POLICY BRIEF

International Reference Pricing and the Most Favored Nation Model

IVI

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BACKGROUND

Ensuring affordable, high-value healthcare remains a pressing challenge in the U.S. system. Total U.S. prescription drug spending has increased steadily over the past decade, from roughly $322 billion in 2015 to $406 billion in 2022,[1] and is projected to continue rising as specialty drug utilization grows. Policymakers are pursuing various strategies to improve value by managing costs while sustaining innovation and access. Among these are proposals to link U.S. drug prices to those paid in other high-income nations, an approach known as international reference pricing (IRP). IRP has been used in many countries to benchmark or cap prices to peer markets as one mechanism to promote affordability.[2]

The Trump Administration's 2020 Most Favored Nation (MFN) Model sought to apply international reference pricing in Medicare Part B by linking reimbursement for certain high-cost drugs to prices in economically comparable OECD countries.[3] Although the model was never implemented and was subsequently rescinded, the Administration revived the MFN approach in 2025. A May 2025 Executive Order directed federal agencies to pursue MFN pricing, followed by letters to pharmaceutical manufacturers in July outlining steps to align U.S. prices with the lowest prices available in other developed nations.[4] In December 2025, CMS proposed two new mandatory payment models—the GLOBE Model for Medicare Part B and the GUARD Model for Medicare Part D—that would incorporate international drug prices into Medicare payment methodologies.[5]

The Administration has also reached voluntary MFN pricing agreements with pharmaceutical manufacturers covering certain medicines and markets.[6] While specific terms of these agreements are not always publicly available, these developments reflect broader policy interest in using international price comparisons to address prescription drug costs. As these approaches evolve, it is important to assess not only their potential to reduce spending, but also their implications for patient-centered value, including access to treatment, incentives for innovation, and the equitable delivery of care.

IVI shares the goal of ensuring that patients have affordable access to the therapies and care they need. Controlling pharmaceutical costs is one component of achieving a sustainable, high-value healthcare system, but it cannot be pursued in isolation. Policies modeled on international reference pricing risk narrowing the conversation to price alone by importing foreign price controls that overlook differences in healthcare systems, market dynamics, and, most importantly, patient priorities. To truly improve value, any future policy must be designed and implemented in ways that reflect the principles of patient-centered value, transparency, equity, and innovation, ensuring that affordability efforts enhance rather than erode the quality and accessibility of care.

WHY IT MATTERS

Efforts to improve healthcare affordability must also strengthen overall value by balancing cost, access, patient outcomes, and innovation. Approaches such as international reference pricing may appear straightforward, but they risk reducing a complex system to a single metric: price. By importing external price controls from countries with fundamentally different healthcare structures and incentives, these policies can inadvertently undermine the very goals of value-based care.[3] For example, restricting access to the most effective therapies for chronic disease could lead to higher rates of preventable hospital admissions and Emergency Department visits, impacting financial stability and quality performance including patient reported outcomes.

Evidence from Europe shows that reference pricing often leads to launch delays, restricted formularies, and hidden pricing strategies. In many single-payer systems, health technology assessments operating under strict budget constraints delay or deny access to innovative and orphan drugs by applying narrow cost-effectiveness thresholds, leaving some regulator-approved treatments unavailable to patients. In the U.S. context, these effects could be magnified, limiting options for patients with rare or complex conditions, constraining investment in new therapies, and slowing the development of innovations that improve quality of life.

Affordability must not come at the expense of access, innovation, or optimized patient outcomes. True healthcare value requires policies that ensure patients can obtain the right treatments at the right time while also supporting a sustainable ecosystem for medical research and equitable access to care.

CONCLUSION

International reference pricing and Most Favored Nation-style models attempt to address the urgent need for healthcare affordability but run the risk of narrowing the focus to price rather than value.

True reform requires a broader lens that considers how policies affect access, equity, patient outcomes, and innovation across the healthcare system.

Importing foreign price controls may appear efficient but can weaken the foundations of a value-driven system. Instead, meaningful progress depends on investing in transparent, patient-centered value assessment that recognizes what matters most to patients and sustains innovation for future generations.

IVI remains committed to delivering rigorous, unbiased evidence to help policymakers design solutions that balance affordability with long-term value, ensuring that every patient can access high-quality, effective, and equitable care.

POLICY RECOMMENDATIONS

IVI supports the shared goal of ensuring that patients have affordable access to needed therapies. However, international reference pricing and the Most Favored Nation model are blunt instruments that oversimplify the drivers of cost and overlook what matters most to patients. To advance affordability within a broader framework of healthcare value, IVI recommends the following actions.

1. **Focus on Maximizing Value, Not Simply Minimizing Cost.** CMS and policymakers should base drug price negotiation frameworks on demonstrated value to patients and society, reflecting therapeutic benefit, quality of life, equity, and long-term sustainability rather than imported cost benchmarks.
2. **Strengthen Patient and Caregiver Engagement.** Policies should be designed from the user's perspective, particularly those who depend most on the healthcare system. Patients and caregivers should be directly involved in defining research questions, identifying meaningful outcomes, and evaluating whether policies achieve their intended goals.
3. **Advance Transparency in Pricing and Policy Decisions.** The government and manufacturers should publicly share pricing data, evidence standards, and evaluation methods. Transparency builds trust and ensures that affordability measures reflect the real-world experiences and needs of patients.
4. **Invest in Patient-Centered Value Research.** Evidence frameworks that reflect patient-reported outcomes and real-world performance help direct resources toward interventions that deliver meaningful benefit, reducing low-value care and avoidable costs such as preventable hospital readmissions, which average over $16,000 each, while preserving access and innovation.
5. **Evaluate and Mitigate Unintended Consequences.** Before implementation, policymakers should assess the potential downstream impacts of any international pricing policy, including effects on research and development investment, access disparities, and care quality. Continuous evaluation will help ensure that reforms achieve affordability without undermining value of future innovation.

REFERENCES

1 Centers for Medicare & Medicaid Services (CMS), Office of the Actuary. National Health Expenditure Accounts. Retail prescription drug spending was approximately $321.9 billion in 2015 and $405.9 billion in 2022.

2 Brookings Institution. "International reference pricing for prescription drugs," 2025. Available at: https://www.brookings.edu/articles/international-reference-pricing-for-prescription-drugs

3 Centers for Medicare & Medicaid Services (CMS), Most Favored Nation Model. The 2020 model would have tested Medicare Part B payments incorporating the lowest GDP-adjusted price among qualifying OECD countries; CMS subsequently rescinded the model before implementation. CMS Most Favored Nation Model

4 Executive Order 14297, Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients, May 12, 2025; White House, President Donald J. Trump Announces Actions to Get Americans the Best Prices in the World for Prescription Drugs, July 31, 2025. The Executive Order directed HHS to communicate MFN price targets to manufacturers; the July letters called on manufacturers to take specific steps toward MFN pricing

5 Centers for Medicare & Medicaid Services (CMS), CMS Proposes New Mandatory GLOBE Model and CMS Proposes New Mandatory GUARD Model, December 21, 2025. The proposed models would apply international pricing benchmarks in Medicare Parts B and D, respectively.

6 By April 2026, the Administration reported MFN pricing agreements with 17 pharmaceutical manufacturers. The arrangements vary and include provisions involving Medicaid pricing, new medicines, and direct-to-patient purchasing.

ABOUT IVI

IVI is an independent nonprofit driving the transformation of U.S. healthcare toward a system that defines and rewards value through a patient- and family-centered lens.

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