IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GRENVILLE DIVISION

Paul A. Roberts, Plaintiff, v. Metropolitan Life Insurance Company, Defendant.	)	C.A. No. 6:18-cv-725-TMC **ORDER**

This case involves Plaintiff Paul A. Roberts' ("Roberts") claims for benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). (ECF Nos. 1 at 1; 19 at 1).[1] The dispute in this case centers on Defendant Metropolitan Life Insurance Company's ("MetLife") denial of long term disability ("LTD") insurance and 401(k) Disability Plan Protection ("401k") benefits under IBM Corporation's ("IBM") long term disability plan ("Plan"). (ECF No. 19 at 3).[2] Pending before the court are the parties' cross-motions for judgment. (ECF Nos. 21; 22). The parties filed replies (ECF Nos. 23; 24), and the matter is now ready for a ruling.

I. Factual and Procedural Background

Roberts suffers from chronic migraines, which began when he was a child and continued through college when he began experiencing photosensitivity with his migraines. (ECF No. 20-3 at 106). Since 2004, Roberts has been treated for migraines by Dr. Alan G. Finkel, a neurologist with the Carolina Headache Institute. (ECF Nos. 20-11 at 8; 22 at 7). Roberts was employed at IBM for more than eighteen years and was able to function relatively normally until 2010. (ECF

[1]Roberts also seeks attorney's fees pursuant to 29 U.S.C. § 1132 (g), and states he will file a separate motion for attorney's fees if he is successful. (ECF No. 22 at 35).

[2]This case was reassigned to the undersigned on March 13, 2019. (ECF No. 25).

No. 20-1 at 2). However, on September 18, 2010, he stopped working due to his intractable migraine headaches and bilateral occipital and nuchal or cervical pain, and he filed claims for Social Security ("SS") disability benefits and short term disability benefits with MetLife, which is the claims administrator for the Plan. *Id.* at 2-3; (ECF No. 20-10 at 68). Roberts was approved for SS disability on August 29, 2012. (ECF No. 20-10 at 60-68). Roberts was also approved for short term disability ("STD") under the Plan, and Roberts received STD benefits for six months. (ECF No. 20-17 at 89). When the STD benefits were exhausted, Roberts applied for LTD benefits under the Plan. (ECF Nos. 20-1 at 63; 20-17 at 89). Roberts was approved for and paid LTD benefits from March 19, 2011, until March 13, 2014, when MetLife notified Roberts that he no longer met the criteria for LTD benefits and that his LTD benefits would be terminated on April 12, 2014. (ECF Nos. 20-1 at 62; 20-15 at 96).

On January 6, 2014, MetLife asked Roberts to undergo an independent neuropsychological evaluation ("INE"). (ECF No. 20-11 at 81). Dr. E.J. Burgess, Psy.D., conducted the INE and issued a written report. (ECF No. 20-11 at 44-57).[3] In his report, Dr. Burgess diagnosed Roberts as suffering from a "conversion disorder, with mixed symptoms, persistent, with psychological/social stressors." *Id.* at 55. Based upon this information, MetLife terminated Roberts' LTD benefits on March 13, 2014. (ECF No. 20-11 at 23-26). Roberts appealed this decision (ECF No. 20-10 at 58), and in November 2014, MetLife reinstated Roberts' LTD benefits effective April 13, 2014, *id.* at 28. In the reinstatement letter, MetLife stated that, because Roberts had been diagnosed with a conversion disorder on January 24, 2014, his LTD benefits were subject to a maximum duration of twenty-four months. *Id.* Therefore,

[3]As Roberts notes (ECF No. 22 at 13), Dr. Burgess is not a medical doctor (ECF No. 20-11 at 44). Dr. Burgess does, however, have a doctorate in clinical psychology with a primary focus on neuropsychology and is board certified. (ECF No. 23 at 2).

MetLife informed Roberts that his maximum LTD benefits would be reached on January 23, 2016. *Id.*

After MetLife reversed its termination of LTD benefits, Roberts was treated by Drs. Steven Prakken and Richard Boortz-Marx and Nurse Practitioners Karen McCain and Emily Davis at Duke Medicine from May 27, 2014, to April 22, 2015. (ECF No. 20-2 at 100-11). MetLife summarizes the clinical notes from these Duke Medicine providers and states that "Roberts was able to: (1) run three to four miles, up to seven, every other day; (2) cycle the other days; (3) work out at the gym; (4) take care of his son who has special needs; (5) drive to perform errands and medical appointments; (6) remain functional and social; (7) get out of the house daily; and (8) take care of his elderly parents who live in his house." (ECF No. 21 at 15). Further, MetLife notes that the clinical notes state that Roberts had improved, his pain was tolerable, and that the medication prescribed helped control his pain. *Id.* at 16. On May 8, 2015, Duke Medicine called MetLife to advise that Dr. Prakken, Dr. Boortz-Marx, and McCain determined that there were no restrictions or limitations precluding Roberts from working and that they would not certify Roberts' disability. (ECF No. 20-8 at 64). On May 15, 2015, based on the foregoing and the evaluation by Dr. Burgess, MetLife again terminated Roberts' LTD benefits finding that he no longer met the definition of disability under the Plan. *Id.* at 63-65. On November 17, 2015, Roberts appealed this decision. *Id.* at 53-56.

On March 7, 2016, MetLife submitted Roberts' claim and file for a peer review by an Independent Physician Consultant ("IPC"), Dr. David Hoenig, a board certified neurologist. (ECF No. 20-2 at 91-111). In his report, Dr. Hoenig opined:

> Based on the documentation provided and from a neurological and pain medicine perspective only, the medical information does not support functional limitations due to a physical condition or combination of physical conditions as of May 16, 2015. It is acknowledged that the claimant has neck pain and headaches. However, there was no documentation of any neurological deficits or any significant cervical pathology on examination. There was no documentation of

> any diagnostic examination that demonstrated any significant pathology that would explain the claimant's worsening headaches, including laboratory studies, lumbar puncture, MRI, MRA and MRV. Although the claimant stated that he has a headache every day, there was documentation that he was able to run up to four miles without an exacerbation of pain, and he was able to take care of his child. There was documentation of mental health pathology. There was also documentation of a neuropsychological evaluation in which it was noted that the claimant had a persistent somatoform pain disorder and he was unaware of the related conversion phenomena. It is possible that his mental health condition may be a factor in his current clinical status, but this is beyond the scope of a neurological and pain medicine perspective.

Id. at 105. MetLife sent Dr. Hoenig's report to Roberts' doctors and requested comments by March 30, 2016. (ECF No. 20-1 at 4-5). Thereafter, Roberts submitted a March 2016 psychosocial evaluation from Dr. Miriam Feliu with the Duke University Pain Clinic and two letters from Dr. Finkel one dated March 30, 2016, and the other dated April 7, 2016. (ECF Nos. 20-2 at 37-38, 84-85; 20-3 at 105-27). Dr. Hoenig attempted to speak with Dr. Finkel. (ECF No. 20-1 at 84). However, his messages were not returned. *Id.* In subsequent advisory reports, Dr. Hoenig stated that this additional documentation did not change his prior opinion. (ECF Nos. 20-1 at 83-85; 20-2 at 43).

On May 3, 2016, MetLife denied Roberts' appeal and upheld the termination of the LTD benefits. (ECF No. 20-1 at 16-21). In its final decision denying Roberts LTD benefits, although MetLife acknowledged that Roberts suffers from neck pain and headaches, MetLife stated that there were no neurological deficits or significant cervical pathology, and no restrictions or limitations were identified. *Id.* at 19. MetLife concluded that Roberts did not meet the Plan's definition of disability because the clinical evidence in Roberts' medical records did not establish that his conditions would cause restrictions and limitations that would prevent him from working. *Id.* at 16. On March 16, 2018, Roberts filed this action. (ECF No. 1).

II. Standard of Review

Before addressing the merits, the court must determine the appropriate standard of review. The parties have stipulated that the Plan contains language which confers discretionary authority on MetLife. (ECF No. 19 at 1-2). Accordingly, the parties contend that the proper standard of review is under the abuse of discretion standard. (ECF No. 21 at 11; 22 at 2-3). The court agrees.

It is well-settled that a denial of benefits under § 1132(a)(1)(B) is to be reviewed de novo in the district court unless "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case the standard of review is abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *see also Feder v. Paul Revere Life Ins. Co.*, 228 F.3d 518, 522–23 (4th Cir. 2009) (abuse of discretion review warranted only when plan "vest[s] in its administrators discretion either to settle disputed eligibility question or construe doubtful provisions of the Plan."). Here, the Plan provides:

> In carrying out their respective responsibilities under the LTD Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the LTD Plan and to determine eligibility for and entitlement to LTD Plan benefits in accordance with the terms of the LTD Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(ECF No. 20-18 at 663). The court finds that the language in the policy granted discretion to the claims fiduciary to interpret the terms of the Plan and determine eligibility for benefits. Accordingly, the appropriate standard of review is whether MetLife abused its discretion in denying Roberts' claim.

III. Discussion

MetLife contends that the denial of LTD benefits was not an abuse of discretion because Roberts failed to establish that he was unable to perform any gainful occupation after May 15, 2015. (ECF No. 21 at 12). Further, MetLife argues that it had advised Roberts that "there were no clinical exam findings nor restrictions or limitations that continued to support an impairment that would preclude Roberts from performing the duties of any occupation." *Id.* MetLife argues that the Plan places the responsibility on Roberts to prove that he is disabled, and that Roberts failed to satisfy his burden. (ECF No. 21 at 16).

MetLife states that it reviewed clinical notes from Duke Medicine, and these notes established that Roberts was able to: "(1) run three to four miles, up to seven, every other day; (2) cycle the other days; (3) work out at the gym; (4) take care of his son who has special needs; (5) drive to perform errands and medical appointments; (6) remain functional and social; (7) get out of the house daily; and (8) take care of his elderly parents who live in his house." (ECF No. 21 at 15) (citing ECF Nos. 20-9 at 17-58; 20-10 at 87-89). In addition, MetLife argues that "the clinical notes state that Roberts had improved, his pain was tolerable, and that the medication prescribed helped control his pain." *Id.* at 16. MetLife notes that Roberts suffered no neurological deficits, pain pathology was not demonstrated, and the MRI had no significant findings. *Id.* (citing ECF Nos. 20-2 at 100-11; 20-8 at 84).

Roberts argues that MetLife's decision was an abuse of its discretionary authority. Roberts contends that the evidence in the record demonstrates that he meets the definition of disability as set forth in the Plan, the approval of benefits for him would meet the purpose and goals of the Plan, and MetLife's decision-making process was not reasoned and principled. (ECF No. 22 at 19-20). Specifically, Roberts argues that MetLife did not give appropriate consideration or analysis to the SS Administration's approval of Roberts' claim (ECF No. 21 at

20). Roberts contends that MetLife merely inserted the following rote language into its final denial letter:

> However, Social Security Administration's (SSA) determination is separate from and governed by different standard than MetLife's review and determination pursuant to the terms of your employer's plan. MetLife initially approved your claim for benefits for the same time period for which the SSA approved benefits. However, we have updated medical records for which Social Security did not have; we determined this information does not provide clinical evidence supporting continued impairment as described above.

Id. at 21 (citing ECF No. 20-1 at 6). Moreover, Roberts argues that MetLife failed to properly analyze how Roberts' symptoms of headaches and pain limit his abilities. *Id.* at 24-25. He contends that it is unreasonable to require that he produce objective tests or other evidence demonstrating his pain and chronic headaches, and such requirements are "perhaps impossible" to meet and not required by the Plan. *Id.* at 26-27. Roberts also argues that MetLife has not set forth any jobs that he could perform. *Id.* at 30. Further, Roberts notes that, after paying Roberts benefits for over four years, MetLife has not identified any change in his medical condition that would provide a basis for a denial. *Id.* at 33. Finally, Roberts contends that MetLife's conflict of interest should be considered in reviewing the denial of LTD benefits. *Id.* at 34.

As determined above, the appropriate standard of review in this case is the abuse of discretion standard. Under the abuse of discretion standard, the court will uphold the administrator's decision so long as it was reasonable. *Ellis v. Metro. Life. Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997); *see also Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan*, 201 F.3d 335, 344 (4th Cir. 2000) (holding that even when an ERISA plan gives an administrator broad discretion to interpret plan language, the court "will enforce the administrator's decisions only if they are reasonable"). In general, a reviewing court should not find an abuse of discretion where the plan administrator's decision is reasonable, "even if the court itself would have reached a different conclusion." *Booth*, 201 F.3d at 340.

To find the decision reasonable, the court must find that it resulted from a "deliberate, principled reasoning process." *Guthrie v. Nat'l Rural Elec. Coop. Assoc. Long Term Disability Plan*, 509 F.3d 644, 651 (4th Cir. 2007). In assessing reasonableness, the court is guided by eight nonexclusive factors:

> (1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary's interpretation was consistent with other provisions in the plan and with earlier interpretations of the plan; (5) whether the decisionmaking process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary's motives and any conflict of interest it may have.

Champion v. Black & Decker Inc., 550 F.3d 353, 359 (4th Cir. 2008) (quoting *Booth*, 201 F.3d at 342-43)). "All eight *Booth* factors need not be," and may not be, "in play" in a given case. *Helton v. AT&T, Inc.*, 709 F.3d 343, 357 (4th Cir. 2013). Moreover, the Fourth Circuit Court of Appeals has held that "the *Booth* factors as more particularized statements of the elements that constitute a 'deliberate, principled reasoning process' and 'substantial evidence.'" *Donnell v. Metro. Life Ins. Co.*, 165 Fed. App'x 288, 294 n.6 (4th Cir. 2006) (unpublished) (citations omitted). Substantial evidence, which "consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance," is evidence that "a reasoning mind would accept as sufficient to support a particular conclusion." *Whitley v. Hartford Life & Accident Ins. Co.*, 262 F. App'x 546, 551 (4th Cir. 2008) (quoting *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1966)) (internal quotation marks omitted).

First, the court turns to the language of the Plan, which provides:

> Under the Long-Term Disability Plan, "disabled" means that during the elimination period and the first 12 months after you complete the elimination period, you cannot perform the important duties of your regular job with IBM because of a sickness or injury. After expiration of that 12 month period, disabled means that, because of a sickness or injury, you cannot perform the important duties of any other gainful occupation for which you are reasonably fit by your

> education, training or experience. You must be under the appropriate care and treatment of a physician on a continuing basis. At your own expense, proof of disability, satisfactory to MetLife, must be submitted to MetLife. "Your regular job at IBM" means the essential functions you regularly perform at IBM that provide your primary source of income.

(ECF No. 19 at 2).[4] As more than twelve months have elapsed, MetLife argues that "disabled" in this case means that, because of a sickness or injury, a person "is unable to perform the important duties of 'any other gainful employment occupation' under the Plan." (ECF No. 21 at 4).

The court finds it important to note that many LTD policies specifically limit benefits after a certain time period when the condition causing the disability cannot be verified or is based on subjective or self-reported symptoms. *See, e.g., Huberts v. ATA Holdings Corp. Welfare Benefit Plan*, No. 1:07-cv-287, 2008 WL 687127, at *4 (S.D. Ind. Mar. 10, 2008) (plan at issue provided for only limited disability benefits for disabilities "primarily based on self-reported symptoms."); *Rupert v. Prudential Ins. Co.*, 2006 WL 910405, at *11 (M.D. Pa. Apr. 7, 2006) (finding that insurer's interpretation of its policy language and its application of a limitation was reasonable where the plan at issue contained a twenty-four month limitation for conditions based on self-reported symptoms and plaintiff's claim was based on self-reported symptomology, namely headaches and depression). Here, the limitation provides that after twelve months, a claimant must be unable to perform any occupation. It is silent as to non-verifiable symptoms or subjective or self-reported symptoms. Where the plan documents do not

[4]The definition of "disabled" for the 401(k) Disability Program and the IBM LTD lan are the same. (ECF No. 19 at 3).

provide a procedure for dealing with disability claims based on subjective complaints of pain, a plan administrator employing a principled reasoning process need not simply accept subjective complaints of pain without question, especially if there is other conflicting evidence in the record. *See DuPerry v. Life Ins. Co. of N. Am.*, 632 F.3d 860, 875 (4th Cir. 2011) (noting that the district court derived this common sense interpretation of the plan language). Neither, however, in such a situation, can a plan administrator simply dismiss subjective complaints of pain, especially where there is objective medical proof of a condition that could cause such pain. *Id.* Moreover, "a diagnosis that 'turns on subjective information' is not necessarily 'less debilitating' and does not give 'a plan administrator unbridled discretion to deny such claims.'" *Laser v. Provident Life & Accident Ins.*, 211 F. Supp. 2d 645, 656 (D. Md. 2002) (citations omitted)).

In its final decision denying Roberts LTD benefits, MetLife repeatedly acknowledged that Roberts suffers from neck pain and headaches. (ECF No. 20-1 at 18,19, 20, 21). However, MetLife stated that there were no neurological deficits or significant cervical pathology, and no restrictions or limitations were identified. *Id.* at 19. MetLife determined that Roberts did not meet the Plan's definition of disability because the clinical evidence in Roberts' medical records did not establish that his conditions would cause restrictions and limitations that would prevent him from working. *Id.* at 16. Additionally, MetLife stated it discounted Roberts' complaints based, in part, on Roberts statements that he is able to run without exacerbation and that he takes care of his disabled son. *Id.* at 19. Finally, MetLife concluded that "the medical information provided for the time period in question did not establish a severity in a physical condition(s) that would have prevented [Roberts] from working as of May 16, 2015, forward." *Id.* at 21.

Here, the fact that the an MRI or other tests did not find any abnormalities only rules out certain causes of migraines; it does not conclusively establish whether someone has migraines or not. Due to the subjective nature of migraines, Roberts submitted the best evidence that he could to prove his condition. *See DuPerry*, 632 F.3d at 873 (noting that plaintiff, who had fibromyalgia, "produced the only types of evidence a claimant in her situation could produce, her own description of the severity of her subjective symptoms, videos showing how she moved in her condition, and her treating physicians' opinions that the pain and fatigue rendered her unable to work."). As for restrictions and limitations, Roberts' treating physician, Dr. Finkel, has noted numerous times in his treatment notes that pain limits Roberts' functioning and Roberts is disabled. (ECF Nos. 20-2 at 85; 20-11 at 8, 13).

The evaluation of and weight to be given to subjective evidence is largely dependent on the circumstances of a particular case.[5] Several courts have rejected the argument that it is unreasonable for an insurer to deny a claim based on a lack of objective medical evidence of total disability where the plan does not explicitly require such proof. *See, e.g., Fitzpatrick v. Bayer Corp.*, No. 04-cv-5134-RJS, 2008 WL 169318, at *10 (S.D.N.Y. Jan. 17, 2008) (listing cases where courts found objective medical evidence requirement not unreasonable). However, other courts have held that such a requirement may be unreasonable in the context of a particular

[5]MetLife cites several cases which it contends support its proposition that the phrase "satisfactory proof" of disability establishes an objective standard. (ECF No. 21 at 14-15). However, in those cases the issue was whether the phrase gave the plan administrator discretionary authority. *See, e.g., Feder v. Paul Revere Life, Ins.*, 228 F.3d 518, 523 (4th Cir. 2000). Here, the court is addressing whether MetLife abused its discretion by requiring objective medical evidence.

case. *See, e.g., Oliver v. Coca Cola Co.*, 497 F.3d 1181, 1195-99 (11th Cir.) (holding that administrator was arbitrary and capricious in requiring objective evidence of pain where the plan did not specifically require such evidence or exclude coverage for pain related disabilities), *vacated in part on other grounds by* 506 F.3d 1316 (2007) (per curiam); *Sarchet v. Chater*, 78 F.3d 305, 306 (7th Cir. 1996) (in light of claimant's fibromyalgia and chronic fatigue syndrome diagnoses, where there are no objective tests which can confirm these diseases, the claimant has furnished sufficient proof to establish total disability).

Here, MetLife specifically acknowledged Roberts migraines and pain, but then stated that "there was no documentation of any neurological deficits or any significant cervical pathology on examination." (ECF No. 20-1 at 19). Further, MetLife stated that "[t]here was no documentation of any diagnostic examination that demonstrates any significant pathology that would explain worsening headaches, including lab studies, lumbar puncture, MRI, MRA, MRV." *Id.*[6] MetLife has not pointed to any language in the Plan limiting proof to only objective data. Therefore, considering the language of the Plan and Roberts' specific diagnoses, by denying Roberts' claim on the ground that he had not provided objective evidence of his pain, despite his submission of medical reports from multiple physicians stating that his reports of pain were consistent with their diagnoses and that Roberts did not appear to be malingering, (ECF No. 20-11 at 57), MetLife engaged in capricious decision making.

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[6]MetLife then notes that Roberts was "able to run without an exacerbation of pain, and [was] able to take care of [his] child." (ECF No. 20-1 at19). Roberts explained that physical activity, such as running, sometimes can alleviate pain and that often he is unable to run because of the pain, (ECF No. 20-8 at 59-60), and he had assistance with the care of his disabled child.

MetLife also argues that it relied on the opinion Dr. Hoenig, who independently reviewed Roberts' medical records. In doing so, however, MetLife disregarded the opinion of Roberts' treating physicians on the severity of Roberts' condition and his inability to work. It is now well-settled that a plan administrator is generally entitled to rely on the recommendation of a consulting physician, even when it is in conflict with the opinion of a claimant's treating physician. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003); *Sheppard & Enoch Pratt Hosp. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994). Nonetheless, a plan administrator "may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Nord*, 538 U.S. at 834. While Dr. Hoenig never personally examined Roberts, Dr. Finkel has been treating Roberts for over a decade. Dr. Finkel is a specialist in the relevant field of neurologic disorders, which migraines are classified under, and he has consistently concluded that Roberts is disabled by his chronic and intractable migraines. Interestingly, in its reply to Roberts' memorandum in support of judgment, MetLife stated that it had previously "accepted Roberts' medical documents from [Dr. Finkel] and his diagnosis of disability as true." (ECF No. 23 at 2). The court finds MetLife's ultimate conclusion and its reliance on Dr. Hoenig's opinion which contradicts Roberts' treating physician "are unreasonable given the absence of contradictory medical evidence and the extent of [Roberts'] disability revealed in [his] medical records and supported by [his] physicians' observations and opinions." *Boyd v. Liberty Life Assurance of Boston*, 362 F. Supp.2d 660, 669 (W.D.N.C. Mar. 11, 2005).

Roberts also contends that MetLife did not properly consider the SS Administration's determination that he is disabled. (ECF No. 21 at 20). The fact that a plaintiff qualifies for SS disability benefits does not mean that a plaintiff qualifies for LTD benefits under ERISA. *Smith v. Cont'l Cas. Co.*, 369 F.3d 412, 420 (4th Cir. 2004) (noting that "what qualifies as a disability for social security disability purposes does not necessarily qualify as a disability for purposes of an ERISA benefit plan"). Although a plaintiff's qualification for SS disability benefits does not render a decision to deny benefits unreasonable, *see Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607 (4th Cir. 1999), it is something this court may consider when determining the reasonableness of the denial of benefits. Here, MetLife contends that its determination to discount the SS Administration's disability finding was based on its consideration of updated medical records that were not available at the time the SS Administration made its disability determination. (ECF No. 21 at 21). While this may be true, MetLife never reviewed the medical records Roberts submitted in support of his SS claim and has not identified what has changed since Roberts was awarded SS benefits, which weighs against finding MetLife's decision to deny benefits reasonable.

Finally, the court turns to Roberts' argument that MetLife is operating under a conflict of interest. A conflict of interest exists when the administrator has a "dual role," such that it "both determines whether an employee is eligible for benefits and pays benefits out of its own pocket." *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 108 (2008). In *Glenn*, the Supreme Court clarified that the presence of a plan administrator's conflict of interest does not alter the abuse of discretion standard of review for benefits decisions. *Glenn*, 554 U.S. 105, 115 (2008). The presence of such a conflict is "but one factor among many that a reviewing judge must take into

account." . . . In particular, the Supreme Court counselled that the conflict of interest should not itself lead to "special burden-of-proof rules, or other special procedural or evidentiary rules." *Williams*, 609 F.3d at 630-31 (citation omitted) (quoting *Glenn*, 554 U.S. at 116).

While a conflict of interest arguably exists, there is no evidence that MetLife improperly denied Roberts' claim or that the denial was based on a desire to materially benefit the company, in direct contravention of MetLife's fiduciary responsibilities. Therefore, ultimately, the court has determined that "[n]o weight [should be] given to a conflict in the absence of any evidence that the conflict actually affected the administrator's decision." *Durakovic v. Bldg. Serv. 32 BJ Pension Fund*, 609 F.3d 133, 140 (2nd Cir. 2010). Moreover, as other courts have noted, MetLife's decision to award at least some benefits rather than deny benefits entirely "manifest[s] an approach demonstrating an unbiased interest that favor[s the claim applicant], making the conflict factor less important (perhaps to the vanishing point)." *Champion v. Black & Decker (U.S.) Inc*., 550 F.3d 353, 362 (4th Cir. 2008) (internal quotations and citation omitted).

In sum, examining the applicable *Booth* factors in light of the evidence, the court concludes that MetLife abused its discretion and acted unreasonably in denying Roberts' claim. When a plan administrator has abused its discretion, a district court may either reverse the decision or remand it to the administrator for further review. *See DuPerry v. Life Ins. of North America*, 632 F.3d 860, 875-76 (4th Cir. 2011). "[R]emand is not required, particularly in cases in which evidence shows that the administrator abused its discretion." *Helton v. AT&T Inc.*, 709 F.3d 343, 360 (4th Cir. 2013); *Weaver v. Phoenix Home Life Mut. Ins. Co.*, 990 F.2d 154, 159

(4th Cir. 1993) ("[A] remand for further action is unnecessary here because the evidence clearly shows that [the administrator] abused its discretion.").

V. Conclusion

Accordingly, based on the foregoing, the denial of benefits is **REVERSED** and judgment is **GRANTED** to Plaintiff.

IT IS SO ORDERED.

s/ Timothy M. Cain
United States District Judge

September 3, 2019
Anderson, South Carolina