ORAL ARGUMENT SCHEDULED FOR MARCH 6 & 7, 2025

No. 25-CV-101

In The
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ELINOR DASHWOOD, Individually and on Behalf of the Estate of Marianne Dashwood and a Class of Individuals Similarly Situated

Plaintiff-Appellant,

v.

WILLOUGHBY HEALTH CARE CO., WILLOUGHBY RX, AND ABC PHARMACY, INC.

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Tennessee
Civ. Action No. 25-CV-101

BRIEF OF THE PLAINTIFF-APPELLANT ELINOR DASHWOOD

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January 23, 2026

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JURISDICTIONAL STATEMENT

The United States District Court for the Eastern District of Tennessee had subject-matter jurisdiction under 28 U.S.C. § 1332(a), as well as federal-question jurisdiction under 28 U.S.C. § 1331 based on a claim arising out of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. This Court has jurisdiction under 28 U.S.C. § 1291, as Elinor Dashwood filed a timely appeal from the final order and judgment of the District Court.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

I. Whether the District Court correctly found that ERISA § 514(a) or § 502(a) preempt wrongful death claims, where the state law only had a tenuous, remote, or peripheral connection with the ERISA plan, and when the state law does not seek to recover a benefit under ERISA and does not require interpretation of terms of the Plan.

II. Whether the District Court erred when it held that a remedy sought under ERISA § 502(a)(3) was barred as compensatory in nature, when the relief seeks to reimburse the Plan itself and, while not required under disgorgement and an accounting for profits, seeks specifically identifiable funds under *Aldridge*.

STATEMENT OF THE CASE

This appeal arises from a civil suit filed by Elinor Dashwood on behalf of the Estate of Marianne Dashwood and a class of individuals similarly situated, for

injuries caused by negligent violation of state law and breaches of fiduciary duty by Willoughby Health Care Co., Willoughby RX, and ABC Pharmacy (collectively "Defendants"). Am. Compl. ¶¶ 1, 21–23. Dashwood filed her Amended Complaint on May 14, 2025, to which Defendants responded with a joint Motion to Dismiss for Failure to State a Claim. Mem. Op. and Order at 6. The district court issued an order granting the Defendants' Motion to Dismiss, to which Dashwood filed a timely notice of appeal. *Id.* at 1, 15.

Prior to her death in 2024, Marianne Dashwood was a participant in an employer-sponsored healthcare plan (the "Plan") governed by ERISA. Am. Compl. ¶ 9. The Plan is sponsored and fully insured by her former employer, Defendant Willoughby Health Insurance Co. ("Willoughby Health"), a nationwide health care insurance company that administers benefits under the Plan and holds full discretionary authority to decide claims for benefits. *Id.* ¶ 11.

Willoughby Health delegates its authority to administer medication benefits to its subsidiary, Defendant Willoughby RX, a pharmacy benefit manager ("PBM") that developed and applies a "formulary" of preferred drugs in deciding prescription drug benefit claims under the Plan. *Id.* ¶¶ 11, 14. Willoughby RX acquired ABC Pharmacy in 2021, bringing this nationwide pharmacy chain into Willoughby Health Care's corporate family tree. *Id.* ABC Pharmacy maintains a store in Johnson City, Tennessee, where Ms. Dashwood lived and worked. *Id.* ¶ 15.

Willoughby RX regularly acts through ABC Pharmacy to switch patients' prescriptions to different drugs on its formulary without notifying the prescribing doctor, unless a patient or doctor expressly objects. *Id.* ¶ 22. That is exactly what happened in this case, leading to Marianne Dashwood's tragic and wholly unnecessary death.

During a hike in December 2024, Marianne cut her leg and developed a serious infection, leading to her hospitalization at Johnson City Hospital Center. *Id.* ¶ 17. Her medical team determined that the infection was caused by MRSA, a life-threatening staph infection. *Id.* Marianne was treated with vancomycin, an intravenous antibiotic, for five days. *Id.* After responding well to the drug, she was released with a prescription for the same drug. *Id.*

After being discharged from the hospital, her sister, Elinor Dashwood, went to retrieve the prescription from ABC Pharmacy in Johnson City. *Id.* ¶ 18. However, the pharmacist handed Elinor a supply of Bactrim instead of the originally prescribed vancomycin. *Id.* When Elinor asked the pharmacist about the discrepancy, the pharmacist said that Marianne's insurance company had switched her prescription to Bactrim, and the pharmacist assured Elinor that Bactrim was simply the generic form of vancomycin. *Id.* ¶ 19.

In reality, Bactrim is not the generic form of vancomycin. While vancomycin is in a class of antibiotics called fluoroquinolones, Bactrim is in a

completely different class labeled sulfa drugs. *Id.* ¶ 20. Moreover, Marianne Dashwood has a well-documented allergy to sulfa drugs and had suffered a severe allergic reaction to another sulfa drug prescribed to her in 2022. *Id.*

Marianne's medical team at Johnson City Hospital knew about her sulfa drug allergy, and this was one reason her doctor had prescribed vancomycin for her. *Id.* ¶ 21. Yet none of the Defendants consulted Marianne's doctor before making this change to confirm whether or not Bactrim was a safe treatment for her. *Id.* ¶ 22. Instead, Defendants Willoughby Health Care and Willoughby RX switched her medication solely for their financial gain—Bactrim is less expensive and Willoughby RX is given financial incentives from its manufacturer. *Id.*

After taking Bactrim for just over a day, Marianne suffered from a severe allergic reaction and died in an ambulance traveling to the hospital. *Id.* ¶ 23. Her sister Elinor brought suit on her own behalf and on behalf of her sister's estate, for which she was appointed Executrix, as well as a class of others similarly situated. *Id.* ¶ 13.

SUMMARY OF THE ARGUMENT

This Court should reverse the district court's granting of Defendants' joint Motion to Dismiss for Failure to State a Claim and remand for trial, because the state law claims brought are not barred under ERISA and the relief sought remains equitable in nature.

ERISA § 514(a) does not preempt the state cause of action because it is only tenuously connected to the benefit plan. Further, § 502 does not preempt the state claim because it could not have been brought under the federal scheme and arises out of a legal basis that is separate from ERISA.

Disgorgement and an accounting for profits are traditional trust-law remedies for fiduciary breaches that harm the Plan itself, not individual participants. Because ERISA treats plan fiduciaries as trustees, courts of equity historically surcharged them for breaches and required disgorgement of ill-gotten gains. Although identifiable funds are not required under the remedy sought, the funds remain specifically identifiable.

ARGUMENT

Standard of Review

This Court reviews *de novo* a district court's dismissal of a claim pursuant to Federal Rule of Civil Procedure 12(b)(6). *Self-Ins. Inst. Of Am., Inc. v. Snyder*, 827 F.3d 549, 554 (6th Cir. 2016) (citing *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp. ("PONI")*, 399 F.3d 692, 697 (6th Cir. 2005)). This Court also reviews *de novo* a district court's determination of whether ERISA preempts a state law, as this is a question of federal law. *Snyder*, 827 F.3d at 554; *see also Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988).

In reviewing a Rule 12(b)(6) motion to dismiss for failure to state a claim, the Court must view the evidence and draw all inferences "in the light most favorable to the non-moving party." *Meyers v. Cincinnati Bd. of Educ.*, 983 F.3d 873, 879 (6th Cir. 2020) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). The Court must reverse the district court's order to dismiss if the complaint "contain[s] sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face," under a plausibility standard that "asks for more than a sheer possibility that a defendant has acted unlawfully." *Iqbal*, 556 U.S. at 678.

I. The District Court Erred in Holding that ERISA §§ 514(a) and 502(a) Preempted Dashwood's Claims Under State Law

A. ERISA § 514(a) Does Not Preempt Dashwood's Claim Where the State Law Does Not Govern Over Matters Shared by ERISA's Congressional Objectives, and Where the Financial Impact of the State Law Does Not Force Substantial Force Substantial Changes in the Structure of ERISA Plans

To decide whether a state law has a preemptive connection to an ERISA plan under ERISA § 514(a), the Court examines Congress's "objectives" in creating ERISA and the "nature" of the state law's "effect" on a covered plan. *Aldridge v. Regions Bk.*, 144 F.4th 828, 839 (6th Cir. 2025); *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 325. Thus, ERISA is primarily concerned with preempting laws that interfere with matters within ERISA's scope of governance, such as detailed reporting requirements for benefit plans and the provision of benefits for employees' family members, but not matters

that are "far afield" from ERISA's objectives. *Aldridge*, 144 F.4th 828, 839; *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 141 (2001); *Shaw v. Delta Air Lines*, 463 U.S. 85, 85 (1983). Further, a state law can be subject to preemption if its financial effects are severe enough to "force an ERISA plan to adopt a certain scheme of substantive coverage," though courts have often found that negative financial effects are not severe enough to trigger preemption. *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 86–87, 91 (2020); *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016); *Aldridge*, 144 F.4th at 839.

In *Rutledge v. Pharmacy Care Management Association*, the Supreme Court found that ERISA did not preempt a state law that permitted pharmacies to halt the sale of a drug if the PBM refused to fully reimburse the drug's acquisition costs, even though this law impacted the drug prescriptions of ERISA beneficiaries. *Rutledge*, 592 U.S. at 91. The Court reasoned that national uniformity in drug prices was not Congress' purpose for passing ERISA, and that the burden of higher drug expenses was not significant enough to dictate ERISA plan choices. *Id.* at 88. In contrast, this Court held in *Aldridge v. Regions Bank* that executive-level employees could not bring a state law claim for a fiduciary breach against a bank for mismanaging their company's ERISA trust fund. *Aldridge*, 144 F.4th at 841. This Court reasoned that a major purpose of ERISA was to create fiduciary duty rules to protect employee benefits plans, but Congress deliberately excluded

executive-level plans from this protection, meaning this law interfered with one of ERISA's most important objectives. *Id.*; *see also Gobeille*, 577 U.S. at 320–21.

Like the state law in *Rutledge*, and unlike the law in *Aldridge*, the Tennessee law does not regulate any area targeted by Congress in passing ERISA. The Tennessee law is a health care safety regulation that ensures that a physician approves all drug substitutions to prevent any substitutions that could endanger a patient's health. Safety regulations are "far afield" from the purpose of ERISA, and "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995) (citing *Hillsborough Cnty. v. Automated Med. Lab'ies, Inc.*, 471 U.S. 707, 714 (1985)).

While the Tennessee law may allow a beneficiary's doctor to refuse a drug substitution for a cheaper drug on Willoughby RX's formulary, the Supreme Court has stated that "ERISA does not pre-empt a state law that merely increases costs . . . even if plans decide to limit benefits or charge plan members higher rates as a result." *Rutledge*, 592 U.S. at 91. The economic impact of the Tennessee law is not severe enough to dictate any particular plan structure, as it does not force Willoughby RX to change or eliminate its preferred drug formulary. Willoughby RX has the freedom to apply its formulary policy by suggesting a different drug

substitution, paying for the more expensive drug, or refusing to administer the drug altogether. The Tennessee law does not have any preemptive connection to Dashwood's ERISA plan under § 514(a), and the district court erred in holding otherwise.

The district court further erred by overstating the breadth of ERISA preemption under § 514(a). While this section provides that ERISA "shall supersede any and all State laws [that] . . . relate to any [ERISA] plan" overstating the breadth of the term "relate to" is "a project doomed to failure, since . . . everything is related to everything else." *Dillingham*, 519 U.S. at 335 (Scalia, J., concurring). Thus, "the statutory text [of § 514] provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended." *Id.* at 336. While the district court emphasized that ERISA preemption is "conspicuous for its breadth," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990), it failed to reflect the most recent guidelines set by the Supreme Court in *Rutledge* to place workable limits on the scope of ERISA preemption.

Additionally, to support its finding of ERISA preemption under § 514(a), the district court only presented examples of cases where state laws were preempted for requiring that ERISA plans provide specific benefits to beneficiaries. *See e.g., Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995). However, these cases are distinguishable from Dashwood's case, because the Tennessee law does

not require Defendants to provide any specific kind of medical benefit to Dashwood under her ERISA plan. Because this Court examines questions of law *de novo* when reviewing motions to dismiss for failure to state a claim, this court should vacate the district court's granting of the motion to dismiss and remand for trial.

B. ERISA § 502(a) Does Not Preempt Dashwood's State Law Wrongful Death Claim Because It Does Not Seek to Recover an ERISA Benefit, and it Does Not Require Interpretation of the ERISA Plan

The Supreme Court established a two-pronged test to determine whether a cause of action under state law is preempted by ERISA § 502(a). If a plaintiff 1) "could have brought his claim under ERISA § 502(a)(1)(B)," and 2) if "there is no other independent legal duty that is implicated," then ERISA preempts the state law. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004). The Sixth Circuit has held that the first prong applies to the entirety of ERISA § 502(a). *Patterson v. UnitedHealth Group, Inc.*, 161 F.4th 415, 422 (6th Cir. 2025). This Court has also "observe[d]" that "*Davila* . . . refer[s] to the pre-emptive force of [§ 502(a)] as a whole." *Id.* at 424. This Court has also adopted the Ninth Circuit's view that "[t]he two-prong[ed] test of *Davila* is in the conjunctive," requiring that both prongs be satisfied for preemption. *Gardner v. Heartland Indus. Partners, LP*, 715 F.3d 609, 613 (6th Cir. 2013) (quoting *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 947 (9th Cir. 2009)). In determining whether the first prong is met,

the Court's "examination looks beyond the label placed on a state law claim," and asks if the claim essentially seeks "'for the recovery of an ERISA plan benefit.'" *Patterson*, 161 F.4th at 422 (quoting *K.B. ex rel. Qassis v. Methodist Healthcare – Memphis Hosps.*, 929 F.3d 795, 801 (6th Cir. 2019)); *see also Davila*, 542 U.S. at 214 (holding as invalid the practice of distinguishing between, for example, "tort" claims and "contract" claims under state law for the sake of ERISA preemption).

Davila's second prong preempts state law claims that require interpretation of an ERISA plan's terms to establish whether a duty was violated. *Davila*, 542 U.S. at 213. For instance, the court in *Gardner v. Heartland Indus. Partners* held that ERISA did not preempt a tort claim against the cancellation of a retirement plan because "[n]obody needs to interpret the plan to determine whether that duty exists." 715 F.3d at 614. Likewise, the Court in *Patterson v. UnitedHealth Group, Inc.* held that ERISA preempted a state law claim against reimbursement collection because each of the breaches of duty "rests entirely upon what Patterson's ERISA-governed plan does (or does not) say." *Patterson*, 161 F.4th at 424.

Here, the first prong does not apply to Ms. Dashwood's claim because she is not seeking to recover a benefit promised under § 502(a). The district court cut off this analysis prematurely by claiming the Sixth Circuit previously ruled that ERISA preempts "wrongful death claims" based upon a refusal to authorize certain benefits. However, this analysis undermines the Court's reasoning by implying that

a claim named wrongful death is uniquely preempted. This label-based preemption was rejected by both this Court in *Patterson* and the Supreme Court in *Davila*. The Tennessee statute in question enables recovery if medication is switched on the formulary without written authorization from the beneficiary's physician. This statute does not offer recovery of a benefit under ERISA, which by contrast is concerned with rights specific to the plan and various fiduciary duties created under the federal scheme.

The lower court claims preemption by characterizing the claim as recovery based upon a mishandling of pharmacy benefits under the Plan. Yet, Ms. Dashwood's claim is not to recover, enforce, or clarify rights under the Plan as required under ERISA § 502(a)(1)(B), because there is nothing in the facts that suggest that the Plan mandates acquiring the physician's authorization as a benefit. ERISA § 502(a)(1)(B) cannot be used to recover, enforce, or clarify a benefit which does not exist in the plan, and so Ms. Dashwood is unable to seek a remedy under ERISA.

Under a similar analysis, the lower court also states the claim was against the fiduciaries, brought against them for their breach of their duties. However, it did so without referring to any specific subsection of § 502(a), and without mentioning which specific fiduciary duty it believed preempted this specific wrongful death claim, and why. One can sue the Defendants under ERISA based

on the breaches of their fiduciary duties, but not one that mirrors the wrongful death claim under Tennessee's law. This statute does not create a cause of action for a failure to speak to the patient about the switch, to look up their medical history before a switch, or even to call the physician, but for a failure to obtain express written authorization from the physician.

Even if the first prong is met, preemption still fails the conjunctive test on the second prong, because there is no need to interpret the terms of this particular plan to discover if a duty was violated. This claim is not based upon injuries due to plan administration, as the lower court argues, because the statute is not enforcing the particular terms of the plan, or their administration. The statute mandates written authorization of a physician before switching medication, regardless of what the plan says or does not say, unlike in *Patterson*. Whether or not the Plan mandates obtaining the physician's written authorization before switching medication does not affect the application of the state law. The only question is what the provider actually did, not what the Plan claimed they would do. Thus, interpretation of the plan is unnecessary.

Due to this, the state law in question is distinguished from that in *Davila*. In that case, the providers did not approve certain services for two of its beneficiaries who subsequently sued under state law. *Davila*, 542 U.S. at 205. One of the patients also "suffered a severe reaction" to an alternative medicine they took as a

result of their denial. *Id.* However, the Court found that the state law would not hold a provider liable "if it denied coverage for any treatment not covered by the health care plan." *Id.* at 213. This meant that the Court would have needed to interpret the benefit plan to determine whether or not the state law applied. *Id.* That is not true of the state law in the case before this Court. As illustrated above, the specific terms of the plan are irrelevant in the face of the state requirement to obtain written authorization before switching medication. The state law applies without interpreting the plan. Because of its failure to meet either prong of the *Davila* test, the state law is not preempted.

II. The District Court Erred in Holding that Dashwood Failed to Plausibly Allege that Defendants' Actions Caused an Injury Remediable Under ERISA § 502(a)(3)

A. The Lower Court Mischaracterized Count II as Seeking Barred Legal Damages Rather Than Appropriate Equitable Relief

Aldridge accurately states that appropriate equitable relief under § 502(a)(3) applies to claims "'that were typically available in equity.'" Aldridge, 144 F.4th at 846 (6th Cir. 2025) (quoting *Mertens v. Hewitt Assocs.*, 508 F.3d 248, 256 (1993)). Expanding upon this logic, the Court explains that compensatory damages, defined as "a request for 'monetary relief' measured by the plaintiff's 'losses'" also do not qualify as an appropriate equitable claim under § 502(a)(3), as they were not typically available at equity. *Aldridge*, 144 F.4th at 846. These contentions are not

at issue here. What remains problematic, however, is the lower court's determination that what Appellant seeks are merely compensatory damages under an umbrella definition of "surcharge."

Because money damages are the "classic form of *legal relief*," the definition of compensatory damages proffered in *Aldridge* precludes a claim for compensatory damages under § 502(a)(3). *Mertens*, 508 U.S. at 255 (emphasis added). This relief, based on losses to an individual plaintiff, is not sought by Appellant or members of the class. Rather, Appellant seeks a restoration of the Plan's assets unduly taken from it. This is a form of surcharge based upon the gains attained by the Plan administrators—Willoughby RX and Willoughby Health. This claim further requires a disgorgement of profits obtained through the fiduciary breaches of the Willoughby defendants.

Under ERISA, a plan fiduciary is typically treated as a trustee, while the plan itself is treated as the trust. *See CIGNA Corp. v. Amara*, 563 U.S. 421, 439 (2011). Claims alleging breaches of a trustee's fiduciary duties were only available in courts of equity, not courts of law. *Id.* Further, courts of equity were permitted to surcharge fiduciaries to make good losses to the trust resulting from breaches of fiduciary duty. *Id.* at 441–42. *See also LaRue v. DeWolff, Boberg & Assocs.*, 552 U.S. 248, 256 (2008) (recognizing that ERISA "does authorize recovery for

fiduciary breaches that impair the value of plan assets" and emphasizing plan assets are treated in a manner analogous to a trust).

Here, the relief sought under Count II is directed at restoring losses to the *trust*—the insurance plan—not the compensation of individual beneficiaries for personal losses. The Willoughby defendants, acting as trustees, were required to administer the formulary in the interests of the Plan beneficiaries. Instead, they acted disloyally in diverting Plan resources for their own financial gain. It is undisputed that Willoughby Health and Willoughby RX are the Plan's fiduciaries. *See* Mem. Op. and Order n.5. Under *CIGNA*, this characterization is analogous to a trustee and requires similar duties and responsibilities. Most importantly, however, breaches of trust were brought before courts of equity, not courts of law. These courts of equity required fiduciaries who breached their duties to restore misapplied assets to the trust and to concede any ill-gotten gains. *CIGNA*, 563 U.S. at 441–42.

While the district court cites *Aldridge* and *Mertens* to claim that surcharge is unavailable, the court incorrectly likens the facts of those cases to the present one. In *Aldridge*, the beneficiaries explicitly sought compensation based on each individual plaintiff's losses. *Aldridge*, 144 F.4th at 846. The beneficiaries in *Aldridge* further alleged that the plan administrator "deprived participants of benefits" in the plan, a personal harm to each plaintiff. *Id.* at 835. Conversely,

Count II asserts that the Willoughby defendants acted disloyally as plan administrators and trustees by manipulating the Plan's drug formulary to divert Plan resources for their own financial benefit through rebates and cheaper drugs. These claims focus on the harm to the Plan as a whole and seek to reestablish plan assets, rather than any individual's personal funds in an effort to make them whole. Making the individuals whole here would be impossible—no amount of money would be able to restore the lives lost due to the negligence of the Willoughby defendants.

Moreover, the district court's reliance on *Mertens* is inapposite to the facts of this claim. *Mertens* addresses a claim against an actuary who provided allegedly negligent services, causing financial losses to the plan. *Mertens*, 508 U.S. at 250. The court repeatedly emphasized that the actuary was a *nonfiduciary*, however, meaning he could not be held liable for fiduciary breaches traditionally addressed in equity. *Id.* at 254. *Aldridge* further emphasizes this point, stating that the Court held that suits were unavailable under § 502(a)(3) for "monetary losses from a nonfiduciary." *Aldridge*, 144 F.4th at 846. While non-fiduciaries are not liable for fiduciary breaches, fiduciaries still retain their duties as plan administrators. Both Willoughby defendants acknowledge their status as fiduciaries and consequently recognize that attached to this title are duties which, when breached, are actionable under courts of equity.

B. *Aldridge*'s Requirement of Specifically Identifiable Funds is Inapplicable to the Claims in Count II as Appellant Seeks Disgorgement and an Accounting for Profits

The district court asserts that Dashwood cannot receive equitable relief available under ERISA § 502(a)(3) for her disgorgement claim, because she is not seeking specifically identifiable funds as required by the *Aldridge* Court. However, the district court fails to distinguish between the equitable restitution sought in *Aldridge* and the accounting for profits and disgorgement of funds gained by the plan administrators in this case. Because Appellant seeks disgorgement and an accounting for profits, the funds need not be specifically identifiable as traditional trust-law remedies imposed personal liability on fiduciaries and did not require tracing to specific funds.

In *Great-West*, the Supreme Court considered a claim by a plan administrator seeking reimbursement from a participant who later recovered money from a third party after the plan had paid the participant's medical expenses. *Great-West Life & Annuity Ins. v. Knudson*, 534 U.S. 204, 207 (2002). The Supreme Court explained that a plaintiff was able to seek restitution under courts of equity "ordinarily in the form of a constructive trust or an equitable lien." *Id.* at 213. Such claims require specifically identifiable funds still in a defendant's possession. *Id.* However, the Supreme Court further acknowledges an important exception to this rule: accounting for profits. *Id.* at n.2. Elaborating on this

principle, the Court states that "[i]f . . . a plaintiff is entitled to a constructive trust on particular property held by the defendant, he may also recover profits produced by the defendant's use of that property, *even if he cannot identify a particular [property] containing the profits sought to be recovered*." *Id.* (emphasis added).

Here, the "particular property" held by the defendants are the Plan's assets and financial benefits, that is, the rebates and cost savings generated through the administration of the Plan. The Willoughby defendants, rather than utilizing their fiduciary control over these assets to adhere to participants' needs, used that authority to generate rebates and cost savings for their own benefit. Once the defendants have been shown to act disloyally in their duties, plaintiffs are able to seek an accounting for and disgorgement of the profits produced by such misuse, even if these profits are not sitting in a separate account. As stated, the relief sought is not based upon personal losses to individual plan participants, but upon the unjust gains produced by the defendants' misuse of the Plan's assets.

Assuming, *arguendo*, the Court disagrees with this analysis, the facts do not stipulate that defendants have dissipated the funds at hand or that they are untraceable. When property or proceeds accruing from such property "have been dissipated so that no product remains," the plaintiff's claim will be barred as a constructive trust or an equitable lien. *Id.* at 214. (quoting Restatement (First) of Restitution, § 215, cmt. a, at 867). Further, the Court in *Montanile v. Bd. of*

Trustees of the Nat'l Elevator Industrial Health Benefit Plan found that such dissipation occurs when proceeds are spent on nontraceable items like services or consumables, while traceable items like a car are specifically identifiable. *Montanile v. Board of Trustees of the National Elevator Industrial Health Benefit Plan*, 577 U.S. 136, 145 (2016).

In the present case, there is nothing presented by the Willoughby defendants to contend that the profits have been spent on nontraceable items. The payments from Bactrim's manufacturer went to Willoughby RX in the form of rebates. These rebates are specific funds which can be traced to individual transactions between Willoughby RX and Bactrim's manufacturer. Such funds can be traced through accounting records that would track these payments. Because these are payments Willoughby RX received and can still trace in accounting records, they meet the specificity requirement this Court requires.

CONCLUSION

For all the reasons set forth above, Appellant, Elinor Dashwood, respectfully requests that this Court reverse the district court's order granting the Defendants' Motion to Dismiss for Failure to State a Claim and remand this case for trial.

Respectfully submitted,

Team 11
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