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WHITE PAPER

Rethinking Oncology Trend, Part II: Portfolio Diversification in Medicare Part D Oncology

Evidence from Oral Oncology Spending, 2019–2025

Yucheng Feng, FSA, MAAA, PhD

Mason Deeley

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SUMMARY

The companion Part B oncology trend paper (Rethinking Oncology Trend: Evidence from Medicare Lung and Breast Cancer Spending, 2018–2024)[1] published in July 2026 demonstrated that oncology spending is more than an inflation story. Rather, spending patterns reflected distinct cycles of therapeutic adoption and replacement.

Although oral oncology drugs accounted for less than 0.6% of total Part D prescription utilization in the study population, they represented approximately 10% to 15% of total Part D allowed cost. Within this relatively small but costly segment, utilization and spending have become increasingly decoupled. A relatively small group of higher-cost, targeted therapies accounts for most of the allowed cost, while a largely different group of older, less expensive therapies continues to dominate prescription volume.

These findings suggest that Part D oncology cannot be understood through traditional measures of utilization or price alone. Instead, spending increasingly reflects changes in therapy mix and the expanding portfolio of precision medicines, representing a distinct economic model of oncology innovation that complements the adoption and replacement models identified in Part B oncology spending patterns.

INTRODUCTION

The Part I paper focused on oncology spending under Medicare Part B and demonstrated that therapeutic innovation has been reshaping oncology spending through two distinct mechanisms: adoption and replacement. Lung cancer treatment experienced a rapid immunotherapy adoption cycle, in which new therapies drove a spike in spending before stabilizing as they became established standards of care. In contrast, breast cancer treatment exhibited a replacement pattern in which newer therapies were partially offset by savings in biosimilar drugs. Together, these findings showed that oncology trend is driven not only by price inflation, but also by how new therapies enter clinical practice.

This sequel examines Medicare Part D oral oncology spending. The Part D oncology market differs structurally from Part B, with a range of oral therapies spanning multiple cancer types, treatment pathways, and patient populations. The growing role of biomarker-directed therapies has further expanded the number of treatment options available to increasingly defined patient populations.

These characteristics raise an important actuarial question: Does therapeutic innovation affect Part D oncology spending in the same way observed under Part B, or does the Part D market exhibit a different economic pattern? This analysis examines Part D spending and utilization from 2019 through 2025 to explore that question.

DATA AND METHODS

This ongoing analysis uses data from multiple Wakely clients' prescription drug events (PDEs) in calendar years 2019 through 2025. The study population includes approximately 11 million member months across 60 Medicare Advantage Prescription Drug (MAPD) Plans, Employer Group Waiver Plans (EGWPs), and stand-alone Prescription Drug Plans (PDPs). These clients have granted Wakely permission to aggregate their data for analysis.

We identified oncology drugs through the Medi-Span Generic Product Identifier (GPI) classification system. Drugs with a GPI therapeutic class of 21 (the first two digits of the GPI) were classified as antineoplastic agents and included in the analysis.

Oral oncology drugs represent a small but disproportionately costly segment of Medicare Part D. While they account for less than 0.6% of total prescription utilization, they represent approximately 10% to 15% of total Part D allowed costs. The analysis compares annual allowed cost and utilization for the leading oncology drugs and organizes them into two groups: 1) higher-cost, targeted therapies that drive cost, and 2) low-cost therapies that drive utilization.

The top 10 drugs by allowed cost include Imbruvica, Xtandi, Ibrance, Jakafi, Pomalyst, Calquence, Brukinsa, Tagrisso, Cabometyx, and Venclexta. Oncologists use these drugs to treat breast, lung, prostate, kidney, liver, and thyroid cancers as well as hematologic malignancies. In contrast, the 10 drugs with the highest utilization include methotrexate, anastrozole, letrozole, hydroxyurea, tamoxifen, abiraterone, exemestane, leucovorin, megestrol, and bicalutamide, most of which are lower-cost generic therapies from an earlier era of oncology treatment and used mostly in patients with hormone-sensitive breast cancers and prostate cancer.

The contrast between these two groups provides the basis for the analysis that follows. By examining Part D oncology drugs through both allowed cost and prescription utilization, we assess whether the therapies that drive spending are also the ones that are driving volume and what that relationship may imply for understanding and forecasting Part D oncology trend.

RESULTS

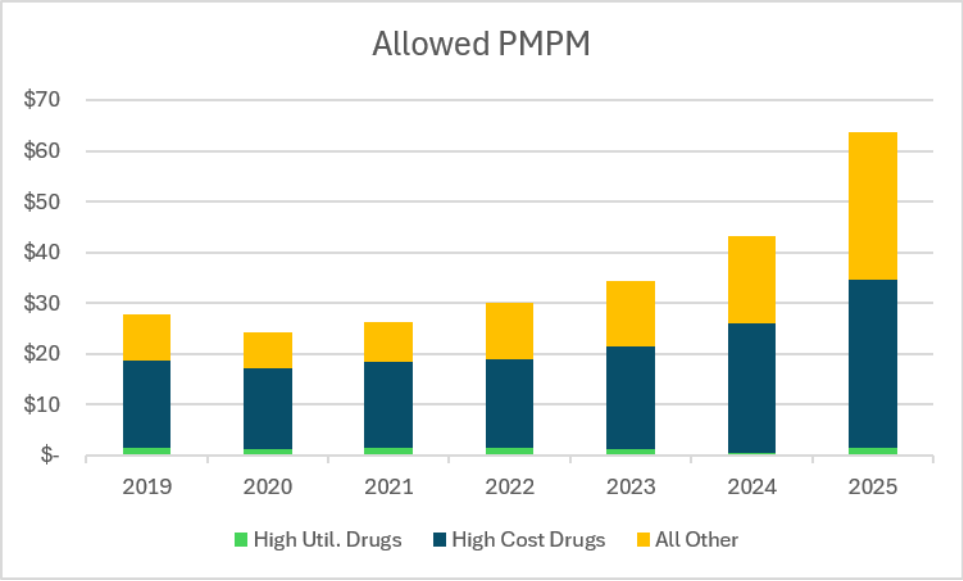
Spending Is Concentrated in Targeted Therapies

Allowed cost per member per month (PMPM) increased substantially over the study period, particularly after 2020. The 10 highest-cost drugs account for roughly 60% of total oncology allowed cost overall, with annual shares ranging from the mid-50s percentile to approximately 65%. In contrast, the 10 most frequently utilized drugs account for less than 5% of total oncology allowed cost. This concentration of spending among a relatively small group of targeted therapies illustrates how Part D oncology growth increasingly reflects therapy mix and drug price rather than prescription volume.

Unlike the Part B pattern, in which a dominant therapy can reshape an established treatment platform, Part D growth increasingly reflects the cumulative contribution of multiple therapies serving different indications and patient populations.

Figure 1 illustrates the concentration of Part D oncology spending among a relatively small group of targeted therapies.

Figure 1. Annual Part D Oral Oncology Allowed Cost by Drug Group, 2019–2025

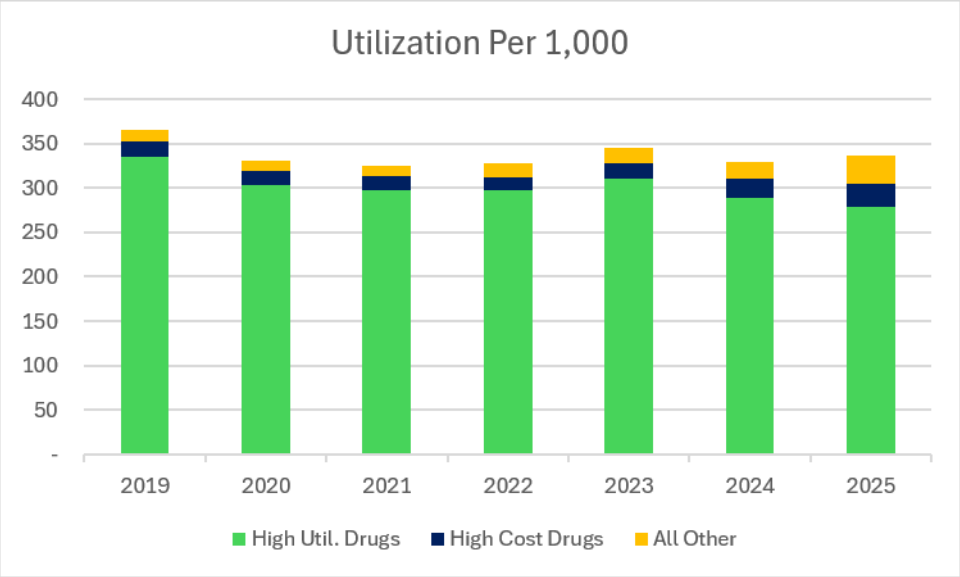


Utilization Follows the Legacy Base

The utilization results tell the other half of the story. Prescription volume is dominated by a largely different set of older therapies. Together, these therapies account for roughly 90% of utilization overall and are generally more mature, less expensive, and widely used.

Figure 2 illustrates the concentration of prescription utilization among these mature, lower-cost therapies relative to the top 10 most costly drugs.

Figure 2. Part D Oral Oncology Utilization per Thousand by Year, 2019–2025



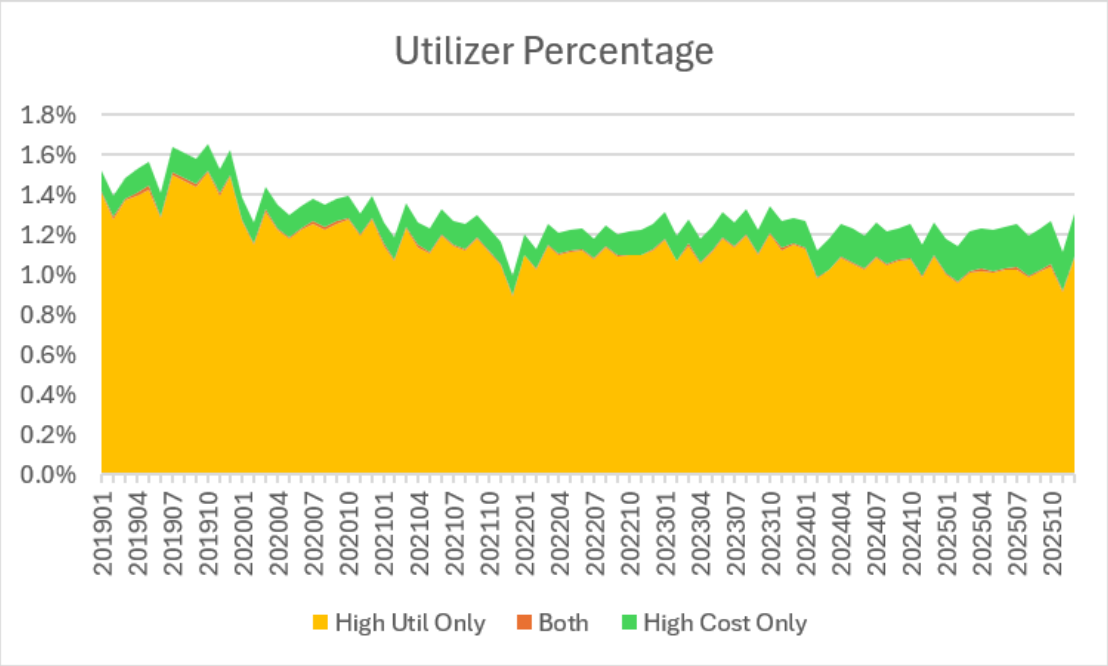
Viewed together, **Figures 1 and 2** show an increasing divergence between utilization and allowed cost over time. After declining between 2019 and 2020, prescription utilization remained relatively stable, while allowed costs continued to rise. This pattern suggests that the recent Part D oncology trend has been driven increasingly by changes in therapy mix rather than growth in prescription volume.

Figure 2 shows that prescription utilization remains concentrated in a stable group of mature generic therapies. Collectively, the 10 highest-cost drugs in **Figure 1** account for only 5% of total oncology prescription utilization on average, despite representing a substantial share of allowed cost. This contrast reinforces the importance of therapy mix; the drugs driving Part D oncology spending are not necessarily the ones driving prescription volume.

Utilizer Segmentation

The previous results demonstrate that different drugs dominate spending and utilization. **Figure 3** extends the drug-level findings to the patient level. Members receiving therapies from both high-cost and high-utilization drugs represent only a small portion of the treated population, indicating that the high-cost and high-utilization drug groups largely serve distinct patient populations. This segmentation suggests that treatment portfolio diversification reflects not only an expanding treatment portfolio, but also increased differentiation in how populations are treated.

Figure 3. Utilizers by Drug Type, 2019–2025



Together, **Figures 1 through 3** show that the Part D oncology market has diversified across three dimensions: treatment portfolio, patient population, and spending. These findings suggest that Part D oncology differs from Part B not only in how therapies are used, but also in terms of patient distribution.

DISCUSSION

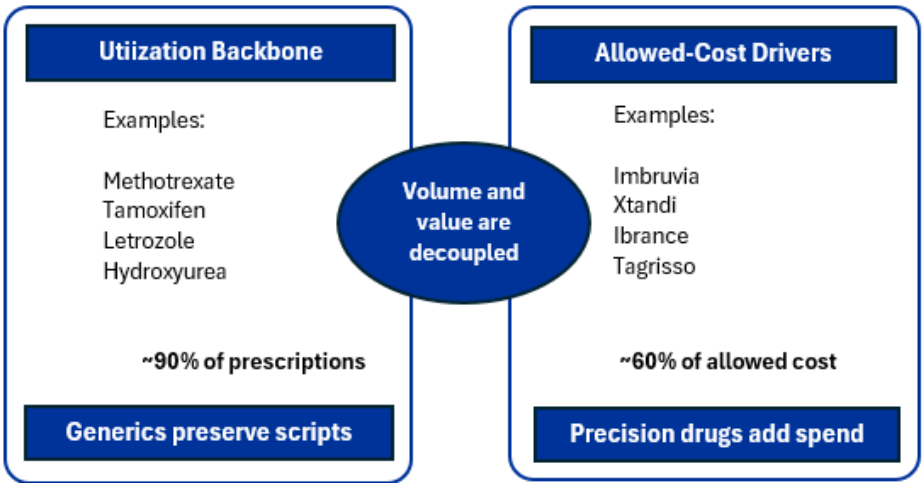
The preceding analyses suggest that Part D oncology is segmented at both the drug level and the patient level. One group of therapies dominates prescription volume, another dominates cost, and the patients who receive these therapies overlap minimally. Together, these findings distinguish Part D from the Part B market and provide the foundation for a third economic model of oncology innovation, as summarized in **Table 1**.

Table 1. Difference Between Part B and Part D Oncology Economics

Dimension	Part B	Part D	Part D Implication
Market structure	A few infused biologics drive spending.	Many oral targeted therapies share the cost base.	Part D is broader and more segmented.
Economic pattern	Adoption and replacement.	Portfolio diversification.	Growth comes from layering, not substitution.
Forecasting challenge	When a new platform becomes standard of care.	How fast the portfolio of oral therapies expands.	Important to track mix, duration, and new entrants.

The Part B paper demonstrated how a breakthrough therapy can reshape spending through platform adoption or therapeutic replacement. Our Part D analysis illustrates the economics of precision medicine operating at scale. Rather than replacing existing therapies, new precision medicines are layered onto an existing treatment portfolio, while older therapies continue to anchor prescription volume. Consequently, spending grows through portfolio diversification rather than substitution. **Figure 4** summarizes the relationship between drug mix, patient segmentation, and spending.

Figure 4. Segmented Market of Part D Oncology Drugs



The findings in this analysis describe a progression from drug-level diversification to patient-level segmentation and, ultimately, provide a new framework for understanding Part D oncology trend. Thus, Part D and Part B should be interpreted together. Part B is where a single breakthrough therapy can create a step change in spending, whereas Part D is where multiple smaller therapies collectively create a steady upward trajectory. The two benefit channels are complementary but behave differently.

We describe this pattern as the Portfolio Diversification Model. Unlike Part B, where innovation often centers on the adoption of a dominant treatment platform or the replacement of existing therapies, Part D innovation occurs through the continued expansion of a diversified treatment portfolio. New targeted therapies are added while legacy therapies remain in widespread use, allowing spending to grow through accumulation rather than substitution.

The portfolio is also dynamic. As therapies mature and face generic competition, their contribution to spending may decline even as utilization remains substantial. The transition from branded Zytiga to generic abiraterone illustrates this life cycle, with Medicare Part D spending declining following generic entry even as the number of beneficiaries receiving abiraterone continued to rise.[2]

IMPLICATIONS FOR MEDICARE AND MEDICARE ADVANTAGE

The implications for Medicare Advantage (MA) organizations is straightforward: Part D oncology requires a mix-driven forecasting model. A small number of high-cost oral therapies can materially affect allowed cost even when the prescription backbone remains anchored in inexpensive generics. Forecasting models should, therefore, account for therapy mix, expanded treatment indications, duration of therapy, and the continued introduction of new precision medicines, rather than relying primarily on prescription volume.

The Medicare Drug Price Negotiation Program adds another consideration to this dynamic. Several high-cost oncology therapies identified in this analysis have already been selected for negotiation, including Imbruvica for 2026 and Calquence, Ibrance, Pomalyst, and Xtandi for the 2027 cycle.[3] As negotiated Maximum Fair Prices take effect, they may moderate spending for established high-cost therapies, potentially increasing the relative significance of newer precision medicines as drivers of future trend.

For example, newer therapies such as Brukinsa may become increasingly important within the cost-driving portfolio as negotiated prices moderate spending for more established competitors. Eligibility for negotiation, however, is subject to statutory criteria, including a minimum period subsequent to Food and Drug Administration (FDA) approval—generally at least seven years for small-molecule drugs and 11 years for biological products—as well as other requirements related to generic or biosimilar competition and drug-specific exclusions.[4,5] Consequently, newer oncology therapies may continue to generate significant spending growth for several years before becoming eligible for negotiation.

More broadly, oncology spending is increasingly benefit-channel specific. Part B is shaped by platform adoption and replacement, whereas Part D is shaped by portfolio diversification. Understanding both benefit channels is essential accurately forecast the financial impact of modern oncology care.

CONCLUSION

Part D oncology tells a fundamentally different story from Part B. Prescription utilization has remained relatively stable in recent years, while allowed cost has continued to rise. Older generic therapies continue to dominate prescription volume, while higher-cost targeted therapies account for most allowed cost. This decoupling of volume and value reflects the growing diversification of both the treatment portfolio and the treated population.

Taken together, the Part B and Part D analyses show that oncology spending is driven by different economic mechanisms across benefit channels. These findings suggest that the future of oncology forecasting lies not in a single trend assumption, but in understanding how different forms of therapeutic innovation reshape the economics of oncology care across both Medicare benefit channels.

ENDNOTES

1. Feng Y, Deeley M. Rethinking Oncology Trend: Evidence from Medicare Lung and Breast Cancer Spending, 2018–2024. Wakely Consulting Group. July 2026. Available at: https://www.wakely.com/wp-content/uploads/2026/07/Rethinking-Oncology-Trend.pdf.

2. Lee MS, Kim TH, Roberson DS, et al. From High Cost to High Access: The Impact of Generic Abiraterone on Medicare Part D Spending in Advanced Prostate Cancer. *Urol Pract*. 2026 Aug 4:101097UPJ0000000000001066. doi: 10.1097/UPJ.0000000000001066. Epub ahead of print. Using Medicare Part D data from 2013–2023, the study showed that after generic abiraterone became available in 2018, total abiraterone spending declined from approximately $1.5 billion in 2018 to $910 million in 2023, while the number of beneficiaries receiving abiraterone continued to increase.

3. Medicare Drug Price Negotiation Program. Fact Sheet: Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2026. Centers for Medicare & Medicaid Services. August 2024. Available at: https://www.cms.gov/files/document/fact-sheet-negotiated-prices-initial-price-applicability-year-2026.pdf.

4. Medicare Drug Price Negotiation Program. Fact Sheet: Medicare Drug Price Negotiation Program: Selected Drugs for Initial Price Applicability Year 2027. Centers for Medicare & Medicaid Services. January 2025. Available at: https://www.cms.gov/files/document/factsheet-medicare-negotiation-selected-drug-list-ipay-2027.pdf.

5. Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: Final Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027. October 2, 2024. Available at: https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf.

ABOUT THE AUTHORS

Yucheng Feng, FSA, MAAA, PhD
Senior Consulting Actuary
yucheng.feng@wakely.com

Mason Deeley
Actuarial Analyst
mason.deeley@wakely.com

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Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.