

FUTURE-PROOFING UK HTA: CAN NICE ABSORB MFN-INDUCED PRICE INCREASES?

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Introduction

- U.S. pricing and trade developments, including revival of a Most Favored Nation (MFN) model and new import tariffs, are expected to narrow U.S.–ex-U.S. price differentials. MFN is being re-introduced to cap drug prices based on the prices paid in other countries (1).
- The aim of MFN is for the U.S. to pay prices that are equal to, or close to, the lowest prices in comparable countries. A method close to basket pricing.
- There has been discussion that the knock-on impact of MFN may see manufacturers increase ex-U.S. prices to offset reduced U.S. revenues or reconsider launches in some markets to avoid lowering the MFN reference price.
- Concurrent UK reforms are changing the UK branded medicines landscape, aimed at balancing affordability, ensuring continued access, and innovation. These have been released alongside the updates from the U.S. and include:
 - The UK-U.S. zero-tariff agreement
 - Updates to the Voluntary Scheme for Branded Medicines Pricing and Access (VPAG)
 - Increases to NICE cost-effectiveness thresholds and ongoing methods updates.
- These concurrent policy shifts on both sides of the Atlantic create a more complex and interconnected pricing environment. Understanding their combined implications is critical for anticipating future launch strategies, pricing corridors, and patient access across key markets.

Objective & Methods

- This study examines how these reforms may enhance the UK's capacity to absorb MFN-related global price pressure, and in turn how open to innovation the UK will remain. A review of MFN policy analyses, VPAG reforms, and NICE methods updates was conducted alongside illustrative modelling.
- For illustrative purposes a recent cost-effectiveness model was anonymised and adjusted to increase the intervention drug cost. In this model the intervention drug cost was more expensive than SoC but was superior in efficacy. SoC costs were high due to healthcare costs associated with lower efficacy and more complications.
- In this model there was a base case ICER of £28,000/QALY, close to the historic (pre-April 2026) acceptability threshold. MFN-related UK price increases of 10%, 20%, and 25% were applied, and assessed against historic (£20,000–£30,000) and revised (£25,000–£35,000) NICE thresholds.

Results

UK reforms

- The UK Government announced a 2026 pharmaceutical trade agreement under which the U.S. grants 0% tariffs on UK exports of medicines for at least three years, in exchange for the UK implementing pricing and access reforms.
- Part of these reforms; the VPAG update, highlights the continued scale of repayments from pharmaceutical companies to the NHS and reinforces the UK's position as a highly price-regulated market. In the context of MFN policies, this creates potential unintended consequences: while the UK achieves strong cost containment it potentially discourages manufacturers from launching in the UK. As such, with MFN on the horizon, the UK government took the decision to drop the VPAG rate to 14.5% (2).
- Alongside the VPAG update, and zero-tariff agreement, the UK government announced NICE's cost-effectiveness threshold was to increase to £25,000–£35,000/QALY for England and Wales, the first uplift since NICE was established in 1999, meaning the threshold has remained broadly static in nominal terms for over two decades, this went live from March 31st, 2026 (2). In combination the UK government will have hoped to balance the impact of MFN on UK pricing and access.

Industry response

- Policy commentary from key opinion leaders such as the ABPI have urged caution over the ability of the UK reforms to soften MFN impacts.
- The ABPI recognised that the 2026 VPAG payment rate for newer medicines will reduce from ~22–23% in 2025 to 14.5% was a positive step. However, they also emphasised rebate levels remain high relative to comparable countries, continuing to impact UK competitiveness and potentially influencing launch decisions and investment. The organisation also pointed to the need for a more sustainable long-term scheme beyond 2028, alongside improved NHS uptake of cost-effective medicines, to ensure that lower rebate rates translate into better patient access and a more attractive environment for innovation (3).
- Historically the ABPI had urged the government to raise the thresholds to the appropriate level when considering inflation, to ~£56,000 (4). A recent report found the increased NICE thresholds still lags behind comparable countries (e.g. Ireland, Netherlands, Sweden) and remains well below an inflation-adjusted equivalent (~£48,000), with major EU markets (France, Germany, Spain) continuing to operate without formal thresholds, allowing greater flexibility (5).

NICE updates

- In parallel to the UK reforms NICE announced the forthcoming EQ-5D-5L value, this is currently under consultation, with NICE set to adopt a new EQ-5D-5L value set (based on updated public preferences) as the preference in future. This value set will improve how health-related quality of life is measured and used in cost-effectiveness decisions (6). The update is expected to change cost-effectiveness results and decision outcomes, as it more accurately reflects current societal values and treatment benefits (6).

MFN updates from the UK Government

- The U.S. implemented a model called GENEROUS (GENERating cost Reductions for U.S. Medicaid) in January 2026. A recent update from the UK government has revealed, according to the GENEROUS model, the UK's price would likely not be used if it is the lowest in the reference basket, instead MFN will reference the second-lowest price, raising questions about how often the UK would still influence global pricing. The model will reference G7 countries plus Denmark and Switzerland (1,7).

Modelling

- The illustrative modelling shows MFN-induced UK price increases of 10–25% raised the ICER from £28,000 up to £172,500. In this scenario drug cost increases result in ICERs that are not cost-effective.

Limitations

- Cost-effectiveness models have multiple variables driving value, and the interpretation of this supplementary modelling can only be considered in the specific case of the cost-effectiveness model used here. In this case study the intervention had superior efficacy resulting in less HRU costs but had a higher drug cost. Due to the non-linear relationships between parameters in the models, results can be unpredictable; therefore, these conclusions shouldn't be assumed for other indications and models.

Discussion & Conclusion

- While MFN-induced price shifts pose risks to ex-U.S. markets, recent UK reforms (threshold uplift, VPAG, and tariff stability) collectively strengthen the UK's structural ability to absorb global pricing pressure without compromising access to innovative medicines.
- These reforms reposition the UK as a comparatively MFN-resilient market, capable of accommodating global price realignment through a combination of HTA flexibility, fiscal buffering, and trade insulation but should be taken with caution as the UK remains more controlled than comparable countries.
- Illustrative modelling shows the fiscal headroom created through VPAG, and the stability offered by the UK-U.S. zero-tariff agreement may not support sustained access in the case of external repricing forces.

Questions remaining

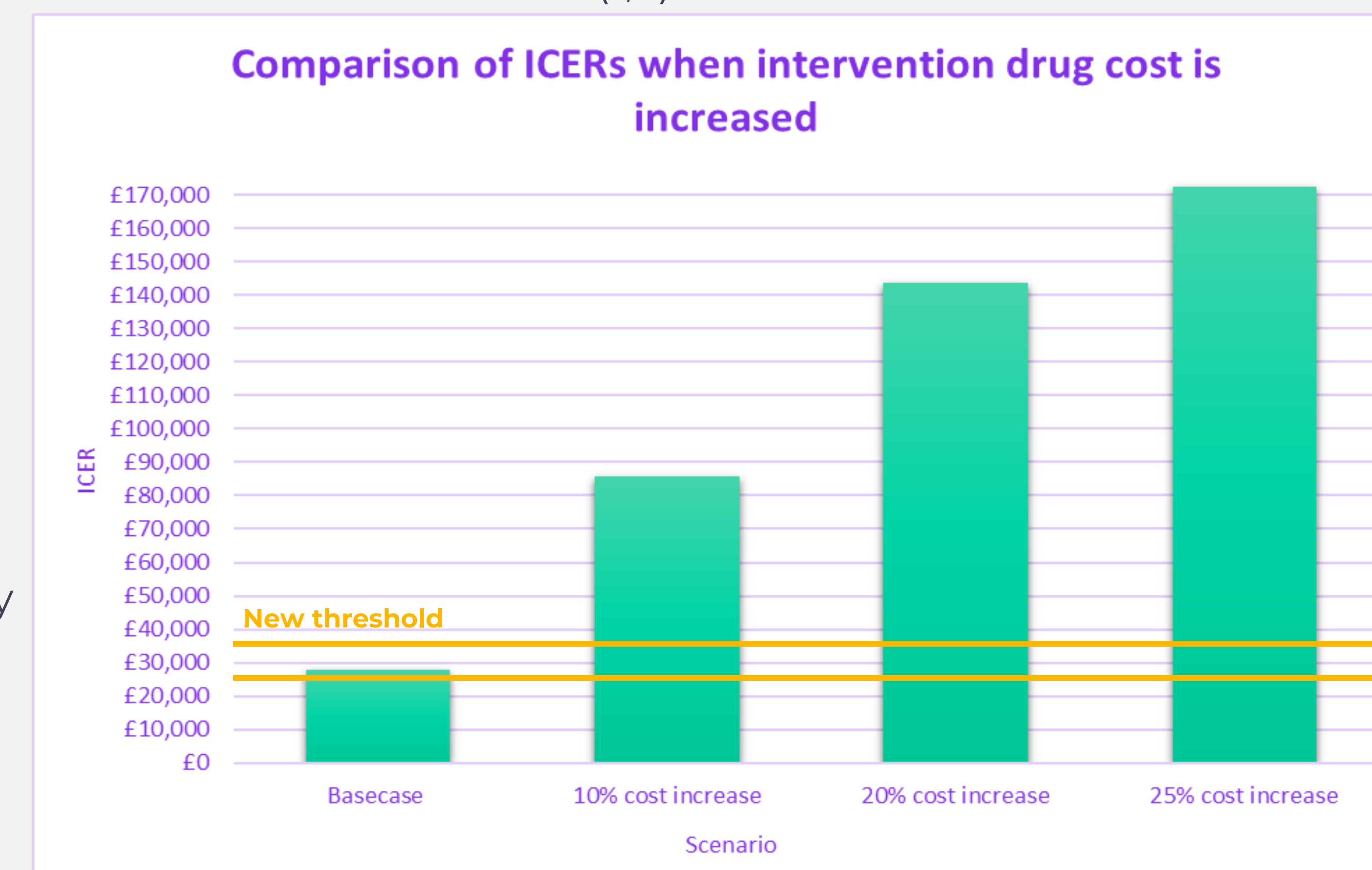
- Whether the UK price is the lowest or second lowest remains to be seen, on a case-by-case basis.
- Results of the illustrative modelling raises questions on whether manufacturers should take the risk of increasing costs. It also raises questions on whether they will refrain from launch in the UK.
- The impact on patient access to innovative drugs remains to be seen.

References

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Abbreviations

ICER: Incremental cost effectiveness ratio
MFN: Most Favored Nation
NICE: National Institute for Health and Care Excellence
QALY: Quality adjusted life years
SoC: Standard of Care
UK: United Kingdom
U.S.: United States of America
VPAG: Voluntary Scheme for Branded Medicines Pricing and Access



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