American Exceptionalism

Why U.S. drug prices are the highest in the world

westhealth

West Health is dedicated to lowering health care costs and improving access to quality health care for older adults, using data, research and informed policy solutions to empower change.

Learn more about West Health and our data and information platform, Mosaic—a comprehensive resource for writers, researchers, and policymakers.

By: Anna Kaltenboeck, President, Verdant Research, Mary Gens, MPP, Senior Research Associate, West Health Policy Center

Key Takeaways

1. For decades, Americans have paid three-to-four times more for prescription drugs than their peers in other high-income countries around the world due to unique features of the U.S. health care marketplace.
2. Unlike other high-income countries, the United States delegates negotiation of drug prices to a market-based system that relies on private sector profit motives and fragments the market power of payers to lower drug prices.
3. Congress took steps to leverage Medicare's power to lower drug prices by granting it authority to negotiate prices; more action is needed if policymakers want to bring the U.S. in line with other high-income countries where prescription drugs are more affordable.

The Problem

Federal policymakers have known for more than 50 years that Americans pay more for prescription drugs than other high-income countries.[1] Despite this knowledge, and overwhelming public support to lower drug prices, little progress has been made toward closing the gap. [2]

> Prescription drug prices are three-to-four times higher in the U.S. than in other high-income countries.

Depending on the measure, prescription drug prices are three-to-four times higher in the U.S. than in other high-income countries.[3] Furthermore, Americans spend twice as much per capita on primary care drugs (e.g., drugs that treat hypertension, pain, depression, diabetes and other common conditions) than residents in other high-income countries, despite using fewer medications.[4] Unfortunately, higher spending does not translate to better health: Americans consistently have some of the worst health outcomes among high-income countries.[5] These trends are worsening: U.S. prescription drug spending is already substantial, and its share of health care spending is growing.[6]

This brief examines how the U.S. health system's approach to prescription drug pricing differs from other high-income countries, and how those differences lead to higher prices for American consumers.

What to Know

Drug prices in the U.S. are higher than in other high-income countries for several reasons:

1. U.S. negotiating power is fragmented.

All countries with health insurance coverage for prescription drugs must decide what and how to pay for them. The governments of most other high-income countries negotiate directly with pharmaceutical manufacturers on behalf of all health plans or residents. In the U.S., pharmacy benefits managers (PBMs) carry out this function—for drugs consumers purchase at the pharmacy—through the private market. A PBM's primary function is negotiating with pharmaceutical manufacturers on behalf of health plans.

> The fragmentation of purchasing power means that pharmaceutical companies can charge payers and patients different prices based on how much negotiating power their PBM has.

Centralized negotiation is common across high-income countries that otherwise differ in how they offer health insurance. Some high-income countries have fragmented insurance coverage offered through a blend of public and private health plans, while others offer universal coverage through a single public payer. Despite the differences in insurance landscapes, other high-income countries generally run negotiations through the national government or coalitions of health insurers. In Belgium, France, Netherlands and the United Kingdom (U.K.), government ministries take on the role of negotiator. By contrast, Germany, Canada and Norway rely on a committee composed of different health insurance plans across the country.[7]

Direct negotiation with manufacturers allows high-income countries to aggregate the purchasing power of their entire population under one umbrella. This approach can, in turn, result in lower prices for all patients. In the U.S., negotiation is broken up across several PBMs, none of which cover all patients. The fragmentation of purchasing power means that pharmaceutical companies can charge payers and patients different prices based on how much negotiating power their PBM has.

2. In the U.S., one drug has many prices.

Pharmaceutical manufacturers set the prices of their drugs. These prices are known as list prices or Wholesale Acquisition Cost (WAC), which becomes the starting point for negotiating all further transactions in the market for prescription drugs.

The structure of the U.S. prescription drug markets means that power to set list price allows pharmaceutical manufacturers to charge different prices to different payers (PBMs and health plans) for the same drug.[8] Manufacturers compete for position on formularies—the tiered drug lists that determine the cost and accessibility of prescription drugs for insured patients—by offering rebates to payers.[9] Gaining access to favorable formulary tiers that serve large populations of patients is generally beneficial to manufacturers because it maximizes the size of their potential market.[10]

Manufacturers may offer more generous rebates and discounts to larger payers with more patients and negotiating leverage, which results in lower net prices for the payer.[11] At the same time, they may offer less generous discounts and rebates to smaller payers that have fewer patients and less leverage, which results in those smaller payers paying higher net prices.[12] Similarly, manufacturers often use their list price as the basis for discounts, fees and rebates offered to other supply chain intermediaries like wholesalers and pharmacies.[13]

Other high-income countries avoid these pricing dynamics by making a drug's negotiated price its maximum reimbursement price, effectively setting a ceiling on further discounts or rebates that might be negotiated by individual health plans or the supply chain.

3. U.S. payers can't say no.

U.S. laws and regulations limit health plans from denying or limiting coverage of certain drugs. As a result, plans often act more as "price takers" rather than being able to effectively negotiate lower prices.

For example, state Medicaid programs are required to cover most FDA-approved prescription drugs sold by the nearly 800 manufacturers that participate in the Medicaid Drug Rebate Program.[14] The program requires manufacturers to rebate a portion of its list price set in statute in exchange for placement on Medicaid formularies.[15] Medicare is required to cover "reasonable and necessary" medical care, which includes most FDA-approved treatments, regardless of their price.[16] Part D plans also are required to cover at least two drugs in each therapeutic class in addition to "protected classes" of drugs for conditions like cancer and HIV/AIDS.[17] Plans in the Affordable Care Act's Exchange are similarly required to cover a list of essential health benefits, which include prescription drugs.[18]

Many other high-income countries have no such obligations. In Germany, drugs found to have no additional therapeutic benefit compared to other options are not negotiated. Instead, their reimbursement is set by average prices of a similar group of drugs. In Belgium, Canada, Netherlands, Norway and the U.K., failed negotiations can lead to non-coverage unless the manufacturer offers a better deal.[19]

Congress began to change this dynamic in 2022 when it authorized Medicare to negotiate

directly with drugmakers for the first time.[20] Prior to that change, the program had few if any tools to lower high drug costs for both beneficiaries and taxpayers. **Medicare began the first round of negotiations in 2023, leveraging its market power to make deals for medicines that are most costly to taxpayers. The Congressional Budget Office projected that Medicare negotiation will save taxpayers nearly $100 billion over the next decade.**[21]

At the same time, recent administrative efforts have explored ways to leverage federal authority to lower drug costs in Medicaid through new payment approaches from the CMS Innovation Center and dealmaking by the administration. While these efforts signal growing interest in more coordinated purchasing strategies, the voluntary nature of the new models and limited transparency of agreements with manufacturers make their impact uncertain – particularly compared to Medicare's statutory, mandatory negotiation framework.

4. High U.S. prices mean high profits.

Finally, financial incentives in the U.S. prescription drug supply chain reward drugs with higher prices.

For example, the business models of wholesalers and pharmacies rely on purchasing drugs at a discount and then marking them up for sale.[22] Under Medicare Part B and most commercial health plans, providers are paid by a formula tied to a markup of the drug's list price. This payment approach can bias treatment selection among therapeutically comparable drugs towards the most expensive drugs.[23] PBMs likewise benefit when list prices increase, because the rebates and fees manufacturers offer payers in negotiations are often tied to a percentage of a drug's list price.[24] Finally, manufacturers benefit from higher prices, which generate greater revenue for their products.[25]

Other high-income countries avoid or reduce incentives to favor high-priced drugs. For example, many explicitly limit wholesalers and pharmacy markups.[26] To compensate pharmacies for their services, many of these countries also pay fixed payments or dispensing fees that are unrelated to the prices of dispensed drugs.[27] In addition, **national governments that negotiate prices with manufacturers have a single goal—lowering costs—that are not tied to competing profit motives.**

What's Next

Americans end up paying more for prescription drug prices than patients in other high-income countries because the U.S. pharmaceutical pricing chain lacks adequate checks to reign in prices and elevate therapies with the greatest therapeutic benefit. Moreover, since different actors within the pricing chain generate more revenue when list prices rise, no single actor can effectively push down prices, nor has adequate incentives to sufficiently limit costs for patients.

To reduce the rapid growth of prescription drug spending, policymakers must address the factors unique to the U.S. system that drive high prices. Congress took a step in this direction in 2022 when it gave Medicare authority to negotiate drug price discounts, reducing the fragmentation of U.S. negotiating power. Congress could increase the saving Medicare generates from its negotiating power by expanding the number and type of drugs that are subject to negotiation. It can also allow Medicare to negotiate on behalf of other plans, such as commercial health plans, increasing their bargaining leverage. In addition, Congress can work to ensure that PBMs have greater incentives to negotiate lower prices by removing potential conflicts of interest, such as joint-ownership of pharmacies.

> Making prescription drugs affordable for all patients in the U.S. requires a system-wide approach to policymaking that factors in each actor's behaviors and incentives.

Making prescription drugs affordable for all patients in the U.S. requires a system-wide approach to policymaking that factors in each actor's behaviors and incentives. Congress can take lessons from other high-income countries as it considers concrete steps to untangle the competing incentives in the U.S. pharmaceutical system that keep costs high for patients.

References

1. Congressional Research Service. (2005). Prescription drug pricing and negotiation in Medicare (RL32511). https://www.everycrsreport.com/files/20051208_RL32511_87ba3ea2675d9203ffe4890864374636946844 94.pdf
2. West Health & Gallup. (2024). Aging in America survey report. https://a-us.storyblok.com/f/1022211/f2d50b3596/west-health-gallup-2024-aging-in-america-survey-report-final.pdf
3. U.S. Government Accountability Office. (2021). Prescription drugs: Information on prices, research, and development, and spending (GAO-21-282). https://www.gao.gov/assets/gao-21-282.pdf
4. National Institutes of Health. (2018). [Article indexed in PubMed]. https://pubmed.ncbi.nlm.nih.gov/30041827/
5. JAMA Network. (2024). [Article in JAMA Internal Medicine]. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2831735
6. Health Affairs. (2024). [Article on healthcare policy/affordability]. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01375
7. Syverson, I. D., et al. (2024). A comparative analysis of international drug price negotiation frameworks: An interview study of key stakeholders. The Milbank Quarterly, 102(4), 1004–1031.
8. U.S. Senate Committee on Finance. (n.d.). Insulin: Examining the factors driving high costs (Committee print). https://www.finance.senate.gov/imo/media/doc/Insulin%20Committee%20Print.pdf
9. American Medical Association. (2024). PBM market share and concentration report. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2024.pdf
   National Institutes of Health. (2024). Pharmacy benefit manager market dynamics and competition (PMCID: PMC10838136). https://pmc.ncbi.nlm.nih.gov/articles/PMC10838136/
10. Health Affairs. (n.d.). Formularies. https://www.healthaffairs.org/content/briefs/formularies
11. Congressional Budget Office. (2024). Prescription drug prices: Trends and policy options. https://www.cbo.gov/system/files/2024-10/58793-rx-drug-prices.pdf
12. U.S. Senate Committee on Finance. (n.d.). Insulin: Examining the factors driving high costs (Committee print). https://www.finance.senate.gov/imo/media/doc/Insulin%20Committee%20Print.pdf
13. Cardinal Health. (2025). Annual report. https://s24.q4cdn.com/128197368/files/doc_financials/2025/ar/f228364d-7e15-414a-a2e2-177651014ef5.pdf
    Cardinal Health. (2025). Form 10-K. U.S. Securities and Exchange Commission. https://www.sec.gov/ix?doc=/Archives/edgar/data/0000721371/000072137125000079/cah-20250630.htm
14. Centers for Medicare & Medicaid Services. (n.d.). Medicaid drug rebate program. https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program
15. Centers for Medicare & Medicaid Services. (n.d.). Medicaid drug rebate program. https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program
    KFF. (n.d.). Understanding the Medicaid prescription drug rebate program. https://www.kff.org/medicaid/understanding-the-medicaid-prescription-drug-rebate-program/
16. Centers for Medicare & Medicaid Services. (n.d.). Medicare coverage determination process. https://www.cms.gov/medicare/coverage/determination-process
17. Medicare.gov. (n.d.). How drug plans work. https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/how-drug-plans-work
18. HealthCare.gov. (n.d.). What marketplace plans cover. https://www.healthcare.gov/coverage/what-marketplace-plans-cover/
19. Anderson, G. F., Hussey, P., & Petrosyan, V. (2024). It's still the prices, stupid: Why the United States is so different from other countries. Public Administration Review. https://doi.org/10.1111/1468-0009.12714
20. U.S. Congress. (2022). Inflation Reduction Act of 2022 (Public Law No. 117-169). https://www.congress.gov/117/plaws/publ169/PLAW-117publ169.pdf
21. Congressional Budget Office. (2022). Estimated budgetary effects of Public Law 117-169, the Inflation Reduction Act of 2022. https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf
22. The Commonwealth Fund. (2022). Impact of pharmaceutical wholesalers on drug spending. https://www.commonwealthfund.org/publications/issue-briefs/2022/jul/impact-pharmaceutical-wholesalers-drug-spending
23. Office of Inspector General, U.S. Department of Health & Human Services. (2012). Least costly alternative policies' impact on prostate cancer drugs covered under Medicare Part B. https://oig.hhs.gov/reports/all/2012/least-costly-alternative-policies-impact-on-prostate-cancer-drugs-covered-under-medicare-part-b/
24. U.S. Senate Committee on Finance. (n.d.). Insulin: Examining the factors driving high costs (Committee print). https://www.finance.senate.gov/imo/media/doc/Insulin%20Committee%20Print.pdf

U.S. Senate. (2019). Drug pricing in America: A prescription for change (Hearing, 116th Congress). https://www.govinfo.gov/content/pkg/CHRG-116shrg43563/pdf/CHRG-116shrg43563.pdf

25. Pfizer. (2025). Form 10-K annual report. U.S. Securities and Exchange Commission. https://www.sec.gov/Archives/edgar/data/78003/000007800325000054/pfe20241231.htm

26. Shah, R., et al. (2022). Pharmaceutical pricing and its impact on patient access and affordability. Journal of Health Policy & Systems. https://jhphs.org/sbrafh/article/view/639
National Institutes of Health. (2022). Drug pricing and health outcomes in the United States (PMCID: PMC9031039). https://pmc.ncbi.nlm.nih.gov/articles/PMC9031039/

27. Australian Government Department of Health and Aged Care. (2023, July 3). Pharmacies get major financial boost from 1 July. https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/pharmacies-get-major-financial-boost-from-1-july