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 U.S. District Court for the District of Minnesota
No. 24-cv-3043, The Honorable Laura M. Provinzino

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, THE AMERICAN BENEFITS COUNCIL, AND THE ERISA INDUSTRY COMMITTEE AS AMICI CURIAE IN SUPPORT OF APPELLEE AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

The Chamber of Commerce of the United States of America, the American Benefits Council, and the ERISA Industry Committee are not publicly traded corporations. They have no parent corporations, and no publicly held company has 10% or greater ownership of their stock.

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INTEREST OF AMICI CURIAE[1]

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation. As the nation's leading advocate for business, the Chamber represents companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files amicus curiae briefs in cases, like this one, that raise issues of concern to the nation's business community.

The American Benefits Council (the "Council") is a Washington, D.C.–based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees, and families. Council members include over 220 of the world's largest corporations and collectively either directly

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[1] All parties have consented to the filing of this brief. *See* FED. R. APP. P. 29(a)(2). No counsel for a party authored this brief in whole or in part. No party, no counsel for a party, and no person other than amici, their members, or their counsel made a monetary contribution to fund the preparation or submission of this brief.

sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans. The Council regularly participates as amicus curiae in cases affecting employee benefit plans.

The ERISA Industry Committee ("ERIC") is a national non-profit business trade association representing approximately 100 of the nation's largest employers in their capacity as sponsors of employee benefit plans for their workers, retirees, and families.

* * *

This case raises issues of profound importance to amici and their members. Many of amici's members are employers that sponsor ERISA-governed health plans that include prescription-drug benefits. Chief among the goals of these plan sponsors is providing cost-effective benefits that address the healthcare needs and preferences of plan participants and beneficiaries. Many employers lack the nuts-and-bolts infrastructure necessary to independently administer health plans and thus rely on third-party administrators, including pharmacy benefit managers ("PBMs"), to handle certain aspects of day-to-day plan operations. Plaintiffs here seek to capitalize on this common arrangement to extract further payments from plan sponsors based on an ill-defined theory of

ERISA liability that just attaches legal labels to general complaints about healthcare costs. Amici's members are not universally supportive of PBM business models in all circumstances and understand that different plans may follow different designs for PBM compensation. The interests of PBMs do not always align with the interests of plan sponsors. But amici are united in their commitment to the strong ERISA principles long recognized by this Court's jurisprudence, and are also united in opposing the efforts by certain plaintiffs' firms to reduce ERISA fiduciary analysis to a drug-by-drug or claim-by-claim assessment of plan pricing decisions. Instead of furthering sound plan design, these lawsuits undermine plan sponsors' efforts to furnish employees and their families high-quality, affordable health coverage by impermissibly trying to make plan sponsors liable for generalized grievances shared by the entire public.

Baseless ERISA lawsuits saddle plan sponsors with litigation expenses that harm plans and their participants. Greenlighting novel and tenuous theories of standing, like Plaintiffs' theory here, would make matters worse. Amici therefore have a strong interest in ensuring that the guardrails against such baseless litigation, including Article III standing requirements, are enforced.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress enacted ERISA in relevant part to encourage employers to offer healthcare and other benefits to their employees. The statute codifies a policy of encouraging employers to choose to sponsor benefit plans, including by providing for predictable procedures and liabilities. Key to this predictability is ERISA's emphasis on prudent processes, rather than optimal outcomes. Congress recognized that excessive regulatory burdens and litigation risks would discourage employers from creating benefit plans and offering robust benefits through them. ERISA thus allows employers to choose whether to offer benefits and to tailor the benefits they choose to offer.

Employers, including amici's members, value the flexibility that ERISA gives them to tailor their benefit plans to the needs and preferences of their workforces. Customizing benefit plans allows employers to promote the health of their employees and their families through cost-effective structures, which in turn helps employers attract and retain talent. Prescription drugs are an essential part of modern healthcare, so employers must contend with an incredibly complex prescription drug supply chain. That complexity results partly from the fact that a

constellation of stakeholders must come together to fill any given prescription—ranging from the manufacturers to the individual patient, with many intermediaries, including wholesalers, pharmacies, prescribing doctors, and often others, in between. Each of these actors has different incentives that can be difficult to harmonize. Plaintiffs vastly oversimplify this picture, which illustrates some of the challenges that employers face to sponsor a prescription drug plan.

Employers have developed innovative strategies to manage costs in this environment while ensuring that employees and families maintain access to needed drugs and services. PBMs offer a wide range of services to plans, ranging from establishing pharmacy networks to adjudicating benefits at the point of sale, whether at a retail pharmacy or otherwise, to assisting plan sponsors with the complexities of formulary development and pharmacy benefit design. The contracts between plans and PBMs govern the wide range of services that PBMs provide to plans and their participants and naturally include terms governing compensation.

Plaintiffs' lawsuit ignores this system-level complexity. As the district court recognized, their allegations require too much speculation to plausibly show that they have standing. They purport to assert

pocketbook injuries but do not allege any concrete losses. Rather, they complain generally that the Plan paid too much and that they did as well. But they allege no facts to support a nonspeculative inference that they paid more than they should have—let alone that such overcharges were caused by Wells Fargo's alleged violation of ERISA.

This case is just the latest entry in the voluminous playbook of baseless ERISA lawsuits. Economically burdensome ERISA class actions, like the one Plaintiffs pursue, harm countless employees and families who receive health benefits through employer-sponsored prescription benefit plans by depleting employer resources that could otherwise be used to fund benefits. Motions to dismiss are an important mechanism for weeding out such baseless and harmful suits. *See Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 425 (2014). The district court rightly used this mechanism to dismiss this case for lack of standing, and this Court should affirm.

ARGUMENT

I. ERISA encourages employers to sponsor plans and protects their discretion to tailor benefits to employees' needs.

ERISA serves "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208

(2004). But "[n]othing in ERISA requires employers to establish employee benefits plans." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). ERISA instead furthers "the public interest in encouraging the formation of employee benefit plans" by leaving the decision whether to sponsor a plan up to employers. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). Given the statute's reliance on the voluntary provision of benefits, the Supreme Court has repeatedly "recognized that ERISA represents a 'careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.'" *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (quoting *Davila*, 542 U.S. at 215).

Congress recognized, moreover, "that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). Adding an overly burdensome regulatory regime on top of those unavoidable complexities "would introduce considerable inefficiencies" with counterproductive consequences. *Id.*; *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (recognizing that such "inefficiencies . . . could work to the detriment of plan

beneficiaries"). Congress therefore sought "not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). In other words, ERISA strikes a "careful balanc[e]" to ensure that employers are not deterred from offering benefit plans in the first place. *See Davila*, 542 U.S. at 215 (quotation marks and citation omitted).

For similar reasons, ERISA generally does not "mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed*, 517 U.S. at 887. "Rather, employers have large leeway to design . . . welfare plans," such as health benefit plans, "as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003); *see also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981) ("ERISA leaves this question" of "the content of the benefit . . . largely to the private parties creating the plan."). ERISA in this fashion gives "employers considerable discretion to fashion private benefit plans tailored to their own (and their employees') needs." *Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 804 (10th Cir. 2004).

In the modern economy, employers can and do design benefit packages, including healthcare benefits, as a tool to attract and retain talented employees. This market-oriented framework promotes the interests of both employers and employees by encouraging employers to offer robust benefits, and by avoiding regulatory burdens and inefficiencies that would have the opposite effect.

II. Employers contract with PBMs to assist with the complex challenge of providing prescription drug benefits.

These incentives for employers to provide benefits have had their intended effect. Most working-age American adults have health insurance coverage through employer-sponsored plans. U.S. Census Bureau, *Health Insurance Coverage in the United States: 2024*, at 5 (Sept. 9, 2025).[2] In all, some 181 million Americans rely on employment-based health plans. *Id.* at 2. Employees broadly prefer this option: more than 75% of eligible workers who are offered health coverage through their employers accept it. Kaiser Family Found., *Employer Health Benefits: 2025 Annual Survey*, at 67 (Oct. 2025).[3]

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[2] https://www2.census.gov/library/publications/2025/demo/p60-288.pdf.

[3] https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf.

"Employer-sponsored plans can be fully insured, meaning the plans buy health insurance for their employees, or they can be self-insured, meaning the employers collect premiums from employees, pay those employees' medical claims, and bear the insurance risk." *PCMA v. Mulready*, 78 F.4th 1183, 1188 (10th Cir. 2023). More than two-thirds of covered workers who have health coverage through employer-sponsored plans are enrolled in self-funded plans (like the Wells Fargo Plan). Kaiser Family Found., *Employer Health Benefits*, *supra*, at 165. Many larger employers prefer self-funding (or "self-insurance"), "in part because the health expenses of larger group health plans are more predictable, and therefore, larger plan sponsors can manage those risks internally while avoiding costs associated with state taxes and insurance fees." Lori Chavez-DeRemer, Sec'y of Lab., *Report to Congress: Annual Report on Self-Insured Group Health Plans*, at 4 (Mar. 2026).[4] Self-funded plans also pay only for the health benefits that participants ultimately use, while fully insured plans must pay the same amount for insurance policies regardless of usage. Many employers that wish to self-fund health

[4] https://beta.dol.gov/system/files/research-data/2026-03/ebsa-annual-report-on-self-insured-group-health-plans-2026.pdf.

benefit plans contract with third parties to assist with plan administration.

A classic example of this dynamic plays out with prescription drug benefits. More than 131 million people, about two-thirds of adults in the United States, rely on prescription drugs, which are particularly important treatments for chronic (and often common) conditions. Georgetown Univ. Health Pol'y Inst., *Prescription Drugs*.[5] "Access to prescription drugs," then, is an "important—and expensive—benefit for a health care plan to offer its beneficiaries." *PCMA v. District of Columbia*, 613 F.3d 179, 183 (D.C. Cir. 2010). Yet even as "[f]illing doctors' prescriptions is a part of everyday life," "beneath these commonplace transactions lies a complex web of contracts and business relationships," involving "drug manufacturers, wholesalers, [and] pharmacies" on one end and patients and payors (like plans) on the other. *Mulready*, 78 F.4th at 1188.

This challenge explains why PBMs often "play a pivotal role in American healthcare." *McKee Foods Corp. v. BFP Inc.*, 173 F.4th 242, 250 (6th Cir. 2026). Employers contract with PBMs to "oversee

[5] https://archive.ph/ypzA4.

prescription-drug benefits for health plans, perform administrative services, help negotiate drug rebates, and set up pharmacy networks, working with health plans, drug manufacturers, and pharmacies along the way." *Id.* "PBMs . . . offer options for health plans to structure their [prescription-drug] benefits," enabling the customization that is usually preferable and often necessary for employers. *Mulready*, 78 F.4th at 1188.

It "would be prohibitively expensive for plans, which must control costs," to offer a benefit that would grant a blanket allowance for participants to "access every drug at every pharmacy." *Id.* So plans must offer prescription benefits on defined terms, which "include what drugs the plan covers (the formulary), how much the plan will pay for those drugs (the cost-sharing terms), and at which pharmacies beneficiaries can have prescriptions filled (the pharmacy network)." *Id.* Different plans may prefer different terms, based on the different needs and preferences of their participants and beneficiaries. *See McKee Foods*, 173 F.4th at 252. An employer with a geographically dispersed workforce might prefer to offer a wider pharmacy network, even if that in turn might raise premiums or prescription copays, while a different employer might find that its workforce would prioritize lower costs over network breadth. "[M]ost

plans do not," and realistically cannot, "assemble their own pharmacy networks," so "hiring a PBM to fine-tune its network" allows a plan to "promote a higher quality of care and can reduce other costs to beneficiaries, such as insurance premiums." *Mulready*, 78 F.4th at 1189. And PBMs provide additional services, too, including operating plans' pharmacy claims administration process, determining how much the patient and the plan pay, respectively, for a given prescription.

All those services come at a cost. Contracts between plans and PBMs must account for the wide variety of services that PBMs provide to plans and frequently include varied and highly detailed arrangements for PBM compensation. *See, e.g.*, *Mulready*, 78 F.4th at 1189 (describing one approach to PBM compensation); *Rutledge v. PCMA*, 592 U.S. 80, 84 (2020) (describing how "the amount that prescription-drug plans reimburse PBMs is a matter of contract" and an aspect of PBM compensation); *Mass. Ret. Sys. v. CVS Caremark Corp.*, 716 F.3d 229, 231 (1st Cir. 2013) ("The sponsors pay fees to the PBM under a contract for its services, which include managing prescription drug claims submitted by those enrolled in the plan."); *Crawford Prof. Drugs, Inc. v. CVS Caremark Corp.*, 748 F.3d 249, 254 n.1 (5th Cir. 2014) ("PBMs generally make money

through service fees from large customer contracts for processing prescriptions." (citation and quotation marks omitted)).

As this discussion illustrates, virtually every aspect of sponsoring and administering a prescription-drug benefit plan entails complex challenges and tradeoffs. Furnishing even one prescription to one patient requires a series of transactions across a web of contractual relationships. The complexity multiplies by orders of magnitude for sponsoring or administering a prescription-drug benefit plan for an entire population of employees and their families. This lawsuit thus concerns an enormously complicated system that is full of interconnected moving parts.

III. Plaintiffs' theory of standing ignores the complex reality of health plan administration.

The district court correctly dismissed Plaintiffs' lawsuit for lack of standing because "their alleged harm is speculative and, ultimately, not redressable." Add. 19; App. 575; R. Doc. 99, at 19. Indeed, Plaintiffs' theory is speculative on multiple independent levels. Rather than plausibly allege "concrete facts" to show that the alleged ERISA violations caused Plaintiffs to pay more—as the law requires, *e.g.*, *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 582 (3d Cir. 2024); *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 524–25 (9th Cir. 2023)—Plaintiffs

rely on conclusory assertions that ignore the complexity of sponsoring and administering a prescription-drug benefit plan. It is easy for plaintiffs to vaguely complain that defendants should have done something to lower their out-of-pocket costs. But Article III requires more.

To establish standing at the pleading stage, a plaintiff must plausibly allege "(1) that he or she suffered an injury in fact that is concrete, particularized, and actual or imminent, (2) that the injury was caused by the defendant, and (3) that the injury would likely be redressed by the requested judicial relief." *Thole v. U.S. Bank N.A.*, 590 U.S. 538, 540 (2020). The second element, causation, more specifically requires the plaintiff "to show a sufficiently direct causal connection between the challenged action and the identified harm," and "[t]hat connection cannot be overly attenuated." *Agred Found. v. U.S. Army Corps of Eng'rs*, 3 F.4th 1069, 1073 (8th Cir. 2021) (citation omitted).

As with any threshold pleading requirement, the complaint's well-pleaded "[f]actual allegations must be enough" to make a *plausible* showing, "above the speculative level." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (citation omitted); *see also, e.g.*, *Animal Legal Def. Fund v. Reynolds*, 89 F.4th 1071, 1077 (8th Cir. 2024) (recognizing that facial

attacks on standing are governed by usual Rule 12(b)(6) standards). Plaintiffs cannot rely on a "speculative chain of possibilities" to show that their asserted injury "is fairly traceable" to the alleged legal violation. *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 414 (2013).

Plaintiffs' theory of standing here is fatally speculative. Start with their two purported injuries. First, they supposedly paid "unreasonable amounts for their prescriptions." Pls. Br. 23. Second, supposedly "excessive costs paid by the Plan"—which they attribute to both "prescription drug prices and administrative fees"—"were then partially passed through to them in the form of increased premiums." *Id.* at 32. At the same time, Plaintiffs do not and could not contend that paying *any* premiums is an injury; they merely complain of "inflated premiums." *Id.* at 2. The two asserted injuries—prescription costs and plan premiums—thus collapse into one: Plaintiffs allegedly paid too much.

That claim of injury is impermissibly speculative, as Plaintiffs' supposedly precise allegations of "specific overcharges" lay bare. Pls. Br. 23 (citing App. 387-90; R. Doc. 64, at ¶¶ 220, 222, 224, 226, 228). Plaintiffs claim to show overcharges by comparing the supposedly "unreasonable prices" that the Plan paid for a handful of drugs with the "acquisition

cost[s]" for those drugs. App. 387-90; R. Doc. 64, at ¶¶ 220, 222, 224, 226, 228. Plaintiffs' cited "acquisition cost" refers to one measure of "the amount that the average pharmacy pays to acquire prescription drugs from wholesalers." App. 316; R. Doc. 64, at ¶ 59. Plaintiffs thus assert "overcharges" by comparing apples (the pharmacy's price for a Plan participant at a retail level) to oranges (a wholesaler's price for the pharmacy). Plaintiffs *do* allege the "cash price" that pharmacies offered other individuals for *other* drugs, *see* App. 344, 346-52, 355-56; R. Doc. 64, at ¶¶ 127, 129, 131, 133, 135, 137, 140-43—just not the ones underlying the supposedly "specific overcharges" for Plaintiffs' own alleged prescriptions. Plaintiffs even cherry-pick their oranges: they admit that another commonly used metric of acquisition costs is available, "but according to Plaintiffs," that alternative "is not truly representative of actual market prices and is susceptible to industry manipulation." Add. 5; App. 561; R. Doc. 99, at 5 (citing App. 317-18; R. Doc. 64, at ¶ 61).

The broader context of this case makes Plaintiffs' allegations even more speculative. Pricing for self-funded plans in the prescription-drug market is complex. For example, it is nothing like pricing for mass-produced consumer goods. There is no default sticker price—like a

manufacturer's suggested retail price—for filling a given prescription. Instead, a "complex web of contracts and business relationships" lies behind each of "these commonplace transactions." *Mulready*, 78 F.4th at 1188. Because prescription-drug arrangements vary across plans and involve multiple contractual and financial components, the price associated with an individual prescription does not, standing alone, reveal a plan's net cost or the compensation received by its vendors. Even diligent plan sponsors may not have access to standardized, transaction-level information that isolates every component of drug-by-drug vendor compensation, and PBM arrangements can be structured in many different ways. Plaintiffs would need to allege facts about prices paid by similarly situated individuals in similarly situated plans to make their monetary comparisons meaningful and their asserted injury plausible.

Even if Plaintiffs could show that participants in similar plans paid less for the same drug, their attempt to base standing on such isolated transactions would still fail. Plans do not promise participants discrete lists of goods and services with itemized prices for each. Nor do they set premiums in the abstract. Plans instead promise participants annual coverage in exchange for premiums—which in turn derive from a web of

factors including the plan's demographics, historical experience, trends, and administrative costs—regardless of the amount of benefits participants actually use during the year. This dynamic helps explain why Plaintiffs' complaint about premiums is speculative, too. They plead no facts to suggest that Wells Fargo could have negotiated a cheaper PBM arrangement for the Plan given the Plan's particular circumstances, demographics, and bundle of PBM services. And any individual participant's payments, whether for particular prescriptions or premiums, cannot be understood outside the context of her broader participation in the Plan.

Plaintiffs' theories are also speculative for another reason. Their factual allegations fail to establish that any such savings for the Plan would have yielded lower premiums for Plaintiffs themselves. As the district court observed, "the Plan authorizes Wells Fargo to require participants to fund *all* Plan expenses, not just expenses related to their own individual benefits," and "the Plan does not require *any* contribution from Wells Fargo" at all. Add. 20; App. 576; R. Doc. 99, at 20 (citation omitted). In fact, Wells Fargo *did* contribute $9.7 billion to fund the Plan between 2019 and 2023, while participants contributed $3.4 billion. S.App. 150-

73; R. Docs. 32-2 to 32-5 (Form 5500s) at Schedule H § II(2)(a)(1)(A)-(B). Of course, that disparity underscores the speculative nature of Plaintiffs' allegations about Plan overcharges: a plan sponsor bearing the lion's share of plan costs already has a powerful incentive to restrain them.

But the disparity also underscores the lack of plausible allegations of traceability. Plaintiffs' standing requires factual allegations showing "that the purported violative conduct was the but-for-cause of [the plaintiffs'] . . . increase in their out-of-pocket costs above what they would have been" had the defendants not violated the statute. *Knudsen*, 117 F.4th at 582. Plaintiffs make no such showing. The district court correctly reasoned that "there are simply too many variables in how Plan participants' contribution rates are calculated to infer that Wells Fargo's payments to ESI for prescription drug payments or administrative fees were the but-for cause of any increases in Plaintiffs' required contributions." Add. 21; App. 577; R. Doc. 99, at 21 (brackets, quotation marks, and citation omitted). Plaintiffs plead no facts supporting a nonspeculative inference that their purported overcharges are fairly traceable to the purported ERISA violation that they assert.

The realities of PBM compensation help reveal what is missing. Plaintiffs do not and cannot allege any facts to draw a causal connection between the prescription charges they object to—or their premiums—and the alleged ERISA violation. Plans rely on PBMs to perform a wide variety of services, from developing pharmacy networks in the first place to keeping the entire claims adjudication system running—and plan-PBM contracts rely on various forms of compensation in exchange for that suite of services, not just the cost of a particular drug. *See supra* Section II. Plaintiffs offer no allegations to support an inference that their purported overpayments resulted from Wells Fargo's alleged failure to monitor the PBM or negotiate more successfully. And because traceability and redressability "are often 'flip sides of the same coin,'" *FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 380 (2024) (citation omitted), it is no surprise that Plaintiffs fail to establish redressability as well. *See* Add. 24-25; App. 580-81; R. Doc. 99, at 24-25.

Part of the problem with Plaintiffs' theory of standing is that they lack a concrete theory of fiduciary breach in the first place. Health plan sponsorship and administration are complicated, especially when it comes to prescription drug benefits. By theorizing that Wells Fargo

should have done something more to reduce their specific share of plan costs, Plaintiffs oversimplify these complexities beyond recognition. ERISA requires prudence, not magic. And no one would sponsor employee benefit plans if they gave rise to liability based on generic complaints about healthcare costs—much less the costs of a particular prescription. "At times, the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs, and courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise." *Hughes v. Nw. Univ.*, 595 U.S. 170, 177 (2022).[6] Difficult tradeoffs abound in designing and operating a health benefit plan. Plaintiffs do not grapple with these tradeoffs, and their theory of standing shows it.

[6] To plausibly plead a breach of ERISA's duty of prudence, plaintiffs' allegations must "show that 'a prudent fiduciary in like circumstances would have acted differently.'" *Meiners v. Wells Fargo & Co.*, 898 F.3d 820, 822 (8th Cir. 2018) (citation omitted). The district court properly fulfilled its duty to start by assessing its subject matter jurisdiction—but if Plaintiffs somehow had standing, they would fail to state a claim for many of the same reasons and others identified by Wells Fargo.

IV. Article III requirements help guard against baseless ERISA litigation, which harms employers and employees alike.

A fundamental purpose of ERISA, as discussed, is to encourage employers to make the voluntary decision to create employee benefit plans and offer robust benefits through them. *See supra* Section I. Congress sought to avoid introducing regulatory "inefficiencies" that "might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing*, 482 U.S. at 11. Such "inefficiencies" may "work to the detriment of plan beneficiaries" in many ways. *Ingersoll-Rand*, 498 U.S. at 142; *see Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 n.25 (1983) (explaining how regulatory "inefficiency . . . presumably would be paid for by lowering benefit levels," or alternatively by "reduc[ing] wages" to "offset the additional expenses").

The Supreme Court has repeatedly recognized that these counterproductive risks include "litigation expenses" borne by plans—and, thus, ultimately by beneficiaries. *Varity Corp.*, 516 U.S. at 497; *accord, e.g.*, *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 149-50 (2001) ("burdens ultimately borne by . . . beneficiaries" include the costs "to contend with litigation"); *FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) ("employee

benefit plans' expenditure of funds in . . . litigation" frustrates ERISA's purposes). ERISA is "an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests—and not all in favor of potential plaintiffs." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993).

Still less does ERISA resolve all disputes in favor of plaintiffs' attorneys. Yet ERISA class-action litigation can sometimes serve the interests of the attorneys more than the putative class members. *See, e.g.*, *Thole*, 590 U.S. at 541 (in case where "the plaintiffs' attorneys requested at least $31 million in attorney's fees," the "plaintiffs [themselves] ha[d] no concrete stake in th[e] lawsuit"—but, "[t]o be sure, their attorneys" did); *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (asking "what would be gained by opening the federal courthouse doors for a" certain novel fiduciary "claim, save for possibly random fortuities . . . or the ancillary opportunity to seek attorney's fees").

Abusive ERISA litigation has flourished in part because "the prospect of discovery in a suit claiming breach of fiduciary duty is ominous, potentially exposing the ERISA fiduciary to probing and costly inquiries." *PBGC ex rel. St. Vincent Cath. Med. Ctrs. Ret. Plan v. Morgan Stanley*

Inv. Mgmt. Inc., 712 F.3d 705, 719 (2d Cir. 2013). That prospect "elevates the possibility that 'a plaintiff with a largely groundless claim will simply take up the time of a number of other people, with the right to do so representing an *in terrorem* increment of the settlement value.'" *Id.* (brackets omitted) (quoting *Dura Pharm., Inc. v. Broudo*, 544 U.S. 336, 347 (2005)). "When that happens . . . , the few plan participants named as plaintiffs and their attorneys get a windfall, and a cost that the administrator incurs may be passed on to the other plan participants." *Cunningham v. Cornell Univ.*, 604 U.S. 693, 711 (2025) (Alito, J., concurring).

Based on concerns like these, the Supreme Court has stressed that the pleading stage is an important moment for courts in ERISA class actions to "divide the plausible sheep from the meritless goats." *Dudenhoeffer*, 573 U.S. at 425. Although the Court in *Dudenhoeffer* was specifically talking about motions under Rule 12(b)(6), the Court has highlighted that lower courts also have other "tools at their disposal to screen out meritless claims before discovery," including, most relevant here, dismissals based on lack of "Article III standing." *Cunningham*, 604 U.S. at 708 (majority opinion).

The facts of this case illustrate the importance of upholding Article III's requirements and not opening the floodgates to suits like this. Wells Fargo employs hundreds of thousands of people and provides healthcare benefits to many of these employees and their dependents. In doing so, it bears the vast majority of these participants' and beneficiaries' medical expenses—as Plaintiffs themselves allege. App. 394; R. Doc. 64, at ¶ 240. Yet Plaintiffs seek to subject Wells Fargo to suit based on unquantified alleged "overpayments" for prescription drugs, Pls. Br. 23, and premiums that were purportedly "increased" by some unspecified amount, *id.* at 32. Their complaint has little to do with redressing that asserted injury and more to do with challenging healthcare costs more generally. App. 318-22; R. Doc. 64, at ¶¶ 64-66 (complaining about spread pricing), ¶ 69 (complaining about PBM rebate practices), ¶ 71 (complaining about PBM vertical integration).[7]

Contrary to the hyperbole of Plaintiffs' amici, *see* PRA Br. (Dkt. 31) at 23-25, dismissing this lawsuit on standing grounds does not broadly

[7] Policymakers are engaged in a variety of ongoing efforts and discussions in this space, including attention to transparency and accountability requirements across the prescription-drug supply chain. Those policy debates, however, do not justify imposing ERISA liability on a plan sponsor without plausible allegations of injury, causation, and fiduciary breach.

foreclose plan participants' standing to challenge any *actual* instances of plans "mismanaging plan assets." The district court applied established precedent to properly reject Plaintiffs' "speculative" attempt to manufacture a novel mismanagement claim. Add. 19; App. 575; R. Doc. 99, at 19; *see, e.g.*, *Knudsen*, 117 F.4th at 582 (affirming dismissal for lack of standing where plaintiffs relied on similarly "speculative allegations"). Affirming that dismissal would promote, not undermine ERISA's statutory policies, which encourage plan sponsors to devote their resources to providing substantive benefits rather than defending against baseless claims.

CONCLUSION

For these reasons and those in Wells Fargo's brief, this Court should affirm the judgment of the district court.

Dated: September 4, 2026

Respectfully submitted,

s/ Michael E. Kenneally

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COMBINED CERTIFICATES OF COMPLIANCE

I certify that this brief complies with type-volume limits because, excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f), this brief contains 5,162 words.

I further certify that this brief complies with the typeface and type style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 365 in Century Schoolbook 14-point font.

In accordance with Circuit Rule 28A(h)(2), I certify that this brief has been scanned for viruses and is virus-free.

Dated: September 4, 2026

s/ Michael E. Kenneally
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CERTIFICATE OF SERVICE

I certify that, on September 4, 2026, the foregoing Brief of Amici Curiae was filed electronically through the appellate CM/ECF system with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit. All counsel of record are registered CM/ECF users and will be served by the CM/ECF system.

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