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2026 Access Pulse Check: Evolving Controls in Oncology

Part 2: The Payer Push

This paper is Part 2 of Hayden's 2026 Oncology Access Pulse Check series and focuses on the evolving mechanisms of payer control in oncology.

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In Part 1 of Hayden's 2026 Oncology Access Pulse Check, we outlined the forces reshaping oncology access. In this installment, we focus on the payer response to those pressures.

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

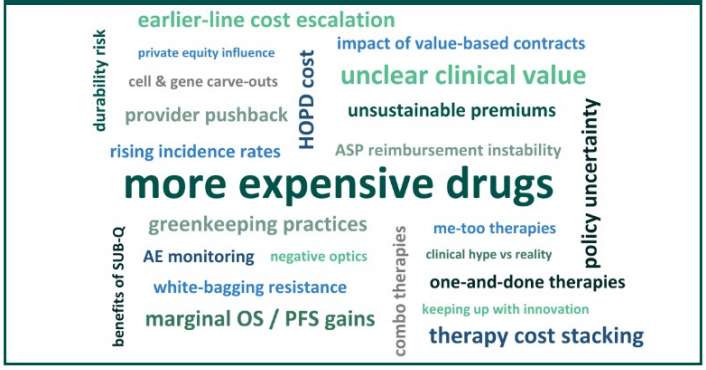
> To put it into context, specialty drugs are probably 1.4% of our overall utilization… but you know what our spend is? It's like 57%, and lot of that's oncology.
>
> – Medical Director, National MCO

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.

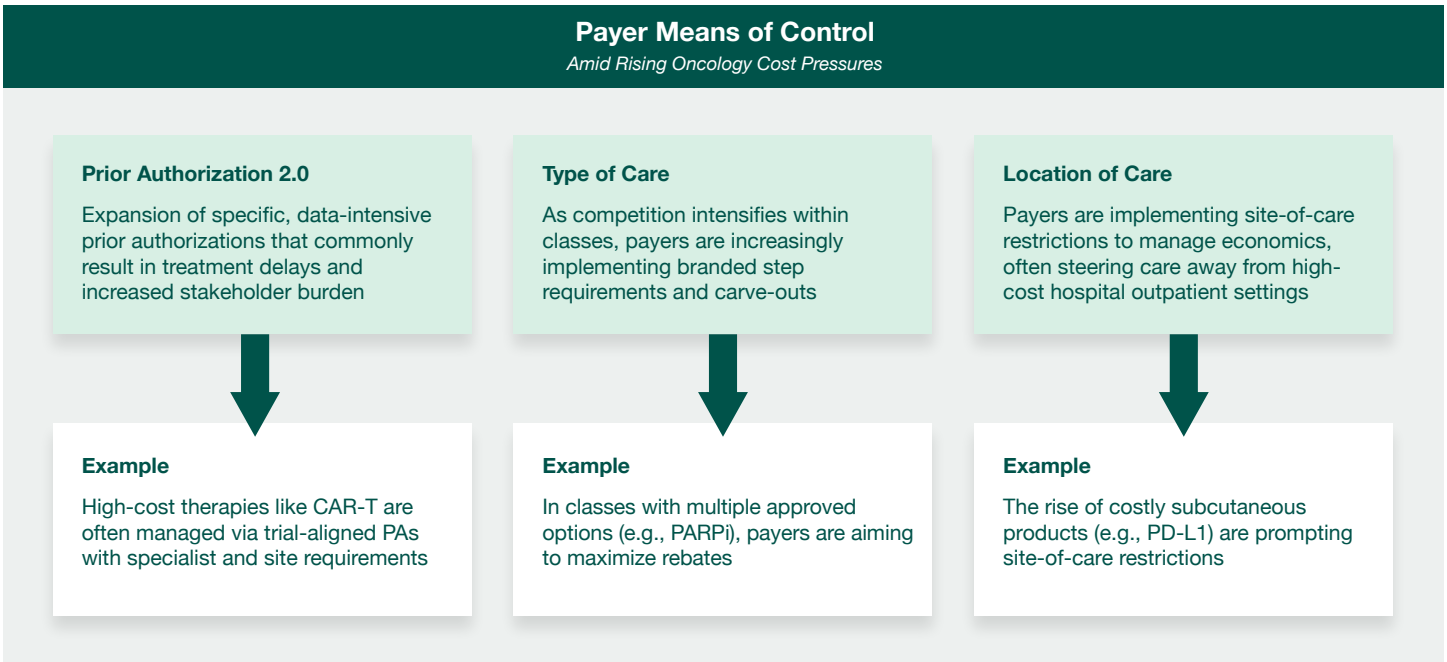
To address internal limitations, particularly the lack of deep oncology expertise, payer organizations are starting to rely on oncology benefit managers (OBMs) like eviCore and Carelon to supplement oncology management. OBMs are positioned as having specialized disease-level focus, harnessing robust 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.

8. https://www.healthcare-brew.com/stories/2025/11/25/eli-lilly-switches-big-3-pbm-alternative-transparent-rival
9. Prior Authorization Often Places Burden on Patients With Cancer, Delays Care - ASCO, https://www.astro.org/news-and-publications/news-and-media-center/news-releases/2024/new-astro-survey-finds-that-prior-authorization-delays-lead-to-serious-harm-for-people-with-cancer
10. https://www.reuters.com/business/healthcare-pharmaceuticals/health-insurers-work-easing-prior-authorization-requirements-ahip-says-2025-06-23/
11. https://www.aetna.com/cpb/medical/data/300_399/0314.html, https://www.aetna.com/cpb/medical/data/300_399/0313.html,
12. https://pmc.ncbi.nlm.nih.gov/articles/PMC8847267/
13. https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-3/us-commercial-health-plan-coverage-of-oncology-therapies-2017--2024
14. https://www.fightcancer.org/sites/default/files/acs_can_part_d_formulary_analysis_final.pdf
15. https://www.nihcr.org/analysis/improving-care-delivery/prevention-improving-health/hospital-outpatient-prices/

About the Author

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Sam is a principal at Hayden Consulting Group and leads the Hayden Oncology practice group. He has a decade of consulting experience and helps clients navigate access and commercial challenges. For questions or to talk oncology access, please email Sam at smcmeley@haydencg.com

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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