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International Reference Pricing and Trump's "Most Favored Nation" Drug Pricing Policy

Trump's Push to Align U.S. Drug Prices with Europe (Trump Era)

During his presidency, Donald Trump decried the wide gap between U.S. and European drug prices and sought to **align U.S. prices with those abroad**. He argued Americans were **"getting a bad deal"** because other developed countries pay far less for the same medications [1]. In his 2019 State of the Union, he railed against "the problem of global freeloading," referring to foreign health systems benefiting from U.S.-funded pharmaceutical innovation while securing lower prices [1]. Trump reserved particular ire for Europe, calling the EU **"brutal"** in negotiations – **"nastier than China"**, as he put it – and insisted **"we have all the cards"** [2]. His blunt message: **Americans should pay less, and Europeans should pay more**. In fact, Trump explicitly described his pricing plan as a **"redistribution, where Europeans are forced to pay more and Americans pay less."** [3]

Trump's "Most Favored Nation" (MFN) proposal was the embodiment of this approach. Announced in late 2020 and revisited in 2025 rhetoric, the MFN model aimed to cap U.S. drug prices at the *lowest price* found in a select group of comparable countries. Specifically, Medicare payments for top-spending drugs would be tied to the **lowest per-capita price in any OECD country** with GDP per capita at least 60% of the U.S. [4]. In Trump's words, this would ensure Americans pay no more than the *"lowest price paid in any developed country."* He highlighted extreme examples: a friend paid only **$88 for a GLP-1 "fat shot" in London vs. $1,300 in New York** for the same drug [5]; a breast cancer drug cost one-sixth as much in Australia, and an asthma inhaler was $500 in the U.S. but $40 in the UK [6]. Such disparities, he argued, were unacceptable and proof that Americans were subsidizing the rest of the world [7] [8].

In the final months of Trump's term, his administration tried to implement the MFN rule via the Center for Medicare & Medicaid Innovation. However, this rushed rule was **blocked by a federal court in Dec 2020** and never took effect [9]. The incoming Biden Administration **formally rescinded** it in 2021, explicitly citing **concerns about patient access** to drugs on the MFN list and the policy's potential impact on **drug prices "in the U.S. *and internationally*."** [10] In short, even U.S. officials recognized that such a drastic reference pricing scheme could have **unintended global consequences**. (Notably, the MFN approach has since resurfaced in political debates – for example, a 2025 bipartisan bill proposed capping U.S. drug list prices at the *average* of prices in six countries – but Trump's version was uniquely aggressive in using the *lowest* price [11].)

The Appeal: Lower Drug Prices for U.S. Patients

At face value, international reference pricing has an obvious **upside for U.S. patients and payers: lower prices**. American consumers currently pay far more for brand-name drugs than patients in other wealthy nations – **about three times higher on average** according to a 2022 HHS report [12]. U.S. prices for some medicines are **many multiples** of those abroad, as Trump repeatedly noted. For example, the U.S. (with ~4% of the world's population) generates roughly **two-thirds of global pharma profits**, reflecting

significantly higher unit prices [7]. By pegging U.S. prices to European levels (where government negotiations or price controls keep costs down), American payers could see **dramatic price cuts**. Trump claimed MFN would slash U.S. drug costs by **"59 to 90 percent, or possibly more,"** saving American patients and programs like Medicare/Medicaid billions [13].

Such **price relief** would be a boon for many Americans struggling to afford medications. It could reduce out-of-pocket costs, improve medication adherence, and ease the budgetary strain on public programs. The MFN model was portrayed as **simple fairness**: Americans shouldn't pay ten times more for the *same* drug made in the *same* factory that Europeans get for a fraction of the price [14]. In essence, reference pricing imports the **benefits of other countries' bargaining power** and cost-effectiveness standards to the U.S., ostensibly putting an end to what Trump called foreign "freeloading" off American R&D [1].

Risks and Counterproductive Effects for the U.S.

While **paying less** is attractive, tying U.S. drug prices to international benchmarks carries **significant risks for the United States** – both immediate and long-term:

- **Immediate Access Disruptions:** A sudden MFN rule could disrupt drug supply chains and provider finances. For instance, under Trump's plan Medicare Part B would reimburse certain drugs at much lower rates. Oncology clinics and other providers worried they **might have to acquire drugs at higher prices than the MFN reimbursement**, incurring losses [15] [16]. This could force providers to switch patients to alternatives or even leave patients without treatment until prices adjust. The **American Society of Clinical Oncology** warned that the MFN model could **"put patients at risk"** by causing **drug shortages, treatment delays, and reduced access** to lifesaving therapies [17]. In fact, the Biden Administration's decision to halt MFN cited concerns that patients **could lose access to certain drugs** if companies or providers pulled back under the new pricing [10].

- **Reduced Incentives for Pharmaceutical Innovation:** Perhaps the biggest argument against aggressive reference pricing is its impact on the **economics of drug development**. The U.S. has historically been the profit center of the global pharma market, and those profits fund a great deal of R&D. Imposing a low-price ceiling via foreign reference could **substantially cut manufacturer revenues** in the U.S. market. In the short run, that mainly hurts pharmaceutical companies' bottom lines, but the **long-term consequence** is less investment in researching new drugs and cures. Multiple analyses predict a chilling effect on innovation:

- The Congressional Budget Office (CBO) projected that an MFN-style policy, by reducing revenues, would lead to **"lower spending on R&D and thus reduce the introduction of new drugs"** over time [18]. The CBO expected manufacturers would also **alter their launch strategies** – for example, **not launching some new drugs in certain low-price countries** – to avoid undercutting U.S. prices [19].
- A 2020 academic study concluded that MFN-level price controls could result in **up to 135 fewer new drug approvals through 2039**, a striking decline in innovation [20]. Another analysis found that for smaller biotech firms (key drivers of novel therapies), the number of new medicines developed could drop by as much as **90%** under MFN, with nearly one million U.S. jobs lost in the sector over a decade [21].

- Historical evidence supports these warnings. Strict price control policies in Europe in the 1980s–90s are often cited as a reason **biopharma investment shifted to the U.S.**, eroding Europe's former leadership in drug innovation [22]. Observers note that **France's pharmaceutical industry "lost its dominance"** in the late 20th century after heavy pricing restraints [23]. Policymakers fear a similar scenario in reverse: if the U.S. adopts Europe's pricing, the locus of innovation might shift again – perhaps to Asia (China's burgeoning pharma industry is frequently mentioned as a beneficiary if U.S. innovation diminishes) [24] [25].

- **Adopting Foreign Value Judgments:** International reference pricing doesn't just import lower prices; it implicitly imports other countries' **health technology assessments and coverage decisions**. Many countries (especially in Europe) determine drug prices or reimbursement based on cost-effectiveness thresholds (often using quality-adjusted life years, or QALYs, to decide what a life-year is "worth"). These thresholds are typically **much lower** than the informal values accepted in the U.S., resulting in **tougher bargaining and sometimes outright refusal to pay for high-cost drugs** abroad. U.S. patient groups and experts raised alarms that MFN would **"effectively endorse the use in the U.S. of discriminatory cost-effectiveness standards used by foreign governments."** [26] In other words, drugs that European systems deem not worth the price (and thus negotiate down or reject) could end up less available to Americans if the U.S. pegs its price to those countries. Some worry this could **restrict American patients' access** to cutting-edge therapies – a trade-off that occurs in Europe, where certain expensive medicines are available only on a limited basis or after delay. While cost-effectiveness is a legitimate tool to curb wasteful spending, the U.S. has historically been more reluctant to use hard cost-benefit cutoffs, partly out of concern that QALY-based decisions **undervalue the elderly or those with disabilities**. By importing foreign reference prices wholesale, the U.S. might indirectly adopt policies it never officially debated.

- **Unintended Domestic Distortions:** A reference pricing rule could also change how drugmakers and payers behave in the U.S. market in unexpected ways. One relevant analogy is the **Medicaid "best-price" clause** already in U.S. law, which guarantees Medicaid the lowest price offered to any private buyer. Economic research has shown this kind of **most-favored-customer clause can paradoxically keep prices higher** in other market segments, because manufacturers avoid offering deep discounts to anyone (since if they do, they must extend it to Medicaid as well) [27] [28]. In fact, when the Affordable Care Act slightly relaxed the Medicaid best-price formula, studies found **net prices fell and overall drug spending dropped** for private buyers [28]. The lesson is that **linking one buyer's price to another's can discourage flexible negotiations**. By the same token, an international MFN requirement might make drug companies less willing to negotiate *any* low-price deals (even for poorer countries or special programs), knowing it could undercut their U.S. revenue. Thus, **some cost relief in the U.S. could come at the cost of higher prices or fewer discounts elsewhere, or even within niche U.S. markets** (manufacturers might, for example, limit 340B drug discounts or other price concessions if those trigger lower reference benchmarks). In short, blunt price matching rules can have **counterintuitive effects** on pricing dynamics.

Risks and Impacts for Europe and Other Countries

Trump's MFN proposal was unapologetically America-first – he **"does not give a about anyone outside the U.S."** in this context, as the user notes. Indeed, the policy was explicitly designed to **pressure foreign countries and firms**: *if the U.S. won't pay more than the lowest price abroad*, drug companies and foreign

health systems have a few unattractive choices. **This has serious potential consequences for Europe and other markets:**

- **Upward Pressure on Drug Prices in Europe:** One likely effect is that pharmaceutical companies will try to **raise prices in low-price countries** to avoid dragging down the U.S. benchmark. Trump bluntly said Europeans have been paying too little and envisioned a redistribution where **Europeans pay more** [3]. If MFN were implemented, the **"glare of the MFN spotlight" threatens Europe's ability to keep prices low** [29]. Companies facing a U.S. mandate that says "match the lowest price anywhere" would be **incentivized to minimize the gap between U.S. and foreign prices** – not necessarily by cutting U.S. prices all the way to international levels (since that hurts them), but by **letting foreign prices rise**. European authorities could find drugmakers far less willing to grant steep discounts or price cuts in negotiations, knowing that a **cheap deal in Spain or Greece, for example, would instantly become the ceiling in the much larger U.S. market**. In effect, to protect their revenue, manufacturers might push Europe toward higher price points. European health systems could then face **budget strain** or be forced to make hard choices (pay more, or say no to certain drugs).

- **Launch Delays and Reduced Access for European Patients:** Alternatively (or additionally), drug companies might respond by **withholding new drugs from some countries** to avoid creating a low reference price. If the **U.S. pegs to the *lowest price, any country that negotiates a rock-bottom price becomes a "problem" for the manufacturer's global strategy. The rational move for pharma may be to delay or skip launches in traditionally low-price markets. This concern was openly voiced when Trump's MFN rule was floated: analysts speculated that launches in Europe – even in major markets like Germany or the UK – could be delayed or foregone entirely***, with patients there waiting longer for new treatments [30]. The idea is that companies might prioritize the U.S. market and **hold off launching in Europe** until much later (perhaps only after U.S. sales have been maximized or when generics are near, etc.), or they might launch but **stall price negotiations indefinitely** if the only acceptable price to Europe would jeopardize U.S. income. This is not an idle worry; there is precedent in existing global pricing strategies. Studies of pharmaceutical launches in Europe show a clear pattern: **countries with lower ability or willingness to pay often experience significant launch lags**. One extensive analysis (2002–2012) found that **international reference pricing was responsible for ~50% of launch delays in lower-income European countries – about one year on average per drug** [31] [32]. Companies deliberately **postpone introducing a drug in lower-price markets** to prevent those low prices from being used as references elsewhere [33]. For example, **Greece** legally requires that a new medicine's price can only be set after at least a few other EU countries have set theirs, which *by design* delays Greek patients' access [34]. This dynamic would intensify if the "other country" influencing your price is not just Germany or France, but the **United States (the world's largest pharma market)**. In short, **European patients could wait even longer** for cutting-edge drugs, undermining one of the core strengths of many European systems (equitable access) in exchange for their other strength (affordability).

- **Undermining of European Pricing Mechanisms:** European health systems have developed tools to secure lower prices while **balancing industry profits with public budgets** – for instance, **confidential rebates, managed entry agreements, and price-volume deals** that cap costs [29]. A lot of pricing information in Europe is kept secret specifically to prevent one country's low price from rippling out via reference pricing. Trump's MFN policy directly threatened this: it would require U.S. payers to know and use the **lowest price abroad**, effectively demanding **transparency of prices**

that are often confidential. Under MFN, **"net price confidentiality is at risk"** for Europe [29]. If companies are forced to disclose or have their lowest price exposed, it could unravel the delicate arrangements Europe uses. **Either companies refuse to offer confidential rebates (since they'd be revealed), or those rebates trigger a U.S. price cut.** Europe might then lose one of its key bargaining levers (steep secret discounts for agreeing to cover a drug). The result could be **higher official prices across Europe** or, if not, companies choosing to **walk away from deals** that would set a "too-low" precedent. Essentially, European payers and policymakers could lose some control over their own pricing systems, being unwittingly pulled into the U.S.'s pricing orbit.

- **Spillover to Other Countries:** While the focus is on Europe, any **"developed" country in the reference basket** could be affected. Trump's MFN comparator list would likely include not just Western Europe but countries like **Canada, Japan, South Korea, Australia** – all places with strict pricing. Those countries too might face pressure to pay more or see slower access to new drugs. Moreover, if companies start avoiding lower-income markets to protect U.S. prices, it could hurt **emerging economies** that often rely on tiered pricing. (Trump's model limited comparators to OECD members above a income threshold [4], so it wouldn't directly use, say, India's or Brazil's prices. But if a company fears *any* low price could eventually leak into reference equations, they may broadly harden pricing globally.)

- **Global Equity Concerns:** By attempting to eliminate the **"subsidy" American buyers provide,** MFN could **redistribute costs globally** – likely in a regressive way. Wealthy U.S. patients would pay less, but patients in poorer (or more budget-constrained) countries could end up paying more or waiting longer. In a sense, the policy aims to correct an imbalance (Americans overpaying) but could do so by **exporting higher prices to others**, rather than purely by cutting U.S. prices and eating into pharma profits. If other countries do *not* agree or are unable to pay more, the worst-case scenario is that **overall R&D spending falls** (fewer new drugs for everyone) *and* those countries see **no improvement in access**. If other countries *do* end up paying more, their health budgets (already often more limited per capita than the U.S.) might strain, potentially leading to cuts in other healthcare services or fewer patients treated with new drugs. In short, Trump's approach, **"America First" in drug pricing, implies someone else foots the bill** – either pharma (via lost revenue and hence less innovation) or foreign health systems (via higher costs), or a mix of both. None of those "someone else" options is particularly palatable for global health. European officials quietly worried that the U.S. was attempting to **upend the global pricing architecture** and that they might be forced into paying more or defending their systems in trade negotiations [8] [35].

Evidence from Case Studies and Past Experiences

Real-world evidence supports these theoretical impacts:

- **European Launch Delays:** As noted, studies of European markets show that **external reference pricing (ERP)** contributes significantly to delayed availability of new drugs in lower-price countries. **Manufacturers often sequence launches strategically** – launching first in the U.S. and high-price European markets (like Germany or Sweden which have higher willingness-to-pay), and **delaying launches in lower-income markets** (Eastern and Southern Europe) to avoid setting a low reference price too early [33] [31]. One study found **half of all launch delays in lower-income EU nations were attributable to reference pricing dynamics** – roughly a one-year delay per drug on average [31]. For example, **Greece and Bulgaria** impose rules that a drug **cannot be reimbursed until it's**

priced in several other EU countries [34], an explicit acknowledgement of ERP: they don't want to be "first" because it would force them to potentially overpay, but this means Greek and Bulgarian patients wait longer by design. These case studies illustrate how reference pricing **shifts the timing and geography of drug access**. If the **U.S.** – the world's largest pharma market – were to become the ultimate reference point, the incentive to delay launches in low-price markets would be even stronger, possibly affecting even mid-sized markets like Spain or Canada (which companies might previously have launched in earlier, but would think twice if a low price there could echo in U.S. Medicare).

- **Best-Price Policies Limiting Discounts:** The **Medicaid best-price clause** example in the U.S. is a cautionary tale about well-intended pricing rules backfiring. Before ACA reforms, drug makers could refuse to give private insurers big rebates (>15%) by citing the Medicaid clause (since any deeper discount would have to be given to Medicaid too, cutting overall revenue) [27]. After the law raised the threshold to 23%, researchers observed that **manufacturers granted larger rebates and net prices fell**, saving money in the commercial sector [28]. And simulations suggested that **removing the best-price rule entirely could cut drug spending further (by ~3.5%)** [28]. This implies that rigid price-linkage policies can make manufacturers **less flexible on pricing**. By extension, an international MFN could make companies think twice about granting, say, a special low price to a country's national health service or a humanitarian program, since that would compel them to lower the U.S. price. **Patients who benefited from those special low-price arrangements could lose out.** In Europe, one key strategy has been confidential rebates – essentially hiding the true low price – but MFN undermines the ability to keep any price truly secret if it must be reported as a reference.

- **Innovation Shifts – The 1980s–90s Case:** As mentioned, Europe's stricter price controls in past decades coincided with a noticeable migration of pharmaceutical research activity toward the U.S. Pharmaceutical historians often note that by the 2000s, **many big drug companies moved R&D centers to the U.S. and US-based biotech flourished**, partly because Europe's market was less rewarding for novel drugs [22]. Now, with China heavily investing in biopharma, there is a fear that history could repeat: if the U.S. adopts heavy price caps, the next wave of medical innovation (including jobs and economic benefits) might gravitate to countries willing to spend more or subsidize development [25] [36]. This is a macro-level "case study" playing out over decades, but it underscores the **trade-off between short-term savings and long-term innovation**.

- **Trump's Tariffs vs. MFN – Industry Reactions:** Interestingly, when Trump announced the MFN policy in 2020 (and revived the rhetoric in 2025), pharma **stock prices actually rose** on the news [37] – investors seemed skeptical that the policy would truly be implemented or upheld. This mirrors how aggressive drug pricing proposals in the past often face legal challenges or political pushback (indeed, MFN was quickly injuncted by courts). The stock bump suggested that markets bet the policy was more *posturing* than reality. In contrast, **pharmaceutical CEOs and trade groups reacted with alarm** in their public statements. For instance, the Global Colon Cancer Association (a patient advocacy group) called MFN a **"dangerous misstep"** that imports foreign price controls which **"undervalue medicines, restrict access to cutting-edge therapies, and diminish incentives"** for new treatments [15] [38]. This encapsulates the industry and patient advocacy case studies where similar price-control ideas were tried: the **immediate effect** might be good (cheaper drugs), but downstream you often see **shortages, fewer new therapies, or delays** in availability [17]. The **balance** between cost and access is delicate – case studies of overly strict price caps (e.g. some

Southern European countries during financial crises) show that companies sometimes withdraw products or do not launch them, leading to real patient harm.

In summary, experiences from various angles suggest that **international reference pricing can indeed lower prices, but not without consequence**. It tends to **reallocate where and when patients get new drugs** (favoring those in high-paying markets) and can have **perverse effects on pricing strategies** (discouraging low-price deals, encouraging secrecy, or homogenizing prices upwards). These case studies are a warning that simply importing foreign prices could solve one problem (U.S. drug affordability) while **exacerbating others** (global access disparities and innovation slowdown).

Outlook and Future Considerations

International reference pricing – especially an aggressive "most favored nation" version – remains a **controversial idea with high stakes**. Trump's particular MFN plan ultimately did not take effect in his first term, and the Biden administration chose a different path (e.g., the 2022 Inflation Reduction Act gave Medicare a limited ability to **negotiate some drug prices** internally, rather than referencing foreign prices). As of 2025, Trump's MFN concept has been **revived in political discourse** (with executive orders drafted and bills introduced) [39] [40], suggesting it could re-emerge if political winds shift. Should a future administration seriously implement MFN pricing, we can anticipate a period of **legal battles** (pharma companies would likely sue, as they did in 2020) and frantic adjustment in global pharma strategy.

One potential **future scenario** is that the mere threat of U.S. reference pricing could spur **international negotiations** of a different kind. Rather than the U.S. unilaterally capping prices, there have been calls (even from industry) for a more cooperative solution – for example, a **"NATO-like alliance" on drug pricing where wealthy countries agree to each pay a fair share of R&D costs** [41] [42]. This could mean Europe agreeing to spend a higher percentage of GDP on new medicines (raising their budgets) while the U.S. reins in its overpayments, narrowing the gap without simply shifting all burden to industry. Whether such global coordination is feasible is uncertain, but it reflects an understanding that **the problem is global**: one country's price controls affect another's innovation. Absent cooperation, the U.S. might also try **trade pressure** – e.g. using trade negotiations or even tariffs to push Europe and others to **raise their drug prices** (essentially the opposite of reference pricing, forcing foreign prices *up*). In fact, Congress has pondered a **"Chief Pharmaceutical Trade Negotiator"** role to tackle "foreign freeloading" via trade agreements [41]. These approaches acknowledge that **asking Americans alone to fund pharma R&D is politically untenable long-term**, but so is simply cutting off the funding without a plan for innovation.

For Europe and other countries, a future with U.S. reference pricing would likely prompt **protective measures**. We might see countries doubling down on **confidential discounts** (perhaps through creative mechanisms that keep list prices high but refund money later, to avoid triggering MFN). Or European governments might accelerate efforts to **jointly negotiate or regulate as a bloc** to strengthen their hand if pressed to pay more. If companies start withholding products, there could be political backlash in those countries against both pharma companies and U.S. policy (for instance, Europeans pointing out that American actions are now why they can't get a new drug). This could strain international relations in health care – a domain that usually isn't in trade wars.

From the **patient perspective**, the ideal future balances affordability with innovation. Pure reference pricing achieves affordability, but as we've seen, could imperil innovation and access. Cost-effectiveness-based pricing (as used in Europe) tries to pay only what a drug is "worth," which is efficient but often results

in limited access to very expensive breakthrough therapies until prices come down. The U.S. has historically erred on the side of **greater access at higher cost**, whereas Europe errs on **cost containment** even if it means saying "no" sometimes. A convergence will be tricky. Perhaps the U.S. will adopt **some** reference pricing (or direct negotiation) to curb the worst price excesses, while Europe may be pushed to **speed up access** and be more flexible in paying for high-value innovations. Notably, new EU regulations and industry proposals are looking at ways to reduce access delays – acknowledging problems like those W.A.I.T. indicators of 500+ days delays in some countries [43] [44]. Solving those requires addressing **root causes** like slow national processes and pricing conflicts [45] – issues that MFN would only magnify if not addressed.

In conclusion, **Trump's international reference pricing/MFN idea is fundamentally about fairness in drug pricing,** but implementing it is fraught with **trade-offs**. It's basically a good idea for U.S. patients to pay less, but it **cannot be viewed in isolation**. The global pharmaceutical system is a squeezed balloon: push on one side, and another bulges. Trump's approach would definitely push down U.S. prices – but the "bulge" could be felt in **higher prices or reduced access elsewhere, and potential ripples in innovation investment**. Europe could see **higher costs or longer waits**, and the U.S. itself could see fewer new therapies in the future as the financial rewards for innovation diminish.

Policymakers will have to navigate these consequences carefully. They might consider **hybrid solutions** – for instance, capping U.S. prices at some **average of peer-country prices** (rather than the absolute lowest) to moderate extremes [11], or excluding certain cutting-edge drug classes to protect incentives. They will also need to **address domestic inefficiencies** (like pharmacy benefit manager practices and patent evergreening) alongside any reference pricing, to tackle the root causes of high U.S. drug costs [46] [47]. The issue is complex, but one thing is clear: **a unilateral MFN pricing policy, as Trump championed, would reverberate far beyond U.S. borders**. It might save American lives and dollars in the short run, but could also **upend the global equilibrium**, with potentially counterproductive results for patients in both the U.S. and abroad. As the world grapples with drug pricing reforms, finding a solution that **reduces U.S. prices without harming innovation or punishing patients elsewhere** remains the ultimate challenge – one that future leaders will have to tackle with more nuance than a blunt "most favored nation" rule.

Sources:

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- Trump's remarks on European pricing ("brutal… nastier than China") and vision of redistributing costs to Europe [2] [3]; examples of U.S.-EU price gaps (GLP-1, cancer drug, inhaler) [5] [6].
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- AMCP federal update on international reference pricing (legal status of Trump's MFN rule and Biden's withdrawal citing patient access and international price impacts) [10].

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