IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

CIVIL ACTION No. 25-CV-101

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

v.

ABC PHARMACY, et al.,
Appellees.

BRIEF FOR PLAINTIFF-APPELLANT

On Appeal from the United States District Court for the Eastern District of Tennessee, Granted _____

Team 3
Attorneys for Appellant

QUESTION PRESENTED

I. Whether ERISA preempts a state-law wrongful death claim where the claim arises from independent state law duties governing pharmaceutical safety, prescription drug substitution, and truthful communication at the point of care, and does not seek plan benefits, challenge coverage determinations, or require interpretation of ERISA plan terms.

Suggested Answer: No.

II. Whether a district court may dismiss a fiduciary-breach claim under ERISA § 502(a)(3) at the pleading stage by concluding that no equitable relief is available, where the plaintiff seeks declaratory relief expressly authorized by the statute, even if certain requested monetary remedies may ultimately be unavailable.

Suggested Answer: No.

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JURISDICTIONAL STATEMENT

The district court had subject-matter jurisdiction under 28 U.S.C. § 1331 because this action arises under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., and included related claims over which the district court exercised supplemental jurisdiction under 28 U.S.C. § 1367.

The district court entered a final order dismissing Appellant's claims with prejudice. Appellant timely filed a notice of appeal. This Court has appellate jurisdiction under 28 U.S.C. § 1291 because the district court's order disposed of all claims against all parties and constitutes a final judgment.

STATEMENT OF THE CASE

a. Factual Background

Marianne Dashwood was a young mother and talented writer from Johnson City, Tennessee. *First Am. Compl.* 9, 16. On December 1, 2024, Marianne cut her leg while hiking with her son. *First Am. Compl.* ¶ 17. This cut later turned into a serious infection, leading to her hospitalization at Johnson City Hospital Center on December 5, 2024. *Id*. Marianne was a participant in a health plan that was sponsored by her employer (Cottage Press) and governed by ERISA. *First Am. Compl.* ¶ 9. The plan was administered by Willoughby Health Care, the insurer and the named plan administrator. *First Am. Compl.* ¶ 13. The prescription drug benefits were administered by pharmacy benefit manager ("PBM") Willoughby

RX pursuant to a plan formulary of preferred drugs. *First Am. Compl.* ¶ 14. Both Willoughby Health Care and Willoughby RX are fiduciaries under ERISA. *First Am. Compl.* ¶ 13-14.

At the hospital, staff diagnosed Marianne with MRSA, which is a "drug-resistant and life-threatening staph infection." *Id.* Because Marianne had a well-documented allergy to sulfa drugs and had experienced a severe allergic reaction in 2022, the hospital treated her with the antibiotic vancomycin instead of a sulfa drug. *First Am. Compl*. ¶ 20-21. After five days with positive results, Marianne was released on December 10, 2024, with a five-day prescription for vancomycin. *First Am. Compl.* ¶ 17.

Marianne's sister, Elinor Dashwood ("Appellant"), brought the vancomycin prescription to an ABC Pharmacy ("Appellee") in Johnson City. *First Am. Compl.* ¶ 18. However, ABC Pharmacy substituted vancomycin for a five-day supply of a cheaper sulfa drug called Bactrim. *First Am. Compl.* ¶ 18, 22. When Elinor asked about the difference between the medications, the pharmacist assured her that Bactrim was merely the generic form of vancomycin, even though the two drugs belong to different antibiotic classes. *First Am. Compl.* ¶ 19-20. The pharmacist explained that the prescription had been switched to Bactrim by Willoughby, but did not identify whether Willoughby Health Care or Willoughby RX had made the decision. *Id.* Neither Willoughby Health Care, Willoughby RX, nor ABC

Pharmacy asked Marianne's doctor if Bactrim was an appropriate antibiotic for her. *First Am. Compl.* ¶ 21. Elinor gave the medication to Marianne for less than two days before Marianne suffered a severe allergic reaction and lost her life during her ambulance ride to the hospital. *First Am. Compl.* ¶ 19, 23.

b. Procedural History

On May 14, 2025, Elinor Dashwood (individually and on behalf of Marianne's estate and a class of others similarly situated) filed a civil complaint in the U.S. District Court for the Eastern District of Tennessee against Willoughby Health Care, Willoughby RX, and ABC Pharmacy. *First Am. Compl.* 1, 11. Count I sued for wrongful death under Tennessee Code § 20-5-106 against Defendants Willoughby RX and ABC Pharmacy. *First Am. Compl.* 8. Count II sued for fiduciary and co-fiduciary breaches of the duties of loyalty and prudence in violation of ERISA against Defendants Willoughby Health Care and Willoughby RX. *First Am. Compl.* 8.

Defendants filed a Motion to Dismiss Plaintiff's Amended Complaint for Failure to State a Claim. *Dist. Ct. Op.* 1. The District Court granted Defendant's motion and dismissed the case with prejudice. Plaintiffs are appealing to the United States Court of Appeals for the Sixth Circuit. *Id.*

SUMMARY OF ARGUMENTS

The district court erred in dismissing Appellant's claims at the pleading stage. First, ERISA does not preempt Appellant's state-law wrongful death claim because the claim arises from independent state law duties governing pharmaceutical safety, prescription drug substitution, and truthful communication at the point of care. Appellant does not seek plan benefits, challenge coverage determinations, or require interpretation of ERISA plan terms. Instead, the claim targets negligent and misleading conduct occurring after any plan-related decision, conduct regulated by state law, and wholly independent of ERISA plan administration. Because the wrongful death claim enforces duties that exist regardless of any employee benefit plan and does not interfere with ERISA's interest in uniform plan administration or duplicate ERISA's civil enforcement scheme, ERISA preemption does not apply.

Even apart from the existence of independent state law duties, preemption is unwarranted because adjudicating Appellant's wrongful death claim would not require any ERISA plan to alter its structure, benefits, or administrative processes. The claim does not mandate coverage, modify formularies, or impose inconsistent administrative obligations on plan administrators. It addresses conduct at the pharmacy counter and can be resolved without reference to plan terms or benefit determinations. ERISA's preemption provision was not intended to extinguish traditional state law remedies for physical injury and death arising from professional

misconduct, and the district court's contrary conclusion improperly expanded ERISA beyond its intended scope.

Second, the district court improperly dismissed Count II by concluding that no equitable relief was available under ERISA § 502(a)(3). Although ERISA does not authorize compensatory damages under that provision, § 502(a)(3) expressly permits traditional equitable relief, including declaratory relief, to redress fiduciary misconduct. Appellant sought a declaratory judgment establishing that Defendants violated ERISA's fiduciary obligations, a form of relief squarely authorized by the statute. The district court erred by resolving remedial questions prematurely and dismissing the claim with prejudice based solely on the potential unavailability of certain monetary remedies. Because Appellant sought equitable relief expressly permitted under ERISA, dismissal at the pleading stage was improper.

For these reasons, the district court's judgment should be reversed, and the case remanded for further proceedings.

ARGUMENTS

I. The District Court Misapplied ERISA Preemption Principles by Treating a State-Law Wrongful Death Claim as a Benefits Dispute.

The district court erred by extending ERISA preemption far beyond its intended scope to dismiss a traditional state law wrongful death claim arising from negligent pharmaceutical conduct. ERISA preempts state laws that regulate the structure, administration, or enforcement of employee benefit plans. It does not displace generally applicable state law duties governing patient safety, professional conduct, or the dispensing of prescription medication. Appellant does not seek plan benefits, challenge coverage determinations, or require interpretation of plan terms. Instead, the claim arises from Defendants' violation of independent state law duties regulating medication substitution and truthful representation at the point of care. Because the wrongful death claim enforces obligations that exist regardless of any ERISA plan and does not interfere with uniform plan administration or duplicate ERISA's civil enforcement scheme, it falls outside ERISA's preemptive reach. Therefore, the district court's dismissal should be reversed.

A. ERISA Does Not Preempt State-Law Claims Based on Independent Legal Duties Governing Patient Safety and Pharmaceutical Conduct.

ERISA preemption turns on the source of the legal duty allegedly breached. A state law claim is preempted only when the defendant's liability derives solely

from the terms or administration of an ERISA plan, and the claim could have been brought under ERISA's civil enforcement scheme. Where, as here, the claim rests on duties imposed by state law that exist independently of any employee benefit plan, ERISA does not apply. Appellant's wrongful death claim arises from long-recognized state law obligations governing pharmaceutical safety, prescription drug substitution, and truthful communication to patients and their caregivers. Those duties apply regardless of whether an ERISA plan is involved and do not depend on plan interpretation or benefit determinations. Because Defendants' alleged liability flows from independent state law duties rather than plan administration, ERISA preemption fails as a matter of law.

Although ERISA preempts state laws that relate to employee benefit plans, the Supreme Court has repeatedly emphasized that this language does not extend preemption to all state law claims that arise in a healthcare setting. Courts therefore distinguish between claims challenging the quality of medical or pharmaceutical care, which fall outside ERISA's scope, and claims challenging the quantity or availability of plan benefits, which may be subject to preemption. ERISA was enacted to regulate the structure and administration of employee benefit plans, not to displace generally applicable state laws governing professional conduct, patient safety, or the delivery of medical care. Consistent with that purpose, the Court has cautioned against interpretations of ERISA that would convert ordinary state law

claims into federal causes of action merely because an ERISA plan appears in the factual background. Because regulation of patient safety and pharmaceutical practice lies at the core of the states' traditional police powers, courts apply ERISA preemption cautiously in this context and refuse to infer displacement absent a clear connection to plan administration.

That principle is reflected in the Supreme Court's preemption jurisprudence. The Court's decisions consistently confirm that ERISA does not preempt state law claims grounded in independent legal duties. In *Aetna Health Inc. v. Davila*, the Court held that ERISA preemption applies only where a plaintiff could have brought the claim under ERISA's civil enforcement provision and no other independent legal duty is implicated by the defendant's conduct, as where the plaintiffs sought to enforce coverage decisions owed solely under the terms of their ERISA plans. 542 U.S. 200, 210 (2004). The Court has repeatedly cautioned against interpreting ERISA to displace areas of traditional state regulation, emphasizing that ERISA regulates employee benefit plans, not the quality or safety of medical care. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 655 to 61 (1995) (rejecting preemption where the state law increased costs but did not dictate plan administration); *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (distinguishing plan administration from medical treatment decisions governed by state malpractice law).

Applying this framework, the Sixth Circuit has emphasized that a state-law claim survives ERISA preemption when it asserts "a violation of a legal duty independent of ERISA," meaning a duty the plaintiff could allege even if no ERISA plan existed. *Briscoe v. Fine*, 444 F.3d 478, 498–99 (6th Cir. 2006). Conversely, preemption applies only where the claim has "no basis whatsoever but for the ERISA plan." *Id.* at 499.

Consistent with both Supreme Court precedent and the Sixth Circuit's approach, the courts of appeals have drawn a firm distinction between claims challenging benefit eligibility or plan administration, which ERISA preempts, and claims challenging the manner in which medical or pharmaceutical services are provided, which it does not. *See Dukes v. U.S. Healthcare, Inc*., 57 F.3d 350, 356 to 57 (3d Cir. 1995) ((holding that malpractice claims challenge how care was delivered, not whether benefits were owed); *Dishman v. UNUM Life Insurance Co. of America*, 269 F.3d 974, 983 (9th Cir. 2001) (where liability arose from independent tort duties, not plan terms). Together, these decisions establish that where liability turns on state law duties governing professional conduct rather than plan terms, ERISA preemption does not apply.

Critically, the duties alleged here would apply in precisely the same manner if Appellant paid cash, used Medicare, or had no insurance at all, confirming that Defendants' obligations do not arise from, and are not conditioned on, the existence

of an ERISA plan. The claim does not require interpretation of plan terms or evaluation of benefit determinations. Rather, it alleges liability based on conduct regulated by state law that operates independently of any employee benefit plan.

Here, Appellant's wrongful death claim arises from Defendants' alleged violation of state law duties governing the dispensing of prescription medication, not from the administration of an ERISA plan. The First Amended Complaint alleges that Appellant's treating physician prescribed vancomycin to treat a life-threatening MRSA infection, and that Appellant presented that prescription to an ABC Pharmacy for fulfillment. *First Am. Compl.* ¶ 17–18. Rather than dispensing the prescribed medication, Defendants substituted Bactrim, a different drug in a different class, without consulting the prescribing physician or obtaining authorization for the substitution. *First Am. Compl.* ¶ 18–22. These allegations concern the manner in which medication was dispensed at the pharmacy counter and the professional obligations governing that conduct, duties imposed by state law that exist independently of any employee benefit plan.

The First Amended Complaint further alleges that Defendants compounded this unauthorized substitution through affirmative misrepresentations and disregard of a known medical risk. Appellant had a documented allergy to sulfa drugs, including Bactrim, and Defendants were aware or should have been aware of that allergy at the time of dispensing. *First Am. Compl.* ¶ 20–21. When Appellant

questioned why the medication provided differed from the prescription, the pharmacist affirmatively represented that Bactrim was merely the generic equivalent of vancomycin. *First Am. Compl.* ¶ 19. Those allegations implicate core state law duties governing truthful communication by healthcare professionals and the safe dispensing of medication to patients. Liability for such conduct does not turn on plan terms, coverage determinations, or benefit eligibility. It turns on whether Defendants complied with independent state law obligations owed directly to the patient and her caregiver.

Under *Davila's* two-part test, ERISA preemption fails as a matter of law. First, Appellant could not have brought this wrongful death claim under ERISA's civil enforcement provision. ERISA authorizes actions to recover plan benefits, enforce plan rights, or clarify future benefits. It does not provide a cause of action for wrongful death, personal injury, or damages arising from negligent pharmaceutical conduct. Appellant does not seek plan benefits or allege an improper coverage determination, but seeks relief for physical harm caused by Defendants' conduct at the point of care. Second, Defendants' alleged liability arises from independent state law duties governing prescription drug substitution, patient safety, and truthful communication, duties that exist regardless of any employee benefit plan. Because Appellant's claim neither falls within ERISA's enforcement scheme nor depends on duties derived from plan administration, both requirements for ERISA preemption

are absent.

In dismissing Appellant's wrongful death claim at the threshold, the district court extended ERISA preemption beyond its intended limits. Appellant's claim does not function as an effort to enforce plan rights or administer plan benefits, and ERISA provides no basis for extinguishing traditional state law remedies for physical injury and death arising from professional misconduct. Because ERISA preemption does not apply, dismissal was erroneous. The judgment should be reversed, and the case remanded for further proceedings.

B. The Wrongful Death Claim Does Not Interfere with Uniform Plan Administration and Falls Outside ERISA's Intended Scope.

ERISA's preemption provision is designed to prevent states from imposing inconsistent requirements on plan structure, benefit design, or administrative processes. It is not intended to shield plan-affiliated entities from liability for conduct that does not affect plan design or administration. Appellant's claim does not seek to mandate coverage, alter formularies, or impose administrative obligations on plan administrators. Instead, it seeks damages for conduct occurring after any plan-related coverage determination, during the dispensing process at the pharmacy counter. Because adjudicating this claim would not require ERISA plans to change how they operate, ERISA preemption does not apply.

Courts, therefore, focus on whether a state-law claim dictates plan operations or merely regulates conduct external to the plan. ERISA preemption is concerned with preserving the uniform administration of employee benefit plans, not displacing generally applicable state laws that regulate conduct outside the plan itself. State law claims are preempted only when they mandate particular benefit structures, dictate eligibility rules, or impose administrative requirements that force plans to operate differently from state to state. By contrast, state laws that regulate professional conduct, patient safety, or the delivery of medical and pharmaceutical services do not implicate ERISA's core objectives, even when the conduct occurs in a setting that involves an ERISA plan. Where adjudicating a claim would not require interpretating plan terms or altering plan administration, ERISA preemption does not apply.

The Supreme Court has repeatedly emphasized that ERISA preemption is driven by concerns about uniform plan administration, not by a desire to insulate plan-related actors from generally applicable state law. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, the Court rejected an expansive reading of ERISA preemption and explained that state laws are not preempted merely because they increase costs or affect entities that contract with ERISA plans. 514 U.S. 645, 656–61 (1995). Rather, preemption applies only when a state law dictates plan choices or interferes with nationally uniform plan

administration. The Court reaffirmed that principle in *Rutledge v. Pharmaceutical Care Management Association*, holding that state regulation of pharmacy benefit managers is not preempted unless it effectively requires plans to adopt specific benefit structures or coverage rules. 592 U.S. 80, 86–88 (2020). Together, these decisions make clear that ERISA preemption does not extend to state law claims that regulate conduct external to plan administration and do not require plans to alter how benefits are designed or administered.

Adjudicating Appellant's wrongful death claim would not require any ERISA plan to alter its structure or administrative processes. The claim does not seek to mandate coverage for any medication, modify formularies, impose new eligibility rules, or regulate how benefits are calculated or paid. Instead, the alleged misconduct occurred after any plan-related coverage determination, during the dispensing process at the pharmacy counter, when Appellant presented a valid prescription to an ABC Pharmacy for fulfillment. *First Am. Compl*. ¶ 17–18. Whether Defendants complied with generally applicable standards governing the dispensing of prescription medication can be resolved without interpreting plan documents or evaluating benefit determinations.

Nor would a judgment in Appellant's favor interfere with ERISA's interest in national uniformity. Liability here would not require plans to operate differently across states or to adopt inconsistent administrative practices. It would simply

require pharmacies and pharmacy benefit managers to adhere to baseline standards of care when dispensing medication and communicating with patients. The First Amended Complaint alleges that Defendants substituted a different medication for the one prescribed and provided inaccurate information regarding that substitution at the pharmacy counter. *First Am. Compl.* ¶ 18–19. Enforcing state law standards governing that conduct does not dictate plan choices or burden plan administration.

The district court's own description of the claim confirms this point. As the court itself recognized, Appellant's allegations center on the substitution of medication and resulting physical harm, not on a dispute over plan benefits or coverage. *Dist. Ct. Op.* at 9–11. Resolving the wrongful death claim, therefore, would not require the court to determine what the plan covered, how benefits were administered, or whether a benefits decision was correct. It would require only a determination of whether Defendants' conduct at the point of care complied with generally applicable state law standards.

Because Appellant's wrongful death claim does not dictate plan structure, alter benefit design, or impose administrative requirements on ERISA plans, it does not implicate ERISA's interest in uniform plan administration. The claim targets conduct at the point of care and can be adjudicated without reference to plan terms or benefit determinations. ERISA preemption does not apply, and the district court's contrary conclusion was in error. The judgment should therefore be reversed.

II. The District Court Improperly Dismissed Count II at the Pleading Stage by Concluding That No Equitable Relief Was Available Under ERISA § 502(a)(3).

The district court erred by dismissing Count II on the ground that no equitable relief was available under ERISA § 502(a)(3). Section 502(a)(3) expressly authorizes traditional equitable remedies to redress fiduciary misconduct, including declaratory relief. Although ERISA limits the availability of compensatory damages, a claim is not subject to dismissal merely because some requested remedies may ultimately prove unavailable. Where, as here, a plaintiff seeks declaratory relief to establish that fiduciaries violated ERISA's substantive obligations, § 502(a)(3) provides an appropriate and independent cause of action. By resolving remedial questions at the pleading stage and dismissing Count II with prejudice, the district court misapplied ERISA and prematurely foreclosed relief that the statute expressly permits. At the pleading stage, the court's role is limited to assessing whether the complaint plausibly alleges entitlement to any relief authorized by the statute, not to resolving the ultimate availability of particular remedies.

When there are fiduciary breaches of duty, ERISA § 502(a)(3) permits a civil action "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to

enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132. Although this provision does not authorize compensatory damages, it does permit traditional equitable relief, including declaratory relief.

The Supreme Court has held that "equitable relief" under § 502(a)(3) refers only to remedies that were typically available in courts of equity and therefore excludes compensatory money damages. *Mertens v. Hewitt Associates*, 508 U.S. 248, 255–56 (1993). At the same time, the Court has explained that § 502(a)(3) functions as a "safety net," ensuring that fiduciary misconduct does not go unchecked simply because other ERISA provisions limit the available remedies. *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996). In *CIGNA Corp. v. Amara*, the Court explained that § 502(a)(3) authorizes traditional equitable remedies that were typically available in courts of equity, including remedies used to enforce fiduciary obligations in trust law. 563 U.S. 421, 438–42 (2011).

Although the Court discussed the origins of remedies like surcharge, it did not decide the scope or availability of monetary relief under ERISA. Interpreting *Amara*, the Sixth Circuit has held that loss-based monetary relief is not available under § 502(a)(3), even when framed as an equitable surcharge. *Aldridge v. Regions Bank*, 144 F.4th 828, 846–47 (6th Cir. 2025). However, *Aldridge* addressed whether monetary relief could ultimately be awarded, not whether a fiduciary-breach claim seeking equitable relief may proceed at the pleading stage. Critically, whether a

particular form of monetary relief is ultimately available is distinct from whether a fiduciary-breach claim may proceed at the pleading stage. At this stage, the court must accept the well-pleaded allegations as true and determine only whether the plaintiff has plausibly alleged entitlement to any form of relief authorized by the statute. Where a complaint seeks declaratory or injunctive relief expressly contemplated by § 502(a)(3), dismissal is improper even if certain requested remedies may later be foreclosed.

Here, Appellant expressly sought a declaratory judgment that Defendants' actions and omissions violated ERISA. Declaratory relief is a traditional form of equitable relief that determines the parties' legal rights without awarding damages. Such relief serves an independent remedial function by establishing whether fiduciaries have violated ERISA's substantive obligations and by clarifying the legality of ongoing practices. Because declaratory relief does not require proof of loss, tracing of funds, or entitlement to monetary recovery, its availability does not rise or fall with the permissibility of surcharge or disgorgement. The district court's failure to account for this independent form of equitable relief was reversible error. Declaratory relief is especially appropriate where, as here, it would clarify fiduciaries' obligations under ERISA and prevent continued or future violations of the statute.

Even if Appellant's requests for surcharge or disgorgement are ultimately barred under *Mertens* and *Aldridge*, her request for declaratory relief on its own is enough to bring the claim within § 502(a)(3). By dismissing Count II with prejudice, the district court treated the claim as though Appellant sought only monetary damages and failed to consider her request for declaratory relief, which ERISA expressly allows. By doing so, the court decided the remedy issues too early and incorrectly concluded that no equitable relief was available as a matter of law. At the Rule 12(b)(6) stage, the court was required to determine only whether any form of equitable relief was plausibly available, not to foreclose relief based on remedies that might later be unavailable.

Although Appellant also requested some forms of monetary relief that ERISA does not permit under § 502(a)(3), that does not turn her claim into a damages-only action. A fiduciary-breach claim should not be dismissed at the pleading stage simply because some requested remedies may later prove unavailable. As long as the plaintiff seeks any equitable relief authorized by § 502(a)(3), dismissal is improper.

Because Appellant sought declaratory relief authorized by ERISA § 502(a)(3), the district court erred in concluding that no equitable relief was available and in dismissing Count II at the pleading stage.

CONCLUSION

For the foregoing reasons, the district court erred in dismissing Appellant's claims at the pleading stage. Appellant's wrongful death claim is not preempted by ERISA because it arises from independent state law duties and does not interfere with the uniform administration of employee benefit plans. In addition, the district court improperly dismissed Count II by concluding that no equitable relief was available under ERISA § 502(a)(3), despite Appellant's request for declaratory relief expressly authorized by the statute. The judgment should be reversed, and the case remanded for further proceedings.

Respectfully submitted,

/s/ Team 3

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Dated: January 23, 2026