Patient access and affordability

2024 Johnson & Johnson Innovative Medicine U.S. pricing transparency data

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At a glance:

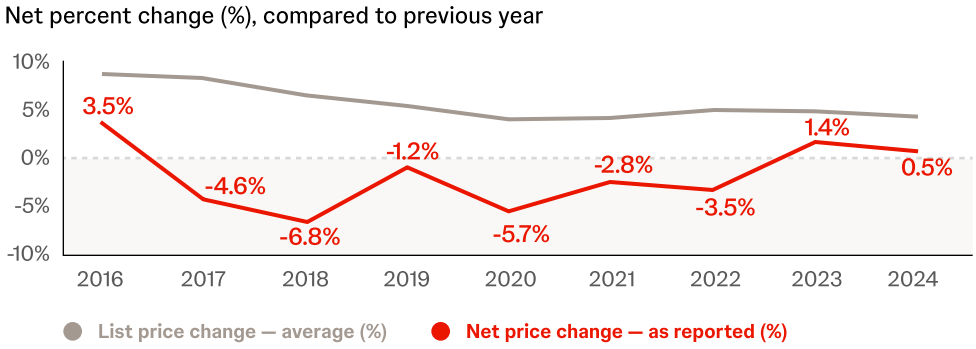
J&J Innovative Medicine is leading where medicine is going

J&J Innovative Medicine's continuous R&D investments, totaling over $90 billion since 2016, are helping save lives today and bringing hope to patients tomorrow.[1] Yet, patients' affordable access to lifesaving medicines is becoming harder each year because of increasing out-of-pocket costs, inadequate insurance benefit design and regulatory hurdles.[2]

Our average net prices have declined a compounded 18.2% since 2016[1]

The changes in our net prices are below overall inflation growth, and are significantly below the change in our list prices.

Net percent change in J&J Innovative Medicine prices, 2016 – 2024[1]



By the numbers

58%

In 2024, J&J provided 58% of total gross sales to the healthcare system through rebates, discounts and fees[1]

$47.8B

In 2024, J&J provided $47.8B in rebates, discounts and fees[1]

$13.5B

Our total R&D spending for 2024, bringing J&J Innovative Medicine R&D spending to over $90B since 2016[1]

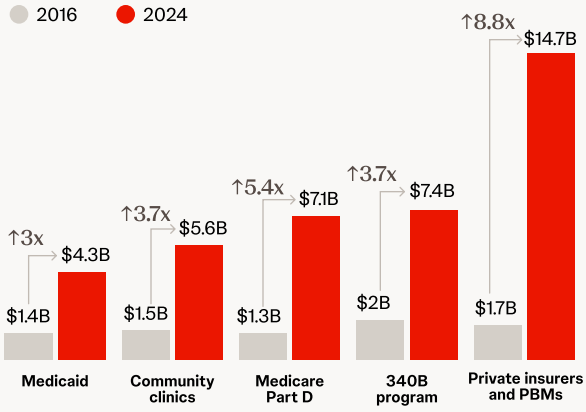
124%

More invested in R&D in 2024 compared to sales and marketing[1]

Rebates, discounts and fees totaled $47.8B in 2024[1]

Nearly half of this total goes to the 340B Program, private health insurers and pharmacy benefit managers (PBMs), whose rebates and discounts have risen significantly since 2016.[1]

Growth in rebates, discounts and fees[1]



Patients need more affordable access, fewer restrictions

Even with lower net prices for middlemen, premiums and deductibles continue to grow for individuals and families.[3] Access restriction tools like strict prior authorization, step therapy and exclusion lists are making it harder for patients to get lifesaving medicines.[4]

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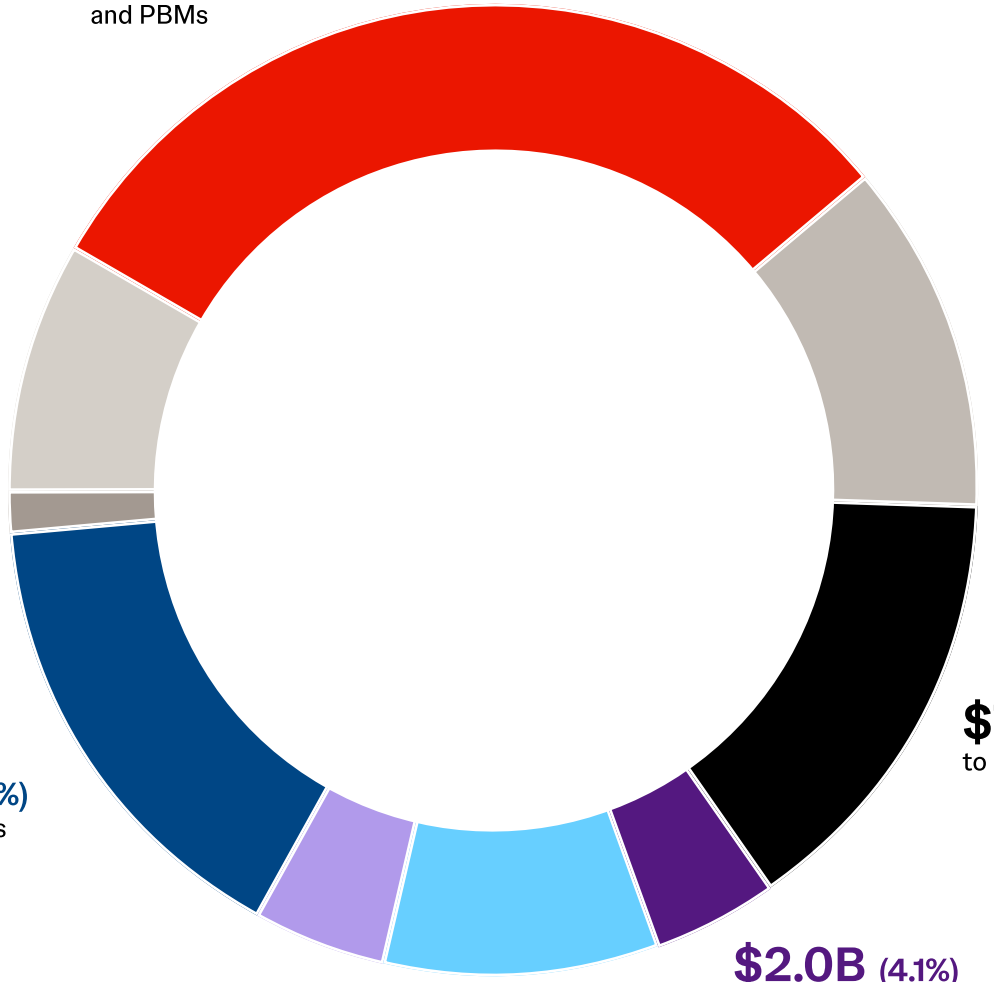
Rebates, discounts and fees by recipient, 2024

In 2024, J&J provided **$47.8 billion in rebates, discounts and fees** to insurers, pharmacy benefit managers (PBMs), hospitals, government programs and other healthcare entities.[1]



All figures according to Johnson & Johnson internal financial accounting. Figures have been rounded.
*"Other healthcare entities" refers to other sites of care, less known payer organizations and other healthcare intermediaries.
†Department of Veterans Affairs and Department of Defense

Introduction

At Johnson & Johnson, our vision is to develop science-based innovations to change and save lives. Every day, our team of scientists, researchers and clinicians works to discover breakthroughs to help patients today and tomorrow.

We also recognize that patients need to have affordable access to these scientific advancements and medical breakthroughs. In the U.S., access and affordability are largely determined by the type of health insurance benefits an individual or family receives through their employer, obtains from the government or purchases on their own. While the rate of uninsured patients has dropped recently, there are three troubling trends undermining patients' affordable access to innovative medicines:[5]

Underinsurance

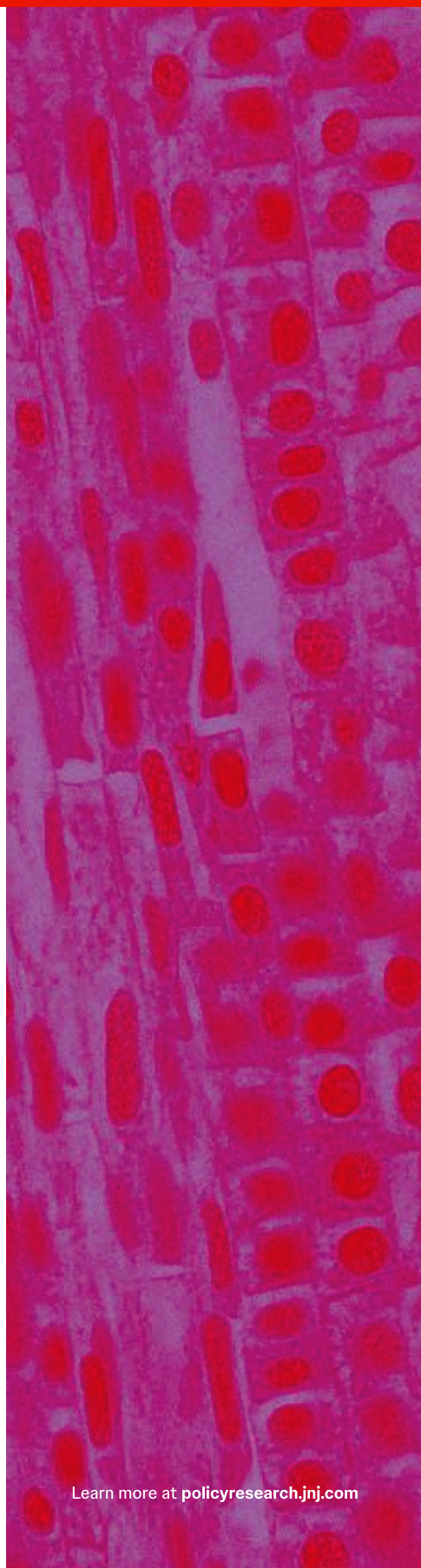
Too many individuals and families are burdened with underinsurance — the phenomenon of paying premiums for insurance that does not cover critical healthcare treatments or leaves patients exposed to high out-of-pocket costs.[5]

Patient assistance diversion

The continuous use of programs by middlemen to divert patient assistance, often a critical lifeline to accessing lifesaving medicines, away from individual patients.[6]

340B Program exploitation

While the federal 340B Drug Pricing Program was originally intended to support vulnerable patient access to outpatient drugs, it is now exploited by large, corporate-like for-profit pharmacy benefit managers (PBMs) and retail pharmacies, who help turn discounts for patients to markups and profits for corporate-like hospitals and for-profit middlemen.[7]



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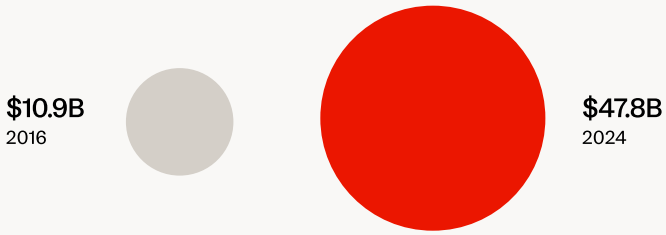
Despite these challenges, J&J continues its efforts to support patients' access to innovative medicines by:

01. Increasing rebates and discounts

In 2024, J&J provided $47.8 billion in rebates, discounts and fees to insurers, PBMs, hospitals, government programs and other healthcare entities.[1]

Rebates, discounts and fees, 2016 vs. 2024[1]



02. Supporting patient access programs

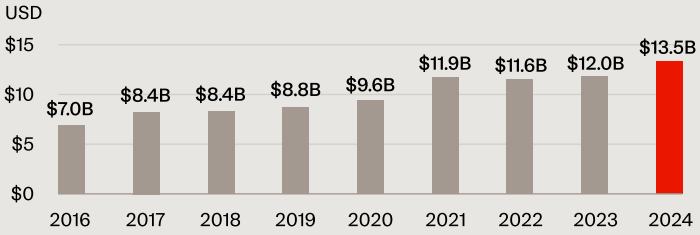
J&J supports patient access through free products provided directly to patients as well as donated through the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF), which totaled $4.5 billion in 2024.[1]

$4.5B

03. Investing in research and development

Since 2016, J&J Innovative Medicine alone has invested over $90B to deliver the next era of treatments and cures for patients.[1]

J&J Innovative Medicine R&D investments, 2016-2024[1]



In the ninth year of J&J's U.S. pricing transparency report, we continue to provide transparency into our pricing, the rebates and discounts we provided and insights into key parts of the healthcare system. These data and insights are intended to help inform the policymaking environment to create a healthcare system that better serves the needs of patients, today and tomorrow.

Part 1:

Pricing transparency and patient costs

While commercial insurers and PBMs continue to benefit from lower net drug prices, patients continue to face high out-of-pocket costs due to distorted incentives and inadequate benefits.[8]

What's happening

This is the eighth year in a row that J&J's rebates, discounts and fees to insurers, PBMs, hospitals, government programs and other healthcare entities have increased.[1] Industrywide, rebates, discounts and fees rose to an estimated $334 billion in 2023.[9]

Why it matters

As rebates and discounts increase, patients are not benefiting.[3] Patients, especially the most vulnerable, are burdened by rising healthcare out-of-pocket costs, which can lead to medication abandonment and worse health outcomes.[10]

- The disconnect between declining net prices and increasing patient costs underscores the need to ensure patients benefit more directly from lower prices.[11]
- Commercial insurers benefit from lower net prices due to our rebates and discounts, but patients still pay rising out-of-pocket costs at the pharmacy.[11]

By the numbers

-18.2%

Compound rate of decline in J&J's net prices since 2016[1]

$47.8B

In 2024, J&J provided $47.8B in rebates, discounts and fees[1]

58%

In 2024, J&J provided 58% of total gross sales to the healthcare system through rebates, discounts and fees[1]

The bottom line on transparency and patient costs

Policymakers must ensure rebates and discounts directly benefit patients.

- Reforms should focus on reducing out-of-pocket expenses, holding PBMs accountable and reforming the 340B Program to ensure discounts are shared with patients.
- Requiring insurers and PBMs to pass rebates and discounts directly to patients at the pharmacy counter would help lower out-of-pocket costs.

Part 2:

Barriers to accessing innovative medicines

The U.S. leads in creating the broadest, earliest access to innovative medicines, but Americans' access to medicines is becoming too complex and too expensive as out-of-pocket costs are growing significantly.[12] Insurance benefit design creates barriers that drive costs up, lead to medication denials and cause care delays for patients.

Why it matters

Access to medications is crucial to improving health outcomes and enabling all to benefit from high-value treatments.

- Patient access barriers like strict prior authorization and step therapy delay or prevent patient access to necessary treatments.[4]
- High out-of-pocket costs deter patients from obtaining prescribed medications, exacerbating health challenges.[5]
- As out-of-pocket costs rise, patient assistance programs are crucial, yet intermediaries and PBMs divert these funds, undermining more affordable access.
- Additional barriers include alternative funding programs (AFPs), which can cause patients to be denied or receive delayed coverage of a needed treatment or medicine.[13]

By the numbers

1 in 3

insured Americans say their out-of-pocket costs for healthcare services have increased over the past year.[14]

41%

of insured Americans taking a prescription medicine report insurer- and PBM-imposed barriers to care in the past year, such as strict prior authorization or step therapy.[4]

51%

of insured Americans managing a chronic condition commonly face challenges when seeking reliable access to care.[15]

The bottom line on access

Addressing these barriers requires reforms that prioritize patient-centered solutions and protect access to health care.

- Policymakers need to focus on reducing out-of-pocket costs and increasing transparency in insurance coverage.
- Strengthened protections for doctor-patient relationships and decision-making are crucial to ensure access to necessary treatments.

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Policy solutions

Implementing policies that expand access, reward high-value care and eliminate barriers like strict step therapy and prior authorization is crucial. These actions will reduce unnecessary delays and costs, ensuring patients receive timely and affordable care.

Reform PBMs to prevent patient access hurdles and lower patient costs.

- Policymakers should advance legislation that would lower out-of-pocket costs, remove deductibles on certain medicines and encourage patients to pay a flat-dollar co-pay rather than a percentage-based coinsurance.[2]
- State and federal lawmakers should ensure that any co-pay assistance that patients receive counts toward their deductible and maximum out-of-pocket limits.[6]
- Reforms should also ensure that patients more directly benefit from manufacturer rebates and discounts.
- Federal and state legislatures should pursue policies that delink PBM fees from list prices.

Enact legislation to protect patients from patient assistance diversion programs that limit access.

- Federal legislation and regulation can prohibit co-pay accumulator or maximizer programs unless a medically appropriate generic equivalent is available.[16]
- At the state level, lawmakers should pass legislation that ensures cost-sharing assistance is counted toward patient out-of-pocket contributions, prohibits third parties from altering or conditioning the terms of health plan coverage or benefit design based on the availability of financial or product assistance for a prescription drug, and requires disclosure about diversion programs to patients.[6]
- State and federal policymakers should prohibit or disincentivize practices that block patients' access to medicine, such as strict prior authorization and step therapy.

Stop alternative funding programs (AFPs) to protect patients.

- The Federal Trade Commission and state regulators should review AFP industry practices.
- The Departments of Labor, Health and Human Services and Treasury should extend the Affordable Care Act's Essential Health Benefit drug coverage standards for individual and small group plans to large group and self-insured plans so patient assistance counts toward a patient's cost-sharing requirements.[17]
- The Department of Labor should help ensure that plan designs prioritize affordability and access to essential medicines rather than maximizing rebates or cost-shifting onto patients by increasing oversight of AFP practices in employer-sponsored plans.
- Congress and states should pursue legislation that prohibits the use of AFPs by group health plans, health insurance issuers and other entities.

Enact legislation to streamline prior authorization requirements.

- Policymakers should advance legislation to improve process transparency, reduce administrative burdens for clinicians and prevent unnecessary delays for patients.
- At the federal level, J&J has supported the Improving Seniors' Timely Access to Care Act (S.1816). It has been reintroduced in the Senate in 2025 with strong bipartisan support.[18]
- Streamlining prior authorization is essential to putting patients over paperwork—a goal echoed by the CMS* "Patients over Paperwork" initiative that aimed to reduce regulatory burden on providers.[19]

*Centers for Medicare & Medicaid Services

Data rates may apply.

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Learn more about how we're pushing forward healthcare policy solutions at policyresearch.jnj.com.

Reform the 340B Program to support its original intent by increasing transparency and accountability.

- Reforms should require that 340B discounts be shared directly with vulnerable patients at the outpatient clinic or at the pharmacy counter.
- Policymakers should take steps to eliminate duplicate discounts and diversion. The lack of transparency in the program limits stakeholders' ability to monitor for these issues.

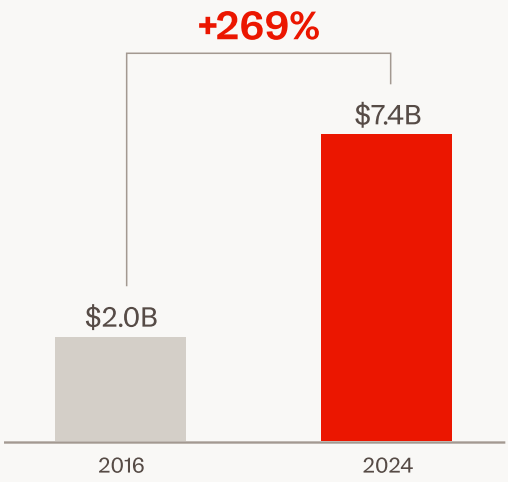
340B is on track to be the largest federal drug program by 2028, exceeding gross drug purchases through Medicare Part D, Medicare Part B, and Medicaid.[7]

Read more about 340B Program reform at our Center for U.S. Healthcare Policy Research.

The 340B Program was designed by Congress to be a narrowly tailored, targeted program enabling manufacturers to restore deep discounts that manufacturers historically had provided voluntarily to safety net providers.

- However, the program has grown out of control as for-profit pharmacy chains and larger health systems have used it to boost profits without directly benefiting patients either in the outpatient clinic or at the pharmacy counter.[7]
- Profits from 340B now account for nearly $65 billion — nearly 10% of gross brand medicine spending — and continue to grow unchecked.[20] Larger hospital systems are spending less on charity care than they are receiving in 340B markup profits.[21]

Johnson & Johnson discounts to 340B providers[1]



The bottom line on policy

Creating a sustainable, patient-centric healthcare system requires policies and regulatory structures that enhance innovation, access and affordability. Policymakers should create a future healthcare system that protects patients and promotes the next wave of medical breakthroughs by:

- Bolstering the U.S.'s leadership role in discovering critical medicines through supporting the robust innovation ecosystem.
- Lowering ever-increasing development costs and reducing regulatory hurdles that hinder the development and manufacturing of life-saving medicines.
- Increasing transparency around how discounts and rebates are used by middlemen, which better ensures savings more directly benefit patients.
- We strive to develop innovative medicines that address unmet patient needs, help improve outcomes in our healthcare systems and contribute to strong societies and economic growth.

Citations

Notes on this report. All information in this report refers to the U.S. operations of the Johnson & Johnson Innovative Medicine, unless noted otherwise. Financial and nonfinancial information covers the period between January 1, 2024, and December 29, 2024, except where noted. The methodologies used for analyses in this report may be different from those used by other organizations. This report is not audited and is not intended to address all our required disclosures.

Additional resources. This report references locations where you can find more information about specific Johnson & Johnson Innovative Medicine programs, disclosures, and patient resources. Financial performance information for our parent company and its subsidiaries, as well as its "Cautionary Note Regarding Forward-Looking Statements" and "Risk Factors," can be found in Johnson & Johnson Annual Reports at jnj.com/corporate-reports. Information on corporate sustainability measures can be found at the Johnson & Johnson Health for Humanity Report at healthforhumanityreport.jnj.com.

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