UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

SERGIO NAVARRO, THERESA GAMAGE, DAYLE BULLA, and JANE KINSELLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans,

Plaintiffs,

v.

WELLS FARGO & COMPANY, MICHAEL BRANCA, MARK HICKMAN, DREW WINELAND, DAVID GALLOREESE, BEI LING, and DOES 1-20,

Defendants.

No. 0:24-cv-03043-KMM-DTS

MEMORANDUM OF LAW IN SUPPORT OF DEFENDANT WELLS FARGO & COMPANY'S MOTION TO DISMISS THE CLASS ACTION COMPLAINT

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PRELIMINARY STATEMENT

Four former participants in the Wells Fargo & Company ("Wells Fargo") health plan commenced this lawsuit, contending that Wells Fargo imprudently entered into and maintained an agreement with the plan's pharmacy benefit manager ("PBM"), Express Scripts, Inc. ("ESI"). Plaintiffs allege that the agreement causes the plan to pay excessive fees for prescription drugs and administrative services, and causes participants to overpay for their share of the cost of prescription drugs and for participating in the plan. Based on these allegations, Plaintiffs assert claims under the Employee Retirement Income Security Act of 1974 ("ERISA"), both individually and on behalf of the plan, for breach of fiduciary duty and violation of ERISA's prohibited transaction rules.

As a threshold matter, the complaint should be dismissed for failing to satisfy Article III's standing requirements. The Supreme Court has established that, to proceed with an ERISA claim, participants cannot merely allege harm to the plan, but must present plausible allegations of harm to themselves that is concrete and particularized and would likely be redressed by the relief sought. *Thole v. U.S. Bank*, 590 U.S. 438, 540 (2020). Plaintiffs fail to do so because: (i) they have received all prescription drug benefits to which they are entitled under the plan; (ii) the plan-wide relief they are seeking would not redress any alleged individual harm; (iii) their individual claims for relief, based on the alleged costs they incurred for plan contributions and certain prescription drugs, are directed at plan design decisions rather than fiduciary conduct, and/or are predicated on speculative theories of injury; and (iv) as former participants, they would not benefit from any prospective injunctive relief.

Independently, Plaintiffs fail to state plausible claims for relief. The Eighth Circuit requires that, to state a viable fiduciary breach claim based on excessive fees, plaintiffs must allege that the fees charged to the plan were excessive relative to the fees paid by comparable plans for comparable services. *Barrett v. O'Reilly Auto., Inc.*, 112 F.4th 1135, 1138-40 (8th Cir. 2024). Here, Plaintiffs make no effort to compare the fees incurred by the plan in connection with its PBM agreement to the fees associated with comparable PBM agreements. Instead, they allege that certain aspects of the arrangement are unreasonable, such as the cost of a tiny percentage of the prescription drugs on the plan's drug formulary. There is no reason to infer from these allegations that the PBM contract is imprudent, particularly since ESI is a widely used PBM. Plaintiffs' individual claims for relief are likewise implausible because they are based on the costs of only a small handful of prescription drugs, rather than a comparison of Plaintiffs' aggregate out-of-pocket costs to what their costs would be with comparable plans and PBM arrangements.

Plaintiffs' prohibited transaction claims fare no better. They are premised on nothing more than the routine practice of using a plan's assets to pay its PBM. Several courts have held that there is no viable prohibited transaction claim absent allegations of self-dealing or other nefarious conduct, none of which are present here. Furthermore, a statutory exemption expressly permits plans to pay reasonable fees for necessary services. Because Plaintiffs have no viable challenge to the reasonableness of the fees paid by the plan, that exemption clearly applies.

Accordingly, the Court should dismiss the complaint in its entirety without leave to replead, for lack of standing and/or for failure to state a claim.

BACKGROUND

The facts recited herein are based on the allegations in the Class Action Complaint ("Complaint"), as well as documents referenced in, embraced by, or integral to the Complaint, which this Court may properly consider on a motion to dismiss for lack of standing or failure to state a claim under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). *See Meiners v. Wells Fargo & Co.*, 898 F.3d 820, 822-23 (8th Cir. 2018); *Carlsen v. GameStop, Inc.*, 833 F.3d 903, 908 (8th Cir. 2016). Among them are the plan document and summary plan description ("SPD"). *See, e.g.*, *Gelschus v. Hogen*, 2021 WL 5087549, at *2 (D. Minn. Apr. 6, 2021) (Doty, J.).

A. The Plan

The Wells Fargo & Company Health Plan (for Eligible Active Employees and their Dependents) ("Plan") is an employee welfare benefit plan governed by ERISA. It provides, inter alia, medical, prescription drug, dental, and vision benefits for eligible employees. (ECF No. 1 ¶ 21.) Wells Fargo is the Plan sponsor. (*Id.* ¶ 20; Declaration of Clare Verplank ("Verplank Decl.") Ex. A at 2.9, 2.25; Ex. B at B-5, B-7.) Participation in the Plan is voluntary. (Verplank Decl. Ex. A at 3.2; Ex. B at 1-17, 1-20, 1-50.) Each year, approximately 200,000 people participate in the Plan. (ECF No. 1 ¶ 205.)

The Plan makes several benefit options available to Plan participants. (Verplank Decl. Ex. B at 1-4.) Some options are insured by a third party that is primarily responsible for paying for covered benefits. (*Id.* Ex. A at 2.19; Ex. B at 1-53 to 1-54.)

Other options are "self-insured," meaning that the Plan assumes direct responsibility to pay for benefits. (*Id.* Ex. A at 2.30; Ex. B at 1-53 to 1-54; ECF No. 1 ¶ 204.)

The Plan's fees and expenses are paid from the Wells Fargo & Company Employee Benefit Trust ("Trust"). (ECF No. 1 ¶ 21.) Each year, Wells Fargo determines the amount needed to fund the Trust. (*Id.* ¶ 204.) Although Wells Fargo historically has provided the majority of the funding,[1] it has no obligation to do so. In fact, the Plan reserves to Wells Fargo the discretion to require participants to fund all expected expenses. (Verplank Decl. Ex. A at 5.2-5.4, 5.8; Ex. B at 1-13.) Participant contributions to the Trust are constant throughout a given year. (*Id.* Ex. B at 1-14, 2-7 to 2-8.) They may be used to pay for any Plan expenses, irrespective of the type of coverage or benefit option the participant elects. (*Id.* at 1-16.) In addition to their contributions, Plan participants must make out-of-pocket payments for covered benefits, including deductible, co-pay, or co-insurance payments, up to an annual out-of-pocket maximum. (*Id.* at 2-14 to 2-15.) The SPD sets forth the required payments. (*Id.* at 2-14 to 2-15, 2-116 to 2-118; ECF No. 1 ¶ 33.)

B. The Prescription Drug Program

One component of the Plan is its prescription drug program. The prescription drug program for the Plan's self-insured options is managed and administered by ESI.

[1] For the years 2019 to 2022, Wells Fargo contributed approximately $7.8 billion to fund the Plan's costs. (Declaration of Russell Hirschhorn ("Hirschhorn Decl.") Exs. A-D at Schedule H § II(2)(a)(1).) The remaining funding came from participant contributions, which totaled approximately $2.7 billion over the same period. (*Id.* at Schedule H § II(2)(a)(2); ECF No. 1 ¶ 204.)

(Verplank Decl. Ex. B at 2-112; ECF No. 1 ¶ 100.) ESI is one of the "big 3" PBMs servicing employee benefit plans nationwide. (ECF No. 1 ¶ 86.) ESI's principal responsibilities as the Plan's PBM are to establish a pharmacy network for the Plan in which participants can purchase prescription drugs at discounted prices, and to process all prescription drug claims submitted by participants. (Verplank Decl. Ex. B at 2-112, 2-115, 2-125; ECF No. 1 ¶¶ 48, 52.) For specialty prescription drugs, coverage is limited to drugs purchased at Accredo, a wholly owned subsidiary of ESI. (Verplank Decl. Ex. B at 2-115.) However, many of these specialty drugs are also included in the SaveOnSP program, which allows participants to receive them at no cost. (*Id.* at 2-116.)[2]

For prescription drugs purchased at pharmacies within the Plan's network, the Plan pays the bulk of the cost once any applicable deductibles have been satisfied, but a participant also must make a co-payment until she has reached her annual out-of-pocket maximum. (*Id.* at 2-16, 2-116 to 2-118.) The co-pay is a fixed payment, the amount of which depends on the category of the prescription drug, e.g., generic, brand-name, or "specialty." (*Id.* at 2-116 to 2-118.) Participants may also purchase prescription drugs at out-of-network pharmacies. (*Id.*) If they do so, the Plan still pays a portion of the cost of the prescription drug, corresponding to the payment it would make if the prescription drug was purchased in-network. (*Id.*)

[2] SaveOnSP administers the Plan's copay assistance benefit, which helps Plan participants eliminate their financial responsibility for hundreds of specialty medications. *See SaveOnSP*, https://www.saveonsp.com/members/.

The Plan pays ESI negotiated fees for its services. (Hirschhorn Decl. Exs. A-D at Schedule C § 2.) In addition, like other "traditional" PBMs, ESI is indirectly compensated by means of a "spread" between the negotiated price for the prescription drugs that the Plan pays to ESI and the amount that ESI pays to the pharmacy. (ECF No. 1 ¶ 62.) The prescription drug prices paid by the Plan to ESI are often linked to a benchmark, such as the "Average Wholesale Price" ("AWP"). (*Id.* ¶¶ 57, 59-60.)

C. The Named Plaintiffs

Plaintiffs are former employees of Wells Fargo and former participants in the self-insured programs offered by the Plan. (*Id.* ¶¶ 14-17.) The Complaint alleges that, on a handful of occasions, each Plaintiff purchased an unidentified prescription drug at an excessive cost. (*Id.* ¶¶ 196-203.)

D. The Complaint

On July 30, 2024, Plaintiffs filed the Complaint on behalf of a putative class of all participants in and beneficiaries of the Plan from July 30, 2018 through the date of judgment. (*Id.* ¶ 213.) The crux of the Complaint is that Wells Fargo[3] violated ERISA by entering into and maintaining the terms of its agreement with ESI. The claimed ERISA violations are premised on the following allegations:

First, Plaintiffs claim that the Plan paid ESI excessive prices for prescription generic and specialty generic drugs. (*Id.* ¶¶ 108-31.) According to Plaintiffs, the pricing for these drugs would have been lower if, instead of agreeing to a pricing model based on

[3] The individually named Defendants were voluntarily dismissed from the case pursuant to a joint stipulation. (ECF No. 27.)

AWP, the Plan had: (i) negotiated prices based on the National Average Drug Acquisition Cost ("NADAC"), which is a weekly average of what certain pharmacies pay to acquire a given drug (*id.* ¶¶ 104-05, 108-31);[4] or (ii) retained a "pass-through" PBM, which generally charges a plan the same amount for a prescription drug that the PBM negotiates to pay the pharmacy (*id.* ¶¶ 71, 104, 149-54). To support this claim, Plaintiffs allege that, among the thousands of drugs covered by the Plan: (i) the costs of approximately 260 unnamed generic drugs exceed NADAC (*id.* ¶¶ 108-11); (ii) the costs to the Plan for approximately 40 specialty generic drugs exceed both NADAC and prices that "pass-through" PBMs allegedly charge their clients (*id.* ¶¶ 126, 151); and (iii) the costs to the Plan for ten of these specialty generic drugs exceed the prices charged to uninsured customers at retail pharmacies (*id.* ¶¶ 115-31). Plaintiffs elsewhere identify other welfare plans that purportedly reduced their prescription drug costs, without explaining whether these plans are similar to the Plan. (*Id.* ¶¶ 183-95.)

Second, Plaintiffs claim that the administrative fees paid by the Plan to ESI are excessive. (*Id.* ¶¶ 139-42.) To support this claim, the Complaint includes a table purporting to show that the "admin fee per participant" paid by the Plan in 2022 was higher than that for five other plans. (*Id.* ¶ 141.) Plaintiffs allege, "on information and

[4] *See Method for Calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid Covered Outpatient Drugs*, Center for Medicaid & CHIP Services, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/ful-nadac-downloads/nadacmethodology.pdf.

belief," that ESI provided those other plans "equivalent or substantially equivalent PBM services." (*Id.*)

Third, Plaintiffs allege that they personally incurred excessive costs due to: (i) the specific amounts paid for prescription drugs in the few instances identified for each of them; and (ii) the required contributions to the Trust and other out-of-pocket costs. (*Id.* ¶¶ 196-203.) Plaintiffs also allege, without any factual support, that due to the Plan's excessive prescription drug costs, other Plan participants experienced depressed or lost wages. (*Id.* ¶ 225.)

On the basis of these allegations, Plaintiffs assert four causes of action:

First, a claim for breach of fiduciary duty on behalf of the Plan, pursuant to ERISA section 502(a)(2), 29 U.S.C. § 1132(a)(2). (ECF No. 1 ¶¶ 221-26.)

Second, an individual claim for breach of fiduciary duty, pursuant to ERISA section 502(a)(3), 29 U.S.C. § 1132(a)(3). (ECF No. 1 ¶¶ 227-32.)

Third, a claim on behalf of the Plan, pursuant to ERISA section 502(a)(2), that Wells Fargo engaged in prohibited transactions under ERISA section 406(a)(1), 29 U.S.C. § 1106(a)(1), by allegedly causing the Plan to exchange property with, accept services from, and transfer assets to ESI, a "party in interest" under ERISA. (ECF No. 1 ¶¶ 233-39.)

Fourth, an identical prohibited transaction claim pursuant to ERISA section 502(a)(3). (*Id.* ¶¶ 240-46.)

ARGUMENT

I. PLAINTIFFS LACK ARTICLE III STANDING TO ASSERT THEIR CLAIMS.

As a threshold matter, Plaintiffs lack constitutional standing to proceed with their claims. "To establish standing under Article III of the Constitution, a plaintiff must demonstrate (1) that he or she suffered an injury in fact that is concrete, particularized, and actual or imminent, (2) that the injury was caused by the defendant, and (3) that the injury would likely be redressed by the requested judicial relief." *Thole*, 590 U.S. at 540 (citing *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992)). "The plaintiff, as the party invoking federal jurisdiction, bears the burden of establishing these elements." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016).

As discussed below, Plaintiffs fail to meet these requirements with respect to the claims asserted in the Complaint for the following reasons:

- They lack standing to pursue claims on behalf of the Plan under ERISA section 502(a)(2) (Counts I and III) because: (i) they do not allege that they have been deprived of any benefits promised by the Plan; and (ii) any monetary harm to Plaintiffs arising from the alleged increased costs to the Plan are not redressable by Plan-wide relief.

- They lack standing to pursue individual claims for relief pursuant to ERISA section 502(a)(3) (Counts II and IV) because: (i) any increased costs that they incurred directly for specific prescription drugs or Plan contributions are attributable to settlor decisions regarding plan design; and (ii) any claim of increased costs incurred indirectly

as a result of the allegedly excessive costs borne by the Plan is too speculative to satisfy Article III's concrete injury requirement.

- They lack standing to seek prospective injunctive relief because they are not current participants in the Plan.

A. Plaintiffs Lack Standing to Pursue Plan-Wide Relief Pursuant to ERISA Section 502(a)(2).

Counts I and III seek relief on behalf of the Plan for alleged fiduciary breaches and prohibited transactions under ERISA section 502(a)(2).[5] (ECF No. 1 ¶¶ 221-26, 233-39.) Because Plaintiffs cannot demonstrate that they failed to receive any benefit to which they were entitled under the Plan, or that relief to the Plan would redress any monetary harm that they allegedly suffered, they cannot satisfy Article III's concrete injury and redressability requirements.

1. Plaintiffs Received All Prescription Drug Benefits to Which They Were Entitled.

Plaintiffs lack standing to bring claims under section 502(a)(2) because they do not claim to have been deprived of any prescription drug benefits promised under the Plan. In *Thole*, the Supreme Court held that ERISA plan participants lacked standing to sue for recovery of investment losses suffered by a defined benefit plan due to alleged mismanagement where plaintiffs received all benefits they were "legally and contractually entitled to receive" under the terms of the plan, and "would still receive the

[5] ERISA section 502(a)(2) provides a plan participant a cause of action "for appropriate relief" under ERISA section 409. ERISA section 409 provides, in relevant part, that any fiduciary who breaches his duties "shall be personally liable to make good to such plan any losses to the plan resulting from each such breach." 29 U.S.C. § 1109(a).

exact same monthly benefits" regardless of whether they won or lost the suit. 590 U.S. at 538-40. In a subsequent ruling that plaintiffs lacked standing to pursue fiduciary breach claims on behalf of a plan where they received all benefits to which they were entitled, Judge Schiltz explained that "*Thole* squarely holds that an injury to a plan that does not affect a plaintiff's benefits does not give that plaintiff standing to sue on behalf of the plan." *Scott v. UnitedHealth Grp., Inc.*, 540 F. Supp. 3d 857, 865 (D. Minn. 2021); *see also Harley v. Minn. Mining & Mfg. Co.*, 284 F.3d 901, 906-07 (8th Cir. 2002) (affirming dismissal because participants were entitled to a set pension benefit and had no right to surplus assets that were reduced due to investment losses); *Taveras v. UBS AG*, 612 F. App'x 27, 29 (2d Cir. 2015) (affirming dismissal where plaintiff alleged harm to the 401(k) plan, but not to her individual plan account); *Leighton v. Delta Air Lines, Inc.*, 2020 WL 12990218, at *8 n.7 (D. Minn. Feb. 18, 2020) (Erickson, J.) (observing section 502(a)(2) "only allows recovery by the plan itself") (citing *Mass. Mut. Life. Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985)).

Here, Plaintiffs lack standing for the same reason. As in a defined benefit retirement plan, Plaintiffs' prescription drug benefits are "not tied to the value of the plan," but instead are "fixed" by the terms of the Plan document, which operate "in the nature of a contract." *Thole*, 590 U.S. at 542-43; *see Scott*, 540 F. Supp. 3d at 864 ("[E]mployer-sponsored healthcare plans . . . are closely analogous to the defined-*benefit* plan at issue in *Thole*, as participants are entitled to their contractually defined benefits regardless of the value of the plans' assets."). And, as in *Thole*, there is no dispute that Plaintiffs received all prescription drug benefits to which they are entitled under the Plan.

Plaintiffs therefore fail to plead the concrete injury necessary to pursue their claims. *See Thole*, 590 U.S. at 542; *see also Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 523-29 (9th Cir. 2023) (holding plaintiffs lacked standing because they received "a fixed set of benefits as promised in plan documents"); *Gonzalez de Fuente v. Preferred Home Care of N.Y. LLC*, 858 F. App'x 432, 433-34 (2d Cir. 2021) (holding plaintiffs who claimed defendants' conduct resulted in "increased out-of-pocket costs and reduced coverage" lacked standing because they "received all of their promised health benefits so far") (brackets omitted); *Scott*, 540 F. Supp. 3d at 861-65 (holding plaintiffs lacked standing because plaintiffs "have no claim on plan assets (including those contributed by plaintiffs), and any loss of plan assets does not affect plaintiffs' entitlement to benefits").

2. Plaintiffs' Alleged Individual Monetary Harm Is Not Redressable by Plan-Wide Relief.

Insofar as Plaintiffs allege in Counts I and III that they suffered individual monetary harm, that harm is not redressable by relief to the Plan, and thus cannot establish standing for their ERISA section 502(a)(2) claims. "A plaintiff suing for breach of fiduciary duty under ERISA § 502(a)(2) does so as a plan representative and hence must . . . seek relief that 'inures to the benefit of the plan as a whole.'" *Knudsen v. MetLife Grp., Inc.*, 2023 WL 4580406, at *3 (D.N.J. July 18, 2023) (internal citations omitted) ("*Knudsen I*"), *aff'd*, 2024 WL 4282967 (3d Cir. Sept. 25, 2024) ("*Knudsen II*"). By definition, then, section 502(a)(2) is not a vehicle by which Plaintiffs can seek direct recovery on an individual basis. *See, e.g.*, *Smith v. Med. Benefit Adm'rs Grp., Inc.*, 639 F.3d 277, 282 (7th Cir. 2011) (ruling section 502(a)(2) does not provide relief for injuries

that the plaintiff, rather than the plan, suffered); *Leighton*, 2020 WL 12990218, at *8 n.7 (observing section 502(a)(2) "only allows recovery by the plan itself") (citing *Russell*, 473 U.S. at 144).

To the extent Plaintiffs may be contending that relief to the Plan could result in individual relief to themselves, their claim fails to satisfy Article III's requirements because their theory of relief is entirely speculative. Under similar circumstances, the Ninth Circuit found that plaintiffs lacked standing to sue their plan's PBM for alleged overcharges under section 502(a)(2). *Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1125 (9th Cir. 2006). Plaintiffs argued that if they won the lawsuit, their plan's drug costs would decrease and the plan might then reduce co-payments or contributions. *Id.* But the Ninth Circuit held that these assertions failed to satisfy Article III's redressability requirement because recovery to the plan would not require the plan sponsor to reduce the costs of benefits for participants. *Id.*

Similarly, here, Wells Fargo is not obligated to pass on to Plaintiffs any recovery received by the Plan. It can continue to set participant contributions at any level and need not change the cost of benefits to participants. (*See* Background § A.) Accordingly, as in *Glanton*, the prospects of relief inuring to individual participants are too speculative to satisfy Article III's redressability requirement. *See* 465 F.3d at 1125; *see also Knudsen I*, 2023 WL 4580406, at *5 (holding plaintiffs lacked standing to assert fiduciary breach and prohibited transaction claims under section 502(a)(2) because "[e]ven if Plaintiffs were to succeed in their ERISA claims and any disgorged funds are deposited back into the plan, whether each participant's costs would be reduced or distributions would be

paid out, remains conjecture");[6] *Winsor*, 62 F.4th at 527 (holding plaintiffs' alleged injuries were not redressable because nothing in plan documents or law required plan to reduce plaintiffs' contributions); *David v. Alphin*, 2008 WL 5244504, at *3 (W.D.N.C. Dec. 15, 2008) (holding plaintiffs lacked standing to challenge pension plan's payment of allegedly excessive fees because they would receive greater benefits only if the plan sponsor amended the plan to provide additional benefits), *aff'd*, 704 F.3d 327 (4th Cir. 2013).

B. Plaintiffs Lack Standing to Pursue Claims for Individual Relief Pursuant to ERISA Section 502(a)(3).

Unlike their section 502(a)(2) claims, Plaintiffs' claims under section 502(a)(3) seek individual relief and, as such, do not suffer from the redressability issues identified above.[7] Plaintiffs still lack standing to bring these claims, however, because they have failed to plead an injury in fact.

[6] On appeal from the district court's decision in *Knudsen I*, the Third Circuit rejected as speculative the argument advanced here: that because the plan had historically required participants to contribute a consistent percentage of total contributions to the plan, a recovery by the plan "may" result in a reduction in participant contributions. *Knudsen II*, 2024 WL 4282967, at *1, *7-8. Although the Complaint here hypothesizes this "would" occur (ECF No. 1 ¶¶ 206-08), the theory is no less speculative.

[7] ERISA section 502(a)(3) grants a plan participant a cause of action to "(A) enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."

1. Plaintiffs' Claims of Individual Harm Arise from Settlor Acts and, As Such, Do Not Establish Standing To Assert Fiduciary Breach or Prohibited Transaction Claims.

Plaintiffs' contention that they incurred harm in the form of increased "premiums, deductibles, co-pays, and other out-of-pocket costs" (ECF No. 1 ¶ 231) because of the ESI agreement fails to establish Article III standing because it is predicated on a challenge to decisions made by Wells Fargo as a plan sponsor, rather than as a plan fiduciary.

"[F]iduciary status under ERISA 'is not an all-or-nothing concept.'" *McCaffree Fin. Corp. v. Principal Life Ins. Co.*, 811 F.3d 998, 1002 (8th Cir. 2016) (citation omitted). Rather, ERISA provides that a person is a fiduciary with respect to a plan only "to the extent" he exercises discretionary authority or control over management of the plan. *See* 29 U.S.C. § 1002(21)(A). Fiduciaries can be liable, therefore, only for decisions made while "wear[ing] the fiduciary hat." *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000). The same is true with respect to liability for prohibited transaction claims, since these claims are also contingent on fiduciary conduct. *See* 29 U.S.C. § 1106(a) ("A *fiduciary* with respect to a plan shall not cause the plan to . . . .") (emphasis added).

When plan sponsors or representatives make decisions regarding plan design, they act in a role "analogous to the settlors of a trust," and thus are not engaged in conduct subject to ERISA's fiduciary provisions. *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996); *see Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 444 (1999) ("In general, an employer's decision to amend a [] plan concerns the composition or design of the plan itself and does not implicate the employer's fiduciary duties."). Matters of plan design

include "the form or structure of the Plan," "who is entitled to receive Plan benefits," and "in what amounts." *See Jacobson*, 525 U.S. at 444.

Courts have held that setting premiums, co-pays, and deductibles are plan design decisions and thus settlor, not fiduciary, functions. *See, e.g.*, *Hannan v. Hartford Fin. Servs., Inc.*, 2016 WL 1254195, at *2-3 (D. Conn. Mar. 29, 2016) (holding defendant was "not a fiduciary with respect to negotiation of the Plan premiums"), *aff'd*, 688 F. App'x 85 (2d Cir. 2017); *Argay v. Nat'l Grid USA Serv. Co.*, 503 F. App'x 40, 42 (2d Cir. 2012) ("Defendants did not act in a fiduciary capacity in setting premiums."); *Moeckel v. Caremark, Inc.*, 622 F. Supp. 2d 663, 678 (M.D. Tenn. 2007) (holding self-funded plan sponsor's "decision to enter into the PBM Agreement with [PBM], and to agree to the various terms contained therein, was a plan design decision, exempt from fiduciary review"); *see also Hartline v. Sheet Metal Workers' Nat'l Pension Fund*, 134 F. Supp. 2d 1, 16 (D.D.C. 2000) (holding setting pension plan contribution rate "was a settlor, not fiduciary, function, because it was a matter of plan design"), *aff'd*, 286 F.3d 598 (D.C. Cir. 2002).

Similarly, the decision of what drugs to cover in a plan's formulary is a design decision that does not implicate fiduciary responsibilities. *See, e.g.*, *Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967, 1001 (N.D. Cal. 2018) (holding plan's decision to enter into agreement with specific PBM was a "plan design decision, exempt from fiduciary review") (citation omitted), *aff'd in part, vacated in part, remanded sub nom. Doe v. CVS Pharmacy, Inc.*, 982 F.3d 1204 (9th Cir. 2020); *Mulder v. PCS Health Sys., Inc.*, 432 F. Supp. 2d 450, 458 (D.N.J. 2006) (noting plan sponsor's decision to

adopt portions of PBM's preferred drug list "was a plan design decision"); *see also Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183, 1201 (10th Cir. 2023) (holding ERISA preempted state law regulating PBMs and stating that a "plan's prescription-drug benefit design comprises the formulary, cost-sharing terms, and pharmacy network").

Plaintiffs' allegations of personal financial harm are attributable solely to the types of design decisions that courts have concluded are nonfiduciary in nature. In particular, Plaintiffs contend that, due to the PBM contract, they incurred higher premiums, deductibles, copays, and out-of-pocket costs. (ECF No. 1 ¶ 231.) That these are all features of the Plan design is evident by the fact that they are described in the SPD (Verplank Decl. Ex. B at 2-7, 2-116), and Wells Fargo has reserved the right to set these components of the Plan at any amount. (*Id.* at B-6; *see also* Part I.A.2, *supra*.)

Accordingly, Plaintiffs' allegations that they incurred excessive costs do not give them standing to assert their claims under ERISA section 502(a)(3).[8]

2. Plaintiffs Lack Standing To Assert Claims of Individual Harm Resulting Indirectly from Alleged Harm to the Plan.

Because the direct monetary harm that Plaintiffs claim to have suffered is not attributable to fiduciary conduct, Plaintiffs have standing to proceed with their section 502(a)(3) claims only if they adequately allege an indirect injury attributable to the Plan's allegedly excessive costs. Plaintiffs have failed to do so because their claims of indirect harm are speculative at best.

[8] Plaintiffs' failure to assert viable fiduciary breach or prohibited transaction claims independently warrants dismissal pursuant to Rule 12(b)(6) for failure to state a claim.

Under similar circumstances, courts have dismissed claims for lack of standing, because the allegations of individual harm were too speculative. For example, in *Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450 (3d Cir. 2003), a case involving a health maintenance organization ("HMO"), plaintiff alleged that plan fiduciaries failed to disclose information about the plan's physician incentive structure, and that this caused the employer, and thus participants, to overpay for care. *Id.* at 453. The Third Circuit held plaintiff lacked standing to pursue section 502(a)(3) claims because her allegations of individual harm were predicated on the "far too speculative" assumption that had the employer not overpaid the HMO, it "would have passed these savings on to its employees" by increasing compensation or benefits. *Id.* at 453, 457. Likewise, in *Knudsen I*, plaintiffs claimed that, absent defendant's alleged fiduciary breaches and prohibited transactions, "[d]efendant 'may' have reduced co-pays and co-insurance or that Plan participants 'may' have received a proportionate distribution of rebates." 2023 WL 4580406, at *5. The court rejected this theory of injury, *id.* at *5-6, and the Third Circuit affirmed, holding it was "speculative that MetLife's alleged misappropriation of drug rebate money resulted in Plaintiffs paying more for their health insurance or had any effect at all," *Knudsen II*, 2024 WL 4282967, at *7. *See also Glanton*, 465 F.3d at 1125 (holding claims that plan sponsor might have reduced copayments and deductibles if plan expenses were lower were insufficient for Article III standing); *Fox v. McCormick*, 20 F. Supp. 3d 133, 142 (D.D.C. 2013) (holding plaintiffs lacked Article III standing to challenge multiemployer plan trustees' failure to collect contributions, where harm was

based on "speculative" theory that additional funding would have increased the fund's benefit accrual rate).

Here, Plaintiffs' allegations of indirect individual harm resulting from the Plan's alleged overpayment in connection with the ESI agreement are equally speculative and thus cannot satisfy Article III's requirements. Plaintiffs' claims hinge on the assumption that the Plan's payment of allegedly excessive prescription drug fees or related administrative fees to ESI caused them to incur higher costs in the form of Plan contributions or deductibles. But this is pure speculation. Participants' contributions do not fund the prescription drug component of the Plan specifically; instead, they fund the Plan's aggregate expenses (*see* Background § A), and many factors affect the amounts Plaintiffs pay in connection with the Plan, including Wells Fargo's reserved right to set them at any amount. Plaintiffs' alternative assertion—that the increased costs to the Plan led to decreased or depressed wages—is even more speculative. *See* Part II, *infra*.

Accordingly, the Court should conclude that Plaintiffs have failed to satisfy Article III's injury-in-fact requirement.

C. Plaintiffs Lack Standing To Seek Prospective Injunctive Relief.

Finally, Plaintiffs lack standing to seek prospective injunctive relief, including removal of the Plan's fiduciaries, replacement of ESI as PBM to the Plan, and appointment of an independent fiduciary. (*See, e.g.*, ECF No. 1 ¶¶ 252-54.) As former participants, "they have not alleged a real or immediate threat of future injury" based on Wells Fargo's conduct; nor would prospective injunctive relief affect them. *See, e.g.*, *Fitzpatrick v. Neb. Methodist Health Sys., Inc.*, 2023 WL 5105362, at *5 (D. Neb. Aug. 9,

2023); *Burris v. IASD Health Servs. Corp.*, 1995 WL 843859, at *10 (S.D. Iowa Oct. 2, 1995).

Accordingly, the Court should dismiss for lack of standing Plaintiffs' claims insofar as they seek prospective injunctive relief.

II. THE FIDUCIARY BREACH CLAIMS SHOULD BE DISMISSED FOR FAILURE TO STATE VIABLE CLAIMS FOR RELIEF.

Plaintiffs' fiduciary breach claims are akin to claims brought against fiduciaries of 401(k) plans challenging the fees associated with recordkeeping and investment management services. A wide body of case law establishes the pleading standards for those claims, within this Circuit and elsewhere. Plaintiffs fail to satisfy these standards. Plaintiffs have not stated a claim on behalf of the Plan under ERISA section 502(a)(2) because they have not presented allegations of comparable plans that paid less for similar prescription drug programs. Likewise, they have not stated a claim for individual relief under ERISA section 502(a)(3) because they have not presented allegations of comparable plans, or comparable prescription drug programs, in which they would have incurred lower contributions or out-of-pocket costs for comparable benefits. Accordingly, Counts I and II should be dismissed for failure to state a claim.

A. Applicable Pleading Standards for Excessive Fee Claims.

The duty of prudence "focuses on the process by which decisions are made, rather than the results of those decisions." *Davis v. Wash. Univ. in St. Louis*, 960 F.3d 478, 482 (8th Cir. 2020) (quotations omitted). To state a claim for breach of fiduciary duty, therefore, plaintiffs must meet a "challenging pleading burden" that requires them to use

available information "and some circumstantial allegations about methods to show that a prudent fiduciary in like circumstances would have acted differently." *Meiners v. Wells Fargo & Co.*, 898 F.3d 820, 822 (8th Cir. 2018) (quotation omitted).

Where, as here, a complaint alleges a fiduciary breach based on excessive costs or fees, but lacks "significant allegations of wrongdoing" concerning the fiduciary's process, to survive dismissal the plaintiff's complaint must allege sufficient facts "to infer that the process was flawed." *Matousek v. MidAmerican Energy Co.*, 51 F.4th 274, 278-79 (8th Cir. 2022) (quotations omitted). Because "the plaintiffs' theory requires an inference of mismanagement from the high costs alone," the "key" to showing that imprudence caused the plan to pay too much is a "sound basis for comparison," a "meaningful benchmark." *Barrett*, 112 F.4th at 1138. This requires Plaintiffs to "make a like-for-like comparison," i.e., "identify similar plans offering the same services for less." *Matousek*, 51 F.4th at 278-79 (citations omitted); *Barrett*, 112 F.4th at 1138 (same). Allegations of excessive costs or fees, unsupported by a meaningful comparison, will not withstand a motion to dismiss. *Matousek*, 51 F.4th at 278-79 ("Even if the fees here look high, we cannot infer imprudence unless similarly sized plans spend less on the same services.").

As discussed below, Plaintiffs fail to support their theories of fiduciary breach with comparisons that are sound or meaningful enough to create an inference of an imprudent process.

B. Plaintiffs Have Failed to Plead a Plausible Claim for Fiduciary Breach on Behalf of the Plan.

Plaintiffs claim that Wells Fargo breached its duty of prudence by causing the Plan to incur excessive costs and fees in connection with the ESI agreement. To state a fiduciary breach claim on this basis, Plaintiffs must identify comparable plans that paid less for a comparable program. *See* Part II.A, *supra*. As the Eighth Circuit recognized, absent such a comparison "the plaintiffs are asking us to . . . draw an inference of mismanagement from the differing costs of two grocery baskets with different items. We would not expect them to cost the same, so their approach just doesn't work." *Barrett*, 112 F.4th at 1139; *see Fritton v. Taylor Corp.*, 2023 WL 5348834, at *2-3 (D. Minn. Aug. 21, 2023) (Tostrud, J.) ("It is difficult to understand how generally applicable market conditions might serve as a 'meaningful benchmark' . . . the 'like-for-like comparison' the Eighth Circuit insisted on in *Matousek* took account of what particular services the recordkeeper provided to the plan.").

Plaintiffs do not identify similarly sized plans that paid less for a comparable prescription drug program. Instead, Plaintiffs focus on components of the prescription drug program, i.e., the costs of prescription drugs and administrative fees paid to ESI, to create an inference of fiduciary breach. Comparisons regarding these component costs do not satisfy the "meaningful benchmark" requirement for purposes of a fiduciary breach claim relating to the Plan's prescription drug program as a whole. *See Matousek*, 51 F.4th at 279-80 (holding plaintiff's comparison of total compensation paid by plan to service provider, with industry average of compensation paid for one category of services, was

not "sound" or "meaningful" because it was not "like-for-like"). Furthermore, even the comparators alleged by Plaintiffs with respect to drug costs and administrative fees fail to meet the "meaningful benchmark" requirement.

1. Prescription Drug Costs.

To support their argument that the Plan's prescription drug costs are too high, Plaintiffs allege that the Plan would pay less for prescription drugs if Wells Fargo retained a "pass-through" PBM instead of a "traditional" PBM like ESI. (ECF No. 1 ¶¶ 149-54.) This is a meaningless comparison because, as Plaintiffs acknowledge, "pass-through" and "traditional" PBMs employ materially different business models. (*Id.* ¶¶ 55-76.) Among other things, "traditional" PBMs are more incentivized than "pass-through" PBMs to drive down the prices paid to pharmacies because, unlike "pass-through" PBMs, a portion of "traditional" PBMs' compensation is generated through "spread." (*Id.* ¶¶ 62, 71.) These lower pharmacy prices benefit participants, insofar as they must pay the pharmacy price instead of a co-pay until their deductibles have been satisfied. (Verplank Decl. Ex. B at 2-117 to 2-118.) In any event, Plaintiffs fail to identify any plans using such "pass-through" arrangements that provide the same or comparable prescription-drug coverage and related services, let alone any that do so for lower aggregate or per-participant costs.

Second, Plaintiffs identify approximately one dozen health plans that allegedly have achieved prescription drug cost savings in various ways. (ECF No. 1 ¶¶ 183-95.) Of these plans, the only one for which Plaintiffs make any effort to establish similarities with the Plan is the PepsiCo, Inc. plan (*id.* ¶ 183), which allegedly also retained ESI as its

PBM. But even for this plan, Plaintiffs fail to compare the aggregate prescription drug costs, or the per participant costs, with those of the Plan. Nor do Plaintiffs allege whether the two plans offer a similar suite of covered prescription drugs and related services to participants. The other plans that Plaintiffs identify are not meaningful comparators either because: (i) Plaintiffs fail to allege relevant similarities between these plans and the Plan (*id.* ¶¶ 184-95); and (ii) unlike the Plan, they have retained a "pass-through" PBM for all or part of their prescription drug programs (which, for the reasons stated above, renders them unsuitable comparators), or assumed total control over their prescription drug formularies, instead of paying a PBM to assist with such services.[9]

Third, Plaintiffs contend that the Plan would have paid lower prices for generic and specialty generic drugs if it negotiated a pricing model based on NADAC instead of AWP. In support, they identify certain specialty generic drugs for which the Plan allegedly pays more than NADAC. (ECF No. 1 ¶¶ 114-26.)[10] But NADAC cannot serve

[9] Unlike plans using the "traditional" PBM model, plans that assume total control over their formularies incur costs and risks associated with overseeing and administering an entire formulary and expend resources developing and maintaining prescription drug expertise.

[10] Plaintiffs' allegations regarding the costs paid by the Plan for the prescription drugs at issue are highly dubious, and the screenshots on which Plaintiffs purport to rely omit key language from the Plan's prescription drug website. For example, Plaintiffs allege that a 90-unit prescription of Fingolimod (0.5 mg) costs the Plan $9,994.37. (*Id.* ¶¶ 120-21.) But the website states that the Plan's cost is only $3,281.46, and could be lower still due to rebates or other incentives:

as a meaningful benchmark because Plaintiffs do not identify *any other plan*, let alone one similarly situated to the Plan, that pays the NADAC amount or pricing based on NADAC for covered prescription drugs. This should come as no surprise, since NADAC is simply a measure of some pharmacies' average acquisition costs, not the prices they charge.

Finally, Plaintiffs compare the Plan's costs for ten specialty generic drugs to the prices certain retail pharmacies charge uninsured customers. (ECF No. 1 ¶¶ 115-31.) The prices of such a small group of drugs establish nothing about the Plan's overall prescription drug costs. But more fundamentally, the fact that a pharmacy may charge an uninsured consumer less than what Accredo charges the Plan is by no means an indication that the Plan is overpaying for the drug relative to what similar plans pay. It

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Fingolimod 0.5 Mg Capsule

Pharmacy: Delivery

Days supply: 30

Quantity: 90

Total medication cost:	**$ 3,331.46**
Plan pays*:	**$ 3,281.46**
You pay:	**$ 50.00**
Applied to your out-of-pocket:	**$ 50.00**
Cost per day:	**$ 1.67**

Your plan pays about 98% of the cost for this medicine.

*The cost to your plan does not include any rebates or other incentives your plan may receive from your use of this medication. Express Scripts may retain or share some rebates with your plan. The cost your plan pays is an approximation and is subject to change.

(Verplank Decl. Ex. C.)

more likely reflects competition, or one of myriad other factors impacting pharmacies' pricing decisions for the millions of Americans without health insurance.

2. Administrative Fees Paid to ESI.

Plaintiffs purport to compare the fees paid by the Plan to ESI to those paid by five other plans. (*Id.* ¶ 141.) But Plaintiffs provide no support for assuming that ESI provided the other plans the same services it provides to the Plan. Although Plaintiffs allege "[o]n information and belief" that ESI provides "equivalent or substantially equivalent PBM services" to each plan (*id.*), publicly available information indicates otherwise.

The sources of the allegations concerning the plans' administrative fees are the plans' Form 5500s for the year 2022. For each plan, the Form 5500 lists a "service code" or codes corresponding to the compensation paid to ESI. These codes are described in the U.S. Department of Labor's instructions for completing Form 5500s. (Department of Labor, 2023 Instructions for Form 5500, https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500/2023-instructions.pdf, at 30.) Although some of the service codes listed for the Plan overlap with the codes listed for the comparators, no comparator lists the *same* set of codes as the Plan.[11] As the Eighth Circuit recently held, the use of comparator plans "is not a way to show that one is better or worse than the other" if the service codes reveal

[11] Throughout the relevant period, the Plan's Form 5500 listed codes 12 (claims processing), 13 (contract administrator), and 50 (direct payment from the plan). (*See, e.g.*, Hirschhorn Decl. Ex. D at Schedule C § 2.) None of the other plans' Form 5500s listed code 50. Only one of the other plans' Form 5500s listed codes 12 and 13 throughout the relevant period. (*See id.* Exs. E-I at Schedule C § 2.)

that the plan at issue and the comparator plans received a different "bundle of services." *Barrett*, 112 F.4th at 1140 (quotation omitted). Stripped of the service codes as a means of establishing that the other plans receive the same services, Plaintiffs have no basis for asserting a claim based on comparable services. *See Riley v. Olin Corp.*, 2023 WL 371872, at *3-4 (E.D. Mo. Jan. 24, 2023) (granting motion to dismiss excessive recordkeeping fee claim where plaintiffs' comparison of plan's fees to other plans was based merely on assertions "that the plans have 'similar sizes and assets' and [included] conclusory language describing the services as 'virtually identical,'" because this failed to establish that the fees were "excessive in relation to the *specific services* the recordkeeper provided to the *specific plan* at issue") (quotation omitted).

In short, the Complaint fails to identify suitable comparators for purposes of evaluating either the Plan's prescription drug program costs as a whole, or even certain aspects of that program. As such it cannot create an inference of fiduciary breach.

C. The Complaint Fails to State a Plausible Individual Claim for Fiduciary Breach.

The Complaint purports to state individual claims for relief, pursuant to ERISA section 502(a)(3), based on three theories: (i) Plaintiffs' required contributions to the Trust must have been excessive because the Plan's costs were excessive; (ii) Plaintiffs incurred excessive out-of-pocket costs because they each paid excessive prices for a few

generic drugs; and (iii) Plaintiffs suffered depressed wages as a result of the excessive costs incurred by Wells Fargo to fund the Plan.[12]

The first theory fails for the reasons stated above with respect to standing—because Wells Fargo reserved the right to determine the rates at which participants must contribute to the Trust, Plaintiffs' effort to connect the Plan's PBM costs to participant contributions (which go to the entirety of the Plan) is entirely speculative. *See Segura v. Fed. Nat'l Mortg. Ass'n*, 2013 WL 3034096, at *2 (D. Minn. June 17, 2013) (Nelson, J.) (ruling a complaint based on conclusory and speculative allegations fails to state a claim under Rule 12(b)(6)). Independent of standing, this theory also fails because it is unsupported by any meaningful benchmarks, i.e., allegations that participants in similarly sized plans, with the same or similar coverage packages, contribute less toward the cost of their coverage.

The second theory fails because fiduciary duties apply to the Plan as a whole, and thus an inference of fiduciary breach cannot be drawn from the experiences of a small subset of participants who purchased a handful of drugs. *See Williams v. Caterpillar, Inc.*, 944 F.2d 658, 665 (9th Cir. 1991) ("[A] fiduciary's duty under ERISA runs to the plan as a whole, not to the individual beneficiary."). Furthermore, the prices Plaintiffs paid for certain prescription drugs do not indicate that their total out-of-pocket costs for participating in the Plan—let alone the prescription drug program—are excessive. Tellingly, Plaintiffs do not identify any similar plans with lower out-of-pocket costs.

[12] Insofar as these claims are directed at settlor, rather than fiduciary, conduct, they are dismissible for the reasons stated in Part I.B.1, *supra*.

Finally, even with respect to the specific prescription drugs identified, the allegations of excessive costs are implausible because they are based on a comparison to NADAC, which for the reasons previously stated is not a meaningful benchmark. *See* Part II.B.1, *supra*.

Finally, the third theory—that the Plan's costs caused a reduction in wages—fails because it is based on conclusory and speculative allegations. Plaintiffs make no allegations concerning their own wages, let alone whether their wages were reduced because of the expenses associated with the prescription drug program. Nor do they allege that workers in similar positions at similar companies earned higher wages. Plaintiffs' allegations as to depressed or lost wages thus fail to meet basic pleading requirements.[13] *See Cudjoe v. Bldg. Indus. Elec. Contractors Ass'n*, 2024 WL 866070, at *6 (E.D.N.Y. Feb. 28, 2024) (holding court need not "accept the conclusory allegation that [plaintiffs] would have received either greater cash wages and/or richer benefits . . . as true").

In short, the Complaint fails to state a claim for fiduciary breach under section 502(a)(3).

[13] Insofar as Plaintiffs seek relief for lost or depressed wages under section 502(a)(2) (ECF No. 1 ¶ 225), this is impermissible because relief under section 502(a)(2) runs to the Plan, and that section "does not provide a remedy for individual injuries distinct from plan injuries," *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 593 (8th Cir. 2009) (quotation omitted); *see* Part I.A.2, *supra*.

III. THE COMPLAINT FAILS TO STATE VIABLE PROHIBITED TRANSACTION CLAIMS.

Plaintiffs' prohibited transaction claims under ERISA section 406(a)(1) should be dismissed because they are based on nothing more than the bare allegation that the Plan engaged in a transaction with a party in interest. (ECF No. 1 ¶¶ 233-46.) Several courts have conditioned the viability of such claims on allegations of self-dealing or intent to benefit the party in interest, neither of which is present here. *See, e.g.*, *Albert v. Oshkosh Corp.*, 47 F.4th 570, 585-86 (7th Cir. 2022) (holding, to state a claim for prohibited transactions under section 406(a)(1), the challenged transaction must look like self-dealing, not "routine payments for plan services"); *Sweda v. Univ. of Pa.*, 923 F.3d 320, 338 (3d Cir. 2019) (holding "absent factual allegations that support an element of intent to benefit a party in interest, a plaintiff does not plausibly allege" a prohibited transaction under section 406(a)(1)). Although the Eighth Circuit has not expressly addressed this issue, its only decision permitting section 406(a)(1) claims to proceed involved allegations of self-dealing. *Braden*, 588 F.3d at 600-02. Thus, it is reasonable to conclude that, absent allegations of self-dealing or other nefarious conduct, the prohibited transaction claims are not viable.

Furthermore, Plaintiffs' prohibited transaction claims are subject to a statutory exemption permitting "[c]ontracting or making reasonable arrangements with a party in interest for . . . services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefore." 29 U.S.C. § 1108(b)(2). Absent a plausible claim that ESI's compensation from the Plan was excessive, this exemption

would clearly apply. Consistent with the exemption, the Second Circuit recently ruled that a plaintiff must affirmatively plead "that a fiduciary has caused the plan to engage in a transaction that constitutes the furnishing of . . . services . . . between the plan and a party in interest *where that transaction was unnecessary or involved unreasonable compensation*." *Cunningham v. Cornell Univ.*, 86 F.4th 961, 975 (2d Cir. 2023) (quotation omitted).

Although the Eighth Circuit stated long ago, under different circumstances, that a plaintiff need not plead facts demonstrating the unavailability of the exemption, *see Braden*, 588 F.3d at 600-02, the Second Circuit's ruling is clearly more persuasive under the circumstances presented here. As a practical matter, it would make little sense to proceed to discovery on the issue of whether the exemption applies if the Court has already dismissed the breach of fiduciary duty claims that were premised on allegations that the fees paid were unreasonable. Concluding otherwise would subject plans to prohibited transaction claims for merely retaining and paying a third party for necessary services. *See Sweda*, 923 F.3d at 337 ("ERISA specifically acknowledges that certain services are necessary to administer plans. . . . Interpreting [section 406(a)(1)] to prohibit necessary services would be absurd, and when one interpretation of a statute leads to an absurd result, we may consider an alternative interpretation that avoids the absurdity.").

Accordingly, Plaintiffs' prohibited transaction claims should be dismissed for failure to state a claim.

CONCLUSION

For the reasons stated herein, the Complaint should be dismissed without leave to replead against all named Defendants.

Dated: September 27, 2024

Respectfully submitted,

PROSKAUER ROSE LLP

By: */s/ Russell L. Hirschhorn*
Russell L. Hirschhorn (*pro hac vice*)
Joseph E. Clark (*pro hac vice*)
Sydney L. Juliano (*pro hac vice*)
Eleven Times Square
New York, NY 10036
Telephone: (212) 969-3286
Facsimile: (212) 969-2900
rhirschhorn@proskauer.com
jclark@proskauer.com
sjuliano@proskauer.com

FAEGRE DRINKER BIDDLE & REATH LLP
Jeffrey P. Justman (#0390413)
Richard A. Duncan (#0192983)
Kiera Murphy (#0401027)
90 S. 7th St., Suite 2200
Minneapolis, MN 55402
Telephone: (612) 766-7000
Facsimile: (612) 766-1600
jeff.justman@faegredrinker.com
richard.duncan@faegredrinker.com
kiera.murphy@faegredrinker.com

Counsel for Defendant Wells Fargo & Company