Evaluation of SF XXXX – Coverage for Scalp Hair Prostheses for Hair Loss Caused by Cancer Treatment

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

02/12/2024

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Defrayal analysis completed by the Minnesota Department of Commerce is independent of AIR's evaluation.

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As requested by Minn. Stat. § 3.197: This report cost approximately $43,114 to prepare, including staff time, printing, and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille, or audio recording. Printed on recycled paper. A 508 compliant version of this report is forthcoming.

Contents

Executive Summary

This proposed mandate would require health carriers to provide health insurance coverage for scalp hair prostheses, including all equipment and accessories, for individuals experiencing hair loss due to cancer treatment.

Several cancer treatments are known to cause hair loss. These include but are not limited to chemotherapy and radiation therapy. Chemotherapy-induced alopecia and radiation-induced alopecia occur across cancer types.

Several states have passed similar laws requiring insurance coverage for scalp hair prostheses due to hair loss caused by various conditions, including cancer treatment–induced alopecia. Additionally, in 2023, a bill was introduced into the U.S. Congress proposing to classify wigs as durable medical equipment that would subsequently be included under the Affordable Care Act essential health benefits.

There are gaps in the literature on alopecia related to targeted therapies and radiation, making it difficult to fully assess the potential impact of the proposed health benefit mandate. While data on the prevalence of alopecia resulting from cancer treatment are inexact, alopecia can occur across different types of cancer and treatment types. This condition is often temporary or specific to the period of treatment but for some individuals it may become permanent.

The total statewide non-public insured population expenditures for wigs for enrollees suffering hair loss as a result of cancer treatment are projected to result in a net increase of $0.13 per member per month (PMPM) for the total non-public insured population in the first year and $0.17 PMPM in Year 10.

The potential state fiscal impact of this mandate is as follows:

- This proposed mandate is estimated to have no fiscal impact on Minnesota's State Employee Group Insurance Plan.
- Commerce has determined that this proposed mandate would likely require defrayal under the Patient Protection and Affordable Care Act, with an estimated cost of up to $185,000 in the first year.
- There is no estimated cost to Minnesota public health coverage programs.

Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Bill Requirements

This Senate bill is sponsored by Sen. Dziedzic and has yet to be introduced.

If enacted, this bill would expand coverage of scalp hair prostheses to include all equipment and accessories necessary for regular use of scalp hair prostheses for hair loss suffered as a result of alopecia areata or

treatment for cancer. Additionally, this amendment would establish a limit of $1,000 per benefit year for scalp hair prostheses, including all equipment and accessories necessary for regular use of scalp hair prostheses, worn for hair loss suffered as a result of treatment for cancer.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Medicare supplemental policies, and the State Employee Group Insurance Program (SEGIP). This would not apply to self-insured employer plans, grandfathered plans, Medicare, and Minnesota public health coverage programs.

This bill would amend Minnesota Statutes 2022, section 62A.28, subdivision 2.

Related Health Conditions and Associated Services/Treatments

Alopecia areata is an autoimmune disease that causes hair loss.[1] Coverage for scalp hair prostheses for hair loss suffered as a result of alopecia areata is currently required by Minnesota Statutes 2022, section 62A.28, subdivision 2.

Cancer treatments are also known to cause hair loss (alopecia). These treatments include but not limited to

- chemotherapy and
- radiation therapy.

Chemotherapy-induced alopecia (CIA) and radiation-induced alopecia (RIA) occur across cancer types. “Scalp hair prostheses,” also known as “cranial prostheses” and “medical wigs,” refer to custom wigs for individuals who have lost hair secondary to a medical condition.[2]

Equipment and accessories necessary for regular use of scalp hair prostheses include but are not limited to

- adhesive or special glue for application and
- removal tools.

Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic.

Relevant Federal Laws

There are currently no federal laws in place addressing coverage requirements for scalp hair prostheses for hair loss caused by cancer treatment. There is a 2023 U.S. Congress bill, the Wigs as Durable Medical Equipment Act, that proposes to implement coverage for wigs (i.e., scalp hair prostheses) as durable medical equipment under the Medicare program for patients with medical hair loss, including alopecia areata.[3] More specifically, the bill would reclassify cranial prostheses as durable medical equipment under the Social Security Act.

Relevant Minnesota Laws

There are currently no state laws in place addressing coverage requirements for scalp hair prostheses for hair loss caused by cancer treatment. Minn. Stat. § 62A.28 provides coverage for scalp hair prostheses for hair loss caused by alopecia areata.[4]

State Comparison

Several states have established or proposed health benefit mandates requiring coverage of scalp hair prostheses for hair loss caused by various conditions, including cancer treatment. Table 1 summarizes seven states' policies related to coverage of scalp protheses for hair loss as a result of cancer treatment. The table includes information on the coverage limit; requirements for medical justification, determination of necessity, or a prescription from the treating physician; and whether coverage is required for hair prostheses when other prostheses are already covered by an insurance policy. This table does not provide an exhaustive list of states that require coverage for scalp hair prostheses in cases of hair loss.

Table 1. States With Health Benefit Mandates for Coverage of Scalp Hair Prostheses for Hair Loss as a Result of Cancer Treatment

State	Established or proposed	Cost limit	Coverage of a prescription or medical necessity determination from treating physician	Insurance policies covering other prostheses must also cover scalp hair prostheses
CT[5]	Est. 2011	$350/yr.	●	
MA[6]	Est. 1998	$350/yr.	●	●
MD[7]	Est. 2000	$350/yr.		
NH[8]	Est. 1992	$350/yr.	●	●
NJ[9]	Proposed 2022	Not defined		
OK[10]	Est. 2000	$150/yr.		
RI[11]	Est. 2006	$350/yr.		

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations that responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received comments from four commercial health carriers that provided information related to insurance coverage.

One stakeholder stated that scalp hair prostheses can cost anywhere from $25 for a low-cost wig made of synthetic hair to $500 for a medium-cost synthetic wig and $3,000 or more for a high-end wig made of real hair.

Three organizations noted that the proposed mandate would expand current health insurance coverage for scalp hair prostheses because most plans align with Minnesota's current statute. Two of the organizations also

highlighted that any cost increases resulting from the enactment of the proposed mandate may lead to higher premiums.

One respondent noted that the bill's language on coverage for "all equipment and accessories necessary for regular use of scalp hair prostheses" lacks clarity and needs further specification, as it does not define what equipment and accessories are included.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and Minnesota Management and Budget (MMB) provided the following cost estimates related to the proposed benefit mandate:

- MMB's health plan administrators estimated an average state fiscal impact of the proposed mandate to be $0.10 per member per month (PMPM), as the bill would expand the current health care coverage for scalp hair prostheses (see the State Fiscal Impact section).
- According to the respondents, coverage for scalp hair prostheses for hair loss due to cancer treatment may result in an increased cost of up to $0.55 PMPM. One respondent noted that approximately 65% of cancer patients experience hair loss due to chemotherapy.

Cost estimates shared in RFI responses may reflect different methodologies, data sources, and assumptions than those used in the actuarial analysis for this evaluation. Stakeholders' results may or may not reflect generalizable estimates for the mandate.

Evaluation of Proposed Health Benefit Mandate

Methodology

The following section includes an overview of the literature review and actuarial analysis performed to examine the potential public health and economic impact of the mandate. The literature review includes moderate- to high-quality relevant peer-reviewed literature and/or independently conducted domestic research that was published within the last 10 years and is related to the public health, economic, or legal impact of the proposed health benefit mandate. For further information on the literature review methodology, please reference https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Public Health Impact

Literature Review

Treatment-Specific Alopecia Data. While data on the prevalence of alopecia resulting from cancer treatment are inexact, alopecia can occur across different types of cancer and treatment types. This condition is often temporary or specific to the period of treatment but for some individuals it may become permanent. CIA is the most common form of hair loss resulting from cancer therapy. Other therapies, such as radiation and targeted therapies, also are associated with alopecia, although rates of alopecia resulting from targeted therapies may be lower than those resulting from systemic chemotherapy.[12,13] Literature discussing hair loss resulting from chemotherapy is less abundant than literature on RIA. RIA has been documented to occur on average within 1–3 weeks of the initiation of treatment, primarily in those with radiation to the head. Hair regrowth from both CIA and RIA typically occurs 2–6 months after treatment.[14] The rate of alopecia for individuals undergoing cancer treatment is not well documented and varies widely depending on the study population and associated

treatment. With differing patterns of diagnosis by oncologists and other gaps in the literature, there is limited literature on impacted individuals.[12,13] While hair loss associated with cancer treatment is considered transitory, permanent alopecia can occur and is more common with combination therapies.[12,13] The increased use of combination therapies may explain the rise in permanent alopecia in individuals undergoing cancer treatment. Some data indicate that 14% of childhood cancer survivors and 30% of breast cancer survivors develop long-term alopecia.[12]

Treatment for alopecia resulting from cancer treatment is limited.[12,14] Certain treatments available for alopecia areata may be inappropriate for individuals with cancer, as many patients have hormone-sensitive tumors. For such patients, certain hair loss medications are contraindicated.[12] Similarly, there are limited preventive options for cancer-related alopecia, and such preventive options may not be covered by insurance.[12,14,15] The use of scalp cooling, a mechanism to reduce the impact of chemotherapy on hair follicles and decrease the incidence of cancer-related hair loss, is gaining popularity.[15] It has been shown to reduce alopecia related to cancer treatment and the need for a wig by up to 50%.[a] The degree to which scalp cooling will alter the incidence of needed scalp prostheses may depend on existing coverage of scalp cooling, which varies broadly on a national scale.

Quality of Life and Psychosocial Impacts of Alopecia. Whether permanent or temporary, the effects of alopecia may significantly impact quality of life. The available literature consistently shows the negative impact of alopecia on patients' reported quality of life.[12,13] The psychosocial impacts of hair loss resulting from cancer treatment range from degradation of self-esteem to burden of time spent on concealment, social anxiety, reported challenges attending work, and depression.[12,14,16] One study found that 30% of patients with gynecological cancer found alopecia to be severely limiting in their cancer treatment, and 14% of those surveyed would reject curative treatment if it was associated with alopecia.[12] The negative impact on quality of life for individuals experiencing hair loss secondary to cancer treatment may be greater than for individuals with non-cancer-related hair loss given the psychosocial challenges of dealing with a life-threatening disease.[14]

Economic Impact

Literature Review

Costs and Coverage for Scalp Prostheses. The cost of scalp hair prostheses varies by manufacturer, quality, and duration of use. Both coverage and annual limits may be equally important to consider as financial barriers for patients. Research for this topic includes studies on CIA, RIA, and alopecia areata due to the limited cost literature for these conditions. One study on scalp hair prostheses for alopecia areata found the average cost to be $1,543 for those experiencing the condition.[1] The average cost may be less for products sought by individuals suffering from CIA, which is typically less permanent. Further, not all individuals with CIA seek insurance coverage even if available. In one study assessing the insurance behavior of those with alopecia areata, only 38.2% sought insurance coverage.[1,17] The same study found broad limitations in awareness of insurance coverage on the part of individuals with alopecia areata.[1] There is no available literature that indicates (a) the rate for individuals seeking scalp hair protheses for alopecia related to cancer treatment, (b) current coverage, or (c) the duration of need or use.

Coverage and maximum annual benefit amounts for alopecia (both areata and related to cancer treatment) vary considerably.[1,17] While focused on alopecia areata, one study found that policies with $350 annual restrictions

[a] This finding may be specific to treatment type and existing susceptibility to alopecia.

did not meet the needs of those with hair loss.[1] The cost of a scalp hair prostheses can vary depending on the quality and manufacturer, and the cost may affect whether individuals are satisfied with and use their scalp hair prosthesis.[1,16,17]

Rising rates of preventive treatments (e.g., scalp cooling) may reduce the incidence of alopecia resulting from cancer treatment, although the cost-effectiveness of these therapies is unknown.[14] The clinical effectiveness of prevention strategies may depend on the chemotherapy regimen, the pre-existing susceptibility of the patient, and whether the cancer treatment–associated alopecia is acute or chronic.[12]

Limitations

There is limited domestic literature from the last 10 years to address the proposed health benefit mandate. Without reliable data on the prevalence of alopecia related to cancer treatment, utilization of scalp hair prostheses, and the percentage of individuals who would seek coverage for these products, it is challenging to assess the potential impact of this mandate. Due to gaps in the literature for alopecia resulting from targeted therapies and radiation, this analysis cannot address the population needs for all forms of alopecia resulting from cancer treatment. Furthermore, most of the literature is focused on alopecia areata, and therefore findings may not be directly applicable to alopecia related to cancer treatment.

Actuarial Analysis[b]

Objective

This actuarial analysis includes analysis of current prevalence of the diagnosis, current levels of coverage and utilization, and potential effects of increased utilization with expanded coverage on cost-sharing, expenditures, and overall premiums.

Assumptions and Approach

The Minnesota Department of Health provided Actuarial Research Corporation with tabulations of the Minnesota All Payer Claims Database (MN APCD) for all enrollees receiving treatment for cancer-related or other hair loss and their claims for wigs from 2019 to 2022 as a snapshot of current prevalence, utilization, expenditures, and enrollee cost-sharing for hair and scalp prostheses for Minnesota commercial health plan enrollees.[18]

The following criteria were used by MDH to identify enrollees who were receiving a cancer treatment or were diagnosed with other hair loss and identify claims for hair and scalp prostheses:

- Enrollees were identified as having received cancer treatment based on Version 13.0 of the Johns Hopkins ACG system. For alopecia areata and other hair loss, the diagnosis codes listed in Appendix C were used to identify enrollees.
- The National Drug Code (NDC) codes listed in Appendix C were used to identify scalp prosthesis claims related to cancer treatment.
- Commerce provided MDH with three Healthcare Common Procedure Coding System (HCPCS) codes: (a) A9282 – wigs, any type; (b) D5924 – cranial prosthesis; and (c) S8095 – wig for medically induced or

[b] Michael Sandler and Anthony Simms are actuaries for Actuarial Research Corporation (ARC). They are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

congenital hair loss. MDH did not find any codes related to D5924 and only a single occurrence of S8095. Therefore, this analysis only includes one HCPCS code: A9282.

For the 2019–2022 period, data for enrollees who had received cancer treatment based on the Johns Hopkins ACG System (Version 13) for categorizing EDC codes, along with data for enrollees who had one of the other identified hair loss diagnosis codes, were tabulated by MDH. Total utilization, expenditures, and enrollee cost-sharing for wigs were calculated for these enrollees. For this period, the proportion of enrollees who had received cancer treatment remained relatively level, with prevalence rates in a narrow range between 0.39% and 0.43% among the full commercial population in the MN APCD (which, per MDH, includes approximately 40% of the total commercial market in Minnesota).[19] The proportion of enrollees diagnosed with other hair loss increased from 0.62% in 2019 to 0.84% in 2022. The observed utilization rates for wigs among enrollees identified as having received cancer treatment or diagnosed with other hair loss ranged from 0.31% to 0.44% and did not show a directional trend.

While there are no data available to identify and track existing coverage levels for hair and scalp prostheses, all insurance companies in the state of Minnesota are currently required to provide coverage for one prosthesis per benefit year for hair loss specifically due to alopecia areata.

For the purposes of this analysis, enrollees utilizing wig coverage as a result of hair loss due to cancer treatment, as well as total plan expenditures and enrollee cost-sharing, were projected under the proposed mandated expansion of coverage. The prevalence rate of enrollees receiving cancer treatment was projected to remain steady at 0.40%, and the prevalence rate of hair loss among enrollees receiving cancer treatment was assumed to be 70% based on a synthesis of studies found in the literature review.[1,20–22] For enrollees suffering from hair loss as a result of cancer treatment, the projection under the proposed mandated expansion of coverage assumes an initial utilization rate of 67% in Year 1 of the projection period, increasing by 2 percentage points annually and ultimately reaching 85% utilization in the 10th and final year of the projection period. The proposed mandate calls for a $1,000 annual benefit maximum without any indexing provision or required level of enrollee cost-sharing. The projection under the proposed mandated expansion of coverage assumes that this $1,000 annual benefit maximum remains fixed throughout the projection period and includes 15% enrollee cost-sharing based on the historical experience.

The overall Minnesota population projections for base year 2025 through 2034 are based on the figures published by the Minnesota State Demographic Center and on the historic non-public health insurance coverage levels from Minnesota Public Health Data Access (65% of the total state population was assumed to be included in the non-public insured population).

Results

This analysis projects cancer treatment and resulting hair loss prevalence in Minnesota for the total non-public insured population and potential utilization and total expenditures under the mandate's expanded coverage.

Table 2 shows (a) the total projected cancer treatment and resulting hair loss prevalence, utilization, and expenditures and (b) the net projected effect on the total non-public insured population PMPM under the proposed mandate's expanded coverage.

Table 2. Total Projected Hair Loss Prevalence, Expenditures, and Total Non-Public Insured PMPM[c]

	Population		Cancer treatment and hair loss prevalence		Projected with mandated coverage			
	Total Minnesota population	Non-public insured population	Enrollees receiving cancer treatment	Enrollees with hair loss due to cancer treatment	Enrollees utilizing coverage	Plan paid	Cost-sharing	Total non-public insured population PMPM change
2025	5,833,655	3,101,454	12,406	8,684	5,818	$4,945,578	$872,749	$0.13
2026	5,863,731	3,107,430	12,430	8,701	6,004	$5,103,022	$900,533	$0.14
2027	5,893,080	3,112,920	12,452	8,716	6,188	$5,260,212	$928,273	$0.14
2028	5,921,625	3,117,886	12,472	8,730	6,373	$5,417,016	$955,944	$0.14
2029	5,949,303	3,122,300	12,489	8,742	6,557	$5,573,306	$983,525	$0.15
2030	5,976,058	3,126,137	12,505	8,753	6,740	$5,728,958	$1,010,993	$0.15
2031	6,001,850	3,139,298	12,557	8,790	6,944	$5,902,507	$1,041,619	$0.16
2032	6,026,651	3,151,878	12,608	8,825	7,148	$6,076,191	$1,072,269	$0.16
2033	6,050,458	3,163,936	12,656	8,859	7,353	$6,250,039	$1,102,948	$0.16
2034	6,073,273	3,175,472	12,702	8,891	7,558	$6,423,979	$1,133,643	$0.17

[c] The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

The total statewide non-public insured population expenditures for wigs for enrollees suffering hair loss as a result of cancer treatment are projected to be $5.8 million in Year 1, of which $4.9 million will be paid by the plans, and to increase to $7.6 million in the 10th and final year of the projection period, of which $6.4 million will be paid by the plans. These expenditures are projected to result in a net increase of $0.13 PMPM for the total non-public insured population in the first year and a net increase of $0.17 PMPM in the 10th year.

This mandated expansion of coverage of hair and scalp prostheses for enrollees suffering hair loss as a result of cancer treatment does not have any potential for downstream effects on medical costs, either in the form of short-term ancillary expenditures or longer-term potential savings.

Data Sources

- Minnesota state population projections are from the *Long-Term Population Projections for Minnesota* published by the Minnesota State Demographic Center.[23]
- Minnesota non-public health insurance coverage levels are from Minnesota Public Health Data Access.[24]
- Trends and projection factors are derived from the National Health Expenditure data compiled by CMS as well as the 2023 Medicare Trustees Report.[25,26]
- MDH tabulations of MN APCD data from 2019–2022 were used for the estimation of cancer and alopecia areata treatment prevalence and historic utilization, expenditures, and enrollee cost-sharing for hair and scalp prostheses.[18]

State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the estimated cost to state public programs.

- MMB estimates the cost of this legislation for the state plan to be $77,400 for partial Fiscal Year 2025 (FY 2025) and $162,540 for FY 2026.
- The defrayal cost assessed by Commerce under the ACA is estimated to be up to $185,000 in the first year.
- There is no estimated cost to state public programs.

Fiscal Impact Estimate for SEGIP

MMB provided SEGIP's fiscal impact analysis, which is based on the prevalence of applicable conditions in the membership of SEGIP health plans, potential changes in utilization, and the potential for future high-cost cases. The partial fiscal year impact of the proposed legislation on SEGIP is estimated to equal $77,400 for FY 2025 ($0.10 PMPM medical cost × 129,000 members × 6 months). By FY 2026, the impact is estimated to equal $162,540, and the amount is estimated to increase 5% each of the following years due to anticipated medical price inflation.

Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 essential health benefits (EHBs) defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b)

of the ACA.[27,28] For further defrayal requirements and methodology, please visit https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

If enacted, this proposed mandate would likely constitute an additional benefit mandate requiring defrayal, as it relates to new coverage requirements that are is not already covered by Minnesota's benchmark plan. The state's benchmark plan includes coverage for "scalp-hair prostheses for alopecia areata,"[29] which is clinically distinct from CIA. The coverage required by the proposed mandate is for hair loss due to cancer treatment, which is considered to be coverage for a new condition not previously covered in the state's EHBs.

The cost of defrayal associated with this proposed mandate is estimated to be between $155,000 and $185,000 in the first year. Commerce based this estimate on data, methods, and assumptions that are consistent with those used by the Actuarial Research Corporation in their actuarial analysis, with adjustments to reflect enrollment and enrollee cost-sharing specific to the individual QHP market.

Costs associated with defrayal are estimated to increase in future years due to expected medical cost trends as well as utilization increases resulting from the coverage requirement.

Fiscal Impact on State Public Programs

There is no estimated cost to Minnesota public health coverage programs, as the proposed health benefit mandate does not apply to these programs.

Appendix A. Bill Text

A bill for an act relating to insurance; requiring health plans to cover scalp hair prostheses for hair loss caused by cancer treatment; amending Minnesota Statutes 2022, section 62A.28, subdivision 2.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2022, section 62A.28, subdivision 2, is amended to read:

Subd. 2.**Required coverage**.(a) Every policy, plan, certificate, or contract referred to in subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair prostheses, including all equipment and accessories necessary for regular use of scalp hair prostheses, worn for hair loss suffered as a result of alopecia areata or treatment for cancer.

(b) The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

(c) The coverage required by this section for scalp hair prostheses, including all equipment and accessories necessary for regular use of scalp hair prostheses, worn for hair loss suffered as a result of treatment for cancer is limited to $1,000 per benefit year.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to all policies, plans, certificates, and contracts offered, issued, or renewed on or after that date.

Appendix B. Key Search Terms for Literature Scan

Alopecia medicamentosa

Biotherapy

Cancer

Cancer treatment

Cancer treatment hair loss

Chemotherapy

Chemotherapy-induced alopecia

Cranial hair prosthesis insurance coverage requirements

Cranial prosthesis

Durable medical equipment

Hair loss

Hair prosthesis

Handtied wig

Medically necessary prosthetics

Monofilament wig

Radiation therapy

Scalp hair prosthesis

Synthetic wig

Wig liner

Wig prosthesis

Wig supplies

Appendix C. Associated Codes

International Classification of Diseases (ICD-10) Code(s):

Name	Code
Alopecia areata	L63
Drug-induced androgenic alopecia	L64
Other nonscarring hair loss	L65
Cicatricial alopecia (scarring hair loss)	L66

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