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UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

LAUREL HILL MANAGEMENT SERVICES, INC.; MINIMALLY INVASIVE SURGICAL ASSOCIATES; ADVANCED WEIGHT LOSS SURGICAL ASSOCIATES,

Plaintiffs-Appellants,

v.

LA-Z-BOY INC.; DOES 1–10; BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendants-Appellees.

No. 25-1727

Appeal from the United States District Court for the Eastern District of Michigan at Detroit.
No. 2:24-cv-13230—David M. Lawson, District Judge.

Argued: June 4, 2026

Decided and Filed: August 19, 2026

Before: GIBBONS, MURPHY, and HERMANDORFER, Circuit Judges.

COUNSEL

ARGUED: Jonathan A. Stieglitz, LAW OFFICE OF JONATHAN A. STIEGLITZ LAW, Los Angeles, California, for Appellants. Matthew G. Mrkonic, HONIGMAN LLP, Detroit, Michigan, for Appellee La-Z-Boy Inc. Nathan S. Scherbarth, ZAUSMER, PC, Farmington Hills, Michigan, for Appellee Blue Cross Blue Shield of Michigan. **ON BRIEF:** Jonathan A. Stieglitz, LAW OFFICE OF JONATHAN A. STIEGLITZ LAW, Los Angeles, California, for Appellants. Matthew G. Mrkonic, HONIGMAN LLP, Detroit, Michigan, for Appellee La-Z-Boy Inc. Nathan S. Scherbarth, ZAUSMER, PC, Farmington Hills, Michigan, for Appellee Blue Cross Blue Shield of Michigan.

HERMANDORFER, J., delivered the opinion of the court in which GIBBONS and MURPHY, JJ., concurred. MURPHY, J. (pp. 16–21), delivered a separate concurring opinion.

OPINION

HERMANDORFER, Circuit Judge. Like many companies, La-Z-Boy sponsors an employee health benefit plan. That plan covers someone the parties call "Patient AA." A few years ago, Patient AA sought healthcare treatment from several medical providers. Before agreeing to treat Patient AA, the medical providers wanted to confirm the reimbursement rate for their services. So the providers contacted the plan administrator, Blue Cross Blue Shield of Michigan, about the reimbursement terms under Patient AA's health benefit plan. Blue Cross employees orally represented that plan reimbursement would be calculated at the usual, customary, and reasonable rate—a familiar standard across industry plans. Relying only on those oral representations, the medical providers then treated Patient AA.

When the medical providers eventually sought reimbursement, however, Blue Cross paid an amount far below the promised rate. The medical providers responded by suing La-Z-Boy and Blue Cross. They pressed state-law claims of negligent misrepresentation and promissory estoppel based upon Blue Cross's misstatements about the reimbursement rate. Those claims triggered a dispute about preemption under the Employee Retirement Income Security Act of 1974 (ERISA), which governs the plan. ERISA's express-preemption provision displaces parties' ability to pursue state-law claims that "relate to" an ERISA plan. 29 U.S.C. § 1144(a). Applying this Court's decision in *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991), the district court determined that the medical providers' claims were preempted. It then ordered dismissal on that basis.

We agree that *Cromwell* dictates dismissal of the providers' particular claims in this case. Under *Cromwell*, ERISA preempts negligent-misrepresentation and promissory-estoppel claims that depend upon a plan administrator's misstatements about the coverage or reimbursement terms of an employer's ERISA plan. And the medical providers' claims, as pled, turn on assertions about the reimbursement terms of La-Z-Boy's ERISA plan. We therefore affirm the district court's application of ERISA preemption.

I

A

Because this appeal arises from the dismissal of a complaint, we accept the complaint's well-pled factual allegations as true. *Ream v. U.S. Dep't of the Treasury*, 174 F.4th 480, 484 (6th Cir. 2026).

La-Z-Boy sponsors an ERISA-regulated health benefit plan for its employees. Among the plan's participants is "Patient AA." Sometime in early 2022, Patient AA sought services and procedures from several out-of-network medical providers. We refer to those entities and their assignees collectively as the Medical Providers.

Before agreeing to perform the procedures, the Medical Providers contacted Blue Cross—the administrator of La-Z-Boy's plan—to determine the "Patient's responsibility versus [La-Z-Boy's] responsibility for paying for medical services[.]" Am. Compl., R.11, ¶ 26. The Medical Providers directed their query to Blue Cross because they "underst[ood]" that Blue Cross "is and was [La-Z-Boy's] agent and representative in connection with stating the manner of payment for medical services and providing other administrative services relating to the Patient's and [La-Z-Boy's] health plan." *Id.* ¶ 7.

The discussion that followed featured oral "promises and representations" from Blue Cross about the terms of La-Z-Boy's ERISA plan. *Id.* ¶ 10. Blue Cross representatives recited the amount of Patient AA's deductible and maximum out-of-pocket expense. They also explained that Blue Cross would reimburse the Medical Providers at the usual, customary, and reasonable (UCR) rate for the specific procedures Patient AA sought. The UCR rate is "based on what providers in the area usually charge for the same or similar medical service," and Blue Cross calculates the UCR rate by utilizing a third-party "medical bill database." *Id.* ¶¶ 17, 20 (citation omitted). According to the Medical Providers, plan administrators across the industry use the UCR rate to set a "limit on the amount [a] health plan will pay." *Id.* ¶ 20 n.3 (citation omitted).

Relying on Blue Cross's statements about the rate of reimbursement, the Medical Providers rendered treatment to Patient AA. The Medical Providers allege that Blue Cross never advised them that Patient AA's "policy" was "subject to certain exclusions, limitations, or qualifications" that could "result in denial of coverage, limitation of payment or any other method of payment unrelated to the UCR rate." *Id.* ¶ 33. Blue Cross also did not "make reference to any other portion" of the "plan" that would have put the Medical Providers "on notice of any reduction in the originally stated payment percentage." *Id.* ¶ 34. Nor did the Medical Providers receive a copy of the plan before providing treatment.

The Medical Providers then "submitted their claims" directly to Blue Cross in the amount of $342,296. *Id.* ¶¶ 40, 41. But Blue Cross paid the Medical Providers only $1,598.40; that amount was "based on Medicare," not the UCR rate that the Medical Providers expected. *Id.* ¶¶ 41, 42.

B

In March 2024, the Medical Providers sued La-Z-Boy and unnamed individual defendants in California state court. After the case was removed to federal court and transferred to the Eastern District of Michigan, the Medical Providers amended their complaint to add Blue Cross as a defendant.

The Medical Providers' suit contends that Blue Cross made misrepresentations regarding the rate at which Patient AA's plan would reimburse them and that the Medical Providers relied on those misrepresentations to render treatment to Patient AA. The Medical Providers asserted state-law negligent-misrepresentation and promissory-estoppel claims against the defendants. For relief, they sought "payment at the UCR rate and not based on Medicare." *Id.* ¶ 52.

La-Z-Boy and Blue Cross each moved to dismiss the complaint for failure to state a claim. Relevant here, they argued that ERISA's express-preemption provision barred the Medical Providers' claims. *See* 29 U.S.C. § 1144(a). The Medical Providers opposed dismissal and, in a single sentence at the end of their opposition brief, requested leave to file a second amended complaint in the event the district court agreed with the defendants' preemption

arguments. The Medical Providers did not include a proposed second amended complaint or explain their case for amendment.

The district court granted the defendants' motions and dismissed the Medical Providers' amended complaint with prejudice. Relying on this Court's decision in *Cromwell*, 944 F.2d 1272, the district court concluded that ERISA expressly preempts the Medical Providers' claims because those claims "'relate to' La-Z-Boy's employee medical plan." D. Ct. Op., R.26, PageID 150 (quoting 29 U.S.C. § 1144(a)). The district court did not discuss the Medical Providers' fallback request for leave to amend.

The Medical Providers timely noticed an appeal. Six days later—and two weeks after the district court entered judgment—the Medical Providers moved for leave to file a second amended complaint. They contended that "amendment is appropriate as Plaintiffs have identified a number of factual distinctions in the Court's dismissal Order that may alter whether the case is preempted by ERISA." Mot. for Leave, R.30, PageID 170. The district court denied the motion because it "lack[ed] jurisdiction to entertain a request for relief touching on the merits of the case while the plaintiffs' appeal is pending." Order Denying Leave, R.31, PageID 188.

II

The Medical Providers argue that the district court erred in dismissing their operative complaint on ERISA-preemption grounds. We disagree. Under our current caselaw, ERISA expressly preempts the Medical Providers' negligent-misrepresentation and promissory-estoppel claims because they "relate to" La-Z-Boy's ERISA plan. 29 U.S.C. § 1144(a).

A

We begin with a procedural issue. The Medical Providers request that we apply ERISA to the new allegations and claims contained in their proposed second amended complaint, rather than limit our review to the operative first amended complaint. We decline that invitation.

When the district court dismissed the Medical Providers' claims with prejudice, it had only the first amended complaint before it. The Medical Providers moved for leave to file their proposed second amended complaint only *after* the district court entered judgment and the

Medical Providers appealed. The district court explained that, in view of that timing, it had no authority to rule on the Medical Providers' motion because jurisdiction transferred to this Court.

The Medical Providers do not contest this order of events. Nor do they dispute that the first amended complaint is the "operative" complaint. Reply Br. 10. Still, the Medical Providers' appellate arguments rely on new allegations and claims—like breach of oral contract—present only in their post-judgment amendment attempt.

We disregard the new material in the proposed second amended complaint because it is not part of the appellate record. The "record on appeal" includes "(1) the original papers and exhibits filed in the district court; (2) the transcript of proceedings, if any; and (3) a certified copy of the docket entries prepared by the district clerk." Fed. R. App. P. 10(a). "Although Rule 10(a), read literally, might suggest that all items filed with the district court are part of the record on appeal," federal appellate courts usually "will not consider matter that was filed with the district court . . . *after* the date of the judgment or order that is challenged on appeal." 16A Wright & Miller's Federal Practice & Procedure § 3956.1 (5th ed. 2026). That is the going rule in our Circuit. *See Clark v. Warden*, 934 F.3d 483, 490 (6th Cir. 2019). For "purposes of this appeal" from the district court's judgment of dismissal, we will "review only the documents considered by the district court" in entering that judgment. *Chelf v. Prudential Ins. Co. of Am.*, 31 F.4th 459, 464 n.2 (6th Cir. 2022). Those documents do not include the proposed second amended complaint.

B

With the scope of our review set, we next move to the merits of the parties' ERISA-preemption dispute. Whether ERISA preempts a state-law claim is a question of federal law that we review de novo. *Self-Ins. Inst. of Am., Inc. v. Snyder*, 827 F.3d 549, 554 (6th Cir. 2016).

By its express terms, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" that ERISA regulates. 29 U.S.C. § 1144(a). That "expansive" provision operates to "ensure that employee benefit plan regulation" is "exclusively a federal concern." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (citation omitted). The provision's preemptive effect extends to state "common law causes of action" that fall

within its domain. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *see also* 29 U.S.C. § 1144(c).

The "literal text" of the phrase "relate to," the Supreme Court has recognized, cannot "be read to extend to the furthest stretch of its indeterminacy, or for all practical purposes preemption would never run its course." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997) (cleaned up). After all, "everything is related to everything else." *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 335 (1997) (Scalia, J., concurring). So, to avoid "limitless application" of preemption, the Court has attempted to develop "workable standards" for applying § 1144(a). *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319-20 (2016).

Through those efforts, the Court has identified "two categories of state laws that ERISA pre-empts." *Id.* at 319. *First*, ERISA preemption applies to state laws that make "reference to" an ERISA plan. *Id.* (citation omitted). A state law makes "reference to" ERISA-governed plans when the state law "acts immediately and exclusively upon ERISA plans," or when the "existence of ERISA plans is essential" to the state law's "operation." *Id.* at 319-20 (citation omitted). *Second*, ERISA preemption applies to state laws that have a "connection with" ERISA plans. *Dillingham*, 519 U.S. at 325. That "connection with" inquiry turns on ERISA's "objectives" and the "nature of the effect of the state law on ERISA plans." *Id.* (citation omitted). "As a shorthand" for the relevant "considerations," the Supreme Court "asks whether a state law governs a central matter of plan administration or interferes with nationally uniform plan administration." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 87 (2020) (citation omitted).

State-law claims, this Court has instructed, might sometimes warrant application of ERISA preemption. If a state-law claim "in essence" seeks the "recovery of an ERISA plan benefit," it has the requisite connection with an ERISA plan and is thus "preempted." *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.* (*PONI*), 399 F.3d 692, 702 (6th Cir. 2005) (citation omitted). That is true no matter the "label" placed on a state-law claim. *Cromwell*, 944 F.2d at 1276. A state-law claim might also trigger ERISA preemption if it

"implicate[s] the relations among the traditional ERISA plan entities, including the principals, the employer, the plan, the plan fiduciaries, and the beneficiaries." *PONI*, 399 F.3d at 698 (citation omitted).

We now turn to applying those standards to the state-law claims in this case.

C

The Medical Providers contend that their negligent-misrepresentation and promissory-estoppel claims neither make "reference to" nor have a "connection with" La-Z-Boy's ERISA-governed plan. *Gobeille*, 577 U.S. at 319-20 (citation omitted). But our decision in *Cromwell* counsels otherwise. *Cromwell* considered materially identical state-law claims to those we now confront: There, healthcare providers asserted negligent-misrepresentation and promissory-estoppel claims against an ERISA-plan administrator based on the administrator's false assurances of coverage. 944 F.2d at 1274-75. We held that ERISA expressly preempted the providers' state-law claims because they "relate[d] to" an ERISA-governed plan. *Id.* at 1278-79; *see* 29 U.S.C. § 1144(a). The same conclusion follows here.

1

Some *Cromwell* discussion is useful. The case involved Lawrence Reinke, who had participated in his employer's ERISA-covered plan until his termination from employment. 944 F.2d at 1274. The next year, Reinke's wife suffered a stroke. *Id.* The Reinkes then sought home-healthcare services from two providers. *Id.* Before rendering treatment, the providers received over-the-phone assurances from Equicor, the ERISA-plan administrator, that Reinke's plan covered the relevant medical services. *Id.* at 1274-75. The providers agreed to provide services based on those assurances. *Id.* at 1275. To facilitate reimbursement, Reinke and the healthcare providers executed an assignment-of-benefits agreement. *Id.* Under it, Equicor could directly reimburse the healthcare providers for any amount due under Reinke's plan terms. *Id.* The providers began treating Reinke's wife and, for a few months, received reimbursement from Equicor. *Id.* But Equicor ceased payment upon realizing that Reinke's employment had been terminated years earlier. *Id.* That termination meant that Reinke and his wife were no longer covered by—or entitled to any benefits under—the plan at issue. *Id.*

The healthcare providers sued to recover the outstanding balance of the payments Equicor denied. Relevant here, the providers asserted four claims against Equicor "based on their reasonable reliance on Equicor's oral assurances of coverage." *Id.* Two claims—for breach of contract and breach of good faith—"were premised exclusively on" the assignment-of-benefits agreement. *Id.* at 1277. The other two—for negligent misrepresentation and promissory estoppel—were "state law claims" arising separately from the assignment provision. *Id.* The district court determined that ERISA expressly preempted those state-law claims. *Id.* at 1275.

A divided panel of this Court affirmed. We accepted the providers' premise that ERISA preemption does not bar state-law claims "whose effect on employee benefit plans is merely tenuous, remote or peripheral." *Id.* at 1276; *see also id.* at 1279 (Jones, J., dissenting). But in assessing state-law claims' effect on ERISA plans, *Cromwell* rejected reliance on "label[s]" in favor of asking "whether in essence such a claim is for the recovery of an ERISA plan benefit." *Id.* at 1276 (majority opinion). Applying that reasoning, we rejected the contention that the providers' negligent-misrepresentation and promissory-estoppel claims were merely tangential to Reinke's ERISA plan. We explained that the claims effectively sought "the recovery of benefits from the [ERISA] plan for health care services rendered to the Reinkes." *Id.* So understood, we continued, those claims were "at the very heart of issues within the scope of ERISA's exclusive regulation" and were "[c]learly" preempted. *Id.* That conclusion followed even though the providers were not traditional plan entities and could not sue to enforce any ERISA rights. *See id.* at 1278. That is because permitting liability on the state-law claims, even to providers outside ERISA's scope, would "affect the relationship between plan principals by extending coverage beyond the terms of the plan." *Id.* at 1276.

2

Cromwell covers the Medical Providers' claims in this case. Like Equicor, which gave oral representations of ERISA-plan coverage to the providers in *Cromwell*, Blue Cross gave oral assurances to the Medical Providers regarding coverage under La-Z-Boy's ERISA plan. *Id.* at 1275. Here, as in *Cromwell*, those assurances were false, and Blue Cross reimbursed the Medical Providers at a rate lower than what was represented over the phone. *Id.* As in

Cromwell, the Medical Providers brought negligent-misrepresentation and promissory-estoppel claims seeking to recover the difference between the amount orally represented and the amount reimbursed. *Id.* *Cromwell* held that ERISA expressly preempted the providers' negligent-misrepresentation and promissory-estoppel claims. Given the materially similar facts here, we are constrained to reach the same preemption result.

Indeed, this is arguably a stronger case for applying ERISA preemption than *Cromwell*. After all, *Cromwell* involved an employee—Reinke—who was unemployed at all relevant times. That meant Reinke was no longer a participant in any ERISA plan when the healthcare providers received oral assurances of coverage. *Id.* at 1274-75. If *Cromwell*'s negligent-misrepresentation and promissory-estoppel claims "relate[d] to an employee benefit plan" even in the absence of *any* ERISA-plan coverage, *id.* at 1278-79, the same should follow with greater force for claims that implicate the terms of Patient AA's still-operative ERISA plan.

3

The Medical Providers make several attempts at sidestepping *Cromwell*. None succeeds.

First, the Medical Providers seize on the assignment-of-benefits agreement in *Cromwell*. By way of background, sometimes a party to an ERISA-covered health plan can enter into a contract assigning its rights under the plan to a third party. An assignment agreement in turn confers "derivative standing" on the third party to pursue claims under ERISA's enforcement provision, 29 U.S.C. § 1132(a). *Brown v. BlueCross BlueShield of Tenn., Inc.*, 827 F.3d 543, 546 (6th Cir. 2016). That permits the third party to file an ERISA suit "in place" of the assignor to recover plan benefits. *Id.* (citation omitted). Such assignments, though, do not enlarge a third party's rights beyond those available under ERISA. So even with an assignment agreement, a third-party assignee cannot assert state-law claims as a means to recover ERISA-plan benefits. *See, e.g.*, *Meadows v. Emps. Health Ins.*, 47 F.3d 1006, 1008 (9th Cir. 1995). That is the type of "alternate enforcement mechanism[]" to § 1132(a) that calls for application of ERISA preemption. *PONI*, 399 F.3d at 698 (citation omitted).

That brings us to the assignment-of-benefits agreement in *Cromwell*. There, as the Medical Providers point out, Reinke entered into an assignment-of-benefits agreement with the

healthcare providers. That agreement purported to permit the healthcare providers to enforce Reinke's rights under his (former) ERISA plan. From there, the Medical Providers contend that *Cromwell* is best understood as a case that applied ERISA-preemption rules to a party seeking to press state-law claims as an "alternate" means of enforcing their assigned ERISA rights. *Id.* (citation omitted). So they seek to limit *Cromwell*'s preemption holding to only those state-law claims that implicate similar assignment-of-benefits agreements.

That account overreads the relevance of the parties' assignment agreement to *Cromwell*'s preemption analysis. Nothing about *Cromwell*'s preemption discussion turned on the assignment-of-benefits agreement. Indeed, that portion of *Cromwell* mentions the agreement only in a passing reference in a footnote. *See* 944 F.2d at 1276 & n.3. That omission was no accident, but instead reflects how *Cromwell* divided the various claims at issue. On one hand, *Cromwell* cast the providers' breach-of-contract and breach-of-good-faith claims as arising directly from the assignment-of-benefits agreement. *Id.* at 1277. On the other hand, *Cromwell* understood the negligent-misrepresentation and promissory-estoppel claims to be "purely state law claims" that were separate from the assignment agreement. *Id.* Yet *Cromwell* held that ERISA expressly preempted those state-law claims all the same. *Id.* at 1276. *Cromwell*, then, did not link preemption of the negligent-misrepresentation and promissory-estoppel claims with the parties' assignment-of-benefits agreement. So the lack of such an agreement here is beside the point.

Second, the Medical Providers contend that "the question" in *Cromwell* "was one of a right to payment," while the question in this case concerns "the extent of payment." Medical Providers Br. 49. They suggest that only right-to-payment claims brought under assignment agreements should implicate preemption because they are purely derivative of a beneficiary's ERISA-plan terms. By contrast, they continue, extent-of-payment claims arise out of "separate agreements" about rates between healthcare providers and plan administrators and thus "do not fall within ERISA's enforcement provision." *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1052 (9th Cir. 1999); *see also Brown*, 827 F.3d at 544, 548-49; *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1350-53 (11th Cir. 2009).

The Medical Providers' attempt to draw a line between *Cromwell* and their claims fails from both directions. We begin with their characterization of *Cromwell* as a "right to payment" case involving an assignment-of-benefits agreement. Medical Providers Br. 49. As just discussed, *Cromwell* did not view the negligent-misrepresentation and promissory-estoppel claims as implicating the parties' assignment agreement. The Medical Providers therefore cannot cordon off *Cromwell*'s dismissal of those claims into their proposed "right to payment" category. *Id.*

Nor have the Medical Providers pled pure "extent of payment" claims, *id.*—that is, claims involving the "breach" of an "agreement" for a rate of payment that is purely "separate" from the ERISA plan, *Anesthesia Care*, 187 F.3d at 1051-52; *Conn. State Dental*, 591 F.3d at 1350. To be sure, the Medical Providers at one point allege that Blue Cross's assurances "had no relation" to Patient AA's "plan document." Am. Compl., R.11, ¶ 39. But that is a "legal conclusion couched as a factual allegation" that "we need not accept as true." *Hensley Mfg. v. ProPride, Inc.*, 579 F.3d 603, 609 (6th Cir. 2009) (cleaned up). Merely saying that claims do not relate to an ERISA plan does not defeat preemption.

We instead assess the substance of the Medical Providers' allegations. Doing so confirms that the Medical Providers tethered their claims to the terms of the ERISA plan. The Medical Providers asked Blue Cross about Patient AA's coverage under the terms of La-Z-Boy's ERISA plan. Specifically, they inquired whether reimbursement for particular procedures would be calculated at the UCR rate—a limit they allege is industry standard for the "amount your health plan will pay." Am. Compl., R.11, ¶ 20 n.3 (citation omitted). Blue Cross allegedly confirmed as much, without stating whether Patient AA's "policy" was "subject to certain exclusions, limitations, or qualifications." *Id.* ¶ 33. And Blue Cross did not "make reference to any *other* portion" of the "plan" that would put the Medical Providers "on notice of any reduction" in the reimbursement rate. *Id.* ¶ 34 (emphasis added). As alleged in the operative complaint, then, the terms of La-Z-Boy's ERISA plan itself—not any separate contract between the Medical Providers and Blue Cross—set the rate of reimbursement for the relevant procedures. That means the alleged "misrepresentations" and "promises" related to the contents

of the plan's terms. *Id.* ¶¶ 57, 59. Because the Medical Providers asserted plan-related claims, caselaw about non-plan-related claims lends them no help.

Third, the Medical Providers suggest that *Cromwell* does not bind us because it is inconsistent with later Supreme Court decisions. We disagree. "One panel is usually bound by the ruling of a previous one." *United States v. Fields*, 53 F.4th 1027, 1046 (6th Cir. 2022). And the Medical Providers identify neither "on-point dictum" nor "'directly applicable' legal reasoning" from an intervening decision of the Supreme Court, *id.* at 1047 (citation omitted), that is "inconsistent" with or "requires modification of" *Cromwell*, *Salmi v. Sec'y of Health and Hum. Servs.*, 774 F.2d 685, 689 (6th Cir. 1985).

The Medical Providers instead discuss various Supreme Court decisions at a high level of generality, reciting the reference-to and connection-with standards and asserting that they collectively stand for the proposition that "preemption must be interpreted narrowly and judiciously, to not override state law except where specifically bargained for." Medical Providers Br. 32. But that does not constitute the type of "legal reasoning" that would allow us to disregard *Cromwell*. *Fields*, 53 F.4th at 1047. Moreover, *Cromwell*'s rationale—that the claims essentially sought "the recovery of benefits" and would "affect the relationship between plan principals," 944 F.2d at 1276—aligns with more recent decisions cited by the Medical Providers, *see, e.g.*, *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) ("[W]e have held that state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption."); *PONI*, 399 F.3d at 700 (state-law claims have connection with plan whenever they "implicate" the "relations among the traditional ERISA plan entities" (citation omitted)).

Fourth, to bolster their case against applying *Cromwell*, the Medical Providers cite out-of-circuit decisions that either decline preemption of similar claims or expressly critique *Cromwell*'s reasoning. Suffice it to say, several of the cited decisions implicate factual or legal distinctions that might explain any difference in outcome. *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 224 (3d Cir. 2020) (addressing an "oral agreement[]" separate from plan terms); *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health & Welfare Tr.*

Fund, 538 F.3d 594, 601 (7th Cir. 2008) (analyzing complete preemption only); *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 145-46 (2d Cir. 2017) (same). And in any event, we may not cast aside *Cromwell*'s controlling reasoning—regardless of whether we would approach preemption the same way if writing on a blank slate.

* * *

Our holding is narrow. Under *Cromwell*, ERISA expressly preempts third-party healthcare providers' negligent-misrepresentation and promissory-estoppel claims when those claims arise out of an ERISA-plan administrator's oral assurances about the terms of coverage or reimbursement under an ERISA-governed plan. Because the Medical Providers' operative complaint falls within *Cromwell*'s confines, the district court properly dismissed it. We do not determine whether ERISA expressly preempts other state-law claims brought by third-party healthcare providers against plan administrators in different factual scenarios.

III

One issue remains. In their opposition to the defendants' motions to dismiss, the Medical Providers—in a single sentence at the conclusion of their brief—requested leave to file a second amended complaint should the district court deem their existing claims preempted. The district court implicitly rejected that request when it dismissed the operative complaint with prejudice. The Medical Providers contend that the district court erred in doing so. We review the district court's decision for abuse of discretion. *Beydoun v. Sessions*, 871 F.3d 459, 464 (6th Cir. 2017).

At the outset, the Medical Providers' briefing to this Court fails to support their "skeletal" amendment argument with any relevant citations, "leaving the court to put flesh on its bones." *Buetenmiller v. Macomb Cnty. Jail*, 53 F.4th 939, 946 (6th Cir. 2022) (cleaned up). We usually consider such undeveloped appellate arguments forfeited. *Id.*

Regardless, the district court did not abuse its discretion. A district court "should freely give leave" to amend "when justice so requires." Fed. R. Civ. P. 15(a). But "implicit in Rule 15(a) is that the district court must be able to determine whether justice so requires, and in order to do this, the court must have before it the substance of the proposed amendment." *Beydoun*,

871 F.3d at 469 (cleaned up). "Indeed, 'a bare request in an opposition to a motion to dismiss—without any indication of the particular grounds on which amendment is sought—does not constitute a motion within the contemplation of Rule 15(a).'" *Id.* (citation omitted). The "district court did not abuse its discretion in this case by failing to rule on a motion that was never before it." *Bunn v. Navistar, Inc.*, 797 F. App'x 247, 257 (6th Cir. 2020); *see also Evans v. Pearson Enters., Inc.*, 434 F.3d 839, 853 (6th Cir. 2006) (no abuse of discretion where plaintiff "requested leave to amend in a single sentence without providing grounds or a proposed amended complaint to support her request").

* * *

We affirm.

CONCURRENCE

MURPHY, Circuit Judge, concurring. The administrator of an employer healthcare plan cannot manage that plan on its own. Just think of all the contracts the administrator might enter. The administrator will likely hire employees to help it implement its claims-processing duties. And it might lease office space to house its operations. It might also buy all sorts of equipment—ranging from computers to cellphones—to conduct those operations. And it might hire outside law or accounting firms to handle litigation or audits that arise. Any of these relationships could lead to state-law contract disputes if one side believes the other has not lived up to its promises.

The administrator's operations will not just implicate the common law of contracts. They will also implicate other nonconsensual duties that States impose on their residents. The operations could affect third parties in many ways. Suppose that an administrator's employee negligently speeds to a business appointment and hits a pedestrian. This conduct might trigger a negligence suit. Or suppose another employee attempts to defraud a landlord by manufacturing fraudulent records to conceal the administrator's financial problems. This conduct might trigger a fraud suit. Or suppose an administrator's supervisors engage in sex or racial discrimination in their hiring practices. This conduct might trigger a suit under a State's antidiscrimination laws.

What happens, though, if a plan administrator manages an employer healthcare plan that falls within the Employee Retirement Income Security Act of 1974 (ERISA)? ERISA has a *broad* preemption clause indicating that the law's "provisions" generally "supersede" state law: "the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any" covered healthcare plan. 29 U.S.C. § 1144(a). At the same time, ERISA has a *narrow* civil-enforcement provision permitting only specific types of private suits. *See id.* § 1132(a). This "carefully crafted" provision allows plan beneficiaries, participants, and fiduciaries to sue over various things. *Aldridge v. Regions Bank*, 144 F.4th 828, 844 (6th Cir. 2025) (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254

(1993)). But the provision does not contemplate any of the hypothetical suits that I have mentioned between plan administrators and the outside parties that they contract with or injure.

This fact poses a conundrum. If we read the preemption provision as broadly as its text might allow, any of the hypothetical suits could be said to "relate to" an ERISA plan. 29 U.S.C. § 1144(a). To give an example, one might say that a contract between a plan administrator and a law firm to defend against a participant's suit to recover benefits "relate[s] to" the plan. *Id.* And the state contract law making that contract enforceable might be said to "relate to" it too. *Id.* Under this view, ERISA would preempt state contract, tort, and employment laws as applied to plan-related suits. But none of the parties who sued would have a federal cause of action under § 1132(a) to challenge the alleged misconduct of the plan administrator or its agents. And ERISA's substantive requirements likely would not cover the conduct underlying these suits either. The result? No enforceable legal duties—neither federal nor state—would apply to the relationship between ERISA plan administrators and outside parties who they contract with to operate the plan or injure during those operations. By passing ERISA, did Congress want to test whether Thomas Hobbes or John Locke was right about human conduct in the state of nature?

No, the Supreme Court and our court have instead read the preemption provision's "relate to" language more narrowly. The Court has suggested that ERISA does not preempt "run-of-the-mill state-law claims" against plan administrators—for things like "unpaid rent" or tortious conduct—even if those claims affect the plan. *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988). And we have held that ERISA does not preempt contract and tort claims between a plan administrator and a "non-fiduciary service provider" that the administrator hires to help it operate the plan. *Penny/Ohlmann/Nieman, Inc. v. Mia. Valley Pension Corp.* (*PONI*), 399 F.3d 692, 700–04 (6th Cir. 2005); *see Aldridge*, 144 F.4th at 840.

If these cases are right, it is not obvious why we have taken a different path for the relationship between a plan administrator and the medical providers that it relies on to provide healthcare services to plan participants. *See Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991). In *Cromwell*, a plan administrator promised medical providers that the plan would cover services to an individual thought to be a plan participant. *Id.* at 1275.

The providers also got an assignment of rights from this individual that allowed them to seek benefits on his behalf under the plan. *Id.* But the administrator later found out that the individual was ineligible for benefits. *Id.* It thus refused to pay some of the providers' bills. *Id.* The providers brought breach-of-contract and breach-of-good-faith claims based on the assignment of rights. *See id.* at 1275, 1277. They also brought negligent-misrepresentation and promissory-estoppel claims based on independent tort and contract duties. *Id.* We held that ERISA preempted all four state-law claims. *See id.* at 1276.

This "poorly reasoned" opinion represents an "outlier" in the courts. *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 236 (3d Cir. 2020) (quoting *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health & Welfare Tr. Fund*, 538 F.3d 594, 601 (7th Cir. 2008)). To be clear, all agree that *Cromwell* got things half right. If a plan participant assigns medical providers the right to benefits, the providers' suit enforcing this assignment looks identical to "[a] civil action" "by a participant" "to recover benefits due to him under the terms of his plan[.]" 29 U.S.C. § 1132(a)(1)(B). And a state-law breach-of-contract suit seeking plan benefits is perhaps the prototypical example of a claim that ERISA preempts. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47–57 (1987); *Transitional Hosps. Corp. v. Blue Cross & Blue Shield of Tex., Inc.*, 164 F.3d 952, 954 (5th Cir. 1999); *Misic v. Bldg. Serv. Emps. Health & Welfare Tr.*, 789 F.2d 1374, 1377–78 (9th Cir. 1986) (per curiam). So *Cromwell* properly found preempted the breach-of-contract and breach-of-good-faith claims tied to the assignment of rights that the medical providers obtained from the purported plan participant. *See* 944 F.2d at 1276.

But *Cromwell*'s resolution of the negligent-misrepresentation and promissory-estoppel claims is another matter. To explain why, I will start with a hypothetical: Suppose that a plan administrator signs a contract with a medical provider to pay a specific price for a medical procedure offered to plan participants. But suppose that the administrator later regrets the price and starts paying a lower amount—in breach of this contract. Could the provider sue for breach? That suit would arise from contractual duties independent of the duties in the plan (unlike in the assignment-of-rights context), so the provider would lack "derivative standing" to sue under ERISA's cause of action in § 1132(a). *Brown v. BlueCross BlueShield of Tenn., Inc.*, 827 F.3d

543, 546–47, 549 (6th Cir. 2016). Yet if we held that the contract claim "relate[d] to" the plan under § 1144(a), ERISA would preempt a state-law contract suit. Under this view, the law would effectively bar administrators from entering legally enforceable contracts with medical providers.

I doubt that Congress meant to deprive administrators of the right to strike deals they deem beneficial—to the detriment of the participants they serve. Rather, a medical provider's contract claim against a plan administrator (or vice versa) would seem to survive ERISA preemption under the Supreme Court's framework. *See Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 86–89 (2020); *Aldridge*, 144 F.4th at 838–40. A state's generally applicable law of contracts would not have an improper "reference to" ERISA plans because it would apply across the board—not just to those plans. *Aldridge*, 144 F.4th at 838. And a medical provider's contract claim against a plan administrator (or vice versa) would not have an improper "connection with" the plan because the duties that the contract creates exist *independently* of the plan and do not "touch matters that ERISA already covers." *Id.* at 838–39; *cf. Rutledge*, 592 U.S. at 93–94 (Thomas, J., concurring). Indeed, I see little daylight between this hypothetical agreement and the one I mentioned between an administrator and a law firm to defend against a participant's suit. Unsurprisingly, then, courts have generally held that ERISA would permit state-law contract claims seeking to enforce contractual duties that arise from these separate agreements. *See Plastic Surgery*, 967 F.3d at 236; *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 530–32 (5th Cir. 2009); *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1050–54 (9th Cir. 1999).

But why should things change when we switch from *consensual* duties created by state contract law to *nonconsensual* duties created by state tort law? Consider a second hypothetical: Suppose that an out-of-network provider asks a plan administrator what it will pay for the out-of-network care of a plan participant. Suppose the administrator intentionally lies by claiming that the plan will pay much more than its terms permit to induce the provider to provide the care. But the administrator then pays a much lower amount (and saves the amount it would have had to pay for in-network care). Could the provider sue the administrator for this blatant fraud? The provider is not a participant, beneficiary, or fiduciary and thus would lack a cause of action under

§ 1132(a). So like the hypothetical contract claim, if we held that the provider's state-law fraud claim "relate[d] to" the plan under § 1144(a), the provider could not recover for the administrator's fraud.

In my mind, though, the same reasons why ERISA does not preempt the contract claim would extend to this tort claim. In both contexts, medical providers sue to enforce *generally applicable* duties that exist *independently* of the plan—whether consensual contract duties or mandatory tort duties. *See* Restatement (Second) of Torts §§ 552–53 (A.L.I. 1977). And, as far as I am aware, ERISA says no more about how administrators should interact with medical providers than it details how they should interact with other third parties, such as lawyers, landlords, or employees. (Interactions with participants or beneficiaries would be different.) So the weight of authority at least allows some negligent-misrepresentation claims to escape preemption when medical providers allege that administrators gave them wrong information about the plan to induce their medical care. *See Healthcare Ally Mgmt. of Cal., LLC v. WSP USA, Inc.*, __ F.4th __, 2026 WL 2319896, at *6–18 (9th Cir. Aug. 11, 2026); *In Home Health, Inc. v. Prudential Ins. Co. of Am.*, 101 F.3d 600, 604–07 (8th Cir. 1996); *Meadows v. Emps. Health Ins.*, 47 F.3d 1006, 1009–11 (9th Cir. 1995); *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1532–34 (11th Cir. 1994); *Mem'l Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243–50 (5th Cir. 1990). *Cromwell* (which predates most of these cases) sits uncomfortably next to them.

Where does this analysis leave things? I agree with Judge Hermandorfer's persuasive showing that we must follow *Cromwell* because this case involves the same types of negligent-misrepresentation and promissory-estoppel claims that it found preempted. Going forward, though, I would interpret *Cromwell* as narrowly as its logic would allow. The majority, for example, rightly notes that nothing we said in *Cromwell* resolves whether providers or plan administrators may pursue state-law contract claims for breaches of agreements that they enter.

* * *

I suspect that some cases finding ERISA preemption in this area might be influenced by skepticism over the underlying state-law claims. Here, for example, the medical providers

suggest that they agreed to provide hundreds of thousands of dollars in care based on nothing more than oral assurances in two phone calls—without seeing the plan or asking for written assurances. And the allegations suggest the care was not for an emergency. The providers called the insurer to determine whether to provide medical services at the beginning of January but did not render care until the end of February. Perhaps this practice of placing a "'verification call' to the plan administrator" before delivering care is the industry custom. *Healthcare Ally Mgmt.*, 2026 WL 2319896, at *2. Still, there may have been questions down the road about whether the providers could prove "justifiable reliance" on the calls. Restatement (Second) of Torts § 552(1). But courts should not allow the merits of the state-law claims to affect the proper ERISA preemption analysis.