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19 **UNITED STATES DISTRICT COURT**
20 **CENTRAL DISTRICT OF CALIFORNIA**
21 **WESTERN DIVISION**

22 COMMUNITY CARE PHARMACY,
23 LLC, on behalf of itself and all others
24 similarly situated,

25 Plaintiff,

26 v.

27 GOODRX, INC.; GOODRX HOLDINGS,
28 INC.,

Defendants.

Case No. 2:24-cv-9490

CLASS ACTION COMPLAINT
JURY TRIAL DEMANDED

1 Plaintiff Community Care Pharmacy, LLC (“Community Care”) is an inde-
2 pendent pharmacy based in Garden City, Michigan. It brings this action on behalf of
3 itself and all others similarly situated pursuant to Federal Rule of Civil Procedure 23
4 against Defendants GoodRx, Inc. and GoodRx Holdings, Inc. (collectively,
5 “GoodRx”) for orchestrating a horizontal conspiracy among certain pharmacy benefit
6 managers (“PBMs”) to fix and suppress the rates of reimbursement paid to independ-
7 ent pharmacies for generic drugs. Plaintiff alleges as follows upon personal
8 knowledge as to itself and its own acts and experiences, and as to all other matters
9 upon information and belief.

10 I. NATURE OF THE ACTION

11 1. PBMs administer pharmacy benefits on behalf of health-insurance plans
12 and other third-party payors (“TPPs”) of prescription drugs. Among other functions,
13 PBMs negotiate the prices that TPPs must pay pharmacies for prescription drugs and
14 process pharmacies’ claims for reimbursement based (in theory) on those pre-nego-
15 tiated prices.

16 2. This case involves an unlawful price-fixing agreement among several
17 PBMs—orchestrated by the PBM rate aggregator, GoodRx—to suppress the prices
18 paid to independent pharmacies for generic drugs. Since January 1, 2024, and possi-
19 bly sooner, at least four PBMs—CVS Caremark (“Caremark”), Express Scripts,
20 MedImpact, and Navitus Health Solutions (“Navitus”) (the “Conspiring PBMs”)—
21 have agreed to participate in GoodRx’s Integrated Savings Program (“ISP”). As part
22 of the ISP, the Conspiring PBMs agree to outsource their pharmacy reimbursement
23 rate decisions on generic drugs to a mutual third party, GoodRx, which sets the rates
24 of reimbursement for them with full knowledge of competitively sensitive infor-
25 mation (“CSI”) across ostensibly rivalrous PBMs. Through their ISP agreements with
26 GoodRx, the Conspiring PBMs (which are horizontal competitors) agree not to out-
27 bid one another on the prices they will pay pharmacies for generic drugs. This
28

1 unlawful price-fixing agreement is referred to herein as the “GoodRx ISP Scheme”
2 or “Scheme.”

3 3. The CSI at the heart of the GoodRx ISP Scheme is the reimbursement
4 rates that individual PBMs have negotiated with pharmacies for generic drugs.
5 GoodRx obtains this proprietary, confidential information from the roster of PBMs
6 it works with for the popular GoodRx discount card. The GoodRx discount card (de-
7 scribed further below) makes PBM-negotiated drug prices (often called “Negotiated
8 Rates”) available directly to consumers, so long as they pay cash for prescription
9 drugs (rather than utilize any insurance benefits they may or may not have). Consum-
10 ers who use GoodRx’s discount card do not know which PBMs’ Negotiated Rates
11 they are getting the benefit of. Behind the scenes, the PBM whose Negotiated Rate
12 is leveraged (the “Leveraged PBM”) processes the transaction and collects a fee from
13 the pharmacy. The Leveraged PBM then shares a portion of that fee with GoodRx.

14 4. Collectively, the PBMs that share their CSI with GoodRx for its dis-
15 count card business (in exchange for their portion of the fees remitted by pharmacies)
16 control roughly 95% of the PBM Services Market (defined below), meaning they are
17 responsible for managing 95% of all pharmacy reimbursement claims. On infor-
18 mation and belief, these PBMs include CVS Caremark, Express Scripts, OptumRx,
19 CarelonRx, Envolve Pharmacy Solutions, Prime Therapeutics, Kaiser Permanente
20 Pharmacy, Humana Pharmacy Solutions, MedImpact, Navitus Health Solutions, SS
21 and C Health, and Perform Rx. They comprise what’s referred to herein as the
22 “GoodRx Information Exchange Network.”

23 5. This antitrust action is not about the GoodRx discount card itself, but
24 rather a new line of business GoodRx has rolled out called the Integrated Savings
25 Program (“ISP”). At bottom, the ISP is an invitation to PBMs to engage in price
26 fixing. As part of the ISP, GoodRx contracts with certain PBMs (i.e., the Conspiring
27 PBMs) to “integrate” GoodRx’s pricing technology into those PBMs’ internal claims
28 processing systems. This integration allows the Conspiring PBMs to use GoodRx’s

1 pricing algorithm—as well as CSI from GoodRx’s Information Exchange Network—
2 to calculate pharmacy reimbursement rates for prescriptions filled for patients in-
3 sured by their third-party payor clients (often referred to by PBMs as “covered
4 lives”). For each claim subject to the Scheme, the Conspiring PBM automatically
5 pays the dispensing pharmacy the lowest reimbursement rate negotiated by any PBM
6 in the GoodRx Information Exchange Network (the “ISP Rate”).

7 6. In public disclosures, GoodRx describes the ISP as follows: “Our inte-
8 grated savings program embeds GoodRx directly into the member’s funded benefit
9 plan.” According to the company, patients simply show their insurance card “at the
10 pharmacy counter, as they normally would” and “behind the scenes, [GoodRx’s] ISP
11 technology compares” the patient’s “insurance plan” price for the drug with
12 “GoodRx’s discount price.” “[E]ligible insurance plan members”—i.e., individuals
13 whose pharmacy benefits are managed by a Conspiring PBM—then get “automatic
14 access to GoodRx’s prescription prices.” That’s because (as GoodRx admits) all
15 PBMs that participate in the ISP agree to calculate pharmacy reimbursement rates for
16 generic drugs in the same way based on the “[l]esser of” (a) the patient’s “insurance
17 price” (the drug price the PBM that manages that patient’s insurance benefits has
18 negotiated with the dispensing pharmacy), or (b) the “GoodRx price” (the lowest
19 price any PBM in the GoodRx Information-Exchange Network has negotiated for the
20 same drug). Put differently, instead of using the pharmacy reimbursement rate that
21 each third-party payor’s own PBM (the “Primary PBM”) has previously negotiated
22 with the dispensing pharmacy, the ISP imposes a different, lower rate of reimburse-
23 ment negotiated by an entirely different PBM (the “Leveraged PBM”) on behalf of
24 entirely different third-party payors.

25 7. The upshot of this Scheme is that the Conspiring PBMs, by coordinating
26 their reimbursement decisions through GoodRx, never pay pharmacies more for ge-
27 neric drugs than any rival PBM has agreed to pay in its separate negotiations with
28 those pharmacies. This is nothing more than price fixing in two simple steps: First,

1 the Conspiring PBMs exchange CSI between themselves (using GoodRx as a con-
2 duit). Second, they all agree to pay the lowest pharmacy reimbursement rate negoti-
3 ated by any PBM within the GoodRx Information-Exchange Network (which
4 GoodRx identifies).

5 8. In the absence of such unlawful coordination, the Conspiring PBMs
6 would have to compete for pharmacies to join their pharmacy networks, including by
7 offering to pay them higher rates of reimbursement for generic drugs (which account
8 for over 90% of all prescriptions) than rival PBMs. The ISP Scheme corrupts this
9 competition between PBMs for network pharmacy services.

10 9. A PBM's pharmacy network is the group of pharmacies that contract
11 with that PBM to provide prescription medications to the PBM's third-party payor
12 clients (and their insured members) under specific terms and pricing agreements. The
13 attractiveness of a health plan is based in part on the breadth of the pharmacy network
14 its members can conveniently access. Any PBM that cannot attract pharmacies (a
15 must-have input) to its network will suffer competitive harms in the downstream
16 market for PBM services sold to third-party payors (the "PBM Services Market"),
17 since those third-party payors need to offer broad and convenient pharmacy networks
18 to attract members into their health plans. In turn, a pharmacy's willingness to join a
19 PBM's network depends on the competitiveness of the reimbursement rates it offers
20 and whether those rates allow the pharmacy to operate with a reasonable profit
21 margin.

22 10. The ISP Scheme curtails this competition among PBMs for pharmacies.
23 Rather than having to pay *more* for generic drugs than rival PBMs to attract pharma-
24 cies to their networks, on a claim-by-claim basis, the Conspiring PBMs now always
25 pay the *lowest* pharmacy reimbursement rate that any rival PBM has succeeded in
26 negotiating—without losing access to network pharmacy services (a necessary in-
27 put). That's because the Conspiring PBMs control 64% of the PBM Services Market
28 (and thus approximately 64% of all prescriptions filled each year), meaning

1 pharmacies cannot refuse to do business with all of them. Put differently, the Con-
2 spiring PBMs control a choke point for any pharmacy seeking to gain access to
3 payors and patients.

4 11. The Conspiring PBMs benefit from the ISP Scheme in different ways.
5 The smaller participating PBMs—MedImpact and Navitus, whose market shares are
6 roughly 5% and 2%, respectively—can consistently free-ride off the reimbursement
7 rates negotiated by larger PBMs at the expense of independent pharmacies. Because
8 of the Scheme, the Conspiring PBMs MedImpact and Navitus now pay the same low
9 reimbursement rates for generic drugs as the nation’s largest PBMs: Caremark and
10 Express Scripts, which account for a combined 57% of the national PBM Services
11 Market. In the absence of the ISP Scheme, smaller PBMs like MedImpact and Navi-
12 tus would not generally qualify for the same volume discounts from pharmacies as
13 Caremark or Express Scripts; they would have to outbid their larger rivals to attract
14 pharmacies to their networks.

15 12. The two largest Conspiring PBMs—Caremark and Express Scripts—
16 have market shares of 34% and 23%, respectively, and have different incentives for
17 participating in the ISP Scheme. Given their buying power, Caremark and Express
18 Scripts are already able to negotiate the best average discounts from pharmacies.
19 However, this does not mean that for any given drug, these PBMs will have secured
20 the lowest price. Instead, it means that across all drugs, these large PBMs will gen-
21 erally obtain the best total discount package from pharmacies. The ISP Scheme en-
22 sures that for *every* generic prescription, the Conspiring PBMs *always* pay the lowest
23 price negotiated by any rival PBM.

24 13. Moreover, the ISP Scheme enables the Conspiring PBMs—in particu-
25 lar, the largest PBMs with the most negotiating power, Caremark and Express
26 Scripts—to profit from fees charged to dispensing pharmacies. As a function of the
27 Scheme, any time the ISP Rate is applied as part of the member’s plan benefit,
28 GoodRx charges the pharmacy a fee for the transaction (sometimes called a

1 “clawback” fee). This fee is then shared among the participants of the ISP scheme,
2 including, on information and belief, GoodRx, the Primary PBM, and the Leveraged
3 PBM. Because the rates negotiated by Caremark and Express Scripts will often be
4 the lowest (and thus are adopted as the ISP Rate), these two Conspiring PBMs stand
5 to gain hundreds of millions of dollars a year from their cut of the clawback fees
6 generated by the ISP Scheme. Rather than passing on the entirety of these fees to
7 payors as “savings,” the Conspiring PBMs pocket at least a portion of them as profit.

8 14. Notably, the fees extracted from pharmacies under the ISP Scheme re-
9 flect a gap—or “spread”—between (a) the amount paid by the third-party payor (and
10 its insured member) to its retained PBM, and (b) the net amount the pharmacy re-
11 ceives from that PBM for dispensing the prescription. Historically, retaining such
12 “spreads” as profit was an important revenue stream for PBMs. However, the practice
13 of “spread retention” (or “spread pricing”) has been harshly criticized in recent years
14 for raising drug prices and harming pharmacies, and many health plans now require
15 their PBMs to “pass through” all negotiated discounts with pharmacies in full, thus
16 precluding spread retention.¹ The ISP Scheme allows the Conspiring PBMs to re-
17 introduce spread retention into their business models without violating the pass-
18 through requirements in contracts with their own third-party payor clients. That’s
19 because for each prescription subject to the ISP Scheme, the PBM that retains the
20 spread (i.e., the clawback fee) is not the PBM that was retained to process the claim
21 on behalf of the third-party payor. Instead, the fee is collected by GoodRx, which has

22 _____
23 ¹ See *Prescription Drugs: Selected States’ Regulation of Pharmacy Benefit Managers*
24 at 1 (March 2024), available at <https://www.gao.gov/products/gao-24-106898> (not-
25 ing criticism). In some states, spread retention has even been banned by statute. Cal-
26 ifornia, Louisiana, Maine, and New York have enacted laws imposing a fiduciary
27 duty on PBMs to act in the best interest of the health plan or other entity to which the
28 duty is owed. See *id.* at 10-11. In addition, Arkansas has flatly prohibited the practice
of spread pricing, while Louisiana prohibits spread pricing unless a PBM provides
regular written notice to policyholders indicating the aggregate spread pricing
amounts charged by the PBM. *Id.* at 12.

1 no contractual relationship to the patient or the payor. On information and belief,
2 GoodRx then distributes this spread to the members of the ISP Scheme.

3 15. For its part in orchestrating the Scheme, GoodRx retains about \$5 per
4 transaction mediated through the ISP. This new revenue stream—which GoodRx
5 sees as “\$200M+ in growth opportunity”—is critical to GoodRx’s long-term viability
6 given the existential issues facing its traditional discount-card business.

7 16. In recent years, many pharmacies, including Plaintiff, have stopped ac-
8 cepting GoodRx’s traditional discount cards because they typically lose money on
9 these transactions. Pharmacy defections have led to massive disruptions in GoodRx’s
10 stock value. By “embed[ding] GoodRx directly into the ... benefit plan[s]” adminis-
11 tered by the Conspiring PBMs, the ISP Scheme eliminates pharmacies’ ability to opt
12 out of transacting with GoodRx. Because of the Conspiring PBMs’ dominant market
13 share, pharmacies have little choice but to transact with the Conspiring PBMs. Now,
14 under the ISP Scheme, the Conspiring PBMs automatically apply the ISP Rate as
15 part of a member’s plan benefit without the need for any external GoodRx discount
16 card to be presented to or accepted at the pharmacy desk. GoodRx and the Conspiring
17 PBMs then extract and share a compulsory fee from the dispensing pharmacy on the
18 back end.

19 17. The “savings” generated by the ISP Scheme come at the expense of al-
20 ready distressed independent pharmacies. Since going live, the ISP Scheme has dra-
21 matically suppressed reimbursement rates paid to independent pharmacies for ge-
22 neric drugs. GoodRx estimates that some 500 to 600 million prescriptions will be
23 subject to the ISP annually. On each of those prescriptions, when the ISP Rate is
24 leveraged, pharmacies are reimbursed at rates far lower than what they would have
25 received absent the Scheme.

26 18. Plaintiff Community Care does not accept the GoodRx discount card.
27 But like other independent pharmacies, Community Care has filled numerous generic
28 prescriptions for insured patients that were subject to the ISP Scheme. For these

1 transactions, the customer presented their normal health insurance card to a Commu-
2 nity Care pharmacist. These cards contain the six-digit Bank Identification Number
3 (“BIN”) associated with the PBM that the patient’s health plan uses to administer
4 pharmacy benefits (i.e., the Primary PBM). As is standard practice, Community Care
5 would then route its claim for reimbursement to this PBM. Ordinarily, the Primary
6 PBM determines the amount the patient and its insurer owe the pharmacy (based on
7 the reimbursement rates that same PBM has negotiated with the dispensing phar-
8 macy). But for prescriptions subject to the Scheme, Community Care’s reimburse-
9 ment claims have been routed to a different PBM (i.e., the Leveraged PBM), and
10 Community Care receives a claim summary containing the Leveraged PBM’s BIN,
11 followed by the letters “GDRX.” These claim summaries also contain notations stat-
12 ing that the reimbursement amount has been calculated based on a “discount con-
13 tract” (rather than the pharmacy’s network agreement with the Primary PBM). For
14 example, where the Primary PBM is Caremark, this notation states, “non-cmk dis-
15 count contract.” On information and belief, the reimbursement amounts for these
16 claims are based on the Leveraged PBM’s Negotiated Rates—rather than the Primary
17 PBM’s Negotiated Rates with the dispensing pharmacy—pursuant to an unlawful
18 agreement between GoodRx and the Conspiring PBMs to automatically apply the
19 lowest Negotiated Rate in the GoodRx Information Exchange Network (the ISP Rate)
20 as part of the patient’s plan benefits.

21 19. These rerouted claims also reflect a “Processing Fee” of between \$7 and
22 \$10, which Community Care must pay to the Conspiring PBMs. On information and
23 belief, such processing fees—which do not ordinarily appear on claims submitted to
24 insurance—are assessed by GoodRx and then shared among the Conspiring PBMs.
25 Community Care Pharmacy has suffered significant losses as a result of the ISP
26 Scheme. On many of these claims, instead of receiving payment from the Primary
27 PBM for the drugs it has dispensed, Community Care has actually owed money.

28

1 20. The GoodRx ISP Scheme is merely the latest exploitative tactic devised
2 by the PBM industry to extract profits from pharmacies and TPPs. After two decades
3 of intense consolidation of the PBM industry—and of PBMs’ vertical integration
4 with other parts of the drug supply chain—the largest PBMs have amassed an un-
5 fathomable degree of buying (or monopsony) power vis-à-vis pharmacies. And they
6 have wielded this monopsony power to decimate independent pharmacies like Plain-
7 tiff Community Care, which they view as competitors to their own PBM-affiliated
8 pharmacies.

9 21. Since 2019, there have been over 7,000 retail pharmacy closures in the
10 United States, over half of which were independent pharmacies. In 2023 alone, 300
11 independent pharmacies closed, with more closures expected in 2024. Such closures
12 harm both pharmacists and the communities they serve, imperiling access to medi-
13 cation and other health services for millions of Americans. Today, over 45% of all
14 U.S. counties have at least one neighborhood that qualifies as a “pharmacy desert,”
15 including one-third of all neighborhoods in the 30 largest US cities, affecting nearly
16 15 million people. The ISP Scheme is poised to further exacerbate this crisis. Not
17 only do generic drugs account for over 90% of all prescriptions that pharmacies fill,
18 they also account for most of the profits pharmacies are able to generate. By sup-
19 pressing reimbursement rates on generic drugs, the Scheme pushes already struggling
20 pharmacies even further towards the brink.

21 22. The ISP Scheme is unlawful under Section 1 of the Sherman Act. Plain-
22 tiff brings this action to stop this unlawful conspiracy and to recover treble damages
23 on behalf of itself and others similarly situated.

24 **II. PARTIES AND CO-CONSPIRATORS**

25 23. Plaintiff Community Care Pharmacy LLC (“Community Care”) is an
26 independent pharmacy based in Garden City, Michigan. Community Care is owned
27 and operated by pharmacist Maisa Jaimie Hider, who is also a physician. Dr. Hider
28 comes from a family of pharmacists. Her mother, Nadia Hider, was the first Arab-

1 American woman to earn a Doctor of Pharmacy degree from Wayne State University.
2 She then opened the first independent pharmacy in Dearborn, Michigan in 1989
3 (known to the Dearborn community as “Nadia’s Pharmacy”). In the tradition of Na-
4 dia’s Pharmacy, Community Care prides itself on building long-term relationships
5 with customers and offering high-quality, personalized care. Among other services,
6 Community Care delivers medication to patients’ homes free of charge and provides
7 complimentary transportation to patients’ doctors’ appointments. Community Care
8 staff are multilingual, with fluency in English, Spanish, and Arabic, enabling them to
9 effectively communicate with their diverse customers (many of whom do not speak
10 English). Staff are also available day or night to answer questions, with Dr. Hider
11 providing her personal cell phone number to many patients with special needs. Dr.
12 Hider acknowledges that running an independent pharmacy like Community Care at
13 a profit is virtually impossible in today’s PBM-dominated landscape. But she refuses
14 to close her doors or sell to a big chain because she knows how much her customers
15 and her community would suffer if she did. In addition, Community Care Pharmacy
16 offers free services to help low-income community members apply for federal and
17 state Medicaid and Medicare and runs other community benefit initiatives in the
18 greater Detroit Metro area.

19 24. Defendant GoodRx, Inc. is a Delaware corporation with its principal of-
20 fice or place of business at 2701 Olympic Boulevard, West Building, Suite 200, Santa
21 Monica, CA, 90404. It is a wholly owned subsidiary of GoodRx Intermediate Hold-
22 ings, LLC, which is a wholly owned subsidiary of GoodRx Holdings, Inc. GoodRx,
23 Inc. transacts or has transacted business in this District and throughout the United
24 States.

25 25. Defendant GoodRx Holdings, Inc. is a Delaware corporation with its
26 principal office or place of business at 2701 Olympic Boulevard, West Building,
27 Suite 200, Santa Monica, CA, 90404. GoodRx Holdings, Inc. transacts or has trans-
28 acted business in this District and throughout the United States.

1 26. At least four PBMs have participated as co-conspirators with Defend-
2 ants in the offenses alleged, having performed acts and made statements in further-
3 ance of the conspiracy (the “Conspiring PBMs”). They include the PBMs CVS Care-
4 mark, Express Scripts, MedImpact, and Navitus. Collectively, these PBMs manage
5 64% of all prescription claims made annually, meaning they control 64% of the na-
6 tional PBM Services Market.

7 27. CVS Health Corporation—a Delaware corporation headquartered in
8 Woonsocket, Rhode Island—owns and operates CVS Caremark, the largest PBM in
9 the nation. Caremark holds roughly 34% of the U.S. PBM Services Market. CVS
10 Health Corporation also owns and operates the insurer Aetna and the nation’s largest
11 retail pharmacy chain, CVS.

12 28. Express Scripts is a Delaware corporation headquartered in St. Louis,
13 Missouri. It is the second largest PBM and is responsible for managing approximately
14 23% of all prescription drug claims in the United States. It is owned by Cigna, a
15 health insurance company.

16 29. MedImpact Healthcare Systems, Inc. is a California corporation head-
17 quartered in San Diego, California. MedImpact is the largest privately held PBM
18 provider in the United States. It holds 5% of the national PBM Services Market.

19 30. Navitus Health Solutions, LLC, is a Wisconsin limited liability com-
20 pany headquartered in Madison, Wisconsin. On information and belief, Navitus con-
21 trols around 1.7% of the U.S. PBM Services Market. Navitus is co-owned by Costco
22 Wholesale Corporation and SSM Health, a Catholic healthcare system in the
23 Midwest.

24 **III. JURISDICTION AND VENUE**

25 31. This case arises under Section 1 of the Sherman Act (15 U.S.C. § 1) and
26 Sections 4 and 16 of the Clayton Act (15 U.S.C. §§ 15 & 26). Plaintiff seeks (1) treble
27 damages for its injuries, and those suffered by members of the proposed Class, re-
28 sulting from Defendants’ anticompetitive conduct; (2) to enjoin Defendants’

1 anticompetitive conduct; and (3) such other relief as is afforded under the laws of the
2 United States.

3 32. This Court has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331
4 (federal question) and § 1337(a) (antitrust), and 15 U.S.C. § 15 (antitrust). This Court
5 also has jurisdiction over this action pursuant to 28 U.S.C. § 1332(d) because this is
6 a class action in which the aggregate amount in controversy exceeds \$5,000,000, ex-
7 clusive of interest and costs, and at least one member of the proposed Class is a citi-
8 zen of a state different from that of the Defendants.

9 33. This Court has personal jurisdiction over Defendants GoodRx, Inc. and
10 GoodRx Holdings, Inc. because each of their principal places of business is in this
11 District; they transact business throughout the United States, including in this Dis-
12 trict; and they are engaging in the alleged antitrust conspiracy, which has a direct,
13 foreseeable, and intended effect of causing injury to the business or property of per-
14 sons and entities residing in, located in, or doing business throughout the United
15 States, including in this District.

16 34. Venue is proper in this District pursuant to Section 12 of the Clayton
17 Act, 15 U.S.C. § 22, and under the federal venue statute, 28 U.S.C. § 1391, because
18 Defendants GoodRx, Inc. and GoodRx Holdings, Inc. maintain business facilities,
19 have agents, transact business, and are otherwise found within this District and cer-
20 tain unlawful acts alleged herein were performed and had effects within this District.
21 No other forum would be more convenient for the parties and witnesses to litigate
22 this case.

23 IV. FACTUAL BACKGROUND

24 A. PBMs: The Powerful Middlemen at the Center of the U.S. Prescrip- 25 tion Drug Supply Chain.

26 35. PBMs sit at the center of the complex pharmaceutical distribution chain
27 that delivers medicines from drug manufacturers to patients in the United States.
28

1 1. *PBMs negotiate with retail pharmacies to secure pricing dis-*
2 *counts for health plans.*

3 36. PBMs typically do not sell their services directly to patients. Instead,
4 PBMs are retained by TPPs, such as large commercial insurance companies, to per-
5 form certain administrative functions. The TPPs that retain PBMs have committed to
6 provide prescription-drug benefits to their enrolled members; they include commer-
7 cial insurance companies but also employers or labor organizations that sponsor
8 health-insurance plans, as well as various public insurance programs that offer phar-
9 macy benefits to members.

10 37. Among other services, PBMs are retained by TPPs to negotiate prices
11 and other contract terms with pharmacies across the nation; these negotiated price
12 schedules dictate what TPPs and their members will pay pharmacies for prescrip-
13 tions. PBMs are also retained to process or “adjudicate” pharmacies’ claims for re-
14 imbursement from TPPs based (in theory) on those pre-negotiated prices.

15 38. U.S. prescription-drug spending reached \$722.5 billion in 2023. Of that
16 amount, approximately 85% was paid by TPPs rather than patients. Given this reality,
17 outpatient pharmacies rely on reimbursements from TPPs to stay in business. When
18 an insured patient fills a prescription, the dispensing pharmacy typically collects only
19 a small portion of the cost of the drug from the consumer at the point of sale, usually
20 in the form of a “co-pay” or “co-insurance” contribution. The TPP (through its re-
21 tained PBM) is then obligated to pay the balance of the negotiated pharmacy reim-
22 bursement rate, which is supposed to cover the Ingredient Cost and a small Dispens-
23 ing Fee.

24 2. *PBMs compete in the input market for pharmacy services to build*
25 *pharmacy networks.*

26 39. To attract and retain TPP clients, PBMs must build networks of retail
27 pharmacies where health-plan members can easily and conveniently get their pre-
28 scriptions filled. Under normal market conditions, PBMs compete against each other

1 to recruit pharmacies into their networks, offering inducements such as superior re-
2 imbursement rates, increased patient volume, and higher dispensing fees. PBMs are
3 thus horizontal competitors in the input market for Network Pharmacy Services. A
4 PBM that is unable to attract pharmacies to its network will risk losing clients, as
5 health plans select PBMs based in part on the adequacy of their retail pharmacy net-
6 works.

7 40. Pharmacies choose which networks to join based primarily on the reim-
8 bursement rates PBMs offer. In general, pharmacies will accept lower reimbursement
9 rates from PBMs that represent significantly more patients because those PBMs can
10 offer more future business volume. Smaller PBMs (which represent fewer patients)
11 cannot promise pharmacies as much future business, and thus do not qualify for the
12 same volume discounts. A smaller PBM seeking to attract pharmacies to its network
13 must therefore offer higher reimbursement rates than the larger PBMs, or else suffer
14 competitive harms in the output market for PBM services.

15 3. *PBM-negotiated reimbursement rates are set forth in network*
16 *agreements with participating pharmacies.*

17 41. PBMs' negotiations with pharmacies largely dictate the price of pre-
18 scription drugs and how they can be accessed by hundreds of millions of Americans.
19 Generally, health-plan members who have already met their plan's annual deductible
20 pay only a portion of their PBM's negotiated pharmacy reimbursement rate as spec-
21 ified by their plan's co-payment or co-insurance schedule; the remainder is paid by
22 their plan.

23 42. The rates of reimbursement negotiated between a PBM and its in-net-
24 work pharmacies are set forth in network agreements. These rates (and many other
25 aspects of these agreements) are confidential and competitively sensitive.

26 43. These Negotiated Rates are generally expressed not in specific dollar
27 amounts for specific drugs, but as formulas, which are then used to calculate the
28 pharmacy reimbursement rate for a particular prescription. These formulas rely on a

1 set of input factors known as “reference prices.” A typical network agreement will
2 state that the PBM will reimburse the pharmacy the lowest of the following reference
3 prices:

- 4 a) Average Wholesale Price (“AWP”) minus a negotiated dis-
5 count percentage, plus a dispensing fee;
- 6 b) the Maximum Allowable Cost (“MAC”), plus a dispensing
7 fee;
- 8 c) the Ingredient Cost submitted by the Provider, plus a dis-
9 pensing fee;
- 10 d) the Usual and Customary Price (“U&C”) (i.e., the phar-
11 macy’s retail list price); or
- 12 e) the pharmacy’s Submitted Claim Amount.

13 44. The first two listed reference prices in the above example are often re-
14 ferred to as “Negotiated Rates” as they are the product of negotiations between PBMs
15 and pharmacies. Because Negotiated Rates are almost always lower than the other
16 reference prices, the vast majority of generic prescriptions are reimbursed based on
17 one of the first two reference prices.

18 45. The Usual & Customary (U&C) price is not negotiated; it’s the retail or
19 cash price for the drug set unilaterally by the dispensing pharmacy. Pharmacies’
20 U&C prices are intended to reflect the amount they would charge to a cash-paying
21 customer without insurance or any discount card. The U&C price is almost never
22 lower than the Negotiated Rates, so is rarely the algorithmically selected reference
23 price.

24 46. The Submitted Claim Amount is also not a negotiated rate; it’s the full
25 reimbursement amount requested from the PBM by the pharmacy, typically based on
26 the U&C price. The Submitted Claim Amount is almost never lower than the Nego-
27 tiated Rates, so is rarely the algorithmically selected reference price.

28

1 47. “Maximum Allowable Cost” is a commonly used metric designed by
2 PBMs to control drug costs for their TPP clients by establishing an ostensibly fair but
3 competitive unit price at the product level, regardless of supplier. Some sources esti-
4 mate that roughly 82% of generic purchases are transacted with pharmacies at MAC
5 prices. PBMs set their own MAC prices, which they keep as part of MAC lists. There
6 is little transparency in how PBMs set their MAC prices, although in theory, the MAC
7 price should account for market realities such as the cost to the pharmacy of acquiring
8 the drug. In general, a PBM is free to change its MAC price lists any time it chooses.
9 PBMs often maintain hundreds of MAC lists for various pharmacies and update them
10 as frequently as daily or weekly. Because PBM reimbursement rates are defined for-
11 mulaically—and because MAC prices can be changed by the PBM unilaterally at any
12 time—pharmacies face significant uncertainty regarding how much compensation
13 they will ultimately receive for generic drugs.

14 48. Historically, MAC lists are proprietary to each PBM and treated as
15 highly confidential. However, under the ISP Scheme, GoodRx management has told
16 industry analysts that GoodRx is now acquiring MAC information from the Conspir-
17 ing PBMs and compensating them in return out of its profits from the ISP Scheme.

18 4. *The PBM industry is highly concentrated.*

19 49. One of the most critical services that PBMs offer their TPP clients is
20 claims adjudication, which is sometimes called claims processing. This is the process
21 of determining in real time at the pharmacy counter (1) whether an individual has
22 prescription-drug benefits, (2) whether the drug in question is covered, (3) the total
23 reimbursement rate to be paid to the pharmacy based on existing contracts, and
24 (4) the portion of that pharmacy reimbursement rate that the pharmacy is to collect
25 directly from the consumer.

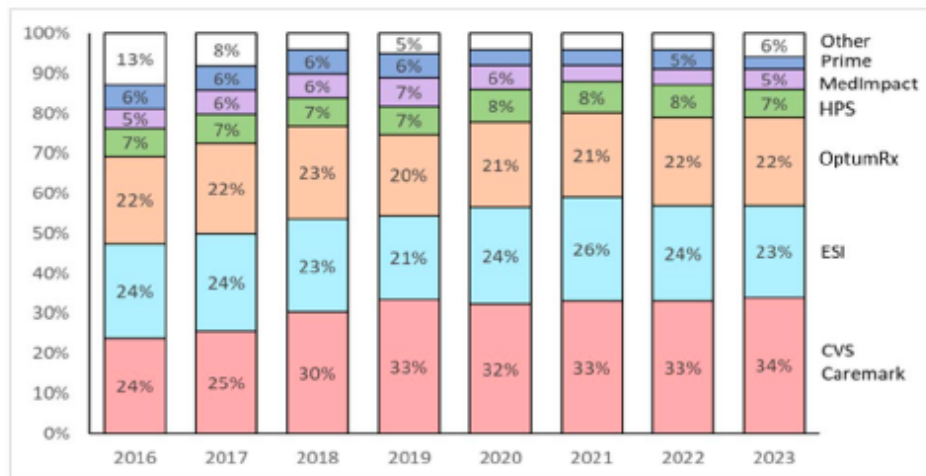
26 50. Although there are estimated to be 66 PBMs in the United States, few
27 of them have the technology or infrastructure required to handle real-time claims
28 adjudication. As a result, smaller PBMs function largely as benefits consultants and

1 typically contract with larger PBMs to perform claims adjudication on their behalf.
 2 These same few large PBMs are responsible for most pharmacy-contract negotia-
 3 tions. This has left the PBM industry highly concentrated when it comes to the key,
 4 relevant functions.

5 51. The FTC measures PBMs’ market share by considering the percentage
 6 of all “prescription claims managed” by each PBM. By the FTC’s measure, after
 7 decades of mergers and acquisitions, the three largest PBMs—Caremark, Express
 8 Scripts, and OptumRx (the “Big Three”)—now manage about 80% of all prescription
 9 claims in the United States. If these Big Three PBMs were standalone companies,
 10 each would rank among the 40 largest companies in the United States by revenue.
 11 The Big Three PBMs, together with the next three largest PBMs—Humana Phar-
 12 macy Solutions, MedImpact, and Prime Therapeutics—manage roughly 94% of pre-
 13 scription-drug claims in the United States.

14 52. As illustrated in the chart below, Caremark accounts for roughly 34%
 15 of all prescriptions filled, followed by Express Scripts at 23%, and Optum Rx at 22%.
 16 Humana accounts for 7% of the market, followed by MedImpact at 5% and Prime at
 17 3%. Navitus controls about 2% of the PBM Services Market.

18 **Figure 4. PBM Services Shares, 2016-2023³⁹**
 19 (% of total equivalent prescription claims managed)

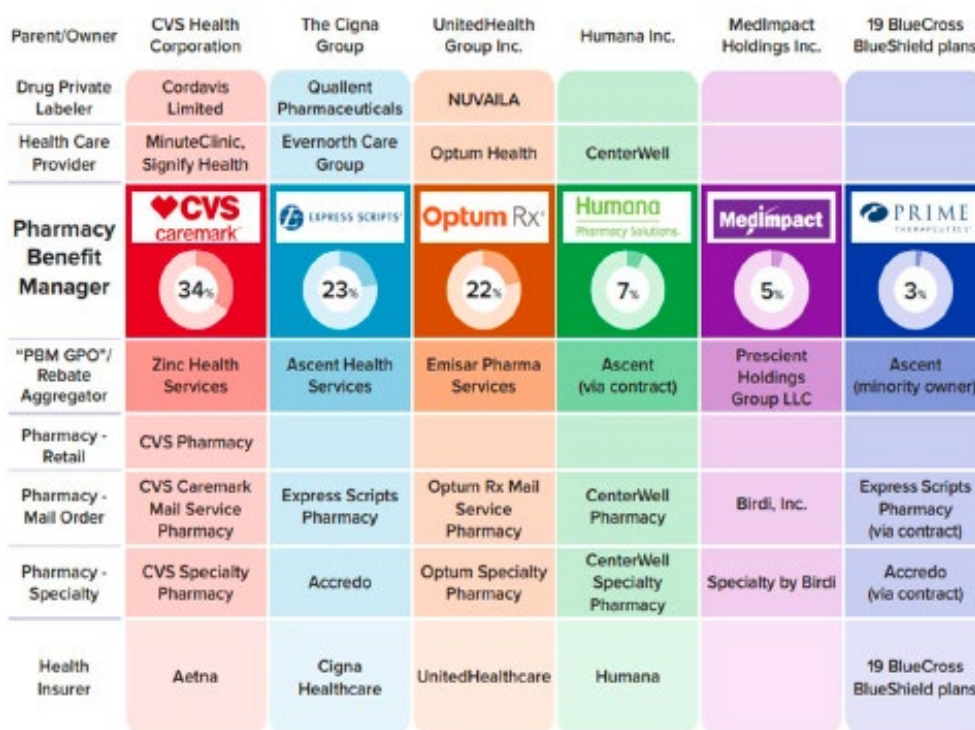


20
 21
 22
 23
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 25
 26
 27 53. PBMs use their market power and negotiating leverage to impose low
 28 reimbursement rates and other onerous contract terms on unaffiliated pharmacies.

5. *Vertically integrated PBMs steer business to their affiliated pharmacy chains at the expense of independent pharmacies.*

54. The Big Three PBMs (and many of the smaller ones) are also vertically integrated with other segments of the drug supply chain, including major health insurers and pharmacy chains. For example, CVS Health owns Aetna (the third-largest health-insurance company by national market share), Caremark (the largest PBM), CVS Pharmacy (the largest retail pharmacy), and CVS Specialty (the largest specialty-drug pharmacy). The Cigna Group owns Cigna Healthcare (the fourth-largest insurer), Express Scripts (the second-largest PBM), and Accredo (the second-largest specialty-drug pharmacy).

Figure 1. PBMs: Ownership and Vertical Integration¹⁶



55. As a result of PBMs' vertical integration with pharmacy chains, PBMs are incentivized to steer patients to their own affiliated pharmacies, even when it's not in the best interest of their TPP clients or those clients' members. One way PBMs give preference to their affiliated pharmacies is by creating "preferred" pharmacy networks consisting of their vertically integrated pharmacies. They then relegate

1 independent and affiliated pharmacies to a less preferred status, requiring patients to
2 shoulder higher co-pays to fill their prescriptions there.

3 56. PBMs can also pay their own affiliated pharmacies higher reimburse-
4 ment rates than unaffiliated ones, lining their pockets at the expense of payors and
5 patients. In 2022, commercial health plans reimbursed affiliated pharmacies roughly
6 80–90% more than unaffiliated pharmacies for two cancer drugs studied by the Fed-
7 eral Trade Commission (generic Zytiga and generic Gleevac). A June 2024 study
8 prepared for the Washington State Pharmacy Association also documented substan-
9 tially higher reimbursement rates for generic drugs filled by PBM-affiliated mail-
10 order pharmacies than by unaffiliated pharmacies.

11 6. *PBMs have decimated independent pharmacies, depriving Amer-*
12 *icans across the nation of pharmacy access.*

13 57. An independent pharmacy is a retail pharmacy that is not directly affil-
14 iated with any chain of pharmacies and is not owned by a publicly traded company.
15 Many independent pharmacies are pharmacist-owned. These pharmacies often offer
16 specialized services such as custom compound prescriptions, medication therapy
17 management, and home delivery.

18 58. Independent pharmacies are essential healthcare providers. This is par-
19 ticularly true in communities with elderly populations, limited transportation options,
20 or language barriers where personalized care is crucial. In rural and medically under-
21 served communities, independent pharmacies are often the sole provider of medica-
22 tion counseling and management as well as the main source for immunizations and
23 rescue medications like EpiPens for allergic reactions.

24 59. Until the 1980s, independent pharmacies were the norm in the United
25 States, with just under 40,000 such establishments spread across the country. Since
26 1980, the number of independent pharmacies has plummeted nearly 50%, leveling
27 off at about 20,000 locations since 2000.

28

1 60. PBMs have played a primary role in the demise of independent pharma-
2 cies. As described above, industry consolidation has given the few largest PBMs
3 enormous leverage over independent pharmacies in price negotiations. PBMs use
4 their market power to demand massive discounts from independent pharmacies,
5 steering business to their affiliated pharmacies instead. The buying power of PBMs
6 has been further magnified by their vertical integration with health insurers and phar-
7 macies, including retail, mail-order, and specialty pharmacies.

8 61. In many instances, independent pharmacies have been replaced by chain
9 pharmacies, the biggest of which is CVS. CVS entered the pharmacy business over
10 50 years ago but saw its biggest period of growth after it merged with the PBM Care-
11 mark in 2007. Between 2013 to 2022, the number of CVS-owned retail pharmacies
12 increased by 28%, from about 7,600 locations to over 9,700 locations. During the
13 same time period, other retail pharmacies declined by 7% overall (from roughly
14 55,200 locations to 51,400 locations) and by 10% within rural areas (from about
15 11,100 to 10,000).

16 62. Vertically integrated PBMs like CVS Caremark use their market power
17 and negotiating leverage to impose low reimbursement rates and other onerous con-
18 tract terms on independent pharmacies, whom they view as “competitors” of their
19 affiliated CVS drug stores. Today, reimbursement rates for independent pharmacies
20 are so low that on an estimated 30–40% of prescriptions, the pharmacy loses money.
21 Pharmacies thus depend upon receiving Negotiated Rates on the higher end of the
22 distribution for a majority of prescription fills to compensate for losses on other drugs
23 with Negotiated Rates that are below the pharmacy’s cost.

24 63. These financial losses are further compounded by various additional
25 fees PBMs impose on independent pharmacies after drug claims are processed and
26 paid—including so-called “direct and indirect remuneration fees,” clawback fees col-
27 lected after the point of sale, ostensibly for the “benefit” of using PBMs’ claim pro-
28 cessing services. Independent pharmacies are forced to pay these fees and accept

1 increasingly unfavorable and arbitrary terms from the major PBMs because, if they
2 opt out, they will lose the ability to do business with the more than 60% of covered
3 lives the major PBMs represent.

4 64. Such tactics have caused, and continue to cause, thousands of independ-
5 ent pharmacies to go out of business. About 7,000 drugstores in the U.S. have closed
6 since 2019, 54% of which were independent. In 2023 alone, over 300 independent
7 pharmacies closed their doors. It is estimated that there will be even more closures in
8 2024, with nearly a third of remaining independent pharmacies at risk of going out
9 of business.

10 65. Closures of local pharmacies affect not only small business owners and
11 their employees, but also their communities and patients. In many rural and medically
12 underserved urban areas, independent pharmacies are the primary healthcare option
13 for Americans, who depend on them to get flu shots, EpiPens, and vaccines.

14 66. The loss of independent pharmacies has hit rural America particularly
15 hard, turning thousands of communities into “pharmacy deserts.” Between 2013 and
16 2022, about 10% of independent retail pharmacies in rural America closed. Today,
17 over 2.4 million rural residents live in pharmacy deserts, meaning that they do not
18 have access to any pharmacy within 10 miles.

19 67. Pharmacy deserts are also now common in U.S. cities, with one study
20 showing that a third of all neighborhoods in major U.S. cities have become pharmacy
21 deserts. Urban communities that are predominantly Black and Hispanic are most
22 likely suffer from lack of pharmacy access. All told, a full 40% of U.S. counties are
23 pharmacy deserts today.

24 68. Limited access to pharmacies leads to patient non-adherence to medica-
25 tion regimens, resulting in poor health outcomes and higher medical costs along with
26 increased hospitalizations and emergency department visits. Non-adherence contrib-
27 utes significantly to healthcare system waste in the United States, with approximately
28

1 \$100 to \$300 billion spent annually on avoidable health care costs due to non-adher-
2 ence.

3 7. *PBMs drive up retail drug prices.*

4 69. While PBMs claim to reduce prescription drug costs, their negotiating
5 tactics with pharmacies systemically inflate retail drug prices for consumers while
6 driving down revenue at independent pharmacies.

7 70. In particular, and as noted above, most network agreements between
8 PBMs and pharmacies include provisions giving PBMs the right to pay pharmacies
9 the “lesser of” various references prices, including (a) the Negotiated Rate for each
10 dispensed drug (which, for generics, is often based on a variable MAC price set uni-
11 laterally by the PBM) or (b) the U&C rate (the price the pharmacy charges cash-
12 paying customers for each drug). Because these “lesser of” provisions protect PBMs
13 from being charged more than other kinds of buyers by pharmacies—namely, cash-
14 paying customers—they are considered “most-favored nation” provisions or
15 “MFNs.”

16 71. Pharmacies have unilateral control over their U&C rates, but no control
17 over PBMs’ MAC prices, which are almost always lower. However, given the vari-
18 ability and opacity of MAC pricing, pharmacies often do not have any idea what
19 reimbursement rate they’ll receive when they dispense a particular drug. Thus, inde-
20 pendent pharmacies—which operate on razor thin margins—are incentivized to set
21 their U&C prices high for *all* drugs to blunt the impact of MAC variability and ensure
22 they will obtain at least the Negotiated Rates from PBMs in connection with all pre-
23 scriptions dispensed to insured patients (the majority of their customers).

24 72. High U&C prices mean high costs for any consumers purchasing their
25 medications out-of-pocket. PBMs’ agreements with pharmacies also deter pharma-
26 cies from giving special discounts to uninsured, cash-paying consumers on an ad hoc
27 basis (as physicians often do), either because PBMs’ agreements with pharmacies
28 flatly forbid discounts, or because PBMs could then use these discounted rates as the

1 pharmacy's U&C price when they perform their "lesser of" reimbursement rate cal-
2 culations.

3 73. The upshot is that PBMs' market power and negotiation tactics vis-à-
4 vis pharmacies have caused the U&C price of all drugs to inflate, to the detriment of
5 all consumers, and uninsured consumers in particular.

6 **B. The Emergence of Prescription Drug Discount Programs.**

7 *1. Pharmacy savings clubs.*

8 74. In the 1990s, some pharmacy chains created subscription-based "sav-
9 ings clubs" to help uninsured customers deal with PBM-fueled high U&C prices.
10 Dues-paying club members would receive discounts off the pharmacy's U&C prices,
11 so long as they paid for the whole cost of the drug themselves (rather utilizing any
12 insurance benefits).

13 75. Pharmacy savings clubs help patients afford the medications they
14 needed and enabled pharmacies to tap into additional revenues from consumers who
15 were willing to pay cash for prescription drugs (particularly generics) but were un-
16 willing or unable to cover inflated U&C prices.

17 76. Pharmacy savings clubs allowed pharmacies to reach direct-pay cus-
18 tomers on their own terms, as each pharmacy could set its own discount rates and
19 eligibility requirements, and for their own benefit, as club proceeds did not have to
20 be shared with PBMs or any other third-party intermediaries. These clubs also ena-
21 bled pharmacies to build customer loyalty, as members would typically continue to
22 frequent the pharmacy even after obtaining insurance.

23 *2. PBM discount cards.*

24 77. In the early 2000s, some PBMs launched their own discount card pro-
25 grams to compete with pharmacy savings clubs for direct-pay business, including the
26 CVS Health Savings Pass, the Citizens Health Card (administered by Express
27 Scripts), and the Advance-PCS Prescription Plan. These PBM-sponsored initiatives
28 employed external discount cards which consumers could present at pharmacies.

1 Pharmacies that accepted these cards agreed to honor the discounts offered by the
2 sponsoring PBM and pay a remittance to the PBM for directing the sale their way.
3 Such remittances reflected a difference—or “spread” kept by the PBM—between (a)
4 what the payor (i.e., the patient) paid for the prescription, and (b) the net sums that
5 the pharmacy earned for dispensing the drugs.

6 78. Initially, only larger pharmacies accepted PBM discount cards because,
7 after honoring the discounts and sharing a portion of the proceeds with the PBM,
8 pharmacies made little to no money on these transactions. Eventually, however, most
9 PBMs began requiring in-network pharmacies to accept their discount cards, mean-
10 ing pharmacies would have to weigh the pros and cons of this requirement when
11 negotiating their network agreements with PBMs.

12 79. Customers who pay cash for drugs—either because they do not have
13 insurance or because they’ve elected not to use their benefits on a given transaction—
14 are known as “direct-pay” (or “cash-pay”) customers. As health plans with high de-
15 ductibles (as well as high co-pays) became more prevalent, the number of direct-pay
16 customers grew. More and more PBMs wanted a piece of the pie, and PBM discount
17 cards proliferated. These discount cards allowed more PBMs to tap into the growing
18 direct-pay, “business to consumer” (B2C) revenue stream, a revenue stream that
19 would otherwise be captured by pharmacies.

20 80. Discount cards also allowed PBMs to keep drug costs down for their
21 TPP clients, who benefitted when members elected not to use their prescription drug
22 benefits and instead paid cash. When a traditional B2C discount card is used to pur-
23 chase medications, the insurer doesn’t have to pay anything. Drug costs are covered
24 entirely by the patient, on an out-of-pocket basis, and their spending on the transac-
25 tion typically does not count toward the patient’s deductible.

26 81. PBM discount cards competed directly with pharmacy savings clubs in
27 the market for direct-pay customers. But eventually, PBMs and the TPPs they served
28 set out to eliminate the competition posed by pharmacy-sponsored clubs. Over the

1 last decade, TPPs or their members brought several lawsuits against pharmacies who
2 operated discount clubs, claiming that the discounts offered to club members could
3 be treated as pharmacies' U&C prices (meaning they could be factored into PBMs'
4 "lesser of" reimbursement calculations). By 2016, such litigation had largely elimi-
5 nated pharmacy savings clubs.

6 3. *GoodRx: A discount platform that aggregates PBM-negotiated*
7 *rates.*

8 82. In 2011, a start-up called GoodRx launched a new kind of B2C discount
9 card program. Whereas other discount cards were sponsored by a single PBM and
10 reflected only the discounts offered by that PBM, GoodRx's model was to aggregate
11 negotiated discount rates from a variety of PBMs and market the lowest prices to
12 potential direct-pay consumers.

13 83. GoodRx's original B2C discount card model took advantage of the var-
14 iable pricing of drugs in the United States. Drug prices are the product of constant,
15 ongoing negotiations between PBMs and pharmacies, which dictate what third-party
16 insurers and their members pay pharmacies and also establish direct-to-consumer
17 prices. These Negotiated Rates can differ dramatically across PBMs, with generic
18 medications subject to the most price fluctuation because of the variable nature of
19 MAC prices. Negotiated Rates can also differ across pharmacies, with larger phar-
20 macy chains (which have more market power) demanding higher pharmacy reim-
21 bursement rates from PBMs. Depending on the rates PBMs have negotiated with
22 particular pharmacies, two consumers might pay wildly different prices for identical
23 prescriptions in the same geographic area. The upshot of all this variation is that if
24 consumers had the ability to know and leverage the Negotiated Rates of various
25 PBMs at different pharmacies in their area, they could reduce their prescription costs.
26 But insured consumers would have to eschew their plan benefits and pay entirely out-
27 of-pocket to do so.

28

1 84. GoodRx’s B2C discount card program provides consumers the ability
2 to engage in this kind of rate-comparison shopping. GoodRx partners with over a
3 dozen PBMs to aggregate information on pharmacy reimbursement rates. These
4 PBMs (which include the four Conspiring PBMs) collectively control over 95% of
5 all prescription-drug claims. Each of GoodRx’s partner PBMs agrees to share its Ne-
6 gotiated Rates with GoodRx, even though these rates are competitively sensitive and
7 subject to contractual confidentiality provisions.

8 85. GoodRx “aggregates” and “normalizes” all this PBM data—which the
9 company claims amounts to “over 150 billion prescription pricing data points every
10 day.” It then uses its patented algorithm to determine the lowest available price on
11 any given date for a particular drug in a particular geographic area. Through
12 GoodRx’s “price comparison platform,” the company presents users with “curated,
13 geographically relevant prescription pricing” selected by GoodRx’s algorithm from
14 among the “negotiated rate[s] provided by one of [GoodRx’s] PBM partners.” Once
15 a user has selected the lowest rate for their prescription available at their preferred
16 local pharmacy, GoodRx displays a “GoodRx code” to the user on its mobile app or
17 website interface. This code reflects “the most favorable prices at the pharmacies
18 based on user locations” (i.e., the “GoodRx Rate”), as illustrated in the screen cap-
19 tures below.

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GoodRx Prescription savings Telehealth Health info Gold membership Search Savings card by mail For healthcare professionals Sign up / Sign in

Generic Lipitor

Atorvastatin | [Switch to brand medication](#)

Prices Medicare Drug Info Side Effects Images

Prescription: 40mg atorvastatin (30 tablets)

Choose pharmacy: Lafayette, IN

- Walmart
- Meijer Pharmacy
- CVS Pharmacy
- Pay Less Super Market Pharmacy
- Walgreens
- Target (CVS)

Price with GoodRx coupon
Print, email, or text this coupon to yourself

\$14.80

Show this coupon at the pharmacy.

BIN: 015995
PCN: GDC
Group: DR33
Member ID: HPP870214

Text Email Print

GoodRx Coupon - This is NOT insurance

How to use GoodRx discounts Get a savings card by mail

Need help?

Scan to get these savings in the GoodRx app.

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GoodRx Prescription savings Telehealth Health info Gold membership Search Savings card by mail For healthcare professionals Sign up / Sign in

Local pharmacy prices

Choose a pharmacy to get a coupon

Lafayette, IN Popularity

Pay less for atorvastatin with GoodRx Gold. Start free trial as low as \$2.46

Pharmacy	Price	Savings
Walmart (Most popular)	\$14.80	Get free savings
Meijer Pharmacy (Low price)	\$8.35	Get free savings (Save 84%)
CVS Pharmacy	\$21.17	Get free savings (Save 83%)
Pay Less Super Market Pharmacy	\$15.54	Get free savings (Save 87%)
Walgreens	\$21.25	Get free savings (Save 82%)
Target (CVS)	\$21.17	Get free savings (Save 82%)

Scan to get these savings in the GoodRx app.

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86. Consumers can take advantage of the GoodRx Rate by presenting the GoodRx discount card at participating pharmacies. But there's a catch: they must be willing to pay cash to fill their prescriptions, without utilizing any insurance benefits

1 they might have. As GoodRx’s website states: “Keep in mind you cannot use GoodRx
2 and insurance at the same time.”

3 87. For direct-pay customers using the GoodRx discount card, the Lever-
4 aged PBM collects a per-prescription processing fee from the pharmacy each time a
5 customer buys a drug using the card. Per its agreement with GoodRx, that PBM then
6 shares a cut of those fees with GoodRx, either as a fixed fee or a percentage of the
7 fee paid by the pharmacy to the PBM.

8 88. As such, the more volume that goes through the GoodRx platform, the
9 more revenue GoodRx generates. GoodRx claims to obtain, on average, a “15-16%”
10 cut of the overall drug price. These fees constitute 73% of GoodRx’s revenues.

11 89. GoodRx’s business model proved wildly profitable. In 2023, its gross
12 profit margin was 77.33%. In 2019 alone, GoodRx collected \$364 million in fees on
13 \$2.5 billion in consumer prescription drug spending through its platform, a 15% com-
14 mission. And in the first three months of 2024, GoodRx brought in over \$145 million
15 in prescription transactions revenue.

16 90. Between 2017 and 2022, traditional B2C discount-card utilization in-
17 creased by nearly 60%. As of 2021, pharmacy discount cards accounted for 5.4% of
18 all prescription adjudications, up from 3.3% in 2017. That growth was driven primar-
19 ily by GoodRx, which grew from 0.5% to 2.5% of all prescription adjudications in
20 the same time period.

21 V. THE GOODRX ISP SCHEME

22 91. This action does not challenge GoodRx’s traditional discount-card busi-
23 ness, but rather a new GoodRx business initiative, called the Integrated Savings Pro-
24 gram (“ISP”). As detailed below, the ISP Scheme makes large amounts of CSI avail-
25 able to competitor PBMs who also participate in the Scheme and agree to allow
26 GoodRx to set rates of reimbursement for them based on this CSI. GoodRx has
27 amassed and continues to amass this database of CSI through the GoodRx Infor-
28 mation-Exchange Network, and it includes PBMs’ Negotiated Rates of

1 reimbursement for generic drugs. The origins and nature of the ISP Scheme are de-
2 scribed below.

3 **A. The Origins of the Scheme: GoodRx’s Discount Card Empire Be-**
4 **gins to Crumble.**

5 92. By 2019, GoodRx had grown into a highly lucrative company, vaunted
6 for its innovation. When the company went public in 2020, it was valued at nearly
7 \$18 billion, more than six times the valuation it had commanded during its last private
8 fundraising only a few years prior.

9 93. Much of this success stemmed from GoodRx’s popularity with insured
10 consumers. But these individuals were not the company’s intended customer base.
11 When GoodRx launched in 2011, it marketed itself as a program for uninsured con-
12 sumers who do not benefit from any PBM-negotiated rates for prescribed medica-
13 tions and must instead pay inflated U&C prices. GoodRx claimed to provide this
14 economically vulnerable pool of customers with a way to access discounted rates
15 similar to those made available to insured individuals—for free. And it claimed to
16 offer pharmacies a way to bring in new business from people who might not other-
17 wise purchase any medications at all due to cost.

18 94. Over time, many insured consumers began to flock to GoodRx as well.
19 This was largely a function of increases in out-of-pocket costs for insured consumers,
20 as insurers and PBMs began to shift more of the cost burden for prescription drugs
21 onto patients in the form of higher co-pays and co-insurance requirements. Increas-
22 ingly, insured individuals realized it was often cheaper to pay cash for medications
23 at the GoodRx Rate than it was to use their plan benefits once the required out-of-
24 pocket contributions were factored in. This was particularly true for high-deductible
25 plan members, who must pay the full cost of their prescription drugs until their annual
26 deductibles are met.

27 95. The influx of business from insured customers benefitted GoodRx’s bot-
28 tom line tremendously. But behind the scenes, GoodRx’s increasing popularity

1 among insured consumers was sowing the seeds of a looming crisis. GoodRx's dis-
2 count card business depends on large numbers of retail pharmacies voluntarily ac-
3 cepting the GoodRx discount card. Yet pharmacies often lose money on GoodRx
4 discount card transactions after paying the required fees to the Leveraged PBM. In
5 the early days of GoodRx, pharmacies were willing to absorb these losses to help
6 uninsured patients (a relatively small pool of consumers) and to bring in new cus-
7 tomers. But this goodwill was premised on the proportion of GoodRx discount card
8 transactions remaining relatively low, and users of the GoodRx card being mostly
9 uninsured patients who otherwise might not purchase any medicines at all. After large
10 numbers of insured patients began using GoodRx, the benefit of accepting the card
11 for most pharmacies evaporated: each time an insured patient uses a GoodRx dis-
12 count card, the pharmacy does not bring a new customer through the door; it simply
13 loses money on a sale it likely would have made anyway. Since 2016, over 80% of
14 GoodRx's prescription transactions have consisted of repeat purchases by an existing
15 GoodRx consumer.

16 96. As GoodRx's user base tilted toward insureds, pharmacies' willingness
17 to accept the GoodRx card waned, and many pharmacies began opting out of accept-
18 ing the GoodRx discount card altogether. This problem reached a tipping point in
19 2022, when Kroger—which accounted for a huge share of GoodRx's business—an-
20 nounced it would no longer accept the GoodRx card. The loss of Kroger caused
21 GoodRx's stock value to plummet by more than 25% overnight.

22 97. GoodRx's increasing popularity with insured patients also brought un-
23 wanted regulatory scrutiny to the PBM industry, posing another threat to the com-
24 pany's long-term viability. The fact that so many insured patients found it cheaper to
25 use the GoodRx discount card than their own insurance plans undermined the narra-
26 tive that PBMs offered a valuable service to health plans and patients. After all, why
27 allow PBMs to manage prescription drug benefits at all—extracting billions of dol-
28 lars in the process—if they do not help make drugs more accessible?

1 98. Financial tensions also arose between GoodRx and its partner PBMs.
2 Early in the history of pharmacy discount cards, many of GoodRx’s partner PBMs
3 were also its horizontal competitors in the market for cash-pay customers. Initially,
4 many PBMs sponsored their own B2C discount cards, each aiming to carve out a
5 share of the cash-pay market for prescription drug purchases by uninsured or other
6 cash-pay consumers. But as GoodRx’s market share grew, it was able to insert onerous
7 contractual provisions into its agreements with partner PBMs that were intended
8 to “restrict the ability of PBMs to compete with [GoodRx] and solicit [its] consum-
9 ers” through those PBMs’ rival discount cards. Then, as even more transactions were
10 being mediated through GoodRx’s discount card rather than through patients’ plan
11 benefits or competing discount cards, GoodRx sought to extract higher fees from the
12 rival-turned-partner PBMs whose rates were being leveraged. But many PBMs
13 balked at the prospect of paying even more money under restrictive contract terms to
14 a company that merely aggregates the PBMs’ own Negotiated Rates—and which
15 would disappear overnight if PBMs decided to stop sharing their payment data. Some
16 PBMs threatened to leave the GoodRx ecosystem altogether.

17 99. These issues made increasingly clear to GoodRx executives that the
18 company’s original discount card model—which was premised on pharmacies’ vol-
19 untary acceptance of an external, consumer-facing discount card—might not be via-
20 ble long-term. This reckoning set the stage for GoodRx to begin orchestrating the ISP
21 price-fixing conspiracy.

22 **B. GoodRx Develops Its “Integrated Savings Program.”**

23 100. In 2021, less than a year after going public, GoodRx began to lay the
24 groundwork for the Scheme alleged herein.

25 101. On July 7, 2021, GoodRx acquired a technology platform called RxNXT
26 LLC. RxNXT enabled GoodRx to rapidly exchange claims data and reimbursement-
27 rate information, both considered CSI, with PBMs.

28

1 102. This new technology would enable GoodRx to execute what it called
2 the “Integrated Savings Program,” the program at the heart of this Complaint. Under
3 the ISP, GoodRx’s “price comparison technology”—a pricing algorithm and an as-
4 sociated database—“is . . . integrated with” participating PBMs’ internal claims pro-
5 cessing platforms, so that each PBM’s plan members “won’t have to do this compar-
6 ison [of out-of-pocket prescription costs] themselves.” Around the same time,
7 GoodRx announced that it was launching a new “B2B2C [i.e., business-to-business-
8 to-consumer] vertical.”

9 103. As a result of this integration, whenever one of the Conspiring PBMs’
10 “covered lives” would fill a generic drug prescription using their insurance benefits
11 (i.e., without using the GoodRx discount card), GoodRx’s ISP platform would “au-
12 tomatically compare their benefit and the GoodRx price and then deliver the lowest
13 one.” If the ISP Rate was lower, it would be applied automatically as part of the
14 patient’s plan benefit, and the amount spent on the drug is applied to the member’s
15 deductible.

16 104. For each ISP transaction where the ISP Rate is applied, the pharmacy
17 would be required to pay a “processing fee” of between \$7 and \$10. On information
18 and belief, GoodRx and the Conspiring PBMs involved in the transaction share these
19 fees among themselves, profiting at the expense of independent pharmacies.

20 105. The ISP was designed to solve GoodRx’s growing existential problems
21 in three ways. *First*, it eliminated pharmacies’ ability to opt out of transacting with
22 GoodRx, since the GoodRx ISP Rate would be automatically calculated and applied
23 as part of an insured patient’s health-plan benefits without the need for any external
24 GoodRx card. *Second*, insured patients would no longer have occasion to learn that
25 their PBM had been unable to secure the best drug prices available; they would
26 simply receive the lowest rate negotiated by *any* PBM automatically through their
27 health plan. *Third*, the proposal would increase the total number of transactions me-
28 diated through GoodRx, as its pricing algorithm would be applied to every generic-

1 drug transaction filled through benefits administered by any Conspiring PBM. In-
2 deed, GoodRx estimates that some 500 to 600 million claims will be subject to the
3 ISP each year, up from 100 million under its traditional discount-card program.

4 106. Participating PBMs also stood to gain from GoodRx's ISP scheme.
5 Smaller PBMs would be able to take advantage of the negotiated reimbursement rates
6 secured by larger PBMs in the input market for Network Pharmacy Services. The
7 coordination between these competing PBMs, facilitated by GoodRx, would thus re-
8 sult in an artificially suppressed reimbursement rate for the pharmacies. Furthermore,
9 the curtailment of competition for pharmacy services among PBMs would drive
10 down all reimbursement rates below competitive levels over time, benefiting all
11 PBMs through their collective monopsony power.

12 107. Additionally, GoodRx would receive clawback fees from dispensing
13 pharmacies every time the ISP Rate was leveraged on behalf of a patient insured by
14 a Conspiring PBM, which, on information and belief, it would then share with the
15 Conspiring PBMs. Thus, on information and belief, these fees reflect a gap (or
16 "spread") between the price paid by the TPP to the Primary PBM and the amount the
17 PBM passes on to the pharmacy for dispensing it.

18 108. Retaining spreads as profit has been an important revenue stream for
19 PBMs. In recent years, though, spread retention has been criticized for raising drug
20 prices and harming pharmacies, leading some state regulators and many TPPs to re-
21 quire PBMs to "pass through" all negotiated discounts and fees in full to the payor,
22 precluding spread retention. The ISP Scheme is an end-run around these contractual
23 and statutory protections, allowing PBMs to reintroduce spread retention into their
24 business models without violating provisions in their contracts with payors requiring
25 the PBM to pass through all discounts. That's because, for each generic-drug pre-
26 scription that is subject to the ISP Scheme, the cartel member that retains the spread
27 (i.e., the clawback fee from the pharmacy) is not the Primary PBM. Instead, the fee
28 is collected by GoodRx, which has no contractual relationship to the PBM's third-

1 party payor. On information and belief, GoodRx then shares its profits from these
2 fees with the Conspiring PBMs involved in the transaction.

3 109. Of course, there is one glaring problem with GoodRx’s ISP Scheme—
4 it constitutes naked price fixing by horizontal rivals. Through the Scheme, participat-
5 ing PBMs agree (1) to share real-time CSI, including pricing data with one another,
6 using GoodRx as a conduit, and (2) to always pay no more than the *lowest* rate ne-
7 gotiated by *any* PBM in the GoodRx Information-Exchange Network. Instead of out-
8 bidding one another’s negotiated pharmacy reimbursement rates, rival PBMs agree
9 to pay pharmacies no more than the lowest rate set by their competitors, curtailing
10 competition between themselves for pharmacy business. This is just price-fixing in
11 two steps: anticompetitive sharing of CSI among horizontal rivals, followed by their
12 agreement not to outbid and instead pay the lowest rate any of them has obtained.

13 **C. GoodRx Invites PBMs to Participate in Its ISP Scheme, and They**
14 **Accept.**

15 110. On information and belief, GoodRx began pitching the ISP Scheme to
16 its partner PBMs sometime in 2022.

17 111. Between November 8, 2022, and October 13, 2023, GoodRx announced
18 deals with several PBMs. Pursuant to these deals, a participating PBM would inte-
19 grate GoodRx’s pricing technology into its in-house pharmacy-benefit plans on or
20 around January 1, 2024, and sooner for some PBMs. This was a sudden departure
21 from prior practice, which several competitors undertook on or around the same time,
22 implying coordination.

23 *1. November 2022: Express Scripts joins the cartel.*

24 112. On November 8, 2022, GoodRx announced the first of its ISP partner-
25 ships with the nation’s second largest PBM, Express Scripts. The deal would go into
26 effect in early 2023, meaning Express Scripts joined the ISP Scheme earlier than any
27 other PBMs. Under the agreement, beneficiaries of plans managed by Express Scripts
28 would “automatically get the lowest out-of-pocket cost” on generic drugs “by

1 comparing the GoodRx price with the price from their Express Scripts PBM plan”
2 and “[a]ll spending will be applied to any deductible.”

3 113. This deal required Express Scripts not to outbid any of its competitors
4 on reimbursement rates paid to pharmacies for generic drugs and to and share its CSI
5 with rivals through GoodRx as a conduit.

6 114. GoodRx co-founder and then co-CEO Trevor Bezdek described the ar-
7 rangement as follows:

8 Under this innovative program, eligible Express group
9 members will automatically access GoodRx prices as part
10 of their pharmacy benefit. This means an eligible Express
11 Scripts member will have seamless access to GoodRx
12 prices for eligible generic medication in instances where
13 that price is lower than their benefit price. Importantly, this
14 keeps visibility of the eligible members’ GoodRx claims
15 within the pharmacy benefit, and it enables out-of-pocket
16 claims [to count toward a] member[’]s deductible.... We
17 believe this innovative collaboration is a strong validation
18 of ... the deep trust consumers have in our technology pow-
19 ered by last year’s acquisition of RxNXT. Next, this col-
20 laboration creates a new distribution channel that we be-
21 lieve expands our market opportunity and represents a way
22 to efficiently gain many incremental users.

23 2. *July to September 2023: Caremark, Navitus, and MedImpact join*
24 *the cartel.*

25 115. On July 12, 2023, GoodRx announced an identical arrangement with
26 another of the Big Three PBMs, Caremark, which was set to go into effect January 1,
27 2024. It required Caremark not to out-bid any of its competitors on reimbursement
28

1 rates paid to pharmacies for generic drugs and to and share its CSI with rivals through
2 GoodRx as a conduit.

3 116. On September 13, 2023, GoodRx announced that it had inked the same
4 deal with the PBM MedImpact, to go into effect January 1, 2024. This deal required
5 MedImpact not to outbid any of its competitors on reimbursement rates paid to phar-
6 macies for generic drugs and to and share its CSI with rivals through GoodRx.

7 117. And on October 12, 2023, GoodRx announced the same arrangement
8 with the PBM Navitus Health Solutions. This deal went into effect immediately, with
9 an expanded roll-out to cover more of Navitus's insureds, planned for January 2024.
10 It required Navitus not to out-bid any of its competitors on reimbursement rates paid
11 to pharmacies for generic drugs and to and share its CSI with rivals through GoodRx.

12 118. In its 2023 Annual Report, GoodRx reported:

13 Our ... priority has been to hone our growth plans for our
14 core prescription transactions offering which includes ex-
15 tending the benefit of GoodRx to commercial insurance
16 programs, or 'funded plans'. We've done this through our
17 Integrated Savings Program, or ISP, with PBM partners
18 like CVS Caremark, Express Scripts, MedImpact and
19 Navitus who aggregate demand for our prescription dis-
20 counts. We are driving real value with payers and their
21 members by seamlessly lowering the cost of their prescrip-
22 tions automatically at the point of sale. We are quickly be-
23 coming a leader in the commercial market for integrated
24 benefits, and while our programs are currently only availa-
25 ble to a subset of our partner PBMs' eligible members,
26 these PBMs cover over 60% of eligible U.S. lives so the
27 opportunity could be significant. The early traction on this
28 program is encouraging and we look forward to continuing

1 to ramp it over time by working to add more PBMs and
2 types of prescription transactions to the program.

3 **VI. DIRECT AND INDIRECT EVIDENCE OF AN UNLAWFUL**
4 **HORIZONTAL CONSPIRACY**

5 **A. Direct Evidence of a Horizontal Agreement.**

6 119. Each of the Conspiring PBMs has agreed contractually with GoodRx to
7 participate in the ISP. On information and belief, these contracts provide that the
8 PBM will agree to pay dispensing pharmacies the lowest amount obtained by any
9 PBM in GoodRx's Information-Exchange Network for generic drugs as part of their
10 plan benefits. Because these contracts explicitly require each PBM to cap its generic-
11 drug pharmacy-reimbursement rates at the lowest negotiated rate any rival PBM has
12 agreed to pay, they constitute direct evidence of a horizontal conspiracy among
13 PBMs.

14 120. Additional direct evidence of a horizontal conspiracy among the PBMs
15 can be found in public statements issued by GoodRx (including those quoted above)
16 and by each of the Conspiring PBMs admitting to both the existence and nature of
17 the ISP Scheme. For instance, the press releases announcing each new partnership
18 between GoodRx and a Conspiring PBM admit both the PBM's agreement to share
19 CSI and its agreement to reimburse pharmacies at the lowest rate negotiated by any
20 PBM in GoodRx's Information-Exchange Network. For instance, in its press release
21 announcing a partnership with Conspiring PBM MedImpact, GoodRx explained that
22 under the ISP Scheme, "[c]ompanies team up at the pharmacy counter" by "integrat-
23 ing GoodRx's price comparison technology with MedImpact's advanced [claims pro-
24 cessing] technology platform." Once MedImpact had joined the ISP Scheme, "when
25 an eligible MedImpact member fills a prescription for a generic medication," the ISP
26 algorithm and database "will automatically compare their benefit and the GoodRx
27 price and then deliver the lowest one." Each of the Conspiring PBMs issued a joint
28

1 press release with GoodRx upon joining the ISP Scheme that admits to identical fea-
2 tures of the cartel.

3 **B. Indirect Evidence of a Horizontal Agreement.**

4 *1. The Conspiring PBMs engage in actions that, absent concerted*
5 *action, would be against their individual economic self-interest.*

6 121. As part of the ISP Scheme, each Conspiring PBM engages in actions
7 that, in the absence of concerted action, would be against their individual economic
8 self-interest, but that maximize profits for the collective under the scheme. These
9 actions against self-interest are strong circumstantial evidence of a horizontal agree-
10 ment among the Conspiring PBMs to reduce competition for pharmacy business and
11 suppress reimbursement rates.

12 122. First, it would be against the unilateral economic self-interest of any in-
13 dividual PBM to pay below-market reimbursement rates to pharmacies for generic
14 drugs (the goal and consequence of coordinating their pricing through GoodRx) be-
15 cause doing so would cause pharmacy defections from those PBMs' networks and,
16 ultimately, economic harm in the output market for PBM services. In the absence of
17 collusion, PBMs would reimburse pharmacies at competitive rates to achieve greater
18 pharmacy satisfaction and avoid the economic harms associated with diminished net-
19 works. However, because PBMs know that their competitors have also agreed to pay
20 below-market reimbursement rates, they are insulated from the competitive risks that
21 would exist absent coordination.

22 123. Second, it would be against the economic self-interest of any individual
23 Conspiring PBM to share its competitively sensitive and proprietary pricing data and
24 strategies with other insurers through a common third party, unless it knew its main
25 competitor PBMs had agreed to do the same. In the absence of concerted action,
26 PBMs would not share such information with rivals (through an intermediary or oth-
27 erwise) because of the risk of competitive harm. After all, competitor PBMs could
28

1 use the information to make superior bids to unaffiliated pharmacies and strengthen
2 their pharmacy networks relative to the competition.

3 2. *The PBM Services Market is susceptible to the formation, mainte-*
4 *nance, and efficacy of a cartel.*

5 124. The PBM Services Market is characterized by numerous features, some-
6 times called “plus factors,” that render it susceptible to collusion and bolster the plau-
7 sibility of the cartel alleged herein.

8 125. First, on the PBM side, there are high barriers to entry that make it dif-
9 ficult for new PBMs to enter the market for pharmacy benefit management services.
10 These barriers include state and federal regulatory requirements and the costs asso-
11 ciated with developing pharmacy networks, building client relationships, and devel-
12 oping the kinds of technologies and infrastructures that enable PBMs to electronically
13 adjudicate millions of pharmacy reimbursement claims each day.

14 126. Second, on the pharmacy side, pharmacies face high exit barriers in the
15 Network Pharmacy Services Market. In the United States, over 80% of all prescrip-
16 tion drug costs are covered by third-party payors. These payors all use PBMs to ne-
17 gotiate prices with pharmacies, process drug claims, and pay reimbursements. Given
18 this reality, pharmacies have no substitutes from which to seek reimbursement for
19 generic drugs but from PBMs retained by third-party payors. The only way for phar-
20 macies to “exit” this third-party payor system is to refuse to fill prescriptions for the
21 vast majority of patients who will not or cannot pay cash, which would spell financial
22 ruin for most pharmacies.

23 127. Third, the associated output market for PBM services is highly concen-
24 trated. Currently, the three biggest PBMs manage 79% of prescription drug claims,
25 and the six largest PBMs collectively manage 94% of all claims. The largest PBM,
26 Caremark, accounts for 34% of all prescription drug claims, followed by Express
27 Scripts (23%), OptumRx (22%), Humana (7%), MedImpact (5%), and Prime
28

1 Therapeutics (3%). Furthermore, five of those six largest PBMs are vertically inte-
2 grated with major health insurers.

3 128. Fourth, the claims submitted by pharmacies to PBMs for reimbursement
4 from insurers are fungible. All claims are submitted using uniform billing codes, no
5 matter the insurer or the pharmacy. This allows GoodRx to set reimbursement rates
6 for drug claims submitted by different pharmacies to different insurers across differ-
7 ent health plans, across the entire country, making it feasible for GoodRx and the
8 Conspiring PBMs to execute their anticompetitive scheme nationwide.

9 129. Fifth, members of the alleged cartel have had ample opportunity to meet
10 and collude. The PBMs' trade association, the Pharmaceutical Care Management As-
11 sociation (PCMA), holds annual meetings, business forums, and policy forums. In
12 addition, several GoodRx executives were formerly executives of PBMs. Scott Paul,
13 GoodRx's Senior Vice President of Healthcare & Consumer Innovation, was the Ex-
14 ecutive Vice President of MedImpact before moving to GoodRx in May 2022, mere
15 months before GoodRx began soliciting PBMs to join its ISP Scheme. Another
16 GoodRx Senior Vice President, Cynthia Meiners, spent twelve years at Express
17 Scripts as a Vice President for Pharmaceutical & Retail Strategies. Agnes Rey-Gi-
18 raud, a current member of GoodRx's Board of Directors, also spent twelve years at
19 Express Scripts, including as Senior Vice President for Contracting, Strategic Sourc-
20 ing & Corporate Strategy. Jim Sheninger, a GoodRx Pharmacy Strategy Officer, has
21 previously worked in leadership at both CVS Health and as Senior Vice President for
22 Cigna Pharmacy Management. And Sara Ptakowski, currently serving as the Senior
23 Director for Strategy & Planning in GoodRx's new "Benefits Solutions" "B2B2C
24 vertical," spent five years at Optum as Senior Director of Corporate Strategy. The
25 revolving doors that exist between GoodRx and the Conspiring PBMs create ready
26 opportunities among their executives for explicit agreements to collude.

27
28

VII. RELEVANT MARKETS AND MONOPSONY POWER

130. This case concerns a horizontal price-fixing arrangement, which is *per se* illegal and for which a market definition is not needed. To the extent that proof of market power is needed, the collective buying power of the Conspiring PBMs can be established with direct evidence, obviating the need for a market definition. On information and belief, the ISP Scheme reduces net reimbursement amounts for generic drugs (i.e., the amounts pharmacies earn on prescriptions subject to the cartel after all fees are paid to PBMs) by at least 15% of the total amount spent on retail prescription drugs. The Conspiring PBMs would not have been able profitably to impose such significant reductions in generic reimbursement rates—well in excess of a small but significant non-transitory decrease in prices of a hypothetical monopsonist—unless they collectively possessed market (buying) power over pharmacists.

131. Moreover, the Conspiring PBMs that now use GoodRx to set their generic drug reimbursement rates are responsible for managing 64% of all prescription drug claims in the United States. Given this market share, pharmacies have no real alternative for payors they can sell generic drugs to, as the Conspiring PBMs gate-keep access to a huge portion of potential patients and prescriptions. The Conspiring PBMs' market share is additional direct evidence of the cartel members' collective market (buying) power over pharmacies.

132. If an antitrust market still needs to be defined, the relevant market is the market for network pharmacy services for purchase by PBMs on behalf of third-party payor clients (the "Network Pharmacy Services Market"). The Network Pharmacy Services Market is the market that has been corrupted by the ISP Scheme. Absent the Scheme, PBMs would compete to enroll pharmacies in their networks by offering superior reimbursement rates on prescription drugs (including generics); instead, the Conspiring PBMs now agree not to outbid each other on pharmacy reimbursement rates for generic drugs. The relevant geographic market is the entire United States,

1 because PBMs enroll pharmacies in their networks (to provide services to their cov-
2 ered lives) nationwide.

3 133. The Network Pharmacy Services Market is an input market. Absent net-
4 work pharmacy services, PBMs would struggle to compete in the associated output
5 market for PBM services for purchase by third-party payors (the “PBM Services
6 Market”). That’s because TPPs decide which PBMs to hire based on the quality and
7 breadth of their pharmacy networks.

8 134. In this input market, pharmacies are sellers of prescription drugs, while
9 PBMs (like the Conspiring PBMs) pay for those products on behalf of their TPP
10 clients. Pharmacies have no reasonable economic substitutes to which they could turn
11 in response to a small decrease in reimbursements (below competitive levels) pro-
12 vided by PBMs for generic drugs.

13 135. The Network Pharmacy Services Market can be corroborated by practi-
14 cal indicia of the contours of competition. With regard to industry or public recogni-
15 tion of the market, there is widespread recognition in the PBM industry that network
16 pharmacy services are a vital input. And pharmacies commonly express decreased
17 willingness to join particular PBMs’ networks when they receive below-market re-
18 imbursements from those PBMs.

19 136. With regard to the peculiar characteristics and uses of network phar-
20 macy services, such services are unique because network pharmacists are compen-
21 sated at pre-negotiated rates by the PBM after each transaction has occurred. By con-
22 trast, in the retail or cash-pay market for prescription drugs, patients pay the phar-
23 macy at the point of sale, based upon U&C (non-discounted) prices which are unilat-
24 erally set by the pharmacy.

25 137. The Conspiring PBMs’ collective market (buying) power over inde-
26 pendent pharmacies can be inferred based on their combined market share in the
27 PBM Services Market, plus evidence of barriers to entry. Four PBMs, including the
28 nation’s two largest, have agreed to use GoodRx’s ISP pricing methodology for

1 generic drug claims. These Conspiring PBMs account for at least 64% of all prescrip-
2 tion drug claims managed in the United States.

3 **VIII. ANTICOMPETITIVE EFFECTS AND INJURY SUFFERED BY** 4 **CLASS MEMBERS**

5 138. Since the ISP Scheme went into effect on January 1, 2024, and possibly
6 sooner, it has significantly curtailed competition and reduced reimbursement rates
7 paid to independent pharmacies for generic drug claims.

8 139. Rather than paying their own Negotiated Rates for generic drugs, the
9 Conspiring PBMs now outsource their rate-setting decisions to GoodRx, which has
10 access to a massive amount of CSI from the GoodRx Information Exchange Network
11 (including each PBM's Negotiated Rates with pharmacies). The PBMs agree to al-
12 ways select the lowest rate when calculating the reimbursements they offer pharma-
13 cies. In other words, the Conspiring PBMs have entered into an unlawful agreement
14 not to outbid each other for what they reimburse pharmacies for generic drugs.

15 140. The outsourcing of Conspiring PBMs' generic drug reimbursement de-
16 cisions, as well as their anticompetitive information exchange, has corrupted the Net-
17 work Pharmacy Services Market (an input market, defined above), replacing inde-
18 pendent centers of decision-making with respect to reimbursement rates with a single
19 effective decision-maker, GoodRx, disrupting the competitive process.

20 141. Both economic theory and antitrust jurisprudence recognize that joint
21 delegation schemes, particularly when accompanied by information exchange, re-
22 duce the intensity of price competition and artificially suppress compensation below
23 competitive levels.

24 142. By analogy, in recent guidance to human resources professionals, the
25 Department of Justice Antitrust Division ("DOJ") stated that "[s]haring information
26 with competitors about terms and conditions of employment" can be anticompetitive
27 by allowing firms to match each other's compensation rather than compete for ser-
28 vices by offering additional compensation. That is precisely what has happened with

1 respect to the reimbursement rates PBMs negotiate with pharmacies for generic drug
2 claims.

3 143. As a result of the GoodRx ISP Scheme, reimbursement rates provided
4 to pharmacies for generic drug claims have been suppressed below competitive lev-
5 els. Navitus and MedImpact, the smaller Conspiring PBMs, now pay the same Ne-
6 gotiated Rates on generics as the nation's largest PBMs, Caremark and Express
7 Scripts. In the absence of coordination, such smaller PBMs would not qualify for the
8 same volume discounts from pharmacies as larger pharmacies and would have to
9 outbid their larger rivals. A smaller PBM that offered pharmacies the kinds of low
10 reimbursement rates that only the largest PBMs qualify for would be unable to build
11 and maintain its pharmacy network and would suffer competitive harms in the output
12 PBM Services Market.

13 144. In addition, the curtailment of competition in the Network Pharmacy
14 Services Market has driven down the pharmacy reimbursement rates all the Conspir-
15 ing PBMs pay pharmacies. Even if the largest Conspiring PBMs, Caremark and Ex-
16 press Scripts, are already able to negotiate the best overall discounts from pharmacies
17 given their massive buying power, it does not mean that for any given drug, these
18 PBMs will have secured the lowest price. It simply means that across all drugs, these
19 large PBMs will usually secure the lowest total "package" of drug prices. The ISP
20 Scheme ensures that for each and every generic drug prescription, the Conspiring
21 PBMs always pay the lowest price negotiated by any rival PBM in the GoodRx In-
22 formation-Exchange Network, which would not be the case absent the alleged cartel.

23 IX. CLASS ACTION ALLEGATIONS

24 145. Plaintiff brings this action on behalf of itself, and all others similarly
25 situated, pursuant to Federal Rules of Civil Procedure 23(a), 23(b)(2), and 23(b)(3)
26 as representatives of the proposed Class, which is defined as follows:

27 All pharmacies in the United States that are not members
28 of the same corporate family as a Conspiring PBM and that

1 were reimbursed for generic drugs pursuant to the GoodRx
2 Integrated Services Program.

3 146. The Class is so numerous that joinder of all members in this action is
4 impracticable. There are tens of thousands, if not hundreds of thousands, of members
5 in the proposed Class.

6 147. Plaintiff's claims are typical of those of the Class because Plaintiff
7 presses the same legal theories, and seeks to redress the same injury, for itself as for
8 all members of the proposed Class.

9 148. Plaintiff and all members of the Class were injured by the same unlawful
10 conduct, which resulted in all of them receiving less compensation for generic drugs
11 from PBMs than they otherwise would have in a competitive market.

12 149. Plaintiff will fairly and adequately protect and represent the interests of
13 the Class. The interests of Plaintiff are not antagonistic to the Class.

14 150. Questions of law and fact common to the members of the Class predom-
15 inate over questions, if any, that may affect only individual members.

16 151. Defendants and the Conspiring PBMs have acted and refused to act on
17 grounds generally applicable to members of the proposed Class, such that injunctive
18 and declaratory relief is appropriate with respect to the proposed Class as a whole.

19 152. Questions of law and fact common to the Class include but are not lim-
20 ited to:

- 21 • whether GoodRx and the Conspiring PBMs have en-
22 tered into a contract, combination, conspiracy, or
23 common understanding to artificially suppress reim-
24 bursement rates for generic prescription drugs;
- 25 • whether, if GoodRx and the Conspiring PBMs en-
26 tered into such a contract, combination, conspiracy,
27 or common understanding, that conduct is a *per se*
28 violation of Section 1 of the Sherman Act;

- 1 • whether the conduct of GoodRx and the Conspiring
- 2 PBMs has in fact artificially suppressed reimburse-
- 3 ment rates paid to members of the proposed Class;
- 4 • the proper measure of damages for the proposed
- 5 Class;
- 6 • the contours of appropriate injunctive relief to reme-
- 7 diate the anticompetitive effects of the challenged
- 8 conduct in the future.

9 153. Plaintiff is represented by counsel who are experienced and competent
10 in the prosecution of complex antitrust and unfair competition class actions.

11 154. Class action treatment is the superior method for the fair and efficient
12 adjudication of the controversy in that, among other things, such treatment will per-
13 mit a large number of similarly situated persons or entities to prosecute their common
14 claims in a single forum simultaneously, efficiently, and without the unnecessary du-
15 plication of effort and expense that numerous individual actions would engender. The
16 benefits of proceeding through the class mechanism, including providing injured per-
17 sons or entities with a method of obtaining redress for claims that might not be prac-
18 ticable for them to pursue individually, substantially outweigh any difficulties that
19 may arise in the management of this class action.

20 X. CAUSES OF ACTION

21 COUNT ONE

22 **Agreement in Restraint of Trade in Violation of** 23 **Section 1 of the Sherman Antitrust Act**

24 155. Plaintiff incorporates each allegation above as if fully set forth herein.

25 156. Defendants and the Conspiring PBMs, directly and through their divi-
26 sions, subsidiaries, agents, and affiliates, engage in interstate commerce in the pur-
27 chase and reimbursement of prescription drugs for health plan members and in the
28 provision of PBM services.

1 157. Defendants and the Conspiring PBMs entered into and engaged in an
2 unlawful contract, combination, or agreement in restraint of trade and commerce in
3 violation of the Sherman Act, 15 U.S.C. § 1.

4 158. Specifically, Defendants and the Conspiring PBMs have combined to
5 form a cartel to artificially suppress reimbursement rates paid to pharmacies across
6 the country for generic drugs, and they have exchanged non-public and competitively
7 sensitive information with one another in order to accomplish that purpose.

8 159. The conduct of Defendants and the Conspiring PBMs was undertaken
9 with the intent, purpose, and effect of artificially suppressing reimbursement rates on
10 generic drugs below competitive levels.

11 160. Defendants and the Conspiring PBMs perpetrated this scheme with the
12 specific intent of decreasing pharmacy reimbursement rates for their own benefit.

13 161. The conduct of Defendants and the Conspiring PBMs in furtherance of
14 the unlawful scheme described herein was authorized, ordered, or executed by their
15 officers, directors, agents, employees, or representatives while actively engaging in
16 the management of the affairs of Defendants and the Conspiring PBMs.

17 162. The GoodRx Cartel has caused the Class to suffer damages in the form
18 of artificially suppressed reimbursement rates.

19 163. There are no procompetitive justifications for the GoodRx Cartel, and
20 any proffered justifications, to the extent cognizable, could be achieved through less
21 restrictive means.

22 164. The GoodRx Cartel is unlawful under a *per se* mode of analysis. In the
23 alternative, the GoodRx Cartel is unlawful under either a quick look or rule of reason
24 mode of analysis.

25 165. As a direct and proximate result of this unlawful scheme, Plaintiff and
26 the members of the proposed Class have suffered injury to their business or property
27 and will continue to suffer economic injury and deprivation of the benefit of free and
28 fair competition unless Defendants' conduct is enjoined.

1 166. Plaintiff and the Class are entitled to recover three times the damages
2 sustained by them, interest on those damages, together with reasonable attorneys'
3 fees and costs under Section 4 of the Clayton Act, 15 U.S.C. § 15.

4 167. Plaintiff and the Class are entitled to a permanent injunction that termi-
5 nates the unlawful conduct alleged herein as well as any other equitable relief the
6 Court deems proper.

7 **XI. PETITION FOR RELIEF**

8 Plaintiff petitions for the following relief:

- 9 a) A determination that this action may be maintained as a class action
10 pursuant to Federal Rule of Civil Procedure 23, that Plaintiff be ap-
11 pointed as class representative, and that Plaintiff's counsel be appointed
12 as class counsel;
- 13 b) A determination that the conduct set forth herein is unlawful under Sec-
14 tion 1 of the Sherman Antitrust Act;
- 15 c) A judgment and order requiring the defendants to pay damages to Plain-
16 tiff and members of the Class, trebled;
- 17 d) An order enjoining the defendants from engaging in further unlawful
18 conduct;
- 19 e) An award of attorneys' fees and costs;
- 20 f) An award of pre- and post-judgment interest on all amounts awarded;
21 and
- 22 g) Such other and further relief as the Court deems just and equitable.

23 **XII. JURY DEMAND**

24 168. Plaintiff, on behalf of itself and the Class, demands a jury trial on all
25 issues triable as of right before a jury.

26 Dated: November 1, 2024

SUSMAN GODFREY L.L.P.

27 By: /s/ Halley Josephs

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