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DEAL OR NO DEAL:

The evolving use of commercial arrangements in nice appraisals

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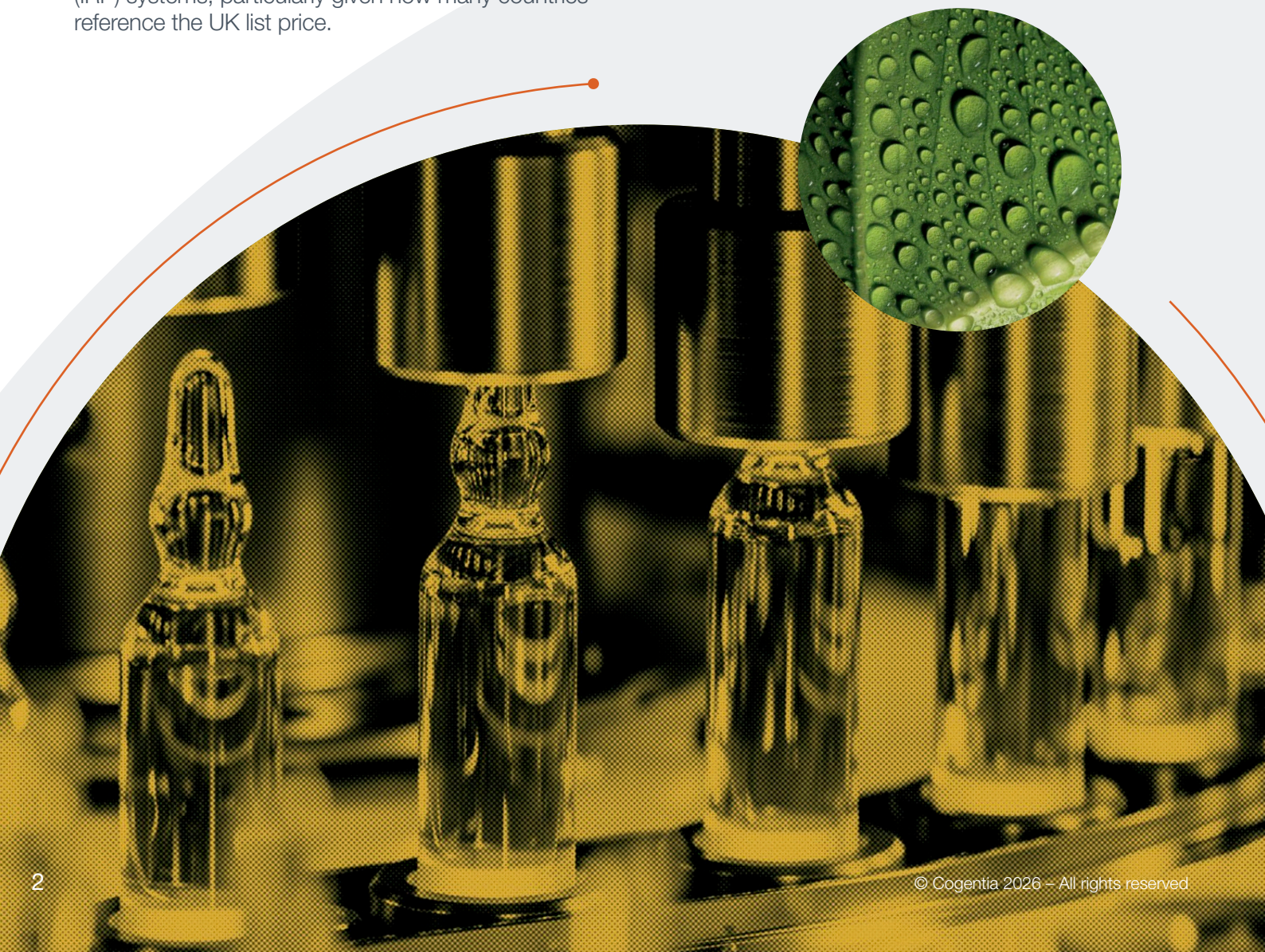
EXECUTIVE SUMMARY

Since the creation of the National Institute for Health and Care Excellence (NICE) in 1999, over 1200 medicines have been appraised for clinical and cost-effectiveness. In the early days of NICE, these medicines were typically reimbursed at list price, or via a transparently stated complex scheme such as a cost cap. As time has passed, manufacturers are increasingly reliant on confidential commercial arrangements with NHS England to facilitate access to medicines. These arrangements, which range from simple discounts through to complex deals such as indication-based pricing, expenditure ceilings and outcomes-based deals, have become a critical part of pricing and reimbursement negotiations in the UK.

Confidential arrangements serve two key purposes. For NHS England, they allow the negotiation of a cost-effective price; for manufacturers, the ability to maintain a high visible price (ie list price) mitigates the risk of spillover through international reference pricing (IRP) systems, particularly given how many countries reference the UK list price.

In recent years, Cogentia has observed an increase in the use of more complex confidential deals. A number of factors have influenced this, from a higher proportion of medicines being indicated for rare diseases, multi-indication products, to increased use of reference pricing systems, as well as the introduction of commercial schemes such as the Cancer Drugs Fund (CDF) and Innovative Medicines Fund (IMF).

To explore this theme further, Cogentia has undertaken a comprehensive analysis of all commercial deals agreed as part of NICE appraisals from the first published technology appraisal through to May 2026, plotting this over time to better characterise the change in approach, and linking this to key milestones in the evolution of UK market access where applicable to contextualise the transformation in the UK commercial landscape.



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The findings of our research are well aligned with the evolving commercial framework over the past 27 years. Uptake of simple and complex patient access schemes increased following their formalisation in the 2009 Pharmaceutical Price Regulation Scheme. Adoption of managed access and commercial access agreements (CAAs) increased following launch of the CDF and IMF in 2016 and 2022, respectively. Finally, a further increase in adoption of CAAs is noted in 2025 following the Trump administration's Most Favored Nation (MFN) policy, which is designed to align US drug costs with those paid by other developed nations.

In a world where IRP is becoming increasingly relevant through mechanisms including MFN in the USA, this trend is not surprising. Without complex commercial deals that to some extent obscure the true paid price, there is a risk that mid-sized markets such as the UK would fall further down the launch sequence for innovative medicines, with manufacturers potentially hesitant to pursue access in the UK if it risks US pricing; the USA accounts for ~50% of global revenue, compared with ~2.5% for the UK.[1]

As part of the UK-US Pharmaceutical Pricing Arrangement, the UK is piloting a number of projects, with a broader commitment to increase spending on new medicines from 0.3% of GDP to 0.6%.[2] Our expectation is that this agreement will lead to a further increase in the use of complex deals, under the umbrella of CAAs.

As the number of commercial options continues to expand, Cogentia supports our clients through timely engagement with key commercial stakeholders, as well as by exploring and modelling the viability and commercial value of a range of potential options, from indication-based pricing to expenditure ceilings.



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INTRODUCTION

For over 25 years, the National Institute for Health and Care Excellence (NICE) has been responsible for assessing new medicines in England, producing evidence-based recommendations across >1200 technology appraisals. To achieve reimbursement, manufacturers must demonstrate that their treatment is cost-effective, ie that any incremental cost to acquire the new medicine is acceptable in relation to the benefits that are expected.

Manufacturers in the UK set a list price for their medicine, informed by a number of factors including analogue assessment, product value proposition, global pricing committees and international reference pricing (IRP). Where, as is often the case, a new medicine is found not to be cost-effective by NICE at list price, manufacturers broadly have two options beyond additional evidence generation:

1. To reduce their list price
2. To provide a confidential discount

The first of these options impacts the publicly visible price, with associated implications for IRP and internal benchmarking across other markets. As such, option 2, the provision of a confidential discount, is a key mechanism for reconciling a manufacturer's global pricing strategy with the NICE requirement for cost-effective allocation of resources.

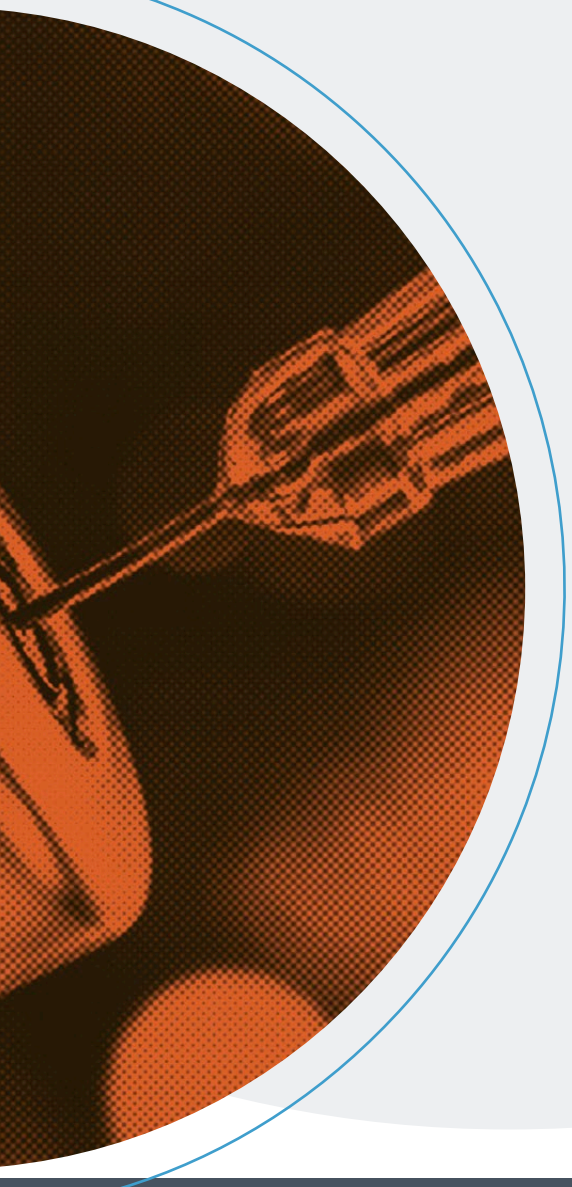
Confidential arrangements benefit both parties. Without them, manufacturers faced with the often considerable discount from list price required to achieve access in the UK would simply walk away, thereby preserving price in other jurisdictions and avoiding IRP spillover.



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Since NICE was established in 1999, commercial arrangements have evolved from informal, product-specific pricing agreements into a structured commercial framework. The introduction of formal patient access schemes (PAS) under the 2009 Pharmaceutical Price Regulation Scheme (PPRS) marked the beginning of this evolution, offering the opportunity for confidential discounts.

Commercial arrangements have since expanded, with strengthened collaboration between NHS England and industry allowing commercial flexibility to facilitate timely patient access. Published schemes place greater emphasis on faster access to innovative medicines, sustainable NHS spending and the use of increasingly complex commercial agreements to manage clinical and financial uncertainty.



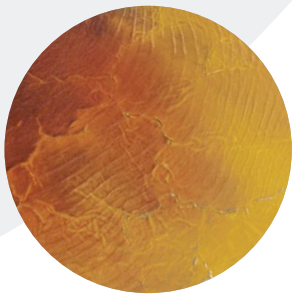
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> *To deliver patient access to proven, affordable and transformative medicines in a financially sustainable way.*
>
> **– NHS England commercial framework, 2025**

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‘To deliver patient access to proven, affordab le and transformative medicines in a financially sustainable way.’ – NHS England commercial framework, 2025

What started as relatively simple flat discounts has developed into a commercial system that allows confidential pricing agreements, outcome-based reimbursement, indication-specific pricing and cost caps in order to manage financial risk and mitigate uncertainty. These options, as well as others detailed in the latest NHS England commercial framework, are described below.



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TYPES OF COMMERCIAL ARRANGEMENTS

Commercial arrangements have become an important mechanism for improving patient access to innovative medicines.[3] The mechanisms available range from simple confidential discounts to more tailored agreements to manage affordability. The appropriate arrangement depends on the nature of the access challenge: acquisition cost, discretion or further evidence generation. Together, these mechanisms allow NICE and NHS England to address distinct but overlapping challenges relating to value.[4] A detailed overview of these schemes is outlined in Table 1.

Table 1. Overview of simple and complex PAS used in NICE technology appraisals

Type of agreement	Mechanism and aim	Advantages	Limitations
Simple PAS	Applies a confidential percentage discount or fixed price reduction to improve cost-effectiveness while maintaining the published list price	• Rapid implementation • Minimal administration • Supports reference pricing • May accelerate NICE recommendation and patient access	• Does not address clinical uncertainty or link payment to outcomes • May be insufficient for substantial uncertainty
Complex PAS	Uses arrangements beyond a simple discount to improve cost-effectiveness while managing uncertainty relating to treatment effectiveness, duration or financial risk. The details of this deal are publicly disclosed	• Shares risk between the NHS and manufacturer • Improves affordability of high-cost medicines • May enable access where a simple PAS is insufficient	• More difficult and costly to implement • May require patient and utilisation monitoring • Limited confidentiality may reduce manufacturer participation
Commercial access agreement (CAA)	Uses confidential terms negotiated between the manufacturer and NHS England, potentially combining several mechanisms, where a simple PAS is insufficient	• Greater commercial flexibility • Can combine multiple mechanisms • Manages price, uptake and financial risk • Can reflect indication-specific value	• Available at NHS England's discretion • May require monitoring and reconciliation • Must be implementable consistently across the NHS

**Unique to gene therapies targeting rare diseases.*

Simple PAS

Simple PAS were introduced to support the reimbursement of medicines that would not represent acceptable value for money at their published list price. Under a simple PAS, the manufacturer offers the NHS a confidential percentage discount or fixed price reduction, reducing the net acquisition cost while maintaining the published list price to support reference pricing. Simple PAS remain the predominant form of commercial arrangement used in NICE technology appraisals. Their continued prevalence reflects their ease of implementation.

Complex PAS

Complex PAS are financial arrangements beyond a simple discount, used to improve cost-effectiveness while managing clinical uncertainty or financial risk between the NHS and the manufacturer. These agreements include additional conditions around treatment effectiveness or duration and improve the affordability of high-cost medicines. Some examples include dose caps, free initiation and outcomes-based agreements. The type of scheme used in a complex PAS is transparently reported. Although complex PAS are still occasionally used, they have become less prominent since the broader, more flexible, confidential CAAs emerged as an option.[3]

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CAAs

CAAs are the newer, broader successor to complex PAS. Unlike complex PAS, where the agreed scheme is publicly reported, CAAs are confidential. Commercial terms are negotiated directly between the manufacturer and NHS England, providing greater flexibility in how financial risks are managed. Compared with simple PAS, CAAs are relatively uncommon and may be considered when the medicine offers enhanced value, typically at or below NICE's cost-effectiveness threshold.[5] A CAA may use one or more mechanisms to manage the financial risk, outlined in Table 2.

Table 2. Overview of the types of CAAs used in NICE technology appraisals





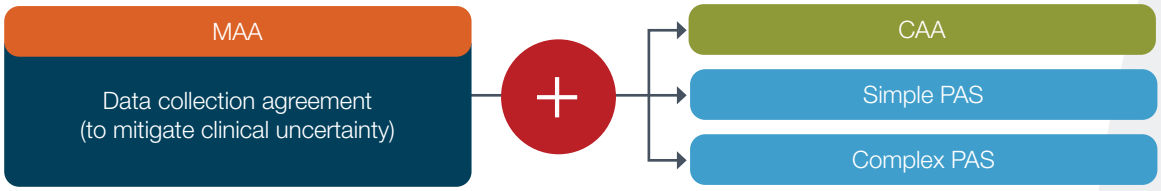

Type of agreement	Mechanism and aim	Advantages	Limitations
Budget cap	Sets a maximum expenditure level, with spending above the cap triggering a manufacturer rebate	• Rapid implementation • Provides budget certainty • Limits financial exposure • Supports access to high-cost or high-volume medicines	• Requires expenditure monitoring and rebate reconciliation • Manufacturer bears expenditure above the cap
Price-volume agreement	Links the net price to uptake, with price reductions or repayments applying above an agreed volume threshold	• Links price to actual use • Reduces risk from unexpectedly high uptake • May support wider access	• Requires accurate utilisation data • Requires threshold monitoring and repayment calculations • Uptake may differ from forecasts
Cost sharing	The manufacturer funds a defined component of treatment, reducing the average NHS cost and sharing financial risk	• Reduces NHS acquisition costs • Preserves the list price • Protects the NHS from part of the expenditure	• Requires manufacturer-funded treatment to be tracked • Requires stock or invoice reconciliation • Savings depend on treatment duration
Start/stop criteria	Defines eligibility and continuation rules so treatment is used only in patients who meet specified criteria or continue to benefit	• Supports appropriate patient selection • Promotes consistent use • Limits ineffective treatment and expenditure	• Requires eligibility checks and monitoring • Criteria may be difficult to apply consistently • Increases clinical administration
Outcomes-based agreement	Adjusts the price or payment when predefined outcomes are not achieved, linking expenditure to observed performance	• Links payment to observed benefit • Shares outcome-related risk • Reduces the cost of underperformance	• Requires outcome collection and validation • Requires financial reconciliation • Expected outcomes may be difficult to specify
Indication-specific pricing	Applies different effective net prices across indications to reflect differences in clinical benefit and cost-effectiveness	• Aligns price with indication-specific value • May support access across different populations • Allows a single operational purchasing price	• Requires indication-level utilisation data • Requires reconciliation of expected and actual use • More complex than a single discount

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Managed access agreements (MAAs)

Managed access agreements (MAAs) provide patient access, typically for 3 to 5 years, while additional evidence is collected to address uncertainties identified during NICE's initial appraisal. They are used when a technology has the potential to be cost-effective but the clinical evidence is not considered sufficient to support routine reimbursement. Companies work with NICE, NHS England and other relevant stakeholders to agree the clinical evidence requirements and data collection plan (Figure 1). Funding is supported by either the Cancer Drugs Fund (CDF) for oncology indications or the Innovative Medicines Fund (IMF) for non-oncology indications.[6, 7]

Figure 1. MAAs are used in combination with commercial arrangements to collect clinical data while supporting patient access





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REVIEW OF PROCESS FOR NEGOTIATING/IMPLEMENTING DEALS

Applying for a PAS in England

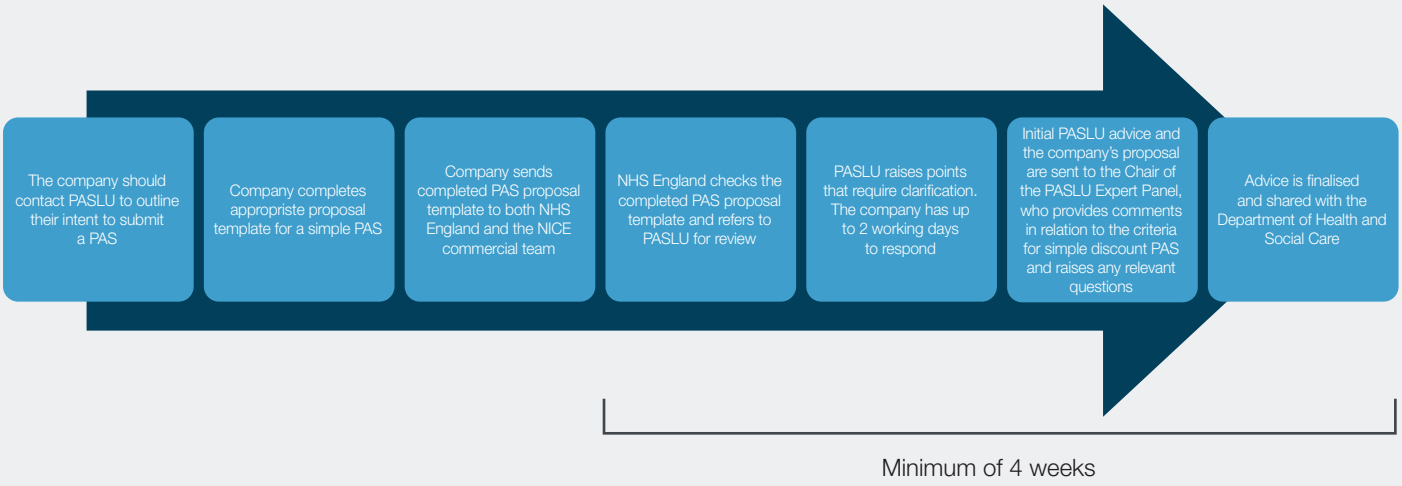
NHS England states that if a company is bringing forward a PAS proposal in the context of a NICE evaluation, this should be done either within the company's initial evidence submission to NICE or at the end of the evaluation process once appeals have been heard and NICE's final guidance has been issued to the NHS. In the case of the former, this requires that a PAS proposal has been submitted to NHS England before the company's NICE submission deadline for that medicine. Only in exceptional circumstances may a simple PAS proposal be accepted at other stages during the NICE appraisal process.

The primary stakeholder involved in evaluating PAS proposals in England is the Patient Access Scheme Liaison Unit (PASLU), an advisory unit at NICE that advises NHS England on the feasibility of implementing drug pricing and access proposals.

Simple PAS

When the company shares their simple PAS proposal with NHS England, NHS England will check the submitted template and then refer the application to PASLU, which will review the submitted proposal and offer advice to NHS England regarding whether the proposed scheme is feasible to implement. When making their recommendations, PASLU considers the simple discount PAS criteria and key principles of implementation outlined in their procedure guidance. This guidance reaffirms the operational independence of NICE and NHS England and respects the role of each stakeholder, while ensuring that any PAS is operationally manageable.[8] After reviewing the evidence submitted by the company, PASLU develops draft advice on the feasibility of implementing the proposed scheme in the NHS. NICE does not comment on a scheme being considered by the PASLU until the review procedure has been completed and the final advice has been sent to NHS England.

An overview of the process for proposing a simple PAS in England is summarised in Figure 2.



Adapted from NICE PASLU guidance[8]

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Complex PAS

As suggested by its name, the process of applying for a complex PAS is more elaborate, as outlined in Figure 3. In its guidance, PASLU states that the timescales for all stages are given as guidance only and the time for each stage can vary substantially according to the needs of each proposal.

Figure 3. Process for proposing a complex PAS in England

	Week 1	Week 1–6	Weeks 7–12
The company should contact PASLU to outline their intent to submit a PAS	Proposal submission	Clarification Input from NHS Review Group Draft advice prepared	Factual error checks Expert panel meeting Final advice to NHS England
	• Company completes appropriate proposal template for a complex PAS • Company sends completed PAS proposal template to both NHS England and the NICE commercial team	• NHS England checks the completed PAS proposal template and refers to PASLU for review • PASLU raises points that require clarification. The company has up to 5 working days to respond • Consultation with PASLU NHS Review Group • Draft advice prepared (with legal advice, if required) and shared with company for factual error checks	• Expert Panel considers the draft advice developed by PASLU to discuss the feasibility of implementing the proposed PAS in the NHS. Representatives of the company are invited to attend part of the expert panel meeting to provide clarification on any points that members of the Expert Panel might raise • The Expert Panel considers and discusses the information provided. The Expert Panel formulates its views on the proposed schemes in a private session after the topic specialists and representatives of the company have left the meeting • PASLU develops the final advice and, following factual accuracy checks by the company, issues the advice to NHS England

Adapted from NICE PASLU guidance[8]

CAA

A CAA can only be considered if a PAS proposal has been fully explored with the NICE commercial team. If NICE identifies that a technology is unlikely to achieve cost-effectiveness with only a PAS, the NICE commercial team will liaise with NHS England to discuss whether a CAA proposal should be considered. At this point, NHS England might contact the company to discuss this option. If a CAA is to be pursued, stakeholders at NICE prepare a pre-appraisal committee meeting (ACM) commercial summary confirming the commercial arrangement being considered and outlining the risks to cost-effectiveness or budget impact that might result from the arrangement. This summary is shared with the company and NHS England up to 4 weeks before the first ACM.[5]



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EVOLUTION OF THE UK COMMERCIAL FRAMEWORK

The evolution of commercial arrangements in NICE technology appraisals reflects a gradual shift from evidence-based recommendations to an integrated model of clinical, economic and commercial decision-making. Over time, successive pricing schemes have expanded the range of agreements and normalised the use of PAS, CAAs and MAAs as tools for improving affordability and patient access.

1999–2006: Early years of NICE

NICE was established in 1999, with the aim to create consistent guidelines to end the 'rationing of treatment by postcode'. Technology appraisals had the sole purpose of creating an evidence base that improved patient access and reduced health inequalities.[9] Early technology appraisals had no commercial schemes.



2007–2008: Early commercial schemes

The first evidence of a complex arrangement emerged in 2007, when NICE recommended bortezomib monotherapy for multiple myeloma, representing an early form of outcomes-based risk sharing.[10] The first dose-capping agreement was seen shortly after in 2008 for ranibizumab and pegaptanib in wet age-related macular degeneration, with the manufacturer covering treatment costs beyond a specified number of injections.[11] These schemes show that commercial arrangements predated 2009 and were implemented very rarely on a case-by-case basis rather than through a standardised process.

2009: The Pharmaceutical Price Regulation Scheme (PPRS)

Effective from 1 January 2009 and running for 5 years, the PPRS introduced flexible pricing arrangements and the formal adoption of PAS. It incorporated PAS into the voluntary pricing agreement between the government and the pharmaceutical industry, establishing a more systematic route for their assessment alongside NICE appraisals.[12] This 2009 agreement coincided with the first meaningful increase in commercial schemes, as it created the procedural framework that allowed companies to formally propose discounts or complex arrangements as part of NICE appraisals. NICE subsequently established its internal PASLU, used to assess the feasibility of proposed schemes for the NHS.

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2014: Updated PPRS

Replacing the 2009 PPRS, the updated 2014 PPRS retained the flexible pricing and PAS framework established under the previous agreement while formally distinguishing between simple and complex PAS. Complex schemes were subcategorised as 'rebates, stock supplied at zero cost, dose capping, outcome-based schemes, expanding the awareness and use of commercial flexibility.[13]

2016: Cancer Drugs Fund reform

The CDF was originally introduced in 2010, to fund cancer medicines that were not routinely available through the NHS, including treatments that NICE had rejected or not yet assessed. However, it was deemed financially unsustainable and funded treatments offering limited value.[6]The 2016 reform restored NICE's central role in deciding which cancer medicines should receive NHS funding. It also converted the CDF into a managed access fund operating within a fixed £340 million budget. However, it was deemed as financially unsustainable and funded treatments offering limited value.[6] The 2016 reform restored NICE's central role in deciding which cancer medicines should receive NHS funding. It also converted the CDF into a managed access fund operating within a fixed £340 million budget. This new model allowed access to new treatments alongside collection of additional evidence to address clinical uncertainty, giving rise to MAAs (Figure 1).[6]



2017: Budget impact tests

In 2017, NICE and NHS England introduced a formal budget impact test into the technology appraisal process. If a new technology was expected to cost the NHS more than £20 million in any of its first 3 years of use, this triggered additional commercial negotiations between the NHS and the manufacturer. When a medicine created significant affordability pressures, the NHS could manage financial and operational impact through funding variation requests, which might include phased implementation over a longer period. This marked an important turning point: a medicine could be considered cost-effective by NICE yet still require further negotiations because of its total financial impact on the NHS, adding a new driver for price discounts and commercial arrangements.[14] This mechanism was applied more recently to tirzepatide for obesity. With the eligible population for this drug being 3.4 million people in England, it was estimated to cost the NHS £317 million per year by Year 3, well above the budget impact threshold. A funding variation request led to a phased implementation approach, prioritising 220,000 patients over 3 years and aiming to treat the full eligible population over 12 years.[15]

2019: Introduction of the Voluntary Scheme for Branded Medicines Pricing and Access (VPAS)

The Voluntary Scheme for Branded Medicines Pricing and Access (VPAS), introduced in 2019 to replace the 2014 PPRS, was a voluntary agreement between the Department of Health and Social Care (DHSC) and the Association of the British Pharmaceutical Industry, running until 2023. Instead of regulating the list price of each individual medicine, VPAS capped growth in overall NHS spending on branded medicines at 2% a year. If medicines exceeded that level, participating companies made payments to the NHS based on their eligible net sales. VPAS strengthened the formal collaboration between NHS England and industry and committed NHS England to developing a national commercial framework for new medicines.[16]

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2021: Publication of the NHS England commercial framework

In 2021, the publication of the official NHS commercial framework for new medicines outlined the types of commercial deals and clarified the pathway to routine commissioning in the NHS and circumstances that would be considered. Its aim was to facilitate faster and more streamlined discussions about value and affordability and to clarify the commercial flexibilities available within NICE and NHS England. The framework provided clear guidance on how the mechanisms fitted together, including the details of simple and complex PAS, CAAs and MAAs.[17]

2022: Innovative Medicines Fund

Following the success of managed access through the CDF, NHS England commissioned the IMF in June of 2022. Its goal was to expand coverage of managed access funding for rare conditions and smaller patient populations. The proposed fund of £340 million a year aimed to give 'quicker access to the most advanced, lifesaving treatments'.[7]

2024: Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) replaces VPAS

The expiry of VPAS in 2023 led to a review of the agreement by the DHSC with a large input from industry. Manufacturers were called to submit proposals and evidence in relation to the 2% growth cap.[18] The Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) came into effect in 2024 with an improved affordability mechanism. Following on from VPAS, its aim was to limit NHS spending on branded medicines. Where sales exceed the agreed allowance, participating pharmaceutical companies make payments to the DHSC based on their eligible sales. VPAG introduced a new affordability mechanism that differentiates between newer and older medicines and will allow the growth rate to rise from 2% in 2024 to up to 4% in 2028.[19] Beyond expenditure control, VPAG included commitments to improve the access and uptake of newer medicines. VPAG established an investment fund to support clinical research, medicines manufacturing and health technology assessment (HTA) infrastructure.

The evolution of policy and commercial frameworks has directly shaped NICE appraisals. The following analysis examines how these changes have influenced the use of commercial arrangements over time.

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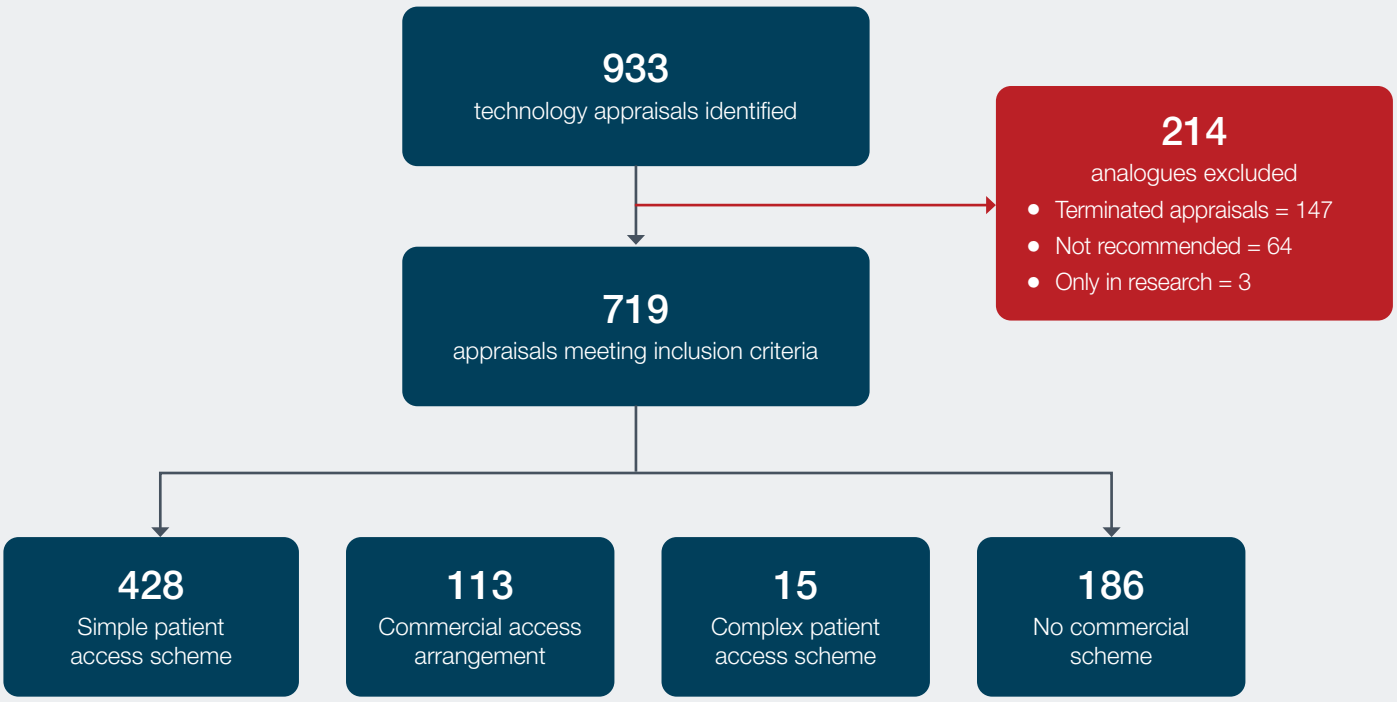
A HISTORICAL ANALYSIS OF COMMERCIAL DEALS

Recognising that commercial arrangements are an increasingly important tool for companies seeking to demonstrate cost-effectiveness and strengthen their value proposition during NICE appraisals, Cogentia has conducted an analysis to quantify the proportion of NICE appraisals incorporating a commercial arrangement and characterise how their use has evolved over time.

A review of the NICE website was conducted in May 2026 to identify technology appraisals containing a commercial arrangement. This research leveraged the list of technologies recommended by NICE that include a commercial arrangement and was supplemented with additional research into appraisals for which no entry was included. Appraisals that were terminated, superseded, non-recommended or recommended only in research were excluded. No date restrictions were applied.

Of the 933 appraisals identified, 719 met the inclusion criteria (Figure 4). As expected owing to its ease of implementation, the simple PAS was the most observed commercial deal, appearing in 428 (60%) appraisals. CAAs were included in 113 (16%) NICE-recommended technology appraisals, with nearly all of these observed after the launch of managed access routes such as the CDF and IMF. Complex PAS arrangements were rare, featuring in only 15 (2%) appraisals, consistent with NHS England's preference for commercial schemes with low administrative burden. Notably, one-quarter of appraisals (n=186, 26%) included no commercial scheme at all – a pattern largely explained by the absence of a formal commercial framework during NICE's early years, and potentially skewed by primary care medicines, where confidential rebate mechanisms are typically used in place of PAS. For a reminder of how these commercial schemes are defined, please see Table 1.

Figure 4. PRISMA diagram of included appraisals and their commercial schemes

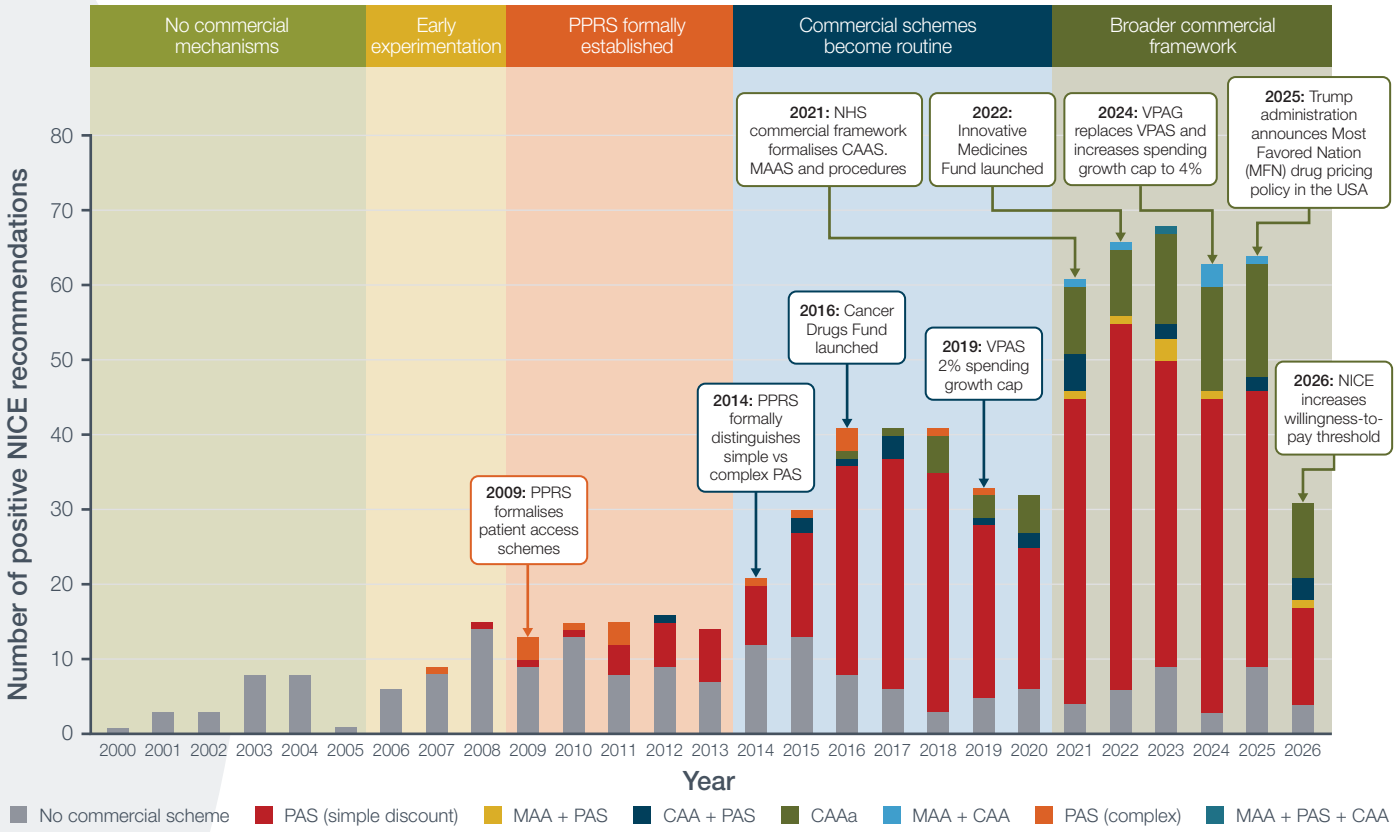


Total exceeds 719 as some appraisals included both a simple PAS and a commercial access agreement

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To understand the incidence of commercial deals across time, and how their usage aligns with evolving frameworks, a stacked column chart of commercial deals included in NICE-recommended technology appraisals is presented in Figure 5.

Figure 5. Evolving use of commercial mechanisms in NICE technology appraisal recommendations



Analysis performed in May 2026.

A decrease in appraisals from 2019 to 2020, owing to the COVID-19 pandemic. NICE temporarily paused or delayed some appraisals and redirected resources towards urgent COVID-19 guidance. Some delayed appraisals were subsequently completed in 2021.[20]

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The findings of our research are well aligned with the evolution of the commercial framework described in the previous section. In the early periods of NICE, the use of simple and complex PAS remained low, underlining that commercial schemes were exceptional rather than routine. However, an increase in PAS usage was observed following the PPRS formalisation in 2009. By 2011, approximately 47% of NICE recommendations included either a simple or complex PAS, and use has remained consistently high since 2016. The first example of the simple PAS appeared in 'Ranibizumab and pegaptanib for the treatment of age-related macular degeneration' (TA155), published in 2008.[11] Of the 15 complex PAS agreements (formally distinguished from simple PAS in 2014), nine involved free stock, three a dose cap and the remaining three comprised an outcomes-based agreement, a single fixed price and a response scheme.

In contrast, CAAs were almost entirely absent before 2016 but have grown steadily following the launch of the CDF and, subsequently, the IMF as managed access routes, for which a commercial agreement (alongside a data collection agreement) is a prerequisite. A further spike in commercial schemes was noted in 2021, following both the COVID-19 pandemic (and reprioritisation of NICE resources accordingly), and the publication of the NHS England commercial framework.



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Interestingly, our analysis suggests an increase in the number of CAAs being proposed by companies and accepted by NICE, particularly in 2026, with over half (14 of 27) of products with a commercial deal involving a CAA as of our data cutoff. While it would be premature to draw firm conclusions from this observation, one plausible driver is the increased focus on reference pricing introduced by the Trump administration's Most Favored Nation (MFN) policy. MFN is designed to align US drug costs with those paid by other developed nations, and depending on the model applied, this benchmark may include net prices after commercial discounts. Since the USA is typically the largest single driver of pharmaceutical company revenue, even a partial narrowing of this pricing gap carries material revenue risk. By pursuing more complex commercial schemes, manufacturers may have more success in obscuring the true price paid in the UK relative to a simple PAS, which may in turn reduce the risk of unfavourable reference pricing being applied. For mid-sized markets like the UK, such strategies are likely to be of increasing importance to avoid delays in access as manufacturers consider launch sequencing implications of MFN.



Separately, a leaked DHSC document, titled 'HMG commitments following the Joint Taskforce', was shared with the newswire APM Market Access and outlined four pilot schemes aimed at strengthening the commercial environment for medicines.[21] Among these is a proposed reform to the managed access pathway that would allow reimbursement at the cost-effective price for existing patients even when a medicine is not ultimately recommended at the end of managed access. If these leaked proposals are accurate, it will be worth watching whether this reform meaningfully shifts appetite towards MAAs.

Overall, commercial schemes have become routine in NICE appraisals, featuring in the vast majority of positive NICE recommendations, with 86% of recommendations in 2025 including some form of commercial mechanism to enhance the technology's value proposition. Early arrangements centred on complex PAS, before simple PAS discounts became the dominant mechanism; more recently, CAAs have grown rapidly, though their use remains far below that of simple PAS. Since 2015, most appraisals have featured a commercial scheme, and manufacturers should now treat them as a core component of their NICE submission strategy.

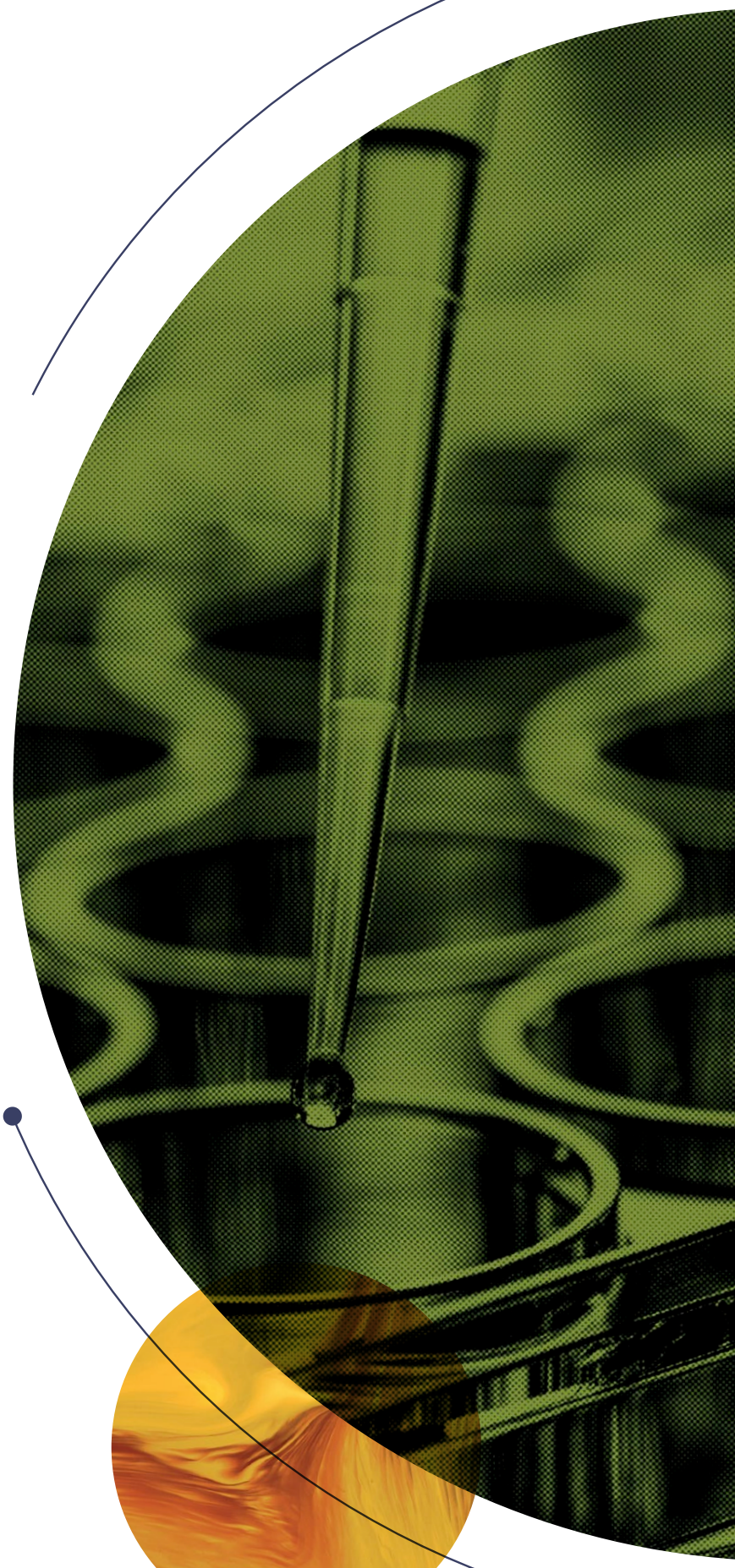
If you would like guidance or advice on applying for commercial arrangements within an upcoming HTA submission, please contact **enquiries@cogentia.co.uk** to learn more about how Cogentia can support with this.

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