

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DIANE MILLER, : CIVIL ACTION
 :
 Plaintiff :
 :
 v. :
 :
 RIDDLE MEMORIAL HOSPITAL, :
 ET AL., :
 :
 Defendants : NO. 98-392

M E M O R A N D U M

Padova, J.

May , 1998

Plaintiff Diane Miller originally brought this action in the Court of Common Pleas of Philadelphia County against Aetna-US Healthcare, Inc., eight doctors, one nurse, one physician assistant, and one hospital. Defendant Aetna-US Healthcare, Inc. ("Healthcare")¹ subsequently removed the action to this Court pursuant to 28 U.S.C.A. § 1441 (West 1994) on the basis of the complete preemption doctrine. Specifically, Healthcare contends that Plaintiff's allegations regarding her discharge from Defendant Riddle Memorial Hospital ("Hospital") to her home rather than to a skilled nursing facility raise a claim under § 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C.A. § 1132(a)(1)(B) (West 1985). In the

¹ In its Notice of Removal, Defendant notes that United States Health Care Systems of Pennsylvania, Inc. d/b/a The Health Maintenance Organization of Pennsylvania is the specific organization that administered the employee welfare benefit plan at issue in this case. For consistency purposes, this entity will be referred to as "Defendant Healthcare" or "Healthcare" throughout this Memorandum.

alternative, Healthcare maintains that this action is removable on the basis of diversity jurisdiction under 28 U.S.C.A. § 1332 (West 1993 & Supp. 1998). Presently before the Court is Plaintiff's Motion to Remand. For the reasons that follow, the Motion will be granted.

I. BACKGROUND

The essential facts, as set forth in the Complaint, are as follows.² On November 10, 1994, Plaintiff was involved in a motor vehicle accident and, as a result, was evaluated that day at the Crozer Chester Medical Center Emergency Room. During that visit, it was determined that Plaintiff's blood pressure was elevated. The next day, Plaintiff went to the office of Defendant Dr. Edward Stankiewicz, where she was examined and subsequently determined to be suffering from post-traumatic sprains and strains of the body including the low back. Dr. Stankiewicz also diagnosed Plaintiff with malignant hypertension.

Plaintiff continued to see Dr. Stankiewicz and Defendant Physician Assistant Guiseppe A. Screnci for treatment of her low back and monitoring of her hypertension from November 11, 1994 until November 21, 1995. Following the motor vehicle accident,

² In determining whether this action should be remanded, the allegations in Plaintiff's complaint are accepted as true; Healthcare has denied any wrongdoing in this action.

Plaintiff also was seen by Defendant Dr. Lovell Harris, who continued to care for Plaintiff's blood pressure condition until November 16, 1995.

In May 1995, Plaintiff was a patient at Defendant Hospital where she underwent a lumbar myelogram at the direction of Dr. Stankiewicz. Subsequent to this procedure, Plaintiff continued to be seen by Dr. Stankiewicz and P.A. Screnci with reference to her low back discomfort and elevated blood pressure. On October 10, 1995, at Dr. Stankiewicz's request, Plaintiff was evaluated by a neurosurgeon for possible surgical management of her low back condition. That neurosurgeon concluded that a surgical decompression would not remedy Plaintiff's condition. However, subsequent to October 10, 1995, Dr. Stankiewicz referred Plaintiff to Defendant Dr. David Bosacco for evaluation of her low back condition. Dr. Bosacco recommended that Plaintiff undergo a lumbar laminectomy and spinal fusion as soon as possible. Thereafter, Plaintiff was given medical clearance for this procedure. (Compl. ¶¶ 36-38.)

On November 10, 1995, a pre-operative examination was performed on Plaintiff at Defendant Hospital. That examination revealed that Plaintiff had a positive history of hypertension. On November 16, 1995, the day the surgical procedure was performed on Plaintiff by Dr. Bosacco, a pre-operative check indicated that Plaintiff's blood pressure was elevated.

Nonetheless, Plaintiff was approved for anesthesia and surgery. Subsequent to the surgery, Plaintiff's blood pressure showed persistent elevations. Three days later, Drs. Bosacco and Stankiewicz, in conjunction with Defendant Drs. Hoey and Lim, and Defendant Hospital, requested that Plaintiff be discharged to a skilled nursing facility rather than to her home.

Between November 19 and 21, 1995, Plaintiff continued to have elevated blood pressure. Such elevated readings resulted in an order to refrain from discharging Plaintiff on November 20, 1995. The next day, because of a decrease in her blood pressure, Plaintiff was discharged to her home, despite a request made by Drs. Stankiewicz, Bosacco, Hoey and Lim to Healthcare and Defendant Dr. Elliot Geher, to arrange for a discharge program of medical care. That night, at approximately 11:30 p.m., Plaintiff returned to the Hospital with complaints of lethargy, right-sided weakness and inability to speak. Her blood pressure was elevated. Approximately one and one-half hours later, Plaintiff was admitted to the Hospital exhibiting generalized seizure activity. She subsequently was diagnosed as having suffered a cerebrovascular accident. (Compl. ¶¶ 50-52.)

Plaintiff's Complaint consists of seventeen counts for which she seeks damages resulting from the allegedly negligent medical care rendered to her by Defendant Healthcare, its agents

and ostensible agents.³ The determination central to this disposition is whether the Complaint is, in part, "as defendants see it, merely an ERISA claim for denial of benefits masquerading as a medical malpractice action, or, as plaintiff[] see[s] it, simply a state malpractice, negligence, . . . action that defendants cannot dress up as ERISA claims." Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., 958 F.Supp. 1137, 1138 (E.D.Va. 1997). If it is the former, the action will remain here; if it is the latter, the case must be remanded to the Court of Common Pleas of Philadelphia County.

³ Distilled to their simplest form, the Counts are as follows: Count I alleges that Defendant Hospital was negligent in failing to select and retain competent medical staff, in failing to treat and monitor the Plaintiff properly and to respond to her signs of increasing blood pressure, and in discharging Plaintiff to her home at a time when her medical care required supervision. Count II alleges that Dr. Bosacco was negligent in performing unnecessary surgery on Plaintiff, in failing to treat and monitor plaintiff properly and in failing to support Plaintiff's request for admittance to a skilled nursing facility when Healthcare denied it. Counts III, V, VII, and IX allege that Defendants Drs. Bosacco, Haughey, Kimless-Garber, and Nurse Trojak failed to secure informed consent from Plaintiff before the surgery on November 16, 1995. Counts IV and VIII allege that Defendants Drs. Haughey and Trojak also were negligent in their care and discharge of Plaintiff. Counts VI, X, XI, XII, XIII, XIV and XV all involve allegations that the remaining individual doctors failed adequately to treat, monitor and diagnose Plaintiff. Count XVI seeks to hold Defendant Healthcare liable for the alleged malpractice of its ostensible or actual agents. Count XVII seeks to hold Defendant Healthcare liable for its negligent selection, retention and supervision of certain treating physicians.

II. LEGAL STANDARD

Removability is determined from a plaintiff's pleadings at the time of removal. See American Fire & Casualty Co. v. Finn, 341 U.S. 6, 14 (1951). In general, a defendant may remove a civil action filed in state court if the federal court would have had original jurisdiction to hear the matter. 28 U.S.C. § 1441(b). The removing party bears the burden of establishing removal jurisdiction and compliance with all pertinent procedural requirements. Boyer v. Snap-On Tools Corp., 913 F.2d 108, 111 (3d Cir. 1990). If there has been a procedural defect or if the court determines that it lacks federal subject matter jurisdiction over the case, the federal court may remand the case to state court. 28 U.S.C. § 1447(c). Removal statutes are strictly construed and all doubts are resolved in favor of remand. See Batoff v. State Farm Ins. Co., 977 F.2d 848, 851 (3d Cir. 1992); Abels v. State Farm Fire & Casualty Co., 770 F.2d 26, 29 (3d Cir. 1985).

III. DISCUSSION

The primary basis for Removal asserted by Defendant Healthcare is that this Court has original jurisdiction over this action pursuant to 28 U.S.C.A. § 1331 and § 502(a)(1)(B) of

ERISA, 29 U.S.C.A. § 1132(a)(1)(B).⁴ Healthcare maintains that certain allegations regarding Plaintiff's discharge from Defendant Hospital to her home, rather than to a skilled nursing facility, raise a claim under § 502(a)(1) of ERISA, thus rendering the entire suit removable to federal court under 28 U.S.C.A. §§ 1441(a) and (c), the Court's supplemental jurisdiction under 28 U.S.C.A. § 1367, and the complete preemption doctrine.⁵ To determine whether these allegations state a claim which "arises under" federal law, and thus is removable, it is necessary to begin with the "well-pleaded complaint rule." See Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63 (1987).

⁴ A district court has original jurisdiction over any action "arising under the Constitution, laws, or treaties of the United States." 28 U.S.C.A. § 1331 (West 1993).

⁵ Title 28 U.S.C.A. §§ 1441 (a) and (c), state in relevant part, as follows:

(a) . . . any civil action brought in a State court of which the district court of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.

(c) Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 of this title is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters in which State law predominates.

A. The Well-Pleaded Complaint Rule

To determine whether a claim arises under federal law, a federal question must be presented on the face of the plaintiff's properly pleaded complaint. Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 9-12 (1983). A defendant cannot convert a plaintiff's state claim into a federal question solely on the basis of an asserted federal defense. See Caterpillar Inc. v. Williams, 482 U.S. 386, 393 (1987). "Even the defense of preemption is insufficient to permit removal to federal court." Lancaster, 958 F.Supp at 1143 (footnote omitted).

However, the Supreme Court has recognized an exception to the well-pleaded complaint rule. If a state law cause of action is completely preempted, it is recharacterized as a federal claim arising under federal law and is removable to federal court. See Metropolitan Life, 481 U.S. at 66-68. This exception, termed the "complete preemption" exception applies when

the pre-emptive force of the [federal statutory provision] is so powerful as to displace entirely any state cause of action [addressed by the federal statute]. Any such suit is purely a creature of federal law, notwithstanding the fact that state law would provide a cause of action in the absence of [the federal provision].

Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 354 (3d Cir. 1995) (citing Franchise Tax Bd., 463 U.S. at 23).

The complete preemption exception applies to state law causes of action that fit within the scope of § 502 of ERISA. Dukes, 57 F.3d at 354. Section 502(a)(1)(B) states in pertinent part, as follows:

- (a) Persons empowered to bring a civil action
A civil action may be brought --
 - (1) by a participant or beneficiary --
 - (A) . . .
 - (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C.A. § 1132(a)(1)(B). "State law claims which fall outside the scope of § 502, . . . are still governed by the well-pleaded complaint rule and, therefore, are not removable under the complete-preemption principles" Dukes, 57 F.3d at 355.⁶

⁶ In Dukes, the Court of Appeals for the Third Circuit ("Third Circuit") discusses in detail the relationship between § 514 of ERISA, which defines the scope of ERISA preemption and § 502, ERISA's civil enforcement provisions. Section 514 provides that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in [§ 4(a) of ERISA] and not exempt under [§ 4(b) of ERISA]." Dukes, 57 F.3d at 355. The Third Circuit instructs that

When the doctrine of complete preemption does not apply, but the plaintiff's state claim is arguably preempted under 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding preemption. It lacks power to do anything other than remand to the state court where the preemption issue can be addressed and resolved.

Id.

B. Application

Plaintiff's Motion does not dispute the fact that the health care benefits plan ("Plan") under which she received the treatment in question is an "employee benefit plan" within the meaning of ERISA § 514(a), 29 U.S.C.A. § 1144(a). See 29 U.S.C.A. § 1002(3). Plaintiff also does not contest Defendant's assertion that the "benefit" provided under the Plan is the provision of medical care, or that Healthcare's conduct in administering the Plan is subject to regulation under ERISA.⁷ Thus the determinative issue to be resolved by this Court is whether Plaintiff's well-pleaded Complaint is essentially a medical malpractice action, and thus concerned with the quality of benefits provided or if it is a suit "to recover benefits due . . . under the terms of [the] plan" and thus involves an issue of quantity of benefits received. 29 U.S.C.A. § 1132(a)(1)(B). If the state law claims focus on the "quality" of the medical benefits provided rather than the "quantity" of the medical benefits received, they fall outside the ambit of § 502(a)(1)(B), and are not completely preempted. See Dukes, 57 F.3d at 356-361

⁷ The only contested fact regarding the Plan is the name of Plaintiff's employer at the time the claim arose. However, both parties agree, and Plaintiff specifically alleges that "at all times relevant to the plaintiff's cause of action, the plaintiff, DIANE MILLER, was a member of the medical health plan of defendant, AETNA-US HEALTHCARE, INC." Thus, as Defendant Healthcare maintains, a determination of the precise name of the employer on whose behalf it administered the Plan is irrelevant to the resolution of the instant Motion.

(holding that claims which attack the quality of benefits provided are not completed preempted under § 502(a)(1)(B), whereas those claims which assert the withholding of "some quantum of plan benefits due" are completely preempted).

After carefully examining and attempting to construe fairly plaintiff's various allegations and claims, it is clear to the Court that this case is at heart, a case which attacks the quality of benefits provided, not the quantity of benefits received. As the United States Court of Appeals for the Third Circuit ("Third Circuit") stated in Dukes:

[The plaintiff's] claims, even when construed as U.S. Healthcare suggests, merely attack the quality of the benefits [] received: The plaintiff[] here simply do[es] not claim that the plan[] erroneously withheld benefits due. Nor do[es] [she] ask the state court[] to enforce [her] rights under the terms of [her] plan[] or to clarify [her] rights to future benefits. As a result, the plaintiff['s] claims fall outside the scope of § 502(a)(1)(B) and th[is] case[] must be remanded to the state court[] from which [it] w[as] removed.

Dukes, 37 F.3d at 356.

In its Motion in Opposition to Plaintiff's Motion to Remand, Healthcare focuses on those paragraphs of the Complaint that it contends contain sufficient "quantity" allegations to support complete preemption. Specifically, Healthcare directs the Court's attention to paragraphs 46 through 52 of the Complaint, which read as follows:⁸

⁸ Plaintiff's Complaint contains 136 allegations. Defendant Healthcare does not argue that the other 129 allegations raise a

46. On November 19, 1995, a request was made by BOSACCO, STANKIEWICZ, HOEY, LIM, and HOSPITAL that plaintiff, . . . , be admitted upon release from HOSPITAL to a skilled nursing facility as the plaintiff, . . . , was neither medically stable nor physically safe to be discharged from HOSPITAL to her home.

47. Between November 19 and November 21, 1995, the plaintiff, . . . , continued to have elevated blood pressure and was treated with various medications which were unable to reduce said blood pressure, and during said period, she was seen and evaluated by HOEY, LIM, STANKIEWICZ and BOSACCO as well as various nursing personnel of HOSPITAL.

48. On November 20, 1995, the plaintiff, . . . , was noted to have an elevated white blood cell count of 1400 and elevated blood pressure of 180/110 which resulted in the issuance of an order to refrain from discharging the plaintiff, . . . , on November 20, 1995.

49. On November 21, 1995 plaintiff, . . . , complained of feeling very light headed and unwell and blood pressure evaluations disclosed that her blood pressure was 170/110 requiring her to be discharged to home via a wheelchair.

50. On November 21, 1995, HEALTHCARE AND GEHR, prior to discharge, were contacted by LIM, HOEY, STANKIEWICZ, BOSACCO, and various nursing personnel of HOSPITAL to arrange for a discharge program of medical care for plaintiff, . . . , at which time it was determined that plaintiff, . . . , should be discharged to her home.

51. On November 21, 1995, at approximately 11:30 p.m. plaintiff, . . . , reappeared in the emergency room of HOSPITAL with complaints of lethargy, right sided weakness, and inability to speak. Blood pressure readings upon presentation were 200/117.

claim under § 502(a)(1)(B). Rather, Defendant maintains that the Court should exercise supplemental jurisdiction pursuant to 28 U.S.C.A. § 1367 over those claims which are beyond the scope of the Court's original jurisdiction.

52. On November 22, 1995, at approximately 1:00 a.m. plaintiff, . . . , was admitted to HOSPITAL exhibiting generalized seizure activity, and subsequently was diagnosed as having suffered a cerebrovascular accident with right hemiplegia and aphasia, left common carotid artery thrombosis, acute inferolateral myocardial infarction, seizure disorder, anemia, thrombocytopenia and history of hypertension.

Healthcare construes paragraphs 46-52 as allegations attacking an administrative decision to deny a benefit due Plaintiff under the Plan -- treatment at a skilled nursing facility. On this basis, Healthcare asserts that Plaintiff's claim falls within the scope of Section 502(a)(1)(B) of ERISA and is completely preempted. The Court disagrees.

While it is true that the allegations contained in paragraphs 46-52 display Plaintiff's dissatisfaction with the conditions of her release from Defendant Hospital, nowhere in the Complaint does Plaintiff state that skilled nursing care is a benefit due her under the Plan. In fact, except to the extent that Plaintiff alleges that at all times relevant to her causes of action she was a member of Healthcare's medical health plan, the Complaint is devoid of any mention of the nature of the Plan and its benefits. Furthermore, Plaintiff does not contend that her alleged injuries are due to Healthcare's failure to provide or pay for any such benefits under the Plan. Instead, the Complaint is replete with allegations that the quality of medical care Plaintiff received was inadequate and with allegations that

Healthcare should be held liable for such inadequacies under agency, ostensible agency and negligence principles.⁹

In a recent opinion of this Court, Hoose v. Jefferson Home Health Care, Inc., No. 97-7568 (E.D.Pa. February 6, 1998), the Honorable Charles R. Weiner, addressed a similar set of circumstances.¹⁰ In opposing plaintiff's motion to remand in

⁹ Healthcare directs the Court's attention to the "independent corollary to the well-pleaded complaint rule . . . [such that] a plaintiff may not defeat removal by omitting to plead necessary federal questions." Rivet v. Regions Bank of Louisiana, 118 S.Ct. 921, 925 (1998). The Court is mindful of this "independent corollary." However, a fair reading of the Complaint simply does not reveal that Plaintiff has so "artfully pleaded" her Complaint such that the Court will uphold removal even though no federal question appears on the face of the Complaint. Id.

¹⁰ Both parties also direct the Court's attention to another recent case in this District. The Court has read that opinion, Hoyt v. Edge, No.CIV.A. 97-3631, 1997 WL 356324 (E.D.Pa. June 20, 1997) (Shapiro, J.) and the cases cited therein, id. at *3, carefully. It is the Court's opinion that the instant case is more like Dukes, 57 F.3d 350, and Hoyt than Lazorko v. Pennsylvania Hospital, No. Civ.A. 95-cv-6151, 1996 WL 7992 (E.D.Pa.1997), and Pell v. Shmokler, No.CIV.A. 96-6002, 1997 WL 83743 (E.D.Pa.1997). As Judge Shapiro noted in Hoyt, "Lazorko's complaint alleged his wife sought medical treatment for three weeks following her hospital discharge but was refused. It also alleged, '[t]he minimal treatment received by Mrs. Lazorko shows either implied or express directives from U.S. Healthcare to the defendants not to give appropriate treatment.'" Hoyt, 1997 WL 356324, at *3 (citing Lazorko, 1996 WL 83743, at *3). In Pell, plaintiff claimed "her condition was exacerbated when her treating physician refused timely to refer her to a pulmonologist, at least in part because of [the HMO's] practice not to refer patients to specialists or for diagnostic testing." Id. (citing Pell at *4). In both Lazorko and Pell, the Court found that the plaintiffs' claims were completely preempted because those plaintiffs alleged an administrative decision to deny a benefit due under a plan. There simply is no such allegation in this case.

Hoose, Defendant United States Healthcare Systems of Pennsylvania, Inc. ("USH"), directed the Court's attention to an allegation in the Complaint that read

Despite the attempts by the physicians to transfer Mr. Hoose to a rehabilitation hospital, Defendant U.S. Healthcare refused to authorize transfer. Mr. Hoose, therefore, had to rely upon home nursing services for wound care and transfer training.

Id. at 6-7. USH argued that the above allegation constituted a claim that Plaintiff was denied a benefit due under his Plan -- transfer to a rehabilitation hospital, and thus came under § 502(a)(1)(B). Judge Weiner disagreed.

The opinion identified two reasons for its holding. First, the Court noted that the allegation Defendant relied upon for support appeared in the "factual background" portion of the complaint, rather than in the allegations that made up the many counts of the complaint. Although this Court does not find this factor dispositive, it is indeed compelling that nowhere in the twelve paragraphs that make up the two counts against Defendant Healthcare does Plaintiff assert benefits due her under the Plan. Specifically, nowhere in those allegations does Plaintiff even mention skilled nursing care, or the denial thereof. Second, Judge Weiner emphasized that in neither the allegation related above nor anywhere else in the complaint did plaintiff state that treatment at a rehabilitation hospital was a benefit due him under his plan or that U.S. Healthcare had denied him that

benefit. Judge Weiner made that determination despite the plaintiff's allegation that, "Defendant U.S. Healthcare refused to authorize transfer." In addition, in Hoose, the defendant also did not contend that treatment at a rehabilitation hospital was specifically provided under the plaintiff's plan. Although in the instant case Defendant does contend that treatment at a skilled nursing facility is a benefit due Plaintiff under the Plan, it remains the case that Plaintiff does not make any allegations which implicate the administrative denial of such a benefit.

In order for the Court to find that Plaintiff's allegations in this case fall within the scope of § 502(a)(1)(B), it must find that when properly construed, such allegations constitute a claim "to recover benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan." 29 U.S.C.A. § 1132(a)(1)(B). The allegations simply do not make such a claim.

Plaintiff does not seek to "recover," to "enforce," or to "clarify" benefits due. The thrust of Plaintiff's allegations surrounding her discharge from the hospital to her home in late November 1995, when fairly construed, is an attack on the quality of care that Plaintiff received subsequent to her November 1994 motor vehicle accident. In this lawsuit, she seeks compensation

for the malpractice she allegedly suffered. Since complete preemption, and hence removal jurisdiction, is absent where an ERISA plan beneficiary or participant challenges the soundness of a medical decision made during the course of treatment, rather than the administrative denial of a medical benefit due under a plan, there is no complete preemption in this case. Lancaster, 958 F.Supp. at 1145. Accordingly, this Court does not have jurisdiction over this action pursuant to 28 U.S.C.A. § 1331 and § 502(a)(1)(B) of ERISA, 29 U.S.C.A. § 1132(a)(1)(B).

C. Diversity Jurisdiction

In the alternative, Defendant Healthcare asserts that this case is removable to federal court on the basis of diversity, pursuant to 28 U.S.C.A. § 1332(a)(1).¹¹ Healthcare states and Plaintiff does not contest that there is complete diversity of citizenship among the parties and that the amount in controversy is in excess of \$75,000. Plaintiff maintains however, that because at least some of the Defendants in this case are citizens of Pennsylvania, e.g., Healthcare and Hospital, the state in

¹¹ 28 U.S.C.A. § 1332(a)(1) provides:

(a) The district courts shall have original jurisdiction of all civil actions where the matter in controversy exceeds the sum or value of [\$75,000], exclusive of interests or costs, and is between --

(1) citizens of different States

28 U.S.C.A. § 1332(a)(1) (as amended 1996).

which this action was brought, Defendants may not remove the action based on diversity.¹²

Plaintiff relies on the language of 28 U.S.C.A. § 1441(b) in support of this argument. Subsection (b) states:

Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties and interests properly joined and served as defendants is a citizen of the State in which such action is brought.

28 U.S.C.A. § 1441(b).

The generally accepted rationale for diversity jurisdiction is to protect the out-of-state party from local prejudice. See generally Boileau v. Bethlehem Steel Corp., 730 F.2d 929, 935 (3d Cir. 1984). That rationale is missing when the out-of-state party voluntarily chooses to sue in the state court of the defendant's home state. See Enviro-Gro Technologies v. Greeley & Hansen, 794 F.Supp. 558, 559 (E.D.Pa. 1992). It is to this end, that Congress limited the right of a defendant to remove a case originally brought by an out-of-state plaintiff in the state court in which the defendant is a citizen. See United States

¹² In her Motion to Remand, Plaintiff also asserts that removal on the basis of diversity jurisdiction was procedurally deficient because Defendant Healthcare did not secure consent for the Removal from all Defendants. Healthcare contests this assertion. However, since the Court finds that it would remand this case even if proper consent were secured, the Court need not resolve this issue.

Fidelity & Guaranty Co. v. Montgomery, 155 F. Supp. 657, 658 (E.D.Pa. 1957) ("The statute clearly indicates that a defendant, seeking federal jurisdiction on diversity grounds, can only have his case removed to the Federal Courts where he is a non-resident of the State wherein the action was brought").

In this case, Plaintiff, Diane Miller, is a citizen of Delaware. Defendant Healthcare is an HMO licensed to provide health care services in the Commonwealth of Pennsylvania. The Defendant nurse, the Defendant physician assistant, and all the Defendant doctors are licensed in the Commonwealth of Pennsylvania. Defendant Hospital is organized under the laws of the Commonwealth of Pennsylvania and is located therein.

Nonetheless, Defendant Healthcare asserts that "[w]hile it is true that 28 U.S.C.A. § 1441(b) requires that all defendants be citizens of a foreign state where removal is based solely on diversity, this requirement is procedural, not jurisdictional, and is deemed waived absent timely objection." (Def.'s Mot. in Opp. to Pl.'s Mot. to Remand at 12.) In support of this statement, Defendant cites In re Shell Oil Co., 932 F.2d 1518, 1522-23 (5th Cir. 1991). The Court agrees with Defendant that in In re Shell, the United States Court of Appeals for the Fifth Circuit ("Fifth Circuit") specifically held that improper removal under § 1441(b) is a waivable removal defect. While this Court reaches the same result, it is instructed as to this issue by the

analysis and conclusions of the Third Circuit in Korea Exchange Bank, New York Branch v. Trackwise Sales Corp., 66 F.3d 46, 50 (3d Cir. 1995).

In Korea Exchange Bank, the Third Circuit concluded that § 1441(b)'s bar against removal by a forum-state citizen is a "defect in removal procedure" pursuant to 28 U.S.C.A. § 1447(c).¹³ The Third Circuit instructed:

[A]n irregularity in removal of a case to federal court is to be considered jurisdictional only if the case could not initially have been filed in federal court. . . . The invocation of the removal machinery by a citizen of the forum state, while error, is not a jurisdictional defect under relevant Supreme Court precedent. Rather, it is a defect in removal procedure which can be waived.

Korea Exchange Bank, 66 F.3d at 50 (internal quotations omitted). Thus, a plaintiff who contests the removability of a case based on § 1441(b) must move to remand within 30 days after the filing of the notice of removal, or the defect will be deemed waived. Id. at 50-51.

In Korea Exchange Bank, the district court sua sponte issued an order summarily remanding the case to state court nearly eight months after Defendant had filed its notice of removal. In In re

¹³ Title 28 U.S.C.A. § 1447(c) provides:
A motion to remand the case on the basis of any defect in removal procedure must be made within 30 days after the filing of the notice of removal under section 1446(a). If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded.

Shell, the plaintiff failed to move to remand the improperly removed case within 30-days of the filing of the notice of removal. In each case, the respective Courts of Appeals held that the removal defect under § 1441(b) had been waived. Since the § 1441(b) defect did not deprive the district courts of jurisdiction, the Courts of Appeals ordered the remand orders be vacated.

In the instant case, the factual predicate that both the Third and Fifth Circuits relied on to find waiver and thus to vacate the district courts' orders, is missing. In this case, the Defendant does not argue and this Court does not find that Plaintiff's Motion to Remand was untimely. Defendant Healthcare filed its Notice of Removal on January 23, 1998. Plaintiff moved to remand on February 19, 1998, fewer than 30 days later. In that Motion, Plaintiff specifically contested the removability of this case based on 28 U.S.C.A. § 1441(b). Thus, Plaintiff's objection was timely under § 1447(c) and the "defect in removal procedure" was not waived.

Since the statute clearly indicates that a defendant seeking federal jurisdiction on diversity grounds in a case of removal can have the case removed to federal court only where "none of the parties and interests properly joined and served as defendants is a citizen of the State in which such action is brought," and because Plaintiff timely objected to removal on

this basis, diversity jurisdiction is an improper ground for removal in this case. 28 U.S.C.A. § 1441(b).

An appropriate Order follows.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DIANE MILLER,	:	CIVIL ACTION
	:	
Plaintiff	:	
	:	
v.	:	
	:	
RIDDLE MEMORIAL HOSPITAL,	:	
ET AL.,	:	
	:	
Defendants	:	NO. 98-392

O R D E R

AND NOW, this day of May, 1998, upon consideration of Defendant's Notice of Removal (Doc. No. 1), Plaintiff's Motion to Remand (Doc. No. 12), and Defendant's Response thereto (Doc. No. 14), it is **HEREBY ORDERED** that Plaintiff's Motion is **GRANTED**. The above-captioned case is **REMANDED** to the Court of Common Pleas of Philadelphia County.

BY THE COURT:

JOHN R. PADOVA, J.