IN THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 25-CV-101

Elinor Dashwood, Individually and on Behalf of the Estate of Marianne Dashwood and a Class or Others Similarly Situated,

Appellant,

v.

Willoughby Health Care Co., Willoughby RX, and ABC Pharmacy, Inc.,

Appellee.

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

Brief for Appellee

Team No. 14
Counsel for Appellee

CORPORATE DISCLOSURE

Appellees hereby certify to the best of their knowledge; no aspect of their current personal or professional circumstances place them in the position of having a conflict of interest with this presentation.

The foregoing statements are true without exception.

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

Appellees believes oral argument is appropriate due to the complex nature of the issues on appeal.

STATEMENT OF JURISDICTION

The District Court had jurisdiction over this action pursuant to 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331. The District Court had jurisdiction as this is a federal question under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

The Sixth Circuit Court of Appeals has appellate jurisdiction now that the District Court entered final judgment. 28 U.S.C. § 1291. Appellant Elinor Dashwood has a filed a timely appeal in response to the final decision of the District Court's order.

STATEMENT OF ISSUES

1. Under ERISA's preemption clause, did the District Court correctly grant a motion to dismiss when ERISA preempts the Tennessee law for a wrongful death claim?
2. Under ERISA § 502(a)(3), did the District Court correctly grant a motion to dismiss when a complaint seeks declaratory judgment and monetary damages as equitable relief?

STATEMENT OF THE CASE

I. Background

Marianne Dashwood was on a work-sponsored healthcare insurance plan that was governed by ERISA at the time of her death. The plan was fully insured by the parent company and Defendant, Willoughby Health, which was granted full discretionary authority to decide claims for benefits under the plan. It also administered those benefits. For medication, Willoughby Health used a subsidiary, Willoughby RX, a pharmacy benefit manager, which had developed a formulary articulating preferred medications. Routinely, Willoughby RX would replace prescribed medications with those on the formulary. ABC Pharmacy was acquired by Willoughby Health and operated under Willoughby RX

Marianne Dashwood sustained a leg infection after cutting herself while out on a hike with her son. The infection led to her hospitalization where she was given an antibiotic for five days and subsequently a five-day prescription for the same antibiotic. When her sister went to ABC Pharmacy to pick up the prescription, she was given a different medication. Upon expressing her confusion, she was offered the explanation that Marianne's insurer had swapped prescriptions and that the new one was merely the generic form of the original prescription. After just over a day of taking the prescription, Marianne suffered an allergic reaction and died on the way to the hospital.

The medication she was given was not the generic form of the original prescription and Marrianne had a documented allergy to the new one. None of the Defendants contacted Marianne or her doctor before performing the swap.

II. Procedural History

On May 14th, 2025, Appellant submitted a first amended class action complaint to the United States District Court for the Eastern District of Tennessee against Appellees, Willoughby health Care Co., Willoughby RX, and ABC Pharmacy, Inc. Complaint R. 1. Appellant brought two claims against Appellees: (1) wrongful death under Tennessee Code and (2) fiduciary and co-fiduciary breaches of the duties of loyalty and prudence. Complaint R. 8–10.

Appellees filed a motion to dismiss ("Defendant's Motion to Dismiss Plaintiff's Amended Complaint for Failure to State a Claim") and the District Court granted the motion to dismiss with prejudice. Complaint R. 1, 15. The District Court determined that (1) ERISA preempts Plaintiff's wrongful death claim and (2) Plaintiff failed to plausibly allege that Defendants' actions have caused a loss or harm under ERISA. Order R. 6–15. Appellant appealed to this Court for review of the two claims discussed in the motion to dismiss order from the District Court.

SUMMARY OF THE ARGUMENT

The District Court correctly granted the Defendants' motion to dismiss Appellant's complaint. Under the first claim, Appellant alleges that ERISA does not preempt the Tennessee law as a predicate for a wrongful death claim. ERISA contains a preemption clause that allows for ERISA's law to prevail instead of a state law. ERISA may preempt a state law if it references or is connected to an ERISA plan. The Tennessee law is connected to an ERISA plan because it deals with the administration of medication.

Additionally, the Tennessee law is preempted by ERISA because it is within the scope of matters that ERISA covers. Congress intended for a wide range of topics to be covered under ERISA to provide uniformity and structure in plan administration. Applying Tennessee law to this case would disrupt Congress' objectives for creating ERISA's preemption clause.

Under the second claim, Appellant alleges that ERISA § 502(a)(3) provides declaratory relief, equitable relief surcharge, and disgorgement relief. Declaratory relief is not available under this subsection of ERISA because it is made available under a previous section of the statute. Equitable relief surcharge is unavailable under this statute because it allows only for relief that was typically available in courts of equity. This was established by the Supreme Court and reinforced by this Court within the last year. Finally, the disgorgement relief is unavailable under 502(a)(3) because the complaint does not seek specifically identifiable funds,

proving that the claim is plaintiff-facing, and merely a guise for monetary compensatory damages.

ARGUMENT

This Court should affirm the District Court's holding that (1) ERISA preempts the wrongful death claim and (2) Dashwood has failed to plausibly allege that Appellee's actions have caused a loss or other harm that is remediable under ERISA § 502(a)(3). To survive a motion to dismiss, must provide "more than labels and conclusions, and formulaic recitation of the elements of a cause of action." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). Conclusions may be legal conclusions to support a framework, but they must be supported with factual allegations. *Ashcroft v. Iqbal*, 556 U.S. 662, 679 (2009).

Appellant has failed to do so. This Court reviews a motion to dismiss de novo. *Sensations, Inc. v. City of Grand Rapids*, 526 F.3d 291, 295 (6th Cir. 2008).

I. The District Court correctly determined that ERISA preempts Dashwood's wrongful death claim.

ERISA contains a preemption clause that explicitly states that they will supersede any and all state laws that relate to any employment benefit plan. ERISA § 514(a), 29 U.S.C. § 1144(a). ERISA "establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

The Supreme Court interpreted the phrase "relates to" to mean a law will reference or connect to an ERISA plan. *Shaw v. Delta Air Lines*, 463 U.S. 85, 96–97 (1983). Congress intentionally used this phrase to capture ERISA's broad application of this clause. *Id.* at 98.

As discussed below, the lower court correctly applied ERISA's preemption clause for two reasons. First, ERISA's preemption clause applies to the Tennessee law because it relates to a plan. Second, Congress intended for wrongful death claims to relate to an ERISA plan and, as such, the Tennessee law is included within the scope of ERISA's preemption clause. This brief will not discuss any of the exceptions under ERISA as the lower court determined none of the exceptions apply. Order R. 7 (discussing in the footnote how exceptions do not apply.).

A. Appellant fails to allege that the Tennessee law does not relates to an ERISA plan under their wrongful death claim.

Tennessee's law as a basis for a wrongful death claim directly connects to ERISA. The Supreme Court reviews ERISA's objectives to determine if a state law has a connection to ERISA. *Rutledge v. Pharm Care Mgmt. Ass'n*, 592 U.S. 80, 86 (2020); *see also Aldridge v. Regions Bank*, 144 F.4th 828, 839 (6th Cir. 2025) (discussing the objectives and the nature of a state law's effect on a covered plan.); *see also Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997) ("Where a State's law acts immediately and exclusively

upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . . that 'reference' will result in preemption."). The state law is connected to ERISA if it ""governs . . . a central matter of plan administration" or "interferes with nationally uniform plan administration." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001). In *Egelhoff*, the Supreme Court held that the preemption clause applied to a state law that automatically revoked a spouse of beneficiary designation upon divorce. *Id.* at 143. It concluded that the functions under state law such as the state governs who may be the beneficiaries. *Id.* at 147. Additionally, the Supreme Court determined that the state law contained a central matter of plan administration because the statute "governs the payment of benefits, a central matter of plan administration." *Id.* at 148.

A state law may also be preempted through a connection if it has an "acute, albeit indirect economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016). But the connection prong is not limited to those subject matters explicitly and directly covered by ERISA. *FMC Corp*, 498 U.S. at 58–59.

In *Gobeille*, the Supreme Court held that Vermont's law is pre-empted because of the connection related to ERISA regarding the reporting, disclosure, and recordkeeping like the requirements in Vermont's law. *Gobeille*, 577 U.S. at 323. The Supreme Court noted that "Pre-emption is necessary to prevent the States

from imposing novel, inconsistent, and burdensome reporting requirements on plans." *Id.* The Supreme Court explained that reporting, disclosing, and recordkeeping are central parts of plan administration. *Id.* Thus, hinting that these various topics are within ERISA's scope and Vermont law did not apply. *Id.*

In *Rutledge*, an Arkansas state law was not preempted because it did not have a connection with an ERISA plan since the issue was in regard to cost uniformity for the medication. *Rutledge*, 592 U.S. at 88. Since the issue did not directly deal with the substantive coverage under ERISA, the cost regulation was not a consideration for preemption. *Id.*

But, the Sixth Circuit has applied the preemption clause to wrongful death claims that directly arose from the benefit plan's coverage. *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995). Specifically, the preemption clause applied because the claims related to the benefit plan. *Id.* Here, the Appellant alleged, under state laws, a wrongful death claim and improper refusal to authorize benefits. *Id.* These claims all arose directly from refusal to authorize medical benefits to Tolton. *Id.* This Court held that taking these facts together can infer there is a connection to an ERISA plan. *Id.* In addition, they emphasized that other circuits have found the ERISA preempted wrongful death claims. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324 (5th Cir. 1992); *Kuhl v. Lincoln*

National Health Plan, 999 F.2d 298, 302–03 (8th Cir. 1993); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993).

The Tennessee law is no different. Appellant fails to allege that there was no connection with an ERISA plan. Complaint, R. 8. Here, Appellant only state that a duty was owed "to dispense medications as prescribed and to refrain from substituting other medications unless authorized by a treating physician to do so." Complaint. R. 8. They fail to establish how the Tennessee law does not connect to an ERISA plan. *Id.* Instead, the Tennessee law does connect because the content of the law is within the scope of ERISA, and it governs a central matter of plan administration.

The District Court reiterated that Willoughby Health has the authority to develop a formulary of covered drugs and its policies and then apply the policies to decide the drug claims. Order R. 10. Dashwood was a participant in the Cottage Press Healthcare Plan (the "Plan"), which is an ERISA-governed benefit from her employer, Cottage Press. Complaint R. 2. Under the summary plan description ("SPD"), the Plan "promises to pay the cost of medically necessary prescription drug medications, subject to a $10 co-pay for all medications filled at ABC Pharmacies." *Id.* at 3. And a medication is routinely switched "unless a plan participant, beneficiary or prescribing doctor expressly objects," under the Plan.

Order R. 3. Furthermore, under the Plan, refusals are permissible and usually within the scope of an ERISA plan.

These facts are similar to *Egelhoff*. Like *Egelhoff,* the statute did not reference an ERISA plan but, rather, what the effect would be on a plan. Here, the Tennessee law, forbids pharmacies and pharmacy benefit managers ("PBMs") from substituting drugs without the express written authorization of the patient's treating physician, and penalizes pharmacies and PBMs that do not obtain such authorization before switching medications." Tennessee Code § 63-1-201. Abiding by these guidelines would impact the plan and its ability to pay for the necessary medication.

The Tennessee law forces ERISA to adopt a plan that would alter the scheme of substantive coverage. Like *Gobeille*, the Tennessee law requires a disclosure of the medication it was proscribed to the patient. Complaint R. 1–2. Specifically, the Tennessee law requires a physician's authorization for substituting medication. *Id*. Following Tennessee law would impose a burden on the current plan because it would require waiting for additional authorization when a person may need quick access to the medication. Moreover, "Willoughby Health . . . administers benefits under the Plan, and is expressly granted full discretionary authority to decide claims for benefits." *Id.* at 3. Willoughby health routinely changing medications is a central part of plan administration in determining what

medications to administer. *Id.* And the fact that the Tennessee law is a basis for a wrongful death claim does not prevent the preemption clause to apply. *Id.* at 2. It is similar to *Tolton*, the basis for the wrongful death claim arose from a refusal of benefits such as the rejection of vancomycin. *Id.* at 8. Taken these facts all together demonstrates a connection to an ERISA plan, and, therefore, the Tennessee law is preempted under ERISA's preemption clause.

B. Appellant did not sufficiently allege that Tennessee law to the wrongful death claim would not undermine Congress' intent for enacting ERISA.

The lower court correctly determined Congress' scope in applying ERISA. Some of the concerns of ERISA's preemption clause navigates are (1) preempting laws to ensure structured benefit plans and (2) limiting binding plan administrators to specific State laws. *Rutledge*, 592 U.S. at 86–87; *see generally Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *see also Egelhoff,* 532 U.S. at 148 (discussing the principal goal of ERISA is to provide uniformity.).

Applying the Tennessee law as a basis for the wrongful death claim will disrupt ERISA's preemption clause structure. Congress intended to create a structure and uniformity under ERISA's preemption clause. *Shaw*, 463 U.S. at 86–87; *See also Egelhoff*, 532 U.S. at 148 ("Uniformity is impossible, however, if plans are subject to legal obligations in different States."). One of the key concerns

is that imposing a requirement for ERISA to master 50 States' relevant laws would undermine Congress' goal to minimize the administrative and financial burden. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). It was important to expand the preemption clause to eliminate the threat of conflicting or inconsistent regulations. 120 Cong. Rec. 29197, 29933 (1974). In *Ingersoll-Rand*, the Supreme Court emphasized that if Congress intended "ERISA's pre-emptive effect to state laws purporting to regulate plan terms and conditions, it surely would not have done so by placing the restriction in an adjunct definition section while using the broad phrase "relate to" in the pre-emption itself." *Ingersoll-Rand Co.*, 498 U.S. at 142. Demonstrating Congress' purposeful omission of specific limiting language. *Id.*

Congress likely intended for wrongful death claims to be included within the scope of ERISA's preemption clause. Congress did not intend to limit the scope of the preemption clause to subject matters covered by ERISA, and the House and Senate both rejected the language that would limit the provision's power. *FMC Corp.*, 498 U.S. at 58–59.

In the creation of ERISA, first, the bill contained a limited preemption clause that could only be applied to state law relating to the specific subject covered in ERISA. *Shaw*, 463 U.S. at 98. Allowing the broad structure of the ERISA's preemption clause fulfills Congress' intent for a clear structure. *Id.* In

Shaw v. Delta Air Lines, New York's Human Rights Law was preempted because the law preventing discrimination was with the structure and parameters of the preemption clause. *Id.* at 100.

This Court should not permit the Tennessee law to prevail because it would disrupt ERISA's preemption clause structure. Applying Tennessee law would disrupt Congress' goal to minimize burdens. Like *Ingersoll-Rand*, where Congress discussed that if ERISA wanted specific limitations, it would include it, ERISA does allow for a "denial of a claim for pharmaceutical benefits." Order R. 9. Here, there is an administrative burden because it requires the Plan to be up to date with other regulations within the state in determining how to administer medications. *Id.*

Furthermore, the Tennessee law would set an example that other state laws may prevail instead of the preemption clause. Similar to *FMC Corp* where the state law would create issues for determining which set of regulations to follow, the Tennessee law would be no different. It is unclear whether other states have adopted a law like Tennessee. Since under the ERISA plan, the plan allows for denial of benefits, and the preemption clause also allows for a wide range of topics, it is important to follow the standards under ERISA. The District Court noted that "Count I does not fit neatly into the category of wrongful death cases that courts have found preempted," but because Congress did not establish a limitation as to the subject, the preemption clause applies to the Tennessee law. *Id.* at 11. As

established by Congress, wrongful death claims including the Tennessee law as a basis for such is covered under the preemption clause. Taken these together does not demonstrate that Appellant sufficiently allege to survive a motion to dismiss. Therefore, ERISA's preemption clause preempts Tennessee's law for wrongful death.

II. The District Court has correctly determined that Appellant has failed to plausibly allege that Defendants' actions have caused a loss or other harm that is remediable under ERISA Section 502(a)(3).

ERISA § 502(a)(3) allows a civil action to be brought, "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title 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.[1] Because Appellant does not seek injunction of any kind, they turn to section (B) of this clause, seeking "appropriate equitable relief" in the form of three remedies: (1) declaratory judgment that the actions and omissions described in the complaint violated ERISA, (2) an equitable relief surcharge for the financial harm suffered by Appellant and Class members as a result of the breach of duty, and (3) disgorgement of all profits from the breach of duty. Complaint R. 10. None of these three forms of relief are appropriate under

[1] We will refer to the statute by its section within ERISA but cite it with reference to the United States Code.

Section (B) of the statute and, therefore, no claim has been alleged *upon which relief can be granted*. Therefore, the complaint was properly dismissed by the lower court.

A. The declaratory judgment relief does not survive 12(b)(6) because it is remediable through other ERISA provisions.

The declaratory judgment claim is not "appropriate" under 502(a)(3) because Congress has provided other means for that remedy. This court held in *Tackett v. M&G Polymers, USA, LLC,* that "[b]ecause § 502(a)(1)(B) fully provides a means for the relief sought by the Retiree Plaintiffs, further equitable relief pursuant to § 502(a)(3) is unavailable." 561 F.3d 478, 492 (6th Cir. 2009). That section of ERISA states that a civil action may be brought "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).

The Declaratory Judgment Act allows courts to "declare rights and other legal relations of any interested party." Though this kind of relief is certainly more equitable than legal, it fits neatly within 502(a)(1)(B) as a clarification of rights. Further, the Supreme Court has long held that 502(a)(3) is a "catchall" provision or a safety net provision. *Varity Corp. v. Howe*, 516 U.S. 489 (1996). It plays the role of offering appropriate equitable relief for injuries caused by violations such as

breaches of fiduciary duty that 502 does not remedy adequately with another provision. *Id*. This reasoning conforms with the Sixth Circuit's in *Tackett*.

The declaratory judgment claim in this case seems to fit the equitable relief standard set forth in 502(a)(3) because it is relief that would typically be awarded by a court of equity: the Complaint seeks, "[a] declaratory judgment that the action and omissions described herein violate ERISA." Complaint R. 10. However, because 502(a)(1)(B) provides an avenue for the declaratory relief, *Tackett* and Supreme Court precedent preclude the use of 502(a)(3) for this claim.

B. The equitable relief surcharge does not survive 12(b)(6) because it is foreclosed by this Court's holding in *Aldridge v. Regions Bank.*

The equitable relief surcharge is not a remedy provided for by ERISA, as recently clarified by this court in *Aldridge,* 144 F.4th at 828. *Aldridge's* reasoning relies heavily on Supreme Court precedent, which established that equitable relief is distinguishable from legal relief and does not include monetary damages such as those sought here. *Id*. at 844-45. In *Mertens v. Hewitt Assocs*., the Supreme Court first articulated that "equitable" in 502(a)(3) is a meaningful qualifier that restricts the type of relief available under the statute. 508 U.S. 248, 255 (1993). The Court noted that equitable relief is a concept rooted the days of the divided bench, court of law and court of equity. *Id*. at 256–57. Equitable relief represented that relief that was typically available in a court of equity (such as injunctions), while legal

relief represented relief that was available in a court of law (such as monetary damages). *Id*.

The Court acknowledges there are exceptions to this divide, most notably in breach of trust cases where courts of equity could award any and all relief. *Id.* However, taking a textualist approach to ERISA, the Court holds that extending the breach of trust interpretation of equitable relief is incompatible with the statute at bar for two reasons. *Id.* at 257–58. First, a broad interpretation (including any and all relief) would render, "equitable" as it is used in 502(a)(3) "superfluous" as a modifier. *Id*. at 258. Second, elsewhere in ERISA, Congress distinguished between legal and equitable relief. 29 USCS § 1132(g)(2)(e). Consistency demands that "equitable" be interpreted the same way within the same statute. *Mertens,* 508 U.S. at 248, 260. Thus, equitable relief in the context of ERISA must be interpreted narrowly to include only that which was typically available in a court of equity. Specifically, this interpretation excludes monetary damages.

Some Circuits have read the Supreme Court's 2011 ruling, *CIGNA Corp. v. Amara,* to effectively overrule *Mertens* and allow for monetary damages as equitable relief. 563 U.S. 421 (2011); *see also Trs. of the N.Y. State Nurses Ass'n Pension Plan v. White Oak Glob. Advisors, LLC*, 102 F.4th 572, 604 (2nd Cir. 2024); *Gearlds v. Entergy Servs.*, 709 F.3d 448, 450 (5th Cir. 2013); *Moyle v. Liberty Mut. Ret. Benefit Plan*, 823 F.3d 948, 960 (9th Cir. 2016); *Raniero Gimeno*

v. NCHMD, Inc., 38 F.4th 910, 914 (11th Cir. 2022). This interpretation improperly reads *Amara.* While *Amara* recognized "monetary 'compensation' for a loss resulting from a trustee's breach of duty, or to prevent the trustee's unjust enrichment" and extended that surcharge remedy "to a breach of trust committed by a fiduciary," it did not do so in all contexts. *Id.* at 422–23. *Amara* stated that "insofar as an award of make-whole relief is concerned" monetary damages fall within the scope of "appropriate equitable relief" under 502(a)(3). In that case an employer in charge of a benefits plan changed the benefits leaving the employees with a smaller package and thus compensatory damages were appropriate under 502(a)(3). *Id.* at 442.

But even if this court chooses to read *Amara* like the other courts do, these Circuits also ignore the fact the Supreme Court stated five years later in *Montanile v. Bd. of Trs. of the Nat'l Elevator Indus. Health Ben. Plan* that any commentary in *Amara* regarding 502(a)(3) was dicta. 577 U.S. 136 n.3 (2016). In that same footnote, the Court pointed to *US Airways, Inc. v. McCutchen* where it reinforced the narrower interpretation of equitable relief from *Mertens.*[2] *Id*.; *see generally US Airways, Inc. v. McCutchen*, 569 U.S. 88 (2013). The Fourth Circuit and the Sixth Circuit (since *Aldridge*) properly read *Amara* and do not give undue deference to

[2] This interpretation is also articulated in *Great-West Life & Annuity Ins. Co. v. Knudson* 534 U.S. 204 (2002) and *Sereboff* v. *Mid Atlantic Medical Services, Inc.*, 547 U. S. 356 (2006).

its dicta. These two circuits have sustained the narrow interpretation of equitable remedies established and upheld by the Supreme Court and they are thus bound to continue doing so.

The Federal Rules of Appellate Procedure along with the 6th Circuit Rules require an en banc review for *Aldridge* to be re-considered, so even if this panel desired, it would not be able to call into question holdings on its own. 6 Cir. R. 32.1(b). Of course, even if it were to do so, it would be bound by the Supreme Court's precedent in *Amara* and *McCutchen* that monetary damages are not appropriate under ERISA's equitable remedy clause.

The facts here are similar to *Aldridge.* Appellant seeks "[e]quitable relief surcharging Willoughby Health Care and Willoughby RX for the direct financial harm suffered by Appellant and Class members as a result of their fiduciary breaches" under 502(a)(3). Complaint R. 10. Although *Aldridge* is not a class action, the remedy available under 502(a)(3) is indiscriminate—all plaintiffs are entitled only to "appropriate equitable relief." A surcharge in this case is analogous to that *Aldridge* where this court held that such a surcharge is not an available remedy under ERISA. Thus, this remedy does not survive 12(b)(6). See Fed. R. Civ. P. 12(b)(6).

Even if this court decides that *Amara*'s dicta is binding, in the complaint Appellant did not allege the harm to the class that *Amara* requires to justify

monetary damages under "equitable relief." Under Rule 23 of the Federal Rules of Appellate Procedure, class certification is appropriate if the claims and allegations satisfy numerosity, commonality, typicality, and adequacy. Commonality requires that "there [be] questions of law or fact common to the class." Fed. R. Civ. P. 23(a)(2). In the complaint, Appellant reference a "common course of conduct" among Defendants as well as a "common nucleus of operative facts and concerns." Complaint R. 6. In fact, the complaint fails to allege any common nucleus of operative fact—it merely states that the Defendants have developed a formulary of preferred drugs and "routinely switches prescribed medications to what it considers similar preferred drugs on its formulary." *Id*. at 3, 5. It does not allege that any other members of the Class have been negatively affected by this policy.[3]

Therefore, under *Amara*, the equitable relief sought for here cannot include monetary compensation, because the members of the Class have not been harmed. This case also differs from *Amara* because the fiduciary breach did not involve taking money from a benefit plan or decreasing a benefits package. In fact, Appellant concedes that the formulary designed by Willoughby RX was aimed at distributing "preferred drugs" Complaint R. 3. Based on what is included in Appellant's Complaint, Class members could just as likely be better off with the

[3] Additionally, Appellant offers no justification that the numerosity requirement is fulfilled other than that there are over 800 participants of the plan and a statement saying, "the class is likely to exceed 100 people." Complaint R. 6.

formulary policy as they could be worse off. Delivering a monetary remedy in this case would *not* be equitable.

C. The disgorgement relief does not survive 12(b)(6) because it does not meet the requirements for a monetary restitution remedy under ERISA § 502(a)(3)

The disgorgement remedy is a restitution claim that is also forbidden under ERISA, although the reasons are not as obvious. Disgorgement remedies fall under the category of restitution remedies, and it is agreed by this and the Supreme Court that restitution remedies, even when monetary, can still fall under the traditional equitable relief umbrella along with things like injunctions. *Mertens,* 508 U.S. 248, 255; *Helfrich v. Pnc Bank*, Ky. 267 F.3d 477, 481 (6th Cir. 2001); *CIGNA Corp.*, 563 U.S.at 421; *Aldridge*, 144 F.4th at 846. In *Helfrich*, this court adopted the 8th Circuit's differentiation between restitutionary and compensatory money damages, holding that the main difference was, "the genesis of the award sought by the plaintiff." 267 F.3d 477, 481 (quoting *Kerr v. Charles F. Vatterott & Co.*, 184 F.3d 938, 944 (8th Cir. 1999)). Explained further: "A restitutionary award focuses on the defendant's wrongfully obtained gain while a compensatory award focuses on the plaintiff's loss at the defendant's hands. Restitution seeks to punish the

wrongdoer …. Compensatory damages …. seek to recover in money the value of the harm done to him." *Id.*[4]

Restitution remedies are not equitable remedies by default, however. This court held in *Aldridge* that restitution remedies are equitable when they "seek specific 'funds' in the beneficiaries' possession—not a money judgment collectable from any of the beneficiaries' general assets." 144 F.4th at 846 (quoting *Great-West Life & Annuity Ins. Co.*, 534 U.S. at 204). *Aldridge* suggests a traceability test for determining specific vs. general assets: if the funds have been used to purchase nontraceable assets, then they are not remediable under a disgorgement claim in this context. *Id.* This complies with precedent that restitution is aimed at the defendant, and not at the plaintiff—a money judgement collectable from general assets is merely monetary damages guised as restitution, because it seeks money for the plaintiff irrespective of where it comes from.

The disgorgement claim in this case, does not fall within the restitutionary umbrella of equitable remedies; in fact, it is disallowed by *Aldridge.* Here, Appellant has not requested specific funds, rather they seek money from the Defendants' general asset*s.* The Complaint refers to all amounts by which

[4] Dan B. Dobbs, LAW OF REMEDIES, § 4.1(1), at 555 (2d ed. 1993) ("Restitution measures the remedy by the defendant's gain and seeks to force disgorgement of that gain. It differs in its goal or principle from damages, which measures the remedy by the plaintiff's loss and seeks to provide compensation for that loss.")" Helfrich v. Pnc Bank, Ky., 267 F.3d 477, 482 (6th Cir. 2001). In other words, restitution is defendant-facing, while damages are plaintiff-facing.

Defendants profited from their formulary program. It does not allege particular accounts, time frame, or anything specifically identifiable. This demonstrates that it is focused more on remedying Appellant than it is on punishing the wrong-doer. Appellant also failed the traceability test in the Complaint because the alleged profits from the breach of duty can have been used to purchase any number of nontraceable assets.

Finally, to use the language to describe the petitioner in *Mertens,* Appellant seems to be "danc[ing] around the word" damages in that they seek compensatory damages and merely guise it as disgorgement in order to be brought in under 502(a)(3). *Mertens*, 508 U.S. at 255. This is evident because the Complaint is far from reaching the restitution burden with the disgorgement claim (it does not seek specific funds) and it fails to allege harm to the Class. Further Appellant attempt three separate claims for relief under ERISA's equitable relief doctrine and none of them are successful. This blatant failure suggests that the intent was merely to secure monetary damages without labeling them as such so as to slip underneath the boundaries around equitable relief that are set forth in *Mertens* and (now) *Aldridge*.

CONCLUSION

For the reasons above, this Court should affirm the District Court's dismissal of Appellant's claims.

/s/Team 14
Attorneys for Appellee