United States Court of Appeals

for the

Eighth Circuit

Case No. 26-1620

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 AN ORDER OF THE U.S. DISTRICT COURT FOR THE DISTRICT OF MINNESOTA IN NO. 0:24-CV-03043-LMP HONORABLE LAURA M. PROVINZINO, U.S. DISTRICT JUDGE

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SUMMARY OF THE CASE

Wells Fargo & Company ("Wells Fargo") provides prescription drug benefits to its employees as part of the Wells Fargo & Company Health Plan (the "Plan"). Express Scripts, Inc. ("ESI"), one of the "big 3" pharmacy benefit managers ("PBMs"), administers the Plan's self-insured prescription-drug program. Plaintiffs alleged that Wells Fargo caused the Plan to pay excessive prescription drug costs and administrative fees to ESI, and participants to pay excessive premiums and out-of-pocket costs for covered drugs. Based on these purported overcharges, Plaintiffs brought claims under the Employee Retirement Income Security Act ("ERISA") on behalf of themselves and the Plan alleging that Wells Fargo breached its fiduciary duties and entered into prohibited transactions.

The district court correctly dismissed Plaintiffs' claims for lack of standing. Plaintiffs failed to demonstrate a traceable injury-in-fact: many factors affected employee contributions, and Wells Fargo set those contributions in its sole discretion, rendering any alleged increase speculative. Similarly, Plaintiffs failed to allege that the specific drugs they personally purchased would have cost less but for Wells Fargo's alleged breaches. Moreover, Plaintiffs' alleged injuries are not redressable. Regardless, even if Plaintiffs had standing, the Court should affirm on the alternative ground that Plaintiffs failed to state a claim. Wells Fargo respectfully requests 15 minutes per side for oral argument.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure, the undersigned counsel states that Wells Fargo & Company is a publicly held corporation, it does not have a parent corporation, and no publicly held corporation owns 10% or more of its stock.

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Knudsen v. MetLife Grp., Inc., 117 F.4th 570 (3d Cir. 2024); *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517 (9th Cir. 2023); *Finkelman v. Nat'l Football League*, 810 F.3d 187 (3d Cir. 2016); *Wallace v. ConAgra Foods, Inc.*, 747 F.3d 1025 (8th Cir. 2014); U.S. Const., art. III, § 2.

2) Whether, in the alternative, Plaintiffs fail to state a claim where the challenged conduct—selecting a PBM, negotiating pricing terms, and structuring the pharmacy benefit—constitutes plan design that does not give rise to ERISA fiduciary liability, and where Plaintiffs fail to identify meaningful benchmarks showing that comparable plans obtained the same services at lower cost.

Pegram v. Herdrich, 530 U.S. 211 (2000); *Barrett v. O'Reilly Auto., Inc.*, 112 F.4th 1135 (8th Cir. 2024); *Doe 1 v. Express Scripts, Inc.*, 837 F. App'x 44 (2d Cir. 2020);

Doe One v. CVS Pharm., Inc., 348 F. Supp. 3d 967 (N.D. Cal. 2018); 29 U.S.C. §§ 1104, 1106, 1132.

INTRODUCTION

This case presents a threshold hurdle of Article III standing, which Plaintiffs cannot clear. Plaintiffs allege that Wells Fargo should have negotiated differently with the Plan's PBM and obtained lower prescription-drug prices for participants. Their theories of injury, however, rest entirely on *speculation*: how PBMs might have responded to different negotiations, what terms they would have accepted, and whether Wells Fargo would have passed any resulting savings to participants. Article III does not permit standing built on such conjecture.

Plaintiffs advance two theories of injury, and both fail to satisfy Article III's injury-in-fact, causation, and redressability requirements.

Their premium-contribution theory posits that, had Wells Fargo negotiated more aggressively with ESI or retained a different PBM, the Plan would have spent less, and Wells Fargo would have reduced Plaintiffs' premium contributions accordingly. That theory fails twice over. First, it requires speculation about how independent, profit-driven PBMs would have responded to different negotiations—and Plaintiffs' own allegations concede that these counterparties seek to maximize their profits and that PBM negotiations involve trade-offs across numerous variables. Second, even assuming lower Plan expenses, the Plan reserves to Wells Fargo the "sole discretion" to set participant contribution rates. Plaintiffs' historical contribution percentages do not establish that Wells Fargo followed a consistent

ratio, much less what it would have done under materially different economic conditions. Multiple circuits have held that such discretion defeats Article III's injury-in-fact and causation requirements.

Plaintiffs' out-of-pocket theory fares no better. While Plaintiffs contend they overpaid for prescriptions, they never allege the specific drugs they purchased would have cost less under a differently administered Plan. Instead, they point to comparisons between certain Plan drug prices and pharmacy acquisition costs or prices available to uninsured consumers—benchmarks that say nothing about what these Plaintiffs would have paid absent the challenged conduct. That is not a particularized injury or one traceable to alleged misconduct; it is speculation dressed up as an overpayment claim.

Lack of redressability is an additional, independent basis for affirmance because Plan-level recovery would run to the Plan, not to Plaintiffs, and nothing in the Plan documents requires distribution to Plaintiffs. Moreover, the "surcharge" Plaintiffs seek individually is, in effect, compensatory damages—legal relief not authorized by ERISA's equitable-relief provision.

Even if Plaintiffs could establish standing, their claims would fail on the merits. The decisions they challenge—selecting a PBM, negotiating pricing terms, structuring the pharmacy benefit—are plan-design functions that do not give rise to ERISA fiduciary liability. Regardless, Plaintiffs fail to identify meaningful

benchmarks showing that comparable plans obtained the same services at lower cost, as this Court's precedents require.

The district court twice carefully considered Plaintiffs' complaint and twice dismissed it. This Court should affirm.

STATEMENT OF THE CASE

A. Factual Background

1. The Plan's terms provide Wells Fargo with sole discretion to determine participant contributions.

Wells Fargo sponsors the Plan, an ERISA welfare plan providing medical and prescription-drug benefits to eligible employees. App. 302-03; R. Doc. 64, at 13-14 ¶¶ 21-22.[1] The Plan includes self-insured benefit options, meaning Plan expenses—including covered medical expenses and administrative fees—are funded through contributions from Wells Fargo and Plan participants. App. 302-03, 306-07; R. Doc. 64, at 13-14, 17-18 ¶¶ 22, 29-32.

The Plan document grants Wells Fargo broad discretion over the amount and allocation of participant contributions. S.App.128, 207; R. Doc. 31-2, at 22 ¶ 5.3; R. Doc. 44, at 9. Participants are responsible for premiums and contributions "as may be specified from time to time as determined by the Plan Sponsor," and Wells Fargo may establish different contribution rates for different classes of participants,

[1] App. refers to Plaintiffs' appendix, Add. to Plaintiffs' addendum, R. Doc. to the district court docket, and S.App. to Wells Fargo's separate appendix.

dependents, or benefit options. S.App.128; R. Doc. 31-2, at 22 ¶ 5.3. The Plan does not require Wells Fargo to make contributions or pre-fund any benefit. S.App.128; R. Doc. 31-2, at 22 ¶ 5.4.

Plaintiffs allege that, from 2018 through 2023, Wells Fargo required participants to contribute approximately 25% to 26% of overall Plan costs. App. 392; R. Doc. 64, at 103-06 ¶¶ 233-43. But participant contributions fund *overall* Plan expenses—not a prescription-drug subaccount—and Plan documents identify variables affecting contribution rates unrelated to prescription-drug benefits. App. 575-77; R. Doc. 99, at 19-21; Add.19-21. Plaintiffs make no allegation that the Plan requires Wells Fargo to maintain any certain employer-participant contribution ratio. App. 580; R. Doc. 99, at 24; Add.24.

2. Plaintiffs challenge selected pricing components of the Plan's pharmacy benefit arrangement but identify no specific alternative that would have produced lower costs with certainty.

ESI, one of the nation's three largest PBMs, administered the Plan's self-insured prescription-drug program. App. 315, 338; R. Doc. 64, at 26, 49 ¶¶ 53, 110. PBMs process prescription-drug claims, negotiate with pharmacy networks, manage formularies, and perform related administrative functions. App. 315; R. Doc. 64, at 26 ¶ 53. When a participant fills a covered prescription, the participant pays the required share—a deductible, co-pay, or coinsurance—and the PBM pays the

pharmacy the remaining negotiated amount, subject to later Plan reimbursement. App. 315; R. Doc. 64, at 26, 7-8 ¶¶ 53-54, 10.

Plaintiffs contend Wells Fargo should have negotiated different prescription-drug pricing or retained a different PBM. App. 334-57; R. Doc. 64, at 45-68 ¶¶ 101-49. Their amended complaint compares certain Plan drug prices to the National Average Drug Acquisition Cost ("NADAC") and to prices charged by pass-through PBMs or retail pharmacies to uninsured consumers. App. 316-17, 341-44; R. Doc. 64, at 27-28, 52-55 ¶¶ 59-60, 120-25. Plaintiffs also contend Wells Fargo should have "used its bargaining power to obtain better rates" from ESI or another PBM. App. 296-97; R. Doc. 64, at 7-8 ¶ 10. Yet Plaintiffs acknowledge that PBMs are "profit-driven entities"—and they identify no specific PBM that would have offered Wells Fargo the same suite of services at lower rates and with overall lower costs to the Plan. App. 315-16; R. Doc. 64, at 26-27 ¶ 55.

Plaintiffs further challenge the Plan's use of Accredo, an ESI-affiliated mail-order specialty pharmacy, alleging that the Plan required participants to obtain certain generic-specialty drugs through Accredo at prices exceeding those available at retail pharmacies to uninsured consumers. App. 343-56; R. Doc. 64, at 54-67 ¶¶ 124-43.

Plaintiffs separately allege that the Plan paid ESI excessive administrative fees and compare that amount to fees paid by selected other plans. App. 360-64; R.

Doc. 64, at 71-75 ¶¶ 155-62. Plaintiffs theorize that lower administrative fees would have reduced Plan costs and participant contributions, but the amended complaint alleges no facts demonstrating that lower administrative fees would have led to lower participant contributions. App. 360-64, 575-77; R. Doc. 64, at 71-75, 101-07 ¶¶ 155-62, 229-44; R. Doc. 99, at 19-21; Add.19-21.

3. Plaintiffs' asserted injuries depend on speculative theories that the district court twice rejected.

The four original named plaintiffs—Sergio Navarro, Theresa Gamage, Dayle Bulla, and Jane Kinsella—are former Wells Fargo employees and former Plan participants. App. 298-301; R. Doc. 64, at 9-12 ¶¶ 14-17. The amended complaint added Erica McKinley, also a former employee, who allegedly remained enrolled through COBRA continuation coverage when the amended complaint was filed, although she no longer is. App. 301, 502; R. Doc. 64, at 12 ¶ 18; R. Doc. 95, at 41. Each named plaintiff allegedly paid premiums for Plan coverage and out-of-pocket amounts for prescriptions. App. 298-301, 385-91; R. Doc. 64, at 9-12, 96-102 ¶¶ 14-18, 217-29. McKinley allegedly paid both employer and employee contribution shares, plus an administrative fee, by electing COBRA coverage. App. 301, 400; R. Doc. 64, at 12, 111 ¶¶ 18, 256, 257.

Plaintiffs' premium theory rests on alleged overpayments by the Plan. They allege that the Plan's overpayment for prescription drugs and administrative fees necessarily increased overall Plan costs and, therefore, participant premium

contributions. App. 390-96; R. Doc. 64, at 101-07 ¶¶ 229-44. But they plead no facts showing that the independent "profit-driven" intermediaries would have agreed to provide the same services at lower costs without otherwise increasing the Plan's expenses. App. 315-16, 326; R. Doc. 64, at 26-27, 37 ¶¶ 55, 79. And it is undisputed that the Plan gave Wells Fargo absolute discretion over contribution rates and that contribution levels may turn on factors wholly unrelated to prescription-drug costs. App. 575-77; R. Doc. 99, at 19-21; Add.19-21.

Plaintiffs' out-of-pocket theory rests on specific transactions for sixteen prescription drugs. App. 385-90; R. Doc. 64, at 96-101 ¶¶ 217-28. They allege prices exceeded pharmacy acquisition costs—for example, Navarro paid $16.06 for a prescription with an acquisition cost of $5.70. App. 385-90; R. Doc. 64, at 96-101 ¶¶ 217-28. But Plaintiffs acknowledge that "acquisition cost" is merely "the amount that the average pharmacy pays to acquire prescription drugs from wholesalers"—*not* the rate a prudent fiduciary would necessarily obtain. App. 316-17, 320-21; R. Doc. 64, at 27-28, 31-32 ¶¶ 59, 68. Plaintiffs also never allege that the specific drugs they purchased would have cost less under a comparable Plan administered without the alleged fiduciary breaches.

B. Procedural Background

1. Plaintiffs filed an ERISA complaint seeking plan-wide and individual relief based on the Plan's prescription-drug program.

The original Plaintiffs filed suit asserting ERISA claims on their own behalf, on behalf of a putative class, and on behalf of the Plan. S.App.1-100; R. Doc. 1, at 1-100. They alleged that Wells Fargo breached fiduciary duties and caused prohibited transactions by mismanaging the Plan's prescription-drug program. S.App.93-99; R. Doc. 1, at 93-99 ¶¶ 221-46. Plaintiffs sought plan-wide relief under 29 U.S.C. § 1132(a)(2), individual equitable relief under 29 U.S.C. § 1132(a)(3), and injunctive relief. S.App.93-100; R. Doc. 1, at 93-100 ¶¶ 221-46, 249-57. Wells Fargo moved to dismiss for lack of Article III standing under Rule 12(b)(1), or alternatively for failure to state a claim under Rule 12(b)(6).

2. The district court dismissed because Plaintiffs failed to plead a non-speculative injury, traceable to the challenged conduct and redressable by the court.

The district court granted Wells Fargo's motion. App. 255-83; R. Doc. 57, at 1-29; Add.31-59. The court explained that Plaintiffs' allegations were "too speculative to show concrete individual harm, too tenuous to show causation, and too conjectural to show redressability." App. 278-79; R. Doc. 57, at 24-25; Add.54-55. The court emphasized that the Plan vested Wells Fargo with discretion to set contribution rates and that Plaintiffs' contribution theory assumed a fixed employer-

participant cost split the Plan did not require. App. 274-77; R. Doc. 57, at 20-23; Add.50-53. The court further concluded that redressability was lacking because even if Plaintiffs prevailed, Wells Fargo may not distribute the Plan's recovery to Plaintiffs. App. 277-78; R. Doc. 57, at 23-24; Add.53-54.

3. Plaintiffs' amended complaint added a new plaintiff and supplemental allegations but did not cure the standing defects.

After receiving leave to amend, Plaintiffs filed their amended complaint on May 8, 2025, adding Erica McKinley as a named plaintiff who allegedly remained enrolled through COBRA coverage. App. 290, 301; R. Doc. 64, at 12 ¶ 18. The amended complaint attached an expert report and added allegations about historical contribution percentages and studies concerning health-plan costs. App. 392-404, 418-32; R. Doc. 64, at 103-15 ¶¶ 233-70; R. Doc. 64-1. But as the district court later observed, the amended complaint's factual allegations "largely mirror" the initial complaint. App. 558; R. Doc. 99, at 2; Add.2.

Wells Fargo again moved to dismiss. Wells Fargo argued the amended complaint failed to cure the standing defects and failed to plead plausible fiduciary-breach or prohibited-transaction claims.

4. The district court again dismissed, holding that Plaintiffs' amended allegations did not establish Article III standing.

The district court granted Wells Fargo's motion to dismiss the amended complaint, concluding that Plaintiffs again failed to demonstrate Article III standing. App. 557-86; R. Doc. 99, at 1-30; Add.1-30.

The court rejected Plaintiffs' renewed premium-contribution injury theory because it still rested on unsupported inferences. App. 575-81; R. Doc. 99, at 19-25; Add.19-25. The court reiterated that participants' contributions cover all Plan expenses—not just prescription-drug costs—and may be affected by factors unrelated to prescription-drug benefits. App. 575-76; R. Doc. 99, at 19-20; Add.19-20. It was thus "speculative" that allegedly higher prescription-drug costs or administrative fees "had any effect at all on Plaintiffs' contribution rates." App. 576; R. Doc. 99, at 20; Add.20.

The court acknowledged that Plaintiffs' historical contribution allegations were "superficially seductive" but concluded they did not overcome three fundamental obstacles: the Plan grants Wells Fargo "sole discretion" to set and modify participant contribution amounts, contributions fund overall Plan expenses, and no one-to-one relationship exists between challenged prescription-drug program costs and Plaintiffs' contributions. App. 559, 577; R. Doc. 99, at 3, 21; Add.3, 21. The court held that McKinley's COBRA allegations did not cure the problem because her contributions still fund more than the prescription drug benefit. App.

579-80; R. Doc. 99, at 23-24; Add.23-24. And the court concluded that Plaintiffs' requested relief to the Plan would not redress their injuries because their theory assumed Wells Fargo would distribute the Plan's recovery to Plaintiffs—though nothing required it to do so. App. 580-81; R. Doc. 99, at 24-25; Add.24-25.

The district court separately rejected Plaintiffs' out-of-pocket theory as "speculative." App. 575, 581-85; R. Doc. 99, at 19, 25-29; Add.19, 25-29. Rather than alleging their specific prescriptions would have cost less absent the alleged fiduciary breaches, Plaintiffs merely pointed to "price comparisons" between certain Plan drugs and prices available to non-participants from other sources. App. 585; R. Doc. 99 at 29; Add.29. Because the court dismissed for lack of standing, it did not reach Wells Fargo's Rule 12(b)(6) arguments. App. 586; R. Doc. 99, at 30 n.8; Add.30 n.8.

Judgment was entered and this appeal followed. App. 587-88; R. Doc. 100; R. Doc. 101; Add.60.

SUMMARY OF THE ARGUMENT

The district court correctly dismissed this case for lack of Article III standing because Plaintiffs' two injury theories—increased premium contributions and inflated out-of-pocket prescription drug costs—both rest on speculation about hypothetical events in a world without Wells Fargo's alleged breaches (the "but-for world").

Plaintiffs' premium theory cannot meet Article III's injury-in-fact and causation requirements because it depends on a multi-step chain of conjecture. First, it depends on speculation that PBMs would have responded to different negotiations with Wells Fargo in ways that produced lower overall Plan costs. Plaintiffs' own allegations refute that inference: they acknowledge that PBM negotiations involve profit-driven counterparties and trade-offs across numerous variables. Second, even assuming lower Plan expenses, Plaintiffs' theory requires the assumption that Wells Fargo would have passed those savings to participants through reduced contributions—but the Plan expressly reserves to Wells Fargo the "sole discretion" to set contribution rates. Multiple circuits agree that this discretion breaks the causal chain and renders the asserted injury speculative.

Plaintiffs' out-of-pocket theory fares no better in satisfying Article III's injury-in-fact and causation requirements. Plaintiffs offer no well-pleaded allegations that the sixteen specific prescriptions they purchased would have cost less but for the challenged conduct. Instead, they point to price comparisons between certain drugs and prices available to non-participants from other sources—a comparison that says nothing about what these Plaintiffs would have paid under a differently administered plan. This defeats both injury and traceability.

Lack of redressability provides an independent basis for affirmance. Prospective injunctive relief would not remedy past injuries and offers Plaintiffs no

future benefit since they are no longer enrolled in the Plan. Plan-wide monetary relief runs to the Plan, not to participants, and nothing requires the Plan to distribute that recovery to Plaintiffs (and indeed, nothing would require such distribution even if they were current Plan participants). And Plaintiffs' request for individual monetary relief under 29 U.S.C. § 1132(a)(3) seeks compensatory damages dressed up as "surcharge"—legal relief unavailable under that provision.

Even if Plaintiffs had standing, their claims would still fail on the merits. The challenged conduct—selecting a PBM, negotiating pricing structures, and determining benefit terms—constitutes plan design, a settlor function that does not give rise to ERISA fiduciary or prohibited transaction liability. *Pegram v. Herdrich*, 530 U.S. 211, 225-26 (2000). And even treating this conduct as fiduciary in nature, Plaintiffs fail to meet the challenging pleading burden requiring meaningful benchmarks to infer a prudent fiduciary would have acted differently.

ARGUMENT

I. PLAINTIFFS LACK ARTICLE III STANDING BECAUSE THEIR ALLEGED INJURIES ARE SPECULATIVE, NOT TRACEABLE TO WELLS FARGO, AND NOT REDRESSABLE.

The Constitution limits federal jurisdiction to actual "Cases" and "Controversies." U.S. Const. art. III, § 2. To invoke that jurisdiction, a plaintiff must demonstrate (1) an "injury in fact that is concrete, particularized, and actual or imminent;" (2) "that the injury was likely caused by the defendant;" and (3) "that

the injury would likely be redressed by judicial relief." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021). Plaintiffs bear the burden of establishing each element "with the manner and degree of evidence required at the successive stages of the litigation." *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992). At the pleading stage, that means "'clearly alleg[ing] facts demonstrating' each element." *Spokeo, Inc. v. Robins*, 578 U.S. 330, 338 (2016) (ellipses omitted). This Court reviews the dismissal for lack of standing de novo. *Animal Legal Def. Fund v. Reynolds*, 89 F.4th 1071, 1076 (8th Cir. 2024).

Plaintiffs' allegations fail all three requirements. Their claimed injuries are speculative—and not traceable to challenged conduct—because they rest on conjecture about how third parties would have behaved and how Wells Fargo would have exercised its discretion. They are also not redressable: as former participants, Plaintiffs cannot benefit from any prospective injunctive relief, any Plan-level recovery would not flow to them, and ERISA does not authorize the individual compensatory relief they seek.

A. Plaintiffs Have Not Alleged A Concrete, Particularized Injury Traceable To Wells Fargo's Conduct.

Plaintiffs advance two theories of injury—inflated premium contributions and out-of-pocket drug costs—but both fail for the same reason: Article III does not

permit plaintiffs to invoke federal jurisdiction by labeling a hoped-for counterfactual as an economic injury.[2]

Injury in fact requires facts showing harm that is "concrete and particularized" and "actual or imminent, not conjectural or hypothetical." *Lujan*, 504 U.S. at 560. Monetary loss qualifies when it is real—even "a few pennies" of actual economic harm can be concrete. *Wallace v. ConAgra Foods, Inc.*, 747 F.3d 1025, 1029 (8th Cir. 2014). But plaintiffs must still plead facts showing they personally paid more than they otherwise would have. *Id.* at 1030-31; *Finkelman v. Nat'l Football League*, 810 F.3d 187, 200-02 (3d Cir. 2016). Conclusory references to "out-of-pocket costs" or "lost 'time and money'" will not do where the complaint never explains how the defendant's conduct financially harmed the plaintiff. *Hekel v. Hunter Warfield, Inc.*, 118 F.4th 938, 943 (8th Cir. 2024).

The same principle controls traceability. The alleged injury must be "fairly traceable" to the defendant's challenged conduct, not the product of "the independent action of some third party not before the court." *Lujan*, 504 U.S. at 560 (ellipses and brackets omitted). When the alleged injury depends on how

[2] Plaintiffs' amended complaint also alleged injury in the form of "lower wages or limited wage growth." App. 409; R. Doc. 64, at 120 ¶ 285. Plaintiffs forfeited that theory by failing to defend it in the district court and failing to raise it on appeal. In any event, the allegation was wholly conclusory: Plaintiffs made no allegations concerning their own wages.

independent third parties would have acted in a but-for world, standing is not impossible—but plaintiffs must plead (and later prove) facts supporting a predictable chain of events showing that those third parties likely would have reacted to the defendant's changed conduct in a way that personally affected plaintiffs. *Food & Drug Admin. v. All. for Hippocratic Med.*, 602 U.S. 367, 383-84 (2024); *Little v. KPMG LLP*, 575 F.3d 533, 541 (5th Cir. 2009) (holding alleged lost-business injury too speculative where it depended on "several layers of decisions by third parties," including whether customers would have replaced KPMG, hired plaintiffs, and paid the same rates); *Dominguez v. UAL Corp.*, 666 F.3d 1359, 1362-65 (D.C. Cir. 2012) (holding alleged overcharge for plane ticket too speculative where plaintiff failed to show that a hypothetical secondary market would have produced a lower price than he actually paid). A plaintiff therefore cannot establish standing through speculation about how independent actors would have behaved in a but-for world. *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 414 & n.5 (2013); *California v. Texas*, 593 U.S. 659, 675 (2021).

These principles apply with equal force to ERISA claims because there is "no ERISA exception to Article III." *Thole v. U.S. Bank N.A.*, 590 U.S. 538, 547 (2020). Although ERISA authorizes suits to restore plan losses, an injury to an ERISA plan is not automatically an Article III injury to plan participants. *Id.* at 544. Instead, a plan participant must trace a line between the challenged conduct and a personal

injury to himself. *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 580-82 (3d Cir. 2024). Where a plan participant's own injury turns on conjecture about what PBMs would have charged, accepted, negotiated, passed through, or absorbed under a hypothetical arrangement, plaintiffs have not pleaded the concrete injury or non-speculative causal connection that Article III requires.

1. Plaintiffs' premium theory rests on multiple conjectural steps that the district court correctly rejected.

Plaintiffs' theory that they paid too much in premium contributions because the Plan overpaid for prescription drugs and ESI's administrative services establishes neither injury nor traceability.

First, its premise—that overall Plan expenses would have been lower absent Wells Fargo's alleged fiduciary breaches—depends on conjecture that sophisticated counterparties would have responded to different negotiations or monitoring by charging millions less for substantially identical pharmacy benefits. Bedrock Article III principles forbid resting standing on that supposition.

Second, even assuming lower Plan expenses, the theory requires the further leap that Wells Fargo would have exercised its unfettered discretion to pass those savings through as reduced premium contributions—the very counterfactual that multiple circuits have held cannot establish a traceable injury-in-fact. The district court thus correctly held that Plaintiffs' premium theory pleads no concrete injury traceable to Wells Fargo.

(a) Plaintiffs' alleged injury relies on layers of conjecture regarding the complex commercial interactions of independent actors.

Plaintiffs' first problem is that their alleged injury depends on hypothetical third-party behavior unfolding in a counterintuitive way. Where causation depends on independent third parties, a plaintiff must allege how those parties predictably would react, not conjecture about how they might behave. *See Clapper*, 568 U.S. at 414 & n.5; *California*, 593 U.S. at 675. As this Court has observed, "[p]laintiffs cannot rely on speculation about the unfettered choices made by independent actors not before the court." *Smith v. UnitedHealth Grp. Inc.*, 106 F.4th 809, 813-14 (8th Cir. 2024) (quoting *Clapper*, 568 U.S. at 414 n.5).

That is exactly what Plaintiffs do here. Their theory is that (1) Wells Fargo should have used its "substantial bargaining power" to demand lower rates from ESI or other hypothetical PBMs (App. 295-97; R. Doc. 64, at 6-8 ¶¶ 8, 10); (2) ESI or those other third parties would have acquiesced, offering the same benefits to Wells Fargo at "drastically lower[]" rates (App. 297; R. Doc. 64, at 8 ¶ 11); (3) this would have saved the Plan "millions of dollars" (App. 297; R. Doc. 64, at 8 ¶ 11); and (4) those savings would have led to Plaintiffs paying lower premium contributions (App. 297; R. Doc. 64, at 8 ¶ 11).

The allegations do not support these inferential leaps. Even assuming Wells Fargo itself could have acted differently, the amended complaint does not plausibly

establish that independent third parties would have responded in ways producing overall savings to the Plan—much less reductions in Plaintiffs' own contributions. To the contrary, Plaintiffs allege that PBM negotiations involve third parties, including the PBMs, that are "profit-driven entities that seek to profit from their intermediary role in the prescription-drug ecosystem," with the largest PBMs (including ESI) publicly traded and thus owing shareholders duties to "maximize profits." App. 315-16, 326; R. Doc. 64, at 26-27, 37 ¶¶ 55, 79; App. 561; R. Doc. 99, at 5; Add.5. They acknowledge that PBM negotiations involve trade-offs across numerous variables—pharmacy networks, formularies, specialty drug designations, claims processing, rebates, drug prices, and administrative fees—such that gaining ground on one term may come at the cost of another. App. 315-16, 321, 331; R. Doc. 64, at 26-27, 32, 42 ¶¶ 55, 69, 94. And they admit that achievable terms are limited by the "parties' willingness to transact." App. 316; R. Doc. 64, at 27 ¶ 57. In other words, Plaintiffs' own allegations refute the notion that the third parties Wells Fargo must transact with "w[ould] likely react in predictable ways" that would reduce overall Plan expenses. *California*, 593 U.S. at 675.

Plaintiffs attempt to fill this gap by cherry-picking terms that other PBMs or ESI allegedly offer—pricing tied to different benchmarks, lower prices for certain generic drugs, or reduced administrative fees. App. 367-70, 380-81; R. Doc. 64, at 78-81, 91-92 ¶¶ 170-75, 204. Those allegations only underscore the theory's

speculative nature. Plaintiffs never allege that any PBM would have furnished Wells Fargo the same suite of services—identical pharmacy networks, mail-order and specialty pharmacy infrastructure, comparable formulary management, and equivalent administrative services—at lower overall cost. Nor do they allege lower *net* costs to the Plan after accounting for rebates, administrative fees, and the full range of prescription drug spending across both generic and brand-name drugs.

Compounding the supposition, participant contributions fund *all health plan expenses*, not merely the pharmacy benefit. App. 580; R. Doc. 99, at 24; Add.24. Had Wells Fargo taken the steps Plaintiffs propose, there is no telling what other vendor arrangements would have changed. And the pharmacy program is only a fraction of the Plan's expenses, which also cover medical, dental, and vision benefits. Lower pharmacy spending thus would not ensure lower Plan expenses overall.

The causal chain here is even more attenuated than those rejected by the Third and Ninth Circuits in *Knudsen* and *Winsor*. In both cases, plan participants advanced premium-contribution theories like Plaintiffs'—alleging that fiduciary breaches increased overall plan costs and therefore their contributions. *Knudsen*, 117 F.4th at 573-75; *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 523-24 (9th Cir. 2023). Both courts held that plaintiffs lacked standing because the connection between fiduciary breach and contributions was speculative given plan-sponsor

discretion. *Knudsen*, 117 F.4th at 580-82; *Winsor*, 62 F.4th at 524-25. Yet the plaintiffs there alleged specific, quantifiable sums withheld from the plans: in *Knudsen*, $65 million in drug rebates allegedly withheld, 117 F.4th at 574; in *Winsor*, contractually defined commissions paid to a benefits manager the plaintiffs claimed should have been disgorged to the plan. 62 F.4th at 521-22. Those causal chains at least attempted to begin with identifiable harm to the plan, and yet they were still insufficient.

Plaintiffs' theory adds a further layer of speculation because it does not even begin with a discrete sum withheld from the Plan. Instead, they posit that, had Wells Fargo negotiated differently, ESI or another PBM would have furnished identical prescription drug benefits for theoretical, unquantified savings in the "millions" or "tens of millions." App. 297, 395; R. Doc. 64, at 8, 106 ¶¶ 11, 243. That reliance on conjecture about independent third parties defeats their premium theory of standing.

(b) Wells Fargo's sole discretion to set contribution rates renders Plaintiffs' premium theory speculative.

Plaintiffs' next problem is Wells Fargo's discretion. Even assuming *the Plan* could have paid less in Plaintiffs' but-for world, Wells Fargo's freedom to set Plaintiffs' premium contributions still renders speculative their premium-overpayment theory.

Under the Plan, Wells Fargo determines the amount and allocation of participant premium contributions. S.App.128, 207; R. Doc. 31-2, at 22 ¶ 5.3; R. Doc. 44, at 9. Participant contributions go toward all health plan expenses, not merely their pharmacy benefit. App. 580; R. Doc. 99, at 24; Add.24. Wells Fargo may set different contribution rates for different participants based on factors like dependents and benefit options. S.App.128; R. Doc. 31-2, at 22 ¶ 5.3. The Plan does not compel Wells Fargo to contribute at all, and participants may be required to fully fund the Plan if Wells Fargo so chooses. S.App.128; R. Doc. 31-2, at 22 ¶ 5.4. However, Plaintiffs allege Wells Fargo has previously contributed some percentage of Plan costs, leaving participants to pay the remainder in premiums. App. 392; R. Doc. 64, at 103-06 ¶¶ 233-43.

Wells Fargo's discretion to set premium contributions renders Plaintiffs' asserted injury-in-fact speculative. Their premium overpayment theory relies on the supposition that, had the Plan cut costs by renegotiating or changing its PBM, Wells Fargo would have passed those savings onto Plaintiffs in the form of lower premium contributions even though nothing compels it to do so. "Allegations that stand on nothing more than supposition cannot establish financial harm." *Knudsen*, 117 F.4th at 580 (quoting *Finkelman*, 810 F.3d at 201). Other circuits have uniformly refused to take the inferential leap Plaintiffs seek here. *See Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598, 608 (6th Cir. 2007) (finding alleged overpayments to plan

"neither concrete nor particularized" where allegations rested on "assum[ption] that [employers] would pass on any increase in reimbursements or administrative fees" to plaintiffs); *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 457 (3d Cir. 2003) (rejecting as "far too speculative" the "notion that [a] firm would have passed the savings" from disgorged insurance overpayments "on to its employees in the form of a higher salary or additional benefits").[3]

The same discretion defeats traceability. Plaintiffs must show Wells Fargo's alleged failure to negotiate with or monitor its PBM was the but-for cause of their premium overpayments. But Wells Fargo's separate discretion to set contribution rates—not an alleged fiduciary function—severs that chain. Even had Wells Fargo negotiated better terms and saved the Plan money, the Plan left it free to hold employee contributions constant or raise them.

Attempting to plead around this issue in their amended complaint, Plaintiffs focused on the alleged consistency in Wells Fargo's historical contribution rates between 2018 and 2023. App. 392-94; R. Doc. 64, at 103-05 ¶¶ 233-40. Supplementing this allegation with an expert report and studies purportedly showing

[3] Plaintiffs attempt to distinguish *Horvath* because the employer there paid all premiums, and the plaintiffs alleged that the employers' premium overpayments led the plaintiffs to receive lower salaries and fewer benefits. Br. 34. *Horvath* is on point, however. Here, as in *Horvath*, Plaintiffs' theory of injury relies on the notion that an employer will pass theoretical cost savings onto employees even though nothing requires it to do so. That speculative jump forecloses standing.

a general link between prescription drug expenses and overall health premium contribution amounts for employees (App. 396-99, 403; R. Doc. 64, at 107-10, 114 ¶¶ 246-53, 266), Plaintiffs allege that Wells Fargo's contribution rates reflect a "policy or practice of setting participant contribution levels at 25-26% of overall Plan health costs," showing "any reduction in overall healthcare spending—*e.g.*, if Wells Fargo stopped causing the Plan to overspend on prescription drugs and related fees by tens of millions of dollars each year—would result in proportionally lower participant contributions[.]" App. 395; R. Doc. 64, at 106 ¶¶ 242-43; *see also* App. 404; R. Doc. 64, at 115 ¶ 269 (alleging, based on expert report, that "Wells Fargo uses percentage-based cost sharing for its employee contributions").

But Plaintiffs' allegations do not plausibly show that Wells Fargo even adhered to a fixed contribution ratio, much less that it would have exercised its sole discretion to maintain that ratio in Plaintiffs' but-for world. The Form 5500s from which Plaintiffs draw their "historical data" belie their premise that the participant share has been "consistent" (Br. 35): the percentage of Plan costs charged to participants varied between 25.00% and 28.59% of total contributions from 2016 through 2023. S.App.150-73; R. Doc. 32-2 to 32-5, at 2-6; R. Doc. 80-1, at 2-6 (2023 Form 5500); https://www.efast.dol.gov/5500Search/ (for 2016-2018 Form 5500s). And because total contributions to the Plan approximated $2.3 to 2.7 billion annually during that period, each percentage point of variance represents a roughly $25

million difference. Such fluctuations do not show that Wells Fargo mechanically set contributions as a *pro rata* share of Plan spending.

Moreover, Plaintiffs cannot allege that *the Plan requires* Wells Fargo to maintain any particular contribution ratio. App. 580; R. Doc. 99, at 24; Add.24. Plaintiffs must thus rely on the supposition that, under materially different economic conditions—with the Plan spending millions less on prescription-drug benefits (App. 370; R. Doc. 64, at 81 ¶ 175)—Wells Fargo would have maintained the same contribution levels despite its discretion to do otherwise. That speculative leap cannot establish a traceable injury-in-fact.

This same pleading failure foreclosed standing in *Knudsen* and *Winsor*. In *Knudsen*, the plaintiffs alleged that, over the prior five years, plan participants paid "around 30% of overall contributions to the Plan." 117 F.4th at 574. And in *Winsor*, plaintiffs similarly alleged employee contribution percentages and furnished examples of "roughly proportionate" cost fluctuations, using these allegations to support their conclusion that "employee contributions are calculated as a *pro rata* share of the total benefits cost." 62 F.4th at 524-25. But in both cases, the plan sponsor had discretion under the plan documents to set contribution amounts, and the courts found that fact dispositive notwithstanding allegations of prior practices surrounding sharing ratios. *See* 117 F.4th at 582; 62 F.4th at 525.

Plaintiffs attempt to distinguish these cases on the ground that the employers did not set participant contributions as a pro rata share of overall Plan costs. Br. 34-36. But that is no meaningful distinction. In both cases, the plaintiffs made analogous contribution ratio allegations, and the courts rejected them because the *plan documents* left the plan sponsors "free to change the employee contribution rates." *Winsor*, 62 F.4th at 525; *Knudsen*, 117 F.4th at 582 (reasoning that there were no well-pleaded allegations that, "*under the Plan documents*," the value of misappropriated drug rebates was used to calculate premiums (emphasis added)). Relying on plan documents makes sense because past practices do not show how plan sponsors would act under the materially different economic conditions alleged, where the sponsor has adopted a brand new PBM arrangement. App. 395; R. Doc. 64, at 106 ¶ 243. Moreover, absent a "plan design" that gives plaintiffs an "individual right" to plan assets, whether hypothetical premium savings or remitted drug rebates, *see Winsor*, 62 F.4th at 525; *Knudsen*, 117 F.4th at 582, plaintiffs' theories of injury require the assumption that sponsors will voluntarily grant those assets to plaintiffs. The Third and Ninth Circuits correctly held that this assumption breaks the causal chain and renders the alleged injury speculative. This Court should hold the same.

(c) Plaintiffs' counterarguments and authorities do not warrant a different result.

Plaintiffs respond that their allegations must be accepted as true at the pleading stage. Br. 40. But whether an injury "is concrete and non-speculative presents a legal question," not a factual one. *Little*, 575 F.3d at 540 n.2. Plaintiffs' allegation of inflated premiums is not historical fact—like whether the traffic light was red. It is a *prediction* about what contributions would have been in a hypothetical world. The district court rejected Plaintiffs' reliance on historical contribution ratios not because it failed to credit those allegations as a factual matter (*contra* Br. 40), but because those ratios do not make it sufficiently likely that contributions would have been lower in the but-for world. Plaintiffs are similarly wrong that the court "ignored" their expert report. Br. 33. The court considered the report's factual information to the extent pleaded, rejected only its conclusory opinions, and held those allegations still did not cure the speculative link between alleged Plan overpayments and Plaintiffs' own contributions. App. 570-71, 575-78; R. Doc. 99, at 14-15, 19-22; Add.14-15, 19-22.

Plaintiffs next argue that the number of inputs that affect premiums is irrelevant because an increase in one input is bound to affect the output—analogizing to a grocery bill in which an increase in the price of eggs increases the shopper's payout even if the price of milk and butter stay the same. Br. 41-44. But a health plan is not akin to a grocery store haul of discrete items; it is more like a restaurant's

prix fixe menu. A diner pays a set price for a bundled three-course meal, and even if the restaurant buys one ingredient at a significant savings, the diner may never see that savings. The uncertainty here is greater still. Even if Wells Fargo had negotiated differently, there is no saying PBMs would have responded in ways that reduced Plan spending. And even if Plan spending dropped, it is speculative to assume Wells Fargo would maintain historical contribution ratios under a brand new PBM arrangement, with nothing in the Plan document requiring it.

Plaintiffs' cited authorities do not support a contrary result because they involve different theories of injury. Br. 43. In *Wilson v. Centene Management Co.*, 168 F.4th 217 (5th Cir. 2026), the Fifth Circuit held that plaintiffs bringing claims for breach of their health insurance contracts had standing based on a *benefit-of-the-bargain* theory: they presented evidence that the provider "network was falsely represented as accurate, adequate, and up-to-date," and "[a]s a result, each policyholder was overcharged to the extent the network was inaccurate." *Id.* at 226. That theory differs fundamentally from the one advanced here. As the district court explained, Plaintiffs received all benefits they were entitled to under the Plan, so they cannot assert an overcharge injury on the theory that they received less than promised. Plaintiffs' overcharge theory instead rests on a far more attenuated causal chain—had Wells Fargo negotiated more prudently, PBMs would have offered better terms, those terms would have saved the Plan money, and Wells Fargo would

have exercised its unfettered discretion as settlor (not fiduciary) to pass those savings to participants as reduced premiums.

Neither *Wilson* nor Plaintiffs' other authorities address anything like this attenuated theory. *See In re Ins. Brokerage Antitrust Litig.*, 579 F.3d 241, 263-64 (3d Cir. 2009) (plaintiffs alleged they paid supra-competitive insurance premiums directly caused by bid-rigging and kickback arrangements, with no intervening speculation about how third parties might respond to different negotiations or about plan-sponsor discretion); *Acosta v. Bd. of Trs. of Unite Here Health*, No. 22-C-1458, 2023 WL 2744556, at *1 (N.D. Ill. Mar. 31, 2023) (plaintiffs alleged defendants unfairly allocated administrative expenses to their plan unit in a multiemployer benefit plan, which under collective bargaining agreement "necessarily reduce[d]" plaintiffs' "compensation by the same amount"). *Knudsen* and *Winsor*, by contrast, squarely addressed premium theories like Plaintiffs' and held them too speculative to establish standing—as this Court should too.

(d) The addition of Plaintiff McKinley does not salvage standing.

Plaintiff McKinley's addition did not cure these deficiencies. App. 400-01; R. Doc. 64, at 111-12 ¶¶ 256-60. Plaintiffs allege that McKinley enrolled in COBRA continuation coverage and thus "by definition and operation of law" paid 102% of her share of Plan expenses. App. 400; R. Doc. 64, at 111 ¶ 256. She posits that lower

Plan expenses would thus necessarily have reduced her COBRA payments. For three reasons, her COBRA status does not grant her standing.

First, McKinley's alleged injury still relies on the assumption that overall Plan costs would have been lower absent Wells Fargo's challenged conduct, which depends on the same conjecture about hypothetical events that defeats standing for her co-plaintiffs. *Supra* I.A.1.a. And as the district court explained, "Plaintiffs' contributions are used to cover *overall* Plan expenses, not specifically or exclusively their prescription drug benefits or ESI's administrative fees" (App. 577; R. Doc. 99, at 21; Add.21), so even assuming certain prescription drug program costs decreased, it is still speculative to assume McKinley's contributions would have dropped since overall Plan expenses may not have.

Second, Plaintiffs' allegation that COBRA premiums are calculated on an "actuarial" or "past cost" basis does not establish that higher overall Plan costs necessarily increased her COBRA payments. App. 400-01; R. Doc. 64, at 111-12 ¶ 258; 29 U.S.C. § 1164(2). Under either calculation method, the product is the predicted "cost of providing coverage . . . for similarly situated beneficiaries," *i.e.*, those who elected the same policy and coverage, not simply a *pro rata* split of anticipated premium costs. 29 U.S.C. § 1164(2)(B)(i). Plaintiffs fail to allege, however, that those with *McKinley's* specific policy and coverage choices are overpaying for COBRA continuation coverage. And the annual payment pled for her

coverage—$8,749.44—is significantly lower than the pled average overall contribution per participant—$15,210. *See* App. 401; R. Doc. 64, at 112 ¶ 260 (alleging Ms. McKinley continues to pay $729.12 per month in COBRA premiums); App. 404; R. Doc. 64, at 115 ¶ 268 (alleging $15,210 average overall contribution per participant for year 2023). Controlling cases are clear: "standing must be particularized, meaning the alleged 'injury must affect the plaintiff in a personal and individual way.'" *Wallace*, 747 F.3d at 1030 (quoting *Lujan*, 504 U.S. at 560 n.1). Plaintiffs fail to plead that for McKinley.

Third, Plaintiffs admit that "[a]s to premium contributions"—whether made by McKinley or the other Plaintiffs—"the relief Appellants seek runs to the Plan by operation of law." Br. 18. As discussed further below, lack of redressability thus independently bars Plaintiffs' claims based on a premium-contribution injury because even if Wells Fargo is required to refund *the Plan*, nothing requires the recovery to be distributed to McKinley or the other Plaintiffs. *Supra* pp. 46-49.

2. Plaintiffs' out-of-pocket theory is non-particularized and speculative.

(a) Plaintiffs allege no facts showing that their own prescription costs would have been lower absent the alleged breaches.

Plaintiffs' theory that they paid too much out of pocket for prescription drugs likewise establishes neither injury in fact nor traceability: it rests on a speculative counterfactual and is not particularized to the drugs they personally bought.

Plaintiffs do not claim that Wells Fargo sets the pharmacy-counter prices they paid. To plead a concrete, particularized injury traceable to Wells Fargo, then, Plaintiffs would have to allege that Wells Fargo could have negotiated materially better terms, that ESI or an alternative PBM would have agreed, and that those changes would have lowered the prices Plaintiffs paid for the sixteen drugs they purchased—not merely the Plan's costs overall. The amended complaint contains no such allegations.

This omission is fatal. Plaintiffs' alleged injury would exist—and would be traceable to Wells Fargo's challenged conduct—only if their own prescription prices would have been lower in their but-for world. "Overpayment" is a conclusory label unless the complaint plausibly explains why the plaintiff would have paid less absent the challenged conduct. *Knudsen*, 117 F.4th at 580-82. And where, as here, the plaintiffs' ability to pay less depends on third parties, those parties' likely, predictable reactions must be pled as well. *Finkelman*, 810 F.3d at 199-202; *Little*, 575 F.3d at 541.

Wallace confirms the requirement of a particularized, non-speculative injury. There, this Court accepted that even a few pennies of actual overpayment for products mislabeled as kosher would be a concrete injury but held the plaintiffs lacked Article III standing because they alleged no "particularized reason" to think the packages they personally purchased were non-kosher. 747 F.3d at 1029-31.

Although the defendant's product line was tainted, plaintiffs did not allege that all or most individual packages were, so it was "pure speculation" that their packages were faulty—and it remained plausible they received exactly what was promised. *Id.*

The same logic applies here. Plaintiffs allege, at most, that certain drugs or groups of drugs in the Plan were priced above selected benchmarks, but they do not allege facts showing that all or most drugs covered by the Plan would have cost less under different PBM negotiations—much less that the handful of prescriptions purchased by Navarro, Kinsella, Bulla, Gamage, or McKinley would have. App. 341, 343-57, 387-90; R. Doc. 64, at 52, 54-55, 98-101 ¶¶ 118-20, 124-46, 220, 222, 224, 226, 228. Without that particularized link, Plaintiffs' alleged injury is speculative just as the *Wallace* plaintiffs' alleged overpayment was.[4]

Finkelman illustrates the same point in a context where injury turned on a but-for hypothetical. The plaintiff there bought Super Bowl tickets on the resale market and alleged that the NFL's ticket-distribution practices inflated resale prices. 810 F.3d at 190-91, 197-202. The Third Circuit held that the alleged price inflation was

[4] Plaintiffs' argument that Wells Fargo "cannot avoid liability" even if it only allowed overcharges for "certain drugs," (Br. 48-49) misses the point. Whether or not Plaintiffs could state a claim for fiduciary breach based on allegations that a subset of drugs were overpriced (they cannot), Plaintiffs cannot establish a particularized Article III injury-in-fact based on allegations that some drugs, though not necessarily the ones they purchased, may have been overpriced.

too speculative because the plaintiff could not show whether the challenged practice increased, decreased, or had no effect on the resale-market price; his allegation that he paid too much rested on "pure conjecture about what the ticket resale market might have looked like if the NFL had sold its tickets differently." *Id.* at 200-01. So too here. Plaintiffs ask the Court to infer that, in a but-for world, Wells Fargo would have negotiated different pricing terms, ESI or another PBM would have accepted them, and those changes would have resulted in lower prices for the sixteen prescriptions the named Plaintiffs purchased. But Plaintiffs' cited transactions involve only a few of the drugs covered by the Plan, while PBM arrangements involve multiple negotiated variables—including pricing formulas for different drug categories, pharmacy networks, PBM-owned pharmacies, rebates and manufacturer concessions, administrative fees, and participant cost-sharing mechanics. App. 314-16, 318, 321-22; R. Doc. 64, at 25-27, 29, 32-34 ¶¶ 52-53, 56, 58, 62, 69-70, 73. For all the amended complaint alleges, a different PBM arrangement could have lowered some Plan-level costs while leaving Plaintiffs' specific drugs unchanged—or even making them more expensive.

Plaintiffs' own allegations confirm how speculative it is that their own prescriptions would have cost less. The amended complaint alleges that, after this lawsuit was filed, Wells Fargo "appear[ed]" to renegotiate with ESI and obtained more favorable pricing—but only on 158 of 260 generic drugs on the Plan's

preferred formulary. App. 366; R. Doc. 64, at 77 ¶ 166.[5] Even within that subset—not all drugs the Plan covers—prices changed on only about 61%. Plaintiffs do not allege that their specific prescriptions were among the 158 whose prices dropped, or that Wells Fargo could have obtained those prices in earlier years. Plaintiffs' allegations about the PepsiCo plan, which also uses ESI, confirm the same defect: none of the drugs that plan allegedly offered at lower prices are drugs these Plaintiffs purchased. S.App.370-71; R. Doc. 65, at 1-2; App. 380-81; R. Doc. 64, at 91-92 ¶ 204. Alleging that "some" products were affected does not establish that Plaintiffs' purchases were among them.

Comparing Plaintiffs' prices to pharmacy acquisition costs does not help. NADAC is an average acquisition-cost measure for pharmacies—not a plan-participant price or a measure of what a prudent fiduciary would have obtained. App. 316-17, 341; R. Doc. 64, at 27-28, 52 ¶¶ 59-60, 120. A pharmacy's acquisition cost says nothing about the components of insured prescription-drug pricing: network access, dispensing arrangements, specialty-pharmacy services, formulary design, rebates, and cost allocation between the Plan and participants. App. 312-14, 335-36,

[5] Plaintiffs' allegation rests on an unsupported assumption that such changes must reflect renegotiation rather than ordinary market fluctuations in drug prices. And notably, Plaintiffs do not allege that this alleged renegotiation resulted in reduced overall prescription drug plan expenses, overall Plan expenses, or employees' individual contribution amounts.

341; R. Doc. 64, at 23-25, 46-47, 52 ¶¶ 46-49, 106, 118-20; App. 581-85; R. Doc. 99, at 25-29; Add.25-29.

Plaintiffs' uninsured cash-price allegations fare no better. Those allegations concern other drugs—not the specific prescriptions on which Plaintiffs base their out-of-pocket injury. *Compare* App. 291-93, 295, 344-53, 355-56, 387-90; R. Doc. 64, at 2-3, 6, 55-64, 66-67, 98-101 ¶¶ 3, 7, 126-37, 140-43, 220, 222, 224, 226, 228 *with* S.App.370-71; R. Doc. 65, at 1-2. Moreover, retail cash pricing reflects a different transaction with different counterparties, different pricing incentives, and no claim for Plan coverage. Article III requires a particularized injury to these Plaintiffs—not an assertion that some nonparticipant could buy a different drug in a different type of transaction at a lower price.

(b) Plaintiffs' counterarguments lack merit.

Plaintiffs' principal response is that monetary overpayment is a paradigmatic Article III injury, but they have not plausibly alleged overpayments as to themselves. Br. 21-23. An "overpayment" is not established merely by comparing the price charged under an insured prescription-drug plan to a pharmacy's average acquisition cost. It requires a well-pleaded basis to infer that, but for the challenged conduct, the plaintiff would have paid less for the prescription the plaintiff actually purchased. *See Finkelman*, 810 F.3d at 200-02; *In re Johnson & Johnson Talcum Powder Prods. Mktg., Sales Pracs. & Liab. Litig.*, 903 F.3d 278, 285-91 (3d Cir. 2018). Plaintiffs

assert that "the higher the price, the more they paid," but that assumes the very point in dispute: whether the prices for these particular drugs would have been lower in the but-for world, rather than merely lower than unrelated benchmarks or prices in different transactions. Br. 19.

Plaintiffs also mischaracterize the district court's decision. The court did not adopt a categorical rule that ERISA health-plan participants can never allege injury without a denial of benefits. The court expressly agreed with *Knudsen* that participants may establish standing based on excessive out-of-pocket costs in an appropriate case. App. 272-73; R. Doc. 57, at 18-19; Add.48-49. But the court held that Plaintiffs' allegations did not show a non-speculative overpayment traceable to Wells Fargo, explaining that allegations about markups on a subset of drugs were "not sufficient to establish a causal connection." App. 275-76; R. Doc. 57, at 21-22; Add.51-52. The second order held the amended complaint did not cure that defect. App. 563-64, 575, 581-86; R. Doc. 99, at 7-8, 19, 25-30; Add.7-8, 19, 25-30. The court's discussion of promised benefits was not a categorical rule; it explained why Plaintiffs pleaded no benefit-of-the-bargain injury: they alleged no denial of promised benefits, no unauthorized pricing method, and no promise to price drugs

at the benchmarks they invoked. App. 581-86; R. Doc. 99, at 25-30; Add. 25-30. That is ordinary Article III analysis, not an ERISA exception.[6]

For similar reasons, Plaintiffs and their amici's argument that the district court erred in analogizing to defined benefit plans—like the one in *Thole*—is misplaced. As the district court correctly explained, unlike a defined contribution plan, where the participants' benefits are tied to the value of their individual accounts, participants' benefits under a defined-benefit plan do not fluctuate with the value of the plan. App. 572; R. Doc. 99, at 16; Add.16. And the Plan here is "closely analogous" to a defined-benefit plan because "Plaintiffs were (or are) 'entitled to their contractually defined benefits regardless of the value of the Plan's assets.'" App. 572; R. Doc. 99, at 16; Add.16. The court's point was not that self-insured health plans are identical to defined benefit pension plans, but that, as with such plans, overpayment by *the Plan* does not automatically translate into a harm to *the participant*. Rather, Plaintiffs must allege a non-speculative link between Wells Fargo's challenged conduct and a concrete, particularized injury to themselves.

[6] Plaintiffs also incorrectly suggest that traceability was undisputed below. Br. 31. Wells Fargo argued that Plaintiffs "fail to allege any non-speculative individual injury caused by Wells Fargo's conduct" (R. Doc. 79, at 22), and the district court agreed, holding that Plaintiffs' allegations were "too tenuous to show causation" (App. 558, 575; R. Doc. 99, at 2, 19; Add.2, 19). In any event, traceability is an element of standing, which goes to the Court's subject matter jurisdiction, which "can never be forfeited or waived." *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 514 (2006).

Plaintiffs—in both their premium contribution and out-of-pocket drug costs theories—failed to do that.

(c) Plaintiffs' authorities are distinguishable.

Plaintiffs' cases confirm that overpayment must be pled, not assumed. *Wallace* rejected standing based on alleged overpayment where allegations failed to show particularized injuries. Plaintiffs' other benefit-of-the-bargain cases each involved a pleaded defect in the plaintiff's own transaction or property—not speculation about hypothetical negotiations with third parties. In *Carlsen* and *Kuhns*, plaintiffs alleged they paid for services with contractual data-protection promises the defendants breached. *Carlsen v. GameStop, Inc.*, 833 F.3d 903, 907-10 (8th Cir. 2016); *Kuhns v. Scottrade, Inc.*, 868 F.3d 711, 714-16 (8th Cir. 2017). In *George v. Omega Flex, Inc.*, the plaintiff alleged her structures contained defective tubing worth less than she paid. 874 F.3d 1031, 1031-32 (8th Cir. 2017). Plaintiffs here allege no comparable defect and no breached promise to price drugs at NADAC or other benchmarks. Their theory requires speculation that different negotiations would have produced lower prices for their specific prescriptions—not the direct benefit-of-the-bargain injury in those cases.

Plaintiffs' defined-contribution authorities fare no better. Br. 24-25, 27. In a defined-contribution plan, a participant's benefit is the value of an individual account, and fees, expenses, losses, and gains are allocated to that account. *See Boley*

v. Universal Health Servs., Inc., 36 F.4th 124, 128 n.2 (3d Cir. 2022); *Davis v. Wash. Univ. in St. Louis*, 960 F.3d 478, 481-82 (8th Cir. 2020). That is why allegations of plan-level excessive recordkeeping fees or investment expenses can plead personal injury in those cases: the excess costs are borne by participant accounts. *See Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 590, 592-96 (8th Cir. 2009); *Davis*, 960 F.3d at 482-84; *Boley*, 36 F.4th at 131-33; *Tussey v. ABB, Inc.*, 746 F.3d 327, 335-37 (8th Cir. 2014); *Tibble v. Edison Int'l*, 843 F.3d 1187, 1197-98 (9th Cir. 2016). Plaintiffs here have no individual Plan accounts whose value Wells Fargo's PBM arrangement could reduce. They, therefore, cannot establish injury merely by alleging that the Plan in the aggregate paid too much—though they have not done even that. They must plead facts showing that Wells Fargo's alleged imprudence caused the specific prescriptions Navarro, Kinsella, Bulla, Gamage, and McKinley purchased to cost more than they would have in a non-speculative but-for world. They have not.

Plaintiffs' district-court authorities only underscore the deficiencies of their allegations. *Express Scripts/Anthem* and *Barbich* involved concrete allegations of lower-cost alternatives tied to the challenged arrangement itself, not merely external benchmark comparisons. In *In re Express Scripts/Anthem ERISA Litigation*, ESI allegedly offered Anthem a lower-price PBM deal that Anthem declined, and Anthem's consultant, acting under the PBM Agreement's own pricing-review provision, concluded that the existing pricing exceeded competitive benchmark

pricing by more than $3 billion annually. 285 F. Supp. 3d 655, 663-66 (S.D.N.Y. 2018). In *Barbich*, the alleged overpayment rested on an internal comparison between two Northwestern health-plan options, one of which allegedly charged higher premiums without commensurate benefits. *Barbich v. Northwestern Univ.*, No. 25-cv-6849, 2026 WL 1552506, at *1-3 (N.D. Ill. Apr. 2, 2026). Plaintiffs allege no comparable lower-price offer from ESI, contract-specific pricing-review finding, or internal Wells Fargo plan option showing that the same prescription benefit was available at a lower price.

Blue Cross is likewise inapposite because it involved insurers alleging that Rite Aid fraudulently reported inflated usual-and-customary prices, causing overpayment under a negotiated "lesser of" reimbursement formula; Plaintiffs allege no fraud, false price reporting, or misapplication of a contractual pricing rule. *Blue Cross & Blue Shield of N.C. v. Rite Aid Corp.*, 519 F. Supp. 3d 522, 529-33, 540-42 (D. Minn. 2021).

And *Stern* is distinguishable because the plaintiffs there allegedly analyzed every one of 404 generic drugs on the plan formularies, and the court distinguished *Navarro* on that basis; in any event, *Stern*'s treatment of NADAC and cash-price benchmarks as sufficient for standing is inconsistent with the more careful Article III approach required by the appellate authorities discussed above. *Stern v.*

JPMorgan Chase & Co., No. 25-cv-2097, 2026 WL 654714, at *8-9 (S.D.N.Y. Mar. 9, 2026); *supra* pp. 37-38.

At bottom, Plaintiffs' out-of-pocket theory asks the Court to accept a faulty pricing syllogism: some benchmark prices were lower than Plan prices; Plaintiffs paid the Plan prices; therefore, Plaintiffs suffered an Article III injury caused by Wells Fargo. That logic omits the essential Article III link. Plaintiffs must plead facts showing their own prescription prices would have been lower under a non-speculative but-for world in which Wells Fargo acted differently. They did not. Their theory is therefore non-particularized, speculative, and insufficient to establish injury-in-fact or traceability.

B. Plaintiffs' Requested Relief Would Not Redress Their Alleged Injuries.

Plaintiffs also lack standing for the independent reason that their alleged injuries are not redressable. To establish redressability, Plaintiffs must show that it is "likely," not "merely 'speculative,'" that their asserted injuries "will be 'redressed by a favorable decision.'" *Lujan*, 504 U.S. at 561. And because "standing is not dispensed in gross," Plaintiffs must demonstrate standing for each "form of relief that they seek." *TransUnion*, 594 U.S. at 431. Plaintiffs sought three relevant categories of relief: (1) prospective relief; (2) Plan-level relief requiring Wells Fargo to "make good to the Plan all losses to the Plan;" and (3) individual equitable

monetary relief, including "fiduciary surcharge." App. 415-16; R. Doc. 64, at 126-27 ¶¶ 310-20. None would redress Plaintiffs' asserted injuries.

1. Plaintiffs' request for prospective relief would not redress any of their alleged injuries.

Plaintiffs do not dispute they lack standing to seek the prospective relief their amended complaint sought. A plaintiff seeking prospective relief must show sufficiently imminent future injury. *Murthy v. Missouri,* 603 U.S. 43, 69 (2024). The four original Plaintiffs were former participants when this case was filed, and McKinley's COBRA coverage ended no later than October 2025. App. 502; R. Doc. 95, at 41; *Murthy*, 603 U.S. at 58 ("The plaintiff 'bears the burden of establishing standing as of the time she brought the lawsuit and maintaining it thereafter.'" (brackets omitted)). Because no named Plaintiff remains enrolled in the Plan, changing the Plan's fiduciaries, PBM, or future administration would not redress their alleged injuries.

2. Plaintiffs' request for Plan-level relief does not redress their alleged injuries.

Plaintiffs' claims for Plan-level relief under 29 U.S.C. §§ 1132(a)(2) and 1109(a) independently fail because Plaintiffs cannot show such relief would likely remedy their asserted injuries.

Section 1132(a)(2) authorizes participants to seek only "appropriate relief under section 1109," and § 1109(a) makes a breaching fiduciary liable "to make

good to such plan any losses to the plan"—relief directed to the Plan, not an individual recovery. 29 U.S.C. §§ 1132(a)(2), 1109(a); *Pilger v. Sweeney*, 725 F.3d 922, 926 (8th Cir. 2013). Plaintiffs concede: "the remedy has to first go to the Plan." App. 510-11; R. Doc. 95, at 49-50. But money going to the Plan does not redress Plaintiffs' alleged injuries unless the recovery would likely be distributed to them. They cannot show that. They identify no Plan term requiring distribution, and Plaintiffs' counsel conceded below that the Plan documents contain none. App. 517; R. Doc. 95, at 56. Their own pleading says only that restored Plan monies "should be allocated, if feasible" to affected participants (App. 410, 414; R. Doc. 64, at 121, 125 ¶¶ 288, 302), not that they must or likely will be.

Plaintiffs argue the district court conflated retrospective relief with prospective funding. Br. 51-52. But the court correctly recognized that even if Wells Fargo were ordered to pay money to the Plan, Plaintiffs have not shown that the money would flow from the Plan to them. App. 581; R. Doc. 99, at 25; Add.25. In observing that the money might instead "offset" future contributions, the court's point was not that Wells Fargo could undo individual awards; it was that the Plan need not distribute the money to Plaintiffs at all. App. 581; R. Doc. 99, at 25; Add.25. Plaintiffs' argument that an employer cannot "claw back" employer contributions because of fiduciary breaches is likewise inapposite. Wells Fargo proposes no claw

back; the point is that even if the Plan recovers overpayments, nothing requires those funds to be distributed to Plaintiffs.[7]

Redressability is lacking where any personal benefit from a plan-level award depends on later discretionary decisions. *Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1125-27 (9th Cir. 2006); *Winsor*, 62 F.4th at 525-27; *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1073-74 (9th Cir. 2009). *Glanton* is illustrative: prescription-drug plan participants argued that plan-level relief would reduce their costs, but the Ninth Circuit found no redressability because nothing required the plan sponsors to reduce participant contributions or copayments. 465 F.3d at 1125.

Nor do Plaintiffs' authorities establish a required distribution. *Braden* involved a defined-contribution 401(k) plan and alleged losses to the plaintiff's individual retirement account, not a self-funded health plan. *Braden*, 588 F.3d at 589-94. *Graden*, *Evans*, and *Harris* are likewise individual-account cases where restored losses could be allocated to participants' accounts because the recovery corresponded to account-level losses. *Graden v. Conexant Sys. Inc.*, 496 F.3d 291,

[7] *Brotherston v. Putnam Invs., LLC*, 907 F.3d 17, 27-28 (1st Cir. 2018) involved the unrelated question of whether a plan fiduciary could avoid prohibited transaction liability for receiving fees from funds in which the Plan invested by pointing to contributions it made to the plan in its role as employer to demonstrate that, on a net basis, it treated the plan no less favorably than similarly situated third parties.

296 n.6, 302 (3d Cir. 2007); *Evans v. Akers*, 534 F.3d 65, 74-75 (1st Cir. 2008); *Harris v. Amgen, Inc.*, 573 F.3d 728, 735-36 (9th Cir. 2009). Those cases do not apply to a self-funded welfare plan with no individual participant accounts, where participants' entitlement is to the benefits the Plan promises, not to a share of Plan assets.

And the Department of Labor Technical Release regarding medical loss ratio rebates is inapplicable and advises only that employers should allocate such rebates "for the benefit of participants and beneficiaries" (Br. 52)—which Wells Fargo could do by allocating any recovery to current participants rather than former ones like Plaintiffs. Article III requires a likelihood of redress, which Plaintiffs cannot show.

3. Plaintiffs' requested individual relief cannot remedy their injuries because it is unavailable.

Plaintiffs' remaining claims for individual relief under Section 1132(a)(3) fail to establish redressability for an independent reason: the remedy they invoke is not authorized by Section 1132(a)(3). Redressability requires a remedy that a court may lawfully award. *Haaland v. Brackeen*, 599 U.S. 255, 294 (2023); *M.S. v. Brown*, 902 F.3d 1076, 1083 (9th Cir. 2018) ("[E]ven where a plaintiff requests relief that would redress her claimed injury, there is no redressability if a federal court lacks the power to issue such relief."). Plaintiffs sought individual monetary relief in the form of "fiduciary surcharge, equitable restitution, and/or other make-whole equitable relief." App. 416; R. Doc. 64, at 127 ¶ 314. On appeal, they rely on surcharge to

argue that their alleged out-of-pocket injuries are redressable. Br. 31. But Section 1132(a)(3) does not authorize compensatory monetary relief merely because Plaintiffs call it "surcharge."

Section 1132(a)(3) authorizes a participant to sue "(A) to enjoin any act or practice" that violates ERISA or the plan, or "(B) to obtain other appropriate equitable relief." 29 U.S.C. § 1132(a)(3).

The Supreme Court has repeatedly defined "equitable relief" in Section 1132(a)(3) in narrow historical terms. In *Mertens v. Hewitt Associates*, the Court held that "equitable relief" means "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." 508 U.S. 248, 256 (1993) (emphasis added). The Court rejected the broader construction Plaintiffs need here: reading Section 1132(a)(3) to encompass "whatever relief a common-law court of equity could provide" in trust cases would "limit the relief *not at all*" because "*all* relief available for breach of trust could be obtained from a court of equity." *Id*. at 255-58.

Great-West confirms the same rule. Section 1132(a)(3) does not permit plaintiffs to impose personal liability on a defendant for "money damages" as "compensation for loss resulting from the defendant's breach of legal duty" because that is "the classic form of legal relief." *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210, 221 (2002). Restitution is equitable only when the plaintiff seeks

particular funds in the defendant's possession; it is legal when the plaintiff seeks recovery from the defendant's general assets. *Id*. at 213-14.

Plaintiffs' surcharge request is one for compensatory damages. They seek money to compensate for alleged out-of-pocket overpayments. App. 416; R. Doc. 64, at 126-27 ¶¶ 314-20; Br. 31. This is loss-based relief measured by Plaintiffs' alleged injury, *not* relief directed to a specific thing or *res*. Although equity courts could order "surcharge" in trust cases against fiduciaries and non-fiduciaries alike, that trust-specific power to impose make-whole monetary liability is precisely the sort of special equity-court authority *Mertens* and *Great-West* refused to import into Section 1132(a)(3). *See Mertens*, 508 U.S. at 255-58; *Great-Wes*t, 534 U.S. at 219.

Plaintiffs rely on *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), and *Silva v. Metropolitan Life Insurance Co.*, 762 F.3d 711 (8th Cir. 2014), but neither establishes redressability here. *Amara* suggested that a beneficiary might obtain monetary compensation against a fiduciary through "surcharge" because equity courts possessed such power in trust cases. 563 U.S. at 441-42. *Silva* then followed *Amara*, stating that "*Amara* changed the legal landscape" by recognizing compensatory equitable remedies under Section 1132(a)(3). 762 F.3d at 722, 724-25.

But the Supreme Court has since made clear that *Amara* did not change the governing interpretation of "equitable relief." In *Montanile*, the Court stated that

Amara's Section 1132(a)(3) discussion was "not essential to resolving that case" and that the Court's interpretation in *Mertens* and *Great-West* "remains unchanged." *Montanile v. Bd. of Trs. of Nat'l Elevator Indus. Health Benefit Plan*, 577 U.S. 136, 148 n.3 (2016).

This Court may recognize that intervening development without sitting *en banc*. A panel "may reconsider a prior panel's decision if a supervening Supreme Court decision 'undermines or casts doubt on the earlier panel decision.'" *United States v. Villareal-Amarillas*, 562 F.3d 892, 898 n.4 (8th Cir. 2009). *Silva* rested on *Amara*'s perceived expansion of Section 1132(a)(3), and *Montanile* later clarified that *Amara*'s discussion was dicta. The Fourth Circuit has already drawn the same conclusion: in *Rose v. PSA Airlines, Inc.*, the court held its own post-*Amara* surcharge cases were no longer controlling because *Montanile* made their reasoning untenable. 80 F.4th 488, 503-04 (4th Cir. 2023). After *Montanile*, *Amara*'s trust-law discussion cannot support make-whole monetary relief under Section 1132(a)(3).[8] And even if it could, the surcharge remedy would still require a "showing of actual harm," *Amara*, 563 U.S. at 444, something Plaintiffs here cannot satisfy.

[8] The Sixth Circuit in *Aldridge v. Regions Bank*, also recently held that surcharge is unavailable under Section 1132(a)(2) under *Mertens*, notwithstanding *Amara* and considering *Montanile*. 144 F.4th 828, 847-50 (6th Cir. 2025). A petition for certiorari from that decision is currently pending, and the Supreme Court has called for the views of the Solicitor General.

Plaintiffs' reference to "equitable restitution" fares no better. Equitable restitution would require Plaintiffs to identify money traceable to particular funds in Wells Fargo's possession. *Great-West*, 534 U.S. at 213-14. Plaintiffs do not allege that their out-of-pocket payments remain in a segregated fund held by Wells Fargo. They instead seek recovery from Wells Fargo's general assets for alleged past financial losses. That is legal relief, not equitable restitution.

Nor can Plaintiffs establish jurisdiction by saying this issue was not pressed or passed upon below. Br. 31. "The question of standing is not subject to waiver" and an appellate court is "required to address the issue even if the courts below have not passed on it, and even if the parties fail to raise the issue before" the Court because "federal courts are under an independent obligation to examine their own jurisdiction, and standing 'is perhaps the most important of [the jurisdictional] doctrines.'" *United States v. Hays*, 515 U.S. 737, 742 (1995). Because Plaintiffs' individual monetary theory depends on unavailable legal relief, it cannot redress their alleged injuries under Article III.

II. PLAINTIFFS FAIL TO STATE A CLAIM BECAUSE THEIR ALLEGATIONS CONCERN PLAN DESIGN AND THEY FAIL TO IDENTIFY MEANINGFUL COMPARATORS.

Even if Plaintiffs had standing, they fail to state a claim. This Court may affirm dismissal for any reason supported by the record. *See, e.g.*, *Carlsen*, 833 F.3d

at 906-11. To withstand dismissal under Rule 12(b)(6), a plaintiff must "state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

Here, Plaintiffs fail to state a claim because the actions they challenge—contracting with a PBM, structuring a formulary, determining premiums and drug prices—are plan design functions, not fiduciary decisions. And Plaintiffs also fail to identify meaningful benchmarks on which to base their allegations of overcharge.

A. PBM Administration Of Pharmacy Benefits Is A Plan Design Decision.

Decisions regarding the form and structure of a plan do not implicate fiduciary duties under ERISA. Employers act in two capacities. *Pegram*, 530 U.S. at 225-26. As settlor, determining what benefits to provide and designing the plan, an employer is not acting in a fiduciary capacity. *Id.* at 226 ("[A]n employer's decisions about the content of a plan are not themselves fiduciary acts."); *see also Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). It is only when exercising discretion to manage and administer the existing Plan that plan sponsors act as fiduciaries. *See* 29 U.S.C. § 1002(21)(A). Accordingly, the "threshold question" is "whether th[e defendant] was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint." *Pegram*, 530 U.S. at 226.

The challenged decisions here are settlor functions, not fiduciary functions. Entering into a PBM agreement—and the terms agreed to—are matters of plan design. *Doe 1*, 837 F. App'x at 49 ("Anthem did not act as an ERISA fiduciary when

it entered into the NextRX and PBM Agreements, even though its decisions may ultimately affect how much plan participants pay for drug prices."); *accord Stern*, 2026 WL 654714, at *11-12; *Doe One v. CVS Pharm., Inc.*, 348 F. Supp. 3d 967, 1001 (N.D. Cal. 2018), *aff'd in part, vacated in part on other grounds, remanded sub nom. Doe v. CVS Pharm., Inc.*, 982 F.3d 1204 (9th Cir. 2020). Plaintiffs' core allegation that "Wells Fargo failed to engage in a prudent and reasoned decision-making process before agreeing to a PBM contract" with ESI does not make out a legally cognizable fiduciary breach claim. App. 364; R. Doc. 64, at 75 ¶ 163.

Nor do Plaintiffs' more specific allegations state a claim. Plaintiffs claim Wells Fargo failed to use its "bargaining power" to contract with a pass-through or other PBM, demand use of a different pricing benchmark, "ensure" certain drugs were not categorized as "specialty," disallow beneficiaries from being "steered" toward Accredo, manage the plan formulary, or negotiate lower administrative fees. App. 364-71; R. Doc. 64, at 75-82 ¶¶ 163-76. But these are classic "decision[s] regarding the form or structure of the Plan such as who is entitled to receive Plan benefits and in what amounts." *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 444 (1999).

Courts confronting similar allegations have uniformly found those claims to attack settlor functions that do not give rise to ERISA liability. *Doe 1*, 837 F. App'x at 46, 49; *Stern*, 2026 WL 654714, at *11 ("Plaintiffs' theory targets the structure of

the pharmacy benefit itself—how the PBM was compensated, how drugs were categorized, what pricing benchmarks were used, and which alternatives were not adopted. Those are choices about the architecture of the benefit offering, not about the discretionary management of plan assets . . . ."); *Doe One*, 348 F. Supp. 3d at 1001.

Because Plaintiffs' fiduciary duty breach allegations arise from actions Wells Fargo took as settlor, not fiduciary, they fail to state a claim. So too for Plaintiffs' prohibited transaction counts, based on the same conduct. *See* 29 U.S.C. § 1106(a)(1); *Spink*, 517 U.S. at 888-89.

B. Plaintiffs Fail To Identify Meaningful Benchmarks As Required To State An ERISA Claim Based On Alleged Overcharge.

Plaintiffs also fail to state fiduciary-breach claims because their allegations do not identify meaningful benchmarks against which to compare Wells Fargo's plan offering. Fiduciary-breach claims are about the decision-making *process*, not its results. *Davis*, 960 F.3d at 482. Such claims present a "challenging pleading burden." *Meiners v. Wells Fargo & Co.*, 898 F.3d 820, 822 (8th Cir. 2018). Where fiduciary breach allegations rely on allegedly excessive costs, the complaint must typically plead facts sufficient to infer "that the process was flawed." *Matousek v. MidAmerican Energy Co.*, 51 F.4th 274, 278-79 (8th Cir. 2022). To meet this bar, a plaintiff must allege a "meaningful benchmark" showing that "similar plans [are]

offering the same services for less." *Barrett v. O'Reilly Auto., Inc.*, 112 F.4th 1135, 1138 (8th Cir. 2024); *Matousek*, 51 F.4th at 278-79.

Plaintiffs fail to do so, focusing on individual components of the Plan—select drug prices and administrative fees—without regard for the overall Plan offering. With respect to drug prices, Plaintiffs do not allege that plans offering the same services use NADAC prices (App. 317-19; R. Doc. 64, at 28-30 ¶¶ 60, 64), nor do amounts that uninsured individuals pay for a subset of drugs indicate that the Plan overpays relative to similar plans (App. 344-56; R. Doc. 64, at 55-67 ¶¶ 126-43). The claim that Wells Fargo should have engaged a pass-through PBM—a wholly different business model—lacks supporting allegations that any such PBM charges similar plans less for the same services. *See* App. 381-85; R. Doc. 64, at 92-96 ¶¶ 206-09, 211-14.

As for administrative fees, Plaintiffs allege that some plans paid ESI lower per capita fees but rely on conclusory allegations that they received "equivalent or substantially equivalent" services. App. 361-62; R. Doc. 64, at 72-73 ¶ 157. Without factual pleadings about specific services rendered, this is inadequate. *See Barrett*, 112 F.4th at 1140. The Form 5500 service codes confirm that the comparator plans "include[] a different bundle" of services. *Id.* at 1139-40.

The closest Plaintiffs come to identifying a similar plan is PepsiCo. App. 380-81; R. Doc. 64, at 91-92 ¶ 204. But even there, Plaintiffs fail to compare aggregate

or per-participant prescription drug costs, relative participant numbers, or suites of covered drugs and related services. App. 380-81; R. Doc. 64, at 91-92 ¶ 204.

In sum, Plaintiffs fail to state a claim because they lack comparators showing similar plans paying less for substantially similar services.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be affirmed.

Dated: August 28, 2026

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g), I hereby certify that this document complies with the type-volume limitations set forth in Fed. R. App. P. 32(a)(7)(B) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this document contains 12,728 words.

I further certify that this document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word in a 14-point Times New Roman font. The brief has been scanned for viruses and is virus-free.

Dated: August 28, 2026

By: */s/ Russell L. Hirschhorn*
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CERTIFICATE OF SERVICE

I hereby certify that, on the 28th day of August, 2026, I electronically filed the foregoing document with the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system, which will send notifications of such filing to all CM/ECF counsel of record.

Dated: August 28, 2026

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