United States Court of Appeals
For The Eighth Circuit
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September 02, 2026

Cory L. Andrews
WASHINGTON LEGAL FOUNDATION
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RE: 26-1620 Sergio Navarro, et al v. Wells Fargo & Company

Dear Counsel:

The amicus curiae brief of the Washington Legal Foundation has been filed. If you have not already done so, please complete and file an Appearance form. You can access the Appearance Form at www.ca8.uscourts.gov/all-forms.

Please note that Federal Rule of Appellate Procedure 29(g) provides that an amicus may only present oral argument by leave of court. If you wish to present oral argument, you need to submit a motion. Please note that if permission to present oral argument is granted, the court's usual practice is that the time granted to the amicus will be deducted from the time allotted to the party the amicus supports. You may wish to discuss this with the other attorneys before you submit your motion.

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District Court/Agency Case Number(s): 0:24-cv-03043-LMP

No. 26-1620

IN THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

SERGIO NAVARRO, 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; THERESA GAMAGE, 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; DAYLE BULLA, 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; 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; 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 LPM/DLM) (Hon. Laura M. Provinzino)

BRIEF OF WASHINGTON LEGAL FOUNDATION AS AMICUS CURIAE SUPPORTING DEFENDANT-APPELLEE AND AFFIRMANCE

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RULE 26.1 DISCLOSURE STATEMENT

Washington Legal Foundation is a nonprofit corporation under Section 501(c)(3) of the Internal Revenue Code. It has no parent, issues no stock, and no public company holds a ten percent or greater interest in it.

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INTEREST OF AMICUS CURIAE*

Washington Legal Foundation is a nonprofit, public-interest law firm and policy center with supporters nationwide. WLF promotes free markets, individual rights, limited government, and the rule of law. It appears often as amicus curiae in Employee Retirement Income Security Act cases that test the bounds of fiduciary liability. *See, e.g., Thole v. U.S. Bank, N.A.*, 590 U.S. 538 (2020); *Amgen Inc. v. Harris*, 577 U.S. 308 (2016).

ERISA was written to encourage employers to offer benefits, not to punish them when they do. Plaintiffs' theory here turns that logic inside out. It stretches Article III to reach a plan participant who received everything her plan promised, and it invites a wave of class actions over the price of cherry-picked prescription drugs. If that theory succeeds, the cost will land not only on plan sponsors but also on the very employees ERISA seeks to protect.

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* No party's counsel authored any part of this brief. No one, apart from Washington Legal Foundation and its counsel, contributed money intended to fund the brief's preparation or submission. All parties consent to the filing of this brief.

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INTRODUCTION & SUMMARY OF ARGUMENT

Group health coverage is a promise about risk, not a menu of prices. A participant pays her share of the premiums, the plan pools that money with contributions from thousands of coworkers and from the employer, and in exchange the plan promises to pay its share of whatever care the year brings. Some participants draw out many times what they pay in. Many draw out far less. No one "overpays" for a covered prescription along the way, because no one bought a prescription. Plaintiffs bought coverage, and here they do not dispute that they received every bit of the coverage they were promised. Add. 24, 26–27.

That undisputed fact decides this appeal. Five former Wells Fargo employees allege that the company let the Plan's pharmacy benefit manager, Express Scripts, charge too much for generic drugs and administrative services, and that harder bargaining would have meant lower pharmacy-counter payments and lower premiums. Add. 7–9. The district court dismissed their complaint twice, concluding that their "alleged harm is speculative and, ultimately, not redressable." Add. 19. It was right both times.

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First, no Plaintiff suffered a concrete injury. In this Circuit, an overpayment injury is measured against the plaintiff's bargain, not against a benchmark of the plaintiff's choosing. *Wallace v. ConAgra Foods, Inc.*, 747 F.3d 1025, 1030 (8th Cir. 2014). Plaintiffs do not allege that they paid a penny more than the Plan's terms authorized, that any benefit was denied or diminished, or that Wells Fargo broke a single promise. Add. 26–27. Their theory is that the same pills could be had cheaper outside the Plan. But an uninsured cash price on a prescription drug is the price of a different product. A quarrel with the cost of a bundle received in full is buyer's remorse, not a concrete injury.

Second, causation and redressability both collapse because the Plan gives Wells Fargo "sole discretion" to set what participants pay. Add. 19. Between any PBM contract term and any dollar in a participant's pocket stands that discretion—Wells Fargo could lawfully have kept every dime of hypothetical savings, and it could lawfully absorb any judgment the same way. Add. 23–25. A theory of standing that depends on guessing how a sponsor *might* have exercised discretion it never promised to exercise in Plaintiffs' favor is the definition of speculation. That is no less true for the Plaintiff who paid COBRA premiums: her rates were

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computed exactly as the statute commands, from the Plan's total estimated costs, and her complaint is merely that the inputs to a lawful calculation should have been smaller. Add. 23–24. Grousing over prices does not make a federal case.

Third, the stakes reach far beyond Wells Fargo. This Plan alone covered 188,798 participants in 2022, Add. 7, and it is structured like the self-funded plans through which most large American employers deliver health benefits. Under Plaintiffs' theory, any participant who finds any drug on any formulary priced above any benchmark can haul her employer into federal court on behalf of a nationwide class—no denial of benefits, no broken plan term, no loss she can trace to her own wallet. Article III has been the bulwark against that litigious business model, and this Court should keep it so. The judgment should be affirmed.

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ARGUMENT

I. PARTICIPANTS WHO RECEIVED EVERY PROMISED BENEFIT, AT THE PRICES THE PLAN'S TERMS SET, SUFFERED NO INJURY IN FACT.

"No concrete harm, no standing." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 417 (2021). Plaintiffs must plausibly allege a concrete, particularized injury—one that "affect[s] the plaintiff in a personal and individual way"—for each claim they press and each form of relief they seek. *Wallace*, 747 F.3d at 1030 (quoting *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 n.1 (1992)); *TransUnion*, 594 U.S. at 431. They have repeatedly failed to do so.

A. An overpayment is measured against the bargain, not against a benchmark.

Plaintiffs lead with what they call a classic pocketbook injury: they paid more at the pharmacy counter, they say, than pharmacies pay to acquire the same drugs, and more than pass-through PBMs or cash customers would pay. Add. 8, 25–26. And they invoke this Court's consumer cases for the rule that overpaying for a good or service is an injury in fact.

The rule is sound; the fit is not. Each of those plaintiffs measured his dollars against something the law recognizes: a contract the defendant allegedly broke, or a product defective as sold. *Carlsen v.*

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GameStop, Inc. found standing because the subscriber was "a party to a breached contract"—GameStop allegedly took his money while violating the very privacy policy he had paid for. 833 F.3d 903, 909 (8th Cir. 2016).

Kuhns v. Scottrade, Inc. was the same: the investor "bargained for and expected protection of his PII," the firm allegedly "breached the contract," and the injury was "the diminished value of his bargain"—and even then, the claim failed on the merits because the contract promised no such thing. 868 F.3d 711, 716, 718 (8th Cir. 2017). *George v. Omega Flex, Inc.* involved buyers of gas tubing alleged to be defective, a product worth less than anyone paid for it. 874 F.3d 1031, 1031–32 (8th Cir. 2017) (per curiam).

And *Wallace* shows the flip side: consumers who claimed they paid a premium for kosher beef lacked standing because they could not allege that the packages *they* bought deviated from what was promised—it was "quite plausible ConAgra sold the consumers exactly what was promised." 747 F.3d at 1030. Economic-harm language comes cheap; the injury still must be an "invasion of a legally protected interest," *Lujan*, 504 U.S. at 560, and a buyer who receives precisely what her contract

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provides, at the cost-sharing her contract prescribes, has suffered no such invasion.

Plaintiffs are *Wallace*-style plaintiffs. No pill was defective and no promise was broken. They "do not dispute that they received their benefits," Add. 27, and they identify no Plan term—no pricing formula, no cost cap, no promise of benchmark parity—that Wells Fargo violated when the Plan charged the cost-sharing it charged. Add. 22, 29. Their alleged overcharge exists only by comparison to prices for a *different* transaction, one they are a stranger to: the uninsured cash purchase of a pill, stripped of the pooled coverage, claims processing, pharmacy network, and catastrophic protection that Plan participants bought and received.

As the district court put it, "it fundamentally cannot be the case" that participants are injured whenever their contractually defined benefits "are available at lower cost to non-participants," absent some promise of that lower cost or some diminution of the benefits themselves. Add. 29. Article III demands "something more than an ingenious academic exercise in the conceivable." *United States v. Students Challenging Regul. Agency Procs.*, 412 U.S. 669, 688 (1973); Add. 29.

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Courts have said the same of other welfare-plan participants who received their full benefits. *See Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 582 (3d Cir. 2024); *Gonzalez de Fuente v. Preferred Home Care of N.Y. LLC*, 858 F. App'x 432, 433–34 (2d Cir. 2021) (summary order); *Scott v. UnitedHealth Grp., Inc.*, 540 F. Supp. 3d 857, 862–64 (D. Minn. 2021).

B. The defined-contribution cases involve a participant's own money; this Plan holds none of it.

Plaintiffs' contrary authority proves the point. Their anchor, *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585 (8th Cir. 2009), was a 401(k) case. Each participant there owned an individual account, and every excessive fee skimmed value directly from it; Braden had standing "because he ha[d] alleged actual injury to his own Plan account." *Id.* at 589, 592–93. So too *Tussey v. ABB, Inc.*, 746 F.3d 327, 331 (8th Cir. 2014) (401(k) plan with participant-directed accounts), and *Cunningham v. Cornell Univ.*, 604 U.S. 693, 697–98 (2025) (defined-contribution plans whose account values are "determined by the market performance" of contributions "less expenses"). In an individual-account plan, the participant's benefit *is* the account balance, so imprudent fees are self-proving injuries.

This Plan is built the other way. It is a self-funded welfare plan whose pooled trust pays all expenses, and participants are entitled to defined benefits—not to any slice of the pool. Add. 3, 16–17. Under such a plan, "no plan member has a claim to any particular asset that composes a part of the plan's general asset pool." *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 440 (1999). That structure is "closely analogous" to the defined-benefit plan in *Thole v. U.S. Bank, N.A.*, 590 U.S. 538 (2020), where benefits are "fixed and will not change, regardless of how well or poorly the plan is managed." *Id.* at 543; Add. 16–17.

And this Court has already drawn the consequence: under both 29 U.S.C. §§ 1132(a)(2) and 1132(a)(3), "the plaintiffs must show actual injury—to the plaintiffs' interest in the Plan under (a)(2) and to the Plan itself under (a)(3)." *Thole v. U.S. Bank, Nat'l Ass'n*, 873 F.3d 617, 630 (8th Cir. 2017), *aff'd*, 590 U.S. 538 (2020). That requirement is nearly 25 years old in this Circuit. Participants who have suffered "no injury in fact" may not sue on a plan's behalf, and losses a plan absorbs without touching the plaintiff's own benefits are no such injury. *Harley v. Minn. Mining & Mfg. Co.*, 284 F.3d 901, 906–07 (8th Cir. 2002) (emphasis omitted).

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Cunningham changes none of this. It resolved a pleading question—whether a prohibited-transaction complaint must anticipate § 1108's exemptions—and in the same breath reminded lower courts that they "must also, consistent with Article III standing, dismiss suits that allege a prohibited transaction occurred but fail to identify an injury." 604 U.S. at 708–09 (citing *Thole*, 590 U.S. at 544). That instruction is this case.

Plaintiffs' out-of-circuit cases prove less than advertised. In *Stern v. JPMorgan Chase & Co.*, the defendants "raise[d] no arguments" on causation, and the complaint benchmarked every one of the 404 generic drugs on the plan's formularies—so the court distinguished the decision below rather than rejecting it. No. 1:25-cv-02097, 2026 WL 654714, at *8–9 (S.D.N.Y. Mar. 9, 2026). Even then, the court noted that the plaintiffs' overpayment allegations "fall apart on closer inspection" because NADAC is an average of pharmacy acquisition costs, showing neither what any pharmacy actually paid nor what any similarly situated participant could have paid. *Id.* at *9 n.5.

Barbich v. Nw. Univ. rested on a different theory—one coverage option alleged to be a strictly worse buy than another on the same

menu—and the defendant waived its redressability defense in a footnote, so the court never reached the question. No. 25 CV 6849, 2026 WL 1552506, at *1–3 (N.D. Ill. Apr. 2, 2026). And when the District of New Jersey faced "nearly identical allegations" against Johnson & Johnson, Add. 28, it dismissed them twice—the second time expressly adopting the decision below: "This Court finds *Navarro* persuasive and applies that court's reasoning." *Lewandowski v. Johnson & Johnson*, No. 24-cv-671, 2025 WL 3296009, at *4–7 (D.N.J. Nov. 26, 2025); *see* Add. 28.

II. WELLS FARGO'S SOLE DISCRETION OVER CONTRIBUTIONS SEVERS ANY CHAIN BETWEEN PBM PRICING AND THE PLAINTIFFS' WALLETS.

Even granting Plaintiffs an injury they cannot prove, their premium-contribution theory fails at both ends—causation looking back, redressability looking forward. Both failures trace to the same Plan terms: Wells Fargo holds "sole discretion" to set participant contributions, may require participants to fund all Plan expenses or none, and never promised to contribute anything itself. Add. 19–20, 23. Those Plan terms are fatal to Plaintiffs' case.

A. A historical 75/25 split is a practice, not a promise.

Plaintiffs' answer is arithmetic: Wells Fargo set participant contributions at roughly 25% of total Plan costs from 2018 through 2023, so premiums rose and fell "in lockstep" with Plan spending, and 25% of a smaller number is smaller. Add. 4, 21. The district court called this "superficially seductive," Add. 21, and that is the right description. A percentage describes how Wells Fargo exercised its discretion in the world that was; it does not bind how Wells Fargo would have exercised that discretion in the counterfactual world that Plaintiffs imagine, where PBM savings materialize and someone must decide where that savings goes.

Nothing in the Plan required Wells Fargo to hold the ratio, and the Ninth Circuit has rejected this exact move on materially identical facts: allegations that contributions tracked overall costs "do not solve the variable of [the employer's] discretion in setting employee contribution rates." *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 524 (9th Cir. 2023); *accord Knudsen*, 117 F.4th at 581–82; *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 457 (3d Cir. 2003).

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Even *Stern*, on which Plaintiffs lean, agreed on this score. It held a lockstep theory built on a consistent 30% cost share "too speculative" where contributions rested in the administrator's "sole discretion," citing the decision below as a case in which that "discretionary structure" was "dispositive." 2026 WL 654714, at *6–7.

Nor is the relationship between drug prices and any participant's premium "one-to-one." Add. 21. Contributions fund the whole Plan—medical claims, not just pharmacy—and individual rates turn on tobacco use, coverage tier, and compensation category. Add. 19–21. The complaint's historical data show, at most, that aggregate contributions tracked aggregate expenses; Plaintiffs identify no Plan term obliging that result, Add. 21–22, and a term of that kind is exactly what *Winsor* holds is missing from a pro-rata theory. 62 F.4th at 525. Assuming success on the merits, *American Farm Bureau Federation v. United States EPA*, 836 F.3d 963, 968 (8th Cir. 2016), still leaves the question whether *these Plaintiffs* were injured by the breach—and "speculation and conjecture are not injuries cognizable under Article III." *Wallace*, 747 F.3d at 1030.

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B. McKinley's COBRA premiums do not close the gap.

Plaintiffs press hardest on Erica McKinley, who continued her coverage under COBRA and so paid both the employer and employee shares of the premium. The employer-employee split, they say, is therefore irrelevant to her. But that observation removes only one link from a chain that remains speculative at every other joint.

McKinley's premium was "calculated based on estimated Plan expenses as required by COBRA"—a fact Plaintiffs do not dispute. Add. 23. She does not allege that her rate exceeded what COBRA or the Plan authorizes, or that she was denied any benefit. Add. 24. Her claim is that the inputs to a concededly lawful calculation should have been smaller—which is the same bundle complaint in a different wrapper, measured once again against a hypothetical better deal rather than against any legal entitlement of hers.

And it is undisputed that total Plan expenses "account for more than" drug spending and PBM fees, Add. 24, so even her theory requires guessing that a different PBM contract would have moved her particular premium, in her particular coverage tier, by some particular amount.

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Article III does not run on that kind of guesswork. *In re SuperValu, Inc.*, 870 F.3d 763, 769–71 (8th Cir. 2017).

C. No judgment could put a dollar back in their pockets.

Redressability fails independently. The plan-wide remedy Plaintiffs seek under § 1132(a)(2) runs, by design, to the Plan as a whole: relief under § 1109 "protect[s] the entire plan" and "does not provide a remedy for individual injuries distinct from plan injuries." *Pilger v. Sweeney*, 725 F.3d 922, 926 (8th Cir. 2013) (citations omitted).

None of the five named Plaintiffs any longer participates in the Plan, so a recovery paid into the trust reaches their pockets only if Wells Fargo, as Plan sponsor and settlor, chooses in its discretion to route it there. Because nothing would stop it from instead channeling any recovery to wellness programs, preventive care, or countless other permissible uses, Plaintiffs are left exactly where they began. Add. 25; *Winsor*, 62 F.4th at 526–27; *Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1125 (9th Cir. 2006).

The surcharge remedy fares no better, though for a narrower reason. Whatever the outer bounds of make-whole monetary relief under § 1132(a)(3) after *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), and *Silva*

v. Metropolitan Life Insurance Co., 762 F.3d 711, 724 (8th Cir. 2014), surcharge lies "only upon a showing of actual harm." *Amara*, 563 U.S. at 444; Add. 19. A remedy that presupposes the injury cannot supply it. Because Plaintiffs received every promised benefit at the prices the Plan set, there is no loss for a surcharge to restore—and redressability cannot bootstrap what injury in fact leaves out.

III. ADOPTING PLAINTIFFS' THEORY WOULD TURN EVERY FORMULARY INTO A CLASS ACTION AND PUNISH THE EMPLOYERS ERISA MEANS TO ENCOURAGE.

Step back and consider what Plaintiffs are asking this Court to hold: that a participant who was denied nothing, promised nothing cheaper, and charged nothing beyond her plan's terms may still sue her employer whenever she can find one drug, on one formulary, priced above one benchmark. Employer-sponsored plans routinely run their pharmacy benefits through PBMs, Add. 4, and a PBM's negotiated prices will always sit above some comparator somewhere. Under Plaintiffs' rule, each of those prices is a federal class action waiting for a named plaintiff.

That regime would punish the parties least deserving of it. Employers who self-fund their plans already bear the lion's share of every claim—Wells Fargo paid roughly 75% of this Plan's costs from 2018

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through 2023, Add. 4—so they already carry every incentive to bargain hard with their PBMs. Congress designed ERISA so that administrative costs and litigation expenses would not "unduly discourage employers from offering [ERISA] plans in the first place." *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (citation omitted). Layer strike-suit exposure onto conduct that ERISA and the Plan expressly permit, and rational employers will respond the way rational actors do: by trimming benefits, raising cost-sharing, or exiting sponsorship—outcomes that injure the very employees whom Plaintiffs claim to champion.

The district court acknowledged that the price comparisons alleged here are "staggering," Add. 29, and WLF does not ask this Court to bless any PBM's pricing. Whether that industry needs reform is a live question—for Congress, for regulators, and for the state legislatures already acting on it. But a policy grievance shared by millions is not a personal injury suffered by these five Plaintiffs, and "[t]here is no ERISA exception to Article III." *Thole*, 590 U.S. at 547. The courthouse door opens for litigants with concrete stakes, not for the well-represented vanguard of a national pricing debate.

CONCLUSION

Plaintiffs received everything their Plan promised, at the prices its terms set. Their quarrel is with the cost of American health care, not with any injury Article III recognizes. The judgment should be affirmed.

Respectfully submitted,

September 1, 2026

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COMBINED CERTIFICATIONS

1. This brief complies with the type-volume limit of Fed. R. App. P. 29(a)(5) because it contains 3,334 words, excluding those parts of the brief exempted by Fed. R. App. P. 32(f). This brief also complies with the typeface and typestyle requirements of Fed. R. App. P. 32(a) because it was prepared in 14-point font using a proportionally spaced typeface, Century Schoolbook.

2. Under 8th Cir. R. 28A(h), SentinelOne® Agent version 25.2.5.437 scanned this brief for viruses and detected none.

/s/ Cory L. Andrews
Cory L. Andrews

September 1, 2026

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.

/s/ Cory L. Andrews
Cory L. Andrews

September 1, 2026

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