEMBLY FLOOR: Passed, 8/25/26

SUBJECT: Perinatal health screenings and treatment

SOURCE: California Coalition for Perinatal Mental Health & Justice
Policy Center for Maternal Mental Health
Sage Therapeutics
PSI-California
Black Women for Wellness Action Project

DIGEST: This bill revises an existing requirement on plans and insurers relating to maternal mental health (MMH) screenings to require case management, care coordination, guidelines, and the standards of care appropriate to the provider's

scope of practice, as specified. Encourages health plans and insurers to provide coverage for outpatient prescription drugs approved by the U.S. Food and Drug Administration (FDA) for MMH. Requires licensed health care practitioners who provide perinatal care for a patient to ensure the patient is screened for MMH consistent with the plan or insurer MMH program, and applicable standards of care.

Assembly Amendments return terminology back to "maternal"(instead of perinatal) mental health, replace medication and digital therapeutics with "outpatient prescription drugs," define case management and care coordination, revise the definition of MMH condition, require, if a patient or client screens positive for a MMH condition, licensed health care practitioners to ensure the patient is offered or receives a clinical evaluation, and if the practitioner diagnoses the patient, the practitioner to make or provide treatment to the patient or client. Makes clarifying changes to this bill such as replacing the term "standards" with "the standards of care" and replace "medical providers" with the term "licensed health care practitioners."

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Services Plan Act of 1975; the California Department of Insurance (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)

This bill:

1) Revises the requirements on plans and insurers to have an MMH program, to include one or more MMH screenings conducted during pregnancy and one or more during the postpartum period in accordance with applicable clinical guidelines and the standards of care appropriate to the provider's scope of practice.

2) Encourages health plans and insurers as part of their MMH programs to provide coverage for outpatient prescription drugs approved by the FDA for MMH.

3) Requires guidelines 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 there is not alignment, permits the guidelines to include, but not be limited to, guidelines adopted by other recognized professional bodies. Indicates this does not expand or alter a licensed provider's existing scope of practice.

4) Requires health plans and insurers to provide case management or care coordination for an enrollee or insured who screens positive for MMH in

accordance with the plans or insurers existing case management and care coordination programs.

5) Indicates case management and care coordination may include identification of available treatment providers and community supports, appointment scheduling, behavioral health navigation, medication access assistance when prescribed, regular patient engagement or follow up, and communication with the referring obstetric and behavioral health providers.

6) Indicates case management and care coordination may be provided by the plan or insurer, or by a delegated provider if case management or care coordination, is already provided pursuant to contract, or in the Health Care Provider Bill of Rights law.

7) Requires a plan or insurer to incorporate MMH screening, referral, care coordination and follow up activities into its existing quality improvement and population health management programs and maintain documentation demonstrating compliance that is available to regulators upon request.

8) Defines case management as a health care process in which a health care professional, acting withing their scope of practice, assists a patient by developing and implementing a coordinated plan of care that integrates the medical and psychosocial support services the patient needs to achieve optimal outcomes.

9) Requires a licensed health care practitioner who provides perinatal care for a patient to ensure the patient is screened for MMH consistent with the plan or insurer MMH program, and applicable standards of care.

10) Requires if a patient screens positive, the licensed health care practitioner to ensure that the patient is offered or receives a clinical evaluation, and if the practitioner diagnoses the MMH, to offer or provide the treatment consistent with the practitioner's scope of practice. This may be satisfied by referring the patient or client to another licensed health care practitioner who is authorized to screen, evaluate, diagnose, and treat the patient or client for MMH.

11) Defines MMH condition to include postpartum and perinatal depression, as defined by the most recent clinical guidelines adopted by ACOG on the screening and diagnosis of MMH during pregnancy and postpartum, regardless of the pregnancy outcome and inclusive of gender-diverse birthing people.

Comments

According to the author of this bill:

> MMH 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. This bill addresses this urgent need by ensuring equitable, comprehensive mental health care for all birthing people. The 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. It 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. This bill will increase access to timely mental health care, reduce societal costs, and improve long-term outcomes, particularly in marginalized communities.

Support if amended. The Students for Patient Advocacy Nationwide request an amendment to define "perinatal period" as the time beginning with pregnancy and extending through 12 months following childbirth.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Assembly Appropriations Committee, CDI 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).

DMHC anticipates minor and absorbable costs.

CalPERS does not anticipate costs associated with this bill.

Costs to DHCS, if any, are likely negligible.

SUPPORT: (Verified 8/25/26)

Black Women for Wellness Action Project (co-source)
California Coalition for Perinatal Mental Health & Justice (source)

Policy Center for Maternal Mental Health (co-source)
California Chapter of Postpartum Support International (co-source)
Sage Therapeutics (co-source)
American Academy of Pediatrics, California
American College of Obstetricians & Gynecologists
Asian Americans Advancing Justice Southern California
Asian Resources, Inc.
Be Mom Aware
Black Women for Wellness Action Project
Breastfeed LA
California Access Coalition
California Association for Nurse Practitioners
California Behavioral Health Association
California Black Women's Health Project
California Catholic Conference
California Latinas for Reproductive Justice
California Nurse Midwives Association
California Perinatal Hub, Inc.
California WIC Association
Citizens for Choice
Claris Health
County of Fresno
Curio Digital Therapeutics
Diversity Uplifts
Ethical Family Building
Everychild Foundation
First 5 California
First 5 LA
Food Empowerment Project
Friends Committee on Legislation of California
Hispanas Organized for Political Equality
Insure the Uninsured Project
Jewish Family and Children's Services of San Francisco, the Peninsula, Marin and Sonoma Counties
Jewish Family Service LA
LA Best Babies Network
Love, Dad
Maternal Mental Health NOW
March of Dimes
Medical Board of California

National Council of Jewish Women Los Angeles
Nourishing Justly
Postpartum Health Alliance
Return to Zero: HOPE
Sacramento Maternal Mental Health Collaborative
South Asian Network
Southeast Asia Resource Action Center
The Children's Partnership
The Crow
The MotherBoard Los Angeles
Western Center on Law & Poverty
Women's Voices for the Earth
One individual

OPPOSITION: (Verified 8/25/26)

Association of California Life & Health Insurance Companies
California Association of Health Plans

ARGUMENTS IN SUPPORT: Cosponsors of this bill (California Coalition for Perinatal Mental Health & Justice, Policy Center for Maternal Mental Health, Postpartum Support International-California, and Black Women for Wellness Action Project) write, "This bill offers California a scalable, affordable, and equity-driven solution to address our MMH crisis. It builds on existing law to improve unintended outcomes without expanding scope of practice or adding significant cost, providing clarity on screening requirements aligning with clinical bodies, and providing coverage for targeted treatments. In a moment of fiscal constraint, this bill is a smart, strategic investment, one that will save the state and private payers cost over time, save lives, close treatment and care coordination gaps and prevent long-term suffering for families across the state." The California Coalition for Perinatal Mental Health & Justice writes that this bill will make significant strides in improving access to mental health care for birthing families, particularly those from marginalized communities, and, 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. ACOG writes, "This bill takes an important step by updating terminology, better reflecting the full spectrum of mental health needs from pregnancy through the postpartum period. ACOG says most notably, the bill requires that screenings, diagnoses, and treatments be guided by clinical standards set by ACOG, ensuring that care is grounded in the most current, evidence-based practices, and, 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 believes this flexibility is critical to improving outcomes and expanding access to effective mental health services for pregnant and postpartum individuals. Finally, ACOG indicates the bill also includes essential provisions for case management, care coordination, and coverage of treatment tools which together create a more comprehensive and responsive system of support for patients during the perinatal period.

ARGUMENTS IN OPPOSITION: The California Association of Health Plans and the Association of California Life and Health Insurance Companies write in opposition to health insurance mandate bills including this one. The opposition writes these bills will increase costs, reduce choice and competition and further incent some employers and individuals to avoid state regulation by seeking other coverage options. Benefit mandates impose a one-size-fits all approach to medical care and benefit design without consideration for consumer choiceThe opposition also indicates that adding new mandates at a time when the Office of Health Care Affordability (OHCA) is working to curb healthcare costs could disrupt those efforts and make it difficult for health care entities to meet the OCHA spending target. The opposition urges the Legislature to consider the cumulative impacts of these mandates on premiums and access to coverage, and they believe that benefit mandates stifle the use of innovative, evidence-based medicine.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
8/25/26 16:39:14

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