## Weekly Checkup

# Codifying MFN Will Make a Bad Policy Worse

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**The recent push to codify "most-favored-nation" (MFN) drug pricing is being sold as a simple fairness fix**: Americans shouldn't pay more than patients abroad for the same medicine. **As a political bumper sticker, that's clean. As federal statute, it's a category error** – one that would hard-wire foreign price controls, opaque side-deals, and administrative coercion into U.S. law while distracting from the competition and benefit-design reforms that actually reduce costs without limiting access.

The administration has tried to operationalize MFN through three channels: an executive directive to pursue MFN-aligned pricing in federal policy, a collection of "voluntary" manufacturer agreements, and a direct-to-consumer cash channel. This makes adhering to the administration's codification request difficult, because **there is still a glaring question that MFN rhetoric studiously avoids: What, precisely, is an MFN price?**

The reason this is hard to answer is simple. **MFN is *not* a truly comparative price.** Most meaningful foreign "prices" are not transparent list prices; they are net prices after confidential rebates, clawbacks, tender discounts, and managed-entry conditions. A statute that pegs U.S. payments to a foreign benchmark must define: the country basket; the unit of comparison; currency conversion; tax treatment; whether the benchmark is ex-factory, wholesale, or tender; and how to handle products that are packaged, dosed, or indicated differently across markets. **When (not if) Congress punts on these details, MFN will become a permanent, amorphous drag on U.S. health care.**

This isn't speculative. Even sympathetic observers have noted that the details of MFN-based "deals" have not been publicly specified at a level that would support clean legislative drafting, making codification more a political slogan than a coherent statutory design.

**Codification would entrench foreign price controls by proxy, without importing the**

**restrictive governance that makes it work abroad**. International reference pricing is not "market pricing." It's a derivative of other countries' rationing and budgeting choices – health technology assessment thresholds, national caps, restricted access, slower uptake, and launch conditioning. Codifying MFN means U.S. law would increasingly take foreign administrative outcomes as a given and treat them as a normatively "correct" price signal. That's not a new price; **it's outsourcing U.S. price formation to foreign governments controlling for their own fiscal constraints.**

Meanwhile, the administration's own MFN rationale leans on the widely cited reality that Americans pay meaningfully more than peer nations, often invoking "nearly three times more" comparisons. Those comparisons may be directionally true – but they do not validate MFN as the mechanism for addressing this potential issue. They describe a differential; they do not justify importing the entire foreign price-setting ecosystem through a statutory back door.

Worse, **the current MFN pathway already illustrates why codification would be economically sloppy.** The reported deals have centered on Medicaid pricing commitments and other concessions – but Medicaid is only about 10 percent of U.S. drug spending, and it already achieves very large statutory discounts, exceeding 80 percent in some cases. That means even "big" Medicaid MFN headlines can translate into limited system-wide savings, while creating strong incentives for manufacturers to recoup revenue elsewhere (commercial net prices, launch sequencing, contracting behavior). **Codifying this model risks locking in a policy architecture that over-promises at the national level and then "makes the math work" through access restrictions or cost-shifting.**

And this scenario isn't hypothetical. The administration is simultaneously pursuing MFN-style payment changes inside Medicare through Innovation Center demonstrations – GLOBE (Part B) and GUARD (Part D) – which would use international benchmarks to determine manufacturer rebates and influence beneficiary cost exposure, with implementation timelines starting in late 2026 and 2027, respectively. Meanwhile, Medicare already has a separate (unfortunate) pricing tool in statute: the Inflation Reduction Act negotiation program. We already saw the confusion that can happen when the maximum fair price and the MFN price don't align. Thus, **MFN on top of existing policy doesn't provide "certainty," it creates overlapping price-control regimes that don't necessarily align.** It invites litigation, arbitrage, and implementation churn.

Voluntary MFN deals are not a stable foundation for legislation, which is exactly what the administration has professed to desire. These arrangements are individually negotiated – narrowly focused, uneven, and creating misaligned incentives for non-party firms – and reshape behavior around what the deals are intended to measure and enforce. **Congress**

**would be codifying a system whose key "wins" are, by design, not a replicable rule but a set of bargains – exactly the kind of thing that degrades quickly once it is translated into a general obligation.**

This all ends in a predictable endpoint: access pressure or cost shifting. If MFN is written as a hard ceiling that outpaces feasible net-price adjustments, the system doesn't magically become efficient. It reacts to the new paradigm. Manufacturers can tighten supply, restructure contracting, or avoid launching through the channels that trigger the benchmark. Plans and PBMs can respond by shifting utilization or tightening coverage. Providers can face acquisition-cost mismatches. **The savings get "found" not only through lower unit prices, but through friction – less availability, slower adoption, narrower access, and more aggressive utilization management.**

The bottom line is this: **Congress should not codify MFN. Instead, it should legislate reforms that actually target the U.S. drivers of high drug spending**: accelerate biosimilar and generic competition, reduce anti-competitive contracting and rebate distortions, increase net-price transparency where feasible, and make benefit design protect patients from high cost-sharing without importing foreign price controls as a statutory crutch. MFN codification is not a reform agenda. It is an amorphous messaging plan built on moving targets, incomplete information, and incentives that virtually guarantee collateral damage.