The 340B Program: Missing the mark for patients

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Johnson&Johnson

Lack of transparency and accountability fuels abuse

340B is a federal program that requires drug manufacturers to provide steep discounts on outpatient drugs to certain, specified safety net providers (known as covered entities). However, today the 340B Program operates with little oversight, making it difficult to track whether billions of dollars in 340B discounts are reaching the patients the program was originally intended to help. Instead, large hospital systems, contract pharmacies and PBMs have taken advantage of loopholes in the program, including a lack of reporting requirements on whether 340B discounts are shared with patients.

Patients, employers and taxpayers are paying the price for 340B abuse

- According to research from IQVIA, 340B increased costs for employer-sponsored plans between $13 and $152 per covered beneficiary, depending on the state, totaling $6.6 billion nationwide in 2023.[1] This is due to lost rebates that would otherwise be available to employer plans.[1]
- State and local governments incurred a $1 billion increase in healthcare costs due to 340B, with the cost per beneficiary approximately 10% higher due to lost rebates to Medicaid and state and local government health programs.[1]
- As the 340B Program has continued to grow, Medicaid spending has increased because the 340B Program blocks Medicaid from receiving certain rebates that would be duplicative of 340B discounts. This creates added pressure to state healthcare budgets.
  - A recent research report found that between 2014 and 2021, the expansion of 340B hospitals and grantees added $391 per enrollee to Medicaid spending—totaling over $32 billion annually.[2] This 340B-driven spending accounts for nearly 10% of Medicaid's budget, significantly increasing costs for taxpayers.[2]

Why it matters

The 340B Program's lack of transparency enables abuses and masks noncompliance with existing prohibitions on:

- Diversion, where a 340B drug is transferred to a person who is not a patient of a covered entity[3]
- Duplicate discounts, a practice where a drug that is eligible for a 340B discount is also subject to a separate discount or rebate from another program (such as Medicaid),[3] resulting in the same drug receiving multiple discounts

Without proper oversight to stem abuse and noncompliance, the 340B Program's adverse impacts on patients, employers and taxpayers will continue to grow.

Widespread violations

The Government Accountability Office (GAO) found that duplicate discount violations represented nearly 28% of the more than 1,500 cases of 340B noncompliance identified by the Health Resources and Services Administration (HRSA) in audited covered entities from 2012–2019.[4]

Another analysis found that 62% of covered entities audited by HRSA in FY 2021 were found to be non-compliant.[5] These findings are particularly striking considering HRSA's very low total auditing volume and limited overall audit capability.[5]

Several covered entities are refusing to participate in approved manufacturer audits, as required by federal law.

340B's impact on states: A closer look

5.4x acquisition cost

A report from the North Carolina State Treasurer found that North Carolina 340B hospitals billed the State Employee Health Plan 5.4 times the acquisition cost of 340B medications, 84.8% more than non-340B hospitals.[6]

$630M profits

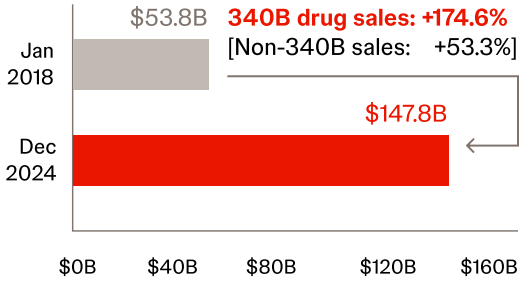
The Minnesota Department of Health found that providers participating in 340B generated at least $630 million in 340B Program profits in 2023 alone, likely a significant undercount since it excluded provider-administered drugs.[7] The state's Medicaid and Basic Health Programs contributed at least $87 million to this amount.[7] There is little transparency into how these funds are benefiting low-income and vulnerable patients in Minnesota.[7]

340B by the numbers

The 340B Program has grown rapidly

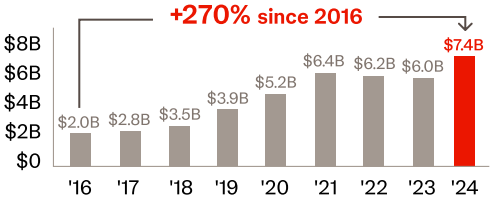
Discounted purchases through the 340B Program reached $147.8 billion in 2024 at list price, growing at more than three times the rate of non-340B sales between January 2018 and December 2024.[8]

340B Program purchases, at list price[8]



In 2024, J&J Innovative Medicine provided $7.4 billion in rebates and discounts to 340B covered entities and DSH hospitals. This indicates a growing amount of money is going to middlemen, rather than being invested in the next breakthrough medicine.[9]

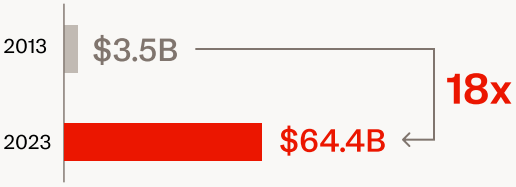
J&J Innovative Medicine 340B rebates and discounts[9]



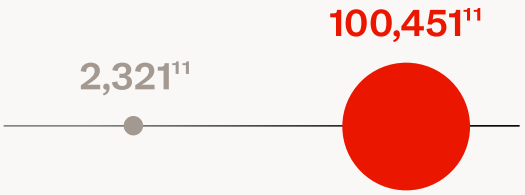
Which has led to exploding profits

In 2013, 340B generated about $3.5 billion in profits for hospitals and PBMs.[10] A decade later, that figure had soared to $64.4 billion.[10]

340B hospital markups and 340B contract pharmacy margin[10]



Provider margins have likely climbed even higher amid continued expansion of contract pharmacy dispensing and hospital participation.[11]



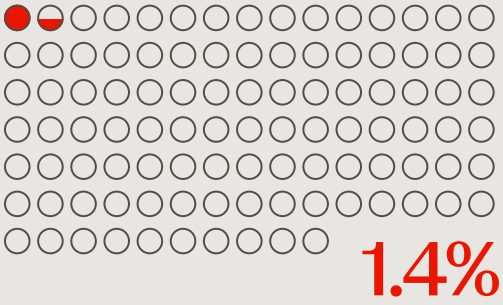
2010: HRSA expands contract pharmacies through non-binding guidance

2020: Contract pharmacy arrangements balloon as for-profit pharmacies rush to capitalize

But patients — including the most vulnerable — aren't benefiting

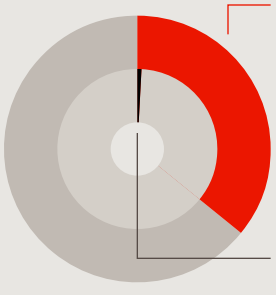
Savings don't reach patients

A recent study found that only 1.4% of 340B-eligible prescriptions at contract pharmacies shared any direct savings with patients.[12]



Many hospitals fail to fund charity care

As the program has rapidly grown, charity care provided by disproportionate share hospitals (DSHs) has declined, suggesting the 340B Program is not delivering on its intended purpose and helping communities most in need.[13]



36% of 340B DSH hospitals spent[14]

less than 1% of their total operating costs on charity care in 2021.[14]

340B growth serves big hospital systems, not patients

The 340B Drug Pricing Program was designed to help eligible safety-net healthcare providers provide access to more affordable medicines for low-income and vulnerable patients. Unfortunately, patients today are not directly benefiting from the program amidst widespread abuse and misuse. Growing 340B profits are extracted by large health systems, contract pharmacies and pharmacy benefit managers (PBMs).

Large tax-exempt institutions buy medicines at steeply discounted 340B prices. These institutions add huge mark-ups before billing patients, employers and taxpayers. In 2023, these profits accounted for a staggering $64.4 billion.[10]

Why it matters

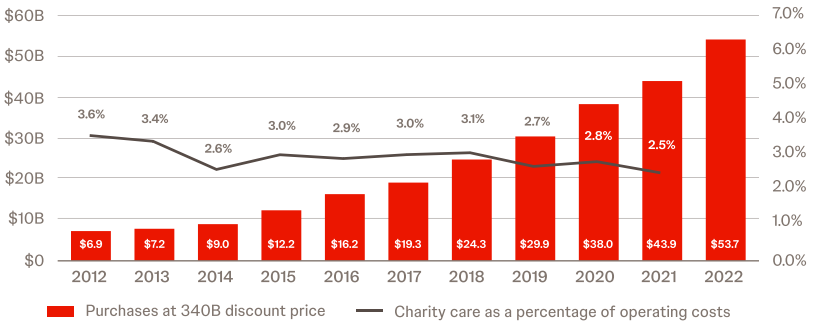
The 340B Program has grown exponentially to become the nation's second-largest federal prescription drug program, behind only Medicare Part D.[15]

As the program has rapidly grown, charity care provided by disproportionate share hospitals (DSHs) has declined, suggesting the 340B Program is not delivering on its intended purpose and helping communities most in need. Without greater transparency and accountability, large health systems and for-profit middlemen will continue leveraging the 340B Program for their own benefit while low-income and vulnerable patients and small, rural hospitals and their patients are left behind.[11]

340B hospitals are redirecting money away from charity care.

Despite 340B DSH hospitals accounting for 78% of 340B sales, most provide charity care below the national average of 2.28%.[16, 17]

Charity care's downward trend: 340B sales growth vs 340B DSH charity care[13]



Who's really benefiting?

Large health systems and for-profit middlemen, such as PBMs, their affiliated pharmacies and third-party administrators, reap massive profits from the 340B Program, while vulnerable patients have little to no savings passed on to them.[11]

PBMs have been criticized for their role in the 340B Program, particularly regarding duplicate discounts—a practice where manufacturers end up providing both a 340B discount and a rebate on the same drug.[7]

Large hospital systems and PBM middlemen profit from high markups

A recent study found that for physician-administered drugs, hospitals charged private insurers more than 3 times the acquisition price, and the markups were higher at 340B hospitals than non-340B hospitals.[6]

340B abuse is accelerating healthcare consolidation, impacting independent providers and pharmacists

340B hospitals are consolidating and acquiring community-based independent physician practices —creating competitive disadvantages for non-340B hospitals and independent practices and driving up healthcare costs.[18]

Roughly 80% of hospital acquisitions between 2016 and 2022 were driven by larger 340B hospitals.[19]

Many 340B hospitals fail to fund charity care.

More than a third of 340B DSH hospitals spent less than 1% of their total operating costs on charity care in 2021.[14]

We support federal reform of 340B to put patients first

Policymakers should reform the 340B Program to ensure low-income and vulnerable patients are directly benefiting.

01 **Reforms should be patient-centered and include increased transparency, accountability and oversight** so that large health systems and PBMs are unable to divert discounts intended to benefit low-income and vulnerable patients.

02 **Policymakers should take steps to eliminate duplicate discounts and diversion, which result in fewer savings for other payers.** A lack of transparency and clear program rules limit stakeholders' ability to ensure program integrity.

03 **State policymakers should oppose policies that lock in and expand abuses of the 340B Program.** Rather, states should seek greater transparency and accountability to ensure discounts are returned to the patient and communities the program is intended to serve.

Supporting efforts to reform 340B for patients

In 2025, the U.S. Senate Health, Education, Labor and Pension (HELP) Committee Chairman released a Majority Staff report on findings from a years-long investigation into the 340B Program. The report calls for legislation to increase transparency and data reporting by covered entities and for-profit middlemen to improve the program and ensure it benefits patients.[20]

In line with its commitment to transparency around the 340B Program, Johnson & Johnson voluntarily submitted data to aid the HELP Committee and supports the recommendations the Committee put forth in the April 2025 Report.

The bottom line:

Johnson & Johnson is strongly committed to the original intent of the 340B Program and believes transparency and increased accountability in the program will improve access to more affordable outpatient medicines for low-income and vulnerable patients.

- All Americans—employers, taxpayers, patients, and state and local governments—pay a price for expanded and uncontrolled 340B spending, either through higher premiums or lost tax revenue. The 340B Program must be modernized and refocused on low-income and vulnerable patients and the true safety-net providers caring for them.
- Johnson & Johnson has recommended common-sense measures to improve transparency and accountability in 340B, such as provisions that would require providers to document 340B prescriptions to eliminate the waste and abuse of duplicate discounts.

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 non-financial 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/about-jnj/annual-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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