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 Dahshwood and a Class of Others Similarly Situated,
Appellee – Plaintiff,

v.

Willoughby Health Care Co., WILLOUGHBY RX, and ABC Pharmacy, Inc.,
Appellant – Defendant.

ON APPEAL FROM
THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TENNESSEE

BRIEF FOR APPELLEES

Team Number: 1

CORPORATE DISCLOSURE

Pursuant to Federal Rule of Appellate Procedure 26.1 and Sixth Circuit Rule 26.1, counsel for Defendant–Appellee certifies that no party to this appeal is a subsidiary or affiliate of a publicly owned corporation, and that no publicly owned corporation that is not a party to this appeal has a financial interest in the outcome of this litigation.

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Pursuant to Federal Rule of Appellate Procedure 34(a) and Sixth Circuit Rule 34(a), Fed. R. App. P. 34(a); 6th Cir. R. 34(a), Appellees-Defendants respectfully request oral argument in this appeal. This case raises important issues concerning national healthcare plans governed by the Employee Retirement Income Security Act of 1974, and, in light of the factual and legal issues presented, Appellees-Defendants believe that oral argument would assist the Court in resolution of this matter.

STATEMENT OF JURISDICTION

This court has jurisdiction because the case at bar derives from a final decision issued by the U.S. District Court for the Eastern District of Tennessee. *See* 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

I. Whether ERISA pre-empts a state-law wrongful death claim that is connected to ERISA plan administration and benefit structures and seeks remedies for injuries allegedly arising from plan administration that are not provided under ERISA.

II. Whether the requested remedies of surcharges and disgorgement of funds are available as equitable remedies under ERISA Section 502(a)(3).

STATEMENT OF THE CASE

Marianne Dashwood ("Marianne") was a participant in a healthcare plan ("Plan") governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. The Plan sponsor was her former employer, Cottage Press, an academic publishing company with locations in Johnson City, Tennessee, and several other college towns in North Carolina and Virginia.

The Plan is fully insured by Appellee Willoughby Health Insurance Co. ("Willoughby Health"), a nationwide health-care insurance company. Willoughby Health also administers benefits under the Plan and is expressly granted full discretionary authority to decide claims for benefits. With respect to medications, Willoughby Health administers benefits through its subsidiary, Appellee Willoughby RX, which is a pharmacy benefit manager ("PBM") that has developed and applies a formulary of preferred drugs in deciding prescription drug claims. Appellee ABC Pharmacy is a nationwide pharmacy chain with retail outlets throughout the United States, including in Johnson City, where Marianne lived and worked. ABC Pharmacy was acquired in 2021 by Willoughby RX and is now a subsidiary of Willoughby RX under the larger corporate umbrella of Willoughby Health Care.

On December 1, 2024, Marianne cut her leg while hiking. The wound became infected, and on December 5, 2024, she was admitted to Johnson City Hospital. Her medical team determined that the infection was caused by a drug-resistant and life-threatening staph infection commonly referred to as MRSA. Marianne was treated in the hospital for five days with the intravenous antibiotic vancomycin and responded well to the treatment. She was discharged on December 10, 2024, with a five-day prescription for vancomycin.

Upon being discharged, Marianne's sister and Appellant, Elinor Dashwood ("Elinor"), brought the prescription to be filled at ABC Pharmacy. ABC Pharmacy filled the prescription with a five-day supply of Bactrim, not vancomycin. When Elinor, who noticed the discrepancy, asked the pharmacist about this, she was informed that Marianne's insurance company had switched the prescription to Bactrim and was also told that Bactrim was simply the generic form of vancomycin. Neither Elinor, Marianne, nor the prescribing physician objected to the change. As common practice among ERISA healthcare plans, Willoughby RX, acting through ABC Pharmacy, routinely switches similar preferred drugs on its formulary for prescribed medication without contacting the prescribing doctor unless a plan participant, beneficiary, or prescribing doctor expressly objects. As alleged in the Amended Complaint, that is what happened in this case.

Bactrim is not the generic form of vancomycin, which is in a class of antibiotics called fluoroquinolones, but is instead an entirely different class of antibiotics known as sulfonamides ("sulfa drugs"). Marriane was allergic to sulfa drugs and had informed her medical team at Johnson City Hospital of this allergy. Neither Willoughby Health Care, Willoughby RX, nor ABC Pharmacy consulted her doctor about whether Bactrim was a safe and appropriate treatment for Marianne.

Elinor subsequently brought suit on her own behalf and on behalf of her sister's estate, for which she was appointed Executrix, as well as on behalf of a class of others similarly situated. Count I asserts a state-law wrongful-death claim against Willoughby RX and ABC Pharmacy. The claim relies on a Tennessee statute that prohibits pharmacies and PBMs from changing prescribed medications without authorization from the treating physician. Although the statute does not provide a private right of action, Elinor alleges that it establishes a duty supporting a claim for wrongful death. She seeks $10 million in compensatory and punitive damages under Count I.

Count II asserts a federal claim against Willoughby Health Care and Willoughby RX for breach of fiduciary duty in violation of ERISA § 404, 29 U.S.C. § 1104, on behalf of the estate and a class of similarly situated plan participants and beneficiaries whose prescription drug coverage is subject to the formulary policy.

Appellees jointly moved to dismiss the Amended Complaint under Federal Rule of Civil Procedure 12(b)(6). The lower court ruled that Elinor failed to state a claim for wrongful death under Tennessee law and failed to state a claim for breach of fiduciary duty under ERISA. The court therefore granted the Appellee's joint motion to dismiss with prejudice.

SUMMARY OF THE ARGUMENT

The lower court correctly granted Appellee's motion to dismiss for failure to state a claim upon which relief can be granted. The Appellant's complaint triggered pre-emption both for the relationship the claim has with the plan in question, as well as for the duplicative nature of the damages requested. The purpose of pre-emption is to promote uniform application of ERISA throughout the nation; thereby preventing state infringement on plans and plan administration.

Appellant's wrongful death state law claim is immediately preempted due to being both "related to" and "connected to" an ERISA governed healthcare plan. The claim in question deals intimately with the administration of pharmaceutical benefits, an area protected by preemption. If granted, the Tennessee law would require a significant administrative burden to be put on the individual plans. Further, the remedies sought by Appellant are duplicative, triggering another preemption statute.

Additionally, Appellant has not plausibly alleged that Willoughby Health Care and Willoughby RX engaged in actions constituting a remediable loss or harm under ERISA Section 502(a)(3). Section 502(a)(3) only allows for equitable relief, and Appellant's requested remedies are damages in substance. First, under the pretense of a "surcharge," Appellant seeks Marianne's lost lifetime earnings as a remedy. While Appellant claims that this as an equitable remedy, and avoids using the word "damages," the monetary nature and amount of the relief sought are more accurately defined as damages. These damages are being demanded for the purpose of mitigating the losses Appellant has suffered allegedly at the hands of Willoughby Health Care and Willoughby RX. Second, Appellant's request for disgorgement of the amounts by which Willoughby Health Care and Willoughby RX allegedly profited from substituting Bactrim for Vancomycin constitutes a request for restitution of ill-gotten gains, which can only be equitable if

Appellant seeks money from a specific fund. Here, the complaint fails to identify a specific fund, so Appellant's request for disgorgement does not constitute equitable relief.

Furthermore, the lower court was correct to grant Appellee's motion to dismiss, because ERISA not only pre-empts laws that are connected to its administration, but also pre-empts laws that duplicate, supplement, or supplant the civil remedies provided ERISA's regulatory scheme. Congress explicitly included within ERISA's civil enforcement provisions a cause of action authorizing participants and beneficiaries to recover, enforce, or clarify rights under ERISA benefit plans. Therefore, absent any alternative legal duty independent of ERISA or the plan terms, Appellant is pre-empted from bringing any state-law cause of action that would contradict Congress' clear intent.

Moreover, the Sixth Circuit has already addressed that a party may not bring a state-law action to recover, enforce, or clarify ERISA plan terms when the remedy sought is not provided under ERISA's regulatory scheme. Put simply, Appellant seeks to supplant ERISA's civil enforcement scheme in clear contradiction of Congress' intent. Accordingly, under Sixth Circuit precedent, the lower court correctly determined that Congress intended to pre-empt state-law actions, granting Appellee's motion to dismiss.

Nevertheless, if Appellant were to have sought to recover, enforce, or clarify their rights under the Plan, the lower court's decision to grant Appellee's motion to dismiss would still hold. When a claim originates only through denials of coverage promised under the terms of a ERISA-regulated employee benefit plan, any liability derives entirely from the particular rights and obligations established by the ERISA plan itself. Here, the Appellees complied with every provision of the Plan, and therefore were not breach of duty imposed by ERISA or the Plan.

ARGUMENT

Standard of Review

The Sixth Circuit reviews a district court's grant of a motion to dismiss *de novo*. *See Taxpayers United for Assessment Cuts v. Austin*, 994 F.2d 291, 296 (6th Cir. 1993). Under this standard, the Court's review is "essentially the same as the district court's." *Forest v. United States Postal Serv.*, 97 F.3d 137, 139 (6th Cir. 1996) (quoting *American Eagle Credit Corp. v. Gaskins*, 920 F.2d 352, 353 (6th Cir. 1990)).

The Federal Rules of Civil Procedure require a plaintiff to plead a claim that is "short and plain" and that shows entitlement to relief. *See Fed. R. Civ. P.* 8(a)(2). To survive a motion to dismiss, "plaintiff must allege facts that, if accepted as true, are sufficient to raise a right to relief above the speculative level and to state a claim to relief that is plausible on its face." *Hensley Mfg. v. ProPride, Inc.*, 579 F.3d 603, 609 (6th Cir. 2009) (internal punctuation omitted). A claim is plausible on its face when "the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged[.]" *Id*. (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 677 (2009)).

I. The lower court correctly held that Appellant's wrongful death claim is pre-empted by ERISA because it is connected to plan administration and benefit structures and seeks additional remedies for injuries arising from plan administration that Congress deliberately chose not to provide.

Under the subsequent, section "A" provides in detail why Count I's cause of action is connected to the administration of ERISA healthcare plans, how this pre-empts Appellant's state-law cause of action, and why the Appellant's have failed to prove any applicable exceptions. Section "B" provides in detail why the state laws at issue here, duplicate, supplement, and supplant

Congress's intent to provide a comprehensive statutory scheme regulating ERISA healthcare plans.

A. Count I is pre-empted because the state law used as its cause of action is connected to ERISA's uniform regulatory scheme.

Congress enacted ERISA to establish a uniform, nationwide framework for governing employee benefit plans. Courts look to congressional intent to determine whether federal law pre-empts state law. *FMC Corp. v. Holliday*, 498 U.S. 52, 56 (1990) Pre-emption applies regardless of, "whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." *Id.* (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983)).

i. Congressional intent

The inquiry into congressional intent "begin[s] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *FMC Corp.,* 498 U.S. at 57 . Three specific provisions of ERISA law speak to the question of pre-emption: (1) the preemption clause, 29 U.S.C. § 1144(a); (2) the savings clause, 29 U.S.C. § 1144(b)(2)(A); and (3) the deemer clause, 29 U.S.C. § 1144(b)(2)(B). *Id.*

First, the statutory language under the preemption clause is purposefully broad, stating: "[e]xcept as provided in subsection (b) . . . , [ERISA] shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Under the savings clause, "[e]xcept as provided in subparagraph (B), nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

Finally, under the deemer clause, Congress narrows the application of the savings clause by providing that an employee benefit plan shall not be "deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B).

The lower court was correct in dismissing Count I of Appellant's complaint, which alleges that the Plan was not preempted by ERISA. The lower court ruled that the claim is pre-empted based on the language of Section 514(a), which has been construed by courts to preempt any state law that is "connected with" or "relates" to an ERISA covered plan. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2011). As stated in *FMC Corp*, these prongs can be satisfied "whether or not the state laws are designed to affect employee benefit plans." *Tolton v. Am. Biodyne,* 48 F.3d 937, 941-42 (6th Cir. 1995).

ii. Prong 1: Relatedness

As to the "relatedness" prong, the lower court correctly found that the claim sufficiently "related to" an ERISA plan, prompting pre-emption. As shown in *Tolton v. Am. Biodyne,* claims alleging a refusal to authorize a benefit, or alleging improper processing of claims for benefits, will be classified as "related" to the ERISA plan in question. *Tolton v. Am. Biodyne Inc.*, 48 F.3d 937, 942 (6th Cir. 1995). In this case, the lower court found that the routine replacement of the prescription medication with generic medication sufficiently related to prescription benefits, thereby prompting preemption.

Additionally, the lower court citing *Rutlege*, recognized that, "ERISA is . . . primarily concerned with pre-empting laws that require providers to structure benefit plans in particular

ways." *Rutledge v. Pharmaceutical Care Management Ass'n,* 592 U.S. 86-87 (2020). This necessitates pre-emption of the Tennessee laws, which would require a change in the way that the pharmaceutical benefits were managed. The administrative burden of requiring permissions for each drug substitution under the Plan, would substantially impact the distribution of benefits; thus infringing upon the plan.

iii. Prong 2: Connectedness

The lower court used the disposition of *Egelhoff* to define a state law as "connected to" an ERISA plan if it, "governs a central matter of plan administration or interferes with nationally uniform plan administration." *Egelhoff*, 532 U.S. at 142 (2011). While the lower court did not address this prong directly, it can be sufficiently satisfied in this case, as the Tennessee law would cause significant changes in how prescriptions are administered through the plan. Additionally, if granted, Appellant's claim would set a dangerous precedent in the sixth circuit on how pharmaceutical benefits are to be managed under ERISA.

iv. Healthcare Plan Sponsored by Cottage Press:

As stated in footnote 3 found on pages 5-6 of the lower court opinion, the Appellant argued that, "neither the Tennessee wrongful death law nor the recently enacted Tennessee pharmacy law concerning medications are intended to regulate insurance or have any effect on insurance plans." *Dashwood v. Willoughby Health Care Co.,* No. 25-CV-101, at * 5-6 (E.D. Tenn Dec. 20, 2025).

Therefore, Count I of Appellant's claim is preempted by their previous disposition in the case to not apply the savings clause to this section. However, if they choose to change their disposition, under ERISA, employer-paid plans to a third-party insurer will be pre-empted. 29

U.S.C. § 1144. The plan in question was sponsored by Cottage Press, and no indication was given that it was under a self-pay model.

B. Count I is pre-empted because Congress intended for ERISA to provide an exclusive regulatory scheme for ERISA-plan participants and beneficiaries asserting improper processing of a claim of benefits.

The lower court correctly ruled that Count I of Appellant's claim is pre-empted under ERISA because the Tennessee tort of wrongful death—as applied here—would contradict Congress' "clearly expressed [] intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987).

To determine whether federal law pre-empts state law, courts look to congressional intent. *FMC Corp.*, 498 at 56; *see also Pilot Life*, 481 U.S. at 45 (stating "The question whether a certain state action is pre-empted by federal law is one of congressional intent. The purpose of Congress is the ultimate touchstone." (internal punctuation omitted)). Pre-emption can be "express[ed] or implied, and is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983). The inquiry "begin[s] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *FMC Corp.*, 498 U.S. at 57.

To address the "growth in size, scope, and numbers of employee benefit plans . . . the operational scope and economic impact of such plans . . . [and] the continued well-being and security of millions of employees and their dependents [] directly affected by these plans," 29 U.S.C. § 1001(a), Congress enacted ERISA for the purpose of "provid[ing] a uniform regulatory

regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). Through ERISA, Congress "establish[ed] standards of conduct, responsibility[ies], and obligation[s] for fiduciaries of employee benefit plans" and provided "appropriate remedies, sanctions, and ready access to the Federal courts." *Id*.; 29 U.S.C. § 1001(b). Indeed, ERISA's civil enforcement scheme "is one of the *essential* tools for accomplishing the stated purposes of ERISA." *Pilot Life*, 481 U.S. at 52 (emphasis added).

Specifically, under ERISA § 502(a)(1)(B) "[a] civil action may be brought "by a participant or beneficiary (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). In short, "if a participant or beneficiary believe[s] that benefits promised to [them] under the terms of the plan are not provided" then they may "bring suit seeking [the] provision of those benefits." *Aetna Health*, 542 U.S. at 210. ERISA plan participants or beneficiaries "can also bring suit . . . to enforce [their] rights under the plan, or to clarify any of [their] rights to future benefits." *Id.*

But where "an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan . . . then the suit falls within the scope of ERISA." *Id.* at 210–11. ERISA's § 502(a) "represents a careful balancing," of Congress' policy choices, and "provid[es] strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." *Pilot Life Ins. Co*, 481 U.S. at 54. Accordingly, "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy" — including the claim at bar — "conflicts with the clear congressional intent to make [] ERISA remed[ies] exclusive and is therefore pre-empted." *Id*.

i. Count I is pre-empted because Congress provides exclusive remedies for beneficiaries of an ERISA healthcare plan to recover, enforce, and clarify rights under an ERISA healthcare plan.

The lower court was correct to rule that ERISA pre-empts Tennessee Code § 63-1-202 as applied to conduct involving the denial or administration of the Plan. *See Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995).

In *Tolton*, for example, the Sixth Circuit answered the same issue before it now: whether a plaintiff may avoid ERISA pre-emption by asserting a state-law wrongful-death claim based on conduct governed by an ERISA health plan. *Id*. at 943. This court answered no, explaining that "[o]ne consequence of ERISA preemption, therefore, is that [ERISA] plan beneficiaries or participants bringing certain types of state actions—such as wrongful death—may be left without a meaningful remedy." *Id*.

Despite the nature of the allegations, Appellant chose not to bring a civil action under ERISA's enforcement mechanisms. Appellant's choice, however, does not negate Congress' clear intent to provide an exclusive remedy through ERISA to recover rights under ERISA plan benefits. In this case, Appellant's wrongful death claim stems entirely from an alleged duty created by Tennessee law requiring Appellees to obtain authorization from specified parties before administering plan benefits pursuant to the governing plan documents. As in *Tolton*, to permit the Appellant to circumvent Congress' clear intent to provide an exclusive civil enforcement remedy to recover benefits under the Plan, would "completely undermine[]" ERISA. *Tolton*, 48 F.3d at 942.

Therefore, the lower court correctly applied Sixth Circuit precedent to rule Count I of Appellant's claim pre-empted.

ii. Count I is pre-empted because Appellant's prayer for relief derives entirely from rights and benefits established through an ERISA healthcare plan.

In *Aetna*, the Supreme Court considered whether individuals could sue an ERISA-plan provider "for alleged failures to exercise ordinary care in the handling of coverage decisions, in violation of a duty imposed by the Texas Health Care Liability Act" ("THCLA"). *Aetna Health*, 542 U.S. at 204. The respondents in *Aetna* alleged that they had "suffered injuries [] arising from Aetna's and CIGNA's decisions not to provide coverage for certain treatment and services recommended by respondents' treating physicians," violating the THCLA's "duty to exercise ordinary care when making health care treatment decisions." *Id*. at 205. The Court determined that despite the respondents attempts to classify the breach of duty as a state cause of action, it was "clear" that the complaint "only" originated through "denials of coverage promised under the terms of ERISA-regulated employee benefit plans." *Id.* at 211. As a result, any potential liability under the state-law claim derived entirely from the "particular rights and obligations established by the benefit plans." *Id*. at 213. Accordingly, the Court concluded, "[u]pon denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action or sought preliminary injunction." *Id.* What the respondents could not do, however, was seek a cause of action based on a state-law duty pre-empted by ERISA.

Applying the Court's precedent, the challenged conduct closely mirrors the denial-of-coverage claims the Supreme Court addressed in *Aetna*. The Plan, through Cottage Press, vested Willoughby Health Care with discretionary authority to decide claims for benefits and to delegate that authority with respect to prescription drug coverage, and Willoughby Health exercised that authority by delegating formulary administration and coverage determinations to Willoughby RX. First Am. Class Action Compl. ¶¶ 11, 13–14, *Dashwood v. Willoughby Health Care Co.*, No. 25-

CV-101 (E.D. Tenn. filed May 14, 2025). When the prescribed vancomycin was not covered and was replaced with Bactrim under the formulary applied by Willoughby RX and implemented through ABC Pharmacy, that action constituted a determination of what benefits the plan would provide. Id. ¶¶ 18–22. As the district court recognized, this substitution occurred pursuant to the plan's terms and policies governing prescription drug benefits. Mem. Op. & Order at 9–10, Dashwood v. Willoughby Health Care Co., No. 25-CV-101 (E.D. Tenn. Dec. 20, 2025). In substance, the alleged wrongful conduct arose entirely from the administration of plan benefits and the refusal to cover the treatment recommended by the treating physician, placing the claim squarely within the category of coverage denials that, under *Aetna*, "only" originate from the enforcement of rights and obligations created by an ERISA plan. As such, Tennessee Code § 20-5-106 is pre-empted and the lower court was correct in granting the motion to dismiss.

iii. ERISA's statutory scheme establishes duties, liabilities, and exemptions for plan fiduciaries.

The lower court was correct to rule that ERISA pre-empts the Tennessee wrongful death claim, because the claim arises from Tennessee's regulation of PBMs which is pre-empted by ERISA's "establish[ed] standards of conduct, responsibility[ies], and obligation[s] for fiduciaries of employee benefit plans" and its provisions provide "appropriate remedies, sanctions, and ready access to the Federal courts." *Aetna Health*, 542 U.S. at 208; 29 U.S.C. § 1001(b).

To determine whether federal law pre-empts state law, courts look to congressional intent. *See FMC Corp.*, 498 U.S. at 56. ERISA requires that a fiduciary discharge their duties "with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1). A fiduciary breaches that duty, *inter alia*, if he "cause[s] the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect—(A) sale or exchange,

or leasing, of any property between the plan and a party in interest," 29 U.S.C. § 1106(a)(1)(A), or if he (1) "deal[s] with the assets of the plan in his own interest or for his own account," or (2) "in his individual or in any other capacity act[s] in any transaction involving the plan on behalf of a party (or represent[s] a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries." 29 U.S.C. § 1106(b)(1)–(2). Similarly, through ERISA Congress established a comprehensive scheme of liability for breach of fiduciary duty. Specifically, under 29 U.S.C. § 1109, a fiduciary "who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter" is "personally liable" to make whole any losses to the plan resulting from such breach "and shall be subject to such other equitable or remedial relief as the court may deem appropriate . . ." And between § 1106 (establishing ERISA's fiduciary duties) and § 1109 (establishing liability for breach of ERISA fiduciary duties), is § 1108(b) which provides an exhaustive effort to determine whether a "contract or arrangement for services between a covered plan and a covered service" breaches a fiduciary duty.

Despite the terms of the Plan, Tennessee Code § 63-1-202 forbids pharmacies and PBMs from substituting drugs without express written authorization, and penalizes pharmacies and PBMs that do not obtain such authorization before switching medications. Count I alleges that the Tennessee PBM law establishes a state-law duty upon Appellees, the breach of which allegedly providing justification for the wrongful death cause of action. Put simply, Congress's comprehensive and carefully calibrated scheme demonstrates an intent to pre-empt state causes of actions like those at bar. The Tennessee law regulating the obligations of ERISA-plan fiduciaries duplicates and supplants the exhaustive regulatory scheme Congress intentionally implemented,

and the lower court was correct to determine that such a law—as applied—is pre-empted under ERISA. 29 U.S.C. § 1132(a)(1)(B).

iv. Although Appellee, ABC Pharmacy, is likely not a fiduciary under ERISA, ERISA's comprehensive civil enforcement scheme creates liability for nonfiduciaries who knowingly participate in a fiduciary breach, thereby pre-empting Count I.

Although Appellee, ABC Pharmacy, is likely not a fiduciary under ERISA, ERISA's comprehensive civil enforcement scheme creates liability for nonfiduciaries who knowingly participate in a fiduciary breach, thereby pre-empting Count I.

ERISA § 406(a) imposes a duty on fiduciaries who engage in prohibited transactions. *See* § 406(a)(1), 29 U.S.C. § 1106(a)(1) ("A *fiduciary* with respect to a plan shall not cause the plan to engage in a transaction, if he knows or should know that such transaction ..." (emphasis added)). However, ERISA § 502(a)(3) "itself imposes certain duties," and liability under this provision "does not depend on whether ERISA's substantive provisions impose a specific duty on the party being sued." *Harris Tr. & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 245 (2000).

ERISA § 502(a) provides, in part, that a civil action may be brought by a participant, beneficiary, or fiduciary "to enjoin any act or practice which violates any provision of [ERISA Title I] 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 title or the terms of the plan." 29 U.S.C. §1132(a)(3). The text authorizing "appropriate equitable relief" only "for the purpose of redressing any violations or . . . enforce[ing] any provisions' of ERISA or an ERISA plan." *Harris Trust*, 530 U.S. at 246. Yet, however, "§ 502(a)(3) admits no limit ([aside from the appropriate equitable relief caveat]) on the universe of possible defendants." *Id*. In contrast, ERISA's other provisions

"do expressly address who may be a defendant." *Id*.; *see*, *e.g.,* § 409(a), 29 U.S.C. § 1109(a) (stating that "[*a*]*ny person who is a fiduciary* with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable" (emphasis added)).

For instance, "§ 502(l) contemplates civil penalty actions by the Secretary against two classes of defendants, fiduciaries and other persons." *Id*. at 248. As the Court articulated in *Harris Trust*, the "implication is that the Secretary may bring a civil action under § 502(a)(5) against an other person who "knowingly participates in a fiduciary's violation; otherwise, there could be no applicable recovery amount from which to determine the amount of the civil penalty to be imposed on the other person." *Id*. (internal punctuation omitted). The Court further reasoned that "if the Secretary may bring suit against an 'other person' . . . it follows that a participant beneficiary . . . may bring suit against an 'other person' under the similarly worder subsection (a)(3)." *Id*. at 249.

Therefore, because ERISA's comprehensive remedial scheme permits Appellant to bring a cause of action under § 502(a) against ABC Pharmacy to determine whether it knowingly participated in a breach of fiduciary duty, any state-law duty that duplicates, supplements, or supplants ERSA's enforcement mechanism is pre-empted by ERISA..

v. Count I is pre-empted under 29 U.S.C. § 1132(a) because it seeks punitive damages against corporate entities related to the Plan's insurer and administrator based on an alleged mishandling of pharmacy benefits under the Plan.

ERISA § 409(a) establishes "[l]iability for Breach of Fiduciary Duty." This section provides that "[a]ny person who is a fiduciary" who "breaches any of the responsibilities, obligations, or duties" imposed by ERISA is "personally liable to make good to *such plan* any losses *to the plan*," and is subject to other "equitable or remedial relief as the court may deem

appropriate." 29 U.S.C. § 1109(a) (emphasis added). What is more, under ERISA § 502(a), a civil action may be brought by a beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. §1132(a).

Construing the plain language of these two statutes together, "the emphasis on the relationship between the fiduciary and the plan as an entity becomes apparent." *Massachusetts Mut. Life Ins. Co.*, 473 U.S. 134, 140 (1985). Notably, the "relevant" fiduciary relationship is defined relative to the plan, and "the potential personal liability of the fiduciary is to make good *to such plan* any losses *to the plan* . . . and to restore *to such plan* any profits of such fiduciary which have been made through use of assets *of the plan*." *Id.* (internal quotation makes omitted).

Here, what is critical is that the statute's silence is as instructive as its text. Namely, "the statutory provision explicitly authorizing a beneficiary to bring an action to enforce his rights under the plan—§ 502(a)(1)(B), . . . says nothing about the recovery of extracontractual damages, or about the possible consequences of delay in the plan administrators' processing of a disputed claim." *Id*. at 144. Thus, there is nothing in ERISA's text—implicit or explicit—that supports the conclusion that Congress intended ERISA to give "rise to a private right of action for compensatory or punitive relief." *Id.*

Appellant seeks $10,000,000 in damages for an alleged breach of fiduciary duty arising from their status as the Plan beneficiary. However, this relief supplement ERISA's statutory and remedial scheme. Even assuming *arguendo* that Count I were brought under an appropriate ERISA provision, and assuming *arguendo* that Appellees violated the terms of the Plan, the court still could not grant the damages Appellant seeks. Under this hypothetical, the most Appellant could recover would be benefits sufficient to make Appellant whole under the governing plan. *See*

Massachusetts Mut. Life Ins. Co., 473 U.S. at 140. Furthermore, ERISA's catchall clause (granting courts the authority to provide "equitable or remedial relief as the court may deem appropriate") reflects Congress's intent to permit relief traditionally available in equity to redress plan-related injuries; it does not, however, authorize punitive damages like those sought in Count I.

Therefore, the lower court was correct to rule that Count I is pre-empted under 29 U.S.C. § 1132(a) because it seeks extra-contractual and punitive relief against corporate entities related to the Plan's insurer and administrator based on an alleged mishandling of pharmacy benefits under the Plan.

II. Appellant has not plausibly alleged that the actions of Willoughby Health Care and Willoughby RX caused a remediable loss or harm under ERISA Section 502(a)(3)

The lower court was correct in dismissing Count II of Appellant's complaint, claiming that the use of the formulary policy by Willoughby Health Care and Willoughby RX to substitute Bactrim for vancomycin was disloyal towards the Plan's fiduciaries. This count fails to state a claim because Appellant has not plausibly alleged that Willoughby Health Care and Willoughby RX engaged in actions constituting a remediable loss or harm under ERISA Section 502(a)(3). Section 502(a)(3) allows plan beneficiaries or participants to sue "to enjoin any act or practice which violates [ERISA] or the terms of the plan, or (. . .) to obtain other appropriate equitable relief." 29 U.S.C. § 1132(a)(3). The Supreme Court has held that the phrase "appropriate equitable relief" allows an individual to seek relief for a breach of fiduciary duty. *Variety Corp. v. Howe*, 516 U.S. 489, 507 (1996). For relief to count as "appropriate equitable relief," both the basis of the claim and the nature of the remedy sought must be equitable. *Sereboff v. Mid. Atl. Med. Servs.*, 547 U.S. 356, 363 (2006).

All parties agree that the basis of Appellant's claim falls under the category of "appropriate equitable relief' because, at common law, courts of equity traditionally had exclusive jurisdiction over breach of fiduciary duties actions brought by beneficiaries. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993). However, the remedy requested by Appellant (surcharging Willoughby Health Care and Willoughby RX for the direct financial harm that Appellant and class members suffered due to the alleged fiduciary breaches) is not appropriate equitable relief. Specifically, under the pretense of a "surcharge", Appellant seeks Marianne's lost lifetime earnings as a remedy. In the alternative, Appellant seeks disgorgement of the amount of money Willoughby Health Care and Willoughby RX allegedly made by substituting Bactrim for vancomycin (a remedy that is also described as a "surchage"). Neither remedy falls under the category of appropriate equitable relief, meaning that Appellant has not made a valid claim under Section 502(a)(3) and the lower court was correct in granting the motion to dismiss.

B. The Request for Marianne's Lost Lifetime Earnings Under the Pretense of a "Surcharge" Does Not Count as a Remedy Typically Available at Equity Because it is Effectively a Request for Damages

In order for a requested remedy to qualify as "appropriate equitable relief," it must not simply be a remedy that courts of equity could have theoretically applied in the days of the divided bench. *Mertens*, 508 U.S. at 256-57. Such a reading would render the language in Section 502(a)(3) superfluous, as one could theoretically seek all remedies for breach of trust from a court of equity. *Id.* at 257. Instead, the remedy must be one that was "typically available in equity." *Aldridge v. Regions Bank*, 144 F.4th 828, 846 (6th Cir. 2025), citing *Mertens*, 508 U.S. at 256. One type of remedy that does not count as having been typically available in equity is "monetary relief for all losses [the participants'] plan sustained as a result of the alleged breach of fiduciary duties."

Mertens, 508 U.S. at 255-59. Another type of remedy that does not count as a remedy "typically available in equity" in certain circuits (including the Sixth Circuit) are surcharges acting as monetary compensation "for a loss resulting from a trustee's breach of duty[.]" *Aldridge*, 144 F.4th at 847, quoting *Mertens*, 536 U.S. at 256.

Aldridge v. Regions Bank serves as one example of surcharges not being considered a valid form of equitable relief under Section 502(a)(3). Here, a group of Ruby Tuesday employees alleged that Regions Bank, which was responsible for helping Ruby Tuesday satisfy its obligations under their pension and retirement plans, had breached its fiduciary duties in a variety of ways, including not informing participants of their right to a payout and failing to pay certain benefits. *Aldridge*, 144 F.4th 835-36. There, the requested remedies included an "equitable surcharge," which was a "surcharge measured by 'the amounts that should have been paid to [Appellant] as benefits under the [p]lans." *Id.* at 847. The Sixth Circuit Court of Appeals ruled that, despite the Appellant using the term "surcharges" instead of "damages," and referring to the surcharges as "equitable," they did not fall within the category of remedies typically available in equity because the term "surcharge" essentially refers to the same concept as "damages," namely the notion of monetary relief granted to a plaintiff as a result of of losses caused by the defendant. *Id.* at 847-848. As stated previously, this remedy is prohibited by the Supreme Court per *Mertens*, a ruling that cannot be avoided by simply utilizing the term "surcharge" instead of "damages". *Mertens*, 508 U.S. at 255-59; *Aldridge*, 144 F.4th at 847-848.

Here, Appellant is essentially doing the same thing the *Aldridge* plaintiffs attempted and failed to do: disguising a request for damages as a request for equitable relief by using the term "surcharge." While the circumstances surrounding the alleged losses are different between the two cases (as Appellant in this case seeks lost lifetime earnings as a result of Marianne's death), the

request for surcharges in the current case is still comparable to the failed request for surcharges in *Aldridge* because it is a request for monetary relief as measured by Appellant's losses allegedly caused by Willoughby Health Care and Willoughby RX. Therefore, *Aldridge* controls here, requiring the court to view the request for surcharges as a damages remedy that does not count as relief typically available at equity. This means that Section 502(a)(3) does not provide for the type of remedy requested by Appellant's complaint. Ergo, Appellant has failed to state a claim and the lower court was correct in granting the motion to dismiss.

C. Appellant's Request for Disgorgement of the Amount Profited from Substituting Bactrim of Vanncomycin Does Not Count as a Remedy Typically Available at Equity Because They Have Not Identified a Specific Fund

Additionally, Appellant's demand for disgorgement of the amounts by which Willoughby Health Care and Willoughby RX allegedly profited from substituting Bactrim for Vancomycin constitutes a request for restitution of ill-gotten gains. *Patterson v. United Healthcare Ins. Co.*, 76 F.4th 487, 497 (6th Cir. 2023). This is problematic for Appellant because seeking money via restitution is not inherently an equitable remedy. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 213 (2002). In order for restitution of ill-gotten gains to be considered an equitable remedy, the money or property in question must be traceable to a particular fund. *Knudson*, 534 U.S. at 213. If the plaintiff is seeking "money judgment collectable from any of the beneficiaries' *general* assets," then the request for restitution of ill-gotten gains does not count as an equitable remedy. *Aldridge*, 144 F.4th at 846. Additionally, the "burden of establishing that the funds they seek are traceable and readily identifiable" is on the plaintiff. *Alexander v. Bosch Auto Sys.*, 232 Fed. App'x. 491, 501 (6th Cir. 2007).

Seeking a specific fund involves more than describing a method of measurement for what the plaintiff thinks they are owed. For example, in *Central States, Southeast and Southwest Areas Health and Welfare Fund v. First Agency, Inc.*, the court ruled that an award of $112,000 as repayment for medical bills did not count as seeking specific funds even though the plaintiff identified the amount of money that they believed was owed and the award was equal to the bills. *Central States, Southeast and Southwest Areas Health and Welfare Fund v. First Agency, Inc.*, 756 F.3d 954, 960-61 (6th Cir. 2014). Without a specific, identifiable fund from which the money was coming, the award is outside the realm of equitable relief.

Here, Appellant has failed to meet its burden of showing that the funds they seek are specific enough for their demand for restitution of alleged ill-gotten gains to be considered an equitable remedy. This is because, like the plaintiff in *Central States*, Appellant has merely identified the amount of money they are seeking (i.e. the amount Willoughby Health Care and Willoughby RX allegedly profited from switching the drugs) without identifying the specific fund the money would come out of. Indeed, Appellant's complaint fails to allege that the supposed ill-gotten gains are still in Appellees' possession. This means that Appellant is in an even weaker position than the plaintiff in *Central States*, as that plaintiff had at least identified specific bills. Therefore, if the plaintiff in *Central States* was held not to have identified a specific fund, then Appellant in this matter has also failed to do so. This means that their request for restitution of ill-gotten gains does not count as "appropriate equitable relief" under Section 502(a)(3). Since neither form of relief sought by Appellant is available under ERISA, the complaint fails to state a claim and the lower court correctly granted the motion to dismiss.

Conclusion

Appellees respectfully ask the Court to uphold the trial court's granting of the motion to dismiss, as Appellant has failed to state a claim. Count I of Appellant's complaint is preempted by ERISA, as the Tennessee wrongful death statute would supplant ERISA's enforcement mechanisms and the decision to switch Marianne's prescription medication was fully compliant with the Plan. Additionally, two of the requested remedies for Count II are not available under ERISA Section 502(a)(3) because they were not typically available in equity. For all the foregoing reasons, Appellant has failed to state a claim and the trial court was correct in granting the motion to dismiss.

Certificate of Compliance

Team 12 certifies that on January 23, 2025, a copy of the Appellees' brief was served on counsel for Appellant through the competition-approved method of service, in accordance with the Rules of the Competition and Federal Rule of Appellate Procedure 25(d). See Fed. R. App. P. 25(d).

Respectfully submitted,

/s/ Team 12