The Wagner Law Group

Disclosure to Welfare Plan Participants: A Fiduciary Duty

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Introduction

When ERISA was enacted in 1974, its primary focus was on employee pension plans, which is understandable since its enactment was a response to highly publicized pension plan failures, such as the failure of the Studebaker Pension Plan. Its requirements with respect to eligibility to participate, vesting, rates of benefit accrual, and funding are applicable solely to pension plans. While its fiduciary requirements are equally applicable to pension plans and welfare benefit plans, the most significant regulations defining prudence and providing investment advice for a fee, while applicable to employee welfare benefit plans that maintained a VEBA under Internal Revenue Code ("Code") Section 501(c)(9), had as their focus tax-qualified defined benefit pension plans.

Over the past three decades, as evidenced most recently by the number of group health plan provisions included in the recently enacted Consolidated Appropriations Act, 2021 (the "CAA"), there has been a shift in Congressional focus, with the enactment of a series of laws directed to employee welfare benefit plans.[1] In general, these enactments are not focused on fiduciary issues in the welfare plan context but, rather, simply impose specified obligations on health plans. Similarly, from a case law perspective, since 2006, the most frequently litigated cases involving an alleged breach of fiduciary duty under ERISA involve 401(k) plans and 403(b) plans. The existing fiduciary principles are not by their terms restricted to employee pension benefit plans, but can equally well – and should – be applied in the welfare plan context. This article will explore one such area – the need to provide information to participants in group health plans that will provide them with the opportunity to identify the choices that are in their own best interests, and to make informed, cost-conscious decisions.[2]

Executive Summary

When Congress enacted ERISA, it anticipated that courts would develop a federal common law of ERISA based on the longstanding common law of trusts. The common law of trusts is not static, and in creating a federal common law of ERISA, a significant element of which is articulating a fiduciary's duties and responsibilities, courts are required to apply long standing and well established principles to new and frequently evolving circumstances.

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[1] For example, past requirements imposed rules regulating coordination of benefits with Medicare, multiple employer welfare arrangements, continuation coverage following an employee's or a dependent's loss of regular health coverage due to certain qualifying events, HIPAA nondiscrimination rules and limitations on preexisting condition exclusions, mental health parity, standards relating to benefits for mothers and newborns, genetic nondiscrimination, post-mastectomy reconstructive surgery, coverage of dependent students on medically necessary leaves of absence, HIPAA privacy/HITECH, the Affordable Care Act, and more recently requirements that COVID-19 testing and vaccinations be covered without cost sharing. The CAA added, among other things, new rules regulating surprise billing for out-of-network services and imposing transparency requirements.

[2] A concrete illustration of such information would be the information provided by an app that would indicate, to employees deciding which type of medical plan to select, the likelihood that they might be over-insuring for medical coverage, particularly where one of the options offered is a consumer directed health plan ("CDHP").

At this point in time, we believe that sponsors of group health plans have a clear ERISA fiduciary duty to provide information to plan participants, to ensure they can make informed decisions in their own best interest. Failure to provide that information should be viewed as a breach of the sponsor's fiduciary duties, and could expose the sponsor to significant liability.

The fiduciary must provide this information in an understandable format. If the average plan participant does not understand the information provided, he or she will be unable to make informed, cost-conscious decisions. While there is no prescribed format for providing the required information, simply providing links to materials that participants cannot reasonably be expected to understand does not satisfy the fiduciary duty. The duty is to provide material information, the determination of which is likely to evolve further over time with advances in both medicine and technology, and will need to be addressed in the courts.

There are no bright line rules with respect to materiality, so fiduciaries will need to exercise their best judgment. Further, the fiduciary's duty is limited to providing material information to plan participants; the manner in which that information will be used by participants, if at all, is not, and cannot be, the fiduciary's obligation. Thus, there may be limits to the benefits of disclosure, but the obligation to disclose material information that will afford employees the opportunity to make informed cost conscious decisions is clear.

The Evolution of ERISA Fiduciary Duties

Most of the statutory duties of a fiduciary under Title I of ERISA[3] are applicable in all time periods. A fiduciary has been and is always required to administer a plan solely in the interest of plan participants and beneficiaries; to diversify the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and to administer a plan in accordance with its terms, so long as those terms are consistent with ERISA. The prudence requirement, however, has a qualifier: while a fiduciary must act "with the care, skill, prudence, and diligence . . . that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims," such determination is made "under the circumstances then prevailing." A prudent investor in 2021 operates under a very different set of guiding principles than a fiduciary in 1821 and, in fact, differently than a prudent investor as late as the 1980s. Furthermore, the issues presented by cybersecurity could not possibly have been foreseen in earlier decades. While the precise nature of the fiduciary responsibilities associated with cybersecurity risks have yet to be defined by either the Department of Labor ("DOL") or case law, although guidance on that subject by the DOL is anticipated in the near future, those risks are undeniably an element of the "circumstances then prevailing" in 2021, as is the difference in information necessary and desirable to be provided to welfare benefit plan participants.

Certain legal and societal changes can require reconsideration of the fiduciary duties of a prudent ERISA fiduciary, not for the purpose of creating new fiduciary duties, but rather for the more limited purpose of determining the manner in which long existing principles of trust law should be applied in different settings. As more data can be retrieved and analyzed with respect not only to employee pension plans, but also employee welfare benefit plans that might be of

[3] ERISA Section 404; 29 U.S.C. §1104.

value to plan participants and beneficiaries, such information would constitute "part of the circumstances then prevailing" that a prudent fiduciary needs to take into account.

Technology has enabled vast amounts of data to be analyzed, and individuals living in prior times would not understand what terms such as "mega data" and "meta data" mean. These considerations are relevant in defining a potential fiduciary duty to disclose general statistical and analytic information with respect to medical coverage because, as the drafters of the Uniform Trust Act wrote in 1999: "The common law of trusts is not static but includes the contemporary and evolving rules of decision developed by the courts in exercise of their power to adapt the law to new situations and changing conditions."[4] Information that most plan participants are not purchasing medical insurance on a basis that is the most cost efficient for the participant[5] would be a clear illustration of such information that a prudent fiduciary should consider providing to plan participants.[6]

The Evolving Needs of a Health Plan Participant

Although neither the Code nor ERISA requires an employer to establish a group health plan, there are a number of different types of medical plans that an employer can offer to its employees[7]—a health maintenance organization ("HMO");[8] a point of service plan ("POS");[9] a preferred provider organization ("PPO");[10] an exclusive provider organization ("EPO");[11] and a high deductible health plan ("HDHP"),[12] which when combined with a health savings account under Code Section 223, creates a Consumer Driven Health Plan ("CDHP"). Another type of CDHP involves a plan with at least somewhat high deductibles and/or copayments that is combined with a health reimbursement arrangement ("HRA"), where the employer provides

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[4] Uniform Trust Act, National Conference of Commissioners on Uniform State Laws," February 9, 1999.

[5] At the present time, it appears that ERISA fiduciary duties in this regard would only go to helping the participant be cost-efficient as to the participant's needs and costs.

[6] Of course, as would generally be true of the obligations of a prudent fiduciary, the fiduciary should exercise due diligence as to any particular statistical or analytic information before accepting the findings.

[7] This itemization of arrangements is not intended to be an inclusive list of all types of medical plans that an employer could offer to its employees, but rather is intended to be illustrative of the types of medical plans that an employer might offer to its employees.

[8] Except for HMOs, the definitions of types of medical plans referenced in the text are not legal terms, and the definitions for these different types of plans were taken from healthcare.gov. An HMO is a type of health insurance plan that usually limits coverage to care from doctors who work or contract with the HMO. It generally will not cover out-of-network care except in an emergency. An HMO may require an individual to live or work in its service area to be eligible for coverage.

[9] A POS plan is a type of plan in which the member pays less if doctors, hospitals, and other health care providers that belong to the plan's network are used. POS plans also generally require a member to get a referral from the member's primary care doctor in order to see a specialist.

[10] A PPO is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. A member pays less if providers that belong to the network are used. Doctors, hospitals, and providers outside of the network can be used for an additional cost.

[11] An EPO is a managed care plan where services are covered only if doctors, specialists, or hospitals in the plan's network are used (except for an emergency).

[12] Because HDHPs have higher deductibles, they generally have lower premiums than other medical plans. Although there is a potential downside that the high deductibles will result in employees forgoing needed medical care, with possibly resulting adverse outcomes and later higher costs to the plan, those risks can be mitigated if the HDHP is combined with an HSA or an HRA.

funds that the participant can apply towards the deductibles and/or copayments.[13] In light of the wide variations in the health status of individuals, selection of the optimal medical plan for an employee is not a one-size-fits-all proposition, and projection of anticipated medical expenses an employee and his or her dependents may incur in any given plan year cannot be precisely calibrated, however, in an employee benefits context, as a starting point, both employers and employees should have as much information available to them as possible to make an informed decision.

Employees do not in all instances make decisions that would appear to be rational ones. For example, a healthy young employee who is advised that there is an 85% likelihood that he is overpaying for medical benefits if he participates in a PPO or EPO rather than a HDHP may still elect the more expensive plan, because his view of life is that if there is a possibility of a negative medical outcome, it will happen to him, and he wants to be prepared for a worst case scenario. An ERISA fiduciary is not responsible for stopping such behavior or for changing the employee's philosophy of life, and is not responsible for the employee's irrational decision if the appropriate information has been provided. However, if an employee is not provided with information sufficient to make informed, cost-conscious decisions, the employee's decisions will inherently be made on an insufficient and legally deficient basis.[14]

In the October 20, 2010 preamble to final regulations on disclosure of fee and other related information to participants in 401(k)-type plans, the DOL explained that the purpose of the regulation is "to ensure that all participants and beneficiaries in participant-directed individual account plans have the information they need to make informed decisions about the management of their individual accounts and the investment of their retirement savings."[15] In the background section of the preamble to those regulations, the DOL further indicated that "participants and beneficiaries are increasingly responsible for making their own retirement savings decisions. This increased responsibility has led to a growing concern that participants and beneficiaries may not have access to, or, if accessible, may not be considering information critical to making informed decisions about the management of their accounts. . . . When a plan assigns investment responsibilities to the plan's participants and beneficiaries, it is the view of the Department that plan fiduciaries must take steps to ensure that participants and beneficiaries are… provided sufficient information regarding the plan . . . to make informed decisions about the management of their individual accounts."[16]

That same emphasis on informed decision-making is set forth in the preamble to the recently issued regulations with respect to health care transparency, indicating that the three agencies (DOL, IRS, and HHS) "are of the view that transparency in health coverage

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[13] Typically, unused HRA amounts for any year can be carried over to the next year, sometimes repeatedly.

[14] Of course, failure to provide all necessary information does not necessarily result in a breach of fiduciary duty. As the late Justice Scalia observed when he was a member of the Court of Appeals for the D.C. Circuit, a fiduciary might by "prayer, astrology, or just blind luck" (*Fink v. National Savings and Trust*, 772 F. 2d. 951, 961 (D.C. Cir. 1984)) make an objectively prudent decision, but that is not the textbook procedure for fiduciary decision making. Similarly, a participant without full information may select a medical plan that is, in hindsight, the most appropriate for that participant, but a prudent fiduciary should not put the participant in a position to have to operate in such fashion.

[15] 75 FR 64909 (October 20, 2010).

[16] Id.

requirements will strengthen America's health care system by giving health care consumers the information they need to make, or assist others in making, informed decisions about health care providers."[17] Listed among the consumer benefits of health care transparency was that "transparency provides necessary information for consumers to make informed health care decisions,"[18] and that it "enables consumers to evaluate health care options and to make cost-conscious decisions."[19]

The health care transparency regulations are directed to health care consumers in general and not specifically participants in health care plans. Several provisions in the No Surprise Billing Division of the CAA concern health care transparency in the ERISA context, but without any characterization of those statutory obligations as fiduciary in nature. As will be described more fully below, however, fiduciaries with respect to group health plans should have an equivalent fiduciary obligation to provide employees considering whether to invest what will become plan assets[20] in one of a choice between or among medical plans[21] with sufficient information to make informed decisions as to the appropriate medical plan to select.[22] As is true of the selection of investments under individual account plans, in hindsight the selection between

[17] 85 FR 72158,72161 (November 12, 2020).
[18] Id.
[19] Id. See also, M. Porter and E. Teisberg, "Redefining Health Care," Harvard Business School Press (Boston, Mass. 2006) ("without appropriate information, consumer choice has little meaning."). The effectiveness of these regulations will be determined over time. Policymakers assume that patients selectively choose high quality providers based on weighing the information about the different providers (*i.e.*, that they make rational decisions). As behavioral economics has taught, however, this may not necessarily be the case. The process by which consumers select health care providers is a complex one, and consumers may use other information sources rather than comparative information. A patient's previous experience with a health care provider may be an important factor. A positive experience with a particular health care provider may positively influence future choices. Social influences such as a physician's general reputation, the influence of a referring physician, and the recommendations of friends and acquaintances may also be factors. Similarly, a physician's communication style may be relevant. There is evidence that patients prefer a health care provider with a friendly and understanding communication style, who listens to the patient, and with whom the patient has a good relationship. Accessibility of the health care provider may also be a factor in physician choice. However, whether consumers will actually use the information is a separate issue from whether the information should be provided to consumers.
[20] See *Hammer v. Johnson Senior Center*, 2020 WL 7029160 (W.D. Va. 11/30/2020) ("Employee premium contributions withheld from employee paychecks constitute plan assets.") The fiduciary duty to provide participants with material information to allow them to make informed decisions is, however, not linked to information with respect to plan assets. It could apply, for example, to a decision whether to continue in employment or retire, and the discussion in the text is not intended to suggest that there must be a nexus between plan assets and the information for there to be a fiduciary duty. The illustration being described in the text, however, is one that involves plan assets (*i.e.*, the amount that a plan participant spends on premiums for health care coverage). Participant cost sharing (*i.e.*, deductibles, coinsurance, and copayments) is also a subject for which there should be a fiduciary duty to communicate. This White Paper does not address the extent to which those fiduciary duties may apply with respect to providing more general information regarding health and health care. To the extent that an employer makes contributions to an employee's health savings account, that information should also be included as part of the information that an employee needs to receive in order to make a fully informed decision with respect to medical plan selection, although those contributions may themselves not constitute plan assets under ERISA.
[21] DOL Regulation §2510.3-102(c).
[22] *Scalia v. Florida Bankers Health Consortium, Inc., et. al.*, Case No. 6:20-cv-1283-ORL-40EJK (M.D. Fla. January 12, 2021), is a recent illustration of the DOL alleging a breach of fiduciary duty under ERISA for an expenditure of medical plan premiums in excess of those necessary to be expended. The action was dismissed on procedural grounds with the DOL having the opportunity to file an amended complaint, but the relevant point is not the outcome of a specific case, but rather what the DOL regards as a breach of fiduciary duty.

or among medical plans will not in all instances be the one most favorable to plan participants and beneficiaries. However, as the case law with respect to the prudence of investment selection and monitoring makes abundantly clear, an unfavorable outcome is not inconsistent with informed decision making, as long as the process utilized, and information provided, are prudent from a fiduciary perspective.

The general set of fiduciary obligations under Title I of ERISA is applicable to welfare benefit plans.[23] Moreover, there is no clear separation between pension plans and welfare plans with respect to HDHPs and HSAs, because of the potential long-term benefits of transferring from a PPO or EPO to a HDHP/HSA arrangement and having the HSA serve as an additional form of nonqualified deferred compensation.[24] As the DOL stated in the preamble to its recently issued final regulations with respect to the voting of proxies, "fiduciaries are required to act in what they believe to be the long term economic interest of such plan participants, which is a core statutory duty of fiduciaries to such participants."[25] (emphasis added.)

Although Title I of ERISA articulates a number of fiduciary duties, Congress relied on the common law of trusts to define the general scope of fiduciary responsibility,[26] and looked to courts to develop a federal common law of trusts, without mandating that the common law of trusts be frozen as of the date of ERISA's enactment. Thus, for example, while the duty of care has been addressed primarily in the context of investments and secondarily with respect to plan administration, the duty of care also obligates a fiduciary to convey complete and accurate information material to a participant's circumstances.[27] Similarly, the Court of Appeals for the D.C. Circuit has stated in a frequently cited opinion that "the duty to disclose critical information is at the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA."[28] (emphasis added.) The common law of trusts identifies two instances in which a fiduciary is under a duty to inform: when a beneficiary requests information about the

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[23] There are circumstances in which the DOL has not extended to welfare benefit plans the rules applicable to pension plans. For example, when the DOL established a new safe harbor for electronic disclosures for pension plans in May 2020, that safe harbor was not extended to welfare benefit plans, which must continue to rely upon the 2002 safe harbor. 85 FR 31884 (May 27,2020). Similarly, the ERISA 408(b)(2) disclosures for pension plans were reserved with respect to welfare benefit plans. DOL Reg. §2550. 408b-2(c)(2), although the recently enacted CAA extends the ERISA Section 408(b)(2) disclosures to group health plans.

[24] Under Treas. Reg. §1.409A-1(a)(5), a nonqualified deferred compensation plan does not technically include a HSA that satisfies the requirements of Code Sections 105 and 106 such that the benefits or reimbursements are not includible in income.

[25] 85 FR 81658, 81661 (December 16, 2020).

[26] *Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund*, 12 F. 3d 1292, 1299 (3d Cir. 1993), citing *Central States Southeast and Southwest Areas Pension Fund v. Central Transport, Inc*., 472 U.S. 559, 570 (1985).

[27] *Krohn v. Huron Memorial Hospital*, 173 F. 3d 542, 547 (6th Cir. 1999); *Palen v. KMart Corp*., 2000 U.S. App. Lexis 10780 (6th Cir. 2000). See also, *Becker v. Long Island Lighting Company*, 129 F. 3d 268, 271 (2d Cir. 1997). ("An ERISA fiduciary has an obligation to provide full and accurate information to the plan beneficiary regarding the administration of the plan.") *Abbruscato v. Empire Blue Cross and Blue Shield*, 274 F. 3d 90 (2d Cir. 2001) (A "failure to provide completely accurate plan information" is a possible breach of fiduciary duty.)

[28] *Eddy v. Colonial Life Ins. Co*., 919 F. 2d 747 (D.C. Cir. 1990). See also, *Bixler v. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3d Cir. 1993); *Neuma, Inc. v. DuPont*, 133 F. Supp. 2d. 1082 (N.D. Ill. 2001); *Grimes v. Prudential Financial, Inc*., 2006 WL 2990025 (E.D. Ark., 10/18/2006). Cf. *Washington v. Bert Bell/Pete Rozelle NFL Retirement Plan*, 504 F. 3d 818 (9th Cir. 2007) (Consistent with its duty of loyalty, a plan fiduciary must disclose material investment information to plan participants.)

nature and amount of the trust property,[29] and when the fiduciary knows that the beneficiary is unaware of critical information.[30] As the Court of Appeals for the Third Circuit stated in *Edgar v. Avaya*, "Indeed the duty to inform is a constant thread in the relationship between beneficiaries and trustees: it is not only a negative duty not to misinform, but to inform when trustees know that silence may be harmful."[31] Thus, a beneficiary about to plunge into a ruinous course of dealing may be betrayed by silence as well as the spoken word.[32] Thus, the case law clearly demonstrates "that ERISA was enacted, at least in part, to ensure that employees have sufficient information about their rights under employee benefit plans to make well informed decisions."[33] The information required to be disclosed might be limited to information that is material, but "information is material if there is a substantial likelihood that nondisclosure 'would mislead a reasonable employee in the process of making an adequately informed decision regarding benefits to which she may be entitled.'"[34] The decision to be made by an employee with respect to a selection among medical plans is more complex than a decision as to whether and how to participate in a 401(k) plan, and there is an element of chance associated with choice of medical plans that is not present in investment decisions.

ERISA Fiduciary Duties With Respect to Employer Sponsored Health Plans

There are different types of disclosure that participants need to receive. One type has been well established under ERISA from the outset—the type of disclosure provided by a summary plan description ("SPD") or summary of material modifications, and more recently by the summary of benefits and coverage ("SBC").[35] However, the information that a participant receives with respect to different medical plans, in isolation, will not necessarily enable the participant to make an informed decision as to which plan he should elect, because SPDs and SBCs are not documents designed to compare the benefits, particularly the potential long term benefits, of selecting one type of medical plan over another. That the principle that a fiduciary

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[29] *Faircloth v. Lundy Packing Co*., 91 F. 3d 648,656 (4th Cir. 1996), quoting Restatement (Second) of Trusts.

[30] Restatement (Second) of Trusts, Section 173. See also, *Bouboulis v. Transportation Workers of Greater New York, Local 100*, 2006 WL 2930201 (S.D.N.Y 10/11/2006), quoting commented to Section 173 of Restatement (Second) of Trusts: a "duty to communicate to the beneficiary material facts affecting the interests of a beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his own protection in dealing with a third person."

[31] 503 F. 3d 340, 350 (3d Cir. 2007). See also, In re *Unisys Corp*., 57 F. 3d 1255, 1264 (3d Cir. 2005) ("Our decisions…firmly establish that when a plan administrator affirmatively misrepresents the terms of a plan or fails to provide information when it knows that its failure to do so may cause harm, the plan administrator has breached its fiduciary duty to individual plan participants and beneficiaries.")

[32] *Howe v. Varity Corp*., 36 F. 3d 746,754 (8th Cir. 1994), aff'd *Varity Corp v. Howe*, 516 U.S. 489, 506 (1996). See also, *Jordan v. Federal Express Corp*., 116 F. 3d. 1005, 1016 (3d Cir. 1997) and *Hammer v. Johnson Senior Center*, 2020 WL 7029160 (W.D.Va. 11/30/2020) (failure to inform employee of the lapse of medical coverage was a breach of the fiduciary duty of prudence).

[33] *Grimes v. Prudential Financial, Inc*., 2006 WL 2990025 (E.D. Ark. 2006); *Flanigan v. General Electric Co*., 242 F. 3d 78, 84 (2d Cir. 2001); ("This court has also held fiduciaries liable for nondisclosure about a current plan when the information was necessary for an employee's intelligent decision about retirement.") See also, *Harte v. Bethlehem Steel*, 214 F. 3d 446 (3d Cir. 2000); *Bowerman v. Walmart*, 226 F. 3d. 574 (7th Cir. 2000); *Beach v. Commonwealth Edison Co.*, 382 F. 3d 656 (7th Cir. 2004).

[34] *Braden v. Wal-Mart Stores, Inc*., 588 F. 3d 585, 599 (8th Cir. 2009), quoting *Krohn v. Huron Memorial Hospital*, 173 F. 3d 542, 551 (6th Cir. 1999).

[35] The three agencies adopted regulations implementing Public Health Services Act Section 2715 in 2015. See, 26 C.F.R. §54.9815-2715; 29 C.F.R. §2590; and HHS Reg. 45 C.F.R. §147.200.

has a duty not to remain silent when silence would be harmful arose under different circumstances, does not mean that it needs to be limited to those circumstances, nor does the requisite degree of information provided to participants in comparing medical plans need to approximate pharmacy-level disclosure as to different medications. Data suggest that many plan participants are over-insuring, and there are accessible and cost-effective tools available for making such information available to plan participants (see footnote 2). This is just the type of information that, from a fiduciary perspective, needs to be communicated to plan participants so that they may use such information in their best interests when determining which medical plan to elect.

An ERISA fiduciary also has a responsibility to take steps to ensure that plan assets (*i.e.*, the employee contributions to a medical plan)[36] are expended in an efficient manner. As the Court of Appeals for the Ninth Circuit stated in *Tibble v. Edison*, "Pursuant to Restatement (Third) of Trusts, a trustee is to 'incur only costs that are reasonable and appropriate to the investment responsibilities of the trusteeship.' Restatement (Third) of Trusts further instructs that cost-conscious management is fundamental to prudence in the investment function, and should be applied "not only in making investments but also in monitoring and reviewing investments . . . ('Implicit in a fiduciary's duty is a duty to be cost-conscious.')….As the Uniform Prudent Investor Act observes, "Wasting beneficiaries' money is imprudent. In devising and implementing strategies for the investment and management of trust assets, trustees are obliged to minimize costs."[37] While the determination of an appropriate medical plan is a different type of investment decision than those referenced in the Restatement (Third) of Trusts and the Uniform Prudent Investors Act, the same principles of cost-consciousness are equally applicable.

Conclusion

While the primary focus of ERISA's duties of prudence and loyalty, has been with respect to investments under ERISA pension plans, ERISA's fiduciary obligations are equally applicable to ERISA's welfare benefit plans, the lack of significant case law and regulatory guidance notwithstanding, as this will inevitably change, and sooner rather than later.

Providing plan participants and beneficiaries with information that will allow them to make informed, cost-conscious decisions with respect to their medical care coverage is not only a "best practice," but is a component of ERISA's fiduciary duties.

[36] A VEBA would also be a welfare plan vehicle holding plan assets.

[37] 843 F. 3d 1187 (9th Cir. 2016). In *Tibble v. Edison International*, 575 U.S. ___ (2015), the Supreme Court indicated that, since ERISA's fiduciary duties are derived from the common law of trusts, "courts must often look to the law of trusts "to determine the contours of an ERISA fiduciary's duty."