

# Right Diagnosis, Wrong Cure

*Trump's MFN price controls aren't the answer to America's high patented drug pricing, but trade deals may be.*

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A year has passed since President Trump issued Executive Order 14297, “Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients.” The order requires pharmaceutical companies to lower the prices they charge Americans for patented drugs to the generally much lower prices they charge citizens of other countries, known as Most Favored Nation (MFN) pricing. The order faces hurdles, including a lack of clarity around its details, as well as legal challenges to the administration’s authority to implement it. However, even if it achieves its intended goal of lowering US drug prices to match those overseas, it would likely have one very bad result: a steep decline in revenue for funding the research and development of new cures, resulting in Americans being denied access to critical cutting-edge medications.

Defenders of the order note that healthcare coverage for an aging US population is growing the fiscal deficit, and drug spending now accounts for 9 percent of federal healthcare spending. But it’s unclear the order will reduce taxpayer expenses. New drugs contribute to reducing future hospitalizations, which account for over 30 percent of federal health spending.

The administration’s goal of securing “fair market value” for US drugs overseas while lowering prices for American patients and taxpayers at home is commendable. To achieve that goal, the administration shouldn’t use price controls but instead turn to trade policy.

## WHY WE PAY MORE

Americans pay up to three or four times what citizens of other countries pay for patented drugs regardless of whether they

use private insurance or rely on taxpayer-funded Medicare or Medicaid (Keyhani et al. 2010). This is primarily because other countries’ public insurers negotiate drug prices directly with drugmakers and use their bulk-buying “monopsony” power to secure significantly lower prices. This doesn’t mean they only pay just above marginal production and distribution cost. There is at least implicit recognition that new drugs are expensive to research and develop, and they deliver immense societal benefits to public health, life quality, and longevity. Developed countries’ negotiated prices account for that to some extent (Comanor 2021).

For instance, many countries adopt centralized Healthcare Technology Assessments (HTAs), which are multidisciplinary and systematic evaluations of the economic, medical, ethical, and social impacts of drugs, medical devices, and procedures. These methodologies are based on academic research and inform drug pricing policy using cost-effectiveness measures such as how many Quality-Adjusted Life Years (QALYs) a new drug is likely to add for patients. Unfortunately, foreign governments game this practice: They manipulate their HTAs through budgetary claw-backs and spending caps while setting arbitrary and outdated thresholds for the estimated value of a year of life that aren’t adjusted for inflation. In the United Kingdom, for instance, a QALY is valued at as little as \$40,000, an estimate that hasn’t been adjusted since 1999. American regulators today value additional years of life at over 12 times that figure.

In contrast, the 2022 Inflation Reduction Act prohibits the US Centers for Medicare and Medicaid Services from negotiating drug prices for all but a few drugs (and those negotiations only began this year). Instead, the CMS generally pays prices that are pegged to the American private market. Specifically,

in most cases Medicaid is legally required to pay the lowest price and Medicare Part B is required to pay the average sales price borne by the private market, while Medicare Part D subsidizes highly regulated private insurers to cover various prescription drugs. Theoretically, this is a form of market-based pricing. However, it perversely incentivizes drugmakers to inflate the drug prices they charge to private patients and insurers (GAO 2014, p. 15), including employer-sponsored health plans, above market-clearing levels (Duggan & Scott Morton 2006). This, in turn, lifts the price of *every* drug that CMS purchases, even if it leads to drugmakers making fewer sales and less revenue from private purchases. And since CMS covers over 160 million Americans and is the biggest buyer in town, this means that drugmakers make windfall gains off US taxpayer-funded purchases while privately insured Americans and those paying out of pocket pay more than they would in a truly free market (Chavehpour et al. 2024).

On the flipside, these revenues help fund the billions of dollars it takes to research and bring new cures to market (DeMasi et al. 2016) while incentivizing drugmakers to let Americans access cutting-edge medicines before the rest of the world (Marar & Rich 2024). Faster generic entry and heavier generic drug consumption and substitution in the United States after patents on existing drugs expire also mean that when net

public sector drug acquisition costs are considered, American taxpayers pay 15 percent *less* on average for medicine relative to Canada, Japan, and the United Kingdom (Philipson et al. 2025). Medicare Payment Advisory Commission data show that when generic substitution is considered, Medicare Part D drug price growth was fairly low between 2014 and 2023, with prices only increasing 18 percent over nearly a decade.

However, none of this changes the fact that US taxpayers, patients, and insurance plan customers indirectly subsidize medicine and pharmaceutical innovation for the rest of the world. Once six or more generic substitutes enter the market, a branded drug's price drops by 95 percent (Conrad & Lutter 2019). But the upfront investments necessary to research, develop, test, seek approval for, and market new cures rely on patented drug sales, not generic sales. And without these, there would be nothing for generic manufacturers to replicate.

#### THE PROS AND CONS OF MFN PRICING

MFN pricing would replace CMS's current drug purchasing system with one that pegs prices to what the public insurer in one or more similarly situated developed countries pays. This would eliminate the incentive for drugmakers to overcharge US private insurers and patients by divorcing CMS prices from private market rates. It would also lower drug prices



while pressuring drugmakers to raise the prices they charge foreign public insurers.

However, it comes with downsides. For one, drugmakers are unlikely to raise the prices they charge other developed countries to levels that would compensate for the decline in US revenue. This is because the foreign governments may be willing to forgo some access to new drugs to avoid paying more. This is exacerbated by difficulties in convincing voting publics to support higher drug prices. The long-term benefits of funding drug research and development are not immediately apparent to voters because new drugs may take over a decade to develop, obtain approvals, launch, and market, not to mention the time it takes for their positive effects on public health to be experienced and reported on.

Conversely, paying more for medicine—or shouldering a tax hike or public debt increase to fund higher drug prices through a public insurer—inflicts pain that is felt or reported on immediately. Pharmaceutical firms might also decide it is worthwhile to charge less than what they charge Americans now just to maintain access to those buyers and markets. Drugmakers are also limited in their ability to raise the prices they charge foreign public insurers because these are typically subject to multiyear contracts. And even if drugmakers respond to MFN pricing by refusing to sell in smaller or less important global markets so as to lift their US prices, the reliance on the domestic legal systems of each country to uphold patent rights means that affected governments may permit US patent infringement by their domestic manufacturers or mandate compulsory licensing of US drug patents on favorable terms. This is why MFN is likely to result in a steep decline in revenue for funding American drug R&D.

### THE ORDER'S UNCERTAIN FUTURE

President Trump tried to introduce MFN pricing on an “experimental” basis in his first term, but this was thwarted by legal challenges from drugmakers and other stakeholders. The EO 14297 attempt is plagued by other hurdles. For one, it doesn’t actually reform the CMS’s payment model; instead, it aims to implement a price control on public and private drug buys alike by threatening drugmakers with punitive actions if they don’t lower their prices. These include targeted antitrust investigations and lawsuits, export restrictions, and revocation of prior FDA approvals for their drugs. The administration’s ability to do this legally is questionable, and much of it is likely to require congressional approval. Besides, even if the legal and legislative pathways are cleared, price controls result in shortages (Reisman 1980), and drug shortages would provoke public backlash. Similarly, lower reimbursement rates for medicine would likely lead to the scaling back of medical services and access to drugs. For instance, CMS (2020) finds that an MFN-like policy could induce “drug payment reductions” for rural providers, which would cause many to close.

The effect on new drug R&D would be especially severe. Philipson & Durie (2021) estimate the effects of revenue loss from a proposed price controls under 2021 legislation titled the Elijah Cummings Lower Drug Costs Now Act. Like EO 14297, the bill would have forced drugmakers to negotiate prices with the US government under threat of punitive fines, would have affected both public and private market transactions, and would have mandated prices that are not significantly higher than those paid overseas. The analysis found that had the legislation passed, it would have resulted in an estimated 167 to 342 fewer new approved drugs over an 18-year timeframe. Given that newly approved cancer drugs alone led to 400,000 fewer lung cancer-related deaths and nearly 130,000 fewer breast cancer deaths in the United States between 2000 and 2016 (MacEwan et al. 2020), the adverse effects of this outcome on public health would have been significant.

Regardless of these hurdles and the potential adverse impacts, the threat of sanctions under the executive order has led to various drugmakers signing “voluntary agreements” to adopt MFN pricing, including a deal on the price of popular weight-loss GLP-1 drugs like Ozempic. However, only 16 drugmakers have signed such agreements, and they apply only to patients who pay cash and to state Medicaid programs, limiting their reach.

President Trump has also sought to adopt MFN pricing models for Medicare Parts B and D drugs on an “experimental basis” after addressing some of the legal and administrative issues that his first administration’s experimental models faced. The two proposed models, GLOBE (for Medicare Part B) and GUARD (for Part D), would incorporate international pricing benchmarks in calculating what the federal government will pay and require mandatory drugmaker participation. However, the models would only affect 25 percent of Medicare beneficiaries in particular geographic areas over a six- to seven-year trial period. They would also likely face legal challenges under the Administrative Procedure Act once the proposals are finalized.

### A GLOBAL DRUG PRICE?

In a nutshell, replacing how the US government pays for drugs with models that replicate the deflated prices that other countries’ public insurers pay using their monopsony power faces significant legal challenges regardless of how it’s attempted. And it would also be a bad idea because it would drastically lower global revenues that fund pharma research into new cures. So how about trying to preserve global revenue through an international agreement on a single price that developed or high-income countries can pay for the same drugs? After all, the benefits to patients from medicines are the same whether they’re taken in Spain, Japan, or the United States. Securing agreement from first-world governments on a single per-unit price for patented medicines that is lower

than the current US price but higher than what those nations currently pay then seems like a worthwhile goal that would eliminate “free riding” off the United States. However, even leaving aside the political and pragmatic difficulties of securing higher drug prices overseas, this goal is neither practical nor desirable for several reasons.

The simplest way to estimate drug prices that all nations should be expected to pay would be to calculate the fixed costs that were incurred in developing each patented drug and then divide that between each country before estimating a single price. For the sake of equity and fairness, this price can be adjusted based on the per-capita gross domestic product of each country and the purchasing-power parity (PPP) of its citizens.

However, the true “fixed costs” incurred prior to a particular drug making it to market as a commercial product may be hard to estimate. Since scores of “dry holes”—failed trials and research projects—are typically undertaken prior to one that successfully yields a commercially viable drug, the apportioned costs would need to account for the cost of these as well in order to incentivize optimal funding for pharma R&D. CBO (2018) estimates that drugmakers must generate a profit margin of 62.2 percent through successful products to generate just a 4.8 percent return on their assets overall. These costs have risen in recent years because of higher failure rates and increased research costs (DiMasi et al. 2016). The economics of infectious disease vaccines and other anti-infection therapies are especially gloomy (Lo et al. 2020; Vu et al. 2020). That’s why estimating the average cost of researching, developing, and bringing a new drug to market (including the sunk costs of failed trials and projects) may be technically feasible, but doing so for specific patented drugs in a way that covers seemingly unrelated sunk costs of projects that preceded a successful one would be much harder. And because foreign governments that set drug prices using HTAs already manipulate them, chances are that R&D cost estimates proposed by those governments will also be deflated.

The “high-powered incentive” to invest in drug research is also tied to the expectation of future profits rather than the mere desire to cover fixed costs with some additional monetary incentive on top (Kyle 2022). This market-based incentive to fund projects based on what is most likely to generate the highest profits can tie drug research to the degree of demand for specific types of drugs, cures, or innovations. This can ensure funding outcomes and allocation that are both socially optimal and economically efficient, assuming that drug prices are determined by public demand rather than extraneous or arbitrary incentives. That is partially why government-funded pharmaceutical research generally generates less return per dollar than privately funded research subject to profit and loss incentives (Proudman et al. 2024). It’s also impossible to say exactly how much profit a new drug will or ought to make ahead of time.

Drug prices incentivize compensation for research and sunk costs of the drug. But they also incentivize the technology transfer and drug uptake and deployment that are necessary to fund manufacturing facilities, supply chains, and education efforts to get the drug into patients’ hands and make it effective. For instance, the pandemic-era World Trade Organization (WTO) waiver on patents surrounding various COVID-19 vaccines was insufficient for foreign manufacturers to replicate, produce, and distribute the drugs themselves at marginal cost (Eccleston-Turner & Rourke 2021). Manufacturers’ ability to do so hinged on cooperation and the transfer of technology and know-how from the companies that developed the drug. Companies undertaking research with the goal of bringing new drugs to market must also account for estimated non-R&D expenses for manufacturing, distribution, and financing. And expectations about future profits also lower the costs of financing, making it possible for smaller, cash-strapped firms to access, thereby incentivizing market entry and competition for the benefit of patients.

A single drug price, even for the world’s developed nations, may still be undesirable and ineffective for funding innovation in-line with public demand even if an appropriate revenue estimate for future drugs could be made. Economists have long recognized that the ability to set different prices in different markets, including geographic markets, is not necessarily anticompetitive or unfair even if those differences aren’t tied to the different costs of servicing each market. Instead, the ability to price-discriminate can optimize resource allocation and lead to increased net output and social welfare by accounting for differences in demand across individual markets. This is especially important in an industry like pharmaceuticals, which is reliant on global revenues across multiple markets for funding research that creates cures in the first place, a process that carries high fixed costs. High fixed costs as a percentage of sales are a distinctive feature of the pharmaceutical industry. Equalizing drug prices across all countries, or just all high-income countries, might seem “fair.” But if the result would be a decrease in global revenues and expected profits of existing and future drugs, then the world could be worse-off as fewer new lifesaving cures make it to market, and the limited drug supply wouldn’t go where it’s most valued. Lichtenberg (2011) found that, as differences in the price of a drug in different national markets increased, so too did the supply of the drug and its uptake.

Price discrimination is a rational strategy for a business when a higher price for a good is charged in markets with more inelastic demand as compared to a market where demand is more elastic and thus sensitive to price hikes. Forcing sellers to charge the same price in two markets with varying elasticity would reduce overall revenue (and thus expected future revenue and profits) by undersupplying the drug in the market with more inelastic demand and oversupplying it in the market

with less inelastic demand. So, then, American taxpayers and patients may be better off in the short run if they paid the same prices as other countries as intended by the Trump administration's 2026 "Great Healthcare Plan." But those Americans would be worse off in the long run because of an undersupply of new drugs if this led to decreased global revenues because of restrictions on drugmakers' ability to price discriminate between national markets. It would also mean that Americans would lose the ability to access the latest drugs before other nations' citizens.

### THE TRADE DEAL SOLUTION

A single global benchmark drug price may be unworkable. But that doesn't mean we can't get other countries to pay more while securing lower prices at home relative to what we currently pay.

Frech et al. (2024) find that while the United States pays disproportionately more for drugs relative to its economic size in GDP terms than all other countries, funding contributions to pharma R&D for each country do roughly correlate with the size of their GDP. This relationship is unsurprising because a nation's economic size determines the overall value of the public good that its citizens consume, as a larger populace means that more people benefit from a new drug. Higher per-capita GDP is also linked to increased demand for health improvement as demonstrated by higher demand for drugs and health-related services as per-capita GDP increases. This is why "national contributions to the global public good increase more than proportionately with increases in a country's GDP [and] larger countries make disproportionate contributions." This suggests that willingness to fund pharma research is lower among smaller economies, which are more likely to get away with freeriding off larger ones that have more to gain or lose from reducing their funding of pharma R&D.

Conversely, the same research that reports significantly lower drug prices in non-US countries also finds that the average non-US Organisation for Economic Co-operation and Development (OECD) member national government pays 80 percent above a patented drug's marginal production cost even with HTA manipulation and spending caps taken into account. The authors attribute this to some combination of altruism, recognition of a drug's societal benefits, and bilateral bargaining. It indicates that other countries are likely to at least slightly raise the prices they pay for drugs if the United States is no longer willing to indirectly subsidize them.

And this willingness to pay is likely to increase through bilateral or multilateral trade negotiations that dangle other benefits, such as lower tariffs and greater access to the US mar-

ket for foreign nations' exporters in pharma and non-pharma sectors—that is, offering "carrots" as well as "sticks." Because foreign governments essentially impose price controls on US patented drugs that foreign drugmakers don't face in the US market, and because those price controls "fail to provide adequate and effective protection of intellectual property rights" (USTR 2025), they constitute non-tariff trade barriers and anti-competitive market distortions (ACMDs). Eliminating ACMDs benefits both the American and global economy. CEBR (2019) found that ACMDs led to 14 percent lower global output; this is why both the World Bank and OECD urge governments to abolish ACMDs.

Narrow tariffs specifically intended to nudge these governments toward paying closer to market value for American patented drugs, then, would be more defensible than broad

## Americans may be better off in the short run under the Trump "Great Healthcare Plan," but they would be worse off in the long run because of the undersupply of new drugs from decreased global revenues.

tariffs justified under questionable interpretations of emergency powers conferred by existing laws that the Supreme Court recently rejected. As with any new government policy, such narrow tariffs would need to weigh costs and benefits, including cost increases that are likely to be borne by American businesses and consumers. They could be worth the temporary pain if they result in a net lowering of trade barriers that fosters competition and innovation.

The administration's December 2025 agreement on pharmaceutical pricing with the UK is a good example of America using its trade leverage to secure higher foreign prices for US innovation. The administration used the threat of tariffs under Section 232 of the Trade Expansion Act and Section 301 of the Trade Act of 1974 to nudge Britain's National Health Service to pay 25 percent more for patented US drugs and lower concessions that it requires from US drugmakers under various rebate schemes. Section 301 allows the US Trade Representative to investigate and enact tariffs or restrictions on foreign nations engaging in unfair trade practices such as intellectual property theft or devaluation.

Conversely, a more "carrot-based" approach that creates a win-win scenario would be to offer lower US trade barriers to foreign firms, greater access to the US market, and abolish domestic ACMDs as well as red tape affecting both US and foreign firms. This is in line with the administration's 2025 EO

14192, “Unleashing Prosperity through Deregulation,” which requires federal agencies to identify anticompetitive rules that they enforce. Because foreign countries have a narrow political incentive to pay more for drugs, concessions needn’t be limited to the pharmaceutical sector. This would also make any trade arrangements that increase foreign governmental spending on US drugs more saleable to their electorates. Unlike tariffs, deregulation and abolishing trade barriers would benefit rather than burden American consumers and businesses with costs and could prove politically popular once Americans see lower prices at the store. And where trade deals and agreements end up fostering supply chains between allied nations and the United States by reducing barriers and costs of the same, they can create high-paying jobs both domestically and abroad while potentially building a political constituency that is against devaluing medicinal innovation.

Replicating such deals with a growing number of developed nations can also work as a “carrot” for agreements with domestic drugmakers to secure lower prices for Americans while maintaining incentives to invest in new drugs to seek similar global sales and revenues. As profit-seeking entities, drugmakers may not want to see lower domestic drug prices even if agreements are secured for foreign countries to pay more. They may argue that this is a step away from market-based pricing. However, the current system is hardly market-based pricing, as pegging the per-unit price of high-volume CMS purchases to the average or lowest private market price leads to artificial inflation of private market prices above what would exist in a competitive or free market.

Conversely, more overall global revenue for funding and developing new drugs may not be a bad thing and may even leave us all better off. Philipson and Jena (2006) studied the sales and effects of therapies for HIV/AIDS that hit the market from the late 1980s onwards. They found that even though those medicines raised social welfare by almost \$1.4 trillion, they raised only \$62.9 billion in profit for the companies that created them, capturing under 5 percent of the total welfare. This result isn’t atypical. The authors considered 200+ prior studies on various patented drugs and their cost effectiveness, finding that drug companies captured under 7 percent of societal surplus in a quarter of the studies, and captured over 25 percent of the societal surplus in only another quarter of the studies. Economic theory suggests that socially optimal outcomes occur when all the surplus can be captured by profits, indicating that even revenues from drug sales under the status quo are undersupplying pharmaceutical innovation (Kennedy 2019). The pain may be felt in the long run by taxpayers and through higher premiums for Americans as the cost of hospitalizations that may have been prevented or reduced by new drugs mount. Ultimately, this is a tradeoff that our societies will have to acknowledge and make through consensus so long as government purchases remain a significant driver of pharmaceutical revenues.

## **UNLEASHING HEALTHCARE COMPETITION: GAIN WITHOUT PAIN**

There are also many reform options that would foster competition to deliver lower drug prices while fostering rather than compromising innovation incentives.

In addition to expediting approvals or streamlining processes for new drugs, directing the FDA to allow more prescription drugs to be sold over the counter would increase competition by shifting drug purchase volumes toward consumers over insurers, who don’t typically cover over-the-counter medications. As Singer (2025) explains:

When people pay out of pocket, they look for better deals, which pressures companies to keep prices competitive. Once insurance takes over the cost, shoppers stop paying attention to price and drugmakers can charge the deeper-pocket third-party payers more without worrying about losing customers.

Allowing more drugs to be sold over the counter would also reduce the cost and time that patients face in securing a “permission slip” from their healthcare provider, freeing resources for patients who are in more dire need. It would also encourage more Americans who would otherwise delay or not try out potentially beneficial medical treatments because of the cost and complexity entailed in seeking a prescription.

Health savings accounts (HSAs), paired with high-deductible health plans, empower patients by allowing them to direct their own medical spending through tax-free and tax-advantaged accounts. This would also foster competition and put downward pressure on drug prices as HSA spenders are more likely to shop around for better deals. Last year’s One Big Beautiful Bill took positive steps by expanding HSA eligibility and the scope of purchases that these accounts are allowed to cover.

On the insurance side, fostering competition between insurers and health plans would lead to lower prices for healthcare coverage and drugs more generally. A complex patchwork of state coverage mandates and other regulations on what kinds of plans customers can buy (and insurers can sell) have not only limited healthcare choice, but also made it virtually impossible to purchase insurance across state lines. Incumbent insurers that benefit from cornering specific state geographic markets may not want these regulations and mandates abolished or standardized because that could erode their market share while forcing them to charge lower prices to plan sponsors and individual customers than they otherwise would. But markets are about upholding competition, not protecting competitors from it. Conversely, broad restrictions on pharmacy benefit managers that affect their ability to negotiate drug prices with drugmakers and pharmacies on behalf of health plans by pooling patients across multiple plans to increase bulk-buying power would likely increase drug prices or insurance premiums for patients (Brannon & Lo Sasso 2021).

**CONCLUSION**

The Trump administration has enjoyed greater success and popular support for its deregulation policies and agreements that reduce trade barriers than it has for its tariffs. Price controls under the MFN executive order and attempts to enact MFN pricing by other means face substantial legal and practical hurdles and are likely to see a massive drop in future revenues for funding new drug development even if they succeed. Trade deals like the recent US–UK agreement on drug pricing are more likely to be successful in spreading the burden of funding medicinal innovation while serving as a “carrot” for securing lower drug prices at home.

The US government has many tools in its kit for securing higher drug prices from foreign governments and lower drug and healthcare costs at home by fostering competition. Regardless, America’s pharmaceutical innovation system, with its eschewal of price controls and support for IP rights, produces cutting-edge cures that the world and US economy benefit from. It also gives Americans access to the most and latest drugs before foreign nationals, and it ultimately delivers lower prices than those found in many other developed countries once generic competitors enter the market. These unique advantages should be acknowledged both here and abroad, and they are worth preserving. Rather than saving taxpayers and patients money in the long run, any reforms that negatively affect research and development incentives will simply lead to fewer new cures, undersupply drugs to those who need them, and burden taxpayers with hospitalizations and other health costs that could have been reduced and prevented by new innovations. R

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