

A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

# **Bill Analysis Report: California Assembly Bill 1682 Scalp Cooling**

APRIL 4, 2026



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

[chbrp.org](https://chbrp.org)

# Analysis of California Assembly Bill 1682

## Scalp Cooling

Summary to the 2025-2026 California State Legislature, April 4, 2026



### Summary

The version of California Assembly Bill (AB) 1682 analyzed by California Health Benefits Review Program (CHBRP) would require state-regulated health plans and policies to provide coverage of scalp cooling cleared by the U.S. Food and Drug Administration (FDA) for patients undergoing chemotherapy for the treatment of cancer, as prescribed by a health care provider.

In 2027, all of the 22.8 million Californians enrolled in state-regulated health insurance would have insurance subject to AB 1682.

### Background

Scalp cooling refers to the process of cooling the scalp before, during, and after chemotherapy infusion to prevent or reduce chemotherapy-induced alopecia, or hair loss. Scalp cooling is used by patients with solid tumors undergoing chemotherapy, since certain regimens may lead to hair loss. Not all chemotherapy drugs cause hair loss; the risk depends on the specific drugs used, their dose, and how they are combined.

Currently, the vast majority of patients who use scalp cooling are women undergoing treatment for breast cancer.

### Benefit Coverage

AB 1682 would require coverage of scalp cooling cleared by the FDA, when prescribed by a health care provider for individuals undergoing chemotherapy for cancer. The FDA has cleared three automated (mechanical) scalp cooling devices for use in the United States: Paxman, DigniCap, and Amma. The bill does not apply to cold caps — manual cooling caps that are stored in a freezer or with dry ice and must be swapped out by hand throughout the infusion — which are not FDA cleared.

AB 1682 would prohibit insurers from applying greater cost-sharing requirements than what they currently provide for other oncology supportive services.

### 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 devices may be less effective for patients with different hair types, such as Black patients with curly hair. There is strong evidence indicating that scalp cooling does not raise the risk of scalp metastasis.

### Cost Impacts

Postmandate, CHBRP estimates AB 1682 would result in 680 additional enrollees receiving scalp cooling, for an additional \$4,010,000 in annual premiums paid by employers and enrollees.

AB 1682 would impact expenses for those using the benefit by increasing cost sharing by a total of \$305,000 across all users, and decreasing expenses for noncovered benefits by \$934,000 for users without coverage at baseline. The impact of AB 1682 on average user out-of-pocket expenses varies by type of user and market type.

### Public Health Impacts

AB 1682 would result in approximately 333 newly covered enrollees experiencing significantly less hair loss than they otherwise would have, which may reduce distress, anxiety, and self-image impacts associated with chemotherapy-induced alopecia.

### Long-Term Impacts

The long-term cost trajectory of AB 1682 may depend on several interacting factors, including the pace of utilization growth relative to per-unit pricing, and the reduction in utilization of other services like medical wigs, cold caps, or mental health services that were not directly modeled in this analysis.

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# Acronyms and Terminology

## Acronyms

**CA** – California

**CalPERS** – California Public Employees' Retirement System

**CDC** – Centers for Disease Control and Prevention

**CMS** – Centers for Medicare & Medicaid Services

**CDI** – California Department of Insurance

**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

**FDA** – U.S. Food and Drug Administration

**NCCN** – National Comprehensive Cancer Network

## Terminology

CHBRP uses the following terminology for this analysis:

**Chemotherapy-induced alopecia:** Chemotherapy-induced alopecia is a side effect of commonly administered chemotherapeutic agents in which patients experience hair loss (Dunnill et al., 2018).

**Scalp cooling:** Scalp cooling refers to the process of cooling the scalp before, during, and after chemotherapy infusion to reduce the amount of drug delivered to hair follicles, thereby aiming to reduce hair loss (Shah et al., 2018). FDA-cleared scalp cooling systems are automated, which allows cool fluid to circulate through the cap to maintain the desired temperature for long periods of time.

**Cold caps:** Cold caps are a form of a scalp cooling device worn during chemotherapy infusions to reduce the incidence or severity of chemotherapy-induced alopecia. Manual cold caps must be reduced in temperature manually — in a freezer or with dry ice — and be swapped out by hand throughout the infusion as they warm up. In this analysis, cold caps refer to non-FDA-cleared manual scalp cooling devices or products.

**FDA cleared:** An FDA-cleared medical device or product that has been reviewed under FDA's 510(k) Premarket Notification process and determined to be substantially equivalent to an existing device already on the U.S. market. FDA clearance is used for devices that have low to moderate risk to consumers, known as Class 1 and Class 2. Class 3 devices, meanwhile, pose the highest risk and must undergo a review process for FDA approval. If manufacturers intend to substantially change the device or product so as to potentially affect safety and effectiveness, information must be submitted to the FDA (FDA, 2024).

**Cost sharing:** Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses<sup>1</sup>).

**Utilization management:** Utilization management techniques are used by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Examples include benefit coverage requirements related to prior

<sup>1</sup> Premiums are paid by most enrollees, regardless of their use of any tests, treatments, or services. Some enrollees may not pay premiums for different reasons. For example, their employers cover the full premium, or they receive benefits through Medi-Cal.

authorization, step therapy, quantity limits, and limits related to the age or sex of the enrollee (such as prescription-only infant formula or prostate cancer screening for men).

**Prior authorization:**<sup>2</sup> Also known as precertification, prior approval, or prospective review, prior authorization is a utilization management technique commonly used by health insurance carriers to ensure that a given medical intervention meets the insurance plan or policy's criteria for coverage (Newcomer et al., 2017). Prior authorization was developed as a tool for insurers to assess the appropriateness of treatment that would result in a hospital admission or a high-cost procedure (Resneck, 2020). The primary uses of prior authorization include coverage evaluation, which allows evaluation of whether a test, treatment, or service is medically necessary and otherwise covered.

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<sup>2</sup> More information about prior authorization is available in CHBRP's 2023 analysis [Prior Authorization in California](#).

## Overview: AB 1682 and Scalp Cooling

On February 3, 2026, the California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)<sup>3</sup> conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 1682, Scalp Cooling, as introduced on February 2, 2026.

### Bill Language of AB 1682

AB 1682 would require state-regulated health plans and policies to provide coverage of FDA-cleared scalp cooling for patients undergoing chemotherapy for treatment of cancer. Non-FDA-cleared cold caps are excluded from the requirement. See the full text of AB 1682 in Appendix A.

If enacted, AB 1682 would apply to the health insurance of approximately 22.8 million enrollees (60% of all Californians) (Figure 1).

- Includes:** Enrollees in commercial or CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), and Medi-Cal beneficiaries enrolled in DMHC-regulated plans and county organized health plans (COHS).

It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, and 80% of Medi-Cal beneficiaries, in addition to commercial enrollees.<sup>4</sup>

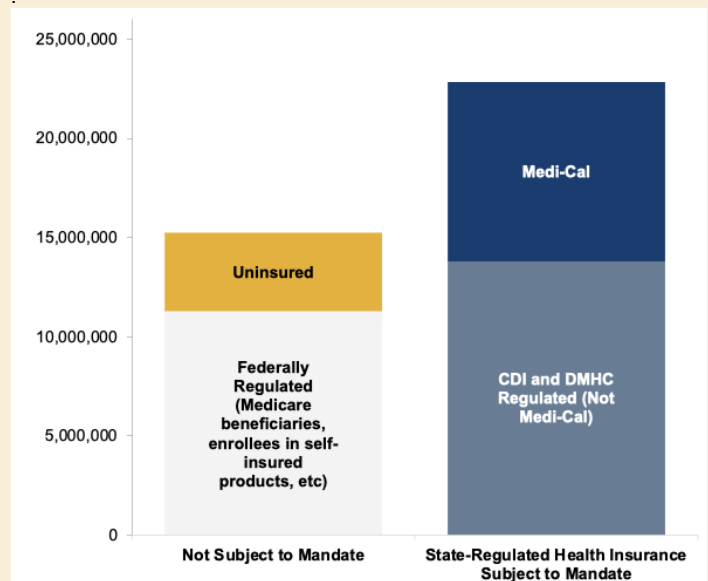
AB 1682 does not prohibit cost sharing or utilization management techniques but would prohibit insurers from applying greater cost-sharing requirements than what they currently provide for other oncology supportive services. CHBRP provides an overview of common cost-sharing and utilization management practices that may be used in its explainers [What Is Cost Sharing?](#) and [Utilization Management: An Overview](#).

### What Is Chemotherapy-Induced Alopecia and Scalp Cooling?

Each year, approximately 185,000 Californians receive a new cancer diagnosis (CCR, 2025). Chemotherapy — medication delivered intravenously to target rapidly dividing tumor cells — is used to treat many common solid tumor cancers, including breast, ovarian, uterine, lung, and sarcomas (Shah et al., 2018).

Chemotherapy-induced alopecia is typically temporary; hair usually begins to regrow within weeks to months after treatment ends (Shah et al., 2018). Chemotherapy-induced alopecia typically begins 2 to 4 weeks after the start of treatment and is consistently among the most commonly reported and distressing side effects of cancer treatment (Dunnill

**Figure 1. Health Insurance in CA and AB 1682**



**Source:** California Health Benefits Review Program, 2026.

Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.<sup>1</sup>

Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

<sup>3</sup> See CHBRP's [authorizing statute](#).

<sup>4</sup> For more detail, see CHBRP's [resource Sources of Health Insurance in California](#).

et al., 2018; Rugo et al., 2017a<sup>5</sup>; Vardy et al., 2022). Unlike most other side effects, hair loss is visible to others, and patients may lose control over who knows they have cancer and when.

Scalp cooling works by cooling the scalp before, during, and after chemotherapy infusion to reduce the amount of drug delivered to hair follicles, thereby aiming to reduce hair loss (Shah et al., 2018). FDA-cleared scalp cooling systems are automated, which allows cool fluid to circulate through the cap to maintain the desired temperature for long periods of time. Manual cold caps, by contrast, are stored in freezers or with dry ice and must be swapped out by hand throughout the infusion as they warm up.

The FDA-cleared scalp cooling systems covered under AB 1682 are marketed under the names DigniCap, Paxman, and Amma. AB 1682 would require coverage for FDA-cleared automated scalp cooling systems; manual cold caps are excluded from the bill.

## Disparities in Chemotherapy-Induced Alopecia and Barriers to Accessing Scalp Cooling

Access to scalp cooling varies by income, insurance status, geography, and provider practice. Patients who are privately insured or live in higher-income ZIP codes are significantly more likely to use scalp cooling, and the absence of coverage creates a significant financial barrier for lower-income patients and those with public insurance (Novice et al., 2024). Most providers support scalp cooling but only 26% routinely initiate conversations about it with patients, often because of cost concerns (Novice et al., 2024). In California, FDA-cleared scalp cooling facilities are concentrated in the San Francisco Bay Area, Los Angeles, and San Diego, leaving patients in the Central Valley, Northern California, and rural areas with limited or no access regardless of insurance coverage. For an in-depth look at clinical guidance, existing disparities, and barriers to access to care for scalp cooling, please see the *Background* section in CHBRP's Technical Brief on AB 1682.

## What Is the Effectiveness of Scalp Cooling?

The key research question for medical effectiveness was: For persons who are diagnosed with cancer, what is the effectiveness of FDA-cleared medical devices or systems before, during, or after the administration of chemotherapy on the incidence or severity of chemotherapy-induced alopecia (hair loss) as compared to no treatment? Additional sub-questions were: What are the effects of FDA-cleared scalp cooling devices on quality-of-life measures? What are the associated harms of FDA-cleared scalp cooling devices?

CHBRP found evidence that FDA-cleared automated scalp cooling devices included in the studies reviewed for this analysis are effective in reducing chemotherapy-induced alopecia.<sup>6</sup> Effectiveness was defined in the literature as 50 percent or less hair loss. The majority of the studies focused on patients with breast cancer, but there is nothing in the literature to suggest that scalp cooling would not be effective for patients with other types of cancer. However, some evidence suggests that scalp cooling devices may be less effective for patients with different hair types, such as Black patients with curly hair. CHBRP found some evidence that scalp cooling devices do not improve quality-of-life measures, such as measures of anxiety, emotional role functioning, and body image, despite reductions in hair loss. Some observational studies found significant improvements in quality-of-life measures, while four randomized controlled trials (RCTs) did not. Finally, while patients frequently report minor adverse effects such as headaches or generalized chills, the incidence rates of scalp metastasis in those using scalp cooling versus no scalp cooling are similar, indicating that scalp cooling does not raise the risk of scalp metastasis.

For an in-depth analysis of the medical effectiveness of scalp cooling devices, please see the *Medical Effectiveness Review* section in CHBRP's Technical Brief on AB 1682, available at [www.chbrp.org](http://www.chbrp.org).

<sup>5</sup> Rugo et al. (2017a) was partially funded by Dignitana AB, the manufacturer of the DigniCap scalp cooling device, and one co-author was a Dignitana employee. CHBRP notes this potential conflict of interest. The finding that chemotherapy-induced alopecia is among the most distressing side effects of cancer treatment is consistent with independent literature cited elsewhere in this report.

<sup>6</sup> The FDA-cleared scalp cooling devices referenced in the studies are the Paxman and the DigniCap. The manufacturer Cooler Heads also has a scalp cooling device, Amma, that was cleared for use in 2021, a few years after the initial launch of the scalp cooling caps.

## Policy Context

### Existing California Law and Regulations

California law requires coverage of medically accepted cancer screening and treatment services in state-regulated plans and policies. DMHC-regulated plans and CDI-regulated policies are required to cover screening, diagnosis, and treatment services for breast cancer. CHBRP finds no existing California requirements related to coverage for scalp cooling devices. CHBRP reviewed the state's Independent Medical Review (IMR) determinations and found one determination related to scalp cooling. (See the *Policy Framework* section in CHBRP's Technical Brief on AB 1682 for a detailed explanation.)

### Similar Legislation in Other States

Two states have passed laws requiring coverage of scalp cooling. In 2025, New York<sup>7</sup> and Louisiana passed laws requiring large-group plans to provide coverage for scalp cooling systems used in conjunction with chemotherapy. The laws do not require scalp cooling to be limited to FDA-cleared devices and products as would be required under AB 1682. Instead, New York and Louisiana define scalp cooling as any device that is used to prevent or reduce hair loss, is designed and intended for repeated use, and is primarily and customarily used to serve a medical purpose.

Including California, there is pending legislation across 11 states that would require coverage for scalp cooling. Bill language varies across states, for example: Kentucky's proposed bill would limit requirements for coverage of scalp cooling to patients receiving chemotherapy for breast cancer; New Jersey's proposed bill would require physicians to inform patients of the availability of scalp cooling to prevent or reduce hair loss.<sup>8, 9</sup>

### Federal Requirements

#### *Affordable Care Act and essential health benefits*

The Affordable Care Act (ACA) requires coverage of 10 broad categories of health care services considered essential health benefits (EHBs) for almost all enrollees in the individual and small-group markets, both inside and outside Covered California.<sup>10,11</sup> These categories include services relevant to cancer, including oncology supportive care services that may fall under ambulatory patient services, chronic disease management, and other categories.

States may require state-regulated health insurance to offer benefits that exceed EHBs.<sup>12,13,14,15</sup> AB 1682 may exceed EHBs, depending on how state regulators interpret coverage requirements. See the *Policy Context* section of CHBRP's Technical Brief on AB 1682 for more explanation.

#### *National guidelines*

The National Comprehensive Cancer Network (NCCN) is a not-for-profit alliance of 33 U.S. cancer centers that provides clinical guidelines for cancer care. The NCCN guidelines for breast cancer recommend considering scalp cooling to

<sup>7</sup> New York Insurance Law § 4303 (q-2) (1).

<sup>8</sup> Kentucky House Bill 25, 26th Regular Session (Ky. 2026).

<sup>9</sup> New Jersey Assembly Bill A2483, 222nd Leg., Reg. Sess. (N.J. 2026).

<sup>10</sup> Large-group, self-insured, and grandfathered plans and policies are exempt from EHB requirements.

<sup>11</sup> For more detail, see CHBRP's issue brief, [Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California](#).

<sup>12</sup> ACA Section 1311(d)(3).

<sup>13</sup> State benefit mandates enacted on or before December 31, 2011, may be included in a state's EHBs, according to the U.S. Department of Health and Human Services (HHS). [Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation](#). Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013.

<sup>14</sup> However, as laid out in the Final Rule on EHBs U.S. Department of Health and Human Services (HHS) released in February 2013, state benefit mandates enacted on or before December 31, 2011, would be included in the state's EHBs, and there would be no requirement that the state defray the costs of those state-mandated benefits. For state benefit mandates enacted after December 31, 2011, that are identified as exceeding EHBs, the state would be required to defray the cost.

<sup>15</sup> In February 2026, HHS released a proposed rule that would alter what benefits would be determined to exceed EHBs. Depending on how these regulations are finalized, the below conclusions about whether benefits included in AB 1682 exceed EHBs would be altered. U.S. Department of Health and Human Services (HHS). [Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program](#). Proposed Rule. Federal Register, Vol. 91, No. 28. February 11, 2026.

reduce the incidence of chemotherapy-induced alopecia for patients receiving chemotherapy, noting that results may be less effective with anthracycline-containing regimens (NCCN, 2026). This recommendation does not distinguish between the FDA-cleared automated scalp cooling devices referenced in AB 1682 and manual cold caps. As previously discussed, manual cold caps would not be required to be covered under AB 1682.

Beyond this NCCN recommendation, CHBRP did not identify other formal U.S.-based clinical practice guidelines on the use of scalp cooling for chemotherapy-induced alopecia. Internationally, the European Society for Medical Oncology (ESMO) recommends the use of scalp cooling for the prevention of chemotherapy-induced alopecia, noting differences in outcome with different treatment regimens (Lacouture et al., 2021).

**Medicare.** Under Medicare, mechanical (referred to in this analysis as automated) scalp cooling is covered and reimbursable. The Centers for Medicare & Medicaid Services recently included the three newly established Current Procedural Terminology (CPT) codes in the 2026 Medicare Physician Fee Schedule, marking that coverage and reimbursement is available throughout the Medicare program (CMS, 2025). (See the *Policy Framework* section of CHBRP's Technical Brief on AB 1682 for more information on the billing codes.)

## Other Programs and Payment Options

Patients may receive assistance paying for scalp cooling through external support, including philanthropic subsidies and manufacturer assistance. For instance, national nonprofits such as HairToStay and The Rapunzel Project provide need-based grants to cover part or all the cost of scalp cooling for eligible patients (HairToStay, n.d.; The Rapunzel Project, n.d.). Device manufacturers such as Paxman offer payment plans and patient assistance for uninsured or underinsured patients. Additionally, some cancer centers providing scalp cooling devices may partner with local nonprofit organizations that provide grant funding to cover the cost of scalp cooling.<sup>16</sup>

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<sup>16</sup> Personal communication, Dr. Frederic Kass, UC Santa Barbara, February 24, 2026.

## Analytic Approach and Assumptions

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of AB 1682, unless otherwise specifically mentioned.

### Language Interpretation

CHBRP made the following assumptions based on the language of AB 1682:

- AB 1682 directly defines scalp cooling as the use of an FDA-cleared device applied to the scalp “before, during, or after” the administration of chemotherapy. Given that scalp cooling is clinically recommended for use before, during, *and* after chemotherapy infusion, CHBRP assumes health plans and policies must cover scalp cooling as prescribed, and is not limited to before, during, *or* after chemotherapy infusion.
- CHBRP assumes that AB 1682 applies to scalp cooling as provided in clinics or facilities where chemotherapy is administered.

### Cost-Related Analytical Approach and Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of AB 1682 on benefit coverage, utilization, and cost for a single year.<sup>17</sup> Full-scale implementation typically requires an initial or immediate term “ramp up” period, which may include educating enrollees, providers, and insurance carriers on the new benefits or coverage; updating procedures and policies; and increasing provider capacity for marginal utilization resulting from AB 1682. The incremental impact estimates below assume there is no initial “ramp up” period in the immediate term and represent annual costs at full-scale implementation of AB 1682. Note that some longer-term dynamics stemming from continued shifts in awareness, behavior, or utilization patterns that may emerge beyond the initial postmandate period are addressed in the text of the *Long-Term Impact* section. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.<sup>18</sup>

#### *Approach and assumptions on baseline coverage and utilization*

- CHBRP’s carrier surveys were used to assess baseline coverage of scalp cooling. CHBRP analyzed Milliman’s Consolidated Health Cost Guidelines Sources Database to identify the eligible baseline population of enrollees with a solid tumor diagnosis undergoing chemotherapy and to examine scalp cooling utilization within that population. There were too few observations in claims data to yield a robust utilization estimate.<sup>19</sup> CHBRP used publicly available reports from manufacturers and content expert input to estimate utilization. See CHBRP’s Technical Brief on AB 1682 for more details regarding the approach and assumptions for this analysis.
- CHBRP assumed 2.0% of the adult population with cancer who are undergoing chemotherapy are utilizing the benefit at baseline. This rate is comprised of users with and without coverage. CHBRP assumed the utilization of the scalp cooling device for users without coverage is 1.0% (Paxman, 2024).<sup>20</sup> Using the coverage rates provided by the carrier

<sup>17</sup> For some analyses, impacts as a result of changes to health insurance benefits may occur over multiple years (e.g., impacts in pregnancy and childbirth rates resulting from changes to utilization of fertility services, staggered implementation, or long-term changes in utilization). CHBRP’s estimates represent the full impact of the mandate in one year even if changes in coverage, utilization offsets, and costs may be realized in more than one year.

<sup>18</sup> CHBRP’s Cost and Coverage Model also assumes enrollees maintain one form of health insurance for the entire calendar year. Examples of state and industry policies and behavior include medications that may be developed or approved in the future, health insurance market changes beyond what is known at the time of publication of this analysis, and statutory changes resulting from other health benefit mandates.

<sup>19</sup> CHBRP notes that although carrier surveys indicated a non-negligible level of baseline coverage for scalp cooling, this coverage did not appear to be reflected in the claims data, which contained too few observations to support a utilization estimate.

<sup>20</sup> Paxman is the largest manufacturer of scalp cooling devices globally. In their 2024 annual report, they report 1% of eligible patients use scalp cooling (Paxman, 2024).

surveys, CHBRP calculated the utilization rate for enrollees with coverage, which is equal to 3.2% at baseline. These assumptions were deemed reasonable by CHBRP's content expert.<sup>21</sup>

### *Approach and assumptions on postmandate coverage and utilization*

- CHBRP assumed utilization of scalp cooling would increase by 20% in the first year postmandate. This increase reflects anticipated awareness generated by the proposed legislation and the recent establishment of permanent medical billing codes for scalp cooling (see *Policy Context*), limited by provider/infusion center capacity constraints. On the provider side, scalp cooling requires infusion centers to establish relationships with device manufacturers to obtain and maintain equipment. Additionally, the process extends the time a patient occupies an infusion chair, depending on the chemotherapy regimen and, in some cases, patient hair thickness (see the *Background* section of CHBRP's Technical Brief on AB 1682). This creates scheduling and capacity challenges for infusion centers operating at or near capacity, which may need to adjust protocols, extend hours, or invest in additional infrastructure to accommodate longer treatment sessions. Patient tolerability can also be an additional limiting factor as not all patients who initiate scalp cooling are able to complete a full course of treatment, and some may discontinue after one or more sessions (see the *Background* section of CHBRP's Technical Brief on AB 1682). This assumption was informed by conversations with CHBRP's content experts, manufacturers, review of literature and manufacturer data, and claims analysis.
- AB 1682 may also reduce utilization of other benefits currently used to address the consequences of chemotherapy-induced alopecia. Some health plans may cover cranial prostheses (i.e., wigs or non-FDA-cleared cold caps) for patients who experience hair loss during cancer treatment. To the extent that scalp cooling successfully prevents alopecia, some enrollees who would otherwise have used this benefit may no longer need to, representing a modest offset to the direct costs of the mandate. CHBRP is unable to quantify this offset with available data but notes it as a potential source of cost reduction that would partially counteract the increase in scalp cooling expenditures.

For further details on the underlying data sources, methods, and assumptions used in this analysis please see CHBRP's Technical Brief on AB 1682, available at [www.chbrp.org](http://www.chbrp.org).

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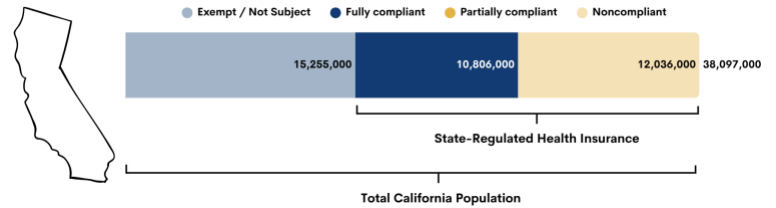
<sup>21</sup>Personal communication with CHBRP content expert Sara Hurvitz, MD, March 6, 2026

# AB 1682 Impacts: Benefit Coverage and Cost

## Benefit Coverage

CHBRP estimates that at baseline, 10,806,000 Californians (47%) with state-regulated insurance subject to the mandate are enrolled in plans or policies in compliance with AB 1682 (Table 6). Postmandate, CHBRP estimates 22,842,000 Californians would have coverage compliant with AB 1682 (Figure 2). Please note that CHBRP’s approach is to assume full compliance postmandate on the part of all health insurance subject to the proposed mandate.

**Figure 2. California Health Insurance and Baseline Compliance With AB 1682**



Source: California Health Benefits Review Program, 2026.

## Utilization and Unit Cost

At baseline, CHBRP estimates that approximately 630 enrollees use FDA-cleared scalp cooling to prevent or reduce the incidence of chemotherapy-induced alopecia. Of these, 440 have coverage at baseline and 190 do not. Postmandate, CHBRP estimates an increase of 680 enrollees who would use scalp cooling with coverage postmandate. Of this 680 total, 90 are enrollees who had coverage at baseline and would continue to have coverage postmandate, but utilization would increase by 20% due to an assumed increase in availability and awareness postmandate (see *Postmandate Utilization Assumptions* in the *Cost Impact Analysis* section of CHBRP’s Technical Brief on AB 1682). The remaining 590 are enrollees who did not have coverage at baseline but would have coverage postmandate. Table 1 provides estimates of the impacts of AB 1682 on utilization and unit cost of scalp cooling.

CHBRP assumed the per-session cost of scalp cooling would not change as a result of the proposed legislation. The cost of a treatment is \$5,000 for Commercial enrollees and \$1,500 for Medi-Cal enrollees. The average cost per patient using scalp cooling (during course of chemotherapy over a year) increases from \$3,700 at baseline to \$4,100 postmandate. This increase reflects a change in the Commercial/Medicaid mix of enrollees using scalp cooling rather than a change in pricing, as Commercial enrollees without baseline coverage gain access. CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of scalp cooling and therefore an increase in enrollee cost sharing for new users of the benefit.

**Table 1. Impacts of AB 1682 on Utilization and Unit Cost, 2027**

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Total number of enrollees using FDA-cleared scalp cooling for chemotherapy-induced alopecia	630	1,310	680	107.94%
With coverage at baseline (a)	440	530	90	20.45%
Without coverage at baseline	190	780	590	310.53%
Average cost per patient using scalp cooling (b)	\$3,700	\$4,100	\$400	10.81%

Source: California Health Benefits Review Program, 2026.

Notes: (a) Enrollees who had coverage at baseline and would continue to have coverage postmandate, but utilization would increase by 20% due to an assumed increase in availability and awareness postmandate. (b) Within this average, unit costs may vary by the number of scalp cooling sessions an enrollee receives.

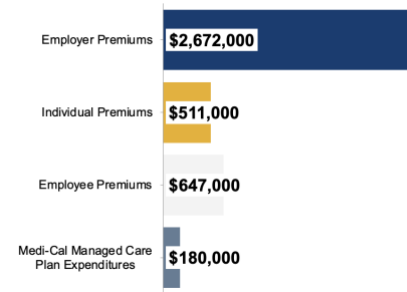
## Expenditures and Premium Impacts

Policies affecting health insurance benefits, such as benefit coverage mandates, impact stakeholders in distinct ways. In terms of direct costs, these stakeholders can generally be grouped into two categories: (1) enrollees who utilize the benefit,<sup>22</sup> and (2) those who do not utilize it. Enrollees who use a benefit may be responsible for paying additional out-of-pocket expenses related to the benefit. Premium increases are expressed in the aggregate, though enrollees who were in plans that already provided coverage for the benefit would not see an increase in premiums.

### Expenditure Impacts on Employers and All Enrollees

As shown in Figure 3, for DMHC-regulated plans and CDI-regulated policies, AB 1682 would increase total premiums paid by employers and enrollees for newly covered benefits by approximately \$4,010,000 or 0.002%. For more details, see Table 8. Enrollee premiums calculated include premiums for those enrollees who had coverage as well as those who newly gained coverage to the benefit. CHBRP did not quantify potential cost offsets due to lack of available data in the literature linking chemotherapy-induced alopecia prevention to measurable reductions in downstream health care utilization. See the *Public Health Impacts* section in CHBRP’s Technical Brief on AB 1682 for more discussion on related benefits stemming from reductions in chemotherapy-induced alopecia.

**Figure 3. Expenditure Impacts of AB 1682 on Employers and Enrollees**



Source: California Health Benefits Review Program, 2026.

Changes in premiums as a result of AB 1682 would vary by market segment (

Table 2; see also Table 7 and Table 8).

**Table 2. Premium Impact Ranges of AB 1682 by Market Segment**

Market Segment	Premium Impact Range (PMPM)
Commercial plans/policies	\$0.015-\$0.027
Individually purchased	\$0.005-\$0.030
CalPERS	\$0.023
Medi-Cal	\$0.002

Source: California Health Benefits Review Program, 2026.

Key: CalPERS = California Public Employees’ Retirement System; PMPM = per member per month.

Below, Table 3 provides estimates of the aggregate impacts of AB 1682 on premiums.

<sup>22</sup>Depending on their health insurance and the benefit in question, enrollees may or may not also pay for the benefit. For example, most Medi-Cal beneficiaries do not have cost sharing and do not pay health insurance premiums, whereas enrollees with health insurance a plan in the individual market may pay both insurance premiums and cost sharing or other out-of-pocket expenses.

Table 3. Impacts of AB 1682 on Premiums, 2027

	Baseline	Postmandate	Increase/Decrease	Percentage Change
<b>Non-enrollee premiums</b>				
Employer-sponsored (a)	\$75,730,916,000	\$75,733,371,000	\$2,455,000	0.0032%
CalPERS employer (b)	\$8,611,855,000	\$8,612,072,000	\$217,000	0.0025%
Medi-Cal (c)	\$42,982,384,000	\$42,982,564,000	\$180,000	0.0004%
<b>Enrollee premiums</b>				
Enrollees, individually purchased insurance	\$25,775,325,000	\$25,775,836,000	\$511,000	0.0020%
<i>Outside Covered California</i>	\$9,551,761,000	\$9,551,902,000	\$141,000	0.0015%
<i>Through Covered California</i>	\$16,223,564,000	\$16,223,934,000	\$370,000	0.0023%
Enrollees, group insurance (d)	\$21,828,135,000	\$21,828,782,000	\$647,000	0.0030%
<b>Total premiums</b>	<b>\$174,928,615,000</b>	<b>\$174,932,625,000</b>	<b>\$4,010,000</b>	<b>0.0023%</b>

**Source: California Health Benefits Review Program, 2026.**

Notes: (a) In some cases, a union or other organization. Excludes CalPERS.

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 49% are state retirees, state employees, or their dependents. About one in five (20.4%) of these enrollees has a pharmacy benefit not subject to DMHC.<sup>23</sup> 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 managed care.

(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

## Enrollee Expenses for Benefit Users

AB 1682 would impact expenses for those using the benefit. Users without coverage would reduce their expenses for noncovered benefits by \$934,000. Postmandate, these users would need to pay cost sharing to access the benefit. CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of scalp cooling and therefore an increase in enrollee cost sharing. Taking into account expanded coverage, including enrollees who previously did not purchase noncovered services and new users, total cost sharing would increase by \$305,000.

The impact of AB 1682 on average user out-of-pocket expenses varies by type of user and market type (Table 4). For users with baseline benefit coverage (i.e., those who have coverage at baseline and would continue to have coverage postmandate) there would be no increase in enrollee expenses per user. In contrast, for users without baseline benefit coverage and who would gain new coverage for scalp cooling postmandate, the average annual enrollee expenses would decrease, ranging from \$4,000 for individual market enrollees to \$4,810 for CalPERS enrollees, due to reduced out-of-pocket expenses for noncovered benefits, partially offset by cost sharing. For new users of scalp cooling postmandate, enrollee expenses would increase due to cost sharing associated with the new benefit; these range from \$0 annual cost sharing for Medi-Cal enrollees to \$1,010 annual cost sharing total for individual market enrollees.





<sup>23</sup> For more detail, see CHBRP's [resource Pharmacy Benefit Coverage in State-Regulated Health Insurance](#).

AB 1682–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits are related to the number of enrollees with health insurance that would be subject to AB 1682 expected to use the relevant tests, treatments, or services during the year after enactment (see Table 7 and Table 8).

It is possible that some enrollees incurred expenses related to scalp cooling for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact. The presence of a deductible not yet met for the year<sup>24</sup> could result in the enrollee paying the full unit cost, but hitting the annual out-of-pocket maximum<sup>25</sup> would result in the enrollee having no further cost sharing. See more information in CHBRP’s Technical Brief on AB 1682, including what else policymakers should consider such as the potential cost of exceeding EHBs.

### WHAT ELSE SHOULD POLICYMAKERS CONSIDER?

The full impacts of legislation may affect more than benefit coverage, utilization, and cost. See more details on each in the fiscal technical brief.

 <p>State spending targets</p>	 <p>Changes in the number of uninsured persons</p>
 <p>Administrative and other expenses</p>	 <p>Potential cost of exceeding essential health benefits</p>

<sup>24</sup> For estimates of enrollees in plans and policies with deductibles, see CHBRP’s [resource \*Deductibles in State-Regulated Health Insurance\*](#).

<sup>25</sup> For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copays and coinsurance for prescription medications is limited to \$250, or \$500 for enrollees in the “bronze plans” available from Covered California, the state’s ACA marketplace (H&SC §1342.73; IC §10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.

**Table 4. Impact of AB 1682 on Average Annual Expenses for Users**

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
<b>Users at baseline with baseline benefit coverage</b>					
% of population with enrollee expenses impact due to AB 1682	0.0007%	0.0029%	0.0030%	0.0013%	0.0026%
Avg. annual enrollee expenses and premium impact for users (a)	\$0	\$0	\$0	\$0	\$0
<b>Users of noncovered benefits at baseline</b>					
% of population with enrollee expenses impact due to AB 1682	0.0016%	0.0009%	0.0011%	0.0013%	0%
Avg. annual enrollee expenses and premium impact for users (a)	-\$4,780	-\$4,210	-\$4,000	-\$4,810	\$0
<b>New users</b>					
% of population with enrollee expenses impact due to AB 1682	0.0046%	0.0030%	0.0037%	0.0039%	0.0012%
Avg. annual enrollee expenses and premium impact for users (a)	\$220	\$800	\$1,010	\$180	\$0

**Source: California Health Benefits Review Program, 2026.**

Notes: Average enrollee expenses includes cost sharing (deductibles, copays, etc.) for covered benefits and out-of-pocket expenses for noncovered benefits. Average annual enrollee premium impact includes the employee portion of the premium only.

(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

**Table 5. Impact of AB 1682 on Average Non-User Enrollee Expenses**

	Large Group	Small Group	Individual	CalPERS	Medi-Cal
% of population without enrollee expenses impact due to AB 1682	99.993%	99.993%	99.992%	99.993%	99.996%
Avg. annual enrollee expenses and premium impact for users (a)	\$0.0576	\$0.0615	\$0.2055	\$0.0439	\$0.0000

**Source: California Health Benefits Review Program, 2026.**

Notes: Average enrollee expenses are \$0. Average annual enrollee premium impact includes the employee portion of the premium only.

(a) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.

## AB 1682 Impacts: Public Health

### Estimated Public Health Outcomes

As presented in the *Medical Effectiveness Review* section of CHBRP's Technical Brief on AB 1682, there is strong evidence that Paxman and DigniCap reduce chemotherapy-induced alopecia compared to no treatment (Kang et al., 2024; Lambert et al., 2024). Evidence on whether scalp cooling improves quality of life measures is weak and mostly null — RCTs have not found significant improvements (Marks et al., 2019). Chemotherapy-induced alopecia is nonetheless consistently associated with psychological distress, anxiety, and reduced wellbeing in the broader literature (Dunnill et al., 2018; Vardy et al., 2022). CHBRP estimates that approximately 680 enrollees would newly use scalp cooling in the first year postmandate.

CHBRP projects no measurable public health impact at the population level; 680 additional users is too small a share of California's population to shift aggregate health outcomes such as premature mortality, disease burden, or mental health service utilization across the state. However, the individual-level benefit for newly covered enrollees is real and may be clinically meaningful. Based on a pooled discontinuation rate of 18% (Kearney et al., 2025) and the rate of meaningful hair preservation observed in comparative studies, approximately 49% of patients who complete the protocol achieve less than 50% hair loss, compared to 0% of untreated patients (Lambert et al., 2024). CHBRP estimates that approximately 333 of the 680 newly covered enrollees would experience substantially less hair loss than they otherwise would have. Whether this translates to measurable improvements in quality of life or reductions in mental health service use is uncertain; the published literature has not established this link.

### Potential Harms from AB 1682

When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate. In the case of AB 1682, potential harms include generalized chills (42% pooled prevalence), cap heaviness (35%), and headache (30%), with a pooled discontinuation rate of 18% (Kearney et al., 2025). Scalp cooling does not appear to worsen cancer outcomes. Studies show no statistically significant difference in the rate of scalp metastasis (the spread of cancer cells to the scalp) between patients who used scalp cooling and those who did not (Kearney et al., 2025; Rugo et al., 2017b).

### Impacts on Disparities

Disparities in access to scalp cooling exist by income, race or ethnicity, and geography; more information can be found in the *Background* section of CHBRP's Technical Brief on AB 1682. Within the first 12 months postmandate, AB 1682 could reduce income-related disparities by removing the cost barrier for enrollees in state-regulated plans and Medi-Cal beneficiaries, though the magnitude is unknown. AB 1682 would not address geographic gaps in facility availability, the time burden of scalp cooling sessions, or potential device fit limitations for patients with tightly coiled hair. The impact on racial or ethnic disparities in utilization is unknown; evidence on whether scalp cooling is equally effective across hair types is limited and mixed (Dilawari et al., 2021; Obuseng et al., 2021).

### Impacts on Disparities and the Social Drivers of Health

Income, employment flexibility, and caregiving responsibilities likely contribute to unequal access to scalp cooling. AB 1682 may reduce income-related disparities by removing the coverage barrier but would not change barriers related to employment flexibility, caregiving responsibilities, or the time burden of scalp cooling sessions.

## Impacts on Premature Death and Economic Loss

Chemotherapy-induced alopecia is a treatment side effect and is not associated with premature death. As described in the *Background* section of CHBRP's Technical Brief on AB 1682, chemotherapy-induced alopecia is associated with indirect economic costs including lost productivity, reduced social participation, anxiety, and depression, all of which may result in additional health care utilization (Dunnill et al., 2018; Rugo et al., 2017a; Vardy et al., 2022). To the extent that AB 1682 increases use of scalp cooling and reduces hair loss among newly covered enrollees, it may reduce some of these downstream costs. CHBRP was unable to quantify this impact and projects no measurable effect on premature death or associated economic loss at the population level.

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## AB 1682 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of AB 1682, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.<sup>26</sup> 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 and Cost Impacts

#### Utilization Impacts

As noted in the preceding section, the estimates do not capture dynamics that may emerge beyond the initial postmandate period. Over the longer term (beyond 2 years), utilization of scalp cooling may increase as awareness of this technology continues to grow among patients and oncology providers. As coverage becomes established and scalp cooling becomes more routine in chemotherapy treatment planning, referral patterns and clinical workflows are likely to adapt, further contributing to utilization growth over the longer term.

#### Cost Impacts

Long-term (beyond 2 years) per-unit costs may shift over time as increased demand could encourage new market entrants or expanded capacity, exerting downward pressure on device and supply costs. The net long-term expenditure impact will depend on the pace of utilization growth relative to any changes in per-unit pricing.

### Long-Term Public Health Impacts

CHBRP expects utilization to increase beyond first-year levels as patient and provider awareness grows and financial barriers are reduced; long-term public health impacts are therefore likely to exceed those projected for the first year. If broader coverage leads some patients to proceed with chemotherapy who would otherwise have delayed or declined due to fear of hair loss, there may be downstream effects on cancer outcomes, though this has not been established in the literature. CHBRP projects no impact on premature death or associated economic loss.

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<sup>26</sup> Full-scale implementation typically requires a “ramp up” period, which may include educating enrollees, providers, and insurance carriers on the new benefits or coverage; updating procedures and policies; and increasing provider capacity for marginal utilization resulting from AB 1682. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The short-term, incremental impact estimated by CHBRP assumes there is no “ramp up” period and represent ongoing annual costs at full-scale implementation of AB 1682, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.

## Appendix A. Legislative Text Analyzed

CHBRP analyzed AB 1682 Scalp Cooling, as introduced on February 2, 2026, per the request of the California Assembly Committee on Health. The text analyzed is copied below.

CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

ASSEMBLY BILL

No. 1682

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Introduced by Assembly Member Hart

February 2, 2026

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An act to add Section 1367.651 to the Health and Safety Code, to add Section 10123.811 to the Insurance Code, and to add Section 14132.65 to the Welfare and Institutions Code, relating to health care coverage.

### LEGISLATIVE COUNSEL'S DIGEST

AB 1682, as introduced, Hart. Health care coverage: scalp cooling.

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 coverage by health care service plans and health insurers for various screening and treatment services with respect to cancer.

This bill would require a health care service plan contract or health insurance policy, except as specified, that is issued, amended, delivered, or renewed on or after January 1, 2027, to provide coverage for scalp cooling, as defined, as prescribed by a health care provider in connection with chemotherapy for persons with cancer. Because a violation of these provisions with respect to a health care service plan would be a crime, this bill would impose a state-mandated local program.

Existing law also provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services pursuant to a schedule of benefits, including various cancer screenings and benefits relating to cancer treatment.

Subject to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, this bill would expand the Medi-Cal schedule of benefits to include scalp cooling, as prescribed by a health care provider in connection with chemotherapy for persons with cancer.

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.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

**SECTION 1.** Section 1367.651 is added to the Health and Safety Code, to read:

**1367.651.** (a) A health care service plan contract issued, amended, or renewed on and after January 1, 2027, shall provide coverage for scalp cooling, as prescribed by a health care provider in connection with chemotherapy for persons with cancer.

(b) Coverage required by this section may be subject to copayments, coinsurance, or deductibles, provided that the copayments, coinsurance, or deductibles applicable to scalp cooling are no less favorable to an enrollee than the copayments, coinsurance, or deductibles that apply to coverage for oncology supportive care services under the same contract.

(c) For purposes of this section, “scalp cooling” is defined 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). “Scalp cooling” does not include non-FDA-cleared cold caps or any non-FDA-cleared scalp cooling products, regardless of whether those products are described as “cold cap therapy” or similar terminology.

(d) This section shall not apply to specialized health care service plans.

**SEC. 2.** Section 10123.811 is added to the Insurance Code, to read:

**10123.811.** (a) A health insurance policy issued, amended, or renewed on and after January 1, 2027, shall provide coverage for scalp cooling, as prescribed by a health care provider in connection with chemotherapy for persons with cancer.

(b) Coverage required by this section may be subject to copayments, coinsurance, or deductibles, provided that the copayments, coinsurance, or deductibles applicable to scalp cooling are no less favorable to an insured than the copayments, coinsurance, or deductibles that apply to coverage for oncology supportive care services under the same policy.

(c) For purposes of this section, “scalp cooling” is defined 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). “Scalp cooling” does not include non-FDA-cleared cold caps or any non-FDA-cleared scalp cooling products, regardless of whether such products are described as “cold cap therapy” or similar terminology.

(d) This section shall not apply to a specialized health insurance policy.

**SEC. 3.** Section 14132.65 is added to the Welfare and Institutions Code, to read:

**14132.65.** (a) Scalp cooling, as prescribed by a health care provider in connection with chemotherapy for persons with cancer, is a covered benefit under the Medi-Cal program.

(b) Coverage required by this section may be subject to copayments or deductibles, provided that the copayments or deductibles applicable to scalp cooling are no less favorable to a beneficiary than the copayments or deductibles that apply to oncology supportive care services that are covered benefits under the Medi-Cal program.

(c) For purposes of this section, “scalp cooling” is defined 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). “Scalp cooling” does not include non–FDA-cleared cold caps or any non–FDA-cleared scalp cooling products, regardless of whether such products are described as “cold cap therapy” or similar terminology.

(d) This section shall be implemented in a manner consistent with federal law and only to the extent federal financial participation is available and not otherwise jeopardized.

**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.

## Appendix B. Impacts of AB 1682 on Benefit Coverage and Expenditures, 2027

Table 6. Impacts of AB 1682 on Benefit Coverage, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,842,000	22,842,000	0	0%
Total enrollees with health insurance subject to AB 1682	22,842,000	22,842,000	0	0%
Percentage of enrollees with coverage for mandated benefit	47%	100%	53%	111.38%
Number of enrollees with fully compliant coverage for mandated benefit	10,806,000	22,842,000	12,036,000	111.38%

Source: California Health Benefits Review Program, 2026.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.<sup>27</sup>

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

<sup>27</sup> For more detail, see CHBRP's [resource Sources of Health Insurance in California](#).

**Table 7. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026**

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS (b)	Medi-Cal (c)		Large Group	Small Group	Individual	
					Under 65	65+				
<b>Enrollee counts</b>										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to AB 1682	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
<b>Premium costs</b>										
Average portion of premium paid by employer (e)	\$619.33	\$539.05	\$0.00	\$770.84	\$367.89	\$632.17	\$780.34	\$573.31	\$0.00	\$127,325,155,000
Average portion of premium paid by enrollee	\$134.02	\$263.52	\$864.90	\$145.41	\$0.00	\$0.00	\$184.88	\$242.16	\$832.16	\$47,603,460,000
<b>Total premium</b>	<b>\$753.35</b>	<b>\$802.56</b>	<b>\$864.90</b>	<b>\$916.25</b>	<b>\$367.89</b>	<b>\$632.17</b>	<b>\$965.22</b>	<b>\$815.47</b>	<b>\$832.16</b>	<b>\$174,928,616,000</b>
<b>Enrollee expenses</b>										
Cost sharing for covered benefits (deductibles, copays, etc.)	\$56.38	\$184.07	\$271.63	\$70.59	\$0.00	\$0.00	\$126.72	\$213.52	\$192.93	\$19,432,815,000
Expenses for noncovered benefits (f)	\$0.01	\$0.00	\$0.00	\$0.01	\$0.00	\$0.00	\$0.01	\$0.01	\$0.00	\$934,000
<b>Total expenditures</b>	<b>\$809.73</b>	<b>\$986.64</b>	<b>\$1,136.54</b>	<b>\$986.84</b>	<b>\$367.89</b>	<b>\$632.17</b>	<b>\$1,091.95</b>	<b>\$1,029.01</b>	<b>\$1,025.10</b>	<b>\$194,362,556,000</b>

**Source: California Health Benefits Review Program, 2026.**

- 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 (20.4%) of these enrollees has a pharmacy benefit not subject to DMHC. 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.<sup>28</sup>
  - (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 will 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; DMHC = Department of Managed Health Care.

<sup>28</sup> For more detail, see CHBRP's [resource Sources of Health Insurance in California](#).

**Table 8. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027**

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	Small Group	Individual	CalPERS (b)	Medi-Cal (c)		Large Group	Small Group	Individual	
					Under 65	65+				
<b>Enrollee counts</b>										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
Total enrollees in plans/policies subject to AB 1682	7,929,000	2,097,000	2,444,000	931,000	8,078,000	965,000	315,000	42,000	41,000	22,842,000
<b>Premium costs (postmandate change)</b>										
Average portion of premium paid by employer (e)	\$0.0220	\$0.0104	\$0	\$0.0194	\$0.0019	\$0	\$0.0235	\$0.0180	\$0	\$2,851,000
Average portion of premium paid by enrollee	\$0.0048	\$0.0051	\$0.0173	\$0.0037	\$0.0000	\$0	\$0.0056	\$0.0076	\$0.0050	\$1,158,000
<b>Total premium</b>	<b>\$0.0268</b>	<b>\$0.0155</b>	<b>\$0.0173</b>	<b>\$0.0230</b>	<b>\$0.0019</b>	<b>\$0</b>	<b>\$0.0290</b>	<b>\$0.0256</b>	<b>\$0.0050</b>	<b>\$4,009,000</b>
<b>Enrollee expenses (postmandate change)</b>										
Cost sharing for covered benefits (deductibles, copays, etc.)	\$0.0011	\$0.0025	\$0.0041	\$0.0008	\$0.0000	\$0	\$0.0023	\$0.0051	\$0.0009	\$305,000
Expenses for noncovered benefits (f)	-\$0.0065	-\$0.0035	-\$0.0046	-\$0.0054	\$0.0000	\$0	-\$0.0073	-\$0.0073	\$0	-\$934,000
<b>Total expenditures</b>	<b>\$0.0214</b>	<b>\$0.0145</b>	<b>\$0.0168</b>	<b>\$0.0184</b>	<b>\$0.0019</b>	<b>\$0</b>	<b>\$0.0241</b>	<b>\$0.0234</b>	<b>\$0.0059</b>	<b>\$3,380,000</b>
<b>Postmandate percent change</b>										
% change insured premiums	0.0036%	0.0019%	0.0020%	0.0025%	0.0005%	0%	0.0030%	0.0031%	0.0006%	0.0023%
<b>% change total expenditures</b>	<b>0.0026%</b>	<b>0.0015%</b>	<b>0.0015%</b>	<b>0.0019%</b>	<b>0.0005%</b>	<b>0%</b>	<b>0.0022%</b>	<b>0.0023%</b>	<b>0.0006%</b>	<b>0.0017%</b>

Source: California Health Benefits Review Program, 2026.

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.

(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.<sup>29</sup>

(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 will 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; DMHC = Department of Managed Health Care.

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<sup>29</sup> For more detail, see CHBRP’s [resource Sources of Health Insurance in California](#).

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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](http://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](https://chbrp.org).

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This analysis is based on existing literature and public sources identified through systematic search methods. This evidence informs the California Legislature about potential impacts of proposed health benefit legislation and does not constitute a policy recommendation from CHBRP.

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