No. 25-2494, 25-2591

In the United States Court of Appeals

FOR THE EIGHTH CIRCUIT

IOWA ASSOCIATION OF BUSINESS AND INDUSTRY; IOWA BANKERS BENEFIT PLAN; IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND; DES MOINES ORTHOPAEDIC SURGEONS, P.C.; IOWA SPRING MANUFACTURING & SALES COMPANY,

Plaintiffs-Appellees/Cross-Appellants,

v.

IOWA INSURANCE COMMISSIONER, Doug Ommen,

Defendant-Appellant/Cross-Appellee.

On Appeal from the U.S. District Court for the Southern District of Iowa
No. 4:25-cv-211, The Honorable Stephanie M. Rose

BRIEF OF THE ERISA INDUSTRY COMMITTEE, THE AMERICAN BENEFITS COUNCIL, AMERICA'S HEALTH INSURANCE PLANS, INC., AND THE ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS AND AFFIRMANCE IN PART AND REVERSAL IN PART

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CORPORATE DISCLOSURE STATEMENT

In accordance with Federal Rule of Appellate Procedure 26.1 and Local Appellate Rule 26.1A, the ERISA Industry Committee, the American Benefits Council, America's Health Insurance Plans, Inc., and the Association of Federal Health Organizations state that they are not publicly held corporations, that they do not have parent corporations, and that no publicly held corporation owns 10% or more of their stock.

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

CASES

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

STATUTES

RULES

TABLE OF AUTHORITIES
(continued)

Page(s)

OTHER AUTHORITIES

INTEREST OF AMICI CURIAE[1]

The ERISA Industry Committee ("ERIC") is a national non-profit business trade association representing approximately 100 of the nation's largest employers in their capacity as sponsors of employee benefit plans for their workers, retirees, and families. ERIC frequently participates as amicus curiae in cases that have the potential for far-reaching effects on employee benefit plan design or administration.

The American Benefits Council (the "Council") is a Washington, D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees, and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans. The Council regularly participates as amicus curiae in cases affecting employee benefits plans.

America's Health Insurance Plans, Inc. ("AHIP") is the national trade association representing the health insurance industry. AHIP is committed to market-based solutions and public-private partnerships that make high-quality coverage and

[1] All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2). No counsel for any party authored this brief in whole or in part, and no entity or person, aside from amici curiae, their members, or their counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

care more affordable, accessible, and equitable for everyone. AHIP's members offer health and supplemental benefits through employer-provided coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Combined, AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's health care and health insurance systems work.

The Association of Federal Health Organizations ("AFHO") is an organization of entities that serve as carriers of health benefit plans under the Federal Employees Health Benefits Program ("FEHBP"). Collectively, the plans of AFHO's carrier members provide health benefits to over 80% of the roughly eight million federal and postal employees, annuitants, and eligible family members who receive FEHBP coverage. Many of the plans are national in scope, covering enrollees in all U.S. states and territories. All of the plans for which AFHO's members are carriers contain prescription benefit terms that are the same for all jurisdictions in which the respective plans operate. Health benefit plans under the FEHBP are governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914, which contains a preemption provision of its own, *see* 5 U.S.C. § 8902(m)(1). Because of its similar wording, courts have held that precedent on the preemption provision in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a),

"provides authority for cases involving the FEHBA provision." *Bostford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002). AFHO's members thus have an interest in decisions, such as the impending one here, that will determine the applicability and scope of ERISA's preemption provision.

This case raises issues of profound importance to amici and their members. Many of amici's members sponsor, provide, or help administer ERISA-governed health plans that include prescription-drug benefits. ERISA's broad preemption of state regulations gives employers freedom that encourages them to establish, customize, and maintain employee health benefit plans. Multistate employers in particular rely on ERISA preemption so they can provide a uniform set of excellent benefits to millions of employees and their families without fear of diverging state regulations and the associated burdens. Fundamental ERISA principles preempt Iowa Senate File 383 ("SF 383"). The district court largely understood and applied those principles correctly. Amici submit this brief to urge the Court to affirm in substantial part and reverse only to the extent that the district court's order permits partial enforcement of SF 383. It is critical that courts recognize and enforce ERISA's preemption of state laws that interfere with the design or administration of ERISA-covered benefit plans—not only for the sake of amici's members but also for all plan

sponsors, plan administrators, and the many employees and family members who benefit from and rely on employer-sponsored health coverage.[2]

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress enacted ERISA "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). For that reason, Congress expressly provided that federal law governing employee benefit plans "shall supersede any and all State laws insofar as they … relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a). This famously "expansive" express preemption provision effectuates Congress's intent "to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'" *Davila*, 542 U.S. at 208 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). Congress designed ERISA's broad federal preemption regime to serve two core goals, both of which ultimately promote "the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

First, preemption preserves employers' discretion in creating and designing benefit plans. "Nothing in ERISA requires employers to establish employee benefits plans [or] … mandate[s] what kind of benefits employers must provide if they

[2] While amici agree with the full range of arguments developed in Plaintiffs' brief, this brief focuses on the substantive preemption issues of particular interest to amici.

choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). The statute reflects a "careful balancing" between sometimes-competing objectives: the regulation of employee benefit plans and "the encouragement of the creation of such plans." *Davila*, 542 U.S. at 215. Congress accordingly drafted ERISA to ensure that "employers have large leeway to design [employee benefit] plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). Federal preemption protects employers' discretion by preventing states from dictating the benefits such plans must offer; how and on what terms benefits must be offered; how disputes over benefit entitlements are to be resolved; recordkeeping, disclosure, and reporting requirements; and other fundamental features of benefit plan design or administration.

Second, and relatedly, ERISA allows employers to offer the same benefits to their workforces nationwide and avoids the burden and expense of adhering to a patchwork of state regulations. "Requiring ERISA administrators to master the relevant laws of 50 States … would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrators—burdens ultimately borne by the beneficiaries." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 321 (2016) (citation, brackets, and quotation marks omitted). ERISA preemption thus ensures that plans are not forced to navigate "conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McClendon*,

498 U.S. 133, 142 (1990). Otherwise, employers could have to provide their workforces with different benefits depending on where they live or work. And, ultimately, the inevitable costs of such disuniformity could harm employees.

Prescription drug benefits squarely implicate these concerns. Employers that sponsor health plans with prescription drug benefits design pharmacy networks tailored to their employee populations' needs in terms of both service and cost. Plan sponsors also use a variety of incentives, including lower participant copays for filling prescriptions at preferred pharmacies, to provide cost-effective benefits and high-quality care through their plans. SF 383 creates insurmountable obstacles to plan sponsors' ability to incorporate these and other popular options in their plan benefits. ERISA accordingly preempts SF 383, both because it purports to override plan sponsors' choices about what substantive benefits to offer and because it would interfere with uniform nationwide plan administration by creating a unique set of Iowa-specific rules. *See PCMA v. Mulready*, 78 F.4th 1183 (10th Cir. 2023) (holding that ERISA preempted similar state statute for these reasons), *cert. denied*, 145 S. Ct. 2843 (2025). The district court correctly applied ERISA's broad express preemption clause as to many of SF 383's provisions. But ERISA preempts more provisions than the district court appreciated, and this Court should fully enjoin SF 383's enforcement.

The Court should also hold that ERISA impliedly preempts SF 383 under principles of obstacle or conflict preemption. These doctrines require preemption "where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (citation omitted). SF 383 does just that, purporting to override employer discretion and create state-specific requirements in the very ways that Congress codified ERISA to prohibit. SF 383 also conflicts with ERISA fiduciaries' duties under the statute, which requires fiduciaries to administer plans prudently, solely in participants' interests, and pursuant to their written terms. *See* 29 U.S.C. § 1104(a)(1)(A), (B), (D). SF 383 puts fiduciaries in an impossible bind when state law requires one thing and participants' interests or written plan terms require another. For this reason, too, the Court should hold that ERISA preempts SF 383 and enjoin its enforcement.

ARGUMENT

I. Federal preemption is essential to ERISA's purpose of encouraging employers to offer benefits to employees.

Rather than obligate employers to sponsor employee benefit plans, Congress chose to "encourag[e]" their formation through a balanced and comprehensive statute. *Davila*, 542 U.S. at 208 (citation omitted). An employer that chooses to create a benefit plan "undertakes a host of obligations, such as determining the

eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Congress understood that making employee benefit administration too complex or expensive, or exposing employers to excessive risk of litigation, would frustrate the statute's purpose of encouraging the voluntary creation of employee benefit plans. *Conkright v. Frommert*, 559 U.S. 506, 517 (2010). In particular, Congress understood that subjecting multistate employers to a thicket of state regulations, including potentially "conflicting legal obligations," would create costs and complications that would discourage them from offering generous benefits. *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 149-50 (2001); *see also, e.g.*, *Gobeille*, 577 U.S. at 321; *Ingersoll-Rand Co.*, 498 U.S. at 142.

To promote these goals, ERISA includes a broad express preemption provision. That provision instructs that ERISA's regulatory regime "shall supersede any and all State laws insofar as they may now or hereafter relate to any [ERISA-governed] employee benefit plan." 29 U.S.C. § 1144(a). This preemption provision applies to all ERISA-governed plans, including health benefit plans that offer prescription drug coverage. The provision's language is "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). Congress phrased

ERISA's preemption provision so broadly "'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law,' thereby 'minimizing the administrative and financial burden of complying with conflicting directives' and ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions." *Rutledge v. PCMA*, 592 U.S. 80, 86 (2020) (citation and brackets omitted).

II. ERISA expressly preempts SF 383.

The key question for ERISA express preemption is whether the state law "relate[s] to" an ERISA plan. 29 U.S.C. § 1144(a). The Supreme Court has consistently "held that a state law relates to an ERISA plan 'if it has a connection with or reference to such a plan.'" *Egelhoff*, 532 U.S. at 147 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)); *accord, e.g.*, *Rutledge*, 592 U.S. at 86.

This case centers on "connection with" preemption (not "reference to" preemption). A state law typically has an impermissible "connection with" an ERISA plan if the law "governs a central matter of plan administration or interferes with nationally uniform plan administration." *Gobeille*, 577 U.S. at 320 (ellipsis and quotation marks omitted). Laws cross this line when they "require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits" or by otherwise "bind[ing] plan administrators to [a] particular choice" about benefits. *Rutledge*, 592 U.S. at 86-87 (citations omitted).

ERISA expressly preempts SF 383 because it has multiple levels of impermissible connections with ERISA plans. Most glaringly, SF 383 purports to dictate what prescription drug benefits ERISA plans must offer, and on what terms. Other aspects of SF 383 intrude into central matters of plan administration and interrupt nationally uniform plan administration in other ways that are equally impermissible. The district court therefore should have enjoined enforcement of SF 383 in its entirety. Briefly reviewing some basic background on employer-sponsored health benefit plans provides context to help understand how SF 383 runs afoul of ERISA.

A. Pharmacy networks and participant contribution amounts are key components of health plans' prescription drug benefits.

Most working-age adults in the United States have health insurance coverage through plans sponsored by their employers. U.S. Census Bureau, *Health Insurance Coverage in the United States: 2024*, at 5 (Sept. 9, 2025).[3] Employer-sponsored health insurance plans cover about 154 million Americans in total. Kaiser Family Found., *Employer Health Benefits: 2025 Annual Survey* 7 (Oct. 2025).[4] And employer-sponsored health coverage is a broadly popular option: more than 75% of eligible workers who are offered coverage through their employer elect it. *Id.* at 67.

[3] https://www2.census.gov/library/publications/2025/demo/p60-288.pdf.
[4] https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf.

More than two-thirds of covered workers who rely on employer-sponsored health insurance are enrolled in self-funded plans. *Id.* at 165. "Self-funded" or "self-insured" plans typically pay for covered benefits out of the employer-sponsor's assets, in contrast to "fully insured" (or simply "insured") plans, in which an employer purchases an insurance policy to cover employees and the insurer pays for benefits out of its assets. *See, e.g.*, *FMC Corp.*, 498 U.S. at 54. This distinction between self-funded and fully insured plans often arises in ERISA preemption cases because the statute's "saving clause," 29 U.S.C. § 1144(b)(2)(A), generally exempts state laws regulating insurance—including the policies that fully insured plans purchase—from express ERISA preemption. *See, e.g.*, *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1985). ERISA's "deemer clause," 29 U.S.C. § 1144(b)(2)(B), clarifies that the saving clause does not allow states to regulate self-funded plans. *See FMC Corp.*, 498 U.S. at 61. "As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relates to' the plans." *Id.* (brackets omitted).

Broadly speaking, a self-funded plan's prescription drug benefit structure has three main components: (1) the "formulary," meaning covered prescription drugs, and related services; (2) the "pharmacy network," meaning the pharmacies and service providers from which plan participants may obtain covered drugs and services;

and (3) the plan sponsor's cost-sharing arrangements with participants, including deductibles, coinsurance, and co-payments or "copays."[5]

A plan's pharmacy network consists of pharmacies that have contracted with the plan to provide prescriptions and related services to its participants at pre-negotiated rates. Plan participants can typically obtain prescriptions at lower costs from in-network pharmacies than from out-of-network pharmacies that have not contracted with the plan in advance. Pharmacy networks allow plans to obtain benefits and cost reductions that plans can then pass on to participants, including by requiring lower participant contributions (both in terms of lower cost shares and lower contributions to the total cost of coverage) and providing more generous benefits. Pharmacies benefit from participating in plan networks due to the increased volume that results, and in exchange, contractually agree to discounted rates and quality service standards that benefit plans and their participants. Negotiating with in-network pharmacies in advance about prescription drug pricing also creates greater cost certainty and predictability for plans, thereby facilitating more accurate projections of prescription drug costs. Interfering with plans' ability to develop and maintain pharmacy networks undermines this cost predictability, and greater unpredictability results in plans needing more conservative about the benefits they cover.

[5] For ease of reference, this brief uses the term "participants" to include spouses, dependents, and anyone else eligible to access health benefits through the plan.

Pharmacy networks also have other systemic benefits for plans and their participants. For example, they serve administrative efficiency because in-network pharmacies follow plan rules for processing claims. With out-of-network pharmacies, on the other hand, plans must negotiate claims-processing individually. Pharmacy networks also enhance quality of care. Screening, monitoring, and selecting pharmacies for the network allows plans to encourage participants to fill their prescriptions through high-quality providers, and plans can exclude from their networks pharmacies that do not meet their standards.

The many benefits of pharmacy networks unsurprisingly lead the vast majority of plans using pharmacy networks for their prescription drug benefits. Studies have shown that health plans' reliance on networks can reduce costs for plan participants without undermining the quality of services. *See* Daniel Polsky & Bingxiao Wu, *Provider Networks and Health Plan Premium Variation*, 56 Health Servs. Rsch. 16, 17 (2021).[6]

Plans can structure prescription drug benefits, pharmacy networks, and participant cost-sharing in different ways. Different employers' workforces have different needs, and ERISA protects plan sponsors' discretion to tailor these plan components to the needs of employees and their families. *See, e.g.*, *Lockheed Corp.*, 517 U.S. at 887 (discussing plan sponsors' freedom under ERISA when designing their

[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC7839649/pdf/HESR-56-16.pdf.

benefit plans); *Alessi*, 451 U.S. at 511 (explaining that "ERISA leaves th[e] question" of what benefits a plan will provide "largely to the private parties creating the plan"). A manufacturing company with a predominantly longer-term and older employee population may have different considerations for its plan than a retail company with a younger and more transient workforce. An employer with a workforce spread across the country may prefer a wider pharmacy network than an employer with a less geographically dispersed workforce. Even similarly situated employers may weigh differently the tradeoffs between pharmacy network breadth and participant costs, and ERISA preserves their ability to structure their own plan's pharmacy benefits accordingly.

Many plans work with pharmacy benefit managers (PBMs) to help them deliver prescription drug benefits. *See, e.g.*, *Mulready*, 78 F.4th at 1188-89 (citing record evidence showing that "PBMs are ubiquitous, administering the drug benefits for around 270 million people"); *PCMA v. District of Columbia*, 613 F.3d 179, 183 (D.C. Cir. 2010) ("[T]he vast majority of insured Americans receive their pharmaceutical benefits through a PBM."). PBMs commonly negotiate prices with drug manufacturers and pharmacies, help plans establish drug formularies,[7] work with plan sponsors in designing pharmacy networks, and process prescription drug

[7] The formulary often lists not only the prescription drugs covered by a plan but also cost information (tier, copay, and/or deductible).

claims. Importantly, plan sponsors make all final decisions about prescription drug benefit design and structure; they call on PBMs to help them effectuate those choices and administer plan benefits.

B. ERISA preempts SF 383 because it interferes with plan benefit design and administration.

In many ways, SF 383 intrudes into the sphere of employee benefit plan regulation that Congress exclusively reserved to federal law. Consider the following illustrative examples of how SF 383's provisions intrude on "central matters of plan administration and interfere with nationally uniform plan administration." *Rutledge*, 592 U.S. at 89.

1. SF 383 impermissibly restricts ERISA plan sponsors' ability to structure prescription drug benefits to meet their needs and preferences. The statute's "anti-discrimination provision," Iowa Code § 510B.4(4), broadly commands that every "[PBM], health carrier, health benefit plan, or third-party payor shall not discriminate against a pharmacy or a pharmacist with respect to participation, referral, reimbursement of a covered service, or indemnification" if the provider is operating within the scope of its license and complying with applicable law. As the district court recognized, this provision flouts ERISA by prohibiting "plans and their sponsors from structuring benefit arrangements that favor particular providers based on legitimate considerations such as price, safety, or convenience." Add. 24; App. 640;

R. Doc. 54, at 24. What SF 383 disparages as "discrimination" is just plans' protected ability to choose the providers with which they contract, and on what terms.

The statute similarly interferes with plans' choices about pharmacy network composition. Its any-willing-provider provisions, Iowa Code §§ 510B.4B(1)(b), 510B.4B(2)(a), "mandate actual network inclusion for any-willing-pharmacy," purporting to override the "strategic decisions about cost, quality, geographic accessibility, and specialized services" that "plan sponsors" make when they "select which pharmacies to include in their networks." Add. 27-28; App. 643-44; R. Doc. 54, at 27-28. The statute's "open-access standard for specialty drugs," Iowa Code § 510B.4B(1)(d), has a similarly impermissible effect. Many plans require patients to obtain specialty drugs, "which treat complex, chronic, and rare diseases," from specialty pharmacies, which "employ staff who uniquely understand how to handle and store these" less commonly prescribed "drugs and how to monitor the patients who take them." *Mulready*, 78 F.4th at 1189. SF 383 purports to tell plans when they may or may not "designate a prescription drug as a specialty drug" and require participants to obtain that drug from the subset of pharmacies uniquely qualified for that task. ERISA reserves that choice to plan sponsors, not states.

While the district court properly understood how the provisions discussed above have an impermissible connection with ERISA plans, it should have further recognized that certain other provisions of SF 383 pose similar problems. Take the

statute's limitation on guidance to preferred pharmacies. Under that provision, "[i]f a pharmacy or pharmacist has agreed to participate in a covered person's health benefit plan," a PBM may not "prohibit or limit the covered person from selecting a pharmacy or pharmacist of the covered person's choice, or impose a monetary advantage or penalty that would affect a covered person's choice." Iowa Code § 510B.4B(1)(a). Many plan sponsors (including in Iowa) choose to have "two-tiered networks," where a subset of "preferred" network pharmacies contract with a plan to offer even lower copayments to its participants. *Mulready*, 78 F.4th at 1189. Yet SF 383 would forbid PBMs from effectuating such choices. That prohibition would impermissibly dictate plans' choices about substantive benefits just like the provisions above. *See id.* at 1198 (holding that such a provision "directs or forbids an element of plan structure or benefit design"). The district court sustained this provision as regulating only PBMs and not plans. Add. 34-35; App. 650-51; R. Doc. 54, at 34-35. But plans make choices about benefit design, including whether to use preferred networks, and rely on PBMs to implement them. So forbidding all PBMs from implementing a plan sponsor's choice to use a preferred network functionally amounts to forbidding the plan from using a preferred network. The district court understood this reality with other provisions of the law but missed the point here.

These provisions of SF 383 reflect the law's most fundamental problem: the statute attempts to dictate the structure and design of prescription drug benefits

plans. The Tenth Circuit in *Mulready* observed how analogous provisions of an Oklahoma statute would have had the effect that "all PBMs could offer Oklahoma ERISA plans is a single-tiered network with uniform copayments, unrestricted specialty-drug access, and complete patient freedom to choose a brick-and-mortar pharmacy." 78 F.4th at 1199. Plans are free to offer such categorically unrestricted prescription drug benefits if they so choose; but virtually none do because that prescription benefit structure would entail sky-high costs ultimately borne by plan participants. The Tenth Circuit understood that Oklahoma's "network restrictions" demanding that outcome were "quintessential state laws that mandate benefit structures," which "ERISA forbids." *Id.* The district court here, to its credit, understood that many of SF 383's provisions reflect equally impermissible attempts to demand that plans provide particular prescription benefits of the State's choosing. *See, e.g.*, Add. 28; App. 644; R. Doc. 54, at 28 (appreciating how any-willing-pharmacy "provisions eliminate the customizability and discretion that ERISA reserves to plan sponsors and fiduciaries"); Add. 32; App. 648; R. Doc. 54, at 32 (correctly concluding that open-access standard for specialty drugs "directly constrains fundamental plan design decisions about how to ensure appropriate care delivery for complex medications, thereby interfering with central matters of plan administration"); *see also* Add. 76; App. 692; R. Doc. 54, at 76 (noting that "many employers maintain uniform plans across multiple states," and that SF 383 would cause "disruption to

established benefit structures [that] contradicts ERISA's objective of promoting nationally uniform plan administration").

Yet the district court should have applied this reasoning to *all* of SF 383's provisions that dictate benefit structures. The district court thought that the "limitation on guidance" provision leaves plans "free to structure their networks and cost-sharing arrangements to incentivize use of preferred pharmacies," and "merely limits the promotional methods PBMs may use to effectuate those preferences." Add. 34; App. 650; R. Doc. 54, at 34. But this logic is hard to square with the district court's (correct) reasoning elsewhere about other provisions. The district court rightly understood, for example, that "[b]y preventing PBMs from using specialty drug designations to direct participants to pharmacies with specialized capabilities," SF 383's open-access standard for specialty drugs "interferes with central matters of plan administration." Add. 31; App. 647; R. Doc. 54, at 31. Although that provision is nominally directed at PBMs, in effect it "eliminates a tool that *plans* use to ensure quality care delivery and cost management for their most complex and expensive medications." Add. 32; App. 648; R. Doc. 54, at 32 (emphasis added). The limitation on guidance provision is no different: despite nominally focusing on PBMs, that provision operates to prohibit *plans* from having certain benefit structures that ERISA allows. In each case, the law directly and materially impacts how plans and

their corresponding benefits are designed and is precisely the type of regulation ERISA is intended to preempt.

The district court similarly erred in analyzing Iowa Code § 510B.8(5). This provision, as the court understood, "mandates that contributions made on behalf of covered persons be credited toward deductibles and out-of-pocket maximums regardless of payment source, including manufacturer coupons and other third-party assistance." Add. 51; App. 667; R. Doc. 54, at 51. The district court properly characterized this requirement as among SF 383's "cost-sharing provisions," and the court enjoined enforcement of related provisions governing cost-sharing on the sound reasoning that "[c]ost-sharing arrangements constitute key benefit designs for ERISA plans." *Id.* Specifically, the court ruled that § 510B.8(6) "exceeds permissible cost regulation by directly constraining how plans must handle participant payments toward deductible requirements." *Id.* That sound reasoning applies equally to § 510B.8(5), which similarly constrains how plans must handle payments not only *by* but also *on behalf of* participants. Yet the district court distinguished § 510B.8(5) "as an administrative mandate that governs PBM operations without constraining fundamental plan design authority." Add. 52; App. 668; R. Doc. 54, at 52. The only apparent basis for that distinction is superficial: subsection (5) refers to PBMs expressly, while subsection (6) is phrased differently and does not. The court should have focused on subsection (5)'s substance, which requires preemption for the same

reasons that the district court identified as to subsection (6). This Court should correct the district court's error and hold that ERISA preempts *all* of SF 383's many provisions that infringe on plans sponsors' discretion in designing prescription drug benefits.

2. While the provisions discussed above (among others) attempt to overrule plans' choices about how to substantively design and administer benefits, other provisions of SF 383 have an impermissible connection with ERISA plans by attempting to overrule the federal government's choices about how to regulate plans. SF 383's reporting and notice requirements are a good example. SF 383 requires PBMs to provide the State with detailed reports about certain prescription drugs that they help plan members obtain. *See* Iowa Code § 510B.8B(4). The law also compels third-party payors—i.e., ERISA plan sponsors—to disclose to pharmacies any restrictions on pharmacy network participation, and to inform plan participants about all pharmacies participating in the plan network. *Id.* § 510B.4B(2)(a)-(b). These mandates intrude into what ERISA contemplates as an exclusively federal regulatory sphere. "[R]eporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA." *Gobeille*, 577 U.S. at 323. State-specific reporting and disclosure requirements like SF 383's therefore "intrude[] upon 'a central matter of plan administration' and 'interfere[] with nationally uniform plan administration.'" *Id.* (quoting *Egelhoff*, 532 U.S.

at 148). Neither of the district court's two reasons for sustaining the reporting requirements bears scrutiny.

First, the court reasoned that because "PBMs … operate outside ERISA's governance structure," "[s]tate reporting requirements imposed upon these entities … encounter no preemption barrier." Add. 54; App. 670; R. Doc. 54, at 54. But the reporting requirements do not regulate PBMs solely in their capacity as PBMs (as a state law requiring PBM licensure might). Instead, the reporting requirements regulate PBMs *in administering ERISA plans*—requiring reports about their facilitation of prescription access for ERISA plan members—and the district court erred in ending its analysis at these provisions' nominal focus rather than their substance. *See Mulready*, 78 F.4th at 1196 ("regulating PBMs 'functions as a regulation of an ERISA plan itself'" (citation and brackets omitted)).

Second, the district court thought that ERISA did not preempt SF 383's reporting and disclosure requirements because they "neither dictate benefit structures nor constrain plan design—the very considerations that animate ERISA's preemptive force." Add. 54; App. 670; R. Doc. 54, at 54. But while dictating substantive benefits is sufficient for ERISA to preempt a state law, it is not necessary. It is blackletter law that ERISA also preempts state laws that "interfere with nationally uniform plan administration." *Rutledge*, 592 U.S. at 89. The court should have held that ERISA preempts SF 383's reporting requirements for that reason. *See Gobeille*,

577 U.S. at 323 ("Differing, or even parallel, regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability. … Pre-emption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans.").

The district court should have ruled that ERISA preempts SF 383's disclosure requirements for similar reasons.[8] The court ruled that ERISA does not preempt Iowa Code § 510B.4B(2)(b) on the ground that "it imposes only modest disclosure requirements with *de minimis* impact on plan administration." Add. 54; App. 670; R. Doc. 54, at 54. Here, too, the district court did not adequately appreciate that "the central design of ERISA … is to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States." *Gobeille*, 577 U.S. at 326. ERISA's express preemption provision reflects Congress's judgment that plans should not be subject to state regulations of these matters, full stop. The district court erred in prioritizing its view about this law's burdens over Congress's judgment about the respective regulatory spheres of federal and state law.

[8] After analyzing ERISA preemption, the district court went on to conclude that Iowa Code § 510B.4B(2)(a) in relevant part violates the First Amendment. Add. 70-72; App. 686-88; R. Doc. 54, at 70-72. Amici agree with that conclusion and write to explain why ERISA preemption requires the same result.

3. The district court correctly identified SF 383's regulations of plan-PBM contracts as another example of the law's intrusion into ERISA's exclusively federal regulatory regime. These provisions require "pass-through pricing," which the law defines as "a model of prescription drug pricing in which payments made by a third-party payor to a [PBM] for prescription drugs are equivalent to the payments the [PBM] makes to the dispensing pharmacy or dispensing health care provider for the prescription drugs, including any professional dispensing fee." Iowa Code § 510B.1(11B). SF 383 demands such pricing by purporting to dictate the terms of plan-PBM contracts: newly "executed, amended, adjusted, or renewed" PBM-pharmacy contracts "shall include" terms requiring pass-through pricing. *Id.* § 510B.8D(1). Moreover, this mandate "shall supersede any contractual terms to the contrary." *Id.* § 510B.8D(2).

The district court correctly concluded that ERISA preempts such attempts to rewrite plan-PBM contracts. Add. 56-60; App. 672-75; R. Doc. 54, at 56-60. ERISA imposes on plan fiduciaries "obligations to enter into contracts with reasonable costs for plan beneficiaries and to exercise prudent judgment in selecting and monitoring service providers." Add. 57; App. 673; R. Doc. 54, at 57 (citing 29 U.S.C. § 1108(b)(2)(A)). "By directly regulating how plan sponsors, who are fiduciaries, may construct their contracts," these provisions "limit[] fiduciary discretion in ways that interfere with their ability to negotiate arrangements they deem most reasonable or

beneficial for plan administration and beneficiaries." *Id.* Such "fiduciary decision-making regarding service provider relationships" is "a central matter of plan administration under ERISA" and thus the exclusive province of federal law. *Id.* SF 383's attempts to regulate plan-PBM contracts would also disrupt nationally uniform plan administration: any plan that contracts with a PBM to administer its prescription benefits nationwide would have to carve out such administration in Iowa for unique treatment, an outcome that ERISA's preemption provision forbids. No relevant precedent has upheld any comparable regulation, which may explain why Iowa essentially abandoned any defense of these provisions below. *See* Add. 57-58; App. 673-74; R. Doc. 54, at 57-58 ("The absence of substantive response to this argument suggests acknowledgment that such contractual mandates exceed permissible state authority.").

Iowa's new attempts to defend these provisions on appeal are not persuasive. The State asserts that "[f]iduciary duties are executed against the backdrop of state law," so "fiduciaries must contract under [Iowa's pass-through pricing requirements]—just as fiduciaries lack discretion to contract against state minimum wage laws and workplace standards." Iowa Br. 44-45. Iowa cites no authority for this assertion, and none exists. Minimum wage laws and "workplace standards" are not the exclusive province of federal law, so those analogies are inapt.

Moreover, the mechanism adopted by the State to accomplish this provision's aims is equally impermissible. The Supreme Court has never blessed any similar attempt by a state to regulate contracts between plans and service providers. The premise of *Rutledge*, for instance, was that the Arkansas law there was a generally applicable regulation of the costs of goods and services with merely incidental effects on ERISA plans. *See Rutledge*, 592 U.S. at 88 ("In short, ERISA does not preempt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage."). SF 383's regulations of plan-PBM contracts are completely different. These provisions do not create generally applicable state laws that incidentally affect ERISA plans; they directly regulate a central aspect of plan administration. Such regulations are the prerogative of federal law alone, so ERISA preempts Iowa's law claiming that power for itself.

* * *

SF 383 runs headlong into ERISA's express preemption provision at every turn. The law's various infirmities are symptoms of a unifying underlying defect: SF 383 straightforwardly attempts to regulate ERISA-governed employee benefit plans. Iowa defends SF 383 as legislation to prop up "independent, rural pharmacies." Iowa Br. 7. But ERISA forbids the State from pursuing that end through the means of regulating ERISA-governed benefit plans. And Iowa all but admits that is

indeed what SF 383 is intended to do. The very first sentence of Iowa's brief decries how "[PBMs]—*and their affiliated health benefit plans*—leverage their outsized market power to impose coercive cost and network restrictions on Iowa pharmacies." *Id.* at 3 (emphasis added). Iowa's objection, in other words, is that some employee benefit plans do not allow their participants to fill prescriptions at local pharmacies as readily as Iowa would prefer.

But Congress chose to reserve that choice to plan sponsors, not the State. Any other approach would risk discouraging employers from establishing employee benefit plans in the first place, lest they be saddled with the burdens of expensive state wish lists and complying with a patchwork of state-specific regulations.

III. Implied preemption compels the same result.

As discussed, ERISA expressly preempts SF 383 based on many impermissible connections with ERISA plans. That alone resolves this case. And independent of ERISA's express preemption provision, ordinary implied-preemption principles require the same conclusion. *See, e.g.*, *Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 869 (2000) (holding that a statute's "saving clause" and "express pre-emption provision" did "*not* bar the ordinary working of conflict pre-emption principles"). Implicit preemption applies when a "state law conflicts with the provisions of ERISA or operates to frustrate its objects." *Boggs*, 520 U.S. at 841; *see also*

Schoedinger v. United Healthcare of Midwest, Inc., 557 F.3d 872, 875 (8th Cir. 2009). SF 383 flunks this test at least twice over.

A. SF 383 impinges on plan sponsors' discretion in designing benefit plans and interferes with uniform plan administration.

The first implied-preemption problem here is clear from the discussion above. ERISA codifies employers' freedom to define the terms of ERISA plans and customize the benefits offered, including by designing provider networks and participant cost incentives, without state interference. *See Shaw*, 463 U.S. at 96-97; *Express Scripts, Inc. v. Wenzel*, 262 F.3d 829, 832-33 (8th Cir. 2001). As detailed above, SF 383 defies this fundamental principle of ERISA by interfering with the choices available to self-funded plans. *See supra* Section II.B.

Applying SF 383 to self-funded ERISA plans also defies ERISA's policy of minimizing the administrative burden on employers who sponsor such plans, especially multistate employers, by requiring them to carve out a unique set of Iowa-specific plan rules. *See Rutledge*, 592 U.S. at 86-87 (explaining that ERISA is "primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways," and thereby "ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions"); *Eide v. Grey Fox Tech. Servs. Corp.*, 329 F.3d 600, 608 (8th Cir. 2003) ("ERISA's preemption of conflicting state laws enables employers to devise and operate benefit plans without concern that they accommodate conflicting regulatory schemes."). By attempting to

impose a state-specific set of rules on plans, SF 383 "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress" in enacting ERISA. *John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 99 (1993) (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)). That direct frustration of ERISA's purpose requires preemption in addition to and independently of ERISA's express preemption provision.

B. SF 383 interferes with ERISA's fiduciary obligations.

A second implied-preemption problem is no less significant. SF 383 conflicts with ERISA's fiduciary provisions and is preempted on this ground as well. *See Boggs*, 520 U.S. at 841; *Schoedinger*, 557 F.3d at 875 ("ERISA preempts state laws that conflict with its provisions or frustrate its objectives."); *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 439 (8th Cir. 1997) (if "a state law … conflicts with a specific portion of the complex ERISA statute," then the "state law is preempted").[9]

First, ERISA imposes on plan fiduciaries the duty to operate their plans prudently and solely in the interest of *all* participants, not just participants in Iowa. *See* 29 U.S.C. § 1104(a)(1)(A)-(B). Various provisions of SF 383 threaten to conflict with plan fiduciaries' fulfillment of their statutory duties. For example, SF 383's

[9] The district court considered fiduciary obligations in portions of its express preemption analysis. *See, e.g.*, Add. 25; App. 641; R. Doc. 54, at 25; Add. 31-33; App. 647-49; R. Doc. 54, at 31-33; Add. 38-39; App. 654-55; R. Doc. 54, at 38-39. Amici focus on implied preemption here but take no issue with the district court's approach.

any-willing-provider provisions require plans to expand their pharmacy networks to include any pharmacy without regard to employers' fiduciary duties to plan participants. For example, if a plan fiduciary determined that a participating provider in the plan's network was overcharging participants for prescriptions or engaging in other improper practices, that fiduciary would have both the right and the obligation to address those improprieties in the manner they see fit for their plan, potentially including removing the provider from the network. Failing to take such action could expose the fiduciary to potential claims by participants alleging breach of fiduciary duty. *See, e.g.*, *Chao v. Merino*, 452 F.3d 174, 182-84 (2d Cir. 2006) (reasoning that "[i]f a fiduciary was aware of a risk to the fund, he may be held liable for failing to investigate fully the means of protecting the fund from that risk," and on that basis affirming finding of breach based on plan fiduciary's failure "to take precautionary steps" against service provider known to have previously embezzled from the fund); *Bartnett v. Abbott Lab'ys*, 492 F. Supp. 3d 787, 797 (N.D. Ill. 2020) ("[a]pplying [same] reasoning"). Congress decided to impose these fiduciary obligations at the federal level, and allowing states to constrain ERISA fiduciaries' oversight of plan service providers could frustrate that choice.

ERISA's fiduciary provisions also require a plan fiduciary to administer the plan in accordance with its written terms. 29 U.S.C. § 1104(a)(1)(D). Additional preemption problems could arise when—as would often be the case—attempting to

comply with SF 383 would impede a plan fiduciary from fulfilling this federal statutory duty. *See Baxter v. Lynn*, 886 F.2d 182, 185 (8th Cir. 1989) ("[A]ny provision of state law which conflicts with a proper provision of an ERISA plan must give way to the latter."). For example, most plans with prescription benefits address participant cost-sharing and copays in their governing plan documents. SF 383's "anti-discrimination" and cost-sharing provisions may contradict plan terms and thus leave a plan fiduciary attempting to comply with state law unable to fulfill this federally imposed fiduciary duty. *Cf., e.g.*, *Minn. Chapter of Associated Builders & Contractors, Inc. v. Minn. Dep't of Pub. Safety*, 267 F.3d 807, 816 (8th Cir. 2001) (holding that ERISA preempted state laws that "negate[d] ERISA plan provisions by substituting the state's requirements for the range of terms found in ERISA apprenticeship plans").

Thus, under SF 383, a "plan's fiduciary faces a Hobson's choice: obey the state law, and risk violating the provisions of the plan (and hence ERISA), or disobey the state law" and hope that an ERISA preemption defense prevails if necessary. *Denny's, Inc. v. Cake*, 364 F.3d 521, 527 (4th Cir. 2004) (internal citation omitted); *see also, e.g.*, *NGS Am., Inc. v. Jefferson*, 218 F.3d 519, 529 (6th Cir. 2000) ("Challenging [state] regulations by violating them and then raising ERISA preemption as a defense in a state enforcement action would have risked breaking the law."). This

Court should prevent this dilemma from occurring by reaffirming the supremacy of federal law now.

CONCLUSION

For all of these reasons and those in Plaintiffs' brief, the Court should affirm the district court's findings of preemption, reverse its findings of non-preemption, and remand for the district court to enjoin enforcement of SF 383 in its entirety.

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I certify that this brief complies with type-volume limits because, excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f), this brief contains 7,085 words.

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CERTIFICATE OF SERVICE

I certify that, on this December 15, 2025, the foregoing Brief of Amici Curiae was filed electronically through the appellate CM/ECF system with the Clerk of the Court. All counsel of record in this case are registered CM/ECF users.

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