Oncology's New Cost Curve: What ASH & SABCS 2025 Mean for Health Plans

By: M. Fisch, 12/15/25

The 2025 American Society of Hematology (ASH/hematology) and San Antonio Breast Cancer Symposium (SABCS/breast cancer) meetings held in December delivered a clear message for payers: oncology is shifting toward highly targeted, often time-limited treatments that reduce reliance on traditional chemotherapy but drive higher up-front spending on drugs and diagnostics. For health plans of all types, the business question is how to prepare benefit design, utilization management, and network strategy for 2026.

In breast cancer, powerful antibody-drug conjugates (ADCs) and new oral targeted agents are moving earlier in the care pathway. Therapies once reserved for metastatic "salvage" use are now being used in curative settings and in the first or second line for advanced disease. Early-stage hormone receptor–positive disease is migrating from inexpensive generic endocrine therapy toward branded oral endocrine agents and CDK4/6 inhibitor combinations used for years. HER2-positive patients are more likely to receive ADCs in place of, or in addition to, conventional chemotherapy. For plans, that means larger patient cohorts exposed to high-cost agents and more complex monitoring for toxicities, even as hospitalization for traditional chemo complications may gradually decline.

In hematologic malignancies, bispecific antibodies and next-generation targeted drugs are reshaping treatment algorithms. In multiple myeloma and follicular lymphoma, bispecifics are shifting from late salvage to earlier relapse, often in fixed-duration regimens. These drugs require specialized centers and close early monitoring but can produce deep remissions and defer later intensive therapies such as transplant or CAR-T. In chronic lymphocytic leukemia (CLL) and chronic myeloid leukemia (CML), new evidence supports finite-course targeted combinations and structured treatment discontinuation strategies, replacing the historic "pay forever" model of continuous oral therapy. This front-loads cost but offers the prospect of lower lifetime drug spend if patients can safely stop treatment.

A cross-cutting theme is the rising role of advanced diagnostics. Blood-based circulating tumor DNA and minimal residual disease tests are increasingly used to decide when to start, switch, or stop therapy. These assays are not incidental—they represent a recurring cost that must be tied to clear, evidence-based management decisions.

For health plans, 2026 will bring sustained upward pressure on pharmacy and lab budgets. The strategic response is not simply restriction, but precision: disease- and line-specific prior authorization; preference for time-limited regimens when outcomes are comparable; concentration of high-acuity therapies in capable centers; and robust outcomes analytics to determine whether higher up-front spend is being offset by fewer hospitalizations, less salvage therapy, and better long-term control of disease.