Prescription Drug Value Chain

The Saga Portfolio first bought GoodRx at the end of 2020 and has added to it throughout 2021. As it has become a larger position in the Portfolio, it makes sense to explain the investment thesis in more detail.

For those who don't care to understand the prescription drug value chain, feel free to skip over this section. While few readers may really care about the fairly complicated prescription drug value chain, it is important to review in order to understand the role that GoodRx plays within the ecosystem. This is my best attempt in trying to explain it in a few paragraphs.

Like many other parts of the U.S. healthcare system, prescription drugs suffer from complex and non-transparent pricing with access largely controlled by health plan payers. The majority of people in the U.S. have insurance provided by either their employer or a government program such as Medicare or Medicaid. Consumers largely rely on third parties to determine which drugs are covered by their health plan, and therefore which drugs may or may not be affordable.

Pharmacy benefit managers (PBMs) play a significant role and sit in the middle of three different parties. They are the intermediary between health insurers, pharmacies, and drug manufacturers. Health insurers hire PBMs to manage prescription drug plans for their covered population. PBMs negotiate on behalf of the health insurer with pharmacies. Pharmacies enter pricing contracts with PBMs in an effort to drive more demand to the store.

The contracts between PBMs and pharmacies determine the price a covered PBM member pays for any particular drug. There are two relevant prices: PBM's negotiated MAC (maximum allowable cost) and Usual & Customary (U&C). MAC prices are the maximum price a PBM will pay a pharmacy for a generic drug. U&C are the cash prices set by the pharmacy that is charged to any uninsured customer not covered by a PBM.

Contracts between the PBM and a pharmacy state that the PBM will reimburse the pharmacy the lesser of:

- PBM's MAC price
- Pharmacy's U&C cash price

MAC pricing surrounds generic drugs, which make up nearly 90% of prescriptions filled in the U.S., but only account for ~20% of total drug costs. Branded drug pricing is typically set by the drug manufacturer and then PBMs may negotiate rebates or a discount from the list price for their covered members. For generics, PBMs will typically set a cap reimbursement rate (MAC price) for a specific dosage and form of a particular drug. The pharmacy then determines which generic version of the drug to supply among the different competing generic drug manufacturers.

An important part of PBM contracts is that the price a PBM reimburses the pharmacy cannot be lower than the U&C cash price set by the pharmacy. However, most pharmacies deal with multiple PBMs, and each PBM can have multiple, if not hundreds, of different MAC lists, one for each of the plans they manage. Therefore, MAC prices for any particular drug can vary significantly at any single pharmacy. This results in the pharmacy likely setting their general U&C cash price above the highest negotiated MAC price so they do not lose revenue.

Pharmacies cannot maintain multiple price schedules for PBMs or submit a different U&C cash price to a PBM than they would offer a cash customer without being in violation of their contract and at risk of being dropped from the PBM network. Therefore, U&C cash prices (the price uninsured consumers pay) are artificially elevated, sometimes reaching over 10 times the price of the pharmacy's wholesale drug acquisition cost at extremes.

A greater share of the population is increasingly exposed to these inflated U&C cash prices. As healthcare costs have risen, so has the cost of insurance. Employers who have historically offered health insurance as a benefit are increasingly shifting the rising costs onto employees in the form of high deductible health plans (HDHPs). Over the last decade HDHPs have grown to ~50% of all commercial health plans and that number is expected to rise. Before someone with an HDHP hits their deductible, they usually have to pay the inflated U&C price for prescriptions. After the deductible is reached, they will typically have a copay or coinsurance. As more insured people are paying costs out of pocket and exposed to artificially inflated prescription prices, they are seeking affordable solutions to crucial products their health depends on.

Prescription Discount Cards

This is where GoodRx and other prescription discount cards come in. The PBM contracts with pharmacies allow PBMs to offer their negotiated MAC prices to people that are not covered insured members by providing them a discount code to use at the pharmacy. Consumers not covered by the PBM can access the PBM negotiated MAC prices as though they were patients within the PBM insurance network.

At the counter, the consumer using a discount code pays the MAC price to the pharmacy instead of the U&C cash price. The pharmacy would not submit a claim to the PBM since the consumer is not a covered member and is paying the full MAC price out of pocket. These prescriptions are

not considered "cash-pay" since the transaction is processed by a PBM therefore are not in conflict with the U&C cash price contract provision. In exchange for the PBM processing the transaction, the pharmacy pays the PBM an administrative fee which the PBM then shares with the discount card vendor that directed the patient to them.

About a decade ago, a bunch of discount cash card companies entered into relationships with PBMs to access their network rates. Discount card companies would direct demand to PBMs, initially targeting the uninsured population who significantly benefited from accessing PBM MAC prices. PBMs benefit from access to a patient segment they otherwise would not have reached, the insurance company benefits by not paying a claim, and the patient pays a lower price than the U&C cash price or even the price offered by their insurance provider.

In the early days of these prescription discount card companies, it was largely a free-for-all greenfield opportunity that was difficult to differentiate. Discount cards were initially considered lead generators for PBMs. However, over the past decade GoodRx has emerged at the dominant leader of the pack. Rather than simply being a lead generator, GoodRx has built a consumer prescription *marketplace* that appears to have winner-take-most competitive dynamics.

GoodRx was successful for a few key reasons:

1. Established relationships with most of the PBMs early on which provided them access to the best MAC prices available on average. In 2014, GoodRx also patented the ability to contract with multiple PBMs and use its technology to show the lowest price for each pharmacy on a single interface. Being able to offer the lowest prices on average in a seamless customer friendly interface has resulted in GoodRx achieving a customer net promoter score (NPS) of 90.

2. Driving top of funnel consumer awareness. GoodRx created a user-friendly interface with healthcare professionals (providers/physicians) through web and app interfaces (NPS of 86). Doctors care about patient prescription adherence and GoodRx works with providers to help consumers better afford medication. It is integrated with the major electronic health record providers, allowing doctors to check prescription pricing while the patient is sitting in their office. Combined with targeted marketing, (~70% of consumers do not even know that prescription pricing varies significantly from pharmacy to pharmacy) GoodRx has accelerated consumer adoption of prescription discount cards.

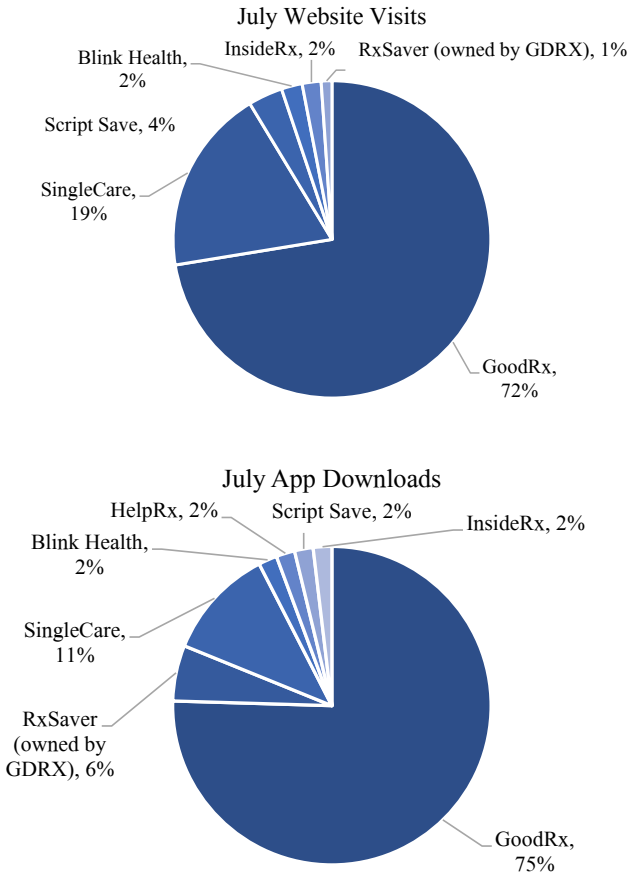
3. Good relationships with pharmacies (point of sale). While pharmacies lose margin by having to accept PBM MAC prices for what may have been higher margin U&C cash prices, discount cards potentially increase foot traffic to their stores to buy other high margin consumer goods.

The above factors helped GoodRx in its early stages, but the creation of a prescription marketplace where PBMs compete with each other for demand on its platform is what will allow GoodRx to continue to succeed into the future. GoodRx has aggregated demand and now has the dominant and growing market share in the discount card space.

The details surrounding MAC pricing are opaque and subject to the private nature of PBM contracts, but industry insiders have stated that MAC prices are negotiated long-term *average* discounts to pharmacy prices. This pricing mechanism has an important implication that strengthens GoodRx's position as the prescription marketplace winner. PBMs are able to provide more favorable pricing to certain members and less favorable pricing to others based on their negotiated average MAC prices. Since GoodRx has aggregated the most demand (7.5 million consumers for prescription-related offerings and reaches ~20 million Americans a month), a PBM can choose to be more price competitive on GoodRx in order to capture that demand. Even if a smaller discount card were able to partner with multiple PBMs, the PBMs are incentivized to price more aggressively on GoodRx to win the greater demand GoodRx has aggregated.

Competition

Among direct competitors that are solely prescription discount card providers, GoodRx is made up ~72% of web traffic and 75% of app downloads. GoodRx acquired RetailMeNot's RxSaver in May 2021 which historically ranked second in Google Play and iOS store app downloads and monthly active users. RxSaver was also the only other major discount card provider that partnered with multiple PBMs.



Source: SimilarWeb, Saga Partners

SingleCare and Blink Health are the next largest discount card providers measured by app downloads. Both work with only one PBM and negotiate pricing directly with pharmacies. SingleCare is about a quarter of the size of GoodRx and is integrated with its own PBM. Only working with one PBM removes any marketplace dynamic and makes it unlikely that prices through that provider will be the lowest available on average.

The major PBMs have their own prescription discount card but have had little traction because like SingleCare and Blink Health, are not a marketplace and therefore are unlikely to be able to offer the lowest prices for drugs all of the time. The largest PBM owned discount card is ScriptSave which was a discount card acquired by MedImpact in 2013.

It is also important to understand the dynamics between discount card programs and pharmacies. Pharmacies have increasingly found themselves in a tough spot with little control over the prices they can charge customers, irrespective of their drug wholesale acquisition costs (cost of goods sold). Because the PBMs/payors have so much bargaining power over pharmacies in setting MAC prices, this leads to pharmacies earning near zero gross profit or even losing money on many prescriptions and then occasionally making significant profits on a small number of prescriptions from uninsured U&C cash paying customers. As prescription discount cards become more prevalent, pharmacies will no longer have the few very profitable U&C-priced prescriptions.

Chain pharmacies increasingly view fulfilling prescriptions as a loss leader driving foot traffic into their store to buy other higher margin products, such as groceries and cosmetics. It is similar to how most gas stations sell gas near breakeven to drive foot traffic and sell higher margin consumable products. Ellis Management Consultants released a consumer survey finding that every new prescription filled at grocery store pharmacies drove more than $40 of incremental sales in other departments. A recent GoodRx study found that half of consumers filling a prescription also purchased a secondary non-pharmacy item, with over half of those spending an incremental $11-$30.

Pharmacies have also tried to get around U&C pricing restraints by partnering with PBMs to offer their own prescription discount card. Costco and Walmart partner with MedImpact for their discount card programs. However, like the other PBMs and discount cards, they don't benefit from GoodRx's multi-PBM marketplace dynamic. Additionally, pharmacies also face a conflict of interest in promoting their discount card since they want customers to pay more at the counter and likely don't prefer customers using their discount card at competing pharmacy locations.

Amazon made headlines in November 2020 when it launched Amazon Pharmacy, following its acquisition of PillPack in 2018. The launch was a combination of Amazon's retail mail order pharmacy and a prescription discount card program called PrimeRx. At its core, Amazon Pharmacy is a pharmacy trying to increase consumer adoption of mail order prescriptions. Its discount card program is in partnership with Express Scripts and is the service that directly competes with GoodRx. It is likely that Amazon only introduced a discount card as a way for Amazon to publicly display third party drug prices for customers, which they wouldn't be able to do otherwise. It is unlikely that Amazon is trying to send customers to competing retail pharmacies to fill prescriptions using Amazon's prescription discount card. Third party surveys indicate that there has been almost no usage of PrimeRx thus far.

The fact that Amazon decided to partner with a PBM and to not directly discount drug prices shows how difficult it is to truly disrupt the prescription drug distribution channel. Disrupting supply chains by streamlining distribution to generate lower prices and a more customer-centric experience is what initially made Amazon successful, and its inability to do so in prescriptions is telling. Like all other pharmacies, Amazon depends on accepting insurance customers where PBMs determine the prices or a discount benefit program which also relies on PBM pricing.

The Shifting Prescription Drug Value Chain and Optionality

GoodRx's success is attributable to the marketplace it built for consumers that works within the existing PBM and pharmacy networks. Creating a consumer-friendly experience that offers the cheapest prices most of the time is a big advantage that feeds its virtuous cycle. The more consumers GoodRx aggregates, the more PBM suppliers are encouraged to aggressively price on GoodRx to win more demand, which then attracts more consumers to GoodRx.

While the uninsured and high deductible plans all benefit from GoodRx prices, the prices available on GoodRx will increasingly become cheaper than copays and coinsurance. PBMs place drugs on different tiers within their formularies. If a prescription is on a higher tier or is a non-preferred drug, it can mean a higher co-pay or no coverage at all. Since GoodRx partners with nearly every PBM, they are able to get the best available pricing from the different PBMs in aggregate.

In 2017, the New York Times found that prices on GoodRx were cheaper than insurance copays ~40% of the time for the top 100 drugs. These prices also assume a customer already hit their deductible. In a June 2021 paper, GoodRx reported that over 55% of prescriptions filled using GoodRx were cheaper than the average commercial insurance copays for the 100 most purchased medications. The best discount available on GoodRx beat the average insurance copayment 89% of the time. The average discount on GoodRx has increased to 79% off list prices compared to 59% in 2016. This supports the thesis that as GoodRx scales, competition amongst PBMs is increasing and the pricing they offer on GoodRx is getting more aggressive and more favorable than the prices offered to insured customers.

GoodRx can increasingly serve more than just the uninsured and underinsured, which is reflected in the fact that 74% of GoodRx monthly active users have some form of insurance. While PBMs are benefitting from the incremental demand and associated administration fees paid by pharmacies, they will find they are losing their legacy power position within the prescription value chain as GoodRx is shining price transparency in a space that has historically been a black box. For the first time in recent history, PBMs are competing for demand that has become increasingly price sensitive as consumers carry more of the burden of healthcare costs. Even the three largest PBMs aren't powerful enough to control drug pricing and GoodRx has become the aggregator within the prescription drug value chain.

GoodRx is also working directly with pharmacies through its subscription product GoodRx Gold. Subscribers pay a monthly fee to access even cheaper prices on 1,000+ prescription drugs at participating pharmacies. It also includes discounts on telehealth and access to mail delivery. It is clear management is putting a lot of resources into Gold and it will be an increasingly important

product in the future. It's possible to imagine GoodRx moving into a marketplace for other medical services and bundling things such as lab tests, x-rays, routine procedures, etc. within Gold.

In 2020, an estimated $3.4 billion in U.S. prescriptions were transacted over the GoodRx platform, providing nearly $500 million in fees earned from PBMs. In 2021, these numbers are expected to grow to a respective $4 billion and $600 million. Total revenues are expected to pass $1 billion in 2022. As a marketplace, GoodRx has limited costs of supply, providing 90%+ gross profit margins. Sales and marketing are the largest operating expense at nearly 50% of sales. Management is targeting adjusted operating margins of over 40% at scale as sales and marketing costs decline as a percent of sales.

One may wonder how GoodRx, another middleman in what is already a crowded value chain, can earn so much money. It is a reflection of how inefficient the prescription market truly is. 20-30% of prescriptions go unfilled largely because of price, therefore GoodRx is potentially able to expand the market by offering lower priced drugs. Additionally, customers who paid inflated U&C prices are now able to utilize GoodRx to bring down the price. Insured customers can increasingly pay less money using GoodRx than using insurance, meaning insurance companies will not have to pay out claims. Paradoxically, GoodRx is lowering the cost of prescription drugs and still able to earn a lot of money.

GoodRx is only scratching the surface of the prescription market. Including the prescriptions that go unfilled, the total U.S prescription market is over $500 billion. Excluding specialty drugs, branded and generic drugs make up ~$350 billion of spend per year; meaning prescriptions transacted over GoodRx consists of just over 1% of the market. In theory, if GoodRx continues to be successful in lowering drug costs, prices will decline to their fair value removing this "arbitrage" opportunity that has been created by the PBMs and regulators (will save the history of U.S. health insurance and explanation of Medicare Part D for another day). If the cost of prescription drugs decline because of greater market efficiency, then the total addressable market should also decline as inflated prices are removed. Note this addressable market does not consider other inefficiently priced health care services such as testing or routine procedures that would benefit from a marketplace such as GoodRx. Regardless, that market is still very large and if prescription drug prices were ever to become perfectly efficient, there will still be a demand for GoodRx. If GoodRx were to no longer exist, the inefficiency would return. As the prescription drug marketplace winner, GoodRx will be able to earn a fair take rate for providing that marketplace.

GoodRx is essentially the Bookings.com or Expedia.com of the prescription drug industry. The biggest difference is that the suppliers of drugs do not control the prices they can charge unlike airlines or hotels which are able to control the prices they charge. That means customers can't disintermediate GoodRx by going straight to the supplier (the pharmacy) and paying the lowest available price. A prescription drug is essentially a commodity whose price is controlled by a third party, but absent a complete regulatory overhaul of the prescription industry, the only way efficiency and transparency can come to the market is through a platform such as GoodRx.

In a more perfect world, a GoodRx would not have to exist, but that is not the world we live in. PBMs act as the pipes of the prescription drug industry. Similarly, in a more perfect world Visa and Mastercard would not charge 2% for every transaction only to return most of it to the users in

a rebate-like incentive. Ripping out the PBMs would be very difficult. There is risk of changes to the contracts between PBMs and pharmacies but those contracts are very complicated, difficult to unwind, and PBMs largely call the shots over pharmacies. If any PBM were to disadvantage GoodRx in any way, another PBM would likely be happy to jump in to access the growing demand that GoodRx has aggregated.

At the end of the second quarter, GoodRx was selling for 24x on an enterprise value to trailing gross profit basis and 17x consensus next twelve-month gross profits. Given that GoodRx has established itself as the winning discount prescription card, has a long runway to grow, and requires little incremental capital or costs to scale, these multiples appear very attractive in my opinion. If GoodRx continues to be successful in lowering drug prices and providing a great consumer experience, it is highly likely that the company will be worth a multiple of the $14 billion enterprise value it sold for at the end of the quarter.