
THE CANCER ATTENTION GAP

What Employers Know, What They've Built, and
What the Gap Costs

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IN PARTNERSHIP WITH LANTERN



The Gap Between What Employers Believe and the Infrastructure They've Built



Cancer is now the top health cost driver for more than half of large employers. Cancer care among privately insured adults under 65 exceeds \$156 billion annually, and costs are projected to reach \$246 billion by 2030. Half of all cancer diagnoses occur in adults ages 20 to 64, the core of the U.S. workforce. More than one in five employees is a cancer caregiver.

Two independent employer research studies converge on the same structural finding. The Cancer Cost Survey examined how large, self-funded employers govern cancer Rx decisions. The Benefits Design Survey surveyed HR and benefits leaders on cancer benefits strategy. Both found that employers are paying enormous sums on cancer with high confidence in their oversight, while operating without the clinical infrastructure that would make that confidence warranted.

This is not primarily a drug-spend story. Costs are not high because drugs are expensive in isolation. They are high because treatment decisions are frequently made without the subspecialty clinical precision that oncology requires, and because the downstream cost of a wrong initial treatment compounds across every subsequent line of therapy, hospitalization, and complication.

THE SCALE OF THE PROBLEM

\$156 billion ⁹ Annual cost of cancer care among privately insured adults under 65	\$246 billion ¹ Projected cost by 2030	1 in 5 More than one in five employees is a cancer caregiver	Half ¹² Of all cancer diagnoses occur in adults ages 20 to 64
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The research documents three compounding gaps:

01

Attention Gap

Cancer is the #1 unmanaged cost risk, but loses the daily executive attention battle to GLP-1s and mental health.

02

Education Gap

94% of employers believe early expert intervention improves outcomes. Only 6% use external oncology experts to review high-cost decisions.

03

Outcomes Gap

77% have full visibility into cancer spend. Only 31% have reduced catastrophic claim volatility.

A FOURTH PATTERN

The Enterprise Paradox

A fourth pattern, the enterprise paradox, surfaces distinctly in the Benefits Design Survey: the largest employers hold the strongest convictions about expert cancer care and have the widest gap between that conviction and what their plans actually deliver, largely because scale produces program fragmentation rather than integration.

**A COMBINED
ANALYSIS OF TWO
INDEPENDENT
EMPLOYER RESEARCH
STUDIES**

The Cancer Cost Survey · The Cancer
Attention Crisis · Rx Decision Survey · 110 self-
funded employers · March 2026

The Benefits Design Survey · The
2026 Cancer Benefits Report · Benefits
Strategy Survey · 130 HR & benefits leaders ·
May–June 2026

Three Compounding Challenges Benefits Strategies Weren't Built For

Before examining what employers are doing, it is worth establishing why cancer resists the management models that work for other high-cost conditions. Three challenges have converged simultaneously, and most benefits strategies were designed before any of them existed at this scale.

01 A Treatment Knowledge Gap

Cancer science is advancing faster than any other area of medicine. Lung cancer alone has evolved from a single disease into dozens of molecularly distinct subtypes, each with different biology, different treatment protocols, and different evidence bases. There were more than 50 new FDA oncology indications in a single recent year¹¹, while oncologists continue learning to use drugs approved years earlier as newer, more complex agents arrive. The volume of medical knowledge now doubles in a fraction of the time it once did, from roughly every 7 years in 1980 to a matter of months today, forcing clinicians to synthesize an ever-larger evidence base for each treatment decision¹³. No individual physician, however skilled, can hold all of it. 60% of oncologists report burnout, with many reducing hours or leaving the field, eroding the community oncology workforce on which most patients depend.

2×

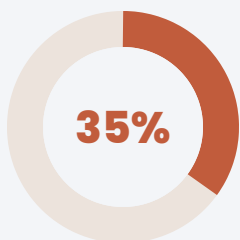
Medical knowledge now doubles in months, not years¹³

60%

Of oncologists report burnout⁴

02 A Diagnostic Knowledge Gap

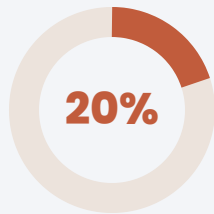
Most new cancer drugs are approved alongside companion diagnostic tests, because precision medicine depends on first identifying the molecular marker the drug is designed to target. Yet genomic testing remains critically underused: only 35% of cancer patients currently receive proper genomic testing. Without the right diagnostic workup, precision medicine is not possible. A targeted therapy cannot work against a mutation that was never identified.



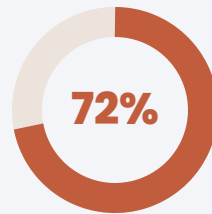
Of cancer patients currently receive proper genomic testing². The rest risk treatment chosen without the molecular picture that precision medicine depends on.

Care Inequities That Compound Both Gaps

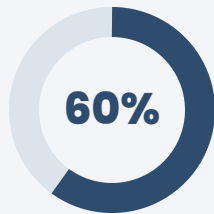
NCI-designated Comprehensive Cancer Centers produce meaningfully better outcomes, yet only 20% of cancer care is delivered there, and 72% of cancer patients travel more than 13 miles for care¹⁴. The result is differential care quality determined by geography rather than clinical need. AccessHope's own research found that the highest odds of a treatment-change recommendation occur in areas of greatest socioeconomic deprivation. Only 60% of cancer treatment in the U.S. is currently guideline-concordant⁸.



Of cancer care delivered at NCI-designated centers³



Of cancer patients travel more than 13 miles for care¹⁴



Of U.S. cancer treatment is guideline-concordant⁸

**86–
393%**

Hospital vs. community-based cost premium⁵

However, the evidence does not support facilitating travel to NCI-designated centers as a universal approach. Travel for cancer care is disruptive, compounding an already overwhelming experience with logistical burden, time away from work and family, and financial stress that research consistently links to worse treatment adherence and outcomes.

Hospital-based cancer care also costs 86–393% more than equivalent community-based care, meaning travel-based benefit designs can increase cost without producing proportionate clinical benefit. The more productive question for benefits leaders is not how to get patients to expert care, but how to get expert care to patients.

WHY THIS MATTERS FOR BENEFITS DESIGN

Standard specialty pharmacy management cannot close these gaps

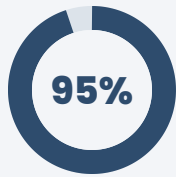
Formulary controls, step therapy, and category-level utilization rules were designed for conditions where treatments behave similarly across a patient population. Oncology operates on different terms entirely.

The right treatment for a given cancer patient is determined by tumor type, stage, molecular markers, and individual biology, factors that do not appear on a formulary or in a step therapy protocol. Managing cancer as a drug class applies the logic of a different kind of problem to a disease where clinical precision at the individual patient level is the determining variable for both outcomes and total cost of care.

Cancer Dominates Cost, But Not Executive Attention

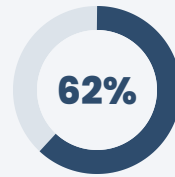


Both studies confirm that cancer sits at or near the top of employer healthcare cost exposure. In the Cancer Cost Survey, 95% of employers report that three or more of their top 10 highest-cost claimants are cancer-driven. In the Benefits Design Survey, 62% of HR and benefits leaders place cancer in their top three cost drivers overall.



Report 3 or more of their top 10 highest-cost claimants are cancer-driven

Source: The Cancer Cost Survey



Place cancer among their top three healthcare cost drivers overall

Source: The Benefits Design Survey

Yet despite that cost dominance, cancer is losing the day-to-day executive attention battle. In the Cancer Cost Survey, 94% of employers report that GLP-1s receive the same or more executive attention than cancer. 62% say GLP-1s receive more; 55% say mental health receives more. When asked directly to name their greatest unmanaged risk over the next three years, 52% identified cancer, more than three times the next-closest concern (AI disruption at 16%; GLP-1 and specialty pharmacy at 15%).

Greatest Unmanaged Risk Over the Next Three Years

More than three times the next-closest concern.

“Which of the following represents your organization’s greatest unmanaged risk over the next three years?”

Cancer drug therapy & oncology claims

52%

AI disruption & workforce transformation

16%

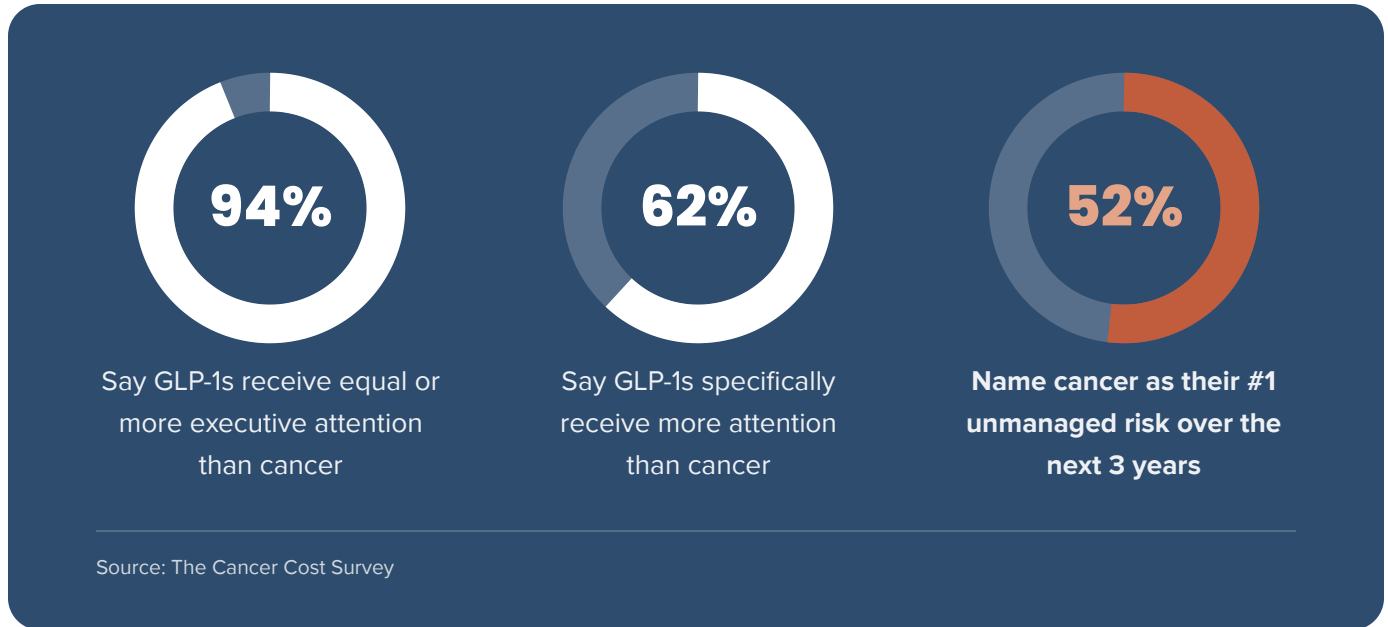
GLP-1 & specialty pharmacy costs

15%

Source: The Cancer Cost Survey

GLP-1s Are Winning the Daily Attention Battle

Despite cancer's cost dominance, employers report that newer, more visible categories command more day-to-day executive attention, while cancer remains the risk they are least confident they have under control.



The Benefits Design Survey adds structural context: among large and enterprise employers (2,500+ employees), 56% have either built an integrated cancer care strategy or are actively working to consolidate point solutions. But the decision to integrate is being driven primarily by employee experience concerns. Leaders who cited improving employee experience as their top priority (36%) outnumbered those focused on cost reduction nearly three to one.

WHAT THIS GAP PRODUCES OVER TIME

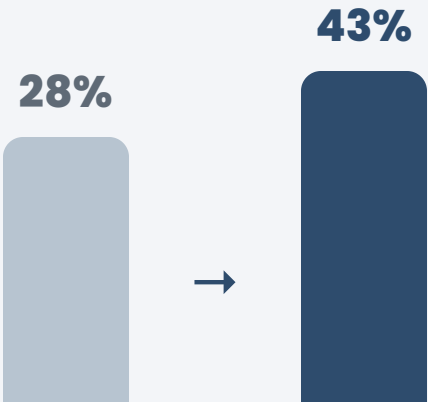
Attention determines infrastructure, and infrastructure determines what is available when an employee is diagnosed

Benefits infrastructure decisions reflect the level of attention paid when tools were selected. Organizations that have not revisited their oncology oversight model in light of how rapidly cancer treatment has evolved toward precision medicine, biomarker-driven therapy, and expanding clinical trial access are likely operating with frameworks built for a different era of cancer care.

The parallel to GLP-1s is instructive

GLP-1 coverage among the largest employers grew from 28% to 43% in a single year¹⁰, only after costs had already surged. The data from both studies suggests employers may be positioned similarly with cancer: aware of the risk, but not yet organized around it in proportion to what that risk demands.

GLP-1 COVERAGE · LARGEST EMPLOYERS



Grew in a single year, only after costs had already surged.



The biggest challenge is balancing access to the most effective treatments with the high and rapidly rising cost of cancer drugs. Many therapies are very expensive and treatment plans can be complex.

— HR Leader, 10,000+ Employees

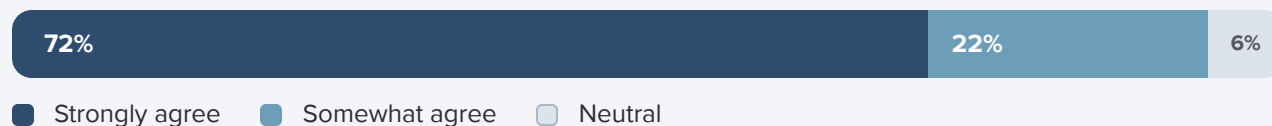
Near-Universal Belief in Expert Care. A Wide Infrastructure Deficit.



The Benefits Design Survey surfaces a pattern that runs through both studies: employers overwhelmingly believe that getting cancer patients to subspecialty expertise faster improves outcomes and reduces costs, and overwhelmingly have not built the infrastructure to make that happen.

Near-Universal Belief in Early Expert Intervention

“To what extent do you agree: ‘Early expert intervention (like access to oncology subspecialists) can meaningfully improve cancer outcomes and reduce downstream costs?’”

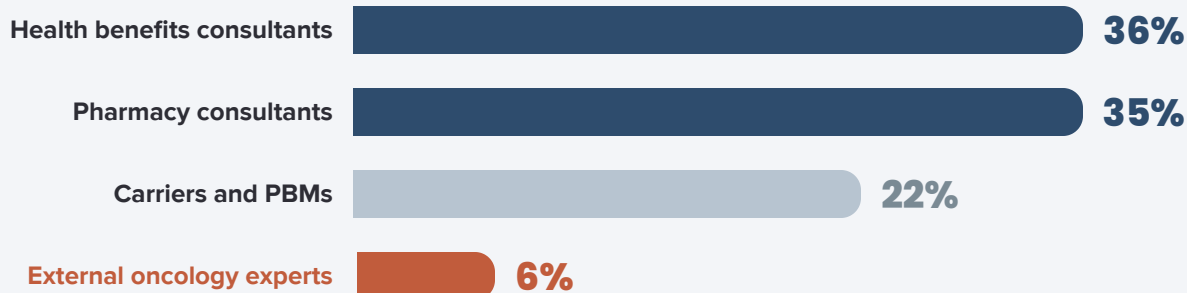


Source: The Benefits Design Survey

Who Is Actually Reviewing High-Cost Cancer Decisions

The Cancer Cost Survey examined who employers rely on to review high-cost cancer drug decisions:

“Who is primarily responsible for reviewing high-cost cancer drug therapy decisions at your organization?”



Source: The Cancer Cost Survey

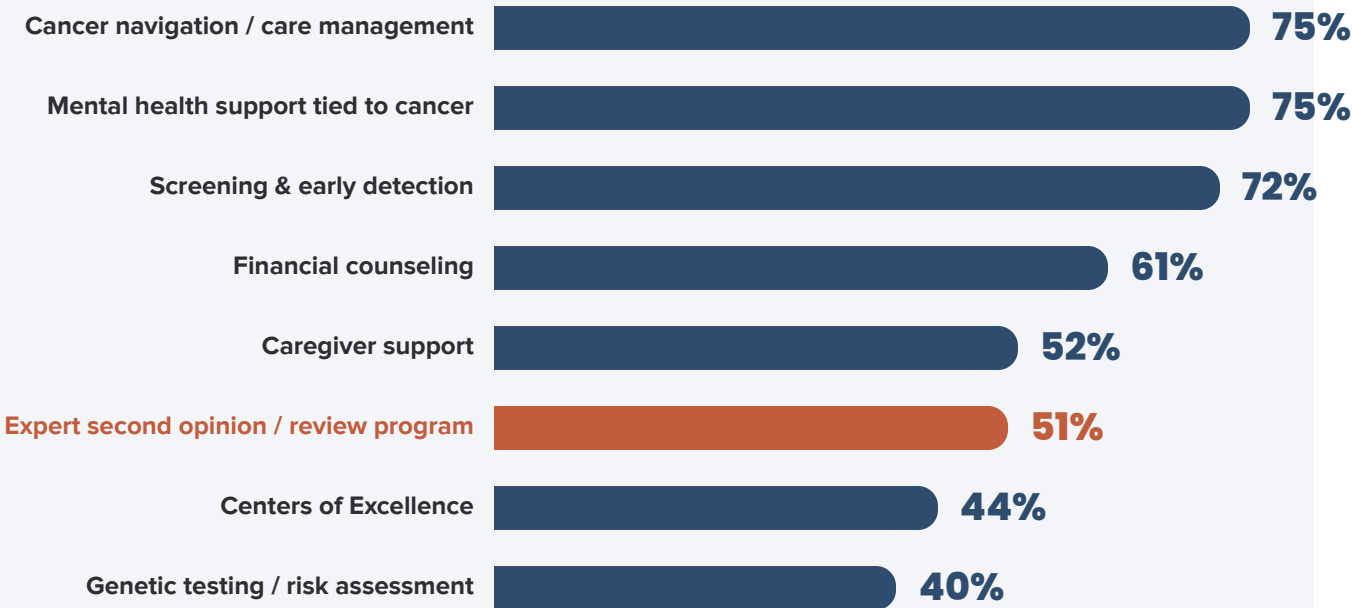
ONLY
6%

Of employers reported using external oncology experts to review high-cost cancer decisions

Health benefits consultants, pharmacy consultants, and PBM partners are capable professionals within their domains. The limitation is not competence; it is the clinical question being asked of them. Whether a patient's oncology treatment plan reflects current subspecialty evidence, whether the right biomarkers were tested, whether a clinical trial is an option, whether treatment sequencing is appropriate: those determinations require subspecialty oncology expertise that sits outside standard specialty pharmacy and consulting frameworks. The Cancer Cost Survey also found that 53% of employers report that half or fewer of their cancer cases go through any structured review process at all.

What Cancer Resources Employers Actually Offer

“Which of the following cancer-specific resources or programs do you currently offer employees?”

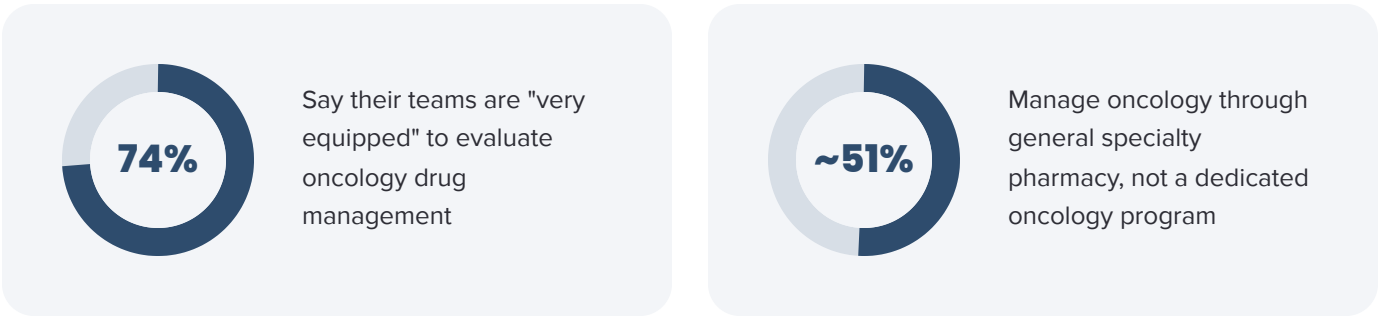


Source: The Benefits Design Survey

Yet only approximately half currently offer an expert second opinion or expert review program. Among leaders who name improving clinical outcomes as their top priority for the next 12 to 18 months, more than half do not yet have an expert review benefit in place.

High Confidence, Misaligned Infrastructure

The Cancer Cost Survey shows that 74% of employers say their teams are very equipped to evaluate oncology drug management decisions. Yet nearly half manage oncology under general specialty pharmacy rather than a dedicated oncology program.



Source: The Cancer Cost Survey

WHY THE 6% NUMBER POINTS TO A CLINICAL ACCURACY PROBLEM, NOT JUST A DRUG-SPEND PROBLEM

The cost lever is clinical precision, not formulary restriction

The 6% finding is often read as a drug-spend observation: Most employers are not applying specialized oversight to high-cost drug decisions. That reading is accurate but incomplete.

Cancer costs escalate not primarily because expensive drugs are selected, but because treatment pathways are misaligned with what the evidence supports. A missed biomarker can mean ineffective first-line therapy. A clinical trial that was never surfaced keeps a patient on a standard protocol that is less effective for their specific disease. Each failure compounds, driving additional lines of therapy, hospitalizations, and toxicity admissions that dwarf the initial drug cost.

When a subspecialist review identifies the right treatment earlier, or corrects a pathway that was misaligned, total cost of care frequently decreases even when the individual drug selected is more expensive. The clinical intervention is the cost lever. The formulary restriction is not.

The more clinically precise treatment was the less expensive one.

This finding is supported by AccessHope program data. A patient with EGFR-mutated lung cancer whose community oncologist missed the critical mutation incurred \$339,000 in total costs over 12 months with a 30% two-year survival probability. The same patient, with subspecialist review before treatment started, received the correct targeted therapy: \$238,000 in total costs, 86% two-year survival probability.

EGFR-mutated lung cancer: total cost of care over 12 months



Source: AccessHope program data. Proprietary and confidential; not derived from either employer survey.



It's mainly shaped by claims experience and real high-cost case reviews. Earlier access to high-quality care often improves outcomes and reduces total long-term costs.

— VP of People, Manufacturing

Visibility Without the Tools to Act on It



The Cancer Cost Survey finds that 77% of employers report strong visibility into cancer spend, with costs fully segmented and reviewed regularly. Yet only 31% have succeeded in reducing catastrophic cancer claim volatility, the outcome that most directly affects plan performance.

High Visibility. Low Control.

“How would you describe your organization’s visibility into cancer-related drug spend? / Have you reduced catastrophic cancer claim volatility?”

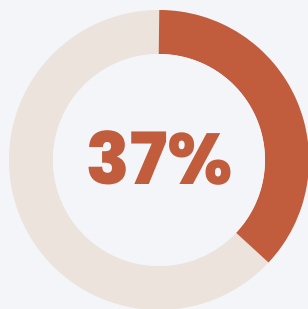
Full visibility into cancer spend



Reduced catastrophic claim volatility



Source: The Cancer Cost Survey



The Benefits Design Survey adds a further dimension: 37% of employers still have meaningful blind spots in their cancer spend data, operating with gaps on a cost category they have already identified as one of their highest-cost areas. This fragmentation typically stems from disconnected carrier data and lagging claims feeds rather than a lack of intent.

Still have data gaps or limited visibility into what their organization spends on cancer, despite naming it a top cost driver.

Source: The Benefits Design Survey

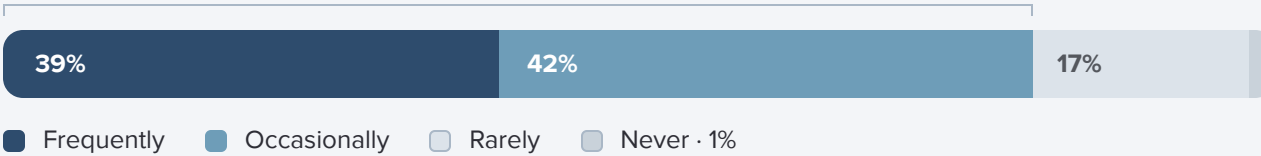
Prior Authorization: Friction at the Wrong Point

Prior authorization is the most commonly deployed cost-control mechanism for cancer drug therapy. The data from the Cancer Cost Survey suggests it is functioning as an access barrier rather than a clinical precision tool.

How Often Prior Authorization Delays Cancer Drug Access

“How often do prior authorization processes delay employee access to cancer drug therapy?”

81% EXPERIENCE DELAYS AT LEAST OCCASIONALLY



Source: The Cancer Cost Survey

In oncology, treatment timing is clinically consequential. Prior authorization creates friction at the drug-access point without resolving the underlying clinical question: whether the treatment being authorized is the most appropriate one for that patient's specific disease at that specific stage.

High PBM Confidence, Limited Ability to Course-Correct

The Cancer Cost Survey found that 63% of employers say they are very confident in their PBM's ability to manage oncology drug decisions, while 42% report they cannot routinely challenge PBM decisions on high-cost oncology drugs.

“How confident are you in your PBM’s ability to manage oncology drug decisions? / Are you able to routinely challenge your PBM’s decisions on high-cost oncology drugs?”

Very confident in PBM's oncology management



Cannot routinely challenge PBM decisions



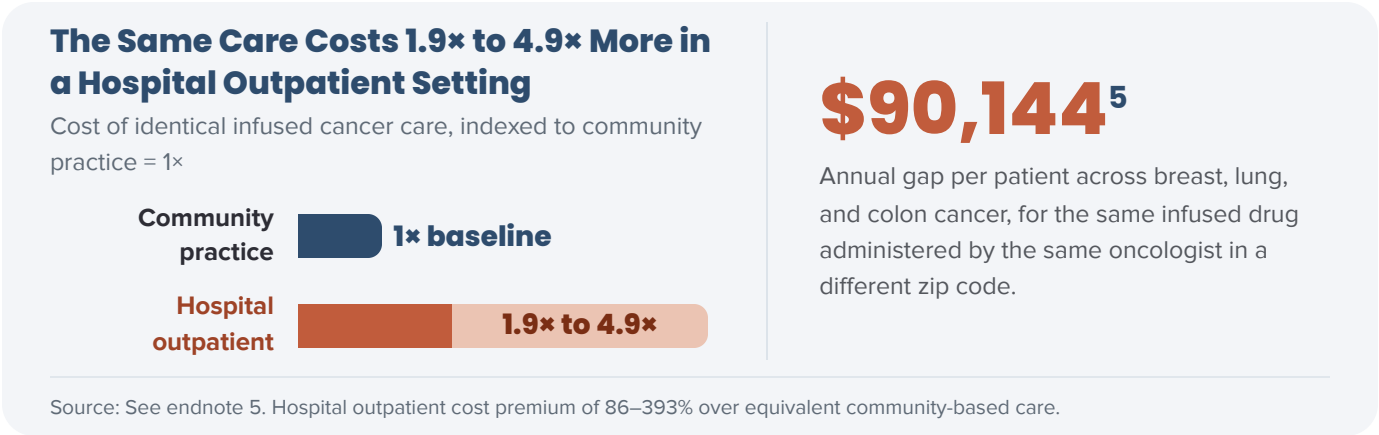
Source: The Cancer Cost Survey

PBMs play an important and legitimate role in specialty drug management. The issue surfaces when confidence in those partners means treatment decisions rarely receive a subspecialty clinical review, eliminating the ability to course correct when care diverges from current evidence-based guidelines.

Site of Care Impact on Cost: A Lever Outside of a PBM's Reach

Infused cancer drugs, among the most expensive therapies in oncology, are typically covered under the medical benefit and billed directly to the health plan, not through the PBM. That means a significant share of cancer drug spend sits entirely outside the cost management framework most employers rely on, with no structured mechanism to influence where those infusions are administered, or what they cost.

The cost differential by site of administration is substantial. Cancer care delivered in a hospital outpatient setting costs 86–393%⁵ more than equivalent care in a community practice, with an annual gap of \$90,144 per patient across breast, lung, and colon cancer for the same infused drug, administered by the same oncologist, in a different zip code.

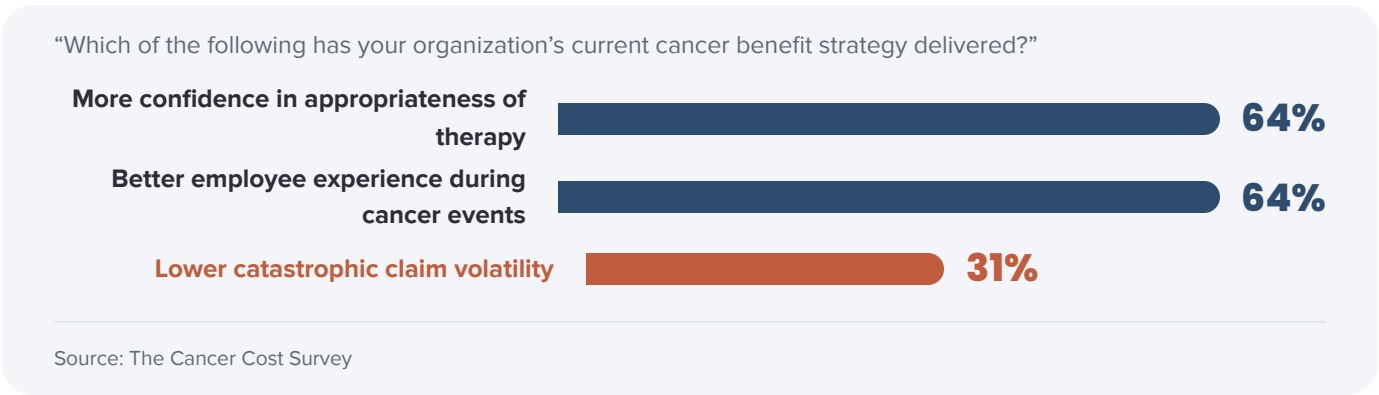


That differential exists not because hospital-based care produces better outcomes for most cancer types, but because hospital outpatient reimbursement rates are structurally higher, a pricing dynamic that prior authorization and formulary management leave entirely untouched.

Shifting infusion care to a home or community setting, where clinically appropriate, is among the most direct hard-dollar savings levers available to self-funded employers, and one that requires neither formulary redesign nor PBM renegotiation.

What Cancer Strategies Are and Are Not Delivering

When asked what their current cancer strategy has delivered, employers in the Cancer Cost Survey cited confidence and employee experience improvements far more often than hard financial results:



WHAT CLOSING THIS GAP REQUIRES

Monitoring spend without the ability to redirect care is insufficient

The outcomes gap is not a failure of effort. Employers are investing in cancer monitoring and oversight. The gap is structural: monitoring spend without the clinical tools to challenge or redirect care pathways cannot produce cost reduction.

Reducing catastrophic claim volatility requires the ability to intervene clinically: to identify when a patient is on a suboptimal therapy, to surface clinical trial eligibility, to flag when a biomarker-driven treatment was never considered, and to recommend treatment sequencing that reflects current subspecialty guidelines.

Getting the initial treatment right is the primary determinant of whether cancer returns, and of whether catastrophic claim volatility can be controlled.

A separate AccessHope outcomes model estimates an 11.6% reduction in mortality risk (approximately 12 avoided deaths per 100) and a 17.8% reduction in cancer recurrence risk (approximately 18 prevented recurrences per 100).

11.6%

Reduction in mortality risk

Approximately 12 avoided deaths per 100

17.8%

Reduction in cancer recurrence risk

Approximately 18 prevented recurrences per 100



Our biggest gap is earlier identification and faster routing. If we can catch cases sooner and guide people to the right care immediately, everything downstream gets better.

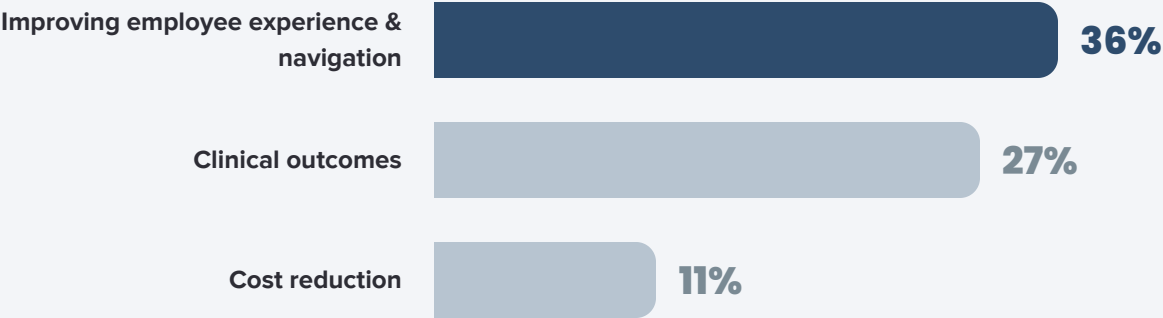
— Director of Benefits, Healthcare

What Closing the Gap Requires: Treatment Adherence

In the Benefits Design Survey, 36% of benefits leaders named improving employee experience and navigation as their top priority for the next 12 to 18 months, outpacing clinical outcomes (27%) and cost reduction (11%) nearly three to one. That finding is worth considering in the context of closing the gap between treatment recommendations and adherence.

Employee Experience Is Outranking Cost on the Near-Term Agenda

Top priority for the next 12 to 18 months



Source: The Benefits Design Survey

Research identifies four principal barriers to patients obtaining expert review: shock following diagnosis, concern about delaying treatment, information overload, and fear of offending the primary clinician.⁶ That last barrier is particularly consequential. Fear of disrupting the patient-oncologist relationship is a documented reason patients forgo expert review even when they want it.

- 01**

Shock following diagnosis
- 02**

Concern about delaying treatment
- 03**

Information overload
- 04**

Fear of offending the primary clinician

One resource that makes a significant difference is a dedicated navigator.

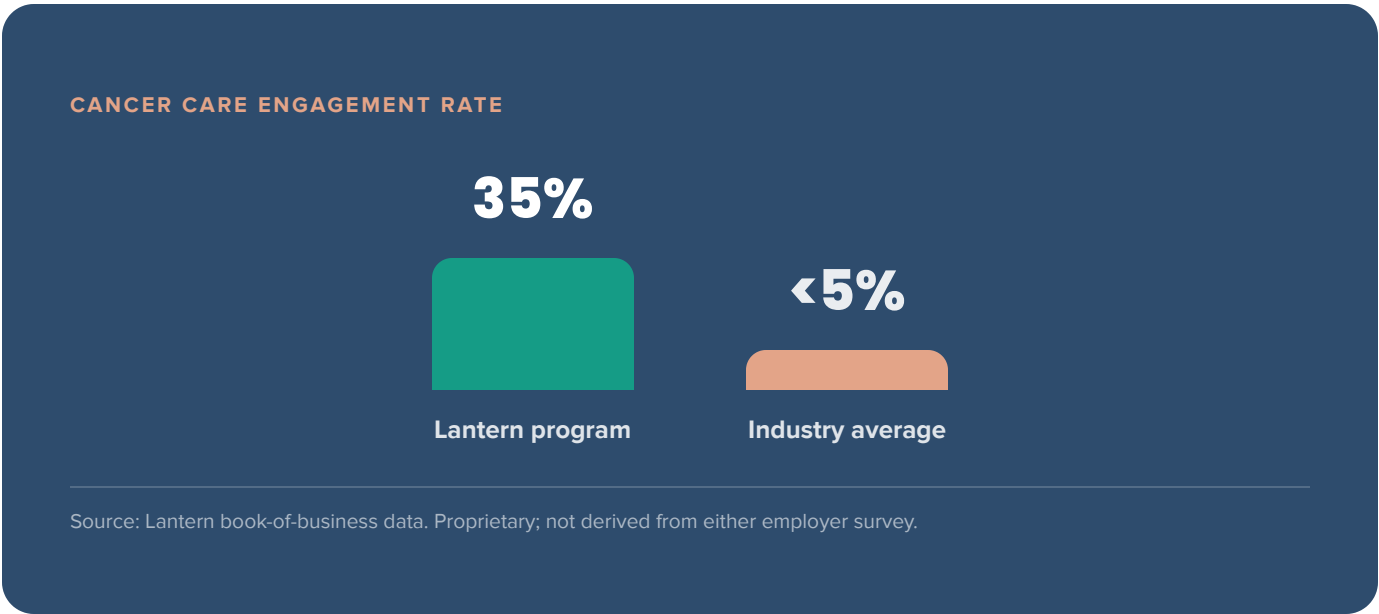
A systematic review of 59 navigation studies found that, among those examining treatment adherence, 71% demonstrated significant improvement, and among those examining treatment initiation, 70% did.⁷



A dedicated oncology nurse navigator can explain what specialist recommendations mean, answer questions a member may be too overwhelmed to ask their physician, and guide them through any recommended changes in a way that preserves rather than disrupts the relationship with their treating oncologist.

Nurse navigators and other care team members are also critical to initial engagement with a patient, paired with timely data integration that allows for outreach within days of diagnosis.

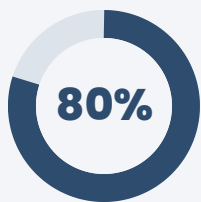
Lantern's oncology nurse-led navigation program offers a benchmark: a 35% engagement rate with cancer patients, against a sub-5% industry average, driven by how quickly the care team makes contact.



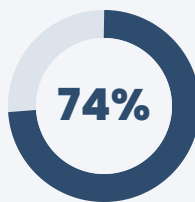
The Largest Employers Are the Most Convinced and the Most Exposed



The Benefits Design Survey surfaces a finding that runs counter to intuition: enterprise employers (10,000+ employees) hold the strongest convictions about expert cancer care (80% strongly agree that early expert intervention improves outcomes) and have the most formal cancer strategies on paper (74% have a documented strategy). Yet they report the lowest visibility into their cancer spend and are less likely than mid-market peers to offer an expert second opinion benefit today.



Strongly agree early expert intervention improves outcomes (enterprise employers, 10,000+)



Have a formal, documented cancer strategy



Actually offer an expert second opinion benefit today

Source: The Benefits Design Survey

1.3M+

Covered lives across 54 enterprise employers

The 54 enterprise employers in the Benefits Design Survey collectively represent more than 1.3 million covered lives. They have built more infrastructure on paper than any other segment. They have not closed the gap between what they believe about expert care and what their plans actually deliver.



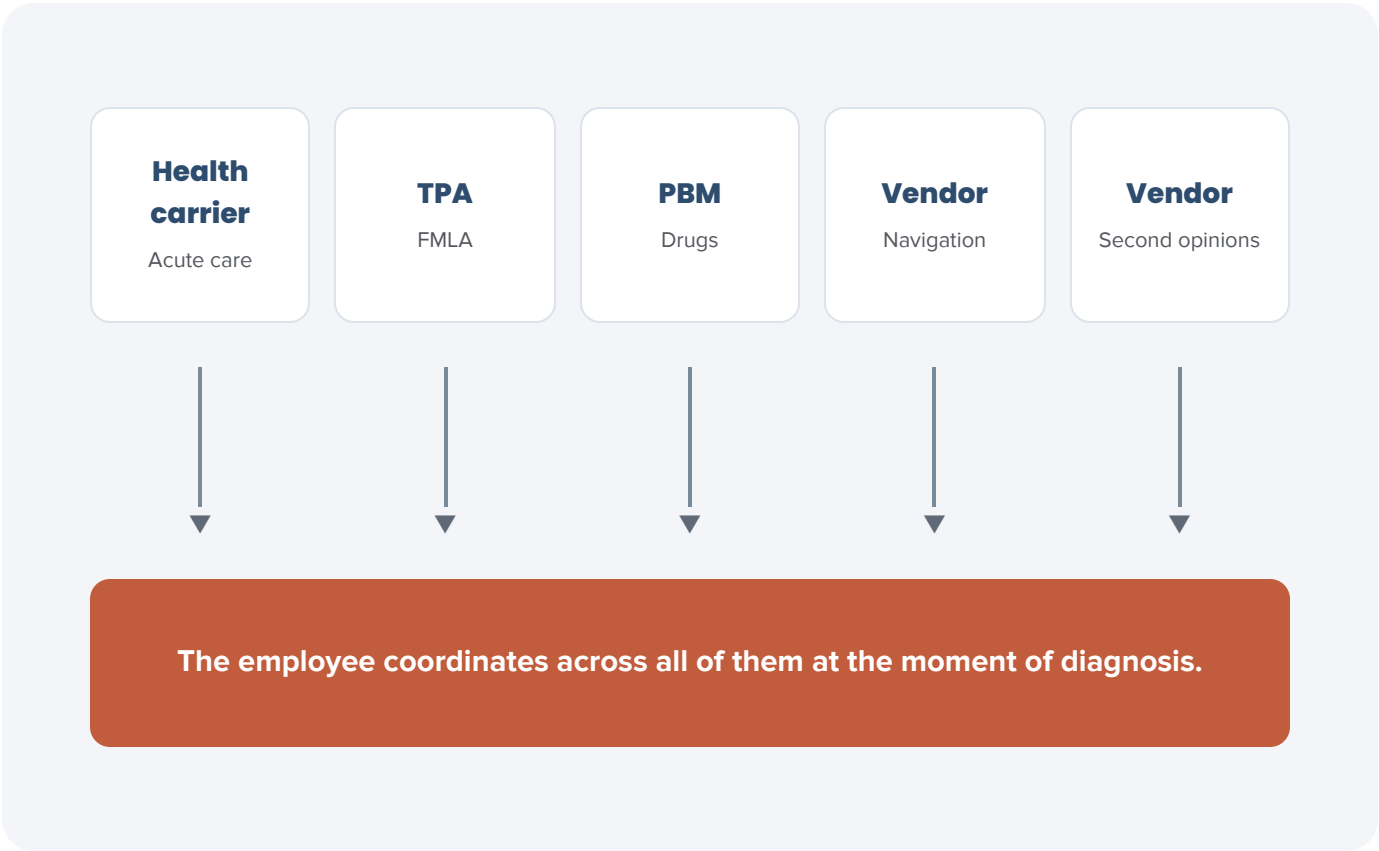
Currently, the health carrier handles chemo, a TPA handles FMLA leave, a PBM handles the drugs, and an EAP handles mental health. The employee is stuck acting as their own project manager. We need to unify these islands into a single, cohesive experience.

— Director of Benefits, Enterprise Retail (28,000 employees)

FINDING 04 · THE ENTERPRISE PARADOX

Among large and enterprise employers (2,500+), 56% have either built an integrated cancer care strategy or are actively working to consolidate point solutions. Leaders who cited improving employee experience and navigation as their top priority (36%) outnumbered those focused on cost reduction nearly three to one.

The explanation enterprise leaders offer in their own words is fragmentation. Cancer care programs exist, but they operate in disconnected silos: The health carrier handles acute care, a TPA manages FMLA, a PBM governs drugs, a separate vendor handles navigation, another handles second opinions. The employee coordinates across all of them at the moment of diagnosis.



For those who haven't built an integrated strategy yet, what that unified experience requires in practice is a consistent clinical relationship, not just integrated technology or a consolidated vendor contract. When a member is diagnosed, the integration failure that large employers describe is experienced by that member as frustrating and overwhelming: there's no one person who knows their case, knows their benefits, and knows when to bring additional expertise back in.

An oncology nurse navigator functioning as a dedicated care team lead, or "project manager," coordinating across insurance, appointments, treatment logistics, and psychosocial support, makes that connection across the care experience and removes the burden from the patient or their caregiver. Ideally, the navigator should have visibility into every part of the patient's care journey, including clinical trial navigation and alternative therapies, if applicable, not just those that go through their insurance plan.

SCALE BRINGS PROGRAMS AND FRAGMENTATION

The enterprise gap is a structural problem, not a commitment problem

Enterprise employers build benefits through accumulation: each program evaluated and added on its own merits over time. The integration failure emerges later, when the employee experience reveals that components were never designed to work together.

The employers in the Benefits Design Survey who are consolidating are not primarily doing so to cut costs. They are doing so because fragmentation creates experience failures at the worst possible moment, when an employee receives a cancer diagnosis and needs a clear pathway, not a vendor directory.

The employers with the most conviction about expert care and the most programs on paper are the ones most likely to find, when they look closely, that those programs are not reaching patients at the point where the treatment decision is actually made.

The Clinical Precision Layer the Research Points Toward

The combined findings from both studies identify a consistent structural gap: the absence of subspecialty oncology expertise at the point of treatment decision. Understanding what closing that gap requires, and why it is harder to replicate than it may appear, provides useful context for evaluating what options exist.

What Evidence-Based Cancer Management Is Not

Evidence-based cancer management is not a second opinion service, a navigation call center, or a virtual clinic. The community oncologist at the center of a patient's care is not the problem; the system around them is. The community oncologist operates under a crushing administrative burden of prior authorizations, documentation, and insurance appeals, consuming the hours that used to go to learning. They are being asked to practice at the frontier of the most complex field in medicine, largely alone. This is not about bad medicine. It is about an impossible system.

What closes the gap is access to the subspecialty depth that already exists at the world's leading cancer institutions. A physician who has spent 20 years exclusively in EGFR-mutated lung cancer cannot be replicated by a generalist reviewing a drug claim. That expertise exists in concentrated form at NCI-designated Comprehensive Cancer Centers, and getting it to every patient requires a system for connecting community-based care to that depth, without requiring patients to change doctors or travel.

What Evidence-Based Management Covers Across the Care Continuum

The data from both the Cancer Cost Survey and the Benefits Design Survey shows that employers are primarily intervening at the drug-authorization point. Evidence-based cancer management operates across a wider span:

The Care Continuum: Where Subspecialty Expertise Changes Outcomes

- 1 Diagnosis:** Precision diagnostics (ensuring the right testing occurs to identify the right treatment) and imaging & surveillance (accurate workup to catch recurrence and progression early). Only 35% of cancer patients currently receive proper genomic testing².
- 2 Treatment Selection:** Course-correcting with evidence-based care to most effectively treat the specific cancer. Treatment recommendations are precise enough that treating oncologists adopt them in approximately two out of three cases, without patients changing doctors or traveling.
- 3 Clinical Trial Access:** Surfacing clinical trial eligibility that would not otherwise be identified. Most community oncologists do not have systematic visibility into applicable trials.
- 4 Supportive Care:** Reducing treatment toxicity that drives acute care utilization. Symptom management interventions reduce ED visits and hospitalizations that represent a large share of catastrophic claim volatility.
- 5 Palliative Care:** Evidence-based palliative care that improves quality of life and reduces late-stage acute care costs.

Financial impact is measured against stage-stratified, actuarially validated total cost of care benchmarks, validated in actual claims data, not modeled projections. Savings are credited conservatively: one cost reduction per case, at the highest-ranked evidence category, with no double-counting.

What Makes This Hard to Replicate

Three components must work together for evidence-based cancer management to be measurable and defensible:

01

Data infrastructure

Combining claims and medical records at an 80%+ medical record fetch rate. Without complete medical record access, patient identification is based on an incomplete clinical picture.

02

Subspecialty expertise

Subspecialists at NCI-designated Comprehensive Cancer Centers spend their entire careers in specific cancer types, and treating oncologists adopt their recommendations in the majority of cases.

03

Purpose-built AI

Trained to categorize recommendations by evidence-based care type and detect in claims data whether those recommendations were adopted, confirming whether the intervention actually happened, which is what makes financial measurement credible.

Without all three working together, the methodology is a spreadsheet. **Together, they become a measurable, scalable system of care that produces claims-validated, actuarially reviewed reduction in total cost of care.**

From Data to Diagnosis: Evaluating Your Own Cancer Benefits Infrastructure

The combined findings from the Cancer Cost Survey and the Benefits Design Survey support a specific set of evaluative questions. Each corresponds to a gap documented across one or both studies:

- 01** Who is reviewing high-cost cancer treatment decisions at your organization, and do they carry subspecialty oncology expertise, or general benefits and pharmacy expertise?

- 02** What percentage of your cancer cases go through structured clinical review, not just prior authorization?

- 03** Is oncology managed through a dedicated cancer program, or as a subcategory within general specialty pharmacy?

- 04** Can your cancer benefits program show you validated, claims-based evidence of total cost of care reduction, not just drug cost trend, enrollment numbers, or screening adherence rates?

- 05** Is your cancer benefits infrastructure built to challenge and redirect care pathways, or only to authorize and monitor them?

- 06** For enterprise employers: when an employee is diagnosed, do they enter a clear, guided pathway, or does their experience depend on which programs they happen to know about and can navigate?

Employers who can answer these questions with specificity are likely operating closer to the model both studies identify as effective. For those who struggle to answer them, that uncertainty may itself reveal the gap highlighted by the research.



Success would mean faster approvals, evidence-based guidance to oncologists upfront.

— Benefits Leader, Large Employer

AccessHope: Evidence-Based Cancer Expertise at Scale

AccessHope is a comprehensive cancer care solution that provides automatic, equitable access to evidence-based cancer expertise. Through sustained partnerships with NCI-Designated Comprehensive Cancer Centers, AccessHope uses a combination of claims data, medical records, subspecialist review, and purpose-built AI to systematically bring subspecialized expertise to community-based care, allowing members to continue care with their local oncologist while receiving the benefit of the most current peer-reviewed clinical science across the full arc of their cancer journey.

Subspecialist review covers the full care continuum: precision diagnostics, treatment selection, clinical trial access, supportive care, palliative care, and imaging and surveillance. This expert-guided approach has been associated with an estimated 11.6% reduction in cancer mortality risk and a 17.8% reduction in cancer recurrence risk. Financial impact is measured against stage-stratified, actuarially validated total cost of care benchmarks in actual claims, not modeled projections.

Today, AccessHope serves more than 10 million members through over 800 organizations, including more than 80 Fortune 500 companies.

10M+

Members
served
today

800+

Organizations

80+

Fortune
500
companies

For more information: myaccesshope.org |
info@myaccesshope.org

IN EXCLUSIVE PARTNERSHIP WITH ACCESSHOPE

Lantern: Transforming Speciality Care



Lantern is the leading Specialty Care Platform built to simplify and elevate the most complex care journeys through a unified, value-driven approach. Lantern supports 12 million members and over 1,000 employers nationwide to deliver high-quality surgical, infusion, and cancer care. Lantern's Network of Excellence is the nation's leading specialty care network built on direct contracts and bundled payments with top-tier specialists and facilities. Lantern's distributed network is the most locally accessible in the industry, leading to higher utilization and a 4% overall annual reduction in healthcare costs observed across Lantern's book of business.

12M

Members supported

1,000+

Employers nationwide

4%

Annual reduction in
healthcare costs

<10 days

To specialist-level access

Within cancer care, Lantern is the only end-to-end program that combines oncology nurse-led navigation, community-based site-of-care optimization, and always-on NCI-level clinical oversight through an exclusive partnership with AccessHope, in a single, integrated solution. Where AccessHope brings subspecialty expertise to the treatment decision, Lantern ensures that expertise reaches the member and stays with them across the full arc of care. Each member is supported by a dedicated care team led by an oncology nurse with an average of 16 or more years of clinical experience, alongside a licensed clinical social worker and a care advocate managing insurance, appointments, and logistics.

Lantern's site-of-care model addresses a cost and access challenge simultaneously. Hospital-based cancer care costs 50% more than equivalent community-based care, and members receiving treatment in hospital outpatient settings pay \$55,000 to \$81,000 more per patient per year than those treated in physician office settings. Lantern navigates members to the highest-quality care available close to home, and for members who require specialist-level intervention, facilitates access in under 10 days. The result is a model in which community-based care and NCI-level oversight are not alternatives but complements: the member does not have to choose between proximity and clinical precision.

For more information, visit lanterncare.com. Lantern Specialty Care is the trade name of Employer Direct Healthcare, LLC.



RESEARCH POWERED BY GATHER

Both studies behind this report were fielded on Gather, the conversational research platform used to survey 240 senior HR and benefits decision-makers across the Cancer Cost Survey and the Benefits Design Survey.

Sources & References

Survey findings are attributed inline to the Cancer Cost Survey or the Benefits Design Survey. AccessHope and Lantern program figures reflect proprietary book-of-business data as noted in context. Externally sourced figures carry the reference numbers below.

- 1 **National cancer-care cost projection (~\$246 billion by 2030).** Mariotto AB, Enewold L, Zhao J, Zeruto CA, Yabroff KR. "Medical Care Costs Associated With Cancer Survivorship in the United States." *Cancer Epidemiology, Biomarkers & Prevention*, 2020.
- 2 **Genomic / molecular testing rate (~35%).** DaCosta Byfield S, Bapat B, Becker L, et al. "Biomarker Testing Approaches, Treatment Selection, and Cost of Care Among Adults With Advanced Cancer." *JAMA Network Open*, 2025;8(7):e2519963.
- 3 **Share of cancer care delivered at NCI-designated Comprehensive Cancer Centers (~15–20%).** National Cancer Institute, Comprehensive Cancer Centers program.
- 4 **Oncologist burnout (~60%).** American Society of Clinical Oncology 2023 national well-being survey; Levit LA, et al. *JCO Oncology Practice*, 2025.
- 5 **Site-of-care cost premium (86–393%; ~\$90,144 annual gap per patient).** AJMC; EBRI top 37 infused cancer drugs; Lantern claims analysis (8 MSAs); Bach et al., *JAMA Oncology*, 2015; University of Pennsylvania, *JCO Oncology Practice*.
- 6 **Barriers to seeking expert review.** Hillen MA, et al. "Cancer patients' trust as a motivator to seek a second opinion." *Psychology & Health*, 2022.
- 7 **Patient navigation systematic review (59 studies; 71%; 70%).** Esposito N, et al. "Patient Navigation in Cancer Treatment: A Systematic Review." *Current Oncology Reports*, 2024.
- 8 **U.S. guideline-concordant cancer treatment (~60%).** Sun et al. "Guideline-Concordant Treatment Among Patients With Non–Small Cell Lung Cancer: A National Cancer Database Analysis (302,744 patients; ~62% concordant)." *Lung Cancer*, 2025.
- 9 **Annual cancer-care cost, privately insured adults under 65 (~\$156 billion).** Zaorsky NG, et al. "Medical Service Use and Charges for Cancer Care in 2018 for Privately Insured Patients Younger Than 65 Years in the US." *JAMA Network Open*, 2021;4(10):e2127784.
- 10 **GLP-1 coverage growth among the largest employers (28% to 43% in one year).** Peterson Center on Healthcare / KFF, 2025 *Employer Health Benefits Survey* (firms with 5,000+ workers, 2024–2025).
- 11 **New FDA oncology indications in a single year (50+).** U.S. Food & Drug Administration, Oncology Center of Excellence Annual Report.
- 12 **Share of cancer diagnoses in adults ages 20–64 (~half; exact figure to be confirmed).** American Cancer Society, *Cancer Facts & Figures 2026*.
- 13 **Doubling time of medical knowledge (~7 years in 1980 to months today).** Densen P. "Challenges and Opportunities Facing Medical Education." *Trans Am Clin Climatol Assoc*, 2011;122:48–58.
- 14 **Distance traveled for cancer care (72% of patients >13 miles).** Unger JM, Gralow JR, Albain KS, Ramsey SD, Hershman DL. "Assessing Populations With Access to National Cancer Institute–Funded Sites Using Local Distance-Based Service Areas." *Journal of Clinical and Translational Science*.

The working-age caregiver-prevalence figure cited in this report is pending source confirmation and will be added here once verified.

About the Two Studies

The Cancer Cost Survey: The Cancer Attention Crisis • Rx Decision Survey

110 benefits decision makers at large, self-funded U.S. employers (5,000+ employees) were surveyed in March 2026 via the Gather research platform. All respondents held C-suite, SVP, EVP, or VP titles in Human Resources or People Operations and were independently screened for familiarity with pharmacy benefit management and drug spend. 95% were primary benefits decision makers; the remaining 5% were senior HR and People Operations leaders who directly participate in benefits strategy, vendor evaluation, and plan design. The sample skews toward mid-to-large employers (5,000–9,999 employees). Fieldwork: March 19–23, 2026. Median completion: approximately 12 minutes.

The Benefits Design Survey: The 2026 Cancer Benefits Report • Benefits Strategy Survey

130 HR and benefits decision makers were surveyed in May–June 2026 via Gather, an online conversational survey. Respondents were senior leaders with direct ownership or influence over cancer benefits strategy at organizations with 500 or more employees. Quotas were applied across organization size to support segmentation. The 130 organizations collectively represent more than 1.6 million covered lives. Nine industries are represented. Organization size data sourced from PureSpectrum panel B2B profiling.

Reporting Conventions

Statistics cited in this report identify the source study in the note that follows each data block. Where findings from both studies appear together, both sources are noted. All percentages are rounded to the nearest whole number. Multi-select question results may exceed 100% when summed. Quotes have been lightly edited for length and clarity.

Limitations

Both studies rely on self-reported data from online panels of HR and benefits leaders. Results reflect respondent perceptions and may not represent the full population of self-funded employers. Sample sizes (N=110; N=130) support directional findings but may not support subgroup analysis at statistical significance. All data was collected at single points in time. AccessHope program data cited in context notes is proprietary and confidential; it is not derived from either employer survey.