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APPLYING THE COMMON FUND DOCTRINE TO AN ERISA-GOVERNED EMPLOYEE BENEFIT PLAN'S CLAIM FOR SUBROGATION OR REIMBURSEMENT

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I. INTRODUCTION

Imagine that you sustain brain injury when your car collides with another vehicle. You incur $1 million in medical expenses, which your employee welfare benefit plan, governed by the Employee Retirement Income Security Act of 1974 (ERISA), covers.[1] You will never be able to work again and are likely to suffer from physical and emotional pain for the rest of your life. You sue the driver of the other vehicle in state court for negligence, seeking $6 million in damages—$3 million for the present net value of your future lost wages, $2 million for past and future physical and emotional pain and suffering, and $1 million for past medical expenses. You settle with the other driver for $1 million—the limit of liability under his automobile liability insurance—in large part because he has no unencumbered assets with which to satisfy any judgment.

As soon as you receive your settlement proceeds, the fiduciary of your ERISA plan sues you in federal court for reimbursement of the $1 million in medical benefits the plan paid on your behalf. The court orders you to pay the $1 million in settlement proceeds to your ERISA plan, even though you were not made whole as a result of your tort lawsuit. Moreover, the court rules that the ERISA plan is not required to pay one cent to your lawyer. You realize that you have gotten absolutely no net benefit from your ERISA plan, that you wasted substantial time pursuing the negligence case, and that you may still owe your lawyer a contingency fee that you will have to pay out of your own pocket.

This result hardly seems fair, particularly given that ERISA was enacted to protect the interests of plan participants and their beneficiaries and to assure the equitable nature of employee benefit plans.[2] Yet, this result would be compelled by existing precedent in many federal courts.[3]

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1. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of the United States Code, including 29 U.S.C. §§ 1001–1461, and the Internal Revenue Code).

2. For a discussion of the purposes of ERISA, see *infra* notes 73–78 and accompanying text.

3. *See, e.g.*, Moore v. Capitalcare, Inc., 461 F.3d 1, 9–11 (D.C. Cir. 2006) (holding that a plan beneficiary must reimburse the plan even though the plan beneficiary was not made whole); Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough, 354 F.3d 348, 360–62 (5th Cir. 2003) (refusing to impose the common fund doctrine which would require the plan to pay its fair share of attorneys' fees and costs incurred in recovering the funds); Walker v. Wal-Mart Stores, Inc. 159 F.3d 938, 940–41 (5th Cir. 1998) (requiring the plan participant to pay the plan the entire settlement amount even though she had not been made whole

Had your claim been governed solely by state law, the common fund doctrine would likely have required the plan to pay its fair share of your attorneys' fees and costs.[4] In addition, state law may well have limited or prohibited the plan's recovery either through an anti-subrogation statute or the common law "made-whole" rule.[5]

In recent years, ERISA-governed employee welfare benefit plans have aggressively pursued recoupment in cases where an injured plan participant recovers medical expenses from a tortfeasor.[6] Typically, plans

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and ruling that the plan did not have to pay any of the attorneys' fees). For a case in which reimbursement was particularly inequitable, see Walker v. Rose, 22 F. Supp. 2d 343, 345 (D.N.J. 1998). There, a nine-year-old boy sustained second- and third-degree burns over most of his body when an aerosol can exploded after being thrown into a fire. *Id.* The boy was covered as a dependent under an ERISA-governed plan that paid more than $1.2 million for medical expenses. *Id.* The boy sued the allegedly responsible parties in state court and his lawyers negotiated a $600,000 settlement. *Id.* When the plan brought suit to enforce its reimbursement right, the court ruled that the plan was entitled to the entire $600,000, leaving the boy and his attorneys with none of the tort recovery. *Id.*

4. For a discussion of state common fund doctrines and statutes, see *infra* notes 65–72 and accompanying text.

5. Most states have adopted the "made-whole" rule, which prohibits an insurer from recovering subrogation or reimbursement until the insured has been completely compensated for all injuries, and several such states have held that insurers cannot contract out of the made-whole rule. *See* GARY L. WICKERT, ERISA AND HEALTH INSURANCE SUBROGATION IN ALL 50 STATES §§ 2.08, 3.18[2] (2d ed. 2006) (observing that most states apply the made-whole rule and that only a minority of jurisdictions allow contract language to override the made-whole rule); *see, e.g.*, Franklin v. Healthsource of Ark., 942 S.W.2d 837, 839–840 (Ark. 1997); Davis v. Kaiser Found. Health Plan, 521 S.E.2d 815, 818 (Ga. 1999); Wine v. Globe Am. Cas. Co., 917 S.W.2d 558, 565 (Ky. 1996); Hare v. State, 733 So. 2d 277, 284 (Miss. 1999); Blue Cross & Blue Shield, Inc. v. Dailey, 687 N.W.2d 689, 699 (Neb. 2004); York v. Sevier County Ambulance Auth., 8 S.W.3d 616, 621 (Tenn. 1999); Rimes v. State Farm Mut. Auto. Ins. Co., 316 N.W.2d 348, 353 (Wis. 1982). Many states have anti-subrogation statutes or administrative regulations completely prohibiting or limiting an insurer's ability to recover subrogation or reimbursement. *See, e.g.*, CONN. GEN. STAT. § 52-225c (2008) (prohibiting subrogation and reimbursement); GA. CODE ANN. § 33-24-56.1 (2008) (limiting subrogation to cases in which the insured has been made whole); IND. CODE § 34-51-2-19 (2008) (limiting subrogation and reimbursement); KAN. ADMIN. REGS. § 40-1-20 (2008) (prohibiting subrogation); ME. REV. STAT. ANN. tit. 24-A, § 2729-A (2008) (limiting subrogation); MINN. STAT. § 62A.095 (2008) (limiting subrogation to cases in which the insured has been made whole); 11 N.C. ADMIN. CODE 12.0319 (2008) (prohibiting subrogation); VA. CODE. ANN. § 38.2-3405 (2008) (prohibiting subrogation).

6. *See* Roger M. Baron, *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 MERCER L. REV. 595, 596 (2004) (observing that, "[l]itigation over reimbursement abounds"); Ellen E. Schultz, *Health Plans Put the Bite on Some Cash Settlements*, WALL ST. J., Sept. 20, 1994, at C1 (discussing increased litigation over subrogation clauses). Many plans also require reimbursement when the plan participant recovers from a third party other than a tortfeasor, such as an insurer that provides uninsured and/or underinsured motorist coverage. *See, e.g.*, Primax Recoveries, Inc. v. Young, 83 F. App'x 523, 525–26 (4th Cir. 2003) (authorizing a plan administrator to seek reimbursement from uninsured motorist coverage proceeds).

include provisions entitling the plan to full reimbursement from any recovery the plan participant receives, irrespective of the amount actually received by the plan participant for medical expenses and irrespective of whether the plan participant is fully compensated for all injuries.[7] Some plans also contain provisions requiring the plan participant to pay all attorneys' fees incurred in the litigation against the third-party tortfeasor.[8] Such provisions are intended to give the plan's claim for recoupment full priority so that every dollar received by the plan participant from a third party will go to the plan until the plan has been fully reimbursed. While some commentators claim these aggressive recoupment attempts are necessary to contain the cost of employee welfare benefit plans,[9] others argue that the cost savings from recoupment are negligible and further argue that such provisions fail to take into account the relative equities between the parties, thwart the civil justice system's ability to compensate injuries, and render many tort cases against negligent third parties economically unfeasible.[10]

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7. For example, some policies or plans contain provisions such as the following:

> This subrogation provision applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Company's right to recover any payments made to you or your dependent by a third party or any insurer acting in place of, or on behalf of a third party or a third party's insurer, because of an injury or illness caused by a third party. Third party means another person or organization.
>
> If you or your dependent receives benefits and have a right to recover damages from a third party, the Company is subrogated to this right. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Company . . . for benefits paid. Any remainder will be yours or your dependents. The Company's share of the recovery will not be reduced because you or your dependent has not received the full damages claimed, unless the Company agrees in writing to a reduction.

Mid Atl. Med. Servs., Inc. v. Sereboff, 303 F. Supp. 2d 691, 697–98 (D. Md. 2004), *aff'd in part, vacated in part, and remanded*, 407 F.3d 212 (4th Cir. 2005), *aff'd*, 547 U.S. 356 (2006).

8. *See, e.g.*, Bishop v. Burgard, 764 N.E.2d 24, 28 (Ill. 2002) (stating the plan at issue provided that "'[a]ll attorney's fees and court costs are the responsibility of the participant, not the Plan.'").

9. *See* THOMAS H. LAWRENCE & JOHN M. RUSSELL, ERISA SUBROGATION 3 (American Bar Association 2000) (urging plan fiduciaries to view recoupment "as essential . . . [to] their overall cost containment efforts"); Mark A. Hofmann, *Health Plan Wins Fight Over Costs Recovery; Ruling Benefits Employers*, BUS. INS., May 22, 2006, at 1 (quoting a representative of the manufacturing industry as stating that "'reimbursements are vital to the ability of health plans to try to keep up with rising health-care costs'").

10. *See* Scott M. Aronson, *ERISA's Equitable Illusion: The Unjust Justice of Section 502(a)(3)*, 9 EMP. RTS. & EMP. POL'Y J. 247, 281–89 (2005) (arguing in Part V that insurers do not consider subrogation when setting insurance rates and that unchecked reimbursement unfairly deprives the tort victim of the right to full compensation); Baron, *supra* note 6, at 620–31 (same); Karen Ertel, *Insurer May Take Share of Damages Award, Supreme Court Rules*, TRIAL, July 2006, at 92, 92 (quoting a trial lawyer as saying that lawyers "'simply will walk away'" from personal

The Supreme Court's recent decision in *Sereboff v. Mid Atlantic Medical Services, Inc.*[11] will likely encourage ERISA-governed plans to assert claims for reimbursement more aggressively.[12] Prior to *Sereboff*, plans were often unsuccessful in recovering reimbursement, in large part because § 502(a)(3) of ERISA limits the relief available to a plan seeking reimbursement to "appropriate equitable relief" necessary to redress a violation of plan provisions requiring reimbursement or subrogation.[13] In several cases, plans attempted to satisfy this requirement by arguing that, in attempting to recover reimbursement, they were essentially trying to impose a constructive trust on funds held by the plan participant. Many such claims failed, however, either because the plan participant no longer had the funds or because the plan was really seeking an award of money damages rather than equitable relief.[14]

In *Sereboff*, however, the Court held that the claim for reimbursement at issue was a claim for "equitable relief" under § 502(a)(3) because both the nature of the relief sought and the basis for the claim were equitable.[15]

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injury cases involving potentially large claims for reimbursement under ERISA); *see also* Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells, 213 F.3d 398, 402 (7th Cir. 2000) (arguing that the "prospect [that a plan will not have to pay its fair share of attorneys' fees] might well deter a suit likely to result in a judgment or settlement not much larger than the benefits available under the plan—and in that event the language on which the plan relies would produce undercompensation for harms that were unrelated to the type of harm to which the benefits pertain").

11. 547 U.S. 356 (2006).

12. *See* Thomas R. McLean & Edward P. Richards, *The Ruling in 'Sereboff*,' NAT'L L.J., Aug. 21, 2006, at 13, 13 (predicting that, after *Sereboff*, "ERISA health plans will be much more aggressive in asserting claims for reimbursement . . . ."); Peter H. Wayne, IV & Mark R. Taylor, *Beware the ERISA Health Plan Lien*, TRIAL, Dec. 2007, at 48, 49 (observing that "*Sereboff* has emboldened ERISA plan administrators everywhere").

13. Section 502(a)(3) authorizes a plan fiduciary to bring a claim for "appropriate equitable relief" to enforce plan provisions requiring subrogation or reimbursement. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (2006). For purposes of § 502(a)(3), "equitable relief" excludes legal relief and means "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993). For a discussion of why plans must bring their reimbursement claims pursuant to § 502(a)(3) of ERISA rather than asserting breach of contract claims based on state law, see *infra* Part IV.B.

14. *See* Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 213–15 (2002) (prohibiting the plan's claim for reimbursement because it was a legal claim for money damages rather than an equitable claim for recovery of particular funds in the possession of the defendant); Primax Recoveries, Inc. v. Sevilla, 324 F.3d 544, 548 (7th Cir. 2003) (finding that the claim asserted by an ERISA fiduciary was for legal rather than equitable relief); Westaff (USA) Inc. v. Arce, 298 F.3d 1164, 1166–67 (9th Cir. 2002), *abrogated by Sereboff*, 547 U.S. at 356 (holding that an ERISA administrator's claim was not a claim for equitable relief where the funds sought were in an escrow account); Bauhaus USA, Inc. v. Copeland, 292 F.3d 439, 444–45 (5th Cir. 2002) (finding that the claim for reimbursement was not a claim for equitable relief where the funds sought were in the registry of the court).

15. *Sereboff*, 547 U.S. at 363. The Court's two-prong analysis is substantially consistent with

The Court held that the relief sought—recovery of particular funds in the possession of the Sereboffs—was equitable in nature.[16] In addition, the Court found that the claim that plan language created an equitable lien by agreement was a claim that sounded in equity.[17] Thus, the Court's holding that plans may recover reimbursement under § 502(a)(3) when the underlying facts support the existence of an equitable lien by agreement provides an additional basis upon which plans may pursue reimbursement.

Even though the *Sereboff* opinion supplies some clarity as to what constitutes a claim for "equitable relief" pursuant to § 502(a)(3), the assertion of subrogation and reimbursement claims continues to raise issues that have not been uniformly resolved. For example, in *Great-West Life & Annuity Insurance Co. v. Knudson*,[18] the Supreme Court acknowledged, but did not resolve, the issue of whether ERISA preempts state-law actions for reimbursement or subrogation.[19] Lower courts have failed to resolve this issue in a consistent manner.[20]

A similar issue is whether ERISA preempts state common fund doctrines. Some lower courts have found state common fund doctrines have been expressly preempted while others have not.[21] Further complicating the question is the possibility that some state laws requiring insurers to pay a pro rata share of attorneys' fees are contained in anti-subrogation statutes that fall within the scope of ERISA's express preemption clause but may nevertheless be saved from preemption because they regulate insurance.

In *Kentucky Association of Health Plans, Inc. v. Miller*,[22] the Supreme Court established a new test for determining whether state laws regulate insurance and are therefore saved from preemption by ERISA's savings clause.[23] Even though the *Miller* test broadened the scope of the savings clause,[24] at least one lower court has recently applied the test in a manner

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its jurisprudence concerning a party's Seventh Amendment right to jury trial. The Court has held that a party is entitled to a jury trial in suits where legal rights, rather than equitable rights, are determined. Chauffeurs, Teamsters and Helpers, Local No. 391, 494 U.S. 558, 564 (1990). In order to determine whether legal rights are at stake in a particular case, the court must first examine the nature of the claim by determining whether analogous eighteenth century claims were tried at law or in equity. *Id*. at 565. Second, the court must determine whether the remedy sought "is legal or equitable in nature." *Id*. (citing Tull v. United States, 481 U.S. 412, 417–18 (1987)).

16. *Sereboff*, 547 U.S. at 362–63.

17. *Id*.

18. 534 U.S. 204 (2002).

19. *Id.* at 220.

20. *See infra* notes 95–98 and accompanying text.

21. *See infra* notes 159–61 and accompanying text.

22. 538 U.S. 329 (2003).

23. *Id.* at 341–42.

24. *See infra* notes 203–14 and accompanying text for a discussion of how the *Miller* test broadened the scope of the savings clause.

inconsistent with congressional intent to save state laws regulating insurance from preemption.[25]

Yet another issue is whether appropriate equitable relief under § 502(a)(3) should be interpreted as relief consistent with equitable principles such as the common fund doctrine.[26] The Court recognized this issue in *Sereboff*, but did not resolve it. Because the Sereboffs had not properly raised the issue below,[27] the Court refused to address their argument that equitable relief is not "appropriate" unless consistent with other equitable principles such as the made-whole rule and the common fund doctrine.

This Article attempts to resolve many of these issues, not only to clarify the law and facilitate its just interpretation, but also to provide plan participants and their counsel with some certainty so they can evaluate the value of the plan participant's tort claim against third parties.[28] Part II of this Article explains subrogation and reimbursement. Part III of this Article explores the historical origins of the common fund doctrine and examines its modern application by the states. Part IV argues that ERISA preempts state-law claims for subrogation and reimbursement, making § 502(a)(3) claims for "appropriate equitable relief" the only mechanism by which plan fiduciaries may enforce subrogation or reimbursement provisions. Part V analyzes whether state common fund doctrines or statutes codifying the doctrine apply to § 502(a)(3) claims and concludes that many state common fund doctrines and statutes are not preempted, either because they do not fall within the scope of the express preemption clause or because they are laws regulating insurance and are therefore saved from preemption. Part VI concludes by urging courts to interpret "appropriate equitable relief" as relief consistent with the common fund doctrine.

II. SUBROGATION AND REIMBURSEMENT

A. *Equitable Subrogation*

Equitable subrogation arises by law, while contractual subrogation arises as a result of contract language.[29] The equitable right to subrogation

25. *See infra* Part V.B.

26. Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 368 (2006).

27. *Id.* at 368 n.2.

28. Issues concerning an ERISA-governed plan's ability to recover subrogation or reimbursement are likely to continue to arise given that in 2002 approximately 137 million people were covered by employer-sponsored health care plans governed by ERISA. Brief for Secretary of Labor as Amicus Curiae Supporting Appellant's Petition for En Banc Rehearing, Qualchoice, Inc. v. Rowland, 367 F.3d 638 (6th Cir. 2004) (No. 02-3614), 2004 WL 3769987, at *13.

29. 1 DAN B. DOBBS, LAW OF REMEDIES: DAMAGES-EQUITY-RESTITUTION § 4.3(4) (2d ed. 1993).

arises when one pays the debt of another who is primarily liable for that debt.[30] The one who paid the debt may then "[step] into the [creditor's] shoes" and assert the creditor's claims against the party who is primarily liable.[31] The subrogated party may recover from the primarily liable party only to the extent the creditor could have recovered on the same claim.[32]

For example, assume that Sally, an automobile passenger, was injured in a car wreck caused by the negligence of John, the driver. Further assume that Sally's health insurer paid her medical expenses. Sally's health insurer may then step into Sally's shoes and assert Sally's claim for those medical expenses against John, the primarily liable party. Subrogation evolved as an equitable remedy to prevent unjust enrichment.[33] If Sally were permitted to recover from both the health insurer and the tortfeasor for the same medical expenses, Sally would be unjustly enriched by the double recovery.[34] Subrogation also ensures that ultimate liability falls on the legally responsible party—John, the negligent driver—rather than the health insurer.[35] Therefore, subrogation ensures a just result by preventing the insured from receiving a windfall and allocating ultimate liability to the negligent tortfeasor.

A claim for equitable subrogation, however, will be defeated or limited when other equitable principles, such as the made-whole rule, the common fund doctrine, laches or unclean hands, prohibit relief.[36] The made-whole rule prohibits subrogation if the insured has not been fully compensated for her injuries because such an insured has not been unjustly enriched.[37] Similarly, equitable principles require application of the common fund doctrine to prevent the unjust enrichment of insurers that would result if insurers were permitted to recover subrogation without paying a fair share of attorneys' fees.[38]

B. *Contractual Subrogation and Reimbursement*

True subrogation provisions authorize the insurer to step into the insured's shoes to pursue his rights against the tortfeasor. In

30. *Id.*

31. *Id.*

32. *Id.*

33. *See* 4 GEORGE E. PALMER, THE LAW OF RESTITUTION § 23.1, at 344 (1978).

34. Subrogation also furthers the principle of indemnity in that it prevents an insured from receiving a windfall. *See* ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW § 96[a] (4th ed., Matthew Bender & Co. 2007).

35. *See id.* In this way, subrogation also ensures that the primarily liable defendant is not unjustly enriched by being relieved of liability. *See* PALMER, *supra* note 33, § 23.1, at 344.

36. *See* JERRY & RICHMOND, *supra* note 34, § 96[b].

37. *See* JERRY & RICHMOND, *supra* note 34, § 96[d][i]; PALMER, *supra* note 33, § 23.1, at 344. Most states apply the made-whole rule to equitable claims for subrogation. *See* WICKERT, *supra* note 5, § 2.08.

38. *See infra* notes 66–72 and accompanying text.

comparison, reimbursement provisions give rise to a contract claim against the insured for reimbursement after the insured has recovered from the tortfeasor.[39] In an effort to secure recoupment where equitable subrogation would be barred, many insurance policies and employee welfare benefit plans include language authorizing subrogation even when the insured has not been made whole.[40] Many insurance policies and benefit plans also obligate the insured, plan participant, or beneficiary to reimburse the insurer or plan for covered medical expenses regardless of whether she has been made whole.[41] In addition, some policies and plans expressly disclaim the common fund doctrine.[42] Yet, on public policy grounds, state courts have frequently applied the common fund doctrine to subrogation and reimbursement claims[43] and have also refused to enforce policy provisions requiring full reimbursement to the insurer.[44]

III. THE COMMON FUND DOCTRINE

A. *Historical Origins of the Common Fund Doctrine*

The common fund doctrine requires that one who passively benefits from a fund created or preserved through litigation must share the cost of the litigation.[45] The development of the common fund doctrine in federal court can largely be traced to three opinions.[46]

First, in *Trustees v. Greenough*,[47] Francis Vose, a bondholder, sued the trustees of a fund out of which the bondholders were to be paid.[48] Vose sued on his own behalf and on behalf of other bondholders.[49] The litigation, which was completely financed by Vose, increased the value of the fund to the benefit of all bondholders.[50] The Supreme Court affirmed

39. LAWRENCE & RUSSELL, *supra* note 9, at 4; John R. Cella, Jr., *The Pursuit of Proceeds by Plans, Participants and Plaintiffs' Lawyers: Dissonant Solutions to an Alliterative Problem*, 22 CAMPBELL L. REV. 317, 319–23 (2000).

40. For an example, see the policy language quoted in *supra* note 7.

41. *Id.*

42. For an example, see the policy language quoted in *supra* note 7.

43. *See infra* notes 66–72 and accompanying text.

44. *See* WICKERT, *supra* note 5, § 3.18[2] (observing that a majority of jurisdictions refuse to allow contract language to override the made-whole rule). For cases in which state courts have so refused, see *supra* note 5.

45. *See* DOBBS, *supra* note 29, § 3.10(2); WICKERT, *supra* note 5, § 2.09.

46. *See* John P. Dawson, *Lawyers and Involuntary Clients: Attorney Fees From Funds*, 87 HARV. L. REV. 1597, 1601–12 (1974); Johnny Parker, *The Common Fund Doctrine: Coming of Age in the Law of Insurance Subrogation*, 31 IND. L. REV. 313, 316–20 (1998).

47. 105 U.S. 527 (1881).

48. *Id.* at 528.

49. *Id.*

50. *Id.* at 529.

the lower court's award of costs, expenses and attorneys' fees to Vose, concluding:

> It would not only be unjust to him, but it would give to the other parties entitled to participate in the benefits of the fund an unfair advantage. He has worked for them as well as for himself; and if he cannot be reimbursed out of the fund itself, they ought to contribute their due proportion of the expenses which he has fairly incurred. To make them a charge upon the fund is the most equitable way of securing such contribution.[51]

The Court observed that the award to Vose was consistent with "the principles of equity and justice."[52]

Second, in *Central Railroad & Banking Co. v. Pettus*,[53] the attorneys, rather than the client, directly asserted a claim for attorneys' fees.[54] The lawyers had filed suit on behalf of a class of unsecured creditors seeking to have their mortgages declared superior to those of other unsecured creditors.[55] The suit resulted in a lien upon certain property, thereby bringing such property within the control of the lower court.[56] In affirming the lower court's award of attorneys' fees, the Court held that an award of attorneys' fees out of the common fund could be made directly to the attorneys.[57] In response to the passive creditors' arguments that they had no contract with the lawyers, the Court reasoned that those who had "accepted the fruits of the [lawyers'] labors" should "contribute to the expenses."[58]

Third, in *Sprague v. Ticonic National Bank*,[59] the Court emphasized that the award of attorneys' fees was within a court's historic equitable power.[60] Sprague sued on her own behalf and successfully asserted a lien upon the proceeds of certain bonds.[61] She then argued that, in doing so, she had established the right of others similarly situated to assert a similar lien by virtue of stare decisis.[62] The Court held that even though Sprague did not purport to represent the entire class and did not automatically create a

51. *Id.* at 532.
52. *Id.* at 536–37.
53. 113 U.S. 116 (1885).
54. *Id.* at 120.
55. *Id.* at 118–20.
56. *Id.* at 124.
57. *Id.* at 124–25.
58. *Id.* at 127.
59. 307 U.S. 161 (1939).
60. *Id.* at 164–65.
61. *Id.* at 162–63.
62. *Id.* at 163.

fund for others similarly situated, she did "for all practical purposes" make a fund available to the others.[63] The Court ruled that the award of attorneys' fees depends upon the individual circumstances in every case, noting that "individualization in the exercise of a discretionary power will alone retain equity as a living system and save it from sterility."[64] The Court has recently affirmed the equitable power of federal courts to award attorneys' fees for the creation of a common fund.[65]

B. *Modern Application of the Common Fund Doctrine*

Today, almost all states have adopted the common fund doctrine in order to prevent the unjust enrichment of claimants who did not contribute to the creation of the fund.[66] Although the common fund doctrine is routinely applied in cases involving subrogation and reimbursement,[67] its reach is much broader. The doctrine is frequently applied in class action cases, cases where a litigant has created or preserved a trust, and cases involving insurers' subrogation or reimbursement claims.[68] The doctrine applies in all cases where an attorney has created the fund by performing legal services and someone other than the attorney's client benefits from the fund without contributing to its creation.[69] In awarding fees and costs, courts have broad discretion and often award a fee based on the fee arrangement between the attorney and her client.[70] Some states have

63. *Id.* at 166–67.

64. *Id.* at 167.

65. *See* Chambers v. NASCO, Inc., 501 U.S. 32, 45 (1991) (citing Alyeska Pipeline Serv. Co. v. Wilderness Soc'y, 421 U.S. 240, 257–58 (1975)).

66. *See* ROBERT L. ROSSI, ATTORNEYS' FEES § 7:20 (3d ed. 2002) (collecting cases); WICKERT, *supra* note 5, §§ 2.09, 3.01–3.51 (observing that the majority of states have adopted the common fund doctrine and examining the application of the rule in all fifty states); Parker, *supra* note 46, at 337–38 (observing that all but two states have adopted the rule); *see, e.g.*, Edwards v. Alaska Pulp Corp., 920 P.2d 751, 755 (Alaska 1996) (stating that the "common fund doctrine is a fee-spreading mechanism which prevents unjust enrichment of those who derive benefit from the efforts of others"); Scholtens v. Schneider, 671 N.E.2d 657, 665 (Ill. 1996) (noting that the doctrine is based "upon equitable considerations of *quantum meruit* and the prevention of unjust enrichment").

67. *See* Parker, *supra* note 46, at 337–38 (calculating that twenty states have specifically applied the common fund doctrine to insurance subrogation while the remaining states that have adopted the common fund doctrine have not specifically addressed its application to insurance subrogation).

68. *See* DOBBS, *supra* note 29, § 3.10(2); Parker, *supra* note 46, at 322.

69. *See* DOBBS, *supra* note 29, § 3.10(2).

70. *See* Parker, *supra* note 46, at 323 & n.54. For a discussion of how attorneys' fees are and should be calculated in class action cases, see generally R. Eric Kennedy, *Class Action Attorney Fees: The Key Role of the Federal District Judge in Fashioning & Monitoring Mass-Tort Common Fund Distributions to Assure a Settlement Deemed Equitable by Both Represented & Unrepresented Class Members, & Both Private & Class Counsel*, 6 SEDONA CONF. J. 173 (2005) and Michael Northrup, *Restrictions on Class-Action Attorney-Fee Awards*, 46 S. TEX. L. REV. 953

explicitly held that an insurer cannot contract out of the common fund doctrine,[71] while several others have enacted statutes requiring its application to insurers seeking subrogation or reimbursement.[72]

IV. ERISA PREEMPTION OF STATE-LAW CLAIMS FOR SUBROGATION OR REIMBURSEMENT

To understand how ERISA impacts an ERISA-governed employee benefit plan's ability to obtain subrogation or reimbursement, one must first consider the purposes of ERISA and closely examine its civil enforcement and preemption provisions.

A. *ERISA*

1. Purpose and Statutory Standards

Congress enacted ERISA in 1974 to protect the interests of employees and their beneficiaries in employee benefit plans.[73] Congress explicitly stated that it was acting to "assur[e]"[74] and "improv[e] the equitable character . . . of such plans."[75] To accomplish these goals, ERISA (1) established participation, vesting and funding standards; (2) imposed various duties upon plan fiduciaries; (3) required greater reporting and

(2005).

71. *See, e.g.*, Bishop v. Burgard, 764 N.E.2d 24, 28–29 (Ill. 2002) (applying the common fund doctrine despite language obligating the plan participant to pay all attorneys' fees and court costs); Hamm v. State Farm Mut. Auto. Ins. Co., 88 P.3d 395, 403 (Wash. 2004) (holding that "the rule requiring a pro rata sharing of legal expenses is based on equitable principles and not on construction of specific policy language[,]" thereby suggesting policy provisions are immaterial (citing Winters v. State Farm Mut. Auto. Ins. Co., 31 P.3d 1164, 1167 n.2 (Wash. 2001))).

72. *See, e.g.*, ARK. CODE ANN. § 23-79-146 (2008) (requiring insurers to pay a pro-rata share of attorneys' fees when recovering subrogation); GA. CODE ANN. § 33-24-56.1(b)(2) (2008) (requiring insurers to pay a pro-rata share of attorneys' fees when recovering subrogation or reimbursement); IND. CODE § 34-51-2-19 (2008) (requiring insurers to pay a pro-rata share of attorneys' fees and expenses when recovering subrogation or reimbursement); IOWA CODE § 668.5 (2008) (requiring contractually subrogated persons to pay a pro-rata share of attorneys' fees and expenses); MINN. STAT. § 62A.095 (2008) (requiring insurers to pay a pro-rata share of attorneys' fees and costs when recovering subrogation).

73. ERISA, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. § 1001(a)–(c) (2006)) (citing the public policy of protecting the interests of plan participants and beneficiaries); *see also* Boggs v. Boggs, 520 U.S. 833, 845 (1997) ("The principal object of the statute is to protect plan participants and beneficiaries."); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90 (1983) ("ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans."); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 515 (1981) (noting that ERISA's primary goal was to benefit employees and that a secondary goal was to contain costs).

74. 29 U.S.C. § 1001(a).

75. *Id.* § 1001(c).

disclosure by plans; and (4) created a system of insurance to insure against loss caused by plan termination.[76] Even though the legislation originally focused on pension plans, ERISA also regulates employee welfare benefit plans that provide employees with "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death."[77] ERISA applies to self-insured plans as well as to plans that purchase insurance to secure benefits.[78]

2. Civil Enforcement Scheme

To enforce the regulatory scheme established by ERISA, Congress included § 502, which has several parts. Section 502(a)(1)(B) authorizes plan participants and beneficiaries to sue to recover benefits.[79] Section 502(a)(2) authorizes plan participants, beneficiaries, or fiduciaries to sue fiduciaries for breach of a fiduciary duty.[80] Section 502(a)(3) authorizes a plan

> participant, beneficiary or fiduciary [to bring a civil action:] (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.][81]

Thus, the only claim that a plan fiduciary may bring under ERISA to recover subrogation or reimbursement from a plan participant or beneficiary is a claim pursuant to § 502(a)(3) for "appropriate equitable relief" to redress an alleged violation of plan terms.

Federal and state courts have concurrent jurisdiction over civil actions to recover benefits under § 502(a)(1)(B).[82] Federal courts have exclusive jurisdiction over claims brought by participants, beneficiaries or fiduciaries pursuant to § 503(a)(2) or (3).[83] Congress created federal question jurisdiction over these claims so that plan participants might have "ready access to the Federal courts" to enforce their new statutory rights.[84]

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76. *See* PAUL J. SCHNEIDER & BARBARA W. FREEDMAN, ERISA: A COMPREHENSIVE GUIDE §§ 1.01, 1.04 (2d ed. 2003).

77. 29 U.S.C. § 1002(1) (2006).

78. *Id.*

79. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (2006).

80. ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2) (2006).

81. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (2006). Section 502 authorizes additional types of civil actions; none are as widely used as those authorized by subsection (a)(1)(B). *See* SCHNEIDER & FREEDMAN, *supra* note 76, § 8.02.

82. ERISA § 502(e), 29 U.S.C. § 1132(e) (2006).

83. *Id.*

84. *See* ERISA § 2(b), 29 U.S.C. § 1001(b) (2006).

3. Preemption Provisions

In addition to the comprehensive civil enforcement scheme, ERISA also contains preemption provisions, described by sponsors of ERISA as its "'crowning achievement.'"[85] For the purpose of replacing conflicting state and local regulation of employee benefit plans with uniform federal regulation,[86] § 514 expressly preempts and "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."[87] ERISA defines state law to include all state statutes, regulations, and common law.[88] However, any state law "which regulates insurance" is saved from preemption.[89] This savings clause is consistent with Congress' belief that state, rather than federal, regulation of insurance is in the public's best interest.[90] To ensure that states do not inappropriately use insurance law to regulate employee benefit plans, Congress included a provision in ERISA known as the deemer clause, which provides that an employee benefit plan shall not be "deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts."[91] Under existing precedent, the savings and deemer clauses have the effect of subjecting insured plans to state laws regulating insurance even though self-funded plans are not subjected to such regulation.[92]

B. *Preemption of State-Law Claims for Reimbursement or Subrogation*

In *Great-West Life & Annuity Insurance Co. v. Knudson*,[93] the Supreme Court acknowledged as an issue, but failed to resolve, whether ERISA preempts state-law claims for subrogation or reimbursement.[94] Lower

85. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987) (quoting Representative Dent in the Congressional Record, 120 Cong. Rec. 29197 (1974)).

86. *Id.* (citing Senator Williams' statement in the Congressional Record, 120 Cong. Rec. 29933 (1974)).

87. ERISA § 514(a), 29 U.S.C. § 1144(a) (2006).

88. ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1) (2006).

89. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (2006).

90. When enacting the McCarran-Ferguson Act in 1945, "Congress . . . declare[d] that the continued regulation and taxation by the several States of the business of insurance is in the public interest . . . ." 15 U.S.C. § 1011 (2006); *see also* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 744 n.21 (1985) ("The ERISA saving clause . . . appears to have been designed to preserve the McCarran-Ferguson Act's reservation of [regulation of] the business of insurance to the States.").

91. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (2006).

92. *See Metro. Life Ins.*, 471 U.S. at 747 (recognizing that its interpretation of the "deemer" clause exempts self-funded plans from state insurance regulation to which insured plans are subject).

93. 534 U.S. 204 (2002).

94. *Id.* at 220 ("We express no opinion as to whether [the plan fiduciary] could have intervened in the state-court tort action brought by [the plan participants] or whether a direct action by [the plan fiduciary] against [the plan participants] asserting state-law claims such as breach of

courts have split on the issue. The U.S. Court of Appeals for the Sixth Circuit and state courts in California, Florida, and Oregon have found state-law claims for reimbursement or subrogation preempted.[95] Similarly, state courts in Kansas and Louisiana have dismissed state-law claims for reimbursement or subrogation for lack of jurisdiction.[96] The U.S. Court of Appeals for the Ninth Circuit and the Supreme Court of Hawaii, however, have found that such claims are not preempted.[97] In addition, state courts in Mississippi, Oklahoma, and Tennessee have found jurisdiction over such claims without specifically addressing preemption.[98] This Article argues that state-law claims for subrogation and reimbursement are expressly, impliedly, and completely preempted by ERISA.

1. Express Preemption

Parties continue to litigate the scope of the express preemption under § 514(a) despite the Court's repeated attempts to clarify the issue.[99] In an early preemption case, the Court, noting that an early draft of the ERISA bill contained a much more limited preemption clause, held that "Congress used the words 'relate to' . . . in their broad sense."[100] The Court concluded that "[a] law 'relates to' an employee benefit plan, in the normal sense of

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contract would have been pre-empted by ERISA.").

95. *See* Cmty. Ins. Co. v. Morgan, 54 F. App'x. 828, 832 (6th Cir. 2002) (finding express preemption); Jefferson-Pilot Life Ins. Co. v. Krafka, 57 Cal. Rptr. 2d 723, 725–26 (Cal. Ct. App. 1996) (finding express preemption and lack of jurisdiction over a claim exclusively within federal court jurisdiction); MEBA Med. & Benefits Plan v. Lago, 867 So. 2d 1184, 1187–90 (Fla. 4th DCA 2004) (finding the health plan's common-law claim for reimbursement preempted by ERISA); Liberty Nw. Ins. Corp. v. Kemp, 85 P.3d 871, 877–79 (Or. Ct. App. 2004) (finding express preemption and implied conflict preemption).

96. *See* Funk Mfg. Co. v. Franklin, 927 P.2d 944, 949 (Kan. 1996) (finding that federal courts have exclusive jurisdiction over claims to recover subrogation or reimbursement); A. Copeland Enters., Inc. v. Slidell Mem'l Hosp., 657 So. 2d 1292, 1302 (La. 1995) (same).

97. *See* Providence Health Plan v. McDowell, 385 F.3d 1168, 1172 (9th Cir. 2004); AFL Hotel and Rest. Workers Health & Welfare Trust Fund v. Bosque, 132 P.3d 1229, 1236–37 (Haw. 2006).

98. *See* Yerby v. United Healthcare Ins. Co., 846 So. 2d 179, 182–83 (Miss. 2002) (holding that the plan fiduciary could intervene in the plan participant's tort law suit to recover reimbursement); Reeds v. Walker, 157 P.3d 100, 109–12 (Okla. 2006) (finding that the state-law claim for breach of contract was within the state court's jurisdiction because it did not seek equitable relief pursuant to § 502(a)(3)); Hamrick's, Inc. v. Roy, 115 S.W.3d 468, 475–76 (Tenn. Ct. App. 2003) (same).

99. *See* De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 808 n.1 (1997) (observing that the Court had decided numerous cases involving the scope of the express preemption clause and that the clause "has also generated an avalanche of litigation in the lower courts"); Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., 519 U.S. 316, 335 (1997) (Scalia, J., concurring) (suggesting that the Court's "prior decisions [addressing preemption] have not succeeded in bringing clarity to the law"). As of 2004, there have been more than 8,000 reported state and federal court cases addressing preemption under § 514(a). *Liberty Nw. Ins.*, 85 P.3d at 873.

100. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 98 (1983).

the phrase, if it has a connection with or reference to such a plan."[101] Under this rubric, the Court found that the following laws were related to an employee benefit plan: a New York law prohibiting employers from implementing plans that discriminate on the basis of pregnancy;[102] a New York law requiring employers to pay certain benefits;[103] a Massachusetts law requiring minimum mental health benefits;[104] a Georgia statute explicitly barring the garnishment of funds or benefits belonging to an ERISA employee benefit plan or program;[105] and a Pennsylvania anti-subrogation statute.[106]

In a series of cases addressing preemption of state-law claims, the Court repeatedly found that state-law claims based on plan provisions were preempted. In *Pilot Life Insurance Co. v. Dedeaux*,[107] the Court found that ERISA preempted Mississippi common law authorizing claims for bad faith and tortious breach of contract for failure to pay benefits owed under the insurance policy.[108] Without analysis, the Court held that the common-law claims undisputedly related to an employee benefit plan and were therefore expressly preempted.[109] In *Metropolitan Life Insurance Co. v. Taylor*,[110] the Court summarily found that ERISA expressly preempted Michigan common law authorizing contract claims for failure to pay benefits and tort claims for mental anguish caused by the failure to pay.[111] In *Ingersoll-Rand Co. v. McClendon*,[112] an employee brought a wrongful-termination claim against his employer based on Texas state tort and contract law, alleging that his employer terminated him just prior to his benefits vesting to avoid paying pension fund contributions.[113] The Court concluded that the state-law claim clearly related to an employee benefit plan and was therefore expressly preempted by § 514(a) of ERISA:

> We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan . . . . Here, the existence of a . . . plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of

101. *Id.* at 96–97; s*ee also* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985).
102. *Shaw*, 463 U.S. at 97.
103. *Id.*
104. *Metro. Life Ins.*, 471 U.S. at 739.
105. Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829–30 (1988).
106. FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990).
107. 481 U.S. 41 (1987).
108. *Id.* at 48.
109. *Id.* at 47.
110. 481 U.S. 58 (1987).
111. *Id.* at 62 (quoting ERISA § 514(a), 29 U.S.C. § 1144(a) (2006)). As discussed in more detail at *infra* notes 137–43 and accompanying text, the Court further found that the state-law claims were completely preempted.
112. 498 U.S. 133 (1990).
113. *Id.* at 135–36.

> action relates not merely to [plan] benefits, but to the essence of the . . . *plan* itself.[114]

In each of these cases, the preempted state-law claims required interpretation of—and were contingent upon—the plan.

In 1995, the Court, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,[115] retreated from its jurisprudence broadly interpreting the express preemption clause.[116] Although the Court affirmed that a state law relates to an employee benefit plan when it references or has a connection with such a plan, the Court held that to determine whether a state law has a prohibited connection with an employee benefit plan, the Court must look to the objectives of ERISA, one of which is to foster nationally uniform administration of benefit plans.[117] In deciding that the New York law at issue, which required hospitals to impose surcharges on certain HMOs and patients, was not preempted, the Court emphasized that although the law would have an "indirect economic influence" given that the surcharges would likely cause an increase in the cost of insurance, it would not "preclude uniform administrative practice or the provision of a uniform interstate benefit package."[118]

Even under its restrictive post-*Travelers* approach to express preemption, the Court made clear that state-law causes of action are preempted if "the existence of a[n] [employee benefit] plan is a critical element of a state-law cause of action[.]"[119] Clearly, the subrogation or reimbursement provisions of a plan are critical to any state-law claim for subrogation or reimbursement.[120] Therefore, state-law claims for subrogation or reimbursement are expressly preempted by ERISA.

The Ninth Circuit's holding to the contrary in *Providence Health Plan* rests on faulty reasoning. The court held that the plan's claim for

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114. *Id.* at 139–40.

115. 514 U.S. 645 (1995).

116. *See id.* at 656–57.

117. *Id.* ("For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections."). *See also* Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After* Pegram v. Herdrich*: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 8–20 (2001).

118. *Id.* at 659–60.

119. De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 815 & n.14 (1997).

120. *See* Cmty. Ins. Co. v. Morgan, 54 F. App'x. 828, 832 (6th Cir. 2002) ("[W]e think it is clear that the dispute cannot be resolved without resort to the terms of the ERISA plan, and that being so, [the plan fiduciary's] state law claim [for subrogation and reimbursement] has a connection with that plan."); Liberty Nw. Ins. Corp. v. Kemp, 85 P.3d 871, 877 (Or. Ct. App. 2004) ("[The] complaint [for reimbursement] derives from and is based on an employee benefit plan . . . . To prevail, plaintiff had to prove the existence of the employer benefit plan and a violation of one of its terms . . . . The claim therefore 'has reference to' ERISA.").

reimbursement did not have the necessary "connection with" or "reference to" the employee benefit plan because the plan was merely attempting to enforce the reimbursement provision through contract law.[121] Amazingly, the court concluded that "[a]djudication of [a claim for reimbursement] does not require interpreting the plan . . . ."[122] Contrary to the court's holding, however, claims for reimbursement and subrogation are based on plan provisions and do require interpretation of such plan provisions.[123] Consequently, state-law claims for subrogation or reimbursement are expressly preempted by § 514(a) of ERISA. This reasoning means that state-law claims for subrogation or reimbursement are preempted regardless of whether the plan fiduciary initiates a direct civil action against the plan participant or third-party tortfeasor, or moves to intervene in the plan participant's tort case. Given that the plan fiduciary's ability to intervene on behalf of the plan is based on plan subrogation and reimbursement provisions, such intervention "relates to" an employee benefit plan in exactly the same way a direct claim for reimbursement or subrogation does.

2. Implied Preemption

Even if not expressly preempted by § 514(a), state-law claims may be preempted according to ordinary principles of implied conflict preemption.[124] In *Ingersoll-Rand Co. v. McClendon*,[125] the Court found that Texas common law authorizing a claim for wrongful termination, allegedly motivated by the employer's desire to avoid contributing to the

121. Providence Health Plan v. McDowell, 385 F.3d 1168, 1172 (9th Cir. 2004).

122. *Id.*

123. Although the Supreme Court has suggested that "run-of-the-mill state-law claims" do not relate to plans simply because they may be brought by or against plans, see Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 833 (1988), claims for reimbursement or subrogation are more than "run-of-the-mill state-law claims" because they are claims that are necessarily based upon the provisions of the plan. Thus, such claims are easily distinguishable from the state-law claim for garnishment that the Court found was not preempted in *Mackey* because the garnishment claim at issue there was in no way based upon the terms of the plan. *See id.* at 831; *see also Liberty Nw. Ins*., 85 P.3d at 876–77 (similarly arguing that state-law claims for reimbursement and subrogation are not generic run-of-the mill state-law claims).

124. Sprietsma v. Mercury Marine, 537 U.S. 51, 64 (2002). State law is impliedly preempted when the scope of the federal legislation indicates that Congress intended to exclusively occupy the entire field of legislation (field preemption), or when it is impossible for a party to comply with both state and federal law or the state law "'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress'" (conflict preemption). *Id.* at 64–65 (quoting Hines v. Davidowitz, 312 U.S. 52, 67 (1941)); *see also* Boggs v. Boggs, 520 U.S. 833, 841 (1997) (noting that express preemption, implied field preemption, and implied conflict preemption are alternative grounds upon which to find ERISA preemption). Ordinary implied preemption principles apply despite the presence of the express preemption clause. *Mercury Marine*, 537 U.S. at 65.

125. 498 U.S. 133 (1990).

terminated employee's pension fund, was impliedly preempted because it conflicted with the exclusive enforcement mechanism provided by § 502(a)(3) to enjoin acts that violate ERISA provisions, including § 510, which prohibits termination of plan participants for the purpose of avoiding vesting of benefits.[126] In so finding, the Court relied heavily upon its conclusion in *Pilot Life Insurance Co. v. Dedeaux*[127] that Congress intended § 502(a) to be the exclusive remedy to enforce ERISA rights:

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.[128]

The Court further held that § 502(a)'s exclusive remedy "is precisely the kind of 'special featur[e]' that 'warrant[s] pre-emption.'"[129] In a later description of its *Ingersoll-Rand* opinion, the Court noted that the state-law claim for money damages "provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA" and was therefore incompatible with the equitable claim available under ERISA.[130]

More recently, in *Aetna Health Inc. v. Davila*,[131] the Court held that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."[132] Under the Court's holding, a state-law claim is preempted when it provides a type of relief unavailable under ERISA even if the elements of

126. *Id.* at 142–44; *see supra* notes 112–14 and accompanying text (discussing the Court's alternative finding of express preemption in *Ingersoll-Rand*).

127. 481 U.S. 41 (1987).

128. *Ingersoll-Rand*, 498 U.S. at 144 (omission in original) (internal quotation marks omitted) (quoting *Pilot Life*, 481 U.S. at 54).

129. *Id.* (alterations in original) (quoting English v. Gen. Elec. Co., 496 U.S. 72, 87 (1990)).

130. Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379 (2002).

131. 542 U.S. 200 (2004).

132. *Id.* at 209.

the state-law claim are not exact duplicates of the ERISA claim.[133]

Given that § 502(a)(3) of ERISA authorizes a plan fiduciary to bring a civil cause of action "to obtain other appropriate equitable relief . . . to redress . . . violations [of plan terms],"[134] any state-law claim for reimbursement or subrogation necessarily conflicts with the exclusive equitable remedy provided by § 502(a)(3) and is therefore impliedly preempted.[135] State-law claims for reimbursement or subrogation are legal claims for money damages and therefore provide a prohibited type of alternative relief unavailable under ERISA. Arguments that state-law claims for reimbursement and subrogation should be permitted disregard the fact that Congress carefully weighed the types of relief that should be available to plan fiduciaries to enforce plan terms—and limited such relief to § 502(a)(3) claims for "appropriate equitable relief" within the exclusive jurisdiction of federal courts.[136] Arguments against preemption also overlook the inequity that would result if courts were to continue to interpret ERISA to broadly preempt state-law claims brought by plan participants and beneficiaries while interpreting ERISA to narrowly preempt state-law claims brought by plan fiduciaries.

3. Complete Preemption

Not only are state-law claims for reimbursement or subrogation expressly and impliedly preempted, but they are also completely preempted, giving rise to federal question removal jurisdiction. Typically, preemption by a federal statute is an affirmative defense that does not give

133. *Id.* at 215–16 (holding that state-law claims are preempted if they attempt "to convert an equitable remedy [available under ERISA] into a legal remedy [available in state court]").

134. ERISA § 502(a)(3)(B), 29 U.S.C. § 1132(a)(3)(B) (2006).

135. *See* Liberty Nw. Ins. Corp. v. Kemp, 85 P.3d 871, 878–79 (Or. Ct. App. 2004) (finding implied conflict preemption because a state law claim for reimbursement is "a preempted alternative enforcement mechanism").

136. Prior to *Sereboff*, it was argued that state-law claims for subrogation and reimbursement were necessary to avoid the regulatory vacuum caused by plans' inability to successfully assert reimbursement or subrogation claims pursuant to § 502(a)(3). *See, e.g.*, Brian A. Perez-Daple, Comment, *Legal Reimbursement Claims by ERISA Plan Fiduciaries*, 72 U. CHI. L. REV. 1103, 1123–24 (2005) (arguing that ERISA preemption of state-law claims creates a regulatory vacuum because recovering subrogation or reimbursement is too difficult under ERISA). Such arguments are arguably much weaker given the Court's opinion in *Sereboff* authorizing plans to seek reimbursement by asserting equitable liens by agreement under § 502(a)(3). Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 364–65 (2006). Moreover, if a plan seeks reimbursement by asserting a constructive trust, another type of equitable relief within the scope of § 502(a)(3), it may avoid some of the earlier problems faced by plans in cases where the defendant no longer had possession of the identifiable funds by simply bringing the § 502(a)(3) claim against the person who is in possession of the funds. *See, e.g.*, Admin. Comm. for the Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Horton, 513 F.3d 1223, 1227, 1229 (11th Cir. 2008) (allowing a plan to bring a § 502(a)(3) claim asserting a constructive trust against the plan beneficiary's conservator who had possession of the funds).

rise to removal jurisdiction because the complaint filed in state court does not raise a federal question on the face of the well-pleaded complaint. However, the Court has recognized an exception to the well-pleaded complaint rule in cases where Congress clearly intended to "so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character."[137]

In *Metropolitan Life Insurance Co. v. Taylor*,[138] the Court extended the complete preemption doctrine—which had previously been limited to claims falling within § 301 of the Labor Management Relations Act—to claims for employee benefits that fall within the scope of § 502(a).[139] The Court found that the plaintiff's complaint, which asserted both a breach of contract claim seeking money owed under the benefit plan and a tort claim for mental anguish caused by the failure to pay, "[was] necessarily federal in character by virtue of the clearly manifested intent of Congress[,]"[140] and that therefore, the suit arose under federal law.[141] The Court reasoned that because § 502 provides exclusive causes of action and sets forth procedures and remedies governing those exclusive causes of action, § 502 completely preempts any state-law claim that comes within the scope of § 502.[142] The Court found the plaintiff's state-law complaint within the scope of § 502 and therefore completely preempted even though § 502 does not authorize any tort claims for mental anguish arising from a wrongful failure to pay benefits.[143]

Similarly, in *Rush Prudential HMO, Inc. v. Moran*,[144] the Court found that a plan participant's amended state-court complaint seeking reimbursement for medically necessary surgery was completely preempted.[145] Interestingly, however, the Court suggested that ERISA also completely preempted the plan participant's original state-court complaint seeking to compel an independent medical review required by an Illinois statute.[146] The Court questioned the district court's remand of the original complaint, implying that removal was appropriate based on complete preemption because a suit to compel an independent review could either be brought under § 503(a)(3) as a suit to force compliance with an ERISA

137. Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 63–64 (1987).

138. 481 U.S. 58 (1987).

139. *Id.* at 64–66.

140. *Id.* at 67.

141. *Id.*

142. Beneficial Nat'l Bank v. Anderson, 539 U.S. 1, 7–8 (2003) (describing the Court's holding in *Taylor*).

143. *See Taylor*, 481 U.S. at 66.

144. 536 U.S. 355 (2002).

145. *Id.* at 363–64.

146. *Id.* at 361–62.

plan or as a § 502(a)(1)(B) claim for benefits or to enforce rights under the plan.[147]

In *Aetna Health Inc. v. Davila*,[148] the Court addressed two consolidated cases in which individuals had sued their HMOs in state court alleging that the HMOs had violated a Texas statute by failing to exercise ordinary care when making coverage decisions.[149] In finding that the cases were properly removed based upon complete preemption, the Court again observed that ERISA was a "'comprehensive legislative scheme'" with an "integrated enforcement mechanism" reflecting careful public policy choices to include certain remedies while excluding others.[150] The Court held that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."[151]

The Court further held that the preemptive force of the civil enforcement provision was so strong that any state-law complaint alleging a cause of action within the scope of § 502 was completely preempted and removable to federal court.[152] The Court concluded that the individuals' claims that their HMOs wrongfully denied coverage were completely preempted because the claims could have been brought pursuant to § 502(a) and were based solely on legal obligations to provide coverage arising from the plan provisions.[153] The Court found it irrelevant that the plaintiffs brought state-law claims for failure to use ordinary care rather than contract claims for benefits owed,[154] that the state-law claims might afford the plaintiffs a remedy greater than the remedy authorized by ERISA,[155] and that the elements of the state-law claim did not precisely duplicate those of an ERISA claim.[156] Thus, just as state-law claims for subrogation or reimbursement are impliedly preempted because the state claims provide an additional judicial remedy not available under ERISA,

147. *Id.* at 362 n.2.

148. 542 U.S. 200 (2004).

149. *Id.* at 204.

150. *Id.* at 208 (quoting Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 147 (1985)).

151. *Id.* at 209.

152. *Id.*

153. *Id.* at 210.

154. *Id.* at 214 ("[D]istinguishing between pre-empted and non-pre-empted claims based on the particular label affixed to them would 'elevate form over substance and allow parties to evade' the pre-emptive scope of ERISA simply 'by relabeling their contract claims as claims for tortious breach of contract.'" (quoting Allis-Chalmers Corp. v. Lueck, 471 U.S. 202, 211 (1985))).

155. *Id.* at 215 ("The limited remedies available under ERISA are an inherent part of the 'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." (citing Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987))).

156. *Id.* at 215–16.

they are also completely preempted because they fall within the scope of § 502(a)(3), which authorizes claims for appropriate equitable relief to redress violations of plan terms.[157]

V. APPLICATION OF STATE COMMON FUND DOCTRINES OR STATUTES TO § 502(A)(3) CLAIMS FOR "APPROPRIATE EQUITABLE RELIEF"

Given that state-law claims for subrogation and reimbursement are preempted, it is necessary to determine whether state common fund doctrines or state statutes codifying the doctrine are also preempted. If not, they apply to a plan's § 502(a)(3) claim for recoupment.[158]

A. *State Common-Law Common Fund Doctrines Are Not Preempted*

Courts have not uniformly resolved whether state common fund doctrines are expressly preempted by ERISA; some courts have found express preemption,[159] while others have not.[160] Many courts have simply concluded, without even performing a preemption analysis, that plan language can invalidate otherwise applicable state law establishing the common fund doctrine.[161]

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157. The state common law authorizing breach of contract claims for reimbursement or subrogation is not saved from preemption as law regulating insurance because such general contract law is not "specifically directed toward entities engaged in insurance" as required by *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341–42 (2003).

158. State laws that are not preempted by ERISA apply to claims brought pursuant to § 502(a). *See* UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 376–77 (1999) (applying California's notice-prejudice rule to a plan participant's § 502(a)(1)(B) claim to recover benefits). There is an alternative to a lawyer's assertion of a state law claim against the plan for fees pursuant to the common fund doctrine. *See, e.g.*, Alleman v. Bluecross Blueshield of Ill., 231 F. Supp. 2d 822, 827 (S.D. Ill. 2002) (finding that a lawyer's state-law claim for fees pursuant to the common fund doctrine was not completely preempted by ERISA because it was not within the scope of claims authorized by § 502). A fair share of the fees and expenses can be deducted from any reimbursement or subrogation awarded to a plan by simply applying the state common fund doctrine to a plan's § 502(a)(3) claim for "appropriate equitable relief."

159. *See, e.g.*, Eberspacher v. Mut. of Omaha Ins. Co., No. 4:04-CV-3304, 2005 WL 1377865, at *6–7 (D. Neb. June 8, 2005) (finding Nebraska's common fund doctrine expressly preempted); IBEW-NECA Sw. Health & Benefit Fund v. Gurule, 337 F. Supp. 2d 845, 857–58 (N.D. Tex. 2004) (finding New Mexico's common fund doctrine expressly preempted).

160. *See, e.g.*, Primax Recoveries, Inc. v. Sevilla, 324 F.3d 544, 548–49 (7th Cir. 2003) (finding that the state common fund doctrine is not preempted); Blackburn v. Sundstrand Corp., 115 F.3d 493, 495–96 (7th Cir. 1997) (same); Bishop v. Burgard, 764 N.E.2d 24, 29–33 (Ill. 2002) (same); Scholtens v. Schneider, 671 N.E.2d 657, 662–67 (Ill. 1996) (same); *see also* Florin v. Nationsbank of Ga., 34 F.3d 560, 564 (7th Cir. 1994) (awarding attorneys' fees in an ERISA class action case pursuant to the common fund doctrine after finding that ERISA did not preempt the common fund doctrine).

161. *See, e.g.*, Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Fund v. Hummell, 245 F. Supp. 2d 908, 912 (N.D. Ill. 2003) (concluding that "state law cannot void explicit . . . provisions in ERISA plans"); Yerby v. United Healthcare Ins. Co., 846 So. 2d 179,

1. Express Preemption

Common fund doctrines established by state common law do not refer to ERISA; instead they are state laws of general application.[162] States apply the common fund doctrine not only in cases in which an insurer is seeking subrogation or reimbursement, but also in class action cases and cases where a litigant has created or preserved trust assets.[163] Under the more narrow interpretation of the express preemption clause announced by the Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,[164] when the state law at issue does not directly reference ERISA, the state law may nevertheless be preempted if it has a forbidden connection with ERISA plans, which is to be determined by examining "the objectives of the ERISA statute" and the effect of the state law on ERISA plans.[165] Using this approach, the Court has repeatedly found that state laws of general application are not preempted if they do not substantially obstruct nationally uniform plan administration and do not address an area of core ERISA concern.

For example, in *California Division of Labor Standards Enforcement v. Dillingham Construction*,[166] the Court held that ERISA did not preempt California's prevailing wage statute after concluding that: (1) the statute governed areas that were traditionally within state regulation rather than areas of core ERISA concern; (2) there was no legislative or other history indicating that ERISA was intended to preempt laws of this type; and (3) the state statute did not bind plans to any particular outcome.[167] The Court held that the law at issue was "'no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not

190–91 (Miss. 2002) (finding that the common fund doctrine does not apply to an ERISA plan's claim for reimbursement without deciding whether ERISA preempted the state common fund doctrine); Palmerton v. Assocs. Health & Welfare Plan, 659 N.W.2d 183, 188 (Wis. Ct. App. 2003) (holding that ERISA plans can disclaim otherwise applicable law mandating application of the common fund doctrine). Many federal appellate court opinions address whether federal common law permits or requires application of the federal common fund doctrine to a plan's claim for subrogation or reimbursement. *See, e.g.*, Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough, 354 F.3d 348, 360–61 (5th Cir. 2003); Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 279 (1st Cir. 2000); United McGill Corp. v. Stinnett, 154 F.3d 168, 173 (4th Cir. 1998); Bollman Hat Co. v. Root, 112 F.3d 113, 116 (3d Cir. 1997). However, very few cases address whether ERISA preempts applicable state common fund doctrines.

162. *See Blackburn*, 115 F.3d at 495 ("Most applications [of the common fund doctrine] have nothing to do with health insurance in general, or employer-sponsored plans in particular."); *Scholtens*, 671 N.E.2d at 663 ("The common fund doctrine is a common law rule of general application.").

163. *See supra* note 68 and accompanying text.

164. 514 U.S. 645 (1995).

165. *Id.* at 656, 658–59.

166. 519 U.S. 316 (1997).

167. *Id.* at 328–41.

possibly have intended to eliminate.'"[168] In *De Buono v. NYSA-ILA Medical & Clinical Services Fund*,[169] the Court found that ERISA did not preempt New York's tax on hospital gross receipts because the tax was in an area of traditional state regulation and there was no evidence that Congress intended to supersede New York's tax law.[170] The Court emphasized that preemption is not required simply because a state law increases the costs of provided benefits or has some effect on plan administration.[171]

Conversely, a state law that regulates an area of core ERISA concern, directly conflicts with an ERISA provision, or significantly interferes with nationally uniform plan administration has a forbidden connection with ERISA and is therefore expressly preempted. For example, in *Boggs v. Boggs*,[172] the Court determined whether Louisiana community property law or ERISA controlled the distribution of pension plan benefits in a case in which the plan participant remarried after his first wife died.[173] Louisiana's community property law would recognize the deceased spouse's bequest of her community property interest in her ex-husband's undistributed pension plan benefits to her sons, while ERISA would require that the pension plan benefits be paid as an annuity solely to her husband[174] as the surviving spouse. The Court found that Louisiana's community property law was preempted because it directly conflicted with an ERISA provision requiring that annuities be paid to the surviving spouse.[175]

In *Egelhoff v. Egelhoff*,[176] the Court considered a Washington statute mandating automatic revocation of the designation of a spouse as beneficiary in the event of divorce.[177] The Court found that ERISA preempted the state law because the law "implicate[d] an area of core ERISA concern"—beneficiary designations and payment of benefits. The law also conflicted with an ERISA provision requiring payment of benefits to a beneficiary designated by the plan participant, and "interfere[d] with nationally uniform plan administration."[178]

Applying the common fund doctrine to an ERISA plan's claim for subrogation or reimbursement does not implicate a core ERISA concern.

168. *Id.* at 334 (quoting *Travelers*, 514 U.S. at 668).
169. 520 U.S. 806 (1997).
170. *Id.* at 814–15.
171. *Id.* at 816.
172. 520 U.S. 833 (1997).
173. *Id.* at 835–37.
174. *Id.* at 836–37.
175. *Id.* at 841–44.
176. 532 U.S. 141 (2001).
177. *Id.* at 144.
178. *Id.* at 147–48.

ERISA does not address subrogation or reimbursement; it neither requires nor prohibits such claims.[179] Moreover, application of the common fund doctrine does not bind the plan to a particular choice; plans may choose to hire their own attorney to pursue subrogation against the tortfeasor or they may rely on the plan participant's lawyer to do so.[180] If the plan chooses to rely on the participant's lawyer, however, it must pay its fair share of the attorneys' fees and costs.[181] States were applying the common fund doctrine well before ERISA, and there is nothing in ERISA's legislative history to suggest Congress intended to preempt the common fund doctrine.[182]

Courts that have found the common fund doctrine expressly preempted have done so because they likened the doctrine to state anti-subrogation statutes, such as the one found expressly preempted in *FMC Corp. v. Holliday*,[183] or the statute prohibiting a method of calculating pension plan benefits found expressly preempted in *Alessi v. Raybestos-Manhattan, Inc*.[184]

In *Holliday*, the Court found that Pennsylvania's anti-subrogation statute explicitly referenced ERISA plans because it provided that "'[i]n actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . payable under section 1719.'"[185] Section 1719 of Pennsylvania's statutes, in turn, governed coordination of benefits payable by "a program, group contract or other arrangement."[186] In addition, the Court determined that the statute also had a "connection" to ERISA plans because it required plan providers to calculate benefit levels differently in Pennsylvania and consequently frustrated administrators' ability "to calculate uniform benefit levels nationwide."[187]

State common fund doctrines are significantly different from the anti-subrogation statute at issue in *Holliday*, which was aimed directly at group health care plans. The common fund doctrine applies to a much broader

179. *See* Scholtens v. Schneider, 671 N.E.2d 657, 662 (Ill. 1996). A recent attempt to amend ERISA so as to explicitly permit all claims for subrogation and reimbursement pursuant to § 502(a)(3) failed. Pension Protection Act of 2005, H.R. 2830, 109th Cong. § 307 (2005).

180. *See Scholtens*, 671 N.E.2d at 667.

181. *Id.*

182. *See* Blackburn v. Sundstrand Corp., 115 F.3d 493, 495 (7th Cir. 1997) ("The common-fund doctrine long predates not only ERISA but also employer-sponsored health plans.").

183. 498 U.S. 52 (1990).

184. 451 U.S. 504 (1981); *see, e.g.*, Eberspacher v. Mut. of Omaha Ins. Co., No. 4:04-CV-3304, 2005 WL 1377865, at *6 (D. Neb. June 8, 2005); IBEW-NECA Sw. Health & Benefit Fund v. Gurule, 337 F. Supp. 2d 845, 857 (N.D. Tex. 2004).

185. *Holliday*, 498 U.S. at 59 (first two alterations in original) (quoting 75 PA. CONS. STAT. § 1720 (1987)).

186. 75 PA. CONS. STAT. § 1720 (2008).

187. *Holliday*, 498 U.S. at 60.

range of cases and "is indifferent . . . to the basis of any particular claim to the fund."[188] In addition, application of the common fund doctrine would not obstruct nationally uniform plan administration to the same extent as application of myriad state anti-subrogation statutes because the common fund doctrine has been recognized in substantially the same form by a large majority of states.[189]

In *Alessi*, the Court found that ERISA expressly preempted a New Jersey statute prohibiting a reduction in retirement benefits based on the employee's eligibility for workers' compensation benefits. The Court found the statute "eliminate[d] one method for calculating pension benefits."[190] Obviously, the statute concerning calculation of benefits in *Alessi* regulates a matter of core ERISA concern; the common fund doctrine does not.

The doctrine is more akin to Georgia's general garnishment statute at issue in *Mackey v. Lanier Collection Agency & Service, Inc.*[191] Even though Georgia's garnishment statute would substantially increase the plan's administrative burdens and costs, the Court nevertheless found that the statute was not preempted, observing that ERISA plans are subject to "run-of-the-mill" state laws, including state laws that might give rise to contract or tort claims against the plan.[192] The Court referenced a case in which an ERISA plan was required, pursuant to state contract law, to pay an attorney.[193] Clearly, ERISA does not preempt state contract law governing the payment of attorneys' fees. Nor should it preempt state law requiring payment of attorneys' fees pursuant to "equitable considerations of *quantum meruit* and the prevention of unjust enrichment."[194] The common fund doctrine is a rule of general application that predates ERISA, governs an area traditionally within state regulation rather than a core ERISA concern, does not bind the plan to a particular outcome, and does not substantially interfere with nationally uniform administration. Therefore, the common fund doctrine does not have a forbidden connection with ERISA and is not expressly preempted.

188. Blackburn v. Sundstrand Corp., 115 F.3d 493, 495–96 (7th Cir.1997).

189. Scholtens v. Schneider, 671 N.E.2d 657, 663 (Ill. 1996). The concern that application of state laws might place a substantial financial burden on plan administrators because they would be forced to master varied laws throughout the states (see for example, *Egelhoff v. Egelhoff*, 532 U.S. 141, 149–50 (2001)), is a much more significant concern in the context of state laws prohibiting and limiting subrogation and reimbursement because there is much more variance among the states in that area when compared to the general uniformity with which states apply the common fund doctrine.

190. Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 521–24 (1981).

191. 486 U.S. 825, 828 (1988).

192. *Id.* at 832–33.

193. *Id.* at 834 n.8.

194. *Scholtens*, 671 N.E.2d at 665.

2. Implied Preemption

The common fund doctrine is also not impliedly preempted by ERISA because it is possible for a plan to satisfy the requirements of ERISA and also satisfy the requirements of a state common fund doctrine.[195] Given that ERISA is silent on the issue of reimbursement and subrogation claims and is also silent on the application of the common fund doctrine to such claims, it cannot be said that the common fund doctrine conflicts with an ERISA provision. Moreover, application of the common fund doctrine operates to further, rather than obstruct, ERISA's goal of protecting the interests of plan participants and their beneficiaries.[196] Although the U.S. Court of Appeals for the Seventh Circuit found that ERISA impliedly preempted a state's common fund doctrine, the court used faulty reasoning.[197] Essentially, the court found that the common fund doctrine was impliedly preempted because it conflicted with the plan provisions disclaiming the doctrine.[198] Conflict, or implied, preemption, however, cannot be based solely upon a conflict between a plan provision and state law. Otherwise, a plan could avoid application of state law simply by including a plan provision to the contrary. Certainly, Congress did not intend to give plans unilateral ability to avoid state law by including inconsistent plan provisions. Thus, common fund doctrines found in state common law are not expressly or impliedly preempted by ERISA and may apply to a plan's § 502(2)(3) claim for reimbursement.

B. *Many State Statutes Codifying the Common Fund Doctrine Are Saved From Preemption*

1. The Savings Clause

Unlike common fund doctrines established by state common law, several state statutes requiring an insurer to pay a portion of attorneys' fees when recovering subrogation or reimbursement may fall within ERISA's express preemption clause. Many such statutes explicitly refer to group health insurance plans or are integral to a statutory scheme that limits an insurer's ability to recover subrogation or reimbursement.[199] Such laws,

195. *See* Boggs v. Boggs, 520 U.S. 833, 841 (1997) (observing that ERISA impliedly preempts state laws that "conflict[] with . . . ERISA or operate[] to frustrate its objects").

196. For a more detailed discussion, see *infra* notes 284–302 and accompanying text, arguing that application of the common fund doctrine serves the purposes of ERISA.

197. *See* Admin. Comm. of the Wal-Mart Stores Inc. Assocs. Health & Welfare Plan v. Varco, 338 F.3d 680, 690 (7th Cir. 2003).

198. *Id.*

199. For examples of state statutes codifying the common fund doctrine as part of a statutory scheme that limits subrogation or reimbursement, see *supra* note 72.

however, regulate insurance and are therefore saved from preemption.

ERISA's savings clause exempts state laws regulating insurance from preemption, as Congress decided that states are best suited to regulate insurance.[200] Although the tension between the express preemption clause and the savings clause has made interpretation of the savings clause thorny,[201] most courts have easily concluded that state statutes limiting subrogation and reimbursement are laws regulating insurance.[202] In *Levine v. United Healthcare Corp.*,[203] however, the Third Circuit found that a New Jersey statute prohibiting subrogation and reimbursement was not a law regulating insurance.[204] In so finding, the Third Circuit misapplied the new test established by the Supreme Court in *Kentucky Association of Health Care Plans, Inc. v. Miller*[205] for determining whether a state law regulates insurance.[206]

Prior to *Miller*, the Court used a two-pronged approach to identify laws regulating insurance. First, the Court considered whether the law at issue regulated insurance under a "common-sense view."[207] Second, it weighed the three factors used to determine whether the practice at issue constitutes the "business of insurance" under the McCarran-Ferguson Act (MFA), which exempts "the business of insurance" from federal antitrust regulation. Those three factors are (1) whether the practice transfers or spreads risk, (2) whether the practice is integral to the relationship between

200. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 744 n.21 (1985). The McCarran-Ferguson Act declared that state, rather than federal, regulation of the business of insurance is in the public interest and that no federal statute "shall be construed to invalidate, impair, or supersede any [state] law . . . regulating the business of insurance." 15 U.S.C. §§ 1011–1012(b) (2006).

201. *See Metro. Life Ins.*, 471 U.S. at 739–40 ("The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.").

202. *See, e.g.*, Singh v. Prudential Health Care Plan, Inc., 335 F.3d 278, 284–86 (4th Cir. 2003) (holding that a subrogation prohibition in Maryland's HMO Act was a law regulating insurance); Med. Mut. of Ohio v. DeSoto, 245 F.3d 561, 573–74 (6th Cir. 2001) (finding that California's statute altering the traditional collateral source rule and prohibiting subrogation and reimbursement is a law regulating insurance); Smith v. Life Ins. Co. of N. Am., 466 F. Supp. 2d 1275, 1291 (N.D. Ga. 2006) (holding that Georgia's anti-subrogation statute, which includes an attorneys' fees provision, is a law regulating insurance); Admin. Comm. of the Wal-Mart Assocs. Health & Welfare Plan v. Willard, 302 F. Supp. 2d 1267, 1282 (D. Kan. 2004) (finding that a Kansas anti-subrogation regulation is a law regulating insurance).

203. 402 F.3d 156 (3d Cir. 2005).

204. *Id.* at 165–67.

205. 538 U.S. 329 (2003).

206. *Id.* at 341–42.

207. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 48–51 (1987).

insured and insurer, and (3) whether the practice is limited to the insurance industry.[208]

Acknowledging that its use of the MFA factors had confused, rather than clarified, the inquiry, the Court in *Miller* abandoned its use of the MFA factors for determining whether a state law regulates insurance.[209] The Court explained that the MFA focuses on whether practices constitute the business of insurance for purposes of antitrust regulation, while ERISA asks whether a state law regulates insurance for purposes of ERISA preemption.[210]

Under the new test articulated in *Miller*, a state law regulates insurance if it is "specifically directed toward entities engaged in insurance" and it "substantially affect[s] the risk pooling arrangement between the insurer and the insured."[211] The *Miller* test supports a much broader interpretation of the savings clause and arguably gives states a greater ability to regulate insurance.[212] To be saved from preemption under the new test, a state law only has to be specifically directed at the insurance industry, rather than be limited to the insurance industry, as required by one of the MFA factors.[213] In addition, a law does not have to directly spread policyholder risk as required by another MFA factor; it only has to substantially affect the risk-pooling arrangement.[214]

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208. *Id.*

209. *Miller*, 538 U.S. at 339–40. The MFA exempts the business of insurance from federal antitrust regulation as long as the state has undertaken to regulate the business of insurance. 15 U.S.C. § 1012(b) (2006). For cases in which the Court applied the MFA factors to determine whether the antitrust exemption applied, see *Union Labor Life Insurance. Co. v. Pireno*, 458 U.S. 119, 122 (1982), which determined "whether the alleged conspiracy [was] exempt from federal antitrust laws as part of the 'business of insurance'" and *Group Life & Health Insurance. Co. v. Royal Drug Co.*, 440 U.S. 205, 207–08 (1979), which determined whether agreements between insurers and pharmaceuticals to fix prices constituted the business of insurance for purposes of the exemption from federal antitrust legislation.

210. *Miller*, 538 U.S. at 339–40.

211. *Id.* at 342.

212. *See* Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another*," 5 YALE J. HEALTH POL'Y, L. & ETHICS 89, 90 (2005); Larry J. Pittman, *A Plain Meaning Interpretation of ERISA's Preemption and Saving Clauses: In Support of a State Law Preemption of Section 1132(a) of ERISA's Civil Enforcement Provisions*, 41 SAN DIEGO L. REV. 593, 599 (2004); Matthew O. Gatewood, Note, *The New Map: The Supreme Court's Guide to Curing Thirty Years of Confusion in ERISA Savings Clause Analysis*, 62 WASH. & LEE L. REV. 643, 673–74 (2005); *see also* Prudential Ins. Co. v. Nat'l Park Med. Ctr., Inc., 413 F.3d 897, 911 (8th Cir. 2005) (court had decided that an Arkansas statute did not regulate insurance but then reversed itself based on the Supreme Court's intervening decision in *Miller*).

213. *See* Gatewood, *supra* note 212, at 674.

214. *Id.* The law at issue does not have to directly transfer risk or "alter or control the actual terms of insurance policies." *Miller*, 538 U.S. at 338. Instead, the law only has to affect the risk pooling arrangement. *Id.* Risk pooling, which refers to an insurer's act of insuring many similar insureds in a single pool in an attempt to decrease the variance in the insurer's expected loss, is arguably a broader concept than risk transfer, which refers to the act of transferring risk from the

Under the first prong of *Miller*, state statutes prohibiting or limiting subrogation and codifying the common fund doctrine are clearly directed towards the insurance industry. The terms of many such statutes explicitly apply to insurers.[215] As the Court held in *FMC Corp. v. Holliday*,[216] decided before *Miller*, anti-subrogation statutes control the terms of insurance policies and are clearly aimed at the insurance industry.[217] In addition, many such statutes are located in the chapter or title of the state code dealing with insurance.[218]

Under the second prong of *Miller*, anti-subrogation statutes "substantially affect the risk-pooling arrangement between the insurer and the insured" because they determine the ultimate net benefit to which the participant is entitled.[219] As the Fourth Circuit noted in *Singh v. Prudential Health Care Plan*, *Inc.*,[220] "it is difficult to imagine an anti-subrogation law of this type as anything other than an insurance regulation, as it addresses who pays in a given set of circumstances and is therefore directed at spreading policyholder risk."[221]

In *Levine v. United Healthcare Corp.*,[222] however, the Third Circuit misapplied the *Miller* test. The New Jersey statute at issue altered the traditional collateral source rule by prohibiting a plaintiff in a tort lawsuit

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insured to the insurer. *See* Gatewood, *supra* note 212, at 674–75; Matthew G. Vansuch, Note, *Not Just Old Wine in New Bottles:* Kentucky Ass'n of Health Plans, Inc. v. Miller *Bottles a New Test for State Regulation of Insurance*, 38 AKRON L. REV. 253, 286 (2005).

215. For example, Georgia's statute provides that a "benefit provider" may only obtain reimbursement when the insured's recovery "exceeds the sum of all economic and noneconomic losses incurred as a result of the injury," requires that the provider's recovery be reduced "by the pro rata amount of the attorney's fees and expenses of litigation incurred by the injured party in bringing the claim," and defines "benefit provider" as

> any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan, or other entity which provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments, or any other benefits under a policy of insurance or contract with an individual or group.

GA. CODE ANN. § 33-24-56.1(a)–(b) (2008).

216. 498 U.S. 52 (1990).

217. *Id.* at 60–61.

218. *See, e.g.*, ARK. CODE ANN. § 23-79-146 (2008) (within chapter 79, "Insurance Policies," of Title 23, "Public Utilities and Regulated Industries") GA. CODE ANN. § 33-24-56.1 (2008) (within Title 33, "Insurance"); MINN. STAT. § 62A.095 (2008) (within Chapter 62A, "Accident and Health Insurance"); *see also* Smith v. Life Ins. Co. of N. Am., 466 F. Supp. 2d 1275, 1291 (N.D. Ga. 2006) (observing that Georgia's anti-subrogation statute "is located within Title 33, Georgia's Insurance Code").

219. Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 338 (2003).

220. 335 F.3d 278 (4th Cir. 2003).

221. *Id.* at 286 (citing *Miller*, 538 U.S. at 342); *see also* Med. Mut. of Ohio v. DeSoto, 245 F.3d 561, 574 (6th Cir. 2000); *Smith*, 466 F. Supp. 2d at 1291.

222. 402 F.3d 156 (3d Cir. 2005).

from recovering damages for injuries for which the plaintiff had previously received compensation from a collateral source.[223] The New Jersey Supreme Court had previously construed the statute to prohibit insurers from seeking subrogation and reimbursement.[224] In doing so, the court noted that, beginning in the mid-1980s, many state legislatures altered the traditional collateral-source rule in an attempt to remedy the liability insurance crisis.[225] The court held that the statute was enacted to limit double recovery by plaintiffs and thereby contain spiraling liability insurance premiums.[226] The court further concluded that the New Jersey Legislature purposefully chose to benefit the liability insurance industry, rather than the health insurance industry, when it altered the traditional collateral-source rule and prohibited subrogation and reimbursement.[227]

The Third Circuit's holding that the New Jersey statute was not a law regulating insurance was based on its finding that the law was not specifically directed towards the insurance industry, given that the statute applied to all civil actions, including actions in which the collateral source may not have been an insurance company.[228] The Third Circuit failed to appreciate that a law regulates insurance if its primary aim is at insurers—even if it also applies to other entities.[229]

The Third Circuit likened the New Jersey statute at issue to Mississippi's bad faith law.[230] In an early savings clause case, *Pilot Life Insurance Co. v. Dedeaux*,[231] the Supreme Court found that Mississippi's bad faith law does not regulate insurance because it is not "specifically directed toward [the insurance] industry" and is rooted "in the general principles of Mississippi tort and contract law."[232] In arguing that the New Jersey statute was a law of general application in the same way that Mississippi's bad faith law generally applies to tort and contract cases, the *Levine* court completely discounted the New Jersey Supreme Court's ruling that the statute was enacted to contain the cost of liability insurance

223. N.J. STAT. ANN. § 2A:15-97 (2008).

224. Perreira v. Rediger, 778 A.2d 429, 439–40 (N.J. 2001).

225. *Id.* at 434.

226. *Id.* at 435–36.

227. *Id.* at 436.

228. Levine v. United Healthcare Corp., 402 F.3d 156, 165–66 (3d Cir. 2005).

229. Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 332, 334–36 (2003) (finding that the "Any Willing Provider" statute at issue was directed towards insurers even though it also necessarily impacted health care providers by prohibiting certain relationships with insurers); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 372 (2002) ("[T]here is no reason to think Congress would have meant such minimal application to noninsurers to remove a state law entirely from the category of insurance regulation saved from preemption."). The *Miller* Court held that laws applicable to self-insured and insured plans are nevertheless laws regulating insurance because any other interpretation would render the deemer clause superfluous. *Miller*, 538 U.S. at 336 n.1.

230. *Levine*, 402 F.3d at 165–66.

231. 481 U.S. 41 (1987).

232. *Id.* at 50 (emphasizing that any tortious breach of contract could lead to the award of punitive damages under state law).

by shifting the responsibility for medical expenses in tort cases from liability insurers to health insurers.[233] Clearly, a law that alters the traditional collateral source rule and prohibits subrogation and reimbursement for the purpose of containing the cost of liability insurance is a law directed at insurers.[234] Contrary to the *Levine* court's finding, state statutes prohibiting or limiting subrogation, including any such state laws which also codify the common fund doctrine, are state laws regulating insurance.

2. The Implied Preemption Override

In a recent line of cases, the Supreme Court has held that state insurance laws that fall within the savings clause may nevertheless be impliedly preempted. In *John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank*,[235] the Court addressed a conflict between a state law requiring "an insurer, in managing general account assets, 'to consider the interests of all of its contractholders, creditors and shareholders'"[236] and ERISA, which requires that fiduciaries act "'*solely* in the interest of the participants and their beneficiaries and . . . for the *exclusive purpose* of . . . providing benefits to participants and beneficiaries.'"[237] Rather than determining that the state law controlled because it was saved from preemption as a law regulating insurance, the Court held that the state law regulating insurance was impliedly preempted because it "'stands as an obstacle to the accomplishment of the full purposes and objectives of Congress.'"[238] In finding that the state law must yield to ERISA, the Court relied on the Supremacy Clause and held that, despite the clear language contained in the savings clause, Congress did not intend to "fundamentally . . . alter traditional preemption analysis."[239]

In two later cases, however, the Court appeared to restrict the scope of implied conflict preemption of a state law regulating insurance. In *UNUM Life Insurance Co. of America v. Ward*,[240] the Court held that California's notice-prejudice rule relates to an employee benefit plan but was saved from preemption because it is a law regulating insurance.[241] The Court then rejected UNUM's alternative argument that even if the notice-prejudice

233. *Levine*, 402 F.3d at 169–70 (Garth, J., dissenting).

234. *See* FMC Corp. v. Holliday, 498 U.S. 52, 60–61 (1990); Med. Mut. of Ohio v. DeSoto, 245 F.3d 561, 573 (6th Cir. 2001).

235. 510 U.S. 86 (1993).

236. *Id.* at 97 & n.7 (referring to N.Y. INS. LAW § 4224(a)(1) (McKinney 1985)).

237. *Id.* at 97 (omissions in original) (citing ERISA, 29 U.S.C. § 1104(a)).

238. *Id.* at 99 (quoting Silkwood v. Kerr-McGee Corp., 464 U.S. 238, 248 (1984)).

239. *Id.* For arguments against implied preemption of state insurance regulation, see generally Donald T. Bogan, *ERISA: The Savings Clause, §502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105 (2001) and Pittman, *supra* note 212.

240. 526 U.S. 358 (1999).

241. *Id.* at 366–77.

rule falls within the savings clause, it was nevertheless impliedly preempted because it directly conflicted with terms of the plan.[242] The Court observed that finding such implied preemption would strip the savings clause of its effect because insurers would be able to avoid any state regulation of insurance simply by including contrary language in ERISA plans.[243]

In *Rush Prudential HMO, Inc. v. Moran*,[244] the Court examined an Illinois statute requiring HMOs to provide people denied benefits with a right to an independent medical review of the denial.[245] After finding that the state law regulated insurance,[246] the Court then turned to Rush's alternative argument that the law was nevertheless impliedly preempted.[247] The Court suggested that state insurance laws providing alternative remedies to those authorized by ERISA would be impliedly preempted and cited *Pilot Life*,[248] *Taylor*,[249] and *Ingersoll-Rand*[250] as examples of cases in which the Court found preemption based on Congress's apparent intent that the civil enforcement remedies provided in § 502(a) be exclusive.[251] The Court then distinguished these earlier cases by concluding that the regulatory scheme providing for an independent medical review did not provide a new cause of action or authorize a new form of ultimate relief.[252] The Court characterized the Illinois law as "garden variety [state] insurance regulation" seeking to limit insurers' ability to mandate policy terms favorable to their own interest, even though the law clearly minimized plan sponsors' ability to shield benefit denials from scrutiny.[253] "It is . . . hard to imagine a reservation of state power to regulate insurance that would not be meant to cover restrictions of the insurer's advantage in this kind of way."[254]

242. *Id.* at 375–76.

243. *Id.* at 376 & n.6.

244. 536 U.S. 355 (2002).

245. *Id.* at 359–61.

246. *Id.* at 366–70.

247. *Id.* at 375.

248. For discussion of *Pilot Life*, see *supra* notes 126–27, 227–28, and accompanying text.

249. For discussion of *Taylor*, see *supra* notes 137–43 and accompanying text.

250. For discussion of *Ingersoll-Rand*, see *supra* notes 124–30 and accompanying text.

251. *Rush Prudential HMO, Inc.*, 536 U.S. at 375–76. Although the Court relied upon the cited cases to support the proposition that a law saved from preemption because it regulates insurance can nevertheless be preempted if it conflicts with the purposes of ERISA, none of the cited cases involved a state law regulating insurance and therefore none clearly provide support for the type of implied override recognized by the Court. Nor did the Court address the provision in the McCarran-Ferguson Act that prohibits finding any state law regulating the business of insurance impliedly preempted by federal law. 15 U.S.C. § 1012(b) (2006).

252. *Rush Prudential HMO, Inc.*, 536 U.S. at 379.

253. *Id.* at 387.

254. *Id.*

In *Aetna Health Inc. v. Davila*,[255] the Court addressed two consolidated cases in which individuals had sued their HMOs in state court alleging that their HMOs had violated a Texas statute by failing to exercise ordinary care when making coverage decisions.[256] In responding to the plaintiffs' argument that the Texas statute giving rise to their claim was saved from preemption because it regulated insurance, the Court held that even if the state law authorizing such claims regulates insurance, it is impliedly conflict preempted because it "provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."[257]

These cases suggest that state insurance law may be impliedly preempted only when the state law conflicts with an ERISA provision or authorizes a state law claim within the scope of § 502(a). Based on these precedents, state laws that regulate insurance by prohibiting or limiting reimbursement and subrogation and requiring application of the common fund doctrine are not impliedly preempted by ERISA for two reasons. First, they do not conflict with any provision of ERISA. Second, they do not obstruct ERISA's exclusive enforcement mechanism because they do not provide a plan participant, beneficiary, or fiduciary with a separate vehicle to assert claims. Instead, such state laws will apply to plans' claims brought under § 502(a)(3) in the same way that California's notice-prejudice rule and Illinois' statute requiring an independent medical review apply to claims for benefits brought pursuant to § 502(a)(1)(B). Thus, insurance statutes codifying the common fund doctrine apply to a plan's § 502(a)(3) claim for reimbursement or subrogation.

VI. CONSTRUING "APPROPRIATE EQUITABLE RELIEF" AS RELIEF CONSISTENT WITH THE COMMON FUND DOCTRINE

Given that many plans are self-funded and therefore may escape application of state insurance regulation applying the common fund doctrine,[258] it is necessary to examine whether federal law requires application of the common fund doctrine to § 502(a)(3) claims for

255. 542 U.S. 200 (2004).

256. *Id.* at 204.

257. *Id.* at 217–18.

258. The deemer clause exempts self-funded plans from state insurance regulation. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985); *see, e.g.*, Culp, Inc. v. Cain, 414 F. Supp. 2d 1118, 1129–30 (M.D. Ala. 2006) (holding that Alabama's insurance law requiring a subrogated insurer to pay a pro rata share of the attorneys' fees does not apply to self-funded plans); Admin. Comm. of Wal-Mart Assocs. Health & Welfare Plan v. Willard, 302 F. Supp. 2d 1267, 1282–84 (D. Kan. 2004) (finding that a Kansas anti-subrogation regulation does not apply to self-funded plans). The discrepancy between insured and self-funded plans makes it possible for self-funded plans to skirt state insurance regulation even though self-funded plans are engaged in the business of insurance in the sense that self-funded plans accept and retain the risk that participants will need health care coverage. For an argument as to how this discrepancy might be ameliorated, see Korobkin, *supra* note 212, at 91.

reimbursement or subrogation. Federal common law governing contract interpretation might require the application of the common fund doctrine as a default rule if the language of a particular plan is silent on the issue.[259] Alternatively, federal law might require application of the common fund doctrine because § 502(a)(3) requires that any award of equitable relief be "appropriate."[260] In other words, "appropriate equitable relief" could be interpreted to be relief consistent with equitable principles such as the common fund doctrine.

Although several courts have addressed whether federal common law governing contract interpretation requires application of the common fund doctrine,[261] few, if any, have specifically analyzed whether such incorporation is mandated by the ERISA provision limiting a plan's recovery to "appropriate" equitable relief.[262] In *Sereboff*, the Court refused,

259. *See, e.g.*, Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells, 213 F.3d 398, 402–03 (7th Cir. 2000) (holding that the federal common law of contracts requires application of the common fund doctrine as a default rule when the plan is silent on the issue and does not give the plan administrator discretion to interpret the plan); Waller v. Hormel Foods Corp., 120 F.3d 138, 141–42 (8th Cir. 1997) (same). Most courts will defer to the administrator's or fiduciary's interpretation of ambiguous plan provisions if the plan gives the administrator or fiduciary discretion to interpret the plan. *See, e.g.*, Moore v. CapitalCare, Inc., 461 F.3d 1, 11 (D.C. Cir. 2006) (holding that if plan language gives the administrator or fiduciary discretion to interpret the plan, then interpretation of ambiguous plan language will be reviewed for abuse of discretion). *But see* Cagle v. Bruner, 112 F.3d 1510, 1522 (11th Cir. 1997) (holding that the plan cannot avoid the default rule supplied by federal common law simply by giving itself discretion to interpret plan provisions).

260. ERISA § 502(a)(3), 29 U.S.C. § 1132 (a)(3) (2006).

261. *See, e.g.*, Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough, 354 F.3d 348, 360–61 (5th Cir. 2003) (refusing to apply the common fund doctrine where the plan provided that attorneys' fees and costs were the responsibility of the plan participant); Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco, 338 F.3d 680, 691–92 (7th Cir. 2003) (holding that federal common law governing contract interpretation imports the common fund doctrine only when the plan is silent on the issue); Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 278–79 (1st Cir. 2000) (holding that federal common law does not require "importation of the common-fund doctrine into an otherwise unambiguous ERISA plan" even when the plan does not directly address attorneys' fees); Walker v. Wal-Mart Stores, Inc., 159 F.3d 938, 940–41 (5th Cir. 1998) (finding that federal common law does not require application of the common fund doctrine in cases where the plan requires full reimbursement but does not mention attorneys' fees); United McGill Corp. v. Stinnett, 154 F.3d 168, 172–73 (4th Cir. 1998) (refusing to apply the common fund doctrine to override the plan's claim for full reimbursement even though the plan did not specifically address attorneys' fees); Health Cost Controls v. Isbell, 139 F.3d 1070, 1072 (6th Cir. 1997) (acknowledging that federal common law might apply to assist in contract interpretation, but holding that resort to federal common law is not necessary where the plan language expressly requires full reimbursement); Ryan *ex rel.* Capria-Ryan v. Fed. Express Corp., 78 F.3d 123, 127–28 (3d Cir. 1996) (refusing to find that federal common law governing contract interpretation requires application of the common fund doctrine where the plan language requires full reimbursement only in the event the insured's recovery is great enough to fully reimburse the plan and pay the attorneys' fees and costs incurred).

262. After *Sereboff*, the Eighth Circuit rejected the argument that "appropriate equitable relief" is relief consistent with the made-whole rule. Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.'

on procedural grounds, to address the argument that "appropriate equitable relief" is equitable relief consistent with equitable doctrines such as the common fund doctrine.[263]

In *Varity Corp. v. Howe*,[264] the Court considered the manner in which the term "appropriate" limited the equitable relief authorized by § 502(a)(3).[265] There, the Court addressed whether claims brought by plan participants for individual relief for breach of fiduciary duty constituted claims for "appropriate equitable relief" pursuant to § 502(a)(3).[266] The accused fiduciary argued that individual relief for breach of fiduciary duty was not appropriate under § 502(a)(3) because § 502(a)(2) was intended to address claims for breach of fiduciary duty and § 502(a)(2) only authorized relief for the plan, not individuals.[267]

The Court rejected this argument, finding that Congress intended § 502(a)(3) to provide a catchall remedy for violations not elsewhere addressed in § 502.[268] In finding that § 502(a)(3) authorized the individual claims, the Court held: "We should expect that courts, in fashioning 'appropriate' equitable relief, will keep in mind the 'special nature and purpose of employee benefit plans,' and will respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others.'"[269] The Court acknowledged that federal trial courts have a role to play in "fashioning 'appropriate' equitable relief" designed to further the purposes of ERISA and suggested that denial of an equitable remedy might be "appropriate" in some circumstances.[270] The Court then found the particular relief sought "appropriate" because ERISA authorized no other remedy to redress the beneficiary's injury and denial of a remedy would not serve any ERISA-related purpose.[271]

In *Harris Trust & Savings Bank v. Salomon Smith Barney, Inc.*,[272] the Court again recognized that the term "appropriate" limits the equitable relief authorized by § 502(a)(3).[273] There, the trustee of a pension plan sued its broker-dealer, a nonfiduciary party in interest, alleging that the

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Health & Welfare Plan v. Shank, 500 F.3d 834, 837–39 (8th Cir. 2007). There, the court found that full reimbursement to the plan was "appropriate." *Id.* at 840. The court did not address application of the common fund doctrine.

263. Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 368–69 & n.2 (2006).

264. 516 U.S. 489 (1996).

265. *Id.* at 494–95.

266. *Id.* at 495.

267. *Id.* at 508–09.

268. *Id.* at 512.

269. *Id.* at 515 (citation omitted).

270. *Id.*

271. *Id.* ("We are not aware of any ERISA-related purpose that denial of a remedy would serve.").

272. 530 U.S. 238 (2000).

273. *Id.* at 253 (recognizing the "appropriate[ness]" criterion in § 502(a)(3)).

broker-dealer participated in a financial transaction prohibited by ERISA when the broker-dealer sold its interest in several motel properties to the plan.[274] Upon discovering that the motel properties were almost worthless, the trustee sued the broker-dealer for restitution of the purchase price with interest.[275] The broker-dealer argued that because ERISA does not impose duties on nonfiduciaries, it had not violated any duty expressly imposed by ERISA, thereby making the § 502(a)(3) claim "inappropriate."[276] The Court rejected this argument, finding that § 502(a)(3) "itself imposes certain duties[.]"[277]

In addition, the Court observed that Congress purposefully delineated which plaintiffs could bring a § 502(a)(3) claim but did not limit the categories of defendants against whom § 502(a)(3) claims may be asserted.[278] The broker-dealer suggested that if fiduciaries were permitted to bring § 502(a)(3) claims against nonfiduciaries for breach of alleged duties outside the scope of ERISA, there would be nothing to stop fiduciaries from suing innocent parties with no connection to the unlawful act or practice.[279] The Court responded by pointing out that the limitation in § 502(a)(3), requiring that the relief sought not only be equitable but also "appropriate," would bar such claims.[280] The Court held that the equitable relief sought by the plan trustee was "appropriate" because it was consistent with "common-law remedial principles" incorporated into § 502(a)(3).[281]

The Court's interpretation of "appropriate" is consistent with several longstanding principles of equitable relief. First, the Court's holding in *Varity* that the equitable relief sought was "appropriate" because there was no other adequate remedy consistent with the general rule that equitable relief based on a right recognized at law should be denied if the plaintiff has an adequate remedy at law.[282] Second, the Court's recognition in *Varity* that a court has discretion to fashion and even deny a remedy is consistent with the discretion long exercised by equity courts.[283] In light

274. *Id.* at 242–43.

275. *Id.*

276. *Id.* at 250–51.

277. *Id.* at 245.

278. *Id.* at 246–49.

279. *Id.* at 250.

280. *Id.*

281. *Id.* at 252–53. In so holding, the Court analogized the plan trustee's claim against the nonfiduciary broker-dealer to a trust beneficiary's restitution claim against a third-party transferee who received trust assets with actual or constructive knowledge that the assets were transferred in breach of the trust. *Id.* at 250–51.

282. *See* DOBBS, *supra* note 29, § 2.5, at 123. Arguably, all § 502(a)(3) claims concern rights recognized at law because all such claims must be for the purpose of ensuring enforcement of plan terms or redressing a violation of plan terms.

283. *See id.* at § 2.4(5), at 108.

of the Court's opinions in *Varity* and *Harris Trust*, it is clear that the term "appropriate" limits the equitable relief that would otherwise be available pursuant to § 502(a)(3). It is also clear that federal courts are to play a role in fashioning "appropriate" equitable remedies by incorporating common-law remedial principles into § 502(a)(3) if such principles are consistent with and serve the purposes of ERISA.

Congress enacted ERISA to protect the interests of plan participants and their beneficiaries and to improve and assure the equitable nature of employee benefit plans.[284] Yet, federal courts' refusal to apply the common fund doctrine to § 502(a)(3) claims for reimbursement or subrogation thwarts these policies. Federal judges have expressed concern about the inequitable results reached in cases where the plan is fully reimbursed and is not required to pay any of the attorneys' fees or costs incurred in obtaining the recovery.[285] Rather than enforcing plan terms simply for the sake of enforcement, courts should interpret "appropriate" as a meaningful limitation on the "equitable relief" authorized by § 502(a)(3).[286] Interpreting "appropriate equitable relief" as relief consistent with the common fund doctrine prevents unjust enrichment on the part of the plan; otherwise plans may free-ride on the efforts of the attorney.[287] Such interpretation is also warranted based on the equitable principle of quantum meruit, allowing a person to recover the reasonable value of the services rendered to the plan.[288] In addition, such an interpretation puts substance over form because it recognizes that a claim for subrogation or reimbursement is in essence an equitable claim—rather

284. *See supra* notes 74–79 and accompanying text.

285. *See* Amber M. Anstine, Comment, *ERISA Qualified Subrogation Liens: Should They be Reduced to Reflect a Pro Rata Share of Attorney Fees?*, 104 DICK. L.REV. 359, 375–76 (2000) ("Courts are troubled by the harsh standard set against beneficiaries who are trying to reduce subrogation liens to reflect a plan's *pro rata* share of attorney fees."); *see, e.g.*, Silcott v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan, No. 97-7044, 1998 WL 422032, at *6 (E.D. Pa. July 24, 1998) (observing the seeming unfairness of requiring the plan participant to pay the entire amount of fees); IBP, Inc. v. Foust, 987 F. Supp. 714, 719 (N.D. Iowa 1997) (observing that application of the common fund doctrine would be both equitable and appealing, but refusing to apply the doctrine because of governing precedent). Justice Stevens expressed concern during oral argument in *Sereboff* that it wasn't equitable to allow the plan to fully recover when the plan participant does not fully recover and recovers only slightly more than the reimbursement claim amount. Transcript of Oral Argument at 30–32, Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (2006) (No. 05-260).

286. Some courts have recognized the need to exercise discretion when awarding such relief. *See, e.g.*, Smith v. Wal-Mart Assocs. Group Health Plan, No. 99-6464, 2000 WL 1909387, at *4 (6th Cir. Dec. 27, 2000) (holding that courts must be mindful of potential inequities when deciding § 502(a)(3) claims); Carpenter v. Modern Drop Forge Co., 919 F. Supp. 1198, 1206 (N.D. Ind. 1995) (holding that "the inherent and equitable authority of the court to determine what is fair" authorized the court to apply the common fund doctrine).

287. If the common fund doctrine is not applied, it is possible that the lawyer will not be paid at all. *See, e.g.*, Walker v. Wal-Mart Stores, Inc., 159 F.3d 938, 939–41 (5th Cir. 1998).

288. *See* Scholtens v. Schneider, 671 N.E.2d 657, 665 (Ill. 1996).

than a contract claim—that should be governed by equitable principles such as the common fund doctrine. Interpreting "appropriate equitable relief" as relief consistent with the common fund doctrine would also increase a participant's incentive to sue third-party tortfeasors, thereby deterring tortfeasors at an appropriate level by holding them liable for all the damage they cause.[289] Finally, such an interpretation would also reduce some of the current obstacles to settlement of the underlying tort case by increasing the beneficiary's share of the recovery by the amount of attorneys' fees the beneficiary is no longer required to pay, thereby making settlement more palatable to the beneficiary.[290]

Several courts have argued that importation of the common fund doctrine is not necessary to prevent unjust enrichment because a plan is not unjustly enriched if the plan language requires full reimbursement to the plan.[291] In essence, these courts conclude that plan participants have agreed to the plan terms, thereby entitling the plans to full reimbursement. These courts, however, ignore the reality that plan participants have absolutely no ability to negotiate the terms of coverage for health care.[292] Moreover, although some might argue that a plan participant impliedly agrees to plan terms by accepting benefits, a plan participant, such as a child, who is not a party to the plan and who has no ability to negotiate terms has not "agreed" to the plan terms in the traditional sense that a party to a contract agrees to contractual terms. This point is especially true for plan beneficiaries who are covered because they are the employee's spouse or dependent, given that many such beneficiaries may have never even seen the plan terms.

289. Courts have acknowledged that failure to incorporate the common fund doctrine may cause some beneficiaries to forgo bringing a tort lawsuit against the tortfeasor responsible for causing the damages. *See, e.g.*, Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells, 213 F.3d 398, 402 (7th Cir. 2000) (arguing that the "prospect [that a plan will not have to pay its fair share of attorneys fees] might well deter a suit likely to result in a judgment or settlement not much larger than the benefits available under the plan—and in that event the language on which the plan relies would produce undercompensation for harms that were unrelated to the type of harm to which the benefits pertain").

290. Courts have observed that failure to incorporate the common fund doctrine may reduce a beneficiary's incentive to sue in certain cases. *See, e.g.*, Harris v. Harvard Pilgrim Health Care, Inc., 208 F.3d 274, 279 (1st Cir. 2000) (recognizing that plan participants will not have an incentive to settle when the settlement offer does not exceed the amount necessary to reimburse the plan and pay attorneys' fees); Bollman Hat Co. v. Root, 112 F.3d 113, 117 (3d Cir. 1997) (acknowledging that it is "troublesome" that failure to apply the common fund doctrine may hinder settlements).

291. *See, e.g.*, Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Varco, 338 F.3d 680, 692 (7th Cir. 2003); *Harvard Pilgrim*, 208 F.3d at 279; Ryan v. Fed. Express Corp., 78 F.3d 123, 127–28 (3d Cir. 1996).

292. Silcott v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan, No. 97-7044, 1998 WL 422032, at *6 (E.D. Pa. July 24, 1998) (observing that "beneficiaries have no ability to negotiate whatsoever" and that "[p]lan providers have sole control of the terms of the plan whether fair or unfair").

In a similar vein, other courts have rejected application of the common fund doctrine when such application is contrary to plan terms, on the grounds that such application threatens the integrity of the plan and obstructs ERISA's goal that plan language control.[293] Such reasoning, however, would suggest that any plan provision is enforceable, regardless of its equity.[294] Clearly, that logic cannot prevail. For example, if a plan unambiguously requires the plan participant to repay the plan twice the amount of benefits paid for by the plan, many courts would likely refuse to enforce such a provision by finding it inconsistent with ERISA's primary purpose of protecting plan participants and beneficiaries, or by finding it inconsistent with the common-law remedial principles that are, according to *Varity*, incorporated into § 502(a)(3).[295]

In non-ERISA cases, many state courts have refused to enforce clear and unambiguous provisions simply for the sake of enforcement, recognizing that requiring full reimbursement to the plan or insurer is inconsistent with and contrary to the equitable principles governing subrogation and reimbursement.[296] A leading treatise addressing restitution also contends that insurance policy terms entitling the insurer to full subrogation or reimbursement should not be enforced because of public policy reasons.

> [Such provisions] are against public policy because the

293. *See, e.g.*, Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough, 354 F.3d 348, 361 (5th Cir. 2003); *Varco*, 338 F.3d at 692; *Harvard Pilgrim*, 208 F.3d at 279; United McGill Corp. v. Stinnett, 154 F.3d 168, 172 (4th Cir. 1998).

294. *See* Baron, *supra* note 6, at 616–20 (noting that ERISA does not address subrogation or reimbursement and arguing that reimbursement and subrogation provisions in plan documents should not be enforced simply " [b]ecause [the plan] say[s] so").

295. During the *Sereboff* oral argument, Chief Justice Roberts asked whether a claim seeking enforcement of a plan provision requiring double reimbursement would constitute a claim for appropriate equitable relief. Transcript of Oral Argument at 50–51, Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356 (2006) (No. 05-260). In response, the Assistant to the Solicitor General, arguing for the United States as Amicus Curiae supporting Mid Atlantic Medical Services, Inc., acknowledged that such a plan term should not be enforced simply for the sake of enforcement and suggested that a federal court could refuse to enforce such a provision by determining "a common law of rights and obligations under ERISA plans" or resorting to doctrines like unconscionability. *Id.*

296. *See, e.g.*, Blue Cross & Blue Shield, Inc. v. Dailey, 687 N.W.2d 689, 699 (Neb. 2004) (refusing to enforce clear and unambiguous language requiring full subrogation based on "important equity and policy concerns to the contrary"); York v. Sevier County Ambulance Auth., 8 S.W.3d 616, 619 (Tenn. 1999) (refusing to enforce clear policy provisions requiring full subrogation because such enforcement "is not compatible with the principle of fairness that underlies all equitable doctrines); Hare v. State, 733 So. 2d 277, 284 (Miss. 1999) (observing that requiring full reimbursement to the insurer simply because the policy so requires "ignores the fact that this type of contract is realistically a unilateral contract of insurance and overlooks the insured's total lack of bargaining power in negotiating the terms of these types of agreements"); Franklin v. Healthsource of Ark., 942 S.W.2d 837, 840 (Ark. 1997) (making a similar observation).

> normal understanding of a subscriber to the health service would be that he has purchased the right to payment of his medical and hospital expenses, when in fact this protection may be illusory if he is a tort victim, since he may be required to pay such expenses out of his own assets; that is, out of the proceeds of his tort recovery for elements of damage which may be wholly separate from the expenses in question.[297]

The same policy concerns motivating courts in non-ERISA cases are present in ERISA cases and do not disappear simply because there is an interest in enforcing the terms of an ERISA plan. Moreover, ERISA itself requires that federal courts ensure that any award of equitable relief is "appropriate." Clearly, courts have discretion to refuse to enforce plan terms that are not consistent with long-standing equitable principles, particularly where enforcement obstructs ERISA's primary goal of protecting the interests of participants and beneficiaries. This is not meant to suggest that courts should readily refuse to enforce plan terms addressing other issues. Rather, it is meant to suggest that in this limited context, courts should refuse to enforce plan terms disclaiming the common fund doctrine because such disclaimer is contrary to long-standing equitable principles governing subrogation and reimbursement claims and contrary to the interests of participants and beneficiaries.

Another argument made against incorporation of the common fund doctrine is that such incorporation would greatly increase the cost of providing benefit plans, which would either discourage employers from providing plans or be passed down to plan participants through higher premiums.[298] Many contend, however, that subrogation and reimbursement do not significantly decrease the cost of health insurance because insurers do not take subrogation or reimbursement into account when calculating rates.[299] Even if we assume that subrogation and reimbursement are taken into account when calculating rates, fears that application of the common fund doctrine would cause rates to skyrocket, or even significantly

297. 4 PALMER, *supra* note 33, § 23.18.

298. *See supra* note 9 and accompanying text; *see, e.g.*, Admin. Comm. of the Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Shank, 500 F.3d 834, 838 (8th Cir. 2007) (concluding that if the plan were not fully reimbursed as required by the plan terms, "all other plan members would bear the cost in the form of higher premiums"); *Harvard Pilgrim*, 208 F.3d at 280–81 (making a similar argument in support of its rejection of the "make whole" doctrine).

299. *See, e.g.*, JOHN F. DOBBYN, INSURANCE LAW IN A NUTSHELL 384 (4th ed. 2003) (arguing that subrogation has not reduced insurance rates because "[i]nsurers consistently fail to introduce the factor of such recoveries into rate-determining formulae, but rather apply such recoveries to increasing dividends to shareholders"); Aronson, *supra* note 10, at 284–85; Baron, *supra* note 6, at 627–28; David M. Kono, Note & Comment, *Unraveling the Lining of ERISA Health Insurer Pockets—A Vote for National Federal Common Law Adoption of the Make Whole Doctrine*, 2000 BYU L. REV. 427, 446–47 (2000).

increase, are not realistic. In 2000, the largest provider of subrogation services reported that for every one million persons covered by its clients, it recovered an average of $4.8 million in subrogation.[300] In other words, a plan, on average, recovers $4.80 in subrogation and reimbursement per covered person per year. Incorporating the common fund doctrine will not eliminate a plan's right to recover subrogation or reimbursement; it will merely require plans to contribute to the attorneys' fees and expenses incurred in obtaining the recovery. If we assume that the plan's share of attorneys' fees and costs is 33.3%, application of the common fund doctrine would only increase the per-person cost of coverage by $1.60 each year.[301] Moreover, given that some plans explicitly incorporate the common fund doctrine and agree to pay a pro-rata portion of the attorneys' fees and expenses,[302] application of the common fund doctrine must be economically feasible. Finally, even if such application does slightly increase premiums, it is arguable that most plan participants would be willing to pay slightly higher premiums to ensure that they are more fully covered if they are injured in a tragic accident caused by a third-party tortfeasor. Interpreting "appropriate equitable relief" as relief consistent with the common fund doctrine in cases where a plan is seeking subrogation or reimbursement is not only consistent with longstanding equitable principles but will also ensure that participants and beneficiaries receive the full extent of coverage expected when they are severely injured in an accident.

VII. CONCLUSION

As this Article demonstrates, the courts have failed to uniformly resolve numerous issues concerning the application of the common fund doctrine to an ERISA plan's claim for reimbursement or subrogation. These issues should be resolved clearly and consistently to give ERISA plans, plan participants, and plan beneficiaries the ability to predict and apply the law. More importantly, however, these issues require careful

300. *See* Brief for Secretary of Labor as Amicus Curiae Supporting Appellant's Petition for En Banc Rehearing, Qualchoice, Inc. v. Rowland, 367 F.3d 638 (6th Cir. 2004) (No. 02-3614), 2004 WL 3769987, at *13.

301. For every $4.80 the plan recovered, it would be required to pay $1.60 for attorneys' fees and expenses. In addition, if the Court were to adopt a clear rule requiring application of the common fund rule, there would presumably be some savings in litigation cost because it would no longer be necessary to determine whether state law or federal law requires application of the common fund doctrine to a § 502(a)(3) claim for reimbursement.

302. *See, e.g.*, Mid Atl. Med. Servs., Inc. v. Sereboff, 303 F. Supp. 2d 691, 697 (2004), *aff'd in part and rev'd in part*, 407 F.3d 212 (2005), *aff'd*, 547 U.S. 356 (2006) ("All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Company net of reasonable attorney fees and court costs prorated to reflect that portion of the total recovery which is due the Company for benefits paid.").

resolution to ensure that ERISA serves its primary goal of protecting the interests of plan participants and beneficiaries.

An ERISA plan's state-law claim for reimbursement or subrogation is expressly, impliedly, and completely preempted by ERISA because such a claim "relates to" an employee benefit plan and is inconsistent with the carefully articulated remedial scheme established in § 502(a) of ERISA. Thus, § 502(a)(3) is the only mechanism by which a plan may seek reimbursement or subrogation. State law requiring application of the common fund doctrine is not preempted by ERISA and therefore applies to a plan's § 502(a)(3) claim for reimbursement. State common-law common fund doctrines are not preempted because they are laws of general application that do not "relate to" an ERISA plan and do not obstruct ERISA's goals. State statutes codifying the common fund doctrine as part of an anti-subrogation statute are laws regulating insurance and are therefore saved from preemption. Finally, ERISA itself requires application of the common fund doctrine because "appropriate equitable relief" is equitable relief consistent with the common fund doctrine.