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A BGB Group Company

Q1 2026

2026 Access Pulse Check: Evolving Controls in Oncology

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Part 1: The Tug-of-War

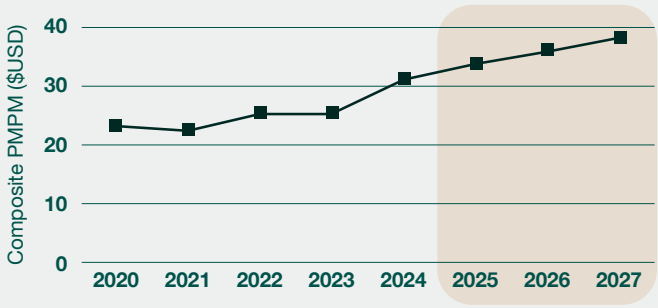
Introduction

The first half of the 2020s has seen remarkable advancements in cancer research and treatment. The development and adoption of novel mechanisms of action and targeted therapies mark a significant leap forward, fueled by 40 years of work in recombinant technology and understanding of the human genome. When we at Hayden speak with physicians, we encounter resounding scientific optimism; the tools in our struggle against cancer are more efficacious and tolerable than ever before, and they are only getting better.

These benefits are spread across a wide variety of therapeutic areas, and patients with multiple myeloma, lung cancer, prostate cancer, and many others, are living longer and enjoying a higher quality of life.[1,2,3] While significant unmet need remains, we encounter a pervasive sense of clinical optimism that continued innovation is on the horizon.

These advances have not come cheap, however. While the oncology field has been scientifically exhilarating, progress has introduced new economic realities and challenges. Beginning at research and development, anticancer research represents nearly one quarter of global pharmaceutical R&D spend.[4] On the treatment side, spending has surged as these therapies have reached clinical adoption, with global spending on oncology therapeutics growing by approximately 75% between 2020 and 2024, and expected expenditures of $441B by 2029.[5] As of 2023, oncology medications accounted for more than 40% of total per-member per-year medical benefit spending, with increases largely driven by infused or injected therapies.[6]

Rising Oncology Costs



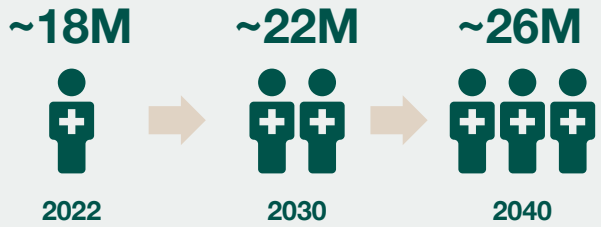
Oncology represents ~41% of Commercial, 56% of Medicare, and 39% of Medicaid total PMPM (2024)

Weighted composite PMPM across Commercial, Medicare, & Medicaid
Source: Prime Therapeutics Medical Pharmacy Trend Report, 2025.

Growing U.S. Oncology Population

2M+ **New cancer cases in 2025**

Total Annual Cancer Survivors



The average list price of a novel oncology agent has nearly doubled since 2020,[7] and cost of therapeutics is paired with ballooning spend on the administration, monitoring, and AE management associated with their use. Not only are the treatments and their associated costs becoming more expensive, but cancer rates are also increasing, raising overall oncology spend even further. The ubiquitous optimism around clinical progress is matched by an equally ubiquitous concern over oncology costs, and mounting pressure to manage these costs in ways that will reshape access, economics, and control.

Hayden's Vantage Point

The Intersection of Oncology's Past & Future

The road was open - access was clear and consistent

Access is becoming more complex, controlled, and congested

Hayden works at the intersection of market access and commercial strategy, which gives us a unique window into the evolving dynamics between payers, provider institutions, patients, and manufacturers.

Our work spans a wide range of therapeutic areas, but oncology represents a uniquely important and rapidly evolving subset of that broader experience. Our client engagements within oncology bring us into regular dialogue with the full spectrum of access stakeholders. We speak with national and regional payers, pharmacy benefit managers, and other decision makers shaping coverage and utilization policy. We also engage with providers across settings from large academic centers and integrated delivery networks to scaled community practices, as well as the nurses, pharmacists, and practice administrators managing the day-to-day realities of delivering care.

Taken together, these perspectives provide a grounded view into how clinical innovation is reshaping the economic landscape, and how mechanisms of control across oncology are evolving in response. It is from this vantage point that we sought to examine the changing access dynamics of the late 2020s, and the challenges that may define the 2030s.

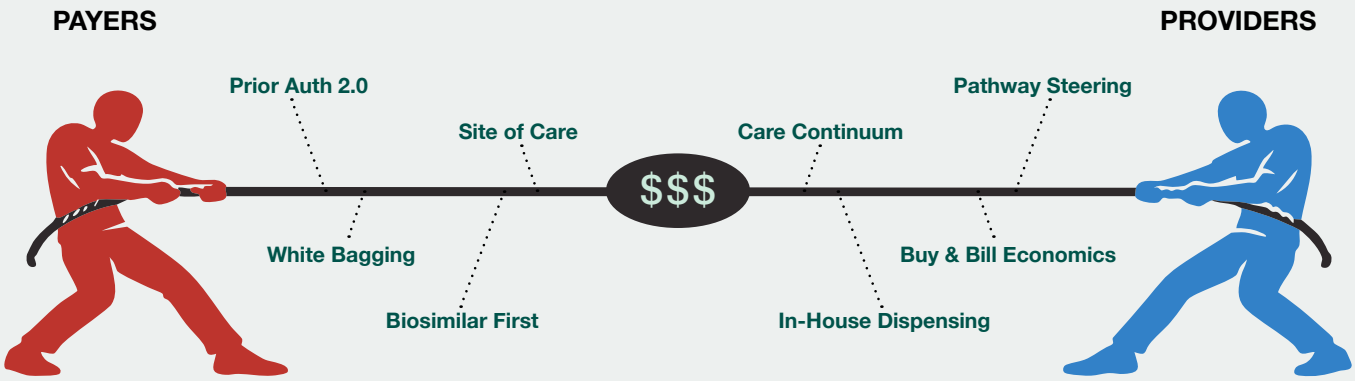
In addition to our existing body of primary and secondary research, we conducted a series of targeted stakeholder interviews towards the end of 2025. Our respondents represent a diverse range of oncology decision makers, including payers, physicians, nurses, and several types of practice administrators. Across these conversations, a dynamic that has been brewing for years, but perhaps not yet fully confronted, crystallized: as payers and providers become more economically driven and more willing to exert control, oncology is rapidly emerging as one of the most consequential access tug-of-wars of the decade ahead.

Primary Market Research Sample

Access Stakeholder		Sample (*N=10*)
Payer	National MCO	2
Clinical	Oncologist	2
	Nurse	1
PHDM	Pharmacy Manager	2
	Practice Manager	1
Other	Self-Funded Employer	1
	Care Coordinator	1

The Oncology Tug-of-War

Oncology's Constant Economic Tug of War



The forces reshaping oncology access are not entirely new. Cost pressure, reimbursement complexity, and stakeholder efforts to manage exposure have been present for decades. What is new is the intensity and scale of the moment. As innovation accelerates and oncology becomes an ever-larger share of total healthcare spend, the mechanisms of control that once operated at the margins are moving closer to the center of the system.

At the heart of this intensification are two focal points of oncology control: payers that make coverage decisions and establish plan-level utilization controls, and sites of care that shape practice-level controls in response to economic pressures. These two gatekeepers are increasingly defining how therapies are accessed, where care is delivered, and how oncology economics are distributed across the system.

Payers are being pushed to balance broad access to lifesaving therapies against mounting affordability concerns and are beginning to deploy more sophisticated tools to manage utilization, steer treatment, and constrain total cost of care.

At the same time, provider institutions and oncology practices are facing their own economic realities. Sites of care are adapting to shifting reimbursement structures, growing administrative burden, and the need to sustain practice economics in an environment of expanding therapeutic choice. These pressures are driving greater influence over prescribing behavior through pathways, operational policies, and practice-level steering.

The resulting dynamic is not a simple story of one stakeholder exerting control over another, but a push and pull between two powerful gatekeepers, each responding to the same underlying clinical-economic tension. Few episodes illustrate this better than the emergence of white bagging.

White bagging is a drug acquisition model under which payers require that specific therapies be dispensed through payer- or PBM-controlled specialty pharmacies rather than being acquired directly by the site of care. In effect, this shifts both operational control and the ability to capture dispensing economics away from provider organizations.

The payer push to implement white bagging mandates is a useful historical example of the broader access contest unfolding across oncology. Payers sought to keep script dispensing revenue within their owned or affiliated pharmacy channels, and providers, in turn, raised concerns around care disruption, logistical complexity, and risks to timely treatment initiation. Ultimately, practices have largely been successful pushing back via open letters, administrative action, and policy initiatives, and we see fewer mandates than we might have expected 3-4 years ago.

Future actions will likely take the same shape – action, reaction, and reaction to the reaction – as payers and providers continue to contest where oncology dollars flow and who ultimately controls the delivery of care.

> One of the biggest challenges we've seen from payers is the push to white bag. For our staff, it's been one of the most frustrating things to deal with: identifying which patients and plans are white-bagged, managing the logistics, dealing with delays. Fortunately, in our region, the state has banned mandatory white bagging, and I wish more states would follow.
>
> – Pharmacy Manager, Traditional Community Organization

Navigating the Zero-Sum Landscape

For manufacturers, this evolving landscape will bring greater nuance and complexity. Shaping access strategies will require a detailed understanding of clinical and economic priorities of customer segments, and a thoughtful plan for engagement across both payer and provider stakeholders. The historical assumption that oncology is "different," and therefore less subject to management, is becoming increasingly antiquated.

Manufacturers will need to anticipate not only traditional coverage and reimbursement questions, but also the evolving mechanisms of control emerging across the ecosystem. These dynamics will vary meaningfully by tumor type, line of therapy, competitive intensity, and setting of care, requiring strategies that are locally informed rather than broadly generalized.

Continuing the Oncology Access Tug-of-War Series

In the sections that follow, we will dive deeper into the two focal points of power shaping the oncology access landscape – payers and providers – examining their evolving mechanisms of control and what they mean for manufacturers navigating this changing environment.

In the first deep dive, we will examine how payers are responding to mounting cost pressures through a set of proliferating control mechanisms, including more intensive prior authorizations ("PA 2.0"), branded step requirements, and emerging site-of-care restrictions.

In the second deep dive, we will turn to providers and sites of care, detailing how pathway development, practice-level steering, and the expansion of operational capabilities are enabling institutions to protect their sustainability.

Finally, we will close by stepping back once more to examine the major developments on the horizon – the future developments that could intensify the tug-of-war over oncology access.

Part 2: The Payer Push

Payers, the entities that design health plans and foot most of the bill for care, face significant oncology-related cost pressures. Some payers report oncology accounting for as much as 60% of annual plan spend despite representing less than 10% of utilization. In response, their customers have asserted significant pressure to curb rising drug and administration costs, with some even threatening to switch plans if expenses were not reduced. The recent PBM changes by Eli Lilly, Tyson Foods, and Genentech illustrate the willingness of large employer groups to responsively adjust their healthcare benefit apparatus when improved cost structures become available.[8] Payers are acutely aware of these dynamics, especially against the backdrop of mounting pressure to deliver returns after a decade of consolidation.

> [On Areas of Biggest Concern] Well, significantly more expensive agents, agents where we're not sure of the clinical value, one and done treatments where you can't recoup any of the costs if it doesn't work, combo therapies as well.
>
> – Medical Director, National MCO

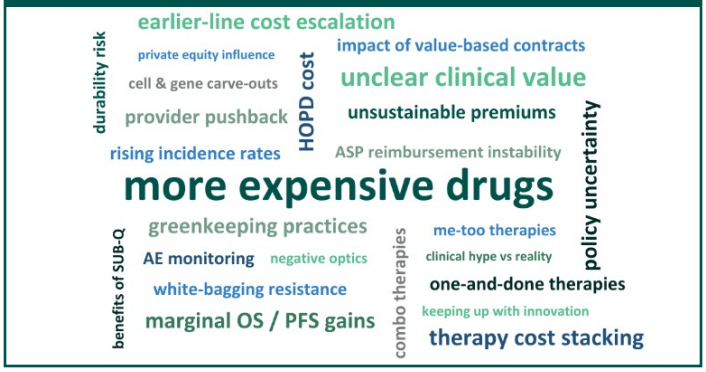
> To put it into context, specialty drugs are probably 1.4% of our overall utilization… but you know what our spend is? It's like 57%, and lot of that's oncology.
>
> – Medical Director, National MCO

In light of these pressures, several cost relief measures have emerged. United's "National Gold Card" program promised simpler prior authorizations in exchange for willing adherence to recommended guidelines. At the federal level, CMS launched the Enhanced Oncology Model, a voluntary Medicare payment model designed to test whether episodic-based reimbursement tied to care quality and total cost of care could improve outcomes while curbing spend. A handful of notable losses of exclusivity, including Avastin, Rituxan, and Herceptin have allowed for a biosimilar-first approach in some therapeutic areas. Overall, these measures have delivered only modest impact on reducing costs, with spend continuing to rise.

Payers have a long list of anxieties: movement of high-priced treatments into earlier lines of therapy; the potential for increased use of cell and gene therapies; subcutaneous formulations of blockbuster therapeutics that could lessen cost relief offered by LOEs, and others. Payers, frustrated by the increasing costs, facing pressure from their customers, are searching for ways to meaningfully reduce cost exposure.

Drivers of Payer Anxiety in Oncology Today

Themes sized by how frequently and intensely payers described their concerns



In parallel with the increasing cost pressures, we see two important developments within payer organizations:

1. Increasing intra-organizational integration
2. Changing interpretation of clinical value

Intra-Organizational Integration

Payers have been acquiring and integrating parts of the healthcare system for decades and promises of true integration across pharmacy and medical benefit are not new. Historically, however, these efforts have fallen short in practice, with fragmented data, misaligned incentives, and limited ability to meaningfully manage medical benefit drugs.

What's changing now is not the ambition, but rather the pressure to execute on this integration. Insights from our panel and prior experience suggest that national payers are operationalizing this integration with increased investment in medical claims fidelity, and more deliberate efforts to link utilization management, contracting, and analytics across benefits.

> They [the medical and pharmacy benefits] are much more integrated. We have the medical technology assessment committee team reporting to P&T now. So, they're no longer in a silo.
>
> – Medical Director, National MCO

While there may be no smoking gun that signals this shift, there have been a series of incremental steps that collectively expand payer control. Medical benefit drugs are increasingly being evaluated using pharmacy-style frameworks, including deeper claims scrutiny, retrospective utilization analysis, and alignment with contracting strategies. These changes give payers more confidence that they can manage high-cost, provider-administered drugs with more rigor than in the past, and they are beginning to act on that confidence.

Changing Interpretation of Clinical Value

Payers have historically offered coverage for oncolytics that demonstrate meaningful clinical value, usually defined as NCCN determination of category 2A or above. Favorable placement has been a surefire path to coverage and reimbursement, even if prior authorization or other low-impact administrative steps are required.

This dynamic has been driven by policy protections like protected class status in Medicare and state protections, patient/doctor/advocacy efforts, and the understandable desire not to prevent cancer patients from receiving lifesaving treatments. Payers are also aware of the optics of restricting or delaying access to cancer therapies and seek to avoid being perceived as creating barriers that could delay treatment for these patients, particularly given that short delays can have meaningful clinical consequences.

> If your baseline is 2 months progression free survival, well it gets marketed as *'oh my god, we've doubled the rate!'* Everybody gets excited, but the cost is 10x. I'm not trying to be insensitive, but you do have to look at the spend and what you're getting for it.
>
> – Medical Director, National MCO

However, increasingly safe and efficacious treatments have raised the bar for what payers consider "meaningful" clinical improvements over time. Patient-reported outcomes, quality of life measures, and manufacturer-sponsored economic analyses have never been particularly impactful in payer decisions. More traditionally impactful evidence, such as primary efficacy endpoints, are now garnering greater scrutiny, especially in therapeutic areas with multiple effective treatment options.

Importantly, when payers refer to a therapy as "differentiated," they are not invoking a formal or standard-

ized definition, but rather a practical assessment of whether a therapy delivers sufficient incremental benefit to justify its price tag. Even improvements in overall survival, long considered the gold standard in proving clinical differentiation, are coming under increased scrutiny. Payers report seeking 10%, 15%, or even 20% increases in absolute gains to earn a "differentiated" evaluation.

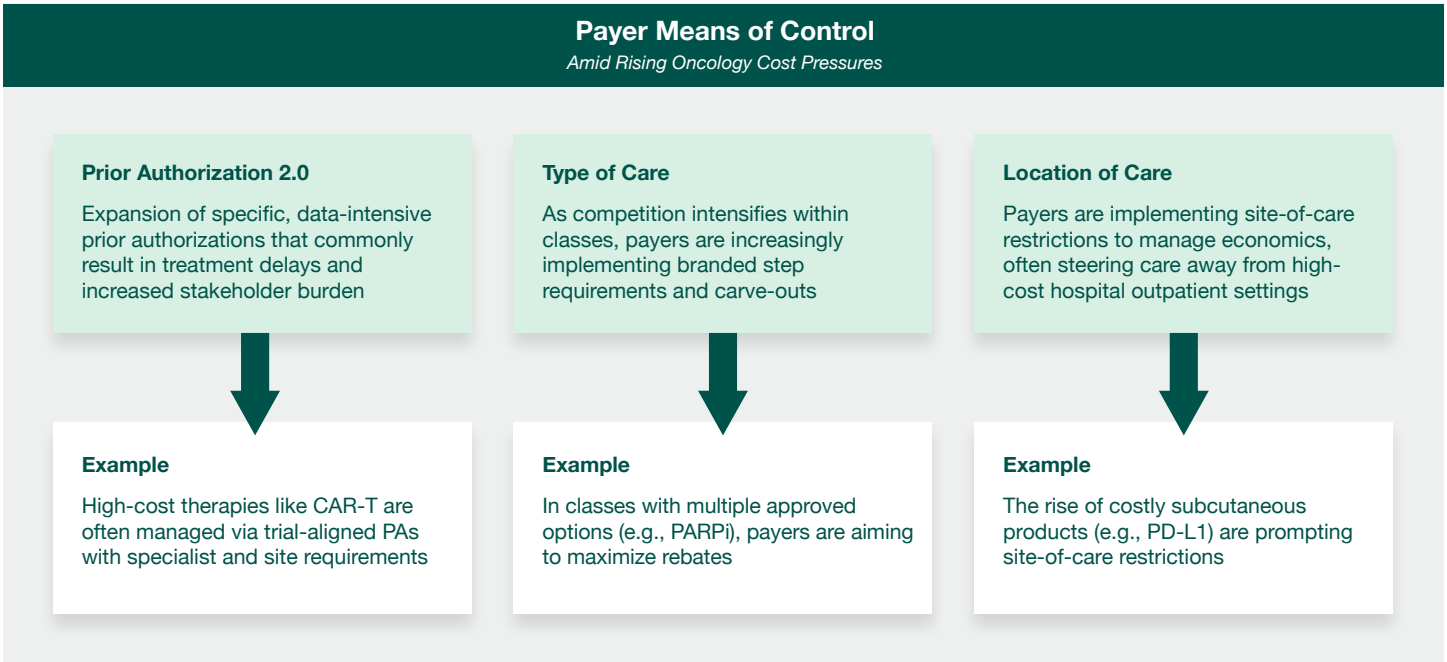
To address internal limitations, particularly the lack of deep oncology expertise, payer organizations are starting to rely on oncology benefit managers (OBMs) like eviCore and Carelon to supplement oncology management. OBMs are positioned as having specialized disease-level focus, harnessing robust KOL input and data analysis to support evaluation of oncology treatments. Payers can pick and choose a variety of OBM-run services, from pathway and policy development to PA review to appeals management to peer-to-peer reviews.

As competitive landscapes continue to crowd, this increasing scrutiny on what defines differentiation is likely to have meaningful effects on payer willingness to manage. It is much easier to control therapeutics seen as "undifferentiated," even if payers are the only ones who define them as such.

That said, at present, therapies that are well-supported by NCCN guidelines generally continue to secure baseline access – typically coverage consistent with the FDA-approved label, often accompanied by prior authorization or other administrative requirements. While exceptions can occur (e.g., off-label use, sequencing, or narrower interpretations of guideline language), this higher bar for clinical value has yet to translate into widespread preferencing or step therapy in oncology. When it does, we believe this dynamic will first take shape in competitively dense therapeutic areas, such as prostate and lung, where clinically comparable options give payers greater confidence to manage based on their definition of perceived differentiation.

Means of Control

If payers have the motive (increasing customer pressure, ballooning oncology costs, need to demonstrate the value of acquisitions) and the means (increased pharmacy/medical integration, coordinated decision making across benefits, ability to interpret "clinical differentiation"), then signs point to likely increased control across oncology in the late 2020s. We are already seeing new and subtle forms of control that we believe will proliferate and should be considered by manufacturers launching or expanding therapeutics.



Control 1: Prior Authorization 2.0

While payers have largely avoided some forms of utilization management across oncology TAs to date, others have proliferated. The use of detailed, data-heavy prior authorizations has grown and has contributed to delays in care for patients.[9] The days of physician attestations "that only require pushing a button" are passing and have been increasingly replaced with specialty physician writing requirements, detailed trial inclusion/exclusion criteria, and a patchwork of diagnostic and report requirements. Practices report invasive mechanisms, like claims-derived contraindications and flagging comorbidities or inconsistencies in care for concomitant, but non-oncologic conditions (e.g., denying platinum/taxane-based care for a historical obesity diagnosis despite HCP preference).

> We are realizing that we're going to go into a world where just going and clicking some buttons on a United, Cigna, Humana, or Blues portal is going to fade away. They're going to want more data around what we're trying to do and why we're trying to do it.
>
> – Practice Manager, Academic Organization

These extensive PAs place increased strain on HCP practices, and present barriers to patient care that can be especially exaggerated in community or rural settings. While payers have pledged to dial back administrative requirements, practice administrators and HCPs remain skeptical, and we expect these requirements to remain a potent tool in the payer toolbox.[10]

Control 2: Type of Care

Step therapies, another reliable payer tool historically used outside oncology TAs, are increasing as well. While many payers have historically deployed "biosimilar first" approaches, even in oncology, the increasing number of brand competitors with limited perceived differentiation has allowed the use of claims-verified steps in several TAs.[11,12] The use of brand step requirements, even when multiple options are NCCN-concordant, has increased markedly across classes and TAs, including NSCLC, breast, prostate, melanoma, and others.[13]

> We are seeing payers choose specific drugs, like Ibrance first versus Verzenio in the CDK4/6s. It's been out the longest, its net price has come down, and payers are saying, 'use this first line it should have the same efficacy.'
>
> – Practice Manager, Academic Organization

It's important to note that oncology TAs are unlikely to be managed with the same level of control seen in indications like diabetes, MS, or anti-inflammatory conditions by 2030. However, we are seeing steps in places that would have been unlikely just 5 years ago. For example, in breast cancer, CDK4/6 inhibitors were historically treated as clinically appropriate physician-choice options, with payer management limited largely to prior authorization. Today, payers are increasingly implementing step edits embedded within prior authorization, and in some cases, brand-level sequencing within this class, despite the absence of head-to-head data.[14]

While payers have historically required direct head-to-head evidence to implement a step in other indications, KOL consensus and payer-determined differentials in efficacy can be sufficient today in an oncology atmosphere where clinical differentiation is up for interpretation. As payers continue to face cost pressures, it is very likely

that branded steps, and other more restrictive forms of control like formulary exclusions or carve outs, will be cemented as management tools for high-cost therapies.

Control 3: Location of Care

Unlike PAs, steps, or exclusions, which seek to control **type** of care, site of care restrictions are more direct efforts to reduce the economics associated with oncology care by controlling the **location** of care. The cost of delivering care in hospital outpatient departments far exceeds the cost of delivering care in other settings like ambulatory centers or physicians' offices – a phenomenon documented well before the 2020s.[15] As hospitals and sites of care have increasingly pushed treatment to outpatient locations to maximize revenue generation and reduce capacity strain, payers have sought to force care to less expensive sites.

> It's actually the hospital outpatient department that we want to steer away from. That's the expensive site of care: that's the culprit.
>
> – Medical Director, National MCO

There have been limits to this practice to date. Monitoring requirements, risks of adverse events, and the need for high-cost rescue medications often limit the ability of payers to restrict care to non-hospital settings. That said, the payers, providers, and practice managers of our panel have a rare common consensus that outpatient economics are approaching a "breaking point." Payers have been implementing soft steering measures, where they work to notify members of lower cost settings, but still largely allow physician discretion for now.

One of the only examples of a true restriction on site of care to date is Center-of-Excellence mandates for CAR-T. However, the impact has been limited as these requirements have been largely symbolic, reflecting the reality that only highly resourced sites could administer these highly sophisticated therapies. As community sites develop the capabilities to do so, these requirements may begin to function as more meaningful levers of control.

> When infusion happens on site at a hospital, there's no transparency, there are no rebates, and the markups are extreme… there's no ceiling and no protection.
>
> – Self-Funded Employer

We expect these measures to slowly harden into formal mandates over time. Improving tolerability of therapies, increasing practice familiarity with adverse event management, expansion to community sites, and growing comfort with outpatient administration at sophisticated sites are all expanding the range of feasible sites of care. This increased optionality will give payers increased latitude to force care to more economically advantageous sites without overtly risking patient safety. Our payer panel expects 2026 and 2027 to include increasing numbers of these mandates, though they acknowledge that it may be 2028+ when full site of care restrictions become operational.

Taken together, these evolving controls reflect a payer community that is willing, and increasingly able, to exert pressure across the oncology access landscape. While the pace and intensity of their controls is still taking shape, the direction of travel is clear: payers are pulling the strings available to them harder as cost exposure grows and clinical opportunity expands. In the next section of this tug-of-war publication, we turn to the other side of the rope to examine how practices and sites of care are responding to the payer push.

Part 3: The Provider Pull

Payers are not the only focal point of control in oncology. Oncology practices, a catchall term we will use to represent academic institutions, integrated delivery networks, scaled community settings, and traditional community settings, have also evolved in the face of increasingly efficacious, complex, and expensive therapies. We will focus specifically on evolutions and expected future behavior associated with economic capture and mechanisms of control exerted on choice of therapeutics to narrow our scope.

While the practice types can vary in their size, patient mix, and capabilities, one important throughline emerged in our panel interviews: a focus on capturing and protecting practice economics. The reason for the focus is different across practices – a rural community may need to capture economics for survival, an academic may need to capture economics to support less lucrative non-oncology care, an IDN or scaled community practice may need to capture economics to satisfy growth requirements of their owner or integrating entities.

Increasing Economic Focus at Oncology Practices

PROVIDER TYPE	PERSPECTIVE
Academic Organization	"The 340B program was originally designed for hospitals that had no resources. My facility, an academic medical center should have never had access to this program, but we do. And we've expanded it to the point where it's embedded as part of our budget and without it our outpatient pharmacy would run at a loss. If that program goes away, we will not run an outpatient pharmacy, infusion center, or specialty pharmacy. We are keeping that money hand over fist because we're losing money everywhere else."
Scaled Community Organization	"Our revenue is generated by buy-and-bill. Changing the structure of how we get paid — ASP +6%, reimbursement changes, authorization — creates a lot of uncertainty. That's why we've had to move to a business strategy with multiple streams of revenue."
Traditional Community Organization	"Our mindset used to be to find the most efficient value-based models and try to also pursue a win-win with lower priced drugs with better margin. But now our focus is needing to drive towards financial margin whenever possible."

This increasing need for economics has naturally created an incentive for practices to use the drugs that offer a greater financial opportunity. Therapeutics can generate wildly different net cost recoveries depending on list price, means of acquisition, patient coverage, and other factors. The graphic below illustrates possible financial outcomes for a practice that administers an oral therapy for EGFR-mutated lung cancer dispensed by in-office pharmacy vs. an infused therapy acquired via buy-and-bill.

Net Cost Recovery Potential by Acquisition Channel

Illustrative HCP-Administered Therapeutic

IV acquired via buy and bill	
Monthly WAC[1]	**$30,000**
Medicare reimbursement[2]	$30,846
Medicare NCR per month[3]	**$846**

Commercial reimbursement[4]	$32,010
Commercial NCR per month[3]	**$2,010**

Illustrative Oral Therapeutic

Oral dispensed via in-office pharmacy	
Monthly WAC[1]	**$16,000**
DIR fees	$19,200
PBM reimbursement[5]	$14,784
DIR fees	$1,182
Medicare NCR per month[3]	**$(2,398)**

AWP	$19,200
PBM reimbursement[5]	$14,784
Commercial NCR per month	**$(1,216)**

Assumptions: 1 Assumes ASP is 97% of WAC; 2 Medicare reimbursement is 106% of ASP; 3 No purchasing discounts; 4 Commercial reimbursement is 110% of ASP; 5 PBM reimbursement 77% of AWP ($19,200); 6 Medicare DIR fees 8% of PBM reimbursement

It is important to approach this discussion with appropriate nuance – provider practices, by and large, are committed to delivering the appropriate care to patients. We are not suggesting otherwise. What we are suggesting is that the economic criteria are becoming even more important to the survival and viability of many of these practices, so that they can continue to see patients at all.

There are largely two opportunities for practices to influence the therapies used by their physicians: pathway development (practice recommendations for what drugs should be used, when), and pathway steering (how practices enforce adherence to those pathways).

Pathway Development

Pathways help inform prescribing and sequencing of therapies and are often tied to treatment recommendations within an organization's electronic health record (EHR) and order set system. Most are based on evidence-based guidelines like NCCN, therapeutic toxicity, and increasingly, economics associated with therapeutic use. P&T decision-making is influenced by both clinical stakeholders (e.g., physicians) and operational administrators (e.g., pharmacy administrators, practice administrators, financial roles). Pathway adoption has been accelerated in part by the continued acquisition or aggregation activity of practice networks like US Oncology; as these entities assimilate formerly independent practices, they often implement their internal pathway solutions.

Growth is not exclusively driven by these acquisitions, however; independent organizations facing the need to streamline treatment decisions and support burdened practice administrators who are responsible for operational updates have led to the growth and adoption of other third-party services like ClinicalPath or Flatiron Assist. They have proven to be an invaluable tool as providers and administrative teams navigate sustained high levels of FDA approvals and a rapidly expanding clinical universe.

There is a universal sense among our panel that pathway utilization will increase, and that pathways will prioritize economics and net cost recovery. As with payers, increasing clinical options with comparable efficacy and tolerability gives leeway to prioritize other factors. Some EHRs already include indicators of economic favorability visible to physicians (stoplights with green/yellow/red, a scale of 1-5-dollar signs are notable examples) that can help guide decisions. Outside of economic weighting, we may begin to see payer coverage as a pathway factor – practices may discourage the use of agents that face burdensome requirements or site-of-care redirects as payers become more controlling.

> [On Pathways] When we first started off, we did maybe our top 5 diagnoses. Now those have become even more robust… it's gone from like 5 indications to maybe 25 indications in our health system.
>
> – Practice Manager, Academic Organization

The increasing use of pathways has important implications for manufacturers. More favorable placement means higher visibility, easier selection, and potentially streamlined ordering and administration processes for patients. A cottage industry of consulting services (including us at Hayden) has emerged to develop pathway placement, practice engagement, and contracting strategies. The importance of favorable pathway placement is doubly important as we expect pathway steering, the second lever of control, to become more prevalent and more severe.

Pathway Steering

Pathway development establishes recommendations for treatment choices across practices. Pathway steering is the behavior by which practices ensure adherence to those recommendations. Steering exists along a continuum, ranging from soft EMR-embedded suggestions to more directive approaches such as automatic population of preferred agents or restricted order sets. In some cases, HCPs may face financial penalties (i.e., reduced bonuses) for diverging from pathway recommendations. Although these penalties remain relatively uncommon today, growing financial pressures are likely to drive more institutions to manage in this manner.

> We decided to add on a 10% bonus being tied to 85% compliance with our internal pathway.
>
> – Practice Manager, Academic Organization

> They've [our doctors] always been in this private practice model and sometimes we need to make decisions based on the financial aspects of the medications. And for the most part, our employee physicians are on board with it. They understand that we've got to remain as viable as possible.
>
> – Pharmacy Manager, Traditional Community Organization

The use of steering does not fall cleanly along practice type lines – we have encountered independent community practices (often perceived to be less economically focused) with rigid steering behaviors and private-equity owned scaled clinics (often perceived to be highly economically focused) that defer almost entirely to physician preference. This introduces significant complexity for manufacturers – it is hard to develop a high-level and generalized practice engagement strategy. Strategies must evaluate and mitigate risks at the local level to ensure appropriate access,

> [On Steering] Not so much. I mean because we're a physician owned practice, we control how we practice... we never restrict a physician's ability to prescribe a particular drug. That's one of the great things about being in a community practice which is we maintain autonomy over the clinical decisions.
>
> – Oncologist, Scaled Community Organization

and unfortunately there are no publicly available data sets that detail practice-level steering like MMIT or Fingertip Formulary for payer controls.

As with pathway adoption, our panel universally expects steering to become more common and more severe given the economic need and increasing clinical optionality as new brands and biosimilars launch. This will likely include lower triggers for corrective practice action (e.g., applying physician consequences at 75% adherence vs. 85% adherence) and more restrictive corrective actions (e.g., 20% of an HCP's EOY bonus is subject to pathway penalties vs. 10%). In some cases, we may begin to see payer-style choice of therapy controls. We have encountered anecdotal situations where practice pharmacies are prevented from dispensing scripts for certain CDK4/6 and BTKi therapies given comparable clinical profiles and economic dynamics.

There may be natural limits to the amount of control practices can wield. Already we have encountered anecdotal reports of primary care physicians, often the first line of triage, hesitating to refer patients to specific oncology sites of care because of their steering practices. Enhanced practice steering, or even outright control, may look like payer white bagging mandates: something that looks good on paper, but does not translate well to reality.

Additional Provider Evolutions

We see practices developing new mechanisms to capture economics beyond just increased control as well. Economic need is a powerful evolutionary stimulant – combine it with a sense that the go-go days of buy-and-bill NCR and outpatient reimbursement could be coming to an end as payers search for ways to cut costs, and you have a recipe for change. We have highlighted several evolutions we believe could necessitate a change in strategic approach for manufacturers through the end of the 2020s.

Increasing Self-Dispense Behavior

Self-dispensing, when in-house practice pharmacies purchase drugs from specialty distributors and seek payer reimbursement, is not a new practice. What is new is urgency and increasing prevalence. Smaller practices are increasingly willing to self-dispense, even if that introduces administrative burden and therapy initiation risks. Self-dispensing revenues account for an increasing proportion of revenues at large practices.

Beyond just economics, this allows for greater dosing flexibility and rapid dose adjustments. Cancer care is

> The molecular targeted drugs in the oral setting, especially our specialty pharmacy, has just continued to balloon and expand. I don't think that bubble's going to pop.
>
> – Pharmacy Manager, Traditional Community Organization

already multidisciplinary and logistically complex, requiring close coordination between multiple clinical, logistical, and administrative roles. Adding external dispensing or additional administrative handoffs introduces further friction and risk into an already strained dynamic; this is something practices are possibly unwilling to take on given the severity of disease and the consequences of delays in care. Keeping dispensing in-house offers greater control, predictability, and continuity across the care continuum.

For manufacturers, this has implications for pharmacy network, distribution, and practice/GPO contracting decisions. Making sure practices can acquire and dispense therapies seamlessly and without losing money on each script is likely to become even more important.

High-Science Care at Community Practices

Historically, oncology group segmentation has been characterized by a relatively simple distinction between academic centers as "high-science" settings and community practices as "low-science." That line is becoming blurred, as many community sites invest in infrastructure, staffing, and clinical sophistication that allow them to manage more complex therapies in-house.

Community practices are adjusting to the safety and monitoring requirements of oncology therapeutics like bispecific antibodies, ADCs, and even CAR-T in some cases. While some expect to continue referring out these patients for treatment, others are building protocols for the acquisition, dispensing, and use of these therapies in-house. This is an exciting development; bringing advanced care closer to patients could help reduce barriers to access like travel and hotel stays.

For manufacturers, this could have significant implications for practice engagement and patient support. Rural or geographically isolated community practices often have different administrative abilities and serve a different patient population versus large academic hospitals, IDNs, or large scaled community practices. A one-size-fits-all approach is unlikely to be successful; understanding how to best engage with the practices and their patients can ensure access success.

> **[On Cell & Gene Therapies] Right now you have a technology that gets locked into academic centers and it's a losing financial proposition for the payers. And they are trying to find a way to get it to the community setting and we are motivated to do that too. We just have to do it in a way that fits within our resources and ability to implement it within our structure.**
>
> – Oncologist, Scaled Community Organization

In sum, these developments reflect a provider community that is not a passive recipient of payer policy, but rather an active participant in the oncology tug-of-war. As economic pressure intensifies and clinical optionality expands, practices are increasingly using pathways, steering, and operational investments to protect sustainability and retain influence over therapeutic decision making. In the final section of this paper, we will zoom out and look ahead. We examine the major developments on the horizon that may further shift this balance – and consider how emerging scientific, economic, and policy forces could reshape the tug-of-war itself as oncology moves toward the end of the decade.

Part 4: Forces That May Shift the Balance

While our crystal ball is not perfect, we do believe there are several events on the horizon that could meaningfully impact patient access in oncology. Some will be exciting, some could be concerning, but all will likely force behavioral changes in payers, providers, and manufacturers.

Targeted Therapies

> More biomarker driven targeted therapies, more efficacy, more precision in subgroups with age, comorbidities, less monitoring. More and more precision.
>
> – Medical Director, National MCO

As testing volumes increase, we expect evolution in the testing and diagnostic access landscape. Today there is a patchwork of testing behaviors and controls across payers and practices. Payers appear interested in controlling testing behavior as pricey NGS testing becomes more common. While lab benefit managers such as Avalon and eviCore have been around for some time, they are presently gaining more influence and there are early signs that commercial plans are implementing controls. Provider accounts are bringing testing in-house to maintain control and quality of the patient journey, as well as to generate economics on testing reimbursement.

> I think we're going to see even more refined molecular profiling to be even more targeted and hopefully we get more mutations for different sites and treatments to exploit those things.
>
> – Oncologist, Academic Organization

The evolution toward precision medicine is well underway. As more biomarker-driven therapies enter the market, testing becomes increasingly common to ensure the right product reaches the right patient at the right time. This is the rare landscape evolution that stands to benefit all oncology stakeholders – patients receive better care, payers enjoy bounded patient populations for novel therapies, and providers can deploy cutting-edge therapies with increasing confidence.

> Minimum residual disease or liquid biopsy are things we can hopefully rely on to assess response and recurrence with just a blood draw rather than relying on imaging which is not the most sensitive way of assessing it.
>
> – Oncologist, Academic Organization

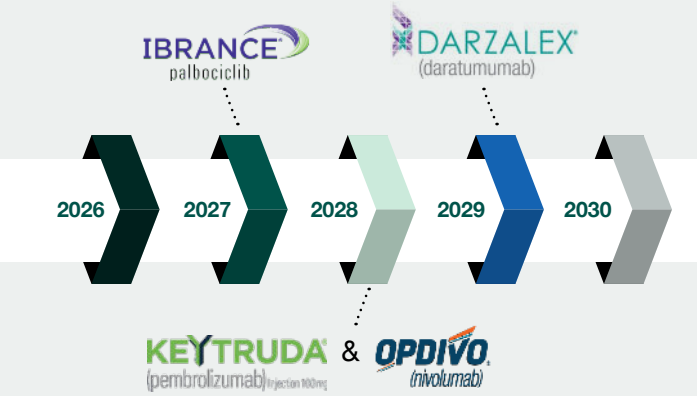
At the same time, expanded testing opens the door to a new wave of data-driven innovation. Companies like Tempus and Caris Life Sciences are seeking to build AI-powered precision medicine platforms with this new ocean of data. There is the real possibility of building out evidence-based pathways, unlocking outcomes-based agreements, and better predicting the probability of trial success. That said, we believe progress will be incremental rather than immediate. Data fragmentation, privacy requirements, various testing standards, and good old inertia will have to be overcome.

Blockbuster Biosimilars

We will likely see the LOE of Ibrance (2027), Keytruda (2028), Opdivo (2028), and Darzalex (2029).[16] The scale of these LOE events will be significant – collectively these therapeutics accounted for more than $25B of US revenue in 2024.[17, 18, 19, 20] Subcutaneous formulations may offset some of the biosimilar impacts, but the scale of these events will affect payer and practice behavior.

Our payer panel expressed universal optimism that these events will offer the opportunity to exert greater controls, increase contracting pressure on manufacturers, and ultimately lower cost. Access risks will certainly emerge for the originator brands, but we expect some more aggressive payer organizations to experiment with controls on competitor brand agents.

Major Oncology LOEs on the Horizon



> With biosimilars or any LoEs that come, we will be benchmarking to those, and this will push towards either a step or level setting on the baseline cost of those cancer drugs.
>
> – Medical Director, National MCO

> We were early adopters in the biosimilar fields and part of that was trying to find any and every opportunity to fill that financial void.
>
> – Pharmacy Manager, Traditional Community Organization

Practices are more skeptical – biosimilar launches can introduce logistic complexities, force adaptation to shifting payer policies, and yield lesser economics than brands. We expect this development to create friction between the two stakeholder groups, and it may be a major catalyst for the control evolutions described above.

However, it is also important to highlight that the practical impact of biosimilars is likely to vary meaningfully by indication rather than uniformly at the brand level, given that many of these agents span numerous tumor types with different competitive dynamics and unmet need.

In indications where biosimilars are payer-defined as clinically comparable, payers will be more inclined to move towards a biosimilar-first approach. Conversely, in indications where branded agents demonstrate clearly differentiated efficacy, payers are likely to be more hesitant to utilize biosimilar steps, especially as oncology continues to move towards targeted precision therapies.

Part B MFP Negotiations

Dr. Adam Fein lists the IRA as one of the five forces exerting downward pressure on the GTN bubble. One element is especially top of mind for our payers, providers, and practice administrators: the effectuation of MFP for Part B drugs in 2028.[21] Today most reimbursement structures for HCP-administered drugs have ASP-based

> The big thing is going to be ASP maybe going away and getting replaced by MFP. The physician reimbursement model for drugs changes completely.
>
> – Medical Director, National MCO

> I can't wait to see those Part B drugs. There's a lot of potential for us there [rebating]. The physicians are the ones that are probably worried. It will be interesting to see what kind of pushback they do.
>
> – Medical Director, National MCO

> We are concerned around the fact that maybe we should get out of this game completely and just renegotiate with our payers. To say, '*hey, we're going to just white bag or brown bag every drug. We don't want to have any specialty distribution anymore... can you give us higher reimbursement that makes up for the loss here and then you guys can control the drugs or can we meet in the middle?'* I think those are things we're considering.
>
> – Medical Director, National MCO

pricing. After Part B negotiation, reimbursement for negotiated drugs in Medicare will be based on MFP. This is impactful on its own, but we expect spillover effects in commercial too. With MFP expected to be significantly lower than current ASP and likely included in ASP calculations, reimbursement risk will pervade both government and commercial channels.

Payers note that decreased ASPs for negotiated drugs could prompt movement away from ASP-based reimbursement in commercial over time. Some have suggested alternatives such as AWP-based reimbursement, driven by the view that ASP erosion will be less of a focus for manufacturers once drugs are negotiated. Given this, some payers theorize that moving away from ASP could provide greater contracting leverage.

Practices are keenly aware of this risk – buy-and-bill net cost recovery has fueled practice economics for years. Even without a change in reimbursement methodology, the expected decrease in ASPs is a significant threat to critical-to-financial-sustainability buy-and-bill economics. This could present a fundamental risk to an important revenue stream and partially explains the urgency to develop additional economic streams described above.

It is important to note that this dynamic remains hugely speculative and should be taken cautiously. The ultimate impact will depend on what negotiated MFPs look like in practice, how MFP is used in ASP calculations, payer and manufacturer willingness to move away from ASP-based reimbursement, and the stability of the policies themselves over the next few years. Most stakeholders raised this as a "watch closely" rather than something to action upon.

In summary, the oncology landscape is facing unusual pressures, changes, and events in the coming years. While no one knows exactly how the chips will fall, it remains critical to monitor the evolving access priorities and control risks to ensure patients continue to benefit from these groundbreaking therapies.

Conclusion: Staying Upright in the Tug-of-War

Across this series, we have traced how accelerating clinical innovation and mounting economic pressure are reshaping oncology access into a sustained tug-of-war between payers and providers and how that tension is increasingly defining the environment manufacturers must navigate. What emerges is not a single inflection point, but a system under strain where control is being tested, adapted, and reasserted across multiple fronts.

For manufacturers, success in this environment will depend on the ability to anticipate where pressure is building, understand how different stakeholders are likely to respond, and engage with access dynamics that are becoming more localized, more conditional, and more economically driven. As the decade progresses, those who recognize the tug-of-war early, and plan accordingly, will be best positioned to ensure continued patient access to the next generation of oncology innovation.

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Further Reading

This paper is part of Hayden's 2026 Oncology Access Pulse Check series.

Explore the full series:

- **The Complete Report: Evolving Controls in Oncology**
- **Part 1: The Oncology Tug-of-War**
- **Part 2: The Payer Push**
- **Part 3: The Provider Pull**
- **Part 4: Forces That May Shift the Balance**

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Hayden Consulting Group, a BGB Group Company, is a strategy and analytics consulting firm that partners with life sciences companies to untangle access complexity, uncover deep insights, and unlock commercial success. Our team of leaders is connected by a common thread – to redefine how the life sciences industry thinks about access. Placing access at the forefront of decision-making is critical to ease the process for patients and their providers to obtain clinically necessary therapies. We're excited to lead the way, driving Access Forward.

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