

A Decisionmaker's Guide to Competing Health Evidence

Most-Favored-Nation Drug Pricing: Five Policies, One Unverifiable Promise

Americans pay more than three times what other wealthy countries pay for the same brand-name drugs after rebates. The Trump administration says it has a fix: tie U.S. prices to what other countries pay. What it has built so far is 26 confidential deals whose terms no one outside government can read, a Medicare model covering about four companies, and savings projections no one can check against public data. Here is what the evidence shows, where it runs out, and what to watch as the legal and legislative fights unfold.

AT A GLANCE

- **What it does:** MFN ties what the U.S. pays for a drug to what other wealthy countries pay. Which countries, which price, and how it's enforced differ across the four mechanisms (confidential company deals, a Medicaid rebate program, a Medicare Part B model now covering about four companies, and the TrumpRx cash-price site), which is most of why the debate is confusing.
- How big it is: U.S. net prices for brand-name drugs run **more than three times those abroad**, and brand-name drugs are 87 percent of U.S. drug spending despite being 7 percent of prescriptions.
- **What's at stake:** Whether the U.S. can import other countries' prices without importing their delays in getting new drugs, and whether companies respond by raising prices abroad, cutting research, or waiting out a three-year deal.
- **What the evidence shows:** The price gap is well documented; the Medicaid model has launched but reported no results, the Medicare model starts in 2027, and the evidence that MFN would change what any payer actually pays comes almost entirely from administration estimates no one outside government can yet check.

Here's what the past year tells you. There's the MFN that could exist on paper, and there's the MFN the administration has built so far: deals whose terms are confidential, a Medicare model from which all 26 signing companies are exempt, leaving about four, a Medicaid model that states join one drug at a time, and,

for commercial insurance, a promise about future launch prices and nothing else. None of the savings figures attached to any of it can be checked against public data. The details follow. The White House says **26 companies** covering 89 percent of the brand-ed market have signed MFN deals. Only two have been seen outside government, and only because **Public Citizen sued** for them; both came back with the drugs, prices, and exit terms blacked out. **Four congressional committees** asked for all the deals in March and haven't gotten them. The administration's **own economists** project \$529 billion in ten-year savings from new drugs launching at MFN prices, on the assumption that U.S. net prices fall about 30 percent, plus \$64.3 billion for Medicaid; **fact-checkers** call the launch-price assumption aspirational, and no data exist to test it. CMS finalized the GLOBE model on September 30, a mandatory Medicare Part B test starting in 2027 that CMS's own actuaries (the agency's in-house cost estimators) expect to save **\$440 million over seven years**, down from \$11.9 billion in the proposal, because companies in the Medicaid model are exempt and **CMS expects only four manufacturers** to be left in it. PhRMA **sued to block it** on October 7. A companion Part D model, GUARD, hasn't been finalized. TrumpRx, the cash-price website, **launched in February**; the White House credits it with \$700 million in savings but **hasn't said how it counted**. One more thing before the numbers: "MFN" is really five different policies with different benchmarks and different evidence. Section 2 separates them.

Who's Saying What

This map describes public positions of major stakeholders. It does not endorse or evaluate them.

The administration. The **White House and Council of Economic Advisers** frame MFN as ending “global freeloading” and **project \$529 billion in savings over ten years**. The President has asked Congress to write it into law. **CMS** calls GLOBE a test that will **lower costs “while preserving medical innovation.”**

Congress. **Senators Josh Hawley and Peter Welch** introduced a **bipartisan bill** that would fine companies for charging more in the U.S. than an international average. **Senator Ron Wyden and three other ranking members** have **requested unredacted copies** of every deal and say Congress can’t write into law what it can’t read. **Senator Elizabeth Warren** has **challenged the \$700 million TrumpRx claim**.

Patient and consumer groups. **Patients For Affordable Drugs Now** **backs an enforceable statutory version of MFN** but calls the voluntary deals secret,

short-term, and limited to Medicaid. **AARP supported the proposed Part D model** while reaffirming support for IRA negotiation. **Public Citizen** sued for the contracts and **says what it got** helps companies raise prices abroad more than it helps patients here.

Industry. **PhRMA opposed the executive order** the day it was signed, blaming high U.S. prices on foreign underpayment and middlemen, and on October 7 it **sued to block GLOBE** as beyond CMS’s authority. PhRMA supports pressuring other countries to pay more. The **26 signing companies** describe their deals as wins for patients and cite the three-year tariff exemption as “a predictable investment environment.” A **Midsized Biotech Alliance** **argues** single-product companies can’t absorb MFN the way large firms can.

Foreign governments. The **United Kingdom** is the first reference country to respond, **raising the price threshold** its health system uses to approve new drugs in exchange for zero U.S. tariffs. No other reference country has followed.

1. Why This Matters Right Now

Americans pay more for brand-name drugs than anyone else. The **best comparison we have**, from RAND using 2022 data, found U.S. prices for brand-name drugs were more than four times what other wealthy countries paid at list, and still more than three times as high after accounting for U.S. rebates (the discounts drug companies pay back to insurers and government programs after the sale). Nobody disputes the gap. The fight is over what to do about it. “Most-favored-nation” pricing, or MFN, borrows a term from trade law, where one country promises another the best terms it gives anyone. Here it means the U.S. should pay no more than what a small group of rich countries pay for the same drug. Take Enbrel, a rheumatoid arthritis drug. **A month’s supply costs \$3,354 on TrumpRx**, the administration’s own discount site; the average across 11 wealthy countries is \$641. Under the company deals and the Medicaid program, the U.S. price would be capped at roughly the second-lowest price among eight such countries; the Medicare model uses a different benchmark, which Section 2 explains. The first Trump administration issued a mandatory Medicare version in 2020; courts blocked it on procedural grounds before it took effect. The second has gone a different way: private deals with drug companies, backed by tariff threats, plus new Medicare and Medicaid test programs. The question is whether tying U.S. prices to foreign prices lowers what Americans pay without changing which drugs get made, when they launch, or whether patients can get them. The honest answer right now is that we don’t know, because the deals are secret, the programs are new, and the other countries may respond by changing their own prices.

2. Why Do Smart People Disagree?

Americans pay about three times what Germans or Canadians pay for the same brand-name drugs. That has held up across twenty years of studies. Other countries get lower prices the way governments usually do: one body negotiates, and it’s willing to refuse to cover a drug until the price comes down. The U.S., outside the VA and Medicaid’s statutory rebates, mostly hasn’t. The gap is real. The deals are a black box. And the only finalized federal MFN model, GLOBE, has been narrowed until it covers about four companies. None of that is in dispute.

What's in dispute is which question you're asking. A lot of the arguing comes from people using "MFN" to mean five different policies:

1. **The company deals.** The benchmark is the second-lowest net price across eight countries (the G7 plus Switzerland and Denmark). Companies promise MFN prices for Medicaid, MFN launch prices on new drugs, and cash discounts on TrumpRx. Enforcement is a tariff threat. Terms are confidential.
2. **GENEROUS (Medicaid).** This is CMS's name for its Medicaid MFN program (the capitals are an acronym, not emphasis). Companies pay states an extra rebate to bring Medicaid's price down to the benchmark. Medicaid already gets large rebates by law, including one tied to the lowest commercial price, so the extra savings are limited.
3. **GLOBE and GUARD (Medicare).** These are CMS's names for its Medicare MFN programs, one for drugs given in doctors' offices (Part B) and one for pharmacy drugs (Part D). They don't set prices. They recalculate an existing rebate against an international benchmark: the lowest price across 19 countries, not the second-lowest. GLOBE runs in a random quarter of the country starting 2027. Its projected savings fell from \$11.9 billion to \$440 million between proposal and final rule for three reasons: companies in the Medicaid model are exempt, and all 26 deal signers are in it; drugs with an IRA-negotiated price are excluded; and the rebate was redesigned to apply only to price growth above the benchmark rather than to the whole price. After those changes CMS expects about four manufacturers in year one and two in year two. The savings are small. GUARD, for Part D (Medicare's pharmacy drug benefit), isn't final.
4. **TrumpRx.** A government website listing cash prices; the company deals require signers to sell some drugs through it. It's a purchase outside insurance; it doesn't count toward your insurance plan's deductible or out-of-pocket limit. At launch the site mostly routed buyers to the manufacturers' own direct-sale programs, such as LillyDirect and NovoCare. It helps the uninsured and people whose plans won't cover a drug. For most insured people, the copay is lower.
5. **MFN launch prices.** The promise that future drugs launch at the MFN price for all U.S. payers. The CEA's \$529 billion estimate, meaning ten years of lower drug spending across all U.S. payers combined, is for this piece alone, and no public data exist to check it.

Once you separate these, the disagreements sort themselves.

THE QUESTIONS BEHIND THE DEBATE

 The question being asked	 What evidence would answer
Are federal programs paying less than they would have?	Net Medicare and Medicaid spending compared with what they'd have paid anyway, after existing rebates
Are patients paying less at the pharmacy?	Out-of-pocket costs by insurance type; TrumpRx usage data, which don't exist
Has the U.S.–foreign gap narrowed, and from which side?	U.S. net prices and foreign net prices over time; both can move
Will companies launch new drugs at MFN prices, or delay and withhold them?	Launch prices and launch timing here and abroad, against pre-2025 patterns
Does this change what gets developed?	Research spending and new drug counts over decades; long lags, many confounders
Can the executive branch do this at all?	The PhRMA v. HHS ruling on GLOBE; what happens to the deals after January 2029

The real disagreement isn't whether U.S. prices are too high. It's whether to pull U.S. prices down, push foreign prices up, or neither, and whether a set of confidential deals that expire in 2029, plus a Medicare model with about four companies in it, can be evaluated as policy at all.

3. What Does the Evidence Show?

It depends which of the five MFN policies you mean. The evidence that U.S. prices are high is strong. The evidence that reference pricing lowers prices in the country doing the referencing is decent, mostly from Europe, and comes with a known side effect: later launches, or no launch, in the countries being referenced. The evidence that the current deals would change what any American pays consists of administration estimates no one outside government can check, because the Medicaid model has produced nothing publicly measurable, the Medicare model hasn't started, and TrumpRx publishes no usage data. The current policy's effect on access abroad can't be measured yet either; what we have is earlier European evidence that reference pricing can delay launches, plus early reports from this year.

How MFN is supposed to save money

A company sells a drug in the U.S. and in eight other countries. Under the deals (the federal models use different country lists and benchmarks), it agrees the U.S. net price won't exceed the second-lowest of the eight. One caveat on the benchmark itself: the foreign prices used in every MFN mechanism are either published prices or figures the manufacturer reports, and neither captures the confidential discounts other countries negotiate. So an "MFN price" can still sit above what those countries actually pay. That leaves two ways to comply. The company can cut the U.S. price, which saves Americans money. Or it can raise its foreign prices (or stop selling in the cheapest countries) so the benchmark rises to meet the U.S. price. That second route saves Americans nothing. It narrows the gap by making other countries pay more, which the administration has said is a goal in itself; Pfizer's contract even **pays HHS a share of the extra foreign revenue**.

For Medicaid, the mechanism is an extra rebate on top of what Medicaid already collects by law: **at least 23.1 percent off for brand drugs, a penalty when prices rise faster than inflation, and a "best price" rule** guaranteeing Medicaid the lowest price any commercial buyer gets. For some older drugs whose prices rose fast, the inflation penalty already pushes Medicaid's net price close to zero, so MFN can't lower it further. So the question isn't how far below list the MFN price is. It's how far below what Medicaid was already paying. For some drugs that could be a lot. For others, nothing. There's a catch on the other side of the ledger too. To get the rebate on a drug, a state has to **adopt coverage rules negotiated by CMS and the manufacturer**, which may be looser than the rules the state uses now. A lower price on a drug more people take can cost more in total. For GLP-1s, that's not a hypothetical.

The price gap

RAND's 2024 study, led by Andrew Mulcahy, is the standard reference: U.S. brand-name prices were 422 percent of other countries' at list, and more than three times as high after adjusting for U.S. rebates. The authors couldn't adjust for foreign rebates, which are also secret, and those would push foreign net prices lower still, so the true net gap is probably larger than three-to-one, not smaller. An **earlier Health Affairs study** by So-Yeon Kang, Gerard Anderson, and colleagues, using a different method and a different set of countries, found much the same: for 79 brand-name drugs that had been on the market at least three years, U.S. prices after rebates ran 3.2 to 4.1 times those in the UK, Japan, and Ontario, and the gap grew the longer a drug had been sold. The RAND study also found U.S. generic prices are lower than abroad, and generics are 90 percent of U.S. prescriptions. The problem is concentrated in brand-name drugs without competition, which is where every MFN mechanism is aimed. That's a point in the policy's favor.

What the deals have delivered

Medicaid could save billions a year under GENEROUS; how many depends on which assumptions you accept, and nobody has measured it. One independent simulation, a **July 2026 JAMA letter** by Thomas Hwang, Lisa Clemans-Cope, and Aaron Kesselheim, estimated what Medicaid would save on high-spending drugs if their net prices dropped to the second-lowest foreign price: about **\$8.6 billion in a single year**. The **CEA's own estimate** is \$14.4 billion in the first year, declining to a ten-year total of \$64.3 billion, or about \$6.4 billion a year on average, after assuming that higher use offsets 20 percent of the gross savings. Both are projections built on prices that haven't been published and on participation nobody can yet confirm; the JAMA letter was written before the final GLOBE rule and before the state coverage terms were known, so neither accounts for the coverage rules states must accept, and the JAMA authors note Congress could get the same result by raising Medicaid's minimum rebate from 23.1 percent to about 49 percent.



What we know:

- U.S. net prices for brand-name drugs are more than three times those abroad, concentrated in drugs without competition.
- Independent and administration estimates both find Medicaid could save billions a year, but both are projections against undisclosed prices, and neither accounts for coverage rules that could raise use.
- Reference pricing can delay launches in the countries being referenced, especially lower-priced ones, and early reports suggest that's starting in Europe.
- IRA negotiation produced real but modest net savings, with prices still far above the MFN benchmark.
- GENEROUS has launched but reported nothing publicly measurable; GLOBE begins in 2027 and will cover about four companies; GUARD isn't final.



What we don't know:

- What's in any of the 26 deals. Only two have been released, and those had the drugs, prices, and exit terms blacked out.
- Whether any company has launched a new drug at an MFN price, which is where the CEA puts almost all the savings.
- How many people use TrumpRx, or what the \$700 million measures.
- Whether MFN, if sustained, would reduce new drug development.

The deals haven't stopped list prices rising. **A drug-pricing re-search firm, 46brooklyn, counted 872 brand-name price increases** in the first two weeks of January 2026, from every company with a deal; Pfizer raised prices on 72 of its own products. That violates nothing, since the deals cover Medicaid and new launches, not list prices. It shows how much of the market they don't touch.

TrumpRx is the only part anyone can observe. KFF **compared 32 brand-name drugs** on the site to prices in 11 countries: 17 were cheaper than the foreign average, 15 more expensive, and 13 cost more than in any comparison country. The "world's lowest prices" claim doesn't survive that. Neither does the harshest critique; for people paying cash for GLP-1s (the diabetes and weight-loss injections such as Ozempic and Wegovy) or fertility drugs, the discounts are real. We have no data on how many people use the site.

The one program with results

Medicare negotiation isn't one of the five MFN policies. It's the program Congress created in the 2022 Inflation Reduction Act that lets Medicare negotiate prices on a short list of expensive drugs. It's useful here because it's the most relevant recent federal program with published negotiated prices and a before-and-after comparison anyone can check. It's also worth saying plainly: Medicare is mostly not getting MFN prices. The deals cover Medicaid and new launches, GLOBE will reach about four companies in Part B, GUARD isn't final, and drugs with negotiated prices are excluded from GLOBE anyway. The first ten drugs came in **22 percent below what plans were already paying net**, even though headline discounts off list ran 38 to 79 percent. The second round came in **44 percent below net** by CMS's count. Real savings, and much smaller than the headlines, which is the gap to remember when reading MFN announcements. And even after negotiation, Medicare's prices for the first ten drugs were on average 78 percent higher than the next-highest country's. True MFN pricing, at least in Medicare, would mean cuts far deeper than anything the IRA has produced, and it would take permanent legislation, not a temporary model that exempts most of the industry.

On innovation, **CBO estimated** the IRA would mean one fewer new drug in the first decade and 13 fewer out of roughly 1,300 over 30 years. Industry-funded estimates run more than ten times higher. What we can observe so far is money, not drugs: **one analysis** found little evidence the IRA cut biopharma venture investment, and **another** found R&D spending and biotech equity investment held up after it passed, though there's also evidence of a shift away from the small-molecule drugs the IRA treats less generously. Investment holding steady is reassuring, but it isn't evidence about innovation itself; that takes a decade to see. No public estimate models the current launch-price framework, which could touch every new launch. Until the terms of each deal and each model are public, treat confident innovation claims in either direction as unsupported.

What happens abroad

This literature is more settled, and it points one way: reference pricing can delay launches, especially in lower-priced markets. If the U.S. references Germany's price, the company has a reason not to give Germany a low price, and the easiest way is not to launch there, or to launch late. **Danzon and colleagues showed this in 2005** across 25 markets. **Maini and Pammolli** estimated in 2023 that European reference pricing alone delays entry in eight lower-income countries by up to a year per drug. The U.S. is a much bigger prize to protect. Early signs fit: **Reuters reported in March** that European launches had fallen sharply, that Insmed delayed a German launch citing U.S. pricing, and that Amgen pulled Repatha from Denmark. Bristol Myers Squibb will **launch Cobenfy in the UK at the U.S. list price**, which is the other way to comply, though the UK's net price after its confidential discounts will likely still sit well below the U.S. price.

One more data point. When CMS tried mandatory Part B MFN in 2020, its actuaries estimated **\$85.5 billion in savings** and said in the rule that part of the savings came from beneficiaries not getting their drugs. Hospitals and drug companies sued, and a court stopped it before it started, finding that CMS had skipped the public comment period the law requires. GLOBE is a fraction of that size partly because of what that estimate showed about access. For scale, Part B drug spending was **about \$66 billion in 2024 alone**.

4. Risks and Unknowns

These are tradeoffs, not predictions.

If companies comply by raising foreign prices... watch for the benchmark to move.

The deals allow it, and Pfizer's contract, one of the two made public, rewards it by paying HHS a share of any extra foreign revenue. The UK has already raised its threshold. If Germany or Japan follow, the "second-lowest price" rises with them, and the U.S. ends up paying about what it did before, with the gap closed from the other side. That may be defensible. It isn't a price cut.

If the deals expire in January 2029 without legislation... watch for prices to snap back.

Pfizer's deal **runs through January 20, 2029**, and the tariff exemption ends the same day, one day after the next inauguration. The CEA's ten-year projection assumes the behavior continues for seven years after that. Nothing public says what happens on January 21.

If GLOBE loses in court... watch the ruling, not the savings.

PhRMA **sued on October 7** in federal court in Washington, asking the judge to vacate GLOBE and block its November 30 effective date. The question is whether the Innovation Center's power to test payment models lets CMS swap an international benchmark into a rebate formula Congress wrote. CMS says GLOBE is a limited experiment; PhRMA says it's price regulation that needs new legislation. The model barely exists now, but the precedent would. If the court upholds it, the Innovation Center (the office that runs Medicare and Medicaid pilot programs) can do this again at larger scale, which is a far bigger power than \$440 million suggests. If a court strikes it, the mandatory federal piece is gone and the policy rests on voluntary deals. The legal outcome matters more than the fiscal one.

If Congress codifies MFN... watch how it fits the program that already exists.

Medicare already negotiates prices under the IRA. GLOBE sidesteps the conflict by excluding negotiated drugs. An MFN statute would create a second benchmark for the same drugs. Which wins? Does a Medicaid MFN rebate trigger "best price" and pull every commercial price down with it? These are drafting questions that decide whether the programs reinforce or cancel each other.

If TrumpRx keeps growing... watch what insurers do.

If enough patients buy outside coverage, plans have a reason to stop covering those drugs. That shifts cost from plans to patients while the headline price falls. No usage data exist to tell whether it's happening.

If prescription drug prices in the consumer price index keep falling... watch for attribution to replace evidence.

The consumer price index, the government's main inflation gauge, tracks what pharmacies are paid for prescriptions; that measure was down 3.1 percent year over year as of July. The administration credits MFN. Economists **told the AP** the likelier causes are IRA prices, biosimilars (cheaper near-copies of biologic drugs such as Humira), and Medicare's GLP-1 program, and that no MFN model had touched any payer in the index. Because the index blends payments from insurers, patients, and every program at once, it can't tell you what any one policy did.

5. How to Read the Evidence Yourself

1. Is this a list price, a net price, or a price somebody actually paid? The list price is the sticker price. The net price is what's left after rebates. A "79 percent discount" off a \$1,000 list price sounds like \$790. If the insurer was already paying \$400 net, the saving is \$190. The first IRA drugs had headline discounts of 38 to 79 percent and net savings of 22 percent. Every MFN announcement works the same way.

2. Compared to what? Medicaid already got large rebates, so "Medicaid saves \$X" only means something measured against what it would have paid anyway. The same applies in reverse: if European launches fall after the MFN order, you want to know what they were doing before, and whether the drop is outside normal swings. The question isn't whether X happened after the policy. It's whether X would have happened without it.

3. Is this a measurement or a projection? The \$529 billion is a projection resting on one assumption about launch prices. The \$8.6 billion Medicaid figure is a simulation. The \$440 million is an actuarial estimate. Nothing published measures what any U.S. payer has paid under an MFN deal, because the deals aren't public, GENEROUS has reported nothing, and GLOBE hasn't started.

4. Which program, and which patients? TrumpRx is a cash purchase outside insurance; it doesn't lower a copay or count toward a deductible. A Medicaid rebate doesn't reach anyone on Medicare. GLOBE applies directly only to Original Medicare in a quarter of the country, though CMS projects some indirect savings in Medicare Advantage. When someone says MFN "lowered prices," ask which price, in which program, for whom.

5. Who can check this? The White House says 26 companies have signed; two contracts have been released, and both were redacted. The White House says TrumpRx saved \$700 million; the agency running it says it doesn't keep the data that would show it. When the only party who can verify a claim is the party making it, weight it accordingly, and ask why the data aren't public.

6. The Bottom Line

The evidence settles less than either side wants. The price gap is real and sits in drugs without competition. Reference pricing can delay launches in cheaper countries. Beyond that, we're working from projections: the deals are secret, GENEROUS has reported nothing, GLOBE starts in 2027 with about four companies in it, and the Medicaid estimates rest on prices nobody has published. The \$529 billion is a bet on launch prices nobody can see. GLOBE is small enough that its legal precedent matters more than its savings.

The tradeoff no version escapes is that a price in one country is a signal to every other. Reference the U.S. to Europe, and companies have a reason to charge Europe more, launch there later, or skip the cheapest markets. The administration has said it wants some of that. If it happens, the gap closes without U.S. prices falling much. If companies cut U.S. prices instead, revenue falls and the innovation argument gets its first real test. There's no design that lowers U.S. prices, leaves foreign prices and launches alone, and leaves revenue untouched. Something gives. Which one, for which drugs, and for which U.S. payers is a values question as much as an empirical one.

Unfortunately, the evidence for the price gap is much stronger than the evidence for any particular fix. The savings and innovation estimates rest on assumptions nobody can test against public data. A decisionmaker should treat them as projections, not findings, whether the number is \$529 billion saved or a hundred cures lost, until the terms, the prices, and the outcomes are public.

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