No. 26-1620

In the United States Court of Appeals
for the Eighth Circuit

SERGIO NAVARRO, ET AL.,

Plaintiffs-Appellants,

v.

WELLS FARGO & COMPANY,

Defendant-Appellee.

On Appeal from the United States District Court
for the District of Minnesota
No. 0:24-CV-03043

BRIEF OF AMICUS CURIAE PATIENTRIGHTSADVOCATE.ORG, INC., IN SUPPORT OF APPELLANTS AND REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Amicus Curiae, PatientRightsAdvocate.org, Inc., is a nonprofit corporation. It does not have a parent corporation, and no publicly held corporation owns 10% or more of its stock.

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IDENTITY AND INTEREST OF THE *AMICUS CURIAE*

PatientRightsAdvocate.org, Inc. (PRA) is a 501(c)(3) non-profit, non-partisan organization that provides a voice for consumers—patients, employees, employers, and taxpayers—to have competition, transparency, and meaningful choices in healthcare.[1] PRA advocates for patients to have easy, real-time access to complete health information and real price transparency. And PRA supports employer access to all pricing, billing, and payment information. This will help employers negotiate better contractual rates for workers and their families, lowering out-of-pocket costs and preventing increases in premiums. PRA further supports patients and employers in ensuring that health plan assets are spent prudently, transparently, and in the best interests of plan participants. PRA believes that plan fiduciaries must be held accountable when plan assets are wasted or the plan's service providers are not adequately monitored.

PRA embraces free market principles. We believe that price transparency will foster a competitive, functional marketplace and restore trust and accountability to the healthcare system. When consumers and employers have access to prices, they can lower costs through: (1) identifying the wide price variation and being empowered with choice; and (2) comparing itemized bills to prices to prevent overcharges, errors, and fraud. Our website, PatientRightsAdvocate.org, shines a light on the problem and the

[1] No party's counsel authored this brief in whole or in part. No person, party, or party's counsel other than the PRA, its members, and its counsel contributed money intended to fund preparing or submitting this brief. All parties have consented to the filing of this brief.

free-market solution. It features patients and innovative employers who are already saving substantially by using price-transparent providers.

PRA submits this brief on behalf of consumers and patients to ensure that their interests are represented in this critically important case. Patients are harmed by inflated drug prices, which increase their out-of-pocket costs at the pharmacy counter and their monthly premiums. PRA has extensive experience with healthcare-related issues and has participated as *amicus curiae* in prior litigation germane to its interests, including ERISA litigation. *See*, *e.g.*, *Lewandowski v. Johnson & Johnson*, No. 26-1107 (3d Cir.); *Massachusetts Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Massachusetts*, 66 F.4th 307 (1st Cir. 2023); *Am. Hosp. Ass'n v. Azar*, 983 F.3d 528 (D.C. Cir. 2020).

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Congress enacted ERISA to hold plan fiduciaries accountable to plan participants when plan assets are mismanaged. That is why Plaintiffs brought this lawsuit. They allege that the sponsor of their health plan—their former employer, Wells Fargo—violated its fiduciary duties of prudence and loyalty to them, the "highest [duties] known to the law." *Donovan v. Bierwirth*, 680 F.2d 263, 272 n.8 (2d Cir. 1982). Wells Fargo outsourced the purchase of prescription drugs to a Pharmacy Benefit Manager—Express Scripts—yet it failed to supervise and monitor Express Scripts to ensure it was charging fair prices. *See Tibble v. Edison Int'l*, 575 U.S. 523, 528-29 (2015); Jeffrey M. Harris*, Using ERISA to Ensure Transparent Health Care Prices*, 36 ABA J. Lab. & Emp. L.

323, 338-39 (2022) (discussing ERISA duties with respect to health plans). Because of these imprudently marked-up prices, Plaintiffs paid more for their healthcare.

Whatever the ultimate merits of Plaintiffs' claims—and the Amended Complaint suggests these claims are highly meritorious—this is a classic case or controversy that belongs in federal court. Yet the District Court disagreed. It twice dismissed Plaintiffs' complaint at the outset, on the novel theory that Plaintiffs' traditional pocketbook injury—being overcharged for healthcare—was not legally cognizable. *See Navarro v. Wells Fargo & Co.*, 2026 WL 591454, at *8-11 (D. Minn. Mar. 3, 2026); *Navarro v. Wells Fargo & Co.*, 2025 WL 897717, at *5-12 (D. Minn. Mar. 24, 2025). In doing so, it refused to credit the Plaintiffs' allegations about the baseline against which to measure their financial injury. It required allegations that Defendant's illegal conduct was the sole cause—rather than a concurrent cause—of Plaintiffs' injury. And it ignored how the addition of a new plaintiff affected its original standing analysis. This Court should correct these errors, lest the "remedial scheme of the statute … fail, and the crucial rights secured by ERISA … suffer." *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 598 (8th Cir. 2009).

ARGUMENT

I. The District Court erred in holding that Plaintiffs lacked standing.

To have standing, a plaintiff must allege: (1) an injury in fact that is (2) fairly traceable to the challenged action of the defendant and (3) likely to be redressed by a favorable decision. *See Tyler v. Hennepin Cnty., Minnesota*, 598 U.S. 631, 636 (2023). In applying this test, the District Court did not undertake the "careful and holistic evalua-

tion of an ERISA complaint's factual allegations" that this Court's precedent requires. *Braden*, 588 F.3d at 598.

A. Injury

"In the context of a motion to dismiss, the injury-in-fact element is not Mount Everest." *Falcone v. Dickstein*, 92 F.4th 193, 203 (3d Cir. 2024). So Plaintiffs "need only allege 'some specific, identifiable trifle of injury.'" *Id.* Indeed, at this stage a plaintiff "can move forward with general factual allegations of injury." *Iowa League of Cities v. EPA*, 711 F.3d 844, 869 (8th Cir. 2013). Plaintiffs plausibly allege that they have "suffered a traditional pocketbook injury." *Bost v. Illinois State Bd. of Elections*, 146 S. Ct. 513, 523 (2026) (Barrett, J., concurring).

Plaintiffs say that Wells Fargo's breach of fiduciary duties made them pay more in drug costs—both in monthly contributions and in out-of-pocket costs at the pharmacy counter—than they otherwise would have paid. Am. Compl. ¶217, ¶229. "This is a classic pocketbook injury sufficient to give [them] standing." *Hennepin Cnty.*, 598 U.S. at 636. A "participant in a self-funded healthcare plan" can allege as a cognizable Article III injury that "mismanagement of plan assets increased his[] out-of-pocket expenses." *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 579 (3d Cir. 2024). And "alleged economic harm—even if only a few pennies each—is a concrete, non-speculative injury." *Wallace v. ConAgra Foods, Inc.*, 747 F.3d 1025, 1029 (8th Cir. 2014). Here, each Plaintiff has alleged far more than a few pennies' worth of economic harm. Am. Compl. ¶¶219-28,

¶¶256-60. "The amended complaint thus alleges an injury that is actual, concrete, and particularized." *Enter. Fin. Grp., Inc. v. Podhorn*, 930 F.3d 946, 950 (8th Cir. 2019).

This case is distinct from *Wallace*, which dismissed a complaint for lack of an actual, particularized injury. *See Wallace*, 747 F.3d at 1030. The plaintiffs there sued a hotdog producer for advertising its hotdogs as "100% kosher"—and charging more for these "kosher" hotdogs—when some of the hotdogs so labeled were not kosher at all. *See id.* at 1027-28. Plaintiffs lacked standing because they claimed no particularized injury: they did not allege that the specific hotdogs *they* purchased were non-kosher. Indeed, they "frankly admit[ted] 'it [was] impossible for any reasonable consumer to detect'" whether the hotdogs were kosher or not. *Id.* at 1030. "Without any particularized reason to think the consumers' own packages of … beef actually exhibited the … defect, the consumers lack Article III standing." *Id.*

The allegations here could not be more different. Unlike the *Wallace* complaint, the Amended Complaint painstakingly details the specific purchases where each of the Plaintiffs experienced injury. Am. Compl. ¶¶219-28. For example, Plaintiff Navarro alleges that in August 2023 he purchased a specific drug that was marked up three times higher than its acquisition cost. Am. Compl. ¶220. And Plaintiff McKinley identifies an October 2024 purchase where she paid double for a 9-tablet prescription. ¶228. Unlike the *Wallace* plaintiffs, these Plaintiffs point to particularized purchases where they experienced actual harm from Defendant's unlawful conduct.

It is no obstacle to standing that Wells Fargo supposedly had "'sole discretion' to set participant contribution rates." *Navarro*, 2026 WL 591454, at *8.[2] When a plaintiff alleges he was overcharged for a product, he has experienced a cognizable Article III injury, even when the seller had discretion to set the product's price. "A buyer who is induced to pay an unlawfully inflated price for goods or services obviously suffers an actual injury—an 'injury in fact.'" *Cnty. of Oakland v. City of Detroit*, 866 F.2d 839, 845 (6th Cir. 1989). "[F]inancial injuries are prototypical of Article III injuries, meaning that paying inflated prices due to [allegedly unlawful conduct] will satisfy injury-in-fact." *Marion Diagnostic Ctr., LLC v. Becton Dickinson & Co.*, 29 F.4th 337, 345 (7th Cir. 2022); *see also Speerly v. Gen. Motors, LLC*, 143 F.4th 306, 314 (6th Cir. 2025) (en banc) (collecting cases).

Take a common case: a buyer alleges "she spent money to purchase sunscreen products [that] she … [would have] paid less for, absent Defendants' misconduct." *Bowen v. Energizer Holdings, Inc.*, 118 F.4th 1134, 1144-45 (9th Cir. 2024). "These allegations outline a theory of economic injury that qualifies as an injury in fact under established Article III standing caselaw." *Id.* at 1147. That is so even though the seller has discretion to set the price of sunscreen. Or take another example. A car manufacturer requires a dealership to pay additional "out of pocket expenses" to buy its cars: "There can be no doubt that this financial harm counts as injury-in-fact." *Danvers Motor Co. v.*

[2] Of course, any such discretion was bounded by Wells Fargo's fiduciary duties under ERISA.

Ford Motor Co., 432 F.3d 286, 292 (3d Cir. 2005) (Alito, J.). That is so even though the manufacturer could always just choose to charge more for its cars in the first place.

When consumers allege they were unlawfully overcharged, the baseline—overcharged relative to what?—is often determined by the market. The market price can set the baseline across a range of different overcharge cases. Take false advertising. A plaintiff had standing to sue a grocery store for charging prices that were inflated relative to the weight of the food. *See John v. Whole Foods Mkt. Grp., Inc.*, 858 F.3d 732, 736–38 (2d Cir. 2017). Or take antitrust. A plaintiff had standing when allegedly unlawful anti-competitive behavior made him pay more for at least one drug purchase than he would have paid with competitive market pricing. *See In re Nexium Antitrust Litig.*, 777 F.3d 9, 16, 32 (1st Cir. 2015). Here, Plaintiffs have pleaded just that: due to Wells Fargo's breach of fiduciary duty, they paid more for specific drug purchases than the drugs were worth on a competitive market. Am. Compl. ¶3, ¶¶219-28.

That is not to say a plaintiff must plead the market value. "There are innumerable ways that a [plaintiff] can show economic injury." *Hinojos v. Kohl's Corp.*, 718 F.3d 1098, 1104 (9th Cir. 2013). In overcharge cases, it is sufficient that a court can draw "a reasonable inference that … the product would have commanded a lower price" but for the allegedly unlawful conduct. *In re Evenflo Co., Inc., Mktg., Sales Pracs. & Prods. Liab. Litig.*, 54 F.4th 28, 40 (1st Cir. 2022). According to Plaintiffs, Wells Fargo had a consistent policy of setting participant contributions at a quarter of the total Plan health care costs. Am. Compl. ¶240. Plaintiffs' Amended Complaint backs this allegation up

by citing past practice and statistical evidence. Am. Compl. ¶¶240-42. From these well-pleaded allegations, a court can reasonably infer that the total Plan costs—and thus the amount of participant contributions—would have been less if Wells Fargo had not breached its fiduciary duties by permitting pervasive overcharges. Am. Compl. ¶3. In other words, the cost of the benefits provided under the health plan would have been lower but for the breach of fiduciary duty. *See Evenflo*, 54 F.4th at 40.

In concluding that Plaintiffs pleaded no injury, the District Court conflated standing with the merits and failed to apply the plausibility standard that governs this stage of the proceedings. *See Navarro*, 2026 WL 591454, at *10. This was error. "[I]t is crucial not to conflate Article III's requirement of injury in fact with a plaintiff's potential causes of action, for the concepts are not coextensive," and "the ultimate merits of the case have no bearing on the threshold question of standing." *Carlsen v. GameStop, Inc.*, 833 F.3d 903, 909 (8th Cir. 2016). *See also Wilson v. Centene Mgmt. Co.*, 168 F.4th 217, 229 (5th Cir. 2026) ("The district court's standing determination was, in substance, a determination on the merits of the 'overcharge-by-fraud' theory.")

The District Court also erred by treating Article III injury in the ERISA context as unique—and distinct from the allegation of economic injury in any other context. *See Navarro*, 2026 WL 591454, at *11 ("The cases on which Plaintiffs rely … did not involve ERISA claims."). This error "make[s] standing law more complicated than it needs to be." *Thole v. U.S. Bank N.A.*, 590 U.S. 538, 547 (2020). "There is no ERISA exception to Article III." *Id.* And "under ordinary Article III standing analysis," *id.*, "overpaying

for a product results in a financial loss constituting a particularized and concrete injury in fact." *Whole Foods*, 858 F.3d at 736. That is so when the defendant allegedly violated its duties under consumer protection or antitrust statutes—and when the defendant allegedly violated its duties under ERISA.

B. Traceability

Under Article III, "the plaintiff must have suffered an injury in fact … that is fairly traceable to the challenged conduct." *Biden v. Nebraska*, 600 U.S. 477, 489 (2023). The burden of pleading traceability is "relatively modest at this stage of the litigation." *In re SuperValu, Inc.*, 870 F.3d 763, 772 (8th Cir. 2017). It is a "low threshold" that is "akin to but-for causation, not proximate causation." *Adam v. Barone*, 41 F.4th 230, 235 (3d Cir. 2022); *see also Walters v. Fast AC, LLC*, 60 F.4th 642, 650 (11th Cir. 2023) (same); *Balogh v. Lombardi*, 816 F.3d 536, 543 (8th Cir. 2016) (similar). Indeed, "[a]n indirect causal relationship will suffice." *Mielo v. Steak 'n Shake Operations, Inc.*, 897 F.3d 467, 481 (3d Cir. 2018). And although a plaintiff's burden may be "heavier" at summary judgment, it is not "stringent" at the pleadings stage. *Id.*

Plaintiffs have easily satisfied this standard by pointing to two distinct economic injuries: (1) increased out-of-pocket costs for specific drugs; and (2) increased monthly contributions. They allege they paid more because Wells Fargo outsourced cost-setting to a profit-driven Pharmacy Benefit Manager that it then failed to adequately supervise. Am. Compl. ¶¶283-86, ¶¶290-93. Wells Fargo breached its "duty of prudence" as an ERISA fiduciary by "failing to properly monitor" Express Scripts. *Tibble*, 575 U.S. at

530. "This failure to monitor resulted in … overpayment to [Express Scripts] and corresponding losses to plan participants." *Ramos v. Banner Health*, 1 F.4th 769, 774 (10th Cir. 2021).

Plaintiffs have provided extensive allegations that individual drug prices for Wells Fargo plan participants were significantly marked up relative to pharmacy acquisition cost. *See, e.g.*, Am. Compl. ¶¶116-38. No prudent fiduciary would agree to such unjustified markups. *See id.* These inflated prices increased the out-of-pocket costs that plan participants paid at the pharmacy counter. Am. Compl. ¶¶217-28, 230-55. As Plaintiffs show by pointing to the specific drugs they purchased, the Wells Fargo plan's negotiated drug prices were significantly higher than what a person with no insurance would have paid, and Plaintiffs had to cover that inflated amount out of pocket. Am. Compl. ¶3, ¶¶217-28. Their injury is thus traceable to the decisions of Defendant.

The District Court concluded otherwise, reasoning that "participant contribution amounts may be affected by several [other] factors." *Navarro*, 2026 WL 591454, at *9. For starters, this does not affect traceability as to the specific drug purchases. That is because the plan participant's share of the cost for specific drug purchases is set by the cost-sharing terms in the plan documents. Am. Compl. ¶33. And regardless, the District Court failed to apply the correct standard. As circuit after circuit has held, "concurrent causation" is "sufficient to satisfy traceability." *New Jersey Bankers Ass'n v. Att'y Gen. New Jersey*, 49 F.4th 849, 855 n.1 (3d Cir. 2022); *see Est. of Parker v. Mississippi Dep't of Pub. Safety*, 140 F.4th 226, 236 (5th Cir. 2025) (same); *Washington Env't Council v. Bellon*, 732

F.3d 1131, 1142 (9th Cir. 2013) (same); *see also Wieland v. HHS*, 793 F.3d 949, 954 (8th Cir. 2015). If the court has "a modicum of confidence" that the defendant's unlawful conduct "is a concurrent cause" of plaintiff's alleged injury, that is enough. *Libertarian Party of Virginia v. Judd*, 718 F.3d 308, 316 (4th Cir. 2013).

Under this standard, it does not matter that there may be "many variables in how Plan participants' contribution rates are calculated." *Navarro*, 2026 WL 591454, at *9. It matters only that the alleged breach of fiduciary duty was one factor contributing to increased patient contributions. After all, the standing analysis is "limited to a screening for mere frivolity," and courts "must carefully separate [their] standing inquiry from any assessment of the merits of the plaintiff's claim." *Barone*, 41 F.4th at 234. The District Court again erred by conflating standing and the merits.

The District Court cited *Knudsen*, 117 F.4th 570, which dismissed a complaint for lack of standing. But that complaint does not resemble this one. In *Knudsen*, the plaintiffs advanced the following theory of standing: they "paid more for their health insurance because [the self-funded health plan] illegally kept $65 million in rebates instead of using those rebates to reduce Plaintiffs' out-of-pocket expenses." 117 F.4th at 578. The panel dismissed the complaint because plaintiffs failed to allege that drug rebates were "used to calculate Plan participants' out-of-pocket costs and that the effect of these inputs would decrease costs." *Id.* at 582. So it was "speculative" that the plan fiduciaries' unlawful conduct resulted in plaintiffs paying more for their health insurance. *Id.*

Here, by contrast, Plaintiffs carefully pleaded facts explaining how imprudent supervision of Express Scripts led them to pay higher costs. *E.g.* Am. Compl. ¶¶115-24. A prudent process—such as contracting with a pass-through Pharmacy Benefit Manager that had no incentive to charge the plan such absurdly marked-up prices, or negotiating with Express Scripts for lower drug prices—would have yielded lower prices for plan beneficiaries. Am. Compl. ¶¶163-75. That is because participants not only pay for a portion of their own drugs' price at the point of sale, but also cover a portion of the Plan's overall spending, and Wells Fargo "always set[] participant contribution levels at 25-26% of overall Plan health costs." Am. Compl. ¶240. So any increased cost to the plan results in a corresponding increase to the costs of plan participants. This is not speculation: Plaintiffs provide factual support for the allegation that employee contributions are set at a consistent percent of the costs to the plan. Am. Compl. ¶¶238-43. In other words, Plaintiffs pleaded that the plan's drug costs are "used to calculate" plan participants' out-of-pocket costs—precisely what the *Knudsen* plaintiffs failed to allege. 117 F.4th at 582.

In any event, the higher drug costs certainly affected Plaintiff McKinley's contribution. That is because she enrolled in COBRA, which requires participants to "pay the combined amount of employee and employer contributions." Am. Compl. ¶257. So regardless of whether Wells Fargo would have maintained the 75%-25% employer-to-employee split, McKinley had to pay the entire inflated cost of the healthcare. *Id.* As to McKinley, the question is not whether she "g[o]t all the benefits to which she was en-

titled" under the terms of the plan. *Navarro*, 2026 WL 591454, at *10. The question is whether Wells Fargo's allegedly imprudent supervision was a concurrent cause of her increased costs. Plaintiffs have alleged that it was, so they have standing. *See Rumsfeld v. FAIR*, 547 U.S. 47, 53 n.2 (2006).

In holding otherwise, the District Court cited *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 525 (9th Cir. 2023). But that case was concededly not "typical," and its distinctive "structural feature[s] … contribute[d] to plaintiffs' failure to sufficiently allege Article III standing" there. *Id.* at 523. The *Winsor* plaintiffs "leap-frog[ed] the [employer] plan and [were] seeking to recover … from … a management and insurance brokerage company that [wa]s a step removed from the contributions plaintiffs pay and the benefits they receive[d]." *Id.* at 523. Here, by contrast, causation is straightforward: Plaintiffs are directly suing their former employer Wells Fargo as sponsor of the self-funded Wells Fargo Plan. Am. Compl. ¶¶21-22.

In *Winsor*, a non-party—the employer—set the plaintiffs' contribution amounts. And, crucially, the *Winsor* complaint "[l]ack[ed] express factual allegations" that "[the employer] has changed or would change employee contribution rates based on [the broker's] alleged breaches of fiduciary duty, or that employee contribution rates are tied to overall premiums." 62 F.4th at 524. By contrast, these Plaintiffs explicitly pleaded that employee contributions were intentionally set at a quarter of the Plan health care costs. Am. Compl. ¶¶240-43. And, regardless, Plaintiff McKinley had to pay the combined amount of employee and employer contributions, meaning that the costs of Wells

Fargo's alleged breaches were all charged to her. This removes "the variable of [employer's] discretion in setting employee contribution rates," making traceability simple. *Winsor*, 62 F.4th at 524. The District Court erred by failing to modify its original analysis in light of McKinley's subsequent addition as plaintiff. *See Navarro*, 2026 WL 591454, at *10 ("The addition of McKinley as a Plaintiff does not change the analysis.").

Even without McKinley's additional allegations, this case is analogous to other cases that found Article III standing. In *Finkelman v. NFL*, the plaintiff claimed that the NFL had violated state law by withholding most Super Bowl tickets for well-connected insiders—thus increasing the price he paid for tickets on the secondary market. *See* 877 F.3d 504, 507-08 (3d Cir. 2017). The court reversed the dismissal of plaintiff's complaint. *See id.* at 507. The key to standing was that the plaintiff's complaint "did not just allege that prices would be lower on the secondary market were it not for the NFL's withholding." *Id.* at 512. Rather, the plaintiff "alleged a causal chain justifying *why* the NFL's withholding set into motion a series of events that ultimately raised prices on the secondary market." *Id.*

So too here. The *Finkelman* plaintiff laid out the causal chain: insiders resell tickets through third-party brokers that charge higher prices, so more publicly available tickets would mean lower prices. *See id.* Plaintiffs similarly describe a causal chain: Wells Fargo sets employee contributions as a consistent ratio of the drug prices it pays the Pharmacy Benefit Manager, yet it fails to respond prudently to the highly inflated drug prices that the Pharmacy Benefit Manager charges, so more prudent supervision would

have meant lower employee contributions. Am. Compl. ¶¶230-55. Like the *Finkelman* plaintiff, these Plaintiffs have "offered economic facts that are specific, plausible, and susceptible to proof at trial." *Finkelman*, 877 F.3d at 513. That suffices for Article III standing.

This case is also analogous to *Cottrell v. Alcon Labs*, 874 F.3d 154, 160 (3d Cir. 2017). There, the plaintiffs claimed they were overcharged for bottles of eyedrops. *See Cottrell*, 874 F.3d at 160. The producers of the eyedrops allegedly designed the eye dropper—that is, the pipette that came with the bottle—to extract drops that were larger than necessary. *See id.* at 159-60. This meant the plaintiffs got fewer doses of eyedrops from each bottle. *See id.* The district court found that plaintiffs' theory was "too speculative," given the "'complex[ity]'" of pharmaceuticals pricing. *See id.* at 168; *cf. Navarro*, 2026 WL 591454, at *9 ("'There are simply too many variables in how Plan participants' contribution rates are calculated' to infer that Wells Fargo's payments to [Express Scripts] for prescription drug payments or administrative fees were the but-for cause of any increases in Plaintiffs' required contributions."). But the court disagreed and held that plaintiffs had standing. *See Cottrell*, 874 F.3d at 169.

Crucially, the *Cottrell* plaintiffs' complaint supported their theory by "citing to numerous … scientific studies." *Id.* Plaintiffs here do likewise. They cite academic research, Am. Compl. ¶109, ¶193, government reports, Am. Compl. ¶¶108-09, ¶246, think-tank papers, Am. Compl. ¶¶247-48, ¶¶251-52, and medical articles, Am. Compl. ¶¶249-50, that all support their theory: the costs that a plan pays for drugs get passed

on to plan participants. Plaintiffs' plausible characterizations of these studies—and plausible inferences from them—must be accepted as true at this stage. *See Kaufman v. CVS Caremark Corp.*, 836 F.3d 88, 94 (1st Cir. 2016); *In re GNC Corp.*, 789 F.3d 505, 517 (4th Cir. 2015).

In sum, the Amended Complaint fully explains and provides extensive evidence for Plaintiffs' theory of traceability: insufficient monitoring of the Pharmacy Benefit Manager leads it to charge higher prices to the plan, which get passed on to plan participants in the form of higher out-of-pocket costs and higher contributions. This easily satisfies the plausibility standard. *See Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

C. Redressability

Redressability requires only that the relief sought "would likely redress at least some of [plaintiffs'] monetary injuries." *Diamond Alternative Energy, LLC v. EPA*, 606 U.S. 100, 114 (2025). "Even 'one dollar' … would satisfy the redressability component of Article III standing." *Id.* Plaintiffs seek monetary relief to remedy past breaches of fiduciary duty, so they satisfy the redressability prong of standing.

Plaintiffs ask the District Court to award them "surcharge, equitable restitution, and/or other make-whole equitable relief to Plaintiffs and members of the class to remedy Wells Fargo's breaches of fiduciary duty." Am. Compl. ¶314. "[C]ourts routinely provide redress for financial harms," including through equitable remedies that make plaintiffs whole with money. *Barone*, 41 F.4th at 236; *see Peters v. Aetna Inc.*, 2 F.4th 199, 218 (4th Cir. 2021); *Lanpher v. Metro. Life Ins. Co.*, 50 F. Supp. 3d 1122, 1145 (D. Minn.

2014) ("classic equitable remedies [under ERISA] will have the effect of conferring a monetary benefit on a party"). Here, a court "could provide redress for [Plaintiffs'] financial harm by … ordering Defendant[] to pay restitution, as requested in the complaint." *Barone*, 41 F.4th at 236. Or it could order the relief of surcharge, a form of "monetary remedy against a trustee." *CIGNA Corp. v. Amara*, 563 U.S. 421, 442 (2011). Any amount of monetary relief that Plaintiffs seek, no matter how small, satisfies the redressability prong for their past injuries. *See Uzuegbunam v. Preczewski*, 592 U.S. 279, 292 (2021).

In holding that Plaintiffs could not satisfy the redressability prong, the District Court once again collapsed standing into the merits and failed to accept Plaintiffs' well-pleaded allegations as true. *See Navarro*, 2026 WL 591454, at *10. The fact that the parties may dispute the proper amount of monetary relief does not affect a court's power to enter such relief for Wells Fargo's "completed violation" of its fiduciary duties. *Uzuegbunam*, 592 U.S. at 293; *see id.* at 292 (seeking "one dollar" for past injuries satisfies redressability). And, at this stage, the Court must accept as true Plaintiffs' well-pleaded allegations that employee contributions were "always" set at 25%. Am. Compl. ¶240.

Even so, Wells Fargo's "discretion" over this percentage (a word that does not appear in the Amended Complaint) does not affect redressability for McKinley's injuries. *Navarro*, 2026 WL 591454, at *10. That is because McKinley paid the full cost of both the employer and employee contributions. Am. Compl. ¶¶256-60. Any "discretion" Wells Fargo had "in setting employee contribution amounts" is irrelevant because

McKinley had to pay the entire inflated cost by herself. *Navarro*, 2026 WL 591454, at *10. She seeks at least "one dollar" to redress this pocketbook injury and therefore has standing. *Uzuegbunam*, 592 U.S. at 292.

II. If the District Court's reasoning stands, it would foreclose meaningful ERISA challenges in the healthcare context.

In *Knudsen*, 117 F.4th 570, the panel addressed the standing of plan participants to challenge the mismanagement of a self-funded healthcare plan. The court found no standing there: unlike these Plaintiffs, the *Knudsen* plaintiffs did not plead facts showing that "purported violative conduct was the but-for-cause of their injury in fact, namely, an increase in their out-of-pocket costs." 117 F.4th at 582. But, as the court emphasized, a plaintiff "may well establish" standing to challenge the mismanagement of self-funded health plans "in a different case." *Id.* at 580. Otherwise, a plan "could charge Plan participants thousands of dollars more in premiums … and Plan participants would have no judicial recourse." *Id.* Affirming the District Court here would immunize even egregious breaches of fiduciary duty from accountability under ERISA.

A. Plan fiduciaries are unquestionably violating their ERISA duties.

ERISA imposes strict fiduciary duties on those who oversee and manage employee benefit plans. An ERISA fiduciary must act "solely in the interest of the participants and beneficiaries"—and "for the exclusive purpose of … providing benefits to participants and their beneficiaries" and "defraying reasonable expenses of administering the plan" —all while demonstrating the "care, skill, prudence, and diligence" of "a prudent man." 29 U.S.C. §1104(a)(1)(A)–(B). In other words, a plan fiduciary must act

"with an eye single to the interests of the participants and beneficiaries of the plan." *Reich v. Compton*, 57 F.3d 270, 291 (3d Cir. 1995). This "duty of loyalty" under ERISA is "exacting," *Leigh v. Engle*, 727 F.2d 113, 132 (7th Cir. 1984), and "absolute," *Reetz v. Aon Hewitt Inv. Consulting, Inc.*, 74 F.4th 171, 181 (4th Cir. 2023). It "protects beneficiaries by barring any conflict of interest that might put the fiduciary in a position to engage in self-serving behavior at the expense of beneficiaries." *Su v. Johnson*, 68 F.4th 345, 352 (7th Cir. 2023).

The duty of prudence similarly encompasses an obligation to monitor the plan and those the fiduciary has entrusted with care of the plan. *See Tibble*, 575 U.S. at 530. A fiduciary may not mismanage plan assets or permit its agents to do so. "Not honesty alone, but the punctilio of an honor the most sensitive, is … the standard of behavior." *Bussian v. RJR Nabisco, Inc.*, 223 F.3d 286, 294 (5th Cir. 2000). The duties of an ERISA fiduciary are thus "the highest known to the law." *Donovan*, 680 F.2d at 272 n.8.

Unfortunately, those who manage and oversee health plans routinely fail to live up to the fiduciary duties that ERISA imposes upon them. Take the facts of this case. An ERISA fiduciary "breach[es] its duty of prudence … by failing to monitor the compensation" it pays to plan service providers. *Bugielski v. AT&T Servs., Inc.*, 76 F.4th 894, 912 (9th Cir. 2023). That is precisely what Plaintiffs say happened here. This is a case about the "mismanagement of prescription-drug benefits." Am. Compl. ¶3. As the Amended Complaint details with numerous specific examples, the plan was paying its Pharmacy Benefit Manager drug prices that were an order of magnitude greater than

what someone would pay on the open market. "No prudent fiduciary would agree to make its plan and participants/beneficiaries pay a price that is fifteen times higher than the price available to anyone who just walks into a pharmacy and pays without using their insurance." *Id.* And, what's more, Wells Fargo allegedly outsourced the initial choice of Express Scripts as its Pharmacy Benefit Manager to a conflicted broker—a broker that was getting kickbacks from Express Scripts. Am. Compl. ¶113.

Because "ERISA's duty of prudence requires plan fiduciaries to make a diligent effort to compare alternative service providers in the marketplace," Am. Compl. ¶2, Wells Fargo should have been comparing the prices that its plan and employees were paying to published prices. *Compare* 84 Fed. Reg. 65524, 65528 (Nov. 27, 2019) ("disclosure of pricing information … allow[s] … employers … to … better utilize market forces to address the high cost of medical care"), *and* 85 Fed. Reg. 72158, 72171 (Nov. 12, 2020) ("Providing employers … with actionable data may also help drive down total health care spending."), *with* Am. Compl. ¶121 ("This comparison reveals staggering markups and unreasonable overpayments.").

The Department of Labor—the federal agency responsible for administering and enforcing ERISA—has recognized that overcharges by Pharmacy Benefit Managers are a serious problem. In proposing a new rule to require greater transparency by Pharmacy Benefit Managers, it explained that PBMs "pushed patients toward higher out-of-pocket costs, marked up low-cost prescription drugs excessively," and "requir[ed] patients to use their own mail-order or specialty pharmacies, even when a local pharmacy

could have filled the prescription more quickly." 91 Fed. Reg. 4348, 4386 (Jan. 30, 2026) (citing Rebecca Robbins & Reed Abelson*, The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, N.Y. Times (June 21, 2024), perma.cc/9TXQ-YHBA). Although PBMs are meant to "reduce drug costs," "they frequently do the opposite": they "charge steep markups on what would otherwise be inexpensive medicines and extract billions of dollars in hidden fees." Robbins & Abelson, *supra*.

In other words, "PBMs inflate prescription drug costs and interfere with patient care for their own financial benefit." House Committee on Oversight and Accountability Staff, *The Role of Pharmacy Benefit Managers in Prescription Drug Markets*, (2024) [2024 House Committee Report], at 3, perma.cc/3KAY-EKSU. Below are just a few of the specific objectionable practices undertaken by PBMs that should be subject to exacting scrutiny on the merits under ERISA's demanding standards governing fiduciaries:

Spread pricing. Recall that PBMs are intermediaries that procure prescription medications for plans. Plans can pay PBMs in either of two ways: pass-through pricing or spread pricing. With pass-through pricing, the plan compensates the PBM with an administrative fee. *See* 91 Fed. Reg. at 4352. So the PBM charges the plan what it paid the pharmacy for the drug and collects a flat fee for its efforts. Am. Compl. ¶73. With spread pricing, by contrast, the PBM pays one price to buy the drug from the pharmacy and then collects a different price from the plan. *See* 91 Fed. Reg. at 4352-53. Simply put, spread pricing is "where the PBM pays the pharmacy low, bills the plan sponsor high, and pockets the difference." House Committee on Oversight and Reform Staff,

A View from Congress: Role of Pharmacy Benefit Managers in Pharmaceutical Markets, at 11 (Dec. 10, 2021), perma.cc/LS36-DYDE. The PBM is thus incentivized to upcharge the plan as much as it can for the drugs—which it often does without disclosing its profits to the plan. *See* 91 Fed. Reg. at 4376.

Pushing patients toward more expensive drugs. PBMs also steer patients toward more expensive drugs. Am. Compl. ¶100, ¶190. One way they do this is by classifying more prescription drugs as "specialty drugs," which have higher prices. See 91 Fed. Reg. at 4378. Another way is by failing to promote cheaper (but chemically identical) generic drugs. PBMs "regularly place higher cost medications in more preferable positions based on their formularies, even when there are lower-cost and equally safe and effective competing options." 2024 House Committee Report at 4.

Steering patients to affiliated pharmacies. "PBMs routinely create narrow and preferred pharmacy networks that can advantage their own pharmacies while excluding rivals." Fed. Trade Comm'n, Interim Staff Report, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, at 31-32 (July 2024), perma.cc/W6UV-C7MS. These affiliated pharmacies create powerful incentives for self-dealing on the part of PBMs. *See* Am. Compl. ¶¶191-93. According to a recent FTC study, the largest three PBMs "reimbursed their affiliated pharmacies at a higher rate than unaffiliated pharmacies on nearly every specialty generic drug examined." Fed. Trade Comm'n, Second Interim Staff Report, *Specialty Generic Drugs: A Growing Profit*

Center for Vertically Integrated Pharmacy Benefit Managers at 2, (Jan. 2025), perma.cc/LYF9-VFBW.

* * *

Ultimately, the incentives of plan fiduciaries and PBMs do not align. Plan fiduciaries have duties of prudence and loyalty to plan participants and beneficiaries, and the law requires them to pay "no more than reasonable compensation" to service providers like PBMs. 29 U.S.C. §1108(b)(2)(A). PBMs, by contrast, are typically for-profit companies that owe fiduciary duties to their shareholders to maximize profits. Am. Compl. ¶5. This means that "the largest P.B.M.s often act in their own financial interests, at the expense of their clients and patients." Robbins & Abelson, *supra*. That leads PBMs to "push patients toward drugs with higher out-of-pocket costs" and to "charge employers … multiple times the wholesale price of a drug, keeping most of the difference for themselves." *Id.* This is a major problem under ERISA, especially when the plan fiduciary has "effectively abdicated its fiduciary duties to a for-profit PBM," giving it "free rein without any meaningful monitoring or review." Am. Compl. ¶285.

Plan fiduciaries are supposed to look out for the best interests of plan participants and avoid mismanaging plan assets. But, as all this shows, they are often not living up to their fiduciary duties. Instead of monitoring the self-interested PBMs to ensure prudent use of plan assets, the fiduciaries turn a blind eye as PBMs price gouge plan participants like Plaintiffs. This prompts the question: "Who will watch the watchmen themselves?" Juvenal, *Satires* VI.347-48.

B. Private lawsuits are key to ERISA compliance and enforcement.

Enter private suits under ERISA. Congress enacted ERISA to "protect … the interests of participants in employee benefit plans … by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. §1001(b). In doing so, it created a private cause of action for plan participants. *Id.* §1132(a). This part of ERISA is "essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). "Congress intended that private individuals would play an important role in enforcing ERISA's fiduciary duties." *Braden*, 588 F.3d at 598.

This Court has properly recognized that an ERISA plaintiff "must offer sufficient factual allegations to show that he or she is not merely engaged in a fishing expedition or strike suit." *Id.* At the same time, "[i]f plaintiffs cannot state a claim without pleading facts which tend systemically to be in the sole possession of defendants, the remedial scheme of the statute will fail, and the crucial rights secured by ERISA will suffer." *Id.* This is part of the "context[]" that judges must account for when applying the pleading standard in a "common sense" way. *Iqbal*, 556 U.S. at 679. This Court thus requires "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." *Braden*, 588 F.3d at 598.

The District Court failed to undertake such an evaluation of the Amended Complaint. Instead, it conflated standing and the merits, made inferences against the Plain-

tiffs, and refused to credit their well-pleaded allegations. It applied the wrong baseline against which to evaluate Plaintiffs' allegations of financial loss. And it required Plaintiffs to make a showing of standing beyond what is required in any other area of law outside ERISA. The District Court's ruling conflicts with *Iqbal* and Article III and threatens to undermine an important remedial statute, all to the detriment of the more than 150 million Americans who rely on employer-sponsored health plans.

CONCLUSION

This Court should reverse.

Dated: July 2, 2026

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with Rule 29(a)(5) of the Federal Rules of Appellate Procedure because it contains 6,497 words, excluding the parts exempted by Rule 32(f). This brief also complies with Rule 32(a)(5)-(6) because it is prepared in a proportionally spaced typeface using Microsoft Word in 14-point Garamond font.

Consistent with Rule 28A(h) of the Eighth Circuit Local Rules, the electronic version of the brief has been scanned for viruses and is virus-free.

Dated: July 2, 2026 *<u>/s/ Jeffrey M. Harris</u>*

CERTIFICATE OF SERVICE

I filed a true and correct copy of this brief with the Clerk of this Court via the CM/ECF system, which notified all counsel.

Dated: July 2, 2026 */s/ Jeffrey M. Harris*