Savings from Most-Favored-Nation (MFN) Drug Pricing Policy

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Executive Summary

The Trump Administration has designed a Most-Favored-Nation (MFN) drug pricing policy framework to address the major differences in drug prices and contributions to the pharmaceutical innovation enterprise across developed countries. To date, the Administration has reached voluntary MFN pricing agreements with 17 of the largest pharmaceutical manufacturers in the world. Moving forward, the Administration expects to reach similar agreements with most manufacturers of sole-source brand name drugs and biologics in the nation. In parallel, the Administration is working with Congress to codify those voluntary agreements into law to ensure that patients continue to benefit from price discounts. This report describes the MFN drug pricing framework and evaluates its fiscal effects.

MFN provisions differ between future drug launches ("prospective MFN") and drugs on the market before MFN began ("existing drugs"). Under the voluntary MFN framework, manufacturers will offer all new drugs launched in the U.S. at prices comparable to those in other high-income countries.[1] This prospective MFN construct applies across all markets in the U.S., inclusive of the private insurance market, and is expected to generate $529B in domestic savings in the next 10 years across all markets. By tying U.S. drug prices to international prices, prospective MFN will lower U.S. prices and put upward pressure on prices paid in other wealthy nations.

The voluntary MFN framework requires manufacturers to make existing drugs available to state Medicaid programs at MFN prices, which would generate $64.3B in federal and state savings in the next 10 years. Discounted prices offered in the direct-to-consumer channel, TrumpRx.gov, will generate large patient savings for prescription drugs commonly purchased outside of insurance, including glucagon-like peptide-1 (GLP-1) drugs for weight loss and fertility medications. Specifically, GLP-1 users without insurance coverage are expected to save $3,000 per year, and couples undergoing in-vitro fertilization are anticipated to realize savings exceeding $6,000. In addition to the voluntary MFN framework, proposed legislation would ensure that health insurers count direct-to-consumer purchases of drugs at MFN prices towards patients' deductibles and out-of-pocket maximums. Finally, as part of the voluntary MFN framework, the Trump Administration secured price reductions for GLP-1 drugs, hereby enabling a fiscally sustainable expansion of Medicare coverage for anti-obesity treatments.

The MFN drug pricing policy framework has been carefully designed to work in tandem with U.S. trade policy efforts. While U.S. trade policy pushes foreign governments to pay their fair share, U.S. pricing commitments provide drug manufacturers with complimentary leverage in their negotiations with other wealthy nations. Taken together, the MFN framework aims to equalize drug prices through the combination of decreases in U.S. prices and increases in prices faced by other developed countries.

[1] The White House. (2025, July 31). Fact Sheet: President Donald J. Trump announces actions to get Americans the best prices in the world for prescription drugs. Available at https://www.whitehouse.gov/fact-sheets/2025/07/fact-sheet-president-donald-j-trump-announces-actions-to-get-americans-the-best-prices-in-the-world-for-prescription-drugs/.

Policy Background

The U.S. consistently pays higher prices for brand-name drugs than other high-income countries. A 2024 report by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that U.S. prices for brand-name drugs were approximately three times those in selected peer nations, even after accounting for manufacturer rebates and discounts.[2]

As a result of these large differences in prices, the U.S. bears a disproportionate share of research and development (R&D) costs for new drugs. Pharmaceutical innovation is a capital-intensive enterprise: it is estimated that it costs between $1B and $2.8B to bring a single new drug to market.[3][4] These sunk R&D costs, which support regulatory approval and market entry worldwide, should in theory be shared globally and proportionally among nations based on their capacity to contribute. However, in practice, the U.S. represents more than half of pharmaceutical manufacturers revenue and as much as 75% for top branded drugs,[5] even when it accounts for less than 5% of the world's population.

Overview of the MFN Policy Framework

The Trump Administration has designed an MFN drug pricing policy framework to address undue and unfair cross-country differences in contributions to the drug R&D enterprise. The MFN framework is directed at branded drugs and biologics not subject to generic or biosimilar competition, which constitute the majority of spending even if they represent a small share of prescriptions.[6] Generic drugs and biosimilars are not targeted by the MFN framework because competitive market forces already result in prices below those paid in other wealthy nations.[7] It should be noted, however, that in some cases, select biosimilars or innovator multisource drugs may be included in TrumpRx.gov or Medicaid MFN offerings to provide optionality for patients or states, respectively.

Definition of MFN

The definition of MFN, or the Most-Favored-Nation price to serve as reference, is a core element across all pillars of the MFN network. The Trump Administration carefully constructed a methodology to derive a pricing metric that is stable, representative of what other high-income countries actually pay for drugs after

[2] Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. *International Prescription Drug Price Comparisons: Estimates Using 2022 Data.* 2024. Available at: https://aspe.hhs.gov/sites/default/files/documents/8e057b0a094e6f9b9d01171fce6698f4/international-price-comparisons.pdf.
[3] Wouters, O. J., McKee, M., & Luyten, J. (2020). Estimated R&D investment needed to bring a new medicine to market, 2009–2018. *JAMA, 323*(9), 844–853. https://doi.org/10.1001/jama.2020.1166.
[4] DiMasi JA, Grabowski HG, Hansen RW. Innovation in the pharmaceutical industry: new estimates of R&D costs. J Health Econ. 2016;47:20-33.
[5] Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. Comparing U.S. and international market size and average pricing for prescription drugs, 2017–2022 (Issue Brief). 2023. Available at https://aspe.hhs.gov/reports/international-market-size.
[6] Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. Trends in prescription drug spending, 2016–2021 (Issue Brief). 2022. Available at https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf.
[7] Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. *International Prescription Drug Price Comparisons: Estimates Using 2022 Data.* 2024. Available at: https://aspe.hhs.gov/sites/default/files/documents/8e057b0a094e6f9b9d01171fce6698f4/international-price-comparisons.pdf.

discounts, does not include loopholes, and is operationally feasible for manufacturers to report and the federal government to audit and implement.

For each country within the basket defined below, MFN is defined as a price net of all manufacturer discounts, rebates, and other concessions, including portfolio-wide claw backs such as the UK Voluntary Scheme for Branded Medicines Pricing and Access (VPAG). The definition of MFN as a net rather than as a list price is a critical element of MFN policy because, just like in the U.S., list prices do not necessarily represent what other countries pay for drugs. If MFN were based on list prices, reference countries could easily circumvent contributing their fair share for drugs by raising list prices while increasing confidential discounts.

Due to the confidential nature of rebates, there are no existing data sets with net pricing information. Net prices will be voluntarily reported by manufacturers following methodological guidance issued by the Centers for Medicare and Medicaid Services (CMS). The process for the reporting and auditing of net pricing data has been carefully designed to avoid conflicts with ex-U.S. confidentiality laws, following the approach designed by the Arbitration Board in Germany, where manufacturers have traditionally been required to submit net pricing information from reference countries.[8] International net prices will be adjusted by the ratio of gross domestic product (GDP) per capita in comparison to the U.S., using a purchasing power parity adjustment and most recent data.

The reference group for manufacturers with MFN agreements includes the G-7 nations (excluding the U.S.), Denmark and Switzerland. These countries represent the largest economies with robust pharmaceutical regulatory systems and comparable health outcomes. While Denmark and Switzerland have smaller economies than the remaining countries in the basket, they complete the list of countries that serve as domicile of the top 10 pharmaceutical corporations by market cap. Their inclusion represents an acknowledgement of shared global responsibility to contribute to pharmaceutical innovation.

The second lowest price will prevent undue influence from outliers, which could create mass fluctuations in price over time, bringing instability in domestic prices. By linking to discrete prices rather than an average across countries, the MFN framework creates clear and discernible targets for trade negotiators and pharmaceutical manufacturers in their dealings with foreign nations, creating an acute pressure to raise specific prices in a targeted, achievable manner.

Medicaid MFN

Background

Under current law, Medicaid receives substantial discounts through the Medicaid Drug Rebate Program (MDRP).[9] Under the MDRP, rebates are estimated as the sum of: (1) a basic rebate, which for branded drugs equals the greater of 23.1% of the Average Manufacturer Price (AMP) or the difference between the AMP and the "Medicaid Best Price"; and (2) an inflation rebate calculated to offset increases in list prices above

[8] Rodwin, M. A., & Gerke, S. (2021). German pharmaceutical pricing: Lessons for the U.S. International Journal of Health Services, 52(1). doi: 10.1177/00207314211040948.
[9] Dolan, R. (2019, November 12). *Understanding the Medicaid prescription drug rebate program*. Kaiser Family Foundation. Available at https://www.kff.org/medicaid/understanding-the-medicaid-prescription-drug-rebate-program/.

inflation. Additionally, states may also negotiate supplemental rebates, including rebates tied to formulary placement, particularly for drugs in competitive therapeutic classes.

While U.S. drug prices are generally higher in commercial and Medicare markets, there is significant variation in Medicaid net prices due to the unique structure of mandatory Medicaid rebates. In some cases, Medicaid prices are lower than MFN prices or are even negative post-rebate. As a result, the majority of Medicaid drug spending net of statutory discounts is concentrated in a smaller number of single source drugs or biologics. Typically, the Medicaid net prices for these drugs are 2- to 3-fold higher than in MFN reference countries. Specifically, total Medicaid net drug spending is estimated at $48 billion per year.[10] A CMS analysis of the distribution of Medicaid net spending suggests that around 62% of Medicaid net spending or $30B is concentrated in the top 150 single source products.

Description

Under the voluntary MFN framework, drug manufacturers agree to provide covered outpatient drugs to Medicaid state programs at MFN prices. This construct will only apply to drugs where the current net price realized by state Medicaid agencies after rebates exceeds the MFN price. MFN rebates, which are operationalized through State supplemental rebates, will not count towards the calculation of Best Price and thus will not affect manufacturer liability under the 340B program.

Savings

Assuming utilization remains constant, the implementation of MFN prices in Medicaid is estimated to decrease net drug spend by $18B per year.[11] It is expected, however, that lower prices will increase utilization enough to offset about 20% of $18B, or $3.6B per year. Accounting for the additional utilization, the implementation of Medicaid MFN across all single source branded drugs and biologics would therefore reduce Medicaid spending on those drugs by $14.4B per year, with an estimated 57% or $8.2B accrued to the federal government and 43% or $6.2B to state governments, based on average Federal Medical Assistance Percentage (FMAP) rates. Greater utilization may also reduce non-drug Medicaid spending by improving disease control and preventing avoidable complications.

Annual savings associated with Medicaid MFN specifically will decrease over time, as existing products lose market exclusivity and new drug launches are subject to the prospective MFN construct. That said, the Medicaid program will still continue to accrue savings generated by prospective MFN; these savings are factored in estimates presented under the prospective MFN section below to avoid double-counting. Over 10 years, total savings are expected to reach $64.3B, with $36.6B accrued to the federal government, and $27.6B to state governments. Therapeutic classes expected to generate the greatest savings include antipsychotics, antiretrovirals, antineoplastics, drugs indicated in inflammatory diseases, and antidiabetics.

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[10] Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2024 (Exhibit 28). January 2026. Available at: https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-28.-Medicaid-Gross-Spending-and-Rebates-for-Drugs-by-Delivery-System-FY-2024.pdf.

[11] Estimated assuming that, for branded drugs and biologics representing $30B in Medicaid net spending, current Medicaid net prices are on average 2.5 times greater than MFN. We assumed a 2.5 times difference as opposed to 3.08 times difference reported in 2024 ASPE evaluation because MFN methodology involves a different set of countries and GDP adjustment.

Discounted Direct-to-Consumer Pricing: TrumpRx.gov

Description

Under the voluntary MFN framework, the Trump Administration has secured discounted pricing for self-administered drugs and biologics purchased in the direct-to-consumer or direct-to-patient channel.

TrumpRx.gov is a website that connects patients directly to these direct-to-patient offers. Patients can then choose their medications and purchase them at participating pharmacies using coupon cards generated on TrumpRx.gov or directly through manufacturers' websites. At this time, TrumpRx.gov is not integrated with insurance, however, legislative MFN efforts proposed by the Trump Administration would ensure commercial health insurance companies count purchases of single-source drugs and biologics at MFN pricing towards beneficiaries' deductibles and out-of-pocket maximums. Additionally, the legislation would lower costs for seniors by clarifying that TrumpRx.gov purchases at MFN prices would count towards the Part D out-of-pocket cap.

As of April 26, 2026, 16 of the 17 companies with voluntary MFN agreements have integrated their discounts into TrumpRx.gov and patients are already benefitting from large savings,[12] especially on weight loss drugs and fertility treatments, for which insured patients often lack access.

GLP-1 Receptor Agonists

Drugs activating the GLP-1 receptor pathway have transformed the treatment of obesity, demonstrating weight loss effectiveness only observed before with costly and invasive bariatric surgery.[13] These include GLP-1 receptor agonists as well as drugs with other mechanisms of action, such as gastric inhibitory polypeptide agonists; for simplicity, we refer to them collectively as GLP-1s. Beyond weight loss, GLP-1s have demonstrated significant effects on glycemic control and cardiovascular risk reduction.[14] Although GLP-1s hold great potential for preventing adverse cardiometabolic events associated with obesity, the high prices in the U.S. coupled with the breadth of the population eligible for treatment have posed challenges for expanded coverage. In a recent survey, only 30% of health plans reported covering GLP-1s for obesity.[15]

The limited insurance coverage made GLP-1s approved for weight loss natural candidates for the direct-to-consumer channel, even if prices available in 2025 prior to MFN negotiations posed significant challenges for access. In recognition of their potential to improve health outcomes, the Trump Administration negotiated substantial reductions in direct-to-consumer prices for Zepbound and Wegovy, the most prominently used GLP-1s for weight loss. Specifically, injectable GLP-1s fell from $1,000 to $1,350 per month to $350 on TrumpRx.gov, with initiation doses priced at $199, down from $500 prior to the

[12] TrumpRx.gov offerings. Available at https://trumprx.gov/browse.
[13] Lin GA, Lee W, Fahim SM, Richardson M, Phillips M, Raymond F, Rind DM. Semaglutide and Tirzepatide for Obesity: Effectiveness and Value; Draft Evidence Report. Institute for Clinical and Economic Review, September 9, 2025.
[14] Garvey WT, Batterham RL, Bhatta M, et al. Two-year effects of semaglutide in adults with overweight or obesity: the STEP 5 trial. Nat Med. 2022;28(10):2083-2091.
[15] PSG Consults. 2024 Trends in Drug Benefit Design Report. 2024. Available at: https://www.psgconsults.com/industry-report/2024-trends-in-drug-benefit-design-report/.

negotiation.[16] For oral GLP-1s, initiation doses are offered at $149, with the highest available strengths priced at $299. Pre-existing GLP-1 users are expected to accrue savings of $1,800 in 2026. Annual savings will reach $3,000 per year by 2028 as prices are further reduced per the MFN agreements.

Fertility Medications

Just like GLP-1s for weight loss, fertility medications are often paid for directly by patients rather than their insurance company due to limited coverage. While one in eight American women need fertility services,[17] only 32% of employer health plans cover fertility medications.[18]

The Trump Administration was able to secure a major decrease in the price of Gonal-F, the leading prescribed follicle stimulating hormone in the U.S. Families with income <550% of federal poverty level, which represent 70% of the U.S. population, are able to access Gonal-F at $25 per 75 units, down from $75 prior to negotiations through a savings program enabled by EMD-Serono.[19] For families with income >550% federal poverty level, Gonal-F is offered at $42 per 75 units at TrumpRx.gov. Cetrotide and Ovidrel also experienced major price reductions, which combined result into thousands of dollars in savings per IVF cycle. Specifically, the cost of prescription drugs for a standard IVF cycle[20] has decreased from $5,187[21] to $2,996,[22] generating $2,191 in savings per IVF cycle. Total savings per live birth are estimated to exceed $6,000, as patients of advanced maternal age often require 3 cycles per live birth. Given current rates of IVF utilization and insurance coverage, decreases in prices for fertility drugs are expected to generate $4.6B in savings to couples pursuing fertility treatments in the next 10 years.[23]

Medicare and Coverage of GLP-1s

Description

When Medicare Part D was enacted, weight loss drugs were perceived to have limited clinical value given their limited effectiveness and unfavorable safety profile and thus were excluded from Part D coverage. The rationale that originally justified excluding weight loss drugs from Part D coverage has been rendered obsolete by the clinical effectiveness of GLP-1 receptor agonists.[13] In 2024, the Biden administration proposed to reinterpret the Part D statute to require coverage of anti-obesity drugs, which could have

[16] The White House. (2025, November 6). Fact Sheet: President Donald J. Trump announces major developments in bringing most-favored-nation pricing to American patients. https://www.whitehouse.gov/fact-sheets/2025/11/fact-sheet-president-donald-j-trump-announces-major-developments-in-bringing-most-favored-nation-pricing-to-american-patients/.
[17] Access to Fertility Care: Findings from the 2024 KFF Women's Health Survey. https://www.kff.org/womens-health-policy/access-to-fertility-care-findings-from-the-2024-kff-womens-health-survey/.
[18] Newhouse, A. (2025, October 28). Fertility treatment benefits as excepted benefits coming for employers. International Foundation of Employee Benefit Plans. https://blog.ifebp.org/fertility-treatment-benefits-as-excepted-benefits-coming-for-employers/.
[19] EMD Serono. Fertility Instant Savings signup. Retrieved March 4, 2026, from https://www.fertilityinstantsavings.com/signup.html?utm_source=TrumpRx.com&utm_medium=website&utm_campaign=fis.
[20] Standard cycle defined as 10 days of stimulation with Gonal-f (r-hFSH) 300 IU / day and Menopur (hMG) 150 IU/day; 5 days of Cetrotide (GnRH) 0.25mg/day; and a trigger shot of Ovidrel (r-hCG) 250 mcg.
[21] Estimated as the sum of $1800 for Menopur, $3000 for Gonal-F, $280 for Cetrotide and $107 for Ovidrel, all based on the standard cycle amounts defined above and pre-MFN agreement cash prices.
[22] Estimated as the sum of $1800 for Menopur, $1000 for Gonal-F, $112.5 for Cetrotide, and $84 for Ovidrel, all based on the standard cycle amounts defined above and MFN agreement cash prices.
[23] $4.6B savings were estimated as the product of the difference in costs per cycle ($2,191), an estimate for number of IVF cycles per year (300,000), the proportion of IVF cycles paid outside of insurance (70%) and 10 years.

driven GLP-1 prices up even higher without any countervailing competitive mechanism to lower costs for patients. As such, this proposal, which was not finalized by the Trump Administration, would have had a major fiscal impact—CMS projected that it would increase spending by $25B in Medicare and $15B in Medicaid over 10 years.[24] Medicare patients would have faced copayments as high as 25% of list price.

Within the MFN policy framework, the Trump Administration developed a plan to expand Medicare coverage for anti-obesity GLP-1s, addressing the inherent limitations in the Biden-era policy. Through the negotiation of price reductions, the Administration established the foundation for a coverage expansion that is both fiscally conservative and improves beneficiary access through decreased cost-sharing.

The policy is operationalized through two models: the Medicare GLP-1 Bridge and the CMMI BALANCE Model.[24] The Medicare GLP-1 Bridge is a time-limited Section 402 demonstration that will begin on July 1, 2026, and will provide Medicare Part D beneficiaries with access to anti-obesity GLP-1 medications outside of the Medicare Part D benefit. Beneficiaries will face a flat co-payment of $50 per month of supply. The data collected from the Medicare GLP-1 Bridge will allow plans to prepare for a successful transition to a longer-term solution for expanded access to GLP-1 drugs under the CMMI BALANCE Model. BALANCE will incorporate GLP-1 drugs within the Part D benefit for participating plans, with established cost sharing limits for beneficiaries using GLP-1s for the access criteria negotiated by CMMI.

Prospective MFN

Description

A core piece of the MFN policy is the commitment of manufacturers to launch all future drug products in the U.S. at comparable prices to those in the list of reference countries. Just like in the other policy cores, MFN is operationalized as a net price construct. In practice, the average net price realized by a manufacturer across all sectors in the U.S., after statutory and voluntary concessions, must be no greater than MFN. This policy design enables manufacturers to have flexibility to account for the existence of statutory discounts and variable exposure to such discounts from drug to drug.

Savings

We estimated savings associated with MFN policy by simulating the policy being applied to FDA's novel drug cohorts starting in 2021 and up to 2025.[25] U.S. and reference country sales for each of the novel drugs identified were obtained from the IQVIA MIDAS® data set,[26] with the exception of Denmark, which was not

[24] Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2024, December 10). Medicare and Medicaid programs; Contract year 2026 policy and technical changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare cost plan program, and Programs of All-Inclusive Care for the Elderly (Proposed rule No. CMS-4208-P, 89 Fed. Reg. 99340). Federal Register. https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare.

[25] U.S. Food and Drug Administration. Novel Drug Approvals at FDA. Available at: https://www.fda.gov/drugs/development-approval-process-drugs/novel-drug-approvals-fda.

[26] The IQVIA MIDAS® is an IQVIA proprietary information service which integrates IQVIA's national audits into a globally consistent view of the pharmaceutical market, and provides estimated product volumes of registered medicines, trends and market share through retail and non-retail

included in analysis due to data unavailability. To obtain a full 10-year period, the remaining 5 years were projected assuming a 3% growth rate in pharmaceutical spending.[27]

Additionally, it was assumed that every year 10% of the novel drug cohort did not have sales to account for non-pricing related delays in U.S. market entry. The convergence of U.S. and foreign net drug prices originating from the combination of prospective MFN with the deployment of trade policy efforts was assumed to result in a 30% decrease in net prices for drugs in the U.S.[28] by the end of the 10-year period.

Using sales data,[29] country weighted average prices were obtained for each novel drug with available data for each year with observed data, 2021 to 2025. For each year-drug combination, the second lowest reference country price was selected as the MFN price to avoid undue influence of outlier prices. This price was then applied to the U.S. observed utilization of the drug to obtain a simulated U.S. spending with an MFN price for every year for which sales of the drug were observed in the U.S. By comparing the simulated spending to the observed U.S. spending, a savings estimate was obtained.

Lastly, using the assumptions described and savings estimate obtained, 5 more years of savings were projected. The result was that prospective MFN was estimated to generate $529B in savings over a 10-year period. An additional projection was run starting with the novel drug cohort of 2025, which involves a mix of drugs more aligned with current innovation pipelines, and under these conditions, prospective MFN was estimated to generate $733B in savings.

Prospective MFN and Drug Innovation

Commenters often raise the question as to how MFN will affect innovation. Through its voluntary agreements with drug manufacturers, the Trump Administration has thoughtfully married responsible pricing policy with trade policy to ensure lower prices for Americans are coupled with higher prices abroad, a concept affirmed by the 17 agreements reached with manufacturers voluntarily. Moreover, when considered in conjunction with related efforts to promote greater efficiency in drug development, the

channels. IQVIA MIDAS sales and volume estimates are projected from IQVIA's audits of standardized list prices and manufacturer, wholesaler, and other invoices; they do not reflect net prices realized by the manufacturers. These data are designed to support country-level trend and pattern analyses, but they remain estimates. The MIDAS data used in this analysis were obtained under license from IQVIA. The statements, findings, conclusions, views, and opinions contained and expressed in this proposed rule are based in part on data obtained under license from the following IQVIA information service(s): IQVIA MIDAS®. Copyright IQVIA. All Rights Reserved. The statements, findings, conclusions, views and opinions contained and expressed herein are not necessarily those of IQVIA or any of its affiliated or subsidiary entities. IQVIA MIDAS Overview. Available at: https://www.iqvia.com/solutions/commercialization/data-and-information-management/midas. MIDAS is a registered trademark of IQVIA. This report does not reproduce any IQVIA MIDAS data directly.

[27] IQVIA Institute for Human Data Science. Understanding the Use of Medicines in the U.S. 2025: Evolving Standards of Care, Patient Access, and Spending. April 2025. Available from www.iqviainstitute.org.

[28] Long-term prospective MFN policy is expected to deliver price convergence between the U.S. and reference countries, after adjusting for differences in GDP per capita. We estimated that this price convergence would translate into a 30% decrease in U.S. prices in comparison to the non-MFN policy counterfactual. 30% represents the midpoint in the price differences estimated absent MFN policy (U.S. net drug prices assumed to be 2.5 times greater than reference countries).

[29] IQVIA national audits and IQVIA MIDAS® reflect local industry standard source of pack prices, which might be list price or average invoice price, depending upon the country and the available information; they do not take into account rebates or clawbacks, details of which are normally confidential, and therefore these estimated prices do not reflect net prices realized by the manufacturers. Sales values reflected in these IQVIA audits are calculated by applying such relevant pricing to the product volume data collected for, and reflected in, such audits. In addition, to allow the national audit sales values to be viewed at a common sales level, MIDAS applies a single average industry margin to the locally reported values.

totality of the Trump Administration's drug policies represents a net positive effect for incentives to innovate through increased global expected value of novel pharmaceutical innovations.

The underlying issue that MFN is designed to solve is not necessarily inflated manufacturer revenues overall, but rather the inequitable distribution of the revenue across countries and overreliance on the U.S. to fund the drug innovation enterprise. In countries with strict price controls, manufacturers accept prices that, while exceeding marginal cost, do not represent the fair share of the sunk costs of R&D. As a result, the U.S. ends up serving as the primary financier of global pharmaceutical R&D. MFN pricing does not reduce the total revenue available to support innovation; it rebalances who contributes to it.

In particular, the prospective MFN framework fundamentally changes the negotiating environment between manufacturers and foreign countries. By signaling that the U.S. will no longer pay prices that implicitly subsidize the rest of the world, MFN creates direct pressure on foreign governments to either forgo access to new innovations or to raise drug prices through the reform of regulatory tools that consistently undervalue innovation. This new environment is expected to result in increases in drug prices in reference countries.

The MFN framework is designed to work in tandem with trade policy efforts to increase foreign revenues for branded products. In this regard, the Trump Administration is already beginning to extract higher contributions to the pharmaceutical innovation enterprise from other wealthy nations. The recently completed arrangement between the U.S. and the UK on pharmaceutical pricing increases net spending on both existing drugs and future launches through a combination of a decrease in clawback rates with an increase in the cost-effectiveness threshold used in economic evaluations of new products.[30] This is an outcome the Administration expects to replicate across other reference nations.

These tailwinds for innovation are further compounded by efforts undertaken by the Food and Drug Administration (FDA) to streamline the FDA's drug development and review processes, with the goal of accelerating patient access to safe and effective therapies. Key efforts under this policy category include the deployment of AI-powered tools to expedite drug reviews,[31] the proposed use of Bayesian methodology to support inference in clinical trials,[32] and the introduction of a new framework to support the approval of individualized therapies,[33] all of which are expected to encourage drug development.

After accounting for the effects of trade policy and streamlined drug development, the global financial basis for innovation is expected to remain robust, with the U.S. remaining the lead, but economically proportional, contributor. This is evidenced by the fact that the 17 agreements reached with manufacturers

[30] The Office of the United States Trade Representative. Arrangement between the Government of the United States of America and the Government of the United Kingdom of Great Britain and Northern Ireland on Pharmaceutical Pricing. Available at https://ustr.gov/sites/default/files/files/Press/Releases/2026/U.S.-UK%20Pharma%20Pricing%20Arrangement%20-%204.2.2026.pdf.
[31] U.S. Food and Drug Administration. FDA Launches Agency-Wide AI Tool to Optimize Performance for the American People. Available at https://www.fda.gov/news-events/press-announcements/fda-launches-agency-wide-ai-tool-optimize-performance-american-people.
[32] U.S. Food and Drug Administration. Use of Bayesian Methodology in Clinical Trials of Drug and Biological Products; Draft Guidance for Industry. 91 Fed. Reg. 9,283 (Jan. 12, 2026) (Docket No. FDA-2025-D-3217).
[33] U.S. Food and Drug Administration. Considerations for the Use of the Plausible Mechanism Framework To Develop Individualized Therapies That Target Specific Genetic Conditions With Known Biological Cause; Draft Guidance for Industry. 91 Fed. Reg. 9,283 (Feb. 25, 2026) (Docket No. FDA-2026-D-1256).

with drug manufacturers were done through voluntary negotiations to design a framework optimized to put upward pressure on international prices in conjunction with lower domestic prices.

Failure to fully rebalance the global innovation ecosystem represents an existential risk to the pharmaceutical industry which will continue to become increasingly over-reliant on the U.S. to fund the revenues of innovative products. Absent U.S. government intervention, inequities in contributions to the drug research enterprise are likely to continue to worsen rather than self-correct. As governments in wealthy nations seek to control taxpayer-funded benefits spending, pharmaceutical pricing will remain an attractive lever. Without the friction created by domestic MFN pricing, manufacturers will continue to accept below-market drug prices abroad knowing they can make up the difference in the U.S. The predictable result would be an even greater share of global R&D costs borne by the U.S. over time. Without MFN to put an end to this dynamic, the already unsustainable differences between what the U.S. and the rest of the world contributes will continue to grow along with the unsustainability of the global innovation enterprise.

Trump vs Biden Drug Pricing Policy

Compared to the Biden Administration's approach to drug pricing under the Inflation Reduction Act (IRA), the voluntary MFN policy framework is superior in every dimension:

Dimension	Biden Policy	Trump Policy
Market Coverage	Limited to a narrow set of drugs under Medicare Parts B and D; commercial and private insurance markets receive no benefit	Ensures fair and sustainable pricing across all U.S. market segments, extending benefits to patients independent of type of insurance coverage
Out-of-Pocket Cost Relief	No out-of-pocket cost relief from decreased drug prices Structural benefit design reforms (e.g., $2,000 Part D cap) only apply to Medicare at a hefty cost of higher premiums and taxpayer spending	Out-of-pocket cost relief in direct-to-consumer market from TrumpRx.gov prices, in Medicare from GLP-1 coverage expansion with flat copay; prospective MFN will result in out-of-pocket savings over long-term

Timeline	Four years after passage of legislation, patients have not yet seen any benefits from decreases in drug prices. Part D out-of-pocket relief associated with $2,000 cap not attributed to drug price reductions but rather by major increases in premiums and taxpayer spending	Six months after the MFN executive order, patients saw major reductions in cash prices of the most popular drugs (GLP-1s)
Overall Impact on Spending	CBO's recent analysis shows that IRA reforms contributed to dramatically increased spending on Part D due to higher premium growth[34]	Nearly $600B in total savings over 10 years

The table focuses on MFN, but the policy contrast for drug manufacturers is broader. The Trump Administration also supports manufacturing of drugs and other products, including stronger incentives for domestic R&D and accelerated timelines for obtaining federal approvals. Biden Administration policies were characterized by redistribution, tax increases and growing regulatory burdens on manufacturing businesses.

Conclusion

The voluntary MFN framework designed by the Trump Administration represents a historic step toward addressing the disproportionate burden borne by American patients and taxpayers in financing drug innovation worldwide. The framework's design ensures that its benefits are broadly distributed across market segments and not limited to those on Medicare, as in Biden-era policy. By anchoring U.S. drug prices to those paid by other high-income nations, the MFN framework fundamentally rebalances the global distribution of pharmaceutical R&D contributions in a sustainable manner, without compromising pharmaceutical innovation.

The MFN policy framework is designed to operate in tandem with U.S. trade policy efforts, creating pressure on foreign countries to pay their fair share of drug innovation. Rather than diminishing the global revenue base that sustains R&D, the framework seeks to rebalance its distribution — ensuring that high-income nations contribute equitably while policies streamlining drug development seek to reduce manufacturer costs. The 17 voluntary manufacturer agreements secured to date by the Administration are

[34] Congressional Budget Office. (2026, February). The budget and economic outlook: 2026 to 2036. Congressional Budget Office. https://www.cbo.gov/system/files/2026-02/61882-Outlook-2026.pdf.

compelling evidence that this approach is both operationally feasible and acceptable to the pharmaceutical industry.

Ultimately, the MFN framework delivers on the core promise by President Trump to lower costs for patients, enhance fiscal sustainability for public programs, and correct the longstanding inequity by which Americans bear a disproportionate share of the global costs of drug innovation.