No. 26-1620

THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

SERGIO NAVARRO, THERESA GAMAGE,
DAYLE BULLA, JANE KINSELLA, and ERICA McKINLEY,
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-Appellants

v.

WELLS FARGO & COMPANY,

Defendant-Appellee.

On Appeal from the United States District Court
for the District of Minnesota
No. 24-cv-3043 (LMP/DLM)

BRIEF OF *AMICUS CURIAE* CHRIS DEACON IN SUPPORT OF APPELLANTS AND REVERSAL

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STATEMENT OF INTEREST OF AMICUS CURIAE

Amicus Chris Deacon is a healthcare policy expert. She previously served as Assistant Director of the Division of Pensions and Benefits, Department of Treasury, in charge of State Employee and School Employee Health Benefits Programs for the State of New Jersey, where she was responsible for coverage for more than 820,000 public employees, retirees, and their families. In that role, she oversaw large-scale contracting with third-party administrators and pharmacy benefit managers and was directly responsible for stewarding public plan assets in the employer-sponsored market.

Ms. Deacon now advises labor-management health funds, state and municipal governments, non-profit policy organizations and large self-funded employers across the country. She has testified before the United States Senate Committee on Health, Education, Labor, and Pensions, United States House Committee on Aging, and the *United States House of Representatives Committee on Education and Workforce, Subcommittee on Health, Employment, Labor* on the subject of healthcare affordability and the structural opacity that impairs employer oversight.

Drawing on her experience administering and advising large self-funded plans, Ms. Deacon submits this brief to assist this Court in understanding how self-funded plans operate, and in particular how a plan's pricing decisions impact plan participants.[1]

[1] All parties have consented to the filing of this brief. Fed. R. App. P. 29(a)(2). No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund preparing or submitting this brief; and no person other than amicus curiae or her counsel contributed money intended to fund preparing or submitting this brief. Fed. R. App. P. 29(a)(4)(E).

PRELIMINARY STATEMENT

This case asks a question that should be easy: when a self-funded plan participant pays more than she should have for a prescription drug, does that plan participant suffer an injury? The district court effectively answered no. Faced with the Plaintiffs' allegations that they paid too much for a variety of charges, the district court dismissed their allegations as too speculative to constitute a concrete injury.

The district court erred by equating self-funded plans, like the one at issue here, with defined-benefit plans. *See Navarro v. Wells Fargo & Co.*, No. 24-cv-3043, 2026 U.S. Dist. LEXIS 42932, at *20 n.5 (D. Minn. March 3, 2026) (stating that the self-funded Wells Fargo & Company Health Plan is "closely analogous to the defined-benefit plan at issue" in *Thole v. U.S. Bank N.A.*, 590 U.S. 538, 542–43 (2020)). In a self-funded health plan, participants and employers jointly pay for benefits through premiums, deductibles, and variable-cost sharing imposed at the point-of-sale. This makes self-funded plans unlike defined-benefit plans, where participants generally receive a fixed benefit and are ordinarily insulated from transaction-level fluctuations in plan spending. By lumping self-funded plans with defined-benefit plans, the district court failed to

grapple with how pricing decisions in a self-funded plan affect plan participants.

The distinction between these two types of plans matters here. The district court analyzed the alleged injury through a plan-level frame, reasoning that Plaintiffs' alleged overpayments did not establish standing unless they plausibly affected Plaintiffs' contractually defined benefits, contribution obligations, or the Plan's ability to provide benefits. But in a self-funded health plan, participant-level costs arise transaction by transaction. Understanding that feature of self-funded plans helps explain why allegations of overpayment in this setting do not fit neatly within frameworks developed for plans in which participants receive fixed benefits largely unaffected by the pricing of individual claims.

In short, the district court's analysis rests on a conceptual error. It treats a self-funded health plan as if participant injury can only be understood at the level of aggregate plan spending, rather than at the level where participants actually experience cost—the transaction. This amicus brief explains why that error undercuts the district court's standing analysis.

I. How Self-Funded Plans Work

A self-funded health plan is not an insurance product in which an employer simply pays a fixed premium to an insurer and transfers the risk away. Instead, in a self-funded plan, expenses are shared between the employer and participants, who pay premiums, deductibles, and copayments. Self-funded health plans are common. KFF, a widely respected non-profit that focuses on health policy, reported that in 2025, 67% of covered workers were enrolled in self-funded plans. KFF, *2025 Employer Health Benefits Survey: Summary of Findings,* at 11. At firms with two hundred or more workers, more than 80% of covered workers are enrolled in self-funded plans. *Id.* Thus, the legal regime governing self-funded plans affects large swaths of Americans.

a. Employers typically outsource management of their plan to third-party providers.

Employers typically do not administer self-funded plans entirely on their own. Rather, employers commonly delegate day-to-day administrative functions to third-party service providers with which they have contracted. These third-party service providers may be contracted to perform any number of services, including, for example, paying claims, resolving disputes, and negotiating payment rates. Although these third

parties manage many aspects of the plan, it remains the employer's duty, as plan fiduciary, to ensure that they are doing so responsibly.

Pharmacy benefit managers ("PBMs") are a category of third-party service providers that are pertinent to this dispute. "PBMs are described as the 'middlemen' in the pharmaceutical supply chain. For ERISA-covered self-insured group health plans, PBMs perform a wide range of services including, but not limited to, organizing pharmacy networks, negotiating pharmacy reimbursement amounts and drug rebates, establishing drug formularies, and processing claims." Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure, 91 Fed. Reg. 4,348, 4,348 (proposed Jan. 30, 2026). These middlemen have been the subject of much scrutiny for playing a role in increasing drug prices. Meredith Freed, *What to Know About Pharmacy Benefit Managers (PBMs) and Federal Efforts at Regulation,* KFF (Feb. 9, 2026), available at https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/.

PBMs are not merely neutral claims processors. Modern pharmacy-benefit arrangements often operate within vertically integrated structures in which what appears to be a negotiation between separate

actors may in fact involve affiliated payers, PBMs, pharmacies, and rebate-aggregation entities. Recent investigative reporting has described similar structures involving affiliated PBM entities that reportedly aggregate rebate negotiations and route rebate-related revenue through subsidiaries, making it difficult for plan sponsors to audit or even identify them. Laura Wadsten & Nathaniel Horwitz, *"Bullshit" — The New Way Health Giants Hide Billions,* Hunterbrook (Jan. 6, 2026). Yet that opacity does not relieve plan fiduciaries of their obligation to prudently monitor the PBMs with which they contract, including whether those arrangements serve participants' interests.

b. Self-funded plans expose participants to pricing decisions.

Unlike a defined-benefit plan, where the participant's entitlement is ordinarily fixed and does not rise or fall with each plan expenditure, a self-funded health plan exposes participants to transaction-level pricing decisions throughout the year. *See* U.S. Dep't of Labor, *Report to Congress: Annual Report on Self-Insured Group Health Plans* at 4–5 (2025) (explaining that, in self-insured plans, the employer or plan pays covered health expenses directly as claims are incurred, rather than shifting that risk to an outside insurer). In employer health coverage,

participants commonly bear deductibles, copayments, and coinsurance in real time; KFF reports that 88% of covered workers with single coverage are in plans with a general annual deductible, and hospital coinsurance requirements remain common as well. KFF, *2025 Employer Health Benefits Survey: Summary of Findings,* at 11–12 (2025). Those features mean that participants are not economically insulated from the plan's pricing structure; they are charged under it, often at the moment they obtain care.

That is particularly true on the pharmacy side. PBMs often design pharmacy networks, manage formularies, and adjudicate prescription claims electronically at the point of sale. The Federal Trade Commission explains that PBMs create pharmacy networks through their contracts with pharmacies and may use network design, including narrow or preferred networks, to steer patients toward particular pharmacies, including affiliated ones. Fed. Trade Comm'n, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies* at 10–13 (2024). The FTC further explains that, "[a]t the point of sale," the pharmacy submits the claim through the PBM's adjudication engine, and "the health plan's design determines the

amounts charged to the patient and plan sponsor." *Id.* at 55. It is at that same point of sale, rather than the plan's aggregate annual accounting, that a participant experiences the consequences of the plan's pricing arrangements with its PBM.

II. Plan Participants May be Injured by Imprudent Management of Self-Funded Health Plans

In a self-funded health plan, participants incur financial obligations in discrete transactions. A participant pays premiums at set intervals and, when seeking care, pays out-of-pocket amounts such as deductibles, copayments, and coinsurance that are directly a function of the plan's pricing arrangements with its service providers. When those pricing arrangements require a participant to pay more than she otherwise would have paid under a prudent arrangement, the participant experiences an economic loss at that moment. That loss is concrete and particularized to her individually, and it is complete—not speculative or contingent on future events—when the payment is made.

The existence of other plan payments does not alter that conclusion, nor does the fact that Wells Fargo had discretion over the plan's overall design. Self-funded plans do not operate on a netting principle across

unrelated claims. A participant's obligation to pay an inflated price for one prescription drug is not reduced or offset because the plan later pays for unrelated medical services elsewhere, or because Wells Fargo enjoys the discretionary authority to set rates in the first place.

An analogy illustrates the point. If a customer is charged $10 for an item that should have cost $5, the customer has suffered an economic injury at the point of purchase. That injury is not undone because the customer later buys other items at a discount or receives value elsewhere in the store. Each transaction is separate, and the overcharge remains.

The same is true here. Prescription drug claims are adjudicated in real time under the plan's pricing structure. The pharmacy counter is the point of purchase and the price the PBM's adjudication system assigns to the claim is the price tag. If that price requires a participant to pay more than she otherwise would have paid under a prudently negotiated arrangement, that overcharge is a concrete, particularized injury the moment it is incurred, regardless of other benefits the plan may provide in the same year or the fact that the employer has discretion over the plan. The presence of unrelated plan payments does not transform a

discrete overcharge into a non-injury any more than a discount on a different item transforms an overcharge at the register.

III. The District Court's Misunderstanding of Self-Funded Plans Affected its Analysis

The district court did not reject Plaintiffs' allegations on the merits. It did not hold that the prices alleged in the Complaint were reasonable or that the challenged plan design benefited participants. Instead, it held that Plaintiffs, despite alleging that they overpaid for prescription drugs, Doc. 64, Amended Complaint ¶¶ 219–28, did not adequately allege an injury. Op. at 9–15.

The district court's holding rests on a categorical premise that does not withstand scrutiny: that the Wells Fargo & Company Health Plan is "closely analogous to the defined-benefit plan at issue in *Thole II*," Op. at 9–10, and that participants therefore are "entitled to their contractually defined benefits regardless of the value of the [Plan's] assets." *Id.* That premise drove the court's conclusion that Plaintiffs were not injured even though they paid more out of pocket for their prescriptions than they would have under a prudent arrangement—because, in the court's view,

they received all the benefits they were contractually promised and had "no claim to any particular asset" of the plan. Op. at 14–15.

That analogy is inapt. In *Thole II,* the Supreme Court addressed a defined-benefit pension plan that promised participants a fixed monthly retirement benefit. *Thole v. U.S. Bank N.A.,* 590 U.S. 538, 542–43 (2020). The participants' entitlement was a sum certain, unaffected by how well or poorly the plan was managed. Thus, participants' benefits were not affected by mismanagement unless it threatened the plan's ability to pay that fixed amount. That reasoning does not extend to a self-funded health plan, where the participant's benefit is not a fixed sum, but rather coverage of medical services and prescription drugs on cost-sharing terms set by reference to the plan's agreed prices. Unlike a pension benefit, a self-funded health plan's cost-sharing terms are not fixed independently of the plan's pricing arrangements. Thus, when the plan agrees to an inflated price for a prescription drug, that inflated price is what the participant owes under her deductible or coinsurance.

Therefore, the district court's conclusion that Plaintiffs received their "contractually defined benefits" and suffered no injury conflates two distinct things: *coverage* (whether the prescription was covered) and *cost*

(what the participant paid for that coverage). In a self-funded health plan, the participant's financial obligation for a covered prescription is not fixed separately from plan pricing—it is determined by the plan price at which the claim is adjudicated. If the Plan agreed to $100 for a drug with a $20 acquisition cost, the participant who has not met her deductible pays $100. If the plan had instead agreed to $25 for the same drug, she pays $25. In both cases, she received exactly her "contractually defined benefit"—her prescription was covered under her plan. But in the first case, she paid $75 more from her own pocket. That difference is a concrete, individualized financial injury. It is not a claim that she deserved better benefits than she received; it is a claim that she overpaid for the benefits she actually got, because the plan's pricing was imprudent.

The district court's analysis departs from the basic framework of self-funded plans, described above. It evaluates Plaintiffs' alleged harm primarily by reference to aggregate plan features, including total benefits paid in a given year and the multiple factors that may influence premiums. Op. at 10. In doing so, the court treated this self-funded health plan too much like a pension or generalized pool of assets and not what

it actually is: a benefits arrangement in which participants bear cost-sharing directly and continuously, paying premiums and deductibles before plan sharing begins. Participant costs rise and fall with plan pricing decisions made in real time; they are not fixed contractual entitlements insulated from how the plan is managed.[2]

The Complaint alleges precisely this kind of harm: that Plaintiffs paid more than they otherwise would have paid for certain prescription drugs because of the plan's pricing design and PBM arrangements with Express Scripts. Doc. 64, Amended Complaint ¶¶ 219–28. Those allegations describe transaction-level overcharges—specifically, discrete financial obligations incurred at the point of sale, from the participants'

[2] The Complaint itself alleges exactly that structure. It alleges a self-funded plan in which expenses are shared by Wells Fargo and participants, with claims paid from plan assets rather than by a third-party insurer. Doc. 64, Amended Complaint ¶¶ 22, 30. It further explains that when a plan participant obtains a prescription drug, the PBM pays the pharmacy for the cost of the drug less the participant's out-of-pocket responsibility, and then collects payment from the plan. *Id.* ¶ 54. It further alleges that participants are responsible for the full cost of covered drugs until meeting their deductible—paying inflated prices out-of-pocket at the pharmacy counter—and that coinsurance is calculated as a percentage of the plan's agreed price. *Id.* ¶ 106. The court nevertheless concluded that these out-of-pocket costs were not cognizable injuries because participants received their "contractually defined benefits." Op. at 14–15.

own funds. The district court discounted those allegations by holding that, because participants received their contractually defined benefits, any overcharge amounted to injury only to the plan, not to Plaintiffs individually. Op. at 14–15. In effect, the court treated the plan's imprudent pricing as an injury exclusively to the plan's asset pool, while ignoring the corresponding out-of-pocket harm to individual participants.

IV. The Alleged Overcharges Are Sufficient to Establish Article III Injury

Viewing self-funded plans correctly, it is clear that the allegations in the Complaint are sufficient to establish Article III injury. Plaintiffs allege that they paid more than required for specific prescription drugs as a result of the plan's pricing structure and PBM arrangements with Express Scripts. Doc. 64, Amended Complaint ¶¶ 219–28. Those allegations describe concrete, out-of-pocket payments made by identified participants in discrete transactions—each Plaintiff obtained specific prescriptions for which Wells Fargo had agreed to prices substantially above pharmacy acquisition cost, and each Plaintiff was required to pay the inflated price, in whole or in part, at the pharmacy counter. As explained above, in a self-funded health plan, such payments constitute

economic injury at the moment they are incurred. That injury does not depend on aggregate plan performance, the total value of benefits received in a given year, or whether other factors also influence participant costs.

The district court concluded that even if the Plan's assets were diminished by imprudent pricing, that constitutes "an injury only to the Plan, not to Plaintiffs," because Plaintiffs "do not have any claim to the Plan's assets." Op. at 15 (citation omitted). But this reasoning does not address the out-of-pocket injury Plaintiffs allege. A participant's out-of-pocket payment at the pharmacy counter does not come from the Plan's assets—it comes from her own funds. When the plan's pricing structure requires her to pay $100 for a drug that should have cost $25 under a prudent arrangement, she has paid $75 of her own money that she would not otherwise have paid.

Whether Plaintiffs' allegations can ultimately be proved is a merits question. But the court's decision to discount those allegations by reference to unrelated annual plan spending reflects a misunderstanding of how premiums, cost sharing, deductibles, and point-of-sale pricing interact in the real world of employer-sponsored health coverage.

This is not a marginal concern. Participants in self-funded plans have no ability to negotiate the prices charged for their care, no visibility into the arrangements that set those prices, and no alternative source of coverage to turn to when those arrangements are imprudent. They absorb the cost twice — once at the pharmacy counter, and again in the wages and premium contributions that fund the plan itself. The fiduciary duty of prudence exists precisely because participants cannot protect themselves through negotiation or exit; it is the mechanism by which the law requires someone else to act on their behalf. Standing to enforce that duty is not a formality. If participants who pay inflated prices at the point of sale cannot be heard to complain of that injury, then the prudence requirement becomes unenforceable by the very people it was designed to protect, and self-funded plans become, in practice, self-policing. Holding fiduciaries accountable for the pricing decisions that reach participants' own pockets does not just resolve this case—it restores the incentive that the statute was designed to create.

CONCLUSION

For the foregoing reasons, the Court should hold that, at the very least, Plaintiffs' complaint adequately alleges that they were injured by

Defendant's imprudent management of Plaintiffs' self-funded health plan. ERISA's fiduciary duties exist because participants cannot bargain for themselves. They cannot negotiate the price of a prescription at the counter, and they cannot see the arrangements struck on their behalf long before they ever arrive there. The duty of prudence was meant to stand in for that missing leverage. If imprudent pricing decisions that reach directly into participants' own pockets are not injuries participants may bring to court, then that duty has no one left to answer to. The more than two-thirds of covered American workers, and more than 80% of workers at large firms, who depend on self-funded plans for their healthcare are entitled to more than a promise of prudence. They are entitled to a means of enforcing it.

DATED: July 2, 2026

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), counsel certifies that this brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(a)(5) because it contains 3,290 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Century Schoolbook.

Counsel further certifies that the electronic version of this brief has been scanned for viruses and is virus-free.

DATED: July 2, 2026

/s/ Jeremy Shur

CERTIFICATE OF SERVICE

I certify that on July 2, 2026, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ Jeremy Shur
Jeremy Shur