Case No.: 25-CV-101

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Elinor Dashwood,

Plaintiff-Appellant,

v.

Willoughby Health Care Corporation,

Willoughby RX, and

ABC Pharmacy, Inc.

Defendants-Appellees

On Appeal from the

United States District Court

for the Eastern District of Tennessee

APPELLANT'S BRIEF

Team 7

Counsel for Plaintiff-Appellant

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JURISDICTIONAL STATEMENT

The United States District Court for the Eastern District of Tennessee had subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 and Section 502(e)(1), 29 U.S.C. § 1132(e)(1), of the Employee Retirement Income Security Act of 1974 ("ERISA"). The district court exercised supplemental jurisdiction over Appellant's state law claims pursuant to 28 U.S.C. § 1367 because such claims are related to Appellant's federal claims and arise from a common nucleus of operative facts such that adjudication of the state law claim furthers the interest of judicial economy. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291 because this is an appeal from a final order.

STATEMENT OF ISSUES PRESENTED

1. Does ERISA preempt § 63-1-202 of the Tennessee Code from establishing a predicate duty to dispense medications as prescribed by a treating physician?
2. Does appropriate equitable relief exist under ERISA § 502(a)(3) for the death of a plan participant, as a result of a formulary policy switching prescribed medications in order to minimize costs and take advantage of drug manufacturer rebates?

STATEMENT OF THE CASE

A. Factual Background

1. Marianne Dashwood's Fatal Medication Switch

At all relevant times, decedent Marianne Dashwood was a participant in the Cottage Press Healthcare Plan (the "Plan"), an ERISA-governed welfare benefit plan sponsored by her employer, Cottage Press, and administered by Defendant Willoughby Healthcare ("Willoughby Health"). (Compl. ¶ 9.) Willoughby Health possessed full discretionary authority to determine benefit claims and delegated prescription drug administration to its subsidiary, Defendant Willoughby RX, a pharmacy benefits manager ("PBM"). Defendant ABC Pharmacy is a nationwide pharmacy chain acquired in 2021 as a subsidiary of Willoughby RX and falls under the corporate umbrella of Willoughby Health. (Compl. ¶ 15.) Plaintiff Elinor Dashwood, Marianne's sister, appointed executor of her estate, and guardian of her orphaned son, brings this action against Willoughby Health, Willoughby RX, and ABC Pharmacies (collectively the "Defendants"). (Compl. ¶¶ 12-15.)

On December 1, 2024, Marianne cut her leg while hiking. (Compl. ¶ 17.) Despite proper wound care, the injury became infected and required hospitalization on December 5, 2024, at Johnson City Hospital Center. *Id.* The hospital diagnosed her with a life-threatening drug-resistant staph infection, MRSA, and treated her with intravenous vancomycin. *Id.* Marianne responded well to the treatment and was discharged on December 10, 2024, with the treating physicians' instructions to continue the vancomycin for five additional days. *Id.*

Elinor filled the prescription at ABC pharmacy. (Compl. ¶ 18.) However, instead of the prescribed vancomycin, the pharmacy dispensed Bactrim. *Id.* When Elinor questioned the change in medication, the pharmacist stated that Willoughby had substituted the medication per the preferred-drug formulary and falsely assured her that Bactrim was simply the generic form of

vancomycin. (Comp. ¶ 19.) This was false. (Comp. ¶ 19.) Bactrim is a class of drugs known as sulfonamides ("sulfas"), while vancomycin is a fluoroquinolone. (Compl. ¶ 20.)

Tragically, Marianne had a well-documented and severe allergy to sulfa-based medications, having suffered a significant allergic reaction in 2022. (Compl. ¶ 20.) At Johnson City Hospital, Marianne informed her physicians of the sulfa allergy, leading to her recommended course of treatment with vancomycin. (Compl. ¶ 21.) After being given the Bactrim by her sister, and despite pharmacy assurances that it was merely her prescribed drug under a generic name, Marianne suffered another catastrophic allergic reaction. (Compl. ¶ 22.) Marianne died later that same day while being transported by ambulance to the hospital. (Compl. ¶ 22.)

2. Willoughby's Formulary Policy

Under the summary plan description detailing participant benefits, "the Plan promises to pay the cost of medically necessary prescription drug medications, subject to a $10 co-pay for all medications filled at ABC Pharmacies." (Compl. ¶ 11.) However, Willoughby RX maintains a policy of routinely switching medications prescribed by treating physicians to "similar," less-expensive formulary alternatives without physician approval or patient consent. (Compl. ¶ 22.) This policy was the reason Marianne's prescription was changed to Bactrim. (Compl. ¶ 18-19.) The lone safeguard granting review of the medication substitution occurs only after the switch and only if the physician or patient expressly objects. (Compl. ¶ 22.)

The motivation behind the drug substitution policy has no medical purpose. (Compl. ¶ 22.) Willoughby Health routinely uses the policy to save money by switching to cheaper drugs and obtaining drug manufacturer payments through "rebates" for most or all other drugs on its formulary. (Compl. ¶ 39.) This was the case here. Bactrim is cheaper than vancomycin, and its

manufacturer provides financial incentives to encourage its use over other drugs. (Compl. ¶ 22.) Tennessee has recognized the dangers of such practices and recently enacted legislation prohibiting pharmacies and pharmacy benefit managers from substituting prescribed medications without the treating physician's authorization. (Compl. ¶ 3.)

B. Procedural History

In May 2024, Elinor Dashwood filed a state-law wrongful death claim under Tennessee Code § 20-5-106, and a federal class action claim alleging fiduciary and co-fiduciary breaches of the duty of prudence and loyalty in violation of ERISA §§ 404, 405. (Compl. ¶ ¶ 39-41.) Elinor sought declaratory and injunctive relief, as well as all other appropriate equitable relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). R. at 5.

Defendants jointly moved to dismiss for failure to state a claim under Federal Rule of Civil Procedure 12 (b)(6). R. at 1. The district court granted Defendants' motion, holding that Dashwood's state-law claim was preempted by ERISA and that the complaint failed to state a plausible claim for fiduciary breach under ERISA. R. at 10-11. The district court dismissed the case with prejudice. R. at 15.

STANDARD OF REVIEW

The Sixth Circuit reviews a district court's dismissal of a complaint pursuant to Fed. R. Civ. P. 12(b)(6) de novo, construing all well-pled allegations in the light most favorable to the plaintiffs. *Republic Bank & Trust Co. v. Bear Stearns & Co.*, 683 F.3d 239, 247 (6th Cir. 2012). The court considers whether the complaint at issue 'contain[s] sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)).

SUMMARY OF ARGUMENT

The district court first erred in finding that Tennessee Code § 63-1-202 is subject to ERISA's express preemption provision. 29 U.S.C. § 1144(a) only supersedes state laws that "relate to" ERISA plans. Courts struggled mightily with the sheer mass of this test and clarified: state laws "relate to" ERISA if they have a "connection with" or make "reference to" ERISA plans. Still, this inquiry is broad and ERISA's text offers little more than "relate to" for guidance, so courts are forced to fall back on the congressional intent behind passing ERISA to support findings of preemption. ERISA will preempt state laws that threaten the uniform administration of plan benefits. However, the district court wrongfully collapsed both halves of the "relates to" test and incorrectly concluded that Tennessee Code § 63-1-202 was preempted.

The district court also erred in finding that Elinor's claim was precluded under 29 U.S.C. § 1132(a)'s complete preemption provision. This test focuses on the nature of the relief sought and the source of the underlying claim. If a claimant both attempts to seek relief under an ERISA plan that Congress intended to preclude and solely seeks relief under a duty committed to them by EIRSA, that claim is precluded. This inquiry focuses on the level of interaction ERISA plans have

with a person's claim and the relief they seek. The district court misconstrued the nature of Elinor's claim and wrongfully found it precluded.

Further, concluding that no appropriate equitable relief is available under ERISA § 502(a)(3) for Defendants' fiduciary breaches of prudence and loyalty was error. Defendants abused their discretionary authority over prescription benefits by systematically substituting prescribed medications for cheaper alternatives and maximizing drug manufacturer rebates, placing their own financial interests above the interests of plan participants. In response, Section 502(a)(3) expressly authorizes courts to award declaratory and injunctive relief, as well as "other appropriate equitable relief" to redress such violations and prevent future harm.

The court additionally failed to address Appellant's claim for injunctive relief, which is independently authorized by the statute and necessary to prevent ongoing fiduciary misconduct that threatens plan participant safety. Other monetary equitable remedies are also available and were improperly dismissed by mischaracterizing Appellant's requested relief as legal damages. Equity typically authorized courts to impose monetary liability on fiduciaries through surcharge and disgorgement to compensate beneficiaries for losses caused by fiduciary breaches and to prevent unjust enrichment.

Should the dismissal be affirmed by this Court, a plan participant's estate would be left without a meaningful remedy for a fatal breach of ERISA fiduciary duties. This is contrary to ERISA's text, the common law of trusts, and the purpose of ERISA to protect plan participants. The complaint plausibly alleges fiduciary misconduct and seeks remedies squarely within the scope of traditional equity. Therefore, the judgment should be reversed, and this case remanded for further proceedings.

ARGUMENT

I. MRS. DASHWOOD'S CLAIM IS NOT PREEMPTED BY EITHER 29 U.S.C. § 1144 OR § 1132 BECAUSE IT DOES NOT RELATE TO ERISA AND DOES NOT SEEK TO SUPLICATE ERISA REMEDIES.

Congress passed ERISA to protect employee benefit plans and ensure all plan beneficiaries uniformly receive the benefits they are rightly entitled to. *Shaw v. Delta Air Lines Inc.*, 463, U.S. 85, 90 (1983). ERISA does so by imposing minimum procedural mandates upon the health plans it governs, but it does not require any specific plan benefits or structures. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins Co.*, 514 U.S. 645, 650-651 (1995). Because ERISA impacts health plans nationwide, it interacts with a variety of state laws that sometimes regulate the same sphere. *Id.* To achieve its goal of uniformity and avoid plan administrators having to learn the laws of multiple states, ERISA includes vast preemption provisions that preempt state laws with ERISA if those state laws "relate to" a plan covered by ERISA. 29 U.S.C. § 1144(a). ERISA additionally preempts state laws that attempt to grant remedies that are exclusively available under ERISA. 29 U.S.C. § 1132(a). These provisions are known as "express" preemption and "complete" preemption, respectively.

Precisely finding express preemption is no simple task, however, due to § 1144's vast applicable range and lack of clarity within its text. *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (calling § 1144 "conspicuous for its breadth."). The Supreme Court has attempted to clarify the statute, finding "state law[s] relate[] to an ERISA plan if [they have] a *connection with* or *reference to* such a plan." *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80, 86 (2020) (emphasis added) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97). However, this

Circuit, joined by others, laments that this test "did not clarify the amorphous nature of the phrase 'relate to.'" *Briscoe v. Fine*, 444 F.3d 478, 497 (6th Cir. 2006).

Complete preemption, however, is more concrete. The Sixth Circuit finds a state statute completely preempted by ERISA if a claimant *both* (1) complains of a denial of benefit plans under an ERISA-regulated plan, *and* (2) duplicates a cause of action provided in ERISA's enforcement provision. *K.B. v. Memphis Hosps.*, 929 F.3d 795, 800 (2019) (citing *Aetna Health v. Davila*, 542 U.S. 200, 214 n.4). A claim based on a statute that meets both of the complete preemption elements is essentially the same as a claim for recovery of ERISA benefits and thus should not be governed by a patchwork of conflicting state laws. *See generally Peters v. Lincoln Elec. Co.*, 285 F.3d 456 (6th Cir. 2002).

Older Sixth Circuit cases employed a text combining express and complete preemption, superseding "state laws that (1) mandate employee benefit structures or their administration; (2) provide alternate enforcement mechanisms; or (3) bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself." *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.*, 399 F.3d 692, 698 (6th Cir. 2005) (citing *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1468 (4th Cir. 1996)) (internal quotations omitted). The first and third elements of this test parallel the express preemption analysis set out in *Rutledge*, while the second generalizes the complete preemption analysis this circuit derived from *Davila*. With this in mind, we consider Elinor's request for state law relief.

A. Mrs. Dashwood's claim neither has a "connection with" nor makes "reference to" an ERISA plan such that it would be preempted by § 1144.

It is well known that litigating express preemption of state laws under ERISA is difficult due to the statute's profound lack of clarity. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) ("a law relates to an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan") (internal quotations omitted); *see also New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins Co*, 514 U.S. 645, 656 (1995) ("…infinite relations cannot be the measure of pre-emption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term…"); *see also See Aetna Health v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring) ("A series of the Court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief."); *see also See Kentucky Assn of Health Plans Inc v. Nichols*, 227 F.3d 352, 357 (2000) ("the wording of [ERISA] combine with the obvious federalism concerns involved ha[s] made it difficult to determine clear boundaries" [for evaluating state law preemption]); *see also Sherfel v. Gassman*, 899 F. Supp. 2d 676, 698 (S.D. Ohio 2012) ("over the years, the Supreme Court has become increasingly frustrated in trying to apply the definition of the statutory term "relate to" applicable to an express pre-emption analysis.").

The core of express preemption analysis hinges upon two words within its guiding statutory mandate: "relates to." 29 U.S.C. § 1144 (ERISA "shall supersede any and all state laws insofar as they may now or hereafter *relate to* any employee benefit plan" that is not exempt from the preemption) (emphasis added). The Supreme Court attempted to clarify this by deeming relation to an ERISA plan to mean "a *connection with* or *reference to* such a plan." *Shaw*, 463 U.S. at 97

(emphasis added). This test, in turn, drew criticism, as "'connection with' is scarcely more restrictive than 'relate to.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001). Because of this rampant lack of clarity, congressional intent analyses are often explicitly invoked and always inform court reasoning in deciding express preemption cases. *Id.* At 150; *see also Travelers*, 514 U.S. at 656 ("We simply must go beyond the unhelpful text [of § 1144] ... and look instead to the objectives of the ERISA statute"); *see also Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 361 (6th Cir. 2000). Evaluating what Congress wanted ERISA to preempt on a case-by-case basis is consistent with Supreme Court precedent. *Travelers*, 514 U.S. at 657. Taking each express preemption test in turn, Tennessee's PBM regulation does not meet the criteria for ERISA preemption.

1. Tennessee Code § 63-1-202 does not have any "connection with" an ERISA plan.

While ERISA's express preemption of state laws is certainly broad, it is by no means without limits. For example, the Supreme Court denounced "uncritical literalism" in finding express preemption because there existed "infinite connections" between ERISA and the state statute at issue. *Travelers*, 514 U.S. at 656.

In finding there to be no preemption under the "connection with" prong, the *Rutledge* court specified that the state law at issue in that case "does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they manage an ERISA plan." 592 U.S. at 88. Their "connection with" analysis honed in on the structure of the state law at issue, and that structure led them to conclude that the state law was not preempted. *Id.* This Circuit mirrors this *Rutledge* construction in *Penny/Ohlmann/Nieman, Inc,* ("PONI"), explaining that one way to

construe "relates to" was a state law that sought to "regulat[e] an ERISA plan itself," essentially binding actors under that plan. 399 F.3d at 698.

Much like the state law in *Rutledge*, this Tennessee law does not single out ERISA plans or even hint at treating ERISA plans differently from non-ERISA plans. Tennessee Code § 63-1-202. This law merely "makes it illegal for a pharmacy or a PBM to change prescribed medications without a treating physician's authorization." *Id.* It applies to *all* healthcare plans, ERISA or not, just as the state law in *Rutledge*. 592 U.S. at 88. Tennessee makes no efforts to impermissibly interrupt ERISA's uniform application to all states, aligning its state law with Congress's intent in passing ERISA. *Travelers*, 514 U.S. at 656. Hence, Tennessee's law does not meet the "connection with" test because it uniformly acts upon healthcare plans, unconcerned with their proximity—or complete lack thereof—to ERISA.

Further, the district court improperly collapses its "connection with" reasoning into "reference to," as the latter is recognized as a distinct line of analysis. *Shaw*, 463 U.S. at 96-97. (state law[s] relate[] to an ERISA plan if [they have] a connection with *or* reference to such a plan) (emphasis added). It does so when concluding "that the claim is preempted, not because it is premised on the denial of benefits under an ERISA-governed plan *per se*, but because it is closely related to such a claim and certainly 'relates to' the administration of prescription drug benefits under the plan." R. at 9.

First, the district court makes clear that it is the *claim,* not *Tennessee's law,* that so closely relates to a denial of benefits. From the start, this analysis veered away from the "infinite connections" the Supreme Court cautioned against. *Travelers*, 514 U.S. at 656. Second, Elinor's claim is based upon a duty independent of ERISA. (Compl. ¶ 3.) Once again, the district court stretched "connection with" far beyond its appropriate logical bounds and found itself far from

ERISA's text. *Travelers*, 514 U.S. at 656. Yes, the "connection with" prong of express state law preemption is broad, but it explicitly cannot touch state statutes with "'too tenuous, remote, or peripheral an effect' on benefit plans" *Van Camp v. AT&T Info. Serv.*, 963 F.2d 119, 122 (6th Cir. 1992) (quoting *Shaw v. Delta Air Lines*, 463 U.S. 85, 100 (1983)). Tennessee's PBM regulation law is one such statute. No logical reading of 29 U.S.C. § 1144 could extend "connection with" as broadly as the district court did, and, when relegated to its appropriate role, Tennessee's statute does not meet its preemption test and must stand.

2. Tennessee Code § 63-1-202 does not "refer to" an ERISA plan.

Because Tennessee's PBM regulation law is not preempted under the "connection with" prong of ERISA's express preemption test, the only way ERISA would preempt it is if the claim made "reference to" ERISA. It does not. (R. at 7 fn.4) ("Because the Tennessee laws at issue here make no mention of ERISA plans, they are not preempted under the 'reference to' prong of ERISA preemption analysis."). Even under the most literal sense of the word, this law does not reference ERISA.

Beyond not mentioning ERISA by name, Tennessee's law in no way "'acts immediately and exclusively upon ERISA plans'" [nor is] "'the existence of ERISA plans [] essential to the law's operation.'" *See Gobeille*, 577 U.S. 312, 319-320 (2016) (quoting *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316, 325 (1997)). Tennessee's law barely interacts with ERISA plans, let alone subjects them to harsh regulations. A key aspect of ERISA's interaction with state laws is that it has no bearing on state laws that do not encroach upon ERISA's spheres of influence. *Rutledge*, 592 U.S. at 89 (the state law at issue was simply a minor cost regulation upon pharmacies that did not make "reference to" ERISA plans). In the same manner,

this Tennessee statute regulates an entirely separate sphere from ERISA and does not even approach express preemption. As such, the law is permissible under ERISA and must stand.

B. Mrs. Dashwood's claim is not preempted by 29 U.S.C. § 1132.

Because we conclude that Tennessee's PBM-regulating statute is not preempted by 29 U.S.C. § 1144, we now must turn to § 1132's additional preemption provision, which, as the district court alleged, preempted Elinor's wrongful death claim. "Complete preemption," seeks to prevent someone from recovering under *both* an ERISA and a non-ERISA claim. 29 U.S.C. § 1132(a). The only way this court could find Elinor's wrongful death claim preempted is if it were to meet both elements of the test established by *Davila*. *See generally* 542 U.S. 200 (2004). The party asserting a complete preemption claim bears the strong burden of demonstrating that the claim meets both steps of the test. *K.B. v. Memphis Hosps.*, 929 F.3d 795, 800 (6th Cir. 2019). If a claimant both (1) complains of a denial of benefit plans under an ERISA-regulated plan *and* (2) duplicates a cause of action provided in ERISA's enforcement provision, only then will a state law be preempted under 29 U.S.C. § 1132. *Id.* A claim that meets both elements of complete preemption would essentially be an ERISA claim for the recovery of ERISA benefits and, therefore, properly governed by ERISA. *See generally Peters v. Lincoln Elec. Co.*, 285 F.3d 456 (6th Cir. 2002).

1. Mrs. Dashwood's claim does not stem from a denial of benefits.

The first step of ERSIA's complete preemption analysis is to isolate why a claimant seeks relief. If the party's claim is founded upon a denial or dispute over benefits granted by an ERISA plan, it meets one-half of the complete preemption test. *K.B.*, 929 F.3d at 800.

The district court claims *Tolton v. American Biodyne, Inc.* is analogous to Elinor's claim—without referencing either prong of the *K.B.* test—but trying to use *Tolton* to support preemption

here is improper, as the two seek relief for distinct reasons. 48 F.3d 937 (1995). (finding an Ohio wrongful death law preempted because an ERISA participant's estate attempted to claim state law remedies that ERISA did not allow). Members of Mr. Tolton's estate were seeking relief under Ohio law because his health insurance company was in the process of "determining what benefits were available to [him] under the plan" for months leading up to his suicide. *Id.* at 942. Unlike Marianne—whose benefits were not in dispute, as ABC pharmacy filled her prescription absent any involvement from Willoughby—Mr. Tolton's claim for relief *did* originate from his insurer's denial of ERISA plan benefits.

The *Tolton* court explicitly acknowledged that its focus was centered upon the process of receiving benefits under an ERISA plan, much like similar express preemption cases. *Id.*; *see also Patterson v. UnitedHealth Grp., Inc.*, 161 F.4th 415 (6th Cir. 2025) (a circuit judge's claim for ERISA relief under a state law was preempted under § 1132 partly because he complained of improper ERISA benefit denial). Conversely, Marianne's benefits were never in dispute. (Compl. ¶ 19.) The first prong of this Circuit's ERISA complete preemption test has no relation to Mrs. Dashwood, as she does not seek relief from the denial of benefits. In citing numerous cases focused on the denial of ERISA plan benefits as a justification for preempting Elinor's claim, the district court simply wastes ink.

2. Mrs. Dashwood's claim seeks relief outside of ERISA mandates.

Absent an affirmative answer to either prong of the *K.B.* test, Defendants' attempt to secure express preemption under § 1132(a) cannot succeed. Elinor's claim survives because she does not premise her prayer for relief on the denial of plan benefits. 48 F.3d 937 (1995). However, Defendants fail to achieve express preemption on the second prong as well because Elinor seeks

relief based on an independent duty. Her claim would be preempted if she were seeking recovery solely based upon a duty owed to her under an ERISA plan. *Davila*, 542, U.S. at 210. Enforcing an ERISA-mandated duty through a state law, unlike what Elinor does in this case, frustrates the statute's purpose and conflicts with Congressional desires for efficiency. *Peters*, 285 F.3d at 469.

Here, Elinor is enforcing a state-based duty pursuant to Tennessee law–providing her either her prescribed medication or a written notice from her prescribing physician that an appropriate switch was performed. Tennessee Code § 63-1-202. This duty does not originate from an ERISA plan, putting it outside the scope of the *K.B.* test. *See generally Patterson v. United Healthcare Ins. Co.*, 76 F.4th 487, 497 (6th Cir. 2023) (because determining if plaintiff could recover required interpreting an ERISA plan, his claim was preempted under ERISA because of the second *K.B.* prong). Conversely, Elinor has based her claim on a duty stemming from state law and wholly unrelated to ERISA. (Compl. ¶ 3.) Evaluating the details of her recovery will not require examining any aspect of her ERISA plan, thereby distinguishing her fully from *Patterson*. 76 F.4th at 497. Even evaluating Elinor's damages is insufficient to bring ERISA preemption into play for a claimant, as using ERISA merely to determine monetary amounts does not transform state law claims into those that cannot proceed. *Id.* (explaining matters purely concerned with the financial administration of establishing damages were not preempted from an otherwise-allowed state law claim). Calculating damages is the only area of this litigation where ERISA is even remotely implicated, and its presence in this sphere is insufficient to preempt Elinor's claim. *Id.* ERISA does not foreclose Elinor's attempts to recover under Tennessee law, nor does it foreclose the mere act of seeking recovery. Her claim is not subject to preemption under 29 U.S.C. § 1132(a).

II. THE DISTRICT COURT ERRED IN DENYING EQUITABLE RELIEF UNDER ERISA § 502(a)(3) FOR DEFENDANT'S FIDUCARY BREACHES.

Defendants violated their statutorily mandated fiduciary duties of prudence and loyalty as required under ERISA by changing participants' prescription medications in the pursuit of drug manufacturer rebates.[1] ERISA § 404(a) requires a fiduciary to "discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries" and "for the exclusive purpose of" providing benefits defraying reasonable administrative expenses. 29 U.S.C. § 1104(a)(1). ERISA further imposes a legal duty requiring plan fiduciaries to act with "the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of a like character and with like aims." 29 U.S.C. § 1104(a)(1)(B). When a fiduciary breaches one of these respective duties of loyalty and prudence, ERISA § 502(a)(3) provides individualized relief for plan participants and beneficiaries through injunctive relief and "all other appropriate equitable relief to (i) redress such violations or (ii) to enforce any provision of this [subchapter] or the terms of the plan. 29 U.S.C. § 1132(a)(3).

The district court erred in dismissing Elinor's claim for failure to state a claim based on the reasoning that no equitable remedy was available. First, the lower court's decision ignored Marianne's requested injunctive relief in its entirety and improperly granted Defendants' motion to dismiss based on a perceived lack of remedy. Second, Marianne is entitled to surcharge as appropriate equitable relief for her loss caused by Defendants' fiduciary breach. Finally, disgorgement is warranted to strip Defendants of the ill-gotten gains resulting from the formulary policy, which places Defendants' financial interests above those of plan participants and

[1] Neither Willoughby Health nor Willoughby RX dispute their fiduciary status under ERISA.

beneficiaries. Each of these remedies was typically available for courts sitting in equity, necessary to enforce ERISA's purpose, and provide the individualized relief necessary to remedy Defendants' breach of their duty to act solely in the best interests of plan participants.

A. The District Court failed to address § 502(a)(3)'s statutorily provided declaratory and injunctive remedy to prevent an ongoing breach of Defendant's fiduciary duties.

1. Marianne Dashwood is entitled to injunctive relief under the plain text of ERISA § 502(a)(3).

Mrs. Elinor Dashwood is entitled to declaratory and injunctive relief under ERISA § 502(a)(3) because Defendants' formulary policy represents an ongoing breach of their fiduciary duties of prudence and loyalty and continues to place plan participants and beneficiaries at risk. An injunction under § 502(a)(3) is the appropriate remedy because Congress expressly authorized plan participants and beneficiaries to seek injunctive relief to "enjoin any act or practice which violates" ERISA or the terms of the plan. 29 U.S.C. § 1132(a)(3)(A). Injunctions are a core form of traditional equitable relief, routinely issued by courts of equity to restrain trustees from continuing to engage in disloyal or self-interested conduct. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993) (identifying injunctions as relief typically available in equity).

Courts sitting in equity may intervene to prevent abuses of the fiduciary's discretion. *See Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996); Restatement (Second) of Trusts § 187 ("Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion"). The Supreme Court has also recognized that equitable relief under § 502(a)(3) could include restructuring plan practices to prevent harm. *CIGNA Corp. v. Amara*, 563 U.S. 421, 440-41 (2011) (quoting *Baltzer v. Raleigh & Augusta R. Co.*, 115 U.S. 634, 645 (1885) ("[I]t is well settled that

equity would reform the contract, and enforce it, as reformed, if the mistake or fraud were shown.").

Here, despite recognizing that Elinor requested declaratory and injunctive relief, the district court erred by granting Defendants' motion to dismiss without addressing injunction remedy. *See* R. at 5-6. Just as in *CIGNA Corp. v. Amara,* in which the Court remedies harm to plan participants' benefits by reforming the terms of the plan, reforming the plan to prohibit Defendant's ongoing disloyal formulary practices is necessary to protect plan participants. *See* 563 U.S. at 425-26. As the executor of Marianne's estate, Elinor is entitled to such relief because Defendants' conduct constitutes a clear, enduring breach of the fiduciary duty of loyalty to plan beneficiaries by subordinating participants' medical interests to Defendants' financial incentives, as demonstrated by the preventable death of Marianne. *See* 29 U.S.C. § 1104(a)(1)(A). Defendants' policy also violates the current terms of the Plan, because the governing document "promises to pay the cost of medically necessary prescription drug medications, subject to a $10 co-pay for all medications filled at ABC Pharmacies." (Compl. ¶ 11.) Rather than dispensing the prescribed antibiotics for Marianne's treatable infection, Defendants chose to avoid paying the cost of medically necessary medication, substituting it for a medication for which Marianne possessed a well-documented allergy. (Compl. ¶ 1.) For these reasons, Elinor respectfully requests that this Court reverse the district court's dismissal and allow the claim to proceed.

2. Defendants' formulary policy creates a continuing risk of irreparable harm.

Monetary relief alone cannot remedy the ongoing risk to plan participants posed by Defendants' formulary practices, because the challenged policy continues to expose plan participants and beneficiaries to unsafe medication substitutions. Equity traditionally intervenes where legal remedies are inadequate to prevent irreparable or recurring injury. *Weinberger v.*

Romero-Barcelo, 456 U.S. 305, 312 (1982) ("The Court has repeatedly held that the basis for injunctive relief in federal courts has always been irreparable injury and the inadequacy of legal remedies."). Consistent with these requirements for injunctive relief, the Supreme Court has recognized that equitable relief is appropriate where fiduciary misconduct creates an ongoing risk of harm to plan participants. *See Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996).

This is precisely the circumstance faced by this Court in the case at hand. Under Defendants' policy, once a medication substitution occurs, the resulting harm from health complications—as demonstrated by Marianne Dashwood's death—is permanent and irreparable. Defendants' safeguards under the current formulary policy are inadequate because medication substitutions occur without review unless a patient or physician notices and objects, resulting in an inherently unreliable safeguard relying on patients being aware of substitutions and having the necessary medical sophistication to advocate for their needs. *See* (Compl. ¶ 22.) Therefore, because the challenged practice is ongoing, and monetary relief alone cannot prevent future harm or deter Defendants' self-dealing, this Court should find Dashwood's allegations plausibly establish a continuing and imminent risk of harm sufficient to support declaratory and injunctive relief at the pleading stage.

3. The District Court erred in granting Defendants' motion to dismiss pursuant to Rule 12(b)(6) based on the sufficiency of Marianne's requested relief.

The District Court dismissed Elinor's claim because it falsely believed that no requested remedy was available. That approach misapplies Rule 12(b)(6). A motion to dismiss tests the sufficiency of the plaintiff's factual allegations and legal claim, not the availability of particular remedies. *Clarke v. Amazon.com Servs. LLC*, 699 F. Supp. 3d 596, 604 (E.D. Ky. 2023) ("Rule 12(b)(6) is tailored to test the sufficiency of the claims in a complaint, not the types of relief sought.

A cause of action and the type of relief requested are distinct elements of a pleading."); *see also Bocock v. Specialized Youth Servs. of Va., Inc.,* 2015 WL 1611387 (W.D. Va. Apr. 10, 2015) ("Rule 12(b)(6) is not the correct procedural tool to dismiss damages because 'Rule 12(b)(6) may only be used to dismiss a claim in its entirety . . . and a demand for relief is not part of a plaintiff's statement of the claim.'"). A Rule 12(b)(6) dismissal may be appropriate only where the plaintiff exclusively seeks relief that is unavailable. *Clarke*, 699 F. Supp. at 604.

That is not the case here. In *Clarke v. Amazon.com Services LLC*, the defendant moved to dismiss the plaintiff's properly pleaded claim under Rule 12(b)(6) because the requested injunctive relief was not available, even though other relief was potentially available. *See* 699 F. Supp. 3d at 600. Just as with the plaintiff in *Clarke*, even if this Court finds that one set of requested relief is contested—here, the equitable surcharge and disgorgement remedies—Marianne did not solely plead a claim for which relief was unavailable because she requested injunctive relief expressly provided for in the text of § 502(a)(3). *See id.* Therefore, because the Complaint seeks injunctive relief authorized by the statute, the district court erred in dismissing the claim based solely on its assessment of the available remedies, and this Court should reverse.

B. The District Court Erred in Holding that *Aldridge* Barred Monetary Relief in the Form of a Surcharge as Appropriate Equitable Relief Under ERISA § 502(a)(3).

1. Section 502(a)(3) Constitutes Mrs. Dashwood's Exclusive Remedy for Individual Relief.

The death of Marianne Dashwood as a result of Defendants' fiduciary breach requires make-whole relief in the form of equitable remedies explicitly provided for under ERISA § 502(a)(3). ERISA was designed with the fundamental goal of "promot[ing] the interests of employees and their beneficiaries in employee benefit plans." *Mertens v. Hewitt Assocs.*, 508 U.S.

248, 256 (1993) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)); *see also* S.Rep. No. 93–127, p. 35 (1973), 1 Leg. Hist. 621 (describing Senate version of enforcement provisions as intended to "provide both the Secretary and participants and beneficiaries with broad remedies for redressing or preventing violations of [ERISA]"). Consistent with that broad mandate, the Supreme Court has emphasized that § 502(a)(3) exists as a "catchall" to prevent remedial gaps and ensure that beneficiaries are not left without recourse when other enforcement provisions do not provide complete relief. *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996) ([ERISA's] structure suggests that these 'catchall' provisions act as a safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy.").

In *Varity*, the Court explained that plaintiffs who could not proceed under § 502(a)(1)(B)—because they have no "benefits due" under the plan—and cannot proceed under § 502(a)(2) —because that provision's connection to § 409 precludes individualized relief—must rely on § 502(a)(3). *Id.* at 515 (holding that plan participants seeking individual relief must rely on § 502(a)(3) "or have no remedy at all"). An interpretation of ERISA that the Court in *Varity* expressly rejected, explaining that it was not aware of any ERISA-related purpose that a denial of a remedy would serve, and that allowing relief under § 502(a)(3) is consistent with "the literal language of the statute, the Act's purposes, and pre-existing trust law." *Id.*

That reasoning fully applies to the case at hand. Elinor cannot obtain relief under § 502(a)(1)(B) because her injuries do not arise from a wrongful denial of plan benefits, as Defendants covered the medication. *See* (Compl. ¶¶ 18-19.) Nor does § 502(a)(2) provide an adequate remedy because this section provides losses to the plan as a whole, and does not afford the individualized make-whole relief necessary to remedy Marianne's death. *See* 516 U.S. at 515. Rather, Elinor's injuries stem from the Defendants' decision as plan fiduciaries to change

participants' prescriptions in order to maximize drug manufacturer rebates. (Compl. ¶ 39.) As with the plaintiffs in *Varity*, if no appropriate equitable relief is available under § 502(a)(3), Elinor would be left without a meaningful avenue to compensate her for Defendant's egregious fiduciary breach. *See* 516 U.S. at 515. Because § 502(a)(3) is Elinor's only viable mechanism to obtain complete relief for Defendants' fiduciary misconduct resulting in the death of her sister, interpreting "appropriate equitable relief" to deny make-whole relief would serve no legitimate ERISA purpose and would directly contradict the Supreme Court's guidance in *Varity*.

2. The District Court mischaracterized Mrs. Dashwood's requested relief as legal damages rather than an equitable surcharge for Defendants' fiduciary breach.

The mere fact that Elinor's requested make-whole relief takes the form of monetary damages does not render her claim legal and remove it from the category of equitable relief. While "appropriate equitable relief" has been clarified to refer only to relief typically available in equity, courts sitting in equity were historically authorized to impose monetary liability on fiduciaries through surcharge, allowing beneficiaries to recover for losses caused by a fiduciary's breach of duty or to prevent unjust enrichment. *Mertens v. Hewitt Ass'n*, 508 U.S. 248, 256 (1996) (explaining that § 502(a)(3) authorizes only those remedies that were "typically available in equity"); *CIGNA Corp. v. Amara*, 563 U.S. 421, 439-42 (2011). However, a fiduciary may only be surcharged under § 502(a)(3) upon showing of actual harm, which may consist of detrimental reliance or the loss of a right protected by ERISA. *CIGNA Corp. v. Amara*, 563 U.S. 421, 444 (2011) (holding that traditional equitable remedies available under § 502(a)(3) include surcharge against a breaching fiduciary to compensate for losses or prevent unjust enrichment).

The district court nevertheless concluded that Elinor's claims sought impermissible compensatory damages by relying on this Court's discussion of equitable restitution in *Aldridge v.*

Regions Bank. 144 F.4th 828, 846 (6th Cir. 2025). The district court improperly read *Aldridge as* categorically foreclosing equitable surcharge by framing it as compensatory damages (a legal remedy). R. at 14. This reading grossly misapprehends *Aldridge* and improperly extends its holding beyond its narrow factual context in which the plaintiffs were high-level executives subject to a "top-hat" plan, a form expressly exempt from ERISA's fiduciary duty provisions. *See id.* at 834. Because ERISA imposed no fiduciary obligations on the defendant, the plaintiffs in *Aldridge* attempted to repackage a contractual benefits dispute as equitable relief under § 502(a)(3), and this Court correctly rejected that effort by holding that plaintiffs could not manufacture equitable remedies in the absence of fiduciary misconduct. *Id.* at 846-47.

Elinor's claim is highly distinguishable. Unlike the plaintiffs in *Aldridge*, who were executives covered by a "top-hat plan," Marianne was a participant in an ERISA-governed welfare benefit plan subject to the fiduciary duties of prudence and loyalty. *See id.* at 846-47 ("[The Participants] do not argue that Regions violated ERISA because, again, the statute exempts top-hat plans from its fiduciary-duty rules."). Nor did *Aldridge* overrule or narrow the Supreme Court's holding in *Amara*, which expressly recognized surcharge as "appropriate equitable relief" under § 502(a)(3) where a fiduciary breach causes actual harm. *See* 563 U.S. at 441-44. *Aldridge* acknowledged *Amara* but distinguished it because the plaintiffs in *Aldridge* could not allege any fiduciary wrongdoing. *Id.* at 846-47. Nothing in *Aldridge* suggests that surcharge is entirely unavailable in cases in which fiduciary duties apply, and actual harm is plausibly alleged.

The court's reliance on *Mertens* likewise misses the mark. *Mertens* rejected compensatory damages against nonfiduciaries, but should not be read to eliminate surcharge against breaching fiduciaries. *See* 508 U.S. at 260-61. *Amara* further clarified that distinction, reaffirming that equity permits monetary make-whole relief against fiduciaries. 563 U.S. at 442. Here, Dashwood

plausibly alleged actual harm—the death of her sister from a drug substitution in pursuit of rebates—directly caused by Defendants' fiduciary breach; exactly the type of loss that *Amara* recognized as sufficient to support surcharge. *See* 563 U.S. at 444. By conflating monetary relief with legal damages and granting Defendants' Dismissal for Failure to State a Claim, the district court improperly restricted § 502(a)(3), depriving Dashwood of a traditional equitable remedy expressly recognized by this Court.

C. Disgorgement is Appropriate Equitable Relief Necessary to Prevent Defendants' Unjust Enrichment From the Challenged Formulary Policy.

1. Disgorgement is the appropriate remedy for stripping Defendants of ill-gotten gains stemming from their fiduciary breaches of loyalty and prudence.

Defendants retain ill-gotten funds from their rebate-driven formulary policy, substituting medications with cheaper alternatives while also reaping drug manufacturer-driven rebates. Disgorgement is an equitable remedy designed to prevent fiduciaries from unjustly enriching themselves by retaining profits obtained through disloyal conduct, thereby "depriv[ing] wrongdoers or their net profits from unlawful activity." *Patterson v. United Healthcare Ins. Co.*, 76 F.4th 487, 497 (6th Cir. 2023); *see also Messing v. Provident Life & Accident Ins. Co.*, 48 F.4th 670, 683 (6th Cir. 2022) (explaining that disgorgement "seeks to punish the wrongdoer" by stripping him "of ill-gotten gains."); *Rochow v. Life Ins. Co. of N. Am.*, 41 F.4th 663, 673 (6th Cir. 2022) (approving equitable disgorgement of funds retained through fiduciary misconduct).

Consistent with *Varity*, equitable relief under § 502(a)(3) is appropriate where the remedy is traditionally equitable and not duplicative of benefits recoverable under § 502(a)(1)(B). 516 U.S. at 512. In *Patterson*, this Court specifically recognized the viability of disgorgement claims under § 502(a)(3), rejecting arguments that equitable disgorgement is unavailable and holding that

plaintiffs plausibly state a claim by alleging that defendants retained disputed funds derived from fiduciary misconduct. 76 F.4th at 495-96. Likewise, Elinor plausibly alleges that Defendants retained financial benefits generated by rebate-driven prescription decisions that violated their fiduciary duties of loyalty and prudence. Disgorgement is therefore necessary to strip those ill-gotten gains and deter fiduciary self-dealing.

2. Mrs. Dashwood Plausibly Alleged Identifiable and Traceable Rebate-Derived Funds.

Elinor plausibly alleged that Defendants retained identifiable, rebate-derived revenue generated by their disloyal formulary practices. Under ERISA § 502(a)(3), equitable monetary relief is available to beneficiaries to compensate for losses caused by fiduciary breaches or to prevent unjust enrichment. *CIGNA Corp. v. Amara*, 563 U.S. 421, 439–42 (2011). This Court recently clarified that restitution or disgorgement falls on the equitable side of the line when it seeks the recovery of specific funds traceable to the defendant's possession. *Aldridge v. Regions Bank*. 144 F.4th 828, 846 (6th Cir. 2025) ("[T]he generic 'restitution' remedy can qualify as either legal or equitable and falls on the equitable side of the divide so long as the plaintiff sought specific funds in the defendant's possession."). Relief must target identifiable funds rather than a defendant's general assets, but at the pleading stage, plaintiffs need only plausibly allege that defendants retained specific, identifiable funds derived from the alleged misconduct. *Patterson v. United Healthcare Ins. Co.*, 76 F.4th 487, 497 (6th Cir. 2023).

The district court held that Dashwood failed to state a claim because she sought recovery of savings rather than identifiable funds. R. at 14. This was a mischaracterization as Elinor sought specific disgorgement of the manufacturer rebate payments generated by Defendants' formulary

policy, which constitute specific, identifiable funds capable of supporting equitable disgorgement. *See Patterson*, 76 F.4th at 495-97; *Rochow*, 41 F.4th at 673-74.

The district court next reasoned that disgorgement was unavailable because the rebate payments flowed to Willoughby RX rather than Willoughby HealthCare. However, ERISA does not permit fiduciaries to evade liability by simply routing plan-related funds through a subsidiary. *See Harris Tr. & Sav. Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238, 250-51 (2000) ("[I]t has long been settled that when a trustee in breach of his fiduciary duty to the beneficiaries transfers trust property to a third person, the third person takes the property subject to the trust . . ."). Further, this Court has allowed claims to proceed where a plaintiff pleaded sufficient factual allegations to suggest an agency relationship between a parent and a subsidiary. *See Midwest Terminals of Toledo Int'l v. Int'l Longshoremen's Ass'n*, No. 22-1330, 2023 WL 4586172, at *5 (6th Cir. July 18, 2023). Here, as in *Patterson*, Dashwood plausibly alleged that Willoughby HealthCare has merely delegated its authority to administer plan benefits to its subsidiary, Willoughby RX, and that each is therefore liable to plan participants and beneficiaries for disgorgement of funds received as a result of their breach of fiduciary duties. *See* 76 F.4th at 498.

The district court further erred in concluding that disgorgement was unavailable because the rebate funds may no longer remain in Willoughby RX's possession. While equitable disgorgement generally requires targeting identifiable funds rather than general assets, plaintiffs at the pleading stage need only allege that defendants retained specific funds or profits derived from the alleged misconduct. *Montanile v. Bd. Of Trs.*, 577 U.S. 136, 144-49 (2016); *Patterson*, 76 F.4th at 495-97. Here, Elinor has done precisely that by alleging that Defendants breached their duties of loyalty and prudence, and engaged in prohibited self-dealing by seeking out drug manufacturer rebates at the expense of plan participants.

Finally, the district court also relied on *Aldridge* in dismissing Dashwood's disgorgement claim, but again misapplied this Court's reasoning. As previously discussed, *Aldridge* held only that § 502(a)(3) cannot convert legal claims into equitable relief when plaintiffs cannot allege fiduciary misconduct or identify traceable assets. *Aldridge*, 144 F.4th 828 (6th Cir. 2025). Here, by contrast, Dashwood alleges classic fiduciary self-dealing prohibited by ERISA's duties of loyalty and prudence, not a contractual dispute over executive compensation and benefits. *See* (Compl. ¶ ¶ 39-41.) Extending *Aldridge* to bar such claims would improperly convert a narrow, fact-intensive decision into a categorical restriction on equitable remedies that conflicts with this Court's precedent in *Patterson*, and the Supreme Court's reasoning in *Amara*.

As such, Elinor plausibly alleged that Defendants retained identifiable rebate-derived revenues generated by the challenged formulary practices, satisfying the traceability requirements at the pleading stage. These allegations satisfy traceability requirements at the pleading stage because they identify a concrete set of funds —manufacturer rebates tied to specific prescription medications—rather than Defendants' general assets. *See Patterson*, 76 F.4th at 495-97 (holding that plausible allegations of retained funds are sufficient at the motion-to-dismiss stage). Because Dashwood's complaint plausibly alleges that Defendants' rebate-driven prescription substitutions generated identifiable revenues retained by Defendants as a result of fiduciary misconduct, she has sufficiently stated a claim for disgorgement under § 502(a)(3).

CONCLUSION

For the foregoing reasons, the Court should reverse the district court's dismissal of Appellant's complaint with prejudice. Tennessee Code § 63-1-202 is not preempted by ERISA, and Elinor Dashwood plausibly alleged claims for fiduciary breach and appropriate equitable relief under ERISA § 502(a)(3), including declaratory and injunctive relief as well as surcharge, and disgorgement. Appellant respectfully requests that this Court overturn the decision of the district court.