SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 1682
AUTHOR: Hart
VERSION: February 2, 2026
HEARING DATE: June 24, 2026
CONSULTANT: Natalie Gehred

SUBJECT: Health care coverage: scalp cooling.

SUMMARY: Requires health plans, health insurers, and Medi-Cal to provide coverage for scalp cooling as prescribed by a health care provider in connection with chemotherapy. Requires cost-sharing for scalp cooling to be no less favorable to the patient than cost-sharing applied to oncology supportive care services.

Existing law:
1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975; California Department of Insurance (CDI) to regulate health and other insurance; and the Department of Health Care Services to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires an individual or small group health plan contract or insurance policy to include at a minimum coverage for Essential Health Benefits (EHBs) pursuant to the Affordable Care Act (ACA), and as outlined below:
   a) Health benefits within the ten federally required categories identified in the ACA;
   b) Health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 (Kaiser Small Group HMO), as this plan was offered during the first quarter of 2014, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan;
   c) Medically necessary basic health care services, as specified;
   d) Health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described; and,
   e) Health benefits covered by the plan that are not otherwise required to be covered, as specified. [HSC §1367.005 and INS §10112.27]

3) Defines "basic health care services" as physician services including consultation and referral, hospital inpatient services and ambulatory care services, diagnostic laboratory and therapeutic radiologic services, home health services, preventative health services, emergency health care services, including ambulance and ambulance transport services and out-of-area coverage (including those provided through the 911 emergency response system), and hospice care. [HSC §1345]

4) Requires health plan contracts and insurance policies, except specialized plans and policies, to provide coverage for screening for, diagnosis of, and treatment for, breast cancer. [HSC §1367.6 and INS §10123.8]

This bill:
1) Requires health plans, health insurers, and Medi-Cal to provide coverage for scalp cooling, as prescribed by a health care provider in connection with chemotherapy for people with cancer.

2) Allows coverage to be subject to copayments, coinsurance, or deductibles, provided that the cost-sharing is no less favorable to a patient than the cost-sharing applied to oncology supportive care services.

3) Defines "scalp cooling" as the use of a medical device or system cleared by the federal Food and Drug Administration (FDA) applied to the scalp before, during, or after the administration of chemotherapy to reduce the incidence or severity of chemotherapy-induced alopecia (hair loss). Clarifies that "scalp cooling" does not include non-FDA-cleared scalp cooling products.

FISCAL EFFECT: According to the Assembly Committee on Appropriations, the California Health Benefits Review Program (CHBRP) estimates costs to the Medi-Cal program would increase by $180,000 (General Fund (GF)), federal funds). CHBRP estimates this bill will increase employer premiums for health plans regulated by DMHC in CalPERS by $217,000, of which some costs would be paid by enrollees and non-state employers. There would be additional state costs for the 26% of CalPERS members with health insurance policies regulated by CDI. The state's share of CalPERS costs would likely be around $150,000 (GF). CDI estimates costs of $6,000 in fiscal year (FY) 2026-27 and $18,000 in FY 2027-28 to review insurance policy forms (Insurance Fund). DMHC anticipates minor and absorbable costs. CHBRP estimates this bill will increase overall premiums paid by employers and enrollees by $4 million annually.

PRIOR VOTES:

Assembly Floor:	67 - 1
Assembly Appropriations Committee:	12 - 0
Assembly Health Committee:	14 - 0

COMMENTS:

1) *Author's statement.* According to the author, this bill is a critical step toward improving supportive cancer care and ensuring that patients receiving chemotherapy can have access to medically necessary treatment. Scalp cooling is an FDA-cleared, evidence-based therapy for chemotherapy-induced hair loss, but insurance coverage remains inconsistent and unpredictable. This leaves many patients to pay significant out-of-pocket costs during an already difficult time. By requiring California health plans and health insurers to cover scalp cooling when prescribed by a provider, this bill helps remove a major financial barrier and supports patients' mental health.

2) *Chemotherapy-induced alopecia.* According to a 2020 review in *Current Oncology*, chemotherapy-induced alopecia is the hair loss that occurs when the cytotoxic drugs in chemotherapy regimens kill rapidly proliferating cells, which, beyond cancerous cells, includes growing hair follicle cells. Because up to 90% of scalp hair follicles are in the growth phase at any given time, scalp hair loss within the first several weeks of chemotherapy initiation can be significant. According to the American Cancer Society, the likelihood of hair loss is dependent on the chemotherapy regimen prescribed. Chemotherapy-induced alopecia is generally reversible three to six months after cessation of chemotherapy, although the new hair may show different texture and color, and some patients experience no hair regrowth or only partial hair regrowth. The *Current Oncology* review highlights that chemotherapy-related hair loss has been shown to have a negative impact on patients' self-

esteem, body image, sexuality, and overall quality of life; in a study of 179 male and female patients who developed alopecia, 56.4% of patients felt that it was the worst side effect of chemotherapy, and 72% patients said hair loss was affecting their social life. According to an integrative review on the effects of alopecia among women receiving chemotherapy published in the *European Journal of Oncology Nursing* in 2020, despite preparation for potential alopecia, women still experience shock and trauma when alopecia occurs. The review also identified a struggle with the complexities of a visual cancer identity, and reported a considerable impact on women's social relationships.

3) *Scalp cooling.* According to the American Cancer Society, scalp cooling works to prevent hair loss by restricting the blood flow to the scalp, which decreases the amount of chemotherapy drug that gets to the hair follicles. Scalp cooling is used before, during, and after each chemotherapy session. Scalp cooling is an established practice in oncology care; in 2022, the American Medical Association adopted a resolution supporting insurance coverage for scalp cooling and recently updated its billing codes for scalp cooling to Category 1, or permanent codes that reflect accepted procedures or services. The National Comprehensive Cancer Network also recommends scalp cooling as a treatment option for those receiving chemotherapy for breast and ovarian cancer, although with the caveat that results may be less effective with treatment regimens containing anthracycline.

   Scalp cooling can be performed with either manual cold caps or automated scalp cooling systems. According to the American Cancer Society, manual cold caps are manually cooled in a freezer or with dry ice and must be switched every 30 minutes to manually regulate the temperature and prevent the cap from warming. In contrast, automated scalp cooling devices automatically circulate a liquid or gel around a snug-fitting silicone cap to cool the scalp to a specific temperature. Automated caps, although they do not require patients to privately rent caps or bring along an aide to help switch caps, are only available at select infusion centers, concentrated in large urban cancer centers and academic medical institutions, according to CHBRP. Three automated scalp cooling systems are available for patients: DigniCap, Paxman, and Amma. Medicare currently covers automated scalp cooling when performed with FDA-approved, automated scalp cooling systems, not manual cold caps. One 2024 meta-analysis examining the efficacy of automatic scalp-cooling devices and manual cooling products showed no significant differences in hair preservation on various chemotherapy regimens.

4) *CHBRP analysis.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed this bill. Key findings include:
   a) *Coverage impacts and enrollees covered*. This bill applies to all state-regulated health insurance. CHBRP estimates that 22.8 million Californians (60% of the state) have Medi-Cal or CDI- and DMHC-regulated insurance subject to this bill. At baseline, 47% of Californians have plans already compliant with this bill. This bill would extend a scalp cooling benefit to the remaining 12 million enrollees.
   b) *Medical effectiveness*. There is strong evidence that FDA-cleared automated scalp cooling devices are effective in reducing chemotherapy-induced alopecia. Some evidence suggests that scalp cooling may be less effective for patients with different hair types, such as for Black patients with curly hair. There is strong evidence that scalp cooling does not raise the risk of scalp metastasis.

c) *Utilization.* CHBRP estimated that at baseline, 630 enrollees use scalp cooling to prevent chemotherapy-induced hair loss, 440 of which have coverage at baseline and 190 of which do not. This bill would result in 680 additional enrollees receiving scalp cooling therapy, 90 of which had coverage at baseline and would continue to have coverage postmandate, but with increased utilization due to an increase in availability and awareness. The remaining 590 additional enrollees are those who did not have coverage at baseline but would have coverage postmandate.

d) *Medi-Cal*. This bill includes Medi-Cal enrollees. Because Medi-Cal coverage generally does not include enrollee cost-sharing, those with Medi-Cal will not experience any change in the cost of utilizing the scalp cooling benefit post-mandate.

e) *Impact on expenditures*. CHBRP estimates that the average cost of scalp cooling per enrollee for a course of chemotherapy over a year is $3,700 (consisting of $5,000 for commercial enrollees and $1,500 for Medi-Cal enrollees). Postmandate, changes in payer mix will increase the average cost to $4,100.

f) *Impacts on premiums.* To cover the new scalp cooling benefit, CHBRP estimates that total annual premiums paid by employers and enrollees would increase by approximately $4,010,000—an increase of 0.0023%, or between $0.005 and $0.029 per member per month (PMPM). Employer premiums are expected to increase by $2,672,000 (between $0.0104 and $0.0235 PMPM), enrollee premiums in the large- and small-group markets are expected to increase by $647,000 (about $0.005 PMPM), and premiums in the individual market are expected to increase by $511,000 ($0.005 PMPM in CDI-regulated plans and $0.0173 PMPM in DMHC-regulated plans). Medi-Cal Managed Care expenses are expected to increase by $180,000 ($0.0019 PMPM).

g) *Impacts on benefit users.* CHBRP projects an increase in utilization postmandate, including both new users and those who did not previously purchase a noncovered service, increasing total enrollee cost-sharing by $305,000 postmandate. For users who did not have baseline coverage, postmandate projected expenses are projected to decrease by $934,000. Average annual enrollee out-of-pocket expenses depend on the user and their insurance type. While users with baseline scalp cooling coverage would experience no change in their expenses, a user without baseline coverage would experience significant average annual savings postmandate, ranging from $0 for Medi-Cal enrollees, to $4,000 in the individual market and $4,810 in the CalPERS market. Because new users of the scalp-cooling benefit will be subject to cost-sharing, their average annual expenses are expected to increase by a range of $180 in CalPERS to $1,010 in the individual market (excluding Medi-Cal, which is not subject to cost-sharing).

h) *EHBs*. It is unclear if scalp cooling under this bill would exceed EHBs. CHBRP's survey to carriers found that many carriers already cover scalp cooling. If scalp cooling is considered part of existing coverage, or if similar coverage determinations are made for scalp cooling as other benefit coverage mandates, then scalp cooling would not exceed EHBs. If scalp cooling is considered a new and additional benefit for coverage, then this bill may exceed EHBs, costing the state $1,442,000 in defrayal costs in 2027.

i) *Public health*. Based on a literature-based rate of meaningful hair preservation of about 49%, CHBRP estimates that this bill would result in 333 of the newly-covered 680 enrollees experiencing significantly less hair loss than they otherwise would. Although 680 users is too small a number to impact public health outcomes at the population level, the individual-level benefit of scalp cooling may be clinically meaningful. According to CHBRP, although randomized control trials of scalp cooling have not found significant improvements in quality-of-life measures, chemotherapy-induced alopecia is consistently associated with psychological distress, anxiety, and reduced wellbeing in the broader literature. Therefore, whether experiencing less hair loss translates to measurable

improvements in quality of life or reductions in mental health service use is uncertain, it may reduce distress, anxiety, and self-image impacts on an individual basis. Beyond patient discomfort that could lead to the discontinuation of the treatment (a 2025 metareview in *Breast Cancer Research and Treatment* found a discontinuation rate of about 18%), scalp cooling is not associated with patient harm. Studies have shown no difference in rates of scalp metastasis between patients who used scalp cooling and those who did not.

j) *Impacts on disparities*. This bill could reduce income-related barriers to accessing scalp cooling but is not anticipated to reduce other disparities in access like the lack of scalp cooling devices in certain areas, the time burden of lengthier chemotherapy sessions, or potential fit issues for patients with tightly coiled hair. CHBRP states that the impact on racial or ethnic disparities in utilization is unknown, and the evidence on whether scalp cooling is equally effective across hair types is limited and mixed.

5) *FDA clearance process.* According to the FDA, the regulation of medical devices is risk-based, which means that the level of regulatory control necessary to demonstrate a reasonable assurance of safety and effectiveness is matched to the level of risk of the device. Automated scalp cooling devices are considered class II medical devices, meaning that they are classified as moderate-risk devices, and are cleared under Section 510(k) of the Food, Drug, and Cosmetic Act, which requires registered device manufacturers to notify FDA of their intent to market a medical device at least 90 days in advance. The review standard for the 510(k) process is comparative, meaning that the manufacturer must provide scientific, non-clinical, and clinical data, as appropriate, to determine if a new device is substantially equivalent to a device that is already on the market. Unlike automated scalp cooling devices, manual cold cap products are not regulated by the FDA. While Medicare coverage of scalp-cooling devices requires FDA clearance, some state laws—like those in New York and Louisiana—do not.

6) *Prior legislation.* AB 2668 (Berman of 2024) would have required health plan, insurer, and Medi-Cal coverage of cranial prosthesis for individuals experiencing permanent or temporary medical hair loss. AB 2668 also would have limited coverage to $750. *AB 2668 was held on the Assembly Appropriations suspense file.*

AB 2464 (Dutra of 2002) would have required a health plan or insurer that provides medical and surgical benefits with respect to the treatment of cancer treated by chemotherapy or radiation therapy to provide coverage for a wig or hairpiece necessary for the comfort and dignity of the enrollee. *AB 2464 was not heard in the Assembly Health Committee.*

7) *Support.* Groups like the California Medical Association, Cottage Health, and the Oncology Nursing Society share that this bill is an important step toward improving supportive care for cancer patients, as hair loss is not simply a cosmetic issue. For many patients, it represents a loss of privacy, identity, and control during a particularly vulnerable period, particularly for working adults and parents whose personal and professional lives may be significantly affected by chemotherapy-induced hair loss. Paxman and Cooler Heads Care share that even though supportive remedies are available for nearly every major chemotherapy side effect, scalp cooling is mostly a cash-pay service. Paxman states that the average patient out-of-pocket cost for scalp cooling is approximately $2,500 per course of treatment, posing a significant financial barrier, especially when cancer patients are also managing the cost of chemotherapy. They support this bill's efforts to align insurance coverage with established clinical practice, professional guidelines, and existing treatment infrastructure. Health Access

states that although Medicare expanded coverage for scalp cooling systems in January, they are not yet covered by Medi-Cal and inconsistently covered by private insurance, often leaving patients to pay out-of-pocket costs ranging from $3,000 to $6,000. Health Access appreciates that this bill provides the same supportive care to low-income Californians despite their income status. CenCal Health, the local Medi-Cal managed care plan in Santa Barbara and San Luis Obispo counties, state that they currently cover scalp cooling under the Treatment Authorization Request process. However, this process requires additional administrative steps that can delay care for members, so CenCal Health supports establishing scalp cooling as a Medi-Cal benefit. Lastly, Biocom specifically supports the bill's use of the FDA regulatory framework as its coverage standard. They state that by limiting the coverage mandate to FDA-cleared devices, the bill ensures that patients receive access to technologies that have met rigorous standards for safety and effectiveness, protecting both patients and the integrity of the coverage benefit. The Rapunzel Project supports efforts to expand access to scalp cooling for patients undergoing chemotherapy, but also request an amendment to reimburse scalp cooling, not prescribe the method by which scalp cooling is delivered. They claim that including manual cold caps is essential for equitable access, as automatic scalp cooling devices are less common in smaller community practices and rural areas. Finally, they provide language from New York, Louisiana, West Virginia, Maryland, and Connecticut legislation that defines scalp cooling systems in a technology-neutral way.

8) *Opposition.* A coalition letter from the Association of Life and Health Insurance Companies, the California Association of Health Plans, and America's Health Insurance Plans state that this bill is one of eleven health insurance mandate bills that they oppose this session on the principle that the bills will increase health insurance premiums, harming health care affordability, access, and flexibility for small businesses and individuals. They share that the Office of Health Care Affordability (OHCA) has established statewide health care spending growth target of 3%, which is being phased in at 3.5% for 2025 and 2026, 3.2% in 2027 and 2028, and 3% percent in 2029 and beyond. These associations emphasize that while OHCA is working to curb healthcare costs and ensure resources are allocated efficiently, adding new mandates could disrupt these efforts by driving up costs for insurers, employers, and consumers, making it difficult for health care entities to meet the established targets. They claim that at this moment, the state should focus on healthcare stability and affordability for all Californians.

9) *Policy comment.* This bill has the potential to exceed EHBs, which means the state will have to pay for the incremental costs to offset federal subsidies for people with qualifying insurance. CHBRP estimates that if scalp cooling is determined to exceed EHBs by DMHC and CDI, this bill would require the state to pay about $1,442,000 in defrayal costs in 2027.

SUPPORT AND OPPOSITION:

Support: Association of Northern California Oncologists
Biocom California
California Medical Association
CenCal Health
Cooler Heads Care, Inc.
Cottage Health
Health Access California
Medical Oncology Association of Southern California
Oncology Nursing Society
Paxman US, Inc.

The Rapunzel Project
Two individuals

Oppose: America's Health Insurance Plans
Association of California Life & Health Insurance Companies
California Association of Health Plans

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