Case No. 25-CV-101

IN THE UNITED STATES COURT OF APPEALS

OR THE SIXTH CIRCUIT

ELINOR DASHWOOD, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF MARIANNE DASWOOD AND A CLASS OF OTHERS SIMILARLY SITUATED

Plaintiff-Appellant

v.

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

Defendants-Appellees.

On appeal from the United States District Court

for the Eastern District Of Tennessee

BRIEF OF APPELLEES

TEAM 16

Counsel for Appelles

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

JURISDICTIONAL STATEMENT

This action was brought under both federal and Tennessee law. The federal claim was brought under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. The United States District Court for the Eastern District of Tennessee had jurisdiction over the federal claim pursuant to 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331, since the claim involves a federal question. The District Court also had jurisdiction over the state law claim pursuant to 28 U.S.C. § 1367(a), since the state and federal law claims arise from a common nucleus of operative fact.

The United States Court of Appeals for the Sixth Circuit has jurisdiction under 28 U.S.C. § 1291. Appellant Elinor Dashwood filed a timely appeal in response to the final decision of the District Court.

ISSUES PRESENTED

1. Does ERISA preempt Appellant's state law wrongful death claim arising under Tennessee Code § 63-1-202?
2. Is the remedy that Appellant seeks for the federal law fiduciary breach claim available under ERISA § 502(a)?

STATEMENT OF THE CASE

I. Procedural History

On May 14, 2025, Plaintiff-Appellant Elinor Dashwood filed a civil action on behalf of the estate of her sister, Marianne Dashwood ("Ms. Dashwood"), in the United States District Court for the Eastern District of Tennessee ("the District Court") against Willoughby Health Care Co. ("Willoughby Health"), Willoughby RX, and ABC Pharmacy, Inc. ("ABC Pharmacy"). Compl.[1] The complaint alleges that Defendants-Appellees changed Ms. Dashwood's prescription to a generic drug without her explicit written consent, and in doing so violated Tennessee Code § 63-1-202. Compl. at ¶¶ 18, 21. The complaint further alleges that this was a routine practice for Defendants-Appellees in violation of ERISA 29 U.S.C. §§ 1104, 1105. Compl. at ¶ 22.

Defendants-Appellees filed a motion to dismiss the complaint under Federal Rule of Civil Procedure 12(b)(6) based on a failure to state a claim. The District Court granted the Defendants-Appellees' motion. Op. at 1. Plaintiff-Appellant thereafter appealed the Opinion and Judgment to the United States Court of Appeals for the Sixth Circuit.

II. Statement of the Facts

Ms. Dashwood worked for Cottage Press, an academic publishing company. Compl. at ¶ 10. At all relevant times, Ms. Dashwood was a participant in the Cottage Press Healthcare Plan ("the Plan"), an ERISA-governed welfare benefit plan sponsored by Ms. Dashwood's employer. *Id.* at ¶ 9. Willoughby Health fully insures the Plan and is the named Plan administrator. *Id.* at ¶ 11. Accordingly, Willoughby Health administers benefits under the Plan and has full

[1] For record citations hereafter, "Compl." represents citations to the Complaint, and "Op." represents citations to the District Court's Memorandum Opinion and Order.

discretionary authority to decide claims for those benefits. *Id.* Additionally, Willoughby Health pays the cost of all medically necessary prescription drug medications filled at ABC Pharmacy, subject to a small co-pay. *Id.* As pharmacy benefit manager, Willoughby RX develops and applies a formulary of preferred drugs to decide what prescription drugs are covered by the Plan. *Id.* at ¶ 14. Willoughby RX is also responsible for deciding prescription drug claims under the Plan. *Id.* Both Willoughby Health and Willoughby RX are Plan fiduciaries under ERISA. *Id.* at ¶¶ 13, 14.

On December 1, 2024, Ms. Dashwood cut her leg during a hike causing a staph infection and a subsequent hospitalization. *Id.* at ¶ 17. Upon her release from the hospital, Ms. Dashwood received a prescription for an intravenous antibiotic, vancomycin. *Id.* Ms. Dashwood's sister, Elinor Dashwood, brought the prescription to an ABC Pharmacy location, where the prescription was allegedly filled with a five-day supply of Bactrim. *Id.* at ¶ 18. Bactrim is a different class of antibiotics, which Plaintiff-Appellant alleges Ms. Dashwood had a severe and well-documented allergy to. *Id.* at ¶ 20. Unfortunately, Ms. Dashwood died shortly after she was discharged from the hospital. *Id.* at ¶ 23.

Elinor Dashwood, on behalf of Ms. Dashwood's estate, asserts that by prescribing Bactrim instead of vancomycin, Willoughby RX and ABC Pharmacy breached their duty outlined in Tennessee Code § 63-1-202 "to dispense medications as prescribed and to refrain from substituting other medications unless authorized by a treating physician to do so." *Id.* at ¶ 35. As recovery for their state law claims, Plaintiff-Appellant seeks compensatory and punitive damages. *Id.* at 10. Plaintiff-Appellant also brings a claim under federal law asserting that through the medication swapping, Willoughby Health and Willoughby RX (collectively and hereafter, "Willoughby Defendants") breached their fiduciary duties established by 29 U.S.C. §

1104(a). *Id.* at ¶¶ 40, 41. As recovery for their federal law claims, Plaintiff-Appellant seeks equitable surcharge and disgorgement of ill-gotten gains. *Id.* at 10. Plaintiff-Appellant also brings a class action suit in accordance with their federal law claim. *Id.* at ¶ 24.

SUMMARY OF THE ARGUMENT

The District Court's dismissal of Appellant's claims should be affirmed. First, Appellant's wrongful death claim is preempted by ERISA. Second, the surcharge and disgorgement remedies sought by Appellant are not available under ERISA § 502(a).

Appellant's Count I—their claim for wrongful death—is preempted by ERISA. ERISA contains an express preemption clause which preempts any and all state laws which "relate to" an employee benefit plan. In accordance with Congressional intent, this preemption clause is read broadly. A key objective of ERISA and of the preemption clause was to eliminate conflicting and inconsistent state regulations, and to establish a uniform national body of employee benefits law. The Supreme Court has held that ERISA preemption extends beyond state laws which directly affect employee benefit plans or the subject matters of ERISA, and instead goes as far to preempt certain state common law tort and contract claims.

The Tennessee law that Appellant claims creates their cause of action is preempted by ERISA since it creates conflicting regulations and different liability conditions compared to other states. When a state law threatens to create a multiplicity of regulation, in conflict with ERISA's goal of uniformity, it is preempted. The Tennessee law, which forbids pharmacies from substituting drugs without express written consent from the patient's physician, creates such a multiplicity by applying a different standard to conduct which is not similarly regulated in other states, as state laws concerning the ability of pharmacies to substitute drugs vary enormously. Since the Tennessee law requires ERISA plan providers to account for conflicting state laws and regulations unique to individual jurisdictions, it threatens national plan uniformity and is preempted.

Appellant's wrongful death claim is also preempted because it depends on a claim of improper processing of benefits. Claims which are essentially alleging improper processing under ERISA plans, which then leads to harm, are preempted. Here, the governing plan document gave Willoughby Health the sole authority and discretion to decide prescription drug claims. In deciding what prescription drugs Ms. Dashwood was entitled to receive under the plan, Willoughby Health was making a benefit determination. Appellant's wrongful death claim depends on the assertion that Willoughby Health improperly administered those benefits under the plan by changing Ms. Dashwood's prescription, which led to her passing. Since Appellant's claim alleges an improper processing of benefits under an ERISA plan, it is preempted.

Furthermore, Appellant's request for compensatory and punitive damages as a remedy for their state law claim is preempted by ERISA § 502(a) and is therefore not recoverable. In drafting the remedies available under ERISA, Congress intended, just as it intended to do with ERISA generally, for § 502(a) to have expansive preemptive effect. Therefore, a state law claim that "duplicates, supplements, or supplants" the remedies prescribed in ERISA § 502(a) is preempted by ERISA. If the Tennessee state law creates the remedies that Appellant ultimately seeks, those remedies would impermissibly compete with § 502(a).

Appellant's claims also meet the test for preemption established by the Supreme Court in *Aetna Health Inc. v. Davila*. Appellant is "complaining of a denial of coverage for medical care" for an ERISA-regulated plan. Additionally, the Tennessee state law does not create a private cause of action, so no independent legal duty was violated. Having met the prongs for the *Aetna Health* test, the compensatory and punitive damages Appellant seeks are completely preempted by ERISA.

Appellant's Count II brings a claim under federal law seeking equitable surcharge and disgorgement of ill-gotten gains in response to the alleged breach of fiduciary duty. To determine whether these remedies fall within the provision of "other appropriate equitable relief" outlined in ERISA § 502(a), we consider whether the remedy was *typically* available in courts of equity. The equitable surcharge sought by Appellant is akin to compensatory damages, which would not have been typically available in courts of equity during the days of the divided bench. Therefore, Appellant cannot recover a surcharge under ERISA.

Alternatively, disgorgement, which is equivalent to restitution damages, *would* have typically been available in courts of equity. However, Appellant seeks to recover damages from general assets, not specific funds. Therefore, compensation for the alleged ill-gotten rebates and savings is not recoverable under ERISA.

ARGUMENT

Appellees seek to have the District Court's dismissal of Appellant's claims affirmed. Regarding Count I, Appellant's state law wrongful death claim is preempted by ERISA for three reasons. First, the Tennessee law that Appellant claims creates their cause of action has an impermissible connection with ERISA benefit plans, since it creates conflicting regulations and establishes different liability conditions across states which ERISA is intended to standardize. Second, Appellant's wrongful death claim is predicated on an argument that the death was caused by improper processing of benefits under an ERISA plan, and such claims are preempted. Third, the remedies Appellant seeks are preempted by § 502(a) and are therefore not recoverable. The District Court correctly determined that Appellant's Count I was preempted by ERISA, and therefore that it must be dismissed. Regarding Count II, even if Appellant could prove a fiduciary breach, the remedies sought are unavailable under ERISA. First, surcharge does not qualify as equitable relief. Second, Appellant fails to identify specific funds from which to disgorge ill-gotten gains. The District Court correctly determined that Appellant's Count II fails because the requested remedies are not available under § 502(a). Thus, the District Court's decision was appropriate and should be affirmed.

I. Standard of Review

The District Court's order dismissing the Complaint with prejudice pursuant to Fed. R. Civ. P. 12(b)(6) for failure to state a claim is reviewed *de novo*. *VCST Int'l B.V. v. BorgWarner Noblesville, LLC*, 142 F.4th 393, 399 (6th Cir. 2025). In order to survive a 12(b)(6) motion to dismiss, the complaint must contain "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Co. v. Twombly*, 550 U.S. 544, 570 (2007). While the Court must take well-pled

factual allegations within the Complaint as true, legal conclusions are not entitled to the same assumption of truth. *Ashcroft v. Iqbal*, 556 U.S. 662, 678–79 (2009). "[W]here the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged—but it has not 'show[n]'—'that the pleader is entitled to relief' " and must be dismissed. *Id.* at 679 (citations omitted).

II. In Accordance With Congressional Intent, ERISA Preemption Is Read Broadly.

The ultimate test for any preemption question is Congressional intent. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). ERISA contains an express preemption clause, § 514(a), which preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144. This express preemption clause is "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). The Supreme Court has consistently recognized that the words "relate to" expands ERISA preemption beyond state laws which are specifically designed to affect employee benefit plans. *See FMC Corp.*, 498 U.S. at 58–59; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983). Indeed, the breadth of the preemption clause goes even further than state laws which affect subject matters directly covered by ERISA, such as reporting, disclosure, and fiduciary duties in relation to benefit plans. *Shaw*, 463 U.S. at 98–99. Rather than being limited to state laws which directly affect benefit plans or affect the subject matters of ERISA, the scope of the preemption clause is "as broad as its language." *Id.* at 98.

The breadth of the preemption clause is emphasized when considering Congress' intent in enacting ERISA was to establish a nationally uniform body of law for employee benefit plans. *Rutledge v. Pharm. Care Mgmt. Ass'n.*, 592 U.S. 80, 86–87 (2020). As the Supreme Court noted

in *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), it is essential to look to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 514 U.S. at 656. The legislative history of ERISA clearly indicates that a key objective was "'to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.'" *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29,197 (1974)). "[T]he basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. In accordance with this goal to avoid a multiplicity of regulation, ERISA's preemption clause has been found to apply to a wide extent of seemingly unrelated state law, including an anti-subrogation law, *FMC Corp.*, 498 U.S. at 59–60, and a variety of state tort and contract claims, such as a claim for wrongful discharge, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990).

Accordingly, the Supreme Court has determined that state law "relates to," and is therefore preempted, an ERISA benefit plan when it "refers to" or has a "connection with" such a plan. *Shaw*, 463 U.S. at 96–97. State law "refers to" an ERISA plan when it acts immediately and exclusively upon ERISA plans or when the existence of the ERISA plan is essential to the law's operation. *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324–25 (1997). The District Court correctly determined that Tennessee Code § 63-1-202 does not "refer to" an ERISA plan. Op. at 7. First, the law does not explicitly refer to ERISA plans. *Id.* Second, the law does not act exclusively upon ERISA plans—rather, it applies to all pharmacies and pharmacy benefit managers, regardless of whether an ERISA benefit plan is in place. Compl. at ¶ 3. For the same reason, the existence of an ERISA plan is not essential to

the law's operation. While § 63-1-202 is not preempted under ERISA because it refers to an ERISA plan, it is preempted because it has an impermissible connection with ERISA plans.

III. The District Court Properly Dismissed Appellant's Wrongful Death Claim Because The Claim Is Preempted By ERISA.

A. The Tennessee law that Appellant's claim creates their cause of action is preempted by ERISA because it creates conflicting regulations and establishes different liability conditions across states, which ERISA's preemption clause was intended to eliminate.

State laws which "risk subjecting plan administrators to conflicting state regulations" have an impermissible connection with ERISA benefit plans and are preempted. *FMC Corp.*, 498 U.S. at 59–60. A key goal of ERISA's preemption clause was "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand*, 498 U.S. at 142. The Supreme Court has therefore consistently held that "where a 'patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation,' we have applied the pre-emption clause to ensure that benefit plans will be governed by only a single set of regulations." *FMC Corp.*, 498 U.S. at 60 (citations omitted).

In *FMC Corp. v. Holliday*, Pennsylvania's anti-subrogation law was preempted by ERISA since it led to different liability conditions for plan providers within Pennsylvania. *FMC Corp.*, 498 U.S. at 59–60. Defendant Holliday was a beneficiary of an employee benefit plan which contained a subrogation clause where the plan member agreed to reimburse the plan if the member recovered on a tort claim against a third party. *Id.* at 54. After Holliday was injured in a

motor vehicle accident, plaintiff FMC paid a portion of her medical expenses. *Id.* at 54–55. When Holliday recovered on her suit against the third party driver, FMC sought reimbursement under the plan—however, Holliday refused to reimburse FMC, and pointed to a Pennsylvania law that forbade subrogation for lawsuits arising from use of a motor vehicle. *Id.* The Supreme Court held that the Pennsylvania law was preempted by ERISA since it had a connection to ERISA benefit plans. *Id.* at 59. The law had a "connection to" benefit plans since "[i]t requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation." *Id.* at 60. Under the Pennsylvania law, ERISA plan providers would be unable to subrogate and recover for any previously paid benefits—however, they would not be subject to those same limitations in any other state which did not have a similar anti-subrogation law. *Id.* This would lead to ERISA plan providers in Pennsylvania facing different rates of return, leading to different liability conditions, and ultimately leading to different benefit calculations. *Id.* By establishing different liability conditions in Pennsylvania compared to other states, the law directly went against ERISA's intent to eliminate conflicting state regulations.

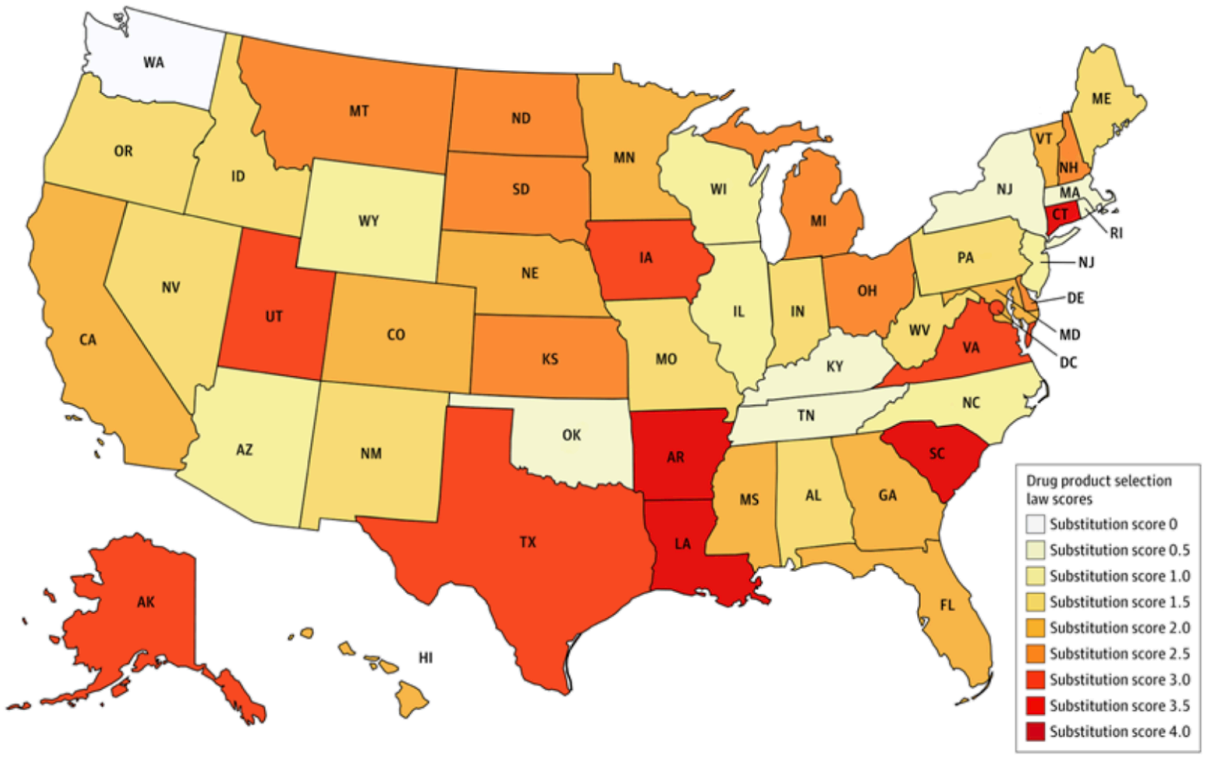
Similarly, in *Ingersoll-Rand Co. v. McClendon*, a plaintiff's state common law wrongful discharge claim was preempted by ERISA because of the potential for conflict in state substantive laws. *Ingersoll-Rand*, 498 U.S. at 142. When plaintiff McClendon was fired from his company of almost a decade, he filed a suit for wrongful termination. *Id.* at 135. While McClendon did not make any claim under ERISA, he alleged that the main reason for his firing was his company's desire to avoid having to contribute to his pension plan. *Id.* at 135–36. Despite McClendon's cause of action being solely a state law wrongful discharge claim, the Supreme Court held that McClendon's state law claim was preempted by ERISA. *Id.* at 137. The

Court reasoned that ERISA's express preemption clause was intended to eliminate conflicting state laws and directives, and that "[a]llowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through § 514(a)." *Id.* at 142. The Court placed particular emphasis on the possibility that states "might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Id.* If ERISA did not preempt these state law claims, then national plan providers would be forced to face extremely different legal landscapes and tailor their plans and benefit determinations to account for each state's individual law—precisely the circumstance which ERISA was intended to prevent.

Tennessee Code § 63-1-202 has an impermissible connection with ERISA benefit plans because it risks creating inconsistent state regulations which threaten ERISA's intent to have a nationally uniform body of law. The law "forbids pharmacies and pharmacy benefit managers ("PBMs") from substituting drugs without the express written authorization of the patient's treating physician." Compl. at ¶ 3. Just as Pennsylvania's anti-subrogation law in *FMC Corp.* created different liability conditions in states allowing versus states disallowing subrogation, Tennessee's written authorization requirement creates conflicting regulations across state lines. While this Tennessee code makes it illegal for a pharmacy in Tennessee to switch a patient to a generic drug without written consent, there is substantial variation in state laws regarding substitution by pharmacies to generic drugs. Chana A. Sacks et al., *Assessment of Variation in State Regulation of Generic Drug and Interchangeable Biologic Substitutions*, 181 JAMA Internal Medicine 16 (2020), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2769770

[10.1001/jamainternmed.2020.3588]. As Sacks et al. found, only seven states and Washington, D.C. required that patients consent to substitution to a generic medication, while 23 states did not require such consent. *Id.* Nineteen states even mandated that pharmacies substitute for generics when generic products were available. *Id.* The sheer variety of state law is detailed below in Figure 2 from the publication.

Figure 2. Heat Map of Generic Substitution Scores



Heat map showing range of small-molecule generic drug substitution scores across all 50 states and Washington, DC. Possible range of scores is 0 to 4, with lower scores reflecting regulatory frameworks more favorable to substitution.

The Tennessee code at issue creates the multiplicity of regulation which the Supreme Court has consistently held is subject to ERISA preemption. The law itself, like Pennsylvania's anti-subrogation law at issue in *FMC Corp.*, essentially changes the regulations and creates conflicting liability standards which ERISA plan providers would be subject to. If the Tennessee law were not preempted, ERISA plan providers would be forced to adjust their plans and their

benefit calculations to account for the fact that what may be legal conduct in Missouri creates the risk of civil liability in Tennessee. Allowing Appellant to bring their wrongful death claim under this law would, like McClendon's claim of wrongful discharge, create "different substantive standards applicable to the same employer conduct"—here, whether a pharmacy may change a patient's prescription to a generic without written consent. *Ingersoll-Rand*, 498 U.S. at 142. Requiring ERISA plan providers to account for conflicting state regulations and a variety of state law claims unique to each individual jurisdiction is "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand*, 498 U.S. at 142. The District Court correctly noted this in its conclusion that "in its application to the prescription drug benefits at issue in this case, the law mandates a specific benefit structure and, in so doing, threatens uniformity in the administration of this multi-state healthcare plan." Op. at 10.

B. Appellant's wrongful death claim relies on an assertion that there was an improper processing of benefits under an ERISA plan, and such claims are preempted.

Additionally, state law claims have an impermissible connection with ERISA benefit plans when the claims are essentially "asserting improper processing of claims under ERISA-regulated plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). This principle has been applied broadly, with numerous courts holding that such claims are preempted even when the claims at issue are wrongful death claims. *See Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 941–42 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131–32 (9th Cir. 1993); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992).

In *Pilot Life Ins. Co. v. Dedeaux*, the plaintiff's common law contract and tort claims were preempted by ERISA since each of the claims were "based on alleged improper processing

of a claim for benefits under an employee benefit plan." *Pilot Life*, 481 U.S. at 48. After plaintiff Dedeaux was injured in an employment-related accident, he sought permanent disability benefits from defendant Pilot Life Insurance Co., who provided the group insurance policy for Dedeaux's long-term disability employee benefit plan. *Id.* at 43. However, Pilot Life only provided Dedeaux with two years of disability benefits, and then went on to reinstate and terminate Dedeaux's benefits on numerous occasions. *Id.* Dedeaux went on to file suit for tortious breach of contract and sought damages for failure to provide benefits under the policy, among other claims. *Id.* at 43–44. The Supreme Court held that all of Dedeaux's state law claims were preempted by ERISA because each of them were fundamentally arguing that Pilot Life had improperly processed and denied his claim for benefits under the plan. *Id.* at 47–48. Even though Dedeaux did not make any ERISA claims, the Court emphasized the breadth of ERISA's preemption clause to conclude that Dedeaux's claims certainly "related to" an employee benefit plan. *Id.*

In *Tolton v. Am. Biodyne, Inc.*, this Circuit directly applied *Pilot Life* to determine that the plaintiff's wrongful death claim was preempted under ERISA. *Tolton*, 48 F.3d at 942. Henry Tolton was a beneficiary of an ERISA benefit plan provided by his employer, and defendant American Biodyne (Biodyne) provided mental health benefits under that plan. *Id.* at 939–40. Tolton informed Biodyne that he was addicted to cocaine and suicidal, but Biodyne refused to authorize inpatient care. *Id.* at 940. Ultimately, Tolton took his own life. *Id.* On Tolton's behalf, plaintiffs brought numerous claims, including wrongful death, medical malpractice, and negligent refusal to authorize inpatient care, against Biodyne. *Id.* This Circuit found that the plaintiffs' claims clearly "related to" employee benefit plans, and were therefore preempted by ERISA. *Id.* at 942. While the plaintiffs only made state law claims, each of their claims was based on "American Biodyne's refusal to authorize psychiatric benefits to Tolton under the plan"

by refusing to authorize inpatient care. *Id.* Since each of their causes of action were essentially predicated on an argument that American Biodyne improperly processed Tolton's mental health benefits under an ERISA plan, which in turn caused Tolton's death, this Circuit held all of the plaintiffs' state law claims to be preempted. *Id.*

Importantly, courts have broadly read plaintiff's claims to allege improper handling of benefits even when the alleged conduct is not solely based on a denial of coverage. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992); *see also Tolton*, 48 F.3d at 941–942; *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131–32 (9th Cir. 1993). In *Corcoran*, plaintiff Corcoran was pregnant and received a recommendation from her doctor that she be hospitalized. *Id.* at 1322–23. When Corcoran sought certification from defendant United, her healthcare administrator, for her hospital stay, United denied authorization for hospitalization and instead only authorized home nursing care. *Id.* at 1324. Due to United's determination, Corcoran left the hospital earlier than her doctor's recommendation, and ultimately lost her child. *Id.* Corcoran then filed a state law wrongful death action against United. *Id.* On appeal, United argued that the claim should be preempted because its decision to deny hospitalization "was not primarily a medical decision, but instead was a decision made in its capacity as a plan fiduciary about what benefits were authorized under the Plan." *Id.* at 1329. On the other hand, Corcoran argued that by determining she did not require hospitalization "United exercised medical judgment which is outside the purview of ERISA pre-emption." *Id.* at 1330. The Fifth Circuit concluded that "United makes medical decisions—indeed, United gives medical advice—but it does so in the context of making a determination about the availability of benefits under the plan." *Id.* at 1331. While the plan documents and the financial influence United's recommendation were strong evidence in favor of United's denial of authorization being solely a medical decision, the Court

determined that those decisions were made "as part and parcel of its mandate to decide what benefits are available under the Bell plan. As the QCP Booklet concisely puts it, United decides 'what the medical plan will pay for.' " *Id.* at 1331–32. In light of ERISA's intent to establish a nationally uniform body of law, the Fifth Circuit concluded that despite the fact that United made a mixed medical and benefit determination, that "The principle of *Pilot Life* that ERISA pre-empts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here." *Id.* at 1332.

Appellant's wrongful death claim is similarly preempted because it essentially depends on a claim of improper processing of benefits under an ERISA plan. As the District Court noted, this case admittedly does not fit neatly into the category of wrongful death claims which have previously been held to be preempted. Op. at 11. However, there is no dispute that the plan at issue is an ERISA governed benefit plan. Compl. at ¶ 9. Just like Pilot Life Insurance Co., Biodyne, and United Healthcare were empowered by their respective plan documents to make benefit determinations, including what benefits people were approved for, the plan document in this case empowers Willoughby Defendants to make policy determinations in deciding prescription drug claims. Op. at 9–10; Compl. at ¶ 11. Under the governing plan document, Willoughby Defendants are granted *full discretionary authority* to decide claims for benefits, including prescription drug claims and what prescription drugs are covered. Compl. at ¶¶ 11, 14. Just like United Healthcare in Corcoran, Willoughby Defendants are empowered by the plan to decide "what the medical plan will pay for." *Corcoran*, 965 F.2d at 1331–32. This includes what prescription drugs patients receive, such as Ms. Dashwood. As the District Court correctly concluded, "[i]t is the application of these policies in administering prescription drug benefits under the plan that Plaintiff challenges in Count I as inconsistent with state law." Op. at 10.

Appellant's claim is fundamentally that Willoughby Defendants failed to properly process Ms. Dashwood's plan benefits by approving a different prescription, which in turn led to her passing. Under the plan documents, whether and what kind of prescription drugs a participant would receive is a benefit determination, and Appellant's wrongful death claim depends on a claim of improper processing of benefits. Just as the Fifth Circuit noted in *Corcoran*, "[t]he nature of the benefit determination is different than the type of decision that was at issue in *Pilot Life*, but it is a benefit determination nonetheless." *Corcoran*, 965 F.2d at 1332.

C. Appellant's claim for remedy is not recoverable because it is preempted by § 502(a) of ERISA.

A state law claim which "duplicates, supplements, or supplants" ERISA's civil enforcement remedies is preempted by federal law. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). § 502(a) establishes ERISA's integrated enforcement mechanism, which states that plaintiffs may bring a claim either to recover benefits due to him under the terms of his plan or obtain injunctive or "other appropriate equitable relief." 29 U.S.C. §§ 1132(a)(1)(B)–(3); *see also Aetna Health*, 542 U.S. at 208. The Supreme Court has consistently held that damages outside of the scope of ERISA are preempted by § 502(a) and are therefore not recoverable. *See Pilot Life*, 481 U.S. at 54; *Ingersoll-Rand*, 498 U.S. at 136. Furthermore, it is well-established by this Court that plaintiffs may not seek damages beyond those specified by ERISA. *See Aldridge v. Regions Bk.*, 144 F.4th 828, 846 (6th Cir. 2025); *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 373 (6th Cir. 2015).

Similar to § 514(a), the express preemption clause, § 502(a) reflects Congress's intent for ERISA to act as "a comprehensive statute for the regulation of employee benefit plans." *Aetna*

Health, 542 U.S. at 208. Accordingly, the clause has expansive preemptive effect. *See id.* at 209 ("[T]he ERISA civil enforcement mechanism is one of those provisions with such 'extraordinary pre-emptive power' that it 'converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.'") (citations omitted). As the Supreme Court explained in *Pilot Life*, the legislative history and the language of the section confirm that the remedies detailed in § 502(a) are intended to be exclusive—this Congressional intent "would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life*, 481 U.S. at 54.

In *Aetna Health*, the Supreme Court outlined its test for determining whether a state law claim is preempted by ERISA: if a plaintiff brings a state law claim "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, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated," then the claim is preempted. *Id.* at 210. This is true whether the remedy is included or excluded in § 502(a). *Id.* at 209. The Court elaborated that a plaintiff is "complaining of a denial of coverage for medical care" if "at some point in time, [the individual] could have brought his claim under ERISA § 502(a)(1)(B)." 542 U.S. at 210.

Appellant's wrongful death claim meets the test for preemption established by *Aetna Health*. As previously explained, Appellant argues that, by switching medications to generic brands, Willoughby Defendants made an improper benefit determination. *See* Compl. at ¶ 40 ("Through these actions and omissions, the Willoughby Defendants *failed* to discharge their duties… for the exclusive purpose of providing *benefits* to Plan participants.") (emphasis added). Appellant certainly could have brought this claim under § 502(a)(1)(B) "to recover benefits due

to him under the terms of his plan" or else "to enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Appellant's state law claims also meet the second and third prongs of the *Aetna Health* test. It is uncontested that Appellant's plan is an ERISA-regulated employee benefit plan. *See* Compl. at ¶ 4. Furthermore, no legal duty independent of ERISA is alleged to have been violated. As Appellant admits, the Tennessee law does not provide any private cause of action in tort. *Id.* at ¶ 3. Therefore, the compensatory and punitive damages Appellant seeks are "completely pre-empted by ERISA § 502(a)(1)(B)." *Aetna Health*, 542 U.S. at 210.

IV. The District Court Properly Dismissed Appellant's Federal Law Claim Because The Remedies Are Unavailable Under ERISA § 502(a).

In addition to its state law claim, Appellant has brought a claim under federal law, alleging that Willoughby Defendants breached their fiduciary duty outlined in § 404 to act "solely in the interest of the participants and beneficiaries" by substituting medications to lower costs and obtain rebates. 29 U.S.C. § 1104. The District Court correctly held that, even if the Willoughby Defendants committed a fiduciary breach, there is no available relief under § 502(a)(3). *See* Op. at 13.

As explained during our discussion of the federal law preemptive effect on state law, § 502(a) outlines the available remedies under ERISA. § 502(a) permits "a participant, beneficiary, or fiduciary… 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(a)(3) (emphasis added). In prescribing "other appropriate equitable relief," ERISA is referencing the time in American history in which courts were divided into courts of equity, which would grant equitable relief such as injunctions, and courts of law, which would grant legal relief such as

compensatory damages. *Aldridge v. Regions Bank*, 144 F.4th 828, 844 (6th Cir. 2025). The Supreme Court has continually adopted a narrow view of "equitable relief," choosing to include only those "categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993). Accordingly, the question when examining Appellant's request for remedy under federal law is whether the remedy sought would have typically been available in courts of equity.

A. Appellant's request for surcharge against the Willoughby Defendants is not an equitable remedy recoverable under ERISA § 502(a).

In *Mertens v. Hewitt Assocs.*, plaintiffs alleged that Kaiser Steel Corporation failed to properly fund employees' plans after phasing out steel-making operations and prompting early retirements by many plan participants. 508 U.S. 248, 251 (1993). Plaintiffs therefore sought "appropriate equitable relief" as compensation. *Id.* at 250. The plaintiffs maintained that the remedy they sought constituted "equitable relief" and therefore fell within the boundaries of § 502(a). *Id.* at 255. The Supreme Court disagreed. The Court held that plaintiffs did not seek traditional equitable relief, such as an injunction or restitution, but instead sought monetary relief. *Id.* This "monetary relief for all losses their plan sustained as a result of the alleged breach of fiduciary duties" was akin to compensatory damages, which the Court characterized as "of course, the classic form of *legal* relief." *Id.*

The Supreme Court has also specifically considered whether surcharges are available under ERISA. Following misleading disclosures about changes to pension plans, plaintiffs brought a suit against CIGNA Corporation asking the Court to alter the terms of their plans to

reflect what had been misrepresented to them. *CIGNA Corp. v. Amara*, 563 U.S. 421, 424–25 (2011). While the plaintiff sought an alteration of terms and not a surcharge, the Court nevertheless took the opportunity to examine the relationship between surcharges and the "other appropriate equitable relief" language of § 502(a). *Id.* at 442. The court explained that "prior to the merger of law and equity… monetary remedy against a trustee, sometimes called a 'surcharge,' was 'exclusively equitable.'" *Id.* The Court therefore concluded that "a fiduciary can be surcharged under § 502(a)(3) only upon a showing of actual harm." *Id.* However, the Court caveated that both the specific application of equitable surcharge to *Amara* as well as "the Court's entire discussion of § 502(a)(3), is best left for a case in which the issue is raised and briefed." *Id.* at n. 3.

The Sixth Circuit recently considered the *Amara* Court's discussion of equitable surcharge in *Aldridge v. Regions Bank*. 144 F.4th 828 (6th Cir. 2025). In *Aldridge*, Ruby Tuesday, Inc. created retirement plans for its high-level employees, administered through Regions Bank. *Id.* at 833. After Ruby Tuesday filed for bankruptcy, Regions ceased payments to the Plan. *Id.* Following a settlement with the bankruptcy estate, participants of the Plan sued Regions under ERISA, seeking an "'equitable surcharge'… measured by 'the amounts that should have been paid to [them] as benefits under' the Plans." *Id.* at 833, 847.

In *Aldridge*, the Sixth Circuit considered, in light of the discussion from *Amara*, whether an equitable surcharge was "typically available in equity." *Id.* at 847. Despite the Supreme Court's ruling in *Amara*, the Sixth Circuit held that "an 'equitable surcharge' for a beneficiary's losses qualifies as a damages remedy that *Mertens* does not permit ERISA plaintiffs to recover." *Id.* at 847. The Court reasoned that the Supreme Court's "surcharge discussion…'was not essential' to its vacatur judgment" and left the issue unresolved. *Id.* at 847–48. Furthermore, the

Aldridge court found that the discussion in *Amara* was inconsistent with the Court's position in *Mertens* and that the Court has since distanced itself from the holding in *Amara*. *Id.* at 849. Therefore, the Sixth Circuit held that "courts may not grant a monetary award" under § 502(a) "to compensate a plan participant for losses caused by a fiduciary" even if that request for a monetary award is framed as an equitable surcharge. *Id.*

The District Court correctly held that the surcharge sought by Appellant was not typically available in courts of equity and is therefore not recoverable under ERISA. *See* Op. at 14. In its amended complaint, Appellant seeks "[e]quitable relief surcharging [the Willoughby Defendants] for the direct financial harm suffered by Plaintiff and Class members as a result of their fiduciary breaches." *See* Compl. at 10.

To decide if Appellant's request for relief is recoverable under § 502(a), we must ask if Appellant is seeking compensatory damages, which are non-recoverable, or restitution, which is recoverable. In requesting surcharge, Appellant is clearly not seeking restitution. The Sixth Circuit has held that equitable restitution recoverable under ERISA "focuses on depriving the beneficiary of ill-gotten gains, as opposed to compensating a fiduciary for its loss." *Messing v. Provident Life & Accident Ins. Co.*, 48 F.4th 670, 682–83 (6th Cir. 2022) (citations omitted). In requesting a surcharge remedy, Appellant seeks not to "punish the wrongdoer," as would be true in equitable restitution, but to make the whole the loss from the alleged breach. *Helfrich v. PNC Bank, Ky.*, 267 F.3d 477, 481 (6th Cir. 2001). Accordingly, Appellant seeks to recover compensatory damages, which the Supreme Court in *Mertens* explicitly held were unrecoverable as they are "the classic form of legal relief." 508 U.S. at 255.

Appellant attempts to disguise its request for compensatory damages by framing it in terms of "equitable relief." However, the mere inclusion of this language does not bypass the

equity requirement established in *Mertens*. The District Court correctly recognizes this as a request for monetary relief that "falls on the nonactionable legal side of the divide." *See* Op. at 14. Just as was true in *Aldridge*, Appellant is merely "request[ing] damages under another label." *Aldridge*, 144 F.4th at 834.

B. Appellant does not identify specific funds necessary for recovery of disgorgement under ERISA § 502(a).

In their claim for relief under Count II, Appellant also seeks to recover "[d]isgorgement of all amounts by which [the Willoughby Defendants] profited through application of their drug switching program." Compl. at 10. Again, the question when examining Appellant's request for disgorgement under federal law is whether the remedy sought would have typically been available in courts of equity. *Mertens*, 508 U.S. at 256.

In *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), the Supreme Court considered whether restitution damages are recoverable under § 502(a). Following a car accident that left the plaintiff with quadriplegia, more than $400,000 was paid from plaintiff's healthcare plan to cover her expenses. *Id.* at 207. Plaintiff successfully sued the manufacturer of the car, upon which the health insurance provider, Great-West Life & Annuity Insurance Co., filed suit to recover the paid medical expenses from the settlement proceeds. *Id.* at 207–08. The Court explained that the *Mertens* holding that "injunction, mandamus, and restitution are categories of relief that were typically available in equity" required further analysis. *Id.* at 214. The Court clarified that "not all relief falling under the rubric of restitution is available in equity" and depends on "'the basis for [the plaintiff's] claim' and the nature of the underlying remedies sought." *Id.* at 212–13 (citations omitted). As the Court explained further, "[F]or restitution to lie

in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession." *Id.* at 213. In *Great-West Life*, the Court found that the plaintiff was not entitled to relief because the proceeds were not in the defendant's possession. *Id.* at 214. Therefore, the plaintiff's request for relief was "not equitable -- the imposition of a constructive trust or equitable lien on particular property -- but legal -- the imposition of personal liability for the benefits that they conferred upon respondents." *Id.*

The Supreme Court has affirmed this holding on several occasions, generating a well-established rule that restitution is equitable, and therefore recoverable, when a plaintiff seeks "specifically identifiable funds" that are "within the possession and control" of the beneficiaries, not recovery from the beneficiaries' "assets generally." *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356, 362–63 (2006). For example, in *Sereboff*, funds were equitable, and therefore recoverable, because the plan "sought reimbursement from beneficiaries who had retained their settlement fund in a separate account." *Montanile v. Bd. of Trs. of the Nat'l Elevator Indus. Health Ben. Plan*, 577 U.S. 136, 143 (2016) (discussing *Sereboff*, 547 U.S. 356).

The Sixth Circuit has reflected the Supreme Court's understanding of the test for equitable relief under ERISA. The Sixth Circuit has allowed recovery of funds when the Plan "contains clear and unambiguous reimbursement provisions." *Longaberger Co. v. Kolt*, 586 F.3d 459, 467 (6th Cir. 2009). However, once those funds dissipate, for example by being spent, but not by becoming commingled with other assets, the funds are no longer recoverable. *Sheet Metal Workers' Health & Welfare Fund of N.C. v. Law Office of Michael A. DeMayo, LLP*, 21 F.4th 350, 354 (6th Cir. 2021) ("In other words, dissipating all of the plaintiff's claimed funds bars recovery under ERISA § 502(a)(3), but commingling those funds does not.").

The District Court correctly recognized that Appellant's claim for disgorgement is a request for the restitution of ill-gotten gains. Op. at 14. On first pass, the request appears to be recoverable under the general holding of *Mertens*. However, the District Court also correctly recognized that the request for disgorgement is ultimately seeking "a money judgment collectable from any of the beneficiaries' *general* assets," not "*specific* 'funds' in the beneficiaries' possession." *Id.*; *see also Aldridge*, 144 F.4th at 846.

First, with respect to the rebates allegedly obtained by Willoughby RX, the District Court correctly reasoned that the Amended Complaint "does not allege that the funds are still in [Willoughby RX's] possession." Op. at 14–15. Furthermore, even if Appellant affirmatively argued that such funds *were* still in the possession of Willoughby RX, Appellant does not establish sufficient facts that, if accepted as true, make a claim for relief plausible. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Appellant does not point to a fund retained in a separate account, per *Montanile*, nor does it allege that the Plan contains "clear and unambiguous reimbursement provisions," per *Longaberger*. Absent an allegation of this effect, Appellant does not meet the bar for recoverability established in *Great-West*, and is therefore seeking legal, not equitable, relief.

The same argument certainly extends to the profit allegedly gained by the Willoughby Defendants by saving money on switching to a cheaper medication. General cost-saving measures are unlikely to exist in a specifically identifiable fund necessary for them to be recoverable. Even if such a fund existed, the Plaintiff does not allege any fact to make that claim plausible. The request for restitution of profits gained through cost-saving measures is similarly legal, not equitable, and therefore not recoverable under ERISA.

CONCLUSION

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

Respectfully submitted,

/s/ Team 16

Team 16

Attorneys for Appellees

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