UNITED STATES DISTRICT COURT
FOR THE 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.

Case No. 0:24-cv-03043-LMP-DTS

PLAINTIFFS' MEMORANDUM IN OPPOSITION TO DEFENDANT WELLS FARGO & COMPANY'S MOTION TO DISMISS

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INTRODUCTION

This is a straightforward case arising from the failure of an ERISA plan sponsor – and its fiduciary designees for whom it has accepted responsibility (*see* ECF 27 at ¶ 2) – to appropriately select and monitor a plan service provider and control plan expenses. Allegations of excessive fees like those asserted here have repeatedly been held sufficient to state a claim under ERISA. *See e.g.*, *Braden v. Wal-Mart Stores, Inc*., 588 F.3d 585, 595-96 (8th Cir. 2009); *Tussey v. ABB, Inc.*, 746 F.3d 327, 336 (8th Cir. 2014); *Larson v. Allina Health Sys*., 350 F. Supp. 3d 780, 799-800 (D. Minn. 2018); *Morin v. Essentia Health*, 2017 WL 4083133, *9-12 (D. Minn. Sept. 14, 2017), *adopted*, 2017 WL 4876281 (Oct. 27, 2017); *Krueger v. Ameriprise Fin., Inc.*, 2012 WL 5873825, at *10-11 (D. Minn. Nov. 20, 2012); *see also Becker v. Wells Fargo & Co.*, 2021 WL 1909632, at *4-5 (D. Minn. May 21, 2021); *Gipson v. Wells Fargo & Co.*, 2009 WL 702004, at *5 (D. Minn. Mar. 13, 2009). There is no reason to reach a different result here.

Defendant Wells Fargo & Co ("WFC") attempts to cloud the issues by contesting standing, but the Court should see clearly through its arguments. WFC's fiduciary breaches cost Plaintiffs money—the "prototypical form of injury in fact." *Collins v. Yellen*, 594 U.S. 220, 222 (2021). First, Plaintiffs paid higher out-of-pocket costs for prescription drugs under the Plan than they would have paid absent Defendants' unlawful conduct. Second, the Plan's overpayments were passed on to them in the form of higher monthly premiums. Those pocketbook harms satisfy Article III, and Plaintiffs properly seek to redress them here.

WFC's contentions regarding the adequacy of Complaint are also meritless. Plaintiffs support their excess fee allegations with not just one, but four benchmarks – published drug acquisition costs, other pharmacy costs, other pharmacy benefit manager ("PBM") costs, and other plan costs. Their allegations are further supported by the bloated administrative fees paid to the Plan's PBM, the improper steering of participants to the PBM's own high-cost pharmacy, conflicts of interest in the selection of the PBM, and the absence of a meaningful request for proposal process. Nothing further is required to support Plaintiffs' breach of fiduciary duty claims, and indeed, Plaintiffs are not even required to allege that the fees were excessive to support their prohibited transaction claims because it is Defendants' burden to show the fees were *not* excessive. *See Braden*, 588 F.3d at 601. Accordingly, the motion to dismiss should be denied.

BACKGROUND

Plaintiffs are former employees of WFC. ECF 1 ("Compl."), ¶¶ 14-17. While employed at WFC, they received healthcare benefits, including prescription-drug benefits, as participants in WFC's Health Plan (the "WFC Plan" or "Plan"). *Id.* at ¶¶ 14-17, 20. WFC is the Plan sponsor and a fiduciary of the Plan. *Id.* ¶ 23. Plaintiffs allege that WFC violated its fiduciary duties and engaged in prohibited transactions under ERISA by mismanaging the Plan's prescription-drug benefits.

I. Prescription Drug Plans Generally

Most employee health plans, including the WFC Plan, include coverage for prescription drugs. Generally speaking, the employer and employee split the cost. The employee is typically responsible for a monthly insurance premium and the full cost of prescriptions until meeting any applicable deductible. *Id.* ¶ 33. Once the deductible is met, the plan begins to cover a portion of the cost of each prescription, with the employee still responsible for either a co-pay or co-insurance for each prescription in addition to the monthly premium. *Id.*

Prescription drug benefits for self-funded group health plans are usually managed and administered by a PBM selected by the plan's fiduciaries. *Id.* ¶¶ 52-54; *see also id.* ¶¶ 55-76 (describing role of PBMs). PBMs are central to determining the prices paid by plans and their participants for prescription drugs. Accordingly, selecting a PBM and negotiating contract terms with the PBM are among the most financially consequential tasks that a health plan fiduciary performs.

The financial terms of the PBM contract—how prescription-drug prices are calculated, how much "spread" the PBM retains, whether and how the PBM passes rebates through to the plan, how much the plan pays the PBM in administrative fees, etc.—are all subject to negotiation. *Id.* ¶¶ 54, 56, 64-70. As WFC's PBM, Express Scripts, recently explained in a court filing, "[p]lan sponsors … exercise control over the entirety of the prescription drug plan offered to their members." *Express Scripts, Inc. v. FTC*, No. 24-cv-1263, ECF 1 (E.D. Mo. Sept. 17, 2024) ("ESI Complaint"), ¶ 41; *see also* Compl. ¶ 102.

II. Mismanagement of WFC's Prescription Drug Program

Instead of prudently managing the Plan's prescription-drug program and carefully monitoring the PBM and prescription drug costs, WFC effectively gave Express Scripts free rein. *Id.* ¶ 230. WFC's mismanagement allowed Express Scripts to engage in unreasonable spread pricing, charge excessive administrative fees, and steer plan beneficiaries to Express Scripts' more-expensive pharmacy. *See id*. ¶¶ 106-55.

Unreasonable Spread Pricing. The prices that WFC agreed to pay Express Scripts for generic drugs are unreasonably high. For example, the average pharmacy pays $876.60 for 90 units of the generic drug fingolimod (used to treat multiple sclerosis). *Id.* ¶ 120. But WFC agreed to make the Plan and its participants pay Express Scripts $***9,994.37*** for a 90-unit fingolimod prescription—a whopping ***1,040.13% markup*** that Express Scripts keeps for itself. *Id.* Meanwhile, a participant could walk into a retail pharmacy or use an online pharmacy and, *using no insurance at all*, pay a far lesser amount for the same 90-day prescription – $891.63 at Rite Aid, $895.63 from Walmart, or $875.09 from Mark Cuban Cost Plus Drug Company. *Id*. ¶ 121.[1]

This is not an isolated example. The Complaint provides numerous instances of WFC's failure to negotiate prices close to pharmacy acquisition cost or available market prices, resulting in the Plan and participants paying exorbitant prices to Express Scripts. *See id.* ¶¶ 109-33. For example, the Complaint analyzes the prices that WFC agreed to make the Plan and its participants pay Express Scripts for the generic drugs that WFC itself designated as "preferred" options on its formulary. *Id.* ¶ 108. Because plans designate drugs as "preferred" options only when they are among the best-priced on the plan, *see* ESI Complaint ¶ 27, the prices for these "preferred" drugs are likely the best available under

[1] The price at Cost Plus Drug Company is even lower today than at the time of the Complaint: the current price for a 90-day supply is $574.58. *See* Fingolimod HCI, *Mark Cuban Cost Plus Drug Company*, https://bit.ly/40k4KGy (Nov. 7, 2024).

the WFC formulary. The Complaint compares WFC's prices for these "preferred" drugs with a benchmark called the National Average Drug Acquisition Cost ("NADAC"), which represents pharmacies' average "acquisition cost," as calculated by the federal government, for these drugs. *See* Compl. ¶¶ 58, 108. In total, across 260 drugs that WFC designated as "preferred," WFC's negotiated prices reflect, on average, a markup of ***114.97%*** above pharmacy acquisition cost. *Id.* ¶ 109; *see id.* ¶¶ 110-11.

These overpayments are even more pronounced for the subset of generic drugs designated as "specialty." *See generally id.* ¶¶ 85-89. Across all generic-specialty drugs on the Plan formulary for which there is a NADAC benchmark, WFC's negotiated prices reflect, on average, a markup of ***383%*** above pharmacy acquisition cost. *Id.* ¶ 113; *see id.* ¶¶ 114-26. Generic-specialty drugs without a NADAC benchmark are likewise overpriced. *Id.* ¶¶ 127-131.

In addition, the Complaint compares the prices WFC negotiated with Express Scripts for generic-specialty drugs to the public price list of a different PBM, SmithRx. *Id.* ¶ 151. That comparison reveals that WFC agreed to make the Plan and its participants pay Express Scripts more than ***two thousand percent more*** for these drugs than SmithRx charges its clients for the same drugs. *Id.* ¶ 152. Further, the Plan's prescription drug costs are also two to four times higher than another large plan that also uses Express Scripts as its PBM. *Id.* ¶ 183.

Excessive Administrative Fees. WFC also agreed to pay Express Scripts excessive administrative fees. In 2022, for example, WFC agreed to make the Plan pay Express Scripts $135.81 per participant in administrative fees—a total of $25.6 million—while comparable plans that used Express Scripts paid between $19.86 and $92.78 per participant. *Id.* ¶¶ 139-42.

Improper Steering. WFC also inexplicably agreed to require Plan participants to obtain *all* prescriptions of specialty drugs from the mail-order pharmacy that Express Scripts owns, Accredo, even though Accredo's prices are routinely higher than the prices retail pharmacies charge for the same drugs. *Id.* ¶ 134. There is no good reason for this.

Conflicts of Interest. WFC's process for retaining Express Scripts was also flawed. WFC engaged a consultant/broker called Aon to assist it with selecting a PBM. *Id.* ¶ 103. According to public reporting, Aon receives compensation from certain PBMs, including Express Scripts, for encouraging clients to select those PBMs. *Id*. Despite Aon's publicly-disclosed financial conflicts, WFC allowed Aon to guide its RFP process and ultimately accepted Aon's conflicted recommendation to retain Express Scripts. *Id.*

* * *

When fiduciaries fail to manage their prescription drug program and fail to monitor their plan's PBM and prescription-drug costs, employees like Plaintiffs bear much of the financial burden. As participants in the Plan, Plaintiffs paid monthly premiums for their prescription-drug coverage and out-of-pocket amounts for co-pays, co-insurance, and deductibles. *Id.* ¶¶ 196-209. Because of WFC's mismanagement, Plaintiffs and other plan participants paid higher premiums for the prescription-drug portion of the Plan and higher out-of-pocket costs on inflated prescription drug prices. *Id.* ¶¶ 96-98, 196-209.

WFC has no excuse for its failure to monitor its PBM and control plan expenses. As early as 2010, prominent media outlets, government entities, and research organizations warned plan administrators about the financial harms that result when they fail to act prudently and allow PBMs to enrich themselves at the expense of plans and their participants. *Id*. ¶¶ 156-80. WFC itself has urged its own clients to "[r]eview your current pharmacy benefit manager contract to ensure that the most aggressive unit cost and appropriate-use strategies are in place," *id.* ¶ 179, and has acknowledged that PBM profits are driven by the very practices alleged here, including "markups on specialty drug prescriptions" and "steering of plan members [to the PBM's] own pharmacy," *id.* ¶ 180. Fiduciaries of many other plans, unlike WFC, have heeded that advice and saved their plans and participants millions of dollars by taking prudent measures that WFC failed to undertake here. *See id*. ¶¶ 181-95.

STANDARD OF REVIEW

I. Rule 12(b)(6) Motion

On a Rule 12(b)(6) motion to dismiss, a court must accept all allegations in the Complaint as true and draw all reasonable inferences in Plaintiffs' favor to determine whether the complaint "contain[s] 'sufficient factual matter' to state a facially plausible claim for relief." *Davis v. Washington Univ. in St. Louis*, 960 F.3d 478, 482 (8th Cir. 2020) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). "The plausibility standard is not akin to a 'probability requirement.'" *Iqbal*, 556 U.S. at 678. Instead, "[t]he key issue is threshold plausibility, to determine whether a plaintiff is entitled to present evidence in support of his claim and not whether it is likely that he will ultimately prevail." *Delker v. MasterCard Int'l, Inc.*, 21 F.4th 1019, 1024 (8th Cir. 2022).

In evaluating whether this standard has been met, "the complaint should be read as a whole, not parsed piece by piece to determine whether each allegation, in isolation, is plausible." *Braden*, 588 F.3d at 594. Because "ERISA plaintiffs generally lack the inside information necessary to make out their claims in detail unless and until discovery commences," *id.* at 598, Plaintiffs are not "required to describe directly the ways in which [defendants] breached their fiduciary duties," or "the process by which the Plan was managed." *Id*. at 595-96. "Rather, it is sufficient for a plaintiff to plead facts indirectly showing unlawful behavior," which give rise to a "reasonable inference" of a fiduciary breach. *Id*.

II. Rule 12(b)(1) Motion

In reviewing a facial challenge to standing under Rule 12(b)(1), "the Court applies the same standard of review applied to a motion to dismiss brought under Rule 12(b)(6)." *Rouse v. H.B. Fuller Co*., 694 F. Supp. 3d 1149, 1156 (D. Minn. 2023) (citing *Stalley v. Catholic Health Initiatives*, 509 F.3d 517, 521 (8th Cir. 2007)). Accordingly, "the non-moving party receives the same protections as it would defending against a motion brought under Rule 12(b)(6)." *Branson Label, Inc. v. City of Branson, Mo*., 793 F.3d 910, 914 (8th Cir. 2015). In reviewing a "factual" challenge to standing, "the court may receive competent evidence such as affidavits, deposition testimony, and the like in order to determine the factual dispute." *Titus v. Sullivan*, 4 F.3d 590, 593 (8th Cir. 1993). However, dismissal for lack of subject matter jurisdiction "should be granted sparingly and with caution." *Huelsman v. Civic Center Corp.,* 873 F.2d 1171, 1174 (8th Cir. 1989);

Wheeler v. St. Louis Southwestern Ry. Co., 90 F.3d 327, 329 (8th Cir. 1996) ("Dismissal for lack of subject matter jurisdiction will not be granted lightly").

ARGUMENT

I. Plaintiffs Have Standing to Pursue Their Claims

WFC contests Plaintiffs' standing to assert Counts II and IV under ERISA § 502(a)(3), *see* ECF 30 ("MTD") at 14-19; to assert Counts I and III under ERISA § 502(a)(2), *see* MTD at 10-14; and to request injunctive relief, *see* MTD at 19-20. These arguments are meritless. Plaintiffs allege that WFC's fiduciary breaches caused them two specific, independently sufficient forms of harm: (1) greater out-of-pocket expenses for their prescription drugs; and (2) increased monthly premiums for their healthcare coverage. *See, e.g.*, Compl. ¶¶ 3-7, 97-98, 137-38, 196-203, 204-09. A "pocketbook injury is a prototypical form of injury in fact." *Collins*, 594 U.S. at 222. Make-whole relief will redress the past harm, and injunctive and equitable relief will prevent the harm from recurring. *See, e.g.,* Compl. ¶¶ 249-54. Article III requires nothing more.

A. Plaintiffs Have Standing to Assert Individual Claims under ERISA § 502(a)(3)

1. Plaintiffs Allege Non-Speculative Monetary Harm

With respect to out-of-pocket costs, the Complaint alleges that each Plaintiff "paid more in … out-of-pocket costs than he [or she] would have paid absent Defendants' fiduciary breaches and prohibited transactions." *E.g.*, Compl. ¶ 196. For example, Plaintiff Navarro was required to pay $17.47 out-of-pocket for a prescription with an acquisition cost of only $4.80—an unreasonable 264% markup. *Id.* ¶ 197. The Complaint describes similar transactions, with similar monetary harm, for each Plaintiff. *Id.* ¶¶ 197, 199, 201, 203. WFC does not argue that these allegations are implausible or speculative.

With respect to insurance premiums, the Complaint alleges that the Plan's overpayments on fees and drugs were passed on to Plaintiffs in the form of higher monthly premiums. *See, e.g.*, *id.* ¶¶ 204-09. Courts routinely recognize increased premiums as sufficient for Article III standing. For example, in *Slack v. Int'l Union of Operating Eng'rs*, 83 F. Supp. 3d 890 (N.D. Cal. 2015), the plaintiffs alleged that defendants' fiduciary misconduct forced them to make higher plan contributions than they otherwise would have made. *Id.* at 906-07. The court held that "[s]uch a pocketbook injury directly suffered by Plaintiffs is sufficient to confer standing." *Id.* at 907; *see also, e.g.*, *In re Ins. Brokerage Antitrust Litig.*, 579 F.3d 241, 275 (3d Cir. 2009) ("Because the plaintiffs … suffered economic harm in the form of higher premiums …, the named plaintiffs have standing[.]").

WFC calls it "pure speculation" that the Plan's overpayments led to increased premiums. MTD at 19. But it is common sense, basic math, and unquestionably plausible that everyone's premiums increase when overall plan spending increases – expenses don't pay themselves. And here, Plaintiffs allege the specific chain of causation with respect to the Plan. The Plan's expenses are paid from the WFC Employee Benefit Trust ("Trust"), which is funded by a combination of employer and employee contributions. *Id.* ¶¶ 21, 204. WFC sets total contributions at the amounts necessary to cover expected costs. *Id.* ¶ 204. And over the past five years for which data is available, WFC consistently allocated responsibility for contributions to maintain a fixed ratio between employer and employee contributions. *Id.* ¶¶ 206-07. Specifically, WFC allocated 25% of overall Plan healthcare costs to employees, with WFC contributing the remaining 75%. *Id.* ¶ 206. Based on this 5-year history, Plaintiffs plausibly allege that "if Defendants stopped causing the Plan to overspend on prescription drugs and related fees by millions of dollars each year—employee contributions would be lower …, in order to maintain the same 75-25 split between employer and employee contributions to which Defendants have demonstrated their commitment." *Id.* ¶ 207. Plaintiffs have thus "paid more in premiums than they would have paid absent Defendants' fiduciary breaches." *Id.* ¶ 208.

Notably, WFC submitted a declaration in support of its motion to dismiss from its Benefits Director (ECF 31), but that declaration does not dispute *any* of these allegations about how WFC passes on overcharges to employees through increased premiums. If WFC could colorably claim that Plaintiffs' allegations about pass-through were inaccurate or implausible, the declaration presumably would have done so.

The out-of-circuit cases that WFC cites are distinguishable. None involved comparable allegations about how increased plan expenses led to increased employee premiums. In *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450 (3d Cir. 2003), the plaintiff did not pay any premiums at all: "The firm pays all premiums … and does not make any specific healthcare deductions from employees' paychecks." *Id*. at 452. WFC mischaracterizes *Horvath* as alleging conduct that "caused the employer, *and thus participants*, to overpay for care." MTD at 18 (emphasis added). The italicized portion is wrong; the plaintiff did not allege that participants paid anything, let alone that they overpaid. *See Horvath*, 333 F.3d at 457. The pension case *Fox v. McCormick*, 20 F. Supp.

3d 133 (D.D.C. 2013), is similar, as the plaintiffs did not argue that the defendant's alleged misconduct increased their contributions.[2]

The decision in *Knudsen v. MetLife Group, Inc.*, 117 F.4th 570 (3d Cir. 2024) ("*MetLife*"), likewise suffered from a problem of pleading that is not present here. In *MetLife*, the plaintiffs claimed that their employer improperly pocketed certain drug rebates instead of allocating those rebates to the plan. But instead of "alleg[ing] a causal chain justifying *why*" their premiums would have decreased absent the misconduct, the plaintiffs vaguely alleged that "it may have been consistent with its fiduciary duties for [MetLife] to reduce ongoing contributions." *Id.* at 581-82. The Third Circuit deemed these allegations insufficient, but emphasized that "in a different case" alleging similar harms, "a plaintiff may well establish such a financial injury sufficient to satisfy Article III." *Id.* at 580.

This is that case. Instead of alleging that the defendant "***may*** have" done various things, Plaintiffs specifically allege, with accompanying data, that WFC "set the required employee contributions each year as a percentage of expected spending by the Plan," Compl. ¶ 206; that WFC purposefully set that percentage "at the level necessary to maintain a consistent and stable ratio of employer contributions to employee contributions," *id.*; and that as a result, "if Defendants stopped causing the Plan to overspend on prescription drugs and related fees by millions of dollars each year[,] employee contributions ***would*** be lower as well," *id.* ¶ 207 (emphasis added). Plaintiffs also allege that they incurred higher out-of-

[2] *Fox* has also been criticized for its misplaced reliance on the "independent actor" doctrine, which does not apply here. *See Slack v. Int'l Union of Operating Eng'rs*, 83 F. Supp. 3d 890, 910 (N.D. Cal. 2015).

pocket costs for prescription drugs, unlike the plaintiffs in *MetLife*. *See supra* at 4-5, 6, 9. These detailed allegations provide "facts that are specific, plausible, and susceptible to proof at trial," *Finkelman v. Nat'l Football League*, 877 F.3d 504, 513 (3d Cir. 2017), and are sufficient for Article III standing.

2. WFC Cannot Excuse the Harm It Caused Based on Its Own Contributions to the Plan or Other Purported "Settlor" Acts

WFC urges the Court to ignore the foregoing harms to Plaintiffs on the ground that such harms "arise from settlor acts." MTD at 15. But this argument has nothing to do with Article III standing (i.e., whether Plaintiffs suffered an injury-in-fact). Instead, it goes to the merits of Plaintiffs' breach of fiduciary duty claims (i.e., whether WFC is liable for their injuries because of a breach of fiduciary obligations).[3] For this reason alone, WFC's standing argument should be rejected. *See Sigetich v. Kroger Co.*, 2023 WL 2431667, at *8 (S.D. Ohio Mar. 9, 2023) ("Defendants fail to explain how this analysis goes to the Court's standing inquiry."). In any event, WFC seriously misconstrues both the nature of Plaintiffs' allegations and the scope of its fiduciary duties.

Nature of Allegations. Plaintiffs do <u>*not*</u> allege that WFC breached its fiduciary duties by setting employee premium contributions at 25% of total premiums (Compl. ¶ 206), or by establishing fixed co-pays, co-insurance amounts, and deductibles (*id.* ¶¶ 33, 97). Rather, Plaintiffs allege that *given the cost sharing arrangement that WFC chose to adopt*, which shifted some of the cost for prescription drugs to Plaintiffs and other Plan participants, WFC had a duty to monitor those costs and ensure they were reasonable. *Id.*

[3] Plaintiffs state a breach of fiduciary duty claim against WFC. *See infra* at § II.B.

¶ 2. Because it failed to do so, Plaintiffs suffered a financial injury for which WFC is responsible. If WFC had set the employee premium contribution amount differently (at 20% or 30%, instead of 25%), or had adopted different co-pay, co-insurance, or deductible amounts, the extent of the harm might have differed to a degree, but the existence of the harm and nature of the claims would be the same. Thus, WFC's purported settlor activities have nothing to do with Plaintiffs' claims. *See Rodriguez v. Intuit, Inc.*, --- F. Supp.3d ---, 2024 WL 3755367, at *5 (N.D. Cal. Aug. 12, 2024) (rejecting defendants' argument that plaintiffs were challenging a "settlor function," finding that "defendants' interpretation mischaracterizes the nature of the allegations").

Scope of Duties. There is no question that WFC has a fiduciary duty to prudently monitor expenses for Plan-related items such as prescription drug costs and to ensure that such expenses are reasonable. This is one of the most fundamental obligations of any plan fiduciary, *see infra* at § II.B.1, and is literally written into the text of the statute, *see* 29 U.S.C. § 1104(a)(1)(A)(ii) (fiduciaries must defray "reasonable" plan expenses). For purposes of Plaintiffs' prohibited transaction claims, it is also a necessary condition of WFC satisfying the "reasonable compensation" exemption in 29 U.S.C. § 1108(b)(2). *See infra* at § II.A. Because Plaintiffs' claims arise from breaches of these basic fiduciary obligations, rather than "settlor" acts, Plaintiffs are entitled to pursue their claims here. *See Hutchins v. HP, Inc.*, 2024 WL 3049456, at *5 (N.D. Cal. June 17, 2024); *accord Erickson v. Born*, 2017 WL 3822728, at *2 (D. Minn. Aug. 31, 2017).

Notably, WFC does not cite a single case in which plan participants were held to lack Article III standing to assert a breach of fiduciary duty claim against a plan sponsor based on a failure to monitor and control plan-related expenses that were passed on in whole or in part to participants. The cases it cites dealt with "setting premiums, co-pays, and deductibles" or "what drugs to cover in a plan's formulary." MTD at 16.[4]

WFC's argument that its fiduciary failure to monitor and control expenses can be ignored on account of its discretionary premium contributions or other acts in a "settlor" capacity would eviscerate the protections of the statute, and smacks of the sort of argument that has been consistently rejected by other courts. *See, e.g., Rodriguez*, 2024 WL 3755367, at *5 ("Citing no binding precedent, the defendants contend that Ms. Rodriguez challenges a settlor function, not a fiduciary function. Intuit's 'decision' to offset matching contributions with forfeitures, they argue, is 'fundamentally a decision regarding how much Intuit will contribute to the Plan' and thus a settlor function. That argument lacks merit.") (internal citation omitted); *Brotherston v. Putnam Invs., LLC*, 907 F.3d 17, 29 (1st Cir. 2018) ("Because Putnam's discretionary contributions were made in Putnam's capacity as employer for the benefit of its employees qua employees, they are irrelevant to the

[4] That is not the only reason the cited cases are distinguishable. ***Only one of Defendant's cited cases discusses Article III standing, and that case does so only with respect to a non-ERISA claim*** in a portion of the opinion that was not even cited by WFC. *See Moeckel v. Caremark, Inc.*, 622 F. Supp.2d 663, 691 (M.D. Tenn. Nov. 13, 2017) ("Moeckel lacks Article III standing with respect to his OBRA claim"). Further, many of the cases **(1)** did not involve plan sponsor fiduciaries as defendants, *see Hannon v. Hartford Fin. Servs., Inc.*, 2016 WL 1254195 (D. Conn. Mar. 29, 2016) (claims asserted against non-fiduciary service provider); *Moeckel*, 622 F. Supp.2d 663 (PBM service provider); *Mulder v. PCS Health Sys., Inc.*, 432 F. Supp. 2d 450 (D.N.J. 2006) (same); **(2)** did not involve breach of fiduciary duty claims relating to failure to monitor expenses, *see Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967 (N.D. Cal. 2018), and/or **(3)** did not even involve a breach of fiduciary duty claim, *see Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183 (10th Cir. 2023).

analysis. … To hold otherwise would be to allow employers to claw back with their fiduciary hands compensation granted with their employer hands.”). This Court should likewise reject WFC’s argument.

B. Plaintiffs Have Standing to Assert Claims on Behalf of the Plan under ERISA § 502(a)(2)

Plaintiffs also have standing to assert their claims on behalf of the Plan pursuant to ERISA § 502(a)(2) (29 U.S.C. § 1132(a)(2)). This section of ERISA explicitly provides that a participant may bring a civil action for appropriate relief under ERISA § 409 (29 U.S.C. § 1109). Plan participants are routinely deemed to have standing to seek plan-wide relief under this provision. *See, e.g., Braden*, 588 F.3d at 592-93 (plaintiff had Article III standing to pursue claim on behalf of plan under 29 U.S.C. 1132(a)(2)); *Peters v. Aetna, Inc*., 2 F.4th 199, 221 (4th Cir. 2021) (health care plan participant had Article III standing to “proceed under § [502](a)(2) on behalf of the plan”) (*quoting Braden*) .

Here, Plaintiffs appropriately seek relief under ERISA § 502(a)(2) because WFC’s failure to monitor and control prescription drug costs impacted not just Plaintiffs, but the Plan as a whole. *See* Compl. ¶ 3 (“Defendants breached their fiduciary duties and mismanaged [WFC]’s prescription-drug benefits program, costing their ERISA plan ***and*** their employees millions of dollars”) (emphasis added). According to WFC’s own Benefits Book, Plan participants have a right to bring suit in federal court where “the plan’s money” is being misused (i.e., wasted). *See* Declaration of Kai Richter (“Richter Decl.”) Ex. 1 at

B-2.[5] This is precisely what Plaintiffs allege here. *See* Compl. ¶ 209 (alleging WFC "forced the Plan to waste [] money by paying excessive prices for prescription drugs and related fees").

1. Whether Plaintiffs Were Denied Benefits under the Plan Is Irrelevant to Whether they Have Standing to Seek Relief Under ERISA § 502(a)(2) Based on a Failure to Monitor Plan Expenses

WFC asserts that "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." MTD at 10. This is a non-sequitur. Plaintiffs are not bringing a claim for denial of Plan benefits under 29 U.S.C. § 1132(a)(1)(B). Rather, Plaintiffs are bringing claims for breaches of fiduciary duty and prohibited transactions under 29 U.S.C. §§ 1132(a)(2) and (a)(3), alleging that Defendants failed to properly monitor expenses and other terms for the Plan's prescription-drug program. Whether Plaintiffs have been denied benefits or would have standing to pursue a claim for deprivation of benefits has no relevance to whether they have standing to pursue the claims they actually brought.

Contrary to WFC's arguments, this case is nothing like *Thole v. U.S. Bank N.A.*, 590 U.S. 538 (2020). The plaintiffs in *Thole* were retired participants in a pension plan who paid no monthly premium and received "a fixed payment each month" that did "not fluctuate with the value of the plan or because of the plan fiduciaries' good or bad investment decisions." *Id.* at 540. They *conceded* that they did not allege "any monetary injury." *Id.* Their theory of standing was that they did not need to allege monetary injury

[5] Page B-2 conspicuously was not included in the "excerpt" of the Benefits Book that WFC submitted with its motion. *Cf.* ECF 31-3.

because ERISA allowed them to stand in the shoes of the pension plan as "representatives" or "assignees" and recover for losses to the plan that were not passed through to participants. *See id.* at 543-44. The Supreme Court rejected that argument, holding that "[t]here is no ERISA exception to Article III" and that plaintiffs must always allege a personal, concrete stake in the lawsuit. *Id.* at 547. Plaintiffs here, unlike the plaintiffs in *Thole*, allege that they suffered a monetary injury and have a stake in the lawsuit. *See* Compl. ¶¶ 30, 196-204, 208-09, 215.

The Eighth Circuit's decision in *Harley v. Minn. Mining & Mfg. Co.*, 284 F.3d 901 (8th Cir. 2002), another pension plan case, is distinguishable on the same grounds. As the *Braden* court explained:

> In *Harley* the plaintiffs were participants in a defined benefit plan who sued to recover losses caused to the plan by the fiduciary's allegedly imprudent investments. Because the plan retained a surplus notwithstanding the losses, however, the plaintiffs' own benefits remained unchanged and they accordingly suffered no harm. … Unlike the *Harley* plaintiffs, Braden has a personal stake in the litigation.

Braden, 588 F.3d at 593 (internal citations omitted).

Here, unlike the plaintiffs in *Thole and Harley*, but like the plaintiff in *Braden*, Plaintiffs allege specific monetary injury—*i.e.*, that they paid inflated premiums on account of the excess drug costs paid by the Plan, and also were forced to bear increased out-of-pocket costs for prescription drugs. Compl. ¶¶ 196-204, 208. Courts routinely recognize these types of monetary harms as sufficient for Article III standing. *See, e.g.*, *In re Ins. Brokerage Antitrust Litig.*, 579 F.3d at 275; *City of Columbus v. Trump*, 453 F. Supp. 3d 770, 787 (D. Md. 2020); *Aetna Inc. v. Insys Therapeutics, Inc.*, 330 F.R.D. 427, 430 (E.D.

Pa. 2019); *AARP v. EEOC*, 226 F. Supp. 3d 7, 18 (D.D.C. 2016) (all holding higher premiums supported standing); *see also supra* at 10. Accordingly, Plaintiffs have standing. *See, e.g.*, *Acosta v. Bd. of Trs. of Unite Here Health*, 2023 WL 2744556, at *3 (N.D. Ill. Mar. 31, 2023) (finding plaintiffs had standing based on similar allegations and rejecting "Defendants' attempts to fit these facts to *Thole*"); *accord Su v. BCBSM, Inc.*, 2024 WL 3904715, at *3 (D. Minn. Aug. 22, 2024) ("Unlike the plaintiffs in *Thole*, the Secretary alleges losses here").[6]

The Third Circuit's opinion in *MetLife* confirms this. Similar to Plaintiffs here, the *MetLife* plaintiffs asserted that "MetLife's illegal conduct has caused them to pay higher out-of-pocket costs, mainly in the form of insurance premiums." 117 F.4th at 573. In moving to dismiss for lack of standing, MetLife relied on *Thole*, and characterized *Thole* as holding that an ERISA beneficiary "has no injury *unless* the plan participants plead that they did not receive promised benefits, i.e., reimbursement of healthcare claims." *Id.* at 579. However, the Third Circuit rejected this argument, and held:

> [W]e agree with Plaintiffs. Thus, we decline to hold that *Thole* … require[s] dismissal, under Article III, *whenever* a participant in a self-funded healthcare plan brings an ERISA suit alleging that mismanagement of plan assets increased his/her out-of-pocket expenses.

Id. at 579. As the court explained, ERISA plaintiffs have Article III standing if their complaint "include[s] nonspeculative allegations, that if proven, would establish that they have or will pay more in premiums, or other out-of-pocket costs" as a result of the

[6] If Plaintiffs do not have standing, it is difficult to see who would. ERISA's fiduciary protections under § 404 and statutory right to bring an action on behalf of the plan under §§ 409 and 502(a)(2) would be rendered virtually ineffective for health plan participants.

defendant's ERISA violations. *Id*. at 580. Plaintiffs have included such non-speculative allegations here. *See supra* at 12-13.[7]

2. Seeking Plan Relief Is Not Incompatible with Asserting Individual Standing under Article III

Defendants contend that Plaintiffs cannot meet the "redressability" prong of Article III standing where relief is being sought on behalf of the Plan under ERISA § 502(a)(2) rather than for themselves individually. MTD at 12-14. However, the Eighth Circuit rejected this argument in *Braden*, holding that "a plaintiff may seek relief under § 1132(a)(2) that sweeps beyond his own injury." *Braden*, 588 F.3d at 593. Like the defendants in *Braden*, WFC has "erred by conflating the issue of [plaintiffs'] Article III standing with [their] potential personal causes of action under ERISA." *Id.* at 592; *see also Cedeno v. Sasson*, 100 F.4th 386, 403 (2d Cir. 2024); *Peters*, 2 F. 4th. at 221.[8]

[7] Defendants' other cited cases are distinguishable for the same reason. In *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517 (9th Cir. 2023), the plaintiffs did not allege that their employer "has changed or would change employee contribution rates based on [the] alleged breaches of fiduciary duty, or that employee contribution rates are tied to overall premiums." *Id.* at 524. In *Gonzalez de Fuente v. Preferred Home Care of N.Y. LLC*, 2020 WL 5994957 (E.D.N.Y. Oct. 9, 2020), the plaintiffs were not responsible for any premium payments and expressly alleged that they "do not use" the plan. *Id.* at *2. And in *Scott v. UnitedHealth Grp., Inc.*, 540 F. Supp. 3d 857 (D. Minn. 2021), the plaintiffs argued that they "do not need to allege that their payroll contributions have increased … in order to state an injury." *Id.* at 863.

[8] The implication of Defendants' argument is that a plaintiff would never have standing to pursue a § 502(a)(2) claim because relief is being procured for the plan and not the plaintiffs themselves. This is manifestly wrong. *See Franklin v. Duke Univ.*, --- F. Supp. 3d ---, 2024 WL 1048123, at *4 (M.D.N.C. Feb. 29, 2024) ("To the extent [defendant] says that it is impossible to show standing in a § 1132(a)(2) claim arising out of a defined benefit plan, the Court respectfully disagrees."); *Brown v. Daikin Am., Inc.*, 2021 WL 1758898, at *4 n.6 (S.D.N.Y. May 4, 2021) ("To be sure, *Thole* must not be read to stand for the sweeping proposition that derivative lawsuits under ERISA do not satisfy Article III standing.").

In any event, the relief that Plaintiffs seek on behalf of the Plan will also benefit them individually. *See Cedeno*, 100 F.4th at 404 (even though "the remedies available under Section 502(a)(2) for fiduciary breaches that violate Section 409(a) inure to the benefit of *the plan*," they "provid[e] … indirect relief to individual plan participants and beneficiaries."); *Hawkins v. Cintas Corp.*, 32 F.4th 625, 634 (6th Cir. 2022), *cert denied*, 143 S.Ct. 564 (2023) ("Plaintiffs will indirectly benefit from a remedy accruing to the Plan").

For example, one of the remedies that Plaintiffs seek is recovery of "losses to the plan." *See* Compl. ¶ 250; 29 U.S.C. § 1109(a). In the event of a recovery, these losses will be restored to the Plan's trust account and *must* be used for the benefit of participants and beneficiaries. *See Graden v. Conexant Sys., Inc.*, 496 F.3d 291, 295 (3d Cir. 2007) ("the plan takes legal title to any recovery, which then inures to the benefit of its participants and beneficiaries"); *see also* Compl. ¶ 209. Although WFC contends it is "speculative" that participants would benefit, *see* MTD at 13, this is only because it is confused about its fiduciary obligations. "If the plaintiffs are ultimately successful in this suit, the fiduciaries should, in accord with their statutory duty of care, strive to allocate any recovery to the affected participants in relation to the impact the fiduciary breaches had on [them]." *Evans v. Akers*, 534 F.3d 65, 74 (1st Cir. 2008); *see also Graden*, 496 F.3d at 296 n.6 ("[A]ny recovery made 'on behalf of the plan' must be paid out to the injured participant."); *Harris v. Amgen, Inc.*, 573 F.3d 728, 736 (9th Cir. 2009) ("We agree with the First, Fourth, and Seventh Circuits that there is no lack of redressability merely because a plaintiff's recovery under Section 502(a)(2) might first go to the [] plan rather than directly to the plaintiff.").

In an analogous situation involving insurance premium rebates, the Department of Labor ("DOL") has instructed employers who receive such rebates that they may not use the rebate share attributable to participant contributions for their own account, and should attempt to "allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates." *See* U.S. Dep't of Labor, *Technical Release No. 2011-4* (Dec. 2, 2011), *available at* www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/11-04. The same process should apply here given the nature of the allegations in this case. *See* Compl. ¶ 208.

Defendants' reliance on *Glanton ex rel. ALCOA Prescription Drug Plan v. Advance PCS, Inc.*, 465 F.3d 1123 (9th Cir. 2006), is misplaced. In that case, the plaintiffs did not sue the plan sponsor for breach of fiduciary duty, but rather a third-party PBM. Because the plan sponsor was an "independent actor" that retained discretion beyond the court's control, the court determined that it was speculative whether any money judgment against the PBM would inure to the benefit of the plan's participants. *Id.* at 1125. Similarly, *Winsor* was brought against a manager/broker to the plan – not the plan sponsor – which "contribute[d] to plaintiffs' failure to sufficiently allege Article III standing." *See Winsor*, 62 F.4th at 523.[9]

[9] WFC's other cited cases also fail to support its position. *David v. Alphin*, 2008 WL 5244504 (W.D.N.C. Dec. 15, 2008) involved a defined benefit pension plan and, as in *Thole*, plaintiffs did not allege that the defendant's conduct "ha[d] any effect on their Pension Plan benefits."*Id*. at *2. Further, as discussed above, *MetLife* supports ***Plaintiffs'*** position. *See supra* at 19-20.

This case is different because it is brought directly against the plan sponsor. In the event of a money judgment against WFC, it may not—and the Court can issue an injunction to ensure it will not—pluck back from the Plan's trust (directly or through employer premium offsets) the very monies it is ordered to pay into the trust as losses to the Plan under ERISA § 409.[10]

Aside from the loss remedy, Plaintiffs also seek other plan relief including removal of the Plan's fiduciaries, appointment of an independent fiduciary, removal of Express Scripts as the Plan's PBM, a search for alternate PBM candidates (with a robust bidding process), and other appropriate measures. *See* Compl. ¶¶ 252-54. This "other equitable or remedial relief" is expressly available under ERISA § 409(a), and will benefit both the Plan and its participants by ensuring they do not bear excessive drug costs and administrative expenses going forward. This further supports Plaintiffs' standing to sue under ERISA § 502(a)(2).

C. Plaintiffs Have Standing to Seek Injunctive Relief

WFC asserts that "Plaintiffs lack standing to seek prospective injunctive relief" because they are former participants in the Plan. *See* MTD at 19. However, this argument once again ignores *Braden*. The *Braden* court held that persons who are injured by alleged

[10] Regardless, "[e]ven a beneficiary who may never receive the trust assets may sue for a breach of trust." *Jo Ann Howard & Assoc., P.C. v. Cassidy*, 2018 WL 6067294, at *13 (E.D. Mo. Nov. 20, 2018) (citing *Scanlan v. Eisenberg*, 669 F.3d 838, 844 (7th Cir. 2012)); *accord Mitchell v. Blue Cross Blue Shield of N.D.*, 953 F.3d 529, 535 (8th Cir. 2020) (rejecting argument that "a favorable judicial decision would not 'redress' any injury the [Plaintiffs] might have suffered because any monetary award would go to VMF, and any declaration of the parties' future rights under the Plan would not benefit the [Plaintiffs] because they are no longer enrolled in the Plan.").

unlawful conduct while enrolled in a plan (as here) may seek relief on behalf of the plan for periods outside the time period they were enrolled. 588 F.3d at 592-93; *see also Tussey v. ABB, Inc.*, 2007 WL 4289694 at *2 (W.D. Mo. Dec. 3, 2007) ("Tussey is not required to demonstrate his personal standing at all points throughout the class period in order to satisfy Article III's case or controversy requirement."). While the Eighth Circuit's analysis was focused on "the period before" plaintiff Braden was enrolled, the same logic applies to the period after Plaintiffs here were enrolled. *See Innis v. Bankers Tr. Co. of S.D.*, 2017 WL 4876240, at *6 (S.D. Iowa Oct. 13, 2017); *Laurent v. PriceWaterhouseCoopers LLC*, 565 F. Supp.3d 543, 549-550 (S.D.N.Y. 2021); *Velazquez v. Mass. Fin. Servs., Inc.*, 320 F. Supp. 3d 252, 257-58 (D. Mass. 2018); *Hay v. Gucci Am.*, 2018 WL 4815558, at *5 (D.N.J. Oct. 3, 2018); *see also Evans*, 534 F.3d at 67-68, 76 (vacating district court order which held plaintiffs lacked standing to sue on behalf of plan participants from 1999-2004 where plaintiffs ceased participating in the plan in 2001 and 2002).[11]

II. Plaintiffs Assert Plausible Claims Against Wells Fargo Under ERISA

WFC's alternative argument that Plaintiffs have not adequately pled their claims is meritless. Plaintiffs' allegations in their 101-page Complaint are more than sufficient to state plausible prohibited transaction and breach of fiduciary duty claims under ERISA.

[11] The case law cited by WFC is not to the contrary. In *Fitzpatrick v. Neb. Methodist Health Sys., Inc.*, 2023 WL 5105362, at *5 (D. Neb. Aug. 9, 2023), the "[t]he plaintiffs' brief [did] not address this issue" and the court did not discuss *Braden* in the section of its opinion relating to injunctive relief. The other case, *Burris v. IASD Health Servs. Corp.*, 1995 WL 843589 (S.D. Iowa Oct. 2, 1995), long predates *Braden*.

A. Plaintiffs State a Prohibited Transaction Claim

WFC's argument for dismissing Plaintiffs' prohibited transaction claims rests entirely on a fiction. WFC asserts that "the Eighth Circuit has not expressly addressed" the pleading standard for a prohibited transaction claim, and urges this Court to adopt the pleading standards that apply in certain other circuits. MTD at 30-31. WFC's assertion is false—in *Braden*, the Eighth Circuit expressly held that a plaintiff is required to plead only a *prima facie* prohibited transaction, and contrary to the law in some other circuits, "does not bear the burden" of negating statutory exemptions or pleading additional elements. 588 F.3d at 601. WFC does not deny that Plaintiffs have pleaded *prima facie* violations of ERISA's prohibited transaction provisions. Under *Braden*, nothing more is required.

ERISA § 406(a)(1) "supplements the fiduciary's general dut[ies] … by categorically barring certain transactions" that pose risks to plans and their beneficiaries. *Braden*, 588 F.3d 585; *see* 29 U.S.C. §§ 1106(a). Specifically, ERISA prohibits plan fiduciaries from causing the plan to engage in certain transactions with a "party in interest." 29 U.S.C. § 1106(a)(1)(A)-(D). The term "party in interest" includes nine types of entities that regularly transact with plans, including "a person providing services to [the] plan." *Id.* § 1002(14)(B). A separate provision, 29 U.S.C. § 1108, enumerates twenty-one exemptions from § 1106(a)(1)'s list of prohibited transactions, including "[c]ontracting … for … services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid," *id.* § 1108(b)(2)(A).

Here, Plaintiffs allege that Express Scripts is a "party in interest" under ERISA and that WFC engaged in prohibited transactions with Express Scripts by causing the Plan to engage in transactions that constituted "an exchange of property between the Plan and Express Scripts prohibited by 29 U.S.C. § 1106(a)(1)(A), a furnishing of services between the Express Scripts and the Plan prohibited by 29 U.S.C. § 1106(a)(1)(C), and a transfer of the Plan's assets to, or use by or for the benefit of Express Scripts prohibited by 29 U.S.C. § 1106(a)(1)(D)." Compl. ¶¶ 234-35, 242. This is sufficient to plead a prohibited transaction claim. In *Braden*, the plaintiff similarly alleged a prohibited transaction between the plan and party-in-interest service provider Merrill Lynch. The district court had held that the complaint was deficient for not also alleging facts negating the § 1108 exemption for services contracts for which "reasonable compensation is paid." 588 F.3d at 600. But the Eighth Circuit rejected that approach as a matter of law: "[Plaintiff] does not bear the burden of pleading facts showing that the … payments were unreasonable in proportion to the services rendered." *Id.* at 601.

WFC urges this Court to ignore binding authority and to instead apply the Second Circuit's pleading standard, under which a plaintiff must plead not only a *prima facie* prohibited transaction, but also that the § 1108(b)(2)(A) exemption does not apply. MTD at 31 (quoting *Cunningham v. Cornell Univ.*, 86 F.4th 961, 975 (2d Cir. 2023), *cert. granted* 2024 WL 4394127 (U.S. Oct. 4, 2024)). But *Braden* squarely holds that no such allegations are necessary, and *Braden* controls in this Court. WFC's view that "the Second Circuit's ruling is clearly more persuasive," *id.*, is irrelevant.[12]

[12] The defendants in *Braden* objected that the pleading standard the court adopted would "render[] virtually any business between a covered plan and a service provider a prima facie 'prohibited transaction." *Braden*, 588 F.3d at 601. The Eighth Circuit rejected this

In any event, Plaintiffs have pled that the expenses the Plan incurs for prescription drugs and administrative fees are unreasonable, as discussed below. *See infra* at § II.B.2; Compl. ¶¶ 236, 243. Accordingly, Plaintiffs *do* allege that the "reasonable compensation" exemption to their prohibited transaction claim does not apply under 29 U.S.C. § 1108(b)(2), even though they are not required to do so under *Braden*.

WFC also contends that other circuits "condition[] the viability of [prohibited-transaction] claims on allegations of self-dealing or intent to benefit the party in interest." MTD at 30. Once again, however, the Eighth Circuit does not. *Braden*, 588 F.3d at 600-03. WFC's assertion that "the Eighth Circuit has not expressly addressed this issue" because *Braden* "involved allegations of self-dealing," MTD at 30, is false. *Braden* ***did not*** involve allegations that the defendant, Wal-Mart, engaged in self-dealing. The allegations were instead that Wal-Mart's "process [for selecting] mutual funds … was tainted" because Wal-Mart allowed Merrill Lynch to select funds even though *Merrill Lynch* had a conflict of interest. *Braden*, 588 F.3d at 590.

The allegations here are quite similar: WFC "needlessly allows Express Scripts to enrich itself at the expense of the Plan and its participants/beneficiaries" and has failed to address Express Scripts' conflicts of interest. Compl. ¶ 9; *see also id.* ¶ 112, 156, 224. In addition, Plaintiffs allege that WFC's process for selecting a PBM was tainted because it "allowed [its] selection of a PBM for the Plan to be guided or managed by a broker with a

concern: "The language of the statute is plain, and it allocates the burdens of pleading and proof." *Id.* at 602. Nothing in the language of § 1106(a)(1) demands that a plaintiff allege the additional elements that WFC tries to import from out-of-circuit authorities.

conflict of interest." Compl. ¶ 103. Accordingly, even if Plaintiffs were required under Eighth Circuit law to plead something beyond a *prima facie* prohibited transaction—which they are not—their allegations are consistent with *Braden* and support their prohibited transaction claim.

B. Plaintiffs Plausibly Allege Wells Fargo Breached Its Fiduciary Duties

Plaintiffs also plead plausible breach of fiduciary duty claims. The Supreme Court, Eighth Circuit, and numerous district courts have all recognized—consistent with established trust law and the text of ERISA itself—that fiduciaries have a responsibility to monitor plan expenses and ensure such expenses are reasonable. Here, the Complaint is replete with extensive, detailed allegations showing that WFC breached this basic duty with respect to expenses for prescription drugs and PBM services. WFC's nitpicking of specific aspects of Plaintiffs' allegations is unreasonable at this stage, and ignores *Braden*'s admonishment that "the complaint should be read as a whole." 588 F.3d at 594; *see also Hughes v. Nw. Univ.*, 595 U.S. 170, 177 (2022).

1. Monitoring Plan Expenses and Service Providers Is a Fundamental Fiduciary Duty

Congress enacted ERISA because "the continued well-being and security of millions of employees and their dependents are directly affected by [employee benefit] plans." 29 U.S.C. § 1001(a). "The principal object of the statute is to protect plan participants and beneficiaries." *Boggs v. Boggs*, 520 U.S. 833, 845 (1997).[13]

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[13] Courts "must be attendant to ERISA's remedial purpose." *Braden*, 588 F.3d at 597, (citing *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 n.8 (1985)). Accordingly, ERISA "should be liberally construed" to protect participants. *Brown v. J.B. Hunt Transp. Servs., Inc.*, 586 F.3d 1079, 1086 (8th Cir. 2009).

One of the ways ERISA achieves this important objective is by establishing certain fiduciary duties in 29 U.S.C. § 1104. Under this section of ERISA, plan fiduciaries must act "solely in the interest of the participants and beneficiaries … for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying ***reasonable expenses*** of administering the plan." 29 U.S.C. § 1104(a)(1)(A) (emphasis added). In addition, fiduciaries must act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent [person] acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. § 1104(a)(1)(B). These twin fiduciary duties are considered "the highest known to the law." *Braden*, 588 F.3d at 598.

An essential component of carrying out these duties is diligently investigating plan service providers and monitoring plan costs. *See Tussey*, 746 F.3d at 336; *accord* Restatement (Third) of Trusts § 88 cmt. a (2007) ("Implicit in a trustee's fiduciary duties is a duty to be cost conscious.");[14] *Tibble v. Edison Int'l*, 843 F.3d 1187, 1198 (9th Cir. 2016) (en banc) ("Wasting beneficiaries' money is imprudent …. trustees are obliged to minimize costs."). Indeed, the DOL's handbook on "Meeting Your Fiduciary Responsibilities" expressly states that "the plan's fees and expenses should be monitored to determine whether they continue to be reasonable." DOL, MEETING YOUR FIDUCIARY RESPONSIBILITIES at 6 (Sept. 2021).[15]

[14] "In determining the contours of an ERISA fiduciary's duty, courts often must look to the law of trusts." *Tibble v. Edison Int'l*, 575 U.S. 523, 528-29 (2015).

[15] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/meeting-your-fiduciary-responsibilities-booklet-2021.pdf.

In this regard, "fiduciaries should be vigilant in 'negotiation of the specific formula and methodology' by which fee payments" will be made, including any indirect compensation that will be paid in the form of "revenue sharing … to plan service providers." *Sweda v. Univ. of Pa.*, 923 F.3d 320, 328 (3d Cir. 2019); *accord Tussey*, 746 F.3d at 336 (failure to properly "monitor and control recordkeeping fees" paid through "excessive revenue sharing" is a breach of fiduciary duty). In addition, fiduciaries of large plans such as the WFC Plan must "leverage the Plan's size to reduce fees." *Tussey*, 746 F. 3d at 336; *see also Braden*, 588 F.3d at 595.

2. Wells Fargo Breached These Basic Duties in Multiple Ways

Plaintiffs plausibly allege that WFC breached these basic fiduciary duties in several respects. Although WFC pleads "not guilty," that is hardly a basis for dismissing the Complaint. *See Wildman v. Am. Century Servs., LLC*, 237 F. Supp. 3d 902, 914 (W.D. Mo. 2017) ("Defendants' arguments that the fees are not excessive and the comparisons to Vanguard funds are inappropriate raise factual issues that cannot be resolved in a motion to dismiss.").

a. Excessive Prescription Drug Costs

Plaintiff's allegations regarding excessive prescription drug costs are supported by not just one "meaningful benchmark," *see* MTD at 22, but **four**.

First, Plaintiffs allege that the drug prices paid by the Plan and its participants substantially exceeded a reasonable amount based on NADAC data published by the federal government. *See* Compl. ¶¶ 58, 108-09, 113-24.[16] Across all 260 generic drugs on WFC's "Preferred Formulary" for which NADAC data is available, the average markup was approximately 115%. *Id.* ¶¶ 108-09. In other words, WFC agreed to pay Express Scripts *more than double* what those drugs actually cost. For the subset of so-called "specialty" drugs, the average markup was even higher – 383%. *Id.* ¶ 113. And for some drugs, the markups were over 1,000% (*id.* ¶¶ 114, 120, 122), 2,000% (*id.* ¶ 116), 4,000% (*id.* ¶ 118), or even 10,000% (*id.* ¶ 124).[17]

Although WFC contends that NADAC data is not an appropriate benchmark that is used by other plan fiduciaries, this is expressly refuted by the allegations in the Complaint. *See* Compl. ¶¶ 57-58, 66, 145. Indeed, WFC itself agreed to prices that are

[16] "Initially designed as a reference point for Medicaid reimbursement rates, NADAC pricing has gained prominence and expanded its application over time. Its usage now extends beyond Medicaid to other federal and state healthcare programs, commercial payers, and pharmacy benefit managers (PBMs)." Richter Decl., Ex. 2.

[17] WFC contends that Plaintiffs' cost comparisons are "dubious" and that it actually charged less than the amounts shown in the Complaint. *See* MTD at 24 n.10. But it is actually WFC that is skirting the truth. The cost figures that Plaintiffs cited are reported accurately, and came from the Plan's website at the time the suit was filed. *See* Declaration of Tyler Haydell ¶¶ 2-4, 6-7. After Plaintiffs filed suit, it appears that the listed pricing information was altered to make it seem more reasonable for purposes of WFC's brief. *Id.* ¶ 8. As of yesterday, however, the price on the Plan's website was once again the higher price identified in the Complaint. *Id.* ¶ 9. In any event, even the lower price for Fingolimod reflecting WFC's temporary alterations ($3,281.46) is still over 3.5 times the NADAC amount ($876.60) and Rite Aid's price for a customer *without* insurance ($891.63). *See* Compl. ¶¶ 120-21. The altered price hardly renders Plaintiffs' claims implausible. *See Morin v. Essentia Health*, 2017 WL 4876281, at *1 (D. Minn. Oct. 27, 2017) ("Defendants argue that the R&R failed to consider certain documents the Plans filed with the DOL. But those documents were filed after Plaintiffs amended their Complaint in this case, apparently in an effort to undermine Plaintiffs' new allegations. The R&R correctly determined that these public filings need not have been considered on a motion to dismiss."). And at this stage, Plaintiffs' allegations regarding Plan expenses must be "[t]aken as true." *Braden* 588 F.3d at 596.

roughly equivalent to pharmacy acquisition cost for branded (i.e., non-generic) drugs. Compl. ¶ 133. At this stage, Plaintiffs' allegations must be taken as true. *See, e.g., Snyder v. UnitedHealth Group, Inc.*, 2021 WL 5745852, at *3 (D. Minn. Dec. 2, 2021) (whether plaintiff's comparators were "meaningful benchmarks" involved "factual issues that the Court cannot resolve on a motion to dismiss"). In any event, WFC is wrong. NADAC "offers a standardized benchmark for drug pricing, promoting fairness and transparency in the healthcare system." Richter Decl., Ex. 2. For example, the PBM Capital Rx, *see* Compl. ¶ 73, "uses NADAC prices" as a benchmark for the prices it charges its plan clients and "does *not* engage in secretive rebating or spread pricing." *Id*., Ex. 3. Similarly, even Express Scripts offers a "ClearNetwork" product with prices based on the lowest of three benchmarks, one of which is NADAC. *Id*.., Ex. 4. This shows that NADAC is not only an appropriate benchmark, but a conservative one, as WFC's own PBM offers a product with prices based on benchmarks that may be *even lower* than NADAC.

Second, Plaintiffs allege that prices for prescription drugs purchased through the Plan were more expensive than the prices for *identical* drugs from retail pharmacies. *See* Compl. ¶¶ 106, 115, 117, 119, 121, 123, 125, 128-31.[18] In other words, an individual who just walked into a retail pharmacy and filled the same prescription without using insurance could have purchased the drugs for less than the Plan did with all of its bargaining power. *Id.* ¶ 106. WFC has no answer for this, other than that it reflects pricing

[18] In many cases, the retail pharmacy price was even lower than the NADAC price, *compare id.* ¶¶ 114-15, 120-21, 124-25, further demonstrating that NADAC is a reasonable and conservative benchmark for retail pricing.

"competition." MTD at 25-26. Indeed. The problem is that WFC never bothered to survey the marketplace. *See* Compl. ¶¶ 70, 75-76, 106.

Third, Plaintiffs allege that the prices the Plan paid for prescription drugs through Express Scripts were more expensive than the prices for the same drugs through other PBMs. *See* Compl. ¶ 104, 152. In support, Plaintiffs include a detailed chart in the Complaint comparing the price charged for 31 specialty drugs by a "pass-through" PBM, SmithRx, versus the price that WFC negotiated from Express Scripts. *Id.* ¶ 151. The difference in price is an astonishing 2,051%. *Id.* WFC offers no explanation for these staggering price differences either, other than a meek footnote. *See* MTD at 24 n.9.[19] Nor is there any legitimate explanation. As Plaintiffs specifically allege, Smith Rx is capable of providing a high level of service comparable or superior to that provided by Express Scripts. Compl. ¶ 150. Moreover, "comparable savings were available to Defendants by contracting with other pass-through PBMs," *id.* ¶ 154, which also offer comparable services, *see id.* ¶¶ 74, 149, 154.[20]

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[19] To the extent that WFC does offer purportedly benign explanations for certain matters in its motion to dismiss, Plaintiffs are not required to rebut WFC's explanations at the pleading stage. *See Braden*, 588 F.3d at 596-597 (holding that an ERISA plaintiff need not "plead facts tending to rebut all possible lawful explanations for a defendant's conduct" because this would "invert the principle that the complaint is construed most favorable to the nonmoving party").

[20] Although WFC argues that "Plaintiffs fail to identify any plans using such 'pass through' arrangements," MTD at 23, it is wrong. Plaintiffs identify several in their Complaint. *See* Compl. ¶¶ 90, 185-188, 190-193, 195; *see also id.* ¶ 150 ("SmithRx is a pass-through PBM that services a wide range of healthcare plans."); ¶ 154 ("Navitus is a pass-through PBM that services a wide range of healthcare plans").

Fourth, Plaintiffs compare the drug prices charged to the Plan with drug prices charged to another large plan sponsored by Pepsico that uses Express Scripts. *See id.* ¶ 183. Here, too, the WFC Plan falls short. The Plan pays over two to four times the cost paid by the Pepsico plan for the exact same drugs purchased from the exact same vendor. *Id.*[21] Once again, WFC fails to explain the differences in price. It merely complains that Plaintiffs compare prices for samples of drugs rather than "aggregate prescription drug costs" for all drugs in both plans. But Plaintiffs are unable to do so in the absence of discovery, nor are they required to do so. Providing comparisons to a representative sample is sufficient. *See Innova Hosp. San Antonio Ltd. P'ship v. Blue Cross & Blue Shield of Ga.*, 892 F.3d 719, 728-29 (5th Cir. 2018) (applying *Braden*).

WFC certainly is not entitled to an unsupported inference in its favor at this stage that aggregate cost comparisons would be any more favorable to WFC than the sample comparisons in the Complaint. Plaintiffs specifically allege that "[t]he Plan's extraordinarily high prices" for the drugs referenced in the Complaint are "not offset by special discounts from Express Scripts for other kinds of drugs." Compl. ¶ 133. Moreover, even if prescription drug costs were somehow reasonable in the aggregate (which there is *zero* reason to believe and which is expressly refuted by the Complaint), this would not excuse the unreasonable prices that WFC allowed the Plan to be charged for the specific drugs shown: "Under ERISA, the prudence of investments or classes of investments offered by a plan must be judged individually." *DiFelice v. U.S. Airways,*

[21] Paragraph 183 contains a typo. The cross references in that paragraph are intended to be to paragraphs 126 and 151 of the Complaint.

Inc., 497 F.3d 410, 423 (4th Cir. 2007) ("Here the relevant 'portfolio' that must be prudent is each available Fund considered on its own …, not the full menu of Plan funds."). The same logic applies to prescription drugs offered on a plan's formulary (i.e., drug menu).

In summary, each of the cost comparisons provided by Plaintiffs are meaningful benchmarks on their own, and properly considered "as a whole," *Braden* 588 F.3d at 594, they create a strong inference that WFC failed to prudently monitor prescription drug costs. Moreover, this inference is further supported by numerous other allegations:

- Plaintiffs identify approximately one dozen health plans that have achieved prescription drug savings that the WFC Plan did not, *see* MTD at 23 (citing Compl. ¶¶ 183-195); *see also Sweda*, 923 F.3d at 330-31 ("Sweda offered examples of similarly situated fiduciaries who acted prudently");

- WFC did not engage in an open request for proposal ("RFP") process for PBM services or survey the marketplace, *see* Compl. ¶¶ 101, 106, as other plan sponsors do, *see id.* ¶¶ 70, 75-76, and as WFC itself does when operating as a broker for other plans, *see id.* ¶ 179; *see also Larson*, 350 F. Supp. 3d at 800 ("Plaintiffs have sufficiently stated a claim that Defendants breached their fiduciary duty by improperly monitoring recordkeeping fees and failing to solicit bids from other recordkeeping services.").

- "Defendants squandered their bargaining power" and failed to leverage the size of the Plan to negotiate better terms, Compl., ¶ 106, contrary to the practices of other plan fiduciaries, *see id.* ¶¶ 8, 93, 144; *see also Tussey*, 746 F. 3d at 336; *Braden*, 588 F.3d at 595.

WFC's suggested pleading standard, demanding still more allegations and benchmarks, is made out of whole cloth.[22] Similar allegations of excess fees paid to plan

[22] No court has ever articulated a rule – much less a categorical one – that requires aggregate, formulary-wide cost comparisons to other plans with the exact same drug formularies and exact same PBM services. *See* MTD at 23. Nor would it make sense to do so – indeed, such comparisons are not even possible prior to discovery. ERISA's pleading

service providers have repeatedly been held sufficient to support an inference of a fiduciary breach. *See supra* at 1 (citing cases). Tellingly, WFC does not cite a single case in the section of its brief dealing with the adequacy of Plaintiffs' allegations regarding "Prescription Drug Costs" (MTD at Section II.B.1).

b. Excessive Administrative Fees

Plaintiffs' allegations regarding excessive administrative fees also support their breach of fiduciary duty claim. Although WFC once again challenges the comparators that Plaintiffs use for purposes of this claim, MTD at 26-27, it ignores the most important comparator of all – the Plan itself. In 2019, the Plan paid "only" $9,235,645 in administrative fees to Express Scripts. Compl. ¶ 140. By 2022, just three years later, that amount had mushroomed to $25,639,955 – nearly 2½ times as much. *Id.* In the meantime, the number of participants in the Plan actually *decreased* from 218,107 to 188,798. *See* Richter Decl. Ex. 5-6;[23] Compl. ¶¶ 141, 205. Thus, the per capita price increase was even worse – 320%. All the while, the services provided by WFC remained the same. *See* MTD

standard is far more flexible. *See Hughes*, 595 U.S. at 177 ("the appropriate inquiry will necessarily be context specific"); *Braden*, 588 F.3d at 598 ("[W]hile a plaintiff must offer sufficient factual allegations to show that he or she is not merely engaged in a fishing expedition or strike suit, … considerations counsel careful and holistic evaluation of an ERISA complaint's factual allegations before concluding that they do not support a plausible inference that the plaintiff is entitled to relief."); *accord Mator v. Wesco Distrib., Inc.*, 102 F.4th 172, 185 (3d Cir. 2024) ("Sweda did not support that allegation [of excessive fees] with any comparisons to other plans"); *Larson*, 350 F. Supp. 3d at 800 (citing *Krueger*, 2012 WL 5873825, at *19-20).

[23] The number of participants at the start of each year is shown on line 5 of the second page of the Forms 5500. WFC omits this page from the 5500 excerpts it submitted for the Plan, *see* ECFs 32-2 through 32-5, even though it includes the same page for Plaintiffs' comparator plans, *see* ECFs 32-6 through 32-10.

at 26 n.11 (noting that service codes were unchanged throughout the relevant period). The fact that WFC allowed per capita administrative fees to jump 320% in three years strongly supports the inference that WFC was not adequately monitoring the fees that were charged. *See, e.g*, *Coppel v. Seaword Parks & Ent., Inc.*, 2023 WL 2942462, at *13 (S.D. Cal. Mar. 22, 2023); *Carrigan v. Xerox Corp.*, 2022 WL 1137230, at *5 (D. Conn. Apr. 18, 2022); *Kruger v. Novant Health*, 131 F. Supp. 3d 470, 479 (M.D.N.C. 2015).

Plaintiffs' comparisons to other plans further illustrate the excessiveness of the fees. *See* Compl. ¶ 141. Like the Plan, all five comparator plans used Express Scripts as their PBM. *Id.* Like the Plan, all five comparator plans identified the services provided under code 12 (claims processing) or code 13 (contract administrator) or both. *See* ECFs 32-6 through 32-10; *compare* ECFs 32-2 through 32-5.[24] But unlike the Plan, which paid Express Scripts $135.81 per participant, the comparator plans paid only $19.86 to $92.78 per participant. Compl. ¶ 141.

WFC argues that not all of the comparator plans listed both service codes 12 and 13 (as the Plan did). *See* MTD at 26 & n.11. But this is hardly a basis for seeking dismissal of the allegations. WFC *admits* that one of the comparator plans—the Railroad Employees National Health and Welfare Plan ("Railroad Plan")—listed both codes 12 and 13. *See id.*

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[24] WFC states that it also listed service code 50 (direct payment from plan). MTD at 26 n.11. But this is hardly a basis for distinguishing the Plan. *See Mator*, 102 F.4th at 186 ("[I]t is unclear why the code 'Direct payment from the plan' exists at all, since every dollar reported on this part of Form 5500 is 'direct compensation paid by the plan.'"). The comparator plans all indicated that the compensation they paid to Express Scripts was "direct compensation" and further indicated that they were *not* making *in*direct payments. *See* ECFs 32-6 through 32-10 at Schedule C § 2, columns (d) & (e).

& ECF 32-10. The Railroad Plan only paid Express Scripts $19.86 per participant – less than 15% of what the Plan paid. Compl. ¶ 141. This massive disparity supports an inference that WFC was not paying adequate attention to the administrative fees paid by the Plan.

Further, the fact that the lowest reported cost among all comparator plans was for the Railroad Plan, which listed *both* codes 12 and 13, shows that the differentials in cost are not attributable to differences in services. Indeed, for purposes of the PBM services provided by Express Scripts, codes 12 and 13 are synonymous – as "contract administrator" (code 13), Express Scripts provided "claims administration" services (code 12). *See* Compl. ¶ 52 (stating that "[m]any plan fiduciaries ***contract*** with [PBMs] to help … ***administer***" prescription drug benefits, and that the PBM's duties as contract administrator include "***processing claims***") (emphasis added). It is therefore understandable that some Plans reported those services under code 12, others under code 13, and others under both.

In summary, there is sufficient overlap that the differences in service codes do not undermine Plaintiffs' claims. *See Mator*, 102 F.4th at 186 ("The different service codes do not undermine the [plaintiffs'] comparisons because they apparently overlap."); *Lucero v. Credit Union Ret. Plan Ass'n*, 2023 WL 2424787, at *4 (W.D. Wis. Mar. 9, 2023) ("The codes listed by the other plans are not identical to defendants' codes, but there is substantial overlap"); *accord Kistler v. Standley Black & Decker, Inc.*, 2024 WL 3292543, at *18 (D. Conn. July 3, 2024) (The service codes on the Form 5500s for the Plan show that the Plan received relatively basic RK&A services … for all relevant years.").

Eighth Circuit law is fully aligned with the Third Circuit's decision in *Mator* and the other cases cited above. *See Barrett v. O'Reilly Auto., Inc.*, 112 F.4th 1135, 1140 (8th

Cir. 2024) (differences in service codes do not automatically warrant dismissal of fiduciary breach claim; claims could have proceeded if there "[h]ad there been allegations that 'the services purchased were sufficiently similar to render the comparisons valid'") (quoting *Mator*).[25] And Plaintiffs expressly allege that the services were similar here. *See* Compl. ¶ 141. Moreover, Plaintiffs have explained any differences in service codes, which are minimal, unlike the plaintiffs in *Barrett*. At best, WFC raises a fact issue for another day. *See Garnick v. Wake Forest Univ. Baptist Med. Ctr.*, 629 F. Supp. 3d 352, 363 (M.D.N.C. 2022) (declining to dismiss claim regarding excess fees based on purported differences in service codes).

c. Steering to a High-Cost Pharmacy Affiliated with Express Scripts

WFC further mismanaged the Plan by steering participants toward Express Scripts' mail-order pharmacy, Accredo, despite Accredo's prices being substantially higher than those of other pharmacies. Compl. ¶¶ 134-38. The Plan documents state that "Specialty medications must be filled through Accredo, your specialty pharmacy," with the explicit assertion that these medications are "not covered" at any retail pharmacy. *Id*. at ¶ 137.

No prudent fiduciary would allow, much less force, plan participants to fill prescriptions at a pharmacy that routinely charges substantially *more* than other widely-used retail pharmacies. *Id.* ¶ 138. While "steering" can significantly reduce healthcare costs

[25] *See also Mator*, 102 F.4th at 188 ("We agree with our sister Circuits' articulation of the relevant law" (citing, *inter alia*, *Matousek v. MidAmerican Energy Co.*, 51 F.4th 274, 278-79 (8th Cir. 2022)).

if participants are guided to lower-cost pharmacies, WFC did exactly the opposite. *Id.* at ¶ 136. WFC conspicuously offers no justification for this contract provision. Plaintiffs' steering allegations further support their breach of fiduciary duty claim. *See Tussey*, 2007 WL 4289694 at *1-2 (plaintiffs stated plausible breach of fiduciary duty claim against plan sponsor for "allowing Fidelity Trust to steer the Plan toward expensive Fidelity funds which in turn paid Fidelity Trust for the business").

3. Wells Fargo's Argument That Plaintiffs Cannot Assert an Individual Claim for Fiduciary Breach Is Repetitive and Meritless

WFC's argument that the Complaint does not plausibly allege an individual claim for fiduciary breach is repetitive of its standing arguments, and meritless. WFC contends that the alleged harm to Plaintiffs from increased premiums is "speculative." MTD at 28. As explained above, however, the Complaint plausibly alleges harm to Plaintiffs. *See supra* at § I.A.1. WFC also asserts that "an inference of fiduciary breach cannot be drawn from the experiences of a small subset of participants who purchased a handful of drugs." MTD at 28. But Plaintiffs' breach of fiduciary duty claims are based on far more than just their allegations about the prices they personally paid for their prescriptions—they are based on extensive allegations concerning pervasive drug overcharges to the Plan and its participants writ large, additional overcharges for administrative fees, and imprudent steering toward Express Scripts' higher-cost pharmacy. *See supra* at 4-6.

CONCLUSION

For the foregoing reasons, WFC's motion to dismiss should be denied.[26]

Respectfully Submitted,

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[26] In the alternative, Plaintiffs respectfully request leave to replead and an opportunity for any necessary jurisdictional discovery.

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