A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Analysis of California Senate Bill 626: Perinatal Health Screenings and Treatment

APRIL 22, 2025

CHBRP

California Health Benefits Review Program (CHBRP)
University of California, Berkeley

chbrp.org

KEY FINDINGS

Analysis of California Senate Bill 626 Perinatal Health Screenings and Treatment

Summary to the 2025-2026 California State Legislature, April 22, 2025

CHBRP

Summary

The version of California Senate Bill (SB) 626 analyzed by California Health Benefits Review Program (CHBRP) would require Department of Managed Health Care (DMHC)–regulated plans and California Department of Insurance (CDI)–regulated policies to cover at least one medication approved by the U.S. Food and Drug Administration (FDA) for perinatal[1] mental health and at least one digital (e.g., app-based) therapeutic approved[2] by the FDA for perinatal mental health. Currently, there is one medication (zuranolone) and one digital therapeutic (MamaLift Plus) with FDA approval for perinatal mental health conditions.

SB 626 would also require that DMHC-regulated plans and CDI-regulated policies provide and report annually on utilization of case management and care coordination during the perinatal period. Finally, SB 626 would require that a licensed health care provider who provides perinatal care for a patient must screen, diagnose, and treat the patient for a perinatal mental health condition according to the clinical guidelines from the American College of Obstetricians and Gynecologists (ACOG).

In 2026, 24.1 million Californians (63% of all Californians) enrolled in state-regulated health insurance would have insurance subject to SB 626.

Benefit Coverage

Benefit coverage for zuranolone would increase from 3% to 54% postmandate. Benefit coverage for MamaLift Plus would increase from 2% to 100% postmandate. SB 626 would not exceed essential health benefits (EHBs).

Medical Effectiveness

Overall, the findings on treatments for perinatal mental health vary. While there is *some evidence* that the FDA-approved medication for perinatal mental health is effective, *not enough research* has been conducted to determine the effect of the digital therapeutic, *not enough research* has been conducted to determine whether screening for perinatal depression improves health outcomes, and there is *conflicting evidence* that care coordination and case management are effective in improving health outcomes.

Cost and Health Impacts[3]

In 2026, CHBRP estimates that SB 626 would result in 328 additional people taking zuranolone and an additional 5,402 people using MamaLift Plus. While CHBRP does not anticipate new people gaining coverage for perinatal mental health screening, CHBRP does estimate an additional 37,581 perinatal mental health screenings.

SB 626 would increase total expenditures by $9,842,000 (0.01%).

Context

Perinatal mental health conditions can include depression, postpartum psychosis, anxiety disorders, bipolar disorder, posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD)[4]. Medication use for mental health conditions during pregnancy is common practice. However, there is limited data on the use of medications to treat mental health conditions during pregnancy because studies are limited and tend to exclude pregnant patients. For this reason, there are very few FDA-approved medications for mental health

[1] For the purposes of SB 626, CHBRP has defined the perinatal period as the period including pregnancy plus 12 months after the end of pregnancy.
[2] While SB 626 specifies digital therapeutics with FDA approval, CHBRP has assumed a broad interpretation of being "approved by the FDA" to include devices classified as either FDA-cleared or FDA-approved. See *Analytic Approach and Assumptions* in the full report for detail.

[3] Similar cost and health impacts could be expected for the following year though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.
[4]Although definitions vary regarding whether perinatal mental health conditions can include conditions that begin before pregnancy, SB 626 specifies its applicability to perinatal mental health conditions that occur during pregnancy, the postpartum period, or the perinatal period. ACOG

conditions specifically indicated for use by pregnant people, although that does not mean that pregnant patients go through their pregnancy without treatment.

Currently, there is one medication with FDA approval and one digital therapeutic with FDA approval for perinatal mental health conditions. Both are indicated specifically for postpartum depression (PPD). In 2023, the FDA approved zuranolone (Zurzuvae), an oral medication used to treat PPD. MamaLift Plus, an FDA-approved digital therapeutic, is an 8-week app-based program for patients aged 22 and older with mild-to-moderate PPD. 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.[5]

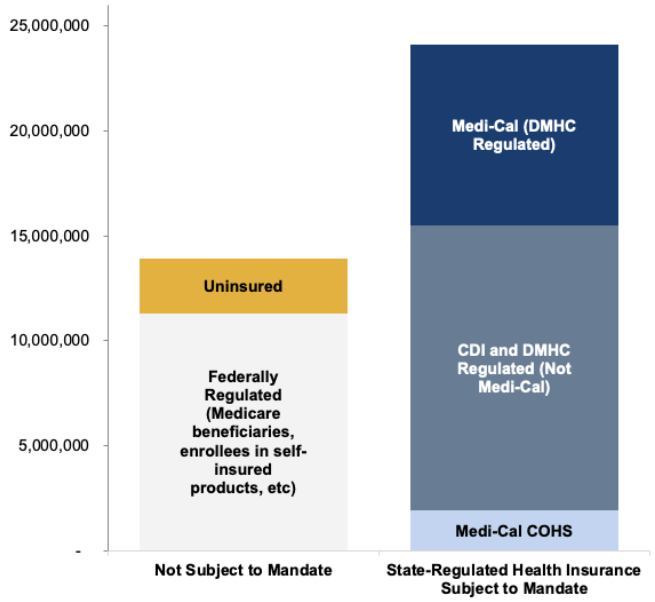
Bill Summary

SB 626 would require DMHC-regulated plans and CDI-regulated policies to cover at least one medication approved by the U.S. Food and Drug Administration (FDA) for perinatal mental health and at least one digital therapeutic approved by the FDA for perinatal mental health.

Additionally, SB 626 would require that DMHC-regulated plans and CDI-regulated policies provide case management and care coordination during the perinatal period; that they annually report to the Department of Health Care Services (DHCS) on the utilization and outcomes of case management; and that they publicly post the information reported.

Finally, SB 626 would require that a licensed health care provider who provides perinatal care for a patient must screen, diagnose, and treat the patient for a perinatal mental health condition according to the clinical guidelines from the American College of Obstetricians and Gynecologists (ACOG). SB 626 would change existing screening guidance — at least once during pregnancy, at least once during the first 6 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 — to follow ACOG clinical guidelines, which recommend that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits.

Figure A. Health Insurance in CA and SB 626



Source: California Health Benefits Review Program, 2025.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[6]
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

Impacts

Benefit Coverage

CHBRP estimates that at baseline, 24,116,000 Californians (63%) with state-regulated insurance subject to the mandate are enrolled in plans or policies impacted by SB 626. With regards to the care coordination and case management provision of the bill, 100% of enrollees are in plans and policies that are compliant. With regards to the coverage of zuranolone, 3% of enrollees are in plans and policies that are compliant; with regards to MamaLift Plus, 2% of

specifically recommends screening for depression, anxiety, and bipolar disorder during the perinatal period.
[5] Refer to CHBRP's full report for full citations and references.
[6] Although COHS plans are not subject to the Knox-Keene Act, DHCS generally updates Medi-Cal managed care plan contracts, All Plan Letters, and other appropriate authorities for alignment of managed care plan benefits, except in cases when the benefit is carved out of the Medi-Cal managed care plan contract or the law exempts specified Medi-Cal contracted providers.

enrollees are in plans and policies that are compliant at baseline.

Utilization

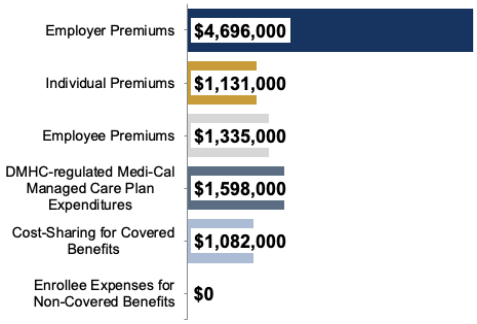
Postmandate, CHBRP estimates that the number of people who use zuranolone with coverage would grow to 345 enrollees and that the number of people who use MamaLift Plus with coverage would grow to 5,402 enrollees. CHBRP estimates an additional 37,581 perinatal mental health screenings postmandate.

Expenditures

For DMHC-regulated plans and CDI-regulated policies, SB 626 would increase total expenditures by $9,842,000 (0.01%). Increases in enrollee expenditures at the per member per month (PMPM) level range from $0.014 for Medi-Cal managed care plans, including COHS, to $0.056 for DMHC-regulated individual plans.

CHBRP assumes a cost offset of $112 per treatment course of zuranolone to account for reductions in other healthcare utilization.

Figure B. Expenditure Impacts of SB 626



Source: California Health Benefits Review Program, 2025.
Key: DMHC = Department of Managed Health Care.

Commercial

Changes in premiums as a result of SB 626 would be 0.01% or less for the different types of plans by market segment and ranges from $0.013 for small-group CDI-regulated policies to $0.047 for large-group DMHC-regulated plans.

Medi-Cal

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, there would be a 0.005% increase in premiums, which translates to a $0.014 increase PMPM (reflecting the changes in coverage of MamaLift Plus, which is assumed to be covered as a medical benefit).

CalPERS

For enrollees associated with the California Public Employees' Retirement System (CalPERS) in DMHC-regulated plans, there would be a 0.004% increase in premiums, which translates to a $0.033 increase PMPM.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 626.

Medical Effectiveness

Overall, the findings on treatments for perinatal mental health vary. While there is *some evidence*[7] that the FDA-approved medication for perinatal mental health is effective, *not enough research*[8] has been conducted to determine the effect of the digital therapeutic, *not enough research* has been conducted to determine whether screening for perinatal depression improves health outcomes, and there is *conflicting evidence*[9] that care coordination and case management are effective in improving health outcomes.

There is *some evidence* that zuranolone is effective for improving depression for patients with severe PPD in which onset begins within the 3rd trimester of pregnancy or the first 4 weeks postpartum, based on two well-designed randomized controlled trials. Because there are only two industry-funded studies with relatively small sample sizes and limited follow-up, it is unclear how

[7] *Some evidence* indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.
[8] *Not enough research* indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.
[9] *Conflicting evidence* indicates that a similar number of studies of equal quality suggest the treatment is effective as suggest the treatment is not effective.

generalizable the effects would be for the entire postpartum population that would be covered by SB 626.

Not enough research has been conducted to determine whether zuranolone is more effective than the selective serotonin reuptake inhibitors (SSRIs) that are currently prescribed for improving health outcomes in women with perinatal depression because there are no studies that compare the two medications. *Not enough research* indicates that there are no studies of the treatment or the available studies are not of high quality, meaning that there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Not enough research has been conducted to determine if the digital therapeutic MamaLift Plus is effective at improving depression for people with mild-to-moderate PPD because there are no studies that meet CHBRP's quality standards. *Not enough research* indicates that there are no studies of the treatment or the available studies are not of high quality, meaning that there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Not enough research has been conducted to determine whether screening for perinatal depression improves health outcomes. CHBRP did not identify any trials comparing the effects of usual care versus screening plus usual care on health outcomes.

There is *conflicting evidence* that care coordination and case management improve health outcomes, including improvements in depressive scores and breastfeeding initiation and continuation, based on five studies. One study showed that engagement in a collaborative care program increased initiation and continuation of breastfeeding at 6 weeks follow-up. However, evidence is limited by a lack of studies that examine case management and care coordination in a clinical setting with control groups. Because case management and care coordination are not defined in SB 626, it is difficult to generalize these outcomes to the legislation.

Public Health

Given the evidence of medical effectiveness of existing treatments and screening as well as the estimated cost impacts of SB 626, CHBRP concludes that passage of SB 626 would have no short-term public health impact at the state level. At the person-level, enrollees with severe PPD for which psychotherapy and/or SSRIs or serotonin-norepinephrine reuptake inhibitors (SNRIs) are not sufficient may find a reduction in depression symptoms with zuranolone.

Long-Term Impacts

Over time, the utilization of both zuranolone and MamaLift Plus may increase as awareness, provider familiarity, and patient adoption grow. The long-term cost implications of SB 626 may be influenced by market dynamics, technological advancements, and evolving coverage policies. While initial costs may be high due to the novel nature of zuranolone and the relatively new market for prescription digital therapeutics like MamaLift Plus, competition and innovation could drive costs downward. As more pharmaceutical and digital health companies enter the market, the introduction of alternative treatments and expanded research may contribute to pricing pressures that reduce costs. Additionally, as the prescription digital therapeutics sector continues to grow, industry standards and guidance from regulatory and payer bodies may lead to more structured reimbursement frameworks, increasing affordability and accessibility. These factors could moderate the long-term cost impact of SB 626 while supporting broader adoption of both pharmacologic and digital interventions for PPD.

Essential Health Benefits and the Affordable Care Act

SB 626 would not exceed the definition of EHBs in California because SB 626 would expand existing benefit coverage and does not create a new coverage requirement.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

Suggested citation

California Health Benefits Review Program (CHBRP). (2025). *Analysis of California Senate Bill 626: Maternal Health Screenings and Treatment.* Berkeley, CA.

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Lists of Tables and Figures

Acronyms and Abbreviations

ACA – Affordable Care Act
ACOG – American College of Obstetricians and Gynecologists
APA – American Psychiatric Association
BIMF – Barkin Index of Maternal Functioning
CA – California
CalPERS – California Public Employees' Retirement System
CCM – collaborative care model
CDI – California Department of Insurance
CGI-I – Clinical Global Impressions-Improvement Scale
CDPH – California Department of Public Health
CHBRP – California Health Benefits Review Program
COHS – County Organized Health System
DHCS – Department of Health Care Services
DMHC – Department of Managed Health Care
EHB – essential health benefits
EPDS – Edinburgh Postnatal Depression Scale
FDA – Food and Drug Administration
HAM-A – Hamilton Anxiety Scale
HAMD-17 – Hamilton Depression Rating Scale
LSM – least square mean
MADRS – Montgomery-Asberg Depression Rating Scale
MIHA – Maternal and Infant Health Assessment
OCD – obsessive-compulsive disorder
PHQ-9 – Patient Health Questionnaire
PMPM – per member per month
PPD – postpartum depression
PTSD – posttraumatic stress disorder
MHPAEA – Mental Health Parity and Addiction Equity Act
RCT – randomized controlled trial
SB – Senate Bill
SSRI – selective serotonin reuptake inhibitor
SNRI – serotonin-norepinephrine reuptake inhibitor
USPSTF – U.S. Preventive Services Task Force

Introduction

The California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP)[10] conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 626, Perinatal Health Screenings and Treatment.

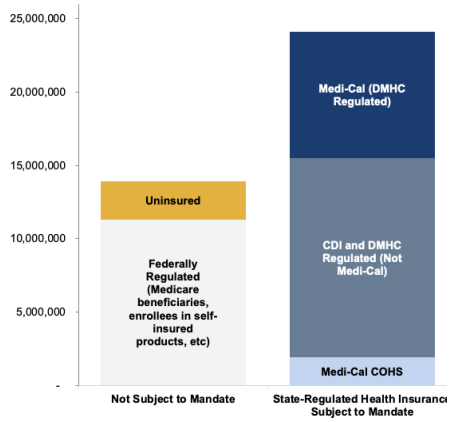
SB 626, Perinatal Health Screenings and Treatment Bill Language

SB 626 would require Department of Managed Health Care (DMHC)–regulated plans and California Department of Insurance (CDI)–regulated policies to cover at least one medication approved by the U.S. Food and Drug Administration (FDA) for perinatal mental health and at least one digital (e.g., app-based) therapeutic approved[11] by the FDA for perinatal mental health.

Additionally, SB 626 would require that DMHC-regulated plans and CDI-regulated policies provide case management and care coordination during the perinatal period; that they annually report to the Department of Health Care Services (DHCS) on the utilization and outcomes of case management; and that they publicly post the information reported.

Finally, SB 626 would require that a licensed health care provider who provides perinatal care for a patient must screen, diagnose, and treat the patient for a perinatal mental health condition according to the clinical guidelines from the American College of Obstetricians and Gynecologists (ACOG). SB 626 would change existing screening guidance — at least once during pregnancy, at least once during the first 6 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 — to follow ACOG clinical guidelines, which recommend that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits (ACOG, 2023a).

Figure 1. Health Insurance in CA and SB 626



Source: California Health Benefits Review Program, 2025.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.

See the full text of SB 626 in Appendix A.

If enacted, SB 626 would apply to the health insurance of approximately 24,116,000 enrollees (63% of all Californians) (see Figure 1).

- **Includes:** enrollees in commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by DMHC and CDI, and Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans or county organized health system (COHS) plans.
- **Excludes:** Medi-Cal Rx pharmacy beneficiaries.

See the following *Analytic Approach and Key Assumptions* section for additional information.

[10] See CHBRP's authorizing statute.
[11] While SB 626 specifies digital therapeutics with FDA approval, CHBRP has assumed a broad interpretation of being "approved by the FDA" to include devices classified as either FDA-cleared or FDA-approved. See *Analytic Approach and Assumptions* for detail.

What Are Perinatal Mental Health Conditions and What Treatments Are Available?

Perinatal mental health conditions can include depression, postpartum psychosis, anxiety disorders, bipolar disorder, posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD) (ACOG, n.d.-b).[12] ACOG specifically recommends screening for depression, anxiety, and bipolar disorder during the perinatal period (ACOG, 2023a). 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, 2023a).

Medication use for mental health conditions during pregnancy is common. However, there is limited data on the use of medications to treat mental health conditions during pregnancy because studies are limited and tend to exclude pregnant patients. For this reason, there are very few FDA-approved medications specifically indicated for use by pregnant people with mental health conditions (Adam et al., 2011), although that does not mean that pregnant patients go through their pregnancy without using medications for mental health conditions. 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 (ACOG, 2023b). Upon diagnosis of perinatal depression, anxiety, OCD, or PTSD, ACOG recommends that the patient be referred for psychotherapy (regardless of severity) (ACOG, 2023a). 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 (ACOG, 2023b).

Currently, there is one medication with FDA approval and one digital therapeutic with FDA approval for perinatal mental health conditions. Both are indicated specifically for postpartum depression (PPD). In 2023, the FDA approved zuranolone (Zurzuvae), an oral medication used to treat PPD. That year, ACOG included zuranolone as a treatment option that should be considered for severe PPD that had onset within the 3rd trimester of pregnancy or within 4 weeks postpartum (ACOG, 2023c). MamaLift Plus, an FDA-approved digital therapeutic, is an 8-week app-based program for patients aged 22 and older with mild-to-moderate PPD. 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. Patients who continuously engage with the app are rewarded with points that can be used to purchase goods from the MamaLift Marketplace (Curio Digital Therapeutics, 2025).

Case management is a service that can be offered to patients who could benefit from professional assistance in navigating the health care system and coordinating specialized care or support services that might be needed for the patient's health or psychosocial goals (Giardino and De Jesus, 2023). A case manager would review the patient's health benefit plan and community offerings and develop a plan for the patient to follow that may help them better access and navigate their existing benefits. Care coordination generally involves both the organizing of patient care processes, and the sharing of information with those involved in patient care. The degree and manner in which coordination occurs can vary broadly (AHRQ, 2024). SB 626 does not establish a definition of what case management or care coordination services should entail, or who should be providing them.

Terminology

Perinatal period: The period including pregnancy plus 12 months after the end of pregnancy.

Postpartum period: The period 12 months after the end of pregnancy.

[12]Although definitions vary regarding whether perinatal mental health conditions can include conditions that begin before pregnancy, SB 626 specifies its applicability to perinatal mental health conditions that occur during pregnancy, the postpartum period, or the perinatal period. ACOG specifically recommends screening for depression, anxiety, and bipolar disorder during the perinatal period (ACOG, 2023a).

Perinatal mental health condition: A mental health condition that occurs during pregnancy, the postpartum period, or the perinatal period that impairs a woman's function. Conditions include perinatal depression, perinatal anxiety disorders, postpartum psychosis, bipolar disorder, posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD).

Collaborative Care Model: A systematic approach to the treatment of depression and anxiety in primary care settings that involves the integration of care managers and consultant psychiatrists, with primary care physician oversight, to more proactively manage mental disorders as chronic diseases, rather than treating acute symptoms (Eghaneyan et al., 2014).

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Analytic Approach and Assumptions

CHBRP has assumed that the eligible population for coverage under SB 626 is people within the perinatal period. Mental health conditions that can occur during the perinatal period include depression, anxiety disorders, postpartum psychosis, bipolar disorder, PTSD, and OCD (ACOG, n.d.-b).

As SB 626 does not define the perinatal period, CHBRP has assumed a definition of pregnancy plus 12 months after the end of pregnancy. This is in alignment with ACOG's assessment of when perinatal mental health conditions are most likely to occur.

CHBRP has assumed that insurance carriers — which are nearly fully compliant with the case management and care coordination provision of SB 626 at baseline — would continue to provide case management and care coordination postmandate at the same level as premandate. Case management and care coordination services are likely to vary from one carrier to the next as well as one patient to the next.

While provision of collaborative care is not included in SB 626, CHBRP included in its medical effectiveness analysis studies that examine programs that include components of case management and care coordination, including collaborative care, a program that usually includes components of each.

As SB 626 modifies existing perinatal mental health screening guidance to follow ACOG guidelines, CHBRP has assumed that the difference in frequency and timing of screening between existing law and current ACOG guidelines would not impact PPD diagnosis and subsequent costs associated with more diagnosis (Leboffe et al., 2023). SB 626 would change existing screening guidance — at least once during pregnancy, at least once during the first 6 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 — to follow ACOG clinical guidelines, which currently recommend that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits (ACOG, 2023a).

DMHC and CDI are responsible for regulating health plans and policies but not supervising licensed health care professionals. For this analysis, CHBRP has determined that bill language amending Section 2 of Health and Safety Code Section 123640 requiring that a licensed health care provider who provides perinatal care for a patient must diagnose and treat a patient for a perinatal mental health condition according to ACOG guidelines is outside the scope of CHBRP review as it does not mandate coverage or the terms and conditions of coverage. CHBRP addressed the bill language requiring that a licensed health care provider screen a patient for perinatal mental conditions according to ACOG guidelines because SB 626 would mandate a change in coverage to an existing screening program with detailed requirements.

As SB 626 specifies coverage of FDA-approved medications and digital therapeutics for perinatal mental health, CHBRP has assumed that the applicable list of treatments includes only zuranolone (Zurzuvae) and MamaLift Plus.[13]

SB 626 would impact services and medications covered under the medical benefit as well as the pharmacy benefit. Drugs that are physician-ordered and administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility), along with the hospital stay or office visit, are generally covered through a medical benefit. Pharmacy benefits cover outpatient prescription drugs by covering prescriptions that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy. As SB 626 mandates coverage of a prescription digital therapeutic, CHBRP has assumed that this falls under the medical benefit.

[13] Zulresso (brexanolone) is an FDA-approved medication for PPD but was discontinued by the manufacturer in December 2024 as part of a strategic shift to focus on the commercialization of Zurzuvae. CHBRP's analysis includes reference to brexanolone for historical context but assumes SB 626 would have no impact on utilization of this drug given its discontinuation.

As of January 1, 2022, outpatient prescription drugs are covered on a fee-for-service basis by DHCS for all Medi-Cal beneficiaries through the Medi-Cal Rx program.[14] Their pharmacy benefit is "carved out" of the coverage provided by Medi-Cal managed care plans, and so SB 626 would not be expected to impact their benefit coverage.

The FDA categorizes medical devices into three different classes based on risk, with Class 1 devices having the lowest risk and Class 3 having the highest. Approval of devices to go to market depends on classification. Class 1 and 2 devices generally need to be classified as "FDA-cleared" prior to going to market. MamaLift Plus is classified as a Class 2 device. Class 3 devices must obtain classification as "FDA-approved" prior to marketing a new device. Nonpharmacological therapies for pain management may be classified as a Class 1, 2, or 3 medical device. Given this nuance, CHBRP has assumed a broad interpretation of being "approved by the FDA" to include devices classified as either FDA-cleared or FDA-approved.

Table 1. Market Segments Subject to SB 626

	Commercial/CalPERS Medical Benefit	Commercial/CalPERS Pharmacy Benefit	Medi-Cal Managed Care Plans Medical Benefit	Medi-Cal Pharmacy Benefit
Subject to SB 626	Yes	Yes (for those regulated by DMHC or CDI)	Yes	No (administered by DHCS)

Source: California Health Benefits Review Program, 2025.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

CHBRP previously analyzed similar bill language, AB 2193 Maternal Mental Health, in 2018. Where applicable, this analysis builds on that previous analysis.

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[14] For more on outpatient prescription drug coverage among Californians with state-regulated health insurance, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

Policy Context

Health benefit mandates may interact and align with the following state and federal mandates, programs, and policies.

California law and regulations

Mental health parity

California law[15] requires plans and policies to cover all mental health and substance use disorders listed in the most recent edition of either the *International Classification of Disease* or the *Diagnostic and Statistical Manual of Mental Disorders* at parity with other medical services. This requirement is similar to those specified by the federal Mental Health Parity and Addiction Equity Act (MHPAEA, see below), but applies to all health insurance plans and policies subject to either the Health and Safety Code or the Insurance Code.

Existing California Law

In 2018, Governor Newson signed AB 2193 into law, requiring health care service plans to develop a maternal mental health program designed to promote quality and cost-effective outcomes. AB 2193 also requires that licensed health care practitioners who provide prenatal or postpartum care for a patient ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.[16]

In 2023, DHCS created the Birthing Care Pathway, a comprehensive policy and care model roadmap intended to cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum. The Birthing Care Pathway is designed to be a strategic roadmap for state entities, managed care plans, counties, providers, social service entities, philanthropy, and other key partners serving pregnant and postpartum Medi-Cal members. The program goals are to reduce maternal morbidity and mortality and address racial and ethnic disparities that disproportionately affect Black, American Indian/Alaska Native, and Pacific Islander individuals.

In 2024, Governor Newsom signed AB 1936 into law, which expanded upon AB 2193 to require that health care service plans and health insurers modify their maternal mental health programs to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first 6 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. AB 1936 also requires that maternal mental health programs include quality measures to encourage screening, diagnosis, treatment, and referral.[17]

Medi-Cal managed care contracts define care coordination as a contractor's coordination of care delivery and services for members, either within or across delivery systems including services the member receives by contractor; services the member receives from any other managed care health plan; services the member receives in fee-for-service; services the member receives from out-of-network providers; services that the member receives through carve-out programs, such as pharmacy, substance use disorder, mental health, and dental services; and services the member receives from community and social support providers.

[15] Health and Safety Code (HSC) Section 1374.72; Insurance Code (INS) Section 10144.5 and 10123.15.
[16] Health and Safety Code (HSC) Section 1367.625 and 123640; Insurance Code (INS) Section 10123.867
[17] Health and Safety Code (HSC) Section 1367.625; Insurance Code (INS) Section 10123.867

Previous California Legislation

As introduced, AB 2193 would have required that plans and policies develop a case management program for enrollees or insureds who may have a maternal mental health condition. The bill was later amended to exclude case management language.

Similar Legislation in Other States

In addition to California, eight other states have passed legislation regarding maternal mental health screenings. New Jersey, Illinois, West Virginia, Florida, Oklahoma, Louisiana, Arkansas, and Massachusetts all have passed legislation since 2006 requiring that health care providers conduct or make available depression screening during either the perinatal or postpartum period. Illinois and Oklahoma require that screening questionnaires be reviewed in accordance with ACOG guidelines. Two states — Illinois and Massachusetts — require insurance coverage of depression screening during the postpartum period. Arkansas requires insurance coverage of screening at the time of birth. Washington requires ongoing payment for maternal depression screening for mothers of children from birth to 6 months specifically for the Medicaid population. Arkansas requires Medicaid to reimburse for depression screening of a pregnant woman.

Only one state — Nevada — has passed legislation requiring maternal mental health treatment coverage. In 2023 Nevada passed SB 232, requiring that the State Plan for Medicaid include coverage for postpartum care services, including mental health screenings and treatment for complications of pregnancy and childbirth, including PPD, for 12 months following the end of a pregnancy.[18] Previous law required coverage for 60 days postpartum.

In 2024, Louisiana passed SB 148, allowing that a prescribing provider of a prescription drug for the treatment of PPD can request an override of an insurance company's fail-first/step-therapy requirement, and the health insurance company must expedite and approve the step-therapy override request if there is no other PPD-specific FDA-approved drug to prescribe that meets the step-therapy requirement (Policy Center for Maternal Mental Health, 2024b).

In addition to California, eight states — Alabama, Arizona, Georgia, Maryland, Minnesota, Mississippi, New Hampshire, and Oklahoma — have proposed legislation in 2025 that would establish or expand upon the state's existing maternal mental health screening requirements, including requiring insurance coverage of screening. Two of those states also aim to address treatment: Arizona HB 2332 would require insurers to not impose or require a step-therapy protocol for any FDA-approved medication for the treatment of PPD; and Alabama SB 191/AB 322 would prohibit the Alabama Medicaid Agency from imposing step-therapy protocols on prescription drugs approved by the FDA for treating PPD (Policy Center for Maternal Mental Health, 2025).

Federal Policy Landscape

Existing Federal Law

The U.S. Preventive Services Task Force (USPSTF) has recommended screening for depression in all adults, including pregnant and postpartum persons, since 2016 (Siu et al., 2016) as a grade B recommendation.

The TRIUMPH for New Moms Act of 2022 established the Task Force on Maternal Mental Health, a panel of federal and nonfederal experts working to identify, evaluate, and make recommendations to coordinate and improve activities related to addressing maternal mental health conditions and co-occurring substance use disorders. The Task Force developed a National Strategy to Improve Maternal Mental Health Care, which features recommendations for a whole-government approach to build the necessary infrastructure to improve care for maternal mental health conditions and substance use disorders. This approach includes increased accessibility, affordability, and equity of maternal mental health care and services (OASH, n.d.).

[18] Nevada SB 232 (2023). For more information, visit https://www.leg.state.nv.us/Session/82nd2023/Bills/SB/SB232_EN.pdf.

The Maintaining our Obligation to Moms who Serve Act (MOMS Act) of 2024 established a program in the military health care system to provide clinical and nonmedical resources to prevent and treat maternal mental health conditions (MMHLA, 2025). Key components of the program include providing mental health screening, counseling, treatment, and parenting support during the perinatal period for military service members and eligible dependents.

Federal Mental Health Parity and Addiction Equity Act

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) addresses parity for behavioral health benefits.[19] The MHPAEA requires that when mental health or substance use disorder services are covered, cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits. Furthermore, for any behavioral health benefits that are covered, coverage must be provided in all classification of benefits (e.g., inpatient in-network benefits, prescription drug benefits, emergency care benefits) in which comparative medical/surgical benefits are provided. The law protects enrollees from facing greater restrictions on access to behavioral health benefits as compared to medical/surgical benefits. The MHPAEA directly applies to large-group health insurance, but the Affordable Care Act (ACA) requires small-group and individual market plans and policies purchased through a state health insurance marketplace to comply with the MHPAEA. This federal requirement is similar to the California mental health parity law described previously,[20] although the state law applies to some plans and policies not captured in the MHPAEA.

SB 626 contains specific requirements regarding treatment coverage for perinatal mental health conditions that DMHC-regulated plans and CDI-regulated policies must provide. Additionally, case management for perinatal mental health conditions could be considered as one aspect of part of mental health parity.

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how SB 626 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[21,22]

Essential health benefits

In California, nongrandfathered[23] individual and small-group health insurance is generally required to cover EHBs.[24] In 2026, approximately 11% of all Californians will be enrolled in a plan or policy that must cover EHBs.[25]

SB 626 would not exceed the definition of EHBs in California because SB 626 would expand existing benefit coverage and does not create a new coverage requirement.

Other Federal or State Programs

As of April 2025, the Health Resources and Services Administration (HRSA) Screening and Treatment for Maternal Mental Health and Substance Use Disorders Program funds 13 awardees to expand health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum people for mental health and substance use disorders. Statewide

[19] Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA.
[20] HSC Section 1374.72; INS Section 10144.5 and 10123.15.
[21] The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to qualified health plans sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website.
[22] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[23] A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers."
[24] For more detail, see CHBRP's issue brief *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[25] See CHBRP's resource *Sources of Health Insurance in California*.

programs are available in Colorado, Kansas, Kentucky, Louisiana, Missouri, Mississippi, Montana, North Carolina, Tennessee, Texas, Vermont, and West Virginia. There is also a regional program in Los Angeles County, California (HRSA, 2025).

In 2019, the Healthcare Effectiveness Data and Information Set (HEDIS) released the prenatal depression screening and follow-up measure and the PPD screening and follow-up measure. These measures report the percentage of deliveries in which members covered by commercial insurance, Medicaid, and Medicare are screened for clinical depression and the percent of those who screen positive receive follow-up care. Several Medicaid agencies, including Medi-Cal, are reporting these measures. California is identified by the Policy Center for Maternal Mental Health as a top performer on both HEDIS measures (Policy Center for Maternal Mental Health, 2024a).

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Background on Perinatal Mental Health

This section provides context for potential impacts of SB 626, including an overview of perinatal mental health conditions, screening guidelines, treatment options, and case management. SB 626 would also require 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. There are several perinatal mental health conditions for which pregnant patients receive treatment. Psychiatric medications are commonly used but not specifically FDA approved for use during pregnancy, because no psychiatric medication is specifically indicated for use during pregnancy. Currently, there is only one medication that is FDA approved specifically for populations with a perinatal mental health disorder, and it is indicated only for PPD. There is also only one FDA-cleared digital therapeutic specifically targeting populations with a perinatal mental health disorder, and it is also only indicated for PPD. Thus, if enacted, SB 626 would currently only impact patients with PPD, for which information on prevalence, disparities, and treatment options are described below. Over the long term, it is possible additional therapeutics will be developed to treat other perinatal mental health conditions that are not otherwise addressed in this analysis.

Perinatal Mental Health Conditions and Prevalence in California

While there is no set of diagnostic criteria specifically for mental health conditions that develop during pregnancy or the postpartum period, the diagnostic criteria for mental health conditions described in the American Psychiatric Association's DSM-5 is generally utilized. It is worth noting that the APA guidelines (used for diagnosis) and ACOG guidelines (used for screening and treatment) have different definitions for when the postpartum period ends (APA: 4 weeks postpartum, ACOG: 12 months postpartum) (ACOG, 2023a). As SB 626 does not define the perinatal period, CHBRP has assumed a definition of pregnancy plus 12 months after the end of pregnancy. This is in alignment with ACOG's assessment of when perinatal mental health conditions are most likely to occur.

For this analysis, CHBRP has assumed that perinatal mental health conditions include depression, postpartum psychosis, anxiety disorders, bipolar disorder, PTSD, and OCD (ACOG, n.d.-b).[26] ACOG specifically recommends screening for depression, anxiety, and bipolar disorder during the perinatal period (ACOG, 2023a). 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, 2023a).

Table 2 describes the prevalence of perinatal mental health conditions at the time of delivery by age and race/ethnicity.

[26] Although definitions vary regarding whether perinatal mental health conditions can include conditions that begin before pregnancy, SB 626 specifies its applicability to perinatal mental health conditions that occur during pregnancy, the postpartum period, or the perinatal period.

Table 2. Prevalence of Any Perinatal Mental Health Condition at Delivery, by Age and Race/Ethnicity, California, 2022

	Any Perinatal Mental Health Condition at Delivery
Age	
<20	6.5%
20–24	7.2%
25–29	7.9%
30–34	8.6%
35–39	9.3%
40+	9.8%
Race/ethnicity	
American Indian or Alaska Native	12.1%
Asian	4.9%
Black	10.5%
Hispanic	6.3%
Multirace	13.6%
Pacific Islander	7.0%
White	13.4%

Source: CDPH, 2024b.

Perinatal Depression

Perinatal depression is the most common perinatal mental health condition that can arise during pregnancy (prenatal depression) or after birth (PPD) (NIMH, 2023). Perinatal depression[27] is an umbrella term that can include diagnoses of major depressive disorder (MDD) and minor depression (CA Task Force, 2017). Symptoms include feeling sad, empty, or hopeless most of the day; feeling irritable, frustrated, restless, guilty, or worthless; losing interest in hobbies or activities; fatigue; difficulty sleeping; difficulty concentrating, remembering, or making decisions; unexplained weight loss; somatic symptoms such as aches, pain, cramps, or digestive problems with no clear cause; challenges with bonding with the baby; persistent doubts about ability to care for the baby; and suicidal ideation or thoughts of harming the baby.

Table 3 describes the prevalence of perinatal depression by age and race/ethnicity as reported by the Maternal and Infant Health Assessment (MIHA) from the California Department of Public Health, 2019-2021 (CDHP, 2024c).

[27] Distinct from perinatal depression and not a mental health condition, “baby blues” refers to a common experience that involves sudden mild mood swings in the first two weeks after delivery (ACOG, n.d.-b). As this is not a perinatal mental health condition, it is not included in this report.

Table 3. Prevalence of Perinatal Depression by Age and Race/Ethnicity, California, 2019-2021

	Prenatal Depression Symptoms	Postpartum Depression Symptoms
Age (years)		
15-19	28.6%	15.1%
20-34	15.5%	14.2%
35+	10.7%	11.2%
Race/Ethnicity		
Asian/Pacific Islander	15.3%	15.2%
Black	23.5%	18.4%
Hispanic	15.6%	12.7%
White	11.5%	12.7%

Source: CDPH, 2024c.

ACOG recommends screening for perinatal depression at multiple points of the pregnancy: the initial prenatal visit, later in pregnancy, and at postpartum visits, by using a standardized, validated instrument (such as the Edinburgh Postnatal Depression Scale [EPDS] or Patient Health Questionnaire [PHQ]–9) (ACOG, 2023a). After a positive screen, the patient should be evaluated through discussion or interview to determine if the patient does indeed have depression and to rule out other possible conditions (differential diagnosis) (ACOG, 2023a).

Perinatal Anxiety Disorders

Perinatal anxiety disorders are a group of conditions that occur during pregnancy or the postpartum period, and can include generalized anxiety disorder (GAD), panic disorder, agoraphobia, social anxiety disorder/social phobia, specific phobia, and unspecified anxiety disorder. Symptoms include excessive anxiety and worry and difficulty controlling the worry, and can occur with restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and/or sleep disturbance. Prenatal anxiety can often co-occur with perinatal depression and has been associated with several adverse pregnancy outcomes including miscarriage, pre-eclampsia, preterm delivery, and low birthweight (Fawcett et al., 2019). A 2019 meta-analysis estimated the prevalence of at least one anxiety disorder during the perinatal period to be 20.7% (Fawcett et al., 2019). Generalized anxiety disorder can appear within the first 6 months of delivery and affects 6% to 8% of recent births (ACOG, 2023a). Panic disorder can appear at 6 to 10 weeks after delivery and affects 0.5% to 3% of recent births. Social anxiety can appear immediately postpartum and affects 0.2% to 7% of recent births (ACOG, n.d.-b).

ACOG recommends screening for perinatal anxiety at multiple points of the pregnancy: the initial prenatal visit, later in pregnancy, and at postpartum visits, by using a standardized, validated instrument (such as the GAD-7 or STAI) (ACOG, 2023a; ACOG, 2023b).

Postpartum Psychosis

Postpartum psychosis is one of the most severe perinatal mental health conditions and is an acute psychiatric emergency warranting immediate medical attention. It is a rare condition, with an estimated global prevalence of 0.089 to 2.6 per 1,000 births (Raza and Raza, 2023). It is most likely to be seen in patients with a diagnosis or family history of bipolar disorder (Raza and Raza, 2023). Symptoms include hallucinations, delusions, mania and/or depressed mood, loss of

inhibitions, feeling suspicious or fearful, restlessness, and confusion (ACOG, 2023a). Symptoms typically develop within 3 to 10 days of birth but can occur later as well (ACOG, 2023b). There are no standard screening tools available to screen for postpartum psychosis (Raza and Raza, 2023). ACOG recommends assessing for postpartum psychosis if a patient responds to a self-harm or suicide question affirmatively (ACOG, 2023a) with immediate referral to emergency care if postpartum psychosis is suspected or diagnosed.

Bipolar Disorder

Bipolar disorder causes shifts in behavior, mood, and energy levels, and is not necessarily caused by the pregnancy, though some women who were predisposed to developing bipolar disorder experience their first onset during pregnancy or the postpartum period or are identified during pregnancy (ACOG, n.d.-b). In 2022, approximately 0.6% of patients who gave birth in California had bipolar disorder (CDPH, 2024b). ACOG recommends that screening for bipolar disorder occurs at both prenatal and postpartum visits using a standardized, validated instrument (such as the MDQ or CIDI) (ACOG, 2023a).

Posttraumatic Stress Disorder (PTSD)

PTSD is a condition that can develop after a traumatic event, and is not necessarily caused by the pregnancy, though can develop for patients who have experienced an unplanned or unwanted pregnancy, traumatic delivery, or poor obstetric outcome (e.g., miscarriage, stillbirth, newborn loss, or preterm birth) (ACOG, n.d.-b). Patients with preexisting PTSD may also experience exacerbated symptoms after a traumatic birth. Symptoms can include intrusive thoughts, avoidance, hyperarousal, and negative world view (ACOG, n.d.-b). The estimated prevalence of PTSD for women in the perinatal period is 1.1% (Fawcett et al., 2019). ACOG does not have a specific recommendation to screen for PTSD, though it may be captured under screening for anxiety disorders (ACOG, 2023a).

Obsessive-Compulsive Disorder (OCD)

OCD is a condition characterized by two core symptoms: obsessions (intrusive thoughts, images, doubts, or urges that cause anxiety or distress) and compulsions (repetitive actions or behaviors used to quell disruptive thoughts) (Fairbrother et al., 2025). To meet diagnostic criteria, these symptoms must cause distress and/or occupy at least one hour/day (Fairbrother et al., 2025). It can develop before pregnancy, during pregnancy, or postpartum (typically 1 to 3 months postpartum) (ACOG, n.d.-b). The estimated prevalence of OCD among pregnant and postpartum women is roughly double that of the general population. One meta-analysis found that 2.1% of pregnant women, 2.4% of postpartum women, and 1.1% of nonperinatal women in the general population had OCD (Russell et al., 2013). Other estimates suggest it can occur in up to 4% of pregnancies (ACOG, n.d.-b) or when assessed continuously throughout the perinatal period, can range from 7.8% during the prenatal period and 16.9% during the postpartum period (Fairbrother et al., 2025). ACOG does not have a specific recommendation to screen for OCD, though it may be captured under screening for anxiety disorders (ACOG, 2023a).

Treatment and Case Management for Perinatal Mental Health Conditions

Treatments for Perinatal Mental Health Conditions

Medication use for mental health conditions during pregnancy is common. However, there is limited data on the use of medications for mental health conditions during pregnancy because studies are limited and tend to exclude pregnant patients. For this reason, there are very few FDA-approved medications specifically indicated for use by pregnant people with mental health conditions (Adam et al., 2011). At this time, the only medication for mental health conditions specifically approved by the FDA for use in pregnant patients is zuranolone (Zurzuvae), although that does not mean that pregnant patients go through their pregnancy without using medications for mental health conditions.

ACOG provides guidelines on the use of medications for mental health conditions during pregnancy and lactation, balancing the risks of medication exposure against the potential harm of untreated mental illness for the birthing person

and fetus (ACOG, 2023b). Upon diagnosis of perinatal depression, anxiety, OCD, or PTSD, ACOG recommends that the patient be referred for psychotherapy (regardless of severity) (ACOG, 2023a). 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 (ACOG, 2023b).

For pregnant patients with bipolar disorder, patients should continue using the mood stabilizers that had previously worked for them, although valproate should be avoided due to its effect on fetal development (ACOG, 2023b). Postpartum psychosis is treated as a psychiatric emergency and typically requires hospitalization, and medications such as benzodiazepines and antipsychotics (ACOG, 2023b).

SB 626 would require 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. Currently, there is only one medication that is FDA-approved specifically for populations with a perinatal mental health condition, and it is indicated only for PPD (zuranolone). There is also only one FDA-cleared digital therapeutic specifically targeting populations with a perinatal mental health disorder, and it is also only indicated for PPD (MamaLift Plus).

In 2023, the FDA approved zuranolone (Zurzuvae) to treat PPD. That year, ACOG included zuranolone as a treatment option that could be considered for treating severe postpartum depression that had onset within the 3rd trimester of pregnancy or within 4 weeks postpartum (ACOG, 2023c). It can be used alone or in conjunction with other medications (SSRIs or serotonin-norepinephrine reuptake inhibitors [SNRIs]) and is meant to be taken over a 2-week period (FDA, 2023). In clinical practice, zuranolone is reserved for use in severe cases of PPD (treatment refractory PPD) and is typically prescribed and monitored by a psychiatrist. Symptom relief from zuranolone in this population lasts for about 45 days and is typically paired with an SSRI for longer-term symptom relief.[28] Zuranolone is not meant to be used during pregnancy, and it is unclear whether breastfeeding during treatment could affect the infant, thus it is recommended that breastfeeding be discontinued while the medication is being used (ACOG, 2023c). See *Medical Effectiveness* for more information about zuranolone.

MamaLift Plus is an 8-week app-based program for patients aged 22 and older with mild-to-moderate PPD. 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. Patients who continuously engage with the app are rewarded with points that can be used to purchase goods from the MamaLift Marketplace (Curio Digital Therapeutics, 2025). Digital therapeutics such as phone-based apps are new and not yet commonly prescribed by physicians. This application would likely be used by patients who cannot otherwise access or afford psychotherapy with a licensed provider.[29] See *Medical Effectiveness* for more information about MamaLift Plus.

Case Management and Care Coordination

There is broad variation in the definition for case management and care coordination, and what those services should entail. Generally speaking, case management is a service that can be offered to patients who could benefit from professional assistance in navigating the health care system and coordinating specialized care or support services that might be needed for the patient’s health or psychosocial goals (Giardino and De Jesus, 2023). A case manager would review the patient’s health benefit plan and community offerings and develop a plan for the patient to follow that may help them better access and navigate their existing benefits. Care coordination generally involves both the organizing of patient care processes, and the sharing of information with those involved in patient care. The degree and manner in which coordination occurs can vary broadly (AHRQ, 2024). SB 626 does not establish a definition of what case management or care coordination services should entail, or who should be providing them.

[28] Personal communication, content expert Misty Richards, MD, MS, UC Los Angeles, April 3, 2025.
[29] Personal communication, content expert Misty Richards, MD, MS, UC Los Angeles, April 3, 2025.

Barriers to Accessing Treatment of Perinatal Mental Health Conditions

Since screening for depression in pregnant and postpartum women has been recommended by the USPSTF since 2016 (Siu et al., 2016), screening in practice has improved but remains inconsistent. In 2023, approximately 85% of prenatal and postpartum patients with commercial insurance, and 62% of prenatal and postpartum patients with Medicaid, received depression screening and follow-up (McCree et al., 2024). In some instances, screening for prenatal depression doesn't occur until late in the pregnancy (Koire et al., 2022) or an opportunity to screen for PPD doesn't occur at all. Women who experience an infant death (including a stillbirth) have an elevated risk of developing depression but are most likely to not attend a postpartum visit where screening could occur and treatment could be initiated (Morgan et al., 2018).

Even when patients are properly screened and diagnosed, access to care remains a challenge. One study found that for pregnant patients attending an intake appointment at a practice where all patients receive depression screening and also has co-located behavioral services, only half of patients who were recommended for psychotherapy received it (Tourtelot et al., 2021). Reasons for this varied: some patients did not have time to attend appointments; confusion in coordination responsibilities led to some patients not receiving psychotherapy; and others attended appointments but stopped attending when the next EPDS screen improved (Tourtelot et al., 2021).

A systematic review that included 13 studies described additional barriers to accessing treatment for perinatal depression (Westgate et al., 2023). Some patients are hesitant to take medication while pregnant or breastfeeding, concerned about how it might affect the baby (Westgate et al., 2023). For those who were referred to psychotherapy, some patients either couldn't get an appointment due to waiting lists or lack of provider availability, or could not attend appointments due to childcare obligations (Westgate et al., 2023).

Disparities[30] in Perinatal Depression

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities. Where intersections between health insurance benefit mandates and social determinants or systemic factors exist, CHBRP describes relevant literature.

CHBRP found literature identifying disparities by race or ethnicity and income.

Race or Ethnicity

Disparities by race and ethnicity can be seen in the prevalence of PPD symptoms, and access to treatment. In California, roughly one in five Black women, one in seven Asian or Pacific Islander women, and one in eight White or Hispanic women develop PPD (CDPH, 2024a). Nationally, the rates of PPD have doubled over the past 10 years, largely driven by increases in the American Indian or Alaska Native, Asian or Pacific Islander, Hispanic, and Black populations (Hill et al., 2024; Khadka et al., 2024). Cultural and language barriers along with trauma and racism make accessing appropriate mental health care services an even greater challenge (Hill et al., 2024).

Income

Disparities in income can be seen in the prevalence of depression symptoms in the perinatal period. In the United States, more women live in poverty than men, and are more likely to have higher rates of food insecurity, inadequate nutritional intake, unstable housing, partner conflict, and other challenges that can impact mental health (Semega, 2019; Smith and Mazure, 2021). Poverty and depression are likely to operate in a cycle, where living in poverty increases the risk of developing depression, and the onset of depression likely increasing the risk of poverty (Smith and Mazure, 2021).

[30] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).

According to the CDPH, poverty is associated with higher rates of prenatal depression symptoms and postpartum depression symptoms (CDPH, 2024a).

Table 4 describes the prevalence of perinatal depression by income:

Table 4. Prevalence of Perinatal Depression by Household Income, California. 2019-2021

Household Income	Prenatal Depression Symptoms	Postpartum Depression Symptoms
0–100% of poverty	20.0%	15.4%
101–200% of poverty	16.8%	14.6%
200%+ of poverty	10.4%	11.9%

Source: CDPH, 2024a

Societal Impact of Perinatal Mental Health Conditions in California

The presence of perinatal depression in California has direct and indirect economic and societal costs. In dollar terms, the societal impact can be indirect (lost wages, etc.) as well as direct (medical care, etc.). A 2019 estimate of births from 2017 found that the societal costs of untreated perinatal depression, anxiety, panic, OCD, and posttraumatic stress disorders in California was $2.4 billion when following the mother-child pair from pregnancy through 5 years postpartum (Luca et al., 2019). This estimate includes pregnancy and birth complications that may arise from untreated perinatal mental health disorders, and amounts to $816 million in maternal productivity losses, $481 million in maternal health expenditures, $109 million in obstetric-specific expenditures, $468 million from preterm births, $388 million from child behavioral and developmental disorders, and $36 million from child injury (Luca et al., 2019). National estimates for the same cohort were $14 billion in economic burden (Luca et al., 2020). Please note, the societal impact discussed here is relevant to a broader population than SB 626 impacts, which would affect the health insurance of a subset of Californians (see *Policy Context*). See the *Benefit Coverage, Utilization, and Cost Impacts* section for estimates of direct cost impacts for the specific population targeted by SB 626.

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Medical Effectiveness

As discussed in the *Policy Context* section, SB 626 would require DMHC-regulated plans and CDI-regulated policies to cover at least one medication approved by the FDA for perinatal mental health and at least one digital therapeutic approved by the FDA for perinatal mental health. Additionally, SB 626 would require that DMHC-regulated plans and CDI-regulated policies provide case management and care coordination during the perinatal period; that they annually report to DHCS on the utilization and outcomes of case management; and that they publicly post the information reported. Finally, SB 626 would require that a licensed health care provider who provides perinatal care for a patient must screen, diagnose, and treat the patient for a perinatal mental health condition according to the clinical guidelines from ACOG. SB 626 would change existing screening guidance — at least once during pregnancy, at least once during the first 6 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 — to follow ACOG clinical guidelines, which currently recommend that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits (ACOG, 2023a).

Additional information on perinatal mental health conditions is included in the *Background* section. The medical effectiveness review summarizes findings from evidence[31] on the effectiveness of treatment interventions including medications and digital therapeutics that are FDA approved, additional pregnancy screenings that are recommended by ACOG guidelines, and case management and care coordination for treatment of perinatal mental health conditions.

The major treatments that this bill would require coverage for are the prescription medication zuranolone (Zurzuvae) and a prescription-only digital therapeutic, MamaLift Plus.

Research Approach and Methods

The search was limited to studies published from 2016 to the present because CHBRP previously conducted thorough literature searches on care coordination and case management for its analysis of AB 2193 in 2018.[32] Additionally, there are no studies prior to this year for the other treatments in this bill. The FDA-approved zuranolone for the treatment of postpartum depression in August 2023 and MamaLift plus in 2024.

A total of 16 studies were included in the medical effectiveness review for this report. The other articles were eliminated because they did not focus on perinatal women, were of poor quality, or did not report findings from clinical research studies. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in CHBRP's Medical Effectiveness Analysis and Research Approach document.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[33] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

[31] Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence in the Medical Effectiveness Analysis and Research Approach document, in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.
[32] Studies of the effects of zuranolone, MamaLift Plus, case management and care coordination, and perinatal mental health screening were identified through searches of PubMed, Cochrane Library, Web of Science Core Collection, Embase, Scopus, PsycInfo, and Cumulative Index of Nursing and Allied Health Literature. The search was limited to abstracts of studies published in English.
[33] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. See CHBRP's website for more information.

Key Questions

1. For perinatal patients, what is the effectiveness of FDA-approved medications on health outcomes, as well as the associated harms, compared to placebo?
2. For perinatal patients, what is the effectiveness of FDA-approved medications on health outcomes compared to selective serotonin reuptake inhibitors (SSRIs)?
3. For perinatal patients, what is the effectiveness of FDA-approved digital therapeutics on health outcomes, as well as the associated harms, compared to usual care?
4. For perinatal patients, does screening for maternal mental health conditions among pregnant and postpartum women result in improved health outcomes compared to usual care?
5. For perinatal patients, what is the effectiveness of case management and/or care coordination on health outcomes, as well as the associated harms, as compared to usual care?

Methodological Considerations

For this analysis, CHBRP has assumed that perinatal mental health conditions include depression, postpartum psychosis, anxiety disorders, bipolar disorder, PTSD, and OCD (ACOG, n.d.-b). PPD includes depression that is present at some point during the 12-month period after delivery. That said, the timing of the onset of the PPD symptoms can begin either before or after delivery (DSM-5, 2013). The effectiveness of antidepressants in treating PPD has been supported by multiple randomized controlled trials (RCTs). The current treatment includes SSRIs as the preferred choice because of safety profiles, experience, and tolerance compared with other antidepressants (Liu et al., 2023). More recently, the FDA approved zuranolone for the treatment of PPD in August 2023, with an indication for the treatment of PPD without regard to severity or timing of the onset of symptoms (FDA, 2023). Note that this differs from the population studied in the clinical trials of zuranolone, which only included patients with severe depression with timing of the onset of symptoms in the 3rd trimester or within 4 weeks postpartum (timing consistent with the mechanism-of-action of the zuranolone). In contrast, ACOG published a practice advisory in August 2023 recommending the consideration of zuranolone for PPD with timing of onset that is consistent with the studies (ACOG, 2023c).

Outcomes Assessed

To assess the effectiveness of pharmacologic treatments, digital therapeutics, screening, case management, and care coordination for perinatal mental health conditions, CHBRP included peer-reviewed RCTs and observational studies that examined two points in time (baseline and follow-up) that included outcomes of condition symptomology, condition remission or response, and quality of life.

FDA-approved prescription medications

Studies of FDA-approved medications for PPD used the Hamilton Depression Rating Scale (HAMD-17) as their primary outcome. The HAMD-17 provides scores for assessment of initial symptoms and clinical progression of symptoms of depression in adults. The score ranges from 0 to 50. Normal is consistent with scores of 0 to 7. Mild depression is consistent with scores of 8 to 13. Moderate depression is consistent with scores of 14 to 18. Severe depression is consistent with scores of 19 to 22. Very severe depression is consistent with scores ≥ 23. A difference of 4.5 points separates the midpoint of mild, moderate, and severe depression. A “response” to treatment is commonly defined as a HAMD-17 score decrease of > 50%. “Remission” is commonly defined as a HAMD-17 score ≤ 7 (MD+Calc, n.d.-c). A meaningful clinical difference is considered an improvement of 2 to 3 points. (CDA-AMC, 2016). Studies of FDA-approved medications for PPD included multiple secondary outcomes including the Montgomery-Asberg Depression Rating Scale (MADRS) score,[34] the EPDS postnatal depression scores (described in the paragraph below), the Hamilton Anxiety Scale

[34] The Montgomery-Asberg Depression Rating Scale (MADRS) score helps stratify severity of depressive symptoms. Absent depressive symptoms is consistent with scores of 0 to 8, mild depression is consistent with scores of 9 to 17, moderate depression is consistent with scores of 18 to 34, severe depression is consistent with scores of 35 to 60 (MD+Calc, n.d.-d). A minimally clinical important difference is considered to be 1.6 to 1.9 points (Masson and Tejani, 2013).

(HAM-A) anxiety scores,[35] the Clinical Global Impressions-Improvement Scale (CGI-I) global impression score,[36] and Barkin Index of Maternal Functioning (BIMF) maternal function scores.[37] Harms were reported as side effects of the medications.

FDA-approved prescription digital therapeutics

Studies of FDA-approved prescription digital therapeutics examined outcomes using the EPDS scores. The EPDS uses a scoring system from 0 to 30, with a score of 10 or more potentially indicating possible depression, and a score of 13 or more suggesting a higher risk of PPD. This tool is for screening only and is not used for diagnosis or assessing the level of depression (MD+Calc, n.d.-a). An improvement of 4 points on the EPDS scale is considered a clinically meaningful improvement (Mao et al., 2021).

Screenings, case management, and care coordination

As SB 626 specifies that screenings for perinatal mental health conditions shall be conducted by licensed health care providers, CHBRP excluded studies of screening programs in other settings (e.g., pediatric well-child visits, neonatal ICU). Studies of screening, case management and care coordination have primarily examined outcomes related to depression assessment scores including the EPDS scores (Cox et al., 1987) and PHQ-9 scores (Kroenke et al., 2001), a self-report questionnaire used to screen for and assess the severity of depression, with a score above 10 indicating possible depression that merits further evaluation by a healthcare professional.

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence for the effectiveness of treatments for maternal mental health conditions during the perinatal period by SB 626. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms are included in the box below.

The following terms are used to characterize the body of evidence regarding an outcome:

Very strong evidence indicates that there are multiple studies of a treatment and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

Strong evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.

Some evidence indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.

[35] The Hamilton Anxiety Scale (HAM-A) helps rate the severity of a patient's anxiety. Mild anxiety severity is consistent with scores of ≤17. Mild-to-moderate anxiety severity is consistent with scores of 18 to 24. Moderate to severe anxiety severity is consistent with scores of 25 to 30. Severe anxiety is consistent with scores of >30 (MD+Calc, n.d.-b).
[36] Clinical Global Impressions-Improvement Scale (CGI-I) Clinician rating evaluating how much has a patient's function has changed. 0 = Not assessed, 1 = Very much improved, 2 = Much improved, 3 = Minimally improved, 4 = No change, 5 = Minimally worse, 6 = Much worse, 7 = Very much worse (Simple and Practical Mental Health, 2024).
[37] The Barkin Index of Maternal Functioning (BIMF) is a 20-item self-report scale to assess functioning in motherhood (BMF, 2025). For more information, see https://barkinindexmaternalfunctioning.com/about/.

Conflicting evidence indicates that a similar number of studies of equal quality suggest the treatment is effective as suggest the treatment is not effective.

Not enough research indicates that there are no studies of the treatment or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Findings on the Effectiveness of FDA-Approved Medications on Health Outcomes

There is one FDA-approved medication for the treatment of perinatal mental health conditions (FDA, 2023): Zurzuvae (zuranolone), an oral version of the neuroactive steroid allopregnanolone, which acts as a positive modulator of gamma-aminobutyric acid ($GABA_A$) receptors (Deligiannidis et al, 2021; Deligiannidis et al., 2023). This class of medications aims to restore allopregnanolone to serum concentrations equivalent to those present during the end of pregnancy, treating mood disorders that are precipitated by the large and rapid fluctuations of this hormone during the 3rd trimester of pregnancy and early postpartum period (Kanes, 2017). An intravenous version of allopregnanolone (called brexanolone) was previously FDA approved for PPD. This medication was delivered via an intravenous (IV) infusion with monitoring of the patient during a hospitalization due to the potential for significant sedation. Brexanolone was discontinued by the manufacturer in December 2024 as part of a strategic shift to focus on the use of zuranolone (Sage Therapeutics, 2024).[38]

CHBRP identified two RCTs that examined the clinical effectiveness of zuranolone for PPD (Deligiannidis et al, 2021; Deligiannidis et al., 2023).

In the first randomized double-blind placebo-controlled trial (funded by the manufacturer of zuranolone, Sage Therapeutics), researchers evaluated a 2-week course of zuranolone 30 mg compared to matching placebo capsules in postpartum women with a major depressive episode within 6 months postpartum (Deligiannidis et al., 2021; n=153). Eligible patients had timing of the onset of depression symptoms during the 3rd trimester of pregnancy or within 4 weeks postdelivery, with HAMD-17 scores in the severe range of 26 or higher. In this study, 41% of the patients were African American and 23% were of Hispanic/Latina ethnicity. At study enrollment, 19% of the patients were on a stable dose of another antidepressant. The patients were able to receive other pharmacologic treatment for their depression if the medication was stable 30-days before or started 14-days after commencement of the study. The characteristics of the two groups, including the number of patients taking other antidepressants, were statistically similar at baseline. The primary outcome for the study was improvement in least square mean (LSM) HAMD-17 depression scores 15 days after starting the 2-week course of the medication. At 15 days, the zuranolone group's mean depression scores improved 4.2 points more than the placebo group ($P = .003$). A change in 4.2 points is clinically significant and is consistent with an improvement from severe depression to moderate depression. Patients in the zuranolone group also responded to the treatment[39] at a higher rate than the placebo group (72% vs. 48% on day 15; $P = .02$) and had a higher depression remission rate[40] than the placebo group (45% vs. 23% on day 15; $P = .01$). Significant improvements for the zuranolone group started as early as the 3rd day[41] and persisted until the end of analysis on day 45.[42] The zuranolone group also experienced significant improvements in other clinical outcomes including lower MADRS depression scores, lower HAM-A anxiety scores, increased CGI-I global impression improvement rates, and increased BIMF maternal function scores

[38] Food and Drug Administration (FDA). (2025). Withdrawal of Approval of a New Drug Application for ZULRESSO (Brexanolone) Solution, 100 Milligrams/20 Milliliters. *Federal Register*. 90 FR 12162-12163.
[39] Response rate is defined as a reduction ≥ 50% in HAM-D score from baseline.
[40] Remission rate is defined as a total score ≤ 7 on the HAM-D.
[41] LSM difference in HAMD-17 depression scores of - 2.7 ($P = .03$), HAMD-17 depression response rate 41% vs. 27% ($P = 0.10$), and HAMD-17 depression remission rate 19% vs. 5% ($P = .02$) for the zuranolone group vs. placebo group, respectively, at day 3
[42] LSM difference in HAMD-17 depression scores – 4.1 ($P = .003$), HAMD-17 depression response rate 75% vs. 57% ($P = .02$), and HAMD-17 depression remission rate 53% vs 30% ($P = .009$) for the zuranolone group vs. placebo group, respectively, at day 45.

compared to the placebo group.[43] The results of these secondary outcomes are included in the footnotes. The improvements were similar in those patients who were and were not using other antidepressants at entrance to the study.

In a second randomized double-blind placebo-controlled trial (also funded by the manufacturer of zuranolone, Sage Therapeutics), researchers evaluated a 2-week course of a higher dose of zuranolone (50 mg) compared to matching placebo capsules in women with a severe major depressive episode within 12 months postpartum (Deligiannidis et al., 2023; n=196). Eligible patients had timing of symptom onset during the 3rd trimester of pregnancy or within 4 weeks postdelivery with a severe HAMD-17 depression score of 26 or higher. In this study, 22% of the patients were African American and 38% were of Hispanic/Latina ethnicity. The patients were able to receive other pharmacologic treatment for their depression if the medication was stable 30 days before or started 45 days after commencement of the study. At baseline, 15% of the patients were also on a stable dose of another antidepressant. Other characteristics of the two groups were similar at baseline. The primary outcome was also an improvement in HAMD-17 depression scores as in the study above. At 15 days, the zuranolone group's depression scores improved 4.0 points more than the placebo group (P = .007). As noted above, a change in four points on the HAMD-17 score is clinically significant and consistent with a change from severe depression to moderate depression. The patients in the zuranolone group also responded to treatment[44] at a higher rate than the placebo group (57.0% vs. 38.9% on day 15; P = 0.02) but had similar depression remission rates[45] compared the placebo group (26.9% vs. 16.7% on day 15; P = 0.11). The difference in outcomes for the zuranolone group generally started on the 3rd day,[46] and persisted until the end of analysis on day 45.[47] Zuranolone patients also experienced significantly improved MADRS depression scores, HAM-A anxiety scores, EPDS postpartum depression scores, and CGI-I global impression improvement rates compared to the placebo group[48] with similar improvements in those patients who were and were not using other antidepressants at baseline.

Summary of findings regarding zuranolone for the treatment of PPD: There is *some evidence* that zuranolone is clinically effective at improving depression symptoms for patients with severe PPD, which begins within the 3rd trimester of pregnancy or the first 4 weeks postpartum. This rating is based on the results of two well-designed RCTs with relatively small sample sizes, short patient follow-up to only 45 days, and the potential bias of industry funding of both studies.

Figure 2. Findings on the Effectiveness of FDA-Approved Medications on Health Outcomes

Findings on the Effectiveness of FDA-Approved Medications Compared to Other Selective Serotonin Reuptake Inhibitor (SSRI) Medications on Health Outcomes

SSRIs are the most common antidepressant currently used to treat PPD. CHBRP did not find any studies that directly compare zuranolone to SSRIs for the treatment of PPD. One study (Meltzer-Brody et al., 2024) examined the effectiveness of zuranolone compared to SSRIs, using an indirect comparison and network meta-analysis of the zuranolone and SSRI data. This study reported that zuranolone patients showed significant improvement in the EPDS

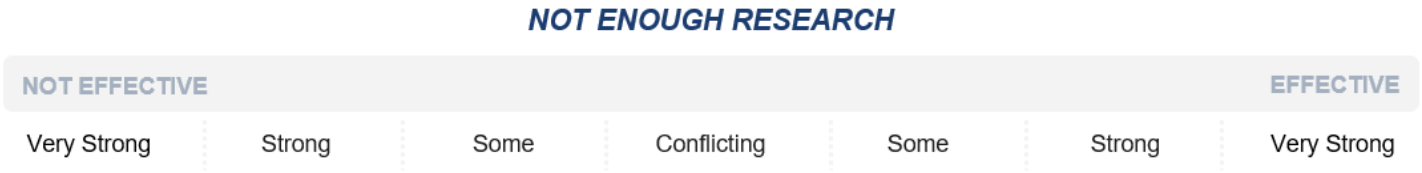
[43] LSM difference in Montgomery-Asberg Depression Rating Scale (MADRS) score of −4.6 points (P = .02) for the zuranolone group vs. placebo at day 15. LSM difference in HAM-A anxiety score of −3.9 (P = .006) for the zuranolone group vs. placebo at day 15. Increase CGI-I global impression improvement rates of 72% vs. 52% (P = .03) for the zuranolone group vs. placebo at day 15. LSM difference in the BIMF maternal function score of +7.2 (P = .02) for the zuranolone group vs. placebo at day 45.
[44] Response rate is defined as a reduction ≥ 50% in HAM-D score from baseline.
[45] Remission rate is defined as a total score ≤ 7 on the HAM-D.
[46] LSM difference in HAMD-17 scores of -2.7 (P = .03), HAMD-17 depression response rate 26.5% vs. 12.5% (P = .012), and HAMD-17 depression remission rate 8.2% vs. 5.2% (P = .41) for the zuranolone group vs. placebo group, respectively, at day 3.
[47] LSM difference in HAMD-17 scores of -4.1 (P = .003), HAMD-17 depression response rate 61.9% vs. 54.1% (P = .17), and HAMD-17 depression remission rate 44.0% vs. 29.4% (P = .02) for the zuranolone group vs. placebo group, respectively, at day 45.
[48] LSM difference in MADRS depression score of -5.1 (P =.003) for the zuranolone group vs. placebo at day 15. LSM difference in HAM-A anxiety of -2.2 (P = .02) for the zuranolone group vs. placebo at day 15. LSM difference in EPDS postpartum depression score of -2.0 (P = .04) for the zuranolone group vs. placebo at day 15. Improvement in the CGI-I global impression improvement rates of 66.7% vs. 46.7% (P = .009) for the zuranolone group vs. placebo at day 15.

scale at day 15 and day 45 (day 15: 4.22-point larger reduction [95% CI: -6.16, -2.28]; day 45: 7.43-point larger reduction [95% CI: -9.84, -5.02] versus SSRIs patients. However, the quality of this review was limited by differences between the zuranolone and SSRI trials in study design, study quality, patient population, placebo groups, outcome measures, and the potential bias of industry funding of the study.

Summary of findings regarding the effectiveness of FDA-approved medications compared to other SSRIs on health outcomes: There is *not enough research* to determine if zuranolone is more effective than SSRIs for the treatment of PPD based on one indirect study comparing the two medications.

Not enough research indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Figure 3. Evidence on the Effectiveness of FDA-Approved Medications Compared to Other Selective Serotonin Reuptake Inhibitor (SSRI) Medications on Health Outcomes



Findings on the Effectiveness of FDA-Approved Digital Therapeutics on Health Outcomes

There is currently one FDA-cleared digital therapeutic for the treatment of perinatal mental health: MamaLift Plus. MamaLift Plus is an app that provides 8 weeks of behavioral interventions, including Cognitive Behavioral Therapy (CBT), Behavioral Activation Therapy (BAT), Interpersonal Therapy (IPT), and Dialectical Behavior Therapy (DBT), as a prescription-only add-on to clinical care for people diagnosed with mild-to-moderate PPD (Curio Digital Therapeutics, 2024). MamaLift Plus is based on a legacy digital therapeutic called “Be-A-Mom” that was developed in Europe by the University of Coimbra for the prevention of PPD (Tang et al., 2022).

There are no clinical trials of MamaLift Plus that meet the CHBRP criteria for inclusion in this report. There is one study of the clinical outcomes of MamaLift Plus (SuMMER study) presented in abstract form at the ACOG national conference in 2024 (Dixit, 2024; n=141) and also published by the FDA as part of the FDA clearance of MamaLift Plus (FDA-CDRH, 2024). The author of the study as presented at ACOG is the CEO and founder of the company that is marketing MamaLift Plus. The SuMMER study is a randomized sham-controlled trial of 141 postpartum women, aged 22 or older, with a clinician-confirmed diagnosis of mild-to-moderate PPD and a EPDS score of 13 to 19. The patients were able to be treated with antidepressants during this study; 21% were on an antidepressant medication at some point during the study period. The characteristics of the two groups, including the number of patients taking antidepressants, were statistically similar at baseline. This study compared the use of the digital therapeutic MamaLift Plus for 8 weeks to a sham intervention at a ratio of 2:1. The sham intervention mimicked the function and patient experience of the treatment (with similar look, feel, workload, and frequency of contact) but without any specific therapeutic content. Using an intent-to-treat analysis, results demonstrated that 86.3% of the MamaLift Plus users achieved at least a four-point improvement on EPDS score[49] versus 23.9% of the sham control group ($P < 0.0001$). This was the primary endpoint. In addition, 83.2% of the MamaLift Plus users achieved an EPDS score <13 versus 32.6% of the sham control group ($P < 0.0001$).[50] The results of the primary endpoint were similar in those patients who did and did not take antidepressants during the study.

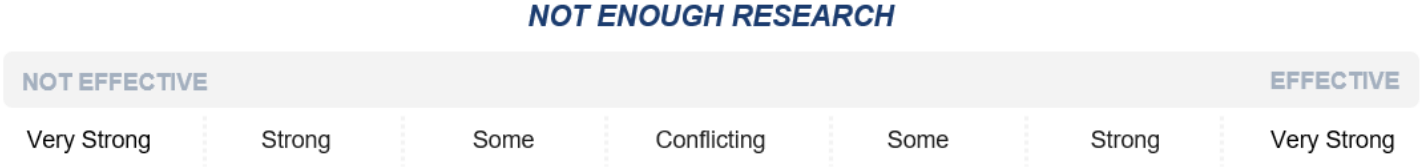
[49] An improvement of 4 points on the EPDS scale is considered a clinically meaningful improvement (Mao et al., 2021).
[50] EPDS score of 13 or less suggests lower risk of PPD.

This study has several limitations, including a relatively small sample size, limited patient follow-up to 8 weeks, lack of publication of the study in a peer-reviewed journal, and the potential bias of industry funding of the study.

Summary of findings regarding FDA-approved digital therapeutics on health outcomes: There is *not enough research* to demonstrate that the FDA-approved digital therapeutic MamaLift Plus is effective for the treatment of mild-to-moderate PPD, as CHBRP did not identify any studies published in a peer-reviewed journal to evaluate the evidence.

Not enough research indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Figure 4. Evidence on the Effectiveness of FDA-Approved Digital Therapeutics on Health Outcomes



Findings on the Effectiveness of Screening for Maternal Mental Health Conditions on Health Outcomes

CHBRP did not find any new trials assessing the effectiveness of screening for maternal mental health conditions.

As reported in the 2018 CHBRP report for AB 2193, the 2016 USPSTF review did not identify any trials comparing the effects of usual perinatal care versus screening plus usual perinatal care on perinatal depression outcomes (CHBRP, 2018; O'Connor et. al., 2016). The review did identify six trials examining the benefits of participation in a perinatal depression screening program; however, all of the trials employed *additional intervention* elements beyond depression screening, such as patient/provider education and home visits from midwives. Therefore, it is not possible to isolate the effects of screening on outcomes alone. While these trials do not directly address whether screening alone is beneficial, they can provide evidence as to whether being identified at risk for perinatal depression as part of a larger perinatal depression intervention leads to improved outcomes.

Summary of findings regarding screening for maternal mental health conditions: There is *not enough research* to demonstrate that screening for maternal mental health conditions is effective for improving health outcomes, as CHBRP did not identify any studies published in a peer-reviewed journal to evaluate the evidence.

Not enough research indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Figure 5. Evidence on the Effectiveness of Screening for Maternal Mental Health Conditions on Health Outcomes

Findings on the Effectiveness of Care Coordination and Case Management

Case management and care coordination can contain elements of traditional mental health case management, such as having a case manager who facilitates linkages to specialized care and monitors their clients' progress, and collaborative or integrated care models, which promote communication across the multiple providers a patient sees to coordinate care for both physical and mental health issues (Byatt et al., 2015; Grote et al., 2015). The specific manner and intensity with which these models of care are applied vary in practice but are used to increase access to a range of treatments and providers, and help women remain engaged in care (Byatt et al., 2015; Sit et al., 2009).

Because SB 626 does not define the exact components of case management and care coordination that would be included, it is hard to assess the effectiveness of interventions. It stands to reason that women enrolled in case management and care coordination will be more likely to access the care and treatments to which they are referred, which may in turn lead to improved health outcomes, but the extent to which this would occur is unknown as the structure and intensity of case management and care coordination programs developed as a result of SB 626 would be likely to vary across health plans. While provision of collaborative care is not included in SB 626, CHBRP included any studies that examined programs that included components of case management and care coordination, including collaborative care, a program that usually includes components of each.

CHBRP found few studies on the effectiveness of care coordination and case management on health outcomes in perinatal women. In the 2018 report for AB 2193 (CHBRP, 2018), CHBRP reported one randomized trial identified by the 2016 USPSTF (Gjerdingen et al., 2009) and a trial evaluating collaborative care interventions that included depression case management compared to usual care.

More recently, CHBRP found two small observational studies comparing pretreatment and posttreatment depressive scores that evaluated collaborative care interventions in perinatal women.

Depressive symptoms

A randomized trial (Gjerdingen et al., 2009; n=506) reported that there was no treatment benefit observed between a case management care intervention and usual care groups with respect to depressive symptoms, clinical depression remission, general health ratings, and daily functioning in the postpartum follow-up period. The usual care control group received treatment for PPD at their primary care provider's discretion and the case management intervention involved referral to a primary care provider, patient education, biweekly telephone consultation with a care manager, and means of referral to mental health providers who utilized both behavioral and pharmacologic treatment approaches. At the 9-month follow-up, there was no difference between usual care and case management care in the number of individuals who screened positive for depression (PHQ-9 score <10) (P = 0.46). In a multisite study of depression outcomes in low-income pregnant women receiving care in public health clinics in Seattle, Grote et al. (2015; 168 pregnant women with screen-detected depression) evaluated collaborative care interventions that included depression case management or usual care.[51] Researchers reported that women in the case management group demonstrated significant within-group improvements in depression severity at every follow-up time point and, when compared with usual care, case management was significantly more effective at reducing depression severity at 6 months (mean difference, −0.24; 95% CI: −0.46 to 0.03; P = 0.03) and 18 months (mean difference, −0.25; 95% CI: −0.45 to 0.04; P = 0.02), but no significant differences were observed between groups at the 3-month and 12-month time points.

Two more recent small observational studies compared pretreatment and posttreatment depression symptoms scores to evaluate collaborative care interventions in perinatal women. Rock et al. (2022; 37 women) reported that, for women that

[51] Maternity Support Services (MSS) is the usual standard of care in the public health system of Seattle-King County for pregnant women on Medicaid, delivered by a multidisciplinary team of public health social workers, nurses, and nutritionists, who routinely screen, at least once, for depression from pregnancy up to 2 months postpartum. It includes services to promote healthy pregnancies and positive birth and parenting outcomes, providing case management services to meet basic needs, and facilitating regular contact with an OB provider. Pregnant women scoring PHQ-9 ≥10 were eligible for intensive MSS-Plus services, which includes more frequent, longer visits from their multidisciplinary team.

screened positive for depression during pregnancy, participation in a collaborative care model (CCM) program[52] achieved the study goal of referral to evaluation for mental health care within a 30-day period and significant improvement and remission from depression based on EPDS scores ($P < 0.05$) at 6 months (study completion). For women enrolled in collaborative care during the postpartum period, there was no statistical difference in depression scores (EPDS score) between women that received collaborative care interventions or usual care at 6-month study follow-up. Bhat et al. (2018; 27 women) reported that women who screened positive for depression during pregnancy (PHQ-9 scores) and enrolled in a rural obstetric clinic collaborative care intervention that included home visits by the case manager and communication via text messaging, PHQ-9 scores significantly declined from baseline to end of treatment (score 15.3 vs. 6.2; 14.4 weeks average end of treatment time)[53].

Breastfeeding

In a retrospective cohort study (Allen et al., 2022; 350 subjects) of eligible pregnant patients referred to a perinatal collaborative care program because of an identified mental health condition[54], engagement in collaborative care was defined as completion of at least two PHQ-9 screens, participation in at least two check-in calls from a care manager, and initiation of either psychotherapy or medication management with one provider. Findings reported that women in collaborative care were more likely to initiate breastfeeding (168 [95%] vs. 47 [87%]; $P = .046$) and continue breastfeeding at 6 weeks postpartum visit (92 [74%] vs. 20 [53%]; $P = .012$) compared to women who did not engage in collaborative care. This difference was still seen after controlling for potential confounders, including race, tobacco use, and other mental health conditions (adjusted odds ratio for initiation, 3.30; 95% CI: 1.09–9.98; adjusted odds ratio for continuation, 3.08; 95% CI: 1.29–7.36).

Summary of findings regarding effectiveness of care coordination and case management on health outcomes: There is *conflicting evidence* whether care coordination and case management on health outcomes is effective based on five studies. Because two of the more recent studies compare the time before treatment to follow-up scores and do not include a control group, it is hard to conclude that the findings are due to case management or care coordination intervention. One study showed that engagement in a collaborative care program increased initiation and continuation of breastfeeding at 6 weeks follow-up.

Figure 6. Evidence of Effectiveness of Care Coordination and Case Management on Health Outcomes

Findings on the Harms of FDA-Approved Medications

The primary side effects of zuranolone are somnolence (excessive sleepiness), dizziness, and sedation. The sedation from zuranolone resolves within 12 hours after taking each dose. The FDA label includes a black box warning to avoid driving within 12 hours after taking each dose of the medication. There was no increased rate of serious adverse events in either study of zuranolone in PPD. Patients on zuranolone are advised to use contraception and to not breastfeed while

[52] This CCM was a three-step approach to screening, referring, and treating women for depression during the perinatal period among their OB, family, and mental health providers (International Marcé Society, 2013). With the use of the CCM, the nurse practitioner was able to meet the individual needs of the women during the scheduled visits and can include medication, therapy, drug and alcohol treatment, domestic violence education, social service referral, and supports for their children and partner

[53] Patients are offered evidence-based treatment for depression by care managers trained in behavioral interventions, such as problem-solving therapy or interpersonal therapy under the supervision of a psychiatric consultant who oversees the care of the patient and makes recommendations to the patient's primary prescriber for psychotropic medications. Patients are offered 6 to 8 weekly sessions of problem-solving therapy with additional support provided to obstetric providers regarding psychotropic medications during pregnancy. Videoconferencing between the psychiatric consultant and the patient was available if there was a need for additional diagnostic confirmation and/or further informed consent discussions.

[54] 264 patients engaged in collaborative care and 86 remained in usual care. Pregnant people who engaged in collaborative care were more likely to self-identify as non-Hispanic Black and less likely to identify as Asian than those who did not engage in collaborative care.

using the 2-week course of the medication (Cha et al., 2024; Fayoud et al., 2024; Li et. al., 2024; Oliveira et al., 2024; Qiu et.al., 2024; Raja et. al., 2024).

Summary of Findings

Overall, the findings on treatments for perinatal mental health vary. While there is *some evidence* that the FDA approved medication for perinatal mental health is effective, *not enough research* has been conducted to determine the effect of the digital therapeutic, *not enough research* has been conducted to determine whether screening for perinatal depression improves health outcomes, and there is *conflicting* evidence that care coordination and case management are effective in improving health outcomes.

There is *some evidence* that zuranolone is effective for improving depression for patients with severe PPD in which onset begins within the 3rd trimester of pregnancy or the first 4 weeks postpartum, based on two well-designed RCTs. Because there are only two industry-funded studies with relatively small sample sizes and limited follow-up, it is unclear how generalizable the effects would be for the entire postpartum population that would be covered by SB 626.

Not enough research has been conducted to determine whether zuranolone is more effective than the SSRIs that are currently prescribed for improving health outcomes in women with perinatal depression because there are no studies that compare the two medications. *Not enough research* indicates that there are no studies of the treatment or the available studies are not of high quality, meaning that there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Not enough research has been conducted to determine if the digital therapeutic MamaLift Plus is effective at improving depression for people with mild-to-moderate PPD because there are no studies that meet CHBRP's quality standards. *Not enough research* indicates that there are no studies of the treatment or the available studies are not of high quality, meaning that there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Not enough research has been conducted to determine whether screening for perinatal depression improves health outcomes. CHBRP did not identify any trials comparing the effects of usual care versus screening plus usual care on health outcomes.

There is *conflicting evidence* that care coordination and case management improve health outcomes, including improvements in depressive scores and breastfeeding initiation and continuation, based on five studies. One study showed that engagement in a collaborative care program increased initiation and continuation of breastfeeding at 6 weeks follow-up. However, evidence is limited by a lack of studies that examine case management and care coordination in a clinical setting with control groups. Because case management and care coordination are not defined in SB 626, it is difficult to generalize these outcomes to the legislation. Additionally, it is important to note that provision of collaborative care is not included in SB 626.

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Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Policy Context* section, SB 626 would require DMHC-regulated plans and CDI-regulated policies to (1) cover at least one FDA-approved medication and at least one FDA-approved digital therapeutic for perinatal mental health; (2) provide case management and care coordination during the perinatal period; and (3) screen enrollees for perinatal mental health conditions during the postpartum and perinatal periods according to ACOG's clinical guidelines.

This section reports the potential incremental impacts of SB 626 on estimated baseline benefit coverage, utilization, and overall cost.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

Analytic Approach and Key Assumptions

As explained in the *Background*, the treatments that would be covered under the SB 626 mandate (zuranolone and MamaLift Plus) are relatively new and only apply to PPD.[55] CHBRP typically would have used Milliman's 2023-2024 Consolidated Health Cost Guidelines Sources Database (CHSD) California data to determine baseline utilization of these products. However, due to the newness of these products, there are no available claims data for MamaLift Plus and too few claims for zuranolone to reliably estimate utilization. As a result, CHBRP relied on literature-based estimates for this analysis.

While zuranolone and MamaLift Plus are the only two FDA-approved options currently available specifically for the treatment of perinatal mental health (and only for PPD) and thus the only treatments that are applicable to this analysis, CHBRP notes that it is possible that additional treatments for PPD and/or other perinatal mental health conditions could receive FDA approval in the future and would impact utilization and cost estimates.

To determine baseline coverage, CHBRP conducted a survey of the largest (by enrollment) providers of health insurance in California. With regards to SB 626's mandate that DMHC-regulated plans and CDI-regulated policies **provide** case management and care coordination during the perinatal period, CHBRP found that all health insurance providers reported already providing care coordination and case management during the perinatal period at baseline (shown in Table 6 and discussed in more detail below). Thus, CHBRP does not estimate any change postmandate for this provision of the bill. Should SB 626 be interpreted to require that DMHC-regulated plans and CDI-regulated policies cover (i.e., pay or reimburse for in addition to **provide**) case management and care coordination services, impacts might differ.

Almost all — 96.2% — of commercial/CalPERS enrollees in plans and policies regulated by DMHC or CDI have a pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription medications.[56] Of the remaining commercial/CalPERS enrollees, 1.2% do not have a pharmacy benefit and 2.6% have a pharmacy benefit that is not regulated by DMHC or CDI. For Medi-Cal beneficiaries in DMHC-regulated managed care plans, the pharmacy benefit is separate and administered by the Department of Health Care Services (DHCS) under the Medi-Cal Rx program; therefore, it is not subject to DMHC regulation. Because SB 626 does not require creation of a pharmacy benefit — only compliant benefit coverage when a pharmacy benefit is present — baseline benefit coverage for

[55] On August 4, 2023, the FDA approved the new drug application for zuranolone, marketed as Zurzuvae, as a prescription capsule for the treatment of PPD. Additionally, MamaLift Plus, the first prescription digital therapeutic for PPD, received FDA clearance on April 23, 2024.
[56] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

enrollees without a pharmacy benefit or whose pharmacy benefit is not regulated by DMHC or CDI is assumed to be compliant.

This analysis uses the following key assumptions:

General Assumptions

- *Inclusion and exclusion of Medi-Cal beneficiaries*: SB 626 would extend its provisions to commercial/CalPERS enrollees in DMHC-regulated plans and CDI-regulated policies as well as Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans and COHS plans. For this analysis, the bill's mandates concerning case management, care coordination, and the coverage of the specified digital therapeutic — assumed to be covered under the medical benefit rather than the pharmacy benefit — are applicable to Medi-Cal beneficiaries. However, for the analysis of zuranolone, CHBRP excluded Medi-Cal Rx pharmacy beneficiaries and Medi-Cal beneficiaries enrolled in DMHC-regulated fee-for-service plans.
    - *Prescription digital therapeutics*: Prescription digital therapeutics present novel considerations for benefit design compared to typical pharmaceutical treatments. The self-administered nature of digital therapeutics may suggest coverage via pharmacy benefits, whereas digital therapeutics used under a physician or therapist's presence are better suited for inclusion under medical benefits (AMCP, 2024). For reference, continuous glucose monitors are covered under medical benefits. Given the novelty of prescription digital therapeutics, no consensus with regards to how they should be covered, nor insights on how it is likely to be covered, CHBRP assumed MamaLift Plus would be covered as a medical benefit. This means that for Medi-Cal beneficiaries, MamaLift Plus is not excluded from the analysis of cost as is zuranolone (for reasons explained above).
- *Prevalence rate of PPD*: To estimate the prevalence of PPD among enrollees, CHBRP applied a prevalence rate of 13.5% among individuals who have given birth, based on the current data from the Maternal and Infant Health Assessment (MIHA) from the CDPH, 2019-2021 (CDPH, 2024c). Note this survey found no statistical difference between the rate of PPD among women with Medi-Cal versus private insurance (13.6 and 13.2, respectively), thus CHBRP used the aggregate estimate. The MIHA survey — an annual, statewide-representative survey of California residents with a recent live birth — collects self-reported information on the experience of symptoms. CHBRP assumed its estimates reflect an accurate prevalence of PPD for the population, which is reflective of the prevalence that would be derived from the use of high/heavy screening for PPD. The PPD rate was applied to the number of people who gave birth in the past year, which was estimated by using the number of births from the CDPH (CDPH, 2025)[57] to arrive at a population estimate of PPD that was applied to SB 626's relevant population of enrollees in commercial/CalPERS and Medi-Cal plans and policies.
- *Utilization management*: Even when a health plan or policy covers a specific treatment, utilization management techniques (such as prior authorization, which requires pre-approval, or step therapy, which mandates trying less expensive alternatives first) might impact access to the treatment.[58] This means that while a drug might be listed within a plan's formulary, management practices may still be applied. As SB 626 does not prohibit these practices, CHBRP assumed no utilization change postmandate due to changes in utilization management practices for both zuranolone and MamaLift Plus. Content expert opinion on this issue is that utilization management is not often the barrier to access of zuranolone when it is covered; because of the newness of MamaLift Plus, no information is available on typical utilization management of this digital therapeutic.

Assumptions Regarding Zuranolone

- *Zuranolone utilization and cost:* To estimate the baseline utilization of zuranolone and the projected increase postmandate, several key assumptions were employed. First, based on data presented in Sage Pharmaceuticals'

[57] Note, about 97% of annual births in California are singleton births such that each birth represents one mother https://www.marchofdimes.org/peristats/data?reg=99&top=7&stop=201&lev=1&slev=4&obj=3&sreg=06.
[58] https://www.chbrp.org/sites/default/files/bill-documents/Prior%20Authorization_final.pdf

2024 annual report, the baseline prevalence of zuranolone utilization within the population experiencing PPD was assumed to be 1% (Sage Therapeutics, 2025).[59] Second, as SB 626 extends coverage to additional individuals with PPD who previously lacked coverage at baseline, CHBRP assumed 1% of these newly covered individuals with PPD would initiate zuranolone postmandate. This utilization rate matches the baseline utilization rate among those with existing coverage (baseline utilization among those who were covered at baseline is assumed to stay the same postmandate given this group does not experience any change in coverage postmandate). Third, CHRBP assumed that prior to the mandate, no individuals were paying for zuranolone treatment fully out-of-pocket due to its high cost, thereby attributing all baseline usage to existing coverage mechanisms. CHBRP assumed that the majority of enrollees using this medication would use one treatment course, though the medication can be used multiple times if it fails initially. Finally, a cost offset of $112 per treatment course was incorporated to account for reductions in other healthcare utilization based on a study that calculated offsets stemming from the use of zuranolone in the form of fewer outpatient visits, fewer inpatient days, fewer adverse event–related visits, and fewer emergency department visits (Anderson et al., 2024). All of these assumptions were supported by CHBRB's content experts.[60]

Assumptions Regarding MamaLift Plus

- *MamaLift Plus utilization and cost*: CHBRP assumed 0% of enrollees use MamaLift Plus at baseline, as it is a new product that is not yet widely available, has limited coverage at baseline, and with which clinicians are not yet familiar.[61] CHBRP estimated that the additional percentage of the population with PPD who would use MamaLift Plus due to SB 626 postmandate (i.e., those with mild-to-moderate PPD who are newly covered for MamaLift Plus) is 10%. This assumption is based on input from CHBRP's content experts[62] and the findings of Brigham et al. (2025), who examined the use of a mobile application for self-management of stress, anxiety, and depression following a targeted intervention in primary care. That study found a 17% utilization rate (from 0%) when providers were actively introduced to the app and encouraged to offer it to their patients. Given that SB 626 does not include a structured intervention to promote provider awareness and recommendation of MamaLift Plus, CHBRP applied a more conservative estimate of 10%. This adjustment reflects the likely positive impact of reduced cost barriers while accounting for the absence of a direct provider-driven intervention, potential challenges in integrating the app into routine care, and variability in patient adoption. CHBRP assumed this population of new users are those with mild-to-moderate PPD who likely faced barriers to obtaining any sort of follow-up care at baseline and thus were likely either infrequent or nonusers of health care services. These utilization assumptions were supported by CHBRP's content experts.[37]
    - The cost of MamaLift Plus was assumed to be $650. This cost is based information provided by Curio Digital Therapeutics.[63] Given the lack of literature on estimated cost offsets from the use of MamaLift Plus in published literature, CHBRP does not include a cost offset adjustment.
    - Although there is limited evidence on the effectiveness of MamaLift Plus, research indicates that live video demonstrates equivalence to in-person care for mental health conditions (Citron et al., 2023). Teletherapy is a key feature of MamaLift Plus; as such, CHBRP assumed that the effectiveness of teletherapy could impact utilization of MamaLift Plus postmandate.

Assumptions Regarding Case Management and Care Coordination

- *Provision of case management and care coordination*: CHBRP assumed that health plans and policies that provide case management and care coordination during the perinatal period at baseline would maintain the same level of provision for these services following the implementation of the mandate. The nature and extent of case management and care coordination services may vary across carriers and patients. CHBRP notes there may be additional

[59] In the U.S., 6,600 women with PPD were treated with Zurzuvae in 2024 out of the approximately 485,000 women with PPD in the U.S. in 2024.
[60] Personal communication, Dr. Leanna Sudhof, March 26, 2025 and Dr. Misty Richards, April 3, 2025.
[61] Personal communication, Dr. Leanna Sudhof, March 26, 2025 and Dr. Misty Richards, April 3, 2025.
[62] Personal communication, Dr. Leanna Sudhof, March 26, 2025 and Dr. Misty Richards, April 3, 2025.
[63] $650 is the all-in cost of MamaLift Plus. It is possible that some users' cost would be lower if fewer features (i.e., fewer therapy sessions) were utilized. CHBRP used the all-in cost to estimate a maximum cost impact.

administrative costs for health plans and policies to produce an annual report on case management, as required by SB 626; however, these costs are unknown and thus not included in the analysis.

Assumptions Regarding Screening

- *Screening per ACOG's clinical guidelines*: CHBRP assumed that 0% of enrollees have coverage of perinatal mental health screening as recommended by ACOG guidelines because ACOG recommends one additional screening during pregnancy beyond what is currently required in California law (see *Policy Context* section for explanation of baseline coverage).
    - CHBRP assumed that SB 626's requirement to screen enrollees for perinatal mental health conditions during the postpartum and perinatal periods according to ACOG's clinical guidelines can result in an increase in claims for reimbursement of screening by providers to health plans. In ACOG's clinical guidance, they note that insurers might or might not reimburse PPD screening separately from the bundled obstetric payment.[64] To estimate the increase in costs stemming from this change, CHBRP used Milliman's 2023-2024 Consolidated Health Cost Guidelines Sources Database (CHSD) California data to estimate the baseline annual number of perinatal mental health screening claims submitted for enrollees who are pregnant/postpartum. From this, CHBRP assumed 0.08 screenings per pregnancy at baseline for commercial enrollees and 0.31 screenings per pregnancy at baseline for Medi-Cal enrollees.
    - CHBRP assumed the average cost (trended) of one additional screening during the perinatal period to be $12.49 for commercial health plans and policies and $13.04 for Medi-Cal health plans, per Milliman's CHSD.
    - An estimated new postmandate number of screenings was calculated by assuming screening would expand from the typical two screenings at baseline (per AB 2193 mandate) to three screenings per ACOG guidelines postmandate as outlined in SB 626. CHBRP acknowledges evidence suggesting that PPD can begin during the 3rd trimester of pregnancy (see *Medical Effectiveness*). Accordingly, increased 3rd trimester screening as recommended by ACOG could help identify individuals at risk and support earlier intervention. However, the literature on the impact of additional screening is quite limited. In one large study examining the effects of ACOG's 2015 recommendation to screen at least once during the perinatal period, researchers found no significant increase in PPD diagnosis rates among privately insured women (Leboffe et al., 2023). Given the limited evidence, for this analysis CHBRP assumes that differences in screening frequency and timing between existing law and current ACOG guidelines would not affect diagnosis rates and related costs.

Table 5. Summary of Markets Impacted by SB 626

SB 626 Requirement	Commercial/CalPERS	Medi-Cal
Coverage of zuranolone	Yes	No (because pharmacy benefit administered by DHCS)
Coverage of MamaLift Plus	Yes	Yes
Provision of case management & care coordination	Yes	Yes
Screening per ACOG's clinical guidelines	Yes	Yes

Source: California Health Benefits Review Program, 2025.
Key: ACOG = American College of Obstetricians and Gynecologists; CalPERS = California Public Employees' Retirement System; DHCS = California Department of Health Care Services.

[64] CHBRP's content expert (Dr. Leanna Sudhof) notes that most providers do not bill and/or are not reimbursed for screening due to the global fee/bundled payment covers all services related to the episode of care.

For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

Baseline and Postmandate Benefit Coverage

As discussed in the *Policy Context* section, SB 626 would apply to state-regulated health insurance, including enrollees in commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by DMHC and CDI, and Medi-Cal beneficiaries enrolled in DMHC-regulated managed care plans or county organized health system (COHS) plans. It should be noted that DMHC regulates the plans of approximately 74% of enrollees associated with CalPERS, and 80% of Medi-Cal beneficiaries, in addition to commercial enrollees. [65]

CHBRP estimates that at baseline, 24,116,000 Californians (63%) with state-regulated insurance subject to the mandate are enrolled in plans or policies impacted by SB 626. With regards to the coverage of zuranolone, 3% of enrollees are in plans and policies that are compliant and with regards to MamaLift Plus, 2% of enrollees are in plans and policies that are compliant at baseline (Table 6). CHBRP finds 100% of enrollees are in plans and policies that are compliant with providing care coordination and case management during the perinatal period. CHBRP assumes 0% of enrollees are in plans and policies that cover screening per ACOG's clinical guidelines, as current California law requires one less screening during pregnancy.

The implementation of SB 626 would mandate full coverage of both zuranolone and MamaLift Plus, leading to an increase in access such that postmandate, 100% of enrollees subject to SB 626 would have coverage for both products. Because Medi-Cal Rx pharmacy beneficiaries are excluded from the analysis of zuranolone (see Analytic Approach and Key Assumptions above), the percentage of all enrollees subject to SB 626 with coverage for zuranolone is 54% (rather than 100%). See Table 6 below for estimates of how many Californians have health insurance that would have to comply with SB 626 in terms of benefit coverage.

Table 6. Impacts of SB 626 on Benefit Coverage, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	24,116,000	24,116,000	0	0%
Total enrollees with health insurance subject to SB 626	24,116,000	24,116,000	0	0%
Percentage of enrollees with coverage for zuranolone (b)	3%	54%	51%	n/a
Percentage of enrollees with coverage for MamaLift Plus (c)	2%	100%	98%	n/a
Percentage of enrollees in a plan that provides case management and care coordination during the perinatal period	100%	100%	0%	0%

[65] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Number of enrollees with coverage for zuranolone (b)	661,982	12,947,784	12,285,802	1856%
Number of enrollees with coverage for MamaLift Plus (c)	464,145	24,116,000	23,651,855	5096%
Number of enrollees in a plan that provides case management and care coordination during the perinatal period	24,116,000	24,116,000	0	0%

Source: California Health Benefits Review Program, 2025.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[66]
(b) For the analysis of zuranolone, CHBRP excludes Medi-Cal Rx pharmacy beneficiaries and Medi-Cal beneficiaries enrolled in DMHC-regulated fee-for-service plans.
(c) For the analysis of MamaLift Plus, because the digital therapeutic is assumed to be covered under the medical rather than pharmacy benefit, there is no exclusion of Medi-Cal.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; pp = percentage points.

Baseline and Postmandate Utilization and Unit Cost

Below, Table 7 provides estimates of the impacts of SB 626 on utilization and unit cost of zuranolone and MamaLift Plus. As mentioned previously, because zuranolone utilization is generally low, with an estimated 1% of those with PPD using zuranolone, and because the analysis excludes Medi-Cal beneficiaries, CHBRP estimates there are fewer than 20 enrollees using zuranolone with coverage at baseline. With SB 626, the number who use zuranolone with coverage would grow to 345 enrollees postmandate, resulting in **an additional 328 enrollees with PPD who use zuranolone due to new coverage postmandate.** For MamaLift Plus, there is an assumed 0% utilization at baseline for those with PPD. Postmandate, CHBRP assumes 10% of those with PPD would be new users of MamaLift Plus, resulting in **5,402 enrollees with PPD who would use MamaLift Plus due to new coverage postmandate.**

Table 7. Impacts of SB 626 on Utilization and Unit Cost, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Eligible populations				
Number of enrollees with postpartum depression (PPD)	54,000	54,000	0	0%
Utilization without coverage				
Number of enrollees using zuranolone	0	0	0	0%
Number of enrollees using MamaLift Plus	0	0	0	0%

[66] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Number of perinatal mental health screenings	0	0	0	0%
Utilization with coverage				
Number of enrollees using zuranolone	17	345	328	1914%
Number of enrollees using MamaLift Plus	0	5,402	5,402	-
Number of perinatal mental health screenings	75,163	112,744	37,581	50%
Unit costs				
Zuranolone cost of treatment course (2 weeks)	$15,902	$15,902	0	0%
MamaLift Plus cost of treatment course (8 weeks)	$650	$650	0	0%
Perinatal mental health screening cost (a)	$12.85	$12.85	0	0%

Source: California Health Benefits Review Program, 2025.
Note: Estimates are specific to people ages 18 to 64.
(a) Unit cost of a perinatal mental health screening presented in table is an average between commercial and Medi-Cal unit costs.

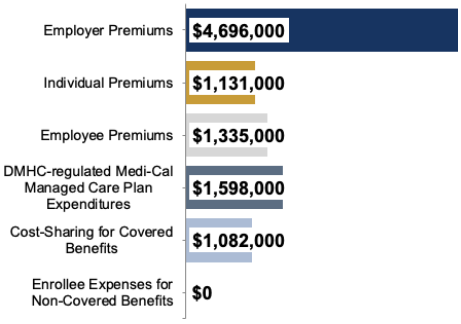
Baseline and Postmandate Expenditures

As described above, SB 626 would increase coverage of two FDA-approved treatments for PPD postmandate — zuranolone and MamaLift Plus — such that postmandate, 100% of enrollees would have coverage in compliance with SB 626. For DMHC-regulated plans and CDI-regulated policies, SB 626 would increase total premiums paid by employers and enrollees for newly covered benefits. Enrollee expenses for covered and/or noncovered benefits would increase. This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies (Figure 7).

Below, Table 8 provides estimates of the impacts of SB 626 on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits.

For DMHC-regulated plans and CDI-regulated policies, SB 626 would increase total expenditures by $9,842,000 (0.01%).

Figure 7. Expenditure Impacts of SB 626



Source: California Health Benefits Review Program, 2025.

Table 8. Impacts of SB 626 on Expenditures, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$68,752,638,000	$68,757,035,000	$4,397,000	0.01%
CalPERS employer (b)	$7,881,873,000	$7,882,172,000	$299,000	0.00%
Medi-Cal (includes COHS) (c)	$38,851,964,000	$38,853,562,000	$1,598,000	0.00%
Enrollee premiums				
Enrollees, individually purchased insurance	$21,757,790,000	$21,758,921,000	$1,131,000	0.01%
Outside Covered California	$6,011,399,000	$6,011,667,000	$268,000	0.00%
Through Covered California	$15,746,391,000	$15,747,254,000	$863,000	0.01%
Enrollees, group insurance (d)	$21,712,866,000	$21,714,201,000	$1,335,000	0.01%
Enrollee out-of-pocket expenses				
Cost sharing for covered benefits (deductibles, copays, etc.)	$18,992,422,000	$18,993,504,000	$1,082,000	0.01%
Expenses for noncovered benefits (e) (f)	$0	$0	$0	0.00%
Total expenditures	$177,949,553,000	$177,959,395,000	$9,842,000	0.01%

Source: California Health Benefits Review Program, 2025.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 54% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[67] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes Medi-Cal beneficiaries enrolled in DMHC-regulated plans and COHS. Assumes expenditures for beneficiaries enrolled in COHS plans are similar to expenditures for Medi-Cal beneficiaries enrolled in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to health insurance sponsored by an employer (or union or other organization), health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(f) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Premiums

At the end of this section, Table 9 and Table 10 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

[67] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

Changes in premiums as a result of SB 626 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 6, Table 9, and Table 10), with health insurance that would be subject to SB 626.

Commercial

The changes in premiums as a result of SB 626 would be 0.01% or less for the different types of plans by market segment and range from $0.013 for small-group CDI-regulated policies to $0.047 for large-group DMHC-regulated plans.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, there would be a 0.004% increase in premiums, which translates to a $0.033 increase in premiums PMPM.

Medi-Cal

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, would be 0.005% increase in premiums, which translates to a $0.014 increase in premiums PMPM (reflecting the changes in coverage of MamaLift Plus, which is assumed to be covered as a medical benefit).

Enrollee Expenses

SB 626–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 6, Table 9, and Table 10) with health insurance that would be subject to SB 626 expected to use zuranolone and MamaLift Plus during the year after enactment.

CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of treatment for PPD and therefore an increase in enrollee cost sharing.

Increases in enrollee expenditures at the PMPM level range from $0.014 for Medi-Cal managed care plans, including COHS, to $0.056 for DMHC-regulated individual plans.

Average enrollee out-of-pocket expenses per user

For enrollees with coverage for zuranolone and MamaLift Plus at baseline, average enrollee cost sharing for covered benefits (which includes deductibles, copays, etc.) ranges from $64 for large-group DMHC-regulated plans to $273 for individual DMHC-regulated plans. Average enrollee cost sharing for CalPERS is $82. Cost sharing for enrollees increases $0.004 for large-group DMHC-regulated plans to $0.01 for individual CDI-regulated plans.

CHBRP estimates are based on claims data and may underestimate the cost savings for enrollees due to plans and insurers negotiating discounted rates that are unavailable to patients and their families.

The presence of a deductible not yet met for the year[68] could result in the enrollee paying the full unit cost, but hitting the annual out-of-pocket maximum[69] would result in the enrollee having no further cost sharing.

[68] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.
[69] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copays and coinsurance is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (HSC 1342.73; INS 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies would remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs.

There may be additional administrative costs for health plans and policies to produce an annual report on case management, as required by SB 626. While the specific cost is unknown, such costs would exist. All health plans and insurers include a component for administration and profit in their premiums. Health plans may pass on administrative costs to enrollees; however, they are expected to be minimal and unlikely to result in increased premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 6, Table 9, and Table 10), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 626.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of SB 626.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

It is possible that lack of (or insufficient) benefit coverage prompts enrollees to seek care from public programs or other payers, including charities, or other departments. Given the relatively high costs of both PPD treatments, CHBRP assumes that enrollees who do not have benefit coverage for PPD treatments do not directly pay for these at baseline (e.g., self-pay). However, in some cases, those noncovered benefits may be provided by public programs or by other, alternative sources.

Table 9. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Includes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	9,508,000	1,038,000	264,000	65,000	36,000	24,116,000
Total enrollees in plans/policies subject to SB 626	8,034,000	2,076,000	2,181,000	914,000	9,508,000	1,038,000	264,000	65,000	36,000	24,116,000
Premiums										
Average portion of premium paid by employer (e)	$557.33	$507.76	$0	$718.62	$276.79	$583.72	$609.11	$567.83	$0	$115,486,475,000
Average portion of premium paid by enrollee	$145.58	$212.63	$818.51	$139.09	$0.00	$0.00	$224.25	$185.49	$777.47	$43,470,656,000
Total premium	**$702.91**	**$720.39**	**$818.51**	**$857.71**	**$276.79**	**$583.72**	**$833.35**	**$753.32**	**$777.47**	**$158,957,131,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$64.42	$164.36	$272.54	$81.59	$0	$0	$122.99	$249.30	$173.93	$18,992,422,000
Expenses for noncovered benefits (f)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total expenditures	**$767.33**	**$884.75**	**$1,091.05**	**$939.30**	**$276.79**	**$583.72**	**$956.34**	**$1,002.63**	**$951.40**	**$177,949,553,000**

Source: California Health Benefits Review Program, 2025.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[70] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[71]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[70] For more detail, see CHBRP's resource *Estimates of Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[71] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Table 10. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Includes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	9,508,000	1,038,000	264,000	65,000	36,000	24,116,000
Total enrollees in plans/policies subject to SB 626	8,034,000	2,076,000	2,181,000	914,000	9,508,000	1,038,000	264,000	65,000	36,000	24,116,000
Premiums										
Average portion of premium paid by employer (e)	$0.0370	$0.0315	$0.0000	$0.0272	$0.0140	$0	$0.0107	$0.0099	$0	$6,294,000
Average portion of premium paid by enrollee	$0.0097	$0.0132	$0.0425	$0.0053	$0.0000	$0	$0.0040	$0.0032	$0.0442	$2,465,000
Total premium	$0.0467	$0.0448	$0.0425	$0.0325	$0.0140	$0	$0.0147	$0.0132	$0.0442	**$8,758,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0043	$0.0101	$0.0140	$0.0031	$0.0000	$0	$0.0022	$0.0044	$0.0099	$1,082,000
Expenses for noncovered benefits (f)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total expenditures	$0.0510	$0.0549	$0.0565	$0.0356	$0.0140	$0	$0.0169	$0.0175	$0.0540	**$9,842,000**
Percent change										
Premiums	0.0066%	0.0062%	0.0052%	0.0038%	0.0051%	0%	0.0018%	0.0018%	0.0057%	0.0055%
Total expenditures	0.0066%	0.0062%	0.0052%	0.0038%	0.0051%	0 %	0.0018%	0.0018%	0.0057%	0.0055%

Source: California Health Benefits Review Program, 2025.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.7% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[72] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[73]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Car

[72] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance.*
[73] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Public Health Impacts

As discussed in the *Policy Context* section, SB 626 would mandate coverage of at least one FDA-approved medication and at least one FDA-cleared digital therapeutic for perinatal mental health. Additionally, SB 626 would require that DMHC-regulated plans and CDI-regulated policies provide case management and care coordination during the perinatal period; that they annually report to DHCS on the utilization and outcomes of case management; and that they publicly post the information reported. Finally, SB 626 would require that a licensed health care provider who provides perinatal care for patient must screen, diagnose, and treat the patient for a perinatal mental health condition according to the clinical guidelines from ACOG. Additional information on disease/condition is included in the *Background* section.

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact[74] of SB 626 on screening, treatment, mental health outcomes, and disparities. See *Long-Term Impacts* for discussion of premature death, economic loss, and social determinants of health.

Estimated Public Health Outcomes

As presented in the *Medical Effectiveness* section, although there is *some evidence* that zuranolone is clinically effective at reducing symptoms of PPD, *not enough research* has been conducted to determine that zuranolone is more effective than commonly used SSRI/SNRI medications. As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, zuranolone is projected to be used by 328 additional patients in the first year postmandate.

As presented in the *Medical Effectiveness* section, there is *not enough research* to determine whether MamaLift Plus is medically effective. However, as presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP estimates that it would be used by 5,402 additional patients in the first year postmandate. Content experts indicate that this is a realistic increase in utilization as MamaLift Plus becomes more widely available and clinicians become more familiar with its offerings and how to prescribe it;[75] as mentioned in the *Benefit Coverage, Utilization, and Cost Impacts* section, MamaLift Plus currently has limited awareness and availability largely because it is new to the market.

As presented in the *Medical Effectiveness* section, there is *not enough research* to determine whether screening for perinatal mental health conditions leads to improved health outcomes. Findings presented in the *Benefit Coverage, Utilization, and Cost Impacts* section show that patients are likely to be screened more postmandate (from 75,163 perinatal mental health screenings at baseline to 112,744 screenings in the first year postmandate). While more screenings would occur, CHBRP assumes that it is unlikely that increasing the number of screenings for depression and anxiety from two to three times during the perinatal period, per ACOG guidelines, would lead to an increase in postpartum depression diagnoses (Leboffe et al., 2023).

There is *conflicting evidence* that case management and care coordination services are medically effective.

Given this information, CHBRP concludes that passage of SB 626 would have no short-term public health impact at the state level. At the person-level, enrollees with severe PPD for which psychotherapy and/or SSRIs/SNRIs are not sufficient may find a reduction in depression symptoms with zuranolone.

Potential Harms From SB 626

When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate. In the case of SB 626, there is evidence to suggest that an increase in the use of zuranolone could result in harm. Potential harms associated with the use of zuranolone include somnolence (excessive sleepiness),

[74] CHBRP defines short-term impacts as changes occurring within 12 months of bill implementation.
[75] Personal communication, Dr. Misty Richards, April 3, 2025

dizziness, and sedation, and as a result of these symptoms, possible risk of injury to the mother or infant. It is recommended that when taking zuranolone, patients use contraception, refrain from breastfeeding, and refrain from driving for 12 hours after each dose. Discontinuation of breastfeeding routines may be uncomfortable and challenging for the patient and infant to navigate, and may result in decreased breastfeeding rates. Despite the possible harms, *some evidence* shows that the benefits of zuranolone outweigh the harms.

Impact on Disparities[76]

As described in the *Background* section, disparities in PPD exist by race/ethnicity and income. In California, roughly one in five Black women, one in seven Asian or Pacific Islander women, and one in eight White or Hispanic women develop PPD (CDPH, 2024a), and poverty is associated with higher rates of prenatal depression symptoms and PPD symptoms (CDPH, 2024a). In populations affected by postpartum depression, it is possible that certain groups may stand to benefit more from improved access to medication treatment. Within the first 12 months postmandate, CHBRP estimates SB 626 would not change disparities by race, ethnicity, or income.

Because SB 626 is exempt from Medi-Cal Rx, disparities could arise in specific health plans and insurance policies that would not receive coverage of FDA-approved medications for perinatal mental health conditions postmandate.

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[76] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document.

Long-Term Impacts

In this section, CHBRP estimates the long-term impact of SB 626, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization, Cost, and Public Health Impacts

Utilization Impacts

Over time, the utilization of both zuranolone and MamaLift Plus may increase as awareness, provider familiarity, and patient adoption grow. Initially, uptake may be tempered by limited provider experience, patient hesitancy due to concerns about side effects — particularly zuranolone's potential impact on breastfeeding — and uncertainties regarding real-world effectiveness. However, as more studies emerge evaluating and proving the efficacy, safety, and long-term benefits of this and other treatments, confidence in their use could expand, leading to greater adoption. Additionally, increasing integration of digital therapeutics into standard postpartum care, along with potential provider education efforts, could further drive utilization of MamaLift Plus.

Given current screening guidelines and the existing treatment landscape, SB 626 does not specifically provide for additional mental health screening or treatment for individuals whose pregnancies end prematurely, are terminated, or result in the birth of a child with acute or chronic conditions. However, if clinical guidelines evolve or new, evidence-based treatments become more widely available and integrated into standard care, the scope of SB 626 could expand to include more targeted screening and treatment for these scenarios. As the treatment landscape advances, whether through innovations in perinatal mental health care, broader provider capacity, or new technologies, the bill's impact might be broader in the future.

Cost Impacts

The long-term cost implications of SB 626 may be influenced by market dynamics, technological advancements, and evolving coverage policies. While initial costs may be high due to the novel nature of zuranolone and the relatively new market for prescription digital therapeutics like MamaLift Plus, competition and innovation could drive costs downward. As more pharmaceutical and digital health companies enter the market, the introduction of alternative treatments and expanded research may contribute to pricing pressures that reduce costs. Additionally, as the prescription digital therapeutics sector continues to grow, industry standards and guidance from regulatory and payer bodies may lead to more structured reimbursement frameworks, increasing affordability and accessibility. These factors could moderate the long-term cost impact of SB 626 while supporting broader adoption of both pharmacologic and digital interventions for PPD.

Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments), whereas other interventions may take years to make a measurable impact (e.g., coverage for tobacco cessation or vaccinations). When possible, CHBRP estimates the long-term effects (beyond 12 months postmandate) to the public's health that would be attributable to the mandate, including impacts disparities, premature death, and economic loss.

In the case of SB 626, CHBRP estimates the change in utilization would yield a slight increase in the number of patients who use zuranolone, and an increase in the number of patients who would use MamaLift Plus. Because zuranolone is

typically reserved for severe cases of postpartum depression, and MamaLift Plus has not yet demonstrated to be medically effective, CHBRP does not expect there to be a state-wide public health impact. However, SB 626 could cover future psychiatric medications that are developed specifically for use in the perinatal population, which could ultimately lead to a broader public health impact.

Impacts on Disparities and the Social Drivers of Health[77]

In the case of SB 626, although evidence shows that disparities by race and ethnicity and income exist, CHBRP projects no changes in these disparities that would be attributable to SB 626.

CHBRP estimates that SB 626 would have no impact on social drivers of health.

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[77] For more information about SDOH, see CHBRP's Public Health Impact Analysis and Research Approach.

Appendix A. Text of Bill Analyzed

On February 21, 2025, the California Senate Committee on Health requested that CHBRP analyze SB 626, as introduced on February 20, 2025.

Below is the bill language, as it was introduced on February 20, 2025.

CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

SENATE BILL

NO. 626

Introduced by Senator Smallwood-Cuevas

February 20, 2025

An act to amend Sections 1367.625 and 123640 of the Health and Safety Code, and to amend Section 10123.867 of the Insurance Code, relating to maternal health.

LEGISLATIVE COUNSEL'S DIGEST

SB 626, as introduced, Smallwood-Cuevas. Maternal health screenings and treatment.

Existing law requires a licensed health care practitioner who provides prenatal, postpartum, or interpregnancy care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions.

This bill would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose, and treat the patient for a maternal mental health condition according to the clinical guidelines from the American College of Obstetricians and Gynecologists.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes, as specified.

This bill would require a health care service plan or health insurer to provide case management and care coordination for an enrollee or insured during the perinatal period. The bill would require a plan or insurers to annually report the utilization and outcomes of case management services to the appropriate department and to post that reported information to its internet website. The bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for at least one medication and one digital therapeutic for maternal mental health, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.625 of the Health and Safety Code is amended to read:

1367.625. (a) A health care service plan shall ~~develop~~ *do all of the following:*

(1) Develop a maternal mental health program designed to promote quality and cost-effective outcomes. The program shall consist of at least one maternal mental health 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. The program shall be developed consistent with sound clinical principles and processes, and shall include quality measures to encourage screening, diagnosis, treatment, and referral. The program guidelines and criteria shall be provided to relevant medical providers, including all contracting obstetric providers. As part of a maternal mental health program the health care service plan is encouraged to improve screening, treatment, and referral to maternal mental health services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees about the program.

(2) Provide case management and care coordination for an enrollee during the perinatal period.

(3) Annually report to the department on the utilization and outcomes of case management services.

(4) Publicly post the information reported pursuant to paragraph (3) on the plan's internet website.

(b) A health care service plan contract issued, amended, or renewed on or after January 1, 2026, shall provide coverage for at least one medication approved by the United States Food and Drug Administration (FDA) for maternal mental health and for at least one FDA-approved digital therapeutic for maternal mental health.

~~(b)~~

(c) For the purposes of this section:

(1) "Contracting obstetric provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, and who is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

(2) "Health care service plan" includes Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section applies to Medi-Cal managed care plan

contracts only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

~~(2)~~

(3) "Maternal mental health" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

~~(c)~~

(d) This section does not apply to specialized health care service plans, except specialized behavioral health-only plans offering professional mental health services.

~~(d)For purposes of this section, "health care service plan" includes Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section applies to Medi-Cal managed care plan contracts only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.~~

(e) Notwithstanding subdivision (a), a Medi-Cal managed care plan shall continue to comply with any quality measures required or adopted by the State Department of Health Care Services. Quality measures included in a Medi-Cal managed care plan's maternal mental health program shall not be inconsistent with quality measures required or adopted by the State Department of Health Care Services.

SEC. 2. Section 123640 of the Health and Safety Code is amended to read:

123640. (a) A licensed health care practitioner who provides prenatal, postpartum, or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.

(b) A licensed health care practitioner who provides perinatal care for a patient shall screen, diagnose, and treat the patient for a maternal mental health condition according to the clinical guidelines from the American College of Obstetricians and Gynecologists.

~~(b)~~

(c) This section shall not apply to a licensed health care practitioner when providing emergency services or care, as defined in Section 1317.1.

~~(c)~~

(d) This section does not preclude any licensed or certified provider acting within their scope of practice from screening for maternal mental health conditions.

~~(d)~~

(e) For purposes of this section, the following definitions apply:

(1) "Health care practitioner" means a physician and surgeon, naturopathic doctor, nurse practitioner, physician assistant, nurse midwife, or a midwife licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code or an initiative act referred to in that division and who is acting within their scope of practice.

(2) “Maternal mental health condition” means a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy and includes, but is not limited to, postpartum depression.

SEC. 3. Section 10123.867 of the Insurance Code is amended to read:

10123.867. (a) A health insurer shall ~~develop~~ *do all of the following:*

(1) Develop a maternal mental health program designed to promote quality and cost-effective outcomes. The program shall consist of at least one maternal mental health 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. The program shall be developed consistent with sound clinical principles and processes, and shall include quality measures to encourage screening, diagnosis, treatment, and referral. The program guidelines and criteria shall be provided to relevant medical providers, including all contracting obstetric providers. As part of the maternal mental health program, a health insurer is encouraged to improve screening, treatment, and referral to maternal mental health services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate insureds about the program.

(2) Provide case management and care coordination for an insured during the perinatal period.

(3) Annually report to the department on the utilization and outcomes of case management services.

(4) Publicly post the information reported pursuant to paragraph (3) on the insurer’s internet website.

(b) A health insurance policy issued, amended, or renewed on or after January 1, 2026, shall provide coverage for at least one medication approved by the United States Food and Drug Administration (FDA) for maternal mental health and for at least one FDA-approved digital therapeutic for maternal mental health.

~~(b)~~

(c) For the purposes of this section:

(1) “Contracting obstetric provider” means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, and who is contracted with the insured’s health insurer to provide services under the insured’s health insurance policy.

(2) “Maternal mental health” means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

~~(c)~~

(d) This section does not apply to specialized health insurers, except behavioral health-only insurers that provide coverage for professional mental health services.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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Appendix B. Cost Impact Analysis: Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc., the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[78] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available on CHBRP's website.[79]

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Current coverage of FDA-approved medications and digital therapeutics for maternal mental health, case and care management, and diagnosis and treatment of maternal mental health for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represented 58% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS and DHCS were queried regarding related benefit coverage.

For this analysis, CHBRP relied on CPT codes to identify services related to SB 626.

Health Cost Guidelines

The Health Cost Guidelines (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the health maintenance organizations and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures — inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.
- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.

[78] CHBRP's authorizing statute requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[79] See CHBRP's Cost Impact Analysis landing page; in particular, see *Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.

- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

Consolidated Health Cost Guidelines Sources Database

Milliman maintains benchmarking and analytic databases that include health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed by CHBRP. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act. It also includes individuals enrolled in DMHC-regulated Medi-Cal plans and Medi-Cal COHS plans.
- CHBRP surveyed the carriers to determine the percentage of the population with coverage for maternal mental health services.

Methodology and Assumptions for Baseline Utilization

CHBRP assumed 0.34% of the population between 18 and 64 had PPD for both commercial and Medi-Cal plans based on 400,129 births in California per year and 13.5% prevalence of PPD for those that give birth (CDPH, 2024c; CDPH, 2025).

Medications approved by the FDA for maternal mental health

- CHBRP assumed that 1% of enrollees with PPD and coverage used zuranolone.
- CHBRP assumed that no enrollees with PPD and without coverage used zuranolone.

Digital therapeutics approved by the FDA for maternal mental health

- CHBRP assumed that 0% of enrollees with PPD and coverage used MamaLift Plus.
- CHBRP assumed that no enrollees with PPD and without coverage used MamaLift Plus.

Methodology and Assumptions for Baseline Cost

- CHBRP assumed an average cost for zuranolone, the only medication currently FDA approved to treat maternal mental health, of $15,902 (O'Callaghan et al., 2024).

- CHBRP assumed an average cost for MamaLift Plus, the only digital therapeutic currently FDA approved to treat maternal mental health, of $650, per communication with Curio Digital Therapeutics.

Methodology and Assumptions for Baseline Cost Sharing

- CHBRP assumed the cost sharing for medications and digital therapeutics for enrollees with coverage is the same as major medical cost sharing. Enrollee cost share is equal to one minus the line of business paid-to-allowed ratio multiplied by the service or script cost.
- Services or scripts provided to enrollees without coverage are assumed to be paid by the enrollee in full.

Methodology and Assumptions for Postmandate Utilization

- CHBRP assumed the utilization rate for enrollees with coverage postmandate for medications is equal to the utilization rate for enrollees with coverage at baseline due to SB 626.
- CHBRP assumed the utilization rate for enrollees with coverage postmandate for digital therapeutics is equal to the utilization rate for enrollees with coverage at baseline plus an increase of 10% of the eligible population.

Methodology and Assumptions for Postmandate Cost

- CHBRP assumed the average cost per service and the average cost per prescription would not change as a result of SB 626.

Methodology and Assumptions for Postmandate Cost Sharing

- CHBRP assumed the cost sharing for medications and digital therapeutics for enrollees with coverage is the same as major medical cost sharing. Enrollee cost share is equal to one minus the line of business paid-to-allowed ratio multiplied by the service or script cost.

Other Methodology and Assumptions

- CHBRP considered rebates to be immaterial for zuranolone.
- CHBRP assumed there would be offsets to the costs of zuranolone of $112 per year (Anderson et al., 2024).
- Digital therapeutics are assumed to be a medical benefit, thus MamaLift Plus is assumed to be covered as a medical benefit.
- Perinatal mental health screening: SB 626 would change existing screening guidance — at least once during pregnancy, at least once during the first 6 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 — to follow ACOG clinical guidelines, which currently recommend that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits (ACOG, 2023a). To identify the utilization and costs of additional screening during the prenatal period that would be consistent with ACOG's clinical guidelines regarding screening for perinatal mental health conditions, CHBRP examined the following CPT/HCPC codes: 96127, G0444, G8431, G8510, G8511, and H0031
    - CHBRP assumed the average cost (trended) of one additional screening during the perinatal period to be $12.49 for commercial health plans and policies and $13.04 for Medi-Cal health plans, per Milliman's Consolidated Health Cost Guidelines Sources Database.
    - CHBRP assumed 0.08 screenings per pregnancy at baseline for Commercial enrollees and 0.311 screenings per pregnancy at baseline for Medi-Cal enrollees, per Milliman's Consolidated Health Cost Guidelines Sources Database.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

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California Health Benefits Review Program Committees and Staff

CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

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