ERISA: RECENT FOURTH CIRCUIT CASE LAW

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PREEMPTION

ERISA's broad preemption provision has received much attention in the Fourth Circuit. Section 514(a) of ERISA provides that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” governed by ERISA. 29 U.S.C. § 1144(a). The Fourth Circuit has held that the scope of this provision reaches state law claims such as intentional infliction of emotional distress, and breach of contract, which relate to the administration of an ERISA governed plan, but which arise under general state laws which themselves have no impact on employee benefit plans. See Powell v. Chesapeake and Potomac Tel. Co. of Va., 780 F.2d 419, 421 (4th Cir. 1985); Holland v. Nat'l Steel Corp., 791 F.2d 1132, 1135-1136 (4th Cir. 1986); Stiltner v. Beretta U.S.A. Corp., 74 F.3d 1473, 1480-1481 (4th Cir. 1996). Additionally, state law waiver and estoppel claims have been held to “relate to” an ERISA plan, and are therefore preempted by ERISA. See White v. Provident Life & Accident Ins. Co., 114 F.3d 26, 29 (4th Cir. 1997); Holland v. Burlington Indus. Inc., 772 F.2d 1140, 1147 (4th Cir. 1985).

Various other laws have been found to “relate to” an ERISA plan. A state common law doctrine that equates substantial compliance with the terms of an insurance policy as actual compliance is preempted when applied to a change of beneficiary provision of an ERISA plan life insurance policy. See Phoenix Mutual Life
Ins. Co. v. Adams, 30 F.3d 554, 560 (4th Cir. 1994). Additionally, the Fourth Circuit has held that a state wrongful death statute that limits reimbursement to an employee benefit plan that pays for injuries caused by third parties is preempted when the damages recovered as a settlement clearly belong to the deceased plan participant and her estate. See McInnis v. Provident Life & Accident Ins. Co., 21 F.3d 586, 589-590 (4th Cir. 1994); cf. Liberty Corp. v. NCNB Nat'l Bank of S.C., 984 F.2d 1383, 1388 (4th Cir. 1993) (damages received as settlement for the wrongful death of a deceased plan participant belong to the participant’s beneficiaries and therefore the limitation on reimbursement does not relate to the plan). Likewise, a state apportionment statute that limits a medical provider’s recovery of settlement funds to fifty percent of the damages recovered by an insured against a third party is preempted. See Hampton Indus., Inc. v. Sparrow, 981 F.2d 726, 729 (4th Cir. 1992). These cases appear to be in agreement with the Supreme Court’s holding in FMC Corp. v. Holliday, 498 U.S. 52 (1990), that a state law precluding reimbursement from a claimant’s tort recovery for benefit payments was preempted by ERISA. The court found that the law directly restricted the plan administrator’s choice of structure for reimbursing liabilities in the event of recovery from a third party.

Although a wide variety of laws have been held to “relate to” an ERISA plan, the Fourth Circuit has put the brakes on the wide-reaching ERISA preemption provision in the area of state law malpractice claims involving professional services to ERISA plans. The Fourth Circuit has held that these claims do not relate to an ERISA plan because they affect neither the core functions performed by ERISA plans, nor the central ERISA players, and are not an alternate enforcement mechanism for employees to obtain
ERISA plan benefits. See Custer v. Sweeney, 89 F.3d 1156, 1164-1168 (4th Cir. 1996) (legal malpractice claim against attorney); Coyne & Delany Co. v. Selman, 98 F.3d 1457, 1466-1472 (4th Cir. 1996) (professional malpractice claim against insurance consultant). An emerging issue in the area of preemption which has not yet been addressed by the Fourth Circuit is medical malpractice claims against an HMO. The Tenth Circuit has confronted this issue and held that ERISA does not preempt a claim that an HMO is vicariously liable for the alleged medical malpractice of one of its physicians. The Tenth Circuit based its decision on the fact that the claim did not involve the administration of benefits or the level or quality of benefits promised by the plan. Furthermore, the Tenth Circuit did not think that reference to the plan to establish an agency relationship between the HMO and doctor implicated the concerns of ERISA preemption. See Pacificare of Oklahoma, Inc. v. Burrage, 59 F.3d 151 (10th Cir. 1995).

Interestingly, while some courts have decided otherwise, the Fourth Circuit has also ruled that employee claims for pension and welfare benefits as remedies in wrongful discharge cases are not preempted when the substantive claim does not relate to the ERISA plan. Pizlo v. Bethlehem Steel Corp., 884 F.2d 116, 120-121 (1989).

Obviously, if there is no ERISA plan then there is no preemption. Whether or not a plan exists has been debated in several cases. The purchase of an insurance policy by an employer does not automatically establish a welfare benefit plan under ERISA. See Custer v. Pan American Life Ins. Co., 12 F.3d 410, 417 (4th Cir. 1993). “[F]or ERISA to apply there must be (1) a plan, fund or program, (2) established or maintained (3) by an employer, employees organization, or both, (4) for the purpose of providing a benefit, (5) to employees or their beneficiaries.” Id. Neither a pension nor retirement

Although ERISA’s preemptive scope is broad, the “savings clause” explicitly saves state laws that regulate insurance from ERISA preemption. 29 U.S.C. §1144(b)(2)(A). However, ERISA further provides in the “deemer clause” that state insurance laws are not saved from preemption if they deem an employee benefit plan to be an insurance company in order to regulate it. 29 U.S.C. §1444(b)(2)(B). The practical affect of these two provisions is what has been dubbed the “self-insurance anomaly.” Self-funded plans are protected from indirect state regulation by the deemer clause, while plans that purchase commercial insurance are subject to any and all state laws that regulate insurance.

Some Fourth Circuit opinions interpreting the savings clause have focused on whether or not the purchase of stop-loss insurance by self-insured plans makes those plans susceptible to regulation by state insurance laws. The Fourth Circuit has answered that question in the negative. See Tri-State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309, 315 (4th Cir. 1994); Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991). Recently the Fourth Circuit reiterated its position when it preempted a Maryland insurance regulation aimed at self-funded employee benefit plans that purchased stop-loss insurance. See American Medical Sec., Inc. v. Bartlett, 111 F.3d 358, 362-365 (4th Cir. 1997). Specifically, the regulation required the self-insured plans to include certain health benefits if the attachment point of their stop-loss insurance was below a mandated minimum. Id. at 362. Although the insurance
regulation would appear to escape ERISA preemption under the savings clause, the court held that the regulation violated the ERISA provision that no ERISA plan shall be deemed to be an insurance contract for purposes of any state law purporting to regulate insurance companies. \textit{Id.} at 364.

In addition to the stop-loss insurance issue, the Fourth Circuit has addressed an intriguing savings clause issue dealing with an action for improper claims processing under state unfair trade practices acts. In an early decision, the Fourth Circuit held that because the insurance savings clause exempts from preemption only those state insurance laws that regulate the “business of insurance,” regulation of purely administrative activities of insurers by an unfair trade practices act is not saved from preemption. \textit{Powell}, 780 F.2d at 423-424. Subsequent to the \textit{Powell} decision the Supreme Court addressed preemption of improper claims processing actions in \textit{Pilot Life Ins. Co. v. Dedeaux}, 481 U.S. 41 (1987). The Fourth Circuit has interpreted the \textit{Pilot Life} decision to mean that any state cause of action for improper claims processing filed against an insurer is not saved from preemption under the savings clause. \textit{Custer}, 12 F.3d at 420.

The savings clause does actually work to save some laws from ERISA preemption. In the area of health care, the Fourth Circuit has held that a state “any willing provider” statute is a law regulating the business of insurance and therefore saved from preemption by the savings clause. \textit{See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.}, 995 F.2d 500, 503-505 (4\textsuperscript{th} Cir. 1993).

There are exemptions to ERISA's broad preemption provision other than the savings clause. For example, joining the growing ranks of its sister circuits, the Fourth

**DISCLOSURE REQUIREMENTS**

ERISA requires a plan administrator to furnish each participant with a summary plan description (SPD) and other relevant plan information. The Fourth Circuit cases addressing this disclosure requirement can be divided into two categories: (1) those discussing what document controls the award and denial of benefits; and (2) those addressing what documents must be provided and when.

A common problem related to the disclosure requirement is whether participants may enforce the terms of an SPD rather than the plan itself. The Fourth Circuit has held that unless a plaintiff can prove both a conflict between the plan and the SPD, and reliance on or prejudice resulting from terms in the SPD, the plan will control. **Martin v. Blue Cross & Blue Shield of Va., Inc.**, 115 F.3d 1201, 1209 (4th Cir. 1997). This rule is based on a recognition by the Fourth Circuit that the SPD is the employee’s primary source of information regarding benefits and therefore should control when the employee has relied on the conflicting terms of the SPD. **Pierce v. Security Trust Life Ins. Co.**, 979 F.2d 23, 27 (4th Cir. 1992).

The existence of a conflict between the terms of the plan and the SPD is often debated. The Fourth Circuit has held that where a plan gives more detail than the SPD
but does not contradict its terms there is no conflict between the plan and the SPD. See Martin, 115 F.3d at 1205; Hendricks v. Central Reserve Life Ins. Co., 39 F.3d 507, 512 (4th Cir. 1994). However, the Fourth Circuit has found a conflict where the SPD allowed a retiring employee to obtain a vested interest in a pension account if he had completed twenty years of service with the firm while the official plan required twenty years of service and the attainment of age sixty. Aiken v. Policy Mgmt. Systems Corp., 13 F.3d 138, 141-142 (4th Cir. 1993).

While determining whether there is a conflict between the SPD and the plan has often been the focus of the Fourth Circuit’s decisions, conflicting terms alone are not enough to obtain a ruling that the terms of the SPD control. See Stiltner v. Beretta U.S.A. Corp., 74 F.3d 1473, 1478-1479 (4th Cir. 1996). In Stiltner the court recognized that there was a conflict between the plan and SPD but refused to allow the plaintiff to base his claim on the terms of the SPD because the plaintiff was unable to demonstrate reliance. Id.

The Fourth Circuit has also addressed cases involving the presence of a disclaimer in the SPD that “the plan controls.” When the employer seeks to enforce the terms of the SPD against the employee the disclaimer in the SPD will be given effect and the plan will control. See Glocker v. W.R. Grace & Co., 974 F.2d 540, 542-543 (4th Cir. 1992), appeal after remand 68 F.3d 460 (4th Cir. 1995). However, if the plan favors the employer rather than the employee, the employer cannot invoke the terms of the plan by relying on a disclaimer in the SPD that designates the plan as controlling. See Pierce, 979 F.2d at 27-28; Aiken, 13 F.3d at 140.
ERISA § 104(b)(4) provides that in addition to the SPD, an administrator must provide plan participants and beneficiaries with “other instruments under which the plan is established or operated” upon request. The Fourth Circuit has construed this provision narrowly as encompassing all “formal or legal documents under which a plan is set up or managed.” *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 653 (4th Cir. 1996), *cert. denied*, 117 S. Ct. 738 (1997). In interpreting this provision the Court explicitly rejected the Sixth Circuit’s interpretation of the phrase (“any documents that would assist participants and beneficiaries in determining their rights under a plan and in determining whether a plan is being properly administered”) as well as that of the Ninth Circuit (“those documents that provide individual participants with information about the plan and benefits”) *Id.* at 654.

A district court may in its discretion assess penalties of up to $100 a day against plan administrators who fail to furnish SPDs and other instruments under which the plan is established or operated within thirty days of when they are requested. *See Glocker*, 974 F.2d at 544. The Fourth Circuit has adopted a two-part test to guide district courts in their decision to impose penalties. *See Davis v. Featherstone*, 97 F.3d 734, 738 (4th Cir. 1996). According to this test, the courts should consider the prejudice to the plaintiff as a result of the delay in receiving the documents, and the nature of the administrator’s conduct in responding to the participant’s request for plan documents. *Id.* Recently the court applied this test in deciding to uphold a penalty award of twenty dollars a day for five-hundred and thirty-one days for an administrator’s failure to provide a copy of the plan to a former employee who had a colorable claim for benefits under the plan,

PLAN AMENDMENTS

ERISA requires that every employee benefit plan be established and maintained pursuant to a written instrument and that the plan provide a procedure for amending the plan and for identifying the persons who have authority to amend the plan. 29 U.S.C. § 1102(a)(1) & (b)(3). Based on that clear statutory directive, the Fourth Circuit has concluded that in order to be effective, "any modification to a plan must be implemented in conformity with the formal amendment procedures and must be in writing." Healthsouth Rehab. Hosp. v. American Nat'l Red Cross, 101 F.3d 1005, 1009 (4th Cir. 1996), citing Coleman v. Nationwide Life Ins. Co., 969 F.2d 54, 58 (4th Cir. 1992). Oral statements do not override the written terms of ERISA benefit plans, Sargent v. Holland, 114 F.3d 33, 37 (4th Cir. 1997), and oral and informal written amendments to ERISA plans are completely incapable of altering the specified terms of the plan’s written coverage, Biggers v. Wittek Indus., Inc., 4 F.3d 291, 295 (4th Cir. 1993). Applying these requirements, the Fourth Circuit has held that a reference to lifetime benefits in non-plan documents provided to retirees can not override an explicit reservation of the right to modify contained in the plan documents. See Gable v. Sweetheart Cup Co., 35 F.3d 851, 857 (4th Cir. 1994). The Fourth Circuit is not the only court to have reached this astonishing conclusion. See Sprague v. General Motors Corp., 768 F. Supp. 605 (E.D. Mich. 1991) (so long as employer clearly reserves the right to modify health insurance benefits it can do so despite statements that it will provide those benefits for life).
If a plan does not provide procedures for amendment, as required by section 402(b)(3) of ERISA, the plan can still be amended but only when the amendment is in writing and accompanied by a clear manifestation of intent to alter the policy or plan. See Biggers, 4 F.3d at 296. In Biggers the employer did not reserve the power to modify its plan but the court found such power inherently reserved to the employer under ERISA. Id. at 295. A situation similar to that in Biggers was addressed by the Supreme Court in Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73 (1995).

However, in that case the Supreme Court found that the plan did contain procedures for amendment because the employer had included in the plan a statement that the company reserved the right to modify or amend the plan. Id. at 79-80. The court found that the reservation clause satisfied the requirements of section 402(b)(3) by identifying the company as the person with authority to amend the plan, and a unilateral company decision to amend as the procedure for amending the plan. Id.

Because a welfare benefit plan is not subject to ERISA’s vesting provisions an employer is free to amend the terms of the plan or terminate it entirely. See Biggers, 4 F.3d at 295; Sejman v. Warner-Lambert Co., 889 F.2d 1346, 1348 (4th Cir. 1989); Doe v. Group Hospitalization & Medical Svcs., 3 F.3d 80, 84 (4th Cir. 1993). However, the Fourth Circuit has held that coverage of a well-defined health procedure of a limited duration vests when the procedure begins, so that a subsequent amendment to the plan does not apply retroactively to deny coverage to the plaintiff. See Wheeler v. Dynamic Engineering, Inc., 62 F.3d 634, 639-640 (4th Cir. 1995). In Wheeler the court found that the plaintiff was entitled to coverage for ongoing cancer treatment as her right to such treatment vested when the procedure began. Wheeler, 62 F3d at 640. In reaching its
decision the Fourth Circuit specifically addressed cases in which employees with AIDS unsuccessfully sued their employers under section 510 for amending their health plans to eliminate coverage for AIDS-related claims. See McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991) and Owens v. Storehouse, Inc., 984 F.2d 394 (11th Cir. 1993). The court found the opinions of the other circuits to be inapposite based on a meaningful distinction between a specific medical procedure terminating after several months, and treatment for AIDS which continues throughout an employee’s lifetime and may well involve a variety of unforeseeable future procedures. Id. at 640. The court emphasized that when the entire procedure terminates within a fixed and relatively short period of time it poses little danger of imposing massive unforeseen costs on the employer. Id.

Retirement plans are subject to ERISA’s vesting requirements and therefore may not be amended freely. ERISA’s anti-cutback rule prohibits amendments to a retirement plan which diminish the accrued benefits of the participants. See Davis v. Burlington Indus., Inc., 966 F.2d 890, 897 (1992).

The Fourth Circuit has addressed when disclosure of contemplated plan changes is appropriate. ERISA provides that plan participants and beneficiaries be apprised of any material modification in the terms of the plan. 29 U.S.C. §1022(a)(1). This notice requirement can be fulfilled by distributing an SPD containing a modification clause at any time before the modification or termination of the plan occurs. See Pierce v. Security Trust Life Ins. Co., 979 F.2d 23, 28, 30 (4th Cir. 1992). In fact, the Fourth Circuit has held that ERISA does not require a fiduciary to furnish information regarding amendments before the amendments are put into effect. See Stanton v. Gulf Oil Corp.,
792 F.2d 432, 435 (4th Cir. 1986). However, it is important to take notice of recent decisions in the Third Circuit which have held an employer liable for breach of fiduciary duty for denying or failing to disclose when asked that it was “seriously considering” an early retirement program. See Fischer v. Philadelphia Elec. Co., 96 F.3d 1533 (3d Cir. 1996); Kurz v. Philadelphia Elec. Co., 96 F.3d 1544 (3d Cir. 1996).

STANDARD OF REVIEW FOR DENIAL OF BENEFITS

The Fourth Circuit has developed a well-settled framework for reviewing the denial of benefits under ERISA plans. See Ellen v. Ellis, 126 F.3d 228, 232 (4th Cir. 1997). This framework is based on the Supreme Court’s decision in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), which determined that the appropriate standard of review is de novo unless the plan grants an administrator discretion to determine eligibility or to construe the terms of the plan. Where the benefit plan does grant the administrator or fiduciary discretionary authority, the denial decision is reviewed for abuse of discretion. See Ellen, 126 F.3d at 232 (citing Firestone, 489 U.S. at 111, 115); Brogan v. Holland, 105 F.3d 158, 161 (4th Cir. 1997); Bedrick v. Travelers Ins. Co., 93 F.3d 149, 152 (4th Cir. 1996); Bernstein v. CapitalCare, Inc., 70 F.3d 783, 787 (4th Cir. 1995); Doe v. Group Hospitalization & Medical Svcs., 3 F.3d 80, 85 (4th Cir. 1993). Under the deferential abuse of discretion standard, the administrator or fiduciary’s decision is not disturbed if it is reasonable, even if the reviewing court would have come to a different conclusion independently. See id. citing Brogan, 105 F.3d at 161; Haley v. Paul Revere Life Ins. Co., 77 F.3d 84, 89 (4th Cir. 1996); Bernstein, 70 F.3d at 787; Fagan v. Nat’l Stabilization Agrmt. of the Sheet Metal Indus. Trust Fund, 60
A fiduciary’s decision is reasonable if it is “the result of a deliberate, principled reasoning process and if it is supported by substantial evidence.” Doe, 3 F.3d at 85.

Disputes over the correct standard of review arise when the plan administrator or fiduciary has discretionary authority and is operating under a conflict of interest. The Supreme Court has recognized that the conflict must be weighed as a factor in determining if there is an abuse of discretion. Ellen, 126 F.3d at 233 citing Firestone, 489 U.S. at 115. The Fourth Circuit opines that in determining whether an administrator or fiduciary has abused its discretion a reviewing court should consider: (1) the scope of the discretion conferred; (2) the purpose of the plan provision in which the discretion is granted; (3) any external standard relevant to the exercise of that discretion; (4) the administrator’s motives; and (5) any conflict of interest under which the administrator operates in making its decision. Haley, 77 F.3d at 89 (citing Restatement (Second) of Trusts). “[T]he court applies the conflict of interest factor, on a case by case basis, to lessen the deference normally given under this standard of review only to the extent necessary to counteract any influence unduly resulting from the conflict.” Ellis, 126 F.3d at 233 (citing Bedrick, 93 F.3d at 152); Bailey v. Blue Cross & Blue Shield, 67 F.3d 53, 56 (4th Cir. 1995); Doe, 3 F.3d at 87. The bottom line is that decisions made by fiduciaries with a conflict of interest are subjected to a “sliding scale” of additional scrutiny. See Ellis, 126 F.3d at 233. “The more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan
terms, the more objectively reasonable the administrator or fiduciary’s decision must be and the more substantial the evidence must be to support it.” Id.

One interesting thing to note about the Fourth Circuit’s de novo standard of review of an administrator’s or fiduciary’s decision is what evidence it allows the court to examine. The Fourth Circuit has taken the position that additional evidence other than that presented to the plan administrator should be permitted as part of the review process if, and only if, such evidence is necessary to resolve the benefit claim. See Quesinberry v. Life Ins. Co., 987 F.2d 1017, 1025 (4th Cir. 1993). In reaching this conclusion the Fourth Circuit looked at the approach taken by several other circuits, citing two circuits that did not allow additional evidence, two that did, and two that distinguished between evidence regarding interpretation of the plan and evidence regarding facts. Based on its review of the law in the other circuits the court then identified seven categories of exceptional circumstances that might warrant an exercise of the court’s discretion to allow additional evidence. The court found that such exceptional circumstances existed in the Quesinberry case and admitted additional medical testimony regarding the plan participant’s cause of death. Id. at 1027.

ATTORNEY’S FEES

Section 502(g) of ERISA provides that the court may in its discretion allow a reasonable attorney’s fee. See 29 U.S.C. § 1132(g)(1). To guide the district courts in determining whether or not to award attorney’s fees the Fourth Circuit has adopted a five-factor test. See Quesinberry v. Life Ins. Co., 987 F.2d 1017, 1029 (4th Cir. 1993). The five factors to be considered by the lower courts are: (1) the degree of the opposing
parties’ culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney’s fees; (3) whether the award of attorney’s fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties’ positions.  Id.  These five factors are not meant to be a rigid test but rather a general guideline.  Id.  The test provides the appellate court with a basis for reviewing whether or not the district court’s award of attorney’s fees was an abuse of discretion.  Id.  Although this five-factor test is completely different than the Title VII standard for awarding attorney’s fees, a majority of circuits have adopted the test.

The Fourth Circuit recently established that only a prevailing party is entitled to consideration for attorney’s fees in an ERISA action.  See Martin v. Blue Cross & Blue Shield of Va., Inc., 115 F.3d 1201, 1210 (4th Cir. 1997).  However, there is no presumption in favor of awarding fees to a prevailing insured or beneficiary as the award is discretionary and not a mandatory fee shifting.  See Quesinberry, 987 F.2d at 1030.  In other words, a party must demonstrate more than just being a prevailing party in order to recover attorney’s fees.  See Custer v. Pan American Life Ins. Co., 12 F.3d 410, 422 (4th Cir. 1993).

SECTION 510 LIABILITY

Interference with protected rights is prohibited by section 510 of ERISA. Plaintiffs who brings claims under section 510 must prove specific intent by the defendants to interfere with their pension rights. See Conkwright v. Westinghouse Elec. Corp., 933 F.2d 231, 239 (4th Cir. 1991); Henson v. Liggett Group, Inc., 61 F.3d 270, 277-78 (1995). Because ERISA claimants confront proof problems similar to those encountered by Title VII plaintiffs, the Fourth Circuit has held that the Title VII McDonnell Douglas framework of shifting burdens of production is appropriate in the context of ERISA section 510 claims. See Conkwright, 933 F.2d at 239; Runnebaum v. NationsBank of Maryland, 123 F.3d 156, 175 (4th Cir. 1997). Under the McDonnell Douglas framework the plaintiff has the burden of presenting a prima facie case after which the burden shifts to employer to provide a legitimate non-discriminatory reason for its actions. If the employer is able to provide such a reason than the burden shifts back to the plaintiff to prove that the employer’s articulated reason is a pretext. Evidence that the employer acted to save money is not enough to support a claim of pretext. Conkwright, 933 F.2d at 239.

Section 510 of ERISA has been interpreted by the Fourth Circuit to provide fully vested employees a cause of action for a denial of their ability to accrue additional retirement benefits. See Conkwright, 933 F.2d at 236 (emphasis added). However, ERISA § 510 does not preclude an employer from revoking health insurance benefits which are being provided gratuitously. See Stiltner v. Beretta U.S.A. Corp., 74 F.3d 1473, 1482 (4th Cir. 1996). But, benefits originally provided gratuitously may become
nongrataitious and thus protected under section 510 of ERISA. Id. at 1484. This can happen when benefits are provided regularly and consistently, when the employer has a formal policy that determines eligibility for the benefits, or when the employer refers to the benefits as an inducement to future employees. Id.

There are conflicting opinions in the Fourth Circuit regarding who can be sued under section 510 of ERISA. At one point the court held that the provisions of section 510 apply only to actions against employers, and not against insurers or other third party administrators of insurance benefits. See Rogers v. Jefferson-Pilot Life Ins. Co., 883 F.2d 324, 326 (4th Cir. 1989). However, in a subsequent opinion the court interpreted the word person in section 510 as indicating that an employee was not limited to bringing an action against his employer, as the definition of person includes any corporation, mutual company or association. See Custer v. PanAmerican Life Ins. Co., 12 F.3d 410, 421 (1993).

**FIDUCIARY LIABILITY**

An ERISA fiduciary is not limited to those named as fiduciaries in the plan instruments but includes any individual who de facto performs specified discretionary functions with respect to the management, assets, or administration of a plan. See Custer v. Sweeney, 89 F.3d 1156, 1161 (4th Cir. 1996); see also Varity Corp. v. Howe, 516 U.S. 489 (1996). To determine fiduciary status, the court must examine the functions performed by the alleged fiduciary. Custer, 89 F.3d at 1162. The court in Custer determined that an ERISA plan’s attorney was not a plan fiduciary. Id. at 1163. The mere fact that an attorney represents an ERISA plan does not make the attorney
an ERISA fiduciary because legal representation of ERISA plans rarely involves the
discretionary authority or control required by the statute’s definition of fiduciary. Id. at
1162. However, legal counsel to a pension plan is not automatically precluded from
being labeled an ERISA fiduciary. Id. Fiduciary status under ERISA is not an all or
1992). A party is a fiduciary only as to the activities that bring the person within the
statutory definition of fiduciary. Id. This means that when a court is determining a
breach of fiduciary duty it must ask whether a person is a fiduciary with respect to the
particular activity at issue. Id. For example, in the Coleman case the plaintiff was
claiming a breach of fiduciary duty by Nationwide for failing to notify her of the
termination of her insurance coverage. Id. at 60. The court looked at the particular
function of notification and found that Nationwide was not a fiduciary as to that function.
Id. at 61-62.

STANDING

Section 502(a) of ERISA identifies what persons are empowered to bring a civil
action under ERISA. See 29 U.S.C. § 1132(a). Standing to sue under ERISA is
somewhat complicated as it is dependent on the type of action brought. Fourth Circuit
cases have addressed who has standing to sue (1) to obtain requested plan information
and recover benefits, (2) for breach of fiduciary duty, and (3) for an injunction and other
equitable relief.

A participant or beneficiary has standing to sue for an administrator’s refusal to
supply requested information or to recover benefits due to him under the terms of his
plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. See 29 U.S.C. § 1132(a)(1). In Davis v. Featherstone, the court held that a former employee who “may become eligible for benefits” is a participant who has standing to sue to obtain a copy of the employer’s disability plan. 97 F.3d 734, 738 (4th Cir. 1996).

Joining the majority of other circuit courts, the Fourth Circuit has held that § 1132(a)(1)(B) does not permit civil actions brought by administrators of self-funded plans. See Provident Life & Accident Ins. Co. v. Waller, 906 F.2d 985, 987-88 (1990) (action to recover advanced benefits not allowed). Additionally, a fiduciary lacks standing under section 1132(a)(1)(B) to bring a suit to recover benefits for a participant or beneficiary as only a participant or beneficiary has standing to bring a claim for wrongful denial of benefits under the statute. See Coyne & Delany Co. v. Blue Cross & Blue Shield of Va., Inc., 102 F.3d 712, 714 (4th Cir. 1996).

The Fourth Circuit has rendered several opinions regarding who has standing to sue as a participant under section 1132(a)(1)(B). Section 3(7) of ERISA defines the term participant as “any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer . . .." 29 U.S.C. § 1002(7). In accordance with ERISA’s definition of participant, a plaintiff who is neither a present or former employee of defendant has no standing to sue as a participant. See Mullins v. Blue Cross & Blue Shield of Va., 79 F.3d 380, 381 (4th Cir. 1996); West v. Murphy, 99 F.3d 166, 168 (4th Cir. 1996). The Supreme Court ruled in Northwestern Mut. Ins. Co. v. Darden, 503 U.S. 318 (1992) that the determination of who qualifies as an employee under ERISA should
be made according to common law principles and adopted a 13 factor test for making the determination. See Darden v. Nationwide Mutual Ins., Co., 969 F.2d 76, 78 (1992). Applying the test adopted in Darden, the Fourth Circuit has held that a sole shareholder of a closely held corporation who is insured under the health policy provided by the corporation is an employee under the common law agency test and therefore a participant in the plan. See Madonia v. Blue Cross & Blue Shield of Va., 11 F.3d 444, 498-99 (4th Cir. 1993).

In addition to satisfying the test of a common law employee an individual must be eligible to receive a benefit under the plan according to the language of the plan itself in order to be a participant. See Clark v. E.I. DuPont De Nemours & Co., No. 95-2845, 1997 U.S. App. LEXIS 321, at *6 (4th Cir. Jan. 9, 1997). The court in Clark held that a leased employee was not a participant entitled to ERISA benefits even though he was counted as part of the covered employees of the plan for the limited purpose of obtaining favorable tax treatment. Id. at *8-11. The plan expressly excluded from the receipt of benefits those individuals who were treated as employees of the company for limited purposes under the leased employee provisions of section 414(n) of the Internal Revenue Code. Id. at *8. Since ERISA allows an employer to limit coverage to certain employees as long as the distinction is not based on age, or length of service, the provision in the plan which excluded leased employees was upheld as enforceable. Id. at *10.

Civil actions for breach of fiduciary duty can be brought by the Secretary, a participant, beneficiary or fiduciary. See 29 U.S.C. § 1132(a)(2). Standing under this section has been granted to a plaintiff who was a participant and beneficiary of the fund
at the time he intervened in a lawsuit in spite of the fact that most of the alleged breaches of fiduciary duty occurred before the plaintiff obtained a direct interest in the fund.  See Brink v. DaLesio, 667 F.2d 420, 427-28 (4th Cir. 1981).  In another case, standing as a participant was not granted to a plaintiff who voluntarily retired from the defendant company, and then sued for breach of fiduciary duty under a new early retirement plan enacted by the defendant after the plaintiff’s retirement date. See Stanton v. Gulf Oil Corp., 792 F.2d 432, 434-35 (4th Cir. 1986).  Standing under this section has also been denied to a service provider who claimed derivative standing to sue after the plan’s third party claims processor had incorrectly stated that the individual to whom services were provided was a participant in the self-insured welfare plan.  See Healthsouth Rehab. Hosp. v. American Nat’l Red Cross, 101 F.3d 1005, 1008-09 (4th Cir. 1996).  A plan sponsor acquires standing to sue as a fiduciary under § 1132(a)(2) to the extent it retains or exercises any of the responsibilities listed in ERISA’s definition of fiduciary.  See Coyne & Delany Co. v. Selman, 98 F.3d 1457, 1464-65 (4th Cir. 1996).

A participant, beneficiary, or fiduciary can sue to enjoin any act or practice which violates any terms of the plan, or to obtain other appropriate equitable relief.  29 U.S.C. § 1132(a).  According to the Fourth Circuit, a union with authority to remove and replace one-half of a plan’s trustees has standing to sue as a fiduciary under this section to the extent that it challenges as violative of ERISA or the terms of the plan, any act or practice which pertains to the appointing and replacing of trustees.  Licensed Div. Dist. No. 1 v. DeFries, 943 F.2d 474, 477-78 (1991).
PLAN TERMINATIONS

Residual Assets. ERISA does not provide as a sanction for failing to pay a liability that the employer forfeit its claim to all excess assets in the plan to which it otherwise would have been entitled by the terms of the plan. Fuller v. FMC Corp., 4 F.3d 255 (1993). Where the Plan mandated the satisfaction of contingent rights accrued under the Plan, unreduced early retirement benefits were required to be paid prior to any reversion of surplus funds. Tilley v. Mead Corp., 927 F.2d 756 (1991). On the date of termination the employer was no longer obligated to make contributions, and the participants no longer were entitled to accrue additional benefits. The rights of both parties became fixed and substantive modifications to the plan altering these rights were precluded. Id. Limitation in amendment provision prohibited employer from amending the plan to add the residual assets amendment and ERISA afforded the employer no basis for altering the substantive terms of the plan after its termination. Audio Fidelity Corp. v. PBGC, 624 F.2d 517 (4th Cir. 1980). Residual assets amendment upheld. Wilson v. Bluefield Supply Co., 819 F.2d 457 (4th Cir. 1987).

Involuntary terminations. The termination date for involuntary termination is set by selecting the earliest date on which participants had notice of termination, and then selecting whatever later date serves the interests of the PBGC. PBGC v. Mize Co., 987 F.2d 1059 (4th Cir. 1993).

Voluntary terminations. Strict compliance with the terms and procedures set forth in Title IV of ERISA is a prerequisite to the termination of an employee retirement and disability benefit plan. Phillips v. Bebber, 914 F.2d 31 (4th Cir. 1990).
CITE LIST

American Medical Security, Inc. v. Bartlett, 111 F.3d 358 (4th Cir. 1997)
Audio Fidelity Corp. v. PBGC, 624 F.2d 517 (4th Cir. 1980)
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