Patient access and cost barriers in the U.S. healthcare system

2025 Johnson & Johnson Innovative Medicine Issue Brief



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Overview

Patients, employers and policymakers are demanding information about the drivers of healthcare costs from hospitals, insurers, providers and drug manufacturers. Johnson & Johnson has played a leading role in advancing value, patient access and innovation, and has worked to advance transparency in the U.S. healthcare system.

The data tells a clear story: Net drug prices are down. Patient costs are not.[1]

As Johnson & Johnson Innovative Medicine issues its 10th annual transparency report, it is evident that fees, discounts and rebates have grown significantly while net price continues to decline. In 2025, Johnson & Johnson Innovative Medicine provided 59.1% of products' list prices to healthcare intermediaries, such as insurance companies and pharmacy benefit managers (PBMs), through fees, discounts and rebates, compared to 35.2% in 2016.[2] Johnson & Johnson Innovative Medicine invested **over $103 billion since 2016** in research and development to deliver breakthrough treatments across some of the most serious diseases.[2] At the same time, fees, discounts and rebates have grown, totaling **$52.5 billion** in 2025, reflecting the increasing share of value flowing through to insurers, PBMs and other stakeholders in the healthcare system.[2] But patients continue to face rising out-of-pocket costs and growing barriers to care.

Because the system patients navigate today is increasingly complex.

Coverage rules, not physicians or healthcare professionals, increasingly determine which medicines patients receive, standing between patients and the medicines they need.[3] At the same time, savings provided by manufacturers, including Johnson & Johnson, through discounts and rebates are not consistently passed through to patients at the pharmacy.[4]

The result is a growing disconnect between manufacturer discounts and the patient experience.[1]

Patients are voicing need for affordable access to valuable medicines.

Despite lower net prices, individuals and families continue to face rising premiums, deductibles and out-of-pocket costs.[1, 5, 6] Even after a prescriber determines a treatment is clinically appropriate, patients often find themselves navigating a maze of insurance hurdles, from prior authorization denials and mandatory step therapy protocols to formulary exclusions, that bury them in paperwork, stretch treatment decisions into weeks-long ordeals and increase the risk of disease progression and increasing healthcare costs.[7, 8]

By the numbers

$52.5B

In 2025, Johnson & Johnson Innovative Medicine provided $52.5B in fees, discounts and rebates.[2]

$11.8B

Our total research and development (R&D) investment for 2025, bringing Johnson & Johnson Innovative Medicine R&D investment to over $103B since 2016.[2]

59.1%

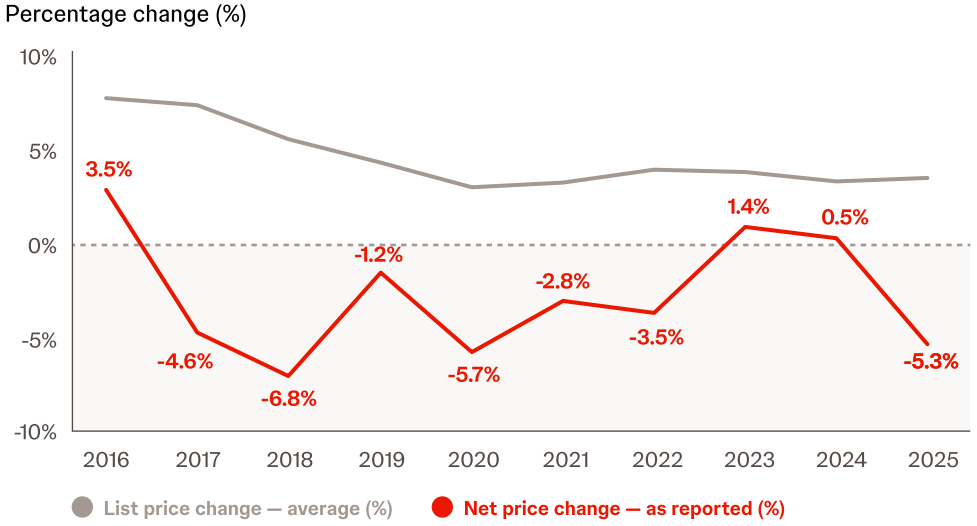
In 2025, 59.1% of Johnson & Johnson Innovative Medicine products' list prices went to healthcare intermediaries, such as insurance companies and PBMs.[2]

Read more at the Center for U.S. Healthcare Policy Research at policyresearch.jnj.com.

Our average net prices have declined a compounded 22.5% since 2016[2]

The changes in our net prices are much lower than overall inflation growth and changes in our list price.[2, 9]

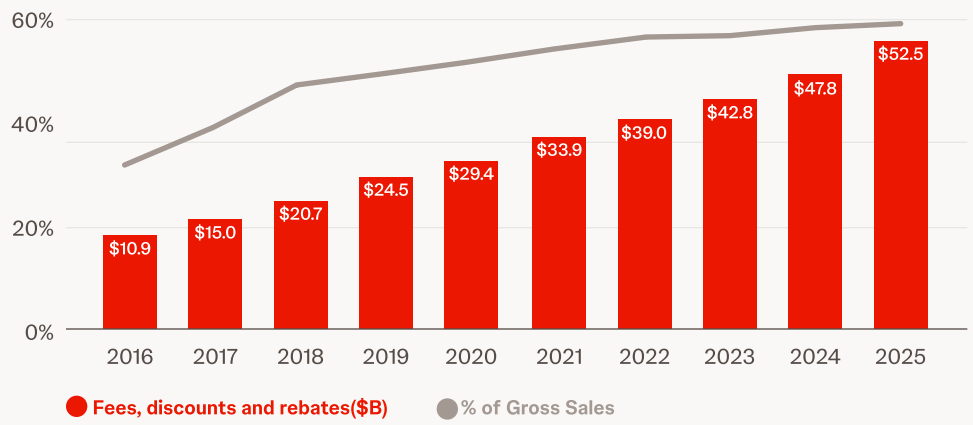
Net percentage change in Johnson & Johnson Innovative Medicine prices, 2016–2025[2]



Fees, discounts and rebates totaled $52.5B in 2025[2]

Our fees, discounts and rebates paid to intermediaries continued to grow. Since 2016, they have not only increased by absolute dollars, but have increased as a proportion of sales.

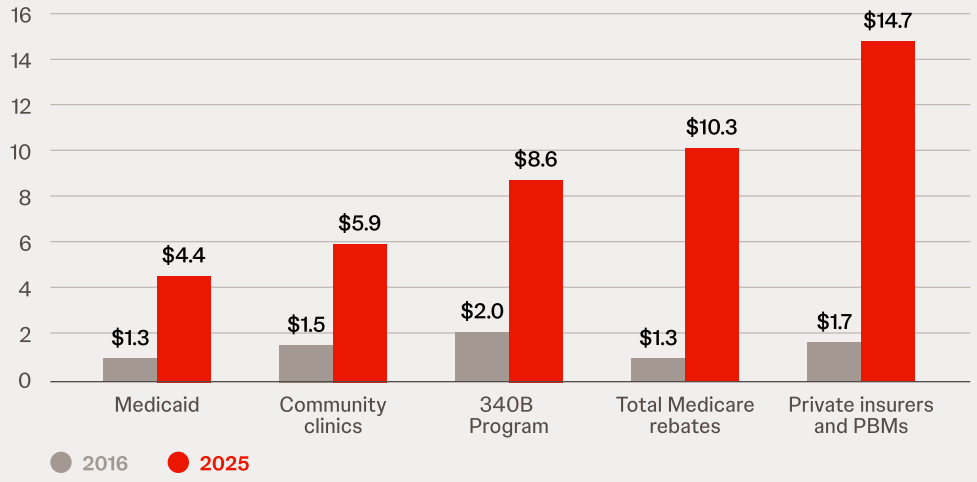
Fees, discounts and rebates reached $52.5B in 2025, accounting for a growing share of gross sales[2]



Much of this growth has gone to private insurers and PBMs

Nearly half of our fees, discounts and rebates go to covered entities in the 340B Program, private health insurers and PBMs. Fees, discounts and rebates have risen significantly since 2016.

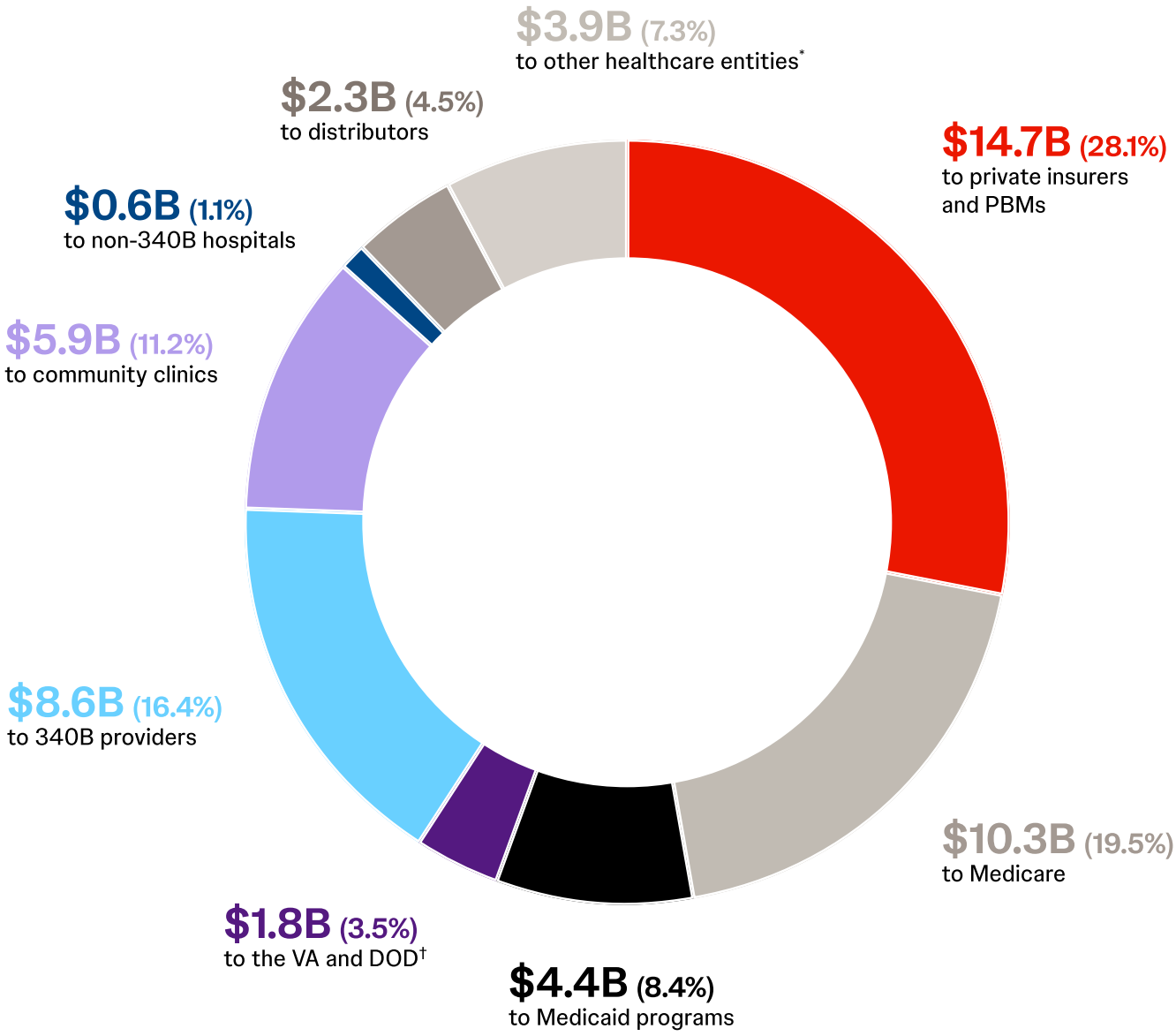
Growth in fees, discounts and rebates, $B[2]



Read more at the Center for U.S. Healthcare Policy Research at policyresearch.jnj.com.

Fees, discounts and rebates by recipient, 2025[2]

In 2025, Johnson & Johnson Innovative Medicine provided **$52.5 billion in fees, discounts and rebates** to insurers, PBMs, hospitals, government programs and other healthcare entities.



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

Read more at the Center for U.S. Healthcare Policy Research at policyresearch.jnj.com.

At Johnson & Johnson, our vision is to develop innovative medicines that change and save lives. Every day, our teams of scientists, researchers and clinicians work to discover and develop breakthroughs to help patients today and tomorrow.

Patients should have affordable access to scientific advancements and medical breakthroughs. In the U.S., access and the cost for medicines are largely determined by the type of health insurance an individual or family receives through their employer, or that they obtain from the government or purchase on their own.[5, 10] While the rate of uninsured patients has dropped from 9.7% in 2020 to 8.2% in 2024, three troubling trends are undermining affordable access to innovative medicines.[10]



People with chronic diseases are being left behind

Even with insurance coverage, patients with chronic conditions face higher out-of-pocket costs, which limit or reduce access. Higher out-of-pocket costs are associated with prescription abandonment or delayed initiation of cancer medications.[11] The Medicare Part D redesign capped annual out-of-pocket costs beginning in 2025, but it left a gap: many treatments for cancer are covered under Part B, where beneficiary coinsurance has no annual limit for those without supplemental coverage.[12, 13]



Prior authorization and utilization management create barriers to care and administrative burden

Utilization management requirements have become substantial obstacles to timely patient care. Medical practices complete an average of 39 prior authorization requests per physician per week, with physicians and office staff spending 13 hours weekly on these requests.[14] These growing administrative demands also contribute to clinician strain, with more than two in five U.S. primary care physicians reporting burnout.[15] An analysis in Health Affairs estimated the economic burden of utilization management at $93.3 billion in costs annually in the U.S.[16] Additionally, a 2025 IQVIA analysis found that over 75% of commercially insured patients were initially denied coverage when attempting to fill a new prescription across five chronic therapeutic areas, and among those who could not overcome their rejection within a year, 64% to 82% failed to initiate any new treatment in the same therapeutic area.[3]



Pharmacy Benefit Managers are growing in power

The pharmaceutical supply chain is now dominated by conglomerates whose business practices result in enormous extraction of value at the expense of patients and the broader U.S. healthcare system. Fees tied to list price can create perverse incentives for PBMs to favor higher list price products. Moreover, PBMs' vertically integrated business model enables self-preferencing arrangements that interfere with patients' timely access to affordable medicine, often raising out-of-pocket costs for patients paying based on list price.[4]

Utilization management requirements:

What they're really costing doctors and patients

By the numbers

39

Average prior authorization requests completed per physician each week.[14]

13 hours

Average time spent weekly by physicians and staff on prior authorization requests.[14]

$93.3B

Estimated annual cost of utilization management to payers, drugmakers, physicians and patients in the U.S.[16]

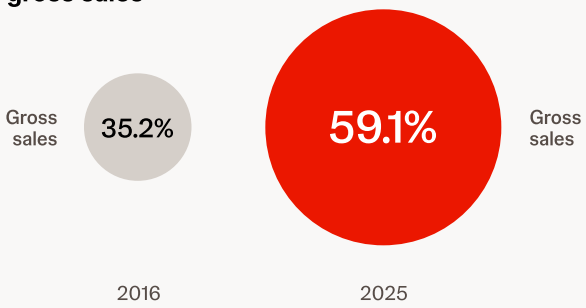
Read more at the Center for U.S. Healthcare Policy Research at policyresearch.jnj.com.

Johnson & Johnson continues to support patient access to innovative medicines by:

1. Supporting policies to ensure discounts and rebates reach patients

In 2025, Johnson & Johnson Innovative Medicine paid $52.5 billion to intermediaries in the healthcare system.[2] This represented 59.1% of gross sales, a significant increase from 2016.

Fee, discount and rebate $ as a percentage of gross sales



2. Supporting patient access programs even where insurance is not enough

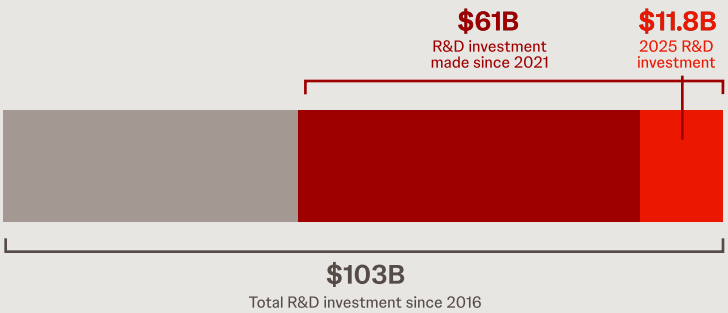
Johnson & Johnson supports patient access through free products provided directly to eligible patients as well as donated through the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) and the Johnson & Johnson Patient Assistance Program (JJPAP), which totaled $5.1 billion in 2025.[2]

$5.1B

3. Investing in research and development for improved outcomes

Over the last year, Johnson & Johnson Innovative Medicine has invested over $11.8 billion to deliver the next era of treatments for patients primarily with a focus on high-need areas of oncology, immunology and neuroscience.[2]

Johnson & Johnson Innovative Medicine has invested over $103B in R&D since 2016[2]



Read more at the Center for U.S. Healthcare Policy Research at policyresearch.jnj.com.

Part 1:

Why are prescription drug net prices falling while out-of-pocket costs rise?

Despite declining net prices, patients' out-of-pocket costs have risen due to opaque insurance designs and rising premiums that shift costs and burdens to patients. Many Americans struggle to understand how cost-sharing mechanisms and rebate structures determine what they pay at the pharmacy counter. Ultimately, transparency has exposed this disconnect. Policymakers must address it.

What's happening

This is the ninth year in a row that Johnson & Johnson Innovative Medicine's fees, discounts and rebates to insurers, PBMs, hospitals, government programs and other healthcare entities have increased. From 2016 to 2025, fees, discounts and rebates paid by Johnson & Johnson Innovative Medicine increased nearly fivefold from $10.9 billion to $52.5 billion.[2] The most significant increases in fees, discounts and rebates went to private insurers, PBMs and the 340B Program.

Why it matters

Commercial insurers pay lower net prices due to our discounts and rebates, but patients still pay higher out-of-pocket costs at the pharmacy. Patients, especially the most vulnerable, are burdened by rising healthcare costs, which can lead to medication abandonment and worsened health outcomes.[17, 18]

According to a 2025 report from IQVIA, Americans spent $98 billion out-of-pocket on prescription drugs in 2024, marking a cumulative 25% increase over five years.[19] This increase in patient burden has occurred during the same period that manufacturers have been lowering net prices and increasing rebates to insurers and PBMs.[1] An analysis of MarketScan claims found that, among commercially insured patients (ages 18–64), out-of-pocket cost for branded medicines increased by 55% between 2019 and 2023 and nearly doubled since 2016 – even after adjusting for inflation.[20]

The health consequences of this patient cost burden are significant. According to an IQVIA report, when out-of-pocket costs exceed $250, over half of prescriptions are abandoned.[5] This highlights the significant impact of high out-of-pocket expenses on patient adherence to physician-prescribed medications.

By the numbers

5.3% decline

Our average net prices have declined by 5.3% since 2024.[2]

The bottom line

While there is growing bipartisan support for PBM reform, policymakers must go further to ensure rebates and discounts directly benefit patients.

- Reforms should require insurers and PBMs to pass rebates and discounts directly to patients at the pharmacy counter, reducing out-of-pocket costs that have grown substantially over five years from 2019-2023, even as manufacturer net prices have declined.[1, 20]
- With evidence that 340B contributes to higher public spending and cost-shifting to patients, strengthened oversight and accountability are critical to realign the program with its original mission of benefiting vulnerable patients. [21]

Read more at the Center for U.S. Healthcare Policy Research at policyresearch.jnj.com.

Part 2:

Which insurance barriers disrupt patients from accessing innovative medicines?

The U.S. leads in medical innovation, but American patients increasingly struggle to access these breakthroughs.[5, 22] High out-of-pocket costs can delay and limit access to high-value therapies, particularly for patients with chronic conditions.[23]

Insurance barriers—such as coverage restrictions, excessive cost-sharing and utilization management—drive up costs and lead to delays or denials of care.[3, 16] Even after FDA approval, delays in insurance coverage can slow patient access to new treatments.[24] Innovation has impact only when patients can access and afford the medicines they need. This benefits patients and their families with improved health outcomes, society through healthier populations, and the American economy through a healthier and more productive workforce.[25, 26]

Why it matters

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

- Patient access barriers like restrictive prior authorization and formulary exclusions are used by insurers to limit patient access to necessary treatments.[3]
- High out-of-pocket costs can deter patients from obtaining prescribed medications, exacerbating health challenges.[11]
- Patient assistance programs are crucial, yet intermediaries and PBMs divert these funds, undermining their intended purpose and inflating patient costs.[27]
- Additional barriers, including alternative funding programs (AFPs), can cause patients to be ineligible for patient assistance programs for a needed treatment.[28]

By the numbers

About 1 in 4

Only about 1 in 4 (28%) insured Americans believes insurance currently provides everyone with affordable access to health care when needed, despite 93% believing it should.[29]

44%

44% of insured Americans taking a prescription report they faced at least one barrier to care in the previous year, including prior authorization, formulary exclusions and step therapy, which prevent many Americans from getting the doctor-prescribed care they need.[30]

98 million

In 2023, patients starting new therapies abandoned 98 million prescriptions at the pharmacy. More than half of new prescriptions for novel therapies went unfilled.[31]

Research & Development

U.S.-based pharmaceutical companies invested $152 billion in R&D in 2021 alone, equal to 34% of sales.[22]



For context, U.S. industries overall invest less than 2-3% of revenues in R&D.[23] Even high-tech sectors, such as software and semiconductors, only dedicate about 15% of their revenue to R&D on average.[32]

The bottom line

- Addressing these barriers requires health plans to prioritize patient-centered solutions and protect access to health care.
- Policymakers can act to reduce patient out-of-pocket costs by reforming utilization management regulation and ensure patient assistance counts toward patient cost-sharing.
- Strengthening protections for the doctor-patient relationship and shared decision-making are crucial to ensure access to necessary treatments.

Part 3:

What policy reforms could improve patient prescription drug costs and access to high-value treatments?

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

Policy solutions

Patient access & cost

- Pass rebates and discounts directly to patients at the point of sale, so lower net prices translate into lower out-of-pocket costs.
- Eliminate patient assistance abuse, including accumulators, maximizers and alternative funding programs (AFPs) that artificially exclude medicines from plan coverage in order to access manufacturer assistance for uninsured patients or foreign suppliers.
- Reform the 340B Program to support its original intent of ensuring affordable access for vulnerable patients.
- Add a requirement in the 340B Program that the manufacturer-provided discounts are used to reduce patient out-of-pocket costs for medicines.
- Reform prior authorization and step therapy to minimize burden, delays in care and ensure clinical rigor.

Accountability & transparency

- Reform PBM incentives to recognize clinical benefit to the patient.
- Increase oversight and accountability for vertically integrated PBMs that can distort formulary decisions, restrict patient choice and increase healthcare costs.
- Enact additional federal and state PBM reforms to de-link fees from list prices and ensure patients benefit from rebates and discounts.
- Enact federal legislation to increase transparency and accountability in the 340B Program, as program participants profit by charging a much higher rate for medications than the discounted price they receive.

Read more at the Center for U.S. Healthcare Policy Research at policyresearch.jnj.com.

The bottom line:

Creating a sustainable, patient-centric healthcare system requires policies and regulatory structures that make innovation accessible and affordable to patients.

Johnson & Johnson continues to advocate for policies that reward innovation that directly benefits American patients, expands equitable access and delivers affordable care to patients. Transparency has shown us where the system falls short. Fixing it is an urgent priority.

Glossary of key terms

340B Drug Pricing Program
A federal program that requires pharmaceutical manufacturers to offer their outpatient drugs to certain safety net providers, known as covered entities, at steeply discounted prices.[33]

Alternative Funding Programs (AFPs)
Programs used by some insurers to redirect patients to external assistance programs, which create additional barriers to accessing prescribed treatments.[28]

Commercial Insurance
Health insurance provided by private companies, typically through an employer or purchased individually, where coverage decisions, cost-sharing requirements and access to medicines are often shaped by plan design and negotiations with intermediaries like PBMs.[4, 34]

Cost-Sharing
The portion of healthcare costs that patients are responsible for paying through deductibles, copays, or coinsurance, which can create financial barriers to accessing care.[35]

Formulary
A list of medicines covered by a health plan. Placement on the formulary and level can determine whether a patient can access a medicine and how much they pay for it.[36]

High Value
Care that delivers evidence-based improvements in patient outcomes and quality of life, with timely access and affordability, while supporting appropriate use and long-term sustainability of the healthcare system.

List Price (Wholesale Acquisition Cost, WAC)
The publicly reported price of a medicine is set by the manufacturer, often used as a starting point for negotiations, but it is rarely what insurers or patients ultimately pay.[37]

Net Price
The actual price received by the manufacturer after fees, discounts and rebates are paid to insurers, PBMs and other entities, typically much lower than the list price.*[38]

Out-of-Pocket Costs
What patients pay directly for their medicines, including deductibles, copayments and coinsurance, costs that are often based on the list price rather than the lower net price.[39]

Pharmacy Benefit Managers (PBMs)
Third-party companies that manage prescription drug benefits for insurers and employers—including negotiating rebates—decide which medicines patients have access to and the cost.[4]

Prescription Abandonment
When a patient does not fill a prescribed medication, often due to high out-of-pocket costs, an outcome sometimes linked to worse health and higher long-term system costs.[5]

Prior Authorization
A requirement that providers obtain approval from an insurer before a prescribed medicine is covered, which can delay or prevent patients from starting treatment.[7, 40]

Step Therapy
An insurance practice that requires patients to try and fail one or more medicines before accessing the treatment originally prescribed by their doctor.[40]

Utilization Management
A set of tools used by insurers and PBMs, such as prior authorization and step therapy, to control costs, which can also create administrative hurdles and delays in care.[41]

Value of Medicines
Valuing medicines should reflect the diverse, decentralized U.S. system — a system that supports treatment decisions that fit the unique needs of each patient through shared-decision making with their physician/provider.

*While fees are distinct from price, discounts and rebates, we include them in this definition of net price to better reflect total reductions from list price.

Read more at the Center for U.S. Healthcare Policy Research at policyresearch.jnj.com.

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