CIVIL ACTION NO. 25-CV-101

IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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

Appellant,

v.

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

Appellees.

On Appeal from the United States Lower court for the Eastern District of Tennessee

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BRIEF FOR THE APPELLANT

Team 1
Counsel for Appellant
January 23, 2026

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I. ERISA preempts a claim that (1) relates to an employee benefit plan covered by ERISA or (2) duplicates the civil enforcement remedy set for in ERISA § 502(a). Dashwood's claim is based on a law that requires pharmacies and PBMs to get authorization from a doctor before swapping out a medication. Does ERISA preempt Dashwood's claim?

II. ERISA § 502(a)(3) authorizes "appropriate equitable relief" to redress fiduciary breaches. Dashwood alleges that plan fiduciaries administered prescription drug benefits through a conflicted substitution program and seeks injunctive relief, surcharge, and disgorgement. Did the district court err in dismissing Count II on the ground that these remedies are categorically unavailable under § 502(a)(3)?

STATEMENT OF THE CASE

I. Factual Background

Prior to her death in 2024, Marianne Dashwood was a participant in an ERISA-governed healthcare plan sponsored by her employer, Cottage Press. Record at 2. Willoughby Health fully insured the plan, administered benefits under the plan, and exercised full discretionary authority to decide claims for benefits. R. at 2. Willoughby Health administered prescription drugs benefits through its subsidiary, Willoughby RX, a pharmacy benefit manager that developed and applied a formulary of preferred drugs in deciding prescription claims. R. at 2. ABC Pharmacy is a nationwide pharmacy chain, acquired in 2021, and is now a subsidiary of Willoughby RX under the broader Willoughby Health corporate umbrella. R. at 2–3.

According to the Amended Complaint, Willoughby RX, acting through ABC Pharmacy, routinely switched formulary drugs for prescribed medications without contacting the prescribing doctor unless a plan participant, beneficiary, or doctor expressly objected. R. at 3. In early December 2024, Marianne Dashwood was hospitalized and treated for a serious drug-resistant staph infection (MRSA). R. at 3. After five days of intravenous vancomycin, she was released on December 10 with a five-day prescription for vancomycin. R. at 3.

Upon discharge, Plaintiff Elinor Dashwood brought the prescription to an ABC Pharmacy in Johnson City. R. at 3. The pharmacy did not dispense vancomycin and instead provided a five-day supply of Bactrim. R. at 3. When Elinor asked about the discrepancy, she was told Marianne's insurance had switched the

prescription and was also told Bactrim was the generic form of vancomycin. R. at 3–4.

Bactrim is not the generic form of vancomycin and is instead a sulfa drug. R. at 4. Marianne allegedly had a well-documented allergy to sulfa drugs and had previously suffered a severe allergic reaction to a sulfa drug prescribed in 2022. R. at 4. Marienne's medical team prescribed vancomycin in part because of this allergy. R. at 4. None of the Defendants consulted her doctor before switching her medication. R. at 4. Plaintiff alleges the switch was not for a legitimate medical reason, but because Bactrim was cheaper, and its manufacturer provided financial incentives to Willoughby RX. R. at 4. After taking Bactrim for just over a day, Marianne suffered a severe allergic reaction and died en route to the hospital. R. at 4–5.

II. Procedural History

Plaintiff Elinor Dashwood filed suit individually, on behalf of Marianne Dashwood's estate, and on behalf of a class of similarly situated individuals. R. at 5. The operative pleading is Plaintiff's two-count Amended Complaint. R. at 1, 5. Count I asserts a Tennessee wrongful death claim against Willoughby RX and ABC Pharmacy. R. at 5. Count II asserts a federal ERISA fiduciary breach claim against Willoughby Health Care and Willoughby RX, alleging violations of ERISA fiduciary duties in connection with administration of the plan's prescription drug benefits and formulary policy. R. at 5. For Count II, Plaintiff seeks declaratory and injunctive relief as well as "other appropriate equitable relief," including surcharge and disgorgement under ERISA § 502(a)(3). R. at 5–6.

Defendants moved to dismiss under Federal Rule of Civil Procedure 12(b)(6). R. at 6. The lower court granted the motion, concluding Count I is preempted by ERISA. R. at 6–11. As to Count II, the court held that even assuming fiduciary breach, Plaintiff failed to state a claim because the requested remedies were not available under ERISA § 502(a)(3). R. at 11–15. Relying substantially on the Sixth Circuit's decision in *Aldridge v. Regions Bank*, the lower court held that loss-based surcharge constitutes impermissible compensatory damages and that disgorgement was unavailable because Plaintiff did not seek specifically identifiable funds. R. at 13–15. The lower court dismissed the case with prejudice. R. 1, 15.

SUMMARY OF ARGUMENT

ERISA preemption serves a key role in enabling Congress to establish a uniform system of benefits. However, ERISA was never meant to be the final say for all state claims related to healthcare. ERISA preempts a specific set of claims that threaten national plan uniformity or govern a central matter of plan administration. But the lower court stepped too far outside of this boundary, denying Ms. Dashwood justice on overly broad interpretations of ERISA preemption.

The lower court incorrectly dismissed Dashwood's wrongful death claim. Contrary to the lower court's determination, both ERISA § 514(a) and ERISA § 502(a) do not preempt Dashwood's wrongful death claim.

ERISA § 514(a) does not preempt Dashwood's claim because the Tennessee statute that Dashwood based the duty for her wrongful death claim on does is not connected with an ERISA plan. The statute does not govern a central matter of plan

administration because there are only a few specific categories that truly govern a central matter of plan administration. The statute does not interfere with nationally uniform plan administration because the statute merely increases costs. Congress did not intend for laws that merely increase costs to pharmacies or PBMs to be preempted by ERISA § 514(a). Furthermore, the lower court lacked any basis for concluding that the statute interferes with nationally uniform plan administration. Thus, the Tennessee statute is not connected with an ERISA plan, and ERISA § 514(a) does not preempt it.

ERISA § 502(a) does not preempt Dashwood's claim because the Tennessee statute does not meet the *Davila* test. ERISA § 502(a) preempts a claim if the underlying statute for the claim meets the requirements under the *Davila* test. Under the *Davila* test, the court must first determine whether the essence of the claim is for the recovery of an ERISA plan benefit. Second, the plaintiff must allege the violation of an independent legal duty. The Tennessee statute that serves as the predicate duty for Dashwood's claim does not meet the *Davila* test because the claim is not based on the denial of benefits and the underlying duty for the claim is independent of ERISA. Thus, ERISA § 502(a) does not preempt Dashwood's wrongful death claim.

The district court erred in dismissing Count II because Plaintiff plausibly alleged that the Willoughby Defendants breached ERISA fiduciary duties and sought relief that ERISA expressly authorizes. ERISA fiduciaries must administer plan benefits solely in the interest of participants and with prudence. Plaintiff

alleged that Willoughby Health and Willoughby RX exercised discretionary authority over prescription drug benefits and implemented a practice designed to generate cost savings and rebates, rather than to protect participant welfare. Those allegations state plausible breaches of ERISA's duties of loyalty and prudence and concern fiduciary plan administration, not medical treatment decisions.

Count II was properly brought under ERISA § 502(a)(3), which authorizes participants to seek injunctive and other equitable relief for fiduciary misconduct. The Supreme Court has recognized § 502(a)(3) as ERISA's "catchall" enforcement provision, designed to ensure that fiduciary breaches do not escape judicial review simply because other remedial provisions are unavailable. Plaintiff seeks equitable enforcement of ERISA's duties, including declaratory and injunctive relief directed at an ongoing practice. Because Count II challenges fiduciary conduct in administering plan benefits and seeks forward-looking equitable relief, § 502(a)(3) provides the mechanism for relief.

The district court further erred by concluding that Plaintiff's requested remedies were categorically unavailable. Supreme Court precedent makes clear that "appropriate equitable relief" under § 502(a)(3) includes traditional equitable remedies drawn from trust law, even when they require monetary recovery.

Loss-based surcharge is a recognized equitable remedy against fiduciaries for harm caused by breaches of duty, and disgorgement seeks to strip fiduciaries of profits obtained through disloyal plan administration. At a minimum, dismissal of these remedies at the pleading stage was improper, as the availability and scope

of equitable relief depend on facts that require discovery. Accordingly, the dismissal of Count II should be reversed and the case remanded for further proceedings.

ARGUMENT

I. The lower court improperly dismissed Count I because ERISA does not preempt Dashwood's wrongful death claim.

Neither ERISA section that Appellees claim preempt Dashwood's wrongful death claim apply to this case. "[T]he 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'." *Allis-Chambers Corp. v. Lueck*, 471 U.S. 202, 208 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)) (addressing whether ERISA preempted a state law wrongful discharge claim). In analyzing whether ERISA preempts Dashwood's claim, this Court must ask whether Congress intended for ERISA to preempt such a claim. If Dashwood's claim is not based on the type of law that Congress intended ERISA to preempt, this Court must hold that ERISA does not preempt Dashwood's wrongful death claim.

Congress enacted ERISA "to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320-21 (2016). Congress added preemption provisions to ERISA "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law." *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). To accomplish these goals, Congress meant for ERISA to preempt laws that "require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits . . . or by binding

plan administrators to specific rules for determining beneficiary status." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 86-87 (2020). ERISA also may preempt a state law if the "acute, albeit indirect, economic effects . . . force an ERISA plan to adopt a certain scheme of substantive coverage." *Id.* at 87 (quoting *Gobeille*, 577 U.S. at 320).

Dashwood based the predicate duty for her wrongful death claim on Tennessee Code § 20-5-106 (the "**Statute**"), which forbids pharmacies and 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. Compl. at 1-2. The Statute only minorly limits PBMs and certainly does not require them to structure benefit plans in a certain way. Thus, the lower court erroneously held that both ERISA § 514(a) and § 502(a) preempt Dashwood's wrongful death claim. Therefore, this Court should reverse the lower court's dismissal of Count I.

A. ERISA § 514(a) does not preempt Dashwood's wrongful death claim.

Appellees' argument that ERISA § 514(a) preempts Dashwood's claim because the Statute relates to an employee benefit plan covered by ERISA incorrectly applies § 514(a). "[A] state law relates to an ERISA plan if it has a connection with or reference to such a plan." *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001). As the lower court indicated, the Statute is not preempted under the "reference to" prong. Record at 7. But the Statute is also not preempted under the "connection with" prong. Furthermore, the lower court lacked any basis to conclude that that ERISA §

514(a) preempts Dashwood's claim because it is closely related to a wrongful death claim premised on the denial of benefits.

1. The Statute does not have a "connection with" an ERISA plan.

Courts do not analyze the "connection with" prong in a highly literal, uncritical sense. *Egelhoff*, 532 U.S. at 147. The Court in *Egelhoff* explained disapproved of such an approach because preemption should not turn on infinite connections. *See id*. The correct approach determining whether a state law has a connection with an ERISA plan is to consider "ERISA's objectives 'as a guide to the scope of the state law that Congress understood would survive.'" *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 86 (2020) (quoting *California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997). More specifically, the Statute has a "connection with" an ERISA plan if it "governs a central matter of plan administration or interferes with nationally uniform plan administration." *Rutledge*, 592 U.S. at 87 (quoting *Gobeille*, 577 U.S. at 320) (applying this standard to determine whether a state law has a "connection with" an ERISA plan).

The Statute lacks a "connection with" an ERISA plan for two reasons. First, the Statute does not govern a central matter of plan administration. Second, the Statute does not interfere with nationally uniform plan administration. Thus, the Statute does not relate to an employee benefit plan covered by ERISA.

a. The Statute does not govern a central matter of plan administration.

The United States Supreme Court expressly listed the types of obligations that govern a central matter of plan administration. These include "determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

In *Tufte*, the court had to determine whether two recently passed North Dakota state bills fit into any of these categories. *Pharm. Care. Mgmt. Ass'n v. Tufte*, 297 F. Supp. 3d 964, 978-79 (D. N.D. 2017). The bill provisions regulated "how PBMs categorize[d] prescription drugs and also require[d] PBMs to make certain cost disclosures to network pharmacies and plan participants." *Id.* at 970. The court noted that the U.S. Supreme Court has consistently held that ERISA does not preempt state laws that regulate transactions regarding an ERISA plan or its agent's involvement in the marketplace for goods or services. *Id.* at 979. The court ultimately held that the laws did not govern a central matter of plan administration because the majority of the statutes' provisions related to "communication issues between pharmacies and PBMs." *Id.*

Like in *Tufte*, the Statute does not fit into any of these categories. The Statute is simple; pharmacies and PBMs must get authorization from a physician before swapping a prescription. A statute requiring a pharmacy or PBM to ask physician for permission to swap a medication simply does not fit into any of these

categories. Instead, the Statute regulates plan administrators' involvement in the marketplace for goods—cheap pharmaceuticals. Furthermore, like in *Tufte*, the Statute regulates PBMs and pharmacies' communication. The Statute requires pharmacies and PBMs to communicate with physicians before making a cost-reducing medication swap. Given the similarity to the statutes in *Tufte*, the Statute does not govern a central matter of plan administration.

b. The Statute does not interfere with nationally uniform plan administration.

The lower court's reasoning that the Statute interferes with nationally uniform plan administration is flawed. First, contrary to the lower court's determination, the Statute's connection to cost regulation exempts any preemption under ERISA § 514(a). Second, the lower court provided no basis for concluding that the Statute mandates a specific benefit structure. Thus, the Statute does not interfere with nationally uniform plan administration.

i. The Statute merely increases costs.

"ERISA does not pre-empt a state law that merely increases costs . . . even if plans decide to limit benefits or charge plan members higher rates as a result." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. at 91. ERISA does not preempt such a law because although it may cause some disuniformity in plan administration, if it merely affects costs, it nonetheless lacks a "connection with" an ERISA plan. *Id.* at 87. In *Rutledge*, the Court analyzed whether ERISA preempted a claim under an Arkansas law because it was "connected with" and ERISA plan. *Id.* at 83. Among other things, the Arkansas law allowed a pharmacy to decline to sell a drug to a

beneficiary if a PBM declined to reimburse the pharmacy at less than its acquisition cost. *Id*. at 85. The Court determined that law was "merely a form of cost regulation." *Id*. at 88. The Court held that ERISA did not preempt a claim under the law because Congress did not intend for ERISA preemption to ensure cost uniformity, and the law did not dictate plan choices. *Id*.

Applying the trial court's reasoning from the case at bar, one could certainly argue that by allowing a pharmacy to decline to sell a drug to a beneficiary, the law interfered with nationally uniform plan administration. In this way, the law limited choices that plan administrators could make regarding a benefit structure. But in *Rutledge*, the Court rejected the respondent's contention that the law interfered with nationally uniform plan administration. *Id*. at 91.

The Supreme Court dealt with a similar issue in *Travelers*, where the Court analyzed whether ERISA preempted a claim under a New York law that increased costs for patients who did not have health insurance through Blue Cross/Blue Shield. *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins.*, 514 U.S. 645 (1995). The Court acknowledged that these increased costs would cause some ERISA plan administrators to choose Blue Cross/Blue Shield over other health insurance providers. *Id*. at 659. Even though the increased costs effectively limited administrators' choices, ERISA did not preempt the law because it did not "bind plan administrators to any particular choice." *Id*.

Like the laws in *Rutledge* and *Travelers*, the Statute merely increases costs. Willoughby RX and ABC Pharmacy switched Marianne's medication to save money.

Compl. at 5. The Statute prevents these entities from swapping medication to save money without getting a physician's authorization. As long as a doctor provides authorization, pharmacies and PBMs are free to swap out as many medications as they would like. Granted, a physician's denial to provide authorization may limit the types of medications pharmacies and PBMs can provide to patients. But this is only a limitation because pharmacies and PBMs want to swap medications to save money. The Statute limits the medications that pharmacies and PBMs can substitute, but only because it increases costs. Like in *Travelers*, while plan administrators may not have *as many* choices, they are still free to "shop for the best deal [they] can get." Thus, the Statute merely increases costs, does not mandate a specific benefit structure, and does not interfere with nationally uniform plan administration.

Appellees may argue that the increased costs to pharmacies and PBMs from the Statute at least constitute "acute, albeit indirect, economic effects . . . [that] force an ERISA plan to adopt a certain scheme of substantive coverage," and thus cause the Statute to be preempted. *Gobeille*, 577 U.S. at 320. However, like in *Travelers*, the Statute does not lock plan administrators into a specific benefit structure. If a physician denies a PBM's request to swap a prescription, the PBM is free to consider other cheap alternatives.

ii. The lower court lacked a basis for concluding that the Statute mandates a specific benefit structure.

The lower court erroneously held that the Statute mandates a specific benefit structure. Concluding that requiring permission before swapping a prescription mandates a specific benefit structure is adopting an unreasonably broad approach that opens the door for endless ERISA preemption claims—claims that Congress could not possibly have intended for ERISA to preempt.

The court relied on an extremely broad understanding of when a statute mandates a specific benefit structure. The court's reasoning boils down to a determination that because the Statute requires pharmacies and PBMs to ask for permission before swapping a medication, the Statute is mandating a specific benefit structure. But the court never defined what constitutes a law that "mandates a specific benefit structure" under ERISA, and it did not use any standard for determining when a law mandates a specific benefit structure. Furthermore, the court provided no precedent to support its broad approach to determining the types of laws that mandate a specific benefit structure.

By the court's logic, any state law that restricts the types of pharmaceuticals a pharmacy or PBM can give a patient—even just through requiring permission from a physician before swapping out medication—mandates a specific benefit structure and thus threatens the uniformity in the administration of ERISA. But such broad preemptive power would completely usurp a state's ability to regulate health care, and Congress did not intend for ERISA to have this effect. *See Travelers*, 514 U.S. at 654-55; *see also De Buono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806, 816 (1997) ("Any state tax, or other law, that increases

the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute").

In contrast, precedent from lower federal courts, while not binding, points toward a holding that the Statute does not mandate a specific benefit structure. The court in *Tufte* specifically addressed when a law does *not* mandate a specific benefit structure. *Tufte*, 297 F. Supp. at 979-80. In *Tufte*, the court addressed an argument from the Pharmaceutical Care Management Association that the statutes at issue "will interfere with the 'benefit structures' selected by ERISA benefit plans and administered by them." *Id*. at 979. The court held that the statutes did not interfere with the selection of benefit structures because the statutes were broad enough that they could also influence non-ERISA health plans. *Id*. at 980. The court ultimately held that the statutes did not interfere with nationally uniform plan administration because they were broad enough to apply to health plans other than ERISA. *Id.*

This clearly defined boundary is understandable, given that courts are careful to avoid an interpretation of ERISA that would enable courts to decide that ERISA preempts any state law relating to health care. *See Dillingham*, 519 U.S. at 329 (explaining that "[i]f ERISA were concerned with any state action—such as medical-care quality standards or hospital workplace regulations—that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, [the Court] could scarcely see the end of ERISA's preemptive reach, and the words 'relate to' would limit nothing"). In fact, The U.S. Supreme

Court expressly cautioned about taking such an approach to ERISA preemption. *See Egelhoff*, 532 U.S. at 147. Thus, under the lower court's approach, one could argue that anything regulating healthcare could threaten the uniformity in the administration of ERISA.

The *Tufte* court ultimately reasoned that because the statutes at issue were broad and affected other health plans in addition to ERISA plans, they lacked the necessary connection to ERISA that would have justified enabling ERISA to usurp a use of state power to regulate health care. *See Tufte*, 297 F. Supp. at 980. The statutes certainly *could have* been interpreted as interfering with the selection of benefit structures. But the court avoided such an interpretation because it would have unreasonably expanded the intended scope of ERISA preemption. *See id.*

Moreover, the Eight Circuit Court of Appeals implicitly affirmed the *Tufte* holding regarding ERISA preemption in *Pharm. Care Mgmt. Ass'n v. Wehbi*, 18 F.4th 956, 964-70 (8th Cir. 2021). In *Wehbi*, the court held that ERISA did not preempt the codified versions of the bills in *Tufte*. *See id*. at 970. The court specifically noted that the provisions were "at most, a regulation of a noncentral 'matter of plan administration' with *de minimis* economic effects and impact on the uniformity of plan administration across states." *Id*. at 968-69.

The Statute, like the bills in *Tufte* and statutes in *Wehbi*, affects other health plans in addition to ERISA plans. Because the Statute affects more than just the interactions between pharmacies, PBMs, and physicians with regard to ERISA plans, the statute does not mandate a specific benefit structure. Further, while the

law may result in increased costs on PBMs and thus have a *de minimis* impact on the uniformity of plan administration across states, such a minor impact does not warrant ERISA preemption. *See id*. at 970. To hold otherwise would be to take an overly broad approach to ERISA preemption and usurp the state's key responsibility of regulating health care.

B. ERISA § 502(a) does not preempt Dashwood's wrongful death claim.

The lower court misapplied ERISA § 502(a) to hold that it preempts Dashwood's claim. Importantly, courts are to presume that Congress did not intend for ERISA to preempt state law in areas of traditional state regulation. *Travelers*, 514 U.S. at 655. Health care is a field of traditional state regulation. *Pharm. Care Mgmt. Ass'n v. Dist. of Columbia*, 613 F.3d 179, 184 (D.C. Cir. 2010). The Court later overruled the presumption against preemption in statutes with express preemption provisions. *P.R. v. Franklin Cal. Tax-free Tr.*, 579 U.S. 115, 125 (2016). However, the presumption remains relevant when analyzing statutes with implied preemption. ERISA § 502(a) does not have an express preemption provision. Rather, the U.S. Supreme Court inferred the preemption by analyzing Congressional intent. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 200-01 (2004). Thus, this Court must presume that Congress did not intend for ERISA § 502(a) to preempt the Statute, since it explicitly regulates interactions between pharmacies, PBMs, and physicians.

In *Davila*, the Court explained that ERISA § 502(a) preempts "[a]ny state law cause of action that duplicates, supplements, or supplants the ERISA civil

enforcement remedy." *Id*. The *Davila* Court provided a two-part test for determining whether ERISA § 502(a) preempts a state law.

Under the *Davila* test, the court must first determine whether the essence of the claim "is for the recovery of an ERISA plan benefit." *Hogan v. Jacobson*, 823 F.3d 872, 880 (6th Cir. 2016) (quoting *Peters v. Lincoln Elec. Co.*, 285 F.3d 456, 469 (6th Cir. 2002)). Second, the plaintiff must allege the violation of an independent legal duty. *Davila*, 542 U.S. at 210. Dashwood's claim does not meet either part of the test. Thus, § 502(a) cannot preempt her claim. Dashwood is free to seek remedies under a wrongful death claim instead of ERISA because she is not seeking additional remedies for injuries that Congress chose to forego.

1. Dashwood's claim is not closely related to a wrongful death claim based on the denial of benefits.

"A claim likely falls within the scope of [§ 502(a)] when '[t]he only action complained of' is a refusal to provide benefits under an ERISA plan and 'the only relationship' between the plaintiff and defendant is based in the plan." *Hogan*, 823 F.3d at 880 (quoting *Davila*, 542 U.S. at 211). Although the lower court concluded that Dashwood's claim is closely related to a claim premised on the denial of benefits, the court provided no reasoning as to *why* the Statute is closely related to such a claim. The court simply made a conclusory statement that it is closely related to such. Furthermore, the court provided no standard for determining when a statute is so closely related to a claim premised on the denial of benefits that ERISA preempts it.

ERISA preempts wrongful death claims based on the denial of benefits because Congress intended for ERISA preemption to cover claims against insurance companies involving the improper processing of a claim for benefits. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). ERISA has preempted wrongful death claims specifically because the claims asserted that insurance companies improperly processed benefit requests. *See Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (holding that ERISA preempted the plaintiff's wrongful death claim against an insurance company alleging an improper refusal to authorize psychiatric benefits under an ERISA plan); *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 302-03 (8th Cir. 1993) (ERISA preemption of a wrongful death claim against an insurance company alleging delayed preauthorization for surgery); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993) (ERISA preemption of wrongful death claim against an insurance company alleging improper withdrawal of authorization for surgery).

If ERISA did not preempt such claims, the lack of preemption would threaten Congress's goal of establishing uniformity in ERISA plan administration. *See Pilot Life*, 481 U.S. at 52. Potential liability would force insurers to vary their claim processing procedures from state to state to comply with each unique state law. *See id*. But Dashwood's wrongful death claim does not implicate this same concern.

To the contrary, Dashwood's claim is logically not sufficiently related to a typical preempted wrongful death claim based on the denial of benefits. The Statute has nothing to do insurance companies, much less an insurance company's denial of

benefits. The Statute also does not relate to Congress's purpose in ERISA preemption of wrongful death claims. A law requiring pharmacies and PBMs to get authorization from a physician before swapping out medication has no meaningful influence on whether an insurance company will authorize a claim for benefits.

Furthermore, Defendants conceded that the Statute is not intended to regulate insurance or have any effect on insurance plans. R. at 3. The only possible link is that the Statute may cause insurance companies to be more reluctant to authorize benefits if PBMs cannot save money by prescribing a preferred medication. But even if this connection makes Dashwood's claim "sufficiently related" to a claim based on the denial of benefits, it is only "sufficiently related" because of increased costs, which Congress specifically did not intend for ERISA to preempt. *See Rutledge*, 592 U.S. at 88. The underlying negligence claim may be the same as in other preempted wrongful death claims, but the law that serves as the predicate duty for the wrongful death claim is completely different.

2. The Statute imposes an independent legal duty that was implicated by the Defendants' actions.

Even if Dashwood's claim is closely related to a claim for the denial of benefits, ERISA § 502(a) does not preempt her claim because the Statute imposes an independent legal duty. "A state-law tort is independent of ERISA when the duty conferred was 'not derived from, or conditioned upon, the terms of' the plan and there is no 'need[ ] to interpret the plan to determine whether that duty exists.'" *Milby v. MCMC LLC*, 844 F.3d 605, 611 (6th Cir. 2016) (quoting *Gardner v. Heartland Indus. Partners, LP*, 715 F.3d 609, 614 (6th Cir. 2013).

In *Gardner*, the court analyzed whether ERISA § 502(a) preempted the plaintiff's claim. 715 F.3d at 611. The plaintiff had filed the lawsuit under Michigan tort law for tortious interference with contract. *Id*. at 612. The court held that ERISA did not preempt the plaintiff's claim because the predicate duty for the tortious interference claim was based under Michigan tort law and not the terms of an ERISA plan. *Id*. at 614. The court noted that "[n]obody needs to interpret the plan to determine whether that duty exists." *Id*.

Like in *Gardner*, the predicate duty for Dashwood's wrongful death claim is independent of ERISA. Pharmacies and PBMs have a duty to get authorization from a physician every single time they swap out a medication. This duty is present regardless of whether the patient has an ERISA plan, is not conditioned upon the terms of the plan, and certainly does not require an interpretation of an ERISA plan to determine whether the duty exists. Thus, the Statute imposes an independent legal duty that was implicated by the Defendants' actions.

Because Dashwood's claim does not meet the *Davila* test, § 502(a) cannot preempt her claim. Thus, neither ERISA § 514(a) nor § 502(a) preempt Dashwood's claim. This Court should reverse the lower court's dismissal of Count I.

II. The lower court erred in dismissing Count II because ERISA § 502(a)(3) authorizes equitable relief for fiduciary breaches, including injunctive relief and traditional equitable remedies such as surcharge and disgorgement.

A. Dashwood plausibly alleged that the Willoughby Defendants breached ERISA fiduciary duties of loyalty and prudence.

ERISA fiduciaries must administer plan benefits "solely in the interest" of participants and beneficiaries and with the "care, skill, prudence, and diligence" of a

prudent fiduciary. 29 U.S.C. § 1104(a)(1)(A)–(B). These duties reflect ERISA's trust-law foundation. *See Varity Corp. v. Howe,* 516 U.S. 489, 496 (1996) (explaining ERISA's fiduciary duties derive from trust law). Plaintiff plausibly alleges that Willoughby Health and Willoughby RX exercised discretionary authority over prescription drug benefits and implemented a formulary substitution practice designed to advance Defendants' financial interests through cost savings and manufacturer rebates, rather than participant welfare. Such allegations state a classic loyalty breach because fiduciaries cannot allow profit incentives to compete with their duty to act exclusively for the participants' benefit. *See Varity,* 516 U.S. at 506 (recognizing fiduciary breach where conduct harms beneficiaries and violates fiduciary obligations).

Plaintiff also plausibly alleges imprudence. Defendants allegedly substituted prescribed medications without physician authorization and without safeguards to verify medical necessity, exposing participants to foreseeable risk of harm. ERISA fiduciary status and liability turn on the function performed, and benefits administration decisions are fiduciary in nature. *Pegram v. Herdrich,* 530 U.S. 211, 226 (2000). Taking the allegations as true, Count II states a plausible claim that Defendants breached ERISA duties of loyalty and prudence in administering the Plan's prescription drug benefits.

The allegations also support an inference that the challenged conduct was not a one-time anomaly, but a systematic plan-administration practice. Plaintiff alleges that the Defendants administered prescription benefits through a formulary

structure and substitution program that generated corporate financial gains through rebates and cost savings. This is important because ERISA's fiduciary rules are directed at ensuring plan benefits are administered consistently with participant interests, not in a manner that creates structural conflicts. On the pleadings, Plaintiff plausibly alleges that Defendants' substitution practice reflects a plan-level benefits decision, and therefore, falls within ERISA's fiduciary governance.

Because Count II alleges fiduciary misconduct in plan administration, the remaining question is whether ERISA § 502(a)(3) authorizes equitable relief to redress that misconduct.

B. Count II Is Properly Brought Under ERISA § 502(a)(3), ERISA's "Catchall" Provision for Equitable Relief for Fiduciary Misconduct.

Plaintiff seeks relief under ERISA's equitable enforcement provision, § 502(a)(3), which authorizes a participant or beneficiary to bring a civil action either "to enjoin any act or practice" that violates ERISA or the plan, or "to obtain other appropriate equitable relief" to redress such violations. 29 U.S.C. § 1132(a)(3). The Supreme Court has made clear that § 502(a)(3) functions as ERISA's "catchall" and "safety net," providing equitable relief for injuries caused by ERISA violations, particularly fiduciary misconduct, when other remedial provisions do not adequately address the harm. *Varity Corp v. Howe*, 516 U.S. 489, 512 (1996). The Court has also confirmed that § 502(a)(3) broadly authorizes "appropriate equitable relief" to redress ERISA violations and enforce ERISA's substantive provisions. *Harris Trust & Sav. Bank v. Salomon Smith Barney Inc.,* 530 U.S. 238,

245–46 (2000). Together, these cases establish that § 502(a)(3) exists to ensure fiduciary breaches are subject to equitable enforcement rather than insulated from judicial review due to ERISA's limited remedial structure. Accordingly, where a plaintiff alleges fiduciary misconduct in plan administration and seeks equitable enforcement of ERISA's duties, § 502(a)(3) provides the proper mechanism for relief.

1. Section 502(a)(3) ensures ERISA fiduciary misconduct is not left without an equitable remedy.

As the Supreme Court recognized in *Varity,* Congress included § 502(a)(3) to operate as a "safety net" that prevents remedial gaps in ERISA's enforcement scheme. 516 U.S. at 512. That function is especially important where the alleged misconduct involves fiduciary plan administration, because ERISA is grounded in trust-law principles designed to hold fiduciaries accountable for disloyal or imprudent conduct. *Id.* Without § 502(a)(3), fiduciaries could engage in conflicted benefits-administration practices that harm participants but evade meaningful judicial oversight.

In addition, the Supreme Court's decision in *Harris Trust* confirms that § 502(a)(3) empowers courts to enforce ERISA's substantive requirements through equitable relief. 530 U.S. 238, 245–46 (2000). Essentially, § 502(a)(3) ensures fiduciary duties remain substantive rather than purely symbolic. *See Id.* Courts may enjoin unlawful practices and provide equitable relief tailored to remedy breaches of trust in plan administration.

2. Count II falls within § 502(a)(3) because Plaintiff seeks equitable enforcement against an ongoing fiduciary plan administration practice.

Count II challenges the Willoughby Defendants' alleged administration of prescription benefits through a formulary substitution practice that prioritized rebates and cost savings over participants' medical interests. Plaintiff alleges this was not a one-time error or isolated dispensing mistake, but a benefits program operating through the Plan's prescription structure. In other words, the alleged misconduct stems from the way the Plan's prescription benefit was administered and implemented across participants, not from medical decision-making by treating physicians. Those allegations place Count II squarely within ERISA's fiduciary enforcement framework. *See Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 111–13 (1989) (recognizing that plan administrators exercising discretionary authority over benefits determinations are subject to ERISA fiduciary principles).

Equally important, Plaintiff's requested relief confirms that § 502(a)(3) is the proper vehicle. Plaintiff does not seek to convert state-law tort damages into an ERISA remedy. Instead, Plaintiff seeks equitable enforcement of ERISA fiduciary duties to stop and remedy the fiduciaries' alleged conflicted administration of plan benefits. Plaintiff requests declaratory and injunctive relief directed at the substitution program itself, including relief preventing prescription substitutions motivated by financial incentives rather than participant welfare. This type

of forward-looking relief is inherently equitable and aimed at preventing continued violations of ERISA's duties of loyalty and prudence.

Finally, allowing Count II to proceed under § 502(a)(3) is consistent with ERISA's structure because Plaintiff seeks remedies tied to fiduciary conduct rather than to a traditional tort theory. The core of Count II is that plan fiduciaries allegedly used discretionary authority over benefits to administer those benefits in a manner that served their own financial interests. The equitable relief requested is tailored to enforce fiduciary duties and to ensure prescription benefit decisions are made in participants' interests. Count II therefore proceeds under § 502(a)(3), and the lower court erred in dismissing it.

C. The lower court misconstrued § 502(a)(3) because Supreme Court precedent recognizes traditional equitable remedies, including relief such as surcharge and disgorgement.

The lower court dismissed Count II on the ground that Plaintiff's requested remedies, loss-based surcharge and disgorgement, constitute impermissible "money damages" and therefore fall outside of ERISA § 502(a)(3). That conclusion rests on an incorrect assumption that monetary relief is categorically unavailable under § 502(a)(3). Supreme Court precedent instead requires courts to distinguish between legal damages and equitable relief particularly where fiduciaries breach duties rooted in trust law. Because surcharge is a traditional equitable fiduciary remedy recognized as available under § 502(a)(3), and because disgorgement seeks to prevent fiduciaries from retaining profits obtained through disloyal plan administration, the lower court erred in dismissing Count II.

1. Loss-based surcharge is "appropriate equitable relief" under § 502(a)(3) because it is a traditional equitable remedy against fiduciaries.

The lower court's holding on the remedy conflicts with controlling Supreme Court precedent. Although § 502(a)(3) does not authorize legal compensatory damages, it does authorize relief "typically available in equity." *Mertens v. Hewitt Assocs.,* 508 U.S. 248, 256 (1993). Courts must therefore evaluate the nature of the remedy requested, not merely whether it involves money. *See Sereboff v. Mid Atl. Med. Servs., Inc.,* 547 U.S. 356, 363–64 (2006) (confirming monetary recovery may qualify as equitable relief under § 502(a)(3) when equitable in nature).

In *CIGNA Corp. v. Amara*, the Supreme Court squarely held that § 502(a)(3) encompasses traditional equitable remedies, including surcharge, which may take the form of monetary relief against a fiduciary for losses caused by a breach of duty. 563 U.S. 421, 441–42 (2011). Surcharge is equitable because it is a classic remedy imposed by courts of equity to hold fiduciaries accountable when they administer trust assets or benefits disloyally or imprudently. Under *Amara*, where a fiduciary breach causes harm, a court may order the fiduciary to make the beneficiary whole through equitable surcharge.

The lower court relied on *Aldridge v. Regions Bank* to conclude that loss-based surcharge constitutes impermissible compensatory damages and is therefore unavailable under § 502(a)(3). 144 F.4th 828, 850 (6th Cir. 2025). But *Aldridge* cannot override the Supreme Court decision in *Amara*, which expressly recognized surcharge as a traditional equitable remedy against fiduciaries for losses caused by breach of duty. 563 U.S. at 441–42. To the extent *Aldridge* is read to foreclose

surcharge where monetary relief is required, that interpretation conflicts with *Amara* and should not control this Court's § 502(a)(3) analysis.

That is precisely what Plaintiff seeks here. Plaintiff alleges that the Willoughby Defendants, acting as plan fiduciaries, used discretionary authority over prescription benefits to implement a substitution practice driven by rebates rather than participants' welfare. When fiduciaries administer benefits through conflicted incentives in violation of ERISA's duties of loyalty and prudence, § 502(a)(3) authorizes equitable surcharge to redress the harm caused by that breach. The lower court therefore erred in dismissing Count II on the ground that surcharge is categorically unavailable.

2. Disgorgement is equitable relief directed at fiduciary profit from misconduct, and dismissal at the pleading stage was improper.

Plaintiff is also seeking disgorgement of profits derived from the Willoughby Defendants' alleged substitution program, including financial benefits obtained through conflicted plan administration. Disgorgement is equitable in character because it is not aimed at compensating tort-style harm. It is aimed at preventing fiduciaries from retaining profits gained through disloyalty and restoring the core fiduciary principle that they may not benefit from a breach of trust.

The lower court's contrary conclusion improperly collapsed the remedies inquiry into a single mistaken rule: that any relief involving money must be legal damages. Supreme Court precedent rejects that approach. *Great-West* requires courts to determine whether the relief sought is equitable in nature rather than

merely whether it results in a monetary reward. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210-14 (2002). Here, Plaintiff's disgorgement request is equitable because it targets fiduciary profits allegedly obtained through breaches of ERISA duties, not ordinary compensatory damages.

At minimum, disgorgement should not have been dismissed at the Rule 12(b)(6) stage. Whether Defendants obtained rebates or other gains, how those gains were calculated, and which entity received or retained them are factual issues that cannot be resolved without discovery.

CONCLUSION

Neither ERISA § 514(a) nor ERISA § 502(a) preempt Dashwood's wrongful death claim. Further, the lower court erred in dismissing Dashwood's ERISA fiduciary-breach claim by misconstruing § 502(a)(3)'s authorization of equitable relief. Therefore, this Court should reverse the lower court's grant of the Defendants' Motion to Dismiss for Failure to State a Claim.

/s/ Team 1
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